IN THE COURT OF COMMON PLEAS

CUYAHOGA COUNTY, OHIO

THOMAS S. ORTMAN, et al., Plaintiffs, -vs- ROBERT ALBERHASKY, M.D., et al., Defendants.	CASE NO. 317279 JUDGE CHRISTOPHER BOYKO

Doc. 214

TELEPHONIC DEPOSITION OF MITCHELL C. KAYE, M.D.

Scottsdale, Arizona
December 6, 1997
10:05 o'clock a.m.

WHITE & ASSOCIATES
CERTIFIED COURT REPORTERS
932 South **Stapley**
Mesa, Arizona **85204**
464-1035

PREPARED FOR: MR. **JACK** LANDSKRONER

BY: Christopher J. White

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SHEET 1

Page

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WITNESS

Kaye, Mitchell C.

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TELEPHONIC DEPOSITION OF MITCHELL C. KAYE, M.D.

Taken at 10:05 o'clock a.m., December 6, 1997, in the Execuiive Conference Room, of the Scottsdale Plaza Hotel, 7200 N. Scottsdale Road, Scotisdaie, Arizona, before Christopher J. White, a Notary Public in and for the County of Maricopa, State of Arizona, pursuant to the rules of Civil Procedure,

The Plaintiffs were represented by their attorneys: The Landskroner Law Firm, Ltd., by Mr. Jack Landskroner.

The Defendants were represented telephonically by their attorneys: Jacobson, Maynard, Tuschman & Kalur, by Ms. Marilyn Miller Crisafi.

BE IT REMEMBERED that the witness does not waive the right to read and sign the deposition, and that notice of filing and other formalities required by law for the taking and returning of the said deposition are waived.

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Scottsdale, Arizona
December 6, 1997
10:05 o'clock a.m.

MITCHELL C. KAYE, M.D.

called as a witness herein, having been first duly sworn, was examined and testified as follows:

EXAMINATION

BY MS. CRISAFI:

Q Dr. Kaye, my name is Marilyn Miller Crisafi. le just met briefly a few moments ago when I called in. I'm the counsel for defendants Arthur Basa, M.D., who is the urologist; and a pathologist, Robert Alberhasky.

I'm going to ask you a few questions today and ask that you answer them verbally, because I can't see, obviously, nods of the head or shakes of the head or hand signals.

Let me ask you if you have had your deposition taken before?

A Yes.

Q Okay. Just briefly, although you have gone through the process, I want to let you know that

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if I ask you a question and you don't understand my question, I'm going to ask you to stop me and either ask me to rephrase it or tell me that you don't understand. Okay?

A That's fine.

Q Okay, If you give me an answer to my question, I'm going to assume that you understood my question, and the answer that you give me will be taken down as your testimony.

Does that seem fair?

A That is fair.

Q Okay. Will you give me your full name?

A Mitchell Craig Kaye.

Q Okay. Your professional address?

A 7331 East Osborn Avenue, Scottsdaie, Arizona.

Q How long have you been at that address?

A Since Julv 15th.

Q And previous to that, were you at 8007 Brant Court in Fairfax Station, Virginia?

A That was my home address, yes.

Q You were with Andrews Air Force Base?

A With the U.S. Air Force, yes.

Q Why did you leave the U.S. Air Force and go to Scottsdale, Arizona?

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A My time commitment with the Air Force was up, and it was always my intention to go into practice.

Q Okay. Why Arizona?

A Mainly because you have snow in Cleveland, and I'm wearing a shirt without a jacket right now.

Q All right. I notice you did your medical training at the Cleveland Clinic Foundation; is that correct?

A I did my residency at the Cleveland Clinic, correct.

Q When you finished the clinic in 1993, when you were chief resident of the department of urology, what did you do between 1993 and your next position?

A I went straight from residency into the Air Force to pay back my time commitment.

Q Okay, So is it fair to say when you were at Georgetown University, it was through the Air Force?

A When I was at Georgetown University, it was being paid for by a health profession's scholarship.

Q Sponsored by the United States Air Force?

A Correct. However, I was not on active duty.

Q Okay. So between 1993 and 1997, you were with Andrews Air Force -- at Andrews Air Force Base

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paying back your time; is that accurate?

A That is accurate.

Q Did you work anywhere between leaving the Air Force base and going to Arizona?

A No.

Q Was there ever any gaps in your medical schooling or your internship or residency?

A No.

Q Are you still currently licensed in Virginia?

A Yes.

Q Are you still currently licensed in Ohio?

A Yes.

Q And are you licensed in Arizona?

A Yes.

Q Any other states in which you're licensed?

A No.

Q Did you take your urology boards more than once?

A No.

Q Are you board.certified in any other specialty?

A No.

Q You have described under your major presentations one involving the squamous cell carcinoma

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of the bladder in a patient on intermittent self-catheterization,

Any discussion in that article about seminoma or embryonal cell cancer?

A No.

Q There's an article you coauthored. It looks like Dr. Cosgrove and Dr. Novick.

Is that Dr. Cosgrove at the clinic?

A Yes.

Q "Retroperitoneal Tumors," Any discussions in that article about seminoma or embryonal cancer?

A No.

Q Under references, number three indicates current therapy in genitourinary surgery. I don't know if that's a chapter in a book. It was coauthored with a Dr. Klein and a Dr. Malacoplakia.

A It is on malacoplakia. It is a book chapter on malacoplakia.

There is no mention of seminoma.

Q I'm sorry. Would you please repeat your answer?

A No mention of seminoma in that book chapter.

Q Thank you. Doctor, what hospitals do you currently have privileges at?

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A Scottsdale Memorial Hospital, Osborn; Scottsdale Memorial Hospital, North; the Indian Hospital; Phoenix Indian Medical Center; and I have -- I'm thinking of the word -- temporary or courtesy privileges at -- what is the name of the downtown one, the big one? St. Joseph's Hospital.

Q Scottsdale?

A That's in Phoenix.

Q Phoenix?

A Yes.

Q When you were in Fairfax Station, can you explain to me whether you only worked on the Air Force base or whether you had hospital privileges there, too?

A The Fairfax Station is my home address.

Q I'm sorry, Doctor. When you were in the Air Force, tell me what hospitals you worked at.

A I worked at Malcom Grove Medical Center, which is the name of the hospital on Andrews Air Force Base. I also performed certain procedures at Walter Reed Medical Center and Bethesda Medical Center if we did not have the capabilities at Andrews.

Q Give me an example of the majority of the types of urologic surgery that you did while in the Air Force and in Scottsdale.

A At present I perform a full range of

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urologic procedures, including urologic oncology, female urology, infertility, basic pediatrics urology.

Q What about surgical procedures?

A I'm referring to both office-based and surgical practice in all those areas.

Q How many orchiectomies have you done in your practice?

A I don't recall, Several.

Q More than 10?

A Yes,

Q More than 100?

A I cannot answer that.

Orchiectomies are done for several reasons.

Q Before we get into those, let's talk specifically about orchiectomies after the finding of a hard mass in the testicles.

After you perform an orchiectomy with that finding and send a specimen of the mass to a pathologist, what percentage of the time in your practice does that copy? back seminoma, and what percentage of the time does that copy? back a mixed cell or embryonal cancer?

A I do not recall specifically. However, I have treated both patients with pure seminoma and mixed

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germ cell tumors, the exact percentage of which I cannot recall right now.

Q Which is more common in your practice?

A I have seen them fairly equally, I cannot say whether one is more common than the other and be precisely sure,

Q Okay. In a population of 30- to 40-year-old males, which finding is more common in your practice; seminoma or embryonal cells?

A Again, the most -- probably the most common is a mixed germ cell tumor. However, seminoma is also a very common finding as the...

Q As what?

A As a most common finding as well. It is close. Very neck and neck.

Q Okay. Doctor, what percentage of your clinical time do you spend doing surgery?

A I devote my practice to -- is 100 percent clinically oriented. How much time I spend on the -- in the operating room varies from day-to-day, but I potentially operate every day.

Q Do you spend 25 percent of your time in the operating room per week?

A At least.

Q Thirty percent?

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A It can be up to 50 percent, approximately.

Q Okay. Doctor, how did you first get involved in this case?

A I received a phone call from Mr, Landskroner who asked me if I would be interested in reviewing some records for him.

Q Did he tell you anything about the case at the time?

A He basically just told me that it was a case involving a patient with testicular cancer. He wanted me to look at whether or not the patient was treated properly and followed properly.

Q Did he tell you what type of testicular cancer the patient had?

A Initially, in our initial conversation, I do not recall.

Q What materials were you sent?

A I was sent a couple of binders, which contained material that included depositions from some of the physicians involved, hospital records from Mr. Ortman's treatment, as well some x-ray reports and lab data.

Q I need to know specifically what you reviewed before writing your June 19th, 1997 report.

