



1 (THE FOLLOWING PROCEEDINGS  
2 WERE HELD IN OPEN COURT IN  
3 THE PRESENCE OF THE JURY.)

4  
5 THE COURT: OUR JURY PANEL IS WITH US.  
6 COUNSEL ARE PRESENT.

7 SIR, YOU UNDERSTAND YOU ARE STILL  
8 UNDER OATH?

9 THE WITNESS: YES.

10

11

12 **SAMUEL HAMMAR,**  
13 CALLED AS A WITNESS BY THE PLAINTIFF, HAVING BEEN  
14 PREVIOUSLY DULY SWORN, RESUMED THE WITNESS STAND  
15 AND TESTIFIED FURTHER AS FOLLOWS:

16 MR. PIUZE: GO?

17 THE COURT: PLEASE.

18

19 DIRECT EXAMINATION

20

21 BY MR. PIUZE:

22 Q. HERE'S THIS PATHOLOGY REPORT I  
23 SHOWED YOU BEFORE. I HAVE MARKED IT 8050.02.

24

25 \* (EXHIBIT 8050.02, PATHOLOGY  
26 REPORT, MARKED FOR I. D.)

27

28 Q BY MR. PIUZE: AND SO FAR WE HAVE

1 LOOKED AT THE DIAGNOSIS UP HERE.

2 AND I WANT TO SHOW YOU SOMETHING  
3 ELSE. PART OF THE PATHOLOGY REPORT -- SORRY, I  
4 TOOK IT TOO FAR AWAY.

5 PART OF THE PATHOLOGY REPORT DEALT  
6 WITH A FROZEN SECTION. ARE YOU AWARE OF THAT?

7 A. YES.

8 Q. PLEASE TELL THE JURY WHAT A FROZEN  
9 SECTION IS, PLEASE.

10 A. SOMETIMES WHEN THE SURGEON IS  
11 OPERATING ON A PERSON AND THEY WANT TO KNOW WHETHER  
12 A SPECIMEN, SAY, CONTAINS CANCER OR MAYBE WHAT TYPE  
13 OF CANCER IT IS, THEY WILL SEND OUT A LITTLE,  
14 USUALLY A SMALL PIECE OF TISSUE FOR A PATHOLOGIST  
15 TO EXAMINE. AND THEY WILL ASK FOR A FROZEN  
16 SECTION.

17 AND WHAT WE DO IS WE TAKE A THIN  
18 SLICE OF THE TISSUE THAT THEY SENT OUT AND WE SNAP  
19 FREEZE IT IN A MACHINE CALLED A CRYOSTAT,  
20 C-R-Y-O-S-T-A-T, AND YOU CAN GET THIS MACHINE DOWN  
21 TO ABOUT, OH, I DON'T KNOW, 25, 30 DEGREES MINUS 30  
22 DEGREES CELSIUS.

23 AND IN THAT CRYOSTAT, THERE IS A  
24 MACHINE CALLED A MICROTOME, WHICH YOU CAN PUT THIS  
25 FROZEN TISSUE IN AND YOU CAN CUT IT BY ADVANCING IT  
26 AGAINST A VERY SHARP STEEL BLADE AND YOU CAN MAKE A  
27 VERY THIN SECTION OF THE TISSUE.

28 YOU CAN TAKE A GLASS SLIDE ABOUT

1 TWO AND THREE-QUARTERS BY THREE-QUARTERS BY  
2 ONE-SIXTH OF AN INCH, DAB THE TISSUE ON, WHICH IT  
3 WILL STICK BECAUSE THE SLIDE IS WARM AND THE TISSUE  
4 IS FROZEN COLD, TAKE THAT TISSUE OUT AND YOU CAN  
5 STAIN IT RIGHT THERE ON THE SPOT. AND THAT'S  
6 CALLED A FROZEN SECTION.

7 AND THEN YOU WOULD PUT A COVER SLIP  
8 ON THE TOP OF THE SLIDE WHERE THE TISSUE IS AND  
9 THEN YOU WOULD LOOK AT IT UNDER A MICROSCOPE AND  
10 YOU WOULD TELL THE SURGEON IN THE OPERATING ROOM  
11 USUALLY BY AN INTERPHONE OR A TELEPHONE THAT HERE'S  
12 WHAT WE FOUND IN THE FROZEN SECTION AND IT MIGHT  
13 BE, YEAH, THERE'S CANCER THERE, HERE'S THE TYPE OR  
14 IT MIGHT BE NO CANCER OR IT MIGHT BE THAT IT LOOKS  
15 TOTALLY NORMAL OR SOMETHING LIKE THAT.

16 Q. THANK YOU.

17 SO THE FROZEN SECTION IS SOMETHING  
18 THAT'S CALLED OUT ALMOST IMMEDIATELY AND THE MAIN  
19 DIAGNOSIS IS SOMETHING CALLED OUT THE NEXT DAY?

20 A. YEAH. THAT'S USUALLY WHAT HAPPENS.  
21 THE TISSUE WOULD BE CUT IN AFTER THE SPECIMEN CAME  
22 FROM THE OPERATING ROOM AND THE FINAL REPORT WOULD  
23 COME OUT THE NEXT DAY.

24 Q. I'D LIKE TO POINT OUT TO YOU THAT  
25 THE FROZEN, THE OPERATIVE CONSULT FROZEN, AND I  
26 APOLOGIZE, I GUESS I SHOULD HAVE THIS CLOSER HERE,  
27 SAYS, F. S. NUMBER 1, F. S. NUMBER 2, F. S. NUMBER 3.  
28 FOR OPENERS, WHAT DOES THAT MEAN?

1           A.     F. S. STANDS FOR FROZEN SECTION.  
2 AND THEN NUMBER 1, NUMBER 2 AND NUMBER 3, WHICH  
3 MEANS THAT THERE WERE THREE FROZEN SECTIONS DONE.

4           Q.     "F. S. NUMBER 1, LYMPH NODE  
5 NEGATIVE FOR TUMDR." I GUESS THAT SPEAKS FOR  
6 ITSELF.

7                     "NUMBER 2, LYMPH NODE NEGATIVE FOR  
8 TUMDR. F. S. NUMBER 3," AND THEN IT SAYS PART 3,  
9 BRONCHIOLOALVEOLAR CARCINOMA. ARE YOU AWARE OF  
10 THAT?

11          A.     YES.

12          Q.     THAT F. S. 3, DOESN'T SAY PAPILLARY  
13 OR ACINAR OR ANYTHING ELSE AND IT DOESN'T EVEN SAY  
14 ADENOCARCINOMA. IT SIMPLY SAYS BRONCHIOLOALVEOLAR  
15 CARCINOMA?

16          A.     YES.

17          Q.     SO IF LYMPH NODE THREE SAYS THIS ON  
18 THE FROZEN SECTION, BUT DOCTOR GELLER'S MAIN  
19 DIAGNOSIS, WHEN WE CAME OUT THE NEXT DAY OR  
20 WHENEVER IT CAME OUT, SAYS PAPILLARY ADENOCARCINOMA  
21 OF THE LUNG. DON'T THOSE TWO THINGS DISAGREE WITH  
22 EACH OTHER?

23          A.     I DON'T THINK THEY REALLY DISAGREE  
24 THAT MUCH. I MEAN, BOTH ARE ADENOCARCINOMA, NUMBER  
25 1. AND THAT'S THE MOST IMPORTANT THING WHEN YOU  
26 ARE DEALING WITH AN ADENOCARCINOMA, AND THAT IT IS  
27 CONSISTENT WITH THE PRIMARY LUNG ADENOCARCINOMA.

28                     AND NUMBER 2, IN THIS TUMDR, IN MY

1 OPINION, THERE WERE AREAS WHERE THE TUMOR DID HAVE  
2 A BRONCHIOLOALVEOLAR GROWTH PATTERN. SO I THINK  
3 THAT WAS A PERFECTLY REASONABLE DIAGNOSIS TO MAKE.

4 IT DID HAVE PAPILLARY AREAS LIKE I  
5 SAID EARLIER. I WOULD HAVE JUST SAID THIS WAS AN  
6 ADENOCARCINOMA THAT SHOWED VARIABLE DIFFERENTIATION  
7 OR MIXED PATTERN.

8 Q. OKAY. WELL, WHAT IF I SAID TO YOU  
9 THAT IF THE FROZEN SECTION SAID ONE THING, IN THIS  
10 CASE, BRONCHIOLOALVEOLAR CARCINOMA, AND IN THE  
11 DIAGNOSIS DR. GELLER DIDN'T SAY, BY THE WAY, THE  
12 FINAL DIAGNOSIS IS DIFFERENT THAN THE FROZEN  
13 SECTION AND HERE IS WHY, IF I SAID HE DIDN'T POINT  
14 THAT OUT, THAT SOMEHOW HE'S ADOPTING THE FROZEN  
15 SECTION DIAGNOSIS, WOULD YOU AGREE OR DISAGREE?

16 A. I DON'T THINK IT MAKES ANY  
17 DIFFERENCE ONE WAY OR THE OTHER.

18 BECAUSE, AGAIN, IT'S NOT GOING TO  
19 HAVE ANY EFFECT ON WHAT HAPPENED WITH RESPECT TO  
20 THIS SURGERY THAT WAS DONE ON THE PATIENT OR WHAT  
21 THE PATIENT'S PROGNOSIS IS. BOTH ARE  
22 ADENOCARCINOMA. THE PATIENT WOULD HAVE HAD EXACTLY  
23 THE SAME TREATMENT WHETHER THEY CALLED IT A  
24 BRONCHIOLOALVEOLAR CELL CARCINOMA OR A PAPILLARY  
25 ADENOCARCINOMA, IT JUST MAKES NO DIFFERENCE  
26 WHATSOEVER.

