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SUPERIOR COURT OF THE STATE OF CALIFORNIA  
FOR THE COUNTY OF LOS ANGELES

RICHARD BOEKEN, )  
)  
Plaintiff, ) Case No. BC226593  
)  
vs. )  
)  
PHILLIP MORRIS, INCORPORATED, )  
)  
a corporation; INTERNATIONAL )  
HOUSE OF PANCAKES, )  
)  
INCORPORATED, a corporation; )  
DOES 1-100, inclusive, )  
)  
Defendants. )  
\_\_\_\_\_ )

Deposition of SANFORD H. BARSKY,  
M D., taken on behalf of the Plaintiff,  
at 11755 Wilshire Boulevard, Suite 1170,  
Los Angeles, California, commencing at  
2:46 p.m., on Wednesday, March 20, 2001,  
reported by Vivian C. Dernburg, CSR  
No. 11339, a Certified Shorthand Reporter  
in and for the State of California  
pursuant to Notice.

Reported by: Vivian C. Dernburg, CSR No. 11339  
Job No.: 0020-VCD

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INSTRUCTION NOT TO ANSWER

(None)

INFORMATION REQUESTED

(None)

1 Los Angeles, California  
2 Wednesday, March 20, 2001  
3 2:46 p.m.  
4

5 SANFORD H. BARSKY, M.D.,  
6 called as a witness by and on behalf of the  
7 Plaintiff was duly sworn by the reporter and  
8 testified as follows:  
9

10 EXAMINATION

11 BY MR. PIUZE:

12 Q Tell us your full name, please.

13 A It's Sanford L. Barsky, M.D.?

14 Q Do you have a C.V. with you?

15 A Yes.

16 Q Can I have it, please.

17 A Sure.

18 Q Thank you.

19 What is this a workers' comp

20 claim?

21 A It's a curriculum vitae.

22 MR. PIUZE: Exhibit No. 1.

23 (The document referred to was  
24 marked by the C.S.R. as Plaintiff's  
25 Exhibit 1 for identification and was

1 attached to and made part of this  
2 deposition's.)  
3 BY MR. PIUZE:  
4 Q Up to date?  
5 A Yes.  
6 Q How many times have you testified  
7 in tobacco-related cases?  
8 A Twice.  
9 Q Names of the cases?  
10 A One case was Conner versus R. J.  
11 Reynolds, and the second was Jones versus R. J  
12 Reynolds.  
13 Q Did you say Carner or Garner?  
14 A Conner.  
15 Q C-a-r- --  
16 A C-o-n-n-e-r, I believe.  
17 Q Where are you from?  
18 A Where am I from?  
19 Q Originally.  
20 A Pittsburg, Pennsylvania.  
21 Q Okay. Where was Conner?  
22 A It was in Jacksonville, Florida.  
23 Q When?  
24 A I think it was four-and-a-half  
25 years ago.

1 Q When was Jones?  
2 A Jones was last August, September.  
3 Q Where?  
4 A In Tampa, Florida.  
5 Q Okay. Have you testified in  
6 depositions on any other tobacco-related cases?  
7 A Yes.  
8 Q What -- how many times?  
9 A I think five times.  
10 Q Did you testify in depositions on  
11 the two cases you've told me about?  
12 A Yes.  
13 Q Let's eliminate those two. Does  
14 that leave three?  
15 A No. I had eliminated those  
16 already. It's five, in addition.  
17 Q Thank you. Names, please?  
18 A One name I recall is Clark.  
19 Another name I recall is Keagan.  
20 THE REPORTER: Can you spell that.  
21 THE WITNESS: I believe it's  
22 K-e-a-g-a-n.  
23 Another is Little. Another is  
24 Boerner.  
25 BY MR. PIUZE:

1 Q B-o-r-n-e-r?  
2 A B-o-e-r-n-e-r, I believe.  
3 And the last one is Mēhlman.  
4 Q Spell that.  
5 A M-e-h-l-m-a-n. Now, in all these  
6 cases the defendant isn't R. J. Reynolds.  
7 Sometimes it's another company. Sometimes it's  
8 more than one defendant. I can't remember the  
9 specifics.  
10 Q Tell me again where Jones was.  
11 A It was in Tampa.  
12 Q Okay. For each of these, if you  
13 could tell me where it was venued and  
14 approximately when you gave the deposition.  
15 A Clark deposition was a phone  
16 deposition.  
17 Q What a great idea.  
18 A So I gave it here or in an office  
19 here, but it was from Jacksonville.  
20 Q Okay.  
21 A Keagan was the same way.  
22 Q I'm sorry. Let's just stop for a  
23 second.  
24 The year approximate, approximate  
25 year?

1           A       It was approximately five years  
2 ago.  
3           Q       Go ahead. Sorry to interrupt.  
4           A       Keagan was approximately four  
5 years ago. I believe it was by phone. I  
6 believe it was Jacksonville.  
7           Q       These cases were in Jacksonville.  
8                    Little?  
9           A       Little was in Charleston, South  
10 Carolina, and that -- the deposition for that  
11 case was about a year ago, and that was given  
12 in Charleston, South Carolina.  
13          Q       Okay, Boerner?  
14          A       Boerner was a phone deposition. I  
15 think that occurred maybe six months to a year  
16 ago, and I believe that was in Jacksonville  
17 also. I'm not sure. It was a phone  
18 deposition.  
19                    And Mēhlman was a deposition in  
20 Los Angeles. It was a phone deposition also,  
21 and I believe that case is in New Jersey.  
22          Q       This year?  
23          A       Yes. That was about a few months  
24 ago.  
25          Q       Spell Mēhlman --

1           A       Actually, I think it was two  
2 months ago.

3                   Mehlman, M-e-h-l-m-a-n.

4           Q       Now, in addition to these -- what  
5 come out to seven matters, have you been  
6 retained by tobacco interests in yet other  
7 lawsuits in which you have not yet testified?

8                   MR. CARLTON: And the witness, of  
9 course, can answer that question with a yes or  
10 a no, but to the extent that you inquire into  
11 the identities of the lawsuits, that would be  
12 an issue.

13                   THE WITNESS: Since 1986, I've  
14 been brought cases to look at by tobacco  
15 attorneys. I've rendered an opinion on many  
16 such cases. I don't know if that constitutes a  
17 retention. Nothing subsequently happens. I  
18 don't give a deposition or anything of that  
19 nature. So I guess my answer to your question  
20 depends on what you mean by "retention."

21 BY MR. PIUZE:

22           Q       Do they give you money?

23           A       Well, they have paid me for my  
24 work on all of these cases, even if I've just  
25 rendered my opinion on them

1 Q So how many times have you have  
2 you been retained for your services on tobacco  
3 cases?  
4 A I'd say since 1987 or '88, maybe  
5 20 to 30 times.  
6 Q Okay. So now, Mr. Carlton had a  
7 point. I want to caution you now. I won't ask  
8 you about this, but stay away from the case  
9 names. I don't care about them I don't want  
10 them, and you'll make your lawyers unhappy if  
11 you slip into them  
12 What were you asked to do in  
13 those -- tell me again how many cases?  
14 A What I said was between 20 and 30.  
15 Q What were you asked to do?  
16 A I was asked to review the slides  
17 as a pathologist and to render an opinion as to  
18 what the slides show.  
19 Q Are you a pathologist?  
20 A Yes.  
21 Q Are you an academic pathologist?  
22 A Yes.  
23 Q Where?  
24 A At UCLA.  
25 Q Okay, I can flip this over, but

1 just for the heck of it, how long have you been  
2 associated with UCLA?  
3 A 16, going on 17 years.  
4 Q Are you a full professor now?  
5 A Yes.  
6 Q Why don't you just tell me the  
7 steps you took. Put approximate years on it.  
8 A Would you like me to start from  
9 birth or from my academic positions?  
10 Q Academic. When did you come over  
11 to UCLA?  
12 A I came over to UCLA in 1984 as an  
13 assistant professor of pathology. I was  
14 promoted in 1991 as an associate professor with  
15 a tenure at the UCLA School of Medicine. I was  
16 appointed a full professor in 1985  
17 approximately.  
18 Q Who's your boss? Who's the head  
19 of your department?  
20 A His name is Dr. Braun.  
21 Q First name?  
22 A Jonathan.  
23 Q Okay, how many pathology  
24 professors are there?  
25 A Probably -- full professors or --

1 Q No.  
2 A I think we have about 40 to 60 on  
3 the faculty.  
4 Q Are we talking clinical too?  
5 A Anatomical, clinical and  
6 experimental.  
7 Q Where do you fit in all of the  
8 above.  
9 A I do anatomical pathology and  
10 experimental pathology.  
11 Q What's anatomical pathology?  
12 A It's the branch that deals with  
13 the diagnosis of tissue, of tumors, of disease  
14 processes usually using a microscope. That's  
15 what anatomical pathology is.  
16 Q Experimental?  
17 A Experimental pathology is the  
18 science of pathology advancing new novelties,  
19 discovering new things about disease, new  
20 science.  
21 Q Do you know Dr. Geller?  
22 A Yes.  
23 Q How?  
24 A He is a professor and head of the  
25 department at Cedars. I've known him for many

1 years. He knows me, and we've interacted on  
2 occasion in courses, et cetera.  
3 Q A professor where?  
4 A He has an appointment at UCLA  
5 because faculty members at UCLA have  
6 appointments.  
7 Q Is he a clinical professor?  
8 A I think he's a clinical professor  
9 or an adjunct professor.  
10 Q Adjunct clinical?  
11 A Yes.  
12 Q Has he ever been on the full-time  
13 teaching staff at UCLA?  
14 A Not since I've been there. Ever  
15 since I arrived in 1984, he's been at Cedars.  
16 Q You talk like Al Davis. Do you  
17 know who he is?  
18 A You mean the Raider owner?  
19 Q Yeah.  
20 A (No audible response).  
21 Q Do you have a geographic identity  
22 crisis?  
23 MR. CARLTON: Objection,  
24 relevance.  
25 MR. PIUZE: Well. Bad joke. The

1 bad joke objection.  
2 Q How long have you known Ms. Tang?  
3 A I'm sorry?  
4 Q How long have you known Ms. Tang?  
5 A Is that person Ms. Tang?  
6 I met her yesterday.  
7 Q How long have you known  
8 Mr. Carlton?  
9 A I met him yesterday.  
10 Q For the first time each?  
11 A That's correct.  
12 Q Ever talked to them before, either  
13 one of them?  
14 A No not before yesterday.  
15 Q Okay. So the one person left in  
16 the room here who isn't taking notes or asking  
17 questions is someone who's not officially  
18 connected with that case. Do you know that  
19 person?  
20 A Yes.  
21 Q Who?  
22 A It's Chris Johnson.  
23 MR. CARLTON: Object to the form  
24 of the question.  
25 BY MR. PIUZE:

1 Q It's Chris Johnson?  
2 A Uh-huh.  
3 Q Yes?  
4 A Yes.  
5 Q How do you know Chris Johnson?  
6 A Well, I met him approximately a  
7 month or two ago.  
8 Q Where?  
9 A At my home.  
10 Q Why?  
11 A He came to me with some slides and  
12 asked me if I would look at them  
13 Q Must have been more than a month  
14 or two ago, don't you think?  
15 A I know it was relatively recent.  
16 I believe it was a month or two ago.  
17 Q Can you put a date on it for me?  
18 A I can't do it better than what  
19 I've just said.  
20 Q How come?  
21 A Just that I don't remember  
22 precisely, but it was recent. I don't think it  
23 was before the new year, and so that would put  
24 it in January or February, and that would be a  
25 month or two ago since we're in March.

1 Q Well, that's not impeachable. So  
2 you think it was in the Year 2001?  
3 A Yes.  
4 Q How long did he spend with you?  
5 A An hour or so.  
6 Q Do you have a microscope in your  
7 home?  
8 A Yes, I do.  
9 Q What kind?  
10 A An Olympus, and I have a full  
11 digital camera setup. I have a lot of  
12 equipment set up at my home.  
13 Q What do you do with it?  
14 A I do work with it.  
15 Q Experimental work?  
16 A Yes.  
17 Q Research work?  
18 A Yes.  
19 Q Litigation work?  
20 A Yes.  
21 Q Um, how did he get invited to your  
22 house?  
23 A He just came with another  
24 attorney.  
25 Q From Kansas City?

1           A       No, an attorney from a firm called  
2       Womble, Carlyle, and they're, I believe, in  
3       North Carolina.  
4           Q       See when he goes for a southern  
5       name on top of that, it bumbles out. But it's  
6       W-o-m-b-l-e Carlyle.  
7           I wasn't listening, I guess, but  
8       what was the lawyer's name?  
9           A       I didn't say it. Her name was Lee  
10      Chaney.  
11          Q       How do you know Lee Chaney?  
12          A       She's brought me cases before, one  
13      or two cases.  
14          Q       One or two?  
15          A       Yes.  
16          Q       Okay. Who else has brought you  
17      cases before?  
18          A       Well, as I said, tobacco attorneys  
19      have been bringing me cases since the mid '80s,  
20      and they include a number of different people.  
21          Q       Okay. So to get back to the  
22      question, who?  
23          A       Well, I can't remember everyone's  
24      name, but some of the people that I can  
25      remember are Bruce Shaffler, who's from

1 Shadbourne & Park; Chris Womble, who's with  
2 Womble, Carlyle; Jim Johnson with Jones, Day;  
3 Stephanie Parker, who's with Jones, Day; Terry  
4 Gaffney, who's with Womble, Carlyle; and  
5 there's been many others that I can't remember.  
6 Q Looking back over the 20 to 30  
7 times when you've looked at slides and nothing  
8 further has occurred, do you have an idea why  
9 it is that nothing further occurred?  
10 MR. CARLTON: Objection. Calls  
11 for speculation.  
12 THE WITNESS: I have an idea on  
13 some of the cases.  
14 BY MR. PIUZE:  
15 Q Okay. Did you give them news that  
16 you thought they wouldn't like?  
17 A Well, considering that these  
18 attorneys represent tobacco companies, some of  
19 the cases I were shown I diagnosed small cell  
20 cancer; some of them I found squamouscell  
21 cancer; some of them I found chains under the  
22 microscope that led to -- suggestive of.  
23 Q Suggestive of what?  
24 A Of a link to tobacco smoke.  
25 Q That's what I had in my mind.

1                    Were there other cases that you  
2 gave them news that you thoughts they might  
3 like more and that was still the end of your  
4 participation?  
5            A        I think so, yes.  
6            Q        What kind of news would that have  
7 been?  
8            A        Well, you know, that's hard to  
9 speculate. I mean, I remember seeing cases  
10 where I've diagnosed a neuro epidermoid  
11 carcinoma.  
12           Q        Say that more slowly.  
13           A        A neuro-epidermoid carcinoma.  
14 There's been cases where I've diagnosed an  
15 Epstein Bar neuro-epidermoid carcinoma. These  
16 are cancers that are not linked to smoking. So  
17 I imagine that would be something that they  
18 would like to her, but some of these cases  
19 never went anywhere. I never heard anything  
20 about them. So I mean, I didn't inquire about  
21 them, so I don't know whether the cases went  
22 away, whether they were dropped, whether they  
23 decided to use someone else. I have no idea.  
24           Q        Okay. Those two categories cover  
25 the whole gamut of times when people have come

1 to show you slides and then never contacted you  
2 again?

3 A I wouldn't say they covered the  
4 whole gamut.

5 Q What else was there? Curtain A,  
6 you showed them news they would like.  
7 Curtain B you showed them news they wouldn't  
8 like. Was there a Curtain C or a Curtain D?

9 A Well, it's not a matter of A or B.

10 Q What is it?

11 A There are many complex issues that  
12 are raised by some of these cases, and again,  
13 without getting into a specific case, I can't  
14 specifically address the questions that you're  
15 raising.

16 Q Okay. We'll get into a specific  
17 case. Don't use the name, no names, just give  
18 me a case.

19 MR. CARLTON: Well, I'll object to  
20 getting into specific cases where he was not  
21 disclosed as an expert.

22 MR. PIUZE: Well, there was no  
23 litigation for all you know, John.

24 MR. CARLTON: Well, then he was  
25 potentially a confidential consultant.

1                   MR. PIUZE: Absolutely, and as  
2 long as I don't know the name of the case, it  
3 will remain confidential forever more.

4                   MR. CARLTON: I'm concerned --

5 BY MR. PIUZE:

6                   Q       Were these one of a kind cancers  
7 never seen in the history of the universe?

8                   A       I'll give you one example. It's  
9 taken 15 years for me to go back to cite  
10 examples that I remember, but I remember one  
11 case that had stains of a small cell, but I  
12 think it could be an atypical carcinoma. I  
13 wanted to get some additional stains. I wanted  
14 to verify in more detail where the tumor was  
15 actually rising, actually.

16                   If my conclusion was a small cell,  
17 you might conclude from that that that would  
18 not be a position that the tobacco companies  
19 would like me to take for the purposes of their  
20 position. On the other hand, if I diagnosed a  
21 typical carcinoid, if you know that is a  
22 typical cancer that is not linked to smoking or  
23 is not significantly shown to be linked to  
24 smoking, that would be a position they would  
25 like. Since I wasn't certain at the time and

1 since I was not afforded the opportunity to  
2 investigate it further, that would be the type  
3 of category that I referred to.

4 Q So Curtain A, Curtain B and  
5 undecided. Do you follow that shorthand?

6 A Yes.

7 Q Out of the 20 to 30, why don't you  
8 give me approximate numbers of how many fell  
9 into non-cancer-related; how many fell into --  
10 MR. CARLTON: Non-cancer-related?

11 BY MR. PIUZE:

12 Q Sorry, non-tobacco-related; how  
13 many fell into probably tobacco-related and how  
14 many fell into the jury was undecided, round  
15 numbers.

16 A I would say from the onset, this  
17 is inaccurate, but if you push it, I would say  
18 probably one third, one third, one third.

19 Q Okay, all right.

20 A I'd like to make a -- an amendment  
21 to an answer that I provided to you earlier.

22 Q You may.

23 A To a question that you posed. You  
24 asked me who my boss was, and I gave you the  
25 name of the chairman of our department. But

1 he's not really my boss. I'm a tenured full  
2 professor at the University of California and  
3 my bosses are the Regents of the University and  
4 the People of the State of California.  
5 That's -- that's who my boss is.

6 Q Just to prove that some of your  
7 bosses are on the ball, I sort of changed my  
8 answer as I was asking it, and I think it will  
9 reflect that it went from your boss to the head  
10 of the department, all in one, in recognizing  
11 your boss.

12 A Okay.

13 Q However, I did pay you last year  
14 by the way as a taxpayer in the State of  
15 California. What was your salary?

16 A Well, the part that I got from the  
17 University of California was roughly \$200,000.

18 Q Okay. And what other part was  
19 there that you didn't get from the University  
20 of California?

21 A Well, I get -- I get some  
22 component from my patents that I've  
23 successfully licensed. I gets some component  
24 from honorary that I give, lectures, invited  
25 talks. I own part of one startup company and

1 I'm a consultant to another company, and I  
2 get -- I get some income from that that  
3 wouldn't be the People of the State of  
4 California.

5 Q Yeah. Compared to the 200,000  
6 that the People of the State of California give  
7 you, how much do you get from litigation?

