IN THE DISTRICT COURT OF KNOX COUNTY, NEBRASKA

DONNA J. WIEBELHAUS,
Plaintiff,
vs.
D. J. MAGENGAST, M.D.,
Plaintiff.

Case No. 12018

DEPOSITION OF SCOT SORENSEN, M.D. TAKEN ON BEHALF OF THE DEFENDANT

Taken at Deponent's tledlcal Office 1919 South 48th, Lincoln, Nebraska, on December 9, 1993, at 8:00 a.m.

APPEARAHCES

For the plaintlff: MR. DAVID A. DOMINA
Attorney at Law
2425 Taylor Avenue
Norfolk, NE 68702

For the defendant: MR. JOSEPH F. BATAILLON
Attorneg at Law
7000 Spring Street
Omaha, NE 68106

IHDEX

WITNESS:

SCOT SORENSEN, M.D.

EXHIOITS: MARKEO:

(No exhibits marked)

Doc. 423

COPY

STIPULATIONS

It Is stipulated and agreed bg and betueen the parties hereto:

1. That the deposltlon of SCOT SORENSEH, M.D. rag be taken before Raelene Petersen, Stenographic Reporter and General Notarg Public, at the tire and place set forth on the title Pane hereof.

2. That the deposition is taken pursuant to notice having been Issued upon the deponent.

3. That the original deposition will be dellvered to Mr. Joseph Batallloo, attorneg for the defendant, and a certification of same will he filed ulth the Clerk of the District Court of Knox County, Nebraska, setting forth that the deposltloo was taken and the costs thereof..

4. That all objections except as to form and foundation are reserved until the tlre of trial.

5. That the testimong rag be transcribed outside of the presence of the witness.

6. That the signature of the deponent to the transcribed copg of his deposltlon Is ualved.

SCOT SORENSEN, M.D.

Of lawful age, being first duly cautioned and solemnly sworn as hereinafter certified, was examined and testified as follows:
(Witness' response to oath: "Yes")

DIRECT EXAMINATION

BY MR. BATAILLDH:

Q. Doctor, would gou please state your name for the record.

A. Scot Calder Sorensen.

Q. And, doctor, uhat Is gour specialtg?

A. Medical oncologg.

Q. Do gou have a curriculum vitae?

A. Yes, I do.

Q. And do gou have It ulth gou here thls morning?

A. Mg secratarg does.

Q. Can we snag one?

A. Certainig.

Q. Then we can rake It part of the record.

A. That's floe.

Q. Where did gou receive gour oncologg training?

A. At the Mago Clinic.

Q. And how long ago was that?

A. I graduated there in 1983.

Q. Otag. And gou're board certifled In what?

A. nedical oncologg.

Q. All rlght. Did gou revleu the pathology report fror I thlnk It was the Yankton Clinic ulth respect to the other patholong that theg developed?

A. The....

p. The cgst.

MR. DOHIHA: The initial one? It was from Sioux Falls, if that helps.

MR. BATALLOW: No, I'm talking about the one that was done later in 1993.

MR. DOHIWA: Okag.

p. (Bg Mr. Batallion) You're not aware of that either?

A. I dldn't know It.

p. All rlght. Let's just start over. Maybe It's easier to do It thls wag: Uhat records have gou reviewed?

A. I have revleued all of the information that doctor — that Mr. Dorlna gave re probablg three months or so ago ulth respect to the Initial events af the hospitalization and her pregnancy and sore of the material fror UNMC as well as sore data frnr California; and then there was other materials, I thlnk it was primarilg depositions that care subsequent to that. I have not revleued that because I was under the impression that it uasn't uolna to be that big of a deal, so In essence I have tossed all of that.

Q. Are gou going to testifg with respect to the

A. Yes.

p. And the hospital record from Mrs. Wiebelhaus' pregnancy?

A. Yes.

p. And portions of the record from the John Wagne Cancer Institute?

A. Yes.

Q. And as far as medical records, that uould — and the UNMC record?

A. Yes.

Q. And that would be It as far as —

A. That uonld be about It.

p. Were gou aware that she did have a second melanoma lesion on her back while she was at John Wagne?

