

1 THE STATE of OHIO,  
2 : SS:  
3 COUNTY of SUMMIT.

4 IN THE COURT OF COMMON PLEAS

5  
6 DOROTHY S. MAYNARD, et al., :  
7 plaintiffs, :  
8 vs. : Case No.97 cv 01 0228  
9 AKRON GENERAL MEDICAL  
10 CENTER, et al.,  
11 defendants.

12 (VOLUME II - PAGES 65 - 96)

13 continued deposition of DIANE MUCITELLI, M.D.,  
14 a defendant herein, called by the plaintiffs for the  
15 purpose of cross-examination pursuant to the Ohio Rules  
16 of Civil Procedure, taken before Constance Campbell, a  
17 Notary public within and for the State of Ohio, at Akron  
18 General Medical Center, 400 Wabash Avenue, Akron, Ohio,  
19 on THURSDAY, JULY 29TH, 1999, commencing at 5:20 p.m.  
20 pursuant to agreement of counsel.

1     APPEARANCES:

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17                    ON BEHALF OF THE DEFENDANT DANIEL GUYTON, M.D.:

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# I N D E X

WITNESS: DIANE MUCITELLI, M.D.

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Cross - examination by Mr. Cullen 89

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PLAINTIFFS' EXHIBITS MARIED

A - photograph of slide 80

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(FOR COMPLETE INDEX, SEE APPENDIX)

(IF ASCII DISK ORDERED, SEE BACK COVER)

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1                                    DIANE MUCITELLI, M.D.

2        of lawful age, a defendant herein, called by the  
3        plaintiffs for the purpose of cross-examination pursuant  
4        to the Ohio Rules of Civil Procedure, being previously  
5        duly sworn, as hereinafter certified, was examined and  
6        testified as follows:

7                                    -----

8                    MISS KOLIS:                    For the record,  
9        we're here at Akron General Hospital, today's date is  
10       July 29, 1999. We're here for the continuation of the  
11       deposition of Dr. Mucitelli if I'm saying her name  
12       correctly.

13                                   THE WITNESS:                    Mucitelli.

14                    MISS KOLIS:                    Dr. Mucitelli. The  
15        purpose is to have you look at some slides, the slides  
16        that were the subject matter of the the lawsuit. I'm  
17        going to ask some questions in follow-up.

18                                   It's my understanding pursuant to the  
19        agreement at the conclusion of our last deposition, that  
20        Mr. Cullen is present today on behalf of Dr. Guyton,  
21        should he elect to do so it's now his opportunity to ask  
22        questions; is that a correct understanding?

23                                   MR. MCGRAW:                    That's our  
24        understanding.

25                                   -----

1                                    CROSS-EXAMINATION

2    BY MISS KOLIS:

3    Q.        Doctor, when last we met ■ had attempted to ask  
4    you some questions about the slides based upon  
5    kodachrome slides I had made of the actual pathology  
6    slides from the biopsy. At that time you indicated that  
7    you didn't feel you could do it without using a  
8    microscope, therefore that is what we're doing here  
9    today.

10                            Re-establishing some of the things that  
11    we had discussed in the last deposition, it is frozen  
12    section C which you determined to indicate a malignancy  
13    in this patient; that's an accurate statement?

14    A.        I have to see my report in order to verify that.

15    Q.        Have you not reviewed your report since the last  
16    deposition?

17    A.        No, I did not. ■ didn't prepare anything ■ would  
18    have to say.

19    Q.        we will say -- hypothetically we will indicate for  
20    the record it is frozen section C, since that is my  
21    recollection.

22    A.        okay.

23    Q.        I'm going to hand you two slides of frozen section  
24    C, would you agree with that?

25    A.        That's correct.

1 Q. what I would like to do before you put them under  
2 your microscope, I would like to ask you these general  
3 questions.

4 when you are doing an intraoperative  
5 frozen section, can I assume that first you have to fix  
6 the specimen, correct?

7 A. That's correct.

8 Q. After you fix the specimen you then place it under  
9 the microscope, correct?

10 A. Wait. Let me clarify.

11 Q. You explain how you do these.

12 A. when you do an actual frozen section the tissue  
13 comes fresh in a specimen container and is zap frozen in  
14 liquid nitrogen. If we are doing two microtomy cuts in  
15 the slides like this, these are the actual frozen  
16 sections with levels, that is why you see deep, meaning  
17 an extra level from the first cut.