8 A Well, before I answer that,  
9 there's a part of the answer that I want to  
10 clarify. The 200,000 doesn't come solely from  
11 the taxpayers. Part of that is supplemented  
12 other grants that I have that offset my salary.  
13 Part of it is also offsets from my clinical  
14 practice where I charge people for the  
15 privilege and the duties of reading their  
16 slides. So the actual part that comes from the  
17 University of California from the taxpayer is  
18 about 90,000 of that 200,000.

19 Q Do you have to split your income  
20 from the clinical practice with the regents?

21 A There's a complex formula in which  
22 there is some sort of split. But I never  
23 really understood it.

24 Q All right. What's your capacity  
25 here today, private citizen or employee of the

1 State of California, of the Regents of the  
2 University of California?  
3 A Well, officially I took a vacation  
4 day, but I am a professor of pathology. So I  
5 guess the answer to you would be both.  
6 Q Let me tell you why I ask. Do you  
7 know Dr. Benowitz?  
8 A No.  
9 Q Ever hear of him?  
10 A No.  
11 Q He's a professor up at UCSF, and  
12 he was giving a deposition. At the end of the  
13 deposition, he asked that the check be made out  
14 to the Regents and not to him. What's your  
15 preference? Is it you here as Dr. Barsky an  
16 individual, or do you want the check made out  
17 to you?  
18 A Yeah, I prefer it that way.  
19 Q Anyways, having cleared up the  
20 components of the 200,000 bucks, roughly, what  
21 did you get from litigation last year?  
22 A I would say I testified in Jones  
23 maybe 30, 40,000 total.  
24 Q Okay. Is that -- let's  
25 split -- let's split the difference and call it

1 35, a ratio of 35 to 200, 17 to 100. Does that  
2 sound appropriate for the last five or six  
3 years?

4 A No. There's two things you have  
5 to realize. I told you that the 200,000 was  
6 only the part from UC, and I said I had  
7 royalties. I had other sources of income, my  
8 patents, et cetera. And in addition -- you  
9 didn't ask me this, but I'll volunteer the  
10 answer -- I have done malpractice cases. I've  
11 testified in medical malpractice cases, and  
12 I've derived an income from that, too.

13 Q And when I said "litigation," I  
14 meant all litigation.

15 A I thought you said tobacco cases.

16 Q I thought you didn't say that.

17 A Well, I thought I did, but she  
18 knows.

19 Q So far I've tried to stay clear of  
20 your private business, but I think you want me  
21 not to. Is it -- do you want to tell me that  
22 you make so much money from your private  
23 patents and consulting work that whatever you  
24 get from litigation is a pittance?

25 A No. I want to accurately attempt

1 to answer your questions.  
2 Q Okay. Being that you brought it  
3 up, what do you get from the patents?  
4 A Well, again, that answer is hard  
5 to precisely tell you because some of the  
6 things I get are stock options in the two  
7 venture companies. I have gotten an income of  
8 one patent. It's ranged between 10 and 15,000  
9 a year. It's on the increase this year, so I  
10 don't know what I'm going to receive.  
11 Q Honorary?  
12 A Several thousand.  
13 Q Per year?  
14 A Yes.  
15 Q Let's stick with the 200, then.  
16 What percentage compared to the 200 -- let me  
17 start that again.  
18 How much do you get from  
19 litigation on a typical year?  
20 A You mean tobacco or all  
21 litigation?  
22 Q Both.  
23 A Well, I had said the last year  
24 from tobacco is between -- I believe I said,  
25 what 30 and 40, something like that.

1 Q You did.  
2 A I get another probably 20 to 30  
3 from malpractice litigation.  
4 Q Then the pending question before  
5 you clarified was, I had a ratio at the time of  
6 something like 17,000 to 100,000, and I asked  
7 if that was a typical ratio going on back five  
8 or six years. Let's stick with tobacco alone.  
9 Is that a typical ratio?  
10 A Probably not. Some years have  
11 been quite high, probably higher than that, and  
12 some years have been lower than that.  
13 Q All right.  
14 A Starting from -- I said I started  
15 this around '86, between '86 and '94, it was a  
16 pittance -- it was a small amount, very small,  
17 several thousand a year.  
18 Q Let's not talk about it -- let's  
19 talk about from '94.  
20 A Well, every time I testify at  
21 trial, the income goes up, and if a year passes  
22 where I haven't testified at trial or did I?  
23 Q Don't forget tobacco litigation.  
24 You've only testified in two trials; is that  
25 correct?

1           A       That's correct.  
2           Q       So last year would have been an  
3 atypically high year because you testified last  
4 year, or am I wrong?  
5           A       I would say it would be one of the  
6 higher years.  
7           Q       So last year was the year you  
8 testified in Jones in Tampa and Reynolds in  
9 Tampa?  
10          A       Right.  
11          Q       Let's stick to the malpractice  
12 consulting into the last year. All litigation  
13 consulting would have yielded what 85,000  
14 bucks, 80,000 bucks?  
15          A       No. I think it would be around 50  
16 or 60.  
17          Q       Total?  
18          A       Total, yes.  
19          Q       For all litigation?  
20          A       Yes.  
21          Q       So last year would have been only  
22 around 10 to 20 thousand bucks for malpractice  
23 litigation?  
24          A       Well, I think I said the  
25 malpractice range was somewhere between 20 and

1 30. Again, I'm estimating. I don't recall  
2 exactly. Some years are better than others for  
3 malpractice.  
4 Q What does that mean?  
5 A Well, I make -- I do more of  
6 it -- better in terms of a return.  
7 Q Does 20 percent, a ratio of one to  
8 five, litigation to your practice over at UC,  
9 sound about right for the last five years or  
10 so?  
11 A I think it's a little high. It  
12 can over five years, but in some years it would  
13 be inaccurate.  
14 Q Have you ever testified in a  
15 tobacco-related case against tobacco?  
16 A No.  
17 Q Has anyone ever asked to you?  
18 A No.  
19 Q When you're doing medical  
20 malpractice cases, give me an idea of -- is it  
21 always pathology?  
22 A Yes.  
23 Q Always defense?  
24 A No.  
25 Q Who's approached you with a

1 plaintiff consultation in a med. mal. case?  
2 A You mean attorneys' names?  
3 Q Yeah, please.  
4 A I just -- I just worked on a case.  
5 The attorney's name was happier and another  
6 attorney's name who comes to mind is Betsy  
7 Jeffries. Another attorney's name who comes to  
8 mind is Phil Michaels.  
9 Q I know Phil Michaels. I don't  
10 know the other two names. Are they local?  
11 A Yes, Orange County.  
12 Q So when you're doing medical  
13 malpractice cases, what's the split, Plaintiff,  
14 defense?  
15 A I have think the edge goes to the  
16 plaintiff side a bit. But it's most -- it's  
17 probably a 60/40 split with the edge going to  
18 the plaintiff's side.  
19 Q How many times have you looked at  
20 Mr. Boekin's slides?  
21 A Twice.  
22 Q Once at your house?  
23 A Well, both occasions were at my  
24 house. The first was when I just looked at the  
25 slides with Mr. --

1 Q Chris?  
2 A Chris.  
3 Q Johnson? Oh, Chris Johnson --  
4 A Chris Johnson.  
5 Q That was Chris Johnson.  
6 Have you read these depositions? You  
7 haven't read these depositions?  
8 A I've read most of them  
9 Q I knew that.  
10 A The first was with him, and the  
11 second was by myself when I photographed the  
12 slides.  
13 Q What is that called, photo  
14 microscopy?  
15 A Yes.  
16 Q And you've got the results here?  
17 A Yes.  
18 Q Can I see?  
19 A Sure.  
20 Q Okay. Thank you very much. These  
21 are for me?  
22 A Sure.  
23 Q How many are there?  
24 A Six or seven, perhaps.  
25 Q One, two, three, four, five, six.

1 So let's make these Exhibit 2-A through F,  
2 please.

3 (The photographs referred to were  
4 marked by the C. S. R. as Plaintiff's  
5 Exhibit 2 for identification and were  
6 attached to and made part of this  
7 deposition.)

8 BY MR. PIUZE:

9 Q How do you do that?

10 A Well. There's a digital camera  
11 attached to the microscope and it sees  
12 everything that you're seeing with your eye.  
13 And then the computer runs it. You click the  
14 shutter. It digitizes -- it makes either a  
15 JPEG or TIF, T-I-F, file, and then you can  
16 enlarge it. You can shrink it. You can  
17 enhance it, and then you can print it.

18 Q Is there any significance to the  
19 order in which these photographs are lined up  
20 right now?

21 A Yes.

22 Q Okay. From top to bottom. Then  
23 we'll go A, B, C, D, E, F -- 2-A, B, C, D, E,  
24 F.

25 What's the significance, please?

1           A       Well, the significance is -- the  
2 order of soft slides, which tell a story in my  
3 mind pertinent to the issues in this case.

4           Q       So there were seven, not  
5 six -- one was stuck together. So it goes 2-A  
6 through 2-G. So these are enlargements, same  
7 piece of material bigger and bigger and bigger  
8 or some are and some aren't?

9           A       Some are, yes. Some are.

10          Q       Okay. Let's go back to  
11 Dr. Geller. Is there any kind of hierarchy  
12 between a frozen section and a final diagnostic  
13 statement?

14          A       I don't think that it is in terms  
15 of hierarchy.

16          Q       If you get -- within the path  
17 report for Mr. Boekin's tumor, dated what,  
18 October 27 --

19          A       Something like that.

20          Q       -- was there seemingly  
21 inconsistent diagnoses?

22          A       I didn't read the report as  
23 indicating inconsistent diagnoses.

24          Q       Okay. Did the frozen section  
25 mention BAC?

1           A       The frozen section said  
2 bronchioloalveolar carcinoma.  
3           Q       Did the final diagnosis not say  
4 that?  
5           A       The final diagnosis did not say  
6 that.  
7           Q       Now, why is that not inconsistent?  
8 I'm sure there's at least four, or five or  
9 seven goods reasons, but tell me anything you  
10 want.  
11          A       Well, you know, I can't put myself  
12 in the mind of Dr. Geller. I don't know what  
13 he was thinking at the time. All I can tell  
14 you is what I would know in a case in which the  
15 frozen section seemed to be different than the  
16 permanent. I would be compelled to write an  
17 explanation because in our quality assurance,  
18 we're always checking the accuracy of frozen  
19 section diagnosis.  
20                So when we render a different  
21 opinion, we give an explanation; the sampling  
22 is different or we've gotten deeper cuts or the  
23 permanence can resolve the cells a little  
24 better, or sometimes the frozen section is  
25 better. It depends on the individual case, but

1 we give an explanation that doesn't leave a  
2 third party or somebody who is reading our  
3 report in the dark when there is a discrepancy.  
4 Now, I saw no explanation on the  
5 report. I just saw the bronchioloalveolar  
6 diagnosis rendered on the frozen and the  
7 diagnosis of the papillary adenocarcinoma on  
8 the final. So I felt that Dr. Geller was not  
9 giving an explanation for a difference and  
10 probably didn't feel that there was a  
11 difference.

12 Q So you are putting yourself in s  
13 head a little bit?

14 A Yes, a little bit.

15 Q Did you ever ask him?

16 A No.

17 Q To your knowledge, has anyone  
18 asked him?

19 A I have no knowledge of that.

20 Q As part of your explanatory  
21 answer, does that mean that the two diagnoses  
22 are seemingly inconsistent?

23 A Well, if I were looking at this  
24 case -- and I have looked at this case -- it  
25 would not be diagnoses that I would render but

1 what you asked me to do was to put myself in  
2 the mind of Dr. Geller. I said initially that  
3 I couldn't precisely put myself in his mind,  
4 but if you asked me to come up with an  
5 explanation for the seemingly inconsistencies,  
6 I would say in his mind probably there was no  
7 inconsistency because when there is, we write  
8 an explanation in our reports.

9 Q I know. I learned all of that,  
10 and this is the lawyer saying "motion to  
11 strike, not responsive."

12 What I'm saying is between the  
13 two, aren't the two diagnoses seemingly  
14 inconsistent?

15 A It's not -- I wouldn't use those  
16 diagnoses if it was my report. It's not --

17 Q I know, but that's a yes or a no,  
18 probably a yes or a no. Aren't the two  
19 diagnoses seemingly inconsistent?

20 A I would say that the two diagnoses  
21 are not seemingly inconsistent.

22 Q Thank you.

23 They are certainly not mutually  
24 exclusive?

25 A I think that's probably more

1 accurate.  
2 Q Well, I'm sure it's more accurate.  
3 But you're sticking with that.  
4 They are not seemingly inconsistent also,  
5 correct?  
6 A Yes.  
7 Q Okay. Besides the path slides and  
8 besides the path reports, what else have you  
9 been given in this case?  
10 A I've been given a detailed group  
11 of medical records which are before me in this  
12 folder.  
13 Q Mr. Boekin's medical records?  
14 A Yes.  
15 Q Okay.  
16 A I've been given a copy of a  
17 deposition of Dr. Samuel Hammer. I've been  
18 given of a copy of a report that he rendered on  
19 his slides, on his review, which also includes  
20 a synopsis of the medical records, and I've  
21 been given a copy of an opinion rendered by a  
22 Dr. Alan Feingold which also included his  
23 synopsis of the medical records.  
24 Q Okay. Do you know Dr. Hammer?  
25 A I don't know him personally. I

1 know of him  
2 Q Okay. Have you ever met him?  
3 A No, I have not.  
4 Q Do you know Dr. Feingold?  
5 A No, I do not.  
6 Q Have you ever met him?  
7 A No, I have not.  
8 Q Do you know of him?  
9 A Yes, I do.  
10 Q You and Dr. Feingold have  
11 testified sometimes against each other in the  
12 same case; is that true or not true?  
13 A It's true.  
14 Q In both of your trial cases?  
15 A I know he was in Conner. I don't  
16 remember exactly if he was in Jones.  
17 Q Okay.  
18 A He may have been. He may not have  
19 been.  
20 Q What about Dr. Hammer? Was he in  
21 any of those cases?  
22 A I don't remember him in Conner.  
23 He may have been peripherally involved in  
24 Jones, but I'm not sure.  
25 Q What do you know of him?

1           A       He is a preliminary pathologist.  
2       He has written an authoritative textbook in the  
3       field, several editions. I think he runs a  
4       practice now. He runs a practice in Seattle,  
5       Washington. He used to be at the University of  
6       Washington.  
7           Q       Do you know anything else of him?  
8           A       No.  
9           Q       Okay. Who is Claire Kruppe,  
10       K-r-u-p-p-e?  
11          A       I don't know.  
12          Q       Have you ever seen the defense  
13       expert witness list in this case?  
14          A       No, I can't say I have.  
15          Q       Do you know who any of the defense  
16       experts are besides you?  
17          A       No, I do not.  
18          Q       Is it sometimes hard to tell the  
19       difference between adenocarcinoma and BAC?  
20          A       Well, BAC is a type of  
21       adenocarcinoma.  
22          Q       Great points, which, of course, I  
23       guess I knew that. But it was a bad question.  
24                    Tell me the best way to ask the  
25       question with the fewest words. Should I be

1 going papillary adenocarcinoma versus BAC -- or  
2 should I be saying non-BAC versus other things  
3 or should I be saying something else. Tell me  
4 the words to use.

5 A Will you allow me to elaborate on  
6 these issues that I made.

7 Q How much am I paying you?

8 A Well, I'm charging you \$450 per  
9 hour.

10 Q Then I certainly would want you to  
11 elaborate.

12 A Well, both non and BAC are types  
13 of adenocarcinoma. They can arise from  
14 different cells of the lung. The most common  
15 is the Type II pneumocyte. Frequently, one can  
16 have a cancer that has BAC areas and other  
17 areas that are non-BAC. Oftentimes one sees  
18 mixed areas.

19 The important point, I think, in  
20 any nomenclature or any classification is to  
21 recognize the different areas that are there  
22 and to diagnosis them. That way there's  
23 nothing hidden. What you see is what you  
24 diagnosis.

25 Now, there are adenocarcinomas

1 that do not have any BAC area growth patterns.  
2 Those are pure adenos. There are many types of  
3 pure adenos. Conversely, there are BACs that  
4 are pure. There are many subtypes. There are  
5 pneumocytes, Type II pneumocytes or different  
6 types of masses -- multifocal, solitary,  
7 diffuse, et cetera. Many forms are mixed.  
8 However and BACs can be differentiated, not  
9 only into adenos but into squamouscell and into  
10 small cell and D-differentiated.

11 Q What does D-differentiated mean?

12 A D-differentiated, it plays a  
13 change in the direction of the pattern. Many  
14 of our cells are differentiated in our body.  
15 It moves into a different direction, which  
16 malignant tumors do. Then it's called  
17 D-differentiation.

18 Q Now, let's just back up a bit.  
19 BAC, can go to more normal --

20 A No. The direction of malignance  
21 formation is always one from well  
22 differentiation to less differentiation or  
23 D-differentiation.

24 Q D-differentiation?

25 A I said that our normal cells were

1 considered well-differentiated. Their status  
2 would be one of the utmost differentiation.  
3 Since cancer cells where the cells are  
4 perturbed.

5 Q What does that mean?

6 A They are altered. They lose some  
7 of their controlling mechanics. They lose the  
8 control to regulate their growth. They grow in  
9 an uncontrolled manner. They lose the ability  
10 to metastasize and grow. This is a loss of  
11 control in the cell. All these things are in  
12 the direction of D-differentiation. That's a  
13 common theme in cancer from normalcy to  
14 D-differentiation.

15 Q And what brought this explanatory  
16 answer of this part of your main answer that  
17 something to the effect that BAC goes toward  
18 D-differentiation. Did I hear that?

19 A Yes.

20 Q Does that mean comparatively it  
21 goes more towards D-differentiation than  
22 others?

23 A Well, you at first asked me  
24 to -- in the best way I know how, to clarify  
25 the issues of adeno vs. BAC adeno versus

1 non-BAC adeno. So to answer that question the  
2 best way I know how, I wanted to put things in  
3 perspective. BACs are considered  
4 well-differentiated tumors, they're not normal,  
5 but they represent E-transformations of the  
6 normal Type II pneumocyte, our clear cell of  
7 the lung. But by and large, they're  
8 well-differentiated tumors when they're pure.  
9 Now, as I also said, they can have  
10 non-BAC areas. They can have adenocarcinoma  
11 areas. They can have large cell differentiated  
12 areas. When they do, they have undergone  
13 further D-differentiation. They have undergone  
14 further changes to deviate even more from the  
15 normal cell of the lung.  
16 Q Okay so if you had a mixed-feature  
17 tumor that had some BAC, and, for instance,  
18 some papillary adenocarcinoma, the BAC would  
19 tend to look a little more toward the normal  
20 side of the universe than the papillary  
21 adenocarcinoma would; is that right?  
22 A I think, you know, it's not  
23 perfectly right, but it's -- you're in the  
24 ballpark there.  
25 Q Well, I sort of stand or sit as a

1 middle person between the geniuses and the  
2 jury. And if I'm getting a little bit, that's  
3 probably all I need to get for now.

4           Anyway, now, I've heard that just  
5 as a general proposition, frozen sections are  
6 less accurate than -- what was the final slide?  
7 Was there a word for that non-frozen that you  
8 used?

