

In The Matter Of:

*April Awkward, et al. v.
Jerome I. Snyder, M.D., et al.*

*Ronald Alan Sacher, B.Sc.
Vol. 1, June 8, 2001
p. 1-84*

RIGLER & O'NEILL COURT REPORTERS, INC.

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*Original File RS060801.V1, 84 Pages
Min-U-Script® File ID: 3025525910*

Word Index included with this Min-U-Script®

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[1] APRIL AWKWARD, et al.,) IN THE
[2] Plaintiffs) CIRCUIT COURT
[3] vs.) FOR
[4]) BALTIMORE CITY
[5] JEROME I. SNYDER, M.D., et al.,) CASE NO.:
[6] Defendants.) 24-C-00-004585
[7]
[8] The Deposition of RONALD ALAN SACHER,
[9] B.Sc. was taken on Friday, June 8, 2001,
[10] commencing at 3:19 p.m., at the offices of
[11] Epstein, Becker & Green, P.C., Suite 700, 1227
[12] 25th Street, N.W., Washington, D.C., before Diane
[13] Gomez, Registered Professional Reporter and Notary
[14] Public in and for the District of Columbia.
[15]
[16]
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[1] APPEARANCES
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[1] PROCEEDINGS
[2]
[3] Whereupon —
[4] RONALD ALAN SACHER, M.D.
[5] a Witness, called for examination, having been
[6] first duly sworn, was examined and testified as
[7] follows:
[8] MS. JONES: Sharon, just let me tell
[9] you we're going to limit him to causation,
[10] damages, and life expectancy.
[11] MS. CHRISTIE: Okay. Well that takes
[12] out a whole bunch of questions.
[13] EXAMINATION
[14] BY MS. CHRISTIE:

[15] Q: Dr. Sacher, I apologize for
[16] mispronouncing your name when we first met. My
[17] name is Sharon Christie. I represent the
[18] plaintiffs in this case. I'll be asking most of
[19] the questions today.
[20] If at any time you don't understand
[21] my question, please tell me. I will be happy to

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[1] rephrase. Please make sure that all of your
[2] answers are verbal so that the court reporter may
[3] take them down. And if at any time you feel that
[4] you need a break, please tell me and I'll be happy
[5] to do that. All right?
[6] A: Yes.
[7] Q: Great. Would you state your full
[8] name and business address, please.
[9] A: My name is the same as I stated
[10] earlier, Ronald Alan Sacher, and business address
[11] is University of Cincinnati Medical Center,
[12] Hoxworth Blood Center, H-o-x-w-o-r-t-h, 3130
[13] Highland Avenue, Cincinnati, Ohio 45267.
[14] (Sacher Deposition Exhibit 1 was
[15] marked for identification and was attached to the
[16] transcript.)
[17] Q: Dr. Sacher, let me show you what
[18] we've marked as Exhibit 1 which is a copy of
[19] curriculum vitae which Ms. Jones has provided to
[20] me. I ask you to take a look at that and let me
[21] if this is the most up-to-date version.

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[1] A: It is, yes.
[2] Q: Okay. Let me — if you want to hold
[3] on to that, I'll ask you a few questions, and if
[4] you need to refer to it, please do. Let me start
[5] first with the first couple of lines. There are a
[6] lot of different letters following your name. And
[7] I would ask you, if you would, to please go
[8] through each of those designations one by one and
[9] tell me what it stands for and what training was
[10] required in order to obtain that designation.
[11] A: Certainly. The B.Sc. is a Bachelor
[12] of Science which is equivalent to the premed
[13] degree in United States. I did that in physiology
[14] and biochemistry in South Africa.
[15] The M.B.B.Ch. is Bachelor of Medicine
[16] Bachelor of Surgery, which is the equivalent of an
[17] M.D. Again, my education was in Johannesburg,
[18] South Africa, and this is would be the medical
[19] degree that is given there.
[20] F.C.A.P. is the Fellow of the College
[21] of American Pathologists. My training initially

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[1] in South Africa was in pathology, although my
[2] focus was hematology, and in that capacity I have
[3] been and am a member of the College of American
[4] Pathologists, and for at least seven years at
[5] Georgetown was chairman of the department of
[6] laboratory medicine as the head of clinical
[7] pathology. I also have pathology boards.
[8] F.A.S.C.P. is Fellow of American
[9] Society for Clinical Pathology, which is a similar
[10] organization. It is an elected fellowship to the
[11] College of Clinical Pathology, as was the F.C.A.P.
[12] to the College of American Pathology.
[13] D.T.M.&H. Is Diploma in Tropical
[14] Medicine and Hygiene. It is the equivalent of
[15] tropical medicine board exams.
[16] And F.R.C.P.C. is Fellow of the Royal
[17] College of Physicians of Canada. I completed my
[18] training in Canada in hematology and
[19] hematopathology, and this is equivalent to those
[20] boards.
[21] Q: All right. Now, your medical

Page 8

[1] training or what we would call medical school in
[2] the United States as I understand it was in South
[3] Africa. Is that correct?
[4] A: My medical school was in South
[5] Africa, that is correct.
[6] Q: And then did you complete a residency
[7] along the lines of the training in the United
[8] States varying from a few years up to I suppose
[9] seven or eight years, depending on the specialty?
[10] A: Actually, I never did a residency in
[11] the United States. I completed some of my
[12] residency in Canada, although I was already
[13] certified when I reached Canada, and did Canadian
[14] certification. I was then attracted to Georgetown
[15] University Medical Center where I completed part
[16] of a fellowship, and subsequently my credentials
[17] were recognized and I became a member of the
[18] faculty in 1978.
[19] Q: Okay. And the fellowship that you
[20] worked on at Georgetown, what was the focus of the
[21] concentration?

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[1] A: That was a fellowship in hematology
[2] practicing as an internist, and subsequently all
[3] my clinical activities at Georgetown were in the
[4] department of medicine or internal medicine in the
[5] division of hematology and subsequently in the
[6] division of hematology oncology.
[7] Q: You also mentioned some work in the
[8] area of hematopathology. Is that right?
[9] A: Yes.
[10] Q: Could you define that for me?
[11] A: I am a certified hematopathologist
[12] and as a hematopathologist, that is the pathology
[13] discipline that studies the tissues and diseases
[14] of the tissues and organs that are involved in the
[15] manufacturing of blood cells as well as diseases
[16] that affect all the blood cell and blood fluid
[17] organs.
[18] Q: All right. Now, you've listed your
[19] current appointment from November of 2000 to the
[20] present as professor of internal medicine at the
[21] university — internal medicine and pathology at

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[1] the University of Cincinnati. Can you estimate
[2] for me what percent of your professional time is
[3] spent in activities related to your work as a
[4] tenured professor at that medical center?
[5] A: Well, let me preface my answer by
[6] saying, of course, that I just recently joined the
[7] University of Cincinnati. I was recruited there
[8] to run the Hoxworth Blood Center, which is a
[9] nationally regarded blood center. And I am the
[10] head of this program, and in that program it
[11] involves many aspects of laboratory testing, the
[12] procurement and storage of blood and blood
[13] components, the laboratory of cellular immunology
[14] and transplant immunology, the laboratory of cell
[15] therapy.

[16] So everything related to blood and
[17] its processing and its manipulation is included in
[18] that domain. Now, to the extent that I am the
[19] administrative head of this program, I also am
[20] involved in teaching internal medicine and do
[21] morning report and ward rounds and lectures to the

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[1] residents and fellows in hem/onc and the residents
[2] in medicine.

[3] I have not restarted my practice in
[4] Cincinnati that I had in Washington because I've
[5] been getting familiar with the processes and
[6] procedures there, but that is due to start in
[7] July, and my practice involves the management and
[8] treatment and diagnosis and management, if you
[9] will, of patients who have all manner of blood
[10] diseases ranging from leukemias, lymphomas to
[11] clotting and bleeding problems. I have a special
[12] interest in that area as well as hematologic
[13] problems of pregnancy. But my practice would be
[14] the same, I would hope, as it was at Georgetown
[15] which involved treating patients with all blood
[16] diseases.

[17] Q: Okay.

[18] A: So I think that covers my clinical
[19] teaching and administrative responsibility. I
[20] also have a research program and actually just
[21] recently we applied for a very large NIH grant to

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[1] study the natural history of perinatal Hepatitis
[2] C. When I was at Georgetown and even currently
[3] I'm involved with transfusion transmitted viruses
[4] and the outcomes of these sorts of problems.

[5] Q: Okay. How long were you at
[6] Georgetown?

