STATE OF OHIO)
) ss:
COUNTY OF LAKE)

COPY

IN THE COURT OF COMMON PLEAS

MARY ANN FEATHERS,)
)
Plaintiff,) Case No. 01CV000824
) Martin Parks, J.
vs.)
)
ROBERTA BROWN, M.D., et al.,)
)
Defendants.)

VIDEOTAPED DEPOSITION OF HOWARD OZER, M.D.

TAKEN ON BEHALF OF THE DEFENDANTS

IN OKLAHOMA CITY, OKLAHOMA

ON JULY 24, 2002

REPORTED BY: ELIZABETH CAUDILL, CSR, RMR, CRR

D&R REPORTING & VIDEO, INC.

ROBINSON RENAISSANCE
119 N. ROBINSON, STE 650
OKLAHOMA CITY, OK 73102
405-235-4106

MID-CONTINENT TOWER
401 S. BOSTON, STE 310
TULSA OKLAHOMA 74103
918-599-0507

1-800-771-1500
DandR4106@aol.com

A P P E A R A N C E S

For the Plaintiff: Donna Taylor-Kolis
(by phone) Attorney at Law
330 Standard Building
Cleveland, Ohio 44113

For the Defendants: Christine Reid
(by phone) Attorney at Law
113 Saint Clair Building NE
Cleveland, Ohio 44114

CONTENTS

* * * * * *

S T I P U L A T I O N S

IT IS HEREBY STIPULATED AND AGREED by and among the attorneys for the respective parties hereto that the deposition of HOWARD OZER, M.D. may be taken on behalf of the Defendants on JULY 24, 2002 in Oklahoma City, Oklahoma, by Elizabeth Caudill, Certified Shorthand Reporter within and for the State of Oklahoma, pursuant to agreement.

IT IS FURTHER STIPULATED AND AGREED by and among the attorneys for the respective parties hereto that all objections, except as to the form of the question, are reserved until the time of trial, at which time they may be made with the same force and effect as if made at the time of the taking of this deposition.

* * * * * *

* * * * * *

HOWARD OZER, M.D.,

after having been first duly sworn at 2:03 p.m., deposes and says in reply to the questions propounded as follows, to wit:

DIRECT EXAMINATION

BY MS. REID:

Q I'm just going to assume you had your right hand up there.

A I did. It's being videotaped so you can confirm.

Q That's right. I forgot about that.

Doctor, my name is Christine Reid, and I represent Dr. Roberta Brown in a case being brought by Mary Ann Feathers, and we're here for your deposition today.

I assume you've had a deposition taken before?

A I have.

Q All right. If at any time throughout this deposition, you, or the court reporter, for that matter, cannot hear me or don't understand a question, please let me know and I'll attempt to rephrase.

A I will. Thank you.

Q You're welcome. Could you give me your current business address, please?

A Sure. I'm at the -- I'm in the section of hematology-oncology in the Cancer Center at the University of Oklahoma Health Sciences Center, which is in Oklahoma City, Oklahoma.

Q Okay. And how long have you been with the University of Oklahoma?

A Little over two years.

Q And your specialty is oncology?

A It's hematology and oncology, yes.

Q All right. Is there any particular type of cancer you subspecialize in?

A Well, I do my research in the area of leukemia, lymphoma, and now in pancreatic carcinoma, but I see patients with all malignancies.

Q Okay. Can you quantify the percentage of your practice that involves the treatment of breast cancer patients?

A Certainly. It's about 30 percent. Because of the demographics, breast cancer being so common, I would say about a third of all my patients are breast cancer.

Q Donna was kind enough to hand me a copy

of your CV. It's a 35-page document. I'm trying to see if there's a date on it. My question is how can I -- maybe you can help me with this -- how I can determine whether this is the most current copy of your CV.

A It's accurate, I'would estimate, within six months. I have not updated it in the last six months and have a few more publications, but I've not remade my CV since that one.

Q Okay. Off the top of your head without me reading your entire CV, are there any publications listed here that DEAL with the diagnosis and treatment of breast cancer?

A There are a couple from the time when I was at Chapel Hill where we were looking at sort of physician's approaches to the diagnosis of breast cancer relating mostly to surgeons. And those are -- are listed in the CV. There's only a few of those. They deal with populations rather than the specifics of breast cancer.

And beyond that, there really isn't anything.

Q Okay. I want to talk to you for a minute about your practice, and specifically AS it relates to the treatment of breast cancer

cancer patients.

I assume that you see most patients after the diagnosis of cancer has been made?

A Yes and no. We -- in medical oncology, we follow patients for life, so that means that if we have patients who have either a hematologic or malignant problem that is cured, we follow them for 15 and 20 years. So we do do annual mammography, and we do breast exams serially in our patient population that is doing well.

Q Okay. But your first contact with a patient, would it typically be after there's been the diagnosis of some type of malignancy?

A That would be more typical, yes.

Q All right. So you're not typically involved in the diag -- the initial diagnostic process?

A Well, I'm not sure what you mean by that. Generally, we're referred patients who have a breast lump. The -- by -- if you mean by initial diagnostic process, we're -- we see patients, and I actually run the breast conference, which is this afternoon, where patients will come in with a lump and have an abnormal mammogram. So the very first visit to

the mammographer I might miss, but from the mammogram on, we're participants.

Q All right. So you at that point might get involved in ordering surgical consultations, biopsies, et cetera?

A That's correct. We have a multi-disciplinary team approach at OU where, once a patient has a suspicious-looking mammogram, they're seen by everybody.

Q Okay. Is it a breast center of some type?

A It is

Q Okay. Can you, for my education, just go through the materials you have reviewed in this case?

A Certainly.

Q You have -- let me interrupt for a second. Do you have a stack in front of you?

A I do.

Q All right. If you could just go through them and list for me what you have, I'd appreciate it.

A Certainly. Give me one moment. I reviewed the office records of Dr. Roberta Brown, the office records of Dr. John Dorsky, the Lake

Hospital System records, the office records of Dr. Green, the deposition of Dr. Brown, the -- I'm not sure what you call it, but the report from Dr. Levitan, the brief report from the other physician.

Q Dr. Resnick?

A Yes, Dr. Resnick. And I believe that's everything.

Q Did you read Dr. Green's deposition?

A I did not see Dr. Green's deposition. Hang on one -- yes, I'm sorry, I did see Dr. Green's deposition.

Q Do you know Armin Green at all?

A I know the name. That's it.

Q Okay. Did you read Mary Ann Feathers's deposition?

A I did not see Mary Ann Feathers's deposition, no.

Q Okay. Do you have any notes, either handwritten or typewritten, within your file?

A I do not.

Q Okay. How do you keep track of the information as you're reviewing it?

A I -- when I give my first report, I review it and immediately write a report, and

then I've spent the last two evenings re-reviewing it for this deposition.

Q All right. But you don't take any notes during that process?

A I do not. I did bring a copy of the AJCC's handbook for cancer staging to address the issue *of* survival statistics.

Q You knew I was going to ask you about that, huh?

A I did.

Q Okay. We'll get to that in a minute. Did you bring any other literature with you?

