THE MT. SINAI
MEDICAL CENTER

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September 15, 1988

Doc. 309

Michael C. Zellers
Law Offices of
Arter & Hadden
1100 Huntington Building
Cleveland, Ohio 44115

RE: Elizabeth Kadar,Admx., etc. vs. Cleveland
Cleveland Clinic Foundation, et al.

Dear Mr. Zellers:

At your request, I have reviewed the following medical records on Mr. Eli Kadar:

1. Operative reports, pathology reports, and physicians' notes from the Cleveland Clinic Foundation, October 1963 through January 1987.

2. Autopsy report (Case No.197327; Autopsy No.M55057), Cuyahoga County Coroner's Office, January 18,1987.

3. Report of Dr. Aryeh Gorenstein, dated November 11, 1987.

4. I have also reviewed two pathology slides No.86-3182, three slides No.86-22544, and 22 slides No.86-26173 from the Cleveland Clinic Foundation.

In summary, Mr. Kadar had a long history of squamous cell carcinoma of the oral cavity dating back to 1963. His records of September 1963, when he first presented, indicate that he smoked approximately two packs of cigarettes per week, certainly a risk cancer for the development of oral cancer, but he apparently stopped smoking in 1964 or 1965. He also (in 1984) gave a history of mild alcohol intake, three to four ounces a week, another potential risk factor for oral cancer. Between

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1963 and 1966, several biopsies revealed multiple areas of squamous cell carcinoma, hyperkeratosis (leukoplakia), and dysplasia (precancerous change>in the lining mucosa of the oral cavity involving palate, cheek, floor of mouth, and gingiva. In February 1966, Mr.Kadar underwent a right hemimandibulectomy for a squamous cell carcinoma invading into the mandible and, in February 1979, because of the recurrent and progressive nature of his disease, he required a wide excision of a recurrent cancer involving the mucosa and skin of the right cheek. This was followed by radiation treatment.

In February 1984, examination by Dr. Zins revealed no evidence of recurrent disease. Hoarseness at that time was attributed to atrophic laryngitis secondary to radiation therapy. Mr. Kadar was seen by Dr. Cowper in February 1984 and again in May 1985 for prosthodontic evaluation and at these visits, no evidence of recurrent carcinoma was seen. In November 1985, he was referred to Dr. Smith for further prosthodontic treatment and in the period January 1986 through March 1986 a mandibular prosthesis was fashioned and fitted. In March 1986, immediately following insertion of the prosthesis, Mr.Kadar noted difficulty and soreness and the prosthesis was adjusted. On April 15, 1986, it was noted that Mr. Kadar was wearing his old denture which was causing ulceration. This was discontinued and a week later, on April 22, his condition had improved but some "angry looking tissue" was still noted. A reline impression was made. On April 24, a new prosthesis was inserted and a new denture was inserted on May 9, 1986. Mr. Kadar continued to have difficulty wearing the new denture and, on June 13, a new denture was inserted.

On July 24, 1986, the patient was seen by Dr. Smith who noted ulceration of the remaining left mandibular alveolar tissue with some extension to the anterior floor of mouth and "partial granulation" was apparent. This was felt to represent non-specific ulceration with the possibility of recurrent tumor and osteo-radiation necrosis to be excluded. Treatment included antibiotics and hydrogen peroxide rinses. On August 7, granulation tissue was still noted. Antibiotics were continued and hyperbaric oxygen treatment was instituted. The lesion did not improve through August, and on September 16, 1986 the patient was seen by Dr. Wood who noted induration along the buccal mucosa with a mass, approximately 3.5 to 4cm in greatest dimension on the left posterior mandible. Biopsyof the lesion (Cleveland Clinic Foundation slides No. 86-22544) revealed the presence of squamous cell carcinoma. After staging surgery, a resection of the tumor was carried out on October 27, 1986.

Examination of the tissue slides prepared at the time of resection (Cleveland Clinic Foundation No.86-26173) reveal an invasive moderately

to poorly differentiated squamous cell carcinoma with invasion into skin and bone. All sampled tissue margins (high risk margins), submandibular gland, and lymph nodes were free of tumor.

On December 12, 1986, granularity of the mucosa of the soft palate was noted and the patient was found to have a tender 1.5 x 1.5cm mass in the left anterior-inferior trapezius region. By December 30, the cervical mass had increased in size and the granularity of the soft palate had increased. Biopsies of the palate revealed invasive squamous cell carcinoma. The cervical mass was not biopsied.

The patient committed suicide on January 17, 1987.

In his letter dated November 11, 1987, Dr. Aryeh Gorenstein states that, in his opinion, a biopsy of the posterior left mandibular area should have been taken in April 1986 and certainly in July 1986 before hyperbaric oxygen therapy was begun.

The issue in this case is not whether a biopsy should have been taken in April or July 1986, but what impact that would have had on the subsequent course of the patient's oral carcinoma. While I agree with Dr. Gorenstein that biopsies in July and most probably in April or May would have revealed squamous cell carcinoma, it is clear from a review of the patient's history and pathology that his ultimate course would not have been affected.

At the time of resection in October 1986, Mr. Kadar's cancer was large and extensively invaded tissues of the oral cavity including bone and skin. Although tumor growth would certainly have occurred in the few months preceding resection, the surgical procedure performed by Dr. Wood in October 1986 appeared to remove all the tumor and, as indicated in the pathology report and Dr. Wood's discharge and operative summaries, all high risk margins were free of tumor. The patient's subsequent course during which he was found to have additional areas of carcinoma on the soft palate was unrelated to the resection of October 1986.

Mr. Kadar unfortunately had an oral and upper airway mucosa that was severely and extensively diseased and provided an extremely "fertile soil" for the growth innumerable squamous cell carcinomas. Mr. Kadar's oral cancers were never and could never be cured by either surgery or radiation. The autopsy findings of additional areas of carcinoma in the tongue, larynx, and pharynx, as well as the biopsy proven areas of carcinoma on the soft palate on December 30, 1986, highlight this problem.

RE: Elizabeth Kadar

The precise nature of the mass, presumably an enlarged lymph node, noted in the left neck in December 1986 was not resolved. Although Dr. Wood thought that the "node" had a metastatic feel, he did indicate that this would be an unusual site for metastatic carcinoma. The node was not biopsied and, at autopsy, no mention is made of a node with metastatic carcinoma. No evidence of metastatic carcinoma was found at autopsy.

It is clear, based on the pathologic and autopsy findings, that Mr. Kadar would soon have died from the local effects of extensive, multifocal squamous cell carcinoma involving the entire oral cavity and upper airways. Even if the left posterior alveolar ridge had been biopsied in the period between April and July 1986, and the tumor resected at that time, it is clear that this would not have had any impact on halting the relentless growth and appearance of new cancers.

It is my opinion that intervention during the period between April and July 1986 would not have resulted in a permanent cure and would not have altered the course of disease in this case.

If I can be of any further assistance to you in this matter, please feel free to contact me.

Sincerely,

Geoffrey Mendelsohn

Geoffrey Mendelsohn, M.D.
Director of Laboratories

GM: bjr