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

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IN THE COURT OF COMMON PLEAS
CUYAHOGA COUNTY. OHIO

JOHN M. HUSTON Executor.)
Plaintiff.)
vs.) CASE NO. 439194
THE CLEVELAND CLINIC FOUNDATION. et al..)
Defendants.)

DEPOSITION OF WILLIAM D TENCH. M.D
ESCONDIDO, CALIFORNIA
JUNE 19. 2002

REPORTED BY PATRICIA Y. SCHULER. RPR. CSR NO. 11949

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Defendants.)

DEPOSITION OF WILLIAM D. TENCH. M.D., taken on behalf of the Defendant. at 555 East Valley Parkway, Escondido. California, on Wednesday. June 19. 2002. at 5:55 p.m. before Patricia Y. Schuler. RPR. Certified Shorthand Reporter. in and for the County of San Diego. State of California.

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WITNESS: WILLIAM D. TENCH, M.D.

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WILLIAM D. TENCH, M.D.,
having been first duly sworn, testified as follows:

EXAMINATION
BY MR. BONEZZI:
Q. Let the record show that this is the deposition of Dr. William Tench, who has been identified as an expert in the case of Huston, H-u-s-t-o-n, versus the Cleveland Clinic Foundation.
Dr. Tench, I am going to be asking you some questions this afternoon pertaining to opinions that you have authored on two separate occasions.
First, the letter is dated February 27, 2002; the second of which is May 30, 2002. If at any time I ask you a question that, first of all, you don't understand, at the conclusion of my question – if you would be so kind as to wait and then tell me you didn't understand it, I will do my best to rephrase: is that fair?
A. That's fine.
Q. If I ask you something that you don't have an answer to, I don't want you to guess, speculate hypothesize engage in conjecture. Just tell me you don't know and I will move on. How's that?
A. That sounds good to me.

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

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

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

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Q. Who is the current chairman of the Department of Anatomic Pathology?
A. The responsibility is now being maintained by two of my more junior colleagues who are sharing the responsibility.
Q. And have they taken the steps to initiate whatever needs to be initiated to get the rest of the department to follow the guidelines?
A. They have not.
Q. How many pathologists are currently associated with this institution?
A. We have six pathologists who are responsible for daily anatomic pathology. And then my other senior associate, Dr. Collins, is the director and the chief. His responsibilities revolve mainly around managing the clinical laboratory and the blood bank that he is associated with, which is the American Red Cross blood bank down in San Diego, but he does not do anatomic pathology any longer. His responsibilities tie him up for management issues.
Q. Of the six pathologists who currently are engaged in the practice of anatomic pathology or interpretation of specimens, how many do that fuii time as opposed to having other responsibilities?
A. Essentially all six of us are responsible full

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

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

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

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

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

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

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A. I believe that we have approximately 325. I am not absolutely sure, but is in that range.
Q. About that?
A. Um-hum.
Q. And Pomerado?
A. Pomerado, I believe, is about 125. Again, I am not absolutely sure.
Q. Do you keep statistics here at this institution, let's say going back in the iast five years, of how many gynecologic cancers have been diagnosed?
A. We do not keep specific statistics on any of the tumor site diagnoses in this institution. If we have a specific interest in finding some particular number, we can request our information services administrator to create a short program for us to generate that information, but we don't generate any kind of regular data on that on a yearly basis.
The tumor board – actually, it would be – well, it is part of the medical records services, but it includes part of the tumor board. They actually track individual malignancy rates at this institution and within the district as a whole, but that is outside of my department. They track that information based on reports that we provide to them so that they can get the

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follow-up information on patients.
So the information is available through the medical records or tumor department, but not through pathoiogy.
Q. And who in that department would be contacted to acquire that information, would you know?
A. It would have to be the current director of the cancer committee, and I am not sure who holds that position currently, but the hospital medical information systems department could probably provide that kind of information.
Q. Does your department maintain, however, the reports that would be submitted that is ultimately utilized to determine the number of cancers or malignancies that are diagnosed?
A. Yes, We keep a computer file. It is kept online constantly. That is available for retrieval through our own computer system. We also keep a paper copy of every report that is generated.
Q. So you would be able to access numbers, at least going back over for the last, say, three years, as it relates to the type of malignancies that have been diagnosed at this institution; would I be correct?
A. We would probably submit that request to the medical records department, the tumor board partly to

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

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

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

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Stone Kettering there may have been one more during that time, and possibly others in my residencies, but I do not recall seeing a primary case arising out of endometriosis since I have been in private practice.

Q. How would you go about to differentiate between a malignancy arising out of endometriosis or a malignant transformation of endometriosis as opposed to an endometrial impiant that has communicated with the ovary where the malignancy arises out of that implant?

A. Let me ask you - the second part of the question that you are asking me is to compare a malignant tumor arising in endometriosis.

Q. Yes.

A. Versus an endometrial adenocarcinoma that has extended to the ovary -

Q. Yes.

A. Or extrauterine location?

Q. Yes.

A. What was the actual question that you had?

Q. How would you go about to differentiate to be able to determine where it came from; in other words, what are the different properties, if there are any?

