DEPOSITION OF DONALD JUNGLAS, M.D.

Dorothy Ross vs. Bennie Allison, M.D.

Page 1 to Page 60

CONDENSED TRANSCRIPT AND CONCORDANCE
PREPARED BY:

Tackla & Associates
1700 Superior Building
815 Superior Avenue
Cleveland, OH 44114
Phone: (216)241-3918
FAX: (216)241-3935

Page 1

The State of Ohio,)
County of Cuyahoga.)SS:
IN THE COURT OF COMMON PLEAS
)Dorothy Ross,)
Plaintiff,)Case No.
-vs-)98CV358014
Bennie Allison, M.D.,)
et al.,)
Defendants.)

Deposition of DONALD JUNGLAS, M.D., an expert witness herein, called by the)Plaintiff as if upon cross-examination under the statute, and taken before Luanne Stone, a Notary Public within and for the State of Ohio, pursuant to the agreement of counsel, and pursuant to the further stipulations of counsel herein contained, on Friday, the 11th day of February, 2000 at 1611 South Green Road, the City of South Euclid, the County of Cuyahoga and the State of Ohio.

- - - o0o - - -

APPEARANCES:

Page 2

On behalf of the Plaintiff:
Chattman, Gaines & Stern, by:
John Scharon, Esq.
Dale Nowak, Esq.

On behalf of the Defendants:
Roetzel & Andress, by:
Joseph E. Herbert, M.D.

- - - o0o - - -

Page 3

P R O C E E D I N G S

DONALD JUNGLAS, M.D., being of lawful age, having been first duly sworn according to law, deposes and says as follows:

CROSS-EXAMINATION OF DONALD JUNGLAS, M.D.

BY MR. SCHARON:

Q Doctor, if you'd just state your complete name for the record.

A Donald W. Junglas, J-U-N-G-L-A-S. My address is 1611 South Green Road, South Euclid, Ohio, 44121.

Q Doctor, by profession, you are a)physician?

A General internal medicine physician.

Q Okay.

A Since 1964, December.

Q And you've provided us with a copy of your CV which I'll ask to be marked and attached.

A Right.

Q I'm looking through the materials that you've brought with you to the deposition, and there are various medical records and correspondence from Mr. Herbert and some

Page 4

depositions. Is this all the material that you've reviewed in the case?

A Right.

Q Okay.

(At this time Plaintiffs Exhibit 1was marked for identification purposes.)

BY MR. SCHARON:

Q I didn't see any notes.

A No, I didn't take any.

Q Did you make any?

A I didn't lake any.

Q You've been Board certified in internal medicine since 1966 with a recertification in '74 according to your CV. Are you due for another recertification?

A I'm grandfathered. My son who is an internist will have to take it again in seven years, but I'm grandfathered.

Q Okay. Were you able to complete your certification on your first and only attempt?

A Yes.

Q Okay.

A Luckily.

Q Yes.

A It's no fun to go through it a second

Page 5

time.
Q If a physician has to go through it a second time, assuming he passes the second time, does that reflect negatively on his qualifications as an internal medicine physician?
MR. HERBERT: Objection.
THE WITNESS: No. Some people don't test very well. So --
BY MR. SCHARON:
Q It doesn't mean he's not competent?
MR. HERBERT: Objection. It depends on the physician.
THE WITNESS: No.
BY MR. SCHARON:
Q I'm sorry?
A No.
Q Okay.
A Not at all.
Q Sometimes those gestures, if you make a shake of the head or a nod, it's not clear on the record.
A I know.
Q I'll just try to remind you, not to be rude, but so that it gets accurately on the

Page 6

record.
A I know you have to have the information verbally.
Q Thank you. Your hospital privileges are at University Hospitals?
A Yes.
Q And Veterans?
A I don't use Veterans. I just use University.
Q Okay.
A I must say very much rarely nowadays. Most people get taken care of, for almost everything, right here.
Q In the office?
A Yeah.
Q If you have patients that you need to refer for minor surgical procedures, they're also referred right within this center?
A Yes, and they have a minor surgical procedure place here. I had my hernia fixed here. I was in and out of here in *two* hours.
Q Okay. Obviously, in a case like this, we may be concerned about talking about a lymph node biopsy. Is that something that

Page 7

would be done right within this office?
A I'm not sure of that. There may be now. I don't know exactly what they do there in total.
Q Okay. I assume you have patients from time to time that you need to refer for lymph node biopsy. Is that true?
A Once in a great while.
Q Okay. Do you do that by referring to an ENT first?
A Usually, uh-huh.
Q Please don't be offended at some of these questions. They are routine questions that we ask of all physicians in this circumstance.
Has any action ever been taken against your medical licensure?
A No.
Q How about your hospital privileges?
A No.
Q That's the end of the apology, okay.
A I understand.
Q Thank you. Do you have an appointment as a teacher of medicine?
A Yes.

