

## PREPARATION AND TRIAL OF A MALIGNANT MELANOMA CASE

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### I. INTRODUCTION

Melanoma is a malignant tumor that originates in pigmented skin cells called melanocytes. It is of special interest for two reasons. First, the incidence of malignant melanoma is increasing at a faster rate than that of any other cancer except bronchogenic carcinoma.<sup>1</sup> If it continues to increase at this rate -- and there is no reason to doubt that it will -- we will be facing an epidemic of this disease.<sup>2</sup>

Second, melanoma that is diagnosed early and treated properly is highly curable.<sup>3,4</sup> Consequently, medical negligence claims based upon failure to properly diagnose malignant melanoma generally do not present the frustrating causation issues that are so common in cancer misdiagnosis cases.

### II. MEDICAL CONSIDERATIONS

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<sup>1</sup> Mastrangelo, Cutaneous Melanoma in Cancer: Principles & Practice of Oncology 1371 (2d ed. 1985) [hereinafter cited as "Cutaneous Melanoma"]; Creagan, Regional and Systemic Strategies for Metastatic Malignant Melanoma, 64 Mayo Clin. Proc. 852, abstract (1989). Dr. Creagan states that "[r]ecreational exposure to sunlight is undoubtedly an etiologic factor." Id. Epidemiologists report that the incidence of malignant melanoma is doubling worldwide every 10 to 17 years. It has increased fourfold among Caucasians in southern Arizona. Cutaneous Melanoma at 1372.

<sup>2</sup> The epidemic may already be upon us. A Westlaw search conducted for this article yielded 92 cases involving malignant melanoma. A Medline inquiry conducted by ATLASearch at the author's request retrieved 428 medical articles on malignant melanoma published in 1990 alone.

<sup>3</sup> See, e.g., Cutaneous Melanoma at 1376, 1379, Tables 39-8 and 39-10 at 1381.

<sup>4</sup> See, e.g., Karakousis, Prognostic Parameters in Recurrent Malignant Melanoma, 52 Cancer 575 (1983); Cutaneous Melanoma at 1381-82.

There are many (11 is a commonly accepted number) different types of malignant melanoma.<sup>5</sup> However, four of these types constitute over 90 percent of all cases. Three of the four dominant types are characterized by a slow, exclusively peripheral enlargement of the primary lesion, known as the radial growth phase, which usually lasts for several years. During this phase the melanoma is essentially incapable of metastasizing. Diagnosis and proper treatment (wide surgical excision) during the radial growth phase results in survival rates approaching 100 percent.<sup>6</sup> If the tumor is not excised during the radial growth phase, it eventually begins to penetrate into deeper dermal tissues; this is called the vertical growth phase. It is during this phase that the melanoma develops the ability to metastasize. The risk of metastasis is primarily related to the thickness of the tumor (Breslow's staging method) and its level of invasion (Clark's staging method) when it is finally excised.<sup>7</sup>

Even when a primary melanoma has entered the vertical growth phase (and it should be noted that the least common of the four dominant types is a vertical growth tumor from its onset), there is an eight-year survival rate, depending on a variety of prognostic factors, of approximately 70 percent.<sup>8</sup>

Due to space limitations, the foregoing discussion is necessarily limited to the most basic considerations. Ultimately, counsel must obtain from his or her expert witnesses the firm and detailed understanding of the medical issues (including access to the pertinent literature) that is essential for the effective presentation of any medical negligence case.

### III. POTENTIAL DEFENDENTS AND THEORIES OF LIABILITY

There are three potential defendants in malignant melanoma cases. The first is the pathologist who fails to recognize melanoma in a biopsied specimen sent to him or her for examination; such misdiagnosis may be negligence. Second, if the pathologist works in a hospital laboratory, the hospital may be vicariously liable under the theory of either

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<sup>5</sup> Cutaneous Melanoma at 1375-76; M. Mihm, Jr. & P. Googe, Problematic Pigmented Lesions: A Case Method Approach 279-370 (1990) [hereinafter cited as "Mihm & Googe"].

