State of Ohio,)
County of Cuyahoga.) SS:

IN THE COURT OF COMMON PLEAS

Angela DiCicco, Administratrix)
of the Estate of Carl Pietrangelo,)
)
Plaintiff,)
)
vs.) Case No. 348542
) Judge P. Cleary
Meridia Hillcrest Hospital,)
Et al.,)
)
Defendants.)

- - - - -

THE DEPOSITION OF SANFORD S. LURIA, M.D.
THURSDAY, JULY 15, 1999

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The deposition of Sanford S. Luria, M.D., a Witness herein, called by the Plaintiff for examination pursuant to the Ohio Rules of Civil Procedure, taken before me, the undersigned, Kathy A. Buhovecky, a Registered Professional Reporter and Notary Public within and for the State of Ohio, taken at the offices of Dr. Sanford S. Luria, Hillcrest Medical Office Building, 6770 Mayfield Road, Cleveland, Ohio, commencing at 3:30 p.m., the day and date above set forth.

APPEARANCES:

On behalf of the Plaintiff:

Dennis R. Lansdowne, Esq.
Spangenberg, Shibley & Liber
2400 National City **Center**
1900 East Ninth Street
Cleveland, Ohio 44114

-and-

George J. Argie, Esq.
6449 Wilson Mills Road
Cleveland, Ohio 44143

On behalf of Sanford S. Luria, M.D.:

Harry Sigmier, Esq.
Weston, Hurd, Fallon, Paisley & Howley
2500 Terminal Tower
50 Public Square
Cleveland, Ohio 44113-2241

On behalf of Defendant Meridia Hillcrest Hospital:

James S. Casey, Esq.
Reminger & Reminger Co., LPA
The 113 St. Clair Building - 7th Floor
Cleveland, Ohio 44114

On behalf of Dr. Jeffrey M.P. Siminovitch, M.D.:

Kevin M. Norchi, Esq.
Davis & Young
1700 Midland Building
101 Prospect Avenue, West
Cleveland, Ohio 44115-1027

On behalf of Dr. Charms and Hill & Thomas Co.:

Dennis R. Fogarty, Esq.
Weston, Hurd, Fallon, Paisley & Howley
2500 Terminal Tower
50 Public Square
Cleveland, Ohio 44113-2241

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SANFORD S. LURIA, M.D.

of lawful age, called by the Plaintiffs for examination pursuant to the Ohio Rules of Civil Procedure, having been first duly sworn, as hereinafter certified, was examined and testified as follows:"

EXAMINATION OF SANFORD S. LURIA, M.D.

BY MR. LANSDOWNE:

Q Doctor, could you state your full name for the record, please.

A Sanford S. Luria.

Q And you are a physician, correct?

A Yes.

Q And you are a urologist?

A Yes.

Q I was provided at some point in this litigation a curriculum vitae attached to your answers to our interrogatories.

Would you just look at that, Doctor, and tell me if that's up-to-date?

A To the best of my knowledge, this is up-to-date.

Q All right. Thank you.

Doctor, you've given a deposition before?

A Yes, I have.

Q Let me remind you of just a few things. I'm

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going to be asking you some questions relative to your involvement in the care and treatment of Carl Pietrangelo back in **1988**.

If at any time you don't understand my question, please tell me and I'll rephrase it and try to make it clear. **If you** don't hear my question, same thing, don't answer. If the phone rings and you don't hear the whole question, tell me that rather than answer.

A Yes.

Q And answer outloud, as you've been doing, so the court reporter can get all of your answers down. Okay?

A Yes.

Q And if at any time you need to take a break, answer a page or something, please feel free to do so and interrupt at any time.

And lastly, if at any time you want to go back and correct, add to, change or modify an answer that you have given previously, stop at any time during the deposition and we'll do so. All right?

A Okay.

Q How many depositions have you given in the last five years, approximately?

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A Probably about four or five.

Q And were any of those cases in which you were a named defendant?

A Yes, these were.

Q All four or five of them?

A Yes.

Q Are any of them pending now? Do you have any cases besides this one pending now?

A Yes, I do.

Q Okay. How many?

A One other, to the best of my knowledge.

Q Have you ever testified as an expert witness in a medical negligence case?

A To the best of my knowledge, I have not.

Q What have you reviewed for the purposes of your deposition today?

A I have reviewed this chart. I previously have reviewed Dr. Siminovitch's deposition, I think around three or four months ago.

Q By "this chart," so the record is clear, you are referring to the patient chart of Mr. Pietrangelo, which I think you have before you?

A That I have, yes.

Q Have you reviewed any films relating to Mr. Pietrangelo?

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A No, I have not.

Q Have you looked at any literature, any texts relating to this case?

A The only literature I have looked at are those articles that I see in the regular journals that may have discussed this type of problem.

Q Any articles that you specifically recall relating to this problem, as you say?

MR. NORCHI: Objection. Go ahead.

A Excuse me. No, I don't specifically -- this type of problem is written up constantly in the journals, and I may, you know, come across articles concerning these situations.

Q So I make sure we're talking about the same thing, when you say "this kind of problem," what are you referring to?

A Cystic type of problems of the kidney.

Q And what journals are you referring to that you regularly review?

A I regularly review the American Journal of Urology is my main journal, and occasionally I read the British Journal of Urology and the journal called, I believe it's called Urology.

Q Do you have any teaching appointments?

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A Yes, I do.

Q Where?

A At Case Western Reserve.

Q What does your teaching **involve?**

A You'll have to see on there. I don't know the exact --

Q Assistant clinical professor, correct?

A Whichever it says on there.

Q How long have you been an assistant clinical professor?

A I believe since 1974 or 1975.

Q What are your teaching responsibilities?

A Normally, first of all, we did have the residents rotate through with us at one time. They do not rotate through with us now but they have in the past. Also, I attend their teaching grand rounds and I attend their journal clubs.

Q When is the last time you had residents rotate through?

A The last time I had residents rotate through is around three or four years ago.

Q And the grand rounds you attend, where is that?

A Usually I attend the grand rounds. We have two grand rounds every month. One is at University Hospital and one is at The Cleveland Clinic.

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Plus whatever other teaching sessions they have I'll attend intermittently. And the journal club usually meets once a month for the University residents. Normally I try to attend that every month.

Q I assume various topics relating to your field are discussed at these meetings?

A Yes, they are.

Q And would cystic type lesions be one of the topics that are topics of discussion from time to time?

A Yes, they are.

Q Do you get written material at these grand rounds and the other meetings you were discussing?

A Usually these are case presentations by the residents and then opened to discussion to the attending staff, like myself.

Q I see. Have you reviewed any summaries relating to this case?

A Could you explain what you mean by summaries?

Q Any kind of writing reviewing the course of events, chronology, anything like that.

A No, I have not

Q Have you reviewed any documents, other than what

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is before you and Dr. Siminovitoh's deposition, that relate to this case?

A Yes, I have. I did review some expert witness reports.

Q Okay. What expert witness reports?

A I reviewed, if I remember correctly, a urologist review and then I think there were some radiology reviews.

Q When did you review those?

A I believe a couple weeks ago.

Q Did you review those here in your office?

A I think that's where I reviewed them.

Q Did you make any notes about those reports?

A No, I did not.

Q Do you have any file relating to this lawsuit somewhere?

A I believe that I do have a file with the deposition of Dr. Siminovitch.

Q And the expert reports?

A I think so. I think I do.

Q What else is in the file?

A To my knowledge, that's probably the best, the most of what's in it.

Q Have you written any notes to yourself or just any notes that you have thrown in that file?

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A Not to my knowledge.

