IN THE COURT OF COMMON PLEAS

CUYAHOGA COUNTY, OHIO

SUZANNE BOYD, ET AL.,

Plaintiffs,

-vs-

JUDGE CALLAHAN
CASE NO. 93CM110447

BERT M. BROWN, M.D., ET AL.,

Doc. 408

Defendants.

- - - -

Continued telephone deposition of DONALD A. SHUMRICK, M.D., taken as if upon cross-examination before Linda A. Astuto, a Registered Professional Reporter and Notary Public within and for the State of Ohio, at the offices of Sindell, Lowe & Guidubaldi, 610 Skylight Office Tower, Cleveland, Ohio, at 5:00 p.m. on Thursday, September 8, 1994, pursuant to notice and/or stipulations of counsel, on behalf of the Plaintiff in this cause.

- - - -

MEHLER & HAGESTROM
Court Reporters
1750 Midland Building
Cleveland, Ohio 44115
216.621.4984
FAX 621.0050
800.822.0650

APPEARANCES:

Charles Young, Esq.
Lynn Lebit, Esq.
Sindell, Lowe & Guidubaldi
610 Skylight Office Tower
Cleveland, Ohio 44115
(216) 781-8880

On behalf of the Plaintiffs;

Patrick Murphy, Esq. (Via Telephone)
Jacobson, Maynard, Tuschman & Kalur
1001 Lakeside Avenue
Suite 1600
Cleveland, Ohio 44114-1192
(216) 736-8600,

On behalf of the Defendants
Bert M. Brown, M.D.
and Cleveland ENT;

John V. Jackson, II, Esq. (Via Telephone)
Jacobson, Maynard, Tuschman & Kalur
1001 Lakeside Avenue
Suite 1600
Cleveland, Ohio 44114-1192
(216) 736-8600,

On behalf of the Defendants
R. Alonso, M.D.
and Garfield Pathology Associates, Inc.

DONALD A SHUMRICK, M D, of lawful age, called by the Plaintiffs for the purposes of cross-examination, as provided by the Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposed and said as follows:

CONTINUED CROSS-EXAMINATION

OF DONALD A SHUMRICK, M D

BY MR YOUNG:

MR YOUNG: Let's go on the record.

Q Dr. Shumrick, you've previously been sworn and I'll stipulate that anything you say is the truth in your opinion.

A Yes, I do.

Q What we're going to do is simply try to supplement very quickly what we did when we were in your office on August 12th If you can't hear a question or anyone cannot be heard, please speak up and let us know that

A I will.

Q Doctor, when I was in your office in August you were unable to find your file and since then you found it, I believe.

A. Right. And I sent it up to Patrick but I do

have one other one that I found just this morning It was a letter from a Dr. Jeffrey Mendelsohn.

Q That was Dr Mendelsohn's report and what's the date of that?

A It's June 23, 1994 I'm sorry I just found it today.

Q. June 23rd of '94?

A This is the letter to Mr. Jackson.

Q I'm just checking the date on that And that begins with --

A. Dear Mr. Jackson: At your request, I have reviewed medical records of the case of Allan Box as well as pathology slides from Marymount Hospital representing a biopsy taken from the base of his tongue

Q That appears to be Dr. Mendelsohn's report in this case

A. Right.

Q. Now, in addition to that you had other materials which you sent off to Pat Murphy and ~~you've~~ I have been through those.

Has he returned those to you now?

A Yes, I have them.

Q You have them there before you?

A. Yes.
Q. In addition to those materials, those that you sent *off* to Pat, and the report of Dr. Mendelsohn, are there any other materials that you have received since the date *of* your deposition August 12th?
A. No, I don't think so.
Q. Okay. You haven't received any other reports?
A. No. No.
Q. Any summaries *of* testimony *of* other experts in this case?
A. No.
Q. Have you had the opportunity to do any research concerning the case in any manner?
A. No. No. Not really, no.
Q. Okay. When you say not really, you seem to be qualifying it some.
A. You're right. I didn't mean that.
Q. You've not had the opportunity to look at any articles which agree or disagree with your opinion, I assume?
A. No.
Q. Have you had the opportunity to talk with Pat Murphy about any *of* the issues that have arisen since your deposition on August 12th?

