



MARCO SCARCI
Thoracic Surgeon

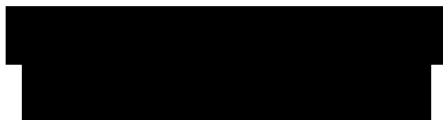
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MEDICAL REPORT PREPARED FOR THE COURT

BY

MR MARCO SCARCI
MD FRCS(ENG) FCCP FACS FEBTS
CONSULTANT THORACIC SURGEON

ON



Address: [REDACTED]

Instructed by: [REDACTED]

Solicitor: [REDACTED]

Solicitor's Reference: [REDACTED]

Date of Diagnosis: 03 March 2020

Date of Report: February 2024

CONSULTING ADDRESS:	REGISTERED AT COMPANIES HOUSE
The Harley Street Clinic (Diagnostic Centre) Imperial Hammersmith Hospital London (Private Wing)	MARCO SCARCI LTD COMPANY NO. 08803833

1. ABOUT THE WRITER: MR MARCO SCARCI

I have been a Consultant for over ten years and am currently a Consultant Thoracic Surgeon at Imperial College NHS Trust based in Hammersmith, London. I also work in the private sector at The Harley Street Clinic.

I run a busy clinical practice which focuses upon the treatment of both cancerous and benign conditions of the lung and chest wall, using minimally invasive surgical techniques. I am also on the trauma rota at St Mary's Hospital treating patients with acquired chest injuries.

In addition to my clinical commitments, I have developed and continue to run a successful International Thoracic Oncology Symposium and was involved in the leadership of the European Society of Thoracic Surgeons.

I maintain an active academic interest and have published over 200 articles in peer-reviewed journals. I continue to research, publish, and lecture in the field of single-port surgery and chest wall conditions, having contributed to numerous chapters and published four books to date on these topics. I am a recognised authority on pectus deformity repair.

In addition to my own academic interests, I am an Associate Editor of the Journal of Thoracic Diseases and the Journal of Thoracic and Cardiovascular Surgery and am the Chief Editor of Frontiers in Thoracic Surgery. I am regularly asked to review articles for inclusion into the most prestigious journals of cardiothoracic surgery.

I have undertaken medicolegal work for over ten years and have a growing practice.

2. INSTRUCTIONS

- 2.1 I have been instructed by [REDACTED] Solicitors to provide a medicolegal report for [REDACTED], dealing with two aspects of this case:

Firstly, whether the patient could have had a lesser lung resection or whether she would have required full resection of the lung in any event; and

Secondly, at various stages, would surgery have been able to provide clear margins, such that radiotherapy could have been avoided.

- 2.2 I was also asked to comment on the causation aspect of this matter and specifically, to comment on the surgical options for resection up to and including June 2019.

3. RECORDS

- 3.1 In order to prepare the report, I have been provided with the following records:

- GP Records
- Glenfield Hospital Records
- University Hospitals of Leicester NHS Trust Records
- Northampton General Hospital Records
- Paginated Chronology

4. BACKGROUND AND HISTORY

- 4.1 The background to the case is lengthy, with Mrs [REDACTED] first presenting to the GP in 2012, with a history of wheeze. She was seen regularly by her GP practice over the following years and with frequency for her chest symptoms from 2017.
- 4.2 On the 12 February 2020 Mrs [REDACTED] demonstrated a soft tissue mass compressing the right main bronchus, which was identified following a bronchoscopy and EBUS.
- 4.3 She subsequently had a PET scan which showed a narrowed section of the proximal right main bronchus associated with low level FDG uptake.



