Pathology Error Results in Alleged Delay in Diagnosis of Malignant Melanoma

The Case

A gentleman presented to his doctor with a “mole” on the back of his hand. A biopsy of the mole was performed, and the specimen was sent to the pathology lab. There was no clinical description or pre-operative diagnosis on the pathology requisition slip. The pathologist’s diagnosis was “pigmented compound nevus” (benign pigmented skin growth). No further surgery was performed. Twenty one months later, a non pigmented subcutaneous nodule developed at the same site. It was excised and diagnosed as malignant melanoma. The original biopsy was re-examined, and sent out to a national pathology consultant group. Their diagnosis of the original specimen was “Malignant Melanoma, Clark’s level 4, Breslow's thickness 1.1 mm.” An amended pathology report was issued. Lymph nodes closest to the patient’s primary mole/lesion were subsequently removed. These were found to be negative for tumor. Additional procedures performed on the patient including PET and bone scans, CT scans of his chest, abdomen and pelvis and an MRI of his head were also negative. The patient had no further therapy. Fourteen months later the patient was diagnosed with widespread cutaneous (skin) metastasis.

Plaintiff’s Allegation

The plaintiff filed a lawsuit, claiming that the pathologist’s original (benign) diagnosis was a misdiagnosis and a breach of the standard of care. Further, the failure to make the correct diagnosis of malignant melanoma and treat it accordingly, resulted in a recurrence, and subsequent widespread metastasis of the patient’s melanoma.
Disposition

This case was ultimately settled for a significant amount of money due in large part to the lack of expert support for the defendant pathologist.

Physician Reviewer’s Commentary

Misinterpretation of melanocytic or pigmented lesions, both benign and malignant, is one of the most common errors leading to medical liability claims against pathologists. These lesions are quite heterogeneous and thus a diagnosis or interpretation is subjective. In many cases examined independently, internationally recognized pathology experts disagree on the diagnosis. Unfortunately, most cases that result in lawsuits have shown poor patient outcomes (recurrence, metastasis or death). Of course when poor clinical outcomes are known, this information often biases the opinions of subsequent reviewers. Not only do plaintiffs’ experts use this bias to strengthen their opinions, but credible defense experts may become biased, as well with regard to how they would have signed out the case. In addition, the anatomic site of these lesions makes interpretation more difficult. It is well established that completely benign acral (peripheral) melanocytic nevi may have atypical or irregular features. Accordingly, one must allow for more atypia in moles or skin lesions to avoid over diagnosing malignant melanoma in patients.

Risk Management Commentary

The following are a number of risk management recommendations that may reduce the risk of medical professional liability for pathologists:

1. **Intradepartmental consultations add strength to defensibility.** Asking the opinions of your professional colleagues can considerably bolster your case in the event of a medical liability claim or lawsuit. But, make sure your inquiries and/or discussions are documented consistently. If the consultation has taken place before your report is dictated, that fact should become part of the report itself.

2. **Choose your consultants carefully.** You may be liable if you accept a consultant’s opinion or diagnosis without question. Under the doctrine of vicarious liability, you may be held liable for a consultant’s errors even if your diagnosis was correct.

3. **Urgent and emergent malignancy reports should be communicated only to the provider who ordered the study or provider covering his/her practice.** Do not send urgent and emergent malignancy reports to the patient’s physician via fax and/or e-mail. Rather, contact the physician verbally either in person or by phone and document such contact.

4. **Note the reporting of a diagnosis in writing.** Avoid potential breakdowns in communication between the pathologist making a diagnosis on a biopsy and the patient’s physician. If you call in a report to a physician or physician’s office, it is essential that you document the call on the report with the date, time the call was made, and with whom you spoke. A simultaneous written report, signed by the pathologist, should be made for all surgical consults to avoid misinterpretation of verbal reports.

5. **Make sure pathology requisition forms are complete.** Pertinent information should not merely be requested on the pathology requisition form, it should be required. This information includes the referral physician’s and patient’s phone numbers, patient demographics, specimen site, pertinent medical history and clinical impression.

6. **Express concerns about whether the referring physician obtained a sufficient representative tissue sample.** Communicating these concerns is not always easy. Such concerns can often be more easily expressed orally, but the pathologist must be sure to properly document them in order to protect himself or herself in the event of a related problem and/or future liability claim.

To Conclude

While not intended to be a comprehensive review of potential liability issues for pathologists, the above risk management suggestions are based on over twenty years of defending pathology medical professional liability claims by MagMutual.
The information provided in this resource does not constitute legal, medical or any other professional advice, nor does it establish a standard of care. This resource has been created as an aid to you in your practice. The ultimate decision on how to use the information provided rests solely with you, the PolicyOwner.

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