

THE STATE of OHIO, -
 : SS:
COUNTY of CUYAHOGA. .

IN THE COURT OF COMMON PLEAS

ELLA HOPKINS, et al., .
 plaintiffs, .
 .
 : Case No. 274355
 .
 :
KAISER FOUNDATION HEALTH :
PLAN OF OHIO, et al., .
 defendants. .

Telephonic deposition of WILLIAM H. HINDLE, M.D.
a witness herein, called by the plaintiffs for the
purpose of cross-examination pursuant to the Ohio
Rules of Civil Procedure, taken before Kelly Keyes
a Notary public within and for the State of Ohio,
at the offices of Donna Taylor-Kolis, Co., L.P.A.,
1015 Euclid Avenue, Cleveland, Ohio on WEDNESDAY,
APRIL 24TH, 1996, commencing at 1:00 p.m. pursuant
to agreement of counsel..

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1 MISS KOLIS: We're not going
2 to swear in the witness, if that is okay with you.
3 It's okay if he promises to tell the truth, how is
4 that?

5 MR. BONEZZI: All right.

6 MISS KOLIS: Since we can't
7 see you I suppose.

8 -----

9 CROSS-EXAMINATION

10 BY MISS KOLIS:

11 Q. Doctor, for the record could you state your
12 name and your business address?

13 A. William H. Hindle, my business address is
14 Women & Children's Hospital, L.A. County,
15 USC Medical Center, 1240 North Mission Road,
16 Los Angeles, California.

17 Q. Currently who is your employer?

18 A. University of Southern California.

19 Q. What is your position with the university?

20 A. Professor of clinical obstetrics and
21 gynecology.

22 Q. If at any time, Dr. Hindle, I ask you a
23 question that you don't understand, tell me to
24 rephrase it for you, all right? Whatever way I can
25 communicate the question the best is what we'd like

1 to seek out today, okay?

2 A. That would be fine.

3 Q. I have reviewed your curriculum vitae, I
4 assume that it is current. For the record, we
5 don't have to go through it in too much detail, we
6 will mark my copy of your CV Exhibit A,

7 Let me ask you this, we can see
8 from your CV where you attended undergraduate
9 school, medical school, et cetera: Subsequent to
10 completing your residency have you had any
11 specialty training, did you do a Fellowship?

12 A. No, I did not do a Fellowship,

13 Q. You are Board certified I gather?

14 A. Yes.

15 Q. In what specialties are you Board certified?

16 A. Obstetrics and gynecology.

17 Q. When did you obtain that Board certification,
18 Dr. Hindle?

19 A. 30 years ago, it says on the CV.

20 Q. I'm not looking at your CV, I'm just asking
21 short introductory questions,

22 MR. RICE: I don't have
23 a CV, do you have an extra copy?

24 MISS KOLIS: Sure, I don't
25 have an extra one,

1 Q. Sorry. I'm handing Mr. Rice your CV since he
2 hasn't had an opportunity to look at it.

3 Dr. Hindle, because I'm not there,
4 I can't see what materials you have. I assume that
5 you have a file relative to this case?

6 A. I have reviewed a file that is in my office
7 and then Mr. Bonezzi has the records.

8 Q. Basically speaking, can you tell me from your
9 memory or whatever is in front of you what medical
10 records you've reviewed in this matter?

11 A. The doctor's office records, his deposition
12 and the --

13 THE WITNESS: What is the
14 other one you told me about, the oncologist,
15 the DS or something like that?

16 MR. BONEZZI: I sent some of
17 the oncology records,

18 A. Some of the oncology records of her
19 subsequent care.

20 Q. Did *you* review the Kaiser chart covering the
21 period of time from January, 1992 through September
22 of 1993?

23 A. No, not all of it, I was sent a portion of
24 it.

25 Q. You did review selected records from Kaiser?

1 A. Some of them.

2 Q. I'm going to flip through here and we'll get
3 you right to some of the more important questions.

4 First of all, the CV you provided
5 to Mr. Bonezzi, are there any publications which
6 you now have in process that are not listed on
7 your CV?

8 A. That are in process?

9 Q. Right. Something that you are working on
10 that has not yet been published.

11 A. About four different chapters for textbooks,
12 but they are --

13 Q. Can I gather based upon my extensive review
14 of the literature you've written that those are all
15 going to be about breast cancer, the chapters that
16 you're writing?

17 A. They are all about breast disorders.

18 Q. Breast disorders, okay.

19 In addition to the medical records
20 that we have just discussed and Dr. Wisler's
21 deposition, have you reviewed the depositions of
22 any of the Kaiser employees?

23 A. No.

24 Q. How did you become involved in this matter,
25 Dr. Hindle?

1 A. Mr. Bonezzi's office called me.

2 Q. Have you done work for Mr. Bonezzi's office
3 previously?

4 A. No,

5 Q. Do you know how they came by your name?

6 A. It was a long time ago, I don't remember what
7 he told me at the time.

8 MR. BONEZZI: I read your
9 literature,

10 A. He now tells me he read my literature,

11 Q. I would suspect that may be how he got your
12 name.

13 Do you recall when you were first
14 contacted in this matter?

15 A. Several years ago.

16 Q. At the time that you were initially
17 contacted, did Mr. Bonezzi give you a general
18 description of what the issues were in this case?

19 A. My recollection is we had a telephone
20 conversation where he went over the case in a
21 general way and then he sent me a summary letter.

22 Q. By summary letter you mean that he summarized
23 the facts of the case for you and put that in
24 written form?

25 A. Yes.

1 Then subsequently he sent me the
2 documents in the medical record and the deposition,

3 Q. To the **best** of your recollection, after you
4 received the medical records and the deposition did
5 you independently verify the **factual summarization**
6 that Mr. **Bonezzi** gave you?

7 A. Oh, yes,

8 Q. **Out of curiosity**, by any chance **do** you **know**
9 the defendant, Dr. Kevin Wisler?

10 A. I do not.

11 Q. Have you spoken with Dr. Wisler regarding
12 this case?

13 A. I have not,

14 Q. **What is your** understanding of **your** role in
15 this **matter**?

16 A. To be an expert witness on the standard of
17 care for obstetricians and gynecologists in
18 evaluating breast disorders.

19 Q. I would ask you at this time to provide to
20 Mr. Bonezzi a photostatic copy of all
21 correspondences between your office and his office,
22 all right? I don't know if you can give it to him
23 today or not before he leaves, **but** sometime within
24 the next week I would like to see the basic
25 correspondence file,

1 A. I assume he has it all in his office.

2 Q. He might, but between the two of you if I
3 could have what would constitute the complete
4 correspondences between the two of you regarding
5 the case, I would appreciate it.

6 A. In any case, he will get that to you,

7 Q. That would be great.

8 You authored a report on
9 August 8th, 1995, do you have that report with you?

10 A. I will in just a moment.

11 Q. Have you located your report?

12 A. I'm searching for it.

13 Q. No problem,

14 Since we are not there physically
15 we can't tell what you are doing.

16 MR. BONEZZI: Are you there?

17 MISS KOLIS: Yes.

18 MR. BONEZZI: I thought I had
19 it, I don't have it with me,

20 MISS KOLIS: Don't worry
21 about it. It's not a real long report, I will just
22 read some things to him I'm sure at some point.

23 Q. Subsequent to writing this report,
24 Dr. Hindle, had Mr. Bonezzi shown you the reports
25 written by other experts in this matter?

1 A. I don't have a record of the exact dates of
2 when I received the different depositions and
3 summary letters of other physicians.

4 Q. To clarify what information I was seeking: I
5 was curious as to whether or not you have read the
6 reports written by other experts in this case?

7 A. There was one by Dr. Rosenthal.

8 Q. Right.

9 A. That I recall.

10 MR. BONEZZI: As far as the
11 other experts, those would be the Kaiser experts.
12 I do not believe that I have provided those to him,
13 but I know I didn't provide Dr. Spatzler.

14 MISS KOLIS: I will accept
15 that answer, Mr. Bonezzi.

16 Q. After you reviewed the materials, Dr. Hindle,
17 did you feel the need for additional material in
18 order to reach your conclusion in this matter?

19 A. No, because my conclusions were based on the
20 medical records I was asked to evaluate and the
21 deposition of the doctor involved, and I have both
22 those documents.

23 Q. That was all you felt you needed.

24 Did you ask at any time to see the
25 film of the mammogram that was performed at

1 Dr. Wisler's request?

2 A. I did not.

3 Q. When you reviewed the medical records and the
4 deposition did you make notes of some sort?

5 A. I did not.

6 Q. Do you recall when you arrived at your
7 opinion in this matter?

8 A. In written form is when I wrote the letter as
9 requested, or the statement of my opinion.

10 Q. Since you **don't** have your file today you are
11 not very certain as to when you were initially
12 contacted regarding the case?

13 A. I would say **it** was about two years ago, but I
14 don't have that,

15 Q. That's all right. As close as you can get
16 **it**, I guess, at this point.

17 By the way, even though this has
18 nothing to do with **it**, are you planning to come in
19 for trial?

20 A. I will come in if requested and that is
21 required.

22 Q. Can you, Dr. Hindle, at this time summarize
23 for me what opinions you hold based upon your
24 review of the records and the deposition of
25 Dr. Wisler?

1 A. Yes.

2 I would say based on the medical
3 record and his clarification in the deposition when
4 he first saw the patient in regard to her breast
5 complaint, his subsequent management of that and
6 then her transfer of care to another facility --
7 that particular recording of her first issue of a
8 breast complaint was on 8-25-90, and I have his
9 office record in front of me.

10 Q. My specific question was: What opinions do
11 you hold as to the care and treatment rendered by
12 Dr. Kevin Wisler to Ella Hopkins?

13 A. In reviewing this record compared to other
14 obstetricians and gynecologists his care was
15 appropriate, and he met the standard of care for
16 obstetrics and gynecology regarding breast
17 disorders.

18 Q. Can you state with specificity the factual
19 basis for that contention?

20 A. The medical records of the doctor, his
21 findings and his evaluation, and the appropriate
22 steps that he took to evaluate his findings.

23 Q. What I will probably do is ask you some
24 specific fact questions to make this easier for
25 myself.

1 First of all, can I gather that
2 what you're saying -- even though you haven't used
3 the word -- is that based upon the presentation of
4 this breast complaint that Dr. Wisler undertook,
5 what you call in your writings, the triad
6 evaluation of the breast; is that what you're
7 talking about?

