IN THE COURT OF COMMON PLEAS
OF SUMMIT COUNTY, OHIO

THERESA L. HARVEY, fka, HYDE,

Plaintiff,

vs.

A.J. ROVNER, M.D.

Defendant.

CIVIL DIVISION

No. CV98 06 2257

DEPOSITION TRANSCRIPT OF:
Lawrence Cooperstein, M.D.

DEPOSITION DATE:
January 11, 2000
Tuesday, 3:30 p.m.

PARTY TAKING DEPOSITION:
Plaintiff

COUNSEL OF RECORD
FOR THIS PARTY:
Lawrence J. Scanlon, Esq.
76 South Main Street
Suite 1612
P.O. Box 2004
Akron, OH 44309-2004

REPORTED BY:
Claire Gross, RDR
Notary Public

ORIGINAL

DEPOSITION OF LAWRENCE COOPERSTEIN, M.D., a witness, called by the Plaintiff for examination, in accordance with the Pennsylvania Rules of Civil Procedure, taken by and before Claire Gross, RMR, a Court Reporter and Notary Public in and for the Commonwealth of Pennsylvania, at Shadyside Hospital, 5230 Centre Avenue, Pittsburgh, Pennsylvania, on Tuesday, January 11, 2000, commencing at 3:30 p.m.

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APPEARANCES:

FOR THE PLAINTIFF:
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FOR THE DEFENDANT:
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LAWRENCE A. COOPERSTEIN, M.D.,
being first duly sworn,
was examined and testified as follows:

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EXAMINATION

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BY MR. SCANLON:

Q. This is Larry Scanlon, and we are here in Pittsburgh to take the deposition of Dr. Cooperstein who has been named as an expert in the above captioned case. Could you tell us your full name, please?

A. Lawrence Cooperstein.

Q. Your present residence address?

A. 880 Old Hickory Road, Pittsburgh. Zip is 15243.

Q. Your date of birth, sir?

A. February 6, 1953.

Q. Your current occupation or profession?

A. I'm a diagnostic radiologist.

Q. What does that mean a diagnostic radiologist?

A. A diagnostic radiologist is involved with diagnostic imaging, all different types of imaging studies from plain x-rays to CT scans, ultrasound, all kinds of different things.

Q. Prior to this deposition I have been given a copy of

your CV, and I've handed you what we'll mark as Exhibit 1 to this deposition, that copy. Have you had a chance to look at it to determine whether or not, in fact, it's a current and accurate CV, Doctor?

A. It is accurate. It is not the most current.

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(Document marked for identification Deposition Exhibit No. 1.)

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Q. What addition should be made to the CV?

A. The only changes would be, I believe, one paper was published that would be added to this, a paper having to do with a particular kind of bone tumor, and the paper that's numbered 25 here has actually been published whereas in this one it says accepted for publication. So I would have the journal and specifics for that. Other than that there really have not been any other change that is I'm aware of.

Q. So that current CV is accurate other than with those additions?

A. To the best of my knowledge, yes.

Q. In connection with the case of Theresa Harvey, have you authored any opinion letters?

A. I believe I have, yes.
Q. I have been given an affidavit that we'll mark as Exhibit 2 to your deposition.

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(Document marked for identification Deposition Exhibit No. 2.)

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Q. I'm going to ask you to take a look at that. It's two pages, three pages. The affidavit itself is two pages. Let me hand that to you.
Q. Doctor, is Exhibit 2 a copy of the opinion letter you've previously discussed?
A. Yes, it is.
Q. Do you know other than that affidavit if you've authored any other written document in connection with the opinions you're prepared to express in this case?
A. I have not.
Q. Have you also brought with you your file?
A. Yes, I have.
Q. -- that you reviewed? Is that file in front of you in the envelope?
A. Yes, it is.
Q. May I see that, sir? You've reviewed the deposition

of Dr. Rovner conduct the on May 23, '97?
A. Yes.
Q. And the deposition of Dr. Slezak, S-L-E-Z-A-K, November 11, 1999?
A. Yes.
Q. Dr. Copeland taken September 8, 1999?
A. Yes.
Q. You read these?
A. Yes.
Q. What about Dr. Margolis' deposition, the radiologist identified in connection with the plaintiff's position in this case, have you read that?
A. I have not.
Q. You've also looked at the report of Dr. Rovner of the barium enema dated December 8, '94?
A. Yes.
Q. And, in fact, you're prepared to support his conclusion in this case, aren't you, Doctor?
A. That is correct.
Q. You've also locked at Dr. Klepic's request for barium enema study?
A. Yes.
Q. That was dated November 29, 1994 with the diagnosis of blood and stool; correct?

A. Yes.
Q. The Aultman Hospital requisition form, it's a request for radiological consult completed by the technologist Bernhart, you've also looked at that as well?
A. Yes.
Q. Other than these three pieces of paper regarding the radiographic examination itself or radiological exam itself, have you looked at any other medical records?
A. I believe not.
MR. OCKERMAN: We you did look at the Korkor report.
THE WITNESS: Yes.
Q. Which one is that, the one that was attached to Dr. Slezak's deposition?
MR. OCKERMAN: Yes, that one right there.
MR. SCANLON: Well, there are two.
Q. Did you also look at this drawing?
A. I did look at that drawing. I found it a little confusing. I looked at it.
Q. Yes. What did you find confusing about those two drawings?
MR. OCKERMAN: Objection. That's not what

he said, but go ahead.

Q. All right?

A. No. I meant only that this one was a confusing drawing. That's all.

Q. How is that? Why is that?

A. Because there are all these different pictures. I wasn't quite sure, trying to read the writing. That was over the top of them. I found it to be a little confusing.

Q. Did you look at the surgical records that were attached as exhibits to the Slezak deposition?

A. I glanced at them.

Q. Pathology exhibits?

A. Everything that was attached to those I at least skimmed through. I won't say I read every word of those in detail.

Q. You've obviously looked at the air contrast barium enema films; correct?

A. Yes.

Q. Let me return to you your file. You charge a flat fee in depositions of $1,500; correct?

A. Correct.

Q. It doesn't matter how long it goes?

A. It doesn't matter.

Q. Or how short?
A. True.
Q. So if I was done by 4:00, which I probably won't be, it would still be $1,500; right?
A. Yes.
Q. Am I correct that you have only supported one plaintiff's case in your career of doing medical-legal work?
A. No. Actually now it's two.
Q. When was the second one? Did that happen recently?
A. The second one came in the mail right about new year's.
Q. And you have decided to support that case?
A. Absolutely.
Q. That case involving barium enemas?
A. No, it does not.
Q. And you've been employed by the firm of Buckingham Doolittle and Burroughs on approximately five to ten cases over the years?
A. Probably closer to ten than five. It may be ten to twelve at this point.
Q. I take it that was not in support of the plaintiff's position, was it, Doctor?
A. For Buckingham Doolittle and burr rose?

