Project to Collect Medical Near-Miss/Adverse Event Information

Medical Safety Information

August 2025

No.225

Failure to Respond to Important Findings in a Diagnostic Imaging Report Marked “Read”

Cases have been reported in which a response to important findings was delayed because a physician other than the attending physician opened the diagnostic imaging report, causing it to be marked “Read” on the system that manages whether reports are read or unread, and the attending physician did not notice that they had not read the diagnostic imaging report.

Three such cases were reported between January 1, 2021 and June 30, 2025. This information was compiled on the basis of the content featured in the Analysis Themes section of the 79th Quarterly Report.

Image of case

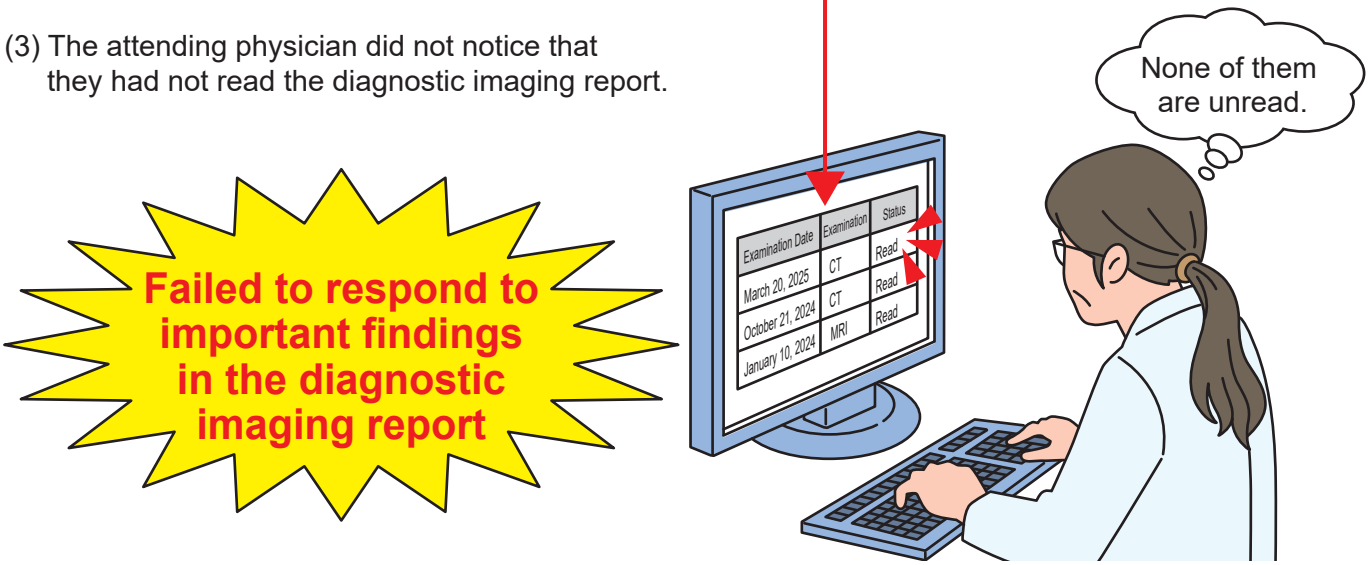
(1) After the radiologist prepared the diagnostic imaging report, it was displayed on the attending physician’s diagnostic imaging report list screen.

Examination Date	Examination	Status
March 20, 2025	CT	Unread
October 21, 2024	CT	Read
January 10, 2024	MRI	Read

(2) A physician other than the attending physician opened the diagnostic imaging report, so the status on the attending physician’s diagnostic imaging report list screen changed to “Read.”

Examination Date	Examination	Status
March 20, 2025	CT	Read
October 21, 2024	CT	Read
January 10, 2024	MRI	Read

(3) The attending physician did not notice that they had not read the diagnostic imaging report.



Failure to Respond to Important Findings in a Diagnostic Imaging Report Marked “Read”

Case

Six months earlier, the patient had been examined in the emergency room due to dysarthria, and was admitted after head and thoracoabdominal CT examinations. The system was designed in such a way that when a physician from the same clinical department as the attending physician opened the diagnostic imaging report, the status of the report changed to “Read” on the attending physician’s diagnostic imaging report list screen as well, so the attending physician during the patient’s hospitalization did not notice that they had not read the report. During an outpatient consultation after discharge, the patient complained of hemorrhoidal bleeding, and when the outpatient physician checked the past imaging, they noticed that the diagnostic imaging report from the thoracoabdominal CT examination carried out at the time of the emergency outpatient consultation six months earlier contained the finding “suspected rectal cancer.”

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

-When a physician other than the attending physician checks a diagnostic imaging report, they will ensure that they inform the attending physician without fail if it contains any important findings.

The measures above are examples. Please consider initiatives suitable for your own facility.

Key Preventive Measures

- **Ensure you operate the system for managing read and unread diagnostic imaging reports at your facility based on an understanding of its design.**
- **Be aware that systems designed in such a way that diagnostic imaging reports opened by physicians other than the attending physician are marked “Read” run the risk that the attending physician might not notice that they have not read the diagnostic imaging report.**

(Comprehensive Evaluation Panel)

* 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.
https://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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