8 A. Yes .

9 Q. That he did a clinical examination, he did a
10 fine needle aspiration, and he did mammography,
11 correct?

12 A. Yes .

13 P. We will get back to those. I have all the
14 facts listed out from his deposition that I'm going
15 to want to talk to you about.

16 In your review of Dr. Wisler's
17 chart do you have any criticisms of the conduct of
18 the plaintiff, Mrs. Hopkins?

19 A. Any criticism of the patient?

20 Q. Yes, that's my question,

21 MR. BONEZZI: Her initial
22 evaluation or her total care?

23 MISS KOLIS: Total care.

24 Q. I assume that you have Dr. Wisler's complete
25 chart?

1 A. Yes.

2 It seems from the notes that were
3 made by the doctor and his staff on the mammogram
4 report that she was advised to return for a follow
5 up and I find no record that she did that.

Q. Have you with particularity and specificity,
7 I suppose, looked at Dr. Wisler's deposition as it
8 regards what he feels may have happened regarding
9 that follow-up appointment?

10 A. Yes, I have read the deposition.

11 Q. If the facts at trial or otherwise are
12 established that Dr. Wisler's office did not
13 schedule Mrs. Hopkins for a follow-up examination,
14 would you be critical of her for not coming in on
15 her own?

16 A. Would I be critical of her?

17 Q. Yes.

18 A. Just to the extent that the patient shares
19 some responsibility of her care, particularly if
20 there is an evaluation of an abnormal finding. The
21 patient would have some responsibility in my
22 opinion.

23 Q. at do you base that opinion on?

24 A. In other cases that I have reviewed and in
-- clinic and in my own practice, the

1 practice of other obstetricians and gynecologists
2 across the country,

3 Q. Let me ask the question in a different way
4 then, Dr. Hindle,

5 If the facts are that the patient
6 was told that the cytology examination was negative
and the mammogram was negative and no information
8 regarding follow **up** was given in that regard, if
9 those are the facts; do you have a criticism that
10 the patient did not come back to Dr. Wisler?

11 MR. BONEZZI: Objection.
12 Donna, are *you* suggesting that Mrs. Hopkins is
13 going to testify that she was never told to come
14 back in two or three months as the records
15 indicate?

16 MISS KOLIS: That's correct,
17 Bill.

18 MR. BONEZZI: Go ahead and
19 answer.

20 A. It is difficult to say that of a woman who **is**
21 being evaluated for a breast mass like she was.

22 She certainly is aware because of
23 the diagnostic procedures that were carried out
24 there was an abnormality and she is not in a
25 position medically to evaluate the reports

1 themselves and be reassured by that; so if she has
2 a persistent mass, in my opinion she has some
3 responsibility to seek follow-up care.

4 Q. Are you stating that if a patient is assured
5 that the results of the testing are negative, that
6 she should not worry about the lump, that she has
7 some independent responsibility to know to come
8 back in for another evaluation?

9 A. The difficulty with that is the
10 interpretation of medical reports, be they x-ray or
11 laboratory reports, they are just reports, they are
12 not infallible in any case.

13 If this patient has persistent
14 symptoms or a persistent problem like a breast
15 mass, in my opinion the patient has some
16 responsibility to return somewhere to have further
17 follow up.

18 Q. I think I understand what your answer is.

19 Do you have any criticisms of any
20 other defendants in this matter?

21 MR. BONEZZI: Objection. Can
22 you be more specific, please?

23 Q. I gather you have no criticisms of
24 Dr. Wisler's initial evaluation and care of
25 Mrs. Hopkins?

1 A. Correct .

2 Q. Based upon your review of the Kaiser records,
3 do you have criticisms of any of the employees at
4 Kaiser in terms of their subsequent care and
5 treatment of Mrs. Hopkins?

6 A. I wasn't asked to evaluate Kaiser records, I
7 do not have those records in their entirety, **so I**
8 have not formed an opinion about that.

9 Q. At the time that you read the Kaiser records,
10 what was your purpose in reading them?

11 A. I was reading all the records that were sent
12 to me and some of them were included in the records
13 that were sent to me.

14 Q. It is not in your report, of course, but can
15 you recall today what you learned about her
16 subsequent course of care in reviewing those
17 Kaiser records?

18 MR. BONEZZI: I'm sorry,
19 Donna. Would you repeat that, please?

20 MISS KOLIS: Sure. I'm
21 asking him if he has a recollection of what he
22 learned about Mrs. Hopkins' subsequent course of
23 care from reviewing the Kaiser records,

24 A. She was diagnosed as having breast cancer and
25 then treated for that subsequently.

1 Q. Do you have a recollection of reviewing
2 portions of the medical records that related to the
3 examinations of her breast that were performed by
4 personnel at Kaiser prior to diagnosis?

5 A. My recollection is that there was an early
6 report of the nurse who did an evaluation, and then
7 subsequently the cancer was diagnosed and
8 subsequently treated.

9 Q. We will probably get back to that later.

10 In reaching your conclusions in
11 this matter did you do a literature search of any
12 sort?

13 A. I did not.

15 and that which you have published, I would gather?

16 A. And the medical records that I have reviewed,
17 yes.

18 Q. Prior to this particular case, Dr. Hindle,
19 have you ever been asked to become involved as an
20 expert witness in a medical negligence case?

21 A. Yes, I have.

22 Q. How frequently have you testified?

23 A. Testify in court?

24 Q. We can break it down that way.

25 How many times have you testified

1 in court?

2 A. Probably about four times in the last
3 ten years.

4 Q. Other than testifying in court, with what
5 regularity are **you** retained to review records?

6 A. Probably once a month.

7 Q. Whom do you review records for?

8 A. Attorneys.

9 Q. See, that's what I get for asking a
10 loose question,

11 Are you predominately retained by
12 attorneys who represent physicians?

13 A. Yes, predominantly.

14 Q. Have you **eves** testified for a plaintiff?

15 A. Yes, I have,

16 Q. What would you guess or if you know what is
17 the percentage of the breakdown between plaintiffs
18 and defendants?

19 A, Probably somewhere between 10 and 20 percent.

20 Q. So about 80 percent of the time **it** would be
21 on behalf of a physician, correct?

22 A. Correct,

23 Q. Doctor, is greater than 50 percent of your
24 current medical practice dedicated to actual
25 clinical medicine?

1 A. Yes.

2 Q. Your CV indicates that you are a professor of
3 clinical obstetrics and gynecology, and you are the
4 director of the Breast Diagnostic Center?

5 A. Correct.

6 Q. Can you tell me approximately what amount of
7 time you spend in your capacity as the director of
8 the Breast Diagnostic Center?

9 A. The majority of it.

10 Q. So your teaching responsibilities are more
11 limited, is that what your answer would be?

12 A. I no longer do obstetrics, I have some
13 general responsibility in the department of
14 gynecology, but my major focus is the Breast
15 Diagnostic Center within the department of
16 gynecology.

17 Q. What are your duties as the director of the
18 Breast Diagnostic Center?

19 A. I established it and I supervise it. I
20 supervise it and each of the resident physicians
21 who are rotating through the service.

22 Q. Are you still doing hands-on medical
23 practice, you are not just supervising?

24 A. I no longer do private practice, my own
25 private patients; but I, of course, examine the

1 patients with the residents and do hands-on work,
2 both with surgery and with examinations,
3 continuously with fine needle aspirations,

4 Q. How many patients would you say you see a
5 week?

6 A. In the clinic we see about 50 new patients
7 a week.

8 Q. Can I gather that the primary purpose of the
9 Breast Diagnostic Center is to evaluate
10 abnormalities of the breast? I know that sounds
11 redundant, but I just want to make sure that's what
12 you guys do there,

13 A. Yes. I would say it is a referral clinic, it
14 is within the county's health care system and the
15 patients there have been referred by other
16 physicians there, either inside the county system
17 or outside of it, if they have a specific
18 complaint.

19 When I say 50 patients, that's
20 50 new patients that have not previously been
21 evaluated.

22 Q. Does your diagnostic center employee nurse
23 practitioners?

24 A. We don't employ anybody directly, the nursing
25 staff is provided by Los Angeles County

1 * Let me ask the question a better way then.

2 In your facility do nurses do the
3 breast evaluations, the clinical breast
4 evaluations, or do the physicians?

5 A. Basically physicians do.

6 Recently with changes in the budget
7 of the county, they have curtailed the nursing
8 staff and they have provided a nurse practitioner
9 who assists us with some of the follow up and
10 referral of the patients, and the follow up with
11 their diagnosis and those who are referred to
12 surgery. She happens to be a nurse practitioner,
13 but she wasn't hired by me nor anyone else to serve
14 that function.

15 Q. So that I will be perfectly clear on it
16 because I want to ask you some questions about that
17 arena: When you are doing a primary evaluation of
18 a breast mass, would you give that responsibility
19 to a nurse practitioner?

20 MR. RICE: Objection.

21 You can answer.

22 A. Not in our setup because we are primarily set
23 up to teach residents in obstetrics and gynecology
24 to do exactly that, So the examinations and the
25 fine needle aspirations are done by the residents

1 under supervision,

2 Q. You indicated that you do have a recollection
3 when you initially looked at the Kaiser records
4 that a nurse was involved in the initial evaluation
5 of Mrs. Hopkins?

6 A. That's my recollection.

7 Q. Can you recall from the document what the
8 nature of the breast examination was?

9 A. I don't have that record in front of me.

10 Q. Do you remember anything about the breast
11 evaluation that was recorded in that document?

12 A. Just that the nurse examined the patient.

13 Q. Do you recall if there were any findings at
14 that time?

15 A. I don't really recall and I don't have that
16 record in front of me. ...

17 Q. Doctor, from your CV it seems that you have
18 authored many publications, especially concerning
19 fine needle aspirations; that would be a fair
20 statement, correct?

21 A. Yes.

22 Q. You are prominent and well studied I guess on
23 the subject of the diagnostic triad.

24 Can you explain to me as simply as
25 possible what the diagnostic triad consists of?

1 A. It consists of a diagnostic approach to a
2 patient with a breast disorder, obtaining a breast
3 oriented history, doing a clinical breast
4 examination. Then if there is a mass to do a fine
5 needle aspiration and to do a mammogram, and then
6 to base the evaluation on all of that information,

7 Q. When **you** say "if there is a mass," can **you**
8 define for me so we don't have a language problem
9 later what a mass means when **you** are **using** that,
10 "If there is a mass to do a fine needle
11 aspiration"?