Q. Yes.
A. That is correct.
Q. You were retained by that firm in order to defend their clients who were accused of malpractice; right?
A. That is correct.
Q. Does Exhibit 2 contain the full extent of the opinions that you're prepared to testify to at trial in this case?
A. Yes.
Q. You're not going to render any opinions on the surviveability issues of Theresa's cancer?
A. Correct.
Q. Are you aware that she's died?
A. I learned that today.
Q. You've been involved in medical-legal work, Doctor, for approximately the last fifteen years?
A. Just about, yes.
Q. And you have given medical opinions in approximately 50 cases; is that true?
A. That's an estimate, but it's probably close.
Q. When you say medical opinions, does that mean that you've actually testified at trial in 50 cases?
A. Oh, no. I've probably testified in trial five times

or less.

Q. You're going to be testifying tomorrow morning in Akron, Ohio, are you not?

A. Yes, I am.

Q. That case involves a CT scan of the lung; correct?

A. Correct.

Q. Have you testified in Canton, Ohio, at any time?

A. No.

Q. Cleveland, Ohio?

A. No, never in Cleveland can you remember any case where you've testified in the state of Ohio before tomorrow.

A. I can remember two times that I've testified in Ohio. I testified in Akron, I believe, in November.

Q. Of?

A. Of '99.

Q. Was that a trial?

A. Yes.

Q. It wasn't in a deposition, was it?

A. Correct. It was a trial.

Q. Which courtroom was that in; do you remember?

A. I don't remember the judge's name.

Q. On whose behalf were you testifying; do you know?

A. I was testifying on behalf of the hospital. I

believe the judge was a woman. Does that help?

Q. Judge Unruh, Judge Bond, Judge Spicer, Judge Cosgrove?

A. Judge Cosgrove.

Q. What firm had retained your services?

A. Retzel & Andress.

Q. How much work have you done for Retzel & Andress over the years?

A. The work I've done for Retzel & Andress has only been in the last couple of years, and I'd say maybe five cases.

Q. How many times have you been retained on behalf of Akron Radiology; do you know?

A. That I don't know.

Q. What about Canton Radiology?

A. I don't know any numbers.

Q. Do you know Dr. Rovner independent of this lawsuit?

A. I do not.

Q. Have you ever spoken to him regarding his opinion in this case?

A. No.

Q. Doctor, Exhibit 3, that report of Dr. Rovner, it does report a single cecal diverticulum. Do you see that?

A. Yes.
Q. In your opinion, if you have one, was that the cause of Theresa's bloody stools?
A. It could have been. I suspect it probably wasn't.
Q. Why do you say that?
A. Cecal diverticulum bleed, but the chance of having significant bleeding from the single diverticulum, I think, is small.
Q. Do you have an opinion as to whether or not there was any cancer present in Theresa Hyde on December 8, 1994?
A. I'm not sure I totally understand the question.
Q. Well, do you have an opinion as to whether or not there was any cancer present in Theresa Hyde on December 8, 1994?
A. Yes, I have an opinion.
Q. What's that opinion?
A. I suspect there probably was.
Q. Do you have an opinion as to where that cancer was located?
A. I suspect it was in her colon.
Q. Doctor, is there any radiographic evidence that you have been shown in this case that supports your conclusion that you swore to under oath that this

mass was found on July 10, 1995, at a rectosigmoid juncture in her abdomen?

A. Again, I'm not certain I followed your question.

Q. Doctor, is there any radiographic evidence that you have seen in this case that supports your conclusion that the cancerous mass that was found on July 10, 1995 in Theresa Hyde was found at the rectosigmoid junction?

A. Radiographic evidence, no.

Q. Has anyone shown you the CT scan of September of 1995?

A. No. I don't believe I've seen that.

Q. Has anyone shown you the MRI of July of 1995?

A. No.

Q. If, in fact, this cancer that was discovered was not found at the rectosigmoid junction, does that change anything in your opinion?

A. It doesn't change my opinion on the interpretation of the barium enema, no.

Q. Why is that?

A. Because I believe that it was interpreted accurately, so it doesn't really change my opinion.

Q. Your expertise is in bone and joint radiology?

A. That's correct.

Q. Have you done any writing in the field of diagnostic procedures such as barium enemas?
A. I've not written anything on barium enemas, no.
Q. Your daily practice includes reading plain x-rays or radiographs; right?
A. Correct.
Q. Interpreting CT scans and MRIs?
A. Correct.
Q. Do you perform barium enemas?
A. Yes.
Q. When was the last one?
A. Yesterday.
Q. How many do you perform on an average wokely basis?
A. On an average weekly basis, probably five or six.
Q. Has that been true for the last five years?
A. Roughly so, sure. It may have gone up some weeks, down other weeks, but in that ballpark.
Q. I noticed that you hadn't had any daily contact with residents here at the hospital for the last eight years or so. Why is that?
A. This hospital years ago had an affiliation with the University of Pittsburgh, and residents did rotate through this department. That affiliation ended eight or nine years ago, and residents, radiology

residents, no longer rotated through this hospital in the last year or so merged into the UPMC or University of Pittsburgh Medical Center system, so the expectation is within the next six months to a year we probably will have residents rotating through this department again.

Q. Do you agree that the standard of care for a diagnostic radiologist requires an accurate reading and comprehensive reading of the barium enema study such as what was done in this case?

A. Yes.

Q. And your opinion, the report of Dr. Rovner, in fact, met the standard of care; correct?

A. Yes.

Q. I assume you were given the December 8 of '94 barium enema to look at; correct?

A. Yes, I looked at it.

Q. What is the purpose of a barium enema study?

A. To diagnose problems in the colon.

Q. What kind of problems?

A. I'd say most commonly barium enema would be used to look for polyps or cancer of the colon. Occasionally we are asked to do the barium enema for other things, but those would be the most common.