Page 8

Q At Case Western Reserve?
A I'm a clinical professor now. I've gotten that old.
Q You've gone through the ranks of assistant clinical professor?
A You start out as a demonstrator, then assistant, associate. Not everybody makes it up the ladder, but they felt sorry for me.
Q Okay. You started to talk a little bit about the general nature of your practice. It's practically exclusively an office practice at this point?
A Yes, headaches to hemorrhoids I tell people.
Q Headaches to hemorrhoids, so from top to bottom?
A Right.
Q And have you had patients in your career with Hodgkin's disease?
A Very rarely.
Q Good.
A Maybe *two* cases in 35 years.
Q Is that right? Now, were these patients that were diagnosed with Hodgkin's

Page 9

while you were their doctor, or did they come to you afterwards?
A I believe they were diagnosed while I was their doctor.
Q Were you involved in their workup to come to the diagnosis?
A What happens today is, if you find somebody with an abnormality, you refer them on for a biopsy, whatever, and if they're found to have some problem, they always end up with an oncologist, and you rarely see them again unless there's a problem while the oncologist is taking care of them in the general internal medicine field. If the patient is cured, and they are then followed by the oncologist, then they come back to you.
Q Do you happen to recall in those couple of Hodgkin's patients that you had how the diagnosis was arrived at?
A You know, I don't know. I'd have to look up their charts.
Q Can you remember at least in general terms the time frame when those cases were diagnosed?

Page 10

A No, I do not.
Q Has it been more than five years, more than ten?
A Oh, you mean how long ago they were?
Q Yes, I'm sorry.
A One was maybe five, and one was probably 15.
Q In your 35 years of practice, Doctor, have you ever been a party to a medical negligence case?
A Once.
MR. HERBERT: Just note my objection.
MR. SCHARON: That's fine.
THE WITNESS: I was defended by Bob Maynard, and we won.
BY MR. SCHARON:
Q What kind of case was it?
A It was an orthopedic case with an infected patella.
Q Off the record.
(At this time a discussion was held off the record.)
BY MR. SCHARON:
Q How much experience have you had,

Page 11

Doctor, as an expert witness in medical negligence cases?
A Oh, I do maybe three cases, three or four cases a year.
Q Okay.
A Most of the time, it's just reports. Once in a while, it's depositions. In this particular week, I happened to have one other deposition this week which is highly unusual. I testified once last year in court. I maybe have testified two times in court, once as a plaintiffs expert and once as a defense expert.
Q Okay. In the case in which you testified as a plaintiffs expert, did that come to you as an independent consultant?
A Yes.
Q Or was this a patient of yours?
A No. Well, it was a patient of mine, yes.
Q Oh, it was a patient?
A Yes.
Q So, you testified on behalf of your patient?
A Right.

Page 12

Q For how long have you averaged, you know, three or four cases a year?
A Maybe ten years.
Q Have you --
A I don't make it a large part of my activities. I consider it a service rather than an employment.
Q Sure. What was it that led you to get involved in it?
A You know, I don't really know.
Q Okay.
A I think somebody asked me once, and I said: well, I might be interested in looking at it, and then your name gets around a little bit.
Q Sure. So, what percentage of your time would you think you spend?
A A half of one percent.
Q Have you ever worked for Mr. Herbert here before?
A Only, I think in the one case where I was a plaintiffs expert, if you will, or, you know, gave testimony on my patient, but otherwise not.
Q So --

Page 13

A He reminded me of that today. I had forgotten.
Q Was he on the other side, or was he representing the plaintiff?
A I think his firm was on the other side.
Q Okay, representing the physician?
A (At this time the witness nodded his head.)
Q Yes?
A Right.
Q Have any of the cases that you've been involved in as a medical/legal consultant involved Hodgkin's disease?
A No.
Q Do you recall about how long you've been aware of and involved in this case, when you would have first been contacted essentially?
A Probablv some time prior to November of '99. So, I would suspect, maybe, October.
Q Okay. Shortly before you wrote your report?
A Yeah.
Q Except for that one situation in which you testified on behalf of your patient,

Page 14

have any of your other medical/legal consulting work or cases been on behalf of plaintiffs?
A On occasion, maybe one in ten.
Q Okay. In addition to looking at the materials in front of you, did you do any medical or on-line research?
A No.
Q Can you tell me which, if any, of the physicians involved in this case you're personally familiar with?
A None.
Q None, not Dr. Lazarus at UH?
A Oh, I'm sorry. I didn't realize you were talking about those people. Yes, I know Dr. Lazarus. He's the only one.
Q Allright.
A I thought you meant of the people that are the defendants.
Q I should have been clearer. It was an ambiguous question. You don't know Drs. Tyler or Allison?
A No.
Q Or how about the other experts in the case, either Dr. John Petrus --

Page 15

A No.
Q -- an oncologist from Akron, or Barry Singer --
A No.
Q -- from Pennsylvania?
A No.
Q Okay. The report of November 18, 1999 --
A Yes.
Q -- is that the only writing that you've produced?
A Well, there was a previous report which I unfortunately don't have. It's on the computer upstairs which I don't know how to access. My secretary that runs that isn't here today, but I think the only difference between that and this was the fact that I hadn't -- I hadn't reviewed the plaintiff expert report of Barry Singer, and the report of John Petrus. I believe that's the only difference. I think that the opinions are the same. I think it just didn't have that information on it.
Q Okay. If it wouldn't be too much of an inconvenience, at the time your secretary is

Page 16

back and able to access that --
A She'll be back Monday.
Q --would you ask her to print it and provide it to Mr. Herbert?
MR. HERBERT: I'm assuming she can do that. If I have a copy of it, I'll see what I can do.
BY MR. SCHARON:
Q Okay. Just to be clear, the reference on the bottom of your November 18th, 1999, report to "corrected version, 11/23/99," does that mean that you think that the version of November 18 did not have items five and six on this list?
A That's what I think, but I'm not sure.
Q Have you discussed the case with any of your colleagues or other physicians?
A No.
Q Your first and primary opinion in the case is that Drs. Allison and Tyler met acceptable standards of care.
A Yes.
Q You're basing that obviously on your review of the records and, of course, on your knowledge and experience.