Q Do you have any notes anywhere about this particular case?

A No, not to my knowledge.

Q Other than your counsel, have you had any discussions with anyone about Carl Pietrangelo since your last visit with him in 1988?

A I may have discussed this case with my associates, you know, here in the office. Once the litigation took place I may have discussed this, you know, with them.

Q Do you recall discussing it with them?

A I probably did discuss it with them. When, I do not recall.

Q What is it that you discussed?

A I probably discussed that I received a, you know, a suit against me concerning this.

Q Did you have any discussions with anyone else about Carl Pietrangelo since your last visit with him in 1988?

A To my knowledge, no.

Q Can you tell me the total number of visits you had with Mr. Pietrangelo? I can't exactly follow --

A I'd have to use my chart to do it.

Q Yes, obviously.

A Do you want me to go in chronological order of those visits?

Q Whatever is easier for you. Right now I just want to know the total number.

A I first saw Mr. Pietrangelo on **10-5-88.** My next time that I saw him was on 10-7-88.

Q And that was at the hospital?

A Yes. My next note in the chart would be on 10-8-88.

Q Did you see him on 10-8-88?

A At that time I presumed this was a situation fully discussed with the patient. And looking at this, I'm pretty sure I saw him.

Q What makes you think that?

A It could have been a telephone call, but from reading this, I'm pretty sure this was a visit here.

Q Why do you say that?

A I can't tell you for sure if it was or wasn't.

Q What makes you think it was a visit?

A Just it's stating here "HH," which means our Hillcrest office.

Q What is the next time that you have there, any contact with Mr. Pietrangelo?

A I do not have a record of a next time. I presume I discussed it with him at some time and it must have been via a telephone conversation, but I have no record on here of the findings. Because my normal process in the office is to discuss the findings **of** the studies, and in this particular case, of his final tests that were done on him and the results.

Q Okay. You think you would have had some kind of conversation with him, whether over the phone or in person, after 10-11-88?

A Yes. Yes, I do. It may not have been an office visit but it could have been a telephone conversation with him.

Q And as far as you can tell, having reviewed your chart, there's no notation about that conversation that you had with him after 10-11-88?

A That is correct.

Q Okay. What would be the reason why there wouldn't be a note about such a conversation?

A I cannot give you an answer. It's ten years ago and I can't give you an answer why.

Q Okay. Is it your normal practice to record conversations or make a note of a

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conversation --

A Yes.

Q -- like that with the patient?

A Yes, it is.

Q And so can you think of the possible reasons why there wouldn't be a note about this conversation?

A Could be many reasons. Number one, I may have dictated it and it didn't, for some reason, wasn't transcribed. Number two, I may have talked to him and inadvertently did not dictate it.

Q Do you think you had just the one conversation or do you think you had more than one conversation?

A I cannot answer you.

Q Do you have any recollection of Carl Pietrangelo at all?

A I really have no recollection of him.

Q If he would have come to the office, there definitely would be a note of a visit like that, right?

A There should be, yes.

Q So that's why you think your contact with him was probably a phone call?

A Yes, I do.

Q I don't know what else to do, other than ask you, do you think you saw him in between 10-11-88 and **1992** or late **1991** when he saw Dr. Siminovitch?

A Our records did not show that **I** saw him in that period.

Q And you certainly have no recollection of seeing him?

A No, I have no recollection.

Q And just to finish the chronology, you don't have any recollection in any notation of having seen Mr. Pietrangelo from **1991** up until the time of his death, correct?

A I have no recollection.

Q And no record?

A And no record.

Q The first visit on 10-5-88 indicates persistent microhematuria, right?

A Yes, that's correct.

Q And where would you have gotten that information?

A He probably was referred to me, and our records showed he was referred by a Dr. Thomas to me with hematuria. And I presume at that time I

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must have -- Dr. Thomas probably sent a note or the patient presented with that history.

Q You have a patient intake form in your records that I don't have, a patient registration form?

A Yes.

Q I don't have that, a copy of this. Maybe at the end of the deposition --

A Be glad to.

Q -- or at a break we can get that. I appreciate that.

MR. NORCHI: Perhaps you can make a copy for all of us?

THE WITNESS: Be glad to.

MR. NORCHI: Thank you.

BY MR. LANSDOWNE:

Q This patient registration form would be something that the patient fills out when they come in for the first visit?

A Right. That is correct.

Q Okay. First of all, you did a physical exam of Mr. Pietrangelo, correct?

A Yes.

Q And the physical exam was normal?

A Physical exam was normal externally.

Q And the plan was to do an IVP and a cysto?

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A And a cystoscopy, yes.

Q What was the purpose of ordering the IVP?

A The IVP, or, intravenous pyelogram, was obtained so I could delineate the upper urinary tract.

Q And what do you mean, delineate the upper urinary tract?

A I want to see the anatomy of the kidneys and the ureters, and, secondarily, the bladder. I will be looking in the bladder, but I'm mainly after the kidneys and ureter.

Q What are you looking for?

A I'm looking for basically, well, I'm looking for a number of things. But basically with someone with hematuria I'm looking for stones or a mass.

Q And by a mass, what do you mean?

A An abnormal area of the kidney.

Q How does that work, when you say, "I'm going to get an IVP," what do you do? Does somebody from your office call the hospital and arrange it or how does that work?

A Yes, that's correct. Our office scheduled this patient for the IVP and the cystoscopy at Hillcrest Hospital.

Q Now, when you do that, do you or does the office request a particular radiologist?

A No, we do not.

Q Walk me through it. What happens when you decide 'I'm going to have this IVP done.' Tell me how it goes.

A Okay. Let me start with when I saw the patient in the office.

Q Okay.

A If you don't mind, it's easier to explain.

Q Perfect.

A After I examined him and checked him, then I told him he needs an x-ray of his kidneys and he needs a visual examination of his bladder, or, a cystoscopy. So I gave -- our office then proceeds to schedule him as an outpatient at Hillcrest Hospital and they'll schedule him to have an x-ray of his kidneys in the radiology department.

And after he's completed the x-ray of his kidneys in the radiology department, then he proceeds over for the cystoscopy in the cystoscopic suite. And all the arrangements are made for the x-ray and our office will tell him what prep, that he needs to clean his bowels out and tell him not to eat anything or drink anything after midnight.

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And then that day when it's scheduled, he presents himself to admitting, the admitting department at Hillcrest Hospital, who then send him to the x-ray department.

Q And then some technician or something does the actual IVP?

A The technician will be there, but probably an M.D. radiologist or a radiologist will inject the contrast material or the technician or whoever it is, but with an M.D. around, and they'll inject the contrast material.

Q Okay. And do you go down -- and this is a dynamic test, an IVP?

A What do you mean by a dynamic test?

Q You're not just taking a snapshot, a photo, a picture, but you're watching --

A No.

Q -- as the --

A No. You're taking an x-ray.

Q Just one film?

A No. You're injecting the contrast material into a vein. And before you inject the contrast material you are taking a plain x-ray, without contrast. Then you are taking a five-minute -- probably fifteen, twenty-minute films. And then

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the films are sent with the patient to the cystoscopic suite where I look at the films.

Q You do like a wet reading?

A I look at them. I do a visual reading, you know, for myself. And the radiologists in the meantime have read them **or will read** them afterwards.

Q Do you ever go to the radiology suite or wherever the IVP is done and watch the procedure yourse1f?

A Very seldom. Sometimes I'm there in emergencies, you know, if I'm here on a weekend and an emergency, we're doing one, I'm sitting and waiting for the films to come out so **I** can look at them.

Q So you get the films before you get a radiology report, correct?