27 Q. HAVE YOU TESTIFIED IN CASES  
28 INVOLVING LUNG CANCER CAUSED BY TOBACCO IN THE

1 PAST?

2 A. I HAVE.

3 Q. GIVE THE JURY AN IDEA HOW MANY  
4 TIMES?

5 A. FOUR CASES.

6 Q. IN SOME OF THE CASES WHERE YOU HAVE  
7 BEEN INVOLVED IN THE PAST, AS THE DEFENDANT,  
8 WHETHER IT'S REYNOLDS OR PHILIP MORRIS OR WHICHEVER  
9 TOBACCO COMPANY IT IS, AS THE DEFENDANT, ON  
10 OCCASION, AND AN OPPOSING EXPERT?

11 MR. CARLTON: OBJECTION, YOUR HONOR,  
12 RELEVANCE.

13 THE COURT: I HAVE TO ASK ONE QUESTION.

14

15 (A DISCUSSION WAS HELD IN  
16 CHAMBERS, NOT REPORTED.)

17

18 (THE FOLLOWING PROCEEDINGS  
19 WERE HELD IN OPEN COURT IN  
20 THE PRESENCE OF THE JURY.)

21

22 THE COURT: ALL RIGHT, PROCEED.

23 MR. PIUZE: THANKS.

24 Q BY MR. PIUZE: SO THE QUESTION IS,  
25 IN THE PAST, IN CASES IN WHICH YOU HAVE BEEN  
26 INVOLVED WHERE A PERSON OR AN ENTITY, WHATEVER, IS  
27 CLAIMING THAT TOBACCO CAUSES LUNG CANCER, HAVE YOU,  
28 IN THE PAST, BEEN OPPOSED IN CASES WHERE THE

1 DEFENSE, TOBACCO COMPANY, WHATEVER IT IS, HAS HIRED  
2 A DR. BARSKY, TO BE ITS CONSULTANT?

3 A. YES.

4 Q. HOW MANY TIMES?

5 A. FOUR TIMES THAT I CAN THINK OF.

6 Q. AND IN AT LEAST SOME OF THOSE  
7 CASES, HAS DR. BARSKY DIAGNOSED A TUMOR AS BEING A  
8 BRONCHIOLOALVEOLAR?

9 A. YES.

10 Q. AND IN THESE CASES IN WHICH THAT  
11 HAPPENED, DID YOU DIAGNOSE, ACCORDING TO THE WORLD  
12 HEALTH ORGANIZATION, A WHAT?

13 A. IN ONE OF THE CASES I DIAGNOSED  
14 ADENOCARCINOMA AND IN ANOTHER CASE I DIAGNOSED A  
15 SQUAMOUS CARCINOMA.

16 Q. ALL RIGHT. NOW, ARE YOU AWARE THAT  
17 DR. BARSKY IS AN EXPERT FOR PHILIP MORRIS IN THIS  
18 CASE?

19 A. I AM

20 Q. HOW?

21 A. I READ A DEPOSITION THAT YOU TOOK  
22 OF DR. BARSKY CONCERNING THIS CASE. THAT WOULD BE  
23 THE MAIN WAY.

24 Q. AND AS PART OF THAT DEPOSITION, DID  
25 IT CONTAIN SOME SLIDES THAT DR. BARSKY EITHER  
26 PREPARED HIMSELF OR HAD PREPARED OF THE MATERIAL  
27 TAKEN OUT OF MR. BOEKEN'S LUNG?

28 A. YES.

1 Q. I HAVE -- YOU RECOGNIZE THESE  
2 DOCUMENTS THAT I AM HOLDING UP HERE?

3 A. I DO.

4 Q. ARE THESE PICTURES OF THE SLIDES HE  
5 TOOK?

6 A. YES.

7 Q. DO THESE PICTURES HAVE SOME SORT OF  
8 A TERM OF ART TO THEM?

9 A. YES.

10 Q. WHAT?

11 A. PARDON ME?

12 Q. WHAT? ARE THEY CALLED MICRO --

13 A. PHOTO MICROGRAPHS.

14 Q. PHOTO MICROGRAPHS.

15 IS THERE AN UP OR A DOWN TO THESE?

16 A. NO, IT DOESN'T MAKE ANY DIFFERENCE.

17 Q. HERS' S WHAT I WANT YOU TO DO, I  
18 WANT YOU TO TAKE A LOOK AT SOME OF THOSE SLIDES  
19 THAT DR. BARSKY HAD AND I WANT YOU TO SHOW US WHAT  
20 IN THESE SLIDES TELLS YOU THAT THIS IS WHAT YOU  
21 THINK IT IS OR WHAT, IN THESE SLIDES, AGREES WITH  
22 WHAT HE THINKS IT IS. OKAY?

23 A. OKAY.

24 Q. PLEASE.

25 A. WELL, IN THIS FIRST PHOTOGRAPH,  
26 MICROPHOTOGRAPH, I THINK THE TUMOR DOES HAVE WHAT'S  
27 CALLED A BRONCHIOLO GROWTH PATTERN AND THE CELLS  
28 ARE CANCER CELLS ARE LINING WHAT APPEAR TO BE

1   PREEXISTING ALVEOLAR SPACES WHICH CONTAIN THIS  
2   MATERIAL IN THERE.   SO I WOULD SAY THAT IN THIS  
3   AREA THE TUMOR DOES LOOK LIKE A BRONCHIOALVEOLAR  
4   CELL TYPE OF CARCINOMA.

5           Q.    FOR THE RECORD THAT WAS 8050.03.

6

7                   \* (EXHIBIT 8050.03, SLIDE,  
8                    MARKED FOR I. D.)

9

10          Q    BY MR. PIUZE: THIS IS 04.

11          A.    IN THIS PHOTOGRAPH HERE WHICH IS AT  
12   THE SAME MAGNIFICATION, HERE THE TUMOR HAS A MORE  
13   PAPILLARY TYPE OF CONFIGURATION WITH THESE  
14   PAPILLARY STRUCTURES, LIKE THIS, RIGHT HERE, WHICH  
15   ARE JUST PROTRUSIONS OF CELLS INTO THESE SPACES. I  
16   THINK YOU CAN SEE WITH YOUR OWN EYES THAT THIS  
17   LOOKS QUITE A BIT DIFFERENT THAN THE LAST  
18   PHOTOGRAPH.

19          Q.    HANG ON ONE SECOND.

20                   HOW DIFFERENT?

21          A.    WELL, I THINK IT LOOKS A LOT  
22   DIFFERENT BECAUSE HERE THEY ARE LINING WHAT LOOKS  
23   LIKE PREEXISTING ALVEOLAR SPACES. HERE THEY LOOK  
24   LIKE THEY ARE FORMING PAPILLARY STRUCTURE. IT IS  
25   POSSIBLE THAT SOME OF THESE ARE PREEXISTING ALVEOLI  
26   BUT THE DOMINANT PATTERN HERE IS A PAPILLARY  
27   PATTERN.

28

1                                   \* (EXHIBIT 8050.04, SLIDE,  
2                                   MARKED FOR I. D.)

3

4                   Q       BY MR. PIUZE:  OKAY, AND HERE IS  
5 PHOTOGRAPH, OR PHOTOMICROGRAPH 8050.05.

6                   A.       THIS IS THAT LYMPH NODE AGAIN THAT  
7 SHOWS THE METASTATIC CANCER.  AND I THINK THIS IS  
8 WHAT IS SO INTERESTING ABOUT LUNG CANCER IN  
9 GENERAL.  HERE YOU CAN SEE THAT IT'S ACTUALLY  
10 DIFFERENT THAN EITHER ONE OF THESE TWO PREVIOUS  
11 CANCERS.  AND THESE CANCER CELLS RIGHT HERE HAVE  
12 WHAT ARE CALLED SIGNET RING, S-I-G-N-E-T, SIGNET  
13 RING, LIKE A RING, APPEARANCES.  THEY HAVE A RING  
14 TYPE OF APPEARANCE WHERE THE NUCLEUS IS AT ONE EDGE  
15 AND THEN THE CYTOPLASM OF THE CELL IS FILLED WITH  
16 MUCUS.

17                               AND THIS, AGAIN, JUST REFLECTS WHAT  
18 CANCER CELLS CAN DO.  THEY CAN MUTATE AND FORM  
19 DIFFERENT TYPES OF DIFFERENTIATION.  AND THIS ONE  
20 THAT IS METASTATIC IN THE LYMPH NODE IS TOTALLY  
21 DIFFERENT THAN THE TUMOR IN THE LUNG.

22                               BUT THAT'S NOT THAT UNCOMMON.  THEY  
23 DO THAT.  AND WHAT HAPPENS IS, AS PRIMARY LUNG  
24 CANCER, THEY LOOK AT IT FROM MAYBE THEIR POINT OF  
25 VIEW AS IF THEY ARE TRYING TO SURVIVE.  SO THE WAY  
26 THAT THEY CAN SURVIVE IS TO PRODUCE A TYPE OF  
27 ENZYMES AS THINGS THAT CAN BREAK INTO BLOOD VESSELS  
28 SO THEY CAN SPREAD TO OTHER ORGANS AND SET UP SHOP

1 IN THESE OTHER ORGANS AND KEEP GROWING.

2 AND THEY DO THAT BY MUTATING AND  
3 HAVING DIFFERENT APPEARANCES AND PRODUCING THESE  
4 DIFFERENT SUBSTANCES THAT ALLOW THEM TO DO THAT.

5

6 \* (EXHIBIT 8050.05, SLIDE,  
7 MARKED FOR I. D.)

8

9 Q BY MR. PIUZE: THANK YOU.

10 AND HERE IS PROBABLY THE LAST.

11 A. THAT'S THE SAME THING, JUST AT A  
12 HIGHER POWER.

13 Q. SO FOR THE RECORD, A HIGHER POWER,  
14 WE ARE LOOKING AT .06.

15 A. HERE YOU CAN SEE THE SIGNET RING  
16 CELL HERE.

17 THAT TYPE OF CANCER BY ITSELF, YOU  
18 SAW IT, THAT WOULD BE A FAIRLY COMMON TYPE OF  
19 CANCER YOU SEE IN THE STOMACH. BUT YOU CAN ALSO  
20 SEE IT IN THE LUNG.

21

22 \* (EXHIBIT 8050.06, SLIDE,  
23 MARKED FOR I. D.)

