

Standardization of the Surgical Pathology Report

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The Association of Directors of Anatomic and Surgical Pathology ("the Association") has concluded that a more standardized surgical pathology report may contribute positively to patient care. As the first step toward achieving this goal the Association has prepared the following recommendations and urges pathologists to seriously consider adopting these for their own surgical pathology reports. The recommendations concern not only the format of the report but also provide suggestions for information to be included in the report. Widespread adoption of these recommendations should make information transfer from surgical pathology laboratories to clinicians more efficient and more complete. It should also improve communication among surgical pathology laboratories when histologic sections are sent from one institution to another.

DEMOGRAPHIC AND SPECIMEN INFORMATION

The Association recommends that:

1. All demographic information be placed in the top portion of the report.
2. Demographic information include the patient's name, location, gender, age and/or date of birth, and race, as well as the requesting physician's name, the attending physician (if different from the requesting physician), and the medical record or unit number.
3. All surgical pathology reports have the name, address, telephone number, and FAX number of the laboratory printed at the top of the report.
4. The surgical pathology number be placed in the top portion of the report on every page and that it be set off from the other information so it can be easily and quickly identified.
5. A summary of the pertinent clinical history be a part of every surgical pathology report.
6. A separate "specimens submitted" section be included in every report. In this section, each separately identified tissue submitted for individual examination and diagnosis would be clearly identified and listed as a separate specimen.

GROSS DESCRIPTION

The Association recommends that:

1. An adequate gross description be a part of every surgical pathology report. Prerecorded gross descriptions are satisfactory providing they include specific information about the particular specimen. Each separately identified tissue specimen submitted for individual examination and diagnosis should have its own gross description. Whether "part" of "all" of the specimen has been submitted for microscopic examination should always be recorded in the gross description.
2. Each block be identified by a unique number and/or letter. Specifically, giving multiple blocks the same identification number or letter is discouraged. A summary listing the sites from which each identified block is taken should be placed at the end of the gross description.
3. Identification of block selections of complex specimens be augmented when appropriate by drawings, photographs, xero-

graphs, etc., but these pictorial records should *not* replace the printed block identification summary recommended in 3 above. Ideally, the pictorial record should accompany the chart copy, the physician copy, and the surgical pathology laboratory copy of the report.

4. If margins are inked, this fact be recorded in the gross description.
5. Distribution of tissue for special studies be recorded in the gross description.
6. When slides or blocks or tissues are received from another laboratory, the number of slides and blocks, the referring hospital's identification numbers and/or letters, and the referring hospital's demographic data be recorded in the pathology report.

MICROSCOPIC DESCRIPTION AND COMMENT SECTION

For purposes of these recommendations a *microscopic description* is defined as a description of the cytologic features and the architectural arrangement of the cells in a histologic section. A *comment* refers to all other pertinent information.

The Association recommends that:

1. Microscopic features be recorded whenever the responsible pathologists deems that it is indicated, but a microscopic description need not be a part of every report.
2. Comments be put into the report whenever the responsible pathologist considers that they are indicated, but a comment need not be written for every case.
3. It be optional whether micro-

scopic descriptions and comments are in separate sections or combined.

4. When "special" stains have been performed, each stain done and the results of the staining be designated in the microscopic or comment section.
5. When immunohistochemical stains have been performed, each antibody tested and the results of the staining be listed in the microscopic or comment section of the surgical pathology report or in a separate immunohistochemical report or both.
6. All tumors for which grading has been shown to be a significant prognostic variable be graded. When a grade is given the grading criteria or grading scheme should be recorded in a comment or in the diagnosis line unless the grading scheme is standard and well understood by all clinicians.
7. A "checklist" approach be used for recording information that is needed for patient treatment and prognosis. A statement whether each item on the checklist is positive or negative should be made. The checklist is used to be sure that all pertinent information has been included in the pathology report. Such information includes but is not limited to grade, depth of invasion, presence or absence of vascular invasion, size of the tumor, type of tumor, etc., and it is often different for different types of resection specimens. The condition of resection margins should be recorded here if clinically indicated. These checklists may be in manuals, on separate sheets, in computers, etc. It is also recommended that there be routine periodic checks of pathology reports to ensure that this information is present and summarized in an easy-to-find area of the comment or in the diagnosis section.
8. All of the information needed to formulate the pathologic stage of a cancer be present in the report, but this information need not be recorded by a number or letter per se. If a stage

number or letter is recorded, then the system used should be specified.

