

State of Ohio,)
County of Cuyahoga.)

- - -

IN THE COURT OF COMMON PLEAS

- - -

THOMAS S. ORTMAN, et al.,)
)
 Plaintiffs,)
)
 v.)
)
ROBERT ALBERHASKY, M.D.,)
et al.,)
)
 Defendants.)

Case No. 317279
Judge
Christopher A. Boyko

- - -

THE DEPOSITION OF ARMIN J. GREEN, M.D.

TUESDAY, DECEMBER 9, 1997

- - -

The deposition of ARMIN J. GREEN, M.D., a Witness herein, called for examination by the Plaintiffs, under the Ohio Rules of Civil Procedure, taken before me, Lauren I. Zigmont-Miller, Registered Professional Reporter and Notary Public in and for the State of Ohio, pursuant to notice, at the offices of Dr. Green, Mentor Medical Park, 8224 Mentor Avenue, Mentor, Ohio, commencing at 5:10 p.m., the day and date above set forth.

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Armin J. Green

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1 APPEARANCES:

2

3 On behalf of the Plaintiffs:

4 JACK LANDSKRONER, ESQ.
 5 The Landskroner Law Firm
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 6 Cleveland, Ohio 44113-1904
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1

8 On behalf of the Defendants:

9 MARILYN MILLER CRISAFI, ESQ.
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4 CROSS-EXAMINATION BY

5 MR. LANDSKRONER

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1 PLAINTIFFS' EXHIBITS MARKED

2

1, 2 and 3

4

3

4

5

6

7

8 OBJECTIONS BY

9

MS. CRISAFI

11(2), 13, 14, 16, 18,

3

20, 30, 33(2), 42, 45,

1

48, 59, 66(3), 72(2), 79

2

3

4

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Page 4

1 (Thereupon, Plaintiffs' Exhibits 1, 2 and
 2 3 to the deposition of Armin J. Green,
 3 M.D., were marked for purposes of
 4 identification.)

5

- - -

6

ARMIN J. GREEN, M.D.,

7 a Witness herein, called for examination by the
 8 Plaintiffs, under the Rules, having been first duly
 9 sworn, as hereinafter certified, deposed and said as
 10 follows:

11

CROSS-EXAMINATION

12

BY MR. LANDSKRONER:

13

Q. Doctor, my name is Jack Landskroner.

14

We've had a chance to briefly meet before the
 15 deposition.

16

Just for the record, we're beginning
 17 today at 5:10. This is in the case of Tom Ortman, et
 18 al., vs. Robert Alberhasky, et al. We're here for your
 19 discovery deposition today.

20

I'm going to ask you some questions.

21

Please make your responses verbal so the court reporter
 22 can take everything down. If you don't understand a
 23 question, please stop me and ask me to rephrase it. I
 24 want to make sure you understand the question I ask you
 25 and answer that. Are those fair instructions?

Page 5

1

A. Yes.

2

Q. Can you state your name for the record.

3

A. Armin J. Green, M.D.

4

Q. What is your professional address?

5

A. 8224, Mentor Avenue, Mentor, Ohio, 44060.

6

Q. Doctor, I've been provided with a copy of
 7 your curriculum vitae, which we've marked as Exhibit 1.
 8 Is that an up-to-date copy or version of your CV?

9

A. Not totally.

0

Q. Okay. What is absent from this CV?

1

A. I'm no longer associate medical director
 2 of Hospice of the Western Reserve, I am now the
 3 assistant medical director of the Lake University
 4 Ireland Cancer Center.

5

Q. Is that affiliated with University
 6 Hospital?

7

A. Yes.

8

Q. Who is the director of that?

9

A. The director is pending. We're in the
 10 process of moving this office into that center within
 11 the next two weeks.

12

Q. So you'll be the assistant director of the
 13 Lake County --

14

A. It's a joint venture between University
 15 and Ireland Cancer Center.

Page 6

1 Q. When did you cease to be involved as the
2 medical director of the Hospice of the Western Reserve?
3 A. Formally as medical director it was about
4 three years ago.
5 Q. Are there different versions of your
6 curriculum vitae that you utilize for speaking
7 engagements?
8 A. No.
9 Q. Or for writing purposes?
10 A. No. This just hasn't been updated.
11 Q. I note you have referenced Board
12 eligibility. Are you a Board certified physician?
13 A. No.
14 Q. Can you tell me what it means to be Board
15 eligible?
16 A. Board eligible at the time of finishing my
17 residency meant that I had eligibility to take the
18 Boards in both hematology and internal medicine.
19 Q. And did you undertake the examinations?
20 A. I took the examination once.
21 Q. Did you pass the examination?
22 A. No.
23 Q. You have not sat for the examination
24 again?
25 A. No.

Page 7

1 Q. Is there a Board certification for
2 oncology?
3 A. Yes.
4 Q. Have you ever sat for that examination?
5 A. No.
6 Q. Do you intend to sit for that examination?
7 A. No.
8 Q. Do you intend to retake your Boards for
9 hematology and internal medicine?
10 A. No.
11 Q. Can you tell me what the purpose of Board
12 certification is?
13 A. It's a matter of passing a test.
14 Q. What does it allow you to do once you're
15 Board certified?
16 A. Nothing more than I can do without being
17 Board certified.
18 Q. Does it allow you to hold yourself out as
19 an expert in a certain area beyond what you do
20 presently?
21 A. Would Board certification allow me to hold
22 myself out any more than I do now?
23 Q. Yes.
24 A. No.
25 Q. What are the benefits to being Board

Page 8

1 certified?
2 A. For me, none.
3 Q. What about for doctors in general?
4 A. For doctors passing the boards was about
5 40 percent when I took them in 1973. Now today a
6 younger doctor needs the boards in order to be on the
7 staff of certain hospitals. There are grandfather
8 clauses because it was a totally different situation
9 when I took them in 1973.
10 Q. You are a licensed physician in the State
11 of Ohio?
12 A. Yes.
13 Q. Are you licensed in any other states?
14 A. No.
15 Q. Have you ever held licensure in any tl
16 t
17 A. No.
18 Q. Are you tl on staff at any
19 hospitals in town?
20 A. Yes.
21 Q. Which hospitals?
22 A. Lake Hospital Systems.
23 Q. Do you have privileges at any other
24 hospitals?
25 A. No.

Page 9

1 Q. What are the hospitals that make up Lake
2 Hospital Systems?
3 A. Lake Hospital West and Lake Hospital East.
4 Q. With this new venture will you have
5 privileges at University Hospitals?
6 A. Probably.
7 Q. Have you ever had your privileges
8 suspended, revoked or diminished in any way from any
9 hospital?
10 A. No.
11 Q. Doctor, are you involved in any
12 publications beyond what's referenced in your CV here?
13 A. No.
14 Q. None are pending publication?
15 A. No.
16 Q. Do either of these publications that
17 you've referenced on your CV have anything to do with
18 the subject matter of the lawsuit?
19 A. No.
20 Q. Your practice is in what areas?
21 A. I'm sorry, I'm not sure I understand.
22 Q. What areas of medicine do you specialize
23 in?
24 A. Hematology and oncology.
25 Q. Can you explain to me what hematology is?

Page 10

1 A. Hematology is the diagnosis and treatment
2 of blood-related disorders and hematological
3 malignancies, which includes lymphomas.

4 Q. And oncology?

5 A. Oncology would be the diagnosis, treatment
6 and care of patients with solid tumors, and that
7 encompasses malignancies of a lot of different organs.

8 Q. I assume that includes testicular regions?

9 A. That would include testicular regions.

10 Q. In the course of your practice in
11 hematology and oncology do you receive regular
12 publications or journals in the trade or profession?

13 A. Yes.

14 Q. What publications do you receive on a
15 regular basis that you review as part of your practice?

16 A. Seminars in Hematology, Seminars in
17 Oncology and the journal Oncology.

18 Q. What about texts that you refer to in the
19 course of your practice?

20 A. There are textbooks that I own but rarely
21 refer to.

22 Q. Is there a text that is utilized for
23 purposes of oncology -- and for purposes of this
24 deposition let's deal more with oncology, not
25 necessarily hematology -- texts that you rely on in the

Page 11

1 course of your practice for oncology that you can refer
2 me to?

3 MS. CRISAFI: Objection.

4 A. One of the textbooks that I own is
5 Davita's Textbook of Oncology. I rarely refer to it;
6 it's mainly here as a reference source.

7 Q. Is there an authoritative text out there
8 that sets forth what good practice is and standards are
9 in terms of oncology?

10 MS. CRISAFI: Objection.

11 A. The problem with oncology is it is such a
12 rapidly changing field that textbooks rarely can keep
13 up with the changes. They change within months
14 sometimes. So I rely more on literature in the
15 journals that I talked about. The textbook -- I mean,
16 I must tell you that I own these textbooks but probably
17 open them less than one time a year.

18 Q. The journals then, do you utilize those as
19 authoritative?

20 A. Yes.

21 MS. CRISAFI: I missed
22 the last part.

23 MR. LANDSKRONER: The
24 question was, do you rely on the journals
25 as authoritative, and he said yes.

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1 MS. CEUSAFI: Is that
2 correct?

3 THE WITNESS: Yes

4 A. There are multiple journals and may be
5 multiple opinions. Which one I decide is authoritative
6 is based on reviewing a number of them.

7 Q. And in terms of reviewing a number, you
8 would assume the authoritative would be the one that
9 takes the majority opinion?

10 A. I would assume it's the one that takes the
11 majority opinion after a period of time where those
12 opinions could be proven.

13 Q. Do you teach anywhere?

14 A. I have a teaching appointment at
15 University Hospitals. At this point in time I'm not
16 actively teaching, but I have over the last 25 years
17 been active in teaching medical students.

18 Q. In the course of just the practice, your
19 practice at the hospital?

20 A. Both formerly at the university, formerly
21 at the VA Hospital, formerly in the hospital setting
22 and formerly in this office.

23 Q. Presently you have no residents that work
24 with you?

25 A. Not at the present time. This will be

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1 reinitiated after a hiatus of about ten years with the
2 new center.

