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## IN THE DISTRICT COURT OF KNOX COUNTY, NEBRASKA

DONNA J. WIEBELHAUS,

Plaintiff,

vs.

D. J. MAGEGAST, M.D.,

Plaintiff.

Case No. 12018

DEPOSITION OF  
SCOT SORESENSEN, M.D.  
TAKEN ON BEHALF OF  
THE DEFENDANTTaken at Deponent's Medical Office  
1919 South 48th, Lincoln, Nebraska,  
on December 9, 1993, at 8:00 a.m.

## APPEARANCES

For the plaintiff:

MR. DAVID A. DOMINA  
Attorney at Law  
2425 Taylor Avenue  
Norfolk, NE 68702

For the defendant:

MR. JOSEPH F. BATAILLON  
Attorney at Law  
7000 Spring Street  
Omaha, NE 68106

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DOC. 423

## STIPULATIONS

It is stipulated and agreed by and between the parties  
hereto:1. That the deposition of SCOT SORESENSEN, M.D., may be  
taken before Raelene Petersen, Stenographic Reporter and  
General Notary Public, at the time and place set forth on the  
title page hereof.2. That the deposition is taken pursuant to notice  
having been issued upon the deponent.3. That the original deposition will be delivered to Mr.  
Joseph Battalio, attorney for the defendant, and a  
certification of same will be filed with the Clerk of the  
District Court of Knox County, Nebraska, setting forth that  
the deposition was taken and the costs thereof.4. That all objections except as to form and foundation  
are reserved until the time of trial.5. That the testimony may be transcribed outside  
of the presence of the witness.6. That the signature of the deponent to the transcribed  
copy of his deposition is waived.

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WITNESS:

SCOT SORESENSEN, M.D.

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EXHIBITS:

MARKED:

(No exhibits marked)

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SCOT SORESENSEN, 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. BATAILLON:

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

A. Scot Calder Sorensen.

Q. And, doctor, what is your specialty?

A. Medical oncology.

Q. Do you have a curriculum vitae?

A. Yes, I do.

Q. And do you have it with you here this morning?

A. My secretary does.

Q. Can we sign one?

A. Certainly.

Q. Then we can make it part of the record.

A. That's fine.

Q. Where did you receive your oncology training?

A. At the Mayo Clinic.

Q. And how long ago was that?

A. I graduated there in 1983.

Q. Okay. And you're board certified in what?

A. Medical oncology.

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1 Q. All right. Did you review the pathology report  
2 from I think it was the Yankton Clinic with respect to the  
3 other pathology that they developed?  
4 A. The....  
5 p. The cyst.  
6 MR. DOHHA: The initial one? It was from Sioux  
7 Falls, if that helps.  
8 MR. BATAILLON: No, I'm talking about the one that  
9 was done later in 1993.  
10 MR. DOHHA: Okay.  
11 p. (By Mr. Battillon) You're not aware of that  
12 either?  
13 A. I didn't know it.  
14 p. All right. Let's just start over. Maybe it's  
15 easier to do it this way: What records have you reviewed?  
16 A. I have reviewed all of the information that  
17 doctor — that Mr. Dordna gave me probably three months or so  
18 ago with respect to the initial events of the hospitalization  
19 and her pregnancy and some of the material from UMMC as well  
20 as some data from California; and then there was other  
21 materials, I think it was primarily depositions that came  
22 subsequent to that. I have not reviewed that because I was  
23 under the impression that it wasn't useful to be that big of a  
24 deal, so in essence I have tossed all of that.  
25 Q. Are you going to testify with respect to the

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1 A. Yes.  
2 p. And the hospital record from Mrs. Wiebelhaus'  
3 pregnancy?  
4 A. Yes.  
5 p. And portions of the record from the John Wayne  
6 Cancer Institute?  
7 A. Yes.  
8 Q. And as far as medical records, that would — and  
9 the UMMC record?  
10 A. Yes.  
11 Q. And that would be it as far as —  
12 A. That would be about it.  
13 p. Were you aware that she did have a second melanoma  
14 lesion on her back while she was at John Wayne?  
15 A. No.  
16 Q. All right. And you were not aware that she had a  
17 cystic lesion in her chest area in 1993.  
18 A. No.  
19 MR. DOHHA: In '93.  
20 MR. BATAILLON: Right.  
21 MR. DOHHA: Okay.  
22 Q. (By Mr. Battillon) And you were not aware that  
23 she had a brain tumor that was diagnosed in '93?  
24 A. Well, I think it was word of mouth, but I  
25 didn't — never got any documentation.