Q. How much time do you devote to the active clinical practice of medicine here at Shadyside?
A. 100 percent.
Q. How much time do you spend involved in medical-legal cases?
A. Very little.
Q. Do you have a practice outside of the hospital?
A. No.
Q. What is the purpose of actually using barium?
A. Barium is a contrast agent that actually stops x-rays, therefore, provides a way of seeing structures that you can't otherwise see with regular x-rays.
Q. Is there anything in these films that you've looked at from the barium enemas, the barium enema study rather, of December 8, '94, that would cause you to dictate a different report than what Dr. Rovner did in Exhibit 3?
A. No.
Q. Do you use spot films when you do barium enema studies?
A. Sometimes yes, sometimes no.
Q. Tell me on what occasion do you use a spot film.
A. If I do a single contrast barium enema, that is not

an air contrast but just with regular barium, I would routinely take spot films.

Q. Why is that?

A. Single contrast enema is just -- is filling the colon up with enema in order to see the contours as much of the colon as one can putting the patient into different obliquityies under the fluoroscopy and applying compression at that particular time is important in seeing much of the colon as possible.

A little different story with the air contrast studies in that a compression is not routinely a part of the study. Fluoroscopic study of the colon is less important because of the ability to see through loops of colon that are air filled, so on a lot of air contrast enemas I would not take spot films.

In fact, during my training when I was a resident being taught to do air contrast studies, we were told not to take spot films.

Q. When you said fluoroscopic study of the colon is less important because of the ability to see through loops of colon that are air filled so on a lot of air contrast enemas I would not take spot films, do you know if that's what Dr. Rovner did in this case?

MR. OCKERMAN: Objection.

A. I've only see seen the films that are available, and those films do not include any spot films. I've seen no spot films on this particular case.

Q. With respect to the fluoroscopic exam itself, was there anything in his deposition that indicated to you that he considered the fluoroscopic exam to be an important part of his examination of this patient?

MR. OCKERMAN: Objection. Deposition say what is it says but go ahead adoctor?

Q. Go ahead.

A. I don't recall.

Q. What did you mean by that fluoroscopic examination is not as important as looking at the films themselves?

A. What I meant was in doing a single contrast barium enema I believe fluoroscopic study is somewhat important in that applying compression, looking at the colon is an integral part of that examination. When one moves to a double contrast or air contrast study, compression is really not part of the examination, and therefore the fluoroscopic study of the colon is really not an important part of the

study. In fact, fluoroscopic, the use of fluoroscopy is really much more there to monitor the flow of the barium and the air into the colon than it is to actually study the colon itself.

Q. Can we use your shadow box, Doctor?

A. Yes.

Q. Doctor, you've put on the shadow box for us eight large radiographic films and one small radiographic film; correct?

A. Correct.

Q. Do these appear to be the films that you looked at in connection with Theresa Hyde Harvey barium enema study of December 8, 1994?

A. Yes.

Q. Did you look at any other films at the time that these were given to you for your opinion?

A. No.

Q. So you just looked at these by themselves?

A. Do you mean in this particular case?

Q. Yes.

A. Because I believe that when I first saw these films, if I remember correctly, and it was sometime ago, I believe Mr. Ockerman brought several cases that I wanted me to look at, and this was one of them.

Q. Were they barium enema studies?
A. No, they were not.
Q. -- cases? You might have looked at other films, but, for example, you weren't given five separate barium enema studies just to take a look at them all and come to a conclusion in this case, did you?
A. No. That's correct.
Q. Now, I want to draw your attention to 1-F that we've marked. In the area of the sigmoid colon do you see any shadow that is inconsistent with barium filling and expanding the area of that structure?
A. No.
Q. You see no shadow?
A. Not as you've described, no.
Q. What about in 1-A? Do you see any shadow in the area of the distal colon, the distal sigmoid colon? This is marked on the other side. This is 1-A. ? I will point to it. This area here, Doctor, I'm calling that a shadow. Is that a shadow?
A. That's air.
Q. But it's black on this film.
A. Correct. The air is black on all of these films.
Q. The purpose of using a contrast is to coat the internal section of the structure; right?

A. Sure. What you're trying to do on an air contrast manage is use the barium to coat the surfaces and the air to distend the lumen.

Q. In Exhibit 1-F, do you have an opinion to a reasonable degree of medical probability as to why the area of the distal sigmoid colon that I've pointed out is shadowed and not illuminated by barium?

A. Well, if I take to mean or to understand what you mean by shadow as to mean filled with air rather than filled with barium? It's because of gravity. Areas -- that film -- that particular film, I believe, was taken with the patient prone. Barium fall noose the dependent parts of the colon by gravity. Air rises to the portions that are nondependent, and that's why that segment that you've pointed to is air filled and the barium has fallen into areas that are dependent.

Q. What's your explanation for that same area appearing on Exhibit 1-A?

A. The same, same explanation. That's an angled view but also taken with the patient prone.

Q. Can you show me a picture that puts the patient on her stomach where that area of shadow is illuminated

by barium illumination?
A. Well, prone is on the stomach.
Q. I'm sorry. On her back.
A. I would take exception with the word illumination.
Q. What's proper, Doctor? What word would you use?
A. I think what -- well, illumination has no meaning to me in terms of looking at the images.
Q. Well, what --
A. It depends what you're asking. I'm not even certain what you're asking.
Q. Why is it white is my question?
A. It's white because the barium is white on the x-rays.
Q. Ened a the black is the x-ray; right?
A. Correct. And the barium falls into areas that are dependent based on gravity. That's why so many pictures are taken to put the patient in different positions and to use gravity really.
Q. Well, show me the picture then that where she was on her belly and that structure is filled by the gravity's effect on the barium, please?
A. Once again prone is on her belly. You just asked me again which films she was on her belly. Those are the prone films.

Q. 1-A and 1-F are prone films where she's on her belly; correct?
A. Correct.
Q. Show me the supine films then.
A. This film here, I believe.
Q. Can you identify that?
A. That is 1-B-T looks as though it was taken with her supine.
Q. And the area of shadow is, in your opinion, gone; correct?
A. Well, the air and the barium have moved around. Again, based on gravity. For instance, this segment here of the transverse colon is filled with barium, white on this film. Here with the patient supine filled with air.
Q. You just pointed to 1-F and 1-B?
A. Correct. The area that you asked about here and the sigmoid colon on 1-F is filled with air, and here on this film here, on 1-B it's filled with barium. This area of the sigmoid colon here on 1-F is filled with barium. Here the same area of the sigmoid colon is filled with air.
Q. Is there any other film, in your opinion, that adequately shows the area of the distal colon being

completely filled by barium in terms of an image, Doctor?

