

Exhibit 459

Robert Fiolek v. United States of America

U.S. District Court for Eastern District of NC, Southern Division
Case No. 4:23-CV-00062

Specific Causation Expert Report of Damian A. Laber, M.D., F.A.C.P.,

Prepared by

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Contents

- I. Introduction..... 3
- II. Background and Qualifications..... 3
- III. Methodology 3
- IV. Standard in This Case 4
- V. Chronic Lymphocytic Leukemia (CLL) 4
 - A. Progression and Complications..... 5
 - B. Diagnostic Approach 5
 - C. Prognosis and Treatment 6
 - D. Adverse Sequelae of the Disease and Therapy..... 8
 - E. Demographics 10
 - F. Recognized Risk Factors 10
- VI. Volatile Organic Compounds (VOCs) and Camp Lejeune Exposure..... 11
- VII. Robert Fiolek Medical History..... 12
- VIII. Robert fiolek exposure history 14
- IX. Analysis and Opinions 16
- X. Reference list..... 18
- XI. Additional Materials considered 20

I. INTRODUCTION

I have been asked to provide my opinions and expert testimony concerning the cause of Robert Joseph Fiolek’s diagnosis of Chronic Lymphocytic Leukemia (CLL). Specifically, I have been asked to opine on whether there is at least as likely as not a causal relationship between Mr. Fiolek’s exposure to the contaminants in the water at Camp Lejeune and his CLL. My opinions stated herein are based upon my knowledge, training, experience, and review of the records and literature. I hold all these opinions to a reasonable degree of medical certainty. I reserve the right to modify and/or expand my opinions should I become aware of additional information regarding this case.

II. BACKGROUND AND QUALIFICATIONS

My name is Damian A. Laber, M.D., F.A.C.P., and I am a Senior Member Tenured at the Moffitt Cancer Center and Head of the Moffitt Medical Group Section of Satellite Oncology at Tampa General Hospital, and Professor of Medicine and Oncologic Sciences, at the University of South Florida in Tampa, FL. I am Board Certified by the American Board of Internal Medicine (ABIM) Subspecialty Hematology and ABIM Subspecialty Medical Oncology.

My Curriculum Vitae, attached hereto, contains information concerning my medical training and experience; the Professional Societies to which I belong, the Editorial Boards, Advisory Councils, and Committees I am serving on or have served on in the past; the selected invited lectures I have given; the articles in which I have participated that have been published in peer-reviewed journals; published abstracts; and matters in which I have provided research support.

As an oncologist, I have treated thousands of patients with cancer, and as a hematologist, I have treated thousands of cases of hematological disorders, which includes CLL. For more complete information concerning my background and qualifications, including a list of my publications from the past 10 years, please refer to my CV. Also attached is a list of cases in which I have testified in the past 4 years and my fee schedule for this case.

III. METHODOLOGY

I have reviewed Mr. Fiolek’s medical records, history, documentation provided for this case, and the relevant medical literature. This includes expert epidemiologists’ findings, publications concerning water contamination at Camp Lejeune, and expert reports listed in the materials I considered. Risk factors were assessed based on my research and my review of peer-reviewed literature, along with other reliable scientific publications and reports. I have also reviewed the depositions provided to me in this case.

In my effort to assess the potential causal relationship between Mr. Fiolek’s exposure to the contaminated water at Camp Lejeune and his disease, I utilized a differential etiology analysis, often referred to as a differential diagnosis. Differential etiology is a standard scientific technique used to identify those contributing factors to the development of a disease by eliminating potential causes until the most probable ones are isolated. This methodology involves several steps.

First, I compile a list of recognized demographic and risk factors for a disease outcome based on what is known within the scientific community and found within the scientific literature, regardless of whether I believe the evidence is sufficient to warrant it as a risk factor for non-Hodgkin lymphoma (NHL). In those

circumstances where the evidence is not definitive, I state that the risk factor "may" be associated with NHL.

Second, I carefully evaluate, for a specific individual, whether any of the risk factors apply based on all available evidence including medical records, work history, patient interviews, depositions, and any other salient evidence that would bear upon the issue.

Finally, for each risk factor that could apply, I draw upon available scientific knowledge and a continuing evaluation of the literature and evidence to determine whether the specific risk factor was, more likely than not, a contributing factor in the development of the individual's cancer. In this case, I also perform that analysis on a different standard: whether the specific risk factor was, at least as likely as not, a contributing factor in the development of the individual's cancer. This differential methodology is commonly used by experts in my field, as well as in my own practice, and is a well-established and reliable approach for making assessments of causation for an individual.

IV. STANDARD IN THIS CASE

The Camp Lejeune Justice Act (2022) requires showing that "the relationship between exposure to the water at Camp Lejeune and the harm is – (A) sufficient to conclude that a causal relationship exists; or (B) sufficient to conclude that a causal relationship is at least as likely as not." The ATSDR Assessment of the Evidence for the Drinking Water Contaminants at Camp Lejeune and Specific Cancers and Other Diseases (Jan. 13, 2017) evaluated whether the "evidence for causality" between the Camp Lejeune water contaminants and certain diseases was "at least as likely as not" or "equipoise and above." I have reviewed the ATSDR's definition of "equipoise and above." Moreover, based upon my many years of training and experience, I have defined "at least as likely as not" to mean a 50% or greater likelihood that the Camp Lejeune water contaminants caused the patient's disease at issue. Where I express my opinions under the standard "more likely than not," such opinions exceed the "at least as likely as not" standard. In the event the differential etiology analysis results in more than one potential cause of the disease, and I am unable to conclude which of the factors is the most likely cause, I would express my opinion that each factor is "at least as likely as not" causally related to the disease.

V. CHRONIC LYMPHOCYTIC LEUKEMIA (CLL)

Chronic lymphocytic leukemia (CLL) and small lymphocytic lymphoma (SLL) are considered the same disease. It is classified as a Non-Hodgkin lymphoma and also as a leukemia. CLL/SLL is a mature B-cell neoplasm characterized by the progressive accumulation of monoclonal B lymphocytes. CLL is considered identical (i.e., one disease with different manifestations) to the Non-Hodgkin lymphoma SLL. The malignant cells seen in CLL and SLL have identical pathologic and immunophenotypic features. The term "CLL" is used when the disease manifests primarily in the blood, whereas "SLL" is used when involvement is primarily nodal.

In the United States in 2024, an estimated 20,700 new CLL cases and 4,440 deaths from CLL were expected.¹

A. Progression and Complications

The clinical course of this disease progresses from indolent lymphocytosis without other evident disease to generalized lymphatic enlargement, with concomitant pancytopenia. Complications of pancytopenia, including hemorrhage and infection, represent major causes of death in these patients. In fact, it is well known that the majority of CLL patients will suffer from multiple infections during their lifetime and many will succumb to infection complications. It is a disease that often causes premature death in the patient. Immunological aberrations, such as autoimmune hemolytic anemia, immune thrombocytopenia, and depressed immunoglobulin levels, can complicate the management of CLL. In this disorder, lymphocyte counts in the blood are usually greater than or equal to 5,000/mm³ with a characteristic immunophenotype (CD5- and CD23-positive B cells).

B. Diagnostic Approach

Tests and procedures used to diagnose CLL include:

- History and physical examination (including bidimensional diameters of the largest palpable lymph nodes in the cervical, axillary, and inguinal nodal sites and dimensions of the liver and spleen below their respective costal margins as assessed by palpation).
- Complete blood count with differential and chemistry panel (including creatinine, bilirubin, transaminases, and alkaline phosphatase). Other blood tests may include lactate dehydrogenase and beta-2-microglobulin. With suspicion of autoimmune hemolytic anemia, testing for reticulocyte count, indirect bilirubin, serum haptoglobin, antiglobulin (direct Coombs), and cold agglutinin may be helpful.
- Flow cytometry (for immunophenotyping).
- Fluorescence in situ hybridization (FISH) (for del(11q), del(13q), del(17p), trisomy 12, and t(11;14)).
- TP53 mutation analysis.
- IGH mutation analysis.
- Serum immunoglobulin levels.
- Hepatitis B and C and HIV tests.
- Computed tomography (CT) is usually not required in the absence of peripheral adenopathy; extensive adenopathy on examination should prompt investigation of retroperitoneal adenopathy.
- Bone marrow aspiration and biopsy is usually not required.

C. Prognosis and Treatment

Prognostic markers help stratify patients in clinical trials, assess the need for therapy, and select the type of therapy. Prognostic factors that may help predict clinical outcomes include cytogenetic subgroup, immunoglobulin mutational status, and CD38 immunophenotype.

An international prognostic index (IPI) for CLL (CLL-IPI) identified four prognostic subgroups based on IGH mutational status, clinical stage, age (≤ 65 years vs. > 65 years), and TP53 status (no abnormalities vs. del(17p) or TP53 mutation or both). A scoring system to predict time to first treatment for early-stage CLL identified three adverse risk factors: unmutated IGH, absolute lymphocyte count higher than $15 \times 10^9/L$, and palpable lymph nodes. Any new prognostic model, including the commonly used CLL-IPI, may become outdated due to the use of highly effective frontline therapies, including BCL2 inhibitors and BTK inhibitors. Revalidation of these prognostic models will be required.

Treatment of patients with CLL must be individualized based on the clinical behavior of the disease. Because this disease is generally not curable, occurs in older populations, and often progresses slowly, it is most often treated conservatively.

In older trials with data collected from the 1970s through the 1990s, the median survival for all patients ranged from 8 to 12 years. However, with the introduction of B-cell receptor inhibitors and targeting of BCL2, the median survival for all patients has not been reached with over 10 years of follow-up.

Treatment of patients with CLL ranges from observation with treatment of infectious, hemorrhagic, or immunological complications, to a variety of therapeutic options administered as single agents or combination therapy. In asymptomatic patients, treatment may be deferred until the disease progresses and symptoms occur. Because the rate of progression may vary from patient to patient, with long periods of stability and sometimes spontaneous regressions, frequent and careful observation is required to monitor the clinical course. Although even asymptomatic patients with del(17p) on fluorescence in situ hybridization (FISH) analysis (or TP53 mutation) may be followed with watchful waiting, frequent monitoring may be required to avert rapid progression. Several randomized trials and a meta-analysis of randomized trials showed no survival benefit for immediate versus delayed therapy for patients with early-stage disease.²⁻⁴ For patients with progressing CLL, treatment is non-curative in most cases. Selected patients treated with allogeneic stem cell transplants have achieved prolonged disease-free survival (DFS), sometimes exceeding 20 years. Prolonged DFS was also noted in young patients (< 60 years) with IGH hypermutation who received the FCR regimen (fludarabine, cyclophosphamide, and rituximab).

Symptomatic or progressive CLL is defined by the International Workshop on Chronic Lymphocytic Leukemia as:⁵

- Evidence of progressive marrow failure—the development or worsening of anemia and/or thrombocytopenia (in some patients, platelet counts $< 100 \times 10^9/L$ may remain stable over a long period; this does not automatically require therapeutic intervention). Cutoff levels of hemoglobin less than 10 g/dL or platelet counts less than $50 \times 10^9/L$ are generally regarded as an indication for treatment.
- Massive (i.e., ≥ 6 cm below the left costal margin), progressive, or symptomatic splenomegaly.

- Massive nodes (i.e., ≥ 10 cm in longest diameter), progressive, or symptomatic lymphadenopathy.
- Progressive lymphocytosis with an increase of 50% or more over a 2-month period, or lymphocyte-doubling time (LDT) less than 6 months. LDT can be obtained by linear regression extrapolation of absolute lymphocyte counts obtained at intervals of 2 weeks over an observation period of 2 to 3 months; patients with initial blood lymphocyte counts less than $30 \times 10^9/L$ may require a longer observation period to determine the LDT. Factors contributing to lymphocytosis other than CLL (e.g., infections or steroid administration) should be excluded.
- Autoimmune complications, including anemia or thrombocytopenia, respond poorly to corticosteroids.
- Symptomatic or functional extranodal involvement (e.g., skin, kidney, lung, or spine). Disease-related symptoms defined as any of the following:
 - Unintentional weight loss of 10% or more within the previous 6 months.
 - Significant fatigue (i.e., Eastern Cooperative Oncology Group performance scale 2 or worse, cannot work, or unable to perform usual activities).
 - Fevers of 100.5°F or 38.0°C or higher for 2 or more weeks without evidence of infection.
 - Night sweats for at least 1 month without evidence of infection.

The following general principles may provide a sequencing for available therapeutic options:

- Despite many therapeutic options, asymptomatic or minimally-affected patients with CLL are often offered observation outside the context of a clinical trial. Therapy often begins when patients develop profound cytopenias, or when symptoms, such as enlarging bulky lymphadenopathy or debilitating symptoms, substantially impact their quality of life.
- Because nontransplant, curative therapy has not been found, the initial goal of therapy is to maximize efficacy (with improvement of overall survival), while introducing the least overall short- and long-term toxicity.
- The U.S. Food and Drug Administration (FDA) approved the biological agents ibrutinib, acalabrutinib, and venetoclax for first-line use in newly diagnosed patients with CLL who require therapy. In patients with adverse prognostic factors (especially del(17p) or mutated TP53), ibrutinib, acalabrutinib, or venetoclax should be considered.
- Standard chemotherapeutic agents, such as fludarabine, bendamustine, cyclophosphamide, and chlorambucil, induce mutational damage to the genome that can manifest as more aggressive and refractory phenotypes upon relapse and can induce second malignancies. Yet, prolonged DFS (over 10 years) can be seen with the use of the FCR regimen in younger patients (<60 years) with IGH hypermutation.

- Avoiding alkylating agents and purine analogs also prevents prolonged cytopenias and the recurrent, long-lasting, and sometimes fatal infections seen after therapy with these agents.
- Avoiding chemotherapeutic agents up-front, when possible, is a new paradigm of sequencing therapy for CLL.
- Older patients with comorbidities may better tolerate the newer biological agents (such as ibrutinib or venetoclax), monoclonal antibody therapy alone (such as high-dose rituximab), or dose modification of standard chemotherapeutic agents combined with rituximab. For older patients (>65 years), the combination of rituximab plus bendamustine (BR regimen) resulted in fewer adverse events and better outcomes than the FCR regimen.

D. Adverse Sequelae of the Disease and Therapy

Infectious complications in advanced disease are, in part, a consequence of hypogammaglobulinemia and the inability to mount a humoral defense against bacterial or viral agents. The predisposition of CLL patients towards infection is a reflection of the global dysregulation of the immune system caused by the disease.⁶ Herpes zoster represents a frequent viral infection in these patients, but infections with *Pneumocystis carinii* and *Candida albicans* may also occur. Early recognition of infections and the institution of appropriate therapy are critical to the long-term survival of these patients. Intravenous immunoglobulin in patients with CLL and hypogammaglobulinemia significantly decreases the number of bacterial infections and delays the onset of the first infection. IVIG has not been shown to prolong survival in patients with CLL and is not recommended in the absence of infections. Patients with CLL who required hospitalization for COVID-19 fared poorly, regardless of the stage of the disease.

