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September 23, 2003 Volume II

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Page 106 IN THE COURT OF COMMON PLEAS OF CUYAHOGA COUNTY, OHIO WILLIAM J. GILL, III, Executor Of the Estate of DANIEL P. GILL, deceased, Plaintiff, vs. Case No. 457639 ROGER A. MANSNERUS, M.D., et al., Defendants. DEPOSITION OF NATHAN LEVITAN, M.D. TUESDAY, SEPTEMBER 23, 2003 VOLUME II Case Not ATHAN LEVITAN, M.D., a Witness herein, called by the Plaintiff for examination under the statute, taken before me, Cynthia A. Sullivan, a Registered Professional Reporter and Notary Public in and for the State of Ohio, pursuant to notice and stipulations of counsel, at the Beachwood Hilton, Dipolmat Room, 43663 Park East Drive, Beachwood, Ohio, on the 25 day and date set forth above, at 6:30 p.m.	Page 108 NATHAN LEVITAN, M.D., of lawful age, called for examination, as provided by the Ohio Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposed and said as follows: EXAMINATION OF NATHAN LEVITAN, M.D. BY MR. MISHKIND: Q. Good evening, Dr. Levitan. A. Good evening. O Q. We met back on August 22nd, so a 11 11ttle bit over what is today's date a 12 11 12 13 be able to complete the deposition this evening 14 15 16 17 18 19 11 115 12 12 13 14 15 16 17 18 19 19 11 115 116 117 118 129
Page 107 1 APPEARANCES: 2 On behalf of the Plaintiff: 3 Becker & Mishkind Co., LPA, by 4 HOWARD D. MISHKIND, ESQ. 5 Skylight Office Tower 6 1660 West Second Street 7 Suite 660 8 Cleveland, Ohio 44113 9 (216) 241-2600 10 11 On behalf of the Defendant: 12 Reminger & Reminger, by 13 ROBERT D. WARNER, ESQ. 14 1400 Midland Building 15 101 West Prospect Avenue 16 Cleveland, Ohio 44115 17 (216) 687-1311 18 19 20 21 22 23 24 25	 Page 109 A. Yes, sir. Q. First, let me ask you whether you have read over your deposition from August 22nd yet. A. Yes, just briefly. Q. When did you do that, sir? A. Last night. Q. Did you make any notes at all when you read over the deposition? A. No. Q. Did you note when you read it over that there were any substantive errors that stood out in your mind? A. No. Q. Did you make any corrections at all to the transcript? A. No. Q. Are there any corrections that need to be made? A. Not that I noticed. Q. When I read over the deposition, I noted that I had requested that you produce your billing records that you have submitted on this case and provide them at least to Mr. Warner. Do you have them with you today?

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Page 110	Page 112
 A. Mr. Warner didn't instruct me to do so, so I didn't follow through on anything on that regard. MR. WARNER: Counsel, I would say that I thought you were going to write a letter to me to summarize anything I might have forgotten. I did give you a bill for the depo today from the last time. I'll just reiterate, as many cases as I have going on, I always tell people to write a short letter. You don't have to make a formal request. But if you want copies of all the billings in this case, I will provide them and get them to you. Please, even at the end of this, a one-minute line saying, Rob, get these. Q. Suffice it to say, Doctor, you don't have your billing records with you today; correct? A. Correct. Q. All right. MR. WARNER: My apologies. Q. Doctor, just a couple housekeeping matters. Since August 22nd, 2003, have you given any additional depositions between then and now over the last month? 	 A. I think that he was a radiologist. Q. The reason you didn't provide standard of care testimony was that you don't hold yourself out as an expert in the area of radiology; true? A. I was simply not asked to focus on standard of care in that case. Q. But you and I have had this conversation before, that you don't hold yourself out as an expert in the area of radiology; is that correct? MR. WARNER: Objection. Asked and answered. A. Correct. MR. MISHKIND: No. It wasn't answered, but I appreciate your comment, Rob. Q. So had you been asked to provide testimony on standard of care with regard to the radiologist, you would have indicated that you didn't feel that that was within your area of expertise; correct? A. Correct, for detailed radiology interpretations. Certainly, as a medicai oncologist I deal with X-rays all the time, but when it comes to a detailed reading, I would
 Page 111 A. Yes. I think I've given one in the last month. Q. Have you testified at trial in the last month? A. Yes, on one occasion. Q. Tell me, let's start with the trial testimony first, when and where was that? A. The trial testimony was in Columbus working with an attorney, Mr. Enders, and the deposition was with an Attorney Gray here in Cleveland. Q. What was the subject matter of the trial in Columbus? A. I believe that was a lung cancer case. Q. Was that a nonsmall cell? A. Correct. Q. Did you testify on standard of care and proximate cause in that case or one or the other? A. As I recall, my testimony was exclusively on standard of care I'm sorry, on proximate cause. Q. Who was the defendant? What 	Page 113 1 defer to the radiologist. 2 Q. Fair enough. What was the name of 3 the plaintiff or defendant or both in that case, 4 please? 5 A. I don't remember. I could probably 6 retrieve that for you, but I don't remember 7 offhand. 8 Q. Was it this month, September? 9 A. It was a couple of weeks ago. 10 Q. It was in Franklin County Common 11 Pleas Court? 12 A. If Columbus is Franklin County, 13 that's right. 14 Q. Do you know what the outcome of that 15 trial was? 16 A. I believe that there was a unanimous 17 verdict for the defense. 18 Q. But you don't remember the name of 19 the doctor? 20 A. I'm not sure of the name of the 21 doctor, no. 22 Q. You don't remember the name of the 23 patient? 24 A. No. 25 Q. The deposition for Mr. Gray was up