A I reviewed the binders that I just

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mentioned with the information that was provided to me.
Q Doctor, I need more specifics. I need to know what records you looked at,
A Mr. Landskroner sent me records that included the depositions of the physicians involved, Dr. Basa, for example.
Q **Okay.**
A It included his notations from his office. It included the reports of other consultants involved in the case, including the physicians at the Cleveland Clinic, at the University Hospital, and associated results of lab tests and x-rays that they had ordered in reaching their conclusions.
Q **Did you review the deposition of Dr. Alberhasky?**
A I believe that I did, yes,
Q **Did you review the deposition of Dr. Peter Lay before writing your report?**
A I do not recall specifically,
Q Did you review records from the surgery center?
A I believe I did, yes.
Q Did you review Dr. Basa's office chart?
A Yes.
Q Did you review the records from West Side

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Imaging and Oncology Center?
A I believe so.
Q **Doctor, do you have in front of you the materials that you reviewed prior to writing the report?**
A There are two binders that Mr. Landskroner has here that appear to be similar to what I had at that time, yes.
Q And to your knowledge, are those complete records from different physicians, or do you know if those are parts of those records?
A I have no way of knowing whether or not these are complete or not. This is just what was provided to me.
MS. CRISAFI: Jack, I need to take a look at those and see exactly what he looked at and whether those are complete and whether those have been itemized out in some way.
I need you to either mark those or bring them back with you.
MR. LANDSKRONER: Marilyn, you have the exhibits that were provided to you, with the exception of the University Hospital records, that were supplemented, including the materials that were -- they composed the materials that were sent to Dr. Kaye with

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the addition of Dr. Alberhasky's deposition, Dr. Basa's deposition, the slides which Dr. Case has had a chance to look at. I think some x-rays as well,
And that composes the same materials that you had that were in the exhibit that was provided to you with the exception of the UH records that were supplemented, and the complete Dr. Lay record, which was also supplemented, because we didn't have the complete record originally.
MS. CRISAFI: So based on your representation, the package I got last night from your office, with the exception of the supplementations you have made, is the copy that was sent to the doctor and upon which he based his report.
I'll accept that. Is that what you're saying?
MR. LANDSKRONER: That's correct.
MS. CRISAFI: Okay.
MR. LANDSKRONER: I think, also, I'm not sure if I provided you any request for production of documents, or a copy of the records that I had, but they would have been the same as well.
MS. CRISAFI: The records that you have from all the treaters?
MR. LANDSKRONER: Well, with the exception of

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the supplements that were made.
Q BY MS. CRISAFI: All right. Doctor, what did you review in preparation for your deposition today?
A I reviewed the records very briefly, and that was it.
Q Did you review the slides?
A I -- the last time I looked at the slides was at least several months ago.
Q What actual x-rays did you look at?
A I do not recall, but I believe it was the CT scan.
MR. LANDSKRONER: Marilyn, incidentally, I have those in my office, if you need to see them.
MS. CRISAFI: Those would be useful to Dr. Semanovich (phonetic) and Dr. Green's deposition, yes, thank you.
Doctor, would that be the January 24th, 1996 CT scan or the June 23rd, 1995 CT scan?
THE WITNESS: I do not recall.
MR. LANDSKRONER: I think, for the record, Marilyn, I think I provided both, but they would be in the packet I have in my office.
Q BY MS. CRISAFI: Okay. Except for the records you just mentioned, anything else that you

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reviewed before your deposition today?
A Just this morning I reviewed my letter that I submitted,
MR. LANDSKRONER: Also, Marilyn, for the record, Dr. Semanovich's report,
Q BY MS. CRISAFI: Okay. Did you review Dr. Green's report?
A Not that I'm aware of.
Q Have you seen the report of Donald Sweet, M.D. (phonetic)?
A I do not believe so.
Q Did you ever have an opportunity to talk with Mr. Landskroner this morning?
A Briefly.
Q How long was that?
A Approximately 15 ninutes.
Q Did you have an opportunity to meet with Mr. Landskroner yesterday?
A Briefly, yes.
Q How long is briefly?
A About an hour.
Q Okay. Prior to yesterday's meeting, did you have an opportunity to discuss the case with Mr. Landskroner by telephone?
A Yes.

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Q When was that?
A It was about the time that he had requested I review the records and submit in writing a brief report,
Q Okay, Fair to say this is sometime after you got the records and before you wrote the report?
A That is correct.
Q About how long did you spend on the phone with Mr. Landskroner at that time?
A I do not know for sure.
Q Did Mr. Landskroner outline what he wanted the findings to show for you?
MR. LANDSKRONER: Objection. Go ahead,
THE WITNESS: No. He asked me to review the case and form my own opinions based on what was within the records.
Q BY MS. CRISAFI: Doctor, in your practice, I assume you have had an opportunity to make a diagnosis of seminoma?
A That is correct,
Q Is that also true of embryonal cell cancer?
A That is correct,
Q Doctor, after you have made a diagnosis of seminoma, do you treat the patient, or do you refer

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that patient to a radiation oncologist?
A That is dependent upon what the staging of the disease is.
Q Why don't you explain that for me.
A If the patient has -- is staged after the initial orchiectomy, and is felt to be a candidate for prophylactic radiation, then that patient would be referred to the appropriate physician.
If that patient has a more advanced disease, such that radiation would not be an appropriate therapy, they would then be referred to the appropriate physician,
Q Okay. But either way, Doctor, once you make the diagnosis, you refer the patient either to a radiation oncologist or another physician?
A Yes. However, I still maintain my role in their care.
Q Okay. But not as far as treating the cancer with either radiation or chemotherapy; is that accurate?
A I do not deliver radiation, and I do not provide all forms of chemotherapy,
Q Okay. What forms of chemtherapy do you provide?
A Related to testicular cancer, I do not

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provide any chemotherapy in my practice.
Q Okay, When you said that depending on the stage, if it's more advanced, I would do this; if less advanced, I would do that. How do you -- with testicular cancer, how do you stage it?
A You look at the initial pathology from the radical orchiectomy specimen, then the patient is staged, typically with evaluation of the abdomen, pelvis, and chest initially, and other tests if indicated.
And, also, you need blood testing, which are very important for following the patient, both pre-orchiectomy and throughout the treatment course.
Q Is that true with seminoma and embryonal cells?
A It's true with all types of testicular cancer.
Q You would look at the pathology. You would evaluate the abdomen, pelvis, and chest, and possibly, and -- not possibly -- and do blood testing; is that correct?
A That is correct. And based on the findings, other tests may be indicated.
Q All right. When you say, "Evaluate the abdomen, pelvis and chest," do you mean by x-ray or CT

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scan or palpation?
A Typically with CT scanning, but a physical exam is always part of the initial evaluation. But CT scanning is the most readily accessible means for doing that.
Q Doctor, do you use radical -- you do lymph node dissection as a means of staging?
A When indicated.
Q When you -- I assume you have had an opportunity to diagnose patients with embryonal cell cancer?
A Yes.
Q When you diagnose a patient with embryonal cell cancer, do you treat that patient or refer him out?
A I treat that patient.
Q Okay. And how?
A Again, how they are treated depends upon the stage of their disease.
Q Would that follow your previous answer that it may be radiation oncology, and it may be chemotherapy?
A That is incorrect. Cnder no circumstances is there a role for radiation in the treatment of embryonal carcinoma.

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Q To whom would you refer out the patient that you diagnosed with embryonal cell cancer?
A Again, it depends upon the stage. It nay not require a referral. at all. It's something that I can, oftentimes, depending on the stage, I'm able to handle myself.
Q With what therapies?
A In cases of a Stage I embryonal, a retroperitoneal lymph node dissection can be performed. This is done by a urologist such as myself.
Q Okay. And that's a treatment therapy you would do?
A That is correct.
Q And in other cases?
A If there were the need, based on the staging, for chemotherapy, I would then refer the patient to an oncologist for the provision of chemotherapy.
Q Okay, In this case there was no retroperitoneal lymph node dissection, was there?
A No, there was not.
Q Okay. Doctor, what percentage of the patients whom you have referred to chemtherapy physicians, when you have diagnosed those patients with embryonal cell cancer, have four courses of

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chemotherapy treatments?
A I can't answer that specifically because this needs to be qualified based on the stage.
Q How many patients in Stage II-A that have been referred out for chemotherapy are treated with four cycles of cheuntherapy?
MR. LANDSKRONER: Objection.
THE WITNESS: If there is a diagnosis of Stage II-A, this person, in my hands, would first be treated with a retroperitoneal lymph node dissection. if this were confirmed to be pathologically a II-A embryonal testicular carcinoma, then zero percent of these patients would receive four cycles of chemotherapy.
Q BY MS. CRISAFI: Instead they would get a lymph node dissection; is that correct?
A As I said, they would get a lymph node dissection, And you asked me what percentage of II-A patients would get four cycles.
And I said, in my hands, these patients would receive a retroperitoneal lymph node dissection, and zero percent would receive four cycles of chemotherapy,
Q Thank you. Doctor, I assume that you have looked at the initial notes from a Dr. Cindy Connell (phonetic) and University Hospital records after Mr.

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Ortman was referred there for care; is that true?
A Yes.
Q Dr. Connell doesn't do a staging based on retroperitoneal lymph node dissection, does she?
A A retroperitoneal lymph node dissection was not performed on Mr. Ortman.
Q So we don't know, based on that, what stage he was when he presented, do we?
A We have a clinical stage.
Q And that is what?
A I need to review the CT scan, but it is a bulky Stage II to the best of my recollection.
Q If you would tell me, in you previous testhny, a person with a bulky Stage II tumor with embryonal cell cancer receives, in your experience, how many courses of cheuntherapy?
MR. LANDSKRONER: Objection. Do you mean after a six month delay in diagnosis, or are you talking about Mr. Ortman's case?
MS. CRISAFI: i'm talking about in his practice. When he has a patient who is presented with a bulky Stage II tumor, that with no radical -- where no retroperitoneal dissection had been performed, what percentage of those patients are disease free after four cycles of therapy?

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MR. LANDSKRONER: With no other factors in consideration. Go ahead and answer.

THE WITNESS: In somebody who has bulky Staqe II disease, these people are followed with each cycle. Some mav receive three cycles; some may receive four.

Aqain, it is difficult to answer that based on the qeneral description of bulkv. Each case needs to be treated individuallv and followed very closelv to minimize the toxicitv of the chemotherapy and still ensure appropriate remission.

Q BY MS. CRISAFI: Well, Doctor, let me ask vou this before we qo anv further into this area.

Are vou qualified to comment on chemotherapv treatments and appropriate numbers of chemotherapv treatments?

A From a urologist's standpoint,

Q Doctor, do you consult with chemotherapy doctors in deciding to go forward with additional chemotherapy?

A Certainly I play a role in the care of all my patients and rely on the expertise of the oncologists, as well, in determining what is the best treatment for each patient.

Q But ultimately it's the decision of the oncologist on how many chemotherapy treatments are

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necessary; is that true?

A Essentially that is true.

Q Okay. Will you be testifying at the time of trial as to how many rounds of chemtherapy Mr. Ortman would have needed?