A. Sure. Well, I think that there are some properties that we are all going to look at in the first place. The starting place for that will be, number one,

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the examination of the uterus, the endometrial cavity itself. Is there a primary tumor, an endometriod tumor arising in the endometrial cavity?

If that is the case and one identifies a tumor of similar morphology outside of the endometrial cavity, then one may raise the question of whether or not that is a metastasis from the original endometrial primary.

One may also see primary tumors arising in the ovary of morphology which is similar to the endometrium. Again, if one finds that arising in an ovary or both ovaries in the absence of any other particular changes, then the general thrust is that this is an endometriod ovarian primary.

Sometimes one may actually find both of these tumors present in the same patient, that is to say there may been an endometriod adenocarcinoma or the endometrium. There also may be an endometroid appearing adenocarcinoma of the ovary, and there may be lots of discussions about whether those are two separate independent primary tumors or whether one came from the other.

But then when you move from looking at that part of the issue and say when did the tumor arise from endometriosis, the first critical thing that you have to be able to do is to actually demonstrate endometriosis.

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That, I think, convincingly has to be followed by demonstrating that there is transformation in part of that lesion that we can still recognize in some form or fashion as being endometriosis which now manifests the tumor characteristics of the transformation that is taking place.

For example, a clear cell adenocarcinoma arising in association with a large amount of endometriosis on the surface of an ovary, I do recall seeing a case like that when I was training. The ovary itself was typically normal, but it had an endometriotic cyst on the surface, which was clearly typical endometriosis. Within a portion of that, the endometriosis had undergone a malignant transformation into a highly malignant clear cell carcinoma.

Q. And both entities occurred at the same time is what you are saying?

A. That is correct. You are able to demonstrate the presence of endometriosis and the second tumor at the same time.

Q. You have read a number of depositions in this case including Dr. Alexander Kennedy's, have you not?

A. I have.

Q. Dr. Alexander Kennedy, who is a gynecologic surgeon here, or the gynecologic oncologist, has opined,

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subsequent to the April 29th surgery, that there was a malignant transformation of endometriosis found in the posterior of the cul-de-sac.

Do you recall that testimony?

A. I recall that comment.

Q. As you put this case together, is there - strike that.

As you put the case together, do you have an opinion whether or not the event, as Dr. Kennedy has described it, is indeed an event that very well could have happened; that is, having a malignant transformation of the endometriosis in the posterior cul-de-sac subsequent to the April 29th, 1999 surgery and at the same time having an endometrial implant demonstrating atypical changes?

A. I have to tell you that I found Dr. Kennedy's interpretation of the pathologic event that may or may not have occurred difficult to fully understand.

Q. Explain.

A. I felt that, judging from the information that was made available to me and examining the original surgical pathology reports and surgical pathology slides, that - and some of the op reports that I read - I don't recall the details, that there was no specific history at the time of the hysterectomy and

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

Q. If I may interrupt you for just a moment. If the endometriosis is extensive, is it likely that some of the endometriosis, regardless of piacement, will indeed be left behind?

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

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

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can appropriately comment on that.

Q. Presuming that what Dr. Kennedy stated in his deposition is correct; that is, that there was extensive endometriosis at the time of the original surgery and that there was endometriosis in the posterior cui-de-sac - I want you to presume that for purposes of this question.

A. Okay.

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

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

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

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

A. That's correct.

Q. Together with a second recut, if I am not mistaken?

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

Q. That is correct.

A. – this year. That is correct.

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

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

A. Yes.

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

MR. BONEZZI: There is.

MS. NISSENBERG: *So* he hasn't see the original recut, except now he has.

MR. BONEZZI: Yes.

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

MR. BONEZZI: Right. Yes, I know that.

THE WITNESS: Right. Those are the slides that I have examined.

BY MR. BONEZZI:

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

A. That's correct.

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Q. Now, you have indicated that in your review of the pelvic wash, that is how you just described it, there were malignant cells?
A. That's correct.
Q. Or you said that there was a malignancy present. I interpret that as demonstrating malignant cells?
A. That's correct.
Q. Were there malignant cells in both the cell block, as you reviewed it, together with the ThinPrep or in just one of them?
A. I believe that there are malignant cells present in both of those preparations. They are derived from the same sample. One is prepared as a histologic cell block section; the other is prepared as a ThinPrep specimen, but they come from the same sample. It is a different manner of preparing the same material.
Q. And the malignant cells that you have seen, is there an abundancy of cells; is there one cell; how many cells did you see?
A. I think that there is a fair amount of material present both in the cell block slide as well as in the ThinPrep slide.
Q. And when you reviewed the pelvic washings for the very first time, do you recall when that was?

