TRANSCRIPT OF PROCEEDINGS

IN THE SUPERIOR COURT FOR THE DISTRICT OF COLUMBIA

CIVIL DIVISION

MARIAH KELLER, Plaintiff, v. CYTOLOGY SERVICES OF MARYLAND, INC., et al., Defendants.	:	Civil Action No. 01CA008316

Deposition of JAMES F. BARTER, M.D.

Pages 1 through 91

Washington, D. C.
April 22, 2003

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SUPERIOR COURT OF THE DISTRICT OF COLUMBIA

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MARIAH KELLER, Plaintiff, vs. CYTOLOGY SERVICES OF MARYLAND INC., et al., Defendants.	Civil Action No. 01CA008316

Washington, D.C.
Tuesday, April 22, 2003

The deposition of JAMES F. BARTER, M.D., called for examination by counsel for Plaintiff in the above-entitled matter, pursuant to Notice, at Sibley Memorial Hospital, Hayes Hall Conference Room 1, Washington, D.C., convened at 6:14 p.m, before Alice Toigo, a notary public in and for the District of Columbia, when present on behalf of the parties:

APPEARANCES:

On Behalf of the Plaintiff:

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On Behalf of the Defendant, Cytology Services of Maryland, Inc.:

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C O N T E N T S

EXHIBITS

P R O C E E D I N G S

[Barter Deposition Exhibit 1 was marked for identification.]

Whereupon,

JAMES F. BARTER, M.D.

was called as a witness and, having been first duly sworn by the Notary Public, was examined and testified as follows:

EXAMINATION BY COUNSEL FOR PLAINTIFF

BY MS. EVANS:

Q Would you give us your full name, please.

A James. F. Barter.

Q Dr. Barter, I am Karen Evans. I am going to be taking your deposition today. You will need to give verbal responses, yes or no instead of nods of head, because, believe it or not, she writes down "Nods head," and we never know whether that is a yes or a no.

A Okay.

Q Have you had your deposition taken before?

A Yes.

Q How many times?

A It would be hard to estimate. I get deposed once or twice a year. That has been over the last five years. Then, prior to that, it had been maybe once a year going back to about seven or eight years ago.

Q So, for the past twelve years, you have been deposed at least once a year?

A I would say maybe ten.

Q Let me have your home and business address, please.

Q The home address is 5968 Searl Terrace, Bethesda, Maryland 20816. Our business address is that, if you wanted to--

Q You can just tell us.

A It is 9715 Medical Center Drive, Suite 230, Rockville, Maryland 20850.

Q What is the name of the facility that you work with?

A I work now in a group called Women's Health Specialists.

Q That is the card you gave me?

A Yes.

Q What address is this, this 9715 Medical Center Drive?.

A That is our main office.

Q What does the A stand for?

A It is just an insignia.

Q You said that the address at 9715 Medical Center Drive is the main office?

A Yes.

Q Is that where you spend the bulk of your time?

A I am there one day a week. I see patients in this building one day a week.

Q This building being?

A Hayes Hall. We sublet an office. Then I am in the operating room the rest of the days.

Q You say you spend one day at the main office address in Rockville and then one day here at Hayes Hall near Sibley. Is it part of Sibley?

A It is part of Sibley.

Q Then the other three days you are in the OR?

A Yes.

Q Is that at Georgetown?

A It could be Georgetown, Sibley, Suburban, Arlington, a number of hospitals.

Q What is your area of specialty?

A I am a GYN-oncologist.

Q So when you are in the OR, you are doing what kind of procedures?

A Surgical procedures in the pelvis.

Q Do you remove cancers?

A Yes, or sometimes benign problems as well.

Q Is any part of your practice dedicated to just regular routine GYN patients?.

A It is very, very small. I do have some patients that I do routine GYN, but most people get referred with a problem.

Q What percent of patients would be like routine GYN?

A 1 or 2 percent.

Q So the patients that you see in Rockville and here at Sibley, those are patients who have some sort of problem in their pelvic area?

A Yes.

Q I was provided with a copy of your curriculum vitae.

MS. EVANS: Let's have this marked as Exhibit No. 2.

[Barter Deposition Exhibit 2 was marked for identification.]

BY MS. EVANS:

Q Can you look at that and tell me if it is current and up to date?

A This is updated except for the change in my business address.

Q I also notice that it said, "Hospital Appointments, D.C. General."

A That is defunct.

Q Let me show you that page of your C.V. Is everything else current?

A The hospitals on that page; yes.

Q Have you written any papers relating to the diagnosis or treatment of cervical cancer that are not listed here in your C.V.?

A No.

Q Your C.V. indicates that you have a faculty appointment at the Lombardy Cancer Center.

A Yes.

Q It also says you are associate professor of obstetrics and gynecology.

Q I was. I was a full professor. Now I am a clinical professor.

Q How should this read?

A This should be--Associate Professor should have an end date on there.

Q What would be the end date?

A Do you have the next page? I don't remember when I was full professor. That needs to be updated. I was a full professor two or three years ago, three years ago.

Q Two or three years ago would be 2000?

A It was right at the time that MedStar came into Georgetown. I think that was about three years ago.

Q So that would have been 2000?

A Yes.

Q So you are a full professor of obstetrics and gynecology.

A Yes.

Q What about your appointment at Lombardy Cancer Center. Do you still hold that?

A I guess as a clinical professor, I would. I don't know if I still have an appointment at Lombardy, per se.

Q What type of professor; is it associate? What is it called? Is it just professor of obstetrics and gynecology?

A Well, GYN-Oncology.

Q What do you do in that capacity?

A What I did at Georgetown was basically clinical practice, saw patients, when I was on the faculty at Georgetown. I just left February 1.

Q There we go. That bridged the gap for me.

A Sorry. What I did there was basically saw patients, took care of patients.

Q You left February of this year. So now do you have any academic responsibilities anywhere?

A No.

Q And you are not sure if you still hold a clinical faculty appointment at the Lombardy Cancer Center?

A I don't think that I have a faculty affiliation with Lombardy. I still am a clinical professor in GYN-Oncology through the Department of OB-GYN. But I think to have an appointment at Lombardy, you have to be full time. And I am not.

Q You said you are clinical professor at Georgetown.

A Yes.

Q What do you do in that capacity?

A Basically, I bring patients there and do surgery at Georgetown, admit them in the hospital for problems and teach the residents through that mechanism.

Q Oh, okay. You are an attending to the residents there?

A Yes.

Q That are going through Georgetown?

A Yes.

Q So you don't have any teaching

responsibilities. You are no longer teaching classes and things of that nature.

A No.

Q Do you still hold licensures in all of these places; Kentucky, North Carolina, Alabama, Maryland, Virginia, D.C.?

A Just in Maryland, Virginia and D.C. The others were with training.

Q November, '97, there is an award here; First Place Scientific Presentations, Advisor, Georgetown University, Resident Research Presentations, "AGUS " Pap Smears. Was that ever reduced to writing?

A Unfortunately, it was never published.

Q That doesn't answer my question. Was it ever reduced to writing? Was there a written something?

A No; there wasn't an article associated with it. It was just a presentation.

Q An oral presentation?

A Yes.

Q I am going to ask you about two of the

abstracts here. No. 4; was that a writing?

A There is an article that is associated with that in my C.V.

Q Can you tell me which one? And do the same thing with No. 5, if there is an article associated with it.

A That actually would be same article. They were different presentations but the same article came out of that. That is Article 16.

Q What about No. 15 here, an abstract. Was that reduced to a writing, an article of some sort?

A Yes.

Q Which one is that?

A It was No. 15; oh, that is the presentations. It was in GYN-Oncology. I don't see that on my bibliography.

Q Do you know what year?

A In the early '90's.

Q That was No. 15?

A On the presentations; yes.

Q I see that there are two additional presentations, 28 and 29. I think they appear to

be the same.

A Yes; it is just that they are presented at different places.

Q They are nice places, by the way. Was there a writing, an article, that came out of these?

A That should be in the bibliography. But it doesn't appear in the bibliography.

Q Do you know where it was published?

A Again, in GYN-Oncology. Dr. Barnes was the lead author on that.

Q Would the title be the same as the presentation?

A Yes.

Q What year was that; '92 or '93?

A Yes. It would have been a couple of years after that.

Q No. 38; was that presentation written up in an article?

A No; that was not written. That was just a presentation.

Q Would that have to do with that award? Is

this the one, the Residents Award?

A If I am not mistaken, it is different. I think it was different than the presentation that won the award.

Q What was this seminar about? What is the clinical significance of the "AGUS" pap smear?

A This was, as I recall, just a presentation that the resident did and looked back at the AGUS experience at Georgetown at that time.

Q There was no writing out of that?

A No.

Q Do you remember what the experience was at Georgetown?

A Not specifically, no.

Q Generally, what do you remember?

A That AGUS can be associated with dysplasia.

Q Let me show you the articles here and your book chapters. Can you just circle for me the ones that are related to the issues in this case; in other words, if they have something to do with cervical cancer, just circle them for me.

A Anything to do with cervix cancer?

Q Yes.

A [Marking document.] These are the ones that are related to cervix cancer.

Q Did you do the non-peer review and the book chapters?

A Yes.

Q You are board-certified in what area?

A OB-GYN and GYN-oncology.

Q Did you pass your board certification in both areas the first time?

A Yes.

Q Is it two parts, written and oral?

A Yes.

Q You passed both the written and the oral portion of the first attempt?

A Yes.

Q You told me earlier that you were at GYN-oncologist. Within that field of specialty, do you have any special interests?

A Not per se; no.

Q The reason I ask is because I notice that

there were a lot of articles, or at least more than one article, about Groshong catheters and washings.

A It is a potpourri. There is not one specific area. It is a lot of different things in GYN-oncology and GYN-surgery.

Q Has your license ever been revoked or suspended?

A No.

Q You told me earlier about the publications. You had some articles that were published in I think GYN-Oncology.

A Yes.

Q Do you consider that an authoritative or reliable source?

MR. VERNICK: Let me object. Do you mean whatever is published in there at any point in time?

THE WITNESS: No; I don't consider it authoritative.

BY MS. EVANS:

Q Is it a good reference source, that publication?

MR. VERNICK: Let me object to what you mean by "good reference source?"

THE WITNESS: There is good information in all of the periodicals.

BY MS. EVANS:

Q Are you on the boards of any particular journals?

A No.

Q Did you used to be at one time on the editorial board?

A No.

Q You have written numerous publications in GYN-Oncology.

A A fair amount; yes.

Q That is a peer-reviewed publication?

A Yes.

Q Does that make it more reliable because it is a peer-reviewed journal than, say, the non-peer-reviewed journals?

A Not necessarily.

Q Is it of any value that your articles, some of them, are peer-reviewed and some are not?

A It is of academic value. There are good non-peer review articles as well.

Q What do you mean by "good academic value?"

A From an academic standpoint, if something is published in something that is peer-reviewed, that carries more weight. But that is not to say that you can only read peer-reviewed journals.

Q Are there any textbooks that are good standard textbooks?

A Yes.

Q Which are they?

A In GYN-Oncology?

Q Yes.

A Hoskins is good. Disiai, Creasman.

Q Those are three textbooks?

A Disiai and Creasman are together. Bill Hoskins is the other text.

Q Any other textbooks?

A I think those are the main ones for GYN-Oncology.

Q Have you done any reports in this case?

A No.

Q Made any writings whatsoever?
A No.
Q About this case.
A No.
Q Have you generated a bill for your time?
A I have probably sent one.
Q Do you have that?
A No; I don't.
Q How many hours have you spent on this case thus far?
A I have probably spent about ten or eleven at this point.
Q What is your hourly fee?
A $350 an hour.
Q That is for review of records?
A Yes.
Q What is your fee for deposition?
A $450 an hour.
Q If you come to trial to testify?
A It is $5,000 a day that I am out of the office.
Q Suppose you are out half a day?

A It depends on if I have to book out the whole day.

Q Do you typically book out the whole day for trial testimony?

A Generally, unless somebody can guarantee me that--as a courtesy, I do that.

Q How many times have you testified at trial?

A I testify in trial about once a year, once every year, year and a half, or so.

Q So, for every deposition, you testify at trial?

A No. It just seems like I do a couple depositions a year and I am in court every year, year and a half, maybe two years.

Q Have you worked on any cases with Mr. Vernick's firm prior to this one?

A Yes; I have.

Q On how many occasions?

A I know one case that went to court.

Q What case was that?

A I don't recall the name of the case, but

it was, I guess, ten years ago.

Q How many times have you worked with Mr. Vernick's firm prior to this occasion? You know of at least two?

A Yes. The name is familiar. I don't really recall any others that I have done work for with them.

Q What about with Ms. Tazzara or her firm?

A Yes; I have some cases from her firm as well.

Q On how many occasions, do you know?

A I would guess a handful over the last ten years or so.

Q Five?

A Probably three to five.

Q Have you received any records that you reviewed and returned to Mr. Vernick?

A No.

Q Are you able to tell me when you first were contacted in this case?

A Not without looking at these letters.

Q Most of them don't have dates on them.

A The earliest date is June, '02.

Q You were contacted by Debbie Sinclair?

A I don't recall who contacted me.

