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. HANECA, RPR, CCR HANECAJC2741

DEPOSITION OF HOWARD MUNTZ, M.D.
EXAMINATION INDEX

EXHIBIT INDEX

APPEARANCES

FOR THE PLAINTIFF MEREL GREY NISSENBERG
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FOR THE DEFENDANT WILLIAM D BONEZZI
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* * * * *

Seattle, Washington; JUNE 22, 2002
9:00
--oOo--
(Exhibit No. 1 marked.)

HOWARD MUNTZ, M.D., witness herein, having been first duly sworn on oath, was examined and testified as follows:

EXAMINATION

BY MS. NISSENBERG:

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

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

Q. And you are a medical doctor?

A. Yes.

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

Have you ever had your deposition taken before?

A. Yes.

Q. Approximately how many times?

Page 5

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

Page 6

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

Page 7

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

Page 8

A. I can't remember the name of the firm. I'm just drawing a total blank on that.
Q. Do you remember what city?
A. It would have been in the general Cleveland area.
Q. Did you actually give a deposition in that case?
A. I did do a deposition, but that case did not go to trial, or if it did, I'm drawing a blank on that, also.
Q. In that case, were you working on behalf of the plaintiff or the defense?
A. I was a defense expert for that case.
Q. And you don't remember the name of the firm?
A. No.
Q. Have you ever worked with Mr. Bonezzi os anyone in his firm before?
A. No.
Q. Why is that funny?
A. We met --
MR. BONEZZI: You'll find out.
A. We have met previously.
MR. BONEZZI: If you ask questions.
Q. How have you met previously?
A. I was an expert witness for a plaintiff, and

Page 9

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

Page 10

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

Page 11

A. Okay. Three cases in Ohio; two are for plaintiffs, one was for defense.
Q. In the cases in which you testified --
A. Actually, I haven't finished.
Q. I'm sorry.
A. Three yielded depositions and one went to trial, at which I did testify. That was for the plaintiff.
One plaintiff case was settled before it went to trial. And then the third case for the defense went to trial, but I was not required to testify at trial.
Q. Have you ever testified on behalf -- the case in which you testified for the defense, that did not involve Mr. Bonezzi's firm, correct?
A. No, it did not.
Q. Do you know personally any of the GYN oncologists at the Cleveland Clinic?
A. No, I do not.
Q. Have you ever discussed any aspect of this case with the GYN oncologists at the Cleveland Clinic?
A. No, I have not.
Q. May I look at the file that you brought with you today?
A. Yes. There's a copy of the letter that I provided Mr. Bonezzi back in March, when I was first

Page 12

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

Page 13

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

Page 14

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

Page 15

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

Page 16

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

Page 17

Q. Did you ever receive the second of Dr. Tench's expert reports?
A. No, I have not.
Q. Were you aware that one exists?
A. I don't think I knew one existed. Did it change?
MR. BONEZZI: That's the one I showed you yesterday.
A. Did it change substantively from his first opinion?
Q. I just want to know if you've seen it.
MR. BONEZZI: This one.
A. I guess not to be difficult, but there's a difference between crossing my retina and getting into my cortex. Could I compare this with his first?
I don't see that there's any substantive difference between these two reports.
Q. Is today the first time that you have reviewed that second report?
A. **Mr.** Bonezzi has reminded me that we actually looked at this together yesterday evening.
Q. That brings up my next question. Did you have a meeting with Mr. Bonezzi prior to today's deposition, other than the one you already told us about?
A. No, the one meeting yesterday.

Page 18

Q. I think you already told me that you met with him at some point after you did the report.
Is that what you were talking about, yesterday's meeting?
A. No, one meeting yesterday.
Q. And then yesterday?
A. No, one meeting, which was yesterday.
Q. Okay.
A. And that includes after the report was written and before today.
Q. So after you submitted this report to Mr. Bonezzi for utilization in this case, you have not spoken to him about this case prior to yesterday?
A. Oh, I assume that we had some conversations just as we were getting ready for the deposition, conversations, most of them revolving around scheduling issues.
And we probably would have just confirmed that he had received my original correspondence, and that was pretty much it.
Q. When you met yesterday with him, did he tell you the nature of the testimony of Dr. Robboy at Duke?
A. Yes, we did speak about that.
Q. What did he tell you Dr. Robboy testified?
A. We spoke at length about the difficulties of

Page 19

the pathology interpretation for this case.
Q. That's what he told you Dr. Robboy testified?
A. That is probably a gross oversimplification. Dr. Robboy has, of course, given extensive deposition testimony, and that's one of the transcripts that I have not had a chance to review.
Q. What did Mr. Bonezzi tell you Dr. Tench testified to at his deposition on Wednesday?
A. I don't recall that he spoke specifically about what Dr. Tench said, other than to review --
MR. BONEZZI: Actually, you have it backwards. We spoke about Dr. Tench as opposed to Robboy.
THE WITNESS: Okay.
BY MS. NISSENBERG:
Q. Now that Mr. Bonezzi has refreshed your recollection, you spoke about Dr. Tench's testimony and not about Dr. Robboy's testimony? Is that your recollection?
A. I honestly don't recall precisely which pathologist we were talking about.
Q. As you sit here today, do you have any information as to how Dr. Robboy at Duke testified on Tuesday of this week?
A. I don't know the details of his testimony.
Q. What do you know about his testimony?

Page 20

A. But I do know that he feels that the material is very difficult to evaluate, and that probably most importantly he is of the opinion that if he had seen the original 1999 material himself as a practicing pathologist, without knowing her subsequent clinical history, that he would more probably than not, or some words to that effect, signed out the case as benign.
Q. Where did you learn that? From his report?
A. No, from speaking with Mr. Bonezzi.
Q. So then you did discuss Dr. Robboy's testimony with Mr. Bonezzi?
A. Correct.
Q. So then the correct testimony of you today is that you discussed both Dr. Tench's testimony and Dr. Robboy's testimony both educed this week, correct?
A. That is correct, but what Mr. Bonezzi has clarified is that the more extensive discussion about the ins and outs of the pathology review, including all the difficulties of sorting out cytology versus histology, were all revolving around Dr. Tench's testimony.
Q. And what you just told me about Dr. Robboy's testimony. is that ail that you know about it from his deposition this week?
A. I think that's a fair statement.
Q. So as you sit here today, you don't know how

Page 21

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

Page 22

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

Page 23

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

Page 24

lawsuit.
Q. Would you agree with Dr. Prayson at the Cleveland Clinic that carcinoma of the ovary typically would demonstrate more cytologic atypia than low-grade or benign lesions?
MR. BONEZZI: Would you read that back, please, because you're reading awfully fast.
MS. NISSENBERG: I can slow down. I can repeat it, because I don't think you got it either.
Q. Would you agree with Dr. Prayson at the Cleveland Clinic that, quote, carcinoma of the ovary typically would demonstrate cytologic atypia than low-grade or benign lesions, end quote?
A. Could you repeat that again?
Q. Would you agree with Dr. Prayson of the Cleveland Clinic that, quote, carcinoma of the ovary typically would demonstrate more cytologic atypia than low-grade or benign lesions?
A. I think that's a normal statement of fact describing any pathological process involving cancer.
Q. Then you agree?
A. Correct.
Q. Is it fair to say that whatever opinions you have regarding the accuracy of the interpretation of the surgical specimen slides of April '99, as well as the

Page 25

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

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

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

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

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

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

Page 26

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

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

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

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

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

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

A. That's true.

Page 27

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

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

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

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

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

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

A. Correct.

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

Page 28

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

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

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

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

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

A. Yes. That is in that deposition.

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

A. I figured that out by reading the depositions.

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

A. That is correct.

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

Page 29

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

Page 30

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

Page 31

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

Page 32

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

Page 33

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

Page 34

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

Page 35

Q. How important is it to you as a GYN oncologist when you're caring for a patient with an ovarian mass to learn whether or not the mass is cancerous?
A. It is very important.
Q. And that would be the same whether it's primary ovarian or in an endometriosis implant on the ovary, correct?
A. That is correct.
Q. Would you agree that with most solid tumors, the earlier you diagnose a cancer, i.e., when the tumor burden is smallest, the better prognosis for a patient in general?
A. That is a correct general statement.
Q. And how important would it be for you as a GYN oncologist caring for a patient with a diagnosed ovarian cancer to know whether or not it is high-grade, i.e., well-differentiated, versus low-grade or poorly differentiated?
A. In general --
Q. I've got it backwards. High-grade or poorly differentiated versus low-grade or highly differentiated.
A. I was quite ready to agree with you just on general principles that, of course, this information is important to a managing clinician.
Q. With epithelial tumors, isn't it true that

