Q&A column, 2/16

Editor: Frederick L. Kiechle, MD, PhD

Submit your pathology-related question for reply by appropriate medical consultants. CAP TODAY will make every effort to answer all relevant questions. However, those questions that are not of general interest may not receive a reply. For your question to be considered, you must include your name and address; this information will be omitted if your question is published in CAP TODAY.

Submit a Question

Q. I am a practicing board-certified pathologist and I have one cytotechnologist to screen Pap tests. She is moving to another city, and I must decide whether to send all Paps to a reference laboratory or to another lab just for screening and then returned to me for sign-out of normal and abnormal Paps. Another option, the least desirable, is to attempt to screen Pap tests on my own. Do I need additional validation of my skills if I choose to be my own primary screener? If I choose to have the Pap tests screened at another hospital, will I have to travel to that hospital for my annual Pap proficiency test?

If I have my slides screened at lab A, but I interpret them at my hospital B, do I need to keep records of the screeners (for example, workload, competency records, ASCUS/SIL ratios) at hospital B for CAP inspections?

Finally, if I have the screeners at lab A sign out the negative Paps and have them returned to hospital B to be put into the patient's record, all with the appropriate information on the report such as where the screening took place, can I have my secretary at my hospital B enter the normal Pap results into our LIS? This would require the secretary to click "sign out" for the report to load into the patient's medical record. She is clearly just going through the manual steps. Because the "sign out" tab has to be clicked, is this a step I would have to do, or is it acceptable to have my secretary perform this task?

A. Pathologists may have Pap tests screened in one laboratory and sent to them at another laboratory to be signed out. The name of any laboratory that has substantially contributed to the interpretation of that test should be on the report. For example: "This test was screened at Oakharbor Hospital, 333 Michigan Ave., Boston, MA." Pathologists may screen and sign out Pap tests without a cytotechnologist. No additional validation of their skill set for that activity is necessary other than passing the national annual proficiency test as a primary screening pathologist.

In general, cytotechnologists tend to be better at screening activities than pathologists, and this is the preferred model. It also allows two individuals with different experiences to review the Pap test and make an assessment. Pathologists who choose to be primary (screening) pathologists have a lower pass rate on the national proficiency examination than do secondary pathologists who review slides screened by a cytotechnologist.

When taking the proficiency test, if the slides are screened by a cytotechnologist, the participating pathologist must take the test at the same laboratory that houses the cytotechnologist (falling under the same CLIA certificate). If he or she does not, the test is considered to have been referred to the second laboratory and referrals are not allowed in proficiency testing.

My understanding is that the laboratory housing the cytotechnologists (lab A) is responsible for their performance, so the pathologist at another site (lab B) does not need to keep records on those individuals. CAP inspectors would not expect lab B to have that information on hand.

The final question is more difficult. There should be no issue with entering the data from the cytotechnologist's interpretation of negative slides into the database of lab B, as long as it is clear that it is the cytotechnologist who performed the primary interpretation and not the pathologist or secretary. If the LIS enters the name of the person who clicks that "sign out" icon onto the report as someone who reviewed the slides, then the secretary cannot do it. The pathologist also should not append his or her name to all of the negative reports, or it will be construed that

he or she looked at all of them. The report should be clear as to who interpreted/reviewed the slides and other individuals who are performing purely clerical functions should not have their names in a final diagnosis field or any field whereby an observer could erroneously surmise that he or she reviewed the slides. There are ways to get around this in some software systems.

Barbara A. Crothers, DO, Pathology Program Director, Walter Reed National Military Medical Center, Bethesda, Md., Chair, CAP Cytopathology Committee

Q. In our public health laboratory, we encounter many environmental organisms from clinical samples. Is it a good idea to place this organism in our MALDI-TOF library? Should we report this organism if it is environmental?

A. The manufacturers of the FDA-approved MALDI-TOF instruments have built libraries of the most clinically important bacteria and yeast. These libraries are likely to be expanded to include medically important mycobacteria and filamentous fungi in subsequent iterations. They are also likely to be expanded to include the less commonly encountered but occasionally medically important microorganisms, some of which are also environmental microorganisms. These manufacturers may find it to their benefit to include more environmental microorganisms in their databases in the future, as public health laboratories represent potential clients, as do laboratories in the food and pharmaceutical industries. The inclusion of such isolates in the databases should not be detrimental to the clinical laboratory, as long as solid microbiologic principles are maintained and used to determine which isolates are pathogens and which may represent contamination.

It is important for microbiologists to resist the temptation to simply name and report everything just because it has become simple and inexpensive to do so. For example, assigned genus and species names to skin and enteric microbiota in a clearly mixed urine culture could do more harm than good by implying causation through the assignment of a name, rather than simply conveying to the clinician that the specimen contains this mixture. As long as solid principles are upheld, any technology that facilitates the laboratory-based diagnosis of infectious diseases is welcome in the microbiology laboratory.

- Murray PR. What is new in clinical microbiology—microbial identification by MALDI-TOF mass spectrometry. *J Mol Diagn.* 2012;14(5):419–423.

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