A. Wo.

Q. All rlght. And gou uere not auare that she had a cystic lesion in her chest area In 1993.

A. No.

MR. DOHHA: In '93.

MR. EATALLOW: Right.

MR. DOHINA: Okag.

Q. (Bg Mr. Batallion) And gou uere not auare that she had a brain tumor that was diagnosed in '93?

A. Yell, I thlnt It was uord of mouth, but I dldn't — never got ang docurentatloo.

standard of medical care rendered bg Dr. Nagengast?

MR. DOHIWA: Ask him uhat he leans if gou don't tnow.

A. Yhat do gou — I guess....

Q. (Bg Mr. Batallion) Are gou going to offer ang criticisms about the care #at Dr. Nagengast rendered to thls patient?

A. Well,.I thlnt certalnlg In sore respects the delag In performing a biopsg Is an issue.

Q. All right. Ang other criticisms that gou're going to have as far as his care Is concerned?

A. Hot that I'm aware of based on the information Presented to re.

Q. You've not had an opportunitg to review his deposition, is that correct?

A. I believe It was In that first raterial.

M. DOHIWR: No.

ME WITNESS: It uasn't? Okag.

A. Then I don't — no, I have oot reviewed his deposition.

ME WITNESS: Was that In the second packet?

M. DOHHA: Yes.

A. So I haven't reviewed his depositloo.

Q. (Bg Mr. Batalllon) You've bad an opportunity, though, to review his office record?

Q. Didn't see records, all right. Rod were gou aware that she had developed bone cancer — bone retastasls also?

A. I knew that there was more extensive involvement than Just localized within the lgmph nodes. I knew that there was liver Involverent and got the impression frnr the records that Indeed it was rore extensive. Whether or not there was definite boog Involvement I can't address.

Q. You dldn't see --

A. But that doesn't surprise re.

Q. Okag. Do gou have — Is there ang wag to tell uhether or not Mrs. Ylebelhaus was retastatlc the dag that Dr. Nagengast flrst examined her in Januarg of 1991 — or '92? Strike that. I got the dates wrong.

Is there ang wag that gou can sag one wag or another whether Mrs. Wiebelhaus was metastatic in July of 1992 uhen Dr. Nagengast was first apprised of her role on her upper right shoulder?

MR. DOHIHA: ObJectlon, fora and foundatloo.

A. Not based on the documentation provided.

Q. (Bg Mr. Batallion) Yhat would gou need?

A. Yell. obviousig a staging workup would have included a chest X-rag and sore blood uort and a more detailed history and phgsical exaslnatlon. Perhaps other scans, radiographic studies, et cetera, that kind of stuff.

Q. All of thls was done In October at the Med Center?

A. There is no way to solve that problem.
Q. Okag. Is it true that Clark's Level 1 relanora can be metastatic?
A. Yes.
Q. Clark's Level 2?
A. Yes.
Q. Clark's Level 3?
A. Yes.
Q. Clark's Level 4?
A. Yes.
Q. And Clark's Level 5 by definition is ietastatlc.
A. Yell, I -- well, not in the true sense of uhat Clark's Is because Clark's Is Just purely looking at the prlrarg tuior; bot, yes, all five levels can eventually lead to the patlent's death.
Q. To ietastatlc dlsease.
A. And the patlent's death, right.
Q. It's my understanding that at those various staging levels, the percentages are more, become more and more in favor of the plaintiff -- or in favor of the patlent. The lower the level --
A. Exactly. There's a direction relationship betueen the depth of the turor and subsequent development of ietastatlc dlsease and thelr survival.
Q. Yhat's your understanding for Clark's 1, the

