AOCD Annual Meeting 2016
Medicolegal Issues in Dermatology & Dermopath

Whitney A. High, MD, JD, MEng
Associate Professor, Dermatology & Pathology
Director of Dermatopathology (Dermatology)
University of Colorado School of Medicine

September 2016
Los Angeles, CA
I have no relevant disclosures
Malpractice in Dermatopathology—Principles, Risk Mitigation, and Opportunities for Improved Care for the Histologic Diagnosis of Melanoma and Pigmented Lesions

Whitney A. High, MD*

Department of Dermatology, University of Colorado Health Sciences Center, P.O. Box 6510, Mail Stop F703, Aurora, CO 80045, USA
Medicolegal Issues with Regard to Melanoma and Pigmented Lesions in Dermatopathology

Amanda Marsch, MD\textsuperscript{a}, Whitney A. High, MD, JD, MEng\textsuperscript{a,b,*}

\textbf{KEYWORDS}

- Medicolegal issues
- Melanoma
- Pigmented lesion
- Dermatopathology
Derm and Dermpath in USA?
Good News!
NEJM 2011

• Examined claims:
  – 40,000 doctors
  – 6 year period
  – Overall 7.4%/year were sued
  – Medical specialty - 55% sued by 65 y/o
  – Surgical specialty - 74% sued by 45 y/o
• N=23,371 cases asserted* 2009-2013
• Cases were clinically coded by specialty
• Just 272 (1.2%) identified with a responsible service of “dermatology”
• Total incurred amount of $20M
• Represented just 0.5% of all incurred costs among all specialties ($4.1B)
### N=272 CBS MPL cases asserted 09-13 with a primary responsible service of Dermatology

by major allegation

<table>
<thead>
<tr>
<th>Allegation Category</th>
<th># cases</th>
<th>Total Incurred Amt</th>
<th>% of cases</th>
<th>% of total incurred</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical TX</td>
<td>122</td>
<td>$5,992,279</td>
<td>45%</td>
<td>30%</td>
</tr>
<tr>
<td>Diagnosis-Related</td>
<td>66</td>
<td>$9,377,865</td>
<td>24%</td>
<td>47%</td>
</tr>
<tr>
<td>Medication-Related</td>
<td>37</td>
<td>$3,047,116</td>
<td>14%</td>
<td>15%</td>
</tr>
<tr>
<td>Surgical Tx</td>
<td>21</td>
<td>$729,496</td>
<td>8%</td>
<td>4%</td>
</tr>
<tr>
<td>Communication</td>
<td>13</td>
<td>$239,521</td>
<td>5%</td>
<td>1%</td>
</tr>
<tr>
<td>Safety &amp; Security</td>
<td>5</td>
<td>$271,239</td>
<td>2%</td>
<td>1%</td>
</tr>
<tr>
<td>Discrimination</td>
<td>3</td>
<td>$49,447</td>
<td>1%</td>
<td>0%</td>
</tr>
<tr>
<td>PT Monitoring</td>
<td>2</td>
<td>$62,335</td>
<td>1%</td>
<td>0%</td>
</tr>
<tr>
<td>Anesthesia-Related Tx</td>
<td>1</td>
<td>$129,290</td>
<td>0%</td>
<td>1%</td>
</tr>
<tr>
<td>Hosp Policy &amp; Proc</td>
<td>1</td>
<td>$78,480</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Provider Behavior</td>
<td>1</td>
<td>$10,375</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Sum:</strong></td>
<td><strong>272</strong></td>
<td><strong>$19,987,444</strong></td>
<td><strong>100%</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>
N=272 CBS MPL cases asserted 09-13 with a primary responsible service of Dermatology

by injury severity

<table>
<thead>
<tr>
<th>Severity Category</th>
<th># cases</th>
<th>Total Incurred Amt</th>
<th>% of cases</th>
<th>% of total incurred</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>50</td>
<td>$787,929</td>
<td>18%</td>
<td>4%</td>
</tr>
<tr>
<td>Medium</td>
<td>179</td>
<td>$7,008,445</td>
<td>66%</td>
<td>35%</td>
</tr>
<tr>
<td>High</td>
<td>43</td>
<td>$12,191,069</td>
<td>16%</td>
<td>61%</td>
</tr>
<tr>
<td>Death</td>
<td>20</td>
<td>$4,956,576</td>
<td>7%</td>
<td>25%</td>
</tr>
<tr>
<td>Permanent significant</td>
<td>16</td>
<td>$5,486,482</td>
<td>6%</td>
<td>27%</td>
</tr>
<tr>
<td>Permanent major</td>
<td>4</td>
<td>$1,738,277</td>
<td>1%</td>
<td>9%</td>
</tr>
<tr>
<td>Permanent grave</td>
<td>3</td>
<td>$9,735</td>
<td>1%</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Sum:</strong></td>
<td><strong>272</strong></td>
<td><strong>$19,987,444</strong></td>
<td><strong>100%</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>
**N=272 CBS MPL cases asserted 09-13 with a primary responsible service of Dermatology**