12 A. What I mean by mass is the dominant breast
13 mass which by definition is a three dimensional
14 distinct mass that it different than the rest of
15 the breast tissue and different from the tissue in
16 the other breast,

17 Q. If someone described an area of thickening,
18 what would that mean to you?

19 A. That would be an area of thickening, that
20 would not be a dominant breast mass.

21 Q. This diagnostic triad that you described, how
22 long would you say that this has been the standard
23 of care in the evaluation of breast disorders?

24 A. I am not even sure of the standard of care
25 everywhere in the United States at this time

1 because the application of fine needle aspirations
2 by primary care providers such as gynecologists is
3 different in different locations. It is something
4 that's available to them, but some physicians who
5 have not been trained in the technique are not
6 comfortable in using and they do not utilize it;
7 but it is something that is available.

8 Q. If a physician is not trained in fine needle
9 aspiration or it is not something that's available
10 at their facility and a person presents with a
11 dominant palpable breast mass, what would that
12 person then be required to do?

13 A, In my opinion they would be required to refer
14 the patient to someone who either does fine needle
15 aspirations or is an expert in examining the breast
16 or does open surgical biopsies.

17 Q. Besides revealing the existence of a lump
18 itself, what can a physician learn during an actual
19 physical examination of a breast?

20 A, Nature of the breast, the rest of the breast
21 tissue, whether there is a tenderness, whether
22 there is changes in the skin, whether there is
23 evidence of infection, whether there is any
24 discharge, whether there are palpable lymph nodes.

25 Q. Can a physician ever reach a definitive

1 diagnosis based on physical examination of the
2 breast only?

3 A. We are into semantics, and by definition it^t
4 is my understanding that to establish a definitive^e
5 diagnosis -- they can establish a clinical
6 impression and they can call that a diagnosis, but
7 it is the clinical diagnosis and not a definitive
8 cause.

9 In my **use** of the word, definitive
10 implies either a cytologic diagnosis with an
11 adequate cell sample or a histologic diagnosis of
12 history obtained by biopsy.

13 Q. So all the physical examination does is add
14 to or subtract perhaps from a clinical impression
15 of whether a lump or a mass is malignant or benign;
16 do you agree with that?

17 A. The most important thing about physical
18 examination is whether the mass is even there.

19 Q. Correct. All right.

20 If a lump is described as smooth to
21 the feel of the physician, what does that indicate
22 to you if anything about the status of the lump?

23 A. If it is smooth it is thought to be a more
24 favorable characteristic by clinical impression,
25 but there is no certainty about whether that

1 relates to a malignancy or benign condition,

2 Q. So it could be smooth and it could be
3 malignant as well?

4 A, Correct.

5 Q. Same thing, the question regarding firmness
6 of the palpable mass, what does that tell a
7 physician clinically?

8 A. The typical breast cancer is ductile
9 carcinoma and they typically infiltrate and have a
10 lot of fibrous reactions, they are very hard and
11 they are irregular.

12 There are other forms of cancer and
13 even the ductile carcinoma sometimes will be
14 related as having a smooth structure or not be firm
15 to palpation, Though typically the most common
16 type of breast cancer is firm and irregular and
17 tends to have lack of mobility,

18 Q. But you are also indicating by your answer
19 that something that is eventually diagnosed as
20 ductile carcinoma doesn't necessary present itself
21 as a firm, hard lump on the first examination?

22 .A* That's correct, and in clinical medicine
23 there is exceptions to everything.

24 Q. Sure.

25 Once again, Doctor, can I assume

1 that your answer in this arena is the same as to
2 the mobility of the lump at the time of
3 examination, that it doesn't really tell you for
4 sure one way or the other whether the lump itself
5 is malignant or benign?

6 A. That's correct and those are all
7 characteristics, the smoothness, the mobility, the
8 lack of hardness that are assumed to be clinically
9 "benign" characteristics, but they are currently
10 not diagnostic.

11 Q. What does a complaint of breast pain or
12 tenderness associated with a lump mean to *you*
13 clinically, does it have any relevance in
14 determining whether something is benign or
15 malignant?

16 A. Yes, it is like the other characteristics
17 that we have been describing, the firmness, the
18 irregularity, the mobility in general and
19 tenderness is considered a "benign" characteristic,
20 and goes along with the others; but as we have been
21 discussing, it is not diagnostic and the clinician
22 would not rely on that as a final diagnosis in
23 doing the management,

24 Q. What does retraction of the skin indicate to
25 you in terms of the skin being retracted in the

1 area where the lump is palpated?

2 A. If there is some change the tissue has
3 probably some scarring below that if it is new.
4 Some women have had retraction for many, many years
5 and that clinically is less significant, Either
6 infections or trauma or tumors can underlie
7 retraction.

8 Q. Do you have a recollection or you can look at
9 Dr. Wisler's chart and see that he made a notation
10 at the time of her presentation in August that
11 there was retraction associated with the mass that
he palpated?

13 A. The record I am looking at is dated
14 May 25, '90 from Dr. Wisler and there is a diagram
15 on it of the breast. On the left side there is
16 part of a circularly mass, going through it with a
17 squiggly line looks like it says "slight retraction
18 afterwards" if I read his writing correctly.

19 Q. I would represent to you that he has
20 testified that that's what he said it says, it says
21 "slight retraction.

22 A. That's what he said in the deposition if I
23 recall.

24 Q. He did.

25 What does thickening of the skin

1 above a lump indicate?

2 A. Thickening of the skin above the lump is like
3 any finding in the breast: The more findings there
4 are, the higher the suspicion is and the greater
5 the need to proceed to a definitive diagnosis.

6 Q. In moving ahead -- and we might have to look
7 at something that Dr. Wisler said.

8 He completed the diagnostic triad
9 OR Mrs. Hopkins, correct?

10 A. Yes.

11 **a.** We have established that,

12 What is your understanding of
13 Dr. Wisler's impression at the conclusion of that
14 procedure?

15 A. Well, the other information in the deposition
16 that he had thought this was a benign breast mass
17 that had some fluid in it, that would indicate some
18 cystic changes of the breast that were responsible
19 for the fluid that was obtained,

20 Q. Do you recall what he said about whether the
21 lump still existed after the aspiration?

22 A. I don't have the deposition in front of me.

23 Q. You are going to have to hold on because we
24 might have to read some information. While Anne's
25 looking for that, I'm going to ask you some other

1 questions.

2 Following the diagnostic triad, if
3 a physician is not assured that the lump that he
4 has examined is benign, what is the next step?

5 A. In any situation a follow **up** of a breast
6 abnormality is to follow it up, re-evaluate it in
7 the future and see if it progresses or changes or
8 subsides.

9 Q. Let me indicate to you -- I understand you
10 don't have the deposition and Mr. Bonezzi can
11 change this at a later time I suppose if he doesn't
12 have it, but Dr. Wisfer was asked in his deposition
13 whether or not the mass resolved followed --

14 MR. BONEZZI: Why don't you
15 tell me where you're reading from first?

16 MISS KOLIS: Page 38, lines
17 7 through 11.

18 MR. BONEZZI: Go ahead.

19 Q. It says my standard thing is if it is
20 completely resolved I put resolved, the context,
21 Doctor, is where I asked him about the lump.

22 Question, what if it has not?

23 Answer, I don't put resolved.

24 Question, you don't put anything
25 down?

1 Answer,. right, from looking at my
2 notes I assume that the mass was still there
3 subsequent to the aspiration,

4 That's what the testimony was,
5 Dr. Hindle.

6 Now,. given that the mass did not
7 resolve following the aspiration, that's what
8 Dr. **Wisler's** testimony is, what should have been
9 the next thing that should have happened to
10 Mrs. Hopkins?

11 A. Two things that did happen, they did the
12 mammogram and he advised her to come back for
13 re-evaluation in I believe the note said two to
14 three months; and then the note that's written on
15 the mammogram report --

16 Q. If we can hypothesize in this matter, let's
17 say for the sake of the question I want to ask is
18 that she did come back in two to three months and
19 the lump was still there.

20 A. Yes.

21 Q- What would the standard of care have required
22 at that time happen to the lump?

23 A. Some further diagnostic procedure or referral
24 to the patient.

25 Q. When you say some further diagnostic

1 procedure are you referring to a repeat **FNA**?

2 A. It could be, or **it** could be a needle tissue
3 core biopsy, or **it** could be an open surgical
4 biopsy.

5 Q. In any event something more definitive would
6 need to occur at that point in time?

7 A. Something further,

8 Q. Something further than had occurred in August
9 and September, correct?

10 A. The reason I **say** further is because this
11 could include repeating the fine needle aspiration,

12 Q. I suggested that as a possibility.

13 A. Yes ,

14 Q. If that fine needle aspiration was once again
15 negative and the cytology was negative, at that
16 point would the standard of care require in the
17 face of a lump that persisted **for** there to be an
18 open biopsy?

19 A. First, let me clarify that I never use the
20 word or try never to use the words negative or
21 positive because negatives are fine, but there is
22 nothing there and both with mammograms and fine
23 needle aspiration you either get specific
24 information or you don't; and if you don't, then **it**
25 doesn't prove that nothing is there because nothing

1 does that, it isn't even true of an open surgical
2 biopsy.

3 You have to look at the report
4 itself and see what he reports, and if he reports
5 like this in this case that there was something
6 there that was not malignant there, then that
7 means that's benign with what you get from normal
8 breast tissue.

9 Many of the lumps and bumps in the
10 breast that are palpable as dominant breast masses
11 are in fact a configuration of fibrocystic changes
12 of normal breast tissue and you would get normal
13 structural cells as they did in that situation.

14 Q. My question is -- and I understand now that
15 you don't want me to use the words positive and
16 negative, so I won't.

17 A* You can use --

18 Q. In order for you to answer my questions, I
19 guess I should ask them in whatever way you are
20 comfortable with them.

21 First of all, let me deal with the
22 cytology that came from Dr. Wisler's FNA.

23 A* It **was** --

24 Q. I don't know what word you want me to use,
25 It didn't say she had a cancer, let's put it that

1 way, right'?