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1 standard of medical care rendered by Dr. Magenast?  
2 MR. DOHHA: Ask him what he means if you don't  
3 know.  
4 A. What do you — I guess....  
5 Q. (By Mr. Battillon) Are you going to offer any  
6 criticisms about the care that Dr. Magenast rendered to this  
7 patient?  
8 A. Well, I think certainly in some respects the delay  
9 in performing a biopsy is an issue.  
10 Q. All right. Any other criticisms that you're going  
11 to have as far as his care is concerned?  
12 A. Not that I'm aware of based on the information  
13 presented to me.  
14 Q. You've not had an opportunity to review his  
15 deposition, is that correct?  
16 A. I believe it was in that first material.  
17 M. DOHHA: No.  
18 ME WITNESS: It wasn't? Okay.  
19 A. Then I don't — no, I have not reviewed his  
20 deposition.  
21 ME WITNESS: Was that in the second packet?  
22 M. DOHHA: Yes.  
23 A. So I haven't reviewed his deposition.  
24 Q. (By Mr. Battillon) You've had an opportunity,  
25 though, to review his office record?

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1 Q. Didn't see records, all right. Had you been aware  
2 that she had developed bone cancer — bone metastasis also?  
3 A. I knew that there was more extensive involvement  
4 than just localized within the lymph nodes. I knew that there  
5 was liver involvement and got the impression from the records  
6 that indeed it was more extensive. Whether or not there was  
7 definite bone involvement I can't address.  
8 Q. You didn't see --  
9 A. But that doesn't surprise me.  
10 Q. Okay. Do you have — Is there any way to tell  
11 whether or not Mrs. Wiebelhaus was metastatic the day that Dr.  
12 Magenast first examined her in January of 1991 — or '92?  
13 Strike that. I got the dates wrong.  
14 Is there any way that you can say one way or  
15 another whether Mrs. Wiebelhaus was metastatic in July of 1992  
16 when Dr. Magenast was first apprised of her role on her upper  
17 right shoulder?  
18 MR. DOHHA: Objection, for a foundation.  
19 A. Not based on the documentation provided.  
20 Q. (By Mr. Battillon) What would you need?  
21 A. Well, obviously a staging workup would have  
22 included a chest X-ray and some blood work and a more detailed  
23 history and physical examination. Perhaps other scans,  
24 radiographic studies, et cetera, that kind of stuff.  
25 Q. All of this was done in October at the Med Center?

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- 1 A. There is no way to solve that problem.  
 2 Q. Okag. Is it true that Clark's Level 1 melanoma  
 3 can be metastatic?  
 4 A. Yes.  
 5 Q. Clark's Level 2?  
 6 A. Yes.  
 7 Q. Clark's Level 3?  
 8 A. Yes.  
 9 Q. Clark's Level 4?  
 10 A. Yes.  
 11 Q. And Clark's Level 5 by definition is metastatic.  
 12 A. Yell, I -- well, not in the true sense of what  
 13 Clark's is because Clark's is just purely looking at the  
 14 primary tumor; but, yes, all five levels can eventually lead  
 15 to the patient's death.  
 16 Q. To metastatic disease.  
 17 A. And the patient's death, right.  
 18 Q. It's my understanding that at those various  
 19 staging levels, the percentages are more, become more and more  
 20 in favor of the plaintiff -- or in favor of the patient.  
 21 The lower the level --  
 22 A. Exactly. There's a direct relationship between  
 23 the depth of the tumor and subsequent development of  
 24 metastatic disease and their survival.  
 25 Q. That's your understanding for Clark's 1, the

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- 1 adverse prognostic indicator of outcome, okay? Further  
 2 analysis of lymph node negative patients, roughly 588 or so,  
 3 recognized that that is probably too thin, that indeed the  
 4 prognosis doesn't start to, quote, drop off, end quote, until  
 5 the tumor is greater than 1.70 millimeters. And when I say  
 6 'drop off,' I'm talking about anything less than that, a 90  
 7 percent survival rate at five years, greater than 1.7. It drops  
 8 down to about 65 percent, and then obviously anything greater  
 9 than 3.7 or thereabouts it drops off even further then, so  
 10 It's a step-wise regression.  
 11 Q. And the speed at which, with which these tumors  
 12 grow is tremendously variable, isn't it?  
 13 A. Yes.  
 14 Q. You can have tumors that are greater -- strike  
 15 that. You can have tumors that grow at a very slow rate and  
 16 tumors that grow at a very quick rate, is that correct?  
 17 A. Correct.  
 18 Q. And if it's a lifelong tumor, it's really  
 19 impossible to tell how deep it really is.  
 20 A. Define 'lifelong.'  
 21 Q. Yell, if it's a mole that has had -- that has been  
 22 present on the patient for their entire life.  
 23 A. Yell, yeah, I guess that per se doesn't have  
 24 bearing with respect to the prognosis. Again, once the  
 25 melanoma has occurred and the depth of the tumor is, again,