A From a urologist's standpoint, based on what is -- what questions I am asked. I would certainly have input from my perspective, yes,

Q And would you tell me your qualifications for commenting on the necessary chmtherapy once a patient has been referred to an oncologist?

A As a urologist, I routinely play a role in the management of urologic -- in terms of urologic malignancies, So from my training as a urologist, I am aware of what is reasonable, acceptable treatment for urologic malignancies.

Q Doctor, in your experience with a patient who presents with a 2.5 centimeter soft tissue mass and a diagnosis of embryonal cell cancer, in your experience, when you have referred that patient to an oncologist for chemtherapy, what percentage of those patients are disease free after two cycles of BEP chmtherapy, if that's the chemotherapy prescribed?

A Can you please clarify for me? When you're saying a 2.5 centimeter mass, where is the mass?

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You need to be specific to ask me that question.

Q Okay. In the paracaval region.

A Okay. So we have a patient with one 2.5 centimeter paracaval lymph node, and that is the only evidence of disease. Is that the correct scenario you're providing to me?

Q The status, post-orchiectomy with a finding of embryonal cell cancer. This patient also has several additional smaller soft tissue densities in the paracaval region. And, yes, that's all the evidence that you have.

A I consider this patient to have non-bulky Stage II disease. I would proceed with a retroperitoneal lymph node dissection, and if this were confirmed to be metastatic disease, consider adjuvant chemotherapy,

Q Doctor, you did not have the benefit of a lymph node dissection.

Let me ask you first of all, have you gone on to refer patients to oncologists without that information, knowing only the information that I have just put before you?

A Have -- can you please repeat that question?

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Q Have you referred a patient to an oncologist for chemtherapy when that patient has findings of a two to three centimeter mass in the paracaval region, status, post-orchiectomy for embryonal cell cancer?

A I have not referred them on initially, because I tend to -- it has been my practice to operate on these patients first, because I'm oftentimes able to do a nerve sparing retroperitoneal lymph node dissection.

Q Doctor, is it fair to say then, you have not had a situation where you have referred a patient to an oncologist for treatment where there has not also been -- let me qualify that.

Status post-orchiectomy with findings of embryonal cancer. You have not had an opportunity to refer those patients to an oncologist without having first done a lymph node dissection; is that true?

MR. LANDSKRONER: Let me just object and say, again, qualifying that those are the only conditions, not taking into consideration any previous cancer treatment.

MS. CRISAFI: If you want to make an objection, make an objection, and I'll note your objection. But I'm going to object to the ongoing

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speaking objections.
MR. LANDSKRONER: Do you want to qualify the question so it's clear?
If you can answer that, Dr. Kaye, go ahead.
TEE WITNESS: Based on what you have asked me, I have referred patients to oncoloqists first, but these are patients that have evidence of bulky metastatic disease.
Q BY MS. CRISAFI: You have done so without first performing a lvmph node dissection?
A In patients with bulkv metastatic disease, and lymph node dissection is not indicated prior to chemotherapy.
Q Okay, In those patients, what percentage of those patients are disease free after two cycles of chermtherapy?
A Most of those patients require at least three cycles of chemotherapy, Some may require four. Some may --
Q Doctor, let me be specific in my question.
What percentage of the patients in that scenario have you referred to oncologists who are disease free after two cycles of chermtherapy?
Can you answer that question?

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MR. LANDSKRONER: Objection. Go ahead and answer, Doctor, if you can.
THE WITNESS: Based on the way you have asked me, I cannot give you a percentage.
Q BY MS. CRISAFI: Why is that?
A At this moment I do not recall.
Q Have you had any patients with that presentation who have become disease free after two cycles of **BEP** chermtherapy?
MR. LANDSKRONER: Objection. Go ahead.
THE WITNESS: Can you please clarify right now, so I know, are you talking about patients with non-bulky retroperitoneal disease or bulky retroperitoneal disease?
MS. CRISAFI: Non-bulky.
THE WITNESS: Okay. I think the last question was answered based on, I was talking about bulky disease.
MS. CRISAFI: Okay.
THE WITNESS: In non-bulky disease, oftentimes if the patient is properly monitored you can see complete melting of the retroperitoneal in embryonal.
Q BY MS. CRISAFI: Melting meaning what?
A Melting meaning shrinking of the retroperitoneal masses with chemotherapy.

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Q How many treatments?
A In general, most patients with non-bulky disease are not given chemotherapy first, in my hands, They undergo retroperitoneal lymph node dissection first.
You're comparing an apple to an orange.
Q Okay. You have the non-bulky disease, and I think I hear you saying you do the retroperitoneal lymph node dissection as a treatment first; is that correct?
A That is correct. And you cannot confuse that with the treatment of bulky disease and try to confuse the issue.
Q When you have patients with non-bulky disease whom you have treated with a lymph node dissection, have those patients then gone on to need chermtherapy?
A In people that have pathologically confirmed disease in the retroperitoneum that is non-bulky, I have sent them on to receive adjuvant chemotherapy. Generally, this has never consisted of more than two cycles.
Q Okay, thank you, Doctor.
Are you critical of Dr. Connell for not performing a lymph node dissection when Mr. Ortman

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presented to her on January of 1996?
A No, because at the time she saw the patient, he had got -- had follow-up for an extended period of time and presented with bulky disease.
Q Okay. **Pour** previous testhny, I understood, was that your understanding was that Mr. Ortman was a non-bulky Stage II disease at the time he had the **2.5** centimeter mass.
Did I confuse that?
MR. LANDSKRONER: Objection. Go ahead,
THE WITNESS: What I said earlier, I -- at the time -- I need to review the CT scan at the time he re-presented to see the extent of the disease he re-presented with in January.
I do not recall the exact measurements of his recurrent disease.
Q BY MS. CRISAFI: All right, Doctor, if he presented with a 2.5 centimeter soft tissue mass, you would agree that's a non-bulky Stage II disease, wouldn't you?
A That is correct.
Q Okay. I want to step back for a minute and ask you to give me a definition of your understanding of standard of care.
A My understanding of standard of care is

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what most -- if you're talking about physicians, what most physicians would do in the same situation based on their -- based on the level of training.

Q Based on their level of training?

A No, based on the -- for example, a standard of care for urologists would be to do what most other board certified urologists would do in that specific situation.

Q Okay, Given the same set of circumstances, you would agree that two or three urologists may be presented with those circumstances and may each arrive at a slightly different course of treatment, and each would be within the standard of care; wouldn't that be true?

A In generalities there are often different ways of approaching the same problem. That is correct, but that's a general statement,

Q Okay. Also, that general statement that a circumstance may be treated in more than one way is consistent with the idea in medicine that there is more than one school of thought about how to approach a problem; is that true?

A That is correct,

Q For example, one urologist may choose to follow-up a patient slightly differently from another

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urologist; is that true?

A That is correct.

Q Would you agree that a doctor has to consider a constellation of things such as prior history, symptoms, and response to current treatment, when he considers follow-up for a patient?

A I mean, that's a very general statement. Can you be more specific?

Q Would you agree that a doctor has to consider a variety of factors when he is planning follow-up care for his patient, including his past history, his current diagnosis, and his current response to treatment?

A That is correct.

Q And each patient's management, based on those things, might be a little different?

A That is potentially correct,

Q Doctor, are you going to have any criticism of Dr. Basa and his surgical care and treatment of Mr. Ortman on May 5th, 1995?

A Was that the date of the orchiectomy?

Q Let me look at the date. Hang on, It was May 10th.

Are you going to have any criticism about his choice of orchiectomy as a procedure on May 10th,

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1995?

A No, ma'am,

Q Would you agree that based on the pathologists informing him the patient had seminoma, that it was proper to refer that patient to a radiation oncologist?

A If the diagnosis were confirmed to be seminoma, then prophylactic radiation and referral to a radiation oncologist is appropriate.

Q What do you mean, "If the diagnosis were confirmed"?

A If, after reviewing the slides -- I often review them myself, as well -- then the patient would be referred to a radiation oncologist.

Q Doctor, as a urologist you have a right to rely on the findings of a pathologist, don't you?

A That is correct.

Q The standard of care doesn't require the urologist to go behind the pathologist and re-review the slides, does it?

A That is correct. However, board certification of urologists includes a basic proficiency in pathology,

Q Okay, So you have the capability to read the slides, but the standard of care does not demand

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that you read them after you are given the diagnosis from a pathologist?

A That is correct.

Q Are you going to have any criticisms of Dr. Basa prior to the August 21st, 1995 visit, which, for your reference, was his last office visit with Dr. Basa?

A No.

Q Okay. What is the most common type of testicular tumor?

A What age group?

Q The 30 to 40 year old male.

A Generally seminoma.

Q Would you agree the treatment of choice for seminoma is radiation?

A It is dependent upon the stage,

Q We have discussed that; is that correct?

A That is correct.

Q Would you agree that 80 to 90 percent of Stage I and II seminomas are cured by radiation?

A Yes.

Q Would you agree that it's rare that there's an incidence of recurrence of that type of cancer after going through radiation treatment?

A For low stage, yes, I would agree.

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Q And for low stage, does that include Stage I and Stage II?
A That includes Stage I and non-bulky Stage II.
Q Doctor, you would agree that there is a low incidence of metastasis even with seminoma; isn't that correct?
A That is correct.
Q Except for the June 19th, 1997 report, did you write any other reports in this case?
A No,
Q Did you keep any notes to yourself as you reviewed the material to author this report?
A No.
Q Do you have a copy of your report in front of you?
A I have Mr. Landskroner's report here, his copy of what I wrote.
Q Okay. By that do you mean that June 19th, 1997, two-page report?
A I have a one-page letter that I wrote.
Q Okay. The second page is just your signature; is that correct? Maybe that's the way it came to me by fax,
Jack, I have a two-page report.