2 (Pages 110 to 113)

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	Page 114		Page 116
1	here in Cleveland?	1	A. If I recall, I think that case has
2	A. Correct.	2	been put off.
3	Q. What firm is Mr. Gray with?	3	Q. Is that a lung cancer case also?
4	A. Sutter something, Sutter O'Connell,	4	A. You know, I'm not sure.
5	I think.	5	Q. Do you remember the name of the
6	Q. Is that a lung cancer case also?	6	doctor that you are testifying on behalf of?
7	A. That was a prostate cancer case.	7	A. No. I really focus most of my
8	Q. Who is the defendant that you are	8	attention on my medical care, and these details
9		9	I simply look at before the deposition. I don't
10	serving as an expert on behalf of in that case?		• •
	A. I can tell you that the name of the	10	retain this information.
11	plaintiff in that case is Hunt, and I believe	11	Q. Doctor, I'm not asking you for a
12	that the defendant the defendants are a group	12	reason for it. I'm just asking you whether or
13	of physicians all of which are being represented	13	not you know or not. A simple yes or no would
14	by Mr. Gray for multiple specialties.	14	be fine.
15	Q. Was your deposition taken by	15	A. I don't recall the details.
16	plaintiff's counsel in that case?	16	Q. In the case that you are an expert
17	A. Correct.	17	for Ed Kreiger down in Florida, remember we
18	Q. Who was plaintiff's counsel?	18	talked briefly about that case at the time of
19	A. I'm not sure.	19	your last deposition? Do you remember that?
20	Q. Was that in August, or was that in	20	A. Yes.
21	September?	21	Q. That's a nonsmall cell cancer case
22	A. That was also a couple weeks ago.	22	as well, correct?
23	Q. So since August you've testified	23	A. Correct.
24	once at trial, and you've had your deposition	24	Q. Do you recall how long of a delay
25	taken one time?	0.0	
23	aren one une.	25	there was between the time that the diagnosis
23		25	-
	Page 115		Page 117
1	Page 115 A. Correct.	1	Page 117 was missed to the date that the cancer was
1 2	Page 115 A. Correct. Q. Have you taken on any new cases to	1 2	Page 117 was missed to the date that the cancer was discovered?
1 2 3	Page 115 A. Correct. Q. Have you taken on any new cases to review in the past month?	1 2 3	Page 117 was missed to the date that the cancer was discovered? A. No.
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	Dece 119		Bacc 139
	Page 118		Page 120
1 deposition.		1	an attorney at the Reminger firm in the case of
	that deposition was not	2	Coon. Remember, you told me that you were
3 completed?	-	3	serving as an expert for Attorney Mingus in a
4 A. Co	rrect.	4	matter by the name of Coon, C-O-O-N?
	hen I talked with you back on	5	A. Okay.
	d, you indicated to me that you were	6	Q. But you couldn't remember exactly
	have your deposition taken in a	7	when the deposition was taken. Do you have any
	are serving as an expert at the	8	better recollection as to the subject matter of
	efense Attorney Murray Lenson and	9	that case?
4 .	position was scheduled for the month	10	A. I do not.
	r, either on the 8th or the 30th.		Q. Or when your deposition was taken?
	quite certain when you looked at	12	A. I do not.
13 your pocket		13	Q. When I took your deposition on
	you know what happened with that	14	August 22nd, I asked you whether you had ever
15 deposition?		15	testified on behalf of a plaintiff in a nonsmall
	hink that case was settled.	16	cell lung cancer case other than the Montgomery
	your deposition at the request of	17	County, the Dayton, Ohio, case, and you
18 Mr. Lenson v	was not taken in September?	18	
	n trying to remember. Actually,	19	but you couldn't recall offhand the name of any
	k of it, I had the deposition, and	20	
	ortly thereafter the case was	21	Do you have any better recollection
22 settled.		22	today as to the name of any other cases
	our deposition was taken on	23	involving nonsmall cell lung cancer that you
	ith, wasn't it?	24	have testified on behalf of a plaintiff at any
	on't recall the date.	25	time during your career?
			and daming your curcery
		<u> </u>	······································
			D
	Page 119		Page 121
1 Q. Th	at was a lung cancer case also,	1	MR. WARNER: Note my objection.
2 wasn't it?		2	Asked and answered. Go ahead and answer again.
3 A. I'm	not sure. I don't remember.	3	A. Well, the Kreiger case is a nonsmall
4 Q. Bu	t you do remember working at the	4	cell lung cancer case that we have discussed
	r. Lenson; correct?	5	this evening that is on behalf of the plaintiff.
6 A. Ye		6	Q. You haven't testified at trial,
	was defending a doctor; correct?	7	though, at this point?
	tually, he was defending a lawyer.	8	A. Correct.
	is was a legal malpractice case?	9	Q. Other than the Kreiger case and this
	s. It was a legal malpractice	10	case in Montgomery County, have there been any
11 case.	or remain a regarmarpractice		
1	ising out of a medical malpractice	12	· · · · · · · · · · · · · · · · · · ·
13 case?	ionig out of a methodi Mdipidetice	1	expert and testified at trial in a nonsmall cell
1	react	13	lung cancer case?
	rrect.	14	A. I don't specifically recall.
	e subject matter of the medical	15	Q. Are there any cases where you have
	ad to do with a cancer matter;	16	served as an expert for plaintiff in a nonsmall
17 correct?		17	cell lung cancer case other than for Mr. Kreiger
	rrect.	18	or in the Montgomery County matter where your
19 Q. Th	at was a lung cancer; correct?	19	deposition was taken as a plaintiff's expert?
	n not certain.	20	A. You know, I just don't retain that
21 Q. Do	you remember the name of the	21	information. I don't recall.
		22	Q. Have you reviewed any literature
	vas involved in that case?	64	
23 A. Id	vas involved in that case? on't.	23	since our deposition that would be relevant to
23 A. Id 24 Q. Wi	on't. nen 1 took your deposition in		
23 A. Id 24 Q. Wi	on't.	23	since our deposition that would be relevant to this case?
23 A. Id 24 Q. Wi	on't. nen 1 took your deposition in	23 24	since our deposition that would be relevant to this case?