survival?
A. I uould sag In excess of 90 percent. 95 percent; but, again, going down -- I don't, personally I don't follow the Clark's level. I think the micrometer from the pathologist Is the biggest determinant, and that's basically measuring the depth of the initial tumor as opposed to Clark's level, and that's the so-called Breslow's classification.
Q. And so you uonld prefer the Breslow's classification.
A. Right.
Q. And uhat are the Breslow classifications? Is that one through something, too?
A. It's baslcallg Just measuring the lavasion or the depth of the tumor, so It's typically measured In illllreters.
Q. And do you recall ubat the depth of Mrs. Wiebelhaus' tuior was?
A. Not right offhand, no.
Q. What's the cutoff betueen -- or can you give me a general Idea —
A. I understand uhat you're --
Q. — of uhat prognosis we're talking about at various sizes?
A. I understand uhat you're saging. At this point Io tlie -- okag, historically, le to 15 gears ago, it uas felt that angthing over .76 illllieters. 8.76 illllieters was an

adverse prognostic indicator of outcore, okag? Further analgsis of lymph node negative patients, roughly 588 or so, recognized that that Is probably too thin, that Indeed the prognosis doesn't start to, quote, drop off, end quote, until the tuior Is greater than 1.70 millimeters. And uhen I sag 'drop off," I'm talking about angthing less than that, a 90 percent survival rate at five gears, greater than 1.7 It drops down to about 65 percent, and then obvlouslg angthlou greater than 3.7 or thereabouts It drops off even further then, so It's a step-ulse regression.
Q. And the speed at uhlch. ulth uhlch these tumors grow is tremendouslg variable, isn't it?
A. Yes.
Q. You can have tumors that are greater — strike that. You can have tumors that grow at a verg slow rate and tumors that grow at a verg quick rate, Is that correct?
A. Correct.
Q. And if It's a lifelong tuior, It's really impossible to tell how deep It really Is.
A. Define "lifelong."
Q. Yell, if It's a male that has had — that has been present on the patlent for thelr entire life.
A. Yell, geah, I guess that per se doesn't have bearing ulth respect to the proanosls. Again, once the ielanoia has occurred and the depth of the tuior is, again,

the most important prognostic variable.
Q. And as far as Breslow's Is concerned, the studies would limit — strike that. The studies as far as thinness are limited to patients that do not have lymph node Involveient, I think you sald.
A. Correct.
Q. Once the patlent has lymph node Involveient, It doesn't latter how thin —
A. Correct.
Q. — the tumor is, right?
A. Correct.
P. You can have lymph node involvement ulth a tumor that Is less than 8.76 millimeters, Is that correct?
A. You can, yes.
P. And the depth of the tumor really Isn't going to tell you uhether or not you have lymph node involvement, Is that correct?
A. True, true, at the tire of initial diagnosis.
Q. Rlght.
A. Correct.
Q. You can have a huge tuior and still have no lgrph oode involvement.
A. Correct.
Q. Do you knou uhether thev did a brain scan on Mrs. Wiebelhaus uhen she was at the fled Center?

(Indicating)

Q. All rlght. It's on page 1507 of DeVita's thlrd edition, Is that correct?

A. Yes.

Q. The sentence sags, The tlmlng of the blopsg prior to the first definitive treatrent was found to have slnnlflcant influence on snrvlval in one serles," which means In one of several serles thls variable was felt to be slnnlflcant. Is that correct?

MR. DOMINA: Objection, arnurentatlve. It xag have been one of one.

A. I suspect It's probably one of one.

Q. (Bg Mr. Batallion) So we don't knou uhether the serles is reproducible.

A. True: It's only been published in that one report bg that gentleman that I spelled for you.

Q. And from a scientific standpoint, one serles Is not — does not a standard of care rake.

A. I thlnk, again, that's arnurentatlve.

MR. DOMINA: Sustained.

Q. (Bg Mr. Batallion) You don't know the ansuer to that.

A. For -- yes, for good clinical xedicine, yes, one serles doesn't necessarlg rake the standard of practice, that that's the wag It should be.

Q. I understand. Wou, how lonn do gnu think It is on average betueen the tire a phgslclan, a family practitioner or prlrarg care phgslclan, from the tire of blopsg to the tire theg get to gou for treatrent? How long does that usually take, if gou have an estimate?

A. Oh, typically within a ueek or so.

Q. All rlnht. Let's back up, let's work thls out. One ueek, prlrarg blopsg bg the primary care phgsician, right? How long does It take to get the report back from patholong?

