Japan Council for Quality Health Care

Project to Collect Medical Near-Miss/ Adverse Event Information

Medical Safety Information

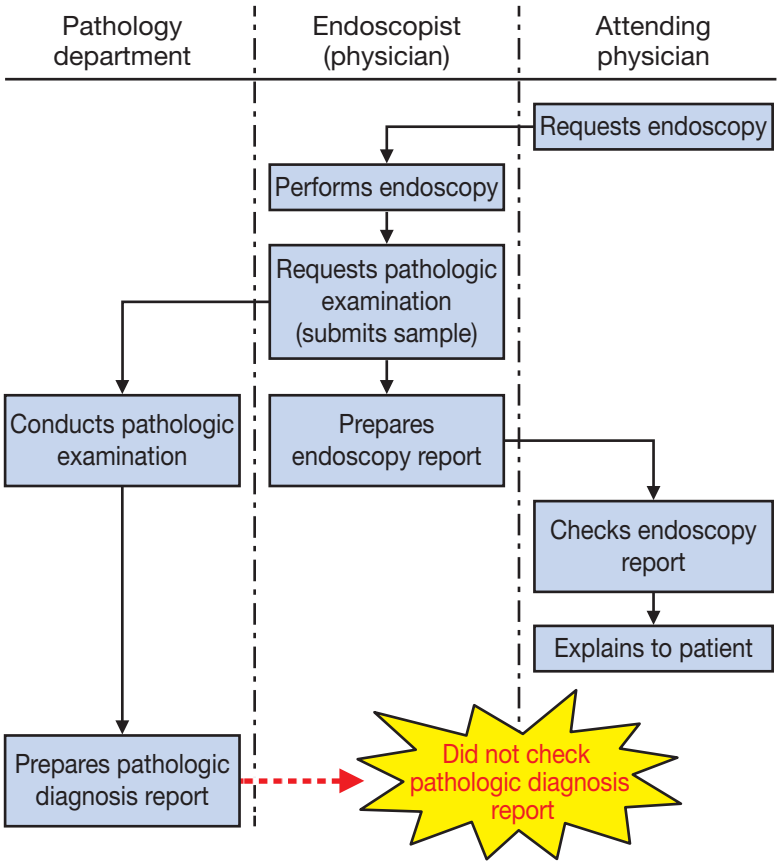
No.150, May 2019

Forgetting to Check the Pathologic Diagnosis Report —Upper Gastrointestinal Endoscopy—

The theme of Medical Safety Information No.71 (October 2012) was Forgetting to Check the Pathologic Diagnosis Report. Since then, 35 similar events have been reported. 26 of these involved diagnosis of biopsy specimens from upper gastrointestinal endoscopy (information collection period: from September 1, 2012 to March 31, 2019). This information was compiled on the basis of the content featured in “Recurrence of Events and Occurrence of Similar Events” in the 55th Quarterly Reports.

Cases have again been reported in which treatment was delayed because the pathologic diagnosis report was not checked.

Image of case



Main Factors Behind Failure to Check Pathologic Diagnosis Report

There was no rule about whether the department of gastrointestinal medicine should check the pathologic diagnosis report and explain it to the patient or whether the surgical department should do so
The endoscopist was notified that the pathologic diagnosis report had been prepared, but not the attending physician
The check of the pathologic diagnosis report, which was not prepared before the patient’s discharge, was not handed over to the outpatient attending physician
The pathologic diagnosis report had not been prepared at the time of the explanation to the patient and was not subsequently checked
The endoscopy was performed to search for the source of bleeding, so the pathologic diagnosis report was not checked

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Case 1

The gastroenterologist performed an upper gastrointestinal endoscopy as a pre-operative examination for colon cancer and took a biopsy. The pathologic diagnosis report was prepared after the patient was transferred into the care of the surgical department, so the gastroenterologist did not check the pathologic diagnosis report. The surgeon had not ascertained that a biopsy had been carried out. The two departments had no rule about which of them should check the pathologic diagnosis report and explain it to the patient. Four years after surgery for colon cancer, the patient underwent an upper gastrointestinal endoscopy to investigate anemia. At that point, the physician noticed that the pathologic diagnosis report from four years earlier mentioned gastric cancer.

Case 2

The physician performed an upper gastrointestinal endoscopy on a laryngeal cancer patient to test for double cancer and took a biopsy. When the pathologic diagnosis report is prepared, the endoscopist who requested the pathologic examination is notified. However, the attending physician who requested the endoscopy was not notified, so they did not check the pathologic diagnosis report. Four years later, the patient complained of difficulty in swallowing, so the physician performed an upper gastrointestinal endoscopy. When they checked the examination results, the physician noticed that the pathologic diagnosis report from four years earlier mentioned esophageal cancer.

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

- **Clarify who is responsible for viewing the pathologic diagnosis report and explaining it to the patient.**
- **Inform the patient that a pathologic examination has been carried out and that the results will be explained to them at a later date.**

Complementary comment by the Comprehensive Evaluation Panel

- **Decide on and implement a procedure for checking and explaining the pathologic diagnosis report.**

* 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.

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