24

25 Q BY MR. PIUZE: SO HERE'S A SERIES  
26 OF FAST QUESTIONS AND I AM JUST ABOUT DONE.

27 A. OKAY.

28 Q. BEFORE I ASK YOU THESE QUESTIONS,

1 THOUGH, I WANT TO GO BACK TO YOUR QUALIFICATIONS  
2 ONE MORE TIME.

3 JUST CONFIRM THE FOLLOWING FOR ME.  
4 YOU ARE A MEMBER OF THE AMERICAN ASSOCIATION OF  
5 PATHOLOGISTS?

6 A. YES.

7 Q. INTERNATIONAL ACADEMY OF  
8 PATHOLOGISTS?

9 A. YES.

10 Q. AMERICAN THORACIC SOCIETY?

11 A. YES.

12 Q. "THORACIC" MEANING WHAT?

13 A. CHEST.

14 Q. AMERICAN SOCIETY OF CLINICAL  
15 PATHOLOGY?

16 A. YES.

17 Q. HOW ABOUT IF I READ THE WHOLE LIST  
18 AND IF THERE'S ONE THAT'S WRONG, YOU TELL ME.

19 A. OKAY, SURE.

20 Q. AMERICAN SOCIETY OF EXPERIMENTAL  
21 BIOLOGY.

22 AMERICAN COLLEGE OF CHEST

23 PHYSICIANS.

24 SOCIETY OF PULMONARY PATHOLOGY.

25 INTERNATIONAL ASSOCIATION FOR STUDY  
26 OF LUNG CANCER.

27 A. YES, ALL OF THOSE.

28 Q. ALL THOSE?

1 A. ALL THOSE.

2 Q. BEFORE I ASKED YOU HOW MANY  
3 PUBLICATIONS YOU HAD DEALING WITH LUNG CANCER AND  
4 YOU SAID, I THINK, SOMETHING LIKE 50.

5 WHAT ABOUT TOTAL PEER REVIEWED  
6 PUBLICATIONS, HOW MANY?

7 A. AT THIS POINT IN TIME, I THINK  
8 THERE'S ABOUT 105, THERE MIGHT BE A COUPLE THERE  
9 NEW

10 Q. AND AS FAR AS BOOKS WE ARE  
11 CONCERNED OR BOOK CHAPTERS, BEFORE WHEN YOU  
12 MENTIONED BOOKS THAT HAD TO DO WITH LUNG CANCER, I  
13 GUESS, ARE THERE OTHERS BEYOND THAT OR HAVE YOU  
14 WRITTEN JUST ON THE LUNG CANCER?

15 A. NO, I HAVE WRITTEN QUITE A BIT  
16 ABOUT OTHER THINGS.

17 Q. NOW, HERE WE GO.  
18 WOULD YOU AGREE THAT IN MOST  
19 PRIMARY LUNG ADENOCARCINOMA THAT YOU SEE, THERE ARE  
20 VARIOUS PATTERNS OF DIFFERENTIATION IN DIFFERENT  
21 AREAS?

22 A. YES.

23 Q. IS THAT REFLECTED IN THE WORLD  
24 HEALTH ORGANIZATION CLASSIFICATIONS THAT YOU  
25 MENTIONED EARLIER?

26 A. YES.

27 Q. IF THAT FROZEN SECTION THAT WAS  
28 MENTIONED AND THE FINAL DIAGNOSIS ARE A LITTLE BIT

1 DIFFERENT, DOES THAT MAKE ANY DIFFERENCE WHATSOEVER  
2 IN THE WAY MR. BOEKEN'S OR ANYONE'S LUNG CANCER IS  
3 TREATED?

4 A. NO.

5 Q. IS IT STATED IN MOST PULMONARY  
6 PATHOLOGY TEXTBOOKS THAT BRONCHIOALVEOLAR CELL  
7 CARCINOMA IS THE ONLY SUBTITLE WITH A MORE  
8 FAVORABLE PROGNOSIS THAN THE OTHERS?

9 A. YES, WITH THE UNDERSTANDING THAT  
10 THE DEFINITION IS THAT OF A HOMOGENOUS TUMOR.

11 Q. SAY THAT AGAIN.

12 A. YES, WITH THE UNDERSTANDING THAT  
13 THE CURRENT DEFINITION OF B. A. C. IS A HOMOGENOUS  
14 TUMOR COMPOSED OF CELLS THAT GROW ALONG  
15 PRE-EXISTING ALVEOLAR SEPTA AND DO NOT SHOW  
16 INVASION.

17 Q. AND THAT MEANS A LOT TO YOU, BUT  
18 SAY THAT SLIGHTLY DIFFERENTLY.

19 A. IT BASICALLY MEANS THAT ALL THE  
20 CANCER CELLS LOOK ALIKE AND THEY ARE GROWING ALONG  
21 THE PREEXISTING WALLS OF THE AIR SPACES AND THEY DO  
22 NOT INVADE INTO ANY OF THE NORMAL TISSUE.

23 Q. NONE OF WHICH IS THE CASE HERE?

24 A. NO.

25 Q. BUT IF THAT WAS THE CASE, WE KNOW  
26 IT ISN'T, BUT IF THAT WAS THE CASE, MOST  
27 AUTHORITIES AGREE THAT THE OUTCOME FOR THAT KIND OF  
28 CANCER IS A LOT BETTER THAN OTHER ADENOCARCINOMA OF

1 THE CHEST?

2 A. THAT IS CORRECT, THAT WOULD HAVE A  
3 VERY FAVORABLE EFFECT.

4 Q. MR. BOEKEN'S OUTCOME, DO YOU THINK  
5 THAT'S VERY --

6 A. HE HAS STAGE 4 LUNG CANCER BECAUSE  
7 IT IS METASTATIC FROM HIS BONE INTO HIS BRAIN.

8 Q. SO NOT FAVORABLE?

9 A. NOT FAVORABLE.

10 Q. AND HIS OUTCOME, DOES THAT MITIGATE  
11 AGAINST ANY KIND OF DIAGNOSIS OF HOMOGENOUS --

12 A. WELL, HIS TUMOR IS NOT HOMOGENOUS.  
13 YOU CAN JUST LOOK FOR YOURSELF AND LOOK AT THOSE  
14 PICTURES THAT I SHOWED IN THE DIFFERENCES IN ONE  
15 AREA TO ANOTHER AND ESPECIALLY THE DIFFERENCES  
16 BETWEEN THE CANCER CELLS AND THE PRIMARY TUMOR IN  
17 THE LUNG AND THE TUMOR THAT IS PRESENT IN THE LYMPH  
18 NODE WHICH IS A METASTASES.

19 Q. ONE LAST AREA AND INJECT SOMETHING  
20 SLIGHTLY DIFFERENT, JUST IN ANTICIPATION.

21 DO YOU KNOW WHAT A PRECURSOR LESION  
22 IS?

23 A. YES.

24 Q. WHAT?

25 A. IN THE CASE OF ADENOCARCINOMA OF  
26 THE LUNG, THERE IS THOUGHT TO BE A LESION FROM  
27 WHICH THIS IS DERIVED FROM, IN MOST INSTANCES. AND  
28 THIS LESION HAS A PRETTY FANCY SCIENTIFIC NAME AND

1 IT IS REFERRED TO AS ATYPICAL ADENOMATOUS SPELLED  
2 A-D-E-N-O-M-A-T-O-U-S, HYPERPLASIA.

3 AND ALL THAT MEANS IS THAT THE  
4 CELLS THAT NORMALLY FORM THESE AIR SACKS IN THESE  
5 BRONCHIOLES START TO INCREASE IN NUMBER AND TO  
6 INCREASE IN SIZE, WITH THE NUCLEUS OF THE CELL  
7 BECOMING LARGER AND STAINING DARKER WITH THE USUAL  
8 DYES THAT PATHOLOGIST STAIN TISSUE WITH.

9 AND THIS IS THOUGHT TO BE THE  
10 PRECURSOR LESION OF PULMONARY ADENOCARCINOMA, AT  
11 LEAST THOSE THAT OCCUR IN THE PERIPHERY OUTER PART  
12 OF THE LUNG.

13 Q. WHAT HAS BEEN PUBLISHED ABOUT THE  
14 RELATIONSHIP OF THIS TO CIGARETTE SMOKE?

15 A. THERE HAS BEEN ONE REPORT BY A  
16 DR. WENG, ET AL, W-E-N-G -- I THINK THAT'S HOW YOU  
17 SPELL HIS NAME -- THAT HE FOUND A RELATIONSHIP WITH  
18 THIS LESION TO SMOKING IN WOMEN BUT DID NOT FIND A  
19 RELATIONSHIP TO SMOKING IN MEN.

20 THERE IS ANOTHER REPORT BY A  
21 DR. KERR, K-E-R-R, WHICH IS PRESENT IN A BOOK AND  
22 ALSO IN A PEER REVIEWED ARTICLE THAT FOUND THAT ALL  
23 OF THE CASES THAT HE SAW OF ATYPICAL ADENOMATOUS  
24 HYPERPLASIA WERE IN CIGARETTE SMOKERS.

25 AND THERE'S ANOTHER PUBLICATION BY  
26 A DOCTOR -- I MAY SAY HIS NAME WRONG, IT'S A  
27 JAPANESE NAME, KINISKY (PHONETIC) OR SOMETHING  
28 ALONG THOSE LINES, AND I APOLOGIZE FOR NOT HAVING

1 THE CORRECT NAME, BUT HE ALSO FOUND THAT ALL OF THE  
2 CASES OF ATYPICAL ADENOMATOUS HYPERPLASIA OCCURRED  
3 IN CIGARETTE SMOKERS.

4 Q. THANKS.

5 SO HAVE YOU READ, IN THE MATERIALS  
6 THAT WERE PRESENTED TO YOU, THAT MR. BOEKEN HAD  
7 BEEN SMOKING SOMETHING IN THE AREA OF TWO TO THREE  
8 PACKS A DAY FOR 40 YEARS?

9 A. YES.

10 Q. IN PACK YEARS, DOES THAT COME OUT  
11 TO TWO A YEAR FOR 40, 80 YEARS, THREE A YEAR FOR  
12 40, 120 YEARS, SOMEPLACE BETWEEN 80 AND 120 PACK  
13 YEARS OF TOBACCO SMOKE?