Q Let me show you two documents. They are both the Defendants' 26(b)(4) statement. This is the first one which outlines the areas of your expected testimony. Here is the second one. Read through that and I will ask you a couple of questions. Just read through the ones that have your name.

A Okay.

Q Before we started the deposition, I went through the materials that you have reviewed and we marked as Exhibit No. 1 an Index to the Medical Records. Did you review all of the documents identified in Exhibit 1?

MR. VERNICK: Counsel, the only exception I will add is that there was a reference to some work-product things that were not in there. There are sections that are there, for example, just looking from the side, like "E) Histology Worklogs" and there was a reference to "Work Product." There

was something in addition to that he didn't get, but you have got everything that he got.

THE WITNESS: I have reviewed everything in this stack, or looked through it.

BY MS. EVANS:

Q In the stack, there are, I think, three depositions, maybe three or four depositions; Mariah Keller, Dr. Lin, Dr. Sokol and Dr. Levitt.

A Yes.

Q Did you review any other depositions?

A No.

Q Have you seen any other medical records that are not identified on that sheet?

A No.

MS. EVANS: Let's have this marked as Exhibit 3.

[Barter Deposition Exhibit 3 was marked for identification.]

BY MS. EVANS:

Q I will hand you what we have marked as Exhibit No. 3 which is entitled, "Second

Supplemental 26(b)(4) Statement of Defendant Cytology Services of Maryland." I asked you to read No. 2 and the information contained under No. 2. Have you had a chance to do that?

A Yes.

Q Is there anything about the statements that are contained under No. 2 which reference the expected areas of your testimony that you would like to change?

A No.

Q The first sentence here in Exhibit No. 3 says, "In addition to the previously identified opinions of Dr. Barter, it is expected that he will testify about the course of care and treatment that the Plaintiff would have received had the cancer been diagnosed in January, 1999, January, 2000 and September, 2000." Is that accurate?

A Yes.

Q What is your opinion with regard to the course of care and treatment that Mariah Keller would have received had the cancer been diagnosed in January of 1999?

A Backtracking from the size of the tumor and her symptoms, she had cancer in January of 1999 and would have needed a radial hysterectomy at that time and, more probably than not, would have gotten adjunctive therapy as well.

Q So it is your opinion that she did have cancer in January of 1999?

A Yes, ma'am.

Q By adjunctive therapy, what do you mean?

A The radiation and platinum.

Q Cispatin?

A Yes.

Q Was this the therapy that she received in 2001?

A Yes.

Q What is the basis for your opinion that she would have required a radical hysterectomy and adjunctive therapy since she had cancer in January of 1999?

A I am predicating that upon the fact that, in January of '01, she had a very large cervical cancer and that, in March of 2000, she had post-

coital bleeding. Backtracking that, she would have had cervical cancer in January of 1999.

Q Do you believe it was present prior to January, 1999?

A Yes.

Q How far back do you think she had cancer?

A I would say probably a year before that, maybe a year or two. And prior to that, she would have had preinvasive disease.

Q So it is your opinion that she had cancer as early as 1997 or 1998?

A I would say a year or two before January, 1999; yes.

Q So that would be '97 or '98?

A Yes.

Q In 1997, what stage cancer do you believe she had?

A At that point, it would have been precancer or possibly early invasion.

Q When you say "precancer," are you talking about carcinoma in situ?

A Or dysplasia; yes. But probably carcinoma

in situ.

Q Again, what is the basis for that opinion?

A The fact that she ended up with a very large tumor that was in the endocervix, a barrel lesion, as we call it, and the fact that she bled after intercourse in March of 2000.

Q What is it about the fact that she had bleeding after intercourse in March of 2000 that tells you the cancer was present as early as 1997?

A She must have had a substantial size of the lesion to bleed.

Q So you believe that she had a visible lesion in March of 2000?

A No; she didn't have a visible lesion because it was up in the canal.

Q A part of the cervix that would not have been visible upon a cervical exam?

A Grossly, the ectocervix would have looked normal.

Q Grossly, it would have appeared normal. But, microscopically, the cancer would have been evident?

A Grossly, the outside of the cervix would have looked normal. Grossly, the canal would have had a cancer in it.

Q Are you saying that, if a physician was able to visualize the canal, they would have seen the cancer?

A Yes.

Q But because I guess the technique doesn't allow visualization, it wasn't discovered?

A Correct. It is up inside the canal, away from normal viewing.

Q Is there some process by which the canal can be examined so that the cancer could have been diagnosed?

A No; there is not. From a physical exam; no.

Q What kind of exam?

A From a physical exam, you couldn't. A hysterectomy specimen, you could.

Q So, short of taking her cervix out and her uterus out, there would be no way to know?

A That's correct.

Q When is the earliest time that you have an opinion that you can state with a reasonable degree of medical probability was the cancer grossly visible?

A I would say that grossly visible a year or so before. Let's say January, '98.

Q Because, by that time, it had moved further down into the cervix?

A You mean grossly visible?

Q Yes.

A Externally?

Q Upon physical examination.

A Upon physical examination. The first visible sign on the ectocervix is September 25 of 2000.

Q What are you basing that on?

A On the notation, there is a small sessile polyp that, on a later exam, is an ulcerated area.

Q Did you see the January, 1999 office-visit note by Dr. Abraham?

A Yes.

Q What does the word "friable" mean?

A It can mean a number of things. It could be inflammation. It could be an area of the cervix that was touched with the speculum when it was introduced.

Q What else?

A It can be malignancy.

Q Are you able to rule out the possibility that, in January of 1999, what Dr. Abraham described as a friable cervix was, indeed, gross evidence of cancer?

A The fact that it wasn't there in January of 2000.

Q How do you know that?

A It is not commented on.

Q Does she comment on the cervix at all, or the appearance of the cervix?

A Yes. She says it is nulliparous.

Q Tell me what a nulliparous cervix looks like.

A Small, healthy.

Q If we were to look up "nulliparous" in a medical dictionary, what would it tell us?

A Not having had a pregnancy.

Q Does that tell you anything about whether or not the cervix was still, indeed, friable in 2000?

A It is not noted as being friable in January of 2000.

Q But you will agree that nulliparous, as a description of a cervix, doesn't tell you anything in terms of what the cervix actually looked like, does it?

A There is no comment that there was friability.

Q Nor is there any comment that it wasn't present; correct?

A We don't usually mention negative findings. I see no evidence that there was friability in January of 2000.

Q So you think it just went away?

A Yes.

Q Do you use nulliparous to describe the appearance of the cervix?

A Sometimes.

Q In what context.

A In the course of an examination.

Q You reviewed the Pap smear reports from 1997 and 1998; correct?

A I have looked at them.

Q So you are aware that they don't indicate the presence of cancer in 1997 or 1998?

A In February of '98, this looks to be normal. You said '97?

Q You said as early as 1997 or 1998, cancer may have been present. What is "present" in your opinion?

A Yes, but you mentioned about a Pap smear specifically.

Q Right; '97 and '98.

A I see the February '98 one. And then the February, '97 one, is noted as being normal.

MR. VERNICK: Negative benign cellular changes.

THE WITNESS: So, normal.

BY MS. EVANS:

Q How do you explain that difference?

MR. VERNICK: What difference?

BY MS. EVANS:

Q Between your opinion that she had cancer present in 1997 and 1998 and the lack of pathologic evidence that supports that?

A As you mentioned earlier, we don't have pathologic evidence. We have cytologic evidence on these reports that there wasn't evidence of cancer. That can certainly happen with something that starts up in the canal. They can be hard to pick up on a Pap smear.

Q Can you tell me how it is that you know that the cancer started up in the canal?

A Yes; because of the fact that it is a barrel lesion.

Q All barrel lesions start in the--in what canal?

A Endocervical canal.

Q So all barrel lesions start in the endocervical canal?

A Yes.

Q They all grow in size and bulk and remain

invisible to the naked eye on physical examination until it is too late?

A Well, I would say that until it erodes into the surface of the cervix. Then it can be seen on a vaginal exam.

Q How is it that you know that it was eroded into the surface of the cervix in September of 2000?

A On the exam, there is mention of a sessile polyp. Then, on the next exam, there is mention of ulceration of the cervix with minimal bleeding.

Q Anything else?

A I think, at that point, it had eroded from the endocervix onto the surface of the cervix.

Q How do you know that it had not eroded onto the surface of the cervix prior to September 23 of 2000?

A That there is no mention, there is no sustained mention, of that.

Q Are you suggesting that, because, in your opinion, Mrs. Keller's cancer started in the endocervical canal, that there was no way that a

Pap smear would detect the presence of that cancer until, was it March or September of 2000?

MR. VERNICK: Objection. Let me first tell you that he is not going to be rendering opinions about the Pap smear in this case. He is not going to be rendering any standard-of-care opinions.

But we have a Pap smear in this case in September of 2000 that I believe shows what, AGUS? As to what might happen in a hypothetical case, I don't know how that is relevant to this case. We have it in this case as to what was reported.

The way you phrased the question is in the context that he already answered it. And he has not answered it in the context of a Pap smear and he is not going to be asked to render an opinion about a Pap smear in this case.

But you can go ahead.

MS. EVANS: Can you let us hear the question again.

[Whereupon, the record was read back as requested..]

MR. VERNICK: Same objection.

THE WITNESS: No; I didn't suggest that at all. What I stated was that it is harder to pick up endocervical primary cancers.

BY MS. EVANS:

Q I guess what I am asking is, with an adequate Pap smear sampling, is it possible to pick up cancerous cells in the endocervical canal prior to the time that it is grossly visible?

A Yes.

MR. VERNICK: Karen, I am going to let you go down this path but he is not going to be rendering opinions about Pap smears, what they can pick up and what they can't pick up.

MS. EVANS: I understand that.

MR. VERNICK: Pretty soon, I am going to advise him to not to answer these questions.

MS. EVANS: Okay.

BY MS. EVANS:

Q It seems to me that your opinion is inconsistent with the Pap smear findings. I am trying to understand how it is that you reconcile

those two pieces of information.

A A lot of times, it is difficult to pick up an endocervical cancer and, a lot of times, if there is a cancer, the Pap smear doesn't always show it because the exterior surface of the cancer may have inflammation in other cells that obscure the cancer cells.

Q So is it your opinion that, in this case, because there was inflammation present, that that obscured the presence of cancer for Mrs. Keller in '97, '98, '99?

A It is my opinion that the Pap smear didn't pick up the cancer for the reasons I have stated.

Q I am trying to understand, is it because you believe that the inflammation obscured the presence of the cancer?

A And also, up in the canal, it can be difficult to access with Pap smears.

Q There was a drawing in here. Can you find that?

A Sure. Which drawing?

Q Not the one that was done by Dr. Jaffurs.

Where is the index? Do you know what this is?

MR. VERNICK: Let me object. He can answer as to what he thinks it is. But, as to why it was drawn or what it is, from Dr. Jaffurs' perspective, he can answer.

MS. EVANS: You didn't provide this to me.

MR. VERNICK: You, technically, shouldn't have it. It is something that I actually drew. So you can ask him whatever you want about it, but it is where it is going to go.

MS. EVANS: Go ahead.

THE WITNESS: This is a drawing of a uterus and a cervix with some lines that, in this context, with a notation of a Stage 1B barrel-shaped cervix and endocervix cancer I assume are referring to an endocervical barrel-shaped cancer.

BY MS. EVANS:

Q Have you had discussions with Mr. Vernick about this drawing?

A No.

Q Have you had discussions with anybody, Dr. Jaffurs, anybody, about this drawing?

A No, ma'am.

Q What is this right here? What do you think that is?

MR. VERNICK: Let me object to him characterizing what some scribbles are on a piece of paper.

BY MS. EVANS:

Q If you know.

A It would be hard for me to interpret somebody else's work. I don't really have an opinion about that. I am not sure what the artist had in mind.

Q So, if I am understanding your opinion correctly, it is your opinion that, as of the time that Mrs. Keller's cancer was diagnosed in January of 2001, she had had cancer for five years?

A I would say that she had had cancer for a year or so before the January '99 visit.

Q You told me earlier one to two years before January of 1999. So, if we use '97, it is '97, '98, '99, 2000, 2001?

A 2001? You have got January of 2001, so

you don't have all of 2001.

Q So she had had cancer for four years?

A I think that is reasonable; yes.

Q Is that the natural history of the progression of cervical cancer?

A In this particular case, I think it its; yes.

Q Tell me why you say that?

A Because in January of 2001, she had a very large endocervical barrel lesion. In March of 2000, she had bleeding after intercourse so that cancer must have had substantial size to have her bleed after intercourse. We have those two points of time. So extrapolating back to a year earlier, it would seem to me that she would have had an endocervical cancer at that time in January of '99.

Q You don't believe that it was possible for the cancer to have grown between January of '99 and 2001 to the size that it was on the time of surgery?

MR. VERNICK: I am going to object to that question.

MS. EVANS: Let me rephrase it.

BY MS. EVANS:

Q Is it your opinion that it is not possible for Mrs. Keller's cancer to have grown to such a size between January of 1999 and January of 2001?

MR. VERNICK: I still don't understand what you are talking about.

MS. EVANS: You don't understand either?

THE WITNESS: I think anything is possible.