by top contributing factors

<table>
<thead>
<tr>
<th>Contributing Factors Code</th>
<th># cases</th>
<th>% of cases* (N=272)</th>
<th>Top Clinical Judgment Factors</th>
<th># cases</th>
<th>% of cases* (N=272)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CJ - clinical judgment</td>
<td>102</td>
<td>38%</td>
<td>CJ1021 - pt assess—failure/delay in ordering diagnostic test</td>
<td>30</td>
<td>11%</td>
</tr>
<tr>
<td>TS - technical skill</td>
<td>101</td>
<td>37%</td>
<td>CJ1004 - pt assessment—narrow dx focus—failure to establish differential diagnosis</td>
<td>19</td>
<td>7%</td>
</tr>
<tr>
<td>BR - behavior</td>
<td>97</td>
<td>36%</td>
<td>CJ4001 - failure/delay in obtaining consult/referral</td>
<td>16</td>
<td>6%</td>
</tr>
<tr>
<td>CO - communication</td>
<td>73</td>
<td>27%</td>
<td>CJ2013 - selection/management therapy—medical</td>
<td>14</td>
<td>5%</td>
</tr>
<tr>
<td>DO - documentation</td>
<td>52</td>
<td>19%</td>
<td>CJ2009 - selection/management medication—other</td>
<td>10</td>
<td>4%</td>
</tr>
<tr>
<td>CS - clinical systems</td>
<td>25</td>
<td>9%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Contributing Factors Code</th>
<th># cases</th>
<th>% of cases* (N=272)</th>
<th>Top Technical Skill Factors</th>
<th># cases</th>
<th>% of cases* (N=272)</th>
</tr>
</thead>
<tbody>
<tr>
<td>TS4008 - technical performance—possible technical problem</td>
<td>56</td>
<td>21%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TS4009 - technical performance—poor technique, other</td>
<td>22</td>
<td>8%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TS1001 - improperly utilized equipment (user error)</td>
<td>8</td>
<td>3%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
N=272 CBS MPL cases asserted 09-13 with a primary responsible service of Dermatology

by final diagnosis*

<table>
<thead>
<tr>
<th>Category of Case</th>
<th># Cases</th>
<th>Sum of Total Incurred Amt</th>
<th>% Cases</th>
<th>% of Total Incurred</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complications</td>
<td>47</td>
<td>$2,369,778</td>
<td>17%</td>
<td>12%</td>
</tr>
<tr>
<td>Cancer of skin</td>
<td>46</td>
<td>$4,665,782</td>
<td>17%</td>
<td>23%</td>
</tr>
<tr>
<td>Poisoning</td>
<td>36</td>
<td>$2,930,922</td>
<td>13%</td>
<td>15%</td>
</tr>
<tr>
<td>Burns</td>
<td>32</td>
<td>$1,177,033</td>
<td>12%</td>
<td>6%</td>
</tr>
<tr>
<td>Anxiety disorders</td>
<td>29</td>
<td>$679,219</td>
<td>11%</td>
<td>3%</td>
</tr>
<tr>
<td>Other skin disorders</td>
<td>22</td>
<td>$368,378</td>
<td>8%</td>
<td>2%</td>
</tr>
<tr>
<td>Cancer; other primary</td>
<td>8</td>
<td>$5,810,260</td>
<td>3%</td>
<td>29%</td>
</tr>
<tr>
<td>Topic</td>
<td>Count</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>-------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laser “accidents”</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cosmetic filler</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Isotretinoin complications</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Missed melanoma</strong></td>
<td>6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chloroquine</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TEN/SJS</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NMSC</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Potent steroids</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Light therapy</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Connective tissue disease</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cryosurgery</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Merkel cell</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Balanitis obliterans with SCC</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Litigation Within Dermatology & Dermatopathology

- **Misdiagnosis** of melanoma is a key problem
- The Doctors Company (1990-2001)
  - “skin cancer” and/or “melanoma”
    - 8.6% of all claims against pathologists
    - 14.2% of all claims against dermatologists
Too much litigation versus too many errors?

