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IN THE CIRCUIT COURT OF THE FIFTEENTH JUDICIAL CIRCUIT
IN AND FOR PALM BEACH COUNTY, FLORIDA
CIVIL DIVISION

- x
DAVID COHEN, as Personal Representative
of the ESTATE OF HELEN COHEN,
Plaintiff, Case No.
v. 50-2009-CA-0040042-MB-AI
R.J. REYNOLDS TOBACCO COMPANY, et al.,
Defendants.
- x

DEPOSITION of GARY M. STRAUSS, M.D. called as a witness by and on behalf of the Defendant, R.J. Reynolds Tobacco Company, pursuant to the Florida Rules of Civil Procedure, before Michael D. O'Connor, Registered Professional Reporter, and Notary Public in and for the Commonwealth of Massachusetts, at G&M Court Reporters, 42 Chauncy Street, Boston, Massachusetts, on Wednesday, November 14, 2012, commencing at 9:12 a.m.

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P R O C E E D I N G S

GARY M. STRAUSS, M.D.

having been satisfactorily identified by the production of his driver's license, and duly sworn by the Notary Public, was examined and testified as follows:

MR. DAVIS: This will be the deposition of Dr. Gary Strauss taken in the matter of David Cohen versus R.J. Reynolds Tobacco Company, et al. pending in the Circuit Court in Palm Beach County. This deposition is being taken pursuant to the Florida Rules of Civil Procedure.

DIRECT EXAMINATION

BY MR. DAVIS:

Q. Good morning, Dr. Strauss.

A. Good morning.

Q. We introduced ourselves shortly before the deposition started. My name is Todd Davis. I represent R.J. Reynolds Tobacco Company. I'm here to take your deposition in the case today. Do you understand that?

A. I do.

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Q. Now, you are Dr. Gary Strauss; is that right?

A. I am.

Q. Dr. Strauss, you've had an opportunity to make introductions with the other lawyers. They may have some questions for you as well. If at any time you don't understand one of our questions, will you let us know?

A. I will.
Q. If you answer our questions, we will assume that you understood the question and you answered the question that was asked. Is that acceptable to you?
A. That is acceptable.
MS. LUTHER: Could I just interrupt. I don't know if we told him somebody is on the phone.
MR. DAVIS: Yes.
A. I'm sorry, I didn't hear that, but that's fine.
MR. DAVIS: I don't know whether anyone else wants to make their appearances before we start. Okay. We'll keep going then.
Q. Dr. Strauss, you've given depositions before?
A. I have.

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Q. You understand that your deposition testimony today is taken under oath?
A. I do.
Q. You understand the same oath is administered as if you were in a court of law?
A. I do understand that.
Q. You understand you're here to give us your best testimony?
A. I understand that.
Q. You will do your best to do that today?
A. I will.
Q. Now, doctor, I see that you've brought with you some materials here to the deposition. Can you describe for us what you have in front of you?
A. I believe everything on the right side here are depositions. What's in this green folder are really the medical records that I had reviewed for the case. Here is my curriculum vitae. I did bring a list of trial testimony and depositions since 1997. I have the requests for the deposition. I have here the notes that I took on the case, and I was asked to bring any bills that I had sent.
Q. That's a very good description, and I'm going to ask you some more questions about what you've brought. But is there anything else that

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comprises your file on the case involving Helen Cohen that you have not brought to the deposition?
MR. GDANSKI: Object to the form.
A. No.
Q. So this is a complete set of materials on Helen Cohen that you've reviewed for this case?
A. Yes.
Q. Do you have in the stack of materials any radiology films that you've reviewed?
MR. GDANSKI: I'm going to object. Films

or CTs? I'm going to object to the form. Are you talking about the actual physical films?
Q. Do you understand my question, doctor?
A. I did.
Q. Can you tell me the answer to that?
A. I didn't look at any films. That doesn't mean I didn't look at any images.
Q. Thank you for that clarification. Did you look at radiographic images of Helen Cohen?
A. I did. In my own hospital I know exactly how to do it. When you get outside images, sometimes they are very difficult to sort of get to the point where you can review them easily, and that was the case here. So I did look at them somewhat, but it wasn't ideal, but it was by myself, and I'm

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not a radiologist.
Q. For the images that you looked at, are all of those images on a CD disk that you brought here to the deposition?
A. There are a bunch of CD disks. I did bring everything that I have.
Q. Can you show me where they are?
A. I just received this Monday and looked at two of them briefly. Then these two additional CDs -- okay, so this one is the one that I tried my best to look at. It's very computer sensitive. So this has the CT. Then this disk I was given by Mr. Gdanski yesterday when we met which includes all the medical records, which I, you know, looked at the CD.
Q. Let me see if I understand what you told me. There's a CD that you brought that has the name of "Helen Cohen" on it and also has in handwriting "CT Scan 3/3/06"?
A. Correct.
Q. That contains the CT scan of Helen Cohen taken on March 3, 2006?
A. I believe it does, yes.
Q. Does it contain any other images?
A. I don't believe so, but that was what I

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tried to look at.
Q. When did you first review this?
A. I got it -- it came in a package with some of the depositions, which probably came -- the first ones came maybe three or four weeks ago, something like that.
Q. Now, the other disk that you brought, it has handwriting on it that says "Cohen Med Rec"?
A. Correct.
Q. Which stands for Cohen medical records?
A. I assume so, yes.
Q. On that disk, is there any imaging or

radiographic film imaging on it?
A. I'm not 100 percent positive.
Q. If there is, is it fair to say you didn't review it before your deposition here today?
A. That is correct, I did not review any images on that disk.
Q. Other than the radiographic images that are on the CD that is entitled "Helen Cohen CT Scan 3/3/06," did you review any other radiographic images of Helen Cohen?
MR. GDANSKI: Object to form.
A. I was at a meeting in Florida, and I got home and went to work. So I got home about nine

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o'clock Monday, and this was waiting for me. So I put a few in my computer, not very successful, and actually really -- I think the first one actually had some ultrasounds that I can't even read, even if I had a good computer. Then I put two in there, and there was nothing productive that came out of that.
Q. So when you say you reviewed this, what you're pointing to is there's a white envelope or packet that you brought to the deposition; is that right?
A. Yes. I think there are ten or 11 CDs, and this was the piece of paper that accompanied it.
Q. Okay. So let's count them. We're talking about the CDs that have the imaging in the white envelope that you received on Monday?
A. Yes.
Q. If you could wait until I finish asking, and I will do the same with you. That way the court reporter doesn't string us both up. Okay?
A. I apologize.
Q. That's okay. Now, the CDs that you received on Monday that you were not able to look at because of the images were not accessible to you, those CDs, there's 14 of those?
A. Yes.

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Q. Also in the white envelope was a one-page document transmittal to you from Mr. Gdanski who represents the Plaintiff?
A. Yes.
Q. Let me do some housekeeping real quick and I'm going to mark all of these for future reference so we can talk about them during the deposition.
You understand you have been identified as an expert witness on behalf of the Plaintiff in the Helen Cohen case?
A. I do.
Q. You understand we're here to question you about the opinions that you will offer at trial of this case?

A. I do.
Q. You are prepared to offer and discuss the opinions you will give at trial in this case?
A. I am.
(Document marked as Exhibit 1 for identification)
Q. Let me hand you what's been marked as Exhibit 1 to your deposition, Dr. Strauss. Do you see that that is a supplemental expert witness disclosure made by the Plaintiff in this case, which identifies you as an expert?

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A. Yes.
Q. Have you seen this document before today?
A. I believe I have. I saw it yesterday. This would seem to be the set -- oh, just a copy.
Q. You have in one of your manila folders you brought to the deposition is the same document that's been marked as Exhibit 1?
A. Yes.
Q. Now --
MR. GDANSKI: Doctor, I know it's not a normal way of talking, and I apologize, but you've got to try a little better to wait for him to finish so that you know exactly what question he's actually going to ask and so that the court reporter can take it down.
I'm more concerned just so you know what question is going to be asked by counsel so that you know what you're actually responding to at the end of the question. So you've got to sit tight and answer the question when he's done answering it.
Q. Mr. Gdanski is right. I'm a little slow when I get my questions out, so you may want to wait until it's all over before you answer. All right?
A. Yes.
Q. Now, the first time that you saw the expert

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disclosure that's been marked as Exhibit 1 was yesterday?
A. Yes.
Q. So this was served in June of 2001. You had not seen it before it was served on defense counsel?
A. I did not see it.
Q. If you look at the subject matter that's identified for you, Dr. Strauss, do you see that the subject matters identified for you, in terms of what opinions you will offer at trial, concern oncology and epidemiology?
A. Yes.
Q. Those are the subject matters you intend to address at trial?
MR. GDANSKI: Object to the form.

A. Yes.
Q. Now, it says that "Dr. Strauss will testify as to the contents of decedent's medical records, lung cancer, and any other smoking-related and caused illnesses. Dr. Strauss will opine that the decedent had and died from primary lung cancer which was caused by smoking cigarettes."
Do you see that?
A. Yes, I do see it.

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Q. Is that a fair representation of the opinions you plan to offer at the trial of this case?
A. Yes.
Q. Now, is it fair to say other than oncology and epidemiology, there aren't any other subject matters that are identified for you in this expert disclosure?
MR. GDANSKI: Object to the form.
A. I believe that is correct.
Q. So in terms of other issues, such as addiction, you are not going to offer opinions at trial about addiction with respect to Helen Cohen; is that fair?
A. That is fair.
Q. And you're not planning on offering any opinions at the trial of this case, and have not been asked to offer any opinions at the trial of this case, in terms of the design of any tobacco companies' cigarettes; is that fair?
A. We didn't talk about it, but I don't think so.
Q. Those subject matters are also not identified in your expert disclosure; is that true?
A. Yes.

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Q. So is it fair to say you have been not asked to and will not opine on those subject matters at trial?
A. I believe it is fair to assert that.
Q. With respect to the phrase in your disclosure that says "any other smoking-related and caused illnesses," do you know what that refers to?
A. Yes.
Q. What does that refer to?
A. Chronic obstructive pulmonary disease, COPD, emphysema, bronchitis; Predominately that. I believe she also had some coronary artery disease. She had a stroke.
Q. Do you plan to offer any opinions about COPD, coronary artery disease or stroke at trial? Let's start there first.
A. Depends whether I'm asked.
Q. Have you been asked by Plaintiff's counsel

to offer any opinions at trial concerning those subject matters?
MR. GDANSKI: Object to form.
A. We talked about COPD, and she certainly had COPD and she was debilitated by COPD, but she died of lung cancer.
Q. So is it fair to say you will not offer an

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opinion at trial that Helen Cohen passed away because of COPD?
A. That is correct.
Q. Do you believe that she had any other disease or disease process, other than primary lung cancer, which caused or contributed to her death?
A. No.
Q. With respect to today's deposition we served -- Defendants served on Plaintiff's counsel a Notice of Taking Deposition Duces Tecum. That's been marked as Exhibit 2 to your deposition. Have you seen Exhibit 2 before today, doctor?
(Document marked as Exhibit 2 for identification)
MR. GDANSKI: You have a lot of paper here.
A. Yes.
MR. GDANSKI: We'll put this over here.
Q. So you had a copy of that in the file that you brought here today?
A. Correct. I received it yesterday.
Q. Did you go through the document request that was attached to the Notice of Deposition to identify responsive documents and bring them here to your deposition?
A. I did, yes.

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Q. Now, I think we've already covered -- if we can go through that real quickly, Dr. Strauss -- we've already covered Item 1 on Schedule A, I believe, where you told us you brought your entire file concerning Helen Cohen to the deposition; is that right?
A. Yes.
Q. So on Item 2, is it fair to say that you also brought your entire file on Helen Cohen that's responsive to Item 2 here to the deposition?
A. Let me just reread it.
MR. GDANSKI: Object to the form.
A. Yes.
Q. Have you prepared any summary of Helen Cohen's case for any reason?
MR. GDANSKI: Object to the form.
A. I did not prepare a report. I did prepare notes that I took as I was reviewing the records, which I had a moment ago. These are my notes.
Q. May I see them?

A. Yes.
Q. Is it all right with you, Dr. Strauss, if I put an exhibit sticker on this one?
A. That would be fine, although I may need to refer to it.

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Q. That's okay. We'll get a copy of it. I'm going to put Exhibit 3 on your typed notes that are dated November 13, 2012, concerning the Helen Cohen case; is that fair?
A. That's correct.
Q. This was typed notes that you made as you went through and reviewed the medical records, radiographic images and other information that you reviewed about Helen Cohen?
A. Correct.
(Document marked as Exhibit 3 for identification)
Q. When did you prepare this?
A. I have one document that's ongoing. I believe the first time that I got records -- we spoke in June -- was July 21st. I can't remember whether I might have done it based upon a few conversations. I actually might very well have. So I might have started in June. Any time I update it, I just save it with today's date on the top.
Q. When do you believe the first time is you were contacted about the Helen Cohen case?
A. I don't specifically remember. I start keeping records when I'm reviewing something that I might theoretically bill for, and the first time I

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did that was July 21st. Another thing you asked me to bring was these records, and that has that spreadsheet.
Q. July 21, 2012 is when you first received materials on the Helen Cohen case?
MR. GDANSKI: Object to form.
A. It doesn't mean I came that day, but that's the first day I opened it and started reviewing it.
Q. Do you have any independent recollection at all of having discussed the Helen Cohen case with anyone, including Plaintiff's counsel, before June of 2012?
MR. GDANSKI: Object to the form.
A. I don't remember when the phone call came. Taylor McParland, I'm not sure if I pronounced her name, but she's either a parallel or nurse who works with Jonathan. She contacted me. She asked if I would be willing to look at the case. She gave me a thumbnail, and I don't have the date, but it was probably in June. I don't know for a fact.
Q. Of 2012?
A. Yes. It wasn't a long time ago.

Q. What thumbnail did she give you about the Helen Cohen case?
A. Actually, on my notes I actually have her

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name and date of birth, and that's probably my review of the records, and there's a few notes above that. I don't specifically recall this, but I suspect those are the notes that I took from the telephone conversation.
Q. You're referring to what's typed up on Exhibit 3 that's under the heading "Taylor McParland and Attorney Jonathan Gdanski"?
A. Yes.
Q. So those are the two sections you believe provided the thumbnail from Taylor McParland -- those two sections comprise the notes that you took from the thumbnail of information that the paralegal at Mr. Gdanski's office provided you?
A. I don't have a specific recollection. Usually when somebody calls me and I'm going to get involved, I would probably open up a file, took her name, phone number. I had not spoken to Jonathan at that point in time. I don't specifically remember that, but my suspicion is, looking for his notes now, that those notes predated actually getting the records.
Q. Now, you also have a letter?
A. It's a bill.
Q. Did you bring with you here today, Dr.

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Strauss, any correspondence that you've had with Plaintiff's counsel?
A. I have not had any except for that and everything like the correspondence I got when I got these disks was this one piece of paper, and I think there might be another comparable piece of paper. But there's no correspondence, written correspondence, that has any substantial information in it.
Q. Do you have with you the transmittal letter sent from Plaintiff's counsel's office that delivered the medical records to you for the first time?
A. I don't know. I don't think I threw anything away. I don't remember whether I had or not. As I went through this last night, I probably would have put it in the front. Actually, this is not dated, and I'm not sure if it came with the medical records.
MR. DAVIS: I'm going to mark as Exhibit 4 this document transmittal sheet that you found within your stack of medical records; is that right?
A. Yes.
MR. DAVIS: That's going to be Exhibit 4.

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(Document marked as Exhibit 4
for identification)
Q. I'm going to mark as Exhibit 5 to your deposition the August 6, 2012 letter from you to Taylor McParland at the Schlesinger law offices which outlines and attaches your invoices; is that right?
A. Correct. The letter is the invoice and the attachment is just the spreadsheet.
Q. All right.
(Document marked as Exhibit 5
for identification)
Q. Can you tell us how much time you spent looking at the materials on the Helen Cohen case in order to render the opinions you offered at trial?
A. It was about, including meeting yesterday and just reviewing everything one more time in preparation for today, I think I've actually spent about 16 hours.
Q. How long did the thumbnail phone call with the paralegal at Mr. Gdanski's office last when you were first contacted?
MR. GDANSKI: Object to the form.
A. I don't recall specifically. I suspect 15 to 20 minutes.
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Q. Were there subsequent phone conversations with the paralegal Taylor McParland or anyone else at Mr. Gdanski's office about the Helen Cohen case?
MR. GDANSKI: Object to the form.
A. I think I might have noted that, and probably did. Not many. I talked to Taylor on July 30th.
Q. Of this year?
A. Yes. Everything is this year. Taylor called me on October 16th, indicating that she was starting to send out a bunch of depositions. Those were the treating physicians, and that we were going to tentatively set up this deposition.
I spoke to Jonathan on 10/24. My recollection is that's the first time I spoke to him. That was a scheduled conference call.
Q. Jonathan is Mr. Jonathan Gdanski?
A. Correct, Mr. Gdanski. We spoke very briefly once or twice last week about the depositions, and we spoke yesterday.
Q. What was the scheduled conference call about?
A. Just that we had never really discussed my opinion in any detail.
Q. How long did that conference call last?
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A. I don't specifically recall, but it was probably 45 minutes.
Q. Do you remember anything that Mr. Gdanski or some other person from his law firm said about the case during that conference call?
A. I believe there was --
MR. GDANSKI: Object to the form.
A. -- somebody else there. I didn't get the name. Nothing specific. I took notes on that, and I can review the notes, but I don't specifically recall anything. We were talking about the case.
Q. Other than that conference call, can you remind me again were there any other phone conversations with anyone at the Schlesinger law firm?
MR. GDANSKI: Object to the form.
A. I do remember.
Q. When did that happen?
A. Thursday or Friday.
Q. What was that about?
A. Actually, that was with Taylor, and I wanted to speak with Jonathan. I got the depositions of Mr. David Cohen, her husband's deposition. It was the longest deposition I had ever seen, 846 pages. I started reading it last

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Thursday.
I wanted to find out some very specific information about Mrs. Cohen's smoking, what she smoked, when she started, and I referred back to some specific pages that are noted in the deposition -- I'm sorry, that are noted in my notes about that.
Q. Can you point me to where that's reflected in your notes that are marked as Exhibit 3?
A. Page 5, right there.
Q. I see. So did you read the entire deposition of David Cohen?
MR. GDANSKI: Object to form.
A. You have to define "read." I looked at the depositions. It's interesting to read about family things, and sometimes I get interested in that, but I skimmed it and tried to sort of pick out important parts.
Q. Now, what information did you ask --
A. My wife is a reading teacher, and she would be offended if I said I read it.
Q. The pages relating to the smoking --
MR. GDANSKI: Object to the form. You can finish, but you may have misspoke.
MR. DAVIS: I'm reading right from the document.

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Q. It says here "Pages related to his smoking," and it identifies three sections in Mr.

Cohen's deposition?
A. Yes.
Q. When you say "his," that meant her, right?
A. That's correct.
Q. You meant Helen Cohen, right?
A. Yes, I did.
Q. So did you ask Mr. Gdanski's office to direct you to these pages that had this information?
A. I did request that.
Q. Did you read any other parts of David Cohen's deposition, other than these three sections that are identified on Page 5 of Exhibit 3?
A. I did.
Q. So if you had to estimate what portion of David Cohen's deposition you actually read, what would it be?
MR. GDANSKI: Object to the form.
A. I picked up each of the parts. I quickly leafed through it to see if there's anything that struck me. It's very hard to do. I perhaps spent an hour and a half totally on that deposition. If I read it, it would take three days.
Q. Did you ask Mr. Gdanski's office to direct

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you to any other part of David Cohen's deposition testimony?
A. No.
Q. What were you looking for when you were asking to be directed to certain pages of David Cohen's deposition testimony about Helen Cohen?
A. Well, you know, I'm sort of curious to know in as much detail as possible exactly what her smoking history was, what she started, how much she started with, how much she smoked when she started, when she was smoking a lot, what she smoked. It's sort of an interest of mine.
My fellows get tired of me when I'm talking to a lung cancer patient, did you smoke, yes, and then I will spend a 15 to 20 minutes getting to the smoking history.
Q. After looking at the medical records on Helen Cohen, do you agree that she stopped smoking sometime in 1990?
MR. GDANSKI: Object to form.
A. I have no reason to disagree. I don't know that independently.
Q. Do you know of any other evidence that suggests that she did not stop smoking sometime in 1990?

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A. No.
Q. Let's see if we can go back to our Schedule A so he can round this out.
MR. GDANSKI: You're not making much

progress.
Q. Other than what we've marked as Exhibit 3 to your deposition, which is your typed notes, have you written any other summary, review or overview, of the Helen Cohen case?
A. No.
Q. Looking at Item 4 on Schedule A of the deposition notice, have you brought with you today any list of scientific or scholarly publications that you reviewed or relied upon in forming your opinions in this case?
A. No, because I reviewed a tremendous amount, written a tremendous amount. I've written reports, but I didn't read any of the specific articles in forming an opinion on this case.
Q. Did you bring any scientific articles with you here to the deposition?
A. No.
Q. Item 5 asks for all other documents, literature, deposition transcripts and/or data you reviewed or relied upon to form your opinions in

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this case. Have you brought all of that information with you here to the deposition?
A. Yes.
Q. You have brought with you a stack of depositions?
A. Yes.
Q. Can I see those? As you're handing them to me, can you tell me whether or not you made any handwritten notes or notations on any of them?
A. When I read something -- well, the ones I read first I read in a little more detail. This is usually the way I mark it, and actually I did. Sometimes I will actually circle that.
Q. So just going through this quickly --
A. No particular order, by the way.
Q. -- we've got Volumes 1 through 4 of David Cohen's deposition in here?
A. Yes.
Q. We have the deposition of Edward Cohen; is that right?
A. Yes.
Q. Did you read that?
A. Yes, I glanced through it. I looked at it.
Q. Did you read it or skim it?
A. I skimmed it.

0036

Q. We have Volume 2 of Edward Cohen's deposition, and that would be true for that volume as well?
MR. GDANSKI: Object to the form.
A. Yes.
Q. The same for Volume 3 of Edward Cohen's

deposition?
MR. GDANSKI: Object to the form.
A. Yes.
Q. We have Volume 5 of David Cohen's deposition, Volume 6 of David Cohen's deposition, Volume 7 of David Cohen's deposition.
A. He's a very prolific author.
Q. You also have two volumes of Dr. Jacobson's deposition in here?
A. Yes.
Q. Did you read all of that deposition?
A. I think I got the first volume of Dr. Jacobson's deposition when I got the first set of depositions, and then I got the second volume when I got the second. That looks like the first deposition I read.
Q. Did you read Volume 2 of Dr. Jacobson's deposition?
A. I skimmed that one, too.

0037

Q. Did you read the deposition of Dr. Wasserman or did you skim it?
A. Probably skimmed it. I didn't take any notes.
Q. You have in here the deposition of Dr. Robert Dudley?
A. Yes.
Q. Did you read that deposition or did you skim it?
A. I'm not sure if this is responsive. My notes of the deposition, probably somewhere in between. I have "300 pages. Nothing useful said." That was my subjective opinion.
Q. All right. Now, you have in here the deposition of Dr. Alexandra Santini. Did you read that deposition or did you skim it?
A. Skimmed it.
Q. You have in here the deposition of Dr. Deborah Baum. Did you read that or skim it?
A. That was actually the second one. I read it. So I guess I read that, because there are some notes on it.
Q. You've put some red flags on this deposition?
A. Yes. That's the way I look at medical

0038

records or depositions.
Q. And you've put some other flags on these other depositions in here, right?
A. Yes. I compete with my grandson who loves those little stickers.
MR. DAVIS: I will put these aside and make a decision about whether I'm going to mark it or not.

Q. Now, you also have a green folder that you brought with you to the deposition that contains Helen Cohen's medical records?
A. Yes.
Q. Did you make handwritten notes on any of her records?
A. Probably not, just because I marked what I wanted to be able to find easily, and my typed notes were -- my handwriting is not very good.
Q. Did you flag any of those medical records?
A. I certainly did.
Q. Okay. Is it all right with you if I mark that entire folder?
A. That's fine, yes.
Q. We're going to mark that as Exhibit 6.
(Document marked as Exhibit 6 for identification)

0039

Q. With respect to the medical records that you received from Plaintiff's counsel, who made the decision about what records to send you or not to send you?
MR. GDANSKI: Object to the form.
A. I assume Mr. Gdanski, but I don't know that for a fact.
Q. Did you ask for all the medical records and radiology images on Helen Cohen?
A. I did not.
Q. Why did you not ask for all the medical records?
A. It looks like a woman who was 81, 82, had a huge number of medical problems, and I was interested -- I wasn't being asked to comment about her normal pressure hydrocephalus or stroke, hypertension or diabetes. I was interested in her lung cancer and what killed her. So I actually think I probably specifically asked to be given focused records, records that would be useful to me.
Q. What huge medical problems did Helen Cohen have?
MR. GDANSKI: Object to the form.
A. Well, I think, frankly, in my notes, which I mostly got from the last hospital admission, and

0040

some others as well, the past medical history included, I think, 22 things.
So she had asthmatic bronchitis, she had chronic obstructive pulmonary disease, she had emphysema, she had hypothyroidism, she had a fibroid tumor of the uterus, she had a hiatal hernia, she had reflux esophagitis, she had GERD, a gastrointestinal reflux disease, she had a penicillin allergy, she had had a cholecystectomy, she had carpal tunnel syndrome, she had had

hyperparathyroidism and hypercalcemia, she had osteoporosis, she had status post hospitalization for a transischemic attack, possible early dementia, a recent hospitalization at DMC, is Delray Medical Center, for staph sepsis. What's missing is recent history of pneumonia and the normal pressure hydrocephalus. She had a lot of medical problems.

Q. I understand your testimony that Helen Cohen had cancer. So if we set that aside, she did not have cancer, how would these huge medical problems that you've identified affect her life expectancy?

MR. GDANSKI: Object to the form of the question.

A. Assuming she didn't have cancer?

0041

Q. Yes, sir.

A. It depends on severity. This list doesn't make an indication of severity, but I knew she had severe -- well, she had had what was felt to be severe COPD, and was oxygen dependent for a period of time. So that's certainly a disease that would likely have shortened her lifespan somewhat. But again, I don't have a clear handle on the severity of that.

Many of the others, you know, she was 81 years old. She wasn't going to live forever. I can't answer that question.

Q. Is it fair to say you have not formed any opinions about how each of these individual huge medical problems that you've identified either individually or collectively would have impacted Helen Cohen's lifespan?

A. That's correct. Certainly you see lots of patients who may have a list of 20 problems and who are really pretty healthy, and other patients who have one medical problem and are done.

Q. If you took out cancer and you took out COPD, would you agree that Helen Cohen would still have a list of huge medical problems that would have affected her life?

0042

MR. GDANSKI: Object to the form. Improper hypothetical.

A. No. I'm not disagreeing, but I haven't looked into them with any degree of forming opinions.

Q. I understand. So you can't say one way or the other to answer that question?

A. That is correct.

Q. You've also provided us a list of trial testimony in depositions since 1998?

A. Yes.

Q. Is it all right if I mark that Exhibit 7?

A. That's fine.
(Document marked as Exhibit 7
for identification)
MR. GDANSKI: What was Exhibit 6?
MR. DAVIS: The medical records.
Q. Can you tell me how many cases you currently have where you've been identified as an expert that involved the Schlesinger law firm?
A. Simple. One. Other cases or all cases? This is the only one.
Q. I don't want the substantive conversations, but you have talked with Plaintiff's counsel from the Schlesinger firm or the paralegal at the

0043

Schlesinger firm about other cases, other tobacco cases?
MR. GDANSKI: Object to the form.
A. No.
Q. You have not?
A. No. Only insofar as Taylor commented that they asked to look at other cases.
Q. Have you worked with the Schlesinger law firm on previous cases as an expert?
A. I don't believe so, no.
Q. Do you know how they came to ask you to become involved as an expert in the Helen Cohen case?
A. I don't. I might have asked, but I don't remember the answer. I'm not even sure I asked.
Q. Your list of depositions identified the Samuel Biondolillo case as the last case that you gave a deposition in in July of 2011?
A. Yes.
Q. Was that your last deposition?
A. Yes.
Q. So it doesn't need to be updated in any way?
A. No. Except for today.
Q. Your last trial testimony identified on

0044

Exhibit 7 is in the estate of Michele Brown-Cohen versus nurse practitioner Elizabeth Dobrowski?
A. Yes.
Q. That was February 22, 2012?
A. Yes.
Q. You've also brought your current version of your curriculum vitae?
A. Yes.
Q. I'm going to mark that as Exhibit 8. Is that all right with you?
A. Yes.
(Document marked as Exhibit 8
for identification)
Q. Does this CV need to be updated in any way?

A. Only because I just got -- one more article needs to be added to it.
Q. Can you tell me what that article is?
A. It's on screening for lung cancer.
Q. Has that been published?
A. It has not. It's going to be published in the Journal of Surgical Oncology.
Q. When is it scheduled to be published?
A. I don't know exactly, but I suspect in the next -- my article got submitted two days ago. It was six weeks late. I suspect it will get published

0045

in early 2013.
Q. Looking back at Schedule A, I think we've made it all the way, if we can get to Item 7 that says, "All publications, literature, data, medical records or other documents forwarded to you by any lawyer representing the Plaintiff in this case."
Have you brought here to the deposition all responsive information in Item 7?
A. Yes. There are none.
Q. Other than what you've brought here?
A. Correct.
Q. Now, Item 8 is your CV, and we've gone through that. You've brought it. Item 9 is a copy of any invoices, receipts, statements or any other records or materials reflecting the compensation in regard to being paid for your study and testimony in this case.
A. Yes.
Q. You brought your invoices, right?
A. Singular, yes.
Q. How much do you charge for deposition testimony?
A. Usually $500.
Q. Is that how much you're charging today?
A. Probably.

0046

Q. Do you charge differently if you appear at trial?
A. No.
Q. Do you require a retainer?
A. No.
Q. I think you told me that you estimated you spent about 15 or 16 hours on the Helen Cohen case?
A. Yes.
Q. So in order to estimate your fees to date outside of this deposition, it would be 16 hours times 500?
A. Yes.
Q. You mentioned that there was a meeting that you had with Mr. Gdanski yesterday?
A. Yes.
Q. How long did that meeting last?

A. I think it was just a little bit shy of two hours.
Q. Where did it take place?
A. At Tufts Medical Center where I work down the block.
Q. Did Mr. Gdanski show you any medical records or other documents during that meeting?
A. Well, he gave me that disk, which has all the medical records. There was one medical record,
0047
which I thought was in the front, but maybe not -- oh, here is another letter.
Q. You handed me another document, a transmittal letter from Mr. Gdanski to you; is that right?
A. Yes.
Q. I'm going to mark that as Exhibit 9.
(Document marked as Exhibit 9 for identification)
A. I think it's this.
Q. The medical record that Mr. Gdanski showed you yesterday at your meeting was documents Bates stamped 210507119000002, which is the August 22, 2005 transvaginal ultrasound performed on Helen Cohen?
A. Yes.
Q. There's several documents that are stapled together. Was it just that document or was it the whole stack?
A. Oh, it was of course the whole stack. There might have been something else, and I'm not sure what it was, but that was the major thing that I looked at.
Q. When did you form your opinions about whether or not Helen Cohen had primary lung cancer?
0048
MR. GDANSKI: Object to the form.
Q. Let me back up. Is it your opinion that Helen Cohen had primary lung cancer?
A. Yes.
Q. When did you form that opinion?
MR. GDANSKI: Object to the form.
A. I presume it was when I first looked at the medical records sometime in the July, even though I had been told that was the hypothesis or supposition here before that.
Q. You were told by Plaintiff's counsel that that was the hypothesis or supposition in that case?
A. That's why they were contacting me.
Q. Is it fair to say you formed your opinion about whether Helen Cohen had primary lung cancer before seeing this August 22, 2005 transvaginal ultrasound on Helen Cohen?
MR. GDANSKI: Object to the form.

A. I had been either in a previous -- I was just showed that yesterday, but I had heard about it before yesterday. I can't recall specifically whether it was Taylor or Mr. Gdanski who told me that. I think perhaps both did.
Q. What do you remember either Mr. Gdanski or the paralegal telling you about this transvaginal

0049

ultrasound?
A. I don't think they told me anything -- well, what I was informed was that the tobacco world tried to make a point she had ovarian cancer rather than lung cancer.
Q. Do you remember being told anything else about that particular transvaginal ultrasound?
MR. GDANSKI: Object to the form.
A. Other than the fact that it might have shown large ovaries.
Q. Do you understand one of the things that you were to do in the case was to dismiss or argue against that Helen Cohen had primary ovarian cancer or some other form of cancer that started outside the lung and metastasized to the lung?
MR. GDANSKI: Object to the form.
A. Before answering that, could I ask you to repeat the question so I'm making sure I'm answering your precise question.
MR. DAVIS: Could you read the question back.
(Reporter read back pending question)
MR. GDANSKI: I object.
A. The short answer to that question is yes. I presume I'll discuss it more later.

0050

Q. Now, what did Mr. Gdanski, the Plaintiff's counsel, discuss with you yesterday about this transvaginal ultrasound?
A. Other than giving it to me, because I hadn't seen it, I think that was it. I might have made some comments to him.
Q. What comments did you make to him?
MR. GDANSKI: Object to the form. About the ultrasound?
MR. DAVIS: Yes, about the ultrasound.
A. Are we getting into the issue of whether she had ovarian cancer now or is that something that --
Q. I'm just asking what you recall telling him yesterday.
A. With all due respect, the tactics of big tobacco are always to sort of try to prove nobody has lung cancer and everybody's got something else. I don't believe -- I mean, there's no basis for the assumptions she had ovarian cancer. She certainly

didn't have ovarian cancer. We can talk about that now or later.
Q. Is that what you told Mr. Gdanski yesterday?
A. Probably.

0051

Q. Is there any situation that you can conceive of where there's a smoker who develops some cancer, and it's suspected that it originates in the lung, but it's unsure where you would say that, in fact, the cancer started elsewhere and spread to the lung?
MR. GDANSKI: Object to the form. Inappropriate hypothetical.
A. Maybe I can request that question to be asked again.
Q. Absolutely.
(Reporter read back pending question)
MR. GDANSKI: Object to the form. I object to the question.
THE WITNESS: Should I answer it or not?
MR. GDANSKI: You can answer the question if you're able to.
A. What I would have to say, without the statement that was suspected of being lung cancer but originated elsewhere, the answer is absolutely yes. When you say suspected of starting in the lung, then there's some reason it is suspected.
Just having cancer in the lung doesn't mean she had lung cancer, because other cancers spread to the lung all the time.

0052

Q. If a tobacco company presented evidence that a cancer started outside the lung and metastasized to the lung and was therefore not primary lung cancer, can you ever conceive of a situation in a court case where you would agree with them?
MR. GDANSKI: Object to the form. Inappropriate hypothetical.
A. The fact that I have accepted a role in that court case means that I've already formulated an opinion that that's incorrect. So again, without that fragment of the sentence, you know, in a court case that I'm involved in, it happens all the time. I see it all the time.
Q. Let's change the hypothetical then. Let's say it's not a court case. That a tobacco company presents evidence that a cancer originated outside of the lung and spread to the lung, can you conceive of a situation where you would agree with that position?
MR. GDANSKI: Object to the form. Inappropriate hypothetical.