A No, just that.

Q Okay. Did you do any other type *of* literature search --

A No,

Q -- prior to today's deposition?

A No, I did not.

Q Okay. Do you have any letters or correspondence from Donna Kolis in your file?

A I do.

Q Okay. Can you just tell me what the dates *of* those are?

A Sure. In no particular order, I have one from February 15th, 2001. That is the

transmittal of the first set of materials; one from August 26 of 2001; one from January 24th of 2002; one from -- actually I take it -- I have two from January 24th of 2002.

Q Donna was working hard that day.

A She was. One from March 20th of 2002, and one from April 22nd of 2002. And that, I believe, is it.

a Okay. If you could do me a favor before you leave today, just have the court reporter make a copy of those --

A Will do.

Q -- for me. Thanks.

Have we gone through all the materials you have reviewed in this case and that are contained within your file?

A Yes, we have.

Q The report I have that was furnished to me by Mrs. Kolis is dated April 13th, 2001. Do you have any additional reports other than that one?

A No. That's it.

Q Okay. Was there a draft sent to Mrs. Kolis before this copy was produced?

A No. This was it.

Q All right. This is the first, the only report?

A Yes, it is.

Q Did you say yes? I'm sorry.

A Yes, I did.

Q Dr. Ozer, I'd like to go to your report and talk about your opinions in this case. First of all, let's talk about your opinions related to the standard of care.

It's my understanding that, in your opinion, Dr. Brown should have sent Mrs. Feathers for surgical evaluation in February of 1999.

A That's correct. I think the appropriate response for a dominant mass is one of two things: either an immediate referral to a surgeon or very close follow-up and repalpation of that mass and remammography.

Q What do you mean by a dominant mass?

A A dominant mass, in women who have fibrocystic changes of the breast, they may feel lumpy both to the patient and to the examining physician. But in this case, the patient reports a new, quote, dominant mass, unquote; in other words, a mass that she has identified is different and distinct, and those warrant close

follow-up.

Q And your opinion about the necessity of close follow-up is irregardless of the fact that Dr. Brown could not palpate that mass?

A That's correct. Particularly given its size, it's at the lower limit of what has been documented in the literature for physicians to be able to detect, and therefore, it is quite understandable that a physician might miss it.

At that point, it warrants referral of the patient to a breast surgeon who is more experienced in detecting such masses or, alternatively, a very careful follow-up to detect whether it's growing or not.

Q What's your understanding of what the size of the mass was in February of 1999?

A Well, the patient describes it as pea sized.

Q Okay. What's the size of a pea?

A That would roughly be half a centimeter.

Q And the literature does document that masses of that size can be difficult for physicians to detect?

A That's correct. Suzanne Fletcher, who

was at UNC when I was there, did a rather elegant study in which they made breast models and put different size masses in those breast models and were able to demonstrate that physicians, in some cases, could not detect half centimeter to one centimeter lesions, but half a centimeter was the point at which they began to become detectable.

Q Assuming the accuracy of that study and that opinion, is it possible that, even if Mrs. Feathers had been referred to a surgeon, the surgeon would not have been able to palpate the mass?

A That is a possibility.

Q How can we know one way or the other whether or not the surgeon would have been able to palpate the mass?

A Well, we can't know one way or the other.

Q And if a surgeon could not palpate the mass, he or she couldn't take any further steps; i.e., a needle biopsy or anything along those lines?

A Well, the appropriate response is that, number one, you're correct, a needle biopsy cannot be done unless the mass can actually be

palpated; but number two, if the patient is complaining about it, you sit with the patient -- and this can either be the surgeon or the general practitioner -- and say we can't find it but you're feeling something, we recommend self-exam and we recommend you come back in two months, a different time of your period, and we will, if necessary -- and we will re-examine you and we may repeat a mammography in three months.

Q Does the standard of care under these circumstances require a follow-up visit in two months?

A Well, I hesitate to say specifically two months, but certainly the standard of care does require that degree of close follow-up.

Q Okay. Well, what's the outline of when the standard of care would require Mrs. -- or Dr. Brown to -- let me start all over again. I'm getting jumbled here.

What does the standard of care require as relates to follow-up for Mrs. Feathers?

A Two to three months would be appropriate and within --

Q Three months for a follow-up visit?

A Correct.

Q How about a mammogram?

A Same thing.

Q As we sit here today, can you say to a reasonable degree of medical probability that had Mrs. Feathers returned in two to three months for a follow-up, which would bring us to April or May of 1999, that the mass would have been palpable or would have been evidenced on mammogram?

A Well, the mass clearly grew in the 16 months, and the tumor, itself, was 1.7 sonometers, and the mass was significantly larger than that, which is fairly typical for the growth of breast cancers.

So, yes, I think that within a reasonable degree of medical probability, it would have been palpable very shortly after February of '99.

Q And detectable on mammogram?

A It was not detectable on mammogram until rather late. I believe she had a mammogram in October of '99 that was read as normal. And again, there's a 15 percent false negative rate, so that's not -- not surprising. But the mammogram, nonetheless, should have been repeated at that second follow-up visit.

Q Is there ever a situation where a patient detects a mass, the physician does not, and referral to a surgeon is not necessary?

A Well, you're implying that the patient is -- does not have a cancer in that situation. And the problem is that we don't know that the patient doesn't have a cancer.

If the physician cannot palpate the mass, it is not, as I said, imperative that the patient immediately be referred to a surgeon, but it is imperative, if that physician chooses not to refer, that the physician then assumes the responsibility of that very close follow-up.

Q Okay. So while a surgical consult may not be necessary, under these circumstances, you must always have close follow-up every two to three months?

A Correct.

Q Do you have any other opinions regarding the standard of care in this case?

A No, I do not.

Q Okay. So just so I can summarize, make sure I'm clear, it's your opinion that either Dr. Brown either should have sent Mrs. Feathers for surgical evaluation or should have arranged

for closer follow-up every two to three months with a follow-up visit and mammogram?

A Correct.

Q Okay. Now, in your report, you state that it's your belief that the tumor identified in June of 2000 is the same mass that was reported by Mrs. Feathers in February of 1999.

A That's correct.

Q What's your basis for that opinion?

A It's in the same location, the patient feels it's the same mass throughout, and it is very close to an area of DCIS when it's ultimately diagnosed. So clearly that area of the breast is involved in the development of this tumor.

Q All right. I must be -- I'm confused about this. Are you -- are you familiar with Dr. Brown's note where she describes the mass as existing at 11:00?

A Correct.

Q And on a mammogram in June of 2000, it's reported the -- the mass is reported at 2:00?

A Correct. Now, there I would differ with Dr. Levitan, although he says it's in a

different quadrant, which is technically correct because of the way that we normally draw a compass, it's actually within the same quadrant. 11:00 and 2:00 are only three hours apart.

Q There's four hours in each quadrant? Is that what you're saying?

A Correct.

Q But regardless of the quadrant analysis, don't those describe a mass in two separate areas on the breast?