Page 36

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

Page 37

Q. Let's start with the stromal invasion that Dr. Tench identified on the B6 slide.
If there were such stromal invasion on -- all we have, of course, is the first recut, but if there were stromal invasion, would that have any significance to you as either a GYN oncologist or a GYN oncologist who likes to read his on slides?
MR. BONEZZI: Let me just object to that.
A. Meanwhile, let me take a look again at his revised opinion.
Q. That's fine. I'm just going to represent to you that this is not part of his letter, but Mr. Bonezzi at Dr. Tench's deposition asked him to draw what he sees under the microscope, looking at the first recut of B6, and to identify the area that's ovarian and to identify the area that is endometrial and where is any invasion, or Dr. Tench showed him where the invasion was across the stroma.
So it doesn't appear there, but it was at his deposition. And those transcripts will be available Monday. I'm sure Mr. Bonezzi will be furnishing you with a copy.
But getting back to my question then, do you disagree with the statement that with epithelial tumors, frankly malignant tumors are characterized partly by

Page 38

dissection into stromal planes?
MR. BONEZZI: Objection. You may answer.
A. This is very helpful, because I understand that we're talking about ovarian stroma.
The difficulty when you're interpreting an ovary that is riddled with endometriosis is that your stromal planes are oftentimes fractured either by growth of the endometriosis or by the surgical dissection required to remove the adherent endometriotic ovarian mass from the pelvis.
With those qualifiers, I would agree that one way we make the diagnosis of malignancy is to demonstrate under the microscope that there are areas of invasion of that malignant epithelium into the stroma.
Q. Would you agree that dense adhesions in the pelvis of the ovary is a significant clinical pathologic factor to be analyzed when you're staging ovarian cancer patients?
MR. BONEZZI: Objection to the term "significant." Go ahead and answer.
A. Again, 1would ask you to clarify in what context you're asking that question.
Q. In what context? What specifics do you want?
You have a patient with an ovarian mass. It's densely adherent and the ovarian mass turns out to be

Page 39

ovarian carcinoma or carcinoma of an endometriosis implant within or on the ovary.
How important is dense adhesions in the pelvis when that ovary is adhesed as a clinical pathologic factor?
A. If all you think the patient has is benign endometriosis, then you would fully expect there to be extraordinarily dense adhesions. In fact, sometimes the worst adhesions we encounter in gynecologic surgery are in women with severe endometriosis.
Q. My question is, in a patient such as that where the benignity has been disproven and carcinoma is proven, the fact of dense adhesions, does it have any clinical pathologic significance to you as a clinician?
MR. BONEZZI: Objection.
A. The second part would be now you have a patient in whom you know she has ovarian cancer. Then dense adhesions in my own clinical experience, as well as in several retrospective research studies, have been shown to have a significant impact in a bad way, a bad impact on the patient's survival.
Q. If you were suspicious of malignancy or it was part of the differential at the time of surgery and you wanted to rule it out, would you do a sampling, a frozen section sampling from the densely adherent side during

Page 40

that surgery?
A. That's where I thought you were going. I would, again, be very clear that if what we thought we were facing in the operating room was garden-variety endometriosis, then indeed we would not be doing any of those additional sampling procedures in the operating room.
Q. Would you agree that approximately 30 percent of patients with epithelial tumors involving the ovary present with Stage I or II disease? And that's Roman numeral I and II.
MR. BONEZZI: Objection.
A. Read that back to me again.
Q. Would you agree that approximately 30 percent of patients who present with epithelial tumors involving the ovary present with Stage I or II disease?
A. My problem with that particular question is that it's not relevant to this case, but, in general, I would agree that that's an appropriate quote that I could put into any textbook.
Q. And one of the purposes for having a classification system by stage for different cancers is that there's some uniformity within stages with respect to treatment modalities, prognoses, etc., correct?
A. That is correct.

Page 41

Q. So you could, for example, pick up the phone and speak to a GYN oncologist in Florida and be discussing a IC patient and he could be discussing a IC patient and you're basically talking about the same kind of patient in those terms, correct?
A. This case, though, would not be applicable --
MR. BONEZZI: Excuse me. As I understand it, what she's asking though, however, is basically a hypothetical or in a general sense.
A. That's a good way for me to think about this.
So I would say hypothetically I have a patient who has garden variety Stage IC ovarian cancer. There is nothing special about her. There's no endometriosis. There's no dense adhesion. It's just a standard ovarian cancer operation.
And yes, indeed, I could easily pick up the phone and talk to my friend down in Florida, maybe because she's going to go down there after my operation and I'm transferring her care to my friend -- fill in the blank -- Neil Thencorsi (phonetic) in Orlando.
I'll pick up the phone and talk to Neil. She has Stage IC ovarian cancer. And yes, you are absolutely right. It would be very easy to have that conversation about a very typical, run-of-the-mill Stage IC ovarian cancer case.

Page 42

Q. What percentage of patients, to your knowledge, with Stage IC ovarian cancer survive five years?
A. You can look almost at any textbook and get various survival figures for Stage IC ovarian cancer, but you will have a fairly broad range of survivals.
You will also have different nomenclature, five-year survival, which may not be equivalent to a cure, versus long-term, disease-free survival, which may be equivalent to a cure.
I would probably accept almost any reputable textbook that you quoted from as being an accurate representation of survival for Stage IC, with the caveat that it would not be applicable to this case.
Q. With your knowledge, what is the general percentage?
A. You would need to give me information about grade, histology, age of the patient, and a lot of other clinical factors before I would properly answer that question.
Q. Are you familiar with the DeVita, Hellman and Rosenberg text?
A. Yes.
Q. I'm sure you consider that fairly authoritative in the field of cancer?
A. Yes. I would accept that as having excellent

Page 43

information that we could use for this discussion.
Q. Do they ascribe any percentage figures for five-year survival for Stage IC under the FIGO system?
A. When you say FIGO, you're implying that you are looking at the survival curves that the International Cancer Committee submits in aggregate, are you not?
Q. I'm just wanting to know what your understanding is of the general survival figures for Stage IC. I know what Dr. Kennedy testified.
Do you recall what he testified?
A. No, I don't.
Q. I believe that he testified it was about 80 percent. Does that sound right to you?
A. No. Eighty percent is too high, if you're going to quote for all Stage ICs, in which you will include the really poorly differentiated subtypes, such as adenosquamous carcinoma or some of the cancers that can arise from endometriosis, which oftentimes have poorer prognosis than other cancers.
Q. Such as clear cell, for example?
A. Correct.
Q. That's almost equivalent to small-cell carcinoma of the lung; it's very poor prognosis, correct?
A. I wouldn't go so far as to say that. The small cell of the lung is a totally different entity compared

Page 44

to clear cell.
Q. I was just referring to prognoses. They're both not good?
A. Small cell of the lung, though, is chemotherapy-sensitive. So in early stages, small cell of the lung is actually curable.
Q. Actually, Stage I -- I mean Stage I, small-cell carcinoma of the lung is sometimes a surgical disease, believe it or not; isn't that true?
A. That's true, but that's small cell of the lung. Again, it has nothing to do with clear cell to the ovary.
Q. Right, but clear cell of the ovary generally has a poorer prognosis, correct?
A. Oh, absolutely. I definitely agree with that.
Q. Are you aware of any or have you read any of Dr. Robboy's pathology texts that he has written?
A. Over the years I'm sure I have read if not the textbook excerpts from it or other papers that he has written.
Q. Do you recall he has a section in Chapter 19 where he's talking about the cancers involving the ovary and he has one subsection on cancers or, excuse me, tumors of low-malignant potential, borderline tumors, and then he has a section on malignant tumors involving the ovary?

Page 45

Do you recall reading this in his book, quote, patients diagnosed with early stage disease confined to the ovary or pelvis demonstrate a five-year survival rate of 80 percent? It's on page 532.

MR. BONEZZI: I will object to the question. The second thing is, is this his newest text?

MS. NISSENBERG: Yes.

MR. BONEZZI: I know I've read it. This is the newest text that just came out?

MS. NISSENBERG: I don't know if it's the last month's.

MR. BONEZZI: His newest text has been out for only a couple of months, and it's already out of print and they're reprinting it.

First of all, she asked if you have even read that newest text.

THE WITNESS: I have not read that particular textbook. And if I've read his pathology textbook, it would have been a few years ago, either looking at cases of interest for myself or studying for my own board examination.

So I wouldn't testify that I have actually read the book, but I'm willing to discuss the content of what he has written, and, again, using my filter as a practicing clinician correctly interpret what he is

Page 41

Q. (Indicating.)

A. I would disagree with that paragraph.

Q. You would disagree with that?

A. Yes. This is an oversimplification of a very complex clinical subject that is appropriate as a snapshot or as a brief synopsis for pathologists, but I would not send any of my OB-GYN residents, for instance, to this textbook to have any educational value about treatment, prognosis, so on and so forth.

