IN THE COURT OF COMMON PLEAS

LORAIN COUNTY, OHIO

GARY DIEDERICH, et al.,

Plaintiffs,

-vs-

JUDGE BETLESKI
CASE NO. 98CV121726

DENNIS CARSON, M.D., et al.,

Defendants.

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Deposition of ATUL C. MEHTA, M.D., taken as if upon cross-examination before Lynn A. Konitsky, a Registered Merit Reporter and Notary Public within and for the State of Ohio, at the Cleveland Clinic Foundation, Desk A-97, Cleveland, Ohio, at 10:10 a.m. on Wednesday, February 23, 2000, pursuant to notice and/or stipulations of counsel, on behalf of the Defendant, Dennis Carson, M.D., in this cause.

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On behalf of the Defendant
Dennis Carson, M.D.

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

CROSS-EXAMINATION OF ATUL C. MEHTA, M.D.

BY MR. POLITO:

MR. POLITO: Let the record reflect that this is the discovery deposition of Dr. Mehta as taken by the Defendants in this matter. This deposition is taken pursuant to agreement of counsel and, Donna, can we get a waiver of any defect in notice or service?

MS. TAYLOR-KOLIS: Oh, absolutely.

Q. Doctor, my name is John Polito. I represent Dr. Dennis Carson in a lawsuit that's been brought by Gary Diederich.

It's my understanding that you have been identified as a possible expert in this matter, although it's been indicated to us that you will be rendering no opinions against my client, Dr. Carson, on issues of standards of care; is

that true?
A. Correct.
Q. It's my understanding your sole role in this case is to comment on Mr. Diederich's medical treatment here at the Cleveland Clinic as well as his present medical condition.
A. Correct.
Q. Okay. Dr. Mehta, for the record, could you state your full name spelling your last name for the record.
A. My name is Atul, middle initial C, Mehta. M-e-h-t-a.
Q. And you're a pulmonologist?
A. Yes.
Q. It's my understanding before we leave here today you will get us a current CV?
A. Yes, sir.
Q. Do you have any subspecialty within the field of pulmonology, doctor?
A. Interventional pulmonology.
Q. How long have you been here at the Cleveland Clinic, doctor?
A. 19 years. This is my 19th year at the Cleveland Clinic.
Q. And your position here at the Clinic is what?

A. I'm a vice-chairman of the pulmonary department. Pulmonary and critical care medicine. I'm a head of the section of bronchology.

Q. Since I don't have your CV and I don't know if you can go by memory, have you ever written on the subject that we're here on today, hard metal disease?

A. No.

Q. Have you ever written on the subject of a patient exposed to either cobalt or tungsten?

A. No.

Q. If I wanted to go to a textbook, doctor, that would be a reliable source on the subject of exposure to tungsten and cobalt, could you refer me to one?

A. Textbook of Pulmonary Medicine by Fishman and one by Roger Bone.

Q. How do you spell the second name?

A. Roger, R-o-g-e-r, B-o-n-e. Neither one of these are occupational medicine textbooks, these are pulmonary medicine textbooks.

Q. Is there any occupational medicine textbooks you could refer me to?

A. There are some, but I don't read them on a regular basis.

Q. My understanding, in referring to the literature, this is a very rare disease?
A. Yes.
Q. How many patients, doctor, would you say you've treated with this condition?
A. Three patients including Mr. Diederich.
Q. Are the other two still living?
A. This was many years ago, I have lost contact with those patients.
Q. So the only one you're currently treating that has this condition is Mr. Diederich?
A. Yes.
Q. Doctor, other than the Cleveland Clinic chart, have you seen any other records in this case?
A. No.
Q. For example, have you ever seen Dr. Carson's office records?
A. This morning I saw a PFT on him and Dr. Dacha, I have seen the records. Did I say I didn't see any? I saw Dr. Dacha's records. Dr. Dacha, the first time when he referred this patient to me, he sent me some records from his office which are part of this record. I certainly reviewed those records.
Q. So were those Dr. Dacha's records himself as

opposed to other people's records?

A. I believe so, yes.

Q. So going back to my question, other than seeing the PFT from '92, have you seen any other records --

A. No

Q. -- of Dr. Carson?

A. No.

Q. Have you ever seen the records of his prior family doctor, Dr. Leano?

A. No

Q. Dr. Arora, the pulmonologist who saw him back in '92, other than the PFT, have you seen any other records from him?

A. No

Q. Have you seen any outside x-rays in this case, doctor?

A. Yes.

Q. What x-rays did you see?

A. The patient came to me with all his x-rays since 1992. Now, I do not remember where those x-rays came from, but this is what was brought by the patient.

Q. Go ahead. I'm sorry I interrupted.

A. So those are the x-rays that I have seen, yes.

Q. Did you make a comment on your -- did you look at the x-rays yourself?
A. Yes, personally, I looked at those x-rays.
Q. Did you make a comment on what you found on the x-rays?
A. Oh, yes, certainly.
Q. Could you tell me where you made that comment and what your comment was.
A. You have to bear with me because this is a big chart and I have to go through my notes.
Q. That's fine. You first saw him in June of '97 if that's of any help.
A. These glasses are new to me. Yeah, here it is.
Q. Okay.
A. June 27, 1997.
Q. Okay.
A. "Severe restrictive lung disease. Suspect pneumoconiosis, exposure to welding fumes, cobalt. Patient doesn't know the constitutes of his welding material. Interstitial disease progressed since 1992."
Q. Am I to understand then, doctor, that in reviewing those, and I can represent to you, doctor, that there were x-rays taken on this man in, I believe 1992. There was one taken on

October 11th of '93.

A. Uhm-hum.

Q. Another one taken on 2-1 of '94. Another one taken on 2-28 of '94. Another one taken on 7-31 of '95. Then there were some taken in conjunction with his last illness which ultimately ended up with a referral to Dr. Dacha and then a referral to you.

Is my understanding correct that you reviewed all of those x-rays?

A. I reviewed all the x-rays the patient brought to me that particular day. Now, I exactly don't remember the dates of those, but when I write this thing that it has progressed I have seen serial x-rays, that there is not '90, '92 then '97.

Q. Right. To my understanding then in 1992 there was interstitial fibrosis seen on chest x-ray?

A. That's my recollection, yes.

Q. Fair to say that, doctor, if this was hard metal disease you would not expect an interstitial fibrosis to clear?

A. Yes.

Q. So you, as a matter of fact, if the man continued

to have exposure from '92 through '97, you would expect on chest x-ray to find a worsening of the interstitial fibrosis?

A. Yes.

Q. So if x-rays during that time were interpreted on several occasions as being normal by a radiologist, you would disagree with them?

A. If they were read as normal I would disagree with that.

Q. Certainly you would agree that an internist would have the right to rely on a radiologist to interpret the films?

A. Would you please rephrase the question --

Q. Many times --

A. -- in all fairness.

Q. Many times you have seen in your practice where you have ordered chest x-rays, now you probably interpret those films yourself --

A. Yes.

Q. -- along with the radiologist, but you are aware that other specialties rely on radiologists because they have an expertise in that area in interpreting films, true?

