IN THE COURT OF COMMON PLEAS

CUYAHOGA COUNTY, OHIO

STANLEY T. MYSLIWIEC,
et al.,

Plaintiffs,

-vs-

JUDGE E. GALLAGHER
CASE NO. 339022

STANLEY R. GAHRING, M.D.,
et al.,

Defendants.

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Deposition of NATHAN LEVITAN, M.D., taken as if upon cross-examination before Kenneth F. Barberic, a Registered Professional Reporter and Notary Public within and for the State of Ohio, at the offices of Reminger & Reminger, Seventh Floor, 113 St. Clair Building, Cleveland, Ohio, a 8:10 a.m., on Wednesday, March 3, 1999, pursuant to notice and/or stipulations of counsel, on behalf of the Plaintiffs in this cause.

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On behalf of the Plaintiffs;

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On behalf *of* the Defendants
Dr. Gahring, Luebbers &
West Side Pathology.

MR. GORDON: Ken, will you mark that?

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(Thereupon, Plaintiff's Exhibit Levitan-1, Notice of Deposition, was mark'd for purposes of identification.)

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NATHAN LEVITAN, M.D., of lawful age, called by the Plaintiffs for the purpose of cross-examination, as provided by the Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposed and said as follows:

CROSS-EXAMINATION OF NATHAN LEVITAN, M.D.

BY MR. GORDON:

Q. Good morning again. My name is Harley Gordon. Seated next to me is my partner, Morey Heller. We represent the plaintiffs in the case and this morning because you have been identified as an expert in this case. I'll be asking you questions primarily in the area of your opinions and the bases of your opinions and then also other areas that might develop.

During the course of my questioning,

Dr. Levitan, please make sure you understand the question before you answer it. Do you understand that, sir?

A. I do.

the question, the question is not clear to you, please don't answer and tell me to rephrase it. Do you understand that?

A. Yes.

Q. If you want to take a break for whatever reason, please tell me and we'll stop these proceedings. Okay?

A. Yes.

Q. First of all, could you give us your full name and home address?

A. Nathan Levitan. 2980 East Belvoir Oval, Shaker Heights.

Q. And what is your professional address?

A. University Hospitals of Cleveland, 11100 Euclid Avenue, Cleveland, 44106.

Q. Mr. Scott was kind enough to forward to us a copy of your curriculum vitae. Let me hand it to you. Is that curriculum vitae which I have handed to you, there is a mark at the bottom February 18th, 1999, is that your current

curriculum vitae?

A. I actually have had some additional publications since this version

Q. Okay. Other than the additional publications, is there any other additions to this curriculum vitae which would bring it current and up to date?

A. Based on a very brief and cursory review of this, I don't believe so.

Q. Could you take more than a brief and cursory review then?

A. Since the completion of this version, as I mentioned, there are some additional publications, I have a somewhat different title at the cancer center and I have one additional degree.

Q. All right. Let's go over each of them then. What is your additional title at the cancer center?

I'm currently the medical director of clinical cancer programs for the cancer center and University Hospitals Health System, which is to say that I'm in change of overseeing cancer patient care.

When you talk about the cancer center, are you

talking by about the Ireland Cancer Center?

A. Correct.

Q. When did you assume that position?

A. Two years ago.

Q. Okay. You also indicated that you have received an additional degree?

A. I earned an MBA as of May of 1996 at the Weatherhead School.

Q. Okay. And then the last item is additional publications. And how many would those be?

A. I can't recall exactly, but perhaps three or four additional publications.

Q. Do any of those additional publications relate in any way to the issues in this case?

A. They do not relate to penile carcinoma.

Q. Okay. What generally do they relate to?

A. As I recall, I wrote a chapter on rehabilitation from cancer in a textbook, I have written an article on cancer and deep vein thrombosis and pulmonary embolism, and I have written a couple of articles on lung cancer, something on esophageal cancer.

Q. Okay. Could you please tell me what publication you authored a chapter for?

A. There's a textbook on rehabilitation medicine and

I was asked to write the chapter pertaining to cancer and rehabilitation.

Q. And could you tell us the author in the title of that publication?

A. I just received a copy of the textbook last week. I believe that the editor is -- you know, I can't remember. I can provide that information for you very easily following my return to my office this morning.

Q. Okay. Offhand, would you have a more current curriculum vitae than the one we have here now?

A. I don't have it with me, but I would be pleased to provide it to you.

Q. Okay.

MR. SCOTT: Off the record.

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(Thereupon, a discussion was had off the record.)

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Q. Dr. Levitan, while we're talking about publications, are there any publications identified in your curriculum vitae and those that you have supplemented to your curriculum vitae this morning that relate to any of the issues in this case?

A.

Q.

A.

or discuss specifically carcinoma of the penis.

Q. Okay. Do any of the articles or publications that you authored relate to dysplasia, carcinoma in situ, invasive cancer, generally speaking?

A. I can't specifically recall. That is not the focus of any of those articles.

Q. Okay. Where were you born?

A. Near Boston.

Q. Are you presently licensed to practice medicine in the State of Ohio?

A. Yes.

Q. Also I note that you have a license in Massachusetts?

A. Yes.

Q. Has your license to practice medicine ever been revoked or suspended for whatever reason?

A. No. And I should clarify that I have since

allowed my license in Massachusetts to lapse. I have not renewed it.

Q. So as we sit here today the only license you have to practice medicine is in the State of Ohio?

A. Correct.

Q. Now, you are board certified in hematology and oncology?

A. Correct.

Q. And that is one board certification, is that correct?

A. Two.

Q. Two separate?

A. Yes.

Which one, is there any order in which you take those?

It makes no difference which, in which order those exams are taken.

Okay. How did you take the exams, in what order?

A. I frankly would have to look at my curriculum vitae. It's been a long time.

Q. Okay.

A. My curriculum vitae indicates that I was boarded in internal medicine in 1983 in medical oncology in 1985 and in hematology in 1986

Q. Okay. Did you pass your boards on, for internal medicine on the first attempt?

A.

Q. Did you pass your boards for medical oncology on the first attempt?

A. Yes, sir.

Q. Did you pass your boards in hematology on the first attempt?

A. Yes.

Q. And referenced in your curriculum vitae is that you are board eligible for blood banking. What does that mean?

A. During the course of my postgraduate training I had enough exposure to blood blanking, which overlaps considerably with hematology, such that I could have taken those boards if I had wanted to.

Q. At the present time what is your practice in terms of specialty?

A. I practice general medical oncology currently.

Q. And how long have you been doing that?

A. I completed my training, as my curriculum vitae indicates, in 1986 and I have been practicing general medical oncology since that time.

Q. Do you have any subspecialty or special interest

in the area of medical oncology?

A. At the Ireland Cancer Center I'm the director of the thoracic malignancy research program. Although in terms of patient care I see all types of patients.

Q. With cancer?

A. Yes.

Q. Okay. And solely with cancer?

A Are you asking whether I see patients with any hemologic disorders?

Q. Let's take that out. The patients that you do see from -- well, I should phrase it this way, do you do general internal medicine?

A. There is a lot of general internal medicine in cancer care.

Associated with the cancer treatment, is that it? So the internal medicine that I practice is, occurs because cancer patients develop general medical problems.

Q. Okay. So, in other words, you don't do general internal medicine in and of itself?

A. Patients do not come to me for general medical care without either a diagnosis of cancer or a suspicion of cancer or a hematologic disorder.