- Harvard Medical Practice Study (1990)
  - 31,000 medical records examined
  - “Negligence” *only* by consensus
  - 1 out of 25 harmed by medical error
  - Only 4% of injured *actually* made claims
1452 claims
90% with medical injury
60% due to wrongdoing by MD
72% without error → no compensation
73% with error → compensation
Litigation fees ~ $52,000
Time to resolution ~ 5 years
Half Full or Half Empty

- 90% of suits involved actual medical injury
- Courts “right” ~ 75%
- Only 0.4% of claims “frivolous”

“Careful & Deliberate”

- 10% of claims without injury
- 75% is a “C”
- ~ $52,000 & 5 yrs to adjudicate

“Wasteful & Fickle”
Purpose of Malpractice Law

“To identify a party injured because of substandard care and compensate the party, so as to make them whole.”

- Malpractice is *tort law*
- It is a *civil action*
  - “Preponderance of the evidence” (>50%)
Elements of Malpractice

Six elements of a *prima facie* case

1. Duty
2. Standard of Care
3. Breach of Duty
4. Cause in Fact
5. Proximate Cause (Legal Cause)
6. Damages

*(failure to prove a single element is fatal)*

"Causation"
Simple Pyramidal Structure

Duty To Act

Negligent Action or Inaction

Damage$ from Negligent Action/Inaction
Duty

- “Contractual” agreement to provide care with proper professional skill
- Opposed to “curbside,” “hallway,” or “sidewalk” consultations
- Courts traditionally reluctant to assign duty to those with only tangential relationship
- Use of “images” (telederm) or actual patient materials (slides) may make one liable

Baker KD, The Federation of Defense & Corporate Counsel
http://www.thefederation.org/documents/baker-sp02.htm
Varying Standards of Care

• Some states:
  – “reasonably prudent physician” of same background, training, experience

• Other states:
  – knowledge and skill common to members in good standing

Notes

The outcome does **NOT** have to be favorable!

You do **NOT** have to be “correct”!
Causation

• Concept of contributory negligence

• Cause in Fact ("But for," causation)
  – Determined by jury
  – Did that actions actually lead to the result?

• Proximate Cause (legal causation)
  – Determined by the judge
  – Was the result foreseeable?
  – Is it "reasonable" to hold the party accountable?
Standard of Care is ALWAYS Established *de novo*

- Expert testimony (difficult to secure & expensive)
- P’s costs often fronted by the attorney
  - in exchange for a ~1/3 interest in any award
- Trial expenses ~ $50,000 - $100,000
- ~ 500 hours of prep = $75,000 - $100,000

“Investment” in jeopardy - $125,000 to $250,000

Honorable Gary Trawick, Judge, Superior Court, North Carolina
Advocating for “Patient’s Compensation” (analogous to Worker’s Compensation)
Show Me the Money!

- **Special damages**
  - medical bills (past, present, future)
  - lost wages (past, present, future)

- **General damages**
  - pain & suffering (*per diem* vs. lump sum)
  - loss of enjoyment/consortium

RARELY PUNITIVE DAMAGES!
US Attorneys Not Really Interested in “Close Calls”

- Average cost of lawsuit
  - Plaintiff’s Atty. = $125-250k

- “Where’s Waldo” cases
  - some pigmented lesions are difficult for ALL experts

- Farmer, et al. (1996)
  - 37 “classic” melanomas & 11 “expert” dermpaths
  - unanimity for “melanoma” in just 11 cases (30%)
“Chilling not only to physicians, but to patients, and *sobering* to lawyers for plaintiffs.”

- A.B. Ackerman, 1996
"The first thing we do, let's kill all the lawyers".

*Henry VI (Act IV, Scene II)*

by William Shakespeare

- 1588-90
Request for Relief

This Court is requested to seek the Death Penalty against DOCTOR for murdering PATIENT in cold blood, when he was warned, when she was resisting and he ordered her murdered, aggressively, on drugs that he knew were contraindicated for her conditions.