BY MS. EVANS:

Q I guess I am trying to figure out why is it that you think the cancer had to have started sometime one to two years prior to 1997. Is it because--

A I am not sure I said that.

MR. VERNICK: I don't think he said that.

MS. EVANS: Prior to 1999.

BY MS. EVANS:

Q My question to you is why is it not as likely that the cancer grew in size between 1999 and 2001?

MR. VERNICK: It did. He has already said that.

BY MS. EVANS:

Q Without having been present in 1997 or 1998.

MR. VERNICK: I think you are missing his opinion.

MS. EVANS: Maybe I am.

MR. VERNICK: He said it a number of times, that there was a certain size or presence--and he has talked about it. I am not going to go back over it--in January of 1999, but it didn't start as that size.

MS. EVANS: I understand that.

MR. VERNICK: That is what he is saying. It goes back a year or so before that to get to that point. Then it goes from that point to January of 2001.

BY MS. EVANS:

Q Are you able to rule out the possibility that the cancer started in January of 1999 and grew to the size, grew to its diagnostic size, between

January of 1999 and January of 2001?

MR. VERNICK: I am going to object to the question.

Go ahead, Doctor, if you can answer it.

MS. TAZZARA: I object, also.

MS. EVANS: I understand his opinion. I am asking him about something different and he knows what I am trying to ask him.

THE WITNESS: I do.

MS. EVANS: Yes; you do.

MR. VERNICK: I think you ought to ask a better question.

MS. EVANS: If the doctor can't answer it, then I will try again.

THE WITNESS: Again, I think, backtracking this from a 6-centimeter endocervical barrel to the point where she had bleeding after intercourse, to me, means that there was a substantial sized cancer at that time. So then, extrapolating and backtracking earlier, my feeling is that the cancer was present in January, 1999.

BY MS. EVANS:

Q I understand that you believe that the cancer was present in January of 1999. But you also believe that the cancer was present prior to January of 1999; is that true?

A Well, it would have to be if we follow that same extrapolation. I don't think that it started in--I mean, these cancers are gradual. This is not like some cancers that can start in a very short period of time and become very large. In general, we don't feel that way about cervix cancer.

Q Now we are getting to what I am trying to get to. Is it your opinion that it was not possible for the cancer to grow from one cell in January of 1999 to the size and bulk it was in January of 2001?

MR. VERNICK: I am going to object. Anything in this world is possible.

MS. EVANS: Sure, it is.

MR. VERNICK: But there are standards that he has testified to and that go to a reasonable degree of probability. But if you want to assume

that the cancer first started in January of 1999--

MS. EVANS: I want him to answer my question. I also want you to stop making speaking objections.

MR. VERNICK: The question is ridiculous.

MS. EVANS: Perhaps it is, but it let me hear it from the doctor and not from you as the lawyer.

MR. VERNICK: The assumption is that the cancer started in January of '99 and could have progressed to the clinical state it was in January of 2001 in that time frame.

THE WITNESS: The reason that I think that that makes sense is because the fact that she seems to be--that she is cured presently from the cancer. So, to me, this represents more of a slow, indolent growth, if you will, rather than something that took off at a rapid accelerated pace.

BY MS. EVANS:

Q Two years would be a rapid and accelerated pace?

A I'm sorry; your question again?

Q You said that this was a slow, indolent growth and not something that took off at a rapid and accelerated pace. I am asking you is two years a period of time that you consider to be a period of rapid growth and acceleration for a cervical cancer?

MR. VERNICK: Let me object. What is on each side? You are starting from one cell to 6 centimeters? Or are you starting from one cell--

MS. EVANS: I am responding to your answer, Doctor. You said that this cancer is not typically one that is slow and indolent and it is not one that is rapid and accelerated.

BY MS. EVANS:

Q I am asking you, by rapid and accelerated, are you saying that this particular type of cancer could not grow in a two-year period of time?

A I don't think so, from her having the post-coital bleeding in March of 2000 and from this being 6 centimeters in January of 2001. I don't think that would happen; no.

Q Why is that; just because of those

clinical features?

A Yes

Q Is there any literature that you can cite me to that supports that this cervical cancer that she had was one that grows slowly; in other words, one that would grow over a four-year period of time versus a two-year period of time?

A I didn't do a literature search. There wouldn't be anything about this specific patient.

Q Would there be anything in the literature about the growth rate of these types of cancers?

A I didn't do a literature search.

Q From your experience in the field, are you aware of such articles?

A I don't know of those articles without doing a search; no.

Q So, at this point in time, the basis for your opinion that this cancer was slow and indolent is the fact that, in March of 2000, she had the postcoital bleeding and the size of the tumor upon diagnosis?

A Yes, that those are two fixed points in

time from which we can extrapolate data; yes.

MS. TAZZARA: I think he also said the fact that she is cured presently. I think that was another supporting factor.

THE WITNESS: As far as the factors of this cancer; yes.

BY MS. EVANS:

Q Who said she is cured at this time?

A If she has been three years or so since treatment, she is got an outstanding chance of being cured.

Q But it is not 100 percent; correct?

A No.

Q What does the fact that she is now--as you said, she has an outstanding chance of not having a recurrence. What does that have to do with telling you what type of cancer it was and the rate of growth?

A Not necessarily the type. But if this were something that was growing very virulently and very rapidly, it would be a cancer that would be harder to control and to cure and there would

probably be disseminated recurrences.

Q By now, you mean?

A Yes.

Q What stage of cancer do you think she had in 1998?

A She was probably microinvasive.

Q What stage would that be?

A I would say 1A-1 or 1A-2.

Q If her cancer had been diagnosed in 1997, would she have required a hysterectomy?

A If she had cancer in 1997, yes; she would have more likely than not needed a hysterectomy.

Q Even though you believe she had carcinoma in situ or dysplasia?

A But that is not what you asked me.

Q I thought that is what you told me she had in 1997.

A Yes, ma'am. But that is not the question you asked me. You asked me if she had cancer in 1997, would she need a hysterectomy. She would have, especially because this was in the endocervix.

Q Let me ask you this. If she had carcinoma in situ or dysplasia in 1997, would she have needed a hysterectomy?

A I'm sorry; carcinoma in situ--

Q Or dysplasia in 1997, would she have required a hysterectomy?

A No.

Q Why not?

A Because a cone would have detected the carcinoma in situ and may have removed it all.

Q If she had carcinoma in situ or dysplasia in 1997, would she have required adjuvant therapy?

A Not for carcinoma in situ; no.

Q So, in other words, she would not have needed radiation or chemotherapy in 1997 if she had carcinoma in situ or dysplasia?

A Yes. Carcinoma or dysplasia is not treated with adjunctive radiation and chemotherapy.

Q In 1998, if she had microinvasive disease, Stage 1A-1 or 1A-2, would she have required a radical hysterectomy?

A Yes.

Q Why is that?

A Because where this is located in the endocervical canal, sometimes, we can, in a patient with a 1A-1, follow them after a cone. But the concentric growth of this would have mitigated against that. The patients that have less than 3 millimeters of invasion, usually that is one tongue. This, I don't think, would have fit that category.

Q You say one tongue?

A Of invasion beneath the basement membrane. When we talk about the 3 millimeters of invasion, that is what we are talking about.

Q Would there have been any other options for treatment of microinvasive disease 1A-1 or 1A-2 in 1998 other than the radical hysterectomy?

A Again, as I stated, because of the fact that this was in the endocervical canal, and, again, this is fast-forwarding through the subsequent years, I think she would have needed a radical hysterectomy with any kind of microinvasion.

Q So you think that, as early as 1998, the microinvasive was in a barrel shape at that time?

A This originated up in the endocervical canal; yes.

Q So that means that it was all around the entire canal like a donut, so to speak?

A I am not sure about at that time. But the fact that this would have been invasive, in my opinion, in several foci I think would have mitigated against doing just a cone.

Q Would there have been any other option available in 1998 for treatment of microinvasive disease 1A-1, 1A-2, to preserve her fertility?

A If it needed something more than--if invasion was such that something more than a cone was necessary, she possibly could have needed just a simple hysterectomy. If she had microinvasion of invasion of any kind, she could have been treated with just radiation.

Q Would she not have been a candidate for a trachelectomy?

A That is an experimental procedure. She

might have been a candidate for that. But, again, that is an experimental procedure.

Q Tell me what is done.

A Well, just the cervix and the parametria are taken out in a radical fashion and the uterus is left in situ.

Q Then how does that preserve fertility?

A Her fertility is preserved with her ovaries being preserved. The point of the radical trachelectomy is just that the patient can carry her own child.

Q So, in a radical trachelectomy, most of the cervix is removed but the womb and the upper opening are left behind?

A Yes.

Q Where, in this area, can that be done; do you know?

MR. VERNICK: Today?

MS. EVANS: Today, 1998? Let's start with today.

BY MS. EVANS:

Q Do you know where it can be done today?

A I think that there are some places in California. I don't know of anybody locally that is doing that. I would say California.

Q You don't do it at Georgetown?

A No.

Q You don't do it here at Sibley?

A No.

Q Fairfax?

A I don't know. I haven't heard of that being done locally.

Q Washington Hospital Center?

A No; not that I am aware of.

Q In 1998, if she had microinvasive disease 1A-1, 1A-2, would she have required chemotherapy and radiation?

A Not for 1A-1 or 1A-2.

MR. VERNICK: Karen, pick a good place for a break?

MS. EVANS: Go ahead.

MR. VERNICK: I don't want to interrupt you.

MS. EVANS: No; I am getting ready to go

to another year.

[Recess.]

BY MS. EVANS:

Q What was the state of her cancer in January of 1999?

A In January of 1999, backtracking from January of 2001 and March of 2000, I feel that she had a centimeter to a centimeter-and-a-half cancer in the endocervix.

Q So what stage would that be?

A That would be a 1B.

Q 1B-1?

A 1B-1; yes, because it would have been less than 4 centimeters.

Q The basis for that opinion is what?

A As I just said, backtracking from January 2001 with a 6-centimeter endocervical barrel lesion through March of 2000 when she had postcoital bleeding.

Q Anything else? Any other basis for your opinion?

A No. That is the basis.

Q As of January, 1999 what treatment would have been indicated if you are correct, that she had Stage 1B-1?

A At that point, she would have had at least a radical hysterectomy and probably would have needed adjunctive therapy based on the fact that this is an endocervical lesion and our desire to do the most that we can to cure the cancer. We are leery of endocervical lesions. The fact that this was concentrically spread around the cervix in January of 2001 would indicate to me that it may well have had parameters such that adjunctive therapy would have been indicated.

Q In 2001, the cancer--you said concentrically. Do you mean it was all around the cervical canal, like a circle?

A Yes.

Q Whenever Mrs. Keller first developed the first cancer cell and it progressed to a sufficient number of cells such that it could be detected, let's say, on a microscope, would the cancer have been in a circular pattern at that early time

period?

A We tend to think of cervical cancer as starting with one cell. Why, in the endocervix, they grow in a concentric or barrel fashion that is symmetrical is not known.

Q I guess what I am asking is let's say the cancer--and I just want to use a clock for reference. Let's say there is one cancer cell at 12 o'clock. As the number of cells increase in size, does it work itself around to, like, 1 o'clock, 2 o'clock, 3 o'clock, all the way around, like that, or does it spread all at once and, all of sudden, it is a circle? Do you understand what I am asking you?

A Yes. I don't think that anybody--I don't know that answer. The observation, though, is that barrel lesions tend to be uniformly symmetrical. It would almost make one think that it was multifocal in its onset. But that is not traditionally the way we think of cervical cancer.

Q So, traditionally, you think that cervical cancer is generally one foci?

A Yes.

Q Is there literature out there that says that barrel-shaped lesions are multi-foci in their development?

A I didn't look at the literature. I don't know that literature off the top of my head; no.

Q So how do you know that in, let's say January of 1997, that this cancer was concentric? Do you know that one way or the other? Is that your opinion?

A I wouldn't know that at any point in time, when it became concentric. At some point, we know it did.

Q But you can't say with a reasonable degree of medical probability at what point in time it became concentric.

A No.

Q You had told me that, as of January, 1999, the cancer was one to one-and-a-half centimeters in the endocervix.

A Yes.

Q Are you talking about depth of invasion?

A I am talking about the gross size of it.

Q I am trying to get some description of what is one-and-a-half centimeters. Are you saying it is just like one grouping of cells that would be one to one-and-a-half centimeters in diameter?

A At that point, it would have taken on the concentricity of the endocervix. It would have been a smaller barrel lesion.

Q So it is your opinion, within a reasonable degree of medical probability, that this was a concentric lesion as of January of 1999?

A I think that is accurate. If not, it would have just been a bulk lesion beginning to spread circumferentially.

Q What is the difference between a bulk lesion that is beginning to spread concentrically or a lesion that is already like a circle?

A The difference would be the degree of involvement around the endocervical canal.

Q Are you able to state that, as of January, 1999, Mrs. Keller's lesion was concentric or if it was bulk and beginning to spread?

A I don't know that.

Q You told me earlier that this diagram here is of a cervix with a barrel-shaped lesion.

MR. VERNICK: Let me object as to your characterization. He thank that he was not able to indicate specifically what somebody else had drawn here.

