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**DEPOSITION OF WILLIAM TENCH, MD 6/19/02 HUSTON VS THE CLEVELAND  
CLINIC**

**PETERSON & ASSOC. COURT REPORTING, INC.**

**Page 1 to Page 78**

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CONDENSED TRANSCRIPT AND CONCORDANCE  
PREPARED BY:

*PETERSON & ASSOCIATES COURT REPORTING, INC.*  
*530 B STREET*  
*Suite 350*  
*San Diego, CA 92101-*  
*Phone: 619-260-1069*  
*FAX: 619-688-1733*



## Page 1

[ 11] IN THE COURT OF COMMON PLEAS  
 [ 21] CUYAHOGA COUNTY, OHIO  
 [ 31]  
 [ 41]  
 [ 51]  
 [ 61] JOHN M. HUSTON Executor. )  
 [ 71] Plaintiff. )  
 [ 81] vs. ) CASE NO. 439194  
 [ 91] THE CLEVELAND CLINIC )  
 FOUNDATION, et al., )  
 [101] Defendants. )  
 [111]  
 [121]  
 [131]  
 [141] DEPOSITION OF WILLIAM D. TENCH, M.D.  
 [151] ESCONDIDO, CALIFORNIA  
 [161] JUNE 19, 2002  
 [171]  
 [181]  
 [191] REPORTED BY PATRICIA Y. SCHULER, RPR, CSR NO. 11949  
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[ 11] APPEARANCES:  
 [ 21] For the Plaintiff  
 [ 31] MEREL GREY NISSENBERG  
 ATTORNEY AT LAW  
 [ 41] 1200 Prospect Street  
 Suite 550  
 La Jolla, California 92037  
 [ 51] For the Defendant  
 [ 61] BONEZZI, SWITZER, MURPHY & POLITO  
 [ 71] BY: WILLIAM D. BONEZZI, ESQ.  
 [ 81] Leader Building, Suite 1400  
 526 Superior Avenue  
 Cleveland, Ohio 44114  
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## Page 2

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 [131] DEPOSITION OF WILLIAM D. TENCH, M.D.,  
 [141] taken on behalf of the Defendant, at 555 East Valley  
 [151] Parkway, Escondido, California, on Wednesday, June 19,  
 [161] 2002, at 5:55 p.m. before Patricia Y. Schuler, RPR.  
 [171] Certified Shorthand Reporter, in and for the County of  
 [181] San Diego, State of California.  
 [191]  
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 [ 5] By MS. NISSENBERG 75  
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[1] WILLIAM D. TENCH, M.D.,  
[2] having been first duly sworn, testified as follows:  
[3]  
[4] EXAMINATION  
[5] BY MR. BONEZZI:  
[6] Q. Let the record show that this is the  
[7] deposition of Dr. William Tench, who has been identified  
[8] as an expert in the case of Huston, H-u-s-t-o-n, versus  
[9] the Cleveland Clinic Foundation.  
[10] Dr. Tench, I am going to be asking you some  
[11] questions this afternoon pertaining to opinions that you  
[12] have authored on two separate occasions.  
[13] First, the letter is dated February 27, 2002;  
[14] the second of which is May 30, 2002. If at any time I  
[15] ask you a question that, first of all, you don't  
[16] understand, at the conclusion of my question - if you  
[17] would be so kind as to wait and then tell me you didn't  
[18] understand it, I will do my best to rephrase: is that  
[19] fair?  
[20] A. That's fine.  
[21] Q. If I ask you something that you don't have an  
[22] answer to, I don't want you to guess, speculate  
[23] hypothesize engage in conjecture. Just tell me you  
[24] don't know and I will move on. How's that?  
[25] A. That sounds good to me.

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[1] Q. If you would continue doing exactly what you  
[2] are doing; that is, speaking in an audible fashion in  
[3] response to a question, I would appreciate it. More  
[4] importantly, the court reporter will appreciate it.  
[5] A. I will do that.  
[6] Q. Would you give me your full and complete name  
[7] together with your business address, please.  
[8] A. My full name is William David Tench. The  
[9] business address is Valley Pathology Medical Associates.  
[10] The address for this institution is 555 East Valley  
[11] Parkway, Escondido, California.  
[12] Q. And how long have you been here?  
[13] A. I have been here since 1985.  
[14] Q. Do you currently hold any type of appointment  
[15] in this department?  
[16] A. I have previously been the chief of the  
[17] anatomic service. I resigned from that position at  
[18] about this time last summer. I am going to be taking  
[19] back over the official position as Chief of  
[20] Cytopathology beginning in the middle of July.  
[21] I am, I believe, as indicated on the official  
[22] hospital contract, the Associate Director of Pathology.  
[23] Q. So you would become the director of the  
[24] Department of Cytopathology in mid July?  
[25] A. I will become the chief of that department.

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[1] Q. What is the difference between the director of  
[2] the department as opposed to being the chief?  
[3] A. It is the same.  
[4] Q. Why did you resign as being the chief of the  
[5] Department of Anatomic Pathology?  
[6] A. I had some prolonged dissatisfaction with the  
[7] cooperation of my other colleagues in satisfying their  
[8] needs to meet our requirements for anatomic pathology  
[9] especially relating to some new standards that have been  
[10] put in place by the college with an association of the  
[11] College of Surgeons in terms of how we report anatomic  
[12] specimens.  
[13] That became a responsibility that was assigned  
[14] in November, the year before last. My colleagues really  
[15] basically refused to meet their responsibilities. After  
[16] beating people over the head for six months, I finally  
[17] said I am not doing it anymore. I really very tired of  
[18] this. I stepped down from the position.  
[19] Q. What exactly would the responsibility have  
[20] been to meet the new guidelines?  
[21] A. The College of Surgeons has determined that  
[22] for reporting of tumors in pathology there is a  
[23] standard - a fairly standard list of information points  
[24] that need to be included in every report, which include  
[25] information describing the gross specimen as well as

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[1] information describing all the features that go into  
[2] making the diagnosis.  
[3] They created that standard for certifying  
[4] institutions to be approved by the American College of  
[5] Surgeons as cancer institutions, which this institution  
[6] currently is certified as. They met with the College of  
[7] American Pathologists and indicated that this was an  
[8] information source that needed to be part of daily  
[9] pathology activity.  
[10] The college produced information that they  
[11] felt was generally useful for reporting tumors. The  
[12] American Association of Directors of Surgical Pathology,  
[13] which is another professional organization, also created  
[14] a listing of information that they felt was also  
[15] appropriate for reporting tumors. The approach in this  
[16] institution was to look at at least those two pieces of  
[17] information that they both existed as well as any  
[18] relevant literature that we might already have and  
[19] create our own check list system for reporting so that  
[20] every report contains the same basis of information.  
[21] That would meet the standard that was required by the  
[22] American College of Surgeons.  
[23] Q. In other words, the purpose of which was  
[24] uniform communication?  
[25] A. Absolutely.

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- [1] Q. Who is the current chairman of the Department  
 [2] of Anatomic Pathology?  
 [3] A. The responsibility is now being maintained by  
 [4] two of my more junior colleagues who are sharing the  
 [5] responsibility.  
 [6] Q. And have they taken the steps to initiate  
 [7] whatever needs to be initiated to get the rest of the  
 [8] department to follow the guidelines?  
 [9] A. They have not.  
 [10] Q. How many pathologists are currently associated  
 [11] with this institution?  
 [12] A. We have six pathologists who are responsible  
 [13] for daily anatomic pathology. And then my other senior  
 [14] associate, Dr. Collins, is the director and the chief.  
 [15] His responsibilities revolve mainly around managing the  
 [16] clinical laboratory and the blood bank that he is  
 [17] associated with, which is the American Red Cross blood  
 [18] bank down in San Diego, but he does not do anatomic  
 [19] pathology any longer. His responsibilities tie him up  
 [20] for management issues.  
 [21] Q. Of the six pathologists who currently are  
 [22] engaged in the practice of anatomic pathology or  
 [23] interpretation of specimens, how many do that full time  
 [24] as opposed to having other responsibilities?  
 [25] A. Essentially all six of us are responsible full

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- [1] time for doing anatomic pathology. I still have side  
 [2] responsibilities in business management because I am an  
 [3] owner of the corporation. That makes me somewhat on a  
 [4] different level than some of my more junior colleagues  
 [5] who are not owners of the corporation.  
 [6] I still have management responsibilities in  
 [7] terms of sort of overseeing the administration of the  
 [8] cytology department. To some extent, I maintain some  
 [9] responsibilities in the anatomic department as a less  
 [10] than chief position.  
 [11] Q. Is the Palomar Pomerado Laboratory System an  
 [12] independent entity, independent from the Palomar Medical  
 [13] Center?  
 [14] A. The Palomar Pomerado Laboratory System is a  
 [15] part of the Palomar Pomerado Health System, which  
 [16] includes Palomar Hospital here where we are, and  
 [17] Pomerado Hospital, which is a smaller institution  
 [18] located approximately 10 miles south of us. These are  
 [19] part of a public health district which is financed in  
 [20] large part by public health monies. The laboratory is  
 [21] part of the hospital district.  
 [22] Q. You mentioned a moment ago that you are an  
 [23] owner or you had some role in ownership. That is what I  
 [24] don't quite understand. What is it that you have a role  
 [25] in ownership of?

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- [1] A. The pathologists provide services to Palomar  
 [2] Pomerado Health System or Palomar Pomerado Health is  
 [3] what we are calling it now. We have a contract to  
 [4] provide laboratory services. The contract is held from  
 [5] the institution or the health service through Valley  
 [6] Pathology Medical Associates, which is -  
 [7] Q. Is that your organization?  
 [8] A. Which is my organization. So we have a  
 [9] contract to provide the services. Three of the  
 [10] pathologists in Valley Pathology are actually owners of  
 [11] the medical corporation.  
 [12] Q. You being one of them?  
 [13] A. I am one of them.  
 [14] Q. How long has this institution had an  
 [15] independent entity performing laboratory work?  
 [16] A. I believe that it has had an independent  
 [17] entity providing laboratory services from the very  
 [18] beginning. The original pathologists were here before I  
 [19] even started in this institution. The person who asked  
 [20] me here, Dr. Henry Tan, had an independent contract with  
 [21] the hospital district. Each of the pathologists then  
 [22] contracted separately with him.  
 [23] Dr. Tan left in - I want to say 1991 or 1992.  
 [24] At which time Dr. Collins, who was one of the other  
 [25] senior pathologists; Dr. Sing, who is in the office next

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- [1] door, and myself, and another pathologist, who is now  
 [2] retired, formed Valley Pathology to hold the contract  
 [3] with the hospital district.  
 [4] Q. To what extent have you in the past or  
 [5] currently initiated directives in how slides are to be  
 [6] maintained or controlled here at Palomar Medical Center?  
 [7] A. I would tell you that the majority of policies  
 [8] and procedures, which are currently in effect, have  
 [9] either been written or reviewed during my previous  
 [10] administration. In that regard, how slides are, for  
 [11] example, stored; how we satisfy the CAP requirements in  
 [12] terms of maintaining stores of slides, how material may  
 [13] be released from this institution to other institutions.  
 [14] I really formed most of the bases of that part  
 [15] of the operation as well as set up the quality assurance  
 [16] operation, which is pretty much currently also in  
 [17] effect.  
 [18] Q. You personally set up the quality assurance  
 [19] program as it relates to the storage of slides, the  
 [20] maintenance of slides et cetera?  
 [21] A. That's correct.  
 [22] Q. Do you have a copy by any chance of the  
 [23] policies and procedures that you initiated relative to  
 [24] quality assurance?  
 [25] A. I can probably get ahold of one of those for

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[1] you, but I don't have one here in my office.  
[2] Q. What I will do is, if you can, please, if you  
[3] would give it to Merel. Then she can, in turn, provide  
[4] it to me?  
[5] A. Okay.  
[6] Q. Have you ever been called by anybody here in  
[7] the last year indicating that slides have been missing,  
[8] misfiled, misplaced?  
[9] A. I have been advised on several occasions, one  
[10] relatively recently, that a slide or slides had been  
[11] missing or misfiled and were not currently available.  
[12] That material was located and replaced in the  
[13] appropriate position.  
[14] Q. Unfortunately the misfiling or misplacing of  
[15] slides is not an uncommon occurrence, albeit not a  
[16] common occurrence but it happens in institutions, does  
[17] it not?  
[18] A. It is a not infrequent occurrence. When slide  
[19] material often is removed subsequent to the initial  
[20] filing, the filing number or date, the year or sort of  
[21] thing, may not be looked at carefully when it gets  
[22] refiled. So it may be refiled in the wrong year.  
[23] Slides may be split in the file so that they are in the  
[24] wrong part of the drawer. Misfiling is a regular  
[25] problem in surgical pathology and cytopathology.

