DEPOSITION OF JOHN J. PETRUS, M.D.

Dorothy Ross vs. Bennie Allison, M.D.

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CONDENSED TRANSCRIPT AND CONCORDANCE
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The State of Ohio,)
County of Cuyahoga.)SS:
IN THE COURT OF COMMON PLEAS
Dorothy Ross,)
Plaintiff,)Case No.
-vs-)98CV358014
Bennie Allison, M.D.,)
et al.,)
Defendants.)

Deposition of JOHN J. PETRUS, M.D., an expert witness herein, called by the)Plaintiff as if upon cross-examination under the statute, and taken before Luanne Stone, a Notary Public within and for the State of Ohio, pursuant to the agreement of counsel, and pursuant to the further stipulations of counsel herein contained, on Tuesday, the 8th day of February, 2000 at 224 West Exchange Street, the City of Akron, the County of Summit and the State of Ohio.

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APPEARANCES:

On behalf of the Plaintiff:
Chattman, Gaines & Stern, by:
John Scharon, Esq.

On behalf of the Defendants:
Roetzel & Andress, by:
Joseph E. Herbert, M.D.

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P R O C E E D I N G S

JOHN J. PETRUS, M.D., being of lawful age, having been first duly sworn according to law, deposes and says as follows:

CROSS-EXAMINATION OF JOHN J. PETRUS, M.D.

(At this time Plaintiffs Exhibit 1 was marked for identification purposes.)

BY MR. SCHARON:

Q Doctor, would you just state your full name for the record?
A John Joseph Petrus, M.D.
Q Thanks. We've marked as Plaintiff's Exhibit No. 1 your CV. Just have a look at it and satisfy yourself that that is your current, up-to-date CV.
A Yes.
Q Great, thanks. We'll make a copy of it and attach it to this transcript. I haven't seen it before today so I'm going to ask you a couple *of* questions that I planned to ask you, assuming I wouldn't see one of these. Where did you do your medical training?
A Medical school --
Q Yes.

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A -- or postgraduate?
Q Start with medical school.
A Northeastern Ohio Universities College of Medicine.
Q Where is that?
A Rootstown, Ohio.
Q Okay. When did you graduate there?
A 1984.
Q What kind of training did you have after that?
A Internal medicine, hematology, medical oncology.
Q What did you do first; an internal)medicine residency?
A An internal medicine residency.
Q Where did you do that?
A Akron General.
Q How long did it last?
A Three years.
Q What did you do at the end of that residency?
A I did one year of my fellowship in hematology/medical oncology at The Cleveland Clinic.
Q And then, since that time, have you

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been in private practice?
A No. Then I did two additional years at the Medical College of Georgia in hematology/medical oncology.
Q That was a fellowship?
A That was a fellowship.
Q Okay. You're board certified in internal medicine and also in the subspecialties of hematology and oncology?
A I'm board certified in internal medicine, hematology, medical oncology and pain medicine.
Q Is the pain medicine board a fairly new board?
A It's a fairly new board, not completely recognized everywhere, but it was pretty rigorous.
Q This is the first time I've seen that one.
A It's mostly anesthesiologists.
Q Have you published any works in the literature?
A I had -- I was second or third author on a paper a few years ago. It had to do with a drug called Amifostine, A-M-I-F-O-S-

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T-I-N-E, in combination with the chemotherapy drug, Carboplatin, C-A-R-B-O-P-L-A-T-I-N, to see if it diminished the bone marrow toxicity.
Q I may have missed it here as I'm looking through the CV. Do you teach medicine?
A Yes.
Q In what capacity?
A I am the head of the hematology/oncology service at the medical school, and, so, I'm responsible for coordinating the hematology/oncology curriculum for the sophomore medical students. I also teach clinical ethics to the junior medical students, and to the senior medical students, I have a hematology/medical oncology rotation that they can elect to study under.
I'm also involved in teaching the internal medicine residents as well as the other residents here at Akron General Medical Center.
Q Okay. So, as they're doing their residency at Akron General, they will work

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with you --
A Yes.
Q -- on rounds and so forth?
A Yes.
Q Okay. That's clinical teaching?
A Clinical teaching.
Q Okay. Where are you licensed to practice medicine?
A Ohio.
Q Okay. Is this the only state you've ever been licensed in?
A Well, I was in Georgia for two years, so I was licensed in Georgia.
Q And have you let that go?
A Yes.
Q Has your license ever been negatively affected in any state?
A No.
Q Has any action ever been taken against your license?
A No.
Q How about, has there ever been any action against your privileges at any hospitals?
A No.

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Q Where do you have privileges?
A Akron General, Summa, Barberton.
Q That's old City Hospital, right?
A The old City Hospital; that's right.
Q Okay.
A Barberton Citizens Hospital, Cuyahoga Falls Hospital, and then there's a hospital within Barberton Hospital called Specialty Hospital.
Q Okay. Are all of those full privileges, or are some of them courtesy privileges?
A I have -- geez, these are complicated questions. I have full privileges everywhere, I think, yes.
Q Where do you see most of your patients?
A Ninety-nine percent of my patients are at Akron General.
Q Did you pass all of your certifications on the first try?
A Yes.
Q Let's see; we're here taking your deposition in this case called Ross versus Allison, et al. You've been named as an expert witness for the defendants, so we're

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taking your deposition here at your offices, nearby your offices in the Physicians' Medical Building next to Akron General Hospital.
A Yes.
Q Do you have any other offices?
A Not that I practice out of.
Q Can you describe for us the nature of your medical practice?
A That's hard. A major -- major interests of mine are end-of-life care. I do a lot of hospice care. I also do a lot of hematology, a lot of medical oncology, and because of my pain medicine interests, I also do a lot of chronic nonmalignant pain.
Q Okay. Can you break your interests down by percentages or give me some rough idea? How much time, for instance, do you spend on medical oncology, and how much of your time do you spend on hematology?
A Let's see; I would say -- there's a lot of crossover, you know, as I change hats among all of these different things. I will say 20 percent nonmalignant pain; 30 percent hematology; 30 percent oncology; 20 percent

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hospice.
Q All right. Do you have any straight internal medicine patients?
A Indirectly. Patients I have assumed that have had initial hematology/medical oncology problems, I also do their internal medicine.
Q Have you ever given a deposition before today?
A Yes.
Q How many?
A Five, six.
Q Under what circumstances?
A One -- two as plaintiff; three as an expert witness.
Q I'm sorry, two as plaintiff what? You said "two as plaintiff."
A Well, as --
Q As an expert witness?
A No, where I was the one being sued.
Q Oh, okay, as a defendant?
A As the defendant, I'm sorry.
Q That'sokay.
A Three as expert witness and then one for federal court. One of the medical

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students was suing the medical school for wrongful dismissal, and I was part of the Academic Review and Promotions Committee.
Q There were no standard-of-care issues involved in that case?
A No.
Q So, let's put that one to the side. Did you give the two depositions as a defendant in the same case or in more than one case?
A Two different cases.
Q Okay. Are those the only two cases that have ever been filed against you?
MR. HERBERT: Note my objection. You can answer.
THE WITNESS: That have been filed?
BY MR. SCHARON:
Q Yes.
A Probably, there have probably been additional filings.
Q Do you know how many?
A Maybetwo.
Q Two others?
A Uh-huh.