2 A. Right.

3 Q. The finding itself does not indicate that she
4 doesn't have cancer. In other words, I guess the
5 issue I am addressing or that you are alluding to,
6 I'm sure, is that there are false negatives?

7 A. Let's be clear about the false negatives. If
8 you don't obtain any cells, then you don't know
9 anything, it is as if you hadn't done the fine
10 needle aspiration, The report says minimal number
11 of epithelial cells present for adequate cytologic
12 examination, no malignant cells identified.

13 Now, they have a normal breast
14 tissue finding in the fine needle aspiration, which
15 is a common finding in doing fine needle
16 aspirations of dominant breast masses, so that is
17 consistent with the benign process, So there is no
18 evidence of malignancy there.

19 Now, this was done with a very
20 small needle, usually a 22 gauge needle, so there
21 could always be sampling error if the needle isn't
22 where something is, then of course you have no
23 sample; but that's true when you're evaluating the
24 whole breast or doing biopsies, if the tissue comes
25 from someplace where the lesion doesn't exist, then

1 you don't know about the lesion,,

2 Q. The question I asked was if you got a
3 persistent lump and the FNA comes back not
4 diagnostic for the cancer, you can't be sure that
5 there is no cancer?

6 A. You can never be sure there is **no** cancer,

7 Q. At that point isn't it acceptable medical
8 practice then to attempt to do a histological
9 diagnosis by an **open** biopsy?

10 MR. BONEZZI: Objection. At
11 what time following the fine needle aspiration?

12 Q. I'll give you the range, three to
13 six months.

14 A. If I heard you correctly, is it acceptable
15 medical practice to do a biopsy? I have to answer
16 yes, it is certainly an acceptable process to do a
17 biopsy and also acceptable practice not to do a
18 biopsy, but to continue to follow the patient when
19 you have concordance of the diagnostic triads that
20 by clinical examination, by fine needle aspirations
21 and by mammogram, they all indicate the benign
22 process- It is perfectly acceptable and it is
23 within the standard of care of obstetricians and
24 gynecologists to continue to **follow** the patient and
25 see if the palpable abnormality changes with time,

1 Q. Let me see if I understand this: You think
2 concordance is obtained when a lump does not
3 deflate, let me ask that first?

4 A. Well, deflating or not deflating is not the
5 issue of concordance, Deflating or not deflating
6 has to do, in my experience, with cysts and if you
7 take cysts and evacuate the fluids then the mass
8 will disappear to palpation.

9 Q. Sure. If you draw fluid and it doesn't
10 deflate, can't you at least make a reasonable
11 clinical conclusion that it in fact is not a cyst?

12 A. Well, we have to be careful about what we're
13 using the term cyst for because what we have now is
14 a fibrocystic disease and it is very common, and as
15 common as the very lumpy, bumpy fibrous
16 irregularity; and if the fine needle aspiration
17 goes up through one of those microcysts, then you
18 would get a small amount of fluid,

19 So it isn't a question of fluid and
20 no fluid, if you have a large palpable cyst the
21 size of a golf ball you're going to get a whole
22 syringe full, but it is clear that you are dealing
23 with a cyst and that should disappear.

24 Q. This was not a large cyst, a large mass at
25 the time that Dr. Wisler palpated it, do you agree

1 with that? It was 1.5 by 2 by 1.5 I think,

2 A. That's fine.

3 Q. You agree with me that those were the
4 dimensions that he recorded?

5 A. They are close to that, I would have to look
6 at that again. 1.5 by 2 by 1.5 is what I see,

7 Q. That's what I just indicated,

8 A. Okay.

9 Q. If this had been a fluid filled cyst and he
10 did an FNA, wouldn't you have expected it to
11 completely collapse?

12 A. Yes,.if the entire mass was a cyst, but the
13 fact that it doesn't collapse doesn't mean that
14 they are what we call microcysts. Microcysts have
15 an amount of fluid in the breast which is very
16 common when you have fibrocystic changes in the
17 breast, which is a very common palpable abnormality
18 and then will be evaluated for dominant breast
19 mass.

20 Q. In reading Dr. Wisler's deposition, do you
21 recall that he stated that if Mrs. Hopkins had
22 returned to him three months later and the mass was
23 still there that he would have referred her out for
24 an open biopsy?

25 A. That's my general recollection and I don't

1 have that in front of me.

2 Q- Do you take issue with the fact that he would
3 have at that point have sent her out for open
4 biopsy?

5 A. No, I believe I stated that the next step is
6 appropriate to do some further procedure, whether
7 that is repeat fine needle aspiration or a tissue
8 core needle biopsy or an open surgical biopsy or
9 whatever the consultant recommends.

10 I have seen similar cases where the
11 consultant surgeon gives breasts oncologists such a
12 strong feeling that the mass is a totally benign
13 process, but the surgeons continue to follow the
14 patient and that is the judgment of the consultant,

15 Q. You don't think that the standard of care
16 requires that a biopsy be performed in the face of
17 a persistent palpable lump?

18 A. No, I do not. When the patient has been
19 referred to a consultant, the consultant in
20 evaluating the entire situation, examining the
21 patient, taking their own history and evaluating
22 the mammogram reports and the fine needle
23 aspiration report, and if their impression of that
24 is that that's totally a benign process, then in my
25 opinion the consultant would be justified in

1 continuing to follow the patient and observe the
2 patient in some future time like in two or
3 ~~three months.~~

4 Q. If you continue to observe and **follow** the
5 patient, what would make you decide to do a biopsy?

6 A. If the patient had a character **of** a **mass**,
7 particularly if **it** is getting larger, or in my
8 opinion, if the patient continues to worry about **it**
9 and they are concerned we might be dealing **with** a
10 malignancy or if **I** have any suspicious whatsoever
11 that **it** might be malignant.

12 Q. You would wait until **it** grew to biopsy **it**?

13 A. I didn't say that,

14 I said **it** is within the standard **of**
15 practice if the consultant who is presumed to be a
16 specialist in breasts on the initial evaluation
17 thinks **it** is totally benign, then that consultant,
18 particularly if the patient is a menstruating woman
19 with breasts changing with her menstrual cycle, may
20 wish to examine that patient again after another
21 menstrual cycle or two months later, or more
22 commonly what you are describing as what would be
23 carried out if the patient would be biopsied.

24 Q. We would carry that biopsy out to make sure
25 there is not carcinoma, a cancer, correct?

1 A. Well, even biopsies don't absolutely prove
2 things aren't there, but that is the next step in
3 the diagnosis of the breast and that is the one
4 that is most commonly done.

5 Q. From your recollection, was Mrs. Hopkins a
6 woman who was still menstruating?

7 A. I believe she had had a hysterectomy.

8 Q. I just wanted to make sure that you
9 understood that.

10 When you do an **FNA** and you draw
11 blood tinged aspirate, what does that mean to you?

12 A. It means one of two things, either that the
13 trauma or the fine needle aspiration created some
14 bleeding in the tissue so some of that blood is
15 drawn out in the needle, or the syringe or the area
16 that you are evaluating has some **prior** hemorrhage
17 bleeding into **it** and you can get that out into the
18 syringe.

19 Q. Is blood in the aspirate a concern to the
20 clinician who is doing an FNA as being suggestive
21 that there is a malignant process occurring?

22 A. It is a concern for two reasons because the
23 blood affects the accuracy of the cytologic
24 evaluation, **it** is harder to interpret **cells** that
25 are in hemorrhage and causing blood clots; so

1 ideally you want to have an aspirate that is not
2 bloody.

3 The paradox is that most carcinomas
4 are vascular, so most aspirations out of carcinoma
5 are bloody aspirates.

6 Q. You can correct me if I'm wrong, I know we
7 are going to get it here because I have a stack
8 here of references.

9 You have written in fact that if
10 the aspirate is bloodied in some way that it really
11 is an indication for an immediate open biopsy?

12 A. What are you quoting?

13 Q. Well, let's see if we can find it. I don't
14 know if Ann wants to steal this, because I must
15 have 30 pages of questions. So I'm going to let
16 Ann look for that, she'll try to find the
17 reference.

18 I'm asking you if that's something
19 that you would have written?

20 A. Well, I'm having a problem with the context
21 of something like that may have been written in
22 because in aspirating cysts, if you get gross
23 fluids that's a sign that there might be some
24 intracystic neoplasm.

25 As I said, with aspiration of the

1 most common breast cancer, ductile carcinoma, in my
2 experience, most of those aspirations are bloody
3 aspirates but you can still make an adequate
4 cytologic interpretation and make the -- finalize
5 the diagnoses of carcinoma, and if you have that
6 then it isn't required to do an open surgical
7 biopsy.

8 Q. Right. If the cytology comes back positive;
9 is that what you're saying?

10 A. If the cytology comes back as malignant.

11 Q. Right. In the instance where you have blood
12 tinged aspirates and the cytology comes back
13 negative, isn't that a circumstance which indicates
14 the need for an open biopsy?

15 A. No.

16 Q. Why not?

17 A. Because it has to do with what cellular
18 material is there. If you don't see cells, you
19 haven't learned anything. If you see totally
20 benign cells in the aspirate like Mr. Wisler did,
21 epithelial cells and no signs of malignancy, that
22 is what you get from normal breast tissue and also
23 some blood from there.

24 Q. So that blood means nothing to you?

25 A. I didn't say blood meant nothing to me, it

1 complicates the procedure- In most malignancy
2 there is blood there, and when there is blood in a
3 cyst it is a sign of a gross cyst where you get a
4 measurable amount of fluid and there might be an
5 intracystic neoplasm and most of those are
6 malignant. It is significant, but not in my
7 opinion an indication for immediate open surgical
8 biopsy,

9 Q. If it is significant but it is not an
10 indication for an immediate surgical biopsy, when
11 given that constellation of factors would a
12 surgical biopsy be necessary?

13 A. If the issue is unresolved as to what the
14 diagnosis is. Again, I would differentiate between
15 a cystic mass where you aspirate blood out of a
16 cyst which is very unusual, but when that happens
17 it is a sign that you may be dealing with an
18 intracystic neoplasm, that is one instance.