3 Q. You had the opportunity to review a report
4 from a Dr. Sweet?

5 A. Yes.

6 Q. Do you know Dr. Sweet?

7 A. No.

8 Q. Are you familiar with Dr. Connell?

9 A. Yes.

10 Q. In what context do you know Dr. Connell?

11 A. I've referred patients to her.

12 Q. Have you socialized with her on any basis?

13 A. No.

14 Q. Have you talked to her at any time about
15 the facts of this case?

16 A. No.

17 Q. Doctor, have you ever been a plaintiff or
18 a defendant in a lawsuit?

19 A. Yes.

20 Q. Can you tell me how many times you've been
21 a defendant in a lawsuit --

22 MS. CRISAFI: objection.

23 Q. -- involving medical negligence?

24 A. How many times have I been involved?

25 Q. As a defendant named in a case involving

Page 14

Page 15

1 medical negligence.
 2 MS. CRISAFI: Objection
 3 to this whole line.
 4 A. I can't give you the exact number of cases
 5 that I've been named in, but probably it's in the range
 6 of four to five.
 7 Q. Did any of those cases involve issues
 8 similar to the issues that are present in this case?
 9 A. No.
 10 Q. None of those cases involved issues of
 11 embryonal carcinoma or seminoma?
 12 A. No.
 13 Q. Were those cases filed in Lake County?
 14 A. Yes. Probably a combination of Lake
 15 County, Geauga and Cuyahoga.
 16 Q. Were you deposed in any of those cases?
 17 A. In two of them.
 18 Q. Were those in Lake County?
 19 A. Yes.
 20 Q. Did either of those cases go to trial?
 21 A. No.
 22 Q. Were there settlements involved in either
 23 of those two cases?
 24 A. No.
 25 Q. Can you tell me how many times that you've

1 any insurance companies?
 2 MS. CRISAFI: Objection.
 3 A. I did sit on a peer review board for PIE
 4 years ago for one year.
 5 Q. Were you at that time a PIE insured?
 6 A. Yes.
 7 Q. When did you cease to be a PIE insured?
 8 A. September of 1997.
 9 Q. Doctor, at the time you rendered your
 10 opinions in this case were you a PIE insured?
 11 A. Well, I would have to check the exact
 12 date. Do you want to know the exact time, the exact
 13 date? I can tell you that at the time I rendered this
 14 opinion, no, I was not.
 15 Q. Do you recall when you were first
 16 contacted to review this case?
 17 A. I don't recall, but I may have it written
 18 down. I don't have it written down. I do not think it
 19 was before September 3rd, which was when my PIE
 20 insurance was discontinued and I started with the new
 21 company, I suspect it was after that.
 22 Q. Do you know if the new company you're
 23 insured by has any involvement with PIE?
 24 A. It's not.
 25 Q. Are you familiar with Dr. Alberhasky?

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Page 16

1 been involved in reviewing medical-legal issues as an
 2 expert?
 3 A. Many. I can't tell you the exact number.
 4 Q. Can you tell me approximately how many
 5 cases you review a year?
 6 A. Ten.
 7 Q. And how many years approximately you've
 8 done that for?
 9 A. Twenty-five -- 23.
 10 Q. In the course of those years can you tell
 11 me what percentage of those cases you've reviewed for
 12 the plaintiff and what percent for the defendant?
 13 A. Ten percent approximately for the
 14 plaintiff, 90 percent for the defendant.
 15 Q. In the course of those reviews in the
 16 years that you've been involved with this have you
 17 testified live in trial?
 18 A. Yes.
 19 Q. Can you tell me the most recent times that
 20 you've testified in trial?
 21 A. The last time that I testified in trial
 22 was probably four years ago.
 23 Q. Doctor, are you a PIE insured?
 24 A. No.
 25 Q. Have you ever sat on any review boards for

1 A. No.
 2 Q. Dr. Basa?
 3 A. No.
 4 Q. Dr. Sidor?
 5 A. No.
 6 Q. I assume then you've never received any
 7 referrals from any of these physicians?
 8 A. No.
 9 Q. If you can, tell me how it is you first
 10 became involved in this case.
 11 A. I got a call from Marilyn Miller Crisafi
 12 asking me if I would be willing to review a case.
 13 Q. Doctor, let me back up. In the course of
 14 your reviewing cases over the years have you ever
 15 testified at trial for a plaintiff?
 16 A. Yes.
 17 Q. Do you recall the last time that occurred?
 18 A. That was probably around six years ago.
 19 Q. Do you recall who the attorney was?
 20 A. Paul Kaufman.
 21 Q. Going back to how you were first contacted
 22 in this case.
 23 A. I just got a telephone call from Ms.
 24 Crisafi asking me if I would be willing to review a
 25 case of testicular cancer.

Page 18

1 Q. Do you know how she came across your name?
 2 A. I've done a number of reviews for PIE in
 3 the past.
 4 Q. Have you ever worked with Ms. Crisafi
 5 before?
 6 A. No.
 7 Q. While you were a PIE insured were you
 8 represented by the Jackson, Maynard Law Firm?
 9 MS. CRISAFI: Objection.
 10 A. As an insured, yes.
 11 Q. Doctor, in the course of your practice I
 12 assume that you see patients that are referred to you
 13 with seminoma?
 14 A. Well, not necessarily seminoma because
 15 seminoma is rarely treated with chemotherapy.
 16 Q. Do you see mixed cell tumors?
 17 A. Yes.
 18 Q. Do you see tumors that are embryonal
 19 carcinoma?
 20 A. Yes.
 21 Q. Are there occasions that you have seen
 22 patients with seminoma?
 23 A. I'm not going to say that there has never
 24 been an occasion where I've seen a seminoma maybe to
 25 give an opinion. I've never treated a patient with

Page 19

1 pure seminoma.
 2 Q. Let Ms. Crisafi tell me what was
 3 your understanding of what your role was going to be in
 4 reviewing this case?
 5 A. I was asked to be an expert with regard to
 6 the complications of chemotherapy that the patient was
 7 administered and to review the case from the standpoint
 8 of damages he could have incurred or been incurred
 9 because of the chemotherapy and the radiation therapy
 10 that this patient received.
 11 Q. If I can kind of glance at your file for a
 12 little bit and see what you reviewed
 13 doctor, as I review these records I see
 14 that there are updated records from Dr. Connell. You
 15 had a chance to look at those?
 16 A. Yes.
 17 Q. It was a deposition of Dr. Mitchell, is that right?
 18 A. Yes.
 19 Q. You've had a chance to read that
 20 deposition?
 21 A. Briefly. It was just sent to me within
 22 the last 24 hours.
 23 Q. I have some medical literature that you
 24 have a part of your file?
 25 A. Yes.

Page 20

1 Q. Is this something that you reviewed in the
 2 course of your review of this case?
 3 A. Yes.
 4 Q. There is a cover letter from Ms. Crisafi
 5 which is dated December 1, 1997 -- I'm sorry, cover
 6 letter dated October 27th of 1997 from Ms. Crisafi
 7 which appears to be an initial letter to you providing
 8 records and materials, a copy of which we have marked
 9 as Exhibit 3.
 10 A. Correct.
 11 Q. Is that the initial letter you received
 12 that provided you the materials?
 13 A. Yes.
 14 Q. There's some handwritten notes here, as
 15 well. Are these notes that were generated by you in
 16 your review of this case?
 17 A. Yes.
 18 Q. Were those notes, if you can recall,
 19 generated at the time you were going through the
 20 original records?
 21 MS. CRISAFI: Objection.
 22 A. Yes.
 23 Q. There appears to be a copy of a report
 24 that you rendered in this case?
 25 A. Correct.

Page 21

1 Q. And a statement for your fees for review
 2 and you involve that in this case?
 3 A. Correct.
 4 Q. Tell me your rate for review literature
 5 and records, initial review is what per hour?
 6 A. \$300 an hour.
 7 Q. So at \$50 an hour as of the time of
 8 your letter dated November 15, 1997, you spent five --
 9 A. Five hours on telephone conversations,
 10 reviewing literature and dictating the letter.
 11 Q. And that I assume, excludes any time you
 12 had in preparation for the deposition today?
 13 A. Correct.
 14 Q. In the course of that for the
 15 deposition today can you tell me what you reviewed
 16 what you specifically reviewed in preparation for the deposition?
 17 A. Details regarding a number of issues
 18 during this patient's care in chemotherapy and
 19 follow-up scans, those were from the medical records
 20 supplied to me by the attorney, and a number of pieces
 21 of medical literature, some of which are in here now.
 22 Q. In reviewing your report -- we've marked a
 23 copy of your report as Exhibit 2, is that correct?
 24 A. Yes.
 25 We've listed a number of materials that

Page 22

1 you've looked at in that report in preparation for
2 writing your report. I review of this case, correct?

3 A. Yes.

4 Q. In addition to the information that's
5 listed in that report and that information which we've
6 now viewed from your file, is there anything else that
7 you reviewed related to this case that we haven't
8 talked about?

9 A. Are you talking about specific books and
10 journals that are not in this file but I might have
11 looked at?

12 Q. Not yet. I was talking about what you
13 looked at, records and materials related to this case.

14 A. No, that is complete.

15 Q. Did you have the opportunity to do any
16 literature searches related to this case in preparation
17 for writing your report?

18 A. The literature search that I did was on my
19 own, it was not a formal literature search, and it
20 reviewed only journals, textbooks and articles that
21 were available to me on an immediate basis.

22 Q. Can you tell me what journals, texts or
23 articles that you did review in preparation for writing
24 this report?

25 A. The journal Oncology and a paperback book

Page 23

1 called Cancer Management - A Multi-Disciplinary
2 Approach.

3 Q. The Journal of Oncology --

4 A. The journal is Oncology -- I'm sorry,
5 Seminars in Oncology.

6 Q. Who is that authored by?

7 A. It's edited by a number of people and
8 authored per issue.

9 Q. It's dated April 1992, Volume 19, No. 2,
10 Seminars in Oncology.

11 Are the article that you have in
12 file from this journal?

13 A. Yes.

14 Q. And I assume that the -- that you
15 thought were pertinent you copied and put into your
16 file?

17 A. Correct. There was another article that
18 was generated by the library, which came from -- I'm
19 not sure where that came from -- the Lancet.

20 Anything else or any other journals or
21 materials that you reviewed?

22 A. No.

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1 Q. You said this Seminars in Oncology, you
2 said one other publication, what was the other
3 publication?

4 A. (Indicating).

5 Q. This is a book entitled, Second Edition,
6 Cancer Management - A Multi-Disciplinary Approach, by
7 Richard Pazdur, P-A-Z-D-U-R, M.D. I'd like to get the
8 cover of that, as well.

9 MS. CRISAFI: Is that
10 1998?

11 MR. LANDSKRONER: That is the
12 1998 edition, correct.

13 THE WITNESS: which is
14 unique because we're not in 1988.

15 BY MR. LANDSKRONER:

16 Q. Did you copy any of the pertinent
17 materials you found in that book?

18 A. No.

19 Q. Is there anything that you reviewed in the
20 last day or so, including the depositions or the recent
21 medical records, which changes your opinion in any way,
22 opinions that you've set forth in your report?

23 A. No.

24 Q. Is there anything that you have not had
25 the opportunity to review that you would like to have

Page 25

1 had the opportunity to review related to this case or
2 the records?

