

Department of Veterans Affairs  
Decentralized Hospital Computer Program

LABORATORY  
ANATOMIC PATHOLOGY  
USER MANUAL

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## Preface

The Anatomic Pathology User's Manual was designed as a training guide and reference manual for Veterans Affairs Medical Center (VAMC) Site Managers, Lab Applications Coordinators, and all users of the Anatomic Pathology module of the Laboratory system. It should be used in conjunction with other documentation of the Laboratory Package. The manual shows users how to enter, edit, and display information for Cytopathology, Autopsy Pathology, Surgical Pathology, Electron Microscopy, preselected lab test lists, and lists of unverified pathology reports. It also shows how to print reports, path micro/dx modification, cum path data summaries, and preselected lab test lists.



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# INTRODUCTION

## Introduction

## Overview of Anatomic Pathology Module

Anatomic Pathology (AP) is divided into four sections: Surgical Pathology, Cytology (Cytopathology), Electron Microscopy, and Autopsy Pathology. For the current version, bone marrows are considered to be part of the Surgical Pathology and do not get a separate accession area or number.

The processes of accessioning, data entry, coding, and editing are similar for each of these sections. The computer program lets you select one of these processes (menus or options) and then the section. That is, if you wish to log in a specimen for Cytology, you first select the “Log-in Menu,” and then you’ll be prompted to choose the Anatomic Pathology section. This manual is organized according to these menus.

The search options are based on SNOMED and ICD9CM coding.

If you have individuals whom you wish to restrict access to only one, or more than one, specific areas, this can be done through the use of specific security keys for each area.

Certain portions of the anatomic pathology data can be extracted by the Health Summary if the accession has been verified/released. Accessions which have not been verified/released indicate this status (i.e., the accession information, but not the diagnosis).

**NOTE:** With the exception of the Workload Menu, the option descriptions reflect the prompts if workload is turned off unless otherwise specifically noted. The specifics of implementation, data capture, and reports are included in the Technical Manual.

## **Functionality**

### Valuable **quality assurance** features

- list of incomplete pathology reports for all areas
- turnaround time reports for all areas of pathology
- generation of defined “groups” of cases requiring additional review
- correlation of all information (i.e., special stains, immunopathology, and electron microscopy studies, etc.), in a single report
- printing of laboratory test results for specified tests for a patient

### Increased **productivity**

- on-line access to historical pathology data (diagnosis & SNOMED codes only)
- immediate availability of information regarding surgical pathology, cytology, and electron microscopy specimens
- access to verified/released reports by non-laboratory personnel
- elimination of paperwork through automatic transfer of data to all appropriate files

### Comprehensive **search/reporting** capabilities

- final pathology reports
- log book of all specimens accessioned, including final diagnosis variety of reports based on morphology and topography field entries
- list of patients with a particular diagnosis
- list of specimens from a particular site
- list of specimens from a particular surgical procedure

### **Workload** statistics

- number of patients reviewed
- number of specimens accessioned
- number of specimens from a particular organ/tissue
- data for LMIP

**NOTE:** The documentation for the overall implementation of the AP module, implementation of workload, the overview of data capture and the reports generated is in the Planning and Implementation Guide.

# ORIENTATION



## Orientation

This manual is organized as shown in the table of contents. The option section is arranged according to the Anatomic Pathology Menu structure as described in the Menu section. If you don't know which menu an option appears on, look at the menu diagram or check the index for the page number in this manual where the option is described.

### **Before You Begin**

- Get an access code from your supervisor and find out which terminal and test data you should use.
- Check with your supervisor for instructions about your menu choices.
- Read the section "Special Commands, Keys, and Conventions."
- See the glossary for computer and lab terminology.
- Read the "User's Guide to Computing" for information on VA FileMan conventions and other useful help on using your computer.
- Review these other manuals available from your Applications Coordinator:

Laboratory User Manual  
Laboratory Package Security Guide

## Special Keys, Commands, and Conventions

The keyboard you will work on is similar to that of a typewriter. However, there are some additional keys and functions you will be using.

### On-line help for documentation

- ? Entering a question mark after a prompt will cause the computer to display instructions or a list of choices for responding to that prompt.
- ?? Two question marks after a prompt will cause a more detailed explanation to be displayed. If you enter two question marks after a menu display, the options on that menu, with their bracketed option names (e.g., [LRAPED]) will appear.
- ??? Three question marks will usually cause more detailed instructions to appear, or a list of choices.

### Enter, Return, or Carriage Return:

There are three uses for the RETURN or ENTER key (denoted in this manual as <RET>. On some keyboards this is the key with the symbol ↵):

- Entering information      After you respond to a prompt, you must press <RET>.
- Accepting a default      If you want to accept the default value (the most likely response or a previously defined response, followed by //), just press <RET>.
- Skipping a prompt      If you do not want to enter any information in response to a prompt, you may press <RET>, and the next prompt will appear if the previous prompt wasn't mandatory.

**NOTE:** You **must** respond to some prompts in order to use the rest of an option. In these cases, the system supplies a message indicating that you must enter a response before continuing. You can use “^” to escape from the prompt but you will lose all information previously entered.

- Delete**                      Deletes previous characters one at a time.



<b>Control Key: (CTRL)</b>	The CONTROL key, like the shift key, is held down while pressing another key.
<b>CTRL/S</b>	stops the printing or scrolling. Useful when viewing a listing longer than your screen length. Some terminals have "HOLD Screen" or "SCROLL/NO SCROLL" for stopping scrolling.
<b>CTRL/Q</b>	causes printing or scrolling to resume after CTRL/S has been used.
<b>CTRL/U</b>	deletes current input line if <RET> hasn't been pressed.
<b>^(up-arrow the upper case of 6)</b>	terminates the line of questioning you are in and returns you to the previous level in the routine. If you continue to enter "^," you can exit the menus and the laboratory system.
<b>Enter</b>	The enter key on a computer terminal is the key you press at the end of each line in order to enter the contents of that line into the computer. In some terminals this key is also called the return key.
<b>Halt</b>	entered at any point in an option will terminate your session immediately.
<b>Continue</b>	entered at any point in an option will terminate your session immediately, but the computer remembers what you were doing when you terminated. When you log on again, you will be asked if you want to continue at that same point.
<b>Press</b>	indicates one keystroke. <b>Example:</b> Press RETURN or <RET> means press the RETURN key.
<b>Press "^" to halt</b>	displayed at the bottom of the screen means that processing will terminate within the selected option, and the computer returns to the menu you selected the option from.

**DEVICE:**  
**RIGHT MARGIN: 80//** These two prompts are included in every option description in which you select a device for printing output. Because each site can specify whether to display each of the above for each terminal that it has, you may not always be asked both prompts. You may always enter "Q" for QUEUE when you are asked for a device. You will then be asked to specify the device to print on and the time to print.

**INTERACTIVE DIALOGUE** Your computer terminal prompts you with questions and you respond with information, such as patient name, name of the test you are requesting, etc.

## Manual Conventions

- Examples of the dialogues for Anatomic Pathology options are shown 10 point Courier font. Printed reports are also in 10 point Courier font. User responses are **bolded**.

```
Select Data entry for autopsies Option: SR Autopsy supplementary report
Data entry for 1990 ? YES// <RET> Autopsy supplementary report
Select Accession Number/Pt name: 2 for 1990
YOKUM,SALLY ID: 234-56-7891
Select SUPPLEMENTARY REPORT DATE: T SEP 12, 1990
DESCRIPTION:
  1>Examination of brain shows no evidence of metastatic carcinoma.
  2><RET>
EDIT Option: <RET>
```

- Reports or replicas of printouts are also in 10 point Courier font except where noted.

```
-----
CLINICAL RECORD :          AUTOPSY SUPPLEMENTARY REPORT  Pg 1
-----
Date died: APR 26, 1990      :Autopsy date: APR 26, 1990 12:55
Resident: HARRY WELBY       : FULL AUTOPSY Autopsy No. A90 1
-----

SUPPLEMENTARY REPORT DATE: AUG 10, 1990 10:43
This is an autopsy supplementary report. It is separate from the
  [etc.....]
```

- The italicized words contained in brackets: *[Enter Print Device Here]*, refer to editor's comments.

- Pressing the return key at the “Select Print Device: *[Enter Print Device Here]*” prompt sends the output to your terminal. You can also send the output to a specified printer.
- Note Box

**NOTE:** The note box indicates that a special action may be recommended or required.



# PACKAGE MANAGEMENT

## Package Management

## Package Management

The Anatomic Pathology module of the Laboratory System has certain aspects that should be noted by the user.

1. Although quality assurance systems have been integral components of clinical pathology and blood usage review for many years, they did not exist as structured systems in anatomic pathology. Recent changes made by the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) in monitoring medical staff functions have necessitated the development of a comparable system for anatomic pathology. Please see the section on AP Quality Assurance for information about Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requirements for Anatomic Pathology.
2. During the verification of reports, the computer records the user of the option LRVERIFY. This is the equivalent of an electronic signature. For more about this part of the program, please see the Verify Release Menu.
3. During log-in, the accessioner can indicate the patient's physician and the pathologist whose name will appear on the report. Care must be taken to ensure that this information is correct.
4. The Workload (WKLD) codes are based on the College of American Pathologists (CAP) codes. The CAP codes are used with the permission of the College of American Pathologists. Specific instruments and products are referenced by the Workload codes. These references should not be perceived as endorsement or approvals by the DHCP system or the Laboratory software package.





# PACKAGE OPERATIONS



For a more complete discussion of implementing and maintaining the Anatomic Pathology module, please see the Planning and Implementation Guide.

## Anatomic Pathology Menus

The main Anatomic Pathology Menu is shown below. Whether you see this entire menu or selected portions depends on how your site sets up its menus and what security keys you have.

```
Select Laboratory Option: 8 Anatomic pathology
                        ANATOMIC PATHOLOGY MENU
```

```
Select Anatomic pathology Option: ?
```

```
D  Data entry, anat path...
E  Edit/modify data, anat path...
I  Inquiries, anat path...
L  Log-in menu, anat path...
P  Print, anat path...
R  SNOMED field references...
S  Supervisor, anat path...
V  Verify/release menu, anat path...
C  Clinician options, anat path...
W  Workload, anat path...
```

Menu items having an ellipsis (...) following the text will contain additional menu items. For example, if you choose D, for Data entry, another menu of options is displayed:

```
Select Anatomic pathology Option: D Data entry, anat path
```

```
Select Data entry, anat path Option: ?
```

```
AU  Data entry for autopsies...
BS  Blocks, Stains, Procedures, anat path
CO  Coding, anat path...
GD  Clinical Hx/Gross Description/FS
GM  FS/Gross/Micro/Dx
GS  FS/Gross/Micro/Dx/SNOMED Coding
GI  FS/Gross/Micro/Dx/ICD9CM Coding
OR  Enter old anat path records
SR  Supplementary Report, Anat Path
SS  Spec Studies-EM;Immuno;Consult;Pic, Anat Path
```

## Menu Descriptions

The primary Anatomic Pathology Menu consists of ten secondary menus which are composed of submenus and options.

<b>Menu Item</b>	<b>Description</b>
<b>Data Entry</b>	Used to enter descriptive or diagnostic data for Autopsy Pathology, Cytopathology, Electron Microscopy, or Surgical Pathology.
<b>Edit/Modify Data</b>	Used to edit entries in log-in data, descriptions or diagnoses in Autopsy, Cytopathology, EM , or Surgical Pathology.
<b>Inquiries</b>	Allows you to search and display on your screen summaries, reports, pathology entries by date for SNOMED or ICD9CM codes specified or a list of accessions.
<b>Log-in</b>	Allows you to log in specimens for autopsy, cytopathology, EM, or Surgical Path, to delete an accession number, to print a list of specimens for a date by accession area, or to print the log book.
<b>Print</b>	Includes options to print user-defined lab tests and patient lists, the log book, reports listing the clinical history and gross description for review, final reports, lists of prisoner of war veterans that have AP specimens, accession lists (by various criteria), lists of path cases by resident, tech or senior pathologist, etc.

<b>Menu Item</b>	<b>Description</b>
<b>SNOMED Field</b>	Allows entering and editing of SNOMED references, file references, entering and editing of medical journal entries, and printing of medical journal references for a SNOMED file entry.
<b>Supervisor</b>	Includes options for printing topography counts, turnaround times, and Quality Assurance Reports, for deleting and editing reports, entering, editing, or deleting lab descriptions or items in a SNOMED field, and for printing incomplete reports or reports with copies of all microscopic/diagnosis changes made to the report since the report was released.
<b>Verify/Release Reports</b>	Contains options for printing a list of unverified pathology reports, selectable by date, and for displaying and printing reports that have been verified by the pathologist.
<b>Clinician</b>	Displays or prints many types of summaries and reports from this menu, including user-defined lab tests and patient lists and cumulative summaries of surgical path, cytopath, EM, and autopsy.
<b>Workload</b>	List of options for anatomic pathology workload

## Anatomic Pathology Menus

- D Data entry, anat path [LRAPD]
  - AU Data entry for autopsies [LRAPAUDA]
    - PD Provisional anatomic diagnoses [LRAPAUPAD]
    - AP Autopsy protocol [LRAPAUDAP]
    - AS Autopsy protocol & SNOMED coding [LRAPAUDAB]
    - AI Autopsy protocol & ICD9CM coding [LRAPAUDAA]
    - AF Final autopsy diagnoses date [LRAPAUFD]
    - SR Autopsy supplementary report [LRAPASUR]
    - SS Special studies, autopsy [LRAPAUDAS]
  - BS Blocks, Stains, Procedures, anat path [LRAPSPDAT]
  - CO Coding, anat path [LRAPCODE]
    - SN SNOMED coding, anat path [LRAPX]
    - IC ICD9CM coding, anat path [LRAPICD]
  - GD Clinical Hx/Gross Description/FS [LRAPDGD]**
  - GM FS/Gross/Micro/Dx [LRAPDGM]**
  - GS FS/Gross/Micro/Dx/SNOMED Coding [LRAPDGS]**
    - GI FS/Gross/Micro/Dx/ICD9CM Coding [LRAPDGI]
    - OR Enter old anat path records [LRAPOLD]
    - SR Supplementary Report, Anat Path [LRAPDSR]
    - SS Spec Studies-EM;Immuno;Consult;Pic, Anat Path [LRAPDSS]
  
- E Edit/modify data, anat path [LRAPE]
  - LI Edit log-in & clinical hx, anat path [LRAPED]**
  - MM Modify anat path gross/micro/dx/frozen section [LRAPM]**
  - SC Edit anat path comments [LRAPEDC]**
  
- I Inquiries, anat path [LRAPI]
  - DS Display surg path reports for a patient [LRAPSPCUM]
  - DC Display cytopath reports for a patient [LRAPCYCUM]
  - DE Display EM reports for a patient [LRAPEMCUM]
  - BD Display stains/blocks for a patient [LRAPST]
  - PA Show list of accessions for a patient [LRUPT]
  - SE Search options, anat path [LRAPSEARCH]
    - MC MORPHOLOGY code search, SNOMED [LRAPSM]
    - DC DISEASE code search, SNOMED [LRAPSD]
    - EC ETIOLOGY code search, SNOMED [LRAPSE]
    - PC PROCEDURE code search, SNOMED [LRAPSP]
    - FC FUNCTION code search, SNOMED [LRAPSF]
    - IC ICD9CM code search [LRAPSI]
    - AX MULTIAXIAL code search, SNOMED [LRAPSEM]
  - CS Cum path data summaries [LRAPT]
  - FR Display final path reports by accession # [LRAPPA]
  
- L Log-in menu, anat path [LRAPL]
  - LI Log-in, anat path [LRAPLG]
  - DA Delete accession #, anat path [LRAPKILL]
  - PB Print log book [LRAPBK]
  - HW Histopathology Worksheet [LRAPH]

```

P  Print, anat path [LRAPP]
   PQ  Print all reports on queue [LRAP PRINT ALL ON QUEUE]
   DQ  Delete report print queue [LRAP DELETE]
   LQ  List pathology reports in print queue [LRAPQ]
   PS  Print single report only [LRAP PRINT SINGLE]
   AD  Add patient(s) to report print queue [LRAP ADD]
   AU  Autopsy administrative reports [LRAPAUP]
       AD  Autopsy data review [LRAPAUVRV]
       AA  Alphabetical autopsy list [LRAPAUUA]
       AS  Autopsy status list [LRAPAUSTATUS]
   AR  Anat path accession reports [LRAPPAR]
       LD  Anat path accession list by date [LRAPPAD]
       LN  Anat path accession list by number [LRAPPAN]
       SD  Sum of accessions by date, anat path [LRAPA]
       PD  Entries by dates, patient & accession # [LRAPPF]
       WK  Path cases by resident, tech, senior or clinician [LRAPAU]
       CP  % Pos, Atyp, Dysp, Neg, Susp, Unsat cytopath [LRAPCYPCT]
       ST  Accession list with stains [LRAPSA]
       WS  Accession counts by senior pathologist [LRAPAUCLC]
   CS  Cum path data summaries [LRAPT]
   LA  Anatomic pathology labels [LRAPLBL]
       LM  Anat path slide labels [LRAPLM]
       LS  Anat path specimen labels [LRAPLS]
       AU  Autopsy slide labels (generic) [LRAUMLK]
   LT  Edit/print/display preselected lab tests [LRUMDA]
       PR  Print/display preselected lab tests [LRUMD]
       EN  Enter/edit user defined lab test lists [LRUMDE]
   PB  Print log book [LRAPBK]
   PA  Print final path reports by accession # [LRAPFICH]

R  SNOMED field references [LRAPREF]
   ER  Enter/edit SNOMED file references [LRAPSRE]
       TO  Topography (SNOMED) reference [LRAPTR]
       MO  Morphology (SNOMED) reference [LRAPMR]
       ET  Etiology (SNOMED) reference [LRAPER]
       DI  Disease (SNOMED) reference [LRAPDR]
       FU  Function (SNOMED) reference [LRAPFR]
       PR  Procedure (SNOMED) reference [LRAPPR]
       OC  Occupation (SNOMED) reference [LRAPOR]
   MJ  Medical journal file edit [LRAPLIB]
   PR  Print references for a SNOMED entry [LRAPSRP]
       TP  Topography (SNOMED) reference print [LRAPTP]
       MP  Morphology (SNOMED) reference print [LRAPMP]
       EP  Etiology (SNOMED) reference print [LRAPEP]
       DP  Disease (SNOMED) reference print [LRAPDP]
       FP  Function (SNOMED) reference print [LRAPFP]
       PP  Procedure (SNOMED) reference print [LRAPPP]
       OP  Occupation (SNOMED) reference print [LRAPOP]

```

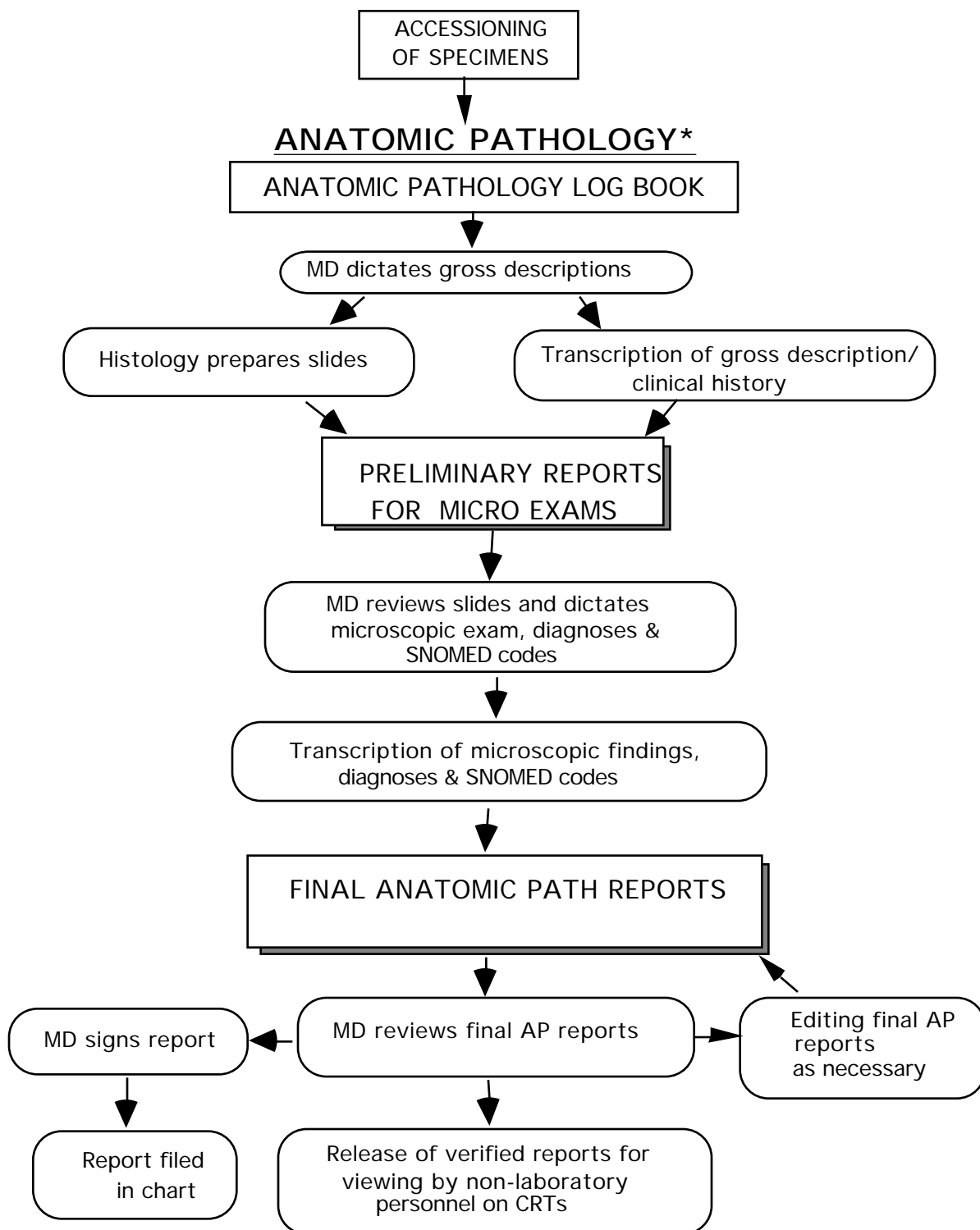
## Package Operations

- S Supervisor, anat path [LRAPSUPER]
  - DD Delete anat path descriptions by date [LRAPDAR] Locked: LRAPSUPER
  - ED Enter/edit lab description file [LRAPDES]
  - ER Edit pathology parameters [LRAPHDR]
  - ES Enter/edit items in a SNOMED field [LRAPSNOMEDIT]
    - TO Topography (SNOMED) enter/edit [LRAPTOP] Locked: LRAPSUPER
    - MO Morphology (SNOMED) enter/edit [LRAPMOR] Locked: LRAPSUPER
    - ET Etiology (SNOMED) enter/edit [LRAPETI] Locked: LRAPSUPER
    - DI Disease (SNOMED) enter/edit [LRAPDIS] Locked: LRAPSUPER
    - FU Function (SNOMED) enter/edit [LRAPFUN] Locked: LRAPSUPER
    - PR Procedure (SNOMED) enter/edit [LRAPPRO] Locked: LRAPSUPER
    - OC Occupation (SNOMED) enter/edit [] Locked: LRAPSUPER
  - IR Incomplete reports, anat path [LRAPINC]
  - MR Print path modifications [LRAPMOD]
  - TC Anatomic pathology topography counts [LRAPC]
  - DS Delete free text specimen entries [LRAPDFS]
  - QA AP quality assurance [LRAPQA]
    - CE QA codes entry/edit [LRAPQACD] Locked: LRAPSUPER
    - CN AP consultation searches and reports [LRAPQACN]
    - CS Cum path summaries for quality assurance [LRAPQAC]
    - CY % Pos, Atyp, Dysp, Neg, Susp, Unsat cytopath [LRAPCYPCT]
    - DC Delete TC and QA codes [LRAPQADEL]
    - FS Frozen section, surgical path correlation [LRAPQAFS]
    - MM Print path micro modifications [LRAPQAM]
    - MR Malignancy review [LRAPQAMR]
    - OR QA outcome review cases [LRAPQOR] Locked: LRAPSUPER
    - RR 10% random case review, surg path [LRAPQAR]
    - SP Edit QA site parameters [LRAPQASP]
    - TC Tissue committee review cases [LRAPQAT]
    - TT Anatomic pathology turnaround time [LRAPTT]
  - AF AFIP registries... [LRAPAFIP]
    - PO Prisoner of war veterans [LRAPDPT]
    - PG Persian gulf veterans [LRAPPG]
  - MV Move anatomic path accession [LRAPMV]
    - Edit referral patient file [LRUV]
  
- V Verify/release menu, anat path [LRAPVR]
  - RR Verify/release reports, anat path [LRAPR] Locked: LRVERIFY
  - RS Supplementary report release, anat path [LRAPRS]
  - LU List of unverified pathology reports [LRAPV]
  
- C Clinician options, anat path [LRAPMD]
  - DS Display surg path reports for a patient [LRAPSPCUM]
  - DC Display cytopath reports for a patient [LRAPCYCUM]
  - DE Display EM reports for a patient [LRAPEMCUM]
  - LT Edit/print/display preselected lab tests [LRUMDA]
    - PR Print/display preselected lab tests [LRUMD]
    - EN Enter/edit user defined lab test lists [LRUMDE]
  - PS Print surgical pathology report for a patient [LRAPSPSGL]
  - PC Print cytopathology report for a patient [LRAPCYSGL]
  - PE Print electron microscopy report for a patient [LRAPEMSGL]
  - CS Cum path data summaries [LRAPT]
  - AR Autopsy protocol/supplementary report [LRAPAUPT]



W Workload, anat path [LRAPW]  
 CW Cytopathology screening workload [LRAPWR]  
 DW Display workload for an accession [LRUWL]  
 EW EM scanning and photo workload [LRAPWE]  
 SW Surg path gross assistance workload [LRAPWRSP]

## ANATOMIC PATHOLOGY WORK FLOW HISTOLOGY



\* Includes Surgical Pathology, Cytopathology, E.M., and Autopsy Pathology

## Description of an Implemented Module

Anatomic specimen processing and report preparation consist of three phases (for purposes of our discussion):

1. **Log-in:** This is the equivalent to accessioning in the clinical lab.
2. **Data entry:** This is the equivalent to "Processing" in the clinical lab package.
  - a) Gross description with printout to go to pathologist with the slides
  - b) Micro description and Dx to secretary for final typing
3. **Final Reports:** This is a hybrid of verification and cumulative report output in the clinical lab package.

### **A. Log-in**

The surgical pathology case is accessioned using "Log-in" which has four suboptions, one for log-in, another to delete an accession, a third to print the log book, and a fourth to print a histopathology worksheet. You may want to have access to some of these options limited. At the conclusion of an accessioning session, or after the last one of the day, you may want to print the Log and Histopathology Worksheet. These can serve as a guide for embedding the next morning, since the specimen submitted is listed, as well as any comment made during accessioning.

After a month of entering data for cytologies and/or surgicals is complete (i.e., there are no incompletes), the log for the month can be printed. By printing it at this time, it will contain the diagnoses of each case with the surgeon and pathologist listed, as well as person releasing the report. Until the permanent monthly log is printed, it might be useful to save the daily logs. Cytologies and autopsies are accessioned/logged-in with similar menus under their respective divisions.

### **B. Data Entry**

The SF 515s are delivered to the pathology secretaries with a tape for dictation in the case of the surgicals, or alone in the case of cytologies. The secretary uses the option Gross description/clinical hx in the Data Entry option and is able to call up each case by accession number and enter the data from each of the headings at the top of the SF 515. At Gross Description, word-processing fields come up so that transcribing can be done. The screen editor feature may be used with any word processing field. This feature is selectable through the MailMan Menu options. At the completion of gross transcription, there is a prompt for another case. When all the transcriptions are completed, they can be printed.

In the Print option, Print All Reports on Queue, select Preliminary Reports. This can be printed double-spaced or single-spaced, depending on your local preferences.

Even if you choose double-space, the final report is single-spaced. It also prints out, on a following page, any cytology, surgical, electron microscopy, or autopsy accession(s) on this particular patient which were previously entered into the system. This function will serve to gradually replace the card index file in the future. This printout is given to the pathologist with corresponding case slides. He will then dictate the microscopic findings and diagnosis. The diagnosis is stored in a separate field from the microscopic findings. If he wants to clarify or add to the gross description, it can be done at this time. When the dictation is complete, the recording media and the reports go to the pathology secretary for final transcription.

The secretary calls up the option Gross Review/Microscopic and SNOMED Coding. At the prompts, the accession number is entered to call up the case. The screen responds with the case and patient identification. The gross is displayed first; therefore, the opportunity exists to edit any changes at this time. The microscopic appears next, permitting transcription from the tape. The pathologist's free-text diagnosis is entered. There are prompts for the pathologist name and for date completed. The SNOMED coding prompts appear last.

### **C. Final Reports**

When all the microscopics with diagnoses are completed, Print All Reports on Queue is called up. Then select Final Reports. Take the default of "NO//" unless you specifically need to print extra copies. For extra file copies and for the Tumor Registrar, the Tissue Committee, etc., the signed copy can be duplicated or a new copy can be generated using the print single report options once it has been verified.

After the reports are signed, they are "released" through the Verify/Release Reports option. The person doing this must have the LRVERIFY key, which functions as the legal electronic signature of the person. The reports may now either be displayed or printed, via the option Pathology Report on a Patient. This option is also installed on the Medical Staff Menu and the Ward and Clinic Clerk Menus.

Health Summary can also access the verified report. Until such time as the report has been released, the message displayed indicates that the report is not verified. There is no other information available unless the patient has had previous completed accessions.

#### **HINTS:**

1. No detailed formatting is necessary for the final cytology or pathology reports, as far as the LIM is concerned. Each station has its own style of writing a cytology, surgical, autopsy, or electron microscopy report. The "word-processing" mode and the report parameters allow the site to specify the wording for the headers, whether the text should appear in upper or lower case, etc. Instruction regarding the word-processor will be necessary, especially for those who have never used MailMan. Your LIM can be of assistance with this.

2. When it comes to SNOMED coding, do it at the time of entering the microscopic and diagnosis. It will require a bit more attention from the pathologist. However, it will be most helpful to the transcriptionist. By including some of the more common codes on the preliminary report and a spot to record the codes for the case, this can be expedited. See the examples in the Edit Pathology Parameters [LRAPHDR] option. The coded diagnoses are not as descriptive nor elaborate as those dictated for the report, but they are extremely valuable. It is necessary to have both volumes of the CAP SNOMED Coding Manuals and Microglossary for Surgical Pathology handy to look up some of the diagnoses — the Alphabetical listing is the more frequently consulted. The WKLD SNOMED manuals have the “synonyms” listed, which are not always in the synonym fields of the SNOMED codes supplied. The easiest method is to edit these to include local synonyms as well. It would be a monumental task to review the WKLD manuals and edit in every synonym. A responsible, talented pathology secretary can be most helpful with this editing process. It can also be an educational experience for anyone coding the anatomic reports. Coding is important, since this will look to search your files for a specific group of patients.

Unless your station has infinite disk space, you will have to purge word-processing periodically. Initially, you might consider keeping one to two months, plus the current month. When you purge the word-processing, you are left with the name and demographics, accession number and SNOMED codes and free text diagnosis.

3. There is an option to list the incomplete reports, (Cytology, Surgical Path, Electron Microscopy, and Autopsy), as well as an option to list the Unverified/Unreleased reports. In the Log-in for these sections, there is also a routine Show List of Accessions for a Patient which is rather handy at the time of doing frozen section or OR consults.

4. The Search options are easy to use — consult with your LIM for assistance in queuing times and some of the set-ups. The WKLD SNOMED manuals are necessary for doing this, since you need the code numbers to set your search parameters. Because of the potential impact on system resources, you may want some of the menu options restricted — again your LIM can assist you in this matter. The section entitled “SNOMED Coding/Searches” includes a detailed explanation of the SNOMED search capabilities.

## Summary of Selected AP Options

To help prevent confusion between the Special Studies and Supplementary Report options, here is a comparison chart:

<b>Special Studies</b>	<b>Supplementary Report</b>
Select type of special study	Enter date/time and single (Consult, frozen section, etc.) free-text field.
Enter ID#, and SNOMED codes	Release supplementary report, "Y" to verify free-text field. (Prompt for verifying only the Supplementary report.)
ID# and SNOMED codes will be displayed on Cum path summary and Log Book	Text deleted when descriptions are deleted.
Data is not archived	
Reports may be retrieved using AP Consultation searches and reports or Search options, Anat path	

## **TC and QA Codes**

The following summarizes the differences between TC and QA Codes:

<b>TC Codes</b>	<b>QA Codes</b>
Numeric TC codes may be assigned description in LAB DESCRIPTIONS file (Screen = AP SURG)	QA codes defined in Lab DESCRIPTIONS file (Screen = I AP General)
Used to review Surgical cases	Entered for Surgical or Cytopath reports
Supervisor option - Edit QA Site Parameters to allow TC code entry	Supervisor option- Edit QA Site Parameters to allow QA code entry
TC code should be entered for each surgical report	QA Codes Entry/edit used to enter QA code for an accession
Use Tissue Committee Review Cases to retrieve reports	QA Outcome Review cases used to retrieve reports

## SNOMED Coding/Searches

For these SNOMED coding and searching functions, you must have access to one set of the following WKLD manuals:

- a) SNOMED - Systematized Nomenclature of Medicine Vol. I and II
- b) SNOMED - Microglossary for Surgical Pathology

Depending on local site factors, you may want more than one copy of one or both of the manuals. These can be obtained from the College of American Pathologists, 5202 Old Orchard Rd., Skokie, IL 60077-1034.

### Description of SNOMED

As part of an effort to standardize the coding of information regarding specific diseases, the Systematized Nomenclature of Medicine was developed. Using the various hierarchically structured systems-oriented axes, it is possible to code all anatomic and physiologic elements of a disease process, both normal and abnormal. Then, sum up these elements as a class of disease or recognized syndrome that has a unique code. For example:

T	+	M	+	E	+	F	=	D
Topography		Morphology		Etiology		Function		Disease
Lung	+	Granuloma	+	M. tuberculosis	+	Fever	=	Tuberculosis
T-2800		M-44060		E-2001		F-03003		D-0188

With the nomenclature and classification categories, any diagnostic level from a presenting problem, sign or symptom to a complex final, clinical or pathological diagnosis can be appropriately and accurately coded for a patient. The procedure-to-diagnosis relationship will permit medical audit and more specific disease costing.

The two codes most commonly used by pathologists are **topography** and **morphology**. The topography field undertakes to provide a sufficiently detailed and structured nomenclature for those parts of the body whose identification might be needed for coding and retrieval of diagnostic data. The morphology field contains the normal and pathological changes or processes occurring in cells, tissues, or organs.

The AP package comes with the TOPOGRAPHY, MORPHOLOGY, and ETIOLOGY files defined. However, the person doing pathology coding will soon discover that the files are not complete, as there are many code numbers in the code books that are not in the file. If a particular topography or morphology doesn't exist, don't panic. Just jot down the name you are trying to enter and complete your case entry. You can go back to make the necessary code entries later. Look up the "Microglossary" first, and if not satisfactory, then try Vol. II, the alphabetical list, of the coding Manual which is comprehensive and has most common synonyms listed. Most of the time you will find it. It will also give the coding number. Now select the option Edit SNOMED files and select the appropriate file (TOPOGRAPHY, MORPHOLOGY, ETIOLOGY, etc.) and enter the code number from your search of the Manual. The chances are that it will show up. Step through the fields until you get to SYNONYM and make your entry. When you go back to the case to code, and re-enter the "problem term," it will be accepted.

**NOTE:** The apparent speed of the lookups may be slightly confusing. The abbreviation is in the same B cross-reference as the name. The synonyms are in the D cross-reference, which is searched after the B and C cross-references.

If after the search of the Manual, you find the term and code you need, but it isn't in the computer files, you will be prompted "Are you adding a new name?" and, of course, you are. Perhaps an example will be helpful at this point: Say you have looked in the Manual and find "adenocarcinoma, metastatic" has the code 81406. When you enter 81406 in the Edit SNOMED Fields option (or using "enter/edit" in FileMan) for the Morphology field you will be prompted, "Are you adding '81406' as a new morphology field (the 3616)?" Answer "YES." The next prompt is for "Name" which has the code number you entered. Edit this to "adenocarcinoma, metastatic." The next prompt is for the SNOMED code — enter 81406. The next prompt is "Abbreviation." The next prompt is "Synonym" and is a multiple field. You may want to enter "metastatic adenocarcinoma." You can also add "meta adeno" for quick lookup.

When adding to the SNOMED files, it is crucial to use the Manual as the primary reference. If you absolutely cannot find the code you need, you can enter a code which is close but with an identifying letter to indicate it is locally created. Another method is to start with your station number followed by three or four digits (including zeros) and record the number and name in a log book. Also write the CAP about obtaining an official recommendation about introducing the code. CAP may very well be working on the problem. When an official code is obtained, the locally created code can be changed to the official one. Previously coded cases will reflect the change. Most of your editing will be confined to adding synonyms for easier lookup at the time of coding.



## Using SNOMED for Searches

The technique of setting up searches is rather easy. The search routines in each Anatomic section (Cytopathology, Surgical Pathology, Electron Microscopy, and Autopsy) are identical. The searches may be as broad or as specific as desired. Each SNOMED code has five characters. Generally, each successive digit narrows the specificity of the search. For example, in topography, the 20000 series is for the Respiratory system, 28000 is for lung, 28200 is for right upper lobe of lung and 28220 is for right upper lobe of lung, posterior segment. Thus, entry of the correct codes is crucial to obtaining the desired output.

Wild cards may be used for any of the SNOMED codes, to broaden the scope of a single search. Entry of wild cards (\*) will allow selection of a specific portion of the code, while not requiring all five digits. For example, entry of 8\*\*\*3 for the morphology code would compile a list of all primary tumors, regardless of type.

**NOTE:** The wild card should only be used if necessary as a “placeholder.” Trailing wild cards should **not** be used, as they will slow down the search. If an asterisk (\*) is entered, it will search for that digit to find a match. If nothing is entered for the digit, it will not search that digit at all.

**Example 1:** Listing of all GU tumors in the last two weeks for GU conference.

```
Topography: 7
Morphology: 8 for all tumors
             8***3 for all primary tumors
             8***6 for all metastatic tumors

Start with Date: TODAY/ T-14
Go to Date: TODAY// <RET>
```

**Example 2:** Listing of all tumors/cancers for the Tumor Registry for both Cytopathology and Surgical Pathology.

```
Topography: ALL
Morphology: 8
           9
```

**NOTE:** It might be easier to give the necessary search options to the people handling the Tumor Registry to generate their own listing, since they are responsible for tracking all cancer cases/statistics.

## Reports

The title "Pathologist": at the end of Anatomic Pathologist reports has been removed. If you wish to have a title (MD., Ph.D., Hematologist, etc.) appear on the report, it is necessary to make entries in the NEW PERSON file (#200), Provider Class field 53.5 which points to PROVIDER CLASS file (#7).

### **Frozen Sections**

1. There is a separate field for entry of the Frozen Section information. If it is turned on (use the Edit Pathology Parameters [LRAPHDR] option), this field will appear in the log-in and data entry options. If there is any entry in the field, it will be included on the reports. The current capabilities for the reporting system of the module for entering and releasing reports are not conducive to allowing immediate release of the frozen section report. If the gross description and frozen section diagnosis are entered and released immediately in order to meet the CAP standard of providing a written frozen section diagnosis at the time of surgery, then the remainder of the data entry for an "amended report" is available for printing and viewing by physicians. The report has already been released and, therefore, the editorial control has been lost.

Manual systems, such as ones which either overprint the SF 515 with headers for gross impression and frozen section diagnosis or use a miscellaneous clinical lab form, are probably far more easily maintained. These can be used for the written report of the frozen section. The remainder of the specimen can then be processed, the gross and microscopic dictated and the report released.

2. Some consideration should be given as to whether the identity of the person to whom the frozen section report was given and the date/time given should be included on the report. This should be included in the text of the report.

### **Bone Marrows**

1. By accessioning the bone marrows, including both the aspirate and the biopsy, all of the functions of the surgical pathology portion of the package can be used. To get a list of the bone marrows for a specified time, select the morphology search option and enter the SNOMED code for the bone marrow (06), enter "ALL" for the morphology prompt and specify the date range. The list provided will include all of the bone marrows within that time, both by patient and by accession number. You can use the topography count option to get a count for a specified time. In addition, the accessions will be included on the Log Book for quick reference.

By entering the aspirate and the biopsy as multiple specimens on the same accession number, all of the information can be integrated into a single report.

2. Example 3, in the data entry option Gross Review Microscopic/SNOMED Coding [LRAPDGS] option, shows how a template can be used to standardize the content of the bone marrow report. As noted in that option, the template is controlled by the LAB DESCRIPTION file #62.5.
3. At the time that the gross reports are submitted to the pathologist for microscopic dictation, it might also be helpful to routinely generate a printout of the patient's most recent peripheral blood counts and other relevant tests which might be helpful in reaching a definitive diagnosis. This can be done using the Enter/Print/Display Preselected Lab Tests [LRUMDA] or by attaching an interim report.

## **Autopsy**

1. Provisional Autopsy Diagnosis (PAD) are issued within 24-72 hours of performance of the autopsy. This data can be entered through the appropriate option and released for viewing by the physician if so desired. The Final Autopsy Diagnosis (FAD) is then entered once the microscopic and/or neuropathology description have been completed. Once the report is finalized, it should be released for viewing by the physicians.
2. The autopsy protocol simulates SF 503 (Rev. 2-79) and is designed to be sent to the chart and clinicians with the clinical and pathological diagnoses (final anatomic diagnoses). For a complete report of the autopsy, including gross and microscopic descriptions, the record is kept on file in Laboratory Service. This latter record may be a picture protocol (SF 507) or a text description of the autopsy. If a picture protocol is used, the microscopic description is written alongside the appropriate picture and gross description.

Here is the beginning of the report sent out:

-----  
CLINICAL RECORD /AUTOPSY PROTOCOL

Pg 1  
-----

Date died: NOV 4, 1986 12:30 / Autopsy date: NOV 4, 1986

Resident: xxxxxx xxxxxxxx M.D. / TRUNK ONLY (N-146-86)  
=====

Clinical diagnoses:

Please see attached clinical summary. (The summaries are usually sent to us by the clinical service)  
-----

Pathological diagnoses:

I. CARDIOVASCULAR SYSTEM:

A. Congestive Heart Failure

1. Cardiomegaly (575 gm.)

2. Hypertrophy, biventricular,

Left ventricle 1.6 cm

Right ventricle 0.6 cm.

B. Pericarditis, fibrinous

C. Atherosclerosis

1. Coronary arteries

...

and so on.

After listing the pathological diagnoses, there is a summary of the case, including the clinical-pathological correlations. The final line of the report is:

COMPLETE AUTOPSY PROTOCOL AVAILABLE IN PATHOLOGY OFFICE

and the patient name, SSN, DOB, and age at death.

**Weights that are entered during log-in of autopsy are displayed when a cumulative path report for a patient is requested.**

According to the 1989 revisions of M-2 Part VI, Chapter 4, the completed autopsy report should be in the patient's record within 60 days after the post mortem examination. The format and extent of the gross and microscopic descriptions will depend on local practice, but sufficient information will be included to support the diagnoses rendered on SF 503. Supplemental reports can be issued as necessary.

Some local practices are to provide the "Final Anatomic Diagnoses and Clinical Summary," followed by a statement that the complete autopsy protocol is available in the Pathology Office. However, any site can enter in the system the entire gross and microscopic descriptions, if desired, since the simulated form is not restricted to a single page. In fact, some of the more interesting cases have been many pages long with much discussion and many references cited.

3. The options Final Autopsy Diagnosis Date [LRAPAUFD] and Autopsy Data Review [LRAPAUVR] expand the module's ability to provide data for various Quality Assurance monitors. When the autopsy has been completed, the [LRAPAUFD] option should be used to enter information into two fields, Major Diagnostic Disagreement and Clinical Diagnosis Clarified. In order to obtain information on the percent of deaths on which autopsies are performed, and the number of cases in which the autopsy provided information which either clarified or contradicted the clinical diagnosis, the [LRAPAUVR] option can be used. This option searches the patient file for deaths occurring within the specified time. It tallies the number of deaths and the number of autopsies. A report is then generated which also includes the entries for the information entered through [LRAPAUFD].

Additional QA codes can be assigned using the QA code entry/edit option in the Supervisor's Menu. An example is provided in the option description of some possible codes for premortem/postmortem correlations.

4. The following reference provides a good explanation of the usefulness of the autopsy for quality assurance:

Schned, Alan R., Mogielnicki, R. Peter, and Stauffer, Marth E;  
A comprehensive Quality Assessment Program on the Autopsy Service;  
Am J Clin Pathol 86:133-138, 1986.



# AP MENU OPTIONS

## AP Menu Options



## AP Menu Options

This section describes and gives examples of most of the options in the Anatomic Pathology module. Options that appear on more than one menu, or generic-type options (e.g., Print SNOMED References or the Search options) may only be described once. At the second occurrence of the option, a reference will be given as to which section to look at for a complete description.

**Data Entry, Anat Path [LRAPD]**Descriptions

<b>Option</b>	<b>Description</b>
<b>Data entry for Autopsies</b>	
Provisional Anatomic Diagnoses	Allows entering the preliminary autopsy diagnoses.
Autopsy Protocol	Allows entry of clinical diagnoses (including operations) and pathological diagnoses for later printing of AUTOPSY PROTOCOL (SF 503).
Autopsy Protocol & SNOMED Coding	Allows entry and editing of autopsy summary and SNOMED codes.
Autopsy Protocol & ICD9CM Coding	Allows entry and edit of autopsy summary and ICD9CM codes.
Final Autopsy Diagnoses Date	Stores date when senior pathologist signs out autopsy. This is when the final diagnoses are made. Includes prompts for MAJOR DIAGNOSTIC DISAGREEMENT (between autopsy & clinical findings) and CLINICAL DIAGNOSIS CLARIFIED.
Autopsy Supplementary Report	Allows entry of a supplementary report for an autopsy.
Special Studies, Autopsy	Allows entry of special studies (photography, electron microscopy, immunofluorescence, consultation) for organs or tissues specified.
Blocks, Stains, Procedures,	Allows entry of blocks, stains Surg Path and procedures used in surgical pathology.

<b>Option</b>	<b>Description</b>
<b>Coding</b>	
SNOMED Coding, Anat Path	Allows entry or edit of the SNOMED codes for any existing Surgical Pathology accession.
ICD9CM Coding, Anat Path	Allows entry or edit of the ICD9CM codes for any existing Anatomic Pathology accession.
Clinical Hx/Gross Description/FS	Enter anatomic pathology specimen gross description and clinical history.
FS/Gross/Micro/Dx (New name for option)	Enter the microscopic descriptions and diagnosis. Edit the gross tissue description and frozen description.
FS/Gross/Micro/Dx/SNOMED Coding (New name for option)	Allows review of gross specimen description, and frozen description entry of microscopic description and diagnoses, and SNOMED coding.
FS/Gross/Micro/Dx/ICD9CM Coding (New name for option)	Allows review of gross specimen description, and frozen description entry of microscopic description and ICD9CM coding for each accession number.
Enter Old Anat Path Records	Enter old (non-current) Anat Path reports for reference and historical purposes.
Supplementary Report, Anat Path	Used to add a supplementary report to any existing anatomic pathology accession.
Special Studies-EM;Immuno;Consult Pic; Anat Path	Used to add a special study report to an existing anatomic pathology accession.

## Data Entry for Autopsies[LRAPAUDA]

### **Provisional Anatomic Diagnoses [LRAPAUPAD]**

The provisional report is issued within 24-72 hours of the performance of the autopsy. With the exception of the Provisional Anatomic Dx Date, the fields are the same as those which appear in the Autopsy Protocol [LRAPAUDAP] option. Data which is entered through this option is then edited when the final report is done. It is not stored separately.

Once data is entered via this option, the accession is automatically placed in the print queue for autopsy report.

By having a separate date field, it allows the issuance of this report to be tracked separately from that of the final report. This field is also used for the calculation of the turnaround time for PADs.

### **Example:**

Select Data entry, anat path Option: **AU** Data entry for autopsies

Select Data entry for autopsies Option: **PD** Provisional anatomic diagnoses

Data entry for 1992 ? YES// **<RET>** (YES)

Select Accession Number/Pt name: **4** for 1992  
BLO,JOSEPH ID: 324-12-3456

CLINICAL DIAGNOSES:

- 1>1. Left CVA
- 2>2. Recurrent UTI.
- 3>3. Aspiration pneumonia.
- 4>

EDIT Option: **<RET>**

PATHOLOGICAL DIAGNOSES:

- 1>PROVISIONAL GROSS ANATOMIC PATHOLOGIC DIAGNOSIS (subject to revision):
- 2>
- 3>1. Bilateral pulmonary edema with bilateral pleural effusion (500cc)
- 4> a. Organizing pneumonia right lung
- 5> b. Pericardial effusion
- 6> c. Calcified granuloma, left upper lobe
- 7>
- 8>2. a. Moderate arteriosclerosis of abdominal aorta
- 9> b. Cardiomegaly with LVH
- 10>
- 11>3. Bilateral granular kidneys (arteriolonephrosclerosis)
- 12> a. 3 x 2 cm cyst left kidney
- 13> b. 0.3 x 0.3 cm hemorrhagic cysts, left kidney
- 14> c. Hemorrhagic bladder mucosa
- 15>

16>4. Cholelithiasis with 25 stones (yellow 0.5 to 1 cm)  
17> a. Congested liver parenchyma  
18> b. Diverticulosis, colon  
19>

EDIT Option: <RET>

PROVISIONAL ANAT DX DATE: T (NOV 25, 1992)

## Autopsy Protocol [LRAPAUDAP]

Allows entry of clinical diagnoses (including operations) and pathological diagnoses for later printing of AUTOPSY PROTOCOL (SF 503).