Autoimmune hemolytic anemia and/or thrombocytopenia can occur in patients with any stage of CLL. Initial therapy involves corticosteroids with or without alkylating agents (fludarabine can worsen the hemolytic anemia). It is often necessary to control the autoimmune destruction with corticosteroids, if possible, before administering marrow-suppressive chemotherapy because it may be difficult for a patient to successfully receive a red blood cell or platelet transfusion. Alternate therapies include high-dose immune globulin, rituximab, cyclosporine, azathioprine, splenectomy, and low-dose radiation therapy to the spleen. Tumor lysis syndrome is an uncommon complication (presenting in 1 of 300 patients) of chemotherapy for patients with bulky disease.

Treatment-induced acute leukemias may also occur in a small percentage of patients. Transformation of CLL to diffuse large B-cell lymphoma (DLBCL) (known as Richter syndrome) occurs in 3% of CLL patients by 5 years and in 5% to 10% of CLL patients within their lifetime. Risk factors for transformation include unmutated IGH, TP53 or NOTCH1 mutations, CDKN2A/B loss, and complex karyotype. Up to 60% to 70% of patients develop a DLBCL clonally related to the CLL, and these patients have a significantly worse prognosis than patients with de novo DLBCL. Patients with a clonally unrelated DLBCL have a much better prognosis, which is similar to de novo DLBCL. However, there is limited availability for real-life sequencing of the immunoglobulin heavy chains in the original CLL sample to compare with the transformed sample. Characteristic molecular signatures may serve as an alternate way to assess prognosis. Up to 20% to 40% of patients with clonally related Richter syndrome are disease-free for more than 5 years after aggressive combination chemotherapy, typically R-CHOP (rituximab, cyclophosphamide, doxorubicin, vincristine, and prednisone) or Pola-R-CHP (polatuzumab, rituximab,

cyclophosphamide, doxorubicin, and prednisone), often followed by autologous or allogeneic stem cell transplant.

Secondary malignancy is a well-known long-term complication of chemotherapy. Survivors of leukemia and lymphoma treatment have an increased risk for developing a second cancer like bladder cancer compared with the general population. CLL is typically characterized by significant perturbations of the immune system, involving both innate and adaptive immune responses and leading to immune suppression from the early stages. Dysfunction of the immune system in turn increases the incidence of secondary malignancies and infections, which represent the major cause of morbidity and mortality for CLL patients.⁷ CLL alters the disease course of these secondary cancers. Inferior overall survival and cancer-specific survival was observed for several common cancers in patients with pre-existing CLL.⁸

BTK inhibitors are a type of drug that work to treat cancers caused by defective B cells, such as CLL where they are widely used. These medications have numerous drug interactions that may necessitate avoidance or dose adjustments. Toxicity is greatest during the first six months of treatment. After six months, patients experience cumulative toxicity, although at a lower rate. Common toxicities include infection, bleeding, diarrhea, and headache. Additional toxicities of clinical interest include arrhythmias, hypertension, infections, bleeding, and hepatotoxicity, including drug-induced liver injury. Pneumonitis and second primary malignancies are uncommon toxicities but can occur. Rare cases of hemophagocytic lymphohistiocytosis have been reported after exposure to BTK inhibitors. Because of these toxicities, BTK inhibitors are generally avoided in patients with cardiovascular disorders, uncontrolled hypertension, and/or a high risk for bleeding (eg, history of major bleeding). They also have to be held for three to seven days before and after surgery to mitigate the risk of perioperative bleeding.

Venetoclax is one of the preferred initial therapies for CLL/SLL. Venetoclax selectively inhibits the anti-apoptotic protein BCL-2, which is overexpressed in chronic lymphocytic leukemia (CLL) cells. BCL-2 mediates tumor cell survival and has been associated with chemotherapy resistance. Venetoclax binds directly to the BCL-2 protein, displacing pro-apoptotic proteins and restoring the apoptotic process, allowing for the death of the cancer cells. The most common toxicities with venetoclax include neutropenia, thrombocytopenia, anemia, diarrhea, nausea, upper respiratory tract infection, cough, musculoskeletal pain, fatigue, and edema and tumor lysis syndrome. Treatment with venetoclax is logistically complicated and follows a strict dose escalation to minimize the risk of tumor lysis syndrome, a life-threatening complication. Tumor lysis syndrome (TLS) is an oncologic emergency that is caused by massive tumor cell lysis with the release of large amounts of potassium, phosphate, and nucleic acids into the systemic circulation. Catabolism of the nucleic acids to uric acid leads to hyperuricemia; the marked increase in uric acid excretion can result in the precipitation of uric acid in the renal tubules and renal vasoconstriction, impaired autoregulation, decreased renal flow, oxidation, and inflammation, resulting in acute kidney injury. Hyperphosphatemia with calcium phosphate deposition in the renal tubules can also cause acute kidney injury. High concentrations of both uric acid and phosphate potentiate the risk of acute kidney injury because uric acid precipitates more readily in the presence of calcium phosphate and vice versa.

Monoclonal antibody directed against the CD20 antigen on the surface of B-lymphocytes are effective and widely used therapies against CLL/SLL. Significant adverse reactions include hepatitis B virus reactivation, hypogammaglobulinemia and Infection, infusion-related reactions, progressive multifocal leukoencephalopathy (PML). As a single-agent or combination with other therapies, many other side effects have been described.

Chemotherapy agents can be effective treatment for CLL. Some of the more common side effects caused by chemotherapy include fatigue, hair loss, easy bruising and bleeding, infection, anemia (low red blood cell counts), nausea and vomiting, appetite changes, constipation, diarrhea, mouth, tongue, and throat problems such as sores and pain with swallowing, peripheral neuropathy or other nerve problems, such as numbness, tingling, and pain, skin and nail changes such as dry skin and color change, urine and bladder changes and kidney problems, weight changes, chemo brain, which can affect concentration and focus, mood changes, changes in libido and sexual function, and fertility problems.

E. Demographics

CLL is more common in men, with a male to female ratio of approximately 1.2:1 to 1.8:1.⁹ The incidence rates among males and females in the United States are approximately 6.75 and 3.65 cases per 100,000 population per year, respectively.¹⁰ In Europe, these incidence rates are 5.87 and 4.01 cases per 100,000 population per year, respectively.¹¹ An estimated 20,700 new cases of CLL are diagnosed annually in the United States: 12,690 in males and 8010 in females.⁹ Worldwide, there are approximately 191,000 new cases and 61,000 deaths per year attributed to CLL.¹²

CLL is mainly a disease of older adults, with a median age at diagnosis of approximately 70 years.¹³ However, while the incidence rises steadily with increasing age, it is not unusual to make this diagnosis in younger adults (eg, from 30 to 39 years of age).¹⁴

The incidence of CLL varies by race and geographic location. In the United States, there is a higher incidence among White Americans compared with African Americans or Asian Pacific Islanders (API; as defined in the SEER database).^{10,14} The incidence of CLL is much lower in Asian countries, such as China and Japan, where it is estimated to occur at a frequency that is approximately 10 percent of that seen in Western countries.^{15–17} The incidence of CLL in Africa is not as low as it is in Asia.^{18,19}

F. Recognized Risk Factors

A risk factor is something that affects a person's chance of getting a disease like cancer. But risk factors don't tell us everything. Having a risk factor, or even many risk factors, doesn't mean that a person will get the disease. And some people who get the disease may not have had any known risk factors. Even if a person has a risk factor and develops cancer, it's not possible to calculate a precise percentage that the risk factor may have contributed to the cancer.

There are very few known risk factors for chronic lymphocytic leukemia (CLL). These include: age, exposure to certain chemicals, family history, gender and race/ethnicity. Age is difficult to study and not clear whether it is a risk factor or just a demographic since most patients diagnosed with CLL are over the age of 50 and the incidence of CLL is higher in older populations. Gender and race are similarly difficult to study and not clear whether they are risk factors or just demographic indicators. Family history: First-degree relatives (parents, siblings, or children) of people with CLL have more than twice the risk for this cancer. The risk of CLL does not seem to be linked to smoking, diet, or infections. Exposure to long-term pesticide use in farming has been associated with a higher risk of CLL. Exposure to certain chemicals is addressed in more detail in the following sections.²⁰ Agent Orange exposure during the Vietnam War has also been linked to NHL, however, the results are inconsistent across different studies, there is no clear pattern of increased risk with increased exposure, and the current data are not enough to definitively say that the exposure causes NHL.²¹

VI. VOLATILE ORGANIC COMPOUNDS (VOCs) AND CAMP LEJEUNE EXPOSURE

Volatile organic compounds (VOCs) are compounds that have a high vapor pressure and low water solubility. Many VOCs are human-made chemicals used and produced in the manufacture of paints, pharmaceuticals, and refrigerants. VOCs are typically industrial solvents, such as trichloroethylene (TCE); fuel oxygenates, such as methyl tert-butyl ether (MTBE); or by-products produced by chlorination in water treatment, such as chloroform. VOCs are also components of petroleum fuels, hydraulic fluids, paint thinners, and dry-cleaning agents, making them common groundwater contaminants.

Some volatile organic compounds (VOCs) known to cause leukemia and lymphoma include:

- **Benzene**
- **Tetrachloroethylene (PCE)**
- **Trichloroethylene (TCE)**

Certain VOCs, including benzene, can pose a lifetime cancer risk via different exposure routes (i.e., inhalation, oral, and dermal) and have been classified as known and probable human carcinogens by the United States Environmental Protection Agency (U.S. EPA), respectively. Based on compelling human and animal evidence, the U.S. EPA has estimated that exposure to 1 $\mu\text{g}/\text{m}^3$ of benzene and in the air over a lifetime would respectively cause 2.2–7.8 cases of leukemia and 13 cases of lung and nasopharyngeal cancers per million people.²² Both benzene and TCE are known to be both genotoxic and immunotoxic, which makes the combination effect of these two chemicals in the water at Camp Lejeune at least additive, if not synergistic.^{23,24}

U.S. Marine Corps Base Camp Lejeune in North Carolina was established in 1942. Specific volatile organic compounds (VOCs) were later discovered in the base's drinking water systems. The Agency for Toxic Substances and Disease Registry (ATSDR) has conducted several epidemiological studies to determine if Marines, Navy personnel, and civilians residing and working at Camp Lejeune were at increased risk for certain health effects due to exposure to water contaminated with VOCs.

I have independently reviewed the ATSDR epidemiological studies, as well as the ATSDR's Assessment of the Evidence.^{25–31} I also have read materials relating to general causation for benzene, TCE, and PCE, including the general causation reports of Drs. Felsher, Hu, Gilbert, Bird, and Mallon, which I rely on based on their experiences in the field of epidemiology. I conclude that it is more likely than not that there is a causal relationship between TCE, PCE, and benzene exposure at Camp Lejeune and CLL.

I have reviewed the New Jersey study conducted by Cohn et al. (1994)³², which reports that in areas with total volatile organic compound (VOC) concentrations above 20 ppb, there was an observed increased risk of Non-Hodgkin lymphoma (NHL) among women. The study further identified that exposure to trichloroethylene (TCE) at levels of 5 ppb was associated with an increased risk of NHL in both women and men. Additionally, exposure to tetrachloroethylene (PCE) at the same concentration level was linked to an increased risk of NHL, particularly high-grade NHL among women.

VII. ROBERT FIOLEK MEDICAL HISTORY

Robert Joseph Fiolek was born on [REDACTED] 1940. In 2014, he presented with an elevated white blood cell count (WBC) and was diagnosed with chronic lymphocytic leukemia (CLL).

In approximately December of 2015, he was treated with a combination of chlorambucil and obinutuzumab. He developed a severe infusion reaction to obinutuzumab but recovered and was able to complete therapy. He responded to the treatment as demonstrated by the decrease in the CLL cells in his body, but over time the CLL returned, and he required change in therapy.

In approximately September of 2016, he started therapy with ibrutinib with a good response to the cancer but developed severe side effects including bleeding, edema, atrial fibrillation, hospitalization necessitating extensive cardiac evaluations and treatment for atrial fibrillation including full dose anticoagulation. Ibrutinib is one of the BTK inhibitor drugs approved in the US for treatment of CLL. The side effects of ibrutinib can be severe but are well recognized and include cardiac complications. Due to the occurrence and severity of the toxicities, Mr. Fiolek's CLL was managed with dose reductions and interruptions of ibrutinib therapy followed by complete discontinuation of the drug.

During 2017 and part of 2018, his CLL maintained a partial remission off therapy. Partial remission (PR) is a response to treatment for chronic lymphocytic leukemia (CLL) where the number of CLL cells and lymph nodes decrease, but they are still detectable. Over time, these detectable CLL cells regrew.

In approximately October 2018 he started therapy with venetoclax with a good response. This new treatment was chosen to avoid the severe toxicities that happened with ibrutinib before.

In approximately March 2024, he was diagnosed with localized bladder cancer. A biopsy showed high-grade non-invasive urothelial carcinoma and pathology could not rule out muscular invasion. He was treated with transurethral resection of a bladder tumor (TURBT). Per his treating physician "the majority of the tumor was ablated". The pathological staging revealed two cancer sites, one on his bladder that was Stage I (pTaNOm0) using the AJCC 8th Edition and the second on his left distal ureter that was also Stage I. Computer tomography (CT) of his body revealed no evidence of metastatic disease. Following that, he received intravesical installation of the chemotherapy agent gemcitabine and, due to left-sided hydronephrosis he underwent a double-J ureteral stent placement. Intravesical gemcitabine, a bladder cancer treatment, involves administering a liquid containing the chemotherapy agent directly into the bladder to kill cancer cells. A catheter is inserted through the orifice of the penis into the bladder and left for a few hours to deliver the gemcitabine liquid into the bladder. This is repeated weekly for 6 weeks as induction therapy, followed by maintenance therapy approximately six weeks after completing the induction.

In approximately July 2024, he had recurrent localized bladder cancer and treated with transurethral resection of a bladder tumor followed by intravesical Bacillus Calmette-Guerin (BCG). Intravesical BCG is a treatment for bladder cancer that involves administering a liquid containing BCG into the bladder. BCG is a live bacterium that stimulates the immune system to attack bladder cancer cells. A catheter is inserted through the penis into the bladder and left for a couple of hours to deliver the BCG liquid into the bladder. The BCG causes inflammation in the bladder wall in order to activate the immune system to kill cancer cells. This is repeated every week for 6 weeks.

In approximately November 2024 he had persistent bladder cancer that was confirmed via cystoscopy and left ureteroscopy biopsy of ureteral tumor and treated with laser ablation of the cancer. As of the last record I had, he remained with persistent/potentially progressive disease in the left distal ureter that will require further therapy.