A Sometimes. It all depends on how the scheduling is.

Q What's the normal, a situation like Mr. Pietrangelo's?

A Like Mr. Pietrangelo's?

Q Or, here for a cysto?

A I don't know what took place ten years ago. My usual schedule is I'll have a number of

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cystoscopies scheduled in the morning, and while I'm doing one case, the x-rays are being done on the following case. And by the time I finish one case, the patient will be transported to the cystoscopic suite with the films, and then I will look at the films and then go ahead with the cystoscopy. If I have a question on an x-ray that I don't understand, then I may walk over to the radiology department with the films.

Q So in the usual situation, you would be looking at the films, the IVP films, before you get a radiology report?

A In this particular case I presume I did. Other times, sometimes I'll have the report and then the films. As a general rule, I look at my own IVPs, with or without the report.

Q All right. Are there particular radiologists at the hospital who are assigned to do IVPs, you know, specialize in urology imaging?

A A number of radiologists may be interested in it. As a general rule, all of the radiologists rotate through, reading the IVP films.

Q This looks like it was read by a Dr. Krudy?

A This IVP was read by Dr. Lalli.

Q This is the urogram?

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A That's the IVP. The other, the retrograde pyelogram was read by Dr. Krudy.

Q All right. I was looking at the pyelogram. Okay.

So the urogram was read by Dr. Lalli. Do you know him, or, her?

A I know Dr. Lalli very well, yes.

Q And how about Dr. Krudy?

A Yes, I know Dr. Krudy very well also.

Q What does the "A.G." stand for, A.G. Krudy?

A I can't tell you. I don't know.

Q How about the "A.F.," A.F. Lalli, do you know what that stands for?

A I don't know.

Q You just know he's Dr. Lalli?

A Yes.

Q Well, let me take them in the order that you were looking at them. Let me back up.

In this case, when you got the IVP films, what did they reveal to you?

A Okay. I can't tell you if I had my report, Dr. Lalli's report or not. I can tell you, from my operative note, what I thought they represented.

Q Okay.

A And in my operative note it states here:

Intravenous pyelogram at this time demonstrates a mass defect in the right kidney with poor filling of the superior infundibular system of the kidney.

Q Let me break that down.

Mass defect, what does that mean?

A That means there was a mass, an abnormal area the kidney, in the upper pole area.

If you want, I can draw you a picture.

Q Why don't you do that. I'd appreciate that.

A This is the kidney here (indicating) and this the ureter here. The upper pole, this is the upper pole area. I saw a mass in this area (indicating).

Q Okay.

A And also it states here that there was poor filling of the infundibula system.

The kidney is made up of two portions. The kidney is made up of the outside portion or the parenchyma or the bulk or meat of the kidney. That's the outside portion of it. The inside portion is what we call the collecting system, and that's where the urine drains. And the collecting system looks like this (indicating) and it drains into the pelvis and

the ureter. And I also felt that it was very poor filling of this area here (indicating) of the collecting system.

Q That would be called the superior --

A Infundibulum, particularly in this infundibula area here (indicating). ***So*** **I** wanted -- **I** decided at that time, when I looked in his bladder, I wanted to put some dye up the kidney in a retrograde manner to see if I could fill out this infundibula.

Q And what happened?

A I have to look. It demonstrated extrinsic pressure on it. In other words, the defect was not in the infundibulum but the defect was pressure on it.

And the reason you do that, there are two different types of tumors in the kidney.

Q Okay.

A If it's in the infundibula system, that would be a transitional cell. If it's in the parenchyma, or the outside, that would be an adenocarcinoma.

Q So that's --

A So you want to know if it is a tumor. If it is a tumor or mass in the infundibular area, could be a stone. So I have to -- I had to

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differentiate those.

Q And you did differentiate that?

A Yes I determined that there was no effect in the infundibular system. But there was a pressure effect on it from this mass in the parenchyma of the kidney

Q And by virtue of what you said before, this mass, when the mass is in the parenchyma, it can be an adenocarcinoma?

A It can. Or it can be a cyst We don't know what But I need to separate the two to make sure I'm not dealing with a growth from the inside out or a growth from the outside in.

Q So you are narrowing your focus, right? Correct?

A Um-hmm.

Q It's better if you say yes or no.

A Yes, yes.

Q And so you ruled out this, I guess, internal effect, is that an appropriate way to say it?

A That is correct.

Q And then what else did the cysto show, any other significant findings?

A Excuse me just one second while I review it

Q Sure.

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A The only -- I found, when I looked in the bladder, there was a little trabeculation.

Q What's that?

A Which means when you look inside you see little ridges. That probably means he was starting to have a little difficulty urinating. And at age 46, it means your prostate is starting to enlarge a little bit. But that's a benign finding. And 1 found a nonobstructive prostate, which is mild inflammatory changes, which means it was just slightly enlarged, and maybe just a little erythema or inflammation of it.

Q You've ruled out one thing with respect to what this mass could be, correct?

A Yes. That is correct.

Q So what are you left with as possibilities for what this mass is as of -- this would be as of 10-7-88 I guess?

A Right. What I needed to determine at that time is, was this a solid mass or was this a cystic mass? And I decided at that time to go ahead with a CAT scan.

Q You had options, diagnostic options, I suppose, correct?

A Right. Yes, I did.

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Q What would those be?

A I could either go as they suggested in the radiology report. They suggested either an ultrasound or a CAT scan.

Q Why did you opt for the CAT scan?

A My reasoning for opting for the CAT scan, the patient had hematuria. The patient had a mass in the kidney. And my feeling was that if I got an ultrasound and it was a cyst or had any abnormalities in it, I would go to a CAT scan. So I went to the CAT scan.

Q I'm sorry. I missed that last answer.

A I had -- the options were, do I get just an ultrasound or do I get a CAT scan, and I felt I would go to the CAT scan.

Q Because you felt that the ultrasound would lead you to the CAT scan anyway?

A It might lead me to a CAT scan anyway, and I preferred to go to a CAT scan.

Q And you mentioned that the radiology reports did suggest -- well, I guess the radiology report actually suggests using CT and ultrasound, at least Dr. Krudy's did?

A Yes. Dr. Lalli states an ultrasound or a CT.

Q Okay. And Dr. Krudy said CT and ultrasound,

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right?

A Yes, I see that. I see that, yes.

Q Okay. Let me ask you, in Dr. Krudy's report it says: This patient is also said to have had prior surgery on the right kidney.

Do you see that?

A Yes, I see that.

Q Do you know what he's referring to?

A No, I don't.

Q In terms of information about a mass such as the one that you saw on the pyelogram, what kinds of things can a CT show you that an ultrasound can't?

MR. NORCHI: Objection.

Q Does that make sense?

A Yes, it does. And I have found in my particular experience, when I have a mass this size and with hematuria, that I happen to prefer, you know, a CAT scan. And then if I get a CAT scan and the radiologist wants an ultrasound for further delineation, you know, I'll order it. But I usually go to it because I happen to want to see the Hounsfield units and also get a -- I get a better idea with this.

Q The Hounsfield units are the measurements of

density?

A Density, yes. But again, I would have no disagreement with someone obtaining an ultrasound. And at meetings I'm at, this is debated. You know, this is debated back and forth.

Q Okay. Did you discuss this patient with either Dr. Krudy or Dr. Lalli?

A I do not remember. I used to discuss cases all the time with Dr. Lalli. Dr. Lalli's interest was urology. And Dr. Lalli has written a book called -- a number of books and articles on x-rays of the kidneys and evaluation. And when Dr. Lalli was here, there wasn't a day that went by where I didn't get over and discuss my films with him.

