Japan Council for Quality Health Care

Project to Collect Medical Near-Miss/ Adverse Event Information

Medical Safety Information

No.144, November 2018

Failure to Submit a Pathology Specimen

Nineteen cases have been reported in which specimens were not submitted for pathologic examination due to their having been lost or discarded after collection. (information collection period: from January 1, 2014 to September 30, 2018). This information was compiled on the basis of the content featured in “Individual Theme Review” in the 23rd Quarterly Report.

Cases have been reported in which specimens collected for pathologic examinations were not submitted.

Cause of Failure	Number of Cases	Main Background Factors
Lost	11	• There was no procedure concerning the handling of pathology specimens in the operating room, so the submission method varied from one clinical department to another • The ward did not have a set place for putting pathology specimens
Discarded	5	• The physician assumed that a specimen had been submitted for pathologic examination and told the nurse to discard it without checking whether it had actually been submitted • There was no container for storing pathology specimens in the operating room and the specimen collected was discarded the following day after being left behind in a tray
Submitted only for other examinations	3	• The internal medicine physician who received the specimen collected by the surgeon assumed that the surgeon had already submitted it for pathologic examination and therefore only submitted it for other examinations

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Case 1

After performing a bone biopsy, the physician handed the pathology specimen and the label to the nurse. The nurse went to submit the specimen to the pathology department, but it had already closed for the day. Accordingly, the specimen ended up being stored on the ward, but the ward did not have a set place for putting specimens. What happened to the pathology specimen after that is unclear, but when the physician saw the patient a month later to explain the results of the bone biopsy, the results were not available and the physician noticed that the pathology specimen had not been submitted.

Case 2

A pituitary tumor was removed. Usually, when a tumor underwent resection, the neurosurgeon submitted it for pathologic examination, but on the day of the operation, the physician who handled specimens was not in the operating room. After the operation had been completed, when the scrub nurse checked with the surgeon what to do about the tumor, the surgeon assumed that a specimen had already been submitted for pathologic examination and told the scrub nurse to discard it. The scrub nurse harbored doubts about whether the tumor should be discarded, but discarded the whole of it. A week later, when the surgeon queried the delay in receiving the results, they discovered that no specimen had been submitted for pathologic examination.

Preventive measures taken at the medical institutions in which the events occurred

- **At the end of the operation, check whether or not there are any pathology specimens, how many there are, and the name of the tissue.**
- **Decide on a place where pathology specimens should be placed and draw up a procedure for submitting specimens.**

* As part of the Project to Collect Medical Near-Miss/Adverse Event Information (a Ministry of Health, Labour and Welfare grant project), this medical safety information was prepared based on the cases collected in the Project as well as on opinions of the "Comprehensive Evaluation Panel" to prevent the occurrence and recurrence of medical adverse events. See the Project website for details.
http://www.med-safe.jp/

* Accuracy of information was ensured at the time of preparation but cannot be guaranteed in the future.

* This information is intended neither to limit the discretion of healthcare providers nor to impose certain obligations or responsibilities on them.

Department of Adverse Event Prevention
Japan Council for Quality Health Care
1-4-17 Kandamisaki-cho, Chiyoda-ku, Tokyo 101-0061 JAPAN
Direct Tel: +81-3-5217-0252 Direct Fax: +81-3-5217-0253
http://www.med-safe.jp/