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- 1 survival?  
 2 A. I would say in excess of 90 percent, 95 percent;  
 3 but, again, going down -- I don't, personally I don't follow  
 4 the Clark's level. I think the micrometer from the  
 5 pathologist is the biggest determinant, and that's basically  
 6 measuring the depth of the initial tumor as opposed to Clark's  
 7 level, and that's the so-called Breslow's classification.  
 8 Q. And so you would prefer the Breslow's  
 9 classification.  
 10 A. Right.  
 11 Q. And what are the Breslow classifications? Is that  
 12 one through something, too?  
 13 A. It's basically just measuring the invasion or the  
 14 depth of the tumor, so it's typically measured in millimeters.  
 15 Q. And do you recall what the depth of Mrs.  
 16 Wiebelhaus' tumor was?  
 17 A. Not right offhand, no.  
 18 Q. What's the cutoff between -- or can you give me a  
 19 general idea --  
 20 A. I understand what you're --  
 21 Q. -- of what prognosis we're talking about at  
 22 various sizes?  
 23 A. I understand what you're saying. At this point to  
 24 the -- okay, historically, let's say 15 years ago, it was felt  
 25 that anything over .76 millimeters, 8.76 millimeters was an

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- 1 the most important prognostic variable.  
 2 Q. And as far as Breslow's is concerned, the studies  
 3 would limit -- strike that. The studies as far as thinness  
 4 are limited to patients that do not have lymph node  
 5 involvement, I think you said.  
 6 A. Correct.  
 7 Q. Once the patient has lymph node involvement, it  
 8 doesn't matter how thin --  
 9 A. Correct.  
 10 Q. -- the tumor is, right?  
 11 A. Correct.  
 12 P. You can have lymph node involvement with a tumor  
 13 that is less than 8.76 millimeters, is that correct?  
 14 A. You can, yes.  
 15 P. And the depth of the tumor really isn't going to  
 16 tell you whether or not you have lymph node involvement, is  
 17 that correct?  
 18 A. True, true, at the time of initial diagnosis.  
 19 Q. Right.  
 20 A. Correct.  
 21 Q. You can have a huge tumor and still have no lymph  
 22 node involvement.  
 23 A. Correct.  
 24 Q. Do you know whether they did a brain scan on Mrs.  
 25 Wiebelhaus when she was at the Fred Center?

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1 (Indicating)

2 Q. All right. It's on page 1507 of DeVita's third  
3 edition, is that correct?

4 A. Yes.

5 Q. The sentence says, 'The timing of the biopsy prior  
6 to the first definitive treatment was found to have  
7 significant influence on survival in one series,' which means  
8 In one of several series this variable was felt to be  
9 significant. Is that correct?

10 MR. DOMINA: Objection, argumentative. It may  
11 have been one of one.

12 A. I suspect it's probably one of one.

13 Q. (By Mr. Battillon) So we don't know whether the  
14 series is reproducible.

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

17 Q. And from a scientific standpoint, one series is  
18 not -- does not a standard of care make.

19 A. I think, again, that's argumentative.

20 MR. DOMINA: Sustained.

21 Q. (By Mr. Battillon) You don't know the answer to  
22 that.

23 A. For -- yes, for good clinical medicine, yes, one  
24 series doesn't necessarily make the standard of practice, that  
25 that's the way it should be.

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1 the blood work, the chest X-ray, and the examination is,  
2 quote, negative, then I say, 'Have the surgeon see the patient  
3 for wide excision.' And so, in essence, there's no sense to  
4 delaying, having the patient see the surgeon, and then see the surgeon,  
5 because it really doesn't accomplish anything in the scheme of  
6 things.

7 Q. So how long do you usually see them after the  
8 surgeon completes the wide excision?

9 A. Oh, within a few weeks or so. It depends on  
10 healing and what their location is.

11 Q. And then you would start the chemotherapy if there  
12 was shown to be metastatic disease?

13 A. Well, okay, I would consider them a candidate for  
14 an investigational study. Chemotherapy is not just routinely  
15 administered after having found that there is metastatic  
16 disease because, keep in mind, there sometimes may be two  
17 different procedures performed: One, the wide excision; and  
18 then, depending on the prognostic information available at  
19 that time, specifically the depth of the tumor, then there may  
20 be -- the next procedure might be a lymph node dissection. Do  
21 you see what I mean?