A. Why would a tobacco company bring up that hypothesis if it were not for legal issues?
Q. Well, let's just take a hypothetical.

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Let's say it's not involved in a court case. You have the same facts about medical records for a particular patient, and so does the tobacco company. You both look at the evidence. The tobacco company looks at the medical records and says, I think this is a cancer that originated outside the lung and spread to the lung. You've looked at that same information.
Can you ever conceive of a situation where you would agree with the tobacco company?
MR. GDANSKI: Object to form. Inappropriate hypothetical. Calls for speculation.
A. The answer is, I see this every day, when tobacco companies are not involved. So I see that all the time. The tobacco industry tremendously changes the way I would view that.
Q. Why would it tremendously change the way you would view that?
A. I would only be asked to review a tobacco case if there was an allegation that it was lung cancer. So there is more than just the fact that the patient had cancer that involved the lung, and was a smoker. More than half of people in our country were smokers at some time in their life.
Q. I'm taking out the litigation altogether.

0054

I'm just saying you're looking at a set of medical evidence, a tobacco company is looking at a set of medical evidence the same that you are, and the tobacco company determines that it is a cancer that originated outside the lung and spread to the lung.
Can you ever conceive of a situation where you would agree with that tobacco company?
MR. GDANSKI: Object to the form.
A. Your question makes no sense. Maybe tobacco would be interested in coming to lectures I give about the nature of cancer and the nature of cancers of the lung. But the involvement of the tobacco companies, you know, tobacco doesn't have the greatest reputation for honesty.
So your question doesn't make any sense to me. The situation you're describing happens all the time and I see it all the time.
Q. So are you saying, Dr. Strauss, that if a tobacco company came to you outside of litigation, presented you with evidence that a cancer originated outside the lung and spread to the lung, that you would be biased against finding that that was the case in agreeing with them?
MR. GDANSKI: Object to form.

A. I didn't say anything like that. I'm
0055
understanding that if a -- the reason that a tobacco company would be interested in any kind of case, unless it was for academic purposes or educational purposes, is because there's been some allegation.
Q. Again, I'm saying take out litigation. Set that aside. As I hear what you're saying is, if a tobacco company came to you, presented you with evidence that a cancer started outside the lung and spread to the lung, the mere fact that they are a tobacco company would not prevent you from agreeing with them; is that true?
MR. GDANSKI: Object to form. Inappropriate hypothetical. Calls for speculation.
A. It's very hard to answer your question. If the question were is it possible to a long-term smoker, somebody who smoked a hundred pack years, developed cancer which involved the lung, is it possible that she had a cancer that originated elsewhere, the answer is absolutely, yes. There's zero question about that.
What makes no sense is, let's forget about litigation, but the tobacco company is coming to me and raising this hypothesis. So it makes no sense.
Q. Is it fair to say that you distrust the tobacco companies which affects your ability to be
0056
able to consider the hypothetical that I presented to you?
MR. GDANSKI: Object to the form.
A. Do I distrust the tobacco companies profoundly, but that doesn't necessarily mean that if you told me it's a nice day, it actually is a nice day. It's a little chilly. But, yes, I'm not sure this is useful to you or me.
Q. But when it comes to the question of whether or not you could agree with a tobacco company on whether or not a cancer is primary lung cancer or a cancer that originated elsewhere and spread to the lung, you can't conceive of a situation where you would agree?
MR. GDANSKI: Object to the form. Asked and answered. Calls for speculation. Misinterprets prior testimony and inappropriate hypothetical.
A. It has not come up. I guess I can conceive of it, but has never happened.
Q. You mentioned earlier that you see every day that cancers originate outside the lung and spread to the lung; is that right?
A. Yes.
Q. And is it fair to say that smokers or people who have quit smoking in the past get primary
0057

ovarian cancer that's unrelated to their smoking?
MR. GDANSKI: Object to the form.
A. Yes, of course.
Q. And is it true that smokers or smokers who have quit get primary gastric or stomach cancer that spreads to the lung that's unrelated to their smoking?
MR. GDANSKI: Object to the form.
A. Well, gastric cancer, you know, may have some relationship to smoking. But gastric cancer can spread to the lung, yes.
Q. And gastric cancer can spread to the lung in patients who have smoked or who have quit in the past and smoked and be unrelated to the smoking, true?
MR. GDANSKI: Object to the form.
A. Yes.
Q. And it's also true that smokers who currently smoke or who have quit in the past developed primary breast cancer that spreads to the lung, and that is unrelated to the smoking, true?
A. Yes.
Q. It's also true that smokers or smokers who have quit in the past develop primary colon cancer that spreads to the lung and is unrelated to the

0058

smoking, true?
A. Yes. Colon cancer, as opposed to rectal cancer, usually doesn't spread to the lung without first spreading to the liver. Rectal cancer can do that.
Q. Now, in each of the situations I've described to you for a smoker or a past smoker who quit where they have those four disease processes that start elsewhere and spread to the lung and unrelated to smoking, patients unfortunately pass away from those types of cancers because of the metastases, true?
MR. GDANSKI: Object to form. Compound. Mischaracterizes the prior testimony.
MR. FILBERT: We're objecting to form in these cases?
MR. GDANSKI: I can state the basis.
MS. LUTHER: Only if we ask for it.
MR. FILBERT: We have been in many depositions when we've had this discussion.
MR. GDANSKI: Are you saying I can't state the precise basis for my objections?
MR. FILBERT: Object to form. That's the rules.
Q. Do you understand my question, doctor?

0059

A. I did, but if you could repeat it.
Q. For each of those scenarios that I've

described for you where you have a primary ovarian, a primary breast cancer, a primary colon cancer, a primary gastric or stomach cancer that occurred in a current or a smoker or a smoker who quit that then spread to the lung, and that's unrelated to the smoking, in each of those scenarios we unfortunately have patients who pass away from each of those types of cancers, true?

A. Sure.

MR. GDANSKI: I'm objecting to the last question. I didn't get it in in time.

Q. Did you understand my question, doctor?

A. I did understand your question. May I grab a refill.

MR. GDANSKI: We have been going a little over an hour, so let's take a break.

(Recess)

BY MR. DAVIS:

Q. Are you ready to begin, doctor?

A. I am.

Q. We talked earlier about the CD disk that was entitled "Cohen Med Rec" that you brought to the deposition today?

0060

A. Yes.

Q. I'm going to mark that as Exhibit 10 to your deposition.

A. Okay.

(CD marked as Exhibit 10 for identification)

Q. Did you review the medical records that are on this disk prior to coming to the deposition today?

MR. GDANSKI: Object to the form. Asked and answered.

A. The answer is, I put it in my computer. I looked at the list of files. I was told by Mr. Gdanski that includes all the medical records, probably 10,000 pages, and I just opened a couple at random to make sure it opened. I looked at it, but I didn't read anything. It doesn't affect my opinions at all.

Q. Now, Exhibit 11 is going to be the CD disk that's entitled "Helen Cohen CT Scan 3/3/06"?

A. Yes.

(Document marked as Exhibit 11 for identification)

Q. Exhibit 12 I'm going to mark as the document transmittal sheet, which was in the white

0061

envelope that contained the 14 CDs of images that you were not able to look at, correct?

MR. GDANSKI: Object to the form.

A. Right. I actually put two of them in, and

12 I didn't even try, and I couldn't actually -- when I saw it was an ultrasound, I couldn't really open it, and I wouldn't want to. I can't read them.

(Document marked as Exhibit 12 for identification)

Q. Understood. But Exhibit 12 is a document transmittal sheet from Mr. Gdanski to you that enclosed the 14 disks of the radiographic images that you were not able to review; is that right?

A. Yes.

Q. Okay. And then attached to that, to make it a composite part of that exhibit, is going to be the white envelope that came from Mr. Gdanski's office to you. Okay?

A. Yes.

Q. Have you had any e-mails with anyone at the Schlesinger law firm or other Plaintiffs' counsel's offices representing the Plaintiff?

MR. GDANSKI: Object to the form. I don't think you're asking for other cases, are you?

MR. DAVIS: Yeah, I'm happy to clear that

0062

up.

Q. With respect to the Helen Cohen case, have you had any e-mail correspondence with the Schlesinger law firm or any other law firm that is representing the Plaintiff in the Helen Cohen case?

A. None that are memorable. I can't remember whether after giving some specific dates I got an e-mail about the deposition or I was just told. I don't remember. It was nothing substantial.

Q. Do you still have that e-mail?

A. I'm not sure.

Q. Well, can you look for it, and if you find it or other e-mails about the Helen Cohen case, would you send those to Mr. Gdanski to produce to us?

A. Sure. I get about 200 e-mails a day, and about every three days I get a message from my system administrator your e-mail is overstocked and can't send. So I get rid of stuff. That wasn't something that I would have specifically tried to keep.

Q. Item 11 of the document request is a list of cases which you have testified at either deposition, trial or other hearing during the period of 2008 to the present, and I believe you brought us

0063

a listing of that that we've already marked as an exhibit, right?

A. Correct.

Q. Item 12, correspondence and communications, including e-mails and faxes between you and your assistants and the Plaintiff or decedent or their

attorneys in this case.
Do you have anything other than what you've brought here or maybe some e-mails that you're going to look for after the deposition?
A. I do not.
Q. And 13, I think you've brought us copies of all the time records you have, right?
A. Yes.
Q. Have you had any --
A. Actually, I do have -- I did mean to print it out. I printed out the letter, but I have an ongoing spreadsheet. I did bring that.
Q. What's the spreadsheet of?
A. That's how I keep a record of my time.
Q. I see.
A. So that included the spreadsheet only through July, the day I sent the letter.
Q. Can you provide Mr. Gdanski with an updated version to provide to us?
0064
A. Sure. Up through, but not including this deposition?
Q. Yes, sir.
A. Sure.
MR. GDANSKI: I reserve the right to object to that, but let's keep going.
MR. DAVIS: That's fine. It's responsive to the notice.
Q. Now, have you had any communications of any kind, either on the phone or some other way, with any of the other experts for the Plaintiff in this case?
A. No.
Q. Do you know who they are?
A. I do not.
Q. Have you brought any -- looking at Item 15 -- have you brought any publications of your own that are relevant to the issues in this case?
A. No.
Q. With respect to the CT scan that's been marked as Exhibit 11 to your deposition, do you intend to discuss any of the radiology findings at trial?
MR. GDANSKI: Object to the form.
A. I suspect, yes.
0065
Q. Do you plan to discuss any of the images on this disk dealing with the CT scan of Helen Cohen taken on March 3, 2006?
MR. GDANSKI: Object to form.
A. Certainly I would expect to be discussing the reports, and if asked, I would be happy to, you know, show the images. I would make the point I'm not a radiologist, and I never in my own practice

form independent opinions, but I'm a thoracic oncologist and see these all the time.

On that disk it was difficult to see 150 images, and I couldn't focus on one. I think at home I had a little better luck. It was a different computer.

Q. So is it fair to say that for all the images that you saw on Exhibit 11 of the CT scan of March 3, 2006, that they were very difficult for you to visualize?

MR. GDANSKI: Object to form.

A. Yes, absolutely. When I first got it, again, dealing at home with a different computer, I believe I was actually able to look at individual images and see it more clearly.

Q. When do you think you had this, when you say you first looked at the CT scan, when do you

0066

think you first did that?

A. It was whenever I got the depositions initially, the first set of depositions. And let me see if I dated that.

Well, it was sometime after October 16th, because on that date I indicated I had spoken to Taylor, and that she was going to send out the depositions, and that disk accompanied a box of the depositions.

Q. When you first looked at the March 3, 2006 CT scan images, how much time did you spend looking at them?

MR. GDANSKI: Object to the form.

A. I can't remember. As an oncologist, not a radiologist, I already knew what the report was, and I just wanted to see it to independently verify it.

Q. With respect to the -- if you need to refer to your records, please do so. With respect to the March 3, 2006 CT scan report, do you disagree with anything that's written in that report?

MR. GDANSKI: Object to the form.

A. No.

Q. Would you add or change anything of that CT scan report?

A. No. I wouldn't generate CT scan reports.

0067

Q. But if you got it, and you looked at the images, would you go back and ask the radiologist to change or modify it in any way?

A. My usual practice is to -- it is when I'm really interested in looking at the images, I always go down, it takes time, and review it with the radiologist or we have a weekly conference that we do that. But I like to look at images with radiologists.

Q. Did you look at the images on the CT scan

of Helen Cohen of March 3, 2006 with any radiologist before forming your opinions?
A. No.
Q. Did you ever go and ask any radiologist what he or she thought about the images on the March 3, 2006 CT scan and whether or not they showed primary lung cancer in Helen Cohen?
A. I would never do that without letting the radiologist -- you know, I go to them all the time, and annoy them, because I like to review on patients I'm seeing. I would never ask them to look at something that has medical legal implications without first telling them that I do, and I've sometimes done that, but I have not done that here.
Q. When you get a radiology report, whether

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it's a CT scan report, PET scan report, ultrasound report, x-ray report from a radiologist, do you accept what's in there and rely on that information as a part of your care and treatment of patients in clinical practice?
MR. GDANSKI: Object to form.
A. Generally, yes. But as I said, I can't read ultrasounds. So if I had reason to be skeptical of something in an ultrasound report, I will take it to another radiologist to read it.
CT scans I can look at and I can form an opinion, not that I would ever totally rely upon my opinion. So it depends upon the study.
Q. Can you ever think of a situation where you've looked at any radiology film, regardless of what it would be, or radiographic image, and went back to the person who prepared the report and asked them to change it in any way?
A. Oh, yeah, sure.
Q. You have?
A. Well, I've disagreed with things and either in hindsight -- yes, occasionally. I have been an oncologist a long time and I see a lot of patients.
Q. When you've done that, has that ever resulted in a change of what's actually written on

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the radiology report?
MR. GDANSKI: Object to the form.
A. Sometimes, yes.
Q. Again, I apologize if I've asked you this. How long do you think you looked at this CT scan originally in terms of the images on the disk that's been marked as Exhibit 11?
A. I don't remember. 20 minutes perhaps. I don't know.
Q. Was there any particular image on there that you focused in on or thought was relevant to your opinions?

MR. GDANSKI: Object to the form.
A. Well, on an average CT, there are often two to 300 images, and the radiologist has to scan every one of them. I'm not a radiologist. I'm not going to be sued for missing something. You can see them on several images.
Q. Now, other than the time that you spent when you originally got the March 3, 2003 CT scan on disk marked as Exhibit 11, how much other time did you spend looking at the radiographic images on that disk?
A. I tried to look at it again yesterday, but had more difficulty. I could see all the images,

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but I couldn't focus in on any one. I couldn't figure out how to do it.
Monday, when I got the 14 disks, I looked at a couple of them. So, you know, not a long time.
Q. So those are the only two occasions that you looked at the radiographic images on the CT scan of March 3, 2006?
A. Yes.
Q. Yesterday when you tried to pull them up, you couldn't see any individual image, because the image was not large enough?
A. What you see is a strip of probably several -- a lot of them. Often you could just sort of -- I click on one, and it fills the whole screen.
Q. Besides the August, 2005 ultrasound, did you discuss any other issue with Mr. Gdanski yesterday?
MR. GDANSKI: Object to the form.
A. Well, we spoke two hours. We talked about various issues on the case. I'm not sure what you're referring to.
Q. I'm just asking if there's any other topics that you remember coming up during that conversation?
A. Besides the ultrasound and what else?

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Q. Besides the ultrasound.
A. Yes, we talked about other things related to the case.
Q. What were those?
A. You'll need to be a little -- I wanted to be certain what my role was in both the case, the deposition. We talked a little bit about the data on ultrasounds as a screening tool for ovarian cancer, something I'm very interested in.
We talked a little bit about what sorts of questions you would probably be talking about today. I needed to -- I wanted to be certain I wasn't going to be talking about addiction, and that was made clear.

Q. Did I understand your testimony previously that you were unable to review and interpret the radiographic images on an ultrasound?
A. Yes. If I go to it, the radiologist says see this, and I can see what she's pointing to. Ultrasounds I can't read at all.
Q. Have you had any contact whatsoever with the Plaintiff, David Cohen, about this case?
A. No. I know people with that name, but not the Plaintiff in this case.
Q. Did you have any contacts or communications

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or telephone calls of any kind with any of Helen Cohen's treating physicians about her care and treatment during the course of her lifetime?
A. No.
Q. Were there any documents that were a part of your file on Helen Cohen that were taken out or not brought here to the deposition?
A. No.
Q. Have you reviewed any of the expert disclosures by any of the Defendants' experts?
A. No. I don't know who they are.
Q. I think you told us earlier, Dr. Strauss, that you are not a radiologist; is that true?
A. That's absolutely true.
Q. Did you do a residency in radiology?
A. No.
Q. Have you done a fellowship in radiology?
A. No.
Q. Have you ever signed a radiology report of any kind?
A. No.
Q. Is it fair to say that you're not qualified to interpret and report on any radiographic films, whether x-rays, ultrasounds or CT scans by any hospital?

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MR. GDANSKI: Object to the form.
A. I don't know exactly what that means.
Q. Let me clarify for a second. At hospitals there are individuals who are identified as being in the radiology department that sign off on and prepare radiographic reports, correct?
A. Yes.
Q. Are you one of those individuals?
A. No.
Q. Has any hospital given you any type of permission to be the person who interprets radiographic films and prepares a radiology report?
A. No.
Q. Do you charge your patients for looking at chest x-rays or any other type of radiographic films?

MR. GDANSKI: Object to the form.
A. I don't charge my patients for anything. I'm an employee of the hospital. I presume the hospital does.
Q. Do you know whether the hospital charges for your time on that issue?
A. No, they charge for my time, but they don't charge for my time reviewing x-rays.
Q. Do you know whether or not your hospital is

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reimbursed at all by any insurance company if you read a chest x-ray, a CT scan, or some other type of radiographic film?
A. Yes, there's no bills to the hospital for that particular purpose, other than it's part of the whole evaluation of the patient.
Q. Have you ever published on radiology?
A. Well, I've written extensively about screening for cancer and how you evaluate the evidence. So the paper that I just sent in yesterday is chest x-ray screening for lung cancer.
Q. Is it fair to say that there are experts in the field of radiology that are board certified in radiology, but you are not one of those people?
MR. GDANSKI: Object to the form.
A. Yes, of course.
Q. Do you believe that you are qualified to compare CT scans on a patient or would you defer that to a radiologist?
MR. GDANSKI: Object to the form. Did you say compare? I object.
A. Those are not mutually exclusive. Any time that the report is relevant to what I'm going to do in thinking about the patient, I always review it with a radiologist. I have been doing this for a

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long time, and CT scans I can read, at least CT scans of the chest and abdomen.
Q. Let me ask a different question. If you had two CT scans of the chest, for example, and all you had was the images looking in front of you, are you qualified to compare those two or would you enlist the aid of a radiologist to help you interpret that comparison?
MR. GDANSKI: Object to the form. Asked and answered.
A. Again, I'm not professionally qualified, but I do that all the time. Again, I do not rely upon my own interpretation, though I always confirm it with radiology. So they're not really mutually exclusive.
Q. Have you compared Helen Cohen's CT scan of March 3, 2006 to any other radiographic image on her?

A. No.
Q. I think these will be easy, but you don't hold yourself out as an expert on pathology, do you?
MR. GDANSKI: Object to form.
A. No.
Q. No, you do not?
A. Yes, I do not.

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Q. Would you ever sign a pathology report or do you lack the qualifications to do that?
A. I would never sign it, and I lack the qualifications to do it.
Q. Is it fair to say that as part of your role as an oncologist that there are a number of things that you can do to assess the primary site of a cancer?
A. Can I request that question again?
Q. Yes, sir. Is it fair to say that as part of your role as an oncologist, there are a number of things that you can do in terms of test or order and studies to conduct to assess the primary site of a cancer?
MR. GDANSKI: Object to the form.
A. Yes.
Q. One of those is a CT scan?
A. Yes.
Q. One of those is a PET scan?
A. Yes.
Q. You might also suggest that the patient be biopsied?
A. I might, yes.
Q. And you might request pathologic staining to try to determine the primary site of the cancer?

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A. Mostly pathologic staining doesn't determine the pathologic type. It does determine the histologic subtype, which may or may not be specific for a primary site.
Q. Do you agree that it's the analysis of a patient's tissue that provides evidence of the primary site of a patient's cancer?
MR. GDANSKI: Object to the form.
A. So let me make sure I'm answering the question you're asking. Does the analysis of the tissue provide evidence as opposed to definitive evidence? I would agree that it provides evidence.
Q. Do you rely on radiologists to identify radiographic abnormalities?
A. Yes.
Q. Do you also rely on a pathologist to distinguish between cancer and benign disease?
A. Yes.
Q. To diagnose cancer pathologically?
MR. GDANSKI: Object to the form.

Q. Let me fix my question. Do you rely on pathologists to diagnose cancer pathologically?
MR. GDANSKI: Object to form.
A. Yes.
Q. Do you rely on pathologists to do staining

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for types of cancer?
A. Yes.
Q. Do you rely on pathologists to do staining for the primary site of the cancer?
MR. GDANSKI: Object to form.
A. The pathologist doesn't do staining for the primary site. Could actually provide some information about primary site, but often doesn't definitively prove primary site. More commonly than not it doesn't definitively prove primary site.
Q. Has there ever been an occasion during your career as an oncologist where an oncologist you worked with suspected that a cancer originated in one organ, but then the pathology report came back and showed that it originated in a different organ?
MR. GDANSKI: Object to the form. Hypothetical.
A. I think the answer to that question is no, because if -- we always deal with cancers of unknown primary site all the time. One of my colleagues is an international expert in that. But the primary site, you know, pathologists often can't give a definitive answer if the radiographic images don't leave a lot of leeway. Patients present with disease and that's not an obvious primary in any of

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the probable sites.
Q. If I understand your testimony, you're saying that the tissue that's analyzed by pathology doesn't provide the identification of the primary site, it's the cell type that is identified that then leads to the conclusion of the primary site of the cancer?
A. I didn't say that either.
Q. Do you agree with what I said?
MR. GDANSKI: Object to the form.
A. Not necessarily.
Q. Do you agree that the cell type that is identified by pathological tissue analysis can identify the primary site of a cancer?
A. I would restate that can be helpful, but usually it doesn't definitively identify the primary site.
Q. If you had your choice between having a pathological tissue sample to analyze to get information about the primary site of the cancer or the cell type, would you get that tissue sample and do that analysis every time?

MR. GDANSKI: Object to the form. Improper hypothetical.
A. Not necessarily.
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Q. Would you more likely than not want to have that pathology tissue sample to analyze to help you determine the primary site or the cell type of the cancer?
MR. GDANSKI: Object to the form.
A. Most of the time, but there are major exceptions to that.
Q. So kind of going back to my question about, have you had an occasion as an oncologist where a colleague of yours suspected a cancer originated in one organ based upon a CT scan, but then when the pathology report came back, it actually showed that the cancer originated someplace else?
MR. GDANSKI: Object to the form. Improper hypothetical.
A. That wasn't the question you asked before, and I wouldn't necessarily agree with that at all.
Q. Has that ever happened over the course of your career?
MR. GDANSKI: Form.
A. You're going to need to restate the question, because I don't think it was a well-framed question.
Q. I will try to ask you a brand new question. Have you ever had an occasion as an oncologist where
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an oncologist that you know suspected that they saw primary lung cancer on a CT scan, then the tissue sample is analyzed by pathology, and the results come back that it is not primary lung cancer, but a cancer that originated somewhere else and spread to the lung?
MR. GDANSKI: Object to the form. Improper hypothetical.
A. Probably, but I can't specifically think of it. Before concluding that it's primary lung cancer, you're going to know the history, the physical exam, the distribution of what you're seeing on all the imaging studies.
So most of the time if it's unclear, we might be calling it an unknown primary initially before we get to the point of being clear.
Q. Now, has that situation ever happened with you, where you looked at a CT scan of the chest, you suspected primary lung cancer, then pathology testing was done, it comes back and you decided that it was not primary lung cancer?
MR. GDANSKI: Object to form.
A. Yes, sir.
Q. How many times has that happened over the

course of your career?
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A. Oh, ten, 15 times.
Q. When it has happened, and the pathology report comes back and shows it's not a primary lung cancer, what have been the primary cancers identified?
A. Most commonly it's actually been renal cell carcinoma, which traditionally goes to the lungs, but usually it's multiple, both sides. But sometimes I've seen a bunch of cases of patients who have actually had hypernephroma, that's a primary renal cell carcinoma, where it looked like it was a solitary mass that looked like it was a lung cancer, and either on biopsy or actually on resection of that mass turned out to be a metastatic renal cell carcinoma.
That's actually the most common situation I've seen.
Q. Were there other primary cancers that you've seen in that situation besides renal carcinoma; did I say that correctly?
A. Renal cell carcinoma, yes. Yes, I've seen, as I said, colon cancers usually don't go to the lung without also going to the liver because of the circulation. But rectal cancers, because of how it varies in terms of the venous drainage, can actually
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go to the lung. I've seen a few cases of rectal cancer presenting as a solitary lung mass without other evidence of rectal cancer until we looked later on.
I've probably seen one or two cases of lymphoma like that, though that doesn't necessarily -- a cancer that didn't originate in the lung. Lots of lymphomas actually will arise in the chest. It doesn't come up often. It's been very, very uncommon.
There's a large literature of cancers and sarcomas traditionally spread to the lung, and I've seen patients with single lung metastases, but more commonly it's multiple on both sides, where we are thinking it's metastatic rather than primary.
Q. In those situations where you saw a CT scan and you suspected primary lung cancer and the pathology came back and it turned out to be something else, did that change, affect how you treated a patient?
MR. GDANSKI: Object to the form.
A. This is pretty uncommon. I'm careful not to label something as a probable lung cancer unless I have really good evidence for it. I'm sure in a few occasions it has changed it.
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There was one patient I can think of, probably cared for 20 years ago, who actually had a lung mass --

MR. GDANSKI: Why don't you stop. I don't know what patient you're talking about, but to the extent you have any -- he's asking very general questions about your history as an oncologist and working with patients generally. If you're going to get into specific patients and their specific case and medical scenario, I don't know the bounds, but I don't want you to disclose any private protected patient information.

Q. Have you done that yet, doctor? You haven't violated any kind of privacy issues, have you, doctor?

A. I don't think so.

Q. I don't think so either. So can you continue. I think you were telling us that it did affect your treatment decision for a particular patient that you were describing, right?

THE WITNESS: Should I answer the question?

MR. GDANSKI: Without disclosing the patient's name or any specifics of that patient.

A. It was a patient who turned out to have a rectal cancer, but interestingly once we knew that,

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the rectal cancer was not otherwise metastatic. The patient then had surgery of the rectal cancer and chemotherapy.

Q. Is it fair to say in those situations where you looked at the CT scan and first suspected primary lung cancer, and it turned out to be some other type of primary cancer or disease process, were you thankful that you had gone ahead and asked to have the pathology done for purposes of treating the patient?

MR. GDANSKI: Object to the form.

A. Pathology is something we almost always do in a patient suspected of cancer, unless it's not going to make a difference in management.

Q. So is the answer yes, that you were glad you went and followed through with getting the pathology in those situations where you suspected primary lung cancer, when in fact it didn't turn out to be the case?

MR. GDANSKI: Object to the form.

A. In those cases, as in the vast majority of cases with a suspected cancer, one would always do pathology, unless somebody is sort of end stage and you're not going to treat them.

Q. You found in those situations that doing

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the pathology assisted you as an oncologist in treating those patients?

A. In hindsight, but that wasn't the reason to do the pathology. The reason to do the pathology is that if you're going to treat the patient, you need to get pathologic confirmation to design what you're going to do.
Q. Do you agree that there are going to be some situations where you have a belief about a patient who has a primary lung cancer, as shown on a CT scan, and as well intentioned as you are in believing that that might be primary lung cancer, there is going to be some situations where, just because of the odds, just because of the circumstances, that doesn't turn out to be the case?
MR. GDANSKI: Object to the form.
A. It's exceedingly rare.
Q. Regardless of whether it's rare or not, do you agree that it's not possible to be right all the time in the practice of medicine, particularly in assessing based on a CT scan alone, whether or not a patient has a primary lung cancer or some other primary cancer that originates somewhere else and metastasized to the lung?
MR. GDANSKI: Object to the form.

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A. I believe it is possible without pathology to make that determination based upon the totality of the clinical circumstances.
Q. I'm sorry, I don't think I asked that question. You may not have heard me right.
My question was, in a situation where you have a CT scan of the chest that's where primary lung cancer is suspected and pathology is not done, you believe as the oncologist that it is a primary lung cancer -- you suspect it's primary lung cancer -- is it true that just because of the odds and circumstances of how medicine works, that you are not able to be right all the time in that situation?
MR. GDANSKI: Object to the form.
A. Yes, I agree with that.
Q. There are going to be some situations, no matter how well intentioned you are, that when you see a CT scan, you suspect it's primary lung cancer, that there are going to be circumstances where that doesn't turn out to be the case, true?
MR. GDANSKI: Object to the form.
A. Yes.
Q. You agree that cancer is not one disease process, is it?
A. Yes. Yes, I agree with it.

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Q. Cancer is a group of hundreds of different diseases, yes?
A. Yes.
Q. Cancers are characterized by their cells of

origin, correct?
A. Cell of origin and, you know -- the histologic subtype may or may not provide very powerful evidence for the primary site.
Q. And cancers arising from epithelial cells are called carcinomas?
A. Yes.
Q. And cancers arising from bone or connective tissues are called sarcomas?
A. Soft tissues, cancers that arise from bones -- soft tissues are usually sarcomas. There are bone sarcomas, but there are a lot of primary bone cancers that are not sarcomas.
Q. Fair enough. Cancers that arise from blood or blood-making cells are considered hematologic cancers, correct?
A. Yes.
Q. And those types of cancers include leukemia, lymphoma, multiple myeloma, and other myeloprolific disorders?
MR. GDANSKI: Object. Hypothetical.

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Object to the form.
A. Myeloprolific disorders, correct, yes.
Q. And to distinguish between these cancers, you need to look at cancers under the microscope, true?
MR. GDANSKI: Form.
A. Yes.
Q. To diagnose these cancers, you need to look at tissue under the microscope, true?
MR. GDANSKI: Object to form.
A. To make a definitive diagnosis of myeloma or lymphoma, you need to get tissue, yes.
Q. When you say "definitive diagnosis," what level of certainty are you talking about there?
A. 100 percent.
Q. 100 percent. Is that the standard by which you measure yourself when you are making a diagnosis in a patient outside of litigation?
MR. GDANSKI: Object to the form.
A. No. You want to do what's right for the patient.
Q. What is the standard of certainty that you use when you are treating patients as an oncologist on a day-to-day basis?
A. In the vast majority of the time we get

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pathology and we get a full assessment. But the major exception to that, and probably, you know, lung cancer is probably the most common and deadly cancer in our society and in the world, it's probably the example where we most commonly don't follow through with it.

If somebody presents what appears to be an obvious lung cancer, whether it's really very, very debilitating, is not going to be candidates for any kind of therapy, in which case we sort of focus on comfort issues or hospice very early on.

Q. I'm trying to understand when you say that something is a definitive diagnosis, are you saying that every diagnosis that you make as an oncologist is a definitive diagnosis at 100 percent?

MR. GDANSKI: Object to the form.

A. I don't remember you asking me that question, and I certainly wouldn't make a statement such as that.

Q. Now, when you make a diagnosis that you believe is reasonably comfortable and accurate according to the medical science, what standard do you use?

A. Depends upon the patient. If it's a patient who is healthy enough to be a candidate for

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any form of therapy that is appropriate for that particular type of malignancy, then we need to be as close to absolute certain as possible in terms of what the cancer is, what the distribution of the cancer is, what the stage of the cancer is, because we're going to institute therapy based upon that.

On the other hand, if you have a patient who is dying when you see them, and has got widespread cancer and you're not going to treat them no matter what they've got, then those are the cases where we will move toward hospice and supportive care or comfort care only from day one or early on.

Q. For those patients that you just described, what is the level of certainty that you have to have in order to make a diagnosis of that patient's type of cancer?

MR. GDANSKI: Object to form.

A. There's no reason to make -- what is the level of certainty you have to have?

Q. That you feel comfortable with.

MR. GDANSKI: Object to the form.

A. That's a different question. If somebody is clearly dying from cancer all over the place, you don't need to be certain at all, because you're not going to do anything at all. You have usually a

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pretty good idea what's going on.

Whether you're going to do additional tests to confirm that or not is depended upon your assessment of the patient, the patient preferences, family preferences, the whole clinical situation.

Q. And those situations where the cancer is widespread, the patient can't be treated or declines treatment, and goes to a hospice, is it fair to say

that you don't have to be certain at all about what type of cancer they may have?
MR. GDANSKI: Object to the form.
A. It's fair to say you may not need to be certain. It doesn't mean you're not certain, but you don't need to be certain, because you're not going to -- bottom line, the diagnosis is really a means to an end. It's not an end in itself.
If you're not going to deal with a particular diagnosis, then there's no particular reason to put somebody through tests that could be invasive, uncomfortable, expensive, et cetera.
Q. Because of that situation, where a patient has widespread disease, is unable to be treated or refuses treatment and decides to go into hospice and not do further follow-up, is it fair to say that you can be less certain about what the true diagnosis is

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of the type of primary cancer that patient has?
MR. GDANSKI: Object to the form.
A. Do you mean is it imperative that you be less certain or are you less certain?
Q. Let's start with the latter.
A. Again, if you're not going to do anything, it's not important to be 100 percent certain or even close to it.
Q. In those situations, what level of certainty are you comfortable with as an oncologist?
A. I've never thought about it. Almost always you're 100 percent certain -- again, I wouldn't want to say I'm 100 percent certain that somebody has got cancer without a histologic diagnosis. But when I see a patient with obvious widespread cancer, I will often speak to my -- the oncologist is the worst person to ask, and I've never seen such a patient we were convinced had widespread cancer and we've done tests and the patient never had cancer in the first place. That's not to say I've not seen patients that I suspect of cancer that turned out not to have cancer.
I always ask the radiologist, What's your differential diagnosis? And they will go along and they will say, some sort of bazaar fungal disease

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that I've never heard of or seen that only occurs in some other parts of the world.
You'll want to be 99 percent sure the patient has cancer, which I think you can be in a case like this, and if you're not going to do anything, it's not critical to know what the primary site is, but often you're pretty certain what the primary site is.
Q. Do you agree that that was the situation with Helen Cohen, that her treating physicians did

not need to be certain about the primary type of cancer that she had, because she had widespread disease, she either could not undergo treatment or refused treatment and went into hospice?
MR. GDANSKI: Object to the form.
A. She died a week later. Sure.
Q. Do you find that when you have to go back and analyze those types of cases for purposes of litigation, that it makes it more difficult to assess the true primary site of the cancer or the disease process because you don't have as much information if the patient had decided to be treated and get pathology?
MR. GDANSKI: Object to form.
A. Could you restate that question, please.