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Q So, a total of four?
MR. HERBERT: Note my objection. Answer to the best of your knowledge, if you know.
THE WITNESS: I'm assuming, yes.
BY MR. SCHARON:
Q Were all of those cases filed here in Summit County?
MR. HERBERT: Can I just have a continuing objection, John?
MR. SCHARON: Sure.
MR. HERBERT: All right.
THE WITNESS: No.
BY MR. SCHARON:
Q Okay. Where were they?
A One was Zanesville, whatever county that is.
Q I'm sorry, one was what?
A Zanesville. I think one might be Portage.
Q Ravenna?
A Yes, and for the rest, I'm assuming Summit.
Q What was the nature of the claim made against you in Zanesville?

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A The patient died as a complication of a bone marrow procedure.
Q Where were you practicing at the time?
A Here.
Q Okay. How did the case come to be brought in Zanesville, if you know?
A That's where the patient was from.
Q I see. What was the bone marrow procedure that was being done?
A A sternal bone marrow.
Q And for what condition?
A He had massive, nonHodgkin's lymphoma, and I was really working to make a diagnosis in the situation, a very unusual presentation.
Q Do you know how that case turned out?
A It settled.
Q Okay. Do you remember the names of any of the attorneys in the case?
A No.
Q Do you remember the name of the case?
A No.
Q The patient?
A Jamie Hall.
Q H-A-L-L?

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A Yes.
Q Were there other defendants besides you?
A The hospital.
Q Do you remember who was first named in the case?
A Me.
Q Tell me about the case in Portage County. What did it involve?
A That was a fairly recent filing, and I'm still not certain what she's suing over.
Q Was it, in fact, a patient of yours?
A Yes.
Q And what was the condition that you treated her for?
A Anemia.
Q So, that case is pending?
A Very pending.
Q Okay.
A I'd be surprised if I ever hear about it again.
Q Who is representing her; do you know?
A I don't even know yet.
Q Do you know the patient's name? I'm trying to identify the case.
A Oh, I recognize that. I'm sorry, but I

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can't recall.
Q Are there other defendants?
A Yes.
Q Who is first named?
A Not me.
Q Do you know who is?
A McCluskey.
Q McCluskey?
A M-C-C-L-U-S-K-E-Y.
Q So, it's question mark versus McCluskey. You don't remember the name of the person?
A No.
Q Okay. Tell me about the Summit County cases.
MR. HERBERT: Just note my objection. If you can, go ahead.
THE WITNESS: One is still pending, Stubblefield.
BY MR. SCHARON:
Q Okay, versus whom?
A Me.
Q Okay. What's the nature of that claim?
A They maintain that he was given an overdose of pain medication or some such

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thing.
Q And the other Summit County case?
A I don't even remember.
Q You don't remember the name?
A No.
Q Is it over with?
A It never blossomed into anything.
Q Okay.
A It's one of those things where you get papers one day, and then you never hear about it again.
Q In which of the cases did you give the depositions?
A The Stubblefield case and the Hall case.
Q Okay, and you've testified as an expert in three cases?
A Yes.
Q Does that include this one or not?
A No.
Q There are three in addition to this case?
A In addition to this.
Q Are those the only three malpractice cases that you've consulted on, or have you

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consulted on others, but it just didn't get to the point of giving depositions?
A There was only one other that I remember consulting on.
Q Okay. What percentage of your time would you estimate you spend in legal consulting?
A Almost none.
Q With respect to the cases that you have done legal consulting on, were you asked to consult by the plaintiff's attorney, the defense attorney or some combination?
A The plaintiffs attorney. The three -- three of the other cases, and I think there were four. Three of the other cases were patients of mine that were suing another physician for one reason or another.
Q Okay.
A One was actually suing B.F. Goodrich for asbestos exposure.
Q Okay. So, were the other three malpractice cases?
A Two of them were, yes.
Q Okay. So, two malpractice cases. One

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was versus B.F. Goodrich --
A Yes.
Q -- for asbestos disease.
A Yes.
Q And what was the other one for?
A Out of the malpractice cases?
MR. HERBERT: There are two malpractice cases and one B.F. Goodrich case.
THE WITNESS: Yes.
MR. HERBERT: Three patients.
THE WITNESS: One of the malpractice cases was for a patient who died of malignant melanoma, and his primary care physician and the pathologist on record failed to make the diagnosis.
BY MR. SCHARON:
Q Okay.
A And the second case was very weird. It was a patient who was suing her own insurance company. She was involved in a car accident and ruptured her spleen. It turned out that she had Hodgkin's disease in her spleen, and her insurance company was refusing to pay, saying that the reason her

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spleen ruptured was because of the Hodgkin's disease, that it wasn't because of her car accident.
Q So, you count that as one of the malpractice cases, as you termed it earlier?
A Yes.
Q So, I'm confused for a moment. Have there been three or four of these consultancies?
A Let me think. It seems there's another one that I gave for another of my patients, and I have two that are scheduled that I haven't given yet. Maybe I'm mistaken.
Q Have you ever been asked to consult by any other defense attorneys defending malpractice cases? The melanoma case, was that one like that?
A No.
Q That was for a patient?
A Yes.
Q So, in any of your legal consulting work, have you consulted for defendants?
A No.
Q Have you ever testified or consulted with Mr. Herbert before?

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A No.
Q Or his firm, Roetzel & Andress?
A I don't know. I think I may have.
Q Okay. Would you remember which of those matters they were involved in?
A I have no idea.
Q Okay. When were you first contacted in this case? Do you recall that?
A I'm not certain. I'm not sure that I could give you a date. It was over a year ago.
Q Over a year ago?
A Yes.
Q Do you know how Mr. Herbert came to contact you about this matter?
A I have no idea.
Q Do you advertise your availability --
A No.
Q --to consult? No?
A No.
Q Have you ever actually testified in court in any of these matters?
A The B.F. Goodrich case.
Q The asbestos case?
A Yes.

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Q Okay. How do you charge for your services? How are you charging for your services in this matter?
A You'd have to ask my secretary.
Q Okay. I'd like to have some idea of how much I'm going to get charged. Your secretary is the only one who knows that?
A Yes.
Q Okay.
MR. HERBERT: Yes. We didn't ask you to bring down a check. He hasn't done it enough yet to know.
BY MR. SCHARON:
Q We've tried our best to list the cases and consultancy matters that you've been involved in. Am I correct that none of those cases involved claims that there was a nondiagnosis or a delayed diagnosis of Hodgkin's disease?
A No.
Q I'm right about that?
A You're correct.
Q That was one of those double negatives. I'll try not to do that anymore. I can't promise that I'll be successful, but I'll

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try.
Okay. Before us you've placed a box which contains various medical records and depositions. Is that all of the material that you've reviewed in this case?
A Yes.
Q Have you done any medical literature review?
A No.
Q Do you plan to?
A No.
Q Have you made any notes?
A Yes.
Q Where are they?
A On my computer.
Q Is your computer here?
A Yes.
Q Could you print them out?
A No.
Q Why not?
A I don't want to.
MR. HERBERT: Off the record for a second.
(At this time a short recess was had.)

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(At this time Plaintiffs Exhibit 2 was marked for identification purposes.)
MR. HERBERT: Is that Exhibit 2?
MR. SCHARON: We've marked this as Plaintiff's Exhibit 2.
BY MR. SCHARON:
Q These are the notes that you just printed out. Are those all of the notes that you've made on the case?
A These are every, single one of them.
Q Thank you very much. These notes go from one to 37.
A Yes.
Q And then the last note is number 101.
A Yes.
Q Are there notes 38 through 100?
A No.
Q Can you explain the 101 on the last note?
A Yes. The one through 37 notes were based on my review of the medical records, and then I was going to start with 101 and keep notes of my, you know, medical perspective on what I had put together up there.