### Example:

Select Data entry for autopsies Option: **AP** Autopsy protocol  
Data entry for 1990 ? YES// <RET> (YES)

Select Accession Number/Pt name: **2** for 1990  
YOKUM,SALLY ID: 234-56-7891

DATE AUTOPSY REPORT COMPLETED: **7 29** (JUL 29, 1990)  
Select AUTOPSY COMMENTS: Carcinoma of right lung//<RET>  
CLINICAL DIAGNOSES:

1> **Carcinoma of right lung**  
2> <RET>

EDIT Option: <RET>

PATHOLOGICAL DIAGNOSES:

1> **I. Respiratory System**  
2> **A. Adenocarcinoma, Right Upper Lobe**  
3> **B. Atelectasis, Both lower lobes etc.**  
4> <RET>

EDIT Option: <RET>

Select Accession Number/Pt name: <RET>

### NOTES:

- The date completed, not the AUTOPSY RELEASE DATE, is used for calculation of the turn-around-time since the autopsy may be released for viewing after the preliminary diagnosis was completed. Thus, it is not possible to tell from the release date/time whether that reflects the preliminary or the final report.
- Once the final report is completed, it can be verified/released for viewing via the clinician option.

## Autopsy Protocol and SNOMED Coding [LRAPAUDAB]

This option allows entry of clinical diagnoses (including operations) and pathological diagnoses and the corresponding SNOMED codes for the tissues and diagnoses.

### Example 1: No Data Previously Entered for Provisional Report

If you answer "YES" to the "Enter Etiology, Function, Procedure & Disease? NO//" prompt, you will be asked to select Etiology, Function, Procedure, and Disease for each Organ/Tissue.

Select Anatomic pathology Option: **D** Data entry, anat path

Select Data entry, anat path Option: **AU** Data entry for autopsies

Select Data entry for autopsies Option: **AS** Autopsy protocol & SNOMED coding

Enter Etiology, Function, Procedure & Disease? NO// <RET>

Data entry for 1989 ? YES// <RET> (YES)

Select Accession Number/Pt name: **75** for 1989

SMITH, JOHN J ID: 000122222

Autopsy performed: November 15, 1989 Acc# 75

DATE AUTOPSY REPORT COMPLETED: **11/16** (NOV 16, 1989)

CLINICAL DIAGNOSES:

1>**CEREBRAL VASCULAR ACCIDENT**

2>**PNEUMONIA**

3> <RET>

EDIT Option: <RET>

PATHOLOGICAL DIAGNOSES:

1>**CARDIOVASCULAR SYSTEM: 1. MODERATE-SEVERE ATHEROSCLEROSIS OF AORTA**

2> **AND LARGE ARTERIES WITH LEFT CAROTID**

3> **ARTERY CALCIFIED BUT PROBE PATENT AT**

4> **BIFURCATION.**

5>**RESPIRATORY SYSTEM: 1. ACUTE BRONCHOPNEUMONIA WITH ABSCESSSES**

6> **AND EVIDENCE OF ASPIRATION, ALL RIGHT-SIDED**

7> **LOBES AND LOWER LEFT LOBE.**

8> **2. PULMONARY EMPHYSEMA**

9> **3. CHRONIC BRONCHITIS**

10> <RET>

EDIT Option: <RET>

Select AUTOPSY ORGAN/TISSUE: **HEART** 32000

. . . AUTOPSY ORGAN/TISSUE NUMBER: 1// <RET>

Select MORPHOLOGY: **54750** INFARCT,HEALED

Select MORPHOLOGY: **52110** ARTEROSCLEROSIS

Select MORPHOLOGY: <RET>

Select AUTOPSY ORGAN/TISSUE: **42000** AORTA 42000

AUTOPSY ORGAN/TISSUE NUMBER: 2// <RET>

Select MORPHOLOGY: **52110** ARTEROSCLEROSIS

Select MORPHOLOGY: <RET>

Select AUTOPSY ORGAN/TISSUE: <RET>

Select Accession Number/Pt name: <RET>

**Example 2:** Finalizing a report for which the provisional report was previously entered.

**NOTE:** If the Provisional Anatomical Diagnosis report was verified/released for viewing by the clinicians and if the pathologist does not want the final report accessible to the clinicians until that portion has been once again been verified/released, it **must be** unreleased prior to entry of the Final Anatomical Diagnosis information. This can be done using the "@" key for the Autopsy accession area since there is no chance for adverse patient outcome.

```
Select Anatomic pathology Option: D  Data entry, anat path
Select Data entry, anat path Option: AU  Data entry for autopsies
Select Data entry for autopsies Option: AS  Autopsy protocol & SNOMED coding
Enter Etiology, Function, Procedure & Disease ? NO// <RET>  (NO)
Data entry for 1992 ? YES// <RET>  (YES)
Select Accession Number/Pt name: 5  for 1992
BOGGESS,HENRY  ID: 234-88-9898

DATE AUTOPSY REPORT COMPLETED: T  (DEC 02, 1992)
CLINICAL DIAGNOSES:
  1>1. Left CVA
  2>2. Recurrent UTI
  3>3. Aspiration pneumonia
EDIT Option: Insert after line: 3
  4>4. Chronic renal failure
  5><RET>
1 line inserted...
EDIT Option: <RET>
PATHOLOGICAL DIAGNOSES:. . .
. . .
11>3.  Bilateral granular kidneys (arterionephrosclerosis)
12>  a.  3 x 2 cm cyst left kidney
13>  b.  0.3 x 0.3 cm hemorrhagic cysts, left kidney
14>  c.  Hemorrhagic bladder mucosa
15>
16>4.  Choletlithiasis with 25 stones (yellow, 0.5 to 1 cm)
17>  a.  Congested liver parenchyma
18>  b.  Diverticulosis, colon

EDIT Option: list line: 1// <RET> to: 19// <RET>
```



```

1>PROVISIONAL GROSS ANATOMIC PATHOLOGICAL DIAGNOSIS: (Subject to revision)
2>
3>1.  Bilateral pulmonary edema with bilateral pleural effusion (500cc)
4>   a.  Organizing pneumonia right lung
5>   b.  Pericardial effusion
6>   c.  Calcified granuloma, left upper lobe
7>
8>2.  a.  Moderate arteriosclerosis of abdominal aorta
9>   b.  Cardiomegaly with LVH
10>
11>3.  Bilateral granular kidneys (arterionephrosclerosis)
12>   a.  3 x 2 cm cyst left kidney
13>   b.  0.3 x 0.3 cm hemorrhagic cysts, left kidney
14>   c.  Hemorrhagic bladder mucosa
15>
16>4.  Choletlithiasis with 25 stones (yellow, 0.5 to 1 cm)
17>   a.  Congested liver parenchyma
18>   b.  Diverticulosis, colon
19>
EDIT Option: 1
1>PROVISIONAL GROSS ANATOMIC PATHOLOGICAL DIAGNOSIS: (Subject to revision)
  Replace P...P With P  Replace (... With <RET>  Replace <RET>
  PATHOLOGICAL DIAGNOSIS:
Edit line: 5
  5>   b.  Pericardial effusion
  Replace b.... With b.  Organizing pneumonia, right lung, with acute
bronchitis  Replace <RET>
           b.  Organizing pneumonia, right lung, with acute bronchitis Pericardial
effusion
Edit line: +1 6
  6>   c.  Calcified granuloma, left upper lobe
  Replace lobe With lobe (gross)  Replace <RET>
           c.  Calcified granuloma, left upper lobe (gross)
Edit line: insert after line: 6
  7>   d.  Emphysema (bilateral) and focal atelectasis (left)
  8> <RET>
1 line inserted.....
EDIT Option: list line: 1// <RET> to: 20// <RET>

```

## AP Menu Options

```
1>PATHOLOGICAL DIAGNOSIS:
2>
3>1.  Bilateral pulmonary edema with bilateral pleural effusion (500cc)
4>   a.  Organizing pneumonia right lung
5>   b.  Organizing pneumonia, right lung, with acute bronchitis Pericardial
effusion
6>   c.  Calcified granuloma, left upper lobe (gross)
7>   d.  Emphysema (bilateral) and focal atelectasis (left)
8>
9>2.  a.  Moderate arteriosclerosis of abdominal aorta
10>   b.  Cardiomegaly with LVH
11>
12>3.  Bilateral granular kidneys (arterionephrosclerosis)
13>   a.  3 x 2 cm cyst left kidney
14>   b.  0.3 x 0.3 cm hemorrhagic cysts, left kidney
15>   c.  Hemorrhagic bladder mucosa
16>
17>4.  Choletlithiasis with 25 stones (yellow, 0.5 to 1 cm)
18>   a.  Congested liver parenchyma
19>   b.  Diverticulosis, colon
20>
EDIT Option: 5
5>   b.  Organizing pneumonia, right lung, with acute bronchitis
Pericardial effusion
Replace P... With <RET> Replace <RET>
      b.  Organizing pneumonia, right lung, with acute bronchitis
Edit line: 10
10>   b.  Cardiomegaly with LVH
Replace galy With galy(480 gm) Replace LVH With left ventricular
hypertrophy
Replace <RET>
      b.  Cardiomegaly(480 gm) with left ventricular hypertrophy
Edit line: insert after line: 10
11>   c.  Pericardial effusion with chronic peritonitis
12>   d.  Focal interstitial fibrosis
13>
2 lines inserted..... [etc.....]
EDIT Option: insert after line: 23
24><RET>
25>CLINICO-PATHOLOGICAL CORRELATION
26><RET>
27>Patient was an 81 year old Hispanic man .....
28><RET>
4 lines inserted.....
EDIT Option: <RET>
```

```

Select AUTOPSY ORGAN/TISSUE: 28000 LUNG          28000
  AUTOPSY ORGAN/TISSUE NUMBER: 1// <RET>
  Select MORPHOLOGY: 36660 EDEMA, LYMPHATIC      36660
  Select MORPHOLOGY: 32800 EMPHYSEMA             32800
  Select MORPHOLOGY: 49000 FIBROSIS              49000
  Select MORPHOLOGY: <RET>
Select AUTOPSY ORGAN/TISSUE: 29000 PLEURA       29000
  AUTOPSY ORGAN/TISSUE NUMBER: 2// <RET>
  Select MORPHOLOGY: 36300 EFFUSION              36300
  Select MORPHOLOGY: EFFUSION
  MORPHOLOGY: EFFUSION// 36330 EFFUSION, SEROSANGUINEOUS 36330
  Select MORPHOLOGY: <RET>
Select AUTOPSY ORGAN/TISSUE: 28100 RIGHT LUNG    28100
  AUTOPSY ORGAN/TISSUE NUMBER: 3// <RET>
  Select MORPHOLOGY: 40000 INFLAMMATION          40000
  Select MORPHOLOGY: <RET>
Select AUTOPSY ORGAN/TISSUE: 28600 LEFT UPPER LOBE OF LUNG 28600
  AUTOPSY ORGAN/TISSUE NUMBER: 4// <RET>
  Select MORPHOLOGY: 44000 INFLAMMATION, GRANULOMATOUS 44000
  Select MORPHOLOGY: <RET>
Select AUTOPSY ORGAN/TISSUE: 71000 KIDNEY        71000
  AUTOPSY ORGAN/TISSUE NUMBER: 5// <RET>
  Select MORPHOLOGY: 52200 ARTERIOLOSCLEROSIS    52200
  Select MORPHOLOGY: <RET>
Select AUTOPSY ORGAN/TISSUE: 57000 GALLBLADDER   57000
  AUTOPSY ORGAN/TISSUE NUMBER: 6// <RET>
  Select MORPHOLOGY: 30010 LITHIASIS             30010
  Select MORPHOLOGY: <RET>
Select AUTOPSY ORGAN/TISSUE: 56000 LIVER         56000
  AUTOPSY ORGAN/TISSUE NUMBER: 7// <RET>
  Select MORPHOLOGY: CONGESTION                 36100
  Select MORPHOLOGY: <RET>
Select AUTOPSY ORGAN/TISSUE: 670000 COLON        67000
  AUTOPSY ORGAN/TISSUE NUMBER: 8// <RET>
  Select MORPHOLOGY: 32710 DIVERTICULOSIS        32710
  Select MORPHOLOGY: <RET>
Select AUTOPSY ORGAN/TISSUE: 42000 AORTA         42000
  AUTOPSY ORGAN/TISSUE NUMBER: 9// <RET>
  Select MORPHOLOGY: 52000 ARTERIOSCLEROSIS      52000
  Select MORPHOLOGY: <RET>
Select AUTOPSY ORGAN/TISSUE: 33010 MYOCARDIUM    33010
  AUTOPSY ORGAN/TISSUE NUMBER: 10// <RET>
  Select MORPHOLOGY: 71000 HYPERTROPHY           71000
  Select MORPHOLOGY: <RET>
Select AUTOPSY ORGAN/TISSUE: <RET>

```

## Autopsy Protocol and ICD9CM Coding [LRAPAUDAA]

This option allows entry of clinical diagnoses (including operations), pathological diagnoses, and the corresponding ICD9CM codes for the pathology diagnoses. If the option doesn't seem to work correctly, check with your site manager. The ICD9CM globals may not have been loaded (possibly because of space shortages).

### Example:

Data entry for 1990 ? YES// <RET> (YES)  
Select Accession Number/Pt name: **2** for 1990  
YOKUM,SALLY ID: 234-56-7891

Autopsy performed: July 28, 1990 Acc# 2  
DATE AUTOPSY REPORT COMPLETED: **7 29** (JUL 29, 1990)  
CLINICAL DIAGNOSES:

1>**Carcinoma of right lung**

2><RET>

EDIT Option: <RET>

PATHOLOGICAL DIAGNOSES:

1> **CARDIOVASCULAR SYSTEM: 1. MODERATE-SEVERE  
ATHEROSCLEROSIS OF AORTA**

2> **AND LARGE ARTERIES WITH LEFT CAROTID**

3> **ARTERY CALCIFIED BUT PROBE PATENT AT**

4> **BIFURCATION.**

5> **RESPIRATORY SYSTEM: 1. ACUTE BRONCHOPNEUMONIA WITH  
ABSCESSSES AND**

6> **EVIDENCE OF ASPIRATION, ALL RIGHT-SIDED**

7> **LOBES AND LOWER LEFT LOBE.**

8> **2. PULMONARY EMPHYSEMA**

9> **3. CHRONIC BRONCHITIS**

10><RET>

EDIT Option: <RET>

Select AUTOPSY ICD9CM CODE: **414.0** CORONARY ATHEROSCLEROSIS  
... OK? YES// <RET>

Select AUTOPSY ICD9CM CODE: **433.1** CAROTID ARTERY OCCLUSION  
... OK? YES// <RET>

Select AUTOPSY ICD9CM CODE: **513.0** ABSCESS OF LUNG  
... OK? YES// <RET>

Select AUTOPSY ICD9CM CODE: <RET>

Select Accession Number/Pt name: <RET>

**Final Autopsy Diagnoses Date [LRAPAUFAD]**

When the autopsy has been completed, this option can be used to enter quality assurance information. If additional, more specific QA information is desired, QA codes can be defined in the LAB DESCRIPTIONS file (#62.5) and entered using the QA Codes Entry/Edit [LRAPQACD] option in the Supervisor's Menu.

**NOTE:** The Final Autopsy Diagnosis Date is not used in the calculation of the turn-around-time.

**Example:**

Select Data entry, anat path Option: **AU** Data entry for autopsies

Select Data entry for autopsies Option: **AF** Final autopsy diagnoses date

Data entry for 1990 ? YES// <**RET**> (YES)

Select Accession Number/Pt name: **2** for 1990  
YOKUM,SALLY ID: 234-56-7891

DATE FINAL AUTOPSY DIAGNOSES: **7 29** (JUL 29, 1990)

MAJOR DIAGNOSTIC DISAGREEMENT: ?

CHOOSE FROM:

0 NO

1 YES

MAJOR DIAGNOSTIC DISAGREEMENT: **NO**

CLINICAL DIAGNOSIS CLARIFIED: ?

CHOOSE FROM:

1 YES

0 NO

2 CONFIRMED

CLINICAL DIAGNOSIS CLARIFIED: **CONFIRMED**

Select Accession Number/ Pt name: <**RET**>

## Autopsy Supplementary Report [LRAPAUSR]

Based on the need to release the autopsy findings within a 60-day turn-around-time, information obtained from additional studies, such as those of neuropathology, can be added as supplemental reports.

### Example:

Select Data entry for autopsies Option: **SR** Autopsy supplementary report

Data entry for 1990 ? YES// **<RET>** Autopsy supplementary report

Select Accession Number/Pt name: **2** for 1990

YOKUM,SALLY ID: 234-56-7891

Select SUPPLEMENTARY REPORT DATE: **T** SEP 12, 1990

DESCRIPTION:

1>**>Examination of brain shows no evidence of metastatic carcinoma.**

2>**<RET>**

EDIT Option: **<RET>**

Select Accession Number/Pt name: **<RET>**

**NOTE:** The report shown on the next page can be generated using the Print Single Report Only [LRAP PRINT SINGLE] option or the Print All Reports on the Print Queue [LRAP PRINT ALL ON QUEUE] option and specifying the desired type of report.

-----  
 CLINICAL RECORD :           AUTOPSY SUPPLEMENTARY REPORT   Pg 1  
 -----

Date died: APR 26, 1990           :Autopsy date:APR 26, 1990 12:55  
 Resident: HARRY WELBY           :FULL AUTOPSY   Autopsy No. A90 1  
 -----

SUPPLEMENTARY REPORT DATE: AUG 10, 1990 10:43

This is an autopsy supplementary report. It is separate from the protocol because there are many instances where the autopsy can be signed out within the sixty day time limit but the brain exam may not be ready until after the deadline is past. The protocol can be sent to the patient's chart and the supplementary report can later follow without having to reprint the entire autopsy protocol.

SUPPLEMENTARY REPORT DATE: AUG 10, 1990 12:35

There can be as many supplementary reports as desired.

-----  
 Pathologist: MARCUS WELBY MD       jg : Date SEP 12, 1990  
 -----

R5ISC                               AUTOPSY SUPPLEMENTARY REPORT  
 OLDER,SAM                       587-69-8316 M DOB: FEB 1, 1901 AGE: 87  
 CCC                               HARRY WELBY

## AP Menu Options

SEP 12, 1990 10:00 ANATOMIC PATHOLOGY R5ISC Page: 2

-----  
OLDER,SAM SSN:587-69-8316 DOB:FEB 1, 1901  
Acc # Date/time Died Age AUTOPSY DATA Date/time of Autopsy  
1 APR 26, 1990 87 FULL AUTOPSY APR 26, 1990 12:53  
Resident:WELBY,HARRY Senior:WELBY,MARCUS

Rt--Lung--Lt Liver Spleen Rt--Kidney--Lt Brain Body Wt(lb) Ht(in)  
405 3000 3450 350 150 150 1234 156 69

Heart(gm) TV(cm) PV(cm) MV(cm) AV(cm) RV(cm) LV(cm)  
450 12 8.5 10.5 7.5 4 1.8

Cavities(ml): Rt--Pleural--Lt Pericardial Peritoneal  
350 200 20 500

PITUITARY GLAND (GM): .15

THYROID GLAND (GM): 55

PARATHYROID, LEFT UPPER (gm): .2

PARATHYROID, LEFT LOWER (gm): .1

PARATHYROID, RIGHT UPPER (gm): .12

PARATHYROID, RIGHT LOWER (gm): .13

ADRENAL, LEFT (gm): 12

ADRENAL, RIGHT (gm): 13

PANCREAS (gm): 80

LIVER

EM E1234-88 Date: APR 26, 1990

EM shows tonofilaments in tumor cells indicating squamous origin.

SNOMED code(s):

T-28500: left lung

M-80703: carcinoma, sq cell

T-56000: liver

M-80106: carcinoma, metastatic

M-44700: granuloma, caseating

E-2001: mycobacterium tuberculosis

F-82600: pain

T-57000: gallbladder

M-41740: abscess

F-82600: pain

-----  
Pathologist: MARCUS WELBY MD jg : Date APR 26, 1990

-----  
R5ISC AUTOPSY PROTOCOL  
OLDER,SAM 587-69-8316 M DOB: FEB 1, 1901 AGE:87  
MEDICINE HARRY WELBY



## **Special Studies Autopsy [LRAPAUDAS]**

This option allows entry of special studies (photography, electron microscopy, immunofluorescence, consultation) for organs or tissues specified.

Any additional studies or supplemental information can be entered using either the Special Studies option or the Supplementary Report option. The Supplementary Report offers only the date/time of the report and a single free-text field. Data entered in this field will be deleted when the descriptions are deleted. The Special Studies option is more restrictive in its application; however, data entered is not deleted when descriptions are deleted. It can then be used for searches, etc., at some time in the future. For both options, entry of data will place the report in the final report print queue.

**NOTE:** Armed Forces Institute of Pathology (AFIP) case information can be entered as a Special Study by designating "Consultation" as the type of study.

## AP Menu Options

### Example:

Select Data entry, anat path Option: **AU** Data entry for autopsies

Select Data entry for autopsies Option: **SS** Special studies, autopsy

Data entry for 1990 ? YES// **<RET>** (YES)

Select Accession Number/Pt name: **ANEY** ANEY,RUSS. 04-27-25 089485948 SC  
VETERAN

ANNEY,R. ID: 089-48-5948 Physician: WELBY,MARCUS

DIED JUN 1, 1990

Autopsy performed: JUN 2, 1990 Acc # 5

Select AUTOPSY ORGAN/TISSUE: LUNG//**<RET>**

AUTOPSY ORGAN/TISSUE: LUNG//**<RET>**

Select SPECIAL STUDIES: EM//**<RET>**

DATE: AUG 2,1990//**<RET>**

ID #: // **15**

DESCRIPTION:**<RET>**

Select SPECIAL STUDIES: ?

ANSWER WITH SPECIAL STUDIES

CHOOSE FROM:

- 1 PHOTOGRAPHY
- 2 FROZEN SECTION
- 3 EM

YOU MAY ENTER A NEW SPECIAL STUDIES, IF YOU WISH

CHOOSE FROM:

- E EM
- I IMMUNOFLUORESCENCE
- P PHOTOGRAPHY
- C CONSULTATION
- F FROZEN SECTION

Select SPECIAL STUDIES: **1 P**

SPECIAL STUDIES: PHOTOGRAPHY//**<RET>**

DATE: AUG 11,1986//**<RET>**

ID #: P789-86//**<RET>**

DESCRIPTION: **<RET>**

1>Photographs of lung gram stains

EDIT Option: **<RET>**

Select SPECIAL STUDIES:**<RET>**

Select AUTOPSY ORGAN/TISSUE:**<RET>**

Select Accession Number/Pt name: **<RET>**

## Blocks, Stains, Procedures, Anat Path [LRAPSPDAT]

This option allows entry of data related to the blocks and special stains done on any type of pathology specimen.

**NOTE:** If workload is turned on for any of the areas, default data will be entered upon log-in. For details regarding a specific area, please see the Implementation Guide.

### **Surgical Pathology**

Under the Surgical Pathology field 8, subfield .012 (specimen), there are 3 subfields:

PARAFFIN BLOCK  
PLASTIC BLOCK  
FROZEN TISSUE BLOCK

Under each of the above fields, there is a multiple containing STAIN/PROCEDURE, in the name field. This field points to the LABORATORY TEST file (#60).

### **Cytology**

For cytology, data can be entered for SMEAR PREP, CELL BLOCK, MEMBRANE FILTER, PREPARED SLIDES, or CYTOSPIN preparation. Under each of these fields, there is a multiple which allows entry of a specific stain(s).

### **Electron Microscopy**

For EM, data can be entered for the EPON BLOCKS. Under that subfield, there is a multiple which allows entry of a specific stain.

### **Autopsy**

For autopsy, data can be entered for the PARAFFIN BLOCK. Under that subfield, there is a multiple which allows entry of specific stains.

### **General**

In File #60, the only fields which currently are necessary for the Blocks, Stains, Procedures option to function are the name field (.01) and the subscript field (4). The subscript field must be =SP. There are other required fields; however, the information entered plays no role at the current time. See example on the next page.

The information entered through this option is useful for 1) tracking the work performed on each accession via the Display Stains/Blocks for a Patient [LRAPST] option, 2) generating labels via the Anat Path Slide Labels [LRAPLM] option, to be

placed on the glass slides used for microscopic examination, or 3) printing using the Accession List with Stains [LRAPSA] option to serve as a workload recording document.

Once specimens have been logged in, the Histopathology Worksheet [LRAPH] option will provide a mechanism for recording what data needs to be entered into the system. The worksheet includes all accessions and all specimens for each accession.

**NOTE:** Some detailed training on how to review/edit the data will be necessary unless the user already has experience in dealing with this option, or other data entry option that involves multiple fields. Dealing with these multiples is not intuitive even to the more experienced user.

**Example 1: Routine Data Entry for Surg Path (workload off)**

Select Anatomic pathology Option: **DATA ENTRY, ANAT PATH**

Select Data entry, anat path Option: **BLOCKs, Stains, Procedures, anat path**

Select ANATOMIC PATHOLOGY section: **SP SURGICAL PATHOLOGY**

- 1. PARAFFIN BLOCK
- 2. PLASTIC BLOCK
- 3. FROZEN TISSUE

Selection (1) : **1 PARAFFIN BLOCK**

Selection (2) : **<RET>**

Enter year: 1990//

Select Accession Number/Pt name: **22** for 1994

HUDSON,ALBANY ID: 001-00-0001

Date/time blocks prepared/modified: NOW// **<RET>** (AUG 26, 1994@13:24) OK ? YES// **<RET>** (YES)

Date/time slides stained: NOW// **<RET>** (AUG 26, 1994@13:24) OK ? YES// **<RET>** (YES)

HUDSON,ALBANY 0001 Acc #: 24 Date: APR 26, 1994

			Slide/Ctrl	Last stain/block date
SKIN				
Paraffin Block				
SKIN	Stain/Procedure			APR 26, 1994 08:00
	H & E STAIN	1		APR 26, 1994 08:00
	ACID FAST STAIN, HISTOLOGY	1/1		MAY 30, 1994 08:30
	PAS WITHOUT DIASTASE	1/1		MAY 30, 1994 08:00
A	Stain/Procedure			APR 26, 1994 08:00
	H & E STAIN	1		APR 26, 1994 08:00

```

PROSTATE CHIPS
Paraffin Block
  B              Stain/Procedure          AUG 26, 1994 13:18
                H & E STAIN              1          AUG 26, 1994 13:19
  A              Stain/Procedure          AUG 26, 1994 13:21
                H & E STAIN              1          AUG 26, 1994 13:21

```

```

Data displayed ok ? NO// <RET> (NO)
Select SPECIMEN: PROSTATE CHIPS// <RET>
Select SPECIMEN: PROSTATE CHIPS// <RET>
Select PARAFFIN BLOCK ID: A//<RET>
  PARAFFIN BLOCK ID: A// <RET>
  DATE/TIME BLOCK PREPARED: AUG 26,1994@13:21// <RET>
  Select STAIN/PROCEDURE: H & E STAIN// <RET>
    STAIN/PROCEDURE: H & E STAIN// B
    SLIDES PREPARED (#): 1// <RET>
    CONTROL SLIDES (#): <RET>
    DATE/TIME SLIDES STAINED: AUG 26,1994@13:21
      // <RET>
  Select STAIN/PROCEDURE: <RET>
  Select PARAFFIN BLOCK ID: <RET>
  Select SPECIMEN: <RET>

```

**NOTES:**

- At the “Select SPECIMEN: PROSTATE CHIPS//” prompt, a return allows you to enter one to nine characters in a free text field to describe specifics of that block in the Example 1: Levels of myocardium were labeled A and H, etc.
- Entry of stains/procedures must be done using VA FileMan. Entry of the stains into File #60 should be done using the FileMan option one. The entry for “H & E STAIN” prompt must be exact in the name field in order for the data entry option to work for the default displayed. Since this stain is performed routinely on all surgical pathology specimens, the default has been included to expedite data entry.

## Example 2: Routine Data Entry for Surgical Pathology Frozen Section

Select Anatomic pathology Option: **D** Data entry, anat path

Select Data entry, anat path Option: **BS** Blocks, Stains, Procedures, anat  
Select ANATOMIC PATHOLOGY section: **SP** SURGICAL PATHOLOGY

1. PARAFFIN BLOCK
2. PLASTIC BLOCK
3. FROZEN TISSUE BLOCK

Selection (1): **3** FROZEN TISSUE BLOCK

Selection (2): **<RET>**

Enter year: 1994// **<RET>** ( 1994) 1994  
Select Accession Number: **24** for 1994  
MALMROSE,DALE ID: 222-22-2222

Date/time blocks prepared: NOW// **<RET>** (AUG 26, 1994@08:01) OK ? YES//  
**<RET>**(YES)  
Date/time slides stained: NOW// **<RET>** (AUG 26, 1994@08:01) OK ? YES//  
**<RET>**(YES)

MALMROSE,DALE 2222 Acc #: 24 Date: AUG 26, 1994

	Slide/Ctrl	Last stain/block date
LYMPH NODE		
Paraffin Block		
LYMPH NOD	Stain/Procedure	
	H & E STAIN	1

Data displayed ok ? NO// **<RET>** (NO)

Select SPECIMEN: LYMPH NODE// **<RET>**

Select FROZEN TISSUE ID: **FS1**

DATE/TIME FROZEN PREPARED: AUG 26,1994@08:01// **<RET>** (AUG 26, 1994@08:01)  
FROZEN TISSUE BLOCK TYPE: **??**

Entry indicates if the frozen tissue block is used for rush  
(rapid) diagnosis or routinely processed (not rush).

CHOOSE FROM: **<RET>**

- 1 RUSH
- 0 NOT RUSH

FROZEN TISSUE BLOCK TYPE: **RUSH**

Select STAIN/PROCEDURE: FROZEN SECTION H & E// **<RET>**

SLIDES PREPARED (#): 1// **<RET>**

CONTROL SLIDES (#): **<RET>**

DATE/TIME SLIDES STAINED: AUG 26,1994@08:01// **<RET>**(AUG 26, 1994@08:01)

Select STAIN/PROCEDURE: **<RET>**

Select FROZEN TISSUE ID: **FS2**

DATE/TIME FROZEN PREPARED: AUG 26,1994@08:01// **<RET>**(AUG 26, 1994@08:01)

FROZEN TISSUE BLOCK TYPE: **RUSH**

Select STAIN/PROCEDURE: FROZEN SECTION H & E// **<RET>**

SLIDES PREPARED (#): 1// **<RET>**

CONTROL SLIDES (#): <RET>  
 DATE/TIME SLIDES STAINED: AUG 26,1994@08:01// <RET>(AUG 26 1994@08:01)

Select FROZEN TISSUE ID: **FS3**  
 DATE/TIME FROZEN PREPARED: AUG 26,1994@08:01// <RET>(AUG 26, 1994@08:01)  
 FROZEN TISSUE BLOCK TYPE: **RUSH**  
 Select STAIN/PROCEDURE: FROZEN SECTION H & E// <RET>  
 SLIDES PREPARED (#): 1// <RET>  
 CONTROL SLIDES (#): <RET>  
 DATE/TIME SLIDES STAINED: AUG 26,1994@08:01// <RET>(AUG 26, 1994@08:01)  
 Select STAIN/PROCEDURE: <RET>  
 Select FROZEN TISSUE ID: <RET>  
 Select SPECIMEN: <RET>

MALMROSE,DALE 2222 Acc #: 24 Date: AUG 26, 1994

	Slide/Ctrl	Last stain/block date
LYMPH NODE		
Paraffin Block		
LYMPH NOD	Stain/Procedure	
	H & E STAIN	1
Frozen Tissue		
FS1	Stain/Procedure	AUG 26, 1994 08:01
	FROZEN SECTION H & E	1 AUG 26, 1994 08:01
FS2	Stain/Procedure	AUG 26, 1994 08:01
	FROZEN SECTION H & E	1 AUG 26, 1994 08:01
FS3	Stain/Procedure	AUG 26, 1994 08:01
	FROZEN SECTION H & E	1 AUG 26, 1994 08:01

Data displayed ok ? NO// Y (YES)

**NOTE:** If you then print labels through the Anat Path Slide Labels [LRAPLM] option, you will get three labels, as follows:

SURG	SURG	SURG
94-22	94-22	94-22
FS1	FS2	FS3
H&E	H&E	H&E
VAMC513	VAMC513	VAMC513

**Example 3:** Editing Data for Cytology (data already entered based on workload profiles)

Select Anatomic pathology Option: **D** Data entry, anat path

Select Data entry, anat path Option: **BS** Blocks, Stains, Procedures

Select ANATOMIC PATHOLOGY section: **CY** CYTOPATHOLOGY

1. SMEAR PREP
2. CELL BLOCK
3. MEMBRANE FILTER
4. PREPARED SLIDES
5. CYTOSPIN

Selection (1): 1 SMEAR PREP

Selection (2): 2 CELL BLOCK

Selection (3): **<RET>**

Enter year: 1994// **<RET>** (1994) 1994

Select Accession Number: **5** for 1994

BEAR,YOGI ID: 004-95-8671

Date/time slides stained: NOW// **<RET>** (AUG 26, 1994@14:13) OK ?

YES//**<RET>**(YES)

BEAR,YOGI 8671 Acc #: 5 Date: AUG 26, 1994

Slide/Ctrl Last stain date

BRONCHIAL WASHING CYTOLOGY

Smear Prep

SMEAR PRE	Stain/Procedure			
	PAP STAIN, SMEAR PREP	2	AUG 26, 1994	14:13

Cell Block

CELL BLOC	Stain/Procedure			
	H & E STAIN	1	AUG 26, 1994	14:13

Data displayed ok ? NO// **<RET>** (NO)

Select SPECIMEN: BRONCHIAL WASHING CYTOLOGY// **<RET>**

Select SMEAR PREP: SMEAR PRE// **<RET>**

SMEAR PREP: SMEAR PRE// **<RET>**

Select STAIN/PROCEDURE: PAP STAIN, SMEAR PREP

// **<RET>**

STAIN/PROCEDURE: PAP STAIN, SMEAR PREP// **<RET>**

SLIDES PREPARED (#): 2// **4**

CONTROL SLIDES (#): **<RET>**

DATE/TIME SLIDES STAINED: AUG 26,1994@14:13

// **<RET>**

Select STAIN/PROCEDURE: **<RET>**

Select SMEAR PREP: **<RET>**

Select CELL BLOCK: CELL BLOC// **<RET>**

CELL BLOCK: CELL BLOC// **<RET>**

Select CELL BLOCK STAIN: H & E STAIN// **<RET>**

CELL BLOCK STAIN: H & E STAIN// **<RET>**

SLIDES PREPARED (#): 1// **2**

CONTROL SLIDES (#): **1**

DATE/TIME SLIDES STAINED: AUG 26,1994@14:13

// **N** (AUG 26, 1994@14:14)



Select CELL BLOCK STAIN: <RET>  
 Select CELL BLOCK: <RET>  
 Select SPECIMEN: <RET>

BEAR,YOGI 8671 Acc #: 5 Date: AUG 26, 1994

		Slide/Ctrl	Last stain date
BRONCHIAL WASHING C			
Smear Prep			
SMEAR PRE	Stain/Procedure		
	PAP STAIN, SMEAR PREP	4	AUG 26, 1994 14:13
Cell Block			
CELL BLOC	Stain/Procedure		
	H & E STAIN	2/1	AUG 26, 1994 14:14

Data displayed ok ? NO// Y (YES)

**NOTE:** Based on this data, you will get seven labels using the Anat Path Slide Labels [LRAPLM] option, as follows:

CY	CY	CY	CY	CY	CY
94-5	94-5	94-5	94-5	94-5	94-5
SMEAR PRE	SMEAR PRE	SMEAR PRE	SMEAR PRE	CELL BLOC	CELL BLOC
H & E	H & E	H & E	H & E	H & E	H & E
VAMC578	VAMC578	VAMC578	VAMC578	VAMC578	VAMC578
CY	CY	CY	CY	CY	CY
94-5					
CELL BLOC					
H & E					
VAMC578	VAMC578	VAMC578	VAMC578	VAMC578	VAMC578

The 3rd line of the label defaults to the preparation technique. If you wish to have the specimen appear on the label, the default should be edited, rather than accepting the default as has been done in this example.

**Example 4: Data Entry for EM**

Select Anatomic pathology Option: **D** Data entry, anat path

Select Data entry, anat path Option: **BS** Blocks, Stains, Procedures, anat path

Select ANATOMIC PATHOLOGY section: **EM**

Enter year: 1992// <RET> ( 1992) 1992

Select Accession Number: **7** for 1992  
BOYD,PORTLAND ID: 539-84-0939

Date/time blocks prepared: NOW// <RET> (JAN 13, 1992@10:34)  
OK ? YES// <RET> (YES)

Date/time sections prepared: NOW// <RET> (JAN 13, 1992@10:34)  
OK ? YES// <RET> (YES)

BOYD,PORTLAND 0939 Acc #: 7 Date: JAN 13, 1992  
Count Last section/block date

KIDNEY

Epon Block

EPON 1	Stain/Procedure	JAN 13, 1992	10:34
GRID EM	5	JAN 13, 1992	10:34
THICK SECTION EM	2	JAN 13, 1992	10:34

Data displayed ok ? NO// **Y** (YES)

**Example 5: Date/Times are not in Sequence**

Select Anatomic pathology Option: **D** Data entry, anat path

Select Data entry, anat path Option: **Blocks**, Stains, Procedures, anat path

Select ANATOMIC PATHOLOGY section: **EM**

Enter year: 1992// **<RET>** ( 1992) 1992

Select Accession Number: **3** for 1992  
SMITH,JOHN Q ID: 123-45-6789

Date/time blocks prepared: NOW//**T@3A** (JAN 08, 1992@03:00) OK ? YES//**<RET>**  
Date/time must not be before date/time specimen received  
(JAN 08, 1992@14:50)

Select Accession Number: **3** for 1992  
SMITH,JOHN Q ID: 123-45-6789

Date/time blocks prepared: NOW//**T@1451** (JAN 08, 1992@14:51) OK ? YES//**<RET>**  
Date/time slides/grids prepared: NOW// **<RET>** (JAN 08, 1992@14:51)  
OK ? YES// **N** (NO)  
Date/time slides/grids prepared: NOW//**T@1450** (JAN 08, 1992@14:50)  
OK ? YES// **<RET>** (YES)  
Date/time must not be before date/time blocks prepared  
(JAN 08, 1992@14:51).

Select Accession Number: **3** for 1992  
SMITH,JOHN Q ID: 123-45-6789

Date/time blocks prepared: NOW//**T@1450** (JAN 08, 1992@14:50) OK ? YES// **<RET>**  
Date/time slides/grids prepared: NOW// **<RET>** (JAN 08, 1992@14:52)  
OK ? YES// **<RET>**

SMITH,JOHN Q 6789 Acc #: 3 Date: JAN 8, 1992

	Count	Last stain/block date
KIDNEY		
Epon Block		
EPON 1		
Stain/Procedure		
GRID EM	5	JAN 8, 1992 14:52
THICK SECTION EM	2	JAN 8, 1992 14:52

Data displayed ok ? NO// **Y** (YES)

Select Accession Number: **<RET>**

Select Data entry, anat path Option: **<RET>**

—

## AP Menu Options

### Example 6: More than one Specimen

Select Anatomic pathology Option: **DATA ENTRY**, anat path

Select Data entry, anat path Option: **BLOCKS**, Stains, Procedures, anat path

Select ANATOMIC PATHOLOGY section: **EM**

Enter year: 1992// **<RET>** ( 1992) 1992

Select Accession Number: **8** for 1992

ADAMS,HOUSTON ID: 121-22-3333

Date/time blocks prepared: NOW// **<RET>** (JAN 13, 1992@10:39) OK ? YES// **<RET>**  
(YES)

Date/time sections prepared: NOW// **<RET>** (JAN 13, 1992@10:39) OK ?  
YES//**<RET>**(YES)

ADAMS,HOUSTON 3333 Acc #: **8** Date: JAN 13, 1992

date	Count	Last section/block
SKIN		
Epon Block		
EPON 1		Stain/Procedure
		JAN 13, 1992 10:39
	5	GRID EM JAN 13, 1992 10:39
	2	THICK SECTION EM JAN 13, 1992 10:39
KIDNEY		
Epon Block		
EPON 1		Stain/Procedure
		JAN 13, 1992 10:39
	5	GRID EM JAN 13, 1992 10:39
	2	THICK SECTION EM JAN 13, 1992 10:39

Data displayed ok ? NO// **Y** (YES)

Coding, Anat Path [LRAPCODE]**SNOMED Coding, Anat Path [LRAPX]**

Although SNOMED coding is usually entered at the time the diagnosis is entered, it may be necessary to enter codes at a later time.

**Example:**

Select Anatomic pathology Option: **D** Data entry, anat path

Select Data entry, anat path Option: **CO** Coding, anat path

Select Coding, anat path Option: **SN** SNOMED coding, anat path

Select ANATOMIC PATHOLOGY section: **SP** SURGICAL PATHOLOGY

Enter Etiology, Function, Procedure & Disease ? NO// **<RET>** (NO)

Data entry for 1990 ? YES// **<RET>** (YES)

Select Accession Number/Pt name: **HUDSON,ALBANY** 05-08-16 366618472

HUDSON,ALBANY ID: 366-61-8472

AGE: 72 DATE OF BIRTH: MAY 8, 1916

PATIENT LOCATION: 1A// **<RET>**

Specimen(s)	Count #	Accession #	Date
SKIN	(1)	23	NOV 21, 1988 not verified
	(2)	22	NOV 20, 1988
PROSTATE CHIPS	(3)	22	JUN 4, 1986
	(4)	567	APR 5, 1982

More accessions ? NO// **<RET>** (NO)

Choose Count #(1-4): **3**

Accession #: 22 Date: JUN 4, 1990

DATE REPORT COMPLETED: JUN 4,1986// **<RET>**

Select ORGAN/TISSUE: **SKIN**

ORGAN/TISSUE: SKIN// **<RET>**

Select MORPHOLOGY: **PSORIASIS**

MORPHOLOGY: PSORIASIS// **<RET>**

Select MORPHOLOGY: **<RET>**

Select ORGAN/TISSUE: **<RET>**

Select Accession Number/Pt name: **<RET>**

Select Coding, anat path Option: **<RET>**

**NOTE:** At the "Enter Etiology, Function, Procedure & Disease ? NO//" prompt, a Y for "YES" allows you to enter etiology, procedure, or Disease codes.

## ICD9CM Coding, Anat Path [LRAPICD]

Use this option to enter or edit only the ICD9CM codes for the tissues of any existing accession. If this option doesn't seem to work correctly, check with your site manager. The ICD9CM globals may not have been loaded (possibly because of space shortages).

### Example:

```
Select Anatomic pathology Option: D Data entry, anat path
Select Data entry, anat path Option: CO Coding, anat path
Select Coding, anat path Option: SN ICD9CM coding, anat path
Select ANATOMIC PATHOLOGY section: SP SURGICAL PATHOLOGY
Data entry for 1990 ? YES// <RET> (YES)
Select Accession Number/Pt name: 22 HUDSON,ALBANY 05-08-16 366618472
Specimen(s):
BRONCH BRUSHINGS
DATE REPORT COMPLETED: JUN 4,1990// <RET>
Select ICD9CM DIAGNOSIS: 491.2 OBSTRUCT CHR BRONCHITIS
. . .OK? YES// NO
Select ICD9CM DIAGNOSIS: 491.9 CHRONIC BRONCHITIS
. . .OK? YES// <RET>
Select ICD9CM DIAGNOSIS: <RET>
Select Accession Number/Pt name: <RET>
Select Coding, anat path Option: <RET>
```

## Clinical Hx/Gross Description/FS [LRAPDGD]

Data entry in this option has been designed to mimic the information on the SF 515. During the log-in process, the specimen entry was an exact match for an entry in the LAB DESCRIPTIONS file (#62.5). The text entered in File #62.5 was thus stuffed into the Gross Description field for editing as shown below.

If the initials of the specific pathologist were included as part of the name, the specimen can then be edited to delete those initials. The gross description which was stuffed from File #62.5 during the log-in will be displayed for editing. By using the edit option, entering an asterisk (\*) at the "Replace" prompt, and the correct information at the "With" prompt, the entry process is greatly expedited. If the screen editor is on, then replacing the asterisk becomes very simple.

### **NOTES:**

- For both the Gross Description and the Microscopic Description word-processing fields, the text entered will automatically wordwrap unless a <RET> and a space are entered. The maximum length of a line is 255 characters. When data is first entered, it calculates the line length, based on the 255 character limit. If you wish to use the <RET> to control the appearance of the text on the screen, you may do so. However, when the report is printed, it will wordwrap and recalculate the lines. In order to prevent this, such as for a listing, you will need to enter at least one space at the beginning of the line. A space at the beginning of a line prevents that line from being joined to the one before it.
- In order to make editing of the gross description or microscopic description easier, enter "P" for print at the "Edit option" prompt. If you then request line numbers and a rough draft, word-processing text will print accordingly. If you enter "L" for List instead, it will list the text by line number on the screen, but will not provide the choice of a device.
- Sometimes you will try to enter a gross description for a specimen which was already logged in and the system will not accept the accession at the "Select Accession" prompt, yet it is obvious that the specimen was logged in with that number assigned. Probably the specimen was logged in using the option designed to enter old data and was not put in the accession file. You will need to go through the regular log-in process, select the same accession, and when the system indicates that it is in the patient file, but not in the accession file, indicate that you wish to add it to the accession file.
- The screen editor (from the new version of MailMan) can be used for any word processing field. Please consult your LIM on how to turn this feature on.

**Example 1: Entry of Information for Surgical Pathology/ASK FROZEN SECTION set to NO**

Select Anatomic pathology Option: **D** Data entry, anat path  
Select Data entry, anat path Option: **GD** Clinical Hx/Gross Description/FS  
Select ANATOMIC PATHOLOGY section: **SP** SURGICAL PATHOLOGY  
Data entry for 1988 ? YES// **<RET>** (YES)  
Select Accession Number/Pt name: **22** for 1988  
HUDSON,ALBANY ID: 366-61-8472  
Specimen(s):PROSTATE CHIPS  
Select SPECIMEN: PROSTATE CHIPS// **<RET>**  
SPECIMEN: PROSTATE CHIPS// **<RET>**  
Select SPECIMEN: **<RET>**  
BRIEF CLINICAL HISTORY:  
1>**Nocturia and difficulty voiding urine.**  
2> **<RET>**  
EDIT Option: **<RET>**  
PREOPERATIVE FINDINGS:  
1>**Same.**  
2> **<RET>**  
EDIT Option: **<RET>**  
OPERATIVE FINDINGS:  
1>**Same.**  
2>**<RET>**  
Edit line: 1  
Replace **A** **<RET>** With **a** **<RET>** Replace **<RET>**  
Same.  
Edit line: **<RET>**  
EDIT Option: **<RET>**  
POSTOPERATIVE DIAGNOSIS:  
1>**Same.**  
2> **<RET>**  
EDIT Option: **<RET>**  
RESIDENT PATHOLOGIST: **ANDERS,R.**  
GROSS DESCRIPTION:  
1>Specimen consists of \* grams of prostate gland tissue.  
EDIT Option: **1**  
1>Specimen consists of \* grams of prostate gland tissue.  
Replace \* **<RET>** With **25** **<RET>** Replace **<RET>**  
Specimen consists of 25 grams of prostate gland tissue.  
Edit line: **<RET>**  
EDIT Option: **<RET>**  
  
Select Accession Number/Pt name: **<RET>**



**Example 2: Entry of Information for a Surgical Pathology Specimen with a Frozen Section/ASK FROZEN SECTION set to YES**

Select Anatomic pathology Option: **D** Data entry, anat path  
 Select Data entry, anat path Option: **GD** Clinical Hx/Gross Description/FS  
 Select ANATOMIC PATHOLOGY section: **SP** SURGICAL PATHOLOGY

Data entry for 1992 ? YES// **<RET>** (YES)

Select Accession Number/Pt name: **26** for 1992  
 DUSTY,ANDY ID: 089-48-5948  
 Specimen(s):  
 LEFT NOSE BIOPSY

Select SPECIMEN: LEFT NOSE BIOPSY// **<RET>**

SPECIMEN: LEFT NOSE BIOPSY// **<RET>**

Select SPECIMEN: **<RET>**

BRIEF CLINICAL HISTORY:

1>**Exc BCC**

2> **<RET>**

EDIT Option: **<RET>**

PREOPERATIVE DIAGNOSIS:

1>**BCC**

2> **<RET>**

EDIT Option: **<RET>**

OPERATIVE FINDINGS:

1>**same**

2> **<RET>**

EDIT Option: **<RET>**

POSTOPERATIVE DIAGNOSIS:

1>**BCC**

RESIDENT PATHOLOGIST: **VADER, TED**

GROSS DESCRIPTION:

1>**SCO a round skin biopsy measuring 1 x 1 x 0.5 cm. There is an ill**

2>**defined depressed central lesion. A suture marks the superior margin**

3>**which is inked in red. Inferior margin is inked in green, anterior blue**

4>**and posterior uninked. Representative sections embedded.**

EDIT Option: **<RET>**

FROZEN SECTION:

1>**Basal cell CA, adequately excised.**

2>**Reported to Dr. Welby at x2420 at 10:55AM.**

EDIT Option: **<RET>**

Select Accession Number/Pt name: **<RET>**

## FS/Gross/Micro/Dx [LRAPDGM]

Use this option to enter just the microscopic descriptions and edit the gross tissue descriptions if necessary. If you enter a specimen name in the Log-in option, the Gross Description field in this option will be automatically filled with an expanded specimen description from the specimen description file.