A Not necessarily. We have the same problem with specific localization that we do with the ability to palpate a mass. What feels different to the patient -- what the patient perceives may not be what the physician perceives, and it may not be what is true in reality.

The tumor may be starting at 2:00 but growing medially and, therefore, actually be a little bit to the -- to the right of where it's initially detected.

Finally, the mass, itself, may -- may actually be spreading over a larger area than what the pathology is showing.

What I mean by that is that the way --

the way you're detecting the mass *is* to rub the breast back and forth. And so -- I've not examined the patient, I don't know whether she has large breasts or small breasts, but you can appreciate that breasts are mobile and the tumor, itself, is mobile. So as you move your -- your fingers across the breast, you may feel it in a different area than it actually is located.

In any event, I think the likelihood, if you use the term more likely than not, more likely than not, what the patient felt, continued to think she felt, and what was ultimately diagnosed were one in the same lesion.

Q And your basis for that is that it's within the different quadrant and there's medical or anatomic explanations as to why you could have two different descriptions?

A That's correct.

Q You mentioned DCIS in your basis for your opinion that it's the same tumor. I'm not sure I understand how that fits in.

A Well, DCIS is a precursor, and more of this tumor is composed of DCIS than actual infiltrating carcinoma. That tends to be a relatively non-lumpy lesion, although it can

appear as a lump. It can be more difficult to detect. And she probably had more of an element of DCIS in February of '99 than she had in June and July of 2000.

Q Is it possible that the tumor identified in June of 2000 is a different mass than that was reported in February of 1999?

A Anything's possible, but I think it's less likely than not.

Q Let's talk about mammograms for a minute. I think you stated earlier that there's a 15 percent false negative rate in mammograms?

A Correct.

Q Is there a particular type of mass that's less detectable with mammograms?

A Lobular carcinoma and DCIS may be a little more difficult to detect.

Q Have you seen the mammograms in this case?

A I have not seen the mammograms, only the written reports.

a I take it you don't have any criticisms of the mammography techs or the radiologist who interpreted the mammograms?

A No, I do not.

Q Let's turn to the survival rates that you speak about in your report, if you would, Dr. Ozer.

A Sure.

Q Now, you brought with you what publication today?

A This is the -- it's a pocket version, but has the same information, the AJCC Staging Manual for all tumors. And I can get the court reporter to make a copy, but breast cancer begins on page 161.

Q Okay. What edition is that?

A This is the undefined edition. Hang on a moment.

Q Now, how does that -- the -- the AJCC is the staging manual?

A Correct.

Q Does the NCCN just relate to treatment guidelines?

A That's right. NCCN publishes treatment guidelines. The AJCC staging system is the one -- it's the American Joint Committee on Cancer, and it's the one that we all adhere to.

I, for example, chair the cancer committee of the university, and we have to meet

their staging guidelines and use their staging system.

And the only identification here is it says copyright 1993. It doesn't have a date other than that or a volume other than that.

Q I'd appreciate it, as you offered earlier, if you could have the court reporter just make a copy of the applicable pages for me.

A I'll do that.

Q Now, you've read Dr. Levitan's report in this case?

A Yes, I have.

Q Does he follow the AJCC staging manual?

A Yes, he does, although I would dispute his survival statistics by a hair. But otherwise, he does.

Q All right. Well, let's talk about the survival statistics. And I assume you're taking what you've listed in your report straight out of the staging manual?

A I am.

Q All right. And it's your opinion that when she was diagnosed in June of 2000, her cancer was Stage IIA; correct?

A That's correct.

Q And then that stage, based upon the type of tumor it was, gives her a greater than 80 percent five-year survival rate?

A It gives -- yes, it gives her a 80 -- at five years, it's 85 percent according to this document.

Q Okay. Because your report -- and I'm not trying to dance on a pin head here, but your report says 80 percent five-year survival.

A Correct.

Q But 85 percent would be more accurate?

A 85 percent would be the more precise number, that's correct.

Q That was a better way to put it. Now, Dr. Levitan uses 88 percent. You don't agree with that?

A I won't argue over 1 or 2 percent. The only point I'll make is that for years four, five and six from diagnosis, the differential between Stage 1 and Stage IIA is 10 percent. And the numbers provided for five years are 95 percent for Stage I and 85 percent for Stage II. So he's a tad optimistic or pessimistic, depending on your point of view, when he says 3 to 5 percent. I'm saying it's closer to 10 percent.

Q All right. Now, for a Stage I cancer, you've stated that the survival rate is greater than 95 percent for five years.

A Correct.

Q Is that the most precise number?

A Yes, that is more precise.

Q Okay. And you're taking issue somewhat with Dr. Levitan's differential between the survival rates for those two stages of cancer?

A Yes. I mean, he says 3 to 5, I'm saying 10. That wouldn't matter much in lots of measurements, but if it's the amount of time you spend at home with your wife, it would be a big difference.

Q Okay. Now, Dr. Levitan figures, though, that he lists -- for the survival rates for a Stage I cancer, he lists 91 percent at five years, 85 percent at 10 years. Do those not come from the staging manual?

A I couldn't tell you where they come from.

Q Okay. And that's why you take issue with them?

A Correct.

Q All right. Do you know Dr. Levitan at

all?

A I know of him, yes.

Q Have you and he been on opposite sides of the fence before in a medical malpractice expert situation?

A That, I really couldn't tell you.

Q Okay. Just curious. Do you agree with Dr. Levitan's statement that the prognosis for a patient with a single microscopically involved lymph node approximates that of a patient with a negative node?

A I would agree with that statement, with the caveat that every time you add a lymph node, your prognosis is impacted just slightly. But I think that's what he means when he says approximates.

Q Okay. If Mrs. Feathers had been diagnosed in 1999, it's your opinion that she would have had a Stage I cancer; right?

A Correct.

Q All right. Assuming that to be true, diagnosing -- why I can't get that -- February of 1999 -- I can't get that date in my head. Assuming a diagnosis in February *of* 1999 Stage I, would she still have needed a lumpectomy?

A Yes.

Q Chemotherapy?

A I believe she would of needed chemotherapy. There are some who might not recommend that; however, the fact that she's a rather -- rather low on her ER/PR expression, and more importantly the fact that she's HER-2 positive, to me is sufficient to warrant chemotherapy. So, yes, I would have recommended chemotherapy for her as a Stage I.

Q Okay. Radiation as well?

A Yes.

a Tamoxifen therapy?

A Yes.

Q So to kind of speak in lawyer terms here, this delay -- I'll have to say alleged delay in diagnosis resulted simply in a 10 percent differential in her survival rate?

A With the -- if you took out the simply, I would agree with that statement.

Q Yeah. That's not -- let me -- let me put it in -- take out that word simply.

So looking at this case on a whole, the alleged delay in diagnosis of the breast cancer for approximately a year or 14 months led solely

to a decrease -- a 10 percent decrease in the survival rate?

A That's correct.

Q **Do** you follow the NCCN guidelines when it comes to treatment regimens for patients?

A We certainly review them and use them as a helpful guide. We don't blindly follow them, no.

Q So they don't necessarily provide a standard of care?

A They provide a framework but not a standard of care.