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A. I believe that Merel brought those to me in the fall of a year ago.
Q. Would that be the fall of 2001, or the fall of 2002?
A. 2000, I think.
MS. NISSENBERG: I really can't remember. I think it was November, but I don't remember the year.
THE WITNESS: I think it was in the late fall of 2000 when she first brought the slides to me, but I am not 100 percent sure on that.
It is correct that I did not get to see the ThinPrep slide initially. That took a substantial amount of time to obtain from the clinic. The original slide that was made available to me was the cell block slide. Then Merel had to proceed to get the ThinPrep slide, which was many months after the original histologic section was examined.
BY MR. BONEZZI:
Q. When you initially examined the cell block absent the Thinprep, what information did you have?
A. I was provided initially with reports and histologic sections from the original hysterectomy and oophorectomy.
I was provided with the cell block slide and a report for it from the pelvic washing obtained at the same time. I was also provided with the vaginal biopsy and its report and then the subsequent small bowel biopsy and its report. But for the pelvic washing material only, I was provided with a copy of the original pathology report and the single histologic section taken from the cell block.
Q. When you reviewed the cell block, did you also have, in addition to that, the other material that you just indicated?
A. I have all the histologic sections that had been provided to Merel at the time.
Q. Which would have also included the vaginal biopsy of June of 2000?
A. That is correct.
Q. Do you happen to recall in which order you would have reviewed these slides?
A. I reviewed these in chronologic order, as I recall, which I began with the hysterectomy material and oophorectomy material followed by the pelvic washing, then followed by the vaginal biopsy, then followed by the small bowel biopsy.
All of that material - I examined the slides first and then examined the report to make sure that I was reading the right material from the right location and the right patient and comparing with what the report

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actually said to what my observations were at that particular time.
So, I looked at the first slides that came first followed with the report and the final information with the slides again to make sure that I was appreciating what was looked at. So each group of material was done in that order.
Q. When you reviewed those slides and when you then assured yourself that the slides that you were reviewing matched up with the reports and you had the numbers correctly, did you take any notes?
A. I did not take notes.
Q. Did you do any dictation?
A. I did not do any dictation. Merel was here in my office with me when I was looking at the material. She sat where she is now and we talked about what I was looking at under the microscope and what I was seeing on the reports as well.
Q. Was any information provided to you at that time as it related to what Dr. Clifton Mountain found when he reviewed the slides?
A. I recall no information about anybody else's review other than that present in the official reports. I had no other information about anyone else's interpretation of any of that material.

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MS. NISSENBERG: For the record, just so you don't spend a lot of time going down the wrong alley, he is not even a pathologist.

MR. BONEZZI: I know he is not. I know exactly who he is and where he came from. I couldn't figure out why a thoracic surgeon or a cardiothoracic surgeon would be sent the material. The man is 80 years old.

THE WITNESS: It is a mystery to me now.

MS. NISSENBERG: 78.

MR. BONEZZI: I was going to say 78. And he is here in San Diego as opposed to being at MD Anderson. I know who he is.

MS. NISSENBERG: Okay.

BY MR. BONEZZI:

Q. So I am not going down the wrong avenue here. When you reviewed these slides, did you attempt to make a comparison between the slides from the right and left ovary and then the pelvic wash and then the vaginal biopsy to see if there were any similar characteristics?

A. I would say that my initial evaluation of the first specimen, which is the hysterectomy and oophorectomy, was to examine the material that was present there, see how it compared to how it was

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actually reported out, how it was managed first grossly, and then report it out.

Having looked at that material, I came to the conclusion that the report was largely within the usual way of reporting that kind of information.

Q. The report you are speaking of is the report that was authored by Dr. Richard Prayson?

A. For the hysterectomy?

Q. Yes, and the bilateral salpingo-oophorectomy?

A. That's correct. Then I looked at the pelvic washing cell block slide and told Merel that I felt that the cell block washing was positive. I recall in that discussion, looking only at that material of the material, that I indicated to her that although I personally felt there were malignant cells in clusters in that material, some of which had actually been dotted at the Cleveland Clinic by either their technologist or pathologist, I would have been willing to accept that someone may have been willing to report less than an absolute malignant diagnosis. That is to say, had they reported a suspicious or atypical cells of marked atypia of undetermined origin, something along that line I could understand as being potentially within an acceptable range of reporting for that kind of material.

Q. If I understand what you just said, that had

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the pelvic wash indicated that there was the presence of atypical cells of undetermined origin, which obviously does not rise to the level of malignancy, that would have been acceptable to you?

A. Markedly atypical cells. In my way of managing a case like that, that may have been the actual diagnostic line, but appended to that would have been some kind of comment that would have indicated that the exact nature of this material was unclear, that malignancy was a significant risk factor, that the cells appeared to be coming from some undetermined source that is not from the uterus and ovarian tissue that had been reported as negative, and that some additional evaluation definitely would have been appropriate, but that the degree of atypia in those cells had to push you in that area of "I am very suspicious that there is malignancy taking place here." I may not be willing to make that diagnosis flat out as an official diagnosis, but we are getting very, very close to that and an additional evaluation needs to be done appropriate to that finding.

Q. Tell me about the characteristics that you saw that were contained within the cell block that rose to the level of marked atypia of unknown origin or undetermined origin?