The LAB DESCRIPTIONS file (#62.5) can also be useful for rapid entry of microscopic descriptions if the pathologists can agree on a standardized text for some of the "\*" (name as it appears in File #62.5), <RET> at line one, <RET> at line two and at the edit option. This will stuff the SPECIMEN DESCRIPTION into the Microscopic Description field for that specimen.

If some editing is required, you will need to re-enter the accession # at the next "Select Accession Number/Pt. name" prompt. When the microscopic description is redisplayed, the text which was copied from File #62.5 can be edited.

**NOTE:** Inclusion of the Frozen Section and Surgical Pathology Diagnosis fields in the edit template is controlled through the Edit Pathology Reports Parameters [LRAPHDR] option in the Supervisors Menu.

### **HINTS:**

1. Use of the space bar and <RET> will not expedite this process because it will only bring back the same patient and ask you to choose from a list of accessions for that patient.
2. This is **only** useful for entry of a SINGLE microscopic finding. If multiple specimens are submitted for which more than one micro must be entered, it may either be done manually OR use "\*" (name)" for the first, complete the remaining prompts and re-enter the accession number to add the remainder of the microscopic description.
3. You can identify cases requiring review by the Tissue Committee by adding the "TC Code" prompt. Use the Edit QA Site Parameters option if you wish to include this prompt in this edit template.

### **Example 1: Entry of Information for a Cytopathology Specimen**

Select Data entry, anat path Option: **GM** FS/Gross/Micro/Dx  
Select ANATOMIC PATHOLOGY section: **CY** CYTOPATHOLOGY

Data entry for 1990 ? YES// **<RET>** (YES)

Select Accession Number/Pt name: **23**  
WASHINGTON,GEORGE CHERRY ID: 012-45-8762  
Specimen(s)  
SPUTUM

GROSS DESCRIPTION:

1>**10cc of tan viscous material submitted**

MICROSCOPIC EXAM/DIAGNOSIS:

1>**Glomerular basement membranes are thickened and there is increased**

2>**mesangial matrix.**

3>**<RET>**

CYTOTECH: **GREEN**, JOHN

PATHOLOGIST: **WELBY**, JOE

DATE REPORT COMPLETED: TODAY// **<RET>** (DEC 01, 1989)

REVIEWED BY PATHOLOGIST: **YES**

Select Accession Number/Pt name: **<RET>**

**Example 2: Entry of Information for a Surgical Pathology Specimen with a Frozen Section**

Select Data entry, anat path Option: **GM** FS/Gross/Micro/Dx

Select ANATOMIC PATHOLOGY section: **SP** SURGICAL PATHOLOGY

Data entry for 1992 ? YES// **<RET>** (YES)

Select Accession Number/Pt name: **26** for 1992

DUSTY,RUSTY ID: 089-48-5948

Specimen(s):

LEFT NOSE BIOPSY

FROZEN SECTION:

1>Basal cell CA, adequately excised.

2>Reported to Dr. Welby at x2420 at 10:55AM.

EDIT Option: **<RET>**

GROSS DESCRIPTION:

1>SCO a round skin biopsy measuring 2 1 x 1 x 0.5 cm. There is an ill

2>defined depressed central lesion. A surface suture marks the superior

3>margin which is inked in red. Inferior margin is inked in green,

4>anterior blue and posterior uninked. Representative sections embedded.

5>**<RET>**

EDIT Option: **<RET>**

MICROSCOPIC EXAM/DIAGNOSIS:

1>**Residual basal cell carcinoma in biopsy site. Adequately excised. See**

2>**also S92-16.**

3> **<RET>**

EDIT Option: **<RET>**

PATHOLOGIST: GINS,RON// **<RET>**

DATE REPORT COMPLETED: **T** (DEC 03, 1992)

TC CODE: **1 1**

## FS/Gross/Micro/Dx/SNOMED Coding [LRAPDGS]

Once the pathologist dictates the microscopic description or frozen section description and returns the preliminary report, the data can be entered. The gross description appears first, providing an opportunity to make any necessary changes noted in the preliminary report. The diagnosis appears last.

For all the word-processing fields, the text entered will automatically wordwrap unless a <RET> and a space are entered. The maximum length of a line is 255 characters. When data is first entered, the line length is calculated, based on this limit. If you wish to use the <RET> to control the appearance of the text on the screen, you may do so. However, when the report is printed, it will wordwrap and recalculate the lines. In order to print this (e.g., for a listing), enter at least one space at the beginning of the line. A space before a character at the beginning prevents that line from being joined to the one before it.

To make editing of the report easier, enter “P” for Print at the “Edit option” prompt. If you then request line numbers and a rough draft, word-processing text will print accordingly. If you enter “L” for List instead, it will list the text by line number on the screen, but will not provide the choice of a device.

The LAB DESCRIPTIONS file (#62.5) can also be useful for rapid entry of microscopic descriptions if the pathologists can agree on a standardized text for some of the more common diagnoses. Entry of (\*) followed by the name as it appears in File #62.5 will stuff the SPECIMEN DESCRIPTION into the Microscopic Description field for that specimen. If some editing is required, you will need to reenter the accession # at the next “Select Accession Number/Pt. name” prompt. When the description is redisplayed, the text that was copied from File #62.5 can be edited.

Inclusion of the Frozen Section and/or Surgical Pathology Diagnosis (or Cytopathology, etc.) fields in the edit template is controlled by the Edit pathology parameters [LRAPHDR] in the Supervisors Menu.

### **HINTS:**

1. Use of the space bar and <RET> will not expedite this process because it will only bring back the same patient and ask you to choose from a list of accessions for that patient.
2. This is only useful for entry of a single microscopic finding. If multiple specimens are submitted for which more than one micro must be entered, you may either do it manually **or** use “\* (name)” for the first, complete the remaining prompts, and re-enter the accession number to add the rest of the microscopic description.

3. You can identify cases requiring review by the Tissue Committee by adding the "TC Code" prompt. Use the Edit QA Site Parameters option if you wish to include this prompt in this edit template. In the example below, the prompt is included.

**NOTES:**

- At the "TC CODE: 1/" prompt, enter numeric between 0 and 9. If a preset description is to be attached to the numeric code and is to be printed on the report generated by the Tissue Committee Review Cases option, this description can be entered into the LAB DESCRIPTIONS file (#62.5). This data is not included on any display or print option other than Tissue Committee Review Cases. It can be edited with the QA Code Entry/Edit option even if the report has been released, to prevent designation of the report as "modified."
- At the "Select ORGAN/TISSUE:" prompt, enter free text description or SNOMED code. Synonyms can be added for a particular code by using the appropriate edit option. Some topography codes are sex-specific and may not be selected if the patient sex is not appropriate.
- Two or more specimens with exactly the same name can be entered, by enclosing the entry in quotation marks for the second and subsequent specimens.

**Example:**

```
Select ORGAN/TISSUE: LIVER 56000 (SNOMED code appears since it is an
identifier)
      ORGAN/TISSUE NUMBER: 1// <RET>
```

The second time around:

```
Select ORGAN/TISSUE: "LIVER"
      ORGAN/TISSUE NUMBER: 2// <RET>
```

To subsequently select one of many of the same entries, choose by ORGAN/TISSUE NUMBER for that particular case (accession).

- For those Surgical Pathology specimens on which EM is being done, entering a comment at the end of the microscopic description to indicate the "EM#-Report to follow" will at least indicate that there will be an electron microscopy and a cross-reference for the SP report will be provided.
- If you wish to enter a disease SNOMED code only, simply enter ^DISEASE at the Morphology prompt to expedite the process.
- If the system doesn't recognize a MORPHOLOGY (but has accepted a TOPOGRAPHY) when you are entering SNOMED coding, you may have a spelling error, or the entry in the MORPHOLOGY file (#61.1) may be entered differently. You can look it up in the SNOMED coding manual and try to enter the actual code, or have the supervisor check the SNOMED reference file and add a new code if necessary.

**Example 1: Entry of Information for a routine Surgical Pathology Specimen**

Select Data entry, anat path Option: **GS** FS/Gross/Micro/Dx/SNOMED Coding

Select ANATOMIC PATHOLOGY section: **SP** SURGICAL PATHOLOGY

Enter Etiology, Function, Procedure & Disease ? NO// **<RET>** (NO)

Data entry for 1990 ? YES// **<RET>** (YES)

Select Accession Number/Pt name: **22** for 1990

HUDSON,ALBANY ID: 366-61-8472

Specimen(s) :

PROSTATE CHIPS

GROSS DESCRIPTION:

1>Specimen consists of 25 grams of prostate gland tissue.

EDIT Option: **<RET>**

MICROSCOPIC EXAM/DIAGNOSIS:

1>**Prostate gland tissue showing glandular and stromal hyperplasia. In one chip of 134 there is a small focus of well differentiated adenocarcinoma.**

2>**<RET>**

EDIT Option: **<RET>**

PATHOLOGIST: WELBY,MARCUS// **<RET>**

DATE REPORT COMPLETED: **NOV 20, 1990**

TC CODE: 1// ?

(ENTER: Numeric between 0 and 9.

TC CODE: 1// **<RET>**

Select ORGAN/TISSUE: **prostate** 77100

ORGAN/TISSUE NUMBER: 1// **<RET>**

WEIGHT (gm): **25**

Select MORPHOLOGY : **WDA** ??

Select MORPHOLOGY: **adenocarcinoma, well** DIFFERENTIATED 814031

Select MORPHOLOGY : **hyperplasia** 72000

Select MORPHOLOGY: **<RET>**

Select ORGAN/TISSUE: **<RET>**

Select Accession Number/Pt name: **<RET>**

## AP Menu Options

### **Example 2: Entry of Information for a Surgical Pathology Specimen with a Frozen Section**

Select Data entry, anat path Option: **GS** FS/Gross/Micro/Dx/SNOMED Coding

Select ANATOMIC PATHOLOGY section: **SP** SURGICAL PATHOLOGY

Enter Etiology, Function, Procedure & Disease ? NO// **Y** (YES)

Data entry for 1992 ? YES// **<RET>** (YES)

Select Accession Number/Pt name: **26** for 1992

DUSTY,ANDY ID: 089-48-5948

Specimen(s):

LEFT NOSE BIOPSY

This accession has a FROZEN SECTION report.

Be sure 'FROZEN SECTION' is entered as a SNOMED code in the PROCEDURE field for the appropriate organ or tissue.

FROZEN SECTION:

1>Basal cell CA, adequately excised.

2>Reported to Dr. Welby at x2420 at 10:55AM.

EDIT Option: **<RET>**

GROSS DESCRIPTION:

1>SCO a round skin biopsy measuring 1 x 1 x 0.5 cm. There is an ill

2>defined depressed central lesion. A suture marks the superior margin

3>which is inked in red. Inferior margin is inked in green, anterior blue

4>and posterior uninked. Representative sections embedded.

EDIT Option: **<RET>**

MICROSCOPIC EXAM:

1>Residual basal cell carcinoma in biopsy site. Adequately excised. See

2>also S92-16.

EDIT Option: **<RET>**

SURGICAL PATH DIAGNOSIS: **BASAL CELL CARCINOMA**

PATHOLOGIST: GINS,RON// **<RET>**

DATE REPORT COMPLETED: DEC 3,1992// **<RET>**

TC CODE: 1// **<RET>**

Select ORGAN/TISSUE: **02140** SKIN OF NOSE 02140

ORGAN/TISSUE NUMBER: 1// **<RET>**

Select MORPHOLOGY: **80903** BASAL CELL CARCINOMA 80903

Select ETIOLOGY: **<RET>**

Select MORPHOLOGY: **09400** SURGICAL MARGINS FREE OF TUMOR 09400

Select ETIOLOGY: **<RET>**

Select MORPHOLOGY: **<RET>**

Select FUNCTION: **<RET>**

Select PROCEDURE: **1141** BIOPSY, EXCISION 1141

Select PROCEDURE: **3082** FROZEN SECTION 3082

Select PROCEDURE: **<RET>**

Select DISEASE: **<RET>**

Select ORGAN/TISSUE: **<RET>**



**Example 3: .i.Using a Template to enter a Bone Marrow Report**

Select Data entry, anat path Option: **GS** FS/Gross/Micro/Dx/SNOMED Coding

Select ANATOMIC PATHOLOGY section: **SP** SURGICAL PATHOLOGY

Enter Etiology, Function, Procedure & Disease ? NO// **Y** (YES)

Data entry for 1992 ? YES// **<RET>** (YES)

Select Accession Number/Pt name: **26** for 1992

HUDSON,ALBANY ID: 366-61-8472

Specimen(s):

BONE MARROW

GROSS DESCRIPTION:

1 **<RET>**

MICROSCOPIC EXAM/DIAGNOSIS:

1> **\*BONE MARROW**

**NOTE:** Enter a "\*" followed by the entry name in the LAB DESCRIPTION file (#62.5). Please see the example under Enter/Edit Lab Description file option under the Supervisor Menu.

2>**<RET>**

EDIT Option: **<RET>**

**After completing the prompts, recall the same accession and you will see the specimen description from the entry in the lab description file in the Microscopic Exam/Diagnosis field:**

Select Accession Number/Pt name: 26 for 1992

HUDSON,ALBANY ID: 366-61-8472

Specimen(s):

BONE MARROW

GROSS DESCRIPTION:

1 **<RET>**

MICROSCOPIC EXAM/DIAGNOSIS:

1> **BONE MARROW**

...

18> DIAGNOSIS:\*

19>**<RET>**

20> COMMENT:\*

EDIT Option: **E**

## AP Menu Options

EDIT Option: 2

2> Polys:\*

Replace \* with 8 Replace <RET>

Polys: 8

Edit line: 3

3> Bands:\*

Replace \* With 0 Replace <RET>

Bands: 0

Edit line: 4

4> Lymphs:\*

Replace \* With 90 Replace <RET>

Lymphs: 90

Edit line: 5

5> Monos:\*

Replace \* With 2 Replace <RET>

Monos: 2

Edit line: 6

6> Eosins:\*

Replace \* With 0 Replace <RET>

Eosins: 0

Edit line: 7

7> Basos:\*

Replace \* With 0 Replace <RET>

Basos: 0

Edit line: 14

14>PERIPHERAL BLOOD:\*

Replace \* With **Lymphocytes markedly increased with frequent smudge cells. Lymphocytes maturing with smudged chromatin and only rare nuclei. Platelets adequate.**

Replace <RET>

PERIPHERAL BLOOD: Lymphocytes markedly increased with frequent smudge cells. Lymphocytes maturing with smudged chromatin and only rare nuclei. Platelets adequate.

Edit line: 16

16>BONE MARROW:\*

Replace \* With **1. Advance lymphoid infiltrate.** Replace <RET>

BONE MARROW: 1. Advanced lymphoid infiltrate.

Edit line: insert after line: 16

16>**BONE MARROW: 1. Advanced lymphoid infiltrate.**

17> **2. Decreased cellular elements.**

18> **3. Decreased stainable iron.**

19><RET>

2 lines inserted.....

EDIT Option: 20

20>DIAGNOSIS:\*

Replace \* With **Chronic lymphocytic leukemia (see comment) with extensive diffuse bone marrow infiltrate.** Replace <RET>

DIAGNOSIS: Chronic lymphocytic leukemia (see comment) with extensive diffuse bone marrow infiltrate.

EDIT Option: 22

22>COMMENT:\*

Replace \* With **The bone marrow shows advanced lymphocytic infiltration.**

Replace <RET>

COMMENT: The bone marrow shows advanced lymphocytic infiltration.

Edit line: insert after line: 22

22>COMMENT: **The bone marrow shows advanced lymphocytic infiltration.**

23>Recommend iron replacement trial to rule out component of iron

24>deficiency in etiology of the observed anemia. Correlate with serum

25>ferritin levels. There is no evidence of transformation to a more

26>aggressive histological type.

27><RET>

4 lines inserted.....

EDIT Option: <RET>

PATHOLOGIST: SPOCK, BENJAMIN, M.D.// <RET>

DATE REPORT COMPLETED: JUN 28, 1988// <RET>

*[The final report is shown below]*

-----  
MEDICAL RECORD : SURGICAL PATHOLOGY Pg 1  
-----

Submitted by: MARCUS WELBY Date obtained: JUN 28, 1988  
-----

Specimen:

LT. POSTERIOR ILIAC CREST BX.  
BONE MARROW ASPIRATE  
-----

Brief Clinical History:

Patient with newly diagnosed (7/87) CLL with gastric involvement at time of Biliroth in 7/87 with progressive anemia/decreased Ct. borderline FL studies.  
-----

Preoperative Diagnosis:

Operative Findings:

Postoperative Diagnosis:

Surgeon/physician: MARCUS WELBY  
=====

PATHOLOGY REPORT

Laboratory: St. Elsewhere VAMC Accession No. 12  
Gross description Pathology Resident BENJAMIN SPOCK

1. Specimen consists of a single cylindrical fragment of bone tissue measuring 0.8 x 0.2 cm. Entire specimen submitted after decalcification.
2. Specimen consists of multiple dark tan soft elongated to irregular fragments of tissue measuring 1.3 x 0.4 x 0.2 cm. Entire specimen submitted in 1 cassette.

Microscopic exam/diagnosis:

DIFFERENTIAL:

Polys:8  
Bands:0  
Lymphs:90  
Monos:2  
Eosins:0  
Basos:0  
Blasts:0  
Promyel:0  
Myelos:0  
Metas:0

PERIPHERAL BLOOD: Lymphocytes markedly increased with frequent smudge cells. Lymphocytes maturing with smudged chromatin and only rare nuclei. Platelets adequate.

- BONE MARROW:
1. Advanced lymphoid infiltrate.
  2. Decreased cellular elements.
  3. Decreased stainable iron.

DIAGNOSIS: Chronic lymphocytic leukemia (see comment) with extensive diffuse bone marrow infiltrate.

COMMENT: The bone marrow shows advanced lymphocytic infiltration. Recommend iron replacement trial to rule out component of iron deficiency in etiology of the observed anemia. Correlate with serum ferritin levels. There is no evidence of transformation to a more aggressive histological type.

SNOMED code(s):

T-06000: bone marrow

M-98233: chronic lymphoid leukemia

D-4010 : anemia

F-10364 : iron stores, bone marrow, decreased (t-06000)

-----  
(End of report)

MARCUS WELBY MD

rg: Date NOV 20, .1990

-----  
HUDSON, ALBANY

SURGICAL PATHOLOGY Report

ID:366-61-8472 SEX:M DOB:5/8/16 AGE: 74 LOC: 1A JOE WELBY MD

## AP Menu Options

### **Example 4:** Using a Template to Enter a Bethesda system Report for a Cytology

Select Data entry, anat path Option: **GS** FS/Gross/Micro/Dx/SNOMED Coding

Select ANATOMIC PATHOLOGY section: **CY** CYTOPATHOLOGY

Enter Etiology, Function, Procedure & Disease ? NO// **<RET>** (NO)

Data entry for 1992 ? YES// **<RET>** (YES)

Select Accession Number/Pt name: **6** for 1992

AZINGER,MARY ID: 234-56-7890

Specimen(s):

CERVICOVAGINAL SMEAR

GROSS DESCRIPTION:

1>Two smears received.

EDIT Option: **<RET>**

MICROSCOPIC EXAM/DIAGNOSIS:

1>**\*BETHESDA**

**NOTE:** enter a "\*" followed by the entry name in the LAB DESCRIPTION file (#62.5). Please see the example under Enter/Edit Lab Description file option under the Supervisor Menu.

2>**<RET>**

EDIT Option: **<RET>**

*[After completing the prompts recall the same accession and you will see the specimen description from the entry in the lab description file in the Microscopic Exam/Diagnosis field:]*

Select Accession Number/Pt name: **6** for 1992

AZINGER,MARY ID: 234-56-7890

Specimen(s):

CERVICOVAGINAL SMEAR

GROSS DESCRIPTION:

1>Two smears received.

EDIT Option: **<RET>**

MICROSCOPIC EXAM/DIAGNOSIS:

1>Statement on Specimen Adequacy

2> ( ) Satisfactory for interpretation

3> ( ) Less than optimal

4> ( ) Unsatisfactory

**5> <RET>**

6> Explanation for less than optimal/unsatisfactory specimen:

7> ( ) Scant cellularity

8> ( ) Poor fixation or preservation

9> ( ) etc.

EDIT Option:**<RET>**

FS/Gross/Micro/Dx ICD9CM [LRAPDGI]

This option allows review of gross specimen and frozen section description, entry of microscopic description and diagnosis and ICD9CM coding for each accession number. If this option doesn't seem to work correctly, check with your site manager; the ICD9CM globals may not have been loaded (possibly because of space shortages).

You can identify cases requiring review by the Tissue Committee by adding the "TC Code" prompt. Use the Edit QA Site Parameters option if you wish to include this prompt in this edit template. In the example below, the prompt is not included.

**Example:**

Select Data entry, anat path Option: **GI** FS/Gross/Micro/Dx/ICD9CM Coding

Select ANATOMIC PATHOLOGY section: **CY** CYTOPATHOLOGY

Data entry for 1990 ? YES// **<RET>** (YES)

Select Accession Number/Pt name: **1** for 1990

BEAR,YOGI ID: 004-95-8671

Specimen(s):

SPUTUM

GROSS DESCRIPTION:

1>Specimen consists of 15 ml of serous milky fluid.

EDIT Option:**<RET>**

MICROSCOPIC EXAM/DIAGNOSIS:

1>No lower respiratory elements are found.

2>

3>DIAGNOSIS: SPUTUM: UNSATISFACTORY

4> **<RET>**

EDIT Option: **<RET>**

CYTOTECH: **GREEN,JOE**

PATHOLOGIST: SQUEEGER,TONY//**<RET>**

DATE REPORT COMPLETED: MAY 12,1989//**<RET>**

REVIEWED BY PATHOLOGIST: YES//**<RET>**

Select ICD DIAGNOSIS: **786.4** 786.4 ABNORMAL SPUTUM

...OK? YES// **<RET>** (YES)

ICD DIAGNOSIS: 786.4//**<RET>**

Select ICD DIAGNOSIS:**<RET>**

Number of slides: 4 //**<RET>**

Number paraffin blocks: 1 //**<RET>**

Select Accession Number/Pt name: **<RET>**

## Enter Old Anat Path Records[LRAPOLD]

Entry of old cases from the “Card file” can be accomplished in several different ways, as follows:

- a) If you do not have sufficient secretarial resources to tackle the whole file, you may decide to enter the historical data on a case-by-case basis as new specimens are received. If so, you will probably need to resolve who will be assigning SNOMED codes to the diagnosis found on the cards. If the old cards are pulled and given to the pathologist with the gross descriptions of the current specimen, the pathologist would have access to the previous information and could do that coding at the same time. The old data could then be entered on that patient, making the cumulative summary comprehensive.
- b) If you have the secretarial resources, then the file can be tackled straightforwardly.

There are two ways to enter the old cases:

**Method A:** There is the direct option of entering “Old cases” and doing the coding in one pass. This is the quickest. However, if you feel that the physician may want to be aware of prior specimen diagnoses, the data will not be found in the option Pathology report for a patient if it is entered through this option. It will show up on the Cumulative Path Report option in the Anatomic Menu and with the gross description print options.

**Method B:** If you want recent old cases available for physician review, then they will have to be individually accessioned and coded. This requires an additional step, plus the extra step of clearing the print queues (unless you want to document the results of the accessioning/coding process).



**Example: Enter Old Anat Path Records**

Select Data entry, anat path Option: **OR** Enter old anat path records

This option skips entering accession number in the Accession Area file.

Is this what you want ? NO// **Y** (YES)

Select ANATOMIC PATHOLOGY section: SURGICAL PATHOLOGY

Enter Etiology, Function, Procedure & Disease ? NO// **<RET>** (NO)

Enter Special Studies ? NO// **<RET>** (NO)

Select Patient Name: HUDSON,ALBANY 05-08-16 366618472

HUDSON,ALBANY ID: 366-61-8472

AGE: 72 DATE OF BIRTH: MAY 8, 1916

PATIENT LOCATION: 1A// **<RET>**

Date (must be exact) specimen taken: **5 6 90** (MAY 06, 1990)

Enter Accession number: **123**

Ac #123 in SURGICAL PATHOLOGY FILE for 90

Patient: HARE,MARCH ID: 433-43-3333

Enter Accession number: **566**

DATE REPORT COMPLETED: MAY 7, 1990// **<RET>** (MAY 07, 1986)

PATHOLOGIST: **FRANKENSTIEN, HAROLD**

Select ORGAN/TISSUE: **SKIN** 01000

ORGAN/TISSUE NUMBER: 1// **<RET>**

Select MORPHOLOGY: **43000** CHRONIC INFLAMMATION 43000

Select MORPHOLOGY: **<RET>**

Select ORGAN/TISSUE: **<RET>**

Select COMMENT: **<RET>**

Date (must be exact) specimen taken: **<RET>**

Select Patient Name: **<RET>**

Select Data entry, anat path Option: **<RET>**

**NOTE:** If you attempt to enter a surgical pathology number, but the system rejects it as already existing, there was probably a clerical error. Go into the option Print Log Book and enter the appropriate information to display what the system has recorded for the SP number in question. The system will display the usual information and you can resolve with which patient the number actually belongs. The fact that the data was entered through [LRAPOLD] and the accession is not in the accession file does not prohibit it from being accessible through this option.

## Supplementary Report, Anat Path[LRAPDSR]

Any additional studies or supplemental information can be entered using either the Special Studies option or the Supplementary Report option. The Supplementary Report offers only the date/time of the report and a single free-text field. Data entered in this field will be deleted when the descriptions are deleted. The Special Studies option is more restrictive in its application. However, data entered is not deleted when descriptions are deleted. It can then be used for searches, etc. at some time in the future. Entry of data will place either report in the final report print queue, but supplemental reports must be “released” before the information is available.

### **HINT:**

AFIP case information can be entered as a Special Study by designating “Consultation” as the type of study.

### **Example: Supplementary Report**

```
Select Anatomic pathology Option: D Data entry, anat path
Select Data entry, anat path Option: SR Supplementary Report, Anat Path
Select ANATOMIC PATHOLOGY section: SP SURGICAL PATHOLOGY
Enter Etiology, Function, Procedure & Disease ? NO// <RET>
Data entry for 1988 ? YES// <RET> (YES)
Select Accession Number/Pt name: 23 for 1990
HUDSON,ALBANY ID: 366-61-8472
Specimen(s):
SKIN

DATE REPORT COMPLETED: NOV 21, 1990// <RET>
Select SUPPLEMENTARY REPORT DATE/TIME: N NOV 21, 1988 11:00
DESCRIPTION:
  1>This is an example of a supplementary report. It can be used to report
  2>the results of recuts
  3><RET>
EDIT Option: <RET>
Select ORGAN/TISSUE: <RET>
Select Accession Number/Pt name: 23 for 1990
HUDSON,ALBANY ID: 366-61-8472
Specimen(s):
SKIN

DATE REPORT COMPLETED: NOV 21,1990// <RET>
Select SUPPLEMENTARY REPORT DATE/TIME: NOV 21, 1990@11:00
// N NOV 21, 1990 11:01
DESCRIPTION:
  1>There can be more than one supplementary report.
  2><RET>
EDIT Option: <RET>
```

**Example: Supplementary Final Report**

MEDICAL RECORD : SURGICAL PATHOLOGY Pg 1

-----  
 Submitted by: JOE WELBY MD Date obtained: NOV 21, 1990  
 -----

Specimen:  
 SKIN  
 -----

Brief Clinical History:  
 Scaly eruption on extensor surfaces of forearms.  
 -----

Preoperative Diagnosis:  
 Psoriasis  
 -----

Operative Findings:  
 Psoriasis  
 -----

Postoperative Diagnosis:  
 Same Surgeon/physician: JOE WELBY MD  
 =====

PATHOLOGY REPORT

Laboratory: R5ISC Accession No. SP90 23  
 -----

Gross description: Pathology Resident: RUSTY KNAIL  
 3mm punch biopsy of skin  
 -----

Microscopic exam/diagnosis:  
 Skin and subjacent tissue showing parakeratosis, elongation and blunting of  
 rete ridges, and neutrophilic abscesses in the parakeratotic layer  
 consistent with psoriasis.

Supplementary Report:  
 Date: NOV 21, 1990 11:00  
 This is an example of a supplementary report. It can be used to report the  
 results of re-cuts, special stains, etc.

Date: NOV 21, 1990 11:01  
 There can be more than one supplementary report.

CONSULTATION AFIP#123456789 Date: NOV 21, 1990

SKIN

This is a description of the findings of EM study.  
 -----

(See next page)

Pathologist: HAROLD FRANKENSTIEN MD rg: Date NOV 21, 1990  
 -----

HUDSON, ALBANY SURGICAL PATHOLOGY Report  
 ID:366-61-8472 SEX:M DOB:5/8/16 AGE:72 LOC:1A  
 JOE WELBY MD

## Special Studies-EM;Immuno;Consult;pic, Anat Path [LRAPDSS]

The special studies option under the data entry menu is useful for entering consultations. For example, if a specimen is sent to AFIP, you can enter it as a consultation; enter AFIP 1234 as the ID and the AFIP report date. It is probably a major waste of time to actually enter the report under the word-processing field since the actual report (hard copy) is charted and filed with the surgical path (cytology, etc.) report.

This data is included on the cum path data summary and the second page of the preliminary report. It is not archived/purged. Additional programming allows searching on these fields. In other words, you can request a search of a specified topography and morphology with a particular special study.

Any additional studies or supplemental information can be entered using either the Special Studies option or the Supplementary Report option. The Supplementary Report offers only the date/time of the report and a single free-text field. Data entered in this field will be deleted when the descriptions are deleted. The Special Studies option is more restrictive in its application; however, data entered is not deleted when descriptions are deleted. For both options, entry of data will place the report in the final report print queue.

Cases cannot be retrieved in the future based solely on the special studies information. In order to use the search options to retrieve cases, you will need to enter a procedure code also. For example, for Immunoperoxidase studies, additional programming accommodates entry of test results for specific procedure codes if so defined in the PROCEDURE FIELD file (#61.5). For consultations such as AFIP, SERS, and SERA, cases can be retrieved using the AP Consultation Searches and Reports [LRAPQACN] option in the Supervisor's Menu **if** the procedure codes are entered.

**Example:**

Select Data entry, anat path Option: **SS** Spec Studies-EM;Immuno;Consult;Pic,  
Anat Path

Select ANATOMIC PATHOLOGY section: **SP** SURGICAL PATHOLOGY

Data entry for 1990 ? YES// **<RET>** (YES)

Select Accession Number/Pt name: **23** for 1990

HUDSON,ALBANY ID: 366-61-8472

Specimen(s):

SKIN

DATE REPORT COMPLETED: NOV 21,1990// **<RET>**

Select ORGAN/TISSUE: SKIN// **<RET>**

Select SPECIAL STUDIES: ?

ANSWER WITH SPECIAL STUDIES

YOU MAY ENTER A NEW SPECIAL STUDIES, IF YOU WISH

CHOOSE FROM:

E ELECTRON MICROSCOPY

I IMMUNOFLUORESCENCE

P PHOTOGRAPHY

C CONSULTATION

F FROZEN SECTION

IP IMMUNOPEROXIDASE

Select SPECIAL STUDIES: **C** (CONSULTATION)

SPECIAL STUDIES ID #: **AFIP#123456789**

DATE: **T** (NOV 21, 1990)

ID #: **AFIP#123456789**

DESCRIPTION:

1>**This is an example of a consultation sent to the AFIP.**

2>**<RET>**

EDIT Option: **<RET>**

Select SPECIAL STUDIES:**<RET>**

Select PROCEDURE: Y333 (ADMINISTRATION OF MEDICATION, EMERGENCY)

Select ORGAN/TISSUE: **<RET>**

Select Accession Number/Pt name:**<RET>**

**NOTE:** A procedure from the Procedure field list or a SNOMED code must be entered at the "Select PROCEDURE" prompt for the report to show up in the search option.

## **Edit/Modify Data, Anat Path [LRAPE]**

### Descriptions

<b>Menu Item</b>	<b>Description</b>
Edit Log-In & Clinical Hx Anat Path	Edit entries in accessions that have been logged in for autopsy, cytopath, EM, or surgical path, but that have no descriptive or diagnostic data entered yet.
Modify Anat Path Gross/Micro/Dx Frozen Section	Allows changing microscopic description and diagnosis after the report has been released. A record is kept of the premodified text, date of change and who made the change. *** MODIFIED REPORT *** will appear on the report.
Edit Anat Path Comment	Allows editing of the accession comments for surg path, cytopath, and electron microscopy sections. The comments will appear on the log book for the appropriate section.

## Edit Log-In & Clinical Hx Anat Path [LRAPED]

You may change entries in accessions that have been logged in for autopsy, cytopath, EM, or surgical path, but have no descriptive or diagnostic data entered yet. For each accession number you may select multiple specimens to edit. In order to edit accessions which have been completed but not released, it is necessary to delete the completion date first.

For quality assurance review purposes, a new field Treating Specialty At Death has been added (63,14.6) for autopsies. If all of the data is entered, it is possible to have data on deaths sort by Service, Treating Specialty and Physician using the QA Outcome Review Cases [LRAPQOR] option in the Supervisor's Menu.

### **Example 1:**

Select Anatomic pathology Option: **E** Edit/modify data, anat path

Select Edit/modify data, anat path Option: **LI** Edit log-in data & clinical hx, anat path

Select ANATOMIC PATHOLOGY section: **SP** SURGICAL PATHOLOGY

EDIT SURGICAL PATHOLOGY Log-In/Clinical Hx for 1990 ? YES// **<RET>** (YES)

Enter SURGICAL Accession #: **23**

HUDSON,ALBANY ID: 366-61-8472 OK ? YES// **<RET>** (YES)

Specimen date: NOV 21, 1990

Report released or completed. Cannot edit Log-in data.

Enter SURGICAL Accession #: **24**

ADAMS,SAM ID: 432-99-4321 OK? YES// **<RET>** (YES)

Specimen date: NOV 21, 1990

PATIENT LOCATION: 1A// **<RET>**

SURGEON/PHYSICIAN: JONES,JAMES// **<RET>**

SPECIMEN SUBMITTED BY: JAMES JONES // **<RET>**

Select SPECIMEN: HERNIA SAC// **<RET>**

SPECIMEN: HERNIA SAC// **<RET>**

Select SPECIMEN: **<RET>**

BRIEF CLINICAL HISTORY:

1>**<RET>**

PREOPERATIVE DIAGNOSIS:

1>

OPERATIVE FINDINGS:

1>**<RET>**

POSTOPERATIVE DIAGNOSIS:

1>**<RET>**

DATA/TIME RECEIVED: NOV 21, 1988@08:58// **<RET>**

PATHOLOGIST: FRANKENSTIEN,HAROLD// **<RET>**

RESIDENT PATHOLOGIST: ZONC,ELMO LEE// **<RET>**

Select COMMENT: **<RET>**

Enter SURGICAL Accession #: **<RET>**

## AP Menu Options

### Example 2:

Select Anatomic pathology Option: **E** Edit/modify data, anat path

Select Edit/modify data, anat path Option: **LI** Edit log-in data & clinical hx, anat path

Select ANATOMIC PATHOLOGY section: **AU** AUTOPSY

EDIT AUTOPSY Log-In/Clinical Hx for 1992 ? YES// **<RET>** (YES)

Enter AUTOPSY Accession #: 4

BLOCK,JOSEPH ID: 324-12-3456 OK ? YES// **<RET>** (YES)

Edit Weights & Measurements ? NO// **<RET>** (NO)

Date Died: NOV 25, 1992

AUTOPSY DATE/TIME: NOV 26,1992// **<RET>**

LOCATION: 1A// **<RET>**

SERVICE: SURGERY// **<RET>**

TREATING SPECIALITY AT DEATH: CRITICAL CARE UNIT// **<RET>**

PHYSICIAN: WELBY,MARCUS// **<RET>**

RESIDENT PATHOLOGIST: GINS,RON// BAD,ED

SENIOR PATHOLOGIST: BAD,ED// GINS,RON

AUTOPSY TYPE: FULL AUTOPSY// **<RET>**

AUTOPSY ASSISTANT: ZONC,ELMO LEE// **<RET>**

Enter AUTOPSY Accession #: **<RET>**



## Modify Anat Path Gross/Micro/Dx/Frozen Section [LRAPM]

Once a report has been completed and released, the data entry options previously used to enter the data can no longer be accessed. Once modified, the report is placed back into the print queue again for reprinting and must be re-released. This report will indicate that it is a modified report. For those cases in which a question arises as to the exact change, both the old and the new report information can be obtained using the Print Path Micro/Dx Modifications [LRAPMOD] option. However, this data only remains in the system until the descriptions are deleted.

### **Example 1: Modify Anat Path Gross/Micro/Dx/Frozen Section**

Select Edit/modify data, anat path Option: **MM** Modify anat path gross/micro/dx/frozen section

Select ANATOMIC PATHOLOGY section: **SP** SURGICAL PATHOLOGY

Modify data for 1994 ? YES// **<RET>** (YES)

Select Accession Number/Pt name: **2** for 1994

ARDEN,TOM ID: 241-22-0000

Specimen(s):

PROSTATE CHIPS

1. MODIFY GROSS DESCRIPTION
2. MODIFY MICROSCOPIC DESCRIPTION
3. MODIFY DIAGNOSIS
4. MODIFY FROZEN SECTION

CHOOSE (1-4): **2**

Are you sure you want to modify MICROSCOPIC DESCRIPTION text ? NO// **Y** (YES)

MICROSCOPIC DESCRIPTION:

1>Glomerular basement membranes are thickenedd and there is increased mesangial matrix.

EDIT Option: **Addlines**

2>**Also present are small prostatic infarcts and foci of squamous metaplasia.**

3>**<RET>**

EDIT Option: **<RET>**

### **NOTES:**

- The report immediately becomes a “modified report” upon selection of the accession, regardless of the type of change entered.
- Once any portion of the report is modified, the status of the accession changes to being unreleased. Once the modification is reviewed and approved by the pathologist, it must be rereleased using the Verify/Release reports [LRAPR] option.
- The text of both the original and the modifications can be reviewed and/or maintained in hard copy using the Print Path Micro/Dx Modifications [LRAPMOD] option in the Supervisor’s Menu. However, these modifications are retrievable by patient, not by date modified. These modifications remain in the system until the descriptions are purged using the Delete Anat Path Descriptions by Date [LRAPHDAR] option.

## AP Menu Options

### Example 2: Report Printout

Select Print, anat path Option: **PS** Print single report only

Select ANATOMIC PATHOLOGY section: **SP** SURGICAL PATHOLOGY

1. Preliminary reports
2. Final reports

Select 1 or 2 : **2**

#### SURGICAL PATHOLOGY FINAL PATIENT REPORTS

Select Patient Name: ARDEN,TOM 02-01-22 241220000 NO NSC VETERAN  
ARDEN,EVE ID: 241-22-0000 Physician: QUACK,IMA

AGE: 72 DATE OF BIRTH: FEB 1, 1922

Ward on Adm: 1 EAST Service: MEDICINE

Adm Date: APR 8, 1993 10:53 Adm DX: DIAGNOSIS

Present Ward: 1 EAST MD: WELBY,JOE

Specimen(s)	Count #	Accession #	Date Obtained
verified LEFT LEG	( 1)	7	AUG 25, 1994 not
verified left hip chip	( 2)	6	AUG 25, 1994 not
PROSTATE CHIPS	( 3)	2	AUG 24, 1994

Choose Count #(1-3): **3**

Accession #: 2 Date Obtained: AUG 24, 1994

Print SNOMED &/or ICD codes on report ? NO// **<RET>** (NO)

Select Print Device: **[Enter Print Device Here]**

-----  
MEDICAL RECORD |

SURGICAL PATHOLOGY

Pg 1  
-----

Submitted by: RAY ROGERS MD

Date obtained: AUG 24, 1994  
-----Specimen (Received AUG 24, 1994 10:37):  
PROSTATE CHIPS  
-----Brief Clinical History:  
Nocturia and difficulty voiding urine.  
-----Preoperative Diagnosis:  
same.  
-----Operative Findings:  
same.  
-----Postoperative Diagnosis:  
same.  
-----Surgeon/physician: AMY NORTH MD  
=====

## PATHOLOGY REPORT

Laboratory: VAMC

Accession No. SP 94 2  
-----

Pathology Resident: ELMO LEE ZONC MD

Frozen Section:  
Basal cell CA.Gross Description:  
Specimen consists of 5 grams of prostate gland tissue.

Microscopic exam/diagnosis:

\*\*\* MODIFIED REPORT \*\*\*

(Last modified: AUG 27, 1994 17:30 typed by PEREZ,ELSIE)

Glomerular basement membranes are thickened and there is increased mesangial matrix. Also present are small prostatic infarcts and foci of squamous metaplasia. Another small infarct and foci of squamous metaplasia.

Supplementary Report:

Date: AUG 26, 1994 18:09

This is an example of a supplementary report. It can be used to report the results of recuts.

Date: AUG 26, 1994 18:10  
-----

RAY ROGERS MD

(See next page)  
ec | Date AUG 25, 1994  
-----

ARDEN, TOM

STANDARD FORM 515

ID:241-22-0000 SEX:F DOB:2/1/22 AGE:72 LOC:1 EAST

ADM:APR 8, 1993 DX:DIAGNOSIS

RAY ROGERS MD

AP Menu Options

-----  
MEDICAL RECORD | SURGICAL PATHOLOGY Pg 2  
-----

PATHOLOGY REPORT  
Laboratory: VAMC Accession No. SP 94 2  
-----

This is another supplementary report.

CONSULTATION AFIP#123456789 Date: AUG 26, 1994 18:17  
PROSTATIC FASCIA

This is an example of a consultation sent to the AFIP.

-----  
JOSEPH MARTIN MD (End of report)  
ec | Date AUG 25, 1994  
-----

ARDEN, TOM STANDARD FORM 515  
ID:241-22-0000 SEX:F DOB:2/1/22 AGE:72 LOC:1 EAST  
ADM:APR 8, 1993 DX:DIAGNOSIS RAY ROGERS MD

## Edit Anat Path Comments [LRAPEDC]

Restrictions in the code prohibit access to this field once the report had been verified/released. Since this field does not appear on the final report, but is included on the log book used internally, the comment field can be used for a variety of purposes. This option allows editing of the accession comments for surg path, cytopath and electron microscopy sections even if the reports have been released. The comments will appear on the log book for the appropriate section until such time as the descriptions are purged.

### **Example 1:** Enter/edit Specimen Comment(s)

Select Anatomic pathology Option: **SC** Edit anat path comments

Select ANATOMIC PATHOLOGY section: **SP** SURGICAL PATHOLOGY

1. Enter/edit specimen comment(s) *[New]*

2. Enter/edit delayed report comment(s) *[New]*

CHOOSE (1-2): **1** *[New]*

EDIT SURGICAL PATHOLOGY specimen comments for 1990 ? YES// **<RET>** (YES)

Enter SURGICAL Accession #: **22**

HUDSON,ALBANY ID: 366-61-8472 OK ? YES// **<RET>** (YES)

Specimen date: NOV 20, 1990

Select COMMENT: This comment will appear on the log book.

// **And so will this one**

Select COMMENT: ?

ANSWER WITH COMMENT

CHOOSE FROM:

1 This comment will appear on the log book.

2 And so will this one

YOU MAY ENTER A NEW COMMENT, IF YOU WISH

ANSWER MUST BE 1-75 CHARACTERS IN LENGTH

Select COMMENT: **<RET>**

On Surgical Pathology reports, a list of all other staff pathologists who have been shown the case, as well as consultants, can be entered into the log-in comment field, for the accession to indicate additional review. It might also be advantageous to include a line to record the name of the clinician and the time contacted on initial malignant specimens.

## AP Menu Options

### Report: Print Log Book

Select Log-in menu, anat path Option: **PB** Print log book

Select ANATOMIC PATHOLOGY section: **SP** SURGICAL PATHOLOGY

SURGICAL PATHOLOGY LOG BOOK

Print SNOMED codes if entered ? NO// **<RET>** (NO)

Log book year: 1990 OK ? YES// **<RET>** (YES)

Start with Acc #: **22**

Go to Acc #: LAST // **<RET>**

Select Print Device: *[Enter Print Device Here]*

NOV 30, 1990 10:40 VAMC Pg: 1

SURGICAL PATHOLOGY LOG BOOK for 1990

# =Demographic data in file other than PATIENT file

Date	Num	Patient	ID	LOC	PHYSICIAN	PATHOLOGIST
------	-----	---------	----	-----	-----------	-------------

11/20	22	HUDSON,ALBANY	8472	1 EAST	MARTIN,JOE	WELBY,JOE
-------	----	---------------	------	--------	------------	-----------

Date specimen taken:10/24/90 Entered by:PEREZ,ELSIE

Released by:PEREZ,ELSIE

PROSTATE CHIPS

This comment will appear on the log book.

And so will this one

**This would provide documentation for quality assurance purposes as well as for general information. In order to get this information incorporated into the final copy, the information described should be entered in the Microscopic Description field.**

### Example 2: Enter/Edit Delayed Report Comment(s)

Select Edit/modify data, anat path Option: **SC** Edit anat path comments

Select ANATOMIC PATHOLOGY section: **SP** SURGICAL PATHOLOGY

1. Enter/edit specimen comment(s)

2. Enter/edit delayed report comment(s)

CHOOSE (1-2): **2**

EDIT SURGICAL PATHOLOGY delayed report comments for 1993 ? YES// **<RET>** (YES)

Enter SURGICAL Accession #: **31**

DOE,JOE ID: 402-03-0456 OK ? YES// **<RET>** (YES)

Specimen date: SEP 22, 1993

Select DELAYED REPORT COMMENT: Also there are many special stains

// ?

ANSWER WITH DELAYED REPORT COMMENT

CHOOSE FROM:

- 1 Report delayed because of decalcification.
- 2 Also there are many special stains

YOU MAY ENTER A NEW DELAYED REPORT COMMENT, IF YOU WISH

Answer must be 1-75 characters in length.

Select DELAYED REPORT COMMENT: 2 Also there are many special stains

Enter SURGICAL Accession #: <RET>

### Report 1: Print Log Book

Select Print, anat path Option: PB Print log book

Select ANATOMIC PATHOLOGY section: SP SURGICAL PATHOLOGY

SURGICAL PATHOLOGY LOG BOOK

Print SNOMED codes if entered ? NO// <RET> (NO)

Log book year: 1993 OK ? YES// <RET> (YES)

Start with Acc #: 31

Go to Acc #: LAST // <RET>

Select Print Device: *[Enter Print Device Here]*

SEP 27, 1993 07:46 REGION 7

Pg: 1

SURGICAL PATHOLOGY LOG BOOK for 1993

# =Demographic data in file other than PATIENT file

Date	Num	Patient	ID	LOC	PHYSICIAN	PATHOLOGIST
------	-----	---------	----	-----	-----------	-------------

9/22	31	DOE,JOE	0456	CARDIOLOG	WELBY,HARRY	WELBY,MARCUS
------	----	---------	------	-----------	-------------	--------------

Date specimen taken:09/22/93 Entered by:GINS,RON

SKIN

Specimen submitted in alcohol.

Report delayed because of decalcification.

Also there are many special stains

## AP Menu Options

### Report 2:

Select Anatomic Pathology Option: **C** Clinician options, anat path

Select Clinician options, anat path Option: **DS** Display surg path reports for a patient

#### SURGICAL PATHOLOGY PATIENT REPORT(S) DISPLAY

Select Patient Name: **DOE,JOE** 03-04-56 402030456 NSC VETERAN  
DOE,JOE ID: 402-03-0456 Physician: HUBER,CAMERON

AGE: 37 DATE OF BIRTH: MAR 4, 1956  
PATIENT LOCATION: CARDIOLOGY// **<RET>**

Is this the patient ? YES// **<RET>** (YES)

Date Spec taken: SEP 22, 1993 Pathologist:MARCUS WELBY MD  
Date Spec rec'd: SEP 22, 1993 16:23 Resident:  
REPORT INCOMPLETE Accession #: 31  
Submitted by: HARRY WELBY Practitioner:HARRY WELBY

-----

Report delayed because of decalcification.  
Also there are many special stains  
Report not verified



## **Inquiries, Anat Path [LRAPI]**

### Descriptions

<b>Menu Item</b>	<b>Description</b>
Display Surg Path Reports for a Patient	Display on the screen surgical pathology reports for a patient.
Display Cytopath Reports for a Patient	Display on the screen cytopathology reports for a patient.
Display EM Reports For a Patient	Display on the screen Electron Microscopy reports for a patient.
Display Stains/Blocks for a Patient	Display tissue blocks and stains for an accession.
Show List of Accessions for a Patient	If you need to find all the accession numbers (in one accession area) for one patient, you may do so with this option. The information is displayed on the screen only; you can't print the list with this option.
Search Options, Anat Path:	All of these options search pathology entries by date for the portion of the SNOMED code specified.
Morphology Code Search Disease Code Search Etiology Code Search Procedure Code Search Function Code Search	
ICD9CM Search	Searches pathology entries by date for ICD9CM diagnosis code.
MULTIAXIAL Code Search, SNOMED	Searches pathology entries by date for the SNOMED codes specified.

<b>Menu Item</b>	<b>Description</b>
Cum Path Data Summaries	Cumulative summary of surgical path, EM, and autopsy for screen display or hard copy.
Display Final Path Reports by Accession	Display final pathology reports which have been verified.

Display Surg Path Reports for a Patient [LRAPSPCUM]  
Display Cytopath Reports for a Patient [LRAPCYCUM]  
Display EM Reports for a Patient [LRAPEMCUM]

The options to display pathology reports for a patient automatically start with a display of the most recent specimen which has been completed/released. No "DEVICE" prompt is included in this option. Reports can be printed through other options.