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 think, as I said last time, I read scores of articles every week, and certainly some of those have to do with lung cancer, but I can't specifically cite you a particular reference. Q. If you remember, I asked you whether or not you were going to take the witness stand and testify that a particular article or a particular chapter in a book was authoritative or generally reliable as it relates to the subject matter in this case, and you told me at the time of your deposition that you had no intention of doing that. Do you remember that? MR. WARNER: Note my objection. Asked and answered. A. I stand by the information that I gave you last time. MR. WARNER: Counsel, to make it easier, all his answers stand as previously indicated. MR. WARNER: If there are any changes, I will let you know. But as far as I'm concerned, everything stands that he previously testified to. MR. MISHKIND: Are you done? You 	 the one that I had at the time of your deposition, and I think you told me that in your updated CV that you have articles that deal with nonsmall cell cancer? A. I don't recall whether any have been published specifically since June of 2002, so I can't tell you. Q. Take a look at your CV. First, tell me, do you have a more current CV than the June 2002 edition? A. Yes. I think my secretary prepared a new one in April. Q. April of 2003? A. Correct. Q. Do you have any A. I'll be glad to provide you with that. Q. Do you have any explanation for why when I asked for an updated CV I was provided with one from June of 2002? A. I'm afraid I don't. Q. If you'll look at the June 2002 CV, could you tell me whether or not any of the articles pertain to nonsmall cell lung cancer? A. You mean any of the articles that
 Page 123 know, if you want to make a statement, go ahead. MR. WARNER: So far we've been here for 20 minutes, and you haven't asked a single question about this case. MR. MISHKIND: Rob, do me a favor, make an objection if you want to, but don't make speeches. MR. WARNER: Objection. Q. I want to make sure that between August and now that there aren't any articles or book chapters or journal articles or abstracts that you intend to testify to at the time of trial that you consider to be authoritative or generally reliable on the topics that are relevant to your opinions in this case. MR. WARNER: Objection. Asked and answered. Answer again. A. As we sit here today, I have no plans to cite any specific references during trial testimony. Q. Actually, Doctor, Mr. Warner provided me with your updated CV. It's actually dated June 10, 2002, which is more current than 	Page 125 1 might have been published since that time; is 2 that your question? 3 Q. Well, the original question that I 4 asked you was to identify any articles that 5 specifically dealt with nonsmall cell lung 6 cancer in your CV from the previous deposition 7 which was an old CV, and you told me that your 8 more current CV had articles that you have 9 written on nonsmall cell lung cancer. 10 I want to find out whether or not 11 this CV which was provided to me, which isn't 12 the most current one, whether or not the June 13 2002 has any references that you have written on 14 the topic of nonsmall cell lung cancer? 15 A. So your question is, looking at all 16 of the publications here, which of these in the 17 June 2002 CV pertain to nonsmall cell lung 18 cancer? You'd like me to go through them and 19 identify those that pertain to nonsmall cell 20 lung cancer? 21 Q. Sure. 22 A. Some of the patients I believe in 23 reference No. 9, I'm not certain, but I think 24 some of those patients had nonsmall cell lung 25 cancer.

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Page 126 Q. That's reference 9 on page A. Seven. I have to verify that, but I think that's true. Reference 12 on page 7 pertains to nonsmall cell lung cancer. Reference 13 on page 7 pertains to nonsmall cell lung cancer. Reference 17 on page 8 pertains to nonsmall cell lung cancer. Reference 20 on page 8, reference 7 on page 9, and reference 8 on page 9. Reference 10 on page 10, reference 17 on page 10, reference 19 on page 11, many of the patients in reference 20 on page 11, many of the patients in reference 21 on page 11, and reference 23 on page 11. I think that does it. Q. Doctor, what I'd ask you to do, if you would, please, is to provide the most current CV that you have prepared and send a copy of that or e-mail a copy of that to Mr. Warner. My understanding is that on the record you represented that April of '03 is what you believe to be the most current edition? A. Correct. Q. Thank you. Doctor, in June of 2000 when Mr. Gill presented to Dr. Mansnerus, was there anything from your review of the records	 Page 128 1 might have had fibromyalgia, that he might have 2 had asthmatic bronchitis. He doubted that the 3 patient had coronary artery disease. He planned 4 on that day to observe the patient, to consider 5 a chest X-ray, and to obtain further testing if 6 the patient was not better in two weeks. 7 Q. A chest X-ray wasn't ordered at that 8 time, was it? 9 A. Correct. He said consider chest 10 X-ray. 11 Q. Do you know what he meant when he 12 said consider chest X-ray? 13 A. No. 14 Q. When you read his deposition, were 15 you able to get a better sense as to what he 16 meant by consider chest X-ray? 17 A. I don't recall that aspect of his 18 deposition. 19 Q. Fair enough. Is there any 20 indication in June of 2000 that the defendant 21 doctor examined in the neck area or palpated in 22 the neck area the lymph nodes? 23 A. You mean was there a palpably 24 enlarged lymph node documented in the chart? 25 Q. Is there any indication that the
 Page 127 of the doctor or his deposition testimony that was concerning in terms of his presentation to Dr. Mansnerus? A. I'm not sure what you mean. Q. Is there anything from a clinical standpoint in June of 2000 that Dr. Mansnerus noted in his records that was concerning from a clinical standpoint or of significance from a clinical standpoint? A. Well, the notes that I have don't really reference necessarily what was going on in Dr. Mansnerus' head, so I can't answer that, but I have summarized some of the clinical details, and that's all I can refer to. Q. What do you make of the June visit to Dr. Mansnerus in terms of the clinical findings that are noted in the record? A. The patient complained of dyspnea on exertion and pain in the left chest, he had a slight cough, had a decrease in exercise capacity, and on examination there was tenderness in the left supraclavicular region, the left neck area. It was the impression, according to my notes, of Dr. Mansnerus that the patient 	 Page 129 doctor palpated or looked for in his clinical assessment whether or not there was any lymph node involvement? A. He did examine the base of the neck area, so that is an area that can contain lymph nodes. That's the best I can answer your question. Q. In his note, though, he doesn't indicate that there was any nodal involvement from a clinical standpoint during his physical exam; true? A. Just tenderness in the area where there are nodes. Q. I believe it's your opinion that he had a metastatic tumor mass that was present in the neck at the time of that June visit; correct? A. I believe that there is no indication in Dr. Mansnerus' record that he had under consideration the possibility of any metastatic or cancer in the neck area as a possible explanation for the patient's symptoms? MR. WARNER: Objection.