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(Reporter read back pending question)
MR. GDANSKI: Object to form.
A. Probably not.
Q. Why do you think that you could still do that?
A. Most of the cases are pretty obvious except for what tobacco is going to falsely claim. Excuse that, with all due respect.
Q. Do you agree in a situation like Helen Cohen, where the disease process was widely spread, that she was either unable to or refused to have a biopsy for pathology, and then went into hospice, that you have less information than you would otherwise have if she had decided to undergo treatment and get a tissue sample for purposes of analysis by pathology?
MR. GDANSKI: Object to the form.
A. Not necessarily. Frankly, my suspicion is, and I see this fairly often when I'm on service at the hospital, where patients come in -- I've never met Mrs. Cohen. I do know that she was admitted -- well, she had the CT scan on the third of March, 2006, and was dead eight days later.
To me, if I were caring for this patient, I would have probably, you know, assumed that this was

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lung cancer, and probably, you know, would not have felt she was a candidate for therapy, and probably would have -- I mean, sometimes the family and patient wants to know, and it would have been simple to do a diagnostic biopsy. It would have been most easy to biopsy the liver rather than the lung. That wouldn't necessarily prove the primary site, but I think the history, the images would lead any reasonable physician to include that she had metastatic lung cancer, which was the opinion of the physicians who cared for her and what her death certificate said.

I'm sufficiently experienced with the strategies of tobacco, no matter what the histology said, you are going to argue it was something else.

Q. Can you ever foresee a situation for yourself where you would agree, whether in a court case or outside of court, that you would agree with a tobacco company that the primary site of origin for a cancer happened outside the lung?

MR. GDANSKI: Object to the form. Asked and answered.

A. Not for a case that I've agreed to be helpful for.

Q. In any of the cases where you've ever

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testified involving a tobacco company, have you ever testified that the cancer originated outside of the lung?

A. Not on cases I've testified on.

Q. Has there ever been a situation where you've ever reviewed a case involving tobacco litigation where you've concluded that the cancer originated outside the lung, and you could not opine that it was primary lung cancer?

MR. GDANSKI: I'm going to stop and try my best to listen to your question. I'm sure it was phrased very carefully. My read of the question is that it may call for a disclosure of potentially privileged information. I don't know the answer.

To the extent he's asking you about conclusions you've reached in cases that you may have reviewed, I don't know, that you've never been disclosed as a witness in, you don't have to answer that.

So keeping that in mind, do you understand my instruction?

THE WITNESS: Yes.

Q. Can you answer my question?

A. It basically comes up virtually in most cases that I've dealt with, and there's not been a

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case that I've been involved in that I agreed with tobacco.

Q. And there's not been a case where you've seen in tobacco litigation where you've looked at the case file and said this is not a primary lung cancer, this is a cancer that originated somewhere outside the lung?

A. Yes.

MR. GDANSKI: What was the question?

(Reporter read back pending question)

A. The answer is yes, I have not agreed with tobacco.

Q. I'm not trying to be tricky. Maybe my phraseology is a little off. I didn't take that as

directed to me. I'm just letting you know that I'm not trying to -- I don't have a different agenda here other than to ask you questions.
Will you at least give me in the situation of Helen Cohen, that because she opted not to have treatment and decided to go to hospice, that there was less information available to her doctors about the type of cancer she had compared to if she had decided to undergo treatment for that cancer?
MR. GDANSKI: Object to form and I object to the introduction to the question.

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A. I'm not sure she would have been a candidate for treatment, in my view.
Q. Let's assume that she was. Let's assume that she was a candidate for treatment.
A. Then we're dealing with different clinical scenarios.
Q. Let's assume she was a candidate for treatment, and she declined to have further tests done on her. Do you agree that because of that, you have less information available to you about the primary site of the cancer compared to what you would have available to you if she had undergone that further testing?
MR. GDANSKI: Object to form. Asked and answered.
A. I certainly agree we have less information about the nature, the precise nature of the cancer, because she did not undergo a biopsy to prove the presence of cancer than if she did, that doesn't indicate I'm less certain about what she has.
The biopsy would have likely been from the liver, and if it confirmed some extremely unusual thing, that that would have changed the opinion.
I have very little doubt that she had cancer, and very little doubt that she had a primary

0100

lung cancer.
Q. Is it true, going back to the different types of cancers there are, if someone had an enlarged lymph node in the mediastinum, you would agree you could not say I diagnose this as lymphoma and not metastatic cancer from the ovary?
MR. GDANSKI: Object to the form. Inappropriate hypothetical.
A. That's a question out in left field. Could you repeat it for me, please.
Q. If someone had an enlarged lymph node in the mediastinum, you could not say I diagnose this as lymphoma and not metastatic cancer from the ovary, true?
MR. GDANSKI: Object to the form. Same objection.

A. So the differential diagnosis is lymphoma versus metastatic lung cancer, and the answer -- yes means I can make that distinction between lymphoma and metastatic ovarian cancer, and no means that I can't make that distinction? I'm sorry, as I try to think of whether it's yes or no --
Q. I will ask it differently. If someone had a --
A. It's a really great question.

0101

Q. If someone had an enlarged lymph node --
MR. GDANSKI: Someone thought about it for a long time.
Q. If someone had an enlarged lymph node of the mediastinum, would you be able to say I diagnose this as lymphoma and not metastatic cancer from the ovary?
MR. GDANSKI: Object to the form. Improper hypothetical.
A. I give up. I don't understand the question. I think you said at the beginning if I don't understand a question -- I don't understand the question.
So if somebody who presents with an enlarged mediastinal lymph node and you immediately think the two possibilities are lymphoma or metastatic ovarian cancer, and can I distinguish those two possibilities, and not even think about the fact that lung cancer is even part of the differential diagnosis; is that the question?
Q. Not at all. I'm saying, as an example, we talked about the different types of cancers there are, and if you had an enlarged lymph node in the mediastinum, you would not be able to distinguish between a lymphoma and metastatic cancer from the

0102

ovary based upon that information alone?
MR. GDANSKI: Object to the form.
A. Based upon the information, meaning you just did a CAT scan of the mediastinum, so you see a lymph node, and you don't know anything else that's going on. You haven't examined the patient. You haven't done an abdominal pelvic CT scan. You haven't done any of the tests.
Q. What's your answer?
MR. GDANSKI: Same objection as before.
A. With all due respect, it's a ridiculous question, and I would not want to -- it's probably the most ridiculous question I have ever been asked.
Q. I don't mean to ask you ridiculous questions, but I do get to ask the questions. You have a patient that has an enlarged lymph node of the mediastinum.
A. Sure.

Q. Is it fair to say that you will not be able to make a diagnosis and say this is lymphoma, it's not metastatic cancer from the ovary?
MR. GDANSKI: Object to the form. Inappropriate hypothetical.
A. So I can't -- seeing a metastatic lymph node, can I say it's not lymphoma -- one more time.

0103

I'm sorry.
Q. If you have a lymph node in the mediastinum, are you able to say, based upon that, whether it's a lymphoma or metastatic cancer of the ovary?
MR. GDANSKI: Object to form. Asked and answered. He already told you. I object.
A. The question is so out in left field, I guess the answer is, I can't distinguish between metastatic ovarian cancer and lymphoma just based upon the image with no other information.
MR. GDANSKI: Note my objection to the question.
Q. Do you agree that you also could not diagnose that situation as metastases from the ovary and not lymphoma?
MR. GDANSKI: Object to the form for all the reasons I've articulated.
A. It sounds like you just rephrased your question.
Q. I just said the converse.
MR. GDANSKI: I object. Asked and answered, as far as I can tell.
A. One more time.
Q. Do you agree you would not be able to

0104

distinguish between those two types of cancers without tissue?
MR. GDANSKI: Object to the form. I object to the form of the question. Inappropriate hypothetical. I object.
MR. DAVIS: Jon, I have been very patient. Object to form is fine, and we can move this process along a lot quicker.
MR. GDANSKI: If you listen to the last question, read back just the last question, it doesn't make any sense. Can you read back the last question? You're asking a series of questions and you're concluding can you distinguish between these cancers, and I'm not sure what we're talking about any more.
Q. Doctor, I'll rephrase the question.
A. Sure.
Q. Is it fair to say in order to distinguish in that situation between lymphoma and metastatic cancer from the ovary or some other type of disease

process that you would need a tissue sample and analyze that tissue sample through pathology?
MR. GDANSKI: Object to the question and I object to the form.
A. That question, you know, did have a third
0105
option, meaning any other disease process. So not necessarily. Now you want to know the total clinical situation. The differential includes lymphoma, metastatic ovarian cancer, or something else, which can include lung cancer.
Do you need tissue to distinguish those situations? Tissue wouldn't give you 100 percent certainty by any means. It would be helpful in saying it's not a lymphoma. But you have to make that decision based upon the clinical information.
Q. Without pathology, could you as an oncologist differentiate between a lymphoma and a metastatic cancer from the ovary when you see an enlarged lymph node in the mediastinum?
MR. GDANSKI: Object to the form. Object to the question.
A. Are you asking me to be 100 percent certain or are you asking me can I be certain to the extent that I know as much as I need to know?
Q. I'm asking you to be certain so that you could treat that particular patient.
A. If we were going to treat the patient, we would certainly want to get tissue. Tissue should tell us lymphoma, with some exceptions, but tissue would not distinguish definitively ovarian cancer
0106
from the most common form of lung cancer, which is now adenocarcinoma of the lung, unless there are special studies that might or might not be helpful.
Q. Do you agree to treat that patient and to make an appropriate diagnosis that you would need pathology?
MR. GDANSKI: Object to the form.
A. Not necessarily.
Q. You disagree with that?
A. Well, she was treated. She was treated in hospice and supportive care. She was not a candidate for chemotherapy. She didn't have ovarian cancer. This is a ferry tale.
Q. I will come back to Helen Cohen, I promise.
A. I believe you.
Q. But with respect to the patient that we're talking about that has the lymph node in the mediastinum, without pathology, you wouldn't be able to diagnose and treat that patient without pathology to distinguish between lymphoma or primary cancer of the ovary?
MR. GDANSKI: Object to the form. I object

to the question.

A. It depends on what you mean by "treat." There are patients who present with -- and it's

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actually more common with lung cancer than other things -- who actually have an obstructed bronchus who are not really candidates for a diagnosis, and we'll often give them palliative radiation therapy to open up a cancer.

I have as a medical oncologist for 35 years who has treated many, many, many thousands of patients during my career, have never given chemotherapy to a patient without having obtained a histologic diagnosis without getting pathology, and I don't think I ever would.

So if the patient were going to be treated by chemotherapy, I would want to get a pathologic diagnosis. The pathologic diagnosis may or may not give you evidence for the primary site. The primary site depends upon not just what the pathology sees, but on the clinical scenario as well, and the latter being more important, the clinical scenario.

Q. Do you know what tissue is the issue means?

MR. GDANSKI: Object.

A. Yes.

Q. What does it mean?

A. Well, that statement, frankly, the more common statement often comes from radiation oncologists who are more likely asked to be treat

0108

without tissue, the more common statement is, no meet, no treat, meaning the same thing.

You want to get at least confirmation that the patient has got cancer. The pathologic pathology may or may not. If somebody has got a clinical scenario of a cancer with an unknown primary that we see very often, particularly in the inpatient service where patients are admitted to the hospital, a lot of them will be cancers with unknown primary, among the common cancers where there is no cancer, but this was not that circumstance.

Q. Do you also agree tissue is the issue also means that in order to diagnose a patient with a particular type of cancer, you need to have a tissue sample from the patient to analyze pathologically?

MR. GDANSKI: Object to form.

A. It's often useful to have that, but it often doesn't give you a definitive primary site. Certainly in this case, if she had a liver biopsy, it's exceedingly unlikely that that would have given you a definitive primary site.

Q. What you don't know, because the test wasn't run, right?

A. That's correct.

Q. Now, do you agree that tissue is the issue
0109
means that you can have an abnormality seen radiographically or even by the naked eye, but you don't know what it is until you look at the tissue under the microscope?
MR. GDANSKI: Form.
A. No, I've never thought of it in those terms.
Q. Is there any part of that statement that you agree with?
MR. GDANSKI: Object to the form.
A. Could you repeat the question?
Q. Sure. Do you agree that tissue is the issue means that you could have an abnormality seen radiographically or even by the naked eye, but you don't know what it is until you look at that tissue under the microscope for sure?
A. The question is what is the standard of knowing. If you want to be 100 percent certain what the cell type is, you need to get pathology. You don't need to get pathology to make a decision about the nature of this cancer, what it is, with all reasonable probability or a very, very high level of probability.
Q. Would you ever treat a living patient, doctor, as an oncologist with less than definitive
0110
certainty about what type of cancer they may have?
MR. GDANSKI: Object to form.
A. Yes.
Q. You do that all the time?
MR. GDANSKI: Object to form.
A. No, I don't do that all the time. It's fairly uncommon. I already mentioned the most common scenario. Somebody presents with major pulmonary symptoms, probably has an obstructive process, is not well enough to undergo a biopsy procedure, but it would be beneficial to sort of open up the airways where we give radiation based upon the presumption of -- the almost certainty of cancer and the presumption of the primary site.
Q. Is it true that it's fairly uncommon that you treat and diagnose patients of some type of cancer without a pathological diagnosis of the tissue?
MR. GDANSKI: Object to form.
A. Yes, it is uncommon.
Q. Do you agree that there are different types of cancers that are carcinomas, sarcomas and hematologic cancers and there are different cell types of cancers?
A. Yes.
0111

Q. Do you agree that there are different types of carcinomas, depending on where they arise?
MR. GDANSKI: Objection to the form.
A. There are different forms of cancers, depending on where they arise, but that's not the only thing that gives different forms of cancers.
Q. Do you agree that you could have a renal cell carcinoma arise in the kidney, but they never arise in the lung?
A. Well, if it's a renal cell carcinoma, meaning by definition, it's arised in the kidney, it arised in the kidney, not in the lung -- the lung is not the kidney -- sometimes it's pretty clear and sometimes it's not so clear from a pathologist's perspective.
Real cancers have -- because that actually is probably the most common situation, where somebody has had something that I actually thought was a lung cancer that turned out to be a metastatic renal carcinoma, there are pathologists that are usually able to be pretty definitive.
Q. You agree that carcinomas can arise anywhere that there's epithelial tissue?
A. Yes.
Q. And all organs contain epithelial tissues?

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A. All solid organs contain epithelial tissues. I guess the blood isn't an organ that contains epithelial tissues.
Q. For example the lungs, GI tract, the genitourinary tract, the pancreas, the breast, prostate, skin, they all have epithelial tissue?
A. Yes.
Q. Do you agree that you could not look at a CT of a tumor in the ovary and say this is carcinoma and the cell type is mucinous adenocarcinoma without tissue?
MR. GDANSKI: Object to the form.
A. Yes.
Q. And do you agree that you could not look at a suspicious node in the lung and say I diagnose this as a squamous cell carcinoma without tissue?
MR. GDANSKI: Object to the form.
A. Yes.
Q. You agree that the different cell types of cancers have different treatment and prognoses?
A. To some extent. But it's more important the stage of the cancer, is it localized, is it surgically resectable, is it amenable to definitive local therapy.
Q. Do you agree other conditions can mimic

0113

cancer radiographically?
MR. GDANSKI: Object to the form.

A. Under certain circumstances, yes.
Q. What other conditions can mimic cancer?
MR. GDANSKI: Object to the form.
A. For example --
Q. Let me ask a better question. What other conditions can mimic cancer radiographically?
A. As a thoracic oncologist, there's a disease called sarcoidosis associated with predominantly large hilar lymph nodes. Those are lymph nodes in the center of the chest as opposed to mediastinal lymph nodes that are -- I'm sorry, hilar lymph nodes are part of the lung itself as opposed to mediastinal lymph nodes that are in the chest, but technically in the lung itself.
Not infrequently over my career I've seen patients who we suspected as having a primary lung cancer that turned out to have sarcoidosis, for example.
There are other collagen vascular diseases that can sometimes present with large lymph nodes.
Q. Do you agree that bacterial infections can mimic cancer radiographically?
A. Well, it's very, very typical for patients

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with lung cancer, for example, to present with an obstructive pneumonia, and the x-ray is read as pneumonia. But usually, you know, you're able to deal with that circumstance.
Q. But outside of that circumstance where you're dealing with a primary lung cancer, do you agree that bacterial infections can mimic or look like cancer radiographically?
MR. GDANSKI: Object to the form. Asked and answered.
A. Depends upon the circumstance. Certainly a bacterial infection can look like -- somebody who is a smoker and presents with a big pneumonia might be read as pneumonia, we might suspect it would be an obstructive pneumonia due to the cancer, but he's not going to present with extensive liver metastases. So it's not an issue relevant to this case.
Q. Do you agree that pneumonia can look like cancer radiographically, outside the context of whether or not a patient has a primary lung cancer?
MR. GDANSKI: Object to the form.
A. No. What happens is pneumonia would basically obscure the central cancer and the image makes it very, very difficult to distinguish the

0115

two.
Q. So you don't believe that pneumonia can mimic cancer radiographically?
MR. GDANSKI: Object to the form. Asked

and answered.
A. It can under certain circumstances, but it won't in a circumstance like this, where the bulk of the disease is metastatic.
Q. Do you agree that granulomas can look like cancer radiographically?
A. Well, granulomas occur in -- a granuloma is something that a pathologist needs to diagnose. So the radiologist will see shadows that could be granulomatous disease, could be cancer, so just based upon the imaging.
Another example of a disease that's not cancer, mimicking cancer, is a disease called Castleman's disease, after Dr. Castleman, who will see big lymph nodes in the chest. It's sort of a hematologic disease that may evolve, but again, that's technically a benign condition.
Q. Do you agree that amyloidosis can look like cancer radiographically?
A. Amyloidosis is a great mimicker. I'm not -- one of my colleagues is a world expert on

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amyloidosis. I'm certainly not. It's actually never come up in the differential diagnosis in my experience. I just don't know the answer to that question.
Q. Do you agree that both abscesses and hamartomas can look like cancer radiographically?
A. When you see an abscess or a hamartoma, we often see those, yes, they can.
Q. Do you agree benign tumors can also look like cancer radiographically?
MR. GDANSKI: Object to the form.
A. Yes.
Q. Do you agree that in large lymph nodes for other reasons, like due to infection, can look like cancer radiographically?
MR. GDANSKI: Object to the form.
A. Yes.
Q. Do you agree tuberculosis can look like cancer radiographically?
A. Yes. It used to be they were common -- it always comes up, but never turns out nowadays to be the issue in my experience.
Q. Do you agree that you cannot look at an enlarged lymph node in the mediastinum and diagnose this as cancer?

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MR. GDANSKI: Object to the form.
A. Right.
MR. GDANSKI: Inappropriate hypothetical.
Q. You also can't look at that enlarged lymph node in the mediastinum and say this is not cancer?
A. Right. If you're just looking at the

enlarged lymph node in the mediastinum -- well, it depends upon the size a little bit. But I would agree with that statement.
Q. You can have suspicions about what that enlarged lymph node is radiographically, but in order to distinguish between the conditions that mimic the cancer and are actual cancer, you have to do pathology, true?
MR. GDANSKI: Object to the form.
A. You don't have to. It depends upon the clinical circumstance.
Q. But it's very uncommon in your practice not to get the pathology to distinguish between a cancer and a non-cancer in that situation?
MR. GDANSKI: Object to the form.
A. Usually when we're doing a biopsy with a strong suspicion of cancer, particularly if it's a patient that I've seen, and I do see quite a few patients without prior to the diagnosis, but most
0118
likely I would be asked if there was a strong reason to think it wasn't cancer.
Q. But in that situation, when you had an enlarged lymph node in the mediastinum, in order to say this is cancer or not cancer, you have to do the pathology to make that assessment, true?
MR. GDANSKI: Object to the form.
A. Usually you would do it. It depends on the circumstances. I think the plan was not to biopsy the mediastinum, which is a more invasive procedure, but to do a liver biopsy.
Q. With respect to --
A. Certainly that's the way -- I mean, if you do -- if you do a node biopsy in somebody who has obvious lymph metastases, and you haven't proven the stage of the disease. If you biopsy the liver, you both have established histology and the stage at the same time.
(Document marked as Exhibit 13 for identification)
Q. Doctor, I'm handing you what's been marked as Exhibit 13. Do you see that's a medical record on Helen Cohen that's dated March 6, 2006?
A. There's a stamp. Is that part of the medical record. Usually the name would be up there.
0119
I assume it's Helen Cohen. I don't know whether that's something that was postdated or whatever.
Q. Bryan Wasserman, that's her doctor. Do you remember?
A. Yes.
Q. I'm assuming his stamp is on there, because it says Bryan Wasserman, but maybe I'm wrong. Is this a medical record you've seen before today?

A. I probably have, but I don't specifically remember this record. Let me read it. I'm having trouble -- I've probably seen it. It doesn't ring specific bells. I can read part of it, but I'm having trouble reading it all.
Q. Let me see if we can get through this document. Do you see that the plan for Helen Cohen was to do a biopsy of her liver either that day or the next morning?
A. Do you want to point that out? I don't see that. I'm sure it's just a penmanship issue.
Q. Look at the very top entry. The top entry is for March 6, 2006, and the first line says "Medical Oncologist."
A. I thought it said that, but I wasn't certain, yes.
Q. Now, it says four lines down, "Reviewed CT
0120
scans with Dr. Rosencrantz." Do you see that?
A. Yes.
Q. "Can obtain mini core image guided liver biopsy." Do you see that?
A. Okay. Sure.
Q. "If patient and family want to pursue this for tissue diagnosis." Do you see that?
A. Yes.
MR. GDANSKI: Object and ask that the entire record be read.
Q. So the purpose here for showing you this is that Helen Cohen's doctor assessed that she could undergo a liver biopsy, right?
A. I'm having trouble with the next line. Could you just read that for me?
Q. Sure. The last line?
A. Next to last line?
Q. "Suspect metastatic lung cancer, given clinical presentation."
A. Oh, yeah. I would certainly agree with that.
Q. So on this date, her doctor, Dr. Koletsky, right?
A. Yes. I've seen a typed note by him, yes.
Q. He's her oncologist, right?
0121
A. I guess he saw her in the hospital.
Q. Do you know whether he's her oncologist?
A. The note I saw was for leukocytosis.
Q. So what Dr. Koletsky has written is "Suspect metastatic lung cancer," right?
A. Yes.
Q. He doesn't say diagnosis metastatic lung cancer, right?
A. That's correct.
Q. At this point in time Helen Cohen is

suspected of having metastatic lung cancer, right?
MR. GDANSKI: Object to the form.
A. Yes.
Q. And they are talking here about doing an image-guided liver biopsy for her, right?
A. Yes.
Q. So the purpose of that was to investigate the type of cancer that Helen Cohen had, right?
A. Yes.
Q. Was that biopsy ever done?
A. It was not.
Q. And you understand that Helen Cohen's doctor assessed that she would be able to undergo that procedure, right?
A. I don't see that he said that.

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Q. Do you have any reason to say that she was unable to undergo that condition?
A. I have no reason.
Q. So assuming she could undergo that, do the medical records also reflect that either she or the family declined to undergo that liver biopsy?
A. I know she didn't have the biopsy. I don't see anything in that record that you showed me that indicated that the family declined it, but it's a penmanship issue. I assume that they declined it. I'm not disputing it.
Q. Let's look at Exhibit 5. Down on the bottom of the second entry, the very last line says, "Needle biopsy of liver today or a.m." Do you see that?
A. Could you read the whole thing to me? I would like to answer your question in the context of the note. It looks to me that that's written by probably pulmonary, I assume. I don't know that for a fact, but I can't read it. I don't know what that first line says.
Q. What first line?
A. The pulmonary, what you gave me is highlighted in yellow.
Q. Yes.

0123

A. Then something, something, something, something, "read CT with doctor" something. "No" something. I can't read it.
Q. I will represent to you this is Dr. Jacobson's note. He's her pulmonologist. Do you accept that?
A. I have no reason to dispute it.
Q. It says down at the bottom, "Needle biopsy of liver today or a.m." Do you see that?
A. I'll take your word for it that that's what it says, yes.
MR. GDANSKI: I would just object and ask

that the entire sentence be read.
A. What does it say after that?
Q. Doctor, there's no intent to hide something.
A. "Probably will go with hospice," if I'm reading it correctly.
Q. Yes. So do you have any reason to dispute that Helen Cohen was medically able to undergo a needle biopsy, but declined to do so?
A. If somebody has a liver and has got things -- holes in the liver, they're able to undergo it. It's a pretty innocuous procedure, but somebody who is five days from her death, you know, is somebody

0124

that maybe you should think twice about.
One of the highlights of bad care is somebody is given treatment for cancer and dies -- I'm sorry, somebody is given chemotherapy and dies within a week or, you know, of that. I mean, this was a patient who obviously was dying based upon what happened. They were discussing hospice at this point in time.
So sure, you know, histology might have -- would have given you additional information that you don't definitively have, it wouldn't have helped in her management. If I were her oncologist and a dying patient, I would argue against doing the biopsy, unless the patient and/or family wanted to be certain. But it looks like there was not -- you know, if they were thinking about hospice before doing the biopsy, why do the biopsy.
(Document marked as Exhibit 14 for identification)
Q. Let's look at Exhibit 14. This is the discharge summary for Helen Cohen from the Delray Medical Center?
A. I've seen this, yes.
Q. And this is dated March 7, 2006, right?
A. Yes.

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Q. Her diagnosis upon discharge was lung cancer was suspected, right?
A. That's not what I'm reading.
Q. Under "Hospital Course."
A. The diagnosis says "Lung cancer with multiple metastases to liver." That's what I see.
Q. Look under "Hospital Course," doctor.
MR. GDANSKI: I object to the form.
Q. Do you see that this doctor filled out the discharge summary, explains that lung cancer was suspected?
MR. GDANSKI: Object to the form.
A. Where?
Q. It's the bottom of the first paragraph of

"Hospital Course."
A. Yes, lung cancer is suspected.
Q. So according to this, doctor, when she left the hospital at Delray Medical Center, she had lung cancer that was suspected, true?
MR. GDANSKI: Object to the form.
A. Yes.
Q. It had not been confirmed, true?
A. Yes.
MR. GDANSKI: Object to the form.
A. It had not been pathologically confirmed.

0126

I would maintain that had she had a biopsy, it would have given you 100 percent proof that she had cancer, but it probably would not have given you 100 percent proof that it was primary lung cancer.
Q. Is it fair to say, doctor, that that's speculation, simply because you don't have the tests and you don't know what it would say?
MR. GDANSKI: Object to the form.
A. It's not speculation. I'm not claiming to be 100 percent certain, but it's far from speculation.
Q. Well, you don't know what the test was, true? You don't know what the results were, right?
A. Discharge diagnosis, lung cancer with multiple metastasis to liver. Nobody, besides the tobacco industry, would disagree with that.
Q. No one disputes that this record says that. This record says that.
A. Nobody would dispute that that's what she had, with the caveat that she didn't have a biopsy to prove that she had cancer at all.
Q. Doctor, do you consider yourself an advocate or an expert?
MR. GDANSKI: Object to the form. Argumentative.

0127

A. Depends on the context.
Q. Today are you an advocate or an expert?
A. I don't know what you mean by an advocate.
Q. Do you know what an advocate is?
MR. GDANSKI: Argumentative. I think I did.
A. I think I do.
Q. Tell me what an advocate is?
A. You tell me.
Q. I'm sorry, I get to ask the questions. What is an advocate?
MR. GDANSKI: Object to the form. Argumentative and harassing.
MR. FILBERT: Jon, the objection is to form. We've gone over this multiple times in multiple depositions. You've told me specifically

multiple times my objection is to form. You've violated that rule over and over. We have been very patient. Just object to form.

MR. GDANSKI: This line of questioning is argumentative.

Q. What's an advocate?

A. One who advocates something.

Q. Do you believe that someone who's an advocate has their biases infect their opinions?

0128

MR. GDANSKI: Object to the form.

A. Given the political season we just went through, I think the answer is yes, but it certainly is not affecting my opinion in this case.

Q. That was going to be my question. Do you believe that you're an advocate or an expert in this case?

A. I am an expert.

Q. Okay. I promise you, we're going to get to all the records, and I know your views, what your view is. All my purpose here is to simply see if we can get through them so I can understand them. That's all.

A. Sure.

Q. Do you agree cancers can arise just about anywhere in the body?

A. That's a pretty broad area. Cancers arise in most organs.

Q. Cancers can spread by direct extension?

A. They can.

Q. They can spread by gaining access to the lymph system?

A. They can.

Q. They can gain access to the blood supply and spread that way?

0129

A. They can.

Q. And once cancer gets in the blood supply, it can go anywhere, right?

A. It can go anywhere, but metastases are not random. They tend to occur in specific organs much more commonly than others.

Q. In the lymphatics are a network of vessels that carry fluid called lymph toward the heart?

A. I'm sorry?

Q. The lymphatic system is a group or network of vessels that carry a fluid called lymph toward the heart?

A. Not lymph toward the heart. They carry lymph to other lymphatic organs. There are many lymphatic organs in the mediastinum, not in the heart. There are no lymph nodes that I know of in the heart itself, I don't believe. I'm not positive of that.

Q. Maybe I phrased it poorly. The lymph fluid goes through the chest area and to the thoracic duct?
A. Yes.
Q. And the thoracic duct runs through the length of the thorax, right?
A. Yes.

0130

Q. Do you agree that cancer can metastasize through the blood?
A. Yes.
Q. Do you agree that cancer can metastasize through the lymph system?
A. Yes.
Q. Do you agree that the lung is a commonplace for metastases to go to?
A. Yes.
Q. And do you agree that almost half the cancers that are found in the lung are the result of metastases to the lung?
MR. GDANSKI: Object to the form.
A. I don't agree with that statement necessarily. It depends upon the context.
Q. Do you agree about -- well --
A. Most of the time it's pretty obvious.
Q. Do you agree that virtually any malignancy can spread to the lung?
A. I never thought of it in those terms. I certainly agree that the lung is one of the common places that cancer spreads to. The pattern, you know, is bilateral multiple masses in both lungs where it's obvious.
Q. Do you agree it's been reported that

0131

somewhere between 30 and 53 percent of all patients who died with a malignancy had a pulmonary metastasis?
A. You'll have to show me where you're getting that. May I take a break?
Q. Sure.
(Recess)
BY MR. DAVIS:
Q. Now, do you see I've handed you what's been marked as Exhibit 15 to your deposition?
A. Yes.
(Document marked as Exhibit 15 for identification)
Q. Do you see this is a portion of a chapter book called "Pulmonary Pathology"?
A. That's the name of the book, not the chapter; is that correct?
Q. Fair enough.
A. Yes.
Q. So there's a discussion in this book that

talks about metastatic lung neoplasms?
A. Yes.
Q. And neoplasms is another word for cancer?
A. No. Neoplasms could be benign or malignant. So neoplasms is not cancer. Where it

0132

says "metastatic lung neoplasms," that's cancer.
Q. Now, it says here in this text that "As the most common neoplasms in the lung were metastatic tumors, a brief discussion of these lesions seems appropriate."
Do you agree the most common neoplasms in the lung are metastatic tumors?
A. I agree that he says that. I guess I'm not -- I don't agree or disagree. I would actually love to see, you know, Dr. Hammar is well respected, and he obviously -- this is a textbook, so it's not primary literature.
So I would actually love to see what references he's citing there. There are four references that are cited in this sentence, but I'm not disputing it. I'm not disputing he says it, and I'm not disputing it's true, but I don't absolutely know it's true.
Q. Dr. Hammar is a respected scientist?
MR. GDANSKI: Object to the form.
A. Yes.
Q. Are you familiar with this textbook called "Pulmonary Pathology"?
A. No. I know it existed.
Q. Do you have any reason to disagree it's

0133

reliable and authoritative?
MR. GDANSKI: Object to the form.
A. I've never understood exactly what "authoritative" means.
Q. Would you feel comfortable in relying on what Dr. Hammar says in his textbook?
MR. GDANSKI: Object to the form.
A. No. I'm actually interested in this, so frankly, reading that -- again, I'm not disputing it. But is that what somebody said or is this a review of some of those references looking at every patient who had cancer involving the lung over 30 years at the Dana Farber or Memorial Sloan-Kettering or MD Anderson, and are you able to dispute that or is this some pathologist. He's simply referencing somebody else.
So I'm not questioning his character or skills, but I guess I would love to sort of see the basis of that.
Q. The next sentence says, "It has been reported that 30 to 53 percent of all patients who died with a malignancy had pulmonary metastasis, and

in 15 to 25 percent with pulmonary spread, the lung was the only site of metastases."

Do you agree with that?

0134

A. I agree that that's what that statement states.

Q. Do you have any reason to disagree with the factual information that's put in that sentence?

A. I have no reason to disagree. Frankly, I would be interested in looking at those references and actually reviewing those references, the 292, 293, 294, 295 and 296.

Q. Do you agree that the most common tumors, metastatic to the lung, arise in the breast, colon, the pancreas, the stomach, the skin, such as melanoma, and kidney?

A. I don't disagree with that. Certainly those cancers can present that way, but the vast majority of the time it's somebody who has got a preexisting known cancer and spread to the lung. No, I don't disagree with that.

Again, I would also indicate I would be interested in looking at the primary references rather than just a review of the references.

Actually, colon should not be there. Rectal should be -- well, actually, I take that back. Colon cancer, when it's end stage, will spread to the liver and then to the lung as well, but it's very uncommon.

0135

The vast majority of these patients are patients who are known to have colon cancer, and rectal can go most directly to the lung without going to the liver.

(Document marked as Exhibit 16 for identification)

Q. I'm going to show you what's been marked as Exhibit 16 to your deposition. Do you see this is a portion of the textbook "Cancer Treatment"?

A. Yes.

Q. By Charles Haskell?

A. Yes.

Q. Do you recognize this as authoritative or reliable?

MR. GDANSKI: Object to the form.

A. I don't understand what you mean by authoritative or reliable.

Q. Is Dr. Haskell a respected scientist in the field of cancer treatment?

A. I actually do have a copy of his book on my shelf, but I have not used it, and I have no reason to dispute that, but I don't independently know that.

Q. Look at Page 1134.

A. Okay.

Q. It says under "Radiographs," the second paragraph, first sentence, "No chest x-ray pattern can differentiate a metastasis from a primary lung cancer." Do you see that?

A. Do you know what MUOR, those malignancies of unknown origin; is that what that stands for?

Q. I believe that's true.

A. It's usually called CUPS, carcinoma with no primary, but that's okay. I see that sentence.

Q. Do you agree with that?

A. Not necessarily. There's always the remote possibility, and I already gave a few examples in my own experience. But most of the time when patients have metastases, they have got a previous primary cancer and there's more than one. But certainly metastases can present as a solitary mass, which would suggest a primary versus metastasis.

So I don't agree with the statement that a chest x-ray -- I mean, if somebody presents with bilateral lung metastases, I guess it's possible they have 15 independent primary lung cancers, but it's almost certainly metastatic disease.

Q. Would you agree most of the time chest x-rays cannot differentiate a metastasis from a primary lung cancer?

MR. GDANSKI: Object to the form.

A. Do I agree with that?

Q. Yes. Most of the time a chest x-ray cannot differentiate a metastasis from a primary lung cancer?

MR. GDANSKI: Object to the form.

A. I don't agree with that. I think a chest x-ray is pretty useful in the proper context.

Q. Look at the next sentence. "Whereas multiple nodules and infiltrates suggest metastasis, patterns suggestive of a primary lung carcinoma, coin lesions, malignant fusions or hilar masses represent metastasis in 45 percent of cases."

