Doc. 234

COURT OF COMMON PLEAS

CUYAHOGA COUNTY, OHIO

ROSE BASTIAN, et al.,	)	
Plaintiff,	)	
vs.	)	Case No. 202353
KEITH R. KOEPKE, M.D.,	)	Judge John L. Angelotta
Defendants.	)	

DEPOSITION UPON ORAL EXAMINATION OF:

BENJAMIN KIM, M.D.

TAKEN AT: 50 North Medical Drive, Salt Lake City, Utah

DATE: April 30, 1992

REPORTED BY: Rockie Dustin, CSR

APPEARANCES

For the Plaintiff:

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Salt Lake City, Utah 84111

For the Defendant:

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THE DEPOSITION OF BENJAMIN KIM, M.D. was taken on April 30, 1992, commencing at 9:30 a.m., at the medical offices of Dr. Kim, 50 North Medical Drive, Salt Lake City, Utah, before Rockie Dustin, a Notary Public in and for the County of Salt Lake, State of Utah.

BENJAMIN KIM, M.D.,

having been first duly sworn to tell the truth, the whole truth and nothing but the truth, was examined and testified as follows:

EXAMINATION

BY MS. REINKER:

Q. Dr, Kim, we met earlier today. My name is Susan Reinker and, as I explained to you, I'm the attorney who is representing Dr. Koepke, who is an internist in the Cleveland area who has been sued by Ms. Bastion, That's why we are here to take your deposition, because you were the one who treated Mrs. Bastian for her breast cancer, at least at first.

I think the record should show that this is the discovery deposition taken by the defendant, as on cross-examination of Dr. Kim by agreement of

(By Ms. Reinker)

counsel.

MS. REINKER: Is that correct?

MR. HARMS: That's correct.

MS. REINKER: And Mr. Harms is here today on behalf of the plaintiff?

MR. HARMS: That's correct.

Q. Doctor, if you don't understand any of my questions today, I want you to tell me that before you try to answer the question, because we are going to be relying on the testimony you give later on when this case goes to trial.

A. All right.

Q. Would you state your name, please, for the record?

A. Benjamin Kim.

Q. And your current business address?

A. Business address is Department of Surgery, University *of* Utah, 50 North Medical Drive, Salt Lake City.

Q. And your profession?

A. My profession is surgeon.

Q. How long have you been here in Utah?

A. I have been here two years.

Q. Do you know the approximate date you came out here?

(By Ms. Reinker)

A. I came out here in the end of March of 1990.

Q. So your care, then, of Mrs. Bastian would have ended in March of 1990 or February of 1990?

A. Yes.

Q. Would you tell us a little bit -- before we get to that, have you had occasion prior to today to discuss this lawsuit with anyone?

A. I was contacted by Mr. Harms' firm, and from your firm as well, indicating that there may be a suit.

Q. I know as far as my firm goes, my secretary and one of my other associate's secretaries called you to set up the deposition. I don't think you Rad any conversations with either -- I know you didn't with me, or any other lawyer in our office, did you, about the case?

A. Not specifically, no.

Q. Did you discuss the actual care rendered to Mrs. Bastian with Mr. Harms or anyone else on behalf of the plaintiff?

A. No.

Q. So you talked about setting up the deposition?

A. Basically I was informed of the pending

(By Ms. Reinker)

lawsuits, at least potential lawsuits.

Q. How about the patient, did you ever talk to her about the lawsuit?

A. I have not spoken with her about her lawsuit, though prior to my moving out here she had indicated some dissatisfaction, And I think the potential might have been there.

Q. At that time did you give her any opinions one way or another about the lawsuit?

A. Not to her.

Q. To whom?

A. I was contacted by -- and I don't recall which firm it was -- I think it may have been Mr. Harms' firm, about any evaluation assessments for a potential lawsuit.

Q. And that would probably be one of the lawyers back in Cleveland, Mr. Blakely or Mr. Newman?

A. I don't recall.

Q. Do you have any notes from that conference?

A. I do not have that currently. I have to tell you that for some reason my notes on her did not arrive with me here. I can gather that perhaps it was left back in Cleveland, yes.

(By Ms. Reinker)

Q. Did you have more than one conversation with Mr. Blakely's office about her case?

THE WITNESS: Let me clarify. Mr. Blakely and you are the same firm?

MR. HARMS: Sure. Let me explain that. It would be good to have this in the record, too. Mr. Blakely is the plaintiff's attorney in this matter. Mr. Blakely and his firm practice law in Ohio. The case is pending now in Ohio. Yesterday Mr. Blakely contacted me and asked if I would sit in on this deposition for him. I'm just an attorney in Salt Lake City. Our firm only practices in Salt Lake City. And I have no other connection with the case other than being here today.

THE WITNESS: Okay. So he has not said anything to you, then, about anything?

MR. HARMS: He gave me a background of what the case was and why we are going to have this deposition.

Q. I believe my question was whether you had more than one conversation with Mr. Blakely or the plaintiff's lawyers about this case.

A. I have had more than one conversation with Mr. Blakely and his law firm with regard to Mrs. Bastian. I don't know whether those

(By Ms. Reinker)

conversations -- how each of those directly related to this case. At least one of them did.

Q. Were the other conversations just basically about the patient's condition, how she was doing?

A. About her -- yes, about her condition.

Q. Did you ever prepare any kind of a written report for Mr. Blakely or his firm?

A. I prepared a report where I was asked to give an assessment of potential lawsuit.

Q. And do you have a copy of that report?

A. I believe that should be back in Cleveland, or it should be in Mr. Blakely's files.

Q. What do you recall of the substance of that report?

A. The substance of the report was to say that I did not feel she was materially -- let me backtrack and say that I felt, you know, she had optimal care rendered.

Q. You are referring to by Dr. Koepke?

A. No. To my care of her. And, you know, the referral from Dr. Salwan, is it?

Q. So you did not make any comments about Dr. Koepke's care?

A. Dr. Koepke's name, I believe, did not come

(By Ms. Reinker)

up until, yes, your office contacted me.