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[1] Q. That would include that phenomena occurring at  
[2] this institution?  
[3] A. That is absolutely true.  
[4] Q. Approximately how many slides, if you know or  
[5] have an idea, are prepared on an annual basis here:  
[6] "here" being Palomar?  
[7] A. Correct. I can't give you a good idea for  
[8] that. I believe that last year we accessioned over  
[9] 20,000 cases here. We accessioned cases at Pomerado  
[10] under a different system, but I can't begin to tell you  
[11] how many slides that is.  
[12] In our laboratory routinely for small  
[13] biopsies, for example, skins and GYNs and gastric  
[14] biopsies, we cut three slides off of every block. For  
[15] major tumor cases we may have - an average breast case  
[16] can easily be 20 slides. It can often be more than  
[17] that. I can't really give you a good sense at all of  
[18] how many slides have been produced a year.  
[19] Q. If you have 20,000 cases, what you are looking  
[20] at at a minimum, depending upon your numbers of breast  
[21] cases, for instance, is well in excess of 100,000?  
[22] A. That is quite possible.  
[23] Q. And can you tell me if this is a referral  
[24] center? Forgive me for asking some of these questions.  
[25] However, I am not from this area.

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[1] A. I would not say that this institution is  
[2] normally thought of in the community as a referral  
[3] center. However, the mechanism for healthcare provision  
[4] has undergone a lot of changes, particularly in Southern  
[5] California and San Diego in particular, so that  
[6] contracts based, for example, on capitation contracts or  
[7] large contracts that some providers may have end up  
[8] making these institutions, Palomar and Pomerado,  
[9] referrals for patients who are cared for by physicians  
[10] under those contracts.  
[11] We would not normally be thought of, for  
[12] example, as like a tertiary center, for example, the  
[13] University Hospital down in San Diego, but we see what  
[14] is available in the community and we see some patients  
[15] who have biopsy work done through pathology contracts  
[16] outside our own district, but then those patients have  
[17] to return to our own hospital district for the  
[18] definitive therapy. So, they end up coming back and  
[19] being referred back to our hospital system.  
[20] It is not what one would normally think in  
[21] many parts of the country as being a large referral  
[22] center from smaller institutions in the community, but  
[23] by the same token it certainly has some referral type of  
[24] base to it.  
[25] Q. How many beds is Palomar?

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[1] A. I believe that we have approximately 325. I  
[2] am not absolutely sure, but is in that range.  
[3] Q. About that?  
[4] A. Um-hum.  
[5] Q. And Pomerado?  
[6] A. Pomerado, I believe, is about 125. Again, I  
[7] am not absolutely sure.  
[8] Q. Do you keep statistics here at this  
[9] institution, let's say going back in the last five  
[10] years, of how many gynecologic cancers have been  
[11] diagnosed?  
[12] A. We do not keep specific statistics on any of  
[13] the tumor site diagnoses in this institution. If we  
[14] have a specific interest in finding some particular  
[15] number, we can request our information services  
[16] administrator to create a short program for us to  
[17] generate that information, but we don't generate any  
[18] kind of regular data on that on a yearly basis.  
[19] The tumor board - actually, it would be -  
[20] well, it is part of the medical records services, but it  
[21] includes part of the tumor board. They actually track  
[22] individual malignancy rates at this institution and  
[23] within the district as a whole, but that is outside of  
[24] my department. They track that information based on  
[25] reports that we provide to them so that they can get the

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[1] follow-up information on patients.  
 [2] **So** the information is available through the  
 [3] medical records or tumor department, but not through  
 [4] pathology.  
 [5] **Q.** And who in that department would be contacted  
 [6] to acquire that information, would you know?  
 [7] **A.** It would have to be the current director of  
 [8] the cancer committee, and I am not sure who holds that  
 [9] position currently, but the hospital medical information  
 [10] systems department could probably provide that kind of  
 [11] information.  
 [12] **Q.** Does your department maintain, however, the  
 [13] reports that would be submitted that is ultimately  
 [14] utilized to determine the number of cancers or  
 [15] malignancies that are diagnosed?  
 [16] **A.** Yes, We keep a computer file. It is kept  
 [17] online constantly. That is available for retrieval  
 [18] through our own computer system. We also keep a paper  
 [19] copy of every report that is generated.  
 [20] **Q.** So you would be able to access numbers, at  
 [21] least going back over for the last, say, three years, as  
 [22] it relates to the type of malignancies that have been  
 [23] diagnosed at this institution; would I be correct?  
 [24] **A.** We would probably submit that request to the  
 [25] medical records department, the tumor board partly to

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[1] tracking it, that's fine.  
 [2] **BY MR. BONEUI:**  
 [3] **Q.** That is correct. I am not asking that he  
 [4] personally do that. If somebody can get that, what I am  
 [5] interested in is actually a breakdown. I will do that  
 [6] myself, but I am interested in looking at the actual  
 [7] numbers of gynecologic malignancies that are diagnosed  
 [8] out of this institution.  
 [9] Do you have any knowledge regarding numbers of  
 [10] malignancies that are diagnosed, again over the last  
 [11] three years, that involve either primary ovarian, or  
 [12] endometroid, or endometrial cancers?  
 [13] **A.** I don't have those numbers off the top of my  
 [14] head. I can tell you that endometrial is going to be  
 [15] the most common that we are going to encounter in this  
 [16] institution, and some type of ovarian present, but much  
 [17] less frequently.  
 [18] **Q.** When you say "some type of ovarian," what do  
 [19] you mean by that?  
 [20] **A.** There is a whole variety of ovarian tumors.  
 [21] Those can include mucinous or sericitic tumors.  
 [22] **Q.** So you are breaking it down, is what you are  
 [23] talking about?  
 [24] **A.** That's correct. For example, I can tell you  
 [25] that the last ovarian tumor that I saw in this

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[1] give us that information because they are tracking those  
 [2] statistics for the state. They have to report that  
 [3] information to the State of California so they maintain  
 [4] the statistics. We provide them with copies - a paper  
 [5] copy of every report of any kind of tumor that comes out  
 [6] of the department. Then they take care of maintaining  
 [7] the state required statistics and reporting it.  
 [8] **Q.** If you had to place a statistical number on  
 [9] the gynecologic malignancies that have diagnosed at this  
 [10] institution as opposed to all other types, would you be  
 [11] able to do that?  
 [12] **A.** I could look into that and see. I can't tell  
 [13] you for sure. I suspect that they could probably  
 [14] provide me with that information if I were to ask them  
 [15] for it.  
 [16] **Q.** Could you ask them for it?  
 [17] **A.** I will give that a try.  
 [18] **Q.** in the same caveat, if you can obtain that  
 [19] information, you can provide it to Merel and then Merel  
 [20] can make the decision of whether or not she will provide  
 [21] that to me?  
 [22] **A.** Okay.  
 [23] **MS. NISSENBERG:** Right. But I am not going to  
 [24] ask him to go through and start counting different  
 [25] individual papers, If he can get someone who is already

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[1] institution was a week before my accident, which was a  
 [2] very poorly differentiated adenocarcinoma of the ovary.  
 [3] That was the first ovarian tumor that I personally  
 [4] reviewed here in probably a month or more.  
 [5] **So**, they are sporadic and the frequency varies  
 [6] considerably. I would tell you that the numbers are  
 [7] relatively infrequent in this institution.  
 [8] **Q.** In the last three years if you had to place a  
 [9] number on the numbers of ovarian carcinomas that have  
 [10] been diagnosed as opposed to the number of endometriod  
 [11] carcinomas diagnosed, could you do that?  
 [12] **A.** I can't give you the number off the top of my  
 [13] head, not really realistically.  
 [14] **Q.** When was the last time that you personally  
 [15] made a diagnosis of a malignancy where that malignancy  
 [16] arose out of endometriosis?  
 [17] **A.** Where a malignancy arose out of  
 [18] endometriosis - the last time I can even vaguely recall  
 [19] a case like that it must be more than a decade ago, and  
 [20] not in this institution. I know that I have seen  
 [21] probably two or perhaps three cases of malignant  
 [22] transformation in endometriosis. I recall one very  
 [23] clearly, when I was a training resident many years ago,  
 [24] of clear cell carcinoma arising out of endometriosis. I  
 [25] know that in my training period perhaps at Memorial

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[1] Stone Kettering there may have been one more during that  
[2] time, and possibly others in my residencies, but I **do**  
[3] not recall seeing a primary case arising out of  
[4] endometriosis since I have been in private practice.  
[5] Q. How would you go about to differentiate  
[6] between a malignancy arising out of endometriosis or a  
[7] malignant transformation of endometriosis as opposed to  
[8] an endometrial implant that has communicated with the  
[9] ovary where the malignancy arises out of that implant?  
[10] A. Let me ask you – the second part of the  
[11] question that you are asking me is to compare a  
[12] malignant tumor arising in endometriosis.  
[13] Q. Yes.  
[14] A. Versus an endometrial adenocarcinoma that has  
[15] extended to the ovary –  
[16] Q. Yes.  
[17] A. Or extrauterine location?  
[18] Q. Yes.  
[19] A. What was the actual question that you had?  
[20] Q. How would you go about to differentiate to be  
[21] able to determine where it came from; in other words,  
[22] what are the different properties, if there are any?  
[23] A. Sure. Well, I think that there are some  
[24] properties that we are all going to look at in the first  
[25] place. The starting place for that will be, number one,

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[1] the examination of the uterus, the endometrial cavity  
[2] itself. ~~Is~~ there a primary tumor, an endometriod tumor  
[3] arising in the endometrial cavity?  
[4] If that is the case and one identifies a tumor  
[5] of similar morphology outside of the endometrial cavity,  
[6] then one may raise the question of whether or not that  
[7] is a metastasis from the original endometrial primary.  
[8] One may also see primary tumors arising in the  
[9] ovary of morphology which is similar to the endometrium.  
[10] Again, if one finds that arising in an ovary or both  
[11] ovaries in the absence of any other particular changes,  
[12] then the general thrust is that this **is** an endometriod  
[13] ovarian primary.  
[14] Sometimes one may actually find both of these  
[15] tumors present in the same patient, that is to say there  
[16] may be an endometriod adenocarcinoma or the  
[17] endometrium. There also may be an endometriod appearing  
[18] adenocarcinoma of the ovary, and there may be lots of  
[19] discussions about whether those are two separate  
[20] independent primary tumors or whether one came from the  
[21] other.  
[22] But then when you move from looking at that  
[23] part of the issue and say when did the tumor arise from  
[24] endometriosis, the first critical thing that you have to  
[25] be able to do is to actually demonstrate endometriosis.