14 A. YES.

15 Q. SO I WANT YOU TO ASSUME THAT'S  
16 CORRECT, THAT HE HAD OVER 80 PACK YEARS OF SMOKE  
17 AND YOU HAVE SEEN HIS PATHOLOGY SLIDES AND YOU HAVE  
18 SEEN THE MEDICAL RECORDS, WAS HIS, REGARDLESS OF  
19 WHAT HIS CANCER IS CALLED, WAS IT CAUSED BY  
20 CIGARETTE SMOKING?

21 A. YES.

22 Q. IS THAT A YES OR CAPITAL YES OR YES  
23 WITH AN EXPLANATION?

24 A. IT'S YES WITHOUT ANY POSSIBLE OTHER  
25 EXPLANATION, IN MY OPINION.

26 MR. PIUZE: I AM DONE ASKING QUESTIONS.

27 THE COURT: SIR.

28 MR. CARLTON, I BELIEVE.

1 MR. CARLTON: THANK YOU, YOUR HONOR.

2 THE COURT: YOU ARE WELCOME.

3

4 CROSS-EXAMINATION

5

6 BY MR. CARLTON:

7 Q. GOOD AFTERNOON, DOCTOR.

8 A. GOOD AFTERNOON.

9 Q. I WANT TO TRY TO GET A FEW THINGS  
10 CLEAR, AT LEAST IN MY OWN MIND.

11 A. SURE.

12 Q. YOU TALKED ABOUT A LOT OF THINGS  
13 TODAY. AND A LOT OF TERMS THAT ARE PROBABLY NEW TO  
14 MOST OF US.

15 ADENOCARCINOMA IS ONE OF THE TYPES  
16 OF LUNG CANCERS; RIGHT?

17 A. YES.

18 Q. AND YOU HAVE CONCLUDED THAT  
19 MR. BOEKEN HAD ADENOCARCINOMA?

20 A. YES.

21 Q. NOW, WE HAVE ALSO HEARD A LOT TODAY  
22 ABOUT SOME SUBTYPES OF ADENOCARCINOMA; RIGHT?

23 A. WE HAVE.

24 Q. AND YOU TALKED ABOUT PAPILLARY  
25 ADENOCARCINOMA?

26 A. YES.

27 Q. I THINK YOU TALKED ABOUT ACINAR?

28 A. YES.

- 1 Q. ADENOCARCINOMA?  
2 A. YES.  
3 Q. SOLID?  
4 A. YES.  
5 Q. AND THEN THE LAST ONE WAS THE ONE  
6 WITH THE LONG NAME, BRONCHIOALVEOLAR?  
7 A. YES.  
8 Q. AND WE WILL REFER TO THAT AS B. A. C.  
9 A. SURE.  
10 Q. YOU UNDERSTAND WHAT WE ARE TALKING  
11 ABOUT?  
12 A. YES.  
13 Q. OKAY. BUT REGARDLESS OF THE  
14 SUBTYPE, EACH OF THOSE THINGS IS A KIND OF  
15 ADENOCARCINOMA; RIGHT?  
16 A. YES.  
17 Q. AND AS YOU HAVE SAID, I THINK,  
18 SEVERAL TIMES TODAY, ADENOCARCINOMA GENERALLY HAS  
19 WHAT DID YOU SAY, A MULTI-VARIANT HISTOLOGY?  
20 A. HETEROGENOUS HISTOLOGY OR SHOWS  
21 WHAT I CALL VARIABLE DIFFERENTIATION.  
22 Q. SO ONE OR MORE OF THOSE SUBTYPES  
23 WOULD BE PRESENT IN MOST ADENOCARCINOMAS?  
24 A. THAT IS CORRECT.  
25 Q. WHETHER THE DOMINANT TYPE WAS  
26 PAPILLARY, ACINAR, SOLID OR B. A. C. ?  
27 A. THAT IS CORRECT.  
28 Q. YOU HAVE WRITTEN A NEXT BOOK ON

1 PULMONARY PATHOLOGY, HAVEN' T YOU?

2 A. YES.

3 Q. THERE' S A LONG CHAPTER I THINK YOU  
4 MENTIONED ON TUMORS OF THE LUNG?

5 A. YES.

6 Q. AND IN THAT TEXTBOOK, YOU HAVE  
7 GIVEN A DESCRIPTION OF HOW B. A. C. IS IDENTIFIED,  
8 HAVEN' T YOU?

9 A. I HAVE, YES.

10 Q. YOU KNOW, I HAVE GOT A COPY OF YOUR  
11 BOOK HERE AND I AM GOING TO TRY TO PULL IT OUT AND  
12 USE IT BUT I THINK YOU UNDERSTAND THAT IT' S A  
13 LITTLE UNWELDY.

14 I WILL SAY THIS IS THE HEAVIEST  
15 BOOK I HAVE EVER FELT.

16 MAYBE THIS ISN' T THE WAY TO DO IT  
17 BUT LET' S GIVE IT A TRY.

18 YOU KNOW, WOULD YOU LIKE TO LOOK AT  
19 THIS? BECAUSE I HAVE A PAPER COPY.

20 A. NO. I KNOW WHAT THAT SAYS, SURE.

21 Q. WELL, LET ME -- I WILL LEAVE IT  
22 THERE AND MAYBE YOU CAN TELL US WHAT YOUR  
23 DESCRIPTION IN THE BOOK OF B. A. C. IS.

24 A. OKAY.

25 DO YOU WANT ME TO DO THAT NOW?

26 Q. YES.

27 A. SURE. IT IS A TYPE OF PRIMARY  
28 ADENOCARCINOMA OF THE LUNG THAT WAS DEFINED IN 1960

1 BY A VERY FAMOUS PATHOLOGIST OF THE UNITED STATES  
2 WHO RESIDED HERE IN CALIFORNIA IN SAN DIEGO WHOSE  
3 NAME IS AVERIL LIBOW, A-V-E-R-I-L, I THINK, AND  
4 L-I-B-O-W AND HE DEFINED IT AS A TYPE OF CANCER  
5 COMPOSED OF WELL-DIFFERENTIATED CELLS THAT  
6 TYPICALLY OCCURRED BEYOND RECOGNIZABLE BRONCHUS IN  
7 THE OUTER PART OF THE LUNG IN WHICH THE GROWTH  
8 PATTERN WAS ALONG THE PREEEXISTING ALVEOLAR  
9 ARCHITECTURE OR THE ALVEOLAR WALLS OF THE LUNG.

10 AND HE INDICATED THAT IT COULD  
11 OCCUR IN AREAS WHERE THERE WAS SOME INCREASE IN  
12 INTERSTITIAL FIBER TISSUE IN THOSE ALVEOLAR WALLS  
13 AND A TUMOR THAT WAS CYTOLOGICALLY  
14 WELL-DIFFERENTIATED.

15 Q. WHAT DOES, AGAIN, I KNOW YOU HAVE  
16 MENTIONED THIS, BUT JUST TO REFRESH OUR  
17 RECOLLECTIONS, WHAT DOES WELL-DIFFERENTIATED MEAN?

18 A. WELL, I THINK I MENTIONED THAT WHEN  
19 THEY TALKED ABOUT WELL-DIFFERENTIATED, IT MEANS  
20 THAT THE CANCER CELLS FAIRLY CLOSELY RESEMBLE THE  
21 NORMAL CELLS.

22 AND IN CASE OF BRONCHIOALVEOLAR,  
23 MOST OF THE TIME THEY ARE DERIVED FROM EITHER THE  
24 CLARA, C-L-A-R-A, CELLS, OR TYPE TWO PNEUMOCYTES.

25 Q. WOULD YOU SAY THAT B. A. C. IS  
26 PERHAPS MORE WELL-DIFFERENTIATED OR BETTER  
27 DIFFERENTIATED, I DON'T KNOW WHAT THE TERM IS, THAN  
28 THE OTHER SUBTYPES OF ADENOCARCINOMA?

1           A.     WELL, IT KIND OF DEPENDS. IF YOU  
2 LOOK AT THE CURRENT W. H. O. CLASSIFICATION THE  
3 ANSWER WOULD BE YES.

4                     IF YOU LOOK AT WHAT HAS BEEN  
5 DESCRIBED IN THE LITERATURE, IT RUNS THE WHOLE  
6 GAMUT FROM SOMETHING THAT IS WELL-DIFFERENTIATED TO  
7 SOMETHING THAT CAN BE POTENTIALLY POORLY  
8 DIFFERENTIATED. AND I SHOW EXAMPLES OF THAT.

9                     IT'S VERY COMMON IN B. A. C. , AGAIN,  
10 TO SHOW VARIABLE DIFFERENTIATION AS SOME OF THE  
11 PICTURES IN THAT CHAPTER ILLUSTRATE.

12           Q.     I THINK WE WILL GET TO SOME OF  
13 THOSE PICTURES.

14           A.     OKAY.

15           Q.     AT THE TIME BEING, LET'S ALSO LOOK  
16 AT SOMETHING ELSE HERE. YOU SAID IN YOUR TEXTBOOK  
17 HERE, AND I WILL JUST READ ON A LITTLE BIT HERE,  
18 AND I AM STARTING FROM RIGHT HERE.

19                     "DOCTOR LIBOW -- " LIBOW IS  
20 IT?

21           A.     YES.

22           Q.     (READING)

23                     "DOCTOR LIBOW ADMITTED THAT  
24 IN 1960 AN ABSOLUTE DISTINCTION COULD  
25 NOT BE MADE BETWEEN A  
26 BRONCHIOLOALVEOLAR CELL CARCINOMA AND  
27 AN ORDINARY PULMONARY ADENOCARCINOMA,  
28 BUT EMPHASIZED THE VERY PERIPHERAL

1           ORIGIN OF THE TUMOR, THE GOOD  
2           CYTOLOGIC DIFFERENTIATION, " IN OTHER  
3           WORDS, THE DIFFERENTIATION BETWEEN THE  
4           CELL TYPES?