22 Q. Yes.

23 A. So patients aren't necessarily routinely started  
24 on chemotherapy just because they have a melanoma removed and  
25 wide excision, okay? I wanted to clarify what I mean.

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1 Q. I understand. Now, how long do you think it is on  
2 average between the time a physician, a family practitioner or  
3 primary care physician, from the time of biopsy to the time  
4 they get to you for treatment? How long does that usually  
5 take, if you have an estimate?

6 A. Oh, typically within a week or so.

7 Q. All right. Let's back up, let's work this out.  
8 One week, primary biopsy by the primary care physician, right?  
9 How long does it take to get the report back from pathology?

10 A. Two days.

11 Q. Then you have to do a wide excision, right? And  
12 who usually does that?

13 A. The surgeon.

14 Q. How long does it take the primary care physician  
15 to get him referred to a surgeon for a wide excision?

16 A. Oh, I would say a week.

17 Q. And then the primary -- then the surgeon has to  
18 get pathology back and then make a recommendation to send  
19 somebody to the oncologist?

20 A. Well, that varies. I think typically what -- I  
21 guess in the normal scenario how that would run is the primary  
22 care physician would say, 'I just did a biopsy of a melanoma.  
23 What should I do?'

24 I don't need to see the patient at that point in  
25 time. I say -- well, assuming that the blood chemistry, all

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1 Q. When do you usually start the chemotherapy, on  
2 what type of melanoma patients?

3 A. Well, okay.

4 Q. If any at all.

5 A. Well, see, again, that's an issue. Chemotherapy  
6 certainly is not very effective in this disease. I think  
7 chemotherapy has a role in patients who have documented  
8 metastatic involvement, for example, in the liver, the bones,  
9 the lungs, whatever. Its benefit is open to question and is  
10 arguable with respect to it really truly has an impact.

11 It is not routinely administered for patients who  
12 are found to have lymph node involvement and are free of  
13 disease elsewhere, okay? There are clinical studies  
14 evaluating whether or not some form of adjuvant therapy is of  
15 any benefit like it is in breast cancer after a mastectomy,  
16 for example; but those trials at this point in time don't  
17 suggest that treatment beyond lymph node removal, as long as  
18 the patient is free of cancer, has truly an impact on the  
19 patient's outcome, okay?

20 So I would start -- I would consider chemotherapy  
21 in someone who has documented metastatic disease and if they  
22 are a candidate for that and do not want to pursue another  
23 form of investigational therapy, be it immune therapy,  
24 interleukin, those types of things.

25 Q. So you may not consult with a patient at all as

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- 1 percentage basis what the increase in her prognosis would have  
2 been, is that correct?
- 3 A. Correct.
- 4 Q. And you can't say that you're even sure that it  
5 would have made a difference.
- 6 A. I think the evidence is clear that it would make a  
7 difference.
- 8 Q. In what respect?
- 9 A. From the standpoint of the things that we talked  
10 about, earlier diagnosis/better survival. In addition to the  
11 statement that's published in that textbook.
- 12 Q. All right. Is there any way of knowing whether  
13 she had lymph node involvement in July of '92?
- 14 MR. DONINA: Objection, asked and answered.
- 15 A. Again, not to my knowledge was that ever  
16 addressed.
- 17 Q. (By Mr. Battillon) Well, it was subclinical even  
18 in October, was it not? By that I mean from a clinical  
19 analysis.
- 20 A. Correct.
- 21 P. If it was subclinical in October and it was  
22 present in July, it would have still been subclinical, is that  
23 correct?
- 24 A. Yes.
- 25 P. All right. And so unless an excision of the lymph

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- 1 Q. All right.
- 2 A. I think --
- 3 Q. How long --
- 4 MR. DONINA: I don't think he's finished.
- 5 Q. (By Mr. Battillon) Are you finished?
- 6 A. I'm trying to collect my thoughts here because I  
7 understand what you're trying to say, and I... All I am, all  
8 I am saying to you is that I think the two-month issue did  
9 have a significant impact on her outcome, but to quantify that  
10 is impossible.
- 11 Q. All right. That would be a reasonable delay? A  
12 month?
- 13 A. Well, you know, on the part of who? The patient  
14 or the medical system or, you know, the physician? I mean,  
15 that's -- because, understandably, if there's other things  
16 going on on the part of the patient, they may say, 'Gee, I  
17 don't want to do that now because I'm having a wedding,' or,  
18 you know, those types of things.
- 19 Q. Is that okay?
- 20 A. Well, I think certainly it jeopardizes the  
21 outcome. It's not to say that just because there is a  
22 suspicious abnormality that that is imminently  
23 life-threatening, that's not to equate that; but I think that  
24 suspicious abnormality becomes more of a life-threatening  
25 potential if indeed the clinical findings are worrisome.