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[1] That, I think, convincingly has to be followed by  
[2] demonstrating that there is transformation in part of  
[3] that lesion that we can still recognize in some form or  
[4] fashion as being endometriosis which now manifests the  
[5] tumor characteristics of the transformation that is  
[6] taking place.  
[7] For example, a clear cell adenocarcinoma  
[8] arising in association with a large amount of  
[9] endometriosis on the surface of an ovary, I **do** recall  
[10] seeing a case like that when I was training. The ovary  
[11] itself was typically normal, but it had an endometriotic  
[12] cyst on the surface, which was clearly typical  
[13] endometriosis. Within a portion of that, the  
[14] endometriosis had undergone a malignant transformation  
[15] into a **highly** malignant clear cell carcinoma.  
[16] Q. And both entities occurred at the same time is  
[17] what you are saying?  
[18] A. That **is** correct. **You** are able to demonstrate  
[19] the presence of endometriosis and the second tumor at  
[20] the same time.  
[21] Q. You have read a number of depositions in this  
[22] case including Dr. Alexander Kennedy's, have you not?  
[23] A. I have.  
[24] Q. Dr. Alexander Kennedy, who is a gynecologic  
[25] surgeon here, or the gynecologic oncologist, has opined,

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[1] subsequent to the April 29th surgery, that there was a  
[2] malignant transformation of endometriosis found in the  
[3] posterior of the cul-de-sac.  
[4] Do you recall that testimony?  
[5] A. I recall that comment.  
[6] Q. As you put this case together, is there –  
[7] strike that.  
[8] As you put the case together, do you have an  
[9] opinion whether or not the event, as Dr. Kennedy has  
[10] described it, is indeed an event that very well could  
[11] have happened; that is, having a malignant  
[12] transformation of the endometriosis in the posterior  
[13] cul-de-sac subsequent to the April 29th, 1999 surgery  
[14] and at the same time having an endometrial implant  
[15] demonstrating atypical changes?  
[16] A. I have to tell you that I found Dr. Kennedy's  
[17] interpretation of the pathologic event that may or may  
[18] not have occurred difficult to fully understand.  
[19] Q. Explain.  
[20] A. I felt that, judging from the information that  
[21] was made available to me and examining the original  
[22] surgical pathology reports and surgical pathology  
[23] slides, that – and some of the op reports that I  
[24] read – I don't recall the details, that there was no  
[25] specific history at the time of the hysterectomy and



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[1] salpingo-oophorectomies, that there was endometriosis  
[2] that was present in the posterior cul-de-sac that was  
[3] left behind at the time of the surgery.  
[4] We knew that there was endometriosis  
[5] associated with the ovaries in the uterus when that was  
[6] removed. We also knew that the patient had had a  
[7] history of endometriosis in her abdomen in the past, but  
[8] I recall nothing in the operative report or any of the  
[9] surgical pathology information that suggested that  
[10] someone was believing that they were leaving  
[11] endometriosis left behind particularly in the posterior  
[12] cul-de-sac.

[13] Q. If I may interrupt you for just a moment. If  
[14] the endometriosis is extensive, is it likely that some  
[15] of the endometriosis, regardless of placement, will  
[16] indeed be left behind?

[17] A. I can't give you a real comment on that. I  
[18] think that is more how the surgeons would choose to treat  
[19] that. As pathologists, we are provided with the tissue  
[20] and some information about where it came from, and not  
[21] infrequently with what kind of distribution it might be  
[22] present.

[23] But in terms of how surgeons might choose to  
[24] manage a patient who had wider spread endometriosis at  
[25] the time that they did a hysterectomy, I don't think I

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[1] arose from some separate implant of the endometriosis is  
[2] very difficult.  
[3] But, it is hard for me to accept the notion  
[4] that there may have been small deposits of clinically  
[5] typical endometriosis, one of which may have given rise  
[6] to this malignant tumor, without forming some kind of a  
[7] mass like lesion that would have been available for  
[8] identification at the time of the original operation.

[9] Q. I know that you have reviewed the recuts from  
[10] the April 29th procedure, and you have also reviewed the  
[11] original material from the April 29th procedure absent  
[12] the B6 slide. However, with the B6 you did review the  
[13] origin recut or the first recut?

[14] A. That's correct.

[15] Q. Together with a second recut, if I am not  
[16] mistaken?

[17] A. I have seen - no, no, I'm sorry. I have seen  
[18] a recut that was sent to me, and then I saw a subsequent  
[19] recut that was sent -

[20] Q. That is correct.

[21] A. - this year. That is correct.

[22] Q. The first time around you saw the original  
[23] recuts, but then what you had was a second recut of the  
[24] B6 slide. In addition to that, you have also reviewed  
[25] the original slides, which I believe I provided to

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[1] can appropriately comment on that.

[2] Q. Presuming that what Dr. Kennedy stated in his  
[3] deposition is correct; that is, that there was extensive  
[4] endometriosis at the time of the original surgery and  
[5] that there was endometriosis in the posterior  
[6] cul-de-sac - I want you to presume that for purposes of  
[7] this question.

[8] A. Okay.

[9] Q. - is it likely that the scenario that you  
[10] laid out before: that is, that you can have two separate  
[11] entities occurring at the same time, and that is what  
[12] Dr. Kennedy indicated; that is, that there was a  
[13] malignant transformation, is, in fact, that's something  
[14] that could indeed have happened in this case?

[15] A. The problem that I have with following that  
[16] line of reasoning is that my interpretation of the  
[17] pelvic washings, which were done simultaneously with the  
[18] hysterectomy and the oophorectomies is that cancer was  
[19] present in that material at the time that specimen was  
[20] obtained and the hysterectomy was performed.  
[21] Whether that cancer was derived from a focus  
[22] of transformation of endometriosis that was removed with  
[23] the specimen, whether it actually arose from  
[24] transformation of a mucinous tumor of the ovaries that  
[25] wasn't examined carefully enough or whether it actually

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[1] counsel, which in turn she provided to you at the  
[2] beginning of May. You have reviewed those together with  
[3] the original recut of the B6?

[4] A. Yes.

[5] MS. NISSENBERG: Excuse me. I think that  
[6] there is a difference in the first recut that he saw,  
[7] which was a second generation recut, versus the new  
[8] recut that you provided in May.

[9] MR. BONEZZI: There is.

[10] MS. NISSENBERG: So he hasn't see the original  
[11] recut, except now he has.

[12] MR. BONEZZI: Yes.

[13] MS. NISSENBERG: What was given to him  
[14] originally - he saw two sets of recuts. They were  
[15] second and third generation.

[16] MR. BONEZZI: Right. Yes, I know that.

[17] THE WITNESS: Right. Those are the slides  
[18] that I have examined.

[19] BY MR. BONEZZI:

[20] Q. And you also examined on both occasions I  
[21] believe, at least the first time around before I sent  
[22] you anything or gave them to you and to counsel, and  
[23] again in May that would be the pevic wash. That would  
[24] be the ThinPrep and the cell block tissue?

[25] A. That's correct.

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[1] Q. Now, you have indicated that in your review of  
 [2] the pelvic wash, that is how you just described it,  
 [3] there were malignant cells?  
 [4] A. That's correct.  
 [5] Q. Or you said that there was a malignancy  
 [6] present. I interpret that as demonstrating malignant  
 [7] cells?  
 [8] A. That's correct.  
 [9] Q. Were there malignant cells in both the cell  
 [10] block, as you reviewed it, together with the ThinPrep or  
 [11] in just one of them?  
 [12] A. I believe that there are malignant cells  
 [13] present in both of those preparations. They are derived  
 [14] from the same sample. One is prepared as a histologic  
 [15] cell block section; the other is prepared as a ThinPrep  
 [16] specimen, but they come from the same sample. It is a  
 [17] different manner of preparing the same material.  
 [18] Q. And the malignant cells that you have seen, is  
 [19] there an abundance of cells; is there one cell; how many  
 [20] cells did you see?  
 [21] A. I think that there is a fair amount of  
 [22] material present both in the cell block slide as well as  
 [23] in the ThinPrep slide.  
 [24] Q. And when you reviewed the pelvic washings for  
 [25] the very first time, do you recall when that was?

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[1] same time. I was also provided with the vaginal biopsy  
 [2] and its report and then the subsequent small bowel  
 [3] biopsy and its report. But for the pelvic washing  
 [4] material only, I was provided with a copy of the  
 [5] original pathology report and the single histologic  
 [6] section taken from the cell block.  
 [7] Q. When you reviewed the cell block, did you also  
 [8] have, in addition to that, the other material that you  
 [9] just indicated?  
 [10] A. I have all the histologic sections that had  
 [11] been provided to Merel at the time.  
 [12] Q. Which would have also included the vaginal  
 [13] biopsy of June of 2000?  
 [14] A. That is correct.  
 [15] Q. Do you happen to recall in which order you  
 [16] would have reviewed these slides?  
 [17] A. I reviewed these in chronological order, as I  
 [18] recall, which I began with the hysterectomy material and  
 [19] oophorectomy material followed by the pelvic washing,  
 [20] then followed by the vaginal biopsy, then followed by  
 [21] the small bowel biopsy.  
 [22] All of that material - I examined the slides  
 [23] first and then examined the report to make sure that I  
 [24] was reading the right material from the right location  
 [25] and the right patient and comparing with what the report

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[1] A. I believe that Merel brought those to me in  
 [2] the fall of a year ago.  
 [3] Q. Would that be the fall of 2001, or the fall of  
 [4] 2002?  
 [5] A. 2000, I think.  
 [6] MS. NISSENBERG: I really can't remember. I  
 [7] think it was November, but I don't remember the year.  
 [8] THE WITNESS: I think it was in the late fall  
 [9] of 2000 when she first brought the slides to me, but I  
 [10] am not 100 percent sure on that.  
 [11] It is correct that I did not get to see the  
 [12] ThinPrep slide initially. That took a substantial  
 [13] amount of time to obtain from the clinic. The original  
 [14] slide that was made available to me was the cell block  
 [15] slide. Then Merel had to proceed to get the ThinPrep  
 [16] slide, which was many months after the original  
 [17] histologic section was examined.  
 [18] BY MR. BONEZZI:  
 [19] Q. When you initially examined the cell block  
 [20] absent the Thinprep, what information did you have?  
 [21] A. I was provided initially with reports and  
 [22] histologic sections from the original hysterectomy and  
 [23] oophorectomy.  
 [24] I was provided with the cell block slide and a  
 [25] report for it from the pelvic washing obtained at the

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[1] actually said to what my observations were at that  
 [2] particular time.  
 [3] So, I looked at the first slides that came  
 [4] first followed with the report and the final information  
 [5] with the slides again to make sure that I was  
 [6] appreciating what was looked at. So each group of  
 [7] material was done in that order.  
 [8] Q. When you reviewed those slides and when you  
 [9] then assured yourself that the slides that you were  
 [10] reviewing matched up with the reports and you had the  
 [11] numbers correctly, did you take any notes?  
 [12] A. I did not take notes.  
 [13] Q. Did you do any dictation?  
 [14] A. I did not do any dictation. Merel was here in  
 [15] my office with me when I was looking at the material.  
 [16] She sat where she is now and we talked about what I was  
 [17] looking at under the microscope and what I was seeing on  
 [18] the reports as well.  
 [19] Q. Was any information provided to you at that  
 [20] time as it related to what Dr. Clifton Mountain found  
 [21] when he reviewed the slides?  
 [22] A. I recall no information about anybody else's  
 [23] review other than that present in the official reports.  
 [24] I had no other information about anyone else's  
 [25] interpretation of any of that material.