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MR. LANDSKRONER: We have a one-page report, Marilyn. I don't know if it came by fax that way. I have a one-page report.
Q BY MS. CRISAFI: Is the last line of substance in your report, "Please contact me in I may be of further assistance?"
A Yes.
MS. CRISAFI: Do you have an extra copy of that report that the court reporter could mark for the purposes of my next few questions?
MR. LANDSKRONER: I don't know. I can run and make one.
MS. CRISAFI: Can you do that at the end of the deposition?
MR. LANDSKRONER: Sure.
Q BY MS. CRISAFI: Doctor, do you plan on offering any opinions at trial outside of this report?
MR. LANDSKRONER: Objection. Go ahead.
THE WITNESS: I basically plan on answering the questions that I have been asked.
Q BY MS. CRISAFI: Well, Doctor, let me have you take a review of your report, and tell me now if there's opinions that you have today beyond those that you have expressed in that report.
A Pertaining to this particular situation, I

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do not believe so.
MS. CRISAFI: And, Jack, if you find before trial that Dr. Kaye will be offering additional opinions, will you let me know so I can question him on those?
MR. LANDSKRONER: I will, And just to the extent of questions that may come into play concerning the amount of chemotherapy that Dr. Kaye can answer within his expertise, I will be asking about those. You have inquired about that somewhat already. And I think that's it,
MS. CRISAFI: All right. And I am -- there is nothing in this report about his opinions about chemotherapy -- well, strike that. We'll get to that.
I'd like to start at the top.
While we're talking about other expertise, except for urology, do you hold yourself out as -- well, first of all, do you hold yourself out as an expert in the field of urology?
A Yes.
Q Do you hold yourself out as an expert in any other field?
A Not within medicine.
Q Out of curiosity, what other fields do you hold yourself out as an expert in?

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A No comment. That's off the record. I'm just kidding.
Q I don't even want to go there, Doctor. Okay. Good for you.
You don't have any experience or training in -- well, strike that.
Are you going to be offering any opinions against Dr. Alberhasky at the time of trial?
A I don't plan on it though I'm able to, I don't plan on it unless I'm asked.
MR. LANDSKRONER: Marilyn, outside of what is in the report, no.
MS. CRISAFI: Okay. Off the record.
(Whereupon a short discussion was held off the record.)
Q BY MS. CRISAFI: Would you tell me about your experience and training in hematology/oncology?
A I have completed a urologic residency. I have not done a hematology/oncology residency. However, from a urologic perspective, I am familiar with the treatment of urologic malignancies,
Q Tell me a little bit about your training, how you get your familiarity with that treatment.
A By being -- by participating and being part of the treatment of many urologic malignancies.

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Q What would that participation include?
A Patient diagnosis, care, and managenent.
Q Anything else?
A Not that I'm aware of.
Q Have you ever attended any continuing medical education seminars on chemotherapy agents?
A Not specifically. However, these are oftentimes a part of urology continuing education, the management of uroloqic maliqnancies.
Q Any part of your residency or training deal specifically with oncology or hematology?
A A larqe portion of my uroloqic training was -- I was participating in the manaqement of uroloqic maliqnancies, and have continued to do so to the present day.
Q Okay, Referring to the second paragraph. You start off by saying, "Early diagnosis of metastatic disease can make a tremendous difference with testicular cancer,"
Tremendous difference in what, Doctor?
A Well, clearly it is the earlier you find a tumor, the smaller the tumor burden, the less this increases your chances of havinq to expose the patient to more aqgressive, toxic, and potentially injurious treatment,

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Q What is the basis for that opinion?
A My clinical experience, and what is available in the literature.
Q What is early diagnosis?
A Early diagnosis means being able to find something, detect something at the earliest possible stage.
Q What does that depend on?
A Close meticulous follow-up.
Q Anything else that early detection is dependent on?
A Close meticulous follow-up with the appropriate diagnostic studies,
Q Well, Doctor, if a patient hasn't even presented to a physician, that would preclude early follow-up, wouldn't it? I mean, you have to establish a relationship with a physician first before you have a follow-up?
A I think we're talking about two different -- I'm not sure what you're asking.
Clearly, if the patient hasn't seen the physician, it's difficult to do the appropriate follow-up.
Q Okay. Thanks, You then say, "Yearly follow-up as recommended after initial therapy in Dr. Basa's note does not comply with an appropriate standard for managing these patients, and is contrary to all that is published in the urologic literature."
I want to know what you mean by "these patients."
A A patient with testicular cancer, period.
Q Does that include all forms of testicular cancer?
A That includes all forms of testicular cancer,
Q You're not drawing any distinction between seminoma, embryonal cell, or any other type of subcategory?
A I am drawing no distinction,
Q You say that yearly follow-up is contrary in all that is published in urologic literature.
First of all, what literature are you referring to?
A I am referring to standard urologic reference sources such as the Journal of Urology, Campbell's Urology, Gillenwater Urology (phonetic), Urologic Clinics of North America, AUA updates series, and other journals such as the Gold Journal of Urology.
Q Did you consult with any of these resources before you wrote this report?

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A I'm routinely reading these to maintain my own fund of knowledge,
Q Did you refer to any of these that you just named prior to writing this report?
A Not specifically. But I routinely go -- I routinely delve into these sources.
Q Did you have any one of these before you as you wrote your report?
A Not specifically, no.
Q Did you have any of them before you, generally, before you wrote the report?
A I maintain an extensive library with all the above-mentioned resources.
Q Did you find it written in one of those articles or books that you just listed for me, a statement that yearly follow-up is contraindicated or below the standard of care?
A That is throughout the literature.
Q You're saying I could pick up the Journal of Urology or a book chapter in Campbell's, and they would all indicate to me that in all cases with testicular cancer, follow-up of one year is unacceptable; is that your testimony?
A What I said was that for testicular cancer patients, I have never seen anywhere documented in the

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literature that a patient be told after prophylactic radiation that they don't need to follow-up for one year.

Everything in the literature refers to close meticulous follow-up to rule out recurrence.

Q "Frequent mnitoring during the first four years after diagnosis, and in particular during the first two years post-orchiectomy, is essential to detect any recurrence at the lowest possible disease volume."

Doctor, what do you mean by frequent mnitoring during the first four years?

A There are several protocols that are in the literature from major institutions such as Memorial, Indiana. These vary slightly, however, we're talking about markers, for example, every one to two months, CT scans and chest x-rays at three month intervals, approximately.

Q Anything else?

A Physical exam, x-ray studies, and appropriate laboratory testing.

Q How often?

A As I said, this is something that there is a little variation in the literature, but most -- this is with blood tests at one to two-month intervals,

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chest x-rays, CT scans at approximately three months in the initial follow-up period.

Q And physical exams how often?

A This is typically done every one to two months, In my own practice, it's done every month.

Q But standard of care does not require every mnth for physical exam?

A The standard of care is every one to two months. That is the range that is presented in the literature as to what is practiced at almost every major oncology center dealing with testicular cancer in this country.

Q Okay.

A And that's well published.

Q So we're clear, you're talking about frequent mnitoring for a patient who's been diagnosed with a Stage **II-A seminoma?**

A I am talking about monitoring all patients with testicular cancer regardless of their initial histology, pathology, and stage.

Q So after a patient with a Stage **II-A seminoma** by **CT** scan, who has had 19 radiation treatments and been declared disease free by the radiation oncologist, you would follow him with the similar closeness that you would follow a patient with

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embryonal cell cancer; is that what you're telling me?

A That is correct, and even more important because there is already the suggestion of metastatic disease, the prophylactic in the retroperitoneum. The prophylactic radiation does nothing to treat above the diaphragm. And that is oftentimes a site of recurrence in somebody that has proven metastatic disease.

It is unheard of to not follow this patient.

Q Did you read Dr. Lay's (phonetic) transcript between the time you wrote the report and now?

A I do not recall.

Q Would you agree that an embryonal cell is a more aggressive tumor type or cancer type than seminoma?

A In general. However, you can see resistant forms of both, but that is correct.

Q So generally embryonal cells are a more aggressive cancer?

A That is correct.

Q **And** still you would follow the seminoma patient with the same regularity and frequency as a patient with embryonal cell?

A That is very correct.

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Q Okay. The second part of that previous sentence about frequent mnitoring, **I** think you set that format at two mnths CT scan, chest x-rays, two to three mnths, and a physical exam one to two mnths, because it's essential to detect recurrence at the lowest possible disease volume.

How do you detect tumors at the lowest possible disease volume? And **I** mean how, by what modalities?

A Physical examination, for example, may detect clinically abnormal lymph nodes on exam, chest x-ray may, for example, show the development of metastatic disease within the chest, CAT scan may show enlarging lymph nodes, or a change in the appearance of the retroperitoneum. Blood tests may show abnormal elevation.

Q Disease volume, and educate me here, is that masured in terms of size, or centimeters, or how is tumor volume measured?

A From a CT scan you can infer the size in centimeters.

Q **Is** that the same for a chest x-ray?

A That is correct.

Q And with tumor markers, that would be an elevation in the result, true?