**Example:**

Select Anatomic pathology Option: **C** Clinician options, anat path

Select Clinician options, anat path Option: **DS** Display surg path reports for a patient

SURGICAL PATHOLOGY PATIENT REPORT(S) DISPLAY  
 Select PATIENT NAME: ARDEN,TOM 02-01-22 241220000 NO NSC VETERAN  
 ARDEN,TOM ID: 241-22-0000 Physician: QUACK,IMA

AGE: 72 DATE OF BIRTH: FEB 1, 1922  
 Ward on Adm: 1 EAST Service: MEDICINE  
 Adm Date: APR 8, 1993 10:53 Adm DX: ACCIDENT  
 Present Ward: 1 EAST MD: QUACK,IMA  
 PATIENT LOCATION: 1 EAST// <RET>

Is this the patient ? YES// <RET> (YES)

Date Spec taken: AUG 25, 1994 Pathologist:ELMO LEE ZONC MD  
 Date Spec rec'd: AUG 25, 1994 19:41 Resident:  
 Date completed: AUG 26, 1994 Accession #: 7  
 Submitted by: JOHN DOE WILLIAMS MD Practitioner:JOHN DOE WILLIAMS MD

-----  
 Specimen:  
 LEFT LEG

CONSULTATION AFIP#12345 Date: AUG 26, 1994  
 This is just a consultation.

-----  
 SNOMED/ICD codes:  
 T-Y9400: LEG

Date Spec taken: AUG 25, 1994 Pathologist:JOHN DOE WILLIAMS MD  
 Date Spec rec'd: AUG 25, 1994 19:36 Resident:  
 REPORT INCOMPLETE Accession #: 6  
 Submitted by: ELMO LEE ZONC MD Practitioner:ELMO LEE ZONC MD

-----  
 Report not verified

## AP Menu Options

Date Spec taken: AUG 24, 1994                      Pathologist: IMA QUACK MD  
Date Spec rec'd: AUG 24, 1994 10:37          Resident: ELMO LEE ZONC MD  
Date completed: AUG 25, 1994                      Accession #: 2  
Submitted by: IMA QUACK MD                          Practitioner: IMA QUACK MD

---

Specimen:  
PROSTATE CHIPS

Brief Clinical History:  
Nocturia and difficulty voiding urine.

Preoperative Diagnosis:  
same.

Operative Findings:  
same.

Postoperative Diagnosis:  
same.

Frozen Section:  
Basal cell CA.

Gross Description:  
Specimen consists of 5 grams of prostate gland tissue.

Microscopic exam/diagnosis: (Date Spec taken: AUG 24, 1994)  
\*\*\* MODIFIED REPORT \*\*\*

(Last modified: AUG 27, 1994 17:30 typed by PEREZ, ELSIE)  
Glomerular basement membranes are thickened and there is increased mesangial matrix. Also present are small prostatic infarcts and foci of squamous metaplasia. Another small infarct and foci of squamous metaplasia.

Supplementary Report:  
Date: AUG 26, 1994 18:09 not verified  
Date: AUG 26, 1994 18:10 not verified  
CONSULTATION AFIP#123456789 Date: AUG 26, 1994 18:17  
This is an example of a consultation sent to the AFIP.

---

SNOMED/ICD codes:

T-18969: PROSTATIC FASCIA  
P-Y333 : ADMINISTRATION OF MEDICATION, EMERGENCY

Select Patient Name: <RET>

<p><b>NOTE:</b> The Cytopath and EM reports work essentially the same way as the above example.</p>
---

Display Stains/Blocks for a Patient [LRAPST]

Information on the specific accessions is entered through the Blocks, Stains, Procedures, Surg Path [LRAPSPDAT] option.

**Example:**

Select Clinician options, anat path Option: **BD** Display stains/blocks for a patient

Select ANATOMIC PATHOLOGY section: **SP** SURGICAL PATHOLOGY

Select Patient Name: HUDSON,ALBANY 05-08-16 366618472 NO NSC VETERAN  
HUDSON,ALBANY ID: 366-61-8472 Physician: WELBY,MARK

AGE: 74 DATE OF BIRTH: MAY 8, 1916

Ward on Adm: 1 EAST Service: MEDICINE

Adm Date: APR 8, 1994 10:53 Adm DX: FALL ON - LEFT HIP

Present Ward: 1 A

MD: WLBY,MARK

PATIENT LOCATION: 1 A// <RET>

Specimen(s)	Count #	Accession #	Date
	( 1)	7	AUG 25, 1994
LEFT LEG	( 2)	6	AUG 25, 1994
left hip chip	( 3)	2	AUG 24, 1994
PROSTATE CHIPS			
Choose Count #(1-3):	3		

HUDSON,ALBANY 8472 Acc #: 2 Date: AUG 24, 1994

Slide/Ctrl Last stain/block date

PROSTATE CHIPS

Paraffin Block

A	Stain/Procedure		AUG 27, 1994	19:26
	TRICHROME STAIN	1	AUG 27, 1994	19:26
B	Stain/Procedure		AUG 27, 1994	19:26
	TRICHROME STAIN	1	AUG 27, 1994	19:26

Select Patient Name: <RET>

## Show List of Accessions for a Patient [LRUPT]

This option allows you to find all the accession numbers, in one accession area, for one patient. This is a screen display only option.

### **Example:**

Select Anatomic pathology Option: **I** Inquiries, anat path

Select Inquiries, anat path Option: **PA** Show list of accessions for a patient

Select ACCESSION AREA: **SP** SURGICAL PATHOLOGY

Select Patient Name: ADAMS,PORTLAND 08-18-27 527031669

ADAMS,PORTLAND ID: 527-03-1669 Physician: WELBY,JOE

AGE: 63 DATE OF BIRTH: AUG 18, 1927

PATIENT LOCATION: 1A// **<RET>**

Is this the patient ? YES// **<RET>** (YES)

SURGICAL PATHOLOGY ADAMS,PORTLAND ID: 527-03-1669

Spec Date/time Acc # PHYSICIAN SPECIMEN(S)

Spec Date/time Acc # PHYSICIAN SPECIMEN(S)

08/25/94 SP94 7 WELBY,MARK LEFT LEG

08/25/94 SP94 6 MARTIN,JOE left hip chip

08/24/94 SP94 2 QUIN,ROSA PROSTATE CHIPS

## Search Options, Anat Path [LRAPSEARCH]

The search options include SNOMED search options (MORPHOLOGY, DISEASE, ETIOLOGY, PROCEDURE, FUNCTION, and MULTIAXIAL) and ICD9CM search options.

### **SNOMED:**

You may search the anatomic reports by site (Topography) and then by the Morphology, Disease, Etiology, Procedure, or Function field. The results should be queued and printed only. You may enter up to six characters of the code. The entries can only contain digits, the letters "X" and "Y" or "\*" for wild cards. One character entered = most general and all characters = most specific.

### **HINTS:**

1. Each search option will display the information in two different formats: first, in alphabetical order by patient, then in numeric order by accession number. This makes retrieval of slides, reports, etc., easier.
2. At the end of each report, there is a summary of the number of accessions searched, as well as the % of codes searched which met the designated criteria.

## **Morphology Code Search, SNOMED [LRAPSM]**

### **Example:**

```
Select Inquiries, anat path Option: SE      Search options, anat path
Select Search options, anat path Option: MC MORPHOLOGY code search, SNOMED
```

```
Select ANATOMIC PATHOLOGY section: SP  SURGICAL PATHOLOGY
```

```
                SURGICAL PATHOLOGY search by MORPHOLOGY code
```

```
TOPOGRAPHY (Organ/Tissue)
```

```
    Select 1 or more characters of the code
```

```
    For all sites type 'ALL' : ALL
```

```
MORPHOLOGY
```

```
    For all choices type 'ALL'
```

```
Choice # 1: Select 1 or more characters of the code: ALL
```

```
Start with Date TODAY// <RET> AUG 30, 1994
```

```
Go to Date TODAY// -365 (AUG 30, 1993)
```

```
Select Print Device: [Enter Print Device Here]
```

## AP Menu Options

AUG 30, 1994 10:25 VAMC Pg: 1  
SURGICAL PATHOLOGY SEARCH(AUG 30, 1993=>AUG 30, 1994)  
# = Not VA patient  
SNOMED TOPOGRAPHY CODE: ALL-- SNOMED MORPHOLOGY CODE: ALL--

---

NAME	ID	SEX	AGE	ACC #	ORGAN/TISSUE	MORPHOLOGY
TEMPLE,SILVIA	6104	F	62	5-94	SKIN OF NOSE	BASAL CELL ADENOMA
UNGER,FELIX	4444	M	83	3-94	LIVER	HYPERPLASIA ADENOCARCINOMA
WALRUS,WALLY	3454	M	68	8-94	BONE MARROW	LEUKEMIA

AUG 30, 1994 10:25 VAMC Pg: 2  
SURGICAL PATHOLOGY SEARCH(AUG 30, 1993=>AUG 30, 1994)  
# = Not VA patient  
SNOMED TOPOGRAPHY CODE: ALL-- SNOMED MORPHOLOGY CODE: ALL--

---

ACC #	NAME	ID	SEX	AGE	MO/DA	ORGAN/TISSUE	MORPHOLOGY
3-94	UNGER,FELIX	4444	M	83	8/24	LIVER	HYPERPLASIA ADENOCARCINOMA
5-94	TEMPLE,SILVIA	6104	F	62	8/24	SKIN OF NOSE	BASAL CELL ADENOMA
8-94	WALRUS,WALLY	3454	M	68	8/25	BONE MARROW	LEUKEMIA

AUG 30, 1994 10:25 VAMC Pg: 3  
SURGICAL PATHOLOGY SEARCH(AUG 30, 1993=>AUG 30, 1994)  
# = Not VA patient  
SNOMED TOPOGRAPHY CODE: ALL-- SNOMED MORPHOLOGY CODE: ALL--

---

RESULT OF SURGICAL PATHOLOGY SEARCH:  
PATIENTS WITHIN PERIOD SEARCHED: 11  
SURGICAL PATHOLOGY ACCESSIONS WITHIN PERIOD SEARCHED: 11

3 OF 11 PATIENTS(27.27%)  
3 OF 6 SNOMED CODE ALL SPECIMENS(50.00%)  
6 ORGAN/TISSUE SPECIMENS WITHIN PERIOD SEARCHED  
(SNOMED TOPOGRAPHY CODE ALL IS 100.00%)

**Disease Code Search, SNOMED [LRAPSD] and Etiology Code Search, SNOMED [LRAPSE] follow the same pattern as the Morphology Code Search.**



**Procedure Code Search, SNOMED [LRAPSP]**

**Example:** Procedure Code Search for Soft Tissue which was positive for the Immunopath Stain Vimentin

Select Search options, anat path Option: **PC** PROCEDURE code search, SNOMED  
Select ANATOMIC PATHOLOGY section: **SP** SURGICAL PATHOLOGY

SURGICAL PATHOLOGY search by PROCEDURE code

TOPOGRAPHY (Organ/Tissue)

Select 1 or more characters of the code

For all sites type "ALL": **1X**

PROCEDURE

Select only procedures with results ? NO// **Y** (YES)

Enter 1 for positive results or 0 for negative results: **1**

For all choices type "ALL"

Choice #1: Select 1 or more characters of the code: **3630004**

Choice #2: Select 1 or more characters of the code: **<RET>**

Start with Date TODAY// **7-1-90** (JUL 01, 1990)

Go to Date TODAY// **AUG 24, 1990**

Select Print Device: *[Enter Print Device Here]*

*[The printout follows the same pattern as other SNOMED searches and will not be printed.]*

**NOTE:** By designating "ASK RESULT" as "YES" in File #61.5 (PROCEDURE FIELD) for the specific procedure code, data indicating the test result can be entered during data entry when that specific procedure code is entered for a case. This can then be used for retrieval of cases via the SNOMED search options.

## ICD9CM Code Search [LRAPSI]

You can search the anatomic reports by the ICD9CM code. Because the search may be lengthy, the results should be queued to a printer. If this option doesn't seem to work correctly, check with your site manager. The ICD9CM globals may not have been loaded (possibly because of space shortages).

### Example:

Select Search options, anat path Option: **IC** ICD9CM code search

Select ANATOMIC PATHOLOGY section: **SP** SURGICAL PATHOLOGY

Select ICD DIAGNOSIS CODE NUMBER: **414 414.0** CORONARY ATHEROSCLEROSIS

...OK? YES// **<RET>** (YES)

Start with Date TODAY// **DEC 4, 1990**

Go to Date TODAY// **T-100** (SEP 13, 1990)

Select Print Device: *[Enter Print Device Here]*

DEC 4, 1990 14:02 SIUG VAMC

Pg: 1

SURGICAL PATHOLOGY SEARCH (SEP 13, 1990=>DEC 4, 1990)

ICD CODE: 414.0 CORONARY ATHEROSCLEROSIS

-----

NAME	ID	SEX	AGE	ACC #
SNITH,JOHN J	000112222	M	53	13

## MULTIAXIAL Code Search, SNOMED [LRAPSEM]

For some types of searches, it is desirable to specify more than one type of SNOMED code for the search criteria. This option provides that additional flexibility.

For those types of codes in which you don't want to specify criteria, merely enter **<RET>** for that prompt. If you enter "ALL," the search will only include cases for which a code is entered.

For some purposes, such as selection of cases for discussion at conferences, additional information on the cases (including physician, the microscopic description, etc.) is useful. By answering the prompts accordingly, the output from the search can be changed. See Example 2.

**Example 1: Search for Soft Tissue which was Positive for the Immunopath Stain VIMENTIN which had a Morphology of a Primary Tumor**

Select Search options, anat path Options: **AX** MULTIAXIAL code search, SNOMED  
 Select ANATOMIC PATHOLOGY section: **SP** SURGICAL PATHOLOGY

SURGICAL PATHOLOGY multiaxial SNOMED search

TOPOGRAPHY (Organ/Tissue)

Select 1 or more characters of the code

For all sites type "ALL" : **1X**

MORPHOLOGY

For all choices type "ALL"

MORPHOLOGY choice # 1: Select 1 or more characters of the code: **88\*\*3**

ETIOLOGY (for all choices type "ALL")

Choice # 1: Select 1 or more characters of the code: **88**

MORPHOLOGY choice #2: Select 1 or more characters of the code: **<RET>**

PROCEDURE

Select only procedures with results ? NO// **Y** (YES)

Enter 1 for positive results or 0 for negative results: **1**

For all choices type "ALL"

PROCEDURE choice #1: Select 1 or more characters of the code: **3630004**

PROCEDURE choice #2: Select 1 or more characters of the code: **<RET>**

DISEASE

For all choices type "ALL"

DISEASE choice #1: Select 1 or more characters of the code: **<RET>**

FUNCTION

For all choices type "ALL"

FUNCTION choice # 1: Select 1 or more characters of the code: **<RET>**

Start with Date TODAY// **10-1-90** (OCT 01, 1990)

Go to Date TODAY// **<RET>** JAN 1, 1990

List by accession number with specimens and microscopic dx ? NO// **Y** (YES)

LIST SPECIAL STUDIES ? NO// **Y** (YES)

Include SNOMED CODES on report ? NO// **Y** (YES)

Enter SEARCH COMMENT: **SOFT TISSUE SARCOMAS VIMENTIN POSITIVE**

## AP Menu Options

### **Example 2: Search for Cases for GI Conference**

Select Search options, anat path Option: **AX** MULTIAXIAL code search, SNOMED

Select ANATOMIC PATHOLOGY section: **SP** SURGICAL PATHOLOGY  
SURGICAL PATHOLOGY multiaxial SNOMED search

TOPOGRAPHY (Organ/Tissue)

Select 1 or more characters of the code

For all sites type 'ALL' : 5

MORPHOLOGY

For all choices type 'ALL'

MORPHOLOGY choice # 1: Select 1 or more characters of the code: **ALL**

ETIOLOGY (for all choices type 'ALL')

Choice # 1: Select 1 or more characters of the code: **<RET>**

PROCEDURE

Select only procedures with results ? NO// **<RET>** (NO)

For all choices type 'ALL'

PROCEDURE choice # 1: Select 1 or more characters of the code: **<RET>**

DISEASE

For all choices type 'ALL'

DISEASE choice # 1: Select 1 or more characters of the code: **<RET>**

FUNCTION

For all choices type 'ALL'

FUNCTION choice # 1: Select 1 or more characters of the code: **<RET>**

Start with Date TODAY// **1-1-88** (JAN 01, 1988)

Go to Date TODAY// **9-8-94** (SEP 08, 1994)

List by accession number with specimens and microscopic dx ? NO// **Y** (YES)

List special studies ? NO// **Y** (YES)

Include SNOMED CODES on report ? NO// **Y** (YES)

Enter SEARCH COMMENT: **<RET>**

Select Print Device: *[Enter Print Device Here]*

SEP 8, 1994 13:20 DALLAS ISC, VERIFICATION ACCT Pg: 1  
 SURGICAL PATHOLOGY SEARCH (JAN 1, 1988-SEP 8, 1994)  
 Date # = Not VA patient For:NORTH,MARGO  
 Taken Patient ID Physician LOC Acc# PATHOLOGIST

-----  
 06/29/89 WALRUS,WALLY 3454 WELBY, JOE 5N 2 WELLS,MARK  
 Specimen(s): TOOTH  
 AS ABOVE

T-54010 TOOTH  
 M-23350 IMPACTED TOOTH  
 PHOTOGRAPHY 1 Date: JUN 29, 1989

-----  
 07/24/89 RABBIT,RUPPERT 4747 SANDERS,HARRY 1E 3 HOUSTON,SAM  
 Specimen(s): GALLBLADDER  
 T-57000 GALLBLADDER  
 M-30010 LITHIASIS

-----  
 08/24/94 UNGER,FELIX 4444 MARTIN,TAD 1 EAST 3 MARTIN,JOE

SEP 8, 1994 13:20 DALLAS ISC, VERIFICATION ACCT Pg: 2  
 SURGICAL PATHOLOGY SEARCH (JAN 1, 1988-SEP 8, 1994)  
 Date # = Not VA patient For:NORTH,MARGO  
 Taken Patient ID Physician LOC Acc# PATHOLOGIST

-----  
 08/24/94 UNGER,FELIX 4444 MARTIN,TAD 1 EAST 3 MARTIN,JOE  
 Specimen(s): LIVER BIOPSY  
 IMPACTED TUSK Glandular and stromal hyperplasia.

T-56000 LIVER  
 M-81403 ADENOCARCINOMA  
 M-72000 HYPERPLASIA  
 CONSULTATION 134 Date: SEP 3, 1994 13:16

SEP 8, 1994 13:21 DALLAS ISC, VERIFICATION ACCT Pg: 3  
 SURGICAL PATHOLOGY SEARCH (JAN 1, 1988-SEP 8, 1994)  
 # = Not VA patient SNOMED FIELDS For:NORTH,MARGO

-----  
 RESULT OF SURGICAL PATHOLOGY SEARCH:  
 PATIENTS WITHIN PERIOD SEARCHED: 28  
 SURGICAL PATHOLOGY ACCESSIONS WITHIN PERIOD SEARCHED: 28  
 ORGAN/TISSUE SPECIMENS WITHIN PERIOD SEARCHED: 12

The following fields were used for the search :  
 TOPOGRAPHY FIELD: 5  
 MORPHOLOGY FIELD: ALL

## Cum Path Data Summaries [LRAPT]

This option provides a cumulative summary of surgical path, cytopath, EM, and autopsy for screen display or hard copy. Data for special studies are also included in this report.

### **Example:**

Select Inquiries, anat path Option: **CS** Cum path data summaries

Cum path data summaries

1. DISPLAY cum path data summary for a patient
2. PRINT cum path data summary for patient(s)

Select (1-2): **1**

DISPLAY cum path data summary for a patient

Select Patient Name: **WASHINGTON, GEORGE** CHERRY 02-01-12 012458762  
NSC VETERAN

WASHINGTON, GEORGE CHERRY ID: 012-45-8762 Physician: STUHR, GARY

AGE: 77 DATE OF BIRTH: FEB 1, 1912

Ward on Adm: 1 EAST Service: PSYCHOLOGY

Adm Date: APR 8, 1993 10:53 Adm DX: STRESS

Present Ward: 1 EAST

MD: STUHR, GARY

PATIENT LOCATION: 1 EAST// **<RET>**

Is this the patient ? YES// **<RET>** (YES)

WASHINGTON, GEORGE CHERRY 012-45-8762 DOB: FEB 1, 1912 LOC:1 EAST

-----  
SURGICAL PATHOLOGY

Organ/tissue: Date rec'd: 03/28/89 Acc #: 9

Report not verified.

Organ/tissue: Date rec'd: 11/08/88 Acc #: 21

SKIN

BIOPSY, PUNCH

PSORIASIS

IMMUNOFLUORESCENCE 21-I Date: NOV 13, 1988

LIVER

PAIN, NOS

LOSS OF VOICE

BIOPSY, NEEDLE

DIABETES MELLITUS

TUBERCULOSIS

CIRRHOSIS

ALCOHOL

HEMANGIOMA

-----  
SURGICAL PATHOLOGY

Organ/tissue: Date rec'd: 11/08/88 Acc #: 21

LIVER

ELECTRON MICROSCOPY E-21-88 Date: NOV 13, 1988 06:27

Organ/tissue: Date rec'd: 11/07/88 Acc #: 20

Report not verified.

Organ/tissue: Date rec'd: 08/01/88 Acc #: 12

Press return to continue or "^" to escape **<RET>**

WASHINGTON, GEORGE CHERRY 012-45-8762 DOB: FEB 1, 1912 LOC:1 EAST

---

## SURGICAL PATHOLOGY

NAIL OF TOE

HEMATOMA

Organ/tissue: Date rec'd: // Acc #: 345

Report not verified.

Organ/tissue: Date rec'd: 06/02/88 Acc #: 7

SKIN

BIOPSY, NOS

DIABETES MELLITUS, ADULT ONSET TYPE

PSORIASIS

ABSCESS

STAPHYLOCOCCUS AUREUS

Organ/tissue: Date rec'd: 05/10/88 Acc #: 5

Report not verified.

## SURGICAL PATHOLOGY

Organ/tissue: Date rec'd: 03/04/78 Acc #: 1

SKIN

KERATOSIS, SEBORRHEIC

Organ/tissue: Date rec'd: 01/02/78 Acc #: 56

BLOOD

NORMAL CELLULAR MORPHOLOGY

Organ/tissue: Date rec'd: 06/07/45 Acc #: 6789

LIVER

CIRRHOSIS

## CYTOPATHOLOGY

Organ/tissue: Date rec'd: 09/25/88 Acc #: 7

SPUTUM

CARBUNCLE

Organ/tissue: Date rec'd: 08/22/88 Acc #: 6

Report not verified.

Organ/tissue: Date rec'd: 05/04/88 Acc #: 1

SPUTUM

NEGATIVE FOR MALIGNANT CELLS

no comment

good specimen

## CYTOPATHOLOGY

Organ/tissue: Date rec'd: 08/04/87 Acc #: 35

Report not verified.

Press return to continue or "^" to escape &lt;RET&gt;

## AP Menu Options

WASHINGTON, GEORGE CHERRY 012-45-8762 DOB: FEB 1, 1912 LOC: 1 EAST

---

Organ/tissue: Date rec'd: 08/03/87 Acc #: 34

Report not verified.

Date rec'd: 08/03/87 Acc #: 33

Report not verified.

Organ/tissue: Date rec'd: 07/31/87 Acc #: 14

Organ/tissue: Date rec'd: 07/31/87 Acc #: 15

ABDOMEN

ACQUIRED DIGITAL FIBROKERATOMA

Organ/tissue: Date rec'd: 07/31/87 Acc #: 30

Report not verified.

Organ/tissue: Date rec'd: 07/31/87 Acc #: 29

Report not verified.

Organ/tissue: Date rec'd: 06/10/87 Acc #: 26

Organ/tissue: Date rec'd: 06/10/87 Acc #: 24

Organ/tissue: Date rec'd: 06/10/87 Acc #: 23

Organ/tissue: Date rec'd: 06/10/87 Acc #: 22

Organ/tissue: Date rec'd: 05/06/87 Acc #: 12

Report not verified.

### CYTOPATHOLOGY

Organ/tissue: Date rec'd: 03/05/87 Acc #: 11

Report not verified.

SPUTUM

POSITIVE FOR MALIGNANT CELLS

Organ/tissue: Date rec'd: 08/20/86 Acc #: 10

Organ/tissue: Date rec'd: 07/21/86 Acc #: 9

SKIN

CARBUNCLE

MALIGNANT MELANOMA

Organ/tissue: Date rec'd: 07/02/86 Acc #: 7

BRONCHIAL BRUSHING CYTOLOGIC MATERIAL

SUSPICIOUS FOR MALIGNANT CELLS

SPUTUM

EM Date: JUL 18, 1986

IMMUNOFLUORESCENCE Date: JUL 18, 1986

Organ/tissue: Date rec'd: 05/13/86 Acc #: 4

LUNG

CHEST PAIN, NOS

ANOREXIA

BIOPSY, ASPIRATION OF TISSUE OR FLUID

POSITIVE FOR MALIGNANT CELLS

Press return to continue or "^" to escape <RET>



WASHINGTON, GEORGE CHERRY 012-45-8762 DOB: FEB 1, 1912 LOC: 1 EAST

---

CARCINOMA, SQ CELL  
 Organ/tissue: Date rec'd: 03/09/86 Acc #: 2  
 Organ/tissue: Date rec'd: 02/24/86 Acc #: 1  
 ELECTRON MICROSCOPY  
 Organ/tissue: Date rec'd: 07/28/87 Acc #: 10  
 Report not verified.  
 Organ/tissue: Date rec'd: // Acc #: ?  
 Report not verified.  
 Organ/tissue: Date rec'd: 07/03/86 Acc #: 1  
 KIDNEY  
 MITOCHONDRIAL ALTERATION  
 GLOMERULONEPHRITIS, MEMBRANOPROLIFERATIVE  
 IMMUNOFLUORESCENCE 89008-K Date: JUL 6, 1986 08:55  
 Organ/tissue: Date rec'd: 04/12/84 Acc #: 2319  
 LIVER  
 NORMAL TISSUE MORPHOLOGY  
 KIDNEY  
 ELECTRON MICROSCOPY  
 Organ/tissue: Date rec'd: 04/12/84 Acc #: 2319  
 KIDNEY  
 IMMUNOFLUORESCENCE 3 Date: JUL 17, 1986  
 Organ/tissue: Date rec'd: 03/04/84 Acc #: 23  
 KIDNEY  
 MITOCHONDRIAL ALTERATION  
 LYSOSOMAL DEBRIS

## Display Final Path Reports by Accession Number [LRAPPA]

You can use this option to display final pathology reports which have been verified for surgical pathology, electron microscopy, or cytopathology from one accession to another.

### **Example:**

Select Inquiry, anat path Option: **FR** DISPLAY FINAL PATH REPORTS BY ACCESSION #

Select ANATOMIC PATHOLOGY section: **SP** SURGICAL PATHOLOGY

SURGICAL PATHOLOGY FINAL PATIENT REPORTS DISPLAY

Enter year: 1991// **<RET>** (1991)

Start with accession #: **1362**

Go to accession #: **1735**

Date Spec taken: JAN 11, 1991 Pathologist: DOE,JOHN

Date Spec rec'd: JAN 12, 1991 Resident:

Date Completed: JAN 13, 1991 Accession #: 23

Submitted by: HARRY WELBY Practitioner:HARRY WELBY

-----  
Specimen:

PROSTATE CHIPS

Brief Clinical History:

Nocturia and difficulty voiding urine.

Preoperative Diagnosis:

Enlarged prostate.

Operative Findings:

Same.

Gross description:

Specimen consists of 25 grams of prostate gland tissue.

Microscopic exam/diagnosis:

Prostate gland tissue showing glandular and stromal hyperplasia. In one chip of 134 there is a small focus of well differentiated adenocarcinoma.

## Log-in Menu, Anat Path [LRAPL]

### Descriptions

<b>Menu Item</b>	<b>Description</b>
Log-In Anat Path	Used to log in accessions in Anatomic Pathology. You must hold the appropriate key to the accession area. The accession is never removed from the system automatically; it can be deleted through "Delete accession #," if the report has not been completed and released. The comments entered are deleted through one of the two purge options in the Supervisor's Menu, approximately every six months depending on the amount of disk space available.
Delete Accession #, Anat Path	Used to delete an accession number for autopsy, cytopath, EM, or surgical path if the report has not been completed and released.
Print Log Book	Prints accessions from one number to another within a year.
Histopathology Worksheet	Prints lists of specimens for a date by accession number.

## Log-in, Anat Path [LRAPLG]

Although the option used for log-in is the same for all areas, the prompts displayed will vary according to the area selected.

During specimen log-in, the system displays other accessions on that patient within five days. This should eliminate duplicate accessions when additional specimens are received for a case with multiple specimens.

If you enter a specimen name in the Log-in option, the Gross Description field in the Microscopic/Gross Review option will be automatically filled with an expanded specimen description from the specimen description file.

If a comment such as "incomplete clinical information" is entered into the system at the time of log-in, it will be printed out on the Log Book. It could then be used to flag surgical and cytologies submitted without adequate clinical information and clinical history. These could then be tallied and investigated as a quality assurance monitor for Anatomic Pathology. It also might be helpful in identifying specific individuals or locations from which incomplete or erroneous SF 515s are being received.

**NOTE:** The entry created in Field .07, Subfile 63.08, SURGEON/PHYSICIAN, is a pointer to the NEW PERSON file (#200). This is also stored in the ACCESSION file (#68) for that accession.

**HINTS:**

1. If an “^” is entered at any point in the data entry, **except** during a multiple entry, the system will display a message and will delete the accession information.
2. If the system will not accept the patient you are trying to enter, there may be a spelling error or a SSN error on the SF 515 or in the computer, in which case you would correct the error before continuing. Another possibility is that the patient is an outside referral case of a non-VA patient. You must then enter the patient as a referral, as follows:

**Example:**

```

Select Patient Name: ? :?
CHOOSE FROM:  1  PATIENT
               2  PERSON
               4  LAB CONTROL NAME
               5  BLOOD DONOR
               6  REFERRAL PATIENT
               7  RESEARCH
               8  STERILIZER
               9  ENVIRONMENTAL
              10  NON PATIENT WORKLOAD
              11  NEW PERSON

      Select: 6
ANSWER WITH REFERRAL PATIENT NAME, OR IDENTIFIER, OR REFERRAL SOURCE
DO YOU WANT THE ENTIRE 18-ENTRY REFERRAL PATIENT LIST? N (NO)
Select REFERRAL PATIENT NAME: GOMEZ, SAM
  ARE YOU ADDING 'GOMEZ,SAM' AS A NEW REFERRAL PATIENT (THE 19TH)? Y (YES)
    REFERRAL PATIENT DOB: 5-5-18 (MAY 05, 1918)
    REFERRAL PATIENT IDENTIFIER: 7896
GOMEZ,SAM ID: 7896
AGE: 76
PATIENT LOCATION: ???// 2E 2 EAST

Assign SURGICAL PATHOLOGY accession #: 19 ? YES// ^

```

Then later in the option, you will probably want to enter the referring hospital/physician in the Comment field(s).

If you have attempted to enter a patient name and you are still at the “Select PATIENT NAME” level, the prompt will show PATIENT NAME in upper case. If this happens, you are in the PATIENT file (#2) already, and entry of “??” will not provide the choice of files, only a choice of patient names. Return to the option name level to begin again. The prompt will then display “Select Patient Name” in upper and lower case, and you will be able to get to the REFERRAL file. If you enter **REF:?**, you will automatically get a listing of patients already in the file.

When a log book is printed, a number will be shown in front of the patient’s name to indicate that it is a non-VA patient. The entries in the Comment field are also included.

## AP Menu Options

### **Example 1:** Log-in of Routine Surgical Path Specimen with ASK FROZEN SECTION set to "NO"

#### ANATOMIC PATHOLOGY MENU

Select Log-in menu, anat path Option: **L** Log-in, anat path

Select ANATOMIC PATHOLOGY section: **SP** SURGICAL PATHOLOGY

Log-In for 1990 ? YES// **<RET>** (YES)

Select Patient Name: **HUDSON,ALBANY** 05-08-16 366618472

HUDSON,ALBANY ID: 366-61-8472

AGE: 72 DATE OF BIRTH: MAY 8, 1916

PATIENT LOCATION: 1A// **<RET>**

Checking surgical record for this patient...

No operations on record in the past 7 days for this patient.

Assign SURGICAL accession #: 22 ? YES// **<RET>** (YES)

Date/time Specimen taken: TODAY// **<RET>** (NOV 20, 1988)

SURGEON/PHYSICIAN: **WELBY,JOE** **<RET>**

SPECIMEN SUBMITTED BY: JOE WELBY MD// **<RET>**

Select SPECIMEN: **PROSTATE CHIPS**

Select SPECIMEN: **<RET>**

DATE/TIME RECEIVED: NOW// **<RET>** (NOV 20, 1988@9:20)

PATHOLOGIST: **WELBY,MARCUS**

Select COMMENT: **This comment will appear on the log book.**

Select COMMENT: **<RET>**

Select Patient Name: **<RET>**

**Example 2: Log-in of Frozen Section Specimen for Surgical Path**

Select Log-in menu, anat path Option: **LI** Log-in, anat path

Select ANATOMIC PATHOLOGY section: **SP** SURGICAL PATHOLOGY

Log-In for 1992 ? YES// **<RET>** (YES)

Select Patient Name: **DUSTY,RUSTY** 04-27-25 089485948 SC VETERAN  
 DUSTY,RUSTY ID: 089-48-5948 Physician: WELBY,MARCUS

AGE: 67 DATE OF BIRTH: APR 27, 1925

PATIENT LOCATION: EMERGENCY ROOM// **SURGERY**

Accession number assigned for 12/02/92 is: 24

Assign SURGICAL PATHOLOGY accession #: 26 ? YES// **<RET>** (YES)

Date/time Specimen taken: TODAY// **<RET>** (DEC 03, 1992)

SURGEON/PHYSICIAN: **WELBY,MARCUS** WELBY,MARCUS

SPECIMEN SUBMITTED BY: MARCUS WELBY MD// **<RET>**

Select SPECIMEN: **LEFT NOSE BIOPSY**

Select SPECIMEN: **<RET>**

DATE/TIME SPECIMEN RECEIVED: NOW// **<RET>** (DEC 03, 1992@10:45)

PATHOLOGIST: **GINS,RON** GINS,RON

Select COMMENT: **Call x3028 or x2420 with frozen results** (Call x3028 or x2420  
 with frozen results)

Select COMMENT: **<RET>**

FROZEN SECTION:

1>**Basal cell CA, adequately excised.**

2>**Reported to Dr. Mark Welby at x2420 at 10:55AM. .**

3>**<RET>**

EDIT Option: **<RET>**

## AP Menu Options

### Example 3: Log-in of Cytopathology Specimen

Select Log-in menu, anat path Option: **L** Log-in, anat path

Select ANATOMIC PATHOLOGY section: **CY** CYTOPATHOLOGY

Log-In for 1990 ? YES// **<RET>** (YES)

Select Patient Name: **HUDSON,ALBANY** 05-08-16 366618472 NON-VETERAN  
(OTHER)

HUDSON,ALBANY ID: 366-61-8472

AGE: 74 DATE OF BIRTH: MAY 8, 1916

PATIENT LOCATION: 1A// **11b**

Assign CYTOPATHOLOGY accession #: 1 ? YES// **<RET>** (YES)

Date/time Specimen taken: TODAY// **<RET>** (AUG 28, 1990)

PHYSICIAN: **WELBY,MARCUS**

SPECIMEN SUBMITTED BY: MARCUS WELBY MD//**<RET>**

Select SPECIMEN: **Prostate chips**

Select SPECIMEN: **<RET>**

DATE/TIME SPECIMEN RECEIVED: NOW// **<RET>** (AUG 28, 1990@12:04)

PATHOLOGIST: **SEEGER,TONY**

Select COMMENT:**<RET>**

GROSS DESCRIPTION:

1>10 cc of tan viscous material submitted.

2>**<RET>**

EDIT Option:

Select Patient Name:**<RET>**

### Example 4: More than one EM Specimen

Select Anatomic pathology Option: **L** Log-in menu, anat path

Select Log-in menu, anat path Option: **L** Log-in, anat path

Select ANATOMIC PATHOLOGY section: **EM**

Log-In for 1992 ? YES// **<RET>** (YES)

Select Patient Name: **ADAMS,HOUSTON** 06-18-62 121223333

ADAMS,HOUSTON ID: 121-22-3333 Physician: ANEY,RUSS

AGE: 29 DATE OF BIRTH: JUN 18, 1962

PATIENT LOCATION: 1B// **<RET>**

Assign EM accession #: 8 ? YES// **<RET>** (YES)

Date/time Specimen taken: TODAY// **<RET>** (JAN 13, 1992)

PHYSICIAN: VADER,ED

SPECIMEN SUBMITTED BY: ED BADER // **<RET>**

Select SPECIMEN: **SKIN**

Select SPECIMEN: **KIDNEY**

Select SPECIMEN: **<RET>**

DATE/TIME SPECIMEN RECEIVED: NOW// **<RET>** (JAN 13, 1992@10:39)

PATHOLOGIST: **GINS,RON** GIN,RON

RESIDENT OR EMTECH: **HSTADTER,WYNN**

Select COMMENT: **<RET>**



**Example 5: Log-in of Autopsy**

## ANATOMIC PATHOLOGY MENU

Select Anatomic pathology Option: **L** Log-in menu, anat path

Select Log-in menu, anat path Option: **LI** Log-in, anat path

Select ANATOMIC PATHOLOGY section: **AU** AUTOPSY

Log-In for 1992 ? YES// **<RET>** (YES)

Select Patient Name: B9898 BOGGESS,HENRY 12-18-25 234889898 NSC VETERAN  
BOGGESS,HENRY ID: 234-88-9898 Physician: WELBY,MARCUS

DIED DEC 1, 1992

Assign AUTOPSY accession #: 5 ? YES// **<RET>** (YES)

Enter Weights & Measurements ? NO// **<RET>** (NO)

AUTOPSY DATE/TIME: **T** (DEC 01, 1992)

LOCATION: **1A**

SERVICE: **MEDICINE**

TREATING SPECIALTY AT DEATH: **INTERNAL MEDICINE**

PHYSICIAN: **BAD,ED**

RESIDENT PATHOLOGIST: **<RET>**

SENIOR PATHOLOGIST: **<RET>**

AUTOPSY TYPE: **F** FULL AUTOPSY

AUTOPSY ASSISTANT: **<RET>**

**NOTES:**

- Date of death must be entered in the PATIENT file (#2) before an autopsy can be entered.
- The system will now allow nonstandard numeric defaults for weights; i.e., 11.0 rather than 11.
- For quality assurance review purposes, a new field Treating Specialty at Death (63,14.6) has been added to the Log-in Anatomic Pathology [LRAPLG] option. If all of the data is entered, it is possible to have data on deaths sort by Service, Treating Specialty, and Physician using the QA Outcome Review Cases [LRAPQOR] option in the Supervisor's Menu.

## Delete Accession #, Anat Path [LRAPKILL]

This option will only work if the report has not been completed and/or verified.

### **Example:**

Select Anatomic pathology Option: **L** <RET> Log-in menu, anat path

Select Log-in menu, anat path Option: **DA** Delete accession #, anat path

Select ANATOMIC PATHOLOGY section: **SP** SURGICAL PATHOLOGY  
Delete an Accession Number

Accession number date: **90** (1990)

Select Accession # : **22**  
HUDSON,ALBANY ID: 366618472 DOB: MAY 8, 1916

ACC # 22  
Report completed &/or released, deletion not allowed.

Select Accession # : **24**  
ADAMS,SAM ID: 432994321 DOB: JAN 23, 1934

ACC # 24 DATE RECEIVED: NOV 21, 1990 08:58 OK to DELETE ? NO// <RET> (NO)  
NOT DELETED

Select Accession # : **24**  
ADAMS,SAM ID: 432994321 DOB: JAN 23, 1934

ACC # 24 DATE RECEIVED: NOV 21, 1990 08:58 OK to DELETE ? NO// **Y**  
Select Accession # : <RET>

Select Log-in menu, anat path Option: <RET>

## Print Log Book [LRAPBK]

Once the specimens have been logged in, printing the log book provides a quick reference. If this report is then reprinted when the reports are completed and released, the final diagnoses (based on the SNOMED codes) and the release information will also be included.

Although specimens entered as “old records” are not entered in the ACCESSION file (#68), those accessions can be accessed using this option. This may be very helpful in resolving problems with duplicate numbers/data entry errors.

The “Log Book” serves as a quick reference and a viable alternative to having the system search for an accession number, but it is necessary for the person making the inquiry to know the approximate date. Printing a list of surgical pathology accessions by patient name, using this option on a monthly or quarterly basis, facilitates the inquiry process during computer downtimes.

### **Example:**

Select Print, anat path Option: **Print log book**

Select ANATOMIC PATHOLOGY section: **SP SURGICAL PATHOLOGY**

SURGICAL PATHOLOGY LOG BOOK

Print SNOMED codes if entered ? NO// **Y** (YES)

Print only Topography and Morphology codes ? NO// **<RET>**

Log book year: 1991 OK ? YES// **<RET>** (YES)

Start with Acc #: **20**

Go to Acc #: LAST // **22**

Select Print Device: *[Enter Print Device Here]*

### **NOTES:**

- Use of the log-in Comment field for documentation of consultations or notification of malignancies as shown above provides one mechanism for documentation for quality assurance purposes.
- Once the word-processing/description fields are purged, the log-in comments will no longer be included; therefore, if this log book is to be used for permanent hard copy of comments, it must be printed for the desired period before the word processing fields are purged.

Surgical Pathology Log Book

NOV 20, 1990 09:31 SURGICAL PATHOLOGY LOG BOOK for 1990

Pg: 1

# = Demographic data in file other than PATIENT file

Date	Num	Patient	ID	LOC	PHYSICIAN	PATHOLOGIST
11/07	20	WASHINGTON,GEORGE	8762	1A	WELBY,MARCUS	WELBY,MARCUS
Date specimen taken:11/07/90		Entered by:		GING,DONALD		
SKIN						

11/08	21	WASHINGTON,GEORGE	8762	1A	FRANKNSTEIN,HAR	WELBY,HARRY
Date specimen taken:11/08/90		Entered by:		GING,DONALD		
		Released by: GING,DONALD				

SNOMED codes:

SKIN

Dx: PSORIASIS

Procedure: BIOPSY, PUNCH

LIVER

Dx: CIRRHOSIS: HEMANGIOMA

Procedure: BIOPSY, NEEDLE

11/20	22	HUDSON,ALBANY	8472	1A	WELBY,JOE	WELBY,MARCUS
Date specimen taken:11/20/90		Entered by:		GING, DONALD		
		Released by:SMITH, SALLY				

PROSTATE

Dx: ADENOCARCINOMA

Reviewed by Dr. Hall on 11/22/90

Notified Dr. Welby on 11/22/90

## Histopathology Worksheet [LRAPH]

Once specimens have been logged in, this worksheet will provide a mechanism for recording data which will subsequently be entered, using the Blocks, Stains, Procedures, Surg Path [LRAPSPDAT] option. The worksheet includes all accessions and all specimens for each accession.

### **Example:**

Select Print, anat path Option: **HW** Histopathology Worksheet  
 HISTOPATHOLOGY DATA SHEET  
 Select ANATOMIC PATHOLOGY section: **SP** SURGICAL PATHOLOGY  
 Select ACCESSION DATE: **T** (NOV 20, 1990)  
 Select Print Device: *[Enter Print Device Here]*

```

                R5ISC
SURGICAL SHEET ACCESSION DATE: NOV 20, 1990      Pg: 1
-----
SURG   :   SPECIMEN       : CASSETTE   : BLOCKS   : SLIDES   : STAINS
-----
90-22 :   PROSTATE CHIPS   :         :         :         :
-----

```

**NOTE:** Some detailed training on how to review/edit the data will be necessary unless the user already has experience in dealing with this option, or other data entry options which involve multiple fields. Dealing with these multiples is not intuitive even to the more experienced user.



## Print, Anat Path [LRAPP]

### Descriptions

<b>Option</b>	<b>Description</b>
Print All Reports on Queue	Prints a report listing the clinical history and gross description for review for patients on the cumulative report print queue, as well as final reports for patients and completed autopsy reports.
Delete Report Print Queue	Deletes the entries on the print queue list for the area specified.
List Pathology Reports in Print Queue	Displays a list of preliminary or final reports in a print queue.
Print Single Reports Only	Prints the report of pathology accessions in cytopath, EM, autopsy, or surgical path for cumulative reports for micro exams.
Add Patient(s) to Report Print	Adds patients to the report print queue. Queue for the area specified.
<b>Autopsy Administrative Reports:</b>	
Autopsy Data Review	Review of autopsy data includes # of deaths, number of autopsies, autopsy %, cases with and without major diagnostic disagreements, and cases in which clinical diagnoses are clarified.
Alphabetical Autopsy List	List of autopsies from one date to another. Report includes patient name, the SSN, Autopsy number, and autopsy date.

<b>Option</b>	<b>Description</b>
Autopsy Status List	List of autopsies from one accession # to another within a year. Report includes Autopsy #, patient name, last four digits of the SSN, location, autopsy date, date of final autopsy diagnoses (FAD), and date autopsy completed.
<b>Anat Path Accession Reports:</b>	
Anat Path Accession List by Date	Prints or displays an accession list for a specific date or a range of dates, alphabetically by patient or in ascending accession number order. If the cytopathology accessions were reviewed by a pathologist, "*" will appear after the slide count.
Anat Path Accession List by Number	Prints or displays an accession list for a specific accession number or range of numbers, by patients alphabetically or by ascending accession number.
Sum of Accessions by Date, Anat Path	Lists accession counts by day from one date to another with totals and number of patients.
Entries by Dates, Patient, and Accession #	Prints a list of accessions by patient, with organ/tissue data, an accession # index, or (for cytopath) a calculation of the percent of positive diagnoses, for specified dates.
List of Path Cases by Resident, Tech or Senior or Clinician	Prints or displays a list of the senior resident's, technician's, pathologist's or clinician's cases for a specified time.



<b>Option</b>	<b>Description</b>
% Pos, Atyp, Dysp, Neg, Susp, & Unsat Cytopath	Prints the number and % of positive, negative, and suspicious specimens for malignancy and unsatisfactory specimens from one date to another.
Accession List With Stains	Lists histologic stains for a selected series of accessions.
Accession Counts by Senior Pathologist	Tallies cases by accession area, sorted by the senior pathologist assigned to the case. Contributes to analysis of quality assurance information, since this information relies on the total number of cases, as well as the data for the "outlyers."
Cum Path Data Summaries	Cumulative summary of surgical path, EM, and autopsy for screen display or hard copy.
<b>Anatomic Pathology Labels:</b>	
Anat Path Slide Labels Anat Path Specimen Labels Autopsy Slide Labels (generic)	Allows labels to be printed for surgical path, cytopath, electron microscopy and autopsy from one number to another within a year. If there is more than one specimen for an accession, a separate label will print for each specimen.
<b>Edit/Print/Display Preselected Lab Tests:</b>	
Print/Display Preselected Lab Tests Enter/Edit User Defined Lab Test Lists	Users can define lab tests and patient lists for display or to print, from one date to another. If tests are not defined by the user, the lab-defined list will be displayed.

<b>Option</b>	<b>Description</b>
Print Log Book	Prints accessions from one number to another within a year.
Print Final Path Reports by Accession Number	Prints accessions from one number to another within a year. Can be used to make tapes for microfiche.

## Print Queue Information

A print queue is a list of reports to be printed. When a gross description for any accession is entered, that accession is added to the preliminary report print queue or list of accessions to be printed on demand. Likewise, when the microscopic description is entered, the accession is placed on the final report print queue. All reports on either of these queues may be printed at any time, usually daily. Please remember at some point to “kill” the queue before the next day’s reports are typed. If this is not done, the previous day’s reports will print again, as well as the current day’s, resulting in a lot of wasted paper and time. Either preliminary reports or final reports may be printed singly without affecting what is on either queue. Reports may also be added to either queue manually, using the Add Patient(s) to Report Print Queue [LRAP ADD] option, in an instance where the old or duplicate report needs to be reprinted.

## Print All Reports on Queue [LRAP PRINT ALL ON QUEUE]

This option prints either preliminary reports listing the clinical history and gross description for review for patients on the cumulative report print queue or final reports for patients and completed autopsy reports.

NOTE: When printing from the print queue, save the print queue until you verify that the reports have been printed successfully. If the printer has problems, runs out of paper, etc., it can be very frustrating to figure out what was in the print queue. If it prints successfully, the print queue can then be deleted. If it is not deleted at that point, that batch of reports will reprint the next time.

### **Example 1: Surgical Pathology Preliminary Report**

Select Print, anat path Option: **PQ** Print all reports on queue

Select ANATOMIC PATHOLOGY section: **SP** SURGICAL PATHOLOGY

1. Preliminary reports
2. Final reports

Select 1 or 2 : **1**

Preliminary reports for SURGICAL PATHOLOGY

Add/Delete reports to/from print queue for 1990? NO// **N**

Select Print Device: *[Enter Print Device Here]*

Surgical Pathology Preliminary Report

-----  
 MEDICAL RECORD : SURGICAL PATHOLOGY Pg 1  
 -----

Submitted by: JOE WELBY MD Date obtained: NOV 20, 1990  
 -----

Specimen:  
 PROSTATE CHIPS  
 -----

Brief Clinical History:  
 Nocturia and difficulty voiding urine.  
 -----

Preoperative Diagnosis:  
 Enlarged prostate.  
 -----

Operative Findings:  
 Same.  
 -----

Postoperative Diagnosis:  
 Same.  
 -----

Surgeon/physician: JOE WELBY MD  
 =====

PATHOLOGY REPORT

Laboratory: R5ISC Accession No. SP90 22  
 -----

\*\*\*\* REPORT INCOMPLETE \*\*\*\*

Gross description: Pathology Resident: RUSS ANEY

Specimen consists of 25 grams of prostate gland tissue.

