COPY

STATE OF OHIO
COUNTY OF CUYAHOGA

Case No. 346,907
Judge Mannan

- - -

IN THE COURT OF COMMON PLEAS

- - -

JAMES SCARLETT, et al.,

Plaintiffs,

vs.

Arthur Porter, et al.,

Defendants.

---------- /

DEPOSITION OF

W. E. BARZELL, M.D.

TAKEN BY: Defendant Herein

REPORTED BY: Betsy Ridenour
Court Reporter and Notary Public
State of Florida at Large

DATE: January 27, 1999
Commencing at 5:00 p.m.

PLACE: 1921 Waldemere Street
Sarasota, Florida

APPEARANCES:

HOWARD D. MISHKIND, ESQ.
Becker & Mishkind Co., L.P.A.
1600 W. 2nd Street
Suite 660
Cleveland, Ohio 44113
Appearing on behalf of the Plaintiffs

EDWARD J. CASS, ESQ.
Gallagher, Sharp, Fulton & Norman
1501 Euclid Avenue
7th Floor
Cleveland, Ohio 44115
Appearing on behalf of the Defendants

Also Present: James Scarlett

INDEX OF EXAMINATION AND EXHIBITS

EXHIBITS MARKED FOR IDENTIFICATION

Thereupon,

W. E. BARZELL, M.D.

was called for examination, and having been first duly sworn by the Court Reporter, was examined and testified as follows:

DIRECT EXAMINATION

BY MR. CASS:

Q. Dr. Barzell, my name is Edward Cass.

A. Okay.

Q. And I represent Dr. Porter in this litigation. I'm sure you're aware of that litigation.

A. Okay.

Q. I'm going to ask you some questions about your treatment of Mr. Scarlett.

A. Sure, okay.

Q. If for any reason you don't -- has your deposition been taken before? I presume it has.

A. In this case?

Q. Not in this case, but in other cases?

A. Yes.

Q. Okay. Feel free to tell me if you don't understand my question and I'll be glad to rephrase it.

A. Okay.

Q. I would kind of like to start with what treatments you have been administering -- you are the primary care physician, I take it, for Mr. Scarlett; is that correct?

A. I'm a urologist.

Q. The last record I have is -- I believe it was January of 1998.

A. Uh-huh.

Q. It's a year old now. Could you tell me what you have -- what has transpired with Mr. Scarlett from a urological standpoint since that time?

A. Well --

Q. Let me see if I can find the record here.

MR. MISHKIND: Do you want to look at mine and save some time?

MR. CASS: Yes.

(Document handed to counsel.)

THE WITNESS: He was seen here July '98 and -- well, first of all, he's been having his suprapubic tube changed on a periodic basis.

BY MR. CASS:

Q. That seemed to be what you were seeing

him for much of the time --

A. Right.

Q. -- on these most recent notes there.

A. Right, yes, he gets his tube changed. And we do periodic cultures, and if he gets a fever we treat him. And then in June -- I usually look in because the suprapubic tube can develop --

Q. Let's just take it from January 5th. That's the last entry I have. Or January 28th, excuse me, is the last entry I have here, and there are two handwritten notes here. I'm not sure if they're your handwriting or whatever.

A. Well, I don't --

Q. Look at 1/5/98.

A. I don't have that.

MR. MISHKIND: Why don't you hand the doctor --

MR. CASS: Yes. It's not marked, but just so you know what I'm talking about.

(Document handed to witness.)

THE WITNESS: I don't know where that note is. It's not here.

BY MR. CASS:

Q. Why don't we just start in January of 1998, and take us up to the present time.

A. Well, I'm trying to tell you, I don't know where that note is in my chart. It's not there.

MR. MISHKIND: This copy came from your office, so it's got to be someplace.

THE WITNESS: Yes, it's from here, but I don't know how it -- they maybe copied it and when they put it back in they misfiled it. So I don't know where that is. But this is my file, so I can tell you.

So January 5th he came for an SP tube change. January 28th he came for an SP tube change. That's a suprapubic tube change.

BY MR. CASS:

Q. Okay. Can we just follow up from there, until the present time?

A. Oh, there it is. I found it. Okay. Sorry. January 5th he had an SP tube change. The 29th --

Q. And an SP tube is what?

A. Suprapubic tube.

Q. All right. Is that the same thing as a Foley catheter?

A. No, it's a -- a Foley catheter goes in the stomach, which he had to have because his

urethra is not passable. You can't get into his bladder.

Q. What happened after January 28th?

A. February 23rd he had an SP tube change. March 16th, SP tube change. Isn't it better just to get a copy of all this?

Q. Yes, I would like a copy.

A. Do you want me to go through every one of these?

Q. Just so I know what we are talking about.

A. Well, he has SP tube changes every three or four weeks here.

Q. Just give me the dates. It looks like you have quite a bit of notes since -- within the last year?

A. Yes. These are all nurse's notes relative to SP tube changes. Wouldn't it be easier if I would just send them to you?

Q. That would be fine. That would be fine.

A. Okay.

Q. Have you seen him or have you treated him for anything other than the tube changes?

A. I was going to tell you when I saw him.

Q. Okay, do that.

A. Okay. On June 29th of '98 he came in, and at that time he had a urine culture showing Serratia, Klebsiella, which are organisms which will block a tube when you have a tube in.

And I scoped him because you need to make sure that there is no stones or tumors that develop around the tube, which sometimes can happen, *so* we periodically scope patients. And he had a clean mucosa.

And it says minimally -- with surprisingly clean mucosa with minimal cath reaction. But there was granulation tissue at the tract. And I told him to drink lots of fluid and I gave him some antibiotics and told him to come back in November.

And then he came periodically again to have his SP tube changed.

Q. Skipping the SP tube changes --

A. Right.

Q. Did he, in fact, come in in November?

A. And then in September he had a problem with an infection and went to see ID Associates. I don't have a copy of that note. It's just -- we changed his tube and -- that's September.

And then he comes in November, Doing

well. PSA is 2.1, and I said I'll see him in July. If the PSA gets over ten or starts to rise, consider second line therapy. I said because of his prior hepatotoxicity, I would rather avoid Casodex. So I wasn't giving him that. In any event, it didn't appear to work in orchiectomized patients.

