

Huston vs. Cleveland Clinic

Deposition of Howard Muntz, M.D.

June 22, 2002



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IN THE COURT OF COMMON PLEAS
CUYAHOGA COUNTY, OHIO

JOHN M. HUSTON, Executor,)

Plaintiff,)
) JUDGE COYNE

vs) No 439194

)
THE CLEVELAND CLINIC)
FOUNDATION, et al.,)

)
Defendants)

DEPOSITION UPON ORAL EXAMINATION
OF
HOWARD MUNTZ, M.D.

Taken at 1326 Fifth Avenue
Seattle, Washington

DATE TAKEN: JUNE 22, 2002

REPORTED BY: JOLENE C. HANCA, RPR, CCR HANCAJC2741

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A P P E A R A N C E S

FOR THE PLAINTIFF MEREL GREY NISSENBERG
1200 Prospect Street
Suite 550
La Jolla, California 92037

FOR THE DEFENDANT WILLIAM D BONEZZI
Bonezzi Switzer
Murphy & Polito
526 Superior Avenue
Suite 1400
Cleveland, Ohio 44114-1491

* * * * *

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1 Seattle, Washington; JUNE 22, 2002
2 9:00
3 --oOo--
4 (Exhibit No. 1 marked.)
5
6 HOWARD MUNTZ, M.D., witness herein, having been
7 first duly sworn on oath,
8 was examined and testified
9 as follows:

11 E X A M I N A T I O N

12 BY MS. NISSENBERG:

13 Q. Would you state and spell your name for the
14 record, please.

15 A. Howard Muntz, H-O-W-A-R-D M-U-N-T-Z.

16 Q. And you are a medical doctor?

17 A. Yes.

18 Q. We're here today because you've been designated
19 as one of the defense experts in this case. We're here
20 to get your deposition as to all the opinions that you
21 have formed in this case that you intend to offer at
22 trial.

23 Have you ever had your deposition taken before?

24 A. Yes.

25 Q. Approximately how many times?

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1 A. Probably four or five times.
 2 Q. With what were those in connection,
 3 specifically?
 4 A. There was one malpractice case when I was a
 5 fellow in Boston that involved nursing error for the
 6 administration of chemotherapy. So I was deposed in that
 7 case as a fact witness, I suppose is the best way to
 8 describe that.
 9 And I've done a few medical malpractice cases
 10 as an expert witness for both plaintiff and defense.
 11 Q. Did any of those involve ovarian cancer?
 12 A. Yes.
 13 Q. What type of cases were those?
 14 A. Oh, one case was a young woman with an immature
 15 teratoma, which is a highly malignant type of ovarian
 16 cancer. That was a failure-to-diagnose-type malpractice
 17 case.
 18 That was only the case, if I'm recalling
 19 correctly, that was ovarian cancer specifically.
 20 Q. And, in that case, did you testify on behalf of
 21 the defense?
 22 A. No, it was on behalf of the plaintiff.
 23 Q. Do you recall what the gist of your opinions
 24 were in that case?
 25 A. In that situation, the woman had been seen in

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1 If you answer the question, I will assume that
 2 you understood it as asked. All right?
 3 A. All right.
 4 Q. How many times have you been named as an expert
 5 witness, to the best of your knowledge?
 6 A. Oh, probably less than half a dozen.
 7 Q. And of the depositions that you have given, the
 8 four to five times, have most of those been in the last
 9 five years?
 10 A. Yes.
 11 Q. How often during the year are you asked to
 12 review medical negligence matters?
 13 A. Probably only about once per year.
 14 Q. What percentage of your clinical time is used
 15 in reviewing cases?
 16 A. Infinitesimal. Small amount.
 17 Q. I wasn't going to tell Virginia Mason. That's
 18 okay.
 19 Have you ever given any talks or speeches
 20 regarding medical negligence litigation?
 21 A. No.
 22 Q. And have you ever worked with any defense firms
 23 in Ohio before?
 24 A. Yes, actually, I have.
 25 Q. What firms were those?

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1 the emergency room, was misdiagnosed with irritable bowel
 2 syndrome and sent home, only to have her ovarian cancer
 3 rupture a few months later and developed disseminated
 4 disease.
 5 Q. Teratoma, is that part of the staging system,
 6 the FIGO staging system? Does that appear in there for
 7 ovarian?
 8 A. An immature teratoma is a germ cell malignancy
 9 of the ovary. So it simply represents one of the three
 10 broad categories of ovarian cancer, and as such, it would
 11 be staged according to the FIGO system.
 12 Q. And there's a substrata of people diagnosed
 13 with early germ cell tumors of the ovary that, in fact,
 14 survive?
 15 A. Correct.
 16 Q. Are you familiar enough with the deposition
 17 process or do you want me to go through some of the
 18 admonitions?
 19 A. I'm familiar with it.
 20 Q. I'll just tell you to just wait for me to
 21 finish my question before you answer. I'll try to do the
 22 same for you.
 23 If I say something that you don't understand or
 24 if I speak too fast, just ask me to repeat it or rephrase
 25 it.

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1 A. I can't remember the name of the firm. I'm
 2 just drawing a total blank on that.
 3 Q. Do you remember what city?
 4 A. It would have been in the general Cleveland
 5 area.
 6 Q. Did you actually give a deposition in that
 7 case?
 8 A. I did do a deposition, but that case did not go
 9 to trial, or if it did, I'm drawing a blank on that,
 10 also.
 11 Q. In that case, were you working on behalf of the
 12 plaintiff or the defense?
 13 A. I was a defense expert for that case.
 14 Q. And you don't remember the name of the firm?
 15 A. No.
 16 Q. Have you ever worked with Mr. Bonezzi or anyone
 17 in his firm before?
 18 A. No.
 19 Q. Why is that funny?
 20 A. We met --
 21 MR. BONEZZI: You'll find out.
 22 A. We have met previously.
 23 MR. BONEZZI: If you ask questions.
 24 Q. How have you met previously?
 25 A. I was an expert witness for a plaintiff, and

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1 Mr. Bonezzi was the counsel for the defense.
 2 Q. Is that the same case that you were just
 3 telling me about?
 4 A. No. It was a different case.
 5 Q. Where was that filed, what state?
 6 A. That was also in Ohio.
 7 Q. So that's two cases that you have given
 8 testimony in in Ohio?
 9 MR. BONEZZI: Excuse me. Listen to his answers
 10 and remember your question. You asked him if he has
 11 given testimony as a defense witness.
 12 MS. NISSENBERG: No, I didn't.
 13 MR. BONEZZI: Yes, you did.
 14 MS. NISSENBERG: I asked if he has given
 15 deposition testimony.
 16 MR. BONEZZI: I'm going to ask you, seriously,
 17 Merel, to listen to his answers, because you're already
 18 starting to ask the same question where he has already
 19 provided you the answer.
 20 BY MS. NISSENBERG:
 21 Q. I asked you how many times you have given
 22 deposition testimony or worked with firms in Ohio, and I
 23 think you said once in the general Cleveland area?
 24 Is it more than once?
 25 A. We can probably clarify matters by talking

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1 A. Okay. Three cases in Ohio; two are for
 2 plaintiffs, one was for defense.
 3 Q. In the cases in which you testified --
 4 A. Actually, I haven't finished.
 5 Q. I'm sorry.
 6 A. Three yielded depositions and one went to
 7 trial, at which I did testify. That was for the
 8 plaintiff.
 9 One plaintiff case was settled before it went
 10 to trial. And then the third case for the defense went
 11 to trial, but I was not required to testify at trial.
 12 Q. Have you ever testified on behalf -- the case
 13 in which you testified for the defense, that did not
 14 involve Mr. Bonezzi's firm, correct?
 15 A. No, it did not.
 16 Q. Do you know personally any of the GYN
 17 oncologists at the Cleveland Clinic?
 18 A. No, I do not.
 19 Q. Have you ever discussed any aspect of this case
 20 with the GYN oncologists at the Cleveland Clinic?
 21 A. No, I have not.
 22 Q. May I look at the file that you brought with
 23 you today?
 24 A. Yes. There's a copy of the letter that I
 25 provided Mr. Bonezzi back in March, when I was first

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1 about three different scenarios. One is when I'm asked
 2 to review a case. The second is when it moves forward to
 3 an actual deposition.
 4 And then last, which is the most infrequent of
 5 the situations, is when I'm actually called to Ohio to
 6 give trial testimony.
 7 Q. And in the case that you referenced earlier,
 8 you said it either didn't go to trial or you don't have
 9 any recollection?
 10 A. Let me pause for a moment and just collect my
 11 thoughts on that, so that I can give you a
 12 chapter-and-verse account of that.
 13 (Telephonic interruption.)
 14 MR. BONEZZI: Go ahead.
 15 (Discussion off the record.)
 16 A. I think I can give you the information you
 17 want --
 18 Q. Great.
 19 A. -- in a concise way without doing the 20
 20 questions, which then confused me, because some of your
 21 legal language in terms of what is testimony, I think of
 22 that being trial testimony, but what I'm realizing now is
 23 you're also talking about deposition as being testimony.
 24 Am I correct?
 25 Q. Correct.

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1 asked to review this case.
 2 Q. This is the opinion letter that you furnished.
 3 Is there anything else in your file?
 4 A. No, blank paper.
 5 Q. Did you make any notes when you reviewed
 6 anything that you did review to give your opinions in
 7 this matter?
 8 A. I'm sure I had a working draft of this, but
 9 that's no longer available, since it would have been
 10 discarded as I created my final document.
 11 Q. Have you ever discussed this case or any aspect
 12 of this case with any GYN oncologist at Virginia Mason or
 13 anywhere else?
 14 A. No.
 15 Q. Do you know any of the pathologists at the
 16 Cleveland Clinic?
 17 A. No.
 18 Q. What is your understanding of the nature of the
 19 plaintiffs claim in this case?
 20 A. Failure to diagnose ovarian cancer.
 21 Q. Do you have an understanding as to any
 22 particular physicians with whom the plaintiff is unhappy?
 23 A. I understand that she's unhappy with the
 24 Cleveland Clinic in general, but I do not know which
 25 physicians in particular the claim is being filed

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1 against.
 2 Q. And with respect to the plaintiffs claim of
 3 failure to diagnose ovarian cancer, can you be more
 4 specific, if you have a more specific understanding of
 5 their claim?
 6 A. I'm not sure I understand the question.
 7 Q. You understand the plaintiff's claim to be that
 8 the Cleveland Clinic failed to make a timely diagnosis of
 9 ovarian cancer.
 10 Is there anything else that you understand
 11 their claim to consist of, any more specifics?
 12 A. That pretty much covers the complete case,
 13 doesn't it?
 14 Q. When were you first contacted in this case?
 15 A. I don't remember.
 16 Q. Was it in the year 2002?
 17 A. I can assume that if I'm writing a letter March
 18 27, 2002, that I would have been contacted a month or two
 19 before then.
 20 Q. Do you recall who contacted you?
 21 A. Someone from Mr. Bonezzi's office.
 22 Q. Was it Mr. Bonezzi?
 23 A. No. I doubt that Mr. Bonezzi and I would have
 24 spoken about the case immediately.
 25 I think, as you're familiar, the usual routine

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1 depositions were done just this week and might have not
 2 even been transcribed yet.
 3 Q. Which depositions did you receive subsequent to
 4 forming your opinions that appear in your letter?
 5 A. I have honestly lost track.
 6 MR. BONEZZI: I will tell you. It was Drs.
 7 Biscotti, Gramlich and Levin.
 8 Q. Mr. Bonezzi has indicated that you were
 9 provided with the depositions of Dr. Gramlich, Dr. Levin
 10 and Dr. Biscotti.
 11 Do you recall receiving those depositions?
 12 A. Yes, I do.
 13 Q. Did you have an opportunity to read those
 14 depositions?
 15 A. Yes, I did.
 16 Q. Were you ever provided with the deposition of
 17 Dr. Braherd, the cytopathologist who read the pelvic
 18 washings in this case?
 19 A. Yes, I did, although that is one of the
 20 depositions I received several months ago.
 21 Q. What about the deposition of Julie Shorie,
 22 S-H-O-R-I-E?
 23 A. I don't think I received that one. Can you
 24 describe to me --
 25 MR. BONEZZI: No, you didn't see that. We

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1 is an office staff member contacts me to see if I'm
 2 available, No. 1; and then, No. 2, after a brief
 3 description of the case, to see if I'm interested in
 4 representing or, I should say, helping with the defense.
 5 Q. Did you request certain materials at the time
 6 that you had this first contact?
 7 A. I would not have requested materials, but they
 8 would have been provided to me automatically.
 9 Q. What materials did you receive for your initial
 10 review?
 11 A. That's listed in the first paragraph of my
 12 letter back to Mr. Bonezzi.
 13 Q. So we can assume that you have provided -- you
 14 were provided with the clinical records of Mrs. Huston's
 15 admission to the Cleveland Clinic from April '99 through
 16 August 2000, the first summary statement of Dr. William
 17 Tench, the statement of Dr. Weiss, and only four
 18 depositions, those of Drs. Prayson, Kennedy, Markman and
 19 Brainerd; is that correct?
 20 A. That's correct.
 21 Q. Is there anything else that you received from
 22 the defense firm for your review?
 23 A. Subsequent to this, I have received copies of
 24 some of the other depositions, although not all of them
 25 have arrived for my review. And I understand that some

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1 didn't send you that.
 2 Q. Did you request at any time any additional
 3 records or deposition transcripts from the defense firm?
 4 A. I've never requested anything, obviously. I'm
 5 simply provided with material as it becomes available.
 6 Q. And the two volumes of records you have in
 7 front of you, those are the medical records that you have
 8 referenced in the letter already, correct?
 9 A. That's correct.
 10 Q. Have you seen the pathology slides in this
 11 case?
 12 A. No, I have not.
 13 Q. Did you ever request to see them?
 14 A. No, I have not.
 15 Q. Prior to today, did you have an opportunity to
 16 meet with defense counsel?
 17 A. Yes, I have.
 18 Q. Approximately how many times?
 19 A. Just once.
 20 Q. Was that before or after your opinion letter?
 21 A. It was after my opinion letter.
 22 Q. And what was discussed during that
 23 conversation?
 24 A. We reviewed the case and discussed in general
 25 the content of my letter from the end of March.

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1 Q. Did you ever receive the second of Dr. Tench's
2 expert reports?

3 A. No, I have not.

4 Q. Were you aware that one exists?

5 A. I don't think I knew one existed. Did it
6 change?

7 MR. BONEZZI: That's the one I showed you
8 yesterday.

9 A. Did it change substantively from his first
10 opinion?

11 Q. I just want to know if you've seen it.

12 MR. BONEZZI: This one.

13 A. I guess not to be difficult, but there's a
14 difference between crossing my retina and getting into my
15 cortex. Could I compare this with his first?

16 I don't see that there's any substantive
17 difference between these two reports.

18 Q. Is today the first time that you have reviewed
19 that second report?

20 A. Mr. Bonezzi has reminded me that we actually
21 looked at this together yesterday evening.

22 Q. That brings up my next question. Did you have
23 a meeting with Mr. Bonezzi prior to today's deposition,
24 other than the one you already told us about?

25 A. No, the one meeting yesterday.

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1 Q. I think you already told me that you met with
2 him at some point after you did the report.

3 Is that what you were talking about,
4 yesterday's meeting?

5 A. No, one meeting yesterday.

6 Q. And then yesterday?

7 A. No, one meeting, which was yesterday.

8 Q. Okay.

9 A. And that includes after the report was written
10 and before today.

11 Q. So after you submitted this report to Mr.
12 Bonezzi for utilization in this case, you have not spoken
13 to him about this case prior to yesterday?

14 A. Oh, I assume that we had some conversations
15 just as we were getting ready for the deposition,
16 conversations, most of them revolving around scheduling
17 issues.

18 And we probably would have just confirmed that
19 he had received my original correspondence, and that was
20 pretty much it.

21 Q. When you met yesterday with him, did he tell
22 you the nature of the testimony of Dr. Robboy at Duke?

23 A. Yes, we did speak about that.

24 Q. What did he tell you Dr. Robboy testified?

25 A. We spoke at length about the difficulties of

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1 the pathology interpretation for this case.