3 A. Not at this time.

4 Q. Nothing that you thought was necessary for
5 you to get a complete review?

6 A. That's correct, no.

7 Q. Doctor, what percentage of your time do
8 you spend in reviewing medical-legal issues?

9 A. Less than one percent.

10 Q. Can you break down for me what the
11 remainder of your time --

12 A. Clinical practice a hundred percent
13 basically. These cases are reviewed at home out of the
14 office.

15 Q. Did you have the opportunity to discuss
16 this case with any other physicians or experts?

17 A. Yes.

18 Q. Who did you discuss it with?

19 A. I discussed it briefly with Dr.
20 Siminovitch.

21 Q. And how do you know Dr. Siminovitch?

22 A. I work with him.

23 Q. Did Dr. Siminovitch in any way have any
24 involvement with your coming on this case?

25 A. No.

Page 26

1 Q. Did you have any involvement with Dr.
2 Siminovitch coming on this case?

3 A. No.

4 Q. What did that discussion entail between
5 you and him?

6 A. It was very shortly after I was contacted
7 by Marilyn Crisafi and I was informed that he may be an
8 expert in this case. I just wanted to briefly discuss
9 some of the details with him, which we did very briefly
10 at a social function. That was actually the total
11 extent of the discussions.

12 Q. What were the issues that you discussed at
13 that time?

14 A. The issue was that he's a urologist and I
15 was just curious in terms of his urological opinion.

16 Q. What did he tell you at that time?

17 A. He did not render an opinion at that time
18 because he had not reviewed the details of the case.

19 Q. Did you have a chance to express your
20 opinions?

21 A. I had not received the case at that time;
22 I had been contacted about probably reviewing it.

23 Q. At no point after that did you have a
24 discussion?

25 A. At no point afterwards. Dr. Siminovitch

Page 27

1 is in this area and it was a coincidence that he was
2 being used. I see him every day and work with him on a
3 very close basis. The case was a coincidental
4 situation. It was never brought up again other than it
5 was a coincidence that we had been called.

6 Q. Does Dr. Siminovitch refer you patients?

7 A. Yes.

8 Q. Do you refer him patients?

9 A. Yes.

10 Q. Your report dated October 27, 1997, were
11 there any drafts of that report that were issued?

12 A. No.

13 Q. Were there any changes made to the report
14 at any time?

15 A. No. When you talk about changes, there
16 were typographical errors before that report was sent
17 to Ms. Crisafi and those changes were taken out before
18 she got it, but there were no changes to the report.
19 That was all done within a period of minutes.

20 Q. Ms. Crisafi didn't have a copy of the
21 report before the changes were made?

22 A. No.

23 Q. In the course of your practice, Doctor, do
24 you treat any patients with any radiation therapy?

25 A. I don't treat -- I'm not -- I do not

Page 28

1 administer radiation therapy, but I work very, very
2 closely with a radiation therapist and make
3 recommendations for radiation therapy on a regular
4 basis.

5 Q. Are you familiar with Dr. Laye?

6 A. Yes. I've worked with him only because I
7 work very closely with East Side Radiology, which is
8 our current radiation therapy unit, and there's a
9 partnership arrangement between East Side Radiology and
10 West Side Radiology. So, when our radiation therapist
11 with whom I deal with on a regular basis is gone, Dr.
12 Laye is there. It's been very infrequent but I have
13 worked with him.

14 Q. So you would refer patients to him?

15 A. No. The patient is referred to the
16 radiation therapy center, and in very rare instances
17 where the radiation therapist with whom I work on a
18 regular basis is gone Dr. Laye has been covering. I
19 have not referred directly to Dr. Laye.

20 Q. I got you. So, while you don't administer
21 radiation therapy, you do prescribe it and then send
22 the patient off to the --

23 A. I recommend it and then I allow the
24 radiation therapist to make the decision as to how
25 much, how and what.

Page 29

1 Q. In your practice do you hold yourself out
2 as an expert in -- I assume you hold yourself out as an
3 expert in the area of oncology?

4 A. Yes.

5 Q. Hematology?

6 A. Yes.

7 Q. Any other areas besides that?

8 A. No.

9 Q. You do not perform any surgery?

10 A. No.

11 Q. Can you tell me how you would determine
12 the appropriate course of therapy for a patient who
13 presented to you with cancer?

14 A. I mean --

15 Q. I understand that's a general question.

16 A. It's a very general question.

17 Q. I'm trying to get an understanding, if a
18 patient comes to you and has cancer, what do you look
19 for?

20 A. A general overview of how I take care of
21 this kind of situation?

22 Q. Yes.

23 A. First of all, we will not see the patient
24 until we have all the records, slides and path reports
25 in front of us. The patient doesn't get through the

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1 door without appropriate studies to confirm they have
2 the diagnosis.

3 Once I have all those, I sit down with
4 the patient in that chair where you are sitting right
5 now and take a complete history, past history, present
6 history, what other problems they have, put it together
7 with the medical reports that I have, do an
8 examination, and then determine the best plan for that
9 patient.

10 I approach the patient in this office
11 by telling them I don't treat path reports, x-rays and
12 slides, I treat individual patients. My recommendation
13 is going to be based on the total picture of what that
14 patient presents with, what the diagnosis is, what kind
15 of malignancy we're dealing with and we put together a
16 plan based on all those factors.

17 Q. So, as you stated, you treat the patient
18 as a whole, not just the reports?

19 A. Right.

20 Q. If a patient presents to you with
21 seminoma, how do you go about determining the
22 appropriate course of therapy for that patient?

23 MS. CRISAFI: Objection.

24 A. I have to be honest and tell you that
25 seminoma patients are generally not referred to a

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1 medical oncologist because I'm very rarely asked, would
2 rarely be asked to render an opinion in someone with a
3 disease that's either treatable or curable with surgery
4 or radiation therapy. I must tell you that I don't
5 think I've ever seen a pure seminoma patient.

6 Q. Sure. A patient presents to you With a
7 mixed cell tumor, embryonal carcinoma and seminoma, how
8 would you go about determining the appropriate course
9 of treatment for that patient?

10 A. That treatment would be based on the
11 extent of disease, primarily based on a staging
12 situation.

13 Q. So the treatment modality is directly
14 affected by the stage of the cancer?

15 A. Yes.

16 Q. And determining what the appropriate stage
17 is is imperative to the treatment modality?

18 A. In any disease.

19 Q. Can you tell me just in lay terms, what is
20 cancer?

21 A. Cancer is a generic term for any one of a
22 broad number of malignant processes. They vary from
23 site to site, they vary from aggressive to slow
24 growing, they vary in terms of what they can do.

25 Some patients who have what appears to

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1 be very extensive cancer and may be told by some
2 doctors they have several months to live will be alive
3 many, many years later, others will be told they'll be
4 alive many years later and they'll be gone within six
5 months. So, it's a huge number of different processes,
6 which is why there is no single cure for cancer.

7 Q. A patient presents to you with embryonal
8 carcinoma, again, the appropriate course of treatment
9 would be based on the staging of the tumor?

10 A. The appropriate treatment would be based
11 on the staging. That's why staging was developed. The
12 reason we stage a patient is in order to determine
13 whether or not, number one, that patient requires one
14 form of therapy over another or no therapy at all.

15 The reason the staging process came
16 into being in the first place with diseases like
17 Hodgkin's in the 1960s is to try to determine why some
18 patients looked like they were going to do well and
19 didn't and other patients on the surface did lousy and
20 they ended up doing well. We now know that by staging
21 a patient we can determine outlook and prognosis.
22 That's how the staging process came into being in the
23 first place.

24 Q. What are the consequences of a mixed cell
25 tumor going untreated and undiagnosed?

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1 MS. CRISAFI: Objection.

2 A. Death.

3 Q. Is early di and t tion of mixed
4 cell tumor or it onal cell carcinoma directly
5 correlate t th outcome for the ti t?

6 MS. CRISAFI: Objection.

7 A. This is what is interesting about cancer
8 of the testicle, which makes it different from
9 virtually all other forms of cancer, and that is that
10 the cure rate for testicular cancer appears to be very,
11 very high even if the disease is not picked up early.

12 That's not true for other forms of
13 cancer, and that's why it's difficult to equate one
14 form of malignancy with another. The more advanced
15 breast cancer is the more difficult it is to treat.
16 With testicular cancer we have very high success rates
17 even with advanced disease.

18 Q. Can you tell me in May -- and if at any
19 point in time you need to look at the records, feel
20 free to do so -- in May of 1995 what Mr. Ortman's
21 diagnosis was based on the correct pathology?

22 A. The correct pathology is a mixed embryonal
23 cell carcinoma, that's what you're telling me?

24 Q. Correct.

25 A. We're assuming that that is the correct

Page 4

1 pathology as of now. The only way that you could have
2 really known what his stage was was to have done what
3 they call a retroperitoneal lymph node dissection, RLND
4 in the urological literature.

5 Q. Based on the records that you've reviewed,
6 were you able to make an assumption as to what stage
7 his cancer was?

8 A. I could tell that the CAT scan --
9 (Thereupon, there was a brief recess.)

10 BY MR. LANDSKRONER:

11 Q. The question was, were you able to make an
12 assumption based on what you reviewed as to what stage
13 his cancer was?

14 A. I'm not sure you could actually stage a
15 patient with just a CAT scan if you want to be
16 accurate. In other words, the difference it would be
17 between one and two. You know, there are some issues
18 here. We're talking about May of 1996?

19 Q. '95?

20 A. '95. I'm not -- the urologist would be in
21 a much better situation to tell you that because, as I
22 say, most of my patients are referred to me with this
23 disease after they've undergone a retroperitoneal lymph
24 node dissection.

25 Q. Can we agree that the diagnosis of

Page 35

1 seminoma in May of 1995 was incorrect?

2 A. I'm only basing that decision on the
3 records that are in front of me. I have to assume
4 based on the circumstances that developed and the
5 picture that developed after this that it was not a
6 correct -- well, let me rephrase that. The patient was
7 treated as having seminoma and obviously it didn't
8 work; therefore, one must assume that he didn't have
9 seminoma, and in retrospect that appears to be the
0 case.

1 Q. You've seen the revised pathology from the
2 original slides?

3 A. I've seen the report. I did not review
4 these records in marked detail with regard to all of
5 that issue.

6 Q. Your concentration was solely on the
7 chemotherapy and radiation issues in the case?

8 A. That's correct. I'm not a pathologist and
9 I'm not a urologist. I know who I can trust in my
0 community, and I am not trained to evaluate pathology.

1 Q. Based on the diagnosis of the report that
2 you read of the revised pathology, radiation was an
3 inappropriate treatment for Mr. Ortman in view of his
4 mixed cell tumor, is that true?