So that's it. And then he got some tube changes, and that's it.

Q. And your next scheduled appointment is not until July of 1999?

A. Correct.

Q. Okay. And doctor --

A. And since then he's come in for tube changes.

Q. If we could make copies of those records, I'd appreciate it.

A. Yes, right.

Q. Let me go back now to the time you first saw Mr. Scarlett.

A. Right.

Q. Do you recall when that was?

A. This was in '93. At that time I thought he had a stage C-2 adenocarcinoma. C-2 is a high advanced local disease.

Q. The first record I have seems to be July 20th of 1993. Is that what you have?
A. Yes, yes.
Q. And he had been diagnosed at that time as having cancer?
A. No, he was -- he hadn't been biopsied yet.
Q. Okay.
A. That was my clinical impression.
Q. And I think you indicated at that time you wanted to rule out metastatic disease?
A. Yes.
Q. And when was he -- when was he diagnosed as having cancer?
A. With the biopsy, which was done on July 20th, '93.
Q. Okay, And that showed --
A. That showed cancer. I'll look here.
Q. It looks like you say your impression was stage C-2 --
A. Right.
Q. Rule out metastatic disease?
A. Right.
Q. And --
A. July 20th, '93 is when we first made the

diagnosis. Moderately to poorly differentiated cancer.

Q. I think you saw him again the next day then, didn't you? July, 22nd?

A. Yes. Yes, we did.

Q. Why don't you just tell me, as best you can, doctor, through the six-month period, July through the end of the year, what the course of treatment was that you administered --

A. Well, he --

Q. -- to Mr. Scarlett.

A. He had what I thought was an incurable cancer, incurable by surgery? radiation or any other local means, because I felt he most likely had what we call micro metastases, which is when a cancer has -- is a Stage C and is poorly differentiated, the attempts at local control are usually futile, so -- such as radiation, surgery, cryosurgery, any of those treatments that are delivered for local control of cancer.

So what we do is we give systemic treatment which will take care of the cancer, no matter where it is in the body.

Q. This is the Lupron --

A. Lupron and Casodex, yes. That's what he

was on, Lupron --

Q. I think they call it the LaBrie treatment or something?

A. LaBrie, exactly.

Q. And you started him on a program of that?

A. Right, yes. And then because he was only 57, I've had a few experiences where even though the cancer looks very bad initially, you can shrink it down to where we can't feel it, and then we can do surgery and then radiate. But it's anecdotal cases. And actually, since that time, since '93 it's been shown that that doesn't even work.

But in any event, we never got him shrunk. We could never shrink him down. I repeated a biopsy down the road. I can't tell you the date, but it's in the record. And the cancer was still there.

And my conclusion to him was that while we could explore him -- he wanted something done. You know, he wanted surgery or something like that, you know. And I said, you know -- I said, you know, we could explore you, but my feeling would be that this is not curable. And I said, if you

insist, we could explore you with the understanding if we found positive lymph nodes we wouldn't do anymore. If we found positive and negative lymph nodes and it was curable, we could take it out. But I said, if you ask me, the best way to go is an orchiectomy.

Q. Well, when you're talking about if there weren't any lymph node involvement you could do surgery, are you talking about a radical prostatectomy?

A. We would consider it. I mean maybe you'd get in there and find it was stuck. I think in his case if I -- we would have either found lymph nodes, probably or most likely found lymph nodes -- actually, yes, because he subsequently was found to have positive lymph nodes -- or we would have found the cancer was unresectable. It was just too advanced when we -- if you get a cancer that's too advanced when you first see a patient, there's no point in making him worse by operating, you know, doing some radical surgery. He's better off just to have hormone treatment.

Q. You considered radiation as well, did you not?

A. Yes.

Q. Did there come a time when the Lupron was causing problems with his liver?

A. Well, there was some liver toxicity and we couldn't tell what was causing what, so we stopped everything.

Q. And you're talking about hepatitis, I think you --

A. Right. And he had a biopsy and it showed hepatitis. Whether -- we never did determine whether this was hepatitis preexisting that was just flared up, which can flare up. In other words, if you had hepatitis and you get a hepatic -- potentially hepatotoxic drug, it can flare up the hepatitis.

We could never tell. I was never convinced, but you could ask Dr. Loewe, who was the guy who did his biopsy, as to what his thoughts were. I was never convinced whether it was hepatitis from Lupron, Casodex, precipitated by those drugs, or whether it was related to -- I'm sorry, am I going too fast?

THE REPORTER: You're going a little fast. Thank you.

THE WITNESS: Or whether this was hepatitis from the virus.

BY MR. CASS:

Q. There was a time when you took him off the Lupron, though?

A. Yes, he had to be because he was --

Q. Because you thought that was aggravating or causing the -- possibly causing the hepatitis?

A. Yes.

Q. At that point -- and I'm not sure if you have the records as to when that was --

A. Yeah.

Q. But I think we're now into 1993, aren't we?

A. Yes.

Q. And you had sent him also for a second opinion, I think to Dr. Pow-Sang?

A. Right, yes.

Q. What, if anything, were you considering doing?

A. Orchiectomy was my first option.

Q. Okay.

A. I can read it in the note. I think I have a note here.

Q. In your record of -- I think it's November 24th --

A. Well, let me read you a note here

4/8/94, which is after he saw Pow-Sang and everybody. And I said: The patient returns for follow-up. Dr. Bregg spoke with Dr. Loewe. LFT's are improved. Dr. Loewe feels that Lupron may be implicated, and therefore, no further Lupron.

MR. MISHKIND: If you could slow down a bit.

THE WITNESS: Can you give her a copy of this?

MR. CASS: Well, I have it here,

MR. MISHKIND: Unfortunately, I can't -- she's got to get your testimony.

THE WITNESS: The patient returns for follow-up. Dr. Bregg spoke with Dr. Loewe. LFT's are improved. Dr. Loewe feels that Lupron may be implicated, and therefore, no further Lupron. Indeed, the patient has not had any Lupron since February 1st. He feels well and comes in today with his wife for a discussion.