2 Q. That's what he told you Dr. Robboy testified?

3 A. That is probably a gross oversimplification.

4 Dr. Robboy has, of course, given extensive deposition
5 testimony, and that's one of the transcripts that I have
6 not had a chance to review.

7 Q. What did Mr. Bonezzi tell you Dr. Tench
8 testified to at his deposition on Wednesday?

9 A. I don't recall that he spoke specifically about
10 what Dr. Tench said, other than to review --

11 MR. BONEZZI: Actually, you have it backwards.
12 We spoke about Dr. Tench as opposed to Robboy.

13 THE WITNESS: Okay.

14 BY MS. NISSENBERG:

15 Q. Now that Mr. Bonezzi has refreshed your
16 recollection, you spoke about Dr. Tench's testimony and
17 not about Dr. Robboy's testimony? Is that your
18 recollection?

19 A. I honestly don't recall precisely which
20 pathologist we were talking about.

21 Q. As you sit here today, do you have any
22 information as to how Dr. Robboy at Duke testified on
23 Tuesday of this week?

24 A. I don't know the details of his testimony.

25 Q. What do you know about his testimony?

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1 A. But I do know that he feels that the material
2 is very difficult to evaluate, and that probably most
3 importantly he is of the opinion that if he had seen the
4 original 1999 material himself as a practicing
5 pathologist, without knowing her subsequent clinical
6 history, that he would more probably than not, or some
7 words to that effect, signed out the case as benign.

8 Q. Where did you learn that? From his report?

9 A. No, from speaking with Mr. Bonezzi.

10 Q. So then you did discuss Dr. Robboy's testimony
11 with Mr. Bonezzi?

12 A. Correct.

13 Q. So then the correct testimony of you today is
14 that you discussed both Dr. Tench's testimony and Dr.
15 Robboy's testimony both educed this week, correct?

16 A. That is correct, but what Mr. Bonezzi has
17 clarified is that the more extensive discussion about the
18 ins and outs of the pathology review, including all the
19 difficulties of sorting out cytology versus histology,
20 were all revolving around Dr. Tench's testimony.

21 Q. And what you just told me about Dr. Robboy's
22 testimony. is that ail that you know about it from his
23 deposition this week?

24 A. I think that's a fair statement.

25 Q. So as you sit here today, you don't know how

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1 Dr. Robboy testified with respect to whether or not there
 2 were malignant cells in the pelvic washing?
 3 MR. BONEZZI: Objection to the characterization
 4 of that testimony. Go ahead and answer.
 5 A. I think it's unclear to me how to answer that
 6 question, particularly when you realize I have not
 7 reviewed the testimony. In other words, I have not had a
 8 chance to see that deposition.
 9 Q. I understand that, but you did discuss Dr.
 10 Robboy's testimony, albeit briefly, with Mr. Bonezzi when
 11 you met with him yesterday, correct?
 12 A. Correct.
 13 MR. BONEZZI: Objection to the
 14 characterization. Go ahead.
 15 Q. Maybe it wasn't briefly, but you met and
 16 discussed with Mr. Bonezzi Dr. Robboy's testimony
 17 yesterday, correct?
 18 MR. BONEZZI: Objection to the way in which
 19 that is phrased. Go ahead and answer.
 20 A. Correct.
 21 Q. And you told me that your understanding of how
 22 Dr. Robboy testified is that it was very difficult to
 23 read the slides, and that if he had been reading the
 24 slides at the time, he would have signed them out as no
 25 problem or normal or whatever, however you described it;

Page 22

1 is that correct?
 2 A. I think that's a fair summary of the gist of
 3 all the pathology review.
 4 Q. And that particular aspect of Dr. Robboy's
 5 testimony you gleaned from Mr. Bonezzi yesterday?
 6 MR. BONEZZI: Objection.
 7 A. Yes.
 8 Q. Is there anything else from Dr. Robboy's
 9 testimony? I know you haven't read the transcript yet,
 10 but anything else about Dr. Robboy's testimony that he
 11 gave this week that you gleaned from Mr. Bonezzi
 12 yesterday?
 13 MR. BONEZZI: Objection. Go ahead and answer.
 14 A. No, I don't think there is anything of any
 15 substantive importance.
 16 Q. As part of your clinical practice, how often do
 17 you personally review GYN slides?
 18 A. All the time.
 19 Q. And as a GYN surgeon, you rely on the pathology
 20 lab to correctly analyze surgical specimens and pelvic
 21 washing slides that are submitted for evaluation,
 22 correct?
 23 A. That is correct.
 24 Q. So it's critical for those interpretations to
 25 be accurate, since you rely on them in making important

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1 clinical decisions for the patient, correct?
 2 A. Correct.
 3 Q. And you're aware that Dr. Kennedy testified to
 4 the same effect in his deposition; is that right?
 5 A. Yes.
 6 Q. Is it your understanding that the plaintiff is
 7 unhappy with Dr. Kennedy for some reason?
 8 A. I don't have any understanding of what the
 9 plaintiff is unhappy about, other than the understandably
 10 sad outcome of the clinical case.
 11 Q. I only ask you that because you go on quite
 12 extensively in your opinion letter about how, in your
 13 opinion, Dr. Kennedy acted appropriately. I thought that
 14 maybe you considered that that was part of their claim.
 15 A. Is he part of the lawsuit?
 16 Q. He's a former employee of Cleveland Clinic.
 17 A. Is he part of the lawsuit?
 18 Q. Only in so much as he was an employee of the
 19 clinic at the time.
 20 A. So he's part of the lawsuit.
 21 Q. But my question is, are you aware or do you
 22 think that the plaintiff is unhappy with Dr. Kennedy's
 23 actions in this case?
 24 A. Whether the plaintiff is happy or unhappy with
 25 Dr. Kennedy is irrelevant to me, if he's part of your

Page 24

1 lawsuit.
 2 Q. Would you agree with Dr. Prayson at the
 3 Cleveland Clinic that carcinoma of the ovary typically
 4 would demonstrate more cytologic atypia than low-grade or
 5 benign lesions?
 6 MR. BONEZZI: Would you read that back, please,
 7 because you're reading awfully fast.
 8 MS. NISSENBERG: I can slow down. I can repeat
 9 it, because I don't think you got it either.
 10 Q. Would you agree with Dr. Prayson at the
 11 Cleveland Clinic that, quote, carcinoma of the ovary
 12 typically would demonstrate cytologic atypia than
 13 low-grade or benign lesions, end quote?
 14 A. Could you repeat that again?
 15 Q. Would you agree with Dr. Prayson of the
 16 Cleveland Clinic that, quote, carcinoma of the ovary
 17 typically would demonstrate more cytologic atypia than
 18 low-grade or benign lesions?
 19 A. I think that's a normal statement of fact
 20 describing any pathological process involving cancer.
 21 Q. Then you agree?
 22 A. Correct.
 23 Q. Is it fair to say that whatever opinions you
 24 have regarding the accuracy of the interpretation of the
 25 surgical specimen slides of April '99, as well as the

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1 pelvic washing slides, is based solely on the deposition
2 testimony that you read, as well as the medical records,
3 since you have never seen the slides yourself?

4 A. I would not limit my opinion in that way,
5 simply because as a practicing gynecologic oncologist, I
6 have had a lot of experience dealing with these difficult
7 endometriosis cases that develop either atypical changes
8 that are not yet malignant or have actually evolved all
9 the way into a malignancy associated with endometriosis.

10 So I would say that I'm filtering this
11 information through my clinical experience to render my
12 opinion.

13 Q. But in this case, you've never seen either the
14 surgical slides or the pelvic washing slides, correct?

15 A. It is true that I have never seen them with my
16 own two eyes, but courtesy of this extensive deposition
17 process, I have read many, many descriptions of both the
18 cytology slides, as well as the histology slides, and
19 since I am familiar with pathology terminology, I have
20 very a good picture in my mind of what these slides look
21 like.

22 Q. When you wrote your original opinion dated
23 March 27, 2002, in which you state basically that you
24 disagreed that these slides were misread, even though you
25 have never seen the slides, because of reading these four

1 Q. Since you read GYN slides in the course of your
2 clinical practice, why is it that you never asked to see
3 the original either surgical specimen slides or pelvic
4 washing slides in this case?

5 A. Because I'm here predominantly as the clinical
6 gynecologic oncologist to try and make sense out of this
7 confusing case from really a patient care standpoint.

8 The pathology aspect of this case is, in my
9 opinion, very well represented already by experts on both
10 sides, both by you and by Mr. Bonezzi.

11 Q. But wouldn't you think that since you're going
12 to give an opinion regarding the adequacy or correctness
13 of the interpretation of these slides, that it would have
14 been important for you to see the original slides?

15 A. No. Partly because I can read these different
16 reports and, again, putting it through my filter as a
17 clinician almost be a one-man jury for deciding how this
18 dispute about the pathology slides should be resolved.

19 Q. Now, you said that you read Dr. Kennedy's
20 deposition. That's referenced in your letter, correct?

21 A. Correct.

22 Q. Then you're aware that Dr. Kennedy testified
23 that Dr. Biscotti had identified for him in person a
24 small focus of high-grade cancer in the original B6
25 slide, correct?

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1 depositions that we talked about, two of the depositions,
2 isn't it true, were of the pathologist and
3 cytopathologist, whose very interpretation is at issue in
4 this case?

5 A. The full text of my letter is as follows:
6 Quote, Drs. Tench and Weiss, comma, in opinions written
7 for the plaintiffs attorney, comma, allege that the
8 Cleveland Clinic pathology department negligently -- and
9 I will emphasize "negligently" -- misread the April 1999
10 histology and cytology material, period. I disagree,
11 period, end quote.

12 I am disagreeing with the allegation that these
13 slides were negligently misread.

14 Q. Are you emphasizing "negligently" because
15 you're saying they might have been misread but it wasn't
16 negligently? Is that where you're going with this?

17 A. I think that's where I'm going with this.

18 Q. Okay. Doctor, going back to my question that I
19 had asked about two minutes ago, isn't it true that the
20 four depositions that you -- of the four depositions that
21 you had read prior to writing your opinion letter, two of
22 those were of the cytopathologist and pathologist, whose
23 very interpretation of the slides are at issue in this
24 case?

25 A. That's true.

1 A. You are misquoting, I think, some of the
2 conversations that they had.

3 Q. I would be happy to show you the quote.

4 A. I know the quote you're going to show me.

5 The difficulty is jumping all the way forward
6 and saying high-grade cancer, when what we may be talking
7 about is atypical.

8 Q. My question to you was, do you recall Dr.
9 Kennedy testifying that Dr. Biscotti pointed out to him
10 in person an area in the original B6 that he interpreted
11 to be a small focus of high-grade cancer?

12 A. Yes. That is in that deposition.

13 Q. You're aware that the original B6 is missing
14 from the Cleveland Clinic?

15 A. I figured that out by reading the depositions.

16 Q. And are you aware further that Dr. Biscotti
17 states that in looking at the first recut of B6, that it
18 is not as dramatic in its atypia or other atypical
19 findings as the original B6 that is missing, correct?

20 A. That is correct.

21 Q. And are you aware as you sit here today that
22 Dr. Robboy testified that the pelvic washings contain
23 atypical cells, atypical cell clusters, irregular nuclei,
24 epithelial cells, as well as other atypia that you would
25 not expect to see in a pelvic wash? Are you aware that

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1 Dr. Robboy testified to that?
 2 MR. BONEZZI: Objection to that. Go ahead and
 3 answer the question.
 4 A. Again, I have not seen Dr. Robboy's transcript
 5 of his deposition.
 6 I would also be concerned that you are stating
 7 all that in a way that is perhaps overly dramatic in
 8 terms of its content.
 9 Q. My question -- I can say it in sotto voce.
 10 My question just is, are you aware that Dr.
 11 Robboy testified to that?
 12 A. I think the simple answer to that question is
 13 no, I'm not aware, because I have not seen the deposition
 14 transcript.
 15 Q. And you're aware that in Dr. Brainerd's
 16 original report that she signed out, there is no mention
 17 of atypia, correct?
 18 A. That is correct.
 19 Q. You are aware that there is not only no mention
 20 of any type of epithelial cells, but that she testified
 21 that there are no epithelial cells present in the pelvic
 22 washings? Do you recall that from her testimony?
 23 A. That I actually do not recall.
 24 Q. Is there anything else that you recall from
 25 reading Dr. Biscotti's testimony relative either to the

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1 original B6 to show you, do we?
 2 MR. BONEZZI: Objection.
 3 A. We have, I think, a very honest recollection by
 4 Dr. Biscotti of what the original B6 looked like. And I
 5 would say that, as I read his testimony, he's been very
 6 forthright in acknowledging that the recut is
 7 underrepresentative of what he saw on the original.
 8 Q. You're aware that Dr. Kennedy testified at his
 9 deposition that he believes that on April 29th, 1999,
 10 there was cancer developing within endometriosis in Mrs.
 11 Huston's ovary?
 12 A. I would substitute the word "in" -- let me
 13 rephrase that. I would drop the word "in" the ovary and
 14 substitute the phrase "on" the ovary, and once we change
 15 it, I would agree completely with what you said.
 16 MR. BONEZZI: What page are you looking at?
 17 MS. NISSENBERG: I'm looking at page 39 of Dr.
 18 Kennedy's deposition, wherein he states at line 3: I
 19 think she had cancer develop --
 20 MR. BONEZZI: Hang on.
 21 MS. NISSENBERG: In response to my question, as
 22 you sit here today, do you believe that Mrs. Huston had
 23 cancer on April 29, 1999, which is on page 38, and then
 24 on 39, Dr. Kennedy states --
 25 MR. BONEZZI: Because I wanted you to complete

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1 pelvic washings or the original B6 that we haven't
 2 covered?
 3 MR. BONEZZI: Objection. Go ahead.
 4 A. It's a fairly open-ended question. The point I
 5 would emphasize, again, is the importance for this case
 6 of not using language in a careless fashion.
 7 For instance, high-grade carcinoma is a phrase
 8 that should be avoided when discussing very small biopsy
 9 material and minute pelvic washings, because with the
 10 amount of cellular material present, the most you could
 11 say is atypia, because you do not have the diagnostiic
 12 material necessary to state anything about, quote,
 13 high-grade carcinoma, end quote.
 14 Q. You're referring to a biopsy. What biopsy is
 15 that?
 16 A. The ovarian tissue from 1999, as well as the
 17 cell block and thin-prep cytology material from 1999.
 18 Q. And you're saying that of the amount of tissue
 19 that was taken from the surgical specimens, that would
 20 not be adequate to make a diagnosis of ovarian cancer?
 21 A. Correct.
 22 MR. BONEZZI: Objection.
 23 A. Because the tissue was quite plentiful, but the
 24 area of abnormality was extremely small.
 25 Q. And, again, we don't have the benefit of the

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1 that line.
 2 MS. NISSENBERG: That's why I went back to read
 3 the question. Let me start over again.
 4 Q. Question to Dr. Kennedy: As you sit here
 5 today, today being February 4th, 2002, do you believe
 6 that Mrs. Huston had cancer on April 29th, 1999?
 7 Answer: I do.
 8 And then on page 39, beginning at line 3, he
 9 states: I think she had cancer developing within, comma,
 10 in the endometriosis of the ovary.
 11 Did you recall that testimony?
 12 A. Yes. And, in fact, like most deposition
 13 testimony, it gets tortured when it's read back by the
 14 court reporter. What Dr. Kennedy is saying is that she
 15 had cancer developing within endometriosis.
 16 Q. Did he say in the ovary? Yes or no.
 17 A. Endometriosis is everywhere in the pelvis,
 18 including on the ovary.
 19 MR. BONEZZI: Excuse me. He says "of' the
 20 ovary, not "in." He says in the endometriosis "of' the
 21 ovary.
 22 MS. NISSENBERG: Okay, within.
 23 MR. BONEZZI: No, within the endometriosis --
 24 MS. NISSENBERG: Wait. Excuse me, Bill.
 25 MR. BONEZZI: No, I don't want you to misphrase

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1 that. He did not say in the ovary. I'm reading it.
 2 MS. NISSENBERG: It says within, comma, in the
 3 endometriosis of the ovary.
 4 THE WITNESS: No.
 5 Q. I'm reading you the direct quote, Doctor.
 6 Within, comma, in the endometriosis of the
 7 ovary. Is that the quote?
 8 A. That is the deposition transcript.
 9 Q. Is the transcript inaccurate?
 10 A. I think it is.
 11 Q. You don't think Dr. Kennedy stated that?
 12 A. If he verbalized that, it was with the typical
 13 hesitation or stutter that we all have during
 14 depositions, but I would rephrase that as follows:
 15 Quote, I think she had cancer developing within
 16 endometriosis of the ovary.
 17 Since I, for instance, dictate all of my clinic
 18 notes and my operative reports, I'm very familiar with
 19 how a good transcriptionist can slightly tilt some of the
 20 meaning of our phrase by simple matters such as putting
 21 in a comma or the extra "in." I think that should be
 22 dropped out, and then the sentence to me as a clinician
 23 makes perfect sense.
 24 Q. Are you aware of Dr. Kennedy -- if Dr. Kennedy
 25 made any corrections to his transcript when he had an

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1 opportunity to read it and make corrections?
 2 A. In all of these deposition transcripts,
 3 including Dr. Kennedy's, I have found many such
 4 situations where there clearly was tortured syntax
 5 probably from a deposition transcription error that was
 6 simply either overlooked or was felt to be so unimportant
 7 as to not be worth trying to change the transcript.
 8 Q. Are you aware that Dr. Kennedy made any
 9 corrections to his transcript in that section, pages 38
 10 and 39?
 11 A. I am not aware of any changes to his
 12 transcript.
 13 Q. Now, you started to say earlier, if you change
 14 it to "on" the ovary, then you would agree with the
 15 statement.
 16 What do you meant by that?
 17 A. The endometriosis, I believe, was on the
 18 surface of the ovary,
 19 Q. Are you aware that Dr. Kennedy told the Hustons
 20 that there was cancer found in review of the ovarian
 21 endometriosis from April of 1999?
 22 A. I was not aware that he had that conversation,
 23 but I would just assume that he told them that, because
 24 that would be the appropriate thing for a clinician to
 25 do.