[7] A: I was at Georgetown actually from
[8] 1977 in end of July, beginning of August as a
[9] fellow and then 1978, first of July, as an
[10] assistant — excuse me, assistant professor of
[11] medicine and pathology. I then got promoted from
[12] 1978 to I believe it was 1989, but that's in my
[13] CV, to full professor. I was tenured in 1983 I
[14] believe as an associate professor, and I became
[15] department chair of laboratory medicine in 1993,
[16] and left Georgetown in November of 2000.

[17] Q: Okay. In your practice that you
[18] referred to before that you hoped to restart in
[19] Cincinnati in July, I believe you said, and you
[20] hoped that it was similar to that in Georgetown,
[21] did that practice involve care of patients on an

Page 13

[1] inpatient basis as well as an outpatient or no
[2] outpatient, all inpatient? What kind of mix did
[3] you have?

[4] A: My practice from 1978 to 1993 roughly
[5] involved in patient and outpatient. The inpatient
[6] activities were essentially rotating on service,
[7] and in the earlier years it was up to three to
[8] five months a year actually being the inpatient
[9] attending of record, seeing all the inpatients.

[10] Also during that period we had an
[11] outpatient clinic which I was also involved with.
[12] So I developed quite a large outpatient base that
[13] I was following, and in 1993 when I took over the
[14] department of lab medicine, I mainly concentrated
[15] on the outpatient practice, but as a teaching
[16] attending I did inpatient teaching attending one
[17] month a year.

[18] Q: Okay. Was your work with the
[19] patients — let me focus on the last five years
[20] say, just to narrow down the time frame a little
[21] bit. Your last five years at Georgetown was your

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[1] work with the patients as the sole treating
[2] physician, or were you working in conjunction with
[3] other physicians in the treatments of these
[4] patients?

[5] A: If the patient was a hematology
[6] patient, in other words, had a blood problem as
[7] broadly defined, then — and the patient was
[8] admitted under our service, I was the primary
[9] attending of record. However, clearly we also had
[10] a consult service where we would be asked to
[11] review patients who had a variety of blood
[12] problems that were identified as ancillary to
[13] their other diagnosis for what they were admitted.

[14] Q: Okay. For those patients for whom
[15] you would be the primary — the attending
[16] physician, you mentioned broadly blood problems.
[17] What types of diagnoses did that include?

[18] A: Oh, the gamut of hematology
[19] problems. In fact, for the most part a lot of my
[20] practice were esoteric hematology complex cases,
[21] thrombosis and thrombotic predisposition, bleeding

Page 15

[1] problems, the management of patients with
[2] lymphomas and lymphoproliferative disorders and
[3] the management of patients with myeloproliferative
[4] disorders and leukemias.

[5] Q: Okay. Was there any particular area
[6] in which you concentrated or specialized within
[7] the broad category of blood problems?

[8] A: I would say that although it
[9] encompassed every aspect of hematology, the
[10] majority of my patients had, in the latter part of
[11] my time at Georgetown, clotting and bleeding
[12] problems and problems in pregnancy. However, I
[13] had a very large patient population, as does any
[14] hematologist with lymphomas and
[15] lymphoproliferative disorders as well as some
[16] patients with myeloid leukemias. That tended to
[17] be more inpatient intensive, so towards the latter
[18] part of my time at Georgetown I had less in the
[19] way of the acute leukemia management, but I still
[20] did manage my patients as well who had that.

[21] Q: Okay. You've listed in your CV a

Page 16

[1] very large number of publications, chapters in
[2] books, etc. And please feel free to look through
[3] when I ask this question, but do any of those
[4] publications, whether they be for journals or for
[5] any other purpose, either listed in your CV or
[6] perhaps some that haven't made it to your CV, that
[7] you have authored, do any of those deal with any
[8] of the issues that you believe are pertinent to
[9] the opinions that you're giving in this case?

[10] A: Yes, in a general sense I think there
[11] are some that actually deal with the diagnosis of
[12] lymphoproliferative diseases, and I think that's
[13] the focus obviously of the case in Mr. Awkward.

[14] Q: Okay. Could you point those out to
[15] me, please.

[16] A: Just before I do that, I will make a
[17] general comment about a virus that we've been
[18] studying that causes lymphoproliferative diseases,
[19] and that is called the human T lymphotropic
[20] virus, and we have been following this — when I
[21] say we, colleagues of mine from around the

Page 17

[1] country, we have an NIH grant that in fact follows
[2] a cohort of people who are infected with this
[3] virus that can produce a lymphoproliferative
[4] disorder. But I'm not going to specifically refer
[5] to those publications.

[6] Q: All right.

[7] A: Page 15, citation — fifth bullet
[8] from the bottom starting off with Ratko,
[9] R-a-t-k-o, that is an article that we published on
[10] the use of immunoglobulin preparations that
[11] includes individuals with chronic lymphocytic
[12] leukemia and lymphoproliferative disorder who are
[13] notoriously deficient in these natural antibodies.
[14] And there are a couple of publications that I have
[15] in this compound called IVIG, and I've given talks
[16] as well on the subject of replacement therapy in
[17] chronic lymphocytic leukemia and
[18] lymphoproliferative disorders.

[19] Q: Okay.

[20] A: Page 16, bullet five from the bottom,
[21] first author Evers, E-v-e-r-s. This is a case of

Page 18

[1] an individual with a T-cell lymphoproliferative
[2] disorder that we reported. And actually on that
[3] page second bullet from the bottom, that is where
[4] I allude to the IVIG role in bone marrow translat
[5] malignancy in immune hematologic disorders
[6] including lymphocytic leukemias and lymphocytic
[7] lymphomas.

[8] Q: Okay.

[9] A: The last citation under Articles on
[10] page 20, before books, is a publication on a
[11] disorder called macroglobulinemia. This is a
[12] lymphoproliferative disorder of a type. It's
[13] analogous to a lymphoma, and in these individuals
[14] they make an abnormal antibody.

[15] Q: Okay.

[16] A: Then under Books, the book that I
[17] authored, citation one under Books, Clinical
[18] Interpretation of Laboratory Tests as well as its
[19] previous edition, the tenth edition, I wrote a
[20] fair amount on lymphoproliferative disorders in
[21] that with regards to the diagnosis and its more

Page 19

[1] diagnosis than management.

[2] Q: Okay.

[3] A: Also citation two under Books I was
[4] the co-author of this little manual called The
[5] White Cell Manual which really evaluates diseases
[6] of white blood cells which clearly includes
[7] lymphoproliferative disorders.

[8] Under Chapters, page 21, citation
[9] one, this is Immuno-hemolytic Anemias in
[10] Hematologic Diseases that includes chronic
[11] lymphocytic leukemia and lymphoma.

[12] Page 25, citation 10, this is an
[13] individual who had an acute lymphoproliferative
[14] disorder, acute lymphocytic leukemia or
[15] lymphoblastic leukemia that we published on
[16] because it had an unusual chromosomal marker, but
[17] it is included in that category.

[18] Q: Okay.

[19] A: And then page 25 under Journal
[20] Supplements, this is a supplement that I edited
[21] that includes lymphoproliferative disorders as one

Page 20

[1] of the categories as well.

[2] Q: Is that true for all of those that
[3] are listed, or were you referring to one in
[4] particular?

[5] A: No. Citation four.

[6] Q: Four. I'm sorry.

[7] A: And I don't believe the attracts that
[8] I've got are really any more additive than what
[9] I've gone through and I think in general that
[10] covers the broad field of lymphoproliferative
[11] diseases that I've published in.

[12] Q: Okay. Thank you. Dr. Sacher, have
[13] you ever been sued for medical malpractice?

[14] A: No.

[15] Q: When did you first become involved in
[16] reviewing medical/legal cases as an expert?

[17] A: Actually, the first time I was ever
[18] asked to review it as an expert was probably in
[19] 1979. I was doing some research on platelets and
[20] the immune abnormalities that platelets have. And
[21] this was a case of an individual who had a heart

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[1] attack after getting the swine flu vaccine. I was
[2] approach by a plaintiff's attorney and rendered an
[3] opinion against the U.S. Government in terms of
[4] the vaccine and its probability of causing a
[5] clotting event. That was the first time.

[6] Q: Okay. In the last five years can you
[7] estimate for me on a yearly basis the number of
[8] cases that you review?

[9] A: It's increased in the last year or
[10] two, and I would say up to about two a month.

[11] Q: Okay. It's increased up to two a
[12] month now?

[13] A: Yes. On an average. Some months
[14] three; some months one.

[15] Q: Sure.

[16] A: But in the last five years, I would
[17] say probably in the order of 10 to 15 a year.

