Constructing Comments in a Pathology Report

Advice for the Pathology Resident

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In 1992, the Association of Directors of Anatomical and Surgical Pathology released a brief guideline laying out the basics of the pathology report. The term microscopic description referred to “a description of the cytologic features and the architectural arrangement of the cells in a histologic section,” whereas a “comment” referred to “all other pertinent information.” The guideline went on to note that neither a microscopic description nor a comment need be a part of every report, but should be added “whenever the responsible pathologist considers that they are indicated.”

We find that in training new pathologists, and in a review of many pathology consults to our institution, the consideration of both when and what to comment in pathology reports remains a challenge. Here, we present general advice to guide rising pathologists in crafting optimal pathology comments.

WHY CREATE A COMMENT?

As pathologists, our communication with clinicians is integral to coordinating proper patient care. Given that hundreds of cases may be seen and signed out in a given week, the effective writing of reports is essential to providing this communication (and avoiding one’s telephone from ringing incessantly). With this goal in mind, comments are used when a diagnosis alone does not sufficiently convey all prudent information.

TIPS FOR WRITING COMMENTS

Comments typically include relevant information that is not a diagnosis. Such information may include pertinent clinical history or test results, abnormal findings altering a typical diagnosis, previous material/diagnoses on the patient, and a differential diagnosis, if applicable. Further studies (eg, special stains, cytogenetics) that are pending and/or may be signed out in an addendum should be mentioned in a comment, as it alerts clinicians to look for further information.

Many systemic illnesses (eg, systemic lupus erythematosus, sarcoidosis) and syndromic cases require clinical evaluation of the patient for a definitive diagnosis to be made. In these cases, clinical correlation should be recommended with a suggestion of the clinical differential. If it’s a definitive diagnosis, don’t write it in the comment. Definitive diagnoses are reserved for the final diagnosis line so as to draw the attention of the clinician and avoid confusion. In the situation where the final diagnosis is unclear (eg, a differential diagnosis list must be included, or a possible diagnosis may be rendered, but not all diagnostic criteria are met), a description of relevant histologic findings and a reference to the comment should be written, with the comment explaining the diagnostic possibilities and/or why a definitive diagnosis cannot be made.

Rare diagnoses are not always well-known. Comments may, in a polite way, be used to educate clinicians on atypical or unexpected diagnoses. As pathologists, we are often aware of entities that may not be on the forefront of a clinician’s mind, which may be expounded upon in the comment, with relevant references as necessary. In general, comments should aim to give the clinician a direction for treatment.

A comment may be used to document where a case has been shown and who has been notified. Intradepartmental consults and external consults/expert opinions may be documented in the comment. As the pathology report is a medicolegal document, accuracy must be maintained in this regard. It is unethical to document showing a case to a colleague without actually showing said case; similarly, if a colleague disagrees with a diagnosis, it is unethical to document that the case was shown without also documenting that differing opinion. Expert opinions or extradepartmental consults are often crafted as verbatim addenda in lieu of a comment, for medicolegal reasons. For similar causes, when a case is intimated to a clinician, documentation should be made in the pathology note, per the College of American Pathologists guidelines.

Apply caution with treatment recommendations. As surgical pathologists typically do not see the patient whose biopsy specimen is before them, limits must be respected in advising treatment to clinical colleagues. “Forcing the hand” of the surgeon is not always welcomed and should be tempered by offering alternatives (eg, “close monitoring of this lesion” in some cases). Personal conversations with the clinician or raising such suggestions in a general discussion forum (ie, tumor board) serve as a better alternative to documenting a formal recommendation in writing.
Use comments to correlate previous material and to address premicroscopic issues. An abbreviated and relevant chronology of a complex clinical history is often useful to future colleagues who may need to refer to the material in your possession. Moreover, as comparing samples to previous biopsy specimens is good practice, documentation of such should be noted, with any relevant differences or similarities expounded upon.

On occasion, sampling errors, storage/preservation errors, grossing errors, or histologic errors may complicate a microscopic diagnosis. In these contexts, it is vital not to unreasonably overextend one’s diagnostic capabilities. At times, a descriptive diagnosis with a comment expounding upon the specimen’s histologic integrity, though undesirable, must suffice in lieu of a definitive diagnosis.

Finally, confirmation of or disagreement with a frozen section diagnosis is requisite in the comment. One must exercise caution in approaching this subject for obvious medicolegal and collegial reasons. If disagreement with a frozen section interpretation is noted, a carefully constructed explanation for the disagreement should be noted in the comment in addition to a telecommunication to the clinician.

REGARDING DICTION

Simple and plain language communicates more clearly. Verbiage for a microscopic description differs from that of a comment in that the audience for these sections is generally different (with the notable exceptions of medical renal, medical liver, and nonneoplastic skin biopsies, in which the clinician is equally—if not more so—interested in the microscopic findings). Thus, language used to address the clinician in a comment should be free of pathology jargon when possible. Brevity is often best: comments should be concise and clearly convey only that information that is relevant to the biopsy specimen at hand.

When composing a comment, consideration must be given as to the degree of certainty to be conveyed. The use of conditional terms (may, might, could) exudes uncertainty. Many pathologists, by way of a legal safeguard, use this language to allow for alternatives to a definitive diagnosis. However, while such language may be obligatory in some scenarios (eg, the nonspecific findings that lead to a differential diagnosis in these cases: “Based on the clinical and histologic findings, a diagnosis of X is favored; however, the differential diagnosis includes...”) Yet again, the prudent pathologist takes control and clinically correlates. Is CCIR needed in this context? Certainly not, given that the prudent clinician will then clinically correlate any pathologic findings presented in a report, understanding that the pathologist cannot be definitive.

Indeed, perhaps CCIR is best reserved as a statement for saying “I cannot interpret these histologic findings without directly examining the patient” or “I do not have enough clinical information available to interpret the histologic findings before me.” Most often, this scenario arises when limited clinical history is available and nonspecific histologic findings are seen that would require an exceptional degree of assumption on the part of the examining pathologist to definitively interpret. Great caution should be taken in making such assumptions.

CONCLUSIONS

We have presented here advice that we hope the modern pathology resident will find useful during training. We note that one’s standing in the scientific community is built on the words that are printed in the literature; similarly, one’s standing among one’s clinical colleagues is constructed by the reports one generates. Using relevant, clear, and concise commentary while avoiding common mistakes, unnecessary phrases, and typographic errors (indeed, among the greatest inventions of the 20th century was the ability to check a printed document electronically for spelling and grammatical errors) not only prevents medical errors and potential harm to a patient, but also is well within the prudent pathologist’s interests of generating a true and reliable report and sustaining an esteemed reputation.

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References