IN THE COURT OF COMMON PLEAS

CUYAHOGA COUNTY, OHIO

JOHN M. HUSTON, Executor,

Plaintiff,

vs.

THE CLEVELAND CLINIC FOUNDATION, et al.,

Defendants.

JUDGE WILLIAM COYNE
Case No. 439194

ORIGINAL

DEPOSITION of **STANLEY J. ROBBOY,** MD, a witness called for examination by counsel for the Plaintiff taken pursuant to the Ohio Rules of Civil Procedure, before ROBIN J. SEYMOUR, Registered Professional Reporter and Notary Public in and for the State of North Carolina, at the Washington Duke Inn, 3301 Cameron Boulevard, Durham, North Carolina, on Tuesday, June 18, 2002, commencing at 9:05 a.m.

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1	Curriculum Vitae	34	*
2	Letter dated 3/6/02 to Stanley J. Robboy, MD from William D. Bonezzi	34	*

* Exhibit marked at the conclusion of the deposition.

STIPULATIONS

Before testimony was taken, it was stipulated by and between counsel representing the respective parties as follows:

1. That any defect in the notice of the taking of this deposition, either as to time or place, or otherwise as required by statute is expressly waived, and this deposition shall have the same effect as if formal notice in all respects as required by statute had been given and served upon the counsel in the manner prescribed by law.

2. That this deposition shall be taken for the purpose of discovery or for use as evidence in the above-entitled action, or for both purposes.

3. That this deposition is deemed opened and all formalities and requirements with respect to the opening *of* the same, expressly including notice of the opening of this deposition, are hereby waived, and this deposition shall have the same effect as if all formalities in respect to the opening of the same had been complied with in detail.

4. That the undersigned, Robin J. Seymour, a Registered Professional Reporter and Notary Public, is duly qualified and constituted to take this deposition.

5. Objections to questions, except as to the form thereof, and motions to strike answers need not be made during the taking *of* this deposition, but may be reserved until any pretrial hearing held before any judge or any court of competent jurisdiction for the purpose of ruling thereon, or at any other hearing or trial of said case at which said deposition might be used, except that an objection as to the form of a question must be made at the time such a question is asked or objection is waived as to the form of the question.

6. That the signature of the witness to the deposition is not hereby waived.

7. That the Ohio Rules of Civil Procedure shall control concerning the use of the deposition in court.

STANLEY J. ROBBOY, MD,

having been affirmed, was examined and testified as follows:

DIRECT EXAMINATION BY MS. NISSENBERG:

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

A Stanley J. Robboy, R-o-b-b-o-y.

Q And you are a medical doctor?

A Yes.

Q I introduced myself off the record. I'll do so again for the record. I'm Merel Nissenberg and I represent the surviving husband and children of Connie Huston who died in September of 2000. The family's filed a suit, as you know, against the Cleveland Clinic Foundation and we're here to get your testimony today as an expert witness since you have been designated as such by the Cleveland Clinic. Is that your understanding as well?

A Yes.

Q Have you ever had your deposition taken before?

A Yes.

Q Approximately how many times?

A Twenty.

Q How recently were the last few?

A One was recently, within the last month or two months, and then probably five or six months before.

Q Do you feel comfortable with the deposition process or do you want me to go through the rules and regulations?

A No, I feel comfortable.

Q The only thing is I speak very fast so I'll try to slow it down. But if you don't understand a question as I asked it, please ask me to rephrase it or repeat it, because if you answer it as asked, I will assume you understood it as asked.

A I will ask.

Q What types of cases did you give deposition testimony in in the last year?

A In gynecologic pathology.

Q Anything involving diagnoses of ovarian cancer?

A I don't remember the cases, but that's a common area that I work with, so...

Q When is the last time that -- that you gave a deposition involving a diagnosis or failure to make a diagnosis of ovarian cancer?

A I don't remember.

Q But you believe that you have done so?

A Oh, yeah.

Q What about with respect to cancer in an endometriosis implant?

A I don't remember if I've had a case like that.

Q Okay. Do you remember the names of any of the cases in the last year or two that you testified in?

A The last case I did was with a lawyer in the firm of Tuggle & Duggin.

Q I think you'll have to spell that for the court reporter.

A T-u-g-g-1-e. I believe D-u-g-g-i-n. And I don't remember the cases before that.

a And what state are they in?

A That was North Carolina.

Q Have you ever given testimony on behalf of a plaintiff or defendant in the state of Ohio?

Let me phrase that in a case that's been filed in the state of Ohio. You may have given your testimony out of Ohio.

A Right. I know there was one case in Ohio many years ago.

Q Any testimony in California?

A I don't believe California.

[Discussion off the record.]

Q Have you ever been deposed as a defendant, whether specifically named as part *of* Duke Medical Center or otherwise?

A Yes.

Q Approximately how many times?

A Once.

Q With what was that in connection?

A An error in -- an alleged error in diagnosis.

Q What type of diagnosis?

A Ovarian cancer.

Q Was that a North Carolina case?

A Yes.

Q How long ago was that, approximately?

A I think it was brought about two or three years ago.

Q Do you remember the name of the case *or* the name *of* the attorney on the other side?

A No.

Q Was that filed in this county where Duke resides?

A Yes.

Q Did the patient survive in that case; do you know?

A Yes.

Q The allegations involved a late diagnosis of ovarian carcinoma?

A No, it was a differential diagnosis of ovarian versus breast cancer that was metastatic to the ovary.

Q And how did you call that diagnosis?

A On the material that I had, I had initially called it metastatic breast cancer. And later, after review, all the material supported that it was probably ovarian cancer.

Q And the patient is still alive, you said?

A Yes.

Q Any other times in which you've been named as a defendant?

A No.

Q Of the depositions that you've given in the last five years, about what percentage has been on behalf of a plaintiff versus a defendant?

A Probably about 80/20 on the defendants.

Q And approximately how many times in the last 10 years have you served as an expert witness?

A You mean in terms of deposition?

Q Well, how many times have you been named as an expert witness? Designared as an expert on behalf of one side or the other?

A I have no idea.
Q How can you break it down so that you can answer the question? How many times have you given deposition testimony?
A Given deposition.
Q Okay. In the last 10 years.
A I probably do about one to two depositions a year.
Q And again, you said about 80/20 defense?
A Yeah.
Q And about how many times per year are you asked to review medical material regarding a medical negligence claim?
A Where I actually know that it's a lawyer asking me, it's probably 5 to 10 times a year.
Q And again, can you break that down plaintiff versus defendant or are you unable to do so?
A I'd probably leave it in the same frequency that I said before.
Q Okay. Now, in terms of your time here at Duke, I notice that you're also listed as a professor of, I believe, ob-gyn?
A Correct.
Q Tell me what percentage of your time do you spend in clinical work as opposed to administrative?

A Probably --
Q All clinical?
A Yeah. Probably three-fourths of my time at least.
Q And of that, can you break that down what percentage is strictly ob-gyn versus gyn pathology?
A I'm not sure I understand the question.
Q Well, you're a professor of ob-gyn as well as a professor of pathology, correct?
A Correct.
Q Can you break down the percentage of time that you spend strictly as ob-gyn, that is clinical obstetrician-gynecologist versus pathologist?
A Zero as an obstetrician-gynecologist. Hundred percent as a gynecologic pathologist.
Q What percentage of your time would you say is spent reviewing medical matters or working on medicolegal work?
A You asked two different questions.
Q Okay. What percentage of your time is spent reviewing medical matters?
A Are you talking of --
Q Medicolegal. In a medicolegal context. Obviously, all your work is medical.
A Okay. Small percent.

Q Can you give me a figure or an estimate?
A Probably 5 percent.
Q What percentage of your annual income in 2000 and 2001 represented work done in medicolegal work?
A Probably about 15 percent.
Q Ana anything other than reviewing medical records or giving deposition or trial testimony that you do in the medicolegal field?
A Yes.
Q What is that?
A I've lectured on medical malpractice.
Q And where have you given those lectures?
A For the College of American Pathologists and for the American Society of Clinical Pathology,
Q Are you able to describe for me the types of topics that you lectured on to those two groups?
A Both generally the same that deal with -- very broad scope, medical malpractice. What it is; what to do if one is sued; how to work with reports so that one writes a tighter, clearer report so that one is not particularly sued. Generally, how to have a better grade of practice.
Q How to prevent medical malpractice claims, in other words?
MR. BONEZZI: Objection. That's not what he

said.

Q (By Ms. Nissenberg) You can answer.

A i said to write a better report. How to -- how to have a tighter, more cogent report.

Q And you said so that you could avoid medical negligence claims? Or is that not part of it?

A I wouldn't characterize it that way. It's how to be a better physician so one is not sloppy.

Q Any other lectures that you've given with respect to medical negligence litigation?

A I may, but none come to mind.

Q Have you ever spoken to any defense attorney groups regarding the topic?

A Not groups.

Q Have you ever spoken to any defense attorneys other than an individual attorney at any one time regarding medical negligence litigation?

A No.

Q When you broke it down to not groups, what were you referring to?

A Quite often 1 speak with attorneys, both plaintiff and defense, as to problems and why people do get into medical malpractice suits.

Q And those are not formal-type conversations?

A I don't know what you mean by "formal."

Q Are they presented in a formal format or simply a telephone conversation?

A No. Telephone or personal contact.

Q Have you ever worked with any defense firms in Cleveland before?

A You asked a question earlier, had I ever had a case in Ohio. One many, many years ago, but I have no idea what the name of the firm is.

Q Are you part of any panel of medical experts or any type of group where the experts are contacted by potential plaintiff's attorneys to review cases?

A No.

Q Do you know Mr. Bonezzi outside of this case?

A No.

Q Do you know personally any of the pathologists at the Cleveland Clinic?

A Do you mean in this case or in general?

Q In general.

A Yes.

Q Which ones?

A Certainly Bill Hart; Tom Gavin, who just died; Howard Levin; John Goldblum. I could see some right in front of me. The fellow who did all the GI pathology, Bob Petrus.

MR. **BONEZZI:** He's no longer there.

THE WITNESS: Right. He went to AmeriPath. A-m-e-r-i-P-a-t-h.

Q (By Ms. Nissenberg) What about Dr. Biscotti? Do you know him?

A Not personally.

Q What do you know of him?

A Only by reputation that he's -- and from readings, that he seems to be a very sound pathologist; just a very thoughtful pathologist.

Q Do you know Dr. Gramlich?

A No.

Q Do you know any of the cytopathologists at the Cleveland Clinic Foundation?

A Mention their names.

Q Dr. Brainard?

A No.

Q Do you know Dr. Prayson?

A Yes.

Q Outside of this case?

A Outside of this case.

Q Have you ever spoken to any of the pathologists whom you've named with respect to any aspect of this case?

A No.

Q Have you ever discussed any aspects of this

case with any other pathologists not at the Cleveland Clinic?

A Yes.

Q With whom?

A One would be Dr. Rex Bentley.

Q Rex Bentley, B-e-n-t-1-e-y?

A Correct.

Q Where is he?

A At Duke.

Q Okay.

A And one is Dr. Bill Xie.

Q Is that S-h-e-a?

A No, it's X-i-e.

Q X-i-e. And where is he?

A Also in my department.

Q All right. Anyone else?

A Probably -- well, make it no.

Q You were about to say you might have spoken with someone else?

A In the normal course, often as I teach and I have residents with me every day, material that comes through, we will often just show it. And so in that sense, it's spoken about, but not discussed.

Q Okay. And when did you have these conversations, first of all, with Dr. Bentley, if it

was more than one conversation, however many?

A It would be -- I was going to ask whenever I got the slides. It would be sometime around when I wrote the opinion letter.

Q Is that the only time you've talked to him about the case?

A Yes.

Q And what about Dr. Bill Xie?

A Same times.

Q Have you spoken to either of those pathologists since receiving additional material after you originally got the slides?

A Speak with them every single day.

Q About this case?

A No.

Q Okay. At the time you reviewed the slides, which we're going to get into, you had a partial amount of the depositions that had been taken, right? To review?

A I believe so, but I'm not sure.

Q Okay. Today we're going to learn all the opinions that you intend to offer at trial and I need to get your most complete testimony. So is there any reason why we can't get that testimony here today?

A No.

Q Okay. When were you first contacted in this matter? Feel free if you need to look at any -- anything.

A I know it's been probably about a half a year ago, but I think Mr. Bonezzi could probably tell you.

Q Well, I'm deposing you, though. He's not under oath.

A I don't know. Let's say sometime in the range of a half a year ago.

Q Okay. So are we dating this to the year 2002?

A I don't remember. I don't remember if it would be the latter part of 2001 or the beginning of 2002.

Q Within the last six months?

A Roughly.

Q And how were you contacted?

A I think by telephone.

Q Who called you?

A I believe the paralegal for Mr. Bonezzi.

Q What did she tell you in that conversation or ask you?

A If -- she said that she has a case dealing with gynecologic pathology, and do I do cases like that, and it involves a question of ovary and a

question of endometriosis,

Q Anything else she told you in that conversation?

A No.

Q Okay. And what did you tell her?

A I'd be happy to take a look at the case.

Q And what was the next contact then you had with Mr. Bonezzi's firm?

A I have no idea.

Q Were materials sent to you to review?

A Sure.

Q Okay. And how did they arrive? By mail?

A By Federal Express.

Q Was there an accompanying letter?

A Yes.

Q Where is the letter?

A Actually, I may have it here.