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Q And note 101 says, "Marrow involvement almost always associated with elevation in alkaline phosphatase (18-Williams)."
A Yes.
Q What's that reference to?
A I had forgotten about that. I think that is the third edition of "Williams" which is an old edition of a hematology textbook, "Williams Hematology."
Q We'll get into a discussion about your review of the records further, but while I'm looking at the notes, I see that note number 29 says that in October, October 10th of (14,1996, "No nodes and again in post chain following fish bone incident two plus."
Can you tell me what you're describing in that note, number 29?
A Number 29, October 10th, 1996, "No nodes," no palpable lymph nodes, and again in the posterior chain following the fish bone incident, they were described as two plus per the medical records that I reviewed.
Q What were described as two plus?
A The lymph nodes.

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Q So, they were present following the fish bone incident?
A Yes, in the posterior chain.
Q Okay. Your statement that there were no nodes on 10/10/96, is that based on Dr. Allison's deposition testimony or the records?
A I don't remember.
Q Okay. Is it your impression from reviewing Dr. Allison's testimony and the records that there were no nodes on 10/10/96?
A I don't remember.
Q Okay, thanks. Do you know any of the physicians involved in this case, any physicians who were involved in the treatment of Dorothy Ross?
A No.
Q Okay. That would include Drs. Azem, Tirgan, Yang, of course Allison and Tyler, Lazarus.
A I've shared patients with Dr. Lazarus, but I've never met him personally. I think I may have spoken to him on the phone once.
Q Have any of these physicians been involved in any of the other cases that

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you've been involved in?
A No.
Q Have they been involved in any of the cases that were filed against you or the cases that you consulted on?
A No.
Q We've been provided with a report of yours dated September 28 of 1999, okay? Does that look familiar?
A Yes.
Q Other than your notes, is this the only writing that you've produced concerning this case?
A Yes.
Q Is this the one and only draft of that report?
A That's the only one I know of.
Q Okay. Well, that's what I'm asking. Were there any other drafts?
A It would have been corrected before that one was sent out. It was all done as part of, you know, going in to correct Microsoft Word or whatever, so it's the only one that exists.
Q Do you have a recollection of whether

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you did do revisions?
A I don't think I did.
Q In the course of working on this case, did you consult with any physicians to discuss it?
A No.
Q Okay. Your first opinion stated in this report is that the care rendered by Drs. Allison and Tyler met acceptable standards.
A Correct.
Q Can you tell me the basis for your opinion? Why do you say that? You'll appreciate that the report simply contains one statement, so --
A Yes. I felt, given the number of co-morbidities involved in her situation and the unusual nature of her presentation, that the care rendered met the standard of care for a general internist.
Q Okay. What are the co-morbidities that you refer to?
A Can I borrow my notes?
Q I'm sorry?
A Can I borrow my notes?

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Q Sure. What were you going to do without them?
A I just assumed you would point these things out to me in the record. Disabling rheumatoid arthritis, electrical wire injury with right body weakness, disabling headaches, numerous work accidents, history of migraine headaches, history of frequent falls, history of chronic leg edema.
(At this time a short recess was had.)
BY MR. SCHARON:
Q You were listing the co-morbid conditions which, when taken together with the unusual nature of her presentation, form the basis of your opinion.
A Yes. Her morbid obesity, and I think that's a pretty good list.
Q Okay. I didn't write down, and maybe I missed it, but is there anything about upper respiratory infections? Did you mention it?
A I did not mention it, no.
Q Should it have been mentioned?
A But we should mention it; recurrent upper respiratory tract infections.

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Q And what was unusual about the nature of her presentation?
A Her initial presentation was anemia.
Q Okay, and that's dating to when? What are you calling the initial presentation?
A March of '95, I think it is.
Q She was anemic then?
A In retrospect, you could see some early signs of a developing anemia. I think her hemoglobin was 11.9, and her MCV was low.
Q You said "in retrospect." Does one need to look in retrospect in order to determine that those numbers are low?
A Yes, because, you know, a biologic system like a human being is not -- you know, it doesn't run like a machine. It's not going to give you the same readings like an odometer on a car or something like that. So, every number you look at, you have to look at with kind of a grain of salt and interpret it.
Q Allright.
A In the laboratory they were using, I'm pretty certain for females, the lower limit for the normal range was 12. So, 11.9, you

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know, that's an insignificant amount. I wouldn't describe that as significant, especially in a premenopausal female.
Q How about her crit?
A Well, the hematocrit, hemoglobin, it doesn't matter which one you're following.
Q Okay.
A I would say the same thing.
Q The 35.5 was not significant with a lower limit of 37, you would say?
A No, not -- in a menstruating female, I would take note of it, but it is so common --
Q Okay.
A --that I wouldn't put anything else into it.
Q She was essentially a new patient to Dr. Allison in March of 1995, correct?
A I don't remember.
Q Hypothetically, if she was coming to Dr. Allison to take over her internal medicine care in March of 1995, would it have been good practice for Dr. Allison to obtain her prior records in order to find out how this machine was working, how her

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body was functioning?
A Hypothetically, it's good practice, but for her to do her own, independent evaluation, I would consider that to be reasonable as well.
Q I'm sorry. How would she do that?
MR. HERBERT: When you say "her," are you talking about the doctor?
THE WITNESS: I'm assuming, yes, the doctor.
BY MR. SCHARON:
Q Oh, for the doctor.
A For the doctor to do her own independent evaluation and just assume she's starting at square zero and try to figure out where she stands would be a reasonable approach.
MR. HERBERT: So that you know, the initial doctor was a Dr. Bennie Allison, so this is --
BY MR. SCHARON:
Q It's not a her.
A Him.
Q Okay. Let's follow this hypothetical, then. The physician is establishing his own

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working knowledge of his patient, and as part of that, he did this blood work on March 29th of 1995.
A Yes.
Q All right?
A Yes.
Q Given those results, when should a physician ought to have followed up and done it again?
A With those levels, and given her history of rheumatoid arthritis, her rheumatoid arthritis was stable, so a number of months is the best answer I could give you.
Q I'll take a range.
A Six to 12.
Q Okay. Now, why did you refer to the presentation of this patient with anemia as being unusual?
A I didn't.
Q Oh.
A I referred to her presentation with Hodgkin's disease beginning with anemia as being unusual.
Q Is that what you think happened?

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A Yes.
Q Okay. When did she first show any signs of Hodgkin's disease?
A In March of '95.
Q You think she had Hodgkin's disease then?
A I think she had Stage IV Hodgkin's disease in '95.
Q What's that based on?
A That's based on the fact that she had an anemia and a mild elevation in her alkaline phosphatase.
Q That's the reference to Williams; is that it?
A Yes.
Q Can you cite me to anything else?
A Can I cite to you anything else as in what circumstance?
Q As support for the statement that this laboratory finding was indicative of bone marrow involvement in March of 1995.
A Because there is no other explanation for her bone marrow -- her bone marrow abnormality. Her anemia -- let me take that back.

