CAUSE NO. 8111*JG99

[redacted], ET AL. * IN THE DISTRICT COURT
VS. * BRAZORIA COUNTY, TEXAS
AMOCO CHEMICAL COMPANY, * 239TH JUDICIAL DISTRICT
ET AL. *

CAUSE NO. 01-CV-1211

[redacted], ET AL. * IN THE DISTRICT COURT
VS. * GALVESTON COUNTY, TEXAS
ABLE SUPPLY COMPANY, ET AL. * 405TH JUDICIAL DISTRICT

NO. 99-CV0131

[redacted], ET AL. * IN THE DISTRICT COURT
VS. * GALVESTON COUNTY, TEXAS
AIR PRODUCTS & CHEMICALS, * 10TH JUDICIAL DISTRICT
INC., ET AL. *

CAUSE NO. 99-7095-E

[redacted], ET AL. * IN THE DISTRICT COURT
VS. * NEUCES COUNTY, TEXAS
ALCOA INC., ET AL. * 148TH JUDICIAL DISTRICT

CAUSE NO. 99-CV-1213

[redacted], ET AL. * IN THE DISTRICT COURT
VS. * GALVESTON COUNTY, TEXAS
AIR PRODUCTS & CHEMICALS, * 10TH JUDICIAL DISTRICT
INC., ET AL. *

CAUSE NO. 10515*JG99

[redacted], ET AL. * IN THE DISTRICT COURT
VS. * BRAZORIA COUNTY, TEXAS
AIR PRODUCTS & CHEMICALS, * 239TH JUDICIAL DISTRICT
INC., ET AL. *

CAUSE 14272*JG00

[redacted], ET AL. * IN THE DISTRICT COURT
VS. * BRAZORIA COUNTY, TEXAS
GAF CORPORATION, ET AL. * 239TH JUDICIAL DISTRICT

DEPOSITION
OF
JAY T. SEGARRA, M.D.

Taken on behalf of the Defendants
9:35 a.m., Wednesday, June 18, 2003

before
Lynn Strickler, CSR #1299

The deposition of JAY T. SEGARRA, M.D., taken on the 18th day of June, 2003, commencing at 9:35 a.m., at the offices of Coast-Wide Reporters, located at 782 Water Street, in the City of Biloxi, County of Harrison, State of Mississippi, before Lynn Strickler, CSR, Freelance Court Reporter and Notary Public within and for the County of Jackson, State of Mississippi.

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NO EXHIBITS

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JAY T. SEGARRA, M.D.,
having been produced and first duly sworn, was examined and testified as follows:

- - -

MR. ALMQUIST: Before we get started, I would like to put on the record that we agreed to one objection good for all present.

MS. PAPANTONAKIS: Yes.

MR. ALMQUIST: And for the format, we decided to address these plaintiffs individually and allow everyone who has questions concerning that plaintiff to ask questions and then move on to the next plaintiff rather than require somebody to come back and ask questions about somebody that was first asked about two hours, three hours earlier.

MS. PAPANTONAKIS: Exactly. And, also, we're going to do the Twist case first.

MR. ALMQUIST: And we're doing the case first. And I guess your book is alphabetical. We can just follow through in your book if you want to.

MS. PAPANTONAKIS: Yes. The first plaintiff is

EXAMINATION

BY MR. ALMQUIST:

Q. Would you state your name for the record, please?

A. Jay Segarra.

Q. Dr. Segarra, we're here today to ask you about some plaintiffs in several cases and we're starting with the [redacted] case. And I have just a couple of short, brief general questions before we get into the individual plaintiffs.

I know you've testified in the past about some studies that you participated in with a group in California. There are several presentations that resulted from that study.

Are you working on any current studies with regard to any type of asbestos-related disease or injuries?

A. Well, I have nothing on the front burner. I have some potential projects that I haven't yet put a lot of time into.

Q. Have you put any time into any of those projects?

A. Yes, I have, but it's not something I'm working on right this second.

Q. Is it anything that you would anticipate

having any work product in, in the next six to eight months, for example?

A. Probably in time for the 2004 ATS meeting.

Q. And what's the nature of that project?

A. It would be pulmonary function values in certain asbestos-exposed subjects, which is the same sort of theme I've been doing before. It's just variations of that.

Q. Who are you working with on that project?

A. With Ray Warshaw and John Thornton and sometimes Al Miller.

Q. Anyone else that you're working with on that group?

A. No.

Q. Is there any particular group that you're studying for that work?

A. It's not a particular group. It's just part of the database.

Q. Is this a further analysis of the data that you've already obtained?

A. Yes. And it's -- by database, I mean the larger database and also the -- sometimes we do some work on the specific database that consists of the aluminum workers from Wenatchee, Washington.

Q. Any other projects that may be on the back

burner other than this project?

A. No, not pertaining to occupational lung disease.

Q. Do the armed services or the V.A. have any type of criteria for diagnosing asbestosis in veterans?

A. Criteria. You mean like criteria that they superimpose upon whatever their doctors decide, no. It's up to the clinical judgment of the doctor.

Q. In order to award service-related disability, are there any guidelines or standards for the V.A. or armed services?

A. They meet a -- anybody who claims any kind of disability, be it pulmonary or otherwise, has to meet a medical board. And the medical board makes the determination. The board consists of certain members. Some of their criteria are general and clinical and sometimes they are specific, but that's up to the board to decide.

Q. But there's no source that you could point me to in any place that would set out any type of criteria that's used by the V.A. in that regard?

A. No. No, there's not actually. I don't work for the V.A. directly, so I don't know for sure. But there's not in the military, anyway. There's a military regulation that governs disability and

criteria for medical discharge, but those have to do with fitness for duty, and that's different than disability. So I don't really know what the V.A. disability criteria are.

Q. You've indicated that these individuals that you see here are -- you don't consider them to be patients in the traditional sense; is that correct?

A. Yes, that's true. I consider there to be a limited doctor-patient relationship based on flow of information at the time that I see them and identification of life threatening conditions that might come to light during the course of the examination. But they are not longitudinal patients, and they're patients that I consult on, on a one-time basis.

Q. If you were examining a patient in private practice, a patient who was your individual patient, not in relation to litigation, typically what protocol would you follow in order to diagnose them with pneumoconiosis? What tests would you order or run?

A. It would be the same protocol that I use for my medical/legal occupational pneumoconiosis evaluations, which is history -- basically it's history and chest x-ray, CT scan, if it's available, particularly high resolution chest CT scan.

If that's not available, then it's basically based on the history and the x-ray. Pulmonary function tests are a measure of impairment, and those are included in all individuals when they're available. And if I'm actually consulting with a patient in the office, I would perform a physical examination.

Q. Typically in a private patient situation, do you require the high resolution CT scan before making the diagnosis?

A. No, I don't. I do the high resolution chest CT scan if there's a clinical indication for it, such as a questionable malignancy that is not satisfactorily resolved by the plain chest x-ray and other information.

Q. And I believe at the last deposition you gave, you were asked some questions -- you mentioned that you thought there was a new ATS standard that was supposed to be published. Is that standard still not out?

A. It's overdue, yeah. I expect it anytime.

Q. Let's turn to the individual plaintiffs, if we could. Let's start with [redacted].

A. Okay.

Q. Okay. You saw Mr. [redacted] on April 18th of 2001. Does that date reflect, there at the corner, the

date of your report or the date that you saw him?

A. The date that I saw him, both.

Q. And do you recall whether at that time you were licensed to practice medicine in the state of Texas or not?

A. I think I had a temporary license. I don't have my briefcase with me. But when I first initiated the licensing process in Texas, they gave me a temporary license. And then the permanent license came through towards the end of the year, October or November of 2001.

Q. And when did you get the temporary license?

A. Early in 2001. I don't remember the exact date.

Q. Did you personally take the occupational history from Mr. [redacted], or did that come from the sheet that's ordinarily filled out?

A. Both. I mean, I took a history, but, yes, this person probably filled out a sheet because most people do. Not everybody does. Sometimes they don't fill it out, in which case I do the whole thing myself.

Q. And I believe you testified -- is it true in this case, as in the others, that you don't maintain copies of the forms that were filled out by Mr. [redacted] with the assistance of the nurse?

A. No. They're just notes. And everything that was -- that would be pertinent to any occupational lung disease evaluation goes into the form regardless of the nature of the information. It all goes into my report.

Q. Does the form that is filled out by these patients have any indication of the locations where these exposures may have occurred? And by that, I mean specific locations, naming companies?

A. No. I don't generally do that. I generally look at the history as generic because this, to me, is an objective scientific evaluation. I'm not trying to attribute anything to any particular company. So I tend to avoid proper names unless there's one -- only one location that the patient insists that that's the only place where he worked where he may have been exposed to whatever substance is of interest, in which case I may put that into the report, but that's rare. Most of the time I avoid that.

Q. Do the forms that these individuals fill out frequently have information about the specific location of where they may have had exposures?

A. Sometimes that might be on the form and sometimes it won't be. It depends.

Q. Do you ever review those forms prior to giving trial testimony in a case?

A. No, never. The forms, as I told you before, go away after the report is generated and reviewed and signed and proofread and so on.

Q. Well, could you be a little bit more specific about how they go away, Doctor?

A. We destroy them. They go in the trash.

Q. They're not returned to plaintiffs' counsel?

A. No. I think sometimes they were in the past. I don't think we do that now. But I don't -- my office staff really has control over them. I don't instruct them one way or the other about the questionnaires.

By forms, I assume you're referring to the four-page questionnaire that each patient fills out when he comes to the office?

Q. That's correct.

A. Yeah. Right.

Q. So those forms are actually destroyed by your staff?

A. I think so. They're supposed to be. They may keep them for a month or so until there's no further problems with the reports because they have my notes on them. But after the reports are -- it's clear there's going to be no addendums to the reports, then they are discarded after that.

Q. The handwritten notes that you take on your

private patients, do you destroy those as well?
A. Yeah. It's just -- it's a worksheet, basically. Whatever goes into the medical record is my report. And, for instance, at Keesler Hospital when I would -- although I handwrite most of my notes at Keesler Hospital, I dictate some of them. And whatever notes I used as I was dictating, those get put in the shredder or the trash.
The new HIPAA regulations say you're supposed to shred anything that has any patient information on it. So nowadays they go into a shredder, just like any other medical office. At least they're supposed to.
Q. Doctor, if you look at the pulmonary function tests that were run by -- on this, the technician is VA, slash, MA. Can you tell me who VA is or what VA, slash, MA means?
A. Yes. That's the initials of the technician who actually performed the test.
Q. And who was that technician?
A. Valerie is her first name. Her last name, I have trouble with it. It's a hard name.
Q. And do you know what MA stands for?
A. No, I actually don't.
Q. Do you know if she's registered --
A. Oh, you know, actually I think MA might be

her last name. And VA is, I think, just the first two letters of her first name.
Q. Do you know if she's a registered pulmonary function technician in the state of Texas?
A. I believe she is. She's worked -- I know she's worked for years at a large hospital in Austin, Texas. I don't know exactly what her certifications are. But Linda Holland who employs her has all that information.
Q. Do you know if the equipment they use is registered with the State of Texas?
A. I believe it is. I'm not sure that pulmonary function equipment needs to be registered, but I don't know. All that information, Linda Holland would have that stuff.
Q. And is the same true with respect to how frequently and how the machines are calibrated? Do you have any information on that?
A. Well, I know that this system is calibrated after every patient.
Q. And how do you know that?
A. Because they -- there's a self-calibration module on the machine that does that, and that's part of the protocol for doing the test. And if the machine falls out of calibration, quote, unquote, it goes down

until it comes back into calibration. That's the protocol for handling the Sensor Medics equipment, and those machines have become popular because of that feature.
Q. Mr. [redacted] gives you a history of being short of breath. Is that an unusual history in a seventy-one year old man, getting short of breath doing physical activity?
A. No.
Q. His pulmonary function tests were normal; is that correct, Doctor?
A. Yes.
Q. Probably aided by the fact that he quit smoking back in 1971, I would imagine?
A. Yeah. It certainly improved the odds for him. His lung volumes are at the lower end of the normal range, but they're still within normal limits.
Q. If you'll assume with me for a moment that Mr. [redacted] testimony in this case is that he was a -- with respect to my client, The Dow Chemical Company, that he may have been there nine hours a week as a truck driver, where he either sat in the truck or went to a waiting room for his truck to be loaded and that this occurred over a period of about two or three years. Do you have any opinion as to whether or not

that could have contributed to any pneumoconiosis that you may have diagnosed in Mr. [redacted]?
MS. PAPANTONAKIS: Object to form.
A. Well, I think that it could have contributed to his pneumoconiosis, yes. I don't think that it would be likely that that would be a significant component of asbestosis. It certainly could be the sole cause of mesothelioma since, as you know, the threshold level of exposure for mesothelioma, if it exists at all, is very low.
MR. SHELTON: Objection; nonresponsive.
BY MR. ALMQUIST:
Q. Given the history that was given by Mr. [redacted] of his other exposures, do you believe that he would have developed a pneumoconiosis even if he had not had these visits to Dow as a truck driver?
MS. PAPANTONAKIS: Object to form.
A. He probably would have, yes.
BY MR. ALMQUIST:
Q. Do you have an opinion as to whether Mr. [redacted] is more likely than not to develop any malignancy in the future as a result of his asbestos exposure.
Well, let me break that down. Do you have an opinion, specifically with respect to mesothelioma,

whether he's more likely than not to develop mesothelioma in the future as a result of his asbestos exposure?

A. Although his risk for developing mesothelioma is greatly increased as a result of his asbestos exposure, the absolute probability of contracting that disease is far less than fifty/fifty.

Q. Okay. Same question with respect to lung cancer?

A. In respect to lung cancer, although his risk is increased similar to my last statement, it does not approach fifty/fifty.

Q. And the same question with respect to any other asbestos-related cancer?

A. My answer would be the same.

MR. ALMQUIST: I believe that's all the questions I have of Mr. [redacted]

MR. PETERS: I don't have [redacted].

MS. PAPANTONAKIS: If no one else has any questions about Mr. [redacted] we'll move on to the next plaintiff, which is [redacted].

- - -

EXAMINATION

BY MR. ALMQUIST:

Q. [redacted] You want to take a moment

to look over his report, Doctor?

A. I could. Although if you just give me time to answer each of your questions, I can probably catch up as you go.

Q. You saw Mr. [redacted] in October of 2001; is that correct?

A. October 10th, yes.

Q. It looks like Mr. [redacted] indicated his first asbestos exposure actually occurred in the Navy from '54 to '58, where he was actually working with powdered asbestos; is that correct?

A. Correct.

Q. Looks like beginning in the mid '60s, he's talking about construction in chemical plants and power plants. Is that also what you recall of his history?

A. Yes. That's what I got from him and from his questionnaire; right.

Q. You noted in his history here that he did smoke -- matter of fact is continuing to smoke one and a half packs of cigarettes daily for fifty years; is that correct?

A. That's right.

Q. What did you advise him with respect to that cigarette smoking, Doctor?

A. The same as I advise everybody, which is

that it's good for everyone to quit smoking. But people who have been exposed to asbestos have a particular reason to quit smoking because of the synergistic increase in risk for lung cancer. I don't use those words exactly, but I kind of fleshed that out a little bit.

Q. His history indicated he had a pneumothorax in 1956. Can you tell us what's meant by pneumothorax?

A. It's air between the lung and the pleural space. The common term would be a collapsed lung. That covers more ground than a pneumothorax is. But basically it means that his lung collapsed suddenly probably because a little air sac ruptured in the wall of the lung.

Q. Do you have any indication that that has anything to do with any occupational exposures he may have had?

A. I doubt strongly that it would have.

Q. Also, he has a history of seven or eight years ago having an unknown pulmonary infection. Do you have any indication that that pulmonary infection had any connection with any occupational exposures to any substance?

A. Well, hold on a second. He has upper lobe infiltrates which are consistent with two different

processes that are vastly different. One of them would be silicosis, based on his silica exposure that he described. And the other, though, would be histoplasmosis or another type of pulmonary infection, such as tuberculosis or other fungal infections.

In this particular patient, because of that history of infection, each of those could account for the upper lobe changes. Not the lower lobe changes, but the upper lobe changes.

Q. What are the other significant medical conditions that Mr. [redacted] suffers from at this time?

A. Well, if you go to my diagnosis and impression section, from a pulmonary point of view I diagnosed him with pulmonary asbestosis; mild chronic obstructive pulmonary disease, or emphysema, depending on which term you want to use; the bilateral upper lobe infiltrates that I just described to you a minute ago. And those are his three pulmonary diagnoses.

I noted also that he had a history of heart disease and diabetes, which you can read in the history section of my report on page one.

Q. Now, in the case of Mr. [redacted], you did a chest x-ray and you have a profusion level of 1/0.

A. That's right.

Q. And I believe you testified in the previous

deposition that's the first abnormal level of interstitial fibrosis?
A. Under the ILO classification system, it's the first abnormal category as you look at the twelve boxes.
Q. And when the profusion level is listed as 1/0, what's the significance of the zero portion of that?
A. It means that at some point during the deliberation, the zero standard was considered and looked at and ultimately rejected in favor of the 1 standard.
Q. But then in this particular patient, you did have to consider a zero or negative finding, normal finding, before reaching your conclusion?
A. In the visual analysis, yes.
Q. Mr. [redacted] had no pleural plaques, thickening or calcifications; is that correct?
A. That's right.
Q. With respect to the pulmonary function test, there is a mild obstructive defect, which I believe you indicate is related to his cigarette smoking; is that correct?
A. I didn't actually say. I think that -- hold on. I think that his cigarette smoking was the

predominant cause of that. As I've testified before, asbestosis in its early stages has initially an obstructive effect on pulmonary function testing due to peribronchial fibrosis, which is the earliest pathologic change in asbestosis.
And then there's a third reason why he might have obstructive disease, and that is the upper lobe nodule infiltrates. Whether they're related to silicosis or to pulmonary infection, fungal disease or TB, that can also have -- can be contributing to the airflow obstruction.
Q. Now, you do indicate in your report that there is some reduction in diffusion capacity that you -- which you say provides physiological correlation for your interstitial radiographic abnormalities.
A. That's right.
Q. Are there other causes of reduced diffusion capacity?
A. Yes. There are -- it's quite possible that his -- the reduction in his diffusion capacity is multifactorial, with asbestosis being one of the factors.
Q. What are the other things that might cause a reduced diffusion capacity in an individual who has not been exposed to asbestos?

A. Well, emphysema itself can cause a reduction in diffusion capacity through destruction of the capillaries that accompany the terminal bronchioles, which is the area where -- the pathologic area where emphysema destroys lung tissue.
The second explanation for the reduction in DLCO would be cigarette smoking within twelve hours of taking the test causes a small but measurable reduction in the DLCO value. It would not account for the entire reduction, however.
Q. In a gentleman who has got a history of smoking for over fifty years, how do you confirm that he's not smoked any cigarettes within the last twelve hours before the test?
A. I can't. That's why I answered the question as I did.
Q. Any other potential cause of the reduction in diffusion capacity?
A. No. Covered it all.
Q. So those findings would not be unusual if you had an individual who is not exposed to asbestos but who had a fifty plus -- or a seventy-five-pack-year history of smoking as Mr. [redacted] has?
MS. PAPANTONAKIS: Object to the form.
A. No. That leap, I can't go with you on that

one, because if you look at the degree of his air -- his degree of reduction in diffusion capacity is out of proportion to his level of airflow obstruction, so that I think that it's quite likely that asbestosis is one of the factors reducing his diffusion capacity even if it isn't the only one.
MR. ALMQUIST: Object to the responsiveness.
BY MR. ALMQUIST:
Q. Could you see those types of findings in an individual who has not been exposed to asbestos but who has the heavy smoking history?
A. Is it possible you mean?
Q. Yes.
A. Yes.
Q. With respect to the upper lobe infiltrates, I'm not sure if any silica claim is being made in this case or not. But is there a question in your mind as to whether these are silica related or related to the histoplasmosis?
A. I just answered that earlier. Yes, I believe that there's a question.
Q. And so you're not here to render an opinion one way or another as to the cause of the upper lobe infiltrates at this time?
A. Well, according to my report, I thought that

silicosis was the more likely one, but that I'm raising the possibility that it certainly could be due to some pulmonary infection that I don't know about. We would have to examine his medical records to tell for sure.

Q. Have you looked at medical records on any -- or do you look at medical records on any of these individuals that you see?

A. There are times that I do. I can't recall offhand whether I looked at medical records for any of these individually. I don't think that I looked at any on Mr. [redacted].

Q. As to Mr. [redacted], as on the other plaintiffs, let me ask you, do you have an opinion as to whether it's more likely than not as to whether or not Mr. [redacted] will develop mesothelioma as a result of his asbestos exposure?

A. Although his risk for mesothelioma is increased, I don't -- that risk still doesn't approach fifty percent.

Q. What about his risk of developing lung cancer in the future?

A. I would answer that the same way.

Q. And with respect to his risk of developing any other form of asbestos-related cancer in the future?

A. I would answer that the same way as well.

MR. ALMQUIST: I believe that's all I've got on Mr. [redacted].

- - -

EXAMINATION

BY MR. PETERS:

Q. Dr. Segarra, my name is Norm Peters. I represent Celanese in this litigation.

With respect to the answers you just provided to Mr. Almquist here in the sense that none of the plaintiffs that we talked about today does not have a greater than fifty percent risk of developing lung cancer, mesothelioma or another asbestos-related malignancy, is that going to be the same answer you're going to have for all these gentlemen, or is it going to be on an individual basis?

A. That answer will be probably similar, but I would reserve the right to answer individually in each case. Just to amplify on your question, comparing -- who is the first one we did, [redacted]?

Q. Mr. [redacted].

A. [redacted]. Excuse me. Comparing Mr [redacted] to Mr. [redacted] Mr [redacted] risk for lung cancer is much lower than Mr. [redacted]. Mr. [redacted] has asbestosis with only a remote history of smoking; whereas Mr.

[redacted] has asbestosis, he's a current smoker and he's got obstructive lung disease. All of those things contribute to his risk of lung cancer. And although it doesn't exceed fifty percent, it comes kind of close. His lifetime risk of developing lung cancer, Mr. [redacted] is about one in three, whereas Mr. [redacted] is less.

Q. Okay.

A. But you didn't ask me that exactly, but -- so as to whether they exceed fifty percent, although mos of them do not, I would reserve that, to make an individual judgment on each one.

Q. I understand. With respect to Mr. [redacted] exposure history, do you in any way try to quantify a dose amount of exposure for these gentlemen that yo generally see in these medical/legal contexts?

A. No. No. This is a clinical evaluation. And the point of the history is to determine whether the history is adequate to have caused the findings that are the radiographic findings.

If the history is inadequate to cause the radiographic findings, then you have to look for another explanation. It's a qualitative assessment. It's not a quantitative assessment. And since it's retrospective, I mean that's fairly obvious that it is

a qualitative assessment.

Q. I understand. Do you take into account the craft that an individual performs in his work history in determining whether or not there is enough exposure to asbestos to develop disease?

A. I do for sure. Now, in Mr. [redacted] case, he was pretty specific about what he did. And the exact name of his job doesn't matter in his particular case because he handled powdered asbestos, he worked around insulators and so on and so on.

But in someone who is not as expressive as Mr. [redacted], then the trade would carry more importance, yes.

Q. Do you take into consideration or do you ask these gentlemen, for instance, a welder, such as Mr. [redacted] here, he removed asbestos from pipes and boilers with hammers. Do you take into consideration how long he might have performed that task or how many times in a particular day, week or year in forming your opinions?

A. When that information is available, yes. If he did it only once, that's different than doing it four times a week for six years. So I try to. Sometimes it's not -- that's not available.

Q. Is that information that is provided or

questioned by the questionnaire?
A. Well, no. The questionnaire just lists -- the person writes down where he worked and what he did. And then he's asked questions about, well, what did you do there; what was your job; what are the kinds of things you were exposed to; did you work with insulation; in what way; or if you didn't handle it, did you work around it, or very rarely. And then we try to break it down into which -- each period, each job period.

So that what applies to the period in Mr. [redacted] case from 1964 to the 1990s might not apply to the period from 1954 to 1958. You know, it's not -- in that way you can kind of get a sense of how much exposure he had in a clinical sense.

Q. Do you consider -- for instance, as you stated from 1964 to 1990s, do you believe that Mr. [redacted] was being exposed to asbestos insulation from pipes and boilers in the 1990s?

A. Well, I know -- sometimes the patients know very well when they were -- when they stopped being exposed and sometimes not, and sometimes they don't. Sometimes it's all insulation to them and they don't really know what it was composed of sometimes.

But I know that asbestos was the predominant

industrial insulator used up until 1972, and it was used sporadically after that in the U.S. But then after about 1975, most exposure between 1975 and the early 1980s was tear-out from old preexisting insulation.

And then after the early to mid 1980s, abatement protocols were in place. And unless there was a serious breakdown in safety protocol, there shouldn't have been significant exposure after that time. But that's what I know. The patients don't know that.

So is it possible he was exposed to it in the 1990s? Certainly. If an abatement protocol broke down, if that big plastic thing that encloses the abatement proceedings was not air proof, he may have been exposed. Is it likely that he was exposed to asbestos then? It's hard to say, I guess I would say.

Q. When you prepare your reports, such as this case, from '64 to '90, do you just, I suppose, reiterate what the plaintiff indicates to you; you have no objective evaluation of the plaintiff's work history in this regard, in forming exposure assessment?

A. I try to report what the plaintiff says. When I form my diagnostic impression, of course I make an interpretation, but I write down what the patient

says. If this patient said that he worked in a clothing factory from 1985 to 1992 and he was heavily exposed to asbestos that was in the pipes and the plant came on line in 1980, well, I would have a hard time diagnosing asbestosis in that person. In fact, I wouldn't. But that's not the case here. I'm just giving you an example.

Q. Sure. And in that example would you note in your report why you would not believe he was diagnosed -- why you wouldn't diagnose him with asbestosis?

A. Because although -- I mean, I believe everything patients tell me. They can -- as I said, insulation is insulation to them. Sometimes they know quite well what the product contained and what it didn't and what the name of the product was and so on. And sometimes it's just dust and insulation to them. And I have to make an interpretive judgment based on what was likely at the time as opposed to what's not likely, which is the same thing I would do in the office in a clinical sense if I were seeing him as a regular patient, as his consulting physician or his treating physician. I would make the same kind of judgment based on what he told me. It's not magic. It's just common sense.

Q. You note about midway through your work history here that he worked around insulators, pipe fitters and boilermakers.

A. Yeah, I see it.

Q. Do you take into consideration his proximity to these other types of crafts going on when performing your exposure assessment?

A. Well, when I say "around," I mean I assume in his immediate work vicinity, like in this same big room, something like that.

Q. Something like that. Is that ten feet maybe? Do you use any type of quantitative --

A. Sometimes -- sometimes they tell me that. Sometimes they don't know or don't say.

Q. Do you believe there's a distance from which, say, Mr. [redacted] could have worked next to an insulator performing insulation work where he would have no exposure to asbestos?

A. That would depend on a lot of things. The answer is probably, yes, theoretically. In practice, I don't know what that would be. It would depend on whether they were working in a confined space. Depends on what the ventilation system was. Depends on whether the insulation product being used was friable and generating lots of dust or not. Depends whether it was

outside or inside. There's a lot of factors.
Q. And do you ask your patients or these plaintiffs those types of questions when evaluating exposure, their exposures, in preparing your report and diagnosis of these people?
A. Sometimes.
Q. Okay. Is that type of information noted on your questionnaire?
A. Most of the time, yeah. Most of the time it is. But it would also be in the report if he answered one way or the other on that.
Q. In the absence of that information in this report on Mr. [redacted] would that indicate that you did not take that into consideration when you prepared your diagnosis?
A. Or it may be that he didn't say or couldn't remember.
Q. We don't know unless we have that questionnaire?
A. No, I wouldn't say that. I mean, the fact that I don't have it in there means that it was not something that he wrote down or responded to.
Q. When you asked him, would you have written down if he couldn't have responded to that? Say you asked him, well, Mr. [redacted] you talked about working

around insulators, pipe fitters and boilermakers and being exposed; can you tell me how long or how far away, on average, you worked around these people? Would you have written down "cannot remember"?
A. I may -- I may have. I may or may not have. Most of them, when they say they worked around it, they mean as far away as from me to the people sitting in the other room. That's what they usually mean. Now, they may not always mean that, but they usually mean that.
Q. We don't know unless we ask?
A. Well, I do ask.
Q. And you know whether or not they did?
A. Sometimes they remember. Sometimes they don't. Sometimes they just say, I don't recall; it was close by; I don't recall the exact distance. That's usually what they say.
Q. What does the new HIPAA law say with respect to destroying questionnaires in the medical/legal context?
A. The HIPAA law says nothing about that. It has to do with protecting patient privacy. And information with patient names on it need to be -- should be handled in a -- there should be an office protocol for handling such information.