A. Well, I guess I did and I told him that I had found Dr. Mendelsohn's report.
Q. And did you discuss Dr. Mendelsohn's opinion?
A. No. We didn't really. I didn't know whether it was important or not but I said that I had found it and I felt very guilty not having kept all the papers together.
Q. All right. Was that just recently that you found that report?
A. It was this morning.
Q. And did Pat have the opportunity to tell you about Dr. Mendelsohn's deposition in any manner?
A. I don't think he -- oh, his deposition, no. No.
Q. Did you have the opportunity to discuss the doubling time theory in any way with Pat?
A. He mentioned it and I told him that to be honest, I don't know anything about that. That isn't something that I with any intelligence can discuss.
Q. So essentially you are where you were when we last talked with you?
A. Exactly.
Q. Except that you've had the opportunity to prepare the supplemental report which we discussed very briefly when we were there

before?
A Right.
Q Now, as I understand it you prepared that supplemental report from your memory in the case and from some materials that Pat had, you hadn't found your file by the time you did that?
A No.
Q But -- is that correct?
A Yes, that's correct
Q But essentially you were just flushing out in that report the opinion that you had briefly expressed in the last deposition?
A. Right.
Q. The supplemental August 19th of 94 report?
A All right.
Q Does that sound right to you?
A Yes.
Q And did you prepare that or dictate it when Pat was actually there?
A No I don't think I did No, I know I didn't because he contacted me a couple of days later and said that he really needed it There was some time element Asked me if I'd please get it in as soon as I could
Q Okay It's really a clarification concerning

the materials that you have that I'm looking for today and I'm going to the materials in the order that they've been supplied to me through Mr. Murphy and I see a letter from Mr. Murphy dated September 14th, 1993 to you.

Do you have that there before you?

A. Yes.

Q. Now, at the bottom of that, at the bottom of that letter is a note.

Is that in your handwriting?

A. Yes.

Q. It's dated 1/9/91?

A. Right.

Q. And what is the relevance of 1/9/91?

A. If I recall it correctly, Mr. Boyd saw someone who on that date felt that the tumor, that's why I quoted it, was not curable or resectable.

Q. So that is a notation that you found in the medical records that were supplied to you?

A. That's right.

Q. And talking about the medical records that were supplied to you, I find that there were excerpts from the hospital records that were supplied to you.

Were there any omissions or materials that

you believe that you needed in order to form your opinion which were not supplied?

A. No.

Q. Any obvious omissions that you felt you needed to form an opinion in the case?

A. No.

Q. Now, when you saw the 1/9/91 notation not curable or resectable, did you agree with that?

A. Yes.

Q. Can you give me an idea in your opinion at what point the metastatic disease became incurable and non-resectable?

A. Well, no. I don't think anyone can. I think, remember he wasn't seen for approximately a year and when he was seen, this was such a fulminating, aggressive tumor that I think that decision was made at that point, but I don't, I don't know, no, I couldn't say when he became unresectable.

Q. Now, you just said something there, you said you don't think that anyone can.

Do I conclude from that statement that essentially because the tumor wasn't diagnosed in November of 1989, and the staging was not done, and the staging was not done between

November of '89 and the fall of 1990, that it's difficult to pinpoint a time between November of '89 and the fall of '90 when it became less probable than not that he could survive the disease? Do you understand that question?

A. I'm not sure.

Q. It's kind of convoluted. Let's ask it this way.

I'm assuming that in November of 1989 had this disease been diagnosed, he probably would have been cured with the proper treatment, would you agree with that?

A. No, I don't think you can say that.

Q. All right.

A. Plus I think I made it clear it's my very firm conviction that his metastasis did not originate with the lesion in the tongue.

Q. We'll get back to that then. Let me go on with some materials here and we'll explore that.

A. Okay.

Q. I'm looking at your copy of Dr. Brett's report to me of January 12th, 1994.

Do you have that there?

A. Yes.

Q. And on page three you have some notations

concerning the second paragraph.
A. Okay.
Q. And you have underlined the first sentence, "a significant proportion of patients who have oral leukoplakia develop malignancy over time."
A. Yes.
Q. And written above that paragraph is "what if he had."
What did you mean by that?
A. I was referring to the paragraph above, the last sentence, "there was no indication that Mr. Brown ever communicated," excuse me, "there was no indication that Dr. Brown ever communicated the pathologic findings to Mr. Boyd." I wrote what if he had?
Q. And what does that mean?
A. Well, he would have told him what the pathologist told Dr. Brown.
Q. And in your position that was that it was a benign report?
A. That's right.
Q. You have in the left-hand margin "not true."
What did you mean by that?
A. That's just rubbish, that a significant proportion of people with -- once again, you

know my feeling about the word leukoplakia. That just isn't true.

Q. Okay. And you've taken the position that essentially there are no pre-malignant oral lesions, correct?

A. Yes.

Q. That's a fair statement of ,your position?

A. Yes. And I think Dr. Brett, am I pronouncing his name correctly?

Q. Yes.

A. He, if I understand, he's a medical oncologist. He doesn't treat these and he doesn't manage them either.

Q. You know, Doctor, in looking through a copy of Medical Oncology Today, the second edition, I found a reference to pre-cancerous lesions, oral lesions.

Would you agree with me there is a great deal of authority that there are pre-malignant oral lesions?