5 A. I would have to make the statement that in

Page 3'

1 view of the fact that this was a mixed cell tumor that
2 radiation therapy would not have been the treatment of
3 choice.

4 Q. ti therapy would have no effect
5 the mixed cell tumor?

6 A. It would have had an effect, but it would
7 not have been curative. That's not fair to say it
8 wouldn't have had an effect. There was no question
9 that on the scan some of the lymph nodes that were
10 present before were not present after. The question is
11 not whether or not it affected it -- you're not going
12 for palliation here when you're dealing with testicular
13 cancer, you're going for cure.

14 Q. Palliation, can you explain that?

15 A. In many situations we know we cannot cure
16 the patient, and in those situations all we're trying
17 to do is shrink it down, buy time, improve quality of
18 life. That could mean ten years, that could mean five
19 years, that could mean ten months, that could mean five
20 months.

21 With an isolated number of diseases we
22 are going for the full-blown treatment to get the
23 patient cured using the word cure. That means the
24 disease will never come back, ever. Testicular cancer,
25 Hodgkin's disease, these are two diseases that we are

Page 3'

1 attempting to literally cure. So it's not fair to say
2 that radiation didn't do anything because it did, but
3 it didn't cure the man.

4 Q. And why did the radiation not cure Mr.
5 Ortman?

6 A. It did not cure him because, in fact, he
7 did not have a seminoma, and the cure rate with
8 radiation of seminoma should approach as close to a
9 hundred percent as you could get.

10 Q. What is the cure rate with radiation and
11 embryonal carcinoma?

12 A. Obviously it's probably -- I cannot give
13 you that statistic because one wouldn't radiate an
14 embryonal cell carcinoma. That statistic probably
15 doesn't exist.

16 Q. That's because it's not radiosensitive?

17 A. I'm not sure I can make that statement.
18 All I can say is that the literature isn't there to
19 support this because it's not something that one has
20 studies or sees, and chemotherapy for this disease has
21 been around for a long time.

22 Q. Does the literature indicate that
23 embryonal carcinoma is not radiosensitive?

24 A. I'm not sure that it does or doesn't. I'm
25 not willing to say that it does or doesn't. I have to

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1 believe that it is radiosensitive because some of the
2 lymph nodes did go down. If you look at one of the
3 scans it states that there was improvement in some of
4 the scans, so that has to imply that it is somewhat
5 radiosensitive. But is it curative, no.

6 Q. This is a mixed cell tumor?

7 A. Yes.

8 Q. With both elements of embryonal and
9 seminoma?

10 A. Yes, which is not uncommon.

11 Q. Which could mean that the seminoma
12 elements of the cancer were radiated?

13 A. If you want to look at it that way, that's
14 not an unrealistic way of looking at it. We do see
15 that in other diseases.

16 Q. I think you've indicated patients with
17 seminoma achieve a cure rate of close to a hundred
18 percent with radiation.

19 A. Should be.

20 Q. Is that true when the stage is increased
21 for seminoma?

22 A. The cure rate should still be very, very
23 high, but it may imply that the patient would need
24 chemotherapy if it's beyond early stage seminoma.

25 Q. What are the early stages of seminoma?

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1 A. The early stage of a seminoma would be a
2 testicular mass with no evidence of anything else.

3 Q. In terms of staging, is it stage one,
4 stage two?

5 A. Two and three. There are a number of
6 different stages that are used.

7 Q. Is stage three also early stage?

8 A. Stage three is the latest stage.

9 Q. What are the percentages of cure for a
10 patient with a stage two mixed cell tumor?

11 A. High, about 80 to 85 percent.

12 Q. What percentage for a patient with a stage
13 three mixed cell tumor or embryonal tumor?

14 A. Still should be high. The literature is
15 there and the numbers go from study to study. We're
16 still talking about a high chance of cure with
17 chemotherapy in the range of 80 to 85 percent.

18 When you start talking about stage
19 three there are various levels of stage three. If the
20 patient has brain metastasis he's stage three and his
21 chance of survival is going to be very, very low,
22 probably zero. On the other hand, the patient could
23 have multiple pulmonary metastasis and nothing else, no
24 liver or brain metastasis, and his chance of cure could
25 be close to 95 percent.

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1 Q. Can you define what recurrence is?

2 A. Recurrence means that the disease is for
3 all practical purposes gone, completely gone, and that
4 at some later date it comes back. That's what we
5 define as a recurrence.

6 Q. What about metastasis?

7 A. Metastasis means it has spread to a
8 distant site from the original area.

9 Q. Is it your opinion or understanding that
10 in Mr. Ortman's case he had been completely cured of
11 cancer after the radiation therapy or that he had not?

12 A. No, I think it's my impression that the
13 radiation therapy just did some minimal things to what
14 was already there and didn't affect the disease at all.

15 Q. I've read in some of the literature that
16 there is a thing called a poor risk germ cell tumor and
17 a good risk tumor. Define those for me.

18 A. Well, one of the problems with poor risk
19 and good risk is that most of the time with cancer --
20 and testicular conditions are a little bit different --
21 we can determine whether or not the tumor is good risk
22 or poor risk by looking at the pathology.

23 We have ways of analyzing cell
24 proliferation, we have ways of analyzing whether cells
25 are aggressive, whether tumor cells are aggressive or

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1 not aggressive. We can do this with a technique called
2 flow cytometry, F-L-O-W, C-Y-T-O-M-E-T-R-Y. We use
3 this exclusively now for breast cancer because there's
4 a correlation between what those studies show and how a
5 woman will do with breast cancer.

6 We know that in certain tumors cells
7 that are poorly differentiated -- which we use that
8 term in lung cancer and colon cancer -- we know those
9 patients have very aggressive disease, and cells that
10 are well differentiated are less aggressive. To
11 determine risk factors based on pathology is what I'm
12 talking about. With testicular cancer it's a lot more
13 difficult. The cells all appear to be the same and
14 look the same.

15 What we define as good risk and poor
16 risk is based on a staging system that was set up in
17 Indiana, and that staging system doesn't take into
18 account what the cells actually look like, but how
19 extensive the disease is at the time of the first
20 diagnosis. So it's a different type of risk analysis
21 compared to all the other cancer that we'll be talking
22 about.

23 Q. At the time of Mr. Ortman's orchiectomy
24 was he a good risk cancer patient or a good risk -- how
25 do you phrase it, good risk -- was it a good risk

Page 42

1 tumor --

2 MS. CRISAFI: Objection.

3 Q. -- or a bad risk tumor, poor risk tumor?

4 A. Okay, so --

5 MS. CRISAFI: Doctor,
6 first, can you answer that question?

7 A. I think that it was a good risk tumor.

8 Q. And what are the ramifications of that?

9 A. Ramifications are that his chances of cure
10 are very high.

11 Q. Statistically -- let's look back in
12 January of 1996 when he returned to the emergency room.
13 Can you tell me, was Mr. Ortman at that point a poor
14 risk patient or a good risk patient?

15 A. I still think that he was a good risk
16 patient.

17 Q. And had his disease advanced over that
18 time period?

19 A. That's impossible for me to say.

20 Q. Did you see anything in the medical
21 records that indicated that there was a spread of the
22 disease?

23 A. The only issue in the medical records that
24 would have reflected a spread of the disease was a very
25 questionable CAT scan dated January 24, 1996. This is

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1 what we're talking about?

2 Q. Yes.

3 A. This CAT scan was read as having -- a CAT
4 scan of the chest dated January 24, 1996 was read as
5 having an eight-millimeter nodule at the medial aspect
6 of the right lung base. The report reads that it
7 probably represents a metastatic lesion. This is a
8 single isolated small -- anything that size, eight
9 millimeters, is small -- lesion. I would have argued
10 that this was a metastatic lesion, although I could
11 never prove that it was or it wasn't without a biopsy.

12 If the treatment of this patient had
13 been dependent on that lesion representing a metastatic
14 lesion, I would have had it removed and biopsied. I
15 would have had it removed because it probably couldn't
16 be biopsied. This is an issue that I come up with as a
17 medical oncologist. However, since the patient at this
18 point in time was going to require chemotherapy based
19 on the abdominal findings alone and the diagnosis of
20 embryonal cell carcinoma, and since the fact that this
21 was or wasn't a metastatic recurrence had no bearing on
22 his treatment, I would not have pursued it.

23 But for the purpose of staging, did
24 this represent a metastatic lesion, I would have had a
25 hard time with that because usually we will see a

Page 44

1 number of metastatic lesions in the lung, not just one,
2 and they will be larger than this.

3 Q. Were there other areas where there was
4 advancement of the disease?

5 A. In the abdomen there were abnormalities on
6 CT.

7 Q. Were they present at the prior CT?

8 A. To be very honest with you, I did not make
9 that comparison.

10 Q. What were the abnormalities that were
11 present on the CT in January?

12 A. According to the description on January
13 24, '96, there were lymph nodes in the pericaval and
14 right paravertebral regions that they say are new since
15 5-23-95 consistent with metastatic disease. The fact
16 that -- we had discussed this before with regard to his
17 radiation therapy -- the lymph adenopathy or lymph node
18 enlargement that was identified in the lower abdomen
19 and right inguinal region on the previous scan of
20 5-23-95 is no longer present or evident, this would
21 imply to me that those areas that were receptive to
22 radiation therapy responded and disappeared and that
23 new areas that were not responding appeared.

24 Q. So was there a spread of this disease?

25 A. I'm not sure that I would use the term

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1 "spread." There were new areas that indicated new
2 growth and other areas that involved improvement. If
3 you want -- the term "spread" is not one that I like to
4 use, but are there new areas there, yes.

5 Q. There's also a mass that was apparent that
6 was 2.5 centimeters by 3.5 centimeters?

7 A. I see a mass that says 2.5 centimeters,
8 but I don't see the 3.5.

9 Q. I think there's other records that
10 indicate that it was 2.5 by 3.5.

11 What is the significance of that mass,
12 if any?

13 MS. CRISAFI: Objection.

14 Are you asking him to assume that there's
15 a 2.5 by 3.5 centimeter mass?

16 A. There is a 2.5 mass, but I don't see the
17 3.5.

18 Q. Assume for me that it's 2.5 by 3.5
19 centimeters, what is the significance of that mass?

20 MS. CRISAFI: Objection.

21 A. I can't answer the question, other than
22 that the mass could represent lymph nodes. It most
23 probably represents tumor growth. Usually these are
24 lymph nodes that just appear out of the chain, out of
25 the lymph node chain and are, therefore, interpreted as

1 a tumor mass.