Page 17

A Yes.
Q Can you tell me factually what the basis is for your opinion?
A They took care of this patient for intercurrent illnesses of which she had a number that involved her upper respiratory tract, and during the period when she had complaints in that area, she had lymph nodes that were discovered on several occasions, and this is not inconsistent with the symptoms that she was complaining of at the time, and I felt that the treatment plan that was outlined was at the standard of care.
Q With respect to the upper respiratory infections, are you talking primarily about sinus infections?
A Sinus, she had some throat pain here and there, and that kind of issue.
Q Okay, and they were also treating her for anemia?
A Well, they were trying to investigate her anemia, yes.
Q Well --
A She was discovered to be mildly anemic,

Page 18

I believe, in June of '96, and had a little bit of a workup at that time which didn't really tell them what the cause of the anemia was. She then was discovered to have a more severe anemia, I believe it was in January of '97, and at that time a more thorough workup was begun.
Q Following the initial discovery of the mild anemia in May of 1996 --
A Right.
Q -- she was given an iron supplement.
A Yes.
Q So, she was treated for that condition.
A That's correct.
Q And she was thought to have iron deficiency anemia?
A Yes. There was some question about whether this was the only cause, but it's the most common cause in somebody of her age group, but there are other things, obviously, that can cause it.
Q In your evaluation of the case, did you in your evaluation of the case focus on whether the doctor's investigation of the anemia --

Page 19

A Yes.
Q -- met acceptable standards of care?
A Initially, when they first discovered the anemia, the treatment with iron was appropriate. When they discovered the anemia to be more severe in January, obviously, they had considered more serious diagnoses, and they began a series of investigations through gastroenterologists initially which culminated, I believe, at the end of April, and then she terminated the relationship with these doctors in May, so that no further workup was done, although they had contemplated doing something further in regards to bone marrow investigation if the GI investigation didn't work.
Q We'll talk in some more detail about those things as we move along. At this time, I'd like to focus on the question of these lymph nodes, at least for a few moments.
In your experience, patients, female patients in their forties who have upper respiratory infections, do they

Page 20

usually or typically have lymphadenopathy?
A They may. Each person reacts in a different way, so they may have lymphadenopathy, yes.
Q If you surveyed, for instance, ten patients in that class of females in their forties --
A Right,
Q --with upper respiratory infections, how many would you typically see with lymph node involvement?
A I would say maybe *two* out of ten.
Q Okay, and would it be typical or would it be unusual for the patients who had lymphadenopathy to have it in the cervical chains as opposed to submandibularly?
A Well, that's a variable thing. I don't know that I've ever really tried to correlate that. Most of the time, the lymph nodes you feel in adults are in the cervical chain for the most part.
Q In the presence of upper respiratory infections, are the lymph nodes in adults typically in the neck or are they typically submandibular?

Page 21

A No, they're typically in the neck.
Q Intheneck?
A Yes, usually on either side of the mandible.
Q If I wanted to look in the medical literature to see some description of patients in this age range with upper respiratory infections and the presence of cervical lymph nodes --
A Yes.
Q -- is there any literature that you would suggest that I go to? Where would I find it, I guess is my question?
A You might find a short reference to the fact that, when people get upper respiratory illnesses, they may manifest cervical lymphadenopathy. I don't think you'd find that there would be a big write-up about it.
Q In a patient in her forties who's got an upper respiratory infection and positive lymph nodes who's treated with antibiotics, how long would you expect that the lymph nodes would remain enlarged?
A Well, many times lymph node enlargement isn't due to just bacterial infection; it's

Page 22

due to viral infection, and sometimes they remain for a long period of time and then gradually resolve. Sometimes they remain, to a smaller degree, indefinitely. I mean, they have this enlargement, and then the enlargement may decrease, the so-called waning of it, but it never completely disappears. So, they may have a few what they call shotty nodes left, little marble size.
Q When you say shotty, that's S-H --
A O-T-T-Y.
Q Not "shoddy."
A Right.
Q Okay. Would you expect those lymph nodes in the presence of treatment to last for weeks or months?
A They usually last for weeks at least, yes.
Q Would you expect them to last for as much as three months?
A It might be a little unusual.
Q Okay.
A In the absence of yet another infection, obviously.

Page 23

Q All right.
A Some people are more reactive with their lymph nodes than others.
Q And you mentioned that the infection could be either viral or bacterial?
A Yes.
Q Is it important to you in your practice to try to differentiate?
A Well, in general, the only bacteria you usually identify is a strep germ. So, you do a throat culture in some individuals who look as though they have strep. Many times, you just don't bother because it doesn't really look like that, or the patient's symptoms don't warrant a throat culture.
Q If you have a patient in which you've done a culture, and it turns out that you've got a bacterial agent, then the appropriate treatment is antibiotics?
A Yes.
Q If you have a patient where you don't think that it's bacterial --
A Right.
Q -- so you don't even do the culture, do you still treat with antibiotics?