18 Q. Thank for that clarification.

19 when you have you them under the scope  
20 at what settings or powers do you look at them?

21 A. First low power, then I go progressively up in  
22 magnification. First low power, start with 4X, 10X,  
23 20X, and higher. I go progressively low to high.

24 Q. High being 400 perhaps?

25 A. Yes, 40X, which is 400.

1 Q. could I ask you then in your delineating these for  
2 reasons that are obvious to everybody we're not going to  
3 mark the slides with exhibit stickers, but we will have  
4 to spacially somehow describe it.

5 I'm pointing my finger at the slide,  
6 tell me what slide that is for identification purposes.

7 A. what slide it is?

8 Q. Yes.

9 A. Frozen section C surgery number S962320,  
10 inpatient's name Maynard on the frozen section. We  
11 identify the actual frozen with the patient's name.

12 Q. 2F, what is the difference between the first one  
13 and the second one?

14 A. This first slide is a section level one from the  
15 actual tissue block that is zap frozen.

16 Q. second?

17 A. Additional level from the same block.

18 Q. when you say an additional level?

19 A. A progressive cut deeper into the block.

20 Q. If I could ask you then to take the more surface  
21 level, I guess we might want to call it that?

22 A. First level.

23 Q. Right. At this point I would like to ask you to  
24 look at it on low power.

25 A. I'm not used to the scope so you have to bear with

1 me. Right, it's under low power.

2 Q. Is this the microscopic slide upon which you based  
3 the diagnosis of malignancy?

4 A. Repeat the question again.

5 Q. Is this the slide upon which you based your  
6 diagnosis of malignancy?

7 A. Not actually. I looked at two slides to base it,  
8 I looked at two slides --

9 Q. This one is the second deeper cut?

10 A. -- to make a diagnosis of malignancy.

11 Q. At the time of making your diagnosis of malignancy  
12 from frozen section C were you aware that the endoscopic  
13 cytobrushings had been negative for malignancy?

14 A. I was aware of atypical cytology that I recall.

15 Q. Have you reviewed the records recently enough to  
16 confirm that is what impression you had?

17 A. No, I haven't reviewed the report.

18 Q. Doctor, can I ask you why?

19 A. I reviewed the cytology prior to the surgery of  
20 this patient.

21 Q. Your impression is that there were some atypical  
22 cells?

23 A. Atypical cells, no definite malignancy identified.

24 Q. I can accept that answer. At the point that you  
25 were looking at this frozen section C were you aware

1 that the specimen was taken directly from the visualized  
2 polypoid mass that was obstructing the bile duct?

3 A. No, during the intraoperative consultation with  
4 Dr. Guyton I went to the surgery room, he performed a  
5 biopsy along with the resident.

6 Q. A strictured area within the bile duct?

7 A. That is what I was told.

8 Q. when you say he was biopsying a strictured area,  
9 is that --

10 A. He showed me the x-ray, he showed me the x-ray in  
11 the intraoperative consultation room, in the surgery  
12 room. That's what he was telling me what he biopsied.

13 Q. Is your disagreement it wasn't your understanding  
14 that this was a specimen taken from a polypoid mass?

15 A. Yes, no recollection of polypoid mass. Sorry, no.

16 Q. Did you consider this specimen to be  
17 representative of the mass?

18 A. After we initially talked about it, yes, it was.  
19 There were other biopsies taken that were negative, he  
20 wasn't getting representative material until this  
21 part C.

22 Q. Before proceeding to high power observation, did  
23 the size of the specimen to you appear to be adequate to  
24 render a firm diagnosis of a malignancy?

25 A. Yes, it did.

1 Q. How comfortable were you with the size of the  
2 specimen?

3 A. I was very comfortable with it.

4 Q. In your years of practice, how do you determine  
5 what size makes you comfortable when you are trying to  
6 determine a malignancy?

7 A. I don't base my diagnosis of malignancy on size.

8 Q. I assume nobody does that. what I'm saying is how  
9 do you define what size sample is adequate to be  
10 representative of malignancy in a particular location?