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- 1 nodes would have been done in July, there's really no way of  
2 knowing whether there was metastatic disease in that lymph  
3 node in July, is that correct?
- 4 A. True.
- 5 Q. And there's really no way to know how long before  
6 July, if it existed in July, that it existed.
- 7 A. True.
- 8 Q. And lymph node involvement is the primary  
9 indicator, notwithstanding the depth of the tumor, as to the  
10 survivability of the patient.
- 11 A. Correct.
- 12 P. So how can you say that it makes any difference in  
13 her outcome?
- 14 A. What you say is true, but the devil's advocate  
15 could come back to you and say, if there was even less  
16 metastatic disease in the lymph nodes at the time of July, for  
17 example, and a node dissection had been performed, that may  
18 have prevented her from seeding to other areas of the body.  
19 May, okay? And I think certainly the issue of the two-month  
20 or two-and-a-half month delay personally, in my own view, I  
21 think is too long for accepted medical practice in a situation  
22 dealing with a very suspicious primary abnormality based on  
23 the evidence that the plaintiff had presented to the  
24 physician, specifically an ulcerated area, those types of  
25 things.

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- 1 A very small role that's been there forever that  
2 has not changed is not something that the physician is going  
3 to be too concerned about as opposed to a larger area that is  
4 now ulcerated and the patient has said that it's changed  
5 within a short period of time. That I think is two different  
6 issues. It would be incumbent upon the physician to be more  
7 meticulous and expeditious in pursuing a workup of that latter  
8 as opposed to the former.
- 9 Q. And how much do you tell the patient?
- 10 A. I would personally say, 'I think I'm more  
11 concerned about this, that this is something that should be  
12 done within the next week, depending on what your schedule  
13 is.'
- 14 Q. Or two weeks.
- 15 A. Two, that's, I mean, yeah, one or two weeks; I  
16 mean, that's arbitrary. I think the issue is how important do  
17 you stress to the patient that this is a worrisome abnormality  
18 that needs to be addressed despite other things that may be  
19 going on in your life, or reassurance and say, 'Well, you  
20 know, I'm not too concerned about it. We can do it whenever  
21 you want to. You decide what your schedule's like.' I think  
22 that's where it's a real decision between the patient and  
23 the physician, but I think it has to be directed by the  
24 clinical appearance and good medical practice on the part of  
25 the physician.

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1 A. Oh, back mole.  
 2 Q. -- "back iole, advise excision."  
 3 A. Okay.  
 4 P. And then we have August 31st, "mole ulcerated,"  
 5 right?  
 6 A. Right.  
 7 P. And then the iole is excised, I believe, on  
 8 9-14-92.  
 9 A. Right.  
 10 P. All right. Do you find that his charting  
 11 generally meets the standard, if you will, of what you see in  
 12 family practitioners in outlying areas?  
 13 A. Yes.  
 14 Q. I want you to assume that the first time he felt  
 15 that the mole should be removed was on August 22nd.  
 16 A. Correct.  
 17 Q. And then there was a delay until September 14th  
 18 before the patient --  
 19 A. Actually had --  
 20 Q. -- actually had the procedure done.  
 21 A. Okay.  
 22 Q. And that obviously he saw it on August 13th and it  
 23 was --  
 24 A. 31.  
 25 Q. -- or 31 and it was ulcerated.

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1 wanted to do it.  
 2 A. And other factors. Obviously she's pregnant and,  
 3 you know, I mean, obviously the pregnancy and her firstborn  
 4 and all that kind of stuff is more of an issue for her than  
 5 anything else.  
 6 Q. Well, if she says to the physician, "I'm going to  
 7 deliver in a week or two. I'd like to wait until after I  
 8 deliver," is the physician supposed to say, "Don't do that."  
 9 A. I would. If there is a clinical, if there is a  
 10 clinical recommendation that this thing needs to be removed  
 11 because I'm concerned that it's malignant, especially in view  
 12 of the ulceration that was documented, at least documented on  
 13 August 31, that that takes precedence over and above the  
 14 pregnancy. That's my opinion.  
 15 Q. Do you --  
 16 A. And that should be done because that isn't that  
 17 big of a procedure. Now, if you told me that she -- that this  
 18 was a gall bladder attack and, you know, that kind of stuff,  
 19 then obviously that's another issue; but, I mean, doing a  
 20 biopsy is an out-patient issue.  
 21 Q. But you can't do it unless the patient lets you do  
 22 it.  
 23 A. Correct.  
 24 Q. And if you tell the patient that it's possibly  
 25 malignant, shouldn't that kind of tell them that maybe you