<sup>6</sup> Eg., Imber & Mihm, Jr., Biological and Prognostic Significance of Vertical Growth Phase Characteristics in Malignant Melanoma, Pathobiology and Recognition of Malignant Melanoma 22 (1986) (citing study demonstrating seven-year survival rates of up to 98 percent).

<sup>7</sup> Cutaneous Melanoma at 1376-78; Mihm & Googe at 279-80. 451-55.

<sup>8</sup> Clark, Jr., Model Predicting Survival in Stage I Melanoma Based on Tumor Progression, 81 J. Nat'l Cancer Inst. 1893, abstract (1989). The authors chose the 8-year interval because deaths beyond 8-years are uncommon. Id. at 1895. Although this study focused on vertical-growth-phase melanoma, there were 122 patients in the study sample (31.6 percent of the total) with radial-growth-phase tumors. The eight-year survival rate of the radial-growth-phase group was 100 percent. Id. at 1898.

respondeat superior or apparent agency. Third, the physician initially consulted by the patient may be negligent if he or she fails to biopsy the lesion or biopsies it improperly.

The paradigm malignant melanoma case is one in which the physician the patient initially consults (typically an internist or a dermatologist) correctly observes that a nevus is suspicious, biopsies it properly, and sends it to a pathologist who misdiagnoses it as a benign nevus when it is actually a primary malignant melanoma. A correct diagnosis would lead to a wide excision of the lesion, which, as noted above, results in a survival rate of between 70 and 100 percent, depending primarily upon the thickness of the tumor and upon whether it is in the radial or the vertical growth phase.<sup>10</sup> Of course, even the 70 percent figure translates into expert testimony that, to a reasonable degree of medical certainty, the patient would have survived if the pathologist had made the correct diagnosis.

As a result of the pathologist's misdiagnosis, no wide excision is performed. Years later, the melanoma recurs at the original site, or the patient becomes symptomatic for metastatic melanoma in the nearby lymph nodes or in organs distant from the original site. (Malignant melanoma can metastasize to any organ in the body.)

It is the absence of wide excision, which is a direct and proximate result of the pathologist's misdiagnosis, that leaves malignant cells at or near the site of the primary lesion. These cells almost inevitably result in metastatic melanoma, although this process may take many years. Thus, even a patient who presents with nothing more than a recurrent melanoma at the original site, which is then properly excised, will eventually develop metastatic disease. Though some such patients do survive, a diagnosis of metastatic melanoma is essentially a death warrant.<sup>11</sup>

The primary issue in the type of case just described is negligence and not causation. The pathologist's negligence may not be easy to prove, because differentiating melanoma from other pigmented lesions can be a difficult task.<sup>12</sup> The proof of negligence will be discussed in the sections on case preparation and trial.

When the pathologist works in a hospital pathology laboratory, as is usually the case, the hospital may be vicariously liable for the pathologist's negligence. Many hospitals attempt to shield themselves from respondeat superior liability by purporting to engage the pathologist as an independent contractor rather than an employee. This shield can be

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<sup>9</sup> "Nevus" is the scientific name for a mole. It is an aggregation of melanocytes, either congenital or acquired. A pigmented lesion is either a benign nevus of one kind or another (and there are many types of benign nevi); an atypical, dysplastic, or borderline nevus; or a malignant melanoma. See Mihm & Googe at ix-xi (table of contents).

<sup>10</sup> See authorities cited in notes 3, 6 and 8, *supra*.

<sup>11</sup> Cutaneous Melanoma at 1381-82.

<sup>12</sup> *Id.* at 1378-79. Mihm & Googe is a 543-page book devoted entirely to the differential diagnosis of pigmented lesion. It contains hundreds of photographs of slides of the many different types of benign nevi and malignant melanocytic lesions

pierced either by demonstrating that the hospital exercises so much control over the pathologist that he or she is a de facto employee, or by providing that the pathologist is an apparent agent of the hospital. These issues will be addressed in the section on case preparation and in the review of the case law.