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1 Q. How important is it to you as a GYN oncologist
 2 when you're caring for a patient with an ovarian mass to
 3 learn whether or not the mass is cancerous?
 4 A. It is very important.
 5 Q. And that would be the same whether it's primary
 6 ovarian or in an endometriosis implant on the ovary,
 7 correct?
 8 A. That is correct.
 9 Q. Would you agree that with most solid tumors,
 10 the earlier you diagnose a cancer, i.e., when the tumor
 11 burden is smallest, the better prognosis for a patient in
 12 general?
 13 A. That is a correct general statement.
 14 Q. And how important would it be for you as a GYN
 15 oncologist caring for a patient with a diagnosed ovarian
 16 cancer to know whether or not it is high-grade, i.e.,
 17 well-differentiated, versus low-grade or poorly
 18 differentiated?
 19 A. In general --
 20 Q. I've got it backwards. High-grade or poorly
 21 differentiated versus low-grade or highly differentiated.
 22 A. I was quite ready to agree with you just on
 23 general principles that, of course, this information is
 24 important to a managing clinician.
 25 Q. With epithelial tumors, isn't it true that

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1 frankly malignant tumors are characterized partly by
 2 dissection into stromal planes?
 3 MR. BONEZZI: Would you read that back for me,
 4 please, or you can read it.
 5 MS. NISSENBERG: I can read it. It's not a
 6 quote, but it's probably confusing.
 7 Q. With epithelial tumors, isn't it true that
 8 frankly malignant tumors are characterized partly by
 9 dissections into stromal planes?
 10 MS. NISSENBERG: It's not a quote.
 11 MR. BONEZZI: It's not a quote, but it's a
 12 quote from your document. If you had it there, you could
 13 read it as opposed to her.
 14 A. I don't like the quote, so I won't agree with
 15 it.
 16 Q. In what way do you disagree?
 17 A. I guess I want to have clarification from you,
 18 since it sounds like this is your own language, what you
 19 mean by stroma.
 20 Q. What is your understanding of stroma?
 21 MR. BONEZZI: Objection. Go ahead.
 22 A. Stroma is everywhere in our bodies. It's the
 23 connective tissue that holds us together, in a simplistic
 24 way of explaining that.
 25 So which stroma are you talking about?

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1 Q. Let's start with the stromal invasion that Dr.
2 Tench identified on the B6 slide.
3 If there were such stromal invasion on -- all
4 we have, of course, is the first recut, but if there were
5 stromal invasion, would that have any significance to you
6 as either a GYN oncologist or a GYN oncologist who likes
7 to read his on slides?

8 MR. BONEZZI: Let me just object to that.

9 A. Meanwhile, let me take a look again at his
10 revised opinion.

11 Q. That's fine. I'm just going to represent to
12 you that this is not part of his letter, but Mr. Bonezzi
13 at Dr. Tench's deposition asked him to draw what he sees
14 under the microscope, looking at the first recut of B6,
15 and to identify the area that's ovarian and to identify
16 the area that is endometrial and where is any invasion,
17 or Dr. Tench showed him where the invasion was across the
18 stroma.

19 So it doesn't appear there, but it was at his
20 deposition. And those transcripts will be available
21 Monday. I'm sure Mr. Bonezzi will be furnishing you with
22 a copy.

23 But getting back to my question then, do you
24 disagree with the statement that with epithelial tumors,
25 frankly malignant tumors are characterized partly by

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1 ovarian carcinoma or carcinoma of an endometriosis
2 implant within or on the ovary.

3 How important is dense adhesions in the pelvis
4 when that ovary is adhered as a clinical pathologic
5 factor?

6 A. If all you think the patient has is benign
7 endometriosis, then you would fully expect there to be
8 extraordinarily dense adhesions. In fact, sometimes the
9 worst adhesions we encounter in gynecologic surgery are
10 in women with severe endometriosis.

11 Q. My question is, in a patient such as that where
12 the benignity has been disproven and carcinoma is proven,
13 the fact of dense adhesions, does it have any clinical
14 pathologic significance to you as a clinician?

15 MR. BONEZZI: Objection.

16 A. The second part would be now you have a patient
17 in whom you know she has ovarian cancer. Then dense
18 adhesions in my own clinical experience, as well as in
19 several retrospective research studies, have been shown
20 to have a significant impact in a bad way, a bad impact
21 on the patient's survival.

22 Q. If you were suspicious of malignancy or it was
23 part of the differential at the time of surgery and you
24 wanted to rule it out, would you do a sampling, a frozen
25 section sampling from the densely adherent side during

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1 dissection into stromal planes?

2 MR. BONEZZI: Objection. You may answer.
3 A. This is very helpful, because I understand that
4 we're talking about ovarian stroma.

5 The difficulty when you're interpreting an
6 ovary that is riddled with endometriosis is that your
7 stromal planes are oftentimes fractured either by growth
8 of the endometriosis or by the surgical dissection
9 required to remove the adherent endometriotic ovarian
10 mass from the pelvis.

11 With those qualifiers, I would agree that one
12 way we make the diagnosis of malignancy is to demonstrate
13 under the microscope that there are areas of invasion of
14 that malignant epithelium into the stroma.

15 Q. Would you agree that dense adhesions in the
16 pelvis of the ovary is a significant clinical pathologic
17 factor to be analyzed when you're staging ovarian cancer
18 patients?

19 MR. BONEZZI: Objection to the term
20 "significant." Go ahead and answer.

21 A. Again, I would ask you to clarify in what
22 context you're asking that question.

23 Q. In what context? What specifics do you want?

24 You have a patient with an ovarian mass. It's
25 densely adherent and the ovarian mass turns out to be

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1 that surgery?

2 A. That's where I thought you were going. I
3 would, again, be very clear that if what we thought we
4 were facing in the operating room was garden-variety
5 endometriosis, then indeed we would not be doing any of
6 those additional sampling procedures in the operating
7 room.

8 Q. Would you agree that approximately 30 percent
9 of patients with epithelial tumors involving the ovary
10 present with Stage I or II disease? And that's Roman
11 numeral I and II.

12 MR. BONEZZI: Objection.

13 A. Read that back to me again.

14 Q. Would you agree that approximately 30 percent
15 of patients who present with epithelial tumors involving
16 the ovary present with Stage I or II disease?

17 A. My problem with that particular question is
18 that it's not relevant to this case, but, in general, I
19 would agree that that's an appropriate quote that I could
20 put into any textbook.

21 Q. And one of the purposes for having a
22 classification system by stage for different cancers is
23 that there's some uniformity within stages with respect
24 to treatment modalities, prognoses, etc., correct?

25 A. That is correct.

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1 Q. So you could, for example, pick up the phone
2 and speak to a GYN oncologist in Florida and be
3 discussing a IC patient and he could be discussing a IC
4 patient and you're basically talking about the same kind
5 of patient in those terms, correct?

6 A. This case, though, would not be applicable --

7 MR. BONEZZI: Excuse me. As I understand it,
8 what she's asking though, however, is basically a
9 hypothetical or in a general sense.

10 A. That's a good way for me to think about this.

11 So I would say hypothetically I have a patient
12 who has garden variety Stage IC ovarian cancer. There is
13 nothing special about her. There's no endometriosis.
14 There's no dense adhesion. It's just a standard ovarian
15 cancer operation.

16 And yes, indeed, I could easily pick up the
17 phone and talk to my friend down in Florida, maybe
18 because she's going to go down there after my operation
19 and I'm transferring her care to my friend -- fill in the
20 blank -- Neil Thencorsi (phonetic) in Orlando.

21 I'll pick up the phone and talk to Neil. She
22 has Stage IC ovarian cancer. And yes, you are absolutely
23 right. It would be very easy to have that conversation
24 about a very typical, run-of-the-mill Stage IC ovarian
25 cancer case.

1 information that we could use for this discussion.

2 Q. Do they ascribe any percentage figures for
3 five-year survival for Stage IC under the FIGO system?

4 A. When you say FIGO, you're implying that you are
5 looking at the survival curves that the International
6 Cancer Committee submits in aggregate, are you not?

7 Q. I'm just wanting to know what your
8 understanding is of the general survival figures for
9 Stage IC. I know what Dr. Kennedy testified.

10 Do you recall what he testified?

11 A. No, I don't.

12 Q. I believe that he testified it was about 80
13 percent. Does that sound right to you?

14 A. No. Eighty percent is too high, if you're
15 going to quote for all Stage ICs, in which you will
16 include the really poorly differentiated subtypes, such
17 as adenosquamous carcinoma or some of the cancers that
18 can arise from endometriosis, which oftentimes have
19 poorer prognosis than other cancers.

20 Q. Such as clear cell, for example?

21 A. Correct.

22 Q. That's almost equivalent to small-cell
23 carcinoma of the lung; it's very poor prognosis, correct?

24 A. I wouldn't go so far as to say that. The small
25 cell of the lung is a totally different entity compared

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1 Q. What percentage of patients, to your knowledge,
2 with Stage IC ovarian cancer survive five years?

3 A. You can look almost at any textbook and get
4 various survival figures for Stage IC ovarian cancer, but
5 you will have a fairly broad range of survivals.

6 You will also have different nomenclature,
7 five-year survival, which may not be equivalent to a
8 cure, versus long-term, disease-free survival, which may
9 be equivalent to a cure.

10 I would probably accept almost any reputable
11 textbook that you quoted from as being an accurate
12 representation of survival for Stage IC, with the caveat
13 that it would not be applicable to this case.

14 Q. With your knowledge, what is the general
15 percentage?

16 A. You would need to give me information about
17 grade, histology, age of the patient, and a lot of other
18 clinical factors before I would properly answer that
19 question.

20 Q. Are you familiar with the DeVita, Hellman and
21 Rosenberg text?

22 A. Yes.

23 Q. I'm sure you consider that fairly authoritative
24 in the field of cancer?

25 A. Yes. I would accept that as having excellent

1 to clear cell.

2 Q. I was just referring to prognoses. They're
3 both not good?

4 A. Small cell of the lung, though, is
5 chemotherapy-sensitive. So in early stages, small cell
6 of the lung is actually curable.

7 Q. Actually, Stage I -- I mean Stage I, small-cell
8 carcinoma of the lung is sometimes a surgical disease,
9 believe it or not; isn't that true?

10 A. That's true, but that's small cell of the lung.
11 Again, it has nothing to do with clear cell to the ovary.

12 Q. Right, but clear cell of the ovary generally
13 has a poorer prognosis, correct?

14 A. Oh, absolutely. I definitely agree with that.

15 Q. Are you aware of any or have you read any of
16 Dr. Robboy's pathology texts that he has written?

17 A. Over the years I'm sure I have read if not the
18 textbook excerpts from it or other papers that he has
19 written.

20 Q. Do you recall he has a section in Chapter 19
21 where he's talking about the cancers involving the ovary
22 and he has one subsection on cancers or, excuse me,
23 tumors of low-malignant potential, borderline tumors, and
24 then he has a section on malignant tumors involving the
25 ovary?

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1 Do you recall reading this in his book, quote,
 2 patients diagnosed with early stage disease confined to
 3 the ovary or pelvis demonstrate a five-year survival rate
 4 of 80 percent? It's on page 532.
 5 MR. BONEZZI: I will object to the question.
 6 The second thing is, is this his newest text?
 7 MS. NISSENBERG: Yes.
 8 MR. BONEZZI: I know I've read it. This is the
 9 newest text that just came out?
 10 MS. NISSENBERG: I don't know if it's the last
 11 month's.
 12 MR. BONEZZI: His newest text has been out for
 13 only a couple of months, and it's already out of print
 14 and they're reprinting it.
 15 First of all, she asked if you have even read
 16 that newest text.
 17 THE WITNESS: I have not read that particular
 18 textbook. And if I've read his pathology textbook, it
 19 would have been a few years ago, either looking at cases
 20 of interest for myself or studying for my own board
 21 examination.
 22 So I wouldn't testify that I have actually read
 23 the book, but I'm willing to discuss the content of what
 24 he has written, and, again, using my filter as a
 25 practicing clinician correctly interpret what he is

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1 Q. (Indicating.)
 2 A. I would disagree with that paragraph.
 3 Q. You would disagree with that?
 4 A. Yes. This is an oversimplification of a very
 5 complex clinical subject that is appropriate as a
 6 snapshot or as a brief synopsis for pathologists, but I
 7 would not send any of my OB-GYN residents, for instance,
 8 to this textbook to have any educational value about
 9 treatment, prognosis, so on and so forth.
 10 Q. Have you ever made a diagnosis of --
 11 A. Can I go off the record?
 12 Q. Ofcourse.
 13 (Discussion off the record.)
 14 Q. I think I was asking you if you've ever
 15 diagnosed malignant transformation of endometriosis.
 16 A. Yes.
 17 Q. And you would agree that only about one percent
 18 of endometriosis undergoes malignant transformation? Is
 19 that the generally accepted percentage?
 20 A. We actually don't know what the percentage is,
 21 and our increasing concern as clinicians in dealing with
 22 women with endometriosis, as we have a large group of
 23 women naturally aging into the cancer-age range, is that
 24 this one percent figure may be lower than it is.
 25 Let me rephrase that. The one percent figure

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1 saying as a pathologist as it relates to clinical
 2 medicine.
 3 Q. Mr. Bonezzi is suggesting that the newest text
 4 doesn't contain that statement. Do you --
 5 MR. BONEZZI: No, I did not say that.
 6 MS. NISSENBERG: Just a second. You asked him
 7 if he's read the newest text.
 8 MR. BONEZZI: That's where it comes from.
 9 MS. NISSENBERG: This comes from the newest
 10 text?
 11 MR. BONEZZI: Yes. That's what I'm trying to
 12 tell you. That's from the newest text.
 13 MS. NISSENBERG: Great. Thank you.
 14 Q. Okay. Let's move on here.
 15 A. I thought we hadn't finished the question.
 16 MR. BONEZZI: And you also know that Dr. Robboy
 17 had disagreements not with the comment. He gave you
 18 qualifiers with that.
 19 Q. I'm going to show you the page that I'm
 20 referring to.
 21 MR. BONEZZI: I will object to the question and
 22 the information that's contained in that because of how
 23 Dr. Robboy responded to the questions, but go ahead and
 24 answer.
 25 A. We're on this page, are we?

