ANATOMIC PATHOLOGY/CYTOLOGY

OBTAINING A PATHOLOGIST
A pathologist may not be “in house”, but can be reached 24 hours per day.
   1. When scheduling a surgery, the laboratory should be called if there is a need for a frozen section on the case.
   2. If a pathologist is needed at any time, call the laboratory.
   3. If a scheduled case requiring pathology services for a frozen section is canceled or rescheduled, please contact the laboratory.

AUTOPSY SCHEDULING
   1. To report an autopsy request, call the laboratory.
   2. The following will be needed to give to the pathologist.
      • Patient Name
      • Signed “Authority for Autopsy” form
      • Name of physician and telephone number
      • Is this a coroner’s case?
      • Has coroner been notified?
      • Has mortuary been notified?
      • Is the body to be embalmed or cremated?
      • Is the body presently under refrigeration?
   3. Send the patient chart and two copies of the autopsy permit with the body only when instructed by the pathologist.

COLLECTION AND HANDLING OF CYTOLOGY SPECIMENS
All specimen containers should be labeled with the patient’s name, hospital number and specimen source.
   1. Cervicovaginal smears (PAP smears). Instructions on how to obtain a PAP smear can be obtained from the laboratory, if necessary
      Call laboratory to obtain PAP smear kit.
      All slides must be labeled and fixed with PAP fixative or immersed in 95% alcohol before returning to the laboratory.
   2. Nongynecologic specimens
      Fluid specimens if refrigerated immediately after collection and on arrival in the laboratory do not require addition of fixative until processed.
      If the specimen appears bloody, the addition of heparin to prevent clot formation is useful. (Collection tubes are available in the laboratory). Transport to the laboratory as soon as possible for processing.
   3. Sputum specimens
      Specimens should be collected directly into Saccamano (green) fixative available in the laboratory. Mucus containing deep cough specimen is required.
   4. Bronchial or gastric brushings
      Direct smears can be prepared from brush devices at the time of bronchoscopy or gastroscopy. The brush is lightly rolled across the slide and spraying with PAP fixative or immersing in 95% alcohol for 5-10 minutes does immediate fixation. All smears must be on slides labeled with the patient’s name.
SURGICAL PATHOLOGY GENERAL POLICY
1. All tissues and foreign bodies removed from patients at Platte Valley Medical Center must be submitted for surgical pathology evaluation unless listed below in the Tissue Review Criteria.
2. Specimen containers should be labeled with:
   • Patient’s full name
   • Patient’s hospital number
   • Type and location of tissue
3. The specimen should be accompanied by a request form with the following information:
   • Surgeon’s name
   • Referring physician
   • Date of surgery
   • Pathology specimen type
   • Pre op and/or Post op Diagnosis (relevant clinical history)
   • Special studies needed
4. For special handling, please confer directly with a pathologist.

HANDLING OF GROSS SURGICAL SPECIMENS
To ensure the proper handling of surgically removed gross specimens the following guidelines should be adhered to:
1. Routine specimens--- (This includes most small specimens such as gallbladders, appendices, hernia sacs, tonsils, etc.)
   • Cover specimens with formalin (approximately 10 volumes of 10% formalin for each volume of tissue. Seal the container. Laboratory personnel will pick up the specimens.
2. Special Handling--- (This includes breast biopsies, kidney biopsies, lymph nodes, liver biopsies for iron or copper determination)
   • Before fixation the pathologist should be contacted.
3. Amputated extremities should be double bagged and placed in a refrigerator. If there are any questions on how a specimen should be handled, consult with the laboratory or a pathologist.

PLACENTAL STORAGE
All placentas should be placed in a container, covered with 10% neutral buffered formalin and labeled with the patient’s name, hospital number and doctor. If chromosome studies are needed, do not put in formalin. Contact the laboratory for instructions.
If no testing is required, the specimen will be discarded after 7 days.
If testing is required, the specimen will be held for 30 days.

SURGICAL CASE REVIEW
1. Tissue/Specimen Cases
   • A classification code is assigned to all pathological specimens at the time of pathological examination according to pre-established criteria. This code is included at the conclusion of each report.
• Code Classification is as follows:
  Code A - Clinical Diagnosis correlates with Pathologic Diagnosis
  Code B - Clinical Diagnosis does not correlate with Pathologic Diagnosis
  Code C - Insufficient information for correlation

This classification process provides for the differentiation in clinical and pathologic diagnosis. All Code B and Code C are reviewed by the hospital Medical Staff Coordinator. Selected cases are referred to the Department of Surgery for review.

2. Non-Tissue/Non-Specimen Cases
These cases are screened in accordance with those procedures listed on the “Exempt Specimen List” with verification of clinical indications included on the Tissue Requisition Slip. If these are not clinically justified or absent from the requisition, the surgeon is contacted for additional information. If unable to determine clinical justification for surgical procedure, the case is referred to the Department of Surgery for review.

TISSUE REVIEW CRITERIA
SIM IV criteria will be utilized as a general guideline for surgical case review to determine those procedures that require tissue removal/confirmation with the exception of the following conditions as decided upon by the PVMC Medical Staff. The Pathologist reserves the right to process any specimen that he/she feels deserves histological evaluation.

1. The following tissues removed do not require submission to Pathology for analysis
   • Cataract/Ophthalmologic hardware
   • Teeth/Dental Hardware
   • Orthopedic Hardware
   • Joint Shavings (if no clinical evidence of infection)
   • Myringotomy Tubes
   • Septal Bones and Cartilage
   • Foreign Bodies
   • Cosmetic Skin/Fat/Liposuction
   • Scars (benign disease)
   • Thrombus, AV Fistula (if no clinical evidence of infections)
   • Rib removed for exposure purposes only (no history of malignancy)
   • IUD
   • Therapeutic Radiation Source
   • Foreskin - Prepubertal (if no evidence of dermatosis or infection)
   • Nail Tissue
   • Bunion, Hammertoe Bone (if no clinical evidence of infection)

2. The following tissues removed should be submitted to the Pathology Department; if desired, only gross examination may be performed:
   • Bone from Osteoarthritis (if no history of malignancy)
   • Hernia Sac
   • Placenta (handled as per separate placental protocol)
   • Vaginal Mucosa
   • Traumatic Amputation

3. All cases not listed above will undergo microscopic examination.