Q. And has your practice been primarily in the

1990's at the University Hospitals of Cleveland?

A. I moved from Boston to the University Hospitals of Cleveland in 1991.

Q. Okay. Are you employed by the hospital? Or let me put it this way, what business relationship, since you have an MBA, do you have with the Ireland Cancer Center?

A. I am employed full time at the Ireland Cancer Center. The actual structure of my compensation is more complicated because I'm employed by a private practice based at the hospital. I would be pleased to go into that in more detail if you're interested.

Q. What's the name of the private practice group?

A. University Physicians, Incorporated.

Q. Okay. And you also -- strike that.

Do you also teach at the medical school?

A. Yes.

Q. Now, handing you what has been marked Exhibit 1, this is a Notice of Deposition that we forwarded to Mr. Scott regarding certain information which we would like relative to your involvement in this case.

Have *you* seen this Notice of Deposition before?

A. I don't believe so.
Q. Could you turn to the second page, please?
A. (Thereupon, the witness so complied.)
Q. We asked in Request Number 1 for your up to date curriculum vitae and you indicated you'll forward that to us?
A. Yes, sir.
Q. Number 2 *of* the Notice of Deposition requests your complete file, including your personal notes. Did you bring your complete file here today?
A. I have it here.
Q. Which consists of three pieces of paper?
A. Correct. Plus the records, which I didn't bring with me.

MR. GORDON: Okay. Why don't we mark these.

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(Thereupon, Plaintiff's Exhibit Levitan-2, Dr. Levitan's report, was mark'd for purposes of identification.)

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(Thereupon, Plaintiff's Exhibit Levitan-3, Dr. Levitan's notes, were mark'd for purposes of identification.)

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Q. Exhibit 2, am I correct, is a copy of your report consisting of two pages?

A. Correct.

Q. Dated December 14th, 1998, is that correct?

A. Correct.

Q. The report has some writing here, it says depo of?

A. I recently received a copy of the deposition of Mr. Mysliwiec. I added that because my report summarizes those records that I have reviewed and at that time I had not yet received that deposition for review.

Q. Okay. And when did you receive the deposition of Mr. Mysliwiec?

A. Yesterday.

Q. All right. Have you reviewed or read any other depositions in this case?

A. Everything that I've read for this case is indicated here.

Q. So you've read the treatment records and what did that consist of?

A. That consisted of all the records that were sent

to me by Mr. Scott and I did not break those down. Perhaps, Mr. Scott, you could help me with a breakdown of those.

MR. SCOTT: We gave, if this is all right with you, all the medical records, all the records of Dr. Kasick and Gahring and all the pathology reports, all of the records *of* Dr. Spirnak, records of all treaters up through the present.

Q. Does that sound correct to you?

A. Yes.

Q. Okay. Did you in any way summarize those record or take any notes relative to your review of those records?

A. I have, my style is to prepare notes as you see here and I have simply flagged important pages such as pathology reports in the record.

Q. Okay. Is there any reason why you didn't bring those records today?

A. I wasn't aware that, that that was requested.

MR. GORDON: We're just going to make a request to have an opportunity to look at those records.

MR. SCOTT: That's okay, Harley. I'll be happy to do that. I frankly did not

tell the doctor to bring anything.

Q. Okay. And then Exhibit 3 is what?

A. Is notes that I've made to summarize important dates that may be raised for discussion.

Q. And when did you prepare Exhibit 3?

A. I don't recall the exact date. But this was prepared following my review of the records several months ago.

Q. And would you have reviewed those records before you authored your report of December 14th, 1998?

A. Yes, sir.

2. And these notes, Exhibit 3, would have been prepared then before your report on December 14th, 1998?

A. Correct.

2. So in terms of this case, so I can understand specifically what you looked at, we know about the treatment records. Then in terms of depositions, you've only read Mr. Mysliwiec's deposition?

. Correct.

And did you ask to read his deposition?

I simply read those records that were sent to me by Mr. Scott.

Q. Okay. Do you have any understanding why

Q. So as we, at the present time you have not read Dr. Luebbers, is that correct?

A. Correct.

Q. In addition, you have not read the depositions of any of the expert witnesses in this case?

reviewed are listed in the letter in front of you.

Q. Okay. You looked at the reports of Dr. Nuovo and Dr. Lee?

A. As I indicated, all the records that I reviewed are in the letter in front of you.

Q. Do you know Dr. Lee?

A. I don't believe so

Q. Okay. Give me one moment. Let me read your notes.

In your notes you state, I think you also indicated this in your report, that Dr. Kasick stated in his deposition he wanted to refer him

to Dr. Gahring or another urologist. Where did you get that information if you didn't read Dr. Gahring's deposition?

A. Well, I must have. I stand corrected. That must have been included in those notes. As I told you, I read these records several months ago. I did not re-read the records prior to today. I rely on my report to prepare for a deposition.

Q. In looking at these notes in Exhibit 3, the treatment records that you reviewed, was that through April of '97?

4. Yes.

2. Have *you* seen any additional records relating to Mr. Mysliwiec since April *of* 1997?

A. Not that I recall.

Q. Now, have you conducted any medical research in regard to this case?

No.

Q. Do you intend to use any demonstrative exhibits during your trial testimony?

21 A. I do not.

Q. Have you discussed this case with any individual other than Mr. Scott and/or any attorney in the Reminger & Reminger law firm?

A. No.

Q. Have you -- strike that.

Do you know Dr. Luebbers?

A. No.

Q. Do you know Dr. Gahring?

A. No.

Q. Do you know Dr. Kasick?

A. No.

Q. Do you know Dr. Spirnak?

A. No.

Q. Do you practice pathology?

A. No.

Q. Do you practice urology?

A. My practice is limited to medical oncology. Though as a medical oncologist I care for patients with urologic malignancies though I'm not a urologist, I'm not a surgeon, I don't do the type of procedures that urologists do.

Q. other than as it relates to cancer?

A. only a urologist would be qualified to carry out.

Q. Okay. The patients that you do see that have urological problems are those that relate specifically to cancer?

A. Correct

Q. In other words, you see those patients that already have cancer associated with the urological tract, is that correct?

A. That either have cancer or suspected cancer.

Q. Okay. Do you treat patients with lesions of the penis that have not been diagnosed as cancer or pre-cancer?

A. I have seen such patients, though my care for any such patient would be in close association with other physicians such as urologists and dermatologists.

Q Okay. So the patients that you do see who would have skin lesions on the penis would be based upon a referral from a urologist or dermatologist?

A The referral could come from anyone. Though all patients that are referred to me either have an established diagnosis of cancer or a suspicion of cancer.

Q. Okay. Just to clarify one point, the patients that you do see with skin lesions, let's say of the penis, are referred to you?

A. Every patient who comes to me is either referred by another physician or is self referred.

Q. Do you practice dermatology?
A My answer to that question would be analogous to the previous line of questioning.
Q. No. Do you practice surgery?
A. Ditto. My answer would be analogous to the previous line of questioning.
Q. Do you practice surgery?
A. No. I work closely with surgeons.
Q. Do you know what a Mohs' procedure is?
A. I do.
Q. What is a Mohs' procedure?
A. A Mohs' procedure is a technique practiced generally by dermatologists in which a thin layer of skin is removed in an effort to eliminate a malignancy and there is an interim analysis during the course of the procedure to determine if additional tissue needs to be removed.
Q. And to your knowledge has the Mohs' procedure been utilized in the treatment of penile cancer?
A. I do not know the answer to that.
Q. Do you know whether any topical chemotherapy cream is associated or used with penile cancer?
A I've never been involved in the treatment of penile cancer with that modality.
Q. Do you know whether laser treatment is used in

conjunction with penile cancer or a pre-cancerous condition?