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7 (Pages 130 to 133)

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 A. All I can say is he didn't note that in his June 22nd note. Q. Fair enough. From the deposition, is there any indication that as of June 22nd he had an index of suspicion that the patient's clinical findings and his subjective complaints might be consistent with some tumor involvement? A. I don't specifically recall that portion of his deposition. Q. If one were examining a patient where there was an index of suspicion that there might be a tumor mass present in the neck area associated with tenderness by the patient's subjective complaint, how would a clinician go about examining for the existence of a tumor mass? MR. WARNER: Objection. A. I'm sorry. I don't understand your question. Q. If a patient complains of tenderness in the neck and there's an index of suspicion on the clinician's part that the tenderness in the neck is associated with a tumor mass, from the standpoint of your clinical exam, what do you feel for? What do you do to correlate the 	 Q. It is a patient that has not had a diagnosis of cancer yet but presents with complaints of left neck pain, and tenderness in the neck is present, and you at least in your mind are questioning whether or not the tenderness in the neck is associated with some underlying tumor mass. MR. WARNER: Note my objection. He's an oncologist. Most of the patients he's going to see have, in fact, cancer. MR. MISHKIND: Object and don't make speeches, please. A. The problem with your hypothetical question is that there would be no reason, given the scenario that you've described, that I would have an index of suspicion for malignancy. Q. Why? A. Because you haven't given me reason to suspect malignancy based on the scenario that you have presented. Q. If you happen to examine a patient that previously does not have a diagnosis of malignancy but presents with complaints of neck pain, and you palpate the area where the neck pain is located and you discover that there's a
 Page 131 patient's symptoms with your concern or suspicion that there might be a tumor mass? MR. WARNER: Note my objection. We've already indicated that the doctor is here on a proximate cause issue, and the prior two-and-a-half hours he talked about not having opinions on standard of care. That sounds like a standard of care question to me as to what a physician should or shouldn't do in a particular circumstance. Note my objection. I think it's outside the scope. MR. MISHKIND: That's fine. Q. Go ahead, Doctor. A. So your hypothetical situation is, I'm examining a patient who I know has cancer, and I think that he or she might have involvement of lymph nodes in the neck, how would I examine that patient? Q. No. That's not my question. If you have an index of suspicion that the patient may have a tumor mass. A. I don't know what you mean by index of suspicion. Is it a patient with cancer or without cancer? 	Page 133 1 tumor mass in that area, how do you go about 2 from a physical standpoint detecting that tumor 3 mass? 4 Is that something that you'd 5 physically be able to feel potentially, or is 6 that something that would only be discoverable 7 on diagnostic studies? 8 A. Well, it all depends on how large 9 the tumor mass is and how superficial or deep it 10 is. 11 Q. Is there any indication in the 12 record that Dr. Mansnerus had any index of 13 concern that the patient might have a tumor mass 14 as of June of 2000? 15 MR. WARNER: Objection. Asked and 16 answered. 17 A. I think you already asked me that 18 question, but I'll answer it the same way I did 19 before which is to say that I don't know what 20 was in his head. I only know what was written 21 in the record, and I have made my own notes 22 about that. As we discussed a few minutes ago, 23 there's no indication based on my notes 24 concerning the June 22nd, 2000, interaction that 25 there was any explicit suspicion of malignancy.