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A That is correct.
Q Doctor, in this case the HCG and AFP were both normal when Dr. Basa drew them; is that correct?
MR. LANDSKRONER: When? At what time?
Q BY MS. CRISAFI: Did Dr. Basa draw more than one set of tumor markers, Doctor?
A I remember reviewing the records that his AFP was abnormal when he presented with his metastatic disease,
Q When was that?
A I believe that was January of '96, about six or eight months after he was last seen by Dr. Basa.
Q Let me ask my question specifically.
Did Dr. Basa ever draw an HCG or an AFP that was elevated?
A There was one that was drawn right before the patient had the orchiectomy that was not elevated.
Q And that's true for the HCG and the AFP; isn't that correct?
A To the best of my knowledge, yes.
Q So there's no evidence to Dr. Basa that the patient had any abnormality in his tumor markers; is that correct?
A At that time that is correct.
Q Well, he didn't go back to see Dr. Basa,

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did he?
MR. LANDSKRONER: Objection.
THE WITNESS: I don't know the scenario. I don't know whether he saw him in follow-up after the initial orchiectomy and radiation.
Q BY MS. CRISAFI: Well --
MR. LANDSKRONER: The records indicate he saw him in August.
THE WITNESS: From what I understand, he was seen in August.
Q BY MS. CRISAFI: Okay. And, Doctor, at that time with previously normal tumor markers, did the standard of care require additional sets be drawn?
A Yes.
Q Why is that?
A To look for elevations.
Q Doctor, does the standard of care require a search for elevation when the initial sets drawn mnths prior were normal?
A Yes.
Q And the basis for your opinion that they were required?
A Because even what appears to be a homogeneous tumor may potentially have areas that were missed. And these may become marker producing

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recurrences.
Q And, Doctor, based on your review of the records, if Dr. Basa had drawn tumor markers again on August of 1995, what would they have shown?
MR. LANDSKRONER: Objection,
THE WITNESS: I cannot predict. However, we know the AFP subsequently elevated into an abnormal range, Perhaps this may have been detected earlier on.
Q BY MS. CRISAFI: You're speaking about the tumor markers drawn in January or February of '96; is that correct?
A That is correct,
Q Why don't we look at those right now.
Look specifically at the January 24th AFP and HCG.
MR. LANDSKRONER: That's from UH, Marilyn?
MS. CRISAFI: It was Southwest General.
MR. LANDSKRONER: Southwest, okay.
Q BY MS. CRISAFI: Did you review the Southwest General records before your deposition today?
A I believe I did, however this was awhile ago,
MR. LANDSKRONER: Marilyn, we're working off my work copy here of the records, so I don't know that for whatever reason if I pulled anything out of there.

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Q BY MS. CRISAFI: Doctor, when is the last time you reviewed the records before giving your deposition today?
A I gave them a quick review this morning and it's been several months since I initially read the whole record.
Q And you're not sure if you reviewed the Southwest records before your deposition this morning?
A I did review everything that was provided to me.
Q So that's yes?
A That is correct.
Q Do you recall whether they were elevated when he re-presented to Southwest in January of 1996?
A I am currently looking for the lab results.
MR. LANDSKRONER: I don't see them in this copy that I have in front of me.
Q BY MS. CRISAFI: Well, Doctor, for this next question, I want you to assume that his quantitative HCG on January 24th, 1996 was less than two, and that the AFP was four, with a reference range from zero to 15 being normal.
On that assumption, Doctor, do you have an opinion whether those test results would have been

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positive if they were drawn in August of 1995?
A If that is prior to treatment, they would most likely have been normal.
Q Thank you, In your -- strike that.
A I'm sorry?
Q I said, "Strike that."
You say in your report that, "Because of the failure to outline a reasonable follow-up schedule, Mr. Ortman only presented when he became symptomatic with bulky metastatic disease."
First of all, have you already testified as to what you believe the standard of care requires as far as a reasonable follow-up schedule; specifically tumor markers every one to two months, a CT and a chest x-ray every three months, and a physical exam every one to two months, correct?
A I stated that, that's correct.
Q Okay. And that's what you meant in your report by a reasonable follow-up; is that right?
A That is correct.
Q "Mr. Ortman only presented when he became symptomatic with bulky metastatic disease."
And, Doctor, what is bulky metastatic disease?
A Bulky metastatic disease would, in his

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case, be an enlargement of the lymph nodes in his retroperitoneum.
Q Doctor, does medicine recognize a certain tumor volume at which time an enlargement is bulky?
A In this case, depending on which literature you look at, it's roughly five to six centimeters.
Q Okay. So in this case, Doctor, he didn't have bulky metastatic disease, did he?
A Or the number and degree and extent of the nodes involved.
Q Okay, What is the number and extent of nodes involved that comprise bulky disease?
A If -- well, what you can have is basically several -- you can have several areas in multiple regions. The nodes may be just between two and a half and five centimeters, or you can have one large bulky mass that's greater than five centimeters,
Q You said several areas with enlargement?
A For example, in the chest and retroperitoneum.
Q Okay. So if you have a smaller tumor, two to three centimeters, in addition to enlargement in several other areas, then that would be considered bulky; is that correct?

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A That's reasonable, yes,
Q Okay. Anything else that would comprise bulky metastatic disease?
A No.
Q Okay, Doctor, in what areas did he have lymph node enlargement?
A To the best of my recollection, without looking at the reports --
Q Doctor, I want you to look at the reports.
A Okay. The chest x-ray showed abnormalities.
Q Where was that?
A That was this x-ray right here.
Where were the x-rays from Southwest?
On January 24th, 1996 there is a nodule in the posterior segment of the right lower lobe.
Q And what are you looking at?
A I'm looking at a chest CT report.
Q Okay. Anywhere else?
MR. LANDSKRONER: Again, I'll just object to qualify it by suggesting that based on what you have in front of you, if you know of any others,
Q BY MS. CRISAFI: Doctor, based on your rearview of the records, except for the isolated nodule in the right lower lobe, was there anywhere else that

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he had enlarged lymph nodes when he re-presented in January of 1996?
A In the retroperitoneum.
Q What study are you looking at to find that?
A CT scan of the abdomen and pelvis.
Q Okay, Anywhere else?
A To the best of my knowledge, and from what I have in front of me, that is it.
Q And you made your statement that he had bulky metastatic disease based on the findings in the CT scan of the 2.5 centimeter soft tissue mass, and the densities -- and the smaller densities in the same areas, and the isolated nodule in the right lower lobe; is that correct?
MR. LANDSKRONER: Objection. Go ahead.
THE WITNESS: That is correct.
Q BY MS. CRISAFI: Doctor, are you qualified to testify as to what difference the tumor volume in January of 24th, 1996 made on his outcome?
A From a urologic standpoint,
Q Based on your treatment -- based on your training as a urologist, what difference does the difference in tumor volume -- what difference did that make in Mr. Ortman's course of treatment, based on your

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experience and training?
A Well, he clearly, at the time he re-presented, he had disease apparentlv above the diaphragm as well as in the retroperitoneum. And this required him to have more extensive chemotherapy than if he were, perhaps, picked up earlier.
Q Doctor, based on your training as a urologist, at what point would he not have needed what you call, more extensive chemtherapy?
And by that I mean, you say that because it was picked up at the tumor volume that it was picked up at, that he needed more chemotherapy.
What tumor volume would you expect to see where he would need normal or anticipated chemotherapy?
A For example, if he were not to have involvement above the diaphragm, with small residual disease in the retroperitoneum, he could have potentially been operated on, and not -- and had limited amounts of additional chemotherapy,
Q Are you qualified to say, based on your experience and training, at what point the additional smaller soft tissue densities appeared in the CT scan of the abdomen and pelvis, as well as the disease above the diaphragm, if that's not the --
A I do not know because there were no tests

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ordered in between when these tests were done and the patient was last seen,
Q Doctor, do you have any information, based on your training as a urologist, as to the speed with which these growths grow?
A Certainly not specifically because it can certainly be variable,
Q So is it fair to say that you're not qualified to say when these first would have been detectible by CT or chest x-ray?
A I wouldn't say I'm not qualified. I'm saying that is a difficult question to answer because the growth rate of one tumor versus another is very variable,
Q Would it have been detectible in his -- his last treatment was on June 23rd, 1995. Would something have been detectible by July 23rd, 1995?
A Pocentially.
Q So based on your experience and training, something that in January of '96 was 2.5 centimeters, and also included several additional smaller soft tissue densities, may have been detectible in July of 1995 where in May of 1995 no such findings were present?
MR. LANDSKRONER: Objection. Go ahead.

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THE WITNESS: It's clearly guessing. I do not know for sure. But clearly when these were detectible is unknown.
Q BY MS. CRISAFI: So you don't know if it would have been detectible in three months?
MR, LANDSKRONER: Objection. Go ahead and answer that.
THE WITNESS: It may have,
Q BY MS. CRISAFI: But you don't know?
A I cannot say with 100 percent certainty.
Q Can you say with probability?
A I cannot answer that question.
Q Why is that?
A Because you're asking me to speculate on an unknown.
Q Okay. You say, "As a result of the manner in which Mr. Ortman was diagnosed and managed, it is my opinion, to a reasonable medical probability, that it was necessary to expose him to a more intensive salvage chemtherapy with documented complications."
First of all, what do you mean by the way in which he was diagnosed and managed?
A I'm referring to the fact that he was initially given the wrong therapy far what his true pathology was.

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He was then not followed-up until he re-presented in pain. So that is what I'm referring to in terms of the way he was diagnosed and managed.
Q The wrong therapy and not followed-up.
Anything else that you mean by, "As a result of the way he was diagnosed and managed"?
A No.
Q Okay. We have already discussed the fact that you're not critical of Dr. Basa about the therapy, because he was given a diagnosis from the pathologist of seminoma; is that correct?
A That is correct.
Q Okay. So your main criticism of Dr. Basa in this case is his follow-up recommendations, and I won't go through them again, but as far as the tumor markers, CT scans, and the physical exam, correct?
MR. LANDSKRONER: Objection. Go ahead.
THE WITNESS: And chest x-rays, that is correct. There was no follow-up plan outlined for Mr. Ortman.
Q BY MS. CRISAFI: That you saw in the documents; is that correct?
A That I saw in the documents, that is correct.
Q Have you read Dr. Basa's deposition?

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A Yes, I have.
Q Doctor, I lost my train of thought, just a minute,
Khat does "salvage" when you're talking about chemotherapy?
A In this case, salvaqe just means a more aqqressive reqimen, Sometimes it would require different druq utilization.
Q Does salvage chemotherapy also mean chmtherapy given to a patient after a recurrence?
A In certain situations, yes.
Q And it doesn't necessarily mean a more aggressive regimen, it could just mean that it's chmtherapy given to a patient who has had a recurrence; is that correct?
MR. LANDSKRONER: Objection.
THE WITNESS: That is reasonable,
Q BY MS. CRISAFI: Doctor, I appreciate you may nave discussed this in an earlier answer, but I'm qoinq to ask you aqain for clarification.
What is the basis for your opinion that as a result of Mr. Ortman's follow-up treatment -- strike that.
What is the basis for your opinion that because Mr. Ortman was told to follow-up in a year that

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he needed more intensive salvage chemotherapy?
A From a urologic standpoint, the smaller the tumor burden at the time of diagnosis you can potentially limit the amount of chemotherapy that you may have to give.
Q In following that, is that in your opinion, he would have needed less chemtherapy if he was detected at the time the tumor burden was smaller?
A In his situation, if he was managed correctly, he may -- in all probability, he would have received less chemotherapy, anywhere from one to two cycles less, depending on how he was managed.
Q Khen you say "managed correctly," do you mean come in for the follow-up tests that we have discussed?
A I'm talking about his entire case as well as his follow-up.
Q Entire case meaning the initial diagnosis of seminoma which was embryonal cell cancer?
A Yes, ma'am.
Q And that's based on your experience as a urologist managing patients with testicular cancer?
A Yes, ma'am.
Q How long have you been treating patients with testicular cancer?