11 A. See that varies, depends on the site. Brain  
12 biopsy could be very minute, very, very tiny amount of  
13 tissue could be taken you can make a diagnosis of  
14 malignant meningioma.

15 Q. It's your testimony in this particular case given  
16 the region being biopsied you felt this was a sufficient  
17 sample size to reach a diagnosis of malignancy?

18 A. Yes.

19 Q. ■ I could ask you to now put this on high power.

20 A. The slide moves, it also has faded. The slide has  
21 faded.

22 Q. Is that something which happens over time?

23 A. Yes.

24 Q. so to the extent that you are indicating that the  
25 slide has faded, does it now make it not possible to

1 detect the same features you saw at the time of your  
2 intraoperative evaluation?

3 A. NO.

4 Q. Did you render an unequivocal diagnosis of  
5 malignancy based upon the changes shown in this slide at  
6 high power?

7 A. Yes, ■ did.

8 Q. Please, with as a much specificity as possible  
9 indicate what changes you see on that slide that enable  
10 you to render a clear-cut diagnosis of malignancy?

11 A. Here we're at 10X, you can't go directly to high  
12 power when you are evaluating a frozen section  
13 diagnosis, you have to see what is occurring within the  
14 specimen.

15                   You can see the specimen is quite  
16 inflamed and edematous, fibrotic, you can see aggregates  
17 of highly atypical cells permeating through a fibrous  
18 wall.

19                   On higher power you have to appreciate  
20 the cytologic features of the malignancy, you can't do  
21 that on lower power. In here at the higher power you  
22 start seeing the loss of polarity of cells, there is a  
23 loss of polarity, aggregates of cells permeating through  
24 the fibrous stroma. prominent nucleoli, no normal  
25 cells, all the nucleoli are like this. often some of

1 the cells have multiple nucleoli. The chromatin pattern  
2 with individual cells are very vesicular in pattern, has  
3 a vesicular chromatin pattern that is an indicative  
4 cytologic feature of malignancy.

5 Q. Anything else?

6 A. Yeah, well, if you look around, look here, you can  
7 see there is a haphazard placement of cells within a  
8 fibrous stroma. It's permeating single pattern and  
9 aggregates, highly indicative of malignancy.

10 Q. Can you define what the normal histology structure  
11 of the slide is supposed to be? In other words, if it  
12 wasn't malignant as you opine, what would I expect to  
13 see on this particular slide?

14 A. Repeat the question.

15 Q. sure. can you define what a normal histology  
16 structure of this slide is supposed to look like?

17 A. If you take an actual frozen section of a bile  
18 duct structure, you should see normal epithelium on the  
19 surface, columnar epithelium and mucosa but in a very  
20 orderly fashion lining the epithelium, you see benign  
21 ducts and glands, regular, in a not haphazard  
22 arrangement.

23 Q. what is the difference between a bile duct  
24 structure -- is it different from a polypoid mass in  
25 your mind?

1 A. Yes, I'm talking -- you are asking me what normal  
2 things ■ should be looking for --

3 Q. Right.

4 A. -- that is a normal structure within a bile duct?

5 Q. Do you see the bile duct upon which you rendered a  
6 diagnosis of bile duct cancer in this slide?

7 MR. CULLEN: I'm sorry, I didn't  
8 get that.

9 Q. I'm asking if she sees the bile duct upon which  
10 she rendered a diagnosis of bile duct cancer?

11 A. Repeat the question again. Do I see an actual  
12 bile duct on the slide, no, ■ don't.

13 Q. Are you aware of normal peribiliary glands?

14 A. Pardon.

15 Q. Peribiliary glands within the structure?

16 A. There are glands that are benign.

17 Q. Do you see those?

18 A. Not in this slide.

19 Q. You don't see them in that slide?

20 A. Not in this slide.

21 Q. what under the microscope should a peribiliary  
22 gland look like?

23 A. They should be round in configuration with a  
24 lumen.

25 Q. So I gather then when I ask this question I

1 already know the answer, could you be looking at  
2 peribiliary gland, not carcinoma as you described it?

3 A. No, this is malignant.

4 Q. Doctor, could I ask you if you want to remove that  
5 slide, I'll give you an opportunity to look at your  
6 second section, cut of frozen section C, correct?