19 The other one is if you keep
20 getting blood in the **aspirate** and you do not have
21 other cellular material that's a normal epithelial
22 cell, then you don't have any answer **as** to what the
23 cytology indicates. This is if you have nothing in
24 the smear,. then you have to proceed either with a
25 repeat fine needle aspiration, tissue core biopsy,.

1 or open surgical biopsy.

2 Are you aware or can you recall that
3 Dr. Wisler testified that when he aspirated this
4 mass what he received was a scant amount of fluid
5 slightly blood tinged?

6 A. **That's** my recollection. I would say that's
7 normal, typical,

8 Q Dr. Hindle, do you routinely observe
mammogram films for your own benefit which have
10 been read by the radiographer when you are
11 evaluating breast disorders?

12 A. No, that is not the standard **of** practice
13 across the country in my opinion.

14 **a.** I agree with you, it isn't. **I** simply asked
15 if you did or didn't.

16 Is it possible in your opinion to
17 make **a** definitive diagnosis of cancer versus **a**
18 benign lesion based upon a mammographic reading?

19 A. A mammographic impression is like a clinical
20 impression, When *you* look at **a** film you are
21 looking at a three dimensional mass suspended in
22 two dimensions of black and white shadows and
23 mammographers do not -- mammographers get very good
24 at the clinical correlation between what they see
25 and perceive on the film and what the final

1 definitive diagnosis is.

2 It is the same as clinical
3 evaluation, doctors who do breast examinations full
4 time as their career activity gets a very high
5 correlation between their impression and the final
6 definitive diagnosis, but neither the clinical
7 breast examination nor any mammogram is
8 definitively diagnostic.

9 Q. What did the mammogram reading in this case
10 that Dr. **Wisler** ordered add to determining whether
11 or not Mrs. Hopkins' mass was benign or malignant?

12 A. I have the report in front of me where it
13 says two areas of each breast show relatively dense
14 breast with the dense region being in the upper and
15 outer quadrant of the right breast, there is no
16 detectable dominant mass, there is no tumor
17 calcification,

18 Q. I know what the reading says. I'm asking you
19 what that added to being able to determine whether
20 or not the mass was malignant or benign?

21 A. It shows no evidence of malignancy by that
22 description and no evidence of a cancer by
23 mammography, We then go back to the diagnostic
24 triad of putting that information together with the
25 history, the clinical examination, the fine needle

1 aspirations and the mammogram,

2 The report that I just read is
3 consistent with a benign process with no evidence
4 of malignancy or no red flag called to action
5 another procedure based on the mammogram report.

6 Q. Is it appropriate to definitively diagnose a
7 palpable mass as benign on the strength of the
8 mammograph reading alone?

9 A. No.

10 Q. Of course it's not,

11 Just by way of background, you're
12 saying FNA is not the standard of care across the
13 country, when did the theory or technique of fine
14 needle aspirations first develop?

15 A. When were fine needle aspirations of the
16 breast first done?

17 Q. Yes.

18 A, 1930.

19 Q. When did they become widely used, I guess is
20 the phrase, in this country?

21 A. They became widely used in Europe after the
22 Second World War and I'm not sure that they are
23 widely used in this country even now except for
24 surgeons use them and have traditionally for many,
25 many years to determine whether a palpable mass is

1 a cyst or a solid mass, Only recently, in my
2 experience, have surgeons done fine needle
3 aspiration cytology of solid masses.

4 Q. Why has fine needle aspirations been added as
5 one of the diagnostic tools for breast diagnosis?

6 A. Do I consider **it** one?

7 Q. I said why has it been added, what are the
8 benefits of doing a fine needle aspiration?

9 A. Because in the 22 gauge needle with a
10 procedure that takes no longer than a venous
11 puncture and no more painful than a venous
12 puncture, one can establish **a** cytologic diagnosis
13 on 90 percent of the neoplasms of the breast if you
14 get an adequate blood sample, it can also be done
15 as an office procedure.

16 Q. You're saying 90 percent because -- we'll
17 loosely go through different numbers in different
I*
19 diagnosis which would appear to be negative is in
20 fact not negative, false negatives is **what** the
21 topic **is**.

22 Are 10 percent of the findings of
23 false negatives incorrect?

24 A. You have to be very specific when you talk
25 about "false negatives" because if you do not have

1 an adequate cell sample then you don't know
2 anything, and for statistical purposes that's
3 considered inadequate or "false negative." It is
4 like a mammogram that doesn't show anything, it
5 doesn't prove that nothing is there, which is why I
6 prefer not to use the terms negative or positive
7 because it gets confusing to everyone involved,

8 Q. In your opinion based upon the cytology
9 report that you saw in this matter, was there
10 adequate cell material to be evaluated?

11 A. The report says cells present for adequate
12 cytologic evaluation.

13 Q. The fact that that cytology reports does not
14 indicate a malignancy which is later found, what
15 does that tell you if anything?

16 A. What does it tell me?

17 Q. Yes.

18 A. Where that fine needle aspiration was done
19 there was not a cancer.

20 Q. Does fine needle aspiration cause scarring on
21 the breast?

22 A. Only if there is a hematoma formation and
23 bleeding of the tissue can you get secondary
24 scarring.

25 Q. Based upon the use of a 22 gauge needle even

1 if there was a hematoma, let's assume ^{there was a} there wa
2 hematoma, where would the scarring extend, what
3 would it look like?

4 A. I had one patient that had a blood
5 desecration that covered her entire breast.

6 Q. That would be something that you could see
7 pretty clearly, wouldn't it?

8 A. Not necessarily, because it is usually in the
9 tissue, It is like when they do mammography needle
10 localization procedures, you can see bleeding
11 within the tissue but you can see nothing on t

12

13 Q. The size of the wound or the puncture,
14 whichever you prefer to call it, is small enough
15 that it can be covered by a circular bandage,
16 correct?

17 A. Yes. In fact, we don't even put Band-Aids on
18 them at all, it is the same size needle that is
19 used to draw blood.

20 Q. Will fine needle aspiration cause a
21 thickening of the skin?

22 A. Usually makes no change whatsoever.

23 Q. I'm skipping my whole page of fine needle
24 aspiration questions because I think I know what
25 you're going to say.

1 Dr. Hindle, fine needle aspiration
2 is only an additional diagnostic technique and does
3 not replace an incisional biopsy; would you agree
4 with that statement?

5 A. They are different in their application.

6 I think we have discussed
7 repeatedly, my approach is that the diagnostic
8 triad, doing a clinical breast examination, fine
9 needle aspiration, mammography, looking for
10 concordance and if you have concordance of that
11 then you can manage the patient on that basis, If
12 you don't and you have a persistent palpable
13 dominant breast mass, then you need to get a
14 definitive diagnosis which you can get by tissue
15 core biopsy or open surgical biopsy.

16 Q. I was able to locate the reference that we
17 were talking about in terms of the blood tinged
18 fluid, it is in your article, "Breast Aspiration
19 Cytology," 1982 I think.

20 A. 1982?

21 Q. 1983 was actually the publication date,
22 American Journal of Obstetrics and Gynecology, do
23 you have that one?

24 A. We are looking for it. You can ask me the
25 question.

1 Q. What I wanted to do was point out to you
2 where in writing I drew my conclusion of things
3 that you had said, and then you can explain to me
4 the correct context if I have misinterpreted it.

5 A. Well, number one, you know, that was what,
6 13 years ago.

7 Q. Yes. Well, we'll go through it and if you
8 want to disavow what you wrote, that's fine, I just
9 want to know.

10 MR. BONEZZI: I will object,
11 that's not what he's saying.

12 MISS KOLIS: I know that.

13 MR. BONEZZI: I am totally
14 surprised that you would even comment on that.

15 MISS KOLIS: Well, he told
16 me he wrote it 13 years ago.

17 It is on page 485 of that article.

18 Q. At the top of the page which is a
19 continuation to the previous section is your
20 comment, and the section that I read says as
21 follows,.

22 "If the cyst recurs it should be
23 aspirated again," I understand that, we have
24 discussed that today. "If bloody fluid is
25 obtained, induration or thickening is palpated

1 after aspiration of the breast cyst, the patient
2 should be referred for open biopsy."

3 A. Right. Now, you remember my previous
4 discussion to the previous question that I
5 differentiated between whether the mass is a gross
6 cyst or it is a solid mass and this entire
7 paragraph reiterates to gross cysts.

8 It is totally consistent with what
9 I have told *you* today, that if you have a gross
10 cyst and you aspirate it and it is grossly bloodied
11 fluid, it indicates that there may be an
12 intracystic neoplasm, this is a different entity
13 and a different approach than a solid dominant
14 breast mass *as* we had in the case that we are
15 discussing. So that paragraph does not apply to
16 this case.

17 Q. Okay, that's fine- You clarified it so that
18 I will know whether to deal with that or not.

19 Based upon your answer, you're
20 saying we're not dealing with a cyst, we're dealing
21 with a solid dominant mass?

22 A. We're not dealing with a gross cyst where the
23 entire mass is a cyst. I have discussed previously
24 that much of the nodularity of the breast is
25 associated with microcysts and some fluid might be

1 obtained,

2 When the typical, say, surgeon is
3 talking about a cyst, they are talking about a
4 gross cyst, something the size of a ping-pong ball
5 that you would get a whole syringe full of fluid
6 out of, not just a small amount of fluid that you
7 squirt out on the slide:

8 Q. So what you said in that particular paragraph
9 only applies to a cyst of a larger size?

10 A. Right.

11 Q. It doesn't apply to a smaller cyst?

12 A. Correct.

13 Q. I think we have been through this, I just
14 want to ask it as directly as I can.

15 After an aspiration if the lump
16 collapses completely or significantly decreases in
17 size, that is indicative that the lump -- I'll call
18 it a lump -- was a cyst, correct?

19 A. The first thing would be that there would be
20 a palpable mass to put the needle into the center
21 to withdraw out a syringe full of fluid, and if the
22 mass as you are palpating it and drawing out the
23 fluid shrinks below your palpating fingers, and
24 when you take out all the fluid it becomes
25 therapeutic as well as diagnostic, and there is no

1 residual palpable mass you have aspirated a **cyst**,

2 Q. You can agree with me that in this situation
3 what Mrs. Hopkins presented with was not a cyst
4 because that didn't happen on aspiration?