Questionnaires or doctor notes are not part of the medical record unless they stand alone by themselves. And the questionnaires that I use when patients come to the office are not part of the medical record, they are my notes. And the report is part of the medical record.
That's the same as any other doctor who does any other kind of evaluation. The notes that he takes prior to performing his report are not necessarily part of the medical record. It's not an unusual practice at all. It's very common.
MR. SHELTON: Objection; nonresponsive.
BY MR. PETERS:
Q. These gentlemen are not your patients; correct?
A. Well, as I told you, as I -- we covered this ground. But at the time that I see them, there's a limited doctor-patient relationship. They are not my regular consulting or primary care patients, no.
Q. How would you define a limited patient? I don't understand what you're talking -- I see it either as they're a patient or they're not a patient, and I don't understand what you're telling me here. I don't know if you can better explain it to me, or is there a legal definition or medical definition or --

A. I don't know what the legal definition would be. The medical definition is that I'm consulting on them on a one-time basis to give them an opinion about their -- the nature of their lung disease, if it exists at all. And my obligations are to convey that information to them and to discuss its implications with them and give them some instruction for follow-up.
If there is an unsuspected finding that comes up in the course of that evaluation that has an immediate impact upon them clinically, then I must communicate that to them. That's pretty much where it stops.
Q. You produced your questionnaires previously in this type of medical/legal context; correct?
A. Have I produced them?
Q. Yes.
A. I don't know.
Q. Has any of the attorneys for which you have performed these medical/legal contexts asked you to destroy those questionnaires?
A. No.
Q. Has any of them asked you to retain those questionnaires?
A. No.
Q. Those questionnaires do form the basis for

your report; correct?
A. They're my notes that I use when I dictate my report, yes. There's additional information in my report that's not in the questionnaires which is in my head at the time that I do it. I dictate the reports five minutes after I see the patient, so there's information that I have made mental notes on that I didn't actually write down on the questionnaire.
Q. But you use the questionnaire in preparing your report?
A. Yes.
Q. Looking at Mr. [redacted] here, particularly the chest x-ray section, where you indicate there's other findings in the upper lobes which you may think are consistent with silicosis or tuberculosis or other fungal disease, did you consider obtaining prior films of Mr. [redacted] to determine the etiology of those findings?
A. Well, I did have a prior film from 1998 and they were unchanged. So all that tells me is that the upper lobe changes were not related to cancer because there would have been a change from 1998 to 2001. Beyond that, I can't say.
Q. In that prior film that you generally review during your reevaluations of these plaintiffs, it's

usually a screening B-Read; right?
A. I don't know.
Q. You don't know?
A. It doesn't say. It would make sense that it would be, but I don't know for sure.
Q. Are you ever provided with the B-Read from the screenings of these plaintiffs?
A. Sometimes.
Q. Not all the time?
A. But not all the time.
Q. Okay. If there did exist some prior films of Mr. [redacted] other than this 1998 film of June 24th, in your regular practice if he was a patient of yours, you would try to obtain those and look at those and try to determine what's going on in his lungs; is that correct?
A. Oh, I think I did determine what's going on in his lungs, pretty much. And he has a stable -- with a stable x-ray over three years, I don't think that it's possible to know much further what's going on in his lungs, as you say, since that film was three years prior to the other one. I think if there were -- if his situation were deteriorating or there was a question of cancer, then I would do some more invasive testing. But as it is, I don't think that's clinically

necessary.
Q. So correct me if I'm wrong, I think I understand your answer; if Mr. [redacted] was a patient of yours and he had some particular issues with his lungs and gives a history of a pulmonary infection, you do not think that it's necessary to look at his prior films in determining the status of Mr. [redacted] condition right now?
A. If his x-ray was stable over a three-year period --
Q. Right.
A. -- then it would not be crucial to do further tests to find out exactly what that -- what those infiltrates were.
Now, having said that, prior to certain things that would happen to him clinically, I might do some other things to evaluate that, such as before I put him on steroids, which I'm not thinking of doing, he has no reason to take them, but if he did -- if I did do that, prior to doing that I would do a skin test for tuberculosis to check to see if he has been exposed to tuberculosis. And I would probably try to obtain old medical records for him. But if I were not contemplating doing that and there was no questionable malignancy, that would be unnecessary.

Q. Where is the perihilar region?
A. We're changing the subject now?
Q. Yeah.
A. Okay.
Q. Where is the perihilar?
A. Perihilar is the area of the lung that surrounds the center of the chest.
Q. What's a granuloma?
A. It's a scar that results from infection in the lung, usually with tuberculosis or fungal disease, where the infection has become engulfed by the immune system in the lung and arrested and it leaves a little pock mark. Almost everybody has them who lives in the south.
Q. Where is the apex?
A. The tops of the lung.
Q. You testified just a moment ago that diffusion capacity can be reduced in an individual who has smoked within twelve hours of the actual pulmonary function test?
A. The DLCO value can be artificially lowered if you smoke within twelve hours of the test.
Q. Would it change -- could it be lowered even further if he smoked within two hours of the test?
A. I mean, sure. The closer you have smoked to

the test, the more of an impact it will have. But the maximum possibility of the impact on the DLCO value is thirty percent or so.

Q. And thirty percent of predicted value, would we add thirty percent to the forty-seven percent that's indicated in the DLCO right here, or was it thirty percent of the forty-seven percent?

A. That's the maximum impact. The average impact is much less than that. We were talking theoretically before. If we're going to talk about him, we would have to decide what's the most likely impact of current smoking. And I don't even know if he smoked within twelve hours. I really don't know if he did or not.

Q. Right. And I am talking generally. I'm just trying to figure this out. Now, thirty percent maximum impact, would that -- how would that arise? I guess how soon before the PFT would he have to smoke, if that's how it's determined?

A. It's not determined. It's just what's likely. It's not -- it's not something you can calculate. It's not like anemia, for instance, which has a measurable, more of a quantitatively predictable impact on the DLCO value.

Smoking has a very variable impact. It may

have none at all. You could smoke prior to your DLCO test and it could still be a hundred percent. It might not change at all. But when it does change, the maximum possible change is about thirty percent. Sometimes it's nothing. Sometimes it's five percent. Might be fifteen percent. It varies.

Q. Okay. Mr. [redacted] didn't present with any rales, did he?

A. I didn't hear any, I don't think. Let me look back on this. No, no rales on him.

MR. PETERS: I will pass the witness.

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EXAMINATION

BY MR. JACOBS:

Q. Doctor, I've got a few questions for you.

A. Okay.

Q. Looking back on your diagnosis and impression, you list number four as history of heart disease; correct?

A. Yes.

Q. Do you agree that heart disease is the number one cause of death in Americans?

A. Yes.

Q. Okay. And what are the risk factors for heart disease?

A. Family history, number one. Number two would be -- is debatable. That's the most important one. But the others would be age, being male, smoking, hypertension, diabetes. And the most underappreciated one, which is becoming maybe second after family history, is inactivity, couch potato.

Q. Lack of exercise?

A. Lack of regular exercise; right.

Q. Let me look on the first page of your report, and in the chest x-ray section you refer to the 1980 ILO classification guidelines; correct?

A. Yes.

Q. And you refer to those -- that classification guideline from 1980 in all these reports, I think?

A. Sure.

Q. And those are the guidelines issued by the ILO that instruct readers of chest x-rays, such as yourself, on how to record the findings you see on those x-rays?

A. That's right.

Q. And when did you first pass -- you passed the B-Reader exam, I think, in '91?

A. I took the test in '92. And by the time it's graded, they issue your certification two months later, so that would be January of '93.

Q. And you're still a B-Reader today?

A. Yes.

Q. And you were a B-Reader when you examined Mr. [redacted] and the rest of these gentlemen; correct?

A. Yes.

Q. In order to pass that B-Reader certification exam, you've got to know and understand those 1980 guidelines?

A. Right.

Q. And you follow those guidelines when you perform your B-Readings?

A. Yes.

Q. Now, the 1980 ILO guidelines do a lot of things. But one of the things they do is they're an attempt to ensure uniformity in interpreting films; correct?

A. Well, you can't ensure uniformity. They're an attempt to increase consistency with -- in reading the films, yes.

Q. And I have a copy of the 1980 guidelines. I may refer to some of them. Would you like a copy, Doctor?

A. If you're going to refer to a specific passage, pass it over. If you're not going to, I don't need them.

Q. Okay. I'll hand you a copy.
A. Okay.
Q. And I don't think we need to mark this as an exhibit. I'm sure everyone here has it.
A. There's actually a new one, by the way, but it doesn't change anything that's in here other than a couple minor symbols. But the new one, the 2000 edition which just came out December of 2002, is exactly the same as the 1980 edition. And there's no change in radiographic interpretation protocol between 1980 and the 2000 edition.
Q. You did mention there were some minor changes. What are those minor changes?
A. Not minor changes. There's a couple of symbols on the -- additional symbols that have been -- that the additional symbols have been expanded a little to include a couple symbols that weren't present on the 1980 one. But the additional symbols, by definition, have nothing to do with pneumoconiosis. They're just extra markings.
Q. I think I understand what you're talking about.
A. Okay.
MR. JACOBS: I have an extra copy for you, Caryn, if you'd like to take a look.

BY MR. JACOBS:
Q. Why don't we look on page three. And at the top there it reads: There are no features to be seen in a chest radiograph which are pathognomonic of dust exposure. What does the term pathognomonic mean, Doctor?
A. What that says is that there is nothing in -- pathognomonic means that what you're looking at, by definition, means that this person has this disease one hundred percent and could not possibly have any other disease. That's what pathognomonic means.
Q. Let me ask you about the twelve boxes in the classification system very briefly. The scale goes from zero to three; correct, in terms of the degree of fibrosis?
A. The major scale, yes. Right.
Q. With zero meaning no abnormalities and three moving up to significant abnormalities?
A. Zero doesn't mean no abnormalities. It means that the -- it means that the -- it just means the normal category. There could be minor abnormalities that don't reach a threshold for being abnormal in a global sense.
Q. But what you do with the chest x-ray is you compare it to the standard -- the chest x-ray of an

individual who you're diagnosing, you take a look at his chest x-ray compared with the standard ILO films; correct?
A. That's right.
Q. And that process, can you describe your process for when you actually physically view the x-rays? What do you personally do when evaluating them? How do you arrange them and things of that nature?
A. You mean what do I do -- how do I do a B-Reading, what do I do?
Q. Yeah. Like you're physically sitting down and reviewing the film.
A. Well, in my office I have a series of view boxes that have the standards around them. And I put the patient's film in the middle and I move them around a little bit to bracket the patient's film between the ones that I think match up and make the -- and do the reading in that way.
When I'm on the road, so to speak, or I'm traveling, I do the same process, but I only have two view boxes -- well, two sets of two, four view boxes. And so I have to take the standards out of the box and put them up, just like I was doing a test. Like during the test, all you have is a view box with two things

and you have to keep taking them out of the box and putting them up and up, up and up and so on. But it's the same process.
MS. PAPANTONAKIS: Can we hold off on doing general questions to the end? We have a lot of plaintiffs to go through.
MR. JACOBS: I understand. But I actually do have a point to what I'm doing with one of his answers that he gave previously. And I'm almost done.
BY MR. JACOBS:
Q. Doctor, and if you rate an x-ray as 1/1, it means you're sure it's a 1; right?
A. It means that I considered no other category other than 1 when I was looking at the film; right.
Q. And if you rate it as a 1/0, the zero there means that it looks -- scratch that question. Let me try a different one.
If you rate it a 1/0, it means you think it looks like a 1, but it also means -- the zero means that you seriously considered a zero?
A. Well, I would -- I mean, I don't know about the word "seriously." It means that the abnormalities were not quite as extensive as the standard 1/1 film. And, therefore, I went back and looked at the zero film

to make sure it didn't belong in the zero category.
MR. JACOBS: I think I'll pass him for now. Thank you, Doctor.
MS. PAPANTONAKIS: Any other questions about Mr. [redacted]?
MR. ALMQUIST: Just briefly.

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FURTHER EXAMINATION

BY MR. ALMQUIST:

Q. Doctor, if you would, turn back to the B-Read on Mr [redacted].
A. Which B-Read?
Q. Your B-Read.
A. The one that's part of the --
Q. Part of your report.
A. Part of my report, yeah. Okay.
Q. Is that your handwriting on this one or someone else's handwriting?
A. Yeah, it's mine.
Q. You've indicated, I think, in prior depositions that sometimes you have somebody else fill these out for you?
A. They fill out the Social, sometimes the name and everything else. All I have to do is check the boxes and fill in the 4C section.

Q. I'm kind of curious because I note that the number one diagnosis here is bilateral upper lobe nodular infiltrates consistent with silica-related pneumoconiosis. And number two is pulmonary asbestosis. Does that look like that's written in a different ink?
A. Yeah. It looks like pulmonary asbestosis got added later. Those aren't diagnoses. Those are just other comments.
Q. Would you recommend that Mr. [redacted] see his personal physician as a result of those findings?
A. Not on an urgent basis, but on a monitoring basis, as summarized in the prognosis/recommendation section.
Q. Did you send a copy of the report that you did to his personal physician?
A. No. But he gets a copy of the report himself, which he was encouraged to share with his personal physician.
Q. Did you inquire as to who his personal physician was?
A. No.
Q. The next page over, the pulmonary function technician, LE, do you recall who LE is?
A. Yes. LE stands for a pulmonary function

technician that I know as Zeke. He has a long Indian name that I can't say.
Q. And do you know what RRT stands for?
A. I think that's registered respiratory therapist, I believe.
Q. Do you know with whom he's registered?
A. I would assume the state respiratory board in Texas.
MR. ALMQUIST: That's all I've got on Mr. [redacted].
MS. PAPANTONAKIS: Anyone else have any questions on Mr. [redacted]?
MR. PETERS: I just have a follow-up one.

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FURTHER EXAMINATION

BY MR. PETERS:

Q. I saw something I wanted to ask you about. In the upper right-hand corner of your report, it has the initials FS, slash, HOUS, slash, LH. FS, what does that stand for; do you know?
A. Foster and Sear.
Q. And I take it the next letters are Houston?
A. Right.
Q. And then LH, Linda Holland?
A. Right.

Q. Okay. And that's the Social Security number of Mr. [redacted]?
A. That's right.
Q. And you went on the road to do this evaluation of Mr. [redacted]; correct?
A. I went to Houston, as you pointed out.
Q. Yes, that's what I'm trying to get at. And was Mr. -- do you know if Mr. [redacted] was -- and I think you testified in the past you sometimes previously -- before going on a trip, you see x-rays and decide whether or not the person has asbestosis or may have asbestosis before you go and see them?
A. You mean did I preview the x-rays in this case?
Q. Yeah. Did you preview the x-rays?
A. I don't know whether I did or not. I'm not sure.
Q. That's not noted anywhere?
A. No. I mean, if I had previewed them, there sometimes would be an x-ray report. Sometimes when I preview, I actually generate a report. And sometimes when I preview, I just make notations on a worksheet and send it back to the law firm.
Q. Would you send a report back to the law firm in addition to a note?

A. I just told you, sometimes I would send an ILO form or an x-ray -- narrative x-ray paragraph when I preview. And sometimes I would just have a list of names and I would make handwritten notes and send that back to the law firm as part of the preview process.
Q. Right.
A. But I don't even know whether I previewed these x-rays or not in advance. I can't say whether I did or didn't.
Q. Okay. But if you did, there would be some indication whether or not you wanted to see this individual in Houston or not?
A. When I preview, I don't know where they come from or where I'm going to see them. But there would be an indication as to whether or not I thought in advance the patient likely had some pneumoconiosis or not.
Q. Okay. Going back to the questionnaire. I believe I read in a past deposition of yours, as early as last August, that you -- I don't want to say always, but you generally send the questionnaire back with the report to the law firm.
A. Yeah, that's what I used to do. And now I don't think we do anymore. I checked with my office. I think we retain those questionnaires and then discard

them, as I explained before, after the reports are no longer in need of any, you know, editing or proofreading or whatever.
Q. And this gentleman, Mr. [redacted], was seen in October of 2001, which is prior to your deposition back in August of 2002. At that time you were sending these questionnaires back to the law firm after you did your evaluation?
A. Oh, I don't know. When I first started doing them, I did. When I gave the deposition, I don't know whether I was referring to old reports or new ones. I can't say. Unless you show me the deposition and let me look at the question, I couldn't say.
Q. I might do that in a minute. We'll get moving through Mr. [redacted] here.
Your temporary license that you received in Texas in 2001, you said in early 2001 you got your permanent license in Texas.
A. That's right.
Q. Does that have any limitations or restrictions on your practicing medicine in the state of Texas?
A. I don't think it includes prescribing any scheduled drugs. Other than that, there was no restriction.

Q. And that's probably something we can get with the state board on.
A. Sure.
Q. And you previously testified that sixty percent of your time is devoted to litigation, and this is medical/legal context. Is that still true today?
A. It varies month to month. Last month it wasn't, but there are some months when that's quite true, yes.
Q. And it's my understanding you were deposed yesterday by some other law firms in some cases?
A. Not yesterday, no.
Q. Do you have a deposition set up tomorrow?
A. Friday.
Q. Friday. Okay.
MR. PETERS: I'll pass.

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FURTHER EXAMINATION

BY MR. JACOBS:

Q. I have a couple of follow-ups about the questionnaires. Doctor, you refer to those questionnaires as your notes; correct?
A. Yes.
Q. Now, in fact, you write on them sometimes; right?

A. Right.
Q. The patient or the plaintiff actually writes on them as well?
A. That's right.
Q. And maybe even a third person, such as a nurse or someone who is also in the office; correct?
A. Correct. And maybe even the technician sometimes, too.
Q. So it has writings from lots of different people?
A. That's true.
Q. Okay. And you mentioned just briefly a moment ago that you changed your policy about whether or not to send back the questionnaires to the law firms; right?
A. Right.
Q. You don't remember exactly when you changed that policy?
A. I don't recall, no.
Q. Why did you change that policy?
A. Well, I consider the questionnaire to be an internal office document. And in regular medicine, we don't consider -- doctors don't consider -- we don't consider our notes as part of the medical record until it's a finished product and actually goes into the

medical record.

For instance, an allergist who sees a patient for the first time and has them fill out a questionnaire, after he dictates his consultation, those questionnaires aren't retained.

When I see a patient at Keesler to do a sleep study, they fill out this long questionnaire. After the evaluation is done, nobody retains that. That's just discarded eventually. This is no different than that. It's not really a big mystery.

And frankly, if all -- if you lawyers got together and decided that you really were fascinated by these questionnaires and wanted to have them, as far as I'm concerned I'd keep them and you could have them. I have no problem with that. It's just that there's nothing in the questionnaire that's not in the report. And so I decided they would be cleaner for me to retain them rather than sending them back to the law firm.

Q. Did anyone ask you to quit sending them back?

A. No. No one asked me to do that.

MR. JACOBS: Pass the witness.

MS. PAPANTONAKIS: Any other questions about Mr. [redacted]? Then we'll move on to Mr. [redacted].

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(Whereupon, a short break was taken.)

EXAMINATION

BY MR. ALMQUIST:

Q. Okay. You saw Mr. [redacted] October 11th of 2001; is that correct?

A. Yes.

Q. In Mr. [redacted] case, you determined he has no pleural plaques, no pleural thickening, no pleural calcifications; is that right?

A. Well, wait a minute now. I had to get through a lot of other stuff. Okay. Yes, I saw him October 11th, 2001.

Q. Okay. And on Mr. [redacted], did you determine he had no pleural plaques, no pleural thickening, no pleural calcifications?

A. Yes.

Q. Now, the film that you were looking at on Mr. [redacted] is a grade 2. Can you tell me what the differences are between 1, 2 and 3?

A. Sure. Grade 1 means there are no technical defects whatsoever. Grade 2 means there are minor technical defects that do not influence the accuracy of the ILO evaluation. Grade 3 means that there are either several minor technical defects or major technical defects which could impair the accuracy of the evaluation, but the film is still interpretable if

one uses the expertise and judgment that the B-Reader has and can bring to the film. Unreadable, which is the fourth category, means that you just can't interpret it at all and you shouldn't try.

Q. What was the problem with the film quality on Mr. [redacted] film?

A. It was slightly underinflated.

Q. And what's the effect on the reading that you get if the lung is underinflated?

A. The lung markings bunch together so that the tissue is not spread out as much.

Q. And when you bunch the markings together, do they appear to be more prominent?

A. They can be, yes.

Q. Mr. [redacted] pulmonary function tests were performed by JLM. Do you know who JLM is?

A. Well, he's a pulmonary function technician. I'm trying to think of which one. I know him by his first name, Joe, but beyond that I don't know. He's from Austin, Texas, I think.

Q. But Mr. [redacted], his tests are normal, as I recall.

A. Is that a statement or a question?

Q. Let's make it a question. Are his pulmonary function tests normal?

A. After correcting for race, they were normal, yes.

Q. Mr. [redacted] also suffers from hypertension and being treated at this point; is that correct?

A. Yes.

Q. He's also overweight?

A. Yes.

Q. And his shortness of breath that you mention in his report, those are consistent with a sixty-four year old overweight individual? Those findings are not unusual in someone like that, are they?

A. Well, I think his symptoms are excessive just based on age and being overweight. I think that overweight people in late, middle age, which I like to think of is sixty-four now --

Q. I'll accept that definition.

A. -- can be short of breath due to being deconditioned or out of shape, as you might put it. But in his particular case, he says he's had progressive shortness of breath over ten years and that there's certain things he can no longer do. That seems a little excessive.

Q. But possible, again, that overweight and out of shape alone could account for that same history; is that correct?

A. Although it's possible, I don't think it's -- I don't think it's likely, but it's possible, yes.
Q. And, again, in Mr. [redacted]case, you considered the zero or normal finding as well as the slightly abnormal finding of 1 on his ILO reading?
A. Yes.
Q. If Mr. [redacted] history of exposure at the Dow Chemical Company was that he only made deliveries and he stayed in the cab of his truck while he was there at the Dow Chemical Company twice a week, maybe two to four hours a day, do you have an opinion as to whether or not that would have contributed at all to his pneumoconiosis?
A. What years are we talking about? 1980 to 1998?
Q. '77 to 1979, he was working as a truck driver, and his only trips to Dow were as a truck driver where he was in the cab of his truck.
A. Yeah. I think although it's -- although they probably contributed, I think that they would represent a minor contribution to his overall exposure.
Q. How would you anticipate someone who is a truck driver sitting in the cab of his truck might be -- was exposed to asbestos?

A. Well, you mean in general, or him in particular?
Q. Well, in general. Would you expect someone who drives into a plant and stays in the cab of a truck to be exposed to asbestos?
A. I mean, if he were taking insulation into the plant, he could have had lots of exposure. Or if he were in the plant and unloading a truck in an asbestos-intensive environment, he could.
It's my -- the history that I took from him is that he worked as a truck driver in the post office from 1980 to 1998 and he had no exposure at all during that period. So I'm sort of puzzled as to what you're -- as to what your question is.
Q. The history he gave as to my client, the Dow Chemical Company, is what I'm asking about now, only Dow, not with respect to any of his other exposures.
A. Okay. And please understand that I don't have a specific history of exposure at Dow.
Q. I understand that. But he's saying in his deposition that at most he drove a truck into the facility, he stayed in the cab, and he may have driven by or seen people who were tearing out insulation while he was sitting in the cab of his truck two times a week, two to four hours, '77-79 time frame.

A. I think that that -- as I said, that could have made a minor contribution to his cumulative exposure. But in of itself, the only asbestos-related disease that could likely have caused would be mesothelioma, along the lines of the questions you asked me before. In of itself, that would be unlikely to cause asbestosis without other exposure.
Q. Sure. And with respect to Mr. [redacted], the same questions, do you think it's more likely than not that he will develop mesothelioma in the future?
A. Although his risk is increased naturally, it's not increased to the point where it becomes likely.
Q. Same answer with respect to lung cancer?
A. Yes.
Q. And same answer with respect to other cancer?
A. Yes.
MR. ALMQUIST: Okay. I believe that's all I've got on Mr. [redacted].
MS. PAPANTONAKIS: Anyone else have any questions about Mr. [redacted]? We'll move on to Mr. [redacted] is the next one.
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EXAMINATION

BY MR. ALMQUIST:
Q. Okay. You saw Mr. [redacted] February 6th of 2002. It looks like this is another Foster and Sear, Houston; is that correct?
A. Correct.
Q. Okay. How old was Mr. [redacted]?
A. I have fifty down here.
Q. I'm a little confused because it's talking about him being exposed in '56.
A. Yeah. My fifty is an error. His date of birth is 4/17/41, so he's -- at the time that I saw him, he was sixty, not fifty. So that fifty should be switched to sixty. The date of birth, I think, is right.
Q. Did he have any other significant medical history, nonpulmonary medical history, that you noted?
A. Not really.
Q. Has he undergone some heart catheterizations?
A. He did, but none of them showed anything.
Q. Does he have a history of any pulmonary diseases in the past?
A. He had pneumonia fifteen years ago, and he gets frequent upper respiratory infections.
Q. On your physical examination, did you note anything with respect to his lungs?

A. No. Nothing abnormal, that is.
Q. I believe you saw no pleural calcifications, but there is some bilateral diffuse pleural thickening?
A. Yes.
Q. No recommendation on your B-Read that he report this to his personal physician?
A. Recommendation on the B-Read?
Q. I'm sorry. Strike that question. There are no comments in section four. Again, we don't -- you couldn't remember the name of who LE, the respiratory technician who performed the --
A. LE is Zeke.
Q. Zeke. You note a very slight restrictive defect. At what level do you believe -- do you diagnose a slight restrictive defect?
A. At a race adjusted TLC of less than eighty-one percent.
Q. And then you also note a mild reduction in diffusion capacity. At what level do you reach the conclusion it's a mildly reduced diffusion capacity?
A. At a -- again, at a race adjusted TLC of between sixty-five and eighty -- and seventy-nine percent.
Q. Do you have an opinion as to whether or not

Mr. [redacted] is more likely than not to develop mesothelioma in the future?
A. Well, as I said before, although his risk is certainly increased, it doesn't reach the point where it becomes likely.
Q. And you understand the reason I'm asking you these questions, because you've reserved the right to express that opinion on a particular plaintiff, so I need to ask the questions again for each one of them.
A. I understand. And perhaps I'm being excessively punctilious about this, but it's just easier.
Q. Well, they're short questions. And with respect to lung cancer, your opinion is that he's not more likely than not to develop lung cancer; is that correct? He has less than a fifty percent chance of developing lung cancer?
A. That's correct.
Q. And he also has a less than fifty percent chance of developing another asbestos-related cancer?
A. That's right.
MR. ALMQUIST: I believe that's all I've got on Mr. [redacted].
MS. PAPANTONAKIS: Anyone else with any questions on Mr. [redacted]? Then we'll move on to the

next one, which is [redacted].

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EXAMINATION

BY MR. ALMQUIST:

Q. Okay. Mr. [redacted], let's see, seventy-one years old. What's his smoking history?
A. Two packs per week for thirty-four years, quitting in 1980, twenty years earlier.
Q. So it's a fairly significant smoking history?
A. No. It's a rather minor smoking history. Two packages per week, if we break that down on pack years --
Q. Oh, I'm sorry, it's a week.
A. Yeah. It's not per day, it's per week. So it's basically sixty-eight divided by seven times two.
Q. On your reading of the x-ray, there were no pleural findings here on Mr. [redacted]; is that correct?
A. That's right.
Q. His pulmonary function tests you indicate were within normal limits with the exception of some small airway obstruction.
A. Right.
Q. Do you believe that has any relation to any exposure to asbestos, or can you say one way or another?
A. Yes. I think asbestos is contributing to

the small airway obstruction.
Q. Is there anything else that may have contributed to that small airway obstruction?
A. His remote smoking history could have contributed to it.
Q. What else might contribute to small airway obstruction if you had an individual with this smoking history but no asbestos exposure?
A. Asthma is a possibility.
Q. Anything else?
A. Well, not in a seventy-one year old. But cystic fibrosis typically begins -- the first pulmonary function abnormality in cystic fibrosis is a small airway obstruction.
Q. Now, it did show on the quality, again, we have a note of a 2 due to scapular overlay. What is scapular overlay?
A. That means that the shoulder blades were -- the outline of the shoulder blades were in the lung fields. What you try to do when you're taking an x-ray is to have the patient lower his shoulders forward so that the shoulder blades get out of the lung fields on the x-ray. It doesn't always work, especially in elderly people.
Q. What's the effect of that on the quality of

the x-ray?
A. In terms of -- you mean in its suitability for interpretation?
Q. Yes.
A. Absolutely nothing.
Q. There's also a note of a calcified granuloma in the right lower lobe. You don't relate that to any occupational exposure to asbestos, do you?
A. No.
Q. Mr. [redacted], do you believe that he has a greater than fifty percent chance of developing mesothelioma?
A. No.
Q. Do you believe he has a greater than fifty percent chance of developing lung cancer?
A. Although his risk is increased, it doesn't exceed fifty percent.
Q. And do you have an opinion as to -- do you believe that he has a greater than fifty percent chance of developing other cancers?
A. No.
Q. Another asbestos-related cancer, I'm sorry.
A. No.
MR. ALMQUIST: I'll pass Mr. [redacted].
MS. PAPANTONAKIS: Anyone else have questions

about Mr. [redacted]? We'll move on to the next one, [redacted].