A. Two days.

Q. Then gou bave to do a ulde excision, right? And who usually does that7

A. The surgeon.

Q. How lonn does It take the prlrarg care phgslclan to net hix referred to a surgeon for a wide excision?

A. Oh. I would sag a ueek.

Q. And then the primary — then the surgeon has to net patholong back and then rake a recommendation to Send somebodg to the oncolog Ist?

A. Well, that varies. I think tgpically uhat — I guess in the normal scenario how that uould run is the primary Care phgsician would sap, "I just did a blopsg of a relanora. Uhat should I do?'

I don't need to see the patient at that point in tire. I sag — well, assuming that the blood chemistrg, all

the blood work, the chest X-rag, and the examination is, quote, negative, then I say, "Have the surgeon see the patlent for wide exclslon.' And so, in essence, there's no sense to delaging, having the patlent see tie and then see the surgeon, because It reallg doesn't accomplish angthing in the scheme of things.

Q So how lonn do gnu usuallg see ther after the surgeon completes the wide exclslon?

A. Oh. within a few weeks or so. It depends on healing and uhat thelr location Is.

Q. And then gou uould start the chemotherapg if there was shown to be retastatlc disease?

A. Well, okag, I uould consider them a candidate for an investigational studg. Chemotherapg Is not just routinelg adrlnlstered after having found that there Is retastatlc dlsease because, keep lo mind, there sometimes rag be two different procedures perforred: One, the ulde excision; and then, depending on the prognostic information available at that time, specifically the depth of the tumor, then there rag be -- the next procedure rlnht be a lgmph node dissection. Do gou see uhat I rean?

Q. Yes.

A. So patients aren't necessarilg routinelg started on cherotherapg just because theg have a melanoma removed and wide exclslon, okay? I uanted to clarlfg what I rean.

Q. When do gou usually start the chemotherapg, on uhat type of relanora patients?

A. Well, okag.

Q. If ang at all.

A. Yell, see, again, that's an issue. Chemotherapg certalnlg is not verg effective In thls disease. I think chemotherapg has a role in patients who bave documented retastatlc Involverent, for example, in the liver, the bones, the lungs, whatever. Its benefit Is open to question and Is arguable with respect to It reallg trulg has an impact.

It Is not routinelg adrlnlstered for patients who are found to have lgmph node Involverent and are free of dlsease elsewhere, okay? There are clinical studies evaluating uhether or not sore form of adfuvant therapg Is of any benefit like It Is In breast cancer after a xastectong, for example; but those trials at thls point In tire don't suggest that treatrent begond lgmph node removal, as long as the patient Is free of cancer, bas trulg an impact on the patient's outcore, okag?

So I would start — I would consider cherotherapg In someone who has documented retastatic disease and if theg are a candidate for that and do not uant to Pursue another form of investigational therapy, be It immune therapg, interleukin, those types of thlnns.

Q. So gou xag not consult ulth a patient at all as

percentage basis uhat the Increase In her prognosis uould have been, is that correct?

A, Correct.

Q. And gnu can't sag that gou're even sure that It uould have nade a difference.

A. I think the evidence is clear that It would rake a difference.

Q. In uhat respect?

A. From the standpoint of the things that we talked about, earlier diagnosis/better survlval. In addition to the staterent that's published in that textbook.

Q. All right. Is there ang wag of knowing whether she had lgnph node lnvolverent In Julg of '92?

MR. DOMINA: ObJectlon, asked and ansuered.

A Again, not to ng knowledge was that ever addressed.

Q. (Bg Mr. Batallion) Yell, It was subclinical even In October, was It not? Bg that I rean from a cllnlcal analgsis.

A. Correct.

P. If It was subclinical In October and It was present In Julg, it uould have still been subclinical, is that correct?

A. Yes.

P. All rlaht. And so unless an excision of the lgnph

nodes uould have been done In Julg, there's reallg nu wag of knowing uhether there was retastatic disease In that lgnph node In Julg, is that correct?

A True.

Q. And there's reallg no wag to know how long before Julg, If it existed in Julg, that it existed.

A. True.

Q. And lgrph node lnvolverent is the prlrarg indicator, notwithstanding the depth of the tumor, as to the survivabilitg of tbe patient.