Q. Did you render -- well, are you aware that the claim in this case is that there was a delay in diagnosing Mrs. Bastian's breast cancer of about a year?

A. That was not made clear to me.

Q. Were you ever asked to render any opinions as to whether earlier diagnosis would have made any difference in your management of this patient?

A. No.

Q. Doctor, have you ever had any conversations, since coming out here, with Dr. Silverman, Dr. Paula Silverman, about this case'?

A. No.

Q. Do you know Dr. Silverman?

A. Yes.

Q. How about Dr. Jean Stevenson, have you ever discussed the case with her?

A. No.

Q. Do you know Dr. Larry Levy in Cleveland?

A. No.

Q. Have you ever discussed the case with Dr. Levy?

A. No, I have not.

Q. Would you tell us just a little bit about

(By Ms. Reinker)

your background and training very briefly, where you went to medical school, your residency, that kind of thing?

A. I received my medical degree at Columbia University in New York College of Physicians and Surgeons. That was in 1978. I did my surgical residency at Yale Newhaven Hospital. I spent two years doing a surgical oncology fellowship at the National Cancer Institute,

Q. What year did you conclude that?

A. That was between 1980 and 1982. And then I joined the faculty at Case Western Reserve in 1985, and I was assistant professor there and also both in general surgery and specifically surgical oncology.

Q. What was your position there in 1989 when you cared for Mrs. Bastian?

A. I was still on the faculty. I was assistant professor in the department.

Q. In the department of surgery?

A. In the department of surgery. I had other cross appointments in general medicine. I was also in surgical oncology there, and I also was director of the breast clinic there.

Q. Is your -- do you have a subspecialty

(By Ms. Reinker)

field in surgical oncology?

A. We consider surgical oncology sufficiently

(By Ms. Reinker)

Q. In general surgery?

A. In general surgery.

Q. When you left in 1990, left Metro, did Dr. Jean Stevenson take over your practice?

A. I wouldn't phrase it quite that strongly. Many of my patients were referred over *to* Dr. Jean Stevenson, and others were sent to doctor -- another physician.

Q. Is Dr. Stevenson also a surgical oncologist?

A. She is a general surgeon. I am not aware of specific training that she received outside the training that was given to her during her residency in surgical oncology.

Q. Who was the chief of surgery at Metro at the time you were there?

A. Dr. Anthony Imbembow was chief of surgery, but he had left and I don't know the exact transition dates. We did have an acting chief of surgery at Metro, which was Dr. Monseur.

Q. Dr. Monseur?

A. Yes. And I don't know what year that was, but I believe Dr. Monseur may have been the acting chairman.

Q. Was he technically your boss, the head of

(By Ms. Reinker)

your department?

A. If he is acting chairman, yes, he would be.

Q. Now, Doctor, you have had a chance a little bit ago to look through the outpatient notes and the records that we give you on Mrs. Bastian?

A. Right.

Q. And from what I can tell, your first contact with this patient occurred on October 10th of 1989; is that correct?

A. That is correct.

Q. And I believe she was sent down to you or came to see you from Dr. Salwan at Parma?

A. Yes.

Q. I'm going to ask you some questions about parts of your consult note, of your patient note, and I want you to feel free to look at that note as I ask you questions. The note is three pages long, I think. Apparently on that date, Mrs. Bastian brought with her the mammogram film, because you refer to them in your note.

A. Yes.

Q. Do you have any recollection at all sitting here today of what those mammogram films looked like?

(By Ms. Reinker)

A. Very vaguely.

Q. Now, I think in your note you refer to the first mammogram as being in February of 1988. It was actually March 14th of 1988. You saw that film, the first film?

A. (Pause.)

Q. It's in the middle of the second page.

A. Right, Yes.

Q. Did you ever see the x-ray interpretation on that film?

A. I don't note that, so I have to assume that I did not see that, to the best of my recollection.

Q. Now, I have got that here and I would like to show that to you. It was interpreted on March 15th of 1988. And, basically, the report that was sent to Dr. Koepke finds no evidence of a malignancy and describes a dense area of the parenchyma. I think it's in the upper right quadrant?

A. Yes.

Q. Were you aware that on that date, March 15th of 1988, certainly around that point in time, no one felt any breast lump?

A. I did not have notes from there, so I can't comment on that.

(By Ms. Reinker)

Q. Now, the second mammogram that you looked at that day was from September 14th of 1989, I think it's probably the -- right there.

A. All right.

Q. And, again, had you ever seen that interpretation before, the one you are now looking at?

A. I don't recollect.

Q. Now, that interpretation describes an ill-defined lesion; correct?

A. Yes.

Q. And I think they give a dimension on it the of 1.8 by 1 centimeter?

A. Yes.

Q. Now, there was no description of any mass lesion in the first interpretation you looked at: correct?

A. Please ask me that again.

Q. If you want to just flip back, there was no description or documented size of any lump or mass in the first mammogram report in 1988, was there? You don't give any dimensions?

A. The report just notes an area of asymmetric dense mammary parenchyma.

Q. And they don't give any size,

(By Ms. Reinker)

measurements, or anything like that of size or measure?

A. I can't read a size measurement, looking at this note.

Q. Now, Doctor, do you have any knowledge from your experience working with breast cancer patients, of what size lesion -- what size does the lump have to be before it's first visible on mammography?

A. The technical resolution of the mammography is extremely fine, meaning we could pick up less than a 1 millimeter size lesion, such as microcalcifications. The interpretation, however, is quite different. So there may be variances between physicians as far as what they call a mass.

Q. Generally speaking, is it about, what, half a centimeter before they call it a defined mass?

A. That totally depends, so you can't make hard and fast rules.

Q. So, then, I gather you would have no opinion as to what would have been seen on a mammogram at any point in time prior to September 14th of '89? Let me try that one over again.

Do you have any opinion as to at what

(By Ms. Reinker)

point in time a specific mass lesion became visible on a mammogram -- could have become a visible mammogram for this lady?

A. Sometime between these two studies.

Q. But you have no opinion as to when specifically?

A. Not exact times, no.

Q. Have you ever seen any notes from Dr. Grant Libe? He was the first surgeon that Mrs. Bastian saw after September of 1989.

