Communication and Documentation of “Critical diagnoses” in Surgical Pathology

1. Principle

All clinically critical diagnostic findings in surgical pathology findings will be communicated directly to the submitting physician.

2. Background

Certain surgical pathology diagnoses may be considered critical diagnoses, particularly significant or unexpected findings. Such diagnoses may include: malignancy in an uncommon location or specimen type (e.g., hernia sac, intervertebral disk material, tonsil, etc.), absence of chorionic villi when clinically expected (potential ectopic pregnancy), change of a frozen section diagnosis after review of permanent sections, temporal artery biopsies (positive or negative) and/or mycobacterial, fungal or other significant infectious organisms identified on special stains. Also included in this category would be the diagnosis of an unsuspected malignancy such as gastric cancer in an endoscopically normal appearing gastric biopsy, gallbladder cancer in a routine cholecystectomy etc. See attached table 1 for additional examples of critical diagnoses in Anatomic Pathology.

3. Policy

When a significant or unexpected diagnosis is rendered it is the responsibility of the reviewing pathologist issuing the diagnosis to promptly contact the submitting physician whose name appears on the pathology requisition form or within Laboratory Information System (LIS). A fellow or resident, under the responsibility of the attending pathologist signing out the report, may also contact the submitting physician. Direct communication of these results by telephone, pager or in-person is required. If the submitting physician is not reachable after reasonable efforts are made to contact him/her, the results may be reported to a fellow, resident, physician assistant, or nurse under the direct supervision of the submitting, attending physician or the Chief of Service. It should be made clear to the person receiving the message that the findings are to be relayed to the submitting physician. The name of the person receiving this message should be recorded. There should be documentation of date and time of such special notification (to be included in the pathology report).

Table 1: Examples of critical diagnoses in Anatomic Pathology

Cases that have immediate clinical consequences:

- Crescents in >50% of glomeruli in a kidney biopsy
- Leukocytoclastic vasculitis
- Uterine contents without villi or trophoblast
- Fat in an endometrial biopsy
- Mesothelial cells in a heart biopsy
- Transplant rejection
- Malignancy in superior vena cava syndrome
- Neoplasm causing paralysis

Unexpected or discrepant findings:

- Significant disagreement between frozen and final diagnosis
- Significant disagreement between immediate interpretation and final FNA diagnosis
- Unexpected malignancy
- Significant disagreement and/or change between primary pathologist and outside pathologist consultation or intradepartmental review
- Significant disagreement between clinical preoperative diagnosis and final pathological diagnosis

Infections:

- Bacteria or fungi in CSF cytology
- Pneumocystitis, fungi or viral cytopathic changes in bronchoalveolar lavage (BAL), bronchial washing in immunocompromised or immunocompetent patients.
- Acid-fast bacilli
- Fungi in FNA of patients
- Bacteria in heart valve or bone marrow
- Herpes in Pap smears of pregnant patients
- Any invasive organisms in surgical pathology specimens of patients.

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Director of Anatomic Pathology Departmental Chairman