MR SCOTT: Oops That's two questions I mean to clarify I'm sorry It is not really two questions. But I want to make sure that the doctor. I want to make sure the doctor heard You were talking about cancer initially.

MR. GORDON: I'll break it down then.

MR SCOTT: Okay

Q Do you know whether or not a Mohs' procedure is used in conjunction with the diagnosis of dysplasia or carcinoma in situ relative to a penile lesion?

A That is outside my area of expertise I do not know the answer to that

Q Similarly, do you know whether topical chemotherapy treatment is utilized in terms of dysplasia or carcinoma in situ identified in a penile lesion?

A I have never used such a treatment in following patients with penile carcinoma

Q Do you know whether that's used in the treatment of such a condition?

A In my experience I'm unaware of it

Q. By reading the literature are you aware that this type of treatment is used?

MR. SCOTT: You're assuming it is?

MR. GORDON: Yeah.

A. I have not been involved in such treatments and I do not know.

Q Okay. And do you know whether laser therapy is used in a situation where you have dysplasia or carcinoma in situ identified in a penile lesion?

A. It is my understanding that surgeons are using laser excision in most areas of the body. The experience that I've had with penile carcinoma has involved more traditional surgical techniques.

Q. And those are what?

A. Excisional biopsy and other conventional surgica procedures to treat cancer.

2. When you say other conventional surgical treatments, what are those as it relates to the treatment of penile cancer?

A. Surgical procedures that involve surgical instruments that are conventional, that are scalpels and knives and so forth.

Q. The long and short of it, to remove the cancer and the surrounding tissue?

A. Correct.

Q. And the excisional biopsy is done by a urologist dermatologist and/or surgeon?

A. Correct.

Q. And the surgical procedures are done by a urologist and/or surgeon?

A. Correct.

Q. Do you know if dermatologists do surgical procedures relative to penile cancer?

A. They'll do superficial procedures, but generally not complex procedures.

Q. Do you receive or read publications directed to urologists?

A. I do not.

Q. Do you read -- strike that.

Do you receive any publications directed to dermatologists?

A. I read general medical oncology publications exclusively and internal medicine publications.

Q. What textbooks do you from time to time look at in the area of oncology?

A. I use a whole variety of textbooks.

Q. Okay.

A. Including DeVita, including Haskell, I frequently use computer literature searches, Harrison's

Textbook of Internal Medicine and others, the authors of which I can't immediately recall.

Q. Is DeVita's publication considered a reliable authority?

A. One of many.

Q. Is Haskell's publication considered a reliable authority?

A. One of many.

Q. And is Harrison's publication considered a reliable authority?

A. One of many. There is no single supreme authority among those textbooks.

Q. What has your experience been in terms of penile cancer in terms of how many cases you see a year?

A. Penile cancer is a rare disorder. No medical oncologist can specialize in this area. In my career I have seen perhaps a dozen cases.

Q. And your career would be approximately how many years?

A. Just over twelve years.

Q. Did you see any penile cancer cases during your internship, residency and/or fellowship?

A. I'm sure I did.

Q. Okay. So that would increase the amount?

A. Correct.
Q. When is the last time you were involved in the treatment of a patient who had penile cancer?
A. December.
Q. And what role do you play in terms of the treatment of a patient with penile cancer?
A. My involvement is to assist with decisions regarding the need for chemotherapy, the need for radiation therapy and prognostic assessment.
Q. Prognostic assessment means what?
A. Helping to determine the prognosis of the patient with such a cancer.
Q. That means what the future would foretell for the patient?
A. And accordingly what treatments would be needed.
Q. Prognostic assessment would be assessing the potential life expectancy of a patient, is that correct?
A. Correct.
Q. Do you also do staging of penile cancer?
A. Staging is a very simple process that is determined by data provided by the surgeon and pathologist.
Q. Are you saying then that you rely upon this staging of the surgeon and/or pathologist?

A. I'm familiar with the staging categories of penile carcinoma and the data used to determine the stage are provided by the surgeon and the pathologist.

Q. Okay. Do you independently stage penile cancer?

A. Whenever I see a patient I review the available data and determine the stage and if for any reason I disagree with the staging assigned by other physicians I would so indicate.

Q. Have you done any studies in the area of the treatment and prognosis of patients who have penile cancer?

MR. SCOTT: Any studies, you say?

MR. GORDON: Yes.

MR. SCOTT: I'm sorry. I wasn't listening. I apologize.

A. All the studies that I have done have been published. And we've discussed the relevance of my publications to penile carcinoma.

Q. So have you done any studies in that area?

A. I believe that I have answered your question.

Q. I don't think you have. I mean yes or no, have you done any studies in the area of penile cancer?

A. I haven't done any studies that specifically

focused on penile carcinoma.

Q. Okay. I notice you are looking at your watch. What time do you need to leave?

A. I need to leave here by ten o'clock.

MR. SCOTT: What time is it? Almost 9:00?

MR. GORDON: Yeah.

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(Thereupon, a discussion was had off the record.)

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Q. Have you consulted with the Reminger & Reminger firm before?

A. I have done expert witness work for them before, yes.

Q. Have you done expert consultations with Mr. Scott before?

A. Yes.

Q. On how many occasions?

A. I don't recall the number.

Q. Okay.

A. A small number.

Q. Have you ever acted as a consultant for a patient?

A. Yes.

Q. On how many occasions?
A. Several.
Q. In the greater Cleveland area?
A. Some in the greater Cleveland area and I believe one in New England.
Q. All right. And in terms of the cases that you have participated in, either by review or giving a report or deposition, going to trial, what would the percentage be of plaintiff versus defendant, patient versus medical care provider?
A. There is a fair representation of both. There may be a slight majority pertaining to defense of the physicians involved, though there is significant representation on both sides.
Q. Could you give me the percentage?
A. I can't.
Q. How many cases do you review a year?
A. I would guess perhaps six to eight cases a year.
Q. And how much do you charge an hour for your review?
A. 250.
Q. And what do you charge for a deposition?
A. It's the same.
MR. SCOTT: $7,000.
Q. And trial?

A The same

Q Have you ever testified in a case involving dysplasia, carcinoma in situ and or carcinoma of a penile lesion?

A I have never testified regarding carcinoma of the penis I cannot recall whether issues of dysplasia and so forth in other cancers have come up I have probably have

Q I was. I overlooked one area What role do you play in the treatment of a patient who is diagnosed with dysplasia of a penile lesion?

A As a medical oncologist I'm often involved in coordinating the care of cancer patients who are seeing multiple specialists A patient with dysplasia would not specifically require services such as chemotherapy that are particular to a medical oncologist. But my involvement would be as a coordinator of care.

Q Which means what as a practical matter?

A Which means following such patients periodically and reviewing reports of other physicians to make sure that the care provided is appropriate

Q Okay What role do you play in a patient who is diagnosed with carcinoma in situ of the penis?

A The same A medical oncologist, as an internist,

plays an important role to make sure there is appropriate follow-up and that the appropriate specialists are involved in that patient's care.