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[1] MS. NISSENBERG: For the record, just so you  
 [2] don't spend a lot of time going down the wrong alley, he  
 [3] is not even a pathologist.  
 [4] MR. BONEZZI: I know he is not. I know  
 [5] exactly who he is and where he came from. I couldn't  
 [6] figure out why a thoracic surgeon or a cardiothoracic  
 [7] surgeon would be sent the material. The man is 80 years  
 [8] old.  
 [9] THE WITNESS: It is a mystery to me now.  
 [10] MS. NISSENBERG: 78.  
 [11] MR. BONEZZI: I was going to say 78. And he  
 [12] is here in San Diego as opposed to being at MD Anderson.  
 [13] I know who he is.  
 [14] MS. NISSENBERG: Okay.  
 [15] BY MR. BONEZZI:  
 [16] Q. So I am not going down the wrong avenue here.  
 [17] When you reviewed these slides, did you  
 [18] attempt to make a comparison between the slides from the  
 [19] right and left ovary and then the pelvic wash and then  
 [20] the vaginal biopsy to see if there were any similar  
 [21] characteristics?  
 [22] A. I would say that my initial evaluation of the  
 [23] first specimen, which is the hysterectomy and  
 [24] oophorectomy, was to examine the material that was  
 [25] present there, see how it compared to how it was

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[1] the pelvic wash indicated that there was the presence of  
 [2] atypical cells of undetermined origin, which obviously  
 [3] does not rise to the level of malignancy, that would  
 [4] have been acceptable to you?  
 [5] A. Markedly atypical cells. In my way of  
 [6] managing a case like that, that may have been the actual  
 [7] diagnostic line, but appended to that would have been  
 [8] some kind of comment that would have indicated that the  
 [9] exact nature of this material was unclear, that  
 [10] malignancy was a significant risk factor, that the cells  
 [11] appeared to be coming from some undetermined source that  
 [12] is not from the uterus and ovarian tissue that had been  
 [13] reported as negative, and that some additional  
 [14] evaluation definitely would have been appropriate, but  
 [15] that the degree of atypia in those cells had to push you  
 [16] in that area of "I am very suspicious that there is  
 [17] malignancy taking place here." I may not be willing to  
 [18] make that diagnosis flat out as an official diagnosis,  
 [19] but we are getting very, very close to that and an  
 [20] additional evaluation needs to be done appropriate to  
 [21] that finding.  
 [22] Q. Tell me about the characteristics that you saw  
 [23] that were contained within the cell block that rose to  
 [24] the level of marked atypia of unknown origin or  
 [25] undetermined origin?

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[1] actually reported out, how it was managed first grossly,  
 [2] and then report it out.  
 [3] Having looked at that material, I came to the  
 [4] conclusion that the report was largely within the usual  
 [5] way of reporting that kind of information.  
 [6] Q. The report you are speaking of is the report  
 [7] that was authored by Dr. Richard Prayson?  
 [8] A. For the hysterectomy?  
 [9] Q. Yes, and the bilateral salpingo-oophorectomy?  
 [10] A. That's correct. Then I looked at the pelvic  
 [11] washing cell block slide and told Merel that I felt that  
 [12] the cell block washing was positive. I recall in that  
 [13] discussion, looking only at that material of the  
 [14] material, that I indicated to her that although I  
 [15] personally felt there were malignant cells in clusters  
 [16] in that material, some of which had actually been dotted  
 [17] at the Cleveland Clinic by either their technologist or  
 [18] pathologist, I would have been willing to accept that  
 [19] someone may have been willing to report less than an  
 [20] absolute malignant diagnosis. That is to say, had they  
 [21] reported a suspicious or atypical cells of marked atypia  
 [22] of undetermined origin, something along that line I  
 [23] could understand as being potentially within an  
 [24] acceptable range of reporting for that kind of material.  
 [25] Q. If I understand what you just said, that had

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[1] A. In the first place in the background of that  
 [2] material as presented in the cell block, there are  
 [3] populations of cells that we can recognize as a normal  
 [4] component of a pelvic washing, which are largely cells  
 [5] of mesothelial origin. They may come off in large flat  
 [6] sheets. They may come off in strips. On rare  
 [7] occasions, they may come off in papillary like groups  
 [8] depending upon what kind of original pathology is taking  
 [9] place. But they all manifest changes that we can  
 [10] recognize as being mesothelial and often some kind of  
 [11] minor mesothelial reactive process,  
 [12] Also, within the background of that particular  
 [13] preparation are scattered cells that look to be probably  
 [14] of histiocytic origin and a scattered inflammatory cell  
 [15] here and there.  
 [16] Q. If I may just interrupt. That would not be  
 [17] uncommon to find what you have just described,  
 [18] specifically in the presence of endometriosis, correct?  
 [19] A. One would expect to find changes like that in  
 [20] the presence of many benign conditions.  
 [21] Q. Including endometriosis?  
 [22] A. Endometriosis could be included. One could  
 [23] have minor surface reactions on the serosa of the uterus  
 [24] or on the surface of the ovaries that can create those  
 [25] kinds of very minimal kinds of changes.

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[1] But accompanying that process is a second  
 [2] process of clusters of cells that look very different.  
 [3] They look different because, in the first place, the  
 [4] nuclei are very irregular. The nuclear membranes are  
 [5] folded and have a very irregular outline. Many of the  
 [6] cells have irregular nucleoli which sometimes touch the  
 [7] nuclear membrane.  
 [8] The nuclei are settled with the cytoplasm in a  
 [9] very irregular distribution kind of pattern. The  
 [10] cytoplasm itself, instead of manifesting the things that  
 [11] are typical of mesothelial cells, which is generally  
 [12] some light, sort of greenish blue staining, sometimes it  
 [13] can be - particularly in cell block material, it can be  
 [14] reddish because of the way the material takes it up.  
 [15] The cytoplasm of these particular cells is clear, which  
 [16] also has to raise one's thoughts about "What am I really  
 [17] looking at?"  
 [18] One might think initially about histiocytes,  
 [19] which generally have clear cytoplasm and some  
 [20] mesothelial cells, which also may have clear cytoplasm,  
 [21] but they have the other more typical features of normal  
 [22] or minimally reactive appearing mesothelial cells to go  
 [23] along with it. The second population of cells does not  
 [24] show those kinds of normal changes.  
 [25] In addition, they are making irregular

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[1] will see in normal and mildly reactive mesothelial cells  
 [2] but may on occasion exhibit, you know, a good deal more  
 [3] nuclear pleomorphism, but we still appreciate the  
 [4] cytoplasm differentiation and increased density towards  
 [5] the nucleus. The nuclei tend to be round and have  
 [6] centrally located nucleoli. The cells look much more  
 [7] like typical mesothelial cells.  
 [8] So we can deal with groups of funny looking  
 [9] mesothelial cells and wonder are we looking at a  
 [10] mesothelial reaction versus a possible mesothelioma, or  
 [11] we can separate this group of cells that we are looking  
 [12] at and say these those look to me like mesothelial.  
 [13] These look like something else that doesn't belong in  
 [14] this space. They are abnormal. They are clustering.  
 [15] Their organization is not typical of anything that  
 [16] normally lives in this particular space. Then the  
 [17] question gets to be are these malignant. Some of the  
 [18] things that one might want to do is to further explore  
 [19] what kind of differentiation those particular cells  
 [20] might demonstrate.  
 [21] Q. Would I be correct in stating that that which  
 [22] you observed did not stand out to such degree that you  
 [23] were willing to call it malignant at the time that you  
 [24] initially reviewed the slide?  
 [25] A. When I initially reviewed the slides, I told

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[1] clusters in which the nuclei are irregularly distributed  
 [2] in papillary or ball like groupings, some of which are  
 [3] relatively substantial size and really raise a very high  
 [4] suspicion of little papillary or aster like fragments of  
 [5] a malignant tumor that are floating around in the fluid  
 [6] and allow the cells to manifest these very irregular,  
 [7] architectural features.  
 [8] Q. Do the atypical cells that you saw that you  
 [9] have described, at least to this extent, are those cells  
 [10] more common to have exfoliated from an actual tumor that  
 [11] has existed or that existed from the time in which the  
 [12] pelvic wash was obtained, as opposed to something much  
 [13] less than an actual tumor formation?  
 [14] A. I think that once one begins to observe this  
 [15] unusual aggregate of manifestations - of cellular  
 [16] manifestations, the abnormal nuclear appearance, the  
 [17] irregularity of the nuclear membranes, the nucleoli  
 [18] which may be here and there, the difference in the  
 [19] cytoplasmic differentiation and the way the cells form  
 [20] these irregular aggregates, that the first thing that  
 [21] really must go through one's mind is "Am I looking at a  
 [22] malignant tumor which has exfoliated into the fluid?"  
 [23] And not likely is that malignant tumor a malignant  
 [24] mesothelioma, which more often than not continues to  
 [25] manifest the cellular differentiation features that we

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[1] Merel that I felt that this was a malignant process, but  
 [2] that I could understand that had it been reported as  
 [3] something very atypical but less than an absolutely  
 [4] diagnostic malignancy, that I could understand how a  
 [5] cytopathologist or could not be willing to make the full  
 [6] step.  
 [7] The problem in part with looking at cell  
 [8] blocks, for example, of this kind of preparation, is  
 [9] that the preparation that the cells undergo in the block  
 [10] preparation itself can induce some changes that are a  
 [11] little bit more difficult to appreciate from one kind of  
 [12] fluid to the next.  
 [13] So instead of being willing to jump on the  
 [14] diagnosis with both feet from the start, you might say  
 [15] "There are clearly some very, very abnormal cells  
 [16] present here in the cell block, and I am very concerned  
 [17] that there is a malignant lesion taking place."  
 [18] Either I don't want to call it, frankly,  
 [19] malignant to start with, I may call it suspicious, or I  
 [20] may use some other term. Very atypical cells present  
 [21] cannot exclude malignancy, but it is well within that  
 [22] range that my initial interpretation occurred.  
 [23] Q. What type of fixative was used?  
 [24] A. I believe in this the original fixative was  
 [25] Bouins, but without looking at the report again I am not

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[1] 100 percent sure of that.  
 [2] Q. Are you aware of whether or not bad fixative  
 [3] causes any greater reaction or causes any type of  
 [4] greater change in the cell?  
 [5] A. I believe that it is fair to say that each  
 [6] different kind of material that we as cytopathologists  
 [7] or pathologists use to fix any cytologic preparation are  
 [8] going to induce some minor variations.  
 [9] If I, for example, took the same pleura fluid  
 [10] and I fixed some of it in Formalin and I fixed some of  
 [11] it Special B fixatives and I fixed some of it in Bouins  
 [12] and some of the others, there may be some minor changes  
 [13] that you are going to see, for example, the staining of  
 [14] pattern. Instead of seeing eosinophilia with one  
 [15] particular fixative, it may no longer be  
 [16] eosinophilic. It may stain more green blue than it  
 [17] did red.  
 [18] So there are going to be some changes that one  
 [19] may see based on the particular kind of fixative that is  
 [20] used for the preparation. But each institution gets  
 [21] used to using the fixatives that they are accustomed to  
 [22] using.  
 [23] And at the same time, during the training  
 [24] process and learning process, one has to become  
 [25] accustomed to seeing what a mesothelial cell looks like

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[1] from that accession including a slide that was B6.  
 [2] Nothing really stimulated my spectacular interest.  
 [3] There were some minor changes in some of the slides.  
 [4] There was endometriosis, which was diagnosed  
 [5] appropriately in the original report. But there was  
 [6] nothing cytological in that material that caught my eye  
 [7] as being markedly atypical or, for example, showing any  
 [8] similarity to either the pelvic washing or to the  
 [9] material that resulted subsequently with the vaginal  
 [10] biopsy and the small bowel biopsy.  
 [11] Q. When you reviewed the slides and - I will  
 [12] start with the left ovary first. You reviewed the  
 [13] material - that would be A1 through A9, if I am not  
 [14] mistaken, I may be.  
 [15] MS. NISSENBERG: That's correct.  
 [16] BY MR. BONEZZI:  
 [17] Q. You would then have compared the findings in  
 [18] that report with what you saw in the slides; is that  
 [19] right?  
 [20] A. That's correct.  
 [21] Q. When you reviewed the slides - and those  
 [22] would have been A1 through A9, you would then have  
 [23] compared what your findings were to that which is set  
 [24] forth in the pathologic interpretation by Dr. Prayson?  
 [25] A. That is correct.