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A. In the first place in the background of that material as presented in the cell block, there are populations of cells that we can recognize as a normal component of a pelvic washing, which are largely cells of mesothelial origin. They may come off in large flat sheets. They may come off in strips. On rare occasions, they may come off in papillary like groups depending upon what kind of original pathology is taking place. But they all manifest changes that we can recognize as being mesothelial and often some kind of minor mesothelial reactive process,

Also, within the background of that particular preparation are scattered cells that look to be probably of histiocytic origin and a scattered inflammatory cell here and there.

Q. If I may just interrupt. That would not be uncommon to find what you have just described, specifically in the presence of endometriosis, correct?

A. One would expect to find changes like that in the presence of many benign conditions.

Q. Including endometriosis?

A. Endometriosis could be included. One could have minor surface reactions on the serosa of the uterus or on the surface of the ovaries that can create those kinds of very minimal kinds of changes.

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

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clusters in which the nuclei are irregularly distributed in papillary or ball like groupings, some of which are relatively substantial size and really raise a very high suspicion of little papillary or aster like fragments of a malignant tumor that are floating around in the fluid and allow the cells to manifest these very irregular, architectural features.

Q. Do the atypical cells that you saw that you have described, at least to this extent, are those cells more common to have exfoliated from an actual tumor that has existed or that existed from the time in which the pelvic wash was obtained, as opposed to something much less than an actual tumor formation?

A. I think that once one begins to observe this unusual aggregate of manifestations - of cellular manifestations, the abnormal nuclear appearance, the irregularity of the nuclear membranes, the nucleoli which may be here and there, the difference in the cytoplasmic differentiation and the way the cells form these irregular aggregates, that the first thing that really must go through one's mind is "Am I looking at a malignant tumor which has exfoliated into the fluid?" And not likely is that malignant tumor a malignant mesothelioma, which more often than not continues to manifest the cellular differentiation features that we

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will see in normal and mildly reactive mesothelial cells but may on occasion exhibit, you know, a good deal more nuclear pleomorphism, but we still appreciate the cytoplasm differentiation and increased density towards the nucleus. The nuclei tend to be round and have centrally located nucleoli. The cells look much more like typical mesothelial cells. So we can deal with groups of funny looking mesothelial cells and wonder are we looking at a mesothelial reaction versus a possible mesothelioma, or we can separate this group of cells that we are looking at and say these those look to me like mesothelial. These look like something else that doesn't belong in this space. They are abnormal. They are clustering. Their organization is not typical of anything that normally lives in this particular space. Then the question gets to be are these malignant. Some of the things that one might want to do is to further explore what kind of differentiation those particular cells might demonstrate.

Q. Would I be correct in stating that that which you observed did not stand out to such degree that you were willing to call it malignant at the time that you initially reviewed the slide?

A. When I initially reviewed the slides, I told

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Merel that I felt that this was a malignant process, but that I could understand that had it been reported as something very atypical but less than an absolutely diagnostic malignancy, that I could understand how a cytopathologist or could not be willing to make the full step. The problem in part with looking at cell blocks, for example, of this kind of preparation, is that the preparation that the cells undergo in the block preparation itself can induce some changes that are a little bit more difficult to appreciate from one kind of fluid to the next. So instead of being willing to jump on the diagnosis with both feet from the start, you might say "There are clearly some very, very abnormal cells present here in the cell block, and I am very concerned that there is a malignant lesion taking place." Either I don't want to call it, frankly, malignant to start with, I may call it suspicious, or I may use some other term. Very atypical cells present cannot exclude malignancy, but it is well within that range that my initial interpretation occurred.

Q. What type of fixative was used?

A. I believe in this the original fixative was Bouins, but without looking at the report again I am not

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100 percent sure of that.
Q. Are you aware of whether or not bad fixative causes any greater reaction or causes any type of greater change in the cell?
A. I believe that it is fair to say that each different kind of material that we as cytopathologists or pathologists use to fix any cytologic preparation are going to induce some minor variations.
If I, for example, took the same pleura fluid and I fixed some of it in Formalin and I fixed some of it Special B fixatives and I fixed some of it in Bouins and some of the others, there may be some minor changes that you are going to see, for example, the staining of pattern. Instead of seeing eosinophilia with one particular fixative, it may no longer be eosinophilotactic. It may stain more green blue than it did red.
So there are going to be some changes that one may see based on the particular kind of fixative that is used for the preparation. But each institution gets used to using the fixatives that they are accustomed to using.
And at the same time, during the training process and learning process, one has to become accustomed to seeing what a mesothelial cell looks like

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

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

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

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

Q. You also reviewed the intraoperative interpretation, correct?

A. That's correct.

Q Did you conclude that that which Dr. Levtn had reported on was accurate?