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1 A. Correct.  
 2 Q. Is that too much of a delay between August 22nd  
 3 and September 14th?  
 4 A. Too much of a delay in her outcome, that may  
 5 have --  
 6 P. Affected her outcome.  
 7 A. -- affected her outcome? I would say possibly. If  
 8 indeed this mole had not ulcerated or was not ulcerated on  
 9 August 22. Now, there's no documentation that it was, but we  
 10 all know that that may or may not have been the case.  
 11 Q. All right.  
 12 A. So, I guess if it indeed had ulcerated in the span  
 13 of eight days or nine days from August 22 to August 31, that  
 14 obviously is a significant issue, okay? So I guess what the  
 15 clinical appearance on August 22 truly is or was has some  
 16 bearing to answer that question.  
 17 P. If the clinical appearance was that there was no  
 18 ulceration on August 22, what difference does it make in your  
 19 opinion?  
 20 A. I would say that the three week or, yeah,  
 21 three-week interval from the time of recommending excision to  
 22 the time of that procedure being done might have had an  
 23 outcome in her -- might have had a different -- it might have  
 24 affected her outcome.  
 25 Q. But that again depends on whether the patient

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1 would like them to have it done?  
 2 A. That's correct.  
 3 Q. If the mole had not ulcerated on August 22nd and  
 4 the patient -- if it was not ulcerated on examination on  
 5 August 22nd and the patient said she wanted to wait until her  
 6 delivery which was expected in a week or two, would it be okay  
 7 in your opinion for the physician to say, "All right, let's  
 8 wait until after you deliver the child."  
 9 A. I would imagine so. Again, what I'm trying to (let  
 10 at is, I think it depends on the clinical suspicion of the  
 11 lesion to make that judgment whether or not excision is  
 12 recommended. Now, he's recommended excision on August 22.  
 13 That I think right there is enough to say he's concerned  
 14 enough about it that it should be done.  
 15 Q. Right.  
 16 A. Or should have been done at some point in time in  
 17 the past if there has truly not been any change in this; but,  
 18 again, there's no documentation one way or another to answer  
 19 that. I think if a physician is willing to document that  
 20 excision is advised based on his clinical judgment, then that  
 21 is something that should be followed through in a relatively  
 22 expeditious fashion over and above any other things that may  
 23 be going on in the patient's life. Now, again, that has to be  
 24 a mutual decision between the patient and the physician.  
 25 Ulceration aside, is what I'm trying to get at.

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1 A. I'd sag three or four.  
 2 Q. Can you tell me in the split whether You've ever  
 3 testified on behalf of the suing part as opposed to the  
 4 physician?  
 5 A. Probably 50/50.  
 6 Q. All right. All cancer cases?  
 7 A. Yes.  
 8 Q. All in Lincoln?  
 9 A. no.  
 10 Q. can you give me an idea of the geographic  
 11 breakdown?  
 12 A. Three of them were out of state -- out of Lincoln,  
 13 and one was in Lincoln.  
 14 Q. And the one in Lincoln, was that for the defendant  
 15 or the plaintiff?  
 16 A. I think that was for the defendant.  
 17 Q. Do you remember anything about that case?  
 18 A. Bog, that was, that was shortly after I came to  
 19 town and so I --  
 20 Q. About in '83 maybe?  
 21 A. Yeah -- no, it was actually '85 or thereabouts.  
 22 Q. What attorney retained you, if you remember?  
 23 A. Bog, I don't even recall.  
 24 Q. Snowden, Kauffman?  
 25 A. It might have been Jim Snowden, but I don't --

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1 was -- one had to do with a failure to diagnose lung cancer  
 2 and, hog, the third one I can't -- I don't even remember.  
 3 Q. All right. And the Case in Lincoln, do you  
 4 remember what the nature of that case was?  
 5 A. That was a failure to diagnose a kidney cancer.  
 6 Q. And both of the cases, the one you did in Lincoln  
 7 and the one you remembered from the Lincoln attorneys, did  
 8 part of that defense revolve around the fact that it wouldn't  
 9 have made any difference as far as outcome is concerned with  
 10 an earlier diagnosis?  
 11 A. Some of them did, some of them, yeah. I don't ....  
 12 Q. That is your rate because I've got to pay it.  
 13 A. A hundred fifty dollars an hour.  
 14 Q. All right. Is that for review as well as for  
 15 testimony?  
 16 A. No, just for the testimony.  
 17 Q. Do you charge for review?  
 18 A. No.  
 19 Q. In this case to date have you made any billing or  
 20 intend to make any billing?  
 21 A. no.  
 22 Q. I asked two questions. Have you made any billing?  
 23 A. No, and I don't intend to make billing for  
 24 anything else prior to this.  
 25 Q. All right. Let me ask you this: If there was a