A. The intent of the study is not to fill areas with barium. The intent of the study is to get enough views to see all parts of the colon in air contrast.

If one were interested in just filling the colon with barium, one could do a single contrast enema which again is a good study. There are other films here that include that area. On some of them the areas are filled with barium and others it's coated with barium and more distended with air.

Q. I just want to make sure your opinion is clear, Doctor. To a reasonable degree of medical probability, the area of shadow on the distal sigmoid colon with the patient in the prone position is caused by gravity; is that correct?

A. Well, again, I think the terminology you're using is probably incorrect. When you say the area of shadow, if you mean that segment of the colon, that seg month of the colon on that particular view is coated with barium and distended with air.

Q. Well, Exhibit 1-F shows an area of the distal sigmoid colon where it is not coated with barium, otherwise it wouldn't be black, it would be white;

isn't that true?
A. Barium is white and all segments of the sigmoid are coated. I don't see any segment of colon that isn't coated.
Q. What's the area I pointed out, Doctor? Is that coated with barium?
A. Yes.
Q. On 1-F?
A. Yes.
Q. Point it out to me.
A. I believe you were talking about this segment of sigmoid here.
Q. Yes.
A. It's coated. That's the coating on the wall.
Q. You're pointing to the external wall itself has a white line; is that right?
A. Yes. Just like all these other segments.
Q. What's your explanation for the black area between the two white lines, Doctor?
A. The black in here?
Q. Yes, sir.
A. That's air.
Q. That's fair air?
A. Yes.

Q. Caused by gravity?
A. Sure. Air rises, barium sinks.
Q. That's an opinion you hold to a reasonable degree of medical probability?
A. Yes, absolutely.
Q. So you would disagree with Dr. Rovner that that's caused by a contraction?
A. Oh, no, I'm not disagreeing with that necessarily at all.
Q. Well, gravity and a contraction, Doctor, do those hold two different meanings to you, sir?
A. You asked a question about what's causing the density on that image. You asked about black and white. What I'm describing to you is black, what is black, which is a air and what is white, which is barium.

Contraction has nothing to do with what's black and what's white. Contraction has to do with the shape of what we are talking about. You simply asked about coating and this is coated. You asked about black and white. I've explained to you why it's black and white. Please may I finish? But bringing up contraction is a totally different thing. Now you're talking contour.

Q. Is the area contracted to your opinion to a medical degree of probability?
A. Yes, I think it's a little bit contracted.
Q. You do?
A. Yes.
Q. Could it be contrasted -- contracted by cancer?
A. Conceivably, but I don't think in this particular case.
Q. Why is that?
A. Because I would say that there are other images on this study of that area where that segment looks normal.
Q. Show us that, will you, please. Reference the exhibits?
A. I think on 1-E that segment looks normal. I think on 1-D that segment looks normal. I think 1-C it show that is segment to be normal. I think 1-B also shows that, and I think 1-H also shows that.
Q. Isn't part of your opinion in this case based on speculation, though, Doctor?
A. Speculation regarding --
Q. Where the cancer was found. Aren't you assume the cancer was not found in the exact area where that shadow is on 1-F, don't you, sir?

A. Oh, no. I'm not speculating. I'm telling you there is explanations as to why the images look as they look, and I don't think you can diagnose cancer from those images.

Q. Is that the purpose then of the barium enema for the radiologist to make a diagnosis of cancer?

A. That is sometimes the outcome of the barium enema. I think the diagnosis of cancer has to be made from tissue. I think that's a pathologic diagnosis, but there is certainly images that one can see that is strongly suspicious of cancer. If the actual diagnosis, I believe, most physicians would agree requires tissue.

Q. So in Exhibit 1-F and Exhibit 1-A you see no area of abnormality in the distal sigmoid colon; is that correct, Doctor?

A. Correct.

Q. You would not comment on the change in shape of that particular area; correct?

A. Correct.

Q. Nor would you comment on the presence of air in that area of the distal colon; correct?

A. I wouldn't comment on it. That's normal.

Q. Even though it's possible, isn't it, Doctor, that

both of those items in those images, 1-A and 1-F, could be caused by cancer; right?

A. No, I disagree with that.

Q. You don't believe that either of those could be caused by the presence of cancer?

A. The air is not cancer. The black is air. That's not cancer. I don't understand where you're going here.

Q. What about the shape, the shape, could that be cancer?

A. Conceivably, but again I think not.

Q. All right. But, in fact, it is where the cancer was found in this case?

A. My understanding is cancer was eventually diagnosed in the sigmoid colon, yes.

Q. So when you sign an affidavit that said the area of cancer was found in the rectosigmoid junction, that was wrong, wasn't it?

MR. OCKERMAN: Objection.

A. Can I see the affidavit again? I'm not sure how I understand that's wrong.

Q. Well, you just testified under oath, sir, that my understanding is the cancer was eventually diagnosed in the sigmoid colon, yes?

A. You're quibbling over words here that don't have exact meaning. Rectosigmoid junction certainly includes part of the sigmoid colon. We are not talking about anatomically different areas.

Q. Well, when you were given this case to look at, were you given the surgical records, sir, regarding the cancer?

A. When I was given the case to look at originally, no.

Q. Before you signed that affidavit did you look at the surgical records regarding where the cancer was found?

A. That I don't recall with certainty.

Q. What you recall seeing is the drawings of Dr. Cocar; correct?

A. I have seen those, yes.

Q. It's three pages we've marked as Exhibit 4. Let me shows those again.

- - - -

(Document marked for identification Deposition Exhibit No. 4.)

- - - -

A. I have seen these. I'm note sure exactly when I first saw them.

Q. Page 429 of that exhibit contains Bates stamp 429,

lower right hand corner.
A. Okay.
Q. It shows a drawing following the flexible sigmoidoscopy. Do you see that?
A. Yes.
Q. You did see that. We had shown you that from your package of documents. Is that what you were relying on in concluding that this mass was found in the rectosigmoid junction?
A. That is possible. I'm not certain in retrospect exactly which pieces of paper I reviewed.
Q. Well, you also at page 430, second part of that document, and we discussed earlier about the location of that mass. Earlier I believe you said that that drawing was confusing to you.
A. Well, just that it's not a great drawing. That's all. It's a confusing piece of paper. There is lots of lines and pictures. That's all I meant by that.
Q. It, in fact, shows the cancer to be on the other side of the same bend using his reference points?
A. That would seem to be the case.
Q. Let me ask you this, Doctor, assuming that the cancer was found in the distal rectosigmoid colon

Theresa, do you have an opinion, to a reasonable degree of medical probability, one way or another, that that area that we've been discussing on Exhibit 1-F is the area where the cancer was found in this patient?