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

Q. Ultimately you reviewed Dr. Biscotti's deposition testimony?

A. That is correct.

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

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

Q. There was a morphologic consistency?

A. Absolutely. The tumor showed a variety of morphologic patterns, but one of them certainly was very, very similar, essentially identical, to the tumor that was present in the pelvic washing. The concern that occurred to me then was was there some other primary tumor that had possibly occurred within the abdomen that had been overlooked at the time of the initial hysterectomy that had somehow been passed on that was now showing up in the subsequent material? But at the same time, I found the subsequent reports very confusing and very inconsistent because the vaginal report showed up, and they performed special

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immunohistological stains that were supposed to help in identifying the location of this -

Q. The cytokeratin stains?

A. The cytokeratin stains and the **CEAs.** The conclusion that they demonstrated on their report was that they felt that this was likely having arisen from the endocervix. To me, that was an amazing jump for anyone to make, looking at a lesion from the vagina and saying that it came from the cervix. Yet, the cervix that had been examined grossly and microscopically approximately a year before was totally normal. There was nothing described in the gross description. There was nothing seen in the microscopic, and there was no clinical history or clinical physical examination to indicate that the patient had anything abnormal going on at the endocervix at all which could have given rise to a tumor that subsequently showed up in the vagina. Then when I looked at the next group of tissue, which was the small bowel, all of a sudden, I believe, on the top of the clinical information which appears at the top of the report it is called "ovarian cancer." I am looking at this history of information. First, we have a hysterectomy that is performed on a person who is known to have a cyst. She has a history

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

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

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

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

Q. I am talking about the overall size of the tumor as opposed to the biopsy size.

A. That I can't tell **you.** I don't recall that information.

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

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

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MR. BONEZZI: Would you read my question back, please.
(Record read.)
BY MR. BONEUI:
Q. All I want to know is this: In April of 1999 was there more than one area of adenosquamous involvement?
A. I believe that one would have to say that there is more than one area of involvement because the pelvic washing is positive.
Q. Let's exclude for the moment the peritoneal fluid.
A. Okay.
Q. Other than the peritoneal fluid and what has been presumably been diagnosed as a – I am going to call it an atypical finding of that an endometrial implant that was adhered to the pelvic wall with the right ovary, that area, excluding the peritoneal fluid, is there any other area such as the vagina?
A. I think that the vagina is an unlikely location for this lesion.
Q. How about the posterior cul-de-sac?
A. And I am not really excited about the posterior cul-de-sac.
Q. You may not be excited, however –

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

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A. Okay.
Q. Explain to me as best as you can how that adenosquamous malignancy then was found in the vaginal cuff in June of 2000 when the tissue that purportedly held that adenosquamous component was removed; where else was it?
A. That tumor was already free in the fluid. That is why it showed up in the vaginal mucosa, in the posterior cul-de-sac. That is why it showed up in the omentum in the small bowel. The tumor, the malignant tumor, was already floating around free in the abdominal cavity. So, those tumor cells could site themselves anywhere they wanted in the space that was left behind.
Q. Actually, they could also have seeded prior to the removal of both the uterus and the ovaries biiateraliy, correct?
A. From the uterus and the ovaries or from another location?
Q. No. Right now my understanding is that the only place, at the time of surgery in April of 1999 that you believe that there was a malignancy was that area that arose in the right ovary or that endometrial implant that was communicating with that right ovary; am I correct?
A. No.

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

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question that both the left ovary, the right ovary, the left fallopian tube, and the right fallopian tube have some focus of malignancy.
A. Okay.
Q. it is all removed.
A. Right.
Q. 16 months later or thereabouts there is also a malignancy now found in the vaginal cuff.
A. Right.
Q. It is your presumption or your opinion that the vaginal cuff or that region was, in all likelihood, seeded simply because we have malignant cells that are free floating in the peritoneal fluid?
A. That is correct.
Q. Now, my question is this: The seeding that could have taken place in the vaginai cuff could have seeded subsequent to the hysterectomy in the bilateral salpingo-oophorectomy or before. Because remember the tumor or the focus or whatever is there is exfoliating, which is what has put the cells into the fiuid?
A. I think that one could accept the fact that if one already had a tumor circulating in the abdominal cavity, that one could have seeded a location in the posterior cul-de-sac and/or vagina at that time. I think that that is reasonable. That certainly could

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

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

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

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Q. But the positive cell finding would not have led you *to* the conclusion that there was a high grade cancer present. That came from the testimony of Dr. Kennedy. I am not trying to mince words here.
A. I understand. The conclusion that I had from looking at the pelvic washing was that there was a high grade cancer present. Where it actually started out or where it was first seen was made only clear to me in reviewing the testimony of Dr. Kennedy and the evaluation that was performed by Dr. Biscotti when he reviewed the original histologic material in which he proposed that there probably was a high grade malignant tumor in one of those slides, which was not made available for my initial evaluation. Regardless of that, the patient actually had a high grade malignant tumor present at the same time.
Q. What I am getting at, sir, is what you have written in your report. The cytologic examination that you made of the material from the pelvic wash did not allow you to conclude that there was a high grade cancer present?
A. In the hysterectomy specimen.
Q. Yes.
A. That is correct.
Q. Not only the hysterectomy specimen, but also

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

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But when I am talking about this part of the specimen, I am talking about that they remove all of this tissue in this operation, and I am thinking of this all as being the hysterectomy specimen from the operation that took place, but it includes -

BY MR. BONEZZI:

Q. Of all the tissue that was removed?

A. Yes. It includes the salpingo-oophorectomies done on both sides.

Q. Is it your opinion that at the time that the pelvic wash material was reviewed by Dr Jennifer Brainard, that if atypical cells were present, that she should have reported the atypicaiity out?