Q Okay. Do you want to take a moment?

A Yeah.

Q I thought you had shown me your entire file.

A See if it's there, but I think I may have that letter.

Q I believe the two volumes that you showed me are simply the medical records for Ms. Huston.

A Right.

Q Oh, I'm sorry. There may be something else here.

A Let me see if I have it here. Yeah, here it is.

MR. **BONEZZI:** Let me see it first. Thank you.

Q (By Ms. Nissenberg) Thank you. All right. You've now handed me a letter dated March 6, 2002, in which Mr. Bonezzi thanks you for your willingness to review the enclosed slides and records on behalf of the Cleveland Clinic Foundation.

Is this the first communication that you had with Mr. Bonezzi, to the best of your knowledge?

A Is that letter from him?

Q Yes.

A Yeah, that would be the first -- that would be the first.

Q And approximately how long before you received this letter did you have the telephone conversation with his paralegal asking for -- whether or not you'd be willing to review the case?

A I can't be certain, but generally there's a lag of two weeks, sometimes three weeks, between when I'm first contacted and the material comes.

Q Had you spoken with Mr. Bonezzi by phone

prior to getting this letter?

A I suspect not.

Q At this time by this letter, it appears that Mr. Bonezzi sent you the slides from April 29, 1999, recuts as well as original slides, which I take to be the cytology slides.

Then he also sent you the slides from June 13, '00, recuts, which I believe to be the vaginal biopsy, and then slides from August 11, questionable as to whether they were original or not with respect to the small bowel excision.

Is that your understanding?

A Whatever is there would be correct.

Q And also he sent you the chart from Mrs. Huston from the Cleveland Clinic, and plaintiff expert reports authored by Dr. Tench and Dr. Weiss. And by the way, this is only one of Dr. Tench's reports.

Okay. Is there anything else that you received at this point in time that you don't think is conveyed in this letter but that you recall receiving?

A No.

Q Okay. And then after you received this material, did you then call Mr. Bonezzi or someone from

his office to convey your opinions?
A I don't remember.
Q How did you let them know what your opinions were?
A I don't remember if I called them or they called me.
Q Okay. With whatever occurred in the conversations, what transpired? What did you tell either Mr. Bonezzi or someone from his firm with respect to your review?
A That I finished.
Q And did you convey any of your opinions?
A I'm sure I did.
Q And what were your opinions at that time having reviewed, I assume, everything that was sent to you at that point in time?
A I frankly don't remember.
Q What was the next contact you had with anyone from Mr. Bonezzi's firm?
A You're asking, you know, for very specific times. I --
Q Well, it doesn't have to be an exact date. It could be --
A Without -- without trying to go through that or playing any games, it was -- somewhere there were

some discussions that the material needed to be reviewed and then Mr. Bonezzi came to my office so that we could talk about the case.

Q And when was that? it doesn't have to be the exact date.

MR. BONEZZI: it was in March.

THE WITNESS: Yeah. It would be sometime shortly after that letter.

Q (By Ms. Nissenberg) Okay.

A And it would be clearly about a couple weeks before my -- my actual report was due.

Q Okay. And the reports were due on April 1st, according to Mr. Bonezzi's letter. So we can assume it was sometime before April lst, correct?

A Right.

Q Okay. At the time that you met with Mr. Bonezzi, what was the conversation? What opinions did you give him at that time?

A Basically, there was a question, was this an ovarian tumor? Let me strike that. Let me go back in a broader scope.

What was occurring in the ovary? There was no question there was a -- a large mass that had been removed from the ovary. And the question was: Was it benign? Was it malignant?

And my impression was that it was a benign tumor.

Then there was a question: What was occurring in the contralateral ovary? And my impression was that was endometriosis.

Q And let me just stop you right there. By "contralateral," you're now referring to the right?

A Correct.

Q Okay. Continue.

A And the all-important question was: What was the process that was occurring in this patient? And my response to Mr. Bonezzi was that the malignancy that caused this lady's death was not at all ovarian. It was actually a tumor arising in endometriosis.

And based upon the chart and the discussion, the depositions that I had, which gave firsthand opinions from the physicians in fact, it was my conclusion that she had endometriosis -- a tumor that arose in endometriosis, most likely in the cul-de-sac region.

Q Now, you mentioned the depositions. By this point and by the point of time in which you wrote your report, you had only read four deposition; isn't that true?

A That's correct.

Q Okay. One of those was Dr. Brainard's, cytopathologist --

A Correct.

Q -- who didn't offer any opinion with respect to where the cancer was since she didn't think there was cancer; correct?

A I don't remember fully what she said, but I'll take that as --

Q Okay. Dr. Markman had basically no recollection of this patient and offered no opinions other than he was treating her for ovarian cancer at the time he saw her. Do you recall that?

A Correct. The one that was critical was Alexander Kennedy, who was the physician who actually operated. And I was not relying on his opinion and conclusions. I was particularly interested in his observations during the operation, what he saw, what was -- you know, what occurred and where things were found.

Q Okay. And it wasn't Dr. Kennedy's theory about the cancer arising in an endometriosis implant whether in or on the ovary or in the posterior cul-de-sac until after Mrs. Huston died; isn't that correct?

A I believe that's what he said.

Q Okay. Now, you had Mr. -- excuse me -- Dr. Kennedy's theory in mind at the time you reviewed these slides, correct?

A I think I have -- let me say -- you asked several parts in the question. It was my theory based upon reading this material that it came from the endometriosis before seeing Dr. Kennedy's impression.

Q So you had not read Dr. Kennedy's theory before you considered that possibility, correct?

A Came to the conclusion.

Q And based on what?

A Pardon?

Q Based on what? What was the basis of your conclusion?

A Having reviewed the slides and the medical record.

Q Was it based at all on any of the deposition testimony you had read to that point in time?

A No.

Q And the slides that you had seen, you've never seen the original B6, have you?

A No.

Q In fact, Dr. Biscotti saw the original B6. Do you recall that?

A That's what it said in the various

depositions.

Q And I take it that you've not had an opportunity to read all of the remaining deposition testimony that's been acquired in this case?

A No. Three of them came while I was away and they're now sitting on my desk to read.

Q Do you recall who those are?

A I wrote the names down, but --

MR. **BONEZZI:** They're Biscotti, Gramlich and Levin.

Q (By Ms. Nissenberg) So as you sit here today, Doctor, you've never read Dr. Biscotti's deposition transcript?

A Correct.

Q And what do you know about his opinions with respect to the slides in this case?

A I know what's been alleged as to what he has said from other people, but I've not read his deposition so I don't know exactly what he actually has said.

Q Well, I'd like to know your understanding of what Dr. Biscotti said.

MR. **BONEZZI:** Objection. You may answer if it has any basis on your opinions.

THE WITNESS: Let me make sure I understand

the objection.

MR. BONEZZI: It's okay. This is for the record.

THE WITNESS: Okay. No no. But you said if -- if it has any bearing on my opinion. His feeling doesn't have any bearing on my opinion, so am I supposed to answer or not answer?

Q (By Ms. Nissenberg) Well, 1 think that you did reference Dr. Biscotti before and what you think that he saw since he's the only one that's seen the original B6.

a But you asked me before what my opinion is and I'm not --

Q Right.

A -- and I'm not basing any of my opinions today on opinions of other people.

Q. Okay. So --

MR. **BONEZZI:** I just want to clarify. His opinion, he said before, was based upon his review of the slides and a review of the medical records. He did not include the depositions. it was after that that you asked him whether he had read any of the transcripts and that's where he was going into it.

THE WITNESS: I did say one piece. The portions that I based from the depositions were the

original observations that people made. Like Kennedy specifically spoke about during the operation what he saw and where things were. I took that as if that's part of the medical report. That's, you know, original observation. Anything else is opinion and that's, I know, not what I'm being asked to talk about today. I'm asked to speak about what my opinions are --

Q (By Ms. Nissenberg) Correct.

A -- based upon my personal observations.

Q Correct. Would it be important for you to know what Dr. Biscotti testified to since he saw the original *of* B6 and you have not?

A To the extent that **I** would like to know what he saw, where he saw it, what he was given. His conclusion of what were on the slides, to me, are irrelevant.

Q And what did Dr. Kennedy testify that Dr. Biscotti told him he found?

A Repeat the question.

Q What did Dr. Kennedy testify that Dr. Biscotti told him he had found?

A It's like the game of Telephone because there's a question whether a cancer was seen, whether a cancer was not seen, that is all very, very muddled and done on sort of half-truths and half-observations, And

that's why I just totally ignore that.

Q Dr. Kennedy testified that he went down to the lab --

. A Right.

Q -- and Dr. Biscotti showed him the slides.

A Right.

Q And showed him specifically the original of B6, which you have not had an opportunity to see.

A Correct.

Q What did Dr. Kennedy testify that Dr. Biscotti showed him he had found on the original B6? You read Dr. Kennedy's deposition.

A I'm not asked to memorize this. We can -- let's pull that out and we can pull it out right now.

Q Okay. If I represent to you that Dr. Kennedy testified that Dr. Biscotti identified a small focus of high-grade cancer in the original of B6, does that refresh your recollection?

A No. I'd like to *see* that as it's in the transcript.

Q Okay. I'll be happy to show it to you, if I brought it with.

I will direct your attention, Doctor, to Dr. Kennedy's transcript, beginning on page 59, where he testifies that he asked Dr. Biscotti to go

back and look at them again. So starting on line 20 and then continuing through lines 15 on page 60.

MR. **BONEZZI:** Start before that if you feel it's significant.

Q (By Ms. Nissenberg) Yeah. Absolutely.

A Point out where I'm supposed to start.

Q Starting with line 20 on page 59 --

A Okay.

Q -- and continuing down to about 12, or you can read before that or after that, as Bill said.

A Okay. I'm going to take a few minutes.

Q No problem.

(WITNESS REVIEWS DOCUMENT.)

A It's not really clear what slides they're actually looking at.

Q Feel free to read the pages before, if it will elucidate which slides he's referring to.

A So it's the 1999 slides that are being reviewed.

Q Correct. I will represent to you that he is referring to the original of B6.

A This is in the deposition where Dr. Kennedy is saying that he has spoken to Dr. Biscotti. And so in a sense, it's like a hearsay for me because I don't know this is actually what the conversation truly was.

But he represents that he asked Biscotti to review the slides and Biscotti said that there was a small area, extremely limited area, that he interpreted to be a high-grade cancer.

Q Right. Do you recall reading that when you read Dr. Kennedy's transcript?

A Yes. And this was from the right ovary.

Q Correct. Do you recall reading that now?

A Yes.

Q Okay.

(DISCUSSION OFF THE RECORD.)

Q Is there anything else about Dr. Kennedy's transcript that we haven't -- well, strike that.

At some point, you requested additional material from Mr. Bonezzi's firm; is that correct?

A I'm not sure that I did.

Q Well, I'm looking at a fax cover page from someone named Marie Brettelle --

A Right.

Q -- saying, Enclosed please find a copy of the complaint you requested.

A Okay.

Q Did you request a copy of the lawsuit?

A Sure. I always like to see the complaint.

Q Okay. And by her statement, I was able only

to find on -- I think she means one -- lab value of CA125 which was done August 7, '00.

Is that something that you also requested, whether or not there were any CA125 levels obtained for this patient?

A Probably.

Q Did you actually have a conversation with this Marie or did you write your request to the firm?

A No, it would be on the telephone.

Q Okay. Is there anything else you requested?

A Not that I remember.

Q Okay. And she then sent you a copy of the CA125, which we know was well after the diagnosis was eventually made; correct?

A I presume.

Q Well, do you know when the diagnosis was made for this patient?

A April 1999.

Q That was the first diagnosis. The diagnosis that this patient indeed had cancer, do you know when that diagnosis was made?

A I believe that was in June of 2000.

Q And that's when Mrs. Huston had her vaginal biopsy?

A Correct.

Q Okay, Was there anything special -- I assume that you reviewed the complaint that was sent to you by Miss Brettelle?

A Correct.

Q Was there anything special in this complaint that stands out to you as you sit here today?

A No.

Q Anything that you relied on for any of your opinions?

A No. I just use that always to double-check against dates and time.

Q Okay. By the way, we're going to attach your CV as Deposition Exhibit 1.

A Okay.

Q And the letter that we referenced dated -- sorry. I can't see the date. March --

A March 6.

Q -- thank you -- March 6 will be Exhibit 2 to the deposition.

Did you ever have any --

MR. **BONEZZI:** How are you going to do that? Because I don't want the original taken.

MS. **NISSENBERG:** Okay, Well, do you want to send a copy to the court reporter?

MR. **BONEZZI:** I would do that. Maybe we'll

have Dr. Robboy do it. I won't even be back until next week.

Q (By Ms. Nissenberg) Okay. Is that possible for someone in your office to make a copy?

A Yes.

MR. **BONEZZI:** I'd rather do it that way.

Q (By Ms. Nissenberg) Okay. Doctor, at the time that you wrote your opinion letter which -- I'm looking for the date on it -- March 28, 2002, you had read the slides except for the original of B6, correct?

A Correct.

Q And you had read -- you had read the two pelvic wash slides from 1999, correct?

A One pelvic wash and one cell block.

Q Okay. And the cell block was from the pelvic wash, was it not?

A Correct.

Q Okay. And then you read the slides from 2000, which would be the vaginal biopsy and the small bowel excision; correct?

A Say that again.

Q Which would be the vaginal biopsy --

A Yes.

