Exhibit 389

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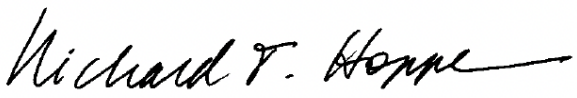

Richard T. Hoppe, MD, FACR, FASTRO, FARS

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Date: February 3, 2025

Re: *Allan Howard vs. United States of America*

I am writing in response to your request for a medical expert evaluation of Allan Howard with respect to the relationship between his development of non-Hodgkin lymphoma and exposures to trichloroethylene (TCE), tetrachloroethylene (PCE), and benzene he experienced while stationed at Camp Lejeune from September 1977 to February 1979.

I. My Background

I am a practicing physician, board-certified in Radiation Oncology by the American Board of Radiology. As my *curriculum vitae* reflects, my current academic appointment is as the Henry S. Kaplan-Harry Lebeson Professor in Cancer Biology and Professor of Radiation Oncology at Stanford University. Previously, I had been Chair of the Department of Radiation Oncology at Stanford and a member of the Board of Trustees of Stanford Hospital and Clinics. My professional career has been devoted to clinical management and research related to the lymphomas, including B-cell, T-cell, cutaneous lymphoma, and Hodgkin lymphoma. These activities are well reflected in my *curriculum vitae*, which includes more than 350 references in the peer-review literature related nearly exclusively to the diagnosis, evaluation, and treatment of lymphomas. In addition, I have contributed more than one hundred book chapters on the same subjects.

I serve on the Steering Committee of the International Lymphoma Radiation Oncology Group. I have been a member of the National Cancer Center Network (NCCN) Guideline Panel for the management of the Non-Hodgkin Lymphomas and currently serve on the T-Cell Lymphoma Panel, Cutaneous Lymphoma Panel, and I am Chair of the Hodgkin Lymphoma Guideline Panel of that organization. My previous service includes the Commission on Cancer of the American College of Surgeons, the Lymphoma Task Force of the American Joint Committee on Cancer, the People Living with Cancer Advisory Panel on Lymphoma of the American Society for Clinical Oncology, and the Board of Scientific Counselors of the National Cancer Institute, National Institutes of Health. In recognition of my contributions to the field of lymphoma, I have been awarded the Karl Musshoff Prize for clinical research from the German Hodgkin Lymphoma Study Group, the Lifetime Achievement Award from the International Society for Cutaneous Lymphoma, the Rodger Winn Award from the NCCN, and Gold Medals from the American Society for Radiation Oncology, the American College of Radiology, and the American Radium Society.

II. This Evaluation

In order to conduct this expert medical evaluation, I reviewed and relied upon the following documents and reports:

- Medical records for Allan Howard from:
    - Department of Veterans Affairs, Dayton VAMC
    - Dayton Physicians Network

    - Kettering Health
    - OSU Wexner Medical Canter
    - Ohio State University Medical Center
    - Quest Diagnostics
    - Kettering Health Network – VA Compensation Intake Center
    - ECP Dayton Med VA GOV
    - Digestive Specialists, Inc.
    - Kettering Health Dayton Pavilion
- Depositions of:
    - Allan Wayne Howard dated 2/16/2024 (Plaintiff)
    - Elizabeth Howard dated 5/7/2024 (daughter)
    - James Pieckenbrock dated 5/7/2024 (friend)
    - Dr. Ahmad Shabsigh
    - Dr. Saba Qureshi
    - Dr. Kelly Miller
    - David A. Savitz, PhD, dated 7/17/2024
- The Expert Report of Morris Maslia dated 10/25/2024
- The Expert Report of Dr. Kelly Reynolds
- The General Causation Reports of:
    - Timothy M. Mallon, M.D., M.P.H., MS.
    - Dean W. Felsher, M.D., Ph.D
    - Kathleen Gilbert, Ph.D
    - Steven B. Bird, M.D
    - Howard Hu M.D. M.P.H. Sc.D
- Short Form Complaint filed on behalf of Allan Wayne Howard on 7/15/24

In addition, I relied upon the peer-reviewed scientific literature that, in my opinion, is the most rigorous and relevant to the issues inherent in this evaluation. As appropriate, such evidence will be cited during this report.

III. Summary of Opinion

It is my opinion that it is more likely than not that Mr. Howard's non-Hodgkin lymphoma (NHL), diffuse large B-cell lymphoma (DLBCL),was caused by his exposure to the contaminated water at Camp Lejeune.

I begin with a discussion of the chemicals in the water at Camp Lejeune, briefly turn to their causative effect of NHL generally, and then to the differential diagnosis etiology of Mr. Howard's NHL.

IV. Chemicals at Camp Lejeune

Based on reports and testing, the water at Camp Lejeune contained TCE, PCE, benzene and the byproducts of their degradation.

a. TCE

Trichloroethylene (TCE) is an industrial solvent that has been widely used in various applications, including degreasing metals and in the production of adhesives and paints. TCE has a biologic half-life of three days. In humans, it is metabolized to trichloroepoxyethane (TCE oxide), then to trichloroacetaldehyde, chloral hydrate and other metabolites including trichloroacetic acid, dichlorovinyl glutathione, and dichlorovinyl cysteine. Some of these metabolites may be more toxic than the parent compound.

Epidemiological studies indicate a link between TCE exposure and the development of non-Hodgkin lymphoma (NHL). Lymphoma is a cancer that affects the lymphatic system, a crucial part of the immune system. There are several mechanisms through which TCE may contribute to the development of lymphoma.

TCE is a genotoxic agent (a property of chemical agents that damages the genetic information [DNA] in a cell)[1] via both direct and indirect effects on the DNA. It may cause chromosome aberrations, chromosome breaks, and sister chromatid exchanges.[2,3] This genetic damage can lead to mutations that contribute to the development of lymphoma

TCE has been demonstrated to cause immune system dysfunction.[4]. It has been shown to have immunotoxic effects, potentially altering immune function and leading to an increased risk of lymphoproliferative disorders, including lymphoma. Evidence from animal studies indicates that TCE exposure causes immunomodulation including autoimmune disease and immunosuppression.[5] Both autoimmune disease and immunosuppression are associated with NHL.[6] Studies conducted of Chinese factory workers exposed to TCE have observed alterations in immune function markers that have been associated with an increased risk of NHL, indicating that the associations observed between TCE and NHL are biologically plausible.[7] In another study of the cohort of Chinese factory workers, total lymphocyte counts decreased with increasing exposures to TCE. Similar exposure-response trends were observed for CD4+ T cells, CD8+ T cells, B cells and NK cells.[8] The study concluded that these results provided evidence that TCE exposure leads to immunosuppression, which is associated with an increased risk of NHL.[8]

Karami et al. conducted a meta-analysis of TCE exposure and risk of lymphatic and hematopoietic cancers.[9] They examined studies published between 1950 and 2011.[9] The meta-analysis for NHL included 293 NHL cases from 12 cohort studies and 8140 cases from 12 case-control studies.[9] Their conclusion was that the data supported as association between TCE exposure and increased risk of NHL (relative risk = 1.32, 95% confidence interval 1.14-1.54).[9] Scott and Jinot conducted another systematic review of the epidemiologic evidence for an association between TCE exposure and NHL.[10] They calculated a relative risk for developing NHL following TCE exposure to be 1.23 (95% CI 1.07-1.42) and for the highest exposure group to be 1.43 (95% CI 1.13-1.82).[10]

b. Benzene

Benzene is a colorless, toxic chemical compound that is widely recognized as an environmental and occupational hazard. It is primarily used in the manufacture of chemicals, plastics, and synthetic fibers. Benzene exposure has been implicated as a causative agent in the development of NHL.

Research indicates that benzene is a hematotoxic agent,[11] meaning it can adversely affect the blood-forming organs, including the bone marrow. This toxic effect can lead to disruptions in the production of blood cells, including lymphocytes, which are crucial components of the immune system. Epidemiological studies have consistently demonstrated an association between benzene exposure and an increased risk of developing various hematological malignancies, including NHL.