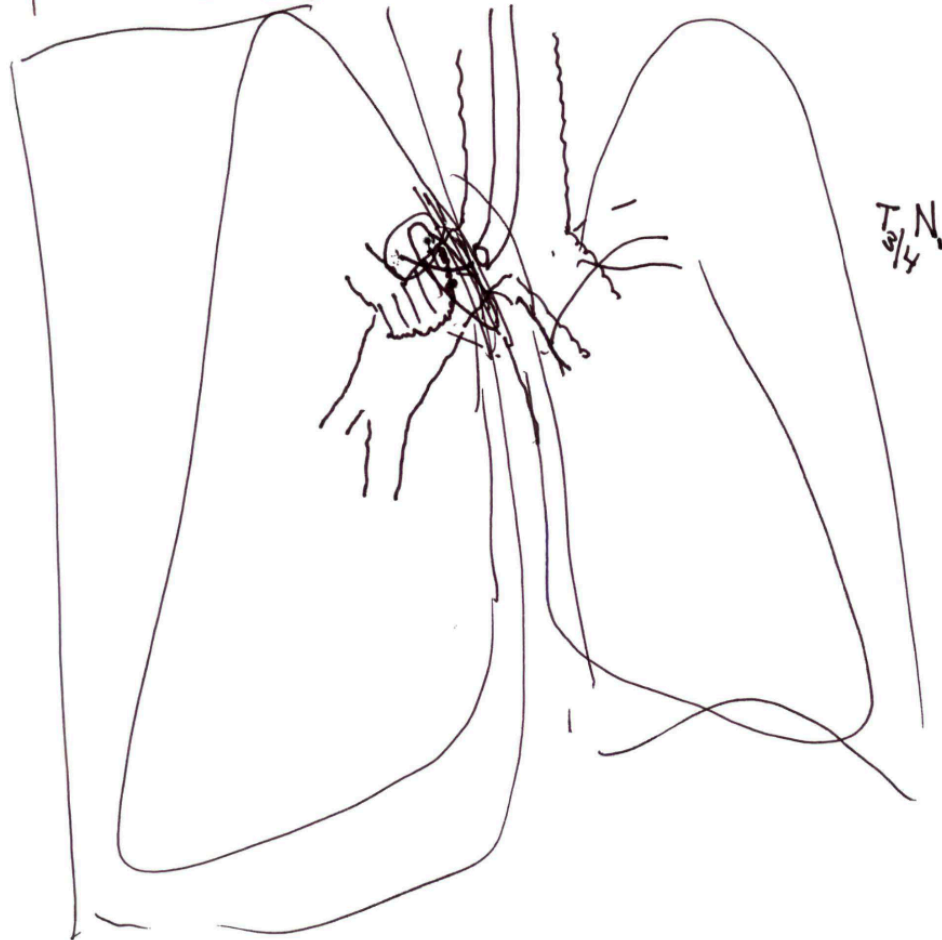
- 4.4 She was then reviewed on 3 March 2020 as an outpatient in the thoracic surgery clinic and had surgery on 11 March 2020.
- 4.5 Below is the diagram drafted by the operating surgeon. This shows how the tumour is originating from the right upper lobe bronchus and abutting the right main bronchus.
- 4.6 I agree with the operating surgeon that in such circumstances, because of the proximal extension of the tumour, the only option was to remove the whole lung.

University Hospitals of Leicester NHS Trust	
Hospital:	Ward:
Consultant:	mfc



mfc

opel 3.3.20



T₃N₁
3/4

For Right Lobectomy/Anch
+ Rt primary 10% Risk of death.

- 4.7 For the avoidance of doubt, I will only deal with the thoracic surgery elements of the case, as set out in the letter of approach. I will therefore only comment on the feasibility of a lesser resection and the impact of the tumour being diagnosed earlier than it was.

5. COMMENT AND CONCLUSION

- 5.1 This case is complex and there are several aspects of this case which are worth mentioning both pre and post-diagnosis.
- 5.2 Initially Mrs [REDACTED] was diagnosed with metastatic adenocarcinoma of the lung, following the bronchoscopic and EBUS biopsy which was performed on 12 February 2020. Below are the multidisciplinary team meeting records from the 19 March 2020.