Page 24

A Well, it depends upon the patient. If the patient has a co-existing ear infection or sinus infection, you may not be able to culture anything significant, but you may treat them on that basis alone, and, so, especially with sinus infections, it's not uncommon to treat, even though many of them are viral, with antibiotics because it's a closed space.
Q What do you need to do to make the diagnosis of a sinus infection?
A Well, most of them are made clinically by the symptoms and signs: a lot of purulent drainage from the nose, headache, a lot of congestion in the nose. Many times people have blocking of the ears in addition. If you really want to be academic, you get a CAT scan of their sinus to see if they have fluid levels, but even that doesn't tell you if it's bacterial.
Q Sure.
A It just tells you they've got --
Q Something in there?
A -- something in there, and it may be pus, or it may be just mucus.

Page 25

Q Are plain film X-rays of any assistance?
A We used to use them. Nowadays they've sort of fallen by the wayside.
Q And would you culture the purulent. drainage?
A You do on occasion.
Q Okay.
A Most of the time, you use a broad spectrum antibiotic.
Q Something like Ampicillin?
A Amoxicillin, cephalosporins.
Q From your review of the records, did you notice whether Drs. Allison or Tyler ever either cultured --
A I don't believe they cultured anything.
Q OrX-rayed?
A No.
Q Let me ask you this question by prefacing this. In retrospect now, do you think that the lymphadenopathy was related to or was a reactive process from the upper respiratory infections?
MR. HERBERT: Just note my objection.

Page 26

THE WITNESS: That's what I'd think, as we're looking at the patient at the time she's visiting. On each occasion after the diagnosis is established, later on, one can go back and say it's possible that this could have represented Hodgkin's disease.
BY MR. SCHARON:
Q Allright.
A Doctors think in the future, and lawyers think in the past. So, when I, you know, look at a case, I'm always thinking: what would I think on the basis of what this complaint is and the findings? Would I think this, or would I not think this? And, unfortunately for this lady, she got struck by lightning. She got a bad disease and had other symptoms that could have been interpreted as something very relatively minor when she was having something relatively major.
Q I won't agree to being consigned to thinking about the past, okay, with all of the other lawyers, but --
A Well, you know what I mean. You know

Page 27

the answer, but --
Q I understand.
A I didn't know the answer as I'm looking at it.
Q Okay. Is it possible in your mind that the upper respiratory symptoms that she was having were because of obstruction from Hodgkin's disease that involved the lymph nodes?
A It wouldn't be obstruction. That's the wrong term. It could be that the lymph nodes were involved with Hodgkin's disease. That is possible.
Q And, then, could that have caused the --
A Oh, could that have been the cause of her symptoms?
Q Yes.
A I don't know how, no.
Q Did you think, as you reviewed her chart, that there ever should have been any additional investigation of the upper respiratory infections to nail down the mechanism of the infection?
A Nothing struck me as being too unusual.

Page 28

Most people in this climate develop something like 3.78 upper respiratory infections per year. They once did a study at Reserve about that, and I don't think she -- I don't think she, you know, was over that number. She had a number of them, but she used to go to the clinic for them all. Many people don't bother to do that.
Q I want to go back to the anemia issue for a moment.
A All right.
Q I think you may have said in June of '96, but I think probably you meant in May of '96 --
A Okay.
Q -- her blood work showed some mild anemia; is that right?
A Yes. I think they did a serum iron at that time which was really -- it was not terribly consistent with iron deficiency but could have been iron deficiency and something else.
Q Are you referring to the fact that the serum iron level was low, but that the total iron --

Page 29

A The total was low also.
Q --the total iron binding capacity was also low?
A Right.
Q In iron deficiency anemia, you would have expected that to be high as opposed to low?
A That's correct.
Q It's kind of a mixed pattern of anemia?
A Yes. Those are very difficult for a doctor, because especially if you're a)family practitioner, general internist, and you're not aware of all the differentials that can go with this, many times you choose to select the thing that you think is the most likely, and in somebody of this age with this history, that's a pretty likely ;scenario, you know, absent their having some kind of hemoglobinopathy, sickle cell disease or thalassemia or something like that.
Q So, is it appropriate to give the patient iron presumptively?
A Yes.
Q Do you --

Page 30

A That's almost always done.
Q You do that even before you've had blood drawn for the iron studies?
A Many times you do.
Q Yes?
A Yes.
Q Good.
A In the older age group, you would be more careful. I mean, in people that you might suspect might have more serious disease in the older age group, you probably don't do that, but in people of this age group, almost assuredly you'd try that.
Q Why wouldn't you do it in the older age group?
A Because there's much more malignancy in the older age group, colon cancer and that type of thing.
Q The TIBC level being low --
A Right.
Q --that's more indicative, is it, of anemia due to chronic illness?
A Yes, some kind of chronic disease, and there was a history in there someplace that she'd had arthritis which later was called

Page 31

rheumatoid arthritis. There was never any workup done for that, and I have no idea whether she had that or not, but if they were thinking that that's what she had, it might have been that they were blaming that on the rheumatoid. I have no idea. I can't think for them, so I don't know.
Q Would the presence of any type of arthritis be sufficient to explain an anemia of chronic illness?
A No, usually it has to be rheumatoid or lupus or some more serious form.
Q So, not just --
A Osteoarthritis, no.
Q No, okay. In that connection, this lady came to these physicians in March of 1995 as a new patient.
A Yes.
Q Because she had to leave her old physician.
A Yes.
Q Okay. If such a patient came to you after leaving another physician, would you make any attempt to get her prior records to see what kind of a past history she's had?