9           A       They're called "final" or  
10 "permanent. "

11          Q       Give me your opinion regarding a  
12 general rule that frozen sections are less  
13 accurate than permanent sections?

14          A       I think it's hard to generalize.  
15 There are many indications in which the frozen  
16 section is more accurate, and those cases would  
17 include in the pathologist's picks the best  
18 area of the tumor to freeze and produce the  
19 frozen section of that. It stems from that  
20 that the tissue that's left is not as good, and  
21 that's made into a permanent. So in that  
22 situation, the frozen section would be more  
23 accurate.

24                   On the other hand, it is true that  
25 if you had -- if you started with the same

1 starting material and you processed, let's say,  
2 a half of it through frozen and half of it  
3 through permanence, the permanent tissue would  
4 probably look better under the microscope.  
5 There would be less artifacts.

6 Q So if we eliminate all variables,  
7 frozen sections are less accurate than  
8 permanent sections?

9 A Well, again, it's hard to  
10 generalize. I gave you an example where frozen  
11 sections would be more accurate. You also have  
12 to realize that the permanent or final one has  
13 the ability to take more sections and one has  
14 the opportunity to study the section longer.  
15 The frozen sections are done like yesterday,  
16 yet the permanent section is kind of like  
17 playing chess. You can sit around, think about  
18 your move, and make it. So when you factor all  
19 of that in, most people would rely on permanent  
20 sections more than frozen. But again, it's an  
21 individual matter.

22 Q That's why I said check out the  
23 variables. I mean, let's just assume that the  
24 tissue comes from exactly the same place just  
25 as you advised me so part of it is made into a

1 frozen section, part of it is made into a  
2 permanent section. So you're chucking out all  
3 variables. The permanent one is more accurate?  
4 A You can't take all tissues from  
5 the same place. So if you take one place, it's  
6 gone. You may take a piece that's juxtaposed,  
7 and I've been in situations where the frozen  
8 section shows what I'm looking for and the  
9 permanent section shows what I'm not. For  
10 example, if I'm looking for the cancer, I may;  
11 see it on the frozen. I may not see it on the  
12 permanent. In that case the frozen section is  
13 more accurate.  
14 Q How well did the frozen cell get  
15 captured in Mr. Boeken's case?  
16 A There were a number of components  
17 to that. They removed some nodes. They had a  
18 biopsy of the lung. They removed more mass and  
19 more lung tissue. So, you know, from the path  
20 reports, it's from different units from  
21 different segments.  
22 Q Humor me a little bit. But how  
23 did the pathologist get the tissue?  
24 A Well, the surgeon removes the  
25 tissue and he hands it down the chain of

1 command to the pathology lab.  
2 Q So the pathology lab does not go  
3 there?  
4 A I don't know the arrangement they  
5 have at Cedars.  
6 Q When does the section get frozen?  
7 A It gets frozen when they get the  
8 permission from the pathology lab to do the  
9 frozen.  
10 Q When do they get permission?  
11 A It's frozen when it's embedded on  
12 a paraffin mounting block called OCT, and  
13 that's put on a cooling chuck and it's held  
14 between 40 and 30 degrees Celsius, and then the  
15 machine has a knife that's called a micron.  
16 It's usually set between 5 and 15 degrees  
17 Celsius. It is stained with hematoxylin stain,  
18 set up, and then the tissue will be  
19 cover-slipped and examined under microscope.  
20 Q Why is the word frozen used to  
21 describe that process?  
22 A Well, it's interesting. The  
23 method was first discovered in a winter in  
24 Minnesota at the Mayo Clinic where surgeons  
25 were complaining that pathologists took forever

1 to render a diagnosis. They would have to sit  
2 around for a week to get a report and they said  
3 wouldn't it be nice if we could get a quick  
4 diagnosis. And then somebody at Mayo Clinic  
5 in, one of their long Minnesota winters which  
6 we don't see here, noticed that some tissues  
7 samples that he put on a window sill were  
8 frozen and that was sort of equivalent of a  
9 paraffin node and the tissue was held solid and  
10 it could be cut. But in Minnesota just like  
11 the cryostats, the tissue becomes frozen.  
12 That's why it is called frozen.

13 Q What year did it happen?

14 A It was in the early 1900s.

15 Q Before the Vikings?

16 A It was after the Vikings.

17 Q It depends on your perspective.

18 A It was definitely before the

19 Minnesota Vikings.

20 Q Okay. What happens to the frozen  
21 section? Where is Mr. Boekin's frozen section?

22 A Well, I would assume it's on a --  
23 on a glass slide that they've stained and  
24 evaluated. The residual tissue, if it hasn't  
25 all been used up in the frozen, is melted back

1 down and processed and made into a permanent  
2 section.  
3 Q Is it possible to go find with  
4 accuracy the tissue that used to be called  
5 frozen section?  
6 A I think hypothetically it would be  
7 possible.  
8 Q Tell me how to go about doing  
9 that?  
10 A Well, it would depend on the  
11 particular lab, and there are methods, you  
12 know, how they archive their samples, how they  
13 retrieve their samples. It would depend on all  
14 those things.  
15 Q You haven't seen the frozen  
16 section, have you?  
17 A I recall initially reviewing 15  
18 slides. I also recall that one or two of those  
19 slides didn't look that well-preserved, and I  
20 assume that that was the residual of the  
21 frozen. In other words, that was the permanent  
22 section of the frozen, which by the way,  
23 usually looks very bad.  
24 The actual original frozen, I  
25 don't recall seeing. It may have been there.

1 It may have not been. It's probably not there  
2 because most of the time it's not filed with  
3 the case.

4 Q So a frozen section does not stand  
5 up as well over time as a permanent mounting?

6 A No. I didn't say that.

7 Q I'm asking you.

8 A No. It can stand up very well  
9 over time.

10 Q No. I said does it stand up as  
11 well as a permanent mounting over time?

12 A Depends on how it's processed and  
13 prepared. If it's made into a slide in which  
14 the cover slip is sealed, hermetically sealed,  
15 it will stand up as well as a permanent section  
16 will.

17 Q Under what circumstances is that?

18 A Under the circumstances of sealing  
19 the slide promptly.

20 Q In other words, when everyone does  
21 a really excellent job?

22 A I think that would be accurate.

23 Q Well, did you see BAC in any of  
24 the slides that you looked at?

25 A Yes.

1 Q Did you see BAC in all of the  
2 slides that you looked at?  
3 A No.  
4 Q Did you see BAC in the slides that  
5 you thought used to be probably frozen?  
6 A Well, I didn't approach the case  
7 that way. I had the luxury, if you will, of  
8 looking at the case in its entirety. I had all  
9 of the slides before me. I reviewed all of the  
10 slides before forming any opinion, and I  
11 reviewed all of the slides, and then I formed  
12 my opinion. I didn't dissect the case out in  
13 the way that you're asking me now.  
14 Q Well, I didn't think my question  
15 implied that at all, and so I'm going to stick  
16 with my question.  
17 Did you see BAC on those slides  
18 that you thought used to be frozen?  
19 A I can't answer you accurately. I  
20 don't remember the specific features of the  
21 slides that I felt might have been frozen.  
22 Q Okay. Were they degraded enough  
23 so that you couldn't do any diagnostic work  
24 with those slides you thought used to be BAC --  
25 A What I'm trying to say is I

1 reviewed 15 slides of the case. I wasn't  
2 reviewing what was the permanent section of the  
3 case and what wasn't. I was looking at this  
4 case in its entirety and looking at it the best  
5 way I can.  
6 Q I understand, and that was your;  
7 job and I understand and I get to tell myself  
8 what my job is?  
9 A My recollection is that most of  
10 the slides had an obviously bronchioloalveolar  
11 pattern. The lymph nodes did not. They were  
12 in a regular pattern, but the primary tumor --  
13 all the slides had BAC in most of the areas.  
14 Q So all of the 15 slides had --  
15 A No. I said there were lymph nodes  
16 that were removed that didn't have a BAC.  
17 Pattern there were a number of lymph nodes.  
18 Q Probably how many?  
19 A I think there were probably at  
20 least three to five slides or more of the lymph  
21 know.  
22 Q Where are those slides?  
23 A Well, after I finished my review,  
24 I turned them back over to Chris Johnson.  
25 Q Both times?

1           A       I only had them one time. He came  
2 and I looked at the slides with him and then my  
3 recollection is he left the slides with me and  
4 I photographed them and I returned it -- the  
5 slides to him  
6           Q       Got it.  
7                    Now, when he was at your house the  
8 first time, he had company, he came with  
9 someone, right?  
10          A       Yes.  
11          Q       And then the second time?  
12          A       I think -- my recollection is he  
13 left the sides with me. I photographed them --  
14          Q       No, I know.  
15          A       Then I returned them to him  
16          Q       Didn't he come to your house the  
17 second time?  
18          A       I think he was like at a hotel or  
19 he might have come to the house. I don't  
20 remember.  
21          Q       Wherever it was, did you meet him  
22 a second time?  
23          A       I believe so, yes.  
24          Q       Was he alone?  
25          A       That, I don't remember.

1 Q Were you?  
2 A I was alone, yes.  
3 Q And you haven't seen the slides  
4 since?  
5 A That's correct.  
6 Q Um, what research is out there  
7 that says to you that BAC is not smoking  
8 related?  
9 A Well, there's a ton of literature  
10 out there, some of which I've conducted myself,  
11 some of which I've relied upon. I became  
12 interested in BAC in the '80s as a very  
13 intriguing and different type of lung cancer.  
14 In the '80s, the literature that was out there,  
15 the dogma about this disease was that it was  
16 scar-arising. It had nothing no do with  
17 smoking, and that it had a very peculiar kinds  
18 of etiology and behavior.  
19 I remember that intrigued me and I  
20 was interested in studying the mechanisms of  
21 metastases and the connection to scarring and  
22 other processes, and I became interested in  
23 this disease. It always stood out in my mind  
24 and in the literature's mind as a different  
25 kind of lung cancer, and I got involved in this

1 in the early '80s and the disease has always  
2 intrigued me in terms of its characteristics,  
3 its biology, its associations. It's a  
4 different kind of lung cancer, there's been a  
5 number of studies, experimental, anatomical,  
6 epidemiological, a number of studies on this  
7 particular tumor, although I will tell you that  
8 compared to other lung cancers, it hasn't been  
9 all that well-studied. There's much that we  
10 don't understand about his disease, and there's  
11 much that needs to be learned about it.

12 Q Okay. So what is the literature  
13 out there that says BAC is not smoking related?  
14 Do you have a listing of it, notes on it, the  
15 hard copies of it?

16 A Well, I brought some articles with  
17 me that advance positions that I may be called  
18 to address in my testimony, and some of these  
19 articles talk about BAC. Some are articles  
20 that I've written that I've -- studies that  
21 I've conducted. Some are studies that other  
22 people have written and conducted.

23 Q Do you agree with the dogma that  
24 was out there that BAC is scar-related, not  
25 tobacco related?

1           A       Many BACs are related to scars.  
2       That doesn't mean that scars are causing them  
3       That means they're seen in association with  
4       scars, they would arise out of scars, or they  
5       could be inducing those scars. I've been  
6       involved in those studies. The tumor has never  
7       had any pathological epidemiological support to  
8       link it to smoking in my opinion, pathological  
9       support.

10       Q       So that's a yes, you agree with  
11       the dogma?

12               MR. CARLTON: Objection.  
13       Misstates the testimony.

14               MR. PIUZE: Okay. I'll withdraw  
15       the question.

16       Q       I was taken by your use of the  
17       word "dogma." I thought it was said in a  
18       negative way, although maybe I was wrong.

19               Do you agree with what you have  
20       classified as dogma that was out there  
21       regarding BAC in 1985?

22       A       I refer to it as "dogma" because  
23       the way I use the term is a state of knowledge  
24       that exists in a given period of time. I  
25       didn't mean it to be negative, but we must

1 remember that nothing is ever static, that  
2 things are dynamic. As new evidence emerges,  
3 we change that. Some people do use the term  
4 "dogma" to mean something inflexible which has  
5 a negative connotation, I didn't mean that.

6 Q Okay.

7 A I was talking about what existed  
8 in the '80s and what attracted me to study the  
9 disease in the first place.

10 Q So today's dogma is different than  
11 the '85 dogma?

12 A Well, we know more about the  
13 disease today, although we still don't know  
14 what we need to know about it.

15 Q In '85 did you agree with that  
16 body of knowledge that you came across  
17 regarding BAC being scar-related in relation.  
18 The way I thought you were using it didn't  
19 necessarily mean the chicken was before the  
20 egg. It just meant there was a chicken. There  
21 was an egg. There was a scar. There was BAC.

22 A Well the dogma in the 1980s was  
23 the tumors were arising out a preexisting scar.  
24 I was bothered by that opinion based upon these  
25 tumors under the microscope. So I conducted

1 the study in the mid '80s the nature of the  
2 scar, the collagen types, and I found out that  
3 many of the BAC are inducing the scar rather  
4 than arising out of a preexisting scar. That's  
5 not saying that BAC can't arise from a scar.  
6 Certainly there are patient's scars in of the  
7 lung in which a tumor emerges. But obviously,  
8 I was bothered by the dogma that existed. I  
9 wanted to address it. I felt that it was a  
10 testable hypothesis and it had a reasonable  
11 chance that my hunch was correct. So in a  
12 sense, then, I disagreed with the dogma or I  
13 felt that maybe we should re-examine this state  
14 of our knowledge.

15 Q Has the -- has your then thought  
16 now become the mainstream thought in 2000 and  
17 2001 that scars don't necessarily preexist BAC?

18 A Well, you know, you've asked me to  
19 jump through a 15 year period. It's not real  
20 easy to do that the definition of BAC is under  
21 gone refinement. The new WHO classification  
22 says that if there's scarring there's lung  
23 destruction if there's lung destruction there's  
24 probably invasion or excuse owe invasion and by  
25 their new definition it's not defined by BAC.

1 Q New WHO -- the court reporter is  
2 wondering how to spell that.

3 A The new WHO stands for World  
4 Health Organization. And the new WHO  
5 classification means every so often the  
6 pathologists tend to revise their  
7 classification schemes, and the New WHO just  
8 refers to the most recent Who classification.

9 Q So saying that you brought it up  
10 and also because it's of overwhelming interest  
11 since 1958, how many times has the WHO changed  
12 the definition of this type of tumor?

13 A Well, you know, the tumor was  
14 first described by Libey and Malsey in the  
15 early part of the century or my part of the  
16 century and before. The WHO made a definition  
17 a decade or so ago and then has recently  
18 modified that.

19 Q Twice?

20 A Yes.

21 Q What's the definition?

22 A Well, now they define BAC as a  
23 pure BAC which doesn't invade. But curiously,  
24 that definition still excepts the fact that the  
25 septi or stroma of the lung is thickened. So

1 obviously, there's some interplay there between  
2 the malignant Type II pneumocyte and the  
3 stroma.

4 Q Well, I guess that's for you  
5 geniuses to figure out. But it also depends on  
6 your definition of "invade" then.

7 A Well, all the definitions are, you  
8 know, subjective. They're based on terminology  
9 and they -- they're based on what different  
10 people mean.

11 Q Well, do you like your definition?

12 A I don't particularly care for it,  
13 but I'm not necessarily troubled by it.

14 Q Do you have a definition?

15 A Well, BACs are a form of lung  
16 cancer. They kill people and they kill people  
17 through multiple mechanisms. They can arise in  
18 multiple sites in the lung. They can be  
19 multifocal. They can cause respiratory  
20 insufficiency. They can spread out through the  
21 lung through aerogenous spread.

22 Q Stop right there.

23 A They can spread through the lung.

24 Q Could you say all of those things  
25 about non BAC adenocarcinoma?

1           A       No. The things that I first  
2 mentioned about BAC are things that are  
3 characteristic of that disease.  
4           Q       Which?  
5           A       The fact that it tends to be  
6 multifocal, more so than any other cancer.  
7 More so than any other cancer it can present  
8 with the same mass and then metachronously, it  
9 can present with different nodules.  
10          Q       Say that world again?  
11          A       Metachronously.  
12          Q       Metachronously?  
13          A       It means a second tumor nodule  
14 that is detected at a later point in time.  
15          Q       Okay.  
16          A       I also said the disease can  
17 manifest diffuse involvements in the lung. It  
18 can spread throughout the lung. It can fill a  
19 whole lobe of the lung. In both matters, it  
20 can kill people. Now, when pathologists use  
21 the term "noninvasive," that's usually a term  
22 that's applied to benign lesions or  
23 premalignant lesions, not malignancy. It's not  
24 cancers that kill people. So in the sense the  
25 definition of the WHO, that the BAC is

1 noninvasive is implying that it's not a cancer,  
2 and as I just told you, it is a cancer in the  
3 true sense of the word. The BAC can also  
4 metastasize. It can spread throughout the lung  
5 through other regional lymph nodes to other  
6 sites as it has done in this case. That's not  
7 a mark of a noninvasive cancer. They have  
8 designed BAC to refer to those cases that do  
9 not invade the stroma of the lung, but as I  
10 just said the stroma is often altered. In  
11 fact, it's a requirement that if be altered to  
12 distinguish adeno from bronchioloalveolar  
13 hyperplasia. That's why I said I had trouble  
14 with the definition, but I can incorporate it.  
15 I always try to list the components of that are  
16 present in the tumor. Rather than saying the  
17 tumor is an adeno or it's a non-BAC, it's  
18 better to be accurate pf what one sees.

19 Q I forget whether this was asked,  
20 and if so, the answer.

21 Did you write a report?

22 A I've taken notes based on the  
23 review of these medical records, and the  
24 pathology that I reviewed, and these are my  
25 notes. I guess you can call that a report.

1 Q When was that created?  
2 A I created it in the past week.  
3 Q Do you have an opinion over  
4 there -- could you write 3 on the upper  
5 right-hand corner.

6 (The document referred to was  
7 marked by the C. S. R. as Plaintiff's  
8 Exhibit 3 for identification and was  
9 attached to and made part of this  
10 deposition.)

11 BY MR. PIUZE:

12 Q How many pages are your notes  
13 slash report?

14 A Three.

15 Q Just go ahead and write 3.

16 When did you -- when, where and to  
17 whom did you relay your authorities after  
18 looking at the slides about what you thought  
19 you saw?