A. Based on the pathological records, yes. That's the area that the cancer was found.

Q. And if when you looked at this on behalf of Dr. Rovner and his lawyer, you didn't say to him, gee, that looks like cancer?

A. No, I did not.

Q. And if you had read this, the same report would have been issued; right?

A. Yes.

Q. Have you ever testified in any domestic or criminal matters, Doctor?

A. I testified in a criminal matter before a grand jury in Buffalo, New York.

Q. What was that for?

A. That was in regards to a gentleman who through some investment schemes scanned scammed me out of some money.

Q. Have you ever testified in any domestic matter?

A. I have not? Any juvenile matter.

A. Never.
Q. Ever been party to a lawsuit?
A. Party to a lawsuit?
Q. Yes, sir.
MR. OCKERMAN: Objection.
Q. Filed suit or been sued?
A. Yes.
Q. On how many different occasions?
MR. OCKERMAN: Objection.
A. There was a suit after I left my previous radiology group. There was a suit filed over some deferred compensation that I became part of along with nine or ten other physicians. That was eventually dropped.

I also filed a civil suit against the same gentleman about whom I testified to a grand jury. That suit I eventually dropped as well: That's it. I have no other suits.

Q. Never been sued yourself?
A. No.
Q. No domestic relations cases?
A. No.
Q. No criminal cases?
A. None.

Q. Been cited into court for any reason?
MR. OCKERMAN: Objection.
A. No criminal cases, no.
Q. Traffic?
MR. OCKERMAN: Traffic tickets, parking tickets.
A. I've had traffic particular thes, parking tickets a couple of speeding tickets.
Q. I'm handing you Exhibit 5, Doctor.

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(Document marked for identification Deposition Exhibit No. 5.)

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Q. It is the CT scan of a pelvis, the abdomen, pelvis, done September 14, 1995. Have you ever seen that report, sir?
A. I don't think I've ever seen this report.
Q. Have you ever looked at that film?
A. Oh, no. I've never seen those films.
Q. Do you think a radiologist can look at a CT and have an impression of an annular carcinoma of the distal sigmoid colon involving a five centimeter long segment?
A. I'm sorry. The question again?

Q. Can you as a radiologist look at a CT scan and have an impression of similar to what Dr. Sayoc, annular carcinoma of the distal sigmoid colon involving the five centimeter long segment?
A. You mean hypothetically could I diagnose that?
Q. Yes.
A. Sure.
Q. Why is that? What is it about the CT scan that allows you to make that kind of impression of carcinoma where you haven't taken a tissue sample yet to determine what the cancer is?
A. Oh, I misunderstood your question. I don't think one can make a definitive diagnosis of cancer just from the images.
Q. Right.
A. I suspect -- well, reading through his report under the top where it says clinical study it says follow-up rectal cancer.
Q. Post flexible sigmoidoscopy; right?
A. It doesn't say that, but if this was done, and there was already a diagnosis of cancer, then he knows what he's looking at is cancer.
Q. So I take it then, to a reasonable degree of medical probability, Doctor, you do not have an

opinion that the area that we've been discussing on Exhibit 1-F is, in fact, not cancerous; correct?

MR. OCKERMAN: Objection.

A. Can you repeat that? That was a double negative?

Q. Sure. I want to make sure that when we come to trial in this case you're not prepared to testify to a reasonable degree of probability that the area that we've discussed on Exhibits 1-F and 1-A, that is, what I call and area of shadow or blackness, which you have called air, is not, in fact, indicative of cancer.

MR. OCKERMAN: Objection.

A. I'm going to testify that I believe the images are normal, that no mass can be diagnosed on those images, and that what you're referring to as the area of shadow, the blackness, is air.

Q. And further, the shape of that area that we are discussing on 1-A and 1-F, in your opinion, it is, in fact, a change in the normal structure of the distal sigmoid colon, is it not, sir?

A. On those two images, the shape is different in that area, yes.

Q. And is it your opinion, to a reasonable degree of medical probability that that wasn't caused by

cancer?

A. It is my opinion that taking the study as a whole, that the study is normal and that no mass can be diagnosed.

Q. I know. I've heard that before, but I'm here to ask you this question. Is it your opinion tortious a reasonable degree of medical probability, that the shape of that segment of the distal sigmoid colon was, in fact, not caused by cancer on December 8, 1994?

A. I would have interpreted that as being probably a transient phenomenon, probably caused by contraction as I can't confirm it on the other images.

Q. So you don't have an opinion that it wasn't, in fact, cancerous of that area of the distal sigmoid colon; correct?

MR. OCKERMAN: Objection. He said how he would interpret it.

A. That's how I would have interpreted the study. I think what I'm trying to give you is prospectively how this study should be interpreted.

Q. Fine. Retrospectively then, Doctor, isn't it a fact that the area that we are discussing on 1-F is, in fact, caused by the presence of cancer in this young

woman?

A. I think retrospectively there is no question that cancer is diagnosed in that area. Whether or not the films demonstrate that, we disagree. I don't think they do.

Q. Handing you Exhibit 6, the operative note of December 29, '95 from Dr. Meyerhoefer, would you take a look at that and tell me if you've ever seen it?

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(Whereupon, there was a recess in the proceedings.)

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Q. Do you think you've seen that surgical report prior to today, Doctor?

A. I think that it's attached to one of those depositions.

Q. Before you came to your opinion in this case, though, you did not look at any of the surgical or pathology materials; correct?

A. To the best of my knowledge, that is correct.

Q. And other than the barium enema study, you saw no other films?

A. Correct.

Q. And when did you come to a conclusion that there was cancer in this patient other than at the rectosigmoid junction because you see, sir, I think your opinions are different than what you put in the affidavit, and I'm trying to have you explain it to me. You sign an affidavit that you felt that the -- since the cancer was found at the rectosigmoid junction, there is no abnormality in the area on that film, but today you're admitting to us that there is something that you wouldn't have commented on, but it is -- there is something visible on that film, and that's exactly where the cancer was.