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[1] that has been fixed in Formalin, what does one look like  
 [2] that has been fixed in Bouins, what does one look like  
 [3] that has been fixed in alcohol, for example, which is  
 [4] what many preparations are that we look at.  
 [5] So you see the same kind of material presented  
 [6] to you after being fixed and/or processed in a variety  
 [7] of different ways. It is simply a matter of becoming  
 [8] comfortable with that as part of your training process  
 [9] and your experience of evaluating that material knowing  
 [10] what those particular limits might be.  
 [11] Q. What is the fixative that is used here?  
 [12] A. In this institution -  
 [13] Q. Yes.  
 [14] A. - we make direct smear preparations that are  
 [15] fixed in alcohol. We make cell blocks that are fixed in  
 [16] a zinc supplemented Formalin.  
 [17] Q. When you looked at the B6 recut for the first  
 [18] time, that was in conjunction with the pelvic washing,  
 [19] correct?  
 [20] A. Now, the B6 recut we are talking about is the  
 [21] initial one that I observed?  
 [22] Q. The initial one when you were sitting where  
 [23] you are sitting now looking through your microscope and  
 [24] Merel was sitting where she is sitting.  
 [25] A. Correct. I looked at that group of slides

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[1] Q. And I presume that what you saw in those  
 [2] slides on the very first time comported with what  
 [3] Dr. Prayson said?  
 [4] A. That is also correct.  
 [5] Q. And I also presume now, going over to the  
 [6] right ovary, based upon what you reviewed for the first  
 [7] time, which would be B1 through B5, that would be, I  
 [8] believe, those would be recuts, and then B6 would be a  
 [9] recut. I don't remember if that was the second or the  
 [10] third one. But anyway, when you reviewed those six  
 [11] slides, I presume once again you would have taken your  
 [12] knowledge of what you saw and compare that to what  
 [13] Dr. Prayson had put down and came to the conclusion that  
 [14] what he indicated was correct?  
 [15] A. That is also correct.  
 [16] Q. At that point did you then wonder whether or  
 [17] not what was seen originally in the pelvic wash or the  
 [18] cell block was, in fact, consistent with a marked atypia  
 [19] since you couldn't find anything to associate it with,  
 [20] or did you still believe that it represented marked  
 [21] atypia of undetermined origin and left it at that?  
 [22] A. My impression when I looked at the cell block  
 [23] after examining the initial histologic sections was that  
 [24] there was a malignant tumor present in the fluid that  
 [25] had not been demonstrated in the histologic sections

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[1] that I had available for review as recorded in the  
[2] report such that either there was a tumor that had not  
[3] been identified at the initial gross examination of the  
[4] specimen, or that there was another possible primary  
[5] tumor located somewhere else in the abdomen which had  
[6] also not been identified at the time the hysterectomy  
[7] had been performed. But I felt that absolutely there  
[8] was a malignant tumor in that patient's abdomen  
[9] somewhere. And more likely than that, it would have  
[10] been associated with one of the lesions in the ovary  
[11] that had unfortunately not been examined and had not  
[12] been seen during the initial examination, and that no  
[13] additional examination had taken place following the  
[14] pelvic washing material because the pelvic washing had  
[15] been called "negative."

[16] Q. You also reviewed the intraoperative  
[17] interpretation, correct?

[18] A. That's correct.

[19] Q. Did you conclude that that which Dr. Levtn had  
[20] reported on was accurate?

[21] A. I felt that it was certainly within the range  
[22] that one would see reported for that kind of material.

[23] Q. Ultimately you reviewed Dr. Biscotti's  
[24] deposition testimony?

[25] A. That is correct.

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[1] immunohistological stains that were supposed to help in  
[2] identifying the location of this -

[3] Q. The cytokeratin stains?

[4] A. The cytokeratin stains and the CEAs. The  
[5] conclusion that they demonstrated on their report was  
[6] that they felt that this was likely having arisen from  
[7] the endocervix. To me, that was an amazing jump for  
[8] anyone to make, looking at a lesion from the vagina and  
[9] saying that it came from the cervix. Yet, the cervix  
[10] that had been examined grossly and microscopically  
[11] approximately a year before was totally normal.

[12] There was nothing described in the gross  
[13] description. There was nothing seen in the microscopic,  
[14] and there was no clinical history or clinical physical  
[15] examination to indicate that the patient had anything  
[16] abnormal going on at the endocervix at all which could  
[17] have given rise to a tumor that subsequently showed up  
[18] in the vagina.

[19] Then when I looked at the next group of  
[20] tissue, which was the small bowel, all of a sudden, I  
[21] believe, on the top of the clinical information which  
[22] appears at the top of the report it is called "ovarian  
[23] cancer." I am looking at this history of information.  
[24] First, we have a hysterectomy that is performed on a  
[25] person who is known to have a cyst. She has a history

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[1] Q. Was that the first time, after reviewing his  
[2] testimony, that you were able to determine from where  
[3] these malignant cells or these marked atypical cells  
[4] that we are seeing in the pelvic wash came from?

[5] A. The first concern that I had about where these  
[6] atypical cells came from occurred when I examined the  
[7] tumor that showed up in the vagina and subsequently in  
[8] the small bowel. It was my sense that the lesion in the  
[9] small bowel, in particular, contained many foci of  
[10] malignant cells that were virtually identical to those  
[11] that were seen in the original pelvic washing.

[12] Q. There was a morphologic consistency?

[13] A. Absolutely. The tumor showed a variety of  
[14] morphologic patterns, but one of them certainly was  
[15] very, very similar, essentially identical, to the tumor  
[16] that was present in the pelvic washing.  
[17] The concern that occurred to me then was was  
[18] there some other primary tumor that had possibly  
[19] occurred within the abdomen that had been overlooked at  
[20] the time of the initial hysterectomy that had somehow  
[21] been passed on that was now showing up in the subsequent  
[22] material?

[23] But at the same time, I found the subsequent  
[24] reports very confusing and very inconsistent because the  
[25] vaginal report showed up, and they performed special

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[1] of endometriosis, and the cystic lesions are called  
[2] "benign," and she is said to have endometriosis.  
[3] Then she has a lesion that is removed from her  
[4] vagina, which is supposedly being derived from her  
[5] cervix, which previously has been completely normal both  
[6] by pap smear exam, physical exam, and an examination of  
[7] the hysterectomy specimen. Then the very next specimen  
[8] that we look at all of a sudden someone is saying she  
[9] has an ovarian cancer. It is sort of like how does all  
[10] of that go back to the original ovarian tissue that we  
[11] had to look at?

[12] So that was sort of the thinking process that  
[13] took place in examining what we were looking at in the  
[14] original cell block material and comparing it to the  
[15] history and to the appearance of the tumor particularly  
[16] in the last manifestation of the small bowel when there  
[17] was a lot more tumor to look at.

[18] Q. What was the size of the vaginal tumor at the  
[19] time of the biopsy in June of 2000?

[20] A. I don't recall, but I believe that it was  
[21] pretty small. The biopsy size -

[22] Q. I am talking about the overall size of the  
[23] tumor as opposed to the biopsy size.

[24] A. That I can't tell you. I don't recall that  
[25] information.

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[1] Q. I believe that it was somewhere in the  
 [2] neighborhood of 5 to 5.5 centimeters in size.  
 [3] A. That would make sense.  
 [4] Q. Now, do you have an opinion as it relates to  
 [5] the origin or the genesis of the vaginal tumor?  
 [6] A. I believe that that vaginal tumor was derived  
 [7] from the same source of the malignant cells that gave  
 [8] rise to the malignant cells in the pelvic washing.  
 [9] Q. Was it seeded in April of 1999, or was it  
 [10] there in that location, in the vaginal location?  
 [11] A. In the vaginal mucosa?  
 [12] Q. Yes.  
 [13] A. I don't have any information except to say  
 [14] that the physical exam that took place at the time at  
 [15] the time she had the operation was completely normal.  
 [16] Q. Except you wouldn't expect to find any type of  
 [17] abnormality if it was in the vaginal mucosa, would you?  
 [18] A. One would expect that on physical examination,  
 [19] particularly at the time of hysterectomy, that one would  
 [20] have been able to physically palpate the tumor mass  
 [21] depending upon how fast the tumor was growing.  
 [22] Q. What happened if it was only microscopic in  
 [23] location?  
 [24] A. The specific location within the vagina may  
 [25] have had a very important influence, again, on how it

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[1] MR. BONEZZI: Would you read my question back,  
 [2] please.  
 [3] (Record read.)  
 [4] BY MR. BONEUI:  
 [5] Q. All I want to know is this: In April of 1999  
 [6] was there more than one area of adenosquamous  
 [7] involvement?  
 [8] A. I believe that one would have to say that  
 [9] there is more than one area of involvement because the  
 [10] pelvic washing is positive.  
 [11] Q. Let's exclude for the moment the peritoneal  
 [12] fluid.  
 [13] A. Okay.  
 [14] Q. Other than the peritoneal fluid and what has  
 [15] been presumably been diagnosed as a - I am going to  
 [16] call it an atypical finding of that an endometrial  
 [17] implant that was adhered to the pelvic wall with the  
 [18] right ovary, that area, excluding the peritoneal fluid,  
 [19] is there any other area such as the vagina?  
 [20] A. I think that the vagina is an unlikely  
 [21] location for this lesion.  
 [22] Q. How about the posterior cul-de-sac?  
 [23] A. And I am not really excited about the  
 [24] posterior cul-de-sac.  
 [25] Q. You may not be excited, however -

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[1] may have manifested. In many situations if the tumor  
 [2] involves the vaginal mucosa proper, it may erode through  
 [3] the mucosal surface and present in the form of bleeding  
 [4] or some kind of discharge. It often will present, for  
 [5] example, in a pap smear that is obtained at the same  
 [6] time.  
 [7] If the lesion is contained entirely within the  
 [8] posterior fornix or the posterior pelvic area and has  
 [9] not eroded all the way through, then certainly one may  
 [10] not be able to identify it during a physical exam and  
 [11] through typical laboratory examinations like pap smears  
 [12] at the time.  
 [13] Q. In April of 1999 can you tell me, based upon  
 [14] the material that you have read and the slides that you  
 [15] have reviewed, if there was more than one location  
 [16] involving the adenosquamous carcinoma that was  
 [17] ultimately diagnosed in June of 2000?  
 [18] A. It is my understanding from reading - from  
 [19] recalling reading the chart information and the  
 [20] pathology information, that the patient was said to have  
 [21] a single mass located in the vagina at the time that  
 [22] biopsy was taken.  
 [23] So, that is about the best I can do in terms  
 [24] of answering that question. I am not sure if that is  
 [25] what you wanted to know or not.