7 A. which I thought was better.

8 Q. That's my next question.

9 A. That is why I did the extra level.

10 Q. Did you do an extra level because you were  
11 uncertain after you examined the first cut?

12 A. No, I was pretty certain this was diagnostic of  
13 malignancy, what I wanted to do was get a better look at  
14 the individual malignancy within the stroma. I  
15 typically normally do a second level on every frozen  
16 section I do, it's routine for me.

17 Q. That's your routine?

18 A. Um-hum.

19 Q. Let me ask you something. Do you have the high  
20 power, what power do you have it on?

21 A. Now I have it under 4X.

22 Q. so you have this under 4X?

23 A. Right now.

24 Q. Let me ask you this question now that you've got  
25 the microscopic there: If I show you this photograph,

1 is this representative of what you are looking at under  
2 4x?

3 A. Um-hum.

4 Q. You said you needed to see the slide, that is why  
5 you couldn't tell me. I'm going to give this to you at  
6 this point, you are sitting at the table looking at the  
7 electron microscope --

8 A. There is not an electron microscope.

9 Q. You are pointing out areas you think are  
10 representative, that is not going to translate on to  
11 paper, the paper can't pick up where the arrows are. So  
12 now that you've identified that can you recognize this  
13 as a photograph of that slide --

14 A. Yes, because -- I can recognize it because it has  
15 the dot, the actual dot.

16 MISS KOLIS: Let's mark this  
17 Plaintiffs' Exhibit A.

18 Q. Show me with your finger where the top of the  
19 slide is. Do I have it upside down if you know? what  
20 I'm asking you is I would like this to be as accurate as  
21 possible.

22 A. If you are looking -- what is this over here, the  
23 actual bar when you took it?

24 Q. I think so, this isn't part of the --

25 A. The slide is actually like this. We're just

1 looking at the whole of the specimen.

2 Q. You don't really care where we put the exhibit  
3 sticker, that is the big question?

4 A. No, this is the whole specimen.

5 MISS KOLIS: Connie, mark it over  
6 here in this area.

7 -----

8 (Plaintiffs' Exhibit A  
9 marked for identification.)

10 -----

11 Q. On Plaintiffs' Exhibit A if you have a pencil do  
12 it this way, pretty much along the lines of the  
13 questions I asked you, in this particular specimen that  
14 we're looking at, this is at high power, please indicate  
15 for me by marking with x's -- let's do this a different  
16 way.

17 what structural changes do you see under  
18 high power on the frozen section C that indicate a  
19 malignancy to you?

20 A. Even on high power?

21 Q. Right, on high power.

22 A. You were asking a benign structure, here is a  
23 benign structure. compare this with something like  
24 this, where you have aggregates of cells that are  
25 discohesive, free-floating in a very mucoid edematous

1 stroma, with prominent nucleoli, vesicular chromatin.

2 Those are the criteria of malignancy.

3 Q. I think I just misunderstood you. I thought you  
4 just said you were indicating to me where the benign  
5 section was?

6 A. No.

7 Q. Let's go back.

8 A. See up here, you were asking me before whether  
9 there are benign structures in the tissue?

10 Q. Right.

11 A. on the second level you can see there are some one  
12 single glands.

13 Q. I can't see where your arrow is.

14 A. Right here, can you see it.

15 Q. I see the blue section, okay. All right. I see  
16 where you are pointing, you are saying that is benign  
17 specimen of tissue?

18 A. No. These are benign reactive glands that are  
19 crushed, somewhat poorly preserved but benign. This is  
20 fibrous stroma around it, down here are the malignant  
21 cells.

22 Q. under a microscope, what do peribiliary duct look  
23 like?

24 A. what do benign peri --

25 Q. Yes, what do these look like?

1 A. They look like -- this is a benign structure right  
2 here. They look like this. very cohesive, with a  
3 lumen, you have small cuboidal cells with inconspicuous  
4 nuclei.

5 Q. would you be able to circle that on the  
6 photograph, the benign area?

7 A. On here, no, ■ can't see it. It's hard, it  
8 doesn't photograph.

9 Q. so what --

10 A. you can see it better on the slide.

11 Q. you can see better on the slide what you are  
12 indicating, is that based upon the photograph you can't  
13 mark the benign areas?