The physician whom the patient originally consults for examination of a pigmented lesion may fail to perform a biopsy because he or she believes, based solely upon clinical examination, that the lesion is a benign nevus (when it is actually a malignant melanoma). In such cases negligence is often very clear.<sup>13</sup> Whether causation is a problem depends upon the length of the delay between the physician's original examination of the lesion and the eventual biopsy resulting in the diagnosis of malignant melanoma.

If the original physician cauterizes the lesion, negligence is clear,<sup>14</sup> but causation is a severe problem because there is no way to determine the thickness of the original tumor or any other prognostic factor. The value of a lost chance of survival may be the only theory of liability available in such cases.

Finally, the physician may perform the biopsy improperly, causing the pathologist either to render a false-negative diagnosis or to improperly stage a recognized melanoma (improper staging is likely to result in inadequate treatment).<sup>15</sup> Here, as in the case of a negligent failure to biopsy, whether causation is a problem will depend on the facts of the particular case.

#### IV. CASE PREPARATION

In the typical case, you will need a pathologist or a dermatopathologist (a specialist in the diagnosis of skin lesions) to establish negligence and a medical or surgical oncologist to establish causation. Retaining these experts early, working with them closely, and expeditiously obtaining the physical evidence (pathology slides) that you need them to examine are the keys to effective case preparation.

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<sup>13</sup> "If doubt exists concerning the precise nature of a lesion, the lesion should be biopsied....Clinical judgment regarding the nature of skin lesion, even among experienced observers, is quite fallible." Cutaneous Melanoma at 1379, 1384.

<sup>14</sup> "Electrocoagulation, curettage, and shave biopsy are mentioned only to be condemned. All skin lesions worthy of removal should be sent to the pathologist for examination and none should be burned off." Id. at 1385.

<sup>15</sup> See id. at 1384-85. The pathologist in such a case would be non-negligent unless he or she should have recognized the inadequacy of the specimen submitted for examination. See Mihm & Googe at 485-86.

#### A. Pre-Suit Investigation

Counsel investigating a malignant melanoma case should obtain certain physical evidence that is not usually needed in medical negligence cases: namely, all pathology slides relating to the plaintiff's melanoma, including slides of the primary lesion, of the recurrent melanoma, of any other skin lesions, of lymph nodes, and of any other tissues that were biopsied for evidence of metastatic disease. The institutions in possession of the slides should produce them as they would produce any medical record, subject to an appropriate agreement for either their return to the institution or their safekeeping by plaintiff's counsel.

Obtain these slides before filing suit so that your expert witnesses can examine them. The existence of a valid claim depends almost entirely upon what the slides reveal. Your experts should see the tumor itself, just as the defendant pathologist did.

A pathologist does not make slides from the entire biopsy specimen; most of the tissue is preserved, usually in a paraffin block. If your experts consider the existing slides inadequate for proper diagnosis or staging, you should obtain the preserved tissue so that your pathologist or dermatopathologist can make new slides. Again, it will be necessary to make an appropriate agreement with the institution concerning the future custody of the preserved tissue and the new slides.

You must, of course, have the defendant pathologist's written report of his or her original misdiagnosis of the lesion. Ordinarily, by gathering medical records as you would in the investigatory phase of any medical negligence case, you will obtain this report; however, if the report is missing from the usual records, it is essential that you locate it. Hospital pathology departments ordinarily keep the originals of all pathology reports; thus, even if the referring physician's records and the hospital clinic's chart do not contain a copy of the pathology's report, you should be able to obtain one directly from the pathology department.