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A My first exposure was during my residency which began in 1987,
Q So for about 10 years; is that correct?
A I have participated in some form or another over the past 10 years, correct.
Q Going back to your report with docmnted complications, I'll read the whole sentence if you don't understand the context, but what docmnted complications are you talking about?
A Mr. Ortman had several complications that were reported including the pain at presentation, the effects of the chemotherapy on his blood count making him more prone to certain types of infections such as fingernail infections requiring antibiotics, which he had reaction to, hypersplenism, those things that have been mentioned in his university hospital documents that I have been provided.
Q Okay.
A And that's not to mention what future risks he is -- what future risks he still has as a result of the combination of radiation and chemotherapy
Q Doctor, a patient who has chemotherapy done, what are the known side effects of chmtherapy based on your experience as a urologist?

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A There is a broad range as there are a broad range of chemotherapeutic agents, These include everything from cardiopulmonary toxicity, neuro toxicity, depletion of bone marrow, in addition to the more common side effects that most lay people are aware of such as nausea, vomiting, hair loss.
I mean, I can provide you with a whole PDR and you can look up pages of complications.
Q Patients after receiving two or three doses of BEP could have nausea, vomiting, and hair loss; is that correct?
A That is correct.
Q Doctor, did you see any evidence that Mr. Ortman had cardiopulmonary toxicity?
A No, I did not.
Q Neuro toxicity?
A To the best of my knowledge, no.
Q Any depletion of bone marrow?
A I believe and, again, I'd have to look at it, but I believe he did have problems, as most do. I believe he did have problems with low white cell count in response to the chemotherapy,
Q Except for the low white count, any other evidence that you saw that Mr. Ortman had depletion of bone marrow?

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A No.
Q Doctor, can patients have depletion of bone marrow after two to three cycles of BEP chemtherapy?
A They can have potential side effects, correct.
Q Including depletion of bone marrow as evidenced by low white cell count?
A Their white cell count can be affected, yes.
Q I'm not sure why you're qualifying your answer,
A Because I just want to be clear,
Q Okay.
A No reason specifically.
Q Okay. Doctor, are you going to have the opinion at trial that his reaction to penicillin was related to his chemtherapy?
A No. His reaction to penicillin was -- certainlv his exposure to penicillin, I think, was part of a chain of events that occurred, but clearly the chemotherapv did not cause the allergy to penicillin.
Q Okay. And --
A That complication is part of a long chain of events.

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Q What is -- for my benefit, will you tell me what that chain of events is?
A In terms of his hypersplenism and need for antibiotics as a result of chemotherapy.
Q Okay. And, Doctor, I think you just told me this, but someone with a low cell count, that can happen after two or three cycles, there may be difficulty fighting infection, is that true?
A People with low white cell counts that are affected by chemotherapy may have difficulty in fighting infections, that is true.
Q Okay. Doctor, can you say to a probability that the -- I think it was a finger infection he had. First of all, was that due to a difficulty from fighting an infection from chemtherapy?
A It certainly is an unusual type of infection and the chemotherapy puts him at a higher risk for that occurring.
Q Will you be saying at the time of trial that there was a causal relation between those two?
A I think it is a reasonable relationship, yes.
Q And, Doctor, can you say to a probability that that's a difficulty he would have not had after

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three cycles of chemtherapy?
MR. LANDSKRONER: Objection. Go ahead.
THE WITNESS: I cannot say that.
Q BY MS. CRISAFI: Doctor, in the last line of that second to the last paragraph you state that, "Presently Mr. Ortman is less than one and a half years from salvage therapy and is still at risk for recurrent testicular cancer."
Currently, December 1996, we're more than a year and a half from his chemotherapy. I'd like to know how that affects your opinion in that last sentence that he still is at risk for recurrent testicular cancer?
A It doesn't affect it. There are cases in literature, despite early response, of delayed recurrence.
It is true that most people recur during the first one to two years. However, there are cases in the literature of late recurrences despite favorable responses noted early on,
Plus there is clear evidence in the literature of second malignancies related to a toposide, for example, one of Mr. Ortman's chemotherapeutic agents,
Q A malignancy relating to a toposide?

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A Exactly.
Q What literature have you found that evidence in?
A There -- the reports are in the urologic literature relating to treatments of urologic malignancies, that is where I have become aware of this information,
Q Can you cite for me the specific journal article?
A At this moment I cannot.
Q In preparation of that opinion, did you have an opportunity to review a specific article that you currently can't recall the title of?
A I'm sure I have, that's part of my routine reading of things like AUA updates and Urologic Clinics of North America where these issues are frequently covered.
Q Did you have before you a certain issue or article from one of those journals as you made that opinion?
A Not at the time. I have made my opinion as part of my fund of knowledge from my routine reading,
Q I guess my question was specifically whether you found an article that said there was a

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likelihood of secondary malignancy related to a toposide?

A There are articles in the literature that talk about secondarv maliqnancies relating to a toposide, yes. I cannot qive you a specific quotation in terms of what the article is at this moment.

Q Okay.

A But it is well documented in the literature,

Q Okay. And currently based on records you have reviewed, you have not seen that Mr. Ortman has demonstrated a second malignancy related to a toposide?

A It is too early to make that judqment.

Q In the literature you have reviewed, when does that second malignancy related to a toposide manifest?

A Several of the cases that have been reported have been over about a four-year period, However, the information on this issue is still qrowing as we have switched people to toposide-based reqimens and we beqin to accumulate more long term data.

So we do not have the final answer on what the true long term malignant secondary malignancy will be.

Q Based on your review of that literature,

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what percentage of the patients that survive the first one to two years without recurrence go on to have the secondary malignancy?

A In the early information, I have seen a range from one-half to four percent.

Q Back to earlier statements. Although mst recur within the first year to two years if they're going to, there are cases of late recurrence.

Based on your review of literature and experience and training, what percentage of those -- what percentage of patients do have a late recurrence?

A That it is more of an anecdotal percentage.

Q I don't know what that means.

A Anecdotal meaning less than five percent, meaning very few.

Q Doctor, what clinical findings would you expect to see if a patient status post-radiation therapy did not have a disease-free status at the close of radiation treatment?

MR. LANDSKRONER: Objection, Go ahead.

THE WITNESS: May I just rephrase?

You're asking me if somebody failed radiation therapy, what would you expect to see?

Q BY MS. CRISAFI: For a Stage II seminoma,

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what would you expect to find on a clinical exam within a month or two after finishing radiation?

A Well, on somebody clinical II-A one month after treatment --

Q One to two mnths.

A One to two months after treatment on a physical exam, unless there was evidence of supradiaphragmatic disease, you probably wouldn't see anything on a physical exam. You may see something changing on a CAT scan or chest x-ray.

Q What would those findings be on a chest x-ray or CT exam that you may see?

A Enlargement of lymph nodes or development of a pulmonary nodule, for example.

Q Do you recall reviewing Dr. Basa's 8-21-95 progress note?

A I'm turning to it at this moment.

Q For the purposes of this question, I want you to assume that Dr. Basa thought that this patient had a Stage 11 seminoma and had completed 19 radiation therapy treatments and was told by the radiation oncologist that he was disease free.

Now, would that -- based on the assumption Basa had that information, is there anything in his clinical findings that would have suggested he would

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not have response -- anything that you see in Dr. Basa's notes there that would suggest to him any findings that the patient did not have the expected response to radiation treatment?

A I'm just quickly looking over the note. August 21st, '95, correct?

Q Which is Dr. Basa's last visit with Mr. Ortman.

A All right, Based on what I can see that's documented, the only part of the physical exam that I see is that his abdomen is soft without palpable mass,

There's no mention as to whether or not he palpated his cervical, supraclavicular, or inguinal lymph nodes present in this document. He just comments on that his other testicle seemed okay.

So the only thing in the exam is the abdomen and other testicle. There is no documentation of any other lymph nodes, which I think is important for testes cancer.

And there's no documentation of a plan for further follow-up testing in terms of radiographic imaging.

Q The question was specifically whether or not any of those physical findings would indicate he

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didn't have anything but the appropriate response to radiation treatment?

MR. LANDSKRONER: Objection, Go ahead.

THE WITNESS: His exam of the abdomen and his contralateral testicle are reported to be normal.

However, the exam is an incomplete exam for testicular cancer follow-up.

Q BY MS. CRISAFI: So can you answer my question?

A I just did. There is nothinq in the limited exam that: he did that is abnormal.

Q Okay, It would suggest to him, with the caveat you indicated to me about the other lymph nodes that were not docmnted as palpated, that would indicate to him that radiation -- the response to the radiation was anything but the anticipated response?

A Within the limits of the sensitivity of his physical exam, that is correct.

Q Can you turn to Dr. Peter Lay's August 16th, 1995 letter?

MR. LANDSKRONER: Is that Basa's chart or the --

MS. CRISAFI: If you split up the Basa correspondence section, it may be in the correspondence section,

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(Whereupon a snort recess was taken.)

Q BY MS. CRISAFI: Doctor, have you turned to the review of Dr. Lay's August 16th, 1995 letter to Dr. Basa?

A Yes, ma'am.

Q Specifically, did Dr. Lay report that Mr. Ortman stated he had no complaints; he was eating well, had no symptoms of nausea, vomiting, fever, or night sweats?

