SUPERIOR COURT OF NEW JERSEY
LAW DIVISION - MORRIS COUNTY
Docket No. L-3475-06

Certified Transcript

CAROLINE CAREY and BERNARD CAREY,

Plaintiffs,

vs.

SAINT CLARE'S HOSPITAL, INC., a/k/a SAINT CLARE'S HOSPITAL/DENVILLE IRVING G. PEYSER, MD, H.K. LEE, MD, et als.,

Defendants.

Deposition of:

MICHAEL S. DREW, MD

TRANSCRIPT of testimony as taken by and before PATRICIA A. SANDS, a Shorthand Reporter and Notary Public of the States of New York and New Jersey, at the offices of THE JACOB D. FUSCHBURG LAW FIRM, 500 Fifth Avenue, New York, New York, on Monday, February 16, 2009, commencing at 10:00 in the forenoon.

Job No. 191913

A P P E A R A N C E S:

THE JACOB D. FUCHSBERG LAW FIRM, LLP
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I N D E X

E X H I B I T S

(Exhibits retained by Ms. Lewis.)

M I C H A E L S.. D R E W, M D,

70-10 Austin Street
Forest Hills, New York 11375,
having been sworn, was examined
and testified as follows:

DIRECT EXAMINATION BY MS. SCHWARTZ:

Q Dr. Drew, my name is Rachel Schwartz, I introduced myself earlier. You've had your deposition taken before?

A Yes.

Q I can dispense with the normal instructions?

A Yes.

Q One instruction I will give, if I ask you a question that you don't understand -- for whatever the reason, it makes no medical sense, I mumble, I jumble, I talk too fast -- you let me know, okay?

A Yes.

Q You authored one report in this matter?

A Yes.

Q It is dated September 30, 2008?

A Correct.

Q I'm going to hand you a CV. Can you tell me if this is complete and up to date.

(Exhibits Drew 1 and 2 marked for identification.)

Q For the record, we have marked as Drew 1, a curriculum vitae and as Drew 2 your report.

The curriculum vitae, is this complete and up to date?

A Yes.

Q No additions or deletions need to be made?

A Nothing substantial.

Q You're currently practicing medicine?

A Yes.

Q On a full-time basis?

A Yes.

Q What is your practice?

A I'm in full-time practice with one other person, we practice general surgery. Today it's exclusively at North Shore Hospital in Forest Hills. I have privileges at Mount Sinai, I haven't practiced there in the last four or five years. I'm the Associate Director of Surgery at the hospital. And director, Co-director of the Bariatric Surgery Program.

I'm in private practice, and I have a

salary at the hospital as well.

Q Your privileges to practice medicine at any hospital, have they ever been suspended, revoked or questioned?

A No.

Q You are licensed to practice medicine in what states?

A Just New York.

Q Have you ever held a medical license in another state?

A No.

Q Has your license to practice medicine in New York ever been suspended, revoked or questioned?

A No.

Q Have you ever been sued for malpractice?

A Yes.

Q On how many occasions?

A I think about eight times.

Q Any of them involve a failure to diagnose cancer?

A No.

Q Are any of these cases currently pending?

A There is, I think two that are current. Two.

Q On the other six times, did you settle, try?

A Three were settled and two were, I was dismissed.

Q Can you in one sentence or less give me each one of them?

A One of the settlements was a death in a bariatric case, the woman died about four months post-op. Another case was a pain after a hernia, or recurrent inguinal hernia. They alleged entrapment.

Q That's a settle?

A That was settlement. And there was a settlement on a common duct injury.

Q The two that are pending, just give me the allegations.

A Bariatric case, a patient came in with a leak --

Q That's it.

A Okay.

Q I don't want to go into anymore. You have counsel for that.

A Right.

Q So I would prefer not to get into that.

A Okay.

Q And what was the other one that's pending?

A The other one is a colonoscopic perforation that I happened to take care of afterwards.

Q The two cases you were dismissed?

A There was an appendectomy.

Q Okay. What was the other one?

A A wound infection following a biliary surgery.

Q How much of your practice involves breast cancer?

A About 20 percent. I would say 20 percent. I do about 500 cases a year, probably 20 percent of my operations are breast related. Probably more in terms of breast patients that you don't end up operating on, but around 20 percent I would say is reasonable.

Q Do you have a sub-specialty in general surgery?

A No.

Q You're just straight general surgeon?

A I do general surgery. The bulk of what I do is abdominal, but I do the full gamut of general surgery.

Q Have you published on the issue of breast cancer?

A No.

Q Do you sit in any multi-disciplinary breast center?

A Do I --

Q Do you treat patients as part of any multi-disciplinary breast center?

A No.

Q Your parents that you deal with breast, issues whether you operate or not, who are they referred to you by?

A Most were referrals from the doctors that I deal with.

Q Are they OB/GYNs, are they internists?

A They are both. OB/GYN I would say is the bulk of it, and internist is the other group. Some are self referred..

Q You have acted as an expert in other cases?

A Yes.

Q On how many occasions?

A I have been doing reviews for about 10 years, maybe 11 years now. I probably see on the average three or four cases a month, of which I become involved in probably one or two of those. And that's a little bit less in the beginning, a little bit more now. But I probably do about one to two cases a month that I have to author a report. Or in New York you don't need to author a report.

Q But out of the three to four cases per month that you review, you opt to act as an expert in one to two of those cases?

A Yes. Probably around 50 percent or more I would say I deem not -- without merit for me.

Q Can you break it down, plaintiff versus defense work?

A Most of my stuff is plaintiff, and that's just what's offered to me. I have done some defense work, two or three cases in the time I met attorneys at depositions and they've asked me to be involved. But most of my work is plaintiff.

Q You said two to three cases defense?
A Yes.
Q All total?
A Yes.
Q Have you ever taught in the area of breast surgery or breast cancer?
A I used to cover the breast clinic at Mount Sinai. When I came to North Shore, I covered the breast clinic. I have given lectures to medical students and residents on breast, you know, breast diseases. I have spoken to the community about breast cancer and breast diseases.
Q When is the last time you did that?
A I would say about two or three years ago at North Shore.
Q And two or three years ago and prior to that, how frequently were you giving these lectures?
A At one time I was probably doing them every year, as part of an ongoing series, and breast cancer was one of the topics. So I would say for about four or five years I probably did it every year.
Q Once a year for four or five years?

A Once a year, yes.

Q Have you ever acted as an expert with the Fuchsberg Law Firm before?

A No.

Q Do you review cases on behalf of any referral services?

A I have one referral service, that it's called "Second Opinion". They are located in New Jersey. And as I know them to be, they act as a clearing house for -- they get cases, they put it together, and they have a roster of experts which they use, and I'm one of them. There is no financial arrangements between them. If I decide to get involved, then my communication is directly with the attorneys.

Q Well, how does Second Opinion make any money?

A I think the attorneys pay them for collating the cases and organizing. I don't know of any other way, but the doctors -- or at least I don't have any financial relationship with them.