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EXAMINATION

BY MR. ALMQUIST:

Q. Okay. Mr. [redacted], let's see, he's fifty-six. You saw him January of 2002. What is his smoking history?
A. A pack a day for the past forty years, forty-pack years.
Q. And does he continue to smoke?
A. At the time that I saw him, he was still smoking.
Q. Now, Mr. [redacted] has a pretty extensive medical history for other problems, does he not?
A. Yes.
Q. And what are some of the other medical problems that he's had?
A. Blood clots in the lower legs; a nerve condition called peripheral neuropathy; chronic liver disease; and COPD, chronic obstructive pulmonary disease.
Q. What's the chronic liver disease?
A. Cirrhosis.
Q. Has he also been diagnosed with chronic

obstructive pulmonary disease?
A. I just said that.
Q. Oh, I'm sorry. And what medications is he taking for that?
A. Inhaled Serevent, Flovent and Albuterol, in addition to his other nonpulmonary medications.
Q. Do you know whether he had taken any of those before the pulmonary function tests were performed?
A. I don't know.
Q. And do you know what his smoking history was before he took the pulmonary function tests, when his last cigarette was?
A. I don't know that either.
Q. Was Mr. [redacted]able to complete the lung volume test?
A. No.
Q. And what were the significant findings on his pulmonary function tests?
A. Well, he had reduced forced vital capacity and a reduced diffusion capacity, reduced DLCO value.
Q. Forced vital capacity is due to his chronic obstructive pulmonary disease and emphysema?
A. Well, I didn't say that. I think that that's likely to be the case, yes. But asbestosis could also be contributing to that. It's hard to say for sure

without getting a lung volume test, which in his case would best be done with plethysmography.
Q. Okay. In Mr. [redacted] case, do you believe he has a less than fifty percent chance of developing mesothelioma in the future?
A. Although his risk is quite increased, it doesn't reach fifty percent. It's far less than that.
Q. What about his risk of developing lung cancer in the future?
A. His risk for developing lung cancer, for a number of reasons, approaches fifty percent, but does not exceed it.
Q. And his risk of developing some other asbestos-related cancer?
A. That would be less than fifty percent.
MR. ALMQUIST: I believe that's all I've got on Mr. [redacted].
MS. PAPANTONAKIS: Anyone else have any questions about Mr. [redacted]? Then we'll move on to Mr. [redacted].

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EXAMINATION

BY MR. ALMQUIST:

Q. Okay. Mr. [redacted], a fifty-four year old welder. What's his smoking history?

A. A half pack for twenty-two years, quitting twelve years ago. Well, ten years ago, I guess, based on the report that I did.
Q. He also has a history of some broken ribs on the left side. What's the significance from a pulmonary evaluation of the history of broken ribs?
A. Usually none. And in his particular case, there was none. There are some times that it can be significant.
Q. What kind of changes can you see in the lungs as a result of broken ribs?
A. Well, there's just a few of them. The most common change, if there is going to be one at all, is some thickening of the lining of the lung right under the broken ribs due to blood getting into the space between the chest wall and the lung.
When their broken ribs are extensive, like, say, most of one thorax, most of one side of the chest, then that can have a restrictive defect on the expansion of that lung.
Q. It looks like in terms of complaints, let's see, it talks about left-sided chest pain not related to exertion. Is that of any significance to you?
A. Left-sided chest pain not related to exertion. No. I would call that atypical chest pain.

It doesn't have a lot of significance to it.
Q. And then he gets mild dyspep --
A. Dyspepsia? Dyspnea, shortness of breath. Right.
Q. I should say shortness of breath rather than trying to pronounce the word. So his main complaint is it takes him longer to do his yard work now?
A. That's right.
Q. Again, on his chest x-ray there were no pleural plaques, no pleural thickening, no pleural calcifications that you found?
A. Right.
Q. The profusion level you found was 1/0 under the ILO standards. Again, you considered the alternative to your conclusion of slightly abnormal, 1, as there to be a normal finding of zero; is that correct?
A. That's right.
Q. Now, you indicated there's a borderline defect with small airway obstruction.
A. The transcriptionist left out the word restrictive. What that should read is borderline restrictive defect with small airway obstruction, but normal diffusion capacity.
Q. What could cause that borderline restrictive

defect?
A. Well, it certainly could -- the most likely cause is asbestosis.
Q. Anything else that might be a cause of that?
A. No.
Q. And with respect to Mr. [redacted], do you believe that he has a less than fifty percent chance of developing mesothelioma in the future?
A. Although his risk is increased, it's much less than fifty percent.
Q. Similarly, he has a less than fifty percent chance of developing lung cancer in the future?
A. Although his risk, again, is increased, it doesn't exceed fifty percent.
Q. And with respect to other cancer, other asbestos-related cancer, his chance of that in the future is less than fifty percent as well?
A. Correct.
MR. ALMQUIST: And that's it on Mr. [redacted].

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EXAMINATION

BY MR. PETERS:
Q. Dr. Segarra, I just have a few questions.
A. All right.
Q. You indicate about middle of the history

section that he has welded inside furnaces and boilers.
A. Right.
Q. Again, you didn't indicate how long he's been doing that type of work; is that correct?
A. Yes.
Q. Did you ask if he welded at any other places other than inside furnaces and boilers and generally in chemical plants?
A. Well, he was a pipe welder. And the way I read that is that intermittently he welded inside furnaces and boilers, not the whole time.
Q. Okay. I understand that. Have you received histories from other welders where they do not actually weld out in the plant themselves, but maybe in a fab shop?
A. Of course. Yes.
Q. And based on those histories, do they also provide a history of being exposed to asbestos in, say, a fab shop?
A. That would depend. The exposure in a fab shop, if they were not insulating pipe themselves, which would be unlikely in a fab shop, or removing insulation from preexisting pipe to make repairs on -- make welding repairs, then they wouldn't have that kind of pipe insulation exposure. The exposure in a fab

shop is most frequently, in general now, not talking about him in particular, but in general, would be from the use of asbestos blankets and protective clothing while welding inside the shop or structures within the shop itself.

Q. Okay. And that's something you would understand from the plaintiff himself --

A. That's correct.

Q. -- if he gave you that history?

A. Right.

Q. In the next line you say he worked with pipe fitters and insulators frequently.

A. Right.

Q. Frequently is kind of vague. Does he give you any other type of indication how frequent it was?

A. You know, the French medical literature, which is very good -- the French are on the cutting edge of medicine. The French medical literature, they never used to quantify anything up until about ten years ago. They used to use the words frequently and commonly and unusually and most often and so on. And nobody thought there was anything wrong with that until recently. Now they've begun to use the same kind of quantitative standards everybody else does.

No. I mean, when I say "frequently," that's

the most -- that's as specific as he got.

Q. What do you mean by "frequently," or are you just repeating what he said?

A. I'm just repeating what he said, yeah.

Q. In your assessment of exposure of an individual, how do you use the term "frequently" in making that assessment?

A. I never thought of it that way. I mean, by "frequently," to me that means several times a month.

Q. Okay. Shortness of breath upon exertion. I'm not going to try to say that term either. Do you ask him what type of exertion that is? Is he trying to jog three miles or is he walking two blocks? Or do you have a general idea that you use, general idea that you use what exertion is?

A. Well, there's mild exertion, there's moderate exertion and there's heavy exertion. And some patients are specific and expressive about that and others are just vague. And I record to the extent to which they were specific. And if they were vague, then my -- the way I record their shortness of breath would be vague.

In his case, mild dyspnea upon exertion. The only physical limitation on it was what I told you, which was that it takes longer to do yard work.

Q. Exertion, is that your word or is that Mr. [redacted] word?

A. My word.

Q. You didn't use the term mild, moderate or --

A. No. That was an overall judgment from saying, well, is shortness of breath a problem for you; what kind of things make you short of breath; how much of a problem is it; what kind of -- are there things you can't do anymore that you used to be able to do. It's the summary of a series of questions that sound like that. And it's sort of a standard thing that all pulmonologists ask patients when they take a history of lung disease.

Q. Would you note that in your questionnaire, which I have a fascination over?

A. You do have a fascination.

Q. I do. I have a great fascination.

A. Sometimes it's noted and sometimes not. As I told you, there are things not -- although everything pertinent in the questionnaire is in the report, at least pertinent to me, there are some things that I may ask at the time of the examination that will be in my head and it will go into my dictation, but I won't have actually physically written them down on the report since only a short time has elapsed between the time I'm looking at the questionnaire until the time I'm

actually dictating the report.

Q. Have you ever failed to put something in your report that was outlined in your questionnaire?

A. I don't know.

Q. Has anyone ever brought that to your attention during a deposition or trial?

A. No. The only thing that might be in the questionnaires that I -- and I say might; I mean, I don't know for sure -- that I don't tend to put in my report, as I told you, I tend not to use proper names, like trade names for products or locations except in uncommon circumstances.

Q. But sometimes that type of information is in there?

A. It may or may not be.

Q. Right. It has been in the past?

A. In some cases.

Q. You indicated that Mr. [redacted] presented with no rales; correct?

A. Yes.

Q. The new ATS guidelines that are overdue, as you stated earlier, do you know what specific changes they have made from the 1986 guidelines with regard to diagnosis of asbestos-related diseases?

A. No. No, I don't. I've had two calls from

people working on that project with questions; one about some data that I've already presented in the past. And the other was about -- I was asked the things that I thought were the most inaccurate parts of the original statement. And it was just a factual question.

But I think they were surveying lots of people who do a lot of B-Reading to ask that question to. And those are the only two things. But it doesn't tell you what's going to be in it. It just tells you the kind of things that they're thinking about in the process of revising the report.

Q. Do you know if it's a practice for an organization -- for the American Thoracic Society to send out the revisions prior to actual implementation of the provisions or doctors to review and comment upon?

A. Sometimes. Not always.

Q. You don't know if that's going to happen here?

A. I don't know, no.

Q. You indicate in the chest x-ray section that you compared your film to an earlier film of May 29th, 1998, and that the interstitial changes have worsened. Was that a significant movement, in your opinion?

A. Well, it's only one minor category, but it crosses the boundary between normal and abnormal, from 0/1 to 1/0. So that would be significant to me, yes.

Q. Okay. Is it significant enough for you to consider that the process may be caused by other -- the movement may be caused by another disease process other than asbestosis?

A. No. I think that's unlikely.

Q. And you've testified in the past that a movement, a major movement may make you wonder if it was caused by another disease process as opposed to asbestosis; isn't that correct?

A. Although I've said that, I think what I meant and what I think I said is that a major movement within a short period of time. A movement of one minor category over a two-and-a-half-year period, I wouldn't consider that to be -- that's entirely within the bounds of the slow progression of asbestosis, or in this case the appearance of asbestosis.

Q. Okay. Mr. [redacted] did he give you any history about being exposed to any types of chemicals on the job?

A. Although he didn't say specifically, I would assume that he would have had to have been exposed to chemicals. I don't generally write down specific

chemical exposure unless they identify specific chemicals, in which case I do.

If they just say I was around toxic chemicals or chemicals, that's not specifically useful, so I don't usually include that, unless the person says I was exposed to hydrogen sulfide, hydrofluoric acid, phosgene and caustic soda, in which case I will put that in there.

Q. Okay. If he was exposed to a specific chemical which he didn't know that required him to be hospitalized, is that something that's asked in your questionnaire?

A. The answer is, yes, but that would sort of -- that would run from the occupational history into the medical history. That's something that would be -- should have been included in his list of hospitalizations that he wrote down or responded to on direct questioning. And if he did write it down or did respond to it in direct questioning, it certainly would have been in the report.

Q. So part of your questionnaire includes a list of hospitalizations?

A. Sure.

Q. You don't have that list of hospitalizations in your report?

A. Oh, it always is, yeah. It comes -- it comes in the medical history section. I said, he himself has a limited past medical history. Certainly if he had been hospitalized for chemical pneumonia and I knew that, I would definitely put that in my report.

Q. Does he specifically -- does your questionnaire specifically ask what hospitals and what doctors he may have seen, who is his family physician?

A. No, it doesn't. I've seen questionnaires that do that. I don't do that. I just ask hospitalizations and what were you hospitalized for and when and so on.

Q. Is this your own prepared questionnaire? Do you make this one up?

A. Yeah. Sure.

Q. You didn't receive it from, say, the Heard, Robins law firm?

A. No. I've -- do you still have a copy of my questionnaire? (Referring to the court reporter.) You can have a copy of it.

Q. Oh, yeah, sure, I'll take a copy.

MR. JACOBS: I think there's a copy in the transcript from last year.

BY MR. PETERS:

Q. Okay. Has it changed since August of 2002?

A. I don't think so.
Q. Okay.
A. I don't believe it has. If there are any minor changes, at the break I'll go out to my car and see if I can dig one up.
Q. Okay. This gentleman was examined by you in December of 2000. Since December of 2000, have there been any revisions to that questionnaire, that you're aware of?
A. The only revisions there would have been would have been extremely minor, like the order of asking questions may have and the review of systems may have changed a little bit, but no significant changes.
Q. If between the time a B-Reading was done and the time you examined the films as part of your examination Mr. [redacted] had been -- had -- well, he had an x-ray, a chest x-ray taken, is that something that you would like to see, too, especially in this instance because of the progression involved?
A. I think the question you're asking is, when you say from the time of his B-Reading, you mean from the time of his original B-Reading that was ever done ever?
Q. Yeah.
A. See, I don't know when his original B-Reading

was done, but --
Q. Let's focus on 5/29/98.
A. Which is the one I had to compare to?
Q. Yes.
A. The film I had to compare to. Are you asking if there was a film done between 5/29/98 and 12/15/00, would I like to see it?
Q. Yes.
A. Sure.
Q. You weren't provided any films, obviously, between 5/29/98 and December 15th, 2000?
A. No. I would have notated that in the report if I had.
MR. PETERS: Okay. I'll pass the witness.
MS. PAPANTONAKIS: Any other questions on Mr. [redacted]? Then we'll move on to Mr. [redacted].

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EXAMINATION

BY MR. ALMQUIST:
Q. Okay. Mr. [redacted] a seventy-five year old retired roofer, according to the occupational history. Got that one, Doctor?
A. Yes.
Q. Now, he had a pretty significant asbestos exposure early on, didn't he?

A. Certainly.
Q. And what was that?
A. Well, he worked as a laborer in a shipyard for two years in the 1940s, and that was prior to working for forty-five years as a roofer.
Q. Would the two years of exposure to insulation dust inside ships in a shipyard be sufficient to cause the radiographic changes that you found in Mr. [redacted]?
A. You mean theoretically?
Q. Yes.
A. Yes.
Q. Now, you talk about exposures to asbestos-containing roofing materials. What roofing materials did he describe that he was claiming exposures to?
A. He didn't say.
Q. Assume with me for a moment that if my client, the Goodrich Corporation, said that the only asbestos-containing material he was around was a plastic cement that contained asbestos that he applied off and on over a period of about three or four weeks, would you believe that's enough of an exposure to asbestos to cause the problems he's showing here or the ones that you found on your exam?
MS. PAPANTONAKIS: Object to the form.

A. Although that wouldn't be enough to cause asbestosis, it certainly would be enough to cause the small pleural plaques that he had, sure.
BY MR. ALMQUIST:
Q. How would he have been exposed to asbestos in plastic cement to get to his lungs?
A. I'm assuming that the plastic cement would be friable and dusty. If it was not, then it wouldn't.
Q. If he was applying a moist product out of a can that contained asbestos during that time frame?
A. That would depend on how it dries and how much exposure to the dried product he had, and those are things that I don't know.
Q. If he applied it simply as a cement and put something on top of it to stick to it and that was his only exposure, would that be the type of exposure that could cause the changes that you found?
A. I suppose it could, but it would be unlikely.
Q. Let's see. You found no interstitial -- or your conclusion, based on the ILO standards, was normal with respect to his interstitial findings?
A. Could you repeat the question?
Q. Yeah, let me repeat the question. In terms of looking at parenchymal abnormalities, you --
A. His profusion was 0/1, which is below the

threshold for interstitial pneumoconiosis.
Q. And his pulmonary function tests were in normal limits?
A. Yes.
Q. And, again, with respect to Mr. [redacted] the chance is less than fifty percent that he'll develop mesothelioma?
A. Although his risk is increased, it's much less than fifty percent.
Q. And what about his chances of developing lung cancer, are those less than fifty percent as well?
A. Although his risk for developing lung cancer is increased, it doesn't approach fifty percent.
Q. Okay. And with respect to his chances of developing another cancer?
A. The answer to that would be the same.
MR. ALMQUIST: And that closes Mr. [redacted] for me.
MS. PAPANTONAKIS: Anyone else have questions about Mr. [redacted]? Then we'll move on to Mr. [redacted].

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EXAMINATION

BY MR. ALMQUIST:

Q. Okay. You did not see Mr. [redacted] you

merely looked at medical records; is that correct, Doctor?
A. That's right.
Q. Okay. He was deceased. Where did you get the history of Mr. [redacted] asbestos exposure?
A. That was sent by the law firm of Heard, Robins and Cloud, Olivia Beard.
Q. And what in particular do you recall those materials containing?
A. All I recall was that -- is what I have in my report. I don't recall -- I mean, I don't recall anything specifically. I just know what I said in my report, which you can read, which is that he had exposure to asbestos during his work within chemical plants and oil refineries over a long period of time.
Q. Your ILO profusion level on the reading that you did here is, again, 0/1?
A. That's right.
Q. So that was basically normal. You had no pulmonary function tests to review; is that correct?
A. No.
Q. That's not correct?
A. I mean, that's correct.
Q. Okay. And the only findings that you made were some pleural findings with respect to Mr.

[redacted] x-rays?
A. He had definite well-defined asbestos-related pleural disease.
Q. And where was that located?
A. In his lateral thoracic walls and -- in the pleural surfaces of his lateral thoracic walls and in the pleural surfaces over his diaphragms on both side
Q. Were any of those calcified?
A. Yes.
Q. Now, Mr. [redacted] evidently had a primary adenocarcinoma of the stomach.
A. That's right.
Q. You're not an oncologist, are you, Doctor?
A. No.
Q. Do you know if that was the ultimate cause of his death or not?
A. Yes, it was.
Q. And upon what epidemiology studies do you rely upon for your opinion that asbestos was a contributing factor to his stomach cancer?
A. Well, in the first place, gastrointestinal cancer has been linked to asbestos exposure in severa textbooks over many years. But the studies that they are based on are largely the Hammond, Seidman and Selikoff studies of insulators, from shipyard

insulators.
Q. Any other group other than the Hammond, Selikoff group that's been studied for --
A. There are some smaller groups where that's been found as well, but I don't recall the specific studies in regards to stomach cancer.
Q. Have you reviewed any follow-up studies on the Hammond, Selikoff group with respect to stomach cancer in particular or gastrointestinal cancers in general?
A. Yes. I think I've read various things about that, yes.
Q. And those numbers are getting smaller with respect to those gastrointestinal cancers; is that correct?
A. I'm not sure exactly the question that you're asking.
Q. Okay. The SMR for gastrointestinal stomach cancer is decreasing as these studies are updated with respect to Hammond, Selikoff; is that correct?
A. There have been -- I think the question you're asking is, there have been papers published which have attempted to redigest the Hammond and Selikoff data in ways that the authors feel are more appropriate. Whether or not I agree with all of that

would depend on the individual paper and study. But some of those papers have recalculated the SMRs and found them to be lower than that originally indicated by Hammond and Selikoff.

Q. Have there actually been some further follow-up of that cohort over the years?

A. I believe so, yes.

Q. And do you know if as a result of the continuing follow-up of the cohort, not just a recalculation of the old numbers, that the SMRs are likewise being reduced?

A. I'm not sure about that.

Q. Do you know what the SMR is for stomach cancer in this group?

A. You mean in the group as a whole or --

Q. For the Selikoff group.

A. -- or in looking at all the various studies?

Q. No. Looking at the Selikoff group to start out with.

A. I'd have to look up the table.

Q. What about the various studies, do you have an opinion today as to what the SMR was on the studies generally?

A. Some of the recalculated SMRs are between one and two and some are over two. It would depend.

Q. Which studies in particular have an SMR over two?

A. I don't recall.

Q. Have you given testimony in trials before attributing stomach cancer to asbestos exposure?

A. I don't think so. Not specifically.

Q. So you've never been qualified as an expert on that issue in any trial testimony that you've given?

A. Well, I've given deposition testimony about nonpulmonary cancers related to asbestos in general. And I've given deposition testimony about colorectal carcinoma and asbestos exposure. I don't recall offhand a case of gastric carcinoma specifically and asbestos exposure.

Q. What are the other risk factors for gastric carcinoma?

A. Various ones. There's a condition known as atrophic gastritis that is prominent in this factor for gastric carcinoma. Certain ethnicities in geographic areas of the world are prone to gastric carcinoma as opposed to others. Smoking is a risk factor for gastric carcinoma. And let me think. Severe mucosal injuries, such as from lye ingestion, has been associated with subsequent increased risk for gastric carcinoma. There's probably others, but those are the

ones I can remember.

Q. How do those rate in terms of what the most significant risk factors are?

A. I think the most significant is the ethnic in geographic preponderance of gastric carcinoma. For instance, it's much more common in southeast Asia than it is here.

MR. ALMQUIST: I believe that's all I've got on Mr. [redacted]

MS. PAPANTONAKIS: Anyone else have any questions about Mr. [redacted]? We'll move on to Mr. [redacted].

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EXAMINATION

BY MR. ALMQUIST:

Q. All right. Mr. [redacted] let's see, you saw him May 1st, 2001.

A. Yes.

Q. What is his smoking history?

A. One and a half packs a day for twenty-three years and up through 1975 when he switched to cigars, and he smoked those since then.

Q. Did switching to cigars help in terms of the smoking issue?

A. Yeah. About halves the risk. The risk of

everything from cigar smokers compared to cigarette smokers is about half, but, of course, half is still a lot.

Q. What are his other medical conditions, nonpulmonary conditions with respect to Mr. [redacted]?

A. Heart disease and hypertension and hyperlipidemia.

Q. He talks about getting short of breath walking a hundred yards, getting palpitations and cramps. Again, those would not be uncommon findings in someone who was suffering merely from heart disease without any asbestosis; is that correct?

A. That's true.

Q. There were no rales, wheezes or rhonchi on your physical exam?

A. True.

Q. No pleural plaques, pleural thickening, pleural calcifications were found?

A. Right.

Q. Did you find some interstitial changes?

A. Yes.

Q. What about the pulmonary function tests?

A. He had mild airflow obstruction with hyperinflation, that means elevated lung volumes, and moderately reduced diffusion capacity.

Q. And is it the moderately reduced diffusion capacity that you believe gave him physiological correlation to the interstitial changes?
A. That's right.
Q. And we've talked about that before today with respect to some of these other plaintiffs, that that could be affected by his having smoked cigarettes within -- or cigars within twelve hours of his testing?
A. Although I think that pulmonary asbestosis is causing at least some of the reduction in diffusion capacity, it's quite possible that his COPD and actual cigar smoking could be contributing to it as well.
Q. As much as fifty percent?
A. No.
Q. What percentage would you assign to it if you were going to assign a percentage?
A. I couldn't. It could be none or it could be a small amount. At most, say, twenty to thirty percent.
Q. Again, this is only a film quality 2 because the costophrenic angles have been cut off as a result of the scapular overlay; is that correct?
A. Yes.
Q. And with respect to Mr. [redacted] do you have an opinion as to whether he's at a greater than fifty

percent risk of developing mesothelioma in the future?
A. Although his risk is increased certainly, it's much less than fifty percent.
Q. Do you have an opinion as to whether or not he's at a greater than fifty percent risk of developing lung cancer in the future?
A. Although his risk is quite increased, it doesn't quite reach fifty percent.
Q. And with respect to -- is he at a greater than fifty percent risk of developing another asbestos-related cancer in the future?
A. No.
MR. ALMQUIST: I'll pass Mr. [redacted].
MS. PAPANTONAKIS: Anyone else have questions about Mr. [redacted]?
MR. JACOBS: I have very few.

EXAMINATION

BY MR. JACOBS:
Q. I'd like to talk to you about the pulmonary function analysis.
A. Okay.
Q. On the first page at the comments section, it says: Good patient effort for all PFTs; is that right?

A. Yes.
Q. If you'll turn to the next page, I note that it appears that they ran four tests, 1, 2, 3 and 4.
A. That's right.
Q. And 3 and 4 appear to be shaded down. What does that mean?
A. Shaded down. What do you mean?
Q. It seems to me that there's a different shading there. Can you explain what that means in terms of the numbers?
A. Oh, yeah. It means that the IVCs on those were lower. The IVCs on the first two were the highest, and, therefore, those are the ones that are used -- those are the ones that were averaged to make the DLCO determination. Can you see that?
Q. Yeah, I can see that. And the same thing is true for the next page, the single breath DLCO; right?
A. They're the same page, really. And do you know the reason for that? The IVC is the most -- is one of the most important parts of the DLCO for accuracy. It's how deep a breath you take when you hold it for ten seconds to get that value.
And that -- the IVC should be approximately equal or within, say, ten or fifteen percent of the FVC. And that's why those first two were rejected in

favor of the second two -- I mean, trials 3 and 4 were rejected in favor of trials 1 and 2.
MR. JACOBS: Pass the witness.
MS. PAPANTONAKIS: Any other questions on Mr. [redacted]? Then we'll move on to Mr. [redacted].
MR. JACOBS: Can I ask one follow-up question?

BY MR. JACOBS:
Q. Doctor, I'd like to ask you one follow-up. Do they discard numbers 3 and 4 there; is that right, when doing the analysis?
A. They don't discard them. They just don't -- it didn't go into the value that was used for interpretation. They're still there.
MR. JACOBS: Gotcha'.