A. Was that at the time?

Q. I haven't provided those to you.

A. As I recall, and looking over my notes, I must have been privy to an operative note. But I don't have a copy of that here with me.

Q. And you don't recall seeing his office note?

A, No, I do not see an office note.

Q. Were you aware that when Dr. Koepke, my client, examined Mrs. Bastian in September of '89, he could not palpate a breast lump at that point in time?

A. I was not aware.

Q. And were you aware that when Dr. Grant Libe first saw her after the mammogram report came

(By Ms. Reinker)

back, Dr. Libe felt he could only barely palpate a lump?

A. I was -- I did not have those notes.

Q. In fact, he used needle localization to do the biopsy because of the difficulty he had in palpating the lump. Were you aware of that?

A. I knew he did a needle localization biopsy.

Q. And that's why needle localizations are done, aren't they, it's a lesion that's kind of hard to find?

A. We do needle localization biopsies for lesions that are either nonpalpable or difficult, and when the abnormality that we are going after is a mammographic abnormality.

Q. Meaning it's a mammographic abnormality, not a palpable abnormality?

A. Or some in some breasts it's difficult to examine. If we rely upon the abnormalities, the mammographic ones, then we have to rely upon some way of confirming. And that's done by needle localization.

Q. By the way, do normal doubling time theories, do they apply to infiltrating lobular carcinoma as well as intraductal carcinoma?

(By Ms. Reinker)

a. Tell me what your doubling theories are,

Q. Well, do infiltrating lobular carcinomas double as they grow from one cell to two to four to eight? Do they develop the same way an intraductal carcinoma develops?

A. You are asking an extremely complex question here, so I think I would have to ask you to be more specific. Cancer cells, in general,. unless either treated in some way, or unless the body defenses can handle it, grow. And growth means cell divisions.

Q. Let's just leave it at that.

A. Okay.

Q. Now, when you saw Mrs. Bastian, she did bring with her the pathology report on the biopsy that Dr. Libe had done; correct?

A. Correct.

Q. And you mentioned that also in your note?

A. Yes.

Q. That's on the second page again. And I think you say here that there was a 3.5 centimeter well-demarcated fibrous area.

Do you see that?

A. Right.

Q. Is that the size that we are considering

(By Ms. Reinker)

to be the size of her original tumor, the 3.5 centimeter well-demarcated fibrous area?

A. This was -- I was quoting from the pathology report. I was not assuming necessarily that that was the tumor. It's just an area there where they were suspicious, presumably, for the tumor.

Q. Do you have any opinion as to approximate size of her breast tumor as of September 1989?

A. I think you can probably say it's likely that the minimal dimensions were the ones that corresponded to the mammography.

Q. The 1.8 by 1 centimeter?

A. Yes.

Q. What is the relevance of this 3.5 centimeter area described in the pathology report from Parma Hospital?

A. It suggests that perhaps the tumor may have been 3.5 centimeters.

Q. So is it fair to say, in your opinion, that the size of the tumor in September of '89 was somewhere in between 1 by 1.8 centimeters and 3.5 centimeters?

A. Yes, grossly.

Q. Grossly? That means by --

(By Ms. Reinker)

A. That means by just view of the naked eye and by palpation. That's different than microscopically.

Q. Do we know what the size was microscopically?

A. I do not know.

Q. Were you able to find that anywhere in the records that I gave you to look at?

A. I'm not trying to trick you, Doctor, because, basically, I couldn't find it or figure it out. I could not. We make best guesses.

Q. And our guess is somewhere between 1.8 by 1 and 3.5, grossly?

A. Right. When we are asked for size, the best estimate will probably be the 3.5.

Q. Now, your conclusion when you saw the patient on October 10th was that, first of all, you wanted to review some more things. That's down at the bottom paragraph of that page. You wanted to look at the pathology slides that she brought with her; correct?

A. Yes.

Q. And you want to know what the ERPR receptors were, the operative margins, and then you were going to talk to the patient again?

(By Ms. Reinker)

A. Right.

Q. Now, in that last paragraph, which continues on the last page, you basically said that after you had done all these things you were going to consider either reexcision or a mastectomy €or surgical treatment of this patient?

A. Yes.

Q. Now, a reexcision is really a lumpcctomy? It's taking out the local area: correct?

A. Reexcision is a local resection of that area.

Q. Which the layperson calls a "lumpectomy"? Is it fair to use that term?

A. I would be careful about that. A lumpectomy is a little too loose.

Q. So let's call it a reexcision, which would not involve taking off the whole breast, just that local area?

A. Yes.

Q. Or a mastectomy, which involves taking off the whole breast?

A. Yes.

Q. So of your knowledge, as of October 10th, you felt that a reexcision might still be a possibility?

(By Ms. Reinker)

A. It's a possibility, though not necessarily a specific recommendation.

Q. But it was a possibility in that the 3.5 centimeter size alone did not rule out the possibility of a reexcision?

A. That's correct.

Q. Now, after that visit with the patient, you did look through the additional materials, some additional materials. I could not find another note where you saw her in her office again until after her surgery. Would you agree with that?

A. That appears to be correct.

Q. And that's why I brought with me that copy of a letter that you wrote to Dr. Salwan.

A. Yes.

Q. Do you have that there in front of you?

A. I do.

Q. I think I would like to have that marked.

(Exhibit 1 marked.)

Q. Now, this letter was written to Dr. Salwan, who was the referring doctor, dated October 13th, 1989?

A. Yes.

Q. And this was written, apparently, after you had had an opportunity, especially, to look at

(By Ms. Reinker)

the pathology slides. And you looked at those slides with a pathologist at Metro, Dr. Park?

A. Yes.

Q. And you came to the conclusion -- you and Dr. Park together, I presume?

A. Yes.

Q. Did you, by the way, actually look at the slides yourself? Do you remember? Or would you normally do that?

A. I usually do look at the slides.

Q. And that diagnosis was a diffuse infiltrating lobular carcinoma?

A. Yes.

Q. That's the type of cancer she had?

A. Yes.

Q. Now, it's my understanding that that type of cancer is relatively rare in the overall picture of breast cancers. I think it's about six to eight percent of all cancers are infiltrating lobular?