MR. CASS: Now --

THE WITNESS: In this setting, considering the recent reports from MGH and Stanford, I don't think that radiation has a place. I don't believe that he's curable

with radical surgery, and considering Dr. Stamey's recent reports about increasing doubling time after positive margins, and since he's had significant hepatic dysfunction that may be reactivated with an anesthetic, I don't think that surgery is a good choice either.

I have therefore recommended that the patient have a bilateral orchiectomy which could be done under local with MAC. No further Lupron or flutamide.

BY MR. CASS:

Q. Now, was it during that visit when you also discussed cryosurgery with the patient?

A. Can I finish reading it?

Q. Sure.

A. The other option is to consider cryosurgery, but once again, he's not that symptomatic, does not have any obstructive complaints, and cryosurgery in this setting can be considered almost experimental, in quotation marks.

Q. Can you tell us what you meant by "not symptomatic"?

A. He had no symptoms from obstruction, from blockage. He didn't -- you know, he was

peeing okay and did not have any trouble urinating.

Mr. Scarlett had a lot of questions which I tried to answer. He will be in Tampa next week, and I have suggested that he check back with Dr. Pow-Sang again.

Q. Did you discuss the ramifications of the cryosurgery with the patient?

A. No.

Q. You did not do that?

A. No, no, Pow-Sang was the guy that was talking to him about it, and I wasn't going to do it.

Q. Now --

A. You know, I don't believe in it, and I mean I didn't believe in it then. And I said if he wanted to have it done, then he could have Pow-Sang do it.

Q. Now, Pow-Sang did talk to him about it, did he not?

A. I don't know.

Q. He did not communicate with you?

A. He might have, but I mean I'd have to go through my records to see if I have a letter in here. Do you want me to -- I'd be happy to do it.

Q. Well, he saw him on April 24th of 1994.

You may have a record -- he may have sent a copy of that record to you.

A. Do you have it?

Q. I have it, yes, I do.

A. It'll make it easier for me if you just let me see it.

Q. Sure.

A. Let me just finish reading this here.

Q. Sure, go right ahead.

A. If he elects to have an orchiectomy, this can be scheduled at a mutually convenient time. If after he sees Dr. Pow-Sang he is still very much in favor of surgery, I would not be totally opposed to doing a pelvic exploration, and if lymph nodes were negative, to proceed with radical surgery under epidural anesthesia if cleared medically.

In summary, therefore, my first choice is for bilateral orchiectomy. The second would be either explorative surgery or cryosurgery.

This is -- and I sent copies to everybody.

MR. CASS: I'll mark Dr. Pow-Sang's record here. I'm not sure this went to you -- it says copy to Dr. Barzell.

THE WITNESS: I'm sure it's in here. If you have it, it would save me the time of going through this voluminous chart to look for it.

(Thereupon, Defendant's Exhibit No. 1 was marked for identification.)

BY MR. CASS:

Q. Doctor, I'll hand you what I have marked as Exhibit 1 here, and this shows a copy went to you from Dr. Pow-Sang. Do you recall that?

(Document handed to witness.)

A. Okay. Yes, I read it.

Q. He seems to say that this was a reasonable option for him.

A. Yes, he did, but he also said that he would -- he thought he had metastatic disease and that hormonal therapy was indicated.

He said: I again told the patient that most likely he has metastatic disease from the onset -- which he agrees with what I told you -- and that hormonal therapy was indicated and probably would be the treatment of choice.

Q. Well, Dr. Pow-Sang says: The patient understands the risks and complications of cryosurgery?

A. Yes.
Q. Including urethral sloughing, urethral cutaneous fistulas --
A. Yes.
Q. -- hematoma and incontinence?
A. Yes.
Q. Now, am I correct that you did not discuss this with the patient, though?
A. No.
Q. But you're aware that it had been discussed with him?
MR. MISNKIND: Objection.
THE WITNESS: I'm not aware. I'm aware now.
BY MR. CASS:
Q. Well, you got this from Dr. Pow-Sang, I presume. It says a copy went to you.
A. Well, I don't know. If you want me to tell you, I will look in my chart.
Q. Do you have any reason to believe he didn't send it to you?
A. No.
Q. You've got the records, so obviously --
Now, at that time Mr. Scarlett was talking about going to Cleveland for that --

A. I don't remember that. I mean he -- I read it here, but I don't remember. I don't think he told me.

Q. After that letter you got from Dr. Pow-Sang, I think you saw him -- or you saw Mrs. Scarlett I think the same day. It doesn't say what -- it says Dr. Barzell spoke with Mrs. Scarlett. This is April 25th, the same day as that.

A. Okay. Yes, she just said he's going to have cryosurgery. She told the nurses. And she wanted us to give him Lupron, and I said I wouldn't give him Lupron.

Q. And that was because Dr. Porter -- she talked to Dr. Porter, or he had talked to Dr. Porter and Dr. Porter had asked for that?

MR. MISHKIND: Objection.

THE WITNESS: Do you have the note?

MR. CASS: I have the note here, yes.

THE WITNESS: Okay. Do you want me to read it?

MR. CASS: It looks like a copy. We'll make it an exhibit.

(Thereupon, Defendant's Exhibit No. 2 was marked for identification,)

BY MR. CASS:

Q. I'll hand you what's been marked as Exhibit 2.

(Document handed to witness.)

A. This is the note I just read. You're talking about the 4/29 note.

Q. You're right. I got the wrong one. I thought it was eleven. Excuse me, doctor.

A, I'm not trying to -- I'm just trying to make things for simplicity's sake, rather than read -- you have and I have a copy.

MR. CASS: We will mark this as 3, and it's a handwritten note.

(Thereupon, Defendant's Exhibit No. 3 was marked for identification.)

(Document handed to witness.)

THE WITNESS: Do you want me to read it? Do you want to read it?

MR. CASS: Sure, go ahead. You can read it into the record. That simplifies my asking you a question about it.

THE WITNESS: Mr. Scarlett called. Will be pursuing cryosusgery -- this is a nurse's note -- several weeks from now in Cleveland, and with Dr. Porter at Urology Services.

Mr. Scarlett was told by Dr. Porter to take Lupron per Dr. Barzell. Dr. Barzell informed and does not agree that Lupron is appropriate in this setting because of his liver. Mr. Scarlett -- I'm adding that now, "because of his liver."