Q For what purpose?

A As I said, it's very important that the patient has coordinated medical care and the medical oncologist generally often plays the role of coordinating such care.

Q In your experience have you seen patients who have had dysplasia which resulted in a laser procedure?

MR. SCOTT: I'm sorry. Just at that stage or after it developed into cancer?

MR. GORDON: No. Just at that stage.

A As I believe I've said, in the dozen plus cases that I have been involved in the surgical procedures have not involved laser treatment

Q Okay. What would apply both to dysplasia, moderate dysplasia and/or carcinoma in situ?

A. Correct.

Q. Then when you have invasive cancer your role would be that of the penis?

A Precisely the same. Determining what types of intervention are needed by multiple specialists.

following that patient over time and coordinating care

Q Okay In terms of the decision whether or do a Mohs' procedure or use a topical chemotherapy treatment for dysplasia or carcinoma in situ, that decision would be made by the urologist or the dermatologist?

A. Correct.

Q. Not you?

A. Correct.

Q. And similarly the decision whether to use a laser procedure or surgical intervention of, of a penile lesion with dysplasia or carcinoma in situ, that would be the decision of the urologist and/or dermatologist or a consulting surgeon?

MR SCOTT: If those modalities are used at that stage?

MR. GORDON: Right.

A Correct.

Q Now, with respect to your report, Exhibit 2, have -- let me rephrase

Am I correct that all your opinions are contained in Exhibit 2?

A That's a very broad question

Q And it's purposely that way. Because at this

stage of these proceedings I'm entitled to find out your opinions and the bases for your opinions. What's why I'm asking, are all your opinions then contained in Exhibit 2?

A. I can't at the moment recall any major points that I have to make that are not included in that document

Q. Okay. Then do you have an opinion as to what the accepted standard of care was for Dr. Luebbers in reading the pathology slides?

A. Could you restate your question?

Q. Okay. Do you have an opinion, to a reasonable degree of medical probability, as to the standard of care required of Dr. Luebbers in reading the pathology slides in February of '93?

A I'm not sure how to answer that question.

Q. And why is that?

A. When one asks a question about standard of care one could list a hundred principles pertaining to pathologic practice. It would be more helpful to me if you could ask a specific question regarding her practice and I could answer as to whether or not that is within the accepted standard of care in my opinion

Q And you feel you are qualified to address what

the accepted standard of care of a pathologist is even though you don't practice pathology?

A I could only comment within my expertise as a medical oncologist

MR SCOTT: Harlan, if it helps in any way, I am not going to be asking him any questions about any pathology, that is what features of a pathology slide might be consistent with what conditions

Q From your understanding, is it the accepted standard of care for a pathologist to accurately interpret tissue on a slide?

MR. SCOTT: I object to that. I don't know what you mean by accurately

A. I would concur.

MR SCOTT: And that's a legal question and it's not appropriately a question. The appropriate legal standard is what is reasonable.

Q. Can you answer the question?

A It is my understanding that a pathologist is trained in the interpretation of tissue specimens and it is his or her obligation to apply that expertise in pathologic evaluation.

Q And going forward, wouldn't you agree that

the accepted standard of care of a pathologist is to appropriately read the tissue that's presented for interpretation?

MR SCOTT: I object to that because that's not a proper question as to what is appropriate You may think appropriate --

Q Well, let me put it this way --

MR SCOTT: There needs to be a definition of appropriate

Q Let me put it this way, assuming hypothetically that tissue presented to a pathologist contains tissue and cells that are either moderate dysplasia or carcinoma in situ, do you agree the accepted standard of care would be for a pathologist to identify those conditions?

MR SCOTT: Objection.

A Recognizing that pathologic interpretations are not black and white and that there is often considerable room for interpretation among different pathologists, I would expect a well trained pathologist to render an opinion that is within the range of interpretation that is determined to be correct in accordance with a community standard.

Q In this case we have the Plaintiff's expert,

Dr McCartx, reading the slides of ebruary of 1993 and he identified moderate ays lasia. Were you aware of that?

A Yes

Q Okay You were also aware that in July of 1996 the issue of the February of 'EE idEy was re-read by two at ologists at Metro and the identified moderate ayElasia, is that correct?

A H have seen those reports

a Okay In addition, were you aware that during the deposition of Dr. Blath he indicated that he had two athologists reviewed the slides and the identified moderate ayElasia?

A I don't specifically recall that detail, but I believe you.

Q. Okay. We'll take that out.

Did you also, were you also aware that Dr. Bernard Ackerman, a dermatopathologist, reviewed the slides and indicated that signs of superficial squamous cell carcinoma were present?

A I was not aware of that

a All right Let me mark this.

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(Thereupon, Plaintiff's Exhibit Lewitan-4, r. Acxermen's report, was mark'd for

purposes of identification.)

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MR. GORDON: Back on the record.

Q. You have now read Dr. Ackerman's report, Exhibit 4, is that correct?

A. Yes.

Q. And the first time you have seen Dr. Ackerman's report is today?

A. Correct.

Q. You were never provided then Dr. Ackerman's report or his opinions before today?

A. Not as far as I can recall.

Q. Do you know Dr. Ackerman?

A. No.

Q. Now, then to go back with what we were discussing, Dr. Ackerman in his view of the slides finds superficial squamous cell carcinoma, is that correct?

A. His report so indicates.

Q. Okay. So we have Dr. McCarty identifying moderate dysplasia, two pathologist at Metro identifying moderate dysplasia and we have Dr. Ackerman identifying superficial squamous cell carcinoma, is that correct?

A. As you demonstrated.

Q Okay. And then we have four pathologists reading these slides to contain moderate dysplasia or superficial squamous cell carcinoma, is that correct?

A As you've demonstrated

Q In comparison to Dr. Lubbers' interpretation of basically reparation atypia?

MR SCOTT: Now that's an improper question where is not only Dr. Hubbard, that's Dr. Connor, that's Dr. Al-Kaisi, that's Dr Nuovo, all of whom are pathologists and all of whom agree that that is only atypia

MR GORDON: Who is Dr Co over?

MR SCOTT: He is another pathologist who read this pathology all those say atypia So you don't have quite the balance that you've indicated. But now, Harlan, let's march on. We have 50 minutes and this is not a subject that he's going to be talking on.

Q So in terms of whether Dr Lubbers associated from the accepted standard of care in the interpretation of these slides, you don't have any opinion?

A As a medical oncologist I certainly cannot interpret pathology slides.

Q Okay. Then do you have an opinion, to a reasonable degree of medical certainty and/or probability, what was present in the penis of Mr. Hyslop in February of 1993, was it dysplasia, carcinoma in situ or a benign condition?

A I'm not qualified to make such a determination.

Q And in rendering your opinions does it matter what was present in terms of whether it was moderate dysplasia, carcinoma in situ or a benign condition at that time?

A It would be more hopeful to me if you could ask me a specific question and I will tell you whether that distinction is important

Q And why do you say that?

A When you ask me a question like in rendering my opinions, that's extremely vague. But I would be happy to answer a specific question and indicate whether that distinction is important

Q Okay. Assuming hypothetically that -- let me back track.

What do you understand superficial squamous cell carcinoma to mean?