[18] Q: Okay. And over the last five years
[19] can you estimate the percent of cases you review
[20] on behalf of plaintiffs versus defendants?

[21] A: Probably in the order of 70 to 75

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[1] percent defense.

[2] Q: Okay.

[3] A: So it's 25 to 30 percent plaintiff.

[4] Q: Okay. Other than the case that you
[5] mentioned, it sounded like your first case
[6] involving swine flu, are there other cases that
[7] you reviewed on behalf of plaintiffs that you have
[8] given opinions favorable to the plaintiffs?

[9] A: Yes.

[10] Q: Are there cases that you have
[11] reviewed and given testimony in, either by way of
[12] deposition or at trial, involving issues that are
[13] similar to the issues in this case involving
[14] lymphoproliferative disorders?

[15] A: Yes.

[16] Q: How many, other than this case?

[17] A: I can recall one definitely, and
[18] there may have been others that I can't recall,
[19] but I would certainly say one where I gave a
[20] deposition.

[21] Q: Okay. Do you recall approximately

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[1] how long ago that case was?

[2] A: I would think about five or six years
[3] ago.

[4] Q: Do you know where the case was
[5] pending, what state?

[6] A: It was in Virginia.

[7] Q: A Virginia case, okay. Do you
[8] remember the name of either the plaintiff or the
[9] defendant in that case?

[10] A: No.

[11] Q: Were you testifying on behalf of the
[12] plaintiff or the defendant?

[13] A: Plaintiff.

[14] Q: Plaintiff. And do you recall who the
[15] plaintiff's lawyer was?

[16] A: It won't come to me. I can't
[17] remember.

[18] Q: Okay. If during the course of the
[19] questions this afternoon, sometimes answers will
[20] come to you. If it comes to you, please let me
[21] know.

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[1] A: I will.

[2] Q: Do you remember the name of the
[3] defense lawyer? That would have been who was
[4] probably asking you most of the questions.

[5] A: No, I don't recall that either.

[6] Q: Okay. How about the name of the
[7] plaintiff or the defendant?

[8] A: That I don't recall.

[9] Q: That case that you were just
[10] referring to, do you recall what the nature of the
[11] allegations were?

[12] A: Failure to diagnose a lymphoma. Or
[13] should I say, to be more accurate, delay in the
[14] diagnosis of lymphoma.

[15] Q: All right. And do you recall how old
[16] the plaintiff was at the time of the alleged delay
[17] in diagnosis?

[18] A: No, I don't. This was an individual
[19] who had a growing mass that was never biopsied.

[20] Q: Okay. Can you estimate for me —
[21] you've given me your estimate in terms of numbers

Page 25

[1] of cases that you've reviewed. Can you estimate
[2] for me what percent of your professional time is
[3] spent either reviewing cases or giving testimony
[4] in deposition or at trial?

[5] A: Oh, it's less than 20 percent I would
[6] say.

[7] Q: Okay. On a monthly basis can you
[8] estimate the number of depositions you give per
[9] month? Again, focus on the last five years.

[10] A: This year I believe I've given about
[11] six or seven, but prior to that maybe at the most
[12] six a year.

[13] Q: Okay. How about trial testimony, how
[14] often does that happen?

[15] A: I think that of the cases I've
[16] reviewed, it's very likely that 20 to 30 percent
[17] went to trial.

[18] Q: Okay. And you testified in those
[19] cases?

[20] A: Yes.

[21] Q: Okay. What are your fees for review

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[1] of records?
[2] A: \$400 an hour.
[3] Q: How about deposition?
[4] A: \$500 an hour portal to portal with a
[5] minimum of a thousand.
[6] Q: And trial?
[7] A: Same rate for trial.
[8] Q: As deposition?
[9] A: Correct.
[10] Q: Have you ever reviewed a case where
[11] there was an underlying allegation of a failure to
[12] diagnosis or treat a septic arthritis?
[13] A: No.
[14] Q: Have you ever reviewed a case prior
[15] to this one for either Ms. Jones or anyone in her
[16] law firm?
[17] A: Yes.
[18] Q: On how many occasions?
[19] A: I would say probably two or three.
[20] Q: And how about the other attorneys
[21] involved in this case, there's a firm in Baltimore

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[1] by the name of Goodell, DeVries, Leech, now, &
[2] Dann — it used to be Leech & Gray — have you
[3] ever reviewed cases on behalf of anyone at that
[4] firm to your knowledge?
[5] A: Yes, I have.
[6] Q: Okay. And on how many occasions?
[7] A: Quite a number of occasions, because
[8] I was also retained as an expert in
[9] transfusion-transmitted disease litigation and
[10] factor concentration for hemophiliacs, and they
[11] represented Bayer Corporation.
[12] Q: Okay. Outside of that class of
[13] cases, do you have any idea of how many times you
[14] worked with the Goodell firm?
[15] A: Probably about five or six.
[16] Q: All right. And within that
[17] classification of cases involving the
[18] hemophiliacs, was it, and clotting factors?
[19] A: Yes.
[20] Q: Do you have any idea how many cases
[21] that involved?

Page 28

[1] A: Oh, there was a very large list and I
[2] got records on a good number of them. Many of
[3] them were settled.
[4] Q: Okay.
[5] A: I really couldn't even estimate.
[6] More than ten.
[7] Q: Okay. When were you first contacted
[8] regarding the Awkward case?
[9] A: Probably just shortly before January
[10] the 5th of this year.
[11] Q: Okay. Do you remember who made the
[12] contact with you?
[13] A: Ms. Jones.
[14] Q: What were you told about the case?
[15] A: I don't recall specifically other
[16] than there was an issue of septic arthritis and
[17] there was a diagnosis of a lymphoproliferative
[18] disorder made on autopsy.
[19] Q: At some point were you provided some
[20] material records or any other material related to
[21] the case?

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[1] A: Yes.
[2] Q: And what was it that you were
[3] provided?
[4] A: I was initially provided with
[5] material records, both relating to hospital
[6] admissions, Saint Agnes Hospital and subsequently
[7] Union Memorial, and subsequently I was also
[8] provided with records from Mr. Awkward's primary
[9] care physician, Richard Hunt, M.D. Thereafter I
[10] was given some depositions. I also did receive
[11] the complaint.
[12] Q: Okay. How about pathology slides,
[13] have you seen any slides?
[14] A: Yes, I have.
[15] Q: Okay.
[16] MS. CHRISTIE: Jean, did you provide
[17] the doctor with a full set of pathology slides.
[18] MS. JONES: Yeah, at least what was
[19] represented as a full set.
[20] MS. CHRISTIE: Right. That's the
[21] best we can do. Okay.

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[1] A: Excuse me.
[2] Q: Yes, sir.
[3] A: I also did receive some records from
[4] Church Hospital, I neglected to mention.
[5] Q: All right. And you mentioned
[6] depositions. Can you tell me what depositions
[7] have been provided to you?
[8] A: The deposition of David K. Sarver;
[9] deposition of Philip M. Buttaravoli, and also some
[10] attachments to his deposition, including articles.
[11] Q: All right.
[12] A: The deposition of Michael M. Kaufman,
[13] Jerome Ira Snyder, April C. Awkward, Desiree P.
[14] Awkward, Jerome Awkward, LaTracia Awkward. And I
[15] believe that covers what I was given, as well as,
[16] of course, the slides that we noted.
[17] Q: Right. All right.
[18] A: And I did see the x-ray of the joint,
[19] of the knee.
[20] I should also mention there was a
[21] small amount or very limited records from the

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[1] University of Maryland Hospital.
[2] Q: Okay. And the records that, the
[3] papers that you have in front of you, does this
[4] constitute your file on this matter, or are there
[5] other things that you have related to this case?
[6] A: No. This constitutes my file.
[7] Q: All right. And the only other thing
[8] that I see here is the curriculum vitae of Dr.
[9] Snyder. Is that correct?
[10] A: Correct. This was attached to his
[11] deposition, and it somehow got out of place.
[12] Q: Okay. That's fine. After reviewing
[13] the material that you had been provided, Dr.
[14] Sacher, did you feel you had sufficient material
[15] in order to form opinions in this case?
[16] A: Yes, I did.
[17] Q: Okay. You didn't feel like you
[18] needed to see anything else?
[19] A: No.
[20] Q: Okay. And I'm going to get to your
[21] opinions in a minute, but let me go through the

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[1] do-you-know questions first. Do you know Dr.
[2] Snyder?
[3] A: No.
[4] Q: Do you know any of the experts? And
[5] let me just review the names and see if any of
[6] these ring a bell. Dr. Sarver?
[7] A: No.
[8] Q: Dr. Kaufman?
[9] A: No.
[10] Q: Dr. Buttaravoli?
[11] A: No.
[12] Q: Whose name I always mispronounce.
[13] A: No.
[14] Q: Dr. Berg?
[15] A: No.
[16] Q: Dr. Remsen?
[17] A: No.
[18] Q: Dr. Crane, Leo Crane?
[19] A: No.
[20] Q: Dr. Dr. Weisburger?
[21] A: No.