Mr. Scarlett informed, and he will contact Dr. Porter and have Dr. Porter call Dr. Barzell.

BY MR. CASS:

Q. Did you ever talk to Dr. Porter?

A. No. Not that I -- I mean I may have, but I don't remember.

Q. Okay. Did you ever attempt to contact Dr. Porter?

A. I don't know, frankly. I can't tell you that. I don't know how to answer that. I don't know. I can't remember.

I think he was going to call me, from what I read here. 5/3, Mr. Scarlett called. He's concerned with the Lupron issue. Has spoken to Dr. Porter's office and has requested that Dr. Porter call you. See, Porter was going to call me.

Q. Okay. Do you recall whether you did

confer with him?

A. I'm going to look here. I don't know. I just answered no, I don't recall, but I'll look here.

Then 5/10/94, Mr. Scarlett called from Tampa. He will be going on a cruise the end of May and will then proceed with whatever plan he decides upon. Patient informed by Dr. Barzell that he should contact Dr. Douglas Johnson at M.D. Anderson -- because this guy was a cryosurgery expert and he was a very honest guy, and I told him to call him and I gave him his number, but I guess he never did call him.

Q. I believe he had the cryosurgery in June of 1994. June 20th, I believe. I don't know if you have any of those records or not.

A. NO.

Q. When did you next see the patient after that cryosurgery of June of 20th, 1994, doctor, if you recall? You can look at your records if you want.

A. I think it's -- I think this is -- can we submit this? Do they have a copy of this?

MR. MISHKIMD: Yes, Mr. Cass has a copy of your letter.

THE WITNESS: This really -- it summarizes the whole thing, this letter.

MR. CASS: Let me see which one it is here. What's the date of that?

THE WITNESS: The date, November 5th, '96.

MR. CASS: November 5th of '96?

THE WITNESS: Yes. It's dated November 5th of '96.

MR. CASS: That must have been one of the most recent ones that he just gave you today?

MR. MISHKIND: No, it's the doctor's report to me that was given to Susan Reinker.

MR. CASS: Oh, okay. I don't think I got that.

MR. MISHKIND: Oh, really?

MR. CASS: No.

BY MR. CASS:

Q. What date did you first see him after his --

A. I'm going to summarize for you here.

Q. That's fine.

A. Otherwise, it will take me an hour to go through my records, because you have to understand

that what I have here is my office records.

I saw him in the hospital, and all those other records are in the hospital.

Q. Okay.

A. So for me to put it together with the records, I can't do it today unless you people can get me the hospital chart, but I can go from my letter that I wrote summarizing the situation.

Q. That's fine. Whatever refreshes your recollection, sir.

First of all, what date are we talking about here?

A. This is a letter dated November 5th, '96 to Howard Mishkind. It says: It is my understanding that you are in possession of a copy of my records. If you desire another copy, let me know. As you know, Mr. Scarlett's last visit to our office in Sarasota prior to his cryosurgery in Cleveland in June of 1994 was on 4/8/94. At that time I discussed various therapeutic options with him, and a copy of that note is enclosed. I did not hear from Mr. Scarlett until July 9, '94 when he presented in the emergency room in sepsis.

So the first time I saw him, if that answers your question, was July 9th.

Q. That answers my question. It was July 9th of 1994?

A. Yes. Do you want me to keep on reading?

Q. Sure, go ahead.

A. The patient at that time gave a history of having had a laparoscopic lymph node infection about three-and-a-half weeks earlier with a single positive node. Five days later he underwent cryo-ablation of the prostate. After returning to Sarasota around July 1st or 2nd, he was apparently seen in the emergency room with a temperature of 103 and treated with Cipro and appeared to improve.

Q. Now, you didn't see him on that occasion?

A. No. The first time I saw him was, as I just said, was July 9th, '94.

On the night of June -- 7/9/94 he called me at 10:00 p.m. complaining of nausea, vomiting, abdominal pain and a temperature of 103.

I met him in the emergency room and after a thorough evaluation by myself, Dr. Jack Reeder, a general surgeon, and Dr. Mark Lipman of Infectious Disease, it became apparent that the patient had a prostato-urethral fistula with abscess formation secondary to prostate

cryo-ablation. He was also exhibiting signs of septicemia.

He was, therefore, adequately prepped preoperatively with intravenous fluids, antibiotics, and on 7/10/94 underwent abdominal exploration and sigmoid colostomy, Hartmann pouch, exploration of retropubic space, drainage of a prostatic perirectal abscess, exploration of the bladder and a suprapubic cystotomy tube insertion,

I have enclosed a copy of the operative report and the emergency room visits for those days.

Q. He was in the hospital until the 20th of July, wasn't he?

A. I can't tell you. I can't tell you that information without the hospital chart.

Q. Now, you did a colostomy at that time?

A. I did not, but Dr. Reeder did.

Q. But a colostomy was done at that time?

A. Right.

Q. Okay. What else was done? Was he wearing a --

A. I just read it.

Q. Was he wearing a catheter at that time?

A. I'll read it again. He had an

exploration, sigmoid colostomy. He had a Hartmann pouch, which closes off the rest of the rectum. He had an exploration of the retropubic space, drainage of a prostatic perirectal abscess, exploration of the bladder and a suprapubic cystotomy tube, or a tube to drain the bladder out.

Q. Okay. This comes directly out of the bladder?

A. Yes.

Q. Not through the penis?

A. No.

Q. He did not have a Foley catheter at that time?

A. He may have had a Foley and a suprapubic tube. He may have had both. I'd have to look at my chart and my records. He probably had both because what you're trying to do is divert the urine totally so that no urine -- so that the urine and the stool don't mix. When stool and urine mix, it's a real problem.

Q. And what --

A. Especially if it's inside the body.

Q. Was the surgery you performed successful?

A. It was successful in saving his life. I

mean he was very -- you know, he was very sick. He would not have made it another day or two.

Q. And what was your follow-up treatment after that?

A. Well, do you want to go through the whole treatment?

Q. Yes, and I'll need to ask you some questions about that.

A. Say, can I just stop here for a second? I was under the impression that I would be done by quarter to six. It doesn't look like it's possible.