2 Q. What is lobulated soft tissue?

3 A. That's just a term that the radiologist

4 uses meaning that it doesn't have well-defined sharp

5 edges, and usually goes along with more of a malignant

6 process than a cystic process.

7 Q. Is there a significance to a disease which

8 develops above the diaphragm as opposed to disease

9 below the diaphragm?

10 A. Yes.

11 Q. What is the significance of that?

12 A. The significance is that it changes the

13 stage to a degree.

14 Q. What is the distinction in stage between

15 it?

16 A. It could still be a stage two, but it

17 would be a higher stage of two.

18 Q. In this case, at least at the time that

19 Mr. Ortman presented in January of '96, are you able to

20 make a determination as to what the stage was?

21 A. Well, if you look at the staging and you

22 assume that -- I mean, I would have to refer to a

23 staging book because I don't generally stage testicular

24 cancer. Do you want me to look at --

25 Q. If you can, yes.

1 A. I can do that.

2 The Indiana staging system -- which is

3 the one that is considered the easiest to use, because

4 it can get very difficult when you start going into

5 this -- states that minimal disease -- it relates to

6 minimal, moderate and advanced disease -- minimal

7 disease is defined as having an elevated HCG and/or

8 AFP -- which is a tumor marker test -- and having

9 cervical lymph nodes palpable -- which is lymph nodes

10 in the neck area -- with or without lymph nodes in the

11 abdomen and/or unresectable but non-palpable

12 retroperitoneal disease -- that means disease that

13 shows up on a CAT scan but can't be felt, which is the

14 case here -- and -- this is important -- minimal

15 pulmonary metastasis, they still consider this to be

16 minimal disease.

17 That is defined as fewer than five per

18 lung and the largest being less than two centimeters

19 with or without abdominal involvement. So I mean,

20 we're talking about less than five per lung field and

21 that's still minimal disease, and this guy has an

22 eight-millimeter lesion which is very debatable.

23 Q. That's for testicular cancer?

24 A. This is for non-seminomatous testicular

25 cancer.

1 Q. And that staged him at what level?

2 A. That would stage him as having minimal

3 disease.

4 Q. It doesn't give a stage in terms of --

5 A. Well, no. If you want to go into the

6 staging situation I would have to get a staging book.

7 We're going into what we call the TNM staging. Again,

8 this changes for every disease. Like I said, I'm

9 usually -- the problem with this is that this staging

10 is very dependent on what a lymph node biopsy

11 dissection shows.

12 This man did not have it, so we're

13 doing this based on guesswork. Anyone could argue what

14 I say, and I could argue what anyone else says.

15 According to -- there's clinical staging and there's

16 pathological staging. This is what it says -- this is

17 the handbook for staging cancer, this comes from the

18 American Joint Committee on Cancer.

19 Q. That's what year?

20 MS. CRISAFI: Note my

21 objection. The doctor stated the patients

22 usually come to him already staged.

23 A. Right. This is the fourth edition 1993.

24 Q. Okay.

25 A. Clinical examination and radical

1 orchiectomy are required for clinical stage.

2 Pathological staging, histological evaluation of the

3 radical orchiectomy specimen must be used for

4 classification. Histologic verification is necessary.

5 Stage two would be anything up to metastasis in

6 multiple lymph nodes. Stage three would be distant

7 metastasis, and that would be evidence of metastasis in

8 the lung, liver, bone.

9 So, on the basis of what we call the

10 TNM staging he would be stage three.

11 Q. Statically, how long after treatment does

12 a patient with embryonal carcinoma have to wait before

13 they're deemed free and clear for recurrence?

14 A. The bulk of the -- the majority of

15 recurrences will occur within the first 24 months after

16 treatment. I think that with this disease -- and

17 again, this is different from cancer to cancer, it's

18 not true for other forms of malignancies. If you're

19 going to talk about testicular cancer I would say that

20 they are better than 95 percent -- there's better than

21 a 95 percent chance that they are cured if they are

22 disease free at five years.

23 But patients who have testicular cancer

24 have a 500 times higher risk of having cancer of the

25 opposite testicle, so they have to be monitored for a

Page

Page 5

1 second new primary just as breast cancer patients who
2 may survive their first breast cancer have to be
3 monitored for the rest of their lives for the opposite
4 breast.

5 Q. So it's a five-year window to be 95
6 percent sure?

7 A. I would say it's a five-year window to be
8 95 percent sure.

9 Q. Does that risk increase or decrease based
10 on the stage of the cancer, if it's testicular cancer?

11 A. Well, obviously -- I mean, you would have
12 to say that the risk changes based on stage, but how
13 significantly does it change depends on how
14 significantly you're talking a stage difference. I'm
15 not sure going from one to two to three makes a
16 difference.

17 We have to use the Indiana staging
18 system. It takes into account what we call good and
19 poor risk subgroups. If you look at the system very
20 carefully you will see that patients with pulmonary
21 metastasis, which is literally the kiss of death for
22 almost any other malignant process we are aware of, it
23 still puts this patient into a good risk category
24 because the chemotherapy is so good today for this
25 disease.

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1 Q. Is there a significance to vascular and
2 lymphatic invasion with regard to risk of recurrence,
3 does that increase or decrease the risk of recurrence?

4 A. I think when you're talking about
5 testicular cancer it's not an issue. I don't think
6 it's an issue with this disease. It's very chronic
7 with other diseases. Assuming the patient is going to
8 get chemotherapy.

9 Q. And so I'm clear, although you've
10 indicated it may not be a significant increase or
11 decrease, if a patient is a higher stage of cancer,
12 that would decrease or increase their risk for
13 recurrence in the future?

14 A. I don't think that's fair. I think that
15 it -- we have to talk about specific diseases. It may
16 be the rule of thumb across the board, but it may not
17 necessarily be true for testicular cancer. It may mean
18 that you have to be more aggressive in treatment, but
19 that doesn't necessarily translate into a change in
20 outcome.

21 To clarify that, if the patient has
22 early stage disease then radical lymph node dissection
23 may be all that's necessary. If the patient has more
24 aggressive disease at the time of the original
25 diagnosis then they may require chemotherapy. There

1 are patients that are cured with this disease with
2 simple surgery alone.

3 Q. So the increase in the stage may affect
4 the aggressiveness of the treatment?

5 A. Yes. We don't know what stage this man
6 had at the beginning because he didn't have a radical
7 lymph node dissection. There was already evidence of
8 lymph node enlargement on the original CAT scan, so
9 it's probable that he would have needed at least
10 several cycles of chemotherapy.

11 Q. And when you say several?

12 A. Two.

13 Q. Am I correct in saying that embryonal
14 carcinoma is a high risk of recurrence than
15 seminoma?

16 A. I'm not sure I could make that statement
17 because, again, it all depends on treatment. The cure
18 rate of embryonal carcinoma with chemotherapy should be
19 very high and the treatment of seminoma with radiation
20 therapy should be very high so that the outcome should
21 be very good for both.

22 Q. Or can you tell me to the extent that
23 you can, because I know you don't deal with this
24 regularly what the complications are from radiation
25 therapy

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1 A. I deal with the complications of radiation
2 therapy all the time. These are patients who are
3 followed up in my office after they're long gone from
4 the radiation therapist. The complications are totally
5 dependent on where the radiation therapy is given, and
6 by that I mean not necessarily the center, because
7 we're assuming all of the centers that radiate now
8 today are state of the art. We had many complications
9 in the past before the standard of care became an
10 issue, before the standard of care was standardized.
11 It depends on the location of the radiation therapy and
12 it depends on the type of cancer you're treating and it
13 depends on the amount of treatment that was
14 administered.

15 Q. In terms of Mr. Ortman's treatment with
16 radiation, did you have a chance to evaluate what the
17 effects of the radiation were upon him?

18 A. I'm not sure that he had any. I didn't
19 look directly at that. I went -- the major
20 complications that patients have in the short term are
21 nausea, vomiting. If the brain is irradiated there is
22 hair loss and headache; if the chest is irradiated
23 because of lung cancer there will be shortness of
24 breath, difficulty swallowing; if the abdomen is
25 irradiated it's another type of situation; if the groin

1 is irradiated, generally you're talking about the
2 possibility of some discomfort in the lower genital
3 region and the intestinal tract. With the newer
4 treatment, I mean since 1994 and up those complications
5 have been fewer and fewer.

6 Q. What are the long-term effects of
7 radiation in a patient?

8 A. Again, depending on where it was,
9 depending on what area of the body was irradiated,
10 generally the long-term effects, potential long-term
11 effects -- and again, they'll talk about this -- when
12 he receives radiation therapy would be those symptoms
13 related to the intestinal tract that could have been
14 involved, irradiated diarrhea, radiation colitis, but
15 these are very, very unusual today with this type of
16 treatment. It's very sophisticated and the equipment
17 is three generations beyond what it was in 1980 or
18 1985.

19 Q. Are there long-term effects in terms of
20 other conditions that may develop from radiation?

21 A. That's an issue that has not been
22 confirmed in the medical literature across the board.

23 Q. Is there a majority opinion on that in the
24 literature?

25 A. Depends on the type of radiation given.

1 Majority of opinions with patients with Hodgkin's
2 disease who have what we call mantle radiation, which
3 involves radiating the whole body, virtually probably
4 they are at an increased risk of having second
5 malignancy. Patients who have had local radiation
6 treatment such as this, it would be very difficult to
7 find any data that confirms that this type of radiation
8 that he received would cause alone a second problem.

9 Q. Is there literature out there that
10 suggests that radiation in combination with
11 chemotherapy increases risk for second malignancy?

12 A. The literature is there. The literature
13 that I have shows that that is not by any means
14 confirmed across the board.

15 Q. Is there a majority opinion on that?

16 A. The majority opinion is that there's no
17 opinion.

18 Q. Is it true that complications from
19 radiation therapy are felt clinically a year or
20 many years after the therapy?

21 A. Absolutely.

22 Q. What is chemotherapy?

23 A. Chemotherapy is a broad term for the
24 administration of chemical substances to treat
25 malignant processes. There are hundreds of different

1 chemotherapy agents that are used to treat well over a
2 hundred different malignant processes, and the
3 combinations are endless.

4 Q. How does it work in terms of the body?

5 A. Well, no one really knows exactly how it
6 works. I mean, what appears to be theoretical in a
7 book or in a test tube doesn't necessarily translate
8 into what really works in the human body.

9 One of the things we talk to medical
10 students about is that there is a chemotherapeutic
11 agent nitrogen mustard, called mustard gas, found
12 during the second world war to kill normal cells. It
13 became an important chemotherapy agent.

14 Someone in the early '60s or late '50s
15 felt if they could modify that molecule and make it
16 benign, when the person took it into their system that
17 cancer cells that were rapidly growing, they would take
18 this substance out, metabolize it into its active
19 ingredient and the cancer cells which were growing
20 faster would self-destruct.