BY MS. EVANS:

Q I want to get an understanding of what it is that we are talking about when you say that it is a barrel-shaped lesion. Can you draw for me a cervix.

A [Begins drawing.] This is our normal cervix.

Q Before you go further, help me to identify the parts of the cervix.

A Sure. This is the cervix.

Q Could you just put an arrow and show me the cervix?

A Sure.

Q What is this up at the top?

A This is the uterus.

Q This is the uterine wall?

A Yes. And this is the vagina.

Q Where is the endocervical area?

A This is the endocervix. And this is the ectocervix.

Q I guess, out here in these areas, this would be the pelvis?

A Yes; this would be the pelvic cavity and then this would be the parametria, or the connective tissue that holds the cervix in place.

Q Would you label that because I won't know when we read the transcript.

A Sure.

Q This is called the pelvic what?

A This would be along the paravaginal tissues and pelvic sidewall. The pelvic sidewall would be down here.

Q The vagina; is that like a tube shape?

A Yes. It is a tube shape. It looks like this. At the top of this is the cervix which juts out into the vagina.

Q So all of this area here is the vagina?

A Yes. That's correct.
Q Did you draw the barrel-shaped lesion?
A Not yet.
Q So this big thing here is the vagina.
A Yes.
Q Then the endocervical canal is actually narrower or smaller than the vagina?
A Yes.
Q You told me earlier that the barrel-shaped tumor, like this, grew in the endocervical canal?
A Yes.
MS. EVANS: Can we mark this.
[Barter Deposition Exhibit 4 was marked for identification.]
BY MS. EVANS:
Q Is it your opinion, with a reasonable degree of medical probability that, in January of 1999, Mrs. Keller would have needed chemotherapy and radiation?
A Yes.
Q In 2000, what stage of cancer is it your

opinion that Mrs. Keller had?

A In March of 2000, she would have been a 1B-1.

Q What about January, 2000?

A Same.

Q The basis of your opinion is the same as in 1999 and the other years?

A It is extrapolating back from what we had in January of 2001.1

Q In terms of treatment, she would have required a radical hysterectomy and probably radiation and chemotherapy?

A Yes; definitely.

Q Did you tell me what size the cancer would have been in 2000?

A To have the degree of bleeding she had in March of 2000, my belief is that the tumor would have been 2 to 3 centimeters. It would have had substantial growth so that it would have bled easily.

Q Do you believe it was 2 to 3 centimeters in January of 2000?

A Yes.

Q What stage of cancer is it your opinion that she had in January of 2001?

A We know she had a 1B barrel.

Q Was it still 1B-1, 1B-2?

Q The 6 centimeters, the figure that you have used to describe the size of the cancer in January of 2001, was that from the surgical pathology or was that from Dr. Lin's examination?

A It is from his examination and also from the pathology reports where they talk about, "a cross section of the cervix and upper vagina reveals a well-circumscribed tan lesion, occupies most of the anterior cervix and upper vaginal wall."

Q Don't they measure it at some point?

A I'm sorry, Up here is the measurement. I skipped that line. "A cross section of the upper vagina reveals a well-circumscribed, tan to pale yellow, firm (lesion) with shiny surface mass measuring 4 by 3.5 by 4.5." Then the comment, "The cut surface of the posterior cervix wall reveals a

well circumscribed pale, yellow to tan, firm lesion measuring 3 by 1.2 by 1.5."

So, if you add these up across the way, you get 7, 4.7 and 6.

Q Why do you add them together?

A Because what happens is you take the uterus and cervix like that and you bivalve it. Then, what they are giving us is the measurements in the two halves of it. So the entire lesion would be the sum of those rather than just one of them by itself.

Q So it was bigger on surgical pathology than it was on clinical examination?

A Dr. Lin estimated it to be about 6 centimeters. I think that this is in that ballpark.

Q Is that typically what is done, that you add the two dimensions to get the size of the tumor?

A Usually, what we go by is the clinical impression which would be 6 centimeters.

Q When you say "we," who--

A GYN-oncologists.

Q You use the clinical impression to stage the cancer?

A Yes.

Q You don't wait for the surgical pathology to stage it?

A There is a clinical stage and then there is a pathologic stage. For instance, if her nodes had been positive, she would be a Stage 1B-2 with positive nodes.

Q If she had positive nodes, that wouldn't put her into a different stage?

A No.

Q What stage of cancer is it your opinion that Mrs. Keller had in September of 2000?

A She would have been between a 1B-1 and a 1B-2, maybe a 1B-2 at that point.

Q Are the treatment options any different at the Stage 1B-1 versus 1B-2?

A Not for a lesion that is up in the endocervical canal. The tendency is to treat them adjunctively when the tumor gets to be a size of

this nature.

Q From the surgical pathology description, are you able to tell exactly where the tumor was in the endocervical canal?

A I can't tell exactly where, but it appears as though it has replaced the endocervical canal and actually grown underneath and onto the ectocervix.

Q Are you talking about the depth of the invasion or are you talking about the distance between the uterus, the top of the endocervical canal close to the uterus, or the bottom of it close to the--

A Do you mean when I say 6 centimeters?

Q Yes.

A It is just like a barrel, just like a rain barrel. You examine the patient like this and it is just like there is a rain barrel right in there that measures 6 centimeters at the mid-portion of the endocervix.

Q If we have got a barrel, are you measuring between the sides from here to here or the length

from top to bottom?

A It is the circumferential diameter at the widest portion of the barrel which is in the center of the barrel. They taper at either end. That is why it really just feels like a barrel.

Q Does that tell you, though, how much of the actual length of the endocervical canal that it takes up?

A It doesn't, per se. But barrel lesions tend to take up the entire endocervix.

Q September, 2000; you told me she had Stage 1B-1 or 1B-2.

A By January, 2001, she was a 1B-2 with 6 centimeters.

Q I am going to ask you what size--

A That would have been three or four months. She would have been a 1B-2 at that point.

Q In September, 2000?

A Yes.

Q What size would the tumor have been?

A It would have been somewhere between 2 and 3 and 6 centimeters.

Q Are you able to state, with a reasonable degree of medical probability, more precisely than between 2 to 3 to 6 centimeters?

A I would say it would be more tending toward--it would be approximately 4 to 5, if my math is correct, in extrapolating from those two parameters which I would have to think about.

Q So is it your opinion, with a reasonable degree of medical probability, that, in September, 2000, the size of the cancer tumor was 4 to 5 centimeters?

A Yes.

Q What is the basis for that mathematical calculation?

A Just based on the fact that she had a large barrel endocervical lesion in January of 2001 that was 6 centimeters and extrapolating back the March of 2000 when she had postcoital bleeding.

Q What is it about those two facts that tell you in September it was 4 to 5 centimeters?

A It is a rough approximation along that time line.

Q I think we have taken care of the first sentence. But, in the 26(b), it says that you are going to testify about the course and care and treatment that the Plaintiff would have received had the cancer been diagnosed in January of '99, January of 2000 and September of 2000. Have we talked about your opinions in that regard?

A Yes.

Q Do you have any opinions with regard to that particular subject matter that we have not talked about?

A I don't believe so.

Q "Specifically, it will be his testimony to a reasonable degree of probability that, had the Plaintiff been diagnosed with cancer in January, '99, that she would have needed the same or similar operation that was accomplished in January, 2000." Have we discussed your opinions in that regard?

A Yes.

Q Is there anything that we haven't discussed?

A No.

Q "This will also be Dr. Barter's testimony with regard to January of 2000 and September of 2000." Have we discussed your opinions in that regard?

A Yes.

Q Anything that we need to discuss that we have not?

A No.

Q "He will also testify about the Plaintiff's need for adjuvant therapy in these three earlier times frames," Have we talked about those opinions?

A Yes, ma'am.

Q "It is his expected testimony that the Plaintiff would have needed adjunctive therapy had she been diagnosed at these earlier time frames."

A Yes.

Q We talked about that. Do you have anything to add that we have not discussed?

A No.

Q "Furthermore, Dr. Barter will address the Plaintiff's current complaints and symptoms. It is

expected that he will testify that these symptoms or complaints would probably have existed even if the cancer had been diagnosed in January 1999, January 2000 or September 2000."

Have we discussed those opinions?

A Yes; it would have been the same treatment, with the same outcomes.

Q So, essentially, what your opinion is that, because she would have needed a hysterectomy and chemotherapy and radiation whenever, that she would have had the same accompanying morbidity and problems?

A Yes.

Q "The basis for this opinion is that the Plaintiff would have needed the same or similar operation and care and treatment that she received in January 2001 if the cancer had been diagnosed at the earlier referenced time frame."

MS. EVANS: Is he specifically going to comment on her complaints about GI distress?

MR. VERNICK: He had read Dr. Lin's deposition and reviewed the records. His opinion

basically dovetailed with Dr. Lin's, that he did not see her and obviously did not treat her but, based on the records, there is no evidence of a lot of these things. That is why I sent him this portion of the Interrogatory Answers, Page 10 and 23, that list certain things.

All this is running to the present. Based on his review of Lin's deposition and the records of Lin, he can comment about what she has or doesn't have, but he is just parroting back what Lin says and what is in his records.

So I think the best evidence of that is from Dr. Lin because he is the one that is treating her. So he is not going to be able to say, she has this inconsistent with Lin, or she doesn't have it.

MS. EVANS: You are talking about current complaints.

MR. VERNICK: Correct.

MS. EVANS: You are not going to opine that she didn't have these things, are you?

THE WITNESS: No; I would defer to Dr. Lin.

BY MS. EVANS:

Q "Finally, Dr. Barter will testify about Mrs. Keller's prognosis both currently and at the earlier time frames referenced." You are going to testify about her current prognosis? I think you already told me that she has an excellent prognosis.

A Yes.

Q Are you able to give me a number percentagewise?

A With the treatment that she had in 2001 with a 1B barrel and having had a radical hysterectomy, radiation therapy and platinum, her survival rate is in the 80 to 85 percent range at five years. If she were to have had a recurrence, more probably than not, she would have recurred by now. Patients do recur with cervical cancer. If they are going to recur, 80 percent do so within two years of diagnosis. So the fact that she is out augments her survival rate even more at this point.

Q What is the basis of that statement that,

if there is going to be a recurrence, 80 percent recur within two years?

A That has been noted in various studies that look at cervical patients and when they recur.

Q Are you able to give me a citation for any of them?

A Not off the top of my head; no.

Q Have you written about it in any of your papers?

A I guess maybe in the lung-cancer article. I don't think I mentioned it in the radical-hysterectomy complication article. I am sure there is some mention in those studies about when they recurred, but I don't remember addressing that specifically.

Q The prognosis in 1997; what is your opinion in that regard?

A Given what pathological state. If we could do it by that, maybe that is--

Q 1997; I believe your testimony was that she had CIN or dysplasia?

A With CIN or dysplasia, the cure rate with

a cone or a hysterectomy is approaching 100 percent.

Q In 1998, I believe your testimony was microinvasive disease 1A-1 and 1A-2?

A 1A-1 and 1A-2 generally should be considered cure 95 percent, 90 to 95 percent, lumping both categories together. That depends on the specific parameters. Obviously, a smaller 1A-1 is going to approach upper '90's as far as survival.

Q Do you have an opinion with a reasonable degree of medical probability as to the size of the microinvasive disease in 1998?

A In other words, if it is a 1A-1 or a 1A-2?

Q Yes.

A I would think it would be a 1A-2.

Q What size? How many centimeters would it be?

A At that point, it would be millimeters. I would say several millimeters.

Q If it was 1A-2?

A Yes. By definition, that would have to be

3 to 5 with no extension greater than 7 across. So those would be the parameters that I would put down, or maybe even a little bit worse at that point.

Q In 1997, do you have an opinion with a reasonable degree of medical probability as to the size of the carcinoma in situ or dysplasia?

A I guess I don't; no.

Q What is your opinion with regard to Mrs. Keller's prognosis in 1999? You told me earlier Stage 1B-1?

A Stage 1B-1 with a radical hysterectomy and adjunctive therapy is going to be--in this particular case, I would say, 85 to 90 percent.

Q You said in this particular case? What is different about her case?

A Just judging from the tumor size. These are all predicated on tumor size. That is why there is a bit of a range in these. You can have a 1B-2 that is 4.2 centimeters and a 1B-2 that is 10 centimeters. I would say that the 1B-2 that is smaller has a chance to do better than a larger 1B-

2. So there is a range in these.

Q Is it your opinion that she was 1B-2 in 1999?

MR. VERNICK: He has already said 1B-1.

MS. EVANS: That's what I thought he said. But we are talking about January 1999.

THE WITNESS: I said she was a 1B-1 at that point; yes. So her survival rate would be well in the upper 80s.

BY MS. EVANS:

Q Do you have an opinion with regard to her prognosis in January 2000?

A A 1B-1? I would say mid 80s.

Q Is this with radical hysterectomy and adjunctive therapy?

A Yes; given the same treatment.

Q March of 2000; is the prognosis the same as in January?

A Yes.

Q September 2000, your opinion was that she had Stage 1B-2. What would her prognosis be?

A Very good. I would say mid 80s.

Q This is with radical hysterectomy and adjunctive therapy.

A Yes.

Q So Stage 1B-1 and Stage 1B-2, the prognosis is the same?