Q Okay. Can we agree that the properties of Mrs. Feathers's cancer did not change between 1999 and the year 2000?

A I would agree, again, in the more likely than not context that that's true.

Q Okay. Do you have an opinion on how long it took Mrs. Tumor -- Mrs. Tumor. It's been a long day, Doctor.

Do you have an opinion on how long it took Mrs. Feathers's tumor to grow to 1.7 centimeters?

A I think the natural history of breast cancer can be anywhere from one to five years.

In this particular case, it's not a overly aggressive or rapidly growing tumor, but I think its origin almost certainly predates '99. I'm not certain whether it predates '98. But I think a ballpark would be an origin at some point in early '98, winter of '98.

If a physician will have difficulty palpating a mass smaller than a half a centimeter, would you expect a patient to be able to palpate that size of a mass?

Well, everyone varies quite a bit. I think patients are more attuned to breast self-examination than are physicians. And I would estimate that the majority of masses that we detect, "we" being -- that we see in the clinic, rather, are brought to our attention by patients rather than physicians being able to pick up a mass when they do a physical exam.

So it wouldn't surprise me that a patient would be able to detect a pea-sized mass for the first time.

Q Just because they have a better sense of their own body and the changes?

A Exactly.

Q Okay. Do you agree with the statement

that the highest risk of recurrence of breast cancer is in the first two years?

A Actually, I -- I can give you the numbers for that, and the answer to that is no. It might be for Stage IV disease but it's not for Stage 0, I or IIA if we look at the statistics.

For example, the majority of relapses have occurred in year five rather than in year one or two for those early stages.

Q What are you looking at? Are you looking at the journal?

A I'm looking at the -- at page 165. And these are the curves. And just to give you an example of how a rapidly recurrent tumor would be, if you look at Stage IV, which is metastatic, these are survival, which is an equivalent to relapse, there is a 60 percent roughly -- 62 percent survival after one year with metastatic disease.

So that means that 38 percent have relapsed and progressed and the patients have died. The majority are dead after two years with metastatic disease.

If you look now at Stage IIA, which is what she's ultimately diagnosed with, her curve

demonstrates that after two years, the decrement from 100 percent is, oh, 10 percent, maybe. So 10 percent of relapsed have progressed and died in the first two years, and then the -- at five years -- remember it's now down to 85 percent.

Q Right.

A So 50 percent of the total 15 percent deaths is 7 percent, and the 7 percent has occurred by about three years. So you have to go to four years before the majority of patients are relapsing and dying.

Q That curve you're looking at, does that only consider patients who have a recurrence and die within five years?

A Actually it considers -- it's an intent -- what we call an intent to treat analysis which is deaths from all causes which is what we use for all our statistics. So it includes patients that die of heart attacks and other things, all thought to be related.

Q Does it include a patient that died of a heart attack but didn't have a recurrence of cancer?

A Yes, it does. That's how we do all our statistics.

Q Okay. Because that statement I gave you, that the highest risk of recurrence is within the first two years, came from Dr. Green during his deposition as Mrs. Feathers's treating physician. I'm not quite sure where he gets that statistic as well.

A I'm not sure, either. And I would dispute that for this kind of a small, slowly growing tumor.

What I tell my patients is that -- the analogy I give them is that it's -- if you take the gondola to the top of the mountain and a group of bad skiers gets off, some of them are going to fall early and some of them will make it most of the way down, but there will be people falling off all the way or falling all the way.

Q Dr. Ozer, I think I'm just about through. I want to take a minute to talk to you a little bit about your experience as an expert in medical malpractice litigation.

A Certainly.

Q You served as an expert in the past before?

A Yes, I have.

Q When did you first start doing this

type of work?

A The very first case I did was in 1984.

Q Do you know about how many cases you review a year?

A I've now reviewed about 55, 58 cases, and it's probably one every six weeks, I would guess.

Q So you've done a total of 55 to 58 since 1984?

A Correct,

Q Any estimate on the breakdown of plaintiff versus defense?

A About 80 percent have been for the plaintiff and 20 percent for the defense.

Q What do you charge to review records?

A I charge an initial retainer fee of $1,500 and then $350 an hour thereafter.

Q How about for deposition? I probably should have asked this sooner. What's the charge for deposition?

A I can give you any number I want now.

Q Oh, no. I'll pull an old transcript.

A It's $1,500 as a flat fee for a deposition because I have to block out the afternoon.

Q Okay. How about trial testimony?

A For trial testimony, I charge $3,000 a day, plus expenses.

Q Do you have plans to come -- actually it's to Lake County, in Mentor, Ohio, in September for the trial of this case?

A If I'm asked, I will.

Q Okay. I'm just going to take a minute to take a look at my notes. 1 think I'm just about through.

What's the risk of breast cancer in the overall population?

A One in eight.

Q One in eight?

A Among women, it's one in eight.

Q Does that change depending on the patient's age?

A It does. The lifetime risk is one in eight. The majority of breast cancer occurs in women over the age of 55 or 60.

Q What's the percent of one in eight? Never mind.

Do you have an opinion whether or not Mary Ann Feathers requires breast reconstruction?

A I saw a discussion in there regarding

that. The majority of women who have a lumpectomy will -- let me take that back. It varies a lot with the individual. It also varies with the size of the woman's breasts.

Obviously if you have larger breasts and you have a lumpectomy, the surgeon is able to do a little bit of reconstruction at the time of the lumpectomy without much of a difference.

If your breasts are very small, a lumpectomy has a greater impact. And it depends a lot on whether the woman doesn't like having asymmetry. I've not seen her, I've not examined her, I've not spoken to her. It would be her call as to whether she needed reconstruction.

Q Is there a time frame you typically wait before you do a reconstruction?

A It can be done immediately. However, in someone who is getting chemotherapy and radiation therapy, it is far preferable to wait at least until all of that is complete and then give them another four to six months before you do reconstruction.

MS. REID: Dr. Ozer, I don't think I have any more questions. I appreciate your time.

THE WITNESS: Certainly.

MS. REID: If you would just have the court reporter make a copy of those letters and the pages of the manual --

THE WITNESS: Will do.

MS. REID: -- I would appreciate it.

THE WITNESS: Okay.

MS. REID: Do you want to talk to Donna for a minute?

MS. KOLIS: Doctor, are you going to read the deposition or would you like to waive the reading?

THE WITNESS: I'm happy with it if you're okay with it.

MS. KOLIS: I'm fine with it. Just indicate for the court reporter that I would like a copy of the transcript.

THE WITNESS: Okay.

(Deposition concluded at 2:48 p.m.)

C E R T I F I C A T E

STATE OF OKLAHOMA)
) ss:
COUNTY OF OKLAHOMA)

I, ELIZABETH CATJDILL, CSR in and for the State of Oklahoma, certify that HOWARD OZER, M.D. was by me sworn to testify the truth; that the above and foregoing deposition was taken by me in stenotype and thereafter transcribed and is a true and correct transcript of the testimony of the witness; that the deposition was taken on JULY 24, 2002 at 2:03 p.m. in Oklahoma City, Oklahoma; that I am not an attorney for or a relative of either party, or otherwise interested in this action.

