

## MEDICAL RECORDS AND CASE REVIEW CONSULTATION

DATE OF REPORT: 2/13/2007

DATE OF REVIEW: 2/9/2007

CLIENT: XXXXX and XXXXXXXX, PA

ATTORNEY: XXXX XXXXXXX, Esq.

TYPE OF REVIEW: Full Review and Report

SUBJECT: XXXX XXXXXXX

RECORDS REVIEWED: 1000 photocopied pages, 2000 to 2006 Hospitalization records of Xouthside Hospital, XXXanta, XX; Assorted medical office records from Drs. Xarrison (FP); Xelman (Onc/Surg); Xeisler, Xarner (Onc/Rad); Xones (Surg/Ear); Xobes (Derm), Xade, Xee, Xlide (Path); Xick (Rad/Dx); Xlugman (Surg/Hand); Xlass (Med/ID); Xamaras (Surg/Spine).

### EXECUTIVE SUMMARY:

This is a case of a 61 year old, active, robust appearing, Caucasian male former pro football player, who was suddenly found in Feb. 2006 to be full of metastatic disease(Mets), including brain Mets, after being admitted via the ER for changes in mental status. His cancer appeared advanced beyond any hope of treatment and he died shortly after this admission in hospice. The deceased had survived initial diagnoses of malignant melanoma since 2000, with recurrence in 2003 and both times with “negative” metastatic disease work-up. The original melanoma lesion was excised in 2000 from the left ear with no apparent symptoms or signs of chronic disease except erectile dysfunction and low platelet counts. A recurrent lesion was removed in 2003 with repeat search for signs of systemic spread. The defining moment of this case was the decision to forego systemic interferon therapy and radiation therapy to treat potential spread of the malignant melanoma due to all radiology imaging being read as “normal”. All these same imaging “staging” studies in 2006 showed diffuse metastatic disease.

The records provided are sufficient for only raising suspicion via the possibility of a missed radiological or laboratory sign of early tumor spread by comparing 2000, 2003 and 2006 studies. The only other abnormal test was the consistently borderline low platelet counts (thrombocytopenia) but this may have been the patients anecdotal normal. A plain film of the facial bones showed an “abnormal density” and a neck CT showed abnormal lymph nodes but the follow up studies were not performed.

The establishment of “probable cause” in my opinion, for establishing, by preponderance of the evidence, any medical negligence, will require a complete re-examination of the available imaging and other “tumor staging” parameters used to recommend against the treatments of interferon and radiation therapies. A full set of all routine, diagnostic, pre and post op and serial follow up studies, biopsy slides, surgical path specimen reports, “red flag” labs such as elevated serum calcium, anemia of chronic disease, elevated ferritin, and other markers of “latent chronic neoplastic disease” will reveal what happened to this once robust man who suddenly fell ill and died of undetected diffuse metastatic malignant melanoma. These suggested re-examinations of these important tests to determine the presence or absence of the spread of cancer in this at risk patient, especially since 2003 when the primary cancer was last observed, will provide the basis for this case to show probable cause.

### CONCLUSIONS:

1. The medical record **does not** document errors of omission or commission by the medical care providers although there appears reasonable suspicion of errors of omission since cancer treatment in 2003 was withheld and when diffuse metastatic disease was eventually discovered, and then it was too late.
2. The medical record **does not** document departure from the acceptable local standard of medical care at this time other than lack of follow-up on platelet count abnormalities and lack of follow up on some incidental findings on x-rays in 2003.

### RECOMMENDATIONS:

Further medical records and expert procurement are necessary to answer the following:

1. Where are the original 2003 PET, CT, nuclear medicine bone scans or other “staging” films and labs stored and used by the oncology team after the recurrent melanoma ear lesion was resected? Who is best to “re-read” these studies for identifying missed lesions and determination of metastatic disease thereby substantiating a wrongful death tort by the negligence of failure to diagnose early metastatic disease in 2003? (We can assist in identifying an academic CT/PET scan radiologist published in melanoma metastasis detection)
2. It is reported by the client’s wife that at an autopsy of an abdominal lesion, healing from a recent I&D of a “carbuncle“, was reported eventually as a malignant melanoma. What happened to the specimen of this earlier abdominal excision? Where is the explanation by that surgeon to discard a skin specimen from a patient with history of recurrent skin melanoma? (this is negligent but not responsible for wrongful death in this case because was done near to patient’s death)
3. Besides consistently borderline low platelets counts on CBC, aforementioned radiology films and labs what other unreviewed records might be “out there” as far as

pathology or lab, x-ray specimens from 2003 to 2006 that might be available to search for missed tumor cell “red flags“. This could include surgical bone fragments and specimens from the knee and back surgeries as these pathology reports and perioperative labs are missing.

4. What medical providers or medical clinic testing records, clinical investigations, dermatopathology slides or other pathology specimens may be available that might show, on re-read, signs of metastasis or paraneoplastic disease? (Note defense can point to robust active lifestyle and lack of any “red flag“ test results as well)

Upon procurement of the aforementioned labs, x-rays, pathology reports, and most of all expert melanoma metastasis radiology expert for film re-reads, I am again available to further assist you in this matter.

I appreciate the opportunity to assist you with this case. If I can be of further litigation assistance please contact me. We believe our further involvement in this case may be of benefit to your cause. We hope it will be a successful litigation for your client and your firm.

XXXXX X. XXXXXXXXX, XX MD, PhD, FXXXX  
Legal Medicine Consultant