Do we really want to eliminate lawyers?
The Doctor’s Defense

• Attack *validity* of the required elements
  – “there was no breach the standard of care”

• Assert an “affirmative defense”
  1. Conflicting legal duty (psychiatrists)
  2. Consent (most often employed defense for procedures)
  3. Statute of Limitations (variable length)
Statute of Limitations

• Time period when a suit must be filed
• Varies from state-to-state
• Tolled in children until a certain age
  – age of “majority,” simply a specified age
• Point of argument in many situations:
  – begins when one is “reasonably” alerted to an injury and not simply “date of service”
Anonymous Pt v. Anonymous Derm
Virginia 1997

- Plaintiff sought care for mole upon leg
- Derm biopsied → interpreted as benign
- Two years later → pt. visited a surgeon
- Surgeon requested medical records
- Derm then re-assessed slide and amended the path report → “melanoma”

Was suit timely?
Court Decision

• SOL *did not* begin at misdiagnosis
• RULING: SOL began 2 years from when the melanoma “moved from epidermis into the dermis”

(When the *heck* was that?)

**Important point:**

The SOL may begin when an injured party *should have been reasonably aware* that an injury had transpired.
What are the issues discussed with damage caps...

are such caps ethical?
are such caps legal?
For states/entities with damage caps there may be an even greater disincentive to sue.

Would you risk $125,000 for a 1 in 5 shot at $150,000?
Do Caps Save Money

• Both economic and non-economic damage caps exist

• Conflicting evidence over whether:
  – non-economic damage caps save money
  – economic damage caps are ethical
Malpractice damage caps not a cure for high health care costs

WASHINGTON – Capping malpractice damages is a health care reform idea that has swirled around Washington for years. But would it make health care less expensive?

The evidence doesn’t show it.

For many years, doctors have complained that they pay huge insurance premiums to defend themselves from malpractice suits. They’re right.

“Defensive” medicine costs continue to increase.
Oregon’s Unique Situation

- Clarke v OHSU
  - $12M+ damages
  - state was substituted for MDs/RNs
  - result - $200k remedy
  - law was unconstitutional “as applied” to case
Structure of US Court System

United States Supreme Court

State Supreme Court

State Appellate Court

State District Court

Federal Circuit Court

Federal District Court
"That $250,000 wouldn't pay for my medication for the rest of my life," [the patient] responded. "$250,000 for my kind of injury, it's nothing. It's a pittance."
Apology Laws

• Now exist in 29 states
• Protect doctor against use of certain statements in situation of:
  – “perceived” medical error
  – negative outcome
• Vary from state to state
Colorado Apology Law

• Broadest in the nation
• C.R.S. 1-25-13
  – protects “any and all statements, affirmations, gestures, or conduct expressing apology, fault, sympathy, commiseration, condolence, compassion, or a general sense of benevolence…”
• Doctor can apologize, describe in detail any mistakes and the information is inadmissible
Texas Apology Law

- Narrower than Colorado’s apology law
- TCP&R Code Sec 18.061(a)(1):
  - protects statements that “expresses sympathy or a general sense of benevolence relating to the pain, suffering, or death of an individual involved in an accident.”
- However, unlike Colorado's law, it does not bar a doctor's admission of liability or fault
How might this work…

• Imagine after a procedure the following statement is made:

  “I am sorry for your pain. I mistakenly failed to close your wound properly and that failure caused your pain and suffering.”

• Colorado – entire statement protected
• Texas – only “I am sorry…” is protected.
• Doctors with fewer claims:
  – used more orientation/education
  – laughed and used more humor
  – spent slightly longer in routine visits (mean 18.3 vs. 15.0 min)

“Sometimes when your first you are last.”
Dermatology & Dermatopathology Litigation
The Doctors Company
- 1998 to 2001 → 144 pathology claims
- 23 (16%) were misdiagnosis of melanoma
  (second only to breast cancer for litigation potential)
Melanoma 13% of *all* pathology claims (44/335)
• False negative 95% (42/44) but false positive 5% (2/44)

(2006 ACS estimates: 63k melanomas, 217k breast cancers)
“Breakdown” of 42 False Negative Claims

- Erroneous “diagnoses” involved:
  - Spitz nevus: 3 cases
  - Dysplastic nevus: 3 cases
  - Spindle cell SCC: 3 cases
  - Atypical fibroxanthoma: 1 case
  - Missed desmoplastic melanoma: 2 cases

No explanation for the other 30 cases.