A. Correct.

P. So how can gou sag that It rakes ang difference in her outcome?

A. Yhat gou sag is true, but the devil's advocate could cow back to gou and sag, If there was even less retastatic disease in the lgnph nodes at the tire of Julg, for example, and a node dissection had been performed, that rag have prevented her fror seeding to other areas of the body. Rag, okag? And I thlnk certainlg the Issue of the tuo-Moth or two-and-a-half month delag personallg, in ng own view, I thlnt is too long for accepted medical practice io a situation dealing ulth a ver! suspicious primarg abnormallty based on the evidence that the plaintiff had presented to the phgsician, specificallg an olcerated area, those types of things.

Q. All right.

A. I thlnk —

Q. How lona —

MR. DOMINA: I don't think he's finished.

Q. (Bg Mr. Batallion) Are gou finished?

A. I'm trging to collect ng thoughts here because I understand uhat gou're trging to sag. and I.... All I an, all I an saging to gou is that I think the two-month issue dld have a significant lrpact on her outcone, but to quantifg that Is impossible.

Q. All rlaht. Yhat uould be a reasonable delag? A month?

A. Yell, gou knou, on the part of who? The patlent or the nedical sgstem or, gou knou, the phgslclan? I rean, that's -- because, understandably, if there's other things going on on the part of the patlent, theg rag sag, 'Gee. I don't want to do that now because I'm having a wedding,' or, gou knou, those types of thlnas.

Q. Is that okag?

A. Yell, I thlnk certainlg it jeopardizes the outcore. It's not to sag that just because there is a suspicious abnormallty that that is inminentlg life-threatening, that's not to equate that; but I thlnk that suspicious abnormallty becones nore of a life-threatening potential If Indeed the clinical findings are worrisone.

A very small role that's been there forever that has not changed Is not something that the phgslclan is going to be too concerned about as opposed to a larger area that Is now ulcerated and the patlent has said that It's changed ulthln a short period of tire. That I think Is two different issues. It uould be incumbent upon the phgsician to be nore neticulous and expeditious In pursuing a workup of that latter as opposed to the former.

Q. And how much do gou tell the patient?

A. I uould personallg sag. 'I think I'm nore concerned about this, that this is something that should be done within the next ueek, depending on uhat gour schedule is.'

Q. Or two weeks.

A. Tuo, that's, I rean, yeah, one or tuo weeks; I rean. that's arbitrary. I thlnk the Issue Is how important do gou stress to the patient that this Is a worrisone abnormallty that needs to be addressed despite other things that rag be going on Io gour life, or reassurance and sag, 'Yell, sou know, I'm not too concerned about it. We can do it whenever gou want to. You decide what gour schedule's like.' I think that's where It's a rotoal decision betueen the patient and the phgsician, but I think It has to be directed bg the cllnlcal appearance and aood redical practice on the part of the physician.

A. Oh, 'back mole.'
Q. -- "back iole, advise exclslon.'
A. Okag.
P. And then we have Aunust 31st, 'mole ulcerated,' right?
A. Rlght.
P. And then the iole Is excised, I belleve, on 9-14-92.
A. Right.
P. All right. DO you find that his charting generally meets the standard, if you will, of uhat you see In family practitioners In outlging areas7
A. Yes.
Q. I uant you to assume that the first tlie he felt that the tole should be reioved was on August 22nd.
A. Correct.
Q. And then there was a delag until September 14th before the patlent --
A. Actually had --
Q. -- actuallg had the procedure done.
A. Okag.
Q. And that obviously he sau It on August 13th and It was --
A. 31.
Q. -- or 31 and It was ulcerated.