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1 Q. When was Mr. Gill scheduled to be 2 seen again by Dr. Mansnerus?	 nodal involvement in it as opposed to let me just leave it at that.
3 A. I know that in his note he said that	3 If you have advanced lung cancer and
4 if not better, additional testing in two weeks,	4 you're able to on physical exam palpate or touch
5 and I know that the patient was actually seen	5 and appreciate the nodal involvement, what does
6 next on July 19th. Now, what actually happened	6 it feel like?
7 with the scheduling details, I can't tell you.	7 A. It's highly variable.
8 Q. You don't know whether this was a	8 Q. In a nonsmall cell lung cancer, does
9 previously scheduled visit or whether the	9 it have any particular characteristics?
10 patient came in because of some increase in	10 A. It's, again, highly variable.
11 symptoms as opposed to having that as a 12 scheduled visit?	11 Q. In Mr. Gill's nonsmall cell lung 12 cancer where there was nodal involvement at the
13 A. Again, in my focus in reviewing this	13 advanced stage of his cancer, can you tell me
14 case, there was no reason to have made notice of	14 what that likely would have felt like?
15 such details.	15 A. I can't generalize.
16 Q. Fair enough. Doctor, we can agree,	16 Q. I'm just trying to understand. Let
17 and I think we talked about this previously,	17 me ask you, why can't you generalize?
18 that when Mr. Gill was diagnosed, he was a	18 A. I don't know how to answer your
19 Stage IV nonsmall cell lung cancer; correct?	19 question.
20 A. Correct. 21 O. The diagnosis was not made until he	20 Q. What does advanced nodal involvement
· · · · · · · · · · · · · · · · · · ·	21 in a metastatic lung cancer in the neck area,
22 in fact was a Stage IV cancer, lung cancer; 23 correct?	 22 what might it feel like? 23 MR. WARNER: Objection. Asked and
24 A. Correct.	23 Mix. WARNER: Objection. Asked and 24 answered. Go ahead.
25 Q. If Mr. Gill's nonsmall cell lung	25 A. There can be tenderness without a
Page 135 1 cancer was less than 3 centimeters in the left 2 upper lobe when it was first diagnosed and there 3 was no evidence of nodal involvement, what stage 4 would you describe the patient to be in? 5 A. You're saying theoretically speaking 6 if a patient is diagnosed with a less than 7 3 centimeter tumor on CT with no evidence, no 8 radiographic evidence, of lymph nodes and no 9 radiographic evidence of distant metastases, 10 what stage is that? 11 Q. Yes. 12 A. That is a T1, M0, cancer. 13 Q. In an otherwise healthy patient, is 14 that the stage that you have a 60 to 80 percent 15 five-year survival likelihood? 16 A. Correct. 17 Q. Thank you. When one talks about 18 nodal involvement, are there occasions where you 19 as a clinician can palpate the area and 20 appreciate the nodal involvement? 21 A. When that occurs in the case of lung	Page 137 1 discernible mass. There can be multiple 2 subcutaneous nodular areas. There can be 3 generalized thickening. There can be a discrete 4 palpable mass. A whole variety of presentations 5 can occur. 6 Q. In June, according to Dr. Mansnerus' 7 records, did he perform an exam of the lymph 8 nodes? 9 MR. WARNER: Objection. Asked and 10 answered. Go ahead and answer. 11 A. I don't know how complete an exam he 12 performed. All I know is he found tenderness in 13 the left neck area. 14 Q. His written record, which presumably 15 was prepared at the time of the events of that 16 examination and long before any lawsuits were 17 under consideration and attorneys were involved, 18 do you see anything in that written record that 19 describes examination of the lymph nodes? 20 A. Not that I recall. 21 Q. Is there a difference between
22 cancer, it is usually extraordinarily advanced 23 nodal involvement.	22 microscopic metastases and clinically 23 significant metastases?
24 Q. Is there a way that you describe	24 A. I don't know what you mean by the
25 what you feel when you palpate an area that has	25 second term.

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 Q. Can a patient have micrometastases of cancer cells in the bloodstream and not necessarily develop clinically significant metastases? A. I don't know what you mean. I'm sorry. Q. When a patient has a primary tumor, how does the process of metastases from that primary tumor originate? A. Spread can occur in three ways; by direct extension, through the lymphatic system, or through the bloodstream. Q. Do you have an opinion in this case, first, whether or not the lung cancer was the primary tumor? A. I believe that the lung cancer was the primary tumor. Q. Do you have an opinion as to how the patient developed metastases in this case? A. I believe that the tumor spread both through the lymphatics and through the bloodstream. Q. When tumor cells are shed or are spread through the bloodstream, does one automatically form some distant metastases of 	 A. I'm not familiar with such literature. Q. Does the body have an ability to fight cancer cells that are spread either through the lymphatic system or spread through the bloodstream? A. Theoretically, that can occur. Q. In fact, in healthy individuals theoretically one's body has a better ability to fight off cancer cells that are shed through the lymphatic system or the bloodstream than someone who has any type of autoimmune or other compromised systemic health status, if you will? A. Well, that discussion usually occurs not regarding spread of cancer from a primary site. That discussion of immune surveillance really refers to the formation of the first nascent tumor cell. In other words, to apply that to a discussion of spread from a primary site to distant organs is really not the correct use of that terminology. It's really about the formation of a single neoplastic cell. Q. Did Mr. Gill have metastases to the hilar nodes?
Page 139 1 that cancer? 2 A. So you're saying can we determine if 3 patients have microscopic tumor cells in the 4 bloodstream and subsequently do not develop 5 growth of those metastases into clinically 6 detectable lesions; is that your question? 7 Q. Not exactly. Let me rephrase it so 8 that we're on the same page. Is it fair to say 9 that not every patient that has cancer cells in 10 their bloodstream will go on to develop a 11 metastasis from a primary site? 12 A. How would we ever know that? You 13 couldn't test that. 14 Q. What is the process? How many 15 cancer cells are required to form a distant 16 metastases? 17 A. Well, theoretically one, although in 18 general multiple tumor cells would spread at a 19 time. But frankly, we don't know that. 20 Q. Well, are you familiar with any 21 literature that talks about the number of cancer 22 cells or tumor cells that are actually shed 23 before one actually gets set up and succeeds, if 24 you will that's probably a poor choice of 25 terms but succeeds in forming a metastasis?	 A. Well, given the fact that he had such massive involvement of supraclavicular and mediastinal nodes, and given the fact that lymphatic spread would generally occur to the hilar nodes first, we can infer that he must have had involvement of the hilar nodes; but to my knowledge, discrete hilar nodes were not seen. But it's also important to clarify that when the PET scan showed increased uptake in the mediastinal from hilar nodes on PET scan. Hilar nodes are a little bit more lateral, but the mediastinal involvement could certainly have masked those. So I think it's overwhelmingly likely that he had hilar node involvement even though we didn't see it discretely described on the PET scan. Q. You mentioned at the very beginning of that statement that he had massive involvement of what? A. Well, we know he had a 10 by 12 centimeter palpable let me look at my notes