Q You are using the past tense there. I hope he's gone on to another hospital.

A Dr. Lalli is retired.

Q Do you know if he's still in the Cleveland area?

A The last I heard, when Dr. Lalli retired he was up in Niagara-on-the-Lake. But I've lost track of him for a number of years.

MR. CASEY: Toronto it would be.

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A That's it.

Q Just so I'm sure, do you have any recollection of discussing Carl Pietrangelo with Dr. Lalli?

A I do not have any specific. All I can say is usually every day, when I finished my cystoscopies and x-rays, I was usually going over cases with Dr. Lalli.

Q Okay. So you probably did?

A Probably did.

Q And how about Dr. Krudy?

A Many times I discussed with Dr. Krudy.

As I stated before, Dr. Lalli also had a very specific interest in urology and was internationally known in the urologic field.

Q Okay. That kind of leads me back to what I had asked before about asking for a particular radiologist from time to time.

Knowing that Dr. Lalli was going to be there, did you from time to time request that he do a review?

A Not necessarily. Most of the radiologists here have trained under Dr. Lalli, in fact, when he was at The Cleveland Clinic.

Q Your operative report looks like it was dictated 10-10-88, is that right? Is that what that

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looks like?

A Yes, it does.

Q So that would have been three days after the procedure, correct?

A According to this, yes. According to this, yes. But I would just like to mention one thing. Over the years, with operative reports, many times operative reports are lost and they have to be redictated. And, therefore, this date -- and it may have been dictated on a date and transcribed later and dictated. So I do not take much credence in the dates on the bottom --

Q Okay.

A -- of the reports.

Q That's helpful. Thank you.

A You're welcome.

Q Because it seemed to me that you probably want to dictate these things the day of the procedure, correct?

A My usual dictation is -- within twenty-four hours my notes are dictated.

Q And I was just wondering if maybe you waited to dictate this until you had -- if there was any --

A No, no, no.

Q So after, on 10-7-88, this would have been an outpatient procedure, I assume?

A Yes, it would have.

Q You would have had a conversation with Mr. Pietrangelo about your findings?

A Yes. I normally have a full discussion, particularly if the patient is awake. And this was done under topical anesthesia, so the patient was awake, you know, when I did this procedure.

Q All right. So, obviously, you don't remember what your conversation was with Mr. Pietrangelo?

A No, I do not.

Q All right. Based upon what you see here, can you tell us what you likely would have told him?

A I would have told him there's an abnormality in the right kidney. I do not like to use the word "mass" and I don't like to use the word "tumor" with a patient, you know, when we're evaluating him, because, you know, it can be benign or malignant and we don't know what the final outcome will turn out. And I probably told him there's an abnormality, I need further studies, you know, it's to delineate the problem.

Q And the further study would be the CAT scan?

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A Would be the CAT scan, yes.

Q And did you recommend that he get that done that day?

A Well, I recommended he have a CAT scan and they probably were able to -- many times patients would like it done right after that day, they've taken off the day, and so they may have been able to accommodate him that day. And from what I can see, he had the CAT scan that day.

Q Now, again, how would that have been arranged? You would have said --

A Either the nurses arranged it, the radiology department arranged it, or our office arranged it. I can't tell you the details. You know, I can't give you the specific details of who arranged it.

Q Would you have requested a particular radiologist to do that?

A Not necessarily.

Q Well, when you say "not necessarily," that leads me to --

A No, I usually don't. The radiologists have been excellent here at Hillcrest. And to my knowledge, I have never had any problems with the reading of a urologic study.

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Q So he apparently goes and has this contract the same day or later in the afternoon I guess?

A I can't tell. You know, I can just see the date's the same date, so I presume it was done that day.

Q Would we be able to find out what time that was done?

A I can't answer you.

MR. CASEY: I highly doubt it. If you want to know, I can look.

MR. LANSDOWNE: Yeah, it's been a long time. But I wonder if the CAT scans, they might have some records. If there's something, I'd appreciate it. Thanks.

BY MR. LANSDOWNE:

Q Did you see Mr. Pietrangelo again on the 7th, after he had the CT?

A My records show that I talked to him on the -- I talked to him or saw him on the 8th, and I can't tell you if I talked to him or saw him. But I do have a record of a discussion with him on the 6th.

Q All right. I see a situation, fully discussed with patient concerning the right renal mass and hematuria.

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First of all, what did you tell him about the hematuria?

A Well, I told him he had blood -- I presume I told him he had blood in his urine and we found an abnormality in the right kidney that needed further evaluation.

Q Did you believe that the right renal mass was the cause of the hematuria?

A I felt it could be contributing to it. I wasn't, you know, I wasn't sure that that was the cause of the hematuria.

Q Did you review the CT film yourself?

A I do not remember if I did or not.

Q What's your usual practice?

A My usual practice is to look at the CT films, but I am not -- I don't consider myself competent as a radiologist in reading the CT films.

Q So you rely upon the radiologist's reading of the CT films?

A Yes, I do rely upon their reading of CT films and their report. Many times I go over it, you know, with them. I can't tell you if I reviewed these films with them or not.

Q Okay. So even if you looked at the film

yourself, the CT film, **you** would have deferred to the radiologist; is that fair to say?

A I always defer to them on CAT scans.

MR. LANSDOWNE: This film we don't have.

MR. CASEY: 10-7?

MR. LANSDOWNE: Yeah. You have looked, I assume, again?

MR. CASEY: I have 10-11. I know that we have that one.

MR. LANSDOWNE: I've got that one, too.

MR. CASEY: 10-7, that I know of, we have not found.

MR. LANSDOWNE: Right.

BY MR. LANSDOWNE:

Q With respect to the right renal mass again, you would have told Mr. Pietrangelo on 10-8 that he needed further studies?

A Yes.

Q And what were the studies you planned?

A What I had planned, I have mentioned two studies here. I said arteriogram and needle aspiration. My usual, and I presume that should be "or" needle, and/or, there probably should be

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"and/or" there. And what I wanted to do was do a needle aspiration of it first by the radiology department, having them put a needle in the cyst and drain it and see if it's a clear cyst, if it's a clear fluid, and also to check the walls of the cyst.

Q What about the arteriogram?

A The arteriogram, in 1988 we were doing more arteriograms than we do today. We very seldom ever order an arteriogram for a renal mass today. And I presume that was left, if there was any question on this cystic structure, then I would have -- or any abnormality -- I would have -- I might have gone to it. That was the end of, almost the end of the era for ordering routine arteriograms for renal masses.

Q And the needle aspiration or your ordering of the needle aspiration was a twofold purpose: One, to check the fluid that's removed, and also to examine the walls of the cyst or the mass?

A Right, the mass, and they examined it at that time.

Q Now, getting back to 10-7 again, when you ordered the -- and I don't even know if that's correct to say you ordered the CT, but when you

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recommended that he get the CT, or did you order it? What is it?

A It states here that the patient will be scheduled for a CAT.

Q All right. And would you have written out something to the radiology department ***so*** they knew what you wanted done?

A May have. I may have called them. I may have talked to them. I can't give you a -- I can't give you a specific answer. Many times when I order a CAT scan I will go over to radiology and talk with the radiologists, you know, and show them the x-rays and show them what I need. Sometimes I won't. I can't answer you if I did or didn't.

Q Would you have given them any directions with respect to the use of contrast?

A My usual order, again, I don't know what it was in 1988. I'd have to see my order. My usual order is with and without contrast, if possible.

Q And that's because you want to get a pre-injection view as well as a post-injection view?

A Yes, that's correct.

Q And the reason you want to get a pre-injection

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view is the contrast can sometimes make it more difficult to see some of the --

MR. NORCHI: Objection.

