Q&A column, 12/14

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Submit a Question

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Q. What are the legal ramifications for medical technologists or medical laboratory technicians if they release results on suboptimal specimens on the insistence of physicians?

A. Probably every laboratory has experienced the "just run it anyway" demand on a specimen. Such requests may come from ordering practitioners, nurses, or other care providers.

Medicolegal claims resulting from mis-performed test-related injury would likely be directed against the facility, the laboratory and its director, not the performing medical technologist (MT or MLT). The plaintiff's argument would be failure to adhere to your own laboratory's good established laboratory practices and procedures, and possibly the manufacturer's directives, which resulted in the reporting of an alleged injurious result. Potential punitive or disciplinary actions to the MLT or MT for actions deemed inappropriate would derive from the employer. However, framing this problem as a medicolegal one is not, in our opinion, most helpful.

From a medical standpoint, providing the practitioner with the right test results from a properly collected specimen is the right thing to do for the patient. It is good standard laboratory practice to have a laboratory policy on specimen rejection that outlines which specimens will be rejected outright (for example, recollectible blood specimens received unlabeled), specimens and analytes that can be run with qualifiers (for example, slight hemolysis of a blood specimen), and irreplaceable, unlabeled specimens for which the test is performed and reported with limitations noted (a surgical tissue specimen for microbiology, for example). For any suboptimally received specimen, the ordering practitioner should be notified of the specimen rejection and a variance or incident report filed in the health care system. These variance reports can be reviewed later by laboratory management to help identify problems with either phlebotomy, specific nurses, nursing units, and so forth, where and for whom education can then take place.

In "heat of the moment" critical care situations, the medical technologist should not be put in the position of arguing with a caregiver. If he or she runs the specimen and reports the results, he or she should inform the immediate supervisor and a pathologist of the incident. At that point, the supervisor and pathologist can support the technologist and provide direct communication.

In summary, appropriate responses by laboratory personnel to inappropriate test demands should help the patient, manage the clinical demand, and avoid legal entanglements. We believe that a pathologist or doctoral scientist (laboratory or section director) should directly intervene in resolving any and every situation, especially with an ordering practitioner, that a technologist believes is becoming "difficult," adversarial, or confrontational. That is the laboratory medical director's and/or section director's responsibility, and it is an important presence, supporting teamwork morale and, ultimately, quality in the health care environment.

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Q. What are the consensus recommendations for the diagnosis of eosinophilic esophagitis, eosinophilic gastroenteritis, and eosinophilic colitis? What is the clinical significance of increased lymphocytes in esophageal biopsy? Has there been a significant increase in diagnosed eosinophilic disorders over the past 10 or so years?

A. There are numerous conditions associated with abnormal eosinophilic infiltrates that affect the esophagus, stomach, and intestinal tract. Having accurate information related to the clinical and endoscopic findings associated with these conditions is important at the time of histopathological evaluation of a specimen. Numerous publications address the histopathological criteria necessary for the diagnosis of eosinophilic esophageal and gastrointestinal disorders. For example, in a comprehensive review article, Hurrell and colleagues, after reviewing more than 200 articles on this topic, present practical information for the biopsy-based diagnosis of these conditions.[1]

Increased numbers of esophageal intraepithelial lymphocytes can be seen in association with several systemic and esophageal disorders including lymphocytic esophagitis, gastroesophageal reflux, and eosinophilic esophagitis. It is important to have accurate clinical and endoscopic information when evaluating representative biopsies that include any of these conditions in the differential diagnosis. Recent articles illustrate the growing concern for the clinical significance of increased esophageal intraepithelial lymphocytes.[2]

Yes, the incidence of some of these disorders (e.g. eosinophilic esophagitis) is on the rise, according to numerous publications.[1,3]

1. Hurrell JM, Genta RM, Melton SD. Histopathologic diagnosis of eosinophilic conditions in the gastrointestinal tract. Adv Anat Pathol. 2011;18(5):335–348.
2. Cohen S, Saxena A, Waljee AK, et al. Lymphocytic esophagitis: a diagnosis of increasing frequency. J Clin Gastroenterol. 2012;46(10):828–832.
3. Zuo L, Rothenberg ME. Gastrointestinal eosinophilia. Immunol Allergy Clin North Am. 2007;27(3):443–455.

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