Letters, 9/17

Joint specimen exams

I write this after reading “Total joints in view: to tilt at or to toss” (July 2017). I just completed my 42nd year as a general pathologist in an acute care community hospital that had 100 beds in 1971 and now has close to 500. From about 1980 (before we went to “separate billing”) through 2014, I fought relentlessly to have and keep the policy that all tissue get a pathology exam. These exams are needed:

- as patient protection from missed occult, significant diagnoses,
- to guard practitioners from failure-to-diagnose lawsuits,
- to be a source for defense against the erroneous particularities of some medical malpractice lawsuits,
- to stave off fraud and abuse claims against the surgeon and the institution about sham surgery or unfulfilled DRG and other such services,
- to provide potential data for institutional organized medical staff efforts in Ongoing Professional Practice Evaluation (OPPE) and Focused Professional Practice Evaluation (FFPE),
- for facility accreditation reasons,
- to provide more accurate data for public health tracking of true incidence and prevalence of disease, and
- to be a source for possible subsequent DNA identification of an unknown deceased person who is thought to be someone who had surgery at that institution.

All of these needs have to do with what is best for the patient and society and nothing to do with cost-effectiveness (which defies accurate analysis) or the pathologist earning more by performing these tedious duties.

The only way to convince organized medicine in the United States that pathology exams must be performed on all removed tissue would be to establish a secure, online, de-identified registry of cases. I suspect no pathology organization has the will to tackle this.

Ervin B. Shaw, MD, Lexington Medical Center, West Columbia, SC

Transgender medicine

I read your article “Making it personal: transgender medicine” by Karen Titus (August 2017). It was fantastic and I can hardly wait until the next installment. I am a graduate student at Rutgers University in the Department of Clinical Laboratory Sciences and this is the topic I have been researching for my final paper. It is very interesting to me, and most of the physicians I encounter in my day-to-day life have no answers to my questions. So thank you for your article. It has made me realize that I am not crazy to wonder about my questions on the diagnosis, lab results, and treatment plans for transgender patients. I have also now been enlightened on billing and laboratory information system issues I hadn’t thought about until now.

Meg Harlin, BSMT(ASCP), CLS(NCA), Clinical Laboratory Scientist, Atlantic General Hospital, Berlin, Md.

Your article is by far the best, most straightforward article I have ever seen on health care for transgender people. So many of the issues I have faced as a transgender woman are discussed and many I never considered but still may face. Thank you for publishing this work. Karen Titus should be commended for such unbiased, direct, factual reporting. I hope your article gets wide circulation.

Jaye S., Naperville, Ill.

All and only the tests our patients need

Testing and sequencing methods continue to proliferate, and the medical-industrial complex-driven competition to offer more and larger panels for genetic and women's health testing, to name just two examples, does not necessarily translate into better care. The direct-to-consumer genetic testing market is particularly troubling. Quality issues aside, interpreting genomic results for inherited cancer or reproductive genetic carrier testing when a variant is detected is not straightforward and should be reviewed in conjunction with a certified genetic counselor or ordering physician to determine individual risk. As a society we must heed priorities, including keeping the costs of health care down while ensuring all Americans receive the care they need. And laboratory medicine needs to lead the march toward value by making sure patients get all the tests they need—and *only* the tests they need.

The Affordable Care Act led the health care industry to look inward, seeking out ways to provide quality care while reducing costs. "Value-based care" became a buzzword, along with "precision medicine."

Today, value-based care is becoming the norm: Hospitals seek to reduce needless admissions, reduce unnecessary medical procedures, and help people stay healthy and out of the hospital. Meanwhile, precision medicine became the blanket term for ensuring that patients receive targeted and effective treatments.

My colleagues and I have developed over the past decade many tests for primary and specialty care, including cancer, women's health, and genetic disease. But as new, more accurate tests are devised, older ones do not necessarily fall by the wayside. Physicians continue to order them, despite newer tests that may be more rapid, more accurate, or more precise—or all three.

To be clear, patient care is not compromised; older tests still work, and work reasonably well in most situations. But in the world of diagnostic testing, newer tests often provide more clinically useful information and may have quicker turnaround.

It is up to us in the diagnostic medicine field to help break old habits, namely by educating our collaborators-in-care about how we can work together to streamline laboratory testing, directing our physician colleagues toward more efficient and more medically relevant tests. We must look inward and scour our own processes and offerings toward better utilization management. We must act as gatekeepers to the laboratory medicine test menu.

Some laboratories, like BioReference Laboratories, are doing just that. BioReference Laboratories has initiated a comprehensive review, starting with its esoteric test offerings in oncology, with the twin goals of reducing unnecessary testing and educating clients. In our multipronged approach we are doing the following:

- Minimizing duplicate and/or redundant esoteric testing by different methods and educating clinicians on why two tests are not necessarily better than one—for example, why FISH and PCR for the same target are most often redundant and unnecessary.
- Minimizing inappropriate esoteric testing—for example, cancer cytogenetic testing for non-cancerous diagnoses, such as fatigue.
- Eliminating serial testing that is not clinically indicated or not

indicated as frequently as ordered, such as qRT-PCR for *BCR/ABL1* more frequently than q3 months when in molecular remission (as per NCCN guidelines 1.2018 for CML).

- Assigning ICD-10 codes postanalytically based on esoteric test results to further refine the diagnosis electronically in the age of EMRs.
- At GeneDx, increasing participation in Pediatric Laboratory Utilization Guidance Services, or PLUGS.

For us, these efforts are more than just about fitting into the parallel tracks of value-based care and precision medicine. They're about greatly reducing the diagnostic journey for patients. And that starts with them getting the appropriate tests. And *only* those tests.

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