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1 aallo, don't quote me on that.  
 2 Q. Have you ever worked with Mr. Snowden before?  
 3 A. I believe so.  
 4 Q. How about Mr. Kauffman?  
 5 A. No, I don't recall.  
 6 Q. That's fine. And the cases out-of-state, what time  
 7 period are we talking about?  
 8 A. There was one I think probably almost a year ago,  
 9 and both attorneys were from Lincoln.  
 10 Q. Do you remember who they were?  
 11 A. One was with Cline, Williams, and if you told me  
 12 the name I could tell you.  
 13 Q. Christensen?  
 14 A. No.  
 15 Q. That's okay. But one was from Cline, Williams?  
 16 A. Yes, he was the defendant's attorney.  
 17 P. And you were testifying for?  
 18 A. On the part of the defendant.  
 19 Q. And what kind of case was it?  
 20 A. That was a, quote, failure to diagnose colon  
 21 cancer.  
 22 Q. All right. And then you have had two others, if  
 23 you can halfway give me an idea, if you can remember.  
 24 A. I don't remember the attorneys and I don't even  
 25 recall such specifics about the cases themselves other than it

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1 lesion on her back that was found after the lesion that we see  
 2 on her right shoulder and that lesion is melanoma, it's a  
 3 malignant melanoma and it's of the same variety as the one  
 4 that was found on her right shoulder, is there really any way  
 5 that you can say which is the primary and which is the  
 6 secondary?  
 7 A. Depends on when the timing of that second lesion  
 8 appeared. In other words, if it appeared after the lymph  
 9 nodes were documented to be proven, then obviously it's  
 10 probably an incidental malignancy and not the primary site.  
 11 Do you see what I'm saying?  
 12 Q. Yeah, how can you say that?  
 13 A. Yeah, okay, I guess also it would also hinge on  
 14 the anatomic location of the, quote, lesion on her back. I  
 15 mean, if it was on the other shoulder or the other flank, then  
 16 that's not, I mean, that's not going to be the primary site of  
 17 her lymph node involvement; but, again, I think whether or not  
 18 it's the primary site responsible for the subsequent hepatic  
 19 involvement and bone and all the things that she died of I  
 20 think is an argumentative issue.  
 21 Q. You can't tell, can you?  
 22 A. You can't tell. I mean, that's going to hinge on  
 23 depth and a guess.  
 24 Q. And a guess. If that lesion in the lower back is  
 25 malignant and even if it's at Clark's Level 1, it can still be

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1 prognosis Is worse for ulcerated lesions.  
 2 Q. How much worse?  
 3 A. I'd have to -- I don't know right offhand. I'd  
 4 have to review that, but there is no question that ulceration  
 5 is an adverse prognostic Indicator, just like tumor depth,  
 6 just like a variety of other prognostic indicators. So I  
 7 think the tire frame of nine days of, quote, assuming there's  
 8 no ulceration to the time that there was ulceration documented  
 9 I think certainly Is an Issue.  
 10 Q. But my question is, at the time of ulceration, is  
 11 it more likely than not that there's already metastatic  
 12 disease?  
 13 MR. DOHHA: Objection, asked and answered.  
 14 Q. (By Mr. Battillon) You can answer that.  
 15 A. It increases the likelihood that there is  
 16 metastatic disease at that time.  
 17 Q. The question is, is it more likely than not that  
 18 there's metastatic disease when it is ulcerated?  
 19 MR. DOHHA: Objection, asked and answered. The  
 20 witness has answered the question.  
 21 MR. EATAILLOH: No, he hasn't.  
 22 MR. DOMINA: Yes, he has. He said it's more  
 23 likely than not.  
 24 M. BATAILLOH: No, no, no, he didn't say that.  
 25 He said it's increased, but I want to know whether it's more