A. Absolutely. I believe that if she were uncomfortable or unequivocal in making a diagnosis, nevertheless she was looking at a pelvic washing specimen that contained cells that deserved additional attention either in the form of additional evaluation of the surgical specimen, which she had been advised was normal, or via additional examination of the abdominal cavity, which may have had a humor located somewhere else in it, which had not been identified at the time of the original surgery.

But there was enough information in that specimen that needed to be reported to say to the

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clinician there is something going on that needs further evaluation. We may take the time to do that in terms of additional evaluation of the specimen that we already have. It may be appropriate for you, if that turns out to be negative, to continue with your evaluation of what else is going on in this patient's abdomen. Does she, for example, have an undiagnosed bowel tumor? Was there a weird mesothelial type tumor arising that is of mesothelial like origin elsewhere in the pelvic cavity that wasn't identified? But certainly something to say we need to do a lot more workup to account for what is going on in this patient before we pat her on the back and tell her goodbye for a year.

Q. Have you reviewed Dr. Regis Weiss' report?

A. I believe that I have looked at Dr. Weiss's report very quickly. I was just kind of thumbing through some of his comments because - we had a conversation, Dr. Weiss, Merel and I had a phone conversation.

Q. When was that?

A. Quite a while back.

Q. What was the gist of the conversation?

A. Part of the conversation was where is this tumor coming from? Is it coming from an ovarian mass that was not diagnosed appropriately in the initial

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evaluation of the ovarian tissue? Was it possibly coming from a tumor in the cervix as proposed in the original biopsy specimen, which didn't make a whole lot of sense? Was it possibly coming from a tumor that had been living in the posterior cul-de-sac in the vagina for a long time and had been not identified on gross examination or through any of the other laboratory pap smear examinations that had been performed? Possibly, was this a tumor that had arisen in some of this patient's relatively extensive endometriosis, which had been sampled relatively simply and, in fact, was a malignant transformation focus of endometriosis. We talked about those kinds of things that took place.

Q. Was the discussion with Dr. Weiss before or after you reviewed the slides for the first time?

A. It was after I reviewed the slides.

Q. Was it before or after you authored your report?

A. I believe it was before that discussion.

Q. Was it before or after Dr. Weiss wrote his report?

A. I don't know how it related to Dr. Weiss' report. Because, again, if I read it, I read it very late and paid little attention to his interpretation. Because my impression was that Dr. Weiss' role in this

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evaluation was as a clinician, and my responsibility was as a pathologist.

Q. Did you discuss whether or not the malignancy arose in an endometrial implant as one of the possibilities?

A. We talked about the possibility of whether or not there had been endometriosis, for example, in the ovary that had given rise to this tumor. So we talked about the possible transformation of the an endometriotic focus but not as something that occurred subsequent to the operation but at the time or before the operation, the first operation had actually occurred.

Q. What I want you to do right now - and I will mark this as Defendant's Exhibit No. 1 after you do what I am going to ask you to do. On B6, you looked at the original recut. In fact, you have the original recut of B6? You have that with you?

A. Let me make sure this is the same slide. This is the second section of B6 that I was allowed to evaluate.

Q. That would be the original recut.

A. Okay.

Q. Now, on that original recut, first of all, can you identify ovarian tissue?

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A. I believe that there is tissue present here which is Consistent with ovarian origin.
Q. What I would like you to do is take that document that I have there and, first of all draw out if you could, please, what is represented on that slide. Because I want you to ultimately mark where the ovarian tissue vis-a-vis where the focus of atypicality is located.
A. I think that this is issue that probably includes stroma. There are some old structures down in here.
Q. Would you mark that for me, please, on that exhibit what area includes the ovarian stroma.
A. I being that everything that I have marked here includes ovarian stroma.
Q. Everything that has a line?
A. Everything that is darkened here.
(Exhibit No. 1 marked for identification.)
BY MR. BONEZZI:
Q. Would you label that for me, please. Now, I would also like you to put your name on that, and the date, This is Defendant's Exhibit No. 1. Now, in relationship to where the ovarian stroma is located, where is the focus of atypicality?
A. I can do that.

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

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

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

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conclusion would be that the cells that are present in the fluid exhibit very many morphologic similarities to the cells that are present in this teeny, teeny focus, and that they may, in fact, be derived from this same lesion of which we are only seeing a very small sample. In other words, my belief is that it is much more likely that we have just seen the edge of what really is a malignant tumor that is happening in this patient. They got lucky. They got a little teeny tiny edge of the tumor, which is really what is going in this patient. They didn't appreciate it when they looked at the initial slides and that was it. So, they were not able to put together the idea that this is malignant tumor and morphologically it *is* virtually the same as the stuff we are seeing floating around in the fluid.