EXAMINATION

BY MR. ALMQUIST:
Q. All right. Mr. [redacted] a fifty-nine year old pipe fitter. You saw him in Houston in February of 2002.
A. Right.
Q. He gives a history of heavy exposure to asbestos materials during his work in chemical plants from nineteen -- from 195 to 1979. Do you know when

that first exposure would have been?
A. No. Unfortunately, there's a digit missing there. Don't know. 1950 something. I would think -- I mean, I don't know for sure, but I would think it would be 1959 because I start going up the line -- I don't know. I shouldn't say. I don't know.
Q. '59, that makes him seventeen, so --
A. That makes sense.
Q. Would that kind of information not be on your questionnaire?
A. It might be. And it would be in here, too, if the transcriptionist didn't miss her number key on that one, one strike.
Q. What's his smoking history?
A. Two packs a day for sixteen years, quitting thirty years ago.
Q. Now, his testimony -- he has been deposed in this case, and with respect to my client, the Dow Chemical Company, he says that he was there for about five months in '70 or '71, at most working about two hundred feet away from insulators who were doing new insulation and can't say whether that insulation contained asbestos or not.
Would that be the heavy exposure that you're reporting here, or would that have occurred at some

other time and place?
A. I couldn't say.
Q. Do you have an opinion as to whether or not working for five months in 1970 or '71, two hundred feet away from insulators who were applying some form of insulation, he's not sure what, could have been sufficient to cause the disease you saw in Mr. [redacted]?
A. Do you mean five months of shift work while that was happening every day for five months? Yeah, sure, that would be possible. It's sort of not the issue, isn't it, because he had exposure over many years.
MR. ALMQUIST: Object to the nonresponsive portion.
BY MR. ALMQUIST:
Q. Your ILO rating on him is 1/0?
A. Yes.
Q. You noted diaphragmatic pleural plaque; is that correct?
A. Yes.
Q. He's been treated for pleurisy in the past. Can pleurisy cause pleural plaques?
A. Pleurisy itself can't. There are some conditions that cause pleurisy that can cause pleural

plaques.
Q. And what are those?
A. Well, trauma would be the most common and -- you mean other than asbestos. Asbestos would be the most common.
Q. Other than asbestos.
A. But trauma would the next most common. And there are some rare conditions such as lupus that can cause pleurisy and pleural plaques, or pulmonary infarction can do that. Pulmonary infarction is when the lung dies as a result of a blood clot, which is also known as a pulmonary embolus. He doesn't have a history of any of these things, however.
Q. On his pulmonary function tests, he had normal lung volumes and diffusion capacity; is that correct?
A. Yes.
Q. And you've noted a minimal obstructive defect.
A. That's right.
Q. And is that consistent with his history of bronchitis?
A. Well, the causes of his obstructive defect are probably a combination of asbestosis and his smoking, remote smoking history. He may -- the third

possibility, and this is not known for sure, but it seems like he has a history of chronic bronchitis and possibly asthma, and that could also be contributing to the airflow obstruction. Probably is, as a matter of fact.
Q. I just was noting that you didn't put that down as physiological evidence of pulmonary asbestosis in your diagnosis/impression, as you do in several of these other reports here today.
A. Well, I use the DLCO drop as I do that since -- although airflow obstruction is a feature of early asbestosis, I don't generally specifically state that in the report, especially if the person had any smoking in the past or has had any history that would be suggestive of asthma, partly because it's somewhat controversial, the linkage between obstructive lung disease and asbestosis. I'm absolutely convinced of it, but not everybody is.
Q. And there's certainly -- there's several strong alternative explanations for that?
A. In his particular case.
MR. ALMQUIST: I believe that's all I've got on Mr. [redacted]
MS. PAPANTONAKIS: Anyone else?
MR. PETERS: Yeah, I have a few.

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EXAMINATION

BY MR. PETERS:

Q. Dr. Segarra, is a chronic productive cough consistent with chronic bronchitis?

A. Sure.

Q. What else -- what other kind of conditions can give you chronic productive cough?

A. Lots of things.

Q. Lots of things.

A. Chronic bronchitis is often a feature of COPD or emphysema. All those can present as chronic productive cough. Emphysema, pure emphysema classically presents as a dry cough, but there's variations. Asbestosis can present as a chronic productive cough, lung cancer can, bronchiectasis, cystic fibrosis, chronic bronchiolitis, rheumatoid lung disease.

Q. Histoplasmosis?

A. No. Tuberculosis can, though.

Q. TB. How does histoplasmosis show up on an x-ray, location, what it looks like?

A. Now we're going to have to do a side course, a mini course in pulmonary fungal disease. There are many ways it can show up. By far, the most common

in that self-limited granuloma that I told you about before that almost everybody in the southeast has from the soil, from soil, fungus from bird droppings, the stuff that you dig up when you hit golf balls. That's the most common.

When histoplasmosis gets a little more extensive, when it gets past that initial layer of immunity, it creates multiple pock marks, if you will, and infiltrates usually in the upper lobes. And in compromised people, such as HIV patients or cancer/chemotherapy patients, it can create a disseminated condition where the entire lung is affected with nodular densities and infiltrates and can be fatal, but that's extremely rare.

Q. Are you saying they're rounded infiltrates?

A. Nodules with -- no. They're nodules and with consolidation around them.

Q. And that would be different than a fibrosis caused by asbestos?

A. Totally different.

Q. Totally different. Location and just appearance?

A. Location and appearance.

Q. Okay. This film that you reviewed was grade 2 due to overexposure. What effect does overexposure

have in the ability to review a film?

A. It makes the film darker and it makes the abnormalities less apparent, so that unless you correc for that, you tend to underestimate how abnormal the film is. The film could be more abnormal than it appears.

Q. Your films that you read of 2/08/02, you gave an ILO scale of one over zero, and you compared your films to the ones of March 18th, '98; is that correct?

A. That's right.

Q. You noted that there had been no interval change. I read that correctly; correct?

A. Yes.

Q. Does that mean that you read the 3/18/98 films as a one over zero also?

A. Although, I didn't do a formal B-Reading on the '98 film, the appearance of the lung parenchyma looked identical from -- it hadn't changed from '98 to 2002.

Q. And I think we've talked about this earlier, but I'm not exactly sure. You're not provided with th actual B-Read or ILO form that's done by the initial screener, say, of the March 18th, '98 film?

A. Not generally, no.

Q. Do you have that in your stack of stuff right there? I think it's underneath the report there.

A. There's a report here from 3/18/98 in this notebook.

Q. Right; in the notebook that you're reviewing there. What does Dr. Fisher give as the ILO rating on his review?

A. 1/2.

Q. You didn't see a 1/2?

A. No.

Q. Is he a bit liberal on his -- would you consider that a bit liberal on his diagnosis of a 1/2?

A. I don't think the 3/18/98 film was 1/2.

Q. You don't think so. Obviously you disagree with Dr. Fisher?

A. Yes.

Q. You note that Mr. [redacted] has a history of prostate cancer. Have you attempted or are offering any opinions today that his prostate cancer is in any way associated with exposure to asbestos?

A. No.

MR. PETERS: Pass the witness.

MS. PAPANTONAKIS: No other questions on Mr. [redacted]. Let's move on to Mr. [redacted].

THE WITNESS: I'd like to take a quick

break.

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(Whereupon, a short break was taken.)

FURTHER EXAMINATION

BY MR. ALMQUIST:

Q. Okay. Briefly on Mr. [redacted], before we leave him, do you believe that he has a greater than fifty percent chance of developing mesothelioma?

A. Although his risk is increased, it's less than fifty percent.

Q. Does he have a less than fifty percent chance of developing lung cancer?

A. Again, although his risk is elevated, it doesn't approach fifty percent.

Q. And does he have a greater than fifty percent chance of developing the other form of asbestos-related cancer?

A. No.

Q. Let's talk about Mr. [redacted].

MS. PAPANTONAKIS: Actually, Mr. [redacted] is next.

MR. ALMQUIST: [redacted]. I'm sorry.

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EXAMINATION

BY MR. ALMQUIST:

Q. Okay. Mr. [redacted], you saw Mr. [redacted] February 7th, 2001.

A. Right.

Q. Do you know if you had gotten your Texas license by that point?

A. Well, as I said, my license came through late in the year, but I had a temporary license in the early part of year. I don't know whether it came before then or not.

Q. Pulmonary function tests on Mr. [redacted] were normal; is that correct?

A. Yes.

Q. Which is, again, fairly consistent with the fact that he has virtually no smoking history?

A. Right.

Q. On your exam, you found no rales, wheezes or rhonchi; is that correct?

A. Yes.

Q. Appears to have had a cardiac dysrhythmia maybe related to a cardiac aneurysm, as well as having hypertension?

A. Yes.

Q. His stress-related substernal chest pain, is that related to his heart condition?

A. His what?

Q. He reported a stress-related substernal chest pain lasting about thirty minutes once or twice a month relieved by rest.

A. Probably.

Q. The palpitations, likewise?

A. Yes.

Q. And, again, his shortness of breath on walking, again, is consistent with having heart problems as well as other problems; is that correct?

A. Well, as you know, that's multifactorial. In his particular case, it's probably due to his lung disease and his heart disease.

Q. You give him an ILO rating of 1/0, which, again, is the first abnormal level?

A. That's right.

Q. Did you have any prior films to compare? Let's see. Yes, you did. No changes -- or minor changes?

A. Right.

Q. Do you believe Mr. [redacted] has a greater than fifty percent chance of developing mesothelioma?

A. Although his risk is elevated, it doesn't exceed fifty percent.

Q. Do you believe he has a greater than fifty percent chance of developing lung cancer?

A. Again, although his risk is higher, it's less than fifty percent.

Q. And do you have an opinion as to whether he has a greater than fifty percent chance of developing another asbestos-related cancer?

A. I do. And I don't think that he has a greater than fifty percent chance of that.

MR. ALMQUIST: Pass Mr. [redacted], if somebody else has got some questions.

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EXAMINATION

BY MR. GOLDEN:

Q. Dr. Segarra, my name is Shawn Golden. I represent Alcoa. Before I get to Mr. [redacted], can I just briefly ask you, in the study that you're working on that's pending regarding the aluminum workers that you mentioned earlier this morning --

A. Yeah. It's not really pending. It's been published already, but there may be some follow-up study to that.

Q. And did I understand you that you're trying to prepare for the 2004 ATS -- was it a conference?

A. It's an annual meeting at which research gets presented.

Q. Will you be presenting your research findings

or the data that you reviewed at that --
A. As I said, I haven't -- we haven't decided to do that yet. It's just a possibility. It's something that's on -- right now is on the back burner. It may get presented next year; it may not.
Q. And you said that your findings have already been published?
A. The initial findings of the study have been published in the European Journal of Oncology in 2001.
Q. Now, going and looking at Mr. [redacted] in the occupational history section at the top of your report. When a patient or an individual comes to see you and tells you that he's a millwright, do you have an understanding either independently or from the gentleman that comes to see you as to what a millwright does?
A. Yes.
Q. And is that just an independent understanding, or is that something that you ask the patient that you're visiting with?
A. Both.
Q. And what is your understanding as to what a millwright does?
A. In general, a millwright is a jack-of-all-maintenance trades in an industrial plant,

so that he does carpentry. In some cases -- some plants it varies a little bit with the particular union, particular region and particular plant, but he may do electrical work, pipe fitting, insulation, rigging, carpentry, as I said. What else. Iron work, machine maintenance and overhauling. I may be leaving out some, but all those trades. Multicraft mechanic is a word that in modern times has sort of replaced millwright as a term.
Q. Synonym.
A. A synonym for that; right.
Q. And do you have an understanding as to Mr. [redacted] craft as a millwright? Did he do one specific craft, or do you have an understanding that he was a multicraft maintenance person?
A. That's my understanding. I mean, at least for those six years.
Q. Sure. Yes, sir. I understand. As to the comment that he rebuilt magnesium pots and worked with aluminum pots, that's a pretty broad statement. Is there any way for you to elaborate on those, as to what Mr. [redacted] did when he was rebuilding magnesium pots or aluminum pots, what he may have worked with?
A. No. But in many cases -- although I can't in this particular case, in other interviews of people

who have worked in metal foundries or aluminum plants, if you are rebuilding pots that contain molten aluminum, in some cases the lining contained asbestos. In other cases you would have to put boards or sheets of asbestos across the work area as you worked on them and then remove them, and that would expose the pot worker, so to speak, to dust from that particular source of asbestos as well as possibly some others.
Q. Okay. Now, there are many -- interstitial markings are caused by numerous things, are they not?
A. Although there are many different causes of interstitial lung disease, there are only a few common causes.
Q. Would welding and grinding bare metal, would that result in interstitial markings?
A. Not likely in of itself. It's possible, but it's not likely.
Q. Further down, Mr. [redacted] commented that from 1963 to 1984 he did air conditioning work. Is there any way for you to now tell what he meant by saying air conditioning work?
A. I assume that means installation and maintenance of heating and air conditioning units on ships. And specifically he said that he insulated ducts and sealed joints with asbestos.

Q. On ships?
A. Well, in terms of doing air conditioning work. Whether it was all on ships or not, I don't think it was. I think some of it was, though.
Q. Did he comment to you or do you recall if you asked him if he worked with refrigerants such as Freon or other type refrigerant chemicals?
A. I don't recall. I would assume that he would have, but I don't know for sure.
Q. Refrigerant chemicals or gases such as Freon, can those result in interstitial markings?
A. No, generally not.
Q. Of the different diagnosing criteria, be it -- it's my understanding that pathological evaluation and assessment is the preferred method for the findings of asbestosis. But if you can't have a -- you can't take the pathology of it, you go to a clinical evaluation or a clinical assessment with the chest x-ray, worker history, physical examination. Is my understanding correct?
A. That's the most common way to diagnose asbestosis is clinical; right. Most patients won't let you chop their lungs up to look pathologically.
Q. Sure. Can you explain in layman terms how it is that someone or why someone would have a

pulmonary function test within normal limits and yet an abnormal chest x-ray?

A. Oh, sure. It's entirely possible to have asbestosis; in other words, interstitial scarring in the lungs caused by asbestos dust exposure without having any measurable impairment on pulmonary function testing. That's quite possible and quite common. In some, but not all cases, as the disease progresses, the pulmonary function tests may or may not become abnormal later.

Q. In a man seventy-three years of age like Mr. [redacted], when would you expect his pulmonary function results to start worsening?

A. Well, if they do worsen, they will worsen slowly over the years.

Q. Mr. [redacted] apparently has worked out at Alcoa in Point Comfort, Texas, for seven months, or a total of seven months, sometime in 1952 as a millwright. That exposure alone for seven months, is that enough by itself, standing alone, to result in Mr. [redacted] diagnosis of mild pulmonary asbestosis?

A. Although, yes, I think that's possible, I think that his actual disease is caused by his cumulative exposure, of which the exposure you mentioned is one component.

Q. And you do think it's possible that exposure alone?

A. Yeah. Heavy asbestos exposure over seven months, it's possible to get asbestosis from that. It doesn't mean that everybody with that exposure will get asbestosis, but it's a sufficient exposure history for asbestosis.

Q. For the individual work history, when you review that with a patient, for instance, and they tell you that they worked as a millwright in chemical plants, aluminum plants and foundries from '50 to '56, do you individualize or break down that information as to what dose of asbestos they received at a particular job site, year or given period?

A. No. I answered that -- well, I didn't answer that exact question, but I answered a similar question before. I don't break it down with job sites. If they tell me that that's the kind of work they did during that work period and they worked in a hundred different plants, I don't try to break it down into each individual plant and how much exposure they got at each one. I would just summarize it for that period.

Q. And you just look at it as a cumulative effect over their entire work history?

A. Over that -- over the period that I

mentioned. In this case, six years. Yes.

Q. And then that six years would be then evaluated cumulatively --

A. As a whole.

Q. -- as a whole from whatever his stated work history or exposure period would be?

A. That's what I've done in this case, yes.

Q. Do you believe that a seven-month exposure is sufficient in 1952, a seven-month exposure in 1952 is sufficient to satisfy the ATS requirements as to duration and intensity?

A. I don't know that there are any specific ATS requirements for duration and intensity. I think that the question you asked me, which is an artificial question, which is that -- I mean, this man has been exposed to asbestos from 1950 to 1956 and then 1963 to 1984, so it's a moot point. Certainly he's had plenty enough exposure to have asbestosis.

But you're asking me a theoretical question, could just those seven months have caused asbestosis, and the answer is yes. Now, are those seven months of exposure in isolation, and as a hypothetical question are they likely to cause asbestosis, no, but it's possible.

Q. Okay. And I know earlier they touched on the

questions about who administered the pulmonary function tests, and you basically directed us as to specific information as to calibration of the machines, the individual's names we should visit with Holland, Bieber & Associates.

A. Well, no. I can answer questions about which technician did it, and I know in general how the machine -- the calibration protocols for the machines. But the particular technical specs, you would have to get that from Holland, Bieber.

Q. For instance, the temperature of the room when Mr. [redacted] sat for his PFT, you wouldn't have that information?

A. Well, it's between seventy and eighty.

Q. And how do you know that?

A. Because it's always between seventy and eighty.

Q. But that's not evidenced on this report?

A. No.

Q. Does the room temperature matter as to the results of the PFT?

A. Not much. Except on top of Mount Everest. They did PFTs on top of Mount Everest recently. Fascinating.

MR. GOLDEN: Given what I have, I think I'll

pass the witness. Thank you for your time, sir.
THE WITNESS: Sure.
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EXAMINATION
BY MR. SPRAGUE:
Q. One quick follow-up. Wes Sprague, Doctor. With respect to duration, would duration of exposure of approximately two weeks be sufficient to cause asbestosis?
A. No.
Q. That doesn't matter in your mind whether it's a light, moderate or heavy exposure?
A. No. Massive exposure over two weeks has been -- there are case reports of that causing pleural plaques. But I don't know of any case of asbestosis caused by a heavy two-week exposure.
MR. SPRAGUE: Thank you, Doctor.
MS. PAPANTONAKIS: Any other questions on Mr. [redacted]? Now we'll do Mr. [redacted].
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EXAMINATION
BY MR. ALMQUIST:
Q. Okay. Mr. [redacted], sixty-five year old bricklayer. Looks like you saw him February 5th of 2002. He was complaining of increasing shortness of

breath on exertion, making climbing scaffolds and playing golf difficult. Did you determine whether he uses a cart, or does he walk the course?
A. I don't know.
Q. And it appears from that fact that he's still climbing scaffolds at the age of sixty-five, he's still working?
A. Yes. Yes, he is, or was.
Q. At the time you saw him in February of 2002, did he give you any further history of having to take time off or having anybody carry him on the job, so to speak, during his work?
A. I don't think so.
Q. He also gave you a history of frequent upper respiratory infections, pleurisy, pneumonia. In fact, he says he's had pneumonia twelve times, and diagnosed with chronic bronchitis; is that correct?
A. Yes.
Q. Of course the diagnosis of chronic bronchitis is significant with respect to the pulmonary function tests, which show a slight obstructive defect with normal lung volumes and mildly reduced diffusion capacity; is that correct?
A. Those are two different questions. But, yes, that's what the pulmonary function tests show, yes.

Q. With respect to the chronic bronchitis, that could explain the slight obstructive defect which was found on the pulmonary function tests?
A. It could explain that, yes.
Q. And on the diffusion capacity, again, I'm trying to recall what you told me earlier, was it eighty percent or seventy percent?
A. I said mild is between sixty and seventy-nine percent of predicted, so his is sixty-seven percent. And he hasn't smoked in a long time.
Q. And you also have about a four year -- almost a four-year interval between films. Was there any indication of any progression of his disease in that time?
A. I didn't see any.
Q. Do you have an opinion as to whether Mr. [redacted] has a greater than fifty percent chance of developing mesothelioma in the future?
A. Again, although his risk is increased, it does not reach fifty percent.
Q. Do you have an opinion as to whether or not he may be at a greater than fifty percent risk of developing lung cancer in the future?
A. Similarly, although his risk is elevated, it's less than fifty percent.

Q. And finally, do you have an opinion as to whether he may have a greater than fifty percent chance of developing another asbestos-related cancer in the future?
A. That would also be less than fifty percent.
MR. ALMQUIST: I believe that's all I've got on Mr. [redacted].
MS. PAPANTONAKIS: Anyone else have any questions on Mr. [redacted]?
MR. JACOBS: I have very few questions.
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EXAMINATION
BY MR. JACOBS:
Q. Doctor, if you'll look at the PFT information.
A. Okay.
Q. There's a notation for the technician of LE, and I know you've answered a lot of questions, but I don't think we've seen LE before today. Do you know who LE is?
A. Yeah. You've asked me that three times, actually.
Q. Really?
A. If not you, then some of the other people. LE is Zeke. Zeke is LE. And the LE stands for -- the

man is from Madras, India, and he has a long name. But to me, he's Zeke.

Q. Okay. For some reason I had not written that one down and I apologize.

A. It's okay. No, no problem. I'm just letting you know.

MR. JACOBS: That's all I've got.

MS. PAPANTONAKIS: Okay. That is the end of the [redacted] plaintiffs that were identified in the notices. But because I am such a nice person and so is Dr. Segarra, we are going to talk about Mr. [redacted] just for you, Art.

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EXAMINATION

BY MR. ALMQUIST:

Q. Okay. Mr. [redacted] a fifty-six year old pipe fitter/welder. In his history, he indicates that for the past two years he's been a field planner in the maintenance department of a chemical plant. Would you be interested in seeing his, if the plant he works for has periodic or annual physical exams, the results of those exams over the last few years?

A. They may not -- may or may not be germane to the issue, but, sure.

Q. And you didn't have a chance to see those

before?

A. No.

Q. Mr. [redacted] does not have any real history of shortness of breath on exertion, cough, chronic cough?

A. That's true.

Q. And you're going to have to help me on --

A. Hemoptysis.

Q. Hemoptysis.

A. Coughing up blood.

Q. Okay. On your x-ray, again, no pleural plaques, pleural thickening or pleural calcifications?

A. That's right.

Q. And you did find some interstitial changes?

A. Yes.

Q. Pulmonary function tests, you indicate a borderline restrictive defect. What is the finding that you base that -- or which reading do you base that borderline restrictive defect on?

A. Well, the TLC is just one percent below eighty-one percent, which is -- and it's eighty percent. So if you look at the secondary lung volumes, the FRC is low, which suggests restriction. However, his FVC and his slow vital capacity are eighty-two percent predicted, which are just on the other side of the normal range.

So when the TLC and the FRC are within one or two percent of each other but they hover around the border between normal and abnormal, that's what I call borderline restrictive defect. That makes sense, doesn't it?

Q. Yeah. Some of them are slightly above what you would call normal, some are -- at least there's one that's slightly below?

A. It's hovering over the line between normal and abnormal.

Q. Okay. Do you have an opinion as to whether or not Mr. [redacted] may be at a greater than fifty percent risk of developing mesothelioma in the future?

A. Although his risk is increased, I don't think it exceeds fifty percent.

Q. Do you have an opinion as to whether he may be at a greater than fifty percent chance of developing lung cancer in the future?

A. Again, although his risk is increased, it's less than fifty percent.

Q. And the same question for other asbestos cancers?

A. And that would be my same answer for that one.

MR. ALMQUIST: That's all I've got on Mr.

[redacted]

MS. PAPANTONAKIS: Anyone else have questions on Mr [redacted]? Now we're going to Mr [redacted]

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EXAMINATION

BY MR. ALMQUIST:

Q. Okay. Mr [redacted] you saw in October of 2001 in Houston, fifty-eight years old. Again, your ILO reading is 1/0, the first abnormal level. And there's no evidence of pleural plaques, pleural thickening or pleural calcifications; is that correct?

A. That's right.

Q. Fairly normal spirometry is your indication, but lung volumes have a very slight isolated reduction.

A. In diffusion capacity, not lung volumes.

Q. Is that kind of an itsy-bitsy, teeny-weeny kind of very slight isolated reduction?

A. Well, it's -- his race correction for his DLCO puts him at seventy-four percent of its predicted value, which is five percent less than normal. So there's a slight reduction in diffusion capacity.

Q. No other abnormalities on his PFTs?

A. On his PFTs, no. Just the diffusion.

Q. It also looks like he has diabetes, hypertension, overweight, obstructive sleep apnea.

Could those be involved in some of his shortness of breath that he has?
A. Yes.
Q. Is he at a greater than fifty percent risk of developing mesothelioma?
A. Although his risk is elevated, it's less than fifty percent.
Q. Is he at a greater than fifty percent risk of developing lung cancer?
A. Again, although his risk is much higher than average, it's less than fifty percent.
Q. And is he at a greater than fifty percent risk of developing another asbestos-related cancer?
A. No.
MR. ALMQUIST: Okay.
MS. PAPANTONAKIS: If that's it for Mr. [redacted], now Mr. [redacted].

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EXAMINATION

BY MR. ALMQUIST:

Q. Okay. Mr. [redacted] is a sixty-four year old retired pipe fitter. It looks like he smoked two packs a day for twenty-six years, quitting in '79; is that correct?
A. Yes.

Q. He, likewise, suffers from hypertension, diabetes, heart disease and has had prior bypass surgery; is that correct?
A. Yes.
Q. Again, the shortness of breath is something that one might expect following bypass surgery?
A. No, not necessarily. In fact, many people have bypass surgery. It cures their shortness of breath if it was heart related.
Q. On your physical exam, no rales, wheezes or rhonchi was heard?
A. Right.
Q. Again, profusion level was only 1/0?
A. That's right. He had pleural changes.
Q. And some pleural changes. No calcification of any of those changes?
A. No.
Q. And you have a reduced diffusion capacity was the only abnormality in the PFT?
A. Yes.
Q. Is it possible that the coronary bypass surgery could have caused some lung markings that you saw on your x-rays?
A. No. Well, wait, wait. Hold on. No. In his case, not. I was checking to see if he had blunted

costophrenic angles because that is a frequent result of bypass surgery, but he didn't have that.
Q. Does Mr. [redacted] have a greater than fifty percent chance of developing mesothelioma?
A. Although his risk is increased, it's less than fifty percent.
Q. And does he have a greater than fifty percent chance of developing lung cancer?
A. My same answer would apply to that one, too.
Q. And does he have a greater than fifty percent chance of developing another asbestos-related cancer?
A. No.
MR. ALMQUIST: I believe that's all for him.
MS. PAPANTONAKIS: If no more for Mr. [redacted], then we'll move on to Mr. [redacted].

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EXAMINATION

BY MR. ALMQUIST:

Q. Okay. Mr. [redacted] you saw back in October of 2000. It looks like Mr. [redacted] was an insulator. Do you know if he was a member of the insulators union?
A. Unless I put it in there, I don't know.
Q. If he was a member of the insulators union and started working for them in '68, was that after Dr. Selikoff had started publishing the results of his work

to the insulators union?
A. Yes.
Q. Has your experience in the past in dealing with insulators been that most of them were familiar with the work of Dr. Selikoff?
A. That's a really broad-based question. I would say the majority of them are familiar with his work. As far as the point at which they became familiar, that varies widely. Some not becoming aware of it until the 1980s.
Q. However, as early as '68, there were green sheets in the union publications reporting on health issues and asbestos; is that correct?
A. I'm not sure about that.
Q. Now, Mr. [redacted] suffered a cerebral hemorrhage from a brain aneurysm and that has disabled him; is that correct?
A. Yes.
Q. And it appears that he didn't have surgery for that condition?
A. Right.
Q. You probably wouldn't recommend heavy exertion for an individual with that condition in any event, would you?
A. Well, not in the immediate aftermath. At

this point, depending on what his general physical condition is, it wouldn't matter.

Q. He also is obese as well, which would account for some of his shortness of breath on exertion and activity; is that correct?

A. Possibly.

Q. His pulmonary function tests showed normal lung volumes and normal diffusion capacity. The only defect you saw was a mild obstructive defect with small airway obstruction; is that correct?

A. Yes.

Q. Now, in your diagnosis and impression you haven't attributed that to -- or mention that finding as having any relation to your diagnosis of pulmonary asbestosis. Does it have some relation to that?

A. Well, the way you asked that question implies that we think that any pulmonary function abnormality has something to do with the diagnosis of asbestosis. And if I've given you that impression, I need to correct that at once.

Pulmonary function tests have nothing to do with the diagnosis of asbestosis. They're simply a measure of impairment. So if you're asking me do I think that pulmonary asbestosis caused or was a contributing factor to his airflow obstruction, I would

say yes. I generally -- as I told you before, I generally don't put that on the reports, not because I don't believe that it's a factor, but because it's somewhat controversial and not all pulmonologists believe that.

Q. Is Mr. [redacted] at a greater than fifty percent chance of developing mesothelioma in the future?

A. Although his risk is elevated, it doesn't exceed fifty percent.

Q. And is Mr. [redacted] at a greater than fifty percent chance of developing lung cancer in the future?

A. Although his risk is quite elevated, it doesn't -- it's less than fifty percent.

Q. And is he at a greater than fifty percent chance of developing another asbestos-related cancer?

A. No.

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EXAMINATION

BY MR. ALMQUIST:

Q. Last is Mr. [redacted]. And I'll tell you what, if you'll take [redacted] -- I'm going to read some of his testimony. If you'll take him at his word, then I may not have any questions for you about Mr. [redacted].

A. Okay.

Q. Because he was asked: Do you remember -- asked about, did you ever work at Dow, in any of the Dow Chemical facilities? His answer: In Plant A at Freeport for a short time. Question: How long? Answer: About three or four months at the longest. Question: And what did you do? Answer: I was a pipe fitter there. Do you remember what year you worked there? Answer: No, I really don't. It's been a long, long time. Question: Was that before '79 or '80? Answer: Yes, it was.

And then he says -- and the question was: And do you believe you were exposed to any asbestos-containing products while you were there? Answer: I really couldn't say. I don't know. I was only there a short time. Question: Did you? Answer: And I didn't work around any, I'm going to put it like that. I will just say no.

So would you say, given that history, that that has anything to do with the asbestosis that you diagnosed in Mr. [redacted]?

MS. PAPANTONAKIS: Object to form.

A. Evidently not.

MR. ALMQUIST: That's all the questions I have on Mr. [redacted].