Mr. Fiolek's treatment for CLL and bladder cancer were both reasonable and necessary.

Since the diagnosis and treatment of CLL he suffered from multiple complications including:

12/01/2015 Severe infusion reaction to obinutuzumab (Gazyva).

11/10/2016-11/11/2016 Hospital Admission due to Rapid Atrial Fibrillation after starting Ibrutinib on 09/07/2016.

7/27/2017: #1 implantable loop recorder implantation flecainide, diltiazem and warfarin therapy.

5/07/2018: persistent atrial fibrillation.

6/04/2018-06/07/2018: Left heart catheterization with selective coronary angiography & Right heart catheterization with dofetilide therapy.

6/02/2020-06/03/2020: Transesophageal Echocardiogram, Pulmonary vein isolation with cryoablation therapy and radiofrequency catheter ablation for typical atrial flutter.

6/18/2021 #1 Removal of implanted loop recorder due to EOL and #2 insertion of new Implanted loop recorder.

2/11/2022 Severe symptomatic low gradient aortic stenosis and heart failure with preserved ejection fraction.

1/06/2017 Mild esophageal dysmotility.

3/2017 Right hand swelling and lymphedema (related to taking ibrutinib).

5/2017-06/2017 Month long Throat infection: fungal and bacterial. Treated with Clotrimazole, Diflucan, Ceftin and Cefuroxime.

5/03/2017-06/14/2017 Nonhealing scalp wound, Staph Aureus (+) after a mechanical fall that required antibiotics, excisional debridement, and wound care.

8/27/2021: Port obstruction.

4/15/2022-04/17/2022 Hospital Admission due to Pulmonary Embolism

2024 Persistent and progressive invasive bladder carcinoma despite local resections, intravesical BCG and intravesical chemotherapy.

His risk factors for CLL included contaminated water at Camp Lejeune and potential agent orange exposure while in Vietnam, but I do not consider agent orange a risk factor in this case because Mr. Fiolek stated he was not directly exposed to agent orange and there are no military records to the contrary. Being a man over the age of 50 placed him within the demographics for CLL.

Mr. Fiolek's sister Joanie was diagnosed with Acute Lymphocytic Leukemia, which Mr. Fiolek believes was the cause of her death.^{FN 1}

Mr. Fiolek's mother, Genevieve Potter, died from bladder cancer.^{FN 2} His father passed away due to acute alcoholism.^{FN 3}

Mr. Fiolek started smoking when he was 16 years old and continued until around 1970. In the early 1970s, he quit smoking and never resumed. Typically, he smoked about one pack a day, although occasionally, his consumption increased to a pack and a half a day. Mr. Fiolek describes his alcohol intake as casual, typically having two or three drinks a week, usually wine with dinner.

In August 2014, around the time of his CLL diagnosis, Mr. Fiolek's BMI was 36.77.

VIII. ROBERT FIOLEK EXPOSURE HISTORY

Mr. Fiolek was first present at Camp Lejeune from November 10, 1961, until January 14, 1962, for infantry training at Camp Geiger.^{FN 4} After this training, he was not at Camp Lejeune again until he returned from September 4, 1964, until October 9, 1964, and during this time he worked at Hadnot Point (which included field training each time he worked at Hadnot Point) and resided in barracks at Hadnot Point.^{FN 5} From October 10, 1964, until November 27, 1964, he was aboard USS Boxer.^{FN 6} Upon his return, from November 28, 1964, until December 19, 1964, he worked at Hadnot Point and resided in barracks at Hadnot Point.^{FN 7}

He was on leave from December 20, 1964, until January 10, 1965, then returned to Camp Lejeune, but moved to off-base housing.^{FN 8} From January 11, 1965, until March 15, 1965, he worked at Hadnot Point and lived off base.^{FN 9} He was on leave again from March 16, 1965, until March 30, 1965, and then from March 31, 1965, until July 13, 1965, he worked at Hadnot Point and lived off base.^{FN 10} He was on leave from July 14, 1965, until July 24, 1965, and then from July 25, 1965, until August 2, 1965, he worked at Hadnot Point and lived off base.^{FN 11} Then he left Camp Lejeune to attend language school.^{FN 12}

¹ Fiolek Dep. 93:18-94:3.

² Fiolek Dep. 87:2-9.

³ Fiolek Dep. 88:18-89:3.

⁴ 00062_FIOLEK_NARA_0000000045-46; 00063_FIOLEK_NARA_0000000055; Fiolek Dep. 107:23-108:17.

⁵ 00062_FIOLEK_NARA_0000000045-46; 00062_FIOLEK_NARA_0000000055; 00062_FIOLEK_NARA_0000000021; Fiolek Dep. 30:15-18; 42:5-17; 111:4-112:23; 114:4-116:1.

⁶ 00063_FIOLEK_NARA_0000000021.

⁷ 00062_FIOLEK_NARA_0000000045-46; 00063_FIOLEK_NARA_0000000055; 00063_FIOLEK_NARA_0000000025.

⁸ 00063_FIOLEK_NARA_0000000045; Fiolek Dep. 124:22-126:7.

⁹ 00063_FIOLEK_NARA_0000000045; Fiolek Dep. 124:22-126:7.

¹⁰ 00063_FIOLEK_NARA_0000000250; 00063_FIOLEK_NARA_0000000045; Fiolek Dep. 124:22-126:7.

¹¹ 00063_FIOLEK_NARA_0000000250; 00063_FIOLEK_NARA_0000000045; Fiolek Dep. 124:22-126:7.

¹² 00063_FIOLEK_NARA_0000000045; Fiolek Dep. 128:12-21.

When Mr. Fiolek returned to Camp Lejeune, he worked at Montford Point (which included field training each time he worked at Montford Point) and lived off base from September 15, 1966, until June 1, 1967, except for a one-day off-base training on February 17, 1967.^{FN 13} Then he moved to on-base housing at Tarawa Terrace, and from June 2, 1967, until June 19, 1967, he worked at Montford Point and lived at Tarawa Terrace.^{FN 14} He was on leave from June 20, 1967, until June 29, 1967, and then from June 30, 1967, until September 1, 1967, he worked at Montford Point and lived at Tarawa Terrace.^{FN 15} He was on leave from September 2, 1967, until September 14, 1967, and then from September 15, 1967, until March 11, 1968, he worked at Montford Point and lived at Tarawa Terrace.^{FN 16} Then he left Camp Lejeune on March 12, 1968, to attend additional training before deploying to Vietnam.^{FN 17} While in Vietnam, Mr. Fiolek served as a translator/interrogator and worked in intelligence gathering. This role was primarily desk-based, and he did not participate in combat activities or field training where he might have been exposed to Agent Orange.^{FN 18}

When Mr. Fiolek returned to Camp Lejeune, he worked at Montford Point and lived in barracks, but it is unclear where on base these barracks were located. Fiolek Dep. 141:7-143:10. He was on base from April 19, 1969, until May 9, 1969, on leave from May 10, 1969, until June 10, 1969, then back on base from June 11, 1969, until June 12, 1969, his last day stationed at Camp Lejeune.^{FN 19} Mr. Fiolek occasionally visited Camp Lejeune after leaving the base, but dates and details are unknown.^{FN 20}

Below is the timeline of Mr. Fiolek's dates on base at Camp Lejeune.

Work	Residence	Start Date	End Date	Days
Camp Geiger	Camp Geiger	11/10/1961	1/14/1962	66
Hadnot Point	Barracks	9/4/1964	10/9/1964	36
Hadnot Point	Barracks	11/28/1964	12/19/1964	22
Hadnot Point	Off base	1/11/1965	3/15/1965	64
Hadnot Point	Off base	3/31/1965	7/13/1965	105
Hadnot Point	Off base	7/25/1965	8/2/1965	9
Montford Point	Off base	9/15/1966	2/16/1967	155

¹³ 00063_FIOLEK_NARA_0000000045; Fiolek Dep. 130:5-131:1; 131:8-133:21.

¹⁴ Fiolek Dep. Ex. 4; Fiolek Dep. 31:22-34:18; 136:3-7; 136:24-137:4.

¹⁵ 00063_FIOLEK_NARA_0000000250; Fiolek Dep. Ex. 4; Fiolek Dep. 31:22-34:18; 136:3-7; 136:24-137:4.

¹⁶ 00063_FIOLEK_NARA_0000000250; Fiolek Dep. Ex. 4; Fiolek Dep. 31:22-34:18; 136:3-7; 136:24-137:4.

¹⁷ 00063_FIOLEK_NARA_0000000045; Fiolek Dep. 139:9-12.

¹⁸ Fiolek Dep.129:18-130:3, 146:21-147:24.

¹⁹ 00063_FIOLEK_NARA_0000000046.

²⁰ Fiolek Dep. 152:15-153:11.

Montford Point	Off base	2/18/1967	6/1/1967	104
Montford Point	Tarawa Terrace	6/2/1967	6/19/1967	18
Montford Point	Tarawa Terrace	6/30/1967	9/1/1967	64
Montford Point	Tarawa Terrace	9/15/1967	3/11/1968	179
Montford Point	Barracks	4/19/1969	5/9/1969	21
Montford Point	Barracks	6/11/1969	6/12/1969	2

Mr. Fiolek consumed a substantial amount of water while stationed on base. His water sources included the kitchen tap, drinking fountains, water buffalos, and the bathroom sink. As a Marine engaged in frequent field training, often for extended durations, he needed to drink ample water for hydration. Additionally, Mr. Fiolek utilized the base's swimming pools and showered daily, occasionally twice a day.

According to the ATSDR tables and as cited in the Expert Report by Morris Maslia, the monthly mean concentration levels of TCE at Hadnot Point during Mr. Fiolek's time on base varied between 19 and 32 µg/L, while Benzene levels consistently remained around 1 µg/L each month. At Tarawa Terrace, where Mr. Fiolek resided during much of his time on base, PCE concentration levels ranged from 44 to 54 µg/L.

I have reviewed the expert report by Dr. Kelly Reynolds, which estimates the ingested exposure for Mr. Fiolek. Based on his deposition testimony and substantial time spent on base, Mr. Fiolek would have also experienced significant exposure to the contaminated water at Camp Lejeune through both dermal and inhalation routes. For instance, Mr. Fiolek showered daily, sometimes twice a day. If he showered for a total of ten minutes, it would approximate the same level of exposure to the VOCs in the water as drinking 2 liters of water.^{25,33} Given that he lived and worked on base and was exposed nearly daily to the VOCs, Mr. Fiolek would have had substantial exposure during his time stationed at Camp Lejeune.

IX. ANALYSIS AND OPINIONS

As detailed above, current medical literature supports a causal relationship between exposure to VOCs in the water at Camp Lejeune and CLL. Mr. Fiolek had substantial exposure to contaminated Camp Lejeune water, and this exposure was sufficient to be a substantial contributing factor to his CLL.

The prevailing scientific consensus is that cancer is caused by the interaction of multiple factors, including genetic, environmental, or constitutional characteristics of the individual.

After conducting the differential etiology analysis contained in this report, it is my professional opinion, to a reasonable degree of medical certainty, that Mr. Fiolek's exposure to the contaminants in the Camp Lejeune water is more likely than not (which exceeds the at least as likely as not standard in this case) the cause of his CLL. My opinion is that, after considering other potential causes of CLL besides Mr. Fiolek's exposure to the contaminated water at Camp Lejeune, none are significant contributors. Mr. Fiolek did not have any other significant risk factor for CLL besides being a man over the age of 50. Even

though he was in Vietnam during the time when agent orange was used, he was not involved in field operations where he could have been directly exposed to it. Further, he testified that he does not recall ever being exposed to agent orange. Moreover, the literature on Agent Orange and NHL has not demonstrated a consistent association or a causal relationship between exposure to the chemical and lymphoid cancers.

Mr. Fiolek did smoke during his younger years; however, he ceased smoking several decades prior to his diagnosis. Additionally, he consumed an average of two to three glasses of wine per week. I do not consider these to be risk factors for CLL. As previously discussed, neither smoking nor alcohol consumption are established risk factors for CLL. While Mr. Fiolek does have some family history of cancer including a sister with ALL, a condition that has not been demonstrated to be a risk factor for CLL. I am not aware of any first-degree relatives who have been diagnosed with CLL.

Mr. Fiolek's medical records indicate he was obese. Obesity is known to heighten the risk of various diseases, including cancers. In Mr. Fiolek's case, his obesity likely contributed to an elevated risk for developing cancer. It is a recognized risk factor for cancer and Non-Hodgkin lymphoma (NHL), operating through pathways such as increased inflammation and compromised immune function. For Mr. Fiolek, it is at least as likely as not that his obesity heightened his vulnerability to cancer by impairing his body's capacity to counteract carcinogenic processes. Additionally, obesity can enhance susceptibility to the effects of environmental carcinogens.

Mr. Fiolek developed high-risk invasive bladder cancer following his CLL diagnosis and treatment, and his treatment for that cancer is ongoing. It is well known that prior chemotherapy and CLL both predispose patients to secondary malignancies. In addition, it is very likely that the intravesical BCG and the intravesical chemotherapy gemcitabine were not effective for Mr. Fiolek due to the presence of immune dysregulation of his CLL and the increased resistance to therapy in secondary malignancies as compared to primary ones. Failure to achieve a complete response after induction BCG is associated with a significant risk of a worsening event and death for patients with CIS or Ta or T1 bladder cancer at increased risk of recurrence.³⁴

While Mr. Fiolek has responded to therapy, unfortunately, he suffers from an incurable disease. Mr. Fiolek will need ongoing cancer surveillance and therapies for the rest of his life, with expected toxicities, side effects, and costs. He remains at higher risk than the normal population of developing severe infections that will likely limit his ability to work and have a normal life. He will require visits to his oncologist approximately every 3 months, laboratory testing, imaging tests, molecular evaluations, possible biopsies and other therapies with the potential complications, toxicities, and cost. It is also my opinion that his CLL diagnosis is likely to result in his premature death.