Q. I'll be as quick as I can.

A. Because, I mean, I have to make other arrangements if I'm not going to make it.

Q. Quarter to six is pushing it because we didn't start at 4:30, unfortunately, but I'll be as quick as I can.

A. I understand. I just want to understand, you know, so I don't -- I just don't -- should I tell my people -- just give me a rough idea.

Q. I'm guessing probably 6:15 at the latest.

A. Okay. All right. I can't tell you

anything that happened between July 9th and July 25th, '94 without the hospital records.

Q. Well, he was in the hospital through the 20th; I do know that.

A. S u - n a time I cannot tell you what happened because I don't have the hospital records.

Q. But you summarized basically what he had done to him during that period of time?

A. Yes, just from that. But I don't have a recollection. I'd have to get the chart and the hospital records.

Q. Okay.

A. He was then -- the next time he was here was on the 25th of July. He saw Dr. Treiman, my partner.

MR. MISHKIND: Here's a copy of the chart, and the tabs show the various -- if for any reason you want to look at that, okay.

(Document handed to witness.)

THE WITNESS: Patient returns for a follow-up. He's had problems sleeping. He does wake up at night with leakage per urethra, which sounds like a bladder spasm.

He had some pain radiating in his right leg. He's noticed a small amount of leakage in the rectum. SP site is clean. They treated him with Ditropan for spasms, Ambien for sleep.

BY MR. CASS:

Q. And Treiman saw him again on August 2nd, didn't he?

A. I don't know. On the 26th he called saying the Ambien didn't help, and Dr. Treiman recommended Xanax.

Q. That's July 26th?

A. Yes.

Q. Okay.

A. And then he saw him August 2nd.

Q. Right.

A. Continues to improve, much less drainage. He has -- still has rectal discomfort. He will follow up with Barzell for suprapubic change.

Then he came to see Dr. Bregg on 8/8/94. Mr. Scarlett comes for follow-up. He's one month status post colostomy, suprapubic tube exploration and drainage of pelvic abscess. He is here for an unscheduled visit because he requested more Percocet and I asked him to come in to be seen. He

states he's still having pain, and if he doesn't take something every four hours the pain is recurrent.

Q. Now, you saw him on the 12th, I think, of August, didn't you?

A. I don't know. I'm just finishing my note here.

Q. Sure, go ahead.

A. Then I saw him on the 12th.

Q. You said he was doing well overall? He hadn't regained his weight yet?

A. Not yet. Incision well-healed. SP in good position. I can still feel the area of rectal perforation on the right.

Q. Now, at this point he had not had the orchiectomy, had he?

A. No.

Q. Okay.

A. SP change under genta 80, three days of Floxin, return in two months. He will have an SP tube change in six to eight weeks.

At this point I'm not in favor of restarting Lupron in view of what Dr. Loewe felt about its contribution to his hepatotoxicity. If he does have a relapse serologically, my

recommendation would be to do an orchiectomy. If they wish to have Lupron, it would have to be given elsewhere.

Q. From what my records show, you next saw him on August 22nd?

A. September, right?

Q. No, I have August, August 22nd here. You have a note anyway. There's an office notation.

A. Whose?

Q. Yours.

A. Where? Can I see it?

Q. I just have a summary here. I can get it for you, though.

(Document handed to witness.)

A. No, this was a nurse. He saw a nurse. He didn't see us. He was having bladder spasms. The patient called. It was not a -- he called. That's a telephone call.

Q. This handwritten note is a nurse's note, not yours?

A. This is a nurse's note saying he called, and my note just says to give him Ditropan.

Q. Okay.

A. But he was not seen. The next time he

was seen was September 22nd by Dr. Treiman. . . . .

Q. Now, he's in this group here?

A. Yes.

Q. He's another urologist with you?

A. Yes.

Q. Let's go through that treatment ,here.

A. Patient comes in with problems with his SP tube. Over the weekend he found he had poor drainage from the tube and the tube was replaced. His wife has been irrigating, but is having trouble getting the fluid to return.

A 22 French silastic catheter was placed. I got a return of approximately 200 cc's of urine. I then irrigated the tube and found it very difficult to get a return of the fluid.

Impression, prostatorectal fistula. I suspect that the patient has lost bladder capacity and that a lot of the urine is flowing into the Hartmann pouch. He can get temporary relief by defecating, which releases some of the urine.

Will put or continue putting in a larger SP tube, and would consider putting in a urethral Foley as well. May consider a cystogram to assess the anatomy.

Q. You seem to have a record the next day,

September 23rd.

A. Yes.

Q. He came in to see you the next day?

A. Yes.

Q. If you can just summarize it briefly. You don't have to read the whole record.

A. I'll have to read it first.

Okay. He was having trouble. What had happened is he developed a stone in the bladder and he closed off his entire prostate fossa, which was obliterated from the cryosurgery. And we couldn't get rid of it, so we decided to bring him into the hospital to try to open the passage from below, get rid of the stone.

And I wasn't optimistic that this could be done, and I have a note in here that I thought eventually he will need to have his urine diverted into an ileal conduit and wear a bag, to get out of that mess down there.

Q. Was that ever done?

A. What, the diversion?

Q. Yes.

A. No, because we were able to go in from below and clean it.

Q. He was in the hospital October 4th for

that?

A. I'm checking my records.

MR. MISHKIND: Here is the chart, doctor.

(Document handed to witness.)

BY MR. CASS:

Q. What is an attempted TURP? I know what a TURP is, but what were you attempting to do there?

A. May I read my note?

Q. Sure.

A. Okay. I couldn't get in from below. It was totally closed off from the cryosurgery. Everything was sloughed and closed off.

So, therefore, I was going to try to do a TURP to clean it up and shave it so he could urinate. Could not get in from below, could not get the stone from above. And I noticed that his bone had disappeared, the symphysis pubis, and that suggests a possible osteitis pubis, which is a pretty severe problem.

So I thought rather than do an open procedure at that time to get things done, that I would get some x-rays and decide what needed to be done next.