Page 32

A In general, I personally do, but many times you don't get them.
Q You mean --
A For whatever reason.
Q You ask, but you may not get them?
A Yes. I usually ask the patient to try to get them, have the record forwarded, but sometimes it just doesn't happen.
Q Okay, but you think it ought to be asked for at least?
MR. HERBERT: Note my objection.
THE WITNESS: In an ideal world, you do that.
BY MR. SCHARON:
Q Do you think that it's standard of care?
A Not necessarily. Some people just prefer to start their own record and take the history.
Q Okay. Did you notice from your review of records of her prior physician -- let me ask you this: did you see any records of her prior physician?
A No, not that I know of.
Q Allright.

Page 33

A Maybe I did, but I don't recall seeing them. Who --
MR. HERBERT: Say the name of the prior physician, and that might jog his memory.
BY MR. SCHARON:
Q Dr. Askari was the prior physician.
A I didn't see any records from him.
Q His records would have been in a bundle under the title of, maybe, Bureau of Disability Determination records.
A No, I never saw anything like that.
Q You didn't see those?
A I saw his name listed in the record, but I didn't know where he came in.
Q Okay. He was a prior doctor. What diagnostic tests would you ordinarily order to determine whether a patient had rheumatoid arthritis?
MR. HERBERT: Objection.
Assuming it's indicated.
THE WITNESS: Personally, I would do a CBC, a sedimentation rate, a rheumatoid factor or an arthritis profile, as they put it on our lab sheets.

Page 34

BY MR. SCHARON:
Q All right.
A That gives you some idea. Some people that have rheumatoid arthritis test negative for everything, and they may have a high sed rate, and that's all you'll find.
Q In that connection, I looked at some blood work that was done in March of 1993 and again in June of 1994, and I'll ask you to assume for purposes of the question that her sedimentation rate in 1993 was 35.
A That's --
Q That lab normal was zero to 15, and her RA screen was negative. Her ANA was negative, less than one to 40. Would that --
A Those don't jump out at me. They don't jump out at me as being wildly abnormal.
Q Okay. In June of '94, the sedimentation rate was 27, lower.
A Again.
Q And the RA screen and the ANA were not positive either.
A Okay.
Q So, would you think, based on those

Page 35

results, that she was a rheumatoid arthritis patient?
A No, I would not.
Q If you have placed a patient with mild anemia on iron presumptively, how long should you wait before you get some follow-up blood work to see what the result has been?
A I would say three to four months.
Q Okay. What effect would you like to see on the blood chemistry then?
A I'd like to see the hematocrit rise.
Q The hematocrit?
A The hemoglobin, hematocrit; the red blood cell indices should rise.
Q And if they don't, what's the next step?
A Then, your therapy is obviously not doing any good, and, then, you have to go further, I would think, and try to figure out why it is that she's anemic.
Q That would be an indication that the presumption that this is iron deficiency is not correct.
A That's correct.
Q All right. Did you pay attention in

Page 36

your review, Doctor, to Dorothy Ross's alkaline phosphatase levels?
A No, but I know it was slightly elevated.
Q I'll represent to you, and you can assume for purposes of the question, that in March of '95 the level was 102. That's a slight elevation.
A Right.
Q In May of '96, 143, and in January of '97, 202, all right?
A Yes.
Q What's the significance, or is there any significance to those measurements?
A Many times there are patients who come in and have a single elevated alkaline phosphatase level, and I have stopped investigating alkaline phosphatase levels because, most of the time, it proves of no value. So, as a single elevated value, I mark it down, but I haven't so far been tripped up. It's not very common that you find a reason.
Q Okay.
A I know there was a reason here, but it's not very common in somebody that you do

Page 37

find a reason.
Q What do you mean?
A Well, some patients may have a small degree of Paget's disease somewhere, and that raises their alkaline phosphatase, and you have to do a total body bone survey and run up the costs, and when you end up, you don't have anything therapeutic you can do about it anyway.
Q What --
A In conjunction with other findings, it may be important, but by itself, I don't put much stock in it.
Q Okay. In considering her blood work in general, her red blood cell count, her hemoglobin, hematocrit, MCV and looking also in conjunction with that --
A Yes.
Q -- analysis at the alkaline phosphatase level, do you have any opinion about whether those values are significant?
A Well, there was a relationship in retrospect, but at the time, looking at the patient, I would probably not have put it together in my own mind. I would probably

Page 3%

have done exactly what they did.
Q In retrospect, what's it indicative of?
A When we know what was going on with this lady, it makes sense that she had these problems; that is, anemia and rising alkaline phosphatase, is what I'm saying.
Q And why does that make sense in this patient?
A Well, because she probably had Hodgkin's disease during this period of time as a cause for both the anemia and the high alkaline phosphatase, or rising alkaline phosphatase. "Probably" I say; we don't know that for sure.
Q Are there any other conditions which could cause a similar pattern?
A I'm sure there are. I can't tell you what they are. They probably would be malignant type conditions, in general. I mean, they would probably be serious conditions.
Q Well, of course, the red blood values and the alkaline phosphatase were reported to the doctors at various times, to Allison and Tyler.