No case details or information regarding financial outcomes.
“It’s unlikely you will ever be sued...”
Each year 1.5 M animals cross the Serengeti...
Taking no solace in the other animals good fortune.
Taking no solace in the other animals good fortune.
Continued Evolution is a Certainty
Five things to make sure of...

1. Make sure the sample is adequate
2. Make sure the history/tissue is right
3. Make sure the report is tight
4. Biopsy books must be run regularly
5. Make sure communication lines are open to between the dermatologist and the dermatopathologist
1. The sample

Alas, this product does not exist…
The Vanishing Biopsy: The Trend Toward Smaller Specimens

Emmy M. Fernandez, MD; Thomas Helm, MD; Michael Ioffreda, MD; Klaus F. Helm, MD

Cutis, Nov. 2005

- Number of shaves increased 1988-2005
- Volume of shaves decreased 1988-2005
- This impacts the accuracy of diagnosis
Case

- 52 year-old VA patient
- 2004 - “dark lesion” on L neck
- Punch biopsy performed
- Diagnosis: irritated junctional nevus
- 2006 - lesion persisted and worried him
- Rebiopsy – Melanoma 0.65 mm
Clinical Presentation
Methods of Sampling

- **Shave** – inadequate for true “r/o melanoma”
- **Punch** – specialized use with difficult lesion
- **Saucerization** – gaining acceptance
- **Excision** – preferred where safe & practical
Punch the thickest area?
Study of Saucercization
(Pariser et al. DOJ 1999; 5:4)

Figure 1. Percentages of specimens which removed entire lesion, part of lesion with insignificant missing portion, or part of lesion with significant missing portion.
Study of Saucerization (Pariser et al. DOJ 1999; 5:4)

Figure 2. Percentages of each specimen type resulting in a histopathologic diagnosis which was completely certain or fairly sure, or in which there was some suspicion. Shown in yellow are those cases in which there was little doubt of lesion malignancy (sum of completely certain and fairly sure).
Level 1
“r/o NMSC”
Level 3
“r/o NMSC”
Level 3 – Higher Magnification
“r/o NMSC”

BCC
The Impact of Partial Biopsy on Histopathologic Diagnosis of Cutaneous Melanoma

Experience of an Australian Tertiary Referral Service

Jonathan C. Ng, MBBS, MBiomedSc; Sarah Swain, MBBS, FRCPA; John P. Dowling, FRCPA; Rory Wolfe, BSc, PhD; Pamela Simpson, BSc; John W. Kelly, MD, BS, FACC

Objective: To compare partial and excisional biopsy techniques in the accuracy of histopathologic diagnosis and microstaging of cutaneous melanoma.

Design: Prospective case series.

Setting: Tertiary referral, ambulatory care, institutional practice.

Patients: Consecutive cases from 1995 to 2006.

Interventions: Partial and excisional biopsy. Other factors considered were anatomic site, physician type at initial management, hypomelanosis, melanoma subtype, biopsy sample size, multiple biopsies, and tumor thickness.

Main Outcome Measures: Histopathologic diagnosis (false-negative misdiagnosis—overall or with an adverse outcome—and false-positive misdiagnosis) and microstaging accuracy. Odds ratios (ORs) and 95% confidence intervals (CIs) obtained from multinomial logistic regression.

Results: Increased odds of histopathologic misdiagnosis were associated with punch biopsy (OR, 16.6; 95% CI, 10.27) (P < .001) and shave biopsy (OR, 2.6; 95% CI, 1.2-5.7) (P = .02) compared with excisional biopsy. Punch biopsy was associated with increased odds of misdiagnosis with an adverse outcome (OR, 20; 95% CI, 10-41) (P < .001). Other factors associated with increased odds of misdiagnosis included acral lentiginous melanoma (OR, 5.1; 95% CI, 2-13) (P < .001), desmoplastic melanoma (OR, 3.8; 95% CI, 1.1-13.0) (P = .03), and nevoid melanoma (OR, 28.4; 95% CI, 7-115) (P < .001). Punch biopsy (OR, 5.1; 95% CI, 3.4-7.6) (P < .001) and shave biopsy (OR, 2.3; 95% CI, 1.5-3.6) (P < .001) had increased odds of microstaging inaccuracy over excisional biopsy. Tumor thickness was the most important determinant of microstaging inaccuracy when partial biopsy was used (odds of significant microstaging inaccuracy increased 1.8-fold for every 1 mm increase in tumor thickness; 95% CI, 1.4-2.4) (P < .001).