Witness my hand and seal of office on this 31st day of July, 2002.

ELIZABETH CAUDILL
Oklahoma Certified Shorthand Reporter
Certificate No. 00161
Exp. Date: December 31, 2002

ELIZABETH CAUDILL, CSR, RMR, CRR
CSR No. 161

DONNA TAYLOR - KOLIS CO. L.P.A.

ATTORNEYS AT LAW

Third Floor - Standard Building
1370 Ontario Street
Cleveland, Ohio 44113-1791
(216) 861-4300
1-800-243-9286
Fax: (216) 621-4959
E-mail: DJTKLaw@aol.com

DONNA TAYLOR-KOLIS

MICHAEL J. SKINDELL

® 48

February 15,2001

Via Federal Express Standard Overnight

Howard Ozer, M.D., Ph.D.
1516 Camden Way
Oklahoma City, OK 73116

RE: Mary Ann Feathers

Dear Dr. Ozer:

Thank you for agreeing to review the matter of Mary Ann Feathers regarding a potential medical negligence claim. Enclosed for your review are the following records:

1. Family Care Associates (Drs. Hackett & Brown)
2. Armin Green, M.D. (Ireland Cancer Center)
3. John Dorsky, M.D.
4. Lake Hospital System

Also enclosed is a check in the amount of $1,500.00 representing a retainer for your services rendered in this matter.

I would like to request that you call me upon completion of your review to discuss your opinions in this matter. If at all possible, I would like to know your opinions within 4 weeks of your receipt of this material.

Again, thank you for evaluating this matter, and I look forward to hearing from you.

Sincerely yours,

Donna Kolis/vjw

Donna Taylor-Kolis

DTK:vjw
Enclosures

EXHIBIT
Ozer

DONNA TAYLOR - KOLIS CO. L.P.A.
ATTORNEYS AT LAW

Third Floor - Standard Building
1370 Ontario Street
Cleveland, Ohio 44113-1701
(216) 861-4300
1-800-243-9286
Fax: (216) 621-4959

DONNA TAYLOR-KOLIS

August 26,2001

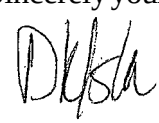
Howard Ozer, M.D., Ph.D.
1516 Camden Way
Oklahoma City, OK 73116

RE: *Mary* ***Ann .Feathers***

Dear Dr. Ozer:

In connection with the above-referenced matter, please call my office at your *earliest* convenience. The deposition of Dr. Brown will be going forward on September 11, 2001 and I would like to speak with you before that date regarding some issues to be addressed at the deposition.

Sincerely yours,



Donna Taylor-Kolis

DTK: sla

LAW **OFFICES** OF

FRIEDMAN, DOMIANO & SMITH CO., L.P.A.

SIXTH FLOOR -STANDARD BUILDING
1370 ONTARIO STREET
CLEVELAND, OHIO 44113-1701
(216)621-0070
FAX (216) 621-4008
TOLL FREE 1-800-280-0070

JEFFREY ti. FRIEDMAN***
JOSEPH C DOMIANO
M DAVID SMITH♦
LISA M GERLACK
LILLIAN V BLAGEFF
STEPHEN S. VANEK
MICHAEL L. EISNER
KEVIN *L.* LENSON

JULIE M. THOMAS
EXECUTIVE DIRECTOR

DONNA TAYLOR-KOLIS
OF COUNSEL

• ALSO MEMBER **OF** DISTRICT OF COLUMBIA BAR
♦ ALSO MEMBER OF FLORIDA BAR
*CERTIFIED CIVIL TRIAL SPECIALIST *BY* THE NATIONAL **BOARD** OF **TRIAL** ADVOCACY

IN CANTON:
BELDEN VILLAGE TOWER
4450 BELDEN VILLAGE STREET NW
CANTON, OHIO 44718-2508

(216) 493-0242

IN MENTOR:
7784 REYNOLDS ROAD
MENTOR, OHIO 44060-5321
(216) 946-0101

IN FLORIDA:
881 PANAMA COURT, #305
MARCO ISLAND, FLORIDA 33937-6284
(941)642.0252

January 24, 2002

Writer's Direct Dial
(216)621-0070

Howard Ozer, M.D., Ph.D.
1516 Camden Way
Oklahoma City, OK73116

RE: ***Mary Ann Feathers***

Dear Dr. Ozer:

In connection with the above-captioned client please be advised that this matter has been set for trial on **April 29, 2002 @ 8:30 am.** I need to *make* arrangements to go over your trial testimony with you should this case go forward. Upon receipt of this correspondence, please call me at the direct dial number listed above.

Sincerely yours,

DKolis/sla

Donna Taylor-Kolis

DTK: sla

LAW OFFICES OF
FRIEDMAN, DOMIANO & SMITH CO., L.P.A.
SIXTH FLOOR - STANDARD BUILDING
1370 ONTARIO STREET
CLEVELAND, OHIO 44113-1704
(216) 621-0070
FAX (216) 621-4008
TOLL FREE 1-800-280-0070
E-MAIL: fds@fdsiaw.com

JEFFREY H. FRIEDMAN ✦*★
JOSEPH C. DOMIANO
M. DAVID SMITH✦
STEPHEN S. VANEK

THOMAS E. CONWAY
MARTIN S. DELAHUNTY III
MICHAEL L. EISNER
KEVIN L. LENSON
MARK S. MILLER
DONNA TAYLOR-KOLIS

JULIE M. THOMAS
EXECUTIVE DIRECTOR

OF COUNSEL
PERRY R. SILVERMAN#
JAMES T. WALTHER

* ALSO MEMBER OF DISTRICT OF COLUMBIA BAR
✦ ALSO MEMBER OF FLORIDA BAR
★ CERTIFIED CIVIL TRIAL SPECIALIST BY THE NATIONAL BOARD OF TRIAL ADVOCACY
ALSO MEMBER OF NEW YORK AND WEST VIRGINIA BARS

EXECUTIVE SUITES OF SOUTH BRIDGE
755 BOARDMAN-CANFIELD ROAD
BOARDMAN, OHIO 44512
(330) 270-0070

IN CANTON:
BELDEN VILLAGE TOWER
4450 BELDEN VILLAGE STREET, NW
SUITE 704
CANTON, OHIO 44718-2508
(330) 493.9242

IN COLUMBUS:
8800 LYRA DRIVE, SUITE 220
COLUMBUS, OHIO 43240
(614) 433-7331

IN ELYRIA:
SPITZER PARK PLAZA
ELYRIA, OHIO 44035-5531
(440) 934-0070

IN LORAIN:
4461 OBERLIN AVENUE
SUITE 102
LORAIN, OHIO 44052
(440) 860-2525

IN MENTOR:
7784 REYNOLDS ROAD
MENTOR, OHIO 44060-5321
(440) 946-0101

March 20, 2002

Howard Ozer, M.D., Ph.D.
1516 Camden Way
Oklahoma City, OK 731 16

RE: Mary Ann Feathers

Dear Dr. Ozer:

The above-captioned lawsuit has now been re-set for **September 26, 2002.** Please have a staff member call my office to confirm that you would be available to testify on September 27th or the morning of September 30th.