There are several possible mechanisms by which benzene contributes to lymphomagenesis. Benzene metabolites can induce genetic mutations, compromise immune function, and promote inflammation, all of which may lead to malignant transformation of lymphocytes. Multiple studies show that it produces genotoxicity in the lymphocytes of exposed humans.[12] It may produce multiple cytogenetic abnormalities in lymphocytes, and it induces specific chromosomal changes associated with NHL in human lymphocytes, The immunosuppression induced by benzene may lead to decreased immunosurveillance. In a recent study of the cohort of Chinese factory workers, benzene exposure was associated with alterations in lymphoid cell types and B-cell activation markers indicative of immunosuppression that could result in an increased risk of NHL.[8] Chronic exposure to benzene is known to result in genetic and epigenetic alterations that enhance lymphocyte proliferation and survival, further contributing to the development of lymphoma.

Benzene has also produced lymphomas in animal studies.[12] Accordingly, there is considerable support for the realization that it can cause human lymphatic tumors.[12] Linet at al. conducted a large study of mortality among benzene-exposed workers in China.[13] They compared causes of mortality in 73,789 benzene-exposed workers with 34,504 non-exposed workers in 12 cities in China.[13] The benzene-exposed workers experienced increased risk for all-cause mortality.[13] Notably, the relative risk for NHL was 3.9 (95% CI 1.5-13).[13] In a large meta-analysis of human studies, Rana et al., reviewed 20 case-control and eight cohort studies that included 9587 patients with NHL.[14] They reported increases in the risk for a wide variety of lymphomas and specifically a doubling of the risk for diffuse large B-cell lymphoma.[14]

c. PCE

Tetrachloroethylene (PCE) is a colorless, non-flammable liquid used for dry cleaning and as a metal degreasing solvent. It is regarded as a toxic substance, a human health hazard, and an environmental hazard. Numerous toxicology agencies regard it as a carcinogen.[15]

A study conducted in four Nordic countries found that high exposure to PCE was associated with an elevated hazard ratio for NHL of 1.23 (95% CI 1.00-1.52).[16] Furthermore, in a long-term mortality study of aircraft manufacturing workers, Boice et al. found an increased standardized

mortality rate of 1.70 (95% CI 0.73-3.34) for workers exposed to PCE.[17] In a long term follow up of the same study cohort, Lipworth et al. defined a standardized mortality ratio of 1.43 (1.00-1.98) related to PCE exposure and the risk for developing non-Hodgkin lymphoma.[18] Thus, the scientific literature supports an association between occupational PCE exposure and NHL.

V. ATSDR

In light of the test results of the water at Camp Lejeune the Government conducted a number of studies of the water. The leading study is what is known as the ATSDR report (ATSDR).

The ATSDR Report, or more fully, the "ATSDR Assessment of the Evidence for the Drinking Water Contaminants at Camp Lejeune and Specific Cancers and Other Diseases"[19] published January 13, 2017, reviewed epidemiological studies involving TCE and PCE exposure conducted by the EPA,[20] IARC,[21] and NTP[22]; meta-analyses conducted by NCI researchers,[9] EPA,[10] and an IARC workgroup[16] for TCE and hematopoietic cancers. ATSDR utilized these reviews and meta-analyses to identify epidemiological studies for TCE and PCE. Meta-analyses of benzene and hematopoietic cancers[23,24,25] were used to identify epidemiological studies for benzene. In addition, literature searches using PubMed were conducted to identify epidemiological studies conducted after the meta-analyses and reviews were completed.

The ATSDR classified the evidence between exposure to the chemical agent and the development of cancer as "sufficient evidence for causation," "equipoise and above evidence for causation," "below equipoise evidence for causation," and "evidence against a causal relationship."[19] "Sufficient evidence" was further defined as sufficient evidence from human studies in which chance and biases (including confounding) can be ruled out with reasonable confidence, **or** there is less than sufficient evidence from human studies but sufficient evidence in animal studies and strong evidence that the agent acts through a relevant mechanism in humans.[19] Sufficient evidence from human studies could be provided by a meta-analysis and/or by several studies considered to have high utility.[19] Considerations with respect to the quality of the evidence included temporal relationship, consistent positive associations (e.g., risk ratio or odds ratio greater than 1.1), magnitude of the effect estimate, exposure-response relationship, and biological plausibility.[19]

"Equipoise and above" evidence implied that the evidence was sufficient to conclude that a causal relationship was at least as likely as not, but not sufficient to conclude that a causal relationship existed.[19] For example, if the degree of evidence from human studies was less than sufficient but there was supplementary evidence from animal studies and/or mechanistic studies that supported causality, **or** a meta-analysis did not provide convincing evidence (e.g., the summary risk estimate was close to the null value of 1.0, i.e., ≤1.1), or if the meta-analysis observed a non-monotonic exposure-response relationship) but there was at least one epidemiological study considered to be of high utility occurring after the meta-analysis had been conducted, in which an association between the exposure and increased risk of the disease of interest had been found and in which chance and biases could be ruled out with reasonable confidence, **or** a meta-analysis has not been conducted, but there was at least one epidemiological study considered to be of high utility in which an association between the

exposure and increased risk of the disease of interest had been found and in which chance and biases could be ruled out with reasonable confidence.[19]

The 2017 ATSDR report concluded, based upon its review, that there was sufficient evidence for causation between TCE exposure and the development of NHL, equipoise and above evidence for causation between PCE and the development of NHL and sufficient evidence for causation between benzene exposure and the development of NHL.[19] The data from the ATSDR Reports combined with the meta-analyses related to TCE exposure[9,10] provide compelling evidence that TCE exposure increases the risk for developing NHL. The ATSDR reports combined with the cohort study of Linet et al (2015)[13] provide a similar degree of evidence for the relationship between benzene exposure and NHL.

Based upon my years of experience, I agree with the ASTDR's definition of "at least as likely as not" or "equipoise and above." I also agree that TCE, PCE, and benzene all cause NHL, at least as likely as not.

VI. General Causation Reports of Drs. Felsher, Hu, Gilbert, Mallon, and Bird

I have reviewed and considered the general causation reports of Drs. Felsher, Hu, Gilbert, and Bird. Based on my background, education, and experience, the reports of these experts are robust and reliable. All have concluded, as do I, that the contaminants in the Camp Lejeune water supply were sufficient to cause NHL. See, for instance, Felsher Report, p. 37-40; Gilbert Report, p.31-35.

VII. Concentrations of Contaminants at Camp Lejeune

I have reviewed the expert report of Morris Maslia, dated October 24, 2024. Based on this report, Appendix H1 in particular, the concentrations of TCE were well in excess of 100 micrograms per liter of water during most of Mr. Howard's stay at Camp Lejeune, peaking at 546 micrograms per liter in December 1978. The MCL for TCE is 5 micrograms per liter. For PCE, levels were well above the MCL of 5 micrograms per liter for the vast majority of Mr. Howard's time on base. It peaked at 24 micrograms per liter – months in November and December of 1978.

I also have reviewed the expert report of Dr. Kelly Reynolds regarding the likely cumulative amounts of TCE, PCE and benzene that Mr. Howard ingested during his time at Camp Lejeune. Considering his days on base and cumulative contaminant exposure concentrations, and based upon his deposition-based informed activities, his cumulative consumption (total µg=days x concentration per deposition exposure assumptions) for TCE ranged between 660,782 ppb ingested to 1,019,982 ppb ingested (depending on assumptions of ingestion), for PCE it was 27,780 ppb ingested to 42,882 ppb ingested (depending on assumptions of ingestion), and for benzene it was 7,859 ppb ingested to 12,132 ppb ingested (depending on assumptions of ingestion).

VIII. Plaintiff Allan Wayne Howard

Allan Howard was 49 years old when he developed renal cell carcinoma. In September 2008, he was noted to have abnormal liver function studies on a pre-employment physical. In October, he underwent an abdominal ultrasound that showed a right kidney mass. A subsequent CT of the chest/abdomen/pelvis with contrast (10/31/2008) showed a large right renal mass with some calcification and some cystic and solid components. It was consistent with a renal cell carcinoma. The chest CT showed multiple bilateral pulmonary parenchymal and pleural-based nodules thought to represent either metastatic disease, granulomas or some benign process. An MRI of the head and a bone scan were negative for metastatic disease. He was asymptomatic, running 10 miles a day and working out six days a week.