Page 39

A Yes.
Q In view of that entire pattern, you know, the hemoglobin, and the red blood cell count, and the alkaline phosphatase changes, should they have done something to investigate further?
A Well, if they feel the way I have just told you that I do, they may have chosen to ignore the alkaline phosphatase and focus on the anemia, which is what I think they did.
Q And that's acceptable?
A Pardonme?
Q That would be acceptable?
A It's acceptable to me.
Q And consistent with --
A Because, as I say, I have had difficulty finding the cause of the high alkaline phosphatase in most people.
Q And it would be consistent with the standard of care to ignore the changes in the alkaline phosphatase in this scenario?
A In my opinion, yes.
Q And these changes in blood values and in alkaline phosphatase chemistry, that is all consistent with a serious disease such

Page 40

as Hodgkin's disease?
A It could be.
Q It could be. Do you have an opinion as to when Dorothy Ross had Hodgkin's disease that involved her bone marrow?
A I have no opinion.
Q Okay. You stated in your report of November 18th, 1999 that you thought that she had Stage IV Hodgkin's disease as early as January 14th of 1997.
A Yes.
Q All right.
A That isn't very early in terms of what we're talking about in the whole record. By the time she developed the more severe anemia, I believe she did have it at that time.
Q And that's in January of '97?
A Yes. I thought you were referring back to when she first developed a high alkaline phosphatase.
Q What I'm trying to do is explore with you --
A I'm sorry.
Q -- the point in time at which you would

Page 41

(1) --
(2) A I would say that as of the discovery of
(3) the severe anemia in January of '97.
(4) Q Okay. In January of '97, she did have
(5) this additional blood work.
(6) A Yes.
(7) Q I wanted to refer to the date of that.
(8) A I think it was January 14th.
(9) Q January 14th of '97?
(10) A Yes, I believe so.
(11) Q Okay, and the results showed an
(12) increase in her anemia.
(13) A Yes.
(14) Q A significant increase.
(15) A Yes.
(16) Q The progression of the anemia, was it
(17) enough that it should have caused these
(18) doctors concern?
(19) A Yes. I believe it did, actually.
(20) Q Okay, and what did the standard of care
(21) require those physicians to do in acting on
(22) that concern?
(23) A I think they should have embarked upon
(24) a thorough workup of her GI tract which she
(25) had had a portion of, seemingly a portion

Page 42

(1) of. I'm not sure how far the endoscopist
(2) looked when she had this fish bone in
(3) November, but if that had not covered the
(4) upper GI tract, then she should have had a
(5) colonoscopy and upper endoscopy.
(6) Q Anything else?
(7) A If that proved negative, she should
(8) have had further workup for investigation of
(9) some other cause.
(10) Q I assume it was acceptable to do the
(11) stool cards to look for some evidence of --
(12) A Yes.
(13) Q -- GI tract blood?
(14) A Unfortunately, in many people that have
(15) GI bleeding, they only have it
(16) intermittently.
(17) Q Yes.
(18) A And you don't pick it up.
(19) Q If you've gotten back a blood result
(20) such as came back on her on January 14th of
(21) 1997 --
(22) A Yes.
(23) Q --what's an acceptable length of time
(24) that might go by before the colonoscopy is
(25) done?

Page 43

(1) A Well, I don't know how things are done
(2) there. You know, in general, I refer the
(3) patient, and within the next month or so
(4) they have it done.
(5) Q In this case, following the January
(6) 17th of 1997 blood results, it wasn't until
(7) March 4th of 1997 that she was referred to
(8) Dr. Yang for the upper GI series, all right?
(9) A Yes.
(10) Q Is that too long?
(11) A It's not too long, but it's longer than
(12) it would have taken me.
(13) Q Allright.
(14) A At least she was referred for it.
(15) Q You indicated in your report that a
(16) note was made in the chart that, if Dr.
(17) Yang's workup was not revealing of the
(18) source of the anemia, a bone marrow
(19) examination would be in order.
(20) A Yes.
(21) Q And that's an appropriate step-wise
(22) procedure.
(23) A Yes.
(24) Q All right. Dr. Yang's --
(25) A His final report, I think, was issued

Page 44

(1) --
(2) Q On April 28th?
(3) A Some time in April.
(4) Q Yes, April 28th of '97.
(5) A Right.
(6) Q And the biopsies were reported the same
(7) day.
(8) A Right.
(9) Q All right, and when Mrs. Ross next saw
(10) Dr. Tyler on May 19th --
(11) A Yes.
(12) Q -- did Dr. Tyler do anything --
(13) A No.
(14) Q --to obtain the bone marrow
(15) examination?
(16) A No.
(17) Q And--
(18) A It seems to me that that visit was for
(19) something totally unrelated, but --
(20) MR. HERBERT: Go ahead and take a
(21) look at it.
(22) THE WITNESS: Pardon me?
(23) MR. HERBERT: Go ahead and take a
(24) look at it.
(25) BY MR. SCHARON:

Page 45

Q This is not a memory test. You can look at the records.
A Yes. She was there for pain in the right arm and shoulder, felt like it was broken. I can't tell what she was taking. That's when he mentions about the diagnosis of rheumatoid arthritis. No mention is made of -- well, he mentions rheumatoid arthritis, iron deficiency anemia, and he gives her medication for her stomach, and, then, an anti-inflammatory and he orders an X-ray of the shoulder.
Q Just to be clear, you referred to "he," but that was actually Dr. Tyler, a she, on the 19th of May.
A Yes.
Q Okay. My question for you, Doctor, is this: given Dr. Yang's report and the biopsy report of April 28th of 1997, didn't the standard of care require Dr. Tyler on May 19th to refer her for this bone marrow examination?
A It would have been appropriate for him to do so. He did not.
Q Again, her, Dr. Tyler.