Do you see that in the second paragraph?

A Yes, I do,

Q In addition, Dr. Lay told Dr. Basa that there was no evidence of disease.

Do you see that paragraph?

A That is correct.

Q Based on that information that the radiation oncologist gave to Dr. Basa, with the understanding that *this* patient had seminoma, was there any reason that Dr. Basa needed to see the patient any earlier than three to six mnths for follow-up?

A I believe the patient needed follow-up sooner, yes.

Q Why is that?

A To monitor him for evidence of recurrence.

Q With these symptoms of this report, why

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would he need to be monitored sooner than that for symptoms of recurrence?

A Because oftentimes recurrence -- recurrences can be picked up prior to a patient being symptomatic. That is the purpose of blood testing, CT scanning and chest x-rays,

Q But we have established that at no time were his tumor markers elevated,

So would you agree that even if Dr. Basa had drawn tumor markers in one to two mnths or six mnths, those would not have been elevated?

MR. LANDSKRONER: Objection. Go ahead.

THE WITNESS: That is correct.

Q BY MS. CRISAFI: Do you have an opinion as to when, if at all, any of these findings would have been palpable?

A His -- unless his retroperitoneal recurrence became massive, it's not likely that these would have been palpable. And this is why CT scanning and chest x-rays are necessary parts of meticulous follow-up, which is the standard in the urologic community.

Q So specifically in this case, a CT scan and chest x-ray were the parts of follow-up that were needed in Mr. Ortman's care?

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A As well as the markers and physical exam.

Just because they were negative doesn't mean it's a part that should be ignored, looking back retrospectively.

Q Okay. But in this case, Doctor, since they were negative and nothing would have been palpable, that made no difference in his outcome, did it?

A I'm sorry, can you repeat the question?

Q Doctor, in this case since the tumor markers were negative throughout, and for a 2.5 centimeter mass, which I think you said would not have been palpable, the fact that these were not done i.e. no palpation on physical exam, no new tumor markers being drawn, did not make a difference in Mr. Ortman's course; would you agree with that?

A In this case that is correct.

Q Okay. Doctor, if a patient had presented two mnths after getting radiation treatment post-orchiectomy for Stage II-A seminoma, if that patient presented for follow-up with nausea, vomiting, weight loss, and loss of appetite, that would increase the physician's suspicion of recurrence, wouldn't it?

A Certainly those symptoms are things that can go along with recurrence as well as complications

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of the therapy.
Q Okay. But those are findings that would prompt a physician to investigate further for evidence of recurrence or non-cure?
A Certainly those are abnormalities that should result in an investiqation to find out what the cause of these abnormal symptoms are, yes.
Q Okay. Doctor, do you know in what time period Mr. Ortman ended up having a CT scan after his last radiation treatment?
A I would have to look at the chart to answer that specifically, But to the best of my knowledqe, the first one was done when he re-presented in January of '96.
Q Okay. Based on the charts with the completion date of his radiation at 6-23-95 and the re-presentation at Southwest on 1-24-96, that's approximately seven months after completion of treatment and five months after his last visit to Dr. Basa, based on that information, that time span is below the standard of care to receive a follow-up CT scan?
A That is correct.
Q And we have discussed exhaustively probably the reasons why that is so; is that correct?

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A In my view, there is no discussion. I don't think you would find one urologist at a major clinical institution who would support Dr. Basa's follow-up protocol,
Q Well, he had a chest CT -- I'm sorry, he had a CT earlier than one year, didn't he?
A You're talking at approximately seven -- I assume this -- we're talking approximately seven, eight months between CT scans.
Q That's earlier than the one year that Dr. Basa recommended though, isn't it?
MR. LANDSKRONER: Objection.
THE WITNESS: I'm sorry. We need to step back and -- can you ask me the question specifically again?
Q BY MS. CRISAFI: Well, Dr. Basa recommended follow-up in one year and Mr. Ortman had a CT scan earlier than that, didn't he?
A Only because he presented with pain from his recurrent disease, if I'm understanding you correctly.
Q Regardless of the reason, he did have a CT scan earlier than that one year; is that correct?
A Yes.
Q Okay, Doctor, you actually looked at the January 24th, 1996 CT scan, the actual film; is that

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correct?
A Months ago, I believe.
Q And we talked about that briefly earlier.
I just want to make sure you don't have any other opinions about what that CT scan -- well, first of all, do you disagree with the findings of the CT that were in the report on January 24th, 1996 as reported by Walter George, M.D. (phonetic)?
A To answer that, I would have to have the scan in front of me.
Q Do you recall -- well --
A I'm not -- I would have to have the scan in front of me to answer that with 100 percent certainty.
Q Would your recollection upon the initial review that that finding on the CT scan was any larger than 2.5 centimeters?
A I do not recall.
MS. CRISAFI: Okay. Jack, I'm just going to ask to recall him if he's going to testify that there was anything greater on that CT scan, and examine him about that, if at the time trial if he goes back and compares them, Okay?
MR. LANDSKRONER: I'll object to it. I don't think he will, but I'll just object to it. Go ahead.

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Q BY MS. CRISAFI: All right. We discussed -- we have discussed what you think the findings would have been, I think I asked you, if you did a CT in August or September or October; is that correct?
A I basically said I could not predict that.
Q Okay. But -- I'm almost done,
Doctor, you talked earlier about what you think Mr. Ortman's future problems may be as a result of the chemotherapy he required for the tumor and cancer when they found it,
What are your opinions about that?
A As I said, certainly anybody who is exposed to chemotherapy, and in his case, this is superimposed upon approximately 2,500 rads of radiation, is at risk for future complications, One of them is secondary malignancy, which we have already discussed.
Q Okay. Anything else?
A Certainly that it is a big enough -- would be a big enough concern for me.
Q I'm not disputing the size of the concern. I only want to know if there's any potential future damages or future injuries that you think Mr. Ortman is prone to as a result of getting treatment when he got it.

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A Only if he were to develop other medical problems down the road that would require additional treatment, that would certainly be affected by the amount of chemotherapeutic agents that he has already received to this point in time. Cumulative doses of a lot of medication enhance the toxicity.

Q Doctor, what problems are you able to see to a probability he may develop down the road?

A As I said, there's a risk of secondary malignancy for a toposide. I have quoted you a general number of a half to four percent that I have seen in the literature as a summary.

Q Anything else except for the secondary malignancy from a toposide that you can say based on your experience you anticipate potential problems for Mr. Ortman?

MR. LANDSKRONER: Objection. Go ahead.

THE WITNESS: Again, I said certainly if he were to develop other medical problems, the fact that he has baseline radiation and chemotherapy may further complicate additional treatments for other medical problems that occur in the future.

Q BY MS. CRISAFI: Right. That's what I'm trying to get a handle on, Doctor, if he were to develop medical problems in the future. I need to know

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what you mean by that.

A If he were -- he were to develop another malignancy, for exanple, certainly this may affect how he can be treated.

Q This meaning what may affect how he is treated?

A The fact that he has already received radiation chemotherapy.

Q How would it affect him?

A It would add to his cumulative dose exposure of these toxic agents.

Q Are there any other injuries or damages that you can say to a probability are a risk to Mr. Ortman except for secondary malignancies and the difficulties if he had a recurrence due to the cumulative radiation and chemotherapy that Mr. Ortman may be at risk due to his receiving chemotherapy when he got it?

A Not specifically.

MS. CRISAFI: Jack, if he thinks of something between now and the time of trial, I reserve a right to question him on those.

MR. LANDSKRONER: I'll object, but go ahead.

Q BY MS. CRISAFI: Doctor, what do you base your opinion on that there is a cumulative effect to a

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patient who has had radiation before chemotherapy?

A The available information in the literature.

Q Anything else?

A No.

Q Well, in your experience, Doctor, do patients have difficulty when they have -- your own patients, have they had difficulty with chemotherapy after radiation first?

A I have had -- in my own personal experience, I have not had any specific patients have complication with this specific scenario.

Q None of your patients have had radiation before chemotherapy?

A That is not -- I did not say that.

Q Have you had patients who have had radiation before chemotherapy?

A Are you talking specifically about testes cancer or any malignancy in general?

Q Cancer of the testes.

A In patients who have cancer of the testes, I have not over the past several years, to the best of my knowledge, had anybody who has had radiation who has then gone on to need subsequent chemotherapy,

Q So you can't testify from your personal

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experience what any potential difficulties would be from that scenario?

A That is correct.

Q Doctor, would you agree that the response of embryonal cell cancer to chemotherapy is excellent?

MR. LANDSKRONER: Objection.

THE WITNESS: That's a general statement. But the cure rate for testes cancer has made dramatic advances over the past several decades.

Q BY MS. CRISAFI: And would you agree with that statement then?

A Yes,

MR. LANDSKRONER: Objection.

Q BY MS. CRISAFI: Okay, Would you agree that chemotherapy is the treatment of choice for embryonal cell testicular cancer?

A That, again, needs to be stage specific.

Q Okay. For the stage that Mr. Ortman presented in January of 1996.

A When he recurred he had disease based on the chest x-ray -- based on the best -- based on the information I was provided, it seems that he had both retroperitoneal and possibly supradiaphragmatic disease.

Chemotherapy is the treatment of choice in

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that situation.
Q Is it your testimony that he would not have needed chemotherapy in May of 1995?
A When he was initially picked up in May of 1995, it is my view that he should have been treated with a retroperitoneal lymph node dissection after his radical orchiectomy,
And, aqain, based on the patholoqic findinqs of the retroperitoneal lymph nodes, the decision as to whether or not he would need adjuvant chemotherapy would be addressed at that time,
Q Can you answer that based on his CT scan that Dr. Lay did whether he would have needed chemotherapy?
A There was a suqqestion of enlarqed lymph nodes, so probably he would need adjuvant chemotherapy after retroperitoneal lymph node dissection,
Q Okay. Thank you.
Doctor, what side effects from the chemotherapy did Mr. Ortman have after his fourth round that were different from those after his third round?
A I'm double-checkinq, but I believe it was perionychia and the evidence of hypersplenism,
Q Anything else?
A I'm looking through the chart.