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1 may be an underestimation. It's at least one percent.
 2 It may be higher.
 3 Q. How many times have you made that diagnosis, by
 4 the way?
 5 A. A number of times. Often enough that I begin
 6 to think that I should go back through my stack of index
 7 cards, because like most obsessive-compulsive gynecologic
 8 oncologists, I keep a stack of index cards of all of the
 9 patients I've treated, and I think if I went back through
 10 my ten years of clinical practice, I would have anywhere
 11 from half a dozen as a conservative estimate to upwards
 12 of 20. That's the upper range.
 13 If I also add together anecdotal cases I've
 14 heard about when I've been chatting about cases with my
 15 other colleagues in town, we may have a Seattle series
 16 that is approaching 50 cases of endometriosis leading to
 17 the development of cancer.
 18 Q. Do you recall Dr. Kennedy's physical
 19 examination of Mrs. Huston prior to her surgery?
 20 A. Yes, I do.
 21 Q. And was there any evidence of any disease
 22 outside of the pelvis during that exam?
 23 A. No, there was not.
 24 Q. Was there anything in the GYN tract that was
 25 visible or palpable that he noted during that

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1 examination?

2 A. Simply the large ovarian tumor mass, which we
3 know now ended up being the clinically unimportant large
4 ovarian tumor involving either the left or right ovary.
5 I lose track of which side is which, but I think that was
6 the dominant physical exam finding, was the large ovarian
7 mass.

8 Q. As you sit here today, you don't know which
9 side was the larger mass?

10 A. I could figure that out just by flipping to the
11 pathology report. The laterality of the lesions are not
12 important to me clinically, so I don't have that off the
13 top of my head.

14 So the left ovary was the large benign tumor,
15 and the right ovary was the endometriotic ovary that is
16 of concern now.

17 Q. Correct. By the way, did you consult any texts
18 or other authoritative sources in forming any of your
19 opinions in this case?

20 A. No. Although, as we discussed, I'm happy to
21 have any one of the standard gynecologic oncology
22 textbooks used for reference material, as long as I
23 reserve the right as a board certified gynecologic
24 oncologist to quibble with any quotes from that, any
25 specific textbook.

1 Q. And a IC ovarian cancer is cancer involving one
2 or both areas with, I believe, the capsules intact?

3 A. No.

4 Q. Or ruptured. And the pelvic washings positive?
5 Is that true?

6 A. You've misquoted the FIGO staging rules.

7 Q. Tell me what a IC is.

8 A. A IC is cancer involving one ovary and the
9 capsule is either ruptured or you have positive
10 peritoneal cytology.

11 Q. And you're aware that the cyst ruptured in this
12 case during surgery, are you not? Do you recall that
13 from the operative report?

14 MR. BONEZZI: You may look at the op report.

15 A. I might as well, because the phraseology, I
16 think, of your question is important.

17 Now that I have reviewed the op note, can you
18 ask me the question?

19 Q. Did the cyst rupture during surgery on April
20 29, 1999, according to Dr. Kennedy?

21 A. Am I allowed to say yes and no?

22 Q. Fine. In what way did they not rupture?

23 A. The important distinction I'm making is that
24 this op note reads like a perfect example of severe
25 pelvic peritoneal endometriosis, including the presence

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1 Q. So the answer is no, you didn't rely on any
2 texts, though?

3 A. No.

4 Q. Would you agree that overall the survival for
5 ovarian cancer tends to be low because most women are
6 diagnosed in later stages?

7 MR. BONEZZI: Excuse me. Did you say
8 "overall"? I didn't hear the beginning.

9 MS. NISSENBERG: I don't remember. Did I say
10 "overall"? Yes.

11 MR. BONEZZI: Thank you.

12 A. Actually, that's a very good question. Could
13 you say it again?

14 MS. NISSENBERG: Could you read it back?
15 (Record read.)

16 A. I think as a general statement that is true.

17 And as a further refinement to the point you're
18 making, I would emphasize that the problem with ovarian
19 cancer is that when it has gone beyond Stage I, it has by
20 definition gained access to the entire peritoneal cavity,
21 so that it becomes very difficult to eradicate cancer,
22 because as soon as it goes beyond Stage I, it has jumped
23 all the way up to a regional disease process with at-risk
24 tissue extending from the pelvic floor all the way up to
25 the diaphragms.

1 of a right-sided ovarian endometrioma.

2 By that I mean there is a large aggregate of
3 chocolate fluid that has dissected into the ovarian
4 tissue and then become encapsulated by a rind of fibrous
5 tissue.

6 With this degree of endometriosis, you actually
7 can make a very straightforward clinical assumption that
8 she has been rupturing those ovarian endometriomas
9 repetitively in the months to possibly years prior to her
10 surgical procedure.

11 We make that determination based upon reading
12 the operative note and its description of extensive
13 endometriosis, very dense adhesions, so on and so forth.

14 So, indeed, the ovarian tissue had ruptured
15 before she was ever operated on,

16 Q. My question is, does Dr. Kennedy state that the
17 cyst ruptured during surgery?

18 A. Yes, he does state that.

19 Q. Could you read that section into the record?

20 A. Actually, it's only a one-page op note, once
21 you drop off the top and bottom of pages 1 and 2.

22 Q. Just read the portion regarding the rupture of
23 the cyst, please.

24 A. He references several places. Let's run
25 through this and catch all the places that he talks about

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1 things like that.
 2 Under postoperative diagnosis, he has the
 3 phrase, quote, evidence of endometriosis, end quote.
 4 Under operative findings, he says, quote,
 5 evidence of chocolate cyst within both ovaries,
 6 suggestive of endometrioma and endometriosis, period, end
 7 quote.
 8 Continuing on, quote, dense adherence of the
 9 right ovary to the pelvic sidewall and endometrial
 10 implants along the anterior vesicouterine peritoneum --
 11 vesicouterine is V-E-S-I-C-O-U-T-E-R-I-N-E, and the next
 12 word is peritoneum -- period, end quote.
 13 Q. I was asking you to read, Doctor, just where it
 14 mentions that the cyst ruptured, not all of Dr. Kennedy's
 15 findings.
 16 A. I'm catching all of the findings that talk
 17 about endometriosis and endometriomas.
 18 Q. That wasn't my question. My question was,
 19 could you read into the record, please, the specific
 20 reference to the cyst rupturing during surgery?
 21 A. I'm getting to that. I'm *sorry*. I was just
 22 going through the op note in sequence and catching the
 23 things that I thought were relevant to --
 24 Q. Since I'm paying by the page, I don't need you
 25 to read the entire operative report into the record.

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1 A. Sorry. Here's the part that you're interested
 2 in.
 3 Under operative procedure, it says, quote, the
 4 right pelvic mass was densely adherent, period. Some
 5 sharp and blunt dissection was done to free up these
 6 masses, period. Chocolate cyst ruptured during the
 7 procedure, period.
 8 Q. Thank you.
 9 A. And then it goes on and talks about irrigation,
 10 and I think I've caught the part that you were interested
 11 in.
 12 Q. Yes. Thank you.
 13 Now, if hypothetically the pelvic wash slides
 14 were, in fact, evidence of or contained evidence of
 15 malignancy, the pelvic wash slides obtained April 29,
 16 1999, would that be consistent with the presence of
 17 cancer in this patient?
 18 MR. BONEZZI: Objection.
 19 A. So we're not going to call the pelvic wash
 20 atypical? We're going to actually make the diagnosis of
 21 malignancy?
 22 Q. Correct.
 23 A. So it's a hypothetical discussion.
 24 Q. Yes.
 25 A. I'm sitting in my office a couple of days after

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1 surgery and my friend at the pathology department calls
 2 me up and says, "Howard, I'm *so sorry* to tell you this,
 3 but the cytology from the pelvic washings of the patient
 4 you just operated on are obviously cancer, there is no
 5 doubt in my mind that we're seeing malignancy in her
 6 pelvic wash"? That's the scenario that you're wanting me
 7 to address?
 8 Q. The scenario is that the pelvic washings
 9 contain evidence of malignancy.
 10 Is that consistent with the presence of cancer
 11 in the patient?
 12 MR. BONEZZI: Objection. Go ahead and answer.
 13 A. I'm wondering why Bill is objecting.
 14 Q. He objects all the time.
 15 A. No, I'm happy that saying yes, that's evidence
 16 that there is malignancy present.
 17 Now as a clinician, I then have to start
 18 thinking what does this mean, and that gets more
 19 complicated.
 20 Q. And we're going to get to that. Don't let me
 21 forget.
 22 A. I'm sure it's probably about three or four
 23 lines down on your list of questions.
 24 Q. Now, hypothetically, if the surgical specimens
 25 from April 29, 1999, contain tumor cells that are

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1 morphologically similar to those present in the vaginal
 2 biopsy of 2000 and the small bowel excision of August
 3 2000, would you agree with Dr. Gramlich of the Cleveland
 4 Clinic that suggested that the cancer shares the same
 5 origin?
 6 MR. BONEZZI: Objection.
 7 A. I like the word "etiology" better than
 8 "origin."
 9 Q. Would you agree with him or disagree with him?
 10 A. I think by stating, quote, origin, end quote, I
 11 would be forced to disagree with him, because I think
 12 using that word creates potential for confusion in terms
 13 of the actual meaning of what he was trying to
 14 communicate.
 15 Q. Have you spoken with Dr. Gramlich?
 16 A. No, I have not.
 17 Q. So you don't know exactly what he was trying to
 18 communicate, do you, other than what appears in the
 19 written word?
 20 A. Well, let me clarify. I would say that if he
 21 means what he said, I would disagree with him. If he
 22 says he meant something different from what was
 23 transcribed, then I would agree with him, because
 24 agreement is like kind of an ephemeral issue.
 25 But in terms of how he is quoted in his

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1 deposition, I think that is not a completely accurate way
2 to phrase the pathology situation.

3 Q. And, again, if there are cell clusters in the
4 April '99 pelvic wash slides that are virtually identical
5 to cell clusters in the small bowel excision of August
6 2000, does that suggest to you that the cancer shares the
7 same origin?

8 A. I would again say etiology -- can I explain why
9 I don't like the word "origin"? Would that be helpful
10 for the deposition?

11 Q. I just want to know if you agree with that or
12 disagree with that.

13 A. No, then I would say I disagree with that
14 because of the use of the word "origin."

15 Q. There was no evidence on April 29, '99, or even
16 shortly thereafter, before Mrs. Huston was discharged
17 after the '99 surgery that there was any extension of
18 tumor to the uterus or tubes, correct?

19 A. I'm sorry. Could you read that -- I believe
20 that's a correct statement. Could you read it back more
21 slowly?

22 Q. There was no evidence on April 29, 1999, or
23 even shortly thereafter, before she was discharged after
24 her '99 surgery that there was any extension of tumor to
25 the uterus or tubes; is that correct?

1 A. I'm still, actually, back at your original
2 question. I haven't moved on yet.

3 Q. But I've asked another question and I'd like an
4 answer, please. Do you want her to repeat the question
5 to you?

6 A. Yes, please.

7 (Record read.)

8 A. Yes, that's very true.

9 Q. And in April of '99 or early May, before she
10 was discharged, there was no evidence of any pelvic
11 extension of tumor? Isn't that true? I'm taking your
12 attention back to April of 1999. Correct?

13 A. Again, that's the whole problem with the
14 retrospective nature of this case review.

15 Q. The question is, in 1999, when Mrs. Huston was
16 a patient at Cleveland Clinic, before her discharge in
17 the first couple of days of May, was there any evidence
18 that you see in the records that there was pelvic
19 extension of tumor in the patient? Yes or no. If
20 there's evidence, please point it out to me.

21 A. Oh, but there's plenty of evidence that there
22 was pelvic extension of her tumor in '99 based upon our
23 subsequent knowledge that her pelvic wash and her ovarian
24 tissue contained at least atypical cells, or I should
25 say, more precisely, there was evidence that there was at

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1 A. Actually, that's a good way to phrase the
2 question, because it makes the situation ambiguous.

3 Are we talking about based upon future
4 knowledge that she was going to develop cancer at the
5 vaginal cuff probably from the deep pelvic peritoneal
6 tissues or are we talking about what people thought they
7 knew in '99?

8 Q. If you go back to '99, no one even suspected
9 or, rather, no one had diagnosed cancer in Mrs. Huston,
10 correct?

11 A. Correct. In 1999, no one had diagnosed cancer.

12 Q. That's right.

13 A. And so she was sent home without any evidence
14 in the minds of her managing clinician that she had
15 cancer anywhere else in her pelvis.

16 Q. That's right.

17 A. In fact, the only thing they thought she had
18 was endometriosis extensively involving her pelvic
19 peritoneal tissues.

20 Q. That's right. And Dr. Kennedy testified that
21 had he known that there was this focus of high-grade
22 cancer in B6, that he would have considered what
23 treatment to render to the patient next? Isn't that
24 true?

25 MR. BONEZZI: Objection.

1 least a premalignant transformation of her endometriosis
2 underway.

3 It may not have been cancer yet, but it was
4 heading in that direction. That's where I'm getting kind
5 of confused by how I should approach this question.

6 Q. The question is not what you're looking at now,
7 knowing what happened to Mrs. Huston.

8 A. Excuse me. I'm sorry. I interrupted. I'm
9 sorry. Go ahead and finish.

10 Q. In the medical records, can you point out to me
11 where anything exists to show that there was pelvic
12 extension of tumor in the patient?

13 A. I guess I'm still confused, because the whole
14 retrospective nature of this lawsuit is that we're going
15 backwards in time. So now we're interpreting, or I
16 should say you're interpreting the endometriosis in her
17 pelvis as representing malignancy, despite the original
18 thought that it represented benign tissue.

19 Q. I'm trying to ask the question more clearly.
20 I'm sorry if I'm being obfuscating in my questions.

21 Is there anything in Mrs. Huston's medical
22 records that are dated April or May of 1999 that reveals
23 that there is pelvic extension of tumor? If there is,
24 point it out to me.

25 A. Then I think I can -- yes, I think that's a

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1 perfect way for you to phrase the question, because I
2 would go back to this operative report and say, ah-hah,
3 we see extensive endometriosis and we see dense adherence
4 of the abnormal right ovary to the pelvic peritoneal
5 tissues.

6 We see in particular reference to adherence of
7 that ovarian tissue to the area of the vaginal cuff where
8 there is description of having to take that adhesion,
9 take those adhesions, take those adhesions down with
10 sharp dissection.

11 So I think there is evidence that if she did
12 not have cancer at this point in time, that she had at
13 least extensive endometriosis that was atypical in nature
14 and potentially premalignant.

15 Q. Now, Dr. Kennedy testified that he found no
16 evidence of tumor at that time outside her ovary.

17 Do you recall that testimony? I can show you
18 the testimony.

19 A. I do recall that. And that's, I think, a
20 reasonable thing for him to state, although he's
21 specifically referencing no evidence of like -- why don't
22 we read that together.

23 MR. BONEZZI: What page?

24 MS. NISSENBERG: Page 40.

25 Q. Beginning with page 39, where he says:

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1 this patient?

2 A. No.

3 Q. And there was no evidence of any
4 lymphadenopathy or positive retroperitoneal or inguinal
5 nodes for the patient, correct?

6 A. There was no evidence of that. On the other
7 hand, they were not evaluated because of the presumption
8 of a benign diagnosis.

9 Q. And had Dr. Kennedy known about the true
10 pathology, they would have undertaken other diagnostic
11 tests or other tests to ascertain the extent of disease,
12 correct?

13 A. That's correct.

14 Q. They may have even done a second-look surgery,
15 correct?

16 A. Correct.

17 Q. And, in fact, they may have gotten or obtained
18 a CA-125, correct?

19 A. Correct.

20 Q. Do you have any information as you sit here why
21 one wasn't obtained for this patient until August of
22 2000?

23 A. Because they did not think she had pelvic
24 peritoneal cancer or a similar malignancy at that time.

25 Q. Until August of 2000?

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1 Certainly, if I, if I had been given information that
2 there had been cancer present, depending on the grade of
3 the clinical findings at the time of surgery, I would
4 have needed to make recommendations as to whether
5 additional treatment was advisable or not.