A. No. I wouldn't.

Q. You would not agree with that?

A. I would not.

Q. Do you take the position that this is an old medical theory and that medical science today

believes that there are no pre-malignant lesions?

A Well, you're being a little inclusive by saying there are no, you know, never say always and never say never.

I don't know exactly what you're talking about. Certainly the rather cavalier way of using the word leukoplakia the way these people do, I mean what are we talking about? What is the histological description of whatever this leukoplakia is.

Q Let me ask it this way then.

I think from your prior testimony you testified that pre-malignant is the problem that you have with it, that benign lesions don't become malignant, but there are benign lesions that occur commonly together with cancerous lesions, is that your position?

A I can accept that, yes.

Q So that if you see certain things, and we defined that previously in your deposition, but if you see certain things that are a warning sign and essentially you eliminate the condition on the tongue because they can occur in common with a cancerous condition and it is just better

to be safe, is that fair?

A. I don't think that is what I was talking about. I was talking about just looking is one thing. That is what leukoplakia is. It's a descriptive term. I was talking about a histological description of what that leukoplakia is. That is what Dr. Brown did. He appropriately biopsied it.

Q. All right. And we didn't talk about the difference between dysplasia and those terms that were used by Dr. Alonso in her written pathology report.

Is there a difference in your mind between dysplasia and that which was set forth in her written report?

A. Well, help me to define what it is you actually mean.

Q. Well, in the telephone conference note made by Dr. Brown he wrote mild dysplasia.

A. Yes.

Q. Would mild dysplasia be consistent with the written diagnosis and microscopic findings contained in her pathology report on the November 22, 1989 biopsy?

A. I don't have before me what her written report

said.
Q. Do you have that there in your materials?
A. I don't know. Do I?
Q. Yes. You should. I have a copy of your materials and it's in that.
A. Help me. Where is it in what you have? You have everything numbered.
Q. Mr. Murphy does.

MR. MURPHY: It should be in the first section, part of Dr. Brown's office chart material. I believe there's a copy of Dr. Alonso's report in there.

A. Okay. Hang on. Okay. I have it. "Moderate papillary hyperplasia with hyperkeratosis, focal mild atypia and chronic inflammation from tongue."
Q. Correct.
A. Is that it?
Q. Is that diagnosis consistent with mild dysplasia?
A. Well, that isn't what she said.
Q. I understand.
A. I'm not sure --
Q. They are the same thing?
A. I don't know. I don't know how to answer that.

Q What is dysplasia?
A It's a changing of the organelles of the reproduction of the cells
Q It is an abnormal cell reproduction?
A I didn't say it was necessarily abnormal It just is a changing of the consistency of the cells
Q All right. It can be benign?
A Yes.
Q Or it can be a condition which will develop into a malignancy, would you agree?
A No.
Q It cannot?
A No. I don't think you can say that
Q I'm saying can possibly I am not talking about will certainly
MR MURPHY: Object to possibilities.
A Yes, anything can possibly happen I suppose
Q Well, we just talked about -- what I'm trying to understand is the extent of your opinion. We talked about the fact that benign conditions don't develop into malignant, and as I understand it with dysplasia, we're talking about a different type of cell reproduction.

A. All right. At that point it is benign.
Q. Okay.
A. And it isn't going to necessarily begin to change before our eyes. If other cells are produced that go beyond just a simple dysplasia, that isn't the same thing. The dysplasia changing into a malignancy, it may well be a dual process.
Q. But it is possible for dysplasia to progress to a malignancy?
A. Dysplasia is dysplasia.
Q. Does good practice require the elimination, surgical removal of dysplasia?
A. Not necessarily, no.
Q. Does it require following and monitoring?
A. Yes, I suppose so.
Q. When you concluded that Dr. Brown properly managed this patient, did you eliminate the consideration of dysplasia from the further management of the patient?
A. No. As I recall, Dr. Brown told the patient to return within one week for follow-up and to hear of the pathologic diagnosis.
Q. Do you recall Dr. Brown's testimony on deposition that dysplasia was consistent with

the written report that he had received?

A. Well, it all depends on what individual -- I don't think there is one single, solid rock hard definition of dysplasia.

MR. MURPHY: Chuck, I'm going to note an objection here. I think you are going pretty far afield from the supplemental reports.

MR. YOUNG: I am just trying to understand what he means by that. I will try to stay on that.

Q. But, Doctor, Dr. Brown recommended that Mr. Boyd follow-up, as you've testified, in your opinion, he instructed the patient in that manner.

A. Yes.

Q. Do you believe that it was important to follow a condition of dysplasia if it was present in the mouth on November 22, 1989?

A. For who to follow it, the patient?

Q. Dr. Brown to follow the patient.

A. Well, I thought he did follow it by telling him to come back.

Q. Okay. So as I recalled your testimony, it was important that he do that only for two reasons, to communicate the pathology report as being

benign and to follow the surgical wound and make sure it was healing.