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 7-25-2000 did describe enlarged hilar nodes, so it was not only the 4.5 centimeter mass in the left upper lobe, but this also described both mediastinal and hilar nodes at that time. Q. Doctor, I want to go back to my question. You said massive involvement, and you started to describe something, and I want to find out what massive involvement you were referring to. A. Yes. He had a left cervical mass that was described on July 25th as being 4 by 3 centimeters that was palpable. This was basically above or into the external regions. There's a lot more inside. The otolaryngology note from 7-28-2000 described a 4 by 4 centimeter mass in the left, and on 8-16-2000 the exam described a 10 by 12 10 to 12 centimeter mass at the junction of the left sternocleidomastoid muscle with the clavicle. This is all, given observer variability and measurement, extraordinarily massive lymph node involvement. Q. This was something that was 	 without question, there was massive disease there at that time. Q. When we talk about several days, we're talking about the difference between June 22nd and the end of July? A. Correct, three-and-a-half weeks, essentially. Q. Approximately a month? A. Correct. That's right. Q. If I understand your testimony correctly, other than with some inflammatory involvement having taken place, you would expect that the mass that's described at the end of July would likely have been palpable in the left neck region a month earlier; true? MR. WARNER: Objection. A. I didn't exactly say that. I said that the tenderness in that region documented on examination on that day was a manifestation of that same involvement. I can't tell you whether a full lymph node examination was done on that day, and I can't tell you whether the nodes were actually palpable on that day.
 Page 143 1 palpable? In other words, the clinician was 2 able to touch and appreciate it without much 3 question; is that a fair statement? 4 A. Correct. 5 Q. This was in the area of the neck on 6 the left side? 7 A. Correct. 8 Q. Was this mass in your opinion likely 9 palpable back in June just a month or a 10 month-and-a-half earlier? 11 A. If one was specifically looking for 12 it, I find it hard to believe that a mass would 13 be palpable that's 3 centimeters on June 19th 14 and it would have been completely undetectable 15 on June 22nd, but I think that the tenderness on 16 June 22nd was the same process. 17 Q. So on June 22nd, do you believe 18 that, I just want to make sure, that he did have 19 a palpable mass in the left neck region? 10 MR. WARNER: Objection. 21 A. He certainly had bulky adenopathy in 22 the left neck region. Now, whether some 23 inflammation occurred that caused this to 24 balloon up and be somewhat more prominent over 25 the next several days, I can't answer that. But 	 Page 145 Q. Can you tell me when Mr. Gill had metastasis to the femur? A. Well, we know that this was radiographically documented in August, and in order for it to be radiographically visible, there has to be a significant size lesion there. It certainly we don't have a measurement, so it certainly was growing over a period of many months, but I can't give you a distinct date. Q. Other than saying many months? A. Correct. Q. So that I don't have to belabor this, are you going to be able to quantify that with any greater specificity at the time of trial other than just saying many months? A. I think it's much easier to say that this extensive lymph node involvement was counted in years, not months. But as far as the lesion on bone scan in the femur, I can't tell you exactly how old it was. Q. Fair enough. A. Recalling of course that these cancers grow extraordinarily slowly and nothing happens in a month in terms of cancer natural history.

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 Q. Can you diagnose lung cancer through an X-ray? A. Well, you can only diagnose any cancer with a tissue biopsy. Q. Can you have a suspicion that a patient has lung cancer by looking at a chest X-ray? A. On occasion. Q. You would agree then that it can make you suspicious that a patient has lung cancer by seeing certain shadows or certain appearances on a chest X-ray? A. I would say that some lung cancers are radiographically visible on a chest X-ray; others are not. Q. Is a nonsmall cell lung cancer radiographically detectable on a chest X-ray? A. Sometimes. Q. Do you know whether or not in this case Mr. Gill's nonsmall cell lung cancer was radiologically detectable on chest X-ray? MR. WARNER: Objection. That's an unfair question since your expert lost the X-rays. Q. Go ahead. 	1question.2Q. Which is it can, nonsmall cell lung3cancer can have an appearance on chest X-ray4that would make one suspicious that the patient5may have lung cancer; correct?6MR. WARNER: Same objection.7A. It can, but it doesn't have to.8Q. I understand. But certainly you9can't rule out the possibility that a nonsmall10cell lung cancer on X-ray gives strike that.11If you have a suspicion that the12patient has nonsmall cell lung cancer based upon13an appearance on chest X-ray, typically that14would launch you off to do other studies to15reach a definitive diagnosis; correct?16A. It depends on the appearance. Very17often we'll give the patient a trial of therapy18for benign conditions and then see the patient19in follow-up a couple of months later.20Q. But ultimately, if you have a21suspicion that the patient does have lung22cancer, the normal process is that you would23launch off to do other studies to rule out or24confirm the existence of cancer; correct?25A. So you're saying if we don't feel
Page 147 A. Well, in retrospect, we don't know that. We know that there was an impression of a left upper lobe pneumonia on the 12-30-99 chest X-ray. We don't know whether that represented cancer itself or whether it was a pneumonia in association with a cancer. We don't know that. Q. What about the presence of pneumonia without evidence of cancer as of December of 1999? MR. WARNER: Same objection. A. What do you mean, what about it? I don't follow your question. Q. Do you have any reason to believe that Mr. Gill did not have pneumonia in December of 1999? MR. WARNER: Objection. A. I believe he did have pneumonia in December of 1999. Q. Let me ask you this, Doctor, when an X-ray is taken, I think you said on occasion one can become suspicious by looking at the chest X-ray based upon the appearance of the film as to whether or not that patient may have lung cancer; correct? A. I stand by my prior response to your	 Page 149 that there's a potential of a benign process that would resolve with conservative therapy, if we had no thought in our mind that that might be going on, would we then proceed with additional tests immediately? The answer is yes. But otherwise, we would try to treat a possible infection or congestive heart failure or whatever else might be going on before doing additional testing. Q. Mr. Gill didn't have any evidence of congestive heart failure, did he? A. Not that I'm aware of. Q. If a follow-up chest X-ray had been ordered and performed at the end of January or early part of February, do you have an opinion as to what that X-ray in this case likely would have shown? MR. WARNER: Note my objection. It goes back again to the same root, that we don't have that original X-ray. MR. MISHKIND: That's fine. A. That's an awfully vague question. I don't know why a repeat would have been done. What about antibiotics? There are so many