Microscopic exam/diagnosis:  
 -----

(End of report)  
 MARCUS WELBY MD rg : Date  
 -----

HUDSON,ALBANY SURGICAL PATHOLOGY Report  
 ID:366-61-8472 SEX:M DOB:5/8/16 AGE:74 LOC:1A JOE WELBY MD

AP Menu Options

NOV 20, 1990 09:27 ANATOMIC PATHOLOGY R5ISC Pg 2

-----  
HUDSON,ALBANY SSN:366-61-8472 DOB:5/8/16

SURGICAL PATHOLOGY

Organ/tissue: Date rec'd: 11/20/90 Acc #: 22  
Report not verified.

Organ/tissue: Date rec'd: 06/04/89 Acc #: 22  
SKIN

PSORIASIS

Organ/tissue: Date rec'd: 04/05/87 Acc #: 567  
SKIN OF FACE

BASAL CELL CARCINOMA

Organ/tissue: Date rec'd: 02/01/85 Acc #: 12  
INGUINAL REGION

HERNIA SAC

Organ/tissue: Date rec'd: 01/02/85 Acc #: 3456  
SKIN

PSORIASIS

CYTOPATHOLOGY

Organ/tissue: Date rec'd: 06/03/90 Acc #: 6  
SPUTUM

NEGATIVE FOR MALIGNANT CELLS

Organ/tissue: Date rec'd: 07/09/88 Acc #: 4588  
URINE

NEGATIVE FOR MALIGNANT CELLS

Organ/tissue: Date rec'd: 05/06/81 Acc #: 1233  
SPUTUM

NEGATIVE FOR MALIGNANT CELLS

ELECTRON MICROSCOPY

Organ/tissue: Date rec'd: 02/01/89 Acc #: 23  
KIDNEY

GLOMERULONEPHRITIS, MESANGIAL PROLIFERATIVE

=====

**Example 2: Surgical Pathology Final Patient Report**

You'll need to decide whether the copy of the report to be charted should contain the SNOMED codes. If the report for the local pathology office file is to have the codes, but the one to be charted is not, you will have to print the reports on the print queue twice, answering the prompts differently each time.

Select Print, anat path Option: **PQ** Print all reports on queue

Select ANATOMIC PATHOLOGY section: **SP** SURGICAL PATHOLOGY

1. Preliminary reports

2. Final reports

Select 1 or 2 : **2**

SURGICAL PATHOLOGY FINAL PATIENT REPORTS

Print SNOMED &/or ICD codes on final report(s)? NO// **Y** (YES)

Save final report list for reprinting ? NO// **Y** (YES)

Select Print Device: *[Enter Print Device Here]*

## Surgical Pathology Final Patient Report

MEDICAL RECORD : SURGICAL PATHOLOGY Pg 1

-----  
Submitted by: JOE WELBY MD Date obtained: NOV 20, 1990  
-----

Specimen:  
PROSTATE CHIPS  
-----

Brief Clinical History:  
Nocturia and difficulty voiding urine.  
-----

Preoperative Diagnosis:  
Enlarged prostate.  
-----

Operative Findings:  
Same.  
-----

Postoperative Diagnosis:  
Same  
-----

Surgeon/physician: JOE WELBY MD  
=====

### PATHOLOGY REPORT

Laboratory: R5ISC Accession No. SP88 22  
-----

Gross description: Pathology Resident: RUSS ANEY

Specimen consists of 25 grams of prostate gland tissue.

#### Microscopic exam:

Prostate gland tissue showing glandular and stromal hyperplasia. In one chip of 134 there is a small focus of well differentiated adenocarcinoma.

SURGICAL PATH DIAGNOSIS: Well differentiated adenocarcinoma.

SNOMED code(s):

T-77100: prostate

M-814031: adenocarcinoma, well differentiated

M-72000: hyperplasia  
-----

(End of report)

MARCUS WELBY MD rg: Date NOV 20,.1990  
-----

HUDSON,ALBANY

SURGICAL PATHOLOGY Report

ID:366-61-8472 SEX:M DOB:5/8/16 AGE: 74 LOC: 1A JOE WELBY MD



**Example 3: Surgical Pathology Report with Frozen Section**

Select ANATOMIC PATHOLOGY section: **SP** SURGICAL PATHOLOGY

1. Preliminary reports
2. Final reports

Select 1 or 2 : **2**

SURGICAL PATHOLOGY FINAL PATIENT REPORTS

Add/Delete reports to/from print queue for 1992 ? NO// **<RET>** (NO)

Print SNOMED &/or ICD codes on final report(s) ? NO// **Y** (YES)

Save final report list for reprinting ? NO// **Y** (YES)

Select Print Device: *[Enter Print Device Here]*

AP Menu Options

-----  
MEDICAL RECORD | SURGICAL PATHOLOGY Pg 1  
-----

Submitted by: MARCUS WELBY MD Date obtained: DEC 3, 1992  
-----

Specimen (Received DEC 3, 1992 10:45):  
LEFT NOSE BIOPSY  
-----

Brief Clinical History:  
-----

Preoperative Diagnosis:  
-----

Operative Findings:  
-----

Postoperative Diagnosis:  
Surgeon/physician: MARCUS WELBY MD  
=====

PATHOLOGY REPORT  
Laboratory: DALLAS ISC-DEVELOPMENT ACCOUNT Accession No. SP92 26  
-----

Gross Description

SCO a round skin biopsy measuring 1 x 1 x 0.5 cm. There is an ill defined depressed central lesion. A suture marks the superior margin which is inked in red. Inferior margin is inked in green, anterior blue and posterior uninked. Representative sections embedded.

Frozen Section:

Basal cell CA, adequately excised. Reported to Dr. Welby at x2420 at 10:55AM.

Microscopic Description

Residual basal cell carcinoma in biopsy site. Adequately excised. See also S92-16.

SURGICAL PATH DIAGNOSIS: Basal cell carcinoma.

SNOMED code(s):

- T-02140: skin of nose
- M-80903: basal cell carcinoma
- M-09400: surgical margins free of tumor
- P-1141 : biopsy, excision

-----  
RON GINS MD (End of report)  
lh | Date DEC 3, 1992  
-----

DUSTY, RUSTY STANDARD FORM 515  
ID:089-48-5948 SEX:M DOB:4/27/25 AGE:67 LOC:SURGERY MARCUS WELBY MD

**Example 4: Change in Prompts if you Select the Autopsy Section**

Select Anatomic pathology Option: **P** Print, anat path

Select Print, anat path Option: **PQ** Print all reports on queue

Select ANATOMIC PATHOLOGY section: **AU** AUTOPSY

1. Autopsy protocols
2. Autopsy supplementary reports

Select 1 or 2: **1**

Autopsy Protocols

(D)ouble or (S)ingle spacing of report(s): **S**

Print weights, measures and coding (if present): ? YES// **<RET>** (YES)

Save protocol list for reprinting ? NO// **Y** (YES)

Select Print Device: **[Enter Print Device Here]**

## AP Menu Options

---

CLINICAL RECORD	AUTOPSY PROTOCOL	Pg 1
-----------------	------------------	------

---

Date died: DEC 1, 1992	Autopsy date: DEC 1, 1992
Resident: A92 5	FULL AUTOPSY Autopsy No.

---

### Clinical History

1. Left CVA 2. Recurrent UTI 3. Aspiration pneumonia 4. Chronic renal failure

---

### Anatomic Diagnoses

#### PATHOLOGICAL DIAGNOSIS:

1. Bilateral pulmonary edema with bilateral pleural effusion (500cc)
  - a. Organizing pneumonia right lung
  - b. Organizing pneumonia, right lung, with acute bronchitis
  - c. Calcified granuloma, left upper lobe (gross)
  - d. Emphysema (bilateral) and focal atelectasis (left)
2.
  - a. Moderate arteriosclerosis of abdominal aorta
  - b. Cardiomegaly(480 gm) with left ventricular hypertrophy
  - c. Pericardial effusion with chronic peritonitis
  - d. Focal interstitial fibrosis
3. Bilateral granular kidneys with severe arterial and arterionephrosclerosis and mesangial thickening
  - a. 3 x 2 cm cyst left kidney
  - b. 0.3 x 0.3 cm hemorrhagic cysts, left kidney
  - c. Hemorrhagic bladder mucosa
  - d. Hemorrhagic bladder mucosa with chronic cystitis and prostatic urethritis
4. Choletlithiasis with 25 stones (yellow, 0.5 to 1 cm)
  - a. Congested liver parenchyma
  - b. Diverticulosis, colon

GROSS BRAIN DIAGNOSIS: No pathologic diagnosis MICROSCOPIC BRAIN DIAGNOSIS: pending - supplemental report to be issued.

#### CLINICO-PATHOLOGICAL CORRELATION

Patient was an .....

---

Pathologist: MARCUS WELBY MD	lh   Date DEC 2, 1992
------------------------------	-----------------------

---

DALLAS ISC-DEVELOPMENT ACCOUNT	AUTOPSY	PROTOCOL
BOGGESS, HENRY 234-88-9898	DOB: DEC 18, 1925 AGE:66 1A	ED BAD

DEC 2, 1992 08:10 DALLAS ISC-DEVELOPMENT ACCOUNT  
 ANATOMIC PATHOLOGY

Pg: 2

-----  
 BOGGESS,HENRY SSN:234-88-9898 DOB:DEC 18, 1925  
 Acc # Date/time Died Age AUTOPSY DATA Date/time of Autopsy  
 5 DEC 1, 1992 66 FULL AUTOPSY DEC 1, 1991  
 Senior:WELBY,MARCUS

SNOMED code(s):

T-28000: lung  
     M-36660: edema, lymphatic  
     M-32800: emphysema  
     M-49000: fibrosis  
 T-29000: pleura  
     M-36330: effusion, serosanguineous  
 T-28100: right lung  
     M-40000: inflammation  
 T-28600: left upper lobe of lung  
     M-44000: inflammation, granulomatous  
 T-71000: kidney  
     M-52200: arteriolosclerosis  
 T-57000: gallbladder  
     M-30010: lithiasis  
 T-56000: liver  
     M-36100: congestion  
 T-67000: colon  
     M-32710: diverticulosis  
 T-42000: aorta  
     M-52000: arteriosclerosis  
 T-33010: myocardium  
     M-71000: hypertrophy

-----  
 Pathologist: MARCUS WELBY MD

lh | Date DEC 2, 1992

-----  
 DALLAS ISC-DEVELOPMENT ACCOUNT AUTOPSY PROTOCOL  
 BOGGESS,HENRY 234-88-9898 DOB: DEC 18, 1925 AGE:66 MEDICINE ED BAD

## Delete Report Print Queue [LRAP DELETE]

Deletes all entries on the report queue for the accession area that is selected.

Select Print, anat path Option: **DQ** Delete report print queue

Select ANATOMIC PATHOLOGY section: **SP** SURGICAL PATHOLOGY

1. Preliminary reports

2. Final reports

Select 1 or 2 : **2**

SURGICAL PATHOLOGY FINAL PATIENT REPORTS

OK TO DELETE THE SURGICAL PATHOLOGY FINAL REPORT LIST? NO//**Y** (YES)  
LIST DELETED !

## List Pathology Reports in Print Queue [LRAPQ]

Whenever data is entered through the Gross Description/Clinical Hx [LRAPDGD] option for any accession area, the system will automatically place the patient in the print queue for preliminary reports. When data is entered through the other data entry options (i.e., those for final surgical path reports, modified reports or supplementary reports), the patient is automatically placed in the print queue for final reports.

### **Example 1: Surgical Pathology Preliminary Report**

Select Anatomic pathology Option: **P** Print, anat path

Select Print, anat path Option: **LQ** List pathology reports in print queue

Select ANATOMIC PATHOLOGY section: **SP** SURGICAL PATHOLOGY

List of pathology reports in print queue

1. Preliminary reports
2. Final reports

Select 1 or 2 : **1**

Select Print Device: *[Enter Print Device Here]*

```
-----
          SURGICAL PATHOLOGY PRELIMINARY REPORTS IN PRINT QUEUE Pg: 1
Acc # Date      Patient                SSN
   22 11/20/90  HUDSON,ALBANY                336-61-8472
=====
```

## AP Menu Options

### **Example 2: Surgical Pathology Final Report**

#### ANATOMIC PATHOLOGY MENU

Select Anatomic pathology Option: **P** Print, anat path

Select Print, anat path Option: **LQ** List pathology reports in print queue

Select ANATOMIC PATHOLOGY section: **SP** SURGICAL PATHOLOGY

List of pathology reports in print queue

1. Preliminary reports
2. Final reports

Select 1 or 2 : **2**

Select Print Device: *[Enter Print Device Here]*

Acc #	Date	Patient	SSN
5	05/09/90	WASHINGTON, GEORGE CHERRY	012-45-8762
15	08/11/90	LORETTA, LYNN M	352-44-1491
21	11/08/90	WASHINGTON, GEORGE CHERRY	012-45-8762
22	11/20/90	HUDSON, ALBANY	355-61-8472



Print Single Report Only [LRAP PRINT SINGLE]

Prints the report of pathology accessions in cytopath, EM, autopsy, or surgical path for cumulative reports for micro exams.

**Example: Preliminary Reports**

Select Anatomic pathology Option: **P** Print, anat path  
 Select Print, anat path Option: **PS** Print single report only  
 Select ANATOMIC PATHOLOGY section: **EM**  
     1. Preliminary reports  
     2. Final reports  
 Select 1 or 2 : **1**  
 Preliminary reports for EM  
 Select PATIENT NAME: **WASHINGTON,GEORGE C.** 02-01-12 012458762 NO NSC VETERAN  
 WASHINGTON,GEORGE CHERRY ID: 012-45-8762 Physician: STUHR,GARY  
  
 AGE: 77 DATE OF BIRTH: FEB 1, 1912  
 Ward on Adm: 1 EAST Service: PSYCHOLOGY  
 Adm Date: JUL 8, 1990 10:53 Adm DX: STRESS  
 Present Ward: 1 EAST MD: WELBY,JOE

Specimen(s)	Count #	Accession #	Date
	( 1)	10	JUL 28, 1990 not verified
	( 2)	6	JUN 10, 1990 not verified
	( 3)	1	JUL 3, 1989 KIDNEY BIOPSY
	( 4)	2319	APR 12, 1989 SPUTUM

More accessions ? NO// **<RET>** (NO)  
 Choose Count #(1-4): **1**  
 Accession #: 10 Date: JUL 28, 1990

Select Print Device: *[Enter Print Device Here]*

AP Menu Options

MEDICAL RECORD |

EM

Pg 1

Submitted by: HAROLD FRANKENSTIEN MD Date obtained: JUL 28, 1990

Specimen (Received JUL 28, 1990 12:35):

Brief Clinical History:

Preoperative Diagnosis:

Operative Findings:

Postoperative Diagnosis:

Surgeon/physician: GARY STEMMONS MD

=====
PATHOLOGY REPORT

Laboratory: SIUG, VAMC

Accession No. EM90 10

Prepared by: IFCAP ADPAC

Gross description:

This is where the gross description should be entered.

Microscopic description:

This is where the microscopic examination description should be entered.

(See next page)

JOHN DOE WILLIAMS MD

ec | Date SEP 2, 1994

WASHINGTON, GEORGE CHERRY

STANDARD FORM 515

ID:012-45-8762 SEX:M DOB:2/1/12 AGE:77 LOC:AMBULATORY SURGERY

GARY STEMMONS MD

DEC 1, 1989 11:41 SIUG  
ANATOMIC PATHOLOGY

Pg: 2

-----  
SURGICAL PATHOLOGY

Organ/tissue:	Date rec'd: 03/28/90	Acc #:	9
Report not verified.			
Organ/tissue:	Date rec'd: 11/08/89	Acc #:	21
SKIN			
PSORIASIS			
IMMUNOFLUORESCENCE 21-I Date: NOV 13, 1989			
LIVER			
PAIN, NOS			
LOSS OF VOICE			
DIABETES MELLITUS			
TUBERCULOSIS			
CIRRHOSIS			
ALCOHOL			
HEMANGIOMA			
ELECTRON MICROSCOPY E-21-88	Date: NOV 13, 1989	06:27	
Organ/tissue:	Date rec'd: 11/07/89	Acc #:	20
Report not verified.			
Organ/tissue:	Date rec'd: 08/01/89	Acc #:	12
NAIL OF TOE			
HEMATOMA			
Organ/tissue:	Date rec'd: //	Acc #:	345
Report not verified.			
Organ/tissue:	Date rec'd: 06/02/89	Acc #:	7
SKIN			
PAIN, NOS			
DIABETES MELLITUS, ADULT ONSET TYPE			
PSORIASIS			
ABSCESS			
STAPHYLOCOCCUS AUREUS			
Organ/tissue:	Date rec'd: 05/10/89	Acc #:	5
Report not verified.			
Organ/tissue:	Date rec'd: 07/31/88	Acc #:	12
ACHILLES TENDON			
ACQUIRED DIGITAL FIBROKERATOMA			
Organ/tissue:	Date rec'd: 07/31/88	Acc #:	475
Report not verified.			
Organ/tissue:	Date rec'd: 03/05/88	Acc #:	457
Report not verified.			
Organ/tissue:	Date rec'd: 02/09/88	Acc #:	456
SKIN			
BASAL CELL CARCINOMA			
Organ/tissue:	Date rec'd: 01/03/88	Acc #:	1
SKIN			
CHRONIC INFLAMMATION			



DEC 1, 1989 11:41 SIUG  
ANATOMIC PATHOLOGY

Pg: 4

-----  
WASHINGTON, GEORGE CHERRY

SSN: 012-45-8762 DOB: 2/1/12

## Add Patient(s) to Report Print Queue [LRAP ADD]

This option allows you to add a patient or patients to a print queue without having to go back into the report and reverify.

### **Example:**

Select Print, anat path Option: **AD** Add patient(s) to report print queue

Select ANATOMIC PATHOLOGY section: **SP** SURGICAL PATHOLOGY

1. Preliminary reports
2. Final reports

Select 1 or 2 : **2**

SURGICAL PATHOLOGY FINAL PATIENT REPORTS

Select Patient Name: **ARCHER, MARK** 07-06-84 433433333  
ARCHER, MARK ID: 433-43-3333 Physician: FRANKENSTIEN, HAROLD

AGE: 10 DATE OF BIRTH: JUL 6, 1984  
Ward on Adm: 2 EAST Service: PEDIATRICS  
Adm Date: APR 8, 1994 10:53 Adm DX: FEVER  
Present Ward: 1 EAST MD: JONES, TOM  
Specimen(s) Count # Accession # Date  
( 1) 123 AUG 31, 1994  
Accession #: 123 Date: AUG 31, 1994

Select Patient Name: **<RET>**

Select ANATOMIC PATHOLOGY section: **SP** SURGICAL PATHOLOGY

1. Preliminary reports
2. Final reports

Select 1 or 2 : **2**

SURGICAL PATHOLOGY FINAL PATIENT REPORTS

Select Patient Name: **HUDSON, ALBANY** 05-08-16 366618472  
HUDSON, ALBANY ID: 366-61-8472

AGE: 74 DATE OF BIRTH: MAY 8, 1916  
Ward on Adm: 3 EAST Service: UROLOGY  
Adm Date: SEP 4, 1993 10:53 Adm DX: PAIN  
Present Ward: 1 EAST MD: QUACK, IMA

Specimen(s)	Count #	Accession #	Date
PROSTATE CHIPS	( 1)	22	SEP 6, 1994
	( 2)	22	JUN 4, 1989
	( 3)	567	APR 5, 1986
	( 4)	12	FEB 1, 1984

More accessions ? NO// **<RET>** (NO)

Choose Count #(1-4) : **1**

Accession #: 22 Date: SEPV 6, 1994

Select Patient Name: **<RET>**

## Autopsy Administrative Reports [LRAPAUP]

### **Autopsy Data Review [LRAPAUVR]**

Use this option to obtain information on the percent of deaths on which autopsies are performed and the number of cases in which the autopsy provided information which either clarified or contradicted the clinical diagnosis. The option searches the patient file for deaths occurring within the specified time. It tallies the number of deaths and the number of autopsies as well as the data entered through the Final Autopsy Diagnosis Date [LRAPAUFD] option.

#### **Example:**

```
Select Print, anat path Option: AU Autopsy administrative reports
  AD Autopsy data review
  AA Alphabetical autopsy list
  AS Autopsy status list
Select Autopsy administrative reports Option: AD Autopsy data review
Start with Date TODAY// <RET> SEP 08, 1993
Go to Date TODAY// 1/1/90 (JAN 01, 1990)

Count only in-patient deaths ? YES// <RET> (YES)
Select Print Device: [Enter Print Device Here]
```

```
SEP 8, 1993 14:44 VAMC Pg: 1
AUTOPSY DATA REVIEW (JAN 1, 1990-SEP 8, 1993)
|-----In-patient-----|DIAGNOSTIC          | CLINICAL DIAGNOSIS
|                          |DISAGREEMENT       | CLARIFIED
Autopsy  Autopsy date    | Yes      No      | Yes  No  Verified
-----|-----|-----|-----|-----|-----|-----
A90  1  MAY 31, 1990  12:00          X          X
A93  1  MAY 11, 1993  15:56          X          X
A93  2  MAY 11, 1993  15:58          X          X
A93  3  MAY 11, 1993  16:03          X          X
A93  4  MAY 11, 1993  16:07          X          X
A93  5  JUN 20, 1993          X          X
A93  6  AUG 6, 1993  12:57          X          X
A93  8  AUG 6, 1993  13:09          X          X
```

Please hold, calculating Autopsy% ...

```
SEP 8, 1993 14:44 VAMC Pg: 2
AUTOPSY DATA REVIEW (JAN 1, 1990-SEP 8, 1993)
|-----In-patient-----|DIAGNOSTIC          | CLINICAL DIAGNOSIS
|                          |DISAGREEMENT       | CLARIFIED
# Deaths # Autopsies  Autopsy% |#Yes  #No  |#Yes  #No  Verified
-----|-----|-----|-----|-----|-----|-----
      10         8      80.0    7      1      8
```

## Alphabetical Autopsy List [LRAPUA]

This option provides a list of autopsies from one date to another and is meant to replace a site's card file of autopsies.

### Example:

Select Anatomic pathology Option: **P** Print, anat path

Select Print, anat path Option: **AU** Autopsy administrative reports

Select Autopsy administrative reports Option: **AA** Alphabetical autopsy list

Start with Date TODAY// **<RET>** DEC 24, 1991

Go to Date TODAY// **1/1** (JAN 01, 1991)

Select Print Device: *[Enter Print Device Here]*

DEC 24, 1991 05:42 VAMC Pg: 1

Autopsy List from JAN 1, 1991 to DEC 24, 1991

Patient	SSN	Autopsy#	Autopsy Date
---------	-----	----------	--------------

PATIENT,FIRST	123-45-6789	AU91-23	3/23/91
---------------	-------------	---------	---------



## Autopsy Status List [LRAPAUSTATUS]

This option produces a list of autopsies from one accession # to another within a year. The report includes Autopsy #, patient name, last four digits of the SSN, location, autopsy date, date of Final Autopsy Diagnoses (FAD), and date autopsy completed.

### Example:

Select Autopsy administrative reports Option: **AS** Autopsy status list

```

AUTOPSY STATUS LIST
Select year: 90 (1990)
Start with Acc #: 1
Go to Acc #: LAST // <RET>
Select Print Device: [Enter Print Device Here]
    
```

```

SEP 12, 1988 10:22 LABORATORY SERVICE R5ISC Pg: 1
Autopsy Status List |-----Date -----|
Acc# Patient ID Loc Autopsy PAD FAD Completed Pathologist(s)
1 OLDER,SAM 8316 CCC 4/26/88 4/26/88 4/26/88 4/26/88 WELBY,MARK
WELBY,HARRY
2 YOKUM,SALLY 7891 1A 7/28/88 7/29/88 7/29/88 7/29/88 WELBY,JOE
ANEY, RUSS
    
```

## Anat Path Accession Reports [LRAPPAR]

### **Anat Path Accession List by Date [LRAPPAD]**

This patient report, printed monthly or quarterly, provides a valuable resource during computer downtime or for those times in which the exact date of the specimen is unknown.

#### **Example 1:**

Select Anatomic pathology Option: **P** Print, anat path

Select Print, anat path Option: **AR** Anat path accession reports

Select Anat path accession reports Option: **LD** Anat path accession list by date

Select ANATOMIC PATHOLOGY section: **SP** SURGICAL PATHOLOGY

#### SURGICAL PATHOLOGY ACCESSION LIST

Start with Date TODAY// **<RET>** (NOV 21, 1990)

Go to Date TODAY// **T-7** (NOV 07, 1990)

List by (A)ccession number (P)atient : Accession number

Select Print Device: *[Enter Print Device Here]*

NOV 21, 1990 14:29 VAMC

Pg: 1

LABORATORY SERVICE SURGICAL PATHOLOGY (NOV 07, 1990 - NOV 21, 1990)

# - Not VA patient

% = Incomplete

Acc # Date Patient ID Loc Physician

-----  
22 11/20 HUDSON,ALBANY 8472 1A JOE WELBY PROSTATE

This comment will appear on the log book.

23 11/21 HUDSON,ALBANY 8472 1A JOE WELBY SKIN %No SNOMED code

**Example 2:**

Select Print, anat path Option: **AR** Anat path accession reports

Select Anat path accession reports Option: **LD** Anat path accession list by date

Select ANATOMIC PATHOLOGY section: **SP** SURGICAL PATHOLOGY

SURGICAL PATHOLOGY ACCESSION LIST

Start with Date TODAY// **<RET>** SEP 02, 1994

Go to Date TODAY// **T-29** (AUG 09, 1990)

List by (A)ccession number (P)atient : Patient

Select Print Device: *[Enter Print Device Here]*

SEP 07, 1994 14:29 VAMC Pg: 1

LABORATORY SERVICE SURGICAL PAT ACCESSIONS (AUG 9, 1994 - SEP 7, 1994)

# - Not VA patient % = Incomplete

Count	ID	Patient	Acc#				
1)	4811	#ANDREWS,JOHN	12 08/30	1	WEST	No	SNOMED code
			14 08/30	2	EAST	No	SNOMED code
2)	3112	#ELIJAH,SAM	13 08/30	1	WEST	No	SNOMED code
3)	0000	ARDEN,EVE	6 08/25	1	EAST	No	SNOMED code
			7 08/25	1	EAST	LEG	
4)	1114	BLARNEY,STONE	16 09/02		AMBULAT	No	SNOMED code
			17 09/03		AMBULAT	No	SNOMED code
5)	0000	DUCK,DAISY	11 08/27		RED CLI	TOE	
6)	1123	PAGES,YELLOW	10 08/26	1	EAST	No	SNOMED code
7)	9832	PILLOW,TED	2 08/24	1	EAST	PROSTATIC	FASCIA
8)	0114	SIMPLE,SARA	1 08/10	1	EAST	No	SNOMED code
9)	4343	SANSOM,TERRY	4 08/24	1	WEST	PROSTATE	

...

## Anat Path Accession List by Number [LRAPPAN]

Prints or displays an accession list for a specific accession number or range of numbers, by patients, alphabetically, or by ascending accession number.

### Example 1: List by Accession number

Select Anat path accession reports Option: **LN** Anat path accession list by number

Select ANATOMIC PATHOLOGY section: **SP** SURGICAL PATHOLOGY

#### SURGICAL PATHOLOGY ACCESSION LIST

Accession list date: 1994 OK ? YES// **<RET>** (YES)

Start with Acc #: **1**

Go to Acc #: LAST// **17**

LIST BY PATIENT ? NO// **<RET>** (NO)

Select Print Device: *[Enter Print Device Here]*

```
-----
```

SEP 08, 1994 14:30	Pg: 1			
LABORATORY SERVICE SURGICAL PATHOLOGY ACCESSIONS for 1994				
# - Not VA patient	% = Incomplete			
Acc num	Patient	ID	Loc	Organ/tissue
-----				
1	SIMPLE,SARA	0114P	1 EAS %	No SNOMED code
2	PILLOW,TED	9832	1 EAS	PROSTATIC FASCIA
3	UNGER,FELIX	4444	1 EAS	LIVER
4	SANSOM,TERRY	4343	1 WES	PROSTATE
5	TEMPLE,SILVIA	6104	1 NOR	SKIN OF NOSE
6	ARDEN,EVE	0000	1 EAS %	No SNOMED code
7	ARDEN,EVE	0000	1 EAS	LEG
8	WALRUS,WALLY	3454	5 NOR	BONE MARROW
10	PAGES,YELLOW	1123	1 EAS	No SNOMED code
11	DUCK,DAISY	0000	RED C	TOE
12	#ANDREWS,JOHN	4811	1 WES	No SNOMED code
13	#ELIJAH,SAM	3112	1 WES %	No SNOMED code
14	#ANDREWS,JOHN	4811	2 EAS %	No SNOMED code
15	WALRUS,WALLY	3454	5 NOR %	No SNOMED code
16	BLARNEY,STONE	1114	AMBUL	No SNOMED code
17	BLARNEY,STONE	1114	AMBUL %	No SNOMED code

**Example 2: List by Patient**

Select Anat path accession reports Option: **LN** Anat path accession list by number

Select ANATOMIC PATHOLOGY section: **SP** SURGICAL PATHOLOGY

SURGICAL PATHOLOGY ACCESSION LIST

Accession list date: 1994 OK ? YES// **<RET>** (YES)

Start with Acc #: **5**

Go to Acc #: LAST// **12**

LIST BY PATIENT ? NO// **Y**

Select Print Device: *[Enter Print Device Here]*

-----  
SEP 08, 1994 14:30 VAMC

Pg: 1

LABORATORY SERVICE SURGICAL PATHOLOGY ACCESSIONS for 1988

# - Not VA patient % = Incomplete

Count	ID	Patient	ACC#	Organ/tissue
1)	4811	#ANDREWS,JOHN	12	No SNOMED code
2)	0000	ARDEN,EVE	6 %	No SNOMED code
			7	LEG
3)	0000	DUCK,DAISY	11	TOE
4)	1123	PAGES,YELLOW	10	No SNOMED code
5)	6104	TEMPLE,SILVIA	5	SKIN OF NOSE
6)	3454	WALRUS,WALLY	8	BONE MARROW

### Sum of Accessions by Date, Anat Path [LRAPA]

This option lists accession counts by day from one date to another, with totals and number of patients.

Select Anat path accession reports Option: **SD** Sum of accessions by date, anat path

Select ANATOMIC PATHOLOGY section: **SP** SURGICAL PATHOLOGY

#### SURGICAL PATHOLOGY ACCESSION/SPECIMEN LIST COUNT BY DAY

Start with Date TODAY// **<RET>** SEP 08, 1995

Go to Date TODAY// **1/1/90** (JAN 01, 1990)

Select Print Device: *[Enter Print Device Here]*

SEP 8, 1994 18:32 DALLAS ISC, VERIFICATION ACCT Pg: 1

#### SURGICAL PATHOLOGY ACCESSION/SPECIMEN COUNT BY DATE

FROM JAN 1, 1990 TO SEP 8, 1994

DATE	Accession Count	Specimen count
APR 30, 1990	1	1
MAY 1, 1990	1	1
AUG 24, 1990	1	1
AUG 10, 1994	1	2
AUG 24, 1994	4	4
AUG 25, 1994	3	3
AUG 26, 1994	2	2
AUG 27, 1994	1	1
AUG 30, 1994	3	3
SEP 2, 1994	2	2
SEP 3, 1994	1	1
Total number	20	21
Total Patients: 16		

**Entries by Dates, Patient and Accession Number [LRAPPF]**

Although this report provides much of the same information as that from Accession List by Date [LRAPPAD] option or Print Log Book [LRAPBK] option, the summary here is by patient and also includes the SNOMED-coded diagnoses. It can be used to provide a full hard copy of the patient's cumulative summary during computer downtimes. This report should either be printed for short periods of time or during non-peak hours, since it includes **all** patients within the time specified, and will be quite lengthy.

**Example:**

Select Anat path accession reports Option: **PD** Entries by dates,patient & accession #

Select ANATOMIC PATHOLOGY section: **SP** SURGICAL PATHOLOGY

SURGICAL PATHOLOGY Entries by Patient & Accession # Index

Start with Date TODAY// **<RET>** NOV 21, 1990  
 Go to Date TODAY// **T-14** (NOV 07, 1990)  
 Select Print Device: *[Enter Print Device Here]*

```

HUDSON,ALBANY                366-61-8472      BORN: MAY 8, 1916
  Organ/tissue: Date rec'd: 11/21/90      Acc #: 23
  Report not verified.
  Organ/tissue: Date rec'd: 11/20/90      Acc #: 22
  PROSTATE 25 GM
    ADENOCARCINOMA, WELL DIFFERENTIATED
    HYPERPLASIA

WASHINGTON,GEORGE CHERRY    012-45-8762      BORN: FEB 1, 1912
  Organ/tissue: Date rec'd: 11/08/90      Acc #: 21
  SKIN
    PSORIASIS
  LIVER
    PAIN
    DIABETES MELLITUS
    CIRRHOSIS
    ALCOHOL
  Organ/tissue: Date recorded: 11/07/90    Acc #: 20
  Report not verified.
    
```

NOV 21, 1990 14:32 Pg 1

SURGICAL ACCESSION INDEX (from: NOV 7, 1990 to: NOV 21,90 )

YEAR	Acc#	Entry	Identifier	File
------	------	-------	------------	------

```

-----
1990 :
  20 WASHINGTON,GEORGE CHERRY    012458762      REFERRAL PT
  21 WASHINGTON,GEORGE CHERRY    012458762
  22 HUDSON,ALBANY              366618472      RESEARCH
  23 HUDSON,ALBANY              366618472
    
```

## List of Path Cases by Resident, Tech, Senior or Clinicians [LRAPPAUL]

This option provides a comprehensive listing, for either pathology residents, senior pathologists, or clinicians of all cases within the specified time. It is particularly useful for residents needing to document a particular number/type of cases in the specified accession area.

### Example:

Select Print, anat path Option: **AR** Anat path accession reports

Select Anat path accession reports Option: **WK** List of path cases by resident, tech or senior

Select ANATOMIC PATHOLOGY section: **SP** SURGICAL PATHOLOGY

1. SURGICAL PATHOLOGY list by Resident Pathologist
2. SURGICAL PATHOLOGY list by Senior Pathologist
3. SURGICAL PATHOLOGY list by Surgeon/Physician

Select 1 - 3: **1**

Select Resident Pathologist: **ANEY, RUSS**

Start with Date TODAY// **<RET>** NOV 21, 1990

Go to Date TODAY// **1 1** (JAN 01, 1990)

Print Topography and Morphology entries ? NO// **Y** (YES)

Select Print Device: **[Enter Print Device Here]**

-----  
 NOV 21, 1990 14:34 R5ISC Pg:1

R. ANEY's SURGICAL PATHOLOGY list from:JAN 1, 1990 to:NOV 21,1990

Count Case# Case date Patient/SSN

-----

1)	17	09/09/90	ADAMS,PORTLAND 527-03-1669
	PROSTATE		
			HYPERPLASIA, GLANDULAR AND STROMAL
2)	22	11/20/90	HUDSON,ALBANY 366-61-8472
	PROSTATE		
			ADENOCARCINOMA, WELL DIFFERENTIATED
			HYPERPLASIA
3)	23	11/21/90	HUDSON,ALBANY 366-61-8472
	SKIN		
			PSORIASIS



**% Pos, Atyp, Dysp, Neg, Susp, & Unsat Cytopath [LRAPCYPCT]**

Use this option to print the number and % of positive, negative, and suspicious specimens for malignancy and unsatisfactory specimens from one date to another. The listing provides information which will assist in meeting a requirement of the College of American Pathologists (CAP).

If you wish to use the same topography list on a regular basis, these topography categories can be entered in the Edit Pathology Reports Parameters [LRAPDHR] option.

If you wish to specify morphology codes, these codes can be entered in the [LRAPDHR] option under MORPHOLOGY ENTRY. If there is no entries, the SNOMED codes which will be used for the search are as follows.

M09010	Unsatisfactory specimen
M09460	Negative for malignant cells
M69760	Suspicious for malignant cells
M80013	Positive for malignant cells

**Example 1:**

Select Anat path accession reports Option: **CP** % Pos, Atyp, Dysp, Neg, Susp, & Unsat cytopath

```

          Cytology Specimens:
Use morphology list? YES// <RET> (YES)
          UNSATISFACTORY SPECIMEN
          NEGATIVE FOR MALIGNANT CELLS
          SUSPICIOUS FOR MALIGNANT CELLS
          POSITIVE FOR MALIGNANT CELLS

Use topography category list? YES//NO
Select 1 or more characters of SNOMED TOPOGRAPHY code (Choice # 1):2
ENTER IDENTIFYING COMMENT: RESPIRATORY
Select 1 or more characters of SNOMED TOPOGRAPHY code (Choice # 2):7
ENTER IDENTIFYING COMMENT: GU
Select 1 or more characters of SNOMED TOPOGRAPHY code (Choice # 3): <RET>

Start with Date TODAY// <RET> SEP 09, 1994
Go to Date TODAY// 1 1 90 (JAN 01, 1990)
Select Print Device: [Enter Print Device Here]

```

## AP Menu Options

SEP 9, 1994 07:23 DALLAS ISC, VERIFICATION ACCT  
CYTOPATHOLOGY COUNTS From JAN 1, 1990 To SEP 9, 1994  
Location Location Count

Pg: 1

-----

RESPIRATORY (2):	3	3
NEGATIVE FOR MALIGNANT CELLS		
GU (7):	1	1
SUSPICIOUS FOR MALIGNANT CELLS		
Total specimens found:		4
UNSATISFACTORY SPECIMEN		
NEGATIVE FOR MALIGNANT CELLS		
SUSPICIOUS FOR MALIGNANT CELLS		
POSITIVE FOR MALIGNANT CELLS		

**NOTE:** As shown in the example above, failure to enter SNOMED codes for each category results in the sum of the % not being equal to 100%; i.e., there are four specimens and only three were coded.

**Example 2:**

Select Anat path accession reports Option: **CP** % Pos, Atyp, Dysp, Neg, Susp, & Unsat cytopat

Cytology Specimens:

Use morphology list? YES// **<RET>** (YES)  
 UNSATISFACTORY SPECIMEN  
 NEGATIVE FOR MALIGNANT CELLS  
 SUSPICIOUS FOR MALIGNANT CELLS  
 POSITIVE FOR MALIGNANT CELLS

Use topography category list? YES// **<RET>** (YES)

51030 ORAL MUCOUS MEMBRANE  
 1Y010 SYNOVIAL FLUID  
 2Y030 SPUTUM  
 2Y410 BRONCHIAL MATERIAL  
 2Y610 PLEURAL FLUID  
 3X110 PERICARDIAL FLUID  
 6X210 ESOPHAGEAL  
 6X310 GASTRIC  
 6X940 PERITONEAL FLUID  
 7X100 URINE  
 8X210 VAGINAL  
 8X330 VAGINAL/CERVICAL  
 X1010 CSF

Start with Date TODAY// **5-1-90** (MAY 01, 1990)  
 Go to Date TODAY// **5/31/90** (MAY 31, 1990)  
 Select Print Device: **[Enter Print Device Here]**

**NOTE:** The topography category list is generated using the Edit Pathology Report Parameters option in the Supervisor's Menu.

## AP Menu Options

JUL 31, 1990 12:51 VAMC

Pg: 1

CYTOPATHOLOGY COUNTS

From MAY 1, 1990 To MAY 31, 1990

Count

-----			
ORAL MUCOUS MEMBRANE (51030):			1
NEGATIVE FOR MALIGNANT CELLS	1	(100.0%)	
SYNOVIAL FLUID (1Y010):			1
NEGATIVE FOR MALIGNANT CELLS	1	(100.0%)	
SPUTUM (2Y030):			12
UNSATISFACTORY SPECIMEN	1	(8.3%)	
NEGATIVE FOR MALIGNANT CELLS	11	(91.7%)	
BRONCHIAL MATERIAL (2Y410):			10
NEGATIVE FOR MALIGNANT CELLS	5	(50.0%)	
SUSPICIOUS FOR MALIGNANT CELLS	1	(10.0%)	
POSITIVE FOR MALIGNANT CELLS	2	(20.0%)	
PLEURAL FLUID (2Y610):			5
NEGATIVE FOR MALIGNANT CELLS	5	(100.0%)	
ESOPHAGEAL (6X210):			2
NEGATIVE FOR MALIGNANT CELLS	1	(50.0%)	
PERITONEAL FLUID (6X940):			4
NEGATIVE FOR MALIGNANT CELLS	4	(100.0%)	
URINE (7X100):			42
NEGATIVE FOR MALIGNANT CELLS	31	(73.8%)	
SUSPICIOUS FOR MALIGNANT CELLS	5	(11.9%)	
VAGINAL (8X210):			1
NEGATIVE FOR MALIGNANT CELLS	1	(50.0%)	
VAGINAL/CERVICAL (8X330):			2
NEGATIVE FOR MALIGNANT CELLS	1	(50.0%)	
CSF (X1010):			5
UNSATISFACTORY SPECIMEN	1	(20.0%)	
NEGATIVE FOR MALIGNANT CELLS	4	(80.0%)	
Total specimens found:			85
UNSATISFACTORY SPECIMENS	2	( 2.4%)	
NEGATIVE FOR MALIGNANT CELLS	65	(76.5%)	
SUSPICIOUS FOR MALIGNANT CELLS	6	( 7.1%)	
POSITIVE FOR MALIGNANT CELLS	2	( 2.4%)	

**Accession List with Stains [LRAPSA]**

If the data is being entered through the Blocks, Stains, Procedures, Anat Path [LRAPSPDAT] option, it can be printed using this option. This summary provides a helpful tool for workload recording.

**Example:**

Select Anatomic path accession reports Option: **ST** Accession list with stains  
 Select ANATOMIC PATHOLOGY section: **SP** SURGICAL PATHOLOGY

## SURGICAL PATHOLOGY STAIN LIST

Stain list date: 1994 OK ? YES// <RET> (YES)  
 Start with Acc #: 20  
 Go to Acc #: LAST// <RET>  
 Select Print Device: *[Enter Print Device Here]*

SEP 9, 1994 07:31 VAMC Pg: 1  
 LABORATORY SERVICE SURGICAL PATHOLOGY BLOCKS/STAINS

```
-----
```

Acc #:	1	AUG 10, 1994	PIMPLE,SIMPLE	706-01-0114P		
TIS						
TISSUE						
Paraffin Block						
A		Stain/Procedure				
		TRICHROME STAIN	1/1	08/25/94	12:41	
Paraffin Block						
B		Stain/Procedure				
		TRICHROME STAIN	1	08/25/94	12:41	
Plastic Block						
C		Stain/Procedure				
		TRICHROME STAIN	1/1	08/25/94	12:41	
Frozen Tissue						
D		Stain/Procedure				
		TRICHROME STAIN	1/1	08/25/94	12:41	
Acc #:	2	AUG 24, 1994	PILLOW,TED	459-85-9832		
PROSTATE CHIPS						
Paraffin Block						
A		Stain/Procedure				
		TRICHROME STAIN	1	08/27/94	19:26	
Paraffin Block						
B		Stain/Procedure				
		TRICHROME STAIN	1	08/27/94	19:26	

## **Accession Counts by Senior Pathologist [LRAPaulC]**

Analysis of quality assurance information relies not only on the data for the “outliers,” but also on the total number of cases. Cases are tallied by accession area, and are sorted by the senior pathologist assigned to the case.

### **Example:**

Select Anatomic pathology Option: **P** Print, anat path

Select Print, anat path Options: **AR** Anat path accession reports

Select Anat path accession reports Option: **WS** Accession counts by senior pathologist

Start with Date TODAY// **1-1-90** (JAN 01, 1990)

To Date TODAY// **9-9-93** (SEP 09, 1993)

Select Print Device: *[Enter Print Device Here]*

SEP 09, 1993 10:07 VAMC  
 Accession counts by Senior Pathologist  
 From JAN 1, 1990 to:SEP 09, 1993

---

Pg: 1

## SURGICAL PATHOLOGY

ASHBERY, JOHN :	165
BLAKE, WILLIAM :	47
BYRNE, DAVID :	89
CHEEVER, JOHN :	72
GLASS, PHILIP :	81
MURDOCH, IRIS :	57
Unassigned accessions :	1

-----  
 Total 512

## CYTOPATHOLOGY

DOSTOEVSKY, FYODOR :	38
PLATH, SYLVIA :	71
SCRIABIN, ALEXANDER :	41
STEVENS, WALLACE :	53

-----  
 Total 203

## ELECTRON MICROSCOPY

ATWOOD, MARGARET :	21
BUNUEL, LUIS :	19

-----  
 Total 40

## AUTOPSY PATHOLOGY

CORTEZAR, JULIO :	4
KUNDERA, MILAN :	3
LEVI-STRAUSS, CLAUDE :	3
METHENY, PAT :	7
Unassigned accessions :	5

-----  
 Total 22

## Unassigned accessions for AUTOPSY PATHOLOGY

MAY 11, 1993 15:56	Accession #:	1
JUN 20, 1993	Accession #:	5
AUG 6, 1993 12:57	Accession #:	6
AUG 6, 1993 13:03	Accession #:	7
AUG 6, 1993 13:09	Accession #:	8

## Cum Path Data Summaries [LRAPT]

Cumulative summary of surgical path, EM, and autopsy for screen display or hard copy.

For example, please see option in the Inquiry Option section.



## Anatomic Pathology Labels [LRAPLBL]

### **Anat Path Slide Labels [LRAPLM]**

Once data has been entered through the Blocks, Stains, Procedures, Anat Path [LRAPSPDAT] option, labels can be generated for an accession, regardless of the area, which can be attached to the glass slides used for microscopic examination. If workload has been turned on for the area and the files have been appropriately setup, default data will have been entered during log-in and labels can be generated based on that with no additional data entry. See the Technical Manual for details.

The labels include five lines of data:

- 1) Accession area (SURG for Surgical Pathology, CY for Cytopathology, etc.)
- 2) Accession number
- 3) Block ID for Surgical Pathology and Autopsy, Preparation Technique for Cytopathology
- 4) Stain/procedure print name
- 5) Facility number from the DD global

The number of labels generated is based on the data entered. One slide label is generated for each slide of a specified stain. The format of the label is designed to allow printing of regular size print on a 1 x 1 inch label.

If workload is turned on for the accession area, these labels can be generated based on default setups without going through the Blocks, Stains, Procedures, Anat Path [LRAPSPDAT] option. The block ID, the stain and the default number of slides will be entered automatically based on the file setups for the Workload Profile. (See the Technical Manual for details.) However, if you do not go through the Blocks, Stains, Procedures, Anat Path [LRAPSPDAT] option to enter the date/time stained, you will not have any workload captured.

For autopsies, it is possible to create a set of generic labels that will be able to be printed immediately after log-in if workload is turned on. Use the Edit Pathology Report Parameters [LRAPHDR] option to enter this listing. See Example 4.

**NOTES:**

- When data is entered through the [LRAPSPDAT] option, or automatically if the workload profiles are built, the individual slide/stain are placed in a queue to be printed. If the two prompts to reprint and to add/delete are both answered "NO," these labels in the queue will print. At that time, the software sets a flag for those labels indicating that they have been printed.
- If the two prompts to reprint and to add/delete are both answered "NO" and there are no labels in the queue to print, a message to that effect will be printed. This is based on the Counter field #63.8122,.07.
- By indicating that you wish to "reprint" slide labels for the specified accession, you will reprint the labels which have previously been printed (flagged to indicate such). Any new stains which have been entered, but which have not been printed for the first time will **not** be included in the reprint.

**Example 1: Surgical Pathology**

Select Anatomic pathology labels Option: **LM** Anat path slide labels

SLIDE LABEL PRINT OPTION

Select AP section: **SP** SURGICAL PATHOLOGY

Enter year: 1990// **<RET>** (1990)

Reprint slide labels? NO// **<RET>** (NO)

Add/Delete slide labels to print? NO// **<RET>** (NO)

Start with accession number: **22**

Go to accession number: LAST// **22**

Select Print Device: **[Enter Print Device Here]**

SURG	SURG	SURG	SURG	SURG	SURG
90-22	90-22	90-22			
A	B	B			
H & E	H & E	MUCICAR			
R5ISC	R5ISC	R5ISC	R5ISC	R5ISC	R5ISC

**Example 2: No Data Entered Through Blocks, Stains, Procedures [LRAPSPDAT] for the Accession (and workload not turned on)**

Select Log-in menu, anat path Option: **LM** Anat path slide labels

Select ANATOMIC PATHOLOGY section: **CY** CYTOPATHOLOGY

Enter year: 1993// **<RET>** (1993) 1993

Reprint slide labels ? NO// **<RET>** (NO)

Add/Delete slide labels to print ? NO// **<RET>** (NO)

Print CYTOPATHOLOGY slide labels for 1993

Start with accession number: **6**

Go to accession number: LAST// **<RET>**

Select Print Device: *[Enter Print Device Here]*

There are no labels to print.