A It depends on the tumor size. If you have a 1B-1 that is 3.8 centimeters and a 1B-2 that is 4.2 centimeters, then they are going to be about the same. So there is some play in these numbers predicated on tumor size.

Q Have I covered everything? That is all that is in the 26.

A I think you have.

Q Oh; not quite. I have just a few last-minute things. Percent of income derived from medical-legal services?

A 5 percent.

Q Have you ever given testimony for a plaintiff, a patient, in a medical-negligence case?

A Yes.

Q When was that?

A I have given testimony through the years

for plaintiffs. Most of what I do is defense work. I would say it is 75, 80 percent defense and the rest plaintiff.

Q Have you testified for a plaintiff in the Washington Metropolitan Area?

A I testified in the past on a laparoscopic oophorectomy. It was a patient that I took care of here. The surgery actually had been done in Baltimore. So it is the area.

Q You were her treating doctor?

A Yes.

Q Did you give an opinion that the doctor in Baltimore had been negligent?

A Yes.

Q Who was the lawyer in that case?

A I don't recall.

Q Other than that one case, have you testified for a plaintiff on any other cases?

A Yes. There was another laparoscopy case in Baltimore recently. I am trying to think of what else. Actually, my first case I did was a patient of mine who had a Pap smear that there was

discussion about. That was about ten years ago. That was my index case--it was for the patient--as a plaintiff expert.

Q Did you testify that there had been negligence by the treating obstetrician or gynecologist?

A I think I did in that case. I don't remember the specifics about it.

Q Was that here in the Washington, D.C. area?

A Yes.

Q That was about ten years ago?

A Yes.

Q Do you remember the name of the patient?

A I don't.

Q Any of the lawyers involved?

A No.

Q Do you keep any kind of list of your cases that you have been involved in?

A No.

Q Do you keep depositions, old ones?

A No.

Q So you have testified for the patient in three cases that you are able to recall?

A That I recall.

Q Do you prefer to testify for the defendant, for the physician?

A The percentage represents the calls that I get. I happen to get more from defense lawyers.

Q Do you get calls from plaintiff's attorneys?

A Yes.

Q Here in the local area?

A I believe so; yes.

Q Within the last five years, have you reviewed a plaintiff's case and given testimony in favor of the patient against a healthcare provider in the Washington area?

A Not that I recall in the D.C. area.

Q Have most of the cases that you have been involved in as an expert witness in which you have testified for the patient been outside of Washington, D.C.?

A Mostly; yes.

Q Do you know Dr. Abraham?
A Yes; I do.
Q How do you know her?
A Through the OB-GYN circles here in Washington.
Q Have you discussed this case with her?
A No.
Q Does she refer cases to you?
A She has not; on.
Q She has not in the past?
A No.
Q Was that because of the nature of the kind of work that you did at Georgetown?
A It seems like they refer to G.W., as best I can tell.
Q Do you know Dr. Jaffurs?
A Yes.
Q How do you know him?
A Same; the GYN circles here in Washington.
Q So, on average, do you see them every month? Every year? What?
A I probably see Dr. Jaffurs every several

years. I probably see Dr. Abraham every couple of months.

Q Have you discussed this case with Dr. Abraham?

A No.

Q Have you told her that you are an expert in the case?

A No.

Q Have you ever had a claim for malpractice filed against you?

A Yes.

Q How many times?

A Three.

Q When was the first one?

A The first one was I guess about eight years ago, now. It was a recovering alcoholic that I talked to about the disposition of her normal ovary which she desired to retain at the time of surgery for an abnormal opposite ovary. She was in her 40s. She ended up getting a cyst on the ovary that she desired to keep in situ and sued me for that. But I had her come back an additional time

in the office so I had two page-and-a-half informed-consent notes. So that didn't go anywhere.

Q It didn't go to trial. Did you take a deposition?

A No; I didn't.

Q It was dismissed?

A I don't think it ever went anywhere. I think it just died a slow death.

Q Do you remember her name?

A No.

Q When was the second time?

A The second was I guess five or six years ago. It was a patient that I did a radical hysterectomy on that had overflow incontinence after the procedure. She sued on that basis. That never went anywhere because they couldn't get an expert witness because I had drawings and explained to her the pros and cons and potential problems after a radical.

Q Who was your lawyer in the second case?

A It is through Georgetown. I don't recall.

Q Do you recall who your lawyer was in the first case?
A They are through Georgetown.
Q Then the last case?
A The last case is current.
Q Have you given a deposition in that case?
A No.
Q Who is representing you?
A Georgetown.
Q Who is the plaintiff's attorney?
A I don't know.
Q What is the nature of the allegations against you?
A I am not sure I am supposed to talk about that, am I?
Q You can tell me what they allege. You don't have to admit to it.
MR. VERNICK: Do you want to talk to me about it?
THE WITNESS: Sure.
MR. VERNICK: It has been filed?
THE WITNESS: Yes--well, no.

MR. VERNICK: The law suit has not been filed?

THE WITNESS: We are not on the record, are we?

MS. EVANS: Yes.

THE WITNESS: I am not going to say anything until we talk to the Georgetown lawyers because I have been told that we are not supposed to talk about stuff.

BY MS. EVANS:

Q Has suit been filed?

A Again, I apologize. I would be glad to have you talk to the Georgetown lawyers but--

Q Who would that be?

A I am not going to say anything. I can get you the name.

Q Let me ask you this. Do the allegations have anything to do with cervical cancer?

A Not at all.

Q Are you a named defendant?

A Yes; with Georgetown Hospital.

Q It is not my firm, is it, Jack Olender and

Associates?

A With all due respect, I would be glad to give you the Georgetown lawyer. I am not going to say anything about it.

Q Do you know Dr. Neil Rosenschein?

A Yes.

Q Have you discussed the case with him at all?

A No.

Q Did you know that he was an expert in this case?

A No; I didn't.

Q Dr. Johnson; do you know him? Harry Johnson from Baltimore?

A No.

MS. EVANS: I think I have to be done.

MR. VERNICK: Would you like to read? Doctor?

THE WITNESS: Yes.

[Whereupon, at 8:45 p.m., the deposition was concluded.]

[Signature not waived.]

CERTIFICATE OF DEPONENT

I have read the foregoing_____ pages which contain the correct transcript of the answers made by me to the questions therein recorded.

_____

Subscribed and sworn before me

this_____ day of _____ 20_____

_____
Notary Public in and for

_____

My commission expires:_____

CERTIFICATE OF NOTARY PUBLIC

I, ALICE TOIGO, the officer before whom the foregoing deposition was taken, do hereby testify that the witness whose testimony appears in the foregoing deposition was duly sworn by me; that the testimony of said witness was taken by me by stenographically and thereafter reduced to typewriting under my direction; that said deposition is a true record of the testimony given by said witness; that I am neither counsel for, related to, nor employed by any of the parties to the action in which this deposition was taken; and further, that I am not a relative or employee of any attorney or counsel employed by the parties hereto nor financially or otherwise interested in the outcome of the action.

Alice Toigo

ALICE TOIGO

Notary Public in and for
the District of Columbia

My Commission expires: August 31, 2007

MARIAH KELLER
Medical Records

[redacted]

1) Chronology (Work Product) and Complaint

2) M. Melody Abraham, M.D.
(2/13/96 - 6/22/01)

3) Cytology Services of Maryland, Inc.
(1/6/98 - 1/10/01)
   A) Pap smear records/documents
   B) Cytology report search requests
   C) Phone messages and faxes
   D) Letters from Attorney Olender
   E) Histology Worklogs (Work Product)
   F) CS of MD Protocol re: review high risk slides (Work Product)
   G) Staging for cervical cancer (Work Product)
   H) Cytotech listing for CS of MD (Work Product)
   I) Jaffurs' diagram (Work Product)
   J) Records of CS of MD produced by Plaintiff

4) Sibley Memorial Hospital
(5/23/96 ER Visit)

5) Jeffrey Lin, M.D.
(3/8/01 - 9/27/01)

6) George Washington University Hospital
(1/17/01 - 1/21/01)

7) George Washington University Hospital
(9/7/01 ER visit)

8) Dwight Stauffer, M.D.
(8/25/89 - 8/26/94)

9) George Washington University Hospital
Radiation Oncology Treatment
(1/18/01 - 6/21/01)

CURRICULUM VITAE

James Francis Barter, M.D.

SOCIAL SECURITY NUMBER 222-36-4668

DATE AND PLACE OF BIRTH March 4, 1951 - Washington, DC

BUSINESS ADDRESS:
Lombardi Cancer Center
Georgetown University Hospital
3800 Reservoir Road, N.W.
Washington, DC 20007
Phone: 202-687-1212

HOME ADDRESS:
5968 Searl Terrace
Bethesda, MD 20816
Phone: 301-320-3576

FAMILY

Married	June 12, 1977 - Anne Bourneuf Iarrobino	
Children	Jessie Caroline	Born: 04-30-80
	James Francis, Jr.	Born: 12-27-82

PREMEDICAL EDUCATION

Washington and Lee University School of Medicine
Lexington, VA
B.S.
Magna Cum Laude
Phi Beta Kappa 06-07-73

MEDICAL EDUCATION

University of Virginia
Charlottesville, VA
M.D. 05-22-77

INTERNSHIP AND RESIDENCY - INTERNAL MEDICINE

University of Kentucky Medical Center
Lexington, KY
Intern, Internal Medicine 06/23/77 - 06/30/78
University of Kentucky Medical Center
Lexington, KY
1st Year Resident, Internal Medicine 07/01/78 - 06/30/79

ADMINISTRATIVE AND COMMITTEE DUTIES

Director Residency Program Obstetrics and Gynecology Georgetown University Hospital Washington, DC	1986 - 1988
Associate Director Residency Program Obstetrics and Gynecology Georgetown University Hospital	1988 - Present
Program Director Sibley Memorial Hospital Washington, DC Affiliate Hospital for Georgetown	01/86 - Present
Education Committee Obstetrics and Gynecology Georgetown University Hospital -General management of all aspects of Interns and Residents Education	01/86 - Present
House Staff Liaison Committee Georgetown University -To continue ongoing rapport between House Staff and attendings	01/86 - 01/87
House Staff Committee Georgetown University -To examine distribution of House Staff officers in the different divisions	03/86 - 06/86
Director Residency Recruitment Obstetrics and Gynecology Georgetown University Hospital	1987 - Present
Utilization Management Committee Georgetown University Hospital -Optimizing quality of care	1986 - 1987
Women's Task Force Georgetown University Hospital -Consolidation of marketing efforts for Georgetown University Hospital, Obstetrics and Gynecology	1986 - 1987
Tumor Board Sibley Memorial Hospital	06/87 - Present

Middle Atlantic Gynecologic Oncology Society Scientific Coordinator Hot Springs, VA Meeting	09/87
Middle Atlantic Gynecologic Oncology Society President Elect	1992
Middle Atlantic Gynecologic Oncology Society President	1993
Middle Atlantic Gynecologic Oncology Society Council Member	1988 - 1991
Georgetown University Hospital Medicine Chairman Search Committee	1990 - 1991
Georgetown University Hospital Radiation Oncology Division 5 Year Review Committee	01/90 - 06/90
Chairman Surgery Department 5 Year Review Committee Georgetown University Hospital	01/91 - 08/91
Clinical Operations Committee Georgetown University Hospital	10/93 - Present
Faculty - Problem Based Learning, Anatomy Course Georgetown University School of Medicine	1993, 1994
Operative Endoscopic Committee Georgetown University Hospital	1992 - 1994
Billing and Collections Committee Department of OB/GYN, Georgetown University Hospital	1992 - 1994
Montgomery County Satellite Office Committee	1996 - Present
Lombardi Cancer Center Clinical Research Committee	1996 - Present
The Society of Gynecologic Oncologists National Task Force on Manpower in Gyn Oncology	1996
Education Courses: Course Director: "Complications in Gynecologic Surgery" Washington, DC	10/90, 10/91

Co-director, Annual Course: 4/90, 4/91
"A Comprehensive Review of Clinical Obstetrics and Gynecology"
Georgetown University Hospital
Washington, DC

Gynecologic Oncology 1990 - Present
OB/GYN Grand Rounds Coordinator
Georgetown University Hospital

Co-Director: 02/93
"Staples in Surgery and Continent Diversions"
Society of Gynecologic Oncologists Annual Meeting
Palm Desert, CA

Moderator: 10/93
"The Progressive Field of Gynecologic Oncology"
American College of Surgeons Annual Meeting
San Francisco, CA

JOURNAL REVIEWER

Gynecologic Oncology 01/91 - Present
Cancer 10/93 - Present
Obstetrics & Gynecology 08/97 - Present
Breast Cancer Research and Treatment 08/97 - Present

CLINICAL COOPERATIVE RESEARCH

Co-Director 03/92 - Present
Gynecologic Oncology Group Studies
Georgetown University Hospital

Gynecologic Oncology Group 1986 - 1994
Endometrial Committee

Gynecologic Oncology Group 1986 - 1994
Gestational Trophoblastic Disease Committee

Coordinator Basic Science Presentations 1993
Gynecologic Oncology Group Meeting, Baltimore, MD