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In subsequent visits, she had iron studies performed that were normal. They did not demonstrate iron deficiency anemia. She ultimately had a bone marrow biopsy which confirmed a diagnosis of Hodgkin's disease involving the bone marrow, and over that period of time, she showed a progressive decline in her hemoglobin and her MCV and a progressive increase in her alkaline phosphatase, all of which are consistent with bone marrow involvement from her Hodgkin's disease.
Q Are they consistent with any other of her co-morbid conditions?
A If you just look at the blood counts themselves, yes. If you include the bone marrow biopsy results, that is the gold standard.
Q That wasn't done until July or the end of June of '97.
A Yes.
Q Okay.
A But there is no other explanation for her anemia or her microcytosis.
Q You say that she did not have iron

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deficiency anemia?
A No.
Q Are you aware of whether Drs. Allison and/or Tyler diagnosed iron deficiency anemia?
A They thought she had iron deficiency anemia.
Q So, they were wrong?
A They were wrong, but given the very unusual nature of her presentation, I could understand it. It *is* exceedingly unusual that someone will have an MCV progress the way hers did, to hit levels as low as hers did and not have either iron deficiency anemia or a congenital condition called thalassemia.
Q Why do you say that she didn't have iron deficiency anemia?
A She had normal iron studies.
Q Allright.
A Her serum iron was low, but so was her TIBC, and those are more consistent with anemia of chronic disease.
Q Couldn't she have some combination that would explain these same results?

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A Oh, I could give you all kinds *of* for-instance explanations as to why she could have these things, but, you know, in medicine, if you have one diagnosis that fits neatly into the package, that's what the patient has.
Q Okay. Do you know of any other Hodgkin's patients who had Stage IV disease for two and a half years before diagnosis and treatment?
A I saw one this morning.
Q Okay.
A And, in fact, it is more the rule than the exception that there's at least a year's delay in diagnosis for Hodgkin's disease,
Q And can you refer me to any literature that would support that statement?
A No. That's just based on my own experience and what I have read in the past. I can't tell you specifically what it came from.
Q Okay.
A But it's very common.
Q How would I find such literature? It exists obviously, you said, based on your

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reading.
A I would start with the general textbooks and read on.
Q Such as?
A Well, Williams.
Q Williams, all right.
A You could consider Wintrobe's "Hematology," DeVita's "Textbook on Oncology" or "Cancer Medicine," I think the title is, and others.
Q Okay. Were the swollen lymph nodes that were documented by Dr. Allison in August of 1996 Hodgkin's disease?
A Yes.
Q Do people in their forties usually have swollen lymph nodes in their neck, not submandibularly, when they get sinus infections?
A It can happen, yes.
Q Is it typical?
A It depends on how good you are at palpating lymph nodes. I find them not that uncommonly, but, you know, that's my expertise. I feel lymph nodes all day long. I can very easily differentiate a normal

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from an abnormal lymph node, but that's based on experience.
Q Would you expect an internist, a general internist to have such expertise?
A It depends on their training and their experience.
Q From your review of the depositions of Allison and Tyler, do you think that they had such expertise and training?
A They felt something.
Q Okay. When a person in their forties has swollen lymph nodes from an upper respiratory infection, how long do you expect the lymph nodes to remain swollen if the patient is being treated?
A It depends on what the -- presuming that it's due to an infection, it depends on what the infection is due to. If it's due to, like, mononucleosis, that's something that could go on for weeks.
Q How about sinus infections?
A Sinus infections?
MR. HERBERT: You're assuming successful treatment?
BY MR. SCHARON:

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Q I'm assuming treatment.
A I don't know that I can honestly answer that question because I put as much into the texture of the lymph nodes as I do the size of the lymph nodes and the location of the lymph nodes, and I'm not sure I could answer that question.
Q Okay.
A I'm 40, and I can feel my lymph nodes.
Q And you don't have an infection?
A Uh-uh, but I do have something that she didn't have, and that is that I have a very skinny neck. Because of the fact that she was over 100 pounds overweight, it makes it much more difficult to discriminate what's in her neck.
Q Are lymph nodes, abnormal lymph nodes from Hodgkin's disease always nontender?
A That's not true. That's the rule, but that's not --there's nothing that's always or never in medicine.
Q Allright.
A And another difficult thing about Hodgkin's disease is, you can have involvement of Hodgkin's disease in a lymph

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node without it causing lymph node enlargement.
Q Have you listed all of the reasons why you think that she had Stage IV Hodgkin's disease in March of '95?
A Yes.
Q When do you think her Hodgkin's disease began?
A I have no idea.
Q Okay.
A Hodgkin's disease is a very unusual type of cancer. You cannot think of it the way you would think of breast cancer where you go from this palpable mass to something that keeps growing, and as it gets bigger, it has a tendency to spread. While Hodgkin's disease tends to spread in a very typical pattern, it can wax and wane for years.
Q What is the typical pattern that Hodgkin's disease spreads in?
A Well, typically, Hodgkin's disease starts in the neck, and, so, the most common presentation is for a patient to come in with lymph nodes in their neck first.

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That's why the most common presentation is for someone to feel lymph nodes in their neck and have the biopsy, Stage I disease.
Then, it will spread very characteristically to the next group of lymph nodes; so, for example, the mediastinum where the lymph nodes are in the middle of the chest, and then it will march on.
Q Or to the armpits?
A Or to the armpits, and then it will march into the abdomen.
Q And that is bone marrow involvement, the last stage?
A Bone marrow involvement, Stage IV disease implies that the Hodgkin's disease has spread beyond the lymph-node-bearing areas themselves. So, that could be bone marrow involvement, lung involvement, liver involvement.
Q Spleen?
A Spleen. Well, spleen, no.
Q No?
A Spleen is considered like a big lymph node when you're doing staging for Hodgkin's

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disease.
Q Okay. Obviously you don't think that her Hodgkin's disease followed this typical progression.
A No.
Q What's the progression that you hypothesize for her?
A Well, I know it was in the bone marrow in March of '95, and because there were no CTs, and there are no other radiographic studies, there's no way of telling what was going on, especially in her abdomen.
Now, she had mixed cellularity Hodgkin's disease, and that type of Hodgkin's disease is much more common below the diaphragm, even at the time of presentation. So, it would not be unusual at all for her to come in with intra-abdominal disease, especially because, if my memory serves, she had palpable lymph nodes on both sides of her neck at some point, and that increases the chances that you have intra-abdominal involvement from Hodgkin's disease.
Q I'm not sure I understand what you're

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saying about how you think her Hodgkin's disease spread.
A I'm telling you that it was a very unusual pattern. I know it was in the lymph nodes -- it was in the bone marrow before you could palpate lymph nodes, but what I cannot tell you *is* whether her Hodgkin's disease began in the lymph-node-bearing area and spread to the bone marrow, but in a way where it evaded the lymph-node-bearing regions that are palpable; so, for example, the mediastinum or the intra-abdominal lymph node bearing regions. It could have potentially started there and spread to the bone marrow, or it could have started in the bone marrow and spread from there. There's no way of telling.
Q Does Hodgkin's disease ever begin in the bone marrow?
A I assume it can. There's no way of being able to tell.
Q Has any expert in the field ever written that it can?
A I don't see how you can exclude it as a possibility. If you have patients with

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Stage IV Hodgkin's disease that's involving the bone marrow, I don't know how you can say that it didn't start in the marrow, other than to say things in retrospect.
Q I appreciate what you're saying. I'm asking whether there's anybody else who has written in the field of your expertise who agrees with that point of view.
A I have no idea.
Q Allright.
A I'm not even saying that it's my point of view. My point of view is that I can't tell you where it started.
Q Was Dorothy Ross anemic in May of '96, the next time blood work was done?
A I'm not sure. I don't have the laboratories in front of me.
Q In May of '96, May 21st, 1996, the red blood count was 4.05, range 4.2 to 5.4; hemoglobin was 9.6, range 12 to 16; hematocrit was 30.1, range 37 to 47.
A Yes, she was anemic.
Q Okay. Did the standard of care which applied to these internists, Drs. Allison and Tyler, or at that point it was Dr.