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1 she has metastatic disease at that time?  
 2 A. Yes.  
 3 MR. BATAILLOH: All right. That's all the  
 4 questions I have.  
 5 (At this time, a short break  
 6 was had.)  
 7 CROSS-EXAMINATION  
 8 BY MR. DOHHA:  
 9 Q. Dr. Sorensen, I want to return to the last subject  
 10 that Mr. Battillon addressed with you because I think there  
 11 may have been some confusion about his question even after it  
 12 was restated. Does the ulceration of a mole suggest the  
 13 presence of metastasized melanoma?  
 14 A. No.  
 15 Q. Does the fact of ulceration make metastasis more  
 16 probable?  
 17 A. Yes.  
 18 MR. DOHHA: That's all.  
 19 REDIRECT EXAMINATION  
 20 BY MR. EATAILLOH:  
 21 Q. I'm not sure that there is any confusion about  
 22 this question, but I'm going to ask you a little bit. When I  
 23 say more probable than not, I mean more likely than not there  
 24 is metastasis. Would you accept that definition when I say  
 25 more probable than not?

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1 likely than not when it's ulcerated that there's already  
 2 metastatic disease.  
 3 MR. DOHHA: He's inferred that's a guess case by  
 4 case. That's the best you're going to get. You're arguing  
 5 with him now.  
 6 M. EATAILLOH: I'd like his answer.  
 7 MR. DOMINA: I'd like you to refrain from  
 8 argument.  
 9 M. EATAILLOH: I'd like his answer.  
 10 A. Could you rephrase the question for me, please?  
 11 Q. (By Mr. Battillon) The question is, at the time  
 12 of ulceration in Mrs. Wiebelhaus, is it more likely than not  
 13 that she has metastatic disease at that time?  
 14 A. Yes.  
 15 Q. All right.  
 16 MR. EATAILLOH: I don't have any further  
 17 questions, doctor. Thank you very much. If I can just look  
 18 at your book for a minute.  
 19 MR. DOMINA: More likely than not or more likely  
 20 than otherwise? More likely than without ulceration?  
 21 ME WITNESS: Well, I assure that's what he meant,  
 22 more likely than without ulceration. I guess I'm --  
 23 Q. (By Mr. Battillon) Oh, no, no. The question is  
 24 very simple. The question is, if she presents with an  
 25 ulcerated lesion on day one, is it more likely than not that

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1 MR. DOMINA: Well, now let's --  
 2 MR. BATAILLOH: Let me change the question, I'll  
 3 change the whole question.  
 4 Q. (By Mr. Battillon) If a patient comes in and we  
 5 know that the mole has changed enough to advise an excision  
 6 and now we have ulceration of the mole, all right. based on  
 7 your opinion, is it more probable than not that there has been  
 8 metastasis on the date that we see the ulceration?  
 9 A. Not to answer the question with a question. but  
 10 are you saying greater than 50 percent?  
 11 Q. Right.  
 12 A. The odds are?  
 13 Q. The odds are.  
 14 A. Okay, now I understand completely what you're  
 15 getting at. No, I would say no to that question.  
 16 Q. Why would you say no to that question?  
 17 A. Primarily because you're saying that assuming that  
 18 there's ulceration, that more than half of those patients will  
 19 have metastatic disease at the time of the clinical diagnosis.  
 20 There is no proof to that effect.  
 21 Q. Okay. But that only assumes half of the question.  
 22 Let me go back and ask you the question again and listen.  
 23 A. All right.  
 24 Q. You have a mole that has obviously changed that  
 25 the physician has advised excision and now it is ulcerated,

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1 Q. My question is, if you biopsy the tissue day one,  
2 can you look at that tissue in your opinion and say it's been  
3 here for X number of --

4 A. No. I answered that question before. No, you  
5 can't.

6 Q. That's what I thought.

7 MR. BATAILLON: All right, I don't have anything  
8 further.

9 MR. DOMINA: You have a right to read and sign the  
10 deposition or you can waive that right.

11 ME YITNESS: I'll waive it. That's fine.

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

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## 1 CERTIFICATE

2 I, Raelene Petersen, Stenographic Reporter and  
3 General Notary Public, duly commissioned, qualified, and  
4 acting under a general notarial commission within and  
5 for the State of Nebraska, do hereby certify that:

6 SCOT SORENSEN, M.D.  
7 was by me first duly sworn to tell the truth, the whole  
8 truth, and nothing but the truth; that the foregoing  
9 deposition was taken by me at the time and place herein  
10 specified and in accordance with the within stipulations;  
11 that I am not counsel, attorney, or relative of either  
12 party or otherwise interested in the event of this suit.

13 IN TESTIMONY WHEREOF, I have hereunto set my hand  
14 officially and attached my notarial seal at Lincoln,  
15 Nebraska, this 11th day of DECEMBER 1993.

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