20 A Well, when Chris Johnson brought  
21 the slides to me, I looked at them in his  
22 presence. The case was an obvious  
23 bronchioloalveolar lung cancer. It had areas  
24 of papillary adeno. It had presence of  
25 D-differentiation and the presence was in the

1 lymph nodes. They looked like mucinous  
2 adenocarcinoma.  
3 Q That was present in the lymph  
4 nodes?  
5 A The metastases.  
6 Q Okay.  
7 A And I related this all to  
8 Mr. Johnson.  
9 Q Okay. How long did it take to you  
10 to look at those 15 slides and come up with the  
11 obvious?  
12 A Well, I looked at them very  
13 quickly initially, and then I spent more time  
14 with them. I spent an hour initially, but I  
15 gave him my opinion fairly quickly. I told him  
16 the obvious.  
17 Q Meaning?  
18 A I told him it was a BAC.  
19 Q No. I mean "fairly quickly,"  
20 meaning 3 minutes?  
21 A 10 to 15 minutes, I'd say.  
22 Q Excellent, okay. And did you have  
23 a chance to look at all 15 of the slides before  
24 you gave that opinion?  
25 A Well, as I was looking at each

1 slide, I was talking out loud so --  
2 Q All right.  
3 A So that means my opinion was  
4 ongoing.  
5 Q Right.  
6 A I wasn't silent, like I didn't say  
7 stop. Let me contemplate on this case, and  
8 then I'll speak. He was in the room and I was  
9 sharing my thoughts with him  
10 Q At the end of the 15 minutes when  
11 you finished sharing your thoughts, had you  
12 looked at all the slides?  
13 A Yes.  
14 Q Excellent. Okay. Now, let's do  
15 something a little more general here. I've  
16 talked to for machine yes -- for money in other  
17 words for money in other words paying to you.  
18 I've talked to many of the defense witnesses,  
19 case specific witnesses, radiologists,  
20 pulmonologists, oncologists, pathologists.  
21 There may be others that I can't even remember.  
22 What -- whose job is it as far as the medical  
23 specialty is concerned to diagnosis the tumor,  
24 This is an A, this is a B this is a C, whatever  
25 it happens to be. Whose job is that?

1           A       It's the job of the pathologist or  
2 the anatomic pathologist.  
3           Q       Why do you use the word  
4 differentiate in your answer?  
5           A       Well I wasn't differentiating. I  
6 was more precisely subclassifying. I was  
7 saying that pathology was a branch of medicine  
8 that had different differentiations, anatomical  
9 clinical, experimental, and I was further  
10 defining my answer to your question.  
11          Q       Good. can -- withdraw that.  
12                    In your clinical practice, do you  
13 sometimes get visits either orally, by phone or  
14 in person, by let's say for the sake of  
15 argument, an oncologist who says, "I want to  
16 give you my two cents about what kind of cancer  
17 this really is, what kind of tumor this really  
18 is"?  
19          A       All the time.  
20          Q       Okay. And does that imply that  
21 there's some disagreement between that person  
22 and you?  
23          A       Well, you know, I deal with  
24 surgical oncologists. I deal with medical  
25 oncologists. These people -- these doctors who

1 are taking care of the patient have formed a  
2 clinical impression of the disease. But they  
3 don't really know for sure what they're dealing  
4 with because if they did, they wouldn't have to  
5 biopsy it.

6 Q They wouldn't what?

7 A They wouldn't have to biopsy it.  
8 But they have their clinical impression, their  
9 clinical biases, if you will. One of the jobs  
10 of a pathologist who is experienced is to look  
11 at the case obviously and not be influenced by  
12 the clinical bias or by what someone else  
13 thinks. That's something that occurs among my  
14 junior colleagues because, you know, you have  
15 to render your opinion based on what you see  
16 under the microscope. You use the clinical  
17 information. That's important to formulate  
18 questions in your mind but the answers that  
19 you're called to give depend on what your  
20 interpretations of the slides are. That's what  
21 your specialty is. That's what your experience  
22 is.

23 Q And tell me about your junior  
24 associates. I didn't quite follow that. They  
25 sometimes get influenced romanced overwhelmed

1 or something like that by the clinicians?  
2 A They get pressured by the clinical  
3 impression of the case.  
4 Q Okay.  
5 A To find somebody or to go along  
6 with that impression.  
7 Q Who's -- okay got it.  
8 So how does -- how did -- let's  
9 leave your juniors out, Jr. colleagues out and  
10 just talk about you. Just describe how it  
11 would occur typically where one of the treating  
12 doctors comes to you to give you a piece of his  
13 or her mind -- and I don't mean that in a  
14 negative way?  
15 A Well, we had a case recently that  
16 I recall quite vividly. It wasn't a lung  
17 cancer. It was a prostate cancer case, and it  
18 was biopsied. He had a high PSA and  
19 subsequently the prostate was re-biopsied and  
20 all of the clinical oncologists felt this  
21 patient had a cancer and they felt the  
22 oncologist was classified. But there was no  
23 cancer there and under the microscope, there  
24 was no evidence of cancer there. It was an  
25 example of a false positive PSA bene. Now. In

1 that situation, a junior, less experienced or  
2 inexperienced pathologist might feel a sense of  
3 pressure to diagnosis what the clinical  
4 impression was, and that's what I'm talking  
5 about.

6 Q Okay. Could you -- when you can  
7 actually remember such an event or not can you  
8 give me a similar example as it might relate to  
9 lung cancer?

10 A Yes.

11 Q Shoot.

12 A There are a number of cases that I  
13 can think of where the surgeon felt a patient  
14 had a malignant lung cancer -- I guess that's  
15 redundant -- a malignant lung tumor or a  
16 cancer, removed a section, and it turned out it  
17 wasn't malignant. It was an infarct or it was  
18 one of these inflamed pseudotumors. That's an  
19 area you have to be objective under of the  
20 microscope. You can't be influenced by the  
21 clinical impression.

22 Q Thank you. Now, let's narrow it  
23 down. Let's just assume that there's cancer in  
24 the lung, no one doubts that there's cancer in  
25 the lung. Can you think of an occasion where

1 one of the treating doctors may come to you to  
2 be discussing whether or not it's a BAC or a  
3 partnership I will airplane yes adeno or a  
4 small cell or whatever, can you think of those  
5 discussions?  
6 A Yes.  
7 Q How would those work?  
8 A Well, as I said earlier in one of  
9 the questions, BAC has some characteristic  
10 gross features or clinical features. It's  
11 usually peripheral. It can pucker the pleura  
12 in a solitary form It may be associated with  
13 a scar. A clinician can appreciate this. They  
14 may say I think this case is a BAC or because  
15 of the lack of those findings the clinician may  
16 say I don't think this is a BAC.  
17 Q I'm sorry to interrupt you, but  
18 where would the clinician even know that the  
19 pathologist maybe even had a different thought  
20 about it?  
21 A No. I'm just commenting on the  
22 clinical impression. This is before the  
23 pathology is studied or analyzed.  
24 Q Well, before the pathology is  
25 studied or analyzed there would be no reason

1 for the clinician to come do you know and talk  
2 to you correct?  
3 A That's correct.  
4 Q Maybe in is a situation that  
5 doesn't exist I don't know that's why I'm  
6 asking these questions but you know the bottom  
7 line is do you sometimes get into discussions  
8 with the clinical doctor when it's medical  
9 oncology or when it's a surgeon or whether it's  
10 a pulmonologist about what that slides really  
11 shows?  
12 A All the time and I'm trying to  
13 answer your question clinicians often form  
14 clinical impressions and in fact, I know what  
15 those clinical impressions are. And I make if  
16 a points of facts when I look at a slide and I  
17 find something that's incongruent or different  
18 from that clinical impression I will calm them  
19 and I will discuss the case with them before  
20 they will discuss it with me because I'm  
21 preparing them for my findings.  
22 Q Well, what about Mr. Boekin's  
23 case? Did he present with the type of  
24 complaints that are typically associated with  
25 BAC?

1           A       Atypical BAC is discovered  
2       incidentally on a chest X ray. The typical BAC  
3       patient does not have clinical complaints. He  
4       had cough. He had productive sputum. I think  
5       there's a notation in the chart he just wasn't  
6       feeling well, and the doctor taking care of him  
7       thought, well, he was having an exacerbation of  
8       his bronchitis or maybe he had an pneumonia or  
9       something like that. And then did an X-ray and  
10      a CT scan and then we found the mass. So his  
11      impression was more than the typical BAC, but  
12      you have to keep in mind that when he  
13      presented, he already had metastasis. He  
14      already had deviated components. I think his  
15      cough was due to the enlarged in its  
16      paratrachea. He had a cough causing the sputum  
17      and causing the pneumonia in the lung. So his  
18      presentation was slightly advanced for the  
19      typical BAC, which tends to be silent.

20           Q       Well, a typical BAC tends not to  
21      be a tumor on presentation, does it?

22           A       Oh, it's a tumor. I mean, it's  
23      asymptomatic, but on chest X-ray there's a mass  
24      on CT scans. There is a mass, and it's seen.

25           Q       What about the size of this mass

1 in Mr. Boekin's case? What does that show in  
2 the presence of BAC?

3 A I think the size supports the  
4 diagnosis of BAC. It was a small tumor. It  
5 was only 1.5 centimeters in size. The  
6 interesting thing it metastasized to the lymph  
7 nodes both in the mediastinum as well as the  
8 hilum BAC tends to be small. I'm not talking  
9 about the diffuse form, the multifocal, but  
10 this was a BAC that D-differentiated and the D  
11 differentiation is what metastasized the lymph  
12 node doesn't look like the BAC. It doesn't  
13 look anything like the BAC. That fits the  
14 concept that this is a BAC that's small, that  
15 D-differentiated and the D-differentiated  
16 portion is what spread so the nodes and  
17 ultimately the other parts where his body.

18 Q Let's go to your articles. Do you  
19 have your articles here?

20 A Yes. The ones I've written?

21 Q Yeah on this subjects.

22 A Yeah, they're amongst these.

23 Q Could we differentiate them?

24 A Sure.

25 Q Go ahead. Which ones are yours?

1           A       These.  
2           Q       Hang on one second. Do you want  
3 to step out? There's no protective order.  
4                    Could we burn a nickel at the next  
5 break and call down to the court at the next  
6 break and find out what we're supposed to do  
7 cause I heard that someone called here for  
8 something, but I don't know what do I have? I  
9 have got yours or non yours?  
10          A       Mine.  
11                 MR. CARLTON: F we don't take a  
12 break now, I don't think they're going to be  
13 there.  
14                 MR. PIUZE: We're taking break  
15 now.  
16                    (Recess taken.)  
17 BY MR. PIUZE:  
18          Q       In Dr. Feingold's report, he  
19 mentions a pathologist who took a look at the  
20 slides down in Miami. Do you recall that?  
21          A       Yes.  
22          Q       Name of the pathologist, do you  
23 recall that name?  
24          A       No, I don't recall that name.  
25          Q       Did you know the name?

1           A       No.  
2           Q       What -- before we go got articles,  
3 would you call yourself a certain -- withdraw  
4 that.  
5                    Do some pathologists specialize in  
6 some parts of the body?  
7           A       Yes.  
8           Q       Do you?  
9           A       Yes.  
10          Q       What?  
11                    THE WITNESS: You know she just  
12 asked me that question.  
13 BY MR. PIUZE:  
14          Q       That was a good question. She's  
15 in trying to become a trial lawyer?  
16          A       I study anatomically in breast  
17 cancer and in language cancer strictly BAC -- I  
18 also specialize experimental in metastasis and  
19 especially in the metastasis of breast cancer  
20 besides BAC.  
21          Q       So what was the other choice  
22 besides experimental?  
23          A       I what said there was a clinical  
24 anatomically and experimental.  
25          Q       As far as you're concerned

1 clinical and experimental?  
2 A And anatomical.  
3 Q Didn't you just use two of those  
4 just now in your answer?  
5 A Yes.  
6 Q Which two?  
7 A Anatomical and experimental.  
8 Q Okay. What percentage of your  
9 time do you spend on each?  
10 A I spend about 50 percent of time  
11 doing research, that's experimental. About 40  
12 percent of my time diagnostic or anatomical.  
13 Q And?  
14 A 10 percent of my time teaching.  
15 Q Let's stick with the research.  
16 How many of your time is devoted to breast  
17 cancer; how much of your time is devoted to  
18 other?  
19 A I study mechanisms of metastasis  
20 predominantly. That's the overlying theme in  
21 the focus of my research. I study breast  
22 cancer probably 75 percent to 80 percent of the  
23 time dedicated to research and I study lung  
24 cancer BAC probably 10 to 15 percent of that  
25 time.

1 Q Devoted to research?  
2 A Correct.  
3 Q Then, into anatomical is it?  
4 A Yes.  
5 Q What percentage of your time is  
6 breast cancer?  
7 A Probably 80 to 90 percent.  
8 Q Is there such a thing as a  
9 pulmonary pathologists?  
10 A Yes.  
11 Q Are you?  
12 A Well, I don't do pulmonary  
13 pathology exclusively. Most pulmonary  
14 pathologists define themselves as those  
15 pathologists who do it exclusively. Since I  
16 don't do it exclusively, I wouldn't fit that  
17 definition. Over at UCLA, I review most of the  
18 pulmonary pathology, and I see most of the lung  
19 cancers. And BAC cancers are shown to me.  
20 So from the standpoint of what I  
21 do, I do diagnostic pulmonary pathology and I  
22 also have three grants to study BAC. But from  
23 the traditional and conventional definition of  
24 conventional pulmonary pathology. Those people  
25 do full-time diagnostic work in pulmonary

1 pathology.  
2 Q Is there a pulmonary pathologist  
3 at UCLA?  
4 A No, well, I'm the closest thing to  
5 it.  
6 Q Who provided the grants for the  
7 research to study BAC?  
8 A One was the Margaret Early  
9 Foundation. They're a granting agency in the  
10 Los Angeles area.  
11 Q Where do they get their money?  
12 A I think they get it from  
13 an -- they have a sum of money that their  
14 founders invested and they live off the  
15 interest. It's like an endowment.  
16 Q It's their own money. They're a  
17 clearing house for third and fourth and fifth  
18 party houses that run through them?  
19 A I don't know. It's a competition.  
20 It's peer reviewed. It's reviewed by  
21 scientific people and they give out money. I  
22 think it's a sum of money that their founders  
23 endowed.  
24 Q Next?  
25 A Next is the Nickel Family

1 Foundation. They're another private endowment  
2 in the Los Angeles area, and I think one of the  
3 members of the family had a bronchioloalveolar  
4 lung cancer. And when they found out I was  
5 studying the disease, they gave me a grant.  
6 The third is the UC Tobacco  
7 Disease Related Research Foundation and it is  
8 founded based on the taxes in California from  
9 cigarettes. This is a peer-review agency that  
10 authorizes grants on the different cancers from  
11 the lung. Some may be tobacco-related. Some  
12 may not be. But the central thing is lung  
13 cancer.

14 Q How many slides -- tell me how  
15 many people donate tissue, lung tissue that you  
16 look the in an average, day, month, week, year,  
17 however you want to give it to me?

18 A I'm a little --

19 Q Not breast tissue the lung tissue?

20 A Well, I'm confused by your  
21 question. You say donates tissue as if they  
22 had a choice of it.

23 Q No, provide. Forgive the word.  
24 Provide.

25 A A number of indications of lung

1 cancer that we're seeing at UCLA is decrease  
2 asking I think that's because of managed care  
3 and HMOs that require patients to go to certain  
4 centers we used to see a lot more than we  
5 currently see but I would say in the average  
6 week I see five to 10 cases of lung cancer.

7 Q And how long has that been the  
8 approximate range?

9 A The past year or so, a couple  
10 years.

11 Q Let's go back more than a couple  
12 years. Let's go back five years and ten years.  
13 So if we get back between, for the sake of  
14 argument, 1991 and 1996, just that cuff area --  
15 I don't care about the individual years -- how  
16 many would you see per week?

17 A Well. There are more patients at  
18 UCLA with lung cancer. But there's another  
19 confounding issue, and that is in that time  
20 span, in that era, we were on a general  
21 sign-out system where I would not just be back  
22 looking at breast and lung. I would be looking  
23 at everything, and every pathologist would be  
24 sharing in everything. So I would do less  
25 breast and less lung. So even though there

1 were more cases, I would probably see less a  
2 number.  
3                   Some of my studies involved a  
4 review of cases. So I have reviewed cases that  
5 I've seen in the past. So that means I've  
6 reviewed these cases. So that adds to the  
7 total. But they're not active patients coming  
8 in for the first time.  
9           Q        Seen where, at UCLA?  
10          A        Yes.  
11          Q        And what percentage of the lung  
12 cancer cases -- let me withdraw that.  
13                    When you're looking at specimens  
14 from someone's chest, lungs, is it always  
15 cancer that you're seeing?  
16          A        No.  
17          Q        How often, of the five or 10 per  
18 week, how many of those is cancer?  
19          A        Oh, no, those are cancers. If you  
20 had asked me how many lung cancers I've seen,  
21 I've seen pulmonary pathology that's not lung  
22 cancers, probably another five to ten cases.  
23          Q        Let's stick with the cancers, five  
24 to ten per week?  
25          A        (No audible response).

1 Q So we're talking 250 to 500 a  
2 year, sounds about right?  
3 A I'm also though -- I share duties  
4 on the service with another pathologists so I'm  
5 only on 50, 60 percent of the time.  
6 Q So a hundred and 25 to 250 a year,  
7 does that sounds roughly right?  
8 A Yeah. I think we're in the  
9 ballpark there.  
10 Q How many of those are -- do you  
11 diagnose as BAC?  
12 A Probably between 20 and 25  
13 percent.  
14 Q How long has that been the case?  
15 A It's been the case for the past  
16 five or so years. Now, these are not all pure  
17 BACs, but they have a BAC component, about 20,  
18 25 percent that I quoted.  
19 Q What about -- okay, well  
20 before -- just so I don't forget, how many are  
21 pure BACs?  
22 A I would say probably a third --  
23 probably a third of that.  
24 Q A third of the 25 percent?  
25 A Correct.

1 Q In a situation -- is Mr. Boeken's  
2 pure BAC?  
3 A No.  
4 Q What is his?  
5 A It's predominantly BAC, but as  
6 I've said before, it has areas of  
7 D-differentiation that are best characterized  
8 as a papillary adeno and he has metastatic  
9 disease in his lymph nodes that look like  
10 signet ring.  
11 Q You did say that.  
12 What happens when you have a mixed  
13 tumor? Do you call them a predominant  
14 one-strain type?  
15 A Well, you know, there's a general  
16 rule in pulmonary pathology and all of  
17 pathology that we tend to call the predominant  
18 pattern. We give a name to that almost all  
19 lung cancer -- almost all lung cancer is not  
20 pure. It's letter owe genius it's mixed so  
21 friction in you have a squamous cell cancer.  
22 You may have some adeno areas. You may have  
23 some areas we tend to call the predominant  
24 area. I don't like that I if I it's more  
25 accurate to simply list the components that

1 make it up so I don't get caught up in that so  
2 I can fraud when the WHO or someone else tends  
3 to be re define their diagnostic term

4 When I list the components, I'm  
5 not making any judgments. I'm saying this is  
6 what I see. There's BAC. There's non-BAC,  
7 whatever, and to me, that's the most accurate  
8 way of doing it.

9 Q When you list them, do you list  
10 them in the order of what?

11 A Well, it depends on the  
12 composition. If there's a small large cell  
13 cancer I'll start business saying small mix,  
14 small cell, large cell. If it's a mixed cell,  
15 it's squamous. I might start crediting the  
16 predominant. I might say it's squamous with  
17 adeno. With the BAC I start with the BAC  
18 because I believe the tumor begins with the BAC  
19 and D-differentiates into the mix or whatever  
20 the differentiation is. So based on those  
21 pictures my diagnosis is in a certain orders so  
22 the person reading the diagnosis can understand  
23 my thoughts processes.