On December 3, 2008, Mr. Howard underwent a right radical nephrectomy. Pathology revealed a clear cell cancer, Grade 2/4, 4.2 cm in greatest dimension. The tumor had a multilocular cystic component. There was focal lymphatic/vascular invasion. Surgical margins were clear. Treatment with high dose interleukin-2 (IL-2) was considered but never instituted. The presumed pulmonary metastases were ultimately considered to be benign nodules. He continued surveillance imaging through December 2016. On November 30, 2016, an MRI at OSU Wexner Medical Center noted that "*There are small to prominent multiple noticeable mesenteric lymph nodes in the central abdomen which are nonspecific. Confluent mesenteric node in the left abdomen … measures 1.3 x 2.5 cm in size. No definite retroperitoneal lymphadenopathy…no discrete enlarged pelvic or inguinal nodes…essentially stable since the prior comparison CT dated 2014."* On April 18, 2019, a computed tomographic scan of the thorax revealed *"No mediastinal or axillary lymphadenopathy."* On July 26, 2020, he underwent a CT of the chest, and on May 23, 2019 he underwent a renal sonogram. The chest CT showed no evidence of adenopathy or masses. The renal sonogram demonstrated no retroperitoneal mass or lymphadenopathy.

In August 2020, Mr. Howard was in a bicycle accident and suffered two fractured ribs, a punctured lung, and a fractured pelvis. Imaging was performed at that time, including a CT of the chest, abdomen, and pelvis. No lymphadenopathy was reported. Several days later, on August 16, he had agonal respirations while at home and while being transferred to the hospital suffered a cardiac arrest for ~10 minutes during which time CPR was performed. He was diagnosed with a saddle pulmonary embolism. Another CT of the chest, abdomen, and pelvis was performed, and no lymphadenopathy was noted.

On June 7, 2023, at age 63, Mr. Howard was brought to the ER for elevated potassium levels. He was also complaining of intermittent right chest pressure/soreness brought on by certain movements. He complained of swelling in the lymph nodes in his armpits. Those nodes were mobile and nontender. A CT of the abdomen and pelvis was performed and showed bilateral inguinal lymphadenopathy, greater on the right (1.6-1.8 cm short axis dimension) than the left (1.2 cm short axis). Repeat potassium was 4.1 and there was mild hypercalcemia at 10.3 (nl. 8.5-10.2). He biked 30-40 miles a day but was complaining of some fatigue and body aches.

Mr. Howard was seen by his PCP, Dr. Qureshi, who first treated his enlarged nodes with antibiotics. When this was unsuccessful, he was seen by Dr. Kelly Miller, a hematologist-

oncologist. A flow cytometry evaluation of the blood was non-contributory (No Immunophenotypic evidence of monotypic B-cell, aberrant T-cell, or immature population). A CT of the neck and chest (8/14/2023) showed enlarged lymph nodes in the left posterior cervical chain and the left supraclavicular region. There was no adenopathy in his chest although possible new right upper lobe nodules were noted. By late July, he noted swollen lymph nodes on the left side of his neck. On August 30, 2023, he underwent a left neck lymph node biopsy that showed a B-cell lymphoma. A PET scan on September 25, showed lymphadenopathy above and below the diaphragm, meaning that he was stage III. He underwent additional percutaneous core inguinal lymph node biopsies (10/9/2023) for flow cytometry and microscopic evaluation. The diagnosis was confirmed as diffuse large B-cell lymphoma (DLBCL), germinal center type, bcl2/6 and c-myc negative. His lactate dehydrogenase (LDH) was normal. His revised International Prognostic Index (R-IPI) was 2 (2 adverse factors: stage III and age >60), which put him in a low-intermediate risk group (predicted progression-free and overall survival ~80%). He had no weight loss, but he did note night sweats.

On October 16, 2023, Mr. Howard started chemotherapy with polatuzumab-vedotin, rituximab, cyclophosphamide, doxorubicin, and prednisone (Pola-R-CHP). This was an appropriate choice of systemic therapy, as he had two adverse risk factors in the R-IPI [NCCN Guidelines]. Treatment was essential for this aggressive lymphoma. Following two cycles of therapy (November 22), a PET scan was repeated and showed interval resolution of the neck and pelvic lymphadenopathy. This was consistent with a complete metabolic response (Deauville 1). No clear evidence for residual or recurrent disease was seen. Another PET scan, performed after the fifth cycle of chemotherapy showed continued response. He received his final dose of chemotherapy (cycle 6) on February 19, 2024. Mr. Howard tolerated the chemotherapy well. He had the expected fatigue and an episode of cough/congestion. At his three-month follow up visit (May 10), he noted mild peripheral neuropathy and an improved energy level.

Mr. Howard's prognosis prior to starting therapy was for an ~80% likelihood of five-year progression free and overall survival. Although he has completed treatment successfully, his likelihood of disease relapse is ~10%. If his disease does relapse, he would be treated with significantly more intensive and potentially toxic therapy. In addition, there are potential late effects from the treatment he has already received. Doxorubicin chemotherapy is associated with late cardiac effects, especially acute heart failure, ischemic heart disease and atrial fibrillation. The cumulative incidence of cardiovascular events at 5 years among patients treated with standard chemotherapy for diffuse large B-cell lymphoma is 11.4%.[26] Rituximab is a known immunosuppressive therapy. It may result in long-term impaired immune health. In a large analysis of rituximab-treated patients by Shree et al., they found elevated incident rate ratios for many immune-related conditions, including viral and fungal pneumonias, meningitis, humoral deficiency, and autoimmune cytopenias.[27] These risks remained high even after 5-10 years of survivorship.[27] Should Mr. Howard experience a relapse of his disease or encounter any of these late effects of treatment it will compromise his life expectancy.

Prior to his diagnosis of lymphoma, Mr. Howard's past medical history included the renal cell cancer (noted above), multiple skin cancers (basal cell carcinomas), gynecomastia, prostatitis, hypothyroidism, prostatic hypertrophy, cataracts, diverticulosis, tubular adenoma of the colon and multiple musculo-skeletal injuries. He had a remote 2-pack year history of smoking. He

was stationed at Camp Lejeune during his military service. His father died of pancreatic cancer or cirrhosis at age 56. Mr. Howard worked as a police officer for 26 years, retiring in 2008.

IX. Camp Lejeune Connection to NHL in Mr. Howard

At issue is the causal relationship between Allan Howard's exposure to trichloroethylene (TCE), tetrachloroethylene (PCE), and benzene at Camp Lejeune and his subsequent development of non-Hodgkin lymphoma (NHL).

Mr. Howard had been stationed at Camp Lejeune as a member of the Armed Forces from September 4, 1977 to February 8, 1979 (>15 months exposure) with annual leave taken as well. During that time, he lived and worked at Hadnot Point. According to the ATSDR 2013 Report (Hadnot Point: Chapter A Factsheet),[28] within the Hadnot Point service area, at times the drinking water concentrations exceeded the maximum contaminant level (MCL) for TCE from August 1953-January 1985. Reconstructed TCE concentrations in Hadnot Point drinking water reached a maximum level of 546 µg/L during December 1978.[28] The MCL for TCE is 5 µg/L. It was set in 1989. Within the Hadnot Point service area, drinking water concentrations regularly exceeded the MCL for PCE from September1977-February 1979. The MCL for PCE is 5 µg/L. It was set in 1992. Reconstructed PCE concentrations in Hadnot Point drinking water reached a maximum level of 24µg/L in November and December of 1978.[28] The MCL for benzene is 5 µg/L. It became effective in 1989. Within the Hadnot Point service area, drinking water concentrations exceeded the MCL for benzene in January 1979.[28] Reconstructed benzene concentrations in Hadnot Point drinking water reached a maximum level of 6 µg/L that month.[28]

During Mr. Howard's 449 days of exposure at Camp Lejeune, he would have likely been exposed to 5,937 ppb/l-M of TCE, 251 ppb/l-M of PCE, 343 ppb/l-M of vinyl chloride, and 70 ppb/l-M of benzene.