But in your opinion it was necessary to do that to follow a condition of dysplasia as well?

A. Mr. Young, you've used the term dysplasia as though it's an absolute concrete entity and I'm sorry, I don't accept it that way.

Q. I'm not trying to infer that in any way.

A. But you're giving it an importance that I'm not sure it justifies.

Q. That's all I'm trying to understand, what in your opinion a diagnosis of mild dysplasia would require of a surgeon considering this lesion.

A. Well, an individual could have a dysplasia from a number of different things. Irritation and rubbing against the teeth and things of this nature that isn't really something you're going to follow.

Q. In your opinion on November 22, 1989, with a telecommunication of mild dysplasia, was Dr. Brown able to rule out the possibility that this would develop into a cancerous condition?

A. No.

Q. Okay. In a section of your materials, and I can't tell whose office records they are, in

handwritten form at the top left corner is Allan Boyd and the date October 12, '90, right hand is written page one with one circled.

Do you see those materials?

A. Hang on. No. Not the dental one, I take it?

Q. No. These are typewritten office notes.

A. Typewritten. Hang on. Okay. Give it to me again.

Q. Let's see if I can describe it. We're talking about probably six sheets, five sheets of paper.

A. Yes.

Q. And on the top left-hand corner is written in handwriting Allan Boyd.

A. Right, I see that. 790 West Minster.

Q. That's it. Now, in that pack of papers we have a report dated October 29, 1990 from Dr. Cervino to Dr. Nowak.

A. Okay. "Dear Mike?"

Q. That's it.

A. October 15th.

Q. Now, as I understand your second primary conclusion, it's your position that the metastasis, the metastatic lymph nodes were in the wrong chain to have metastasized from the

tongue, is that correct?
A. Yes.
Q. And you would agree that it was possible for tongue cancer to metastasize to those nodes but that to a probability they metastasized generally in a different form from the tongue, is that right?
A. Yes.
Q. Now, where would you expect tongue cancer on the left margin of the tongue to first metastasize to?
A. Typically to the digastric triangle, the upper cervical lymph nodes.
Q. All right. Now, as I recall from, and you conclude from the CT Scan of October loth, 1990 that that was not the manner in which these nodes metastasized, is that correct?
A. The nodes didn't metastasize. They were always there.
Q. I'm sorry, the disease metastasizes to the nodes.
A. Yes, sir.
Q. But is the CT Scan of October loth, 1990 the basis for your conclusion that there was a different form of metastasis?

A. Not necessarily.
Q. What physical --
A. The description of where the lymph nodes were, their size and the extent, as an example, to the fact that they literally became necrotic. They outgrew their own blood supply they were growing so rapidly. This is a very aggressive, invasive tumor.
Q. But my question is --
A. And I based my opinion on that.
Q. On the aggressive nature of the tumor?
A. Well, I mean if I may use the term, it is almost like a science fiction thing. It is growing so rapidly, within days it seems to have gotten bigger by several of the reports.
Q. Now, I understand the aggressive nature in which the tumor developed in the fall of '90.

But what I'm looking for is a clarification on your apparent conclusion that the metastasis occurred in the wrong chain of lymph nodes?
A. Not only the wrong chain, the wrong location.
Q. Now, when I look at the records of Medina Community, the records of Dr. Cervino, this report for instance down about the third sentence there he states he did have other

smaller but enlarged nodes in the left neck higher up in the mid cervical and jugulodigastric region.

A. Okay.

Q. Now, that is the region to which you conclude the metastasis would first occur, correct?

A. Yes.

Q. Is it because the lower nodes are larger and are growing more quickly that you conclude that the metastasis is not from the tongue?

A. No. The lower nodes are supraclavicular which is a, when one understands the lymphatic drainage of the tongue, which is totally out of place. I would think it would come from the lung or from the mediastinum or from somewhere below the clavicles.

Q. When he refers to enlarged nodes higher up in the mid cervical and jugulodigastric region, those are not the nodes to which you would expect the metastasis to first occur?

A. Yes, I would, but you see there is a difference of involvement.

Q. In other words, the nodes further down are larger and the metastatic lesions appear more aggressive in the lower nodes?

A I think one would logically have to accept that the lower nodes were involved with tumor before the upper nodes were and that's why they progressed in such size

Secondly, Dr. Cervino I feel is wrong in that he really doesn't understand nasopharyngeal carcinoma and its metastasis

Q Well, Dr. Cervino Dr Hazra and Dr. Frome essentially all concluded that this was metastatic tongue cancer, did they not?

A Well, he says, if I can quote him, 'I would not be surprised if it's coming from the nasal pharynx "

Q That is before they identified the tongue lesion but you are aware of the fact that all of these doctors later concluded that this was metastatic tongue cancer, correct?