24 Q If you had your theoretical tumor  
25 that was 10 percent BAC, 90 percent other,

1 you'd start with BAC?  
2 A Yes I would but I would make a  
3 point of emphasizing that it had a large  
4 D-differentiated components. I mean I would  
5 say 10 percent is BAC and 90 percent is a large  
6 and other differentiated.  
7 Q In all other situations. Meaning  
8 when there's no BAC present, would you always  
9 list the largest component first?  
10 A No as I stated in the mixed small  
11 large cell, since that's sorts of analogous to  
12 the BAC issue. Small cells can change as they  
13 grow. I'll start with the small cell component  
14 first regardless of the percentage. But for  
15 the non small cell tumors that are mixed I  
16 usually will start with the largest component,  
17 but again, the way I diagnosis things, I just  
18 write the percentage of the components that are  
19 present. So the order then doesn't really  
20 matter.  
21 Q So this case, what are the  
22 percentages?  
23 A Oh, I think 80 to 90 percent to me  
24 looks like a BAC. So I would say  
25 bronchioloalveolar lung carcinoma. I would

1 subtype it. It looks non-mucinous. It looks  
2 like a solitary mass, so it's not diffuse.  
3 It's solitary and then it has areas of  
4 papillary adeno. It has these papillary areas  
5 that I've tried to show in my photographs, and  
6 then as I tried to denote today, in the lymph  
7 nodes, metastasis. It doesn't look at all like  
8 a BAC. It looks like an adenocarcinoma  
9 signorina cell.

10 Q What is it having said all of that  
11 if you put yourself in Dr. Geller's head that  
12 you think -- once you got in his head, you  
13 thought that he believed what?

14 A Well, I want to again clarify that  
15 I can't really put myself in his head but if  
16 you push me to come up with might be going on,  
17 I don't think in his mind he thought it was a  
18 big distinction between what he wrote on the  
19 permanent final diagnosis and what he wrote on  
20 the frozen because if he thoughts this was a  
21 difference of substance rather than a  
22 difference of new's, he would have  
23 written -- he would have been compelled as a  
24 boards certified competent pathologist that he  
25 is he would be compelled to write an

1 explanation for the difference. We're required  
2 by quality assurance to always explain whether  
3 a frozen section is different from the  
4 permanent.

5 Q We at UCLA or we pathologists  
6 throughout the world?

7 A I think that's a standard  
8 throughout the United States. He didn't he  
9 made a diagnosis of papillary adeno but I made  
10 a diagnosis of BAC so in his mind I would  
11 guess -- he thoughts that was a difference of  
12 new's rather than substance.

13 Q Well is it?

14 A If there tumor were a pure BAC,  
15 versus a pure partnership I will air yes adeno  
16 it would be a difference that would be  
17 substantial but this tumor is mixed and it's  
18 predominantly BAC but it does have areas of  
19 papillary adeno.

20 Q So leaving the poor guy that has  
21 to explain this to the jury, can't help  
22 wondering why it's 90 percent BAC why they  
23 didn't make it into a new diagnosis?

24 A Well, the pure clarification says  
25 that if the new tumor is not BAC, you basically

1 emphasize the non BAC areas. You basically  
2 say -- dr. Geller left that out perhaps because  
3 it was already mentioned in the frozen. He did  
4 not write that the frozen section was incorrect  
5 that this was wrong that we were mistaken he  
6 left it in so the way I read that is he  
7 diagnosed papillary adeno because that's what  
8 the WHO says to do and he didn't say with BAC  
9 areas because he's already written that in the  
10 frozen section. That's what I think happened  
11 but again I can't shall sure I can't be inside  
12 his heads.

13 Q Let's jump to Dr. Hammer. Even if  
14 you can't be inside of his head, you can be  
15 inside of his depo, which you read, correct?

16 A Correct.

17 Q What was his explanation for the  
18 slides?

19 A Well I recall Dr. Hammer seeing  
20 that there was BAC areas in the tumor and he  
21 talked affidavit length about the new WHO  
22 classification and he employed it.

23 Q That was your read?

24 A Yes.

25 Q Let's go a step further.

1 Causation. What was your read there?  
2 A By Dr. Geller or Dr. Hammer.  
3 Q Well Dr. Geller didn't mention  
4 causation did he?  
5 A No he didn't.  
6 Q Therefore?  
7 A Dr. Hammer seemed to be of the  
8 opinion that all lung cancers are associated  
9 with smoking.  
10 Q Did he say that?  
11 A That was the impression I got from  
12 reading his deposition.  
13 Q I know. But did he say that?  
14 A Well, again, you know you're  
15 asking me to comments on my reading of his  
16 deposition entirely and without focusing on any  
17 specific statements that he said, I came away  
18 with his belief that this cancer was linked to  
19 smoke asking that BACs are linked to smoking  
20 and papillary adenos are linked to smoking and  
21 that all lung cancers are linked to smoking.  
22 Q Was there a time within -- let's  
23 see. Tell me the year you started practicing  
24 medicine.  
25 A Well, that depends what you define

1 as "practicing medicine."  
2 Q Tell me the year that you -- when  
3 can you get a license in this state, your  
4 second year of residency?  
5 A Well, I was in Massachusetts at  
6 the time, and when you finish your internship,  
7 you can get a medical license. But I didn't  
8 practice medicine at the time I was doing a  
9 pathology residency. So that was the problem  
10 I had a problem with your question.  
11 Q What year was that?  
12 A It was 1975.  
13 Q Did there used to be a lot less  
14 adenocarcinoma diagnosed in '75 than now?  
15 A Yes.  
16 Q By what factor?  
17 A Well, you know, I did a study that  
18 looked at that question in our UCLA population,  
19 but that was -- that's been addressed by  
20 numerous different studies, some of which are  
21 included in my list there. Adenocarcinomas,  
22 both non-BAC, adenos mixed, and pure BACs have  
23 risen dramatically by probably, I would say,  
24 five-fold.  
25 Q Is it possibly to separate that

1 out, in other words, over the course of the  
2 last quarter decade, now that you've been  
3 paying attention -- that's a true statement  
4 that you've been paying attention to those  
5 issues for 25 years now, correct?  
6 A I wouldn't say that was accurate.  
7 When I was a resident in pathology I wasn't  
8 paying attention to learning lung cancer. When  
9 I was, I was focusing on the issue of  
10 pathology. But when I became interested in BAC  
11 in the mid '80s, I would say from that point on  
12 and certainly in the '90s, I've become  
13 interested in the question.  
14 Q Having been interested in the  
15 question, you've looked retrospectively  
16 backwards?  
17 A Yes.  
18 Q How far?  
19 A Well UC, we went all the way back  
20 to when the hospital was first formed in the  
21 '50s.  
22 Q When you told me about a five-fold  
23 increase in adenocarcinoma, that would be from  
24 when to when?  
25 A Probably from the '50s to the

1 '90s.

2 Q Okay. Is that still going on  
3 right now?

4 A I haven't looked at it per se in  
5 the last part of this decade, but the  
6 adenocarcinomas are clearly the  
7 predominant-type we see, and BAC is a part of  
8 that.

9 Q Did it used to be thought that  
10 even into the '70s, that adenocarcinoma was  
11 less likely to be linked with smoking than, for  
12 example, small cell?

13 A Yes. The classic case control  
14 studies and the covert studies that began in  
15 the '50s that were carried into the early '60s  
16 made the observation that certain cell types  
17 were linked to smoking in terms of relative  
18 risk, and they were squamouscell and small  
19 cell. The adeno cell and large cell didn't  
20 have as compelling an epidemiological link in  
21 that period of time.

22 Q With the passage of time, that's  
23 changed, hasn't it?

24 A There's been an increase, as I  
25 stated, in adenocarcinomas and BAC. But if you

1 look carefully at the increase, you find the  
2 increase in both smokers and nonsmokers.

3 Q Well, excuse me. So far I'm not  
4 talking about -- I'm not talking about  
5 causation. I'm just talking about the  
6 increase. I thought I was only talking about  
7 the increase in adenocarcinoma or whatever.  
8 That's what I want to talk about.

9 A As we said earlier in the  
10 deposition, adenocarcinoma includes BAC as well  
11 as non-BAC. So I'm lumping the two together.  
12 There's an increase in adeno that has increased  
13 over the last several decades. I'm saying that  
14 increase has increased in smokers as well as  
15 nonsmokers to characterize the population that  
16 has been at risk for this increase.

17 Q Okay. Over the course of the last  
18 30 or 40 years now, most people believe there  
19 is a greater link between adenocarcinoma and  
20 tobacco than was felt to exist 20 or 30 years  
21 ago, correct?

22 A That's a difficult question to  
23 address. Certainly. There's more  
24 adenocarcinomas in nonsmokers as well as  
25 smokers. So that raises issue to explain the

1 reason for this increase. If smoking was the  
2 only explanation, you would expect adeno to go  
3 up in the smokers and adeno to stay the same in  
4 the nonsmokers.

5 Q That may be, and I think you might  
6 have said that or something like it three  
7 times. But that still doesn't answer the  
8 question.

9 The question is simply now, as  
10 compared with 20 or 30 years ago, don't most  
11 people in the medical field that deal with lung  
12 cancer believe that there is a link between  
13 smoking and adenocarcinoma as opposed to 20 or  
14 30 years ago?

15 A There have been some new emerging  
16 studies that have been published in the Journal  
17 of the National Cancer Institute that have  
18 shown a higher risk with the development of  
19 smoking with respect to adeno than existed in  
20 the '50s and '60s.

21 Q For the sake of argument, in the  
22 '50s or '60s, would you be in the position to  
23 say that X percent of adenocarcinomas were  
24 linked to smoking? Could you tell me that?

25 A The percentage was low. The link

1 was there, but it wasn't a convincing link in  
2 terms of epidemiological causation.

3 Q Can you give me a range of numbers  
4 for "low"?

5 A Well, the relative risk for  
6 adenocarcinoma was much lower than it was for  
7 squamouscell and small cell. I think various  
8 studies ranged from slightly in the ones to  
9 twos to threes, in that range.

10 Q One of the Defendant Phillip  
11 Morris's clinical experts within the past week  
12 said something like now and days, it's believed  
13 that 75 to 90 percent of adenocarcinomas are  
14 smoking related. I think -- I'm pretty sure he  
15 said that. Does that sound right to you?

16 Weintraub.

17 A I would refine that, and I would  
18 say those numbers are accurate. But I would  
19 use the term "are observed in smokers." 60 to  
20 70 percent of adeno are observed in smokers,  
21 are seen in patients or people who smoke  
22 cigarettes.

23 Q Okay. So you don't agree with the  
24 numbers. You think it's 60 or 70 percent?

25 A I thought that's what you just

1 mentioned.  
2 Q No. I said 75 to 90.  
3 A Oh, I think the numbers change  
4 with sex. I think females have a less strong  
5 association than males. I don't think we  
6 differ significantly. I put those numbers a  
7 little less. I thought you said 75 to 80.  
8 Maybe I was projecting what I thought.  
9 Q Well, I'm putting to you 75 to 90,  
10 and I'll even give you a male only, just to  
11 move it along. I don't care if you agree or  
12 disagree. I just want to hear what you have to  
13 say.  
14 A I'm close to agreement. I would  
15 put it at 75 or 80.  
16 Q Now, it's also correct -- so this  
17 is a -- let me just back up a second -- a  
18 two-step-process: One, there's a lot more  
19 adenocarcinoma being diagnosed now than  
20 previously, correct?  
21 A Correct.  
22 Q And two, the link between  
23 adenocarcinoma and smoking has become stronger  
24 with the passage of time. We're talking about  
25 going 30, 40 years, true?

1           A       True. But I want to caution you  
2 that there are different types of  
3 adenocarcinoma in terms of the lung. There's  
4 central ones, there's peripheral ones, there's  
5 scar. Most of them don't necessarily break the  
6 anatomical distribution down to answer the  
7 question what specific kinds of adenos. The  
8 other question, most studies of this nature  
9 don't break down the distinction between BAC  
10 and non-BAC because they both contribute to the  
11 process of adenocarcinoma.

12           Q       But I'm not going to do a study,  
13 but I'm going to just ask. Adenocarcinoma  
14 generally has become a much more frequent  
15 diagnosis with the passage of time, over 30 or  
16 40 years; the same is true of BAC, correct?

17           A       Yes.

18           Q       Going back -- and even now you  
19 weren't interested at the time, but you've  
20 studied backwards. Now going back 30 or 40  
21 years, what was the thought about BAC and  
22 tobacco? How often was it observed in smokers  
23 versus nonsmokers?

24           A       Well, the thought was that it  
25 wasn't related to smoke. It was a tumor of the

1 lung that wasn't -- that was different than the  
2 other -- than many of the other types of lung  
3 cancer.

4 Q Well, how is that different. If  
5 it is, from what you already said about  
6 adenocarcinoma in general?

7 A Well, there was a stronger link to  
8 adenocarcinoma than there was to BAC.

9 Q So the stronger link being 3 to 4  
10 percent?

11 A I'm sorry, I don't follow that  
12 question.

13 Q I thought you told me that going  
14 back 30 or 40 years, it was thought that maybe  
15 3 or 4 percent of adenocarcinomas were caused  
16 by tobacco. Didn't you say that?

17 A No. I didn't say that. I was  
18 saying "relative risk." You asked me  
19 epidemiologically, what the relative risk was,  
20 and I said the relative risk was between 1 or  
21 2, as a relative risk, and probably 4.

22 Q Define "relative risk."

23 A Relative risk is if you take two  
24 groups of patients, one of which has an  
25 exposure and one of which doesn't. In this

1 case, it would be cigarette smoking, what is  
2 the increased observation of the disease in  
3 this case. It would be lung cancer in the  
4 population exposed versus the unexposed  
5 population.  
6 Q So going back 30 to 40 years, it  
7 was thought that smokers were between one and  
8 two and three and four as likely to have  
9 adenocarcinoma, correct?  
10 A Correct.  
11 Q And couple up to modern times,  
12 that two or three or four risk factor has  
13 become what now and days?  
14 A It's become more significant in  
15 recent studies.  
16 Q Why?  
17 A I've seen various reports over  
18 five, six, seven, et cetera.  
19 Q What did you say after seven?  
20 A I said over five, six, seven,  
21 et cetera.  
22 Q What is the et cetera?  
23 A Well, it just means in that range.  
24 Q Five to seven?  
25 A Yes.

1 Q Times as likely?  
2 A Yes.  
3 Q Okay. Let's do the same type of  
4 thing with BAC. Was there a relative risk  
5 factor that was even used with BAC 30 or 40  
6 years ago?  
7 A In the -- in the '50s and '60s,  
8 cohort studies which singe the epidemiological  
9 link of the lung cancers to smoking. I don't  
10 remember the epidemic of BAC in this setting.  
11 Q Okay. Since then?  
12 A There are two points that we needs  
13 to make before we directly address that. Mbst  
14 of the recent studies have been what we call  
15 "case control studies." They're retrospective  
16 studies looking at a given disease and  
17 exposure. The strength of the '50s and '60s  
18 studies is that they were forward, longitudinal  
19 studies that were called "cohort studies,"  
20 rather than controlled studies.  
21 Q Prospective?  
22 A Mbst epidemiological studies told  
23 me that the retrospective, controlled studies  
24 are controlled by a bias. Mbst of these  
25 studies they have been retrospective,

1 controlled studies. There have been a few  
2 cases in that nature dealing with BAC, but  
3 there are, to my knowledge, no prospective,  
4 forward-looking studies viewing an increased  
5 risk in BAC and I find this relative of BAC,  
6 this whole relative risk, applies to  
7 populations. They don't apply to any  
8 individual. If you smoked, it would not be  
9 appropriate for me to say you have a higher  
10 risk than I do to get lung cancer.

11 Q Did you smoke?

12 A No.

13 Q Did I?

14 A I just met you today. How would I  
15 know?

16 Q Well, there are many ways.

17 A I'm not clear of a way. I can't  
18 read your mind. I don't know if you ever  
19 smoked.

20 Q That wasn't one of the choices. I  
21 know you weren't clairvoyant.

22 A The point I want to make is you  
23 can't generalize relative risk, which applies  
24 to populations, to one's own relative risk.  
25 You can't ever generalize things that apply to

1 populations to a given individual case. I  
2 don't think any epidemiologist would ever do  
3 that. Every individual case has a certain set  
4 of unique circumstances that determines what  
5 ones' s dealing with.

6 You know, as a pathologist, I'm  
7 not an epidemiologist. You asked me about  
8 epidemiological questions. I try to deal with  
9 it on my knowledge, but the pathologist's mind  
10 set is different. We look at the evidence in  
11 an individual case, and that evidence  
12 supersedes any epidemiological study. It has  
13 to do it by definition. When I have look at a  
14 biopsy -- I would never have to look at any  
15 biopsy because I would then apply the  
16 epidemiological literature to the number of  
17 some disease.

18 Q Remember, we were talking about a  
19 clinician coming down and sort of debating what  
20 kind of a tumor existed with you?

21 A Uh-huh.

22 Q Yes?

23 A Yes.

24 Q Thanks. Has that ever happened  
25 between you and a radiologist?

1           A       I wouldn't term it a debate. I  
2 would term it a discussion.

3           Q       Does the radiologist sometimes try  
4 to diagnosis what subtype of tumor it is based  
5 on films alone?

6           A       I deal with radiologists in the  
7 setting of mammography and breast cancer, and  
8 they make opinions based on the calcification  
9 and the films. And they may make opinions, but  
10 like I said before, that opinion does not in  
11 any way interpret my opinion of the slides.

12          Q       You don't need to tell me that  
13 because I got the point already.

14          A       You asked me the question again,  
15 so I answered you again.

16          Q       Well, I didn't, but you did.

17          A       Okay.

18          Q       But anyway, who cares?  
19                    What about in lung cancer cases?  
20 Do you ever have a radiologist debate you over  
21 what type of cancer it is?

22          A       I would not say a radiologist. I  
23 would say -- and again, I would term it a  
24 discussion rather than a debate. I would say  
25 it's more likely the thoracic surgeon.

1           Q       Can BAC be diagnosed by looking at  
2 films?  
3           A       Um, there could be a -- a question  
4 raised that one is dealing with BAC, but it  
5 cannot be precisely diagnosed. If it could,  
6 you would never need to look at tissue under  
7 the microscope.  
8           Q       It sounds like the Full Employment  
9 Act to me here, but sure, I get your point.  
10           Do you think that a BAC looks  
11 different on a film than a non-BAC  
12 adenocarcinoma?  
13           A       I would think it does. I mean, if  
14 a tumor were central, if it was next to the  
15 main stem bronchus, if it were large, I  
16 might -- I think that that X-ray would not be  
17 showing what the BAC tumor was. However, you  
18 can be surprised if you look at the tissue  
19 under the microscope.  
20           Q       Have you seen films in this case?  
21           A       No.  
22           Q       Have you read the radiology  
23 reports in this case?  
24           A       Yes.  
25           Q       Did you see puckering?

1           A       I didn't see a mention of  
2           puckering, but I did also read the pathology  
3           report that describes a 1.5 centimeter mass  
4           right under the pleura approximately 1  
5           centimeter under the pleura. The way the  
6           biopsy was done, they removed it and then they  
7           went back. So I think it's hard for the  
8           pathologists to identify puckering, per se.  
9           Q       I'm not asking you now about  
10          puckering. I'm asking if you saw any mention  
11          of the word "puckering" on the pathology  
12          report?  
13          A       No, I did not.  
14          Q       Is there some word that a  
15          radiologist might use synonymous to  
16          "puckering"?  
17          A       That's a pretty characteristic  
18          term I've seen puckering, but it's not  
19          mentioned radiologically. So they use the word  
20          like stellite as they did here or irrelevant or  
21          suspicious.  
22          Q       What about the word "stellae"? Is  
23          the word "stellae" related to one type of  
24          carcinoma versus another, maybe small cell or  
25          large cell? What about that?