Q. However, if there is another tumor located in another area that goes undetected, the likelihood is that the morphology of that tumor would be the same or similar to that which you see in B6?

A. It could be.

Q. Have you reviewed Dr. Robboy's report?

A. I saw Dr. Robboy's initial letter, but I have not seen Dr. Robboy's report.

MS. NISSENBERG: It is the same.

THE WITNESS: Well, the initial letter -

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okay - that indicated that he felt that, as I recall, there were minimal, very unexciting changes present in the pelvic wash.

BY MR. BONEZZI:

Q. Yes. Do you know who Dr. Robboy is?

A. Yes. Dr. Robboy has got a list of publications that is longer than my body, not just my arm.

Q. How tall are you?

A. I am 5, 8. He has been in this business writing about GYN pathology for many, many years. He is well recognized not only as a national but an international expert in GYN pathology.

Q. Do you consider him a national and international expert in GYN pathology?

A. My sense is that he certainly would fulfill those criteria.

Q. It is not his criteria that I am interested in, but yours.

A. I mean, Dr. Robboy has written, like I said, extensively in this area. In my book that qualifies him in that area of expertise, certainly.

Q. Have you ever written in the field of gynecologic pathology?

A. I have not written in solid gynecologic

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pathology. I have written in pap smear cytopathology.

Q. That is all listed in your CV, which I have already seen?

A. Yes, it is.

Q. Have you written, since your last publication, which is dated, I believe, 2000, "Preliminary Assessment of the AutoCyte Prep Directive Vial Experience."

A. I have another publication that I would be more than happy to give you a reprint of that was published in Acta Cytologica.

Q. That is probably "The Validation of the AutoPap Primary Screening Sensitivity" or is it another one?

A. No. It is an evaluation of the sensitivity of the - yes, of the AutoPap Primary Screening.

Q. I would love to have it. That one is a very difficult one to get.

A. Yeah. I will give you a reprint of that.

Q. I will take it. Have you learned about any of Dr. Robboy's opinions, as he expressed them yesterday, between the hours of 9:00 and 12:00?

A. Yes. Merel came in before you got here and chatted with me briefly about some of Dr. Robboy's comments that were made during her deposition of him.

Q. What was it that you were told?

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A. I was told that Dr. Robboy reconsidered, I should say, during his deposition the nature of the atypical cells that were present in the pelvic washing material that in his original evaluation he felt were - that there really was no atypia of any significance whatsoever. And then subsequent to a reevaluation, he came to the conclusion that certainly in retrospect that in all likelihood there were malignant cells present in the pelvic washing that were, nevertheless, a challenge to diagnose.

Q. Anything else?

A. What else did we talk about - I believe there was some discussion about the transformation of endometriosis into a fully malignant tumor, which we see on a very rare basis, he indicated occurs extremely rarely, which again has certainly been my own personal experience. I was a little bit surprised that he might have seen more of that as a consultant, but it just doesn't happen that often.

Q. He indicated he does see it more because of the center that he works it; however, it is still an -

A. Unusual.

Q. - uncommon phenomenon.

A. At this point of the day, I don't fully remember any of the other conversations that we had

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earlier. I'm sorry. The major thrust was Dr. Robboy's reevaluation of what was actually place in the pelvic washing.

Q. Dr. Tench, how often have you worked with Merel in cases?

A. We were discussing that briefly before you came in too, trying to remember.

Q. It is not often that the expert uses as a greeting "Dear Merel" as opposed to "Ms. Nissenberg."

A. That's correct. The first case that Merel sent me was many years ago, a case simply to look at the histologic material on a skin biopsy taken from a young woman that had been misdiagnosed as a benign skin adnexo lesion from her cheek.

I simply advised her that it was, as the original pathologist had indicated, a review of basal cell carcinoma. That was my level of involvement with her at that opportunity.

Merel presented me with histologic material from a three- or four-year old child who presented –

Q. i am going to stop you there instead of having you go through all the cases. Just tell me how many.

A. That is the second. The third case was a fine needle aspiration of a breast mass. There were three cases, I believe.

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Q. Did you ever work with Dr. Weiss when he was here in San Diego as a partner of Dr. Goldfarb?

A. I, in the past, have looked at some of Dr. Weiss' previous material when he was still in practice here. I have worked at another private laboratory that did pap smears. I believe we did some biopsy for Dr. Weiss' private practice when he was still at Sharp Hospital.

I knew him vaguely from my post-training period. I trained here in San Diego from 1976 to 1979, or 1975 to 1979. He was around about that time. I knew of him. I did work for him when I worked in the other laboratory, which was down in San Diego.

And then also I was on the faculty as an attending at the University of California, San Diego, I believe, when Dr. Weiss was still operating at the university hospital. So I saw his material there as well.

Q. Other than cases that you have worked with on Ms. Nissenberg, have you associated yourself with her or she with you as it relates to any committees, any teaching, any associations, anything?

A. I have done no other social or professional activities with Ms. Nissenberg.

MR. BONEZZI: Doctor, I would candidly like to

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spend more time, but I think that given the hour of the day, I will end the deposition at this point.