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EXAMINATION

BY MR. SPRAGUE:

Q. Doctor, Wes Sprague again. With respect to Mr. [redacted], does his pulmonary function test results show any impairment that you associate with asbesto exposure?

A. No.

Q. Would the impairment that is noted in the pulmonary function testing be due to his chronic obstructive pulmonary disease?

A. That's right. Or at least predominantly due to chronic obstructive pulmonary disease. Margaret Becklake studies suggest that people with asbestos-related pleural disease have measurable airflow obstruction, but that's true in her population group, comparing asbestos-exposed individuals with pleural disease as opposed to asbestos-exposed individuals without disease. The people with the pleural disease have more airflow obstruction than those without. But on an individual basis, the effect is small. And so I think in his case, predominantly it's due to his smoking.

Q. With respect to your diagnosis of asbestos-related pleural disease, is that based upon the chest x-ray reading?

A. And the exposure history; right. Both.
MR. SPRAGUE: That's it, Doctor. Thank you.
MS. PAPANTONAKIS: Any other questions on any other plaintiffs in the [redacted] group?
MR. ALMQUIST: Any other general questions on [redacted], I guess.
MS. PAPANTONAKIS: Yeah, in the [redacted] group.

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(Whereupon, there was an off-the-record discussion.)
MS. PAPANTONAKIS: If no one else has any questions for Dr. Segarra in the [redacted] group, then we'll go ahead and take a quick thirty-minute break for lunch and come back and do some more cases.

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(Whereupon, a lunch break was taken.)
MS. PAPANTONAKIS: For the record, Dr. Segarra has already been produced in the [redacted] case, so we are not here on the [redacted] case again. That case has been completed as far as Dr. Segarra testifying on it, so we're going to move now to the [redacted] case. I believe there's only one plaintiff in the [redacted] case.
MR. JACOBS: Let me ask one question. Was the [redacted] notice quashed?

MS. PAPANTONAKIS: I do not know. I just know that he's already been produced in the [redacted] case.
MR. RULON: Caryn, I don't want to interrupt the proceedings, but I would object to the [redacted] notices being disregarded. I just want that objection noted for the record.
MS. PAPANTONAKIS: It was my understanding that he shouldn't have been reoffered for [redacted] because of the fact that he had already been deposed on the [redacted] case.
MR. RULON: My only point is, I don't know that, so I just wanted to reserve the objection.
MR. PETERS: I'll join in that because I know he was produced, but the particular plaintiff that I noticed him for hasn't been talked about previously.
MS. PAPANTONAKIS: Okay. Let's move on to [redacted] then.

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EXAMINATION

BY MR. PETERS:

Q. Okay. Dr. Segarra, Norm Peters again. If you can look at Mr. [redacted] in the [redacted] case.
A. Sure. [redacted], got it.

Q. This gentleman, you have indicated that he was a pipe fitter/welder from about 1954 to 1983. Am I reading that correctly?
A. Yes.
Q. Did he indicate to you -- well, you note in your report that he worked with insulators. Did he indicate to you what type of work that entailed?
A. Well, he told me he was a pipe fitter/welder and that he worked with insulators who were insulating while he was doing his pipe fitting and welding duties, so I assume that's what he meant when he said that.
Q. Did he indicate to you how that worked, how a pipe fitter/welder would work with an insulator, what type of process that was or how close they were or --
A. I don't recall specifically whether he himself said that or not. But what I hear frequently from pipe fitters and welders is that insulators removed insulation prior to them welding or pipe fitting; or conversely, they would be coming behind them insulating pipe that they had been laying down or repairing. That's what I hear most frequently.
Q. Okay. What's this gentleman's smoking history, if you would?
A. He smoked a pack a day for just four years, quitting in 1954. I would consider that -- well, that

is statistically an insignificant smoking history.
Q. Okay. And this gentleman suffers from chronic low back pain, type II diabetes, hypertension and diverticulitis.
A. Diverticulitis, yes.
Q. Which is?
A. Inflammation of little out pocketings of the colon, which occasionally can cause pain and discomfort, but is not considered a life threatening problem.
Q. In fact, problems have continued since 1983, is what you state in here; is that correct?
A. That's right.
Q. You also note in here that he stopped taking his blood pressure medicine two weeks ago. It's not noted in here why, but do you have any recollection or do you see any reason why?
A. I don't recall, no. I mean, I could tell you the reasons why patients typically stop taking blood pressure medicine, but there's a short list.
Q. But you don't know?
A. I don't recall why he himself stopped taking it, no.
Q. You note that he has dyspnea upon moderate exertion. Do you attribute that to -- or can you

attribute that to his hypertension?
A. No, not necessarily. No.
Q. How about his obesity?
A. That could be a component, certainly.
Q. What about diabetes?
A. That doesn't cause shortness of breath in of itself.
Q. You indicate -- well, you indicated, I suppose he indicated to you, also, that he can no longer run. I haven't seen that before in any of your reports. What do you mean by that other than just the obvious?
A. I'm just reporting what he said.
Q. You don't know if he was running two miles before he started having shortness of breath or --
A. No. No. Sometimes I get patients who are runners and they say that they used to run three miles a day and now they run just a half a mile and can barely make that, but that's not the case here.
Q. You wouldn't expect a sixty-eight year old gentleman with chronic back pain and is overweight to be a runner, would you?
A. No.
Q. You indicate that he had no rales when you listened to his chest.

A. That's right.
Q. All right. You note that he had a 1/1 ILO rating in the mid and lower lung zones; is that correct?
A. Correct.
Q. You also noted pleural surfaces revealed circumscribed pleural thickening, in profile. What does "in profile" mean?
A. On edge.
Q. On the edge of?
A. It means that the plaque, which is a flat lesion, is oriented on edge or anterior posterior so that it shows up as like a disc on edge, if you're looking at it like this. When it's en face, it means that it's turned like this so you're looking through the thin portion of it.
Q. The thickening wasn't calcified, though, was it?
A. No.
Q. And you noted no change in the films from March 7th, '98 until you read films on February 6th, 2001?
A. That's right.
Q. He had a normal pulmonary function test; correct?
A. He did.

Q. In your diagnosis/impression section you indicate pulmonary asbestosis based on pleural and parenchymal x-ray. Is that meant to read that you're basing his asbestosis on the pleural findings, or is that just --
A. No. It's that he's got parenchymal x-ray changes and exposure history. And all the pleural findings are related to asbestos, and when they are present, they increase the specificity of the parenchymal findings for asbestosis.
Q. Okay. The same set of questions you've been asked over and over again. Do you believe or is there a greater than fifty percent chance that Mr. [redacted] is going to develop a lung cancer as a result of his asbestos exposure?
A. Although his risk is increased, it's not -- it's less likely than not that he will get lung cancer.
Q. How about mesothelioma? Same question.
A. Again, although his risk is greatly increased compared to nonasbestos-exposed individuals, that risk does not reach the point where it becomes likely that he will get that disease.
Q. How about any other asbestos-related associated malignancy?
A. His risk for some of those cancers, although

increased, is less than fifty percent.
MR. PETERS: I'll pass the witness.
MS. PAPANTONAKIS: Anyone else with any questions about Mr. [redacted]? Anyone else with any questions about any of the plaintiffs in the [redacted] case?
MR. JACOBS: I have one question on Mr. [redacted].

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EXAMINATION

BY MR. JACOBS:
Q. At the end you note in your prognosis and recommendation, you note that Mr. [redacted] voiced his intention to see his regular physician within the next four hours.
A. Yes.
Q. What was his reason for that, if you remember or if you can tell from your report?
A. Yeah. I strongly encouraged him to.
Q. Could it have something to do with his blood pressure having been two thirty over one twenty-five?
A. That was the whole reason for it.
MR. JACOBS: Pass the witness.
MS. PAPANTONAKIS: Anyone else with any questions about any of the plaintiffs in the

[redacted] case? Then that's it. Now we'll move on to the [redacted] case.

MR. SIAHATGAR: Excellent. All right. I've got eight in the [redacted] case in alphabetical order; [redacted]

MS. PAPANTONAKIS: That's all of them that have been noticed.

MR. SIAHATGAR: That's what I thought.

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EXAMINATION

BY MR. SIAHATGAR:

Q. Dr. Segarra, my name is Bijan Siahatgar. You and I have actually met once before. I think it was last fall. I'm sure you don't remember me, but that's okay. And I would like to ask you some questions about a variety of these guys.

A. Sure.

Q. Let's start with [redacted] All right. It looks to me, and you may need to flip through your history a little bit, that this gentleman smoked a half pack of cigarettes for about thirteen years; correct?

A. Right. Yes.

Q. And it appears the man died in 1968?

A. No.

Q. I mean, ceased smoking in 1968, excuse me.

A. To some that would be considered a death.

Q. If he had died in 1968, it would be a much shorter deposition. But he ceased smoking in 1968.

A. Some people have described their life as ending when they stop smoking. But, no, not him.

Q. All right. I would like to make sure that his medical history, in your opinion, is unrelated to asbestos exposure, notably liver cirrhosis?

A. No.

Q. Unrelated; correct?

A. Unrelated.

Q. All right. Glaucoma?

A. No.

Q. Unrelated?

A. Unrelated.

Q. All right. Rather than saying no, how about saying unrelated.

A. Okay.

Q. All right.

A. How about if I say that his liver cirrhosis, glaucoma, acid reflux and hypertension are all unrelated.

Q. To asbestos exposure?

A. To asbestos exposure.

Q. Beautiful. And then you mention the fact that he was diagnosed with a lung cancer two years prior?

A. Right.

Q. Back in either late 1999 or 2000; correct?

A. Yes.

Q. The lung cancer was excised. He underwent various treatment for it. And as far as you are concerned, at the time he saw you in January of 2002 his lung cancer had not recurred; correct?

A. Yes.

Q. Do you have any idea whether his lung cancer has recurred in the year and a half since you saw him on January 23, 2002?

A. At this time I don't know.

Q. When is the last time you saw this gentleman, [redacted]?

A. The date on my report, January 23rd.

Q. You have not seen him since then; right?

A. Have not.

Q. You actually have no independent recollection of this gentleman; right?

A. I don't have much independent recollection. The fact that he had a lung cancer is -- I remember a few things, but not much.

Q. Essentially when you testify at trial, you're going to testify based on your report and the medical records?

A. Of course.

Q. Solely?

A. Yes.

Q. All right. Do you have any plans to see this gentleman again, [redacted]?

A. I have not been asked to see him again.

Q. So sitting here today, you have no future plans to see this gentleman?

A. Right.

Q. Is it fair to say that all your opinions relating to this gentleman are set forth in this report, your January 23, 2002 report?

A. All my opinions for questions that have been framed so far. You could certainly ask me questions that might generate additional opinions. But basically if you ask me questions limited to the questions that are framed as part of my report, these are all the opinions I'll be giving you.

Q. Good. His current medications, Xalatan, Protonix and Procardia, any of those for purposes of either his lung cancer or an asbestos-related disease?

A. No.

Q. You talk about frequent heartburn and mild nocturia. Neither one of those are related to asbestos exposure; correct?
A. No.
Q. Not correct, or it is correct?
A. Neither of them are related to asbestos exposure.
Q. Same thing as to his chronic cough or hemoptysis, neither one of them are related to asbestos exposure; correct?
A. Well, he doesn't have those.
Q. There is no chronic cough.
A. Right.
Q. So, therefore, obviously it's not related to asbestos exposure.
A. Right.
Q. Right. His wheezing is not related to asbestos exposure; correct?
A. Probably not.
Q. His dyspnea also is unrelated to asbestos exposure?
A. Some of it could be related to asbestos exposure. But, I mean, the man has lung cancer and that could account for a lot of his shortness of breath.

Q. Right. But my question was, is there any way that you can say with any type of reasonable certainty that his dyspnea is related to any type of asbestos exposure he may have had?
A. Well, I think that it probably is. He's had this for two or three years. And I don't think his lung cancer has been growing for three years. More likely it's been growing for about a year or so.
Q. You note in the last line of your history that this man has not been diagnosed with a primary pulmonary disease until recently. Why do you mention that in your report?
A. Well, only because when I took his pulmonary history, he had never been told that he had emphysema or any other condition prior to this time. That's all.
Q. The physical exam appears normal; correct?
A. Yes.
Q. In other words, from a pure physical exam, this man was no different than any other sixty-four year old man or a healthy individual?
A. Well, other than the fact that he had a catheter for chemotherapy in his arm. Other than that, he was --
Q. Completely normal?
A. -- he looked the same as anybody else.

Q. All right. Let's turn to the chest x-ray section.
A. Okay.
Q. You note a mild diffuse interstitial pattern?
A. Right.
Q. And the profusion was 1/0?
A. That's right.
Q. And, again, as you've been asked a dozen times today already, the 1/0 diffusion is the minimal level of diffusion -- of profusion to qualify for an asbestos-related disease?
A. No. Qualify for asbestosis.
Q. Asbestosis.
A. Asbestos-related disease is a more encompassing term. And that would include pleural findings.
Q. Right. Pulmonary function tests, there was a slight restrictive defect; correct?
A. Yes.
Q. What do you attribute his restrictive defect to?
A. In his particular case, I think his restrictive defect is due to his lung cancer.
Q. Let's talk about his lung cancer for a second. Mr. [redacted] lung cancer, you opine, was

related at least in part to his previous asbestos exposure; right?
A. Sure.
Q. And, again, the knowledge you have of whatever asbestos exposure he may have had is based purely upon what he may have told you when you visited with him or whatever he filled out in his form?
A. That's right.
Q. You'll agree that his lung cancer could be caused or attributed -- could be caused by his cigarette smoking history?
A. In part, it certainly is caused by the cigarette smoking.
Q. Isn't it true that ninety percent of all lung cancers, and I believe this man had adenocarcinoma, are caused by cigarette smoking?
A. Worldwide, certainly.
Q. Is it possible that this man's lung cancer was caused exclusively by his cigarette smoking?
A. I find that a difficult question because he was exposed to two major sources of carcinogens, that is, asbestos and cigarette smoking, and synergistically they caused his lung cancer. I have trouble separating the two of them, though.
Q. Do you have an opinion whether or not he

would have developed lung cancer regardless whether he had been exposed to asbestos or not?
A. I think his chances of developing lung cancer would have been much less if he had not been exposed to asbestos.
Q. That really wasn't my question. My question was, can you sit here and tell the jury that the man would not have been diagnosed with lung cancer even if he had not been exposed to asbestos?
A. Although I can't say for sure, I can say that he probably would not have developed lung cancer if he hadn't been exposed to asbestos.
Q. Okay. The pulmonary asbestosis that you have diagnosed this man with, it doesn't cause him any pain, does it, as far as you're concerned?
A. In this case, probably not.
Q. Does his pulmonary asbestosis restrict his ability to function, do, I guess, his everyday activities?
A. Well, in his case it's hard to say because he has lung cancer which was stage four when diagnosed, which means that it's not really curable. And so his activities are restricted as a result of -- for a number of reasons, and likely that will get worse.
Q. Is there anything in your report that

indicates that this man has a restricted ability to do his everyday activities of daily living?
A. Sure. He has -- he gets short of breath after walking a hundred and fifty feet on level ground, weeding the garden, taking out the trash, going to the mailbox. Now, his basic activities of daily living, such as getting dressed and taking a shower, those have not been associated with shortness of breath, but these other things have been.
Q. You'll agree with me that some of his shortness of breath could be attributable to his smoking history as well, could it not?
A. Well, let's see. Only if he had COPD, but I don't think he had that. Let's look at his pulmonary function tests. Hold on. Yeah, he has no airflow obstruction at all, so that there is -- there is no evidence that his smoking has anything to do with his activity restriction.
Q. So your opinions relative to this man in general right now is that based on his reported work history, it is your opinion that his lung cancer is attributable to, at least in part, to his asbestos exposure and also that his pulmonary asbestosis is related to the same?
A. Yes.

MR. SIAHATGAR: All right. That's all I have for this guy. Anybody else?
MR. PETERS: Yeah, I've got some.
- - -
EXAMINATION
BY MR. PETERS:
Q. Dr. Segarra, you noted in your chest x-ray portion of your report that there is a mass in the left A-P which corresponds to the location of the original lung cancer. Do you see that? Second from the bottom in chest x-ray section.
A. Left A-P window is what it should read. Yes.
Q. It is much smaller than five centimeters, however. Are you saying there that there's a potential lung cancer process or malignancy?
A. It's not potential. He has lung cancer.
Q. Are you saying that he did have it?
A. Yeah. That's what I'm trying to tell you guys. This guy doesn't have a lung cancer that's been cured. This guy has stage four lung cancer which has metastasized to a rib.
And I don't have -- at the time I did his report, I didn't have his medical records, but that's what was known about him at the time. And that is

something that chemotherapy very rarely cures. That's something that is slowed down by chemotherapy, but that tends to eventually progress at some point.
Q. Okay. I was mistaken. I had thought you had said earlier that it was excised out and that --
A. No, no, I didn't say that. I never said that.
Q. And some of his restriction is caused by the lung cancer, as you previously stated?
A. Yes.
Q. Okay. Under your diagnosis/impression on number two, you have S, slash, P. What does that stand for?
A. S, slash, T?
Q. S, slash, P chemotherapy.
A. Oh. Status post chemotherapy. It means that he just underwent chemotherapy.
Q. I gotcha'.
MR. PETERS: I pass the witness.
MS. PAPANTONAKIS: If there are no other questions, then we will move on to Mr. [redacted].
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EXAMINATION
BY MR. SIAHATGAR:
Q. [redacted]

A. Okay. Got it.
Q. All right. This is a gentleman who has -- let me back up.
Dr. Segarra, do you have any independent recollection of this gentleman, [redacted]?
A. No.
Q. Your testimony is and will be based solely upon your report today and as well at the time of trial?
A. Yes.
Q. And do you have any plans to see this gentleman again?
A. None at this time.
Q. You have not seen him since January 22, 2002?
A. No.
Q. This gentleman smoked one pack of cigarettes a year for twenty years?
A. One pack per day for twenty years.
Q. One pack per day. What did I say, a pack per year?
A. Yes.
Q. One pack per day, daily for twenty years.
A. Right.
Q. His atypical chest pain is not related to asbestos exposure; correct?

A. That's unclear to me at this time.
Q. All right. Occasional palpitations and gets leg cramps after walking two or three blocks. You certainly don't attribute that to asbestos exposure?
A. No.
Q. Correct?
A. Correct.
Q. All right. He has mild ortho --
A. Orthopnea.
Q. Orthopnea and heartburn. Again, you don't attribute either one of those to asbestos exposure?
A. No.
Q. Correct?
A. Right.
Q. The early morning productive coach, you don't attribute that to asbestos exposure; correct?
A. Oh, in part that is probably related to asbestos exposure, yes.
Q. And also where he says that he's been short of breath with moderate to heavy exertion, can you tell us with any reasonable certainty that that's related to asbestos exposure?
A. Yes, it probably is.
Q. You note pleurisy in the past. Why is pleurisy significant to you?

A. I just note it when the patients say it.
Q. Certainly pleurisy is not related to asbestos exposure?
A. Not unless there's an asbestos-related pleural effusion, which is rare. And I don't think there was in this case.
Q. That was my next question, but we'll move on.
Physical exam. It looks like his physical exam was normal?
A. Yes.
Q. Let's move on to the chest x-ray. What's significant to me is that there was unilateral diffuse pleural thickening on the left. Do you see that?
A. Yes.
Q. Is that usually indicative of asbestos exposure if it's unilateral?
A. No. Unilateral diffuse pleural thickening is most often the result of -- well, it can be the result of an asbestos-related pleural effusion. But in terms of likelihood, it's most likely related to a previous pneumonia, where the infection has gone from the lung into the pleural space.
Q. Now, pneumonia can also cause interstitial markings, could it not?

A. Not really, no. It can cause focal scars in one area of the lung, but it will not cause diffuse interstitial markings.
Q. And that's what we're talking about here, that whatever you've seen here could be related to a prior pneumonia?
A. No. His parenchymal lung disease could not be related to a prior pneumonia. The unilateral diffuse pleural thickening on the left side could be.
Q. All right. I believe you had an earlier film dated back in June of 2001, and whatever your view of that film was, was no different than your view of his film as of January of 2002?
A. Right.
Q. In other words, his condition hadn't worsened?
A. Correct.
Q. His pulmonary function test was normal?
A. Yes.
Q. In other words, this man's lungs function like a normal sixty-five year old man?
A. Within the limits of that, yes.
Q. All right. Moving on to your diagnosis/impression, you diagnosed pulmonary asbestosis based on the interstitial changes on the

chest x-rays and his exposure history; is that right?
A. That's right.
Q. If he had not taken a chest x-ray and done all these other tests, is there any way to determine whether or not this man had an asbestos-related disease?
A. Well, you can't tell if anyone's had an asbestos-related disease without doing a chest x-ray.
Q. Right. And that's what I'm trying to say right now. If you had just done a physical exam of this individual and you had done a lung volume test or a pulmonary function test, the man would be no different than any other sixty-five year old man; correct?
A. Well, although that's true, even if the pulmonary function test was abnormal, you can't diagnose asbestosis from a pulmonary function test and a physical exam. You need radiographic findings.
Q. I understand. But my question really was, if you just do a physical exam of this gentleman and you do the pulmonary function test, there's just no way to diagnose this guy with any kind of asbestos disease?
A. Okay. True.
Q. True. Based on your report -- let me back up. Does this guy's pulmonary asbestosis cause him any

pain?
A. Well, he has atypical chest pain when he gets up in the morning that lasts ten to fifteen minutes. That could be related to asbestosis. But that's the only area -- the only symptom that would be related to pain in him.
Q. All right. Does his pulmonary asbestosis restrict his ability to conduct his everyday activities of living?
A. He has shortness of breath with moderate to heavy exertion, but that generally does not include basic activities of daily living, so, no.
Q. All right. And as with all these other people that we've spoken about, whatever the pulmonary asbestosis is that you've diagnosed this man with, the odds of him developing any kind of more severe or serious asbestos-related disease is less than fifty percent; correct?
A. No. That's a bit of a leap. His risk for developing mesothelioma and lung cancer are much higher than the average person, but they're not so high that they exceed fifty percent.
Q. I don't think that was my question. My question simply was, does this man's pulmonary asbestosis mean that he has any -- strike that. Isn't

it true that his -- despite the pulmonary asbestosis that you've diagnosed this man with, his odds of developing any more serious asbestos-related disease is less than fifty percent?
A. Oh, no, that's not true. See, that's a separate question. He has a greater than fifty percent chance of progression of his asbestosis itself. But he has less than a fifty/fifty chance of actually developing cancer, per se.
Q. Okay. So if we're talking about a separate disease, you will agree there's a less than fifty percent chance that his disease will progress into a different disease?
A. Yes. Particularly a malignancy.
MR. SIAHATGAR: That's all I have for this guy.
MR. PETERS: Not me.
MS. PAPANTONAKIS: No other questions, then we'll move on to Mr. [redacted]

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EXAMINATION

BY MR. SIAHATGAR:
Q. [redacted] You saw Mr. [redacted] on January 22, 2002?
A. Yes.

Q. Do you have any independent recollection of this gentleman?
A. No.
Q. Your testimony today as well as at trial will be based solely upon your report and your records on this individual; correct?
A. Yes.
Q. Do you have any plans to see this man again?
A. Not at this time.
Q. And it's true you have not seen this gentleman since January 22, 2002?
A. No.
Q. Correct?
A. It's true.
Q. All right. You have listed in your report the fact that he has a past medical history of benign prostate disease, hypertension and peripheral edema. You'll agree with me all three of those are unrelated to asbestos exposure; correct?
A. In his case, yes.
Q. His current medications are -- is Norvasc?
A. Right.
Q. Again, that has nothing to do with any kind of asbestos disease; correct?
A. No.

Q. No, or yes, that's correct?
A. No. I said no.
Q. "No" meaning it does? I think we need to clarify here.
A. No. "No" meaning that it has nothing to do with any asbestos-related disease.
Q. Thank you. Occasional heartburn, moderately frequent nocturia. Both of those are unrelated to asbestos exposure; correct?
A. True.
Q. Much better. Again, we talk about the dyspnea upon heavy exertion. Again, in this guy's case, that's unrelated to any kind of asbestos exposure; correct?
A. Incorrect.
Q. You believe his dyspnea is related to his asbestos -- potential asbestos exposure?
A. I think that his shortness of breath on heavy exertion is related to his asbestos exposure, yes.
Q. However, you accurately note right afterwards that this dyspnea upon heavy exertion does not interfere with his daily routine; correct?
A. Although that's true, how do you know that that's accurate?
Q. Well, I presume that it's accurate since you

list it there. Are you telling us that this is inaccurate in your report?
A. I believe it's accurate, but that's the first time you've given me credit for an accurate statement.
Q. Make a note of it. All right. Physical exam for this individual is completely normal?
A. Yes.
Q. In other words, this man, this sixty-eight year old man had a normal physical exam for similar age, similar condition?
A. That's right.
Q. All right. The chest x-ray, let's move on to that section. There is a -- the x-ray revealed diffuse interstitial pattern consisting of small, irregular linear opacities?
A. Yes.
Q. Do you attribute that -- could that be caused by a prior pneumonia or some other type of disease?
A. No.
Q. You believe that that is related exclusively to prior asbestos exposure?
A. Yes.
Q. Other than these small, irregular linear opacities visible on his x-ray, is his x-ray otherwise normal?

A. Yes.
Q. Let's move on to the pulmonary function test. I believe that was normal as well?
A. Yes.
Q. In other words, this gentleman's lungs functioned like the lungs of a normal sixty-eight year old man?
A. Yes.
Q. The diagnosis, again, is based purely on the x-ray; correct? In other words, if you had just done a physical exam and done a pulmonary function test, there's no way that you could have determined whether or not this gentleman had an asbestos-related disease or not; correct?
A. The answer to the first part of your question is, yes, it's based on the x-ray and the exposure history. I object to the wording of the second part of the question because I can't diagnose any asbestos-related disease based on the physical exam and the pulmonary function test.
But if you're asking me, does he have a normal physical exam and a normal pulmonary function test, that's true, he does.
Q. All right. Good. And, again, with all these other individuals, the fact that you have

diagnosed him with mild pulmonary asbestosis, his chances of developing mesothelioma, lung cancer or some other separate disease is less than fifty percent; correct?
A. Although his risk for developing those diseases is elevated, it's less than fifty percent, yes.
MR. SIAHATGAR: Let me object to everything before your statement that it's less than fifty percent as nonresponsive.
BY MR. SIAHATGAR:
Q. Does his mild pulmonary asbestosis cause this individual any pain?
A. Apparently not.
Q. And does his mild pulmonary asbestosis restrict this man's abilities to do his everyday functions, everyday living functions?
A. No.
Q. It does not?
A. Does not.
Q. Can this man generally function like a normal human being, as far as you're concerned?
A. In terms of his exercise tolerance, it's only mildly impaired.
MR. SIAHATGAR: That's not really responsive

to my question, so I'm going to have to object.
BY MR. SIAHATGAR:
Q. Can this man generally function like a normal human being?
A. Well, I don't know exactly what you mean. He has no objective impairment on pulmonary function test. And he has mild subjective impairment based on shortness of breath with exertion.
Now, if he were completely normal, he would have no respiratory symptoms and he would have normal pulmonary function tests. So I can't really go beyond that.
Q. All right. Let me ask you this: Do you have any independent recollection of this gentleman telling you that whatever his condition was impedes his ability to conduct his everyday living activities and do whatever he generally wants to do?
MS. PAPANTONAKIS: Object to form.
A. No, I have none.
MR. SIAHATGAR: Pass on this witness.
MS. PAPANTONAKIS: If no one else has any questions, then we'll move on to Mr. [redacted].
MR. JACOBS: Can I ask one question going back to Mr. [redacted]? I'm sorry.
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EXAMINATION
BY MR. JACOBS:
Q. You refer to heavy exertion here, and I know that there was some discussion about mild, moderate. I'm just asking, can you give me some examples of what you mean by heavy exertion here?
A. Digging in the garden, lifting heavy objects, moving furniture, that kind of thing.
Q. Heavy objects, like fifty pounds, sixty pounds?
A. Well, it depends on the individual. But something that strains, a strain that is outside the normal scope of their activity. And, really, that's the way the American Heart Association grades shortness of breath with exertion.
Grade one is where you are -- none is where you're not short of breath at all except with exertion that is at the limit of your exercise tolerance, which everybody has. You can't not have it. But grade one is when you're short of breath only with activities that you would not normally do unless requested to or except in an emergency.
Grade two is shortness of breath with activity -- the heavier of activities that you would do as a normal part of your weekly routine even though

they're not activities of daily living.
And grade three is when you're short of breath with any exertion, even basic activities of daily living, such as getting dressed or taking a shower. And grade four is shortness of breath at rest, or class four, same thing; one, two, three, four.
Q. And is it true that one of the ways to quantify that is they call them exercise tolerance tests?
A. No. That's apples and oranges. You quantify that in just the way that I told you. It's a historical phenomena. It's not something that you measure with a machine.
And exercise-- a pulmonary exercise tolerance test is designed to measure a number of parameters, including oxygen consumption, heart rate, respiratory rate and so on. And in so doing, the test is designed to determine, among other things, whether a person's shortness of breath is more related to their heart disease or to their lung disease when that's a clinically important question.
MR. JACOBS: Okay. That's all.
MS. PAPANTONAKIS: Now if there's no more questions on that plaintiff, we'll move on to Mr. [redacted].