Q -- parts of the mass?

A Usually the reason we do it is, again, I am not a radiologist, but it's -- if there's **a** change in the Hounsfield units and what we call the enhancement of it.

And if, in this particular case -- or **you** want me to hold up? Do you have more questions?

Q Go ahead.

A In this particular case, if I can read the report to you, in this particular case they were reading their density as 24, which was slightly greater than it was, greater than pure fluid and normal surrounding tissue around it. And they felt that this could possibly be a hemorrhagic cyst or blood in the cyst. And that's why I wanted them to put a needle, I wanted the radiology department to put a needle in it.

Now, as you mentioned, he did have an IVP earlier in the day. So he had, according to their report, he did have some contrast material in his system.

Q So they couldn't get a pre-injection study?

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A Right. But they still could give me a Hounsfield unit, and the unit was in the range. And that would not change anything because, I mean, it's still in the cystic area and I am going to have it aspirated. And I did make arrangements to have it aspirated **so** I could get a definitive answer on the fluid.

Q All right. I guess if a radiologist were to say that contrast material can make it more difficult to appreciate calcification in a cyst, that's something that you would defer to the radiologist on?

A Um-hmm.

Q If you could say yes, please.

A Yes, yes.

Q Do you know whether that's true or not?

A No, I do not. I do not.

Q Have you ever read any articles, studies about the effect of contrast material on appreciating the ability, the ability to appreciate calcification in cysts?

A No, I can't discuss that. I can only tell you he had a CAT scan aspiration without contrast the next day or two days later. So you have a study here without contrast.

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Q Under these circumstances, and I assume this happens from time to time that somebody has an IVP and then later on in the day they have a CT, correct?

A Yes.

Q In those circumstances, does the radiologist give more contrast for the CT?

A I do not know that answer.

Q If your usual order was with and without contrast and you got this report back which just says "with contrast," would you have discussed that with another radiologist now, Dr. Demarco?

A In this particular case, you know, I can't tell you what took place at that time. I don't remember. In this particular case, I don't see that that's a major -- that's a factor, because the reading is within an area slightly more than a cyst. And, secondly, we're -- I'm going to have to put a needle, have a needle put in it. And when the needle is put in, that's done without contrast. So they are going to obtain the study without contrast and they'll be able to see, as you mentioned, if there's calcifications, if you felt the calcifications were going to be masked by the contrast

material.

Q Now, when you said "more than a cyst," you are referring to the HUs again?

A Excuse me?

Q When you said, in your last answer, you said it's "more than a **cyst"?**

A Than a pure fluid cyst.

Q Okay. And the reason you are saying that is because of the 24, right?

A Yes.

Q That's the Hounsfield units?

A Yes.

Q What's pure fluid, like 20?

A I do not know the exact numbers of it.

Q So what was the significance of this CAT scan report of 10-7-88 to you, as the urologist?

A As a urologist, I'm looking at a cyst that is slightly abnormal because of it being a hemorrhagic cyst and because of the possibility of it being a hemorrhagic cyst. So I, at this point, have to determine if this fluid has abnormal cells in it and I have to make sure that I'm not dealing with a tumor and I must have cytologic examination of that fluid.

Q Did you assign to this mass or the cyst any kind

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of a ranking or category?

A I usually divide cysts myself into simple cysts and complex cysts. And I considered this just a little more complicated than a simple cyst.

Q What are the factors that differentiate simple from complex? And this sounds like this is your own personal system. Correct?

A Yes, that is correct.

Q Okay. What are the factors that differentiate simple from complex cysts? And we're talking, of course, about renal cysts.

A Renal cysts, that is correct. If I see -- I separate -- a simple cyst has clear walls, as this had, with no septations.

Q And the reason this is a little more complicated is because --

A Because the fluid was clear, but it was a little -- the Hounsfield unit was a little more than what a clear cyst should be, and they were reading this as a hemorrhagic cyst.

Q Now, what if the cyst has calcifications? Where does that go into your simple-complex dichotomy?

A A little more than a simple cyst.

Q And then I guess it depends on the extent of the --

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A Right.

Q -- calcifications?

A If I have a see-saw, on one end of the pendulum is complex and the other end is simple, and then -- then you have variance. And that's the methodology **I** use for **cysts.**

Q So calcifications would be one of those things that pushes it down the see-saw towards the complex side, right?

A Right.

Q And there's no report on 10-7-88 of any calcifications, correct?

A That is correct. But on 10-11-88 there is no report, without contrast, of calcifications.

MR. CASEY: Dennis, you have that film, right?

MR. LANSDOWNE: I do.

BY MR. LANSDOWNE:

Q All right. Are you familiar with the Bozniak category for cysts?

A I have seen that mentioned. I am not that familiar with Bozniak and I do not know the details of Bozniak to really discuss it, you know, in a satisfactory manner.

Q In your scale of simple-complex, if you

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determine that a cyst is complex, what do you do?

A Are you talking about Mr. Pietrangelo?

Q I'm just talking about in your system here, your simple-complex system?

A It all depends. After -- I have to examine the patient. I have to go over the history, you know, and then I make, with all the information, I'd have to make a clinical judgment to determine.

Q So what, you're ordering the aspiration, thinking that you might get some blood in the fluid, correct?

A That is correct.

Q And that would account for the HU of 24?

A Yes.

Q All right. Then the CT-guided aspiration was done, correct?

A Yes, that is correct.

Q Were you present during that procedure?

A No. To my knowledge, I was not. But again, I cannot tell you for sure. It's ten years ago.

Q Do you know Dr. Charms?

A Yes, I do.

Q Have you had any conversations with Dr. Charms

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about Mr. Pietrangelo?

A I cannot answer you. Usually when Dr. Charms -- Dr. Charms is not here. I believe he's out in California right now. But usually Dr. Charms or any of the radiologists, after they aspirate, will give me a call, you know, and let me know.

And the aspirating fluid was clear that he obtained, you know, grossly clear, and the cytologic evaluation revealed no evidence of malignancy.

Q And no evidence of blood in that?

A No evidence. Right.

Q So that fluid didn't explain the 24 HUs density, correct?

A Um-hmm.

Q You have to say yes.

A Well, the 24 meant that it was fluid. And at this time the aspirant gave no indication of a malignancy.

Q You got clear fluid?

A Clear fluid, and we had no cytologic evidence of a malignancy

Q So what was your thinking then about why there was a density of 24 if you didn't have any blood to explain?

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A Just -- the fluid may just have been a thicker fluid and it gave us this 24. But it didn't give us a solid mass. This is not a solid mass.

Q I'll ask it this way. What is the accuracy rate, if there is such a thing, in aspirating renal cysts?

A I can't give you -- I cannot give you the figures. Aspiration, you know, over the years the aspiration studies have been very good and I'm constantly reading articles stating about them.

In my particular experience -- I can only give you my experience. And particularly with the radiologists here, we've had very good results with our -- with aspirations over the years.

Q I mean you're getting how much? What percentage of the fluid of the cyst are you getting?.

A I can't tell you how much they took out. My usual experience with the aspirations, they removed most of the fluid. And in my experience, I have not done cyst aspirations since I was a resident, and we did not have CAT scans when I was a resident so we did them with different methods. And my experience, when I

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did them, you know, I usually aspirated all of the fluid and we used to put in solutions to sclerose it, and so we had to empty all of the fluid out.

Q If you don't get any finding from the aspiration of any malignancy, does that rule out malignancy in that mass?

A It does not rule out malignancy but we have a good indication there's no evidence of malignancy. But it does not rule out malignancy.