Q -- slides and the small bowel excision?

A Yes.

Q Those are the 2000 slides --
A Correct.
Q -- that you referenced?
You had read the medical records and then the depositions of Dr. Brainard, Dr. Kennedy, Dr. Markman and Dr. Prayson; correct?
A Correct.
Q Is there anything else that you relied on or reviewed in forming any of the opinions --
A No.
Q -- that are in your letter?
Did you have any conversations with any physicians at the Cleveland Clinic regarding this patient?
A No.
Q Pathologists.
What subsequent depositions have you read? I know -- I think Mr. Bonezzi said you have not read Dr. Gramlich's deposition, Dr. Levin's and Dr. Bonezzi. Have you read everyone else's?
MR. **BONEZZI:** Dr. Biscotti.
Q (By Ms. Nissenberg) Dr. Biscotti.
A No. The four I read are mentioned in my report.
Q Okay, And when did you receive the expert

opinions of the plaintiff's experts? Was that accompanying the March 6, 2002 letter?

A I don't remember when I -- this letter was written while I was traveling and I know that I carried a number of these depositions with me and was reading them then. So I can't tell you the exact date and time, but they were all close within that period.

Q Have you seen Dr. Tench's supplemental report?

A I've seen it without having read it. Mr. Bonezzi told me that it exists and I have not had a chance to sit down and read it carefully.

Q Do you know either of those physicians, Dr. Tench or Dr. Weiss?

A No.

Q Would you agree that Memorial Sloan-Kettering has a very reputable training program for pathologists?

You're not going to disagree with that, are you?

A I might. It's -- it's a good program,

Q Are you aware, as you sit here today, that Dr. Biscotti feels that when he looked at the vaginal biopsy in the year 2000 and then looked back at the original B6, that both showed the same process?

A There have been some comments in the chart,

but I don't want to say whether that is his feeling or not unless I hear it really or read it in a deposition.

Q Okay. And if you read it in a deposition, would that have any bearing on your opinions?

A No.

Q Are you aware, as you sit here today, that Dr. Biscotti testified that when he looked at the vaginal biopsy of 2000 and looked at the original B6, that both show adenosquamous carcinoma?

A Are you saying that's what he says?

Q That's what I'm saying. Are you aware of that?

A No.

Q Would that have any bearing on your opinion?

A No.

Q What would be the significance to you as a pathologist if both the vaginal biopsy and the original B6 show not only the same process, but both show the same adenosquamous carcinoma?

A I would say it would be significant, but given the material that I've seen, and I've seen the recuts of the B6, I would say there's no adenosquarnous carcinoma present there.

Q Are you aware, as you sit here today, that Dr. Biscotti testified in his deposition that the recut

A No.

Q Okay. You believe that cancer arising in an endometriosis implant that basically takes over the ovary, as in this case where there was almost no ovarian tissue seen at pathology -- do you believe that that would be a primary ovarian or would that be cancer in the endometriosis implant? You would agree there's a distinction?

A Not really.

Q *So your testimony is that primarily ovarian adenosquamous and adenosquamous of an endometriosis implant are one and the same?

A In the ovary --

MR. **BONEZZI**: Excuse me. Would you read that back, please.

(*READ BACK.)

MR. **BONEZZI**: Thank you.

THE **WITNESS**: Can you repeat that again. I have to hear it slowly.

(*READ BACK.)

Q (By Ms. Nissenberg) That was a follow-up to your previous testimony, it wouldn't make any difference.

A What I'd like now is to restate that to make sure I understand it.

Q Thank you.

A We're talking about a tumor in the ovary, and your question is: Is an adenosquamous carcinoma that has arisen in the ovary the same as an adenosquamous carcinoma that's associated with endometriosis that is found only in the ovary?

Q Not only in the ovary. I didn't qualify that.

A But arising in the ovary.

Q *Right. Primary ovarian versus cancer that is in the ovary, but in an endometriosis implant.

A In the ovary.

Q Yes.

A I would say they would be the same.

MR. BONEZZI: Just read that last question back for me, please. The answer I got.

(*READ BACK.)

MR. **BONEZZI:** Got it. Thank you.

MS. NISSENBERG: I forgot where I was going with that with, all the questions and answers back and forth.

MR. BONEZZI: I'm sorry.

MS. **NISSENBERG:** That's okay.

Q (By Ms. Nissenberg) Do you recall that the B specimen -- and by the way, looking at the actual

reports, do you recall that the description of B contains references to both the right and left in the pathology report?

A I do remember there was some confusion and that's why I spent a lot of time trying to decide what was the left side and what was the right side.

Q And basically A represents the left?

A The left.

Q And B represents the right, correct?

A Correct.

Q And in fact, the frozen section was taken from the left, which was the larger mass?

A That's correct.

Q But the adhesions, the mass being completely adhesed to the side wall and probably to the top of the vagina, was on the right side; isn't that correct?

MR. **BONEZZI:** Objection. Go ahead and answer it.

THE WITNESS: No.

Q (By Ms. Nissenberg) That's not correct?

A That's not correct.

Q Okay. In what way is that not correct?

A The vagina was never mentioned.

Q Okay. The --

A It was -- the adhesions were to the side

wall.

Q Okay. And that side was not sampled during frozen section, correct?

A That's correct.

Q And microscopic sections of the mass on the right were not obtained, even though it was the side with the adhesions; correct?

A That's my understanding.

Q Okay. And that's something that really should be done; don't you agree?

A No, I don't agree. I disagree.

Q Disagree? Wouldn't it be necessary to obtain those microscopic sections to see whether or not there's tumor involved causing the adhesions as opposed to a chemical reaction?

A No.

Q Would you agree that it is not good medical practice to be missing a surgical specimen slide that has been alleged by deposition testimony to contain a small focus of high-grade cancer in a patient?

MR. **BONEZZI:** Objection to the form. Go ahead and answer.

THE **WITNESS:** I was going to say, you're asking multiple pieces there. I'd rather you break that down into simple pieces.

Q (By Ms. Nissenberg) Okay. Would you say that it is good medical practice for a slide that has been described by the gyn pathologist at the Cleveland Clinic as a key slide to be missing and not locatable?

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

THE WITNESS: It's a -- it's a compound question. I'd rather not answer it that way.

Q (By Ms. Nissenberg) Okay. Answer it the way you'd like to answer it then.

A Okay. One always likes to find slides in the files, but it's just a matter of course that, you know, a certain number of slides are going to end up not being in the correct place for any number *of* reasons.

Your question almost implied as if someone was purposely removing or moving or hiding slides, and that's not the intent. You'd like to find the slides, but very often, they're not there.

Q And what is your understanding of where the slide disappeared to?

A I have no idea.

Q Well, you're saying that this is not the intent as though you know what the intent was, if there was an intent.

A Very often, if there's a slide that's been

shown around, that may get displaced. Not uncommonly for teaching purposes, a slide will be held and then later it's misplaced. That's just a common occurrence in any medical institution.

Q Are you aware that this slide has been missing since it was shown by Dr. Biscotti at a pathology conference?

MR. **BONEZZI:** Objection. That's not correct.

MS. **NISSENBERG:** I think that is correct.

MR. **BONEZZI:** No, it is not. That is not his testimony.

MS. **NISSENBERG:** I believe he testified that he took a photograph of only the recut of B6 because it was missing when he went to make the photographs for the conference.

MR. **BONEZZI:** His testimony was that he singularly removed B6, placed it into the mailbox of Richard Prayson, MD.

MS. **NISSENBERG:** Right.

MR. **BONEZZI:** He did not have it at the time of the conference.

MS. **NISSENBERG:** That's exactly what I said.

MR. **BONEZZI:** Well, you're implying that it was shown at the conference and then became misplaced.

MS. **NISSENBERG:** No. I'm sorry. What I said

was he had to take a photograph of the recut of B6 for the conference.

THE WITNESS: I've gotten lost in the question.

Q (By Ms. Nissenberg) Okay. Do you have any knowledge -- well, strike that.

Would you agree or disagree that it is not good medical practice for a key pathology slide to be missing?

MR. **BONEZZI:** Objection. Go ahead and answer it.

Q (By Ms. Nissenberg) It s just a yes or no question.

MR. **BONEZZI:** You may answer it the way you feel is appropriate.

THE WITNESS: It's like a God-and-country type of question. You hope that all the material is going to be in the file, and sometimes it's not. Obviously, if it's not, it's not the best practice, but it's certainly not anything that's unusual.

Q (By Ms. Nissenberg) Where is *Here the medical records state that a review of the slides from 2000 were questionable for malignancy?*

Do you recall reading that in the medical records?

A. A slide from 2000?

Q I'm sorry. The slides from '99.

A There have been commentaries all through the chart on that. The reality is I've asked to see the slides and just based on my experience, given the number of B6 slides and the other slides, I see no tumor. And I would be very surprised if a slide that would be a fraction of a millimeter away would have any obvious tumors. So I tend to discount all of that discussion.

Q Well, you would agree that just because slides are numbered B1 through 6, it doesn't mean that they came actually one after the other. When the dermatome makes the slides, some tissue is not placed in it; isn't that true?

A That's not what we're talking about. Your question is Slides B1, B2, B3. They can come from very different areas in the tissue.

But you were talking about the recuts. And the recuts are going to be a fraction of a millimeter -- most likely it would be somewhere within the range of 20 to 30 microns deeper than the original.

And you're not going to have a flagrant cancer in one section and nothing in the next. And

given that I've seen the next, I don't have the concern that you're raising.

Q Well, you're referring to it as a flagrant cancer. If in fact there was -- there were cells suspicious for malignancy or some other reason to suspect malignancy, not flagrant as you describe it, because in fact Dr. Biscotti has said that the B6 original was much more dramatic than the atypia seen in the first recut, then you could see the second and third generation recuts of B6 not showing any atypia; isn't that true?

A Conceivable, but there's a big difference between atypia and cancer, so...

Q What is your understanding of those references in the chart made by Dr. Cipoletti, the resident for Dr. Kennedy, that was signed by Dr. Kennedy, as well as the entry by Dr. Schwartz, that the slides revealed questionable for malignancy?

A I will give you an example which will answer my question.

More than once I have written as one of my own reports that the patient does not have cancer. A clinician will come down and say, Couldn't this be a cancer?

And I will say, No.

The clinician will say: Are you sure it can't be cancer?

And I will say, No.

Three pages down in the chart, they'll say he went to see the pathologist who said it might be cancer.

Six pages down, someone else will interpret his material and say it is likely to be cancer.

And nine pages down, it will say it's a -- it's a cancer.

A lot of what's in the chart is the game of Telephone.

Q In fact, Dr. Kennedy was the physician who knew that the April '99 scenario and the June 2000 scenario didn't comport with one another and so went to do an investigation; isn't that true?

A I believe so.

Q And he knew that the mass that was present in 2000 was not going to be explained by what the pathology reports from 1999 showed; isn't that true?

MR. **BONEZZI:** Objection.

THE WITNESS: He knew that there was a discrepancy, but the discrepancy is not answered by the lack of a cancer in the ovary, nor is it answered by

the descriptions of the atypia and the other things that have been alleged in the ovary. That still does not explain the type of recurrence this patient has.

Q (By Mr. Nissenberg) Are you aware why there's no addendum pathology report from 1999 after Dr. Biscotti came up with his findings in July of 2000 or June of 2000?

A Are you asking for supposition or fact?

Q For a fact, if you know why there's no addendum report.

A No fact. I can only surmise.

Q Okay. And this patient was treated for ovarian carcinoma after July -- after early July of 2000, correct?

A Incorrectly treated, but yes, treated.

Q She was treated with a working clinical diagnosis of ovarian carcinoma, correct?

A Yes. The key word used "working."

Q Okay. But the treatment for malignancy in an endometriosis implant, whether in the posterior cul-de-sac or elsewhere, would be the same; would it not? If you know.

A Let's dissect the question. Let me put it -- the way you're asking the question, it's unanswerable. You'll have to define it with more specificity.

Q If a patient were diagnosed with malignancy in an endometriosis implant in the posterior cul-de-sac, are you aware of what the gold standard treatment for that would be or would have been in the year 2000?

A I can surmise, but basically I would leave that decision to the treating gynecologic oncologist.

Q Okay. Fine. The final report from the vaginal biopsy signed out by Dr. Levin 1 believe stated that it was compatible with a tumor of endocervical origin. Do you recall seeing that?

A Yes.

Q Okay. Now, you're not aware of what Dr. Levin testified to in his deposition; is that correct?

A I have not read the deposition.

Q Do you have any information as to how he testified?

A Other than what's been in all of the material I read prior to the material that I've not read.

Q I'm sorry. Could you repeat that?

A There's many -- there's many discussions throughout the record as to what Dr. Levin and what all the various physicians have seen.

So my total knowledge is based upon those

comments. My knowledge is not based upon what Dr. Levin has actually said in his deposition because I've not read his deposition yet.

Q Okay. I will represent to you that Dr. Levin in his deposition testified that it was also compatible with a tumor of other gyn origin besides endocervical.

MR. **BONEZZI:** Excuse me. He testified that it could be, because you asked him specifically could it be compatible with anything else. He said --

MS. **NISSENBERG:** I think I specified actually, ovarian, and I think I specified with an endometriosis implant. And he said it could be compatible with both.

MR. **BONEZZI:** Yes, it could be is the operative term.

Q (By Ms. Nissenberg) Were you aware of that?

A No, but it's -- it's reasonable.