Page 46

A I'm sorry. I don't know --
Q Dr. Tyler is a her.
A Yes. I don't know whether she saw it or didn't see it at that time.
Q I want to go back to the subject of lymphadenopathy.
A Yes.
Q And appreciating that you've had a couple of Hodgkin's patients in your career, did those patients have lymphadenopathy?
A Usually. Sometimes you find it by doing a chest X-ray and finding enlarged mediastinum lymph nodes.
Q Are swollen lymph nodes in the neck which are due to Hodgkin's disease always tender or nontender?
A They're classically described as matted. They grow together, and they don't form a single node, but rather a conglomeration of many nodes that are sort of stuck together. They're pretty dramatic if you see somebody who's got Hodgkin's lymphadenopathy.
Q What about the question of tenderness?
A Smaller -- you know, I'm not -- I

Page 47

haven't seen enough of it to really know. So, I can't really answer that question.
Q Okay.
A I can tell you that many times the lymph nodes that you feel in patients who you have sent for biopsies, sometimes a single needle biopsy, which is what the ear, nose and throat people usually do, comes back showing nothing or showing reactive lymph node hyperplasia, and it sometimes takes quite a while to make a diagnosis of Hodgkin's because there's a particular cell that a pathologist must see before he can diagnose it. So, sometimes you miss them.
Q Sure. I appreciate that. I appreciate your statement to me about the relative lack of frequency with which you've seen such patients.
A Correct.
Q Let me ask you this, then. Hypothetically, if a patient came to you with lymph nodes, would you dismiss the possibility that they could be a sign of malignancy just because they were tender?
MR. HERBERT: Just object to the

Page 48

form of the question. You can answer. I think it's argumentative, but you can answer.
THE WITNESS: Probably not. Some people are tender when they don't have lymph nodes.
BY MR. SCHARON:
Q And the tenderness can be related to other structures in the same area?
A Yes, exactly.
Q The neck muscles?
A Some people are just a little -- they're just sensitive.
Q Have you reached any conclusions about when Dorothy Ross first would have had Hodgkin's disease, how long she had it for?
MR. HERBERT: Objection. Asked and answered. I think it was.
THE WITNESS: Well, I think she probably had it --
BY MR. SCHARON:
Q We talked about Stage IV. Now I guess I'm trying to go beyond that.
A First of all, I'm not a staging expert. So, I won't even get into that, okay?

Page 49

Q Okay.
A I think she had Hodgkin's as early as August of '96, and she probably had Hodgkin's in May of '96.
Q Okay. That's without regard to any opinion about staging.
A That's correct. I wouldn't even get into that.
Q Okay. So, --
A I don't know enough about it.
Q I just want to be clear --
A Right.
Q --that that's not something about which you will express an opinion.
A Absolutely not.
Q Why is it, Doctor, that the severe anemia that she exhibited in January of '97 indicates to you Stage IV?
A Because I feel that by that time, her bone marrow is not producing cells very well.
Q And that's the reason for the anemia?
A Yes. If you know that she has Hodgkin's, you're pretty sure that she has it in the bone marrow.
Q At that point?

Page 50

A Yes.
Q Allright.
A I never say "always," and I never say "never."
Q Could her anemia, as exhibited in May of '96, the prior year, be due to a combination of iron deficiency and anemia of chronic disease?
MR. HERBERT: Objection.
THE WITNESS: Yes.
BY MR. SCHARON:
Q And I appreciate your statement about not wanting to get into the issues of staging, and I don't mean to do that with you. So, let me ask you: do you know at what stage Hodgkin's is most often diagnosed, or is this something that you would consider to be beyond your expertise?
A It's beyond my ability to tell you.
Q Okay.
MR. HERBERT: Off the record for a second.
(At this time a short recess was had.)
BY MR. SCHARON:

Page 51

Q We just had a brief colloquy here about whether you have any opinions or not concerning Dorothy Ross's prognosis.
A No.
Q Okay, you don't. Likewise, would you have any opinions about her survival chances given various treatment regimens for her Hodgkin's disease?
A No.
Q Obviously, I don't want to belabor areas about which you haven't reached any conclusions and don't expect to talk about.
A Right.
Q Is it within the scope of your knowledge to tell us whether Hodgkin's disease is curable?
A I believe it is.
Q Okay.
A But I believe people that have had it always have follow-up, at least in my experience, from their oncologists for evermore. So, there is always that nagging doubt, I think.
Q And is it within the scope of your training and knowledge to tell us whether

Page 52

the success rates for treating Hodgkin's disease are better if the disease is diagnosed at Stage I or II versus Stage IV?
MR. HERBERT: Objection.
THE WITNESS: I don't know.
BY MR. SCHARON:
Q Okay, Doctor. This is my only chance to ask you about your opinions, and to explore with you what the basis for them is, okay? Have you reached any other conclusions, or do you plan to express any other opinions other than those that we've talked about here?
A No.
MR. HERBERT: Just note my objection. It's the same thing that I said the last time, but --
MR. SCHARON: I know it's difficult.
MR. HERBERT: Right.
MR. SCHARON: I find that that question is objected to by both sides all the time.
MR. HERBERT: Right. You do the best you can.