5           A.     YES.

6           Q.     (READING)

7                     "AND THE TENDENCY TO SPREAD  
8           WITHIN THE LUNGS AS FEATURES  
9           CHARACTERISTIC OF, " AND I WILL JUST  
10          SAY B. A. C.   "LIBOW FURTHER COMMENTED  
11          ON ANOTHER AREA OF CONTROVERSY  
12          CONCERNING B. A. C. CARCINOMA WHEN HE  
13          SAID, 'TO INSIST THAT TUMORS BE CALLED  
14          BRONCHIOALVEOLAR GROW ON THE  
15          UNALTERED WALLS OF ALVEOLAR OR WITHOUT  
16          DESTRUCTION OF PULMONARY ARCHITECTURE  
17          IS TO ADD CONFUSION.   BECAUSE SOME OF  
18          THE ILLUSTRATIONS PRESENTED USUALLY  
19          SHOW BOTH OF THESE CHANGES IN VARYING  
20          DEGREE. ' "

21                    THAT'S PRETTY MUCH THE -- THAT WAS  
22          TRUE OF B. A. C. BEFORE THE W. H. O. RECLASSIFIED IT?

23          A.     YES.   AND THAT GOES INTO THE KIND  
24          OF THE QUESTION OF HOW BROAD YOU WANT TO MAKE THE  
25          SPECTRUM OF B. A. C.   AND THAT'S KIND OF BEEN THE  
26          PROBLEM BECAUSE SOME PATHOLOGISTS WHO SAW ANY TYPE  
27          OF B. A. C. TYPE PATTERN WOULD SAY THIS IS B. A. C.  
28          OTHER PATHOLOGISTS WHO SAW MAYBE THE AREA WHERE IT

1 WAS INVADING OR DESTROYING THE LUNG WOULD SAY, GEE,  
2 THAT'S NOT A B. A. C. PATTERN, THAT'S SOMETHING ELSE  
3 AND THEY CALL IT SOMETHING ELSE.

4 SO THAT'S KIND OF THE PROBLEM THAT  
5 EXISTED AND THAT'S WHY THE NEW W. H. O.  
6 CLASSIFICATION DECIDED THAT THE SIMPLEST WAY TO  
7 SOLVE THIS PROBLEM WAS TO MAKE B. A. C. A PURE TUMOR  
8 IN WHICH THE CANCER CELLS LINING OF THESE AIR SACKS  
9 AND DID NOT SHOW INVASION. IF EVERYBODY COULD SEE  
10 THAT AND ACCEPT IT, THEN, I THINK, IT WOULD BE EASY  
11 AS FAR AS CLASSIFICATION.

12 Q. OKAY. I MAY BE A LITTLE SLOWER.  
13 BUT AS I UNDERSTAND WHAT YOU JUST TOLD US, THE  
14 DIFFERENCE, THE MAIN DIFFERENCE BETWEEN THE 1999  
15 W. H. O. DEFINITION AND THE OLD CLASSIFICATION IS  
16 THAT UNDER THE 1999 DEFINITION, THERE CAN BE NO  
17 INVASION?

18 A. THAT'S ONE OF THE MAIN DIFFERENCES,  
19 YES.

20 Q. ALL RIGHT. ARE THERE OTHERS?

21 A. THE OTHER ONE WOULD BE THAT THE  
22 CANCER CELLS ALL HAVE TO BE OR END ALONG THE  
23 ALVEOLAR WALLS. THERE COULDN'T BE ANY AREAS WHERE  
24 IT SHOWS LIKE ACINAR TYPE DIFFERENTIATION.

25 Q. SO IT HAS TO BE PURE B. A. C. ?

26 A. PURE B. A. C.

27 Q. PURE B. A. C.

28 NO INVASION?

1 A. RIGHT.

2 Q. CAN YOU TELL US, AGAIN, IN A LITTLE  
3 MORE DETAIL, WHAT DOES INVASION MEAN?

4 A. WELL, WHAT IT MEANS FROM A BIOLOGIC  
5 POINT OF VIEW IS WHAT IS BAD, BASICALLY, WHEN A  
6 CANCER INVADES INTO NORMAL TISSUE AND WHEN IT DOES  
7 THAT, THE CELLS HAVE MUTATED ENOUGH TO WHERE THEY  
8 CAN PRODUCE SUBSTANCES THAT ALLOW FOR THAT TO  
9 HAPPEN. AND ONCE THAT HAPPENS, THEN THE CANCER CAN  
10 DO BAD THINGS LIKE SPREAD TO OTHER PARTS OF THE  
11 BODY.

12 SO THAT'S WHAT INVASION IS ABOUT.

13 AND IN MOST CASES OF B. A. C. THAT  
14 WERE INITIALLY DESCRIBED, AND I TALK ABOUT THAT  
15 EXTENSIVELY IN THAT CHAPTER AND WERE REVIEWED BY A  
16 PERSON BY THE NAME OF DR. CLAYTON, IS THAT YOU WILL  
17 ALWAYS SEE IN THE CENTER A CENTRAL SCAR. AND YOU  
18 USUALLY SEE IN THAT SCAR AREAS WHERE THE CANCER HAS  
19 INVADED INTO THAT SCAR AND THEN AROUND IT YOU WILL  
20 OFTEN SEE A B. A. C. PATTERN OR YOU MIGHT SEE A SOLID  
21 PATTERN OR YOU MIGHT SEE AN ACINAR PATTERN.

22 USUALLY IN THE CENTER WHERE THE  
23 SCAR IS, YOU WILL SEE AN ACINAR PATTERN.

24 Q. YOU ARE FAMILIAR WITH THE  
25 LITERATURE ON B. A. C. , I TAKE IT?

26 A. YES.

27 Q. AND IT WOULD BE CORRECT THAT ALL OF  
28 THE LITERATURE ON B. A. C. BEFORE 1999 DEALT WITH THE

1 CLASSIFICATION OR DEFINITION OF B. A. C. AS IT  
2 EXISTED THEN; RIGHT?

3 A. I WOULD SAY THAT'S TRUE. AND I  
4 WOULD ALSO SAY IT IS TRUE THAT MANY PATHOLOGISTS  
5 DON'T NECESSARILY LOOK UP ALL OF THE PRECISE  
6 CLASSIFICATIONS. BUT I WOULD AGREE WITH YOU, SURE.

7 Q. SO THAT IN ASSESSING THE BULK OF  
8 THE LITERATURE ON B. A. C. , THE 1999 W. H. O.  
9 CLASSIFICATION REALLY DOESN'T APPLY?

10 A. WELL, IT DOESN'T APPLY TO WHAT THE  
11 TUMORS THAT WERE CALLED B. A. C. IN THE PAST WERE  
12 CALLED. BUT IT DOES, AT LEAST, MAKE IT EASIER  
13 BECAUSE NOW, IF YOU SEE A TUMOR THAT, SAY, HAS A  
14 B. A. C. GROWTH PATTERN AND I THINK THIS IS ACTUALLY  
15 EMPHASIZED IN THE W. H. O. , THEY TELL PATHOLOGISTS  
16 HOW TO TAKE CARE OF THAT, AND THAT IS, IS TO SAY  
17 THAT IT SHOWS A MIXED PATTERN AND THAT'S WHAT WOULD  
18 BE DONE NOW AND THEY WOULD USE THE B. A. C.  
19 DESIGNATION ONLY FOR WHAT WE JUST DESCRIBED, A  
20 TUMOR THAT DID NOT SHOW INVASION AND HAD A PURE  
21 ALVEOLAR SEPTAL GROWTH PATTERN.

22 Q. OKAY. BUT IN THE PAST, A  
23 PATHOLOGIST COULD IDENTIFY A TUMOR AS B. A. C. , EVEN  
24 IF IT DISPLAYED SOME OF THE OTHER CELL  
25 CHARACTERISTICS; RIGHT?

26 A. WELL, THEY COULD. BUT, SEE, THAT  
27 WAS THE PROBLEM, THAT IS, ONE PATHOLOGIST MIGHT  
28 CALL THAT A B. A. C. AN ANOTHER PATHOLOGIST WOULD

1 CALL THAT AN ACINAR PATTERN OR IF IT SHOWS AREAS  
2 WHERE THE TUMOR WAS PRESENT AS SOLID CELLS, THEY  
3 WOULD SAY THAT'S AN AREA WHERE IT'S POORLY  
4 DIFFERENTIATED. AND KIND OF DEPENDS ON, YOU KNOW,  
5 WHAT PATHOLOGIST WAS GOING TO SAY WHAT.

6 IF YOU GO BY THAT OLD RULE, I SAID,  
7 IS THAT YOU CLASSIFY BY THE BEST DIFFERENTIATED  
8 AREA AND GRADE BY THE WORST, THERE WOULD BE SOME  
9 TUMORS THAT HAD A B. A. C. GROWTH PATTERN THAT YOU  
10 WOULD SAY, WELL, THIS COULD BE A B. A. C. , BUT IN  
11 AREAS COMPOSED OF SOLID CANCER CELLS THAT DIDN'T  
12 SHOW ANY OF THAT TYPE OF GROWTH PATTERN WHICH WOULD  
13 MAKE IT A POORLY DIFFERENTIATED B. A. C.

14 AND THAT'S WHERE THE CONFUSION HAS  
15 EXISTED.

16 SO WHEN WE DID THIS NEW W. H. O. , WE  
17 TRIED TO SAY THAT IT WAS EASIER FOR PATHOLOGISTS TO  
18 JUST SAY THAT THERE'S VARIABLE TYPE OF PATTERNS  
19 THAT YOU SEE IN THIS ADENOCARCINOMA.

20 Q. PUTTING ASIDE THE ELEMENT OF  
21 CONFUSION THAT MIGHT HAVE EXISTED IN LOOKING AT THE  
22 LITERATURE ON B. A. C. , WHICH APPLIED THE ONLY  
23 CLASSIFICATION, THE TUMORS THAT WERE AT ISSUE OR  
24 BEING EVALUATED IN THAT LITERATURE MAY WELL HAVE  
25 INCLUDED TUMORS WITH VARIABLE HISTOLOGY, ISN'T THAT  
26 RIGHT?