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EXAMINATION
BY MR. SIAHATGAR:
Q. All right. Dr. Segarra, I'd like to ask you some questions about [redacted].
A. Okay.
Q. [redacted], even though he says he's a lifelong nonsmoker, will you agree that he was probably exposed at least to some secondhand smoke while he was growing up, based on the fact that his mother died of emphysema?
A. I certainly think that that's possible, but I don't know that for sure.
Q. His atypical chest pain, do you agree that is unrelated to any type of asbestos exposure?
A. It may or may not be. I can't say for sure.
Q. All right. He has occasional sweats, nausea, palpitations and leg cramps. All of those are unrelated to asbestos exposure; correct?
A. Correct.
Q. Frequent heartburn, also unrelated to asbestos exposure; correct?
A. Correct.
Q. Chronic nonproductive cough, occasionally associated with wheezing, also unrelated to asbestos

exposure; correct?
A. No. That probably is related at least in part to asbestos exposure.
Q. Which one, the cough or the wheezing?
A. Not the wheezing, but the cough.
Q. So you believe that the nonproductive cough may be related to asbestos exposure?
A. That's true.
Q. The wheezing, however, is not?
A. Well, the wheezing probably isn't because -- but that would depend on whether or not he has asthma. He has no evidence of asthma, so I basically -- let me back up. Some people with asbestosis wheeze, but generally that's people with more advanced forms of asbestosis.
Q. Unlike this gentleman?
A. Unlike this gentleman; right.
Q. All right. He notes the fact that he has been increasingly short of breath with exertion. Can you attribute that to the asbestos, any potential asbestos exposure or something else?
A. Oh, yeah, sure. That could well be related to asbestos exposure, at least in part.
Q. Can it also be in part as a result of a lung condition, as a result of either smoking or having

inhaled secondhand smoke?
A. No.
Q. And then you also talk about the fact that this man gets short of breath after climbing two flights of stairs; correct?
A. Yes.
Q. And then you also note that he had pneumonia once as a teenager?
A. That's right.
Q. The physical exam, again, on this gentleman was completely normal?
A. Yes, it was.
Q. And with regard to the chest x-ray, can you tell the jury why the pneumonia may be relevant?
A. Actually, I don't think the pneumonia is relevant at all.
Q. You talk about a benign granuloma in the chest x-ray. Certainly that's not related to asbestos exposure; correct?
A. It's not. But it's also not related to pneumonia either.
Q. That wasn't my question.
A. I'm sorry.
Q. That's fine. The profusion was 1/0; correct?
A. Yes, that's right.

Q. Do you have -- let me back up. The film dated 6/8/01 compared to the film you took six months later or the one you viewed, there had been no changes; right?
A. Yes, that's right.
Q. In other words, there had been, again, no progression of the disease --
A. Correct.
Q. -- as far as you could tell by viewing the films?
A. Yeah. It was only six months difference, but, yes.
Q. All right. The pulmonary function test was completely normal?
A. Yes.
Q. In other words, this fifty-six year old man's lungs functioned like any other fifty-six year old man's lungs or any normal fifty-six year old man's lungs?
A. Within the acceptable normal range for that, yes. Actually, his mid flows were slightly reduced at fifty-six percent of predicted. Sixty percent is the cutoff for mid flows, but that --
Q. Your opinion at the time was that these pulmonary function tests --

A. Yeah, they're within normal limits anyway. His most important parameters were in the normal range.
Q. Based on his physical exam and his pulmonary function tests, there's no way for you to be able to tell this jury that this guy had any kind of asbestos-related disease; correct?
A. Based on --
Q. Solely his physical exam and his pulmonary function tests.
A. From that, I would not make any of those conclusions; right.
Q. You needed the x-ray to be able to determine whether this man had any kind of disease?
A. And his exposure history.
Q. Right.
A. Right.
Q. Okay. And, again, as we've talked about with all these other individuals, based on the pulmonary asbestosis that you've diagnosed this gentleman with, his odds of developing any kind of lung cancer, mesothelioma or other different asbestos-related disease is less than fifty percent; correct?
A. Although the risk is elevated, it is less than fifty percent, yes.

MR. SIAHATGAR: Let me object to the nonresponsive portion of your answer.
BY MR. SIAHATGAR:
Q. Does this guy's pulmonary asbestosis cause him any pain?
A. It's possible that his asbestosis is contributing to his atypical chest pain.
Q. But you don't know that for sure?
A. I don't know that for sure; right.
Q. Other than that, can you tell the jury that his pulmonary asbestosis that you diagnosed him with causes him any pain?
A. No.
Q. Does his pulmonary asbestosis, again per your diagnosis, restrict his ability to conduct his everyday activities of daily living?
A. Not his basic activities of daily living, no.
Q. Does it restrict his ability to function as a human being?
A. Well, he has trouble climbing stairs.
Q. Is that the extent of your answer?
A. To that extent, the answer would be yes.
MR. SIAHATGAR: That's all I have for this guy. Anybody else?
MS. PAPANTONAKIS: We'll move on to Mr.

[redacted].

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EXAMINATION

BY MR. SIAHATGAR:
Q. Dr. Segarra, I'd like to ask you some questions about [redacted].
A. Okay.
Q. You have no independent recollection of this gentleman?
A. No.
Q. Is that correct?
A. That's right.
Q. And your testimony today as well as at trial will be based solely upon your report and the medical records?
A. That's right.
Q. And you have not seen this gentleman since January 23, 2002; right?
A. Correct.
Q. And you have no plans of seeing him again?
A. Not at this time.
Q. This man has smoked a pack of cigarettes a day for forty-five years.
A. He has.
Q. That's a heavy smoking history?

A. It is.
Q. In his report, you list in his report a variety of past medical history events, none of which are related to asbestos exposure? And specifically I'm referring to the pulmonary embolism, the phlebitis in the right leg, the atherosclerotic heart disease, the pneumonia, the hypertension, the hyperlipidemia, those.
A. None of those are related to asbestos.
Q. All right. Going on in your report, the guy has suffered or suffered a heart attack two years ago and underwent an angioplasty; right?
A. Yes.
Q. You don't attribute that to any type of potential asbestos exposure?
A. No.
Q. Correct?
A. Correct.
Q. The deep venous thrombophlebitis that he developed after one of his hip surgeries certainly is unrelated to asbestos exposure?
A. It's unrelated.
Q. The pulmonary embolism is also unrelated; correct?
A. Correct.
Q. The medications he's taking, Lipitor, I'm

not going to pronounce all of those, all of those are unrelated to any type of asbestos exposure in the past; correct?
A. Correct.
Q. The rare episodes of exertional chest pain, you certainly cannot attribute that to any type of asbestos exposure in this individual; correct?
A. That's right.
Q. Would you agree with me that this man's primary problem these days is his heart condition?
A. That's probably true.
Q. And the last couple of sentences in the history section, where you talk about he has slowly increasing dyspnea on exertion, you certainly would not attribute that to any type of asbestos exposure in the past; correct?
A. Correct.
Q. And, again, you note that he was treated for pneumonia in 1973?
A. I did.
Q. Despite these heart conditions and everything else, he had a completely normal physical exam; right?
A. Right.
Q. And even his chest x-ray was pretty much normal except for some small noncalcified diaphragmatic

pleural plaques bilaterally?
A. That's right.
Q. Do you believe that his pneumonia could have any effect at all on that x-ray, lung x-ray?
A. It hasn't in this case.
Q. His pulmonary function test was, again, within normal limits?
A. Yes.
Q. In other words, this sixty-four year old man's lungs pretty much operate the same as any normal sixty-four year old man's lungs would?
A. That's right.
Q. Based on his physical exam and his pulmonary function test, there's no way that you or anybody else could diagnose this guy with any type of asbestos-related disease; right?
A. Just based on those, no.
Q. That's a correct statement?
A. That's correct.
Q. Basically what you need was an x-ray to see the diaphragmatic pleural plaques bilaterally in order to diagnose this man with pleural abnormalities?
A. That's right.
Q. Again, the odds of this man developing any kind of lung cancer, mesothelioma or another separate

disease is less than fifty percent; correct?
A. Correct.
Q. You recommended that he cease smoking?
A. Yes.
Q. Is this man in any kind of pain as a result of his pleural abnormalities?
A. No.
Q. Can he function normally, do his everyday functions or everyday activities of daily living -- strike that.
Do his pleural abnormalities restrict his ability to conduct his everyday activities of daily living?
A. No.
MR. SIAHATGAR: That's all I have for this guy. Pass the witness.
MS. PAPANTONAKIS: Anyone else have any questions about Mr. [redacted]? Now we'll move on to Mr. [redacted].

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EXAMINATION

BY MR. SIAHATGAR:
Q. Dr. Segarra, I'd like to ask you some questions about [redacted].
A. Okay.

Q. I understand that you saw [redacted] on January 23, 2002?
A. Correct.
Q. It's my understanding that you have no independent recollection of this individual?
A. True.
Q. Your testimony here today as well as at the time of trial will be based solely upon your report as well as the medical records on this individual?
A. Yes, unless I'm asked other questions about him; right. That's true.
Q. Do you have any plans to see this individual again?
A. Not at this time.
Q. And you have not seen him for approximately a year and a half?
A. No.
Q. Is that correct?
A. That's right.
Q. This man smoked one pack of cigarettes per day for over forty years.
A. Yes, that's true.
Q. That's a huge amount of cigarettes. It's an outrageous amount, isn't it, Doctor?
MS. PAPANTONAKIS: Object to form.

A. I don't know how to answer that question. I would simply say that that was a fairly heavy smoking history.

BY MR. SIAHATGAR:
Q. If that's a fairly heavy smoking history, Doctor, what do you consider a very heavy smoking history?
A. Three packs a day for fifty years.
Q. All right. We'll get to that guy next.
This guy has, you list in his history, cardiac dysrhythmia which was placed there three years ago; right?
A. Excuse me?
Q. He has cardiac dysrhythmia. Did I pronounce that correctly?
A. Yes, that's right. He had a "pacemaker" placed three years ago.
Q. Right. Also had a history of hypertension?
A. Right.
Q. Chronic mild peripheral edema?
A. Yes.
Q. All of those are unrelated to any kind of potential asbestos exposure in the past; correct?
A. That's right.
Q. Hernia repair. Certainly the hernia is

unrelated to asbestos exposure; correct?
A. Correct.
Q. This wheezing that you note that he occasionally has at night is unrelated to asbestos exposure?
A. Probably unrelated.
Q. And you say that for the last five years he's slowly had increasing dyspnea, which you'll agree in this individual's case is unrelated to potential past asbestos exposure?
A. No. I think that it is related to his asbestos exposure.
Q. Do you believe his dyspnea is in any way related to his cigarette smoking history?
A. It may well be.
Q. Can you tell the jury with any kind of reasonable medical probability whether this is related primarily to his cigarette smoking history or to his potential asbestos exposure?
A. Well, yes. I can say that it's -- although it could be related to his cigarette smoking, I think it's unlikely since he does not have a smoking-related lung disease such as COPD or emphysema. He doesn't have that. So that instead in this particular man, I think his shortness of breath with exertion is due to

his asbestosis and to the fact that he's overweight.
Q. That's what my next question was going to be Dyspnea just means shortness of breath; right?
A. Right.
Q. And this is a gentleman who is about five-eleven, almost three hundred pounds?
A. Yes.
Q. This is an obese man; correct?
A. Well, probably so, yes.
Q. Other than the fact that this man is obese, nonetheless, he still has a normal physical exam?
A. No. His blood pressure was elevated.
Q. Oh, that's right.
A. And he also had rales at his bases that I believe are related to his asbestosis.
Q. And do you believe that the crackles at the bases, are those related to his cigarette smoking, potential asbestos exposure, both, neither?
A. It's not related to cigarette smoking. It's related only to asbestosis.
Q. Let's talk about his chest x-ray. His profusion was 1/1?
A. Yes.
Q. And you note here that the pleural surfaces reveals diffuse pleural thickening versus pleural fat.

Why do you make that differentiation on this gentleman right here?
A. Oh, only because in obese individuals who have extensive pleural thickening, there's a chance that some of the pleural thickening could be fat deposited in between the wall of the chest and the lung. And that's the only reason I said that.
Q. The pulmonary function tests for this individual were within normal limits; correct?
A. Yes.
Q. So what we basically have is a sixty-four year old man whose lungs function like any other normal sixty-four year old?
A. Within the limits of such, yes.
Q. And despite the fact that he's obese?
A. Well, the obesity generally doesn't have anything to do with it unless he's -- only morbid obesity has a slight effect on the pulmonary function test, so that would be neither here nor there.
In spite of the fact that he has asbestosis, his pulmonary function test, as we measured it, was within normal limits, yes.
Q. Can you tell us whether his pulmonary asbestosis causes him any pain?
A. I don't think it's causing pain, per se, no.

I think it's only causing shortness of breath.
Q. And can you tell us whether his pulmonary asbestosis is restricting his ability to conduct his daily activities of living?
A. The specific restrictions that I got from him was that he has trouble gardening and mowing the lawn, but he still does those things.
Q. Other than those two things which he still continues doing, is there any other restrictions that he has as a result of his pulmonary asbestosis?
A. Not that I can tell.
Q. You would certainly agree that his heart condition is this gentleman's main problem, main concern at this time?
A. No. I think that they're fixed. Don't forget, unlike the previous person we spoke about, he has no history of progressive cardiac atherosclerosis. He had a pacemaker placed for dysrhythmia and he's been okay since then.
Q. And this man still has a pacemaker embedded in his chest; right?
A. Well, sure.
Q. Yeah. And with regard to all these -- that we talked about with all these other guys, his odds that his pulmonary asbestosis will progress to either

cancer, mesothelioma or some other separate disease, the odds are less than fifty percent; right?
A. Although elevated, they're less than fifty percent; right.
MR. SIAHATGAR: That's all I have for this individual.
MS. PAPANTONAKIS: If there aren't any more questions about Mr. [redacted], let's talk about Mr. [redacted]
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EXAMINATION
BY MR. SIAHATGAR:
Q. Dr. Segarra, I'd like to ask you some questions about [redacted]
A. Okay.
Q. Again, you have no independent recollection of this individual?
A. True.
Q. Your testimony will be based solely upon your report and this individual's medical records?
A. Yes.
Q. You have not seen him since April 11, 2002?
A. That's right.
Q. And you have no plans to see him again at this time?

A. Not at this time.
Q. This is a gentleman who has smoked two packs of cigarettes daily for the past thirty-six years. Will you agree with me that this guy is a very heavy cigarette smoker?
A. Yes.
Q. It looks like there's a history of heart disease and his father has emphysema, which tells you that his father is probably a smoker as well?
A. Wait. You misphrased that a little bit. There's a history of heart disease and emphysema in his father, both.
Q. Right.
A. Both of those had to do with his family history, not his history.
Q. Right. So you would assume that his father was a heavy smoker as well?
A. Although I don't know that for sure, that would make sense, yes.
Q. With regard to this individual's, [redacted], past medical history, you will agree with me that acid reflux, hyperlipidemia, polio, degenerative joint disease are all unrelated to asbestos exposure; correct?
A. Yes. Correct.

Q. The medications he's taking, Cephalexin and Paxil, can you tell the jury what those are for or what he's taking those for?
A. Cephalexin is an antibiotic, which I assume he's taking for a temporary skin infection or something. Paxil is an antidepressant.
Q. All right. You say on general systems review, his chief complaint is dysphagia for solids, memory loss and tension headaches.
A. Right.
Q. Any of those three related in any way to asbestos exposure?
A. Probably not.
Q. You also mention that he has frequent palpitations, exertional leg cramps, sweats, intermittent hematemesis, frequent heartburn and other gastrointestinal complaints.
A. Yes. Hematemesis is misspelled. The last "a" should be an "e" in that word.
Q. All right. None of those would be in any way related to asbestos exposure; correct?
A. Correct.
Q. In fact, you relate most of those to the acid reflux?
A. Well, some of them.

Q. The chronic productive cough he's had for the past three or four years, do you attribute that to his cigarette smoking? Let me back up. You do not attribute that to asbestos exposure; correct?
A. I think that some of it could be related to asbestos exposure. Some of it is probably related to asbestos exposure. Some of it is probably related to cigarette smoking. And some of it may be related to acid reflux.
Q. Okay.
A. It's that hoarseness that clues me into that.
Q. All right. Again, you mention the fact that he had an episode of pleurisy about twenty years ago. Why is it that you list that in your report?
A. I just always -- it's one of the standard questions. And if I get a positive response, I put it in there.
Q. All right. His physical exam was normal; correct?
A. Yes.
Q. And his chest x-ray revealed a diffuse interstitial pattern, small, irregular linear opacities; right?
A. Right.

Q. Otherwise, the x-ray was normal?
A. Yes, that's right.
Q. And I take it that you relate that interstitial pattern to past asbestos exposure?
A. Yes.
Q. You had a chest x-ray that was taken approximately six months -- well, a little more than that, eight months before your April 11 visit. And, again, that one was essentially the same as the one that you saw when you saw this individual, Mr. [redacted], back in April of 2002?
A. That's right.
Q. In other words, there had been no progression of his disease?
A. Radiographically, that's true.
Q. Well, was there any other progression of his disease that you can tell us about?
A. No.
Q. Pulmonary function tests, it looks like normal spirometry and lung volumes, but whatever abnormal values he had in there you attributed to his cigarette smoking?
A. Well, no, I didn't say that. I simply said the DLCO is mildly reduced, and I pointed out that he was a current smoker. And the -- I think that his

reduced DLCO is due to asbestosis and potentially the fact that he may have smoked prior to taking the test, but I don't know for sure whether that's the case or not. I simply raise that as an issue because it's something you have to consider in someone who is a current smoker at the time the test is done.
Q. Someone who smokes two packs of cigarettes a day?
A. Well, yes. Sure.
Q. Again, his pulmonary --
A. But please understand, I'm not saying that he has a smoking-related lung disease. I'm saying the smoking itself interferes with the technical measurement of the DLCO. Those are two different things.
Q. Right. His pulmonary asbestosis, can you tell us whether that causes him any pain?
A. It doesn't appear to be at this time.
Q. And based solely on his physical exam and his pulmonary function test, is there any way that you can just by looking at those two things, identify this man as having asbestos-related disease?
A. Well, his DLCO is reduced, so I'll say that, despite a normal physical exam. Again, I have to object to the implication that I could ever find an

asbestos-related disease just based on the physical exam and the pulmonary function test. Of course you need the x-ray for that. But he does have a reduced DLCO for reasons that I've already covered.
Q. Does this -- does his pulmonary asbestosis in any way restrict his ability to conduct his everyday living functions?
A. Yes. He has difficulty doing manual labor or yard work.
Q. Other than that, can you tell us any other restrictions that this man has as a result of the pulmonary asbestosis?
A. He gets out of breath after walking two blocks.
Q. Which you don't attribute to his cigarette smoking?
A. No. He has no smoking-related lung disease, so it can't be related to cigarette smoking.
Q. And, again, this man's pulmonary asbestosis, you cannot tell us -- strike that.
As far as you're concerned, the odds of his pulmonary asbestosis graduating to become a lung cancer, mesothelioma or some other separate lung disease is less than fifty percent?
A. Although it's greatly elevated, it is less

than fifty percent, yes.
MR. SIAHATGAR: Object to the nonresponsive portion of his answer. That's all I have for Mr. [redacted]

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EXAMINATION

BY MR. PETERS:
Q. Dr. Segarra, what is dysphagia?
A. Dysphagia with "g," D-Y-S-P-H-A-G-I-A?
Q. Yes.
A. Trouble swallowing.
Q. Is that due to his gastroesophageal reflux disease?
A. Probably.
Q. And I know you've testified in the past about that disease and its ability or inability to cause interstitial fibrosis.
Do you in this instance relate any of the interstitial fibrosis findings of Mr. [redacted] due to that disease?
A. No. As I've testified before, I generally only see that in neurologically impaired individuals with well-documented cases of aspiration and aspiratior pneumonia, which this man doesn't have. I do think his acid reflux may be causing the dysphagia and the

hoarseness, though.
Q. Right. This is a gentleman with a seventy-two-pack-year smoking history; right?
A. Yes.
Q. Do you find it odd or is it surprising that he has no lung disease associated with that seventy-two-pack-year smoking history?
A. You know, that's the thing. It's not unusual. I know it's hard to imagine, but there are some people that don't seem to be all that susceptible to COPD and emphysema and others that are. And once we -- you know, we don't quite know why certain people's lung tissue appears to be resistant in terms of developing emphysema and others appear to be highly susceptible. That's a pulmonary mystery, really.
Q. In such a situation as this, where there is a seventy-two-pack-year smoking history and no evidence of COPD or emphysema, do you question the validity of the pulmonary function test itself?
A. Well, I would question it except that I've looked at all the curves and -- wait a minute. Where are the curves? I need his pulmonary function test back.
Q. I think I may have it. No, I don't have it either.

A. Well, at least when I looked at -- when I originally interpreted his PFTs, I looked at all the curves and they were completely valid. So there's no problem with the validity of the test. I wish I could show that to you personally, and perhaps eventually I'll be able to do that, but I can't do it right now.
Q. Is there anything else that goes into determining the validity of the PFT test other than the inspection of the curves?
A. Well, there's lots of curve inspection that you do. You look at the volume-time curves and the flow-volume loops. That tells you whether the first part of the test was valid or not. The first part of the test is where you have the patient breathe in as hard as he can and blow out as hard as he can. That's the spirometry and that measures airflow obstruction present or absent and how bad it is.
The second part is a measurement of the lung volumes, how big or small the lungs are. There's a gas equilibrium curve that you can inspect. And the third part is the diffusion test, where you have the patient breathe in as deep as he can and hold his breath for ten seconds. And that measures the efficiency at which oxygen gets into the blood. That test you look at the IVC and see if it matches up with the FVC. You look at

the length of time he held his breath and whether he held all of it for that ten seconds, and you can tell that from the curve. If all of those curves are fine, then that's a valid test.
Q. What about the characteristics of the individual himself who is being tested? Pulmonary function tests, as I understand it, are based on age, race, weight?
A. Not weight.
Q. Not weight.
A. Just age and height.
Q. Age and height.
A. Yes.
Q. Is that adjusted for race?
A. Race is something you correct after the fact. There are some predicted values that take race automatically into consideration. In these cases, any time race came into it, I would make a correction afterwards, a post, you know, a correction after the data had already been obtained, which is fine. There's no problem with that. That's within ATS standards.
MR. PETERS: Pass the witness.
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EXAMINATION
BY MR. JACOBS:

Q. I think I just have two questions, Doctor. You note that he's taking Paxil. You don't note in there as to why he's taking the Paxil, though. Obviously it's for depression. But we don't know when he was taking it, how long he was taking it or anything like that?
A. No, I don't know. Paxil is used for depression and panic disorder. And I don't know which of those two were the case for him.
Q. Okay. And I guess this is a good time to ask this question. I noticed that -- I think this person has the longest smoking history we've seen. I've read something previously and I just want to make sure it's still true. Smoking increases an individual's likelihood of developing asbestosis; correct?
A. It does, yes.
MR. JACOBS: Thank you.
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(Whereupon, a short break was taken.)
EXAMINATION
BY MR. SIAHATGAR:
Q. Dr. Segarra, I'd like to ask you some questions about [redacted] please.
A. Okay.
Q. I believe this individual has a medical

history of atherosclerotic heart disease?
A. Yes.
Q. He suffered eight heart attacks in the last seven years?
A. That's what he said.
Q. The most recent one that you know of is in April of 2001?
A. Right.
Q. And that one being the most recent one before your January 23, 2002, visit with the individual?
A. Yes.
Q. You have not seen the individual since January, 2002?
A. Correct.
Q. You don't know if the guy has had any heart attacks since January, 2002?
A. I don't know.
Q. And you have no plans on seeing this individual again; correct?
A. Not at this time.
Q. You have no independent recollection of this individual?
A. Well, some of the elements of his history sound familiar, but I can't picture him.
Q. My understanding is that your testimony here

today and at the time of trial will be based solely upon your report and this gentleman's medical records?
A. That's right.
Q. In addition to the eight heart attacks this man had, he has also had four coronary stints during angioplasties?
A. Yes.
Q. And if you look at the current medications he's taking, the nitroglycerin/isosorbide, the Lipitor, the Metoprolol and the Accupril, all of those are related to his atherosclerotic condition and his heart condition?
A. That's right.
Q. Certainly everything we've talked about so far is completely unrelated to any type of prior asbestos exposure; correct?
A. That's right.
Q. He complains about sharp chest pain occurring once every two months. Clearly that's not related to asbestos exposure; right?
A. Probably not.
Q. The increasing dyspnea on exertion which has actually slowed down, do you relate that in any way to his asbestos exposure?
A. Yes. It's probably partly related to

asbestos exposure.
Q. The manual labor that is particularly difficult for this individual, can you tell us whether that's related to his heart disease or related to some sort of prior asbestos exposure?
A. Well, he doesn't have exertional chest pain right now, so I would think it would be related to his asbestos exposure.
Q. And you also list the individual had pneumonia twice?
A. Yes.
Q. In the '70s?
A. Right.
Q. Why is it that you note the fact that he had rib fractures from a motorcycle accident? Is that in any way relevant to your opinions here in this case?
A. It's a standard question. I always put it in there if it's present. And it is not related to this man's report in particular because it would only be related if he had plaques right over the areas of rib fracture, and it would raise the question if the plaques were related to his rib fractures. But since he doesn't have -- didn't have any plaques on his ches x-ray at all, it's not an important question.
Q. All right. His physical exam was essentially

normal except for slightly elevated blood pressure and the fact that he's somewhat overweight?
A. Yes.
Q. The chest x-ray was normal except for the diffuse interstitial pattern?
A. He had diffuse interstitial lung disease at an ILO profusion of 1/1.
Q. Other than that, the x-ray was normal?
A. Yes.
Q. There was a prior x-ray that you were able to compare his January, 2002 x-ray to and it was basically the same?
A. From seven months earlier and it was the same.
Q. Correct?
A. Yes.
Q. So there had been no progression at least in those seven months?
A. No radiographic progression, that's right.
Q. Do you attribute his pneumonia that he had twice in the 1970s in any way to the abnormal chest x-ray you found?
A. No.
Q. The pulmonary function test was normal except for a mild restrictive defect?

A. He had a mild restrictive defect, that's right.
Q. And I take it you attribute the mild restrictive defect to his prior asbestos exposure?
A. Yes.
Q. Do you attribute it to anything else?
A. No.
Q. Will you agree with me that this man's most significant problem is his heart disease, his heart condition?
A. Yes.
Q. And as with all these other individuals, you'll agree with me that the odds of his pulmonary asbestosis turning into a lung cancer, mesothelioma or some other type of asbestos-related disease or a more significant asbestos-related disease is less than fifty percent?
A. Though that's a significant risk, it's less than fifty percent, yes.
MR. SIAHATGAR: Let me object to the nonresponsive portion of the answer.
BY MR. SIAHATGAR:
Q. Does this man's pulmonary asbestosis cause him any pain?
A. Probably not.

Q. And does his pulmonary asbestosis in any way restrict his abilities to conduct his activities of daily living?
A. Yes.
Q. In what regard?
A. It creates exercise limitation, shortness of breath with exertion, in particular for manual labor.
Q. And you're reading that out of the, I guess, the second to the last line of your history section?
A. That's right.
Q. Other than that, do you attribute his pulmonary asbestosis to any restriction of his abilities to function or do his everyday functions of living?
A. No.
Q. Correct?
A. Correct.
MR. SIAHATGAR: That's all I have for this guy.
MS. PAPANTONAKIS: If there are no other questions on Mr. [redacted], are there any other questions about any other plaintiffs in the [redacted] case group? If not, then we'll move on to the [redacted] group.
MR. SIAHATGAR: Doctor, thank you for your time.
THE WITNESS: You're welcome.
MS. PAPANTONAKIS: And the first plaintiff in [redacted] we will talk about will be Mr. [redacted].