6 And when I asked him to stage either clinically
7 or surgically what she would have been at the time, he
8 says: She would have been Stage I based on what I found.
9 And he says he didn't have the pathologic findings.

10 And then he says, lines 11 through 13: But I
11 found no evidence for any tumor at that time outside of
12 her ovary.

13 My question is just do you remember reading
14 this in Dr. Kennedy's deposition prior to me showing it
15 to you now? Do you remember reading that or you don't
16 remember reading it?

17 A. I'm sure I read it, but I actually don't
18 remember reading it.

19 Q. Okay. There was also no evidence at the time
20 of peritoneal implants outside of the pelvis anywhere,
21 correct?

22 A. He also did not look for them.

23 Q. Do you see anything in the medical records
24 dated the end of April, early May '99 that states that
25 there are peritoneal implants outside of the pelvis in

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1 A. By the time she presents with a vaginal mass in
2 June of 2000, you have a cancer diagnosis, and at that
3 point in time you don't need a CA-125 level to help you
4 render a diagnosis.

5 Q. Why was one obtained in August of 2000?

6 A. That was obtained so that you could ascertain
7 where her baseline level was as you're giving her
8 chemotherapy to monitor for her response to therapy.

9 Q. Actually, that's after she had already had
10 chemotherapy? Isn't that true?

11 A. She had already started some chemotherapy
12 treatments, but remember she had measurable disease in
13 the summertime of 2000 in the form of the vaginal mass
14 that was easily detected clinically.

15 Q. By the way, since your opinion that the slides
16 were not negligently misread is based on, quote, the
17 difficulties faced by even the most expert pathologists
18 when evaluating biopsy material and peritoneal washings
19 in the setting of extensive endometriosis, end quote,
20 would that be your opinion if in fact the vaginal biopsy
21 of June of 2000, which you have not seen, was read out as
22 normal?

23 MR. BONEZZI: Objection.

24 A. That's a confusing question.

25 Q. Can you read it over to me?

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1 MS. NISSENBERG: Do you want to read it?

2 THE WITNESS: You can skip the part where she's
3 quoting.

4 (Record read.)

5 MR. BONEZZI: Let me object.

6 A. But the vaginal biopsy in June of 2000 was read
7 out as cancer.

8 Q. Correct. But your opinion that the 1999
9 slides, both surgical specimens and pelvic washings, that
10 they were not negligently misread because you're aware of
11 the difficulty for even the most expert pathologists in
12 interpreting biopsies and peritoneal washings in the
13 presence of extensive endometriosis, I mean that opinion
14 is formed without even seeing the slides, correct?

15 A. Correct.

16 Q. And you're prepared to say that it's such a
17 difficult thing, that if somebody misses cancer, it can
18 happen because there's extensive endometriosis in these
19 patients and even the best pathologists can miss it,
20 correct?

21 A. Correct.

22 Q. Would your opinion be the same if the vaginal
23 biopsy of June of 2000 was read out as normal?

24 MR. BONEZZI: Objection.

25 A. So you're saying the vaginal tissue in this

1 The best way to explain that is, because I do
2 review my own slides for my patients and I sit down
3 frequently with our pathologists and look at slides
4 together and review all these cases at least at Virginia
5 Mason for our own gynecologic cancer conferences, I have
6 a very deep understanding of when it's a difficult
7 diagnosis, and even the most expert pathologists can
8 render an opinion that in retrospect based upon
9 subsequent clinical behavior is found to be in error
10 versus the situation where it was a really negligent
11 mistake where even I having looked at the slides would
12 say yes, that's obviously cancer and this pathologist,
13 this hypothetical pathologist who called it benign indeed
14 made a mistake.

15 In other words, I'm going back to my notion
16 that because I am a clinician dealing with cancer on a
17 daily basis, I almost can propose myself as a one-person
18 jury to mediate these disagreements between pathologists
19 and say, you know, this really was a hard case and it's
20 unfair for Dr. Tench, for instance, to accuse the
21 Cleveland Clinic pathologist of malpractice, because I
22 can bet you more than a quarter that if the roles had
23 been reversed, Dr. Tench could easily have made the same
24 diagnosis back in '99 had he been on staff and I had
25 presented him with a similar pathology quandary.

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1 hypothetical situation is cancerous, obviously cancer?

2 Q. Yes.

3 A. And a pathologist does a biopsy and incorrectly
4 labels that specimen as benign? Is that what you're
5 saying?

6 Q. You haven't seen the original slides, but
7 you're prepared to come into court and say that they were
8 not negligently misread because it's just hard to get
9 these things right when a patient has got extensive
10 endometriosis? Isn't that true? Isn't that what your
11 opinion says?

12 A. That's true.

13 Q. In June of 2000, when Mrs. Huston had her
14 vaginal biopsy, another slide that you haven't seen or
15 set of slides that you haven't seen, if those had been
16 read out as normal and the plaintiff claimed that they
17 were negligently misread, quote, unquote, would your
18 opinion be the same, that they're not negligently misread
19 because it's very difficult for even the most expert
20 pathologists to correctly interpret biopsies with a
21 patient who has extensive endometriosis?

22 MR. BONEZZI: Objection. It doesn't make
23 sense.

24 Go ahead and answer, if you can.

25 A. I think I'm understanding a little bit better.

1 Q. So your opinion is that Dr. Tench would not
2 have picked up what he picked up when he looked at these
3 pelvic washing slides?

4 A. I will say that more probably than not, if Dr.
5 Tench through some violation of space-time continuum had
6 been sitting at the Cleveland Clinic in '99 reading out
7 Connie Huston's slides that he probably would have
8 rendered the same written report as the Cleveland Clinic
9 pathologist, looking at both cytology and histology, did
10 in '99.

11 Q. So he would have misread them, but not
12 negligently?

13 A. I think that's a very proper way to phrase it.
14 It goes down to an issue of negligence. I don't think
15 there was anything negligent done by the pathologist in
16 this case.

17 Q. What about the B6 slide Dr. Biscotti analyzed
18 at Dr. Kennedy's request in 2000 and on which he
19 identified a small focus of high-grade cancer? Is it
20 your opinion that Dr. Tench would have missed that, also,
21 if he had been sitting at the Cleveland Clinic?

22 A. I think so.

23 MR. BONEZZI: Objection to the manner in which
24 that question was asked. You know darn well how Dr.
25 Biscotti arrived at that conclusion. It wasn't until

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1 after he made the comparison with the vaginal biopsy.
2 MS. NISSENBERG: That has nothing to do with
3 the question.

4 MR. BONEZZI: It certainly does. The way in
5 which you have phrased it is absolutely misleading.

6 Q. Mr. Bonezzi is referring to the fact that Dr.
7 Biscotti had the vaginal biopsy slide at the same time
8 that he looked at B6.

9 Nevertheless, Dr. Kennedy testified that Dr.
10 Biscotti identified for him a small focus of high-grade
11 cancer.

12 So is your answer the same, that in your
13 opinion Dr. Tench would also have read this out as normal
14 tissue, normal endometriotic tissue, had he been at the
15 Cleveland Clinic reading the surgical specimens in April
16 of '99?

17 MR. BONEZZI: Objection.

18 A. I would actually go one step further and I
19 would say that every single one of the expert
20 pathologists retained by both plaintiff and defense in
21 this case, if they had, again, through some violation of
22 space-time continuum become the staff pathologist in
23 1999, I predict that all of them would have read this out
24 as benign.

25 The most, the most serious diagnosis that I

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1 cancer and surface epithelial ovarian cancer behave
2 biologically the same way, with dissemination directly
3 into the peritoneal cavity.

4 Q. Have you ever treated patients when you're
5 doing surgery where the cyst ruptures and seed the
6 remaining GYN tissue that is left after the surgery?

7 A. Can you ask that question again?

8 Q. Sure. I might have said that in a confusing
9 manner.

10 Have you ever operated on patients where the
11 ovarian cyst contained cancer cells, the cyst ruptures
12 during surgery and seed tissue that is remaining after
13 the surgery?

14 A. It's a hypothetical concern with any ovarian
15 cancer in which the epithelial cancer has become
16 encapsulated and, therefore, is not in direct contact
17 with the peritoneal cavity.

18 Q. I don't think that answered my question. Do
19 you want me to repeat the question?

20 A. I guess I did answer it, because it's a
21 hypothetical concern. We never actually know what
22 happens, though, for those patients with a true
23 encapsulated ovarian cancer that ruptures during surgery.

24 Q. So you're not aware as you sit here of any
25 patients on whom you have performed surgery in which the

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1 think could have been rendered based upon my
2 understanding of the clinical nature of this case would
3 have been endometriosis with some areas of atypia.

4 Q. In fact, as we mentioned before, both the
5 surgical specimen report for Section B, including B6, as
6 well as the final report on the cytopathology specimen,
7 the pelvic washing, omitted any reference to atypia.
8 Isn't that true?

9 A. That is true.

10 Q. So Dr. Kennedy didn't even have the benefit of
11 knowing that atypia existed in both B6 as well as in the
12 pelvic washings in his decision on how to treat this
13 patient. Isn't that true?

14 A. That is true.

15 Q. Is it a true statement that the most common
16 form of dissemination of epithelial tumors throughout the
17 peritoneal cavity is by exfoliation of malignant cells
18 through the surface of the ovarian capsule?

19 A. If you're talking about an epithelial ovarian
20 cancer, then that's a true statement.

21 I would go one step further and say that it is
22 also a true statement if you're dealing with the very
23 similar malignancy that arises from the surface of the
24 adjacent pelvic peritoneum.

25 In other words, the primary pelvic peritoneal

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1 cyst ruptured, leaving cancer cells to seed remaining
2 tissue -- and when I say remaining tissue, tissue left
3 after the surgery -- you're not aware of any patients on
4 whom you have operated that that has occurred?

5 A. I suspect that it has happened, based upon the
6 patient's clinical course, but I guess I'm kind of
7 struggling with the scientific precision of do we ever
8 really know what happens to an individual cancer cell
9 that drops onto the pelvic peritoneal surface when you're
10 removing a ruptured cystic ovarian cancer.

11 But I would agree with you. The hypothetical
12 concern is that ovarian cancer is implantable, which is
13 why we try whenever possible when we're dealing with a
14 cystic encapsulated tumor mass to remove it intact.

15 Q. That's why, in fact, when assigning a patient
16 to either the IC or IIC category, the FIGO staging system
17 asks the clinician to consider whether the cyst had
18 ruptured spontaneously or during surgery. Isn't that
19 true?

20 A. That is true, in particular because if you've
21 operated on somebody in whom the ovarian cyst ruptured
22 before you got into the abdomen, that's a much more
23 serious situation, perhaps more analogous to Connie
24 Huston's case, because you have had that tissue
25 contaminated in the pelvic peritoneum for an unknown

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1 period of time, possibly days, weeks, months, before you
2 even operated on her in the First place.

3 Q. So in those patients for whom the cysts have
4 ruptured spontaneously, when you're assigning them to the
5 category, they would be the IIC versus the patients where
6 the cysts have ruptured during surgery and not before and
7 they would be a IC, correct, according to the FIGO
8 staging system?

9 MR. BONEZZI: Would you read that back, please.
10 (Record read.)

11 MR. BONEZZI: Thank you.

12 A. We're getting into an area of technicality,
13 which is always better explained as a structured
14 statement rather than a question-and-answer, because
15 we're getting ourselves tripped up here.

16 For instance, if I'm operating on somebody who
17 has ovarian cancer -- again, I'm talking hypothetically,
18 but a standard ovarian cancer, which is a true primary
19 ovarian cancer in which the mass has become densely
20 adherent to the pelvis, probably the point of adherence
21 indeed represents malignancy.

22 So when I reach my hands down in the pelvis and
23 gingerly begin to mobilize that ovarian tumor mass up and
24 into my operative field, it inevitably breaks at the
25 precise point where there is cancer penetrating through

1 Q. Getting back to my original question about IC
2 versus IIC, as to whether or not the cyst had ruptured
3 spontaneously, i.e., not before -- I mean on their own
4 before surgery versus during surgery and not before, it's
5 important to know if the patient is a IC or a IIC because
6 that has a difference in the impact on survival, correct?

7 A. Clinically, there is a great deal of overlap in
8 the prognosis between Stage IC and Stage IIC. So I would
9 hesitate to make a general statement about survival
10 without knowing all of the other information that I have
11 mentioned before, such as grade, histology, exactly what
12 the adhesions were. In other words, were they benign
13 endometriosis or were they actually malignant adhesions.

14 And then you would also factor in subtleties
15 such as the extent of her surgical staging, do we really
16 know what her pelvic-peri workup, the status is, do we
17 know what the status of her diaphragms are, so on and so
18 forth.

19 Q. And the FIGO system suggests that the
20 clinician, No. 1, ascertain whether the rupture of the
21 cyst was spontaneous or caused by surgery, as well as
22 ascertaining whether the malignant cells in the pelvic
23 washings are from the peritoneum or from the -- or
24 obtained in the ascites. Isn't that true?

25 A. Yes.

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1 the capsule into the pelvic peritoneal sidewall.

2 Now, if I am surgeon who does not understand
3 the spread patterns and clinical behavior of ovarian
4 cancer, I might misclassify that patient as Stage IC,
5 using the exact FIGO criteria that you're quoting.

6 However, if I look more carefully and do some
7 biopsies from that pelvic peritoneum and prove under the
8 microscope that there actually is cancerous cells deep in
9 the pelvic peritoneal tissue, then she officially
10 qualifies as Stage IIC, because I have a written
11 pathology report documenting spread to peritoneal
12 tissues.

13 Q. And you just reminded me of something that I
14 had forgotten to write down, and I'm glad you did.

15 Isn't it true that microscopic sections should
16 be obtained at the area of dense adhesion to ascertain
17 whether or not that represents malignancy versus a
18 chemical reaction causing the adherence?

19 A. You would not do those additional microscopic
20 sections if you thought you were only dealing with only
21 benign endometriosis, but it certainly is my clinical
22 practice when I'm operating on a woman with documented
23 ovarian cancer or a similar cancer of the pelvic
24 peritoneum to do all those additional biopsies and submit
25 them separately for histology evaluation.

1 Q. And it's because of the impact on prognosis of
2 the different criteria for allotting cases to either IC
3 or IIC? Isn't that true, in general?

4 A. I think that you're blending two uses of the
5 FIGO staging system.

6 The first use of the FIGO staging system is
7 simply for reporting results to not just national
8 databases but also the international database that tracks
9 ovarian cancer.

10 In that situation, one of the rules is that
11 when in doubt about the true stages of a woman's
12 malignancy, that you report for data management purposes
13 the lower of the stages.

14 For example, if you had a patient that you
15 weren't sure whether she was going to be categorized as a
16 IC or IIC, you would report her out as a IC for the
17 purposes of tumor registration.

18 We have this discussion all the time when we're
19 doing our cancer conferences, because we're part of the
20 SER -- that's S-E-R -- the SER database here in the King
21 County area, Seattle.

22 And then, of course, we have requirements for
23 American College of Surgeons Tumor Registry to report
24 this information through our own registry process. But,
25 I'm sorry, I'm rambling here.

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1 Q. I'm going to charge you for part of this
2 transcript.

3 A. Perfect. You know that the clinician, when
4 they're making decisions about does she need
5 chemotherapy, yes or no, so on and so forth, will take
6 this discussion up to a more fine level of discussion so
7 that we can render treatment decisions.

8 Q. So if Mrs. Huston had been a IC on April 29,
9 1999, you couldn't tell me exactly the range of five-year
10 survival? You thought 80 percent sounded high, but you
11 couldn't give me an actual range.

12 A. That's correct, because specifically if we're
13 to accept the hypothesis that she had high-grade
14 carcinoma, again quoting from your interpretation of one
15 of the pathology reports, that she had high-grade, say
16 Grade III, IC disease, at least IC disease -- and I would
17 also remind you, again, that that is a IC identification
18 for purposes of reporting it to the Tumor Registry.