Additionally, defense counsel would like to take your deposition in June of 2002 and I would ask that you or a staff member contact our office to advise us of your dates of availability.

Sincerely yours,

Donna Taylor-Kolis

DTK:sla
Enclosure

DONNA TAYLOR - KOLIS CO. L.P.A.

ATTORNEYS AT LAW

Third Floor - Standard Building
1370 Ontario Street
Cleveland, Ohio 44113-1701
(216) 861-4300
1-800-243-9286
Fax: **(216) 621-4959**

DONNA TAYLOR-KOLIS

January 24, 2002

Howard Ozer, MD., Ph.D.
1516 Camden Way
Oklahoma City, OK 73116

RE: Mary Ann Feathers

Dear Dr. Ozer:

Enclosed **please** find the deposition testimony of Mary Ann Feathers' subsequent treating physician, Armin Green, M.D. I would like for you to read it to determine whether or not you are in agreement with the opinions that he has in this matter. when you concluded reading it,, please give me a *call* so we *can* discuss the *same.*

Sincerely yours,

D Kolis / jme

Donna Taylor-Kolis

DTK: jme
Enclosure

LAW OFFICES OF
FRIEDMAN, DOMIANO & SMITH CO., L.P.A.
SIXTH FLOOR -STANDARD BUILDING
1370 ONTARIO STREET
CLEVELAND, OHIO 44113-1704
(216) 821-0070
FAX (216) 621-4008
TOLL FREE 1-800-280-0070
E-MAIL: fds@fdslaw.com

JEFFREY H. FRIEDMAN ♦* ★
JOSEPH C. DOMIANO
M. DAVID SMITH ♦
STEPHEN S. VANEK
MICHAEL L. EISNER

THOMAS E. CONWAY
KEVIN L. LENSON
MARK S. MILLER
DONNA TAYLOR-KOLIS

JULIE M. THOMAS
EXECUTIVE DIRECTOR

OF COUNSEL
PERRY R. SILVERMAN#
JAMES T. WALTHER

* ALSO MEMBER OF DISTRICT OF COLUMBIA BAR
♦ ALSO MEMBER OF FLORIDA BAR
★ CERTIFIED CIVIL TRIAL SPECIALIST BY THE NATIONAL BOARD OF TRIAL ADVOCACY
ALSO MEMBER OF NEW YORK AND WEST VIRGINIA BARS

IN BOARDMAN:
EXECUTIVE SUITES OF SOUTH BRIDGE
755 BOARDMAN-CANFIELD ROAD
BOARDMAN, OHIO 44512
(330) 270-2000

IN CANTON
BELDEN VILLAGE TOWER
4450 BELDEN VILLAGE STREET. N.W.
SUITE 704
CANTON, OHIO 44718-2508
(330) 493-0222

8800 LYRA DRIVE, SUITE 220
COLUMBUS, OHIO 43240
(614) 433-7331

IN ELYRIA:
SPITZER PARK PLAZA
511 BROAD STREET
ELYRIA, OHIO 44035-5531
(440) 934-0070

IN LORAIN
4461 OBERLIN AVENUE
SUITE 202
LORAIN, OHIO 44052
(440) 960-1104

IN MENTOR
7784 REYNOLDS ROAD
MENTOR, OHIO 44060-5321
(440) 946-0101

April 22, 2002

Howard Ozer, M.D., Ph.D.
1516 Camden Way
Oklahoma City, OK 73116

RE: May Ann Feathers

Dear Dr. Ozer:

This case has yet again been reset for trial. The new trial date is September 16, 2002. At this point, the Defendant has not made an attempt to settle the claim and we do not know whether or not they will.

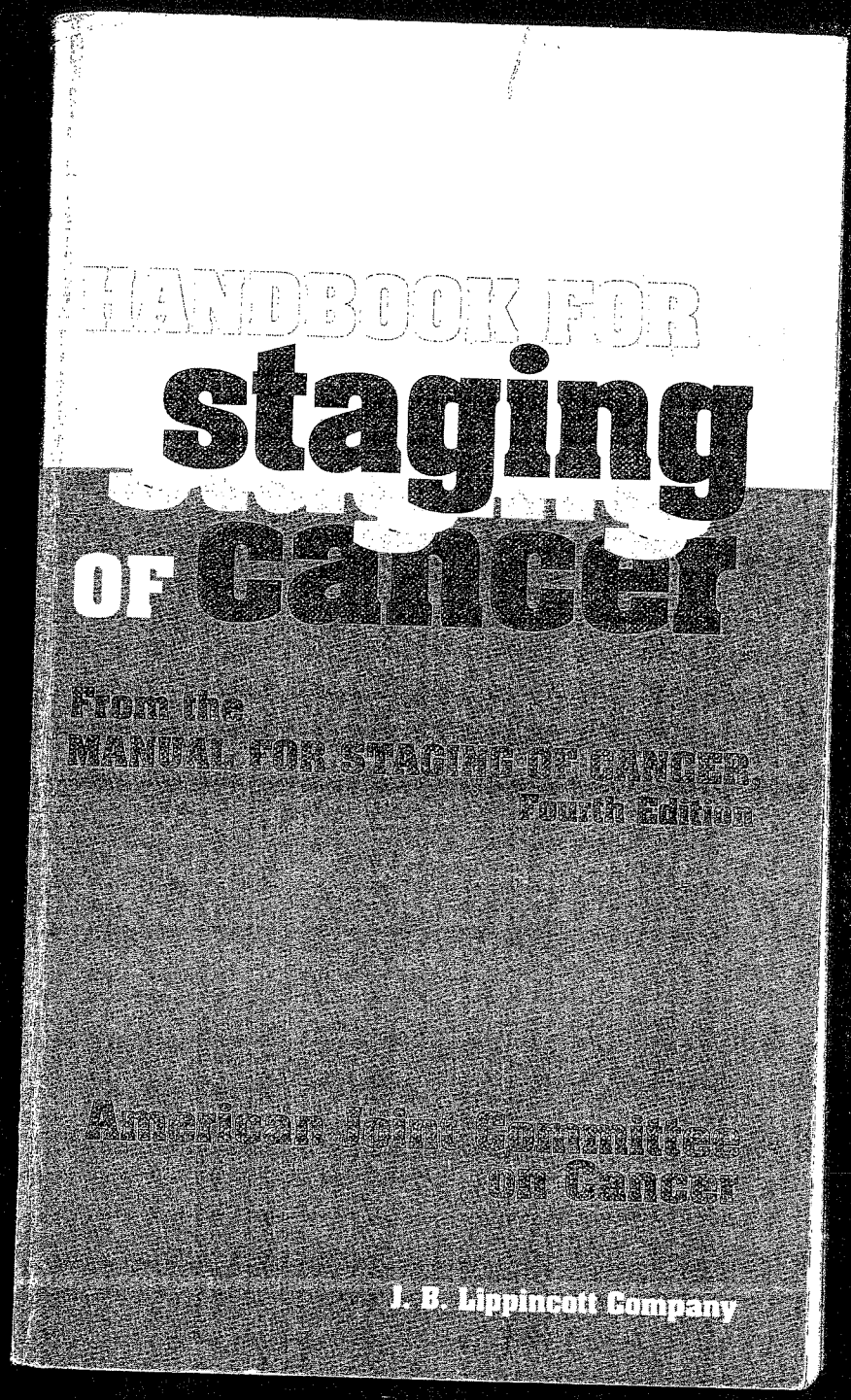
Enclosed please find the expert reports for Dr. Brown.