27 A. WELL, I THINK THEY DID, AND AT  
28 LEAST IN SOME INSTANCES, IF YOU LOOK AT THE PAPERS

1 BY CLAYTON, WHICH ARE PROBABLY THE MOST SIGNIFICANT  
2 WITH RESPECT TO CLASSIFICATION OF B. A. C. , HE  
3 CLASSIFIED THEM INTO THREE TYPES; A NONE MUCINASE  
4 B. A. C. , A MUCINASE B. A. C. AND A SCLEROTIC B. A. C.

5 Q. LET'S LOOK AT THE PICTURES IN YOUR  
6 BOOK.

7 BEFORE WE GO THERE, HOWEVER, DO YOU  
8 RECOGNIZE THESE ILLUSTRATIONS IN YOUR BOOK?

9 A. SURE.

10 Q. AND THOSE WERE OBTAINED FROM  
11 DR. BARSKY, WEREN'T THEY?

12 A. HE DID A GREAT STUDY AND HE DID A  
13 NICE STUDY WITH LUNG CANCER TO SHOW THAT THE SCARS  
14 IN LUNG CANCER DOES NOT PRECEDE THE TUMOR, BUT IN  
15 FACT, ACTUALLY IS CAUSED BY TUMOR WHICH I THINK  
16 ALMOST EVERYBODY ACCEPTS.

17 Q. WELL, I DON'T THINK ANYONE CAN  
18 QUITE READ THAT. BUT LOOKING AT THIS PICTURE RIGHT  
19 HERE, THIS IS 3260, ILLUSTRATION 3260, ISN'T IT?

20 A. YES.

21 Q. AND THE WAY YOU DESCRIBE 3260 IS  
22 THAT -- YOU KNOW, THIS MIGHT HELP IF YOU WERE TO GO  
23 DOWN TO THE SCREEN. DO YOU THINK YOU COULD DO  
24 THAT?

25 A. SURE, IF YOU WOULD LIKE ME TO.

26 Q. IT SAYS HERE, BRONCHIOALVEOLAR  
27 COMPOSED OF RELATIVELY SMALL CUBOIDAL TO COLUMNAR  
28 CELL GROWTH IN ALVEOLAR PATTERN.

1                   CAN YOU JUST EXPLAIN A LITTLE BIT  
2 WHAT YOU ARE TALKING ABOUT?

3                   A.     SURE.  THESE ARE THE ALVEOLAR  
4 SEPTUM  THESE ARE THE CANCER CELLS.  AND CUBOIDAL  
5 JUST MEANS THAT THEY ARE RECTANGULAR SHAPED AND  
6 THEY COME UP LIKE THIS.  AND COLUMNAR MEANS THAT  
7 THEY ARE TALLER LIKE THIS.

8                   AND WHAT YOU SEE HERE MOSTLY ARE  
9 THE NUCLEI OF THE CELLS WHICH ARE DARK.  YOU DON' T  
10 SEE THE CYTOPLASM VERY WELL.

11                  Q.     SO IS THIS SORT OF A TYPICAL B. A. C.  
12 PATTERN RIGHT HERE?

13                  A.     THIS WOULD BE A TYPICAL  
14 NON-MUCINOUS B. A. C. PATTERN.

15                  Q.     YOU SAY NON-MUCINOUS.  THERE' S A  
16 TYPE OF B. A. C. THAT DOES NOT PRODUCE MUCUS; RIGHT?

17                  A.     THAT IS CORRECT.

18                  Q.     THAT' S NON-MUCINOUS?

19                  A.     YES.

20                  Q.     AND THEN THE OTHER KIND WOULD BE  
21 MUCINOUS?

22                  A.     YES.

23                  Q.     WHICH PRODUCES MUCUS?

24                  A.     YES.

25                  Q.     AND THE B. A. C. THAT WAS SEEN HERE  
26 IN MR. BOEKEN' S TUMDR WAS WHICH?

27                  A.     WELL, TO ME IT WAS A B. A. C.

28                  Q.     OR THE GROWTH PATTERN?

1           A.     THE GROWTH PATTERN OF B. A. C. , IT  
2 WAS AREAS WHERE THERE WAS PRODUCING MUCUS AND THERE  
3 WAS AREA WHERE IT DIDN' T APPEAR TO BE PRODUCING  
4 MUCUS.

5           Q.     NOW, THE NEXT ONE, LET' S SEE, 3261,  
6 WHICH SAYS HERE, "ANOTHER REGION OF THE TUMDR SHOWN  
7 IN FIGURE 3260, HAS AN OBVIOUS ACINAR APPEARANCE. "

8           A.     YEAH, HERE' S WHERE THE CELLS, THE  
9 CANCER CELLS, WHICH ARE THESE CELLS HERE, THEY LOOK  
10 LIKE THEY ARE FORMING THESE GLANDULAR STRUCTURES,  
11 TUBULAR STRUCTURES AND THAT WOULD BE REFERRED TO AS  
12 AN ACINAR PATTERN.

13          Q.     THIS IS THE SAME TUMDR THAT HAD THE  
14 B. A. C. PATTERN IN 3260; RIGHT?

15          A.     THAT IS CORRECT.

16          Q.     AND THEN 3262 IS HERE, AND IT SAYS,  
17 "IN THIS REGION OF THE SAME TUMDR"; RIGHT?

18          A.     YES.

19          Q.     "CELLS ARE LARGE AND POORLY  
20 DIFFERENTIATED. THIS AREA OF THE TUMDR WOULD BE  
21 CLASSIFIED AS LARGE CELL UNDIFFERENTIATED  
22 CARCINOMA. "

23                         FIGURES 3260 THROUGH 326 TO SHOW  
24 THE --

25          A.     "HETROGENITY, "  
26 H-E-T-R-O-G-E-N-I-T-Y.

27          Q.     "THAT EXISTS IN MANY LUNG TUMDRS. "  
28 SO WHAT CAN --

1           A.     THESE ARE THE CANCER CELLS HERE.  
2 THEY ARE BIG.   AND THEY DON'T SHOW ANY OF THE OTHER  
3 PATTERNS WHERE THEY ARE FORMING GLANDS, THEY ARE  
4 NOT GROWING ALONG OBVIOUS ALVEOLAR SEPTA.   THESE  
5 CELLS YOU SEE IN HERE ARE INFLAMMATORY CELL  
6 LYMPHOCYTES.   THIS IS A NUCLEUS OF THE CELL.   THESE  
7 ARE THE NUCLEOLI.

8           Q.     OKAY.   AND AGAIN, ALL OF THOSE  
9 GROWTH PATTERN OCCURRED IN THE SAME TUMDR?

10          A.     YES.

11          Q.     AND THE LAST PICTURE, I THINK, WE  
12 WILL LOOK AT, THIS IS 3265, I BELIEVE THIS IS A  
13 DIFFERENT TUMDR?

14          A.     YES.

15          Q.     AND IT SAYS, "THIS IS A TYPICAL  
16 NON-MUCINOUS TYPE OF B. A. C. , COMPOSED OF COLUMNAR  
17 AND HOBNAIL CELLS GROWING IN AN ALVEOLAR PATTERN.

18          A.     THESE ARE THE ALVEOLAR WALLS,  
19 AGAIN, RIGHT HERE.   AND THESE ARE THE CANCER CELLS.  
20 THIS IS THE NUCLEUS.

21                   WHAT HOBNAIL MEANS IS ACTUALLY A  
22 SHAPE WHERE THE NUCLEUS, INSTEAD OF BEING AT THE  
23 BASE OF THE CELL, LIKE IT IS HERE, IT'S WAY OUT  
24 TOWARDS THE TOP OF THE CELL.   THAT'S A HOBNAIL  
25 SELL, H-O-B-N-A-I-L.

26          Q.     NOW, I THINK YOU TOLD US EARLIER  
27 THAT YOU WERE ON THE COMMITTEE OR GROUP THAT WAS  
28 RESPONSIBLE FOR THE 1999 W. H. O. RECLASSIFICATION OF

1 B. A. C.

2 A. I WAS.

3 Q. AND THERE WAS SOME DEBATE ABOUT  
4 THAT RECLASSIFICATION, WASN' T THERE?

5 A. THERE WAS. I ACTUALLY VOTED  
6 AGAINST IT.

7 Q. AND WHAT WAS THE DEBATE?

8 A. WELL, THE DEBATE WAS WHETHER YOU GO  
9 WITH WHAT HAS TRADITIONALLY BEEN PUBLISHED OR YOU  
10 GO WITH WHAT WAS ACCEPTED. AND THE REASON THAT IT  
11 WAS --

12 Q. WELL, BEFORE WE MOVE BEYOND THAT,  
13 YOU SAID WHAT WAS TRADITIONALLY, GONE BEYOND WHAT  
14 WAS TRADITIONAL. EXPLAIN.

15 A. WOULD BE THE NON-MUCINOUS, THE  
16 MUCINOUS AND SCLEROTIC VERSUS A TUMOR WHERE IT WAS  
17 ALL IN SITU, WITHOUT ANY INVASION, AND IT WAS ONLY  
18 IN A CLASSIC ALVEOLAR SEPTAL GROWTH PATTERN.

19 Q. THAT WAS -- OKAY. THAT WAS THE  
20 DEBATE, WHETHER TO CHANGE TO THAT NEW DEFINITION?

21 A. SURE.

22 Q. AND YOU VOTED AGAINST IT; RIGHT?

23 A. WELL, I DID. BUT FROM A PRACTICAL  
24 POINT OF VIEW, IT DOESN' T REALLY MAKE ANY  
25 DIFFERENCE.

26 THE ONLY THING THAT MAKES A  
27 DIFFERENCE, REALLY, IS HOW WE, IF THERE' S INVASION  
28 AND WHETHER OR NOT THERE' S METASTASES. OTHER THAN

1 THAT, A B. A. C. VERSUS A NON-B. A. C. , TO MY WAY OF  
2 THINKING, IT MAKES NO DIFFERENCE. I MEAN, BECAUSE  
3 THE WAY THE TUMOR IS GOING TO BEHAVE IS THE WAY  
4 IT'S GOING TO BEHAVE.