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Page 150 1 variables there. 2 Q. So you can't answer my question as 3 stated? 4 A. Ask me once more. 5 Q. If a follow-up X-ray had been 6 ordered and performed at the end of January or 7 early part of February, in light of what we know 8 was diagnosed in this case in July, do you have 9 an opinion as to what that X-ray likely would 10 have shown? 11 A. Well, if we hypothesize that the 12 infiltrate seen on the December 30th, 1999, 13 X-ray was not a pneumonia but actually the 14 cancer, we don't know that, but let's 15 theoretically hypothesize that that was the 16 case, then that probably would not have improved 17 with antibiotics, and it probably would have 18 been again visible on a subsequent X-ray. But, 19 you know, there's so many hypotheticals in that 20 answer that one can't rely on it. 21 Q. If you have an X-ray where there is 22 a suspicion of pneumonia, have you in your 23 practice seen in follow-up X-rays where there's 24 resolution of the pneumonia, but yet there is 25 evidence of some persistent infiltrate or	 Q. What does your time line show for December? A. My note says December 30th, 1999, four-day history of cough, yellow-green sputum, nonpleuritic substernal chest soreness, sore throat, fatigue, malaise, lungs clear, fever 101.4. Impression, viral bronchitis or bronchitis/upper respiratory infection. Rule out pneumonic. Plan chest X-rays. Q. In the interpretation of the chest X-ray, is the patchy infiltrate in the left upper lobe suggestive of pneumonia? A. That's my understanding. Q. The radiologist indicated, suggest follow-up radiographs to document clearing; correct? A. I don't have that in my notes. I believe you, but I don't have it in my notes. Q. All right. In your notes is there any indication that Dr. Mansnerus listened for a heart murmur? A. Well, again, I wasn't asked to focus on standard of care, so I didn't pay attention to those details. Q. If a CAT scan, CT scan, had been
Page 151 1 something that causes you to raise a suspicion 2 that the patient may have a neoplasm? 3 A. So you're saying your theoretical 4 situation is a patient presents with an 5 infiltrate and clinical signs of pneumonia and 6 we treat with antibiotics, and then we wait the 7 requisite two months to repeat an X-ray, that 8 interval being what's generally required for a 9 pneumonic infiltrate to resolve, and then 10 there's residual abnormality, can that raise 11 concern for something noninfectious being 12 present in the lung? The answer is yes. 13 MR. WARNER: Can we take a break? 14 MR. MISHKIND: Sure. 15 (Brief recess.) 16 Q. I want to ask a couple questions 17 about the December 30th examination by 18 Dr. Mansnerus and the significance of that. 19 From your review of the record, is there any 20 indication that Dr. Mansnerus examined the lymph 21 nodes in the neck in December? 22 MR. WARNER: Objection. 23 A. You know, I didn't pay attention to 24 that. If you want to pull out the records, I'd 25 be glad to look at it.	Page 153 1 ordered or if there was reason to order a CT 2 scan during the interval between January and 3 prior to July of 2000, would the diagnosis of 4 Mr. Gill's lung cancer likely have been made 5 earlier than it was? 6 A. 7 A. 8 Q. 9 hat causes one to suspect or at least have an 10 index of concern that there may be a neoplasm 11 and you want to then go on to the next 12 diagnostic study to rule out or confirm the 13 presence of lung cancer, is the CT scan the next 14 diagnostic tool in the line of the tools that 15 you use? 16 A. 17 antibiotics for suspected pneumonia and waited a 18 couple of months and repeated a chest X-ray in 19 your hypothetical and then there's still an 10 abnormality that persists, what's the next test? 19 you have an X-ray and you have a patient with 19 you have an X-ray and you treat for whatever 19 you have an X-ray and you treat for whatever 1