STATE LICENSES

Kentucky	#19545	07-01-78
North Carolina	#25770	01-23-82
Alabama	#10781	04-13-83
Maryland	#D32793	09-06-85
Virginia	#38704	10-01-85
District of Columbia	#15565	12-17-85

PROFESSIONAL SOCIETIES/HONOR SOCIETIES

American Medical Association	1973 - Present
Phi Beta Kappa	1973 - Present
Alpha Epsilon Delta, President	1972 - 1973
Diplomate, National Board of Medical Examiners	1978
Bayard Carter Society	1983 - Present
Duke Obstetrics and Gynecology	
Medical Association of the State of Alabama	1983 - 1986
Charles E. Flowers Society	1985 - Present
University of Alabama Obstetrics and Gynecology	
American Society for Colposcopy and Cervical Pathology	1985 - Present
District of Columbia Medical Society	1986 - 1996
Society of Gynecologic Oncologists	
Candidate Member	March 1986 - 1988
Member	1988 - Present
Montgomery County Medical Society	May 1986 - 1991
Washington Gynecologic Society	October 1986 - Present
Nominating Committee	1989
Mid Atlantic Gynecologic Oncology Society	May 1986 - Present
Hippocrates - Galen Society	February 1987 - 1990
American College of Obstetrics and Gynecology	
Junior Fellow	1984 - 1988
Fellow	1989 - Present
American College of Surgeons	
Fellow	1989 - Present

AWARDS

Cash Prize - Resident's Day Research Presentations Duke University	June 1983
Travel Grant Award American Radium Society Meeting Acapulco, Mexico	April 1985
First Place Scientific Presentations Advisor, Georgetown University Resident Research Presentations "AGUS" Pap Smears	November 1997

HONORS

Washingtonian Magazine Best Doctors in Washington, DC	1989, 1993, 1996

INTERNSHIP AND RESIDENCY - OBSTETRICS AND GYNECOLOGY

Duke University Medical Center
Durham, NC
Intern, Obstetrics and Gynecology — 07/01/79 - 06/30/80

Duke University Medical Center
Durham, NC
Resident, Obstetrics and Gynecology — 07/01/80 - 06/30/83

RESEARCH

National Institutes of Health — 1974
Bethesda, MD
Summer Research Program
Worked on isolating rabbit lung surfactant

University of Alabama Medical Center — 07/83 - 01/84
Birmingham, AL
Research Assistant in Tumor Immunology
(Dr. Max Cooper) - Worked on characterizing lymphocyte subtypes in ovarian cancer ascites fluid using monoclonal antibodies and on prostaglandin production by peritoneal macrophages

FELLOWSHIP - GYNECOLOGIC ONCOLOGY

University of Alabama Medical Center
Birmingham, AL — 01/84 - 01/86

PROFESSIONAL APPOINTMENTS

Instructor
Obstetrics and Gynecology
University of Alabama Medical Center
Birmingham, AL — 01/84 - 01/86

Instructor
Obstetrics and Gynecology
Georgetown University Medical School
Washington, DC — 01/86 - 06/87

Lombardi Cancer Center - Faculty Appt.
Georgetown University Medical School
Washington, DC — 01/86 - Present

Associate Professor
Obstetrics and Gynecology
Georgetown University Medical School
Washington, DC — 06/87 - Present

HONORS (continued)

Good Housekeeping
401 Best doctors for Women August 1997

RESEARCH AND GRANTS

$6,000 Award from Georgetown University Biomedical Research Support Grant for A Study on Thromboxane Synthetase Inhibitor (CGS-13080) Effect on Blood Flow in Radiated Canine Intestine. May 1986.

$5,000 from Ciba-Geigy for Continued Studies on Thromboxane Synthetase Inhibitor (CGS-13080) Effect on Blood Flow in Radiated Canine Intestine. September 1986.

$10,000 Research Education Grant from U.S. Surgical Corp. 1990.

$10,000 Research Education Grant from U.S. Surgical Corp. 1991.

Co-Principle Investigator, Gynecologic Oncology Group (N.C.I. - cooperative group). 1991-Present. $200,000.

Co-Chairman: A Study of BB-94 by Intraperitoneal Infusion in Patients with Advanced Cancer. British Bio - Technology, Ltd. November 1993 - 1994. $40,000.

Co-Principle Investigator: An Open Multicenter Phase II Study of Intravenous Topotecan Given as Five Daily Doses in Advanced Ovarian Cancer to Patients Failing Paclitaxol and Cisplatinum. November 1993 - December 1994. Smith Kline Beecham Pharmaceuticals. $7,000.

Co-Principle Investigator: Phase II Open Label Dose Escalation Study of BB2516 in Patients with Serologically Progressing Ovarian Cancer. Spring 1995 - 1996. $40,000.

Co-Principle Investigator: Genetic Counseling for Ovarian Cancer Risk. Georgetown University Hospital.

Co-Investigator: Multicenter Study of Women's Health: Case-Control Study of Adenocarcinomas of the Uterine Cervix. $79,440.

Co-Investigator: An Open-Label, Randomized, Comparative, Multicenter Phase III Study of Oral versus Intravenous Topotecan as a Single Agent, Second-Line Therapy Administered for Five Days in Patients with Advanced Ovarian Cancer. Smith Kline Beecham. 1997. $26,000.

Principal Investigator: A Randomized, Double-Blind Comparison of Oral Ondansetron and Intravenous Granisetron in the Prevention of Nausea and Vomiting Associated with Moderately-High Emetogenic Chemotherapy. Glaxo Wellcome. 1997. $30,000.

Principal Investigator: A Phase III Randmized Open Label Study of DOXIL/CAELYX versus Topotecan HCl in Patients with Epithelial Ovarian Cancer Following Failure of First-Line, Platinum-Based Chemotherapy. Sequus. 1997. $46,000.

Principlal Investigator: A Single-Blind, Controlled, Randomized, Multicenter, Prospective Evaluation of Absorbable Poly (L-Lactide/Glycolide) Suture in Abdominal Fascia Closure in Patients with Compromised Wound Healing. Ethicon, Inc./Johnson & Johnson. 1997. $8,000.

BOARD CERTIFICATION

National Boards Parts I, II, III	June 1975, September 1976, March 1978
American Board of Obstetrics and Gynecology (written)	June 1983
American Board of Obstetrics and Gynecology Gynecologic Oncology Boards (written)	June 1987
American Board of Obstetrics and Gynecology (oral)	December 1987
American Board of Obstetrics and Gynecology Gynecologic Oncology Boards (oral)	December 1988

HOSPITAL APPOINTMENTS

Attending Staff, Carraway Methodist Hospital
Birmingham, AL
July 1985 - December 1985

Attending Staff, Veterans Administration Hospital
Birmingham, AL
July 1985 - December 1985

Georgetown University Hospital
Washington, DC
January 1986 - Present

District of Columbia General Hospital
Washington, DC
November 1986 - Present

Arlington Hospital
Arlington, VA
September 1986 - Present

Sibley Memorial Hospital
Washington, DC
January 1986 - Present

ABSTRACTS PRESENTED/POSTER SESSIONS

1. "Prognostic Value of Peritoneal Washings in Patients with Malignant Mixed Mullerian Tumors of the Uterus." Holcombe, GE, Spzack, CA, Creasman WC, Barter JF, Harris RE, Johnston, WW. Annual Scientific Meeting of the American Society of Cytology, Atlanta, GA, November 1984.

2. "Leiomyosarcoma: 12 Year Experience at Duke University." Barter, JF, Smith, IB, Spzack, CA, Clarke-Pearson, DC, Creasman, WC. Obstetrics and Gynecology Resident Presentation Day. June 30, 1983.

3. "Update on In Utero DES Exposure." Barter, JF. Postgraduate Course Gynecologic Oncology, Southern Medical Association, New Orleans, LA, November 1984.

4. "Complications of Radical Hysterectomy Followed by Radiation Therapy for Early Stage Cervical Cancer." Barter, JF, Shingleton, HM, Soong, SJ, Hatch, KD, Orr Jr., JW. Mid Atlantic Gynecologic Oncology Society, Hot Springs, VA, September 20, 1986. writing?

5. "Complications of Radical Hysterectomy Followed by Radiation Therapy for Early Stage Cervical Cancer." Barter, JF, Shingleton, HM, Soong, SJ, Hatch, KD, Orr Jr., JW. American College of Obstetrics and Gynecology District IV, San Juan, PR, November 17, 1986. writing

6. "Oral Methotrexate for Treatment of Nonmetastatic Gestational Trophoblastic Disease." Barter, JF, Soong, SJ, Hatch, KD, Orr Jr., JW, Partridge, EC, Austin Jr., JM, Shingleton, HM. Felix Rutledge Gynecologic Oncology Society, Houston, TX, May 1987.

7. "Oral Methotrexate for Treatment of Nonmetastatic Gestational Trophoblastic Disease." Barter JF, Soong SJ, Hatch KD, Orr Jr., JW, Partridge EC, Austin Jr., JM, Shingleton HM. Marriott Marquis Hotel, American College of Obstetrics and Gynecology District IV, Atlanta, GA, November 1987.

8. "A Phase I/II Study of Intraperitoneally Administered Doxorubicin Entrapped in Cardiolipin Liposomes in Patients with Ovarian Cancer." Potkul, RK, Delgado, G, Treat, JA, Lewandowski, GS, Barter, JF, Forst, D, Rahman A. Middle Atlantic Gynecologic Oncology Society, Baltimore, MD, October 1988.

9. "Analysis of Pre-operative Historical Features and Extent of Surgery as Predictors of Major Complications in Patients Receiving Adjuvant External Beam Radiotherapy for Stage I Endometrial Cancer." Lewandowski, G, Torrisi, J, Barnes, W, Potkul, R, Barter, JF, Delgado, G. Mid Atlantic Gynecologic Oncology Society, Baltimore, MD, October 1988.

10. "Cervical Cylindrectomy for Cervical Dysplasia." Lencke, S, Delgado, G, Barnes, W, Barter, JF, Potkul, R. Mid Atlantic Gynecologic Oncology Society, Baltimore, MD, October 1988.

11. "Risk Factors Associated with Development of Clostridium Difficile Diarrhea on a Gynecologic Service." Waggoner, S, Holloway, R, Lewandowski, G, Potkul, R, Barter, JF, Barnes, W, Delgado, G. The Felix Rutledge Society, London, England, 1989.

12. "Effects of Human Interferon on Human Papillomavirus Induced Lesions of Human Epithelial Xenografts in Athymic Mice." Barnes, W, Delgado, G, Holloway, R, Jenson, A, Weck, P, Kreider, J, Barter, JF, Potkul, R, Johnson, C, Lancaster, W. The Felix Rutledge Society, London, England, 1989.

13. "Effects of Human Interferon on Human Papillomavirus Induced Lesions of Human Epithelial Xenografts in Athymic Mice." Barnes, W, Delgado, G, Holloway, R, Jenson, A, Weck, P, Kreider, J, Barter, J, Potkul, R, Johnson, C, Lancaster, W. The Mid Atlantic Gynecologic Oncology Society, Williamsburg, VA, 1989.

14. "Risk Factors Associated with Development of Clostridium Difficile Diarrhea on a Gynecologic Service." Waggoner, S, Holloway, R, Lewandowski, G, Potkul, R, Barter, JF, Barnes, W, Delgado, G. The Mid Atlantic Gynecologic Society, Williamsburg, VA, 1989.

15. "Cervical Cancer Pulmonary Metastases." Barter, JF, Soong, SJ, Hatch, KD, Orr Jr., JW, Shingleton, HM. Society of Gynecologic Oncologists, San Francisco, CA, February 1990.

16. "Low Dose Infusional 5Fu as Salvage Therapy for Ovarian Cancer." Jarvis, T, Barter, JF, Potkul, R, Barnes, W, Delgado, G. Georgetown University Dept. OB/GYN Resident Research Day Presentations, Washington, DC, June 1990.

17. "Intravenous Pyelograms Following Radical Hysterectomy." Olah, E, Potkul, R, Barter, JF, Delgado, G, Barnes, W. Georgetown University Dept. of OB/GYN Resident Research Day Presentations, Washington, DC, June 1990.

18. "Use of Groshong Catheter for Intraperitoneal Treatment." Waggoner, S, Johnson, J, Barter, JF, Barnes, W, Potkul, R, Delgado, G. Mid Atlantic Gynecologic Oncology Society, Wilmington, NC, October 1990.

19. "Radical Hysterectomy in Older Patients." Shuster, P, Barter, JF, Potkul, R, Barnes, W, Delgado, G. American College of Obstetricians and Gynecologists District IV, White Sulfur Springs, WV, October 1990.

20. "Colonic Surgery on Previously Irradiated Pelvic Malignancies." Burnett, AF, Potkul, RK, Barnes, W, Barter, JF, Delgado, G. American Association of Obstetrics and Gynecology District IV, Greenbrier, White Sulfur Springs, WV, October 1990.

21. "Manometric Characterization of Rectal Dysfunction Following Radical Hysterectomy." Barnes, W, Delgado, G, Maher, K, Potkul, R, Barter, JF, Waggoner, S, Johnson, J, Benjamin, S. Society of Gynecologic Oncologists, Orlando, FL, February 1991. President's Award Paper

22. "Reverse Hysterocolposigmoidectomy (RHCS) For Resection of Pan-Pelvic Tumors." Barnes, W, Johnson, Barter, JF, Potkul, R, Delgado. Society of Gynecologic Oncologists, Orlando, FL, February 1991.