A water contamination study conducted in New Jersey in the 1990s examined 75 communities with TCE and PCE in drinking water.[29] The study found positive associations between TCE and PCE exposure levels—similar to or lower than those at Camp Lejeune—and NHL incidence. "The highest assigned TCE level was 67 ppb, the highest assigned PCE level was 14 ppb, the highest assigned total non-THM VOC level was 92.9 ppb."[29]

NHL incidence among women was also associated with the highest TCE (>5 ppb) (RR = 1.36; 95% CI 1.08-1.70).[29] For diffuse large cell NHL and non-Burkitt's high-grade NHL among females, the RRs were 1.66 (95% CI 1.07-2.59) and 3.17 (95% CI 1.23-8.18), respectively, and 1.59 (95% CI 1.04-2.43) and 1.92 (95% CI 0.54-6.81), respectively, among males.[29] Perchloroethylene (PCE) was associated with incidence of non-Burkitt's high-grade NHL among females, but collinearity with TCE made it difficult to assess relative influences. The results suggest a link between TCE/PCE and leukemia/ NHL incidence.

X. Mr. Howard's Time and Exposure at Camp Lejeune

Based on data provided, it appears that Mr. Howard spent almost 450 days living and working on Camp Lejeune in the Hadnot Point area. The military records reveal the following:

Exposure Dates	Total Days	Exposure Location (Work and Residential)
9/4/1977-9/30/1977	27	Hadnot Point
10/1/1977-10/31/1977	31	Hadnot Point
11/1/1977-11/18/1977, 11/29/1977-11/30/1977	20	Hadnot Point
12/1/1977-12/31/1977	31	Hadnot Point
1/1/1978-1/31/1978	31	Hadnot Point
3/7/1978-3/31/1978	25	Hadnot Point
4/1/1978-4/30/1978	30	Hadnot Point
5/1/1978-5/31/1978	31	Hadnot Point
6/1/1978-6/30/1978	30	Hadnot Point
7/1/1978-7/13/1978, 7/29/1978-7/31/1978	16	Hadnot Point
8/1/1978-8/31/1978	31	Hadnot Point
9/1/1978-9/30/1978	30	Hadnot Point
10/1/1978-10/31/1978	31	Hadnot Point
11/1/1978-11/30/1978	30	Hadnot Point
12/1/1978-12/28/1978	28	Hadnot Point
1/13/1979-1/31/1979	19	Hadnot Point
2/1/1979-2/8/1979	8	Hadnot Point
	449	

During his time at Camp Lejeune, Mr. Howard would do normal day to day activities—eating, drinking, showering, and cleaning with the contaminated water provided by the water system. According to testimony, Mr. Howard:

1. Drank a glass of water and a glass of "bug juice" (likely prepared with water) at breakfast each morning. With lunch he drank two glasses of water and with dinner another two glasses. (Howard p. 29-31)
2. In the field, he carried as many as four canteens filled with water, which he might refill on particularly hot days, consuming as many as six or seven canteens. The water came in "water buffaloes" which were tanks that held 400-500 gallons of water (Howard p. 32-34)
3. Most of the time he showered twice per day (5-10 minutes each). (Howard p. 24, 27)
4. In addition, he showered once per week for 30-45 minutes while cleaning his weapons (Howard p. 25-26)
5. He washed his T-shirts, boxers and socks weekly (Howard p. 44-45)
6. He trained in a swimming pool for a couple of days once a year for more than an hour (Howard 45-47)
7. He mopped the floors of the barracks daily for ~45 minutes with a deeper clean once a week that took almost a day (Howard p. 47)

Based upon these activities, Dr. Kelly Reynolds (cited above) estimated that his cumulative consumption for TCE ranged between 660,782 ppb ingested to 1,019,982 ppb ingested (depending on assumptions of ingestion), for PCE it was 27,780 ppb ingested to 42,882 ppb ingested (depending on assumptions of ingestion), and for benzene it was 7,859 ppb ingested to 12,132 ppb ingested (depending on assumptions of ingestion).

In my opinion, the level of exposure to TCE, PCE and benzene that Mr. Howard experienced during his 449 days living and working on Camp Lejeune was more than sufficient to cause his NHL and was substantial.

XI. Differential Diagnosis Methodology to Determine the Etiology of the NHL

Based on the days of exposure and the levels of TCE, PCE, and benzene in the water during Mr. Howard's time at Camp Lejeune, it is my opinion that the contaminated water was more likely than not, the cause of Mr. Howard's NHL. This opinion is based on a differential diagnosis methodology.

The basis of a differential diagnosis methodology is to start with listing the potential causes of the condition, in this case, NHL, and then evaluating the likelihood of any given cause based on the evidence. Those potential causes for which there is no evidence can be discounted and those for which there is strong evidence, like the known exposure to the contaminated water, can be credited.

In this case, I have considered the known or potential causes of NHL. The only known or potential cause of the NHL here was the exposure to the water at Camp Lejeune.

For instance, when exposed to burning phosphorous on a single occasion while employed as a police officer, he was wearing a mask. (Howard p. 57-58). When maintaining his motorcycle he used only citrus-based degreasers, not petroleum based, and he wore protective gear including gloves, an N-95 mask and eye protection (Howard p. 58-60) There is also no evidence of any family history that is relevant (Howard p. 123-124), no evidence of other exposures to chemicals (Howard p. 60), and no medical history of any NHL precursors such as immunosuppression, autoimmune disease, infection with immunodeficiency virus or organ transplantation prior to his lymphoma diagnosis.

Considering the potential causes of the NHL in this case and the weak, or absent, evidence for all but the water at Camp Lejeune, I am left with the conclusion that the contaminated water was more likely than not the cause of Mr. Howard's NHL.

In a Bove et al. study in 2024, "Cancer Incidence among Marines and Navy Personnel and Civilian Workers Exposed to Industrial Solvents in Drinking Water at US Marine Corps Base Camp Lejeune: A Cohort Study" the authors compared the cancer incidence for marine and navy personnel stationed at Camp Lejeune vs. Camp Pendleton (where the drinking water was allegedly/purportedly not contaminated).[30] Bove et al. found that the hazard ratio for developing NHL for the comparison of Camp Lejeune vs. Camp Pendleton civilian workers was 1.19 (95%

confidence interval 0.83, 1.71) and for diffuse large B-cell lymphoma the hazard ratio was 1.48 (95% confidence interval 0.81, 2.70) (Table 5).[30]

Given the lack of any other risk factors for the development of NHL (e.g., immunosuppression, autoimmune disorders, HIV infection, EBV infection, hepatitis C virus infection, organ transplantation, familial history, or exposure to herbicides) and the increased risk for lymphoma among individuals exposed to TCE, PCE, and benzene, I conclude that it is more likely than not that in Mr. Howard's case the additive exposure to TCE, PCE and benzene increased the risk of and was likely a significant contributing cause of his diffuse large B-cell lymphoma. Furthermore, I conclude to a reasonable degree of scientific and medical certainty that Mr. Howard's exposure to TCE, PCE and benzene while stationed at Lejeune was an independent cause of his lymphoma.

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Quaglino P, …**Hoppe R**, Pro B, Swerdlow SH, Barosi G. Identifying and addressing unmet clinical needs in primary cutaneous B-cell lymphoma: A consensus-based paper from an ad-hoc international panel. Hematol Oncol. 2024 Jan;42(1):e3215. doi: 10.1002/hon.3215.PMID: 37649350

Alig SK, …**Hoppe R**, et al. Distinct Hodgkin lymphoma subtypes defined by noninvasive genomic profiling. Nature. 2024 Jan;625(7996):778-787. doi: 10.1038/s41586-023-06903-x.PMID: 38081297

Shree T, … **Hoppe RT**, et al. A clinical trial of therapeutic vaccination in lymphoma with serial tumor sampling and single-cell analysis. Blood Adv. 2024 Jan 9;8(1):130-142. doi:10.1182/bloodadvances.2023011589. PMID: 37939259

Binkley MS, ,…**Hoppe RT** on behalf of the GLOW Consortium. International Prognostic Score for Nodular Lymphocyte–Predominant Hodgkin Lymphoma. Journal of Clinical Oncology *in press*

My testimony in the past 4 years

Deposition and trial. October 2021. James Dato v. Shawn Devin Evans MD et al.
San Diego County Superior Court
Cynthia Chihak. Chihak & Martel, 12555 High Bluff Dr., Suite 150, San Diego CA 92130
Represented plaintiff.