Q. Have you ever made a diagnosis of --

A. Can I go off the record?

Q. Ofcourse.

(Discussion off the record.)

Q. I think I was asking you if you've ever diagnosed malignant transformation of endometriosis.

A. Yes.

Q. And you would agree that only about one percent of endometriosis undergoes malignant transformation? Is that the generally accepted percentage?

A. We actually don't know what the percentage is, and our increasing concern as clinicians in dealing with women with endometriosis, as we have a large group of women naturally aging into the cancer-age range, is that this one percent figure may be lower than it is.

Let me rephrase that. The one percent figure

Page 46

saying as a pathologist as it relates to clinical medicine.

Q. Mr. Bonezzi is suggesting that the newest text doesn't contain that statement. Do you --

MR. BONEZZI: No, I did not say that.

MS. NISSENBERG: Just a second. You asked him if he's read the newest text.

MR. BONEZZI: That's where it comes from.

MS. NISSENBERG: This comes from the newest text?

MR. BONEZZI: Yes. That's what I'm trying to tell you. That's from the newest text.

MS. NISSENBERG: Great. Thank you.

Q. Okay. Let's move on here.

A. I thought we hadn't finished the question.

MR. BONEZZI: And you also know that Dr. Robboy had disagreements not with the comment. He gave you qualifiers with that.

Q. I'm going to show you the page that I'm referring to.

MR. BONEZZI: I will object to the question and the information that's contained in that because of how Dr. Robboy responded to the questions, but go ahead and answer.

A. We're on this page, are we?

Page 48

may be an underestimation. It's at least one percent. It may be higher.

Q. How many times have you made that diagnosis, by the way?

A. **A** number of times. Often enough that I begin to think that I should go back through my stack of index cards, because like most obsessive-compulsive gynecologic oncologists, I keep a stack of index cards of all of the patients I've treated, and I think if I went back through my ten years of clinical practice, I would have anywhere from half a dozen as a conservative estimate to upwards of 20. That's the upper range.

If I also add together anecdotal cases I've heard about when I've been chatting about cases with my other colleagues in town, we may have a Seattle series that is approaching 50 cases of endometriosis leading to the development of cancer.

Q. Do you recall Dr. Kennedy's physical examination of Mrs. Huston prior to her surgery?

A. Yes, I do.

Q. And was there any evidence of any disease outside of the pelvis during that exam?

A. No, there was not.

Q. Was there anything in the GYN tract that was visible or palpable that he noted during that

Page 49

examination?
A. Simply the large ovarian tumor mass, which we know now ended up being the clinically unimportant large ovarian tumor involving either the left or right ovary. I lose track of which side is which, but I think that was the dominant physical exam finding, was the large ovarian mass.
Q. As you sit here today, you don't know which side was the larger mass?
A. I could figure that out just by flipping to the pathology report. The laterality of the lesions are not important to me clinically, so I don't have that off the top of my head.
So the left ovary was the large benign tumor, and the right ovary was the endometriotic ovary that is of concern now.
Q. Correct. By the way, did you consult any texts or other authoritative sources in forming any of your opinions in this case?
A. No. Although, as we discussed, I'm happy to have any one of the standard gynecologic oncology textbooks used for reference material, as long as I reserve the right as a board certified gynecologic oncologist to quibble with any quotes from that, any specific textbook.

Page 50

Q. So the answer is no, you didn't rely on any texts, though?
A. No.
Q. Would you agree that overall the survival for ovarian cancer tends to be low because most women are diagnosed in later stages?
MR. BONEZZI: Excuse me. Did you say "overall"? I didn't hear the beginning.
MS. NISSENBERG: I don't remember. Did I say "overall"? Yes.
MR. BONEZZI: Thank you.
A. Actually, that's a very good question. Could you say it again?
MS. NISSENBERG: Could you read it back?
(Record read.)
A. I think as a general statement that is true.
And as a further refinement to the point you're making, I would emphasize that the problem with ovarian cancer is that when it has gone beyond Stage I, it has by definition gained access to the entire peritoneal cavity, so that it becomes very difficult to eradicate cancer, because as soon as it goes beyond Stage I, it has jumped all the way up to a regional disease process with at-risk tissue extending from the pelvic floor all the way up to the diaphragms.

Page 51

Q. And a IC ovarian cancer is cancer involving one or both areas with, I believe, the capsules intact?
A. No.
Q. Or ruptured. And the pelvic washings positive? Is that true?
A. You've misquoted the FIGO staging rules.
Q. Tell me what a IC is.
A. A IC is cancer involving one ovary and the capsule is either ruptured or you have positive peritoneal cytology.
Q. And you're aware that the cyst ruptured in this case during surgery, are you not? Do you recall that from the operative report?
MR. BONEZZI: You may look at the op report.
A. I might as well, because the phraseology, I think, of your question is important.
Now that I have reviewed the op note, can you ask me the question?
Q. Did the cyst rupture during surgery on April 29, 1999, according to Dr. Kennedy?
A. Am I allowed to say yes and no?
Q. Fine. In what way did they not rupture?
A. The important distinction I'm making is that this op note reads like a perfect example of severe pelvic peritoneal endometriosis, including the presence

Page 52

of a right-sided ovarian endometrioma.
By that I mean there is a large aggregate of chocolate fluid that has dissected into the ovarian tissue and then become encapsulated by a rind of fibrous tissue.
With this degree of endometriosis, you actually can make a very straightforward clinical assumption that she has been rupturing those ovarian endometriomas repetitively in the months to possibly years prior to her surgical procedure.
We make that determination based upon reading the operative note and its description of extensive endometriosis, very dense adhesions, so on and so forth.
So, indeed, the ovarian tissue had ruptured before she was ever operated on,
Q. My question is, does Dr. Kennedy state that the cyst ruptured during surgery?
A. Yes, he does state that.
Q. Could you read that section into the record?
A. Actually, it's only a one-page op note, once you drop off the top and bottom of pages 1 and 2.
Q. Just read the portion regarding the rupture of the cyst, please.
A. He references several places. Let's run through this and catch all the places that he talks about

Page 53

things like that.
Under postoperative diagnosis, he has the phrase, quote, evidence of endometriosis, end quote.
Under operative findings, he says, quote, evidence of chocolate cyst within both ovaries, suggestive of endometrioma and endometriosis, period, end quote.
Continuing on, quote, dense adherence of the right ovary to the pelvic sidewall and endometrial implants along the anterior vesicouterine peritoneum -- vesicouterine is V-E-S-I-C-0-U-T-E-R-I-N-E,and the next word is peritoneum -- period, end quote.
Q. I was asking you to read, Doctor, just where it mentions that the cyst ruptured, not all of Dr. Kennedy's findings.
A. I'm catching all of the findings that talk about endometriosis and endometriomas.
Q. That wasn't my question. My question was, could you read into the record, please, the specific reference to the cyst rupturing during surgery?
A. I'm getting to that. I'm *sorry.* I was just going through the op note in sequence and catching the things that I thought were relevant to --
Q. Since I'm paying by the page, I don't need you to read the entire operative report into the record.

Page 54

A. Sorry. Here's the part that you're interested in.
Under operative procedure, it says, quote, the right pelvic mass was densely adherent, period. Some sharp and blunt dissection was done to free up these masses, period. Chocolate cyst ruptured during the procedure, period.
Q. Thankyou.
A. And then it goes on and talks about irrigation, and I think J've caught the part that you were interested in.
Q. Yes. Thankyou.
Now, if hypothetically the pelvic wash slides were, in fact, evidence of or contained evidence of malignancy, the pelvic wash slides obtained April 29, 1999, would that be consistent with the presence of cancer in this patient?
MR. BONEZZI: Objection.
A. So we're not going to call the pelvic wash atypical? We're going to actually make the diagnosis of malignancy?
Q. Correct.
A. So it's a hypothetical discussion.
Q. Yes.
A. I'm sitting in my office a couple of days after

Page 55

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

Page 56

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

Page 57

deposition, I think that is not a completely accurate way to phrase the pathology situation.
Q. And, again, if there are cell clusters in the April '99 pelvic wash slides that are virtually identical to cell clusters in the small bowel excision of August 2000, does that suggest to you that the cancer shares the same origin?
A. I would again say etiology -- can I explain why I don't like the word "origin"? Would that be helpful for the deposition?
Q. I just want to know if you agree with that or disagree with that.
A. No, then I would say I disagree with that because of the use of the word "origin."
Q. There was no evidence on April 29, '99, or even shortly thereafter, before Mrs. Huston was discharged after the '99 surgery that there was any extension of tumor to the uterus or tubes, correct?
A. I'm sorry. Could you read that -- I believe that's a correct statement. Could you read it back more slowly?
Q. There was no evidence on April 29, 1999, or even shortly thereafter, before she was discharged after her '99 surgery that there was any extension of tumor to the uterus or tubes; is that correct?