For example, you have a family practitioner who orders a chest x-ray. He would have the

right to rely on a radiologist to interpret those films?

A. He has a right to rely on it, yes.

Q. Okay.

A. If that's the question.

Q. Okay. And certainly if a chest x-ray, if chest x-rays showed an infiltrate that was suspected as pneumonia, you would want to get a follow-up chest x-ray?

A. Certainly, yes.

Q. And if it was pneumonia and it cleared -- strike that.

If it cleared, you would have the inkling that it was probably pneumonia, true?

A It would reduce the suspicion for other things, yes.

Q On the other hand, if the infiltrate persisted, despite antibiotic treatment, you would have to start thinking of other things, true?

A. Correct.

Q. So if a family practitioner received a report back that the x-ray was clean, it would give him some reliance that you were dealing with a pneumonia as opposed to some other process?

A Yes.

Q. Doctor, I want you to take a look at a chest x-ray report of 2-28-94 if you would.

MS. TAYLOR-KOLIS: Let me just say for the record before we start doing this, I'm going to object to this line of questioning by Mr. Polito as I made it specifically clear that the doctor had indicated to me that he did not want to participate in this case as an expert witness.

Having postured that, that objection for the record, I will allow this, at least on a limited basis, and if we have to resolve it with the court at a later time, we will.

MR. POLITO: Just let the record reflect that this doctor has testified that based on his review of outside films it was his opinion that this interstitial fibrosis existed since 1992. My inquiry is, I wanted to show him some chest x-rays that showed indeed that at least the radiologist interpreted it differently.

MS. TAYLOR-KOLIS: Okay, and I accept that. And I agree with you that he

has stated that he read the films. He's never seen the radiologist's interpretation and it's manifestly clear that without those interpretations he was able to come up with the right diagnosis.

MR. POLITO: Okay.

Q. Doctor, from your review of this 2-28-94 report it would appear from this reading of this report that this was a clean x-ray, would you agree?

A. Yes.

Q. Then I'm going to show you, doctor, a chest x-ray report of ten --- strike that. 7-31-95. You would also agree that that's a clean chest x-ray?

A. Well, there's no change from 2-28-94, so it's in that relation.

Q. And if we go back to the 2-28-94 report which I just showed you, you just admitted that that was a clean chest x-ray.

A. Right.

Q. So if there's been no change since 2-28-94, it would mean then on 7-31-95 it was also a clean chest x-ray?

A. Probably.

Q. So based on those two chest x-rays, one done in

1994 and one done in 1995, there was no findings at least on chest x-ray consistent with hard metal disease, would you agree? At least in terms of the x-ray interpretation as opposed to your interpretation.

A. Would you please rephrase the question.

Q. Based on the interpretations of the radiologist in February of 1994 as well as July of 1995, that these were clean chest x-rays, based on the chest x-ray interpretations alone, there would be no evidence of hard metal disease, true?

A. There's no evidence of fibrosis.

Q. Well, there was no evidence of any type of infiltrates seen on these two chest x-rays according to your interpretation?

A. Right.

Q. Have you seen any of the EMH, Elyria Memorial Hospital records on this patient?

A. Yes.

Q. They would be contained in this file?

A. Yes.

Q. The only records you've seen would be contained within the CCF chart?

A. Yes.

Q. Have you seen any employment records of

Mr. Diederich?

A. Yes.

Q. Specifically what employment records did you see?

A. I wanted to know what he was being exposed to at work because the first time when he came to me, although I had suspicion, I did not have definite documentation, so I asked him to bring me the information from his occupation, from his work site, that what are the substances he's being exposed to.

Q. Did he then bring you the MSDS sheets showing he was exposed to cobalt and tungsten?

A. Yes.

Q. Again whatever materials he did bring to you would be contained within the chart?

A. Yes.

Q. That's the material safety data sheet?

A. Right.

Q. To your knowledge, had he ever provided this to any other physician prior to you?

A. No. I have no -- but this is the first time -- I said no in the sentence, that when I asked him, that what were the things that he was exposed to at work, he had no clue.

Q. Okay.
A. And, therefore, I suspected that nobody had asked him that particular question before or that he would have showed this thing to anybody else before.
Q. Have you seen any depositions, doctor, that were taken in this case?
A. No.
Q. Have you seen any expert reports authored by anybody in this case?
A. No.
Q. Specifically a Dr. Brower, have you seen his report?
A. No.
Q. Dr. Anthony DeMarco?
A. No.
Q. Dr. Carl Culley?
A. No.
Q. Do you know any of those physicians?
A. I know Tony DeMarco, he's in town. He's at Metro General Hospital and his girlfriend is a friend of mine. Tony DeMarco and I have interacted on some cases so I know him on a professional basis.
Q. I want to talk about -- how should we refer to

it, is it pneumonitis secondary to cobalt, tungsten poisoning, how do you want me to refer to it so we're on the same page?

A. Hard metal interstitial disease.

Q. Could you describe that for me, what it is, doctor.

A. Exposure to hard metals such as cobalt, tungsten, nickel, cadmium, titanium and tentillum upon inhalation can cause fibrotic reaction in the lung. And close to ten percent of patients exposed to this hard metals would have a fibrotic reaction into the lung.

It's a gradually progressing condition associated with shortness of breath, cough, deteriorating lung function and chest x-ray findings. That's been the record from this condition and there's no good treatment for this condition except to remove the individual from the environment.

Q. Is it a restrictive disease then?

A. Yes. It is a restrictive lung disease.

Q. Now, you gave some of the symptoms, but they would include shortness of breath, cough, with or without production?

A. Usually a dry cough, yes.

Q. Anything else in terms of symptomatology of this disease other than shortness of breath, usually a dry cough?

A. Yes. There are certain things which are not pertaining to this case which could occur with, you know, exposure to hard metals, something which is referred as hypersensitivity pneumonitis has been reported with hard metal disease which may be associated with wheezing and productive cough. On occasion it has also been known to cause asthma. It has also been known to cause cardiomyopathy, enlargement of the heart and the symptoms related to these involve patients who present with, but in this particular situation he came in with fibrosis of the lung and that is what I am mainly referring to.

One other thing I should add is that under the microscope there are classical findings of giant cells and, therefore, this interstitial fibrosis is reported as giant cell pneumonitis and that's a telltale sign of hard metal exposure.