Sincerely yours,



2/7/2025

Damian A. Laber, MD, FACP
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Moffitt Cancer Center
Professor of Medicine and Oncologic Sciences
University of South Florida

X. REFERENCE LIST

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XI. ADDITIONAL MATERIALS CONSIDERED

1. Expert Reports

1. Expert Report of Morris L. Maslia, P.E., D.WRE, DEE, Fellow EWRI - October 25, 2024
2. General Causation Expert Report of Dean W. Felsher, MD, PHD. [Leukemia, and Non-Hodgkin lymphoma] - December 9, 2024
3. General Causation Expert Report of Howard Hu, MD, MPH, SC. D. - December 9, 2024

4. General Causation Expert Report of Kathleen M. Gilbert, PHD. [TCE, Non-Hodgkin Lymphoma, and Leukemia] - December 9, 2024
5. General Causation Expert Report of Lukasz Gondek, MD, PhD. [Leukemia] - December 9, 2024
6. General Causation Expert Report of Steven B. Bird, MD. [Hematopoietic Cancers: Leukemia & Non-Hodgkin's Lymphoma] - December 9, 2024
7. Specific Causation Expert Report of Kelly Reynolds, MSPH, PhD – February 7, 2025

2. Plaintiff Deposition Materials

1. Deposition Transcript – Robert Fiolek (Plaintiff) Vol. I – February 8, 2024, and accompanying exhibits
2. Deposition Transcript – Robert Fiolek (Plaintiff) Vol. II – January 30, 2025, and accompanying exhibits
3. Deposition Transcript – Walter Wardell, M.D. (Treating Physician) - August 13, 2024, and accompanying exhibits
4. Deposition Transcript – Jeraldine Fiolek (Fact Witness) – April 25, 2024, and accompanying exhibits

3. Plaintiff Medical Records

1. Carolina East Medical Center, 00062_FIOLEK_0000001025 - 00062_FIOLEK_0000005642
2. UNC Health, 00062_FIOLEK_0000010548 - 00062_FIOLEK_0000010623
3. Coastal Carolina Health Care, 00062_FIOLEK_CCHC_0000000001 - 00062_FIOLEK_CCHC_0000000901
4. Carolina East Medical Center, 00062_FIOLEK_CEMC_0000000001 - 00062_FIOLEK_CEMC_0000000842
5. Carolina East Medical Center, 00062_FIOLEK_CEMC_0000000942- 00062_FIOLEK_CEMC_0000004436
6. VA Medical Records - 00062_FIOLEK_VHA_0000000001-00062_FIOLEK_VHA_0000000051
7. Carolina East Medical Center - 00062_FIOLEK_0000010458 - 00062_FIOLEK_0000010495
8. Military Medical Records - 00062_FIOLEK_0000000062 - 00062_FIOLEK_0000000087

9. Dr. Ellen Huffman-Zechman - 00062_FIOLEK_0000000271 - 00062_FIOLEK_0000000275
10. Craven Regional Medical Center - 00062_FIOLEK_0000000308-00062_FIOLEK_0000000313
11. VERIS Exam Request - 00062_FIOLEK_0000000267-00062_FIOLEK_0000000268
12. QTC Medical Services - 00062_FIOLEK_0000000250-00062_FIOLEK_0000000253
13. QTC Medical Services - 00062_FIOLEK_0000000258 - 00062_FIOLEK_0000000261
14. Coastal Orthopaedics and Spinal Surgery - 00062_FIOLEK_0000000284 -
00062_FIOLEK_0000000291
15. Carteret General Hospital - 00062_FIOLEK_0000000262 - 00062_FIOLEK_0000000266
16. Dr. Ellen Ruth Huffman-Zeichman - 00062_FIOLEK_0000000280-00062_FIOLEK_0000000283
17. Dr. Ellen Ruth Huffman-Zeichman - 00062_FIOLEK_0000000276-00062_FIOLEK_0000000279
18. Dr. Mark W Heffington - 00062_FIOLEK_0000000254-00062_FIOLEK_0000000257
19. VA Benefits Decision- 00062_FIOLEK_0000000330
20. VA Examination - 00062_FIOLEK_0000000269 - 00062_FIOLEK_0000000271
21. Craven Region Medical Center - 00062_FIOLEK_0000000292 - 00062_FIOLEK_0000000307
22. Carolina East Physicians - 00062_FIOLEK_0000000207 - 00062_FIOLEK_0000000249
23. VA Medical Records - 00062_FIOLEK_0000000320 - 00062_FIOLEK_0000000325
24. Military Medical Records - 00062_FIOLEK_0000000134 - 00062_FIOLEK_0000000143
25. Military Medical Records - 00062_FIOLEK_0000000165 - 00062_FIOLEK_0000000186
26. VA Dental Rating - 00062_FIOLEK_0000000329
27. Military Medical Records - 00062_FIOLEK_0000000090 - 00062_FIOLEK_0000000133
28. Military Medical Records – 00062_FIOLEK_000000008 - 00062_FIOLEK_0000000061
29. Orthopedic Meical Group - 00062_FIOLEK_0000000314 - 00062_FIOLEK_0000000319
30. Military Medical Records - 00062_FIOLEK_0000000187 - 00062_FIOLEK_0000000206

31. QTC Medical Records - 00062_FIOLEK_0000000004 - 00062_FIOLEK_0000000007
32. Military Medical Records - 00062_FIOLEK_0000000144 - 00062_FIOLEK_0000000165
33. VA Dental Record - 00062_FIOLEK_0000000326 - 00062_FIOLEK_0000000328
34. Carolina East Medical Center - 00062_FIOLEK_0000010629 - 00062_FIOLEK_0000010987
35. Carolina East Internal Medicine - 00062_FIOLEK_CEMC_0000010354 - 00062_FIOLEK_CEMC_0000010513
36. Carolina East Medical Center 00062_FIOLEK_CEMC_0000010514 - 00062_FIOLEK_CEMC_0000010874

4. Military Records

1. VA Claim 00062_FIOLEK_000000049 - 00062_FIOLEK_0000000050
2. Robert Fiolek ITT Training & Duty

5. Plaintiff Profile Form & Short Form Complaint

1. Robert Fiolek Discovery Pool Profile Form, 00062_FIOLEK_DPPF_000000001-00062_FIOLEK_DPPF_0000000014
2. Robert Fiolek Short Form Complaint - Filed March 15, 2024

In addition to the materials listed here, I have considered all further materials referenced within this report.

All facts and data listed herein are either identified by bates number or are publicly available to and accessible by Defendant United States of America.

Dr. Laber reserves the right to review and consider additional facts, data and publications;

Dr. Laber reserves the right to consider the report of any other witness in this action; and

Dr. Laber reserves the right to supplement this list of reliance files.

Exhibit 1

CURRICULUM VITAE

August 2, 2022

NAME:

DAMIAN A. LABER, M.D., F.A.C.P.

CURRENT POSITIONS:

Senior Member, Tenured
Section Chief of Moffitt Medical Group at TGH
Department of Satellite and Community Oncology
Moffitt Cancer Center

Professor of Medicine and Oncologic Sciences
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EDUCATION:

UNDERGRADUATE EDUCATION AND HIGH SCHOOL:

Colegio Nacional de Buenos Aires Buenos Aires, Argentina	Bachelor in Sciences	1981-1986
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CONTINUED

POSTGRADUATE EDUCATION:

University of Buenos Aires Buenos Aires, Argentina	M.D.	3/1987-1/1992
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POSTGRADUATE PROFESSIONAL TRAINING:

Huron Hospital Cleveland Clinic Health System, Cleveland, Ohio	Intern in Internal Medicine	7/1994-6/1995
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Huron Hospital Cleveland Clinic Health System, Cleveland, Ohio	Resident in Internal Medicine	7/1995-6/1997
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Hillcrest & Southpointe Hospital Cleveland Clinic Health System, Cleveland, Ohio	Chief Resident	6-12/1996
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Fred Hutchinson Cancer Research Center Seattle, Washington	Bone Marrow Transplant Resident	11/1995
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Baylor College of Medicine Houston, Texas	Fellow in Hematology/Oncology	7/1997-6/2000
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U.T. M.D Anderson Cancer Center Houston, Texas	Fellow in Hematology/Oncology	9/1998-2/1999
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ACADEMIC AND PROFESSIONAL EXPERIENCE:

ACADEMIC APPOINTMENTS:

Senior Member (Tenured)	Moffitt Cancer Center Tampa, Florida	2014-current
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Chief Section of Satellite Oncology at Tampa General Hospital	Moffitt Cancer Center Tampa, Florida	2014-current
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Damian A. Laber, M.D., F.A.C.P.
Page 3

Professor of Oncologic Sciences	University of South Florida Tampa, Florida	2014-current
Professor of Medicine	University of South Florida Tampa, Florida	2013-current
Director of the Division of Hematology and Medical Oncology	University of South Florida Tampa, Florida	2013-current
Co-Director of the Hemophilia Treatment Center	University of South Florida Tampa, Florida	2013-current
Professor of Medicine (Endowed) Gussman Chair in Internal Medicine	The University of Oklahoma Tulsa, Oklahoma	2010-2012
Director of the OU Tulsa Cancer Center	The University of Oklahoma Tulsa, Oklahoma	2010- 2012
Chief of the Section of Hematology and Medical Oncology	The University of Oklahoma Tulsa, Oklahoma	2010- 2012
Associate Professor of Medicine (Tenured)	University of Louisville Louisville, Kentucky	2007-2010
Scientist	James Graham Brown Cancer Center Louisville, Kentucky	2001-2010
Director, Genitourinary Cancer Clinical Research Program	University of Louisville James Graham Brown Cancer Center Louisville, Kentucky	2001-2010
Director, Hematology and Medical Oncology Fellowship Program	University of Louisville James Graham Brown Cancer Center Louisville, Kentucky	2001-2010
Associate Faculty, Clinical Research, Epidemiology and Statistics Training Program (CREST)	University of Louisville School of Public Health and Information Sciences Louisville, Kentucky	2003-2010

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Damian A. Laber, M.D., F.A.C.P.
Page 4

Assistant Professor of Medicine	University of Louisville Louisville, Kentucky	2001-2006
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HOSPITAL APPOINTMENTS:

Staff Physician	Tampa General Hospital Tampa, Florida	2013-current
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Staff Physician	Hillcrest Medical Center Tulsa, Oklahoma	2010-2012
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Staff Physician	Saint Francis Hospital Tulsa, Oklahoma	2010-2012
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Staff Physician	St. John Medical Center Tulsa, Oklahoma	2010-2012
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Staff Physician	University of Louisville Hospital Louisville, Kentucky	2001-2010
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Staff Physician	Norton Hospital Louisville, Kentucky	2001-2010
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Staff Physician	Jewish Hospital Louisville, Kentucky	2001-2010
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Staff Physician	Veterans Affairs Medical Center Louisville, Kentucky	2001-2010
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Staff Physician	Taylor Regional Hospital Campbesville, Kentucky	2001-2008
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TEACHING:

SELECTED EDUCATIONAL ACTIVITIES:

Core Faculty, Hematology/Oncology Fellowship Moffitt Cancer Center and University of South Florida	2013-current
Lecturer, Hematology/Oncology Fellowship Core Curriculum Moffitt Cancer Center and University of South Florida	2013-current
Lecturer, Internal Medicine Lecture Series Department of Medicine, University of South Florida	2013-current
Lecturer, Leadership Enhancement and Development Medicine International, University of South Florida	2015-current
Lecturer, Hematology Case Conference series Tampa General Hospital and Section of Satellite Oncology, Moffitt Cancer Center	2018-current
Lecturer, Hematology Pathology Case Conference series Tampa General Hospital and Section of Satellite Oncology, Moffitt Cancer Center	2018-current
Lecturer, Hematology/Oncology Journal Club Tampa General Hospital and Section of Satellite Oncology, Moffitt Cancer Center	2018-current
Expert Discussant, CME Accredited: USF-TGH GU Tumor Board Tampa General Hospital and University of South Florida	2019-current
Expert Discussant, CME Accredited: Tampa General Hospital GI Tumor Board Tampa General Hospital and University of South Florida	2019-current
Expert Discussant, CME Accredited: USF-TGH Head & Neck Tumor Board Tampa General Hospital and University of South Florida	2019-current
Expert Discussant, CME Accredited: TGH/USF Thoracic Tumor Board Tampa General Hospital and University of South Florida	2019-current
Faculty Leader, Hematology/Oncology Writing Club Moffitt Cancer Center and University of South Florida	2021-current

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Damian A. Laber, M.D., F.A.C.P.

Page 6

Faculty Leader, Community Medicine Academy The University of Oklahoma, School of Community Medicine	2010-2012
Faculty and Mentor, Internal Medicine Residency Program The University of Oklahoma, Tulsa	2010-2012
Faculty, Summer Institute The University of Oklahoma, School of Community Medicine	2010-2012
Director of the Hematology and Medical Oncology Fellowship Program University of Louisville, Louisville, KY	2001-2010
Faculty, PHCI 626 Clinical Trials III: Practicum in Clinical Trials Clinical Research, Epidemiology and Statistics Training (CREST) Program National Institutes of Health Clinical Research Curriculum Award (K30) School of Public Health and Information Sciences, University of Louisville	2003-2010
Faculty, BIOC-675/875 Cancer Biology Course Graduate Program, Department of Molecular Biology, University of Louisville	2005-2010
Organizer and moderator of the Writing Club J. G. Brown Cancer Center, University of Louisville	2004-2010
Moderator, Hematology Grand Rounds J. G. Brown Cancer Center, University of Louisville	2001-2010
Moderator, Multi-Modality Conference J. G. Brown Cancer Center, University of Louisville	2001-2010
Moderator, Tumor Conference J. G. Brown Cancer Center, University of Louisville	2001-2010
Organizer, moderator and presenter of the Fellows Conference J. G. Brown Cancer Center, University of Louisville	2001-2010
Lecturer, Internal Medicine Lecture Series Department of Medicine, University of Louisville	2001-2010

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Damian A. Laber, M.D., F.A.C.P.

Page 7

Lecturer, Primary Care Clerkship—Integrated Lecture Series School of Medicine, University of Louisville	2001-2010
Course Director, 2007 Annual Louisville Update in Oncology, ASCO Review Galt House East, Louisville, KY	9/08/2007
Course Director, Second Annual Louisville Update in Oncology, ASCO Review The Marriott Hotel, Louisville, KY	7/15/2006
Course Director, Second Annual Louisville Update in Hematology The Marriott Hotel, Louisville, KY	2/26/2005
Course Director, First Annual Louisville Update in Oncology, ASCO Review The Camberley Brown Hotel, Louisville, KY	2/04/2006
Faculty, Progress in the Treatment of Colorectal Cancer Norton Hospital, Louisville, KY	3/19/2005
Course Director, First Annual Louisville Update in Hematology The Camberley Brown Hotel, Louisville, KY	2/26/2005
Organizer and moderator of the Oncology Clinical Trials Conference J. G. Brown Cancer Center, University of Louisville	2003-2004
Organizer and moderator of the Genitourinary Tumor Board J. G. Brown Cancer Center, University of Louisville	2002-2003
Organizer and moderator of the Cancer Genetics Program J. G. Brown Cancer Center, University of Louisville	2001-2002
Moderator, organizer and coordinator of the Fellows Journal Club Baylor College of Medicine, Houston, Texas	1998-2000
Moderator and presenter at the “International visiting physician educational program: The contemporary management of the patient with breast cancer” Baylor College of Medicine, Houston, Texas	11/10/1999

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Damian A. Laber, M.D., F.A.C.P.