21 It makes a lot of sense. The problem
22 is that that agent called Cytosan, C-Y-T-O-X-A-N, is
23 actually metabolized by the liver within 20 seconds
24 into its active form. It is still today one of the
25 most important chemotherapy agents that we have, it's

1 been around 30 years.

2 The meaning of this story is that what
3 looks good on paper has absolutely no bearing on what
4 works in the human body. So we don't really know
5 exactly how these things work, although we have some
6 idea as to what they do in terms of cell cycle and cell
7 growth and inhibiting tumor cells, but it doesn't
8 really work that way.

9 Q. In terms of just the theory behind
10 chemotherapy, my understanding of it was that it breaks
11 the good cells and the bad cells and eliminates
12 them so the body can regenerate good cells.

13 A. That's a very naive way of looking at it.
14 We don't have any better way of doing this, but there
15 are other ways to look at it. I think that's a very --
16 that's the way that most people think about it.

17 We are also aware now in 1997 of what
18 we call killer cells and tumor suppressor agents, and
19 the body has all kinds of things going on that cause
20 cells to live or die, and it's possible that some of
21 these chemotherapy agents simply potentiate the killer
22 cells to make them kill tumor cells more readily or
23 immobilize or sometimes inactivate the cancer cells,
24 they're more susceptible to the normal body's
25 processes.

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1 Someone has to explain why when we give
2 chemotherapy tumor cells may melt away and we don't see
3 terrible destruction of the bone marrow in patients.
4 Most of my patients never step foot in a hospital. I
5 could show you black and white pictures of cancer
6 patients whose x-rays have gone from markedly abnormal
7 to perfectly normal and they never stepped foot in a
8 hospital with a complication.

9 It's not really destroying the normal
10 cells to any degree. Probably what it's doing is a
11 combination of a lot of things. It's probably allowing
12 these factors we haven't identified in a lot of cases
13 to kill the cancer cells on their own.

14 We know the cancer cells are developing
15 in the human body all the time and we all aren't dying
16 of cancer. For some reason when this system breaks
17 down cancer cells develop somehow or we actually kill
18 the cells. I don't think it's as straightforward as it
19 appears.

20 Q. why treat a cancer patient with
21 chemotherapy in a hospital as opposed to treating them
22 on an outpatient basis?

23 A. Depends on the patient, depends on the
24 insurance and depends on a number of factors. 99
25 percent of the chemotherapy that I administer is done

1 very high. Side effects would be nausea, vomiting and
2 hair loss.

3 There's the potential for pulmonary
4 toxicity with the Bleomycin, which is always possible,
5 but I've never seen it, especially with the dosages
6 that he got. Bleomycin is used in higher dosages for
7 other diseases without problem. The possibility of
8 nerve damage, what we call neurotoxicity, the
9 possibility of kidney damage with the platinum. All of
10 these are acute, I'm not talking about any long-term
11 problems, no.

12 Q. Is the goal of chemotherapy to treat the
13 patient as best you can with the least amount of
14 toxicity?

15 A. Yes. But when you're following a
16 protocol -- when you have a disease with a potentia
17 cure, you want to make sure that you follow a standard
18 protocol. There is a standard protocol for testicular
19 cancer, that standard protocol today is abbreviated
20 BEP, that's what this patient got.

21 That protocol calls for dosages
22 calculated out based on a meter squared dosing
23 calculation. Meter squared is a number calculated from
24 the patient's weight and height. So the dosages are
25 calculated out by formula.

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1 right here in this office.

2 Q. Does the stage of the cancer affect
3 whether or not you can do it at home?

4 A. No. It's the treatment, not the stage.
5 Obviously -- well, let me clarify that statement. The
6 more ill a patient is, by that I mean the more
7 debilitated the patient is, the more reasonable it
8 would be to put them in the hospital. But even
9 85-year-old patients are being treated in this office
10 right next door. I have an effusion center where they
11 come in and are treated as an outpatient.

12 Q. I've read the term toxicity related to
13 chemotherapy, what does that mean?

14 A. Toxicity is simply a term that relates to
15 the potential side effects.

16 Q. In a case such as Mr. Ortman's where you
17 have the drugs that were utilized in treating for
18 testicular embryonal carcinoma, what are the side
19 effects of chemotherapy?

20 MS. CRISAFI: Objection.

21 A. The potential side effects of those
22 drugs -- he received drugs that are abbreviated BEP.
23 The B is Bleomycin, the E is Etoposide and P is
24 Platinol, which is platinum. These are standard drugs
25 used on a routine basis. The potential for toxicity is

1 The toxicity is taken into account in
2 the studies that are done long before this becomes
3 standard therapy in which they've studied varying
4 dosages per meter squared and come up with one that
5 works with the lowest toxicity. It doesn't mean
6 there's no toxicity.

7 Q. Does chemotherapy have a cumulative effect
8 in the body?

9 A. Yes.

10 Q. So with each dose the body is taken to a
11 higher toxic level?

12 A. With each dose the potential for problems
13 is definitely going to change.

14 Q. Does it increase?

15 A. It increases. But it's important to
16 understand that it may not become a factor until you've
17 reached a certain level beyond which there becomes an
18 issue with dosage.

19 Q. Explain that to me.

20 A. What I'm explaining to you, what I would
21 tell you is that in the original studies that were done
22 for this disease -- and this is anecdotal and I can't
23 verify this is true -- one conceivable scenario here is
24 they gave patients two, four, six, eight, ten and
25 twelve cycles of therapy.

1 In the old days -- and the old days was
2 in the early '80s -- we used to give everybody a year
3 of treatment. Some of the studies might have shown
4 that patients did very well until they received eight
5 cycles and then they started to have all kinds of
6 problems with complications such as infections and
7 pneumonia, but they didn't have any problems when they
8 had two, four, six treatments.

9 When they did these studies they found
10 that the patients that got four cycles of therapy did
11 just as well as those who got six, eight and ten, but
12 they didn't have the complications, and patients who
13 got two treatments didn't do as well.

14 So what I'm saying to you is that it's
15 possible, yes, as you get more and more treatment that
16 you will have more and more problems, but it doesn't
17 necessarily follow a straight line. You may have no
18 problems until you have six treatments and then you
19 suddenly get into toxicity. This patient only got
20 four, which has been the standard of care.

21 Q. Does that vary from patient to patient?

22 A. Absolutely.

23 Q. So a patient could have three treatments
24 of chemo and hit that fourth level and be toxic?

25 A. Absolutely.

1 Q. The side effects that you referenced of
2 toxicity, you mentioned infection, what else besides
3 that once the patients reaches that level of toxicity?

4 A. Significant bone marrow suppression is the
5 thing that we worry about.

6 Q. What does that mean?

7 A. The bone marrow is literally destroyed by
8 the chemotherapy and the bone marrow needs to -- you
9 have to treat problems related to bone marrow
10 suppression. By that I mean anemia, which would
11 require red cell transfusions, leukopenia, which means
12 a significant suppression of the white cell count -- to
13 me significant means under 1,000 -- for which we have
14 growth factors that can stimulate that. This patient,
15 as far as I can tell, never received those, and to me
16 that is the major toxicity that we have to worry about.

17 Also, toxicity to the platelets where
18 the platelet counts drop and the patient will
19 hemorrhage or bleed. Platelet counts normally run
20 between 150,000 and 450,000. Generally we get
21 concerned if it's under 75,000, under 50,000. I never
22 saw that to be a problem here.

23 Q. Did Mr. Ortman have any of those side
24 effects?

25 A. He had problems with anemia. What's

1 interesting is that chemotherapy rarely causes problems
2 with the red cells without first causing problems with
3 the whites and platelets. He never had either of
4 those.

5 I'm not sure that the anemia problem
6 that he was hospitalized for and treated for was a
7 direct consequence of the chemotherapy. I'm not going
8 to deny it might have been indirect, but I can't tell
9 you that it was a direct one.

10 Q. Did Mr. Ortman have problems with his
11 white count?

12 A. I never saw a white count that was in the
13 range that required growth factors.

14 Q. Did he have problems with infection?

15 A. He had an infection of his finger for
16 which he required a hospitalization.

17 Q. Is that related to the chemotherapy?

18 A. I couldn't tell you that it was or wasn't.
19 I would be very hard pressed to say that it was. His
20 white cell count was 10,000. The immunity we're
21 dealing with here is generally one of white cell
22 mediated immunity.

23 Patients are susceptible to infection
24 because their white counts drop. This is a very common
25 problem with high doses of chemotherapy. His white

1 count according to the records that I reviewed never
2 went to a level that Dr. Connell considered giving him
3 growth factors.

4 A growth factor is what we call GM-CSF.
5 There's two companies that make this. This is a simple
6 shot in the arm that makes the bone marrow produce
7 white cells for patients who have had
8 chemotherapy-induced bone marrow suppression and it's a
9 very -- it's something which is readily available,
10 something which is used on a routine basis for patients
11 getting high doses of chemotherapy.

12 At no point in time did that patient
13 receive this. That would imply to me that bone marrow
14 suppression was never a major problem here. It could
15 have been, but it wasn't. Now, she may have -- that
16 may be somewhere in these records, but I wasn't aware
17 of it.

18 Q. Do you know if these developments occurred
19 prior to the fourth treatment or in the fourth
20 treatment?

21 A. Which developments?

22 Q. The developments of the infection and
23 the --

24 A. The infection was after the fourth
25 treatment. I'm not sure of the timing.

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1 Q. The anemia, did Mr. Ortman have a problem
2 with that after the --

3 A. Not that I know of, no.

4 Q. Just as a generality, the opportunity to
5 cure depends on the extent of the disease; is that a
6 true statement?

7 MS. CRISAFI: Objection.

8 A. It's a true statement, but I don't want it
9 to be taken out of context. If the disease is in his
10 brain then he's got no chance of cure, if the disease
11 is in his lung and in his abdomen only then he has a
12 chance of cure. Yes, the statement is that based on
13 one scenario being more extensive than the other his
14 chance of cure is diminished. Again, you have to cross
15 a line before that becomes a point.

16 Q. Is it true that the greater the extent of
17 the disease the greater the risk to the patient?

18 MS. CRISAFI: Objection.

19 A. To a point. With testicular cancer you
20 have to cross that line before it becomes a significant
21 point. That line in my opinion would be liver, bone
22 and brain metastasis.

23 Q. When there is less disease is less
24 treatment required?

25 MS. CRISAFI: Objection.

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1 A. I can answer the question, and the answer
2 to that question would be yes because if he had a
3 retroperitoneal lymph node dissection and he had
4 minimal disease in his abdomen it's conceivable that he
5 would not have required chemotherapy. But based on the
6 CAT scan findings, it's almost inevitable that he would
7 have required chemotherapy just based on the CAT scan
8 findings alone.