Q Were you aware that in reviewing -- I'm sure that when you reviewed the pathology report, you noted that the endocervix was examined very carefully and that no cancer was found in that?

A Yes, that's correct.

Q When is the last time you personally diagnosed malignant transformation of endometriosis?

A Certainly within the last month,

Q It's a fairly rare entity, isn't it?
A Yes.
Q Approximately one percent of malignancies in endometriosis -- excuse me -- in the ovarian cancers are caused by malignant transformation; isn't that true?
A Say that again.
Q One percent?
A You said some other material.
Q One percent of those cancers, cancers of the gyn tract, one percent is what is represented by malignant transformation of endometriosis; isn't that true?
A You garbled parts.
Q Do you want her to read it back?
A No, because you've -- you phrase it in such a way that you at times added material and sometimes you subtracted it.
Q Okay.
MR. **BONEZZI:** What he's saying is that the first time you said it you used the term "ovarian."
MS. **NISSENBERG:** Okay.
MR. **BONEZZI:** The second time, you used the term gyn --
Q '(By Ms. Nissenberg) All right. Gyn

malignancies. Okay.

A One percent of cases of endometriosis will have malignant transformation, roughly.

Q One percent?

A Roughly.

Q How often have you made that diagnosis? You said you made one within the last month. When was the last time before that?

A I've actually made that reasonably often because I'm in a referral institution and, as you will see in my CV, one of the big studies I did was to review all the cases of malignant transformation at Duke.

Q Okay. But across the broad spectrum of medical institutions and private physicians' offices, it's about one percent. It's fairly uncommon; is that true?

A Uncommon.

Q Have you seen anyone's opinion or are you aware of anyone's opinion that the morphology of B6 and the vaginal biopsy and the small bowel excision are the same?

A I've not seen anyone directly say B6 is the same as the vaginal biopsy.

Q If hypothetically you were to see that

Dr. Biscotti, who iooked at the original B6, believes that the morphology of B6 and the vaginal biopsy were the same, would that have any significance to you as a pathologist?

A As an expert, it would not, because I would say based on my experience, seeing the area that is so close by, I think it's going to be impossible to say --

Q Okay. I don't want to cut you off, but you're talking about what you saw in the recut.

A Right.

Q I'm asking you hypothetically if Dr. Biscotti testified that the original B6 that he has seen with his own eyes --

A Right.

Q -- and the vaginal biopsy, which you saw at the same time, compared them, that they showed the same morphology, would that have any significance to you as a pathologist?

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

THE WITNESS: My comment is the same because I would want to sit and know what -- what actually he saw. If you see one cell or group of cells that looks identical, that's not the same as if you see a massive tumor and really are able to compare a whole mass to

what's present elsewhere. So I would say it's inadequate.

Q (By Ms. Nissenberg) Do you believe that if the morphology were the same, hypothetically, between B6 original, vaginal biopsy, and the small bowel excision, that it would tend to show the same origin for the cancer?

A In this case, no.

Q In general?

A Possibly. I mean, if you think -- if you think that the tumor, and that's the recurrence, has come from the site that you're talking, in the ovary, you can say sure.

Given that we're dealing with endometriosis and that there's evidence of endometriosis elsewhere and thicker, I would say probably not.

Q Wouldn't you agree that cancer in an endometriosis implant tends to recur in the vaginal cuff? If you know.

A Not particularly. It's one of the sites where it can recur, but certainly -- the way you phrased it, it's certainly not the preference.

Q Where does it generally recur?

A Most of the cases that I've seen have been

more generalized in the abdominal cavity.

Q Outside of the peritoneum?

A No. Inside. Inside the abdominal cavity.

Q Okay. And in what -- what site?

A Most commonly, somewhere in the omentum or somewhere in the region of the posterior cul-de-sac, somewhere along the ligaments, the uterosacral ligament region. Usually when they recur, there will be a sort of mass lesion of the peritoneum.

Q How often do they recur in the vaginal cuff?

A As in this patient, I think pretty unusual.

Q And why is that?

A When they recur, they tend to be small nodules. This is one that's a 6-centimeter nodule in the vagina that's eroded the bone, grown up to cause hydronephrosis. That's not really compatible with an ovarian -- you know, endometriotic tumor of the ovary that's implanted. They don't --

Q Which brings me to my next question. Wouldn't you agree that in forming your expert opinions, it would be helpful to have the accurate medical history for the patient?

A It always is.

Q In your report, you refer to the revisit of Mrs. Huston to the Cleveland Clinic in June of 2000

with ureteral obstruction. That's not in fact the case, is it?

A My understanding was she had hydronephrosis.

Q In June of 2000?

A If I wrote it, that's what I thought.

Q It would be important to have an accurate history, though, wouldn't it?

A Sure. Generally.

Q If hypothetically the pelvic wash slides, either of them or both, showed cells suspicious for malignancy, *of* what significance would that be to you as a pathologist in this setting?

A Depends what you would call -- what were the words you used again? Suspicious, It depends -- depends how the words are used.

Q What is the meaning in your mind when I say "cells suspicious for malignancy"? Have you ever used that language in reporting out pelvic wash slides?

A I have a range of words which convey the -- which convey the concern that I have.

Q Okay. Have you ever used that terminology?

A Suspicious for malignancies? Yes, certainly.

Q Okay. And what does that mean to you? Is that on a scale of --

A That would be on a higher-end scale.

Q Okay. So you're looking, for example, at precursor lesions or precursors to cancer to a definite diagnosis of malignancy and it's somewhere in that scale?

A Not only precursor, but sometimes that someone has missed something.

Q Okay. So then with your understanding of how you use the terminology suspicious for malignancy with the cells, if hypothetically the pelvic wash slides, either of them or both, had shown cells suspicious for malignancy, of what significance would that be to you as a pathologist in this setting for this patient?

A That you'd have to worry that the patient has a cancer somewhere.

Q Then further in -- I'm sorry. Did you have more to say?

A Yeah. It could mean that something else was present. It could mean potentially there's some -- you know, a reactive process that is not cancerous.

Q Okay. And you're referring to reactive mesothelial cells in the pelvic wash?

A No. When you have reactive mesothelial cells, those I tend to discount.

Q Right. You would expect to see those for this patient, wouldn't you?

A Yeah. With this size sheer mass.
Q Okay. By the way, when you looked at the pelvic wash slides, what did you see besides reactive mesothelial cells, if in fact you saw those?
A The initial time I looked at them, I saw reactive mesothelial cells in the pelvic wash, and in the cell block, there were several clusters of cells that were slightly different that initially I passed off as being nothing more than reactive.
Q And by your answer, I take it that you had a second look?
A Oh, yes.
Q And what did you see then?
A In a case like this, when you're looking for an answer, and that's when you go back and review and re-review and especially 2s this -- this is the time when you read various depositions and people have their thoughts as to what's been seen and you go back and see it a third time, fourth time, fifth time.
Q Right.
A There are several clusters of cells only in the cell block, not in the pelvic wash --
Q But -- you mean ThinPrep®? The cell block was from the pelvic wash and the ThinPrep® was from the pelvic wash, so I just want to make sure your testimony

reads clearly. There was one of each slide made. So you said in the cell block only, not --

A Theres' a -- there's a spun-down tissue. There's one that was centrifuged.

Q I'm sorry?

A There's one that was centrifuged, which is an H and E section.

Q I'm sorry. I'm not getting what you're saying.

A There's two different techniques. You have the fluid --

Q Right.

A -- and I think the ThinPrep® is just the ordinary fluid.

Q Okay.

A And then some of the fluid is spun down and processed as if it's a histological section.

Q Into making the cell block?

A Cell block.

Q Okay. So now --

A And it's a cell block. One is entirely negative. The other has some of the atypical cells that initially I passed off as -- well, I just passed off as slightly atypical, without much concern.

Q Okay.

A And then on review and re-review, saw that there were many clusters of cells that had a higher degree of suspicion of being atypical.

Q Anything else?

A No.

Q They were suspicious for being atypical or they were atypical?

A They were atypical.

Q So they had a higher degree of suspicion for what? Possible malignancy?

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

THE WITNESS: If I had been a treating pathologist, the initial pathologist, I would have looked at the slides and said, At most, they're slightly atypical, and that would be the end. Probably would not even have commented on them.

Given this case where we're going back retrospectively and trying to find clues to what has occurred in Mrs. Huston -- Huston, and especially after seeing all the discussions and the various reports, then go back and look and say, Could these cells be related to the cancer that this lady, you know, later received?

So there are a few cells with mitoses and

some that are slightly more atypical.

Q (By Ms. Nissenberg) Are you aware, as you sit here today, how Dr. Gramlich testified in his deposition last Tuesday?

A No.

MR. **BONEZZI:** Objection.

THE **WITNESS:** No.

Q (By Ms. Nissenberg) Okay. Dr. Gramlich, I will represent to you, testified that the first time he looked at the pelvic wash, he agreed with Dr. Brainard, the cytopathologist, that they were negative, I think was the word he used.

A Right.

Q But on re-looking at them prior to his deposition, he realized now that there were atypical cells, atypical cell clusters. He specifically stated that the fact of the clustering was significant, and irregular nuclei on the cells. And so he didn't think that the original reading was correct.

Would you agree with that?

MR. BONEZZI: Objection to the question. Go ahead and answer.

Q (By Ms. Nissenberg) I don't know how long ago it was since you looked at the pelvic wash slides.

A Sometime ago, but no.

Q Okay.

A The issue that you're raising is: With a retrospective scope, can you identify lesions? And you know, with this comment, I mean, if that's what he said, I wouldn't disagree with it. Is that the way you would practice medicine? No.

Q If a patient had -- first of all, were you able to make any determination whether the types of cells you were seeing, other than the reactive mesothelial cells, in the pelvic wash were morphologically similar to any of the subsequent slides that you looked at, such as the vaginal biopsy?

A I would never even try to do that with a -- with a cell block.

Q Okay. Assuming that the pelvic wash hypothetically was suspicious for malignancy, but the surgical pathology slides were negative, would you as a pathologist recommend that the surgeon look for a primary source somewhere other than where the specimens came from that you're examining?

MR. **BONEZZI:** Objection. Go ahead and answer,

Q (By Ms. Nissenberg) Did you understand my question?

A No, I understand your question.

Q I thought so.

MR. BONEZZI: I didn't.

THE WITNESS: Let me take this into my routine daily practice.

Q (By Ms. Nissenberg) Okay.

A If I see something that's atypical and if I think that there is a cancer that is lurking somewhere, I will either make a very specific note, and sometimes with quite an emphatic note in the record, or I will call the clinician, and then say that, Here is a sixth sense; I am worried that there is something present that we're just not seeing.

You know, we may have a little clue, but it's something that we all need to put our heads together and rethink the entire -- the entire situation.

On the other hand, on a case like this, if I had seen these slides, I would have passed them off. It's not something that would have alerted me to say, Here's something we need to go back and re-examine.

Q But in your practice, if you're convinced that the pelvic wash slides are showing cells suspicious for malignancy, and yet the surgical specimens that you've been given don't show any

malignancy to the best of your knowledge, you would make some recommendations to the treating surgeon in terms of "we need to do something"?

A Again, it depends on what you mean by "suspicious for," because that's such a broad scope.

All I can say is on an individual case, if it's something that I thought had a reasonable chance of finding a malignancy, then I would -- as I do, I call the clinician and sometimes we'll discuss it to say, you may want to think about something.

But quite often on something like this, I would have passed this off and just said, at most, you know, slight atypia, and ignored it and that would have been the end.

Q When do you think Mrs. Huston first had cancer?

A Sometime before 1999.

Q Since you're convinced the cancer she had was in an endometriosis implant in the posterior cul-de-sac --

A Or somewhere in that region.

Q -- or somewhere in that region, what stage, if you can stage it, would the cancer have been by April 29, 1999?

A Actually, there's no staging system for

endometrial -- or cancer arising in endometriosis. So she would be not having any stage.

Q Okay.

A If you would want to use something like an ovarian staging system, I mean, if you'd say by analogy, this might be similar to a primary tumor arising in the peritoneum; not an ovarian cancer, but a tumor arising in the peritoneum. And then you would use more of the ovarian tumor staging, and she would be a Stage IIIC. So she would already be a high-grade tumor.

Q By April 29, 1999?

A Correct.

Q And why is that?

A Because it would be then tumor present in the pelvis. It could be a IIC or a IIIC. IIC is defined as a tumor that's in the pelvic cavity. And she then also has the fluid.

Q But if you were to use the ovarian carcinoma staging system, the FIGO system, she would be a IC --

A No.

Q I believe that would be cancer --

A Well, if --

MR. **BONEZZI:** Let her finish.

Q (By Ms. Nissenberg) -- in either ovary with

positive peritoneal washings. I believe that's the FIGO IC for ovarian carcinoma; is that correct?

A That's correct. But you're asking -- that's with the assumption that the tumor has arisen. The primary tumor is in the ovary.

Q Correct.

A And you asked me my question, and I'm saying, this is not an ovarian tumor.

Q Okay. If in fact the cancer was in an endometriosis implant in the ovary, then would that change your answer? In other words, not primary ovarian?

A Yeah, but you're saying hypothetically if the endometriosis were in the ovary and you could establish that's where the primary tumor occurred, and the only other lesion that was found were positive washes, then it would be a stage IC.

Q Okay. Now, you stated that you believe that if this were in the posterior cul-de-sac or in that region, then by April '99, she would be a stage either IIC or a IIIC using a peritoneal --

A Essentially using the ovarian tumor staging.