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Allison, did it call for any investigation?
A What was the MCV?
Q Well --
A I'm assuming --
Q That's okay. I'll find it. May 22, 1996, you wanted the MCV?
A Yes.
Q 74.3, with a range of 81 to 99 for females.
A Okay. My answer is yes.
Q And what should have been done?
A It depends. "Investigation" may be too strong a word. I would say that it requires explanation.
Q Okay.
A So, the differential diagnoses for a hypochromic-microcytic anemia would be iron deficiency anemia, anemia of chronic disease, thalassemia, sideroblastic anemia or lead poisoning.
Q What's required to work one's way through that differential?
A If he thought that it was due to active rheumatoid arthritis, nothing. If he thought that this was iron deficiency

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anemia, then it would be to figure out where she was bleeding from. Because she's a menstruating female, it would have been reasonable to assume that it was due to menstrual blood losses and/or possibly to evaluate her gastrointestinal tract to see if she was bleeding.
If he thought it was due to sideroblastic anemia, it would have required a bone marrow.
If he thought that this was due to thalassemia, that's a congenital disorder, and he would have had that possibly by history or had consistent prior blood work.
Q If he thought it was due to iron deficiency anemia, would he get iron studies?
A Yes.
Q And did he do that in June of 1996?
A Yes.
Q And if he thought, after getting those iron studies, that this was iron deficiency anemia, he was wrong?
A Yes.
Q After these iron studies came back, he

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then got stool cards that were negative, okay.
A Is that a question?
Q That was in July. I'm telling you. Hopefully your notes will reflect the same thing.
A Yes.
Q What should Dr. Allison have done then to continue down this path of investigating or working up the anemia?
A Presuming he still felt that this was iron deficiency anemia, given the fact that this was a menstruating female, it would have been reasonable to either evaluate the gastrointestinal tract at that time or to give her iron replacement therapy and to see how she would do with that. A therapeutic trial of iron would be reasonable.
Q And do you give the iron to the patient before you do the iron studies? Should that be done?
A You can still make sense *of* them if you do that.
Q Won't giving the iron mask some of the results?

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A A therapeutic trial of iron is a reasonable way -- I mean, it's an old-fashioned way of making a diagnosis of iron deficiency anemia, so --
Q So, you give the iron and then what; check again to see whether or not the levels have come back?
A Yes, yes, and you should still be able to make sense out of the numbers.
Q Okay. If you do that the old-fashioned way of giving a trial of iron, how long do you wait to check the numbers again to see whether the levels have come back up?
A At least three to five weeks.
Q And, then, you should get follow-up blood work?
A Yes.
Q If these doctors did not get follow-up blood work for this lady from the time the iron studies were done in June of 1996 until January of '97, that wouldn't be acceptable; would it?
MR. HERBERT: Note my objection to the hypothetical to the extent the facts would be excluded, but you can answer.

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THE WITNESS: I would go back to my original statement and that is: it depends on what their explanation is of the anemia.
BY MR. SCHARON:
Q Okay. If Dr. Allison thought in June of 1996, after the iron studies came back, that she had iron deficiency anemia, okay, and he got stool cards in July of 1996 that were negative, shouldn't he have gotten follow-up blood work long before January of 1997?
MR. HERBERT: Just note my objection to the extent that it would exclude the facts, but you can answer.
THE WITNESS: Ideally, yes; not necessarily.
BY MR. SCHARON:
Q Well, what in this record excuses it? I mean, what explains why it wouldn't have been appropriate in this case?
A The supposition -- you're asking me to make suppositions as to what he was thinking at the time, and that's very difficult for me to do.

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Q No. We know from the records and from his deposition that he thought she had iron deficiency anemia, right?
MR. HERBERT: Well, do you want him to assume that?
BY MR. SCHARON:
Q I'm asking you: is that true?
A I don't remember. Based on the record, if that's what you're telling me, I'll take it at that.
Q But you have no recollection of whether Dr. Allison --
A I know he thought she had iron deficiency anemia, but I can't tell you when he thought that she had iron deficiency anemia.
Q If he didn't think she had iron deficiency anemia, there wouldn't have been any reason for him to prescribe iron in June of '96; would there have been?
A No.
Q Okay. So, assuming that Dr. Allison thought that she had iron deficiency anemia in June of 1996, and he did his iron studies and he got stool cards, shouldn't he have

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gotten follow-up blood work on this lady before January of 1997?
MR. HERBERT: Just note my objection. When you start the question "assuming," are you assuming all of those things were able to be done and available, and the patient was compliant?
THE WITNESS: And I am assuming that he assumed that her iron deficiency anemia was due to menstrual blood losses, and in that situation, if she had no further symptomatology, it's understandable. You're expecting me to jump through these hoops, and I just feel that I can't. I don't know exactly what he was thinking at the time. I don't -- I mean, I could -- I mean, if you're asking me what I would do, I'm a hematologist, and I don't know that I could answer the question of what would be the standard for a general internist.
BY MR. SCHARON:
Q Okay.
A I mean, I'm a hematologist.
Q Fair enough.
A A hematologist will get blood counts at

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the drop of a hat. Maybe I'll get some from you before the day's over.
Q Unlikely, unlikely. Mrs. Ross was diagnosed several times with sinus infections; is that right?
A Yes.
Q In February, March, May of 1996, three times that I particularly made note of. Would you characterize her sinus infections as being chronic or recurrent or chronic/recurrent?
A I don't know.
Q Do you think that her sinus infections adequately explain her lymphadenopathy?
MR. HERBERT: Note my objection. Are you asking this question in retrospect?
THE WITNESS: Yes, in what sense?
BY MR. SCHARON:
Q Sure.
A In retrospect?
Q Yes.
A Okay. If you're asking me in retrospect, I think those lymph nodes were Hodgkin's disease. If you are asking me: could she have had lymphadenopathy based on

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another condition other than Hodgkin's disease at the same time she has Hodgkin's disease, well, based on the supposition for bone marrow, I would say yes.
Q Allright.
A By the same token, lymphadenopathy, enlarged lymph nodes in the neck in patients with Hodgkin's disease can seem to respond to antibiotic therapy.
Q Did hers?
A I don't know.
Q Would it be acceptable for an internist to conclude that lymphadenopathy in the neck of a patient with sinus infections need not be investigated because the nodes were tender?
A Not necessarily.
Q Okay. Could you elaborate on that answer?
A It is more often than not that tender lymphadenopathy will imply reactive lymph nodes, a reaction to some type of inflammation going on, but, again, there are no absolutes in medicine.
Q Have you ever seen any other Hodgkin's

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patient present in the way you are hyphothesizing that Dorothy Ross presented?
A Yes.
Q How many times?
A Just this morning.
Q Is that the only other time?
A It's the only one I recall where the primary manifestation was with anemia, and Hodgkin's disease, if you don't have a lymph node to biopsy, is exceedingly difficult to diagnose by bone marrow biopsy, by needle biopsy of, like, a lung or whatever. So --
Q How many Hodgkin's patients have you treated in your career?
A I would say at least 40 or 50.
Q Other than this person that you saw this morning -- forget that for a moment. Have you read about any other patients presenting as you have described Dorothy Ross, with the presenting symptom of anemia?
A What's the question?
Q I'm trying to get a feeling for how often this unusual presentation of anemia in a patient with Hodgkin's disease occurs.