A Again, it's a very vague question.
Q When you read Ackerman's report to indicate superficial squamous cell carcinoma, what did that mean to you?
MR SCOTT: Does he say carcinoma in situ? Signs of superficial squamous cell
A. When a pathologist determines that frank carcinoma is present, as a medical oncologist would indicate the importance of making every effort to remove that carcinoma
Q. Why?
A. The primary treatment for basil carcinoma, as with most cancers, is to perform complete surgical removal.
Q. Now, based upon what Dr. Ackerman says, signs of superficial squamous cell carcinoma, does that mean to you frank carcinoma?
MR. SCOTT: We, we don't know what it means. Harley, and if you want to give him that hypothetical, if in the event there was frank carcinoma is that invasive cancer, that's what you are saying?
MR. GORDON: No, I'm not saying that I'm just saying why limited
MR SCOTT: This doctor can't really

interpret what another doctor is saying by that definition as opposed to

A Perhaps I can answer your question this way, if I had a patient with a penile lesion and frank carcinoma identified therein I would recommend surgical excision of the lesion

Q. All right. Then I'm saying in terms of what you have just said, when there is a reference to signs of superficial squamous cell carcinoma, would you then on the basis of that pathological diagnosis recommend excision?

MR SCOTT: Well, he don't know what he means by that he don't know what Dr Ackerman means by that Is it invasive cancer, metastatic, is it simply carcinoma in situ, is it dysplasia? You can't take that person's definition and then ask the doctor how to apply it.

Q. Can you answer my question?

A Again, the best way I can answer your question is if a patient under my care has a lesion on the penis which is determined to be frank carcinoma, that excision is the appropriate treatment in fact it hadn't already been carried out

Q All right Assume hypothetically t at there is

present carcinoma in situ of the penile lesion, what would your recommendation be in terms of treatment?

MR. SCOTT: The doctor has answered that question.

A. Again the same answer as I provided a minute ago, surgical excision is the appropriate treatment if it has not already been carried out.

Q Okay. Now, if you have moderate dysplasia identified in a penile lesion, what is your recommended course of treatment?

A If it is possible to resect the area that involved dysplasia that is reasonable. If it is a wide area than either excision or very close follow-up would be indicated depending upon the details of the lesion.

Q. So with respect to a pathologic diagnosis of a lesion of the penis which has moderate dysplasia, the preferable recommendation is to have excision, is that correct?

A If it is feasible to perform an excision and it isn't excessively disfiguring, excision is preferable. But there are many cases because of the nature of the organ where very close follow-up is also appropriate.

Q Why is excision preferable?
A If there's --
Q Under those circumstances?
A As with any part of the body, if there is a localized area of dysplasia that can be easily removed that is the preferred course. But, again, if it is an extensive area, as is often the case, close follow-up is needed and excision may not be feasible,.
Q. Okay. Excision is preferable because you can remove the moderate dysplasia and that reduces the risk of developing invasive cancer, is that correct?
A. Correct
Q. Okay.
A. If it is present in a very localized area.
Q. Okay. In this opinion, in this case do you have an opinion as to whether there is any moderate dysplasia of a localized area which would require an excision as the course of treatment?

MR. SCOTT: In this case?

MR. GORDON: Yes.

A. As I understand it, the area that was excised in February of 1993 was interpreted by some pathologists as showing dysplasia, by other

pathologist as not but in fact her case excision was performed. So regardless of whether or not dysplasia was present, the appropriate surgical procedure was completed.

Q And are you saying by that excision all the dysplastic cells were removed at that time, to a reasonable degree of medical certainty?

A Well, I can't answer that question because there's not a uniform agreement that dysplasia was present at all.

Q Assuming moderate dysplasia was present, were all the cells involving moderate dysplasia removed?

A I'm unable to answer that question.

Q Do you know what the, do you know what I mean when I say margins in terms of a pathological specimen?

A I do.

Q Do you know whether, in terms of the February of '98 specimen whether margins were identified?

A I am not aware of pathology reports which specifically indicate a positive margin following review of this lesion.

Q Okay. And if you don't have the report involving -- let me rephrase the question.

If you don't have margins identified you

can't determine whether the dysplastic cells or the cancerous cells are beyond the area of margin, is that correct?

MR. SCOTT: Objection.

A. Would you rephrase your question?

Q. If you don't have the margins identified one cannot then determine whether the dysplastic or cancerous cells are still present beyond the margin, is that correct?

A. Well, it's very important to differentiate between frank cancer and dysplasia. When frank carcinoma is present obtaining negative margins is of greater importance because, as I've said, dysplastic lesions particularly in an area such as the penis will often always be closely followed.

MR. GORDON: Could you repeat the answer, Ken?

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(Thereupon, the requested portion of the record was read by the Notary.)

- - - -

A. I believe I said will often be closely followed.

Q. Is carcinoma in situ of the penis considered frank carcinoma?

A. Carcinoma in situ refers to carcinoma that has not invaded through a basement membrane. But it is a lesion that should be surgically excised.
Q. All right. Then are you saying that carcinoma in situ is frank carcinoma?
A. Carcinoma in situ is a category of carcinoma.
Q. All right. But --
A. I'm not sure what frank means.
Q. That's what you told me, what you mentioned in terms of frank carcinoma. That's the terminology that I'm using based on what you have said. So I just want to find out whether carcinoma in situ is considered by you to be frank carcinoma?
A. Carcinoma in situ is a category of carcinoma and for that reason whenever possible should be treated with complete surgical excision.
Q. All right. But going back, you mentioned the terminology frank carcinoma in your deposition testimony. I just want to clarify. Do you consider carcinoma in situ as frank carcinoma?
A. Perhaps you could re-read the sentence where I used that term and then I can clarify that for you.
Q. I don't know. You used the terminology frank carcinoma. I didn't use the terminology.

A Well, again, if you would re-read the sentence where I used that term I will clarify it for you.

Q We'll have to do that then at another time.

Then is moderate dysplasia considered carcinoma?

A No.

Q All right. Now, if you have moderate dysplasia the decision whether to do excision or close follow-up, is that up to the urologist or dermatologist following the patient?

A I would say this, the decision concerning the feasibility of resecting an area of dysplasia depends upon the details of the anatomy and generally the urologist or dermatologist would make that determination.

Q Okay. Where do you -- strike that.

What's your basis that if you do have dysplasia it is preferable to excise the lesion and/or have close follow-up?

MR SCOTT: Are you talking about a slight, mild, I mean mild, moderate, severe cancer in situ? What kind of dysplasia are you talking about?

Q You mentioned that if you have moderate dysplasia the preferable approach is excision or you can

close follow-up. Where did you get that, or what is the basis of your opinion that that's, that is the treatment for that type of condition?

A. There's a basic principle in medical oncology that various parts of the body can, as a result of exposure to some carcinogens that you may or may not be able to identify, become susceptible to transformation into cancers. Very often, very often large areas become dysplastic. As an example, large members of the mucous membrane, the mouth, the throat, esophagus, the lung, the cervix and other areas can become dysplastic. Which means that there's a risk that carcinoma can develop. Very often it's simply impossible to surgically remove large areas of dysplasia and in such cases, which are extremely common, close follow-up is the form rather than excision.

Q. Okay. And I'm asking you what do you base that course of treatment on? Is that identified in any textbook, any literature?

A. It's a very individualized decision.

Q. What is based upon what the treating physician feels is appropriate?

A. Based upon the details of the pathology, the anatomy and the opinion of the surgeon involved

Q But is there any literature, publications that indicate if you do have moderate dysplasia, this is the course of treatment if you have moderate dysplasia?

