Intraoperative Diagnosis Miscommunication
An Opportunity for Improvement
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DOI: 10.1309/AJCP2IG2XQFMXGWU

Intraoperative consultations/frozen section analyses are among the most stressful parts of a pathologist’s duties. By design they have a strict time limit, the sampling of a lesion may be insufficient, the histology is usually inferior to permanent sections, little or no ancillary studies are available, consultation is less likely to be available, the specimen may not be in the pathologist’s immediate area of expertise, and the clinical consequences may be quite significant. In addition, every mistake is likely to be identified by the leisurely Monday morning quarterback review of a wide array of permanent slides, ancillary studies, and consultations. Indeed, it is perhaps most impressive how few errors are actually made during intraoperative consultation.

In this issue, Talmon et al1 point out yet another way in which an intraoperative consultation can go awry. In their study, they reviewed 1,131 intraoperative consultations and compared the written pathologist’s report with that dictated by the surgeon in the operative report. They found discrepancies in as many as 9.9% of cases, and in 0.3% of these cases, the discrepancies were between a benign and malignant diagnosis. These results are in line with those published by Roy et al.2

The authors reviewed a number of possible reasons for these discrepancies. In some cases, the diagnoses were relayed in person and in other cases by phone. In one case, the diagnosis was relayed to a nurse who then relayed the wrong diagnosis to the surgeon. In many cases there seems to have been more conversation between the surgeon and the pathologist than what was written down on the pathology report. In some cases the surgeon may have already dictated the operative report before the results of the intraoperative report were available.

In reviewing this list, I recognize myself at almost every step of the process. There are some surgeons with whom I have to chat about their case while the frozen section is being cut and stained; I certainly have longer discussions about margins and diagnoses with the surgeons in the context of what they are going to do next than I would dream of putting in the written report. In many practice settings, a pathologist who refuses to say anything more than what he is willing to write down is not likely to last, although obviously they have to use their best judgment about what they actually say and who they say it to. In addition, sometimes I cannot get the surgeon on the phone and I have to give the diagnosis to the nurse to tell the surgeon, although I always try and listen to what the nurse actually says. As I get older and my hearing becomes less acute, this becomes more and more difficult. Sometimes when I call the room it takes a long time for them to answer the phone, and it is the surgeon himself/herself who answers, so I know that he/she was busy dictating the operative report on the same line on which I was trying to call. Although these are all potential sources of error, it is unclear to me what I can do as the pathologist to change any of them.

However, there is one thing that I have total control over, and that is the choice of words that I use for frozen sections. Talmon et al1 have already reviewed the potential problems with using the word “No” in this setting,3 and indeed problems with “No” accounted for the most significant discrepancy in this series. For whatever reason, this is a lesson that pathologists have to learn for themselves. Until this mistake happens to them, most pathologists simply cannot believe that it will. Pathology organizations could make a real difference in reducing errors in intraoperative consultations and
all surgical pathology reports if they were to publish lists of “recommended alternatives” to using the word “No.” There really is “No” excuse for an error with “No.”

However, it is not just “No” that is the problem here. Although many of the intraoperative diagnoses that these authors list in their tables are succinct and to the point, many are not. No surgeon in the world is interested in listening to a long descriptive diagnosis when his or her hands are deep inside an operative site. “Benign,” “Malignant,” “Suspicious,” and “Deferred” are all diagnoses that are as straightforward as possible and likely reduce the chance of miscommunication. Of all of these, the one that pathologists are most likely not to use is the word “Benign.” It does not occur in any of the tables that Talmon et al.1 include. Why pathologists are unwilling to use the word benign is unclear to me, but it is a word that does not sound like anything else and every surgeon knows what it means. Pathology organizations could also do pathologists and their patients a service by listing “recommended terminology for intraoperative consultations.” These would have to be presented carefully to allow individual practices to adapt the terminology to their own particular needs and the desires of their surgeons. It is highly likely that miscommunication between pathologists and surgeons would be reduced if they were all working from the same list of understood terms. We already have “recommended” terminology for final diagnoses of carcinoma that are embedded in the College of American Pathologists tumor summaries.4 It would seem that the same improvement in communication could be achieved with a similar list for intraoperative consultation as well.

References