Q Are you paid by Second Opinion or by the attorney directly?

A By the attorney. Everything is from

the attorney.

Q Did this case come from Second Opinion?

A No.

Q Do you know how they got your name in this case?

MS. LEWIS: Objection.

You can answer.

THE WITNESS: I don't remember. I -- I don't remember.

Q Do you advertise your medical/legal services?

A No.

Q Have you ever?

A No.

Q Are you board certified?

A I'm board certified and re-certified twice.

Q In what speciality?

A In general surgery.

Q How many times did you sit for the boards?

A Each time I passed on my first attempt.

Q Have you attempted any other boards?

A No.

Q Is there a board certification in breast surgery, breast disease?

A No. No.

Q Are there special certifications available in breast surgery or breast disease?

A Not that I am aware of. People do oncology, but not a, as a specific for breasts.

Q Now, you're a general surgeon -- I just want to understand the difference. Okay, you are a general surgeon who works on breasts about 20 percent of the time; correct?

A Correct.

Q In those 20 percent of cases, how many of those cases are dealing with breast cancer?

A I would say probably one a month. I probably deal with one or two breast cancers a month that I personally deal with. My partner probably has the same amount. So in the practice, we deal with probably 25 to 50 cases a year.

Q Who is your partner?

A His name is Moises, M-O-I-S-E-S, Tenembaum, T-E-N-E-M-B-A-U-M. We have been

practicing together for almost 30 years.

Q Moises, M-O-Y-S-E-S?

A M-O-I.

Q M-O-I?

A Yes. The Argentinian version.

Q Do you consider yourself a surgical oncologist?

A No.

Q So in these breast cancer patients, you only deal with the surgery?

A I only deal with the surgery. Absolutely. If they need chemotherapy, radiation therapy, I make the appropriate referrals.

Q Do you have any discussions with patients as to their prognosis with regard to the cancer?

A It will often come up. Again, most of the time I would defer to the oncologists, but, you know, you're dealing with people and they have questions and I will answer them.

Q But when it comes to oncology issues, you would defer to an oncologist?

A Yes.

Q Or a surgical oncologist?

A A medical oncologist.
Q Is there a surgical oncology speciality?
A I think there is a surgical oncology speciality. I don't know if there is a specific board, but you can certainly take a fellowship in surgical oncology.
Q And there are physicians who specialize in surgical oncology?
A Yes.
Q Do you know Dr. Billy Diehl?
A I don't.
Q You have authored one report in this case?
A Yes.
Q September 30, 2008; correct?
A Correct.
Q Did you dictate the report and have it transcribed?
A Yes.
Q You dictated the entire report yourself?
A Yes. This is the -- at this time, I think I was dictating them to my secretary and she would transcribe it.

Q And you dictated the entire report yourself?

A Yes.

Q Did you use any other report to get the background facts into your report?

A The only -- the material I used was 1 through 10. So that that's what the background material that I used that are listed there.

Q Did you have the report of Dr. Maniatis?

A No. Since this report, I have seen the reports of Dr. Diehl, of Dr.. Bill -- the radiologist, Matusi. I have seen the report of Dr. Deligdisch. I have seen -- there is another radiology report, I think the defense report.

Q Maniatis?

A Maniatis is one.

Q Have you reviewed anything else since the preparation for your report?

A No.

Q Has your review of any of those materials changed your opinion in this matter?

A No.

Q When did you review the defense

expert reports?

A Oh, I would say in the last week in preparation for this.

Q Did you review any medical literature in preparation for your report?

A No.

Q Did you review any medical literature in preparation for your deposition?

A No. The only thing I looked at was a, ah, I went on the -- I Googled the Gail, G-A-I-L, model, to refresh what I thought about it.

Q Now your report has the same footnotes as the report of Dr. Maniatis. Did you note that?

A Well, when I wrote this, I didn't see, ah -- you know, this may have been some something that Ms. Lewis asked me to do, but I didn't see his or her report at the time.

Q Okay, so I'm going to show you Dr. Maniatis's report. And in particular, those footnotes that are on the bottom. If you look at the text above, it is identical.

A Yes.

Q Now, is it your testimony that you

created that report, that language in your report through dictation?

A This report -- I wrote a report, then I gave it to Ms. Lewis who, we went over it, and she asked if it would be okay if we put that in.

Q Okay.

A I, you know, as a legal point of, as a legal matter, I have no objection to what it -- it didn't alter what my feelings are on it. So that's where that came from.

Q Does this report contain a summary of all of your opinions in this matter?

A Yes.

Q When you get pathology reports back from a physician, do they often have recommendations in them?

A Pathology reports generally do not. Radiology reports might, but I think pathology reports usually stand by themselves.

Q So it's up to the physician to make an interpretation of the pathology, and make the appropriate recommendations?

A Yes.

Q You would agree that there are

different grades of hypoplasia?

A Absolutely.

Q Have you reviewed any depositions in this matter, in addition to what you have reviewed as listed in your report of September 30?

A Yes.

Q What depositions?

A The deposition of Dr. Diehl, the deposition of the oncologist --

Q Doctor Diehl wasn't deposed. Not the reports.

A I'm sorry.

Q A deposition.

A The only deposition -- oh, I'm sorry. The only deposition I have seen is Dr. Deligdisch's deposition.

Q When did you look at that?

A Also within the last several days.

Q Was there anything that you had requested but did not receive?

A No.

Q You would agree that certain grades of hyperplasia are more likely to be premalignant?

A Yes.

Q And those deal with the atypical hyperplasia?

A Atypical has a higher incidence of predisposition to cancer, but the idea that hyperplasia in and of itself has no increased incidence of, ah, no increased predisposition, I would disagree. That seemed to be the premise of your deposition with Dr. Deligdisch and many of the reports. So that I disagree with strongly.

Q Atypical cells, in and of themselves, can put a patient at higher risk for breast cancer?

A Atypical hyperplasia has a higher predisposition to breast cancer than does hyperplasia. But they both have an increased predisposition to cancer.

Q Hyperplasia, in and of itself, has an increased risk of the patient developing breast cancer?

A Absolutely.

Q The question then is how much of an increased risk; right?

A Yes.

Q And the question then becomes, at what point do you need to do something about it; right?

A Yes.

Q So it's your testimony, then, that hyperplasia at no time -- strike that.

It's your testimony that hyperplasia in all forms presents some increased risk of cancer?

A I think that hyperplasia, in all forms, represents an increase.

Now, if we're talking about Ms. Carey, she had more than just hyperplasia. She had hyperplasia with papillary type, she had sclerosing adenosis. And she had, ah -- I'm blocking out. There was one other issue that I felt increased -- she had papillomatosis, if I recall. So she had several issues, several factors in that pathology report which increase her predisposition to forming breast cancer.

Q You would agree that there is no relationship between inter-ductal papillomas and florid hyperplasia?

A I don't think there is a relationship.