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[1] Q: Joel Morse, who is an economist I
[2] believe?
[3] A: No.
[4] Q: Do you know any of the plaintiffs in
[5] this case? That would be April Awkward, Desiree,
[6] LaTracia Awkward, or Jerome Awkward?
[7] A: No.
[8] Q: And did you know the decedent who was
[9] also named Jerome Awkward?
[10] A: No, I did not.
[11] Q: Doctor, let me ask you this: When
[12] you were provided the records and the material to
[13] review, were you asked to review this material to
[14] develop an opinion with regard to any particular
[15] area?
[16] A: Yes.
[17] Q: And what was that?
[18] A: I was asked to evaluate the degree of
[19] lymphoproliferative disorder that he had, what
[20] type it was. I was also asked to assess the
[21] effect that this had on the disease outcome as

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[1] well as his potential likelihood of longevity.
[2] And, in general, I was also asked to review the
[3] mechanism and the cause of death.

[4] Q: All right. Let me take these one by
[5] one then. Did you come to an opinion as to the
[6] degree of lymphoproliferative — that's a tongue
[7] twister — disorder that Mr. Awkward had?

[8] A: Yes.

[9] Q: And what's your opinion in that
[10] regard?

[11] A: My opinion is, and I concur with the
[12] original pathologist's diagnosis, which was called
[13] a well-differentiated lymphocytic lymphoma, that
[14] he had what we now call a small-cell lymphocytic
[15] lymphoma, and it is exactly the same disease
[16] entity. That more likely than not he had
[17] substantial involvement of his bone marrow as well
[18] as several organ systems and that this played a
[19] role in the rapid progression of the toxic shock
[20] syndrome, if you will, from the beta hemolytic
[21] streptococcal infection that he had, leading to

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[1] the progression of the beta hemolytic step
[2] infection in his thigh.

[3] Q: How do you define well-differentiated
[4] lymphocytic lymphoma?

[5] A: There are many ways to classify
[6] lymphomas, but perhaps I could just start off by
[7] simply defining what a lymphoma is.

[8] Q: That's fine.

[9] A: It is an unregulated growth and
[10] proliferation of cells of the immune system termed
[11] lymphocytes.

[12] Q: And what does the term
[13] well-differentiated — well, what does the term
[14] "lymphocytic" add to that description of lymphoma?

[15] A: Lymphocytic refers to the cell
[16] appearance or morphology and the
[17] well-differentiated refers to the maturation of
[18] the cell.

[19] Q: Okay. You also mentioned small cell.
[20] What significance does that have?

[21] A: The mature lymphocytes are generally

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[1] small cells.

[2] Q: Okay.

[3] A: And the well-differentiated implies
[4] that they are small and they have regular round
[5] nuclei.

[6] Q: Okay. There have been descriptions,
[7] I'm sure you've seen it in the testimony in this
[8] case, opinions given that this was in essence an
[9] indolent disease, not — and I'm going to
[10] paraphrase, but one of the experts has testified
[11] that in his opinion this was something that Mr.
[12] Awkward and many persons die with, do not die
[13] from. What's your opinion in that regard?

[14] A: That is true in a good number of
[15] patients with this type of lymphoma, and I might
[16] also mention at the start that this type of
[17] lymphoma can spill over into the bloodstream at
[18] which time it's called a chronic lymphocytic
[19] leukemia but it's the same disease entity and same
[20] cells as the swelling in the lymph nodes which is
[21] refers to as the lymphoma, "oma" meaning tumor.

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[1] Q: Okay. What about in Mr. Awkward's
[2] case, do you believe that it was true that it was
[3] indolent in his particular case?

[4] A: Well, the disease itself in the way
[5] that it progresses for the most part implies a
[6] slow growth, and in that context is indolent. But
[7] there are several clinical stages that we refer
[8] to, or degrees of disease, that have prognostic
[9] implications.

[10] Q: What are those?

[11] A: There actually are two different
[12] classifications, but I will refer to the one term,
[13] the Rai, R-a-i, classification. And by my
[14] estimation and review of the records as well as
[15] autopsy findings and Dr. Hunt's records, Mr.
[16] Awkward had at least a stage three.

[17] Now, that staging is generally
[18] referred to in the context of chronic lymphocytic
[19] leukemia, but I'm using those two terms
[20] synonymously because he had extensive involvement
[21] of his bone marrow. And many patients, many that

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[1] I've treated, have we refer to as aleukemic
[2] lymphocytic leukemia, which is the same as having
[3] the lymphoma predominantly involving the marrow
[4] but also involving the tissues without necessarily
[5] extensive involvement of the bloodstream.

[6] Q: Okay. In your opinion did he have
[7] the lymphoma or did he have the leukemia or does
[8] it not make much difference?

[9] A: In my opinion he had the lymphoma
[10] from the point of view that he had a large lymph
[11] node in his abdomen.

[12] Q: Yes.

[13] A: Many lymph nodes, as a matter of
[14] fact, according to the autopsy. And also an
[15] enlarged spleen. He also had involvement of other
[16] organs such as the liver. But he had involvement
[17] of his bone marrow as shown by the autopsy
[18] findings of lymphoid nodules in a very unusual
[19] site, the patella. The kneecap.

[20] So I believe that he had extensive
[21] involvement of his marrow that didn't spill out

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[1] into his bloodstream. Or if it did, it was
[2] attenuated by the treatment that he had been
[3] getting, the Prednisone.

[4] Q: Let me back up first to ask you some
[5] questions about the staging. You said I believe
[6] you said you're using the Rai classification?

[7] A: Yes.

[8] Q: Okay. And in your opinion Mr.
[9] Awkward is at least a stage three.

[10] A: Correct.

[11] Q: Under that classification how many
[12] stages are there?

[13] A: Four.

[14] Q: All right. How do you determine, how
[15] would you determine what stage a given patient was
[16] in?

[17] A: It is based on the laboratory
[18] findings as well as the clinical findings. And,
[19] again, I should also preface my answer by saying
[20] that there are a lot of classifications, and this
[21] is a complex disorder because it's based not only

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[1] on the nature of the cells and their involvement
[2] of the organ systems and lymph nodes, their
[3] pattern of involvement, but also the effect that
[4] they have on the bone marrow.

[5] And in this case why I'm categorizing
[6] him as at least stage three is that the records
[7] from Dr. Hunt indicate that he was anemic for a
[8] good many years while he was being followed by Dr.
[9] Hunt, and indeed at least three years previously
[10] he had evidence of splenic malfunction.

[11] Q: Could you point out to me
[12] specifically what it is you're relying on in Dr.
[13] Hunt's records?

[14] A: First of all, if one looks at the
[15] laboratory results dated, and I believe this is
[16] May the 28th, 1998, and I might say that this is
[17] the most recent laboratory test that I saw prior
[18] to his admission to Union Memorial, at that time
[19] he had a hemoglobin of 11.1 with a hematocrit of
[20] 35.7. That is anemic. So by definition anemia
[21] puts him into stage three.

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[1] Q: Simply by virtue of having anemia on
[2] blood, as you pointed out, on his blood work?

[3] A: Correct.

[4] Q: That's sufficient to put him into
[5] stage three?

[6] A: That is correct.

[7] Q: All right.

[8] A: Parenthetically, this test result
[9] also shows platelets that are somewhat large,
[10] suggesting increased platelet turnover and a test
[11] called a sedimentation rate which is very high,
[12] indicating that there was some active inflammation
[13] going on, presumably the same disorder that was
[14] causing Dr. Hunt to treat him with steroids, i.e.,
[15] what was called vasculitis.

[16] Q: Okay.

[17] A: This anemia was noted also in
[18] December of '97 on Dr. Hunt's records. And indeed
[19] this anemia was also noted in April of '96, but
[20] more specifically there was evidence of splenic
[21] malfunction noted here by the demonstration of

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[1] what's called Howell-Jolly bodies.

[2] Q: And what are those?

[3] A: Those are remnants of the nuclear
[4] material in red blood cells that are normally
[5] removed by the spleen, and finding them implies
[6] either having no spleen or a spleen that's not
[7] functioning very well.