MR. OCKERMAN: Objection. Go ahead.

A. I think what I've said is that I would have interpreted it still would interpret it the study as normal.

Q. Let me read it to you because you said In retrospect, knowing that a mass was found on July 10, 1995, at the rectosigmoid junction, I do not see anything that is suspicious for a mass in this area on the December 8, 1994 films.

A. That's true.

Q. And you swore under oath that the mass was found at that location?

MR. OCKERMAN: Objection.

Q. Didn't you? You signed this under oath?

MR. OCKERMAN: I think you're mincing words here, Mr. Scanlon, so let's be clear. July 10, 1995, the conclusion of Dr. Korkor, large infiltrating fungating mass at the level of the rectosigmoid junction.

MR. SCANLON: His affidavit says --

MR. OCKERMAN: That says July 10, 1995.

MR. SCANLON: It says in retrospect knowing that a mass was found on July 10, 1995.

MR. OCKERMAN: In the rectosigmoid.

Q. In the rectosigmoid junction I do not see anything that is suspicious for a mass in this area on the December 8, 1994 films.

A. Correct.

Q. When you signed that affidavit, though, you hadn't even looked at the surgical records to find out where the surgery was conducted; correct?

A. I believe that's true. I don't think I saw the surgical records until later.

Q. The area that we've been discussing on 1-F, you described it as being a partial contraction, that is, to explain the narrowing of the outline of the

sigmoid colon that we see; correct?

MR. OCKERMAN: Objection.

A. I do believe I said it was most likely a contraction.

Q. Did you say partial contraction?

MR. OCKERMAN: I think he said little.

A. I don't remember using the word partial.

Q. All right. What about little? Do you remember saying that?

A. Honestly I don't remember that either.

Q. You don't? What caused that contraction? Do you have an opinion as to a reasonable degree of medical probability?

A. What caused it?

Q. Yes.

A. I don't know that anybody knows what causes portions of the colon to contract. You see it will a the time on barium enema studies, so, no, I have no opinion as to what caused that.

Q. Were you, once again, show me in the other films this area of the distal sigmoid colon becomes filled with barium when the patient is in different positions. Speak slowly, please?

A. Here with the patient supine that segment is here.

Q. Exhibit B?
A. 1-B. It is white and hence filled with barium. I believe it is partially filled with barium here in this segment here on 1-H.
Q. You see no areas of overlapping colon in 1-B?
A. Oh, yes. There is overlap in on all the films of portions of the colon. That's the nature of the colon. That there is overlap.
Q. 1-H?
A. In 1-H-I think that segment that we see in 1-F a sweeping across this way is that same segment that I see sweeping across here. Here it's filled with barium. Here it is filled with air.
Q. 1-H is the post evacuation film, is it not?
A. Yes, it is.
Q. Would you expect a significant change in the shape of the colon and that's why you do air contrast, isn't it, Doctor, to expand the shape of the colon to look for defects?
A. The reason one does air contrast is to coat the inner wall with barium, fill the lumen with air which allows one to see inside the lumen, if you will. It's particularly useful when one has overlapping structures as in the colon.

Q. I'm surprised you haven't asked to see Dr. Margolis' deposition. Do you know who he is?

MR. OCKERMAN: Objection. Dr. Margolis' deposition was not delivered to my office until Friday of last week, so --

MR. SCANLON: Well, I'm here to find this witness' opinions out. I'm going to move to limit him to what he has reviewed and what he has testified to today for $1,500 I think we are entitled to have all of your opinions.

MR. OCKERMAN: Larry, what do you want me to do when the deposition isn't here in time to get to to him?

MR. SCANLON: That's not true because I had mine within a week.

MR. OCKERMAN: Well, I didn't have mine until last week.

MR. SCANLON: Whatever.

MR. SCANLON:

Q. Do you know Dr. Margolis?

A. If he's the doctor Margolis I think it is in San Francisco?

Q. Yes.

A. Then I know of him, yes.

Q. He helped write the American College of Radiology Standards in this area. Do you know that?
A. I was not aware of that.
Q. You're a member of the American College of Radiology, are you not, sir?
A. Yes.
Q. Board certified?
A. Yes.
Q. Is in a a test that you have to undergo?
A. Yes.
Q. Did you pass it on the first time?
A. Yes.
Q. Now, this gravity that you explain is the reason why the lumen isn't filled with barium so that it repels the x-rays and appears as a white image, why is it that other parts of the colon in the same position don't show that similar kind of combination of blackness caused by air and a contraction?
MR. OCKERMAN: Objection.
A. I don't know about the contraction, but there are plenty of areas in the colon that I could point to where there is both barium and air.
For instance, I would say take a look at 1-D, which is a decubitus film, a patient lying on

the side, and the barium falls and there are dependent portions, the air rises up. That's why we see fluid levels.

Q. Sure. Do you see areas of contraction on 1-D?

A. On 1-D-I do not. Everything looks very distended.

Q. Exactly. Which is the purpose of air; right?

A. Correct. Including the segment that you're interested in, I might add.

Q. Where is that? Show us.

A. It's right in here.

Q. And on 1-C, is that the same that's another decubitus film?

A. Yes, that is correct: Well, no. I beg your pardon. That is not a decubitus film. That's a prone film shot cross table.

Q. Prone. Is that like 1-F?

A. It is similar to 1-F in that both of those films were taken prone. 1-F was taken prone but shooting the x-ray back to front whereas 1-C was taken with the patient prone shooting the x-ray side to side.

Q. Can you visualize the area of the distal colon in 1-C that we've been discussing?

A. The distal colon, yes. This is the rectum here. Rectosigmoid junction is probably in this area right

here. Then these are loops of the sigmoid colon.
Q. Do you see any kind of contraction in the area of the distal sigmoid colon on 1-C?
A. Contraction, no, I do not.
Q. Do you see a narrowing of the lumen?
A. No.
Q. And on 1-E, can you describe that film for us?
A. 1-E is a decubitus film with the patient lying on the left side, and that's what it is.
Q. Do you see any narrowing of the lumen of the -- any part of the colon in this patient?
A. I do not.
Q. On 1-H, that's the post evacuation film?
A. Correct.
Q. Do you see any narrowing of the lumen of the colon of this patient in that film?
A. Yes, I do.
Q. Where?
A. I see a narrowing of the lumen in the cecum and part of the right colon where the colon is beginning to collapse, which is normal for a post evacuation film. And I see narrowing of the small area here.
Q. What area are you pointing to?
A. I'm pointing to a piece of the sigmoid colon, which

is narrowed somewhat compared to the other segments of the sigmoid.

