Environmental Health Associates, P.A.

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Amy Fair
Simmons Browder Gianaris Angelides & Barnerd, LLC
One Court Street
Alton, IL 62002

RE: Roy Wayne Duncan

Dear Ms. Fair:

At your request, I have reviewed deposition testimony and brief medical records of Mr. Roy Duncan. I am writing to report the results of my evaluation.

Mr. Duncan was approximately 75 years old, thin, appearing younger than his age according to one of his physicians, and active when, in November, 2010, he developed low back pain. A CT scan of the abdomen was carried out on November 15, 2010 because of a suspicion of possible kidney stones. The results were unremarkable except for enlargement of his right adrenal gland. This was re-assessed with a repeat CT scan of the abdomen on May 16, 2011. This showed no change in the adrenal gland, which was considered to be a benign adrenal adenoma. However, a new left pleural effusion of moderate size was noted, together with bilateral lower chest and diaphragmatic pleural calcifications. A CT scan of the chest on May 18, 2011 confirmed the presence of the left pleural effusion and the bilateral calcified pleural plaques, and also disclosed a pleural based soft tissue density in the left upper lobe. Mesothelioma was suggested. The next day, a thoracentesis was carried out, with removal of approximately 800 cc's of pleural fluid. The cytology examination, including immunohistochemical stains, was considered positive for malignancy and consistent with mesothelioma. A PET scan on May 31, 2011 revealed no area of definite hypermetabolic activity.

Mr. Duncan was then evaluated at the Mayo Clinic. On June 14, 2011, he was taken to the emergency room and underwent video-assisted thoracoscopy. Approximately 800 cc's of pleural fluid were removed. The surgeon noted "evidence of extensive pleural plaques on both the anterior and lateral chest wall as well as along the diaphragmatic surfaces." He also noted that there were "very suspicious nodules on the diaphragmatic surface." Various areas of pleura were biopsied. At the end of the procedure, a talc pleurodesis was carried out. The pathology evaluation, including immunohistochemical stains, revealed malignant mesothelioma of the epithelial variety.

Post-operatively, Mr. Duncan developed atrial fibrillation, which was quickly brought into normal sinus rhythm with medication. His follow-up visits indicated that, although he continued to have chest pain, it was easily controlled. He had no significant weight loss or shortness of breath. The most recent medical records available to me are dated August 10, 2011.
His physicians did not consider him a good surgical candidate, and were holding off on

chemotherapy until such time as his clinical condition would deteriorate. During Mr. Duncan's deposition testimony on October 12, 2011, he testified to profound fatigue that seriously limited his physical activities, but no other serious progression of symptoms.

Prior to the onset of his malignant mesothelioma, Mr. Duncan's past medical history included adult-onset diabetes well controlled on oral medication, elevated lipids well controlled on medication, high blood pressure well controlled on medication, and an enlarged prostate gland. He remained active despite these conditions. He had smoked one pack of cigarettes per day for about 40 years, having stopped smoking in approximately 2001. It is well known that cigarette smoking plays no role in the causation or progression of malignant mesothelioma.

According to Mr. Duncan's deposition testimony, he served in the United States Navy from 1952-1956 as a Fireman Apprentice, eventually moving up to machinist mate second class. In the course of his ordinary and routine duties, he experienced exposures to asbestos-containing packing, gaskets, and insulation that occurred in association with a variety of equipment, including valves, pumps, the lube oil purifier, and other equipment. He then worked at a manufacturing facility known as Square D from the end of 1956 until his retirement in 1990, except for a period of four years. For over two decades, he had frequent exposures to asbestos-containing molding compounds used to manufacture molded electrical components. Mr. Duncan personally poured thousands of fifty pound bags of molding compound into hoppers and barrels, and was a close bystander to others who did the same work. This caused the molding compound to become airborne, as did numerous other circumstances in the manufacturing process. Mr. Duncan personally knew several co-workers at the Square D facility who developed mesothelioma.

Based on the information available to me, it is my opinion, within a reasonable degree of medical certainty, that Mr. Roy Duncan experienced significant exposures to asbestos beginning in approximately 1952 and continuing intermittently for several decades. His numerous asbestos exposures cumulatively constituted the direct and sole cause of his bilateral calcified and uncalcified pleural plaques. His numerous asbestos exposures also cumulatively constituted the direct and sole cause of his malignant mesothelioma. This disease is incurable. It will inevitably cause his death, unless some other cause of death supervenes. It is highly likely that malignant mesothelioma will in fact prove to be his cause of death rather than some other hypothesized supervening cause. The atrial fibrillation he experienced after his video-assisted thoracoscopy is a complication of his malignant mesothelioma and/or his surgical procedure for mesothelioma.

Please let me know if you have any questions concerning this report, or desire clarification.

Sincerely,

Edwin C. Holstein MD, MS

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