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[1] A. But, you know, I would accept it, but I think  
 [2] that it is very unlikely. I really don't think that  
 [3] that is where the lesion occurred. I think that if we  
 [4] had had the opportunity to go back and reexamine the  
 [5] gross tissue that remained after the initial pathologic  
 [6] examination, that in all likelihood we would have found  
 [7] plenty of evidence of that tumor arising either in the  
 [8] right side or the left side, and that being the location  
 [9] where this tumor really best start. Whether it did so  
 [10] in association with endometriosis, which certainly seems  
 [11] to be similar to the B6 slide recut that I have had an  
 [12] opportunity to look at, but it may also have been a  
 [13] manifestation of what was really an LMP tumor that  
 [14] wasn't adequately examined at the time of the initial  
 [15] examination.  
 [16] Q. Here is what I need to find out. Let's  
 [17] presume for purposes of this question that the right  
 [18] ovary had an endometrial implant that had a very small  
 [19] focus or foci of an adenosquamous component.  
 [20] A. Okay.  
 [21] Q. But that tissue where it presents has already  
 [22] been removed because a bilateral salpingo-oophorectomy  
 [23] has already been performed -  
 [24] A. Okay.  
 [25] Q. - together with the hysterectomy.

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[1] A. Okay.  
[2] Q. Explain to me as best as you can how that  
[3] adenocarcinoma malignancy then was found in the vaginal  
[4] cuff in June of 2000 when the tissue that purportedly  
[5] held that adenocarcinoma component was removed; where  
[6] else was it?  
[7] A. That tumor was already free in the fluid.  
[8] That is why it showed up in the vaginal mucosa, in the  
[9] posterior cul-de-sac. That is why it showed up in the  
[10] omentum in the small bowel. The tumor, the malignant  
[11] tumor, was already floating around free in the abdominal  
[12] cavity. So, those tumor cells could site themselves  
[13] anywhere they wanted in the space that was left behind.  
[14] Q. Actually, they could also have seeded prior to  
[15] the removal of both the uterus and the ovaries  
[16] bilaterally, correct?  
[17] A. From the uterus and the ovaries or from  
[18] another location?  
[19] Q. No. Right now my understanding is that the  
[20] only place, at the time of surgery in April of 1999 that  
[21] you believe that there was a malignancy was that area  
[22] that arose in the right ovary or that endometrial  
[23] implant that was communicating with that right ovary; am  
[24] I correct?  
[25] A. No.

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[1] Q. Tell me where you thought it was then.  
[2] A. I think that that is a very good possibility.  
[3] On a histologic basis, the focus that is present in the  
[4] resect is very similar to the lesion that we are seeing  
[5] both in the pelvic washing and in the subsequent  
[6] sections of the tumor. I think that there is also a  
[7] very good possibility that there was a lot more of that  
[8] tumor sitting in one or both of those ovaries either  
[9] arising in larger foci of endometriosis, which were not  
[10] sampled in the original examination -  
[11] Q. But wasn't that removed?  
[12] A. It was removed, but the tumor is already  
[13] there. The tissue was not examined to determine whether  
[14] or not that lesion was actually present. There was a  
[15] lot of abnormal ovary on both sides. They took  
[16] typically what we would normal sample volumewise, and  
[17] they made the diagnosis that they made. But they missed  
[18] the very abnormal focus that had been present in those  
[19] original slides. Unfortunately, because they missed  
[20] that and they missed the positive fluid, they did not  
[21] undergo the opportunity to examine all the rest of the  
[22] tissue that was removed at that time to further  
[23] characterize where all of that may have been coming  
[24] from.  
[25] Q. Let's just presume for purposes of this

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[1] question that both the left ovary, the right ovary, the  
[2] left fallopian tube, and the right fallopian tube have  
[3] some focus of malignancy.  
[4] A. Okay.  
[5] Q. It is all removed.  
[6] A. Right.  
[7] Q. 16 months later or thereabouts there is also a  
[8] malignancy now found in the vaginal cuff.  
[9] A. Right.  
[10] Q. It is your presumption or your opinion that  
[11] the vaginal cuff or that region was, in all likelihood,  
[12] seeded simply because we have malignant cells that are  
[13] free floating in the peritoneal fluid?  
[14] A. That is correct.  
[15] Q. Now, my question is this: The seeding that  
[16] could have taken place in the vaginal cuff could have  
[17] seeded subsequent to the hysterectomy in the bilateral  
[18] salpingo-oophorectomy or before. Because remember the  
[19] tumor or the focus or whatever is there is exfoliating,  
[20] which is what has put the cells into the fluid?  
[21] A. I think that one could accept the fact that if  
[22] one already had a tumor circulating in the abdominal  
[23] cavity, that one could have seeded a location in the  
[24] posterior cul-de-sac and/or vagina at that time. I  
[25] think that that is reasonable. That certainly could

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[1] have occurred at the same time frame.  
[2] Q. Can we just take a 30 second break?  
[3] A. Sure.  
[4] (Recess taken.)  
[5] BY MR. BONEZZI:  
[6] Q. How soon after reviewing the slides for the  
[7] first time did you write your report? The first report  
[8] is dated February 27.  
[9] A. I think that is probably within a week or two  
[10] of having written the first report. It may have been a  
[11] little bit longer than that. Because as I said, in the  
[12] back of my small mind at this moment, I believe that we  
[13] looked at the slides for the first time in the late  
[14] fall. It may have been that I actually wrote the letter  
[15] after that in the early spring, but I do not recall what  
[16] the actual time period was. I really have to apologize  
[17] for that.  
[18] Q. Do you have your report in front of you? The  
[19] one I am talking about is dated February 22.  
[20] A. Okay.  
[21] Q. You state in the second paragraph "Based on  
[22] this preliminary evaluation, it is my opinion that a  
[23] high grade cancer was present in the original surgical  
[24] specimen performed of the hysterectomy in 1999 (based on  
[25] deposition testimony)."



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[1] Whose deposition testimony are you referring  
[2] to?  
[3] A I believe that I am referring to Dr.  
[4] Biscotti's deposition, but I am not **100** percent sure.  
[5] Q Well, one of the first depositions taken was  
[6] in February at the time at which this was written. The  
[7] individual who had been deposed would have been  
[8] Alexander Kennedy.  
[9] A That is probably actually where the first -  
[10] where that first impression actually was derived. It  
[11] was from Dr. Kennedy's deposition.  
[12] Q So your opinion that there was a high grade  
[13] cancer relative to the original surgical specimen is  
[14] based upon what Dr. Kennedy testified at his deposition;  
[15] is that correct?  
[16] A That is correct. There had been a tumor that  
[17] had not been appreciated on the initial evaluation, and  
[18] that that was responsible for the malignant tumors that  
[19] showed up subsequent.  
[20] Q And it was Dr. Kennedy who testified that  
[21] after the vaginal biopsy in June of 2000 he then  
[22] contacted Dr. Charles Biscotti and requested that he do  
[23] a review of the slide material from April of 1999.  
[24] Dr. Biscotti obtained information and passed that on to  
[25] Dr. Kennedy. That is what he testified to as it relates

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[1] to what was seen on B6?  
[2] A I believe that **is** what I read, sir.  
[3] Q That is what you are referring to in your  
[4] initial report, that the opinion that you held as it  
[5] related to high grade cancer was not based upon your  
[6] review of the slide material including the pelvic wash,  
[7] but what Dr. Kennedy had testified to in his deposition,  
[8] just on that original evaluation?  
[9] MS. NISSENBERG: I am going to object. He has  
[10] never seen the original, since you haven't made it  
[11] available, since the Cleveland Clinic can't find it.  
[12] BY MR. BONEZZI:  
[13] Q It makes no difference. The fact is your  
[14] opinion was based upon - at least this is what it says  
[15] right here, "Based on this preliminary evaluation, it is  
[16] my opinion," etcetera, et cetera, and that is based on  
[17] deposition testimony.  
[18] A Right. **My** impression is that there was a high  
[19] grade cancer that Dr. Kennedy reported that Dr. Biscotti  
[20] had identified on subsequent review, but that,  
[21] nevertheless, the pelvic washing was still positive at  
[22] that time. **So** I didn't have the opportunity to see a  
[23] high grade malignant tumor in the histology material  
[24] that was obtained from that original hysterectomy, but I  
[25] did see positive cells in the pelvic washing.

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[1] Q But the positive cell finding would not have  
[2] led you to the conclusion that there was a high grade  
[3] cancer present. That came from the testimony of  
[4] Dr. Kennedy. I am not trying to mince words here.  
[5] A I understand. The conclusion that I had from  
[6] looking at the pelvic washing was that there was a high  
[7] grade cancer present. Where it actually started out or  
[8] where it was first seen was made only clear to me in  
[9] reviewing the testimony of Dr. Kennedy and the  
[10] evaluation that was performed by Dr. Biscotti when he  
[11] reviewed the original histologic material in which he  
[12] proposed that there probably was a high grade malignant  
[13] tumor in one of those slides, which was not made  
[14] available for my initial evaluation.  
[15] Regardless of that, the patient actually had a  
[16] high grade malignant tumor present at the same time.  
[17] Q What I am getting at, sir, is what you have  
[18] written in your report. The cytologic examination that  
[19] you made of the material from the pelvic wash did not  
[20] allow you to conclude that there was a high grade cancer  
[21] present?  
[22] A In the hysterectomy specimen.  
[23] Q Yes.  
[24] A That is correct.  
[25] Q Not only the hysterectomy specimen, but also

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[1] from the information from the bilateral  
[2] salpingo-oophorectomy?  
[3] A Well, I am **including** all of that in the same  
[4] group. The bilateral salpingo-oophorectomy,  
[5] hysterectomy specimens are all a part of the same  
[6] surgical specimen. No, I did not have an opportunity to  
[7] identify a malignant tumor in any of these original  
[8] sections, but I was informed of that information based  
[9] on Dr. Kennedy's deposition of what Dr. Biscotti had  
[10] told him he had seen in the review of that same  
[11] material.  
[12] Q So when you speak of a hysterectomy, a  
[13] hysterectomy, in your parlance, means the removal of the  
[14] uterus together with the tubes and the ovaries, right?  
[15] A You know -  
[16] MR. BONEZZI: That **is** what you did, too.  
[17] MS. NISSENBERG: Total versus radical.  
[18] THE WITNESS: In an absolutely accurate way  
[19] the hysterectomy refers to the uterus alone.  
[20] Appropriately it should be referred to as a hysterectomy  
[21] with bilateral salpingo-oophorectomy, but we often sort  
[22] of just sort of put it together with the hysterectomy  
[23] specimen. Unless, in some cases, they may be removed  
[24] separately, and we talk about each little piece  
[25] separately.