A. I certainly agree that that sentence says what you said. I would be very interested in what reference six is, and I don't agree with that. It says coin lesions, they are talking about a patient with multiple coin lesions. Malignant effusions certainly can occur in lung cancer and metastatic disease and hilar masses, plural, I don't agree or disagree. I agree you read the sentence correctly.

Q. Do you have any reason to dispute the sentence that I read?

MR. GDANSKI: Object to the form.

A. I do disagree with it. I think if somebody

presents with a primary mass without other things -- again, you've not -- without other suggestions, particularly where you may be suspecting that you're dealing with a stage one lung cancer, which is highly curable with surgical resection, again, solitary metastases can be the manifestation of metastatic cancer. I've seen that, but that's not common.

Q. Do you agree it can often be difficult to distinguish between metastatic cancer to the lung as opposed to primary cancer of the lung?

MR. GDANSKI: Object to the form.

A. I don't. In the context of the history of a solitary nature -- the bottom line is a patient with a solitary lung mass, that looks like it's a malignancy, but without obvious other sites of metastatic disease, would assumed to be a primary early stage lung cancer until proven otherwise. It's usually not difficult, but can sometimes be metastatic disease.

Q. Do you believe cancer of any site can spread to the hilum or the mediastinum?

A. No, I don't think so. Certain cancer from many sites might, but I don't agree that cancer from any site can --

0139

Q. I will try to be more specific. Do you agree that cancer from the pancreas can spread to the hilum or the mediastinum?

A. Yes.

Q. Do you agree that cancer of the breast can spread to the hilum or the mediastinum?

A. Absolutely.

Q. Do you believe that cancer of the colon can spread to the hilum or the mediastinum?

A. Very uncommonly without also first spreading to the liver, considering the nature of the venous pattern.

Q. Do you believe primary ovarian cancer can spread to the hilum or the mediastinum?

MR. GDANSKI: Object to the form.

A. Very uncommon.

Q. But it can?

MR. GDANSKI: Object to the form.

A. Yes.

Q. You've seen that in your patients?

A. I can't specifically recall seeing ovarian cancer presenting with multiple pulmonary metastases, I can't specifically recall a case of ovarian cancer that spread to the hilum mediastinum without lots of other evidence of metastatic ovarian

0140

cancer.

Q. Do you agree that primary stomach or GI

cancer can spread to the hilum or mediastinum?
A. Stomach or GI cancer, again, we already talked about colon cancer, which is a GI cancer, which can, but it's usually pretty obvious. Gastric cancer usually will involve the liver, but it can spread to the lung and chest nodes.
Q. And the hilum and the mediastinum?
A. Yes.
Q. Do you agree primary cancer of the thyroid can spread to the hilum or mediastinum?
A. Can and -- when thyroid cancer spreads, it's usually to the lungs. That's often what we call a micronodule pattern. It's thyroid cancer, and thyroid cancer is a papillary or follicular thyroid cancers might spread when they spread beyond the thyroid and regional nodes to the lungs and not so much the hilum or mediastinum.
Q. Do you agree that the radiographic appearance that suggests metastases to the lung includes multiple nodules and infiltrates?
MR. GDANSKI: Object to the form.
A. Those are two separate questions. Do I agree that --

0141

Q. Let me break them out. Do you agree that the radiographic appearance that suggests metastasis to the lung includes multiple lymph nodes?
MR. GDANSKI: Object to the form.
A. Lymph nodes?
Q. The radiographic appearance that suggests metastases to the lung includes multiple nodules?
MR. GDANSKI: Object to the form.
A. Yes, by all means. Multiple nodules within the lung.
Q. The radiographic appearance that suggests metastases to the lung that includes infiltrates?
A. It could, but usually you're going to see nodular densities.
Q. The radiographic appearance that suggests metastasis to the lung may also include when you have multiple nodules and infiltrates, true?
A. Well, multiple nodules. Infiltrates doesn't so much, you know, you certainly would be thinking more of infectious, unless you're thinking of a specific type of lung cancer, bronchoalveolars cancer, which is a cancer that often looks more like bilateral pneumonias.
Q. Do you agree that if you just had the history of a person who smoked or who was currently

0142

smoking, that alone would not be enough to make a determination that that person had primary lung cancer?
MR. GDANSKI: Object to the form.

A. Most people -- do you mean if a smoker -- if somebody who is a smoker, and knowing nothing else about them, whether there's any suggestion of cancer at all, that they have primary lung cancer? I certainly wouldn't diagnose a smoker as having lung cancer unless there's some other evidence that there's cancer.

Q. Let me ask a different question. If you had a patient that had symptoms like Helen Cohen as of February or March of 2006, you had no radiographic films, and all you knew was that she had been a smoker in the past, that alone would not be enough to make a diagnosis of primary lung cancer, would it?

MR. GDANSKI: Object to the form.

A. I totally agree with that question.

Q. And again, if you had no radiographic film, no other testing, and a patient tells you that they have smoked in the past or are currently smoking, and has symptoms, that alone would not be enough to make a diagnosis of primary lung cancer?

0143

MR. GDANSKI: Object to the form.

A. You're talking about 100 million people in this country. I would agree.

Q. Do you agree that you could have postobstructive infiltrates from tumors that obstruct the bronchus?

A. Of course.

Q. Do you agree that you could have postobstructive infiltrates from tumors in the mediastinum or hilum outside of the lungs obstructing the bronchus?

MR. GDANSKI: Object to the form.

A. The hilum is in the lung. The mediastinum is in the chest outside of the lung. The answer to your question is, yes.

Q. Do you agree that you could have mucus or other debris obstructing a bronchus that could give the same appearance?

MR. GDANSKI: As what?

MR. DAVIS: As postobstructive infiltrates from tumors in the mediastinum or hilum.

MR. GDANSKI: Object to the form.

A. You're not going to have mucus in the mediastinum or the hilum. It could be central in the chest. Mucus plugging is often something that

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can be an issue, but usually the clinical setting is sort of a giveaway for that.

Q. Do you agree that sometimes the pathologist cannot determine what kind of cancer he or she is looking at under the microscope, and then orders additional staining to be done on the tissue?

MR. GDANSKI: Object to the form. Calls for speculation.
A. Could you restate the question or could you just ask it?
Q. Yes. In some cases the pathologist can use special staining to try and diagnose the cancer seen under a slide?
MR. GDANSKI: Object to the form.
A. Absolutely, yes.
Q. And when that happens, the tissue is put on the slide and stained by the pathologist to try to determine what kind of cancer a patient has, correct?
A. It can provide evidence.
Q. And different kinds of cancers stain in different ways?
MR. GDANSKI: Object to the form.
A. To some extent, yes.
Q. And stains can also be used to help

0145

determine the primary site of where the cancer arose?
A. To a considerable extent, yes.
Q. Sometimes you can have cell types of cancers that look the same, regardless of where they arise?
MR. GDANSKI: Object to the form.
A. Absolutely. Most cancers in adults are adenocarcinomas, and there's a good chance she might have had, we don't know that, and adenocarcinoma is under -- from the breast, colon, lung, and other sites can look the same and special stains are often helpful there. What's often very helpful is the clinical scenario, with the latter being most important.
Q. But you would again agree that the pathologist needs the tissue to put on the slides and staining to try to help determine the primary site?
MR. GDANSKI: Object to the form.
A. It's often done.
Q. This will be an easy one.
MR. GDANSKI: You said that earlier to one that was very not easy.
Q. No tissue was ever obtained in Helen

0146

Cohen's case?
A. To the best of my knowledge, no.
Q. Do you agree that there was no tissue obtained from Helen Cohen to determine whether she had a condition mimicking cancer or actually had some type of cancer?
MR. GDANSKI: Object to the form.
A. Well, I have no question she had cancer. I

can't imagine anything mimicking this clinical scenario. But she didn't have a tissue diagnosis to confirm with 100 percent certainty that she had cancer. This was not mimicking cancer. Maybe she mimicked death three days later.

Q. Do you agree there was no tissue obtained in Helen Cohen's case to determine the cell type of cancer?

A. Yes.

Q. And do you have any opinions on the cell type of cancer that Helen Cohen had?

A. Do I have --

Q. Let me rephrase it. Are you going to offer any opinions at the trial of this case about the cell type of cancer that Helen Cohen had or are you unable to do that because we don't have a tissue sample?

0147

MR. GDANSKI: Object to the form.

A. I could speculate, but I can't say for sure.

Q. I don't want your speculation. So is it fair to say that you are unable to tell us today what cell type of cancer that Helen Cohen had at the time of her death?

MR. GDANSKI: Object to the form.

A. If you ask me what I thought she had it, I'd be glad to tell you in terms of cell type, but I certainly can't tell you with any degree of certainty what cell type she had.

Q. Do you agree that in all the medical records that you've looked at on Helen Cohen, there's not a single doctor that makes any mention of a cell type of Helen Cohen's suspected cancer?

MR. GDANSKI: Object to the form.

A. No, I don't agree.

Q. You don't agree?

A. Right.

Q. There's a medical record that you've seen that references a cell type of Helen Cohen's suspected cancer?

A. There's a sentence in the deposition that speculated on the cell type.

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Q. Whose deposition speculated on a cell type?

A. Dr. Jacobson.

Q. I'll come back to the deposition in a second. In terms of a medical record on Helen Cohen that you have seen or are aware of, there is no medical record that reference any cell type diagnosis for her suspected lung cancer; is that true?

A. I've certainly not seen every medical record, but there's nothing that I've seen that

speculated in the medical records what kind of cell type.
Q. You've looked at pages and pages of medical records, but you haven't found that, have you?
A. Right. I have not. Let me look at the CT report. No, no medical record that I've seen.
Q. Now, with respect to Dr. Jacobson's speculation about the cell type, do you know whether or not today he still holds that opinion?
MR. GDANSKI: Object to the form.
A. I've not spoken to Dr. Jacobson today.
Q. Have you read the second volume of his deposition?
A. I've scanned it. I do know that he was a little bit intimidated by you guys.

0149

Q. You're not being serious, are you, doctor?
A. I'm not being serious.
Q. Are you aware, as we sit here today, that Dr. Jacobson withdrew his speculation about that?
A. We haven't talked about what he said. Why don't you show it to me.
Q. I will. I promise we're going to get to this when we get back. I'm not going to chew up the time, but I promise I'll show it to you.
MR. GDANSKI: Show him what?
MR. DAVIS: What he asked me to show him.
(Discussion off the record)
(Luncheon Recess)

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AFTERNOON SESSION
BY MR. DAVIS:
Q. Dr. Strauss, I've got some housekeeping issues to start off with. Are you ready to restart your deposition?
A. I am.
Q. Do you understand you're still under oath?
A. I am.
Q. With respect to Exhibit 10, that's the CD marked "Cohen Med Rec," am I right that you did not review or rely upon these documents in order to form your opinion because you couldn't access them?

A. I could access them. I got it yesterday. I opened it up and I opened to random documents that were some old records. But I didn't read those.
Q. And you're not relying upon the documents that are on the CD that's been marked as Exhibit 10 to form your opinions in the case, are you?
MR. GDANSKI: Object to the form.
A. Yes, that's correct.
Q. Now, I've taken the 14 disks that you provided, and marked them as Exhibit 17 through 30. Can you confirm that that's accurate?
(CDs marked as Exhibits 17 through 30 for identification)
0151
A. I don't see anything on that. This is, it looks like 20 and 21. So that one wasn't marked, it looks like. Here is another one. It looks like 26 is missing.
Q. I suspect what happened is they may have fallen off. Okay, handing them back to you, is that Exhibits 17 through 30, the 14 disks?
A. Yes.
Q. Hopefully we don't have to ask about them again. Exhibit 3, which is your typed notes, there's yellow highlighting?
A. Yes.
Q. What does the yellow highlighting signify?
A. I hadn't known to bring them, so it's really just to direct my attention. So I guess it's something I just wanted to make clear that I could find again.
Q. So now, did anybody ask you to highlight those particular parts of your typed notes?
A. No. Nobody actually asked me to take notes.
Q. Now, with respect to the depositions of Helen Cohen's treating physicians that were taken in the case, are you relying on those in any way to form your opinions?
0152
A. No.
(Document marked as Exhibit 31 for identification)
Q. I've marked as Exhibit 31 a portion of the medical record that came out of Exhibit 6, which is all the medical records you have on Helen Cohen, that includes the August, 2005 ultrasound that you discussed with Mr. Gdanski yesterday; is that right?
A. Yes.
Q. I promised at the conclusion of the morning session that I would show you the testimony of Dr. Jacobson. Do you see on Page 295 and 296 -- on Exhibit 3 you don't have Volume 2 of Dr. Jacobson's deposition, do you?

A. No. I stopped taking notes.
Q. Did you read Dr. Jacobson's second volume?
A. That was the first one I looked at. If there was any I read, it was the first one.
Q. Do you see on Pages 295 and 296 where Dr. Jacobson is asked the question, "Given the information from the tumor markers and the ultrasounds that we've gone over today, which you had not been provided, you cannot say to a reasonable degree of medical probability that Helen Cohen had small cell lung cancer"?

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A. May I read 295 and 296?
Q. Yes. Have you read Pages 295 and 296?
A. Just up to 296. So what was your question again?
Q. Looking at Pages 295 and 296 of Dr. Jacobson's Volume 2 of his deposition, do you agree that he withdrew his opinion about Helen Cohen having small cell lung cancer?
MR. GDANSKI: I object.
A. Let me just read. "Given the information from the tumor markers and the ultrasounds, that's 296, that we've gone over today which you had not been provided, you cannot say to a reasonable degree of medical probability that Helen Cohen had small cell lung cancer? Object to form. I cannot say that."
So I guess I'm not sure how you would interpret that. I'm not sure he's actually retracting it. I'm not sure he's saying she had small cell lung cancer --
Q. Let's not quibble. "In your last deposition you talked about how -- Helen Cohen and small cell lung cancer. Given the evidence that you've seen today with the tumor markers and the vaginal -- the pelvic ultrasound, do you want to

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withdraw that opinion? Answer: I would withdraw that opinion."
A. Oh, I'm sorry. Okay, yes.
Q. So you know of no treating physician of Helen Cohen that's even speculated that she's had small cell lung cancer at the time of her death?
MR. GDANSKI: Object to the form.
A. Part one still stands, but he withdrew the opinion. So if somebody says it was probably small cell carcinoma and withdraw the opinion, he's still speculated.
Q. Now --
A. If you asked me that question, it wouldn't have affected my opinion whatsoever.
Q. Do you agree before recommending treatment for a patient that you also want to stage a cancer

to see how it has spread?
A. Yes.
Q. Do you agree that generally CT scans of the chest, the abdomen and the pelvis are done to check for other primary sites, and to see if and how widespread the disease is?
MR. GDANSKI: Object to the form.
A. Typically somebody with a suspected lung cancer, we'll usually do a CAT scan of the chest and

0155

abdomen.
Frankly, in our institutions and many institutions, if you order a CT of the chest, it will include the upper abdomen, including the adrenals. We don't necessarily need to do the pelvis, though we often will be doing PET scans as well, which is a whole body scan.
Q. That's another test that is typically ordered when a patient is suspected of having cancer is a PET scan, right?
A. It's a very useful test to stage the disease.
Q. And it's a useful test also to assess whether there might be primary sites in the body and how widespread the metastases is?
MR. GDANSKI: Object to the form.
A. Well, you've asked two separate questions. I certainly agree with the second part, how widespread the metastases are. In terms of suggesting other primary sites, it depends on the primary site.
Q. Do you agree that PET scans can be helpful in determining a primary site?
A. It's not their primary use at all. It's approved for patients who have solitary pulmonary

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nodules to see if it's malignant or not and for staging of other established cancers.
I don't believe it's approved -- I may be wrong about this, I have not looked at that -- but I don't believe it's actually approved by any organization for searching for a primary site, particularly because certain primary sites don't tend to pick up -- don't have PET avidity or not.
Q. Have you ever used the PET scan for purposes of identifying a primary cancer site?
A. No, I don't think I have.
Q. Do you agree that the more widespread the disease is that the primary site is more difficult to identify?
MR. GDANSKI: Object to the form.
A. Not necessarily.
Q. Do you agree that more often than not that if the disease is widespread, the primary site is

more difficult to assess?
MR. GDANSKI: Object to the form.
A. I disagree with that. The vast majority of the time we know the primary site, and you're doing it purely for staging purposes, to stage the whole body, with the exception of the brain, where PET is not a good test for evaluating the brain.

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(Document marked as Exhibit 32 for identification)
Q. Let me hand you what's been marked as Exhibit 32 to your deposition. Do you see this is a copy of a March 3, 2006 CT scan on Helen Cohen?
A. I do see that, yes.
Q. Do you see there that the radiologist says that lung cancer is suspected?
A. I certainly do.
Q. So in terms of the radiographic evidence, you would agree that this radiologist said that lung cancer was suspected, but he did not say that it was confirmed?
MR. GDANSKI: Object to the form.
A. I don't see that he said lung cancer is suspected. He doesn't -- I don't see the word "confirmed" in here.
Q. Do you agree Helen Cohen did not get a workup to assess primary sites of cancer outside the lung?
MR. GDANSKI: Object to the form.
A. Why in the world would you want to do that to make sure she had an obvious diagnosis.
Q. That's not my question. My question is simply she did not get a workup to identify primary

0158

sites of cancer outside the lung, did she?
MR. GDANSKI: Object to the form.
A. She also didn't go through the amusement park. It was not indicated. I don't mean to give you a hard time, but I don't mind giving you a hard time when you ask questions that are irrelevant to the case.
Q. Well, you understand one of the issues in the case whether or not she had a primary lung cancer or not, right?
A. I understand that that's the main issue from your perspective. It's not an issue at all, as far as I'm concerned.
Q. You've seen deposition testimony from Helen Cohen's treaters where they say they could not identify the primary site of her cancer?
A. You're going to have to show it to me.
Q. You're not aware of that?
A. You'll have to show it to me.
Q. I'm just asking you, are you aware of it or

not?
A. We just talked about Dr. Jacobson's deposition.
Q. We did. Are you aware of any other doctors that have testified that he or she could not

0159

identify the primary site of Helen Cohen's cancer?
MR. GDANSKI: Object to the form.
A. My depositions are there. I'd be glad to spend the next couple of hours going through every page of it to verify the assumptions of your question. I can't answer that at this point in time.
As I said, it's very difficult to read thousands of pages of depositions.
Q. Do you agree that it is relevant to an assessment of whether or not Helen Cohen had primary lung cancer is to look for cancer outside of the lung?
A. Not if somebody --
MR. GDANSKI: Object to the form.
A. -- has an obvious cancer.
Q. Well, the question, though, is with Helen Cohen, not that she had an obvious cancer. The relevant question is, did that cancer originate in the lung area or in the chest or outside that area and spread to the chest or the lung?
MR. GDANSKI: Object to the form. Asked and answered. Are you asking him if that's the relevant question?
Q. Do you understand my question?

0160

A. No, I don't.
Q. Do you agree, doctor, that one of the relevant questions in this case is whether or not Helen Cohen had a primary lung cancer or she had a cancer that started elsewhere and spread to the lung?
MR. GDANSKI: Object to the form.
A. That's a relevant question from your perspective. That is grandstanding in my opinion. She had metastatic lung cancer. I would say with 99 percent certainty, she had cancer, given the fact that there's a one percent chance perhaps that she didn't have cancer, since the biopsy was done, and in my view a 90 percent chance this was primary lung cancer. I didn't say 100 percent. Those are the probabilities I would assert.
Certainly one would not, in a woman who is dying from metastatic lung cancer and would be dead seven, eight days after the CT scan, to start doing PET scans to look for a second primary site is totally ridiculous.
Q. Doctor, is there any piece of evidence that

would change your mind so that you would conclude that Helen Cohen did not have a primary lung cancer, but instead, had a cancer that originated outside

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the lung and spread to the lung?

MR. GDANSKI: Object to the form.

A. Not unless I've overlooked major aspects of the case.

Q. Tell me what you know about Helen Cohen's family history of cancer?

A. I don't know for an absolute fact that it's accurate, but I did take it from medical records. Family history of cancer or family history? Well, let me just read. Mother died of diabetes and heart, presumably heart disease. Father died of stroke. One sister died of stomach cancer. Aunt died of lung cancer. Two cousins died of breast cancer.

Q. Do you believe Helen Cohen's family history placed her at an increased risk of primary stomach cancer?

A. No.

Q. Do you agree that Helen Cohen's family history placed her at increased risk of breast cancer?

A. Not necessarily. I would modify my first answer that stomach cancer is also not necessarily.

Q. So it might or it might not?

A. Right. A lot of people say stomach cancer,

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because of, you know, do they truly mean gastric cancer or do they mean some abdominal cancer. So I don't have any details.

Q. But do you agree that family history of stomach cancer, such as Helen Cohen had, is a risk factor for her to develop stomach cancer?

MR. GDANSKI: Object to the form.

A. I do not know that. I don't know, you know, whether her sister truly had gastric cancer. I don't know the subtype of the gastric cancer, and it's not necessarily cancer that is very strongly related to any specific genetic risk factor.

Q. Is it fair to say you can't rule out that Helen Cohen's family history placed her at an increased risk of stomach cancer?

MR. GDANSKI: Object to the form.

A. I can't rule anything out.

Q. Do you hold that opinion to a reasonable degree of medical probability?

MR. GDANSKI: Object to the form.

A. Yes.

Q. Do you agree that you cannot rule out that Helen Cohen's family history put her at an increased risk of breast cancer?

A. The question is what's cousins? Are we
0163
talking about a second degree relative, first cousins, are we talking about a third cousin three times removed? So I don't know that.
Q. So you can't rule that out; is that fair?
A. Of course.
Q. Do you hold that opinion to a reasonable degree of medical probability?
MR. GDANSKI: Object to the form.
A. I can't rule it out. I think it's extraordinarily doubtful.
Q. But you hold that opinion to a reasonable degree of medical probability, correct?
MR. GDANSKI: Object to the form.
A. Sure. Your question about the aunt that died of lung cancer?
Q. Yes. So with that history, just like you've called into question about the breast cancer or the stomach cancer, you can't say one way or the other whether that history placed her at increased risk?
MR. GDANSKI: Object to the form.
A. Again, I don't know which side, I don't know whether it's a great aunt or something else.
What I do know, and that's something I know a fair amount about, is that among -- what is the
0164
issue of genetic risk in people who are smokers, and people who are smokers, which of course you raise the risk of lung cancer by 20 to 50 or more times, a first-degree relative with lung cancer, if you're a smoker, increases your risk probably about twofold, so that might or might not be relevant. I don't know that.
Q. I think I understand what you're saying. Because you don't know the specifics about Helen Cohen's family member or aunt with reported lung cancer, you can't say whether that placed her at an increased risk, true?
A. Obviously the thing that placed her at an increased risk was her 100 pack year history of cigarette smoking.
Q. How would you go about ruling out a primary ovarian cancer in a patient?
MR. GDANSKI: Object to the form. Incomplete hypothetical.
A. Why would I want to do that?
Q. You have a patient that presents symptoms that may or may not be primary ovarian cancer, and you need to rule it in or rule it out.
A. Show me the symptoms that you may or may not have had that would be primary ovarian cancer?
0165

Q. I haven't gotten to Helen Cohen, but I will. She comes into you, and she may or may not have primary ovarian cancer, how do you rule it out?

MR. GDANSKI: Object to the form.

A. I have a lot of expertise in the issue of screening for cancer, including screening for ovarian cancer. I lecture on it all the time. We don't have any effective tools for screening for ovarian cancer.

Ultrasound is a particularly unuseful test. There are two large studies, including one very large randomized study, that looked at transvaginal ultrasounds for screening for ovarian cancer. It's called the PLCO study. It stands for prostate, lung, colon, ovary. So it was a National Cancer Institute randomized study of 150 men and women, so half of them were women, and they were randomized to screening for PSA for prostate cancer, chest x-ray for lung cancer, sigmoidoscopy for colon cancer, and transvaginal ultrasound and CA-125 for ovarian cancer.

What they found is about, I believe, three and a half percent of the 30,000 women or so had abnormal transvaginal ultrasounds, and the positive predictive value of that for ovarian cancer, meaning

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the proportion of women who actually had an abnormal transvaginal ultrasound that turned out to be cancer, was less than one percent. I believe it was .97 percent.

Another very large study of abdominal ultrasounds --

Q. Can I stop you?

A. Sure.

Q. Can I go back to my question?

MR. GDANSKI: He's in the process of answering.

MR. DAVIS: I don't think so.

MR. GDANSKI: I object to stopping him from answering the question.

Q. Let me see if I can ask a more tighter question.

A. Sure.

Q. What tests would you run or studies would you run to rule out primary ovarian cancer in a patient?

MR. GDANSKI: Object to the form.

A. Well, I wouldn't be doing any test to rule out primary ovarian cancer, unless the patient presented with symptoms that suggested primary ovarian cancer.

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Typically abdominal pelvic pain, often with ascites, you know, she had liver metastases,

metastases to the substance of the liver as opposed to the surface of the liver, are very uncommon with ovarian cancer.

So this is not a presentation that in the least bit suggests itself to be ovarian cancer. So I wouldn't be doing anything. The vast majority of tests you would do, you might wind up with an abnormal test, but the vast, vast majority of those abnormal tests are false positives.

Q. You have a patient who presents symptoms of ovarian cancer. Would you do a CT scan of the pelvis to help you rule in or rule out primary ovarian cancer?

MR. GDANSKI: Object to the form.

A. We probably would. But actually an ultrasound is probably a better test to look for a solid mass, as well as omental metastases.

Q. Would you also try to obtain tissue for pathological analysis?

A. If you suspect that the patient had ovarian cancer, which there's no reason to -- Mrs. Cohen did not have ovarian cancer. Let me make that very clear. And there was no reason to suspect ovarian

0168

cancer. In fact, there's lots of reasons to say that this is clearly not ovarian cancer.

But if somebody presents with symptoms of ovarian cancer, it's actually a tricky diagnosis. Often it's made at the time of exploratory laparotomy, because so many of the tests are inconclusive or the alternative is somebody might present with ascites and you'll tap it, and you will prove that isn't primary ovarian cancer.

Q. What are the symptoms that are consistent with a primary stomach or GI cancer?

A. Well, GI includes esophagus, stomach, small intestine, colon, rectal --

Q. How about if I narrow it to say stomach or gastric cancer; does that help out?

A. Sure.

Q. What symptoms are consistent with a patient who has primary stomach or gastric cancer?

MR. GDANSKI: Object to the form.

A. Well, usually, unless it's presenting as metastatic disease, which often occurs, gastric cancers have gone down dramatically in that sense in the United States. But typically it's GI symptoms. So it could be, you know, left upper quadrant pain, difficulty swallowing, pain swallowing, those sorts

0169

of symptoms.

Q. Could it be pain in either side?

A. Well, sure. The stomach is sort of in the midline, but it's mostly on the left side.

Q. Could it be constipation?
A. Other than you're not eating, so there may be a change in bowel habits. Constipation shouldn't be a primary symptom of gastric cancer.
Q. What about stomach cancer, if you're differentiating between stomach and gastric?
A. Where I said stomach, people often refer to stomach as anything in the abdomen. But gastric, you know, I'm referring specifically to the stomach, the true stomach.
Q. What would be symptoms that would be consistent with primary breast cancer?
A. Breast cancer, you know, usually does not present -- we do very well with breast cancer.
(Phone)
Q. The question was, what symptoms are consistent with primary breast cancer?
A. Well, the most common presentation are no symptoms, and either a mass in the breast or an abnormal mammogram. When breast cancer spreads, the vast majority of the time it spreads to the bone or
0170
the regional lymph nodes.
Breast cancer is not a common cause of cancer of unknown primary, with the exception of a woman that presents with an axillary lymph node presumed to be breast cancer from that side, there was no evidence that she had breast cancer.
Q. Do you know whether or not any of her doctors did any radiology studies that would have looked for a tumor or an abnormal lymph node in her breast area?
A. A tumor -- well, you know, I didn't see a mammogram done that last week or so of her life, and I didn't look at extensive records. So I must admit, I don't know whether she had had mammograms in recent years.
A CAT scan, frankly, will often sometimes show axillary adenopathy and a mass in a breast. That's often why you do a CAT scan, you do see that, especially if you did have the CAT scan and you possibly would have dealt with that, but you wouldn't have ordered the CAT scan for that purpose.
Q. What are the symptoms that are consistent with the primary colon cancer?
A. More and more to a greater extent, people are presenting with they found a polyp, they repeat
0171
it, and eventually they find a colon cancer. So we're seeing a lot of patients asymptomatic with colon cancer.
The symptoms of colon cancer depends upon where in the colon or rectum it is. On the left side it can be constipation. On the right side it

may be no symptoms or some anemia, because you're losing blood.

She didn't have clear colon symptoms that I'm aware of from the records that I saw. There's no evidence for colon cancer here. Her CEA was not very elevated. I think it was a tiny bit elevated with colon cancer.

Q. For primary ovarian cancer, can you have a patient that presents with no symptoms but does have primary ovarian cancer?

MR. GDANSKI: Object to form.

A. The answer is yes. But we don't -- we don't screen for it in the woman at average risk. The lifetime risk for a woman of average risk, without a genetic risk factor to develop ovarian cancer, is one in 70 in her lifetime as opposed to one in eight, nine or ten for breast cancer, and we don't screen for it.

We actually do screen for it in women who

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have a mutation that puts you at risk or strong family history. So we don't have any good screening tests for looking for ovarian cancer.

And it's not a, you know, I refer to that PLCO study, the reason that the "O" was added -- it was initially the PLC study, because there were other studies, and Pat Schroeder, who was a female senator, said how can we do prostate cancer screening without doing something for women, so they put in ovarian cancer, even though it was never an appropriate disease to screen for, as it is much less common and no good screening test.

So they did the test and did the study and they proved there's no good screening test.

Q. Can you have primary stomach or gastric cancer in a patient, and that patient present with no symptoms?

A. Well, I mentioned that gastric cancer -- in 1930 it was the most common cancer in the United States. It's now No. 10, I believe. It is still one of the most common cancers in the Far East where they actually do screen for it. But we don't screen for it unless somebody has got some risk factor, GERD, but we don't screen for it. Usually if you're looking for it, there's some symptom that leads you

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to look for it.

Q. I appreciate that. That's very helpful. But with respect to my question, is it true that you can have a patient with a primary stomach or gastric cancer, and they present with no symptoms?

MR. GDANSKI: Object to the form.

A. What do they present? What's making you think of it?

Q. Let me rephrase it, then. Is it true that a patient can be in a doctor's office, have no symptoms of primary stomach or gastric cancer, yet still be sitting in that office with primary gastric or stomach cancer?

MR. GDANSKI: Object to the form.

A. Of course. The whole nature of screening is that there is this asymptomatic preclinical phase, which is years long. If you don't look, you're not going to find it. So it's very possible that that patient has gastric cancer, but there is no way you're going to know about it if they don't have symptoms and you're not looking for it.

Q. I think you told me a risk factor for primary colon cancer is polyps; did I understand that correctly?

A. Absolutely.

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Q. And you're aware that Helen Cohen had had a surgery to remove polyps, aren't you?

A. I believe I read somewhere that she had a history of a colonic polyp. The vast majority of colon cancers arise in polyps. The vast majority of polyps are colon cancers.

Q. Do you know what the timeline is? Have you ever gone back and looked and analyzed about whether she was ever asked to follow up on getting another colonoscopy and whether she did it or not?

MR. GDANSKI: Object to the form.

A. The answer is, I don't specifically know. If somebody has polyps, she should have another colonoscopy probably three years later, something like that. It depends upon who is doing the recommendations and the nature of the polyp.

Q. Does the fact that she had those polyps, which were removed, reflect that she was at increased risk for later on having primary colon cancer?

MR. GDANSKI: Object to the form.

A. So many people have polyps, and having polyps is a -- I guess I don't exactly know the answer. Lots of people don't have colonoscopies to know that. So I don't know that.

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The risk is small, and the asymptomatic -- bottom line is, it takes -- to go from polyps to cancer is probably ten years. To go from polyps to dying from metastatic cancer, it's a lot longer than that.

There's no evidence whatsoever that she had gastric cancer, colon cancer, ovarian cancer. I know you didn't ask me that question. I'm just trying to be helpful to you.

Q. And you are.

A. Thank you.
Q. Is it true that Helen Cohen had gastroesophageal reflux disorder, which is a risk factor for stomach or gastric cancer?
MR. GDANSKI: Object to the form.
A. Yeah. The major risk factors are something called Barrett's esophagus, which is a pathologic abnormality, which is not cancer, but which is precancer, and people with GERD will have that. Those patients may be appropriate candidates for screening. GERD itself I don't think is. Certainly nobody is recommending it.
Barrett's esophagus is a risk factor. I don't believe there's any evidence she had Barrett's esophagus.

0176

Q. Doctor do you use two markers to help you identify the primary site of a cancer?
MR. GDANSKI: Object to the form.
A. Mostly not.
Q. I'm going to hand you what's been marked as Exhibit 33 to your deposition.
(Document marked as Exhibit 33 for identification)
A. The only possible exception to that would be PSA for prostate cancer. Two-thirds of the patients with elevated PSAs have benign causes.
Q. Do you see this is a fact sheet issued by the National Cancer Institute?
A. Yes, I do.
Q. It's dated 12/7/2001 as when it's reviewed?
A. Yes.
Q. Now, do you believe that the National Cancer Institute is a reliable institution with respect to cancer issues?
MR. GDANSKI: Object to the form.
A. I was a fellow at the National Cancer Institute, and I often like to say that I know firsthand how little those people know. No, I'm being facetious. I agree with that.
Q. You look at the "Key Points," and it says

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the second one, "Tumor markers may be used to help diagnose cancer, predict a patient's response to certain cancer therapies, check a patient's response to treatment or determine whether cancer has returned." Do you see that?
A. Yes, I do see it.
Q. Do you agree with that?
A. Not necessarily.
Q. Which part do you disagree with and which part do you agree?
MR. GDANSKI: Object to the form.
A. I think, frankly, diagnosing cancer is

actually not very useful. It's usually to confirm a diagnosis once you have it, because of, you know, the very poor positive predictive value.

The one we most commonly use for diagnosing it is PSA for prostate cancer. But there's extensive data that two-thirds to three-quarters of patients with an elevated PSA will actually have benign prostatic hypertrophy or benign causes.

CA-125, which is a marker that we most strongly associate with ovarian cancer, is commonly elevated in a variety of other things.

I actually wrote an article -- there was seminars in Hematology Oncology in 1994, and I wrote

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the article on tumor markers and lung cancer. It was actually dealing with all sorts of cancers, and I reviewed the literature as it existed at that point in time.

CA-125 was elevated about 30 percent of the time, and actually can be a useful tumor marker in following response to therapy, but is useless in making a diagnosis and the PLCO study, the one that had 75,000 women got randomized to transvaginal ultrasound and CA-125 versus no screening, usual care, the positive predictive value for an elevated CA-125 for ovarian cancer was a little higher than the ultrasound, which was less than one percent. I think it was about three percent.

Q. What other conditions elevate CA-125?

A. A lot of benign conditions, including COPD may have it. But it's elevated in a lot of epithelial cancers, including lung cancer. I often order it in my lung cancer patients, because I think it's actually somewhat useful in assessing a response to chemotherapy, if that's what we're doing. But it's not the least bit useful in predicting, in ruling in or ruling out anything.