[8] Q: Was that finding noted on any of the
[9] subsequent blood studies?

[10] A: I did not see any mention made of
[11] that.

[12] Q: Okay.

[13] A: On the subsequent studies, but they
[14] do indicate moderate Howell-Jolly bodies, and that
[15] certainly is of significance.

[16] Q: Would you expect to see that as a
[17] continuing finding?

[18] A: Yes.

[19] Q: If the spleen was malfunctioning in
[20] 90 — I believe you said '96?

[21] A: I would expect that, yes. But of

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[1] course we do know that his spleen was enlarged,
[2] and enlargement of the spleen actually in and of
[3] itself implies grade two. Subsequently with, of
[4] course, the anemia, this implies grade — well,
[5] stage three.

[6] Q: Okay. Are there other causes of
[7] splenic malfunction other than a
[8] lymphoproliferative disorder?

[9] A: Yes.

[10] Q: Can you tell me what some of those
[11] are?

[12] A: Well, certainly certain autoimmune
[13] disorders might cause that. If the spleen is
[14] overworking that it can't perform its cleaning
[15] function of removal of these particles from the
[16] red blood cell, then it will not do so, and it may
[17] be overworking by clearing out other bits of
[18] immune debris.

[19] Q: Okay. Is there any indication in
[20] your opinion of any reason other than a
[21] lymphoproliferative disorder that would cause

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[1] evidence of a splenic malfunction in Mr. Awkward?

[2] A: No.

[3] Q: Let me just take a look at this. In
[4] April of '96 I believe you've indicated in your
[5] opinion he was also anemic at that time. Is that
[6] correct?

[7] A: Yes.

[8] Q: Okay. And at that time he had a
[9] hemoglobin of 13.1 and a hematocrit of 39.2. Is
[10] that right?

[11] A: Correct.

[12] Q: Okay. Other than the anemia, are
[13] there any other findings that in your opinion are
[14] findings that would put Mr. Awkward in a stage
[15] three classification as opposed to some other
[16] level?

[17] A: No. That's the definition of it.

[18] Q: Okay.

[19] A: I did find that there was a point
[20] where his platelet count was low, but this was
[21] preterminally and it could be explained by other

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[1] reasons. Platelets counts being low puts one into
[2] a stage four.

[3] Q: Okay. That was my next question,
[4] what would put someone into a stage four. Is
[5] there anything other than a low platelet count?

[6] A: No, that's the definition, the
[7] phenomenon of thrombocytopenia, which is a low
[8] platelet count.

[9] Q: Okay.

[10] A: I will again note that he did have an
[11] increase in his mean platelet volume, suggesting
[12] increasing platelet turnover, which goes along
[13] with a lymphoproliferative disorder or an
[14] autoimmune disorder.

[15] Q: Okay. Back to the classification for
[16] a moment, what puts someone in a stage two, what
[17] findings puts him in a stage two?

[18] A: Enlarged lymph nodes and spleen.

[19] Q: All right. And how about a stage
[20] one?

[21] A: Stage one is an enlarged lymph nodes

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[1] alone, and stage zero is just simply an elevation
[2] of the white cell counts.
[3] Q: Okay. The staging that you referred
[4] to, what is that used for in terms of treatment of
[5] patients?
[6] A: Well, it's used primarily for
[7] prognostication and clearly treatment, since this
[8] is an indolent disorder, for the most part it's
[9] not a curable disorder, treatment is based on
[10] clinical symptoms and rate of progression of
[11] either white blood cell counts or tissue
[12] enlargement.
[13] Q: Okay. In terms of prognostication,
[14] are you referring to life expectancy or other
[15] prognostications?
[16] A: Life expectancy.
[17] Q: Okay. What in your opinion is the
[18] life expectancy of someone in a stage three as Mr.
[19] Awkward was?
[20] A: Between three and five years.
[21] Q: And is that from the point of

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[1] diagnosis or from the point that they first go
[2] into a stage three?
[3] A: That's actually an interesting
[4] question to answer, because most of the time it is
[5] on the basis of the diagnosis. But, of course, we
[6] don't know how long they've had that disease
[7] before. But I will, to a reasonable degree of
[8] medical certainty, say that he had this disorder,
[9] this lymphoproliferative disorder dating back at
[10] least to 1996.
[11] Q: What are you relying on for your
[12] determination that his life expectancy was three
[13] to five years? And by that I mean in terms of any
[14] studies or medical literature. Is there anything
[15] of that nature that you rely on?
[16] A: Yes. The medical literature speaks
[17] to the issue of the Rai stages, and Rai stage
[18] factor is the prognostic category based on
[19] survival codes.
[20] Q: Okay. And is there some book, text
[21] or journal articles that I could go to that

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[1] discusses the Rai classification and in terms of
[2] life expectancy?
[3] A: Yes.
[4] Q: And what would that be?
[5] A: In fact, any general hematology
[6] textbook that's current and up to date would refer
[7] to this. There are other ones termed the Binet
[8] classification, B-i-n-e-t, but I think a lot of
[9] North Americans use Rai, since he's a New Yorker.
[10] Q: Okay. Can you give me any examples?
[11] You said any good hematology text, which I'm sure
[12] to you has a lot of meaning but to me, not being a
[13] hematologist, has no meaning at all. Are there
[14] any in particular that you could point me to?
[15] A: Well, certainly my book is good.
[16] Q: Okay. All right.
[17] A: I'd be happy to refer you to that
[18] one. However, there are many general texts of
[19] hematology. There are texts that — Williams
[20] Hematology or Wintrobe that are useful resources.
[21] They're not authoritative but they're useful

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[1] resources.
[2] Q: Wintrobe?
[3] A: W-i-n-t-r-o-b-e. There's Hoffman is
[4] another one. There are a good number of them.
[5] Q: All right. Good.
[6] Now, you mentioned in terms, I
[7] believe in terms of classification that you saw
[8] involvement of the spleen, the liver and the bone
[9] marrow, I believe in Mr. Awkward's autopsy. Could
[10] you point out to me what it is you're referring to
[11] when you say that involvement of the spleen, what
[12] shows the involvement of the spleen and the liver
[13] and the — you mentioned a little bit about the
[14] bone marrow.
[15] A: Well, actually I reviewed the slides
[16] myself.
[17] Q: Oh, that's right. I had forgotten
[18] about that. Then tell me what it is you're
[19] relying on in the slides or in any of the other
[20] material that you've reviewed to base your opinion
[21] that he had involvement of those organs.

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[1] A: Well, my answer is a combination of
[2] the gross findings on the autopsy as performed by
[3] the pathologist at the time who described enlarged
[4] lymph nodes in the abdomen and also an enlarged
[5] spleen.

[6] Q: All right.

[7] A: There was no description of any
[8] microscopic findings, although I'm sure that they
[9] were done since slide seem to have been taken.
[10] However, on my review of the slides there was
[11] quite evident accumulations of these small
[12] lymphocytes with mature features in a number of
[13] organs. And including, as I said, in the bone
[14] marrow, and the bone marrow site was the patella,
[15] which is very unusual. This is normally a very
[16] acellular or a hypocellular, meaning having very
[17] few cells, and yet there was a lymphoid aggregate
[18] in that bone marrow.

[19] So I have no doubt that in fact
[20] extensively there was involvement of the rest of
[21] the marrow, and I think I'm almost sure that the

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[1] anemia was a consequence of that.

[2] Q: Okay. I'm going to have to ask you,
[3] if you would, to explain in layman's terms what
[4] you mean when you talk about the patella and
[5] lymphoid aggregates in the patella and what
[6] meaning that has.

[7] A: The patella is the kneecap.

[8] Q: Yes.

[9] A: And normally in an adult the patella
[10] would be this kneecap. The marrow component of it
[11] really is devoid of cells. Since the major blood
[12] producing sites are in the vertebral column and
[13] the sternum and the ribs.

[14] Q: Right.

[15] A: Now, lymphoid aggregates implies that
[16] there are nodules, there are accumulations,
[17] circular accumulations of collections of these
[18] mature lymphoid cells or mature lymphocytes. So
[19] that is what I was referring to. There are
[20] collections of these lymphocytes in the acellular
[21] kneecap.

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[1] Q: Where did they come from?

[2] A: They come from — originally, of
[3] course, they are produced in the bone marrow and
[4] then they get programmed in different sites in the
[5] bone marrow or in the thymus gland, and then they
[6] circulate in the bloodstream and then they go to
[7] the organs that are termed lymphatic organs. That
[8] includes lymph nodes and the liver and the spleen.

[9] Q: Okay. Then how in Mr. Awkward's case
[10] did they end up in the kneecap?