Q So you would agree with my statement?

A I do.

Q Can you give me a percentage of times where hyperplasia, not atypical hyperplasia -- strike that.

Is it your testimony that hyperplasia of the atypical type eventually progresses and turns into cancer?

A Not always. The numbers that you want to attach to it, roughly it has about a five times -- a woman who has a biopsy which has atypical hyperplasia, has a five-time greater chance of developing cancer than a woman who doesn't have atypical hyperplasia. However, a woman with hyperplasia probably has a two times greater.

So we're dealing, as I say, we may, you know, a lot of, I saw the reports quibbled over the idea that it's not atypical. Hyperplasia and especially papillary, and especially when you add it with sclerosing adenosis, as she did, there is nobody who would disagree, including the expert reports I saw, who said she wasn't at an increased risk of developing breast cancer.

Q The only issue is what needs to be done for that?

A That's right.

Q Okay.

A That's right.

Q Of your patients, how many of your patients return with some type of hyperplasia, atypical or otherwise?

A I would say the vast majority, probably -- I would say the majority don't. Many of the biopsies we see are fibrocystic changes. You can have papilloma, you can have a fibroid adenoma, which is a common thing.

So, you know, when you get hyperplasia and when you start getting sclerosing adenosis, that puts it in a different level of surveillance.

Q You're saying "majority". Can you give me a percentage?

A I don't know. As I say, it's certainly a common enough occurrence that a surgeon who looks at the biopsy report that Ms. Carey had, would look at that and say, okay, there's no question that is benign, but there's no question that she needs to be

followed. It's a very simple premise here. I agree with Dr. Diehl that this is a simple case.

Q You also agree that the findings, as noted by the pathologist, are benign?

A Absolutely.

Q And a fibroid adenoma is not premalignant; agreed?

A I would say it's not. Again, you can find literature that says it is, but I think the general consensus in the field is that fibroid adenomas, in and of themselves, are not a premalignant condition.

Q You would agree that the majority of atypical cells are not premalignant?

A The majority --

Q Let me rephrase the question.

A Yes.

Q You would agree that the majority of not atypical hyperplasia is not premalignant?

A Yes.

MS. LEWIS: I want to object to the form of the question. It's after the fact, but --

MS. SCHWARTZ: That's okay.. There

were about four negatives in the question.

Q You would agree that the medical literature indicates that women with fibroid adenoma were less likely to progress breast cancer?

MS. LEWIS: Objection.

Do you understand that question?

THE WITNESS: I do. I think that there are, you can find papers that say they have actually a less, a less predisposition. You can also find papers that show that there is a higher predisposition.

So I think, as I say, while it's a, you could find papers on both sides, clearly, I think the general consensus as we sit here today, is that a fibroid adenoma, in and of itself, is not something that would leave a women at increased risk of developing breast cancer in the future.

Q But does it leave her at a decreased risk?

A I would say that that would be -- I would probably say no.

Q So atypical hyperplasia puts a patient at a greater risk for breast cancer than non-atypical hyperplasia?

A Yes.

Q Inter-ductal epithelial hyperplasia is not atypical?

A Correct.

Q What recommendations do you make for follow-up in a patient with findings such as Ms. Carey's?

A I think this is obviously the crux of the matter and why we're here. This is a patient who clearly should have been followed by the breast surgeon. He should have seen her six months later for an examination and most likely a sonogram. He clearly should have seen her a year later for an examination and a sonogram and/or a mammogram. And then she should have been followed on a yearly basis, depending on what the sonogram and/or mammogram showed.

I think that that was, I mean, even Dr. Peyser agreed that that would have been the appropriate follow-up for this patient. I don't think it's controversial. And there is

no, there is nobody involved in this case who doesn't say that there is an increased risk. Albeit smaller, not as much as atypia, but clearly there's not an expert who said that she's not at some increased risk for breast cancer.

I'm not saying she needed treatment for it, I'm not saying she needed a prophylactic mastectomy, I'm not saying she needed an MRI. She needed to be seen by a breast surgeon, and she needed to be considered for at least a sonogram and most likely a mammogram. Very simple.

Q You have had patients with whom you have made recommendations and they have failed to follow them; yes?

A Yes.

Q And you have had patients whom you have recommended they return, and they have ceased to return; agreed?

A Yes.

Q You have had patients who you sent to another doctor for continued care, continued monitoring, and they have failed to do that; agreed?

A Yes.

Q You can't force a patient to follow through with your instructions; correct?

A Absolutely.

Q Did you make any character judgments in this case?

A Character -- no.

Q Okay, did you make an assumption as to who was telling the truth, the plaintiff or Dr. Peyser, as to what was told to this patient regarding follow-up?

A I think that the record speaks for itself. I don't think that Dr. Peyser ever said he told the patient anything about follow-up. He planned to do that on his next visit, which never occurred.

And I -- one of the most telling things is when Mr. Carey developed a mass three years later, she came back to Dr. Peyser. It wasn't, I don't think she felt uncomfortable, it wasn't like she hadn't done what he told her to do. Everything the record would point to, would show she did what she did. She had the biopsy, she was told to go. And when she developed another problem, she came back to him.

There is nothing in the record that there is any behavior otherwise. His, when he saw her in October of '04, he didn't write that she didn't do what I said to do, and she didn't come back. There is none of that. This was a, you know, there is no reason to believe in her mind she didn't do exactly what she was supposed to do.

Q Now, you said that Dr. Peyser testified at his deposition that he was going to discuss the follow-up care when she returned to his office.

A Yes.

Q Did he instruct her to return to his office?

A Yes.

Q And did she return to his office?

A She did not.

Q Do you know why?

A I don't know why. You know, there is no way of knowing that.

Q So Dr. Peyser did prescribe some type of follow-up in coming back to his office; agreed?

A Yes.

Q And she failed to do that?

A Yes.

Q So did she, contribute, then, at least in part, to her delay?

A Well, the question is that the note, we know what the note says. Okay. We know what the chart says.

My criticism of Dr. Peyser, and where I feel he failed below standards, is he had lots of other options. Had he felt strongly about it -- we all deal with breast cancer.. This is not an uncommon thing, as you and I both know, it's probably the largest contributor to malpractice issues and follow-up issues.

And number one, he should have, if he felt strongly that she wasn't doing what he said, the first thing you do is you would send a registered letter that you're on record, he has documentation.

The second thing he didn't -- which would have been the easiest thing to do, she had two referring doctors that he had written to at the time of the first surgery, before the first surgery. It would have been a simple matter for him to -- he said he met Dr. Manlangit in

the hallway many times, it would have been a very simple thing to say, listen, I need to see this woman, she's not doing what I say. That never occurred. He never wrote a letter to Dr. Gargano, saying your patient is not being complaint. So it leads me to believe that Ms. Carey, in her mind, did what she was supposed to do.

Q So we know that Dr. Peyser instructed the patient to come back to the office, and she failed to do that?

MS. LEWIS: Objection.