Select Anatomic pathology labels Option: **<RET>**

**Example 3: Cytology (no data entered through [LRAPSPDAT], workload profiles built). (Had label printer problems when it came to this number.)**

Select ANATOMIC PATHOLOGY section: **CYTOPATHOLOGY**

Enter year: 1993// **<RET>** (1993) 1993

Reprint slide labels ? NO// **Y** (YES)

Start with accession number: **5**

Go to accession number: LAST// **5**

Select Print Device: *[Enter Print Device Here]*

CY	CY	CY	CY	CY	CY
93-5	93-5	93-5			
SMEAR PRE	SMEAR PRE	CELL BLOC			
PAP SMP	PAP SMP	H & E			
VAMC 578	VAMC 578	VAMC 578	VAMC 578	VAMC 578	VAMC 578

Select Anatomic pathology labels Option: **<RET>**

## AP Menu Options

### **Example 4:** Autopsy (no data entered through [LRAPSPDAT], workload turned on, generic list entered in the LAB SECTION file (#69.2))

Select Anatomic pathology labels Option: **LM** Anat path slide labels

Select ANATOMIC PATHOLOGY section: **AU** AUTOPSY

Enter year: 1993// **<RET>** (1993) 1993

Reprint slide labels ? NO// **<RET>** (NO)

Add/Delete slide labels to print ? NO// **<RET>** (NO)

Print AUTOPSY slide labels for 1993

Start with accession number: **1**

Go to accession number: LAST// **1**

Select Print Device: *[Enter Print Device Here]*

AU	AU	AU	AU	AU	AU
93-1	93-1	93-1	93-1	93-1	93-1
HEART	R LUNG	L LUNG	LIVER	SPLEEN	L KIDNEY
H & E	H & E	H & E	H & E	H & E	H & E
VAMC 578	VAMC 578	VAMC 578	VAMC 578	VAMC 578	VAMC 578
AU	AU	AU	AU	AU	AU
93-1	93-1	93-1	93-1	93-1	93-1
R KIDNEY	L ADRENAL	R ADRENAL	PROSTATE		
H & E	H & E	H & E	H & E		
VAMC 578	VAMC 578	VAMC 578	VAMC 578	VAMC 578	VAMC 578

**NOTE:** Based on the following setup in [LRAPHDR]

Select GENERIC LABEL: PROSTATE// ?

ANSWER WITH GENERIC LIST

CHOOSE FROM:

1	HEART
2	R LUNG
3	L LUNG
4	LIVER
5	SPLEEN
6	L KIDNEY
7	R KIDNEY
8	L ADRENAL
9	R ADRENAL
10	PROSTATE

YOU MAY ENTER A NEW GENERIC LIST, IF YOU WISH  
ANSWER MUST BE 1-30 CHARACTERS IN LENGTH

## Anat Path Specimen Labels [LRAPLS]

Labels can be generated for a variety of purposes. Once a series of specimens are logged into the system, a batch of labels can be printed. One label is generated for each specimen. If several specimens are submitted on a single accession, each specimen will get a separate label.

The labels print on the same label stock as the rest of the lab and contain three lines of information, including the full accession number, the patient ID information, and the specimen. The specimen text is the text entered during log-in of the accession.

### Example:

```
Select Anatomic pathology labels Option: LS Anat path specimen labels
Select ANATOMIC PATHOLOGY section: SP SURGICAL PATHOLOGY
Enter year: 1990// PRINTER
```

```
Start with accession number: 22
Go to accession number: LAST// 22
```

```
REMEMBER TO
ALIGN THE PRINT HEAD ON THE FIRST LINE OF THE LABEL
```

```
ENTER NUMBER OF LINES FROM
TOP OF ONE LABEL TO ANOTHER: 7// <RET>
Select Print Device: [Enter Print Device Here]
```

```
SURG 1120 22 Date taken:11/20/90
HUDSON,ALBANY 366-61-8472
PROSTATE CHIPS
```

### Autopsy Slide Labels (Generic) [LRAUMLK]

This option allows the user to print slide labels for an autopsy EVEN IF no generic labels have been entered and no data has been entered through the Blocks, Stains, Procedures, Anat Path [LRAPSPDAT] option for specific blocks.

#### Example:

Select Laboratory DHCP Menu Option: **AN**atomic pathology

ANATOMIC PATHOLOGY MENU

Select Anatomic pathology Option: **P** Print, anat path

Select Print, anat path Option: **LA** Anatomic pathology labels

Select Anatomic pathology labels Option: **AU** Autopsy Slide Labels (generic)

Autopsy Slide Labels

Enter year: 1993// **<RET>** (1993) 1993

Enter Autopsy Case number: **1**

Want labels for whole case? YES// **<RET>** (YES)

Enter total number of blocks :**20**

Want to enter additional stains :? NO// **<RET>**

Select Print Device: *[Enter Print Device Here]*

AU	AU	AU	AU	AU	AU
93-1	93-1	93-1	93-1	93-1	93-1
1	2	3	4	5	6
H & E	H & E	H & E	H & E	H & E	H & E
VAMC578	VAMC578	VAMC578	VAMC578	VAMC578	VAMC578

AU	AU	AU	AU	AU	AU
93-1	93-1	93-1	93-1	93-1	93-1
7	8	9	10	11	12
H & E	H & E	H & E	H & E	H & E	H & E
VAMC578	VAMC578	VAMC578	VAMC578	VAMC578	VAMC578

AU	AU	AU	AU	AU	AU
93-1	93-1	93-1	93-1	93-1	93-1
13	14	15	16	17	18
H & E	H & E	H & E	H & E	H & E	H & E
VAMC578	VAMC578	VAMC578	VAMC578	VAMC578	VAMC578

AU	AU	AU	AU	AU	AU
93-1	93-1	93-1	93-1	93-1	93-1
19	20				
H & E	H & E				
VAMC578	VAMC578	VAMC578	VAMC578	VAMC578	VAMC578

## Edit/Print/Display Preselected Lab Tests [LRUMDA]

### **Enter/Edit User Defined Lab Tests Lists [LRUMDE]**

You can create patient lists, which allow you to easily monitor results of specific CH-subscript tests, using this option. These lists may be

1. created by the user
2. transferred from another user **if** the user has no list(s) already defined or
3. edited/modified by the user.

Although it is possible to transfer the test list from another user, the lists are user-specific. Once the lists are created, the results may be printed using the Print/Display Preselected Lab Tests [LRUMD] option.

If no test list is created or transferred, the Print/Display Preselected Lab Tests option will print the generic list defined by the laboratory.

#### **Example 1:**

Select Print, Anat path Option: **LT** Edit/print/display preselected lab tests

Select Edit/print/display preselected lab tests Option: **EN** Enter/edit user defined lab test lists

You have no test lists. Instead of creating your own  
would you prefer to another user's lists ? NO// **<RET>** (NO)

Select LABORATORY TEST NAME: **PT** PROTHROMBIN TIME

Enter list#, order# : **1,1**

Select LABORATORY TEST NAME: **PT-CC**

Enter list#, order# : **1,2**

Select LABORATORY TEST NAME: **APTT**

Enter list#,order# : **1,3**

Select LABORATORY TEST NAME: **<RET>**

```

Test order#: 1  2  3  4  5  6  7
-----|-----|-----|-----|-----|-----|-----|
Test list#:1 |PT      |PT      |APTT    |      |      |      |
-----|-----|-----|-----|-----|-----|-----|
(E)nter/edit a test (D)elete a test list (R)emove all test lists
Enter E, D, R, or <CR> to accept lists:<RET>

```

## AP Menu Options

### Example 2: To Print Test Lists

Select Edit/print/display preselected lab tests Option:  
EN Enter/edit user defined lab test lists

SEP 1, 1992 19:31 VAMC Pg: 1

Test list for GINS, RONALD

Test order#:	1	2	3	4	5	6	7	
Test list#:	1	HGB	HCT	WBC	PLT	WESTERG	PT	PTT
Test list#:	2	PMN	LYMPH					
Test list#:	3	GLUCOSE	BUN	CREAT	NA	K	CL	CO2
Test list#:	4	T. BIL						
Test list#:	5	SGOT						
Test list#:	6	SGPT						
Test list#:	7	ALK PHO						
Test list#:	8	ALBUMIN						
Test list#:	9	PROTEIN						

'^' TO STOP: ^

(E)nter/edit a test (D)elete a test list (R)emove all test lists  
(P)rint test lists  
Enter E, D, R, P or <CR> to accept lists: P

Select Print Device: *[Enter Print Device Here]*



SEP 1, 1992 19:31 VAMC  
 Test list for GINS, RONALD

Pg: 1

Test order#:	1	2	3	4	5	6	7
Test list#: 1	HGB	HCT	WBC	PLT	WESTERG	PT	PTT
Test list#: 2	PMN	LYMPH					
Test list#: 3	GLUCOSE	BUN	CREAT	NA	K	CL	CO2
Test list#: 4	T. BIL						
Test list#: 5	SGOT						
Test list#: 6	SGPT						
Test list#: 7	ALK PHO						
Test list#: 8	ALBUMIN						
Test list#: 9	PROTEIN						
Test list#: 10	CHOL						
Test list#: 11	CPK	LDH	LDH1	LDH 2	LDH 3	LDH 4	LDH 5

**NOTES:**

- New prompt, “^ TO STOP” If test lists more than one screen, only one screen at a time is displayed
- You can now print test lists.

### **Edit Print/Display Preselected Lab Tests [LRUMDA]**

After you have created/defined a list, verified results may be printed for patient, controls or referrals, provided data is entered in the LABORATORY DATA file (#63). Lists of patients may be transferred to or merged with another user; however, the list of patients is user-specific. In adding or editing the patient list, you may group the patients. If patients are grouped, you can retrieve results for a specified group of patients or a single patient, instead of automatically getting results on all patients in the list. Group names can be alphabetical, numeric, or a combination.

It is possible to retrieve microbiology results using this option, by responding to the prompt appropriately. The information provided, shown in Example 3, reflects all data **except** the antibiotic sensitivities. The status of the data, i.e., Preliminary Report or Final Report, is also included.

For the CH subscript tests, no units or reference ranges are included with the data.

If you haven't defined a test list, the system will use the default list entered by the Laboratory Information Manager (LIM).

**Example 1:**

Select Edit/print/display preselected lab tests Option: **P** Print/display preselected lab tests

Print/display tests for a single patient or group ? NO//<RET> (NO)

1) SAMUELS, CHARLES

(R)emove a patient (A)dd/edit patients (T)ransfer list to another user  
 (D)elete list (M)erge list with another user  
 Enter R, A, T, D, M or <CR> to accept list: <RET>

Print/display microbiology results instead of defined lab tests ? NO// <RET> (NO)

Print by (T)est list (P)atient list  
 Enter T or P: **P**  
 Print ALL test lists ? YES// **N** (N)

Enter test list number(s): **6**  
 Start with Date TODAY// **5.30.93** (MAY 30, 1993)  
 Go to Date TODAY// **1.13.92** (JAN 13, 1993)  
 Select Print Device: *[Enter Print Device Here]*

APR 18, 1994 08:32 VAMC  
 List for: GINZ,RALPH

Pg:1

---

089-48-5948	LOC:1 TEST			Patient: DUSTY,ANDY
		NA	K	CL
05/25/93 09:19	140		8H*	2L*
05/24/93 16:18	canc			
05/24/93 16:17	123L			
10/16/92 23:57	140	4.5		104L*
09/30/92 13:40	140	4.3		102L*
09/23/92 11:55				100L*
08/07/92 13:47				75L*
04/16/92 17:28	140	4.3		100
04/16/92 16:53	140	4.5		97L
04/16/92 16:53	140	4.2		103
04/16/92 16:52	140	4		97L
04/16/92 16:25	140	3.2L		98L
04/07/92 11:19	145	canc		
02/13/92 14:30	135	4.3		103

---

## AP Menu Options

### **Example 2: Retrieval of Chemistry Results for a Group of Patients (by patient)**

Select Edit/print/display preselected lab tests Option: **P** Print/display lab tests for selected patients

Print/display tests for a single patient or group ? NO// **Y** (YES)

1. Single patient
2. Group of patients
3. Patients for a ward
4. Patients for a clinic

Select 1,2,3 or 4: **1. 1**

Print/display microbiology results instead of defined lab tests ? NO//<RET>  
(NO)

Print by (T)est list (P)atient list

Enter T or P: **P**

Print ALL test lists ? YES// **N** (NO)

Enter test list number(s): **1,2,4**

Start with Date TODAY// **11/18/88** (NOV 18, 1988)

Go to Date TODAY// **11/30/88** (NOV 30, 1988)

Select Print Device: **[Enter Print Device Here]**

SEP 28, 1989 08:38 St. Elsewhere VAMC

Pg:1

List for: GINZ,RALPH

PT GRP:1

-----  
SSN:416-40-5800 LOC:RENAL CONSULT Patient: COOPER,MARTIN  
=====

SSN:340-05-2342 LOC:11W Patient: DELIBERATO, S

CREAT CREA-C BUN BUN-CC BLD

11/30 04:00

1.8

11/28 12:49

1.8

11/28 11:56

1.8

11/23 15:30

URINE

3+

11/23 04:04

1.8

32

-----  
HAPTO FREEHGB C3 C4 CPK LD

11/30 04:00

1084

11/30 04:00

2.9

11/30 04:00

339

117

984



## AP Menu Options

### **Example 4: To Print a User's Patient List (new functionality)**

Print/display tests for a single patient or group ? NO// <RET> (NO)

1) PATIENT,FIRST (HEM) 2) PATIENT,SECOND (ONC)

(R)emove a patient (A)dd/edit patients (T)ransfer list to another user

(D)elele list (P)atient group deletion (M)erge list with another user

(S)end list to printer

Enter R, A, T, D, P, M, S or <RET> to accept list: S

Select Print Device: *[Enter Print Device Here]*

SEP 8, 1994 11:02 VAMC  
Patient list for: NORTH,MARGO

Pg: 1

---

1) ADAMS,LENNY B. (2) WASHINGTON,GEORGE CHERR

Print Log Book [LRAPBK]

For a description and example of this option, see Log-In Option section.

## Print Final Path Reports by Accession Number [LRAPFICH]

Use this option to print final path reports from one accession to another within the same calendar year.

This option can be used to make tapes for microfiche (See Microfiche of Path Reports).

Select Print, anat path Option: **PA** Print final path reports by accession #

Select ANATOMIC PATHOLOGY SECTION: **SP** SURGICAL PATHOLOGY

Select Accession YEAR: **1990** ( 1990)

Start with accession #: **3**

Go to accession #: **3**

Select Print Device: *[Enter Print Device Here]*

```
-----
MEDICAL RECORD | SURGICAL PATHOLOGY Pg 1
-----
Submitted by: HARRY WELBY Date obtained: MAR 16, 1990
-----
Specimen (Received MAR 16, 1990 15:55):
BONE MARROW
-----
Brief Clinical History:
-----
Preoperative Diagnosis:
-----
Operative Findings:
-----
Postoperative Diagnosis:
Surgeon/physician: HARRY WELBY
=====
PATHOLOGY REPORT
Laboratory: SLC Accession No. SP90 3
-----
Gross description:
-----
HARRY SMITH DO (See next page)
vtn| Date MAR 19, 1990
-----
BARF, BART SURGICAL PATHOLOGY Report
ID:101-05-2286 SEX:M DOB:5/22/86 AGE:4 LOC:PHRENOLOGY
HARRY WELBY
```



-----  
 MEDICAL RECORD | SURGICAL PATHOLOGY Pg 2  
 -----

PATHOLOGY REPORT  
 Laboratory: SLC Accession No. SP90 3  
 -----

Several spicules of bone are received as well as 10 unstained slides with material on them.

Microscopic exam/diagnosis:

-----  
 HARRY SMITH DO (See next page)  
 vtn| Date MAR 19, 1990  
 -----

BARF, BART SURGICAL PATHOLOGY Report  
 ID:101-05-2286 SEX: M DOB:5/22/86 AGE:4 LOC:PHRENOLOGY  
 HARRY WELBY

-----  
 MEDICAL RECORD | SURGICAL PATHOLOGY Pg 3  
 -----

PATHOLOGY REPORT  
 Laboratory: SLC Accession No. SP90 3  
 -----

CELLULARITY: HYPER CELLULAR

M:E RATIO: 1.5:1

DESCRIPTION: There is megaloblastoid rubroid and myeloid proliferation.

-----  
 HARRY SMITH DO (See next page)  
 vtn| Date MAR 19, 1990  
 -----

BARF, BART SURGICAL PATHOLOGY Report  
 ID:101-05-2286 SEX:M DOB:5/22/86 AGE:4 LOC:PHRENOLOGY  
 HARRY WELBY

AP Menu Options

-----  
MEDICAL RECORD | SURGICAL PATHOLOGY Pg 4  
-----

PATHOLOGY REPORT  
Laboratory: SLC Accession No. SP90 3  
-----

DIAGNOSIS: BONE MARROW EXAMINATION:  
MEGALOBLASTIC BONE MARROW  
COMMENT: Suggest B12 and folate studies.

-----  
HARRY SMITH DO (See next page)  
vtn| Date MAR 19, 1990  
-----

BARF,BART SURGICAL PATHOLOGY Report  
ID:101-05-2286 SEX:M DOB:5/22/86 AGE:4 LOC:PHRENOLOGY  
HARRY WELBY

-----  
MEDICAL RECORD | SURGICAL PATHOLOGY Pg 5  
-----

PATHOLOGY REPORT  
Laboratory: SLC Accession No. SP90 3  
-----

RESIDENT:  
SNOMED code(s):  
T-06000: bone marrow  
M-75950: megaloblastic erythropoiesis

-----  
HARRY SMITH DO (End of report)  
vtn| Date MAR 19, 1990  
-----

BARF,BART SURGICAL PATHOLOGY Report  
ID:101-05-2286 SEX:M DOB:5/22/86 AGE:4 LOC:PHRENOLOGY  
HARRY WELBY

## SNOMED Field References [LRAPREF]

### Descriptions

<b>Option</b>	<b>Description</b>
Enter/Edit SNOMED file References	Allows entry or edit of file references that may be printed on patients' records or used for reference reading.
Topography (SNOMED) Reference Morphology (SNOMED) Reference Etiology (SNOMED) Reference Disease (SNOMED) Reference Function (SNOMED) Reference Procedure (SNOMED) Reference Occupation (SNOMED) Reference	
Medical Journal file Edit	Allows entry or editing of medical journals that can be listed in file references on patients' records.
Print References for a SNOMED Entry	Allows printing of medical journal references for a SNOMED file entry.
Topography (SNOMED) Reference Print Morphology (SNOMED) Reference Print Etiology (SNOMED) Reference Print Disease (SNOMED) Reference Print Function (SNOMED) Reference Print Procedure (SNOMED) Reference Print Occupation (SNOMED) Reference Print	

## Enter/Edit SNOMED File References [LRAPSRE]

This option allows entry or edit of file references that may be printed on patients' records or used for reference reading. As shown below, the references may be restricted by topography and may be turned ON/OFF depending on the entry in the field List on Patient Record. This example is for the Morphology field. The other fields work the same way.

### **Example:**

Select Anatomic pathology Option: **R** SNOMED field references

Select SNOMED field references Option: **?**

ER Enter/edit SNOMED file references

MJ Medical journal file edit

PR Print references for a SNOMED entry

Select SNOMED field references Option: **PR** Print references for a SNOMED entry

Select Enter/edit SNOMED file references Option: **?**

TO Topography (SNOMED) reference

MO Morphology (SNOMED) reference

ET Etiology (SNOMED) reference

DI Disease (SNOMED) reference

FU Function (SNOMED) reference

PR Procedure (SNOMED) reference

OC Occupation (SNOMED) reference

Select Enter/edit SNOMED file references Option: **M** Morphology (SNOMED) reference

Select MORPHOLOGY FIELD NAME: **WDA** (SNOMED) reference ADENOCARCINOMA, WELL DIFFERENTIATED 814031

Select TITLE OF ARTICLE: **Well-differentiated adenocarcinoma of the prostate**

AUTHOR(S): **Kern WH** (SNOMED) reference

MEDICAL JOURNAL: **CANCER**

VOLUME: **41**

STARTING PAGE: **2046**

DATE: **1978** (1978)

LIST ON PATIENT RECORD: **YES**

Select TOPOGRAPHY RESTRICTION: **77**

Select TOPOGRAPHY RESTRICTION: **<RET>**

Select TITLE OF ARTICLE: **<RET>**

Select MORPHOLOGY FIELD NAME: **<RET>**

NOTE: The pathology report below, shows how the journal reference is included since the field List on Patient Record was set to "YES" and the condition for the topography restriction (i.e., prostate (77)) was met.

```

-----
MEDICAL RECORD :                SURGICAL PATHOLOGY                Pg 1
-----
Submitted by: JOE WELBY MD                Date obtained: NOV 20, 1990
-----
Specimen:
PROSTATE CHIPS
-----
Brief Clinical History:
    Nocturia and difficulty voiding urine.
-----
Preoperative Diagnosis:
    Enlarged prostate.
-----
Operative Findings:
    Same.
-----
Postoperative Diagnosis:
    Same.
                Surgeon/physician: JOE WELBY MD
=====
                PATHOLOGY REPORT
Laboratory: R5ISC                Accession No. SP88 22
-----
Gross description:                Pathology Resident: DUSTY ANDRUS
    Specimen consists of 25 grams of prostate gland tissue.

Microscopic exam/diagnosis:

                *** MODIFIED REPORT ***
(Last modified: NOV 21, 1990 09:01 typed by GINS, DONALD)
Prostate gland tissue showing glandular and stromal hyperplasia. In one chip
of 134 there is a small focus of well differentiated adenocarcinoma.
Also present are small prostatic infarcts and foci of squamous metaplasia.

Reference:
Well-differentiated adenocarcinoma of the prostate
Kern WH
CANCER vol.41 pg. 2046 Date: 1978
-----
                (End of report)
Pathologist: MARCUS WELBY MD                dg : Date NOV 21, 1990
-----
HUDSON,ALBANY                SURGICAL PATHOLOGY Report
ID:366-61-8472    SEX:M    DOB:5/8/16    AGE:74    LOC: 1A
                JOE WELBY MD

```

## Medical Journal File Edit [LRAPLIB]

This option allows entry or editing of medical journals that can be listed in file references on patients' records.

### **Example:**

Select JOURNAL: **JAMA**

JOURNAL ABBREVIATION: JAMA// **<RET>**

FULL NAME: **JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION**

CITY OF PUBLICATION: CHICAGO// **<RET>**

NLM CALL NUMBER: **J11248**

NLM TITLE CONTROL NUMBER: **12398767**

COMMENT:

1> **<RET>**

## Print References for a SNOMED Entry [LRAPSRP]

This option allows SNOMED file references to be printed on patients' records or used for reference reading. The example below describes how to request a printout for the Morphology field. The option works essentially the same for the other SNOMED fields.

### **Example:**

Select Anatomic pathology Option: **R** SNOMED field references

Select SNOMED field references Option: **?**

```
ER  Enter/edit SNOMED file references
MJ  Medical journal file edit
PR  Print references for a SNOMED entry
```

Select SNOMED field references Option: **PR** Print references for a SNOMED entry

Select Print references for a SNOMED entry Option: **?**

```
TO  Topography (SNOMED) reference print
MO  Morphology (SNOMED) reference print
ET  Etiology (SNOMED) reference print
DI  Disease (SNOMED) reference print
FU  Function (SNOMED) reference print
PR  Procedure (SNOMED) reference print
OC  Occupation (SNOMED) reference print
```

Select Print references for a SNOMED entry Option: **M** Morphology (SNOMED) reference

Select MORPHOLOGY FIELD NAME: **WDA** (SNOMED) reference ADENOCARCINOMA, WELL DIFFERENTIATED 814031

Select Print Device: *[Enter Print Device Here]*

```
NAME:  ADENOCARCINOMA, WELL DIFFERENTIATED
      SNOMED CODE:  814031      ABBREVIATION:  WDA
```

TITLE OF ARTICLE: Well-differentiated adenocarcinoma of the prostate

```
AUTHOR(S): Kern WH      MEDICAL JOURNAL:  CANCER
VOLUME:  41      STARTING PAGE:  2046
DATE:  1978      LIST ON PATIENT RECORD:  YES
TOPOGRAPHY RESTRICTION:  77
```

## Supervisor, Anat Path [LRAPSUPER]

### Descriptions

<b>Option</b>	<b>Description</b>
Delete Anat Path Descriptions by Date	Deletes gross description, microscopic/diagnosis text, specimen, comments, and record of modifications since release of report.
Enter/Edit Lab Description File	The specimen description for an entry in this file will be entered as the gross description for an accession if the SPECIMEN name entered at log-in time exactly matches the LAB DESCRIPTION NAME. The specimen description for an entry in this file will be entered as the microscopic description for an accession if an "*" precedes the exact match in the LAB DESCRIPTION file when an entry is made at the microscopic description prompt.
Edit Pathology Parameters (New name for this option)	Allows editing of path report headers for anatomic pathology; can specify upper or lower-case printing of SNOMED & ICD9CM codes. <b>OLD NAME was Edit Pathology Report Parameters.</b>
Enter/Edit Items in a SNOMED field	Enter or edit entries in one or more SNOMED fields. You must have the LRAPSUPER key to use this option.
Topography (SNOMED) enter/edit Morphology (SNOMED) enter/edit Etiology (SNOMED) enter/edit Disease (SNOMED) enter/edit Function (SNOMED) enter/edit Procedure (SNOMED) enter/edit Occupation (SNOMED) enter/edit	



<b>Option</b>	<b>Description</b>
Incomplete Reports, Anat Path (New name for this option)	Use this option to print a list of the incomplete Anatomic Pathology section reports.
Print Pathology Modifications	Prints a report with all copies of microscopic/diagnosis changes made to the report since the report was released (verified). Contains both the original and modified data.
Anatomic Pathology Topography Counts	Prints counts of organ/tissues (SNOMED topography) specified by code, from one date to another; shows # of patients, accessions, and organ/tissues for the time specified. If more than one topography is requested, there will be a count and percentage of the total organ/tissues within the time period for each topography.
Delete Free Text Specimen Entries	Allows deletion of free text specimen entries for surgical path, cytopath and electron microscopy for a time selected. Workload data associated with the specimens will also be deleted.
<b>AP Quality Assurance Reports</b>	
QA Codes Entry/Edit	Edit the QA code with this option. This will allow access to that specific field once the report has been released, without placing the report into a print queue or classifying the report as "modified."
	<b>NOTE:</b> This data is not included in any display or print option other than Tissue Committee review cases.

<b>Option</b>	<b>Description</b>
AP Consultation Searches and Reports	Internal and external consultations may be entered for individual anatomic pathology accessions using procedure codes from the SNOMED manuals.
Cum Path Summaries for Quality Assurance	The process of reviewing the diagnoses for correlation is greatly simplified by compiling a consolidated report of the cum path data summaries for all patients having specimens accessioned for a specified accession area.
% Pos, Atyp, Dysp, Neg, Susp, Unsat Cytopath	Prints the number and % of positive, negative, and suspicious specimens for malignancy and unsatisfactory specimens from one date to another.
Delete TC and QA Codes	Allows deletion of all tissue committee and quality assurance codes for an anatomic pathology section for a specified time.

<b>Option</b>	<b>Description</b>
Frozen Section, Surgical Path Correlation	Allows searches on a regular basis to identify cases for review, to determine correlation between frozen section and permanent section diagnoses, if documentation of physician diagnoses are appropriate, and if a second pathologist agrees with the original diagnosis.
Print Path Micro Modifications	Prints path reports that have modified microscopic descriptions from one date to another.
Malignancy Review	Simplifies and expedites the review process for all malignancy cases that required review by a second pathologist. Generates a report that includes an alphabetical listing by patient, listing by accession number, and calculations. Also useful for quality assurance studies by other clinical services.
QA Outcome Review Cases	Provides a list of cases that have been reviewed for JCAHO.
10% Random Case Review, Surg Path	Searches the topographies entered for the time specified, then randomly selects 10% of the cases for each topography, to be included on the report required for Quality Assurance. The report generated includes a summary of the topography counts, a listing of the cases identified, and copy of the final report for each accession identified.

<b>Option</b>	<b>Description</b>
Edit QA Site Parameters	Allows the TC code prompt to appear when the pathologist enters the final diagnosis, thus enabling cases to be selected later using the Tissue Committee Review Cases option.
Tissue Committee Review Cases	Produces a listing of cases by TC code (if set in the Edit QA Site Parameters option), followed by statistical information on the number of accessions, and number and percentage for each code. Additional information is then provided for each case on the list, including an expanded version of the "Cum path data summary" with admitting/discharge information and ICD9-CM codes, and the final report for the accession number listed.
Anatomic Pathology Turnaround Time	Provides the number of days cases submitted to pathology were in the lab before being signed out.
Move Anatomic Path Accession	If it is necessary to transfer data associated with a specific surgical pathology accession from one file to another, this option is used.
<b>AFIP Registries</b>	List of AFIP registries
Persian Gulf Veterans	List of veterans who served in the persian gulf with pathology specimens.
Prisoner of War Veterans	List of prisoners of war veterans that have anatomic pathology specimens for the the time specified.
Edit Referral Patient File	Edit referral patient file fields.

## Delete Anat Path Descriptions by Date [LRAPDAR]

Use this option to delete the word-processing fields for the gross description, the frozen section, the microscopic description, any modifications in the microscopic diagnosis and the specimen log-in comments. The capability to exclude purging of the microscopic description field and/or the frozen section description field exists.

This option does **not** delete the data associated with the specimen which is related to the blocks, stains, and procedures. This is accomplished using the Delete Free Text Specimen Entries [LRAPDFS] option.

All personnel involved with each of the areas should be notified in advance of purging, to ensure that all necessary hard copies have been printed for future reference. It is also desirable to print both the list of incomplete reports and unverified reports, using the Incomplete Reports, Anat Path [LRAPINC] and the List of Unverified Path Reports [LRAPV] options. This will allow necessary follow up and resolution before purging.

NOTE: The length of time which the full text should be left on the system before these fields are deleted is to be determined by the site based on storage capabilities and frequency of access to the data.

### **Example:**

Select Supervisor, anat path Option: **DD** Delete anat path descriptions by date

Select ANATOMIC PATHOLOGY section: **SP** SURGICAL PATHOLOGY

Remove descriptions from SURGICAL PATHOLOGY File

Start with Date TODAY// **1-1-91** (JAN 01, 1991)  
Go to Date TODAY// **12-31-91** (DEC 31, 1991)

OK to DELETE DESCRIPTIONS (clinical,pathological)  
from one date through the other ? NO// **Y** (YES)

OK to delete Microscopic Description/Diagnosis entries ? NO// **<RET>** (NO)

OK to delete Frozen Section Description entries ? NO// **<RET>** (NO)

.....  
OK DONE !

## Enter/Edit Lab Description File [LRAPDES]

Using the LAB DESCRIPTIONS file; (#62.5), it is possible to copy generic gross and microscopic descriptions into both the Gross Description field (#63.08,1 for Surgical Pathology, #63.09,1 for Cytopathology, and #63.08,1 for Electron Microscopy) and the Microscopic Description field (#63.08,1.1 for Surgical Pathology, #63.09,1.1 for Cytopathology and #63.02,1.1 for Electron Microscopy) for subsequent editing. The description which is pulled will be the only data which appears in the field. These will not appear until the user leaves the accession. Thus, if editing is to be done, the user must return to the accession.

QA codes in the LAB DESCRIPTIONS file must have the AP General (I) screen.

### **Example 1:** Entry of a Specimen Description

Select Supervisor, anat path option: **ED** Enter/edit lab description file

Select LAB DESCRIPTIONS NAME: **PROSTATE CHIPS** PROSTATE GLAND TISSUE

NAME: PROSTATE CHIPS// **<RET>**

EXPANSION: PROSTATE GLAND TISSUE Replace **<RET>**

SCREEN: AP SURG// **<RET>**

SPECIMEN DESCRIPTION:

1>**Specimen consists of \* grams of prostate gland tissue.**

EDIT Option: **<RET>**

Select LAB DESCRIPTIONS NAME: **<RET>**

#### NOTES:

- At the "SPECIMEN DESCRIPTION" prompt, enter the text that you wish to be copied. Use some symbol such as "\*" or "/" at those places in the text where edits will routinely be made, such as those to enter measurements.
- Specimen description for an entry in this file will be entered as the gross description for an accession if the Specimen name entered at log-in time exactly matches the Lab Description Name. The specimen description for an entry in this file will be entered as the microscopic description for an accession if a "\*" precedes the exact match in the LAB DESCRIPTION file # (62.5) when entering data at the microscopic description prompt.
- If you can't get all of the pathologists to agree on a single description, you can enter a description name, a character and the initials of the pathologist. When logging in the specimens, the person doing the entry can then enter the specimen name, exact character and the initials of the pathologist doing gross descriptions that day, and the correct description will be selected. For example, PROSTATE-DG and PROSTATE-CR could reflect two slightly different versions preferred by two pathologists. The same process can also work for the microscopic descriptions.

**Example 2: Entry of an Autopsy QA Code**

Select Supervisor, anat path Option: **ED** Enter/edit lab description file

Select LAB DESCRIPTIONS NAME: **A1**

Are you adding A1 as a new LAB DESCRIPTION? **YES**

NAME: A1// **<RET>**

EXPANSION: **AU PRE/POSTMORTEM CORRELATION - Diagnosis confirmed/verified**

SCREEN: **AP GENERAL**

SPECIMEN DESCRIPTION:

1> **<RET>**

Select LAB DESCRIPTIONS NAME: **<RET>**

**Example 3: Enter a Template to use the Bethesda System Description.**

Select Anatomic pathology Option: **S** Supervisor, anat path

Select Supervisor, anat path Option: **ED** Enter/edit lab description file

Select LAB DESCRIPTIONS NAME: **BETHESDA**

ARE YOU ADDING 'BETHESDA' AS A NEW LAB DESCRIPTIONS? **Y** (YES)

LAB DESCRIPTIONS EXPANSION: **BETHESDA SYSTEM FOR REPORTING CERVICAL/VAGINAL**

LAB DESCRIPTIONS SCREEN: **C** AP CYTO

SPECIMEN DESCRIPTION:

1> **Statement on Specimen Adequacy**

2>  **Satisfactory for interpretation**

3>  **Less than optimal**

4>  **Unsatisfactory**

5> **<RET>**

6> **Explanation for less than optimal/unsatisfactory specimen:**

7>  **Scant cellularity**

8>  **Poor fixation or preservation**

9>  **etc.**

10> **<RET>**

EDIT Option: **<RET>**

Select LAB DESCRIPTIONS NAME: **<RET>**

## Edit Pathology Parameters [LRAPHDR]

This option provides significant site flexibility in configuring the various pathology report.

1. Specific headers are entered for each of the areas within Anatomic Pathology. For Surgical Pathology, REPORT HEADER 1 appears above the gross description, REPORT HEADER 2 appears above the microscopic description and REPORT HEADER 3 appears above the frozen section diagnosis if there is an entry in the frozen section field for that accession and REPORT HEADER 4 appears above the diagnosis if there is an entry in the diagnosis field for that accession. See Example 1.
2. By using the SNOMED & QA Coding field, it is possible to include information at the end of the preliminary reports. In Example #1 below, the field is used to provide a standardized mechanism for the pathologist to enter relevant comments and codes when dictating the microscopic description.
3. By using the Topography Category field, it is possible to standardize a list of topographies used in other options. See Example 2.
4. By using the Select Slide Label field (under Cytology) it is possible to select what will appear on the lable. See Example 2.
5. By using the Morphology Entry field, it is possible to control the specific codes to be included in the report, % Pos, Atyp, Dysp, Neg, Susp, & Unsat Cytopath specimens [LRAPCYPCT]. See Example 3.
6. By answering yes to the New Pg for Supplementary Rpt. field, it is possible to cause the Supplementary Report to print on a new page. This field is also available for Autopsy cases. See Example 5.

Printing the gross description in double-spacing for the pathologist to review/edit when he is dictating the microscopic descriptions is helpful. This can be done by entering "double" for the "Gross Description Spacing" prompt. The final report is not affected by this entry it will remain single-spaced.



**Example 1: Surgical Pathology**

NOTE: At the "SNOMED & QA CODING:" prompt, enter free text word processing. Anything entered in this field will appear at the end of the preliminary report. This is specific for each type of report.

Select Supervisor, anat path Option: **ER** Edit pathology parameters

Select LAB SECTION PRINT NAME: **SP** SURGICAL PATHOLOGY

REPORT HEADER 1: Gross description:// ?\_

ANSWER MUST BE 1-50 CHARACTERS IN LENGTH

Enter the heading you want displayed when path report is printed.

REPORT HEADER 1: Gross description:// <RET>

REPORT HEADER 2: Microscopic exam: Replace <RET>

REPORT HEADER 3: Frozen section diagnosis:// <RET>

REPORT HEADER 4: Diagnosis:// <RET>

PRINT SNOMED/ICD CODES: LOWER CASE// <RET>

GROSS DESCRIPTION SPACING: DOUBLE// <RET>

LINES IN A LABEL: 7// <RET>

ACCESSION PREFIX: SP// <RET>

PRINT SF-515 LINES: YES// <RET>

NEW PG FOR SUPPLEMENTARY RPT: YES// NO *[New]*

ASK TC CODES: YES// <RET>

SNOMED & QA CODING:

1)\*\*\*\*\*

2)\*\*\*\*\*

3)<SPACE><RET>

4)PLEASE CIRCLE ALL APPROPRIATE CODES & INDICATE A TOPOGRAPHY & MORPHOLOGY:

5)<RET>

6)QA CODE: 0 Inadequate clinical information

7) 1 Pathology as expected

9) 2 Disease tissue, expected pathology NOT found

10) 3 Normal tissue, disease expected

11) 4 Unexpected tissue for procedure

12) 6 Tissue is absent, but expected

13) 7 Insufficient tissue

14) 8 Foreign bodies

15)<SPACE><RET><RET>

16)SNOMED CODES: Topography:\_\_\_\_\_

17) Morphology:\_\_\_\_\_

18) Etiology:\_\_\_\_\_

19) Procedure:\_\_\_\_\_

20) Common procedures:

21) 3082 Frozen section(FS) 1149 Fine needle aspiration (FNA)

22) 1140 Biopsy, NOS 1142 Biopsy, open (OP)

23) 1141 Biopsy, excisional 1143 Biopsy, needle (NB)

24) 1100 Excision (resection) 3219 Frozen tissue storage

25) 3205 Tissue Processing,RUSH

26)<SPACE><RET>

27) 0654001 AFIP consultation 0654004 Internal (intradepartmental)

28)<SPACE><RET>

29) 0656 Outside case, slides returned

EDIT Option: <RET>

*[Edit pathology parameters (Example 1 cont'd)]*

## AP Menu Options

Select TOPOGRAPHY CATEGORY: <RET>  
Select MORPHOLOGY ENTRY: <RET>  
ASK FROZEN SECTION: YES// <RET>  
ASK SURG PATH DIAGNOSIS: YES// <RET>

### Example 2: Cytopathology

Select Supervisor, anat path Option: **ER** Edit pathology parameters  
Select LAB SECTION PRINT NAME: **CY** CYTOPATHOLOGY  
REPORT HEADER 1: Gross Description// <RET>  
REPORT HEADER 2: Microscopic description Replace <RET>  
REPORT HEADER 3: <RET>  
REPORT HEADER 4: Diagnosis:// <RET>  
Select SLIDE LABEL: SMEAR PREP// ?  
ANSWER WITH SLIDE LABEL  
CHOOSE FROM:  
CELL BLOCK  
CYTOSPIN  
MEMBRANE FILTER  
PREPARED SLIDES  
SMEAR PREP

YOU MAY ENTER A NEW SLIDE LABEL, IF YOU WISH

Answer must be 1-30 characters in length.

Select SLIDE LABEL: SMEAR PREP// <RET>

SLIDE LABEL: SMEAR PREP// <RET>

PRINT NAME: SMEAR// ?

Answer must be 1-9 characters in length.

PRINT NAME: SMEAR// <RET>

Select SLIDE LABEL: <RET>

PRINT SNOMED/ICD CODES: LOWER CASE// <RET>

GROSS DESCRIPTION SPACING: SINGLE// <RET>

LINES IN A LABEL: 7// <RET>

ACCESSION PREFIX: CY// <RET>

PRINT SF-515 LINES: YES// <RET>

NEW PG FOR SUPPLEMENTARY RPT: YES// <RET>

ASK TC CODES: YES// <RET>

SNOMED & TC CODING: <RET>

13) 09010 Unsatisfactory Specimen

14) <RET>

15) Also: \_\_\_\_\_

16) \_\_\_\_\_

17) <RET>

18) Common procedures: 1149 Fine needle aspiration (FNA)

19) 1143 Biopsy, needle (NB)

20) 0654004 Internal consultation (intradepartmental)

21) 0654001 AFIP consultation

EDIT Option: <RET>

Select TOPOGRAPHY CATEGORY: ?

ANSWER WITH TOPOGRAPHY CATEGORY

CHOOSE FROM:

YOU MAY ENTER A NEW TOPOGRAPHY CATEGORY, IF YOU WISH

Answer must be 1-7 characters in length and contain only digits, and the letters 'X' and/or 'Y'.

One character enter -> most general

*[Edit pathology parameters (Example 2 cont'd)]*

All characters entered -> most specific

Select TOPOGRAPHY CATEGORY: **51030**  
COMMENT: ORAL MUCOUS MEMBRANE// <RET>

Select TOPOGRAPHY CATEGORY: **1Y010**  
TOPOGRAPHY CATEGORY COMMENT: **SYNOVIAL FLUID**  
COMMENT: SYNOVIAL FLUID//<RET>

Select TOPOGRAPHY CATEGORY: **2Y030**  
TOPOGRAPHY CATEGORY COMMENT: **SPUTUM**  
COMMENT: SPUTUM//<RET>

Select TOPOGRAPHY CATEGORY: **2Y410**  
TOPOGRAPHY CATEGORY COMMENT: **BRONCHIAL MATERIAL**  
COMMENT: BRONCHIAL MATERIAL//<RET>

Select TOPOGRAPHY CATEGORY: **2Y610**  
TOPOGRAPHY CATEGORY COMMENT: **PLEURAL FLUID**  
COMMENT: PLEURAL FLUID//<RET>

Select TOPOGRAPHY CATEGORY: **3X110**  
TOPOGRAPHY CATEGORY COMMENT: **PERICARDIAL FLUID**  
COMMENT: PERICARDIAL FLUID//<RET>

Select TOPOGRAPHY CATEGORY: **6X210**  
TOPOGRAPHY CATEGORY COMMENT: **ESOPHAGEAL**  
COMMENT: ESOPHAGEAL//<RET>

Select TOPOGRAPHY CATEGORY: **6X310**  
TOPOGRAPHY CATEGORY COMMENT: **GASTRIC**  
COMMENT: GASTRIC//<RET>

Select TOPOGRAPHY CATEGORY: **6X940**  
TOPOGRAPHY CATEGORY COMMENT: **PERITONEAL FLUID**  
COMMENT: PERITONEAL FLUID//<RET>

Select TOPOGRAPHY CATEGORY: **7X100**  
TOPOGRAPHY CATEGORY COMMENT: **URINE**  
COMMENT: URINE//<RET>

Select TOPOGRAPHY CATEGORY: **8X330**  
TOPOGRAPHY CATEGORY COMMENT: **VAGINAL/CERVICAL**  
COMMENT: VAGINAL/CERVICAL//<RET>

Select TOPOGRAPHY CATEGORY: **8X210**  
TOPOGRAPHY CATEGORY COMMENT: **VAGINAL**  
COMMENT: VAGINAL//<RET>

Select TOPOGRAPHY CATEGORY: **X1010**  
TOPOGRAPHY CATEGORY COMMENT: **CSF**  
COMMENT: CSF//<RET>

Select TOPOGRAPHY CATEGORY: **?**  
ANSWER WITH TOPOGRAPHY CATEGORY  
CHOOSE FROM:

- 51030 ORAL MUCOUS MEMBRANE
- 1Y010 SYNOVIAL FLUID
- 2Y030 SPUTUM
- 26410 BRONCHIAL MATERIAL
- 2Y610 PLEURAL FLUID
- 3X110 PERICARDIAL FLUID
- 6X210 ESOPHAGEAL
- 6X310 GASTRIC
- 6X940 PERITONEAL FLUID
- 7X100 URINE
- 8X210 VAGINAL
- 8X330 VAGINAL/CERVICAL
- X1010 CSF

Select TOPOGRAPHY CATEGORY: <RET>  
*[Edit pathology parameters (Example 2 cont'd)]*

## AP Menu Options

Select MORPHOLOGY ENTRY: <RET>  
ASK CYTOPAH DIAGNOSIS: <RET>

### NOTES:

- These topography categories are then used as the list referred to in the % Pos, Atyp, Dysp, Neg, Susp, & Unsat Cytopath [LRAPCYPCT] option.
- The accession prefix appears on the hard copy reports and in the microscopic slide labels.

### Example 3: Use of Prompt "Select MORPHOLOGY ENTRY" for Cytopathology

Select Anatomic pathology Option: **S** Supervisor, anat path

Select Supervisor, anat path Option: **ER** Edit pathology parameters

Select LAB SECTION PRINT NAME: **CY** CYTOPATHOLOGY  
REPORT HEADER 1: GROSS DESCRIPTION // <RET>  
REPORT HEADER 2: MICROSCOPIC DESCRIPTION // <RET>  
PRINT SNOMED/ICD CODES: // <RET>  
GROSS DESCRIPTION SPACING: // <RET>  
LINES IN A LABEL: // <RET>  
ACCESSION PREFIX: CY// <RET>  
PRINT SF-515 LINES: // <RET>  
NEW PG FOR SUPPLEMENTARY RPT: YES// **NO** [New]  
ASK TC CODES: // **YES**  
SNOMED & TC CODING:  
1><RET>  
Select TOPOGRAPHY CATEGORY: 7// <RET>  
TOPOGRAPHY CATEGORY: 7// <RET>  
COMMENT: GU// <RET>  
Select TOPOGRAPHY CATEGORY: <RET>  
Select MORPHOLOGY ENTRY: **NORMAL CELLULAR MORPHOLOGY**  
(morphology list is edited here)

NOTE: The change allows a site to create an alternate list of morphology selections for cytology percentages instead of the exported list of %positive, negative, suspicious, and unsatisfactory.

ASK CYTOPAH DIAGNOSIS: <RET>

**Example 4: Electron Microscopy**

```

Select Anatomic pathology Option: S Supervisor, anat path

Select Supervisor, anat path Option: Edit pathology parameters

Select LAB SECTION PRINT NAME: EM EM
REPORT HEADER 1: Gross Description// <RET>
REPORT HEADER 2: Microscopic Description Replace <RET>
REPORT HEADER 3: <RET>
REPORT HEADER 4: Diagnosis:// <RET>
PRINT SNOMED/ICD CODES: LOWER CASE// <RET>
GROSS DESCRIPTION SPACING: <RET>
LINES IN A LABEL: <RET>
ACCESSION PREFIX: EM// <RET>
PRINT SF-515 LINES: <RET>
NEW PG FOR SUPPLEMENTARY RPT: YES
ASK TC CODES: YES
SNOMED & TC CODING:
  1><RET>
Select TOPOGRAPHY CATEGORY: <RET>
Select MORPHOLOGY ENTRY: <RET>
ROUTINE PROCEDURE 1: 2// <RET>
ROUTINE PROCEDURE 2: 5// <RET>

ASK EM DIAGNOSIS: YES// <RET>

```

**NOTES:**

- The prompts “ROUTINE PROCEDURE 1” and “ROUTINE PROCEDURE 2” are new and are asked when EM is entered when prompted for the LAB SECTION PRINT NAME.
- ROUTINE PROCEDURE 1 is the number of times procedure is routinely performed. (For EM the number of thick sections made per block.)
- ROUTINE PROCEDURE 2 is the number of times routine procedure is performed. (For EM the number of grids routinely made per block.)

### Example 5: Autopsy

```
Select Supervisor, anat path Option: ER Edit pathology parameters
Select LAB SECTION PRINT NAME: AU AUTOPSY
REPORT HEADER 1: Clinical History// <RET>
REPORT HEADER 2: Anatomic Diagnoses// <RET>
REPORT HEADER 3: <RET>
REPORT HEADER 4: <RET>
PRINT SNOMED/ICD CODES: LOWER CASE// <RET>
GROSS DESCRIPTION SPACING: <RET>
LINES IN A LABEL: <RET>
ACCESSION PREFIX: A// <RET>
PRINT SF-515 LINES: <RET>
NEW PG FOR SUPPLEMENTARY RPT: YES// ?? <-new
    If a page feed is wanted before printing the supplementary
    report a 'YES' is entered.
    CHOOSE FROM:
        1      YES
        0      NO
        1      yes
        0      no
NEW PG FOR SUPPLEMENTARY RPT: YES// <RET>
ASK TC CODES: <RET>
Select GENERIC LABEL: PROSTATE// <RET>
    GENERIC LABEL: PROSTATE// <RET>
Select GENERIC LABEL: <RET>
SNOMED & TC CODING:
    1<RET>
Select TOPOGRAPHY CATEGORY: <RET>
Select MORPHOLOGY ENTRY: <RET>

Select Supervisor, anat path Option:<RET>
```

## Enter/Edit Items in a SNOMED Field [LRSNOMEDIT]

The SNOMED-coded diagnoses are not as descriptive or elaborate as the information dictated for the final report, but they are very valuable since they will be the only remaining diagnoses after the word-processing fields are purged.

Entries in the file include the field name (which is printed on the reports, etc.,) the code number, and multiple synonyms. To make data entry of the SNOMED codes easy, other synonyms can be added to reflect popular terminology.

### **Example:**

Select Enter/edit items in a SNOMED field Option: ?