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You said that you saw a patient this morning, but you couldn't think of any others in the 40 or 50 Hodgkin's patients that you've seen.
A It's very unusual for a patient with Hodgkin's disease to present with anemia, and, so, if a patient with Hodgkin's disease presents with anemia, that pretty much implies that there's bone marrow involvement.
Q But this is a very unusual presentation?
A Yes.
Q Is this presentation described anywhere in the medical literature?
A Oh, I'm sure it is. Hodgkin's disease has a reputation of being one of the more difficult diagnoses to find sometimes. I mean, unusual presentations for Hodgkin's disease are known to occur. It's one of the things you think about in a patient who presents, for example, with fever of unknown origin. It's one of the diagnoses you think of when you have, you know, somebody who has isolated lymphadenopathy. In somebody who has an unexplained anemia, I always think

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about the lymphoproliferative disorders: nonHodgkin's lymphoma, Hodgkin's disease. It's part of the differential diagnoses.
Q After your review of these records, looking back on it, when do you think that Dorothy Ross should have been diagnosed with Hodgkin's?
A Should have been?
Q Yes.
MR. HERBERT: Just note my objection. You can answer.
THE WITNESS: I doubt that she could have been diagnosed as early as March of '95. I don't think that that's a possibility. The best way I could answer that question is: the earliest she could have been diagnosed was probably in August of '96.
BY MR. SCHARON:
Q When she would have had the documented lymphadenopathy.
A But "should have been," I could not answer.
Q Do you physicians know how long it usually takes Hodgkin's to progress from

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stage to stage?
A That varies tremendously from patient to patient.
Q Is there thought to be some general time frame or not?
A Not that I'm aware of. I'm sure that maybe somebody has written that someplace, but, again, I think Hodgkin's disease, more so than tumors arising from solid organs like breast, prostate, whatever, has a much more uncertain history. We know much less about how it starts. We're not even sure what the actual malignant cell is for certain in Hodgkin's disease. I mean, most of what you're seeing is an inflammatory response.
Q Just from looking at the general literature, what's the business about the Reed-Sternberg cell?
A The Reed-Sternberg cell is characteristic for Hodgkin's disease, and most people will accept the fact that that probably is the malignant cell associated with Hodgkin's, but what's unusual about Hodgkin's disease is that it's the only

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cancer I can think of where your diagnosis is based on this entire constellation of inflammation, the reaction to whatever the cancerous process is, as opposed to finding this continuous, monotonous colony of cells that you see with most types of malignancy. Hodgkin's disease defies the rules.
Q Is it true that, in order to make the diagnosis of Hodgkin's, you have to find the Reed-Sternberg cell in the biopsy?
A It's ideal. I mean, a pathologist would be much more uncomfortable with the diagnosis of Hodgkin's disease without seeing Reed-Sternberg cells. It can be done, but they are very uncomfortable in doing it.
Q Do you have an opinion about when she first had a mediastinal mass?
A She could have had that as early as March of '95. A chest X-ray was obtained at that time, and it was normal.
Q The chest X-ray was done in May of '96, and it was normal?
A A chest X-ray was done in July of '97 and showed, really, not that significant of

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an abnormality based on the way the radiologist interpreted that X-ray. So, again, I told you that Hodgkin's disease is notorious for involving lymph nodes without causing their enlargement. So, she could have had mediastinal lymph node involvement even prior to '95.
Q Ordinarily, would a patient with Stage IV Hodgkin's disease have symptoms?
A Not necessarily.
Q Usually?
A If you're talking about the symptoms, the B symptoms: fever, night sweats, weight loss, not necessarily.
Q Is it usual, though, more often than not?
A I can't answer, no. I don't know the answer to that question.
Q The volume of disease, the volume of abnormal tissue in Hodgkin's disease, does that increase over time?
A Well, we've already mentioned the fact that Hodgkin's disease waxes and wanes over time. So, again, compared to, like, breast cancer or prostate cancer, you cannot think

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of it as a process that starts with one cell and just keeps doubling and doubling and doubling. It waxes and wanes, waxes and wanes. It could stay the same for an extended period of time. It could start growing in a very short period of time. There is no specific answer to that question.
Q The stage at which the disease is diagnosed, is it a prognostic factor for whether it can be cured?
A The stage is the only prognostic -- well, the stage and the type of Hodgkin's disease you're dealing with are the only prognostic features I know of, in addition to the B symptoms.
Q Is it generally true that the earlier Hodgkin's disease is diagnosed and treated, the more successful the outcome is?
A If you mean "earlier" as the earlier stage --
Q Yes.
A Yes, Stage I Hodgkin's disease has a better prognosis than Stage IV Hodgkin's disease.

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Q Or better than II, better than III as well?
A Yes.
Q Within the stages, is there some decrease in prognosis or chance of favorable outcome depending on whether there are B symptoms present?
A B symptoms connote a worse prognosis.
Q Within the stage?
A Yes.
Q As compared with --
A Yes.
Q --the A patients having no symptoms?
A Right.
Q What ongoing laboratory studies support your position that she had Stage IV disease from March of '95 on?
A The progressive decline in her hemoglobin, hematocrit, MCV, and the progressive increase in her alkaline phosphatase.
Q Allright.
A That's it.
MR. HERBERT: And when you said "labs," you didn't mean to include the bone

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marrow?
MR. SCHARON: Correct.
MR. HERBERT: All right.
THE WITNESS: Laboratory-wise, that's it.
BY MR. SCHARON:
Q Allright.
A Then, that was confirmed by the bone marrow diagnosis which is the gold standard for evaluation for anemias.
Q There's no doubt that she had bone marrow involvement when the biopsy was done, right?
A I have not reviewed the slides myself, nor my pathologist, but looking at her records, that appears to be the case.
Q Are there classic symptoms and signs of Hodgkin's disease?
A Classic in that, if a patient has them, I would say they have Hodgkin's disease, but not classic in that they occur in every patient.
Q Understood. You don't have to have them all --
A Right.

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Q -- in order to have the disease, but what are the symptoms and signs that can occur?
A Enlargement of the lymph nodes.
Q Okay.
A B symptoms, those are the classic.
Q Fever of unknown origin, night sweats?
A Unexplained weight loss greater than ten percent of your body weight, and drenching night sweats lasting for over two weeks without explanation. Other ones attributed to Hodgkin's disease but which do not connote a worse prognosis would be generalized itching and pain in the lymph nodes when ingesting alcohol.
Q Are you aware of what stage Hodgkin's is most often diagnosed at?
A It would be Stage I, Stage II, that constellation.
Q What percentage of patients?
A I'm not sure I know a statistic off the top of my head.
Q Okay. Are you aware of the statistics for the prognosis for a cure in a patient diagnosed at Stage II?