#### B. Discovery

When a recurrent lesion is diagnosed as malignant melanoma, the slides of the original lesion are almost always re-examined by the chief of the pathology laboratory in question, who will often prepare a revised report. If the patient is referred to another institution for treatment, a pathologist or dermatopathologist at the treating institution will also re-examine the slides. These re-examinations frequently reveal that the original lesion was malignant melanoma and should have been diagnosed as such. Sometimes the defendant pathologist will simply confess error in light of the re-examination. If so, you in effect have a stipulation of negligence. If not, you should consider deposing not only the defendant pathologist, but also the defendant's chief of pathology (assuming that he or she has written a revised report diagnosing the original lesion as melanoma). In addition, you should speak with the pathologist or dermatopathologist at the treating institution, as they are potential expert witnesses in your favor.

You should not depose the defendant until your expert pathologist or dermatopathologist has reviewed the slides with you and has demonstrated and explained to you, in detail, exactly what is on the slides that should have led the defendant to make the diagnosis of melanoma. The diagnosis of skin lesions is a highly technical field involving a specialized language; unless you know the language and understand clearly the features that differentiate malignant melanoma from the defendant pathologist's erroneous diagnosis, you will not be able to depose the defendant effectively. The importance of this point cannot be overstated. It is your pathologist or dermatopathologist who will show you how to prove that the defendant's misdiagnosis of the lesion was negligent. Ideally, you should have your expert put his suggestions for deposing the defendant in writing.

Because many years may pass between the removal of the primary lesion and the recurrence or development of symptomatic metastases, the pathologist may not remember their actions at the time of the original misdiagnosis. In that event, it is entirely proper to ask the defendant what they would most likely have done based on standard operating procedure.

If the pathologist works in a hospital laboratory but the hospital claims that he or she is an independent contractor and not an employee, you must request production of all contracts between the hospital and the pathologist. The contracts may reveal that the pathologist is under the total direction and control of the hospital's chief of pathology, that the pathologist is paid a flat fee regardless of the numbers of hours worked or specimens examined, and other facts that either make the pathologist an employee of the hospital as a matter of law or at least make status an issue for the jury. On the issue of control, you will want to depose the chief of pathology and a managerial officer of the hospital.

### C. Establishing Damages

The elements of damage for the plaintiff with malignant melanoma are past and future medical expenses; loss of earnings, earning capacity, and future earnings, past and future pain and suffering; loss of enjoyment of life; and mental anguish due to the patient's awareness or fear that he or she may be, or in fact is, terminally ill. If your state allows recovery for a spouse and minor child's loss of consortium, such claims should be added to the complaint. If the plaintiff patient dies before trial, you are in effect prosecuting two consolidated claims: a medical negligence survival action, with the above elements of damage terminating as of the date of the patient's death; and a wrongful death claim, with the elements of damage provided in your state's wrongful death act.

In preparing your proof of damages, remember that your client may be terminally ill. If your jurisdiction allows priority assignment in such circumstances, by all means move for one. However, even if you get a priority assignment, you still must prepare for the possibility that the plaintiff may not live to attend the trial. It is therefore essential to take at least one videotape deposition of your client. Furthermore, the progression of metastatic melanoma is often painful and disfiguring. The side effects of treatment can be horrendous. These considerations

may justify a series of videotaped depositions, to preserve for trial the evidence of your client's deterioration and suffering over an extended time.

If your client is not already seeing a psychotherapist when you are retained, you should make such a referral as soon as possible. The client will be suffering great emotional pain, and a therapist is better qualified than anyone (including the client and the client's family) to testify about the mental suffering associated with terminal cancer.

You will need an economist to testify concerning economic loss. Due to the physical deterioration resulting from progressive metastatic melanoma, the client may suffer a loss of earnings and earning capacity. The economist must calculate this item of damages separately. If the client dies before trial, the calculation of the loss of future earnings can be performed as in any other wrongful death case, pursuant to the formula provided by your state's wrongful death act. On the other hand, if the client is still living at the time of trial, the calculation is more complicated. Your causation experts must inform the economist of the client's life expectancy. The economist must then calculate the client's anticipated loss of future earnings and earning capacity during his or her projected lifetime, followed by a separate wrongful-death type calculation from the anticipated date of the client's death.