A. Yes. You could argue over a few percentage points, but that's the 10 percent.

Q. Clearly, this is not the most common type of breast cancer that you see?

A. That is correct.

Q. Infiltrating lobular cancer, carcinoma,

(By Ms. Reinker)

has some characteristics that are different from other kinds of breast cancer, does it not?

A. Yes.

Q. What is significant about this kind of cancer to you?

A. The infiltrating lobular carcinoma has basically two important things. One is that they do have, relative to the other, the common scirrhous type of breast cancer, a slightly more favorable prognosis. But it carries an increased risk for a bilateral/contralateral tumor.

Q. For the tumor appearing in the other breast?

A. Yes.

Q. Are infiltrating lobular carcinomas also thought to be, by some people at least, multicentric and multifocal in the breast?

A. I think we have a higher suspicion for multifocality, yes.

Q. Meaning that they can be present in more than one spot in the breast?

A. That can be true for any tumor.

Q. Is there a higher incidence or suspicion of that with infiltrating lobular carcinoma?

A. Usually infiltrating lobulars, when they

(By Ms. Reinker)

are infiltrating are one lesion. And because the standard of treatment used to be mastectomy, that sufficed the question of multifocality is a much more difficult one because that depends very much about how carefully the studies are done.

Q. When you wrote your letter to Dr. Salwan, what did you mean by the use of the word "diffuse infi1trating"?

A. I meant that there were areas that were involved with the carcinoma throughout, that this is not a well circumscribed lesion.

Q. There were areas involved throughout what, throughout the breast?

A. The slides. The pattern of the cancer cells were, one, suggestive of a more widespread type of involvement.

Q. Now, you sent to Dr. Salwan a -- in your letter you sent to him a copy of an article from Johns Hopkins University, a Johns Hopkins study from the Annals of Surgery?

A. Yes.

Q. Now, I think I got out the correct article. Is that the one you are referring to?

A. Yes.

Q. Now, that article was a study *of*

(By Ms. Reinker)

infiltrating lobular cancer patients; correct?

A. Yes.

Q. I think there were 99 patients with this type of cancer who were studied in that article.

A. Correct.

Q. **Is** it fair to say that the main focus of that article was to give physicians advice as to how to handle the other breast?

A. Yes.

Q. And then in that article, all 99 of those patients had radical or modified radical mastectomies?

A. Yes.

Q. The majority school of thought for treatment of infiltrating lobular carcinoma, at least in 1989, was that you do a mastectomy: correct?

A. In the country at large, yes.

Q. If Mrs. Bastian had been diagnosed with breast cancer sooner than she was at some point in time, it would have still been infiltrating lobular carcinoma: correct?

A. I don't know. How much sooner?

Q. Well, does ductal cancer become infiltrating lobular? Can we assume that since her

(By Ms. Reinker)

diagnosis in September of '89 was infiltrating lobular carcinoma, that if somehow somebody could have made that diagnosis a few months earlier, or a year earlier, it would have been the same type of cancer?

A. Sure. Early diagnosis of the same cancer would have given you the same cancer.

Q. That's my question. So if she were diagnosed even a year earlier, it still would have been infiltrating lobular carcinoma?

A. This is a little tricky. At some point a process started that became infiltrating lobular carcinoma, and it's one possibility that that's the diagnosis you would have.

Q. I guess just to -- once this process started, at whatever point in time it was biopsied, it would have been the same histological type?

A. Carcinomas don't change type.

Q. In your letter to Dr. Salwan, the second paragraph of that letter deals primarily with your thought as to how to handle her other breast; correct?

A. Yes.

Q. And that was because some physicians, or some researchers, have recommended going ahead and

(By Ms. Reinker)

removing the opposite breast to avoid the risk of

Q. But there are schools of thought that go both ways?

A, Yes.

Q. And the Johns Hopkins article basically arrives at the conclusion that you don't need to remove the other breast?

A. That is correct.

Q. Which is the treatment that you recommended for this lady?

A. That is correct.

Q. I should say that's the course you chose to follow with her, is to not remove the other breast?

A. That is correct.

Q. By the way, does anyone know why this

(By Ms. Reinker)

particular type of cancer has a higher incidence of developing in both breasts?

A. Not to my knowledge.

Q. If a patient gets this kind of cancer in both breasts, can it be at the same point in time?

A. Sure.

Q. Can it be at different points in time?

A. Yes.

Q. In either of those two cases, is -- are both breast lesions thought to be primary lesions?

A. That depends upon the pathology, but yes, we believe that a contralateral type of cancer in someone with a lobular debriscus or a second delobal primary.

Q. It's not considered to be a metastasis from the first breast?

A. No.

Q. Now, you recommended that Mrs. Bastian have a mastectomy of her right breast?

A. Yes.

MS. REINKER: Off the record.

(Discussion off the record.)

Q. And was that based on the type of cancer she had, the diffuse nature of her infiltrating lobular cancer?

(By Ms. Reinker)

A. Yes. It was -- that recommendation was based upon several factors. One was the type of cancer that it was.

Q. You say type of cancer?

A. Lobular.

Q. The infiltrating lobular.

A. And the diffuse nature of it, the uncertainty as far as the margins of resection and the size of the lesion.

Q. Again, the majority school of thought back in '89 was that a patient with this type of cancer needed to have a mastectomy; correct?

A. I would back off from "majority." I would say the most conservative, meaning the safest and best curative option, would have been that.

Q. In your opinion, was that the strongest indication for her to have a mastectomy, the histological type of cancer that she had?

A. No.

Q. Did you discuss with her the possibility of having a lumpectomy even at that point in time?

A. I had discussed with her various options but left the specific recommendation open until I had a chance to review the pathology and to review all of the other studies and to order up further

(By Ms. Reinker)

clinical studies.