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 dictates that a repeat chest X-ray should be done, and that repeat chest X-ray then has some suspicious findings on it, is the next tool that is used to rule out or confirm lung cancer a CT scan? A. Well, the interval is actually important because I wouldn't jump to a CT scan in a patient recovering from pneumonia until that two-month period and a repeat chest X-ray had occurred because premature expectation of reason to go ahead and get a CAT scan. Q. Well, Doctor, I want to concentrate on just my question because you've made it very clear that you've not been asked and don't intend to testify on standard of care issues, so I don't want to put you in a position where I have to start asking you standard of care questions. Q. No, I am not. MR. WARNER: I noted my objections earlier, but Counsel persists. Q. No. No. Doctor, you volunteer 	1use, couldn't you?2MR. WARNER: Objection. Asked and3answered.4A. I'm doing my very best to answer5your questions fully.6Q. Doctor, you're doing the very best7to answer them the way you want to answer them.8MR. WARNER: I think you're being9argumentative.10MR. MISHKIND: That's fine. I'll11move on.12MR. WARNER: I don't think we need13to get into that.14MR. MISHKIND: That's fine. I'll15save it for trial.16Q. Do you have an opinion as to when17Mr. Gill first developed the lung cancer?18MR. WARNER: Objection. Asked and19answered. Go ahead and answer again.20A. Well, we know that lung cancers21develop over a period of many years.22Q. In this case, Doctor, do you have an23opinion as to when Mr. Gill's lung cancer24developed? I want you to just deal with25Mr. Gill and answer my question. You either do
 Page 155 things when you feel that it's appropriate to do it, but you don't when you don't feel it's appropriate. All I'm asking is, after a repeat chest X-ray is done, if one has a suspicion that there is cancer, lung cancer, is a CT scan the next test that is normally used? A. I stand by my prior answer. Q. No. I'm not going to have you stand by it. Is a CT scan the next test after a chest X-ray, or are there other tests that can be used? Do you go directly to a biopsy, or is a CT scan the normal algorithm, if you will, after a chest X-ray? A. If you have waited the proper period of time for that abnormality on the chest X-ray and it shows a persistent abnormality that could be consistent with cancer, then the next appropriate test is a CT scan. Q. Without going into all those explanations, you could have just said, yes, the CT scan would be the appropriate next test tos 	 Page 157 or you don't. A. I think we have to go back at least five or six years from the point of diagnosis to the formation of the first cancer cell. Q. So that it's your opinion that Mr. Gill's cancer was five or six years old at the time? A. At least. Q. Five or six years old at least at the time that the diagnosis was made? A. Correct. Q. Just a couple more minutes, Doctor, and then we will be done. Do you practice primary care medicine? A. For my cancer patients, yes. Q. Do you act as a primary care doctor when you refer a patient with a questionable lump or abnormality? A. I'm sorry. I don't follow your question. Q. Do you act as the primary care doctor when a patient is referred to you with a questionable growth or a questionable abnormality? A. Well, once I become involved in the

13 (Pages 154 to 157)

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1	care of that patient, I also generally function	1	matter?
2	as the primary care doctor; which is to say, I'm	2	A. Yes.
3	involved in the treatment of their day-to-day	3	MR. WARNER: Note my objection.
4	kinds of medical problems. Then when I'm	4	He's answered the question twice. This is the
5	following these patients for evidence of	5	third time. He said everything in the
6	recurrence over time, I also, again, will become	6	deposition that he's
7	involved in many of their primary care needs.	7	MR. MISHKIND: Rob, don't go on and
8		8	
9	Q. Doctor, the report that you wrote in		say what he said.
11	October of 2002, which we talked about briefly	9	MR. WARNER: That's what he said.
10	when we met the first time, has four areas that	10	MR. MISHKIND: Don't testify for
	summarize the opinions that you hold in this	11	him.
12	case; is that correct?	12	MR. WARNER: Don't yell.
13	A. Correct.	13	MR. MISHKIND: Because you are so
14	Q. You intend to confine your testimony	14	inappropriate. You know you can object, but
15	at the time of trial to those four opinions that	15	don't start summarizing what he said. I get
16	are expressed in your report; is that also	16	aggravated with you because you do it over and
17	correct?	17	
18	A. We haven't that is to say,	18	MR. WARNER: You asked the question
19	Mr. Warner and I have not discussed anything	19	three times.
20	about trial, but these four points and certainly	20	MR. MISHKIND: Be quiet. I'll ask
21	everything else that has been elucidated during	21	it five times if I want to.
22		22	MR. WARNER: He stands by the same
23		23	answers. You don't have to change your answers.
24	Q. Well, Doctor, you still as you sit	24	MR. MISHKIND: No, he doesn't have
25	here now do not intend to provide standard of	25	to. You are not entitled under Local Rules to
	here now do not intend to provide standard of	25	to. Tou are not enumed under Local Rules to
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1 AFFIDAVIT	
2 I have read the foregoing transcript from	
3 page 106 through 161 and note the following	
4 corrections:	
5 PAGE LINE REQUESTED CHANGE	
6	
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16	
17	
18 NATHAN LEVITAN, M.D.	
19	
20 Subscribed and sworn to before me this	
21 day of, 2003.	
22	
23	
24 Notary Public	
25 My commission expires	
Page 163	
1 CERTIFICATE 2	
3 State of Ohio,)	
4) SS: 5 County of Cuyahoga.)	
6	
7 8	
9 I, Cynthia A. Sullivan, a Notary Public	
within and for the State of Ohio, duly	
10 commissioned and gualified, do hereby certify that the within named NATHAN LEVITAN, M.D. was	
11 by me first duly sworn to testify to the truth,	
the whole truth and nothing but the truth in the 12 cause aforesaid; that the testimony as above set	
forth was by me reduced to stenotypy, afterwards	
13 transcribed, and that the foregoing is a true and correct transcription of the testimony,	
14	
I do further certify that this deposition	
15 was taken at the time and place specified and was completed without adjournment; that I am not	
16 a relative or attorney for either party or	
otherwise Interested in the event of this 17 action. 1 am not, nor is the court reporting	
firm with which I am affiliated, under a	
18 contract as defined in Civil Rule 28(D). 19 IN WITNESS WHEREOF, I have hereunto set my	
hand and affixed my seal of office at Cleveland,	
20 Ohio, on this 29th day of September 2003, 21	
Cynthia A. Sullivan, Notary Public 24 Within and for the State of Ohio	
25 My commission expires October 6, 2006.	

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