1           A       No. The characteristic appearance  
2 of almost all cancers is stellae. The Greeks  
3 recognized this. That's why they used the term  
4 "carcinoid." It connotes the invasive  
5 tendencies of stellites, most cancers and the  
6 BAC appearance.

7           Q       And if I told you I saw the words  
8 stellite and it tipped me off that the cancer  
9 was BAC, what would you say?

10          A       No. I would say stellite would  
11 tip you off that you're dealing with a cancer.

12          Q       Um, what do you think the odds are  
13 of my changing your opinion on this BAC in  
14 Mr. Boekin today?

15          A       What are the odds that you'll  
16 change my diagnostic opinion?

17          Q       Yeah.

18          A       Zero.

19          Q       I agree. How do you choose  
20 articles that weren't written by you to bring  
21 here today? How did you choose out of -- how  
22 many are there that deal with the subject, a  
23 thousand?

24          A       There's quite a bit. I'm  
25 interested in BAC and I review articles. I

1 keep a collection of articles. Some of these  
2 articles I've relied on in previous testimony  
3 and previous cases. Some are new articles that  
4 I've added that I thought were important to the  
5 specific issues of this case.

6 Q All right. For every one of these  
7 articles, is there an article that disagrees  
8 with it?

9 A Um, I would say most of these  
10 articles represent the consensus of the fields.  
11 Some of the articles may have other articles  
12 that challenge the nuances, but not  
13 substantively.

14 Q Remember when you were talking  
15 about cohort studies?

16 A Yes.

17 Q Cohort is prospective, correct?

18 A Usually. It can be retrospective.  
19 It depends on what defines a cohort study  
20 versus a case control and your starting points.  
21 The cohort study looks at exposure and then  
22 quantifies that first then looks at the  
23 disease. Most are prospective. The  
24 retrospective looks at the disease and then  
25 tries to determine the disease. Most of those

1 are retrospective.  
2 Q Don't you have studies regarding  
3 BAC and tobacco?  
4 A I'm sorry?  
5 Q Do you have both prospective and  
6 retrospective studies regarding BAC and  
7 tobacco?  
8 A Most of these studies are  
9 retrospective. I said earlier in my testimony  
10 that I was not aware of a prospective cohort  
11 study that looked at BAC occurrence in smokers  
12 versus nonsmokers.  
13 Q So it's not most of them. It's  
14 all of these are retrospective?  
15 A Some of the studies are neither  
16 retrospective nor prospective. They would fit  
17 the term "epidemiological," and they would not  
18 be epidemiological at all. Some of them are.  
19 Q What is this?  
20 A I brought everything that I was  
21 provided that's part of the medical records.  
22 Q This is from Hammer, right?  
23 A Yes. That's part of his -- I  
24 thought you had listed one of those other  
25 things.

1 Q No, no. So what are these RSIs on  
2 top? Do you know what that means?  
3 A Most of that I really couldn't  
4 figure out. It seemed to be some documentation  
5 of records. I really didn't pay that much  
6 attention to that. I was looking for the  
7 substantive medical records.  
8 Q These are records reviews, right?  
9 A It's some sort of inventory; some  
10 sort of documentation that was meaningless to  
11 me, so I looked through all the material to try  
12 to extract the relevant medical information  
13 that was pertinent in this case.  
14 Q Where did you put that?  
15 A Well, I -- I summarized that on  
16 these notes that I took.  
17 Q In the black binder. They're  
18 straight and narrow, the medical records?  
19 A I have to say, they're a bit out  
20 of order. I usually find the medical records  
21 in the historical order.  
22 Q Who puts them in the historical  
23 order?  
24 A Well, in most charts, the records  
25 are kept in the historical order. I don't do

1       autopsies at the moment, but when I, did we  
2       would review all of the history in a historical  
3       order.  
4               Q       What's the biggest grant you've  
5       ever gotten?  
6               A       It depends what you mean by "big."  
7       You mean longest? You mean the most money?  
8       You mean the most important?  
9               Q       Well, I guess that's insight. Of  
10      course, I meant the most important.  
11              A       The biggest grant is always my  
12      most recent one cause it keeps the research  
13      going.  
14              Q       Okay. Of tertiary interest to me,  
15      what is the one for the most money?  
16              A       It's hard to answer that because  
17      there's ones for a shorter duration, over a  
18      longer duration. Also you have to put in  
19      inflation, what it buys.  
20              Q       What's the number? Just give me  
21      the biggest number.  
22              A       Well, I like to think of my funds  
23      building aggregate because it's all money.  
24      Currently, I have about 5 to \$700,000 in direct  
25      support. It all comes from various grants.

1 The biggest grant was probably about a million  
2 dollars over a five-year period.  
3 Q From?  
4 A The National Cancer Institute.  
5 Q For?  
6 A The study of the desmoplastic  
7 response to breast cancer invasion. I also use  
8 parts of that study to study BAC, the scarring.  
9 Q What part?  
10 A I'm sorry?  
11 Q You use part of it to study BAC,  
12 to study what part? The million bucks, what  
13 part?  
14 A I can't answer that because the  
15 money is used to buy common equipment, common  
16 supplies, common personnel. I just devoted  
17 part of that study to BAC because it's a  
18 scar-inducing cancer just like breast cancer is  
19 desmoplastic.  
20 Q Just give me the percentages of  
21 what part was used to study BAC versus breast  
22 cancer.  
23 MR. CARLTON: Object. Asked and  
24 answered.  
25 THE WITNESS: 10 to 20 percent

1 BAC; 80 to 90 percent breast cancer.  
2 BY MR. PIUZE:  
3 Q Okay. You don't know Dr. Strauss  
4 by any chance, do you?  
5 A Dr. Strauss?  
6 Q Yeah.  
7 A No.  
8 Q He's an oncologist who was deposed  
9 down at the airport today, Harvard, Dana  
10 Harper, bunch of stuff like that, around the  
11 same time.  
12 So anyway, is there any type of  
13 risk factor that exists anyplace now and days  
14 for BAC and tobacco?  
15 A There have been some retrospective  
16 case control studies that have shown an  
17 increased relative risk in BAC with smoking  
18 exposure. There have been some studies to this  
19 effect, but the predominant studies don't  
20 convincingly show an epidemiological link  
21 between smoking and BAC.  
22 Q Who are the authors of the ones  
23 that show a link?  
24 A Well, two studies that come to  
25 mind are a study by Faulk that was done down in

1 New Orleans and a study that was done by, I  
2 believe, Mbrabia and Wynder, W-y-n-d-e-r, I  
3 think. The first guy's name is Mbrabia. That  
4 would be, M-o-r-a-b-i-a.

5 Q One of those was the study of 87  
6 people?

7 A As I recall the numbers were  
8 fairly small. So I think that was a  
9 possibility.

10 Q One was a study of 21 people?  
11 A Yes.

12 Q 60 to 70 percent linked?  
13 A 60 to 70 percent link?  
14 Q Between BAC and smoking?  
15 A Yes.

16 Q Your critique of those?  
17 A Well. I have a couple  
18 critiques --

19 MR. PIUZE: Angel, isn't it  
20 amazing that I know this stuff? Weeks ago, it  
21 was completely foreign. I think it's amazing I  
22 know this stuff.

23 THE WITNESS: Well, I thought  
24 there was a question.

25 BY MR. PIUZE:

1           Q       It was, but I've withdrawn it.  
2           A       My criticisms are different for  
3 the given study. One study I recall took the  
4 diagnosis of BAC that was made in the records  
5 and didn't actually review the indications and  
6 standardized the criteria. It didn't have one  
7 or a team of people reviewing the cases. It  
8 just took what was recorded. That obviously  
9 varied bits because certain pathologists are  
10 involved. Who knows who reads the slide? They  
11 may have read the slides in a totally different  
12 context. Any study like that, you must review  
13 the cases and standardize the criteria.  
14                   I think this one study -- I think  
15 in one study, they did review the cases, but I  
16 don't remember which study was which. These  
17 are small studies relative to risk bias. When  
18 you ask somebody who has a lung cancer, "Have  
19 you ever smoked, "they's may tend to say "yes"  
20 more than somebody who has no problem. They  
21 may tend to blame it on certain things and  
22 there is something known in the literature  
23 called "relative bias."  
24           Q       I want to make sure I understand  
25 that people lie that they smoke?

1           A       What I'm saying is it's known that  
2 retrospective case control studies are not as  
3 reliable as longitudinal or prospective cohort  
4 studies.

5           Q       I think that's probably for sure,  
6 but it wasn't the question.

7                    Are you saying that sometimes in  
8 these retrospective studies people lie?

9           A       There may be a failure in sampling  
10 bias. There may be a failure to remember.  
11 There may be a conscious attempt to not be  
12 accurate.

13          Q       How could someone that didn't  
14 smoke say, "yes," I smoked cigarettes?

15          A       It's known that a nonsmoker will  
16 fail to say they stopped smoking when they  
17 stopped. It's also known that people tend to  
18 blame things in their mind on certain  
19 relationships. Somebody gets breasts cancer.  
20 It's not at all uncommon to say, "I was in a  
21 car accident 10 years ago and it's linked."

22                    That's not the kind of unbiased I'm  
23 referring to. There's other explanations. I'm  
24 not saying they lie. I'm saying there's  
25 explanations in which the study isn't as good.

1 I'm also saying, though, looking  
2 at the studies side by side, one isn't as good.  
3 In one, there's a dose response. In another,  
4 there's not. In one there's the declining risk  
5 and another, there isn't.

6 I think I can characterize it by  
7 saying the studies are small and you can't  
8 characterize it. But you said the numbers are  
9 60 to 70 percent, the studies are great but we  
10 have a significant non-association where  
11 there's a 40 to 30 percent non-association.  
12 That is significant. That prevents you from  
13 generalizing the epidemiology to an individual  
14 case. You can't make that argument. That's  
15 fallacious.

16 Q Oh, forget it.

17 Does marijuana cause cancer?

18 A Well, one of the studies I was  
19 involved with is we saw in heavy chronic  
20 marijuana smokers, the same type of airways as  
21 we saw in tobacco smokers. There's some  
22 issue -- in our particular study we had not  
23 observed cancer yet in the lungs, but these are  
24 very young people. So the jury is still out on  
25 that question.

1 Q Does crack cocaine cause cancer?  
2 A Same thing. The jury is still  
3 out.  
4 Q Tell me the type of marijuana use  
5 you just described. What does it mean?  
6 A Well, in that study we examined  
7 chronic users of marijuana. These were people  
8 who smoked a number of joints per day for a  
9 number of years.  
10 Q What number?  
11 A You know, I don't know off the top  
12 of my head. The study was published in 1998.  
13 I haven't reviewed it recently.  
14 Q How many years -- in other words,  
15 when I said "what number," I was meaning what  
16 number of numbers per day. Now on to what  
17 number of years?  
18 A Again, I'd have to refer to that  
19 study, and I could answer you if I just looked  
20 at the paper, and I just don't remember off the  
21 top of my head, and I don't want to give you  
22 erroneous information.  
23 Q Does heroine cause cancer?  
24 A I'm not aware of any  
25 epidemiological study linking heroine with

1 cancer.  
2 Now, in all these questions of me,  
3 I'm assuming that you mean epidemiological  
4 causation.  
5 Q As opposed to?  
6 A Well, there's many different  
7 types. There's experimental causation.  
8 There's causation on an individual case basis.  
9 There's causation in an animal setting.  
10 There's causation in a lab setting.  
11 Q Fine. Does marijuana cause cancer  
12 under any of those subheads?  
13 A Well, the study that I was  
14 involved with showed precancerous molecular  
15 changes in heavy smokers of marijuana. There's  
16 been a subsequent study that shows an increase  
17 of head and neck cancers in chronic marijuana  
18 smokers.  
19 Q What is "chronic"?  
20 A Well, it means a number of joints  
21 per day over a number of years. Well, off the  
22 top of my head, I don't know. It's a big  
23 number of days and joints and years. I just  
24 don't know the specifics.  
25 Q Under any of those subheadings

1 that you just gave me, does heroine cause  
2 cancer?  
3 A I'm not aware of any  
4 epidemiological study.  
5 Q How about boredom? Does boredom  
6 cause cancer?  
7 A I'm not aware of any link of  
8 boredom to cause cancer.  
9 Q Do my questions cause boredom?  
10 A No.  
11 Q I guess it depends who you ask  
12 cause I'm getting pretty bored?  
13 THE REPORTER: I'm almost out of  
14 paper?  
15 MR. PIUZE: Good timing.  
16 Q Okay. Did Phillip Morris cause  
17 Mr. Boekin's cancer?  
18 MR. CARLTON: Objection.  
19 Argumentative, lack of foundation.  
20 BY MR. PIUZE:  
21 Q If you're not going to give any  
22 opinion on it, that's great. I'd be happy to  
23 hear it.  
24 A I don't think Phillip Morris  
25 caused Mr. Boekin's cancer.

1 Q Did tobacco cause his cancer?  
2 A I don't think it caused his  
3 cancer.  
4 Q Did tobacco play any role in  
5 causing his cancer?  
6 A Well, in examining the specifics  
7 of this case, which your questions really  
8 didn't get into, I didn't see any evidence, a  
9 molecular or histopathological link to smoking  
10 to this cancer. I see evidence to the  
11 contrary.  
12 Q What's the evidence to the  
13 contrary?  
14 A It's a BAC, a cell type that's  
15 weakly linked at best to smoking. We find  
16 evidence of scarring. We find evidence of  
17 bronchioloalveolar carcinoma. We find no  
18 evidence of airway disease in terms of  
19 dysplasia.  
20 We have a clinical course that is  
21 typical of a D-differentiated BAC that, per se,  
22 doesn't address that issue. But it's just part  
23 of my opinion of a BAC. So it's a lack of  
24 evidence linking the two and the presence of  
25 evidence not linking the two.

1 Q Tell me about the clinical course.  
2 Expound on that a little more, please.

3 A Well, this patient had a  
4 D-differentiation on presentation. He had  
5 metastases in his lymph nodes. He had a very  
6 D-differentiated tumor. Based on the slides,  
7 it didn't even look like a BAC only. It  
8 apparently spread to his bones fairly quickly.  
9 It was detected on the CT of his bones. He had  
10 it at L-3 and L-4 and possibly his shoulder and  
11 then he had vertebral and intervertebral  
12 metastases.

13 Q Well, once he was diagnosed, he  
14 was a dead man anyway when he had that  
15 metastases anyway, right?

16 A Well, when he was diagnosed, he  
17 would be considered a Stage 3-A, and they don't  
18 have a very good survival rate. I think it's  
19 10, 15 percent. I think it's a five year  
20 period. There have been cases, I think, that  
21 have survived. So I wouldn't say ipso facto he  
22 was a dead man. He's not a dead man yet.

23 When 10 to 15 percent have a five  
24 year survival, that means 10 to 15 percent  
25 survive five years, and those people aren't

1 dead men.  
2 Q And men, men, men, but women get  
3 this too, right?  
4 A Absolutely. That's one of the  
5 distinguishing features of BAC. It's sex ratio  
6 demographic is about equal over the years.  
7 Q Whereas other types of  
8 adenocarcinoma what?  
9 A The other types have more a male  
10 dominant ratio and several, the squamous and  
11 small cell, it's even more, so --  
12 Q What's clonality?  
13 A Cancers are thought to be  
14 alterations that arise within a single  
15 transformed cell, a single cell gives rise to  
16 the progeny that constitutes cancer. That's  
17 referred to as "clonality," meaning one clone,  
18 monoclonality, meaning one cell, whereas our  
19 tissues are derived from many cells and are  
20 polyclonal. Cancers are thought to arise from  
21 a single cell that's clonality or  
22 monoclonality. Tissues are plural.  
23 Q I'd like to give you your  
24 photomicrographs back temporarily. You had  
25 them in an order. I labeled them but

1       apparently missed two of the slides, correct?  
2           A       No. I don't know what you did. I  
3       gave you the slides that I had.  
4           Q       Are they in the order that you  
5       think they should be?  
6           A       They were in the order that if I  
7       was called to, I would present the case in.  
8           Q       Okay. I'm going to start with the  
9       No. 2 -- will be the first number, and then  
10       we'll go on to A, B, C, D, E, F -- oh, one that  
11       I missed I'm going to put 2-G on, and one that  
12       I formerly put 2-G on becomes F. Just in case  
13       anyone wonders about the handwriting.  
14                   Starting with 2 and going through  
15       them, will you just describe -- tell me the  
16       number and tell me what you see that leaves you  
17       to believe that you're looking at BAC and not  
18       adenocarcinoma or some non-BAC type.  
19                   Don't answer that question. It's  
20       a crummy question. Don't answer it. I  
21       apologize.  
22                   As you go through each slide,  
23       identify the slide and then tell me what you  
24       see that is significant to the opinions that  
25       you expressed here?

1           A       All right. Slide two depicts the  
2 bronchioloalveolar lung cancer. It depicts it  
3 next to a scar which occupies the upper right  
4 side of this photograph.  
5           Q       Can you show us the scar?  
6           A       This is the scar and radiating --  
7           Q       Show me -- you were pointing away  
8 from me.  
9                    Go ahead.  
10          A       And radiating out of the scar in a  
11 lipidic fashion or a scaly growth fashion are a  
12 population of alveolar cells with thickened  
13 septa --  
14          Q       I can't see what you're doing.  
15 Can you show me off --  
16          A       Alveolar cells with thickened  
17 septa, which in my mind, recapitulate the  
18 framework. This is a photograph diagnostic of  
19 bronchioloalveolar and the characteristics in  
20 relation to the tumors that we call BAC. So  
21 that's what that photograph is depicting and  
22 that's what is depicted on this photograph.  
23                    Then the next photograph, which is  
24 labeled 2-A is simply a higher power  
25 magnification of this process, now ignoring the

1 scar, but focusing on the lipidic growth  
2 pattern of these cells, some of which have  
3 produced dilated spaces again with a thickened  
4 septa.

5                   And it's important to point out  
6 that these cells are single. They're aligning  
7 the alveolar space, but they are not  
8 perforating. They're single, and that's a  
9 characteristic of BAC. It's a single spread  
10 throughout the alveolar septa of the lung.

11                   These cells look like Type II  
12 pneumocytes and that's depicted in the next  
13 slide, which is 2-B. It's just a higher powered  
14 magnification and how they jut into the spaces  
15 that they align. There's some mucous material  
16 within these spaces, incidentally, that can be  
17 sometimes seen.