Q. What about on 1-B?

A. 1-B looks entirely normal.

Q. Which position is that taken in?

A. 1-B is taken supine.

Q. 1-A, what position is that taken in?

A. Which one?

Q. This one.

A. 1-A, that's an angled shot taken with the patient prone.

Q. So 1-A and 1-F are prone films; correct?

A. Correct.

Q. Are there any other prone films that were taken?

A. It looks as though the post evacuation film was taken prone.

Q. And on that film, 1-H, you do see a narrowing of the sigmoid colon; correct?

A. In that one small area that I pointed to, yes.

Q. Why is that? Do you have an opinion as to why that area of that sigmoid colon is narrowed in 1-H?

A. Yes. It's normal to see areas of narrowing in a post evacuation film. That's what happens when one evacuates the colon.

Q. Do you believe the American College of Radiology recommendations represents standards for radiology?
A. I believe they represent guidelines.
Q. Does your interpretation of this barium enema follow those guidelines, Doctor?
A. I believe it probably does.
Q. Let me hand you Exhibit 7. It's a three-page pathology report.

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(Document marked for identification Deposition Exhibit No. 7.)

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Q. I ask you to review it generally to see if you recall seeing that.
A. (Witness reviews document.).
I think again a copy of this was attached to one of those depositions that I read, I think.
Q. Sir, now that you've had a chance at my request to review the operative report of Dr. Meyerhoefer, the CT scan of Dr. Sayoc, the pathology report that I've pit in front of you just now, is there any doubt in your mind that this cancer was never found in the rectosigmoid junction of this patient?
MR. OCKERMAN: Objection.

A. That question makes no sense to me.
Q. Well, you were just wrong about saying the cancer was in the rectosigmoid junction in your affidavit, weren't you?
MR. OCKERMAN: Objection.
A. I don't believe so.
Q. No? You still are of the opinion that this mass was found in the rectosigmoid junction?
A. It says here preop diagnosis, poorly differentiated add enknow carcinoma of the rectosigmoid. Postop diagnosis same. That certainly sounds to me like a rectosigmoid cancer. I don't follow how you say -- I don't understand the confusion.
Q. You signed an affidavit based on the information you were given; right?
A. Correct.
Q. You were given a report where there was -- Dr. Korkor's drawing describing this as being an area of the rectosigmoid junction; right?
A. Correct.
Q. You read the deposition, though, of Dr. Slezak, the surgeon, who is being called by Dr. Rovner, and attached thereto was this report of Dr. Meyerhoefer, the surgeon; correct?

A. Okay.
Q. Have you read it?
A. Yes.
Q. So it says the same thing, preoperative diagnosis, rectosigmoid cancer postoperative diagnosis, rectosigmoid cancer. Reading these reports, though, it's clear that this cancer was not found at the rectosigmoid juncture; is that right; doctor?
MR. OCKERMAN: Objection.
A. Again, I think you're quibbling over terms. It's not as if we are talking about widely different areas here. The rectosigmoid junction including, as I said, a portion of the sigmoid. I think we are all in the same anatomic area. I'm not certain --
MR. OCKERMAN: Objection. Mr. Scanlon, every report you've shown him says rectosigmoid junction. Now you want him to interpret Dr. Meyerhoefer's words? Is that what you're trying to get at?
Q. In retrospect there is an abnormality that's consistent with the location of where this cancer was removed from this patient; correct?
A. No.
Q. No? You didn't say that earlier in this deposition,

sir?

A. I don't believe so.

Q. You have testified for the firm of Buckingham Doolittle and Burroughs on how many occasions?

A. I testified at trial?

Q. Yes, sir?

A. I can't tell you the exact number. I'm not certain I've ever testified in a courtroom for that firm.

Q. You've done depositions?

A. Yes, I have.

Q. On how many different occasions do you think you've been deposed in connection with cases where the firm of Buckingham, Doolittle and Burroughs has asked to you render an opinion in favor of their client?

A. I suspect a number of depositions for them. I would put that only a guess because I have not reviewed in any way the numbers -- but maybe five to ten, somewhere in that neighborhood.

Q. So you would agree with Dr. Slezak whose deposition you have been provided, and you have read, that the area that we've been discussing at 1-F, is, in fact, more likely than not the area where the cancer is located in this patient?

MR. OCKERMAN: Objection.

A. I'd have to go back and look at his deposition. I don't remember it in detail.
Q. So is it your opinion -- I've asked you this now a couple of times, and I've gotten different answers. The record will reflect that -- that on 1-F, that area where I've pointed out a narrowing of the lumen and the presence of darkness, which you say is air, that that is, in fact, not caused by cancer? Is that your opinion in this case?
MR. OCKERMAN: Objection.
A. My opinion is that the study was interpreted correctly, that the study is normal.
Q. I understand that. I know that. I know that's what you're here to say?
A. I'm not sure how question is any different than that.
Q. I'm asking you if you know retrospectively in this patient, as you look at that x-ray today, with everything you've seen in this case, is it your opinion that that area is not where the cancer was found, that area of narrowing and darkness?
A. Oh, anatomically there is no question that cancer is diagnosed in the rectosigmoid area. You seem to be making a big deal out of whether it was exactly at

what's been referred to as the rectosigmoid junction or somewhere else many but there is no question that that part of the colon is where the cancer is eventually diagnosed. My opinion is it can't be diagnosed on those films. It cannot be diagnosed on the study that we have.

Q. To you that is not a readily visible lesion, what we see on 1-F; correct?

A. Correct.

Q. You wouldn't describe it as appearing like an apple core?

A. No.

Q. It doesn't have any characteristics consistent with plaque?

A. No.

Q. You see no shelving; is that correct?

A. Correct.

Q. But, in fact, the narrowing does create a shelf, doesn't it, Doctor, at 1-F?

A. Again, we are picking over definitions of words. My opinion is that the study was interpreted as normal. I still interpret it as normal, and I think you're trying to make particular words mean particular things to get me to say something different, but

that's my opinion.
Q. I understand. There is no shelving in your opinion, then in Exhibit 1-F, in the area of the distal sigmoid colon?
A. Correct.
Q. You do not see the presence of an annular mass?
A. Absolutely not.