Conclusions: Among melanoma seen in a tertiary referral center, histopathologic misdiagnosis is more common for melanomas that have been assessed with punch and shave biopsy than with excisional biopsy. Regardless of biopsy method, adverse outcomes due to misdiagnosis may occur. However, such adverse events are more commonly associated with punch biopsy than with shave and excisional biopsy. The use of punch and shave biopsy also leads to increased microstaging inaccuracy.

Arch Dermatol. 2010;146(3):234-239
4 mm Punch Biopsy by Volume

- Assume 4 mm cylinder
  Volume of punch is = 50.3 mm$^3$

- Assume is two 3.5 um ‘silhouettes’ on slide
  “Volume” inspected is = 0.112 mm$^3$

The dermatopathologist is inspecting $\frac{1}{450}$th of the overall volume of the sampling!!!
TIP:
Secure a representative biopsy

(pssst – medicolegally, this is ALWAYS the clinician’s obligation)
If the problem is truly the sample itself, eventually the error will be discovered....
2. Make sure the clinical history and the tissue are right

- 65 year woman
- chest
- “r/o NUB”
Prevent An Error Before It Occurs

• “Crap in = Crap out”
  – “r/o melanoma” on *everything*
  – “r/o cancer” on *everything*
  – “rash”
  – “238.2” for *everything*

• Multiple specimens in the same bottle

• Curetting of a pigmented lesion

• Mismarking shaves, punches, excisions
Can’t be successful with this attitude:

Not my job!
When a error leads to a lawsuit...
Everyone involved is a target...

“throw them all against the wall, see who sticks!”
I might even promote doing biopsies in “3D”:
- **Description** (or what was **Done**)
- **Diameter** (size or extent)
- **Diagnosis**

Sample submittal form for cutaneous biopsy specimens.
Jury finds oncologist negligent for withholding crucial information from pathologist

August 4, 2014 by the pathology blawg • 5 comments

A Massachusetts jury found an oncologist was negligent when he failed to provide pertinent clinical information to a hematopathologist that may have prevented an erroneous diagnosis of non-Hodgkin lymphoma in a patient who subsequently died from treatment complications.
Chain of Dependency

- Biopsy
- Courier
- Logging
- Grossing
- Embedding
- Cutting
- Labeling
- Reading

Potential for error exists at each point.

You need to provide as many “clues” to the correct diagnosis as you possibly can!
Not including a **REALISTIC** clinical impression decreases error detection (as does mismarking punch/shave, etc.)

Ultimately, P09-41107 was a BCC but tissue placed on the slide was spongiotic dermatitis.

Ultimately, P09-41109 was spongiotic dermatitis but the tissue placed on the slide was BCC.
Be careful about what you place in the trash...
The Utility of Submitting Fibroepithelial Polyps for Histological Examination

Thomas J. Eads, MD; Tsu-Yi Chuang, MD, MPH; Vilma C. Fabré, MD; Evan R. Farmer, MD; Antoinette F. Hood, MD


Abstract

Background
The fibroepithelial polyp (FEP) is a common cutaneous lesion that is often removed for medical or cosmetic reasons. We examined the utility of submitting clinically diagnosed FEPs for routine microscopic examination.

Design
We reviewed 11,500 consecutive cutaneous pathology reports. Materials submitted with the clinical diagnosis of FEP or a synonym were reviewed and the histopathologic slides were examined. A comparison group of specimens submitted with the clinical diagnosis of melanocytic nevus was reviewed.

Setting
The biopsy reports were generated at a regional non-hospital-based dermatopathology laboratory providing service to physicians (dermatologists and non-dermatologists) practicing ambulatory medicine predominantly within a 4-state region (Ind, Ky, Tenn, and WV).

Results
Of 1335 clinical specimens submitted as FEPs, there were 5 malignant tumors. In the comparison group of 697 clinically diagnosed melanocytic nevi, there were 6 malignant tumors. In comparison with clinically diagnosed melanocytic nevi, the likelihood that a lesion clinically diagnosed as FEP would be a malignant tumor on histological examination is very low (relative risk, 0.4). None of the lesions clinically diagnosed as FEPs by dermatologists proved to be malignant.