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A At Stage II, it's probably 80, 90 percent.
Q How about Stage I?
A About 90 plus percent, easily.
Q And moving down to III and IV?
A III and IV are probably each around 65 percent. III and IV are fairly similar prognostic-wise.
Q Okay. What are the treatment options for Hodgkin's disease diagnosed at Stage II?
A Where? Where is the disease?
Q Above the diaphragm.
A And how is it staged; a staging laparotomy, or was it staged clinically using CAT scans, X-rays?
Q CAT scans and biopsy, lymph node biopsies.
A Okay. If you're talking about clinical staging for Stage II or I Hodgkin's disease, if you're not going to include a staging laparotomy, that patient has to get chemotherapy. You may consider involved field radiation therapy as well.
Q Is the kind of chemotherapy that she got, the ABVD chemotherapy, the type of

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chemotherapy that --
A That is one of the reasonable regimens.
Q Do you know what percentage of patients who receive ABVD chemotherapy for Stage II Hodgkin's achieve remission?
A It's the majority, but I don't remember the exact percentage.
Q Would you know how many patients who receive that regimen at Stage IV achieve remission?
A I don't know offhand.
Q Less than those that receive that regimen for Stage II?
A Less than Stage II, yes.
Q Can you tell me what the typical follow-up medical surveillance or follow-up regimen is for a patient who has achieved remission after ABVD chemotherapy diagnosed at Stage II?
A For Stage II, and where is the disease again; in the neck and the mediastinum?
Q Yes.
A That patient needs to be seen every three months for routine lab work, obviously history, physical examination,

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routine lab work, radiologic follow-up.
Frequency of CT scans, I would not define that frequency without knowing more specifics about the patient.
Q It would not include bone marrow biopsy?
A Not on a routine basis.
Q And for how long would the three-month follow-up persist?
A My routine would be every three months for two years, every four months for the third year, every six months for the fourth and fifth years, and then I'd like to follow them once a year thereafter. That's a routine. There are no standard guidelines.
Q Do you know what percentage of Hodgkin's patients diagnosed at Stage II who have ABVD chemotherapy are cured?
A Well, I know that the overall cure rate is somewhere in the 80 to 90 percent range, but that also includes patients who have had relapses and have been salvaged, and I don't know that I can split that out for you.
Q Can Hodgkin's disease be cured?
A Oh, yes, definitely.
Q Okay.

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A Even Stage IV Hodgkin's disease can be cured.
Q "Cured" means it's gone, and it won't come back?
A Yes.
Q You stated in your report that her ultimate need for high dose chemo and bone marrow transplant was due to the inherent resistance of her disease and was independent of the delay in diagnosis.
A Yes.
Q Can you explain that for me, please?
A Once you decide which therapy you're going to give a patient, their ultimate outcome is purely based on the inherent sensitivity of their malignancy to the therapy that you're using. So, for example, if she would have had a sustained clinical response to her ABVD chemotherapy, there would have been no reason to consider a bone marrow transplant.
Q All right.
A Because there was evidence of persistence and/or progression of disease, despite the use of ABVD, that meant that she

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required consideration of salvage chemotherapy, and it is very reasonable to consider in a fairly young patient as this to utilize high dose chemotherapy with stem cell rescue for Hodgkin's disease.
Q Do you know, are there patients diagnosed at Stage II who have high dose chemo and stem cell rescue?
A First line, only as part of an experimental protocol. That would not be considered standard therapy.
Q Are there patients diagnosed at Stage II who are refractory to chemotherapy, ABVD therapy --
A Yes, very definitely.
Q --who have to move on to bone marrow transplant?
A Yes.
Q How often does it happen percentagewise, if you know?
A I don't know offhand. I would say maybe a third of the patients.
Q A third?
A Uh-huh.
Q Can you cite me to any studies that

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would back that up?
A Like I said, it's just a general sense.
Q So, no, you couldn't cite me to any?
A No.
Q We discussed quite awhile ago your involvement in bone marrow treatment. Do you do bone marrow transplants?
A I do not.
Q You refer your patients that require that to somebody else then?
A Yes.
Q Have you ever had to refer a patient diagnosed at Stage II Hodgkin's disease for bone marrow transplant?
A Yes.
Q How often have you done that?
A Twice.
Q Okay. You understand this is my only chance to ask you questions about what you're going to testify to at trial.
A I'm comfortable.
Q Have we covered all of your opinions in this case, all of the ones that you expect to express at trial?
MR. HERBERT: Just note my

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objection to the extent that, obviously, he can't anticipate every question I might ask him, but you have touched --
MR. SCHARON: Well, you --
MR. HERBERT: Let me finish. All I was going to say, John, is that, you know, if you ask him the question from the standpoint of has he touched on, you know, the issues that he intends to testify to at the time of trial, I think the answer to that is yes. I don't anticipate pulling any rabbits out of a hat. He's going to talk about the stuff he talked about today, but he can answer.
BY MR. SCHARON:
Q I'm just trying to find out if there are any other areas that we haven't talked about that you're planning to testify to.
A I answer the questions. I don't ask them.
MR. HERBERT: Are there any other issues in terms of things that you haven't told him already about your review of the records, about your feeling that, you know, she had the bone marrow involvement back in

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March of 1995, anything like that, any other issues?
THE WITNESS: I can think of no substantive issue.
MR. HERBERT: For what it's worth, I can't either.
BY MR. SCHARON:
Q In terms of the unusual presentation that you've described, the fact that it presented first as anemia, is that the only unusual feature?
A Well, it depends on how you describe that. It's not that common for a woman who's 48 years old to be diagnosed with Hodgkin's disease. I mean, with mixed cellularity Hodgkin's disease, there's not the peak presentations that you see with the other varieties, but you classically think of Hodgkin's disease in younger patients and older patients than where she is. She kind of falls between the peaks of presentation. So, that would be another unusual feature to her presentation.
I am intrigued by how small the lymph nodes were in her neck, given how much

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Hodgkin's disease she had elsewhere. Most of the patients that I have seen diagnosed with Hodgkin's disease even at an early stage, Stage I and Stage II, have much more obvious involvement in their necks. It is not as subtle as hers was.
Q Tell me what information you're talking about. What was the size that you're referring to?
A Well, the -- if I remember correctly, the general surgeon that removed the lymph nodes, and, now, I am assuming that he went to the biggest lymph node that he could find; he described it -- I think he described it as, like, two, two and a half centimeters, something like that. The pathologist measured it out at three centimeters diameter. You know, three centimeters is my two fingers together. It is not unusual for patients to, you know, have a mass like this (motioning).
MR. HERBERT: For the record, like twice the size?
THE WITNESS: To have a four centimeter, six centimeter mass in their

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neck, where it's not where you're trying to discriminate in your own mind as to whether this is normal or pathologically enlarged.
BY MR. SCHARON:
Q Okay.
A Especially given the fact that there was the fact that, you know, I think that her disease first became clinically manifested in '95 and wasn't diagnosed until '97, and that she had significant bulk disease within her chest, I was kind of impressed as to how little she had in her neck.
Q Okay. I just want to be complete and make sure I understand all of the unusual features of the presentation. Is there anything else that you can think of, Doctor?
A A prior history of rheumatoid arthritis actually leans you more towards the idea of nonHodgkin's lymphoma.
Q Was there a definitive diagnosis of rheumatoid arthritis?
A I did not look at her chart from that direction, so I cannot answer.
Q Okay. I didn't mean to interrupt your