Q Why doesn't it rule out malignancy?

A There can always be a malignancy there but we can't find it.

Q Is that one of the problems with doing aspiration of a renal cyst, that the fluid you get may be fine, but there's other fluid in there and there's a malignancy in there and you are not getting it?

MR. FOGARTY: Objection.

A No, there's no other fluid. If it's a simple cyst, we're getting all the fluid. We're getting a mixture of all the fluid. If it's a complex cyst, then, no, we're not getting into all the compartments. But in a simple cyst,

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with no septi in it, we're getting a mixture of all that fluid.

Q How do you know there was no septi in this?

A From the CAT scan.

Q You are satisfied that there was not multiple compartments in the cyst?

A Yes. Yes, I am.

Q Based upon the reports?

A The reports of the CAT scan.

Q Now, again, if the radiologist had told you on 10-11-88 that there were calcifications in that cyst, what would you have done?

MR. SIGMIER: Objection.

MR. FOGARTY: Objection.

MR. SIGMIER: Speculation.

You can answer. Go ahead.

A On which date, 10-7 or 10-8?

Q 10-11.

A If he had told me, on 10-11, that there were calcifications, I would have, at that time, if the fluid was clear, I probably would have watched it for about three or four months and then obtained another CAT scan or an ultrasound at that time.

Q Why?

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A To see if there was a change in it. Calcification does not -- calcification in the rim does not mean there's a malignancy, but you have to watch it.

Q You said calcification in the rim?

A Yes. You stated **if** there's calcification in it, on the outside of it, that means that you have to watch it. You have to keep an eye on it.

Q What is it about calcification that makes you want to keep an eye on it?

A Calcification can be a mass or tumor.

Q If you had been told that this cyst had calcification on it, your level of suspicion about a malignancy would have been heightened?

MR. FOGARTY: Objection.

MR. SIGMIER: Objection. Speculation.

MR. FOGARTY: Hypothetically? I'm sorry. You are talking hypothetically?

MR. LANSDOWNE: Yes. That's why I said "if," "if you'd been told."

MR. SIGMIER: He's asking you hypothetically.

A Hypothetically, there is a slight increase if it's *in* the rim.

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Q Are you able to, yourself, look at a CAT scan and tell if there's calcifications or not?

A Sometimes I can and sometimes I can't. If it's overt, I can't. I usually leave the reading, the interpretation of the CAT scans to the radiologist.

Q I mean, if I was to reach in that bag there and pull out the CAT scan, do you think you'd be able to?

A I might or might not. Again, I'd have to study it for awhile.

Can I take a break for a second?

Q Sure.

(Recess.)

BY MR. LANSDOWNE:

Q Doctor, I have here films from the 10-11-88 scan of Carl Pietrangelo at Hillcrest Hospital.

You don't have a view box in here?

A I can look up.

Q Can you take a look at those and tell me what they reveal to you.

A I really can't read them. I see a mass there but I really can't read any detail of these. This **is** not my expertise.

Q Okay. Let me just ask you specifically whether

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or not you see any calcifications in the cyst or in that mass?

A I really can't tell if there are calcifications or parenchyma -- or just thickening of the parenchyma around it. Looking at these films, I cannot give you a reading.

a Can you give me any information about the simple-complex nature of that cyst?

A No, I couldn't.

Q You defer to the radiologist?

A I defer to them. This is not my expertise.

Q Fair enough.

I guess we should mark this so we know what we're talking about, and we'll mark the drawing and that.

- - - - -

(Plaintiff's Exhibit Nos. 1 and 2 were marked.)

- - - - -

BY MR. LANSDOWNE:

a What was your plan after getting the results of the aspiration?

A Okay. With results like this, I cannot give you specifically, you know, what was said or not or discussions with me.

But in a similar situation, with a clear

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fluid in a cyst and negative cytology and a patient with hematuria, I follow these patients conservatively and I usually recheck them in three to four months. And at that time, I may obtain a follow-up ultrasound or repeat the CAT scan.

If the hematuria continues, then I'm faced with two situations: Number one, does he have idiopathic hematuria or does he have blood in the urine for some unknown reason or is he just leaking blood? Some patients just leak blood from their basement membranes in the kidney. The kidney is a filter, just like a coffee filter. And some coffee filters will have coffee grinds come through. And some kidneys will have blood come through. And/or, is he bleeding from the cyst?

And then I'm faced with a situation, three to four months down the line, if the hematuria continues or the blood continues, and if I can't find an explanation after repeating the CAT scan, repeating an ultrasound, then I'm faced with possible surgical exploration at a later date.

Q I'm trying to break your answer down a little

bit, Doctor.

Before, when I asked you the hypothetical question about if the radiologists had told you that there were calcifications in the cyst, you said that hypothetically, given that information, you'd have had the person come back in a few months.

A Yes.

Q And I'm trying to remember specifically whether you said you would have another CAT scan done.

A Yes.

Q You definitely would have had a CAT scan?

A CAT scan or --

MR. NORCHI: Or ultrasound.

A -- or ultrasound, and I would treat that similarly as I treat -- you asked me this particular case at this time with the information that I had. And in this particular case, with the information, you asked me my thought process of what I had at that time, and that with this cyst, as the reading shows here, I would have had him come back in three to four months.

Q Okay.

A And I would have checked his urinalysis to see

if there still was blood present. And if there was blood present, then I would have obtained an ultrasound and/or CAT scan.

Q That's what you believe you would have done with Mr. Pietrangelo, based upon the information that you have now?

A Yes.

Q Or the records that you have?

A Yes.

Q But my question before related to the hypothetical situation which is not before you, which is where, in addition to getting the information that you got from the radiologist about the renal aspiration biopsy, he said to you, or, the report says this cyst has calcifications in it.

A Um-hmm.

Q What change does that make in your plan or care of this patient --

A At this time --

Q -- hypothetically?

MR. NORCHI: I object. I think he answered the question as a hypothetical before, with the idea that the calcifications are the added feature overlaid on top of the

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situation you already had. I think he answered that question. I'm confused.

BY MR. LANSDOWNE:

Q I got confused, too. That's why I'm trying to find out the difference that extra information would have made to your care of the patient.

You've now told us what you believe you would have done with Mr. Pietrangelo, correct?

A Correct.

MR. NORCHI: With calcifications.

MR. SIGMIER: I thought he answered it that way, but I suppose you'll have to clear it up.

BY MR. LANSDOWNE:

Q It's my fault. Let me try it again. I'm sorry.

As of 10-11-88, okay, we've already discussed that we don't have a note or any record of a conversation that you had with Mr. Pietrangelo, correct?

A Correct.

Q But certainly you believe you would have had a discussion with him after this CT-guided aspiration biopsy, correct?

A That is correct.

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Q And obviously you don't remember that discussion, correct?

A That is correct.

Q But based upon your practice, you can tell us what you believe you would have discussed with him and how you would have planned to follow him, correct?

A Yes.

Q That's what I want to know, based on the information as it was.

A Okay. You want me to discuss Mr. Pietrangelo, this case?

Q Right.

A No hypothetical?

Q No hypotheticals this time.

A Okay. I would see Mr. Pietrangelo back in three months. I would check his urinalysis, number one. If the urinalysis still showed blood, I would obtain an ultrasound and/or CAT scan to see if there was any change and I would again, I would again be watching these Hounsfield units.

If there was no change, I would sit down and discuss the situation fully with him and probably recommend that we keep an eye on him, maybe repeat it again in three to six months.

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If there was a change in Hounsfield units or if calcium did appear or it enlarged, then I probably would recommend surgical exploration of this cyst.