[11] A: I think this emphasizes the degree of
[12] involvement that he had, and, as I've pointed out,
[13] he already had evidence of it extensively in the
[14] lymph nodes of his abdomen at a number of sites.
[15] Also had involvement of his liver, had an
[16] enlargement of the spleen with extensive
[17] involvement there. In fact, he even had some in
[18] his lung. And why it ended up in the kneecap I
[19] think is proportional to the degree of involvement
[20] of the marrow. It's a very unusual site, and I
[21] think it implies extensive disease.

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[1] Q: Is it — but these lymphoid
[2] aggregates, they're not produced in the kneecap,
[3] are they?

[4] A: No, but they in fact cede there from
[5] the bloodstream.

[6] Q: Could their presence be explained in
[7] any way by the type of infection that he had?

[8] A: No.

[9] Q: Could it be explained in your opinion
[10] in any way other than the lymphoproliferative
[11] disorder?

[12] A: No, not these types of cells.

[13] Q: And you told me about the spleen, you
[14] found evidence in the spleen?

[15] A: Yes.

[16] Q: As well as the liver?

[17] A: Yes.

[18] Q: And that was on the autopsy slides
[19] from the spleen and the liver I assume?

[20] A: Yes, in conjunction with the gross
[21] description of an enlarged spleen.

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[1] Q: Yes. Okay. All right. Was there
[2] evidence in your opinion of involvement of any
[3] other organs other than the spleen and the liver?

[4] A: Well, I believe I indicated that I
[5] did see a tissue section from the lung, but for
[6] the most part those were the major organs.

[7] Q: Okay. And what specifically did you
[8] see in the lung?

[9] A: A small aggregate of lymphoid cells.
[10] In a site where they should normally not be.

[11] Q: What significance does that have in
[12] terms of your opinion as to the progression of Mr.
[13] Awkward's disease?

[14] A: That particular location, really very
[15] little significance. Other than the fact that
[16] again it's implying, but I think there's much more
[17] compelling evidence, that it's quite widespread
[18] and he had fairly extensive accumulation of these
[19] abnormal lymphocytes.

[20] Q: Okay. Can you describe for me
[21] generally the progression of a well-differentiated

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[1] lymphocytic lymphoma of the type that Mr. Awkward
[2] had from the beginning to end stage?

[3] A: Unfortunately it's not an arithmetic
[4] or natural progression as it goes from stage one
[5] to the next to the next to the next. It may
[6] actually start out quite extensive and suddenly
[7] involve a number of different sites and produce
[8] its effects. But, in general, as I implied by the
[9] definition, this is unregulated growth of cells
[10] that are normally part of the immune system, and
[11] as being part of the immune system they circulate
[12] in the circulatory system that involves the immune
[13] circulation. We refer to this as the lymphatic
[14] system.

[15] So any lymph node that's part of the
[16] lymphatics can undergo enlargement and any organ
[17] system where the cells normally congregate can
[18] undergo involvement, liver and spleen being part
[19] of that. So, therefore, in summary, it starts off
[20] in the marrow but it could also start off at
[21] anywhere along that circulation where these

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[1] abnormal cells grow out of control.

[2] Q: Okay.

[3] A: And then they may either grow and
[4] expand that area where they originated or they may
[5] spill out into the rest of the circulation and
[6] spread and cede to other areas.

[7] Q: And is there any treatment for this
[8] disorder?

[9] A: There is treatment. One can control
[10] the rate of growth and accumulation of these
[11] cells, for example, in the blood and even in the
[12] marrow. One can control the rate of expansion of
[13] the lymph nodes themselves or even enlargement of
[14] the spleen by either chemotherapy or irradiation
[15] therapy. But — and indeed there are some
[16] individuals who have actually been "cured" by bone
[17] marrow transplantation. But my own personal
[18] experience in an individual who got a bone marrow
[19] transplant from his identical twin, it relapsed.
[20] So the implication always is that these indolent
[21] diseases are not readily curable. They may be

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[1] controllable to some degree, but ultimately they
[2] get out of control.

[3] Q: Okay. To what degree in your opinion
[4] is a well-differentiated lymphocytic lymphoma,
[5] stage three, as you said Mr. Awkward was in, to
[6] what extent is that controllable?

[7] A: Again, in the aggregate — now
[8] clearly there are individuals, and I personally
[9] had experience with people who have a difficult
[10] time with any treatment that you give to them,
[11] because if the marrow is extensively involved and
[12] treatment is given, all their blood counts
[13] decline, and sometimes they don't respond very
[14] well to that. These cells are very complex and
[15] they're very idiosyncratic. They are part of that
[16] individual's immune makeup. So depending upon
[17] which cells of this immune makeup are abnormal and
[18] accumulate, so you can get a variety of features.
[19] Vasculitis could be one. Immune destruction of
[20] any tissue could be another. Or immune
[21] destruction of blood cells. Or it could be growth

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[1] and proliferation of any site within that
[2] circulation.

[3] So it's very difficult to say, one,
[4] how they can naturally progress. We do talk in
[5] terms of aggregates and groups of people. And
[6] also, although using the Rai stage, and, again,
[7] this is part of the reason why there's so many
[8] different classifications and stages, is because
[9] not only their appearance but their biological
[10] behavior can be very varied. There is a type of
[11] lymphoma called a mantle cell lymphoma, which is
[12] also part of the spectrum, that does very much
[13] worse.

[14] Q: Okay. But how about in Mr. Awkward's
[15] case. Do you have an opinion as to whether his
[16] disease at the stage in which you've testified
[17] that he was in at the time of his death, the
[18] extent to which that was controllable?

[19] A: I think that the lymphoproliferative
[20] disorder per se might have been controllable but
[21] its biological behavior was such that, as

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[1] demonstrated by this galloping infection that he
[2] had, that at any time he could succumb to a
[3] devastating infection.

[4] Q: Okay.

[5] A: Whether or not that was treated.

[6] Q: Let's take away the infection for the
[7] purposes of my question. Okay. And let's assume
[8] for the purposes of this question that he did not
[9] develop the streptococcal, Strep A infection that
[10] he had. If he had been — if he had been
[11] diagnosed and treatment was begun, do you have an
[12] opinion as to the degree to which his disease, his
[13] lymphoproliferative disease could have been
[14] controlled?

[15] MS. JONES: Objection and a
[16] hypothetical. Go ahead.

[17] A: Without further data, I could not
[18] speculate. Namely, the degree to which his natural
[19] antibody level was decreased, and I believe it
[20] was. Again, this is based on my review of the
[21] pathology diagnosis; for example, the spleen

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[1] showing quite extensive diminution of normal
[2] natural lymphocytes. And also the adrenal gland
[3] showing really quite extensive atrophy from the
[4] steroids that were given to control the vasculitis
[5] presumably. So it is difficult to dissect those
[6] two features out, because I believe that they are
[7] related.

[8] Now, conceivably, if he was given
[9] treatment for the lymphoproliferative disorder,
[10] had that been diagnosed, he may well have lived
[11] three years. Again, my figure that I'm throwing
[12] out is based on best estimates of the staging
[13] system as well as his own idiosyncratic disease
[14] features.

[15] Q: Okay. Based on your review of the
[16] records did you see any clinical signs of the
[17] lymphoproliferative disorder outside of the blood
[18] work that you've referred to, and the findings on
[19] autopsy. Prior to — I'm talking about prior to
[20] the time he went to Saint Agnes Hospital. Did you
[21] see any clinical signs other than the blood work

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[1] that we've talk about?

[2] MS. JONES: Objection to the form.
[3] Go ahead.

[4] A: Clinical meaning from external
[5] examination?

[6] Q: Yes.

[7] A: No, I didn't see anything on external
[8] examination, but clearly, as I pointed out,
[9] laboratory-wise as well as subsequent on autopsy,
[10] it was there.

[11] Q: Okay. What about the vasculitis, do
[12] you think the vasculitis was in any way connected
[13] to the lymphoma?