Q. Is the fistula at this point still opsn?
A. Yes.
Q. And you've made no attempt to close it surgically?
A. You cannot close it. You cannot close that fistula.
Q. You did have him in once at a later time to close it surgically, didn't you?
A. **No.**
Q. No?
A. **No.**
Q. Okay.
A. **No,** those fistulas can't be closed. I mean there are attempts at closing them which are horrendous. You have to swing muscle slabs, and the success rate is very pour and the patient can succumb to the procedure.
Q. **I** thought that he was admitted once to have that done.
A. Yeah, I think they looked at it.
Q. And you thought that maybe it was closed at that time?
A. Well, actually it wasn't here. They were going to do it -- Pow-Sang was going to do it. That's my recollection.

Q. But you did get an opening -- going back to what we were talking about, you did get an opening for the urine to pass through?

A. No, I didn't. No, I didn't on that time. I don't remember when we did it. We must have brought him back in. Or I think he went and got Pow-Sang to do it. I think that's what happened. I had to send him to -- I'll have to look -- this is the hospital records?

MR. MISHKIND: Yes.

THE WITNESS: But it doesn't have all the progress notes.

MR. MISHKIND: It's not a complete chart, but they --

THE WITNESS: I'd have to look at my records.

MR. MISHKIND: It's chronological in order, so if you want to --

THE WITNESS: Osteitis pubis, metastatic prostate, 10/11.

On 10/10/94, we readmitted him for Kennedy and I to do a debridement. Let me see if we did actually do that.

Yes, we have a note here 10/13/94 by Dr. Kennedy, and we did an irrigation,

debridement and curettage of the symphysis. pubis. He basically had a osteomyelitis of the bone, and the abscess had developed -- had gone into the bone and destroyed the bone in the pubic bone there. So we went and had to get all that infection out.

And so Ed Kennedy went in and we did that together. We did it and we just took out a whole wad of bone, the infection.

BY MR. CASS:

Q. Are you talking about the 13th through the 16th?

A. I'm looking. And let me see what I did there. And at that time, when he did that, I did a -- I explored the retropubic space, did the debridement and helped Dr. Kennedy. We did it together.

The retropubic space was severely desmoplastic relating to his previous surgery. The bladder was stuck to the undersurface of the rectus. The dilation and curettage will be described by Jeff Kennedy.

What I did is I went in and got the bladder off the bone so that it wouldn't injure the bladder, and then helped him expose the bone, and

then we put in drains.

Q. And those drains were permanent drains or --

A. No?

Q. -- temporary?

A. Temporary.

Q. How long would they remain in or how long did they remain in?

A. I can't tell you without looking at the records. I suspect a week, but I'd have to get the hospital chart.

Q. I see you saw him again on the 21st of October in the office?

A. Yes. Well, let's look. Actually, he was seen on the 18th by Dr. Bregg. Status post recent curettage of bone. He needs to see Barzell on Friday. We may need to do an ileal conduit. Okay.

And I saw him here on 10/21/94. And I discussed exploration with ileal conduit formation, suprapubic cystostomy with cystolithotomy, and I said I could make no guarantees relative to the suprapubic pain since I'm not certain whether it's related to the SP tube or a large proteinaceous debris within the bladder or his osteitis pubis or

nerve involvement by carcinoma.

Q. Am I correct that this is all related to the fistula, though?

A. Yes. And the abscess more than the fistula. The abscess. The fistula wouldn't do it, it's the abscess.

Q. The abscess comes first and then the fistula --

A. No, the fistula comes first, it's unrecognized, and you get an abscess.

Q. Okay. And the abscess follows the fistula?

A. Yes.

Q. Now, at this point is the abscess still -- is there still an infection in there?

A. Yes, but it's low. You know, it's not life-threatening. Let me just read a little bit here so I can get an impression of what's going on. Because I don't remember this. It's been a while.

MR. MISHKIND: Off the record.

(Thereupon, there was a discussion had off the record.)

THE WITNESS: Okay. Let's go back to that -- where were we?

- - -

BY MR. CASS:

Q. Give me the days you're talking about, doctor.

A. I don't know. You were asking me. Where were we last?

Q. I think when I last asked you, I was talking about the 21st of October, 1994.

A. Okay. Okay. What happened on that date is we discussed various options, which would be to do an ileal conduit and remove all the pus, and do a diversion, and we also talked about talking to Dr. Pow-Sang about whether he could do something.

And we discussed it, and I told him my own feeling would be rather than do a reconstruction, we would do an ileal conduit, but to go see Pow-Sang.

He went to see Pow-Sang, and Pow-Sang scoped him and was able to get through into the bladder.

Q. That was in November we're talking about now?

A. Yes, November. He was able to get in. And then he decided that he wanted to do a reconstruction, a big reconstruction on him with flaps, which had about a ten percent success rate.

He saw Dr. Bregg, and Bregg talked to him again, and at one time he was leaning towards maybe having an ileal conduit done, which is a diversion. And that's how far I got.

Q. Now, we're into November now; is that correct?

A. Yes.

Q. All right. I know he saw Dr. Pow-Sang on November 2nd?

A. Yes, November 28th. He's already had the surgery by Pow-Sang, and --

Q. That was November 11th through the 14th he was at the Moffitt Clinic?

A. Yes, and then he was seen subsequently, and they were talking about -- they were talking about doing the reconstruction.

Q. What was it that Pow-Sang did in the Moffitt Clinic, if you know, doctor?

A. Yeah. He went in, into the bladder, and put a catheter in from below.

Q. That's to allow the urine to flow?

A. Well, to decrease the fistula problem.

Q. So the fistula is still open at that point?

A. Yes.

Q. Okay.

A. As far as I, you know, can remember and know. I wasn't there. He said he couldn't see it, but I assume it was open just from his symptoms. Pow-Sang's note says he didn't see it.

Q. Did not see the fistula?

A. Right.

Q. Now, it seems like -- and I'm not sure who -- well, there's a note on December 1st through December 6th of 1994, you had him back in Sarasota Memorial then.

A. Okay.

Q. And I see notes per you and Dr. Bregg.

A. Okay.

Q. Am I correct that at that point you thought the obvious fistula was then closed?

A. Dr. Bregg dictated that note.

Q. Okay. I wasn't sure whose note it was.

A. Findings, the obvious fistula now appeared to be closed, and this determination was made because on a rectal just before the case, the hole could--

THE REPORTER: Excuse me. The rectal --

THE WITNESS: I'm sorry. Do you need a copy of this thing? Would that be better?