Page 8

Moderator and presenter at the “International visiting physician educational program: The contemporary management of the patient with breast cancer” 10/15/1999
Baylor College of Medicine, Houston, Texas

Moderator and presenter at “ASCO Update” 7/14/1999
Houston, Texas

Moderator and presenter “Combined Modality Therapy for Stage III NSCLC” 2/23/1999
Houston, Texas

Moderator of the Multi-disciplinary Oncology Tumor Board 1998
Ben Taub General Hospital, Houston, Texas

MENTORING FACULTY

Jennifer Eatrides	Moffitt Cancer Center	2018-current
Mintallah (Menna) Haider	Moffitt Cancer Center	2017-current
Ankita Patel, MD Faculty	Moffitt Cancer Center	2014-current
Michael Jaglal, MD Faculty	Moffitt Cancer Center	2014-current

MENTOR - INSTRUCTOR OF VISITING SCHOLARS

Shujun Xiao, Medical-PhD Student, Lanzhou University, China	2019
Cheng Juan, MD, Associate Chief Physician The First Hospital of Lanzhou University, China	2019
Junfeng Jiang, MD, China	2018
Xi Xia Pei, MD, China	2018
Lina Zhou, MD, China	2018
Yanyan Xie, MD, China	2017
Yingang Xiao, MD, China	2017
Mingbin Chen, MD, PhD, Chief Physician Department of Oncology Kunshan First People’s Hospital Affiliated to Jiangsu University, China	2017
Wu Chongyang, Associate Chief Physician Oncology, Oncology Department Second Hospital of Lanzhou University, China	2016
Wei Yan, Director Oncology, Oncology Department Guigang City People’s Hospital, China	2016

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Damian A. Laber, M.D., F.A.C.P.

Page 9

Zhou Shaozhang, Deputy Chief Oncology, Second Department of Chemotherapy Tumor Hospital Of Guangxi Zhuang Autonomous Region, China	2016
Zhihui Liu, MD, Deputy Chief Physician, Chemotherapy Department The Affiliated Tumor Hospital of Guangxi Medical University, China	2015

MENTORING HEMATOLOGY AND MEDICAL ONCOLOGY FELLOWS

Anthony Wood, MD	2020-current
Julian A Marin Acevedo, MD	2019-2022
Jennifer M Logue, MD	2018-2021
Ariel Grajales-Cruz, MD	2017-2020
D Alan Kerr, MD, PhD	2016-2019
Laidy Isenalumhe, MD	2015-2018
Jennifer Eatrides, MD	2015-2018
Jose D. Sandoval Sus, MD	2014-2017
Blakely D. Kute, MD	2010-2010
Alireza Abdolmohammadi, M.D.	2010-2010
Fatima S. Raza, M.D.	2010-2010
Nagendra Natarajan, M.D.	2009-2010
Cesar Rodriguez-Valdez, M.D.	2009-2010
Raul Storey, M.D.	2009-2010
Michael Driscoll, M.D.	2008-2010
Wenqing Zhang, M.D., Ph.D.	2008-2010
Dong Xiang, M.D., Ph.D.	2008-2010
Mohamad Janjua, M.D.	2007-2010
Fadi Kayali, M.D.	2007-2010
Amir Harandi, M.D.	2006-2009
Gullierme Rabinowits, M.D.	2006-2009
Arash Rezazedah, M.D.	2006-2009
M. Iltaf Khan, M.D., Ph.D.	2005-2008
Mian Mushtaq, M.D.	2005-2008
Padmini Moffett, M.D.	2005-2008
Wangjiang Zhong, M.D., Ph.D.	2005-2008
Carlos Arce-Lara, M.D.	2004-2005
Stephanie Wagner, M.D.	2004-2007
Monte E. Martin, M.D.	2004-2007
Fadi Hayek, M.D.	2003-2006
Stephen Makoni, M.D.	2003-2006

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Simeon Jaggernauth, M.D.	2003-2005
Ifeoma Roseline Okeke, M.D.	2003-2005
Muneeb A. Choudry, M.D.	2002-2005
Yi Feng, M.D., Ph.D.	2001-2004
Carolina Salvador, M.D.	2001-2004
Yasonda Devabhaktuni, M.D.	2001-2004
Goetz H. Kloecker, M.D., MSPH	2001-2004
Apurva C. Mehta, M.D.	2002-2003
Dilawar Khan, M.D.	2000-2003
Mary Li, M.D., Ph.D.	2000-2002

MENTORING INTERNAL MEDICINE RESIDENTS

Constantine Logothetis, M.D.	2020-2022
Monte E. Martin, M.D.	2001-2004

MENTORING STUDENTS - OBSERVERS

Charles Seifer, Student. Medical Doctor, USF	2021
Saif Zaman, Student. Medical Doctor, USF	2021-current
Cheri Hines, Student Biomedical Sciences and Arts in Psychology, USF	2019-2020
Martha Williams, Student Public Health and Biomedical Sciences, USF	2019
Danielle Curtis, Student Cell & Molecular Biology and Public Health, USF	2018-2019
Zain Rahmat, Student in Biomedical Sciences, University of South Florida	2017
Martha Chavez, Student in Biomedical Sciences, University of South Florida	2016
Rehan Muhammad, Masters student, Morsani College of Medicine, USF	2015
Daniel Ross, Medical Student, Morsani College of Medicine USF	2013-2015

MEDICAL LICENSURES:

Florida State	2013-Present
Indiana State	1999-Present
Drug Enforcement Administration (DEA)	2000-Present

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BOARD CERTIFICATIONS:

Diplomate, ABIM Subspecialty Medical Oncology (Re-certified 2011 and 2021)	2001-2031
Diplomate, ABIM Subspecialty Hematology (Re-certified in 2010 and 2020)	2000-2030
Diplomate, American Board of Internal Medicine (Re-certified in 2008)	1997-2018

PROFESSIONAL SOCIETIES:

American Society of Clinical Oncology	1999-Present
American Society of Hematology	2002-Present
American College of Physicians (Fellow 2005)	1994-Present
American Society of Internal Medicine	1994-Present
European Hematology Association	2006-Present
Greater Louisville Medical Society, Kentucky	2001-2012
American Medical Association	2001-2012
Southwest Oncology Group	2001-2010

EDITORIAL BOARDS, ADVISORY COUNCILS AND COMMITTEES - SERVICE

EDITORIAL BOARD:

Cureus Journal of Medical Science	Reviewer	2022-current
Medical Sciences	Reviewer	2021-current
IMpact	Editor	2018-current
Journal of Cancer Prevention & Current Research	Editor	2014-2018
Cancer Control Journal	Reviewer	2014-2018
Indian Journal of Medical Research	Reviewer	2016
Chemotherapy	Reviewer	2008
The Journal of Urology	Reviewer	2007
Southern Medical Journal	Reviewer	2007
Annals of Internal Medicine	Reviewer	2006
Thrombosis and Haemostasis	Reviewer	2005
Canadian Medical Association Journal	Reviewer	2005
Archives of Internal Medicine	Reviewer	2004
Archives of Pathology	Reviewer	2004
ABIM Subspecialty Oncology	Reviewer	2001

CONTINUED

ABIM Subspecialty Hematology	Reviewer	2001
Bone Marrow Transplantation	Reviewer	2000

COMMITTEES:

Chair, Moffitt Medical Group Faculty Committee at TGH Section of Satellite Oncology, Moffitt Cancer Center, Tampa, FL		2014-current
Member, Internal Medicine Division Directors Committee University of South Florida, Tampa, FL		2013-current
Member, Hematology/Oncology Fellowship Committee Moffitt Cancer Center and University of South Florida		2013-current
Member, Cancer Committee Tampa General Hospital, Tampa, FL		2013-2020
Member, Oncology Service Line Tampa General Hospital, Tampa, FL		2013-2018
Chairman, OU Tulsa Cancer Center Committee University of Oklahoma, Tulsa, OK		2010-2012
Member, Utilization Management Committee University of Louisville Hospital, Louisville, KY		2009-2010
Member, Radiation Oncology Chairman Search Committee University of Louisville, Louisville, KY		2008-2010
Member, Anatomic Pathology Chief Search Committee University of Louisville, Louisville, KY		2008-2010
Member, Data & Safety Monitoring Board J. G. Brown Cancer Center, University of Louisville		2006-2010
Member, Quality Assurance and Quality Control Committee J. G. Brown Cancer Center, University of Louisville		2006-2010

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Damian A. Laber, M.D., F.A.C.P.
Page 13

Chairman, Hematology and Medical Oncology Fellowship Committee J. G. Brown Cancer Center, University of Louisville	2004-2010
Chair, Genitourinary Oncology Group–CSRC J. G. Brown Cancer Center, University of Louisville	2001-2010
Member, Clinical Scientific Review Committee J. G. Brown Cancer Center, University of Louisville	2001-2010
Chairman, Hematology and Medical Oncology Fellow Selection Committee J. G. Brown Cancer Center, University of Louisville	2001-2010
Member, Pain Committee University of Louisville Hospital, Louisville, KY	2001-2010
Member, Taylor Regional Hospital Cancer Committee Taylor Regional Hospital, Campbellsville, KY	2003-2010
Member, Transfusion Medicine Faculty Search Committee University of Louisville, Louisville, KY	2004-2005
Member, International Medical Committee Jefferson County Medical Society, Kentucky	2001-2004
Advisor, Standards of Care Committee, Kentucky Cancer Program Kentucky Governor’s Breast Care Task Force	2001
Member, Medical Records Committee Meridia Huron Hospital, Cleveland, Ohio	1994-1997

AWARDS AND NAMED LECTURESHIPS

HONORS AND AWARDS:

Potential for Major Clinical Applications, Second Place “A Phase I Study of AS1411 (AGRO100) in Advanced Cancer” Research!Louisville 2005, Louisville, KY	2005
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Damian A. Laber, M.D., F.A.C.P.
Page 14

Fellow of the American College of Physicians ACP, Philadelphia, PA	2005
Best Teaching Faculty Award Division of Medical Oncology and Hematology J. G. Brown Cancer Center, University of Louisville	2003
Certificate of Merit, Associates Abstract Competition American College of Physicians, Columbus, OH	1996
Honorable Mention Award, Meridia Huron Hospital Resident Essay Competition Meridia Huron Hospital, Cleveland, Ohio	1996

SELECTED INVITED LECTURES:

“Immunotherapy for cancer, many advances in this rapidly evolving field” The Second Yangcheng Lake Cancer Forum. Affiliated Kunshan Hospital of Jiangsu University Kunshan, Suzhou, Jiangsu, China	12/4/2020
”Genitourinary Malignancies” CME AMA PRA Category Credits 3 rd Annual Interprofessional Seminars in Applying Precision Medicine for Hematologic Malignancies and Solid Tumors in Federal and Public Health Settings. The Westin Tampa Waterside. Tampa, FL	9/28/2019
“Hemophilia, Past, Present and Future” CME AMA PRA Category Credits Oncology Grand Rounds, Edwards Comprehensive Cancer Center. Huntington, WV	3/8/2019
“Pancreatic Cancer, Metastatic Disease” CME AMA PRA Category Credits OncLive® 2018 State of the Science: GI Malignancies-ASCO GI Updates Tampa, FL	2/27/2019

CONTINUED

“Advances in Castration-Resistant Prostate Cancer” CME AMA PRA Category Credits Tampa General Hospital CME lecture series St Petersburg, FL	2/13/2018
“Prostate Cancer” CME AMA PRA Category Credits Tampa General Hospital CME lecture series Tampa, FL	10/19/2017
“Follicular Lymphoma” Hematology/Oncology Conference San Juan City Hospital, San Juan, PR	5/4/2017
“Atypical Hemolytic Uremic Syndrome” CME AMA PRA Category Credits Medicine Grand Rounds. Florida Hospital, Winter Park, FL	4/20/2016
“Multiple Myeloma” CME AMA PRA Category Credits Hematology/Oncology Conference. San Juan City Hospital, San Juan, PR	3/3/2016
“Update in Multiple Myeloma” CME AMA PRA Category Credits Hematology/Oncology Grand Rounds. Marshall University, Huntington, WV	2/19/2016
“Colorectal Cancer” CME AMA PRA Category Credits Hematology/Oncology Conference. San Juan City Hospital, San Juan, PR	3/26/2015
“Understanding Testing and Monitoring in Chronic Myeloid Leukemia” CME AMA PRA Category Credits Internal Medicine Conference, Case Western Reserve University Program. St. Vincent Charity Hospital, Cleveland, OH	3/20/2015

CONTINUED

“Renal-Cell Carcinoma, Translating the Science into Patient Care” CME AMA PRA Category Credits Internal Medicine Grand Rounds. The University of South Florida, Tampa, FL	8/14/2014
“Renal-Cell Carcinoma” CME AMA PRA Category Credits Internal Medicine Grand Rounds. Orlando Regional Medical Center, Orlando, FL	2/27/2014
“Heparin Induced Thrombocytopenia, Awareness Can Save Lives...” CME AMA PRA Category Credits Internal Medicine Grand Rounds. The University of South Florida, Tampa, FL	11/7/2013
“Hemorrhage, Related to Anticoagulants” CME AMA PRA Category Credits Internal Medicine Grand Rounds. The University of Oklahoma, Schusterman Campus, Tulsa, OK	1/20/2012
“Advances in Renal Cell Carcinoma” CME AMA PRA Category Credits Medicine Grand Rounds. Hillcrest Medical Center, Tulsa, OK	11/9/2011
“Renal Cell Carcinoma, Translating the Science into Patient Care” CME AMA PRA Category Credits Surgery Grand Rounds. The University of Oklahoma, St. John Medical Center, Tulsa, OK	9/7/2011
“Heparin Induced Thrombocytopenia” CME AMA PRA Category Credits Internal Medicine Grand Rounds. The University of Oklahoma, Schusterman Campus, Tulsa, OK	7/8/2011
“Prostate Cancer” CME AMA PRA Category Credits Internal Medicine Grand Rounds. The University of Oklahoma, Schusterman Campus, Tulsa, OK	1/21/2011

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“Hemorrhage, Related to Anticoagulants” CME AMA PRA Category Credits Hematology Grand-Rounds. University of Louisville, Kentucky	10/23/2009
“Renal-Cell Carcinoma, Translating the Science into Patient Care” CME AMA PRA Category Credits Internal Medicine Grand-Rounds. University of Louisville, Kentucky	9/24/2009
“Advances in Prostate Cancer” CME AMA PRA Category Credits Medicine Grand Rounds. The Methodist Hospital, Houston, TX	6/10/2009
“Advances in Prostate Cancer” CME AMA PRA Category Credits Internal Medicine Grand Rounds. Huron Hospital, Cleveland, OH	5/18/2008
“Update in Castrate-Resistant Prostate Cancer” CME AMA PRA Category Credits Internal Medicine Grand Rounds. Trinity Hospital, Minot, ND	5/8/2008
“Anticoagulation: Current Standards & Future Trends” CME AMA PRA Category Credits 2007 Hemostasis and Thrombosis Symposium. Galt House East, Louisville, KY	10/20/2007
“Genitourinary and Gastrointestinal Malignancies” CME AMA PRA Category Credits 2007 Annual Louisville Update in Oncology, ASCO Review. Galt House East, Louisville, KY	9/08/2007