THE WITNESS: We know that he wrote in his chart that the patient was to return, in, I think three weeks he wrote, of when he saw her on January 8. So, I mean, that's what he wrote, it doesn't necessarily mean what he told her. There is some controversy, but, again, I give him the benefit of the doubt. That was the plan, I give him the benefit of the doubt, he did call.

But, again, there are -- that's not where this should have ended, in my opinion. And in most people's opinion.

He had lots of recourse, a couple of which were very, very simple.

(Discussion off the record.)

A I'm saying that if you write the letter, you have to write the letter. In breast cancer, you have to write. You have to be on record as sending something.

Q Okay, so it's your testimony, then, if the patient had received -- strike that.

It's your testimony that if Dr. Peyser had written a letter telling her to come back, as instructed in the office, that would have been in compliance with accepted standards of care, and he would not have deviated; is that true?

A That's true.

Q And it's your testimony that his telephone call to the patient advising her to come back, as discussed in the prior visit, was not acceptable and not compliant; is that true?

A It's true, it's not compliant, because it's left a message. You don't know who you spoke, you don't know if she got the message. If he had spoken to her on the phone, or if his secretary had said I spoke to her and told her to come back, I would have felt that

that was sufficient. But leaving a message, we all have answering services and we all have phones, and you don't know who got the message, or even if it was the correct telephone number.

Q So with this benign finding, he needed to actually put it in writing that she needed to come back; yes?

A The patient had a benign tumor, which was at increased risk for developing breast cancer. That's all. You know, I think that in his mind, he treated her as if it was purely a fibroid adenoma, and there's nothing that had to be done. And that's my objection, is there's nobody who looked at this case who said she wasn't at increased risk. And that increased risk behooved him to follow up with her, and she needed follow-up. Everybody would agree, including Dr. Peyser, that said had she come back, he would have gotten a sonogram and he would have been instructed her in self breast examination.

Q You said he had the opportunity to speak with Dr. Manlangit.

A Yes.

Q And discuss with him that the patient

had not returned. Do you know whether that happened?

A Neither of them ever recalled that happening, so I'm going to assume it didn't.

Q Did the patient return to Dr. Manlangit after this?

A I believe she did. I don't have the chart, but I don't know.

Q Well, if the patient had never returned to Dr. Manlangit's office again, what good would it have been to tell Dr. Manlangit that his patient didn't return?

MS. LEWIS: Objection.

Q She didn't return to Manlangit either?

MS. LEWIS: Objection. Objection. Don't even answer it.

MS. SCHWARTZ: That's fine, I'll withdraw it.

Q Did you real the slides?

A No.

Q Would you deem Ms. Carey a compliant patient?

A Yes.

Q Did she have any gynecological or

breast exams after this mass was removed from her breast from 2001 to 2004?

A I don't think so.

Q Did she do self breast exams?

A I don't know. I don't know that anybody ever commented on that.

Q If she had not done self breast exams and had not been back to a doctor for any gynecological or breast care in three years, is she still deemed a compliant patient?

MS. LEWIS: Objection.

You can answer.

THE WITNESS: It depends on what she was told. If she was told you have a benign problem, then, you know, that's it. You may get another, you could develop another fibroid -- come back.

We tell people to come back if there is an issue, and we tell people to come back on a routine basis. There is a big difference. And coming back when they think there is a problem, which is what she did, is being compliant in her mind as to what she was told.

Q And even if she was told to come back

for a routine basis, she didn't do that, either; agreed?

A We don't know that she was told that.

Q Well, what is routine for a GYN exam? Annual?

MS. LEWIS: Are you a GYN expert?

THE WITNESS: I'm not a GYN expert.

Q Are you familiar with what a routine follow-up care -- strike that.

Are you familiar with routine care for GYN?

MS. LEWIS: Given what age?

MS. SCHWARTZ: Whatever her age was, she was 30, 20 something.

MS. LEWIS: Twenty-nine.

A I'm not a GYN expert. I will tell you that in my opinion, from taking care of patients, many women who are not having issues who don't have, have not had pregnancy, have not had problems, don't go to the gynecologist at age 30 on a yearly basis. But I don't know that. There is nothing in the record -- every time Ms. Carey dealt with Dr. Peyser, she did exactly what she was instructed to.

Q Except the last visit?

A The last visit we don't know that there was, that she was told to come back. The chart says that. That's the only time that there was something that seemed to be out of character. That's why it's unusual. When she was told to go to a sonogram, she went the very next day. When she came for surgery, she showed up. When she came for the post-op visit, she showed up. When she had a problem, you know, she came. She went to every doctor that she was ever told to go to, with the exception of this visit. So makes you wonder.

Q How big was the mass when she came back in 2004?

A The mass, when she came back in 2004 to Dr. Peyser's examination was about 2 sonometers. He called it a discord thickening. He was not -- he called it a, he thought it was a recurrent fibroid adenoma. This is was a woman who had a Stage III breast cancer at the time, that the examining physician did not even have a suspicion that it was a carcinoma.

So this is a patient who was difficult to follow. It's a young woman with thickened breast. Here was an expert with 33 years of

practice and 4,000 cases, who examined her, didn't think it was a cancer. Allowed two months to go by until he did it. So that's why this is a patient who needed follow-up by an expert.

Q Is it your position that the cells from where the benign breast mass was removed, that the remaining cells, the hyperplasia that remained, turned into the cancer?

A I don't think there is anyway of -- this was a patient whose breast tissue was turning over, if you will. She was developing hyperplasia. I think that the pathology report shows that the lesion was, the hyperplasia was there. It doesn't talk about -- you wouldn't talk about margins. This is the breast tissue as it exists.

So you're talking about a patient whose remaining breast tissue is at risk of forming a cancer. And I don't think anything was necessarily left. I think that this was what you would expect, or this is what you would fear most in a patient with this breast pathology.

Q When do you believe this patient

developed cancer in this area?

A I think that judging by the fact of the size, and the fact that she had 14 out of 25 nodes positive at the time, I think she probably developed it within six months to a year of the first biopsy. This is not something that classically develops in a year.

And I mean, we know that she didn't have it four years before, but I would say this is, you know, two to three years in the making. You know, again, that's obviously we can all speculate. But I think it's fair to say this is not something that occurred even a year earlier. This is an advanced disease that has been growing for a while.

Q Was it in the same location?

A It was in the same location in terms of the same quadrant of the breast. Again, I think there was a lot of, you know, controversy of is it the same -- it doesn't matter. Okay. This is not -- no one here is alleging that a half of a cancer was removed. It didn't matter, if she came back with a tumor in the medial portion of her breast, it wasn't so much the area, it was the breast tissue. The

fibroid adenoma that Dr. Peyser removed the first time was an incidental finding. It was a point 6 sonometer lesion in a 4 sonometer area of hyperplasia. That was an incidental finding. This was the breast tissue she had. And the follow-up, your concerned about her breast tissue in both sides. I mean, this is breast tissue that is at risk of forming a cancer.