A. I don't know.

Q. You don't know that?

A. No. I mean they can conclude it in retrospect but I don't know that that makes it specific How did they explain away while he literally is being consumed by the lymph nodes in the neck the tongue goes totally unnoticed even by the patient, not mentioning it until the person just

happened to pick it up in conversation.
Q. Well, Doctor, if there was a second primary tumor, would you assume that the second primary tumor would be growing with the same aggressiveness as the, same as the metastatic lesion that you're describing?
A. No. Not necessarily.
Q. Now, why, how are you able to conclude that there is a second primary simply because the initial primary didn't grow with the same aggressive nature?
A. What I'm actually saying is that even tumors have patterns that they follow and for the lesion on the tongue to be so totally innocuous and then to give a metastasis to an area that is so unbelievably aggressive, that isn't the way squamous cell carcinoma portrays itself.
Q. I understand. But what I'm trying to understand is, as I understand your testimony, the tongue tumor is essentially resting passively, it is not growing aggressively, correct?
A. It wasn't growing at all.
Q. And from that you conclude in part that there must be a second primary tumor?
A. Yes.

Q. What would you expect of a second primary tumor then in terms of growth and progression?
A. It may metastasize, it may have been under the clavicle, it may not have been detected and may have been a completely different tumor.
As it was read, if I recall it correctly, it was read as moderate -- hang on.
MR. MURPHY: Looking for a path report?
THE WITNESS: Yes.
MR. MURPHY: From the second tongue biopsy?
THE WITNESS: Well, when it was reread.
Q. You're looking for the Cleveland Clinic interpretation?
A. I suppose so, yes. Because it was read, as I recall it, as moderately --
MR. MURPHY: The Cleveland Clinic material should be kind of at the bottom of the packet if it is in the same order.
THE WITNESS: Okay. I have kept it in that order.
A. Okay. I have it here, okay. The findings on this biopsy, this is by Dr. Nunez --

Q. This pertains to what date, Doctor, the November, 1989 lesion?
A. The letter is written on January 16th, 1991 and I think they're referring to the slides.
Q. The Marymount slides?
A. Yes. S89-5227.
Q. Right. Those are the Marymount slides.
A. He said the findings are highly suspicious for a well differentiated squamous cell carcinoma. Well, a well differentiated squamous cell carcinoma doesn't act the way this one did if it had metastasized to that neck.

One, it metastasized to the wrong place in the neck.

Secondly, by its unbelievable aggressive behavior, that isn't the way a well differentiated squamous cell carcinoma behaves.

Q. If we look at the next page we see that his diagnosis on the 1990 slides is moderately differentiated squamous cell carcinoma.

Does the difference between well differentiated and moderately differentiated make that much of a difference?

A. Well differentiated tumor shows pearls and so forth. You know, I don't know. But under

number one, he says suspicious for well differentiated squamous cell carcinoma.

The lesion is difficult to interpret even then, even retrospectively he's saying it's difficult.

What I'm trying to understand is what you would expect of the second primary tumor which you contend must have existed in Allan Boyd.

I'm saying the probability that there was another primary is very good because of the behavior of the lesion in the tongue and the behavior of the metastasis from wherever it came in the neck. I think that's a reasonable statement.

I understand the question of the chain of lymph nodes.

But it's --

It isn't so much the chain, Mr. Young. These are supraclavicular. I mean they are, there's just almost no way for it to get down there, you know, from a lymphatic channel basis.

Well, when we say almost no way to get there, it's well understood in the community that tongue cancer can metastasize to any area of the body, isn't it?

A Yes, that's true.
Q I mean it can go to the liver, it can go to practically much any organ in the body in terms of possibility?
A Absolutely.
Q When we talk about what is generally accepted, we're talking about it usually happens in a different way, correct?
A Well, let me put it this way. It can only go by one of three routes. It can do it by direct invasion. It can do it by invading blood vessels and then traveling throughout the body lodging in the liver or some other place, or it can go by lymphatic spread.

Now, I would submit to you that this tumor probably by lymphatic spread, but I just can't see that as describing, quiescent tongue lesion, causing the massive growth in the cervical neck.
Q And I appreciate that and excuse my ignorance. What I'm trying to understand is --
A It isn't ignorance, Mr. Young, it is just knowing and understanding how these things, how do I put it, carry out their tasks.
Q. What I'm looking for is what -- I understand that the metastatic lesion was aggressive and

that the tongue lesion was quiescent, it was not growing, and I'm looking for what you would expect of a second primary tumor in terms of progression in the fall of 1990.

A. Well, I would expect a, in the sense of what was detected, I would expect a lesion that was anaplastic, there was no differentiation whatsoever and I would expect that it would be the lesion that would metastasize quickly and with great vigor as I think it did.