14 A. No.

15 Q. with the photograph, can you mark areas in  
16 changes, structural changes you believe indicate  
17 malignancy?

18 A. On this photograph?

19 Q. Yes.

20 A. ■ can't see anything. I could see better under  
21 the microscope. This is bad, this is a very bad  
22 picture. you can't see any detail to it.

23 Q. There is not enough detail on there for you?

24 A. No, all I see is vascular spaces. See. This is  
25 fibrous tissue, vascular spaces, I can't see benign

1 structure, I can't see malignant structure, I can see  
2 the malignancy on the actual frozen slide and benign.  
3 sorry, but I can't.

4 MR. MCGRAW: So the record is  
5 clear, Exhibit A you just showed her, was that the first  
6 frozen section C or the second?

7 MISS KOLIS: I believe it's the  
8 second frozen section C.

9 Q. If you want to remove that slide, what I would  
10 like to do before I destroy this is put it back where it  
11 belongs.

12 Have you looked at G24 and G33? You  
13 might want to take G24 first, there is G24-1 and G24-2.

14 A. G24-1, okay.

15 Q. Those are permanent sections, correct?

16 A. Yes.

17 Q. These are the permanent sections of the frozen  
18 section, correct?

19 A. I would have to see the actual report again.

20 MISS KOLIS: Do you happen to  
21 have her report handy?

22 A. My frozen was in C, goes in block C, I'm not sure  
23 of this permanent section of strictured area.

24 Q. I represent to you it is but let's find your  
25 report.

1 A. I can't recall from three years.

2 Q. Doctor, I understand you can't recall. Let me ask  
3 you this question --

4 A. I have to see the actual report.

5 Q. we filed a lawsuit against you on behalf of your  
6 client, can you explain why you haven't reviewed the  
7 report?

8 MR. MCGRAW: objection. Don't  
9 answer that, it's argumentative.

10 MISS KOLIS: Yes, it is  
11 argumentative.

12 A. I would say this much, it's best to review the  
13 report before you answer a question. That's all.

14 MR. CULLEN: which one are we  
15 talking about?

16 MISS KOLIS: Her actual report.

17 MR. CULLEN: Here.

18 MR. MCGRAW: Is that it?

19 THE WITNESS: Yes. This way ■ can  
20 see.

21 A. This is slide G24, G22 section of distal  
22 intrahepatic common bile duct and mucosal surface,  
23 right.

24 Q. so the first question is, permanent section G24  
25 you also read as indicating a malignancy; is that an

1 accurate statement?

2 A. Yes.

3 Q. while we're at it, so we don't have to waste a lot  
4 of time, can you by looking at the report confirm that  
5 the other section which you read and confirmed the  
6 malignancy was G33 that is on the table? You can look  
7 at your report first.

8 A. Multiple lymph nodes were submitted in G11, G18 as  
9 well as in G30-G33. There is lymph nodes in G33. I  
10 don't recall, I have to refresh my mind. Additional  
11 sections from the -- section G24 -- on G24 I recognize  
12 there were malignant and glandular structures. G24 is  
13 the one I made the diagnosis of malignancy. G33  
14 contains the atypicality of the epithelial surface of  
15 the bile duct, G24.

16 Q. Can I have G33 up for a second?

17 A. G33 contains lymph nodes and additional tissue  
18 around the bile duct.

19 Q. Is that indicative of a carcinoma?

20 A. There are changes in epithelium here that are  
21 preneoplastic and atypical, severe papillary dysplasia.

22 Q. My question is, is that slide unequivocal for  
23 making the diagnosis of a malignancy?

24 A. I did not make the diagnosis of malignancy on this  
25 slide.

1 Q. That is not my question.

2 A. No, G24 is not diagnostic, but there are changes  
3 within the bile duct epithelium that are both  
4 preneoplastic and severe dysplasia. Borderline in situ  
5 papillary carcinoma.

6 Q. or could be read as, what you are telling me is  
7 you don't read them as exhibiting --

8 A. No, there are changes of -- epithelial changes  
9 that are diagnostic of severe dysplasia, papillary well  
10 differentiated adenocarcinoma in my opinion. The actual  
11 slide where you saw gland in the bile duct are present  
12 on G24, maybe that is where the confusion is arising.