Q So it was in the same quadrant, but not necessarily the same location?

A I don't think it's, you know, that's again, I don't think it matters. It was in the upper outer quadrant of the breast.

Q I understand that to you it doesn't matter.

A Right.

Q I'm just trying to get as to where your opinion is. Was it in the same exact location?

A My opinion, I would say it was in the same area. You know, exact location, you know, when you make an incision, Dr. Peyser's contention that because he made an incision 2 millimeters -- by the way, he was never sure

that he made a second incision. It would be my opinion that no surgeon would make an incision a sonometer away from a previous one, because through the same incision you can stretch it and you cover a lot of, you can remove and examine a lot of breast tissue, but I think it was in the same area of the breast, yes.

Q You agree that fibrocystic change does not -- strike that.

You would agree that fibrocystic change does not change into cancer, does not grow into cancer?

A I agree with that statement, fibrocystic change does not, in and of itself, is not a predisposition to breast cancer.

Q And you would agree that women with fibrocystic change are not at an increased risk for the development of breast cancer because of the change in and of itself?

A Correct.

Q You would agree that just because a breast cancer occurs in the same area of a prior excised fibroid adenoma or fibrocystic change, that the cancer did not necessarily develop from that breast tissue that remained?

A Well, in this case we're talking about dysplasia, not fibrocystic change. It was fibrocystic change, but that's not what we're talking about.

Q Fair enough.

A We're talking about the dysplasia. But, yeah, I think just because it occurred there, her whole -- that wasn't the only -- you would make, the assumption would be her entire breast is of similar tissue. And so the risk is, you know, throughout the entire breast and even the other breast. Which is again, why they opted most likely for a bilateral mastectomy. So it has less to do with where the biopsy was, and more to do with her breast tissue.

Q Because of the breast tissue that was there in her breast, would you agree that even if it had been diagnosed at an earlier stage, that she would have required the bilateral mastectomy, given the nature of her breast tissue?

A I think that the treatment about a breast, again, the mastectomy may or may not have been offered. And that, but I think the

issue in the delay here is not the bilateral or not the other mastectomy, it's the extensive nodal involvement, which is what is going to affect her prognosis.

Q But just with regard to the surgery, you would agree that it's possible she would have had the bilateral mastectomy at not matter what stage she was diagnosed at?

MS. LEWIS: Don't speculate.

A I think, you know, again, she's a young woman with a breast cancer. Many women opt for a prophylactic mastectomy on the other side. As I say the issue here, the left side was being treated prophylactically. The issue here is what the prognosis is, because of the extent of the disease.

Q I'm sorry, it was my misstatement.

A Okay..

Q The left side was always prophylactic, whether it was at the time of diagnosis or four years prior it would have been prophylactic; agreed?

A Yes.

Q Okay. The right side, the breast that was --

MS. LEWIS: I'm going to object. I'm going to object to that question.

MS. SCHWARTZ: Okay.

Q The right breast, which is the side that ultimately had the cancer, that breast, going back now to 2001, you would agree that some patients would have opted to have a mastectomy of the right breast, even if she had been diagnosed with a smaller cancer?

MS. LEWIS: Don't speculate.

A I think the treatment for breast cancer is you have options. And again, depending on the pathology and depending on what she wanted to do, it's variable.

Certainly, you know, a mastectomy is always an option. Most people opt for breast conserving operations. But I think that, you know, it's a choice that she would have had to make at any time.

Q But given the nature of her breast tissue -- and you've just told me her breast tissue has this type of dysplasia in it that would have been there in 2001, and it was there in 2001 and it was there in 2004; is that true?

A Yes.

Q So she would have been faced with the same dilemma as to mastectomy versus breast conserving treatment whether it was 2001 or 2004; agreed?

MS. LEWIS: Objection. Objection.

MS. SCHWARTZ: Are you directing him not to answer?

MS. LEWIS: Yes.

MS. SCHWARTZ: Why?

MS. LEWIS: Because your question has multiple parts.

MS. SCHWARTZ: Okay, let me rephrase. Since directing him not to answer is not the appropriate remedy.

MS. LEWIS: That's all right.

Q You would agree that this patient would have had the same dysplasia in 2001 as in 2004 in her breast, the same makeup of breast tissue?

A Yes. Her breast tissue was her breast tissue, yes.

Q You would agree that her breast tissue in this case of dysplasia, put her at an increased risk for developing cancer?

A Yes.

Q As you have told me about 50 times today?

A Absolutely.

Q And that did not change from 2001 to 2004; correct?

A Correct.

Q You would agree that mastectomy would have been an option given to her, considering the nature of her breast tissue, if it had been diagnosed in 2001, 2, 3, 4, or 5?

A Yes.

Q You would agree that there are small tumors which have a poor prognosis?

A Yes.

Q And large tumors where a patient does well?

A Yes.

Q Is it your understanding that Dr. Peyser advised this patient to return to her OB/GYN for care?

A I don't -- there is no, there is no record, and I don't think there's anything that he said at his deposition which talked about anything other, anything other, any follow-up at all. His plan was to discuss that at the

next visit, which never occurred.

Q You would also agree, though, that the plan to have her back was a plan of follow-up, to have her back to the office?

A To have her back was the follow-up, yes.

Q You would agree that if Dr. Peyser had advised the plaintiff to return to him if there were any changes in her breast, that that would have complied with accepted standards of care?

A No, I don't. I think that's the major issue here.

Q So routine follow-up was not appropriate?

A Routine follow-up for this patient would have been a yearly examine, not coming back when you have a problem.

Q Right, but that's not appropriate; correct? The routine, one year, once per year was not appropriate?

A Once a year is a -- you said --

Q Bad question.

A Okay.

Q Let me rephrase the question.

A Yes.

Q You would agree that an annual follow-up after he saw her in 2001 would have been inappropriate?

A By whom?

Q By Dr. Peyser.

A An annual follow-up by Dr. Peyser, following a six month visit and then annual follow-ups would have been the appropriate follow-up.

Q Okay, but the first follow-up needed to be six months?

A The first one should have been six months.

Q The standard of care required him to have her back in six months, is that your testimony?

A Yes.

Q Were breast MRIs used in January of 2001?

A They were.

Q Were they used routinely?

A No, I don't -- again, the idea that some of the expert raised that she needed some special treatment -- she needed follow-up by a

breast surgeon. And the follow-up would have been an examination and a sonogram, and maybe a mammogram.

Nobody -- at least it's not my opinion that she needed to be enrolled in some MRI program, that she needed gene testing, that she needed genetic counseling. She needed to be followed by a breast surgeon for an examination, a sonogram and possibly a mammogram, depending on the findings, then you decide what to do.

Q Because in your report, you state that she required MRIs depending on the findings.