Q. And in terms of progression or growth of the primary lesion, the second primary lesion, what would you expect?

A. I would expect this to be not a pushing, but an invasive type lesion and it doesn't have to grow to great size.

Q. All right. Now, let me go to your report then of August 19, 1994. You raise three points which you contend are relevant concerning the second primary lesion.

The first is Mr. Boyd was unusually young.

A. Yes.

Q. What relevance does that have to this case in your opinion?

A. Squamous cell carcinomas in the head and neck

area in people of his age are unusual. One wouldn't expect to find a malignancy of this kind in someone of his age.

Q. Does that impact on your opinion that there was a second primary lesion?

A. I don't know. I've never thought of it that way.

Q. Okay. Does that impact in your opinion in any manner on the probability of cure at any point in time?

A. Well, the curability of younger people who develop squamous cell carcinomas of the head and neck is not good.

Q. And when you say that, are you drawing that from studies with which you're familiar?

A. It is more or less -- well, no, from actual experience.

Q. And when you draw on actual experience, are you familiar with the occurrence of T1 lesions?

A. Yes.

Q. Stage 1 lesions?

A. Yes.

Q. And probability of survival from those?

A. Yes.

Q. Do you believe that the probability of survival

for a person under the age of 40 from a stage one oral cancer squamous cell carcinoma is less than for a person in their fifth, sixth or seventh decade?

A. Yes.

Q. Is there a statistical probability which you would place on the difference?

A. No. That would be difficult because there are so few of them.

Q. All right. And when we talk about them, there being so few of them, on how many occasions would you have treated a person with squamous cell carcinoma of the tongue under the age of 40?

A. Twice.

Q. Over a period of how long?

A. They were both in at the same time. Is that what you mean?

Q. No. Over your career.

A. Oh, I don't know. I can't go all the way back. I remember the two cases that I mentioned because they were both extremely unusual and secondly they were both in their twenties.

Q. What stage were they in when they presented to you?

A Yeah were at stage one

Q Both with lesions under two centimeters?

A Yes.

Q Of the mobile tongue?

A Yes

Q And what was the outcome of the cases?

A They both died

Q When did this occur?

A Oh, I'd say six or seven years ago Both patients were actually in the hospital on our service at the same time which just totally was unusual.

Q And were they in their twenties did you say?

A Yes.

Q Both of them?

A Yes.

Q Okay.

A One was 21 and one was 23

Q If look at your report and if see 'secondly, the mode of metastasis was extremely unusual,' that refers to the explanation you've just given us?

A Which?

Q I see 'secondly, the mode of metastasis was extremely unusual ' It is stated that the major metastasis was actually in the left

supraclavicular area.
A. Maybe the word mode wasn't correct. The location and the activity of the metastasis.
Q. I see. You believe that the enlarged nodes, which were two and a half centimeters above the supraclavicular node or lesion, had come from that metastatic lesion?
A. From which metastatic lesion?
Q. From that node?
A. I'm sorry, I'm confused.
Q. I look at, if I look at the October loth, 1990 CT study, the report is dated October 11th.
Do you have that there?
MR. MURPHY: That would be in the same packet of records with the records from Dr. Cervino that you were talking about before. It should be a page or two in front of that.
THE WITNESS: All right. Hang on.
MR. MURPHY: My paperclips remain secure.
A. No. They are. They did. Okay. Is this a letter from Mitchell Fromm?
Q. No. I'm referring to the report dated October 11, 1990 of a CT Scan done by Dr. Nowak.

Actually it was at the request *of* Dr. Nowak.

MR. MURPHY: A couple *of* pages before you get to Fromm's letter.

MR. JACKSON: Chuck, are you able to give us any estimate on how much longer?

MR. YOUNG: Not much longer, John.

A. I'm sorry, I can't find that.

Q. Let me read this to you, Doctor, because I know you've seen the report and there's a notation to it.

A. This is October what?

Q. October 10th of 1990 and in the second paragraph of the interpretation Dr. Kunst has written next, let's see, "soft tissue density in this immediate area appears prominent but may also represent post-biopsy complication."

Do you remember that?

A. Yes.

Q. Okay.

A. Kind *of.*

Q. Essentially he's saying that there is a soft tissue density at the area that they biopsied, and he's unable to clearly visualize that but he goes on to say, "however, at the next highest CT

section we note at least two enlarged cervical lymph nodes with the more medial just lateral to the jugular vein measuring 2.2 centimeters in diameter and with a second node lying somewhat more laterally measuring 1.2 centimeters."

He goes on to state "approximately four centimeters higher in the neck lying medial to the sternocleidomastoid muscle we note an additional lymph node on the left measuring one centimeter in diameter at the borderline of significance."

Now, he's finding positive nodes higher than the supraclavicular node to which you referred, which was the primary or the largest area of metastasis.

A Was this after the neck was biopsied?