Q. So that was done, you knew that, after Dr. Rice did his biopsy?

A. Right.

Q. Let me go back to a couple of things you mentioned.
A. Yes.
Q. You mentioned that this condition can produce asthma-like symptoms?
A. Yes.
Q. So this disease process then can mimic asthma?
A. We are to be very clear here so we do not mislead anybody in all fairness.
Q. Okay.
A. That this patient has interstitial lung disease.
Q. I'm not -- I'm just saying that --
A. Okay.
Q. I'm just saying that though, but I understand that because when he came to you he already had chest x-ray findings --
A. Right.
Q. -- of fibrosis.
A. Right.
Q. So at the time you saw him, there was already fibrotic changes seen on chest x-ray?
A. Yes.
Q. So you, and clearly the initial thought by some people, thought it might be another pneumonia, but when it didn't clear, then other issues had

A. Right.
Q. For example, did Dr. Dacha ever make the diagnosis of a hard metal disease?
A. He made the diagnosis of interstitial disease, but he did not make the diagnosis of hard metal disease.
Q. Were you also aware that within his differential diagnosis was bronchial asthma?
A. Probably.
Q. Okay. So I guess what I'm trying to get to is that the condition before it's ultimately diagnosed can mimic that of asthma?
A. No. No.
Q. No?
A. No. I didn't say that. See that's what I don't want to mislead you, I don't want to mislead anybody.
Q. Okay.
A. Asthma is one part of hard metal problems. That's separate. Some patients get hypersensitivity pneumonitis, that is separate. Some patients get interstitial pulmonary fibrosis. Did his condition mimic asthma? Answer to the question is no, his condition did

not mimic asthma.

Q. Okay. We'll get to asthma in a second, I want to talk to you about that.

If you wanted to rule in or rule out this hard metal disease, what tests would you order?

A. One is bronchoscopy and bronchiole alveoli lavage and if bronchiole alveoli lavage reveals giant cells in a typical setting where you know there's exposure to certain metals, a typical chest x-ray finding, typical pulmonary function findings.

Q. What would be the typical chest x-ray?

A. Interstitial -- let's say, a patient comes in with exposure, known exposure to hard metals.

Q. Okay.

A. And hypothetically the patient has worked ten years with this metal.

Q. Okay.

A. He has interstitial infiltrates on the chest x-ray. He has pulmonary functions which reveal that there is restriction of his pulmonary functions.

Q. Okay.

A. And obviously he's symptomatic from this condition. And then the test for me would be, or

diagnostic test would be that if I do bronchoscopy and a bronchiole alveoli lavage, that is washing the lungs or the alveoli, and if I find giant cells in this typical setting, that would be a diagnosis of giant cell pneumonitis from hard metals.

The second thing would be that doing an open lung biopsy like what we did in this particular setting would be diagnostic of giant cell pneumonitis.

Q. But again, you're talking about a hypothetical patient who already has interstitial fibrosis seen on chest x-ray?

A. Right.

Q. As was the case with Mr. Diederich?

A. Right.

Q. Let's talk about asthma for a second. What is asthma?

A. Asthma is a condition that is caused by inflammation of the -- let me rephrase it, please. It's an eosinophilic inflammation of the airways characterized by repeated narrowing and dilatation of the airways.

Q. It's my understanding that about five to eight percent of the U.S. population has asthma?

A. Yes, five percent of the U.S. population, close to it.
Q. The typical signs and symptoms of asthma would be dyspnea?
A. Dyspnea, yes.
Q. Coughing?
A. Cough.
Q. With or without production?
A. With production.
Q. Okay. And wheezing?
A. Wheezing.
Q. Anything else that you would expect with asthma?
A. An episodic nature of the disease, that it's not constant.
Q. Would you expect to find any changes seen on a chest x-ray with asthma, doctor?
A. It's a broad question.
Q. I know it's a broad question, but typically aren't your chest x-ray findings normal with asthma?
A. Usually the chest x-rays are normal, however findings such as hyperinflation, atelectasis and pneumothorax could be found in patients with bronchial asthma.
Q. But if a physician suspects asthma and gets back

a normal chest x-ray, a normal chest x-ray certainly does not rule out asthma?

A. You're right.

Q. You describe it as an episodic disease and by that you mean it flares up and goes away?

A. Right.

Q. So a patient may come to his physician once or twice a year for asthma-like flare-ups, true?

A. Yes.

Q. As opposed to seeing a physician on a constant basis for something more like hard metal disease?

A. Well, again, I don't want to mislead. Once again, asthma, it's a spectrum of disease just like diabetes; somebody's diabetes is controlled by just diet and exercise and somebody needs to take insulin four times a day.

Asthma, it goes anywhere on the spectrum from mild intermittent asthma close to severe persistent asthma. So depending on the severity of the illness, that they are better and worse, so again it's a spectrum of the disease and not always episodic as I probably made you perceive that.

Q. But isn't this disease usually characterized by periods of illness alternating with periods of

good symptom control?

A. Majority of the patients, yes.

Q. And exacerbation of the respiratory symptoms at work is not unusual with patients with asthma, true?

A. If they have occupational asthma.

Q. It can be exercise-induced asthma?

A. Yes.

Q. Exercise such as playing basketball can aggravate asthma or bring on the symptoms of asthma?

A. Yes. Uhm-hum.

Q. Respiratory infections are also a stimuli for asthma, true?

A. Yes, absolutely.

Q. Are persistent chest x-ray abnormalities consistent with the diagnosis of asthma, doctor?

A. No.

Q. It would be more consistent with something like hard metal disease, would it not?

A. Yes.

Q. And treatment of asthma would include what, doctor?

A. Once again, as I mentioned before, the spectrum of illness, patients with mild asthma, they could be treated with drugs called beta antagonists on

an as-needed basis and as needed one can add steroid inhalers, theophyllines, oral steroids and antileukotrienes.

Q. Are they the type of drugs that will give them, help them overcome the episodic type symptoms the patient is having?

A. Not only episodic symptoms but to remain symptom-free by the maintenance therapy.

Q. Okay. But even though taking those maintenance drugs, it's not unusual for them to have another flare-up?

A. Yeah.

Q. So it wouldn't be unusual then for a patient with asthma to see his doctor once or twice a year for episodic-like flare-ups?

A. Right.

Q. Doctor, I want to go back to your initial meeting with Mr. Diederich.

Did he give you a work history, doctor?

A. Now, this is two-and-a-half years ago, but this is the work history which we got from him. Patient worked seven years at concrete saw blade plant. He works as a welder. That's the history we have. And there are fumes in the air.

Q. But at that point he didn't tell you what kind of

fumes he was exposed to, it wasn't until later?
A. No. That's the first visit he said that there's fumes in the air.
Q. But he didn't tell you specifically what the fumes were?
A. No.
Q. Going back to, he indicated he was a welder, what else did he give you in terms of, did he wear any protective clothing or respirators?
A. No. Patient does not wear mask.
Q. I want to talk to you about that for a second, doctor.

Doctor, what's the purpose of a mask?

A. To prevent inhalation of certain particles.
Q. Including cobalt and tungsten?
A. I guess so, yeah.
Q. Did Mr. Diederich ever tell you that he had been advised to wear a mask when welding back in 1992?
A. I didn't ask him that specific question, so I don't remember him relating that information to me.
Q. From your review of that chart do you see anything in there that indicates that he had been advised by a pulmonologist back in 1992 that he should wear a mask when welding?