Conclusions
Our data suggest there is an extremely low prevalence of malignancy in lesions clinically diagnosed as FEPs. We conclude that cutaneous lesions diagnosed as typical FEPs by dermatologists need not be submitted for microscopic examination.

Arch Dermatol. 1996;132:1459-1462

• 5 of 1335 “skin tags” contained a malignancy
  – 4 BCC, 1 SCC
  – compared to 6 malignancies in 697 “moles”
  – is this a reason to require submission of all tissue?
Biopsy from posterior neck of a 34 year old woman.

“Rule out tag.”
This ink can be used in clinical settings as well (and not just Mohs).
3. Make sure the report is tight

Initial Check

• Correct patient?
• Does biopsy technique & gross size match?
• Was history and clinical info accurate?
• Is the final assessment plausible?

University of Colorado Dermatopathology Consultants
Department of Dermatology
1900 N. Fitzsimons Parkway
Suite 120
Aurora, CO 80045-7503

DERMATOPATHOLOGY REPORT

Physician: [redacted]  DOB: [redacted]  Received: 11/7/2011

Diagnosis: Site: Nasal tip  SHAVE  ICD9: 173.31
Basal Cell Carcinoma, Infiltrative Growth Pattern, Margins Positive

Comments:
The tumor islands extend to the deep surgical margin.

We have retained this slide for our files. We appreciate the opportunity to review this case.

Clinical History:
None.

Clinical Impression:
Rule out basal cell carcinoma versus scar.

Gross Description:
Received is a 0.5x0.5x0.1 cm tan-gray fragment of skin in formalin labeled with the patient’s name and biopsy site. Margins inked in black and submitted in two in one cassette.

Microscopic Description(s):
The specimen is a shave biopsy of skin present as multiple H&E stained sections on one slide. The pathologic process is that of a proliferation of basloid epithelial islands that demonstrate attachment to the overlying epidermis and extension into the dermis. Peripheral palisading of nuclei is prominent. The lesion demonstrates an infiltrative growth pattern. The tumor islands extend to the deep surgical margin.
No Path Report is Beyond Reproach

No stone tablet.

No burning bush.
CLINICAL/GROSS DESCRIPTION:

The patient is a 41-year-old white female with two biopsies form a lesion of the left heel. Specimen A is labeled "left heel midline" and specimen B is labeled "left heel medial". The clinical impression is rule out melanoma. Two slides contain multiple sections of skin representing two punch biopsies, which have been bisected.

MICROSCOPIC:

A: Sections of acral skin show nests of melanocytes with moderate cytologic atypia along the dermal-epidermal junction. A few single melanocytic cells are also noted. The melanocytes focally show poor cohesion. Melanophages are present in the underlying dermis associated with a patchy lymphoid infiltrate. Atypical melanocytes extend to both lateral surgical margins.

B: Sections of acral skin show nests of atypical melanocytes and single atypical melanocytes along the dermal-epidermal junction. The melanocytic cells show variable pigmentation. The dermis shows a patchy lymphocytic infiltrate. Atypical junctional melanocytes extend to the lateral surgical margins.

IMPRESSION:

A: Junctional nevus with architectural disorder and moderate cytologic atypia, skin, left heel midline.

B: Junctional nevus with lentiginous architectural disorder and severe cytologic atypia, skin, left heel medial.
This is MELANOMA.

If any other diagnosis returns from the dermatopathologist, it should be treated with great suspicion.

Ultimately, the diagnosis was ALMM 1.6 mm deep.
4. Keep a biopsy book and run it routinely to look for "drops"
A Real Case

• 23 y/o woman with lesion upon the leg
• Punch biopsy at FM clinic
• Biopsy to local dermpath, who issues a "placeholder" dx, but requests consultation
• University dermpath recognizes it as difficult melanocytic process:
  – performs stains,
  – solicits FISH studies
  – take to University Consensus Conference
• Ultimately, evidence favors melanoma
• University issues report = melanoma
  - copy of report marked “received” at local lab
  - it existed on servers at lab for 3 years
• Dermpath who requested the consultation never updates “placeholder” report
• Neither FM doc nor patient ever make any inquiries in to matter
• 3 years later:
  - pt develops recurrence, + lymph node in groin
  - metastatic disease
Two of the Best Instruments for Safer Medical Care

- Telephone
- Tincture of Follow Up
Thank you