## V. TRIAL CONSIDERATIONS

### A. Expert Testimony

If your case involves a pathologist's misdiagnosis, the first question is whether the malignant melanoma was so obvious that any competent pathologist should have seen it. If the answer is yes, the pathologist violated the standard of care by failing to make the correct diagnosis, and your experts should so testify. You can present this testimony through a pathologist, a dermatopathologist, or both.<sup>16</sup> I recommend that you use both.

The standard of care for any medical generalist, and even for many specialists, includes knowing when to refer to a specialist or subspecialist. There is no question that some lesions present substantial diagnostic difficulties.<sup>17</sup> A pathologist presented with such a lesion should recognize that it is hard to diagnose and should therefore have the slides reviewed by a dermatopathologist because of the latter's special expertise in the differential diagnosis of skin lesions. Failure to make such a referral or consultation may constitute negligence. Again, both a pathologist and a dermatopathologist are qualified to express an opinion on this violation of the standard of care; however, only the latter is qualified to establish causation by

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<sup>16</sup> Every dermatopathologist was a general pathologist before entering the subspecialty of dermatopathology and is therefore qualified to testify to the standard of care for a general pathologist.

<sup>17</sup>See, e.g., Mihm & Googe at 193-219, 326-48.

testifying that a dermatopathologist would have made the diagnosis of malignant melanoma.

If the defendant is an internist, dermatologist, or family practitioner who failed to biopsy the lesion, cauterized the lesion, or otherwise removed it without sending it to a pathologist, you will need one or more experts of the same specialty as the defendant to testify that such action violated the standard of care. Of course, you will still need a pathologist and a dermatopathologist and a medical or surgical oncologist to establish causation, if indeed it can be established at all.

If the plaintiff patient is still alive and attends the trial, your causation experts, as well as the economist and the psychotherapist, will be testifying about the plaintiff's life expectancy. You should seriously consider having the plaintiff absent from the courtroom during such testimony. This may be absolutely necessary if the plaintiff is in denial as to the terminal nature of metastatic melanoma.

#### B. Demonstrative Evidence

Many trial lawyers know the value of photographic blow-ups of important medical records in medical negligence cases. In a malignant melanoma case, however, such blow-ups are absolutely essential. The crucial evidentiary fact in a melanoma misdiagnosis case is the appearance of cells on a slide. You must enable the jury to actually see the malignant cells that the defendant failed to see (or failed to properly interpret). The testimony of your pathologist or dermatopathologist that the defendant negligently misdiagnosed the lesion will be meaningless to the jurors if they cannot see the actual cells. Therefore, you must obtain photographic blow-ups of the slides of your client's primary and recurrent lesions.

A pathologist always conducts the microscopic examination of skin lesions under more than one power of magnification, because features revealed at lesser and greater magnifications each have their own diagnostic value.<sup>18</sup> Accordingly, the blow-ups of your client's slides must also show varying powers of magnification. Armed with these materials and a pointer, your pathologist can truly educate the jury, enabling them to see and to understand the appearance of normal cells, atypical cells, and malignant cells. By properly using the blow-ups, your expert will enable the jury to recognize, with their own eyes, the microscopic features of the lesion that should have led the defendant to make the diagnosis of malignant melanoma.

The power of this kind of evidence cannot be overstated. The jury will understand that your expert has taught them, within a half-hour on the witness stand, how to recognize malignant melanoma. This realization will in turn convince them that the defendant pathologist, with years of training and experience, should have made the correct diagnosis.

It is also useful to obtain blow-ups of slides showing classic examples of the type of melanoma involved in your case. For example, if your client's primary lesion

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<sup>18</sup> See, e.g., Mihm & Googe at 288-302.