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Q All right.
A I believe that to be it.
Q What is perionychia and hypersplenism from? I mean, how does it relate to chmtherapy?
A Perionychia is an infection, and clearly with somebody with altered immunity, as all people are on -- as most people are on chemotherapy, are more prone to infections, that's kind of why they have isolation areas in certain hospitals to protect patients.
Q Okay. People in chemotherapy have increased risk infection, and in this case Mr. Ortman got a perionychia infection?
A Yes. Your question?
Q Is that true?
A That is what is in the records.
Q Okay. Mr. Ortman could have gotten this perionychia infection after his second or third round of chemotherapy, isn't that true?
A It is possible.
Q What about the hypersplenism, is that from -- he had chemotherapy and because of that he had an enlarged spleen?
A That was a finding that was not noted on his prior CT scans and clearly this developed through

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his treatment course,
Q Any relationship that has to chermtherapy, though?
A Clearly with chemotherapy you're altering his blood count and there is a cumulative effect of -- there is a cumulative effect related to his treatment that in high probability contributed to the hypersplenism.
Q Okay. You'd agree, though, that an altered blood count from chemotherapy could have come from the cumulative effect of two rounds or three rounds of BEP chemotherapy, too?
A You increase your risk the more you increase your cumulative dose.
Q I understand that. But isn't it true that's a cumulative effect that could have happened after two or three cycles of BEP?
A It is potentially possible. However, you increase the risk the more you're exposed, too.
Q Okay, Doctor, do you have any opinion about Mr. Ortman's risk of recurrence of testicular cancer?
A Yes.
Q What is your opinion about his risk of recurrence within one and a half years with no evidence

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of disease status?
A As I stated earlier, there is a nigh probability that at two years he is cured. However, the literature shows that there is always the -- the literature shows that there have been cases of late recurrence despite his favorable picture at present.
Q Okay. And that was the discussion we had about secondary malignancy; is that correct?
A No.
Q That's something separate; isn't that correct?
A Secondary malignancy is one issue. When I was talking about secondary malignancy, I'm talking about lymph nodes, types of tumors.
Q Right.
A In terms of recurrence of his testes cancer, he is not out of the woods yet,
Q But we discussed although there is a one- to two-year window in which time there is greatest recurrence, if at all, is in that one- to two-year window that there is some evidence that you have discussed in a time period after that?
A Most recurrences are during the first two years.
Q Okay. I guess the reason I bring this

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back up, Doctor, is that I want to know if you're going to offer any other opinions about recurrence of cancer-related diseases that we have not already discussed?

A Right now, I do not -- I am not aware of anything else to the best of my knowledge,

Q Doctor, have you ever had a patient who was diagnosed initially with seminoma who was later found to have embryonal cancer?

A No.

Q Okay, Would you agree that after orchiectomy for treatment of seminoma, the clinical evaluation for possible extragonadal metastatic disease should include quantitative, post-orchiectomy serum radioimmunization of HCG and AFP, chest x-ray films, and abdominal CT scan?

MR. LAMDSKRONER: Objection to the form. Go ahead.

THE WITNESS: That is correct. That is what we talked about as follow-up.

Q BY MS. CRISAFI: And in this case after he had his orchiectomy, Mr. Ortman had an HCG and AFP, chest x-rav, and an abdominal CT scan, didn't he?

A As part of his initial staging, that is correct,

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Q Doctor, have you ever reviewed a case for Mr. Landskroner in the past?

A No.

Q Have you ever reviewed a case for Landskroner and Phillips or for the Landskroner law firm?

A No.

Q Doctor, what year did you first begin reviewing cases for medical malpractice purposes?

A While I was in the Air Force, the U.S. government asked me to review cases.

Q Were those part of a malpractice litigation?

A I would assume that to be so. However, I do not know, I was just given charts to review.

Q Are you a member of any reviewing agency or a firm that gives lawyers your name as a consultant?

MR. LANDSKRONER: Objection. Go ahead.

THE WITNESS: Not that I'm aware of. If I was I'll get off the mailing list.

MS. CRISAFI: Off the record.

(Whereupon a short discussion was held off the record.)

Q BY MS. CRISAFI: Doctor, what year did you first review a case for a law firm or a lawyer?

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A To the best of my knowledge, this is the first time. I have given one deposition when I was a resident. And this is the first time I have reviewed a case for a law firm other than the U.S. government.

Q When you reviewed cases for the U.S. government, were you required to give a deposition?

A I never gave a formal deposition for the U.S. government.

Q Did you have to testify in a trial for the U.S. government?

A No.

Q Have you ever testified in a trial for a medical malpractice case?

A No.

Q Have you been sued for medical malpractice?

MR. LANDSKRONER: Objection,

THE WITNESS: No.

Q BY MS. CRISAFI: Have you ever had a claim brought against you for malpractice?

MR. LAMDSKRONER: Objection.

THE WITNESS: No.

Q BY MS. CRISAFI: In that instance when you were deposed as a resident, was that as a consultant or because you were involved in an action?

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MR. LANDSKRONER: Objection.

THE WITNESS: My name just happened to be on the chart, but I was in no way involved in the issues.

Q BY MS. CRISAFI: Okay. So it involved care and treatment that you gave although you were not involved in the issues?

A It didn't involve any care that I gave, no.

Q Okay. What I'm trying to distinguish out, Doctor, is whether you were asked to look at a case by an outside institution, or whether it was because your name was on a chart of a patient who brought an action.

MR. LANDSKRONER: Objection. Go ahead.

THE WITNESS: My name was on a chart for a patient that brought an action against the clinic.

Q BY MS. CRISAFI: Okay. Are you currently reviewing other cases for any other lawyers?

MR. LANDSKRONER: Objection.

THE WITNESS: No.

Q BY MS. CRISAFI: Do you know where Mr. Landskroner got your name?

A Yes, I do.

Q Where was that?

A William Lucas.

Q Is he a physician, a lawyer, or do you

know?

A He's a lawyer.

Q Is he a friend of Dr. Malacoplakia?

That's all the questions that I have. I appreciate your time this afternoon,

(Whereupon Exhibit No. 1 was marked and the deposition concluded at 12:35 o'clock, p.m.)

MITCHELL C. KAYE, M.D.

***

STATE OF ARIZONA)
) ss.
COUNTY OF MARICOPA)

BE IT KNOWN that the foregoing testimony was taken before me, CHRISTOPHER J. WHITE, a Notary Public in and for the County of Maricopa, State of Arizona; that the witness before testifying was duly sworn to testify to the whole truth; that the questions propounded to the witness and the answers of the witness thereto were taken down by me in shorthand and thereafter reduced to typewriting under my direction; that the foregoing pages are a true and accurate transcript of all proceedings had upon the taking of said testimony, all done to the best of my skill and ability.

I FURTHER CERTIFY that I am in no way related to any of the parties hereto nor am I in any wise interested in the outcome hereof,

DATED at Mesa, Arizona, this 7th day of December, 1997,

NOTARY PUBLIC

My Commission Expires
August 4, 1998

Mitchell C. Kaye, M.D.
Diplomate, American Board of Urology
Fellow, American College of Surgeons

8007 Brandt Court
Fairfax Station, Virginia 22038

June 19, 1997

Mr. Jack Landskroner
Landskroner & Phillips Co., L.P.A.
55 Public Square, Suite 1040
Cleveland, Ohio 44113-1904

Dear Mr. Landskroner:

I have reviewed the records, the pathology findings *and slides for Mr. Thomas Ortman's treatment* beginning in June of 1995. It is clear from these records that the histologic diagnosis of embryonal carcinoma was missed by Dr. Alberhasky, the reviewing pathologist, resulting in Mr. Ortman being exposed *to* an improper initial therapy. *This* is clearly documented in the revised pathology report by Dr. Tancinco, and the Subsequent *review* and findings by Dr. Levin *at* the Cleveland Clinic as well as Dr. Abdul-Karim *at* University Hospital. Clinically localized testicular cancer demonstrating the presence of embryonal carcinoma within the orchiectomy specimen is most appropriately treated with *retroperitoneal lymph* node dissection. If intraoperative findings are favorable a modified nerve sparing technique can be used preserving the nerves necessary for ejaculation. If micrometastatic *disease* was *initially noted at the time of lymph* node surgery a *limited adjuvant* course of chemotherapy would be considered. This therapeutic course almost always is curative. Mr. Ortman, on the other hand, was *exposed* to an unnecessary course of prophylactic retroperitoneal radiation *and* a *significant* delay *in* proper therapy as a result of the pathologic misdiagnosis.

Early diagnosis of metastatic disease can make a tremendous difference with testicular cancer, a disease *that* has a high potential *for cure* with initial recurrence. Yearly follow-up as recommended after initial therapy in Dr. Basa's note does not comply with an appropriate standard for managing these patients and is contrary to all that is published in the urologic literature. Frequent monitoring during the *first four years after diagnosis*, and *in particular during* the first two years post orchiectomy, *is* essential to detect any recurrence *at the* lowest possible diiase volume. Because of the failure to outline a reasonable follow-up schedule, Mr. Ortman only presented when he became *symptomatic with* bulky metastatic disease. It is probable *that* he would have been detected with a lower recurrent tumor volume.

As a result *of* the manner in which Mr. Ortman was diagnosed and managed, it is my opinion with reasonable medical probability, *that* it was necessary to expose him to a more intensive salvage chemotherapy with documented complications. Presently, Mr. Ortman is less than 1 ½ years from salvage therapy and is still *at* risk for recurrent testicular cancer.

Please contact me if I may be of further assistance.

Sincerely,

Kaye MD

Mitchell C. Kaye, M.D., F.A.C.S.
Assistant Professor of Surgery
Uniformed Services University *of the Health Sciences*

EXHIBIT 1
IN RE M. KAYE
DATE 12-6-97
CHRISTOPHER J. WHITE
COURT REPORTER