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[1] But when I am talking about this part of the  
[2] specimen, I am talking about that they remove all of  
[3] this tissue in this operation, and I am thinking of this  
[4] all as being the hysterectomy specimen from the  
[5] operation that took place, but it includes -  
[6] BY MR. BONEZZI:  
[7] Q. Of all the tissue that was removed?  
[8] A. Yes. It includes the salpingo-oophorectomies  
[9] done on both sides.  
[10] Q. Is it your opinion that at the time that the  
[11] pelvic wash material was reviewed by Dr. Jennifer  
[12] Brainard, that if atypical cells were present, that she  
[13] should have reported the atypicality out?  
[14] A. Absolutely. I believe that if she were  
[15] uncomfortable or unequivocal in making a diagnosis,  
[16] nevertheless she was looking at a pelvic washing  
[17] specimen that contained cells that deserved additional  
[18] attention either in the form of additional evaluation of  
[19] the surgical specimen, which she had been advised was  
[20] normal, or via additional examination of the abdominal  
[21] cavity, which may have had a tumor located somewhere  
[22] else in it, which had not been identified at the time of  
[23] the original surgery.  
[24] But there was enough information in that  
[25] specimen that needed to be reported to say to the

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[1] clinician there is something going on that needs further  
[2] evaluation. We may take the time to do that in terms of  
[3] additional evaluation of the specimen that we already  
[4] have. It may be appropriate for you, if that turns out  
[5] to be negative, to continue with your evaluation of what  
[6] else is going on in this patient's abdomen.  
[7] Does she, for example, have an undiagnosed  
[8] bowel tumor? Was there a weird mesothelial type tumor  
[9] arising that is of mesothelial like origin elsewhere in  
[10] the pelvic cavity that wasn't identified? But certainly  
[11] something to say we need to do a lot more workup to  
[12] account for what is going on in this patient before we  
[13] pat her on the back and tell her goodbye for a year.  
[14] Q. Have you reviewed Dr. Regis Weiss' report?  
[15] A. I believe that I have looked at Dr. Weiss's  
[16] report very quickly. I was just kind of thumbing  
[17] through some of his comments because - we had a  
[18] conversation, Dr. Weiss, Merel and I had a phone  
[19] conversation.  
[20] Q. When was that?  
[21] A. Quite a while back.  
[22] Q. What was the gist of the conversation?  
[23] A. Part of the conversation was where is this  
[24] tumor coming from? Is it coming from an ovarian mass  
[25] that was not diagnosed appropriately in the initial

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[1] evaluation of the ovarian tissue? Was it possibly  
[2] coming from a tumor in the cervix as proposed in the  
[3] original biopsy specimen, which didn't make a whole lot  
[4] of sense? Was it possibly coming from a tumor that had  
[5] been living in the posterior cul-de-sac in the vagina  
[6] for a long time and had been not identified on gross  
[7] examination or through any of the other laboratory pap  
[8] smear examinations that had been performed? Possibly,  
[9] was this a tumor that had arisen in some of this  
[10] patient's relatively extensive endometriosis, which had  
[11] been sampled relatively simply and, in fact, was a  
[12] malignant transformation focus of endometriosis. We  
[13] talked about those kinds of things that took place.  
[14] Q. Was the discussion with Dr. Weiss before or  
[15] after you reviewed the slides for the first time?  
[16] A. It was after I reviewed the slides.  
[17] Q. Was it before or after you authored your  
[18] report?  
[19] A. I believe it was before that discussion.  
[20] Q. Was it before or after Dr. Weiss wrote his  
[21] report?  
[22] A. I don't know how it related to Dr. Weiss'  
[23] report. Because, again, if I read it, I read it very  
[24] late and paid little attention to his interpretation.  
[25] Because my impression was that Dr. Weiss' role in this

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[1] evaluation was as a clinician, and my responsibility was  
[2] as a pathologist.  
[3] Q. Did you discuss whether or not the malignancy  
[4] arose in an endometrial implant as one of the  
[5] possibilities?  
[6] A. We talked about the possibility of whether or  
[7] not there had been endometriosis, for example, in the  
[8] ovary that had given rise to this tumor. So we talked  
[9] about the possible transformation of the an  
[10] endometriotic focus but not as something that occurred  
[11] subsequent to the operation but at the time or before  
[12] the operation, the first operation had actually  
[13] occurred.  
[14] Q. What I want you to do right now - and I will  
[15] mark this as Defendant's Exhibit No. 1 after you do what  
[16] I am going to ask you to do. On B6, you looked at the  
[17] original recut. In fact, you have the original recut of  
[18] B6? You have that with you?  
[19] A. Let me make sure this is the same slide. This  
[20] is the second section of B6 that I was allowed to  
[21] evaluate.  
[22] Q. That would be the original recut.  
[23] A. Okay.  
[24] Q. Now, on that original recut, first of all, can  
[25] you identify ovarian tissue?

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[1] A. I believe that there is tissue present here  
 [2] which is Consistent with ovarian origin.  
 [3] Q. What I would like you to do is take that  
 [4] document that I have there and, first of all draw out if  
 [5] you could, please, what is represented on that slide.  
 [6] Because I want you to ultimately mark where the ovarian  
 [7] tissue vis-a-vis where the focus of atypicality is  
 [8] located.  
 [9] A. I think that this is issue that probably  
 [10] includes stroma. There are some old structures down in  
 [11] here.  
 [12] Q. Would you mark that for me, please, on that  
 [13] exhibit what area includes the ovarian stroma.  
 [14] A. I being that everything that I have marked  
 [15] here includes ovarian stroma.  
 [16] Q. Everything that has a line?  
 [17] A. Everything that is darkened here.  
 [18] (Exhibit No. 1 marked for identification.)  
 [19] BY MR. BONEZZI:  
 [20] Q. Would you label that for me, please. Now, I  
 [21] would also like you to put your name on that, and the  
 [22] date, This is Defendant's Exhibit No. 1.  
 [23] Now, in relationship to where the ovarian  
 [24] stroma is located, where is the focus of atypicality?  
 [25] A. I can do that.

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[1] Q. If you can take - do you have a red pen right  
 [2] there? We will use the red.  
 [3] A. Okay. The focus of abnormal material is right  
 [4] about in here (indicating).  
 [5] Q. How much of the ovarian tissue is involved as  
 [6] opposed to the endometrial tissue?  
 [7] A. The focus of very abnormal cellularity in the  
 [8] glandular differentiation material appears to be  
 [9] surrounded by material that looks like endometrial  
 [10] stroma.  
 [11] Q. Can you tell me, based upon your review there,  
 [12] whether the area of atypicality, that focus of  
 [13] atypicality, has arisen within the endometriosis and  
 [14] then ultimately invaded into the ovarian stroma, or is  
 [15] it the other way around?  
 [16] A. I think that the focus here is certainly  
 [17] consistent with having arisen within the endometriosis,  
 [18] but one cannot say that with 100 percent certainty.  
 [19] Q. Is it more likely than not?  
 [20] A. It looks fairly consistent arising within some  
 [21] endometriosis, but the cellular material itself is quite  
 [22] atypical and not manifesting the usual morphology that  
 [23] one sees in plain, run of the mill endometriosis as is  
 [24] present elsewhere in the slides from the specimen.  
 [25] Q. What does that tell you?

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[1] A. Well, it makes me wonder, first, is this a  
 [2] focus of malignancy that has arisen in the focus, which  
 [3] I think is a reasonable possibility. It also means that  
 [4] another possible differentiation that one might raise is  
 [5] that this is another focus of actually a tumor that  
 [6] isn't endometriosis that seems to be sitting side by  
 [7] side or adjacent to the endometriosis. But I think that  
 [8] it certainly looks much more like it is being derived  
 [9] from endometriosis.  
 [10] What has actually happened is that the very  
 [11] atypical cells that are forming this gland appear to  
 [12] have broken through the basement membrane that surrounds  
 [13] approximately 80 percent of the abnormal gland and  
 [14] started creeping outward into the surrounding stromal  
 [15] tissue, which is probably of endometriotic origin in the  
 [16] first place. But they are no longer contained within  
 [17] well defined glandular basement membrane. It becomes a  
 [18] solid, but a very irregular solid proliferation of very  
 [19] atypical appearing cells with very irregular nuclear  
 [20] membranes and quite prominent nucleoli.  
 [21] Q. Based upon that review of the B6 slide, the  
 [22] original recut, are you able to draw any conclusion of  
 [23] whether what you see represents a malignancy?  
 [24] A. I think that it is highly suspicious of being  
 [25] a malignancy.

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[1] Q. But it does not right to the level, however,  
 [2] of being called a frank malignancy, correct?  
 [3] A. It is one of those changes that is very small  
 [4] and sits very much on the fence. The question gets to  
 [5] be are you willing to call it malignancy because it  
 [6] appears to be invading beyond the basement membrane  
 [7] surrounding the glands so there is actually stromal  
 [8] change? In which case, most of us would say that is  
 [9] malignant, but it is really, really tiny, or is this  
 [10] almost more like an in situ process in which the  
 [11] malignant transformation has taken place inside the  
 [12] basement membrane within the glandular structure that  
 [13] already exists.  
 [14] My feeling is that the lesion has penetrated  
 [15] beyond the basement membrane and has invaded the stroma  
 [16] adjacent to this gland and therefore represents an  
 [17] extremely minute focus of what, nevertheless, is still  
 [18] cancer.  
 [19] Q. Would you expect that that minute focus of  
 [20] what you now believe is cancer to have exfoliated to the  
 [21] point or to the degree that you see those cells in the  
 [22] pelvic wash, or because of the minute focus would you  
 [23] conclude that those malignant cells that you claim exist  
 [24] in the pelvic wash actually come from another site?  
 [25] A. That is a very interesting differential. My

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[1] conclusion would be that the cells that are present in  
 [2] the fluid exhibit very many morphologic similarities to  
 [3] the cells that are present in this teeny, teeny focus,  
 [4] and that they may, in fact, be derived from this same  
 [5] lesion of which we are only seeing a very small sample.  
 [6] In other words, my belief is that it is much  
 [7] more likely that we have just seen the edge of what  
 [8] really is a malignant tumor that is happening in this  
 [9] patient. They got lucky. They got a little teeny tiny  
 [10] edge of the tumor, which is really what is going in this  
 [11] patient. They didn't appreciate it when they looked at  
 [12] the initial slides and that was it. So, they were not  
 [13] able to put together the idea that this is malignant  
 [14] tumor and morphologically it is virtually the same as  
 [15] the stuff we are seeing floating around in the fluid.  
 [16] Q. However, if there is another tumor located in  
 [17] another area that goes undetected, the likelihood is  
 [18] that the morphology of that tumor would be the same or  
 [19] similar to that which you see in B6?  
 [20] A. It could be.  
 [21] Q. Have you reviewed Dr. Robboy's report?  
 [22] A. I saw Dr. Robboy's initial letter, but I have  
 [23] not seen Dr. Robboy's report.  
 [24] MS. NISSENBERG: It is the same.  
 [25] THE WITNESS: Well, the initial letter -

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[1] pathology. I have written in pap smear cytopathology.  
 [2] Q. That is all listed in your CV, which I have  
 [3] already seen?  
 [4] A. Yes, it is.  
 [5] Q. Have you written, since your last publication,  
 [6] which is dated, I believe, 2000, "Preliminary Assessment  
 [7] of the AutoCyte Prep Directive Vial Experience."  
 [8] A. I have another publication that I would be  
 [9] more than happy to give you a reprint of that was  
 [10] published in Acta Cytologica.  
 [11] Q. That is probably "The Validation of the  
 [12] AutoPap Primary Screening Sensitivity" or is it another  
 [13] one?  
 [14] A. No. It is an evaluation of the sensitivity of  
 [15] the - yes, of the AutoPap Primary Screening.  
 [16] Q. I would love to have it. That one is a very  
 [17] difficult one to get.  
 [18] A. Yeah. I will give you a reprint of that.  
 [19] Q. I will take it. Have you learned about any of  
 [20] Dr. Robboy's opinions, as he expressed them yesterday,  
 [21] between the hours of 9:00 and 12:00?  
 [22] A. Yes. Merel came in before you got here and  
 [23] chatted with me briefly about some of Dr. Robboy's  
 [24] comments that were made during her deposition of him.  
 [25] Q. What was it that you were told?