19 As a clinician, I'm thinking she has at least
20 IIC disease. And we, actually, do not have any
21 information about her upper abdominal disease status.
22 She could easily be of the equivalent of a Stage IIIA or
23 worse, had further surgical staging procedures been done.

24 Q. Well, that's all speculation.

25 A. But the whole case is speculative.

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1 as a Stage IC in early May or end of April, April 30,
2 1999, for example, what would have been her percent
3 chances for five-year survival?

4 I know you said that 80 percent seemed high to
5 you. So I'm asking you what range of percentages you can
6 give me for Stage IC.

7 A. IC what, question mark?

8 Q. Ovarian or endometriosis, cancer of an
9 endometriosis implant within or on the ovary.

10 A. Those are two totally different scenarios.

11 Q. Is it your testimony that the staging system
12 for ovarian carcinoma is not utilized for patients with
13 cancer in an endometriosis implant within the ovary? Is
14 that your testimony?

15 MR. BONEZZI: Objection to that question.

16 A. My testimony is that she has primary pelvic
17 peritoneal carcinoma arising from endometriosis, and that
18 the ovary had only a focus of this endometrial malignancy
19 on the surface of the ovary.

20 So I'm objecting to using any staging or
21 survival statistics based upon ovarian cancer literature.
22 It is not applicable to this case.

23 Q. Is it your testimony that a patient with cancer
24 in an endometriosis implant within or on the ovary is not
25 staged according to the FIGO system for staging of

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1 Q. In fact --

2 MR. BONEZZI: Objection.

3 Q. In fact, she wasn't even staged to IC at the
4 time, correct?

5 A. Because she didn't have cancer. She wasn't
6 staged as cancer at all.

7 Q. You don't think she had cancer in '99?

8 A. I actually do not think she had cancer in '99,
9 but, more importantly, the clinicians managing her in '99
10 did not think that she had cancer. So she was not
11 staged.

12 Q. You're digressing from my question, which was,
13 if she were staged to IC in April or early May of '99,
14 can you give me a range? I know you think 80 percent is
15 high, but a range of figures of percentages for five-year
16 survival that are generally ascribed to Stage IC patients
17 such as that?

18 MR. BONEZZI: Objection.

19 A. Your line of questioning has drifted from the
20 hypothetical, which is what we were talking about before
21 when you were asking me about ovarian cancer IC, what are
22 the overall survival statistics, and now we've drifted
23 into, quote, she, end quote. So now I think we're
24 talking about Mrs. Huston again, are we not?

25 Q. The question is, had Mrs. Huston been diagnosed

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1 ovarian carcinoma that we have been talking about in this
2 deposition?

3 A. I would have to check back with my own
4 reference books, because I'm trying to remember now if
5 FIGO has agreed on a staging system for primary
6 peritoneal cancer, and I don't think they have.

7 Q. Let's go back to my other question.

8 What is the generally accepted five-year
9 survival for patients with Stage IC ovarian carcinoma
10 using the FIGO system for IC?

11 A. So we're back to a hypothetical situation.

12 Q. If you want to call it a hypothetical, that's
13 fine. Just give me the percentages. You think 80
14 percent is too high?

15 A. Eighty percent would be the upper range.

16 Q. What would be the lower range?

17 A. The lower range would be in the range of 30 to
18 40 percent, possibly lower if you are looking at, you
19 know, poorly differentiated carcinomas, adenosquamous
20 carcinomas, clear-cell carcinomas, those rare but fatal
21 types, of which Mrs. Huston had the adenosquamous
22 carcinoma ovarian.

23 Q. So adenosquamous carcinoma even in a IC is
24 fatal? Is that your opinion? That's the word that you
25 just used.

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1 A. It is very difficult to cure, and so the
2 fatality rate is very high.

3 Q. So your testimony is that for IC, that the low
4 range of five-year survival is 30 to 40 percent or
5 possibly lower?

6 A. I think that's a fair statement.

7 Q. What about IIC?

8 A. IIC blends in really with the survival
9 statistics for Stage IIIA, because a lot of us feel that
10 there is really no clinical entity of IIC disease,
11 because as soon as you have disease involving the pelvic
12 peritoneum, you also by definition have at least
13 microscopic disease of the abdominal peritoneum, which
14 pulls your stage assignment up to IIIA.

15 That, for instance, is why we have this
16 disconnect between the data that we report to FIGO using
17 their staging nomenclature and our clinical decisions
18 and, indeed, our prognostic discussions with patients.

19 For instance, we would in no way tell a patient
20 with IIC ovarian cancer that she had a good prognosis.
21 We would be emphasizing to her that she has a very
22 serious malignancy and would need aggressive treatment
23 and we would hope that we could cure her.

24 Q. To reask my question, what is the percentage of
25 five-year survival for IIC ovarian carcinoma, using the

1 A. Correct, because I would say I'm worried that
2 you might actually have clinically occult Stage IIIA
3 disease, that you have poorly differentiated carcinoma,
4 and the FIGO aggregate data includes lots of women with
5 well-differentiated cancers that would clinically behave
6 better than my patient with adenocarcinoma of
7 the ovary, so on and so forth.

8 That's why you need to always include all these
9 qualifiers when you're discussing this.

10 Q. So your opinion is that Mrs. Huston did not
11 have cancer in 1999, in April of '99; is that correct?

12 A. I think that more probably than not, she had
13 premalignant atypical endometriosis.

14 Q. And would that still be your opinion if the
15 pelvic washings are proven to contain malignant cells
16 that you said earlier would be consistent with cancer in
17 the patient?

18 A. You can have a pelvic wash that contain
19 individual cells that look malignant, but they can be
20 shed from an area of premalignant tissue.

21 Q. No, I think I asked you earlier if the pelvic
22 washings were proven to contain malignant cells, would
23 that be consistent with the diagnosis of cancer in the
24 patient, and I believe you said yes.

25 Did I misquote you?

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1 FIGO system?

2 A. Quoting from the FIGO annual reports?

3 Q. Whatever you utilize in order for you to know
4 what the range of survival is, five-year survival for
5 patients who are staged as a IIC. What's the range?

6 A. I will answer the question two ways. No. 1, if
7 you want the FIGO survival, then we should just look that
8 up in the FIGO annual report, because they will have a
9 five-year survival for women that the FIGO system has
10 assigned to Stage IIC.

11 Q. Are you aware of what that is as you sit here?

12 A. No. I would have to look it up. I'm assuming
13 it's going to be in the range of 50 to 60 percent.

14 MS. NISSENBERG: Off the record.

15 (Discussion off the record.)

16 A. I never answered part 2 of the question.

17 Q. I didn't realize there was a two-part.

18 A. Part 2 of the answer. Clinically, I would put
19 that patient in a lower survival rate, particularly if
20 she had Grade III malignancy.

21 Q. But my question was only the percentage of
22 five-year survival for a stage IIC.

23 So by that patient, you're talking about a IIC
24 patient? You would tell them this is what FIGO says your
25 five-year survival is, but it's really worse than that?

1 A. You're quoting me correctly, but I'm
2 embellishing the answer to make it more clear.

3 Q. So if, in fact, Mrs. Huston's pelvic washings
4 indeed contain malignant cells on April 29, 1999, if it's
5 proven that they indeed contain malignant cells, not an
6 isolated cell here and there, would your opinion still be
7 the same, that she did not have cancer on April 29, 1999?

8 A. Her cytology material did not contain enough
9 cellular material to make that diagnosis of an outright
10 malignancy. So your question doesn't at all match up
11 with what we know about her either clinically or based
12 upon the pathology review.

13 Q. You as you sit here don't even believe that she
14 had malignancy in the pelvic washings in April of '99,
15 correct?

16 A. I believe that more probably than not they were
17 atypical endometriosis cells that based upon her
18 subsequent clinical history can be viewed as
19 premalignant.

20 Q. Now, my hypothetical is that the pelvic
21 washings contain true malignant cells and not the
22 isolated here and there, true malignant cells. That's my
23 hypothetical, not what you believe actually was in the
24 pelvic wash slides, even though you may disagree with
25 some of the other people who have testified in this case,

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1 including Cleveland Clinic pathologists and/or defense
2 experts.

3 MR. BONEZZI: Objection. Misstates the
4 testimony.

5 Q. Hypothetically then, can you state that the
6 patient did not have cancer, given that scenario?

7 A. So you're giving me a scenario now. We have
8 pelvic washings that have large aggregated clusters of
9 malignant cells. So there's no ambiguity.

10 Again, like I said, my pathology colleague
11 calls me up and says, "Howard, there is no ambiguity.
12 These cells are detached from a true invasive cancer
13 somewhere in that patient's abdominal cavity."

14 That's the hypothetical we're talking about
15 now, and I'd say yes, that indicates that she has cancer
16 someplace.

17 Q. So you don't believe she had cancer, because
18 you don't believe that malignant cells existed in the
19 pelvic washings; you just think that there was atypia and
20 possibly some premalignant endometriosis cells, correct?

21 A. That's a fair statement.

22 Q. And is that the basis of your opinion that she
23 did not have cancer in 1999?

24 A. More probably than not, she did not have cancer
25 in 1999.

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1 Q. And that's the basis? Is that the basis? I'm
2 asking.

3 A. The basis for what?

4 Q. What is the basis or what are the bases that
5 Mrs. Huston did not have cancer on April 29, 1999?

6 A. That the cytology and histology material even
7 with a very aggressive interpretation by your expert
8 witnesses did not meet my threshold for really proving
9 that she had a frank malignancy in '99.

10 So I think it fails to meet the 51 percent,
11 more-probable-than-not criteria that attorneys require to
12 bring this into a courtroom.

13 Q. When do you think Mrs. Huston first developed
14 cancer?

15 A. There's no way to really know that for sure. I
16 would speculate that it probably, you know, became a
17 frankly malignant process sometime between the spring of
18 '99 and the summer of 2000.

19 Q. We know that she had cancer diagnosed at the
20 Cleveland Clinic in June of 2000.

21 A. Correct. She obviously had cancer in June of
22 2000. You asked me when did it become cancer,

23 Q. And you can't say?

24 A. It's just -- you know, it's a continuum. You
25 would start with normal cells that go through a

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1 premalignant phase and then they develop frank, invasive
2 malignancy.

3 Q. And you can't tell me as you sit here today
4 when you think this frank malignancy was first present in
5 Mrs. Huston, correct?

6 A. That's correct.

7 Q. What is your opinion as to when Mrs. Huston was
8 first diagnosable with cancer?

9 MR. BONEZZI: Objection.

10 A. I cannot even begin to speculate about that.

11 Q. I would like you to presume that you were
12 Mrs. Huston's treating GYN oncologist in April of '99.

13 Hypothetically, if you were told that both
14 pelvic washings and B6 contained malignancy, how would
15 you have gone about treating the patient?

16 A. I would have reviewed the microscope slides
17 myself, because that would be an important part of my
18 decision-making process, to see for myself just how
19 malignant-appearing these cells were, because I'm
20 facing --

21 MR. BONEZZI: Wait. What she wants to know is
22 what treatment plan would you initiate hypothetically.

23 Q. What diagnostic tests as well. What would you
24 have done after you looked at the slides, assuming you
25 were satisfied that your pathology department had read

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1 them correctly?

2 MR. BONEZZI: Objection. Ask your question
3 without throwing those caveats in. All right?

4 A. That's okay, although it's helpful, because
5 this particular case, it's so ambiguous that we would
6 automatically be getting pathology second or third
7 opinions before we committed a healthy woman to
8 potentially toxic chemotherapy.

9 Q. So the first thing you would do is you would
10 look at the slides yourself and maybe even have them
11 relooked at by someone else or another facility.

12 What diagnostic tests or levels would you
13 obtain for the patient?

14 A. I'll try to run through this very quickly,
15 because I know we are running behind schedule.

16 CA-125 blood test. We would do the usual chest
17 X-ray, abdominopelvic CAT scan. If there is any
18 ambiguity about this being a gastrointestinal primary, we
19 would do a colonoscopy, an upper endoscopy study, so on
20 and so forth.

21 Q. You would try to determine the extent of
22 disease, correct?

23 A. Correct. Just the usual diagnostic workup that
24 any oncologist would do.

25 Q. Assuming then that you decided the patient had

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1 either cancer or endometriosis implant within or on the
2 ovary or primary ovarian, what treatment would you
3 recommend for her?

4 A. I might have to take her back to the operating
5 room if I felt that I had -- either I personally, if I
6 had done her surgery, had not done an adequate job of
7 evaluating her upper abdomen, again because I didn't
8 think she had cancer.

9 So I would have taken a quick look, but I would
10 have not done any omental biopsies, certainly not have
11 exposed her to the surgical risk of a lymph node
12 dissection for this kind of clinical story, but I might
13 say, you know, I need to go back to the operating room to
14 thoroughly evaluate whether or not she actually has Stage
15 III disease, because it's quite possible that she has
16 retroperitoneal lymph node involvement or lymph node
17 disease, diaphragmatic implants that I did not appreciate
18 at the time of my initial exploratory surgery.

19 Or I might decide that she has Grade III
20 disease, it's at least Stage IIC based upon what I have
21 learned from my pathology interpretation, and I would
22 move straight to either chemotherapy if I felt she had a
23 disseminated process that placed her entire pelvic
24 peritoneal cavity at risk for malignancy or I would
25 consider pelvic radiation therapy if I felt that her

1 moving target. I think we all would be in agreement that
2 right now, including in 1999, that we would treat her
3 with carboplatin taxol therapy.

4 Q. And that would be whether or not she had
5 primary ovarian Stage IC or carcinoma arising into
6 endometriosis implant within or on the ovary?

7 A. Correct.

8 Q. Do you recall from reading Dr. Biscotti's
9 testimony that when he looked at both the vaginal biopsy
10 and the original B6 that both show adenosquamous
11 carcinoma?

12 A. I think you're misinterpreting what he either
13 said or was trying to say.

14 Q. You don't recall that testimony?

15 A. The Biscotti deposition went around in circles
16 on this issue. So you can choose your quotes. I'm sure
17 Dr. Biscotti would be quoted differently by Mr. Bonezzi.

18 Q. I'll look for the exact quote. I didn't
19 testify. Dr. Bonezzi did. I mean Dr. Biscotti. Sorry.
20 I'm getting tired.

21 I'm going to read to you from page 37, and I
22 asked Dr. Biscotti --

23 MR. BONEZZI: Which line?

24 MS. NISSENBERG: Beginning with line 8.

25 Q. Okay. And at that point, did you then decide

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1 disease was limited to the pelvis.

2 Q. So you would do a second-look surgery in that
3 case?

4 A. No. I would have to decide whether or not a
5 second-look surgery was necessary for my clinical --

6 Q. Okay. And if you were convinced that the
7 patient after doing this workup was a IC, would you
8 recommend her for any type of chemotherapy with a medical
9 oncologist?

10 A. She has a Grade III disease for this
11 hypothetical discussion?

12 Q. The hypothetical is that she's IC.

13 A. No, it's very important, because if she had
14 only Grade I, I might wonder whether chemotherapy was
15 required. It would get back to this whole debate about
16 IC, ruptured versus not.

17 Although -- I'm sorry. Let's back up for a
18 second, because your hypothetical includes that she has
19 positive peritoneal cytology that's unambiguously
20 positive.

21 So I would treat that patient with chemotherapy
22 even if she had Grade I disease.

23 Q. Are you aware of the gold standard for the
24 chemotherapy that would be used?

25 A. There is no true gold standard, because it's a

1 that the typical cells -- it should be "atypical,"
2 speaking of --

3 A. It's a typographical error.

4 Q. -- that you saw were actually a focus of
5 high-grade carcinoma?

6 Answer: Yes. When I had taken both specimens
7 in aggregate, I decided that -- well, let me take that
8 back. I decided that they were carcinomas, that they
9 were adenosquamous carcinomas.

10 Question: Both were?

11 Answer: Both were.

12 Do you recall reading this testimony? I didn't
13 make this up. This is Dr. Biscotti's testimony, his
14 language.

15 A. Yes, but on the prior page is the entire
16 context in which your conversation with Dr. Biscotti was
17 taking place.