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EXAMINATION
BY MR. GEOFFROY:
Q. Doctor, my name is Ray Geoffroy. I represent Reynolds Metals Company and I've got some questions for you about Mr. [redacted], [redacted].
A. Okay.
Q. Based on your report, you examined Mr. [redacted] February 1st, 2001?
A. Right.
Q. I know that we've talked about this -- well, some of the other attorneys earlier have talked about this, but would you have had your temporary license to practice in Texas at that time, on February 1st, 2001?
A. I don't recall. I'm not sure.
Q. And this was in Corpus Christi where you would have traveled to do this examination?
A. That's right.
Q. And Foster and Sear is the plaintiffs' firm that would have referred Mr. [redacted] to you?

A. Yes.
Q. At the time of your examination, Mr. [redacted] was sixty-nine years old; right?
A. Yes.
Q. And he was an iron worker?
A. That's right.
Q. And based on your report, he reported direct, ambient and bystander exposure to various asbestos materials; right?
A. Yes.
Q. And I just wanted to see if you could break that down for me a little bit in the sense that we've got three different types of exposure, direct, ambient and bystander.
A. Sure.
Q. In terms of direct, are you referring to hands-on --
A. Yes.
Q. -- type of exposures? And I think you've got a couple of examples in here. He cut and replaced gaskets.
A. Yes.
Q. He packed pumps and valves. Is that direct as well?
A. That's right.

Q. He used fire blankets and asbestos gloves. Is that direct as well?
A. Direct; right.
Q. And then you've got bystander exposure. And I assume that's -- he is not working hands-on with material, with asbestos-containing material, but working at some distance away from some other trade person who was working with that?
A. In close proximity to people who were using it directly; right.
Q. And you've explained that in your report as well, in the sense that Mr. [redacted] had bystander exposure to dust from pipe fitters and insulators; right?
A. That's right.
Q. And then the last type of exposure you've got for Mr. [redacted] is ambient exposure. Can you explain that for me?
A. That's exposure from dust that was in the air that he was breathing even though he was not working directly where the asbestos was being used.
Q. Okay. So that's different from bystander and from direct?
A. Right. The only reason I say it's different is because, to me, bystander exposure is where there's

a particularly concentrated environment, asbestos-intensive environment, but the other people working in the plant or the room or the factory, or whatever it is, may not be exposed to that level if they are on the assembly line or they're working in another part of a large enclosure or large room.
Ambient exposure is where, say, in a paper mill, where the paper machine operators are exposed to asbestos because there's asbestos -- friable asbestos material being disrupted elsewhere in this big inhalation chamber, so to speak.
Q. And do you have any independent recollection of Mr. [redacted]?
A. Separate question? No.
Q. Separate question, yes, sir.
A. I thought we were still talking about ambient exposure.
Q. Well, we're coming back for a second to it. How would he have related an ambient exposure to you when he came to his examination?
A. He would have said that he worked in -- that the environment was dusty all the time and that part of the reason it was dusty is because there was insulation all over the place. That's what I mean by ambient.
Q. Is that an independent recollection, or is

that what he said?
A. No. No, those aren't his exact words. That's typically what he would have said that would have led me to put ambient in there as one of his type of exposure.
Q. Would that be something that he wrote on his form that he filled out before his examination?
A. He may have written it on his form or he may have told me directly. It would depend.
Q. You don't recall?
A. I don't recall.
Q. Back in 2001, would this be the time when you retrieved the forms and then returned them to the plaintiffs' firm?
A. It's quite possible that the plaintiffs' firm would still have the form. I'm not sure.
Q. As far as Mr. [redacted] smoking history, what is that?
A. A pack a day for thirty-two years, so thirty-two-pack years, quitting twenty years earlier.
Q. Quitting in 1980?
A. '80; right.
Q. And that's a fairly heavy smoking history; correct?
A. Well, although it's a fairly heavy dose of

smoking, so to speak, that's mitigated by the fact that it's twenty years remote. So that would go into his risk calculation, the fact that he quit twenty years ago.
Q. And Mr. [redacted] has a medical history limited to hypertension; correct?
A. Yes.
Q. How tall is Mr. [redacted]?
A. Five-foot-five.
Q. And he's two hundred and twenty-two pounds?
A. Yes.
Q. Does that make him overweight?
A. Yes.
Q. In terms of obesity, how would you qualify him?
A. I really couldn't say whether he's obese or not without looking at his frame, whether he has a small, medium or large frame. You have to make that assessment before you use the term obesity unless it's really obvious. If he were three hundred and twenty-two pounds, then we could say it from here. He weighed two hundred and twenty-two. He's overweight, but he may or may not be obese.
Q. And that would depend on your physical examination of him?

A. Yes.
Q. And if he were obese --
A. I would have said so.
Q. -- would that be something you would have noted in here?
A. Generally. Usually.
Q. Usually, but not always?
A. Perhaps not always, but for the most part I do. It's my general practice.
Q. In Mr. [redacted], you report that he complains of some shortness of breath upon exertion; right?
A. Yes.
Q. Is that something that you would find consistent with a sixty-nine year old man who is overweight and has got a thirty-two-pack-year history of smoking?
A. No. He had -- he's had progressive dyspnea with exertion to the point where he now has it after walking just one block. And that's much more than we would expect just with age and smoking history. You would have to -- that would indicate -- that would suggest that he has a lung disease or two different lung diseases.
Q. Are you saying that his smoking history has no -- does not factor in at all into his shortness of

breath?
A. No, I didn't say that. I said that smoking, per se, wouldn't cause that. It would only factor into that if he had a smoking-related lung disease. Now, if we turn to his diagnosis and impression section, he has two different lung diseases caused by two different things. He has pulmonary asbestosis caused by asbestos exposure and he has COPD caused by smoking. And both of those are contributing to his shortness of breath.
Q. Turning to the chest x-ray -- actually, one last thing on the history. Mr. [redacted] had pneumonia as a child; right?
A. Yes.
Q. And with respect to the chest x-ray, the film quality is grade 2 due to the scapular overlay. That's with the shoulder blades that you told us earlier?
A. That's right.
Q. And you found a diffuse interstitial pattern of irregular linear opacities within all six lung fields?
A. That's right. Six lung zones; right.
Q. Lung zones. Of size and shape T/S, profusion 1/1?
A. That's right.

Q. Now, what's the significance of finding those opacities in the upper lung zones versus strictly the mid and lower lung zones?
A. Asbestosis generally begins in the lower lung zones and may include the mid and upper lung zones after a time. But other than that, it doesn't have any significance. You hardly ever see asbestosis just in the upper lung zones. That would be quite rare.
Q. Are you attributing the opacities in the upper lung zones to an asbestos exposure?
A. Yes. I think it's part of the same diffuse interstitial process because the pattern of the scarring is the same as is in the lower lung zones.
Q. And Mr. [redacted] has no pleural plaques, pleural thickening, pleural calcifications; correct?
A. On his chest x-ray, that's right.
Q. You also noted that there are scattered calcified nodules in the perihilar areas; right?
A. That's right.
Q. And that's not related to asbestos exposure; correct?
A. I don't think so, no.
Q. Were there any markings, in your opinion, on the x-ray that you would relate to Mr. [redacted] pneumonia as a child?

A. No.
Q. On the pulmonary function test, Mr. [redacted] had normal lung volumes and diffusion capacity; correct?
A. Yes, that's true.
Q. And then he had a minor -- is that minor or mild? I can't tell from --
A. Where?
Q. It's the third line on the bottom.
A. Oh, it's cut off, part of the record is cut off.
Q. Is that minor?
A. Mild.
Q. Mild.
A. Obstructive defect.
Q. And is that something that you would attribute to his smoking history?
A. Predominantly.
Q. If you'll flip back to the chest x-ray, peribronchial cuffing is noted. What is peribronchial cuffing?
A. It's thickening of the large airways in the center of the chest on the chest x-ray.
Q. That's not related to asbestos exposure?
A. It could be, yeah. It's a feature of both

asbestos exposure and chronic bronchitis from smoking; both.
Q. So in this case --
A. Probably both.
Q. As it relates to Reynolds Metals Company, if Mr. [redacted] came in and saw you in 2001 and told you that he worked at Reynolds Metals Company between one week and two months in the late '50s or early '60s, he can't recall which decade or exactly the duration, and he worked as an iron worker; his only job responsibility was to tie steel; he didn't cut gaskets; he didn't pack pumps, valves.
A. Okay.
Q. He didn't have any direct exposure, and he doesn't claim -- or he did not claim that he had any bystander exposure --
A. Okay.
Q. -- from pipe fitters or insulators.
A. This is during the one week to two-month period that he spent at Reynolds Metal; right, that you're talking about now, that he didn't have any bystander exposure?
Q. Correct.
A. Okay.
Q. And my question to you would be, would that

work history be sufficient to cause his pulmonary asbestosis?
MS. PAPANTONAKIS: Object to the form.
A. You mean in a hypothetical sense, would that work history alone be able to account for his pulmonary asbestosis, no.
BY MR. GEOFFROY:
Q. And as it relates to the entire -- looking at his entire work history.
A. I think that if it's more towards the two-month range, it could have made a small contribution to his asbestosis, but not to a significant degree.
Q. And what would be the exposure?
A. Well, if he was working -- I mean, he told me he didn't have bystander exposure, but he worked around asbestos; right? Didn't you say that?
Q. He said he comes in and says he didn't have direct exposure. He doesn't claim --
A. Didn't have direct, didn't have bystander exposure. He just had ambient exposure between one week and two months. If it was one week, I'd say that that was insignificant in terms of contributing to the asbestosis. If he had two months of exposure, it would be a minor component, but not very significant.

I mean, you can do the math. I mean, he does have asbestosis and he worked -- he had exposure from 1950 to the mid 1970s. That's twenty-five years. Twenty-five years times twelve, let's see, that's two hundred and seventy-five months. And what we're saying is two of those two hundred and seventy-five months at the maximum, according to your hypothetical question, two of the two hundred and seventy-five months were involved with ambient exposure to asbestos.
So of all the ambient exposure he had, one percent of it was at this particular plant you're talking about. Okay. So that's the contribution to -- I mean, that would be the -- as best as I can tell, that would be how much that would be contributing to his asbestosis.
Q. I just want to make sure that I've got it straight, then, is that by itself, this work history scenario that I've just described to you is not sufficient; right?
MS. PAPANTONAKIS: Object to form.
A. By itself, it's not sufficient; that's right.
BY MR. GEOFFROY:
Q. And you're saying that --
A. But then your second question was, could it have contributed at all?

Q. Right.
A. And I said that, yes, to a small extent.
Q. Right. I just want to make sure that we're clear.
MR. GEOFFROY: Dr. Segarra, that's all I've got. Thank you, sir.
MS. PAPANTONAKIS: Anyone else have any questions about Mr. [redacted]? Then does anyone have any questions about Mr. [redacted]?
MR. PETERS: I do.
- - -
EXAMINATION
BY MR. PETERS:
Q. Dr. Segarra, will you look at Mr. [redacted] please.
A. Got it.
Q. Okay. This guy gave you a work history as a boilermaker?
A. Yes.
Q. And he's been a boilermaker, it looks from your work history, from about 1965 to 1997?
A. Yes.
Q. You don't know and you don't actually expect him to be exposed to any type of asbestos-containing insulation in the year 1997 as a boilermaker, do you?

A. Not unless he was involved with a poorly controlled tear-out or a formal abatement program.
Q. And you have no evidence of that?
A. No, other than -- no, I don't have any direct evidence of that. You're right, I don't.
Q. And I think you testified earlier, and correct me if I'm wrong, that approximately 1980 or early '80s is about the period of time when you might believe that his -- any exposure to asbestos may have ceased?
A. No. What I said was that new asbestos was -- the use of new asbestos in industry went down abruptly around 1972, and that existing supplies which were still used began to be depleted around the mid 1970s. And that safety -- even allowing for a slow phase-in of safety procedures, most plants had those well in place by the early 1980s. So that exposure that occurred after the early 1980s, what I said was, is that that would be due to poorly supervised tear-out projects or abatement, actual abatement in most cases.
Now, there are exceptions. For instance, there's a famous plant in Birmingham, Alabama, that actually manufactured asbestos products with hardly any environmental controls in the mid to late 1980s, but those are exceptions. My statement to you was a

general statement.
Q. And specifically, though, you have no evidence that any defendant in this case were not properly installing these safety standards at the appropriate time frame?
A. No. As I sit here today, I don't plan to give you any testimony about specific safety protocols for any of the plants that these people may have worked at.
Q. You made a statement in your explanation a minute ago that existing supplies were still being used into the mid to late '70s?
A. I hear that all the time from my patients.
Q. You're talking about existing supplies of what?
A. Asbestos products.
Q. What type of asbestos products?
A. Block insulation, pipe insulation, board insulation, etcetera.
Q. Other than hearing that from your plaintiffs, do you have any other type of evidence that that actually occurred?
A. It is an oral history, so to speak. I don't have anything documented, I mean, nothing written that it occurred. But frequently they tell me that although

asbestos stopped being shipped at such-and-such a date, that they used up what they had over the next several years until they didn't have any more. I hear that all the time.
Q. Okay. Have you seen any -- have you spoke to any -- well, strike that.
This gentleman has a forty-pack-year smoking history, if I read that correctly; is that right?
A. Say that again. I'm sorry.
Q. Forty-pack-year smoking history?
A. Yes.
Q. He has osteoarthritis in the knees and hands and he was treated for pneumonia twice in the past two years. Osteoarthritis and pneumonia, that's not anything related to asbestos exposure; is that correct?
A. No, it's not related to asbestos exposure, and neither is the pneumonia.
Q. And the pneumonia itself, twice in the past two years, are those single events, or is that a continuing condition with this gentleman?
A. Although I don't know for sure, I interpreted it as two different events.
Q. And the reason I ask, of course, is because pneumonia can -- on an x-ray can show -- well, I understand it can show -- mimic the changes they see

pursuant to asbestosis or interstitial fibrosis, in some instances.
A. Well, yes, you're right. And sometimes people with diffuse interstitial lung disease will develop a cold or an upper respiratory infection. They go to the emergency room or to a doctor who is unfamiliar with them, they'll do an x-ray and they'll see lung disease, and they'll think, oh, gee, maybe he's got pneumonia and they'll treat him with antibiotics. And the same thing will happen the next time they get a cold. Yes, that's possible. But I can't say whether it happened in this case or not. I have no idea.
Q. Right. You don't know if it's a single event or a continuing process?
A. I expect that it was two different events. The continuing process hypothesis is something you have raised that I have no evidence for.
Q. And I guess the way he reported it to you, based on what's written here, and that's all we have to go by is based on what you wrote, you believe it's two separate events?
A. That's right.
Q. The exertional chest pressure lasting several minutes occurring once or twice a week,

relieved by rest, is that something that's related to asbestos exposure?

A. No. I mean, that sounds like something that would be more likely related to heart disease rather than asbestos exposure. The only caveat to that is that there's one paper which raised a lot of interest about two years ago, and it was in an Australian journal which looked at a large population of asbestotics and found that they have a higher incidence of angina-type chest pain compared to other individuals with the same smoking history, age and risk factors who were not exposed to asbestos. In other words, raising the idea that somehow asbestos exposure makes you more susceptible to pain that you would otherwise relate to heart disease.

I have not seen that study repeated or developed since then. And that's the reason why I was answering not your questions, but the other guy who was here. That's the reason I was answering his questions in the way that I did. But as a caveat, I'm simply telling you that, that that paper exists, but I haven't seen anything since then on that subject.

Q. It's just kind of -- it's out there as a hypothesis right now?

A. Well, no. It was a study, but, you know, in

medicine, one study doesn't -- generally is something that you're not supposed to -- one single study is something that you might note with interest, but it's good to have other studies, too, to reinforce that, especially a revolutionary concept.

Q. Okay. The plaintiff's exertional leg cramps and frequent heartburn, both of which are not related to asbestos exposure; is that correct?

A. That's right.

Q. The nocturnal wheezing is not related to asbestos exposure; correct?

A. Probably not.

Q. Can you attribute the chronic productive cough to asbestos exposure?

A. It's likely that some of it is related to asbestos exposure, but probably not all of it.

Q. And the same -- would that be basically the same answer we've been hearing today about the progressive dyspnea?

A. Yes. The shortness of breath with exertion is probably related to asbestos exposure, that's right.

Q. And partially related to cigarette smoking?

A. Yes. Partly related to his cigarette smoking, insofar as his cigarette smoking was the predominant cause of his COPD, slash, emphysema.

Q. You have no way of providing us an estimation -- a percentage of his dyspnea, that shortness of breath that's attributed to his cigarette smoking, you can't do that, can you?

A. No.

Q. On his physical exam, it looks like he had slightly elevated systolic blood pressure?

A. That's right.

Q. But you don't diagnose hypertension in this gentleman, do you?

A. Well, he's got systolic hypertension, yes.

Q. Oh, I'm sorry. He's experiencing -- or you heard some rhonchi in his chest. Is that how you say that?

A. Yes, rhonchi, that's right.

Q. What is rhonchi? What does that sound like?

A. Rhonchi are low-pitched sounds that occur on expiration, especially expiration that's prolonged. And it implies the presence of airflow obstruction. It's most commonly seen in asthma, COPD, chronic bronchitis and emphysema.

Q. And this gentleman had COPD, as we discussed?

A. Yes.

Q. You didn't hear any rales?

A. I did not.

Q. Let's look at the chest x-ray. You saw mid and lower lung zones bilaterally, diffuse interstitial pattern of opacities. And you gave that profusion rating a 1 over 1.

A. Right.

Q. And you also saw pleural disease which you identified as circumscribed pleural thickening, pleura plaque, in profile. Is that bilateral?

A. Yes. B-2 on the right, A-2 on the left.

Q. You noted that there's some healed fractures of the ribs, 4, 5, 6 and 7. Any of those locations of the rib correspond with the pleural thickening that you saw?

A. Although that's possible, I thought that it was unlikely to be just related to rib fractures since it was worse on the other side where the rib fractures weren't compared to the side where the rib fractures were.

Q. I'm sorry. It was more --

A. The pleural thickening was worse on the side that didn't have the rib fractures rather than the side that did have the rib fractures. That's why I didn't think the pleural thickening had anything to do with the rib fractures.

Q. Did you consider whether or not, if that was the case, whether the rib fractures were the cause on the side where they were -- the cause of the pleural plaques on the side they actually occurred and that the other side where you saw worse pleural plaques were some cause of a different disease?
A. Gee, that would be invoking a third disease. I mean, although that's theoretically possible, that would be very unlikely, I think.
Q. Would you expect in a general sense, though, that -- well, certainly there are times bilateral pleural plaques that are worse on one side than the other due to asbestos exposure?
A. Certainly. Even unilateral sometimes.
Q. Sure. But the combination of a broken rib fracture and a pleural plaque together on one side, is that generally going to show a greater or worse pleural plaque situation than it would be on the other side? See what I'm saying here?
A. Well, I think I do, but I'm not sure.
Q. The combination.
A. If I were going to attribute pleural plaques to rib trauma in the presence of rib fractures, I generally do that when there's a huge asymmetry between the extent of the pleural plaques on the side where the

trauma took place as opposed to the other side. That's just common sense.
When the plaques are a little worse on the side that doesn't have the rib fractures, then that leads me to think that the rib fractures are having no effect -- no impact on the pleural plaques at all.
Q. Okay. It was approximately three and a half years between the time the films that you read of 11/30/98 were taken and the films of February 8, 2002, the day your report was done.
A. That's right.
Q. And you didn't notice any progression of any disease process there, did you?
A. That's right.
Q. We've already discussed that you found this gentleman suffered from COPD or emphysema, which we already discussed was due to his cigarette smoking; right?
A. Yes. Yes. The COPD was related to that, that's right.
Q. And a slightly reduced diffusion capacity which you indicate is seventy percent; right?
A. That's right.
Q. Normal would be eighty percent, low range normal?

A. Yes.
Q. And you indicate in here that Mr. [redacted] is a current smoker. But you have no way of determining what effect that smoking would have on diffusion capacity in this gentleman?
A. No. Because the reduction in DLCO was only mild and he was a current smoker, I didn't make a great deal of it in terms of his diagnosis and impression. If you would ask me now what I thought of it, I would tell you that it was -- the small reduction in DLCO was due to all three, his asbestosis, his COPD, slash, emphysema and the smoking as a separate issue. The only way to know for sure would be to redo his test at a time when he was smoke free over the previous twelve to twenty-four hours.
Q. And I believe that answer was responsive to what you were reading in number one, paragraph number one in diagnosis and impression, where you don't have the information relating to reduced diffusion capacity found on the pulmonary function test; is that correct?
A. That's right. Because the reduction was only mild and he was a current smoker, I chose not to emphasize that in my diagnosis section.
Q. And you are of the opinion that this gentleman's asbestosis -- well, he doesn't have a

greater than fifty percent chance of developing lung cancer as a result of the asbestosis?
A. Although his risk for lung cancer is increased, it's less than fifty percent.
MR. RULON: Object to the nonresponsive portion.
BY MR. PETERS:
Q. And the same -- if I ask the same question with mesothelioma, you'd give me the same answer; right
A. I would, yes.
Q. And if I ask the same question with regard to other asbestos-associated cancers that you believe are associated to asbestos exposure, you would give me the same answer; correct?
A. That's right.
Q. One other thing on shortness of breath that this gentleman was experiencing. We talked about the cigarette smoking. We talked -- or the COPD. We talked about the potential for asbestos exposure. How about the hypertension; can that cause a little bit of a condition which would cause you to be short of breath at certain times?
A. No. But look at his chest pain. I mean, that's a better question. The guy's got chest pain. I think he needs to have ischemic heart disease ruled

out. That was the thing that I told him at the time of the exam that he ought to have done soon.
Q. I see what you're saying. All right.
A. But the blood pressure is not a big deal.
Q. But the blood pressure in relation with chest pain, is that a big deal?
A. Yeah, I mean, it could potentially be. But the blood pressure in of itself would not be.
MR. PETERS: I will pass the witness.
- - -
EXAMINATION
BY MR. RULON:
Q. Dr. Segarra, my name is Chris Rulon. I represent one of the defendants in the [redacted] group. You understand that; correct?
A. Well, you just told me that; right.
Q. Okay. Fair enough. I haven't met you before, so I just wanted to let you know that. I'm going to ask you a few follow-up questions about Mr. [redacted].
A. Okay.
Q. The report that you have -- I know you have a thick notebook there, but the report that you have about Mr. [redacted], is your copy seven pages?
A. Well, my report is two pages, and then

there's an ILO form which is the third page. And then the next five pages are the pulmonary function test reports.
Q. So you've got a total of eight pages?
A. Of which one was a duplicate, so really there's only seven pages. For some reason they like to give double copies of the DLCO things for reasons I can't fathom, but that's okay.
Q. So you've got a total of eight pages; correct?
A. Eight pages, that's right.
Q. And as far as you can tell, that's a true and correct copy of the material that was generated during your assessment of Mr. [redacted]; correct?
A. Yes.
Q. And that assessment was done on February 8th, 2002; correct?
A. That's right.
Q. The notation FS, slash, HT, and then there's a Social Security number on the first page, do you see that?
A. Yes.
Q. What does that refer to?
A. That's the law firm that contracted me to examine the patient, Foster and Sear, and HT is

Houston, Texas.
Q. Okay. Thank you. And consistent with your prior testimony, you established only a limited physician-patient relationship with Mr. [redacted]; correct?
A. That's right.
Q. You didn't treat him, you didn't medicate him, you didn't restrict his activities; correct?
A. Well, that's largely correct. The only recommendation I made out of the limited doctor-patient relationship, as you put it, is that in addition to the normal things that I tell people who are diagnosed with pneumoconiosis, I advised that he get an evaluation to rule out the possibility of heart disease in this particular case.
Q. Okay. But with that qualification, no treatment, no medication, no restriction?
A. That's right.
Q. And you haven't seen Mr. [redacted] since February, 2002; correct?
A. Correct.
Q. And I would assume you have no current plans to see him; correct?
A. Not at this time.
Q. And you made no independent efforts to verify

the work history that he gave to you; correct?
A. Independent efforts?
Q. In other words, you took him at his word?
A. Yes, I did.
Q. You didn't go out and follow up, go to the places that he said he worked, that sort of thing? I mean, that's not something you do; correct?
A. Not something -- something outside the scope of what clinical doctors do.
Q. And that's my point. You didn't make an independent effort to verify that?
A. No.
Q. And his smoking history is significant; correct, one pack a day for forty years?
A. Yes, it is.
Q. Turn the page to page two.
A. Okay.
Q. There's a diagnosis/impression. You've got item 1 and then under that 2, 3 and 4.
A. Yes.
Q. Items 2, 3 and 4, those are not asbestos related; correct?
A. Correct.
Q. Okay. Would you be able to agree with this statement, the most likely cause of the obstructive

defect you noted on the PFT results for Mr. [redacted] would be his COPD, emphysema and smoking history?
A. I think that's the predominant cause, yes. I think that the asbestosis is probably contributing to that airflow obstruction to a mild extent.
Q. But the predominant cause would be the COPD, emphysema and smoking; correct?
A. Yes, that's right.
MR. RULON: Doctor, that's all the questions I have. Thank you for your time.
MS. PAPANTONAKIS: If there are no other questions about Mr. [redacted] let's talk about Mr. [redacted]. Does anyone have any questions about [redacted] in the [redacted] group? Then I guess we're not going to talk about him. Going, going, gone.
The next plaintiff in the [redacted] group is [redacted] Does anybody have questions about [redacted]?
MR. PETERS: Yes.
- - -
EXAMINATION
BY MR. PETERS:
Q. All right. Mr. [redacted] here presents as an industrial painter/drywall technician; correct?

A. Yes.
Q. Can you explain to the jury what this gentleman did as an industrial painter/drywall technician and when he did that?
A. I think he did painting, preparation of surfaces painting and basically construction of walls in industrial plants. Probably also commercial and residential areas as well.
Q. And he gives you this history as between 1964 and 1993, it would seem like?
A. Yes, exactly. Although -- let me see. Yeah. I think -- I didn't get the impression that he had much asbestos exposure from 1964 to 1968 because that seemed to me to be mostly painting in nonindustrial settings. I thought -- it seemed to me most of his exposure occurred from 1970 to 1993. And, of course, I'm reading from my report, but the way I wrote it, I think that's what I was conveying.
Q. And the 1970 to '93 time frame is the period he worked in commercial settings; is that correct?
A. Industrial settings, yes.
Q. Industrial settings.
A. Yes.
Q. You note that he had direct exposure to asbestos-containing joint compounds; is that correct?

A. Yes.
Q. And you say ambient/bystander exposure to dust from boiler insulation, pipe covering, gaskets and insulating cement; correct?
A. That's what he told me.
Q. That ambient exposure that we talked about, is that just being there while work is going on with asbestos-containing products?
A. Well, bystander would be close by while it was going on. Ambient would be where the dust from the asbestos activity is forming a -- appears to be forming a part of the respiratory environment of other workers in other parts of the plant.
Q. So there's a delineation of some proximity between ambient and bystander?
A. Although what you say is true, there's not a hard -- there's no -- there's no distinct line between the two. It's more qualitative.
Q. Bystander would be more than ambient?
A. Oh, yeah, I think so. Usually. Yeah, generally.
Q. Give me an example of bystander exposure.
A. I'm a painter and I am painting an area of ducts that have just been insulated by insulators that are moving down a pipe next to me. Or I am operating a

drill press next to pipe fitters who are tearing off pipe insulation, repairing a leak and then replacing the insulation next to it. I would consider that bystander exposure. Or a sheet metal worker who is laying down sheet metal over freshly insulated ducts where a team of insulators is going before me on a scaffold. I mean, those are all examples of bystander exposure.
Q. Same question with ambient. Can you give us some examples of ambient?
A. Ambient is I'm working as a digester operator in a paper mill in a closed environment where there is asbestos being removed from -- installed and removed from dryers, boilers and kilns even though I'm not directly working right next to it.
Q. And, again, there's no hard and fast line between bystander and ambient. I guess the further you get away from it, it goes from bystander to ambient?
A. I think that's fair, yes.
Q. And certainly the further you get away from a task that's generating dust, the less exposure you'd have?
A. The less exposure, unless it's a closed chamber, in which case the exposure never drops below a certain level. Now, not everything is a closed

chamber, but if there is a closed chamber, then that would be the case.