13 Q. why don't you pull up G24, the first section. ■  
14 hope I've got your reading.

15 Tell me, Doctor, first of all, what  
16 power are you looking at?

17 A. 10X.

18 Q. Is that high enough for you to see changes that  
19 you feel are consistent with malignancy?

20 A. No. I have to study the cytology features at the  
21 higher magnification. It does present at a lower power,  
22 10X I'm seeing atypicality based upon architectural  
23 features.

24 Q. Thinking through this case after it was filed  
25 against you, did you have an opportunity to review any

1 pathology literature regarding the reading of these  
2 particular kinds of slides, slides taken in the  
3 peribiliary area?

4 A. Can you repeat the question?

5 Q. sure. I want to know if since we filed the  
6 lawsuit, if you reviewed any pathology literature  
7 regarding the reading of this type slide?

8 A. No, I'm not.

9 Q. Are you aware one of the most frequently  
10 overcalled malignancies is the peribiliary gland?

11 A. I'm aware you can mistake benign structure for  
12 malignancy.

13 Q. You were aware of that when you read these slides?

14 A. Yes. I go through a diagnostic criteria in my  
15 brain, you have to determine what you see is benign on  
16 the slide versus malignant, that's how I approach.

17 Q. Your file read then of G24, tell me what  
18 structures you see and how they indicate an unequivocal  
19 malignancy?

20 MR. MCGRAW: Do you need to  
21 increase the power, Doctor?

22 A. First of all you have to see on lower power the  
23 atypicality of this epithelium surface. The surface is  
24 very well differentiated right behind haphazard  
25 distorted arrangement of malignant appearing glands,

1 right here. This is what if you go on higher  
2 magnification you see they are quite angulated, they  
3 have outpouching, this is architectural features of  
4 malignancy. They have cytologic criteria of malignant  
5 nucleoli. Architectural outpouching, haphazard  
6 arrangement and inflamed stroma, More of the same here.

7 Q. were there any other slides around G24 that had  
8 changes that established or suggested malignancy? In  
9 other words, slides that were cut contiguous?

10 A. This was the slide that was diagnostic of focal  
11 invasive carcinoma of the bile duct stricture site.  
12 This is the diagnostic slide.

13 Q. The prominent feature that made you determine that  
14 this was diagnostic was what?

15 A. The architectural pattern, outpouching of the  
16 gland and cytologic features.

17 Q. When you cytologic features, you mean the  
18 appearance of what?

19 A. The chromatin, which is vesicular, the nucleoli.

20 Q. when you read the permanent section, did you ask  
21 the advice of any other person interpreting them?

22 A. when I did the actual permanent section?

23 Q. Permanent section, yes?

24 A. No, I did not.

25 MISS KOLIS: Doctor, ■ don't have

1 any further questions for you.

2 THE WITNESS: These are not  
3 originals, these are levels, this is the actual  
4 original.

5 MR. CULLEN: They don't change  
6 your interpretation, do they?

7 THE WITNESS: No, they don't.  
8 These are levels.

9 MISS KOLIS: Let the record  
10 reflect ■ asked the hospital for the originals, this is  
11 what was given to me.

12 MR. CULLEN: can we go back to  
13 the frozen?

14 THE WITNESS: Are you going to ask  
15 questions too?

16 MR. CULLEN: Do you mind, Doctor?

17 THE WITNESS: NO.

18 -----

19 CROSS-EXAMINATION

20 BY MR. CULLEN:

21 Q. can you put the slide up that was diagnostic, do  
22 you have a little arrow pointing in this?

23 A. Yes.

24 Q. Can you walk me through the diagnosis? You've got  
25 two frozen slides?

1 A. One is deep, one is a first cut. This is an  
2 additional level. Just means deep, is an additional  
3 level,

4 Q. Are these marked, how are they identified?

5 They are identified by the surgical number of the  
6 surgical specimen from where it came, what patient, the  
7 patient's name. S gives you the surgery number, that  
8 refers to my report, S962320.

9 This is basically low power. The slide  
10 has faded because stain fades over time, since 1996, it  
11 loses its quality. You still can see the cells that are  
12 involved within the wall of this bile duct. These are  
13 the cells that were interpreted as malignant.