Page 58

A. Actually, that's a good way to phrase the question, because it makes the situation ambiguous.
Are we talking about based upon future knowledge that she was going to develop cancer at the vaginal cuff probably from the deep pelvic peritoneal tissues or are we talking about what people thought they knew in '99?
Q. If you go back to '99, no one even suspected or, rather, no one had diagnosed cancer in Mrs. Huston, correct?
A. Correct. In 1999, no one had diagnosed cancer.
Q. That's right.
A. And so she was sent home without any evidence in the minds of her managing clinician that she had cancer anywhere else in her pelvis.
Q. That's right.
A. In fact, the only thing they thought she had was endometriosis extensively involving her pelvic peritoneal tissues.
Q. That's right. And Dr. Kennedy testified that had he known that there was this focus of high-grade cancer in B6, that he would have considered what treatment to render to the patient next? Isn't that true?
MR. BONEZZI: Objection.

Page 59

A. I'm still, actually, back at your original question. I haven't moved on yet.
Q. But I've asked another question and I'd like an answer, please. Do you want her to repeat the question to you?
A. Yes, please.
(Record read.)
A. Yes, that's very true.
Q. And in April of '99 or early May, before she was discharged, there was no evidence of any pelvic extension of tumor? Isn't that true? I'm taking your attention back to April of 1999. Correct?
A. Again, that's the whole problem with the retrospective nature of this case review.
Q. The question is, in 1999, when Mrs. Huston was a patient at Cleveland Clinic, before her discharge in the first couple of days of May, was there any evidence that you see in the records that there was pelvic extension of tumor in the patient? Yes or no. If there's evidence, please point it out to me.
A. Oh, but there's plenty of evidence that there was pelvic extension of her tumor in '99 based upon our subsequent knowledge that her pelvic wash and her ovarian tissue contained at least atypical cells, or I should say, more precisely, there was evidence that there was at

Page 60

least a premalignant transformation of her endometriosis underway.
It may not have been cancer yet, but it was heading in that direction. That's where I'm getting kind of confused by how I should approach this question.
Q. The question is not what you're looking at now, knowing what happened to Mrs. Huston.
A. Excuse me. I'm *sorry.* I interrupted. I'm *sorry.* Go ahead and finish.
Q. In the medical records, can you point out to me where anything exists to show that there was pelvic extension of tumor in the patient?
A. I guess I'm still confused, because the whole retrospective nature of this lawsuit is that we're going backwards in time. So now we're interpreting, or I should say you're interpreting the endometriosis in her pelvis as representing malignancy, despite the original thought that it represented benign tissue.
Q. I'm trying to ask the question more clearly. I'm *sorry* if I'm being obfuscating in my questions.
Is there anything in Mrs. Huston's medical records that are dated April or May of 1999 that reveals that there is pelvic extension of tumor? If there is, point it out to me.
A. Then I think I can -- yes, I think that's a

Page 61

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

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

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

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

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

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

MR. BONEZZI: What page?

MS. NISSENBERG: Page 40.

Q. Beginning with page 39, where he says:

Page 62

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

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

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

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

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

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

A. He also did not look for them.

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

Page 63

this patient?

A. No.

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

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

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

A. That's correct.

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

A. Correct.

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

A. Correct.

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

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

Q. Until August of 2000?

Page 64

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

Q. Why was one obtained in August of 2000?

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

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

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

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

MR. BONEZZI: Objection.

A. That's a confusing question.

Q. Can you read it over to me?

Page 65

MS. NISSENBERG: Do you want to read it?
THE WITNESS: You can skip the part where she's quoting.
(Record read.)
MR. BONEZZI: Let me object.
A. But the vaginal biopsy in June of 2000 was read out as cancer.
Q. Correct. But your opinion that the 1999 slides, both surgical specimens and pelvic washings, that they were not negligently misread because you're aware of the difficulty for even the most expert pathologists in interpreting biopsies and peritoneal washings in the presence of extensive endometriosis, I mean that opinion is formed without even seeing the slides, correct?
A. Correct.
Q. And you're prepared to say that it's such a difficult thing, that if somebody misses cancer, it can happen because there's extensive endometriosis in these patients and even the best pathologists can miss it, correct?
A. Correct.
Q. Would your opinion be the same if the vaginal biopsy of June of 2000 was read out as normal?
MR. BONEZZI: Objection.
A. So you're saying the vaginal tissue in this

Page 66

hypothetical situation is cancerous, obviously cancer?
Q. Yes.
A. And a pathologist does a biopsy and incorrectly labels that specimen as benign? Is that what you're saying?
Q. You haven't seen the original slides, but you're prepared to come into court and say that they were not negligently misread because it's just hard to get these things right when a patient has got extensive endometriosis? Isn't that true? Isn't that what your opinion says?
A. That's true.
Q. In June of 2000, when Mrs. Huston had her vaginal biopsy, another slide that you haven't seen or set of slides that you haven't seen, if those had been read out as normal and the plaintiff claimed that they were negligently misread, quote, unquote, would your opinion be the same, that they're not negligently misread because it's very difficult for even the most expert pathologists to correctly interpret biopsies with a patient who has extensive endometriosis?
MR. BONEZZI: Objection. It doesn't make sense.
Go ahead and answer, if you can.
A. I think I'm understanding a little bit better.

Page 67

The best way to explain that is, because I do review my own slides for my patients and I sit down frequently with our pathologists and look at slides together and review all these cases at least at Virginia Mason for our own gynecologic cancer conferences, I have a very deep understanding of when it's a difficult diagnosis, and even the most expert pathologists can render an opinion that in retrospect based upon subsequent clinical behavior is found to be in error versus the situation where it was a really negligent mistake where even I having looked at the slides would say yes, that's obviously cancer and this pathologist, this hypothetical pathologist who called it benign indeed made a mistake.
In other words, I'm going back to my notion that because I am a clinician dealing with cancer on a daily basis, I almost can propose myself as a one-person jury to mediate these disagreements between pathologists and say, you know, this really was a hard case and it's unfair for Dr. Tench, for instance, to accuse the Cleveland Clinic pathologist of malpractice, because I can bet you more than a quarter that if the roles had been reversed, Dr. Tench could easily have made the same diagnosis back in '99 had he been on staff and I had presented him with a similar pathology quandary.

Page 68

Q. So your opinion is that Dr. Tench would not have picked up what he picked up when he looked at these pelvic washing slides?
A. I will say that more probably than not, if Dr. Tench through some violation of space-time continuum had been sitting at the Cleveland Clinic in '99 reading out Connie Huston's slides that he probably would have rendered the same written report as the Cleveland Clinic pathologist, looking at both cytology and histology, did in '99.
Q. So he would have misread them, but not negligently?
A. I think that's a very proper way to phrase it. It goes down to an issue of negligence. I don't think there was anything negligent done by the pathologist in this case.
Q. What about the B6 slide Dr. Biscotti analyzed at Dr. Kennedy's request in 2000 and on which he identified a small focus of high-grade cancer? Is it your opinion that Dr. Tench would have missed that, also, if he had been sitting at the Cleveland Clinic?
A. Ithinkso.
MR. BONEZZI: Objection to the manner in which that question was asked. You know darn well how Dr. Biscotti arrived at that conclusion. It wasn't until

Page 69

after he made the comparison with the vaginal biopsy.
MS. NISSENBERG: That has nothing to do with the question.
MR. BONEZZI: It certainly does. The way in which you have phrased it is absolutely misleading.
Q. Mr. Bonezzi is referring to the fact that Dr. Biscotti had the vaginal biopsy slide at the same time that he looked at B6.
Nevertheless, Dr. Kennedy testified that Dr. Biscotti identified for him a small focus of high-grade cancer.
So is your answer the same, that in your opinion Dr. Tench would also have read this out as normal tissue, normal endometriotic tissue, had he been at the Cleveland Clinic reading the surgical specimens in April of '99?
MR. BONEZZI: Objection.
A. I would actually go one step further and I would say that every single one of the expert pathologists retained by both plaintiff and defense in this case, if they had, again, through some violation of space-time continuum become the staff pathologist in 1999, I predict that all of them would have read this out as benign.
The most, the most serious diagnosis that I