A. No.
Q. Doctor, if he had worn a protective mask while welding from 1992 up till 1997, you would agree that his interstitial fibrosis would have been less?
A. No, I can't agree with that, you know, because things will still go through the mask or by the side of the mask. It depends on the type of the mask to be worn.
Q. Certainly. But certainly, doctor, he wouldn't have that full intake of fumes that he would have without the mask, true?

What would be the purpose of the mask if it doesn't help at all?
A. Well, sometimes the mask may not help if it's just a smoke, you know, if it's smaller particulates. Every mask has its own characteristics, how much it would prevent the inhalation. So if the particles or the smoke is less than the protection offered by the mask, I don't think it would have made any difference.
Q. If this man sees you back in 1992 and you tell him to wear a protective mask when welding, what would you have told him to wear?
A. Well, what I would have told him to wear is

whatever your occupational, whatever your physician at the plant or whoever is in charge, depending on what he's using at his workplace, recommends. There are different recommendations for different masks -- different occupations. I mean, people that work with asbestos, they have to wear it from head to toe, those type of things.

Q. The purpose of the mask is to reduce the exposure to the fumes, to the smoke, to the particles, true?

A. Yes.

Q. Were you aware back in 1992 that he had been diagnosed with asthma by a pulmonologist?

A. No.

Q. Did he ever tell you that?

A. He told me that he was treated for asthma, but my, you know, my thinking was that it was from Dr. Dacha.

Q. Okay. So when you say your thinking was it was from Dr. Dacha, it was your thinking that Dr. Dacha had diagnosed him with asthma?

A. That he was receiving treatment for asthma from Dr. Dacha. He didn't tell me about any other physicians and my conversation only was with

Dr. Dacha. This is what he said, patient treated as asthmatic with only mild improvement since 1992.

Q. To your knowledge then, while this man worked for Diamond Products in any position, did he ever wear any protective clothing at all?

A. Not to my knowledge.

Q. Let's take a look at your first note there, doctor. This first note is not your note, is it, doctor?

A. That's my assistant. He would gather all the information for me to save me some time and then I go over entire note. As you see, the first line of my note which says, reads that I have reviewed H&P outlined by Mr. Christi and agree with his findings in the chart, chest x-ray reviewed, patient reexamined and findings verified,

Q. Cardiomegaly, that's an enlarged heart?

A. Yes.

Q. To your knowledge had the patient ever been referred for a workup of cardiomegaly prior to seeing you?

A. Not to my knowledge.

Q. So you weren't aware that back in 1994 he had

been referred over to a cardiologist at EMH for a workup and the workup was normal?

A. I don't think I had that knowledge when I -- because I ordered another echocardiogram myself.

Q. Okay.

A. So I'm not aware of his cardiology workup and I don't remember it.

Q. The echo that you ordered, was it a normal echo?

A. It was a normal echocardiogram.

Q. So if I were to tell you that a similar echo was done in 1994, it would be consistent with what you found in 1997?

A. Yes.

Q. His PFT at the time you saw him showed what, doctor?

A. As my first note says, severe restrictive lung disease, that is what I saw the first time he came to me.

Q. And that was a PFT from when?

A. Okay. Let's see. He was here in June.

Q. I don't know if this helps you, doctor, down at the bottom right there.

A. No, I have that. No, I'm just looking at this, the numbers from -- is that the May 16th PFT?

Q. Right.

A. Okay. It is based on Elyria Memorial Hospital PFTs that I made that conclusion that he had severe restrictive lung disease.
Q. Based on what specific numbers, doctor?
A. FEVl of 32 percent, total lung capacity of 43 percent.
Q. How did that compare to his one done back in 1992?
A. 1992, only part of 1992 was -- this is a full PFT, I think, which I vaguely remember it was just spirometry on 1992. I don't think total lung capacity was checked.
Q. Okay.
A. And can I refer to 1992?
Q. Sure.

MS. TAYLOR-KOLIS: Sure.

If you have any additional documents you want him to look at, I think that's complete, but I don't want to make that representation.

MR. POLITO: Fine.

A. The thing is that this 1992 study is totally unreliable.
Q. Why?
A. Because the patient was constantly coughing and I

would not make any conclusion based on this particular study.

Q. Did he ever give a history of having pneumonia to you or your assistant?

A. I have to go back to my records. "Patient treated for questionable pneumonia with no improvement." That was in November of '96. "Left chest pain, increased cough with clear mucous. And hot spells." And this was in 11-96 he had one pneumonia.

Q. Were you aware of any pneumonias prior to November of '96?

A. No.

Q. In terms of then his treatment protocol, you referred him over to Dr. Rice for a biopsy?

A. Yes.

Q. In the interim you were able to get these MSDS forms from his employer?

A. Right. Uhm-hum.

Q. Which showed that he was exposed to cobalt and tungsten?

A. Yes.

Q. And then the biopsy did indeed confirm giant cell pneumonitis consistent with exposure to those metals?

A. Yes.
Q. I want to talk to you now, doctor, about his course after that biopsy up to the present time.
A. Uhm-hum.
Q. You, I think, wrote a note to Dr. Dacha dated July 29th, 1997 --
A. March 6th -- hold on. Yeah, here it is July 29th, 1997.
Q. At that time you already knew the results of the open biopsy?
A. Yes.
Q. And you now felt at this point that his symptoms could be explained by his exposure to cobalt at work?
A. Yes.
Q. At that time you put him on a steroid?
A. Yes.
Q. Anything else other than a steroid initially?
A. No.
Q. Okay. Take me through then, doctor, without me going through each visit, how this man did up to the present time.
A. All right. I will follow the notes.
Q. Fine.
A. Would that be okay?

Q. That would be great.
A. So his biopsy was somewhere in June of '97.
Q. It was actually July 15th.
A. Yes. I saw him on July 29th, 1997 when I had the diagnosis of giant cell pneumonitis from hard metal exposure.
Q. So?
A. So we removed him from that environment and I treated him with Prednisone, 60 milligrams once a day for eight weeks and then to taper it by five milligrams every other week if he responds.

I also placed him on Zantac. That is just an antacid type of medication to prevent any steroid-related symptom damage. So he went home and came back to see me, as scheduled, in October, on October 15th, 1997 when he was still on 60 milligrams of Prednisone.

Q. How would that dose, how would you describe the dose of Prednisone?
A. It's a reasonably high dose of Prednisone.
Q. How was he doing in October of 1997?
A. In October of '97 he was showing subjective improvement which is not uncommon with steroids. It's a euphoria. Steroids make you feel better even if you are not getting better, so there was

some subjective improvement he felt, but there was minimal objective improvement meaning that there was no significant improvement in his breathing tests.