18                   And the next slide, which is 2-C I  
19 photographed an area where there's more  
20 proliferation, and although there's still some  
21 single cells, there's cells which are now  
22 filling these spaces and the alveolar spread  
23 pattern is a little disrupted. And there is an  
24 area that I would label as papillary adeno,  
25 meaning there's areas of papillae, a Greek word

1 for them meaning there's spaces in these cells.  
2 The framework of the septum looks a little more  
3 disrupted unlike this spread along --

4 Q "This," you're pointing back to  
5 2-A now?

6 A Right. I'm pointing back to  
7 contrast the spread in this space. There's  
8 more disruption of the septum

9 One could make a case that there's  
10 invasion of the septum as opposed to  
11 non-invasion, depending on who defines it,  
12 keeping in mind that invasion of the lung can  
13 also have intra-alveolar spread in the lung,  
14 which is a type of invasion. And like I said,  
15 the pure BAC -- that's why I said the new WHO  
16 classification is a little disconcerting.

17 Anyhow, next photograph is 2-D, is  
18 a photograph of the one of the major bronchi.  
19 This patient, according to the records, was a  
20 very heavy smoker who smoked up until the time  
21 of diagnosis and then abruptly quit. He had an  
22 80-year pack history allegedly in the chart.  
23 With such heavy smoking up until the time the  
24 tissue was removed, I expected to find evidence  
25 of tobacco smoking related bronchiole damage

1 like the kinds of changes I observed in my  
2 study in tobacco and marijuana and cocaine  
3 users. But I didn't conduct molecular studies  
4 but histopathologically, this lung -- I don't  
5 see metaplasia or hyperplasia I don't see --  
6 Q Tell us the number of that one.  
7 A It's 2-D.  
8 Q So in Mr. Boeken's particular case  
9 when he believed Phillip Morris that their  
10 tobacco products would not harm him, it turned  
11 out that he was correct?  
12 MR. CARLTON: Objection. Assumes  
13 facts not in evidence, argumentative, calls for  
14 speculation.  
15 BY MR. PIUZE:  
16 Q Is that right?  
17 A Your question in my mind is a  
18 little convoluted. Can you maybe explain it a  
19 little bit more to me.  
20 Q Sure. This is known as a  
21 hypothetical.  
22 Assume Mr. Boeken, being more  
23 attuned to big business than government and  
24 government regulation, was more prone to  
25 believe Phillip Morris's corporate statements

1 about what they knew or didn't know as far as  
2 his health risks were concerned as contrasted  
3 with what the Surgeon General might have said  
4 to him as a member of the populous about what  
5 the Surgeon General thought his health risks  
6 were from smoking, and he took Phillip Morris's  
7 words over that of the General Surgeon. As it  
8 turned out in his case, his decision to rely on  
9 Phillip Morris's words didn't hurt him  
10 correct?

11 MR. CARLTON: Objection,  
12 argumentative, improper hypothetical.

13 THE WITNESS: In the charts, he  
14 has a history of chronic bronchitis.

15 BY MR. PIUZE:

16 Q Right.

17 A He has a history of some  
18 exasperation of asthma. These things have an  
19 association with smoking. So his smoking may  
20 have harmed him in that capacity. He makes  
21 mention that he's something -- some vague  
22 statements that he gets short-winded or he  
23 tires or something like that, if I  
24 recall -- that may not totally be accurate --  
25 but there's some gist to that in that sense

1 that may have harmed him What I'm seeing  
2 here -- I don't see evidence of central airway  
3 disease from the perspective of premalignant  
4 alterations that have been linked to smokers,  
5 heavy smokers. They sometimes have squamous  
6 metaplasia. They sometimes have hyperplasia.  
7 They sometimes have squamouscell hyperplasia.  
8 Q They sometimes have nothing?  
9 A That's right.  
10 Q Most of them have nothing?  
11 A No most of them have something.  
12 You know, most smokers don't have lung cancer.  
13 There's a genetic interplay of the enzymes in  
14 smoke to our efficiency of repair. There's a  
15 interplay between environment and home. Some  
16 people are immune to carcinogens.  
17 Q What percentage of people who  
18 smoke get lung cancer, heavily smoke?  
19 A The number of people in my mind,  
20 that sticks in my mind is 10 or 15 percent.  
21 Q 15 percent men; 10 percent women?  
22 A The vast majority don't.  
23 Q But the vast majority you said  
24 would have changes that would be showing on  
25 their equivalent of 2-D, right?

1           A       Right, precancerous lesions. In  
2           our young chronic tobacco users, we find  
3           changes at a very high percentage, the  
4           precancerous changes are much more common than  
5           the cancerous changes, but when you have the  
6           absence of precancerous changes, as in this  
7           case, it raises issues as to whether smoking  
8           was damaging the epithelia in the way you would  
9           expect it to damage it in pre --  
10          Q        There's nothing to say that he's  
11          going to have cancer in that area before he's  
12          going to get cancer in a different area, is  
13          there or isn't there?  
14          A        If you look at people who smoke  
15          who get lung cancer -- some of these are  
16          adenocarcinoma; some of these are periphery --  
17          you usually find damage in the airways.  
18          Q        "Usually," meaning 50 percent of  
19          the time, 99 percent of the time?  
20          A        I would quote my study, and I  
21          don't remember the numbers off the top of my  
22          head, but they were fairly high.  
23          Q        Your studies are over here?  
24          A        Those are someone else's. If you  
25          ask me that question at trial, I'll be prepared

1 to tell you the precise numbers that we found.

2 Q Well, if you're going to be  
3 prepared, I won't ask you. If you're prepared,  
4 Mr. Carlton will ask you before I do.

5 A The next slide is 2-E. It shows a  
6 prominence of a Type II pneumocytes in a small  
7 focus, and actually, that is depicted better on  
8 the next photograph, 2-F. It's a higher  
9 powered magnification. This is an area of what  
10 I would call bronchioloalveolar hyperplasia.  
11 It's not atypical hyperplasia, but it's a  
12 lesion that we often see in the lung. And the  
13 thinking in this field is these kinds of  
14 lesions antedate the appearance of carcinomas.

15 I cite this to show that  
16 Mr. Boeken's case the histopathology that I was  
17 observing -- notwithstanding his lung cancer,  
18 the histopathology which I am observing is  
19 located within the lung and not within the  
20 central airways.

21 Q Therefore?

22 A Well, this lesion has had some  
23 interest lately, but it's not a lesion related  
24 to smoking. It's a lesion that occurs -- I see  
25 this lesion all the time when I review cases of

1 cancers in nonsmokers. This lesion may be a  
2 precursor to peripheral adeno or peripheral  
3 BAC, which is what Mr. Boeken had. I can't see  
4 a direct link. I just found this focus. I am  
5 just showing what I find or what I don't find,  
6 which I think is relevant.

7           And the final two photographs,  
8 which are labeled 2-G -- or 2-G -- 2-F and 2-G,  
9 and actually, they're out of order. 2-G is a  
10 lower powered photograph of one of the  
11 metastases in the paratracheal nodes and 2-F is  
12 a high powered magnification. I was surprised  
13 that in the diagnoses, nobody mentioned how  
14 different this looked compared to the primary  
15 tumor. My diagnosis here would be a metastatic  
16 signet ring carcinoma and mucinous as well.  
17 They have a bluish feature and the mucinous are  
18 pushed to the side. There is an indication  
19 that this tumor really D-differentiated.

20           Finding this explains in my mind  
21 the subsequent clinical aggressive course  
22 because looking at the BAC that's 1.5  
23 centimeter tumor, you would never predict that  
24 this cancer is going to be fatal in this  
25 patient. You'd never predict that. But

1 looking at this, it would predict it.  
2 Q What do you mean by "fatal"?  
3 A Well, it spread to his bones and  
4 his brain and the prognosis now is extremely  
5 dismal. And I think we can assume it will be  
6 fatal. I said earlier that the Stage 3-A cases  
7 are not all fatal, but now he has brain  
8 metastasis which is fatal.  
9 Q Well, the Stage 3-A, even though,  
10 they are not all fatal, how many are fatal?  
11 A Well, there's a 15 percent  
12 fatality rare in five years. That's the death  
13 rate. What's alarming in my mind about this  
14 tumor is it's so D-differentiated.  
15 Q This being F and E?  
16 MS. TANG: I'm sorry, I might be  
17 mistaken, but are there two photos labeled G?  
18 THE WITNESS: This should be G and  
19 we should change one of them to H and  
20 everything should be fine.  
21 BY MR. PIUZE:  
22 Q Fine. I flunked alphabet.  
23 A So this is a metastatic mucinous  
24 signet ring carcinoma, very aggressive.  
25 Q Let's see your notes -- notes

1 slash report.  
2 Pretty good handwriting.  
3 A I'm not a doctor. I'm a  
4 pathologist.  
5 Q Well, I was going to say in  
6 addition to this, there's also blood stains on  
7 here.  
8 A I don't think so.  
9 Q Please, just for the record tell  
10 me the title and authors of the papers that you  
11 decided you should bring here, and as you go  
12 through each, I'd like you to just tell me what  
13 feature it is in that particular paper that you  
14 think is worthy.  
15 A Well these papers are in no  
16 particular order right now. There's a paper by  
17 Weng et al. called "Incidence of atypical  
18 bronchioloalveolar cell hyperplasia of the  
19 lung: Relation to histological subtypes of  
20 lung cancer." It supports my conclusion or my  
21 statements that bronchioloalveolar hyperplasia  
22 is a precursor typically of BAC. It also  
23 addresses smoking with these lesions and finds  
24 no correlation, so that's the significance.  
25 Q What's the year of these

1 publications?

2 A 1992.

3 THE REPORTER: Are you attaching  
4 these?

5 MR. PIUZE: Yeah.

6 THE WITNESS: The next one is by  
7 Sone, et al. It's called "Results of  
8 three-year mass screening programme for lung  
9 cancer using mobile low-dose spiral computed  
10 tomography scanner" published in the "Journal  
11 of Cancer." It's a recent paper. It just came  
12 out 2001.

13 It talks about the use of a spiral  
14 CT scan, which as you know, is a very sensitive  
15 technique to detect early lung cancer. It's  
16 been touted to be used in screening programs.  
17 The paper detects a very high rate of BAC and  
18 adenocarcinoma in a largely nonsmoking  
19 population.

20 There are some patients who are  
21 smokers, but there are many that are not. In  
22 fact, there are more that are not than are  
23 smokers. So it just talks about the prevalence  
24 in BAC and how most of these patients are  
25 asymptomatic and they can benefit from this

1 type of test.  
2 BY MR. PIUZE:  
3 Q Stop for a second.  
4 So was that a hint that I should  
5 be putting numbers on these individuals things?  
6 So the last the last document you  
7 just mentioned, the head author is Sone, make  
8 that Exhibit 5.  
9 (The document referred to was  
10 marked by the C. S. R. as Plaintiff's  
11 Exhibit 5 for identification and was  
12 attached to and made part of this  
13 deposition.)  
14 BY MR. PIUZE:  
15 Q The one prior to that, the head  
16 author is Weng?  
17 A Correct.  
18 MR. PIUZE: Make that 4.  
19 (The document referred to was  
20 marked by the C. S. R. as Plaintiff's  
21 Exhibit 4 for identification and was  
22 attached to and made part of this  
23 deposition.)  
24 BY MR. PIUZE:  
25 Q Let's talk a bit about the

1 spiral -- what is it, spiral CT or spiral MRI?  
2 A It's spiral CT.  
3 Q Where is one? Where is the  
4 closest one, do you know?  
5 A I think we have one at UCLA.  
6 Q They're pretty rare, aren't they?  
7 A They're starting to proliferate.  
8 All of the big medical centers are trying to  
9 get money to buy them now because there's  
10 evidence that they're better than routine CT  
11 scans. So they're still rare, but they're not  
12 going to be rare in a year.  
13 Q In terms of screening certain  
14 things, or in general?  
15 A No. They're used to screen for  
16 lung cancer.  
17 Q So every time I start coughing and  
18 grab my internist by the throat and say "you  
19 better not screw up this X ray," he's always  
20 said I'll have another radiograph, but the last  
21 time he said I'll get you a spiral CT --  
22 A I have to tell you, there's a  
23 danger in this approach, too. It's a very  
24 sensitive technique. It will pick up early  
25 lung cancer. It will pick up non-lung cancers.

1 There are many precursors to lung cancer that  
2 you don't need removed. If you don't know you  
3 have it, you'd be just as well off. But this  
4 technique is so sensitive, it can pick these  
5 up.

6 Q Can't it differentiate between  
7 cancer and non-cancer?

8 A No. So we're getting a lot of  
9 things in pathology that are benign and are  
10 removed from these people needlessly. But it's  
11 a Catch 22. With the increase in sensitivity  
12 you're going to decrease specificity.

13 Q You didn't make that up, did you?

14 A I said it. No. It's something  
15 that's well-known in the field. I've stated it  
16 many times in different contexts.

17 Q Sounds pretty good. Too good for  
18 a Tuesday afternoon. Let's hear about the  
19 next, sorry.

20 THE WITNESS: Next paper is by  
21 Mbrabia and Wynder called "Cigarette Smoking  
22 and Lung Cancer Cell Types." This is a paper  
23 that I referred to earlier. It's an earlier  
24 paper that addresses lung cancer and peripheral  
25 cancers such as adeno cell that are weaker than

1 more recent tumors. This was written in 1991,  
2 so it wasn't written that long ago, about a  
3 decade ago.

4 Q Make that No. 6, please. Would  
5 you put a 6 on that.

6 (The document referred to was  
7 marked by the C. S. R. as Plaintiff's  
8 Exhibit 6 for identification and was  
9 attached to and made part of this  
10 deposition.)

11 BY MR. PIUZE:

12 Q Next?

13 A The next study is by Grover, et  
14 al., and the lung cancer study group called  
15 "Recurrence and Survival Following Resection of  
16 Bronchioloalveolar Carcinoma of the Lung-The  
17 Lung Cancer Study Group Experience" and this  
18 just addresses the issues of smoking and  
19 chronic lung disease and the differences in BAC  
20 versus non BAC adeno and it observes that BAC  
21 is seen quite frequently in nonsmokers and  
22 therefore it obviously has risk factors that  
23 are not related to smoking in those patients.

24 MR. PIUZE: No. 7.

25 (The document referred to was

1 marked by the C. S. R. as Plaintiff's  
2 Exhibit 7 for identification and was  
3 attached to and made part of this  
4 deposition.)

5 THE WITNESS: The next paper is by  
6 Wynder et al. called "Association of Dietary  
7 Fat and Lung Cancer" and that's in my list  
8 because it addresses issues that diet, lack of  
9 fruits and vegetables, high fat intake, are all  
10 risk factors. There are many risk factors to  
11 lung cancer in addition to tobacco smoking and  
12 many risk factors, especially with BAC, we  
13 still don't understand.

14 But anyhow, this paper just talks  
15 about other risk factors, and this is No. 8.

16 (The document referred to was  
17 marked by the C. S. R. as Plaintiff's  
18 Exhibit 8 for identification and was  
19 attached to and made part of this  
20 deposition.)

21 THE WITNESS: The next paper is by  
22 Auerbach and Garfinkel, a paper called --  
23 addressing "the Changing Pattern of Lung  
24 Carcinoma" published in 1991 and observes the  
25 increase in adeno and the decrease -- and the

1 comment on decrease on squamouscell. It also  
2 addresses BAC and the rise of BAC. So  
3 this -- the findings in this paper  
4 really -- this paper was published before my  
5 1994 paper, so I guess we can say that my paper  
6 reiterated what Auerbach was observing and this  
7 is what we're marking as 9.

8 (The document referred to was  
9 marked by the C. S. R. as Plaintiff's  
10 Exhibit 9 for identification and was  
11 attached to and made part of this  
12 deposition.)

13 THE WITNESS: Should I go on?

14 BY MR. PIUZE:

15 Q Oh, please?

16 A The next paper, which would be  
17 labeled 10, is by Barkley and Green of  
18 "Bronchioloalveolar Carcinoma," a review  
19 article. He cites my work and others' work  
20 talking about the increased incidence in BAC  
21 occurring in young nonsmoking females. It  
22 talks about other epidemiological  
23 investigations that are needed, raises the  
24 possibility of a viral etiology because of  
25 experimental evidence linking sheep BAC to a

1 retrovirus, and that is No. 10.

2 (The document referred to was  
3 marked by the C.S.R. as Plaintiff's  
4 Exhibit 10 for identification and was  
5 attached to and made part of this  
6 deposition.)

7 THE WITNESS: The next paper is by  
8 Adi Gazdar called, "The Molecular and Cellular  
9 Basis of Human Lung Cancer" published by  
10 "Anticancer Research." It talks about the key  
11 molecular alterations in p53 and other genes  
12 and other cancers, and those that are related  
13 to smoking. And that's No. 11.

14 (The document referred to was  
15 marked by the C.S.R. as Plaintiff's  
16 Exhibit 11 for identification and was  
17 attached to and made part of this  
18 deposition.)

19 THE WITNESS: The next paper,  
20 which we're labeling 12, is by Harlamert, Mira  
21 et al. called, "Thyroid Transcription Factor-1  
22 and Cytokeratins 7 and 20 in Pulmonary and  
23 Breast Carcinoma." This paper is in my list  
24 because I anticipated that thyroid  
25 transcription factor immunostain would have

1 been done in this case. It turns out that it  
2 wasn't, and it's usually done to confirm the  
3 diagnosis of BAC or adeno because it usually  
4 expresses the Type II pneumocytes. This paper  
5 really isn't relevant because of the fact that  
6 the immunostain wasn't done.

7 (The document referred to was  
8 marked by the C.S.R. as Plaintiff's  
9 Exhibit 12 for identification and was  
10 attached to and made part of this  
11 deposition.)

12 BY MR. PIUZE:

13 Q What significance do you put on  
14 the facts that the stain wasn't done?

15 A Well, I think the people involved  
16 consented with a histological H&E appearance of  
17 the cancer that it was a primary lung cancer  
18 and that it was a tumor of the Type II  
19 pneumocytes. But it's something that's usually  
20 done as part of the package.

21 Q What triggers it being done?

22 A The desire to be complete,  
23 sometimes the desire to bill the patient an  
24 additional fee, you know, with managed care.  
25 When there's a question of an adenocarcinoma

1 possibly being a metastatic lesion, the stain  
2 will be done because it's very strongly  
3 positive in BAC and in adenocarcinoma and in  
4 Type II pneumocyte-derived tumors. We usually  
5 do it. It's just part of the package.

6 Q Thank you.

7 A The next paper is 13 --

8 Q But, you know what? Let's not go  
9 on quite yet.

10 You've had the path report for a  
11 long time, haven't you?

12 A Yes.

13 Q And you've had the slides from the  
14 beginning of your involvement?

15 A Yes.

16 Q So you knew that those stains  
17 weren't done?

18 A No, I actually didn't. I had the  
19 slides previously, as I told you, and I  
20 photographed them, but I wasn't sure whether  
21 they were from the a complete set. I wasn't  
22 sure, for example, whether Dr. Hammer had  
23 performed additional testing.

24 In a case that I was involved  
25 with, I think it was Little, Dr. Hammer had

1 performed thyroid transcription factor tests on  
2 the material, and since I didn't know this and  
3 I had to compose my reliance list and actually  
4 Chris Johnson brought the slides back, I didn't  
5 know whether there was additional slides. So I  
6 just wanted to cover that eventuality.