18 It goes back to the ability, looking in
19 retrospect, knowing what the slides look like in 2000,
20 that you can more easily pick out a cell here or a cell
21 over there either in the cytology or histology material
22 of '99 that bears a resemblance to the 2000 material.

23 Q. I'm not asking you whether or not Dr. Biscotti
24 said that somebody saw this as adenosquamous back in '99.

25 I'm asking you, do you recall his testimony

23 (Pages 89 to 92)

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1 that when he compared both the vaginal biopsy and the
2 original B6, and he saw the original B6, that both
3 contained adenosquamous carcinoma? Do you recall that
4 now?

5 A. Oh, I agree with you that this is what it says
6 in the deposition, and I guess I should simply let Dr.
7 Biscotti try and clarify what he meant.

8 Q. And does that suggest to you that the cancer
9 shared the same origin or etiology, as you would like to
10 say?

11 A. I think I would agree with that, especially now
12 that you're allowing me to use the word "etiology."

13 Q. Would you also answer in the affirmative if I
14 used the word "origin" or only with the word "etiology"?

15 A. Only with the word "etiology."

16 Q. Do you recall Dr. Biscotti referring to the
17 original B6 as a "key slide"?

18 A. Oh, yes. I think it is a key slide.

19 Q. Would you agree that it's not good medical
20 practice for a key slide to be missing from an
21 institution?

22 MR. BONEZZI: Objection.

23 A. Actually, I would go one step further and just
24 state that it is very common for a slide like this to be
25 missing. It is so common that it almost becomes standard

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1 Q. Would you agree that a cytopathologist reading
2 pelvic wash slides needs to be able to recognize cells
3 suspicious for malignancy?

4 A. Yes.

5 Q. And is the cytopathologist's experience and
6 training part of the ability, would you say, to recognize
7 such cells?

8 A. Yes.

9 Q. Are you aware of the level of experience and
10 training that Dr. Brainerd had at the time she read the
11 cytology specimens in this case?

12 A. I can't remember now exactly what her level of
13 experience was, but I'm sure it's referenced in her
14 deposition in detail.

15 Q. So you don't recollect that she had not
16 actually completed her formal cytopathology training at
17 the time she read these slides, correct?

18 MR. BONEZZI: Objection.

19 A. I don't recollect that.

20 Q. Are you familiar with the term first-order
21 tumor kinetics?

22 A. Yes.

23 Q. What does that mean to you?

24 A. It just describes the growth pattern or
25 algorithmic growth rate of the cancer cell when it's

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1 of care that you can't lay your hands on a really
2 interesting slide.

3 Because it has been passed around so many
4 times, it gets simply lost because it gets distributed
5 around the department. It's probably in the bottom of
6 somebody's briefcase and they don't even know it's there.

7 Q. Do you recollect in the discharge summaries
8 from August of 2000 references to review of slides reveal
9 questionable malignancy or cancer, post-status, further
10 review of pathology? Do you recall language to that
11 effect?

12 A. Oh, yes. I think that's also a very honest
13 assessment of the case.

14 Q. What is your understanding of what those
15 references mean?

16 A. It goes back to the whole issue that Alexander
17 Kennedy as a very reputable and caring clinician wanted
18 to know for his own sake why Mrs. Huston developed this
19 fatal malignancy and he did the appropriate retrospective
20 review of all the material that had been removed from her
21 hysterectomy specimen back in '99.

22 Q. Would you agree that a pathologist reading
23 surgical specimens needs to be able to recognize cells
24 suspicious for malignancy?

25 A. Yes.

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1 growing with first-order kinetics.

2 Q. And that theory is used partly to support the,
3 I believe, generally accepted belief that it is easier to
4 treat a cancer when the tumor burden is small and has not
5 disseminated? Isn't that true?

6 A. It's easier to treat the cancer when the tumor
7 burden is smaller. And dissemination is simply kind of
8 part of that whole process, is it not?

9 Q. So, in fact, you would want to treat the tumor,
10 most solid tumors -- I'm not talking about the rare
11 exceptions, but you would want to treat most solid tumors
12 when the tumor burden is smaller before the cancer has
13 spread, correct? Would you agree with that as a general
14 principle?

15 A. I hate to slow us down, but you're blending two
16 concepts together in one question again.

17 Q. The question is, would you prefer --

18 A. When you're talking about the size of the tumor
19 burden, you're talking about the individual measurements
20 of, say, a tumor mass, whether it's one millimeter or one
21 centimeter. Dissemination refers to spread pattern
22 throughout the body.

23 So you could have disseminated cancer that's
24 like tiny, microscopic, one or two millimeters, or you
25 can have a local tumor that's ten centimeters in size.

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1 So you're blending two concepts together.

2 In general, though, of course you want to treat
3 cancer as early as you can find it. I don't quibble with
4 that.

5 Q. Now, you seem to think that Dr. Weiss ignored
6 the existence of positive pelvic washings. You state
7 that Dr. Weiss has ignored the presumptive presence of
8 malignancy in adjacent pelvic peritoneal tissues.

9 Is that your opinion?

10 A. And then I go on to say in parenthesis, if the
11 plaintiffs theory in this case is accepted, close
12 parenthesis, end quote.

13 Q. So is it your opinion that Dr. Weiss has
14 somehow ignored the positive pelvic washings?

15 A. What I'm referring to is that he has assigned
16 her to Stage IC, as I gather you have also from your line
17 of questioning. That's why you keep on asking about
18 survival statistics for Stage IC disease.

19 That's where he gets his, I believe, 80 percent
20 five-year survival quotation. He actually quotes her at
21 60, dash, 80 percent, I believe, in his original letter
22 to you.

23 Q. That's correct. If the tumor is appropriately
24 treated, end quote.

25 A. Yes. So this paragraph in my original

1 actually made the same mistake that we're both making as
2 we talk back and forth. I'm taking into account the
3 notion that she has a really poorly differentiated
4 aggressive malignancy and I'm giving her a higher stage
5 assignment than IC or even IIC.

6 Q. But if Dr. Weiss is correct in ascribing a IC
7 to her, do you still disagree with his figures for
8 five-year chance of survival?

9 A. Yes, I do, because there's plenty of literature
10 from the ovarian cancer studies that if you have a
11 typical ovarian cancer, setting aside all discussion
12 about peritoneal cancer, endometriosis, so on and so
13 forth, just a normal Stage I ovarian cancer, that factors
14 like dense adherence, so on and forth, positive
15 peritoneal fluid, all of them will pull that survival
16 number down.

17 Remember again that the FIGO literature is
18 quoting survival in aggregate, so that you have an
19 average which is made up of lows and highs.

20 I'm saying that she is on the wrong side of the
21 survival curve here and the wrong side -- sorry, the
22 wrong side of the bell curve, so I cannot mix my syntax.

23 She's at the bottom end of any bell curve that
24 we would draw around any Stage IC, IIC group of patients.

25 Q. I think your answer sort of begs the difference

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1 statement is challenging that overly optimistic
2 estimation of her survival, had her diagnosis been truly
3 cancer and had her diagnosis been made in 1999.

4 So those are two very important qualifications.
5 I feel that --

6 Q. What was the first?

7 A. If her cancer -- can you read it back? I like
8 the way I said it the first time. How did I say it?

9 (Record read.)

10 A. Correct.

11 Q. So if she had been diagnosed with cancer in
12 1999?

13 A. No. If she had cancer at all and if that
14 cancer had been diagnosed in 1999, I think her survival
15 would have been much lower than the 60 to 80 percent
16 quoted by your expert witness.

17 Q. And what do you think it would have been?

18 A. I think it might have been as low as 20
19 percent.

20 Q. Based on what?

21 A. I think that she probably had unrecognized
22 Stage III disease, if your theory is accepted that she
23 had cancer, true invasive cancer of this histology type
24 in 1999.

25 So I'm blending together two things. So I

1 between a IC and IIC, because the reason Dr. Weiss is
2 ascribing a IC category to her is because of the presence
3 of the positive peritoneal washings.

4 So by your answer, you seem to imply that if
5 she had all this and then she also had these positive
6 washings, it would move her or upstage her to a worse
7 category?

8 A. No. Let me clarify.

9 Q. Okay, good.

10 A. That's a very good point. The IC category
11 includes patients who are assigned to that category
12 because their ovarian capsule ruptures during surgery.
13 They would be classified as Stage IC even if their
14 peritoneal washings were benign.

15 Q. But in the patient -- in other words, in this
16 patient, obviously the pelvic washings are obtained upon
17 immediate entry into the peritoneal cavity, to the
18 abdominal cavity, before the cyst ruptured.

19 So we're not saying that the cyst ruptured and
20 caused a positive pelvic washing? You don't think that's
21 what we're saying; is that correct? It wouldn't make
22 sense.

23 A. I'm in total agreement, and you're not
24 understanding my point.

25 Q. Okay.

25 (Pages 97 to 100)

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1 A. Dr. Weiss is quoting aggregate survival data
2 for Stage IC.

3 Q. Right.

4 A. And one way he gets to a higher survival number
5 than I'm willing to accept is that he's not throwing out
6 the patients who have IC only because the cyst ruptured,
7 despite having benign cytology in the pelvic washings.
8 He's not throwing out the patients with the really bad
9 histology like adenosquamous.

10 And, furthermore, he's keeping her stuck at IC,
11 when I think we have all agreed that she's at least IIC,
12 and I'm saying clinically she's probably worse than that.

13 Q. Well, I disagree that we've all said she's a
14 IIC. Obviously, that's not what we think, nor do our
15 experts think that. That may be your opinion, but that's
16 certainly not the opinion of all of us in this case.

17 IC contains patients with, as we know, positive
18 peritoneal washings and cancer involving one, or left or
19 right ovary, correct?

20 A. (No audible response.)

21 Q. So if you put her in the category of IC, I mean
22 the fact that she's got positive washings, well, you say
23 it's a grouping and it includes patients that have benign
24 washings, but it also includes patients that have
25 positive peritoneal washings, correct?

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1 prophylactic hysterectomy and bilateral oophorectomy
2 because of a strong family history for breast or ovarian
3 cancer, and perhaps she's even one of our patients who
4 has a documented mutation in one of the cancer-causing
5 genes.

6 We routinely do extensive peritoneal washings,
7 looking for any evidence of pelvic peritoneal malignancy
8 in the patient at the time we do their prophylactic
9 surgery.

10 In that situation, the one case I'm
11 remembering, we did not find any evidence of cancer,
12 despite very close sectioning of her ovaries, fallopian
13 tubes and her endometrium.

14 We did have positive peritoneal cytology. My
15 colleague re-explored her afterwards and did additional
16 samplings of the omentum and found small deposits of
17 cancer in the omentum.

18 Presumably, this patient had clinically and
19 indeed pathologically occult carcinoma of the pelvic
20 peritoneum that was unrecognizable even in the hands of a
21 skilled gynecologic oncologist working with expert
22 pathologists.

23 Q. So there are situations that you know of even
24 anecdotally in which a patient has positive pelvic
25 washings, no known primary, but treatment is rendered to

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1 A. That's correct.

2 Q. So now what percentage? Do you think she was
3 20 percent, did I hear you say, or what percentage do you
4 think she had of survival as of April of '99?

5 A. I think her chances of survival could have been
6 as low as 20 percent, even if diagnosed in 1999 and given
7 chemotherapy at that point in time.

8 Q. And as high as what?

9 A. I would probably not quote her more than 50
10 percent.

11 Q. Have you ever treated patients who have
12 positive pelvic washings, you were unable to really
13 ascertain the site for the primary cancer, but you treat
14 them presumptively for GYN malignancy?

15 A. I can't think of a situation in my personal
16 practice where that's happened, but I have anecdotally
17 shared stories with my colleagues where they have had
18 actually that scenario.

19 Q. How have they treated the patients, if you
20 know?

21 A. It's variable, depending upon the clinical
22 circumstances. The stories I'm recollecting, a cancer
23 was discovered with subsequent diagnostic evaluations.

24 The one anecdote, I think, that is probably
25 relevant to this case is a woman undergoing a

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1 the patient presumptively for malignancy, correct?

2 A. Correct, because what we're dealing with is
3 probably a cancer of unknown primary, is the best way to
4 view that.

5 It is recognized biologically that you can have
6 a primary cancer site that disseminates, particularly
7 since we're dealing with pelvic peritoneal tumors, and
8 you are never able to recognize the primary site. You're
9 simply treating the metastatic disease.

10 Q. And are you aware of what type of treatment is
11 rendered to these patients that we've been discussing?

12 A. They would all get carboplatin taxol
13 chemotherapy.

14 Q. Thank you. That's what I was looking for.

15 By the way, did she have any risk factors for
16 ovarian carcinoma?

17 A. Age of 52. I don't as I sit here now recollect
18 what her family history was. I just thought of that,
19 because I was anecdotally talking about women with family
20 histories of breast and ovarian cancer.

21 Those would be the two most important things
22 that I would want to know about.

23 (Brief recess.)

24 Q. I think we were just going over Mrs. Huston's
25 risk factors for ovarian carcinoma, and I believe that

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1 you stated if she was age 52 and family history, if she
2 had a family history --

3 A. As it just so happened, I flipped open to this
4 page in the record, which is a handwritten history note
5 from around the time that she was admitted to the
6 hospital for her first operation.

7 There is mention here that she had surgery in
8 1976 for endometriosis, and endometriosis itself is now
9 recognized as a risk factor for ovarian cancer.

10 She had birth control pills for a year only.
11 It is recognized that long-term use of birth control
12 pills is protective against ovarian cancer or similar
13 cancers of the pelvic peritoneum, but this brief exposure
14 to oral contraceptives would not be protective.

15 The next entry here, there is a mention that
16 she has no biological children of her own, and not having
17 children is a risk factor for developing ovarian
18 carcinoma.

19 The next entry here is that she started having
20 her natural menstrual cycles at about age 11.

21 That's relatively young for her generation, and
22 so we can presume that she had a longer period of time
23 during which she had normal ovulatory function, and that
24 itself becomes a risk factor for cancer of the ovary and
25 similar pelvic peritoneal malignancies.

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1 She still was having some episodic menstrual
2 cycles around the time that she presented for her surgery
3 in 1999, and it is felt that in some women, especially
4 the women who have endometriosis associated with
5 malignancies, that the erratic hormonal function around
6 the time of the perimenopause might be one of the
7 triggers for development of these types of malignancy.

8 And the one thing I don't see here is family
9 history, which is very important in discussing inherent
10 risk factors for developing these malignancies.

11 I would assume that it's buried somewhere here
12 in the chart. Her husband may not know her family
13 history. Unfortunately, she, of course, is no longer
14 around for us to ask that.

15 Q. But Dr. Kennedy would have ascertained that
16 when he saw the patient, correct?

17 A. Possibly. As I said, if it's in the record,
18 it's buried deep in the file and I cannot locate it right
19 now.

20 Q. That last reference that you made, continuing
21 to have periods erratically and --

22 MR. BONEZZI: Episodically.

23 Q. Did you use the word "erratic"?

24 A. I think I said "episodic."

25 Q. I thought you said the risk factor was erratic

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1 periods around or in conjunction with.

2 A. No. What I'm pointing out is it sounds like at
3 age 52 she was not postmenopausal, but was still
4 perimenopausal.

5 And the subtlety I'm pointing out is that the
6 hormonal fluctuations, highs and lows of estrogen levels,
7 which are typical of perimenopause, may be associated as
8 a triggering event for cancers associated with
9 endometriosis.

10 These are estrogen-stimulated malignancies, and
11 so the high-estrogen levels of the perimenopause may be
12 one of the etiological factors behind what happened to
13 her.

14 Q. So at the time she first presented to the
15 Cleveland Clinic, she was of an age group that is
16 considered to be a risk factor? You listed her age.

17 A. Correct.

18 Q. That's the first. She had history of
19 endometriosis. That's considered a risk factor for
20 ovarian cancer.

21 She was nulliparous, N-U-L-L-I P-A-R-O-U-S, no
22 children biologically.

23 She had started her periods at a relatively
24 young age with longer exposure to ovulatory function,
25 which is also a risk factor, and the hormonal fluctuation

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1 in conjunction with these episodic periods during her
2 perimenopausal period would also be a risk factor,
3 correct?