Q. Let's talk initially subjectively, then we'll talk about the PFT.

A. Right.

Q. At that time he was back to work full time, if you refer to your October '97 note.

A. You know, I don't have that, I don't have that information, I'm sorry. Okay. Back *to* work full-time job, right.

Q. He was walking half a mile a day?

A. Right.

Q. He was able to climb a flight of steps?

A. Right. Yes.

Q. Okay. The PFT done on that date, 10 of '97, showed what?

A. I have to find that. Do you have that handy with you?

Q. I think I do, doctor. Here it is.

A. I'm going to compare this with the study from May of 1997 performed by Dr. Dacha.

Q. Okay.

A. And I see there is no significant change in his

lung functions.

Q. So his --

A. His FEV1 *is* 1.51 which was 1.40 in May of 1997.

Q. Okay.

A. And his diffusion capacity was 11.48 and was 13.6 when he came to see me here.

Q. Okay. So a mild improvement?

A. Well, the thing is, what it is is basically there's a technical variation. If I do the same test the next day --

Q. It could be plus or minus?

A. Yes, plus or minus, so I would not call it any significant change. When I put someone on steroids, when I'm looking for improvement I'm looking for substantial improvement, 20 percent or higher improvement to claim that steroids are working to impact on my therapy, that I would continue with high dose steroids or reduce the steroids rapidly to a minimum dose, you know, to reduce the side effects.

Q. You next saw him when?

A. I want to clarify.

THE WITNESS: Can I clarify something?

MS. TAYLOR-KOLIS: Sure.

A. I don't want to mislead anybody.
Q. Sure.
A. Back to work full time meaning that, not doing the same job of what he was doing.
Q. Oh, right.
A. It was my understanding that he had to be removed and he was removed from the environment where he was exposed and I told him never to get back into that area. So back to full-time job meaning that he was doing some other duties probably at the same site or some other area, so this has nothing to do with his old occupation.
Q. Got it.
A. Okay.
Q. So we're at the last visit?
A. We are now at March 18th, 1998.
Q. Got it. How was he doing at that time?
A. March 18th, subjective and objective deterioration on lower dose of steroids. His FEVl had actually gone down and his diffusion capacity had gone down as well.
Q. What had you lowered the steroid from, 60 to 10?
A. Right. This is how usually it is done, you reduce the steroids from 60 by five milligrams every other week. And we are trying to find out

the good maintenance dose. You can't leave someone on 60 milligrams of Prednisone because of profound side effects.

Q. Exactly.

A. So we were tapering his steroids. As he came down to ten milligrams of Prednisone, his symptoms got worse as well as his pulmonary function showed deterioration.

Q. What did you do?

A. At the time, increased Prednisone again to 20 milligrams per day.

Q. When's the next time you saw him?

A. I saw him in May of 1998.

Q. Okay.

A. At that time there was some subjective improvement. And this was just now my own gut feeling, I wanted to reduce his Prednisone so I reduced to it 15 milligrams today.

Q. Was a PFT done in May?

A. Do you have a copy of that?

Yes, it was done. As you see here in March I ordered spirometry and DLCO, I ordered it for the following, yes.

Q. Okay.

A. And there was, yeah, his FEVl had not budged, yet

his DLCO had come up from 9.8 to 12.6 between these two visits, so I reduced the dose of Prednisone to 15 milligrams a day.

Q. You saw him next when?

A. I saw him in June of 1998.

Q. How was he doing at that time?

A. In June of 1998, let's see here. Recently discharged from the hospital. He had hospitalization since my last examination on him, as he mentioned recently discharged from the hospital following a bout of left-sided chest pain which was found to be neuromuscular chest pain. Pain had improved. And that is what had happened.

Q. When you say neuromuscular chest pain, was this unrelated then?

A. No. My thinking was that it was related to his steroid use.

Q. Okay.

A. There are a couple things; one, his condition excelled. He had a severe cough as a result of his fibrosis. Every time he tried to do a moderate degree of exertion, take a deep breath, that would make him cough, along with a high dose of steroids and I thought that might have caused

a rib fracture.

Q. Ultimately was a rib fracture diagnosed?

A. Yes, this is what I think I said, "suspect fractured rib worsens neuromuscular chest pain leading to reduced air entry and hyperventilation with exercise."

Q. Was a PFT done in June?

A. A PFT, let's see. I did not make a note of that, so I'm not so sure.

Q. I didn't see one in my chart, but the next one I see is September.

A. No. The thing is, usuaily when the PFTs are done I write it in my chart and I don't see it and also, that I did not order it in May. in May my last note doesn't say come back with PFTs so probably I did not order the PFTs on him.

Q. When did you next see him?

A. I saw him in September of 1998.

Q. How was he doing at that time?

A. Spiro, no change. Diffusion capacity, there was mild reduction. His cough had persisted. He had leg cramps, muscle cramps, his shortness of breath was somewhat worse. His chest pain was somewhat better.

And again, because there was further

reduction, I don't have the numbers here, I didn't write the numbers, but I did write that there was a, diffusion capacity was down and, therefore, I increased Prednisone to 15 milligrams from 12-and-a-half milligrams.

Q. I thought you had --

A. We didn't talk about that, but when he came with chest pain --

Q. In June?

A. We reduced it to 12-and-a-half.

Q. So now you're bumping it back up to 15 a day?

A. Right.

Q. When did you see him next after September of '98 because I don't have anything after that point?

A. Yeah, I saw him in December of 1998.

Q. Okay.

A. At that time there was improvement in his diffusion capacity and he said that he was no worse than before.

Q. And is he still on the 15?

A. At that time he was on 15 milligrams of Prednisone and I had added Colchicine on him, it's a pill, Colchicine, .6 milligrams twice a day.

Q. What is that?

A. It's just an antifibrogenic medication that reduces fibrosis scarring formation in the lung. I think during the time there was new data coming out that this drug may prevent further scarring in the lung, so I placed him on that medication.

Q. So up to that placing him on this drug, the only drug you had him on was Prednisone and was he still on the Zantac as well?

A. He was on Zantac, yes.

Q. So other than those two drugs, had you prescribed any other long-term drugs for him?

A. No.

Q. And this Colchicine was going to be a long-term drug?

A. Colchicine was going to be a long-term drug if it would produce some improvement.

Q. When did you see him next after, was it December you just said?

A. Yes, December. I saw him in April of 1999.

Q. How was he doing then?

A. Diffusion capacity had further gone down. His shortness of breath had increased. His dyspnea on exertion had increased. There was some side effects of steroids such as emotional instability and being very labile, emotionally labile. He

also had frequent urination and thirst.

That is what I suspected and then I thought that the majority of his problems were as a result of the side effect of steroids.

Q. Okay.

A. So I further reduced his steroids. At that time I put him on Imuran, 150 milligrams a day.

Q. What's that, doctor?

A. Imuran is actually a chemotherapy agent in higher dosages and I put him on this to use its antiinflammatory reaction so that I can reduce the dose of steroids. So it is kind of a steroid sparing agent. I used it because he was having lots of side effects from steroids.