Q -- using ovarian tumor staging.

Wouldn't it be likely that Dr. Kennedy would have seen some clinical evidence of this

during the surgery?

A He did. He described that there was the, you know, endometriosis, you know, in multiple areas. And that's commonly -- based on my experience of having gone back with patients that later had overt cancer that's arisen in the endometriosis, the endometriosis and the earlier tumor was present, but you couldn't -- you couldn't look at it and say that's grossly cancer.

Q But it would be of such a size in the posterior cul-de-sac that -- or in that region that Dr. Kennedy would have noted it?

A No. Absolutely not. Absolutely not.

Q Okay. So are you saying that Dr. Kennedy saw an endometriosis implant in the posterior cul-de-sac at the time of surgery and left it?

A Yeah. He said there were adhesions and he described -- he described endometriosis in several different places as being essentially widespread.

Q I don't believe that he referred to seeing any endometriosis in the posterior cul-de-sac, if I'm not mistaken.

A Somewhere in there, there was a specific comment that it was in the posterior cul-de-sac. The operative note, if I remember, said the anterior vesical vaginal region --

Q Right.
A -- but later on in some places, he said there was also posterior cul-de-sac, and it was more widespread.
Q I'm just looking for that operative note.
A May we take a break for just a few moments?
Q Sure.
(RECESS TAKEN FROM 10:23 AM UNTIL 10:31 AM.)
Q Before we took a break, Doctor, I believe that you were stating that Dr. Kennedy had described either in his operative report or in his deposition that he visualized endometriosis in the posterior cul-de-sac of Ms. Huston.
Can you point to me in either document where that description of his operative findings appears?
A Yes. Page 84, line 6.
Q Okay. And are you not referring to Dr. Kennedy's theory that he developed subsequent to Ms. Huston's death that that's where he believes that the cancer arose?
A Part is his theory about the cancer and where it arose, but part is also, I believe, his operative finding. In the pelvic endometriosis, in the posterior cul-de-sac. To me, that's a pretty clear statement as

to what he saw.

Q Is there any reference that he saw that or that he visualized that or that he was aware of that at the time of the surgery? Is there any statement that states that?

A It's in the absence. If he -- if he thought that this was a logical place where it could have arisen, but hadn't seen it, then he would have said, This is a tumor that he believes had arisen in endometriosis in the cul-de-sac which he had not been able to see at the time of surgery.

But the fact that he makes a clear-cut statement there that there was endometriosis in the cul-de-sac, I take as an operative finding.

Q By the way, do you know that he testified that there was cancer developing within the endometriosis of the ovary? Do you recall that he stated that in his deposition?

A I don't remember.

Q Okay. I'll show you page 39 when I asked him: *As you sit here today, do you believe that Mrs. Huston had cancer on April 29, 1999?*

Answer: *I do.*

This is at page 38.

And then I asked: *What type of cancer do*

you think she had?

And he says: *On that date or subsequently?*

And I say: *On that date.*

And he says: *I think she had cancer developing within -- in the endometriosis of the ovary.*

Were you aware of that testimony as you sit here today?

A May I see that?

Q Absolutely.

A Where is this again?

Q Starting on 38, with the part that's highlighted.

A May I take a moment?

Q Of course.

(WITNESS REVIEWS DOCUMENT.)

Q Do you recall reading that testimony when you read Dr. Kennedy's transcript?

A Yes, but during -- without reading all the antecedent pages, the question is: What was his thinking at the time on April 29 as opposed to what was his thinking later after he had seen the operative finding and he had done his thinking later.

Q Well, I have to disagree with you, Doctor,

because on April 29, 1999, Dr. Kennedy did not think that Mrs. Huston had cancer developing within the endometriosis of the ovary. That was his opinion when I deposed him.

On April 29, everyone was under the impression Mrs. Huston did not have cancer; isn't that true?

On April 29, 1999, the findings were to the effect that Mrs. Huston did not have cancer; isn't that true?

A I believe so, but there have been so many opinions back and forth, I -- 1 can't put all this together as to who thought what at the moment --

MR. **BONEZZI:** She's talking about after the operation on April 29 and after the tissue had been reviewed for purposes of pathologic interpretation was concluded, the overall total opinion was that Mrs. Huston did not have any type of malignancy.

THE WITNESS: That's correct.

Q (By Ms. Nissenberg) So this opinion about Dr. Kennedy believing that she had cancer developing within the endometriosis of her ovary was not his opinion on April 29, 1999. It was his opinion as I asked him, as I just related to you; isn't that true?

I say: *As you sit here today, do you*

believe that Mrs. Huston had cancer on April 29, 1999?

And that was his answer.

A Okay. That's his answer.

Q Okay. If Mrs. Huston had a IIC or a IIIC cancer in April of 1999, you would expect to have a positive peritoneal wash, wouldn't you?

A Based on my experience, probably, but certainly not always. Quite commonly, it's negative.

Q With a IIIC, it would be negative?

A I have seen it plenty of times negative.

Q Having read Dr. Tench's first report, do you disagree with any of his findings?

A May I see his first report?

MR. **BONEZZI:** You have it right there.

(WITNESS REVIEWS DOCUMENT.)

THE WITNESS: Now, your question was again?

Q (By Ms. Nissenberg) Having looked at the first of Dr. Tench's reports, do you have any disagreements with what he states therein?

A Yes, I do.

Q And what is that?

A In the second paragraph, he says that the patient has a high-grade cancer present in the uterus.

Q The uterus?

A Hysterectomy.

Q I'm sorry. He doesn't state *uterus.*

A Sure he does. Hysterectomy.

Q 1 think he's referring to the total abdominal hysterectomy with bilateral salpingo-oophorectomy that was performed in 1999.

A That's not what he said. But given -- given that may be the supposition, I would certainly disagree with it because I do not feel that there is any cancer in the ovary.

Let's see. The next sentence: "...contains malignant cells that were not diagnosed at that time...

That is -- you know, that's stated with a view to the past, and we've gone through that quite extensively. Based on the material that was present, regardless of what one thinks later on, it would be a mistake to call that a malignancy at the time, because if you did, that would lead to a tremendous number of false positive diagnoses of cancer.

And the last statement is -- I really don't have an agreement or disagreement with. That's a conclusion based upon the first two sentences.

Q Well, let me ask you then. Putting aside the fact that we're looking at this through a retrospective scope, which is true in any medical malpractice litigation, is the statement true that the pelvic washing cytology specimen obtained at the time of the surgery in 1999 contains malignant cells?

Is that a true statement or is that a false statement, in your opinion, having looked at the pelvic wash slides yourself?

A They may be malignant.

Q Now, do you -- I'm sorry.

A But you can only say that after you put together the entire case. It could not be said prospectively going forward. That would be an inappropriate diagnosis to call them malignant.

Q Have you had an opportunity to see Dr. Tench's supplemental report?

A Let's say 1 saw it, but I haven't had a chance to read it.

Q Okay. Would you please read it now and tell me with what you disagree.

(WITNESS REVIEWS DOCUMENT.)

A Let's go through this slowly. We'll start on the second paragraph.

He states, *There is a focus of cellular*

atypia in the B6 recut located in association with endometriosis which is highly suspicious for a malignancy.

I would agree that there is a focus of cellular atypia. I would not say that it is highly suspicious for malignancy. Based on my own experience, I have seen this any number of times and 1 have never diagnosed it as highly suspicious for malignancy nor have I seen these to go on to become cancer.

Q That's because the malignant transformation of endometriosis is such a rare event?

A No. The supposition is it's rare and the -- most of the endometriosis that you see is absolutely bland.

If you take only those cases with a very high degree of atypia, then I would expect of those cases only, the frequency of malignant transformation should be quite high. And in --

Q And -- I'm sorry.

A And in my experience, that is not the case.

Q And in fact, the right ovary -- actually, B6 is described as right fallopian tube and endometriosis and almost no ovarian tissue, correct?

If you recall from the original path

report?

A Right. And 1 think it was actually ovary and it had some fallopian tube.

Q On the final diagnosis, Doctor, it states: Right fallopian tube, salpingectomy -- that's B -- as well as above that, the right ovary B.

But when you look at the description, I believe that B6, which is the only aspect of the B slides or the B cassettes that deals with the ovary states: Fallopian tube, cyst wall with question mark, residual ovary,

Is that -- am I reading that correctly?

A I don't have it here, but --

Q Oh, I'm sorry.

A -- I'll assume you're reading it --

Q B6.

A Without re-reviewing the slide at this particular moment, when you have endometriosis and you have adhesions and you have fallopian tube and you have the ovary, it's not always easy to discern what exactly is in the ovary, what is in the fallopian. And so I would not particularly sit and quibble whether it's ovary, fallopian tube.

Q Right. But you've seen examples in which endometriosis has almost supplanted the ovarian tissue?

A Correct.

Q Okay. So are you through with the first sentence?

A Yes.

Q Okay. Next sentence of the second paragraph?

A Okay. Now, the second sentence, he is -- Dr. Tench is basing his opinion on the testimony of Dr. Biscotti --

Q Which you have not read.

A -- which I have not read.

Q Okay. So moving on. This again refers to Dr. Biscotti's testimony?

A Right. Anything that -- Dr. Biscotti says that there's a focus of cellular atypia in the original section that was more severe than in the recut.

Q And since you haven't seen the original of B6 and you haven't read Dr. Biscotti's testimony, you really couldn't comment fairly on that?

A Only to the extent that having seen thousands upon thousands of cases where there are recuts, you may find individual cells that would be more atypical, but I would be very surprised, as we discussed before, to find a tremendous gross discrepancy from cellular atypia on a one-cell layer to suddenly something that you would call highly suspicious of cancer or cancer in

the immediate next section.

Q But again, since you haven't seen the original B6, would you defer to Dr. Biscotti's testimony as to what he saw when he personally visualized that slide?

MR. **BONEZZI:** Objection. You can answer.

THE WITNESS: No, I'm going to reserve that until I actually see what his testimony is.

Q (By Ms. Nissenberg) Okay. If I've represented his testimony correctly, that in fact the original of B6 was much more dramatic and much more marked in the degree of atypia, such that according to Dr. Kennedy, he referred to it -- to Dr. Kennedy as a small focus of high-grade cancer, and since Dr. Biscotti is the only one that's seen the original B6 and you haven't, would you defer to his opinion with respect to what he saw when he personally visualized the original of B6?

MR. **BONEZZI:** Objection.

THE WITNESS: I would defer to his opinion as to what he saw, but having been in this situation any number of times of having seen, you know, highly atypical lesions and where we have had major conferences and disagreements, I would not -- I would not give weight to say that that is a malignant focus.

We've had, you know, great discussions where some people will say something is cancer and some will say it is not.

Q (By Ms. Nissenberg) Okay. In looking at the sentence that you were just referring to --

A Uh-huh.

Q -- *Given the presence of this focus in the original material, the standard of care would require that an intensive additional effort be undertaken to search for additional and more diagnostic foci of atypia*.

A There I would say no. Based on my experience, and this is where we're talking earlier of cases that show atypia, primarily large macronucleoli, we have followed those and it's uncommon to actually see those go on and become cancerous.

Q But you did tell us earlier that there are situations in which you get back to the surgeon or the treating physician and say, We probably need to look for something else here. Those situations exist, do they not?

A They do and that's on an individual consideration.

Q On an individual basis, correct?

A Yeah.

Q Okay.

A But the fact that he's used the words here does not mean that this would be one of the cases.

Q In your opinion, it wouldn't, of course?

A Well, no, you'd have to go back and ask Dr. Biscotti: Was that his opinion? You know, what would he do in that case, since he saw them? What was his degree?

Q Okay. That's more than fair.

Okay. What about the next sentence?

A Okay.

Q And this again is based on his finding that there were malignant cells.

A Right. And that I disagree with.

Q Okay. However, if you accepted his premise that there were malignant cells in the pelvic washing, would then the rest of his sentence be accurate?

A I take the second half of that sentence as being wishful thinking. He first states declaratively there are malignant cells present. That's -- that's his opinion. Then he goes on. He says, *If* -- and now he changes it to supposition.

Now, essentially, *if there were malignant cells,* he says, *then there should be additional other foci of cancer that should have been present*

and should have been identified.

Q So you disagree with that? You think that's wishful thinking?

A That's wishful thinking because that's -- that just doesn't happen in medicine.

Q Okay. And the last sentence in his opinion, that the atypical cells present in the B6 recut are morphologically similar to those seen in the pelvic washings, the vaginal biopsy and the small bowel excision, you obviously disagree with that?

A Let me read this.

Q I'm sorry.

A First, there's a factual error here that YOU will need to explain.

It is my opinion that the atypical cells present in the recut of S99-20450 -- that's an entirely new number, isn't that?

Q I don't think so. I think that's --

A There's the C99 --

Q That's the --

A -- 17617.

Q I believe the C refers to the --

A Cytology.

Q -- cytology.

A Okay.

Q This is the first recut of B6 that you've seen.

A Okay. Okay. *There are similarities in the vaginal biopsy and the small* **bowel** *excision.*

I would defy anybody to say that the cells present in the pelvic washings could be compared to the cells found in the tumor and call them similar. If he had a blind reading of these and had five different tumors and the pelvic washings, I suspect he'd have a very difficult time saying which belongs to which.

Q What about similarities between B6, the small bowel, and the vaginal biopsy?

A There are some similarities.