14 Q. what are the characteristics that you use to make  
15 that determination?

16 A. we make the distinction by architectural pattern.  
17 You see there is no structure to the cells, no organized  
18 pattern, discohesive aggregates, have the criteria of  
19 prominent nuclei and vesicular chromatin. some cells  
20 have two nuclei. some have one, some have two.  
21 Additional slides that is a level that is a lot more  
22 prominent, you can see the cells a lot better in a  
23 deeper section.

24 Q. Can you show me that?

25 A. That is the purpose of doing a small frozen

1 section on a small specimen, you have to do additional  
2 levels.

3 Q. which was done?

4 A. In this case it's typical.

5 Q. You testified this was an adequate sample?

6 A. Yes, an adequate sample.

7 Q. If it wasn't adequate you would have requested --

8 A. I would have told the surgeon.

9 on low power you can see that the whole  
10 structure is outlined by these dots, what you see on  
11 high power are fibrous edematous stroma, a lot of  
12 inflammation and necrosis associated in a benign  
13 structure here I can't point out on her photograph.

14 Q. Can you point it out on the slides?

15 A. Here is a benign ductal structure. In this  
16 particular one you can see the difference between this  
17 benign structure which is clearly benign but down here  
18 there is the whole aggregate of cells that are haphazard  
19 infiltrating this fibrous tissue, diagnostic of  
20 malignancy. These are not normal cells. These are  
21 abnormal malignant cells permeating through the inflamed  
22 desmoplastic stroma, discohesive.

23 If you compare this with something  
24 benign, you can see clearly, see the difference. There  
25 is a slight lumen here, these are the characteristics of

1 a benign structure. Here you see discohesiveness, you  
2 see the cells permeating in a haphazard fashion through  
3 the inflamed desmoplastic stroma. Along with cytologic  
4 features, that is what I based my diagnosis on.

5 Q. The frozen section you reviewed with a colleague  
6 by the name of Dr. Runyon --

7 A. Dr. Anne Caveny.

8 Q. I'm sorry. Did you make your diagnosis prior to  
9 consulting with her?

10 A. Yes, I did.

11 Q. Then she --

12 A. Confirmed it.

13 Q. she confirmed it. Did you have any discussions  
14 about it?

15 A. we just went over the atypicality of the cytologic  
16 features of the glands. we discussed all the malignant  
17 criteria together.

18 Q. she agreed with you?

19 A. she agreed with my interpretation, which I thought  
20 was good quality assurance by showing it to another  
21 pathologist.

22 Q. Have you spoken to her since?

23 A. No. Last time I saw Dr. Caveny was in July when I  
24 was there as a pathologist, June, July.

25 Q. Since you didn't really have a question as far as

1 your diagnosis in your mind, what was the purpose of  
2 consulting with Dr. Caveny?

3 A. For quality assurance, because the lesion is --  
4 the specimen is small, so you like to confirm *it*, to  
5 have a confirmation of your impression. we did that  
6 typically in our cases during frozen sections, not just  
7 on this case, on many cases.

8 Q. was there a policy with the group?

9 A. No, no policy, just up to the individual person.

10 Q. I see. So when the diagnosis was relayed to  
11 Dr. Guyton, both you and Dr. Runyon had evaluated --

12 A. Dr. Caveny.

13 Q. Dr. Caveny.

14 A. Yes, I told Dr. Guyton myself and Dr. Caveny  
15 reviewed the slides, we interpreted as we said as  
16 malignant, as an adenocarcinoma.

17 Q. The permanent section, why did you not have -- why  
18 did you not confer with a colleague on those?

19 A. Because the diagnosis of malignancy was made on  
20 frozen section, there is no indicated policy to show *if*  
21 the case is to begin with malignant, the tissue section  
22 shows *it*, there is no need to show *it* to a colleague.  
23 The need arises when you don't have -- when you have a  
24 positive frozen section, nothing in the slides, then one  
25 should show *it* to a colleague.

1 Q. It wasn't required for the permanent?

2 A. No, it wasn't required.

3 MR. CULLEN: That's all I have.

4 MISS KOLIS: okay, we're done.

5

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9 (Deposition concluded; signature not waived.)

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PAGE/ LINE

This image shows a blank sheet of handwriting practice paper. It features two vertical columns of horizontal lines designed for letter formation. Each column contains four identical sets of lines. In each set, there are three horizontal lines: a top solid line, a middle dashed line, and a bottom solid line. The left column's middle dashed line is dotted, while the right column's middle dashed line is solid. The entire page is white with black lines, providing a clear guide for practicing letter height and placement.