Q. How much Imuran did you have him on?

A. 150 milligrams per day.

Q. Was he still on the Colchicine at this time?

A. At that time, yes, he was still on Colchicine at that time.

Q. So as of what date are we talking about now?

A. Let me take you back. He was placed on Colchicine on June 24th, 1998 and he was on Colchicine at least till April of 1999.

Q. Was it stopped then?

A. Okay. Let me -- I have to -- no. He continued

on it until July 1999.

Q. Imuran was started in April of 1999?

A. Imuran was started on April 13th of 1999.

Q. So as of April then of '99 he was on the Prednisone, Colchicine?

A. And Imuran was added.

Q. Still on the Zantac?

A. He's still on Zantac, yes.

Q. When's the next time you saw him after April then?

A. July of 1999.

Q. How was he doing at that time?

A. His dyspnea on exertion persisted. General weakness persisted, however he was able to climb a flight of stairs. And let's see. My last impression, subjectively stable, objectively there was some improvement.

Q. So a PFT was done on that day?

A. Yes. His DLCO was improved to some extent.

Q. Do you have any idea what it was at that time?

A. I have to go back and look at it.

What's the date we are talking about now?

Q. July of 1999.

A. I have the PFTs on July of 1999. July 1999, his diffusion capacity, which was 6.77 in April of

1999, it had gone up to 13.1 in July of '99. 7-2-99.

Q. So in terms of an improvement, how would you describe that?

A. There was a significant improvement because as you see it was 22 percent in April and it went up to 44 percent. It doubled since I added Imuran in his therapy.

MS. TAYLOR-KOLIS: For clarification, you mean lung capacity?

THE WITNESS: No. Diffusion capacity.

MS. TAYLOR-KOLIS: Oh, sorry.

Q. What was his lung capacity?

A. His lung capacity we did not check:. I did not do all the tests all the time he came in. His FEV1 was unchanged. FEVl was 1.32 in April of 1999 which was unchanged. It was 1.27 in July of 1999, but the diffusion capacity which is a very important parameter, had doubled during this time.

Q. When's the next time you saw him after July of '99?

A. Then I saw him in November of 1999.

Q. Is that the last time that you have seen him?

A. Yes, this is the last time I have seen him.
Q. Why don't you go ahead and just tell me how he was doing at that time. We can get the note.
A. He remains on Colchicine. He remains on Imuran. The dose of Imuran has been increased to 175 milligrams per day. The dose of Prednisone has been reduced to 7-and-a-half milligrams per day. And --
Q. The Colchicine is how much?
A. .6 milligrans once a day.
Q. Okay.
A. It might be an error on my part that I ordered once a day, but it should be twice a day and he's been on it twice a day all along.
Q. The Colchicine?
A. Yes. So it might be a slip of pen on my part.
Q. Got to watch those slippery pens.
A. We do, in all fairness.
Q. How was he doing subjectively?
A. Subjectively he was about the same as compared to his previous appointment in July of 1999. He complained of poor sleep. He worked full time whatever duty he was doing, but, however, he had continued to have lots of cough and chest wall pain persisted all this time.

Q. Okay. Did you do --
A. His numbers, yes, his numbers did not change in November of 1999.
Q. Meaning what, doctor?
A. We are at November 1999, his FEVl remains 1.31.
Q. Okay.
A. And his diffusion capacity is 14.51.
Q. And in --
A. It was 13 point -- 13.1 -- no. 13.01, I'm sorry.
Q. Was his total lung capacity measured at that time?
A. No. Total lung capacity was not measured at that time.
Q. And when are you planning on seeing him again, do you know?
A. Three to four months from November, so he should be coming next month to see me.

MS. TAYLOR-KOLIS: He has a scheduled appointment in March.

A. Yes.
Q. At that time -- I assume you again will get another pulmonary function study?
A. Yes. He's going to get a diffusion capacity alone at that time.

Now basically what is happening is that I

have stabilized him, it seems that he's stable at the present time. And now my job is to balance his medications so that he gets minimal side effects because these are very powerful medications and we want to minimize the side effects of this medication. Actually I have discontinued his Colchicine on the last visit.

Q. So that's no longer?

A. Right.

Q. So as of the present time he's still taking Prednisone, 7.5 milligrams per day?

A. Yes, sir.

Q. And the Imuran at 175 milligrams per day?

A. Correct. Now, as I recollect from my notes, at this stage I feel that his disease is not going to get any better so I'm not going to push any medications and maintain him on the least amount of medication.

Q. So what is your plan then, in terms of medications, for him in the future, doctor? If he stays, let's assume he stays stable --

A. Right.

Q. Okay. -- will you keep him on the same dose of Prednisone or attempt to lessen it?

A. No. I'm not going to reduce Prednisone because

I'm afraid that if I stop Prednisone and for some reason his disease progresses, in my experience with other fibrotic conditions, that it is very hard to bring it back again under control, so he will always remain on 7-and-a-half milligrams of Prednisone.

Q. How about the Imuran?

A. Imuran, the first step I did was I took him off the Colchicine. Now when I see him, if there's no deterioration, that means taking him off the Colchicine did not do any damage, then I will slowly reduce Imuran to probably a hundred or 75 milligrams, 75 or a hundred milligrams per day to keep this condition under control.

Q. Is that something, assuming he stays stable, that he would need the rest of his life?

A. Probably, yes.

Q. So in terms of the Prednisone, 7.5 milligrams and the Imuran assuming, as you said that there's been no worsening of his condition, those are two medications that you would predict that he's going to need for the rest of his life?

A. Time-out.

Q. Okay.

- - - -

(Off the record.)

- - - -

Q. At the present time, doctor, do you plan on putting him on any other medications?

A. No.

Q. Okay.

A. I'm going to take this thing as one visit at a time because nobody has enough experience with this condition. It does not respond to anything and I would be happy if I can keep him at this level.

If he deteriorates I don't know what I would do for him. I'd probably put him back on a very high dose of Prednisone, then once again taper it and bring it to a maintenance level, that is what I would do. I may try Cytoxan on him if Imuran doesn't work.

Q. At the present time it appears that the Imuran is working?

A. I don't know what is working, but he's stable.

Q. At the present time, if you could put it in layman's terms, what is his lung capacity, how would you describe it?

A. It is he has lost 70 percent of his lungs.

Q. Do you have an opinion, doctor, if that's going

to get any worse?
A. His lung condition you mean?
Q. Yes.
A. His lung condition is going to get worse.
Q. Do you have an opinion, doctor, what his lung capacity was in 1992?
A. No, I don't have any opinion on that because the only breathing test you gave me is totally unreliable.
Q. So you don't know if -- so you have no opinion then what his lung capacity was in 1992, is that a fair statement?
A. I don't know what his lung capacity was, nothing attached to that, yes.
Q. Okay. I guess I wanted to know if I would ask that question, what was his lung capacity in 1992, 1993, 1994, 1995, 1996; is it fair to state that you have no opinion as to what it was in any particular year prior to you seeing him?
A. I'm sure it was low and it was not a normal capacity because this did not come overnight. This is an insidious disease and it slowly deteriorated, that's my opinion because when he came to me his lung capacity was 40 percent of predicted, if I'm not mistaken. If I can go back

to that May of 1997 PFT and we looked at his total lung capacity it was, his total lung capacity at that time was 43 percent.