Previous Care Plan	
Date of MDT:	19/03/2020
Careplan agreed at MDT:	No
MDT Comments:	1 Current smoker; 5 pack years 25 year old female referred via ICE form. CLINICAL/MEDICAL HISTORY = 7 year hx of dyspnoea, recurrent right chest infections and reduced exercise tolerance. Associated with right sided chest pain. COMORBIDITY = Asthma anxiety/depression smoker. QUESTION TO BE ANSWERED = Discussed with Dr. Jeffrey 7 year hx of wheeze - possible stridor and recurrent chest infection - found to have enlarged calcified lymph node obstructing right main bronchus . Possibility of PET and EBUS discussed with patient. MDT 30/01/20: CT - Stenosis right bronchus. For TB culture. Discussed with surgeon - refer to SR. MDT 20/02/20 Plan: Provisional histology reports malignant epithelioid tumour - potentially either carcinoid or adenocarcinoma, pending further immuno. For PET-CT and VQ scan. MDT 27/02/20 Plan: EBUS biopsy in Glenfield histology confirms well differentiated adenocarcinoma. SR to see to consider radical resection of tumour. For surgical histology review (procedure performed 11/03/20). MDT 19/03/20 Plan: Patient has had a pneumonectomy - re-discuss next week with histology.

- 5.3 Both these biopsies turned out to be incorrect and in fact, Mrs [REDACTED] did not have a metastatic adenocarcinoma of the lung but instead pulmonary adenoid cystic carcinoma.
- 5.4 There was certainly no negligence on the part of the surgeon in performing the biopsy, as abnormal tissue was indeed retrieved.
- 5.5 It would, however, be worth approaching a histopathologist to determine whether there was any negligence in the interpretation of the samples taken at biopsy.
- 5.6 The fact that the operating surgeon approached the surgery with a diagnosis of localised adenocarcinoma of the lung makes a significant difference to the treatment pathway.

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- 5.7 Thoracic surgeons dealing with lung cancer know that the characteristics of adenoid cystic carcinoma are such that it can metastasise at some distance from the original tumour, travelling underneath the mucosa and the nerves. This means that even if there is a macroscopic appearance of clearance, it is normal practice to proceed to frozen section intra-operatively to check for margin.
- 5.8 Had the margin been positive, knowing that this would have been adenoid cystic carcinoma, a thoracic surgeon would have proceeded to undertake a carinal sleeve pneumonectomy. This is in operation in which part of the bifurcation of the airway is removed and the contralateral bronchus is reattached. This is done to achieve a good clearance and negative margin.
- 5.9 I do not think that there has been any negligence on the part of the treating thoracic surgeon.
- 5.10 It is difficult to comment on whether, year by year surgery would have been able to provide for clear margins, but, as a general rule, the earlier that the tumour is diagnosed, the better the chance of obtaining clear margins and performing a lesser lung resection.
- 5.11 In this case, the lesser option would be a sleeve resection in which the airway would be detached from the upper part of the right lung and then the remaining airways re-attached to restore airway continuity.
- 5.12 It is my opinion that a sleeve would be most likely possible as a surgical option in both November 2017 and October 2018, potentially even in January 2019 but in this later date, it would certainly have been necessary to check the margin on frozen section and whether this would be undertaken is, as explained above, wholly dependent on the results of the histopathology.
- 5.13 When the tumour was diagnosed in February 2020, it was 22mm and at this stage, was too large for a sleeve resection. Complete removal of the lung was, at this stage, the appropriate surgical intervention.
- 5.14 In terms of adjuvant radiotherapy, this is a very contentious topic and there isn't much evidence to support either approach. Indeed, several oncologists previously declined to offer radiotherapy in such cases.
- 5.15 In the medical literature there isn't much in terms of strong evidence - pulmonary adenoid cystic carcinoma is a rare clinical entity, but several, more or less large, case studies supports the use of adjuvant (that is after surgery) radiotherapy if margins are positive.
- 5.16 This view changed when Professor Corinne Faivre-Finn, a Professor of Thoracic Radiation Oncology in Manchester and a world expert on lung oncology, recommended the use of adjuvant radiotherapy in these cases. I consider her research, findings and comments to be very authoritative. They are also supported by a further eight world-experts in this field.
- 5.17 In a patient so young, it was reasonable to offer radiotherapy and as an operating surgeon, I would have pushed for her to have this treatment offered were she under my care.
- 5.18 The initial reluctance to offer radiotherapy can be explained by the fact that this patient had a complete removal of the right lung and adjuvant radiotherapy increases the risk of bronchopleural fistula, especially on the right side (that is the opening of the airway closure with contamination of the space where the lung was, this is a very serious complication). It

[REDACTED]

is my opinion that in a patient so young it was the right thing to do and the benefits outweighed the risks.