Q. Now, if you look on Page 3 of this fact sheet, do you see that it discusses CA 15-3?

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A. Yes.

Q. That's a tumor marker that can be elevated in breast cancer?

A. Yes.

Q. And there's also CA 19-9, right?

A. Yes.

Q. That's a tumor marker that can be elevated for pancreatic cancer, gallbladder cancer, bile duct cancer and gastric cancer?

A. Right. It can also be elevated in other things. Both of these can be elevated in lung cancer.

Q. Do you use either CA 15-3 or CA 19-9 to make a diagnosis of primary lung cancer?

A. No.
Q. Underneath, a little bit later on, there's the CEA --
A. Yes.
Q. -- tumor marker?
A. Yes.
Q. That is elevated in colorectal cancer and breast cancer, true?
A. But it's elevated in lots of other things.
Q. True, but it is --
A. True. It is elevated in lots of other

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things, including a lot of benign conditions.
Q. What tumor markers did Helen Cohen have that were elevated?
MR. GDANSKI: Object to the form.
A. I didn't look through every record, but the two I commented on were the CEA and the CA-125.
Q. Those are the two that you spotted?
A. Yes.
(Document marked as Exhibit 34 for identification)
Q. Let me hand you what's been marked as Exhibit 34 to your deposition. Do you see this is the test results for Helen Cohen's tumor marker analysis?
A. I see the CEA here --
Q. I think the last page goes into the other ones.
A. Okay. So the CEA was 88.2, which is abnormal. Normal is three. So the CA-125 was 115. Usually the upper limit of normal is 35. It looks like they are saying here the upper limit of normal is 21.
Q. Would you consider that to be a very high result?
A. Absolutely not.

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MR. GDANSKI: Form.
A. Mildly elevated.
Q. Mildly elevated?
A. Mild to moderate, but it's certainly not very high.
Q. Do you see that it's also elevated for CA 15-3?
A. Yes. Is that 164 or 1,640? I'm not sure. I guess it's 1,640.
Q. I think it's 39.
A. Oh, yes, I'm sorry. Totally misread that. So it's mildly elevated. The CA 19-9, which is the marker we most strongly associate with pancreatic cancer or gastric cancer, is normal.
Q. And CEA tumor marker was elevated at 88.2?
A. Yes.

Q. Where would you rank that; mild, moderate or high?

A. Certainly not very high. Normal is three. Probably moderate. It's not very high. It's not of any diagnostic significance, given that we know that she had lung cancer with massive liver metastases.

Q. If you had a patient that had these tumor markers elevated, and you knew nothing else about the patient, what primary cancers would you suspect?

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MR. GDANSKI: Object to the form.

A. I wouldn't be thinking about the patient unless I knew something else about the patient.

Q. Okay.

A. I don't believe in our board exams they would have asked that question, because these markers are not useful diagnostics.

Q. If you had a patient who had test results of these elevated tumor markers, like Helen Cohen's, that came back, and also there was a CT scan that suspected primary lung cancer, what would you do to rule out the other primary cancers that are put in play because of these tumor markers?

MR. GDANSKI: Object to the form.

A. I wouldn't do anything. It doesn't affect the diagnosis whatsoever. It sort of confirms that she's got lung cancer, you know, particularly the extensive liver metastases.

Q. What would you do to rule out in that patient whether they have a primary ovarian cancer, a primary stomach cancer, primary breast cancer, or a primary colon cancer?

MR. GDANSKI: Object to the form. Asked and answered.

A. The best way to rule it out would be to do

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an autopsy. I'm being facetious here. Short of that, you're not going to rule it out.

It doesn't come up as a realistic consideration, given the fact that there was no evidence for gastric cancer and there's no evidence for ovarian cancer, and all the tests that we have, you know, if they are abnormal, are much more likely to be false positives than true positives.

Do you know how you rule something out? I guess I'm not supposed to ask the questions.

MR. GDANSKI: Just let him ask the questions. Don't be facetious, because it doesn't reflect on the record.

Q. Doctor, other than the August, 2005 ultrasound on Helen Cohen that you discussed yesterday with Mr. Gdanski, did you review any other ultrasounds, pelvic ultrasounds, on Helen Cohen before arriving at your opinions?

MR. GDANSKI: Object to the form.
A. I didn't review that ultrasound. I just looked at the report.
Q. Let me fix my question, then. Before arriving at your opinions in the case, did you review the pelvic ultrasound reports on Helen Cohen, other than the one that Mr. Gdanski showed you

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yesterday, because I think you told us you had seen that after you formed your opinion?
A. I believe I saw one that was sometime in the 1990s. I don't remember when.
Q. Do you know whether there are any other pelvic ultrasounds on Helen Cohen between 1990 and the August, 2005?
A. I didn't say 1990. I said 1990s. So I don't know when that one -- the answer is, I do not know.
(Document marked as Exhibit 35 for identification)
Q. I'm handing you Exhibit 35. Do you see that's a pelvic ultrasound on Helen Cohen dated July 23, 1997?
A. Yes.
Q. Did you review that pelvic ultrasound before forming your opinions in this case?
A. I don't know whether this is the one that I had seen. I don't remember for sure. I thought it was earlier, but I don't know.
Q. Do you want to look through your materials?
A. Let me just read this. Do you want me to look through this?
Q. It's up to you. Let me just ask you. Do

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you recall seeing what's been marked as Exhibit 35 before you formed your opinions in the case?
A. I remember seeing one other ultrasound report -- it may be this one -- which was found abnormal.
Q. Do you want to look through it?
A. If you would like me to.
Q. It's up to you.
A. It's not going to -- it's not going to affect my opinions.
Q. All right. Then I'll just keep going, then.
A. We have a normal pelvic ultrasound from 1997.
Q. Her ovaries demonstrate a normal size and echogenic pattern, with the left at 1.2 by .8 by 1.1 centimeters, and the right 1.4 by 1.8 by 1.0 centimeters, right?
A. Yes.
Q. You've got no reason to question the

accuracy of this report, do you?
A. No.
Q. Let me hand you what's going to be marked as Exhibit 36, and ask you if you've seen that document before forming your opinions in the case.

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(Document marked as Exhibit 36 for identification)
A. Not that I recall. Again, I've seen one. I thought it was earlier. I don't think I've seen this.
Q. Now, this one is dated September 15, 1998?
A. Yes, it is.
Q. It's on Helen Cohen again?
A. Yes, it is.
Q. And this one, they did a pelvic sonogram, but neither ovary could be identified, right?
A. That's what it says.
Q. Let me hand you what we've marked as Exhibit 31 to your deposition, which contained the August 22, 2005 ultrasound on Helen Cohen.
A. Yes.
Q. This transvaginal ultrasound says that the right ovary measures 3.6 by 2.5 by 3.5 centimeters with multiple shadowing hyperechoic foci consistent with calcifications, true?
A. Yes, that's what it says.
Q. It also says the left ovary measures 4.1 by 2.7 by 4.0 centimeters, also demonstrating multiple high-density shadowing lesions consistent with calcifications?

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A. Yes.
Q. The impression is "Bilaterally enlarged ovaries with shadowing foci suspicious for calcifications, Ob/Gyn consultation is recommended," true?
A. Yes.
Q. Do you have any reason to doubt the accuracy of this ultrasound?
A. Absolutely not.
Q. Now, if you had a patient that -- let me back up. Can we agree that looking at the July 23, 1997 ultrasound and the August 22, 2005 ultrasound, do you agree that there are suspicious masses in Helen Cohen's ovaries?
MR. GDANSKI: Object to the form.
A. I don't have an independent opinion. I don't see the word suspicious masses. I see she had bilaterally enlarged ovaries, which suggested some calcifications.
Q. Are you saying that those are not suspicious for some type of malignant process going on?

A. I think an overwhelming probability is that, as I already mentioned to you, you take 30,000 women and do a transvaginal ultrasound, about three
0188
percent of them are going to have abnormal ultrasounds, and less than one percent of those are going to be ovarian cancer. So it's not a useful test for screening for ovarian cancer.
I'm sure if it were my patient, I would probably consult a gynecologist.
Q. If she were your patient, would you tell her after getting back this ultrasound that shows that her ovaries are both enlarged, would you tell her to go home, don't worry about it?
MR. GDANSKI: Object to the form.
A. No, I didn't say that.
Q. What would you tell her?
A. I would say that the -- I would say that -- it's very unlikely that I would be ordering a transvaginal ultrasound, unless there was some reason that I'm suspicious of something in the pelvis. But that's not the question you've asked.
I would say that the ovaries are enlarged. The overwhelming probability is that she's got some benign process, and if we wanted to explore it further, I would refer her to a gynecologist, not an obstetrician, for his or her evaluation of the patient.
Q. And if Helen Cohen presented on that day in
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your office with these two results, you wouldn't tell her, we can say you don't have primary ovarian cancer based on these test results, would you?
MR. GDANSKI: Object to the form.
A. I can't say she doesn't have primary anything based upon this. The overwhelming probability is that she probably had some -- benign processes of the ovary are extraordinarily common, and ovarian cancer is a relatively rare cancer.
Q. Are ovaries supposed to be getting larger in an 81-year-old postmenopausal patient like Helen Cohen?
A. I'm not an expert, so I don't know the answer to that question. But I think normally I wouldn't think so, but the vast majority of the time if they do, it's going to be a false positive.
That's why you wouldn't do this test unless there's some clinical indication, because the overwhelming probability is that this is a false positive if a true positive is defined as cancer and a false positive is defined as something else.
Q. It's not a question of whether you would do the test results, it's a question of we have the test results, right, and the question is, what do

you tell Helen Cohen; do you tell her you need to
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have further follow-up to rule out that there is the a malignancy that is starting in your ovaries?
MR. GDANSKI: Object to the form.
A. That's the last thing I would tell her. I would cite the data and the limitations of the data is that, you know, if you decide to undergo screening, and frankly, this was in patients who were 55 to 75, but I wouldn't recommend doing the test unless there was some clinical indication.
If for some reason the test was ordered by somebody else, and they asked me about it, I would cite the results that, you know, the probability that she's got cancer based upon this is less than one percent, the probability she has ovarian cancer based on this is less than one percent.
Q. Would you agree that you would recommend to Helen Cohen that she needed further follow-up and steps to rule out that there was some primary cancer that was occurring in her ovaries?
A. Since I wouldn't have been the one who ordered the test, but I'm very interested in screening, so I would point out the limitations and why I wouldn't have done the test unless there was a clinical indication, I would point out to her it's probably benign, there's a 99 percent chance that
0191
she doesn't have ovarian cancer, but if she was concerned and wanted to get it further evaluated, I'm not the person who is going to do it, so she should see a gynecologist.
Q. Do you consider yourself an expert in ovarian cancers?
MR. GDANSKI: Object to the form.
A. I'm knowledgeable in ovarian cancer.
Q. I'm talking about do you consider yourself as someone who is a go-to person for assessing primary ovarian cancer?
MR. GDANSKI: Object to the form.
A. Gynecologic oncology is a separate specialty, which are obstetricians and gynecologists who do surgery, but they also do chemotherapy. It's one of the two.
So ovarian cancer is in our hospital, and patients with known ovarian cancer, would be referred to a gyn oncologist rather than a medical oncologist. That wasn't always the case, and I've certainly treated a lot of ovarian cancer early in my career.
Q. You do not hold yourself out as an expert in gynecological cancers, do you? That's not your specialty, is it?
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MR. GDANSKI: Object to the form.
A. I'm a medical oncologist. I've passed my boards. There's a lot of questions on ovarian cancer and I've dealt with it throughout my career. It's not been a research focus of mine, although I'm interested in screening or ovarian cancer. I gave a lecture on ovarian cancer two months ago, which I do on a regular basis, to point out the limitations of screening.
Q. On this patient, Helen Cohen, if you saw these results with Helen Cohen, she's in your office, you would tell her you need to go see a specialist in gynecological cancers, because that's their area of specialty and not mine, true?
MR. GDANSKI: Object to the form.
A. Not true. The reason she would be in my office is because she was concerned or suspected of having cancer. If, in fact, this test was done for some reason, and she didn't have extensive liver metastases or a big mass in her lung strongly suggestive of lung cancer, I would certainly suggest that she see a gynecologist or even a gynecologic oncologist; probably a gynecologist. That's what they're recommending.
But if this were a patient of mine who
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actually had extensive lung cancer with liver metastases, the last thing I would do would be to have her see a gynecologist. It would be a useless test.
Q. As of August 22, 2005, you know of no medical record or radiographic image that showed any type of mass or abnormality in Helen Cohen's chest, true?
MR. GDANSKI: Object to the form. Can you repeat the question?
A. Yeah, I'd like you to repeat the question.
(Reporter read back pending question)
MR. GDANSKI: Object to the form.
A. Yes.
Q. So the situation you're talking about where someone is in your office and has something that may be suspicious in their chest, that's not what's happening to Helen Cohen in August 22, 2005, right?
A. Somebody with no suspicion of cancer, an abnormal pelvic ultrasound showing enlarged ovaries without a mass, would not be in my office.
Q. Because that's not the focus of your treatment in oncology, right?
MR. GDANSKI: Object to the form.
A. It's probably not -- there's no -- there's
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very little reason to suspect cancer in this circumstance.

Q. Well, what would be -- if you got these test results for Helen Cohen, she's 81 years old, she's postmenopausal, an ultrasound shows that she has enlarged ovaries on both sides, what would be in your differential diagnosis?
A. The question is why is she in my office in the first place? She wouldn't be in my office for this reason.
Q. Is there some reason you don't want to answer that question?
MR. GDANSKI: What is that question?
A. You're not making yourself clear.
Q. You're the expert, and I'm asking you about your opinions in this case. Helen Cohen's test results come back to you on this date, on April 22, 2005. You know about the prior pelvic ultrasound that shows the size of both of her ovaries. You now see that both of her ovaries are enlarged, as shown on this ultrasound of August 20, 2005. She's 81 years old. She's postmenopausal. What is in your differential diagnosis?
MR. GDANSKI: Object to the form.
A. If I were a primary care physician, and

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somebody who is expert in screening, and I think I'm expert in screening in cancer, I would discourage screening for ovarian cancer, unless it's a patient with genetic breast cancer or a strong family history, in which case we do it, without much success, because we don't have any effective tools.
But if I were a primary care doctor and I saw this report, I would do what the -- and I didn't even know, you know, what the probability of ovarian cancer is, which I do based upon this very large randomized study, but if I didn't know that, I would send her to a gynecologist.
Q. And what would be in your differential diagnosis?
MR. GDANSKI: Object to the form.
A. I think the large majority is that it's going to be some sort of benign ovarian neoplasm or a cyst or solid cyst. But ovarian cancer certainly is among the possibilities, but they're not reading an ovarian mass. They are just reading large ovaries.
Q. You don't read this as suggesting that there are masses in both of Helen Cohen's ovaries?
A. Educate me. Show me where the word "masses" is?

0196

Q. You're relying on that alone to say they are not masses in Helen Cohen's ovaries?
A. If there were masses in the ovaries, why wouldn't they say there are masses in the ovaries.

Q. So your opinion is if a radiographic report doesn't say the word "mass" in it, you can't say that there's an actual mass seen?
A. Frankly, if there was a mass, I would expect the ultrasonographer to say there's a mass or a suspicious mass. They are not saying this. They are saying bilaterally enlarged ovaries with calcifications. The word "mass" is not in here.
Q. Let me ask you a different question. Did you ever see any reference in Helen Cohen's medical records that reference --
(Phone)
(Recess)
BY MR. DAVIS:
Q. Doctor, is it your testimony that if any radiology report does not say the word "masses," that you cannot opine or conclude that a mass actually exists?
MR. GDANSKI: Object to the form.
A. If the radiologist doesn't say there's a mass, I can't conclude there's a mass?

0197

Q. Yes.
MR. GDANSKI: Object to form.
A. Yes, I guess I would say that, if I understand the question correctly. They didn't say mass. They just said enlarged ovaries.
Q. You'd read that in an 81-year-old female patient like Helen Cohen who was postmenopausal, that her ovaries should be atrophied?
A. I believe the answer to that question -- now I graduated medical school 40 years ago. I believe that that's the case, but I've not studied that.
Q. By "atrophied," in other words, they are shrinking and not getting larger, right?
A. Her ovaries are abnormal. The question is whether there's any reasonable suspicion this is cancer, and you can't rule it out based upon this. There's nothing here that would suggest cancer, and as I said, this large study indicates 99 percent of the time it's not cancer.
Q. The study that you keep talking about is a screening study, correct?
A. Correct.
Q. It's a study when a patient presents with no symptoms, true?

0198

A. Absolutely.
Q. Helen Cohen presented with symptoms, didn't she?
MR. GDANSKI: Object to the form.
A. Of course. She had symptoms of metastatic lung cancer.

Q. No, sir. At the time Helen Cohen had this transvaginal ultrasound in August of 2005, she presented with symptoms, didn't she?
A. Actually, you know, frankly, I don't know the answer to that question. I don't think -- I know she had the ultrasound. I don't know who ordered it. I don't know why they ordered it.
So, let's see, the physician was Michele Cohen -- 81-year-old woman with right upper quadrant pain. Okay. Let me see if there's anything else in here. You'll need to show me those records.
I don't believe I've reviewed them. I don't know why that was done, other than that one statement.
Q. Are you referring for the first time here today at your deposition about the symptoms that Helen Cohen presented with around the time period that she had the August 22, 2005 ultrasound?
A. I would hope to learn what those symptoms

0199

are. I haven't learned it, other than this one sentence in the ultrasound report.
MR. GDANSKI: Object to the form.
Q. You formed your opinions in this case without knowing what those symptoms are, true?
MR. GDANSKI: Object to the form.
A. You'll need to -- I would love to see why this was ordered and what the discussion was by Dr. Cohen after it was ordered.
Q. You did not investigate that issue before forming your opinions?
A. Certainly not, no.
Q. You do not know the symptoms she presented with and the reason why she had this transvaginal ultrasound in August of 2005 before forming your opinions, did you?
MR. GDANSKI: Object to the form.
A. No. Though I presume that since there was no masses indicated in this, it doesn't suggest ovarian cancer, Dr. Cohen probably concluded there's no evidence for ovarian cancer, and decided not to pursue that, but I don't know the answer to that question. I would be very thrilled to look at that.
Q. Anything that you said about Dr. Cohen, what she did or did not, is pure speculation, is it

0200

not?
A. Absolutely.
Q. You don't have any evidence of it, do you?
A. That's correct.
Q. Now, what does the scientific data show for a woman that presents with symptoms and has bilateral ovarian abnormalities or masses, is postmenopausal, 81 years old, has a tumor marker of

for CA-125 that's elevated, there's no mass in the lungs --
A. Do we know what the CA-125 was at that point in time?
Q. We know what it was in --
A. When she died?
Q. Yes. Let me get to that. What does the data show for women who present with symptoms and have bilateral ovarian masses and/or abnormalities that are postmenopausal, 81 years old, they have an elevated tumor marker of CA-125, there's no mass in the lungs, there's no masses in the liver at the time, what would be in your differential diagnosis as an oncologist?
MR. GDANSKI: Object to the form.
A. It sounds like you asked me two questions, so I would need to hear that question again.

0201

Q. For a woman who presents with symptoms and has either a bilateral ovarian masses --
A. What are the symptoms?
Q. Let me finish. For a woman who presents with symptoms and has bilateral ovarian masses or abnormalities, is postmenopausal, is 81 years old, has elevated CA-125 tumor marker, there's no mass in the lungs, there's no masses in the liver, what would be in your differential diagnosis for that patient?
MR. GDANSKI: Object to the form.
A. What are the symptoms? You didn't tell me.
Q. How about the one that you know about?
A. Right upper quadrant pain is not particularly a symptom of ovarian cancer, increasing of abdominal girth maybe due to ascites. Again, I would be seeing this patient. I wouldn't have ordered the pelvic ultrasound. But I guess I'm very curious as to what Dr. Cohen's interpretation was at the time.
I think there's an overwhelming probability from this that she didn't have ovarian cancer, she did have enlarged ovaries. There's no masses unless the radiologist misread it and failed to identify a mass, and, you know, the data is overwhelming that

0202

she didn't have ovarian cancer.
Q. Can we go back to my question. What would be in your differential diagnosis for the patient that I described?
MR. GDANSKI: Object to the form.
A. What are the symptoms?
Q. She has a symptom of primary ovarian cancer. Pick anyone.
MR. GDANSKI: Object to the form. I object to this question.

A. I'm supposed to pick a symptom?
Q. Let me try again. You can't answer that question, doctor?
A. You've not asked -- I apologize, but you've not asked a clear question.
Q. Let's have a patient who has pelvic pain.
A. All right.
Q. Who has got bilateral ovarian masses or abnormalities, postmenopausal, 81 years old, has an elevated tumor marker CA-125, no masses in the lung, no masses in the liver at the time, what would be in your differential diagnosis as an oncologist?
MR. GDANSKI: Object to the form.
A. She probably had -- again, we don't know what her CA-125 was at this point in time. We do

0203

know that at the time that she was dying of metastatic lung cancer, she had a moderately elevated CA-125.
My suspicion is that it was not elevated at this point in time, but I'm speculating, as are you. If she had pelvic pain, I would think she needed to see a gynecologist. There was probably some ovarian process that's causing some discomfort, ovarian cancer, among them.
In that same study where it indicated that the positive predictive value of having -- screening study, the positive predictive value of abnormal vaginal ultrasound, was less than one percent, meaning less than one percent of patients who had had cancer, and about three percent who had an elevated 125 had cancer, if you had both it was actually higher, it was 23 percent, but that wouldn't apply here, because this was when she had obvious metastatic lung cancer. So that doesn't apply here.
But if she had -- if I knew for a fact that she had a normal chest x-ray, no evidence of any cancer in the ovary, and had an elevated CA-125 and an abnormal -- though not a mass -- I would try to reassure her that she probably didn't have any

0204

cancer, but I would certainly want her to see a gynecologist, and I'd probably send her to a gyn oncologist as opposed to a gynecologist. Again, not relevant to this case.
Q. Would you agree that was a very long-winded answer?
A. I would definitely agree it was a long-winded answer. It was a long-winded question, though.
Q. Is the short answer to my question that primary ovarian cancer would be in your differential diagnosis for the patient I described?

MR. GDANSKI: Object to the form.
A. I want to make sure I'm answering the question in context. If the patient had bilateral enlarged ovaries, had an elevated CA-125 that we had no evidence for at the time that she had this, and had no evidence of anything in the chest or the liver to indicate metastatic cancer, then ovarian cancer would be in my differential diagnosis, but it would still be much more likely that she didn't have ovarian cancer, but it would be higher than if she just had either test at all.
Q. In order to rule out that she did not have primary -- that this patient did not have primary

0205

ovarian cancer, further tests and studies would need to be done, true?
MR. GDANSKI: Object to the form. This patient, are you talking about in your hypothetical or Mrs. Cohen?
MR. DAVIS: This patient that we're talking about.
MR. GDANSKI: Which one is that?
Q. Do you understand my question, doctor?
MR. GDANSKI: Object to the form.
A. You're talking about Mrs. Cohen or are you talking about this hypothetical patient who had no relationship to Mrs. Cohen?
Q. I'm talking about the hypothetical patient who had postmenopausal and bilateral ovarian masses or abnormalities, 81 years old, CA-125, no mass in the lungs, no mass in the liver.
MR. GDANSKI: What about the CA-125? I object. All you said was CA-125.
Q. Let me ask it again. It seems Mr. Gdanski needs some help.
MR. GDANSKI: Maybe you need to read the handwriting on your paper better.
MR. DAVIS: Do you want to help him out any more?

0206

MR. GDANSKI: Keep going.
MR. DAVIS: Thanks.
Q. Doctor, I'm talking about the patient who presents with either bilateral ovarian masses or abnormalities, postmenopausal, 81 years old, has an elevated CA-125 tumor marker, there's no mass in the lungs, there's no mass in the liver. Do you agree that you would have to do further tests and analysis to rule out primary ovarian cancer in that patient?
MR. GDANSKI: Object to the form.
A. If you wanted to rule it out. But if she was having pelvic pain, you would probably want to deal with whatever benign cause. So what you would need would be a laparotomy. She would need to have

her ovaries removed.
Q. Do you agree for this patient --
A. I agree for that hypothetical patient, who has no relationship to Mrs. Cohen.
Q. Do you agree with this hypothetical patient that you would need to do a pelvic CT scan to see whether or not there was any presence of primary ovarian cancer and do a tissue biopsy if it weren't done?
A. What I'm told by my radiology is when you really suspect the ovary, the ovary is sometimes
0207
difficult to see on CT scan, and ultrasound is better at looking at the ovaries or an MRI of the ovaries.
So in that hypothetical patient with bilateral enlarged ovaries without masses and an elevated CA-125, which, again, we don't know in Mrs. Cohen at that time, and probably was not elevated at that time, she would definitely need further workup.
And I believe the further workup would be discussed that you're 81 years old at this point in time. Do you want to remove the ovaries. Probably they would find benign findings, but it would probably relieve her pelvic symptoms.
Q. If they were removed, they would submit them to pathology and see whether or not there was any malignancy that started in the ovary, true?
A. If there was any cancer in the ovary. The only way you can rule something out is you need something that's 100 percent sensitive. So removing the entire ovaries is 100 percent sensitive and you're negative. So that's the way you would rule it out. My suspicion is it would have shown cysts, which is likely what she had.
Q. That's speculation on your part, isn't it?
MR. GDANSKI: Object to the form.
0208
A. Yes, of course.
Q. Another option for this patient instead of removing the ovaries would be to do a tissue biopsy, draw tissue out, put it on a microscope and see?
A. If she's having pelvic pain, symptoms that were felt to be related to the ovaries, of course a needle biopsy is probably benign, it's probably not cancer, and a needle biopsy would be useless, unless it did show cancer, which it almost certainly wouldn't, because there's no evidence that she ever had ovarian cancer.
It also wouldn't be addressing her symptoms, which is the major reason you're doing a procedure in the first place.
Q. Do you agree, then, with a patient who has pelvic pain, has bilateral ovarian masses or

abnormalities, postmenopausal, 81 years old, there's no mass in the lungs, there's no evidence of mass in the liver, that your differential diagnosis would include in that patient primary ovarian cancer?

MR. GDANSKI: Object to the form.

A. Of course it would include it in the differential diagnosis, but it would be way down. It would be much more likely to be some other non-cancerous ovarian pathology.

0209

Q. Slightly different hypothetical. Slightly different scenario. You have a patient who presents with pelvic pain and has bilateral ovarian masses or abnormalities, is postmenopausal, is 81 years old, and there's no mass in the lungs, do you agree, based upon the information, if you had that information, that primary ovarian cancer would be in your differential diagnosis?

MR. GDANSKI: Object to the form.

A. The only difference in the question is, is it between enlarged ovaries and now masses in the ovaries?

Q. No. I will rephrase it. You have a patient who presents with pelvic pain who has bilateral ovarian masses or abnormalities, postmenopausal, 81 years old, and has no mass in the lungs, do you agree that for that patient, primary ovarian cancer would be in your differential diagnosis?

MR. GDANSKI: Object to the form.

A. I don't see the difference between the question I just answered and this different question. I thought that was exactly the same question you asked before.

Q. Again, I don't -- bear with me, because I

0210

don't believe you've answered this. This is a slightly different question. I've taken out no mass in the liver. That's an additional one I've taken out.

A. Okay.

Q. So let me ask it again. You have a patient who has pelvic pain, presents with bilateral ovarian masses or abnormalities, is postmenopausal, is 81 years old, there's no mass in the lung. Do you agree that primary ovarian cancer would be in your differential diagnosis?

MR. GDANSKI: Object to the form.

A. Yes. It's the same as before. It would be low down, but it would be in the differential diagnosis. What the ultrasound might show, if it was ovarian cancer, some other evidence of omental metastases, but all having no relevance to this case.

Q. For each of these patients we have been describing the circumstances for, you would refer those patients out to a gynecological oncologist, true?
MR. GDANSKI: Form.
A. They wouldn't be seeing me in the first place. So it wouldn't be my place to do that or not.
Q. But if they came in with these results, and you got them, you would send those patients out to a gynecological oncologist, true?
A. A patient without cancer, with nothing in the lung, liver, and bilateral ovarian abnormalities, with an elevated CA-125 and pelvic pain, I would definitely send her to a gynecologist or a gynecologic oncologist.
Q. So you would not be the person to answer the question about what was going on in the particular patient?
MR. GDANSKI: Object to the form.
A. I don't do surgery on anybody. This patient probably needs laparoscopic surgery to find out what's going on in that hypothetical situation which bears no resemblance to what was actually going on.
Q. Why are you distinguishing between whether Helen Cohen's situation is bilateral masses or bilateral abnormalities?
A. Because there's no masses. Usually ovarian cancer presents with masses in one ovary, sometimes both ovaries.
Q. Do you agree that the size of the bilateral abnormalities seen in the ultrasound for Helen Cohen, dated August 22, 2005, size wise is consistent with a mass?
MR. GDANSKI: Object to the form.
A. No. I mean, if you would have asked me two days ago what is a normal-sized ovary, I wouldn't be able to answer it, but I did look it up. Usually ovaries are less than three centimeters. So these are large ovaries somewhat, but there's no mass. If there was a mass, they would have said a mass.
Q. When you looked at that data, did you do it for the purpose of this deposition?
A. Yes.
Q. What article did you look at?
A. I looked at Google.
Q. What article?
A. Google Scholar.
Q. What article in Google Scholar?
A. I could Google it now if I had a computer. I was looking for normal ovarian size. It's not

something that I keep in the back of my head.
Q. In what age patient did you look at?
A. I tried to find that, and I couldn't find it. I didn't spend -- I'm sure if I were absolutely -- I'm not arguing with you. I'm not an expert in

0213

what is the normal sized ovary in an 81-year-old or an 80-year-old. It sounds like she had bilaterally enlarged ovaries. That's the way the ultrasound was read, and I'm not quibbling with that.

I'm quibbling with your conclusion that she had ovarian cancer, of which there's no evidence, and the overwhelming probability is she did not.

Q. Helen Cohen presents you with these findings as shown in Exhibit 36, in Exhibit 31 concerning her ultrasound results and her enlarged ovaries, and she's your patient. Do you tell her that based upon these results, you can rule out that that she had cancer of the ovary?

MR. GDANSKI: Object to the form.

A. As I told you earlier, the only way you can rule something out is if you have a test that's 100 percent sensitive, meaning people who have the disease, always have the abnormal test, and you're negative. That's the only way you can rule something out.

So there's no way to rule it out. I was being facetious, but if you wanted to rule it out, you need to remove the ovaries.

Q. Would you tell Helen Cohen, then, that in your differential diagnosis, it is that she might

0214

have primary ovarian cancer?

MR. GDANSKI: Object to the form. Asked and answered.

A. I would tell her that in the differential diagnosis, this primary ovarian cancer or metastatic disease could be something else. But the overwhelming probability is she does not have ovarian cancer.

Q. Would you tell her she needed to be followed up either with an ultrasound or a CT scan or an x-ray or further radiology?

A. Well, again, if she was having --

MR. GDANSKI: Object to the form.

A. If she were having symptoms, I would definitely want her to -- make her feel better, no matter what's the cause. If she were having symptoms, I would definitely want her to see a gynecologist or gynecologic oncologist.

Dealing with cancer patients my whole life, and I think here the probabilities are extraordinarily low that this was ovarian cancer, and I would reassure her it's exceedingly unlikely

that she had ovarian cancer, but I can't -- I'm not the person she would go to to make that differential.

0215

I would tell her that, you know, I'm not an expert in what they're going to do, and they may do an MRI. But I think probably what she would need would be a laparoscopy to remove the ovaries. That is a test that has 100 percent sensitivity, should relieve the symptoms related to the ovaries itself, and that would rule out ovarian cancer if you removed both ovaries and they slice it appropriately and there's no cancer. That's the only way to do it.

Q. How often does ovarian cancer involve both ovaries?

A. The answer is, that's well known. I just can't quote that statistic. Ovarian cancer often involves both ovaries. There's a stage where it's involving -- I think it's Stage 1B if it's involving both ovaries. It could be multicentric, meaning it's originating in both ovaries, because whatever the carcinogenic factor, it would be effective in both ovaries. But it's much more common in one ovary.

The fact that she had bilaterally involved enlarged ovaries, would make it less suspicious to me, not claiming expertise, so I may be wrong about that, but the fact that she had bilaterally enlarged

0216

ovaries would, in my view, probably lessen the probability she had ovarian cancer, whereas if she had one enlarged ovary with masses, that's where you would be concerned about it.

Q. If Helen Cohen were at surgical risk and ovarian cancer was suspected, what would your recommendation be?

A. Give her some pain medication and see if the pain is controlled. We're talking about minimally invasive surgery, laparoscopic. We're not talking about a big incision. You can remove the ovaries laparoscopically. You can't do a standard ovarian cancer operation, which is a big operation laparoscopically.

Q. Do you know whether or not the ovaries that are discussed in the August 22, 2005 ultrasound of Helen Cohen were solid or cystic?

A. I only know what -- no, I don't. I just know that it's enlarged, and there's some calcifications. It's suspicious for calcifications.

Q. Do you know how they enlarged?

MR. GDANSKI: Object to the form.

A. No. How would I know that? Ovarian cysts -- benign ovarian neoplasms are not uncommon.

25 Q. The ultrasound report on Helen Cohen
0217
1 doesn't describe them as benign ovarian cysts, does
2 it?
3 A. It does not. But it certainly doesn't
4 describe it as suspicious masses.
5 (Document marked as Exhibit 37
6 for identification)
7 Q. I'm going to hand you what's been marked as
8 Exhibit 37 to your deposition. Do you see this is a
9 new patient questionnaire that Helen Cohen completed
10 on September 11, 2005? The signature and the date
11 is on the last page, doctor.
12 A. I do.
13 Q. So this is several weeks after the
14 transvaginal ultrasound that she had done?
15 A. Yes.
16 Q. And at this time she's reporting painful,
17 oversized ovary right side?
18 A. That's what it says here.
19 Q. She's also reporting constipation; is that
20 true? It's on the second page.
21 A. Yes, along with wheezing, shortness of
22 breath, yes.
23 Q. Have you seen this document?
24 A. No.
25 Q. Let me see if I can ask a better question.
0218
1 Have you seen this document before coming here to
2 your deposition?
3 A. No.
4 Q. So you formed your opinions in this case
5 without seeing this document, true?
6 A. Yes.
7 Q. And on the last page, there's a question
8 put to her on the questionnaire. "Do you have any
9 other gynecological history that the doctor needs to
10 know about," and she reported, "No, except current
11 enlarged ovary on the right side," correct?
12 A. Yes, that's what's written here. May I
13 just read this whole document? The last mammogram
14 was done two and a half years before she was
15 diagnosed with metastatic lung cancer. Okay.
16 Q. We know Helen Cohen was reporting pelvic
17 pain to Dr. Lubekian?
18 A. All I know is painful, oversized ovary,
19 right side.
20 Q. Do you feel comfortable enough to know that
21 that's pelvic pain?
22 A. I don't see the word "pelvic" on here.
23 Q. Where is the ovary located; in the pelvis?
24 A. It is.
25 Q. Can we say it's pelvic pain?
0219

A. I guess so. I'll acknowledge that. You can argue that she's got pain and an oversized ovary, but I will grant that, yes.