Counsel for Dr. Brown would like to take your discovery deposition sometime in late June, or early July. Please call my office with available dates.

Sincerely yours,

Donna Taylor-Kolis

DTK/jme


HANDBOOK FOR
staging
OF Cancer
From the
MANUAL FOR STAGING OF CANCER
Fourth Edition
American Joint Committee
on Cancer
J. B. Lippincott Company

le bus
ssified

: desmoplastic variant also exists.
lanomas are identified according to site (e.g., mucosal, ocular, vaginal
urethral). The staging classification described in this chapter appli
o those arising in the skin.

IOGRAPHY

ch CM, Murad TM, Soong SJ, et al: A multifactorial analysis of mel
oma: Prognostic histopathological features comparing Clark's and
slow's staging lesions. Ann Surg 188:732–742, 1978
slow A: Thickness, cross-sectional areas and depth of invasion in the
gnosis of cutaneous melanoma. Ann Surg 172:902–908, 1970
slow A: Prognosis in cutaneous melanoma: Tumor thickness as a
le to treatment. Pathol Annu Part 1:1–20, 1980
k WH Jr: The histogenesis and biological behavior of primary malig
t melanoma of the skin. Cancer Res 29:705–717, 1969
f AW, Rodriquez-Sains RS, Rigel DS, et al: "Small" melanomas:
ation of prognostic variables to diameter of superficial spreading mel
mas. J Dermatol Surg Oncol 8:765–770, 1982

BREAST

25

Breast

C50.0 Nipple
C50.1 Central portion
C50.2 Upper-inner quadrant
C50.3 Lower-inner quadrant
C50.4 Upper-outer quadrant
C50.5 Lower-outer quadrant
C50.6 Axillary tail
C50.8 Overlapping lesion
C50.9 Breast, NOS

The following TNM definitions and stage groupings for carcinoma of the breast are the same for the AJCC and the UICC/TNM projects. This staging system for carcinoma of the breast applies to infiltrating and *in situ* carcinomas. Microscopic confirmation of the diagnosis is mandatory and the histologic type and grade of carcinoma should be recorded.

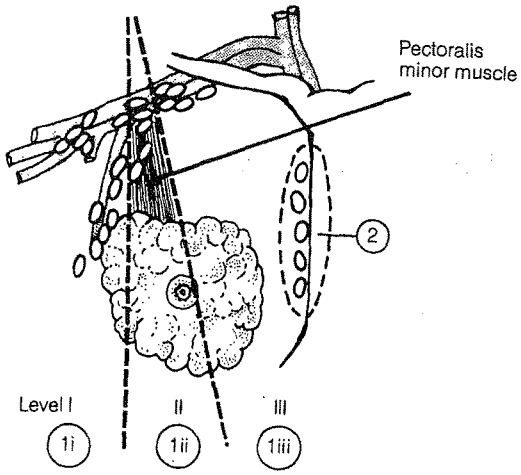
ANATOMY

Primary Site. Situated on the anterior chest wall, the mammary gland is composed of glandular tissue within a dense fibroareolar stroma. The glandular tissue consists of approximately 20 lobes, each of which terminates in a separate excretory duct in the nipple.

Regional Lymph Nodes. The breast lymphatics drain by way of three major routes: axillary, transpectoral, and internal mammary. Intramammary lymph nodes are considered with the axillary lymph nodes for staging purposes. Metastases to any other lymph nodes—including supraclavicular, cervical, and contralateral internal mammary nodes—are considered distant (M1). (Please refer to diagram.) The regional lymph nodes are:

(1) Axillary (ipsilateral): interpectoral (Rotter's) nodes and lymph nodes along the axillary vein and its tributaries, which may be divided into the following levels:
   (i) Level I (low-axilla): lymph nodes lateral to the lateral border of the pectoralis minor muscle
   (ii) Level II (mid-axilla): lymph nodes between the medial and lateral borders of the pectoralis minor muscle and the interpectoral (Rotter's) lymph nodes
   (iii) Level III (apical axilla): lymph nodes medial to the medial margin of the pectoralis minor muscle, including those designated as subclavicular, infraclavicular, or apical.

REGIONAL LYMPH NODES



Note: Intramammary lymph nodes are coded as axillary lymph nodes.

(2) Internal mammary (ipsilateral): lymph nodes in the intercostal spaces along the edge of the sternum in the endothoracic fascia.

Any other lymph node metastasis is coded as a distant metastasis (M1), including supraclavicular, cervical, or contralateral internal mammary lymph nodes.

Metastatic Sites. All distant visceral sites are potential sites of metastases. The four major sites of involvement are bone, lung, brain, and liver, but this widely metastasizing disease has been found in almost every remote site.

RULES FOR CLASSIFICATION

Clinical Staging. Clinical staging includes physical examination, with careful inspection and palpation of the skin, mammary gland, and lymph nodes (axillary, supraclavicular, and cervical), pathologic examination of the breast or other tissues, and imaging *to* establish the diagnosis of breast carcinoma. The extent of tissues examined pathologically for clinical staging is less than that required for pathologic staging (see Pathologic Staging). Appropriate operative findings are elements of clinical staging, including the size of the primary tumor and chest wall invasion and the presence or absence of regional or distant metastasis.

Pathologic Staging. Pathologic staging includes all data used for clinical staging and surgical resection as well as pathologic examination of the primary carcinoma, including not less than excision of the primary carcinoma with no tumor in any margin of resection by gross pathologic examination.

A case can be included in the pathologic stage if there is only microscopic, but not involvement at the margin. If there is tumor in the margin of resection by gross examination, it is coded as TX, because the extent of primary tumor cannot be assessed. Resection of at least the low axillary lymph nodes (Level I)—that is, those lymph nodes located lateral to the lateral border of the pectoralis minor muscle—should be carried out. Such a resection ordinarily will include six or more lymph nodes. Metastatic nodules in the fat adjacent to the mammary carcinoma, without evidence of residual lymph node tissue, are considered regional lymph node metastases.

CLASSIFICATION

primary Tumor

The clinical measurement used for classifying the primary tumor (T) should be the one judged most accurate (e.g., physical examination or mammogram). Pathologically, the tumor size for classification (T) is a measurement of the invasive component. For example, if there is a large in situ component (4 cm) and a small invasive component (0.5 cm), the tumor is classified as T1a. The size of the primary tumor should be measured before any tissue is removed for special studies, such as for estrogen receptors.

