WHAT’S WRONG WITH THIS REPORT?

A 54-year-old male presents to the ED with nonspecific abdominal pain and bloating sensation. His vitals are WNL, his abdominal exam is soft, no rebound, BS active. His CBC, CMP and amylase are all WNL. He is discharged home with undiagnosed abdominal pain-nonsurgical abdomen. He presents three days later to a different ED, requires a partial small bowel resection, and has a long, complicated hospital stay. Read the report carefully; can you identify an area for concern?

Answer:

Buried in the Findings section of the CT report is the statement; “However, attention is directed to the multiple loops of dilated small bowel, consistent with a small bowel obstruction.”

Learning points:

1. While the serious abnormal finding is included in the report, it is buried. Radiologists, pathologists, and other specialties who provide consultative reports should think about how their reports are being read in the clinician’s busy workflow and ensure that important findings are very apparent in the areas clinicians read.
2. Additional communication, such as a phone call, should be considered. The American College of Radiology has published the “ACR Practice Parameter for Communication of Diagnostic Imaging Findings,” which provides examples of, and guidance on “non-routine communication of significant findings.”
3. The clinician has responsibility to see and act on the findings in such reports. Reading a complete report and/or calling the consultative service can improve the quality of the information transferred.
4. Building redundancy into the system improves the safety for all. Relying on one person to read one sentence in one report is bound to fail. Involving patients in the process can also help. “What were my results?”, Open Notes, and patient portals are all potential strategies to increase the redundancy in systems of information.