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(Document marked for identification Deposition Exhibit No. 8.)

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Q. Exhibit 8 is the MRI of July 17, 1995. You haven't seen that film, have you?
A. I have not.
Q. In connection with the opinions you're going to render in this case, would the MRI of July 17, 1995, make any difference to that opinion?
A. No, it would not.
Q. Nor would I take it, the CT scan of September of 1995 in a we've previously discussed, September 14; right?
A. Correct.

MR. SCANLON: Let me take a five-minute break. I may be done.

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(Whereupon, there was a recess in the proceedings.)

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Q. We put up on the box your MRI -- our MRI for this patient from July of 1995. You haven't seen it before today. We did show you the report. My question is are you able to identify any view of that MRI in which you would see an abnormality in the area of the distal sigmoid colon?

A. On this sheet of film here someone has actually made some marks on it. I would agree that the area that's marked is abnormal.

Q. Can you identify which view that is? Is it numbered, Doctor?

A. It's an axial view. I would say in this particular group of films it's labeled image 31 of 46, 31/46. That one is abnormal. 32 is abnormal. 33 is abnormal. 34 is abnormal.

Q. How would you describe that abnormality?

A. I'd say that that segment of colon shows circumferential thickening of the wall.

Q. What does that mean, circumferential?

A. It means it's completely surrounding the lumen.

Q. Could that cause the lumen to contract?
A. It could cause the lumen to be narrow, yes.
Q. Would it change the diameter of the bowel itself?
A. Of what part of the bowel?
Q. External versus internal or would it only control the internal dimension of the lumen?
A. It would be both. The bowel segment itself is abnormally thick, so abnormally big externally, and as it goes around circumferentially, it may narrow the lumen.
Q. How would you describe what area of the colon was involved in those four views?
A. These two sheets of film are a part of the same sequence which are numbered here on this lateral scout image. The ones I've said are abnormal are 31 through 34 perhaps. That would be down in here, at least based on these particular images, we are looking at proximal rectum based on those images right as the very top of the rectum right before the sigmoid sweeps in to join it. That's what I would say based on these particular scout images and these particular cut that is I think show the abnormality in question.
Q. Let's --

A. Let me change that just a little bit. Just looking at this for the first time the interpretation of these images does take some time. I believe actually that there are two loops of bowel on those particular images and that the rectum is actually part of the rectum is actually behind the segment that I've called abnormal, so I believe probably the rectum is collapsed here, and that is actually just at or just proximal to the rectosigmoid junction. Now we are seeing two loops, the rectum behind the abnormal loop in front, so probably right at that bend and we are catching both loops one in front of the other. I think that's anatomically really what we are seeing here.

Q. When you say proximal to the rectosigmoid junction in layman's terms, what do you mean, Doctor?

A. In layman's terms, I mean that segment of colon just before the rectosigmoid junction, so that would be the distal end of the sigmoid right as its going to join the segment that we call the rectum.

Q. Anything else you want to comment on in those films?

A. I think that's the case. There are a lot of images here, and you really haven't given me the time that I really need to feel confident about this. But on

a quick first look, that's the segment that's abnormal. Whether it's proximal part of the rectum or right at the rectosigmoid juncture even the distal part of the sigmoid, I'm not totally certain of without going through every image piece by piece. But that's how I would interpret that.

Q. Thank you. Doctor, you've HAD a moment to look at the CT scans of September 14, '95; correct?

A. Correct.

Q. Do you see any abnormality in that study in the area of the distal sigmoid colon?

A. I think that there is some abnormality here in the proximal rectum where there is some thickening of the wall, and that extends into the distal part of the sigmoid as well where there is some thickening of the wall and probably I would describe as some stranding or some streaking of the tissue into the pericolic fat. That's about the only other abnormality. It's really not an abnormality but the uterine line something extremely thick. I understand she just delivered or had recently delivered a baby, so that would be normal.

Q. Do you see an annular carcinoma of the distal sigmoid colon of about five centimeters?

A. I see thickening of the wall of the colon in that area, which is probably due to the cancer, but that would not have been my way of expressing that.
Q. How would you have expressed it?
A. Just as I stated to you, abnormal thickening of the wall.
Q. If you had known there had been a previous diagnosis of cancer, would you have said something different in your report?
A. I may or may not have. At the very most, I may have said thickening of the wall in the area previously diagnosed cancer, something to that effect.
Q. Is this a circumferential finding in the area of the distal colon similar to what we said you saw in the MRI?
A. It's not as clearly circumferential on this particular study as I felt it was on the MRI. I wouldn't be so certain of that based on this study.
Q. Now that you've seen the MRI and the CT scan, would you agree that that thickening of the wall of the colon is in the area of that contraction shown on the barium enema study?
A. Yes.
Q. No doubt in your mind?

A. It's the same anatomic area.
Q. And do you have an opinion one way or another whether or not endoscopic exam of Theresa in December of '94 would have led to the diagnosis of cancer?
A. I do have an opinion.
Q. What's that opinion?
A. I suspect it probably would have.
Q. Do you have an opinion whether or not that diagnosis would have led to a different outcome?
A. I don't have an opinion on that.

MR. SCANLON: Doctor, I have no further questions. Thank you for your time today.

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(Whereupon, the proceedings were concluded at {time} {a.m.|p.m.})

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COMMONWEALTH OF PENNSYLVANIA) CERTIFICATE
COUNTY OF ALLEGHENY) SS:

I, Claire Gross, RDR, a Court Reporter and Notary Public in and for the Commonwealth of Pennsylvania, do hereby certify that the witness, LAWRENCE COOPERSTEIN, M.D., was by me first duly sworn to testify to the truth, the whole truth, and nothing but the truth; that the foregoing deposition was taken at the time and place stated herein; and that the said deposition was recorded stenographically by me and then reduced to printing under my direction, and constitutes a true record of the testimony given by said witness.

I further certify that the inspection, reading and signing of said deposition were not waived by counsel for the respective parties and by the witness.

I further certify that I am not a relative, employee or attorney of any of the parties, or a relative or employee of either counsel, and that I am in no way interested directly or indirectly in this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office this 12th day of January, 2000.

Claire Gross

Notary Public
Notarial Seal
Claire Gross, Notary Public
Pittsburgh, Allegheny County
My Commission Expires May 9, 2002
Member, Pennsylvania Association of Notaries