Multiple Simultaneous Ipsilateral Primary Cancers

The following guidelines should be used when classifying multiple simultaneous ipsilateral primary (infiltrating, grossly measurable) carcinomas. These criteria do not apply to one grossly detected tumor associated with multiple separate microscopic foci.

1. Use the largest primary carcinoma to classify T.
2. Enter into the record that this is a case of multiple simultaneous ipsilateral primary carcinomas. Such cases should be analyzed separately.

Simultaneous Bilateral Breast Carcinomas

Each carcinoma is staged separately.

Inflammatory Carcinoma

Inflammatory carcinoma is a clinicopathologic entity characterized by diffuse brawny induration of the skin of the breast with an erysipeloid edge, usually without an underlying palpable mass. Radiologically, there may be a detectable mass and characteristic thickening of the skin over the breast. This clinical presentation is due to tumor embolization of dermal lymphatics. The tumor of inflammatory carcinoma is classified as T4d.

Paget's Disease of the Nipple

Paget's disease of the nipple without an associated tumor mass (clinical) or invasive carcinoma (pathologic) is classified as Tis. Paget's disease with a

nonstrable mass (clinical) or an invasive component (pathologic) is sified according to the size of the tumor mass or invasive component.

Skin of the Breast

Dimpling of the skin, nipple retraction, or any other slun change except those described under T4b and T4d may occur in T1, T2, or T3 without changing the classification.

Chest Wall

The chest wall includes the ribs, intercostal muscles, and serratus anterior muscle but not the pectoral muscle.

DEFINITION OF TNM

Primary Tumor (T)

Definitions for classifying the primary tumor (T) are the same for clinical and for pathologic classification. The telescoping method of classification can be applied. If the measurement is made by physical examination, the examiner will use the major headings (T1, T2, or T3). If other measurements, such as mammographic or pathologic, are used, the examiner can use the telescoped subsets of T1.

TX Primary tumor cannot be assessed
TO No evidence of primary tumor
Tis Carcinoma *in situ:* intraductal carcinoma, lobular carcinoma in situ, or Paget's disease of the nipple with no tumor
TI Tumor 2 cm or less in greatest dimension
T1a 0.5 cm or less in greatest dimension
T1b More than 0.5 cm but not more than 1 cm in greatest dimension
T1c More than 1 cm but not more than 2 cm in greatest dimension
T2 Tumor more than 2 cm but not more than 5 cm in greatest dimension
Tumor more than 5 cm in greatest dimension
Tumor of any size with direct extension to chest wall or skin
T4a Extension to chest wall
T4b Edema (including peau d'orange) or ulceration of the skin of the breast or satellite skin nodules confined to the same breast
T4c Both (T4a and T4b)
T4d Inflammatory carcinoma (See the definition of inflammatory carcinoma in the introduction.)

Note: Paget's disease associated with a tumor is classified according to the size of the tumor.

Regional Lymph Nodes (N)

NX Regional lymph nodes cannot be assessed (e.g., previously removed)
N0 No regional lymph node metastasis

BREAST CANCER

SURVIVAL ACCORDING TO AJCC STAGE

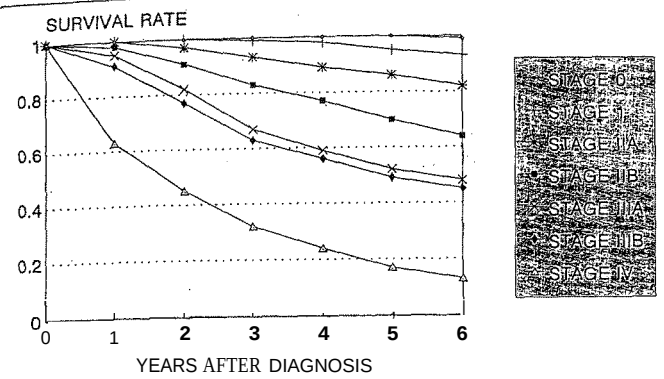


Fig. 25-1. Relative survival rates according to stage of disease. Data taken from 50,834 patients listed in the Surveillance, Epidemiology, and End Results Program of the National Cancer Institute. Patients were diagnosed between 1983 and 1987. Stage 0 represents 4,601 patients; Stage I, 16,519; Stage IIA, 14,692; Stage IIB, 8,283; Stage IIIA, 1,656; Stage IIIB, 1,389; and Stage IV, 3,694.

N1 Metastasis to movable ipsitateral axillary lymph node(s)
N2 Metastasis to ipsilateral axillary lymph node(s) fixed to one another or to other structures
N3 Metastasis to ipsilateral internal mammary lymph node(s)

Pathologic Classification (pN)

pNX Regional lymph nodes cannot be assessed (e.g., previously removed, or not removed for pathologic study)
pN0 No regional lymph node metastasis
pN1 Metastasis to movable ipsilateral axillary lymph node(s)
pN1a Only micrometastasis (none larger than 0.2 cm)
pN1b Metastasis to lymph node(s), any larger than 0.2 cm
pN1bi Metastasis in one to three lymph nodes, any more than 0.2 cm and all less than 2 cm in greatest dimension
pN1bii Metastasis to four or more lymph nodes, any more than 0.2 cm and all less than 2 cm in greatest dimension
pN1biii Extension of tumor beyond the capsule of a lymph node metastasis less than 2 cm in greatest dimension
pN1biv Metastasis to a lymph node 2 cm or more in greatest dimension

pN2 Metastasis to ipsilateral [illegible] that are fixed to one another or to other structures

I3 Metastasis to ipsilateral internal mammary lymph node(s)

Distant Metastasis (M)

MX Presence of distant metastasis cannot be assessed
MO No distant metastasis
MI Distant metastasis (includes metastasis to ipsilateral supraclavicular lymph node(s))

STAGE GROUPING

Stage 0	Tis	N0	M0
Stage I	T1	N0	M0
Stage IIA	T0	N1	M0
	T1	N1	M0
	T2	N0	M0
Stage IIB	T2	N1	M0
	T3	N0	M0
Stage IIIA	T0	N2	M0
	T1	N2	M0
	T2	N2	M0
	T3	N1	M0
	T3	N2	M0
Stage IIIB	T4	Any N	M0
	Any T	N3	M0
Stage IV	Any T	Any N	M1

Note: The prognosis of patients with N1a is similar to that of patients with pN0.

HISTOPATHOLOGIC TYPE

The histologic types are as follows:

Carcinoma, NOS (not otherwise specified)
Ductal
Intraductal (*in situ*)
Invasive with predominant intraductal component
Invasive, NOS
Comedo
Inflammatory
Medullary with lymphocytic infiltrate
Mucinous (colloid)
Papillary
Scirrhous
Tubular
Other

Breast

Lobular
In situ
Invasive with predominant *in situ* component
Invasive

Nipple
Paget's disease, NOS
Paget's disease with intraductal carcinoma
Paget's disease with invasive ductal carcinoma
Other

Undifferentiated carcinoma

HISTOPATHOLOGIC GRADE (G)

GX Grade cannot be assessed
G1 Well differentiated
G2 Moderately differentiated
G3 Poorly differentiated
G4 Undifferentiated