Q. So 43 percent meaning that at that time it was, he had lost approximately?

A. 57 percent of his lung by scarring.

Q. You are saying from May of 1997 up till November of 1999 he had lost an additional 13 percent?

A. 13 percent.

Q. Although that's not been tested?

A. No. It's not been tested. There might have been some improvement with all these medications and, you know, taking him out of the environment, but as I mentioned that, if you ask my opinion when did this thing start, I think it probably started when he first became symptomatic and I can't give you a precise lung capacity on him, but this process started at the time when he started having the symptoms.

Q. Well, it probably started even before he had symptoms, wouldn't that be true?

A. Oh, yeah.

Q. So it would be fair to say if this man began working at Diamond Products back in 1985 without any protective gear on, it probably started as

far back as then, true?
A. Yeah, probably.
Q. So it would be fair to say from 1985 till 1993, if he had exposure at work to fumes, dust, whatever, that would have contributed to his hard metal disease, true?
A. Yes.
Q. And you would agree that if he was exposed during that period of time without any protective device, that his lung capacity would have been diminished from '85 to '93 due to that disease?
A. That's too much speculation on my part going all the way back to '85. It does take some time before the disease started. It's not the day you started working, you start the disease.
Q. It all contributes towards it, doctor, true?
A. It does contribute, yes.
Q. I guess that's where my question is. Do you have an opinion in 1993 what his total lung capacity was? You say he's lost 70 percent now. Do you know how much he had lost as of '93?
A. It was not normal. If you ask me to speculate what would have been his diffusion capacity I, first of all, I would make a statement that it was not normal, number one.

Now if you ask me to pick a number, I don't think it would be fair to anybody for me to pick a number and say that it was 50 percent of predicted or whatever, 60 percent, but if you put me on the spot and say I have to pick a number, I would say probably it was 60 percent.

Q. 60 percent?

A. Total lung capacity 60 percent of what it should have been because the temper of the illness, what I have seen of him in the last two-and-a-half years or -- yeah, last two-and-a-half years, that I think it is coming down gradually.

Q. So now it's between 30 and 40 percent of predicted?

A. Yes, right.

Q. At the present time, is there any plans for this man to have a lung transplant?

A. Right now, no. Yet he's very close to the transplant window. Let me clarify that.

When the diffusion capacity falls below 40 percent of predicted, when the FEV1 goes below 30 percent of predicted --

Q. So you say the FEV1 below 30, the diffusion capacity below 40?

A. 40 percent, yes.

Q. Okay.
A. We consider lung transplantation. That is we are looking, the term we use is a transplant window. We don't want to do it too early or we don't want to do it too late. He's very close to being within the transplant window.

Now, you asked me about my subspecialty in pulmonary and I probably didn't give you all the information -- just a slip of mind -- that I'm also a lung transplant physician. I have been taking care of lung transplant patients for the last 11 years, more than that probably.

And based on that I'm trying to push this thing as far back as possible, you know, postpone it as much as I can because he's a young guy and if transplant doesn't go very well, then, you know, he will be between a rock and a hard place.

Q. So at this point he's not yet a candidate for a lung transplant?
A. Right.
Q. Do you have an opinion whether or not he will be in the future or is it --
A. If you ask my opinion, in the future he will require a lung transplantation.
Q. What's the basis of that opinion?

A. Reading about this particular condition, whatever knowledge I have is that this is, it will slowly, the fibrosis will continue to get worse and he's so close, his numbers are so close to the transplant window, any further insult such as pneumonia or any further scarring for whatever reason, would bring him into the window.

Q. But it appears from discussions with you he's been pretty stable over the past several years?

A. He had a rocky course. I mean, if you ask me his FEVl diffusion capacity in 1997 and if you ask me his capacity today, I mean, we can draw a straight line there, but you see in between he's gone up and down. That bothers me.

Suppose he gets pneumonia or gets a bad influenza, he would be down in the dumps.

For an example, if he ends up on a ventilator, he has no reserve in his lungs and he gets a pneumonia or gets influenza, he ends up on the ventilator, I would have a hard time, first of all, getting him off the ventilator and whatever damage he will have from this pneumonia would immediately bring him into the transplant window, that he would be disabled, he would be in a wheelchair, he wouldn't be able to do what he's

doing right now. I'm pushing him to remain active as much as he can to keep his muscles in shape. But if he ends up in the hospital on a ventilator, I bet you that he would require a lung transplantation.

Q It sounds as though there's a lot of if's in there.

A I mean, as we usually talk possible and probable, I would say it's probable that he would require a lung transplantation.

Q When?

A That I don't know.

Q You can't tell me it's going to be five years from now, ten years from now, twenty years from now?

A If he gets pneumonia tomorrow he would require a lung transplant in a month or two months. If he gets pneumonia five years from now, he would require lung transplantation five years from now.

Q What if he never gets pneumonia, doctor?

A It's unlikely that he would not get pneumonia because -- let me justify that. He's on Prednisone which is an immunosuppressing agent. Imuran is an immunosuppressant and so I'm very much afraid.

If you once again ask me a question, is he going to develop pneumonia or is he not going to develop pneumonia, he is going to develop pneumonia. It's a miracle if he doesn't get a bad infection in his lung with all the immunosuppressants.

Q. So if I were to ask you, doctor, do you have an opinion to a reasonable degree of medical probability when he will need this lung transplant, when would it be?

A. At the next insult to his lung. I mean, that's a fair statement because I don't know when the next insult is going to be.

Let me further give you, to just help everything, we do lung transplantation today up to the age of 65. And how old is this gentleman today?

MS. TAYLOR-KOLIS: 34.

A. He's 34 years old, so anywhere from now to age 65. And again, in 30 years I'm sure we'll be doing lung transplantation to age 70 or 75, I don't know, I can't predict. But this span, he's so young -- if he were 64 I would say he's not a lung transplant candidate -- but he's so young that it is very likely that something is going to

happen to him in the next 30 years, that's where I'm coming from.

Q. What about his life expectancy, doctor?

A. His life expectancy is diminished as a result of this condition as well as if he requires lung transplantation.

Q. Why is it, first of all, reduced because of this condition?

A. Once again, if he gets any further insult to his lungs he will end up on the ventilator and with related complications.

Q. Okay. And does he also have a decreased life expectancy because of the transplant?

A. If he requires lung transplantation, as you remember I mentioned he would be between a rock and a hard place, is that five years survival from lung transplantation today is close to 50 percent. Not all lung transplant patients, you know, go out of the hospital with flying colors. Every year there's an increasing mortality.