General Compensation

$400/hour for record review
$500/hour for preparation of reports
$1000/hour for depositions
$1500/hour for trial testimony
Travel expenses including first class/business class airfare

RICHARD HOPPE'S CV

February 6, 2025

Richard T. Hoppe

CURRICULUM VITAE

RICHARD T. HOPPE, M.D., F.A.C.R.
Henry S. Kaplan-Harry Lebeson Professor in Cancer Biology
Professor, Department of Radiation Oncology
Stanford University School of Medicine

EDUCATION AND DEGREES:

1963-1967	Cornell University, Ithaca, New York. BA, 1967 Major: Biological Sciences
1967-1971	Cornell University Medical College, New York, New York. MD, 1971 Gustave J. Nobak Prize for Research in Anatomy (1969)

SCHOLARSHIPS AND HONORS:

New York State Regents' Scholarship for the Study of Medicine (1967-1971)
Phi Eta Sigma Honor Society (1964)

POST-DOCTORAL TRAINING:

July 1971-June 1972, Medical Intern, Cornell Cooperating Hospitals-North Shore Hospital, Manhasset, New York, and Memorial Hospital, New York, New York
July 1972-September 1975, Post-Doctoral Fellow, Division of Radiation Therapy, Stanford University, Stanford, California
1974-Chief Resident, Division of Radiation Therapy, Stanford University, Stanford, California
October 1975-June 1976, Post-Doctoral Fellow, Cancer Biology Research Laboratory, Stanford University, Stanford, California

ACADEMIC HISTORY:

July 1976-September 1977 - Acting Assistant Professor, Department of Radiology, Division of Radiation Therapy, Stanford University School of Medicine, Stanford, California
July 1976- present - Consultant, Palo Alto Veterans Administration Hospital, Palo Alto, California
October 1977-August 1983 - Assistant Professor, Department of Radiology, Division of Radiation Therapy, Stanford University School of Medicine, Stanford, California
September 1983-April 1989 - Associate Professor, Department of Radiation Oncology, (Department of Radiology, Division of Radiation Therapy, 1983-1986; Department of Therapeutic Radiology 1986-1987), Stanford University School of Medicine, Stanford, California
May 1989 - Present - Professor, Department of Radiation Oncology, Stanford University School of Medicine, Stanford, California
July 1994 – Present –The Henry S. Kaplan-Harry Lebeson Professor in Cancer Biology

APPOINTMENTS:

Director, Radiation Oncology Resident Training Program 1985-2000
Acting Chairman, Department of Radiation Oncology, Stanford University School of Medicine, September 1992-July 1994
Chairman, Department of Radiation Oncology, Stanford University School of Medicine, July 1994-2011
Vice-Chairman, Department of Radiation Oncology, Santa Clara Valley Medical Center,

1994-2000
Acting Chief of Radiation Oncology, Stanford University Hospital, 1992-1994
Service Chief, Department of Radiation Oncology, (Stanford University Hospital) (Stanford Hospital and Clinics), 1994-2011
Stanford-Emanuel Radiation Oncology Center (SEROC) Board of Governors, 2005-2011
Co-Director, Stanford Multidisciplinary Cutaneous Lymphoma Clinic, 1992-

SERVICE:

Editorial Boards

Current Problems in Cancer, Associate Editor, 1986-1991
Journal of Clinical Oncology, Editorial Board, 1987-1989; 2008-2010; 2011-2013
International Journal of Radiation Oncology, Biology and Physics,
Associate Editor, 1988-1995; Editor 1995-2011
Site Editor, Hodgkin's disease and malignant lymphomas, 1990-1994
Editorial Board -2011
Oncology Times, Editorial Board, 1990-
Advanced Medical Publishing, Editorial Board, 1992-
The Cancer Journal from Scientific American, Editorial Board, 1994-2000
Cancer Journal, Editorial Board, 2000-2006
*ACR Journal Advisor (*previously, *Internet Radiation Oncology Journal Club*, *Cogent Medicine*) Editor, Lymphoma Section, 1995-2018
PDQ Extramural Board of Associate Editors, International Cancer Information Center, National Cancer Institute, National Institutes of Health, 1988-?
Clinical Lymphoma & Myeloma (Clinical Lymphoma), Editorial Board, 1999-2008
MDVista.com, Editorial Board, 1999-2001
NexCura.com, Medical Editorial Board 2000-2012
NCCN Journal, 2002-

Committees and Professional Activities

Stanford University:
Committee on Libraries of the Academic Council, 1980 - 1983
Undergraduate advisor, 1980 – 1990
Malcolm A. Bagshaw Memorial Resolution Committee, 2012
Stanford University School of Medicine:
Residency Review Committee, 1983 - 1984
Task Force on Transplantation Medicine, 1985
Department Senator, Stanford Medical School Faculty Senate, 1987 - 1990
Cancer Center Program Steering Committee, 1991-1997
Executive Committee, 1992 - 2011
Quality Committee (Chair) 1995
Search Committee, Director of Clinical Cancer Center 1995-6
Task Force on Faculty Compensation 1996-1997
Search Committee, Department of Medicine Chair, 1996
Performance Bonus Work Group, 1997
Chair, Clinical Chairs Group, 1997 -1999
Finance Committee, 1999-2001
Internal Governing Council 2000-2002
Clinical Cancer Steering Committee, Chair, 2001-2004
Search Committee, Cancer Center Clinical Director, 2003
Advanced Residency Training at Stanford (ARTS) Review Committee, 2007-
?Search Committee, Cancer Center Clinical Director, 2009
Search Committee, Department of Medicine Chair, 2011

Stanford University Faculty Practice Program (integrated into Stanford Health Services in 1995):
Board of Directors 1992-1995
Clinic Operations Committee 1992-1995
Strategic Planning Committee 1992-1995
Combined Modality Cancer Clinic Task Force 1992-1995
Stanford Medical Review, Faculty Advisor, 1999-2000
Stanford Molecular Imaging Scholars Program (SMIS) – Advisory Board, -2012

Stanford University Hospital:
Bone Marrow Transplantation Review Committee, 1987-2000
Medical Board 1992-2000
Service Chief, Department of Radiation Oncology, Sept. 1992-2011
Quality and Organizational Performance Committee of the Hospital Board, 1996-1997

Stanford University Medical Center:
Graduate Medical Education Review Committee, 1989-1997
Cancer Center Executive Planning Committee, 1993-1997
Work Group on External Affiliations for the Medical Center, 1992-1994
Clinical Cancer Center Steering Committee, 1997-2004; Chair 2001-2004

Stanford University - Department of Radiology:
Faculty Advisory Committee for The Faculty Practice Plan. 1979-1981
Promotions Advisory Committee, 1983-1986 Chairman 1985-1986

Stanford University - Department of Radiation Oncology:
Director, Radiation Oncology Training Program, 1985-1998
Clinical Sciences Planning Committee, 1987-1990
Steering Committee, Patient Resource Center, 1989-1990
Promotion Advisory Committee, 1989-1992
Appointments and Promotions (A&P) Committee, Chair, 2012-
Search Committee, GU Radiation Oncologist, 2011-2012
Search Committee, Tenure-line Radiation Physicist, 2011-2012
Search Committee, CNS Radiation Oncologist, 2012-2013
Incentive Plan Subcommittee, 2012-
Kaplan Fellowship Committee, 2015

Stanford University – Department of Medicine:
Search Committee, Director Division of Oncology, 2011-2012
Search Committee, Division of Oncology, Faculty member for the lymphoma program, 2010-2015; 2021-2023

Stanford Health Services (SHS) (integrated into UCSF/Stanford Health Care in 1997):
Stanford Faculty Practice Group (SFPG) Governance Board 1995-1997
Practice Operations Committee (Chair) 1995-1997
Clinical Operations Steering Committee 1996
Kaiser/Stanford Pathology Work Group 1996
Medical Direction Task Force 1996-1997

UCSF/Stanford Health Care (Dissolved in 1999-2000)
Physician Board 1998-1999
Contracts Committee 1998-1999, Co-Chair 1998-1999
Clinical Policy Subcommittee 1997-1999
International Advisory Committee 1998-1999

