Diagnosis: ← Routine specimens (CODE: D + F9)

A

Site (procedure):

Tissue with findings

Pertinent negatives

Diagnosis: ← Large/complex specimens with malignancy (CODE: DLARGE = F9)

A

Site (procedure):

Diagnosis

Tumor size: _

Extent: _

Lymph vascular invasion: _

Perineural invasion: _

Surgical margins: _

Background changes

Lymph Nodes: _

Comment:

This is where you communicate with the clinician/surgeon. This is the proper place to discuss the degree of certainty of the diagnosis, what the pathologic differential diagnosis is, possibly incorporating information from prior pathology specimens or the EMR that are helpful in interpreting the pathologic findings. Also, if there are pending tests or next steps that you recommend, indicate that here. Finally, if the findings are discussed with a clinician, you can indicate so here, and if there is a reference to a publication in PubMed that the reader is directed to, place the citation here.

Clinical Information:

In most cases, this is directly transcribed from the requisition. Information that is relevant yet gleaned from reviewing the patient's chart should also be indicated here. If a requisition lists only an ICD-10 code, consult references (i.e. a "google search) to translate the code to a useful diagnostic code. Please do not just copy the ICD-10 code.

Microscopic Description:

The microscopic description, although not required in every case, is a useful place to practice the art of describing pathologic findings in a given case. Be aware that these are rarely read by clinicians, so your writing here is for an audience of pathologists. At LLUMC, all surgical pathology reports with major findings (i.e. malignant cases) should be accompanied by a photomicrograph. According to the adage, "a picture is worth a thousand words". Accordingly, most cases signed out will not have microscopic descriptions per se. Residents are strongly encouraged to pick several interesting cases and write a microscopic description of these cases. This will help to build and reinforce the skills of describing pathologic processes and building upon pathologic terminology.

At LLUMC, the "Micro field" is most often used to indicate the results of immunohistochemical/special staining studies, as well a list of regulatory disclaimers and resident oversight statements

PREVIEW DAY WORKFLOW

1) **Case Assembly and ID Verification**:
    a. Compare requisition and slides – verify identity matches
    b. Enter accession number in Online Review application in Cerner; ensure that proper report is open while reviewing slides/requisition
2) **Review Demographics and History**:
    a. Ask question “does it make sense that this tissue would be coming from this location from a patient with these demographics?”. Also, are there any “red flags” present from reviewing this material?
    b. If so, the next step is review of the patient’s EMR to determine appropriate history
        i. Notes tab: Consultation notes, procedure notes, H&P, etc
        ii. Procedure tab: GI procedure notes
        iii. Radiology: X-ray, CT, MRI reports
        iv. Microbiology: Culture results, etc (also look for antibody results under lab tab)
3) **Review Pathology History Inquiry**:
    a. Determine what prior pathologic specimens/workups have been done previously
4) **Read the Gross Description**:
    a. Review what specimen was actually received
    b. What major gross findings were documented in the gross description?
    c. Incorporate major gross findings into specimen diagnosis line when relevant (i.e. tumor size, structures involved, gross distance to closest margin)
5) **Review the Glass Slides**:
    a. Review all of the slides, generally in order received.
    b. It is good to look at a slide of tumor first so you know what the pathology you are looking for in the remaining lymph nodes, margins, etc.
    c. Always look at the block key concurrently with the slides, so you know the rationale for each slide (margin, plane of sectioning, contiguous sections, etc)
6) **Generate and Audit Report**:
    a. After reviewing the slides and gross, construct the pathologic diagnoses for each specimen.
    b. Multiple specimens can be combined into a single diagnostic line <u>only if each specimen shows the same diagnosis</u> (i.e. multiple negative margins, a brain tumor submitted in four specimens, etc)
    c. Order ancillary studies as necessary (after consultation with a supervising pathologist); document pending studies in micro field with IP8 + F9 template
    d. Take photomicrographs of representative pathology (save with legend and as “non-chartable”).
    e. Read through both diagnoses and specimen list to ensure that you have given each specimen a diagnosis.
7) **Spell Check and Final Report Review**:
    a. Spell check report (remember that not all pathology terminology will be in the dictionary)
    b. Final step: Read through the entire report to ensure that the report is:
        i. Complete
        ii. Is free of contradictory statements, double-negatives, etc
        iii. Communicates the information that is needed by the clinician to treat the patient, and contains no/minimal extraneous information that is not relevant to patient care

EXAMPLES

Diagnosis:

A

Stomach, random (biopsy):

Antral and oxyntic-type gastric mucosa with minimal chronic inactive superficial gastritis

No *Helicobacter* organisms seen on routine H&E staining; immunostain pending

Diagnosis:

A

Descending colon polyp (biopsy):

Tubular adenoma

Diagnosis:

A

Bone, left femur (biopsy):

Fragments of unremarkable bone and marrow elements

No evidence of osteomyelitis seen

Diagnosis:

A

Ascending colon, appendix, and terminal ileum (right hemicolectomy):

Invasive adenocarcinoma, moderately-differentiated

Tumor size: 3.7 cm

Extent:

Tumor present in cecum, invades full-thickness muscularis propria, into subserosal adipose tissue; overlying serosa uninvolved

Lymph vascular invasion: Present, focal

Perineural invasion: Not identified

Surgical margins: Widely clear

Background changes:

Small pedunculated tubular adenoma of ascending colon

Fibrous obliteration of the appendiceal lumen

Diagnosis:

A

Prostate (radical prostatectomy):

Adenocarcinoma (Gleason pattern 4 + 3 = 7, grade group 3)

Extent: Tumor confined to prostate gland; no extraprostatic extension seen

Lymph vascular invasion: Present, focal

Perineural invasion: Present, multifocal

Surgical margins: Focal positive (right posterior base)

Background changes:

High-grade prostatic intraepithelial neoplasia (PIN)

Nodular stromal and glandular hyperplasia

Chronic prostatitis

Single periprostatic lymph node with metastatic adenocarcinoma (1/1)

Metastatic deposit measures 0.8 cm

Extranodal extension: Not identified