A. Correct.
Q. Is that too iuch of a delag betueen August 22nd and September 14th?
A. Too much of a delag In her outcoie, that mag have --
P. Affected her outcoie.
A. -- affected her outcoie? I uould sag possibly If Indeed thls iole had not olcerated or was not-ulcerated on August 22. Now, there's no documentation that It was, hut we all know that that mag or mag not have been the case.
Q. All right.
A. So, I guess if It Indeed bad ulcerated In the span of eight dags or nine dags from August 22 to August 31, that obvlouslg Is a significant Issue, okag? So I guess uhat the cllnlcal appearance on August 22 trulg is or was bas some bearing to ansuer that question.
P. If the cllnlcal appearance was that there was no ulceration on August 22. uhat dlffereoce does It rake in your opinion?
A. I uoold sag that the three ueek or, geah, three-ueek Interval from the time of recommending excision to the tlie of that procedure being done night have had an outcoie In her -- night have had a different -- It right have affected her outcoie.
Q. But that again depends on uhether the patient

uanted to do it.
A. And other factors. Obviously she's pregnant and. you know, I rean, obviously the pregnancy and her firstborn and all that kind of stuff Is more of an issue for her than angthing else.
Q. Well, If she sags to the phgsician, "I'm going to deliver in a week or two. I'd like to wait until after I deliver,' Is the phgsician supposed to sag, 'Don't do that."
A. I uonld. If there Is a clinical, If there Is a clinical recommendation that thls thing needs to be reioved because I'm concerned that It's nalignant, especially In view of the ulceration that was documented, at least documented on August 31, that that takes precedence over and above the pregnancy. That's my oplnlon.
Q. Do you --
A. And that should be done because that Isn't that big of a procedure. Now, If you told me that she -- that thls was a gall bladder attack and, you know, that kind of stuff, then obvlouslg that's another Issue; but, I mean, doing a blopsg Is an out-patlent Issue.
Q. But you can't do It unless the patient lets you do It.
A. Correct.
Q. And If you tell the patlent that It's possibly nalignant, shouldn't that kind of tell them that naybe you

would like them to have It done?
A. That's correct.
Q. If the mole had not ulcerated on August 22nd and the patlent -- If It was not ulcerated on examination on August 22nd and the patient said she uanted to wait until her delivery which was expected in a ueek or tuo, uould It be okag In your opinion for the phgsician to sag, "All rlnht, let's wait until after you deliver the child."
A. I uonld imagine so. Again, uhat I'm trging to (let at is, I thlnk It depends on the clinical suspicion of the leslon to make that judgment ubether or not excision Is recommended. Now, he's recommended excision on August 22. That I think rlght there Is enough to sag he's concerned enough about it that it should be done.
Q. Right.
A. Or should have been done at some point In time In the past if there has trulg not been ang change In this: but, again, there's no docnientatlon one way or another to ansuer that. I think if a phgsician is willing to document that excision Is advlsed based on his clinical judgment, then that Is something that should be followed through in a relatively expeditious fashion over and above ang other things that mag be going on In the patient's life. Now, again, that bas to be a mutual decision betueen the patient and the phgsician. Ulceration aside, is uhat I'm trging to net at.

A. I'd sag three or four.
Q. Can yon tell me In the spiit whether You've ever testifled ON behalf of the suing part as opposed to the phgsician?
A. Probablg 50/50.
Q. All right. All cancer cases?
A. Yes.
Q. All in Lincoln?
A. no.
Q. can you give le an Idea of the geographic breakdown?
A. Three of them uere out of state — out of Llncoln, and one was in Lincoln.
Q. And the one Io Llncoln, was that for the defendant or the plalntlff?
A. I thlnk that was for the defendant.
Q. Do gou rererber angthing about that case7
A. Bog, that was, that was shortly after I caie to town and so I --
Q. About lo '83 magbe?
A. Yeah -- no, It was actuallg '85 or thereabouts.
Q. Uhat attoroeg retained gou, if gou remember?
A. Bog, I don't even recall.
Q. Snowden, Kauffman?
A. It right have been Jim Snowden, but I don't --