Q. Was it your decision or hers to have a mastectomy as opposed to a local reexcision?

A. The decision is always the patient's.

Q. Did you discuss with Mrs. Bastian before her surgery the option for reconstruction of her breast?

A. I'm sure I mentioned that to her.

Q. Back in 1989, what sort of reconstruction would you have discussed with her or offered to her?

A. I offered to refer her to a plastic surgeon. I myself do not do the reconstructions. I refer that specific discussion to a plastic surgeon. I offer the patients the opportunity to speak with a plastic surgeon if they so desire.

Q. The type of reconstruction that would have been offered to this lady back in 1989, would that have been the type that would have been started at the time of her mastectomy?

A. There are many ways to do this, so I don't make a specific recommendation.

Q. Do you know whether she could have had a reconstruction that was done at the time of her mastectomy?

A. Yes, she could have.

(By Ms. Reinker)

Q. Do you know whether she was aware of that? Would you have told her that that was a possibility, if she so chose?

A. I'm sure I would have if she chose to go the reconstruction route. I would have mentioned that.

Q. Do you have any recollection of her response when you offered reconstruction?

A. Not specifically.

Q. Now, I would like you to take a look at the surgery note. Do you see that there? Primarily the pathology report from the surgery. Now, that procedure was done on October 23, I believe, 1989?

A. Yes.

Q. Did you do the surgery yourself?

A. Yes.

Q. Do you recall anything specific about that surgery?

A. Not extraordinary. It was a very smooth operation.

Q. Now, I would like you to take a look at the pathology report.

A. All right,

Q. My copy of that report is two pages long.

A. I have a copy here.

(By **Ms.** Reinker)

Q. Now, the entire breast that had been removed was sent down to the pathology department; correct?

A. Yes.

Q. I would like you to take a look at the first page of the pathology report.

A. All right.

Q. There is a longish paragraph?

A. Right.

Q. Now, the final diagnosis was "residual infiltrating lobular carcinoma of breast with multifocal lobular carcinoma in situ and focal lobular carcinoma in situ with apocrine features."

That was their final diagnosis; correct?

A. Right.

Q. Reading through the gross description about six or seven lines down, there is a sentence that begins, "On sectioning the specimen through the nipple.. ." Do you see that sentence?

A. Yes.

Q. It says, "An irregular area of fibrosis deep to the nipple is noted, and that area measured approximately 2 by **1.8** centimeters"?

A. Yes.

Q. That's one area. Then going on further

(By Ms. Reinker)

down there is another sentence, just four or five up from the bottom of that paragraph. It starts, "On serial sectioning of the breast..." Do you see that sentence?

A. Yes.

Q. It says, and I'm quoting, "An irregular area of fibrosis with fine nodularity is felt in the inferior medial quadrant of the breast. That area measured 3.5 by 2 centimeters"?

A. Yes.

Q. And then the report goes on to say, "The rest of the breast shows irregular areas of fibrosis"?

A. Yes.

Q. Now, there is no specific microscopic description that I could find of those three areas. It seems to me that -- did you ever see a microscopic report on this pathology report that you remember?

A. Yes, there should be.

Q. There is something missing here, isn't there?

A. There may be something missing because you have here labeled eight through W, all of the sections that were done. So, two things; one is

(By Ms. Reinker)

that those would have been read out, and they have also -- they should have the slides on file.

Q. We haven't been able to find any microscopic report yet at Metro on that. But those areas that I had you look at, the one deep to the nipple, the one in the inferior medial quadrant, and then the irregular areas of fibrosis in the rest of the breast, could those areas have also been infiltrating lobular cancer?

A. From what I see in the report, I would not make that assumption, but it doesn't specify.

Q. I was just wondering if those were the areas that the pathologist referred to in the final diagnosis when they talked about multifocal lobular carcinoma in situ.

A. You have to make a very clear distinction here between infiltrating lobular carcinoma and in situ lesion. They are very radically different entities.

Q. But it's my understanding that there still is -- people aren't certain what the relationship is between the two; isn't that correct?

A. Right. We don't understand the full pathogenesis and the relation between the two.

Q. And carcinoma, lobular carcinoma in situ,

(By Ms. Reinker)

is still thought to be precancerous, isn't it?

A. It is felt to be a marker of high risk for infiltrating lobular carcinoma,

Q. So we just don't know the relevance of those areas that you and I looked at before as to what they were because we don't know the microscopic report on them; is that correct, the area deep to the nipple, the area in the inferior medial quadrant, and the other areas of the breast?

A. Not from reading this. Not until you have -- since they took the representative sections and reviewed each of those.

Q. Not until we see the microscopic report on those, we can't really tell what --

A. Right. The summary report does not specify specifically what each of those sections corresponded to.

Q. Is it even possible that those areas were either infiltrating lobular or lobular carcinoma in situ? That's a possibility, isn't it, from what we see here?

A. My interpretation of this is that they saw residual tumor, I presume, around the area of the prior biopsy. But, as you point out, you wouldn't want to make that assumption until you went back and

(By Ms. Reinker)

made correlations between the sections and the areas where it was taken from.

Q. Women who have breast cancer generally have had it, at least in microscopic form, for a very long time before it reaches the size that it can be diagnosable; correct?

A. You have to be more precise. What is "a very long time"?

Q. Sometimes years.

A. It could be years.

Q. Isn't there a general feeling that *to* get from that very first abnormal cell to a lesion that can be either seen on mammogram or palpated, it can be many years, sometimes?

A. It's a hypothesis.

Q. I mean, people don't just --

A. You don't go from one cell to a five centimeter lesion in one week.

Q. It takes some period of time for it to grow to the point it can be detected?

A. Yes.

Q. Now, in my copy of the Metro chart, I could not find ERPR studies, estrogen receptor/ progesterone receptor studies done. Were they done at Metro?