9 Q. The extent of the chemotherapy is what's
10 undetermined?

11 A. Yes, I would have to say yes.

12 Q. And I think you indicated that depending
13 on the stage of the disease he might have required as
14 little as two chemotherapy treatments.

15 A. He might have required no chemotherapy if
16 he walked into the doctor's office and said, I have a
17 lump in my testicle, period, and he was found to have
18 nothing other than a lump in his testicle. He would
19 have had stage one, had the testicle removed, he would
20 have gone home and that would have been the end of his
21 problem.

22 Q. At least as far as we know at the time of
23 the CAT scan it would have ranged between two
24 chemotherapy treatments and four?

25 A. Yes. That's a very difficult call, but I

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1 would have to say that most people who would look at
2 that would probably say, in 1995 we would say it would
3 be reasonable to give this guy what we call adjuvant
4 chemotherapy, and that would have been two treatments.

5 Q. Can chemotherapy affect memory?

6 A. There are people who say it does. I got
7 to tell you, I have all kinds of patients who tell me
8 they read about this. I treat a minimum of eight
9 patients a day with chemotherapy four days a week in
10 this office and I can't tell you that I've ever seen it
11 to be a problem, but I will tell you that I hear about
12 this.

13 Q. How about cold and hot sensitivity?

14 A. I think there are a number of functional
15 complaints that patients can experience, and my
16 attitude is this, there are a lot of things we know it
17 can do and a lot of things that probably aren't
18 related. I tell patients anything they have now that
19 they didn't have when they started chemotherapy I have
20 to blame it on whether it's psychosomatic or not.

21 My statement to patients is, two months
22 after the chemotherapy is discontinued any symptoms
23 that you still have are probably not related and four
24 months afterwards I can guarantee that there is no
25 longer a relationship between these symptoms and the

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1 chemo.

2 Q. So there's no long-term effects from the
3 chemo, at least in your experience?

4 A. In my experience, if chemotherapy is given
5 in very high doses to toxic levels there could
6 potentially be nerve damage that will be pertinent, but
7 not with the drugs that he got and the dosages that he
8 got. This patient got standard dosages of a standard
9 protocol of standard drugs, and four courses of therapy
10 should virtually cause no long-term toxicity.

11 Q. It's clear that the shorter the duration
12 of the treatment for the patient the better it is for
13 the patient?

14 A. There's no question about that. We're
15 always trying to shorten treatments. For all I know
16 the original therapy for this treatment was something
17 like 12 months and it was shortened to four cycles or
18 two cycles or whatever. We used to give chemotherapy
19 for breast cancer for two years, then one year, then
20 six months.

21 Q. What is hematocrit?

22 A. Hematocrit is the red cell count. That
23 refers to the red blood cell count.

24 Q. And hemolytic?

25 A. Hemolytic means destructive. Hemolysis

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1 means destruction of the red blood cells.

2 Q. What are neutrophils?

3 A. White blood cells.

4 Q. How do chemotherapy agents affect the
5 white blood cells?

6 A. The potential is there for them to be
7 suppressed in the bone marrow and, therefore, not be
8 produced in the right quantities.

9 Q. And that would lead to infection?

10 A. Could potentially lead to infection.

11 There's a huge variation between what is normal and
12 abnormal and risk and non-risk for infection.

13 Q. Did you note that in April of 1996 Mr.
14 Ortman was admitted to the hospital and received some
15 blood transfusions?

16 A. I was aware of that, yes.

17 Q. What was the purpose of that?

18 A. I'm not quite sure looking at the medical
19 records that I could understand why he had that
20 problem. He definitely had a problem and he definitely
21 needed transfusions. The data that I saw referred to
22 something like hemolytic anemia, yet the Coombs test,
23 C-O-O-M-B-S, which is the test for hemolysis, was
24 negative, and there was no confirmed diagnosis of a
25 hemolytic process. The data in that chart is

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1 unexplained to me in terms of why that blood count
2 dropped.

3 Q. Would you defer to the treating physician?

4 A. Absolutely. It never happened before and
5 it never happened again. I really can't evaluate -- I
6 would had to have been right there to see what was
7 going on at that time.

8 Q. I've read and heard a little bit about
9 bulky disease versus non-bulky disease.

10 A. It's a generalized term. Bulky generally
11 means larger than a certain number, but it varies from
12 description to description. In general, if it's
13 visible on a CAT scan we talk about it, it could be
14 defined as bulky, but in my opinion bulky means very
15 large, generally greater than five centimeters.

16 Q. Is there a significance clinically?

17 A. Yes. Bulky generally means -- again,
18 we're talking about numbers. I would define something
19 as being bulky -- that's usually a radiologist's
20 descriptive term. I consider something bulky if it's
21 over five centimeters. But again, that's an empiric
22 descriptive term a radiologist will use sometimes, it
23 doesn't mean that much to me. There is an oncologist's
24 term for bulky when we refer to these diseases, and
25 generally it means huge amounts of disease.

1 Q. Does that mean higher staging?

2 MS. CRISAFI: Objection.

3 A. Well, that's interesting because it
4 doesn't necessarily change the stage. We generally --

5 MS. CRISAFI: objection.

6 Jack, what was your question again, does
7 it change the stage?

8 MR. LANDSKRONER: Yes.

9 A. It doesn't have to change the stage, but
10 it could change the outcome.

11 Q. So if there's bulky disease is it a
12 greater risk for the patient?

13 A. If there's bulky disease I would possibly
14 use a different treatment form. I can give you an
15 example.

16 Q. Please.

17 A. It's a very important term in Hodgkin's
18 disease because you can have Hodgkin's disease
19 localized just to the chest and if it's bulky disease
20 you would use radiation treatment and chemotherapy, if
21 it's not bulky disease you would use only radiation
22 therapy. So the fact that its stage is the same,
23 because it could still be stage two, the treatment
24 choice would be changed by the definition of bulky.
25 Now, in this particular disease I'm not

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1 sure that it carries with it the same implications, and
2 there is literature on bulky disease Hodgkin's, but
3 there isn't literature on bulky disease embryonal cell
4 carcinoma because it's all treatable with the same
5 treatment.

6 Q. Bulky adenopathy, what is that?

7 A. That simply means that there are large
8 lymph nodes that the radiologist is describing in his
9 words as bulky. Again, I use the definition of five
10 centimeters or greater, and I don't see that number
11 here. I would have gone to the radiologist and said,
12 show me the scan, let me see what we're talking about
13 here.

14 Now, the answer to the question,
15 though, that you want is would it have changed my
16 treatment, no.

17 Q. In terms of prescribing the course of
18 therapy that's appropriate for Mr. Ortman's condition
19 in January of 1996 or in February when Dr. Connell saw
20 him, you've indicated that four treatments of
21 chemotherapy were appropriate at that time.

22 A. Literature is very unclear about four or
23 three.

24 Q. What did you rely on in terms of
25 literature to make a determination at least as

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1 referenced in your report that four was appropriate?

2 A. The specific piece of literature came from
3 the Lancet August 10th, 1991 showing chemotherapy
4 regimens from 1984 to 1989, because that's when they
5 had the study completed with the exact dosages that
6 this patient received per meter squared at per
7 Dr. Connell's notes, standard therapy four cycles.

8 Q. This is from 1991 and then in 1995 did you
9 see in the literature more recent --

10 A. Yes, there is other literature that states
11 that three may be appropriate.

12 Q. In 1995 can you tell me what the majority
13 opinion was as to how many doses or treatments would
14 have been required for Mr. Ortman as standard?

15 A. I think that the majority -- I can't give
16 you a majority opinion because I've got literature that
17 says three and four.

18 Q. In terms of 1995?

19 A. I think that there is literature that
20 states that these studies were not showing which one
21 was better. Obviously we talked about this before, and
22 you're absolutely correct, the lowest number is the
23 best for the patient, but you have to weigh the risk of
24 the treatment against the potential for cure, and is
25 one more treatment going to cause a problem for the

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1 patient when you consider the potential for cure versus
2 the potential for risk.

3 The actual dose of Etoposide -- which
4 is the E in the BEP -- has been calculated out to be
5 maximum 2,000 milligrams per meter squared before any
6 potential risk in terms of long term or short term
7 occurs, that would equal four treatments. So we know
8 that the risk of the fourth treatment in the majority
9 of cases is greatly outweighed by the benefit.

0 Q. In this case we know that at least after
1 the third treatment Mr. Ortman still had disease
2 present.

3 A. No. We know that Mr. Ortman had a PET
4 scan, a scan which only University does, a scan which
5 is considered to be experimental because the FDA has
6 not approved it, a scan which nobody has a lot of
7 experience with because nobody has done a lot of them
8 because nobody has had one for a long time that showed
9 a question of residual disease that was interpreted by
0 the treating physician as being residual, and based on
1 that interpretation in her judgment a fourth treatment
2 was administered.

3 Q. Would you defer again to the treating
4 physician to make that judgment call?

5 A. Absolutely. I'm not sure that I would

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1 have made the same judgment call, and I can tell you
2 why, because I wouldn't have done the PET scan, and I
3 wouldn't have done the PET scan because I didn't have
4 it available to give in 1995 sitting in my office in
5 Lake County. No one else had a PET scanner except for
6 Cindy Connell down at University Hospital or a treating
7 physician at University Hospitals, remembering that the
8 vast majority of these seminomas are not treated at
9 University Hospitals, they're treated in the community.

10 Q. Was it your understanding that when Mr.
11 Ortman began his treatment for chemotherapy he was to
12 have a series of four or three treatments?

13 A. I could not comment on that.

14 Q. Again, would you defer to Cindy Connell?

15 A. I don't have the information, so I don't
16 know.

17 Q. If she had intended on giving a course of
18 three chemotherapy treatments, would you have disagreed
19 with her decision to do that?

20 A. No, absolutely not, and I wouldn't have
21 agreed with her decision to give the fourth. She even
22 stated that by giving the fourth treatment she was
23 eliminating the one agent which is the potential for
24 toxicity, which is not uncommon.

25 Q. The fourth, say that again.

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1 A. The fourth cycle was not the same as the
2 first three, if I'm not mistaken. Is that correct?

3 Q. I think that's correct.

4 A. She eliminated an agent because of the
5 potential for long-term toxicity. That was a judgment
6 call on her part.

7 Q. Doctor, if a PET scan had showed no
8 potential complications or problems in the way you've
9 indicated to me is that it's unclear and Mr. Ortman
10 appeared to have been cured after three treatments,
11 would you have given the prophylactic fourth treatment
12 as part of a series of chemotherapy into this protocol?