(Document marked as Exhibit 38 for identification)

Q. I'm going to hand you what's been marked as Exhibit 38 to your deposition. Do you see this is Dr. Lubekian's evaluation of Helen Cohen on that day?

A. It looks like it's a day later. This is dated September 12th.

Q. Okay. You're correct, yes. While you're reading that, have you seen this document before you reached your opinions in the case?

A. No. Where it says "Family History," is that intended to mean noncontributory? On the first page, family history does nothing, but on the next line there's something that I can't read. I don't know if that means noncontributory.

Q. Anyway, with respect to the symptoms that she reported, she reported having constipation, correct?

A. Yes.

Q. She also reported to Dr. Lubekian she had enlarged ovaries, right?

0220

A. Yes. So here it's ovaries as opposed to the other thing that says right ovary.

Q. And under "Impression" on the second page, do you see where the second line down says, "Patient has not had a previous u/s," which stands for ultrasound?

A. Yes. I see that.

Q. We know that that's not accurate, because we've seen the previous ultrasounds that Helen Cohen had, right?

A. Yes. Eight and nine years ago, I think.

Q. And is it fair to say that it doesn't appear that Dr. Lubekian had the benefit of the prior ultrasounds when he was evaluating her on September 12, 2005?

A. I can't, you know, I don't know that.

Q. You don't know one way or the other?

A. No. I haven't spoken to him. The patient has not had a previous ultrasound. Does that mean in our system where you can review it, ever? He's not being specific.

Q. Do you see Dr. Lubekian suggested a repeat ultrasound in six months?

A. Sure do.

Q. Do you know whether that was ever done?

0221

A. I do not know. I suspect it was not.

Q. By the time six months had rolled around,

we know that Helen Cohen had passed away.
MR. GDANSKI: Object to the form.
A. Yeah. It was March 11th, wasn't it? So she died virtually six months to the day. She was in big trouble by then.
Q. Excuse me?
A. She was in big trouble six months later.
Q. Do you agree that Helen Cohen, at this time of her life, was a poor surgical risk?
A. At what time of her life?
Q. As of September 12, 2005. Let me ask it a better way. Do you agree Helen Cohen as of September 12, 2005, was a poor surgical candidate?
A. I don't know exactly what was going on. She's short of breath. Elsewhere I note that she's using oxygen, but I don't know that she's using it at this point in time. Laparoscopies are pretty benign procedures.
What I can conclude from this is the physician -- I don't know what his field is, but I suspect he's a gynecologist -- was not sufficiently concerned that he needed to do anything at this point in time.
0222
Q. Do you know whether that was decided because she was a poor surgical candidate?
A. I don't see any discussion about it. Let me just make sure I didn't overlook this. "Patient has not had a previous ultrasound. Those could have been present for many years. Patient has multiple medical issues."
So he's a fellow of the American College of Obstetrics and Gynecology. So he's a gynecologist, yes.
Q. So in September of 2005, did you see anywhere in the medical records where one of Helen Cohen's physicians made the statement that she was a poor surgical candidate?
A. I did not. But I would deny that it probably exists somewhere.
(Document marked as Exhibit 39 for identification)
Q. Let me hand you what's been marked as Exhibit 39. It's an office note on Helen Cohen made by Dr. Michele Cohen. It's dated September 16, 2005.
A. Yes.
Q. Had you seen this document before forming your opinions?
0223
A. No.
Q. Had you seen it before coming to the deposition today?
A. No.

Q. Down under "Plan," it has four things. It has "One, Labs. Two, Encourage weight loss. Three, Can't present care. Four, Follow-up. Gyn (poor surgical candidate)." Do you see that?
A. The third bullet is -- oh, what is --
Q. I'm assuming that's c-o-n-t, for continue present care?
A. Probably, yes. And "follow-up gyn, poor surgical candidate." Okay.
Q. So we know at least Dr. Cohen documented Helen Cohen was a poor surgical candidate as of that time, right?
A. Yes. May I read the rest of the record you gave me. "Patient complaining of painful swollen" something. "After last visit started on metformin." It's a diabetic for nuance of diabetes mellitus. "Neck supple, lungs clear, but," something else. "Abdomen soft, positive bowel sounds, mild, tender right lower quadrant" --
Q. Can I ask you about that. At least from there Helen Cohen was continuing to report some

0224

tenderness in her right lower quadrant?
MR. GDANSKI: I object. Doctor, if you want to continue reading it, you can.
A. Yes.
Q. Are you ready, doctor?
A. Yes.
Q. Her history of present illness shows that she had been having problems with pelvic discomfort, right?
A. Yes.
Q. It also discusses the transvaginal ultrasound with the large ovaries, true?
A. Yes.
Q. And so we know that Helen Cohen was, at least at this time, still having some discomfort in her right lower quadrant, right?
A. Yes.
Q. And where would you put the right lower quadrant?
A. On the right side, and in the lower part of the abdomen, pelvic.
Q. Do you agree Helen Cohen would not have been able to withstand intubation and general anesthesia at this time?
A. I certainly wouldn't be the one to make

0225

that assessment.
Q. So you don't have any opinion on that?
MR. GDANSKI: Object to the form.
A. I don't have any definitive opinion on that.
Q. Do you have any opinion on that?

A. She's an elderly woman with lots of symptoms. I think she would be at very high risk.
Q. What role was her obesity playing in whether or not she was at high risk at this time for surgery?
A. It makes it more complicated.
Q. Do you believe she would have been able to withstand treatment for ovarian cancer if it had been administered at this time or don't you know?
A. What kind of treatment?
Q. Chemotherapy.
A. Why would you give chemotherapy with just enlarged ovaries without any other incidence of ovarian cancer? There are sort of fairly easy to give, not terribly toxic therapies, that are not first line, but can be used for advanced ovarian cancer. But there's no evidence of advanced ovarian cancer, and she almost certainly didn't have it.
Q. Assuming she had primary ovarian cancer for

0226

my question, would she have been able to withstand the treatment for that disorder?
MR. GDANSKI: Object to the form.
A. I can't answer that without having the clear sense of how she was doing at this point in time. At this point in time she has a given history, she's got symptoms. So I just don't have enough information to make that judgment.
The answer is, there's some evidence that it's not so toxic for chemotherapy, and laparoscopic surgery is something that's not super invasive, but it's still surgery, and there can be potential complications. So I just can't answer those questions.
Q. Helen Cohen would be a high-risk patient for the laparoscopic surgery as well, wouldn't she?
A. I would think so.
Q. Would you agree that if primary ovarian cancer was suspected at this time or in the differential diagnosis at this time, it would have been prudent for Dr. Lubekian or Dr. Cohen not to do anything, given Helen Cohen's advanced age, her multiple medical problems, and the poor prognosis for ovarian cancer?
MR. GDANSKI: Objection to the form.

0227

A. This would be the situation where maybe one should do a -- you can certainly needle the ovaries. Of course a negative one wouldn't prove anything, and wouldn't treat anything. But if she had ovarian cancer, it might have shown cancer, and one might have given her -- like there's a drug called etoposide, which can be given orally. They are relatively easy to administer and not terribly toxic

therapies that elderly patients with multiple medical co-morbidities could tolerate.
Q. Do you agree there was no imaging done on Helen Cohen in 2006 that showed her ovaries?
A. At least none that I've seen. I certainly interpret this that nobody in particular thought she had ovarian cancer, but they just wanted to repeat the ultrasound, which is prudent. I'm certainly not an expert in that, but that certainly sounds to me like the appropriate thing to do here.
Q. Given Dr. Cohen's opinion that Helen Cohen was a poor surgical candidate, do you agree that it would have been prudent for her, i.e., Dr. Cohen, not to insist on any invasive procedure to get a diagnosis on Helen Cohen, given her age, and other medical conditions at the time?
MR. GDANSKI: Object to the form.

0228

A. The overwhelming probability, and we know in September of 2005 she had bilateral enlarged ovaries, probably had some right-sided pelvic pain, had multiple co-morbidities, but no mass. So this was exceedingly unlikely to be ovarian cancer. It's not that whatever was causing the enlarged ovaries -- it's not too inclined that maybe the enlarged ovaries were somehow responsible for her pain, but it was very unlikely she had ovarian cancer.
If she strongly suspected she had cancer, they probably would have done something more. I have no direct evidence for that.
Q. Well, we know that when lung cancer was suspected several months later, the decision was made not to do anything, right?
A. This was six months earlier, it would be a different situation. It doesn't sound like she was dying in the next week. It sounded like that decision was ultimately hers, but probably very appropriate in March of 2006.
Q. Do you know what her doctors may have told her about whether she should have any follow-up about the bilateral ovarian abnormalities?
A. It sounded like -- well, it sounded like obstetrician-gynecologist suggested repeat

0229

ultrasound in six months, and Dr. Cohen was suggesting follow-up gyn, but a poor surgical candidate.
Q. Do you agree that Helen Cohen had a poor diet and was also obese?
A. Well, I certainly saw multiple records to her being obese, and I guess I don't think I read anything about her diet specifically.
Q. Do you agree that poor diet and obesity are both risk factors for colon cancer?

A. Poor diet and obesity are not independent factors. They are very much related. Certainly, you know, the western diet, you know, lots of meat, red meat is a risk factor. Obesity is somewhat of a risk factor. But I think those are not independent factors.

(Document marked as Exhibit 40 for identification)

Q. I will show you what's been marked as Exhibit 40. Do you see that this is a November 27, 2002 record from Dr. Wasserman?

A. Yes.

Q. And do you see on Page 2 where he advises Helen Cohen to have a colonoscopy every five years and ordered a screen for occult colorectal cancer?

0230

A. May I read the whole record. Your question is do I see he advised her to have a colonoscopy every five years to screen her for colon cancer?

Q. Yes.

A. I do see that.

Q. Had you seen that document before your deposition?

A. No, I had not.

Q. So you hadn't seen it before forming your opinions?

A. Yes, that's correct.

Q. Now, I want to see if I can speed this up. That's Exhibit 40, right, doctor?

A. That's correct.

(Documents marked as Exhibits 41 and 43 for identification)

Q. I'm going to give you Exhibit 41, 42 and 43, and ask you if these are each separate visits for --

A. I should just read all three.

MR. GDANSKI: Let him contemplate his next set of questions.

A. I think you gave me two copies of the same record.

Q. Sorry.

0231

A. These are both 6/2/2004.

Q. You have Exhibits 40 and 41, right?

A. I have Exhibits 41 and 43.

MR. DAVIS: I'm going to put on the record, we do not have a 42.

Q. My only point with those is in Dr. Wasserman's plan, both times he recommended that she have a colonoscopy every five years, right?

A. Yes.

Q. Do you know when her last colonoscopy was.

MR. FILBERT: Object to the form.

A. No.

Q. Did you investigate that before reaching your opinions in the case?
MR. FILBERT: Object to the form.
A. No.
Q. Do you agree that the tumor marker CEA is elevated in colon cancers?
A. It can be elevated in colon cancer most commonly in the setting of metastatic disease to the liver, and elevated CEA is a prognostic factor on colon cancer.
If you present with colon cancer with an elevated CEA, you're going to do less well than if you present with colon cancer with a normal CEA,

0232

even just for staging.
Q. In a 80-year-old woman with a history of colon polyps, no colonoscopy for more than 14 years, liver metastases and a clear chest x-ray and an elevated CA of 82.2, what would be in your differential diagnosis?
MR. GDANSKI: Object to the form.
A. She had an elevated CEA at -- the only time we know about the elevated CEA is when she's diagnosed with metastatic lung cancer. So the diagnosis is established, there's no evidence of colon cancer.
Q. I'm asking you a different question. If you have a 80-year-old woman with a history of colon polyps, no colonoscopy from more than 14 years, liver metastasis, a clear chest x-ray and an elevated CEA of 88.2, what would be in your differential diagnosis?
MR. GDANSKI: Object to the form.
A. She has metastatic cancer if she has liver metastases.
Q. What type of metastatic cancer is in your differential diagnosis for this patient I described?
A. Almost any epithelial cancer will be associated with an elevated CEA. The one that's

0233

been associated with it since the 1960s, when it was first described, is colon cancer, but it's totally nonspecific.
Q. So with a patient I've described, you would agree that primary colon cancer is in your differential diagnosis?
MR. GDANSKI: Object to the form.
A. It's in the differential diagnosis, but there are no symptoms to suggest colon cancer.
Q. Now, for a 80-year-old woman with a history of colon polyps, no colonoscopy for more than 14 years, liver metastases, and a clear chest x-ray, what would be in your differential diagnosis?
MR. GDANSKI: Object to the form.

A. Clear chest x-ray?
Q. Yes.
A. You can do a CT scan of the chest, abdomen and pelvis.
Q. I think I'm asking a different question. Would you agree with me that if you have an 80-year-old woman with a history of colon polyps, no colonoscopy for a period of 14 years, liver metastases, and a clear chest x-ray, that colon cancer would be in your differential diagnosis for that patient?

0234

A. Of course it would be in the differential diagnosis. It would be at the top.
Q. What would you have to do to rule in or rule out primary colon cancer in that patient?
A. It's the same situation. She's got liver metastases and a week from death, you're not going to do anything to rule it in or rule it out, because she's not a candidate for any kind of therapy.
A colonoscopy is a useful test for diagnosing localized colon cancer. I suspect you would do a liver biopsy to see what she, you know, and it would probably show adenocarcinoma. If it were colon cancer, again, it could show an adenocarcinoma if it's lung cancer as well, but it could show something else.
There are certain immunohistic chemical markers that make colon cancer more or less likely and lung cancer more or less likely, and you could have done that panel. But again, it's a hypothetical that bears no relationship to this case, because she didn't have a normal chest x-ray, and you've not included CT of the chest in your question.
Q. She did have a normal chest x-ray -- Helen Cohen had a normal chest x-ray in February of 2006,

0235

true?
A. Show me the chest x-ray.
Q. You don't know about that?
MR. GDANSKI: Object to the form.
A. I've seen it, but you're going to need to show it to me or I will look for it.
Q. Do you want to look for it?
A. I do.
Q. I'll tell you what, I'll show it to you.
A. I think we'll be here a long time if I have to look for it.
Q. I think you said several times today that colon cancers typically metastasize to the liver, true?
A. Yes, when they metastasize.
Q. And the liver is the most common site for

colon cancers to metastasize to, true?
A. Yes, besides the regional lymph nodes.
Q. And you agree that with primary colon cancer, the liver is typically one of the first sites which the metastatic disease goes to?
A. Yes. I would agree with that.
Q. When did --
A. Apart from the lymph nodes.
Q. When did Helen Cohen first have evidence of

0236

liver disease?
A. To the best of my knowledge, you know, on that terminal admission.
Q. So you're saying in March of 2006?
A. Right. I don't see that she had many -- she was admitted not long before that, but I didn't see imaging studies.
(Document marked as Exhibit 44 for identification)
Q. Doctor, I've handed you what's been marked as Exhibit 44 to your deposition. This is an IP NM WBC scan on Helen Cohen; is that right?
A. IP NM -- yes.
Q. It's basically a white blood cell count scan on Helen Cohen?
A. I assume so. I've never seen that IP NM WBC scan. "The study demonstrates a small focal area of abnormal activity along the medial right iliac bone near the SI joint. There is expected bone marrow and splenic and hepatic activity, although this hepatic activity is inhomogeneous with increased activity respectively in the inferior aspect of the right hepatic lobe with mottled, poor uptake of hepatic activity in the remaining liver. Postoperative changes of the hips are noted.

0237

Scoliosis is noted. Focal right iliac lesion, which is indeterminate, but a site of infectious process cannot be excluded." The date is January 22, 2006.
Q. So had you seen this document either before your deposition today or before you had arrived at your opinions?
A. I have not.
Q. Do you agree that this reflects that there's an intrinsic hepatic disease suspected in Helen Cohen?
A. Intrinsic hepatic disease is -- I certainly agree that that's what the radiologist or nuclear medicine doctor who interpreted this wrote.
Q. How do you interpret this scan?
A. I have never ordered it, and wouldn't know specifically how to interpret it. I believe these scans have very limited utility.
I know she had been admitted with staph

sepsis, and I did not read in detail about that, but I suspect she had a staph aureus in her blood, and they were probably doing this to look for some occult abscess, but I don't know that.

Q. Have you investigated that question before you arrived at your opinions?

A. Absolutely not. And there's not even a --

0238

I'm looking for why the study was done. The answer is, I have no idea when the study was done, because I did see that staph aureus sepsis.

Staph sepsis, I didn't know much about it, and now seeing this, I'm putting two and two together. Two and two might be three or five and not four.

Q. Do you know whether or not anyone followed up on the scan?

A. Since I didn't know the scan was done, and I had never ordered it in my life, I have no idea.

Q. Do you know whether or not the scan is abnormal?

A. Well, it certainly sounds like the interpretation is that it's abnormal.

Q. And do you know what steps were done to investigate whether or not Helen Cohen had intrinsic hepatic disease?

A. No.

Q. If Helen Cohen actually had cancer, do you agree that she likely had liver metastases as of January, 2006?

A. Oh, I'm sure she had liver metastases as of January, 2006.

Q. Do you agree that if Helen Cohen had

0239

cancer, that she likely had liver cancer as of January, 2006?

A. When you say "liver cancer," are you talking about metastatic disease to the liver or are you talking about primary hepatocellular carcinoma? Do I think she had primary hepatocellular carcinoma? I don't.

Q. Do you agree that before 2006 there is no x-ray or CT scan that shows that Helen Cohen had evidence of lesions in the liver?

A. Do I know whether, prior to 2006, she had any -- I do not know.

Q. Do you know of any evidence in the medical records or the radiographic films or images that you've looked at that supports an opinion that she had lesions in the liver before 2006?

A. Other than maybe this, whatever this means, but it doesn't mean much to me. But, no.

Q. I'm going to hand you what's been marked as Exhibits 46 through 48, and ask if you can identify

those as chest x-rays that were done on Helen Cohen?
(Documents marked as Exhibits 46 through 48 for identification)
A. 47 is a chest x-ray done on January 19, 2006. 46 is a portable chest x-ray done on 1/5, so

0240

two weeks earlier, I believe. And 48 is a portable chest x-ray done on 1/21.
Q. So do you take issue at all with anything that's in the chest x-rays that are marked as Exhibits 46, 47 and 48?
A. No.
Q. And you accept them as accurate?
A. I have no reason not to accept them as accurate. No acute or active process.
Q. Do any of those chest x-rays show any evidence of a primary lung cancer in Helen Cohen?
A. No. You're talking about portable chest x-rays, which are just done in the bed when somebody is sick, which have major limitations, even from the standard of chest x-rays.
Q. What cancers do you think of commonly as metastasizing to the ovary?
A. Breast cancer, Krukenberg tumors are classic for that, gastric cancer, because it can spread throughout the abdomen. Ovary cancer, breast and gastric would be the ones that I would commonly think of. Colorectal cancer, if there's extensive omental metastases, extensive intra-abdominal metastases, not in the liver but the abdomen, the ovaries will be sitting there, so those could be

0241

involved as well.
Q. Do you agree that lung cancer, primary lung cancer, typically does not metastasize to the ovary?
A. It's not a common site of metastatic disease.
Q. I think you mentioned Krukenberg tumors?
A. Right.
Q. What are they?
A. Well, I think they are metastatic cancers, cancers not arising in the ovary, that spread to the ovary. I believe the original reports really referred to breast cancer, but I would not want to assert that with certainty. That's just my remote memory.
Q. Have you ever had a patient with Krukenberg tumors?
A. Sure. I've seen patients who have had breast cancers metastatic to the ovary, gastric cancers.
Q. Are Krukenberg tumors, do they originate anywhere else besides the breast?
A. Well, I mean, it's not specifically

referring to breast cancer, though I think we most commonly think of breast cancer as doing that. But other cancers that will metastasize within the

0242

peritoneum, within the abdominal pelvic cavity.

Q. Can you give me some examples of Krukenberg tumors that originate outside of the breast area?

A. Just what I said, I am not prepared to render -- to give you other examples.

Q. Can --

A. Oh, lymphomas will involve the ovaries.

Q. Are you saying lymphoma is a Krukenberg tumor?

A. You know something, I'm not sure. I would need to check what the current definition of Krukenberg tumor is.

Q. Can Krukenberg tumors arise in the stomach or as a gastric cancer?

A. Yes. I said that just a moment ago.

Q. I'm sorry if I didn't hear you. Can Krukenberg tumors arise in the colon?

A. I think I said that as well. It's usually in the context of widespread metastatic disease, and peritoneal implants, you know, I've certainly seen them many times. But you think more of actual involvement of the liver substance.

Q. Do you hold yourself out as an expert in Krukenberg tumors?

MR. GDANSKI: Object to the form.

0243

A. Certainly not.

Q. Have you ever done any research or investigation about Krukenberg tumors?

A. No.

Q. Can CA-125 be increased with Krukenberg tumors?

A. I don't know the answer to that question. I suspect the answer is yes, but I don't know the answer to that question.

Q. When Krukenberg tumors present any ovary, how do they present; is it unilateral, bilateral, or you don't know?

A. The answer is, I don't know. But if it's metastatic, I believe it's more commonly going to be bilateral, but I don't know that for sure.

Q. Do you know what the prognosis is of a Krukenberg tumor?

A. I think it really depends upon the prognosis of the primary. Breast cancer, for example, when it's metastatic, particularly nowadays we can often treat it effectively with hormonal types of therapies or targeted therapies. It sort of depends upon the primary cancer.

So if you say it's from breast cancer, I

can't quote any studies on this, the prognosis would
0244
be much better if it were a primary breast cancer than a primary gastric cancer.
Q. Is your area of expertise in the area of the prognosis of Krukenberg tumors?
MR. GDANSKI: Object to the form.
A. No.
Q. Do you know whether or not a hiatal hernia is a risk factor for reflux esophagitis?
A. No. I've never thought of the question in those terms or known definitively the answer. But I think since the hernia is sort of preventing reflux, I think the answer is probably yes. But it's not something I've ever been involved in or know for a fact.
Q. Is reflux esophagitis a risk factor for gastrointestinal cancer?
A. Yes. It's a risk factor for -- most esophageal cancers are in the esophageal gastric junction. Gastric reflux and Barrett's esophagus are major risk factors for that, particularly Barrett's esophagus.
Q. Do you agree Helen Cohen had a fairly large hiatal hernia?
A. I know she had a hiatal hernia. I don't know anything about the size.
0245
Q. If Helen Cohen had bilateral ovarian masses or abnormalities, a history of colon polyps, a large hiatal hernia and reflux esophagitis, would ovarian metastasis from a GI primary be in your differential diagnosis?
MR. GDANSKI: Object to the form.
A. It wouldn't be something that I would be thinking of primarily. I guess it would be in the differential diagnosis, because anything is in the differential diagnosis. No. It's a stretch to say the least.
Q. Are you aware of any evidence that when Helen Cohen was being treated for suspected lung cancer in March of 2006, that any of her doctors knew about the bilateral ovarian abnormalities that showed up on her ultrasound?
MR. GDANSKI: Object to the form.
A. Yes.
Q. You are aware of that?
A. Yes.
Q. Who are you aware of it --
A. Dr. Cohen.
Q. Do you know whether or not Dr. Cohen communicated that information to any of Helen Cohen's doctors who were specifically directed at
0246

treating her suspected cancer?
MR. GDANSKI: Object to the form.
A. I don't believe any -- I'm not sure anyone got to the point of treating her suspected cancer. She was a week from death.
Q. Let me rephrase the question. Do you know whether Dr. Cohen told any of the doctors who were evaluating Helen Cohen in March of 2006 for suspected lung cancer and who were focused on evaluating her for that -- let me back up.
A. That's fine.
Q. Dr. Cohen was not part of the team of physicians that was analyzing the suspected lung cancer in Helen Cohen, true?
MR. GDANSKI: Object to the form.
A. I don't know that for a fact, but I assume it's not true. She's the one -- isn't she the one who dictated the discharge summary?
Q. You have in a treatment staff, typically you have an oncologist who's helping to assess whether a patient has cancer, right?
A. Usually, if she doesn't have cancer, the primary doctor would be running the show, and they would be consulting an oncologist.
Q. Do you know whether Dr. Cohen --
0247
MR. GDANSKI: Have you finished, doctor?
THE WITNESS: No.
A. I think the oncologist was consulted not for suspected cancer, but because of the elevated white count of 30,000.
Q. Do you know whether the abnormal transvaginal ultrasound was ever put into the medical records that were at Delray Medical Center at the time that Helen Cohen was being evaluated for suspected lung cancer?
MR. GDANSKI: Object to the form.
A. I have no idea.
Q. Do you know whether Dr. Michele Cohen told anybody that was trying to evaluate Helen Cohen for suspected lung cancer that she had had these bilateral ovarian abnormalities approximately six months earlier?
A. I am not privy to her private communication with other consulting physicians.
Q. So you don't know?
A. I don't know.
Q. Do you agree that because Helen Cohen never underwent additional biopsy or testing after suspected lung cancer that her physician there who were treating her did not rule out primary ovarian
0248
cancer, primary colon cancer, primary breast cancer or primary stomach or gastric cancer?

MR. GDANSKI: Object to the form.
A. If they wanted to rule it out, there's no way of doing that. You can't rule it out other than by autopsy.
Q. There's something in between before autopsy, right? There's a tissue sample that could have been taken from Helen Cohen to assess whether or not she had primary lung cancer or some other type of cancer or disease, true?
MR. GDANSKI: Object to the form. Asked and answered.
A. One could have considered -- a biopsy was considered, actually recommended, but not pushed, I presume. We're talking about a week before her death. A biopsy almost certainly would have shown cancer, and almost certainly would not have proven absolutely what the primary site was or more likely than not the biopsy wouldn't have proven the primary site. The primary site was pretty obvious, as it was to her physicians.
Q. Where does liver cancer typically metastasize to?
A. Well, liver cancer is very uncommon in this
0249
country. They did a whole lot of tumor markers, and the one tumor marker they didn't do is an alpha-fetoprotein or AFP, which is a screening test for liver cancer. She didn't have any of the risk factors. It was not a dominant liver mass.
So I don't think the thought came to anybody's mind, except you. So they didn't rule it out. There's no way to rule it out. But there was no evidence for a primary liver cancer. This was metastatic disease diffuse metastases to the liver. That's not how a primary hepatic cellular carcinoma presents.
When it does metastasize, it can present or metastasize to both lungs, the pleura, to the intra-abdominal lymph nodes, and occasionally to bone, and rarely to the brain.
Q. Do you know of any medical record where Helen Cohen's physicians suspected that she might have had a primary myeloproliferative disorder before her death?
A. The oncology consult was actually done for elevated white count. May I see the record. I would like to read the initial note again. I think that might have been in something that may have been considered at that point in time.
0250
Q. Do you want to look at your note?
A. Should I read it or do you want me to speak out loud?
Q. Well, let me hand you Exhibit 49, so we can

make sure we're talking about the same document.
(Document marked as Exhibit 49
for identification)
A. We are.
Q. Do you see there, doctor, that this is an oncology consultation for Helen Cohen, dated March 4, 2006?
A. It actually says consultation. So it's a hematology oncology consultation. So I think he was focusing more on the elevated white count.
Q. Yes. And Dr. Koletsky was evaluating leukocytosis, which is an elevated white count?
A. Correct.
Q. So one of the things that he said from this result is that the white count has increased to date to 31,900?
A. I believe so, but I just need to confirm that.
Q. Did you find it, doctor?
A. No. I suspect this is a reaction here. We find normally infection and recent IV steroid usage,

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and a primary myeloproliferative disorder would be less likely, but needs to be ruled out.
Q. Primary --
A. Myeloproliferative disorder.
Q. He's not talking about primary lung cancer there, is he?
A. No.
Q. Do you know what tests were done to rule out that she did not have a primary myeloproliferative disorder?
A. I know what he's recommending. I think they sent for flow cytometry, and they said there would be a follow-up report, but I think I saw the flow cytometry, but I didn't see that. The answer is, I don't. Obviously in the context of what she had, this is not myelofibrosis.
Q. So what he was recommending was to do some molecular tests to look for some mutations that might be related to the myeloproliferative disorder?
A. Yes.
Q. Do you know what the test results showed?
A. I was looking for it, and I think I saw some comment that they had done it, and report to follow, but I don't believe I saw the result of the BCRA. I'm sure it's negative, but I don't know for

0252

a fact.
Q. Are you aware that the cells from that particular blood specimen did not proliferate, and therefore, the chromosomal analysis was not possible?
A. I didn't know that. Clearly this was a red

herring. She had a marked leukemoid reaction in the context of dying of her metastatic lung cancer.
Q. Are you aware a repeat peripheral blood specimen or bone marrow aspirate was suggested?
A. Repeat what? I don't know if she had a bone marrow ever before. That wouldn't have been very useful in this circumstance.
They did recommend leukocyte alkaline phosphatase, but there's a coma after leukocyte. It should be leukocyte alkaline phosphatase or LAP. In patients with a leukemoid reaction, the LAP is usually very high. In patients with chronic myelogenous leukemia, the LAP is low.
Q. Do you see that's the test results I was mentioning that the peripheral blood specimens on Helen Cohen did not proliferate in culture, and therefore the chromosomal analysis was not possible?
A. Yes.
Q. And that's a document that we've marked as
0253
Exhibit 50?
A. Yes.
(Document marked as Exhibit 50 for identification)
Q. It also says a repeat peripheral blood specimen or bone marrow aspirate when clinically appropriate is suggested, correct?
A. Yes.
Q. Do you know whether that was ever done on Helen Cohen?
A. Since this report was generated on March 10, 2006, and she died on March 11, 2006, I suspect it was not done, but I don't know for a fact. I don't believe it would have been critical for her care. May I have a brief break?
Q. Yes.
(Recess)
BY MR. DAVIS:
Q. You've got in front of you what's been marked as Exhibit 32; is that right?
A. That's correct.
Q. That's the CT scan, dated March 3, 2006 for Helen Cohen?
A. Yes, it is.
Q. I want you to describe for me --
0254
A. It's actually a CTA, CT angiogram. Usually they are specifically done to rule out pulmonary emboli.
Q. Is that your understanding about why that CTA scan was done?
A. It doesn't say on the requisition. But that's usually why one would order a CTA as opposed to a CT.

Q. I'd like for you to tell me what your opinion is about why this CT scan shows a primary lung cancer in Helen Cohen?
A. Well, it shows diffuse mediastinal adenopathy, meaning lymph nodes in the mediastinum, which is outside is lung in the chest. And it also shows dense consolidation in the posterior segment of the right upper lobe, extends down to diffusely involve the right hilar region surrounding the right bronchus and right lower lobe pulmonary artery, without obvious enhancement.
There seems to be a mass in the center of the chest, the hilum is in the lung, the mediastinum is outside the lung but in the chest, but is probably causing blockage of the posterior segment of the right upper lobe.
So this abnormality in the lung associated

0255

with diffuse adenopathy and associated with diffuse liver metastases is most consistent with a primary lung cancer, which is what they are saying.
Q. This CTA report describes what they are seeing as a dense consolidation, true?
A. Correct.
Q. It does not describe what they see as a mass, true?
MR. GDANSKI: Object to the form.
A. That's very typical in lung cancer, particularly if you have a central mass causing some obstruction of the airways, you know, the blackness of the -- the whiteness on the CT of the collapsed lung sort of blends in with the hilum and mediastinum.
Q. Do you contend there was a mass seen on the CT scan?
A. No. They're not describing a mass, but it's very typical for central lung cancers that are causing collapse where you really can't see the mass. You would need to do a bronchoscopy where you probably would see an endobronchial lesion.
Q. Do you believe that on the CT scan that you reviewed, the March 3, 2006 CTA scan that you looked at before coming to your deposition, did you see any

0256

mass in the center of Helen Cohen's chest?
A. Well, I saw dense abnormalities in the center of the chest, which include the mass and the hilar lymph nodes, which are extremely difficult to distinct, as well as collapse of the lung.
So it's a totally typical way of lung cancer presenting.
Q. If I hear what you're saying, you saw dense abnormalities, but you did not see a mass of the CTA scan, true?

MR. GDANSKI: Object to the form.
A. As I said, I do think I'm seeing a mass, but the mass is integrated with the hilar lymph nodes and the collapsed lung around it.
Q. So just tell me straight up one way or the other, did you visualize a mass in the area that you just described for Helen Cohen?
MR. GDANSKI: Object to the form. Asked and answered.
A. Infiltrate-like mass appears to be invading the right hilum with an associated adenopathy in the mediastinum. The word "mass" is in the report and that's what I saw. The answer is, yes, I did see a mass.
Q. What was the size of the mass?

0257

A. Because it's -- you can't distinguish the node from the mass from the collapse. You can measure the size, if I can actually get the CT scan, because it's a measuring tool, but that doesn't mean that's the mass. There's certainly collapse of the lung because of the mass obstructing the airway in the center of the right chest.
Q. Is it fair to say what you were describing as a mass in the center of Helen Cohen's chest, you did not measure it, true?
MR. GDANSKI: Object to the form.
A. Right, because I could not actually -- I was given a CD, which I could not sort of manipulate it like you can in my own hospital.
Q. If you were going to reach an opinion about a patient of yours, would you want to have that ability to manipulate the CTA scan to confirm that what you are seeing is in fact a mass or something that is mimicking a cancerous mass?
MR. GDANSKI: Object to the form.
A. As I told you earlier, if this were my patient, I would be reviewing the CT scan with the radiologist. I knew the report, and I looked at the CT scan, and I agreed with it. But if it were my patient, I would have access to or hospital computer

0258

and a radiologist who I would review it with.
But the radiologist who read this, and I'm absolutely not a radiologist, even though I'm very experienced in the diagnosis and treatment of lung cancer, but there's an infiltrate-like mass that appears to be invading into the right hilum with associated adenopathy into the mediastinum.
Q. Do you know what they mean in the CTA report when they say "infiltrate-like mass"?
MR. GDANSKI: Object to the form.
A. Infiltrate means some collapse, pneumonia. The word is pretty descriptive. It certainly

strongly supports a cancer.

Q. It is suspicious for cancer, but not definitive, true?

MR. GDANSKI: Object to the form.

A. Lung cancer is suspected, yes.

Q. But when they say "infiltrate-like mass," that alone is not definitive or to a reasonable degree of medical probability that it's cancer, true?

MR. GDANSKI: Object to the form.

A. The radiologist can't make that diagnosis. The clinicians who cared for her and filled out the death certificate were much more definitive than

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that.

As I said to you earlier, I would say I'm 99 percent sure she had cancer and I'm 90 percent sure she had lung cancer.

Q. Where do you contend this infiltrate-like mass was in Helen Cohen?

A. In the center of the right chest.

Q. Again, was your view of the infiltrate-like mass, when you looked at the actual images, blocked by other structures?

MR. GDANSKI: Object to the form.

A. I'm not a radiologist. Usually on the chest x-ray there are often other structures -- there are major vessels, there are lymph nodes, there's the heart. To me it was pretty clear of lung cancer. This is a classic presentation of an advanced lung cancer.

Q. I want you to bear with me on the next question. You alone are the person who has to make the call up or down for purposes of a patient that walks in and shows this dense consolidation, and this infiltration-like mass as seen and described in Helen Cohen's CTA scan of March 3, 2006. Are you with me so far?

A. I'm a hospital of one?

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Q. You're a hospital of one.

A. Okay. Sure.

Q. You look at this. Can you say to a reasonable degree of medical probability for purposes of diagnosing and treating that patient that this is in fact a primary lung cancer?