Q And in fact, Dr. Biscotti testified that the same process and the same adenosquamous carcinoma was seen in both the original B6 and the vaginal biopsy; isn't that true?

A Please repeat that.

Q And in fact, Dr. Biscotti testified that the same morphology, the same process and the same adenosquamous carcinoma were seen in both the original B6 and the vaginal biopsy. Do you recall that or --

A No, I haven't seen his --

Q Okay.

A But the comment is that there's a layer of cells on the endometriosis that has some features, but I would not go further than that. And I certainly wouldn't compare a single layer of cells to a nodule of tumor.

Q Would you disagree then with Dr. Biscotti?

MR. BONEZZI: Objection.

THE WITNESS: Again, I haven't read Dr. Biscotti, so...

Q (By Ms. Nissenberg) Okay. Assuming hypothetically that I'm correctly -- this isn't really hypothetical.

I'm representing to you that Dr. Biscotti testified that he saw adenosquamous in the same process in both the original B6 and the vaginal biopsy. Would you disagree with that?

A Yeah, that I would.

MR. BONEZZI: Objection.

THE WITNESS: There's no way that anybody would look at the ovarian slide, that B6, from the recuts I have, and call that adenosquamous carcinoma.

I think your comment is saying as he puts the whole case together, he's saying that could be.

Q Okay.

A But anyone looking at that one slide would

actually never call that adenosquamous whatsoever.

Q Dr. Biscotti testified that at the time he looked at the vaginal biopsy, and then he had B6 there. So it's after the 1999 surgery. It's in 2000.

A Right.

Q That at that time, it was his opinion and it is his opinion, that both show the same process and both show adenosquamous carcinoma.

Is Dr. Biscotti wrong?

MR. **BONEZZI:** Objection.

THE WITNESS: I would like to see the context that he's described that in.

Q (By Ms. Nissenberg) Okay. And in fact, he has seen the original B6 and you have not?

A Correct.

MR. **BONEZZI:** Objection.

Q (By Ms. Nissenberg) Now, you state in your opinion that the pelvic tumor -- I assume you're referring to the tumor that was biopsied in the year 2000, the vaginal biopsy -- was of a substantially different histologic type than the neoplasm in the right ovary.

What is that based on?

A Observation.

Q Okay. Now, you saw the recut of the right

ovary and you're saying that you really can't make a histologic determination.

A Please -- please -- let me have a copy of what I've written.

(DOCUMENT PROVIDED TO WITNESS.)

A Which paragraph?

Q it starts with *My review.*

A First thing, 1 think I have the slides backwards here.

Q You have the slides backwards?

A The slide.

Q The slide backwards?

A Because 1 think we said that the large ovarian tumor was left; is that not correct?

Q That's correct.

A Okay. So my report then has an error. so *My review of the ovarian fallopian tube and uterine specimens from 1999 confirm that the neoplasm in the right ovary was benign.*

That should be the left ovary.

Q Oh, that should be the left ovary?

A Yeah.

Q Okay. The left ovary was benign.

A Uh-huh.

Q Okay.

A Okay. And then we -- now we jump to the next sentence. The endometriosis that was present in the recut slides I reviewed from the left fallopian tube -- and I believe that should be right fallopian tube, correct?

Q Okay. That would be -- that would be the slide recut of B6, but you also, I'm sure, looked at the left side slide. So I don't know which one you're referring to. You want to correct that?

A I'd have to go back and re-look at the slides to double-check that.

Q Okay. But I believe that you state that whichever side you examined, it was a substantially different histologic type than the vaginal biopsy?

A Yes. The large ovarian tumor was a mucinous tumor -- it was a cyst and a mucinous tumor that was benign.

Q Okay. So what you're saying then, if I'm reading your report and what you're saying to amend it now, is that the histology of the cyst adenoma on the left, which was dominant mucinous and partly serous, is a different histology than the vaginal biopsy of June of 2000?

A Correct.

Q Okay. That goes without saying. What about

the right, even though you haven't seen the original? Can you state definitively that the histology of the B6 specimen and the original is different than the histology of the vaginal biopsy in June of 2000?

A There are some similarities. *It was a single layer of cells with large prominent -- a large prominent nucleus, distinct cytoplasmic borders* --

Q Okay.

A -- *and somewhat eosinophilic cytoplasm that had some morphologic similarity to that present in the vagina.*

Q So we almost need to redo that whole paragraph since you have the slides backwards and...

When you're referring to the different histology, you're referring to the left as opposed to the right, correct? You're referring to the left cystadenoma?

A Right.

Q Okay. Correct not right.

A And there was endometriosis on the right, and the endometriosis, most of it was just absolutely typical endometriosis. And there was a -- you know, an area of atypia that I would not --

Q Okay. But your statement that it was a different histologic type refers to the left side, not

the right?

A Correct. Correct. And even to the right side, I would not have linked the two.

Q And you also state in your report that the cells in the pelvic wash in retrospect share similarities with the cancer that later developed.

In what way did they share such similarities?

A That they were glandular.

Q Anything else?

A Without having seen them, but it was -- they were glandular. There were some mitoses and some large nucleoli. which could be present in any atypical smears.

Q And are those the only bases on which you state that in retrospect they share similarities with the cancer that later developed?

A I believe so.

Q And in fact, when you looked at the pelvic wash slides, you saw epithelial cells, didn't you?

MR. **BONEZZI:** Object.

THE **WITNESS:** That is correct.

Q (By Ms. Nissenberg) Are you aware, as you sit here today, that Dr. Gramlich testified that the pelvic wash slides were not absolutely benign?

MR. **BONEZZI:** Objection. He hasn't seen the

transcript.

Q (By Ms. Nissenberg) Are you aware that he testified to that?

A No.

Q Okay. Was there anything in Dr. Weiss's report with which you disagreed?

THE WITNESS: This is yours?

MR. **BONEZZI:** Uh-huh.

THE WITNESS: I'm going to take a minute and read his report.

(WITNESS REVIEWS DOCUMENT.)

(RECESS TAKEN FROM 10:58 AM UNTIL 11:03 AM.)

THE WITNESS: Your question was: Did I have any disagreements?

Q (By Ms. Nissenberg) Yes. And I recognize that you are not practicing as an ob-gyn. You said no amount of your clinical time you spend in ob-gyn. And you're also not a gyn oncologist. But with that proviso, do you have any disagreements?

A Let me disagree first with your supposition.

Q Okay.

A I am not a gynecologic oncologist nor do I treat the patients. But I do teach the gynecology residents. Much of the type of material that's here, we do discuss.

Q Okay.

A And based on the team approach that we have, I'm certainly familiar with a good deal of this.

Q Okay.

A My first disagreement is in paragraph 3 that begins, *The development of a vaginal mass discovered* --

Q *Diagnosed?*

A *Diagnosed.* Correct.

Q Okay.

A It's in the last sentence of that paragraph where it says, *The vaginal apex* -- well, *an endometria1 implant at the vaginal apex where the right ovary was adherent...*

I'm not sure that that was described in the record. The adhesions were *to* the -- if I remember -- the pelvic side wall and not to the vagina.

Q And if in fact Dr. Kennedy described either in his deposition or in the op report that it was also adherent at the vaginal apex, would you then still have the same disagreement with that sentence?

A Yes, because he says in the sentence above, "persistence of cancer." And I don't believe that the ovarian specimen with the endometriosis was a cancer.

Q I'm sorry. I think you are misreading that.

He says, "...persistence of cancer present in an endometrioid implant at the vaginal apex..." --

A Wait a minute. Let me read this.

Q -- which comports with your theory that there was already cancer in endometriosis in the posterior cul-de-sac or that region at the time.

A Right, That's -- that's my belief. But I took this sentence to mean that he said the right ovary was cancerous and it was a persistence of the ovarian cancer.

Q Well, I think, in all fairness, that you are only reading part of the sentence.

A Okay.

Q Because he says, "...cancer present in an endometrioid implant at the vaginal apex..."

A Right. But persistence -- it's the word *persistence*.

Q Well, if in fact your theory is correct, that it was present in April 1999 and it wasn't picked up until June or July of 2000, and it's the same location and it's the same cancer, wouldn't *persistence* be an appropriate word then? It wasn't a new primary. According to your testimony, it was there in April 1999.

A Right. It's an old -- it's an old -- okay.

Q So then that -- *persistence* might be appropriate?

A That's fine. As long as we're clear that we're talking -- it was a cancer that was present there before. Whatever words you want to use are fine.

Q Okay. I think you agree then.

A The next sentence, "The diagnosis of the original cancer in the right ovary..."

Q And by this he's referring to the original B6?

A Right. And I would disagree with that --

Q Okay.

A -- based upon the recut.

And then the word *negligent*. I mean, that's going to be a lawyer's term. That's my concern in that paragraph.

In the next sentence, "The pelvic washings...", again, we're talking about missing cancer cells found in review.

We've discussed this, that on a prospective basis, I think that would be inappropriate to call that cancer because that would mean many -- there would be many, many false positives in that.

Q So you don't disagree that cancer cells --

A I'm not sure we can call them cancer cells. We've said that they're, you know, atypical cells. You know, when you put the whole picture together, there may be the cancer cells. But 1 think that becomes a missing -- a moot point.

I think the intent of this paragraph really sounds like it's a gross negligent read of the slides, and 1 just disagree with that.

Q Well, that's your interpretation or your --

A That's correct.

Q -- inference that it refers to gross.

A That's correct, but you asked me what -- what do I disagree with. And that's how I --

Q Okay.

A -- interpret what he has said there.

Q Okay. And your major point is that you're looking back on it in review and not prospectively?

A That's correct.

Q Okay. So taking out the word *negligently,* which is a legal term in this sense, you don't disagree that they were misread prospectively, you just disagree --

A As I said, if I were reading that, the slide, I would not have even identified anything particularly wrong. So I do -- you know, I am concerned by that

whole concept.

Q Let me restate it. You disagree that they were misread prospectively?

A Correct.

Q Okay. The last sentence?

A That I agree with.

Q Okay.

A Now, let's go to the discussion.

Q Discussion.

A I have a number of problems with the first sentence of the discussion. Dr. Weiss speaks of *correctly diagnosed.* If -- let me take a second.

(WITNESS REVIEWS DOCUMENT.)

A I really find the problem with the word *correctly.* I mean, if a diagnosis for cancer had been made at the time of the initial surgery, of course the patient would have had some earlier further treatment. What it would be, how effective it would be, would be another matter that we'll get to. But I disagree with the problem of *correctly* because I don't think that it was incorrectly diagnosed.

Q Based on what you've already testified to?

A Right.

Q Okay.

A Okay. "The surgical stage of her ovarian

cancer...'' I've already stated I don't think that this is an ovarian cancer. Okay. And therefore, it's not a Stage IC.

I believe that this was really a higher grade lesion. And as a higher grade lesion, the survival would drop down quite dramatically for Stage II -- you know, Stage II, Stage III. We're talking of a survival probably in the range of -- somewhere in the range of 20 or 30 percent to 50 percent, possibly.

The next sentence, "The defendants' failure to make a timely diagnosis..." Well, again, if I were the surgical pathologist, there is no way that I could have made a diagnosis, and therefore, the word *timely* becomes meaningless. And "beneath the standard of care'' is, you know, a legal concern.

"The failed diagnosis..." Well, I couldn't have made the diagnosis. Obviously, if someone had made a diagnosis -- if someone could have said that this was a cancer, of course there would have been a 16-month earlier treatment, but I'm not sure even with that, whether the next part of the sentence would be pertinent. It says "...at which time she had advanced disease with little chance of cure."

My feeling is that this is a Stage II -- if you use the ovarian or peritoneal -- Stage I? or Stage III tumor, in which case it is already advanced at the time *of* the initial surgery. And **I** don't want to say little chance of cure, but certainly the cure rate is nothing close to what ehe -- Dr. Weiss has said.

"The tumor was refractory to treatment..." is his statement. I will leave that to the gynecologic oncologist, but just watching the course, I mean, this extraordinarily rapid course and the drugs that she received, my supposition is this is a highly refractory cancer whether she was treated back in 1999 or 2000. But in that I would defer to the clinician, to the gynecologic oncologist.

And the rest of that sentence, I will leave to the gynecologic oncologists who are dealing with the palliation and complications.

Q Okay. What are -- I'm sorry. I thought you were done.

A No. There's another paragraph on page 2.

Q Oh.

A It says, "Mrs. Huston was a healthy woman..." The definition, you know, obviously is what is

"healthy"? I think all of us are like leaky pipe systems and we don't know whether one day it's going to be the heart or a bone or prostate cancer or accident.

So outwardly, you know, certainly I will take that she's healthy. If she has a cancer that's already Stage II or Stage III at the time of the operation, she's not healthy. So take your pick. Is the cup half full or half empty, depending if you're looking at her from the outside or from the inside.

And the same issue, a Stage IC in the 60 to 80 percent. I believe she's higher stage already. And a normal life expectancy, obviously, would follow. If she has a higher stage tumor, it's going to be less.

Q If hypothetically she were a Stage IC, then would you agree with the statements Dr. Weiss makes in that respect?

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

THE WITNESS: If she were Stage IC, which I would interpret him meaning or your hypothetical question meaning, that this was truly an ovarian cancer that had fluid and nothing else, just with, you know, ovarian statistics, 60 to 80 percent would be

reasonable.

But the fact that she had the recurrence in the manner that she did is unlike an ovarian cancer, so...