7 Q Okay. So let's continue.

8 A Number 13 is by Tina  
9 Hernandez-Boussard and Pierre Hainut called "A  
10 Specific Spectrum of p53 Mutations in Lung  
11 Cancer from Smokers: Review of Mutations  
12 Compiled in the IARC p53 Database." It talks  
13 about the p53 gene as an important marker of  
14 smoking-related cancer. It talks about what  
15 kinds of cancer the p53 gene is mutated in and  
16 whatever the specific mutations say. We have a  
17 way now to identify those cancers that are  
18 related to smoking and the way to exclude those  
19 cancers. And because we have that available,  
20 it's important to know that.

21 Q How?

22 A Well, if you want to prove or  
23 support a -- a causal relationship, you have  
24 the ability to do it.

25 Q How does it work?

1           A       Well, you can do an immunostaining  
2 or you can do PCR from microdissected DNA and  
3 you can look and you can address the question  
4 "is the p53 Gene altered, if so, how is it  
5 altered?" I noticed in this case I didn't see  
6 any evidence of that, so I would be quick to  
7 evaluate the p53 gene.

8           Q       You didn't see any evidence of  
9 what?

10          A       I didn't see any evidence of any  
11 genetic study that would link this cancer.

12          Q       Is this definitive?

13          A       Well, when you do the  
14 fingerprinting study, that's sort of blood left  
15 at a crime scene, the findings may be more  
16 definitive than you just say there's blood at a  
17 crime scene. We're in a molecular age now.  
18 Molecular evidence in my mind is very  
19 important.

20          Q       Well, what's the reliability  
21 factor on this question? If I go -- if I run  
22 up to Mr. Boeken's house and I scrape something  
23 off, what do I have to scrape the tissue off  
24 of? Where? His lungs? His body?

25          A       No. We're interested in his

1 cancer, not anyplace in his body, what the  
2 evidence is linking his cancer to smoking.  
3 Q So if I got some of his cancer and  
4 tissue -- what are you interested in his lungs  
5 or anyplace in his body?  
6 A I would say the more -- I would  
7 say both.  
8 Q Okay. So where would I get it  
9 from, his lungs and where else?  
10 A Well, I have the tissue in -- I  
11 assume you have the paraffin blocks in his  
12 tissue. You have it already in a form  
13 Q Okay. So why haven't you done  
14 that?  
15 A Well, why haven't I done it?  
16 Q Yeah.  
17 A For a number of reasons.  
18 MR. CARLTON: Again, that's  
19 argumentative.  
20 BY MR. PIUZE:  
21 Q Okay. Well, why haven't I done  
22 that?  
23 A I can't answer you, why you  
24 haven't done it.  
25 Q That one wasn't argumentative.

1 Let's go back to the argumentative one.

2 Why haven't you done it?

3 A For three reasons. First, I  
4 didn't know I was authorized to do it, I wasn't  
5 given the tissue to do it with, and I wasn't  
6 asked to do it. The second reason is I'm as  
7 an expert witness, asked to look at this case  
8 and render my opinion based on the evidence  
9 that's before me. This case is a BAC. I would  
10 expect the p53 Gene not to be altered. I would  
11 expect it not be to mutated because the rate of  
12 the mutations in BAC is very low.

13 However, if I saw it was altered,  
14 it would be very important. But it's not up to  
15 me to prove the case. It's up to me simply to  
16 evaluate the data that's in front of me.

17 Q Okay. So let's assume now that  
18 the p53 gene is altered. What do you have to  
19 say then? What's the degree of probability  
20 that that altered gene means smoking caused  
21 this cancer?

22 A It would depend on the kind of  
23 alteration. Is there a point mutation? What's  
24 the point mutation. What is the point of the  
25 point mutation? Is it a hot transition? Is it

1 a G transition? There are too many  
2 possibilities to answer that question.  
3 Q So even if we do this test, this  
4 test is not absolutely definitive?  
5 A No. It depends on the kind of  
6 test you would do.  
7 Q What kind of test would you do?  
8 A Well, I would do a test to  
9 determine if the p53 gene was altered. I would  
10 do a test to determine the nature of the  
11 alteration.  
12 Q What is the test?  
13 A You would need a PCR and a p53 to  
14 determine the alteration.  
15 Q Who does that?  
16 A Well, our lab does it, not for  
17 litigation, but for research purposes.  
18 Q Is it expensive?  
19 A It's not expensive.  
20 Let me continue with the answer.  
21 There is a clinical trial drug vaccine against  
22 p53 in patients who have untreated cancer,  
23 especially lung cancer, and they will admit  
24 patients to the vaccine if and only if the p53  
25 gene is altered. So they measure the p53 gene.

1 But they do that in a clinical setting.  
2 Q How long does it take?  
3 A A couple weeks.  
4 Q Well --  
5 A It would important in this case to  
6 know at what stage the p53 was altered. It may  
7 have been altered in the metastases. I think  
8 it would be important to look at the BAC  
9 because that's where it is beginning. That is  
10 just one test that is not present.  
11 Q How often do you see a test like  
12 that being present?  
13 A It depends on the setting.  
14 Q Well, let's start with all  
15 settings, any and all settings. How often do  
16 you see it?  
17 A We do an immunostain screening of  
18 breast cancer. We sometimes do it of bladder  
19 cancer and we sometimes do it of lung cancer.  
20 Q How often of lung cancer?  
21 A Maybe 10 percent of the time.  
22 Q Tell me one more time; p53 gene  
23 alteration and the other test you would like to  
24 see done is a what?  
25 A Well, there are other genes that

1 have been activated in lung cancer that have  
2 been linked to smoking. K-Ras. Another gene  
3 is Harvey-Ras, and then there's N-Ras.  
4 Q Harvey-Ras?  
5 A Harvey, like the guy's name  
6 Harvey. There are a number of molecular  
7 alterations that's have been observed in lung  
8 cancer.  
9 Q Okay. But before we get onto  
10 K-Ras and Harvey-Ras, you mentioned one subset  
11 of the p53 gene alteration, some other test  
12 you'd like to run, some other screen, some  
13 other like --  
14 A I said sequencing to determine the  
15 type of the alteration and its location.  
16 Q Yes, you did.  
17 Okay. Let's forge on here.  
18 What's the next one?  
19 A Well, I was mentioning before we  
20 went back to the thyroid transcription factor,  
21 paper 13, called, "A Specific Spectrum " This  
22 paper is like the Gazdar paper. It just talks  
23 about the importance of mutations in smokers  
24 and in pointing to -- or in support of being a  
25 smoking-related etiology.

1 (The document referred to was  
2 marked by the C. S. R. as Plaintiff's  
3 Exhibit 13 for identification and was  
4 attached to and made part of this  
5 deposition.)

6 THE WITNESS: The next paper is by  
7 Ikeda et al. talking about "The Changing  
8 Pattern of Lung Cancer by Histological Type,"  
9 and this paper observes the increasing  
10 incidence of adenocarcinoma over the decades  
11 and bronchioloalveolar carcinoma. 70 percent  
12 of their adenos were BACs, and actually this  
13 paper -- again, it antedated my paper. So you  
14 can say my paper confirmed those findings.  
15 This is 14.

16 (The document referred to was  
17 marked by the C. S. R. as Plaintiff's  
18 Exhibit 14 for identification and was  
19 attached to and made part of this  
20 deposition.)

21 THE WITNESS: Next paper, which  
22 would be labeled 15, is entitled -- it's by  
23 Mayne et al. -- "Familial Cancer History and  
24 Lung Cancer Risk in United States Nonsmoking  
25 Men and Women." It talks about that there are

1 genetic or familial risk factors that are  
2 linked to lung cancer that are in operation,  
3 and it just points out that, you know, there's  
4 genetic components to lung cancer like there is  
5 in many cancers. And some patients have a  
6 genetic predisposition.

7 (The document referred to was  
8 marked by the C.S.R. as Plaintiff's  
9 Exhibit 15 for identification and was  
10 attached to and made part of this  
11 deposition.)

12 THE WITNESS: The next paper,  
13 which is 16, by Park et al. is called  
14 "B-Adrenergic Mitogenic Signal Transduction in  
15 Peripheral Adenocarcinoma: Implications for  
16 Individuals with Preexisting Chronic Lung  
17 Disease." It talks about a possible connection  
18 between drugs that are used to treat asthma and  
19 peripheral lung adenocarcinomas. It makes the  
20 point that I alluded to earlier that peripheral  
21 adenomas of the lung, which include BACs, are  
22 increasing in both smokers and nonsmokers,  
23 increasing purportedly in both groups and  
24 therefore raising the possibility that there is  
25 possibly a risk factor unrelated to smoking

1 that occurs in both sexes.

2 (The document referred to was  
3 marked by the C. S. R. as Plaintiff's  
4 Exhibit 16 for identification and was  
5 attached to and made part of this  
6 deposition.)

7 THE WITNESS: Next paper is by  
8 Wang called "Coordinate Expression of  
9 Cytokeratins 7 and 20 Defines Unique Subsets of  
10 Carcinomas." This paper was included again in  
11 the event that there may have been those  
12 immunostains done, which there wasn't.

13 BY MR. PIUZE:

14 Q So you just made that paper 17.

15 (The document referred to was  
16 marked by the C. S. R. as Plaintiff's  
17 Exhibit 17 for identification and was  
18 attached to and made part of this  
19 deposition.)

20 THE WITNESS: The next is the new  
21 WHO classification which we've talked about  
22 before several times in this deposition. I am  
23 citing it because -- I told you my  
24 reservations, but I'm comfortable in using  
25 it -- I want to define what's present and what

1 isn't and that fits my classification.

2 (The document referred to was  
3 marked by the C. S. R. as Plaintiff's  
4 Exhibit 18 for identification and was  
5 attached to and made part of this  
6 deposition.)

7 THE WITNESS: The next one is 19.  
8 It's by Wynder, and this paper may  
9 be -- actually this was in duplicate. I had it  
10 in twice. I must have had it in twice. I  
11 pulled it from two lists. So we'll just  
12 scratch it and the next paper is  
13 entitled -- it's by Wu et al., "Lung Carcinoma  
14 Patients with a Family History of Cancer and  
15 Lymphocyte Chromosome 9 Aberrations." It just  
16 talks about families that have genetic  
17 aberrations, there's an increased chance of  
18 lung cancer, talking about lung cancer as a  
19 multiple factor to disease in which the genetic  
20 and environment interplays. So that will be  
21 19.

22 (The document referred to was  
23 marked by the C. S. R. as Plaintiff's  
24 Exhibit 19 for identification and was  
25 attached to and made part of this

1           deposition.)  
2           THE WITNESS: The final reliance  
3 document is Sam Hammer's chapter from his  
4 textbook on common neoplasms of the lung where  
5 he talks about BAC. He illustrates the  
6 D-differentiation concepts in a picture of BAC.  
7 He sites my work with scarring in BAC with  
8 permission from a book that I published in the  
9 "American Journal of Pathology," and that's why  
10 that's there.

11           (The document referred to was  
12 marked by the C. S. R. as Plaintiffs'  
13 Exhibit 20 for identification and was  
14 attached to and made part of this  
15 deposition.)

16 BY MR. PIUZE:

17           Q All right. Now, let's go to yours  
18 just continue the same numbering system Let  
19 us have the lead author and the title.

20           A There's one paper here -- the  
21 papers must have slided together. There's one  
22 paper that is not mine.

23           Q Sure.

24           A It's No. 21. It's by Denissenko,  
25 an article called "Preferential Formation of

1 Benzo[a]pyrene Adducts at Lung Cancer  
2 Mutational Hotspots in p53." It addresses the  
3 fact that this -- this procarcinogen, which is  
4 well known to be in cigarette smoke, can  
5 cause -- can develop adducts in lung cancer  
6 tissue. These adducts are found in mutational  
7 hotspots in the p53 gene in people who get lung  
8 cancer related to cigarette smoking. I would  
9 expect to find these adducts present in their  
10 tissue, and I would use that as a finding,  
11 important finding.

12 And in this case I saw no  
13 measurements of those. So I don't know if  
14 there are any adducts in -- in the bronchiole  
15 histopathology. That looked normal to me.

16 Q Spell that word.

17 A A-d-d-u-c-t-s.

18 (The document referred to was  
19 marked by the C.S.R. as Plaintiff's  
20 Exhibit 21 for identification and was  
21 attached to and made part of this  
22 deposition.)

23 THE WITNESS: Okay. That is the  
24 end of the papers, and then I will get into  
25 mine -- let me just put these in an order,

1 historical order. The first paper which would  
2 be 22 is a paper by myself et al., "Rising  
3 Incidence of BAC and Its Unique Clinical  
4 Features." It observes the increase in BAC and  
5 also the increase in adeno and the rise in  
6 population from 1950 to 1990. It talks about  
7 the unique aspects of this disease  
8 geographically biologically. It talks about  
9 how these diseases are different from other  
10 cancers in terms of its multifocality.

11 (The document referred to was  
12 marked by the C. S. R. as Plaintiff's  
13 Exhibit 22 for identification and was  
14 attached to and made part of this  
15 deposition.)

16 THE WITNESS: The next paper is by  
17 myself, et al. talking about the "Multifocality  
18 of BAC: Evidence and Implications of a  
19 Multiclonal Origin." I mentioned earlier in my  
20 deposition -- and by the way, this is 23 --  
21 that BACs are often multifocal. They differ  
22 from other BAC cancers. This article shows  
23 that at least some of the time they are  
24 different clones that give rise to BAC. It's  
25 multiclonal, hence. But it's separate clones

1 that are affected. It's a field phenomenon, if  
2 you will. And that phenomenon is seen in  
3 virally induced cancer-like due to Hepatitis-B  
4 and gives rise to multiclonal tumors. And it  
5 was this finding that led me to investigate the  
6 retroviral relationship of BAC, which I'll on  
7 in a second.

8 (The document referred to was  
9 marked by the C. S. R. as Plaintiff's  
10 Exhibit 23 for identification and was  
11 attached to and made part of this  
12 deposition.)

13 THE WITNESS: And the next paper  
14 is 24. It's the marijuana, cocaine, tobacco  
15 smoking study. It looked at the effect of  
16 these agents on the bronchial epithelium and  
17 noted profound changes with smoking on the  
18 bronchial epithelium

19 Q Does that mean we can rule  
20 Mr. Boekin out as a dope smoker?

21 A Again, I tried to make the point  
22 repeatedly in this depo. You can't make  
23 conclusions about an individual case with  
24 epidemiological evidence. We know he took to  
25 smoke of tobacco, and yet he doesn't have any

1 changes, and he could have smoked one of the  
2 other substances, too, and had no changes.

3 (The document referred to was  
4 marked by the C. S. R. as Plaintiff's  
5 Exhibit 24 for identification and was  
6 attached to and made part of this  
7 deposition.)

8 THE WITNESS: And then the final  
9 paper is 25 -- well, that's one of my most  
10 recent papers that I did in collaboration with  
11 a number of scientists in Europe. It's by M  
12 De las Heras et. al at the Moredun Institute in  
13 Scotland where they have this endogenous  
14 disease of sheep called jaagsiekte, the BAC  
15 equivalent in sheep. Which can quantify this  
16 clone and from this study, we took the protein  
17 from this, injected antibodies and showed that  
18 human beings expressed a similar protein. And  
19 that's the last of my reliance documents.

20 (The document referred to was  
21 marked by the C. S. R. as Plaintiff's  
22 Exhibit 25 for identification and was  
23 attached to and made part of this  
24 deposition.)

25 BY MR. PIUZE:

1 Q Have you told me about all of the  
2 opinions that you presently intend to give at  
3 the time of trial on this man?  
4 A I think so.  
5 MR. PIUZE: You may go, to quote  
6 "a famous movie, "let me not be so famous,"  
7 Joan Wilder.  
8 Do you remember that Joan Wilder?  
9 Do you remember that, you and your sister may  
10 go?  
11 Okay. Seeing that you've been a  
12 party to the stipulations before, is it okay  
13 with you guys if she does the same stipulation?  
14 MR. CARLTON: I'm sorry. The time  
15 frame has to be sort of foreshortened here  
16 because of trial.  
17 MR. PIUZE: You're kidding me.  
18 Do you really think he's going to  
19 get on the witness stand?  
20 MR. CARLTON: What are you  
21 thinking, 14 days is fine. 5 days I have a  
22 problem with.  
23 MR. PIUZE: No, 14 days.  
24 MR. CARLTON: 14 days from  
25 receipt.

1 (The stipulation from the  
2 deposition of Peter Julien, M.D., was  
3 incorporated as follows:

4 "MR. PIUZE: Anyway, here's  
5 the stipulation. You can go.

6 "The court reporter can be  
7 relieved of her duty to maintain  
8 the original under the Code of  
9 Civil Procedure.

10 "She will send the original  
11 of this deposition to whom,  
12 Ms. Williams?

13 "MS. WILLIAMS: To our  
14 offices.

15 "MR. PIUZE: To Arnold &  
16 Porter. And if there are any  
17 changes, additions deletions or  
18 corrections to the transcript,  
19 Ms. Williams will notify me within  
20 two weeks of her receipt. If not,  
21 I can use a -- my copy as if it's  
22 a signed original.

23 "MS. WILLIAMS: So  
24 stipulated.

25 "THE WITNESS: I have a

1 right to review that and make any  
2 corrections?  
3 "MS. WILLIAMS: Yes. 15  
4 days from the time that I get it  
5 to you.  
6 "THE WITNESS: Okay.  
7 "MR. PIUZE: Two weeks from  
8 your receipt -- that's what you  
9 just agreed to -- which is less  
10 than 15 days.  
11 "MS. WILLIAMS: I think we  
12 should do 15 days since that's  
13 been the standard so far.  
14 "MR. PIUZE: Excuse me?  
15 "MS. WILLIAMS: 15 days has  
16 been the standard. That's what we  
17 just said this morning.  
18 "MR. PIUZE: Okay. ")  
19 MR. PIUZE: Okay. That's it.  
20 (Whereupon, at 7:21 p.m., the  
21 deposition of Sanford H. Barsky, M.D., was  
22 concluded.)  
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I, SANFORD H. BRASKY, M D., do hereby declare under penalty of perjury that I have read the foregoing transcript; that I have made any such corrections as appear noted, in ink, initialed by me, or attached hereto; that my testimony as contained herein, as corrected, is true and correct.

EXECUTED this \_\_\_\_ day  
of \_\_\_\_\_, 2001, at  
\_\_\_\_\_, \_\_\_\_\_.  
(City) (State)

\_\_\_\_\_  
SANFORD H. BRASKY, M D.

1 STATE OF CALIFORNIA )  
 : ss.  
2 COUNTY OF LOS ANGELES )  
3

4 I, the undersigned, a Certified  
5 Shorthand Reporter of the State of California, do  
6 hereby certify:

7 That the foregoing proceedings were  
8 taken before me at the time and place herein set  
9 forth; that any witnesses in the foregoing  
10 proceedings, prior to testifying, were placed  
11 under oath; that a verbatim record of the  
12 proceedings was made by me using machine  
13 shorthand which was thereafter transcribed under  
14 my direction; further, that the foregoing is an  
15 accurate transcription thereof.

16 I further certify that I am neither  
17 financially interested in the action nor a  
18 relative or employee of any attorney of any of  
19 the parties.

20 IN WITNESS WHEREOF, I have this date  
21 subscribed my name.

22  
23 Dated: March 27, 2001

24  
25 \_\_\_\_\_  
VIVIAN C. DERNBURG  
CSR No. 11339