THE REPORTER: Yes, but I need to understand what you're saying.

THE WITNESS: The obvious fistula now appeared to be closed. This is Dr. Bregg speaking. This determination was made because on a rectal just before the case, the hole could no longer be felt and only a dimple was felt in that area.

Clinically on cystoscopy, the area hole was no longer visualized. And it goes on.

So at that time, even though I was going to do a major big operation, I decided that since it looked like he had a chance of closing the fistula, I said let's just do -- you know, just clean out the bladder, clean out the proteinaceous mass, put a Foley in and just hope for the best. And if the fistula reoccurs, we can always do the big operation.

MR. CASS: Do you know whether --

THE WITNESS: And fortunately, we didn't do it because he did okay.

BY MR. CASS:

Q. The fistula apparently did close of its own accord?

A. The fistula did close and we got all the tubes out and we got all kinds of junk out of his bladder; stones, proteinaceous mass. And I thought that that was the most conservative thing. And in retrospect, it was the right decision because it never opened up again after.

And so this is a summary of the hospitalization.

Q. Now, up until --

A. -- by doctor -- this is a summary of the hospitalization by Dr. Bregg on 12/6/94.

Q. Up until --

A. The patient was admitted and brought to the operating room. At the time of surgery the clinical impression was that there is an excellent chance that this fistula might have closed based on the rectal exam under anesthesia and the cystoscopic appearance.

In view of that, he was simply taken to the operating room, where a large mucoid-type bladder stone was removed, and he had a relatively uneventful recovery.

Q. Now, subsequent to that hospitalization --

A. Yes.

Q. -- I take it that he is seen here in this office again?

A. Yes.

Q. Mid December?

A. Right, for stitch removal, and so on and so forth.

Q. And he seemed to be doing much better at that point?

A. Right.

Q. Had anything been done in the way of an orchiectomy at that point?

A. I don't know. I'd have to look at my records.

Q. He's not taking Lupron, I presume? I think you said earlier you took him off and you didn't want him back on again?

A. No, we did an orchiectomy in December '94.

Q. When he was in for the surgery?

A. Yes, at the same time.

Q. So in addition to what you were describing here then, the orchiectomy was done then?

A. Yes. And I knew he needed hormone treatment because his cancer would have come back,

and he couldn't take Lupron, so we did the orchiectomy.

Q. The orchiectomy then alleviates the need for Lupron?

A. Yes, and it also prevents the cancer from coming back for a couple years. It gives him a two or three-year window.

Q. You had earlier discussed and considered radiation. I'm talking about back before --

A. Not really. I said we discussed it and I said it wasn't optimal.

Q. You did not feel that that was --

A. No, because I thought he was too advanced for it.

Q. Okay.

A. As I mentioned, I thought his cancer was beyond local treatment. He needed systemic treatment. Systemic being treatment of cancer anywhere in body.

Q. Now, the orchiectomy itself --

A. Is systemic.

Q. -- was made necessary by the cancer?

A. Uh-huh.

Q. Not by the problems he had with the fistula?

A. Right. The orchiectomy was necessary because of his cancer, the fact that it was spread and because there was a low likelihood that cryosurgery would have controlled it without an orchiectomy.

Q. That was in 1994?

A. Right.

Q. And you said that you get about a three-year window at that point?

A. Usually a two to three-year window with an orchiectomy.

Q. And he's had more than that, actually?

A. Right. But his PSA is starting to rise again.

Q. I was going to ask you about that. I'd like to continue on through. We have a few more -- I won't belabor this, but I would like to go through it.

A. All right. I'll move on to my next chart.

Q. I think you see him in February of '95?

A. Hold on a second. Okay. Here we go. I have January 5 here. Dr. Bregg changed his tube, suprapubic tube.

February '95, Dr. Bregg. Having pain.

He put him on antibiotics.

Q. Are infections because of these tubes fairly commonplace? I mean you get this pretty often?

A. Infection and the fact that he had the abscess and the stones, yes.

Patient comes in 2/24/95. My impression was prostatorectal fistula, status post colostomy presumably healed. Two, possible sphincteric prostatic urethral disruption from previous cryosurgery.

Q. What does that mean?

A. That means that the area of the prostate, the mechanism that controls urine and the urethra were completely destroyed by the cryosurgery.

Q. Okay.

A. We recommended a urethrogram. And he had healed the urethra, so that also told us that from the urethral end the fistula was healed. So it healed from both sides.

Q. I see on February 28th, Dr. Goldberg makes a comment that the urethra is mildly irregular, some reflux noted --

A. Yes.

Q. -- in the distal left ureter?
A. Ureter, yes.
Q. Now, from then on, I take it the major problems that he encountered because of the fistula are pretty much over; is that correct?
A. Well, I think you have to consider the problems from the fistula as being of two kinds. One is the acute problem that one has with infection, fever and risk to his life and well-being.
Q. And that was over?
A. That was over.
The second problem relates to the chronic discomfort that one has with a small contracted bladder, any problems he may have had from that bone that we took out, and of course, the fact that he had an SP tube.
So yes, the acute life-threatening problems from the fistula and abscess were over. But the chronic problems were not.
Q. The SP tube that he has in now does what? That diverts the urine?
A. Yes, it diverts the urine. So he's completely closed off from below. And plus, his sphincter doesn't work. So if we were to clamp

that SP tube, the urine would have nowhere to go.

Q. So the SP tube basically is a permanent thing?

A. A permanent thing.

Q. As well as the colostomy?

A. As well as the colostomy, unless he has a ileal conduit to divert the urine. Or unless he goes for a fancy reconstruction with flaps, a surgery that would require probably three to four hospitalizations, three months apart, with extensive muscle flaps and -- I mean I wouldn't -- I mean I personally would question anyone who did it as to whether he was in his right mind because it has a low chance of success.

It could, you know. I mean, you know, you could do it and sometimes you might get away with it; make him a new urethra, a new sphincter. You'd have to have artificial valves. But then you'd have a small bladder, and you'd have to make a bigger bladder. You're talking about putting a guy through surgery for two years straight. Low risk of -- of success.

And then the patient, also you have to understand, has a limited life from his prostate cancer, which is progressing. So whatever life he

has left, you know, it's not an option.