A No It has to be individualized

Q Or similarly if you have carcinoma in situ this is the course of treatment for carcinoma in situ in a lesion of the penis, is there any literature that identifies that course of treatment?

A As I believe I've explained a few minutes ago, it is generally accepted in medical oncology that a carcinoma in situ should be removed surgically whenever possible That requirement is of greater importance than an area of dysplasia which can be followed

Q Okay Then plaintiff's urology expert, Dr. Blath, has given his opinion that the standard of care for the treatment of dysplasia of a penile lesion includes excision, laser treatment, or treatment of topical anti-cancer cream. Do you disagree with that?

MR SCOTT: Or monitoring the record reflects.

A Am I responding to your comments and Mr Scott's comments?

Q. Just my comment.

A. As I've said, an effort should be made to remove the area of dysplasia if that is feasible. Otherwise, close follow-up is often undertaken.

Q. Well, the question is more specific. Do you disagree with Dr. Blath's opinion that the standard of care for treating moderate dysplasia in a penile lesion is excision, laser treatments, Mohs' procedure or use of topical anti-cancer cream?

A. Am I to understand his comments don't leave room where close follow-up is necessary? And is he suggesting that close follow-up in certain cases is contrary to the standard of care?

Q. No, he's not saying that. He's saying that the initial treatment is excision, laser treatments, Mohs' procedure or topical anti-cancer cream. Do you disagree with that?

A. I agree with that with the addition that in many cases such treatment is not possible and close follow-up is also within the standard of care.

Q. Okay. The standard of care of a urologist and/or dermatologist, is that what you are saying?

A. Yes.

Q. Okay. And what does that close follow-up

entail?

A. This is highly variable depending upon the details of the situation. But the urologist and/or dermatologist should see that patient at a reasonably frequent interval to make sure that there is not evidence of progression from one type of lesion to carcinoma.

Q. And what is the frequency?

A. Again, that's highly variable depending upon the situation. Every few months.

Q. In your practice then do you, if there is moderate dysplasia or carcinoma in situ you direct the urologist or dermatologist to excise the lesion?

A. I believe that I've answered that question extremely comprehensively regarding the role.

MR. SCOTT: And repeatedly.

Q. But do you direct, I'm changing the question, yo are presented with -- strike that.

If you had been presented with -- strike that. I have to backtrack.

Have you seen cases in which there was moderate dysplasia of a penile lesion?

A. Yes.

Q. And how many have you seen?

A. I can't recall.
Q. And what was the treatment in those cases?
A. The treatment is individualized based on whether excision is feasible or whether follow-up is necessary in place of complete excision.
Q. Do you know what indeed was done in those cases?
A. I can't recall the specifics of each case.
Q. And how many cases of moderate dysplasia have you seen?
A. Again, I believe you just asked me that question. I refer you to the record. Perhaps you can read my response.
Q. Can you be so kind, to move this thing along could you tell me your response?
A. Well, I believe that I've answered that question and I would ask you to re-read my response.
MR. SCOTT: He has answered that. He believes he has seen moderate dysplasia in the twelve cases or whatever.
Q. Have you seen carcinoma in situ in a penile lesion?
A. Yes.
Q. How many?
A. I can't recall the specific number.
Q. And what was the course of treatment?

A The course of treatment is consistent with that which I have already explained to you

Q And have you seen invasive cancer in a penile lesion?

A. I have.

Q. And how many cases?

A. Again, I can't recall the specific number.

Q. And what was the course of treatment?

A. The course of treatment was consistent with that which I have already described to you

Q Excision?

A Correct

Q Okay Now. Dysplasia is a pre-cancerous condition is that correct?

MR SCOTT: Objection

A Dysplasia can but not does not necessarily progress to carcinoma

Q. So are you saying that dysplasia is not a pre-cancerous condition?

MR SCOTT: Objection Harley!

Q. Yes or no, that's all.

MR SCOTT: No. it doesn't take a yes or no answer Those conditions that progress to cancer obviously are pre-cancerous Those that don't ever and

regress obviously are not I mean come on, let's go on.

MR GORDON: No It's very important

Q Are you saying that dysplasia is not considered a pre-cancerous condition?

A As I explained, dysplasia can but not does not always progress to carcinoma

Q But that still doesn't answer my question.

MR SCOTT: Yes it does

Q Is dysplasia considered a pre-cancerous condition, yes or no?

MR. SCOTT: Harlan he's answered that question He's not required to give you yes and no And he's answered fully, some dysplasias do, some don't

MR. GORDON: That's a different issue.

MR. SCOTT: It's not Where those don't then they can't be pre-cancerous

Q In the medical community is dysplasia considered a pre-cancerous condition?

A. The best way that I can answer your question, the clearest and most thoughtful way I can answer your question is to say dysplastic lesions can

but don't necessarily progress to carcinoma.

Q. You still haven't answered my question.

MR. SCOTT: Yes, he has.

Q. In the medical community is dysplasia considered a pre-cancerous condition?

A. Sir, I believe that to the best of my ability I've answered your question

Q. Dysplasia is an abnormal condition, is that correct?

A. What do you mean by abnormal?

Q. That means different from normal. Do all people have dysplasia? That's what I'm saying. Is dysplasia a normal or abnormal condition?

A. Dysplasia is a condition that can progress to carcinoma and therefore needs to be either excised or closely followed.

Q. I know. You mentioned that before. I just want to know is dysplasia a normal or abnormal condition?

A. I don't use terms like normal and abnormal because I think they're extremely vague.

Q. Is dysplasia considered a benign condition?

A. Dysplasia is a change that does not represent malignancy. If we are classifying all lesions as benign versus malignant then I guess you could

call dysplasia benign. But I actually think in medical terminology that would be misleading. Dysplasia is a term describing changes in the tissue which could but do not always lead to carcinoma.

Q. Because there is a potential that dysplasia can develop into cancer would you agree with the diagnosis of dysplasia of a, of tissue of the penis that a treating physician has to be more vigilant than if it was considered a benign tissue?

MR. SCOTT: Objection.

A. I believe that I've repeatedly on multiple occasions in the past hour and a half stated that dysplastic lesions in any part of the body need to be either excised or carefully followed because of the potential to progress to carcinoma.

Q. So, again, with the diagnosis of dysplasia, moderate dysplasia, does the vigilance of index of suspicion of a treating physician increase in any way?

MR. SCOTT: Objection. You are not giving enough facts. But go ahead, doctor, answer if you can.

A. I would, I would give the same answer that I've given to you a dozen times before this morning. I don't understand how I have failed to answer that question for you.

Q. Okay. Your opinion is that the biopsy of February of '93 did not show any evidence of invasive cancer?

A. I believe I said to you that as a medical oncologist I'm not able to interpret pathology slides.

Q. But in your report you said this biopsy, referring to the February of '93 biopsy, showed no evidence of invasive cancer. Do you still stand by that?

A. I believe that in saying that it showed no evidence of invasive cancer I was basing that determination on the pathology report rendered at that time. I was not indicating that I had personally reviewed those slides and made a judgment as to how they should be interpreted.

Q. All right. But, in any event, you still stand by your statement this biopsy of February of '93 showed no evidence of invasive cancer?

MR. SCOTT: Based on what the report says?

MR. GORDON: Right.

Q Is that correct?