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thought process. Was there anything else?
A The other intriguing thing was her description, the patient's description of B)symptomatology which she did not seem to share with anybody, and there's not one doctor who indicated, including the two that treated her, B symptomatology, and I thought that was kind of unusual.
Q Meaning?
A Well, I don't know why she wouldn't tell somebody. You know, she had these profound symptoms and, yet, she never bothered to mention them to a physician.
Q Which symptoms are you talking about?
A She -- if memory serves, she described pretty significant night sweats that were ongoing for months prior to this diagnosis, and, yet, every single doctor that talks about her Hodgkin's disease calls it Stage IV-A.
Q Okay, were there any other symptoms like that?
A Not that I recall.
Q Okay. How does your patient population break down in terms of the stage at which

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patients have been diagnosed?
A The vast majority of my patients with Hodgkin's disease are early stage.
Q Oneortwo?
A Probably more Stage II than Stage I. It's very unusual to have Stage III. I probably have more Stage IVs than Stage IIIs. That's the best answer I can give you.
Q Okay.
A I don't think I could break it down percentagewise. In an oncologist's mindset, the patients on your mind are the ones that are not doing well, and Hodgkin's disease patients tend to do very well, so you don't worry about them as much, so they're not on my mind. I don't recall them.
Q How do patients do who have been diagnosed at late Stage IV who have been refractory to aggressive chemotherapy and who then go through bone marrow transplant?
A I've only had two patients go through bone marrow transplant. One is alive, and one is dead.
Q So, 50/50?

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A Yes.
Q Are you aware of what the prognostic factors for survival are in patients who have been refractory to aggressive chemo who have to go through bone marrow transplant?
A After successful remission in their bone marrow?
Q I'm asking, if you look at the patients who, yes, are refractory to initial treatment and who have to go on to bone marrow transplant, are there prognostic factors that point to whether those patients are likely or not to survive?
A It all comes down to whether or not you can elicit a complete response to therapy. If after your therapy you have a complete response, then the prognosis is better. If there is no complete response, there is no chance for cure.
Q And what does complete response mean exactly?
A No evidence of disease anywhere.
Q Okay. What's her status as of now, or as of the last time you've seen any documentation?

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A There's a new sort of like modified -- a modifier that they use for her, and it would be --what's the word?
Q CRU?
A Yes, CRU, complete response that you cannot definitively demonstrate. I can't remember what the "U" stands for. It's on the tip of my tongue, and that's her situation. She has this positive gallium scan. They're questioning whether she has sarcoidosis which is another cause for the potential for lymphadenopathy, but there's no evidence of growth. The biopsies they have taken do not demonstrate any evidence of recurrent disease.
Q Would you think that her prognosis is any different from your personal two-patient experience?
MR. HERBERT: Just note my objection.
THE WITNESS: She's --
MR. HERBERT: Let me finish my objection. To the extent that his personal experience isn't exactly a statistical study, but he can certainly answer.

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THE WITNESS: She is -- if I remember correctly, she's about two years out from her transplant.
BY MR. SCHARON:
Q July.
A Okay, so 18 months out from her transplant, and things are promising for her. She has not shown any evidence of definite recurrence over this period of time. The longer she goes in this status, the more comfortable I'll feel, but that's --
Q Statistically, how far out does she need to go before she can feel --
A Most recurrences occur within two years. The standard is, most oncologists like to quote five years. For Hodgkin's, that might be a little bit long.
Q There's still some significant percentage of patients who come out of this process of bone marrow transplant who die between two and three years, and then does it level off after that?
A It continues to decline the farther out you get from successful remission.

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Q The rate of death declines?
A Yes.
Q So, there's a leveling?
A Well, a leveling to an oncologist means that there are no further incidences after that point, and that doesn't occur at two years or three years; that occurs later.
Q Okay. Earlier, you were talking about the fact that, looking at this case retrospectively, the earliest demonstration of clinical abnormality was her anemia.
A Yes.
Q If we take away the modifier of looking at the case retrospectively, when was the first clinical indication of Hodgkin's disease?
MR. HERBERT: Just note my objection to the question. I mean, do you understand what he's asking, when he's telling you to put aside retrospect?
BY MR. SCHARON:
Q I'm trying to put you in the place of these physicians.
A Well, if you're asking me to do this prospectively, I wasn't there. I can't do

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it. I mean, every single thing I've done for this case has been retrospectively.
Q Okay.
A So, I cannot answer that question.
Q Let me just review my notes and see if I have anything more.
MR. HERBERT: For the record, if his office sends you guys a letter about whatever his charge is for the time here today, you'll take care of that?
MR. SCHARON: Sure.
MR. HERBERT: Okay.
MR. SCHARON: Within reason.
MR. HERBERT: I wouldn't imagine it would be more than Dr. Singer.
MR. SCHARON: Who knows.
BY MR. SCHARON:
Q You have no idea what your charge would be for two hours of your time?
A No. We did this --we did our charges five years ago as a group based on what we considered to be reasonable for this kind of work, and I have no idea what it is.
MR. HERBERT: So, you're going to get a break because of inflation anyway.

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THE WITNESS: I actually prefer not to know what I charge for anything.
BY MR. SCHARON:
Q Do you have an opinion as to what her long-term prognosis is for survival?
A At this point, things look very optimistic.
Q If you were talking *to* one of your patients, and they said: what are my chances, would you tell them: things look very optimistic, or would you give them some)percentage?
A I would not give them a number.
Q No percentage?
A No, because the numbers --there's a common misperception among laypeople that these percentages translate into something significant for them personally, when the truth of the matter is that those statistics are to be used for making therapeutic decisions. Every patient is unique. Every cancer is unique. So, once I have made those therapeutic decisions within the best of scientific probability, the rest is based on their specific situation overall, and as

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long as somebody's doing well, there is no reason to be anything but optimistic.
Q Okay. What if you weren't talking to a patient but you were talking to one of your partners?
A It would be the same thing.
Q Okay.
A And their response to me would be the same thing. If you have someone in clinical remission, why would you assume that they wouldn't stay there?
Q No. The question is just: statistically, what are her chances?
A Someone who is at 18 months post bone marrow transplant who is still in remission, I have no idea what the answer to that question is.
MR. SCHARON: Okay. I don't have any other questions for you. Thanks for your time today.
MR. HERBERT: He'll reserve the right to read it.

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CERTIFICATE
The State of Ohio,)
County of Cuyahoga.)
I, Luanne Stone, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the above-named witness, JOHN J. PETRUS, M.D., was by me first duly sworn to testify to the truth, the whole truth and nothing but the truth in the case aforesaid; that the testimony then given by the above-referenced witness was by me reduced to stenotypy in the presence of said witness; afterwards transcribed; and that the foregoing is a true and correct transcription of the testimony so given by the above-referenced witness.
I do further certify that this deposition was taken at the time and place in the foregoing caption specified and was completed without adjournment.
I do further certify that I am not a relative, counsel or attorney for either party, *or* otherwise interested in the event of this action.

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IN WITNESS WHEREOF, I have hereunto set my hand and seal of office at Cleveland, Ohio this ---------- day of ----------
A.D., 2000.

_____
Luanne Stone, f.k.a., Protz-
Notary Public
Within and for the State of Ohio
My commission expires *4/6/03.*

Concordance Report

Unique Words: **1,362**
Total Occurrences: ***4,287***
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Total Words In File: **11,902**
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