Page 70

think could have been rendered based upon my understanding of the clinical nature of this case would have been endometriosis with some areas of atypia.
Q. In fact, as we mentioned before, both the surgical specimen report for Section B, including B6, as well as the final report on the cytopathology specimen, the pelvic washing, omitted any reference to atypia. Isn't that true?
A. That is true.
Q. So Dr. Kennedy didn't even have the benefit of knowing that atypia existed in both B6 as well as in the pelvic washings in his decision on how to treat this patient. Isn't that true?
A. That is true.
Q. Is it a true statement that the most common form of dissemination of epithelial tumors throughout the peritoneal cavity is by exfoliation of malignant cells through the surface of the ovarian capsule?
A. If you're talking about an epithelial ovarian cancer, then that's a true statement.
I would go one step further and say that it is also a true statement if you're dealing with the very similar malignancy that arises from the surface of the adjacent pelvic peritoneum.
In other words, the primary pelvic peritoneal

Page 71

cancer and surface epithelial ovarian cancer behave biologically the same way, with dissemination directly into the peritoneal cavity.
Q. Wave you ever treated patients when you're doing surgery where the cyst ruptures and seed the remaining GYN tissue that is left after the surgery?
A. Can you ask that question again?
Q. Sure. I might have said that in a confusing manner.
Have you ever operated on patients where the ovarian cyst contained cancer cells, the cyst ruptures during surgery and seed tissue that is remaining after the surgery?
A. It's a hypothetical concern with any ovarian cancer in which the epithelial cancer has become encapsulated and, therefore, is not in direct contact with the peritoneal cavity.
Q. I don't think that answered my question. Do you want me to repeat the question?
A. I guess I did answer it, because it's a hypothetical concern. We never actually know what happens, though, for those patients with a true encapsulated ovarian cancer that ruptures during surgery.
Q. So you're not aware as you sit here of any patients on whom you have performed surgery in which the

Page 72

cyst ruptured, leaving cancer cells to seed remaining tissue -- and when I say remaining tissue, tissue left after the surgery -- you're not aware of any patients on whom you have operated that that has occurred?
A. I suspect that it has happened, based upon the patient's clinical course, but I guess I'm kind of struggling with the scientific precision of do we ever really know what happens to an individual cancer cell that drops onto the pelvic peritoneal surface when you're removing a ruptured cystic ovarian cancer.
But I would agree with you. The hypothetical concern is that ovarian cancer is implantable, which is why we try whenever possible when we're dealing with a cystic encapsulated tumor mass to remove it intact.
Q. That's why, in fact, when assigning a patient to either the IC or IIC category, the FIGO staging system asks the clinician to consider whether the cyst had ruptured spontaneously or during surgery. Isn't that true?
A. That is true, in particular because if you've operated on somebody in whom the ovarian cyst ruptured before you got into the abdomen, that's a much more serious situation, perhaps more analogous to Connie Huston's case, because you have had that tissue contaminated in the pelvic peritoneum for an unknown

Page 73

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

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

MR. BONEZZI: Would you read that back, please.

(Record read.)

MR. BONEZZI: Thank you.

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

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

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

Page 74

the capsule into the pelvic peritoneal sidewall.

Now, if 1am surgeon who does not understand the spread patterns and clinical behavior of ovarian cancer, I might misclassify that patient as Stage IC, using the exact FIGO criteria that you're quoting.

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

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

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

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

Page 75

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

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

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

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

A. Yes.

Page 76

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

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

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

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

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

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

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

Page 77

Q. I'm going to charge you for part of this transcript.
A. Perfect. You know that the clinician, when they're making decisions about does she need chemotherapy, yes or no, so on and so forth, will take this discussion up to a more fine level of discussion so that we can render treatment decisions.
Q. So if Mrs. Huston had been a IC on April 29, 1999, you couldn't tell me exactly the range of five-year survival? You thought 80 percent sounded high, but you couldn't give me an actual range.
A. That's correct, because specifically if we're to accept the hypothesis that she had high-grade carcinoma, again quoting from your interpretation of one of the pathology reports, that she had high-grade, say Grade III, IC disease, at least IC disease -- and I would also remind you, again, that that is a IC identification for purposes of reporting it to the Tumor Registry.
As a clinician, I'm thinking she has at least IIC disease. And we, actually, do not have any information about her upper abdominal disease status. She could easily be of the equivalent of a Stage IIIA or worse, had further surgical staging procedures been done.
Q. Well, that's all speculation.
A. But the whole case is speculative.

Page 78

Q. In fact --
MR. BONEZZI: Objection.
Q. In fact, she wasn't even staged to IC at the time, correct?
A. Because she didn't have cancer. She wasn't staged as cancer at all.
Q. You don't think she had cancer in '99?
A. I actually do not think she had cancer in '99, but, more importantly, the clinicians managing her in '99 did not think that she had cancer. So she was not staged.
Q. You're digressing from my question, which was, if she were staged to IC in April or early May of '99, can you give me a range? I know you think 80 percent is high, but a range of figures of percentages for five-year survival that are generally ascribed to Stage IC patients such as that?
MR. BONEZZI: Objection.
A. Your line of questioning has drifted from the hypothetical, which is what we were talking about before when you were asking me about ovarian cancer IC, what are the overall survival statistics, and now we've drifted into, quote, she, end quote. So now I think we're talking about Mrs. Huston again, are we not?
Q. The question is, had Mrs. Huston been diagnosed

Page 79

as a Stage IC in early May or end of April, April 30, 1999, for example, what would have been her percent chances for five-year survival?
I know you said that 80 percent seemed high to you. So I'm asking you what range of percentages you can give me for Stage IC.
A. IC what, question mark?
Q. Ovarian or endometriosis, cancer of an endometriosis implant within or on the ovary.
A. Those are two totally different scenarios.
Q. Is it your testimony that the staging system for ovarian carcinoma is not utilized for patients with cancer in an endometriosis implant within the ovary? Is that your testimony?
MR. BONEZZI: Objection to that question.
A. My testimony is that she has primary pelvic peritoneal carcinoma arising from endometriosis, and that the ovary had only a focus of this endometrial malignancy on the surface of the ovary.
So I'm objecting to using any staging or survival statistics based upon ovarian cancer literature. It is not applicable to this case.
Q. Is it your testimony that a patient with cancer in an endometriosis implant within or on the ovary is not staged according to the FIGO system for staging of

Page 80

ovarian carcinoma that we have been talking about in this deposition?
A. I would have to check back with my own reference books, because I'm trying to remember now if FIGO has agreed on a staging system for primary peritoneal cancer, and I don't think they have.
Q. Let's go back to my other question.
What is the generally accepted five-year survival for patients with Stage IC ovarian carcinoma using the FIGO system for IC?
A. So we're back to a hypothetical situation.
Q. If you want to call it a hypothetical, that's fine. Just give me the percentages. You think 80 percent is too high?
A. Eighty percent would be the upper range.
Q. What would be the lower range?
A. The lower range would be in the range of 30 to 40 percent, possibly lower if you are looking at, you know, poorly differentiated carcinomas, adenosquamous carcinomas, clear-cell carcinomas, those rare but fatal types, of which Mrs. Huston had the adenosquamous carcinoma ovarian.
Q. So adenosquamous carcinoma even in a IC is fatal? Is that your opinion? That's the word that you just used.

Page 81

A. It is very difficult to cure, and so the fatality rate is very high.
Q. So your testimony is that for IC, that the low range of five-year survival is 30 to 40 percent or possibly lower?
A. I think that's a fair statement.
Q. What about IIC?
A. IIC blends in really with the survival statistics for Stage IIIA, because a lot of us feel that there is really no clinical entity of IIC disease, because as soon as you have disease involving the pelvic peritoneum, you also by definition have at least microscopic disease of the abdominal peritoneum, which pulls your stage assignment up to IIIA.
That, for instance, is why we have this disconnect between the data that we report to FIGO using their staging nomenclature and our clinical decisions and, indeed, our prognostic discussions with patients.
For instance, we would in no way tell a patient with IIC ovarian cancer that she had a good prognosis. We would be emphasizing to her that she has a very serious malignancy and would need aggressive treatment and we would hope that we could cure her.
Q. To reask my question, what is the percentage of five-year survival for IIC ovarian carcinoma, using the

Page 82

FIGO system?
A. Quoting from the FIGO annual reports?
Q. Whatever you utilize in order for you to know what the range of survival is, five-year survival for patients who are staged as a IIC. What's the range?
A. I will answer the question two ways. No. 1, if you want the FIGO survival, then we should just look that up in the FIGO annual report, because they will have a five-year survival for women that the FIGO system has assigned to Stage IIC.
Q. Are you aware of what that is as you sit here?
A. No. I would have to look it up. I'm assuming it's going to be in the range of 50 to 60 percent.
MS. NISSENBERG: Off the record.
(Discussion off the record.)
A. I never answered part 2 of the question.
Q. I didn't realize there was a two-part.
A. Part 2 of the answer. Clinically, I would put that patient in a lower survival rate, particularly if she had Grade III malignancy.
Q. But my question was only the percentage of five-year survival for a stage IIC.
So by that patient, you're talking about a IIC patient? You would tell them this is what FIGO says your five-year survival is, but it's really worse than that?