(By Ms. Reinker)

A. Yes. I have those reports here.
Q. What were they?
A. The estrogen receptor was 51 fentimals (phonetic) per milligram of protein.
Q. That would make her ER positive; correct?
A. Yes.
Q. And the progesterone?
A. That level was five fentimals per milligram of protein.
Q. Is that what you would consider borderline? It's positive but it's a low positive?
A. The Nichols Institute considers five through 100 positive.
Q. So she was high, but she was on the very low end of it?
A. So she was positive, and she was at the low end of positive.
Q. Now, you excised 17 lymph nodes at the time of her surgery?
A. Yes.
Q. And they were all negative; correct?
A. Yes.
Q. And Dr. Stevenson, in her notes later on, makes reference to DNA flow cytology studies?
A. Yes.

(By Ms. Reinker)

Q. I didn't see those either in my copy of Metro charts.

A. I have those available,

Q. I'm going to ask you for copies of those today before I leave.

A. Sure.

Q. She says, basically, that the cytometry showed the tumor was diploid (phonetic)?

A. Yes.

Q. And there was a low S phase?

A. Yes.

Q. And all of those things are good prognostic factors, are they not?

A. Yes.

Q. The absence of positive nodes, the positive ERPR, the diploid nature of the tumor, and the low S phase, those are all favorable prognostically?

A. Yes, all favorable prognostic indicators.

Q. In addition to that, you did all the series studies for metastatic diseases, looking for tumors spread throughout her body?

A. Yes.

Q. And that was all negative as well?

A, Yes.

(By Ms. Reinker)

Q. And that was also a positive finding?

A. It meant she had no metastasis detected.

Q. Good prognosis at that point?

A. It meant that, for the tumor, she had the best prognosis.

Q. Dr. Stevenson, in some of her notes later on, referred to this patient as a stage one. Would you agree with that?

A. No.

Q. And why would you disagree with that?

A. Because a 3.5 centimeter lesion is catagorically a stage two.

Q. Would that alone make her a stage two?

A. Yes.

Q. Dr. Stevenson referred to her as a low-risk patient. Would you disagree with that?

A. She was biologically low risk.

Q. All those positive prognostic factors that we talked about before, ERPR, DNA flow studies, let's see here, the absence of nodal involvement, the low S phase, the diploid nature of the tumor, we can assume that those results would all have been the same if this tumor would somehow have been removed at some point in time, can we not?

A. It's reasonable.

(By Ms. Reinker)

Q. Now, your plan of treatment for this patient after this surgery was what?

A. She was placed on adjuvant therapy,

Q. Now, my understanding is the only treatment she got was tamoxifen?

A. Yes

Q. And that is a medication given to suppr ovarian activity?

A. Tamoxifen is an antiestrogen.

Q. And the reason she was given tamoxifen because she had the ERPR positive findings; is th correct?

A. She was given tamoxifen for four reason The first was that she was estrogen receptor positive. Her tumor was, I presume, at least 3.5 centimeters. She was postmenopausal. And tamoxi has relatively few side effects.

Q. Would she have gotten the tamoxifen if diagnosis had been made at some point earlier, assuming she was postmenopausal and ERPR positive the point of diagnosis?

A. She may not have gotten it.

Q. At what point in time would she not hav needed it?

A. She may not have needed it, and you hav

(By Ms. Reinker)

to remember that we are now in an area where there is a tremendous amount of controversy. But if she were a small lesion, one could make the argument that she may not have required it, or that one might not have recommended tamoxifen,

Q. How small?

A. Less than three centimeters, at least according to the studies that have been done.

Q. Now, you told me earlier that it's possible in this case that the tumor size described -- that -- in this case we really don't know for certain her exact tumor size; correct?

A. Exactly, we may not.

Q. So is it fair to say that in the height of caution you decided to give her the tamoxifen?

A. I made the best reconstruction from the data available of what I thought her tumor size, et cetera, were.

Q. Does tamoxifen play any impact on the development of cancer in the other breast?

A. It may.

Q. What is novadex?

A. Tamoxifen.

Q. Is that the brand name for tamoxifen?

A. Yes.

(By Ms. Reinker)

Q. Is there a reason, if these patients are at higher risk of developing -- patients with infiltrating lobular carcinoma can develop it bilaterally, is there any reason that they are not put on full chemotherapy?

A. We usually reserve chemotherapy for treatment. So standard cytotoxic chemotherapy, I don't know of anyone who would treat with that for the other breast. Some people might argue that she should be put on cytotoxin chemotherapy as an adjuvant therapy. This business of tamoxifen, you are going to see, as an adjuvant therapy, as quite controversial right now.

Q. Now, this lady did not get routine cytotoxic chemotherapy, did she?

A. No.

Q. Tamoxifen is not considered that kind of chemotherapy?

A. It's a hormonal agent. It's called a what?

A. A hormonal agent.

Q. What was your plan for follow-up with this patient?

A. Follow-up would be examination every three months, yearly contralateral mammography, blood work

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when she was seen every three months, chest X rays every six months, and bone scan yearly.

Q. There is some indication that this patient may now have an abnormality in her other breast. If that in fact is occurring, would that surprise you?

A. It wouldn't surprise me, no.

Q. That's part the bilateral nature of infiltrating lobular carcinoma; correct?

A. It depends on what it is. Our index of suspicion and care with which you follow the other breast is heightened by lobular carcinoma.

Q. Assuming that she still does not have any evidence of metastases, would the development of an infiltrating lobular carcinoma in her other breast change your prognosis?

A. Prognosis with respect to?

Q. For long-term survival.

A. It depends on the other breast lesion, when that is detected, at what stage.

Q. This lady now apparently has developed some form of leukemia. Are you aware of that?

A. I was aware of that in, **I** think, my last conversation with the law firm.

Q. What did they tell you about that?

A. They said, I believe, chronic lymphocytic

(By Ms. Reinker)

leukemia.

Q. Does that have any relationship to her breast cancer?

A. Not that I am aware of.

Q. Do you have any -- have you been given any idea what her prognosis is from her leukemia?

A. No.

Q. Do you treat patients with that kind of leukemia?

A. I refer them to a medical oncologist.

Q. Based on your general knowledge, what is your prognosis for that kind of leukemia?

A. It varies.

Q. You have no opinion, in her case, what her prognosis is?

A. Not without looking at her smears, bone marrow, a whole series of evaluations.

Q. What is your opinion of what -- or what was your opinion back in 1989, when you were treating this lady as to her prognosis from her infiltrating lobular breast cancer, based on everything you knew after her surgery and all the prognostic studies that have been done?

