Handling Amendments in Surgical Pathology

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Disclosures

- None
Outline

- Definitions of amendment/addendum
- Why the distinction matters
- When to amend
- Ensuring the amended report reaches those it needs to
- Use of amended reports as a quality indicator/quality improvement tool

Limitations

- Differences in institutional policies
- Clinician’s expectations
- Information Technology
  - Lab information system (LIS)
  - Electronic medical record
  - IT/LIS support

- We will focus on ideas and principles!
Definitions

- No universally accepted definition for amended vs addendum reports

- Other terms:
  - Supplementary (usually synonymous with addendum)
  - Corrected (sometimes synonymous with amended, but may be used for changes in sections of the report other than the diagnosis field)
  - Revised (sometimes used synonymously with amended, but may be used for changes exclusively in the diagnosis field)

 Definitions

- Meier, et al* described their experience with standardization of terms for alterations to pathology reports after sign-out

- Originally six terms (addendum, addition, amendment, correction, revision, supplement), reduced to 2:
  - Amendment – applied to all changes that were not purely additions of information to the case
  - Addendum – reserved for reports that purely added information to the case without alteration of previously reported material

*Am J Clin Pathol 2008;130:238-246
Royal College of Pathologists of Australia

- Amended reports: “... instances where significant information in the original report is deemed to be incorrect (in error) and which is identified at a date later than issuing of the original report. Such information may relate to patient demographics, specimen details, or significant alteration of diagnosis or important prognostic parameters”

RCPA policy (cont’d)

- Supplementary reports: “... instances where further information or refinement of diagnosis or further ancillary test results are expected at the time of issuing of the original report and the fact that such information will be available in future is mentioned in the body of the original report on the case.”
Why does it matter?

- Presentation – appearance in LIS/EMR, printed reports
- Replacement of original report vs adding to it
- QA implications
- Activation of policies re: alerting of submitting/most responsible physicians and others in the circle of care

To Amend or Addend?

**Amendment**
- Significant change from original report content
- New report replaces previous report in medical record
- Requires additional notification of responsible clinicians
- Rate used as a quality indicator

**Addendum**
- Used to communicate additional or supplemental information
- Does not replace original report (usually above or below it)
- Usually no special notification required
- Not used as quality indicator
What is a significant change?

- Use of the term “significant” in definitions certainly implies a judgment call!

- Ask yourself these questions:
  1) Does it conflict with the original report?
  2) Would a reader/recipient of the original report be expecting this new information?
  3) Does the new information potentially change treatment plans or the prognosis implied by the original report?
  4) What will happen if nobody reads this?

Scenario #1

- A pathologist received a perianal excisional biopsy specimen and rendered a diagnosis of “Squamous cell carcinoma in situ, please see comment”

- A line in the comment field states “there is definite evidence of invasion”

- The case is presented at MCC by a radiation oncologist who asks “Which is correct?”

- Case reviewed with the original pathologist, who confirms that the error is in the comment, not the diagnosis
Scenario #1

- The pathologist should now:
  A. Create an addendum clarifying the original report
  B. Amend the original report so that the comment agrees with the diagnosis
  C. Nothing – the diagnosis section is correct and the problem in the comment is an obvious typo which has already been clarified with the clinician.

Scenario #2

- Pathologist A at Hospital A receives a breast lumpectomy. Diagnosis: DCIS with positive margins. Sends to pathologist B at Hospital B for second opinion.
- Pathologist B reports invasive carcinoma on this specimen.
- Pathologist A in the meantime has become aware that the patient will been referred to Hospital B for further management.
Scenario #2

- Pathologist A should:
  
  A. Issue an addendum
  
  B. Issue an amended report
  
  C. Do nothing – there is already a report issued at the hospital where the patient is being managed.
  
  D. Send for another expert opinion

Scenario #2 Follow-up

- Patient seen at hospital B.
- No report in EMR at hospital B as patient was not a registered patient when pathology consultation was performed.
- Original report from hospital A (with no addendum or amendment) was the only pathology report on the patient chart from the first surgery
- Had re-excisions over the next couple of years showing residual DCIS
- Existence of original consultation report with macroinvasion discovered years after the fact
Scenario #3

- Pathologist renders a diagnosis of “adenocarcinoma, signet ring cell type” on a random endoscopic gastric biopsy
- Partial gastrectomy specimen received several weeks later. No gross tumour identified; well sampled (then re-examined and re-sampled) but no microscopic tumour found
- Original biopsy reviewed – benign dissociated mucous neck cells, negative for malignancy

Scenario #3

- What should be done with the original biopsy report?
  A. No change to the original biopsy report, but the results of the retrospective review of the biopsy should be commented on in the report of the resection specimen.
  B. Issue an amended report, changing the original biopsy result to negative.
  C. Issue an addendum to the biopsy result, indicating the results of the retrospective review.
  D. Nothing- the damage has already been done.
Do amended reports reach the right provider(s)

- Even non-amended pathology reports may not be issued to the physician most responsible for the patient’s care.
- This issue may be magnified for amended reports:
  - The amended report may be issued significantly later than the original report, increasing the likelihood that the patient has been referred on to other physicians.
  - These physicians may have received a copy of the original (erroneous) report but may not receive a copy of the amended report (and may not even have access to the EMR where the amended report resides).

- Failure to deliver 11.7% of amended reports with changes in the diagnosis field to the current treating physician:
  - All of these cases had a malignant diagnosis.
  - All cases were amended >21 days after original signout.
  - Failure occurred despite a documented discussion with a physician.
Amendments as QA

- Amendment rates often cited in the literature as a measurement of "report defects"
- May be measured at the departmental or individual pathologist level to:
  - Identify trends
  - Hone in on areas for potential improvement
  - Compare with similar departments/ individuals or benchmarks –but use with caution*


Amendments as QA

- Amendment rate does NOT equal pathologist error rate
  - Not all amendments are due to pathologist error
  - Not all errors are detected/result in amendments
  - High amendment rate: Poor performance vs. better detection?
Amendments as QA

- Question: Does the use of amendment rates as a performance indicator affect the willingness of a pathologist to amend a report?
- Retrospective studies* highlight phenomenon of “faux addenda” (addenda which should have been amendments)
- Clear policies, education, and fostering of a non-punitive culture may help reduce this practice


Quarterly Report Example

<table>
<thead>
<tr>
<th>Amended reports</th>
<th>Number</th>
<th>% per total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change in diagnosis/comment</td>
<td>31</td>
<td>0.36%</td>
</tr>
<tr>
<td>Change in macroscopic description</td>
<td>4</td>
<td>0.05%</td>
</tr>
<tr>
<td>Change in micro</td>
<td>2</td>
<td>0.02%</td>
</tr>
<tr>
<td>To correct clinical information</td>
<td>6</td>
<td>0.07%</td>
</tr>
<tr>
<td>To correct patient's ID</td>
<td>2</td>
<td>0.02%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>45</td>
<td>0.53%</td>
</tr>
</tbody>
</table>
Core elements of an amendment policy

- Define which reports should be amended (vs. addended)
- Designate who can initiate an amendment
- Policy/mechanism for entering reason for amendment
- Notification policy for clinicians (including documentation of notification)
- Retention of original report

Summary

- Distinction of reports with significant changes (amendments) vs reports with additional information (addenda) is important
- Assessment of “significance” requires some judgment – if in doubt probably best to amend
- Special effort may be necessary to ensure that treating physicians are made aware of amended reports
- Tracking amendments can provide valuable information to target areas of potential quality improvement, but caution is needed when used as a performance indicator
Many thanks for your attention and participation!