TO	Topography	(SNOMED)	enter/edit
MO	Morphology	(SNOMED)	enter/edit
ET	Etiology	(SNOMED)	enter/edit
DI	Disease	(SNOMED)	enter/edit
FU	Function	(SNOMED)	enter/edit
PR	Procedure	(SNOMED)	enter/edit
OC	Occupation	(SNOMED)	enter/edit

Select Enter/edit items in a SNOMED field Option: **MO** Morphology (SNOMED)  
enter/edit

Select MORPHOLOGY FIELD NAME: **ADENOCARCINOMA**

1	ADENOCARCINOMA, INTESTINAL TYPE	81443
2	ADENOCARCINOMA, METASTATIC	81406
3	ADENOCARCINOMA, MICROINVASIVE	81405
4	ADENOCARCINOMA, MODERATELY DIFFERENTIATED	814032
5	ADENOCARCINOMA, POORLY DIFFERENTIATED	814033

TYPE '^' TO STOP, OR

CHOOSE 1-5: **<RET>**

6	ADENOCARCINOMA, UNDIFFERENTIATED	814034
7	ADENOCARCINOMA, WELL DIFFERENTIATED	814031
8	ADENOCARCINOMA, CYLINDROID TYP ADENOID CYSTIC CARCINOMA	82003

CHOOSE 1-8 **4** ADENOCARCINOMA, MODERATELY DIFFERENTIATED 814032

NAME: ADENOCARCINOMA, MODERATELY DIFFERENTIATED Replace **<RET>**

SNOMED CODE: 814032// **<RET>**

ABBREVIATION: **MDA**

Select SYNONYM: MODERATELY DIFFERENTIATED ADENOCARCINOMA// **<RET>**

Select TITLE OF ARTICLE: **<RET>**

Select MORPHOLOGY FIELD NAME: **MDA** ADENOCARCINOMA, MODERATELY DIFFERENTIATED  
814032

NAME: ADENOCARCINOMA, MODERATELY DIFFERENTIATED Replace **<RET>**

## Incomplete Reports, Anat Path [LRAPINC]

Incomplete reports are lacking a "DATE/TIME COMPLETED." Since the data is entered in the FS/Gross/Micro/Dx [LRAPDGM] or FS/Gross/Micro/Dx/SNOMED Coding [LRAPDGS] options, they generally are reports for which the microscopic description was not entered.

The listing of "Incomplete Reports" is **not** the same as the listing of "Unverified Reports." Reports can be completed, signed, and distributed even though the verification/release step was overlooked.

### **Example:**

Select Anatomic pathology Option: **S** Supervisor, anat path

Select Supervisor, anat path Option: **IR** Incomplete reports, anat path

Select ANATOMIC PATHOLOGY section: **SP** SURGICAL PATHOLOGY

SURGICAL PATHOLOGY Incomplete Reports  
 Start with Date TODAY// **<RET>** NOV 22, 1990  
 Go to Date TODAY// **11 1** (NOV 01, 1990)  
 Select Print Device: *[Enter Print Device Here]*

Incomplete SURGICAL PATHOLOGY Reports					
FROM NOV 22, 1990 TO NOV 1, 1990					
Acc #	Date	Patient	ID	Location	Pathologist
20	11/07/90	WASHINGTON,GEORGE	8762	1A	WELBY,MARCUS



Print Pathology Modifications [LRAPMOD]

A copy of the modifications provides useful documentation for quality assurance purposes. This option provides a consolidated report with both the original and the modified data. These changes must be printed **before** purging the word processing fields!

**Example:**

Select Supervisor, anat path Option: **MR** Print path modifications

Print pathology report modifications

Select ANATOMIC PATHOLOGY section: **SP** SURGICAL PATHOLOGY

Select Patient Name: ARDEN,TOM 02-01-22 241220000 NO NSC VETERAN  
ARDEN,TOM ID: 241-22-0000 Physician: LEE,ROB

AGE: 72 DATE OF BIRTH: FEB 1, 1922  
Ward on Adm: 1 EAST Service: MEDICINE  
Adm Date: APR 8, 1993 10:53 Adm DX: ACCIDENT  
Present Ward: 1 EAST MD:

Specimen(s)	Count #	Accession #	Date Obtained
LEFT LEG	( 1)	7	AUG 25, 1994 not verified
left hip chip	( 2)	6	AUG 25, 1994 not verified
PROSTATE CHIPS	( 3)	2	AUG 24, 1994

Choose Count #(1-3): **3**  
Accession #: 2 Date Obtained: AUG 24, 1994

Select Print Device: *[Enter Print Device Here]*



MEDICAL RECORD	SURGICAL PATHOLOGY	Pg 2
----------------	--------------------	------

PATHOLOGY REPORT

Laboratory: VAMC

Accession No. SP 94 2

mesangial matrix. Also present are small prostatic infarcts and foci of squamous metaplasia. Another small infarcts and foci of squamous metaplasia.

Supplementary Report:

Date: AUG 26, 1994 18:09

This is an example of a supplementary report. It can be used to report the results of recuts.

Date: AUG 26, 1994 18:10

This is another supplementary report.

CONSULTATION AFIP#123456789 Date: AUG 26, 1994 18:17  
PROSTATIC FASCIA

This is an example of a consultation sent to the AFIP.

SNOMED code(s):

T-18969: PROSTATIC FASCIA

P-Y333 : ADMINISTRATION OF MEDICATION, EMERGENCY

ANA WELBY MD	(End of report) ec   Date AUG 25, 1994
--------------	---

ARDEN, TOM

STANDARD FORM 515

ID:241-22-0000 SEX:M DOB:2/1/22 AGE:72 LOC:1 EAST

ADM:APR 8, 1993 DX:ACCIDENT

ROB LEE MD

## Anatomic Pathology Topography Counts [LRAPC]

A breakdown of the specimens accessioned within a specified time may be useful for quality assurance purposes, survey responses, etc. This option searches all topographies coded for the accessions within the time specified; therefore, only those with SNOMED codes entered can be evaluated.

### **Example:**

Select Supervisor, anat path Option: **TC** Anatomic pathology topography counts

TOPOGRAPHY COUNTS

Select ANATOMIC PATHOLOGY section: **SP** SURGICAL PATHOLOGY

TOPOGRAPHY (Organ/tissue)

Choice # 1: Select 1 or more characters of the code: **01**

Choice # 2: Select 1 or more characters of the code: **2**

Choice # 3: Select 1 or more characters of the code: **5**

Choice # 4: Select 1 or more characters of the code: **6**

Choice # 5: Select 1 or more characters of the code: **7**

Choice # 6: Select 1 or more characters of the code: **<RET>**

Start with Date TODAY// **<RET>**

Go to Date TODAY// **1 1** (JAN 01, 1988)

Select Print Device: *[Enter Print Device Here]*

```
-----
NOV 22, 1990 08:26      LABORATORY SERVICE R5ISC
Topography Count      SURGICAL PATHOLOGY TOPOGRAPHY COUNTS      PG:1
                        From:JAN 1, 1990 To:NOV 22, 1990
-----
```

```
T-2.... 2          12.50%
T-5.... 3          18.75%
T-7.... 2          12.50%
T-01... 7          43.75%
```

# Patients: 11

# accessions: 22

# organ/tissues: 16

% = % of organ/tissues

## Delete Free Text Specimen Entries [LRAPDFS]

This option lets you purge data associated with the specimen regarding the special stains. Separating this from the purging of other word-processing fields provides additional flexibility for the site in determining the length of time to keep data on-line. This may be particularly important for evaluation of workload over an extended period of time.

### **Example:**

Select Supervisor, anat path Option: **DS** Delete free text specimen entries

Select ANATOMIC PATHOLOGY section: **SP** SURGICAL PATHOLOGY

Remove free text specimen entries from SURGICAL PATHOLOGY File

Start with Date TODAY// **1 1 89** (JAN 01, 1989)

Go to Date TODAY// **12 31 89** (DEC 31, 1989)

OK to DELETE FREE TEXT ENTRIES from

JAN 1, 1989 to DEC 31, 1989? NO// **Y** (YES)

. . . . .  
OK, DONE.

## AP Quality Assurance [LRAPQA]

Although quality assurance systems have been integral components of clinical pathology and blood usage review for many years, they did not exist as structured systems in anatomic pathology. Recent changes made by the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) in monitoring medical staff functions have necessitated the development of a comparable system for anatomic pathology.

Quality assurance in anatomic pathology can be defined as the mechanisms and programs which assure quality care through accuracy in tissue/cell diagnosis. In anatomic pathology, the diagnosis is based on a number of steps, beginning with the submission of tissue/specimens for examination, examination of the specimens, evaluation and correlation of clinical data and history, assessment of the morphological observations, and concluding with the issuance of a final diagnosis. Since quality assurance deals with outcomes, the clinical course of the patient subsequent to the diagnosis must also be evaluated. This encompasses issues related to the timeliness of the report and correlation of the pathology report with other clinical findings/reports (e.g., diagnostic radiology).

To simplify the process of identifying cases for both internal and external review, a group of options has been created to extract cases to meet preset criteria for surgical pathology. These include:

- 100% review of cases involving frozen sections
- 100% review of cases involving a bone, muscle or soft tissue malignancy
- 100% review of cases involving a gynecological malignancy
- 100% review of cases involving a malignancy from a specified topography
- 10% random review of cases
- Listing of cases sent for consultation (AFIP, SERS, etc.,)

In addition, options have been created to extract cases for cytopathology, including:

- 100% review of cases involving a malignancy or suspicious morphology
- 100% review of cases accessioned for correlation of diagnoses

Options are also included to assist in the performance of surgical case review by the Tissue Committee (TC). By entering a numeric QA code at the time the case is finalized, the pathologist assists in the extraction of cases according to certain criteria designated by the Tissue Committee.

## Summary of TC and QA Codes

The following table summarizes the differences between TC Codes and QA Codes:

<b>TC Codes</b>	<b>QA Codes</b>
- Numeric TC codes may be assigned description in LAB DESCRIPTIONS file (Screen=AP SURG)	- QA codes defined in LAB DESCRIPTIONS file (Screen=I AP General)
- Used to review Surgical cases	- Entered for Surgical or Cytopath reports
- Supervisor option - Edit QA Site Parameters to allow TC code entry	- Supervisor option- Edit QA Site Parameters to allow QA code entry
- TC code should be entered for each surgical report	- QA Codes Entry/edit used to enter QA code for an accession
- Use Tissue Committee Review Cases to retrieve reports	- QA Outcome Review cases used to retrieve reports

## QA Codes Entry/Edit [LRAPQACD]

You can enter or edit both QA and TC codes with this option. This will allow access to that specific field once the report has been released, without placing the report into a print queue or classifying the report as "modified."

This data is not included in any display or print option other than Tissue Committee review cases and QA outcome review cases. Only entries in the LAB DESCRIPTION file using the AP GENERAL (I) screen can be selected.

### Example 1: Surgical Pathology - Editing of TC Code and Entry of QA Code

```
Select AP quality assurance reports Option: CE Quality assurance code entry
Select ANATOMIC PATHOLOGY section: SP SURGICAL PATHOLOGY
Data entry for 1990 ? YES// <RET> (YES)
Select Accession Number/Pt name: 5630 for 1990
ELIOT,THOMAS S. ID: 451-14-6629
Specimen(s):
COLON POLYPS X2
```

Select SPECIMEN COMMENT:

TC CODE: 1// ?

CHOOSE FROM:

1 1  
2 2  
3 3  
4 4  
5 5  
6 6  
7 7  
8 8  
9 9  
0 0

TC CODE: 1// **2**

Select QA CODE: ?

ANSWER WITH QA CODE

YOU MAY ENTER A NEW QA CODE, IF YOU WISH

QA codes must be less than 3 characters.

Selects entries with less than 3 characters

ANSWER WITH LAB DESCRIPTIONS NAME

DO YOU WANT THE ENTIRE LAB DESCRIPTIONS LIST? **Y** (YES)

CHOOSE FROM:

C1 CYTOLOGY CORRELATION QA REVIEW-no disagreement  
C2 CYTOLOGY CORRELATION QA REVIEW-minor disagreement (no Dx/Rx change)  
C3 CYTOLOGY CORRELATION QA REVIEW-major disagreement (Dx or Rx change)  
F1 FROZEN SECTION QA REVIEW-no disagreement  
F2 FROZEN SECTION QA REVIEW-minor disagreement (no Dx/Rx change)  
F3 FROZEN SECTION QA REVIEW-major disagreement (Dx or Rx change)  
M1 MALIGNANCY QA REVIEW-no disagreement  
M2 MALIGNANCY QA REVIEW-minor disagreement (no Dx/Rx change)  
M3 MALIGNANCY QA REVIEW-major disagreement (Dx or Rx change)  
R1 RANDOM QA REVIEW-no disagreement  
R2 RANDOM QA REVIEW-minor disagreement (no Dx/Rx change)



R3 RANDOM QA REVIEW-major disagreement (Dx or Rx change)  
S1 SERS/SERA QA REVIEW-no disagreement  
S2 SERS/SERA QA REVIEW-minor disagreement (no Dx/Rx change)  
S3 SERS/SERA QA REVIEW-major disagreement (Dx or Rx change)  
S4 SERS/SERA QA REVIEW-legitimate disagreement

Select QA CODE: **M1** MALIGNANCY QA REVIEW-no disagreement

Select QA CODE: **<RET>**

Select Accession Number/Pt name: **<RET>**

**NOTE:** Although the "TC CODE: 1/" prompt is a numeric set, no description is included. If a description is entered into the LAB DESCRIPTIONS file (#62.5), specifying AP SURG as the screen, that description will appear on the report generated by Tissue Committee Review Cases.

## AP Menu Options

### Example 2: Entry of QA Code for Autopsy

Select AP quality assurance reports Option: **CE** Quality assurance code entry

Select ANATOMIC PATHOLOGY section: **AU** AUTOPSY

Data entry for 1992 ? YES// **<RET>** (YES)

Select Accession Number/Pt name: **63** for 1992  
SMITH,JESSE ID: 111-22-3333

Select AUTOPSY QA CODE: **??**

CHOOSE FROM:

A1 AU PRE/POSTMORTEM CORRELATION - Diagnosis confirmed/verified  
A2 AU PRE/POSTMORTEM CORRELATION - indeterminate  
A3 AU PRE/POSTMORTEM CORRELATION - significant clarification of  
diff.Dx  
A4 AU PRE/POSTMORTEM CORRELATION - major unsuspected/additional Dx  
A5 AU PRE/POSTMORTEM CORRELATION - major disagreement in Dx  
A6 AU PRE/POSTMORTEM CORRELATION - clinical info insufficient  
A7 AUTOPSY QA REVIEW - no disagreement on peer review  
A8 AUTOPSY QA REVIEW - minor disagreement on peer review (no Dx  
change)  
A9 AUTOPSY QA REVIEW - major disagreement on peer review  
  
D1 DEATH CLINICAL FACTORS - unremitting course of disease  
D2 DEATH CLINICAL FACTORS - error in judgment/treatment  
D3 DEATH CLINICAL FACTORS - complication or therapeutic proc.  
D4 DEATH CLINICAL FACTORS - unrecognized diagnosis w/ premortem  
evidence  
D8 DEATH - NO PRONOUNCEMENT DOCUMENTED

Select AUTOPSY QA CODE: **A1** AU PRE/POSTMORTEM CORRELATION - Diagnosis  
confirmed/verified

Select AUTOPSY QA CODE: **D1** DEATH CLINICAL FACTORS- unremitting course of  
disease

Select AUTOPSY QA CODE: **<RET>**

Select Accession Number/Pt name: **<RET>**

## AP Consultation Searches and Reports [LRAPQACN]

Internal and external consultations may be entered for individual anatomic pathology accessions using procedure codes from the SNOMED manuals which include:

- 0650 Consultation NOS
- 0651 Consultation, Limited
- 0652 Consultation, Intermediate
- 0653 Consultation, Extensive
- 0654 Consultation, Comprehensive

However, the procedure code may be up to seven digits. This allows further flexibility in specifying the type of consultation, etc., For example, external consultations might include:

- 0654001 AFIP consultation
- 0654002 SERS external review
- 0654003 SERA external review

Internal consultations might include:

- 0654004 Consultation, internal
- 0654005 GI conference
- 0654006 Pulmonary conference
- 0654007 Renal conference
- 0654008 Morbidity & Mortality
- 0654009 Tumor Board

By entering the procedure codes for the individual cases, the information is documented as part of the Cum path data summary for the patient for future reference. By entering specific ID numbers and dates for the case using the Spec Studies-EM;Immuno;Consult;Pic, Anat Path option, the cross-referencing is complete.

Searches are specific for the accession area, including all topographies. However, the search can be broad (to include all procedure codes starting with 065) or narrow (all 4-7 digits specified). Cases are listed by patient, then by accession number, followed by the calculations and the data for that specific accession. The data for each accession is identical to that included on the "log book"; i.e., the accession information, the SNOMED codes, and all special studies information.

The following abbreviations are used:

- AFIP = Armed Forces Institute of Pathology
- SERS = Systematic External Review of Surgical Pathology
- SERA = Systematic External Review of Autopsies

## AP Menu Options

### **Example: Listing of Cases Sent to SERS**

Select Supervisor, anat path Option: **QA** AP quality assurance reports

Select AP quality assurance reports Option: **CN** AP consultation searches and reports

Consultation search with report.

This report may take a while and should be queued to print at non-peak hours.

OK to continue ? NO// **Y** (YES)

Select ANATOMIC PATHOLOGY section: **SP** SURGICAL PATHOLOGY

Choice # 1 Select consultation code (must begin with 065): **0654002**

Choice # 2: Select consultation code (must begin with 065): **<RET>**

Start with Date TODAY// **1-1-90** (JAN 01, 1990)

Go to Date TODAY// **1-31-90** (JAN 31, 1990)

Select Print Device: **[Enter Print Device Here]**

**NOTE:** In this example, the search will contain all topographies for which the procedure code 0654002 (SERS external review) has been entered. This search and case listing can be used for several purposes, including:

- tally of number and type of cases sent to SERS
- documentation of AFIP # for each specific case sent to SERS
- reviewing specific outcomes for quality assurance purposes; i.e., # cases sent, # agreements, # disagreements, etc.

*[Listing of cases sent to SERS Printout]*

OCT 16, 1990 14:55 SURGICAL PATHOLOGY SEARCH(JAN 1, 1990=>JAN 31, 1990) Pg 1

# = Not VA patient

SNOMED TOPOGRAPHY CODE: ALL-- SNOMED PROCEDURE CODE: 0654002

---

NAME	ID	SEX	AGE	ACC #	ORGAN/TISSUE	PROCEDURE
CHxxxxxxx, Cxxxxx	xxxx	M	92	284-89	PROSTATE	SERS EXTERNAL REVIEW
CUxxxxx, Pxxxx	xxxx	M	62	95-89	PROSTATE	SERS EXTERNAL REVIEW
DIxxxxxxxxxx, Jxxxxx	xxxx	M	61	205-89	COLON	SERS EXTERNAL REVIEW
KNxxxxxx, Rxxxx	xxxx	M	42	23-89	ESOPHAGUS	SERS EXTERNAL REVIEW
POxxxxxxxx, Nxxx	xxxx	M	62	518-89	SKIN OF TRUNK	SERS EXTERNAL REVIEW

---

OCT 16, 1990 14:55 SURGICAL PATHOLOGY SEARCH(JAN 1, 1990=>JAN 31, 1990) Pg 2

# = Not VA patient

SNOMED TOPOGRAPHY CODE: ALL-- SNOMED PROCEDURE CODE: 0654002

---

ACC #	NAME	ID	SEX	AGE	ORGAN/TISSUE	PROCEDURE
284-89	CHxxxxxxx, Cxxxxx	xxxx	M	92	PROSTATE	SERS EXTERNAL REVIEW
95-89	CUxxxxx, Pxxxx	xxxx	M	62	PROSTATE	SERS EXTERNAL REVIEW
205-89	DIxxxxxxxxxx, Jxxxxx	xxxx	M	61	COLON	SERS EXTERNAL REVIEW
23-89	KNxxxxxx, Rxxxx	xxxx	M	42	ESOPHAGUS	SERS EXTERNAL REVIEW
518-89	POxxxxxxxx, Nxxx	xxxx	M	62	SKIN OF TRUNK	SERS EXTERNAL REVIEW

---

OCT 16, 1990 14:55 SURGICAL PATHOLOGY SEARCH(JAN 1, 1990=>JAN 31, 1990) Pg 3

# = Not VA patient

SNOMED TOPOGRAPHY CODE: ALL-- SNOMED PROCEDURE CODE: 0654002

---

RESULT OF SURGICAL PATHOLOGY SEARCH  
 PATIENTS WITHIN PERIOD SEARCHED: 563  
 SURGICAL PATHOLOGY ACCESSIONS WITHIN PERIOD SEARCHED: 565

5 OF 563 PATIENTS (0.89%)  
 5 OF 669 SNOMED CODE ALL SPECIMENS( 0.75%)  
 669 ORGAN/TISSUE SPECIMENS WITHIN PERIOD SEARCHED  
 (SNOMED TOPOGRAPHY CODE ALL IS 100.00%)

## Listing of cases sent to SERS Printout (contd)

DEC 27, 1989 08:19 ST. ELSEWHERE Pg: 4  
 SURGICAL PATHOLOGY CONSULTATIONS

```

-----
KNxxxx,Rxxxx          xxx-xx-xxxx
  Organ/tissue:          Date rec'd: 01/04/89  Acc #:  23
  ESOPHAGUS
    SERS EXTERNAL REVIEW
    ACUTE INFLAMMATION
  CONSULTATION AFIP#2249480-1 Date: OCT 20, 1989
-----
CUxxxxxx,Pxxxx          xxx-xx-xxxx
  Organ/tissue:          Date rec'd: 01/09/89  Acc #:  95
  PROSTATE
    SERS EXTERNAL REVIEW
    HYPERPLASIA, GLANDULAR
-----
DIxxxx,Jxxxxxx          xxx-xx-xxxx
  Organ/tissue:          Date rec'd: 01/13/89  Acc #: 205
  COLON
    SERS EXTERNAL REVIEW
    ADENOMATOUS POLYP
  CONSULTATION AFIP#2249395-1 Date: OCT 18, 1989
-----
CHxxxxx,Cxxxxx          xxx-xx-xxxx
  Organ/tissue:          Date rec'd: 01/19/89  Acc #: 284
  PROSTATE
    BIOPSY, NOS
    SERS EXTERNAL REVIEW
    INFLAMMATION
    ADENOCARCINOMA
  CONSULTATION AFIP#2249417-3 Date: NOV 21, 1989
-----
Fxxxx,Nxxxxx          xxx-xx-xxxx
  Organ/tissue:          Date rec'd: 01/30/89  Acc #: 518
  SKIN OF TRUNK
    SERS EXTERNAL REVIEW
    BOWEN'S DISEASE
    KERATOSIS, ACTINIC
  CONSULTATION AFIP#2249406-6 Date: OCT 18, 1989
  
```

NOTE: This last page is particularly useful as a work list for tracking cases submitted, but for which no report has been received, such as accession #95 above.

## Cum Path Summaries for Quality Assurance [LRAPQAC]

By compiling a consolidated report of the cum path data summaries for all patients having specimens accessioned for a specified accession area, the process of reviewing the diagnoses for correlation is greatly simplified.

For example, by routinely printing the report for cytology on a monthly basis, the reviewer can determine the number of cases in which a subsequent specimen was submitted to surgical pathology and whether the diagnoses correlate. In the following case, the patient underwent a fine needle biopsy on 1/4/89 (submitted to Cytopathology) and subsequently underwent surgery on 1/26/89, at which time specimens were submitted to Surgical Pathology and Electron Microscopy.

### Example:

Select AP quality assurance reports Option: **CS** Cum path summaries for quality assurance

Quality assurance cum path data summaries  
for accessions from one date to another

Select ANATOMIC PATHOLOGY section: **CY** CYTOPATHOLOGY

Do you want to specify a site/specimen (Topography) ? NO// **YES** (YES)

TOPOGRAPHY (Organ/Tissue)

Select 1 or more characters of the code

For all sites type 'ALL' : ALL

Start with Date TODAY// **1/1/89** (JAN 01, 1989)

Go to Date TODAY// **1/31/89** (JAN 31, 1989)

Select Print Device: *[Enter Print Device Here]*

## AP Menu Options

OCT 16, 1989 11:45

ST ELSEWHERE VAMC

Pg 1

ANATOMIC PATHOLOGY

CYTOPATHOLOGY QA from JAN 1, 1989 to JAN 31, 1989

-----  
ARDVARK, JIMMY JR.

SSN: 333-22-2444 DOB: APR 4, 1944

### SURGICAL PATHOLOGY

Organ/tissue: Date rec'd: 01/08/89 Acc #: 726  
BONE MARROW

LYMPHOCYTIC INFILTRATE  
Organ/tissue: Date rec'd: 01/26/89 Acc #: 435  
LYMPH NODE OF NECK

FROZEN SECTION  
MALIGNANT LYMPHOMA, UNDIFFERENTIATED CELL TYPE  
IMMUNOPEROXIDASE IP89-43 Date: JAN 30, 1989  
#1. FROZEN SECTION

### CYTOPATHOLOGY

Organ/tissue: Date rec'd: 01/04/89 Acc #: 16  
LYMPH NODE OF NECK

BIOPSY, FINE NEEDLE  
HYPERPLASIA, ATYPICAL LYMPHOID  
IMMUNOPEROXIDASE IP89-6 Date: JAN 6, 1989

### ELECTRON MICROSCOPY

Organ/tissue: Date rec'd: 01/26/89 Acc #: 45  
LYMPH NODE OF NECK

ELECTRON MICROSCOPY  
MALIGNANT LYMPHOMA, UNDIFFERENTIATED CELL TYPE  
S89-435-1

Organ/tissue: Date rec'd: 01/04/89 Acc #: 3  
LYMPH NODE OF NECK

LYMPHOCYTIC INFILTRATE  
C89-16



**% Pos, Atyp, Dysp, Neg, Susp, & Unsat Cytopath [LRAPCYPCT]**

Use this option to print the number and the % of positive, negative, and suspicious specimens for malignancy and unsatisfactory specimens from one date to another. The listing provides information which will assist in meeting a requirement of the College of American Pathologists (CAP). The prompt "Use topography category list?" will appear only if a topography list has been created using the [LRAPDAR] option in the Supervisor's Menu.

The morphology list and the topography category list are defined using the Edit Pathology Report Parameters [LRAPDHR] option.

**Example 1: Using morphology entry list**

Select Anat path accession reports Option: **CY** % Pos, Atyp, Dysp, Neg, Susp, & Unsat cytopath

Cytology Specimens:

Use morphology list? YES// **<RET>** (YES)

Use topography category list? YES//**NO**

Select 1 or more characters of SNOMED TOPOGRAPHY code (Choice # 1): **2**

ENTER IDENTIFYING COMMENT: **RESPIRATORY**

Select 1 or more characters of SNOMED TOPOGRAPHY code (Choice # 2): **7**

ENTER IDENTIFYING COMMENT: **GU**

Select 1 or more characters of SNOMED TOPOGRAPHY code (Choice # 3): **<RET>**

Start with Date TODAY// **<RET>** NOV 21, 1988

Go to Date TODAY// **1 1** (JAN 01, 1988)

Select Print Device: **[Enter Print Device Here]**

```

-----
NOV 21, 1988 14:35                               Pg: 1
CYTOPATHOLOGY From JAN 1, 1988 To NOV 21, 1988
  Location                               Location Count  Count
-----
RESPIRATORY (2):                               3
  NEGATIVE FOR MALIGNANT CELLS                 2      (66.7%)
  GU (7):                                       1
  SUSPICIOUS FOR MALIGNANT CELLS               1      (100.0%)
Total specimens found:                         4
  UNSATISFACTORY SPECIMEN                       ( 0.0%)
  NEGATIVE FOR MALIGNANT CELLS                 2      (50.0%)
  SUSPICIOUS FOR MALIGNANT CELLS               1      (25.0%)
  POSITIVE FOR MALIGNANT CELLS                 ( 0.0%)
  
```

**NOTE:** As shown in the example above, failure to enter SNOMED codes for each category results in the sum of the % not being equal to 100%; i.e., there are four specimens and only three were coded.

## AP Menu Options

### **Example 2:** Using default morphology codes and defined topography category listing

Select AP Quality Assurance Option: **CY** % Pos, Atyp, Dysp, Neg, Susp, & Unsat cytopath

Cytology Specimens:

Use morphology list? YES// **NO**

% POSITIVE FOR MALIGNANT CELLS  
% SUSPICIOUS FOR MALIGNANT CELLS  
% NEGATIVE FOR MALIGNANT CELLS  
% UNSATISFACTORY SPECIMEN

Use topography category list? YES// ?

ANSWER "YES", "NO", "^", "@"

or press RETURN key to accept default response (if one)? YES//<RET>

51030 ORAL MUCOUS MEMBRANE  
1Y010 SYNOVIAL FLUID  
2Y030 SPUTUM  
2Y410 BRONCHIA MATERIAL  
2Y610 PLEURAL FLUID  
3X110 PERICARDIAL FLUID  
6X210 ESOPHAGEAL  
6X310 GASTRIC  
6X940 PERITONEAL FLUID  
7X100 URINE  
8X210 VAGINAL  
8X330 VAGINAL/CERVICAL  
X1010 CSF

Start with Date TODAY// **5-1-90** (MAY 01, 1990)

Go to Date TODAY// **5/31/90** (MAY 31, 1990)

Select Print Device: **[Enter Print Device Here]**

**NOTE:** The list at the "Use topography category list? YES//" prompt is generated at the using the Edit Pathology Report Parameters option in the Supervisor's Menu.

JUL 27, 1990 12:51 VAMC Pg: 1  
 CYTOPATHOLOGY COUNTS From MAY 1, 1990 To MAY 31, 1990

Location	Location	Count	Count
ORAL MUCOUS MEMBRANE (51030):			1
NEGATIVE FOR MALIGNANT CELLS	1	(100.0%)	
SYNOVIAL FLUID (1Y010):			1
NEGATIVE FOR MALIGNANT CELLS	1	(100.0%)	
SPUTUM (2Y030):			12
UNSATISFACTORY SPECIMEN	1	(8.3%)	
NEGATIVE FOR MALIGNANT CELLS	11	(91.7%)	
BRONCHIAL MATERIAL (2Y410):			10
NEGATIVE FOR MALIGNANT CELLS	5	(50.0%)	
SUSPICIOUS FOR MALIGNANT CELLS	1	(10.0%)	
POSITIVE FOR MALIGNANT CELLS	2	(20.0%)	
PLEURAL FLUID (2Y610):			5
NEGATIVE FOR MALIGNANT CELLS	5	(100.0%)	
ESOPHAGEAL (6X210):			2
NEGATIVE FOR MALIGNANT CELLS	1	(50.0%)	
PERITONEAL FLUID (6X940):			4
NEGATIVE FOR MALIGNANT CELLS	4	(100.0%)	
URINE (7X100):			42
NEGATIVE FOR MALIGNANT CELLS	31	(73.8%)	
SUSPICIOUS FOR MALIGNANT CELLS	5	(11.9%)	
VAGINAL (8X210):			1
NEGATIVE FOR MALIGNANT CELLS	1	(50.0%)	
VAGINAL/CERVICAL (8X330):			2
NEGATIVE FOR MALIGNANT CELLS	1	(50.0%)	
CSF (X1010):			5
UNSATISFACTORY SPECIMEN	1	(20.0%)	
NEGATIVE FOR MALIGNANT CELLS	4	(80.0%)	
Total specimens found:			85
UNSATISFACTORY SPECIMENS	2	(2.4%)	
NEGATIVE FOR MALIGNANT CELLS	65	(76.5%)	
SUSPICIOUS FOR MALIGNANT CELLS	6	(7.1%)	
POSITIVE FOR MALIGNANT CELLS	2	(2.4%)	

## Delete TC and QA Code [LRAPQADEL]

This option allows purging of the Tissue Committee (TC) codes and the Quality Assurance (QA) codes. Separating this from the other purges allows additional flexibility for the site in determining the length of time to keep data on-line.

### Example:

Select AP quality assurance reports Option: **DC** Delete TC and QA codes

Select ANATOMIC PATHOLOGY section: **SP** SURGICAL PATHOLOGY

Delete Tissue committee/QA codes from SURGICAL PATHOLOGY File

Start with Date TODAY// **1-1-90**

Go to Date TODAY// **3-3-90**

OK to DELETE TC/QA codes

from one date thru another ? NO// **<RET>** (NO)

Select AP quality assurance Option: **<RET>**

## Frozen Section, Surgical Path Correlation [LRAPQAFS]

By entering a procedure code (3082) for each case involving a frozen section, a search can be done on a regular basis to identify cases for review. These cases can then be reviewed to determine:

1. whether the frozen section diagnosis correlates with that of the permanent section diagnosis
2. whether the documentation of the required physician diagnosis was appropriate, and/or
3. whether a second pathologist agrees with the original diagnosis.

In order to expedite the review process, the report generated includes the data obtained from the search; i.e., alphabetical listing by patient followed by the listing by accession number and the calculations, and a copy of the final report for each accession identified.

### Example: Frozen Section Search

#### ANATOMIC PATHOLOGY MENU

Select Anatomic pathology Option: **S** Supervisor, anat path

Select Supervisor, anat path Option: **QA** AP quality assurance

Select AP quality assurance Option: **FS** Frozen section, surgical  
path correlation

Frozen section search with optional permanent path reports.  
This report may take a while and should be queued to print at  
non-peak hours.

OK to continue ? NO// **Y** (YES)

Do you want corresponding permanent pathology reports [*New*]  
to print following search ? NO// **<RET>** (NO)

-----  
Start with Date TODAY// **<RET>** MAR 19, 1992  
Go to Date TODAY// **1 1** (JAN 01, 1992)  
Select Print Device: [*Enter Print Device Here*]

NOTE: This search includes all topographies.

## AP Menu Options

MAR 19, 1992 07:05 SURGICAL PATHOLOGY SEARCH(JAN 01, 1992=>Mar 19, 1992) Pg 1  
# = Not VA patient

SNOMED TOPOGRAPHY CODE: ALL -- SNOMED PROCEDURE CODE: 3081 or 3082-

```
-----  
NAME                ID    SEX  AGE  ACC #  ORGAN/TISSUE          PROCEDURE  
VOxxx,Dxxxxxxxx    xxxx  M    31   435-92 LYMPH NODE OF NECK    FROZEN SECTION  
                    PIRIFORM RECESS      FROZEN SECTION  
WAxxx,Jxxxxxxxxxxx  xxxx  M    58   443-92 LARYNX                FROZEN SECTION
```

MAR 19, 1992 07:05 SURGICAL PATHOLOGY SEARCH(JAN 01, 1992=>Mar 19, 1992) Pg 2  
# = Not VA patient

SNOMED TOPOGRAPHY CODE: ALL -- SNOMED PROCEDURE CODE: 3081 or 3082-

```
-----  
ACC #  NAME                ID    SEX  AGE  ORGAN/TISSUE          PROCEDURE  
435-92 VOxxx,Dxxxxxxxx    xxxx  M    31   LYMPH NODE OF NECK    FROZEN SECTION  
443-92 WAxxx,Jxxxxxxxxxxx  xxxx  M    58   LARYNX                FROZEN SECTION  
                    PIRIFORM RECESS      FROZEN SECTION
```

MAR 19, 1992 07:05 SURGICAL PATHOLOGY SEARCH(JAN 01, 1992=>Mar 19, 1992) Pg 3  
# = Not VA patient

SNOMED TOPOGRAPHY CODE: ALL -- SNOMED PROCEDURE CODE: 3081 or 3082-

RESULT OF SURGICAL PATHOLOGY SEARCH:

PATIENTS WITHIN PERIOD SEARCHED: 33

SURGICAL PATHOLOGY ACCESSIONS WITHIN PERIOD SEARCHED: 33

2 OF 33 PATIENTS (6.06%)

2 OF 38 SNOMED CODE ALL SPECIMENS (5.26%)

38 ORGAN/TISSUE SPECIMENS WITHIN PERIOD SEARCHED

(SNOMED TOPOGRAPHY CODE ALL IS 100.00%)

-----  
MEDICAL RECORD : SURGICAL PATHOLOGY Pg 1  
-----

Submitted by: JOE WELBY MD Date obtained: JAN 26, 1992  
-----

Specimen: (Received JAN 26, 1992)  
1. RT. NECK NODE  
2. RT NECK NODE.  
-----

Brief Clinical History:  
-----

Preoperative Diagnosis:  
-----

Operative Findings:  
-----

Postoperative Diagnosis:  
Surgeon/physician: JOE WELBY MD  
-----

PATHOLOGY REPORT

Laboratory: R5ISC Accession No. S92 435  
-----

GROSS DESCRIPTION: Pathology Resident: Rxxxxxxxxxxxxxxxxxxxxx  
-----

1. Specimen previously submitted for frozen section FS DIAGNOSIS: Malignant undifferentiated tumor consists of two irregular necrotic soft to firm lymphoid tissue pieces altogether measuring 2.5 x 2 x 1.5 cm. All embedded. Specimen were sent for flow cytometry, electronmicroscopy and immuno staining.
2. Specimen is similar measuring 4 x 3 x 2.5 cm. This is an enlarged lymph node, firm which on cut section shows a fish-flesh surfaces. Representative sections are embedded.

1. FS DIAGNOSIS: Malignant undifferentiated tumor

MICROSCOPIC DESCRIPTION/DIAGNOSIS:  
DIAGNOSIS BASED ON LIGHT AND ELECTRON MICROSCOPY (EM9-45) AND IMMUNOSTUDIES: Undifferentiated, non Burkitt's type (high grade diffuse lymphoma) IgM lambda positive, involving right and left neck lymph nodes. Dr. D. Variak, hematopathologist, Southwestern University, concurs with the diagnosis.  
-----

MARCUS WELBY MD (End of report)  
rg: Date MAR 17,.1992  
-----

VOxxxx,Dxxxxxxxxx SURGICAL PATHOLOGY Report  
ID:xxx-xx-xxxx SEX:M DOB:5/8/59 AGE: 31 LOC: 1A  
JOE WELBY MD

## **Print Path Micro Modifications [LRAPQAM]**

Use this option to print path reports that have modified microscopic descriptions from one date to another. The information indicates the order of the entries — the original report followed by the first modification, the second modification, etc.

### **Example:**

```
Select Anatomic pathology Option:  S  Supervisor, anat path
Select Supervisor, anat path Option:  QA  AP quality assurance reports

Select AP quality assurance reports Option:  MM  Print path micro
modifications
Select ANATOMIC PATHOLOGY Section:  SP  SURGICAL PATHOLOGY

Start with Date TODAY//  6/1/90  (JUN 01, 1990)
Go      to      Date TODAY/ 6/30/90 (JUN 30, 1990)
Select Print Device:  [Enter Print Device Here]
```



-----  
MEDICAL RECORD : SURGICAL PATHOLOGY Pg 1  
-----

Submitted by: BHABE Date obtained: JUN 5, 1990  
-----

Specimen: (Received JUN 6, 1990)  
RECTAL Bx.  
-----

Brief Clinical History:  
Hx of ACUTE DIARRHEA.  
-----

Preoperative Diagnosis:  
DIARRHEA  
-----

Operative Findings:  
SESSILE POLYP 4MM SIZE AT 15 CM - BX DONE.  
-----

Postoperative Diagnosis:  
S/A  
-----

Surgeon/physician:  
-----

=====

PATHOLOGY REPORT

Laboratory: Hines VAMC Accession No. S90 3017  
-----

GROSS DESCRIPTION:

A particle of soft grayish white tissue that measures 0.3 cm in diameter.  
All embedded.

MICROSCOPIC DESCRIPTION/DIAGNOSIS:

\*\*\* MODIFIED REPORT \*\*\*

(Last modified: JUN 21, 1990 09:17 typed by RENC,NORMA)

Date modified: JUN 21, 1990 09:17 typed by RENC,NORMA

Small hyperplastic polyp.

-----  
Small adenomatous polyp.  
-----

(See next page)

VXXX. VXXXXX MD

nr : Date JUN 7, 1990  
-----

Wxxxx, CARTER

SURGICAL PATHOLOGY Report

ID:xxx-xx-xxxx SEX:M DOB:7/14/19 AGE: 73 LOC: MHC

JOE WELBY MD

## **Malignancy Review [LRAPQAMR]**

As detailed in M-2, Part VI, Chapter 2, entitled "Surgical Pathology and Cytology Services" dated July 10, 1989, all cases involving soft tissue, bone, muscle, or gynecological tissue should be reviewed by a second pathologist. While it is possible to do individual searches of several morphology codes, this option both simplifies and expedites the process. Cases are identified by topography; i.e., soft tissue and bone/muscle (T1) or gynecological (T8), and include all SNOMED morphology codes beginning with 8 and 9 and ending in 1, 2, 3, 6, or 9.

The report generated includes the data obtained from the search — alphabetical listing by patient followed by the listing by accession number and the calculations, a copy of the final report for each accession identified, and a cum path data summary, if requested.

This option can also be used to generate listings of cases and final reports for quality assurance studies being performed by other clinical services.

**HINT:** By including the cum path data summary as well as the final report for the accessions, it is possible to identify which cases involved new malignancies, thus requiring documentation of physician notification.

### **Example 1: Listing of all Bone and Soft Tissue Malignancies for Surgical Pathology Case Reviews**

```
Select Supervisor, anat path Option:  QA  AP quality assurance reports
Select AP quality assurance reports Option:  MR  Malignancy review
Select ANATOMIC PATHOLOGY Section:  SP  SURGICAL PATHOLOGY
Malignancy review
```

```
This report may take a while and should be queued to print at non-peak hours.
OK to continue ? NO// Y (YES)
```

```
Do you want corresponding permanent pathology reports <- [New]
to print following search ? NO// Y (YES)
```

```
Include suspicious for malignancy cases? YES// <RET>
1. Bone and soft tissue
2. Female genital tract
3. Other topography
```

```
Select 1, 2, or 3: 1
```

```
Do you want corresponding permanent pathology reports
to print following search ? NO// <RET> (NO)
```

```
Start with Date TODAY// 11-1-89 (NOV 01, 1989)
Go to Date TODAY// 11-30-89 (NOV 30, 1989)
Select Print Device: [Enter Print Device Here]
```

DEC 27, 1989 07:05 ST. ELSEWHERE VAMC  
 SURGICAL PATHOLOGY SEARCH(NOV 1, 1989=>NOV 30, 1989) Pg: 1  
 # = Not VA patient  
 SNOMED TOPOGRAPHY CODE: 1----- SNOMED MORPHOLOGY CODE: MALIGNANT-

NAME	ID	SEX	AGE	ACC #	ORGAN/TISSUE	MORPHOLOGY
VOxxx,Dxxxxxxxx	xxxx	M	31	435-89	VERTEBRA	CARCINOMA, METASTATIC
WAxxx,Jxxxxxxxx	xxxx	M	58	443-89	KNEE JOINT	CARCINOMA, METASTATIC

DEC 27, 1989 07:05 ST. ELSEWHERE VAMC  
 SURGICAL PATHOLOGY SEARCH(NOV 1, 1989=>NOV 30, 1989) Pg: 1  
 # = Not VA patient  
 SNOMED TOPOGRAPHY CODE: 1----- SNOMED MORPHOLOGY CODE: MALIGNANT-

ACC #	NAME	ID	SEX	AGE	MO/DA	ORGAN/TISSUE	MORPHOLOGY
443-89	WAxxx,Jxxxxxxxx	xxxx	M	58	11/01	KNEE JOINT	CARCINOMA,MET
435-89	VOxxx,Dxxxxxxxx	xxxx	M	31	11/28	VERTEBRA	CARCINOMA,MET

DEC 27, 1989 07:05 ST. ELSEWHERE VAMC  
 SURGICAL PATHOLOGY SEARCH(NOV 1, 1989=>NOV 30, 1989) Pg: 1  
 # = Not VA patient  
 SNOMED TOPOGRAPHY CODE: 1----- SNOMED MORPHOLOGY CODE: MALIGNANT-

RESULT OF SURGICAL PATHOLOGY SEARCH:  
 PATIENTS WITHIN PERIOD SEARCHED: 482  
 SURGICAL PATHOLOGY ACCESSIONS WITHIN PERIOD SEARCHED: 482

2 OF 482 PATIENTS( 0.41%)  
 2 OF 34 SNOMED CODE 1 SPECIMENS (5.88%)  
 539 ORGAN/TISSUE SPECIMENS WITHIN PERIOD SEARCHED  
 (SNOMED TOPOGRAPHY CODE 1 IS 6.31%)

NOTE: The final reports and cum path data summaries for these two patients would be included following this page.

## AP Menu Options

### **Example 2:** Listing of lung malignancies for correlation of surgical pathology diagnoses with that of diagnostic radiology

Select Anatomic pathology Option: **S** Supervisor, anat path

Select Supervisor, anat path Option: **QA** AP quality assurance reports

Select AP quality assurance reports Option: **MR** Malignancy review

Select ANATOMIC PATHOLOGY Section: **SURGICAL** PATHOLOGY

Malignancy review

This report may take a while and should be queued to print at non-peak hours.

OK to continue ? NO// **Y** (YES)

Do you want corresponding permanent pathology reports <- **[New ]**  
to print following search ? NO// **Y** (YES)

**NOTE:** If the ANATOMIC PATHOLOGY section is CYTOPATHOLOGY, the following prompt appears:  
"Include suspicious for malignancy cases ? YES//"

Include suspicious for malignancy cases? YES// **<RET>**

1. Bone and soft tissue
2. Female genital tract
3. Other topography

Select 1, 2, or 3: **3**

TOPOGRAPHY (Organ/Tissue)

Select 1 or more characters of the code

For all sites type 'ALL' : **28**

Do you want corresponding permanent pathology reports  
to print following search ? NO// **<RET>** (NO)

Start with Date TODAY// **11-1-89** (NOV 01, 1989)

Go to Date TODAY// **11-30-89** (NOV 30, 1989)

Select Print Device: **[Enter Print Device Here]**

**NOTE:** The report is not included, as the format is identical to that in Example 1.

## QA Outcome Review Cases [LRAPQOR]

If the outcome of the quality assurance review is entered using the QA Codes Enter/Edit [LRAPQACD] option, the results can be retrieved in a variety of formats, depending on how the prompts are answered.

The report can sort by accession number, by QA code and pathologist or by QA code only. It is also possible to print only specific QA codes.

For the Autopsy area, the data for the inpatient death and the % autopsies by clinical service and treating specialty is also included.

### **Example 1:** Listing of surgical path cases reviewed by QA code and pathologist

```
Select AP quality assurance Option:  QA outcome review cases
Select ANATOMIC PATHOLOGY section:  SP SURGICAL PATHOLOGY
Start with Date TODAY// 5-1-90 (MAY 01, 1990)
Go to Date TODAY//5-31-90 (MAY 31, 1990)

Sort by QA CODE and PATHOLOGIST ? NO// Y (YES)
Sort by QA CODE only ? NO// <RET>
Select Print Device:  [Enter Print Device Here]
```

## AP Menu Options

SEP 17, 1990 07:33

VAMC

Pg:1

QA CODES FOR SURGICAL PATHOLOGY From: MAY 1, 1990 To: MAY 31, 1990

Acc # Rec'd

-----  
Pathologist: CXXXXXX,GXX

F1 FROZEN SECTION- QA review-no disagreement

2355 05/01/90

2430 05/07/90

Number of cases: 2

R2 RANDOM QA REVIEW-minor disagreement (no Dx or Rx change)

Number of cases: 1

2433 05/07/90

Number of cases: 1

R3 RANDOM QA REVIEW-major disagreement (Dx or Rx change)

2456 05/01/90

Number of cases: 1

Total cases: 4

Pathologist: JXXXXXXXXX,VXX.

F1 FROZEN SECTION- QA review-no disagreement

2423 05/04/90

2488 05/09/90

Number of cases: 2

Total cases: 2

Pathologist: KXXXX,SXXXX

M1 MALIGNANCY QA REVIEW- minor disagreement (no Dx or Rx change)

2559 05/11/90

Number of cases: 2

Total cases: 2

Pathologist: MXXXX,ZXXXXXXXX

F1 FROZEN SECTION- QA review-no disagreement

2338 05/01/90

Number of cases: 2

Total cases: 2

Pathologist: RXXX,CXXXX

M1 MALIGNANCY QA REVIEW- minor disagreement (no Dx or Rx change)

2637 05/16/90 Number of cases: 2

**Example 2: Listing of Autopsy Cases by QA Code Only**

Select AP quality assurance Option: **QA** outcome review cases

Select ANATOMIC PATHOLOGY section: **AU** AUTOPSY  
 Start with Date TODAY// **10-1-91** (OCT 01, 1991)  
 Go to Date TODAY// **10-31-91** (OCT 31, 1991)

Sort by QA CODE / PATHOLOGIST ? NO// **Y** (YES)  
 Sort by QA CODE only ? NO// **Y** (YES)  
 Select Print Device: **[Enter Print Device Here]**

DEC 3, 1992 11:57 St. Elsewhere VAMC  
 QA CODES for AUTOPSY From: OCT 1, 1991 To: OCT 31, 1991  
 Acc # Date Pathologist

Pg: 1

-----  
 A1 AU PRE/POSTMORTEM CORRELATION - Diagnosis confirmed/verified  
 122 10/21/91 WELBY, MARCUS  
 128 10/31/91 CASEY, BEN  
 Total QA Codes: 2

A4 AU PRE/POSTMORTEM CORRELATION - major unsuspected/additional Dx  
 115 10/11/91 WELBY, MARCUS.  
 126 10/25/91 WELBY, MARCUS  
 Total QA Codes: 2

D1 DEATH CLINICAL FACTORS- unremitting course of disease  
 122 10/21/91 WELBY, MARCUS  
 128 10/31/91 CASEY, BEN  
 Total QA Codes: 2

D3 DEATH CLINICAL FACTORS- complication or therapeutic proc.  
 126 10/25/91 WELBY, MARCUS  
 Total QA Codes: 1

D4 DEATH CLINICAL FACTORS- unrecognized diagnosis w/ premortem evidence  
 115 10/11/91 WELBY, MARCUS  
 126 10/25/91 WELBY, MARCUS  
 Total QA Codes: 2

D8 DEATH - NO PRONOUNCEMENT DOCUMENTED  
 124 10/23/91 KATHURIA, SATINDER  
 128 10/31/91 CASEY, BEN  
 Total QA Codes: 2

Total cases reviewed: 5

## AP Menu Options

DEC 3, 1992 11:57 St. Elsewhere VAMC  
QA CODES by SERVICE, TREATING SPECIALTY and CLINICIAN  
From OCT 1, 1991 To OCT 31, 1991

---

Pg: 2

A1 AU PRE/POSTMORTEM CORRELATION - Diagnosis confirmed/verified

SERVICE: MEDICINE

TREATING SPECIALTY: HEMATOLOGY/ONCOLOGY

CLINICIAN: SMITH,JOHN MD

Autopsy: 128 Date: 10/31/91

TREATING SPECIALTY: INFECTIOUS DISEASE

CLINICIAN: BROWN,JOSEPH

Autopsy: 122 Date: 10/21/91

Total QA Codes for A1: 2

A4 AU PRE/POSTMORTEM CORRELATION - major unsuspected/additional Dx

SERVICE: MEDICINE

TREATING SPECIALTY: GASTROINTESTINAL

CLINICIAN: SAUNDERS,MICHAEL

Autopsy: 126 Date: 10/25/91

TREATING SPECIALTY: PULMONARY

CLINICIAN: ?