CONTINUED

“From Bench to Bedside in Louisville: AS1411, a Novel Cancer Therapy that Targets Nucleolin” Biomarkers, Genetics and Chemoprevention Seminar J G Brown Cancer Center Memorial Lecture Series, Louisville, KY	1/16/2007
“Current Controversies in Diagnosis and Management of Prostate Cancer” CME AMA PRA Category Credits Internal Medicine Update 2006, Norton Healthcare and University of Louisville. The Marriott Hotel, Louisville, KY	12/01/2006
“Genitourinary and Gastrointestinal Malignancies” CME AMA PRA Category Credits Second Annual Louisville Update in Oncology, ASCO Review. The Marriott Hotel, Louisville, KY	6/11/2006
“Advances in the Treatment of Prostate Cancer” CME AMA PRA Category Credits Seventh Annual Anatomic Pathology Update. The Galt House East Hotel, Louisville, KY	5/20/2006
“An Update on Advances with Multikinase Inhibitors in Renal Cell Cancer” CME AMA PRA Category Credits Hematology-Oncology Grand Rounds. University of Cincinnati, Ohio	4/07/2006
“Advances in Systemic Therapy for Colorectal Cancer” CME AMA PRA Category Credits Colorectal Surgery Conference. University of Louisville, Kentucky	2/20/2006
“Update in General Hematology” CME AMA PRA Category Credits First Annual Louisville Update in Hematology, ASH Review. The Camberley Brown Hotel, Louisville, KY	2/04/2006
“Management of Renal Cell Carcinoma” CME AMA PRA Category Credits Long Island International Oncology Network Meeting. Long Island, New York	2/01/2006

CONTINUED

“Molecular Targeted Therapies for Renal Cell Carcinoma” Tumor Board. Baptist Montclair Medical Center, Birmingham, AL	1/30/2006
“Advances in Prostate Cancer” Man to Man-Louisville Prostate Cancer Support Group Baptist Hospital East Cancer Center, Louisville, KY	9/10/2005
“Research Advances in Genitourinary and Gastrointestinal Malignancies” CME AMA PRA Category Credits First Annual Louisville Update in Oncology, ASCO Review. The Camberley Brown Hotel, Louisville, KY	6/11/2005
“Advances in Systemic Therapy for Colorectal Cancer” Colorectal Surgery Conference University of Louisville, Kentucky	4/18/2005
“Innovations and Clinical Trials in Colorectal Cancer” CME AMA PRA Category Credits Symposium: Progress in the Treatment of Colorectal Cancer. Norton Hospital, Louisville, KY	3/19/2005
“Heparin Induced Thrombocytopenia in Louisville” CME AMA PRA Category Credits First Annual Louisville Update in Hematology. The Camberley Brown Hotel, Louisville, KY	2/26/2005
“Advances in Prostate Cancer” BIOC-675/875 Cancer Biology Course, Graduate Program Department of Molecular Biology, University of Louisville	2/11/2005
“Advances in Prostate Cancer” CME AMA PRA Category Credits Internal Medicine Grand-Rounds. University of Louisville, Kentucky	5/06/2004
“Advances in Treatment Strategies for Prostate Cancer” Campbesville, Kentucky	3/09/2004

CONTINUED

“New Strategies for Prostate Cancer Treatment: A Multi-Modality Approach” Louisville, Kentucky	2/05/2004
“Update in Heparin Induced Thrombocytopenia” CME AMA PRA Category Credits Cardiology Grand-Rounds. University of Louisville, Kentucky	1/29/2004
“VEGF: An Emerging Target for Anticancer Therapy” Medical Oncology Multi-Modality Conference J. G. Brown Cancer Center, University of Louisville, Kentucky	1/29/2004
“Update in the Management and Diagnosis of Deep Vein Thrombosis” CME AMA PRA Category Credits Internal Medicine Update 2002, Norton Healthcare and University of Louisville. Louisville, Kentucky	11/15/2002
“Maximizing Oncologic Therapy. A focus on Prostate Cancer” Tennessee Pharmacist Association Meeting Nashville, Tennessee	8/22/2002
“Prostate Cancer” CME AMA PRA Category Credits Oncology Symposium on Breast, Prostate and Lung Cancer. University of Louisville, Kentucky	6/1/2002
“Advances in Prostate Cancer” CME AMA PRA Category Credits Internal Medicine Grand-Rounds. University of Louisville, Kentucky	10/24/2001
“Platinum Compounds” University of Louisville, James Graham Brown Cancer Center Louisville, Kentucky	7/14/2000
“Thrombotic Thrombocytopenic Purpura, from Moschcowitz to Clopidogrel” Hematology Conference, University of Louisville, James Graham Brown Cancer Center Louisville, Kentucky	7/14/2000

CONTINUED

“Thrombotic Thrombocytopenic Purpura, from Moschowitz to Clopidogrel” CME AMA PRA Category Credits Hematology/Oncology Research Conference, University of Alabama at Birmingham Birmingham, Alabama	6/15/2000
“Aspergillus in AML” Intra-City Hematology Conference Houston, Texas	4/5/2000
“Anti-RhD IVIG for the treatment of ITP” CME AMA PRA Category Credits Intra-City Hematology Conference. Houston, Texas	3/15/2000
“Anaplastic Large Cell Lymphoma” CME AMA PRA Category Credits Intra-City Hematology Conference. Houston, Texas	12/15/1999
“Therapeutic Plasma Exchange” CME AMA PRA Category Credits Intra-City Hematology Conference. Houston, Texas	10/6/1999
“Hemochromatosis” CME AMA PRA Category Credits Intra-City Hematology Conference. Houston, Texas	6/30/1999
“Autoimmune Hemolytic Anemias” CME AMA PRA Category Credits Hematology Intra-City Conference. Houston, Texas	5/12/1999
“Waldenstrom’s Macroglobulinemia” CME AMA PRA Category Credits Intra-City Hematology Conference. Houston, Texas	4/14/1999

CONTINUED

“Molecular Oncology” Baylor College of Medicine Didactic Conference Houston, Texas	11/12/1998
“Thyroid Cancer” Baylor College of Medicine Didactic Conference Houston, Texas	5/7/1998
“Solid Tumors of Childhood” Baylor College of Medicine Didactic Conference Houston, Texas	3/12/1998
“Tumor Markers” Baylor College of Medicine Didactic Conference Houston, Texas	11/6/1997
“Staging of Lung Cancer” Veterans Affairs Medical Center Oncology Conference Houston, Texas	8/13/1997

MILITARY SERVICE: None

CONTINUED

BIBLIOGRAPHY:

ARTICLES PUBLISHED IN PEER-REVIEWED JOURNALS:

1. Laber DA. Radiotherapy for small-cell lung cancer. *N Engl J Med*. 1999;340(25):2003-2004.
2. Laber DA, Ravakhah K, Smith HR. Acne conglobata associated with spondyloarthritis and ankylosis of the wrists. *J Clin Rheumatol*. 1999;5(3):169-172.
3. Hesketh PJ, Arena F, Patel D, Austin M, D'Avirro P, Rossi G, Colowick A, Schwartzberg L, Bertoli LF, Cole JT, Demetri G, Dessypris E, Dobbs T, Eisenberg P, Fleischman R, Hall J, Hoffman PC, Laber DA, Leonard J, Lester EP, McCachren S, McMeekin S, Meza L, Miller DS, Nand S, Oliff I, Paroly W, Pawl L, Perez A, Raftopoulos H, Rigas J, Rowland K, Scullin DC Jr, Tezcan H, Waples J, Ward J, Yee LK. A randomized controlled trial of darbepoetin alfa administered as a fixed or weight-based dose using a front-loading schedule in patients with anemia who have nonmyeloid malignancies. *Cancer*. 2004;100(4):859-868.
4. Makoni SN, Laber DA. Clinical spectrum of myelophthisis in cancer patients. *Am J Hematol*. 2004;76(1):92-93.
5. Laber DA, Martin ME. Etiology of thrombocytopenia in all patients treated with heparin products. *Eur J Haematol*. 2005;75(2):101-105.
6. Fentress DS, Orrico LA, Kruspe M, Briscoe KS, Laber DA. Multiple Myeloma. *Hospital Physician*. 2006;5:11.
7. Laber DA. Risk factors, classification, and staging of renal cell cancer. *Med Oncol*. 2006;23(4):443-454.
8. Laber DA. Why did he die? *Cancer Invest*. 2006;24(3):331-332.
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84. Meng L, Thapa R, Kim RD, Laber DA, Xie H. Disparity of treatment-related adverse events and outcome in patients with early-onset metastatic colorectal cancer (mCRC). DOI: 10.1200/JCO.2022.40.16_suppl.6560 Journal of Clinical Oncology 40, no. 16_suppl (June 01, 2022) 6560-6560.
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PRESENTATIONS:

1. Laber DA. Acne conglobata causing ankylosis of the wrists and ankylosing spondylitis. Oral presentation. American College of Physicians, Ohio Chapter. Columbus, Ohio. October 1996.
2. Laber DA. Higher dose docetaxel in patients with hormone refractory prostate cancer (HRPC). Long-term results of a phase II study. Poster session. 39th Annual Meeting of the American Society of Clinical Oncology, Chicago, IL. May 31-June 3, 2003.

CONTINUED

3. Choudry MA, Laber DA (Mentor). Phase II Study of Cyclophosphamide, Etoposide and Estramustine in Patients with Androgen Independent Prostate Cancer. Poster session. Research!Louisville 2004. November 8-12, 2004. Honorable Mention Award.
4. Choudry MA, Laber DA. Phase II Study of Cyclophosphamide, Etoposide and Estramustine in Patients with Androgen Independent Prostate Cancer. Poster session. 2005 Prostate Cancer Symposium, Orlando, FL. February 17-19, 2005.
5. Laber DA. Phase II study of higher dose docetaxel in androgen independent prostate cancer. Poster session. 2005 Prostate Cancer Symposium, Orlando, FL. February 17-19, 2005.
6. Laber DA. Update on the First Phase I Study of AGRO100 in Advanced Cancer. Poster session. 41st Annual Meeting of the American Society of Clinical Oncology, Orlando, FL. May 13-17, 2005.
7. Laber DA. A Phase I Study of AS1411 (AGRO100) in Advanced Cancer. Faculty Research Day Poster Competition Winner, Second Place: Potential for Major Clinical Applications. Research!Louisville 2005. October 31- November 4, 2005.
8. Martin ME, Laber DA. A phase I Study of Docetaxel in Combination with Doxorubicin HCl Liposome Injection in Advanced Androgen Independent Prostate Cancer. Poster session. 2006 Prostate Cancer Symposium, San Francisco, CA. February 24-26, 2006.
9. Moffett PU, Laber DA. Update on a Phase II Study of Cyclophosphamide, Etoposide and Estramustine in Patients with Androgen Independent Prostate Cancer. Poster session. 42nd Annual Meeting of the American Society of Clinical Oncology, Atlanta, GA. June 2-6, 2006.
10. Laber DA. Proposed Guidelines for Anticoagulation during Cardiac Surgery Using Argatroban. Poster session. 11th Congress of the European Hematology Association. Amsterdam, The Netherlands. June 15-18, 2006.
11. Laber DA. Pregnancy-Induced Pure Red-Cell Aplasia, A Distinct Syndrome. Poster session. 11th Congress of the European Hematology Association. Amsterdam, The Netherlands. June 15-18, 2006.
12. Laber DA. A phase II study of docetaxel in combination with doxorubicin HCl liposome injection in advanced androgen-independent prostate cancer. Poster session. 2007 Prostate Cancer Symposium, Orlando, FL. February 22-24, 2007.

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13. Laber DA, Perisetti NM, Ferguson LA, Kloecker GH. A Phase II Study of Docetaxel in Combination with Doxorubicin HCl Liposome Injection (Doxil) in Metastatic Androgen-Independent Prostate Cancer. Poster session. 2008 Prostate Cancer Symposium, San Francisco, CA. February 14-16, 2008.
14. Mhaskar R, Koipallil G, Thomas N, Visweshwar N, Laber DA, Patel AK, Jaglal M. Meta-Analysis of Direct Oral Anticoagulants for the Treatment of Venous Thromboembolism in Patients with Active Malignancy. Poster session. 2018 American Society of Hematology Annual Meeting. San Diego, CA. December 1-4, 2018
15. Jaglal M, Laber DA, Patel AK, Haider M, Eatrises J, Visweshwar N, Abowali H. A Meta-Analysis on the Efficacy of Thrombopoietin (TPO) Agonists in Reducing the Need of Platelet Transfusion before Procedures in Chronic Liver Disease Patients. Poster session. 2019 American Society of Hematology Annual Meeting. Orlando, FL. December 7-10, 2019

RESEARCH FUNDING:

GRANT SUPPORT

HRSA H30MC24046-02-00, Southeast Region Comprehensive and Diagnostic Bleeding Disorders Treatment Center Program P.I.: Damian A. Laber	6/2013-5/2014 \$ 15,000
CDC 5U27DD000862-02, Public Health Surveillance for the Prevention of Complications of Bleeding and Clotting Disorders P.I.: Damian A. Laber	9/2013-9/2014 \$ 10,000
NIH K30HL004149, Clinical Research Curriculum Award (K30) Clinical Research, Epidemiology & Statistical Training P.I.: Carlton A. Hornung Role: Faculty	8/2000-7/2005 \$ 1,000,000
Kentucky Lung Cancer Research Program "A Novel Marker and Therapeutic Target for Lung Cancer" P.I.: Paula J. Bates Role: Co-Investigator	9/2001-8/2004 \$ 150,000

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CLINICAL RESEARCH SUPPORT

1. TGH: Pro00026925. MCC 18796
Association of immune thrombocytopenic purpura and cancer: long term experience in two affiliated academic centers
Co Investigator. 2014-current
Investigator initiated
2. USF IRB#: Pro00016133. A Phase II Multicenter Randomized Trial Evaluating 3-year Disease Free Survival in Patients With Locally Advanced Rectal Cancer Treated With Chemoradiation Plus Induction or Consolidation Chemotherapy and Total Mesorectal Excision or Non- operative Management
Co Investigator 2015-2019
Memorial Sloan Kettering Cancer Centerj. Budget \$100,000
3. TGH: CSEG101A2202 WIRB® Protocol #20172010
A phase 2, Multicenter, Open-Label Study to Assess PK/PD of SEG101 (crizanlizumab), with or without Hydroxyurea/Hydroxycarbamide, in Adult Sickle Cell Patients with Vaso-Occlusive Crisis
Co Investigator. 2018-2019
Novartis Pharmaceuticals. Budget \$ 20,000
4. TGH: B5201002: An open level extension study to evaluate the safety of Rivipansel (GMI-1070) in the treatment of one or more vaso-occlusive crisis in hospitalized subjects with sickle cell disease
Co Investigator. 2015-2019
Pfizer Pharmaceuticals. Budget \$ 30,000
5. TGH: B5201003: A phase 3, multicenter, randomized, double-blind, placebo-controlled, parallel-group study to evaluate the efficacy and safety of Rivipansel (GMI-1070) in the treatment of vaso-occlusive crisis in hospitalized subjects with sickle cell disease
Co Investigator. 2015-2019
Pfizer Pharmaceuticals. Budget \$ 30,000