A I'm only making reference to a pathology report I am not indicating my opinion as to the pathologic diagnosis because as a medical oncologist I can't review pathology slides

Q. But you are assuming for purposes of your opinions that there was no evidence of invasive cancer?

MR SCOTT: For purposes of what opinion?

MR GORDON: Of his opinions in this case.

MR. SCOTT: What opinions specifically?

MR GORDON Any of these opinions

MR SCOTT: Well, all right

A I'm only rendering the report of the pathologist.

Q What I'm trying to get at, is there any information that you have gleaned to indicate that there was invasive cancer present in February of '93?

A Upon my review of the medical records pertaining to the care of Mr. Melichar there is no

indication from the single pathology report datec February, 1993 that there was invasive cancer present.

Q. Now, then assuming hypothetically indeed that either moderate dysplasia was present or carcinoma in situ was present in February of 1993, okay?

A. Okay.

Q. And Dr. Luebbers reported out, among other things, reparative atypia but did not report out the moderate dysplasia or the carcinoma in situ in her report, okay?

A. Okay.

Q. Would you agree that the physicians that were treating Mr. Mysliwiec and who were aware of the report were misled by the information in her

MR. SCOTT: Objection. What you say -- first of all, what you are saying is not even answerable. I mean, if in fact in your hypothetical the true diagnosis was dysplasia and the doctors were not told of dysplasia, then ergo the doctors did not know of dysplasia, so that's a tautology. What's the point of this question?

MR. GORDON: By asking the question and if I repeat the question through Ken you can see the point of the question.

MR. SCOTT: No, It is just, if the; did not know there was dysplasia then, and it was there then of course the pathologist did not tell the clinicians that it was there and the clinicians did not become aware. That's obvious. So I mean why are we even --

MR. GORDON: There is a further point if you are listening.

MR. SCOTT: All right. I will try to listen again.

A. Why don't you repeat the question for me.

Q. It is too complicated now, but I'll repeat it.

A. Okay.

Q. Assuming hypothetically indeed that the interpretation of the slides should have been moderate dysplasia or carcinoma in situ and Dr. Luebbers did not report that in her report, the physicians relying upon her report were misled in terms of the diagnosis of the penile tissue, is that correct?

MR. SCOTT: Now I'm going to object

because you know from the record that both of those doctor have said that even if the interpretation was dysplasia it would make no difference. So it's unfair to kind of ambush this witness in that manner. You're talking about the facts of this case, are you not?

Q Can you answer the question?

A I can answer the question by explaining the principles of management of such lesions which are, as I've stated, if there is carcinoma present every effort should be made to ensure that complete excision has been accomplished

If there is dysplasia present and the area of dysplasia has been removed, then follow-up is appropriate.

If there is dysplasia present and it is not feasible to remove all of that area then follow-up is appropriate

Q. Would you agree that treating physicians rely upon the interpretations of the pathologist in terms of making treatment decisions?

A. Yes.

Q. Okay And you do tha ?

A. Yes.

Q. Now, in Paragraph 5 you say 'In my opinion, regardless of whether or not dysplasia was present in this specimen, the appropriate course of action was to follow the patient closely for evidence of new or non-healing lesions suspicious for malignancy ' Is t at your statement?

A You've read that correctly

Q Okay Now, you just indicated, though, that if there was dysplasia present the course of treatment would have been excision and then follow-up, is that correct?

MR. SCOTT: No, that's not.

A I don't believe that's what I said. I believe I said, again --

Q You said if there's moderate dysplasia or carcinoma in situ the preferable approach is excision, is that right?

MR. SCOTT: No. You are misstating his testimony He said repeatedly that if it was cancer in situ he would have excised it if possible, with moderate dysplasia excision and follow-up, following up is always an option.

A. That's correct.

Q. But you didn't identify the fact that one of the

modes of treatment is excision in your report, is that correct?

A. As I recall in writing this report I was making reference to the fact that an excisional biopsy had been performed, i.e., the area in question had been surgically removed. For this reason whether or not dysplasia was present in this area it had already been removed and subsequent follow-up was appropriate.

And then you state further, "The presence or absence of dysplasia on the original biopsy specimen from February of '93 would not have altered the nature of the patient's subsequent close follow-up." Would you explain that for me?

MR. SCOTT: I thought we just did.

A. As I have said, following the removal of a lesion from the penis or any other part of the body follow-up of that area is necessary because other lesions can certainly develop adjacent to it. Hence, after this excisional biopsy was completed follow-up was the appropriate course and it appears was carried out.

Are you testifying that it doesn't matter to a clinician whether the pathologist reports out

reparative atypia or moderate dysplasia as it relates to treatment decisions by the clinician?

MR. SCOTT: You mean in this case where there has been an excisional biopsy done?

A. Well, in this case if you look at the records you see that there were areas of inflammation in multiple locations on the penis and inflammatory changes of the penis can be precursors of carcinomas and may also actually be pre-cancerous changes and for that reason such a patient requires periodic follow-up by a dermatologist and/or a urologist.

So this patient had physical signs that were indications of a risk for penile carcinoma regardless of whether dysplasia was or wasn't present in that specimen and those physical findings merited periodic follow-up as I believe he received.

Q. Are you saying then, to a reasonable degree of medical -- let me withdraw that.

Is it your opinion then that Dr. Gahring complied with the accepted standard of care, to a reasonable degree of medical probability?

MR. SCOTT: Objection.

A To the extent that I as a medical oncologist can comment on urologic standards, it appears that this patient had reasonable follow-up visits. I am not able to assess his specific actions in evaluating subsequent lesions because that's out of my area of expertise.

Q. Okay. Similarly, do you have an opinion, to a reasonable degree of medical certainty and/or probability, whether Dr. Kasick complied with the accepted standard of care?

A As a medical oncologist it appears that this patient had periodic follow-up for occurrence of penile lesions following the initial excision and as a medical oncologist that appears to be the appropriate course of care

Q Would you defer to a board certified urologist in determining what the accepted standard of care was for Dr. Gahring?

A I would defer in evaluating a specific lesion.

Q Such as here?

A If you were to show me a picture of a specific lesion on a penis and ask me do you think that merits topical antibiotics or surgical excision, I would defer to a urologist or dermatologist.

Q Would you refer to a board certified dermatologist as to the accepted standard of care that Dr. Kasick should have complied with?

A Well the determination of standard of care, and I would ask for Mr. Scott's help because I think it is somewhat of a legal issue, as a medical oncologist I can say that close follow-up is necessary and I can delineate the principles of care for such a patient What I can't do as a medical oncologist is render an opinion about a specific lesion and whether it should be handled surgically.

Q Do you have an opinion, to a reasonable degree of medical certainty, as to whether according to the accepted standard of care re-biopsy should have been done sometime after February of 1998?

A Again, that would be a question of judgment based on the appearance and suspiciousness of a particular lesion and that would be a decision to be made by the dermatologist and/or urologist

Q That would be outside of your expertise?

A Yes.

Q Okay Now, in terms of your opinions, in your report you do not address or give any opinions regarding timing or progression of this lesion.

is that correct?

I don't believe --

Let me rephrase the question.

Do you have an opinion as to what stage the cancer was in in 1993, 1994, 1995, to a reasonable degree of medical certainty and/or probability?

MR SCOTT: Well, I'm going to object Because your question assumes that the patient had cancer in 1993. It is not in the record about that and in 1994 and even parts of 1995

Q. All right. Let me go to that then.

Do you have an opinion to a reasonable degree of medical certainty and/or probability, whether the patient had cancer in 1993?