13 A. If I had been treating him and I thought
14 he was cured after three and the data that I have in
15 front of me shows that three treatments of the dosages
16 that he got were equivalent to four, I would not have
17 given him the fourth treatment because the standard is
18 at least noted in the medical literature that three to
19 four is appropriate.

20 Q. Did he receive the doses that are
21 recommended within three or within four treatments?

22 A. He received these doses, and the total
23 cumulative dose below which a problem would occur is
24 what he got in the four. This refers to a total of
25 four.

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1 MS. CRISAH: I think
2 that answers his question.
3 A. I will bring up one other factor, and that
4 is that the PET scan that was done after all of his
5 chemotherapy was completed on April 9th -- I'm sorry,
6 on May 2nd, 1996. I have a PET scan dated May 2, 1996.
7 This patient has now received four cycles of
8 chemotherapy and not received any more cycles of
9 chemotherapy.
10 This PET scan has a report in it that
11 says two foci which are less than one centimeter in
12 size of the right base may be inflammatory, but
13 metastatic disease cannot be excluded. In comparison
14 with the previous study, only a single less than one
15 centimeter focus of uptake was seen. Then it goes on
16 to say that there was improvement overall.
17 Bottom line, we have a PET scan that is
18 read as the potential for metastatic disease, and we
19 know that he doesn't have it because he's alive and
20 well. I take issue with the other PET scan showing
21 metastatic disease because I don't think that PET scan
22 was definitive enough to make that diagnosis.
23 My point to you is that if this PET
24 scan done on May 2nd were the one that we were relying
25 on, he would have gotten another course. We have a

1 employment. In those who do not return to work,
2 factors other than health often play a part. The
3 majority of patients do not have persisting
4 psychological problems. There are four references.
5 Q. I'll make a copy of that, as well.
6 MS. CRISAFI: Jack, I'll
7 make a copy of whatever he has.
8 A. So, to answer your question, yes, the
9 potential is always there. It's variable from patient
10 to patient. This is a study that was done for that
11 purpose.
12 Q. Doctor, I'm not sure if you noted, but it
13 was referenced to you in the letter Ms. Crisafi wrote
14 to you on October 27, 1997, on February 6, 1997 Mr.
15 Ortman had an elevated HCG most likely secondary to FSH
16 increase.
17 A. I don't remember that. Go ahead.
18 Q. What is the significance of the increase
19 of HCG all the way into 1997?
20 A. What was the HCG, it's still elevated.
21 HCG is a tumor marker which basically translates into a
22 blood test that we use to follow patients with cancer.
23 Certainly cancers have markers that make it reasonable
24 to follow them for progression and other tumors are
25 not -- we can not follow them with a blood test.

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1 radiologist reading a PET scan shows metastatic
2 disease.
3 Q. Doctor, to the extent that you treat
4 patients with chemotherapy, do you deal at all with the
5 fear of cancer that's associated with that?
6 A. Absolutely.
7 Q. Can you explain to me what type of
8 psychological effects there are to the extent that you
9 can within your expertise for the fear of cancer?
10 MS. CRISAFI: objection.
11 Are we talking about testicular cancer?
12 BY MR. LANDSKRONER
13 Q. Actually, just cancer in general.
14 A. I think that patients who have cancer are
15 always worried that something is going to happen later
16 on; however, some patients worry more than others.
17 It's a variable from one patient to another in terms of
18 what they're going to worry about.
19 I happen to have an article entitled,
20 the paragraph is entitled The Psychsocial Consequences
21 of Treatment for Germ Cell Tumors. This article is
22 quoted as saying, despite the occurrence and
23 persistence of late toxic events, most patients are not
24 functionally impaired following chemotherapy for germ
25 cell tumors. Ninety percent of these men return to

1 HCG is one test that can be used in
2 certain cases to determine whether a patient has active
3 disease or not. It was assumed that in this particular
4 situation this was a false positive elevation, and
5 tumor markers are really only reliable if they're
6 dramatically elevated and dramatically change with
7 treatment.
8 Q. What is FSH?
9 A. Follicle stimulating hormone, which is a
10 hormone produced by the pituitary gland. It has to do
11 with endocrine pathways.
12 I think what that translates to in
13 terms of what you're concerned about is that it was not
14 related to the testicular cancer but rather related to
15 something physiological in his body.
16 Q. Is there a hospital protocol at Lake
17 Hospitals that you work at that deals with the number
18 of treatments for any specific type of cancer?
19 A. Actually, no, but there will be with the
20 new cancer center, because this is coming -- most
21 places don't have standard protocols, they follow what
22 is in the literature. With the new cancer center as we
23 develop it -- this is one of the reasons we're doing
24 this -- there will be clinical pathways that we'll
25 define for each disease what is standard of care. With

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1 this particular situation it's not an **issue** because the
2 standard of care is published.

3 Q. In your report there's a reference to some
4 literature that you referred to, bottom of the
5 paragraph on the second page. Is that the literature
6 that is included in your file?

7 A. Yes, all of that is here.

8 Q. Have you seen any recent literature that
9 exists as to the correlation between Etoposide with
10 radiation and increased risk of recurrence?

11 A. I have that literature.

12 Q. Is that also included in there?

13 A. Yes.

14 Q. Is that something that you agree with, you
15 disagree with or are unsure of?

16 A. Well, I mean, this is the title of the
17 article, **Increased Risk** --

18 MS. CRISAFI: Wait a
19 second. What's the question?

20 A. I have the article and I disagree that
21 there's a correlation between radiation and Etoposide
22 together.

23 Q. Did you find any literature out there that
24 suggests that that's inaccurate?

25 A. Are we talking about Etoposide in

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1 radiation or chemotherapy in radiation?

2 Q. Etoposide was part of the chemotherapy
3 radiation.

4 A. But there are multiple chemotherapies in
5 which the combination of radiation and chemotherapeutic
6 agent is important. I'm talking about specifically
7 Etoposide for testicular cancer, that's a separate
8 isolated specific issue.

9 Q. For the purpose of this case, at least the
10 Etoposide or any of the medication that Mr. Ortman
11 received?

12 A. I found no -- well, could you rephrase?

13 Q. The question is, there's some literature
14 that suggests there may be a correlation between the
15 two. Did you see there is a correlation?

16 A. There's a correlation between the
17 Etoposide --

18 Q. And radiation for future problems With
19 recurrence.

20 A. There is literature to support that
21 Etoposide is potentially an agent that could cause
22 problems. The combination of radiation and Etoposide
23 is not supported by the medical literature as being
24 together an increased factor. He was below the dose of
25 Etoposide required to cause any of the problems that

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1 are described in the literature according to the study
2 that I have.

3 Q. Doctor, is it your opinion that the delay
4 in the treatment of Mr. Ortman's embryonal carcinoma in
5 no way lowered his chances for recurrence?

6 A. My opinion is that the delay had no effect
7 on his chance of a cure.

8 Q. How about his chance for recurrence?

9 A. Well, chance of cure means that he's not
10 going to recur, so I'm translating that into the same
11 words.

12 Q. And it's your opinion that the treatment
13 that Mr. Ortman received was in no way affected by the
14 delay as well?

15 A. That is a statement I can't make.

16 Q. Did you note in your review that Mr.
17 Ortman had any problems with his bone marrow?

18 A. He had a bone marrow biopsy, and I just
19 reviewed that. I know that he had it. I'm not sure
20 that it changed anything. Again, he never required
21 more than red blood cell transfusions. Most of these
22 patients that have that probably routinely we will give
23 them what we call growth factors, he never received
24 that. Even that is something that is taken care of
25 readily.

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1 Q. What is photopenic?

2 A. Photopenic?

3 Q. P-H-O-T-O-P-E-N-I-C.

4 A. Let me see. Oh, in an x-ray report.

5 Q. Yes.

6 A. It means that there's a lack of density --
7 it means that there's an area that isn't as dark as it
8 should be and that could translate into an abnormal
9 area. But again, this is a PET scan. I don't read PET
10 scans and really have only seen a few reports because
11 we don't really do PET scans on a regular basis. They
12 cost thousands and thousands of dollars and are not
13 covered by insurance for the most part. They have some
14 type of an experimental situation there where they get
15 it covered.

16 Q. There's an indication in this PET scan
17 dated 4-9-96 that the osseous right hemipelvis is
18 photopenic and doesn't demonstrate the usual marrow
19 uptake seen in a patient undergoing chemotherapy. This
20 is felt to be secondary to prior radiation therapy and
21 lack of functional marrow within these osseous
22 structures.

23 A. Right. That only means that the radiation
24 therapy probably killed some of the cells in that area
25 of the bone, which is totally irrelevant. It would not

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1 be picked **up** by anything other than a PET scanner.
2 That would be 1,000th of his bone **marrow** reserves, and
3 we would **see** that with any radiation therapy.
4 There should be no evidence of any
5 residual problem because that area would have no
6 bearing **on his** health. Again, it's a PET scan **finding**,
7 and I'm not really **familiar** enough with PET **scans** to
8 tell you what -- I could tell you that the implications
9 clinically *are* meaningless.

0 MR. LANDSKRONER: Okay, thank
1 you, Doctor. That's all I have. I
2 appreciate your time.

3 I finished at a couple **minutes** to 7:00.

4

5 (DEPOSITION CONCLUDED)

6 ...

7

8

9

ARMIN J. GREEN, M.D. (Date)

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I

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1 STATE OF OHIO,)
2 COUNTY OF CUYAHOGA.) SS:
3 CERTIFICATE
4 I, LAUREN L ZIGMONT-MILLER, Registered
5 Professional Reporter and Notary Public within and for
6 the State of Ohio, duly commissioned and qualified, do
7 hereby certify that the within-named witness, ARMIN J.
8 GREEN, M.D., was by me first duly sworn to tell the
9 truth, the whole truth and nothing but the truth in the
0 cause aforesaid; that the testimony then given by him
1 was reduced to stenotypy in the presence of said
2 witness, and afterwards transcribed by me through the
3 process of computer-aided transcription, and that the
4 foregoing is a true and correct transcript of the
5 testimony so given by him as aforesaid.

5 I do **further** certify that **this** deposition was
6 taken at the time and place in the foregoing caption
7 specified.

8 I do further certify that I am not a relative,
9 employee or attorney of either party, or otherwise
3 interested in the event of this action.

1 IN WITNESS WHEREOF, I have hereunto set my hand
2 and affixed my seal of office at Cleveland, Ohio, on
3 this 11th day of December 1997.

4 _____
5 Lauren I. Zigmont-Miller, RPR and Notary
Notary Public in and for the State of Ohio.

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