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6. TGH: SGSC-005 WIRB® Protocol #20152821. A Phase 2 Study of the Safety and Effectiveness of SANGUINATE™ in the Treatment of Vaso-occlusive Crises in the Ambulatory Setting: A Placebo-Controlled, Single-Dose, Single-Blind Study in Adults with Sickle Cell Disease
Co Investigator. 2017-2018
Prolong Pharmaceuticals. Budget \$ 24,000
7. TGH: SGHY-001: An Open-label Phase 1 Safety Study of SANGUINATE™ infusion in patients with acute severe anemia who are unable to receive red blood cell transfusion
Co Investigator. 2016-2017
Prolong Pharmaceuticals. Budget \$ 57,000
8. MCC/TGH: Iron Clad: 1V1T14039: Can Iron Lessen Anemia Due to cancer and chemotherapy: A multicenter, randomized, double-blinded, controlled study to investigate the efficacy and safety of Injectafer® (ferric carboxymaltose injection)
Co Investigator. 2016-2017
Luitpold Pharmaceuticals. Budget \$ 15,000
9. TGH: Protein X USF IRB# Pro00031626
Analysis of the components of “Protein X” and their effects on transformation of blood progenitor cells
Co Investigator. 2016-2017
Investigator initiated.
10. USF IRB Study # Pro00005698: The Role of Myeloid Derived Suppressor Cells (MDSC) in Human Pancreatic Cancer Progression.
Co Investigator. 2015-2016
Investigator initiated.
11. USF IRB#: Pro00016144: Pilot Study of Preoperative chemoradiation for glioblastoma.
Co Investigator. 2014-2015
Investigator initiated.
12. USF IRB#: Pro00015970: CDC Public Health Surveillance Project (CDC PHSP) for Bleeding Disorders: Population Profile, Mortality Reporting and the Registry for Bleeding Disorders Surveillance.
Principal Investigator at USF. 2013-2014
Sponsor: CDC. Budget \$ 10,000

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13. HSPPO # 433-03 WIRB® Protocol #20031122: Phase 1 Study of AS1411 in Advanced Solid Tumors.
Principal Investigator. 2005-2006
Sponsor: Antisoma Research Ltd. Budget \$ 350,000
14. HSPPO # 433-03 APT-1-0603 WIRB® Protocol #20031122: Phase 1 Study of AGRO100 in Advanced Solid Tumors.
Principal Investigator. 2003-2004
Sponsor: Aptamera, Inc. Budget \$ 250,327
15. HSPPO # 03.0252: A Study of Circulating Nerve Growth Factor in Patients with Prostate Cancer.
Principal Investigator. 2003-2008
Investigator initiated.
16. HSC # 398-02: Evaluation of a Novel Cancer Marker.
Principal Investigator. 2002-2004
Sponsor: Kentucky Lung Cancer Research Fund. Budget \$150,000
17. HSC # 415-02: A Study of Nucleolin Stained Sputum Samples in Patients with Lung Cancer or Pulmonary Metastasis, and in Patients at High Risk for Lung Cancer or Pulmonary Metastasis.
Principal Investigator. 2002-2004
Sponsor: Kentucky Lung Cancer Research Fund. Budget \$150,000
18. HSPPO # 312-01: A Retrospective Study of Heparin-Induced Thrombocytopenia (HIT) and Thrombosis Syndrome (TS).
Principal Investigator. 2001-2004
Investigator initiated.
19. HSPPO # 03.0575: Phase I/II Study of Docetaxel (Taxotere) in Combination with Doxorubicin HCl Liposome Injection (Doxil) in Advanced Androgen-Independent Prostate Cancer (AIPC).
Principal Investigator. 2003-2009
Sponsors: Ortho-Biotech and Sanofi-Aventis. Budget \$ 221,000

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20. HSPPO # 01.0486: A Phase II Study of Cyclophosphamide, Etoposide, and Estramustine in Metastatic Androgen-Independent Prostate Cancer.
Principal Investigator. 2001-2010
Investigator initiated.
21. HSPPO # 04.0289: Phase II Study of Oxaliplatin and Capecitabine in Advanced Head and Neck Cancer.
Principal Investigator. 2004-2008
Sponsor: Sanofi-Aventis. Budget \$ 277,000
22. HSPPO # 02.0559: Phase I Study of Capecitabine, Temozolomide and Thalidomide in the Treatment of Advanced Solid Tumors.
Principal Investigator. 2002-2010
Investigator initiated.
23. HSPPO # 05.0591: A retrospective study of cancer patients.
Principal Investigator. 2005-2010
Investigator initiated.
24. HSPPO # 07.0369: Markers of Thrombosis in Patients with Cancer Treated with Systemic Therapy.
Principal Investigator. 2005-2010
Investigator initiated.
25. HSPPO # 08.0350: A Phase II, Open Label, Single-Arm Study of AS1411 in Patients with Metastatic Renal Cell Carcinoma.
Principal Investigator at UofL. 2008-2010
Sponsor: Antisoma, Inc. Budget \$ 500,000
26. HSPPO # 07.0297: (ECOG 2805) ASSURE. A Randomized, Double-Blind Phase III Trial of Adjuvant Sunitinib vs Sorafenib vs Placebo in Patients with Resected Renal Cell Carcinoma..
Principal Investigator at UofL. 2007-2010
Sponsor: University of Michigan. Budget \$ 8,750
27. HSPPO # 07.0172: (3066K1-404-WW) A Randomized Trial of temsirolimus versus Sorafenib as Second-Line Therapy in Patients with Advanced Renal Cell Carcinoma Who Have Failed First-Line Sunitinib Therapy.
Principal Investigator at UofL. 2007-2010
Sponsor: Wyeth Pharmaceuticals, Inc. Budget \$ 219,095

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28. HSPPO # 07.0220: H3E-MC-JMHR: A Randomized Phase 3 Study of Pemetrexed in Combination with Cisplatin versus Cisplatin Monotherapy in Patients with Recurrent or Metastatic Head and Neck Cancer.
Principal Investigator at UofL. 2007-2010
Sponsor: Lilly Research Laboratories. Budget \$ 86,562
29. HSPPO # 08.0324: (3066K1-3311-WW) Phase 3b, Randomized, Open-Label Study of Bevacizumab (Avastin) + Temsirolimus (Torisel) vs Bevacizumab (Avastin) + Interferon-Alfa (Roferon) as First-Line Treatment in Subjects With Advanced Renal Cell Carcinoma.
Principal Investigator at UofL. 2008-2010
Sponsor: Wyeth Pharmaceuticals, Inc. Budget \$ 280,075
30. HSPPO # 08.0535 - VEG108844: A Study of Pazopanib versus Sunitinib in the Treatment of Subjects with Locally Advanced and/or Metastatic Renal Cell Carcinoma.
Principal Investigator at UofL. 2008-2010
Sponsor: Glaxo Smith Kline. Budget \$ 197,459
31. HSPPO # 08.0509.: A randomized placebo-controlled trial of the efficacy and tolerability of flexibly dosed pregabalin in the treatment of cancer-induced bone pain.
Principal Investigator at UofL. 2008-2010
Sponsor: Pfizer. Budget \$ 25,000
32. HSPPO # 09.0144: E3805 – CHARTED: ChemoHormonal Therapy versus Androgen Ablation Randomized Trial for Extensive Disease Prostate Cancer.
Principal Investigator at UofL. 2009-2010
Sponsor: ECOG. Budget \$ 20,000
33. HSPPO # 09.0067: CALGB 90203: A Randomized Phase III Study of Neoadjuvant Docetaxel and Androgen Deprivation Prior to Radical Prostatectomy versus Immediate Radical Prostatectomy in Patients with High-risk, Clinically Localized Prostate Cancer.
Principal Investigator at UofL. 2009-2010
Sponsor: SWOG. Budget \$ 20,000
34. HSPPO # 09.0066.: S0421: Phase III Study of Docetaxel and Atrasentan versus Docetaxel and Placebo for Patients with Advanced Hormone Refractory Prostate Cancer.
Principal Investigator at UofL. 2009-2010
Sponsor: SWOG. Budget \$ 50,000

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35. HSPPO # CRAD001L2202 An open-label, multicenter phase II study to compare the efficacy and safety of RAD001 as first-line followed by second-line sunitinib versus sunitinib as first-line followed by second-line RAD001 in the treatment of patients with metastatic renal cell carcinoma.
Principal Investigator at UofL. 2009-2010
Sponsor: Novartis. Budget \$ 182,914
36. HSPPO # Incyte - INCB 18424-351 JAK2 - A Randomized, Double-blind, Placebo-controlled Study of the JAK Inhibitor INCB018424 Tablets Administered Orally to Subjects with Primary Myelofibrosis (PMF), Post-Polycythemia Vera- Myelofibrosis (PPV-MF) or Post-Essential Thrombocythemia-Myelofibrosis (PET-MF).
Principal Investigator at UofL. 2009-2010
Sponsor: Incyte. Budget \$ 89,242
37. HSPPO # 07.0359: 20050236-BB-IND-8362: A Randomized, Open-Label, Controlled, Phase II Trial of Combination Chemotherapy with or without Panitumumab as 1st-Line Treatment of Subjects with Metastatic or Recurrent Head and Neck Cancer and Cross-over Second-Line Panitumumab Monotherapy of Subjects who Fail the Combination Chemotherapy.
Principal Investigator at UofL. 2007-2009
Sponsor: Amgen. Budget \$ 82,500
38. HSPPO # 07.0333: 20062088-105: Phase 2, Single Arm, Open-Label, Multi-Center Trial of Panitumumab Monotherapy in Patients with Platinum-refractory Metastatic or Recurrent Squamous Cell Carcinoma of the Head and Neck.
Principal Investigator at UofL. 2007-2009
Sponsor: Amgen. Budget \$ 46,699
39. HSPPO # .: CRAD001L2401: An open-level, multi-center, expanded access study of RAD001 in patients with metastatic carcinoma of the kidney who are intolerant of or have progressed despite any available vascular endothelial growth factor receptor tyrosine kinase inhibitor therapy.
Principal Investigator at UofL. 2009
Sponsor: Novartis Pharmaceuticals.

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40. HSPPO # 08.0013: G-0034: A Phase 3 Randomized, Open-Label Study of Docetaxel in Combination with CG1940 and CG8711 versus Docetaxel and Prednisone in Taxane-Naïve Patients with Metastatic Hormone-Refractory Prostate Cancer with Pain.
Principal Investigator at UofL. 2008
Sponsor: Cell Genesys, Inc. Budget \$ 75,545
41. HSPPO # 06.0472: A Randomized, Double-Blind, Multicenter Study of Denosumab Compared with Zoledronic Acid in the Treatment of Bone Metastases in Hormone-Refractory Prostate Cancer.
Principal Investigator at UofL. 2006-2008
Sponsor: Amgen. Budget \$ 78,800
42. HSPPO # 130.07: CA183002-A Multicenter, Randomized Double-Blinded Phase II/III Study in the First-Line Treatment of Advanced Transitional Cell Carcinoma (TCC) of the Urothelium Comparing Vinflunine/Gemcitabine to Placebo/Gemcitabine in Patients who are Ineligible to Receive Cisplatin-Based Therapy (VINCENT).
Principal Investigator at UofL. 2006-2007
Sponsor: BMS. Budget \$ 72,025
43. HSPPO # 321-05: CA183001—A Phase II Study of Intravenous (IV) Vinflunine in Patients with Locally Advanced or Metastatic Transitional Cell Carcinoma (TCC) of the Urothelium.
Principal Investigator at UofL. 2005-2007
Sponsor: BMS. Budget \$ 41,445.00
44. HSPPO # 165-06, S0431 Phase II Study of Trastuzumab (NSC-688097) in Advanced High Grade Salivary Carcinoma.
Principal Investigator at UofL. 2006-2007
Sponsor: SWOG. Budget \$ 15,000
45. HSPPO # 746-01 Protocol B9E-US-S188: Randomized Trial of Gemcitabine Plus Docetaxel vs. Docetaxel Plus Capecitabine in Metastatic Breast Cancer in 1st and 2nd Line Patients.
Principal Investigator at UofL. 2001-2005
Sponsor: Eli Lilly and Company. Budget \$ 48,000
46. HSPPO # 352-05: Open Label, Non-Comparative Treatment Protocol for the use of Sorafenib in Patients with Advanced Renal Cell Carcinoma.
Principal Investigator at UofL. 2005-2006
Sponsor: Pharmanet, Inc. Budget \$ 30,000

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47. HSPPO # 336-03: Three Arm Randomized Open-Label Study of Interferon Alfa Alone, CCI-779 Alone, and the Combination of Interferon Alfa and CCI-779 in First Line Poor-Prognosis Subjects with Advanced Renal Cell Carcinoma.
Principal Investigator at UofL. 2003-2005
Sponsor: Wyeth. Budget \$ 120,600
48. HSPPO # 593-04 TLK 286.3020: Randomized Study of TLK286 (Telcyta) versus Gefitinib (Iressa) as Third-Line Therapy in Locally Advanced or Metastatic Non-Small Cell Lung Cancer.
Principal Investigator at UofL. 2004-2005
Sponsor: Telik. Budget \$ 39,500
49. HSPPO # 568.04, B9E-US-337: A Research Study of Avastin plus Gemcitabine plus 5-Fluorouracil and Leucovorin (same as A + FFG) compared to Avastin plus Oxaliplatin and 5-Fluorouracil and Leucovorin (same as A + FOLFOX 4) as Patients with Metastatic Colorectal Cancer.
Principal Investigator at UofL. 2004-2005
Sponsor: Lilly Research Laboratories. Budget \$ 25,500
50. HSPPO # 600-03: A Randomized, Double Blind, Placebo Controlled, Multicenter Phase III Study Comparing GW572016 and Letrozole versus Letrozole in Subjects with Estrogen, Progesterone Receptor Positive Advanced or Metastatic Breast Cancer.
Principal Investigator at UofL. 2003-2005
Sponsor: GSK. Budget \$ 118,525
51. KCI # 98-3: A Phase II Study of Docetaxel in the Treatment of Advanced Prostate Cancer Refractory to Primary Hormonal Manipulation and Anti-androgen Withdrawal.
Principal Investigator at UofL. 2001-2005
Sponsor: Aventis Pharmaceuticals Inc. Budget \$ 64,000
52. HSC # 9-02 Protocol (20010102): A Randomized, Open-Label Study of Darbepoetin Alfa (Novel Erythropoiesis Stimulating Protein, NESP) Using Fixed Weight-Based Dosing for the Treatment of Anemia in Subjects with Non-myeloid Malignancies Receiving Multicycle Treatment.
Principal Investigator at UofL. 2002-2003
Sponsor: Amgen Inc. Budget \$ 49,550