A. I thought that she would fall into our best prognostic group, stage two carcinoma.

(By Ms. Reinker)

Q. Which was what percentage?

A. Better than 70 percent survival in five years.

Q. And you did not feel at that point that she needed radiation treatment of any kind?

A. Such as?

Q. I don't know. Did you ever discuss radiation with her?

A. When I discussed options for treatment, I would have said to her that if she had -- or if she decided, regardless of recommendations, that she wanted a local recission, then I would have suggested radiation. But not if she went total mastectomy and resection.

Q. So if she would have chosen to have a local recission, she would have gotten the radiation treatment?

A. I would have recommended that.

Q. But since she did not choose to go that route, she did not receive the radiation?

A. That is correct.

Q. You also did not feel she needed a full course of adjuvant cytotoxic chemotherapy?

A. I did not feel that would be in her best interest.

(By Ms. Reinker)

Q. Do you know what Dr. Stevenson's criteria was for calling this lady a stage one?

A. No, I don't.

Q. Basically, you considered her to be a stage two, based on an assumption as to what her tumor size was; correct?

A. Yes.

Q. If, in fact, her tumor size was 1.8 by 1 centimeter, as the mammogram report shows, then she would have been a stage one; correct?

A. Yes.

Q. And if that were in fact the true dimension of the tumor, where would that put her, prognostically, as a stage one?

A. Better than a stage two.

Q. And that's the best possible prognostic stage to be, is a stage one, is it not?

A. That's the earliest, yes.

Q. Do you know the difference between -- you said a better than 70 percent survival if she was a stage two, based on tumor size alone. But if her tumor size was under 2 centimeters, if in fact the mammogram was right and it was 1.8 by 1, what percentage rate of survival do'es she then have?

A. It would be better, but how much better

(By Ms. Reinker)

you can't say. These numbers are statistical numbers. So for any given patient, you know, they either get disease or they die from disease or they don't. But these are -- if you take a thousand women, they apply. So it gives you some sense of how well they might do. But it doesn't predict the outcome for each patient.

Q. Would her new development, the development of the leukemia, shorten her life expectancy?

A. Without knowing the current status of her leukemia, I can't answer that.

Q. How about it developing -- if indeed she was developing cancer in the other breast, would that shorten her life expectancy?

A. Not necessarily, if it's detected early and treated.

Q. And again, if she does develop cancer in the other breast, that's part of the course for some women who have infiltrating lobular carcinoma; correct?

A. And also for women who have in situ lobular carcinoma,

Q. And that is not considered to be a metastatic lesion from the first cancer?

A. Usually not, but you need to depend upon

(By Ms. Reinker)

the pathology. If, in fact, she develops it in the other breast, the same factor would apply that we talked earlier, that she has had it for a considerable period of time for it to become diagnosable. And, again, I think you have to be careful about what the considerable time factor is.

Q. What does that mean to you? How long would you say a woman has cancer cells in her breast before it can be become diagnosable?

A. That's a tough question now, because of mammography and all -- but occasionally we will pick up carcinoma incidentally. So very often we may be not looking at the cancer cells per se but a secondary response to it. So that's -- you know, I think you have to specify each situation.

Q. So you really have no opinion as to how long a woman has had cancer cells in her breast before they become diagnosable by mammography or any other way?

A. I have opinions, but I think in this case, especially with the in situ lesions, that would be extremely difficult to know. Because remember that there is a distinction between cancer cells per se and cancer cells that invade outside. And so you can have cancer cells, or what we call, you know, in

(By Ms. Reinker)

situlogical cancer cells, or has not yet developed the characteristics of invasion.

Q. So are you saying that if the pathology report on the breast that you removed found in situ cancer cells, you are assuming she also had those in situ cells in her other breast?

A. No, though she may, and I won't be surprised if she could have those.

Q. Doctor, is there anything that I haven't asked you about this case which you feel you would like to render some opinions about or talk about?

A. Specifically?

Q. I'm just asking if there is anything in your mind that you are burning to say, to tell me, about this patient or this case?

A. No, other than I think that this -- we are dealing with a histology that is infrequent, and we are dealing with a fairly diffuse process. And that makes decision making more complex than your standard run-of-the-mill breast cancer.

Q. This kind of cancer is somewhat difficult to diagnose, is it not?

A. I don't know how you mean that.

Q. I have read some articles that say that sometimes this is a hard cancer to diagnose because

(By Ms. Reinker)

of the way it grows, or something like that.

A. You would have to be more specific.

Q. Do you have any opinion as to whether -- well, I think I asked you this earlier, whether earlier -- at what point in time this breast cancer could have been diagnosed?

A. You can always diagnose it earlier, but the practical reality is, I don't know how much earlier you can do that. You have to have convergence of several things. One is what modalities you use to study and your level of suspicion.

Q. Well, I'm asking you to base that on the assumption that nobody was ever really able to palpate a breast lump. Dr. Libe thought maybe he could, but there was never really any palpable breast lump. We know the mammogram in September reported only a 1 by 1.8 centimeter lesion.

I'm just wondering if you had any opinion, with those assumptions, how much earlier it would have even been possible to diagnose this lesion.

A. I mean, you could -- you know, we have pathologic data showing that people sometimes will find carcinomas that were never detected. So it's a theoretical question which I think is, you know, not

(By Ms. Reinker)

helpful.

Q. So you really, then, don't have any opinion as to when this became diagnosable?

A. Not from what I can gather back here. Because you have an initial mammogram that apparently was read as being low suspicion, And then you have a second mammogram with a suspicious lesion. And if it wasn't palpable, then we really don't have other modalities as yet that would help us.

MS. REINKER: I think that's all I have.

MR. HARMS: I have a few, if I could follow up on a couple of things.