A. I think there's no way to make a determination of that.

Q. And why is that?

A. Well, if we know that this cancer in December of 1996 was a T1N2 Stage 3, we know that cancers of this type develop over a long period of time, over a period of a number of years It's not possible to determine with greater certainty exactly how many years that is. But we know that

cancers such as this are old at the time of diagnosis.

Q And old would be what time frame, years or months?

A. Measured in years.

I should, I should clarify that by saying that just because a cancer is old doesn't mean that it was clinically detectable at an earlier point in time but rather that pathologically speaking cancer cells were present for a long period of time Pathologically speaking cancer cells were present for a long period of time

Q Do you have an opinion, to a reasonable degree of medical certainty and/or probability, whether moderate dysplasia or cancer in situ was present in 1993?

MR SCOTT: We have already gone through that The doctor said he doesn't know any more than what's contained in the reports.

A I have no information in that regard.

Q Do you have an opinion, to a reasonable degree of medical certainty and/or probability, as to whether dysplasia and or carcinoma in situ was present in 1994?

A. In 1994?
Q. Yes.
MR. SCOTT: I thought we have gone through that as well.
A. I have no information to make a determination either way.
Q. Do you have an opinion, to a reasonable degree of medical certainty, as to whether in 1994 --
MR. SCOTT: 5 you mean. I thought you were going to the next year. Go on.
MR. GORDON: There is a logic to what I am doing.
MR. SCOTT: Go ahead. Let me hear your logic.
Q. Do you have an opinion, to a reasonable degree of medical certainty and/or probability, as to whether cancer was present in 1994? And I'm referring to obviously in his penis.
A. As I've explained, the only reference point that we can really use is December of 1996 and as I've told you we can go back in time and say that the age of such cancers is generally measured in years rather than months, but I'm not able to tell you that the first neoplastic cell occurred

in 1995 or 1994 or 1993, et cetera.

Q. Then in 1996 we have metastatic penile cancer, is that correct?

A. In 1996 we have involvement of inguinal nodes. The term metastatic is used in many different ways, but to state it more correctly we know that we have N2 disease in 1996.

Q. Okay. So you wouldn't use the term metastasize?

MR. SCOTT: I think what the doctor is saying is that people use it differently, but in this instance it would obviously --

A. The term often is used to refer to tissue spread and therefore I use the term very carefully so as not to be misleading.

Q. So in September of 1996 there was spread of the cancer to the nodes?

A. Well, precisely we know that in December,

December.

Q.

growing for some period of time?

A. Correct.

Q Okay. And to reach that condition in December of 1996 the cancer would have been present for at least a year, is that correct?

A Correct.

Q And to reach the condition in December of 1996 the cancer would have been present, would you agree, at least two years?

MR SCOTT: Objection. He's answered that question.

A I believe that I've explained it, that you can try to guess for a determination on my part as to exactly how many years old that cancer is and I believe I've explained that except for saying that it is years old based on what we know of the natural history of such a cancer. I would be unable to determine with greater accuracy exactly what year the cancer began.

Q Okay. In your report you do not address the issue in terms of surviviability of Mr Myslivec, is that correct?

A. Correct.

Q. And I assume therefore you don't have any opinions in that regard since you didn't include it in your report, is that correct?

A Well, there are data regarding predicted care

rates for this cancer on a stage by stage basis.
Q. Okay. But in this case you didn't discuss in your report his survivability, is that correct?
A. As I recall, I have not included any specific statistics regarding his predictive five year survival in my report.
Q. Okay. And therefore can I assume you have no opinion that you intend to offer in this case in that regard?

MR. SCOTT: Objection.

Q. Because you didn't include it in your report?
A. When you ask me that open-ended question the reason that I requested clarification is because one could ask me 5,000 questions about this case to which I would hopefully provide an answer. I certainly haven't included 5,000 paragraphs in my report. So to ask if all of my opinions'are included is an extremely confusing question. I would be happy to answer any additional questions that you have for me regarding this case.
Q. I just asked you, I assume you do not intend to offer an opinion in terms of survivability because you have not rendered, not identified that in your report?

MR. SCOTT: Harlan, I'm going to asl

him at the trial of this case about his opinions about survivability

MR. GORDON: Although it is not in his report? I'm surprised.

MR. SCOTT: Don't be and go ahead and finish your deposition.

Q. Is there any reason why you did not include your opinion as to survivability in your report?

A. Again, allow me to clarify that I believe it would be unreasonable to ask me a question to which I have a response, a question of your determination, and then ask me why it wasn't included in my report. I have no way of reading your mind to know exactly which questions you would like to ask me and therefore I couldn't have preempted this session by including all the answers to your questions in my report

Q. Well, we could go on a different process, though. The reports, according to our rules that we, that we follow, indicate that the opinions of the expert should be in his report. That's why. So therefore let me ask you the question, were you asked to give your opinion before December 14th, 1998 regarding this patient's survivability?

A I can't recall.

Q. And if you were asked would you have included that in your report?
A. I don't believe that I was given specific instructions as to which points should be addressed in my report and, and also in the malpractice cases that I have been involved in I don't believe I've ever been told that any answer to any question that I may be asked is expected to be included in my report.
Q. Well, be that as it may, were you asked to -- strike that.

If you had been asked to give an opinion regarding survivability before December 14th you would have included that in your report?

MR. SCOTT: Objection.

A. I don't recall whether I was asked that so I can't really answer your question.
Q. Okay. Well, do you have an opinion, to a reasonable degree of medical certainty and/or as of today?
A. I can tell you that we know as of December of 1996 that he had a T1N2 Stage 3 cancer. We know that the predicted cure rate for someone with a cancer in Stage 3 is somewhere in the

range of 40 to 50 percent We know that he had a T1N2, which is on the earlier end of the spectrum of Stage 3 disease So I would predict that as of December of 1997 he had approximately a 50 percent likelihood of cure from his penile carcinoma

Your question was where do we stand today This is now more than two years later. All that I can tell you based on the data with which I'm familiar concerning penile carcinoma is t at the surviwal curwe plateaus at about five years, meaning that if someone is disease free at wiwe years they're probably cured and also that the survival curve breaks off fairly rapidly over the first two years, which is to say that a great many of the occurrences happen within the first two years So the best I could do in terms of predicting his outcome right now is to say that he has a better than 50-50 chance of being cured of his cancer.

MR SCOTT: We're going to take to run.

MR GORDON: If he has to leave he has to leave.

MR. SCOTT: Go ahead.

A. I can take five more minutes.

MR. GORDON: It's going to take longer.

Q. You would agree that the earlier you diagnose penile cancer the better the prognosis, is that correct?

A. Well, I would agree that there is a definite correlation between cancer stage and prognosis and if a patient is diagnosed with a Stage 1 cancer he has a higher likelihood of cure at five years than a Stage 2 and so forth, Stage 3 and Stage 4.

Q. So assume hypothetically Mr. Mysliwiec's cancer was in a Stage 1 condition, let's say two years before 1996 and now it's in a Stage 3, you would agree that based upon the delay of the diagnosis there is a reduction in the survivability, is that correct?

A. Well, you're making a lot of assumptions about this specific case which I think are, are questionable. But I can tell you that in general if a penile cancer or a lung cancer or a breast cancer can be diagnosed at an earlier point in time and at an earlier stage the predicted five year survival which correlates with stage would