23. "Use of the Biopty Gun in Gynecologic Oncology." Johnson, J, Waggoner, S, Potkul, RK, Barter, JF, Barnes, W, Delgado, G. Mid-Atlantic Gynecologic Oncology Society Sixth Annual Meeting, Ocean City, MD, October 1991.

24. "Response of HPV Lesions to Interferon in Human Xenografts." Barnes, W, Jenson, A, Johnson C, Holloway R, Delgado G, Barter JF, Potkul, R, Lancaster W. Society of Gynecologic Oncologists, San Antonio, TX, March 1992.

25. "Inefficacy of Continuous Infusional 5-Fluorouracil For Refractory Ovarian Cancer." Burnett, AF, Barter, JF, Hines, J, Jarvis, TJ, Johnson, JC, Barnes, W. Mid-Atlantic Gynecologic Oncology Society, Richmond, VA, October 1992.

26. "Groshong Central Line Placement Under Fluoroscopy." Burnett, AF, Lossef, SV, Barth, KH, Barter, JF, Johnson, JC, Barnes, W. Mid-Atlantic Gynecologic Oncology Society, Richmond, VA, October 1992.

27. "Ineffectiveness of Low Dose Continuous Infusional 5-Fluorouracil for Refractory Ovarian Cancer." Barter, JF, Jarvis, TJ, Potkul, RK, Johnson, JC, Barnes, W. American College of Obstetrics and Gynecology District IV, San Juan, PR, November 1992. From the Podium.

28. "Human Papillomavirus 18 as a Risk Factor for Recurrent Cervical Cancer." Burnett, AF, Johnson, J, Grendys, E, Willett, G, Barter, JF, Barnes, W. American College of Obstetrics and Gynecology District IV, San Juan, PR, November 1992. Poster Presentation

29. "Human Papillomavirus 18 as a Risk Factor For Recurrent Cervical Cancer." Burnett, AF, Barnes, W, Johnson, JC, Grendys, E, Barter, JF, Willett, G, Doniger, Gynecol Oncol 49 (1), 127-128, 1993. 24th Annual Meeting, Society of Gynecologic Oncologists, Palm Desert, CA, February 1993.

30. "Accuracy of In-Cyt-103 Immunoscintigraphy in Ovarian Cancer Patients Undergoing Second-Look Laparotomy." Waggoner, S, Barnes, W, Barter, JF, Delgado, G, Keyes, Gynecol Oncol 49 (1), 143-144, 1993. 24th Annual Meeting, Society of Gynecologic Oncologists, Palm Desert, CA, February 1993.

31. "Preservation of Multiple Oncogenic Human Papillomavirus Types in Recurrences of Early Stage Cervical Cancers." Burnett, AF, Moore, J, Grendys E, Willett, G, Johnson JC, Barter, JF, Barnes, W. Middle Atlantic Gynecologic Oncology Society Meeting, Georgetown University Medical Center, Washington, DC, September 1993.

32. "Vulvar Reconstruction Using a Mons Pubis Pedicle Flap." Potkul, R, Barnes, W, Barter, JF, Delgado, G, Spear, S. 25th Annual Meeting Society of Gynecologic Oncologists, Orlando, FL, February 1994.

33. "Morbidity of Second Look Laparotomy: The Georgetown University Hospital Experience." Mahtre, K, Hines, J, Johnson JC, Barnes W, Barter JF. Resident Research Day. Washington, DC, November 1994.

34. "Does Pelvic Radiation Alter Papanicolaou Smear Interpretation by the Computerized Papnet System?" Barter JF, Willett G, Moore JL, deBrito P, Laver N, Mango LJ. American College of Obstetrics and Gynecology, Bermuda, October 1995.

35. "Poly (ADP-ribose) Polymerase Differences in African American versus Caucasian Women with Cervical Cancer." Roberts, C, Barter, JF, Smulson, M. Georgetown University Dept. of OB/GYN 14th Annual Resident Research Day, Washington, DC, December 1995.

36. "Phase I Trial of Baltimastat (BB-94), A Novel Matrix Metalloproteinase Inhibitor in Patients with Advanced Cancer." Wojtowiez-Praga, S, Low, J, Marshall, J, Ness, E, Dickson, R, Barter, JF, Sale, M, McCann, P, Cole, A, Hawkins, M. American Society Clinical Oncologists, Philadelphia, PA, May 1995.

37. "Cancer Screening Practices in Women from High Risk Breast Cancer Families." Isaacs, C, Peshkin, B, Reutenauer, J, Reed, M, Main, D, Magnant,C, Pennanen, M, Berg, C, Barter, JF. Submitted for presentation ASCO Annual Meeting, Denver, CO, May 17-20, 1997.

38. "The Clinical Significance of the "AGUS" (Atypical Glandular Cells of Uncertain Significance) Pap Smear." Sarafian, M, Webb, K, Barter, JF. Georgetown Residents' Projects Seminar, Washington, DC, November 1997.

39. "Prolonged Oral Etoposide In Recurrent or Advanced Leiomyosarcoma of the Uterus: A Gynecologic Oncology Group (GOG) Study." Rose, P, Blessing, J, Soper, J, Barter JF. 29th Annual Meeting of the Society of Gynecologic Oncologists, Orlando, FL, February 7-11, 1998.

PEER REVIEW JOURNALS

1. Barter JF, Addison WA, Hidalgo H, Hammond CB: Inferior Vena Cava Thrombosis with Oral Contraceptives: Documented by Computer Tomography. Obstet & Gynecol 61, 595, 1983.

2. Barter JF, Addison WA, Rosenberg ER, Hammond CB: Anterior Sacral Meningocele Presenting as a Pelvic Mass Diagnosed only at Cellotomy after Extensive Workup. J Reprod Med 2, 684, 1983.

3. Eden RD, Wahbeh CJ, Barter JF, Williams AY, Killam AP, Gall SA: Serial Nephelometric Urinary Profile as an Index of Renal Involvement in Severe Pregnancy Induced Hypertension. Am J Obstet & Gynecol 147, 106, 1983.

4. Holcomb, G, Creasman, WT, Barter, JF, Johnston, WW, Szpak, CA: Peritoneal Washings in Patients with Mixed Mullerian Tumors of the Uterus. Acta Cytologica, 28, 632-655, 1984.

5. Barter JF, Smith EB, Spzack C, Clarke-Pearson D, Creasman WC: Leiomyosarcoma of the Uterus; Clinicopathologic Study of 21 Cases. Gynecol Oncol 21 (2), 220, 1985.

6. Barter JF, Austin Jr. JM, Shingleton HM: In Utero DES Exposure Associated with Adenocarcinoma of the Endometrium. Obstet & Gynecol 67, 84S, 1986.

7. Geszler G, Szpak CA, Harris RE, Creasman WT, Barter JF, Johnston WW: Prognostic Value of Peritoneal Washings in Patients with Malignant Mixed Mullerian Tumors of the Uterus. Am J Obstet & Gynecol 155, 83-9, 1986.

8. Barter JF, Hatch KD, Orr Jr. JW, Shingleton HM, Gore H: Isolated Abdominal Wound Recurrence of an Endometrial Adenocarcinoma Confined to a Polyp. Gynecol Oncol 25 (3), 372-375, 1986.

9. Barter JF, Orr Jr. JW, Hatch KD, Shingleton HM: Diethylstilbesterol in Pregnancy: An Update. South Med J 79 (12), 1531-1534, 1986.

10. Barter JF, Addison WA, Livengood CH, Rosenberg ER: Calcific Pelvic Lymphadenopathy Presenting as a Post Menopausal Adnexal Mass: A Case Report. J Reprod Med 29 (3), 209-213, 1984.

11. Orr Jr. JW, Barter JF, Kilgore LC, Soong SJ, Shingleton HM, Hatch KD: Closed Suction Pelvic Drainage after Radical Pelvic Surgical Procedures. Am J Obstet & Gynecol 155, 867-71, 1986.

12. Barter JF, Orr Jr. JW, Holloway RW, Hatch KD, Shingleton HM: Psammoma Bodies in a Cervicovaginal Smear Associated with an Intrauterine Device. J Reprod Med 32, 147-8, 1987.

13. Barter JF, Mazur MW, Holloway RH, Hatch KD: Melanosis of the Cervix. Gynecol Oncol 29, 101-4, 1988.

14. Barter JF, Soong SJ, Hatch KD, Orr Jr. JW, Partridge EC, Austin Jr. JM, Shingleton HM: Treatment of Nonmetastatic Gestational Trophoblastic Disease with Oral Methotrexate. Am J Obstet & Gynecol 157, 1166-1168, 1987.

15. Barter JF, Shingleton HM: Treatment of Lymph Node Metastases in Cervical Cancer. Alabama J Med Sciences, 23 (1), 19-22, 1986.

16. Barter JF, Shingleton HM, Soong SJ, Hatch KD, Orr Jr. JW: Complications of Combined Radical Hysterectomy - Post Operative Radiation Therapy in Women with Early Stage Cervical Cancer. Gynecol Oncol 32, 292-6, 1989.

17. Barter JF, Szpack C, Creasman WT: Uterine Leiomyomas with Retroperitoneal Lymph Node Involvement. South Med J, 80, 1320-1322, 1987.

18. Barter JF, Soong SJ, Hatch KD, Orr Jr. JW, Partridge EC, Austin Jr JM, Shingleton HM: Treatment of Nonmetastatic Gestational Trophoblastic Disease with Sequential Intramuscular then Oral Methotrexate. Gynecol Oncol 35, 82-84, 1989.

19. Torrisi JR, Barnes W, Popescu G, Whitfield G, Barter JF, Lewandowski G, Delgado G: Postoperative Adjuvant External-Beam Radiotherapy in Stage One Endometrial Carcinoma. Cancer 64, 1414-1417, 1989.

20. Delgado G, Potkul R, Treat JA, Lewandowski G, Barter JF, Forst D, Rahman A: A Phase I/II Study of Intraperitoneally Administered Doxorubicin Entrapped in Cardiolipin Liposomes in Patients with Ovarian Cancer. Am J Obstet & Gynecol 160, 812-9, 1989.

21. Barnes W, Delgado G, Holloway R, Jenson A, Weck P, Kreider J, Barter JF, Potkul R, Johnson JC, Lancaster W: Effect of Human Interferon on Human Papillomavirus Induced Lesions of Human Epithelial Xenografts in Athymic Mice. Gynecol Oncol 32, 114, 1989.

22. Barter JF, Marlow D, Kamath RK, Harbert J, Torrisi JR, Barnes W, Potkul R, Newsome JT, Delgado G: Thromboxane Synthetase Inhibitor (CGS-13080) Effect On Blood Flow In Radiated Canine Intestine. Gynecol Oncol 40, 218-21, 1991.

23. Shuster PA, Barter JF, Potkul R, Barnes W, Delgado G: Morbidity After Radical Hysterectomy in Relation to Age. Obstet & Gynecol 78, 77-79, 1991.

24. Barter JF: Life and Contributions of George N. Papanicolaou. Surg Gyn Obstet 174, 530-532, 1992.

25. Barnes W, Johnson J, Waggoner S, Barter JF, Potkul R, Delgado G: Reverse Hysterocolposigmoidectomy (RHCS) for Resection of Panpelvic Tumors. Gynecol Oncol 42, 151-155, 1991.

26. Barnes W, Waggoner S, Delgado G, Maher K, Potkul R, Barter JF, Benjamin S: Manometric Characterization of Rectal Dysfunction Following Radical Hysterectomy. Gynecol Oncol 42, 116-119, 1991.

27. Burnett AF, Barnes WA, Johnson JC, Grendys E, Willett G, Barter JF, Doniger J: Prognostic Significance of Polymerase Chain Reaction Detected Human Papillomavirus of Tumors and Lymph Nodes in Surgically Treated Stage IB Cervix Cancer. Gynecol Oncol 47, 343-347, 1992.

28. Burnett AF, Potkul R, Barter JF, Barnes W, Delgado G: Colonic Surgery in Gynecologic Oncology; Risk Factors For Morbidity. J Reprod Med, 38 (2), 137-141, 1993.

29. Potkul R, Barnes W, Barter JF, Delgado G, Spear S: Vulvar Reconstruction Using A Mons Pubis Pedicle Flap. Gynecol Oncol 55, 21-24, 1994.

30. Burnett AF, Grendys E, Willett G, Johnson, JC, Barter, JF, Barnes W: Preservation of Multiple Oncogenic Human Papillomavirus Types in Recurrences of Early Stage Cervical Cancers. Am J Obstet & Gynecol 170, 1230-3, (1993).

31. Burnett AF, Barter JF, Johnson JC, Potkul R, Jarvis T, Barnes, W: Inefficacy of Low Dose Continuous Infusional 5-Fluorouracil as Salvage Therapy for Ovarian Cancer. Am J Clinic Oncol 17 (6), 490-493, 1994.