5 A. Correct,

6 Q. You told me what bloody aspirate means, so I
7 don't need to ask that.

8 Just so 3 have this established,
9 your literature that you have written -- you have
10 written a couple of different things but they are
11 all pretty similar -- suggests that for patients
12 being treated following this aspiration, they do
13 need to be followed up on, especially when that
14 mass does not disappear; what is your time period
15 for a follow-up?

16 A. In my opinion, all patients with breast
17 disorders ought to be followed up to be certain
18 that the disorder resolves, whether it be pain,
19 whether it be masses, whatever the situation is, so
20 they should be followed **up**,

21 Q. I understood that and you probably
22 misunderstood my question, which is okay.

23 **Time frame for follow-up?**

24 A. Depends on what the problem is. If the
25 patient has an infection they need to be followed

1 up in a short period of time, three or four days to
2 make sure they are responding to treatment.

Patients who have big masses who are menstruating
4 woman should be followed in the subsequent
5 menstrual cycle or another cycle, so we are then
6 talking about two months.

7 It depends on what index of
8 suspicion clinically, when you are the **one** dealing
9 with a benign or malignant process and get the
10 impression **it** is a benign process, then
11 three months **is** an adequate **followup** as **most breast**
12 tumors do not grow rapidly, and if you're likely to
13 see **some** change **it** takes several months.

14 Q. So in this particular case three months would
15 have been the appropriate time to return for an
16 evaluation?

17 A. That's correct in my **opinion and** my
18 experience across the country.

19 Q. If that mass had not changed in that
20 three month period, would you then schedule a
21 person to come in again in another three months?

22 A. **IS** this a theoretical question on what I
23 would do on a mass that has not changed in three
24 months?

25 Q. Yes .

1 A. As long as everything else in my evaluation,
2 going back to the diagnostic triad process and
3 there is no suspicion of malignancy, then I would
4 continue to follow it and see what happened; and if
5 it changes in characteristic, if it gets larger or
6 harder or firmer or less mobile or more irregular
7 then I would proceed to a definitive diagnosis, not
8 only by cytology but by a tissue core biopsy or an
9 open surgical biopsy.

10 Q. When you say "tissue core biopsy," you are
11 discussing another method of obtaining the material
12 that you could get by an open biopsy, but it is a
13 different method, correct?

14 A. Yes, you get a much smaller sample,

15 Q. What's the benefit of doing a tissue core
16 sample versus an open biopsy?

17 A. Open biopsy is an outpatient surgical
18 procedure that is usually done in a surgical
19 facility, often in a hospital, requires at least a
20 day of the patient's time and considerable cost is
21 involved on the health care system,

22 The tissue core needle biopsy, it
23 is an office procedure that is being done under
24 local anesthesia and the patient can go home or
25 continue her activities within an hour after that

1 procedure,

2 Q. If the lump itself doesn't change but the
3 skin in the area begins to thicken, would that be
4 an indication to do either the tissue core or an
5 open biopsy?

6 A. Or to do a skin biopsy,

7 Q. So you agree with me that some sort of biopsy
8 should be done if in addition to the lump there **has**
9 been a thickening of the skin in the area?

10 A. In anything that is progressing you should
11 evaluate the patient for further diagnostic
12 studies.

13 Q. Doctor, when a pathologist is looking at a
14 slide containing cells of infiltrating ductile
15 carcinoma what will he see, if you know?

16 MR. BONEZZI: Objection.

17 Donna, you are asking him for a pathologic
18 interpretation or that which he has been provided
19 with by a pathologist?

20 MISS KOLIS: No, I'm asking
21 him if he knows -- some people who do what he does
22 actually get an interest in pathology and can tell
23 me what they would expect to see on a slide. If he
24 doesn't know the answer, that's okay.

25 A. Certainly in teaching at an institution we

review all the slides, we do not make a definitive
2 diagnosis or write definitive reports, that stuff
3 is done by trained pathologists.

4 In the case of cancer a needle is
5 used and kept within the cancer, the entire slide
6 is usually covered with malignant cells and it is
7 quite obvious looking at the slide in any of its
8 aspects that you are dealing with malignancy,

9 Q. Dr. Hindle, do you agree with me that
10 infiltrating ductile carcinoma is the most common
11 type of breast cancer?

12 A. Yes.

13 Q. Infiltrating ductile carcinoma generally
14 feels like a hard cell mass to the touch; do you
15 agree with that?

16 A Typically the mass is a hard, irregular,
17 dense mass with limited mobility.

18 Q. We are going to go back in this area that you
19 don't like, sooner or later I think I will probably
20 get the right answer.

21 Which is a bigger problem with fine
22 needle aspirations: One, false positives, that is
23 FNA saying there is cancer when there isn't any;
24 two, false negatives, that is FNA failing to find
25 cancer that is really there?

1 MR. BONEZZI: Objection.

2 Go ahead and answer,

3 A. In my experience, like I said, I don't agree
4 with the definitive cytologic reports of this, but
5 following them along in my experience of being
6 associated with approximately 5,000 fine needle
7 aspirations, a so-called cytology diagnosis of
8 false positive is incredibly rare, there are
9 biologic processes of everything that happens a
10 few times.

11 If you get the so-called false
12 negatives, then I go back to what I said before,
13 that for statistical purposes those slides that
14 don't have adequate cell samples are considered
15 "false negative," In my opinion if you don't have
16 adequate cells you haven't learned anything, you
17 can't draw any conclusions from it.

18 There is a sampling problem with
19 fine needle aspiration because you have a 22 gauge
20 needle which is a relatively small needle and of
21 course you have to get it in the appropriate place
22 and the cells that you obtain do reflect where the
23 needle has been; but if you don't have the needle
24 in the right place then you are going to get misled
25 because you will have different cytology than the

1 lesion if perchance you have sampling error and the
2 needle misses the lesion.

3 I understand that, if *you* want to just
4 explain this to me a different way.

5 I suppose referring you back to the
6 article that I previously asked you to look at, the
7 one that was in the ~~American~~ Journal of Obstetrics
8 and **Gynecology**, 1983.

9 A. Yes.

10 Q. On page 484, I understand this was a
11 retrospective review of a patient population that
12 was a little higher than 1100 people, right,
13 somewhere in that neighborhood?

14 A. Yes.

15 Q. On page 484 basically what you say is that
16 23 percent of cancers were not detected by
17 aspiration cytologic evaluation in that particular
18 retrospective group.

19 A. Where are *you* on this page 484?

20 Q. 484, my copy is probably highlighted I would
21 think and it is page 484 -- let's see if we can
22 find it for you real quickly,

23 Go to 483. Sorry.

24 A. Okay.

25 Q. 483, beginning of the last paragraph on the

1 page says of those lesions that proved to be
2 malignant cytologically by open biopsy, 11 to 23
3 percent of your grouping were not detected by
4 aspiration cytologic examination.

5 A. Yes, that's the statement.

6 Q. Then at a time later I think you have written
7 that there is a range on that, there is no
8 reference to the fact that that only happens when
9 there is an inadequate amount of aspirate; is that
10 a fair statement?

11 A. There is no reference in this article to
12 that?

13 Q. No. If you can find it, let me know,,

14 A. If you looked I presume it is not there.

25 Q. I don't see it. I haven't seen it in any of
16 your writings, that's why I'm asking you.

17 A. What are *you* asking me?

18 Q. In trying to answer these questions you seem
19 to be -- and *you* correct me if I'm wrong -- seem to
20 be saying that when I'm calling something a false
21 positive, you seem to be implying that that can
22 only exist if the sample size is not adequate?

23 A. Did you say what you meant to say, you just
24 said false positive?

25 Q. False negative. I'm sorry.

A. I make that distinction with the experience that I had over the last 20 years. If you don't have adequate cells you can't come to any conclusion, and cytologically that's called false negatives.

Then I explained about sampling here, and if you haven't obtained the specimen in a tumor and some cancers are very dense, very thick, very fibrous -- and it is very difficult to get cells from the cancer, but that is very unusual in my experience. The typical infiltration ductile carcinoma that is using an abundance of cell and since the needle remains in the mass and all those cells are malignant cells.

Q. I think that I know -- you have added to the answer.

In other words, there is no such thing as sampling error where for whatever reason the physician when he does the fine needle aspiration in the lesion draws out materials that doesn't contain the cells in it even though there is a malignancy there, that does happen?

A. Yes.

Q. We'll go on to the next group of questions hopefully, if I can turn the page on my notes.

1 That study that I just quoted from,
2 the average figure is around 10 percent of the
3 cases that the physician gets incorrect information
4 or no information at all from an FNA; would you
5 agree with me on that?

6 A. I wouldn't say incorrect information. You
7 either get cytologically meaningful information or
8 you don't, and if you don't then you have to
9 proceed.

10 Now, sometimes the size of a
11 pathology -- there are borderline cases and they
12 really can't make a decision, then you need either
13 further cytology or histology by a biopsy or a
14 tissue core biopsy.

15 Q. You know, in discussing sample errors when
16 performing FNA to hit the target, is that more
17 difficult when the tumor is small?

18 A. **Yes .**

19 Q. Even if someone is using good technique there
20 is a possibility of sampling error when the tumor
21 is of a smaller size; do *you* agree with that?

22 A. Yes, that's always true.

23 Q. Sorry, Doctor, I'm lining out questions as I
24 have written them here.

25 This particular patient is

1 described on the mammography as having
2 fibrocystic -- and I'm not sure if it says change
3 or disease, Have you got the mammogram that
4 Dr. Wisler ordered?

5 A. The copy I have says clinical diagnosis
6 fibrocystic disease with cyst aspiration
7 approximately one week ago, dated 9-1-90.

8 Q. Based on your experience in doing this, when
9 a person has fibrocystic disease -- I don't know if
10 I like the word disease or fibrocystic changes --
11 the mammogram can come back negative to see
12 anything even though you can palpate a lump,
13 correct?

14 MR. BONEZZI: Objection to
15 the form of the question,

16 Go ahead and answer it, Doctor,

17 A. That's accurate, To take the fibrocystic
18 changes out of it, that's true of all mammograms.
19 Mammograms can come back and not show anything
20 mammographically and there can be by clinical
21 examination a dominant breast mass.