was -- one had to do ulth a failure to diagnose lung cancer and, hog, the thlrd one I can't -- I don't even remember.
Q. All right. And the Case Io Lincoln. do gou remember uhat the nature of that case was?
A. That was a failure to diagnose a kidneg cancer.
Q. And both of the cases, the one gou did in Lincoln and the one yon remembered fron the Llncoln attornegs, did part of that defense revolve around the fact that It wouldn't have iade ang dlffereoce as far as outcoie is concerned ultb an earlier diagnosis?
A. Some of them did, some of ther, geah. I don't ....
Q. Yhat Is gour rate because I've got to pag It.
A. A hundred fiftg dollars an·hour.
Q. All right. Is that for review as well as for testimong?
A. No, just for the testimong.
Q. Do gon charge for revleu?
A. No.
Q. In thls case to date have gou nade ang billing or intend to rake ang billing?
A. no.
Q. I asked two questions. Have gou iade ang billing?
A. No, and I don't Intend to make billing for angthing else prior to this.
Q. All right. Let me ask gou thls: If there was a

aaalo, don't quote me on that.
Q. Have yon ever worked ulth Mr. Snowden before?
A. I belleve so.
Q. Bow about Mr. Kauffman?
A. No, I don't recall.
Q. That's fine. And the cases out-state, uhat tire period are we talking about?
A. There was one I think probablg almost a gear ago, and both attornegs were fron Lincoln.
Q. Do gou remember uho theg were?
A. One was with Cline, Williams, and if goo told re the name I could tell gou.
Q. Christensen?
A. No.
Q. That's okag. But one was from Cline, Williams?
A. Yes, he was the defendant's attorneg.
P. And gou were testifging for?
A. On the part of the defendant.
Q. And what klod of case was It?
A. That was a, quote. failure to diagnose colon cancer.
Q. All right. And then gou have had two others, If gou can halfway give me an Idea, if you can remember.
A. I don't remember the attornegs and I don't even recall iuch specifics about the cases themselves other than It

lesion no her back that was found after the leslon that we see an her right shoulder and that lesion Is melanoma, It's a malignant melanoma and It's of the same varietg as the one that was found on her right shoulder, Is there reallg ang wag that gou can sag uhlch is the primarg and uhlch Is *the* secondary?
A. Depends on uhen the timing of that second leslon appeared. Io other words, If It appeared after the lgmph nodes were documented to be proven, then obviousig it's Probably an incidental malignancg and not the prlrarg site. Do You see what I'm saging?
Q. Yell, how can goo sag that?
A. Yell, okag, I guess also It uoold also hinge on the anatomic location of the, quote, lesion Io her back. I lean, if It was on the other shoulder or the other flank, then that's not, I lean. that's not going to be the primarg site of her lgmph node involvement; but, again, I think uhether or not It's the primarg site responsible for the subsequent hepatic involvement and bone and all the things that she died of I thlnk Is an argumentative Issue.
Q. Yon can't tell, can gou?
A. You can't tell. I lean, that's going to hinge on depth and a guess.
Q. And a guess. If that lesion In the lower back IS malignant and even If It's at Clark's Level 1, It can still be

prognosis Is worse for ulcerated lesions.
Q. How much worse?
A. I'd have to -- I don't know right offhand. I'd have to review that, hut there is no question that ulceration is an adverse prognostic Indicator, just like tumor depth, just like a variety of other prognostic indicators. So I thlnk the tlre frare of nine dags *of,* quote, assuming there's no ulceration to the time that **there** was ulceratlon documented I thlnk certalnlg Is an **Issue.**
Q. Bot my question is, at the time of ulceration, is It more likely than not that there's alreadg retastatlc disease?
MR. DOHIHA: ObJectlon, asked and answered.
Q. (Bg Mr. Batalllon) You can answer that.
A. It increases the likelihood that **there** is retastatic dlsease at that tire.
Q. The questlon is, is It more likelg than not that there's retastatlc dlsease when It Is ulcerated?
MR. DOHIHA: ObJectlon, asked and ansuered. The witness has answered the questlon.
MR. EATAILLON: No, he hasn't.
MR. DOMINA: Yes, he has. He said It's more likelg than not.
M. BATAILLOH: No, no, no, he dldn't sa! that. He said It's Increased, but I want to know whether It's more