- 5.19 The question that remains is whether radiotherapy could have been avoided had she been diagnosed earlier.
- 5.20 I think that most likely, in 2017 and 2018, the operating surgeon would have been able to achieve a clear margin with a smaller sleeve resection. 2019 is too close to call, owing to the size of the tumour and he was unable to avoid it in 2020.
- 5.21 In conclusion, I believe that Mrs [REDACTED] suffered a series of unfortunate events which started when she was not referred in a timely manner to a respiratory physician by her GP and then she had a misdiagnosis of her condition which guided the further action of the operating surgeon.

6. DECLARATION

I, Mr Marco Scarci, declare that:

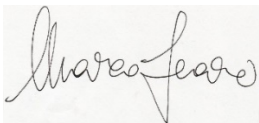
1. I understand that my duty in providing written reports and giving evidence is to help the Court, and that this duty overrides any obligation to the party by whom I am engaged or the person who has paid or is liable to pay me. I confirm that I have complied and will continue to comply with my duty.
2. I confirm that I have not entered into any arrangement where the amount or payment of my fees is in any way dependent on the outcome of the case.
3. I know of no conflict of interest of any kind, other than any which I have disclosed in my report.
4. I do not consider that any interest which I have disclosed affects my suitability as an expert witness on any issues on which I have given evidence.
5. I will advise the party by whom I am instructed if, between the date of my report and the trial, there is any change in circumstances which affect my answers to points 3 and 4 above.
6. I have shown the sources of all information I have used.
7. I have exercised reasonable care and skill in order to be accurate and complete in preparing this report.
8. I have endeavoured to include in my report those matters, of which I have knowledge or of which I have been made aware, that might adversely affect the validity of my opinion. I have clearly stated any qualifications to my opinion.
9. I have not, without forming an independent view, included or excluded anything which has been suggested to me by others, including my instructing lawyers.
10. I will notify those instructing me immediately and confirm in writing if, for any reason, my existing report requires any correction or qualification.
11. I understand that;
 - (i.) my report will form the evidence to be given under oath or affirmation;

- (ii.) questions may be put to me in writing for the purposes of clarifying my report and that my answers shall be treated as part of my report and covered by my statement of truth;
- (iii.) the court may at any stage direct a discussion to take place between experts for the purpose of identifying and discussing the expert issues in the proceedings, where possible reaching an agreed opinion on those issues and identifying what action, if any, may be taken to resolve any of the outstanding issues between the parties;
- (iv.) the court may direct that following a discussion between the experts that a statement should be prepared showing those issues which are agreed, and those issues which are not agreed, together with a summary of the reasons for disagreeing;
- (v.) I may be required to attend court to be cross-examined on my report by a cross-examiner assisted by an expert;
- (vi.) I am likely to be the subject of public adverse criticism by the judge if the Court concludes that I have not taken reasonable care in trying to meet the standards set out above.
12. I have read Part 35 of the Civil Procedure Rules, the accompanying practice direction and the Guidance for the instruction of experts in civil claims and I have complied with their requirements.

7. STATEMENT OF TRUTH

I confirm that I have made clear which facts and matters referred to in this report are within my own knowledge and which are not. Those that are within my own knowledge I confirm to be true. The opinions I have expressed represent my true and complete professional opinions on the matters to which they refer. I understand that proceedings for contempt of court may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief in its truth.

Signed:



Mr Marco Scarci
Consultant Thoracic Surgeon
February 2024