4 A. Specifically for the endometriosis-associated
5 cancers.

6 Q. Is that the total list of her risk factors for
7 ovarian as you sit here?

8 A. Did you catch family history, which is a blank
9 in terms of my knowledge, but would be an important
10 influence in discussing this?

11 Q. But even if we don't know her family history,
12 the other items I have mentioned, those are all risk
13 factors for ovarian carcinoma, correct?

14 A. Correct, as well as similar cancers of the
15 pelvic peritoneum.

16 Q. In your report, you state on the second page:
17 Because Mrs. Huston's malignancy was aggressive and
18 demonstrated no response to chemotherapy, it would be
19 incurable whether it was diagnosed in April 1999 or June
20 2000.

21 Does that suggest that her chances for survival
22 in April of 1999 were zero, in your opinion?

23 A. Oh, I think my attempt at prognostic
24 percentages that we discussed earlier was pretty
25 accurate, about 20 percent.

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1 The trouble is, when we're talking about one
2 individual person, the survival percentages are difficult
3 to wrap our hands around, but the emphasis I'm making is
4 that it's very, very low. If not zero, it was certainly
5 very low, even in 1999.

6 Q. Would this be the 20 to 50 percent high, 20
7 percent low to 50 percent high you told me?

8 A. Correct.

9 Q. So instead of the word "incurable," would you
10 amend your opinion then to state that her disease, if
11 appreciated and diagnosed in April of 1999, only carried
12 a survival rate of a low of 20 percent to a high of 50
13 percent?

14 A. No, because we know from her personal history
15 that her unique malignancy was unresponsive to
16 chemotherapy and, therefore, her own cancer was
17 incurable.

18 So I am sticking by the "incurable" statement
19 as it refers to her personally, even though I am saying
20 in aggregate women like her might have about a 20 percent
21 chance of cure.

22 Q. We don't know if her cancer would have been
23 incurable had she received chemotherapy in April 1999, do
24 we?

25 A. I disagree with that statement. More probably

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1 A. -- best treated with chemotherapy.

2 Q. But, in your opinion, it wasn't treatable?

3 A. We would not know that in June of 2000.

4 In other words, we would have a patient with a
5 pelvic malignancy, which is treatable with chemotherapy,
6 and at that time, we hope she will be one of the patients
7 who has a response to that treatment and, therefore,
8 could become one of the 20 percent who do live after
9 there's cancer.

10 Q. One of the, I'm sorry?

11 A. She could become one of those 20 percent who
12 survives after this malignancy.

13 Unfortunately, her subsequent clinical course
14 demonstrated that she did not have a cancer that was
15 responsible -- excuse me, did not have a cancer that was
16 responsive to chemotherapy and, therefore, we can say
17 retrospectively her cancer was incurable.

18 Q. But she was not treated until her cancer was
19 fairly widespread; isn't that true?

20 A. That is true.

21 Q. So she wasn't given an opportunity to see
22 whether or not she would be responsive to chemotherapy
23 when her tumor burden was much smaller, i.e.,
24 microscopic? Isn't that true? Was she given that
25 opportunity or not?

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1 than not, based upon the complete lack of response to
2 chemotherapy in the year 2000, it is presumed that her
3 cancer would be unresponsive to chemotherapy in 1999.

4 Q. Would you agree that her disease and her tumor
5 burden were far more extensive in June of 2000 than they
6 were in April of 1999, when at the most there was only
7 microscopic evidence of disease, if you accept the
8 plaintiff's pathology reports?

9 A. That is a correct statement.

10 Q. So by your earlier testimony, we know that in
11 general it's easier to treat cancer when the tumor burden
12 is smaller, correct?

13 A. That is correct.

14 Q. Yet you are telling us that she was incurable
15 and had zero percent chance of survival back in April
16 1999, had the correct diagnosis been made? Is that what
17 you're saying?

18 MR. BONEZZI: Objection.

19 A. That is correct.

20 Q. Why is it that Mrs. Huston was sent by Dr.
21 Kennedy to Dr. Markman for chemotherapy in July of 2000?

22 A. Because this type of malignancy, if she has any
23 hope of cure at all, is going to be -- I lost my strain
24 of thought there.

25 (Record read.

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1 A. Your question has two aspects to it that I'll
2 break apart.

3 I will agree that she did not get chemotherapy
4 in 1999, when her cancer was probably only microscopic or
5 perhaps was only premalignant, depending on which premise
6 you follow in terms of the etiology of her subsequent
7 malignancy.

8 The second issue, though, is that she did
9 receive chemotherapy in 2000, at a time when she had what
10 we call measurable disease, and we saw absolutely no
11 response to that chemotherapy.

12 So the inherent biological nature of her cancer
13 is that it did not have any response at all.

14 Q. In fact, we don't even know the true extent of
15 disease when she started chemotherapy, because the only
16 thing that had been done was the vaginal biopsy, which
17 led to a diagnosis of cancer, and no other tests or
18 diagnostic procedures were undertaken for the patient at
19 that time? Isn't that true? Yes or no.

20 A. You're lumping a very rapid sequence of
21 clinical events together.

22 Q. I'll break it down.

23 In June of 2000, Mrs. Huston had a vaginal
24 biopsy.

25 From that point until the time that Dr. Kennedy

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1 started referring in the records to a diagnosis of
2 ovarian cancer and she was sent to Dr. Markman at the
3 Cleveland Clinic for chemotherapy, no other diagnostic
4 procedures were undertaken for her to determine the
5 extent of disease? Isn't that true?

6 A. When did she have her exploratory surgery,
7 again, for the bowel obstruction?

8 Q. August of 2000, at the time the CA-125 was
9 obtained.

10 A. Refresh my memory. At what point does she
11 actually get her first dose of chemotherapy during that
12 very rapid sequence of events around June, July and
13 August?

14 Q. In July of 2000, prior to the time that any
15 diagnostic tests were undertaken to determine the extent
16 of disease. Do you recall that?

17 A. Diagnostic tests were undertaken. We had the
18 diagnostic biopsy. We had a physical exam. We had a
19 very good sense of her disease burden at that time.

20 Q. No CA-125 was obtained, correct?

21 A. That is my understanding.

22 Q. That's correct. They were not obtained, or the
23 levels were not obtained until August of 2000.

24 At the time that she began chemotherapy, the
25 only thing that the Cleveland Clinic knew was that there

1 Q. I'm making correct representations.

2 Would you agree that if the pelvic washings
3 contained cells suspicious for malignancy, that
4 appropriate follow-up for this patient would have been
5 less than one year?

6 A. I think that's a very accurate statement.

7 Q. And were you aware that that is the time period
8 that Mrs. Huston was told to wait before coming back to
9 the Cleveland Clinic?

10 A. Yes, that was the time period that she was
11 instructed, because she was presumed to have benign
12 disease and was placed on the standard one-year rotation
13 to come back for routine GYN examinations.

14 However, she did have symptoms preceding her
15 arrival for that routine appointment, and some of the
16 delay in diagnosis may have been related to ignoring
17 vaginal bleeding and abnormal symptoms of discomfort,
18 back pain, so on and so forth. It is unfortunate she
19 waited until June to come in for her biopsy.

20 Q. There's no evidence, Doctor, in the records
21 that Mrs. Huston had any vaginal bleeding prior to July
22 8th, is there?

23 A. I disagree. I believe that there's clear
24 mention that she had some vaginal bleeding.

25 Q. Feel free to look through the records.

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1 was a diagnosis of adenosquamous from the vaginal biopsy,
2 correct?

3 A. I think that's correct.

4 Q. And what Dr. Kennedy was able to ascertain by
5 having Dr. Biscotti look back at the slides, correct?

6 A. That's a separate issue, because what we're
7 talking about now is her clinical course in June, July,
8 August, during which she had a relentless progression of
9 the disease, despite having received one dose of
10 chemotherapy.

11 Q. At the time of the vaginal biopsy and before
12 she started her chemotherapy, other than the biopsy,
13 nothing was done to determine the extent of disease in
14 the patient? Isn't that true?

15 A. I would have to review the record again to make
16 sure.

17 I'm not at all bothered by what you're stating.
18 There was a cancer diagnosis, chemotherapy, and then the
19 rest becomes clinically apparent whether or not she
20 responds to treatment.

21 Q. And she, in fact, for example, had no urinary
22 symptomatology at the time the vaginal biopsy came back?
23 Isn't that true?

24 A. I don't know that one way or the other. I
25 assume that will be in the medical record.

1 A. (Witness reviews documents.)

2 I don't really think that's actually important
3 to the case.

4 Q. You just stated that it's unfortunate that she
5 ignored symptoms of bleeding and other symptoms and
6 waited, as though somehow it's Mrs. Huston's fault, is
7 the implication, but, in fact, if the patient had not had
8 any vaginal bleeding until a date subsequent to the
9 vaginal biopsy...

10 Do I stand corrected? Is there an episode of
11 bleeding prior to the vaginal biopsy, prior to July 8th?

12 A. (Witness reviews documents.)

13 Q. In order to save time, I'll make a
14 representation, but you're welcome to spend as much time
15 as you need going through the record.

16 I don't believe that there was any episode of
17 vaginal bleeding until July 8th, when Mrs. Huston
18 presented to the emergency room, I think it's Firelands
19 Community Hospital, and was then sent to the Cleveland
20 Clinic, which was a date subsequent to the vaginal
21 biopsy.

22 So getting back to your original statement that
23 unfortunately the patient ignored vaginal bleeding, you
24 also mentioned back pain.

25 Are you aware that a bone scan was done for

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1 this patient, I believe in July of 2000, that was
2 negative for cancer? Are you aware of that?
3 A. Yes, I'm aware of that, although the typical
4 back pain of a deep-seated pelvic malignancy is not
5 related to bone metastases. It's just more of kind of a
6 crampy back pain that is analogous to women in labor who
7 sometimes have back pain.

8 Q. Mrs. Huston would have no reason to suspect
9 that she had a pelvic malignancy if she started having
10 some back pain? Isn't that true?

11 A. She would have no reason to have any inkling of
12 why she was having back pain, other than perhaps
13 recognizing that if she was having any new abnormal
14 symptom, that presentation to her physician earlier than
15 the scheduled one-year visit would be appropriate.

16 Q. Dr. Kennedy was telling her to come back in one
17 year because he was relying on the pathology that had
18 been read out from the April '99 surgery, correct?

19 A. Absolutely.

20 Q. And he had a right to rely on that, correct?

21 A. Yes.

22 Q. And Mrs. Huston in turn was relying on Dr.
23 Kennedy's advice to come back in one year because she
24 trusted him and he told her that the pathology was
25 normal, correct?

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1 present.

2 A. Oh, I think I did.

3 Q. You said sometime between spring of '99 --
4 MR. BONEZZI: Right.

5 A. And that's --

6 Q. But now you're saying several months before,
7 you just said.

8 A. That puts us well into that time frame.

9 Q. And by several months, you think it was present
10 by January 2000?

11 A. That's where I would think it would be
12 completely inappropriate for me to try and place a
13 specific date, because that would quickly veer into what
14 I would call junk science.

15 I would be upset if any expert witness in this
16 case tried to place any precise dates on that kind of
17 line of questioning.

18 Q. And, again, you can't say whether her cancer
19 was diagnosable, correct, other than June of 2000?

20 A. We do know that it was a sizable malignancy at
21 the vaginal apex, easily detected with a routine clinical
22 examination.

23 That's why I'm saying, just that's common
24 sense, a few months earlier, it probably also was
25 diagnosable by routine pelvic exam.

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1 MR. BONEZZI: Objection. Go ahead and answer.

2 A. A patient who is not having any abnormal
3 symptoms would, of course, simply come back in the
4 one-year scheduled visit as a matter of routine.

5 Q. In fact, I believe Mrs. Huston went to a
6 chiropractor for her back pain and it resolved.

7 Do you recall that from the medical history?

8 A. Oh, I don't recall that it resolved.

9 Q. So you don't think Mrs. Huston was wrong in
10 relying on Dr. Kennedy telling her to wait one year to
11 come back, do you?

12 A. No, I think she was appropriately scheduled for
13 her one-year visit with Dr. Kennedy.

14 I certainly don't want to imply that it was
15 like her fault if she missed an opportunity to come in a
16 little bit earlier and have her vaginal tumor mass
17 diagnosed when it was smaller.

18 I was merely commenting on the notion that the
19 large progression of her disease or, more accurately, the
20 local growth of her tumor was taking place for several
21 months before she came in for that June visit.

22 Q. Can you give me a time now? Before you weren't
23 able to say when you thought that the cancer --

24 MS. NISSENBERG: Bill, stop it.

25 Q. -- when you thought that the cancer was

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1 Q. In fact, Dr. Kennedy thought it was
2 endometriosis when he saw it, didn't he?

3 A. I'm not sure exactly what he thought it was.

4 Q. You don't recall that from his testimony?

5 MR. BONEZZI: Don't guess, if you don't know.

6 A. I don't recall actually what he said, but I
7 would also postulate that he may not even himself truly
8 remember.

9 I'm placing myself in his shoes. You're
10 examining the patient. You are a cancer doctor, so you
11 have seen these types of malignancies before, and he knew
12 he had to biopsy it.

13 In fact, it was -- on his requisition, he said,
14 quote, R, slash, O, space, P-A-T-H, end quote, or rule
15 out path.

16 Q. And, also, Doctor, rule out endometriosis,
17 correct?

18 A. Correct, because he's thinking his differential
19 diagnosis is maybe it's endometriosis, because we know
20 this can happen where you have endometriosis grow into
21 the vaginal cuff after a hysterectomy, but he's also
22 saying, as a gynecologic cancer doctor, "I wonder if this
23 is cancer, we need to do the biopsy to rule out path,"
24 because the most proximate record of what he actually was
25 thinking sitting in that examining chair, doing her

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1 speculum examination, is that requisition, and the first
 2 phrase is "rule out path."
 3 Q. Correct. And, in fact, he was surprised that
 4 the diagnosis came back and it was not endometriosis. Do
 5 you recall that?

6 MR. BONEZZI: If you don't know, tell her.

7 A. I don't know exactly how he phrased his
 8 deposition testimony, but, again, I think that Dr.
 9 Kennedy and I are similar in our clinical approach to our
 10 patients.

11 I suspect that he was dismayed, would have been
 12 a better phrase to use, for how he probably felt when he
 13 got the phone call from the pathologist. It sounds like
 14 she was a very nice woman, and he would have known
 15 immediately what this meant for her.

16 Q. By the way, have you read Mr. Huston's
 17 deposition testimony in this case?

18 A. No, I have not. I don't think I have that
 19 either.

20 Q. Are you aware as you sit here today what Mr.
 21 Huston testified what Dr. Kennedy told Mr. and Mrs.
 22 Huston when the correct diagnosis was made in June of
 23 2000?

24 A. No, I don't know what he said.

25 MS. NISSENBERG: ~~I~~mdone.
 (Deposition concluded at 11:55 a.m.)

CERTIFICATE

STATE OF WASHINGTON)

) ss

COUNTY OF SNOHOMISH)

I, JOLENE C. HANECA, a Certified Shorthand Reporter
 and Notary Public in and for the State of Washington, do
 hereby certify that the foregoing transcript of the
 deposition of HOWARD MUNTZ, M.D., having been duly sworn,
 on JUNE 22, 2002, is true and accurate to the best of my
 knowledge, skill and ability.

IN WITNESS WHEREOF, I have hereunto set my hand and
 seal this 24th day of June, 2002.

JOLENE C. HANECA, RPR, CCR

My commission expires:
 March 28, 2006

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AFFIDAVIT

STATE OF WASHINGTON)

) ss

COUNTY OF KING)

I have read my within deposition, and the
 same is true and accurate, save and except for changes
 and/or corrections, if any, as indicated by me on the
 "CORRECTIONS" flyleaf page hereof.

HOWARD MUNTZ, M.D.

SUBSCRIBED AND SWORN TO before me this
 day of , 2002.

NOTARY PUBLIC in and for the
 State of Washington,
 residing at

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