MS. NISSENBERG: Can I ask a question?

MR. BONEZZI: Go ahead.

EXAMINATION

BY MS. NISSENBERG:

Q. Dr. Tench, is it possible that when the cyst ruptured during the April 29, 1999 surgery, that malignant material was seeded at that time even though the surgical specimens were removed?

A. It could have occurred at that time, certainly. The real problem is unfortunately we never had any idea what was left over in the tissue that wasn't examined because we were limited – or the original tissue examination was limited to that which is relatively typical, 8 or 9 blocks of a lesion, which on initial evaluation looked sort of plain.

As I said, the real problem is that had the fluid been appreciated for being what it was at that time, it's more than likely that they could have pulled that tissue out of the bottle and run a lot more of it through and answered a lot of important questions about that was going on right then and there.

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FURTHER EXAMINATION

BY MR. BONEZZI:

Q. Doctor, you are aware, are you not, from your review of Dr. Kennedy's op note that the pelvic wash was obtained prior to any type of removal of any organ or any tissue?

A. I believe that is correct.

Q. The pelvic wash would have been done prior to the time that the cyst or cysts were ruptured, correct?

A. That is correct.

MR. BONEZZI: Thank you. That's all I have.

(The deposition of WILLIAM D. TENCH, M.D. concluded at 7:55 p.m.)

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STATE OF CALIFORNIA)
) ss.
COUNTY OF SAN DIEGO)

I, the undersigned, hereby declare that I am the witness in the within matter, that I have read the foregoing deposition and know the contents thereof, and I declare that the same is true of my own knowledge except as to those matters, I believe them to be true.
I declare under penalty of perjury that the foregoing is true and correct.
Executed on this day of , 2002, at , California.

WILLIAM D. TENCH, **M.D.**

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STATE OF CALIFORNIA)
) ss.
COUNTY OF SAN DIEGO)

I, PATRICIA Y. SCHULER, RPR, Certified Shorthand Reporter for the State of California, do hereby certify:
That prior to being examined, the witness named in the foregoing deposition was by me duly sworn to testify to the truth, the whole truth and nothing but the truth.
That said deposition was taken before me at the time and place therein set forth and was taken down by me in machine shorthand and thereafter was transcribed into typewriting under my direction and supervision, and I hereby certify the foregoing transcript is a full, true and correct transcript of my shorthand notes so taken.
I further certify that I am neither counsel for nor related to any party to said action nor in any way interested in the outcome thereof.
IN WITNESS WHEREOF, I have hereunto subscribed my name this 24th day of June, 2002, at Murrieta, California.

PATRICIA Y. SCHULER, RPR
CSR NO. 11949

Look-See Concordance Report

UNIQUE WORDS: 1,439
TOTAL OCCURRENCES: 4,903
NOISE WORDS: 384
TOTAL WORDS IN FILE: 14,67
SINGLE FILE CONCORDANCE
CASE SENSITIVE
COVER PAGES = 3
INCLUDES ALL TEXT OCCURRENCES
DATES ON
IGNORES PURE NUMBERS
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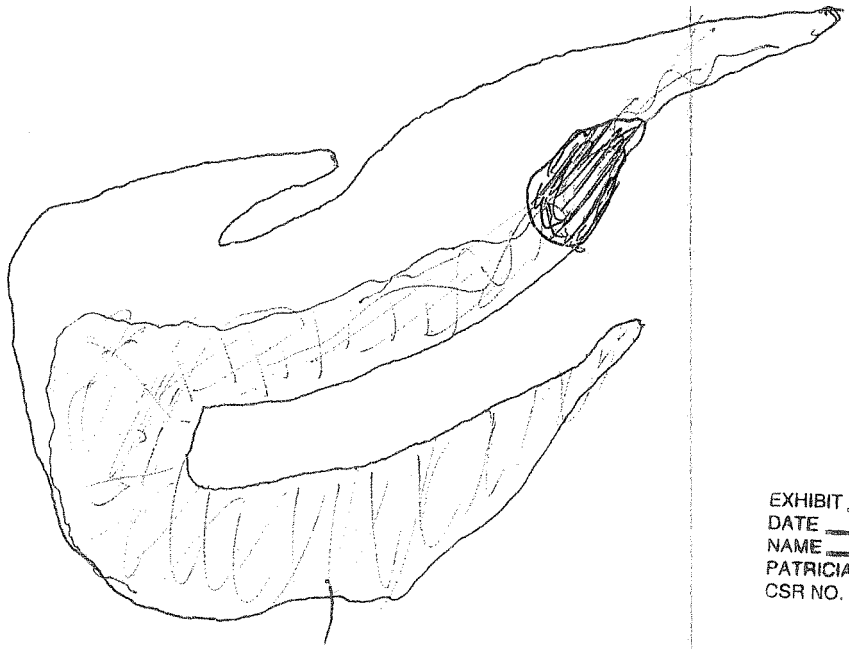

Bill Tench
6/19/02

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

Def Dep
Ex 1