One year survival is 75 percent; five year survival is 50 percent, meaning 50 percent of our patients die within five years. Some patients do go up to ten years, but all these patients eventually die as a result of transplant-related

complications.

Q. Are you finding the numbers are getting better though as it's being refined?

A. Yes. Numbers are getting better, but we have -- I mean, it's not getting better as fast as we would like it to. Not like -- again, I'm not just making it up, but comparing the renal transplantation, the numbers are superb. If you're talking about heart transplantations, the numbers are excellent. Lung transplantation numbers are not getting that much better.

Q. In terms of your articles, have you written on the subject of lung transplant?

A. Yes.

Q. Have you also talked in there about the survival rate?

A. Yes.

Q. Okay.

MS. TAYLOR-KOLIS: Here's his CV. Do you want to take a look at it?

MR. POLITO: I would like to get a copy so the doctor can tell me what articles --

A. Do you want me to point it out to you?

Q. Yes, that's fine.

- - - -

(Off the record.)

- - - -

A. This is all I can come up with right now. There might be one or two missed, but that's not to hide any information from you.

Q. That's fine. Doctor, why don't we have that marked as Defendants' Exhibit A and then I can just put on the record that you were kind enough to note for me the articles that refer to lung transplants.

A. I have folded the pages here.

Q. Got it.

- - -

(Thereupon, Defendants' Exhibit A was marked for purposes of identification.)

- - - -

Q. Doctor, how many times then has his lung capacity been checked here at the Clinic?

A. Probably one or two times. The thing is it's an extensive test, number one. It's an expensive test. And number two, it doesn't help me change my therapy. I mainly rely on FEVl and diffusion capacity, so that's more functional parameters I look at.

Q. So the FEV1, I mean, if you were considering a lung transplant, say, you take out the total lung capacity, if you were doing it just on the FEV1 --

A. Right, yes.

Q. -- what figure are we talking then?

A. FEVl and diffusion capacity.

Q. What percentage of predicted puts him within that transplant?

A. 30 percent.

Q. Okay.

A. You know, this test -- maybe this should be off the record. It costs lots of money. We don't want to spend like $300 per visit, you know, just to do the checking because I'm not going to do anything different.

Q. Okay. You wrote a report dated September 25th, 1998. To whom it may concern.

A. Uhm-hum.

Q. And in there you say, "It is my opinion Mr. Diederich's condition is unlikely to improve and he will require continued medical care over his entire lifetime."

A. Yes.

Q. "If he continues to worsen, his life expectancy

could be affected by this condition and he may even require lung transplantation, however, the timing of these events cannot be predicted at the present time."

Is that still your opinion now?

A. Yes.

Q. You, doctor, in your experience see people day in and day out with pulmonary problems, true?

A. Yes.

Q. Okay. That's basically all you do.

A. Uhm-hum.

Q. And in your career, doctor, fair to say then you've only seen three patients with the condition that Mr. Diederich has?

A. Yes.

Q. So it's, at least in your own experience, seeing thousands of patients, it's a very rare disease?

A. It's a rare condition.

Q. A very rare condition for you as a lung specialist, true?

A. Yeah.

Q. I assume though on the other hand you see people with asthma day in and day out?

A. Yes.

Q. That's a much more common thing to see?

A. Yes.
Q. When you do an exam on a patient with asthma, what normally do you find, doctor?
A. The physical examination?
Q. Yes.
A. A patient may have nasomucosal edema, sinus-related symptoms, signs of sinusitis. They may have postnasal drip. They may have wheezing and they may have a normal examination if they come in between attacks. I think the asthma diagnosis is more based on the history of the patient as well.
Q. When you treat, you not only treat the asthma, you also treat the sinus condition as well?
A. Certainly.
Q. How often do you plan to see him in the future?
A. Every three months, every three to four months.
Q. Is he seeing any other physician other than yourself at the present time?
A. Not to my knowledge. He does go to see Dr. Dacha periodically, but as I understand, Dr. Dacha is not modifying his medications, he's leaving it to me. He's going to local hospital for the blood tests which I'm ordering for his Imuran therapy.
Q. Is that to make sure it's within the therapeutic

range?

A. No, so that he doesn't have any ill effects. Imuran, as I mentioned, it's a cytotoxic drug and sometimes can produce anemia, liver damage and also reduce blood counts so I'm trying to keep it within a certain range so it doesn't have side effects.

Q. What percentage of people who are exposed to cobalt and tungsten in the workplace actually develop this disease, doctor?

A. About ten percent.

Q. So if a patient was working in that -- strike that.

If an employee was working in that environment, should they be wearing some sort of protective mask or respirator?

A. There are guidelines, you know, and I'm not an occupational specialist so I probably wouldn't be able to tell you the correct, wouldn't be able to give you the correct answer.

Q. Certainly though, forget if you are an occupational specialist or not, you, as the physician would recommend that he wear some sort of protective mask while welding?

A. No, you just mentioned employee. The employee is

not going to come to me.

Q. No, I'm talking about if a man came to you and indicated to you --

A. Okay.

Q. -- he was being exposed to gasses and fumes while welding.

A. Well, I would recommend that he goes and follows the guidelines of the manufacturer of the substances that he's exposed to as to what type of precautions he's going to take because different things require different types of specific protection. We have an individual in the institution who does part of that work so I would refer him to him.

MR. POLITO: Okay, doctor, that's all I have. Thanks.

MS. TAYLOR-KOLIS: Doctor, you have the right to read your deposition for accuracy This is a very good court reporter so I'm sure she will be accurate, however, you might want to read it for its content.

THE WITNESS: Certainly.

MS. TAYLOR-KOLIS: John, can we secure a waiver of the seven day

reading requirement?

MR. POLITO: Sure.

ATUL C. MEHTA, M.D.

C E R T I F I C A T E

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

I, Lynn A. Konitsky, a Notary Public within and for the State of Ohio, authorized to administer oaths and to take and certify depositions, do hereby certify that the above-named ATUL C. MEHTA, M.D., was by me, before the giving of their deposition, first duly sworn to testify the truth, the whole truth, and nothing but the truth; that the deposition as above-set forth was reduced to writing by me by means of stenotypy, and was later transcribed into typewriting under my direction; that this is a true record of the testimony given by the witness, and was subscribed by said witness in my presence; that said deposition was taken at the aforementioned time, date and place, pursuant to notice or stipulations of counsel; that I am not a relative or employee or attorney of any of the parties, or a relative or employee of such attorney or financially interested in this action.

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office, at Cleveland, Ohio, this _____ day of _____, A.D. 20 __.

_____
Lynn A. Konitsky, Notary Public, State of Ohio
1750 Midland Building, Cleveland, Ohio 44115
My commission expires February 8, 2005

W I T N E S S I N D E X

E X H I B I T I N D E X