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[1] okay - that indicated that he felt that, as I recall,  
 [2] there were minimal, very unexciting changes present in  
 [3] the pelvic wash.  
 [4] BY MR. BONEZZI:  
 [5] Q. Yes. Do you know who Dr. Robboy is?  
 [6] A. Yes. Dr. Robboy has got a list of  
 [7] publications that is longer than my body, not just my  
 [8] arm.  
 [9] Q. How tall are you?  
 [10] A. I am 5, 8. He has been in this business  
 [11] writing about GYN pathology for many, many years. He is  
 [12] well recognized not only as a national but an  
 [13] international expert in GYN pathology.  
 [14] Q. Do you consider him a national and  
 [15] international expert in GYN pathology?  
 [16] A. My sense is that he certainly would fulfill  
 [17] those criteria.  
 [18] Q. It is not his criteria that I am interested  
 [19] in, but yours.  
 [20] A. I mean, Dr. Robboy has written, like I said,  
 [21] extensively in this area. In my book that qualifies him  
 [22] in that area of expertise, certainly.  
 [23] Q. Have you ever written in the field of  
 [24] gynecologic pathology?  
 [25] A. I have not written in solid gynecologic

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[1] A. I was told that Dr. Robboy reconsidered, I  
 [2] should say, during his deposition the nature of the  
 [3] atypical cells that were present in the pelvic washing  
 [4] material that in his original evaluation he felt were -  
 [5] that there really was no atypia of any significance  
 [6] whatsoever. And then subsequent to a reevaluation, he  
 [7] came to the conclusion that certainly in retrospect that  
 [8] in all likelihood there were malignant cells present in  
 [9] the pelvic washing that were, nevertheless, a challenge  
 [10] to diagnose.  
 [11] Q. Anything else?  
 [12] A. What else did we talk about - I believe there  
 [13] was some discussion about the transformation of  
 [14] endometriosis into a fully malignant tumor, which we see  
 [15] on a very rare basis, he indicated occurs extremely  
 [16] rarely, which again has certainly been my own personal  
 [17] experience. I was a little bit surprised that he might  
 [18] have seen more of that as a consultant, but it just  
 [19] doesn't happen that often.  
 [20] Q. He indicated he does see it more because of  
 [21] the center that he works at; however, it is still an -  
 [22] A. Unusual.  
 [23] Q. - uncommon phenomenon.  
 [24] A. At this point of the day, I don't fully  
 [25] remember any of the other conversations that we had

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[1] earlier. I'm sorry. The major thrust was Dr. Robboy's  
[2] reevaluation of what was actually place in the pelvic  
[3] washing.  
[4] Q. Dr. Tench, how often have you worked with  
[5] Merel in cases?  
[6] A We were discussing that briefly before you  
[7] came in too, trying to remember.  
[8] Q. It is not often that the expert uses as a  
[9] greeting "Dear Merel" as opposed to "Ms. Nissenberg."  
[10] A That's correct. The first case that Merel  
[11] sent me was many years ago, a case simply to look at the  
[12] histologic material on a skin biopsy taken from a young  
[13] woman that had been misdiagnosed as a benign skin adnexo  
[14] lesion from her cheek.  
[15] I simply advised her that it was, as the  
[16] original pathologist had indicated, a review of basal  
[17] cell carcinoma. That was my level of involvement with  
[18] her at that opportunity.  
[19] Merel presented me with histologic material  
[20] from a three- or four-year old child who presented -  
[21] Q. i am going to stop you there instead of having  
[22] you go through all the cases. Just tell me how many.  
[23] A That is the second. The third case was a fine  
[24] needle aspiration of a breast mass. There were three  
[25] cases, I believe.

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[1] Q. Did you ever work with Dr. Weiss when he was  
[2] here in San Diego as a partner of Dr. Goldfarb?  
[3] A I, in the past, have looked at some of  
[4] Dr. Weiss' previous material when he was still in  
[5] practice here. I have worked at another private  
[6] laboratory that did pap smears. I believe we did some  
[7] biopsy for Dr. Weiss' private practice when he was still  
[8] at Sharp Hospital.  
[9] I knew him vaguely from my post-training  
[10] period. I trained here in San Diego from 1976 to 1979,  
[11] or 1975 to 1979. He was around about that time. I knew  
[12] of him. I did work for him when I worked in the other  
[13] laboratory, which was down in San Diego.  
[14] And then also I was on the faculty as an  
[15] attending at the University of California, San Diego, I  
[16] believe, when Dr. Weiss was still operating at the  
[17] university hospital. So I saw his material there as  
[18] well.  
[19] Q. Other than cases that you have worked with on  
[20] Ms. Nissenberg, have you associated yourself with her or  
[21] she with you as it relates to any committees, any  
[22] teaching, any associations, anything?  
[23] A. I have done no other social or professional  
[24] activities with Ms. Nissenberg.  
[25] MR. BONEZZI: Doctor, I would candidly like to

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[1] spend more time, but I think that given the hour of the  
[2] day, I will end the deposition at this point.  
[3] MS. NISSENBERG: Can I ask a question?  
[4] MR. BONEZZI: Go ahead.  
[5]  
[6] EXAMINATION  
[7] BY MS. NISSENBERG:  
[8] Q. Dr. Tench, is it possible that when the cyst  
[9] ruptured during the April 29, 1999 surgery, that  
[10] malignant material was seeded at that time even though  
[11] the surgical specimens were removed?  
[12] A. It could have occurred at that time,  
[13] certainly. The real problem is unfortunately we never  
[14] had any idea what was left over in the tissue that  
[15] wasn't examined because we were limited - or the  
[16] original tissue examination was limited to that which is  
[17] relatively typical, 8 or 9 blocks of a lesion, which on  
[18] initial evaluation looked sort of plain.  
[19] As I said, the real problem is that had the  
[20] fluid been appreciated for being what it was at that  
[21] time, it's more than likely that they could have pulled  
[22] that tissue out of the bottle and run a lot more of it  
[23] through and answered a lot of important questions about  
[24] that was going on right then and there.  
[25] ///

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[1] FURTHER EXAMINATION  
[2] BY MR. BONEZZI:  
[3] Q. Doctor, you are aware, are you not, from your  
[4] review of Dr. Kennedy's op note that the pelvic wash was  
[5] obtained prior to any type of removal of any organ or  
[6] any tissue?  
[7] A. I believe that is correct.  
[8] Q. The pelvic wash would have been done prior to  
[9] the time that the cyst or cysts were ruptured, correct?  
[10] A. That is correct.  
[11] MR. BONEZZI: Thank you. That's all I have.  
[12] (The deposition of WILLIAM D. TENCH, M.D.  
[13] concluded at 7:55 p.m.)  
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[1] STATE OF CALIFORNIA)  
[2] ) ss.  
[3] COUNTY OF SAN DIEGO )  
[4] I, the undersigned, hereby declare that I am the witness  
[5] in the within matter, that I have read the foregoing  
[6] deposition and know the contents thereof, and I declare  
[7] that the same is true of my own knowledge except as to  
[8] those matters, I believe them to be true.  
[9] I declare under penalty of perjury that the  
[10] foregoing is true and correct.  
[11] Executed on this       day of       , 2002, at  
[12]       , California.  
[13]  
[14]  
[15]  
[16] WILLIAM D. TENCH, M.D.  
[17]  
[18]  
[19]  
[20]  
[21]  
[22]  
[23]  
[24]  
[25]

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[1] STATE OF CALIFORNIA)  
[2] ) ss.  
[3] COUNTY OF SAN DIEGO )  
[4] I, PATRICIA Y. SCHULER, RPR, Certified Shorthand  
[5] Reporter for the State of California, do hereby certify:  
[6] That prior to being examined, the witness  
[7] named in the foregoing deposition was by me duly sworn  
[8] to testify to the truth, the whole truth and nothing but  
[9] the truth.  
[10] That said deposition was taken before me at  
[11] the time and place therein set forth and was taken down  
[12] by me in machine shorthand and thereafter was  
[13] transcribed into typewriting under my direction and  
[14] supervision, and I hereby certify the foregoing  
[15] transcript is a full, true and correct transcript of my  
[16] shorthand notes so taken.  
[17] I further certify that I am neither counsel  
[18] for nor related to any party to said action nor in any  
[19] way interested in the outcome thereof.  
[20] IN WITNESS WHEREOF, I have hereunto subscribed  
[21] my name this 24th day of June, 2002, at Murrieta,  
[22] California.  
[23]  
[24] PATRICIA Y. SCHULER, RPR  
[25] CSR NO. 11949

**Look-See Concordance Report**

---  
 UNIQUE WORDS: 1,439  
 TOTAL OCCURRENCES: 4,903  
 NOISE WORDS: 384  
 TOTAL WORDS IN FILE: 14,67

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 SINGLE FILE CONCORDANCE

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 CASE SENSITIVE

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 COVER PAGES = 3

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 INCLUDES ALL TEXT  
 OCCURRENCES

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 DATES ON

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 POSSESSIVE FORMS ON

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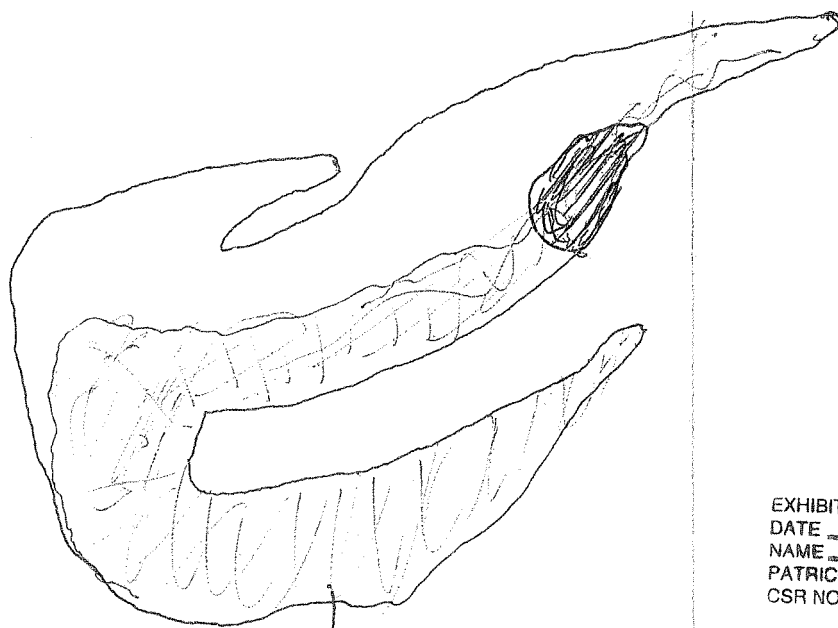
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Ovarian

Bill Tench  
6/19/02

EXHIBIT 1  
DATE 6-19-02  
NAME W. Tench  
PATRICIA Y. SCHULER, RPR  
CSR NO. 11949

Def Dep  
Ex 1