Page 83

A. Correct, because I would say I'm worried that you might actually have clinically occult Stage IIIA disease, that you have poorly differentiated carcinoma, and the FIGO aggregate data includes lots of women with well-differentiated cancers that would clinically behave better than my patient with adenosquamous carcinoma of the ovary, so on and so forth.
That's why you need to always include all these qualifiers when you're discussing this.
Q. So your opinion is that Mrs. Huston did not have cancer in 1999, in April of '99; is that correct?
A. I think that more probably than not, she had premalignant atypical endometriosis.
Q. And would that still be your opinion if the pelvic washings are proven to contain malignant cells that you said earlier would be consistent with cancer in the patient?
A. You can have a pelvic wash that contain individual cells that look malignant, but they can be shed from an area of premalignant tissue.
Q. No, I think I asked you earlier if the pelvic washings were proven to contain malignant cells, would that be consistent with the diagnosis of cancer in the patient, and I believe you said yes.
Did I misquote you?

Page **84**

A. You're quoting me correctly, but I'm embellishing the answer to make it more clear.
Q. So if, in fact, Mrs. Huston's pelvic washings indeed contain malignant cells on April 29, 1999, if it's proven that they indeed contain malignant cells, not an isolated cell here and there, would your opinion still be the same, that she did not have cancer on April 29, 1999?
A. Her cytology material did not contain enough cellular material to make that diagnosis of an outright malignancy. So your question doesn't at all match up with what we know about her either clinically or based upon the pathology review.
Q. You as you sit here don't even believe that she had malignancy in the pelvic washings in April of '99, correct?
A, I believe that more probably than not they were atypical endometriosis cells that based upon her subsequent clinical history can be viewed as premalignant.
Q. Now, my hypothetical is that the pelvic washings contain true malignant cells and not the isolated here and there, true malignant cells. That's my hypothetical, not what you believe actually was in the pelvic wash slides, even though you may disagree with some of the other people who have testified in this case,

Page 85

including Cleveland Clinic pathologists and/or defense experts.
MR. BONEZZI: Objection. Misstates the testimony.
Q. Hypothetically then, can you state that the patient did not have cancer, given that scenario?
A. So you're giving me a scenario now. We have pelvic washings that have large aggregated clusters of malignant cells. So there's no ambiguity.
Again, like I said, my pathology colleague calls me up and says, "Howard, there is no ambiguity. These cells are detached from a true invasive cancer somewhere in that patient's abdominal cavity."
That's the hypothetical we're talking about now, and I'd say yes, that indicates that she has cancer someplace.
Q. So you don't believe she had cancer, because you don't believe that malignant cells existed in the pelvic washings; you just think that there was atypia and possibly some premalignant endometriosis cells, correct?
A. That's a fair statement.
Q. And is that the basis of your opinion that she did not have cancer in 1999?
A. More probably than not, she did not have cancer in 1999.

Page 86

Q. And that's the basis? Is that the basis? I'm asking.
A. The basis for what?
Q. What is the basis or what are the bases that Mrs. Huston did not have cancer on April 29, 1999?
A. That the cytology and histology material even with a very aggressive interpretation by your expert witnesses did not meet my threshold for really proving that she had a frank malignancy in '99.
So I think it fails to meet the 51 percent, more-probable-than-not criteria that attorneys require to bring this into a courtroom.
Q. When do you think Mrs. Huston first developed cancer?
A. There's no way to really know that for sure. I would speculate that it probably, you know, became a frankly malignant process sometime between the spring of '99 and the summer of 2000.
Q. We know that she had cancer diagnosed at the Cleveland Clinic in June of 2000.
A. Correct. She obviously had cancer in June of 2000. You asked me when did it become cancer,
Q. And you can't say?
A. It's just -- you know, it's a continuum. You would start with normal cells that go through a

Page 87

premalignant phase and then they develop frank, invasive malignancy.
Q. And you can't tell me as you sit here today when you think this frank malignancy was first present in Mrs. Huston, correct?
A. That's correct.
Q. What is your opinion as to when Mrs. Huston was first diagnosable with cancer?
MR. BONEZZI: Objection.
A. I cannot even begin to speculate about that.
Q. I would iike you to presume that you were Mrs. Huston's treating GYN oncologist in April of '99.
Hypothetically, if you were told that both pelvic washings and B6 contained malignancy, how would you have gone about treating the patient?
A. I would have reviewed the microscope slides myself, because that would be an important part of my decision-making process, to see for myself just how malignant-appearing these cells were, because I'm facing --
MR. BONEZZI: Wait. What she wants to know is what treatment plan would you initiate hypothetically.
Q. What diagnostic tests as well. What would you have done after you looked at the slides, assuming you were satisfied that your pathology department had read

Page 88

them correctly?
MR. BONEZZI: Objection. Ask your question without throwing those caveats in. All right?
A. That's okay, although it's helpful, because this particular case, it's so ambiguous that we would automatically be getting pathology second or third opinions before we committed a healthy woman to potentially toxic chemotherapy.
Q. So the first thing you would do is you would look at the slides yourself and maybe even have them relooked at by someone else or another facility.
What diagnostic tests or levels would you obtain for the patient?
A. I'll try to run through this very quickly, because I know we are running behind schedule.
CA-125 blood test. We would do the usual chest X-ray, abdominopelvic CAT scan. If there is any ambiguity about this being a gastrointestinal primary, we would do a colonoscopy, an upper endoscopy study, so on and so forth.
Q. You would try to determine the extent of disease, correct?
A. Correct. Just the usual diagnostic workup that any oncologist would do.
Q. Assuming then that you decided the patient had

Page 89

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

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

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

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

Page 90

disease was limited to the pelvis.

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

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

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

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

Q. The hypothetical is that she's IC.

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

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

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

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

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

Page 91

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

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

A. Correct.

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

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

Q. You don't recall that testimony?

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

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

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

MR. BONEZZI: Which line?

MS. NISSENBERG: Beginning with line 8.

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

Page 92

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

A. It's a typographical error.

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

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

Question: Both were?

Answer: Both were.

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

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

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

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

I'm asking you, do you recall his testimony

Page 93

that when he compared both the vaginal biopsy and the original B6, and he saw the original B6, that both contained adenosquamous carcinoma? Do you recall that now?
A. Oh, I agree with you that this is what it says in the deposition, and I guess I should simply let Dr. Biscotti try and clarify what he meant.
Q. And does that suggest to you that the cancer shared the same origin or etiology, as you would like to say?
A. I think I would agree with that, especially now that you're allowing me to use the word "etiology."
Q. Would you also answer in the affirmative if I used the word "origin" or only with the word "etiology"?
A. Only with the word "etiology."
Q. Do you recall Dr. Biscotti referring to the original B6 as a "key slide"?
A. Oh, yes. I think it is a key slide.
Q. Would you agree that it's not good medical practice for a key slide to be missing from an institution?
MR. BONEZZI: Objection.
A. Actually, I would go one step further and just state that it is very common for a slide like this to be missing. It is so common that it almost becomes standard

Page 94

of care that you can't lay your hands on a really interesting slide.
Because it has been passed around so many times, it gets simply lost because it gets distributed around the department. It's probably in the bottom of somebody's briefcase and they don't even know it's there.
Q. Do you recollect in the discharge summaries from August of 2000 references to review of slides reveal questionable malignancy or cancer, post-status, further review of pathology? Do you recall language to that effect?
A. Oh, yes. I think that's also a very honest assessment of the case.
Q. What is your understanding of what those references mean?
A. It goes back to the whole issue that Alexander Kennedy as a very reputable and caring clinician wanted to know €or his own sake why Mrs. Huston developed this fatal malignancy and he did the appropriate retrospective review of all the material that had been removed from her hysterectomy specimen back in '99.
Q. Would you agree that a pathologist reading surgical specimens needs to be able to recognize cells suspicious for malignancy?
A. Yes.