■ have read the foregoing transcript and  
the same is true and accurate.

DIANE MUCITELLI, M.D.

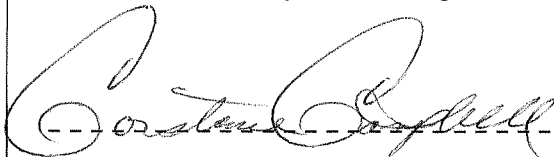
1 The State of Ohio,

2 County of Cuyahoga. : CERTIFICATE:

3 I, Constance Campbell, Notary public within and for  
4 the State of Ohio, do hereby certify that the within  
5 named witness, DIANE MUCITELLI, M.D. was by me first  
6 duly sworn to testify the truth in the cause aforesaid;  
7 that the testimony then given was reduced by me to  
8 stenotypy in the presence of said witness, subsequently  
9 transcribed onto a computer under my direction, and that  
10 the foregoing is a true and correct transcript of the  
11 testimony so given as aforesaid.

12 I do further certify that this deposition was taken  
13 at the time and place as specified in the foregoing  
14 caption, and that I am not a relative, counsel or  
15 attorney of either party, or otherwise interested in the  
16 outcome of this action.

17 IN WITNESS WHEREOF, I have hereunto set my hand and  
18 affixed my seal of office at Cleveland, Ohio,  
19 this 3rd day of August, 1999.

20   
21 -----

22 Constance Campbell, stenographic Reporter,  
23 Notary Public/State of Ohio.

24 Commission expiration: January 14, 2003.

25

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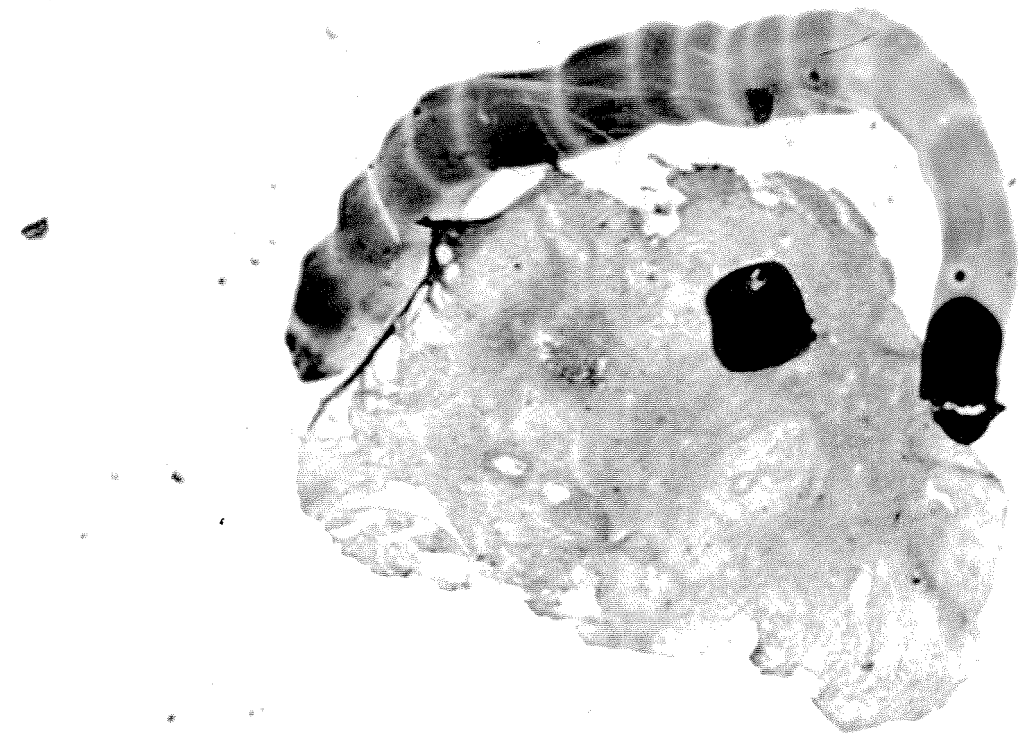
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