Q Yes, it was.

A Well, then, that could explain all kinds of different things.

Q How so?

A Well, you can see a lymph node. There is a general reaction to the biopsy itself. I mean just because a node is enlarged does not mean that it's metastatic.

Q I understand. He notes enlarged nodes above in

tᕹe lymphatic chain, tᕹe primary metastatic tumor.

Aᑫᗩ my queᔑtion to you is ᕹecauᔑe tᕹeᔑe areᔑ ᔑmaller noᗩeᔑ, is it your ᗩoᔑition that the metastasis ᔑorkeᗩ uᗩ the chain as oᑭᑭoᔑeᗩ to down?

A I don't know. I ᗩon't know how tᕹat can ᕹven ᕹe anᔑweᕹeᗩ

Q. Why?

A. Becauᔑe afteᕹ, if I read correctly, the ᕹiopsy was taken on tᕹe 2nd?

Mᑫ MURPHY: I ᕹelieve it ᔑas Octoᕹer 2nᗩ

A And the pre-ᗩ ᗩiagnoᔑis ᔑas tᕹe left neck abscess.

Q Right.

A Aᑫᗩ tᕹey ᗩiᗩ an I&D of a left neck aᕹᔑceᔑs oᕹviously theᵞ theᑫ had a gᕹoᔑᔑ coᵚtaminatioᵚ of the oᗩeᕹatiᔑe ᔑite

ᗩut as I ᕹeaᗩ it correctly soᵐᕹplaᑕe, theᕹe was a ᔑailling of the contents of t e aᕹsceᔑs itᔑelf So any enlargement of any noᗩe fᕹoᵐ that poiᵗnt on, it ᔑouldᗩ ᗩe veᕹy ᗩifᶠicult to tell ᔑhetheᕹ it ᔑaᔑ ᗩue to inflaᵐmatoᕹy ᕹeaᑕtion ᶠᕹoᵐ the I&D anᗩ/oᕹ ᔑas it due to incᕹeasing

metastasis.

I mean the questions that you're asking me just aren't answerable. Whether it went up the chain or down the chain, I don't know that there is significance to that, but, you know, you may think there is but I don't know how anyone can say.

Q. Do you believe or do you have an opinion concerning whether these enlarged nodes were evidence of metastatic disease in the cervical lymphatic chain in October of 1990?

A. Which large nodes?

Q. The enlarged nodes that we just described?

A. The ones from the supraclavicular area?

Q. No. Those above the supraclavicular area.

A. I don't know. I mean how can one say. They could have been inflammatory.

Q. All right. Doctor, in your first paragraph of the report of August 19, 1994 the last sentence, you talk about the CT Scan makes note of a lesion that was seen in the trachea at the carina and extended to the bronchus, correct?

A. Yes.

Q. Now, have you ever seen the CT report of November of 1990?

A. I don't know.
Q. It was not in your materials.
To your knowledge, has Mr. Murphy ever shown you that report?
A. I don't recall it.
Q. All right. There is a subsequent CT report on which that soft tissue shadow believed to be a tumor doesn't appear and they conclude that it was mucus.
Have you seen that CT study?
A. I think I am aware of that, yes.
Q. How are you aware of it?
A. I don't know but I think I am aware of the fact that they did think it was mucus.
Q. Would that cause you to conclude that that area visualized on the CT Scan of October loth, 1990 was not in fact a second primary tumor?
A. Yes, it probably would.
Q. Okay. Now, the last sentence, this is what I was getting to, "this was never pursued."
You don't have any criticism of the diagnostic procedures and the staging procedures that were done at Medina, do you?
A. No, I don't.
Q. I mean they did a subsequent CT Scan, a triple

esophagoscopy, esophagoscopy, laryngoscopy, all of those are proper procedures?

A Yes, they certainly are

Q There aren't any second primary tumor, you're aware of that?

A Yes.

Q If there was such a second primary tumor, do you have an opinion as to where it was located?

A No, I don't I would feel it probably wasn't in the head and neck area.

Q And what area would you expect it to be located in?

A Some area below the clavicle 12 to 15 percent of head and neck tumors do originate from below the clavicles.

Q Would you expect such a tumor to be shown on CT study?

A It may or it may not.

Q It may or may not?

A Right Plus, as I recall it, was there an autopsy done?

Q. No. There was not.

A. That might have shed some light

Q Just skipping down, Doctor, you agree that it's possible to find -- would you agree that it is

possible that the metastatic disease diagnosed in 1990 in fact originated with the tongue lesion?

MR. MURPHY: Objection.

A. I would say it is possible but highly improbable.

Q. And I'm trying to understand what you conclude a the impact of a second primary tumor to be on the probability of survival of Allan Boyd.

Do you have an opinion concerning that?