[14] A: I do believe that it was, and I guess
[15] in answering your previous question, could that
[16] have been a clinical sign, I believe that more
[17] probably than not it was. Because we had a
[18] phenomenon that was presenting itself with
[19] evidence in the laboratory of ongoing
[20] inflammation, yet it seemed to be controlled by
[21] steroids. And, although there was no tissue

Page 62

[1] diagnosis of vasculitis, the clinical features
[2] were suggested, as Dr. Hunt had indicated; and I
[3] do believe that without an explanation for the
[4] vasculitis that — and knowing that he had a
[5] lymphoproliferative disorder, that they were
[6] related. More probable than not.
[7] Q: You mentioned earlier, when I asked
[8] you sometime ago about your opinions, that you had
[9] opinions involving — regarding the involvement of
[10] the bone marrow and the several organ systems. I
[11] believe we've covered that. I just want to make
[12] sure. We talked about the liver, the spleen, the
[13] patella. Was there anything else you were
[14] referring to?
[15] A: No, I think we covered that.
[16] Q: Okay. You also said that you
[17] believed that lymphoma played a role in the rapid
[18] progression of the toxic shock syndrome. Is that
[19] right?
[20] A: Yes.
[21] Q: Okay. Explain to me what that

Page 63

[1] opinion is and what you're basing it on.
[2] A: Well, toxic shock syndrome is really
[3] an aberrant immune response to the organism. And
[4] it involves a concept termed superantigen, antigen
[5] meaning a foreign material that comes into the
[6] body that is normally handled and processed by the
[7] immune system.
[8] Now, clearly the immune system and
[9] immune surveillance involves the cells of the
[10] immune system as well as mediators. His immune
[11] system we know was abnormal. It was abnormal for
[12] several reasons. One, he had the
[13] lymphoproliferative disorder, and, two, he was
[14] also clearly immunosuppressed from even that low
[15] dose of steroids as determined by his adrenal
[16] gland. However, the uniqueness of this organism
[17] — because not everybody who get a streptococcal
[18] infection develops toxic shock syndrome — the
[19] uniqueness of this organism in producing the toxin
[20] in an individual who is already susceptible and
[21] compromised by a disturbed immune function I

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[1] believe was all additive and allowed this process
[2] to gallop. And it clearly was. And, in fact,
[3] even the histology and the appearance of the
[4] tissue, that there was no inflammatory response to
[5] the toxin implies a, what we call a paralysis of
[6] the immune system or paresis as well as the toxin
[7] itself causing tissue destruction.
[8] Q: Do you have an opinion as to when the
[9] infection began?
[10] A: I know exactly when it began, but I
[11] believe that it probably was evident, was
[12] certainly in his thigh on the 18th, but I don't
[13] know when it began.
[14] Q: But you do believe it was present at
[15] the time he was seen at Saint Agnes?
[16] A: Probably.
[17] Q: I take it you believe that the site
[18] of infection was the thigh?
[19] A: Yes.
[20] Q: And what are you basing that opinion
[21] on?

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[1] A: On my review of the records, material
[2] as well as my background, education, experience,
[3] and knowledge of the immune system.
[4] Q: Okay. Tell me, in terms of your
[5] knowledge of the immune system, what is it that
[6] leads you to conclude that it was the thigh where
[7] the infection started?
[8] A: Well, clearly that is the template on
[9] which I'm analyzing the medical records, and the
[10] records show extensive involvement and tissue
[11] destruction of the thigh and relatively little
[12] destruction or damage of the knee joint itself, or
[13] even the cartilage of the knee joint. So I firmly
[14] believe that this occurred in the thigh, and I
[15] think that any fluid accumulation and involvement
[16] of the knee was secondary to the evolving toxin
[17] release from the thigh.
[18] Q: If the infection began in the thigh
[19] as you've testified and there was fluid collection
[20] in the knee as a result of the, if I've understood
[21] you correctly, as a result of the spreading

Page 66

[1] toxins, do you have an opinion as to whether an
[2] examination of the fluid in the synovial joint
[3] would have shown the presence of the streptococcal
[4] A infection?

[5] MS. JONES: I'm going to object only
[6] on the basis of timing. Are you talking about —

[7] MS. CHRISTIE: At Saint Agnes.

[8] MS. JONES: I don't know what Dr.
[9] Sacher was talking about was accumulation of flood
[10] by the time he got to Union or —

[11] MS. CHRISTIE: I'm talking about at
[12] Saint Agnes.

[13] A: My answer actually was considering
[14] the evolution toward the time from Saint Agnes to
[15] Union, when clearly a tap was done.

[16] Q: Right.

[17] A: I believe and I have an opinion that
[18] if a tap was done at Saint Agnes it would not have
[19] been diagnostic.

[20] Q: Why not?

[21] A: Because I think that this was a

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[1] predominantly toxin-related damage produced by a
[2] local infection in the thigh and, with the absence
[3] of the inflammatory response, I don't know how
[4] easy it would be for anybody to interpret the
[5] results at Union when it was already manifest,
[6] just looking at those results, compared to 36
[7] hours previously at Saint Agnes where I really am
[8] convinced that it would have been nondiagnostic.

[9] Q: Can you explain to me how you believe
[10] the infection spread once it started in the thigh?

[11] A: Well, I think it's evident that these
[12] sorts of phenomena are related to toxin-induced
[13] tissue damage. Of course the organisms are there
[14] producing the toxin, but the toxin causes severe
[15] damage to the tissue, and once that tissue barrier
[16] is compromised, then, of course, it spreads beyond
[17] that site of original injury.

[18] Q: And how does it spread? Is it from
[19] adjacent tissue to adjacent tissue, or does it
[20] spread in some other fashion?

[21] A: In those circumstances, from adjacent

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[1] tissue to adjacent tissue. Of course, one can get
[2] blood spread subsequently. On even as part of
[3] that.

[4] Q: How about in Mr. Awkward's case, do
[5] you have an opinion as to how the organism spread
[6] from the thigh?

[7] A: I think it was by contiguity, from
[8] adjacent tissue to adjacent tissue.

[9] Q: You've said that you don't believe a
[10] tap at Union Memorial would have been diagnostic.
[11] Is that correct?

[12] A: That is correct.

[13] Q: Do you have any opinion as to what
[14] the cause of the knee pain was that he complained
[15] of on admission to Saint Agnes?

[16] A: I believe that was referred pain.

[17] Q: And what do you mean by that?

[18] A: Specifically, that there was
[19] infection in the thigh and that with the
[20] presumably evolution of the toxin, that although
[21] this — at what point did the toxin totally

Page 69

[1] overwhelmed the system I don't know. It was in
[2] that 36-hour period. But this produces a clinical
[3] reaction, and obviously the bodies senses that as
[4] a need for a response, and pain is part of that
[5] response.

[6] Q: In terms of the knee fluid, when Mr.
[7] Awkward got to Union Memorial they did tap the
[8] knee, correct?

[9] A: Yes.

[10] Q: And that did yield some positive
[11] results in terms of the presence of an infection.
[12] Is that correct?

[13] A: Yes.

[14] Q: Do you have an opinion as to at what
[15] point between the time Mr. Awkward got to Saint
[16] Agnes and the time that he was admitted to Union
[17] Memorial, at what point along that time line the
[18] knee — a knee tap would have been positive?

[19] A: No. It would be total speculation.
[20] I really have no opinion at what point it would be
[21] other than evolving.

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[1] Q: But it was not diagnostic in your
[2] opinion at Saint Agnes. Is that correct?

[3] A: That is correct.

[4] Q: Would not have been. Okay.

[5] A: In fact, I would have expected much
[6] more of an inflammatory response under normal
[7] circumstances in sepsis of a knee joint than he
[8] had. Again, I think it was really quite
[9] attenuated by his disease processes, both the
[10] steroids as well as the lymphoproliferative
[11] disorder.

[12] Q: What do you mean by that? I'm not
[13] sure I understand that.

[14] A: Specifically, one tends to find
[15] higher levels of certain types of cells in an
[16] aspirate from the knee in a septic arthritis, and
[17] he didn't have nearly that degree. And also there
[18] were I think occasional organisms identified. I
[19] don't know how one would necessarily interpret
[20] that in the setting of the lower counts and the
[21] fact that he really had little, if any, elevation

Page 71

[1] of his white cell count, overall blood count.

[2] Q: Okay. At which point are you talking
[3] about?

[4] A: At Union.

[5] Q: At Union?

[6] A: Yes.

[7] MS. JONES: Could I just take a short
[8] break?

[9] MS. CHRISTIE: Oh, sure. Absolutely.

[10] (There is a recess from the record.)

[11] Q: The higher levels of certain types of
[12] cells that you mentioned, what types of cells are
[13] you referring to?

[14] A: Cells that are called
[15] polymorphonuclear leukocytes, neutrophils.

[16] Q: Okay. And I want to make sure I
[17] understand what you said. You would have expected
[18] to see higher levels of those cells at Union?

[19] A: Yes.

[20] Q: And then you mentioned occasional
[21] organisms?

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[1] A: I looked at what I thought were two
[2] tissue reports, reports of fluid. One was really
[3] mostly unremarkable other than the occurrence of
[4] occasional bacteria.