5 IF IT METASTASIZES, IT METASTASIZES  
6 AND THAT'S WHAT THE CLINICAL DOCTORS HAVE TO TAKE  
7 INTO ACCOUNT WHEN THEY TREAT THE PATIENT.

8 Q. YOU DON'T DISAGREE WITH  
9 DR. GELLER'S DIAGNOSIS OF FROZEN SECTION, PART  
10 THREE SLIDE, DO YOU, THAT WAS B. A. C. ?

11 A. NO. BECAUSE THE OTHER THING IS  
12 THAT HE MIGHT HAVE SEEN, AND I DON'T RECALL IF I  
13 SAW THE FROZEN SECTION SLIDE, HE MIGHT HAVE SEEN  
14 THAT AREA OF THE TUMOR WHERE IT DID HAVE A  
15 BRONCHIOALVEOLAR CELLULAR GROWTH PATTERN SO THAT  
16 WOULD HAVE BEEN A FINE DIAGNOSIS TO MAKE.

17 AND AGAIN, IT DIDN'T AFFECT THE  
18 OUTCOME OF WHAT WAS DONE TO THE PATIENT OR WHAT HAS  
19 HAPPENED TO THE PATIENT ONE WAY OR THE OTHER.

20 Q. ALL RIGHT. AND THEN YOU, YOURSELF,  
21 DID A REPORT?

22 A. I DID.

23 Q. AND THAT REPORT WAS BASED ON A  
24 REVIEW OF THE PATH SLIDES THAT WERE CREATED AT  
25 CEDARS-SINAI?

26 A. RIGHT.

27 Q. NOW, ON PAGE 4 OF YOUR REPORT,  
28 AGAIN, YOU WERE -- YOU -- WHICH SLIDES WERE MOST

1 IMPORTANT TO YOUR DIAGNOSIS OF MR. BOEKEN'S TUMOR,  
2 DO YOU REMEMBER?

3 A. WELL, I DON'T REMEMBER THE EXACT  
4 NUMBERS. THE ONES THAT HAD BEEN MOST IMPORTANT  
5 WERE THE SECTIONS OF THE TUMOR WHICH ESTABLISHED  
6 THAT HE HAD AN ADENOCARCINOMA AND THEN THE NEXT  
7 ONES THAT WOULD HAVE BEEN JUST AS IMPORTANT WOULD  
8 BE THE FACT THAT THE HILAR LYMPH NODES AND THE  
9 PARATRACHEAL LYMPH NODES SHOWED METASTASES BECAUSE  
10 THAT WOULD GIVE YOU THE ANATOMICAL STAGING OF THE  
11 TUMOR.

12 Q. LOOKING AT PAGE 4 OF YOUR REPORT,  
13 IT SAYS HERE, SLIDES D AND E WERE STAINED TO  
14 REPRESENT TUMOR WITH OVERLYING INKED PLEURA.

15 WHAT ARE PLEURA?

16 A. OKAY. IN THE LUNG, IF YOU LOOK AT  
17 THE LUNG, GO BACK TO THAT ONE PICTURE MR. PIUZE  
18 SAID SHOWS THE VERY SURFACE OF THE LUNG IS THE  
19 PLEURA. AND MOST ADENOCARCINOMA ARE BELOW THE  
20 PLEURA. AND IF THEY GET CLOSE TO THE PLEURA, THEY  
21 START TO INVADE THROUGH THE PLEURA. THAT'S  
22 IMPORTANT FOR THE ANATOMICAL STAGES. IT'S CALLED  
23 THE VISCERAL PLEURA. AND THERE'S SOME ELASTIC  
24 TISSUE IN THAT.

25 IF THE TUMOR PENETRATES THAT  
26 ELASTIC TISSUE, IT'S A P-1 LESION. IF IT GOES  
27 THROUGH THE PLEURA, IT'S CALLED A P-2 LESION. AND  
28 IF IT INVADES THROUGH THE VISCERAL PLEURA AND

1 INVADES INTO THE PARIETAL PLEURA, WHICH LINES THE  
2 CHEST WALL, IT IS CALLED P-3 LESION.

3 AND THAT'S IMPORTANT WITH STAGING  
4 WHICH HAS TO DO WITH IMPORTANCE OF WHAT THE  
5 PROGNOSIS IS AND WHAT TYPE OF THERAPY THE PATIENT  
6 MIGHT RECEIVE.

7 Q. BUT THERE WAS NO INDICATION OF  
8 INVASION OF THE PLEURA?

9 A. NO, THAT'S CORRECT. IT DID NOT  
10 INVADE TO THE PLEURA.

11 Q. SO THAT'S WHAT SLIDE B AND E  
12 SHOWED. SLIDE F WAS STATED TO REPRESENT A RANDOM  
13 GROSSLY NORMAL SECTION OF LUNG TISSUE. SO THAT'S  
14 NOT PART OF THE TUMOR?

15 A. THAT IS CORRECT; YES, SIR.

16 Q. SLIDE G WAS STATED TO REPRESENT THE  
17 FROZEN SECTION CONTROL; RIGHT?

18 A. FAIR ENOUGH.

19 Q. THEN YOU SAY HERE, THE TUMOR HAS  
20 THE FEATURES OF AN ADENOCARCINOMA BEING COMPOSED OF  
21 CUBOIDAL AND COLUMNAR EPITHELIAL CELLS, AND YOU  
22 TOLD US WHAT CUBOIDAL AND COLUMNAR CELLS ARE. THEY  
23 ARE SHAPES; RIGHT?

24 A. RIGHT.

25 Q. WHAT'S AN EPITHELIAL CELL?

26 A. WELL, AN EPITHELIAL CELL IS A CELL  
27 THAT IS DERIVED FROM EITHER, FROM THE EPIDERM,  
28 WHICH IS A CELL THAT LINES BODY CAVITIES, COVERS

1 THE SURFACE OF YOUR BODY, YOUR SKIN. IT IS  
2 BASICALLY A RECTANGULAR CELL. A WRONG CELL, A  
3 POLYGONAL CELL OR CUBOIDAL OR COLUMNAR, THEY LOOK  
4 MORE LIKE BUILDING BLOCKS.

5 Q. THIS TUMOR CONSISTED OF EPITHELIAL  
6 CELLS?

7 A. IT DID.

8 Q. WHICH SOMETIMES APPEAR TO BE GOING  
9 IN AN ALVEOLAR DISTRIBUTION, ALTHOUGH THERE ARE  
10 AREAS WHERE THE TUMOR HAS AN ACINAR COMPONENT AND  
11 IS INVADING THE LUNG PARENCHYMA SOMETIMES APPEAR TO  
12 BE GROWING IN AN ALVEOLAR DISTRIBUTION. THAT WOULD  
13 BE A B. A. C. GROWTH PATTERN?

14 A. YES.

15 Q. UNDER THE PRE-1999, W. H. O.  
16 CLASSIFICATIONS, THIS TUMOR COULD HAVE BEEN  
17 CLASSIFIED AS A B. A. C. ADENOCARCINOMA; RIGHT?

18 A. I THINK THERE WOULD HAVE BEEN SOME  
19 PATHOLOGISTS WHO MIGHT HAVE CLASSIFIED IT THAT WAY.

20 Q. DO YOU KNOW WHETHER, ASIDE FROM THE  
21 FROZEN SECTION, THERE WERE OTHER AREAS OF THE TUMOR  
22 THAT SHOWED A B. A. C. GROWTH PATTERN?

23 A. I THOUGHT THERE WERE, YES.

24 Q. YOU ARE AWARE OF LITERATURE, AREN'T  
25 YOU, REGARDING USING THE OLDER DEFINITION, PRE-1999  
26 W. H. O. DEFINITION OF B. A. C. , THAT QUESTIONS THE  
27 RELATIONSHIP BETWEEN B. A. C. AND SMOKING?

28 A. I AM, YES.

1 Q. AND YOU PARTICIPATED IN SOMETHING  
2 CALLED THE LUNG CANCER STUDY GROUP?

3 A. YES, I DID.

4 Q. ARE YOU FAMILIAR WITH AN ARTICLE BY  
5 GROVER PANTADOSE, AND THE LUNG CANCER STUDY GROUP  
6 CALLED "OCCURRENCE AND SURVIVAL FOLLOWING RESECTION  
7 OF BRONCHIOLOALVEOLAR OF THE LUNG"?

8 A. I MEAN, THAT, I DON'T HAVE ANY  
9 DOUBT THAT THAT WAS PROBABLY ONE PUBLISHED BY THE  
10 LUNG CANCER STUDY GROUP. YOU HAVE TO REALIZE THAT  
11 THERE WERE MANY, MANY ARTICLES PUBLISHED BY THAT  
12 GROUP.

13 I DON'T RECALL, YOU KNOW, THE  
14 INFORMATION IN THAT.

15 Q. THIS IS DEFENDANT'S 7151 WHY?

16 MR. PIUZE: YOUR HONOR, I WOULD MAKE THE  
17 SAME OBJECTION AS THIS MORNING. IF HE HASN'T READ,  
18 RELIED ON OR REVIEWED IT, HE SHOULDN'T BE  
19 CROSS-EXAMINED ON IT.

20 THE COURT: FOUNDATION.

21 MR. CARLTON: YES, YOUR HONOR.

22 Q BY MR. CARLTON: DOES YOUR NAME  
23 APPEAR HERE?

24 A. WELL, I WAS CERTAINLY PART OF THE  
25 LUNG CANCER STUDY GROUP. IT LOOKS LIKE YOU HAVE A  
26 YELLOW HIGHLIGHTED, I PROBABLY DID.

27 Q. AND THIS SAYS "THE LUNG CANCER  
28 STUDY GROUP EXPERIENCE"?

1 A. YES.

2 Q. THIS BEING A PUBLICATION RELATED TO  
3 THE LUNG CANCER STUDY GROUP, IS THIS SOMETHING YOU  
4 WOULD HAVE READ?

5 A. YOU KNOW, IT WELL COULD BE THAT I  
6 READ IT. I DON'T REMEMBER IT, TO BE QUITE HONEST.  
7 I CAN'T REMEMBER.

8 Q. WOULD YOU CONSIDER ANY PUBLICATION  
9 BY THE LUNG CANCER STUDY GROUP TO BE REPUTABLE AND  
10 AUTHORITATIVE ON THE SUBJECT OF THE ARTICLE?