Stanford Hospital and Clinics (SHC)
Medical Board 2000-2008
Medical Executive Committee, 2008-2011
Board of Trustees 2000-2009
Credentials and Policies/Procedures Committee 2000-2009
Quality Committee 2000-2009
Internal Governing Council 2000-2002

Contracts Committee 1999-2006
Strategic Planning Group 2000-2002
Adult Market Development Strategic Work Group Committee 2000-2001
Payor and Pricing Strategic Work Group Committee 2000-2001
Turnaround Committee 2001-2002
Council of Clinical Chairs 2002-2011

University of California, San Francisco
Search Committee, Chair of Department of Radiation Oncology, 1998

State/Regional:

California Radiological Society (CRS)
Executive Committee 1993-2004

Northern California Radiation Oncology Society (NCROS/NorCROS)
(A Component Society of the California Radiological Society [District 12])
Nominating Committee, 1985
Secretary-Treasurer 1987-1989
Vice President - 1989-1991
President - 1991-1993
Executive Committee, 1987-2004

California Radiation Oncology Society (CROS)
Secretary-Treasurer 1988-1989
Vice President 1990-1991
President 1992-1993

California Medical Association (CMA)
Scientific Advisory Panel on Radiology 1992-1993

Los Altos Golf and Country Club
Finance Committee, 2009-2012

Northern California Cancer Center (NCCC)
Clinical Research Steering Committee 1990-1991
Board of Trustees, Alternate Member 1990-1991

Northern California Oncology Group (NCOG) (Dissolved in 1990)
Lymphoma Committee - Chairman 1984-1990
Executive Committee 1984-1990
Radiation Therapy Committee 1984-1990
Protocol Committee, 1987-1990
Publications Committee, 1988-1990

National/International:

American College of Radiology (ACR)
Fellowship, 1990
Alternate Councilor, State of California 1993-1996
Councilor, State of California, 1996-2004

Committee on Radiotherapeutic Equipment, 1981-1986
Cancer Committee on Strategic Plan for Radiological Sciences, 1982-1983
Item Writing Committee, Radiation Therapy In-Training Examination, 1983, 1985
Committee on Patterns in Radiation Therapy, 1985-1987
Commission on Radiation Oncology, 1996-1999; 2005-2013
Joint ACR/ASTRO Committee on Economics, 1999-2001

Task Force on Weekly Treatment Management, 1997-1999
Committee on Appropriateness Criteria - Expert Panel on Radiation Oncology – Hodgkin's Disease Work Group, 1997-2007, Chair 2004-2007
Board of Chancellors 2005-2011
Awards Committee, 2007-2009
Governance Committee, 2009
Commission on Human Resources, 2008-2012
Bylaws Committee, 2011-2013

American College of Radiology Imaging Network (ACRIN)
Advisory Panel 1999-2002

American College of Radiology Patterns of Care Study (PCS)
Site Surveyor, 1975
Member, Advisory Committee, 1988-2006
Chairman, Consensus Committee on Hodgkin's Disease, 1988-1994

ECOG-American College of Radiology Imaging Network (ECOG-ACRIN)
Radiation Oncology Co-Chair E2410 - Phase II Trial of Response-Adapted Therapy Based on Positron Emission Tomography (PET) for Bulky Stage I and II Classical Hodgkin Lymphoma (HL) 2011-2012

American College of Radiology Quality Research in Radiation Oncology (QRRO)
Executive Committee, 2008-2009

American College of Radiology Association (ACRA),
Board of Trustees, 2005-2011
Human Resources Commission, 2008

Accreditation Council for Graduate Medical Education (ACGME)
Specialist Site Visitor in Radiation Oncology 1986, 1990
Residency Review Committee for Radiation Oncology, 2003-2006
Appeal Panel Member for Radiation Oncology, 2009-2022

American Board of Radiology (ABR)
Trustee 1999-2007
Secretary-Treasurer 2004-2006
Executive Committee 2004-2006
Examination Committee 1999-2007 (Chair 2002-2004)
Relief Examiner for Oral Board Examination in Radiation Oncology, 1987;
Guest Examiner for Oral Board Examination in Radiation Oncology, 1988, 1992, 1995, 1998
Task Force for Written Examination, 1990-1992
Radiation Oncology Written Examination Committee 1992-2007
Strategic Planning Committee, 2002-2007
CME Program Planner, Radiation Oncology Written Exam, 2004
Nominating Committee, 2006-2007
Lifetime Service Award, 2010
Committee on Lymphoma/Leukemia, 2011-2012

American Cancer Society, California Division
Psychosocial Committee - Ad hoc member for grant review, 1984

American College of Surgeons (ACoS)
Commission on Cancer

National Cancer Data Committee, Subcommittee on Non-Hodgkin's Lymphoma, 1996

American Joint Committee on Cancer (AJCC)
Lymphoma Task Force (for the 6th Edition), 1999-~2000
Lymphoma Task Force (for the 7th Edition), 2005=
Hematological Malignancies Expert Panel for AJCC Cancer Staging System, 8th Edition 2014-

American Medical Association (AMA)
Graduate Medical Education Committee,
Specialist Site Visitor in Radiation Oncology 1986, 1990
Residency Review Committee for Radiation Oncology, 2003-2007

American Radium Society (ARS)
Resident Essay Committee, 1986 - 1989, Chairman 1987-1989
Janeway Lecture Committee, 2004-2007
Scientific Program Committee, 2005-2006
Representative to the ACR Board of Chancellors, 2005-2011
Executive Council, 2009-2011

American Society of Clinical Oncology (ASCO)
Cancer Education and Training Committee, 1981-1984
Program Committee 1982-1983, 1988-1991, 1998-1999
Public Relations Committee, 1984-1989
Nominating Committee, 1985-1986, 1987-1988, 1992-1993
Ad Hoc Committee to Review Federal Funding, 1985
Constitution and Bylaws Committee, 1987-1990
Oncology Training Programs Committee, 1996-l997
People Living with Cancer, Advisory Panel (Hodgkin's Disease and Non-Hodgkin's Lymphoma) 2005-

American Society for Radiation Oncology (formerly, American Society for Therapeutic Radiology; American Society for Therapeutic Radiology and Oncology) (ASTRO)
Board of Directors, 1993-1999
Member-at-Large, 1993-1995
President-Elect, 1995-1996
President, 1996-1997
Chairman, 1997-1998
Abstract Reviewer, 1995-1996, 2009, 2010
ASTRO International Relations Committee, 1995-2005
Chairman, 2000
ASTRO Awards Committee, 1996-2000
Chairman, 1998
ASTRO Program Committee, 1980-1981, 1985-1987
ASTRO Education Committee, 1983-1986, 1995-1997
ASTRO Radiation Research Committee (ex officio) 1996-1997
ASTRO Annual Meeting and Program Committee, 1989-1992, 1995-1997
Vice Chair, 1996
Chair, 1997
ASTRO Annual Meeting Site Selection Committee, 1996-1999
ASTRO Education and Development Fund, Board of Directors, 1993-1998
President, 1997-1998
ASTRO Government Relations Committee, 1997-1998
ASTRO Nominating Committee, 1997-1998
ASTRO Radiation Research Committee, 1995-1996
Ex-Officio Member, 1996-1997
ASTRO Practice Standards and Guidelines Committee, 1994-1995

ASTRO Finance Committee, 1994-1995
ASTRO SCOPE of Radiation Oncology Working Group Steering Committee, 2000
ASTRO Task Force on the Role of Rad. Oncology Endovascular Brachytherapy, 2000
ASTRO Strategic Planning Committee, 1997-1999; 2002-
ASTRO Public Relations Committee, 1995-1996
ASTRO Economics Steering Subcommittee, 1999
ASTRO Annual Meeting - Local Arrangements Sub-Committee 2000-2001
SCOPE of Radiation Oncology Working Group Steering Committee – 200-2001
ASTRO Fellows Task Force 2005
ASTRO Fellows Selection Committee, Vice Chair 2005-2008; Chair 2008-
Foundation Task Force 2005-2007
Radiation Oncology Institute –
Steering Committee, 2007
Campaign Cabinet, Academic Co-Chair, 2007-2010
Nominating Committee, 2011-~2012
ASTRO-ARRO Journal Club Faculty, 2010-2011
ASTRO History Committee 2022-

