

Pool Report # 2

from: David Brown, Washington Post Medical Correspondent

5/23/2008

Mayo Clinic note 8/18/2000 by primary care physician John Eckstein MD

Reports two biopsies of left temple and one from left upper arm.

“Confirmed by Dr. Thomas Colby and reviewed with Doctors D. J. DiCaudo, K. O. Leslie, and J. W. Williams at Mayo Clinic Scottsdale: Left lateral temple excisional biopsy revealed malignant melanoma with focal superficial invasion (0.23 mm thickness) overlying dermal scar. The left medial temple punch biopsy demonstrated malignant melanoma (2.2 mm in thickness) and was HMB-45 and S-100 positive. The left upper lateral arm excisional biopsy showed malignant melanoma in situ approximately the lateral margins.”

Dr. Colby said that “both temple lesions rose in the region of the temple and were unlikely metastasis to the temple from some distant site. Both of the temple lesions extended to the lateral margins of the biopsies.”

The note mentions he had a skin lesion removed from the area in 1996 and the specimen from this procedure had been reviewed: “Finally, a review of a left temple excisional biopsy from 1996 showed atypical junctional melanotic proliferation.”

Mayo Clinic Note, 8/18/2000 dermatology consult, Suzanne Connolly MD

She notes McCain “had both basal cell and squamous cell carcinomas removed” in the past. “These have been from the head and neck, upper torso region.”

She recommends skin check every 3 months for two to three years and then every six months thereafter.”

Mayo Clinic note 8/18/2000 with ENT surgeon Michael Hinni MD.

This is the visit in which McCain and his wife and “the physician friend that also sat in” (that physician not identified) and heard the surgical plan. The plan already includes extensive removal of neck lymph nodes even though it is not yet known whether the cancer has spread to any of them.

“Certainly there needs to be wide local excision of the primary melanoma, and certainly the lymph nodes need to be assessed. Certainly, given the cervical parotid incision that would be required for rotation flap closure of this defect (I think the best cosmetic result ultimately will come from that as opposed to skin grafting), it seems feasible to use this incision to remove all of the lymph nodes in his neck that are at risk, as he is going to incur the morbidity of the incision. The morbidity of the neck dissection is limited. . . . If a malignancy should be found at any lymph node, then I would want to remove the deep lobe of the parotid gland as well with primary resection.”

Mayo Clinic note 8/18/2000, consult with Tom Fitch MD

Notes that the temple biopsies “demonstrated two separate areas of invasive malignant melanoma.” One was “very superficial” 0.23 mm. The medial biopsy showed “a more

deeply invasive malignant melanoma, 2.2 mm.” The left upper arm biopsy  
“demonstrates an in situ malignant melanoma.”

“We also began a preliminary discussion of the possibility of participating in an  
investigational treatment protocol.”

What this protocol was and why it was not pursued further is not explained in later notes.

Pathology report from the Armed Forces Institute of Pathology, August 9, 2000

Signed by George P. Lupton MD, chairman Dept of Dermatopathology, and Sylvana M.  
Tuur-Saunders MD, Department of Dermatopathology.

This and the following letter address the question whether the two areas of melanoma on  
his left temple are related to each other or arose independently.

The punch biopsy sample from the skin of “left temple, medial: malignant melanoma (2.2  
mm)” notes that “The atypical cells extend into the dermis to a depth of approximately  
2.2 mm as measured from the overlying granular cell layer (Breslow thickness). . . “The  
vertical orientation of this lesion with only focal epidermal involvement above it is highly  
suggestive of a metastasis of malignant melanoma and may represent a satellite  
metastasis of S00-9572-A” (which is the “skin, left temple, lateral” biopsy).

Letter to John P. Williams MD of National Naval Medical Center from Thomas V.  
Colby, MD of Mayo Clinic Scottsdale, Aug. 15, 2000.

“Comment: The punch biopsy of the medial temporal lesion shows possible vascular  
invasion with vertical orientation, raising the possibility of a metastasis to this site,  
possibly from the other temple lesion. Given their proximity and the history of the prior  
(1996) lesion at this site, it may also be that these represent separate foci of melanoma  
arising in a region of atypical melanocytic proliferation. We suspect both of these lesions  
arose in the region of the temple and would doubt metastasis to the temple from some  
distant site in the head and neck. It may be that additional sampling from the nodular  
lesion of the medial temple will help clarify this issue. Both of the temple lesions extend  
to the lateral margins of the biopsies.”

Dermatopathology report, 8/18/2000

Left anterior shoulder frozen section: nodular, pigmented basal cell carcinoma.

Lymph node screen, 8/19/2000

Injection to identify sentinel node. “228 microcuries of 99mTc filtered sulfur colloid  
intradermally” Sentinel node “was located in the region of the left submandibular angle”

Surgical report, 8/19/2000

Surgeons: M.L. Hinni (ENT), S.F. Bansberg (ENT), W.M. McLeish (Oph), D.J.  
DiCaudo (derm)

Description of procedure: “Wide local excision, left temporal scalp, with en bloc  
superficial parotidectomy and left lateral selective neck dissection; wide local excision, in

situ melanoma, left arm with primary closure; left cervicofacial rotation/advancement flap disclosure; evacuation of small facial hematoma.”

There is a three-page, single-space description of the procedure. What follows are a few details from it.

“About 1 mm of methylene blue injected into the melanoma before any skin incisions made, to help in identification of sentinel node.”

“great auricular nerve was sacrificed”

there was meticulous dissection of many branches of the facial nerve.

After the melanoma and the superficial part of the parotid gland were taken out en bloc, skin was taken from behind his left hear was cut and “rotated superiorly to fill the temporal defect, and it fit nicely.”

sentinel node with blue dye was identified, taken to the pathology laboratory for frozen sections.

“All frozen section margins on the skin edges circumferentially and on the nodes demonstrated no evidenced of cancer.”

After being taken to the recovery room, McCain was briefly returned to the operating room for the evacuation of about 30 cc of blood “in the facelift plane out near the corner of the mouth.” The wound was reopened and the blood removed and “small subcutaneous bleeders coagulated.” He was not reintubated in this short procedure but had his airway protected with “an LMA”.

Pathology report from intraoperative review of the tissue, which was prepared as frozen sections:

“Sentinel lymph node (deep), FS: negative for malignancy.”

Periparotid lymph nodes “negative for malignancy” same for jugular node.

Modified left neck dissection “all neck nodes negative for malignancy.”

“parotid gland tissue is without pathologic abnormality.”

Tissue taken out included (but was not limited to): “superficial lobe of parotid gland, sentinel lymph node in the superficial lobe of the parotid”, three additional “microscopic lymph nodes . . . in the superficial lobed; one jugular lymph node; 33 lymph nodes from the left neck dissection.

This appears to be a total of 38 lymph nodes.

The report was signed by Kevin O. Leslie, MD, pathologist

McCain was discharge on 8/21/2008

Procedure note, 9/01/2000

A small amount of skin of an elliptical shape was excised “at the point of rotation along the anterior limb of the wound” on the left side of his face. This was for cosmetic purposes.

He had further revision of scar on left temple, 4/9/2001 at Mayo

In several notes Dr. John Eckstein notes the “astute” observation by Capitol Physician Dr. John Eisold, who noticed the left temple lesion in July, 2000 and recommended that McCain have it examined further.

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