Q So you believe that you had a conversation with Mr. Pietrangelo in which you **told** him **to** come back in three or four months?

A That is my normal process in this situation.

Q And again, wouldn't normally you chart a recommendation like that?

A Normally I would chart it, and I cannot explain to you why it is not charted.

Q And normally, if you recommend that a patient come back in three to four months and they don't come back, do you have a system to send them a letter and say you are supposed to be back here in three to four months?

A We have a system when I see them in the office and I have them see our secretary before they leave. I don't know when I, you know, when I talked to him and I can't -- I don't know if I talked to him at night at home or what. I can't give you an answer.

Q Okay. But I'm talking about for any patient, if you tell that patient to return in three to four

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months, is there any follow-up?

A Yes. Normally we have a follow-up here in the office.

Q And the follow-up would be?

A A postcard, a postcard sent that you missed your appointment.

Q And a copy of that postcard I guess would go in the file, correct?

A I can't answer you on that. I would presume but I can't answer you.

Q Your office people would know that?

A Yes. But I can't give you a specific answer.

Q Now, apparently these guys all heard something and understood something and I didn't.

How would, what you described as what you believe your treatment for Mr. Pietrangelo and your plan would have been, how would that have changed if you had been told by the radiologist or in his radiology report that the cyst had calcification in it?

MR. FOGARTY: Objection.

MR. SIGMIER: It's a hypothetical. You understand that?

A Yes. If it had calcium, again, I would bring the patient back in three months, with the

negative cytological findings. And also, with no evidence of gross blood, of blood present, I would probably repeat it in three months. I would repeat the CAT scan and/or sonogram, and if I saw no change, I probably would follow him another three to six months.

Q You mentioned your colleague, or, former colleague, Dr. Lalli, as somebody who's well-regarded --

A Yes.

Q -- with respect to imaging of renal cysts.

Are there other people in the field that come to mind that are either urologists or radiologists that you consider to be experts in the field?

A I can't give you specific names today. I'm not, you know, familiar with them. I knew Dr. Lalli. Dr. Lalli was eminent when I was a resident and we were very lucky at Hillcrest Hospital for him to come here after I had been in practice here for around eight, ten years.

Q I just have to ask a couple questions that I think I know the answer to but I'd better make sure.

When did you find out that Mr. Pietrangelo

was diagnosed with cancer?

A When you issued the suit against me.

Q Did you have any discussion with Dr. Siminovitch at any time about Carl Pietrangelo?

A None whatsoever.

Q Do you know Dr. Siminovitch?

A Yes, I do.

Q How is it that you know him?

A He is a fellow colleague in the area. He's on the staff at Hillcrest Hospital and he's on the staff here.

Q When did you find out that Mr. Pietrangelo became a patient of Dr. Siminovitch?

A I believe when I saw the suit, when both our names were on it.

Q Did you at that time mention it to him?

A No, I did not.

Q For a patient like Mr. Pietrangelo, who makes the decision as to whether further diagnostic studies should be performed, the radiologist or the urologist?

MR. SIGMIER: Objection. That's pretty broad, isn't it?

Q Yeah, it is. I mean, I'm not intending to -- if you can't answer it, I can ask another question.

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I'm just asking in general.

A In general, the attending physician, the urologist makes the decisions on what studies are ordered.

Q With respect to Mr. Pietrangelo, you made the decision as to what diagnostic tools you wanted to use, correct?

A That is correct.

Q And you relied, of course, on the radiologist, as you said, with respect to the CAT scan readings?

A Yes.

Q I just need -- I had a question about something in here, another thing that I don't have.

A Sure.

Q Can you tell me what this paper is out of your folder, out of your office chart for Mr. Pietrangelo?

A Yes. This is just -- he probably had Emerald Health insurance at that time, and this is just giving us approval so we can proceed with studies.

Q And what are you asking for approval to do?

A Probably for the cystoscopy.

Q Do you know what this Procedure/Diagnosis

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section is there? I'm talking right here (indicating), Procedure/Diagnosis.

A Yeah, I can't answer. It said nephroureterectomy, which means removal of the kidney, or other GU neoplasms. Maybe it was a permission. See, it says approval from 10-11 to the 16. That probably was the approval for the aspiration, and they wanted a diagnosis so we put "GU neoplasm."

Q Well, the procedure is a --

A I don't know what, why that's there, but it says "GU" --

Q That's removal of a kidney?

A Of a kidney and the ureter. See, that's not the treatment for a renal adenocarcinoma. But it says "other GUs," so that is probably in that period of time. That's when the aspiration was done.

Q Who is this Betty Chika?

A Must work for Emerald.

Q It's not one of your people?

A No. We're required, before you do anything, usually with insurance companies, to have approval.

Q I don't have these cards either.

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A That's probably Hillcrest Hospital admitting. When they come in, they take information on each patient.

Q Attending physician Robert Shapiro?

A My associate

Q Your associate. Okay. So he was admitted the next time --

A They go on different names.

Q Okay. I take it you have not seen Dr. Siminovitch's records, correct?

A I have not.

Q And you've not seen the University Hospital records, correct?

A I have not.

Q You have no opinion as to the cause of Mr. Pietrangelo's death, correct?

A I do not have any opinion.

Q Do you have an opinion as to whether Mr. Pietrangelo had a malignancy in his right kidney back in October of 1988?

A My studies at that time do not demonstrate any evidence of a malignancy at that time.

Q I guess I really need to know if you have an opinion as to whether he did or didn't at that time?

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A From my studies, I cannot -- put it this way: From my studies, I determined I could not find a malignancy at that time.

Q Okay. But as we discussed before when we were talking about the aspiration, there can be a malignancy there and the aspiration doesn't get it, correct?

MR. FOGARTY: Objection. Go ahead.

A I found no indication of a malignancy on my studies at that time.

Q Okay. Well, let me put it this way. I expect there's going to be testimony in this case that a malignancy did exist at that time, and the testimony is going to be to the effect that the CT scans should have -- well, with respect to the second CT scan, there were calcifications shown, that further studies were warranted and that further studies would have led to the discovery of a malignancy in that kidney. That's just going to be the testimony, the opinion of a doctor in this case.

Do you disagree with that opinion?

MR. FOGARTY: Objection.

MR. NORCHI: Objection.

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MR SIGMIER: Objection Go ahead You understand it's a hypothetical

A I cannot answer that. I cannot answer that. I'm not a radiologist and I cannot answer that

Q And you are not an oncologist either, correct?

A That is correct

Q So as to issues about if a malignancy had been diagnosed in 1985, what the likelihood of cure would be, you are not going to be offering any opinions on that?

A I cannot offer it. I'm not an oncologist.

MR. LANSDOWNE: All right. Except for getting copies of some of those records that we don't have, I don't have any other questions for you at this time

However, I would state that if Dr Luria is going to review other parts of the record and offer opinions based upon other parts of the record that he hasn't seen and so I haven't been able to ask him about today, then I would want to be notified about that so I can find out what those opinions might be

BY MR. LANSDOWNE:

Q And I just want to be clear about this last thing, too

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You don't have any indication or reason to believe that you saw Mr. Pietrangelo any time in 1989, '90, '91, '92, '93, '94, '95 or '96?

A That is correct.

Q Okay. And you do record some phone calls with your patients?

A Usually I record phone calls, yes.

MR. LANSDOWNE: Okay. Doctor, thank you for your time.

THE WITNESS: You're welcome.

MR. LANSDOWNE: There might be other questions.

EXAMINATION OF SANFORD S. LURIA, M.D.

BY MR. CASEY:

Q Doctor, I have some questions. My name is Jim Casey, and as I said, I represent the hospital in this case.