Q (By Ms. Nissenberg) Well, hypothetically, you used the ovarian staging system even though you thought it was in the endometriosis implant.

A Right.

Q So if she were a IC using the ovarian system, FIGO system --

A And this were truly an ovarian cancer and the only spread was the fluid, yes, I would say that she --

Q What, hypothetically, if she were having this cancer in the endometriosis implant in the posterior cul-de-sac or similar region, and she were truly a IC, using that staging system --

A Then she would --

MR. **BONEZZI:** Objection.

THE WITNESS: I'm sorry.

MR. **BONEZZI:** Objection. I mean, that doesn't make sense.

Q (By Ms. Nissenberg) Well, it makes sense because you're saying that even if it's in the endometriosis implant, you're going to use the ovarian staging system hypothetically.

MR. **BONEZZI:** Objection.

THE **WITNESS:** What I'm saying is if it's in an implant and it's, you know, not in the ovary --

Q (By Ms. Nissenberg) Uh-huh?

A -- then she would have already had wider spread. So I would consider that a higher stage tumor.

Q Okay. And what bases do you have for your opinion that it was in the endometriosis implant as opposed to the ovary?

A I don't see the cancer there in the ovary.

Q I'm sorry?

A I don't see cancer in the ovary.

Q In the recut?

A In the recut. Second, the ovarian tumor -- let me restate this.

Let us take a hypothetical. Let us say it's cancer. Okay. There's cancer in the ovary hypothetically. Certainly, a minimum amount of cancer because this ovary has been looked at grossly. They've opened it. They've sectioned it. So there was nothing, you know, overtly cancer. It would be a microscopic cancer.

The surgeons have now removed the ovary. So the only thing that is present in the patient immediately after the finishing of the operation is

the fluid. You just don't see a person that has fluid getting a 5-centimeter tumor and getting lysis and destruction of the anterior pubic symphysis. That doesn't -- it doesn't happen.

Q Well, you've heard of the term *apparent complete resection?*

A I can imagine what it means.

Q Okay. And wouldn't you agree that the surgeon, while he may feel that he's removed all the cancer, can leave microscopic disease behind? You would agree with that theory, would you not?

A Oh, sure. Absolutely. But microscopic tumor left behind would not give this kind of a recurrence.

Q *If in fact the cancer were in an endometriosis implant in the ovary or on the ovary, not adhesed to the peritoneal wall, then that would account for the dropping of the cells into the pelvic wash if they were malignant, correct?

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

(*READ BACK.)

THE **WITNESS:** That's one possibility.

Q (By Ms. Nissenberg) And if in fact the cancer were, as I've suggested, in an endometriosis implant in or on the ovary, then could you stage it in

April of 1999?

A Repeat the question.

Q If in fact the cancer were in the endometriosis implant -- in an endometriosis implant in or on the ovary, then how would you have staged it or how would you stage it now retrospectively in April of '99?

A I think we've gone through that much earlier in this deposition when you asked how do I view cancer that arises in endometriosis in the ovary as opposed to an ordinary cancer that arises in the ovary without endometriosis. They would be staged similarly, the same way. They would be using the ovarian tumor classification system.

Q Okay. Would you agree that the final pathology reports for 1999 should have included the findings of atypia -- let's -- let me strike that.

Let's talk about the surgical pathology report. Would you agree that the final report needed to mention the atypia that Dr. Biscotti has described in B6?

A The answer --

MR. **BONEZZI:** Objection. Go ahead.

THE WITNESS: The answer is no, because based upon my review of the slides and my ordinary practice,

I would not have remarked on it.

Q (By Ms. Nissenberg) Now, directing your attention to the pelvic wash slides, would you agree that the final report should have included a reference to either the atypical cells the fact that they were epithelial cells, the fact that there were atypical cell clusters, the fact that there were irregularly shaped nuclei, the fact that there were mitoses? Do you think that any of those should have been included in the final report for the surgeon's benefit?

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

THE WITNESS: If they had been seen. We've gone through this multiple times already. I reviewed the slides initially knowing that there was a cancer. I mean, so this was not a routine type of a case that I might see, But it's knowing that there is a lawsuit, so I know that there has to be a tumor and it's -- obviously, behooves me to look more carefully. With that knowledge, I still did not see anything present.

So your answer is: Should it be? If one sees it, obviously, it should be there. I don't think this is easily to see.

Q (By Ms. Nissenberg) Assuming that the cytotechnologist put dots on the slide to point out the

atypia that Dr. Brainard then looked at when she saw the slides, should that atypia have been included in the final record for the surgeon's benefit?

A You've asked a very compound question and I may break it down.

Not uncommonly, the cytotechnologist will put dots. That's their role, to find what they think are atypical areas. It is then the role of the cytopathologist to decide whether that is atypical or not. And that is a judgment call on the pathologist.

And quite commonly, we'll decide it is -- you know, they are not atypical, and in that case, there may be no comment made whatsoever.

Q Well, you're assuming that the cytopathologist has correctly read the pelvic wash slides in your answer, correct?

A Obviously.

Q if the cytopathologist missed the atypia, I wouldn't expect her to report it or him to report it, correct?

A Right.

Q If the cytopathologist sees atypia, would you, in your practice here at Duke, expect the pathologist to -- cytopathologist to include it in the

final report?

MR. **BONEZZI:** Objection. Go ahead.

Q (By Ms. Nissenberg) You can answer.

A Yes. If a degree of atypia is seen that is worthwhile to note it, it would be noted. Not uncommonly, there's slight degrees of atypia. They just decide they don't mean anything and they're not reported.

Q If in fact the cells seen in the pelvic wash were reported to Dr. Gramlich not what you -- or Dr. Levin not what you would expect to see in a pelvic wash slide?

I believe Dr. Levin testified to that. It might have been Dr. Gramlich.

MR. **BONEZZI:** No, Dr. Levin is not a cytopathologist.

Q (By Ms. Nissenberg) Okay. Sorry. It was Dr. Gramlich. I'm sorry.

If in fact the pelvic wash slides revealed cells that you would not expect to see in a pelvic wash slide, should those findings have appeared in the final report?

I'm referring to --

A I understand. You're making it very black and white.

Q Well, if the slide showed atypia, if the slide showed irregular nuclei, if the cells -- if the slide showed atypical cell clusters, at Duke would those be reported in the final report by the cytopathologist?

A If someone saw them and saw, you know, sufficient amounts, they might. But again, I had to sit down and spend probably 20 minutes to find -- I think there were a total of two mitoses. And that is not the way the slides are read.

Q Okay. I'm not asking how long it took for you to find it.

A Right.

Q My question is: If these were seen, did they belong, these findings, in the final report? Not whether or not they could have been seen. Not how long it took you to find them.

Assuming that these were seen, hypothetically, wouldn't they belong in the final report and aren't they put in the final report at Duke, especially in a patient who's presenting for pelvic masses of unknown etiology?

MR. BONEZZI: Objection. Go ahead and answer.

THE WITNESS: I'm not sure that I can answer

that.

Q (By Ms. Nissenberg) Okay. At Duke, are you telling me that the standard is not to report the findings that I've just described to you if they are seen by the cytopathologist?

MR. **BONEZZI:** Objection.

Q (By Ms. Nissenberg) Is that the standard here?

MR. **BONEZZI:** Objection to what the standard is here. Go ahead and answer.

THE WITNESS: Yeah, I'm not sure I can really answer that.

Q (By Ms. Nissenberg) Okay. So you can't tell me as you sit here today, whether or not when you teach pathology residents -- and I assume that you do --

A Right.

Q -- whether or not you tell them that if you see personally cells that don't normally belong in a pelvic wash, epithelial cells and/or atypical cells and/or atypical cell clusters and/or irregular nuclei, you don't teach them to include that in the final pathology report for the slides?

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

THE **WITNESS:** The way I take your question is

you're talking about degrees. Not uncommonly some of these findings are found and they are ignored.

Q (By Ms. Nissenberg) Do you think it was appropriate to not recognize these findings at the time?

MR. **BONEZZI:** Objection.

THE **WITNESS:** I've told you multiple times that I would not have seen them.

Q (By Ms. Nissenberg) Assuming that they were seen though, you can't say as you sit here, that they should have been reported out to the surgeon?

A If they were seen and if the person who saw them thought that they were significant, they would be reported. Those are two big *ifs*.

Q And as far as the ability to see them, would that depend at all on the training or experience of the cytopathologist?

MR. BONEZZI: Objection.

THE **WITNESS:** I would -- yeah, I would say yes.

Can I ask a question? Because you're just asking that as a blank yes or no. Are there any qualifications on your last question?

Q (By Ms. Nissenberg) No.

If in 1999 the surgical specimens had been

read out as showing cells suspicious for malignancy, or as Dr. Kennedy said Dr. Biscotti told him, showing a small focus of high-grade cancer, what recommendations, if any, would the pathologist make back to the treating surgeon?

A You've just given me two choices that are so far apart, I couldn't even start to answer.

Q I'll break it down.

A Break it down.

Q If in 1999 the surgical specimens showed cells suspicious for malignancy, what would the pathologist recommend to the treating surgeon, if anything, with respect to the patient?

A In the pelvic wash or the --

Q The surgical specimens or pelvic wash.

A Probably would recommend nothing. It's -- he would just make the statement and there would be no recommendation.

Q So he wouldn't recommend specific steps to take next to ascertain whether or not there's frank malignancy anywhere?

A No. Well, he would have said by the statement in the ovary -- if he had said there was suspicion. But the fact it was a pathologist who had the ovary and had already examined it fairly

thoroughly, there could be a suspicion that there is no cancer there because that's been examined.

For the fluid, on the other hand, if someone said there's suspicion of cancer, then this would be thrown back to the clinician to think about what other possible sources. Could this be from the stomach? Could it be from the lung? Could it be from some other area that's throwing off a cancer?

Q Could be from an endometriosis implant, could it not?

MR. **BONEZZI:** Objection.

THE WITNESS: It could be from anything. It could be benign. It could be irritation. It could be chemical.

Q (By Ms. Nissenberg) So if in fact the pelvic wash would have been read out hypothetically as showing cells suspicious for malignancy, if the pathologist who read the surgical specimens was confident that there was no cancer in those specimens, as we discussed earlier today, then in fact the pathologist or the clinician would look elsewhere for the primary site, correct?

MR. **BONEZZI:** Objection.

THE WITNESS: The person would look elsewhere, but much of the looking is generic so

it's -- it's not that you're specifically looking at a specific organ. You would just start a potential, very mild workup for cancer.

Q (By Ms. Nissenberg) Right. But in this case where the patient had no clinical evidence of disease outside of the pelvis --

A Right.

Q -- everything else was negative, both on clinical exam and through any diagnostic procedures, you would look for the gyn source first, would you not?

A Well, we've already removed all the gyn organs.

Q Well, you've left -- no, you've not done a radical hysterectomy. You've done a total abdominal hysterectomy. So you've left gyn tissue behind in this patient, correct?

A If any surgeon went ahead and did a radical after that, he would be brought into a court immediately for negligence.

Q I'm not suggesting that Dr. Kennedy should have done a radical. I'm just --

A No. No. I understand that.

Q Okay.

A I'm saying the question as it's asked is inappropriate. That would be absolutely inappropriate.

And it would be unheard of for a cancer to occur in the paracervical soft tissue after the hysterectomy has been done. It would just be unheard of.

Q The point is that there was gyn tissue left in this patient after the surgery.

A Not in my sense, no.

Q You don't consider the vagina to be gyn?

A The patient's already had a pelvic exam and nothing was seen there. You might do a pap smear which would just be in the routine course. But you would not go back and do a vaginectomy or --

Q I don't know how you got on this subsequent surgical bent, but my question is --

A You brought up the --

Q No. My question originally was: If the pelvic wash slides were positive, were correctly -- or let me strike that.

If hypothetically the pelvic wash slides were correctly read as positive, but the surgical specimens that had been submitted were negative and the pathologist was confident that they were correctly read out as negative, then wouldn't the treating physician look for a primary site elsewhere starting with the gyn area?

And you said it was all gone. And I'm

disagreeing with that since it wasn't a radical. I'm not saying you should have done a radical.

A Okay.

Q Okay. Wouldn't the treating surgeon in this case have looked for another site beginning with the gyn tissue that was remaining in this patient, if in fact what was removed didn't show any cancer?

A First, you slipped in the word if the -- if the cytology was positive.

Q I said hypothetically if it was correctly read as showing malignancy. Okay.

A But regardless. No, I don't think so. I think the surgeon would be puzzled and wonder what is the source. I do not think that the surgeon would look and say this is something within the gynecologic tract.

Q You're aware that Dr. Kennedy testified that Mrs. Huston had no evidence of cancer, endometrial cancer, tubal cancer or peritoneal cancer, any evidence of that? Do you remember that testimony?

MR. BONEZZI: Objection.

THE **WITNESS:** Vaguely, but I would go back and reread it. But continue on, please.

Q (By Ms. Nissenberg) Well, that was my question, that he didn't feel that there was any evidence of peritoneal cancer, tubal cancer or

endometrial cancer, Do you remember that? But getting back to my other question, is it your testimony that if Dr. Kennedy was told that the pelvic washings were positive for malignancy -- this is my hypothetical -- but that the surgical specimens absolutely did not show any cancer, did that --

A Let me just stop you there to make sure I'm reading what you're saying.

Q Thank you.

A That first he's being told that the pelvic wash -- you know, the cell block or the wash, whatever you wish -- actually has cancer, not suspicious, but has cancer --

Q Okay.