INTRAOPERATIVE CONSULTATION

The Association recommends that:

1. The intraoperative consultation report be incorporated verbatim into the final report. The persons responsible for the intraoperative report should be identified. If there is a discrepancy between the intraoperative diagnosis and the final diagnosis, this should be recorded and discussed in a comment.

FINAL DIAGNOSIS

The Association recommends that:

1. The organ, the site, and the procedure, as well as the diagnosis, be specified in the diagnosis section. These can be set off from the diagnosis by a dash or a colon.
2. The format of diagnoses be standardized within each pathology department.
3. Anatomic diagnoses should be set off so that they can be quickly and easily identified.
4. Each separately identified tissue submitted for individual examination and diagnosis be listed in the diagnosis section along with the anatomic diagnosis for that specimen.

GENERAL CONSIDERATIONS

The Association recommends that:

1. Specimen(s) submitted, clinical information, clinical diagnosis, intraoperative diagnosis, gross description, microscopic description, comments (when they are not combined with the microscopic description), and anatomic diagnoses be clearly separated and identified in such a way as to be readily and easily found in the report.

Printing should be of sufficient quality to be easily read.

2. A search for prior histologic and cytologic accession numbers be carried out for each case and pertinent prior specimen numbers be recorded in the current surgical pathology report.
3. The results of special study results such as electron microscopy, immunohistochemistry, flow cytometry, receptor status, data, etc., be incorporated or summarized in the surgical pathology report whenever possible. If this information is not a part of the surgical pathology report, the fact that tissue has been sent for the study should be recorded in the surgical pathology report.
4. Information regarding procedures other than routine handling of tissue such as gross photography, decalcification, specimen X-ray, freezing of samples, and placing specimens in a tissue bank be recorded in the pathology report.
5. Intradepartmental consultations be documented in the surgical pathology report, either by identifying the consultant in the comment section or at the end of the surgical pathology report or by having the consultant co-sign the report.
6. When external consultation is initiated by the pathologist, that fact be recorded in the pathology report. When the consultant's report is received, a supplemental report containing the consultant's interpretation and opinions should be issued.
7. Clinically significant unexpected findings immediately be conveyed to clinicians, and the fact that a call was made be documented in the surgical pathology report.
8. References be cited in the surgical pathology report when pertinent.
9. It is acceptable for the responsible pathologist to make suggestions for additional studies or procedures in the surgical

pathology report if he/she thinks they will contribute to the case. They can be incorporated in the surgical pathology report as long as it is emphasized that they are only suggestions.

10. When an amended report is issued, the fact that it is an amended report be clearly and prominently noted. The changes that have been made in the report should be specified if the new report is a com-

plete one; if only changes are recorded in the amended report that fact should be specified.

11. The date of receipt of the specimen and the date of the final report appear in all surgical pathology reports.

Book Review

Knight B. Forensic Pathology, 584 pp, New York, Oxford University Press, 1991 (\$149.95)

This is a most welcome book on Forensic Pathology that, in my opinion, belongs on the book shelf of each and every hospital pathologist who is called on to do medical-legal autopsies as well as the 400 plus board-certified forensic pathologists in the United States.

The book makes its appearance at a critical time since violence and crime are on the increase and more forensic autopsies are being done. Policy makers are being asked to take an increasing interest in death investigation. The public's demand for capital punishment and more severe jail sentences for crime require more and more competent forensic autopsies.

The book is easily handled, not heavy or bulky, and covers the entire range of sudden, violent, and suspicious deaths that

encompasses the domain of the coroner/medical examiner.

While reviewing the book, I had the occasion to refer to the book for several cases I was investigating and found the book most helpful. One case involved a death during a surgical procedure and the other an agrochemical poisoning, two topics that are poorly covered in available textbooks.

The black and white photographs are for the most part satisfactory. However, those photographs showing massive injuries to the body are somewhat "sterile" and are adequate for presentation in court so as not to inflame the jury. The line drawings are excellent and could be utilized in court to explain details of body injuries to the jury.

The references or further readings at the end of each discussed topic are up-to-date and for the most part adequate. In Chapter 5, Head and Spinal Injuries, no reference is made to

C. B. Courville's *Forensic Neuropathology*. Chapter 15, Fatal Pressure on the Neck, makes no reference to P. Vanezis's *Pathology of Neck Injury*, even though several references are made to Vanezis's articles on vertebral artery trauma in forensic science journals.

The appendix lists some special staining to demonstrate early myocardial damage which I have not been able to duplicate to date. An interesting conversion table was weight of bodies in stones.

One big question: Why do the English hyphenate Post-Mortem?

In general, I like the book and believe it will assume an important place among the available textbooks of Forensic Pathology.

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