[5] Q: Okay.

[6] A: In fact, if we go back to Union,
[7] perhaps I should look at the record to be quite
[8] accurate.

[9] Q: Okay. That's fine.

[10] A: I was referring specifically to the
[11] report entitled Sterile Body Fluid collected on
[12] 1/20/99 at 1317 hours.

[13] Q: Okay.

[14] A: Indicating few gram positive cocci in
[15] pairs, no polymorphonuclear leukocytes seen.

[16] Q: Okay. What is the significance of
[17] the few gram positive cocci in pairs?

[18] A: Well, in this context one could argue
[19] that this may well be organisms that have
[20] colonized the outer portion of the skin. One can
[21] still get organisms, even though one might

Page 73

[1] sterilize the skin, that actually may grow.
[2] Certainly one would expect that if bacteria were
[3] in the joint, there would be an inflammatory
[4] response in response to those bacteria.

[5] Q: Can you say to a reasonable degree of
[6] medical probability that the report of the few
[7] gram positive cocci in pairs is as a result of
[8] contamination from the skin as opposed to what was
[9] actually in the knee aspirate itself?

[10] A: No, I can't. Again, I'm not sure,
[11] because there was another report of surgical wound
[12] left knee with moderate polymorphonuclear
[13] leukocytes and many gram positive cocci in chains,
[14] where these are coming from. But, again, I think
[15] that with all of this and the relatively low white
[16] cell count in the bloodstream, it would be
[17] difficult to totally interpret and make the
[18] diagnosis of a septic arthritis, primary in the
[19] knee.

[20] Q: Okay.

[21] A: I think this is most consistent with

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[1] spread from the thigh.

[2] Q: Very early on when I asked you what
[3] you were asked to do with regard to this case and
[4] what you had opinions that you're prepared to
[5] render, you said you were asked to evaluate the
[6] degree of the lymphoproliferative disorder and the
[7] type, which we discussed, correct?

[8] A: Correct.

[9] Q: Okay. You also were asked to
[10] evaluate the outcome of the disease? And I wasn't
[11] quite sure what you meant by that. Or I may have
[12] misunderstood what you said?

[13] A: Well, perhaps I doesn't articulate it
[14] as well as I should, but the implication was the
[15] relationship between the disease, the
[16] lymphoproliferative disease, the steroids that he
[17] had been receiving, and the rapid deterioration
[18] following the infection with the organism and then
[19] subsequent development of the toxic shock
[20] syndrome.

[21] Q: All right. In my understanding,

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[1] based on discussion we've just been having is that
[2] your opinion is that the lymphoproliferative
[3] disorder, as well as the steroid use, added to the
[4] rapidity with which this infection spread. Is
[5] that right?

[6] A: Yes. Although, again, I think I also
[7] implied in a previous answer that the superantigen
[8] toxic shock syndrome phenomenon could occur in
[9] anybody with a degree of rapidity, but I believe
[10] that since this is all immune related that it
[11] probably compounded the situation.

[12] Q: Okay.

[13] A: And I think we discussed that.

[14] Q: Indeed. You've told me that you
[15] believe that Mr. Awkward had a life expectancy of
[16] three to five years, correct?

[17] A: Correct. I think we already
[18] discussed my statement that I thought more
[19] probable than not it would be closer to three for
[20] the reasons that I articulated.

[21] Q: Yes. And then you did explain that.

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[1] And then you also said that you were asked to
[2] evaluate or discuss the mechanism and cause of
[3] death. Is that right?

[4] A: Well, only in the context that this
[5] was a galloping toxic shock syndrome from a
[6] streptococcal organism and this produced a
[7] fulminant picture with death as the outcome.

[8] Q: Okay. You've answered my question.
[9] You don't think the cause of death was anything
[10] other than the infection, do you?

[11] A: No.

[12] Q: Have you been asked to evaluate any
[13] other aspects of this case?

[14] A: Not as far as I know. I think we've
[15] covered pretty much everything. Obviously, I'll
[16] respond to any questions that are asked of me.

[17] Q: And I do understand that. We have
[18] talked about your opinions regarding life
[19] expectancy, and I believe we've covered your
[20] opinions regarding the cause of Mr. Awkward's
[21] demise and the degree to which the underlying

Page 77

[1] lymphoma and steroid use contributed to that. I
[2] just want to make sure we've covered all the
[3] opinions that you hold in regard to those topics.

[4] A: I believe so.

[5] Q: Okay. If you give me a second, I
[6] think we're all going to be off the hook here.

[7] Doctor, you mentioned early in the
[8] deposition that one of the things that you also
[9] reviewed was the x-ray of the knee.

[10] A: Yes.

[11] Q: Did you find anything that was
[12] significant in that x-ray with regard to the
[13] opinions that you've rendered today?

[14] A: No, I wouldn't say that it changed or
[15] added to my opinions.

[16] Q: Okay. If you review any additional
[17] material or you develop any additional opinions in
[18] this case that we've not yet discussed, and there
[19] may be other depositions that you see because
[20] there are a few more depositions that remain to be
[21] taken, would you please let Ms. Jones know that

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[1] you have additional opinions so that she can let
[2] me know.

[3] A: I'd be happy to do that.

[4] Q: Thank you. And then finally, this
[5] case is scheduled for trial November the —
[6] beginning I believe November the 26th of this year
[7] in the circuit court for Baltimore City. Do you
[8] intend to testify at trial?

[9] A: I do, yes.

[10] MR. MANOOGIAN: Objection. He will
[11] testify or not at the request of counsel. So I
[12] think that's a matter you would have to take up
[13] with Ms. Jones. However, to be on the safe side,
[14] plan on him being there.

[15] MS. CHRISTIE: I assumed he would be
[16] but that's why I asked.

[17] Q: Occasionally I have had experts say
[18] no, I'm going to be out of the country on that
[19] day, then I know they're not going to be there.

[20] That's all the questions I have.

[21] EXAMINATION

[1] waive reading and signing.

[2] (Thereupon, at 4:51 p.m., the
[3] deposition was adjourned.)

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[1] BY MS. LACEY:

[2] Q: Doctor, this is Lauren Lacey. I'm
[3] representing Saint Agnes in this matter. I just
[4] have I think one or two questions for you, and
[5] they're pretty much follow-up questions.

[6] I listened to your deposition
[7] testimony today, and I take it that you have no
[8] criticisms of the care rendered by Saint Agnes'
[9] staff or nurses. Is that correct?

[10] A: That is correct.

[11] Q: And I heard the exchange before. In
[12] the event that you testify at trial, I am assuming
[13] that you will not testify to any breaches in the
[14] standard of care by Saint Agnes as well?

[15] A: That is correct.

[16] MS. LACEY: Okay. Thank you very
[17] much. No further questions.

[18] MR. MANOOGIAN: My questions will
[19] take about two hours. Do you want to do them
[20] now?

[21] We have no questions. We do not

[1] District of Columbia

[2] to wit:

[3] I, Diane Gomez, a Notary Public of the
[4] District of Columbia, do hereby certify that the
[5] within-named witness personally appeared before me
[6] at the time and place herein set out, and after
[7] having been duly sworn by me, according to law,
[8] was examined by counsel.

[9] I further certify that the examination was
[10] recorded stenographically by me and that this
[11] transcript is a true record of the proceedings.

[12] I further certify that I am not of counsel
[13] to any of the parties, nor related to any of the
[14] parties, nor in any way interested in the outcome
[15] of this action.

[16] As witness my hand and notarial seal
[17] this _____ day of _____, 2001.

[18]

[19] Diane Gomez

[20] Notary Public

[21] My commission expires: 6/14/2005

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[1] CERTIFICATE OF DEPONENT
[2]
[3] I hereby certify that I have read and
[4] examined the foregoing transcript, and the same is
[5] a true and accurate record of the testimony given
[6] by me.
[7] Any additions or corrections that I feel
[8] are necessary, I will attach on a separate sheet
[9] of paper to the original transcript.
[10]
[11]
[12]
[13] RONALD ALAN SACHER, B.Sc.
[14]
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[1] WITNESS: Ronald Alan Sacher, B.Sc.
[2] CASE: April Awkward, et al. vs. Jerome I. Snyder,
[3] M.D. et al.
[4] DATE TAKEN: June 8, 2001
[5] Please note any errors and the corrections thereof
[6] on this errata sheet. The rules require a reason
[7] for any change or correction. It may be general,
[8] such as "To correct stenographic error," or "To
[9] clarify the record," or "To conform with the
[10] facts."
[11] PAGE LINE CORRECTION REASON FOR CHANGE
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