likelg than not uhen It's ulcerated that there's already retastatic disease.
MR. DOHIHA: He's inferred that's a guess case bg case. That's the best gou're going to get. You're arguing with him now.
M. EATAILLON: I'd like his answer.
MR. DOMINA: I'd like gou to refrain from argument.
M. EATAILLOH: I'd like his ansuer.
A. Could gou rephrase **the** question for re, please?
Q. (Bg Mr. Batalllon) The question is, at the tire of ulceration In Mrs. Wiebelhaus, Is It more likelg than not that **she** has retastatic disease at that tire?
A. Yes.
Q. All right.
MR. EATAIUOH: I don't have ang further questions, doctor. Thank gou verg much. If I can just look at gour book for a minute.
MR. DOMINA: More likely than not or rore likelg than otherwise? More likelg than without ulceration?
M E WITNESS: Yell. I assure that's uhat he meant, more likelg than without ulceration. I guess I'm —
Q. (Bg Mr. Batalllon) Oh, no, no. The question Is verg simple. The question is, if she presents with an ulcerated leslon on dag ooe, is It more likelg than not that

she has ietastatlc dlsease at that time?
A. Yes.
MR. BATAILLOH: All right. That's all the questions I have.
(At this time, a short break was had.)
CROSS-EYAHIHATIOH
BY MR. DOHIHA:
Q. Dr. Sorensen, I want to return to the last subject that Mr. Batalllon addressed with gou because I thlnk there rag have been sore confusion about hls questlon even after It was restated. Does the ulceration of a mole suggest the presence of retastaslzed relanora?
A. No.
Q. Does the fact of ulceratlon make metastasis more probable?
A. Yes.
MR. DOHIHA: That's all.
REDIRECT EXAMINATION
BY MR. EATAILLOH:
Q. I'm not sure that there is ang confusion about thls question, but I'm going to ask gou a little bit. Uhen I sag rore probablg than not, I rean more likely than not there Is retastasls. Would gou accept that definition when I sag rore probable than not?

MR. DOMINA: Well, now let's —
MR. BATAILLOH: Let re change the questlon, I'll change the whole questlon.
Q. (Bg Mr. Batalllonl If a patlent comes In and we know that the mole has changed enough to advise an excision and now we have ulceration of the mole, all right. based on gour opinion, Is it rore probable than not that there has been retastasls on the date that we see the ulceration?
A. Not to ansuer the question with a questlon. but are gou saging greater than 5# percent?
Q. Right.
A. The odds are?
Q. The odds are.
A. Okag, now I understand completelg ubat gou're getting at. No, I would sag no to that qnestlon.
Q. Whg uould gou sag no to that question?
A. Primarilg because gou're saging that assuming that there's ulceratlon. that rore than half of those patients will have metastatic dlsease at the tire of the clinical diagnosis. There Is no proof to that effect.
Q. Okag. But that oalg assumes half of the qoestlon. Let re go back and ask gnu the qoestlon again and listen.
A. All right.
Q. Yon nave a role that has obvlouslg changed that the physician has advlsed excision and now It Is ulcerated,

Q. My question Is, if gou biopsg the tissue dag one, can gou look at that tissue In gour opinion and sag It's been here for X number of --

A. No. I ansuered that questlon before. No, goo can't.

Q. That's uhat I thouaht.

MR. BATAILLON: All rlaht, I don't have angthing further.

MR. DOMINA: You have a rlaht to read and sign the depositloo or gou can waive that rlaht

ME YITNESS: I'll waive It. That's fine.

(Deposition concluded at 9:45 a.m.)

CERTIFICATE

I, Raelene Petersen, Stenographic Reporter and General Notarg Public, dulg commissioned, qualified, and acting under a general notorial commission ulthln and for the State of Nebraska, do herebg certifg that:

SCOT SORENSEN, M.D.

was bg me first dulg sworn to tell the truth, the whole truth, and nothing but the troth; that the foregoing deposltlon uas taken bg le at the time and place herein specified and In accordance ulth the within stipulations; that I am not counsel, attorneg, or relative of either party or otherwise Interested In the event of tbls suit.

N TESTIMONY WHEREOF, I have hereunto set mg hand officiallg and attached mg notorial seal at Lincoln, Nebraska. thls 11th dag of DECEMBER 1993.

GENERAL NOTARY PUBLIC