MR. GDANSKI: Object to the form.

A. As I said, I wouldn't treat this patient, because she was dying. But your putting me in a hypothetical situation, which bears no relationship to reality. Teams of doctors who have expertise in this would look at this.

When I looked at this, I knew what the report would say. She died a couple days later. To

me this is lung cancer. This is metastatic lung cancer.
Q. Let's come back to my question.
MR. GDANSKI: He answered your question.
Q. In this case as an expert, you haven't consulted with another oncologist or hematologist, have you, about Helen Cohen?
A. No.
Q. You haven't consulted with a radiologist, correct?
A. Correct.

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Q. You are, in fact, a hospital of one for your expert opinions in this case, aren't you?
MR. GDANSKI: Object to the form.
A. No.
Q. Is there anybody else, doctor, besides yourself that you're relying upon to form your opinions in this case?
MR. GDANSKI: Object to the form.
A. I'm relying on the body of knowledge that exists with regard to how lung cancer presents, its natural history, the relationship between smoking and lung cancer. So I'm certainly not relying upon myself for anything. It's, with all due respect, an absurd question.
Q. It is not. You have not consulted any other expert in any other field to reach your opinions in this case about Helen Cohen, have you?
A. Yes, that's correct.
Q. So you're the hospital of one. You've got to play all the roles here, doctor, and I'm asking you, if this patient, Helen Cohen, came in, and this CTA scan was your patient, you saw it, you see the dense consolidation, you see the infiltrate-like mass, would you alone be able to render an opinion to a reasonable degree of medical probability that

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Helen Cohen had primary lung cancer?
MR. GDANSKI: Object to the form. Asked and answered.
A. Yes. Easily.
Q. You would.
A. You didn't ask me 100 percent certain, but you asked me to a reasonable degree of probability. I would say I'm 90 percent certain she had lung cancer.
Q. What's your understanding of reasonable degree of medical probability?
A. I guess, you know, I'm not a lawyer, but I'm told reasonable degree of medical probability is 50.1 percent or greater. Here my degree of certainty is, you know, I'm picking out a number, and I'm saying 99 percent sure she had cancer, and

90 percent sure she had lung cancer.
Q. So if you were the hospital of one, this was your patient, this is not a litigation case that you're evaluating, you're going to be able to say, I can look at this CT scan, and say that this dense consolidation and this infiltrate-like mass is primary lung cancer?
MR. GDANSKI: Counsel. I object. It's five o'clock. It was just asked and answered. It

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was clearly just asked and answered on the record with a direct answer.
MR. DAVIS: It has not.
MR. GDANSKI: I object that it's been asked and answered. I object that you're using this witness and wasting time. I counsel you to use time efficiently to the point we're not repeating questions. You can answer the question again. At some point the asked and answered objection was because you're repeating questions hoping to get a different answer, which you're probably not going to get.
MR. DAVIS: Jon, the witness came today to talk about his opinions. The process has been somewhat slow because of the familiarity or lack of familiarity with the records, and we've had to spend some time with that. I'm not blaming Dr. Strauss for that. I'm not blaming anybody for that. It's the circumstances we're dealing with today.
I don't agree with you that we've wasted time here today. There's been a fair amount of stuff we've had to cover. So let's just settle that aside. Can you repeat my question?
A. I understand it. I don't accept the validity of your question, but my answer is yes.

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Q. So in your normal practice, when you're outside of litigation, you would not be a hospital of one, correct?
MR. GDANSKI: Object to the form.
A. Correct.
Q. You would see this CT scan on Helen Cohen, and you would say I've got my suspicions, but I need to talk to a radiologist to confirm those suspicions, true?
MR. GDANSKI: Object to the form.
A. Yes.
Q. So you wouldn't be able to say with any degree of certainty in that situation what exactly was going on with Helen Cohen, true?
A. Well --
MR. GDANSKI: Object to the form.
A. -- the difference here is I'm not a hospital of one, because I have a radiologist

report. I always look at films with radiologists, but sometimes when I have the report and it's pretty obvious what I'm seeing, I may not. So I'm not a hospital of one even in this case. I've got all of the medical records.

Q. Doctor, my question is outside the context of litigation, outside the context of a lawsuit. If

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you saw Helen Cohen's CT scan, you alone would not then evaluate that patient as having confirmed primary lung cancer, what you would instead do is take that to a radiologist and confirm that your suspicion was accurate, true?

MR. GDANSKI: Object to the form.

A. Here I have the radiologist's report and the film.

Q. So the answer to my question was yes, right?

MR. GDANSKI: Object to the form. Asked and answered.

A. I guess so.

Q. It's yes, right?

MR. GDANSKI: Object to the form. Asked and answered. What's going on here?

A. This is a litigation case.

Q. I'm not asking you about a litigation case.

MR. GDANSKI: Are you suggesting the doctor should have violated rights and gone to -- I object. This is abusive. It's abusive.

Q. Back to my question.

MR. GDANSKI: Which has been asked and answered.

Q. The answer is, if you saw Helen Cohen's CT

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scan outside the context of litigation, you would not make a diagnosis of primary lung cancer all by yourself, you would rather take that CT scan, talk with a radiologist, and have the radiologist confirm that your suspicion is accurate?

A. Frankly, that comes up fairly often.

MR. GDANSKI: Object to the form.

A. We do consults in the hospital.

Q. The answer to that question is yes?

MR. GDANSKI: He's answering your question. Answer the question as you see fit, doctor.

A. If I saw the patient as a consultation and I had the report and I had the CT, I might just, because I like to do it in general, and it's good for teaching fellows and students with me, but you know, with the report and the CT scan, this is really no reason to do that.

Q. Wait a minute. You've testified numerous times that outside the context of litigation you've gone and used a radiologist to confirm what you see

21 --
22 A. But here I have the report. If I were
23 consulted in the hospital, if I were Dr. Koletsky,
24 where I had this report, if I were consulted on 3/4
25 or 3/5, and I had the report, saw the patient, I
0267
1 would presumably have access to the hospital
2 computer, generally I do that, because for teaching
3 purposes, but this was not a gray case. This was
4 pretty clear.
5 Q. So you agree that more likely than not, if
6 you had gotten this case outside of the context of
7 litigation, your general practice would have been to
8 take the CT scan to a radiologist and confirm your
9 suspicion that Helen Cohen had primary lung cancer?
10 MR. GDANSKI: Object to the form. Asked
11 and answered. Mischaracterizes his prior testimony.
12 A. I don't know what to say. Usually, yes.
13 My hospital CT would have been loaded and would have
14 been looked at, and I'd probably have wasted the
15 radiologist's time if I asked him to look at it
16 again.
17 MR. DAVIS: Can you repeat that answer.
18 (Reporter read back previous answer)
19 Q. Is it your testimony that Helen Cohen had
20 an endobronchial lesion?
21 A. I think it's possible.
22 Q. Did you visualize one on the CT scan?
23 A. You can't visualize an endobronchial lesion
24 on a CT scan. The blockage of the bronchus, as
25 described, strongly suggests that. You need to --
0268
1 you would visualize that in bronchoscopy, and she
2 probably would have died if she had.
3 Q. In terms of confirming your suspicion of
4 primary lung cancer, a bronchoscopy was not done to
5 verify it, true?
6 MR. GDANSKI: Object to the form.
7 A. It was definitely not done.
8 Q. So what I said was true, right?
9 MR. GDANSKI: Object to the form.
10 A. To me the diagnosis was well established by
11 this point in time, and the procedure was not
12 necessary in a patient who was a few days from
13 death.
14 Q. You say that the diagnosis was confirmed at
15 that time. That's not what the CT scan report says,
16 does it?
17 A. It's not what the CT scan reports, but
18 that's what the death certificate says, and that's
19 what the discharge summary says.
20 Q. The CTA scan report of March 3, 2006 says
21 that lung cancer is suspected, right?
22 A. That's what --

MR. GDANSKI: Object to the form. That's been asked and answered.
A. Yes.

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Q. And you're not going to sit here and say that you're relying on the death certificate in this case to form an opinion?
A. No.
Q. You're not, are you?
A. I'm not relying on the death certificate, but the death certificate reflects the facts of this case.
Q. Do you know anything that Dr. Dudley, who filled out the death certificate, did to investigate the cause of Helen Cohen's death before he signed it?
A. I don't.
Q. You don't?
A. I said I don't.
Q. And I think you described his deposition in your notes, your typed notes, as nothing useful in that deposition, true?
MR. GDANSKI: Form.
A. I need to -- I don't remember the doctor, but I suspect it's correct.
Q. So do you know whether Dr. Dudley spent one minute, ten minutes, two hours or several days with Mrs. Cohen before he wrote on the death certificate what he wrote?

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A. I don't know.
Q. Did you investigate that before making any reference to the death certificate?
A. I wouldn't know how to investigate that.
Q. Do you agree that death certificates are inherently unreliable?
A. Death certificates are often unreliable.
Q. More likely than not what's on the death certificate is unreliable?
A. I absolutely disagree with that. More likely than not the death certificate is correct, but they are often wrong. In this case --
Q. A substantial majority --
MR. GDANSKI: Are you still answering the question. Come on.
MR. DAVIS: Are you finished?
MR. GDANSKI: No, he was not.
MR. DAVIS: Jon, we'll get this ironed out. No one is going to cut him off. No one is going to do that. If I interrupted him, I apologize. That's not my goal.
Q. Did I interrupt you?
A. Yes, you did.
Q. Please, finish.

25 A. There is considerable literature that death
0271
1 certificates can often be wrong. But to say they
2 are often wrong than correct, I am not an expert in
3 death certificates. I have not done any studies on
4 death certificates. But to say it's more likely
5 than not to be wrong I believe is a gross distortion
6 of the truth.
7 Q. Can you tell us here today what percentage
8 of death certificates accurately show the true
9 diagnosis and cause of death?
10 A. I'd be glad to research that. Of course,
11 you know, you may not know that, other than by
12 autopsy. But I cannot.
13 Q. Is it that you say that you suspect she has
14 an endobronchial lesion?
15 A. Because she had collapse of one of the
16 lobes of the lung, although that theoretically could
17 be the lung mass itself. So I'm reading from the
18 CT, a report. "This dense consolidation extends" --
19 that's consolidation in the posterior segment of the
20 right upper lobe -- "dense consolidation extends
21 down to diffusely involve the right hilar region
22 surrounding the right bronchus and right lower lobe
23 pulmonary artery, but without obvious encasement."
24 So it's around the right bronchus. So it's
25 probably causing -- you know, you can't assess an
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1 endobronchial lesion by CT can.
2 Q. Do you agree pneumonia can also result in a
3 collapsed lung?
4 MR. GDANSKI: Object to the form.
5 A. Usually not. There's inflammation of the
6 lung, but usually pneumonia is not going to cause
7 the collapse itself. There may be a mucus plugging,
8 something we talked about hours ago, which can lead
9 to collapse of the lung. But collapse of the lung
10 usually means there's something actually obstructing
11 the bronchus, the airway to that lobe of the lung or
12 that segment of the lung.
13 So pneumonia itself usually does not do
14 that, although you can have big wads of pus or mucus
15 plugging.
16 Q. Where do you contend the lung cancer was
17 located?
18 MR. GDANSKI: Object to the form.
19 A. I thought I already told you. In the
20 center of the right chest, central lesion in the
21 right lung.
22 Q. What part in the central chest is it
23 located near?
24 A. The posterior segment of the right upper
25 lobe. So it's probably in the central part of the
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lung in the right upper lobe. There are three lobes on the right side. I think she had a right upper lobe central lung cancer.
Q. Did you identify the location of the lung cancer on the CT scan?
A. Yes -- well, again, with the caveat that you can't distinguish the nodes from the collapse and the mass itself, but it's all in that area.
Q. Did you see anything else of importance in the March 3, 2006 CT scan, other than what you have described?
MR. GDANSKI: Object to the form.
A. Yes. She had diffuse metastatic disease in the liver.
Q. Other than that, is there anything else specific to her chest area? Do you understand my question? I will rephrase it if you don't.
A. Yes.
Q. Okay. The liver is below the diaphragm; is that right?
A. Correct.
Q. Did you see anything of importance, of significance, to you above the diaphragm in the March 3, 2006 CT scan, other than what you've described?

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A. Other than the collapse of the right posterior --
MR. GDANSKI: Object to the form.
A. -- segment?
Q. Yes.
A. Other than the collapse of the posterior segment at the lower lobe, the extensive adenopathy encasement in the bronchus and the extensive diffuse mediastinal adenopathy. Apart from that, everything seemed to be perfectly normal.
Q. So you're not saying that there was encasement, are you?
A. I believe -- let's see. So it's surrounding the bronchus and right lower lobe pulmonary artery, but without obvious encasement.
Q. What does "without obvious encasement" mean to you?
A. They are describing that it's totally surrounding it. The CT has limitations in evaluating this. To see an endobronchial mass, which she probably had, one would have needed to do a bronchoscopy or an autopsy.
Q. Say that again?
A. One would have needed to do a bronchoscopy, that she wouldn't have survived, or an autopsy.

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Q. What would the bronchoscopy hope to have identified?

A. Well, again, to me there was no diagnostic doubt -- well, the 90 percent -- there was no question she was dying of cancer, and I think a 90 percent chance she had a primary lung cancer. So I don't think it would have been helpful, because she was dying and was going to be dead in eight days from this point in time.
But it might have given you more anatomic description and provided pathology of the nature of the cancer.
Q. Do you diagnose and treat your own patients with the standard of reasonable degree of medical probability?
MR. GDANSKI: Object to the form. Asked and answered eight hours ago.
A. No. In medicine -- in the practice of medicine, 50.1 percent has -- it's never a meaningful number. It doesn't reflect -- you're sort of inclined to think it's a little more likely than not. I'm not saying this is 50.1 percent lung cancer. I would say I'm 90 percent sure she had a primary lung cancer; not 100 percent, but 90 percent.
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Q. When you treat your own patients, do you ascribe to the level of certainty of 100 percent --
MR. GDANSKI: Object to the form.
Q. -- or 95 to 100 percent?
MR. GDANSKI: Object to the form. Asked and answered.
A. Most of the time we actually have a clear mass and a biopsy that confirms it's lung cancer. So once in that situation, we're 100 percent here, but not 100 percent because she never had a biopsy.
So I would say I'm as certain as I could be without the benefit of a biopsy, which I believe was not necessary or warranted given that this woman was dying and not a candidate for any kind of meaningful therapy during this last admission in March of 2006.
Q. Can you tell us anything about the size of the lung cancer that you claim was present in Helen Cohen's chest?
MR. GDANSKI: Object to the form.
A. I know for a fact you asked me that exact question before, and the answer is I did not have the tool. I was not able to do it easily. And if I did and I was measuring something, what I would be measuring is I could not distinguish the nodes from the mass from the collapse.
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MR. GDANSKI: Counsel, it appears to me that you may be asking questions over and over again. I don't know what to tell you. It's 5:20.
I would just ask that we move along to questions

that were not asked and answered already.
Q. If I were to show you a CT scan, would you be able to distinguish between what is tumor and what is pneumonia or would you ask for help from a radiologist?
MR. GDANSKI: Object to the form.
A. I thought I had answered that question before. If you showed me a CT scan that I didn't know anything about it, I would want to know something about the patient, and I would certainly want to get help from a radiologist, either in the form of a report that they had previously issued or preferably a living radiologist who would review the films with me.
Q. Irrespective of whether you got the report or not, are you able to look at a CT scan, such as what was done on Helen Cohen on March 3, 2006, and identify what is tumor, what is pneumonia, and what is not tumor?
A. I believe nobody could do that, because I think it's all -- it's lymph nodes, mass, and

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collapse all sort of together. It's a very, very common scenario in lung cancers that occur in the central part of the chest.
Q. Can postobstructive pneumonia, unrelated to primary lung cancer, show up as a dense consolidation on a CTA scan, such as Helen Cohen had?
MR. GDANSKI: Object to the form.
A. Post consolidation --
Q. Can postobstructive pneumonia show up as dense consolidation on a CTA scan, such as what Helen Cohen had on March 3, 2006?
A. It probably did in this case, yes.
Q. Can the dense consolidation you see with Helen Cohen be caused by enlarged nodes in the hilum and mediastinum?
A. Mediastinum, yes. So it's possible she didn't have an endobronchial mass, but it was just the lymph nodes that were enlarged and extrinsically compressing the bronchus. That's definitely a possibility.
Q. Can you say that one more time?
A. I believe it was most likely an endobronchial mass in the center of the lung, but sometimes, you know, one will see an obvious mass

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elsewhere in the lung and some central consolidation where the nodes themselves are pressing on the airways, not something inside the airway.
I could draw a picture more easily than explain it, but outside the airway that's pressing on it causing collapse.

Q. Did you see any of that with Helen Cohen?
A. As I said, you can't quite distinguish it on the CAT scan. Since in this case it really looks like the mass, the metastatic nodes and the collapse are all in the center of the chest.
Q. Do you agree that the radiologist, who interpreted the March 3, 2006 CT scan, went back and looked at Helen Cohen's April 15, 2005 CT scan?
A. He didn't say it. Where he basically says the infiltrate was not present on the 4/15/05 when a prior CTA of the chest was performed, and then when he talks multiple low attenuation enhancing masses are identified filling the liver. The liver on 4/15/05 was normal. So I'm assuming he actually had the film and looked at it.
Q. Do you agree that the infiltrate that's described in the new right upper lobe was not present on February 15, 2006?
MR. GDANSKI: Hold on.

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A. Yes. He certainly says the infiltrate was not present on 2/15/05.
MR. GDANSKI: You said 2/15/06. You misspoke.
Q. I don't think so.
A. She wasn't alive on 2/15/06.
Q. She was alive on 2/15/06.
A. I'm sorry, 4/15/06.
Q. Do you see that the radiologist said Mrs. Cohen had a new right upper lobe infiltrate that was not present on April 15, 2006, right?
MR. GDANSKI: Where in here does it say April 15, 2006?
A. April 15, 2005.
MR. GDANSKI: You're misspeaking, and it's causing confusion or maybe you're talking about different things. You said April 15, 2006. Maybe it's written wrong.
MR. DAVIS: I'll get it cleared up.
Q. Do you agree, if you look at the chest x-rays that I showed you earlier --
A. The chest x-ray reports?
Q. Yes. Let me back up. Are you aware of any radiology on Helen Cohen that showed a right upper lobe infiltrate prior to the March 3, 2006 CTA scan?

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A. No.
Q. Do you agree that one did not exist before the March 3, 2006 CTA scan?
MR. GDANSKI: Object to the form.
A. What did not exist?
Q. The right upper lobe infiltrate.
MR. GDANSKI: Object to the form.
A. I guess I don't have an opinion. Certainly

it wasn't seen on April 15, 2005, and the portable chest x-rays at the bedside are certainly not films that one would do if one were expecting a central lung infiltrate.

Q. Do you agree that the dense consolidation in the posterior segment of the right upper lobe was not present on April 15, 2005 when a prior CTA of the chest was performed?

A. I thought that's what the radiologist said and what we talked about multiple times.

Q. And you agreed with that assessment?

A. I never saw the -- I never saw the April 15, 2005 CAT scan. I'm sure it's correct.

Q. As you sit here today, do you feel reasonably comfortable relying on what the radiologist said about the assessment of the April 15, 2005 prior CTA of the chest?

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MR. GDANSKI: Object to the form.

A. Sure. It should be pretty -- you have a grossly abnormal CT scan and you have one from a year earlier. So I presume it's a competent radiologist. Certainly on the one from March of 2006, which I looked at, I could see it, and so I assume or I'm reasonably confident it wasn't misinterpreted 11 months earlier.

Q. Do you agree that cancer cells destroy or displace pulmonary vessels?

A. Cancer cells don't --

Q. Let me back up. That lung cancer destroys or displaces pulmonary vessels?

A. Sure it destroys pulmonary vessels, but it certainly will displace or encase the vessels.

Q. When you say that, what does it look like on a CTA scan?

A. I'm not certified to read CT scans, but I certainly am not qualified to read CT angiograms. So we have real experts who do that in a hospital.

Q. Do you believe lung cancer would not leave blood vessels unharmed or you don't know?

A. I think neither of those. What do you mean by that? I don't understand your question.

Q. Have you ever seen a situation where a

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blood vessel runs through a cancer and it is unharmed?

MR. GDANSKI: Object to the form.

A. I don't fully understand your question. I'm not sure how I would ask a radiologist that question. I've not seen a radiologist report that -- and I think it's not a coherent question in my opinion.

Q. Do you have any opinions about the density of any nodes that were present in Helen Cohen's --

A. "Density" meaning what?
Q. You talked about there's some lymph nodes that are enlarged with Helen Cohen; did I understand that right?
A. Sure.
Q. Do you have any opinions about their density?
MR. GDANSKI: Object to the form.
A. It does say the dense consolidation extends down to diffusely involve the right hilar region surrounding the right bronchus, and right lower lobe pulmonary artery, but without obvious encasement. So I guess I'm just saying what the report is, and it's not something that I ever questioned in the real world in evaluating patients the density of the
0284
lymph nodes.
When you do PET scans, you will see the avidity of the lymph nodes. A PET scan is a functional test, while a CAT scan is essentially an anatomic test.
Q. Let me hand you what's going to be marked as the next exhibit.
(Document marked as Exhibit 51 for identification)
Q. Do you see this is a chest x-ray of Helen Cohen that was taken on March 3, 2006?
A. Yes.
Q. This is Exhibit 51?
A. Yes.
Q. Do you agree that the right upper lobe infiltrate, there was a right upper lobe infiltrate that was identified on this chest x-ray?
A. I certainly agree that that's what the radiologist, who is the same radiologist who interpreted the CT scan, said.
Q. He says that this right upper lobe infiltrate was not identified on prior available study of February 15, 2006, right?
A. Yes.
Q. And do you have any reason to dispute his
0285
findings?
A. None whatsoever.
Q. Was the mass that you believe is in Helen Cohen's chest, was it solitary?
A. No. Diffuse liver metastases, that's a mediastinal lymph node involvement.
Q. Was the lung cancer in Helen Cohen's chest, in your opinion, solitary?
MR. GDANSKI: Object to the form.
A. People can get multiple lung cancers, but this all looks like one very aggressive lung cancer that had spread to hilar and mediastinal lymph nodes

and to the liver. I believe this is one process.
Q. We've seen Dr. Jacobson's testimony where he changed his opinion about whether Helen Cohen had primary lung cancer after he reviewed the transvaginal ultrasound and other ultrasounds of Helen Cohen, and also her tumor markers. Do you remember that?
A. Yes, I remember we talked about it.
Q. And he changed his opinion from her having primary lung cancer to saying that he was unable to say that she had primary lung cancer based upon that evidence. Do you remember that?
MR. GDANSKI: Object to the form.

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A. Yes, I do.
Q. Now, you've now seen that evidence as well today, and is it right that you're not changing your opinion?
A. Not at all. Yes, it's correct, I'm not changing my opinion at all.
MR. DAVIS: Why don't we take a break here. I'm going to get organized for the home stretch.
(Recess)
(Ms. Luther leaves the deposition and is replaced by Ms. Rossel via speakerphone)
BY MR. DAVIS:
Q. Doctor, can you identify the specific bronchus that you contend the endobronchial lesions was in?
A. Of course not, because I cannot tell you for certain if there's an endobronchial lesion. It was probably in the bronchus to the posterior segment of the right upper lobe, because that's where the collapse is. If it wasn't in the bronchial lesion, which I suspect it was, but I can't conclude, it's most likely to be, since they're seeing the -- at least the reporting collapse in the posterior segment of the right -- probably the bronchus of the right posterior segment

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of the right upper lobe. That's as much as I can say here.
Q. I think you told us just a second ago that you were unable to prove that, true?
MR. GDANSKI: Object to the form.
A. Absolutely, yes.
Q. Now, outside an endobronchial lesion, if that's not in play with Helen Cohen, what is in play with her that supports your opinion that she has primary lung cancer?
A. She has extensive mediastinal adenopathy, right-sided hilar adenopathy, she's got collapse of the part of the right lung, she's got diffuse liver metastases, she's been a long-term smoker and dead

eight days later after this test. This is how lung cancer unfortunately tragically behaves.
Q. Mediastinal lymph nodes or enlarged mediastinal lymph nodes is what you're talking about, right?
A. I don't remember. We talked about it before. I don't remember saying it -- I mean, how else can you get collapsed if there's not an endobronchial lesion. Hilar or mediastinal lymph nodes can compress the bronchi from the outside and push it in as opposed to an endobronchial lesion
0288
which is right inside and just sort of grows and blocks off part of the airway.
Q. Mediastinal lymph nodes or hilar lymph nodes, either singularly or when seen together, are not enough to make a diagnosis of primary lung cancer, true?
MR. GDANSKI: Object to the form.
A. I thought we talked about that about eight hours ago. Just if you see a hilar or mediastinal lymph node, no, you cannot make a diagnosis of lung cancer from that.
Q. Looking at Helen Cohen's CT scan from March 3, 2006, whatever may be going on with her mediastinal lymph nodes or lymph nodes in the hilar region, that alone cannot give you a diagnosis of primary lung cancer, correct?
MR. GDANSKI: Object to the form.
A. I did not say that I'm 100 percent certain, and nobody can say they are 100 percent certain. But as concluded by all the physicians caring for her, the person who filled out the death certificate, and this clinical scenario, you know, I'm 90 percent sure she's got a primary lung cancer.
Q. I think we're miscommunicating. I'm saying with what you see on the CTA scan for Helen Cohen
0289
for March 3, 2006, with respect to hilar lymph nodes or mediastinal lymph nodes, that alone cannot give you a diagnosis of primary lung cancer, true?
MR. GDANSKI: Object to the form.
A. Yes.
Q. Doctor, is it fair to say you're not going to offer any opinions at trial about when Helen Cohen was diagnosed with chronic obstructive pulmonary disease, are you?
A. I don't know. It depends on what I'm asked. I don't suspect I will be asked that question.
Q. You don't expect to be asked that question?
A. Right. She had longstanding COPD.
Q. And you haven't prepared any opinions to offer here today about when those symptoms were

first present in her; is that true?
A. That's correct.
Q. And by "symptoms," I meant COPD. Did you understand that?
A. Actually, I should have corrected your question. I'm not sure what the symptoms were, but she had longstanding chronic obstructive lung disease.
Q. And you're not prepared to tell us today

0290

when that first presented or manifested itself in Helen Cohen, true?
A. Not exactly. All the records indicate it was longstanding.
Q. And that's the best that you can say?
A. I could look it up easily. I'm sure that there's a lot more information that I haven't prepared to talk about.
Q. Do you agree that Helen Cohen's medical records, and the other evidence you reviewed, showed that she had primary lung cancer being first suspected in March of 2006?
A. Yes.
Q. And do you know of any medical record or evidence showing that Helen Cohen had primary lung cancer before 2006?
A. Any evidence that she specifically -- I don't believe -- no.
Q. To the best of your knowledge, do you agree that Helen Cohen's, what you contend is Helen Cohen's primary lung cancer, first manifested itself in March of 2006?
MR. GDANSKI: Object to the form.
A. Not necessarily. This is a lady with multiple medical co-morbidities who didn't have an

0291

obvious cancer in 2005. I'm sure it biologically existed at that point in time. The increasing shortness of breath related to it, I don't know. It certainly was not clinically suspected and it was not manifest, based upon any of the records that I reviewed, prior to March of 2006.
Q. And to the extent it may have been present earlier or manifested itself earlier, you can't tell us a month or a year; is that fair?
A. Yes.
Q. I want to ask you some questions about Exhibit 3 to your deposition.
A. This?
Q. No. Your typed notes. I want to turn to Page 3, if you could. This is a conversation that you had -- let me back up. Page 3 has a section called "Talked to Taylor McParland on July 30, 2012," correct?

A. Yes.
Q. Underneath that are bullet points where you summarized your conversation with the paralegal at the Schlesinger firm?
A. Yes.
Q. And it says, the fourth bullet, "Taylor did not know much, even in terms of pathology." Do you see that?
A. Yes.
Q. Did you ask if any pathology had been done?
A. Yes.
Q. Why did you ask that?
A. I see it. I suspected it was not done, and I asked her that. She, if I recall the conversation correctly, she was not certain, but she didn't know of it.
Q. There's a first bullet that says, "Have to be diagnosed before 1990 and 1996." Do you see that?
A. I do.
Q. Is that something that Taylor McParland said to you during that conversation?
A. My question is whether that's a mistake, and I think I thought she did, but I suspect it was either my error or her error.
Q. Well, you wrote this down or typed this up around the same time that you had the conversation with her?
A. I'm sure I did this as we spoke.
Q. What do you remember about the conversation with Taylor McParland where she's telling you that Helen Cohen has to be diagnosed before 1990 and 1996?
A. I don't think she expanded upon that. Again, I think either she made an error or I made an error or -- I don't know.
Q. Have you ever had any conversations with Mr. Gdanski or anyone else at the Schlesinger firm, other than Taylor McParland, where they have had a conversation with you about the timing for when a particular patient in the tobacco litigation has to be diagnosed?
A. No.
Q. So help me out again, doctor. Why is it that you've got the notes here saying that -- and I'm assuming this is related to Helen Cohen has to be diagnosed before 1990 and 1996; am I correct?
MR. GDANSKI: Object to the form.
A. Obviously these notes refer to Helen Cohen.
Q. So do you know why Taylor McParland was bringing that up?
A. I don't. I have been involved in other --

I've testified in other cases in Florida, based upon what I believe is the Engle decision, if I'm remembering correctly, that there were constraints about when the diagnosis was made. I don't know whether this case relates to that, and I don't

0294

remember the specific dates. But that's why I was sensitive to that comment.

Q. I see. So you were sensitive to it, to Taylor McParland's comment, because you knew it would have some significance to the legal issues in the case?

MR. GDANSKI: Object to the form.

A. Yes.

Q. Do you know whether those legal issues would impact the ability of a Plaintiff to recover in the case?

MR. GDANSKI: Object to the form. Calls for a legal conclusion.

A. I don't specifically, but I believe the answer is yes.

Q. Why do you believe the answer is yes?

MR. GDANSKI: Objection. Calls for a legal conclusion.

A. Because I think I've had discussions relating to that in other cases where other attorneys.

Q. I see.

A. I did, but I don't remember the exact dates.

Q. When this came up with Taylor McParland,

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you understood that there may be some ramifications for the Plaintiff if the diagnosis was not made in certain date periods?

A. As I reviewed this, the question is whether this should have said 2000 to 2006, because obviously I know this was diagnosed in 2006, not 1996. So again, obviously there's something wrong with that comment.

Q. Do you understand that if there's a diagnosis or a determination about when a disease process happened in the Engle litigation, it could have some adverse effects in terms of the ability of a Plaintiff to recover?

MR. GDANSKI: Didn't you just ask that?

MR. DAVIS: I have not.

MR. GDANSKI: I bet you did. I object. Asked and answered.

A. I think the answer is yes. You have to be diagnosed within whatever those dates are.

Q. Have you ever taken into consideration conversations you've had with Plaintiff's counsel about when a particular diagnosis or disease process

presents itself when you form opinions in the case?
A. It's not my concern. It's their concern.
Q. Do you take into consideration what those
0296
Plaintiffs' lawyers have said to you about that in terms of assisting you to prepare your opinions in the case?
MR. GDANSKI: Object to the form.
A. No.
Q. At the very back of this Exhibit 3, there's a life expectancy table. When were you provided that?
MR. GDANSKI: Object to the form.
A. What do you mean when was I provided that?
Q. How did you come to possess Table A-2, life expectancy at various ages in 2003 by sex and race.
A. This comes from, I believe -- if you want, I can get the reference and send it to you. But there's a report, I believe, prepared in 2005, roughly, on the life expectancy of -- you know, she's 81 years old. It wasn't something I was asked to address, but what I was thinking about, you know, what is her life expectancy if she didn't -- assuming she made it to what her age was, but didn't die of lung cancer.
Obviously -- so it's of interest to me, and I cite this. Again, I cut off the table, but if you look at the age, I mean, at birth you're going to make it 78. At age 80, if you're Caucasian, white,
0297
your average life expectancy, they don't say 81 or 82, but they have five-year intervals. At age 80, your life expectancy is nine years if you're Caucasian. It's eight years if you're a white male. It's 9.6 years if you're a white female --
MR. GDANSKI: Doctor, he gets it. I'm not sure he asked you that. He just asked you how you got it.
Q. Have you been asked by Mr. Gdanski or anyone else representing the Plaintiff to offer opinions about this life expectancy table at trial?
A. No. Actually, I think I raised it and I won't be asked that question.
Q. You don't intend to be offering opinions at trial about Helen Cohen's life expectancy based upon the various medical conditions she had, right?
A. Correct.
Q. Do you agree if Helen Cohen had stopped smoking by 1964 when the Surgeon General's report came out, that she would have substantially reduced her risk of primary lung cancer?
MR. GDANSKI: Object to the form.
A. So she was 40 years old. Absolutely.
Q. And do you agree that if she had quit then,

that she would have reduced her risk of having lung
0298
cancer by over 90 percent?
MR. GDANSKI: Object to the form.
A. So she was 40 years old. Probably close to
it.
Q. Do you agree that she would have reduced --
MR. GDANSKI: Are you finished?
THE WITNESS: Yes.
A. If you asked me to give a number, I
probably would have said less. But greatly would
have decreased her risk of developing lung cancer
had she quit in 1964.
Q. There's a Surgeon General's report in 1978;
is that true?
A. I believe there is.
Q. Let's assume that in 1978 that Helen Cohen
had quit smoking. Do you agree that she would have
substantially reduced her risk of having lung
cancer?
MR. GDANSKI: Object to the form.
A. So if she were to quit in 1978 versus 1990
-- it's never too late to quit, but she presumably
had a -- so if she started smoking at.
(Phone)
Q. Do you agree if Helen Cohen had quit
smoking by 1964, she would have reduced her risk of
0299
lung cancer up to 90 percent compared to a never
smoker?
A. So she started smoking, let's say, in 1941,
about. So she would have actually been smoking --
actually, I retract that. I think she would have
substantially reduced, but again, did she smoke two
packs a day? If she had smoked from 1941 to 1964,
so 23 years, at 46 pack years, I think her risks
would have remained.
It would have been greater if she had
stopped, and I think -- but it would have been more
than 50 percent, but it wouldn't have been 90
percent, because she already had a 40 pack year
history or 50 pack year history of smoking.
Q. Do you agree if she stopped in 1964, that
she would have reduced her risk of having lung
cancer compared to a never smoker somewhere between
over 50 percent and 70 percent?
A. I'm sorry, your question is?
Q. If Helen Cohen had stopped smoking in 1964,
do you agree that she would have reduced her risk of
lung cancer compared to a never smoker somewhere
over 50 percent and up to 75 percent?
A. Probably, yeah, I think I would accept
that.
0300

Q. If Helen Cohen had stopped smoking in 1978, do you agree that she would have reduced her risk of lung cancer by over 50 percent, and up to 65 or 70 percent, compared to a never smoker?

MR. GDANSKI: Object to the form.

A. So 1978. So at that point in time she had been smoking for 37 years, two packs a day. So she had a 75 pack year history of smoking. I think it would probably be less than that.

Q. Would it still be over 50 percent but not as high as 70 percent?

A. I can't quote that exactly. I'm not sure of any data -- well, actually there are some models that actually allow you to plug in the numbers. But my bet is that it would probably be less than 50 percent. It would still be very substantial.