22 Q. Do you have an opinion what the percentage of
23 breast cancer is that are missed by mammography?

24 A. Ten percent,

25 Q. Excuse me?

1 Ae Ten percent.

2 Q. Ten percent, okay.

3 A. We're talking about palpable breast cancer
4 because non-palpable ones are only found by
5 mammography.

6 Q. Right, I'm sorry. I should have included
7 that, clearly I meant what percentage of palpable
8 breast cancers are missed by mammography.

9 Have you seen the mammogram reading
10 that was done at Kaiser in April of 1992?

11 A. I saw another mammogram report and I don't
12 remember the date of it. In fact, I think there
13 were two of them, there was one that didn't show
14 anything and then there was one that finally showed
15 it was cancerous; is that correct?

16 Q. I will represent to you that neither of the
17 mammograms said anything about cancer if that helps
18 you to remember,

19 My question is just --

20 Ae I don't have that record here.

21 MR. BONEZZI: He may have
22 seen that, he may have only seen that which
23 Dr. Rosenthal set forth in his June 9th, 1994
24 report, the mammograms and the impressions of
25 those.

1 Dr. Hindle, as a clinician who is regularly
2 practicing in diagnosing and treating breast
3 disorders, if you receive a mammogram that
4 indicates: Number one, fibrocystic disease;
5 number two, the finding says there is distortion of
6 the nipple possibly secondary to the previous
7 surgery, assume that statement is out there, does
8 FNA cause nipple distortion?

9 A. It would be very unusual in my experience.
10 As I said, if you have secondary hemorrhage there
11 might be some changes in the subsequent mammogram
12 or some distortion of the nipple.

13 Q. What causes nipple distortion in a mammogram?

14 A. What causes it?

15 Q. Yes.

16 A. General causes are some sort of trauma like
17 blood trauma, some sort of infection or a
18 malignancy.

19 MR. BONEZZI: Can we take a
20 one minute break?

21 MISS KOLIS: Yes.

22 -----

23 (Recess had.)

24 -----

25 BY MISS KOLIS:

1 Hindle. in evaluating this case did you
2 read the surgical description in the eventual
3 pathology of Mrs. Hopkins that was performed by
4 Dr. Dietz?

5 MR. BONEZZI: Why don't you
6 read it and refresh his memory, because I may have
7 sent that to him and I don't recall as we sit here,
8 Q. Ann is going to have to sift through the
9 medical records,

10 Let me ask you this question,
11 perhaps you don't know, but we can start it this
12 way: In hindsight, do you have an opinion today
13 whether or not the mass that was evaluated by
14 Dr. Wisler in September of 1990 was in fact
15 cancerous?

16 MR. BONEZZI: Objection to^o
17 the term "mass."

18 Go ahead and answer, please^e:

19 My conclusion is that the mass he evaluated^d,
20 the area that he evaluated showed no evidence of
21 malignancy and therefore was not cancer^f:

22 At that time, is that what you're saying^g?

23 At that time.

24 But my question to you is this: In
25 hindsight, given the eventual diagnosis, do you^h

1 have an opinion whether or not that lump -- we'll
2 call it a lump or a mass, whichever you prefer to
3 call
4 it -- was in fact cancerous?

5 MR. BONEZZI: Objection, He
6 just answered at the time that Dr. Wisler became
7 involved with it it was not cancerous,

8 MISS KOLIS: What is the
9 basis of --

10 MR. BONEZZI: Leads to
11 subsequent -- you can answer that, but **that's** a
12 different question.

13 Q. What's the basis of that opinion,
14 Dr. Hindle?

15 A. Because the complete evaluation by the
16 diagnostic triad revealed no evidence of malignancy
17 when that evaluation was done by the physician when
18 he saw the patient on the 25th of August, 1990.

19 Q. This may be a difficult question for you to
20 answer, but I'm going to try anyway: Do you feel
21 that it is appropriate for an OB/GYN to fail to
22 perform a breast examination of a patient based
23 upon the fact that the exam had previously been
24 performed by a nurse practitioner?

25 MR. RICE: Objection.

1 A. you are asking me a theoretical question, if
2 a nurse practitioner does an examination and finds
3 no abnormality, whether that examination needs to
4 be repeated by a physician?

5 Q. I didn't use that phrase.

6 Let's say a nurse practitioner **does**
7 an examination and records **a** notation of thickening
8 in the breast, thickening **is** an abnormality, isn't
9 it?

10 A. **Yes.**

11 Q. After five or so months down the road, if you
12 are an OB/GYN and you are looking at a medical
13 record that indicates that the nurse has done an
14 exam and noticed thickening, at that time **does** the
15 standard of care require that the physician
16 independently examine the breast?

17 MR. RICE: Objection.

18 A. In my experience if some abnormality of the
19 breast has been described there should be some
20 follow up of that. The physician could do the
21 examination, he could refer the patient to someone
22 else; but if there is an abnormality detected and
23 the physician was aware of that, then the physician
24 has some responsibility to do some further
25 evaluation **or** have some further evaluation done,

1 Q. By another physician?

2 A. Yes.

3 Q. In your opinion in the situation -- we will
4 just stick with this ~~X~~ ~~aning~~. If there is a recorded
5 thickening of a breast is it adequate in terms of
6 the accepted standard of medical care for a
7 physician to simply lay their hand on a patient's
8 breast while the patient is laying down; is that a
9 complete breast examination?

10 A. If I understand the question, you're asking
11 me two different things.

12 A complete breast examination of
13 course is an examination of both breasts, the
14 axillary areas, the axillary area, the supracavicular
15 areas comparing one side to the other and those are
16 the standard steps to go through.

17 If the patient complains of a
18 specific problem localized to a specific place,
19 like any physical examination then the physician
20 may as well examine exactly what it is the patient
21 or some other health care professional has pointed
22 out as the problem and not do the complete breast
23 examination.

24 Q. Let's ask the question a little more
25 specifically.

1 Just assume for the sake of my
2 question that the patient we're talking about is
3 Mrs. Hopkins and that she has been reported to have
4 thickening in the area of the breast where the fine
5 needle aspiration had previously occurred. Would
6 it be acceptable in terms of the standard of care
7 of medical practice for a breast evaluation for a
8 physician while the patient is lying down to simply
9 put their hand on the area?

10 MR. RICE:

Objection.

11 A. You mean to examine that area?

12 Q. Yes, just assume for the sake of my question
13 that that's the extent of the examination,

94 A. Is the patient coming to this physician to
15 have a breast evaluation?

16 Q. That's not part of my question, but if you
17 want to assume that you can assume further that the
18 patient is concerned about a persistent lump in
19 their breast.

20 A. If the patient has that complaint and the
21 patient has come for a breast evaluation, then in
22 my opinion any primary care physician should do a
23 complete breast examination or refer the patient to
24 some physician who is going to do a complete breast
25 examination.

1 Q. Do you know what this cancer was eventually
2 staged by Dr. Dietz?

3 A. I don't have Dr. Dietz' report in front of
4 me, different people put different stages in
5 different reports.

6 Q. In the textbook which you have authored, I've
7 got it laying here somewhere, you have a chart in
8 there in terms of staging breast cancer, don't you?

9 A- Yes,

10 Q. would you agree with me that a breast cancer
11 should be staged a TIV if there is chest wall and
12 muscle involvement?

13 A. Yeah. I don't have the whole staging in
14 front of me, but it is very specific about
15 involvement or what the subclassifications are,

16 Q. The chart then that is in your textbook then
17 is one that you would follow?

18 A. I believe now it has been revised, but it is
19 essentially similar to what you are looking at.

20 Q. This is your 1990 textbook, you are telling
21 me that there has been a revision since that one?

22 A, Not the textbook, but I think the staging
23 process has been -- a more current staging process,
24 but essentially it hasn't changed from what you are
25 looking at,

1 Q. But do you basically agree with me that
2 something would be staged a TII if there is chest
3 wall and muscle involvement?

4 A. Yes.

5 Q. Did you note that Kaiser when they initially
6 examined this lesion, I'm going to **say** August of
7 1993 included in the chart that it was a TIIb, does
8 that sound familiar to you?

9 A. I don't have that record in front of me and I
10 remember seeing different stages by different
11 consultants and different physicians.

12 Q. If the doctor had staged it at TIIb based
13 upon his physical examination of the lump at that
14 time, and that cytology then later staged it
15 at TIV. The person who actually had done the
16 lumpectomy is the better person to know the extent
17 of the tumor, aren't they?

18 MR. RICE: Objection.

19 A. Essentially, yes,

20 Q. I have a couple more questions if I can find
21 them.

22 Let's see if you agree with this:
23 When a ductile carcinoma becomes invasive and
24 starts involving layers of skin, the physical exam
25 will reveal thickening of the skin as a clinical

sign of the dermal involvement?

A. If the cancer is involving the skin?

Q. Yes.

A. In cancer involving the skin you can usually feel the induration or the mass right below that or the thickening of the skin, some change in the skin.

Q. Sometimes can you just feel the thickening of the skin, but not actually palpate the lump behind it?

A. That would be very unusual because the cancer should be superficial and should be below the skin to get involved with the skin. Everything is possible pathologically, but in general you feel a palpable mass in my experience where there is skin involvement.

Q. Let's see what else I wanted to ask you.

Do you have any opinion based upon an invasive ductile carcinoma being diagnosed as a T1V what the five year life expectancy of that person would be?

A. No, I do not hold myself out as an oncologist about life expectancy of malignancy.

Q. So you won't be testifying at trial as to life expectancy based on diagnostic times or

1 stages?

2 A. That's correct, I will not be testifying as
3 to that aspect,

4 Q. You have no opinions on that, you rely upon
5 medical oncologists for that information?

6 A. Yes.

7 Q. Do you agree with me that a delay in
8 diagnosis, generally speaking, impairs a person's
9 ability for long-term survival?

10 A. What is your definition in this question of
11 delay in diagnosis?

12 Q. Let's assume hypothetically that there is a
13 19 month delay in diagnosis of this particular
14 carcinoma, do you have an opinion based on your
15 experience as to whether or not that would diminish
16 the person's chances of long-time survival?

17 MR. RICE: Objection.

18 A. I don't have direct experience because I
19 don't follow these patients throughout their life
20 as they have been treated; but in everything that I
21 have read and all the consultants that I have
22 talked to say that approaching a year in the
23 progress of a cancer the prognosis is limited and
24 certainly not as good as if it had been diagnosed
25 two years previous to that.