32. Burnett AF, Lossef SV. Barth KH, Grendys E, Johnson JC, Barter JF, Barnes W: Insertion of Groshong Central Venous Catheters Utilizing Fluoroscopic Techniques. Gynecol Oncol 52 (1), 69-73, 1994.

33. Waggoner S, Johnson J, Barter JF, Barnes W: Intraperitoneal Therapy Administered Through a Groshong Catheter. Gynecol Oncol 53, 320-325, 1994.

34. Waggoner S, Barter JF, Delgado G, Barnes W: Case-Control Analysis of Clostridium Difficile Associated Diarrhea on a Gynecologic Oncology Service. Infectious Diseases in Obstetrics and Gynecology 2, 154-161, 1994.

35. Hines J, Tucker A, Grendys E, Ascher S, Barter JF: Spontaneous Preoperative Internal Jugular and Subclavian Vein Thrombosis Associated with an Early Stage Synchronous Ovarian/Endometrial Malignancy. Gynecol Oncol 56, 298-301, 1995.

36. Wojtowiez-Praga S, Low J, Marshall J, Ness E, Dickson R, Barter JF, Sale M, McCann P, Cole A, Hawkins M: Pharmacokinetics of Batimastat (BB94): A Novel Matrix Metalloproteinase Inhibitor in Patients with Ovarian Cancer. Proc Am S Clin Oncol 14, 474, Abst 1536, 1995.

37. Moore J, Barter JF: Second Look Laparotomy. Semin Surg Oncol 10 (4), 276-82, 1994.

38. Hughes C, Gomez-Caminero A, Benkendorf J, Isaacs C, Barter JF, Lerman C: Factors Associated with Knowledge about Inherited Breast-Ovarian Cancer Susceptibility. (Submitted for Publication) 1996.

39. Kuettel M, Javedan K, Barter, JF. Treatment of Locally Advanced Vaginal Cancer Presenting in the Rectovaginal Septum using External Beam Irradiation and High Dose Rate Brachytherapy. (Submitted for Publication) Gynecol Oncol, 1996.

40. Wojtowicz-Praga S, Low J, Marshall J, Ness E, Dickson R, Barter JF, Sale M, McCann P, Moore J, Cole A, Hawkins MJ: Phase I Trial of a Novel Matrix Metalloproteinase Inhibitor Batimastat (BB-94) in Patients with Advanced Cancer. Investigational New Drugs 14, 193-202, 1996.

41. Malfetano J, Teng N, Moore D, Barter JF, Lopez A, Schink J, Cole A, Rasmussen H: Marmimastat, a Novel Matrix Metalloproteinase Inhibitor in Patients with Advanced Cancer of the Ovary: A Dose-Finding Study. Proc Am Soc Clin Oncol 15, 283, 1996.

42. Rose P, Blessing J, Soper J, Barter JF: Prolonged Oral Etoposide in Recurrent or Advanced Leiomyosarcom of the Uterus: A Gynecologic Oncology Group Study. (Submitted for Publiction) Gynecol Oncol, 1997.

43. Hughes C, Gomez-Caminero A, Benkendorf J, Kerner J, Isaacs C, Barter JF, Lerman C: Ethnic Differences in Knowledge and Attitudes about BRCA-1 Testing in Women at Increased Risk. Patient Education and Counseling 32, 51-62, 1997.

44. Spear S, Pennanen M, Barter JF, Burke JB: Prophylactic Mastectomy, Oophorectomy, Hysterectomy and Immedicate "TRAM" Flap Breast Reconstruction in a BRCA-1 Positive Patient. (Submitted for Publication), 1997.

ARTICLES - NON PEER REVIEW

1. Barter JF: Gynecologic Oncology Teaching Module. Georgetown University Medical Center. 1986, 1988, 1991, 1995.

2. Barter JF, Sanz LE: Staplers for Gynecologic Surgery - What's Available? Contemp Obstet Gynecol, October 87-99, 1986.

3. Barter JF, Sanz LE: Surgical Staples. Contemp Obstet Gynecol January 1988.

4. Holloway RW, Barnes WA, Barter JF: The CO2 laser: A Guide to Its Use in Lower Genital Tract Disorders. Part I: Cervical Intraepithelial Neoplasia and Excisional Cone Biopsy. The Female Patient 13, 13 - 19, 1988.

5. Holloway RW, Barnes W, Barter JF: The CO2 Laser: A Guide to Its Use in Lower Genital Tract Disorders. Part II: Vaginal and Vulvar Lesions and Condylomata Acuminata. The Female Patient 13, 14 - 19, 1988.

6. Barter JF, Sanz LE, Burnett AF: Latest on Staplers. Contemp Obstet Gynecol 40, 18, April 15, 1995.

7. Barter JF: Pseudomyxoma Peritonei. Cancer Case Presentations; The Tumor Board: Commission of Cancer of the American College of Surgeons: In Press.

BOOK CHAPTERS

1. Barter JF, Sanz LE. Surgical Staplers. Contemporary Gynecologic Surgery, Luis Sanz, M.D., editor, Medical Economics, Oradelle, NJ, 1988.

2. Barter JF, Barnes W. Second Look Laparotomy. Ovarian Cancer, Rubin S, Sutton G, editors, McGraw Hill, New York, NY, 1992.

3. Grendys E, Barter JF, Barnes, W. Gestational Trophoblastic Disease. Laboratory in Obstetrics and Gynecology, Gerald D. Willett, M.D., editor, Blackwell Scientific Inc., Boston, MA, 1993.

4. Barter JF, Burnett AF, Sanz LE. Innovations in Surgical Staplers. Gynecologic Surgery, Luis Sanz, M.D., editor, 1994.

5. Sanz LE, Barter JF. Laparoscopic Assisted Vaginal Hysterectomy. Gynecologic Surgery, Luis Sanz, M.D., editor, 1994.

6. Moore J, Barter JF. Second Look Laparotomy. Clinical Obstet and Gynecol, (28) 185-192, Hugh Shingleton, M.D., editor, 1994.

IN THE SUPERIOR COURT OF DISTRICT OF COLUMBIA
CIVIL DIVISION

[redacted]

MARIAH KELLER,	*	
	*	
Plaintiff	*	
	*	
vs.	*	Civil No. 01CA008316
	*	Calendar 7, Judge Beck
CYTOLOGY SERVICES OF MARYLAND, INC., et al.	*	Next Event: Discovery Closed 12/30/02
	*	
Defendants	*	

SECOND SUPPLEMENTAL 26(B)(4) STATEMENT OF DEFENDANT CYTOLOGY SERVICES OF MARYLAND, INC.

Comes now, the Defendant, Cytology Services of Maryland, Inc. (hereinafter CSM), by and through undersigned counsel, submits the following supplement to the 26(b)(4) Statement previously filed:

1. Howard Adelman, M.D.
New York, New York

Dr. Adelman has already been deposed and provided his opinions with regard to the cytology specimens at issue in this case.

2. James S. Barter, M.D.
5698 Searl Terrace
Bethesda, Maryland 20816

In addition to the previously identified opinions of Dr. Barter, it is expected that he will testify about the course of care and treatment that the Plaintiff would have received had the cancer been diagnosed in January, 1999, January, 2000 and September, 2000. Specifically it will be his testimony, to a reasonably degree of probability, that had the Plaintiff been diagnosed with cancer in January, 1999

that she would have needed the same or similar operation that was accomplished in January, 2001. This will also be Dr. Barter's testimony with regard to January, 2000 and September, 2000. He will also testify about the Plaintiff's need for adjuvant therapies at these three earlier time frames. It is his expected testimony that the Plaintiff would have needed adjuvant therapies had she been diagnosed at these earlier time frames. Furthermore, Dr. Barter will address the Plaintiff's current complaints and symptoms. It is expected that he will testify that these symptoms or complaints would probably have existed even if the cancer had been diagnosed in January, 1999, January, 2000 or September, 2000. The basis for this opinion is that the Plaintiff would have needed the same or similar operation and care and treatment that she received in January, 2001 if the cancer had been diagnosed at the earlier referenced time frames.

Finally, Dr. Barter will testify about Ms. Keller's prognosis, both currently and at the earlier time frames referenced.

3. Preston C. Sachs, M.D.
2240 M Street, NW, Suite 401
Washington, DC 20037

In addition to the statements previously provided concerning the opinions of Dr. Sachs, it is expected that he will testify that through a surrogate mother, the Plaintiff, to a reasonable degree of probability, can have a biological child, if she so desires. He will testify about the process of invitro fertilization, both in general terms and in relationship to the Plaintiff's condition. Furthermore, he will testify

about general issues concerning the Plaintiff's fertility and the impact or affect of her prior course of care and treatment and her cancer.

This Defendant reserves the right to utilize any treating physicians, including Dr. Lin and Dr. Gindorf, as previously identified in the original 26(b)(4) Statement. Furthermore, this Defendant reserves the right to utilize experts identified by Co-Defendant Abraham as if completely identified and referenced in this 26(b)(4) Statement.

Respectfully Submitted,

Andrew E. Vernick, Esquire, #367716
Wharton, Levin, Ehrmantraut & Klein
104 West Street
Annapolis, Maryland 21404
(410) 263-5900
Attorneys for Defendant
Cytology Services of Maryland, Inc. and
William Jaffurs, M.D.

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this 16th day of December, 2002, a copy of the foregoing Defendant Cytology Services of Maryland, Inc.'s Second Supplemental Rule 26(b)(4) Statement was faxed and mailed, first class, postage prepaid to:

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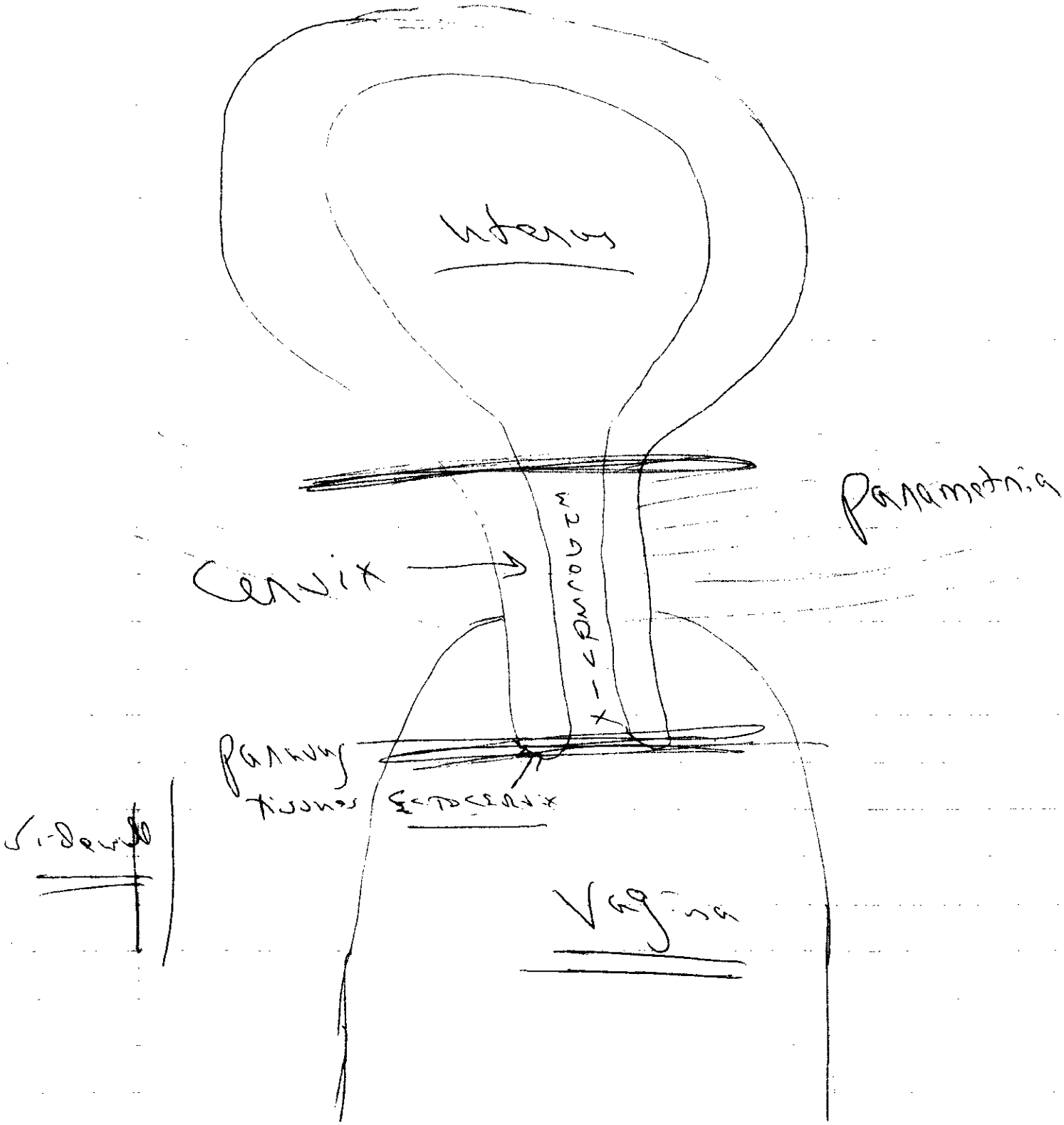
Uterus
Cervix
Parametrium
Vagina