So yes. If your question is for practical purposes, this is a permanent situation.

Q. Did the --

A. Could someone close it? Yes.

Q. But you wouldn't recommend it?

A. I personally wouldn't recommend it.

Q. And so that's why you consider this SP tube to be a permanent thing for him?

A. For practical purposes, yes.

Q. Now, there was talk about possibly removing that and having his system work on its own. Was there any attempt to actually try that?

A. Yes, but that would -- we tried it a few times and he just couldn't urinate. That talk was in relationship with what Pow-Sang said, that he had seen -- he had talked to some of the surgeons up there -- and I'm going from my recollection years ago.

Q. That's all right.

A. And that they were going to do some, you know, major reconstruction. You know, it would be in same heroic measures as putting that guy's arm -- you know, the guy with his arm --

Q. Yeah, yeah.

A. I mean not that much., But it would be that type of heroic measure to go and do it.

So the problem with those things, though, if they work, you know, it's great, everybody is a hero. If they don't work, it's a problem.

Q. So it's really not in the cards for him?

A. I don't think so, no.

Q. Okay.

A. I mean if he was cured from his prostate cancer I would say, well, it's a consideration, but he's not cured from his prostate cancer. And what I'm afraid of, by the time he got through with the surgery, then we would deal with problem with the prostate cancer.

Q. And there's nothing more you can do for the prostate cancer in the way of radiation or anything like that? It would not help it any?

A. No. Radiation would be dangerous and wouldn't be helpful because once it's in the lymph nodes -- once the cancer goes in the lymph nodes, there's no point in addressing doing local therapy for someone who doesn't have symptoms. The cat's out of the bag.

Q. Would that destroy the cancer that was

in those lymph nodes?

A. No. Not likely, no. Because the amount of radiation you need for -- to destroy prostate cancer is about 7,000 rads. And you can't deliver safely to the abdomen more than 5,000. So you cannot deliver an adequate dose to sterilize lymph nodes.

Q. Since what we have just reviewed, the past year-and-a-half, there's a -- we started with the current stuff, but he's basically coming in now just to have his SP tube changed?

A. Basically, he comes in for three or four things.

Q. You mentioned also the PSA?

A. Right. He comes in to look at the PSA, and then we're going to follow this. It's starting to slowly rise. If it starts to go up a lot, then we would consider him for second line therapy, a drug called Ketoconazole, which is given for fungus that works. But I wouldn't consider it for him until the PSA went well over ten.

Q. What is his PSA now? I know it was down in the single -- under one for quite a while.

A. I'll tell you right now. 2.1.

Q. And that's over a period of time it's

risen to 2.1?

A. In June it was 2. So it hasn't gone up that much. So it's a slow creep up. So as long as it's a slow creep up, we'll just continue to watch him.

The other reason I see him is to change his tube, and the nurses see him. And then periodically I have to make sure he doesn't have complications from the tube, such as a stone or a tumor in the bladder.

And then we periodically need to look at the kidneys to make sure they're not being adversely affected.

So he's being seen for three reasons; the tube change, the kidneys, to make sure the kidneys are okay, and then the PSA.

Q. Now, you're the urologist who is primarily --

A. Treating him.

Q. -- treating him?

A. Yes.

Q. Pow-Sang is --

A. Pow-Sang was involved only when the problems got so difficult that I figured I wanted to get another opinion.

Q. So he started out as a second opinion --
A. Right.
Q. -- but he actually got in and did some surgical repair as well?
A. Yes, because he was trying to evaluate him for a possible total reconstruction.
Q. What about infections? Has he had periodic infections?
A. Well, the thing is that you have to consider for practical purposes, that he will always have an infection because he has tubes. And there's no way if a person has tubes that he doesn't have an infection. And if we culture him, he's always going to have something.

We don't treat infections in patients who have a tube unless the patients have symptoms; a fever, bleeding, discomfort. The reason being is that if I gave him an antibiotic, I would destroy 95 percent of the bacteria that are sensitive to that antibiotic. Then it would be five percent that aren't that would grow. And then we would give another antibiotic and we would destroy 95 percent of those bacteria.

Within a very short period we would end up with an antibiotic -- a bacteria that is

resistent to everything. Then we have a life-threatening problem. So we cannot treat these infections.

Now, the only time he does get an antibiotic is when we change his tube, because that can lead to a flare. Whenever we manipulate him, it can lead to a flare.

MR. CASS: Doctor, that's all the questions I have. I said 6:15, but we got you out of here at six.

THE WITNESS: Thank you. You're very nice. Thanks a lot.

MR. MISHKIND: I have nothing for you right now.

(Thereupon, the deposition was concluded at 6:05 p.m.)

CERTIFICATE OF OATH

STATE OF FLORIDA)
COUNTY OF SARASOTA)

I, the undersigned authority, certify that W. E. BARZELL, M.D. personally appeared before me and was duly sworn.

WITNESS my hand and official seal this 12th day of March, 1998.

Betsy Ridenour

BETSY RIDENOUR
Notary Public
State of Florida

STATE OF FLORIDA NOTARY PUBLIC
BETSY E. RIDENOUR
My Comm Exp. 2/14/2002
No. CC 716384
[ ] Personally Known [ ] Other I.D.

DEPOSITION CERTIFICATE

STATE OF FLORIDA)
COUNTY OF SARASOTA)

I, BETSY RIDENOUR, Court Reporter and Notary Public, do hereby certify that I was authorized to and did stenographically report the deposition of W. E. BARZELL, M.D. that my shorthand notes were thereafter reduced to typewriting by means of computer-aided transcription by me; and the transcript is a true and complete record of my stenographic notes.

I FURTHER CERTIFY I am neither an attorney or counsel of any of the parties in said event, nor a relative or employee of any attorney or counsel employed by the parties hereto, nor financially interested in the event of said cause.

Dated this 12th day of March, 1998.

Betsy Ridenour

BETSY RIDENOUR
Court Reporter and
Notary Public, State
of Florida at Large

STATE OF FLORIDA NOTARY PUBLIC
BETSY E. RIDENOUR
My Comm Exp. 2/14/2002
No. CC 716984
( ) Personally Known ( ) Other I.D.