1 Q. Let me ask it this way: What sources do you
2 consider authoritative in determining life
3 expectancy based on cancer staging?

4 A. I don't know of any.

5 Q. So no one is authoritative? I'm sorry I
6 don't mean to laugh.

7 Let me ask a different question: I
8 gather, and not happily I'm sure, that based upon
9 what you do for a living that you end up diagnosing
10 breast cancer?

11 A, Sure.

12 Q. At your facility do you perform chemotherapy?

13 A* Me personally or --

14 Q. Not you personally, the facility itself,

15 Are you a full service breast
16 facility I guess is what I'm asking?

17 A. Yes and yes, when you are talking about the
18 facility, and I personally do not do either.

19 Q. Once there is a diagnosis of breast cancer
20 whether it is by fine needle aspiration or
21 otherwise, you then refer your patients to a
22 medical oncologist for treatment?

23 A. Yes, and we continue to follow them.

24 Q. Do you participate in the treatment
25 decisions?

1 A. Only in giving the clinical information and
2 following the patient along and raising questions
3 if I have some of the clinician who initially
4 managed the patient,

5 Q. Given that it is in the front of your
6 textbook I gather that you agree that a patient who
7 is a Stage III or IV with a breast cancer should
8 receive systemic treatment by way of chemotherapy?

9 A. Each case is individual, but in general
10 that's true.

11 Q. What would mitigate against a person
12 receiving chemotherapy with a Stage 111
13 or IV carcinoma?

14 A. Certain types of malignancy that are very
15 uncommon that are not ductile carcinoma, that there
16 is no evidence of any systemic involvement; but in
17 general most Stage II and III would have
18 chemotherapy or hormonal therapy,

19 Q. In the case of an invasive ductile carcinoma
20 is it standard for a person with Stage III and IV
21 to receive chemotherapy systematically?

22 A. Well, they receive adjuvant therapy, it
23 depends on -- in my experience of observing the
24 care of these patients, it depends on their
25 estrogen retention status and their lymph node

1 status and it is an individual decision and they
2 would have adjuvant therapy of sorts, either they
3 would have hormonal therapy or chemotherapy.

4 MISS KOLIS: We are done,
5 but Mr. Rise may have some questions for you.

6 MR. RICE: Hi, Doctor, My
a name is Jay Rice and I just have a couple of
8 questions and I think to some extent they are
9 redundant of what you have already been talking
10 about, I want to make sure I understand.

11 THE WITNESS: Just for my
12 interest, who do you represent?

13 MR. RICE: In this
14 particular case I represent Kaiser.

15 THE WITNESS: Thank you.

16 -----

17 CROSS-EXAMINATION

98 BY MR. RICE:

19 Q. Can you just tell me, Doctor, what are the
20 criteria that you use for determining whether a
21 fine needle aspiration is needed?

22 A. Needed?

23 Q. Yes.

24 A. That is your question?

25 Q. Yes, what is the criteria that you use for

1 determining whether a fine needle aspiration is
2 needed or appropriate?

3 A. In my opinion the indication for fine needle
4 aspiration of the breast is a palpable dominant
5 breast mass.

6 Q. Is that the only criteria?

7 A. That indication for fine needle aspiration
8 and knowing that **you** can get a sample of cells,
9 There are peripheral uses of **it and** where a patient
10 complains of an area where the doctor doesn't feel
11 anything or to follow up with patients who are
12 concerned about **it**, but because **you** can get a
13 sample of the cell in the area of the concern is
14 the indication, the medical indication and why I
15 think the physician should be doing **it** is a
16 palpable dominant breast mass,

17 Q. Doctor, what criteria do you rely on to
18 determine what results are negative? I understand
19 we have had some discussion about what **is** meant by
20 negative, but can you just tell me what criteria
21 you rely upon to tell whether or not the results
22 are negative?

23 A. I will. differentiate again, I don't use that
24 term. They are either adequate cells or they are
25 not, if they are not adequate cells then **it** is just

1 as if you've never done the fine needle aspiration
2 and draw no conclusion whatsoever.

3 If there are no malignant cells
4 they will report that as ductile epithelium and
5 that will show fat tissue, that will show
6 connective tissue, so that one will notice that the
7 needle was in essentially normal breast tissue and
8 not in a neoplasm, so that would be reported in
9 some circles as "negative"; but you can see why I
10 don't like to **use** that term because it is confusing
11 to everybody.

12

13

14

15

16

17 aspiration of a palpable mass and the mammogram and
18 look at a concordance of all of those findings and
19 manage the patient then according to that
20 evaluation,

21 MR. RICE: Doctor, I don't
22 have anything further,

23 Thank you, Doctor.

24 MR. BONEZZI: Anything else?

25 MISS KOLIS: I have one

I further question that I forgot to ask.

2

3

RECROSS-EXAMINATION

4

BY MISS KOLIS:

5

Q. Dr. Hindle, do you do hormone replacement therapy for woman who are post-hysterectomy?

6

7

A. Yes.

8

Q. As part of any evaluation that you do of a patient who you are going to be prescribing various medications for that purpose, do you do a complete breast exam at that time?

10

11

12

A. At the time that you are going to administer a hormone replacement?

13

14

Q. Right. If you got someone in and they need to be evaluated for hormone replacement therapy because of their hysterectomy, do you do a complete breast exam at that time?

15

16

17

58

A. Am I the physician taking care of the patient, is that your question?

19

20

Q. Yes, if you are the person taking care of the patient.

21

22

A. If I were personally taking care of the patient, I would.

23

24

Q. Why would you do that?

25

A. Any situation that I function in there are a

1 multitude doctors of involved and the patient may
2 have been examined a week before or a month before
3 or at some other time, and when our patients -- we
4 do not do complete total workups every time we see
5 the patient,

6 If the patient was coming in for
7 hormone therapy and has already been evaluated, if
8 I have that evaluation in her medical record, then
9 in the clinical situation of taking care of the
10 patient as we do at the county clinic, we would go
11 ahead and write her a prescription.,

12 Q. But if she is in for that purpose, for a
13 complete physical, what are the medical indications
14 for doing a breast examination in conjunction with
15 hormone replacement therapy?

16 A. For a complete physical, that would include a
17 complete physical examination.,

18 MISS KOLIS: I don't have
19 any further questions.

20 MR. BONEZZI: We will read.

21 -----

22 (Discussion had off the record.)

23 -----

24 BY MISS KOLIS:

25 Q. Dr. Hindle, it is my understanding from

1 Mr. Bonezzi's assistant, Maureen, that you are
2 going to charge me \$300 an hour for today's time,
3 by my watch I now owe you about \$600, right?

4 A. No. That's time out of my office, so it
5 might be slightly more.

6 Q. Do you want to prepare a bill and send it to
7 me?

8 MR. BONEZZI: What I'm going
9 to do, Donna, is I already arranged that he is
10 going to send the bill to me and I will go ahead
11 and pay it and then I will send the bill back to
12 you, so there won't be any delay in payment.

13 MISS KOLIS: There wouldn't
14 be, just tell me where and I'll address it today.
15 I would send him a check today, I'm just trying to
16 figure out how much I owe him.

17 MR. BONEZZI: I appreciate
18 that, but it is the time out of his office also.

19 MISS KOLIS: You take care
20 of everything and let me know what I owe him.

21 Thank you very much, Dr. Hindle.

22 -----

23 (Dr. Hindle Deposition Exhibit A
24 marked for identification.)

25 (Deposition concluded; signature not waived.)

ERRATA SHEETNOTATIONPAGE/LINE

I have read the foregoing
transcript and **the** same is true and **accurate**.

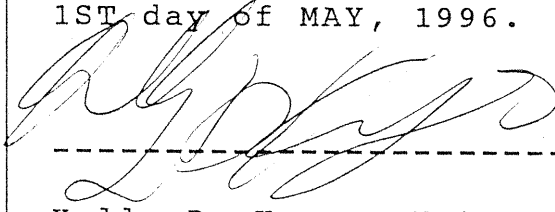
WILLIAM H. HINDLE, M.D.

1 The State of Ohio, .

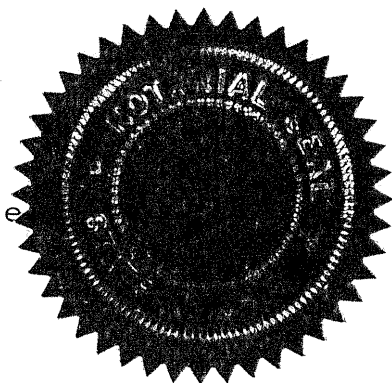
2 County of Cuyahoga. : CERTIFICATE:

3 I, Kelly D. Keyes, Notary Public within and for
4 the State of Ohio, do hereby certify that the
5 within named witness, WILLIAM H. HINDLE, M.D., was
6 by me first duly sworn to testify the truth in the
7 cause aforesaid; that the testimony then given **was**
8 reduced by me to stenotypy in the presence of said
9 witness, subsequently transcribed onto a computer
10 under my direction, and that the foregoing is a
11 true and correct transcript of the testimony so
12 given as aforesaid. I do further certify that this
13 deposition was taken at the time and place as
14 specified in the foregoing caption, and that I am
15 not a relative, counsel or attorney of either
16 party, or otherwise interested in the outcome of
17 this action.

18 IN WITNESS WHEREOF, I have hereunto set my hand and
19 affixed my seal of office at Cleveland, Ohio, this
20 1ST day of MAY, 1996.

21 
22 -----
23 Kelly D. Keyes, Notary Public/State

24 Commission expiration: 12-1-98.
25



Look-See Concordance Report

UNIQUE WORDS: 1,382
 TOTAL OCCURRENCES: 5,001
 NOISEWORDS: 384
 TOTAL WORDS IN FILE: 14,945

SINGLE FILE CONCORDANCE

CASE SENSITIVE

COVER PAGES = 4

INCLUDES ALL TEXT OCCURRENCES

DATES ON

INCLUDES PURE NUMBERS

POSSESSIVE FORMS ON

MAXIMUM TRACKED OCCURRENCE
THRESHOLD: 50NUMBER OF WORDS SURPASSING
OCCURRENCE THRESHOLD: 6

LIST OF THRESHOLD WORDS:

breast [108]
 Dr [52]
 fine [51]
 mass [64]
 needle [66]
 patient [60]

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