A Depending on the findings. If she comes back now and she has a sonogram which is equivocal, or you have a mammogram which is difficult to read, one of the options you have clearly is an MRI. I would not say that she needs an MRI as a routine screening. She doesn't need a mammogram as a routine screening, but she does need to be followed by a breast surgeon for this disease.

Q So the standard of care did not require Dr. Peyser to order a screening MRI in

this patient?

A Absolutely not.

MS. LEWIS: Asked and answered about a million times.

MS. SCHWARTZ: A million times? I just started the questioning five minutes ago.

Q When do you believe this cancer was first clinically diagnosable?

A I would think that certainly a year later it would be my -- if you're asking me to hypothesize, I would say that when this patient returned at a year, he would have found some thicking there. Some, the sonogram would not have been normal breast tissue. You might have opted for a core biopsy. You have lots of options. But in my opinion, this would not have been a normal examination and a normal sonogram that he would passed on and said you know what, see me again in a year. But then again, that's a hypothesis.

Q Now, she was diagnosed with a III, Stage III?

A Yes, IIIC.

Q IIIC. Is she going to die from her

disease?

A Most likely, yes.

Q Her chance of dying from this disease is greater than 50 percent?

A Yes.

Q You state in your report on page 6 that the diagnosis of cancer would have occurred when the cancer is at a more treatable, perhaps even curable stage, thereby, improving Ms. Carey's likelihood of survival.

A Yes.

Q Correct?

A Yes.

Q And what stage do you believe her cancer would have been diagnosed if she had come back one year later?

A I think that you would have, hopefully, ideally found it within a node free situation.

Q That's a II?

A Yeah.

Q So you believe that one year later it was about a II?

A You know, it depends on the size. But a I to a II, but, again, I think the major

issue here is she would have had a much better chance of being node, disease free in her lymph nodes.

Q Now, you don't discuss in your report the prognosis for each stage?

A No.

Q You would defer to a medical oncologist?

A I think it's better handled by an oncologist. But I think clearly we would all agree that II's do better than III's, and I's better than II's.

Q And you agree that even patients with Stage I and the smallest tumor do not have 100 percent survival?

A Correct.

Q Particularly disease-free survival; agreed?

A Correct.

Q So that patients with Stage I cancer have lesser than a 100 percent chance of disease-free survival?

A Yes. There is no 100 percent, right.

Q And patients with Stage II have a lesser than a 1 percent chance of disease-free

survival?

A Lesser than --

Q Lesser than a Stage I, they have less of a chance of disease-free survival than a patient with Stage I?

A Yes.

Q Okay, but you're going to defer all of those to a medical oncologist?

A Yes.

Q Do you know whether Dr. Peyser sent the reports with the pathology to Dr. Manlangit?

A He said he did not.

Q Do you know whether he discussed the pathology with Dr. Manlangit?

A He said he did not.

Q Do you know whether he discussed the plan for follow-up with Dr. Manlangit?

A Again, I think both of them testified that there was no communication between them following the surgery.

Q Do you know whether Dr. Manlangit tried to reach out to this patient after he failed to return to his office? After she failed to return to his office? I'm sorry.

MS. LEWIS: Objection.

THE WITNESS: I think it was his testimony, I think I saw a deposition -- you know, he -- as far as his testimony was, and from his chart, I don't think he ever knew that she had even had the biopsy.

Q But he knew she was going for the biopsy?

A He -- what he knew is that he had referred her to Dr. Peyser. He never followed it up, he never knew whether she had followed up or complied. I think that was the last he knew of that issue.

Q And he, being Dr. Manlangit?

A Dr. Manlangit.

Q And did Dr. Manlangit have a duty to follow up on his patient that he referred to a breast surgeon?

MS. LEWIS: Objection. Don't answer, it's not your area.

Q Well, let me ask you this: As a breast surgeon, when a patient is referred to you by an OB/GYN, do you send that physician a letter advising that the patient came to you?

A I usually send a letter about the initial meeting, and what the plan was, whether, you know, again with breast disease, you may say I'm doing nothing, I'm going to biopsy, I'm going to schedule, I'm going to see her in six months, and you do that.

And usually after the operation, we send a note saying that we did the biopsy. You know, again, now whether you send a pathology -- but you would outline in that letter my plan is have her return to you, or to see her in six months, or a year, or return when necessary, PRX.

Q And we know that the first letter was sent in this case, we know that there was no second letter; is that agreed?

A Agreed.

Q Okay. And we know that Dr. Manlangit did not contact Dr. Peyser to find out if the patient underwent biopsy; correct?

MS. LEWIS: Objection.

THE WITNESS: Correct.

Q And do you have an opinion that he acted or did not act within the accepted standards of care?

MS. LEWIS: Objection, objection, objection. Don't answer.

Q You are not qualified as an OB/GYN, is that why you're not comfortable?

A Yes, I don't know what their standards are. I know what the standards of care for the general, for the breast surgeon should be.

Q Well, when you have a patient who had not followed up with an OB/GYN, have you ever had that happen before?

MS. LEWIS: Objection.

MS. SCHWARTZ: Let me ask a different question.

MS. LEWIS: Yeah.

Q Had you ever had a patient that came to you for an initial consultation and you recommended a biopsy that never went through with that biopsy?

A Yes.

Q Did you hear from the breast surgeon with regard to that patient? I'm sorry, did you hear from the OB/GYN with regard to that patient?

A If that happens, I'm very meticulous

about documenting and speaking to the gynecologist, and having my chart reflect the fact that the patient is refusing the procedure, or the patient was seen at, you know, Sloane Kettering, and underwent the procedure there. So, I mean, I try and close the loop as best as I can.

Q Do you ever refer your patients to anyone?

A Sure.

Q And when you refer your patients, do you always receive a letter back from the referred physician?

A I would say that, you know, "always" is a strong word, but I would say, and especially when you're dealing with oncology and radiation, those would be the ones, you know, if we send them -- we do a lot of consulting, and we get letters the vast majority of the time.

Q And do you -- did you ever have a patient who failed to follow up with one of your physicians that you have referred them to?

A Yes.

Q And in that circumstance, did you

receive a call from the physician who you referred? You wouldn't know?

A No, you wouldn't necessarily know if they didn't show up.

Q And if you didn't receive a letter, did you then place a call to that consultation physician, the consulting doctor?

A Again, it depends what the issue was.

If I had a patient who came to me with abdominal pain and I said you know what, I think you should see the endoscopist, you know, I think you have an ulcer. If they didn't follow-up, I may or may not follow-up.

If I had a patient who had rectal bleeding and I sent them to a GI doctor for colonoscopy because I felt cancer was an issue, I would follow-up with that doctor.

Q You would agree that there was no note of a mass by this patient until shortly before the visit to Dr. Peyser in 2004?

MS. LEWIS: Objection. I don't understand. Do you understand the question?

THE WITNESS: I think Dr. Peyser's note said that she felt something six

weeks before her visit to him in October of '04.

Q Are you familiar with the Gail Model?

A Yes.

Q And that's for breast cancer risk assessment?

A Yes.