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53. HSPPO # 06.0428: A Randomized Phase 3 Trial of Alimta (Pemetrexed) and Carboplatin versus Etoposide and Carboplatin in Extensive-Stage Small Cell Lung Cancer.
Co-Investigator. 2006-2010
Sponsors: Lilly Research Laboratories. Budget \$ 115,000
54. HSPPO # 06.0074: Randomized, Phase II, Open-Label Controlled Study of Two Different Doses and Schedules of EMD 72000 (Matuzumab) in Combination with Pemetrexed or Pemetrexed alone, as Second-Line Treatment in Subjects with Stage IIIB/IV Non Small-Cell Lung Cancer and Progressive Disease after First-Line Treatment with a Platinum Analogue in Combination with Either Taxanes or Gemcitabine.
Co-Investigator. 2006-2010
Sponsors: EMD Pharmaceuticals, Inc. Budget \$ 45,000
55. HSPPO # 00.0362: A Phase III Multi-Institutional Randomized Study of Immunization with the gp 100: 209-217 (210M) Peptide Followed by High Dose IL-2 vs. High Dose IL-2 in Patients with Metastatic Melanoma.
Co-Investigator. 2001-2010
Sponsors: NCI/EPP and Chiron. Budget \$ 26,500
56. HSPPO # 04.0567, S9925: Lung Cancer Specimen Repository Protocol, Ancillary.
Co-Investigator. 2004-2010
Sponsor: Southwest Oncology Group. Budget \$ 15,000
57. HSPPO # 04.0648: Phase II Trial of Biochemotherapy (Cisplatin, Vinblastine, DTIC, plus IL-2 and Interferon) + Digoxin in Patients with Metastatic Melanoma.
Co-Investigator. 2004-2008
Investigator initiated.
58. HSPPO # 566-04, S0124: Randomized Phase III Trial of Cisplatin and Irinotecan versus cisplatin and Etoposide in Patients with Extensive Stage Small-Cell Lung Cancer.
Co-Investigator. 2004-2007
Sponsor: Southwest Oncology Group. Budget \$ 6,000
59. HSPPO # 145-06: Randomized Phase III Trial of Adjuvant vs Neo adjuvant Chemotherapy with Cisplatin and Docetaxel for Patients with Early Stage Non small Cell Lung Cancer.
Co-Investigator. 2006-2007
Sponsors: University of Pittsburgh. Budget \$ 25,000

CONTINUED

60. HSPPO # 215-05, BAY 43-9006: Phase II Randomized, Placebo Controlled Study of Sorafenib in Repeated Cycles of 21 Days in Combination with Dacarbazine (DTIC) Chemotherapy in Subjects with Unresectable Stage III or Stage IV Melanoma.
Co-Investigator. 2005-2006
Sponsor: Bayer Pharmaceuticals and Onyx Pharmaceuticals, Inc. Budget \$ 76,580
61. HSPPO # 507-04: Phase III Trial of Doxorubicin and Cyclophosphamide (AC) Followed by Weekly Paclitaxel With or Without Trastuzumab as Adjuvant Treatment for Women with HER-2 Over-Expressing or Amplified Node Positive or High-Risk Node Negative Breast Cancer.
Co-Investigator. 2004-2005
Sponsor: Intergroup. Budget \$ 15,000
62. HSPPO #, M200-1203: Phase II Open-Label Study of M200 in Combination with Dacarbazine (DTIC) in Patients with Metastatic Melanoma Not Previously Treated with Chemotherapy.
Co-Investigator. 2004-2005
Sponsor: Protein Design Labs, Inc. Budget \$ 72,476
63. HSPPO # 418-04: A Two Stage Trial of STA-4783 in Combination with Weekly Paclitaxel for Treatment of Patients with Metastatic Melanoma.
Co-Investigator. 2004-2005
Sponsor: Synta. Budget \$ 47,685
64. HSC # 568-01: Phase II Study of Temozolomide and Thalidomide in the Treatment of Advanced Melanoma.
Co-Investigator. 2001-2005
Sponsor: Schering Plough. Budget \$ 60,000
65. RTOG # 99-02: A Phase III Protocol of Androgen Suppression (AS) and Radiation Therapy (RT) vs. AS and RT Followed by Chemotherapy with Paclitaxel, Estramustine, and Etoposide (TEE) for Localized, High-Risk, Prostate Cancer.
Co-Investigator. 2002-2004
Sponsor: RTOG. Budget \$ 30,000
66. HSC # 904-00: Nucleolin: A Novel Marker and Therapeutic Target for Lung Cancer.
Co-Investigator. 2001-2004
Sponsor: Kentucky Lung Cancer Research Fund. Budget \$150,000

CONTINUED

67. HSC # 454-99: Early Phase Development of Tumor Markers for Improved Diagnosis and Treatments in Recently Diagnosed Breast, Lung Colon, Head and Neck, Melanoma, Ovarian and Uterine Cancer.
Co-Investigator. 2001-2004
Investigator initiated.
68. HSC # 210-01: Open Label Multi-Center Trial of Femara (letrozole) 2.5 mg as First-Line Therapy in Postmenopausal Woman with Metastatic Breast Cancer Relapsing following Adjuvant Tamoxifen Therapy.
Co-Investigator. 2001-2004
Sponsor: Novartis Pharmaceuticals Corp. Budget \$ 20,000
69. HSC # 568-02, SWOG 0008: Phase III Trial of High-Dose Interferon Alpha-2b vs. Cisplatin, Vinblastine, DTIC plus IL-2 and Interferon in Patients with High-Risk Melanoma.
Co-Investigator. 2002-2003
Sponsor: SWOG. Budget \$ 8,450
70. HSPPO #, S0341: Phase II Trial of OSI-774 (NSC-718781) in Patients with Advanced Non-Small Cell Lung Cancer and a Performance Status of 2.
Co-Investigator. 2001-2003
Sponsor: Southwest Oncology Group. Budget \$ 10,000
71. HSC # 361-01: Phase III Randomized Study of Adjuvant Immunotherapy with Monoclonal Antibody 17-1A versus No Adjuvant Therapy Following Resection for Stage II (Modified Astler-Coller B2) Adenocarcinoma of the Colon.
Co-Investigator. 2001-2003
Sponsor: NCI. Budget \$ 25,875
72. HSC # 630-00: A Prospective, Randomized, Open-Label Phase III Trial of Chemotherapy with Carboplatin and Paclitaxel, versus Carboplatin and Paclitaxel in combination with ISIS 3521, an Anti-sense Inhibitor of Protein Kinase C Alpha, in Patients with Advanced, Previously Untreated Non-Small Cell Lung Cancer.
Co-Investigator. 2001-2003
Sponsor: ISIS Pharmaceuticals. Budget \$ 60,000
73. HSC # 471-00: Randomized Study of Dacarbazine Plus G3139 (Bcl-2 Antisense Oligonucleotide) in Patients with Advanced Malignant Melanoma.
Co-Investigator. 2001-2003
Sponsor: Genta Incorporated. Budget \$ 63,450

CONTINUED

74. HSC # 13-00: A Multicenter Study of NeoAdjuvant CVD/IL-2/IFN in Patients with Stage III Malignant Melanoma.
Co-Investigator. 2001-2003
Sponsor: Chiron Corporation and Schering Corporation. Budget \$ 17,500
75. HSC # 861-00: A Multi-Center, Open-Label, Randomized, Two-Arm Trial of Irinotecan (CPT-11) Versus the Combination of Oxaliplatin + Irinotecan (CPT-11) as Second-Line Treatment of Metastatic Colorectal Carcinoma.
Co-Investigator. 2001-2002
Sponsor: Sanofi-Synthelabo Inc. Budget \$ 120,000
76. HSC # 142-01: A Multi-Center, Open-Label, Randomized, Three-Arm Study of 5-Fluorouracil (5-FU) Plus Leucovorin (LV) or Oxaliplatin or a Combination of 5-FU/LV + Oxaliplatin as Second-Line Treatment of Metastatic Colorectal Carcinoma.
Co-Investigator. 2001-2002
Sponsor: Sanofi-Synthelabo Inc. Budget \$ 120,000

Exhibit 2

Damian A. Laber, MD, FACP – Legal Expert Fee Schedule

Date: April 1, 2024. This fee schedule supersedes any prior fee schedule agreement for my services.

\$3,000.- (three thousand) retainer is required prior to initiation of any work and at all times. Any residual balance will be returned after I have acknowledged receipt of notification of closure of the case and after payment of final bill.

\$600 (six hundred) an hour for case review and any work related to the case except deposition and trial testimony as listed below.

\$3,500 (three thousand five hundred) flat fee for deposition up to 4 hours (irrespective of the final amount of time). If more time is needed, the fee for additional deposition time is \$1,000 (one thousand) an hour with no fractionation. Deposition fees are non-refundable and are due 30 calendar days in advance.

10,000 (ten thousand) per day flat fee for trial testimony (irrespective of the final amount of time) plus expenses. Trial testimony fees are non-refundable and are due 30 calendar days in advance.

For any work that requires travel outside my office the billing time starts when I leave my office and ends when I return to my office, plus expenses.

Fees for live or any electronic appearance are non-refundable and are due 30 calendar days in advance.

All payments should be made to Axvina, Inc as listed on the W-9.

Bills for the balance of charges not covered by the advance payment(s) will be sent when I deem appropriate. Payments for the balance of charges are to be made within thirty (30) days from the date of bill. Late payments will result in additional fees of 10% of the amount owed per month, unless I have agreed in writing to waive such fees. Failure to pay within this time period—by which I mean failure to receive any form of payment or failure of a check to clear, etc. will be construed as a complete termination of my consultative responsibilities. Receipt of payment will be interpreted as a request for continuation of services under these agreed terms.

I reserve the right to withdraw if I feel participation will compromise my professional reputation or for any personal reason.

If you agree with all these terms, please submit a payment. Receipt of payment will be interpreted as agreed with the terms listed here.

Damian A. Laber, MD, FACP – Legal Expert Fee Schedule

My contact information is:

Office address (please do not request signature):

3008 W Bay Court Ave

Tampa, FL 33611

Telephone number (mobile): 1-813-774-1464

Email (preferred): Damian.Laber@gmail.com are best for me.

I reserve the right to change, modify, add, or remove portions of this Fee Schedule at any time.

I will provide this document anytime upon request.



Damian A. Laber, MD, FACP

4/1/2024

Date

Exhibit 3

<u>Date</u>	<u>Testimony</u>	<u>Case</u>	<u>Attorney</u>	<u>Attorney's Location</u>
3/12/15	Deposition	D'INNOCENZI vs MAYO CLINIC JACKSONVILLE	Cheryl L. Worman	Jacksonville, FL
3/29/18	Deposition	Lester Clark	Erin Vorhees	Bentonville, AR
5/19/18	Deposition	Pamela Humpreys	Tina Bell	Indianapolis, IN
6/7/19	Deposition	Tetreault-Shirley v AbVie et al	Todd W. Gardner	Seattle, WA
8/9/19	Deposition	Joseph Turner	Tina Bell	Indianapolis, IN
9/25/19	Deposition	Zyla Adams	Erin Vorhees	Bentonville, AR
10/10/19	Deposition	Bleiweis	Gerry E. Mitchell	Washington DC
4/7/20	Deposition	Michael Griffin	Daniel P. Massey	Scottsdale, AZ
6/12/20	Deposition	David Gunter	Francis M. "Brink" Hinson, IV	Columbia, SC
9/4/20	Deposition	Kara Warren	Ryan Prochaska	Wichita, KS
10/28/20	Deposition	William Floyd Case	Jeffrey C. Rickard, Esq.	Birmingham, AL
3/25/21	Deposition	Ray Heverly Case	Norman A. Moses	Boardman, OH
4/13/21	Deposition	LaTanya Shaw Case	Laurie A. Amell	Washington, DC
4/27/21	Deposition	Hamil Case	Matt Birch	Kansas City, MO
20/12/2022	Deposition	Stewart Dodge Case	Tina Bell	Indianapolis, IN
1/20/22	Deposition	Taeusch v Mid-Atlantic	Gary B. Mims	Fairfax, VA
7/13/22	Deposition	Willard Case	Matt Birch	Kansas City, MO
8/4/22	Deposition	Teresa Hendrix Case	Melody Piazza	Little Rock, AR
9/21/22	Deposition	Debra Bowers Case	Ellis Turnage	Cleveland, MS
10/11/22	Deposition	Hamil Case	Matt Birch	Kansas City, MO
12/7/22	Trial	Teresa Hendrix Case	Melody Piazza	Little Rock, AR
12/27/22	Deposition	Sabrina Kikuc Case	Lincoln Woodard	West Hartford, CT
1/11/23	Deposition	Jeanne Cimino Case	Stephanie Z. Roberge	New Haven, CT
3/30/23	Deposition	Shaw, Jason Case	Travis Brennan	Lewiston, ME
6/23/23	Deposition	Myers Case	Daniel Singer	Kansas City, MO
8/9/23	Deposition	Holt Case	Gary B. Mims	Fairfax, VA
9/19/23	Deposition	Lohman Case	Steven Garver	Reston, VA
11/1/23	Deposition	Ebert case	Holly Wojcik	Merrillville, IN
11/9/23	Trial	Lohman Case	Steven Garver	Reston, VA
11/14/23	Deposition	Sim Rice Case	Paul Ford	Jonesboro, AR
12/14/23	Deposition	Devore Case	Matt Birch	Kansas City, MO
1/25/24	Deposition	Robatzen Case	Halley M. Stephens	Tallahassee, FL
2/13/24	Deposition	Gregory Burgess Case	Gregory Kash	Raleigh, NC
3/28/24	Deposition	Clingen Case	Micael Rodriguez	Houston, TX

4/9/24	Deposition	Hack Daniel Case	Scott M. Perry	Arlington, VA
5/29/24	Deposition	Blake Meyer Case	David R. Morantz	Kansas City, MO
7/18/24	Deposition	Montenegro Case	Michael R. Kennedy	New Haven, CT
9/17/24	Deposition	Bargides Case	Stephen P. Griffin	Canton, OH
9/25/24	Deposition	Heather Smith	Stephanie Z Roberge	New Haven, CT
12/12/24	Deposition	Alberto Bello	Tullio E. Iacono, Esq.	Miami, FL
12/17/24	Deposition	Kenley Case	Nicholas J.N. Stamatis	Arlington, VA
1/7/25	Deposition	Pucillo Case	Steven R. Davis	Houston, TX
1/22/25	Deposition	Lewis Case	Christine Mast	Atlanta, GA