EXAMINATION

BY MR. HARMS:

Q. The first item is, when you were talking earlier about the actual decision of what type of surgical procedure to use, you indicated that you had advised Mrs. Bastian that there were a wide range of curative options. Did you recommend a single one of those to her as probably her best bet for a least intrusive yet best result, or did you just say, "Here is what we can do"?

A. I made a very strong recommendation for

(By Mr. Harms)

her to undergo a total mastectomy and mass redissection.

Q. And that is in fact what she underwent?

A. Yes.

Q. What were the considerations that you mace that strong recommendation upon? Why did you choose that route rather than something less invasive or a reecission?

A. Based upon the pathologic review.

Q. So, in your opinion, at least, at the time of the surgery you performed, a less -- a breast conserving procedure, or less intrusive procedure, other than the radical modified mastectomy that was performed was not in her best interest?

A. That is correct.

Q. Dealing with this histological type of carcinoma, just generally with an infiltrating lobular carcinoma, is that a higher risk of recurrence than a normal other type of breast cancer or, you know, what goes into determining what the risk of recurrence is?

A. The risk of recurrence is dependent upon histology and then all the other process prognostic factors that we talked about, like size of tumor, the differentiation of the tumor, the ERPR status,

(By Mr. Harms)

and the S phase, and the lymph nodes.

Q. So the size of the tumor at excision relates directly to the risk of recurrence?

A. It's one of the factors that weighs into recurrence risk.

MR. HARMS: Other than getting back into the doubling-rate-growth-chart area, I think everything that I had has been covered. So I don't think I have anything else.

FURTHER EXAMINATION

BY MS. REINKER:

Q. Doctor, are you aware of the current recommendation as to the cutoff point at which lumpectomies should no longer be performed?

A. There are different recommendations. In general, it has to do with the size of the lesion versus the size of the breast. And factored into it are also the histologic features of the particular tumor.

Q. Isn't it a fact that current thinking is that any tumor less than four centimeters in size can be safely handled with a lumpectomy?

A. Not necessarily.

Q. So you would disagree with any reports on

(By Ms. Reinker)

role in resection.

Q. And the fact that this lady had infiltrating lobular carcinoma played a role in your recommendation for a mastectomy?

A. The findings of positive margins from the primary biopsy and the diffuse nature made me make that recommendation, that she not undergo simple lumpectomy.

Q. Doctor, how did you happen to leave Case and come out here? Just out of curiosity,

A. I came up to head surgical oncology here.

Q. Just a different position you were offered?

A. It's a bigger scope.

Q. What is your position here?

A. I am associate professor here, and chief of surgical oncology for the University of Utah.

MS. REINKER: Okay. I have nothing else.

MR. HARMS: I have nothing else.

(Concluded at 11:00 a.m.)

REPORTER'S CERTIFICATE

STATE OF UTAH)
) ss.
COUNTY OF SALT LAKE)

I, ROCKIE E. DUSTIN, Certified Shorthand Reporter and Notary Public for the State of Utah, certify:

That the foregoing deposition of BENJAMIN KIM, M.D. was taken before me pursuant to notice at the time and place therein set forth, at which time the witness was put under oath by me;

That the testimony of the witness and all objections made at the time of the examination were recorded stenographically by me and were thereafter transcribed;

That the foregoing deposition is a true record of the testimony given by the witness and of all objections made at the time of the examination.

I FURTHER CERTIFY that I am neither counsel for nor related to any party to said action nor in anywise interested in the outcome thereof.

IN WITNESS WHEREOF, I have subscribed my name and affixed my seal this 5th day of May, 1992.

ROCKIE E. DUSTIN, CSR
Notary Public in and for the
County of Salt Lake, State of Utah

My Commission Expires:
July 4, 1993

NOTARY PUBLIC
ROCKIE DUSTIN
844 East Oxford Drive
Kaysville, Utah 84037
My Commission Expires
July 4,1993
STATE OF UTAH

WITNESS SIGNATURE CERTIFICATION

STATE OF UTAH)
) *ss.*
COUNTY OF _____)

BENJAMIN KIM, M.D. deposes and says: That he is the witness referred to in the foregoing deposition; that he has read the same and knows the contents thereof; that the same are true of his own knowledge,

_____

BENJAMIN KIM, M.D.

SUBSCRIBED and SWORN to before me this ___ day of _____, 19___.

_____

Notary Public

Residing at_____

My commission expires:

_____

CORRECTIONS

Deposition of: BENJAMIN KIM, M.D.
Taken: 4-30-92

PAGE	LINE	CORRECTION	REASON

SIGNATURE _____ DATE _____

October 13, 1989

EXHIBIT 1
DATE 4-30-92
WITNESS Kim
ROCKIE DUSTIN, REPORTER/NOTARY

Fayiz A. Salwan, M.D.
6789 Ridge Road
Parma, Ohio 44129

Dear Doctor Salwan:

Thank you for referring Roseaqnes Bastian. Her operative notes, pathology report, mammograms and pathology slides were all reviewed in conjunction with Dr. Yaqen. Radiologist, and Dr. Chung-Moon Park, of Pathology. The patient has a diffuse infiltrating lobular carcinoma and from Dr. Lieby's operative report and from the submitted slides it would appear reasonable to assume that there may be some residual tumor following biopsy. The mammogram shows bilateral calcifications which appear benign and the enlarging density for which the patient underwent biopsy. Because the lesion is described as being 3 cm and because of the diffuse nature of its histology, I would recommend that the patient undergo a total mastectomy with axillary dissection.

The management of the contralateral breast in lobular carcinoma has been controversial, but because the patient's left mammogram appears normal and relatively easy to interpret, both on physical exam as well as mammographically, close follow-up with physical exam q.3 months and yearly mammograms should suffice without necessitating prophylactic biopsy or mastectomy. A review of the Johns Hopkins experience just published in Annals of Surgery is enclosed for your perusal. I have conveyed these recommendations to the patient and her husband together with recommendation for a preoperative bone scan, CXR, and liver function test to exclude possible metastatic disease. Again, thank you for the referral. Please contact me if I can further elaborate.

Sincerely,

Benjamin Kim, M.D.

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