Cutaneous Lymphoma Foundation
Medical Advisory Council 2017-

Eastern Cooperative Oncology Group (ECOG)
Lymphoma Committee, Co-Chairman for Radiation Therapy, 1991-*1992*
Radiation Therapy Committee, 1991-*1992*
Radiation Therapy Chair E2496 – Randomized Phase III Trial Comparing ABVD + Radiotherapy and the Stanford V Regimen in Patients with Intermediate or Advanced Stage Hodgkin Lymphoma

GLOBAL NLPHL (GLOW)

Executive Committee

Retrospective Analyses Oversight Committee

HoLISTIC
Advisory Committee (2019-

Institut National du Cancer (France)

Reviewer for grant proposals, 2019

International Database for Hodgkin's Disease
Steering Committee 1990-1995

International Harmonization Project in Lymphoma

Member 2004-2007

International Lymphoma Radiation Oncology Group
Steering Committee, 2010-

International Society for Cutaneous Lymphoma (ISCL)
Board of Directors, 2011-2019

International Society for Radiation Oncology (ISRO)
Board of Directors, 1997-2001
Scientific Committee for ICRO 2001, 2000-2001

International Task Force on Hodgkin's Lymphoma

1999-2002

International Union Against Cancer (UICC)
UICC Panel of Experts, 2001-2004
UICC TNM Expert Advisory on Lymphoma, 2002-2007, 2008-2012, 2013-2018

KWF Kanker Bestrijding (Dutch Cancer Society)
Reviewer of research proposals - 2003

National Cancer Center Network (NCCN)
Board of Directors, 2001-2004
Panel on Guidelines, Lymphoma, 1996-2017
Panel on Guidelines, Primary Cutaneous Lymphoma, 2017-
Panel on Guidelines, T-Cell Lymphoma, 2017-,
Panel on Guidelines, Hodgkin's Disease (Hodgkin Lymphoma), 1997- ; Chair, 1997-

NCCN Hodgkin's Disease Panel (Editorial Board), 2002-; Chair,2002-

National Institutes of Health, National Cancer Institute (NCI)
Board of Scientific Counselors, 2005-2010
Lymphoma Steering Committee (LYSC)
Hodgkin's Lymphoma Working Group, 2011-2014
Clinical Trials Planning Meeting, Lymphoma Committee, Hodgkin Lymphoma Subcommittee, 2014

Radiological Society of North America (RSNA)
News Editorial Board, 2003-2009
Maintenance of Certification Subcommittee 2005-2007
Public Information Advisors Network 2003-~2010

Society of Chairs of Academic Radiation Oncology Programs (SCAROP) 1992-
Board of Directors, Member at Large, 1996-1998
Education Committee, 1994-1996
President-Elect 1998-2000
President 2000-2002
Executive Committee 1998-2004

Union for International Cancer Control
UICC TNM Project – TNM Literature Watch, Lymphoma 2011-2019

United States Cutaneous Lymphoma Consortium (USCLC)
Membership Committee, Chair Radiation Oncology Section

Consultant to the Dean, University of Alabama School of Medicine, 1985
Consultant to the Dean, University of Texas Health Sciences Center at San Antonio, 1987
Consultant to the Dean, Emory University School of Medicine, 2004
Consultant to the Dean, University of Cincinnati College of Medicine, Charles M. Barrett Cancer Center 15-16 May 2007

POST-DEGREE HONORS AND AWARDS:

Diplomate:
National Board of Medical Examiners 1972
Certified, American Board of Radiology (Radiation Therapy) 1976 (Lifetime Certificate)
Re-Certified, American Board of Radiology (Radiation Oncology) January 1, 2016
Fellowship, American College of Radiology (FACR) 1990
Fellowship, American Society for Therapeutic Radiology and Oncology (FASTRO)
Fellowship, American Radium Society (FARS)

Licensure:
New York (112671) 1972
California (G23743) 1972

Awards:
Robert Reid Newell Memorial Award, Stanford University, Department of Radiology, 1976.
American Cancer Society, Junior Faculty Clinical Fellowship, (1977-1980).
Agnes Axtell Moule Faculty Scholar (1979-1983).
Fellow, American College of Radiology, 1990
The Henry S. Kaplan Memorial Prize for Teaching, Department of Radiation Oncology, Stanford University, June 1991
The Janeway Award, American Radium Society, 2002
The American Society for Radiation Oncology (ASTRO) Gold Medal, 2006
ABR Lifetime Service Award, March 1, 2010

Honorary Professor, Shantou University Medical College, Shantou, China, 2011
American College of Radiology (ACR) Gold Medal, 2013
Association of Residents in Radiation Oncology (ARRO) 2012-2013 Educator of the Year Award
The Henry S. Kaplan Memorial Prize for Teaching, Department of Radiation Oncology, Stanford University, June 2017
The Karl Musshoff Prize, The German Hodgkin Lymphoma Study Group, October 2018
The Rodger Winn Award, from the National Cancer Center Network (NCCN), March 2019
The Inaugural Gold Medal of the American Radium Society (ARS), April 2019
Lifetime Achievement Award, International Society of Cutaneous Lymphoma, March 2020
The Albion Walter Hewlett Award from the Department of Medicine, Stanford School of Medicine 2022 (awarded 2023)

Named Lectureships/Keynote Addresses:

Third Annual E. Richard King Memorial Lecture, Medical College of Virginia, Virginia Commonwealth University, November 2, 1995
The First Philip Rubin Lecture: The Contributions of Radiation Therapy to the Management of Advanced Hodgkin's Disease. ICRO, Beijing, China, June, 1997
The Second Annual Richard G. Evans Memorial Lecture, University of Kansas, September 10, 1999
The Jerry Vaeth Lecture, San Francisco, 2001
The Annual Oration in Radiation Oncology (Honoring Simon Kramer), Radiological Society of North America, November 28, 2001
The Janeway Lecture, American Radium Society, April 30, 2002
The Vera Peters Lecture, The Princess Margaret Hospital, June 6, 2002
The Martin Schneider Memorial Lectureship, University of Texas Medicine Branch, September 30, 2003
The John Ultmann Lecture, at the Sixth International Symposium on Hodgkin's Lymphoma, Cologne, Germany, September 15, 2004
The Franz Buschke Lecture, UCSF, May, 2008
Ho Hung-Chiu Medical Foundation Lecture, Hong Kong, 2010
Keynote Lecturer at DEGRO-25 (Deutsche Gesellschaft fur Radioonkologie E.V.), June 2019
Keynote Lecture at The Pediatric Hodgkin Consortium, February 2023 Palo Alto CA.
Keynote Lecture at the Children, Adolescent and Young Adults Hodgkin Lymphoma International Meeting, October 2023, Memphis TN

"Bests/Who's Whos"

The Best Cancer Specialists in the US. Good Housekeeping, 1992
The Best Doctors in America (Woodward/White), 1992, 1993, 1998
The Best Doctors in America. American Health, 1996

The Best Doctors in America: Pacific Region, 1996-1997
Top Doctors in the Bay Area San Francisco Focus, 1997
Best Docs in Silicon Valley. San Jose Magazine, 2000
America's Top Doctors (Castle Connolly Medical, Ltd.) 2004, 2007, 2008, 2009, 2011 (11th ed.), 2013 (12th ed.), 2015 (14th ed.), 2016, 2017, 2018, 2020; Top Doctor for 15 Years 2020; 2021
Bay Area Consumers' Checkbook, "Best Doctors", 2005, 2007
Best Doctors in America (Best Doctors, Inc.) 2005-2006, 2007-2008, 2009-2010, 2011-2012
Empire Who's Who Among Executives and Professionals in Education, 2006-2007
America's Top Doctors for Cancer (Castle Connolly Medical, Ltd.) 2007, 2008, 2009, 2010, 2011 (7th ed.), 2018
Patients' Choice Award (American Registry) 2008, 2009
America's Top Radiologists (Consumers' Research Council of America), 2008