Q. I think you've testified in the past that if a smoker quit 25 years before developing lung cancer, that person would more likely than not have developed lung cancer; is that true?

MR. GDANSKI: Object to the form.

A. I presume it is, yes.

Q. I don't want to misquote you. Does that sound like something you said in the past?

MR. GDANSKI: Object to the form.

0301

A. It is something I probably said in the past. But as more time goes on, you know, I reported that more than 50 percent of lung cancer was in former smokers. In 1975 where the average ratio of abstinence was seven years, but they were up to 40 years.

Now that's 18 years ago, and I'm seeing a lot of lung cancer in people who had smoked heavily but stopped 30 years ago.

Q. So if Helen Cohen had quit smoking by 1981, do you believe that it's more likely than not she would not have developed lung cancer?

MR. GDANSKI: Object to the form.

A. I know that she did develop lung cancer. So at that point in time -- I think in her particular case, knowing or I believe that she -- I believe I know she developed lung cancer in 2006. I think in her case, probably more likely than not she would have still developed the lung cancer, because she had by that point in time had smoked -- what is it, 1981? So it would have been 80 pack years. That's a lot of smoking.

Q. I know we have the benefit of hindsight now. Let's say in 1991 we don't know whether or not Helen Cohen is going to develop lung cancer, and if

0302

she stops then, do you agree that she probably will not develop lung cancer?

MR. GDANSKI: Object to the form. Incomplete hypothetical.
A. I'm sorry, the question is had she stopped in 1981, and we don't know anything about her --
MR. GDANSKI: Did you say '81 or '91?
MR. DAVIS: '81.
A. And we don't know anything about her history. I'm not giving a definitive answer if we have no idea what her future was. It would certainly be very substantial. I think she was a 80 pack year smoker, and I can't answer that question. I'm not sure.
(Document marked as Exhibit 52 for identification)
Q. Doctor, I'm going to hand you what's been marked as Exhibit 52 to your deposition. Do you see this is a prospective study of smoking, antioxidant intake and lung cancer in middle-aged women for the USA?
A. Yes.
Q. Do you see this is a publication by researchers who were involved with the Harvard nurses study?

0303

MR. GDANSKI: Object to the form.
A. Yes.
Q. You recognize that the Harvard nurses health study is one of the database of information that scientists often look to to help answer questions about risks?
A. Yes.
Q. And you have used studies from that nurses health study in the past to assist you as an oncologist, have you not?
A. Yes. And I know all five of the authors quite well.
Q. And it's published in a reliable peer reviewed journal?
MR. GDANSKI: Object to the form.
A. Yes.
Q. Have you seen this article before?
A. Not recently, but I think I have, yes.
Q. I want to turn to Page 476.
A. Let me quickly look at the abstract.
MR. GDANSKI: What section?
Q. Let me know when you're ready, doctor, and I'll direct you.
A. Okay.
Q. If you look down at Page 476 on the

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left-hand column, you'll see this nurses health study was established in 1976, and it involves about 121,000 female nurses?
A. Yes. I'm not getting that from the

article, but I know that.
Q. If you go to Page 477, this particular study assessed, if you look on the right-hand side of the right column, the first sentence, it says, "593 confirmed cases of lung cancer were diagnosed during 1.793089 million person year follow-up."
Do you agree this was a large study?
A. Absolutely.
Q. The general rule is the larger the study, the more reliable the results?
MR. GDANSKI: Object to the form.
A. Yes.
Q. The more accurate the statistical analysis?
A. Yes.
Q. I want you to go to Page 478. The left-hand column, first sentence. It says, "Although the effect of smoking can appear to persist for a number of years after stopping, quitters had a relative risk of approximately 50 percent lower than the figure for continuing smokers with adjustment for age after two to five years and

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a relative risk approaching that of nonsmokers after ten to 14 years."
Do you see that?
A. I do see that.
Q. Do you agree with that statement?
MR. GDANSKI: Object to the form.
A. I certainly agree with that in this particular study. The other data doesn't suggest that. So this is an outlier, and frankly, this is the nurses health study. So these are nurses. Nurses used to smoke a whole lot. They don't any more.
I agree that the reduction in risk as seen in this study reduced much more quickly than other data would suggest.
Q. And do you agree that if you look on Table 2 of Page 478, that if you look at that data table, the women who had smoked for ten years or more, the risk of lung cancer was the same as that of a never smoker after adjusting for age and age of smoking initiation?
A. If you would say this one more time.
Q. If for women who had not smoked for ten years or more, the risk of lung cancer was the same as that of a never smoker after adjusting for age

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and age of smoking initiation?
MR. GDANSKI: Object to the form.
A. It looks to me like it's after 15 years. Am I reading this -- wait a second. One is relative risk and the other is adjusted for age, two-year follow-up interval. Yes, I would agree with this.

Q. So in other words, after ten years of smoking cessation, there was no increase of lung cancer from smoking in the study?
A. Right.
MR. GDANSKI: Object to the form.
A. I believe that's not true for the average person. There's lots of data. They didn't make up the data. That's what the data shows. These are nurses and you can only get so much from the question actually asked.
I certainly agree that in the nurses health study the risk reduced much more rapidly, maybe women more than men, but, yes.
Q. And this Table 2 shows risk reduction was for all cell types, correct?
A. It would require me to read this a little more carefully. I suspect you're correct, but I'm not sure.

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(Document marked as Exhibit 53 for identification)
Q. Let me hand you what's been marked as Exhibit 53 to your deposition. Do you agree that this is an article that's entitled "Fruits and Vegetables and Lung Cancer Findings From the European Perspective Investigation Into Cancer and Nutrition."
A. Certainly that's the title of the article.
Q. And this was published in the International Journal of Cancer, which is a respected journal?
MR. GDANSKI: Object to the form.
A. Yes.
Q. And this study also looked at the risk reduction of smoking cessation in lung cancer, correct?
A. I would have to read this article. I actually don't think I've read this article.
Q. Let's see if you can turn to Page 273 of the article. This article in Table 3 outlines what are called hazard ratios, right?
A. Yes.
Q. It's entitled "Distribution of Frequency and Intensity of Smoking For Lung Cancer, Cases By Gender and Hazard Ratios For Each Stratum Stratified

0308

By Symptom," right?
A. Yes.
Q. What this table is doing is looking at what the hazard ratio is, and comparing that for nonsmokers, current smokers, and how long people have smoked and the risk of lung cancer, correct?
A. It's a complicated table. If you were going to ask me about it, I need to look at this.

Q. A hazard ratio is similar to a risk ratio?
A. Yes. It's a risk ratio that takes into account time.
Q. If you look at the bottom of Table 3, there's a section there that talks about ex-smokers, quit smoking. Do you see that?
MR. GDANSKI: As much as I want to move things along, I'm not going to do that at the expense of him not being able to read this. I object. He told you he has never read it and you continue to ask him questions without giving him the opportunity to read the study. I don't think that's fair.
Q. Dr. Strauss, can you answer my questions about this study?
MR. GDANSKI: He said no.
A. I can't. I'd be glad to read the article

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and comment upon it. This is a complicated article that you're asking me to tell you something. If you asked me whether a number on central line says something, I will agree the number is there, but I'm not going to interpret this without having a chance to read the article and see what they actually did.
(Document marked as Exhibit 54 for identification)
Q. Doctor, can I hand you what's been marked as Exhibit 54. Have you seen this article before, "Lung Cancer Risk Reduction After Smoking, Observations From a Prospective Cohort of Women"?
MR. GDANSKI: While he's reading it, at some point I'm going to stop, because I've got to go. I'm obviously trying to be patient. I don't want to have to do that if you have 20 minutes left. At some point I need to make a flight and go home. I have an eight o'clock flight.
MR. DAVIS: All right.
MR. GDANSKI: I'm told we're ten minutes from the airport.
A. I've seen the article.
MR. GDANSKI: I'd ask you to be mindful of the time restraint. It doesn't pay to come back here for five minutes.

0310

Q. With respect to this article, this is looking at lung cancer risk reduction after smoking cessation; is that right?
A. Yes. These are complicated articles that I'm more than happy to comment on, but this is not something that...
Q. Let me see if I can speed this up. If you look at Table 2, which is on Page 923, it says, Table 2 is "Lung Cancer Risk After Smoking Cessation By Pack Years of Smoking History Iowa Women's Health

Study in 1986 to 1999," right?
A. Yes.
Q. It has on the left-hand column "Years of Smoking Abstinence" broken out by a certain number of years, correct?
MR. GDANSKI: I object.
A. Where is it saying years of smoking abstinence?
Q. Far right-hand side of Table 2.
MR. GDANSKI: I object to asking questions about this study.
Q. Are you ready?
A. In a couple of hours. What is your question?
Q. My question is simple. If you look above

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Table 2, if you look at under the "Discussion" section, the third line up from the bottom of the right-hand column, there's a sentence that says, "However, the relative risk of lung cancer among former smokers was observed to approach that of never smokers after ten to 15 years."
Do you see that?
A. I see that.
Q. So that was one of the findings in this study, right?
MR. GDANSKI: Object to the form.
A. I agree that that sentence says that. I'm not prepared, and I presume that's something in the reporting, and I'm not prepared to comment further on this.
Q. Do you agree that statement is consistent with your own knowledge?
MR. GDANSKI: Object to the form.
A. No. I disagree. I think that the risk persists for much longer than ten to 15 years. Once you're beyond 25 years, there was very little data.
I'm familiar with the nurses health studies that show a much more rapid decline in risk than other studies have shown, and again, I'm sure that's correct data. This is a complicated study I need to

0312

look at. I certainly agree that that sentence says what you said it says.
Q. Can you identify for us here today any studies that are not consistent with the findings in either the Harvard nurses study or the part of the finding of this study that we just read?
MR. GDANSKI: Object.
A. I would be happy to, but I did not bring the study. So I would give it to you, but there's a lot of literature about the elevated risk. I'm not the least bit arguing is a great benefit of smoking and it's never too late -- there's a great benefit

of smoking cessation and it's never too late.
I think to say one of the Surgeon General's report, the earlier ones, I believe it was '78, and I can find that reference easily, said that after five years the risk is that of approaching lifelong not smokers, and that's totally false. I believe it never really approaches that. Granted, the nurses health study said otherwise. So there's different data.
Q. Can you identify any studies that are inconsistent with the Harvard nurses study as you sit here today?
A. Yes. I could easily do it, but I can't

0313

cite the reference. If you're interested, I would be glad to provide it to you.
Q. You mentioned earlier in the deposition that Helen Cohen at one time had a transischemic attack; is that right?
A. Right. That was on the list of past medical history.
Q. Are you relating that in any way to smoking in terms of the opinions you will offer at the trial of this case?
A. I don't think so. Certainly stroke is a major risk factor of certain vascular diseases, but I don't think that's going to come up.
Q. Can you go back to Exhibit 3 for a minute. Do you see on Page 3, in the section where you talked to Taylor McParland?
A. Yes. 7/30.
Q. July 30, 2012. You have in the second bullet of "Diagnosis of COPD Before." What did you mean to say or convey when you typed that there?
MR. GDANSKI: Object.
A. I don't remember.
Q. Is that something that Taylor McParland had conveyed to you during the conversation?
A. Probably, but I'm sure by that point in

0314

time I looked at some of the records, and I'm sure I knew that.
Q. Did you take from that conversation that Taylor McParland was telling you that Helen Cohen had a diagnosis of COPD before 1990?
MR. GDANSKI: Object to the form.
A. No, not at all. It was assumed before she was diagnosed with lung cancer.
Q. On Page 4 of these typed notes, there's a section called "Discussion with Jonathan Gdanski, 10/24."
A. Yes.
Q. Is everything that's laid out here things that Mr. Gdanski was telling you and you were making

note of them?
MR. GDANSKI: Object to the form.
A. I think he was responding to my questions.
Q. You were asking him a question about these topics, and then he would answer, and then you would write things down?
A. Probably, yes. The question is do we need to be 100 percent sure that she had lung cancer, and I can't say with 100 percent certainty she had lung cancer. I can say with 90 percent certainty. So I was questioning what is the legal standard.

0315

Q. There's a section that says "Tobacco may claim ovarian cancer." Is that something that Mr. Gdanski told you and you put down?
A. I think I knew that from initial discussions with Taylor, even before I looked at the records.
Q. And I think you described the ovaries of Helen Cohen as of 2005 as being suspiciously enlarged ovaries; is that fair?
MR. GDANSKI: Form.
A. Suspicious, yes.
Q. So you did describe Helen Cohen's ovaries as being suspiciously enlarged ovaries?
MR. GDANSKI: Object to the form.
A. You know, these were notes that I was taking for myself, and yesterday I was asked to bring them. So I wouldn't read too much into that.
Q. But that's what you wrote down?
A. That's what I wrote down.
Q. That's what you typed up?
MR. GDANSKI: Object to the form.
A. That's what I typed up.
Q. Now, this bullet here that says "This patient clearly had lung cancer." Do you see that?
A. Last bullet, yes.

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Q. Is that something that Mr. Gdanski told you?
A. No. It's not his place to tell me.
Q. How did that issue come up where you felt like you needed to document this in this typed note?
A. These are just informal notes in a telephone conversation that I thought would be seen by nobody but me.
Q. Did you make any typed or handwritten notes during your meeting with Mr. Gdanski yesterday?
A. I don't think I did during the meeting.
Q. Did you do after the meeting?
A. I reviewed it after the meeting. For example, I think that the last -- on Page 3, where I talk about the -- the last bullet, the first section, had hematology consultation on 3/4/06 for

leukocytosis. That was not included in previous notes.
Q. Help me out here. Either during the meeting with Mr. Gdanski yesterday or following the meeting with Mr. Gdanski yesterday, did you make any handwritten or typed notes about that meeting?
A. Not about the meeting. After I went home, you know, I reviewed the records again, and I made a few changes to my notes; very few.

0317

Q. What changes to your notes did you make?
A. The issue about the hematology consultation. I can't remember what else looking at this that I added here.
Q. Did you change the phraseology of your notes following the meeting with Mr. Gdanski?
A. In my notes to myself, I commented that -- I think in my conclusions, typical TI, tobacco industry bullshit, and I took that out when I was asked to produce this.
Q. Why did you write that down?
A. I'm so used to what you're doing, you know, she didn't have lung cancer. We don't know, but it was either ovarian cancer, gastric cancer, primary liver cancer, colon cancer. That's what tobacco companies usually do, trying to prove it's not lung cancer. Lung cancer doesn't exist, I guess, from your perspective.
Q. What --
A. It's offensive.
Q. What other, if any, changes did you make to the phraseology of your notes?
A. I don't think I made any.
Q. Do you have a version of that prior draft?
A. No.

0318

MR. GDANSKI: Are you done? Otherwise, I'm done.
MR. DAVIS: Brent has questions.
MR. FILBERT: I have questions.

CROSS EXAMINATION

BY MR. FILBERT:
Q. I want to ask you a few questions. My name is Brent Filbert. Let me ask you first, you're currently board certified in what areas?
A. Internal medicine, medical oncologist and hematology.
Q. Have you ever failed a board certification test?
A. No.
Q. You began working as an expert on tobacco cases for Plaintiffs' law firms back in the late 1990s; does that sound about right?
A. Yes. It was actually during the year that

I did my master of public health, when I left my job and became a full-time student at the Harvard School of Public Health, and I believe I was contacted by a law firm that year, and that was the first case I was involved with.

Q. And so since that time around the late 1990s, when you have consulted on tobacco cases,

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you've always consulted for the Plaintiffs; is that right?

A. Yes.

Q. During that time, how much would you say you've been paid as an expert witness working on tobacco cases?

A. I don't know the answer to that question.

Q. Any idea?

A. No.

Q. More than $500,000?

A. No, absolutely not.

Q. I'm just trying to find out. So more than $100,000?

A. I don't know.

Q. Well, if you were paid $80,000 in the year 2000, and you've worked on tobacco cases since that time, haven't you?

A. I was paid $80,000 when?

Q. In the year 2000. I will just represent to you, you testified that in the year 2000 or in 2000 you testified you had been paid $80,000 for working for the law firm of Mr. Finns in tobacco cases?

A. That's not true. I never testified to that.

Q. You never testified to that?

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A. Absolutely not.

MR. GDANSKI: Mr. Finns?

MR. FILBERT: Yes.

Q. Do you know who Mr. Finns is?

A. Yes. He's a friend of my brother's.

Q. You worked with him on tobacco cases, right?

A. I did.

Q. You testified in the Boeken depo in 2001 that you had earned $80,000 consulting for Mr. Finns on tobacco litigation?

A. I don't believe that's correct. That might have been what I earned during an entire year for legal consulting, which would be medical malpractice.

Q. Do you agree if you said that in a deposition in 2001, that that would have been an accurate statement?

A. I don't remember stating that, and I don't think I did.

Q. That wasn't my question. My question is, if you said that in a deposition in 2001, that that would have been an accurate statement at that time?
A. I don't think I did. If I said something, it would be accurate, but I don't believe I said

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that. I don't believe it's true.
Q. So getting back to my original question, you worked on tobacco cases for approximately 15 years now, right?
A. 13.
Q. So over that time you've been paid by the hour, now you charge $500 per hour, right?
A. Hmm-hmm.
Q. And prior to that you charged $450 per hour for consulting on tobacco cases?
A. Hmm-hmm.
Q. So over those 13 years, you would agree you probably made several hundred thousand dollars?
A. I already answered that. No.
Q. You absolutely have no idea how much you've made working as an expert witness in tobacco cases?
A. I don't.
Q. As you sit here today, you can't say that you've made more than $300,000?
A. Right. I cannot say that.
Q. Well, how do you keep track of how much you make doing your expert work?
A. I keep track of how much time I spend per case.
MR. GDANSKI: I need to take a break. I

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can't stay any more. Do you guys want to reschedule this deposition or do you want to give me a few minutes and call someone to have them call in and finish up.
MR. FILBERT: That's fine.
(Recess)
(Mr. Gdanski leaves the deposition and is replaced by Brittany Chambers)
BY MR. FILBERT:
Q. Doctor, when we left off, I was asking a few questions how much you had been paid working as an expert witness in tobacco cases. I just want to make sure I understand, as you sit here today, you have no idea how much you've been paid over the years working as an expert witness in tobacco cases; is that right?
A. Yes. That's correct.
Q. You said that you maintain records of how much you're paid as an expert witness. Do you have records that you can access to find out how much you have been paid?
A. If I choose to. No, I won't give you that.

That's none of your business.
Q. It's none of my business how much you have been paid as an expert witness?

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A. Yes. That's my private contracting. I pay taxes. It's -- I don't see how that's relevant.
Q. Doctor, I'm not trying to be intrusive. I'm not asking for your tax returns. I'm just asking if you maintain records of how much you're paid as an expert witness working on these tobacco cases, and you said that you do maintain records?
A. I maintain records, but the vast majority of the medical legal consulting I do is on malpractice.
Q. I understand. I'm asking about tobacco cases.
A. So it's buried in there.
Q. Okay.
A. But I have been asked for that, and I'm not willing to give you hard numbers. I'm almost -- I would say I'm 100 percent certain that $80,000 from the Finns case is wrong. I don't remember saying it, and I think it's absolutely wrong. If you would like, I would give you that figure. I will look it up, but I'm sure it's wrong.
Q. When you say that you're unwilling to give me an amount, sitting here today you're unwilling to tell me how much you think you have been paid?
A. Yes. It's like asking for my tax returns.

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It's none of your business.
Q. Let me make sure I understand this, doctor. This is pretty simple stuff. You're unwilling to tell me how much you have been paid as an expert witness working on tobacco cases; is that fair?
A. Yes.
MS. CHAMBERS: Object to form. Asked and answered.
A. It's not something I choose to share with you or anybody besides my accountant and my wife.
Q. Do you have any idea how much you have been paid as an expert witness working on tobacco cases in the year 2012?
A. Probably zero. I don't think I've -- I think this is the only case that I've -- new case I've gotten in 2012. I did submit a bill in July. It hasn't been paid. There's another case that actually is supposed to go to trial in a couple of weeks in New York that I met with the attorney. Actually, I might have actually met with that attorney earlier. So I may have received something for that earlier in the year.
Q. Okay. But you can't tell me an amount you have been paid in 2012?

A. Correct.

Q. In 2011, can you tell me an amount?
A. No.
Q. 2010?
A. No.
Q. You said that there's a case --
A. May I take a look at the list of depositions I gave you?
MR. DAVIS: They are in the stack somewhere here, doctor. It's Exhibit 8 or Exhibit 9.
A. The last deposition I had in a tobacco case, there were two in 2010, and I testified at one trial in 2010, that's the Nathan Cohen trial, and one trial in 2011.
Q. Okay. You mentioned that there's a trial in a couple of weeks. Are you scheduled to testify in any upcoming tobacco trials?
A. Yes.
Q. Tell me the names of the trials -- first of all, let me ask this. How many trials are you scheduled to testify in tobacco trials?
A. That's the only one I know of.
Q. Just one then, right?
A. Yes.
Q. When is that set to go to trial?
A. It's supposed to -- I'm scheduled to testify Wednesday and Thursday, the 29th and 30th of this month. Two weeks from now.
Q. What's the name of the case?
A. William Champagne versus, I believe, Philip Morris and R.J. Reynolds.
Q. That's a case here in New York?
A. This is Massachusetts.
Q. All right. It's been a long day. The case is in New York?
A. It is. White Plains. Jerry Block is the attorney.
Q. He's with the Weiss --
A. No. Levy, Phillips & Konigsberg.
Q. Outside of that trial, no other scheduled trial testimony?
A. I think Jonathan said that this one is sort of tentatively rescheduled for February of next year.
Q. I'll get to that in just a second. I'm trying to finish up fast here. So do you have any depositions in tobacco cases that are scheduled?
A. No. I think this is the only case that I have been involved in that has not been deposed yet.
Q. Okay. And what have you and Jon discussed about you going down to testify in this trial in --

it's scheduled in February, right?
A. I think that's what he said, yes.
Q. Were you told you were expected to go down and testify?
A. I don't think he said that, but I understand that.
Q. That's your understanding that you would go down there to testify?
A. Sure.
Q. It's your understanding you're expected to go down and testify at the trial in this case?
A. Yes.
MR. FILBERT: Okay. I don't think I have any further questions.
MR. DAVIS: I have just a few follow-up questions.

REDIRECT EXAMINATION

BY MR. DAVIS:
Q. Dr. Strauss, do you agree that as of March 3, 2006, the symptoms and complaints that Helen Cohen presented with could be consistent with primary colon cancer that had metastasized to the lung?
A. Based upon what I know?
Q. Just her symptoms and complaints. Do you

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agree that her presentation, including her symptoms and complaints as of March 3, 2006, before the CT scan was done, was consistent with a primary colon, cancer that was metastatic to the lung?
A. If she had colon cancer that metastasized to the liver and the lung, sure, her symptoms could be due to metastatic lung cancer.
Q. Do you agree as of March, 2006, before the CT scan was done on Helen Cohen, that her presentation and her symptoms and complaints could be consistent with a gastric or a stomach cancer that had metastasized to the lung?
A. There's zero evidence that that's the case. If they had gastric cancer, sure, she could have had these symptoms.
Q. Do you agree as of March 3, 2006, before the CT scan was done on Helen Cohen, that her presentation and symptoms and complaints were consistent with ovarian cancer that had metastasized to the lung?
A. Not totally inconsistent, but because ovarian cancer typically doesn't go within the substance of the liver as opposed to the surface of the liver, that's very unlikely. So anything can happen.

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Tumors don't read textbooks, but I think ovarian cancer is even less likely than gastric and

colon, which I think are also zero possibilities. So I guess it can be less likely.

Q. Do you agree as of March 3, 2006 that Helen Cohen's presentation and symptoms and complaint before she had the March 3, 2006 CTA scan, that it was consistent with primary breast cancer that had metastasized to the lung?

A. As I say, there's zero evidence for that. So I think knowing what I know, I think it's actually not consistent with any of those things. She had lung cancer.

Q. But again, I'm saying you don't have the CT scan in front of you as of March 3, 2006, and Helen Cohen presents just like she did in Delray Medical Center, as of that time with the same symptoms and complaints, do you agree that that presentation would be consistent with a primary breast cancer that had metastasized to the lung?

A. It's consistent with pneumonia, without any evidence she had cancer. You're asking a question that has no relevance to this case.

Q. Do you agree that looking at the March 3, 2006 CT scan alone, not knowing anything else, that

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that could be consistent with Helen Cohen having a primary colon cancer that metastasized to the lung?

MS. CHAMBERS: Object to form.

A. It's so hard to put aside what I know. If I know nothing, then anything is possible. But sorry, I can't respond any better to your question.

Q. I'm just asking, if you had a single piece of evidence in front of you of the March 3, 2006 CTA scan of Helen Cohen, and looking at that CT scan that you say was consistent with a primary colon cancer that had metastasized to the lung?

MS. CHAMBERS: Object to form.

A. No. I know what I know about this case, and the history is extraordinarily unlikely to be due to anything other than lung cancer.

Q. I'm not asking about the history and the presentation. We went through that separately.

A. We certainly did.

Q. I'm asking about having the CT scan in front of you, and that's all you have, is the March 3, 2006 CTA scan of Helen Cohen. Looking at that alone, do you agree that that could be consistent with a primary colon cancer that had metastasized to the lung?

A. I guess it could be consistent with any

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cancer.

MS. CHAMBERS: Object to the form.

Q. Sorry.

A. It could be consistent with any cancer for

a question that I don't accept the validity of the question.
Q. It could be consistent with any cancer that had metastasized to the lung?
A. Sure.
MR. DAVIS: Thank you.
RECROSS EXAMINATION
BY MR. FILBERT:
Q. Doctor, I forgot to ask this question. I apologize. You have been asked a lot of questions today, and I just want to make sure that you have expressed every opinion that you have formed in this case based upon your review of the medical records and other evidence that's been produced here today?
A. I guess I --
MS. CHAMBERS: Object to form.
A. I guess I don't understand the question. The vast majority of the day was spent talking about the other cancers that you think she had, that she didn't have. We spent a minimum amount of time talking about lung cancer, causation, and my

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opinions very much related to that.
I expect to be testifying to a considerable extent about that, but we didn't really deal with that at all.
Q. I guess your major opinions in the case, with respect to lung cancer and the cause of lung cancer, you've expressed those here today, and then the expert disclosure that you went over, right?
MS. CHAMBERS: Object to the form.
A. I guess so, sure.
Q. Finally, can you tell me for 2012, what percentage of your income comes from your medical legal work?
A. I can't tell you.
Q. You can't tell me that?
A. Yes.
Q. Sitting here today, you have no idea what percentage?
A. I can't tell you what it is. I don't know.
Q. What about for 2011?
A. I don't know.
Q. 2010?
A. I don't know.
MR. FILBERT: All right.
MR. DAVIS: I have one final housekeeping

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issue. The questions are done. Just so I don't forget, I just want to mark as the next exhibit the depositions that Dr. Strauss brought here today. They have got notes on them and flags on them, and I would ask the court reporter to reproduce the flags and make a copy of this.

(Document marked as Exhibit 55
for identification)
CROSS EXAMINATION
BY MR. MICHELMAN:
Q. This is Scott Michelman. I appreciate you bearing with me. You have been here a long time. I just have a couple of quick things.
You mentioned earlier that you had looked up the size of her normal ovaries on the internet, correct?
A. Yes.
Q. Is there any other research you did, Google or otherwise that we haven't discussed today, that you did to relate to your opinions and your work on this case?
A. No.
Q. During the break today, did you and Mr. Gdanski discuss the case or your testimony?
A. No. We talked about our families, mostly

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his kids and my grand kids.
MR. MICHELMAN: I have no further questions. Thank you, doctor.
MS. CHAMBERS: Are the Defendants done?
MR. DAVIS: Done.
CROSS EXAMINATION
BY MS. CHAMBERS:
Q. This is Brittany Chambers from Schlesinger Law Offices. Doctor, I apologize for jumping in in the middle and not being there in person, but I have a couple questions for you. Can you hear me okay?
A. I can hear you fine.
Q. Doctor, is it your opinion to a reasonable degree of medical probability that Helen Cohen had primary lung cancer?
MR. DAVIS: Object to form.
A. It is my opinion to near certainty, 90 percent certainty, that she had primary lung cancer.
Q. And is it your opinion to a reasonable degree of medical probability or expertise that Helen Cohen died of primary lung cancer?
A. Yes, it is.
Q. And is it your opinion to a reasonable degree of medical probability or certainty that Helen Cohen's lung cancer was caused by her smoking

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cigarettes?
MR. DAVIS: Object to the form.
A. Yes, it is.
Q. Doctor, are you prepared to discuss at trial and explain to the jury that each cigarette Helen Cohen smoked contributed in a substantial way to her development of lung cancer?
MR. DAVIS: Object to the form.

A. Each cigarette that she smoked contributed to her development of lung cancer; is that the question?
Q. Yes.
MR. DAVIS: Objection.
MR. FILBERT: I join in that objection.
A. Certainly it's a cumulative exposure over time, yes. So certainly every cigarette contributed to it.
Q. You're prepared to express that opinion at trial, correct?
A. Absolutely.
Q. And I understand that you have a CD that has the medical records in this case?
A. Yes. Jonathan gave that to me yesterday when we met.
Q. Are you prepared to comment on all of the
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records in the case that we have?
MR. DAVIS: Objection.
MR. FILBERT: Form.
A. I've not reviewed it, except I opened it. If I'm asked to, I will. I'm told that there are 10,000 pages, and I would hopefully be looking at selected records rather than every record.
Q. Are you prepared to explain at trial how the relevant medical records relate to your opinions and conclusions in this case?
A. Yes.
Q. Are you prepared to explain at trial to a reasonable degree of medical probability why Mrs. Cohen did not have colon cancer?
A. Can you repeat that? I think I missed a word or two?
Q. Are you prepared to discuss at trial to a reasonable degree of medical probability why Helen Cohen did not have colon cancer?
A. Absolutely.
Q. And are you prepared to explain to a reasonable degree of medical probability why Mrs. Cohen did not have ovarian cancer?
A. Absolutely.
Q. Are you prepared to discuss and explain to
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a reasonable degree of medical probability why she did not have gastric cancer?
A. Absolutely.
Q. And are you prepared to discuss and explain at trial to a reasonable degree of medical probability why Mrs. Cohen did not have any other form of cancer, other than primary lung cancer?
A. Absolutely.
Q. Are you prepared to comment on the relevant portions of David Cohen's deposition that are

relevant to your opinions?
MR. FILBERT: Form.
A. It was an 800-page deposition, and most of it I glanced at. I would hope to be asked or be a little more directed about what I would be asked.
Q. I understand. It was a long deposition. It was about seven volumes. You're telling me you perused it and found portions you found relevant in formulating your opinions, right?
MR. FILBERT: Form.
A. Right. It was more about what she smoked and how much she smoked, but it was very limited.
Q. Okay. In reviewing certain portions of David Cohen's deposition, are you prepared to explain at trial those portions that you deemed
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relevant?
MR. FILBERT: Form.
A. Sure.
Q. Have you reviewed and are you prepared to discuss the death certificate in this case?
A. I've reviewed the death certificate, and I'm certainly prepared to discuss the death certificate in this case.
Q. Have all the opinions you've expressed today held within a reasonable degree of medical probability?
A. Yes.
MS. CHAMBERS: Doctor, those are all the questions I have for you. I would just like to put on the record we would reserve the right to have Dr. Strauss comment on the Defendants' expert testimony and opinions should that be necessary.
MR. DAVIS: I don't have any additional questions. Defendants object to Dr. Strauss relying on any additional records or depositions outside of what he said he was prepared to discuss today and what he said he reviewed before his deposition today.
MR. FILBERT: I join in that objection.
MS. ROSSEL: I join in that objection.
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MR. MICHELMAN: As do I, and I have a couple follow-up questions.
RECROSS EXAMINATION
BY MR. MICHELMAN:
Q. What I thought I heard you say, is it your opinion in this case that every cigarette mattered?
A. Yes, I said that. What I meant is that the risk of lung cancer is related to cumulative exposure over time. I don't know how anyone is going to measure the effect of one cigarette out of the millions she probably smoked during her lifetime.

Q. What was Ms. Cohen's pack year smoking that you contend caused her lung cancer in this case?
A. Well, it varied. I think it could have been as much as two packs a day for 50 years. So that's 100 pack years. It might have been less than that for -- it was somewhere in the 50 to 100 pack year range.
Q. And if we took out five pack years, so it was 95 pack years or 45 pack years, could it still be your opinion that her smoking was the cause of her lung cancer?
MS. CHAMBERS: Object to the form.
A. Absolutely.

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Q. What if we took out ten pack years, so her smoking history ranged from 40 pack years to 90 pack years, it's still your opinion that smoking was the cause of her lung cancer?
A. Of course.
MS. CHAMBERS: Object to the form.
MR. MICHELMAN: I have no further questions.
MR. DAVIS: I just have three.

REDIRECT EXAMINATION

BY MR. DAVIS:
Q. Doctor, can colon cancer metastasize endobronchially?
A. Actually, I suspect the answer is yes, but I don't believe I've ever seen that. I'm not sure. I don't recall a case offhand.
Q. Can breast cancer metastasize endobronchially?
MS. CHAMBERS: Object to form.
A. I believe so, but I can't specifically recall a case.
Q. Can ovarian cancer metastasize endobronchially?
A. I suspect it can, but I've never seen a case.

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Q. Can gastric or stomach cancer metastasize endobronchially?
A. I don't know. I suspect it can, but I've never seen a case.
Q. Are you aware of any cancer whose primary site is outside the lung that does not metastasize endobronchially?
A. Please repeat the question.
Q. Are you aware of any cancer that's origin is outside the lung that does not metastasize endobronchially?
A. Not specifically --
MS. CHAMBERS: Object to form.
A. -- but usually the way we diagnose this

would be with a fine needle aspirate, a CT-directed fine needle aspirate. So you're not assessing that unless there's some specific respiratory symptoms where a bronchoscopy is indicated. I'm not aware of any that can't, but it doesn't come up very often.

MR. DAVIS: Okay. Thank you.

(Whereupon the deposition concluded at 7:29 p.m.)

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ACKNOWLEDGMENT OF DEPONENT

I, GARY M. STRAUSS, M.D., do hereby certify that I have read the foregoing transcript of my testimony, and further certify that it is a true and accurate record of my testimony (with the exception of the corrections listed below):

Page	Line	Correction
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GARY M. STRAUSS, M.D.

SUBSCRIBED AND SWORN TO BEFORE ME THIS _____ DAY OF _____, 20___.

_____ _____
(NOTARY PUBLIC) MY COMMISSION EXPIRES:

0343

CERTIFICATE

Commonwealth of Massachusetts
Suffolk, ss.

I, Michael D. O'Connor, Registered Professional Reporter and Notary Public in and for the Commonwealth of Massachusetts, do hereby certify that GARY M. STRAUSS, M.D., the witness whose deposition is hereinbefore set forth, was duly sworn by me and that such deposition is a true record of the testimony given by the witness.

I further certify that I am neither related to or employed by any of the parties in or counsel to

this action, nor am I financially interested in the outcome of this action.

In witness whereof, I have hereunto set my hand and seal this 14th day of November, 2012.

Notary Public

My commission expires
December 3, 2015