Page 95

Q. Would you agree that a cytopathologist reading pelvic wash slides needs to be able to recognize cells suspicious for malignancy?
A. Yes.
Q. And is the cytopathologist's experience and training part of the ability, would you say, to recognize such cells?
A. Yes.
Q. Are you aware of the level of experience and training that Dr. Brainerd had at the time she read the cytology specimens in this case?
A. I can't remember now exactly what her level of experience was, but I'm sure it's referenced in her deposition in detail.
Q. So you don't recollect that she had not actually completed her formal cytopathology training at the time she read these slides, correct?
MR. BONEZZI: Objection.
A. I don't recollect that.
Q. Are you familiar with the term first-order tumor kinetics?
A. Yes.
Q. What does that mean to you?
A. It just describes the growth pattern or algorithmic growth rate of the cancer cell when it's

Page 96

growing with first-order kinetics.
Q. And that theory is used partly to support the, I believe, generally accepted belief that it is easier to treat a cancer when the tumor burden is small and has not disseminated? Isn't that true?
A. It's easier to treat the cancer when the tumor burden is smaller. And dissemination is simply kind of part of that whole process, is it not?
Q. So, in fact, you would want to tseat the tumor, most solid tumors -- I'm not talking about the rare exceptions, but you would want to treat most solid tumors when the tumor burden is smaller before the cancer has spread, correct? Would you agree with that as a general principle?
A. I hate to slow us down, but you're blending two concepts together in one question again.
Q. The question is, would you prefer --
A. When you're talking about the size of the tumor burden, you're talking about the individual measurements of, say, a tumor mass, whether it's one millimeter or one centimeter. Dissemination refers to spread pattern throughout the body.
So you could have disseminated cancer that's like tiny, microscopic, one or two millimeters, or you can have a local tumor that's ten centimeters in size.

Page 97

So you're blending two concepts together.
In general, though, of course you want to treat cancer as early as you can find it. I don't quibble with that.
Q. Now, you seem to think that Dr. Weiss ignored the existence of positive pelvic washings. You state that Dr. Weiss has ignored the presumptive presence of malignancy in adjacent pelvic peritoneal tissues.
Is that your opinion?
A. And then I go on to say in parenthesis, if the plaintiffs theory in this case is accepted, close parenthesis, end quote.
Q. So is it your opinion that Dr. Weiss has somehow ignored the positive pelvic washings?
A. What I'm referring to is that he has assigned her to Stage IC, as I gather you have also from your line of questioning. That's why you keep on asking about survival statistics for Stage IC disease.
That's where he gets his, I believe, 80 percent five-year survival quotation. He actually quotes her at 60, dash, 80 percent, I believe, in his original letter to you.
Q. That's correct. If the tumor is appropriately treated, end quote.
A. Yes. So this paragraph in my original

Page 98

statement is challenging that overly optimistic estimation of her survival, had her diagnosis been truly cancer and had her diagnosis been made in 1999.
So those are two very important qualifications. I feel that --
Q. What was the first?
A. If her cancer -- can you read it back? I like the way I said it the first time. How did I say it?
(Record read.)
A. Correct.
Q. So if she had been diagnosed with cancer in 1999?
A. No. If she had cancer at all and if that cancer had been diagnosed in 1999, I think her survival would have been much lower than the 60 to 80 percent quoted by your expert witness.
Q. And what do you think it would have been?
A. I think it might have been as low as 20 percent.
Q. Based on what?
A. I think that she probably had unrecognized Stage III disease, if your theory is accepted that she had cancer, true invasive cancer of this histology type in 1999.
So I'm blending together two things. So I

Page 99

actually made the same mistake that we're both making as we talk back and forth. I'm taking into account the notion that she has a really poorly differentiated aggressive malignancy and I'm giving her a higher stage assignment than IC or even IIC.
Q. But if Dr. Weiss is correct in ascribing a IC to her, do you still disagree with his figures for five-year chance of survival?
A. Yes, I do, because there's plenty of literature from the ovarian cancer studies that if you have a typical ovarian cancer, setting aside all discussion about peritoneal cancer, endometriosis, so on and so forth, just a normal Stage I ovarian cancer, that factors like dense adherence, so on and forth, positive peritoneal fluid, all of them will pull that survival number down.
Remember again that the FIGO literature is quoting survival in aggregate, so that you have an average which is made up of lows and highs.
I'm saying that she is on the wrong side of the survival curve here and the wrong side -- sorry, the wrong side of the bell curve, so I cannot mix my syntax.
She's at the bottom end of any bell curve that we would draw around any Stage IC, IIC group of patients.
Q. I think your answer sort of begs the difference

Page 100

between a IC and IIC, because the reason Dr. Weiss is ascribing a IC category to her is because of the presence of the positive peritoneal washings.
So by your answer, you seem to imply that if she had all this and then she also had these positive washings, it would move her or upstage her to a worse category?
A. No. Let me clarify.
Q. Okay, good.
A. That's a very good point. The IC category includes patients who are assigned to that category because their ovarian capsule ruptures during surgery. They would be classified as Stage IC even if their peritoneal washings were benign.
Q. But in the patient -- in other words, in this patient, obviously the pelvic washings are obtained upon immediate entry into the peritoneal cavity, to the abdominal cavity, before the cyst ruptured.
So we're not saying that the cyst ruptured and caused a positive pelvic washing? You don't think that's what we're saying; is that correct? It wouldn't make sense.
A. I'm in total agreement, and you're not understanding my point.
Q. Okay.

Page 101

A. Dr. Weiss is quoting aggregate survival data for Stage IC.
Q. Right.
A. And one way he gets to a higher survival number than I'm willing to accept is that he's not throwing out the patients who have IC only because the cyst ruptured, despite having benign cytology in the pelvic washings. He's not throwing out the patients with the really bad histology like adenosquamous.
And, furthermore, he's keeping her stuck at IC, when I think we have all agreed that she's at least IIC, and I'm saying clinically she's probably worse than that.
Q. Well, I disagree that we've all said she's a IIC. Obviously, that's not what we think, nor do our experts think that. That may be your opinion, but that's certainly not the opinion of all of us in this case.
IC contains patients with, as we know, positive peritoneal washings and cancer involving one, or left or right ovary, correct?
A. (No audibile response.)
Q. So if you put her in the category of IC, I mean the fact that she's got positive washings, well, you say it's a grouping and it includes patients that have benign washings, but it also includes patients that have positive peritoneal washings, correct?

Page 102

A. That's correct.
Q. So now what percentage? Do you think she was 20 percent, did I hear you say, or what percentage do you think she had of survival as of April of '99?
A. I think her chances of survival could have been as low as 20 percent, even if diagnosed in 1999 and given chemotherapy at that point in time.
Q. And as high as what?
A. I would probably not quote her more than 50 percent.
Q. Have you ever treated patients who have positive pelvic washings, you were unable to really ascertain the site for the primary cancer, but you treat them presumptively for GYN malignancy?
A. I can't think of a situation in my personal practice where that's happened, but I have anecdotally shared stories with my colleagues where they have had actually that scenario.
Q. How have they treated the patients, if you know?
A. It's variable, depending upon the clinical circumstances. The stories I'm recollecting, a cancer was discovered with subsequent diagnostic evaluations.
The one anecdote, I think, that is probably relevant to this case is a woman undergoing a

Page 103

prophylactic hysterectomy and bilateral oophorectomy because of a strong family history for breast or ovarian cancer, and perhaps she's even one of our patients who has a documented mutation in one of the cancer-causing genes.
We routinely do extensive peritoneal washings, looking for any evidence of pelvic peritoneal malignancy in the patient at the time we do their prophylactic surgery.
In that situation, the one case I'm remembering, we did not find any evidence of cancer, despite very close sectioning of her ovaries, fallopian tubes and her endometrium.
We did have positive peritoneal cytology. My colleague re-explored her afterwards and did additional samplings of the omentum and found small deposits of cancer in the omentum.
Presumedly, this patient had clinically and indeed pathologically occult carcinoma of the pelvic peritoneum that was unrecognizable even in the hands of a skilled gynecologic oncologist working with expert pathologists.
Q. So there are situations that you know of even anecdotally in which a patient has positive pelvic washings, no known primary, but treatment is rendered to

Page 104

the patient presumptively for malignancy, correct?
A. Correct, because what we're dealing with is probably a cancer of unknown primary, is the best way to view that.
It is recognized biologically that you can have a primary cancer site that disseminates, particularly since we're dealing with pelvic peritoneal tumors, and you are never able to recognize the primary site. You're simply treating the metastatic disease.
Q. And are you aware of what type of treatment is rendered to these patients that we've been discussing?
A. They would all get carboplatin taxol chemotherapy.
Q. Thank you. That's what I was looking for.
By the way, did she have any risk factors for ovarian carcinoma?
A. Age of 52. I don't as I sit here now recollect what her family history was. I just thought of that, because I was anecdotally talking about women with family histories of breast and ovarian cancer.
Those would be the two most important things that I would want to know about.
(Brief recess.)
Q. I think we were just going over Mrs. Huston's risk factors for ovarian carcinoma, and I believe that

Page 105

you stated if she was age 52 and family history, if she had a family history --
A. As it just so happened, I flipped open to this page in the record, which is a handwritten history note from around the time that she was admitted to the hospital for her first operation.
There is mention here that she had surgery in 1976 for endometriosis, and endometriosis itself is now recognized as a risk factor for ovarian cancer.
She had birth control pills for a year only. It is recognized that long-term use of birth control pills is protective against ovarian cancer or similar cancers of the pelvic peritoneum, but this brief exposure to oral contraceptives would not be protective.
The next entry here, there is a mention that she has no biological children of her own, and not having children is a risk factor for developing ovarian carcinoma.
The next entry here is that she started having her natural menstrual cycles at about age 11.
That's relatively young for her generation, and so we can presume that she had a longer period of time during which she had normal ovulatory function, and that itself becomes a risk factor for cancer of the ovary and similar pelvic peritoneal malignancies.