A. I don't understand the question. What do you mean impact?

Q. Well, let me get to it this way.

Do you have an opinion concerning the size of the tongue lesion that was present on November 22, 1989?

A. I'm sorry, say that once more? Do I have --

Q. An opinion concerning the size of the tongue lesion that was present on November 22, 1989?

If I recall, it was just a few millimeters.

Q. And that's taken from Dr. Brown's description?

A. Yes.

Q. Although we didn't know in November of 1989, we know now that the tongue cancer was not totally removed from Allan Boyd's tongue in 1989, do we

not?

A. No. We really don't, do we? All we know is that it, on a subsequent biopsy it was proven positive.

But that doesn't mean that it wasn't completely removed necessarily with Dr. Brown's biopsy and then there was a recurrence, not necessarily persistence but a recurrence adjacent to that area.

Q. Are you aware of facts and testimony in this case that the site of the biopsy never healed?

MR. MURPHY: Objection.

A. No, I don't think I am.

Q. If the site of the biopsy remained sore and did not heal, would that cause you to conclude that not all of the tongue cancer was removed on November 22, 1989?

A. Well, not necessarily. What would bother me is the fact that Mr. Boyd never complained about it. In fact he never mentioned it to anyone. Certainly he didn't mention it to any of the doctors.

Q. Well, he certainly did and he went in to see Dr. ~~Percenco~~ Parsanko at least in May of 1990 and we know that, and he mentioned it to others. But that's

a different issue.

If the site did not heal, would that cause you to conclude that not all the cancer had been removed from the tongue on November 22, 1989?

A. Not necessarily.

Q. I understand not necessarily. To a reasonable medical probability.

A. No. I don't think you can make that kind of a sweeping statement.

Q. If the tongue cancer had not been totally removed on November 22, 1989, would you expect the tongue to heal?

A. No.

Q. If cancer cells remained in the tongue, squamous cell cancer cells after November 22, 1989, the tongue would remain sore and the healing would not take place, correct?

A. It doesn't necessarily have to be sore, but you're right, healing would not take place.

Q. Doctor, if it was the November, '89 tongue lesion which metastasized, would you agree that if diagnosed in November of 1989 and properly treated, Allan Boyd would probably have been cured?

MR. JACKSON: I object to that.

A. Is that what you're saying, if it was?
Q. If it was the tongue lesion which metastasized --
A. Yes.
Q. -- would you agree that if diagnosed in November of '89 and properly treated, Allan Boyd probably would have been cured in this case?
A. Yes.
Q. You testified I think that Mr. -- well, strike that.

You testified that you do have Dr. Mendelsohn's report, correct?
A. Yes.
Q. And you've had the opportunity to discuss that in part with Mr. Murphy, right?
A. Yes, I guess so. It wasn't much of a discussion.
Q. Well, in your experience, are you or would any physician be able to conclude that Allan Boyd's tongue cancer had metastasized some years before the biopsy in November of 1989, based on --

MR. MURPHY: Object. You can ask what his opinion is but I don't know of his opinions about other doctors' opinions.

MR. YOUNG: Could you read the

question that?

- - - -

(Thereupon, the requested portion of the record was read by the Notary)

- - - -

Q -- the size of the metastatic tumor which was found in the fall of 1990?

MR JACKSON: I'll object You asked him two questions there. One. Whether he had an opinion and two. Whether any doctor could have an opinion.

Q Do you understand the question, doctor?

A Obviously can't speak for any doctor. I think it is possible that there was metastasis before, that we're assuming now that the metastasis in the neck came from the tongue

Q Correct

A I think it is possible, if this assumption is correct, that it could have happened before the biopsy of the tongue

Q That's fair, doctor But would you say that it could have happened several years prior to the biopsy of the tongue?

MR MURPHY: Objection.

A So That would be an absurdity that it would

lie there dormant physiologically for years. That is a long time.

Q. All right. And we know that there were no palpable lymph nodes in November of 1989, correct?

A. Yes.

Q. And had it metastasized long before, we would expect such nodes to be palpable, would we not?

A. Yes. That would be a reasonable conclusion.

Q. Doctor, let me take just one minute here.

A. All right.

MR. YOUNG: Doctor, I have nothing further. John, do you have any questions?

MR. JACKSON: Not at this time.

MR. YOUNG: Doctor, thank you very much for your time and I appreciate you not going forward with Friday. We'll be down to see you in about a week and talk to you then.

MR. MURPHY: Exactly a week I guess.

_____

DONALD A. SHUMRICK, M.D.

C E R T I F I C A T E

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

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

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office, at Cleveland, Ohio, this ____ day of _____. A.D. 19 __.

_____
Linda A. Astuto, Notary Public, State of Ohio
1750 Midland Building, Cleveland, Ohio 44115
My commission expires October 24, 1997

LAWYER'S NOTES

PAGE	LINE	