Page 53

BY MR. SCHARON:
Q My colleague points out that you testified earlier today that Drs. Allison and Tyler, in your opinion, appropriately treated Ms. Ross's anemia initially.
A Yes.
Q Do you have an opinion about whether their continuing treatment of her anemia remained in accordance with acceptable standards?
A They just continued what they began, and then, when they found it was more severe, they began a workup for the cause of this. So, in a sense, they were already suspecting something else but had to rule out a GI lesion first.
Q Not to argue with you, did the doctors not also treat her as though they still believed it was iron deficiency anemia by increasing her dosages of iron?
MR. HERBERT: Objection.
THE WITNESS: They did, but this was in conjunction with beginning the workup and considering other avenues of approach.
BY MR. SCHARON:

Page 54

Q I'm reading here from the record. I asked you: do you have an opinion about whether their continuing treatment of her anemia remained in accordance with acceptable standards, and you said they just continued what they began, and then when they found it was more severe, they began a workup for the cause of this. So, in a sense they were already suspecting something else but had to rule out a GI lesion first.
A Yes.
Q Are you saying that their treatment continued to be in accordance with acceptable standards of care?
A Well, what you do is, you continue what you're already doing while you're pursuing other avenues.
Q So, that is acceptable?
A Yes.
Q All right.
MR. SCHARON: If we can just have a minute.
(At this time a short recess was had.)
BY MR. SCHARON:

Page 55

Q Did your review of her records give you a list of her, I'll call them, preexisting conditions, preexisting to the time that she first became a patient of Drs. Allison and Tyler in March of '95?
A There's some reference to arthritis, I think, in one of her -- I think it's June 5th of '96. There's a medical history. It says "arthritis," which I assume they thought was rheumatoid arthritis. It doesn't say that.
Q Okay.
A And that is the only thing that I see there.
Q Okay. In view of the blood work that had been done in May of '96, should the doctors have done any investigation of this rheumatoid arthritis or the hypothesis that she had rheumatoid arthritis?
A In general, if the patients are not terribly symptomatic of it, you may not do any further workup. If their complaints are that they have a lot of hot, swollen, tender joints, yes. If their complaints are not of that nature, which in her case they weren't,

Page 56

they might have just chosen not to further investigate that.
Q And just assume that, yes, that's rheumatoid arthritis, but it's not active?
A That's correct. Some people with rheumatoid arthritis have so-called burnout; that is, they have an anemia. They have had their arthritis. It just doesn't manifest itself subsequently, or it may crop up later. It's a very difficult disease many times.
Q Have you reached any conclusion, Doctor, about whether Mrs. Ross's presentation was unusual for a Hodgkin's patient?
A No.
Q When you were talking about the fact that referral of patients for lymph node biopsy can result in needle aspiration which may not be diagnostic of a problem, I just want to understand. Are you saying that that's the type of lymph node biopsy that would be done in a patient referred for workup, a patient such as Mrs. Ross?
A Well, ordinarily, what you do is, you

Page 57

send the patient to somebody, and you say to them: see if you can find out the cause for this, and if they do a needle biopsy, and it's negative, you then rely upon their judgment and expertise as to whether they think, you know, an open biopsy would be indicated.

Q Okay, but you're not rendering any opinion about what type of biopsy would be appropriate?

A Oh, no.

Q Do you have an opinion as to whether a patient with Stage IV Hodgkin's disease would have lymphadenopathy due to the disease?

MR. HERBERT: Objection.

THE WITNESS: Oh, I'm sure they would.

BY MR. SCHARON:

Q Okay. All right.

A Many times the lymph nodes are intra-abdominal, and you don't even know they have them, or, as they say, they're on the mediastinum, and you take a plain film for some other reason and find big lymph

Page 58

nodes. So, then the diagnosis is Hodgkin's, sarcoidosis.

Q How would those nodes on the mediastinum show up on a plain film X-ray?

A Just a big, white blob on a black background,

Q Does the scope of your knowledge permit you to tell us whether, or does it permit you to form a conclusion about whether Hodgkin's disease can begin in the bone marrow?

A No.

MR. SCHARON: I don't have any other questions for you. Thanks

MR. HERBERT: We'll reserve the right to read it.

MR. SCHARON: I appreciate your time.

- - - o0o - - -

Page 59

CERTIFICATE

The State of Ohio,)
County of Cuyahoga.)

I, Luanne Stone, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the above-named witness, DONALD JUNGLAS, M.D., was by me first duly sworn to testify to the truth, the whole truth and nothing but the truth in the case aforesaid; that the testimony then given by the above-referenced witness was by me reduced to stenotypy in the presence of said witness; afterwards transcribed; and that the foregoing is a true and correct transcription of the testimony so given by the above-referenced witness.

I do further certify that this deposition was taken at the time and place in the foregoing caption specified and was completed without adjournment.

I do further certify that I am not a relative, counsel or attorney for either party, or otherwise interested in the event of this action.

Page 60

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office at Cleveland, Ohio this ---------- day of ----------
A.D., 2000.

_____
Luanne Stone, f.k.a., Protz-
Notary Public
Within and for the State of Ohio
My commission expires 4/6/03.

Concordance Report

Unique Words: **1,063**
Total Occurrences: **2,824**
Noise Words: **384**
Total Words In File: **8,485**
Single File Concordance
Case Sensitive
Noise Word List(s): **NOISE.NOI**
Cover Pages = **0**
Includes **ALL** Text Occurrences
Dates **ON**
Includes Pure Numbers
Possesive Forms **ON**

- - S - -

- - T - -