Page 106

She still was having some episodic menstrual cycles around the time that she presented for her surgery in 1999, and it is felt that in some women, especially the women who have endometriosis associated with malignancies, that the erratic hormonal function around the time of the perimenopause might be one of the triggers for development of these types of malignancy.
And the one thing I don't see here is family history, which is very important in discussing inherent risk factors for developing these malignancies.
I would assume that it's buried somewhere here in the chart. Her husband may not know her family history. Unfortunately, she, of course, is no longer around for us to ask that.
Q. But Dr. Kennedy would have ascertained that when he saw the patient, correct?
A. Possibly. As I said, if it's in the record, it's buried deep in the file and I cannot locate it right now.
Q. That last reference that you made, continuing to have periods erratically and --
MR. BONEZZI: Episodically.
Q. Did you use the word "erratic"?
A. I think I said "episodic."
Q. I thought you said the risk factor was erratic

Page 107

periods around or in conjunction with.
A. No. What I'm pointing out is it sounds like at age 52 she was not postmenopausal, but was still perimenopausal.
And the subtlety I'm pointing out is that the hormonal fluctuations, highs and lows of estrogen levels, which are typical of perimenopause, may be associated as a triggering event for cancers associated with endometriosis.
These are estrogen-stimulated malignancies, and so the high-estrogen levels of the perimenopause may be one of the etiological factors behind what happened to her.
Q. So at the time she first presented to the Cleveland Clinic, she was of an age group that is considered to be a risk factor? You listed her age.
A. Correct.
Q. That's the first. She had history of endometriosis. That's considered a risk factor for ovarian cancer.
She was nulli parous, N-U-L-L-I P-A-R-0-U-S, no children biologically.
She had started her periods at a relatively young age with longer exposure to ovulatory function, which is also a risk factor, and the hormonal fluctuation

Page 108

in conjunction with these episodic periods during her perimenopausal period would also be a risk factor, correct?
A. Specifically for the endometriosis-associated cancers.
Q. Is that the total list of her risk factors for ovarian as you sit here?
A. Did you catch family history, which is a blank in terms of my knowledge, but would be an important influence in discussing this?
Q. But even if we don't know her family history, the other items I have mentioned, those are all risk factors for ovarian carcinoma, correct?
A. Correct, as well as similar cancers of the pelvic peritoneum.
Q. In your report, you state on the second page: Because Mrs. Huston's malignancy was aggressive and demonstrated no response to chemotherapy, it would be incurable whether it was diagnosed in April 1999 or June 2000.
Does that suggest that her chances for survival in April of 1999 were zero, in your opinion?
A. Oh, I think my attempt at prognostic percentages that we discussed earlier was pretty accurate, about 20 percent.

Page 109

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

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

A. Correct.

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

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

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

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

A. I disagree with that statement. More probably

Page 110

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

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

A. That is a correct statement.

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

A. That is correct.

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

MR. BONEZZI: Objection.

A. That is correct.

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

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

(Record read.

Page 111

A. -- best treated with chemotherapy.

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

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

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

Q. One of the, I'm sorry?

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

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

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

A. That is true.

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

Page 112

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

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

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

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

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

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

Q. I'll break it down.

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

From that point until the time that Dr. Kennedy

Page 113

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

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

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

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

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

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

Q. No CA-125 was obtained, correct?

A. That is my understanding.

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

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

Page 114

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

A. I think that's correct.

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

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

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

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

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

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

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

Page 115

Q. I'm making correct representations.

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

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

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

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

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

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

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

Q. Feel free to look through the records.

Page 116

A. (Witness reviews documents.)

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

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

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

A. (Witness reviews documents.)

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

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

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

Are you aware that a bone scan was done for

Page 117

this patient, I believe in July of 2000, that was negative for cancer? Are you aware of that?
A. Yes, I'm aware of that, although the typical back pain of a deep-seated pelvic malignancy is not related to bone metastases. It's just more of kind of a crampy back pain that is analogous to women in labor who sometimes have back pain.
Q. Mrs. Huston would have no reason to suspect that she had a pelvic malignancy if she started having some back pain? Isn't that true?
A. She would have no reason to have any inkling of why she was having back pain, other than perhaps recognizing that if she was having any new abnormal symptom, that presentation to her physician earlier than the scheduled one-year visit would be appropriate.
Q. Dr. Kennedy was telling her to come back in one year because he was relying on the pathology that had been read out from the April '99 surgery, correct?
A. Absolutely.
Q. And he had a right to rely on that, correct?
A. Yes.
Q. And Mrs. Huston in turn was relying on Dr. Kennedy's advice to come back in one year because she trusted him and he told her that the pathology was normal, correct?

Page 118

MR. BONEZZI: Objection. Go ahead and answer.
A. A patient who is not having any abnormal symptoms would, of course, simply come back in the one-year scheduled visit as a matter of routine.
Q. In fact, I believe Mrs. Huston went to a chiropractor for her back pain and it resolved.
Do you recall that from the medical history?
A. Oh, I don't recall that it resolved.
Q. So you don't think Mrs. Huston was wrong in relying on Dr. Kennedy telling her to wait one year to come back, do you?
A. No, I think she was appropriately scheduled for her one-year visit with Dr. Kennedy.
I certainly don't want to imply that it was like her fault if she missed an opportunity to come in a little bit earlier and have her vaginal tumor mass diagnosed when it was smaller.
I was merely commenting on the notion that the large progression of her disease or, more accurately, the local growth of her tumor was taking place for several months before she came in for that June visit.
Q. Can you give me a time now? Before you weren't able to say when you thought that the cancer --
MS. NISSENBERG: Bill, stop it.
Q. -- when you thought that the cancer was

Page 119

present.
A. Oh, I think I did.
Q. You said sometime between spring of '99 --
MR. BONEZZI: Right.
A. And that's --
Q. But now you're saying several months before, you just said.
A. That puts us well into that time frame.
Q. And by several months, you think it was present by January 2000?
A. That's where I would think it would be completely inappropriate for me to try and place a specific date, because that would quickly veer into what I would call junk science.
I would be upset if any expert witness in this case tried to place any precise dates on that kind of line of questioning.
Q. And, again, you can't say whether her cancer was diagnosable, correct, other than June of 2000?
A. We do know that it was a sizable malignancy at the vaginal apex, easily detected with a routine clinical examination.
That's why I'm saying, just that's common sense, a few months earlier, it probably also was diagnosable by routine pelvic exam.

Page 120

Q. In fact, Dr. Kennedy thought it was endometriosis when he saw it, didn't he?
A. I'm not sure exactly what he thought it was.
Q. You don't recall that from his testimony?
MR. BONEZZI: Don't guess, if you don't know.
A. I don't recall actually what he said, but I would also postulate that he may not even himself truly remember.
I'm placing myself in his shoes. You're examining the patient. You are a cancer doctor, so you have seen these types of malignancies before, and he knew he had to biopsy it.
In fact, it was -- on his requisition, he said, quote, R, slash, O, space, P-A-T-H, end quote, or rule out path.
Q. And, also, Doctor, rule out endometriosis, correct?
A. Correct, because he's thinking his differentia1 diagnosis is maybe it's endometriosis, because we know this can happen where you have endometriosis grow into the vaginal cuff after a hysterectomy, but he's also saying, as a gynecologic cancer doctor, "I wonder if this is cancer, we need to do the biopsy to rule out path," because the most proximate record of what he actually was thinking sitting in that examining chair, doing her

speculum examination, is that requisition, and the first phrase is "rule out path."
Q. Correct. And, in fact, he was surprised that the diagnosis came back and it was not endometriosis. Do you recall that?
MR. BONEZZI: If you don't know, tell her.
A. I don't know exactly how he phrased his deposition testimony, but, again, I think that Dr. Kennedy and I are similar in our clinical approach to our patients.
I suspect that he was dismayed, would have been a better phrase to use, for how he probably felt when he got the phone call from the pathologist. It sounds like she was a very nice woman, and he would have known immediately what this meant for her.
Q. By the way, have you read Mr. Huston's deposition testimony in this case?
A. No, I have not. I don't think I have that either.
Q. Are you aware as you sit here today what Mr. Huston testified what Dr. Kennedy told Mr. and Mrs. Huston when the correct diagnosis was made in June of 2000?
A. No, I don't know what he said.
MS. NISSENBERG: I'm done.
(Deposition concluded at 11:55 a.m.)

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

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