Q Do you use that in your practice?

A Yes.

Q How frequently?

A You always, you know, when the indications are there, you know, we have a computer on the desk and you could plug it in, you get a sense of what the risks are. It's nice to show the patients.

But, again, you have to know, and I think Dr. Diehl was sort of being a little bit disingenuous -- the Gail Model does not talk about people 30 years old. So his idea of extrapolating well, I'm going to use 35, because it doesn't go down to 30, there is a reason it doesn't apply to a 30-year old, is because it doesn't have any valid statistics. So you can't glean anything from that.

So I mean, that whole idea, you know,

where he's, well, I'll use 35, because that's the lowest it goes, and extrapolate from that, I don't think is valid.

Q Wouldn't the numbers be lower if the patient was younger?

A Well, the patient, 30-year old patient has to now survive five years and not develop cancer to get to be 35. So the numbers are, you know, you can't say anything about it. And probably one of the reasons is that 30-year old people who develop this type of disease are obviously in a different group. They are developing things earlier, they have a much longer outlook on, you know life expectancy.

So but all I know is that statistics, for whatever reason the Gail Model does not, specifically does not include -- it's valid for people from 35 to 90, I believe.

(Recess.)

Q Would you agree that findings without atypia are associated with a negligible or null risk -- strike that.

Would you agree that findings without atypia are associated with negligible additional risk of breast cancer?

A I think that that's my, you know, criticism. And again, I think your experts are being a little bit disingenuous. But, you know, we all know that the risk is increased with hyperplasia without atypia. We all know that it's not as great as atypia.

But to say that it's a -- it's a risk, it's an increased risk, and why wouldn't you deal with that? It's a foolishness not to, you know, to say -- it's just not true. It is an increased risk. Is it as high as atypia? We all agree it's not, but that doesn't mean it doesn't warrant close observation and follow-up.

Q Have you ever used the Gail Model in your practice for a patient under 35?

A No, you can't. If you plug in, it doesn't accept it.

Q Do you use the Gail Model in your practice now?

A Yes.

Q Have you ever had a patient under 35 with breast cancer?

A Yes.

Q How many?

A Oh, I can think of at least three or four that come to mind.

Q What is the incidence for patients 29 with breast cancer?

A It's extremely low.

Q One in 200,000?

A I don't know the number.

Q It's about 1 in 200,000.

A Okay, I would accept that.

Q You would agree that using the Gail Model on this patient with the statistics of 35 years, old puts her at about 1.7 increased risk of breast cancer?

A Yes.

Q And 1.7 is lower -- strike that. 1.7 -- strike that.

Did you apply the Gail Model to this patient, assuming that she was 35?

A I did.

Q You did. And what number did you come up with?

A It came up with -- I think it came up with her risk was 0.3, and a similar population would be 0.5. And I don't remember the, ah, I think it was 1.5 or 1.7, but, again, the point

here is that it's increased. We all agree that it's increased. And there is no reason to, you know, we can't talk about it as if there wasn't an increase. And that's the only reason I'm here, is that this was not -- she was not followed as if there was any risk to her.

Q You would agree that pursuant to the Gail Model, assuming that she was 35, okay, the follow-up is only recommended for a patient with risk factors in aggregate, placed her at a risk greater than 1.7 times the risk of an average woman without factors?

A I don't think the Gail -- the Gail Model talks about the risk of developing breast cancer and, you know, in terms of certain things. There's nobody who would have a patient who had this pathology report in a 40-year old -- you don't base the individual care of a patient on a number on the Gail Model. It's useful information, it tells you, you know, what the risks are.

But, again, we are talking about here about basic routine follow-up. A woman who has not an increased number on the Gail Model who is 40, you would still get a yearly mammogram,

that's what you would do. And there is no, you know, the Gail Model is not designed for an individual, to tailor an individual routine follow-up or routine care.

Q Now, the Gail Model includes clinical practice guidelines in oncology; correct?

A Yes.

Q And you would agree these are the most frequently updated clinical practice guidelines available in oncology?

A They are.

Q And these guidelines address cancer detection?

A Yes.

Q And they address cancer prevention?

A Yes.

Q And they address cancer risk reduction?

A Yes.

Q And they address work up?

A Yes.

Q Follow-up?

A Yes.

Q Diagnosis?

A Yes.

Q Treatment?

A Yes.

Q And supportive care?

A Yes.

Q You would agree that the guideline algorithms are nationally accepted to be the best practice guidelines available?

MS. LEWIS: Objection.

THE WITNESS: They are used, and everybody knows who use them, there are certain -- there other issues that we talk about, you know, parity, family history and things like that, that the Gail Model does not include, because they haven't been able to find an association. But it doesn't mean you don't ask those questions, it doesn't mean we don't consider them.

It's a, it's a tool. It's not, you know, nobody plugs in a number and decides okay, you're going to do this. It tells you -- you use it more in terms of prevention and what to do with higher risk patients. Does this patient, should a patient like this be getting birth

controls, using birth control pills, should a patient like this be getting hormone -- an older woman be getting hormone receptors. Hormone replacement therapy. It's used for that type of issues, not for what I would consider routine management of patients with breast disease.

Q You would agree, though, that these are the best practice guidelines out there? They may not be perfect, but they're the best available?

A They are guidelines, yes..

Q You would agree that these guidelines are followed by the academia?

A Yes.

Q And they are followed by private institutions?

A Yes.

Q And physicians?

A Yes.

Q Hospitals?

A Yes.

Q And the Gail Model indicates that -- I just want to recap, bear with me. The Gail

Model indicates that follow-up is recommended when the patient's risk is 1.7 times, greater than 1.7 times; correct?

A You know what, I don't know that that's true. I don't know that for a fact. I'm sorry.

Q That's okay. You would agree that when you calculated this patient as if she was 35, her number was less than the number required for follow-up by the Gail Model? Solely the Gail Model?

MS. LEWIS: Objection.

THE WITNESS: I don't think the Gail Model would take, would look at this patient, who had this pathology report, and say your risk is not 1.7 -- I'm using that as a number, and say you're home free, go, and come back when there's a problem. That's not what the usage of the Gail model is.

There is nobody who takes care of his patient, including Dr. Peyser, by the way, who said I wanted her to come back, she needed to come back, I wanted to do a sonogram -- there is nobody who would use

the Gail Model to say you have no risk, forget about it, go home.

And that's, that's, I think -- and I don't think Dr. Diehl said that. Dr. Diehl spoke of a slight increase. You know, slight increase is increase, you know. And again, where no one here is advocating putting this woman in a bubble.. The follow-up we're advocating is very, very simple follow-up.

Q This patient had no family history of any significance for breast cancer; correct?

A She had, as it turned out we know from the records that it was a second or third cousin. Dr. Peyser, his impression was that it was an aunt. And, again, it doesn't -- it's not a factor that you hang your hat on and say I'm going to do this.