America's Top Oncologists (Consumers' Research Council of America), 2008
Cambridge Who's Who Registry Among Executives and Professionals in the Field of Education and Research, 2009
Presidential Who's Who among Business and Professional Leaders, 2010
Cambridge Who's Who Registry of Executives and Professionals, 2011
Who's Who in Medicine and Healthcare, 2011-2012
US News and World Report Best Doctors in America, 2011
Leading Physicians of the World (International Association of Health Care Professionals), 2012
Top Doctors: San Francisco, 2012 (Castle Connolly Medical Ltd)
Who's Who in America, 2011; 2013 (67th Edition); 2014 (68th Edition)
Best Doctors in America 2013 database (www.bestdoctors.com), 2019-2020
Newsweek Health: Top Cancer Doctors 2015
Who's Who Top Doctors "Honors Edition", 2015-2016
San Francisco Magazine, Top Doctors 2015, 2018, 2021
Top Doctors for Cancer (Castle Connolly), 2016, 2017, 2018
Who's Who in the World (Marquis). 2018, 2020
California Magazine Top Doctors, Top Oncologist 2020
America's Most Honored Doctors (The American Registry) 2020

Visiting Professor:

Hebrew University, Hadassah Medical Center, Jerusalem, Israel, November 20-29, 1979
Medical College of Ohio, Department of Radiation Therapy, Toledo, Ohio, January 20-22, 1987.
University of Pennsylvania and the Fox Chase Cancer Institute, Department of Radiation Oncology, March 23-24, 1988.
Bodine Center for Cancer Treatment, Thomas Jefferson University Hospital, Department of Radiation Oncology and Nuclear Medicine, Philadelphia, PA, Sept. 22, 1989.
Duke University, Division of Radiation Oncology, Durham, NC, Nov. 17, 1989.
Loyola University, Department of Radiotherapy, Chicago, IL, March 14-15, 1991
University of Florida, Department of Radiation Oncology, Gainesville, FL, March 20-22, 1991
University of Kansas Medical Center, Department of Radiation Oncology, Kansas City, KS, July 31, 1991
University of Pennsylvania and the Fox Chase Cancer Institute, Department of Radiation Oncology, Philadelphia, PA, February 5-6, 1992
Mayo Clinic, Department of Radiation Oncology, Rochester, MN, March 4-6, 1992
University of Wisconsin Comprehensive Cancer Center, Department of Radiation Oncology Madison, WI, November 17-18, 1993
M.D. Anderson Cancer Center, Radiotherapy Department, Houston, TX, January 10-11, 1994
Professeur Invite en Cancerologie, Universite de Montreal, Reseau interhospitalier de Cancerologie, Montreal, Quebec, March 1, 1995
McGill University, Department of Oncology, Montreal, Quebec, Canada, March 2, 1995.
Medical College of Virginia, Virginia Commonwealth University, Department of Radiation Oncology, Richmond, VA, November 2-3, 1995
The University of Kansas Medical Center, Department of Radiation Oncology, Kansas City, KS, November 15, 1995
University of Florida, Department of Radiation Oncology, Gainesville, FL, February 22-24, 1996
University of California, San Francisco, Department of Radiation Oncology, San Francisco, CA, October 17, 1996
University of Kansas, Kansas City, KS, Department of Radiation Oncology, September 10, 1999

The Princess Margaret Hospital, Department of Radiation Oncology, Toronto Canada, June 6-7, 2002
University of Maryland, Department of Radiation Oncology, Baltimore, MD, January 2008
Queen Elizabeth Hospital, Hong Kong, China, April, 2010
University of Florida College of Medicine, Department of Radiation Oncology, February 21-22, 2014
Fox Chase Cancer Center, Department of Radiation Oncology, January 28, 2015
University of Texas Southwestern, Department of Radiation Oncology, March 27, 2015
University of Miami, Sylvester Comprehensive Cancer Center, Department of Radiation Oncology, January 15, 2016
University of North Carolina, Department of Radiation Oncology, September 8, 2017
The Mayo Clinic, Scottsdale AZ, May 4, 2018
The Mayo Clinic, Rochester MN, February 29-March 1, 2024

MEMBERSHIPS:

American Society for Radiation Oncology
American College of Radiology
American Society of Clinical Oncology
Northern California Radiation Oncology Society
California Radiological Society
California Radiation Oncology Society
American Society of Clinical Oncology
American Radium Society
European Society for Therapeutic Radiology and Oncology
American Association for Cancer Research
International Lymphoma Radiation Oncology Group
International Society for Cutaneous Lymphomas
Pacific Northwest Radiological Society (Hon.)
Radiation Research Society
European Society of Medical Oncology, Corresponding Member
California Academy of Medicine
Society of Medical Friends of Wine

PUBLICATIONS:

1. Hoppe RT, Goffinet DR, and Bagshaw MA. Carcinoma of the nasopharynx. Eighteen years experience with megavoltage radiation therapy. Cancer 1976; 35:2605-2612.

2. Fuks Z, Hoppe RT, and Bagshaw MA. The role of total skin irradiation with electrons in the management of mycosis fungoides. Bull Cancer 1977: 64:291-304.

3. Hoppe RT, Fuks Z, and Bagshaw MA. The rationale for curative radiotherapy in mycosis fungoides. Int J Radiat Oncol Biol Phys 1977: 2:843-851.

4. Price NM, Constantine VS, Hoppe RT, Fuks ZY, Farber EM. Topical mechlorethamine therapy for mycosis fungoides. Brit J Derm 1977; 97:547-550.

5. Hoppe RT, Fuks ZY, Strober S, and Kaplan HS. Long term effects of radiation on T and B lymphocytes in the peripheral blood after regional irradiation. Cancer 1977; 40:2071-2078.

6. Price NM, Hoppe RT, Constantine VS, Fuks ZY, and Farber EM. The treatment of mycosis fungoides. Adjuvant topical mechlorethamine after electron beam therapy. Cancer 1977; 40:2851-2853.

7. Hoppe RT, Williams J, Warnke R, Goffinet DR, Bagshaw MA. Carcinoma of the nasopharynx - the significance of histology. Int J Radiat Oncol Biol Phys 1978; 4:199-205.

8. Proctor MS, Price NM, Cox AJ, Hoppe RT. Subcutaneous mycosis fungoides. Arch Dermatol 1978; 114:1326-1328.

9. Hoppe RT, Burke JS, Glatstein E, Kaplan HS. Non-Hodgkin's lymphoma. Involvement of Waldeyer's ring. Cancer 1978; 42:1096-1104.

10. Hoppe RT, Portlock CS, Glatstein E, Rosenberg SA, and Kaplan HS. Alternating chemotherapy and irradiation in the treatment of advanced Hodgkin's disease. Cancer 1979; 43:472-481.

11. Slavin S, Gottlieb M, Strober S, Bieber C, Hoppe RT, Kaplan HS, and Grumet FC. Transplantation of bone marrow in outbred dogs without graft-versus-host disease using total lymphoid irradiation. Transplantation 1979; 27:139-142.

12. Gottlieb M, Hoppe RT, Calin A, and Strober S. Arthritis in a patient with mycosis fungoides: complete remission after radiotherapy. Arthritis Rheum 1979; 22:424-425.

13. Strober S, Slavin S, Fuks Z, Kaplan HS, Gottlieb M, Bieber C, Hoppe RT, Grumet FC. Transplantation tolerance after total lymphoid irradiation. Transplant Proc 1979. 11:1032-1038.

14. Castellino RA, Hoppe RT, Blank N, Young SW, Fuks Z. Experience with lymphography in patients with mycosis fungoides Cancer Treat Rep 1979; 63:581-586.

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RICHARD HOPPE'S FEE SCHEDULE AND TESTIMONY HISTORY

Richard T. Hoppe, MD

Testimony in the past 4 years

Deposition and trial. October 2021. James Dato v. Shawn Devin Evans MD et al.
San Diego County Superior Court
Cynthia Chihak. Chihak & Martel, 12555 High Bluff Dr., Suite 150, San Diego CA 92130
Represented plaintiff.

General Fees

$400/hour for record review
$500/hour for preparation of reports
$1000/hour for depositions
$1500/hour for trial testimony
Travel expenses including first class/business class airfare

RICHARD HOPPE'S PUBLICATION LIST

Richard T. Hoppe, MD

Last 10 years Publications

PUBLICATIONS – JOURNALS

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