Japan Council for Quality Health Care

Project to Collect Medical Near-Miss/ Adverse Event Information

Medical Safety Information

No.53, April 2011

Specimen mix-up at pathological diagnosis

Six cases of mix-up of specimens of different patients during pathological diagnosis have been reported (information collection period: from January 1, 2007 to February 28, 2011; the information is partly included in “Individual Theme Review”(p. 82) in the 22nd Quarterly Report).

Cases of specimen mix-up between patients during pathological diagnosis have been reported.

Types of mix-up	Situation	
	At specimen sampling (outside the pathological examination room)	At specimen handling (inside the pathological examination room)
Incorrect label attached	2	2
Mix-up of container with specimen	0	1
Mix-up of tissue when making the specimen	0	1

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Case 1

The primary nurse for outpatient care arranged the order sheets for Patient A and Patient B on the desk, and attached a hand-written label on the specimen bottles. Upon receiving the specimens, the medical technologist noticed that two bottles had the same names written on them. The nurse wrote the name of Patient A on both specimen bottles for Patient A and Patient B. Since the specimens could no longer be distinguished, tissue diagnosis was carried out again.

Case 2

Patient A was scheduled to have surgery for the right breast cancer. A biopsy was carried out in two sites on the right breast and one site on the left breast. The specimens were submitted to the pathological department. Cancer was reported for both the right and left breasts, so a bilateral mastectomy was performed. From the postoperative pathological examination results, cancer was observed in the specimen of the right breast, but not observed for the left breast. From the investigation, it was assumed that when the medical technologist inserted the specimen into the cassette, the description on the application for a pathological tissue examination was misread, and a mix-up in the container with the specimen of patient A's left breast and the container with the specimen from Patient B.

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

- **Complete the handling of the specimen of one patient before moving on to the next patient.**
- **When working with a specimen, organize the working environment.**

* 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 "Comprehensive Evaluation Panel" to prevent occurrence and recurrence of medical adverse events. See quarterly reports and annual reports posted on the Japan Council for Quality Health Care website for details of the Project. http://www.med-safe.jp/

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

* This information is neither for limiting the discretion of healthcare providers nor for imposing certain obligations or responsibilities on them.

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