I want to start with your relationship with Hillcrest Hospital in 1988.

Can you and I agree that you were not an employee of Hillcrest Hospital in 1988?

A That is correct.

Q You were an independent medical practitioner on staff at the hospital?

A That is correct.

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Q As I heard your testimony earlier, this patient came to you on a referral by a Dr. Tumay?

A I believe that is Dr. David Thomas.

Q Thomas. So this patient was a patient of Dr. Thomas, and when the hematuria became present, Dr. Thomas referred the patient to you?

A To the best of my knowledge, that's correct.

Q You then took on this patient as a private patient in your practice?

A That is correct.

Q And when you took the patient in, you determined that some radiologic studies needed to be performed on this patient?

A That is correct.

Q And it was then your decision to have those radiologic studies performed at Hillcrest Hospital?

A That is correct.

Q And you then made the arrangements with the hospital to set up those procedures?

A Yes.

Q You also were aware that the radiologists who were interpreting films at the hospital were also medical practitioners like yourself who were not employed by the hospital; you knew

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that?

A Yes.

Q So do you have any reason to believe that if you had decided to send this patient to South Pointe or to University Hospitals or to Mt. Sinai or to the Cleveland Clinic to have those studies done that they would not have been accomplished there?

A No.

Q So is it fair to say then that Hillcrest Hospital was the site that you chose to provide medical care and treatment to your private patient?

A Yes.

MR. CASEY: That's all I have. Thank you.

MR. NORCHI: I have no questions. Thank you, Doctor.

MR. FOGARTY: No questions. Thank you.

CONTINUED EXAMINATION OF SANFORD S. LURIA, M.D.

BY MR. LANSDOWNE:

Q Briefly, Doctor, how many groups of radiologists are at Hillcrest?

MR. CASEY: Or were in '88?

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Q In '88 were there different groups?

A To my knowledge, there was just one group.

Q And who made the arrangements with the group, the hospital, to provide those radiologic services?

A I presume it was done with the hospital and the medical staff.

Q I mean, do you know anything about those arrangements?

A No, I don't. That would be contractual with the hospital.

Q And do you know what kind of arrangement it was at all?

A No, I don't.

Q You just knew that Hillcrest had radiologists and that you could send your patients there?

A Yes.

Q And Hillcrest Hospital would have sbme radiologists there?

A Yes.

Q And that's what you did?

A Yes.

MR. LANSDOWNE: Okay.

MR. SIGMIER: Okay. I think you should read this if it's typed up, okay?

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THE WITNESS: Um-hmm. Right.

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THE STATE OF OHIO,)
COUNTY OF CUYAHOGA.) SS: CERTIFICATE

I, Kathy A. Buhovecky, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within-named witness, Sanford S. Luria, M.D., was first duly sworn to testify the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony then given by him was by me reduced to stenotypy in the presence of said witness, afterwards transcribed on a computer/printer, and that the foregoing is a true and correct transcript of the testimony so given by him as aforesaid.

I do further certify that this deposition was taken at the time and place in the foregoing caption specified.

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

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, on this 28th day of July, 1999.

Kathy A. Buhovecky

Kathy A. Buhovecky, Notary Public
within and for the State of Ohio
My Commission expires January 11, 2003.

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THE STATE OF _____)
) SS:
COUNTY OF _____)

Before me, a Notary Public in and for said state and county, personally appeared the above-named Sanford S. Luria, M.D., who acknowledged that he did sign the foregoing transcript and that the same is a true and correct transcript of the testimony so given.

IN TESTIMONY WHEREOF, I have hereunto affixed my name and official seal at _____, this _____ day of _____, 1999.

_____
Sanford S. Luria, M.D

_____
Notary Public

My Commission expires: _____

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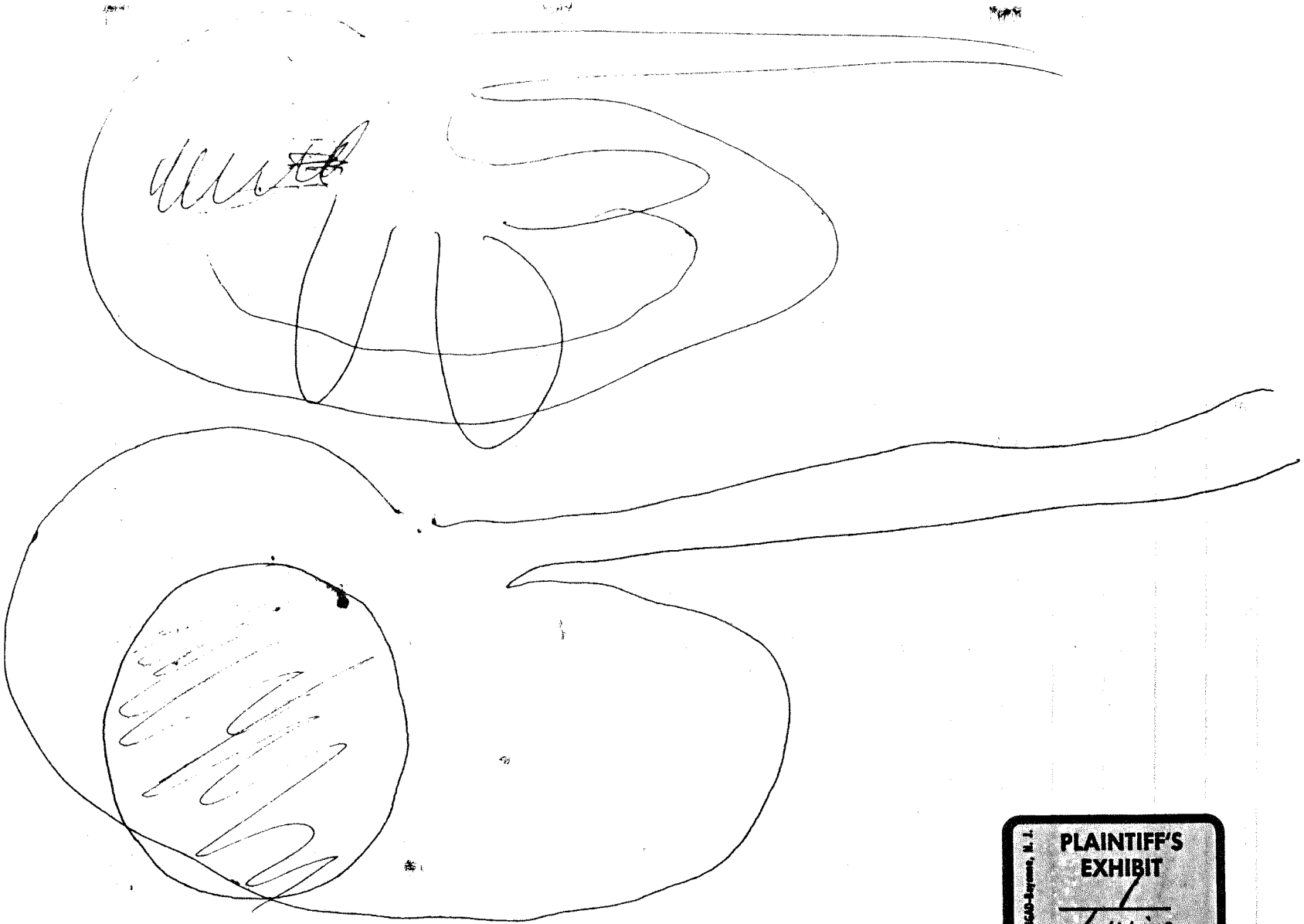

PLAINTIFF'S EXHIBIT
1
Luria