11 A. I WOULD, YES.

12 Q. AND WOULD YOU RELY UPON IT IN YOUR  
13 OWN RESEARCH?

14 A. WELL, IT DEPENDS HOW YOU MEAN "RELY  
15 ON IT." I MEAN --

16 Q. CONSIDER.

17 A. SURE, I WOULD CONSIDER IT.

18 Q. AND AMONG THE THINGS THAT THIS  
19 PARTICULAR REPORT FINDS IS THE FOLLOWING, ISN'T IT  
20 TRUE, AND I MIGHT HAVE TO ASK YOU TO EXPLAIN THIS,  
21 IF YOU CAN.

22 "IF ONE LOOKS AT DEMOGRAPHIC  
23 AND HISTORIC DIFFERENCES BETWEEN  
24 NON-BRONCHIOALVEOLAR ADENOCARCINOMA  
25 AND BRONCHIOALVEOLAR ADENOCARCINOMA,  
26 THE MULTI-VARIANT LOGISTIC REGRESSION  
27 REVEALS ONLY THAT ADVANCING AGE, LACK  
28 OF HISTORY OF CHRONIC OBSTRUCTIVE

1 PULMONARY DISEASE AND A NON-SMOKING  
2 HISTORY WERE CORRELATED WITH THE  
3 BRONCHIOLOALVEOLAR CARCINOMA GROUP. "  
4 ISN'T THAT WHAT IT SAYS?

5 A. I CAN'T READ IT FROM HERE, BUT YOU  
6 KNOW, I BELIEVE THAT THAT'S WHAT HE --

7 Q. CAN YOU EXPLAIN TO US, IN MAYBE A  
8 LITTLE BIT SIMPLER TERMS, WHAT THAT MEANS?

9 A. MAYBE YOU COULD READ IT ONE MORE  
10 TIME.

11 BUT I THINK WHAT WOULD BE MORE  
12 IMPORTANT FOR ME TO KNOW IS THAT DID THEY LIST THE  
13 PATIENTS AND DID THEY GIVE A SMOKING HISTORY FOR  
14 EVERY PATIENT.

15 Q. YOU WANT ME TO SHOW YOU A COPY OF  
16 THE ARTICLE?

17 A. SURE, THAT WOULD BE GREAT.  
18 THANK YOU.

19 Q. THAT, BY THE WAY, APPEARS ON PAGE  
20 787.

21 THE COURT: HE HAS BEEN ASKED TO EXPLAIN  
22 SOMETHING -- HOW MUCH LONGER?

23 MR. CARLTON: I AM ALMOST DONE, YOUR  
24 HONOR.

25 THE WITNESS: I CAN'T TELL FROM THIS  
26 ARTICLE HOW MANY PEOPLE WERE SMOKERS AND  
27 NON-SMOKERS. AND I CAN'T TELL FROM I AM SORRY,  
28 READING THAT STATEMENT HOW MANY WERE SMOKERS.

1 ALL THEY SAID THAT THE ODDS RATIO  
2 WOULD FAVOR, LET'S SEE HOW THEY SAY IT.

3 HE SAID A NON-SMOKING HISTORY CAN  
4 ALSO BE USED AS A PREDICTOR OF BRONCHIOLOALVEOLAR  
5 CELL CARCINOMA IN PLACE OF CHRONIC LUNG DISEASE  
6 PROBABLY CAUSING A STRONG ASSOCIATION OF CHRONIC  
7 LUNG DISEASE IN SMOKING.

8 BUT THAT STILL DOESN'T TELL YOU HOW  
9 MANY PEOPLE ARE SMOKERS. BUT THAT'S LIKE THE  
10 ARBUCK ARTICLE, IT ALSO SAYS THAT B. A. C. OCCURS IN  
11 NON-SMOKERS BUT THE DATA SHOWS SOMETHING DIFFERENT.

12 I DON'T KNOW IF I CAN TELL.

13 Q. JUST TO CUT TO THE CHASE THEN,  
14 ISN'T IT TRUE THAT THIS STATEMENT SAYS THAT  
15 BRONCHIOLOALVEOLAR CARCINOMA IS CORRELATED WITH A  
16 NON-SMOKING HISTORY AMONG OTHER THINGS?

17 A. THAT'S WHAT IT SAYS. BUT IT STILL  
18 DOESN'T TELL YOU HOW MANY PEOPLE WERE SMOKERS  
19 VERSUS NON-SMOKERS.

20 MR. CARLTON: ALL RIGHT, NOTHING FURTHER,  
21 THANK YOU.

22 MR. PIUZE: I CAN DO THIS IN THREE OR  
23 FOUR MINUTES.

24 /// /// ///

25 /// /// ///

26 /// /// ///

27 /// /// ///

28 REDIRECT EXAMINATION

1

2 BY MR. PIUZE:

3 Q. NUMBER 1, YOU MENTIONED, WHEN YOU  
4 WERE BEING SHOWN PICTURES OUT OF YOUR TEXTBOOK THAT  
5 DR. BARSKY HAD DONE A GREAT STUDY THAT SAID  
6 SOMETHING ABOUT THE SCAR. TELL US AGAIN.

7 A. WELL, ONE, THERE IS A TYPE OF  
8 CANCER IN THE LUNG THAT IS REFERRED TO AS A SCAR  
9 CARCINOMA. AND THIS KIND OF HISTORICALLY IS A  
10 TUMOR THAT OCCURRED IN AN AREA OF PREEXISTING  
11 SCARRING. AND THE SCAR COULD HAVE BEEN DUE TO,  
12 SAY, OLD TUBERCULOSIS, A PREVIOUS AREA OF WHAT'S  
13 CALLED AN INFARCT, WHICH WOULD BE AN AREA WHERE THE  
14 BLOOD SUPPLY WAS LOST TO THE LUNG AND HE GOT A SCAR  
15 OR MAYBE AN OLD AREA OF, MAYBE, FUNGAL INFECTION.  
16 AND THAT'S CALLED SCAR CARCINOMA.

17 AND WHAT DR. BARSKY DID THERE WAS  
18 SOMETHING THAT I VERY STRONGLY BELIEVE IN WHICH  
19 SHOWS THAT THE MAJORITY OF SCARS THAT YOU SEE IN  
20 CANCER ARE CAUSED BY A CANCER ITSELF.

21 AND WHAT DR. BARSKY WAS WRITING  
22 ABOUT IS CALLED A DESMOPLASTIC,  
23 D-E-S-M-O-P-L-A-S-T-I-C, REACTION, WHICH IS PRESENT  
24 IN ALMOST ALL ADENOCARCINOMA OF THE LUNG. AND IT'S  
25 A VERY COMMON THING AND SOMETHING THAT DOESN'T  
26 PRECEDE THE TUMOR BUT IS SOMETHING THAT IS CAUSED  
27 BY THE TUMOR.

28 AND THE REASON THAT THIS IS

1 IMPORTANT TO ME, AT LEAST IN ONE OF THE CASES I WAS  
2 INVOLVED WITH IN THIS AREA OF CIGARETTE SMOKE  
3 CAUSATION WAS THAT THERE WAS A STATEMENT THAT THE  
4 TUMOR WAS A SCAR CARCINOMA.

5 Q. SO THE SCAR IS CAUSED BY THE TUMOR?

6 A. CAUSED BY CANCER. IT DOES NOT  
7 PRECEDE IT.

8 Q. SCAR CAUSED BY CANCER.

9 SECOND -- THERE'S ONLY FOUR, SO  
10 SECOND.

11 BEFORE 1999, YOU WERE ASKED, USING  
12 THE OLD CLASSIFICATION, WOULD SOME PATH -- WOULD  
13 PATHOLOGISTS CALL THIS, WHAT YOU HAVE BEEN LOOKING  
14 AT UP ON THE SCREEN, A B. A. C., AND YOU SAID SOME  
15 WOULD.

16 SO WHAT'S THE COROLLARY TO THAT?

17 A. SOME WOULDN'T, SOME WOULD CALL IT A  
18 PAPILLARY ADENOCARCINOMA. AND ONE WOULD MAYBE EVEN  
19 CALL IT AN ACINAR ADENOCARCINOMA.

20 Q. NUMBER 3, REGARDLESS OF BEFORE 1999  
21 OR AFTER 1999, BEFORE RECLASSIFICATION OR AFTER  
22 RECLASSIFICATION, DO YOU HAVE ANY DOUBT THAT THIS  
23 CANCER, ADENOCARCINOMA WAS CAUSED BY SMOKING?

24 A. NO.

25 Q. AND LAST, 4, YOU SORT OF  
26 HIGHLIGHTED THIS IN YOUR LAST COUPLE ANSWERS TO MR.  
27 CARLTON, EVEN IF YOU FOUND A PURE B. A. C., WHICH  
28 THIS ISN'T; RIGHT?

1 A. YES.

2 Q. EVEN IF YOU FOUND A PURE B. A. C. , DO  
3 YOU THINK THOSE ARE RELATED TO SMOKING?

4 A. ABSOLUTELY.

5 MR. PIUZE: I AM DONE.

6 MR. CARLTON: NOTHING FURTHER, YOUR  
7 HONOR.

8 THE COURT: SIR, YOU MAY STEP DOWN. YOU  
9 ARE EXCUSED.

10 THE WITNESS: THANK YOU.

11 THE COURT: AND IT'S TIME FOR OUR JURY TO  
12 GO HOME, LADIES AND GENTLEMEN. WE WILL SEE YOU  
13 TOMORROW MORNING AT 8:45. HAVE A SAFE TRIP HOME.  
14 I HOPE ALL GOES WELL WITH MR. FLORES' CAR.

15

16

17 (AT THIS TIME, THE PROCEEDINGS  
18 IN THE ABOVE-ENTITLED MATTER  
19 CONTINUED TO THURSDAY, APRIL 19,  
20 2001 AT 9:00 A.M.)

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