You have a 30-year old with this pathology. As far as Dr. Peyser knew, her aunt had breast cancer. He knew that she was 30 years old and didn't have a child. So she has risk factors for breast cancer, whether the Gail Model puts it at a number that you or somebody doesn't consider very high, she has --

and again, Dr. Peyser is not saying that he didn't, he didn't want to do these things. So I don't, I don't understand some of the questions. But, nevertheless, this is a woman who needed follow-up, by anybody's criteria.

Q Again, this patient did not have any significant family history for breast cancer; agreed?

A She did not.

MS. SCHWARTZ: I'm almost done. Do you have any questions?

MS. LEWIS: I have to take a second to think about it.

MS. SCHWARTZ: Go ahead. I'm going to just go over my notes real quick.

MS. LEWIS: I just have a couple of questions.

EXAMINATION BY MS. LEWIS:

Q Doctor, just for clarification, is it your testimony that the cancer in Ms. Carey arose at the same location as the location of the biopsy and excision in 2001?

A Yes.

MS. SCHWARTZ: Objection.

Asked and answered.

Q Doctor, is it your opinion the Gail Model is the standard of care, and was the standard of care in 2001 with respect to follow-up treatment for a patient such as Ms. Carey?

A I don't think the Gail Model would necessarily address a follow-up in a patient such as Ms. Carey. Number 1, she doesn't fit in the Gail Model, and it's not designed to tell you how to routine follow, routinely follow a patient.

Q And with respect to cancer staging, do you have a general familiarity with the concept of prognoses in patients according to the stage and lymph node involvement?

A I do.

Q And just based on your general knowledge and familiarity with the staging of cancer, what -- if the cancer had been caught at a Stage I, what would her prognosis have been as of that time?

MS. SCHWARTZ: Just note my objection. Two reasons: First, this doctor has already testified that he would defer to an oncologist in this regard.

Secondly, this doctor did not author anything about prognosis or staging in his report. So all of these now numbers he is about to give us are new testimony that certainly should have been provided in writing prior to this deposition.

MS. LEWIS: Noted.

THE WITNESS: I think the five-year survival of a patient with Stage I would be in the range of 90 to 95 percent. Stage II, probably 65. And Stage III, probably 30.

Q Okay, and with respect to pervasive lymph node involvement, had Ms. Carey been diagnosed at a time prior to invasion into, I think 14 nodes --

A She had 14 out of 25 nodes involved.

Q Just generally based on what knowledge you have in your practice, would her outcome have been any different?

A Yes, I think that the more, the more lymph nodes you have, the worst the prognosis. And she also had lymph nodes involved in all three levels, which would again indicate a much more, a wider spread of the disease.

Q And, Doctor, just so the record is clear, you did read and were provided the radiology report of our expert, Dr. Maniatis; correct?

A Yes.

Q Okay, just so the record is clear on that. And, Doctor, do you have any reason to disagree with the content of that report?

A None.

Q And, Doctor, is it your opinion that the defendant in this case attempts to offer two conflicting defenses?

A Well, I think that one of the defenses is that the patient didn't comply. And, you know, that other one is that it wasn't necessary.

Q Just so the record is clear, are you in any way, shape or form giving an opinion here today with respect to the care that was or was not rendered to Ms. Carey from, or by Dr. Manlangit?

A I am not.

Q In your practice as a surgeon who treats patients with breast disease and performs excisions of breast masses, is it the

habit and practice of a surgeon in performing such a role to personally review pathology slides?

A No.

Q And what is your description or understanding of what a multi-disciplinary breast cancer center is, or breast center is?

A That would be a center where under one roof, if you will, a surgeon practices with a radiologist, with an oncologist, with a radiotherapist. It's a sort of one-stop shopping, if you will, for women with breast disease.

Q And with respect to that initial diagnosis of breast disease, in your opinion does it make a difference whether or not the patient is diagnosed by a doctor who is a part of such a center?

A No.

Q And how about with respect to doctors who may come forward to testify as experts?

A I think that there's, you know, none of the experts I think -- Memorial is not a, necessarily a, ah, a one place where everything is done under one roof. You know, this

oncologist at Memorial often would treat people who were biopsied elsewhere, who had chemo therapy elsewhere. Again, it has nothing to do with the level of expertise or the type of treatment.. It's, many respects it's convenience, it's insurance driven. But I think if the people are qualified, they are qualified no matter how they practice.

Q And just for the record, just to clarify in terms of how we reached out to you as an expert. It was not through any referral service whatsoever?

A It was not.

MS. LEWIS: Okay, thanks.

MS. SCHWARTZ: Are you done?

MS. LEWIS: Yes.

MS. SCHWARTZ: I have some.

EXAMINATION BY MS. SCHWARTZ:

Q Doctor Maniatis, she's a radiologist?

A Yes.

Q And you reviewed her report?

A I did.

Q Did you review the films?

A No.

Q So you would be relying totally upon

a radiologist?

A Yes.

Q You would defer to a radiologist in this regard?

A Yes.

Q You gave me some numbers for cancer staging. What is the basis for those opinions, what literature is that from?

A I think that's standard literature. I don't, you know, just from reading about breasts. And those are, you know, those are rough. You know, the numbers change, because the treatment for breast cancer changes so dramatically from year to year, you know, with the type of treatment. So again, I think that they are not etched in stone. But the idea being that Stage I has a better prognosis than Stage III.

Q Did this patient have an aggressive tumor?

A I think it would be aggressive, on the basis of the number of lymph nodes involved, yes. It's also ER negative and PR negative, so that would be, you know, that would be, ah -- I don't know aggressive. It

would be a poor prognosis.

Q What grade was her tumor?

A The grade I think was 3. Most of the features were at the highest, with the mitotic figures, I think the grade was -- I don't -- I am not sure.

Q Grade 3 is poorly differentiated?

A Yeah, I think she was at the upper level of most of the poorer prognostic elements.

Q And these elements, these factors, poor or good prognostic indicators don't change over the time of the tumor; correct?

A The features of the tissue themselves, right, of the cancer itself wouldn't change. The spread would.

Q She would have had these poor prognostic indicators absent the spread to the nodes -- the poorly differentiated, the ER, PR negative -- those would have all been the same whether she was diagnosed in 2001, 2, 3, or 4?

A One would think so, yes.

Q Okay. And HER 2 NEU, did we go over that?

A HER 2 NEU was, I think, was

nonreactive in her case. She was HER 2 negative.

Q And that was -- I'm sorry.

A That was nonreactive, she was not HER 2 negative.

Q And is that a poor prognostic indicator or a good prognostic indicator?

A That's a better prognostic indicator. But she was what we call a triple negative, which is not a good prognosis.

Q And the triple negative, again, would have been present whether she was diagnosed in 2001 or 2004; correct?

A Yes.

MS. SCHWARTZ: I have nothing further, thank you for your time.

MS.. LEWIS: Thank you.

(The deposition was concluded at 11:17 a.m.)

(Exhibits retained by Ms. Lewis.)