A -- and he has done his operation and knows that there's nothing there that he has seen. That's -- I'm just trying to repeat what you have said to me.

Q No, the second part of that was that he's been told that the 'surgicalspecimens that he removed --

A Right.

Q -- that were sectioned, those sections didn't show any cancer.

A Okay.

Q Is it your testimony that Dr. Kennedy, if you

know what a gyn oncologist would do, would not have then looked for another source for a primary within the gyn tract for this patient first?

A I think, based on the experience from our clinicians, he would start looking or thinking about cancer from any source, which could include anything that might be left back in the gynecologic tract after the organs had been removed or from some other source.

Q Would you agree that with an oophorectomy, any suspicious lesions should be submitted for microscopic examination?

A If I understand the intent of that, yes.

Q Wouldn't you agree that positive pelvic washings and dense ovarian adhesions are two very important clinical pathologic findings with respect to gyn cancer for a patient?

A I don't understand the intent of what's being asked there.

Q Obviously, positive pelvic washings are significant in terms of clinical pathologic relevance?

A Right.

Q Okay. Are you aware or do you agree that dense pelvic adhesions share the same significance from a clinical pathologic standpoint?

A No, I don't.

Q You don't agree?
A As you've asked the question, no, I don't.
Q Okay. Well, do you want to change the question in any way, if you don't like the way I asked it?
A Yeah. Any time that I -- that there are dense adhesions, you obviously wonder what's causing the adhesion. You certainly think about it. You just don't blandly pass it by. But it doesn't particularly mean there's a cancer. It could be inflammation. This lady certainly had a Dalkon shield in the past. So you just wonder what are the other thoughts. So you just give some extra thought to it.
Q There was no evidence of pelvic extension of this disease back in '80 -- I mean '99 -- excuse me -- was there?
A What do you mean by "pelvic extension."
Q What's your understanding of that term?
A That's what I was asking you. It's a very vague term. If someone said, Is there pelvic disease? You know, there's multiple foci; there's scarring; there's -- what he means -- what he calls endometriosis, which could be seen as probably multiple fibrotic deposits. To me, that's -- and if that were all cancer, that's extension. It just means that there

are multiple areas that are abnormal.

Q So using the ovarian staging, for example, as you applied it before, pelvic extension of disease would be a Stage II, correct?

A IIC in the pelvis.

Q And would you agree the patient's diagnosed with early stage ovarian cancer -- I'm sorry.

Patients diagnosed with early stage disease confined to the ovary or pelvis demonstrate a five-year survival rate of 80 percent?

A No.

Q So if that appeared in one of your pathology texts, was that an error?

A It depends -- again, we're playing like a scholar here. If it's ovarian and confined to the ovary, it's one stage. You used the word "pelvis."

To me, "pelvis" can also mean that you have tumor that's spread throughout the pelvis or it's in multiple areas. So then you suddenly change, if you're using an ovarian classification, from a stage, potentially, like a IA to a Stage IIC. Big difference. So we'd have to dissect exactly how you're using the words each time.

Q Well, early stage disease would not refer to a IIC, would it? This is your language.

A I'm sure.
Q Early stage disease does not refer to a Stage IIC, does it?
A Generally not.
Q Okay. So when you state: *The patients diagnosed with early stage disease confined to the ovary or pelvis demonstrate a five-year survival rate of 80 percent,* is that incorrect?
A Show me what I've stated there, please.
Q Chapter 19, page 532.
A I presume you're talking about my book?
Q I am.
A Can you show me because --
Q Okay.
A May I take a break for a moment?
Q Yeah.
(RECESS TAKEN FROM 11:39 AM UNTIL 11:41 AM.)
Q (By Ms. Nissenberg) I was showing you, I believe -- did I get to it? It's 532 in your prognosis and treatment under "Malignant Lesions," the part that I've underlined.
A Which chapter is this? What --
MR. **BONEZZI:** Chapter 19.
THE WITNESS: Chapter 19. So we're dealing with ovarian tumors. Show me where you want me to

read.

Q (By Ms. Nissenberg) I was just asking if this statement is correct, the part that is underlined which is the quote that I gave you.

(WITNESS REVIEWS DOCUMENT.)

A Good. I'm ready.

Q Is that still your opinion?

A This is a generic statement, so for purposes of this trial, you have to define what we mean by "early stage disease," you know, in the pelvis.

Even under the FIGO system, early stage disease -- and in a case like this could be, you know, potentially ovary just touching the fallopian tube, which makes it a Stage II, which would have a very different prognosis than a tumor that's more extensive.

So -- and this is also generically for all -- you know, for all lesions. And on top of that, we're talking -- well, this is the whole gamut of ovarian tumors, including those that are malignant, but low -- you know, low order malignancy.

So you cannot take a statement like this and apply it directly to a case like this.

Q So you're -- I'm sorry. You're including LMP

tumors in this statement?

A I think this is for -- no, I don't think the LMPs are in here.

Q Because they wouldn't appear under a subsection entitled "Malignant Lesions"?

A But there are, you know, whole ranges of tumors, like the granulosis cells, which are also lower orders that would be considered malignant lesions but have a very high prognosis rate.

So you've picked something up out of one chapter that's a generic about all ovarian tumors and trying to apply it to something very specific.

Q And you can have malignant degeneration of an endometriosis implant and another mass in the ovary; isn't that true?

A Well, certainly.

Q And some malignant degeneration of endometriosis is a very slow process while others are quick or faster; is that true?

A Some are faster, but I suspect almost all these tumors are slow in the development.

Q And when do you think Mrs. Huston's cancer was first diagnosable?

A It's a very tough question. With all the skills that the clinicians had and the pathologists had

where he thought it was in April of '99 and what stage he thought it was, if he could stage it. But he has not told me when it was first diagnosable.

MR. **BONEZZI:** You then asked the question as it related specifically to pathology and I indicated that he has been talking about the pathology for two and a half hours.

MS. **NISSENBERG:** But he hasn't answered this question nor have I asked it.

MR. **BONEZZI:** Yes, you have.

Q (By Ms. Nissenberg) What answer did you give when I asked it before, Doctor? When was this cancer first diagnosable? Because I missed the answer if I asked it before.

A It certainly wasn't at the time of 1999 because --

MR. **BONEZZI:** She didn't ask you because. She asked you when it was diagnosable.

THE WITNESS: I know it. I know it. I mean, it's -- it would be sometime between then and the year 2000. I can't give you an answer.

Q (By Ms. Nissenberg) Okay. Well, was it diagnosable by June or July of April -- of 1999?

MR. **BONEZZI:** Objection.

THE WITNESS: It certainly was not by

April of '99.

Q (By Ms. Nissenberg) Well, that's what you've already said. It was not diagnosable at the time of the surgery.

A Right.

Q Between then and June of 2000, when did it become diagnosable, in your opinion?

A I couldn't even start to give you an answer.

Q And you can't say how differentiated the endometriosis cancer was in April of 1999, can you? You cannot tell me the degree of differentiation since nobody saw it in April of '99, correct?

A Having seen many, many adenosquamous tumors, you know, that have occurred and then reoccur over a period of time, they don't get worse because they start out very badly, you know, very poorly differentiated.

Given that we've seen two -- in this lady, two biopsies with adenosquamous, my impression is that the adenosquamous that she had early on and whenever it began was as poorly differentiated then as it was when she had the vaginal recurrence and as the small bowel tumor.

Q You've never seen these tumors de-differentiate over time?

A No, because they're bad at the beginning.

Q But you don't know personally because this tumor was not excised, resected, analyzed or anything else?

A That's correct.

MS. NISSENBERG: Okay. I think I'm done.

(PAUSE.)

MS. NISSENBERG: I am done.

MR. BONEZZI: We will read.

MS. NISSENBERG: Thank you very much.

MR. BONEZZI: I'll take a copy, please.

(DEPOSITION CONCLUDED AT 11:49 AM.)

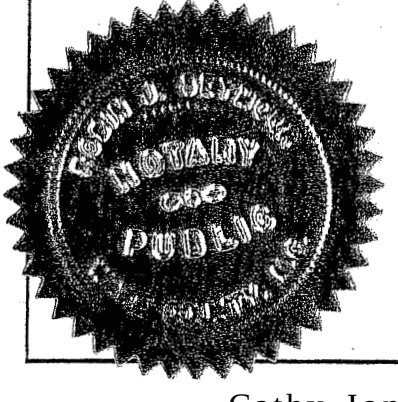
(SIGNATURE RESERVED.)

CERTIFICATE

I, ROBIN J. SEYMOUR, a Registered Professional Reporter and Notary Public in and for the State of North Carolina, do hereby certify that there came before me on June 18, 2002, the person hereinbefore named, who was by me duly sworn to testify to the truth and nothing but the truth of his/her knowledge concerning the matters in controversy in this cause; that the witness was thereupon examined under oath, the examination reduced to typewriting by me personally; and the transcript is a true record of the testimony given by the witness.

I further certify that I am neither attorney or counsel for, nor related to or employed by, any attorney or counsel employed by the parties hereto or financially interested in the action.

IN WITNESS WHEREOF, I have hereto set my hand and affixed my official seal, this the 21st day of June, 2002.



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PERSONAL & CONFIDENTIAL

March 6, 2002

Stanley J. Robboy, M.D.
Department of Pathology
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Durham, North Carolina 27'710

Re: Patient - Connie Huston, Deceased
E/O Huston vs. The Cleveland Clinic
BSMP File No. 240143

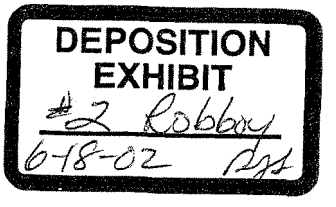
Dear Dr. Robboy:

First of all, I wish to thank you for your willingness to review the enclosed slides and records on behalf of my client, The Cleveland Clinic Foundation (CCF} I am currently defending CCF concerning a suspected primary ovarian cancer. I use the term "suspected", since it is uncertain whether the Decedent did, indeed, have a primary ovarian carcinoma. The following information details The Clinic's interaction with Connie Huston, Deceased.

Mrs. Huston was a 54 year old, white female, who presented to the Clinic in April of 1999. On Aprit 29, 1999, she underwent a surgical procedure performed by Alexander Kennedy, M.D., wherein he performed a total abdominal hysterectomy, with a bilateral salpingo-oophorectomy. Prior to the actual removal and subsequent to entering the peritoneal cavity, Dr. Kennedy obtained fluid, which was sent to Pathology/Cytology for interpretation of the pelvic washing. Also sent to Cytology was a thin prep.

Intraoperatively, a portion of ovarian tissue was sent to Pathology for an intraoperative interpretation. I am enclosing a copy of the pathology report for your perusal, which concludes with information pertaining to the "frozen section", which was interpreted as benign, Ultimately, the tissue removed, which was placed in cassettes A and B, was reported out as being benign. Mrs. t-iuston left the Clinic, and did not return until June of 2000.

Approximately 11 months later, i e , in March of 2000, and while at an aerobic class, Mrs Huston started to have back pain She was seen by her family practitioner, who felt that her concerns were related to lumbosacral strain However, in June of 2000, as a result of vaginal bleeding, she presented to the Clinic's ER. Ultimately, a vaginal biopsy was obtained, and this specimen was interpreted as being positive for an adenosquamous carcinoma of the vagiria



Eventually, it was thought that Mrs. Huston had a primary ovarian cancer. As a result, on July 13, 2000, Mrs. Huston was seen by Maurie Markman, M.D., a Medical Oncologist wifh a subspecialty in Gynecologic Oncology. Dr. Markman felt that Mrs. Huston might benefit from chemotherapy. Carboplatin was administered (x1), and then she received Taxol on two other occasions. The chemotherapy received did not provide any relief. Dr. Markman has informed me that he felt that Mrs. Huston's carcinoma was refractory to any treatment. Mrs. Huston died on September 9, 2000.

In conversing with many of the physicians at the Clinic, and specifically Alexander Kennedy, M.D., I am now of the belief that Mrs. Huston did not have a primary ovarian tumor. It is Dr. Kennedy's absolute belief that Mrs. Huston suffered from a "neoplasm arising from endometriosis". After Dr. Kennedy provided this information to me, I reviewed *"Blaustein's Pathology of the Female Genital Tract (3rd Ed.)"* to familiarize myself with this phenomenon. In further discussion with Dr. Kennedy, it is his belief that the progression, or transformation, of the endometriosis into the neoplasm occurred in the posterior cul-de-sac. I have spoken with Charles Biscotti, M.D., at the Clinic, Head of the Department of Cytopathology, to confirm that the biopsy obtained of the vaginal cuff in June of2000 indeed demonstrated an adenosquamous component. Dr. Biscotti confirmed this.

I have enclosed the following for your review:

1. 04/29/99: Specimen S99-20540 (recuts);
2. 04/29/99: Specimen C99-17617 (original slides);
3. 06/13/00: Specimen S00-30398 (recuts);
4. 08/11/00: Specimen S00-41742 (original slides ?);
5. Connie Huston's CCF chart; and
6. Plaintiff's expert reports authored by William D. Tench, M.D., and Regis J. Weiss, M.D.

Our expert reports are due in this case on April 1, 2002 I look forward to meeting with you on Tuesday, March 19, 2002, lo discuss this case.

I await your reply.

Very truly yours,

William D. Bonezzi

WDB/mmk
Enclosures

(Federal Express Overnight Delivery)