Q. And you would -- at that point you're assuming that the asbestos dust is just floating around the air the whole time and not settling, or it settles and then --

A. In the closed chamber hypothesis, yes. But in a plant where, say, the walls were open, the further you get away from the exposure, the exposure gets -- becomes less and less, yes.

Q. And you're not an industrial hygienist by training or experience, are you?

A. No. But many of the -- although I'm not, most of the principles of industrial hygiene are just common sense and, you know, you can -- the common sense part comes in where the dose of an inhalational material is going to vary with distance and, also, it's going to vary with the degree to which airflow is present or absent in any particular environment.

Q. Right. But you don't intend to do a dose assessment --

A. No.

Q. -- quantitative dose assessment?

A. No, no, no. That's a separate issue. No.

Q. You note that he had some exposure to

xylene. Why is that significant enough to put in your report?

A. Well, as I said before, I try to put chemical exposure when it's specific. And he wrote -- he either wrote down or told me that he was exposed to xylene, so I put it in the report.

Q. And do you know what xylene is?

A. Yes. It's a hydrocarbon benzene ring with some methyl groups attached to it here and there, which as a hydrocarbon can act as a potential carcinogen for certain cancers, particularly lung and bladder cancer.

Q. Okay. You indicate that he tore insulation off pipes. Did he -- I guess if it's not in here, do you know how a painter or drywall technician would be required or why he would be required to tear insulation off pipes?

A. I don't know.

Q. That's just something --

A. That's just what he said he did, yeah. I don't know.

Q. Okay.

A. I mean, if I could -- I don't know if he said this or not because I don't recall. But just what other people have said is that although somebody may have worked as a painter/drywall technician or whatever

as their main job, there are times they may be called in to spell somebody else. Their job during shutdowns may be totally different than their regular job. They may have been in the labor pool for a year or so here and there, you know. There's all sorts of reasons why that might have been the case.

Q. But specifically with Mr. [redacted], you don't remember?

A. I don't know. I just know that he told me he did what, you know, what it says that he did.

Q. That's a general statement on your part?

A. That's a general statement, what I said before, right.

Q. Sure. He's got a twenty-five-pack-year smoking history; correct?

A. Yes.

Q. He's got posttraumatic stress disorder. Did he indicate from what that occurred?

A. No.

Q. And the two medications that he's taking, what are they for?

A. Clonazepam and Citalopram. I'm not sure about the Citalopram. It's not a drug that I've prescribed in the past. The Clonazepam is a benzodiazepine similar to Valium, Serax and Ativan,

which its primary medical use is to treat restless leg syndrome and nocturnal myoclonus because it's a muscle relaxer. But it's also a good treatment for panic disorder and some types of complicated anxiety and depressive disorders.

Q. Which would tie into the posttraumatic stress disorder?

A. Yes.

Q. You indicate he has frequent episodes of sharp chest pain lifting heavy object, coughing, sneezing or deep breathing. You don't attribute that to any asbestos exposure, do you?

A. No.

Q. Okay. And does that -- what does that sound like to you? Is that muscular?

A. Sounds muscular. May not be, but it sounds muscular.

Q. He has frequent palpitations and cramps in his legs after walking two blocks. Do you attribute that to asbestos exposure?

A. No.

Q. Do you attribute it to anything that you can see from his physical -- your examination of him?

A. Not from his physical exam. But that history suggests a possibility -- it doesn't prove it, but

suggests a possibility of claudication, which can be a sign of peripheral vascular disease, inadequate blood supply to the legs.

Q. Okay. And he doesn't have a cough, hemoptysis or hoarseness; correct?

A. Right.

Q. Then in the past twenty years, he's had slowly progressive dyspnea upon exertion which now occurs after walking a hundred yards, climbing two flights or cutting grass.

A. That's right.

Q. And, again, the shortness of breath that we're talking about here, do you attribute any of that to his smoking history?

A. No.

Q. Are you attributing that solely to his asbestos exposure?

A. Yes.

Q. Okay. And he's got some fractured ribs here that you note on the left side two years prior to your examination; correct?

A. That's right.

Q. Looking at the physical examination, basically normal. Am I reading that right?

A. Yes, you are.

Q. No rales?

A. That's right.

Q. Now, on the chest x-ray, you give him a one over zero; right?

A. Yes, that's right.

Q. And you see pleural plaques, not bilateral, are they? Oh, I see. Bilaterally.

A. Yes.

Q. Okay. And they're the same on both sides?

A. That's right.

Q. But not calcified?

A. Not calcified.

Q. And you looked at films from almost three years earlier and compared them with the films that you took on January 31st, 2001, the date of your report, and you found no progression; right?

A. That's right.

Q. PFTs are normal?

A. Yes.

Q. You note in your impression section that he has no silicosis at this time. Do you expect him to develop silicosis; is that why you phrased it like that?

A. No, not necessarily. Let's see. I must have got a history that he had some -- yeah, he had some

sandblasting exposure, so I simply raise that as a -- I just indicated that there was no evidence of that since that seems to be a topic of high interest these days.

Q. Okay. He doesn't have a cancer right now; correct?

A. Correct.

Q. And, again, as we discussed in the past today, there is -- he does not have a fifty percent chance of contracting an asbestos-related lung cancer correct, based on his exposure?

A. That's right. Although his risk is increased, it's less than fifty percent.

Q. Right. The same question and the same answer with mesothelioma; correct?

A. That's right.

Q. And the same question and same answer with any other malignancy that you attribute to asbestos exposure; correct?

A. Correct.

Q. Did he indicate to you whether or not he wore any respiratory protection while he did his work as a painter/drywall technician?

A. I don't think he did. Oftentimes if they do, I will state that.

Q. Okay. And you expect a patient or even a

plaintiff in one of these medical/legal contexts to provide you with a full and complete history of his work including whether or not he used appropriate respiratory equipment?

A. Most patients will generally say whether they used a mask or not when being exposed to various things, be they chemicals or asbestos. And, in fact, in most cases of sandblasting exposure, they specify whether they used a desert hood or an air-fed hood, but that's not always the case. It's just frequently they do.

Q. But you would have asked him in your oral history with him if he used a mask?

A. Most of the time, yeah. It could be that I didn't. I don't recall whether I did or not.

Q. If he did use a dust mask while doing his drywall work, does that in any way change or modify your opinions as to his extent of exposure to asbestos-containing products during that work?

A. Not really. This seems -- it seems like he had an exposure that's fully sufficient to explain the radiographic findings. The dust masks, plain old dust masks generally become ineffective after an hour or so of use. And unless it were changed regularly, then it would not significantly mitigate the overall exposure.

Q. And if he did use one, the evidence does show that he used one, you have no -- any personal knowledge or evidence of Mr. [redacted] himself whether or not he did change out that dust mask?
A. Yeah, I just don't. I can't recall whether that was discussed. In fact, I would have to assume that it wasn't since I didn't put it in my report.
MR. PETERS: Okay. I'll pass the witness.
MS. PAPANTONAKIS: Any other questions on Mr. [redacted]? Then let's talk about Mr. [redacted]

EXAMINATION

BY MR. PETERS:
Q. Dr. Segarra, if you would, look at Mr. [redacted], please.
A. Which group is he?
Q. He's in the same group we're talking about.
A. Oh, yeah, I have it. Yes. Okay.
Q. [redacted]. Okay. Mr. [redacted] presents himself as a retired boilermaker/pipe fitter; correct?
A. Yes.
Q. And you saw him back in February of 2002?
A. That's right.
Q. And, again, you've testified in the past, I

believe, today that this report provides us with your whole medical workup of Mr. [redacted] in this case?
A. That's right.
Q. When do you believe his first exposure to asbestos began?
A. Probably as an outside machinist in the shipyard in the 1960s. It's unclear whether he had any back in the Navy. It doesn't seem that way.
Q. Okay.
A. So my interpretation of this is that he had exposure from '67 to '68 in the shipyard, and from 1974 to 1998, or thereabouts, as a boilermaker/pipe fitter.
Q. Right. Because from '68 to '73 he's moving dirt; is that correct?
A. Correct.
Q. So '74 to '98 as a boilermaker/pipe fitter. And we talked in the past about when exposures may have stopped or declined to some extent with regard to --
A. Yes.
Q. -- the time frame of his alleged exposures.
A. That's right.
Q. Okay.
A. I should point out that he said that he had exposure on every job from '74 to '95, which is a little unusual, but that's what he said.

Q. I see. I see where you wrote that. And while he may believe that -- well, never mind.
We know also that he's a fifty-pack-year smoker?
A. Yes.
Q. And he had a previous history of throat cancer in 1977?
A. That's what he said, yes.
Q. Radiation therapy was used to treat that?
A. That's right.
Q. And about two weeks prior to your examination of Mr. [redacted] here, he was actually hospitalized for bronchitis and a sinus infection; is that right?
A. Yes.
Q. What are the medications that he's taking, what are they used for or they treat?
A. Well, asthma and chronic bronchitis.
Q. Does he have a history of chronic bronchitis?
A. Well, he didn't say that -- he didn't make that statement, per se. But he said he was hospitalized for bronchitis and a sinus infection at one point. He doesn't really meet the criteria for chronic bronchitis since he doesn't have any chronic cough, so it's unclear.

Q. What is mild orthopnea?
A. It's shortness of breath when you lie flat as opposed to when you sit up.
Q. What can be a cause of that?
A. Possible causes include chronic sinus congestion and congestive heart failure.
Q. And asbestos exposure is not a cause of that; is that correct?
A. Not generally unless it's -- unless you have severe asbestosis. It's not a common feature of mild asbestosis.
Q. Which Mr. [redacted] has mild asbestosis; right?
A. That's right.
Q. Again, he has shortness of breath upon exertion as stated in your report; right?
A. Yes.
Q. And there's various reasons for that shortness of breath, including bronchitis, a chronic bronchitis syndrome?
A. Well, I just said he didn't have chronic bronchitis. I know he's taking Iophen for that. But what I just said is he doesn't meet the criteria for chronic bronchitis. So if we're going to talk theoretically, that's one thing. But if we're going to talk what his shortness of breath is most likely

related to, then we'd have to skip over chronic bronchitis. And instead, I would have to attribute that to asbestosis or an asbestos exposure.

Now, what I did do, though, not so much chronic bronchitis, but I did diagnose him with COPD based on his pulmonary function test and his smoking history.

Q. Right.

A. And that certainly would be contributing to his dyspnea on exertion.

Q. Okay. Why do you have chronic bronchitis in your impression section, then?

A. Simply, you know -- I don't know, I probably shouldn't have. The reason I put it in there is because he came with that diagnosis, but then he denied chronic cough. And you can't really have chronic bronchitis without chronic cough, because even though it's related to COPD, you have to have chronic cough to have that particular entity.

Q. Did he indicate to you when his treatment for pneumonia was in the past?

A. If he did, I would have put it down. No, I guess he didn't.

Q. And because it was in the past, it wasn't -- and how it's written here, it wasn't an active disease

process?

A. Right. That's right.

Q. The physical exam, basically normal? A little high blood pressure?

A. Well, no, not so much that. His breath sounds were somewhat reduced. And his I/E ratio was reduced a little bit. That would go along with COPD or would go along with airflow obstruction in general.

Q. What's the I to E ratio?

A. The length of time it takes to get air in versus the length of time it takes to get air out.

Q. And that's an obstructive defect?

A. Yes. It correlates with an obstructive defect.

Q. Right. But he had no rales?

A. He didn't.

Q. The chest x-ray we indicated earlier showed what you believe to be a mild asbestosis; right?

A. That's right.

Q. You indicate there is unilateral blunting of a costophrenic angle. What does that mean?

A. That means that the angle rather than being sharp is -- the sharp part is dull, it's blunted. And that's generally due to scarring in that angle or fluid. And when it's unilateral, as I've said before,

it's usually due to reasons other than asbestos exposure, except in the rare cases where it's due to mesothelioma, which I don't think was the case here. So in his particular case, it was probably due to one of his pneumonias.

Q. And you noticed some noncalcified bilateral diaphragmatic pleural plaques also in this gentleman.

A. Yes, that's right. Both sides.

Q. You saw the emphysema in this gentleman in the x-ray also; correct?

A. That's right.

Q. In the PFTs, pulmonary function testing, you note that he had a mildly reduced diffusion capacity in a current smoker. That diffusion capacity is indicatec to be sixty-one percent?

A. Right.

Q. And we've talked extensively as to the effects of smoking, a current smoker, someone who smoked in the last twelve hours would have on that diffusion capacity; right?

A. Yes, we have.

Q. Nothing changes there with your opinions, obviously?

A. No.

Q. The radiation treatment for his throat

cancer, would that have any effect on the lungs in terms of scarring or anything?

A. No. It obviously was very limited.

Q. As far as we know from the --

A. It was outside the -- the port was outside the lungs.

Q. Right. Okay. With regard to his prognosis, Mr. [redacted] does not rise to the level of a fifty percent chance of contracting asbestos-related lung cancer; correct?

A. Although that's true, his particular risk is higher than most of the others due to his asbestos exposure --

Q. Right.

A. -- the presence of asbestosis --

Q. Right.

A. -- his smoking and the presence of COPD/emphysema. All those things are increasing his risk. So although it approaches fifty percent, it doesn't exceed it.

Q. Okay. The smoking history -- well, strike that. Same question with regard to mesothelioma, he's not at or near a fifty percent risk of contracting mesothelioma based on his asbestos exposure; correct?

A. Although his risk is elevated, again, it

doesn't exceed fifty percent.
Q. Same question with regard to any other cancers, malignancies that you correlate or associate with asbestos exposure, same answer?
A. Although that would be my same answer, there's a question that is, as far as I'm concerned, unresolved about his throat cancer, both in terms of latency and also as to what sort of cancer that really was. And I just don't have any opinion about that until there's medical record correlation with that issue.
Q. All right. Are you saying that his throat cancer, it's possible that was related to his asbestos exposure?
A. Well, since you frame the question, let me look now. He contracted that in 1977, assuming it really was a throat cancer. And the minimal latency period for attributing a non-lung cancer to asbestos is fifteen years. That would bring us back to 1962, and he had not yet had any exposure then, so I cannot attribute that particular throat cancer to asbestos exposure.
MR. PETERS: Okay. I'll pass the witness.
MS. PAPANTONAKIS: If there are no other questions about Mr. [redacted], then we will talk

about [redacted].
THE WITNESS: Can we go off the record for a second?
- - -
(Whereupon, there was an off-the-record discussion.)
EXAMINATION
BY MR. GOLDEN:
Q. Dr. Segarra, Shawn Golden again with Alcoa. I'm going to ask you some questions about [redacted].
A. All right.
Q. Mr. [redacted] presented to you as a sixty-two year old Caucasian male. He was retired. His trade or occupation, he was an auto or truck mechanic. And he reported exposure to asbestos dust from about 1961 to 1991; is that correct?
A. That's right.
Q. And your report was done October the 11th, 2000, and that would have been before you would have been licensed in Texas?
A. That's right.
Q. Nonetheless, you were a certified B-Reader for nine-plus years by that time?
A. That's right.
Q. And in the history section of Mr. [redacted],

you reported that he was being treated for hypertension, hyperlipidemia, osteoarthritis, coronary artery disease, acid reflux and emphysema. Are any of those conditions attributable to his exposure to asbestos?
A. No.
Q. Since October the 11th, 2002, have you seen Mr. [redacted] since that date?
A. I don't think so, no.
Q. Do you have any plans to see him again?
A. Not at this time.
Q. Any testimony you would give at the trial of this particular individual would be based on your report and the medical records review?
A. Yes.
Q. I note in here your report states that he is not using any inhaled bronchodilators. When he reported to you on October the 11th, 2000, should he have been using inhaled bronchodilators? Is there some indication that in the past he should have been using that?
A. No. I think -- I mean, not necessarily. I just thought that it was surprising that since he had a history of emphysema, and if you look at his pulmonary function tests, he has severe COPD, at least moderate

to severe COPD, that he was not using inhaled bronchodilators because most patients with that condition are.
Q. Did he give you or do you recall if he provided you any basis why he wasn't using any bronchodilation therapy?
A. Although he did not -- although I don't recall whether he did, most patients who are not using it are not using them for one of three reasons. Either their primary doctor didn't diagnose the emphysema prior to me seeing them. Second is that they're expensive and some patients can't afford them. And the third reason is that in that particular patient's experience, they didn't help. All of them may have been the reason, but I don't recall whether any of that applied to this patient.
Q. Yes, sir. And then the next couple of sentences down, it says general review of systems is essentially negative. What is meant by that statement?
A. It just means that when I asked him about all his other symptoms, that none of them -- there was no additional -- there were no additional symptoms in regard to, you know, anemia or throwing or coughing up blood that relate to other diseases. All that was negative.

Q. Okay. The next sentence states that Mr. [redacted] has had a productive cough for the past thirty years occasionally associated with wheezing. Is that attributable to his past asbestos exposure?
A. Some of it is attributable to his previous asbestos exposure. But a large part of it is no doubt related to his COPD and emphysema.
Q. Okay. Mr. [redacted] had heart surgery in 1988. And then your report notes that he has noticeable shortness of breath upon exertion since his heart surgery.
A. Yes.
Q. Does that statement exclude the possibility that any shortness of breath could be attributable to his asbestos exposure, or is that just --
A. No, it doesn't exclude the possibility. It's just since he told me that, I put that in there, and that's just a -- since that was an interesting landmark, historical landmark, that's all.
Q. Then you noted he had a history of emphysema dating back to '91, and then in '87 he treated for pneumonia.
A. That's right.
Q. He's approximately five-five and a hundred and eighty-five pounds. Depending on his build, he may

or may not be overweight?
A. That's right. I think he probably is overweight. I don't think he's obese. At least I didn't think so at the time.
Q. His pulse and his blood pressure appear normal?
A. Yes.
Q. Are there any other statements in the paragraph that's entitled physical exam that are remarkable concerning Mr. [redacted]?
A. Yeah. He's got a lung exam that has decreased breath sounds, increased expiratory time; all of which are findings that you see in COPD. And plus, there's the scar from his heart surgery.
Q. But nothing else that would be attributable to asbestos exposure?
A. Not on his physical exam.
Q. Okay. Going to the chest x-ray, you noted it was grade 1 and that there were diffuse interstitial pattern, small, irregular linear opacities within the mid lung zones bilaterally, of size and shape T/S, profusion 1/0?
A. That's right.
Q. And he did not present -- or his chest x-ray did not present any pleural surfaces which demonstrated

pleural plaques or pleural thickening or pleural calcifications?
A. That's right.
Q. And all three of those, plaques, thickening and calcifications, those would be markers for asbestosis?
A. They would be.
Q. Again, his chest x-ray showed where he had undergone a heart bypass surgery?
A. Yes.
Q. And compared to an earlier film, you didn't see where there had been any interval change?
A. That's right.
Q. I know that you stated many times today that sometimes prior B-Reads are forwarded to you when you do your medical/legal evaluation --
A. Yes.
Q. -- and sometimes they're not. When they are forwarded to you, is it peculiar or is it normal for the B-Reader to assign a profusion level? For instance, if you got a report that didn't have a profusion level on it, would that make a difference to you?
A. Well, in the first place, let me go back to what you said. What I said is that there are times

that the x-rays are forwarded to me for review prior to doing them and sometimes they're not. I also said as a separate issue completely that at the time that I examine these individuals, sometimes there are B-Readings from prior x-rays that are stuck inside the x-ray jackets of the old films that I compare them to and sometimes they're not. So just with that understanding, yes.
Now, on the old B-Readings from previous readers, when I see one that doesn't have any ILO profusion or kind of ILO nomenclature, my assumption generally is that that person who read it was not a B-Reader. But, I mean, that may not be the case, but that's what I would assume.
Q. Nonetheless, you would do your own B-Reading evaluation and --
A. Oh, of course.
Q. -- make your own independent analysis?
A. Of course. And if ever there is a time where I haven't looked at the x-ray and I've just written down what some other B-Reader has said, his name and the specific B-Reading would always be prominently attributed on the report.
Q. In your report.
A. I would never quote from someone else's

B-Reading without attribution; never. So anytime that there's a chest x-ray on my reports with a description, that's something that I have directly done.

Q. Okay. The pulmonary function testing paragraph, you again note in your report that his PFTs demonstrate a severe obstructive defect with normal lung volumes.

And my question is, and maybe it's for my own edification, is I see there's various tests and values on a PFT.

A. Right.

Q. Is one of those tests or values more important than any other on there?

A. That's a great question. When I say by normal lung volume, I mean the TLC was normal.

Q. Total lung capacity?

A. Total lung capacity; right. That determines whether you have restriction or not, and that determines whether you have hyperinflation or not, and that was normal.

The FRC is an indication of air trapping and is elevated, which is no surprise in somebody with emphysema.

Q. Okay. And the other question I have, and maybe it's for my own edification again from sitting

here all day and listening to various people ask you questions, but if you were looking at a chest x-ray and you knew that the gentleman had a smoking history, would his smoking history present the same type of markings on that chest x-ray as asbestos exposure or any other exposure to --

A. No. No. That's a good question, too, but, no, it doesn't. The only kind of marks that you get on an x-ray from smoking itself is you can get what's known as a pattern of smoker's bronchiolitis. And what that refers to are thickening of the normal bronchiole markings in the center of the chest as they -- on an x-ray, here's the center of the chest, and then there's the lines that go out from the chest that are the normal bronchiole markings. Those are thickened sometimes in smokers as a result of smoking with a combination of either chronic bronchitis or this bronchiolitis thing I was telling you about.

Asbestosis are discrete, in other words, separate little linear opacities that are in the periphery of the lung zones that are discontinuous with the markings in the center of the chest. They're not just an accentuation of normal bronchiole markings, they're separate scars.

Q. They're clearly different?

A. They're different. Now, I mean, I will say that to someone who is inexperienced in doing B-Reading or reading chest x-rays of people with occupational lung disease, they may not see that much of a difference, but an experienced reader should be able to distinguish between the two fairly easily in most cases.

Q. And I think your diagnosis and impression paragraph is self-explanatory. You diagnosed mild pulmonary asbestosis based on the interstitial changes on the chest x-ray and his exposure history that he provided to you. And you also noted that the reduced diffusion capacity provided some physiological correlation with the interstitial radiographic abnormalities.

A. Yes.

Q. Can smoking also cause the reduced diffusion capacity?

A. Well, smoking itself can, but he's an ex-smoker; he's quit. So when you're no longer smoking, the smoking is not going to interfere with the value. Now, in his case, he's got COPD and emphysema, and certainly that is probably contributing to the reduction in diffusion capacity, but is probably not accounting for the complete reduction.

Q. Okay. Then again in diagnosis and impression, you noted the COPD, emphysema, with a moderate to severe description, and you advise clinical follow-up, and for him to seek -- or you recommended initiation of bronchodilator therapy.

A. That's right.

Q. And then you noted his heart disease, status post coronary artery bypass grafting.

A. That's correct.

Q. Now jumping to the fifty percent questions, Dr. Segarra, that you've been asked repeatedly today.

A. Okay.

Q. Is it more likely than not that Mr. [redacted] is going to develop an asbestos-related cancer?

A. Although his risk for asbestos-related cancers is increased, it does not exceed fifty percent.

Q. And your answers would be the same for mesothelioma or any other cancer which you associate with asbestos exposure?

A. Well, since you used the term asbestos-related cancer, that was sort of all inclusive. You covered all three.

MR. GOLDEN: Okay. Fair enough. Thank you for your time today, sir.

THE WITNESS: You're welcome.

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MS. PAPANTONAKIS: Does anyone else have any other questions about any plaintiff in the [redacted]case group? Okay. Then we're going to stop for today and --

MR. PETERS: Let me ask just two more questions.

MS. PAPANTONAKIS: Okay.

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EXAMINATION

BY MR. PETERS:

Q. Have you been provided by the Heard, Robins, Cloud law firm or any other law firm that you've done these -- that you've worked with in these medical/legal examinations any documents or information concerning my client, Celanese?

A. No.

Q. You have no personal knowledge yourself through any source of any use of asbestos-containing products during any time frame in the history of Celanese's existence?

A. Well, now, not in relation to these clients. But in general you mean?

Q. Yeah.

A. I believe there were a group of people who worked at a Celanese plant one time who told me that

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they were exposed to asbestos-containing acoustic ceiling tiles that were made by Celanese. At least that's my understanding, but that was several years ago.

Q. That we made asbestos -- you think -- you think someone told you --

A. Unless I'm remembering this wrong, that's what I recall. But that was several years ago and I may have it mixed up.

MR. PETERS: Okay. That's fine. I pass him.

MS. PAPANTONAKIS: Anyone else have any other questions?

MR. JACOBS: Well, I mean, I think a lot of us have general questions we probably could ask him, but nothing specific as to the plaintiffs we have discussed today. I think that's probably safe to say.

MS. PAPANTONAKIS: Well, if you've got some general questions as far as these cases, go ahead.

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EXAMINATION

BY MR. JACOBS:

Q. Let me ask a few very quick questions here, Doctor. When I use the term environmental tobacco smoking, do you know what I mean by that?

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A. You mean passive secondhand smoke.

Q. Yes. Do you believe that environmental tobacco smoke is a risk factor for lung cancer?

A. I think that it's a weak risk factor for lung cancer. In other words, if you have long-term, heavy exposure over many years, the SMR, if you will, for lung cancer for such an exposed individual can exceed two in some cases, in some studies, and by no means all of them.

Q. Okay. That was going to be my next question, is do you believe that there is a consensus in the scientific and medical communities about this issue?

A. I think there is a consensus. I think the consensus has been hyped by the popular press quite a bit. And by far, the worst thing environmental cigarette smoke does is it causes asthma in children; I mean, vastly increases the incidence of asthma in kids. And that's the biggest -- that should be the biggest public health aspect that should be emphasized in terms of getting people not to smoke around their kids. But as far as causing cancer in adults, yes, there is an increased risk, but it's not huge.

Q. Okay. Now, on that increased risk, when was that consensus in the medical and scientific community reached?

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A. Ten years ago, roughly.

Q. If I want to go back and look and see when that consensus was reached, what would I need to look at in order to make that determination?

A. American Cancer Society Journals. There's been -- I'm sure there's been ATS and -- I know there's been ATS and ACCP consensus statements on the danger of secondhand cigarette smoke. And I'm sure I have them, I'd just have look them up to tell you for sure. And, I mean, if that's something that you wanted desperately, my office staff could probably provide you with reprints on that information.

Q. We're not just talking about case studies here; right, we're talking about epidemiology?

A. No. No, of course. No, I'm talking about -- and not just epidemiologic studies, but I'm talking about a consensus on the issue. Right.

Q. Okay. And one further question. When did the scientific and medical community reach the consensus that primary tobacco smoke causes lung cancer?

A. Consensus, or when was the first convincing evidence? The first convincing evidence was probably a hundred years ago, but the --

Q. Consensus.

A. -- the consensus was probably the surgeon general's report on cigarette smoking and lung cancer which was in '52, if I remember correctly.

MR. JACOBS: That's all I have for today.

MR. PETERS: You're not going to let me talk about [redacted] and [redacted] today?

MS. PAPANTONAKIS: It's my understanding that the [redacted] case has already been discussed fully with Dr. Segarra, so, no, I'm not.

MR. PETERS: And in response, upon checking with my office, as of July of 2002, [redacted] had not indicated that he was making a claim against Celanese as of July of 2002.

MR. WALKER: And Caryn, what are we going to do about the plaintiffs in the [redacted] case, just for the record?

MS. PAPANTONAKIS: For the record, we will get another date and reoffer Dr. Segarra for the [redacted] case as well as the [redacted] case.

(Witness excused)

(Whereupon, said deposition concluded at 4:45 p.m.)

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CERTIFICATE

STATE OF MISSISSIPPI

COUNTY OF JACKSON

I, Lynn Strickler, CSR, Freelance Court Reporter and Notary Public, duly commissioned for the County of Jackson, State of Mississippi, do hereby certify:

That on the 18th day of June, 2003, there appeared before me JAY T. SEGARRA, M.D., who was sworn and examined to tell the truth, and that the preceding two hundred seventy-eight (278) typewritten pages contain a full, true and correct copy of my stenotype notes and/or electronic tape recording of the testimony of JAY T. SEGARRA, M.D.

That the witness has chosen to WAIVE the reading and signing of the deposition.

That I am not related to or in anywise associated with any of the parties to this cause of action, or their counsel, and that I am not financially interested in the same;

IN WITNESS WHEREOF, I have hereunto set my hand, this 29th day of June, 2003.

_____

Lynn Strickler, CSR No. 1299, Notary Public,
State of Mississippi, County of Jackson.
My commission expires 6-12-2004.