Autopsy: 115 Date: 10/11/91

Total QA Codes for A4: 2

D1 DEATH CLINICAL FACTORS- unremitting course of disease

SERVICE: MEDICINE

TREATING SPECIALTY: HEMATOLOGY/ONCOLOGY

CLINICIAN: SMITH,JOHN MD

Autopsy: 128 Date: 10/31/91

TREATING SPECIALTY: INFECTIOUS DISEASE

CLINICIAN: BROWN,JOSEPH

Autopsy: 122 Date: 10/21/91

Total QA Codes for D1: 2

D3 DEATH CLINICAL FACTORS- complication or therapeutic proc.

SERVICE: MEDICINE

TREATING SPECIALTY: GASTROINTESTINAL

CLINICIAN: SAUNDERS,MICHAEL

Autopsy: 126 Date: 10/25/91

Total QA Codes for D3: 1

D4 DEATH CLINICAL FACTORS- unrecognized diagnosis w/ premortem evidence

SERVICE: MEDICINE

TREATING SPECIALTY: GASTROINTESTINAL

CLINICIAN: SAUNDERS,MICHAEL

Autopsy: 126 Date: 10/25/91

TREATING SPECIALTY: PULMONARY

CLINICIAN: ?

Autopsy: 115 Date: 10/11/91

Total QA Codes for D4: 2



D8 DEATH - NO PRONOUNCEMENT DOCUMENTED

SERVICE: MEDICINE

TREATING SPECIALTY: HEMATOLOGY/ONCOLOGY

CLINICIAN: SMITH,JOHN MD

Autopsy: 128 Date: 10/31/91

TREATING SPECIALTY: INFECTIOUS DISEASE

CLINICIAN: BROWN,JOSEPH

Autopsy: 124 Date: 10/23/91

Total QA Codes for D8: 2

DEC 3, 1992 11:58 St. Elsewhere VAMC  
 AUTOPSY DATA REVIEW (OCT 1, 1991-OCT 31, 1991)

Pg: 3

Treating Specialty	-----In-patient-----		
	#Deaths	#Autopsies	Autopsy%
	45	14	31.1
CARDIOLOGY	4		
CCU	2		
ENDOCRINE	3	1	33.3
EXTENDED CARE	3	1	33.3
GASTROINTESTINAL	3	2	66.7
GENERAL SURGERY	1		
HEMATOLOGY/ONCOLOGY	9	1	11.1
INFECTIOUS DISEASE	4	2	50.0
INTERMEDIATE CARE	3		
MICU	1		
ORTHOPEDIC	1	1	100.0
PERIPHERAL VASCULAR	1		
PULMONARY	4	4	100.0
RENAL	3		
RICU	2	2	100.0
SICU	1		

Select AP quality assurance Option: <RET>

### 10% Random Case Review, Surg Path [LRAPQAR]

As detailed in M-2, Part VI, Chapter 2, entitled "Surgical Pathology and Cytology Services," dated July 10, 1989 random case review of cases is required. However, the specific formula detailed makes selection of cases based on topography codes difficult. This option searches the topographies entered for the time specified, then randomly selects 10% of the cases for each topography to be included on the report. All SNOMED morphology codes are included in the case selection.

The report generated includes:

1. a summary of the topography counts,
2. a copy of the final report for each accession identified, and
3. a listing of the cases identified (in the same format as that for the log in book).

For those facilities in which a 10% sample would exceed the 300 case per annum (25 case per month) maximum, the listing will expedite selection of cases, since all of the topography, morphology, and procedure codes are included.

NOTE: Since the case selection is random, reprinting the report will not provide the same listing of cases.

#### Example:

Select AP quality assurance Option: **RR** 10% random case review, surg path

10% Surgical Pathology Review

This report may take a while and should be queued to print at non-peak hours.

OK to continue ? NO// **Y** (YES)

Do you want corresponding permanent pathology reports *[New ]*

to print following search ? NO// **<RET>** (NO)

Start with Date TODAY// **<RET>** MAR 19, 1992

Go to Date TODAY// **1 1 91** (JAN 01, 1991)

Select Print Device: *[Enter Print Device Here]*

MAR 19, 1992 12:56 VAMC Pg: 1

10% Surgical Pathology Review from JAN 1, 1991 to MAR 19, 1992

-----  
Total accessions: 22

Topography 0: 12  
Topography 2: 1  
Topography 5: 2  
Topography 6: 5  
Topography X: 1  
Topography Y: 1

Accessions for review: 6 (25.00%)

MAR 19, 1992 12:56 VAMC Pg: 1  
 10% Surgical Pathology Review from JAN 1, 1991 to MAR 19, 1992  
 ACC # NAME SSN

5-91	BARK,ROY	496-48-5818
	LIVER	
	CIRRHOSIS, MICRONODULAR	
7-91	JOHNSON,RUSSELL	049-25-1785
	APPENDIX	
	INFLAMMATION, ACUTE FIBRINOUS	
	SKIN	
	POLYP, FIBROEPITHELIAL	
1-92	BROWN,LEIGE	086-42-1357
	RIGHT LUNG	
	CARCINOMA, SQ CELL	
	INFLAMMATION, GRANULOMATOUS	
5-92	MALMROSE,DALE	222-22-222
	LYMPH NODE OF NECK	
	HODGKIN'S DISEASE, NODULAR SCLEROSIS	
6-92	WILDE,JACK	222-33-2222
	SKIN OF FACE	
	WOUND, ABRADED	
	TOE	
	WOUND, CONTUSED	
	AUDITORY CANAL, OSSEOUS PORTION	
	INSPISSATED CERUMEN	
10-92	SMITH,JOHN A	417-02-03441
	APPENDIX	
	ACUTE INFLAMMATION	

## **Edit QA Site Parameters [LRAPQASP]**

Surgical case review is a JCAHO-mandated medical staff monitoring function. In most, if not all, facilities, this function is performed by the Tissue Committee. Cases for review are selected based on correlation of preoperative and postoperative diagnoses. If the pathologist is actively involved in this evaluation, a TC code can be assigned at the time the final diagnosis is made. This code can be entered into the system and later used for selecting cases, using the Tissue Committee Review Cases option.

If the field is set to include the "TC Code" prompt in the edit template for the Microscopic/Gross Review and Gross Review/ Microscopic/SNOMED Coding options, the user will be required to enter data, since the field is mandatory.

### **Example:**

```
Select AP quality assurance reports Option: SP Edit QA site parameters
```

```
Select LAB SECTION PRINT NAME: SP SURGICAL PATHOLOGY  
ASK TC CODES: YES// <RET>
```

NOTE: At the "ASK TC CODES: YES" prompt, enter "Y" for yes to have the "TC code" prompt appear in the data entry edit template. "N" for no.

## **Tissue Committee Review Cases [LRAPQAT]**

Surgical case review is a JCAHO mandated medical staff monitoring function. In most, if not all, facilities, this function is performed by the Tissue Committee.

Cases for review are selected based on correlation of preoperative and postoperative diagnoses. At the time the pathologist issues the report, a QA Code can be assigned. This code is then entered during data entry of the microscopic description and SNOMED coding if the prompt "ASK TC Code" is set to "YES" using the Edit QA Site Parameters or the Edit Pathology Reports Parameters options. Assignment of a free text description to the numeric code is then done by entering the description in the LAB DESCRIPTIONS file (#62.5) and specifying "APSURG" as the screen. If a facility chooses not to have a preset description displayed as a default, no entry is necessary in the LAB DESCRIPTIONS file.

By allowing the TC codes to be included on the report to be specified, additional flexibility has been provided. In the report shown in the example, TC Codes were not included since these are cases in which the expected pathology was found.

The listing of cases by TC Code is followed by statistical information on the number of accessions, and number and percentage for each code. Additional information is then provided for each case on the list, including:

1. An expanded version of the "Cum path data summary" which also incorporates admitting/discharge information and ICD9CM codes from the PATIENT TREATMENT file.
2. The final report for the accession number listed.

These have been included to expedite review of the cases by the committee members and minimize the impact on the pathology office.

Although it is less common, TC codes can also be assigned to accessions from other areas if desired. This can either be done for only specific cases using the QA Codes Entry/Edit [LRAPQACD] option or for all cases if the ASK TC codes is turned on for that area.

## AP Menu Options

### Example 1:

```
Select Anatomic pathology Option:  S  Supervisor, anat path
Select Supervisor, anat path Option:  QA  AP quality assurance reports
Select AP quality assurance reports Option:  TC  Tissue committee review cases
Select ANATOMIC PATHOLOGY section:  SP  SURGICAL PATHOLOGY

                                TC CODE SEARCH
This report may take a while and should be queued to print at non-peak hours.
                                OK to continue ? NO// Y  (YES)

Select a number from 0 to 9 (Choice# 1):  1  (1)
ENTER IDENTIFYING COMMENT:  1//  TISSUE AS EXPECTED
Select a number from 0 to 9 (Choice# 2):  <RET>

Start with Date TODAY//  <RET>  MAR 19, 1992
Go    to    Date TODAY//  1 1  (JAN 01, 1992)

Also print cumulative path data summaries ? NO//  <RET>  (NO)
Select Print Device:  [Enter Print Device Here]
```

MAR 19, 1992 13:02 VAMC

Pg: 1

TC Code Search from JAN 1, 1992 to MAR 19, 1992

Patient	SSN	Acc#	Date
-----			
TC Code: 1 TISSUE AS EXPECTED			
ANDRUS,DWIGHT	228-22-8899	9	MAR 7, 1992
ARCHER,MARK	433-43-3333	2	JAN 7, 1992
BROWN,LEIGE	086-42-1357	1	JAN 7, 1992
MALMROSE,DALE	222-22-2222	4	JAN 7, 1992
MALMROSE,DALE	222-22-2222	5	JAN 8, 1992
SMITH,JEREMY,L.	580-82-0234	3	JAN 7, 1992
SMITH,JOHN A	417-02-0344	10	MAR 7, 1992
SOMEBODY,SAM	707-00-0045	7	JAN 13, 1992
WILDE,JACK	222-33-2222	6	JAN 13, 1992

TC Code: NONE

ANEY, RUSS	528-96-1936	8	JAN 14, 1992
BARF,BART	101-05-2286	11	MAR 8, 1992

MAR 19, 1992 13:02 VAMC

Pg: 2

TC Code Search from JAN 1, 1992 to MAR 19, 1992

Patient	SSN	Acc#	Date
-----			
TC Code: NONE			
CUMQUAT,EARNEST Q.	234-03-4567	12	MAR 8, 1992
GUNN,PETER J.	142-22-9087	13	MAR 8, 1992
HUN,ATILLA	086-42-4680	14	MAR 8, 1992

MAR 19, 1992 13:02 VAMC

Pg: 3

TC Code Search from JAN 1, 1992 to MAR 19, 1992

TC Code	Count	% of Accessions
1	9	64.29
NONE	5	35.71
-----		
Total	14	

TC Code: 1 TISSUE AS EXPECTED

## AP Menu Options

### Example 2: Cytopathology

#### ANATOMIC PATHOLOGY MENU

Select Anatomic pathology Option: **S** Supervisor, anat path

Select Supervisor, anat path Option: **AP** quality assurance

Select AP quality assurance Option: **Tissue** committee review cases

Select ANATOMIC PATHOLOGY section: **CYTOPATHOLOGY**

#### TC CODE SEARCH

This report may take a while and should be queued to print at non-peak hours.

OK to continue ? NO// **Y** (YES)

Select a number from 0 to 9 (Choice# 1): **1** (1)

ENTER IDENTIFYING COMMENT: 1// **<RET>** NO PROBLEM

Select a number from 0 to 9 (Choice# 2): **<RET>**

Start with Date TODAY// **<RET>** MAR 26, 1992

Go to Date TODAY// **1 1** (JAN 01, 1992)

Also print cumulative path data summaries ? NO// **<RET>** (NO)

Select Print Device: *[Enter Print Device Here]*

MAR 26, 1992 19:20 VAMC Pg: 1  
TC Code Search from JAN 1, 1992 to MAR 26, 1992  
Patient SSN Acc# Date obtained

---

TC Code: 1 NO PROBLEM  
ANDRUS,SHIRLEY 529645664 1 JAN 9, 1992

TC Code: NONE

MAR 26, 1992 19:20 DALLAS-ISC Pg: 2  
TC Code Search from JAN 1, 1992 to MAR 26, 1992

---

TC Code	Count	% of Accessions
1	1	100.00
NONE	0	0.00
-----		
Total	1	

TC Code: 1 NO PROBLEM

TC Code: NONE



**Example 3: Electron Microscopy**

Select Anatomic pathology Option: **S** Supervisor, anat path  
 Select Supervisor, anat path Option: **QA** AP quality assurance  
 Select AP quality assurance Option: **Tissue** committee review cases  
 Select ANATOMIC PATHOLOGY section: **EM**

TC CODE SEARCH

This report may take a while and should be queued to print at non-peak hours.

OK to continue ? NO// **Y** (YES)

Select a number from 0 to 9 (Choice# 1): **1** (1)  
 ENTER IDENTIFYING COMMENT: 1// **<RET>** NO PROBLEM  
 Select a number from 0 to 9 (Choice# 2): **<RET>**

Start with Date TODAY// **<RET>** MAR 26, 1992  
 Go to Date TODAY// **1 1** (JAN 01, 1992)

Also print cumulative path data summaries ? NO// **<RET>** (NO)  
 Select Print Device: **[Enter Print Device Here]**

MAR 26, 1992 19:26 VAMC Pg: 1  
 TC Code Search from JAN 1, 1992 to MAR 26, 1992  
 Patient SSN Acc# Date obtained

-----  
 TC Code: 1 NO PROBLEM  
 MALMROSE, DALE 222222222 1 JAN 8, 1992

## **Anatomic Pathology Turnaround Time [LRAPTT]**

To effectively monitor the laboratory portion of the turnaround time (TAT), a comparison is made of the REPORT RELEASE DATE with the DATE RECEIVED to calculate the number of "days in lab." A check is done of the dates involved, to ensure exclusion of holidays and weekends. If REPORT RELEASE DATE has a date entered, that date will be used in the calculation of turnaround time for all areas except Autopsy. For autopsies, the TAT can be calculated for either the PAD (based on the PROVISIONAL AP DIAGNOSIS DATE) or the FAD (based on the DATE AUTOPSY REPORT COMPLETED).

Turnaround time reports generated for each accession area may include either all cases for the period requested, or only cases exceeding a specified time for the period requested.

If the TAT reports are to include only the exceptions, flexibility is provided for each site to designate the acceptable time each time the report is generated. In addition to the list of the cases exceeding the time specified, the report provides:

1. count of accessions
2. average TAT for the completed cases
3. number and % of cases exceeding the limit
4. the number of incomplete cases not included in the calculations

If the cases analyzed are from sources other than the Patient file, totals and calculations are included for the Patient file and the referral file separately.

In those cases in which the % of cases exceeding the limit is unacceptable, reprinting the same report using different limits may be valuable in investigating and reviewing the data.

### **Example 1: Surgical Pathology**

Select QA quality assurance reports Option: **TT** Anatomic pathology turnaround time

Select ANATOMIC PATHOLOGY section: **SP** SURGICAL PATHOLOGY  
Start with Date TODAY// **9-1-94** (SEP 01, 1994)  
Go to Date TODAY// **1-1-94** (JAN 01, 1994)  
Identify cases exceeding turnaround time limit ? NO// **Y** (YES)  
Enter limit in days: 10  
Select Print Device: *[Enter Print Device Here]*

**NOTE:** At the "Identify cases exceeding turn around time limit ? NO//" prompt enter "YES" to include only those cases exceeding a specified time limit. Enter <RET> to include all cases.

SEP 9, 1994 10:02 DALLAS ISC, VERIFICATION ACCT Pg: 1

Turnaround time for SURGICAL PATHOLOGY (Exceeding 20 days)

From: JAN 1, 1994 To: SEP 9, 1994 Lab work

Acc # Rec'd Entry ID Typist Released Days Pathologist

-----  
 1 08/10/94 SIMPLE,SARA 0114P ec EMBREE

If '#', '\*' or '?' is after Acc # then demographic data is in file indicated:

# = Referral file \* = Research file ? = Other file listed below

Total cases: 17

Incomplete cases: 10

Complete cases: 7

Average turnaround time (days): 2.86 Cases exceeding limit: 4 (57.14%)

Total PATIENT file cases: 14

Incomplete cases: 7

Complete cases: 7

Average turnaround time (days): 2.86 Cases exceeding limit: 4 (57.14%)

Total REFERRAL PATIENT file cases: 2

Incomplete cases: 2

Complete cases: 0

Total RESEARCH file cases: 1

Incomplete cases: 1

Complete cases: 0

## AP Menu Options

### Example 2: Autopsy Provisional Anatomical Diagnosis

Select AP quality assurance Option: **TT** Anatomic pathology turnaround time

Select ANATOMIC PATHOLOGY section: **AU** AUTOPSY

1. Turnaround time for PAD
2. Turnaround time for FAD

Select 1 or 2: **1**

Start with Date TODAY// **11-1-92** (NOV 01, 1992)

Go to Date TODAY// **<RET>** DEC 3, 1992

Identify cases exceeding turnaround time limit ? NO// **<RET>** (NO)

Select Print Device: **[Enter Print Device Here]**

DEC 3, 1992 10:30 VAMC Pg: 1

PAD Turnaround time for AUTOPSY

From: NOV 1, 1992 To: DEC 3, 1992

Lab work

Acc # Performed Entry ID Typist Completed Days Pathologist

---

1	F	05/31/92	HIPPO,HUNGRY	2212	lab		COUGAR
1	F	05/11/92	EMBREE,SUSANN	9877			
1	F	08/24/92	UNGER,FELIX	4444	ec	08/24/92	<1 PATHOLOGIST

F= FULL AUTOPSY H= HEAD ONLY T= TRUNK ONLY O=OTHER LIMITATION

Total cases: 11

Incomplete cases: 10

Complete cases: 1

#### NOTES:

- For the PAD, the calculation is based on the entry in the Provisional Autopsy Dx Date field (File 63, Field 14.9).
- For the FAD, the calculation is based on the entry in the Date Autopsy Report Completed field (File 63, Field 13).

## Move Anatomic Path [LRAPMV]

If it is necessary to transfer data associated with a specific surgical pathology accession from one file to another (e.g., REFERRAL file to PATIENT file, **or** from one patient to another within the PATIENT file) this option can be used.

This option eliminates the need to edit the global for those occurrences in which a surgical pathology accession is assigned to a patient and the error is not detected until after the report has been verified/released.

This option is locked with the LRLIAISON key because of the implications of such a data transfer.

**Example:**        Accession Originally Entered on a Referral Patient who was  
                         Subsequently Admitted

### ANATOMIC PATHOLOGY MENU

Select Anatomic pathology Option: **S**upervisor, anat path

Select Supervisor, anat path Option: **MV** Move anatomic path accession

Move an accession from one patient to another

Select ANATOMIC PATHOLOGY section: **SP** SURGICAL PATHOLOGY

Accession Year: 1992 ? YES// **N** (NO)

Enter YEAR: **91** ( 1991)

Move Accession Number: **8** for 1991

ANEY, RUSS ID: 089485948

File: REFERRAL PATIENT

Move accession to

Select Patient Name: **ANEY, RUSS**

04-27-25

089485948

File: PATIENT

OK TO MOVE? NO// **Y** (YES)

Move Accession Number: **8** for 1991

ANEY, RUSS ID: 089-48-5948

File: PATIENT

Move accession to

Select Patient Name: **ANEY, RUSS**

04-27-25

089485948

File: PATIENT

No need to move accession to the same patient

## AFIP Registries [LRAPAFIP]

This option lists the AFIP registries.

### **Prisoner of War Veterans [LRAPDPT]**

Use this option to list prisoner of war veterans who have anatomic pathology specimens for the time specified.

#### **Example:**

Select AFIP registries Option: **PO** Prisoner of war veterans

Select ANATOMIC PATHOLOGY section: **SP** SURGICAL PATHOLOGY

SURGICAL PATHOLOGY SEARCH FOR PRISONER OF WAR VETERANS

Start with Date TODAY// **1/2/94** (JAN 02, 1994)

Go to Date TODAY// **<RET>** (APR 6, 1994)

Select Print Device: *[Enter Print Device Here]*

APR 6, 1994 08:28 VAMC Pg: 1  
LABORATORY SERVICE SURGICAL PATHOLOGY POW VETERANS  
From: JAN 2, 1994 to APR 6, 1994

Patient	DOB	ID
ADAMS,HOUSTON POW PERIOD WORLD WAR II - EUROPE Specimen date: 02/01/94	JUN 18, 1962	121-22-3333
-----		
DUSTY,ANDY POW PERIOD KOREAN Specimen date: 03/31/94 Specimen date: 03/18/94 Specimen date: 02/24/94	APR 27, 1925	089-48-5948
-----		

**Persian Gulf Veterans [LRAPPG]**

Use this option to list veterans who served in the Persian Gulf with pathology specimens.

**Example:**

Select AFIP registries Option: **PG** Persian gulf veterans

Select ANATOMIC PATHOLOGY section: **SP** SURGICAL PATHOLOGY

Start with Date TODAY// **2/1/94** (FEB 01, 1994)

Go to Date TODAY// **<RET>** APR 6, 1994

Select Print Device: *[Enter Print Device Here]*

APR 6, 1994 08:25 VAMC Pg: 1  
 LABORATORY SERVICE SURGICAL PATHOLOGY PERSIAN GULF WAR  
 From: FEB 1, 1994 to APR 6, 1994

Patient	DOB	ID
DUSTY, ANDY	APR 27, 1925	089-48-5948
PERSIAN GULF WAR		
Specimen date: 03/31/94	Accession number: 17	
Specimen date: 03/18/94	Accession number: 14	
Specimen date: 02/24/94	Accession number: 6	

## Edit Referral Patient File [LRUV]

This option allows you to edit referral patient file fields.

### **Example:**

Select Supervisor, anat path Option: **EDIT REFERRAL** patient file

```
Select REFERRAL PATIENT NAME: DUSTY,ANDY          04-27-58      089485948
NAME: DUSTY,ANDY// <RET>
SEX: MALE// <RET>XXXXXXXX
DOB: 04/27/58// <RET>
MARITAL STATUS: <RET>
RELIGION: <RET>
IDENTIFIER: 089485948// <RET>
REFERRAL SOURCE: <RET>
PROVIDER: <RET>
STREET ADDRESS: <RET>
STREET ADDRESS 2: <RET>
STREET ADDRESS 3: <RET>
CITY: <RET>
STATE: <RET>
ZIP CODE: <RET>
PHONE: <RET>
OFFICE PHONE: <RET>
PHONE #3: <RET>
PHONE #4: <RET>
DATE OF DEATH: <RET>
```



## **Verify/Release Menu, Anat Path [LRAPVR]**

### Descriptions

<b>Option</b>	<b>Description</b>
Verify/Release Reports, Anat Path	Allows displaying and printing of reports after they are verified by the pathologist.
Supplementary Report Release,	Allows displaying and anat path printing of supplementary reports after they are verified by the pathologist.
List of Unverified Pathology Reports	Provides a list of unverified pathology reports and supplementary reports for surgical pathology, cytopathology or electron microscopy, selected by date.

## Verify/Release Reports, Anat Path [LRAPR]

This option allows the reports to be approved for release to medical personnel on the wards with access to a CRT. Reports should **not** be released until the final report has been reviewed and signed by the pathologist. Once the report is released, the information can be viewed by persons outside the laboratory with the necessary access. The information can be extracted either by the Health Summary option or the [LRAPCUM] in the Clinician Menu. Changes which need to be made after the report is released must be accomplished using the modified or the supplemental report options as appropriate to the change.

### **Example 1: Release of Surgical report**

Select Verify/release menu, anat path Option: **RR** Verify/release reports, anat path

RELEASE PATHOLOGY REPORTS

Select ANATOMIC PATHOLOGY section: **SP** SURGICAL PATHOLOGY

Data entry for 1994 ? YES// **<RET>** (YES)

Select Accession Number/Pt name: **7** for 1994  
ARDEN,TOM ID: 241-22-0000

REPORT RELEASE DATE/TIME: **N** (AUG 30, 1994@11:34)

**NOTE:** Once the report is released, the release information is included on the log book as shown below.

Select Print, anat path Option: **PB** Print log book

Select Log-in menu, anat path Option: **PB** Print log book

Select ANATOMIC PATHOLOGY section: **SP** SURGICAL PATHOLOGY

SURGICAL PATHOLOGY LOG BOOK

Print SNOMED codes if entered ? NO// **<RET>** (NO)

Log book year: 1994 OK ? YES// **<RET>** (YES)

Start with Acc #: **7**

Go to Acc #: LAST // **7**

Select Print Device: **[Enter Print Device Here]**

AUG 30, 1994 11:38 VAMC

Pg: 1

SURGICAL PATHOLOGY LOG BOOK for 1994

# =Demographic data in file other than PATIENT file

Date	Num	Patient	ID	LOC	PHYSICIAN	PATHOLOGIST
------	-----	---------	----	-----	-----------	-------------

8/25	7	ARDEN,TOM	0000	1 EAST	WILLIAMS,JOHN DO	ZONC,ELMO
------	---	-----------	------	--------	------------------	-----------

Date specimen taken:08/25/94

Entered by:PEREZ,ELSIE

Released by:NORRIS,MARIA

LEFT LEG

**NOTES:**

- At the "RELEASE REPORT" prompt, enter the Date/time the report is to be released.
- Once released, the name of the person releasing the report can be obtained from the logbook.
- If a report is modified, it will need to be re-released. In this case, the original date/time will be stored in the appropriate Original Release Date field and this new date can be entered. This new date will not affect calculation of the turnaround time except in the case of autopsy reports. In that particular case, the Release Date/Time can be deleted for the Provisional Diagnosis.
- In order to meet the requirements of CAP and JCAHO, no option exists to "unrelease a report" Changes in reports should be done using either the modified or supplemental reports options. In the rare event that an accession is assigned to the wrong patient and the data needs to be corrected, the Move Anatomic Path [LRAPMV] option can be used if appropriate. If not, the global will need to be edited to "unrelease" the report before anything else can be done. Editing will need to be done by someone from the IRM staff with programmer access. Once the LRDFN for the patient is ascertained, fields .03 (Date Report Completed) and .11 (Release Report) need to be deleted for Files #63.08 (SURGICAL PATHOLOGY), #63.09 (CYTOPATHOLOGY), or #63.02 (ELECTRON MICROSCOPY).
- A check exists to ensure that the report has a "date completed" before allowing its release. If there is no date report completed, the user will get "BEEPED" and see the message: "No date report completed, cannot release" after selecting the Accession Number/Pt name.

**Example 2: Release of an Autopsy Report**

Select Anatomic pathology Option: **V** Verify/release menu, anat path

Select Verify/release menu, anat path Option: **RR** Verify/release reports, anat path

## RELEASE PATHOLOGY REPORTS

Select ANATOMIC PATHOLOGY section: **AU** AUTOPSY

Data entry for 1992 ? YES// **<RET>** (YES)

Select Accession Number/Pt name: **5** for 1992  
BOGGESS,HENRY ID: 234-88-9898

AUTOPSY RELEASE DATE/TIME: **N** (DEC 02, 1992@08:11)

Select Accession Number/Pt name: **<RET>**

## Supplementary Report Release, Anat Path [LRAPRS]

Use this option to release supplementary reports for Surgical Pathology, Cytopathology or Electron Microscopy.

Select Verify/release menu, anat path Option: **RS** Supplementary report release, anat path

RELEASE SUPPLEMENTARY PATHOLOGY REPORTS

Select ANATOMIC PATHOLOGY section: **SP** SURGICAL PATHOLOGY

Data entry for 1990 ? YES// **<RET>** (YES)

Select Accession Number/Pt name: **1** for 1990

ANDERS, ANDREW ID: 553-12-1234

Specimen(s):

SKIN

Select SUPPLEMENTARY REPORT DATE:1-7-1990@10:00:00// **<RET>** JAN 7,1990 @10:00

RELEASE SUPPLEMENTARY REPORT ? NO// **Y** (YES)

Select Accession Number/Pt name: **<RET>**

## List of Unverified Pathology Reports [LRAPV]

Use this option to print or display a list of unverified pathology reports for surgical pathology, cytopathology, or electron microscopy for a specified section and time period.

### **Example 1: Surgical Path**

Select Verify/release menu, anat path Option: **LU** List of unverified pathology reports

Select ANATOMIC PATHOLOGY section: **CY** CYTOPATHOLOGY

1) List of unverified SURGICAL PATHOLOGY reports

2) List of unverified SURGICAL PATHOLOGY supplementary reports

Select 1 or 2: **1**

Start with Date TODAY// **<RET>**

Go to Date TODAY// **T-30** (AUG 09, 1990)

Select Print Device: **[Enter Print Device Here]**

SEP 9, 1990 09:29 SIUG Pg: 1  
CYTOPATHOLOGY UNVERIFIED REPORTS  
BY DATE SPECIMEN TAKEN FROM AUG 9, 1990 TO SEP 9, 1990

DATE	Accession number	Patient	SSN
08/22/90	11	ANDRUS, SHIRLEY	529-64-5664
08/16/90	5	BEAR, YOGI	004-95-8671

### **Example 2: Cytopathology**

Select Verify/release menu, anat path Option: **LU** List of unverified pathology reports

Select ANATOMIC PATHOLOGY section: **SP** SURGICAL PATHOLOGY

1) List of unverified SURGICAL PATHOLOGY reports

2) List of unverified SURGICAL PATHOLOGY supplementary reports

Select 1 or 2: **2**

Start with Date TODAY// **<RET>** SEP 24, 1990

Go to Date TODAY// **<RET>** SEP 24, 1990

Select Print Device: **[Enter Print Device Here]**

SEP 24, 1990 11:43 SALT LAKE ISC Pg: 1  
SURGICAL PATHOLOGY UNVERIFIED SUPPLEMENTARY REPORTS  
BY DATE SPECIMEN TAKEN FROM SEP 24, 1990 TO SEP 24, 1990

DATE	Accession number	Patient	SSN
09/24/90	7	ANDERS, ANDREW	553-12-1234

## Clinician Options, Anat Path [LRAPMD]

### Descriptions

<b>Option</b>	<b>Description</b>
Display Surg Path Reports for a Patient	Display on the screen surgical pathology reports for a selected patient if the report has been verified.
Display Cytopath Reports for a Patient	Display on the screen cytopathology reports for a selected patient if the report has been verified.
Display EM Reports for a Patient	Display on the screen EM reports for a selected patient if the report has been verified.
Enter/Edit User Defined Lab Test Lists	Create new test lists or change the name or individual tests on an existing list. These are lists created by a clinician to follow tests for specific patients. If there are no lists already created under a user's name, he may use another user's list.
Print/Display Preselected Lab Tests	Displays or prints user-defined lab tests and patient lists from one date to another. If tests are not defined by the user, the lab-defined list will be displayed.
Print Surgical Pathology Report for a Patient	If report results have been released, you may print the surgical pathology report for a patient.
Print Cytopathology Report for a Patient	If report results have been released, you may print the cytopath report for a patient.

<b>Option</b>	<b>Description</b>
Print Electron Microscopy Report for a Patient	Prints an electron microscopy report for a patient, if results have been released.
Cum Path Data Summaries	Displays or prints the cumulative summary of surgical path, cytopath, EM, or autopsy.
Autopsy Protocol/Supplementary Report	If autopsy report is verified, prints report.





Date Spec taken: AUG 25, 1994                      Pathologist:ELMO LEE ZONC MD  
Date Spec rec'd: AUG 25, 1994 19:41              Resident:  
Date completed: AUG 26, 1994                      Accession #: 7  
Submitted by: JOHN DOE WILLIAMS MD              Practitioner:JOHN DOE WILLIAMS MD

---

Specimen:  
LEFT LEG

CONSULTATION AFIP#12345 Date: AUG 26, 1994  
This is just a consultation.

---

SNOMED/ICD codes:  
T-Y9400: LEG

Date Spec taken: AUG 25, 1994                      Pathologist:JOHN DOE WILLIAMS MD  
Date Spec rec'd: AUG 25, 1994 19:36              Resident:  
REPORT INCOMPLETE                                  Accession #: 6  
Submitted by: ELMO LEE ZONC MD                      Practitioner:ELMO LEE ZONC MD

---

Report not verified



## Edit/Print/Display Preselected Lab Tests [LRUMDA]

This option allows for user defined lab tests and patient lists for display/print from one date to another. If tests not defined by the user the lab defined list will be displayed.

Please refer to the Print Menu for examples of this menu.

Print Surgical Pathology Report for a Patient [LRAPSPSGL]

Print Cytopathology Report for a Patient [LRAPCYSG]

Print Electron Microscopy Report for a Patient [LRAPEMSGL]

If report results have been released (using the option, Verify/Release Pathology Reports [LRAPR]), you may print the surgical pathology report for a patient. For reports that have several pages (End of report) will appear at the bottom of the last page, and (See next page) will appear on all preceding pages. In addition, the words "see signed copy in chart" appear above the pathologist's name in lieu of the signature. The Print Cytopathology Report for a Patient [LRAPCYSG] and Print Electron Microscopy Report for a Patient [LRAPEMSGL] options work essentially the same as this option.

**Example:**

Select Clinician options, anat path Option: **P**

Select Patient Name: **WASHINGTON,GEORGE CHERRY** 02-01-12 012458762  
NSC VETERAN

WASHINGTON,GEORGE CHERRY ID: 012-45-8762 Physician: STUHR,GARY  
AGE: 77 DATE OF BIRTH: FEB 1, 1912  
PATIENT LOCATION: CARDIOLOGY// **<RET>**

Specimen(s)	Count #	Accession #	Date
SKIN	( 1)	9	MAR 28, 1990 not verified
	( 2)	21	NOV 8, 1989
	( 3)	20	NOV 7, 1989 not verified
SKIN	( 4)	12	AUG 1, 1989

TOENAIL

More accessions ? NO// **<RET>** (NO)

Choose Count #(1-4): **2**

Accession #: 21 Date: NOV 8, 1989

Print SNOMED &/or ICD codes on final report(s) ? NO// **y** (YES)

Select Print Device: **[Enter Print Device Here]**

-----  
MEDICAL RECORD | SURGICAL PATHOLOGY Pg 1  
-----

Submitted by: HAROLD FRANKENSTIEN MD Date obtained: NOV 8, 1989  
-----

Specimen (Received NOV 8, 1989 13:31):  
-----

Brief Clinical History:  
-----

Preoperative Diagnosis:  
-----

Operative Findings:  
-----

Postoperative Diagnosis:  
-----

Surgeon/physician: GARY STUHR MD  
=====

PATHOLOGY REPORT

Laboratory: SIUG

Accession No. SP88 21  
-----

Gross description:

Skin ellipse 2x1x.3 cm

Microscopic exam/diagnosis:

Psoriasis

IMMUNOFLUORESCENCE 21-I Date: NOV 13, 1988

SKIN

This is an immunofluorescent study of the skin specimen submitted. There is no evidence of immune deposits in the basement membrane.

ELECTRON MICROSCOPY E-21-88 Date: NOV 13, 1989 06:27

LIVER

This is an electron microscopic study of the liver biopsy. There are may giant mitochondria in all grids examined.

SNOMED code(s):

T-01000: skin

M-48840: psoriasis

P-1148 : biopsy, punch

T-56000: liver

M-49500: cirrhosis

-----  
See signed copy in chart

HARRY WELBY

(End of report)

rg | Date NOV 8, 1989  
-----

WASHINGTON, GEORGE CHERRY

WORK COPY ONLY !!

ID:012-45-8762 SEX:M DOB:2/1/12 AGE:77 LOC:CARDIOLOGY

GARY STUHR MD

## Cum Path Data Summaries [LRAPT]

Cumulative summary of surgical path, cytopath, EM and autopsy for screen display or hard copy.

### **Example 1: Screen Display**

Select Clinician options, anat path Option: **CS** Cum path data summaries

Cum path data summaries

1. DISPLAY cum path data summary for A patient
2. PRINT cum path data summary for patient(s)

Select (1-2): **1**

DISPLAY cum path data summary for a patient

Select Patient Name: **DUSTY,ANDY**                      04-27-25                      089485948                      SC VETERAN

DUSTY,ANDY ID: 089-48-5948 Physician: GINS,RON

AGE: 68 DATE OF BIRTH: APR 27, 1925

PATIENT LOCATION: 1 TEST// **<RET>**

Is this the patient ? YES// **<RET>** (YES)

DUSTY,ANDY                      089-48-5948                      DOB: APR 27, 1925 LOC: 1 TES

---

SURGICAL PATHOLOGY

Organ/tissue:	Date rec'd: 03/31/94	Acc #:	17
Report not verified.			
Organ/tissue:	Date rec'd: 03/18/94	Acc #:	14
Report not verified.			
Organ/tissue:	Date rec'd: 02/24/94	Acc #:	6
Report not verified.			
Organ/tissue:	Date rec'd: 06/25/93	Acc #:	14
Report not verified.			
Organ/tissue:	Date rec'd: 06/21/93	Acc #:	6
Report not verified.			
Organ/tissue:	Date rec'd: 12/03/92	Acc #:	26
Report not verified.			
Organ/tissue:	Date rec'd: 12/02/92	Acc #:	24
LIVER			

CIRRHOSIS

Organ/tissue:	Date rec'd: 09/24/92	Acc #:	8
Report not verified.			
Organ/tissue:	Date rec'd: 08/31/92	Acc #:	23
LIVER			

Organ/tissue:	Date rec'd: 12/26/91	Acc #:	8
Organ/tissue:	Date rec'd: 12/26/91	Acc #:	8
LIVER			
INFLAMMATION			
LYMPH NODE			
INFLAMMATION			
ESOPHAGUS			
FROZEN SECTION			
INFLAMMATION			
STOMACH			
NORMAL TISSUE MORPHOLOGY			
Organ/tissue:	Date rec'd: 04/28/91	Acc #:	2
APPENDIX			
ACUTE INFLAMMATION			
Organ/tissue:	Date rec'd: 04/26/91	Acc #:	1
SKIN			
EXCISION, COMPLETE			
BASAL CELL CARCINOMA			
BONE MARROW			
BIOPSY, NEEDLE			
NORMAL TISSUE MORPHOLOGY			

---

 CYTOPATHOLOGY
 

---

CYTOPATHOLOGY			
Organ/tissue:	Date rec'd: 04/11/94	Acc #:	16
Report not verified.			
Organ/tissue:	Date rec'd: 03/29/94	Acc #:	10
Report not verified.			
Organ/tissue:	Date rec'd: 12/01/92	Acc #:	25
Report not verified.			
Organ/tissue:	Date rec'd: 04/28/92	Acc #:	19
Report not verified.			
Organ/tissue:	Date rec'd: 12/17/91	Acc #:	6
SPUTUM			
UNSATISFACTORY SPECIMEN			
Organ/tissue:	Date rec'd: 04/26/91	Acc #:	1
SPUTUM			
ACUTE INFLAMMATION			
NO EVIDENCE OF MALIGNANCY			

---

 ELECTRON MICROSCOPY
 

---

Organ/tissue:	Date rec'd: 12/17/91	Acc #:	1
Report not verified.			

Select Patient Name: <RET>

## AP Menu Options

### Example 2: Hard Copy

Select Clinician options, anat path Option: **CS** Cum path data summaries

#### Cum path data summaries

1. DISPLAY cum path data summary for A patient
2. PRINT cum path data summary for patient(s)

Select (1-2): **2**

Select Patient Name: **ANDRUS,LEE** 04-27-25 089485948 SC VETERAN

DUSTY,ANDY ID: 089-48-5948 Physician: GINS,RON

AGE: 68 DATE OF BIRTH: APR 27, 1925

PATIENT LOCATION: 1 TEST// **<RET>**

Is this the patient ? YES// **<RET>** (YES)

Another patient: ? NO// **Y** (YES)

Select Patient Name: **ANDRUS,ANN** 05-23-52 101052352P NSC VETERAN

Pat Info: VERY SICK

ANDRUS,ANN ID: 101-05-2352P Physician: HILL,BILLY R.

Infection control warning:

VERY SICK

AGE: 41 DATE OF BIRTH: MAY 23, 1952

Ward on Adm: PSYCH Service: PSYCHIATRY

Adm Date: AUG 23, 1991 07:53 Adm DX: TIRED HOUSEWIFE SYNDROM

Present Ward: PSYCH MD: HILL,BILLY R.

PATIENT LOCATION: PSYCH// **<RET>**

Is this the patient ? YES// **<RET>** (YES)

Another patient: ? NO// **N** (NO)

Select Print Device: *[Enter Print Device Here]*

APR 18, 1994 10:28 St. Elsewhere VAMC

Pg: 1

ANATOMIC PATHOLOGY

-----  
ANDRUS,ANN

SSN:101-05-2352PDOB:MAY 23, 1952

#### SURGICAL PATHOLOGY

Organ/tissue: Date rec'd: 03/07/94 Acc #: 11

Report not verified.

Organ/tissue: Date rec'd: 11/22/93 Acc #: 39

Report not verified.

#### CYTOPATHOLOGY

Organ/tissue: Date rec'd: 02/24/94 Acc #: 2

Report not verified.

Organ/tissue: Date rec'd: 07/17/91 Acc #: 5



SPUTUM  
 CARCINOMA, SQ CELL  
 Organ/tissue: Date rec'd: 04/28/91 Acc #: 4  
 SPUTUM  
 UNSATISFACTORY SPECIMEN  
 BRONCHIAL WASHING CYTOLOGIC MATERIAL  
 CONSULTATION, INTERNAL  
 CARCINOMA, SQ CELL  
 BRONCHIAL BRUSHING CYTOLOGIC MATERIAL  
 CARCINOMA, SQ CELL

ANATOMIC PATHOLOGY

-----  
 DUSTY, ANDY SSN:089-48-5948 DOB:APR 27, 1925

SURGICAL PATHOLOGY  
 Organ/tissue: Date rec'd: 03/31/94 Acc #: 17  
 Report not verified.  
 Organ/tissue: Date rec'd: 03/18/94 Acc #: 14  
 Report not verified.  
 Organ/tissue: Date rec'd: 02/24/94 Acc #: 6  
 Report not verified.  
 Organ/tissue: Date rec'd: 06/25/93 Acc #: 14  
 Report not verified.  
 Organ/tissue: Date rec'd: 06/21/93 Acc #: 6  
 Report not verified.  
 Organ/tissue: Date rec'd: 12/03/92 Acc #: 26  
 Report not verified.  
 Organ/tissue: Date rec'd: 12/02/92 Acc #: 24  
 LIVER  
 CIRRHOSIS  
 Organ/tissue: Date rec'd: 09/24/92 Acc #: 8  
 Report not verified.  
 Organ/tissue: Date rec'd: 08/31/92 Acc #: 23  
 LIVER  
 Organ/tissue: Date rec'd: 12/26/91 Acc #: 8  
 LIVER  
 INFLAMMATION  
 LYMPH NODE  
 INFLAMMATION  
 ESOPHAGUS  
 FROZEN SECTION  
 INFLAMMATION  
 STOMACH  
 NORMAL TISSUE MORPHOLOGY  
 Organ/tissue: Date rec'd: 04/28/91 Acc #: 2  
 APPENDIX  
 ACUTE INFLAMMATION  
 Organ/tissue: Date rec'd: 04/26/91 Acc #: 1  
 SKIN  
 EXCISION, COMPLETE  
 BASAL CELL CARCINOMA  
 BONE MARROW  
 BIOPSY, NEEDLE  
 NORMAL TISSUE MORPHOLOGY

## AP Menu Options

APR 18, 1994 10:28 St. Elsewhere VAMC  
ANATOMIC PATHOLOGY

Pg: 2

-----  
DUSTY,ANDY

SSN:089-48-5948 DOB:APR 27, 1925

### CYTOPATHOLOGY

Organ/tissue: Date rec'd: 04/11/94 Acc #: 16

Report not verified.

Organ/tissue: Date rec'd: 03/29/94 Acc #: 10

Report not verified.

Organ/tissue: Date rec'd: 12/01/92 Acc #: 25

Report not verified.

Organ/tissue: Date rec'd: 04/28/92 Acc #: 19

Report not verified.

Organ/tissue: Date rec'd: 12/17/91 Acc #: 6

SPUTUM

UNSATISFACTORY SPECIMEN

Organ/tissue: Date rec'd: 04/26/91 Acc #: 1

SPUTUM

ACUTE INFLAMMATION

NO EVIDENCE OF MALIGNANCY

APR 18, 1994 10:28 St. Elsewhere VAMC  
ANATOMIC PATHOLOGY

Pg: 3

-----  
DUSTY,ANDY

SSN:089-48-5948 DOB:APR 27, 1925

### ELECTRON MICROSCOPY

Organ/tissue: Date rec'd: 12/17/91 Acc #: 1

Report not verified.

## Autopsy Protocol/Supplementary Report [LRAPAUPT]

If the autopsy report has been verified/released, it will be accessible through this option. The report content will reflect the current content of the report.

For example:

1. If the site enters a provisional gross anatomical diagnosis and releases the report, this will be accessible until the accession is “unreleased.”
2. If the site enters a provisional gross anatomical diagnosis and does not release the report, this will not be accessible until the accession is “released.”

### **Example:**

Select Anatomic pathology Option: **C** Clinician options, anat path

Select Clinician options, anat path Option: **AR** Autopsy protocol or supplementary report

Select Patient Name: **BOGGESS, HENRY** 12-18-25 234889898 NSC  
VETERAN

BOGGESS, HENRY ID: 234-88-9898 Physician: WELBY, MARCUS

DIED DEC 1, 1992

Autopsy performed: DEC 1, 1992 Acc # 5

Select Print Device: *[Enter Print Device Here]*

## AP Menu Options

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CLINICAL RECORD	AUTOPSY PROTOCOL	Pg 1
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---

Date died: DEC 1, 1992	Autopsy date: DEC 1, 1992
Resident:	FULL AUTOPSY Autopsy No. A92 5

---

### Clinical History

1. Left CVA
2. Recurrent UTI
3. Aspiration pneumonia

---

### Anatomic Diagnoses

PROVISIONAL GROSS ANATOMIC PATHOLOGICAL DIAGNOSIS: (Subject to revision)

1. Bilateral pulmonary edema with bilateral pleural effusion (500cc)
  - a. Organizing pneumonia right lung
  - b. Pericardial effusion
  - c. Calcified granuloma, left upper lobe
2.
  - a. Moderate arteriosclerosis of abdominal aorta
  - b. Cardiomegaly with LVH
3. Bilateral granular kidneys (arterionephrosclerosis)
  - a. 3 x 2 cm cyst left kidney
  - b. 0.3 x 0.3 cm hemorrhagic cysts, left kidney
  - c. Hemorrhagic bladder mucosa
4. Choletlithiasis with 25 stones (yellow, 0.5 to 1 cm)
  - a. Congested liver parenchyma
  - b. Diverticulosis, colon

---

Pathologist: MARCUS WELBY MD | Date

---

DALLAS ISC-DEVELOPMENT ACCOUNT				AUTOPSY PROTOCOL
BOGGESS, HENRY	234-88-9898	DOB: DEC 18, 1925	AGE: 66	1A ED BAD

DEC 2, 1992 07:49 DALLAS ISC-DEVELOPMENT ACCOUNT  
 ANATOMIC PATHOLOGY

Pg: 2

-----  
 BOGGESS,HENRY SSN:234-88-9898 DOB:DEC 18, 1925  
 Acc # Date/time Died Age AUTOPSY DATA Date/time of Autopsy  
 5 DEC 1, 1992 66 FULL AUTOPSY DEC 1, 1992  
 Senior:WELBY,MARCUS

-----  
 Pathologist: MARCUS WELBY MD | Date

-----  
 DALLAS ISC-DEVELOPMENT ACCOUNT AUTOPSY PROTOCOL  
 BOGGESS,HENRY 234-88-9898 DOB: DEC 18, 1925 AGE:66 MEDICINE ED BAD

## **Workload, Anat Path [LRAPW]**

### Descriptions

<b>Option</b>	<b>Description</b>
Cytopathology Screening Workload	Records date/time cytopathology slides are screened and captures screening workload.
Display Workload for an Accession	Displays tests and WKLD codes for an accession for a date for an accession area.
EM Scanning and Photo Workload	Option allows recording workload for scanning and photography of EM grids and making of prints.
Surg Path Gross Assistance Workload	Use this option to record workload for gross description and cutting of surgical tissue by a non-physician.

## Cytopathology Screening Workload [LRAPWR]

This option is used to enter the workload for screening by the cytotechnologist. (If this is not done by a cytotech, but is done by the pathologist, no workload should be tallied.)

The date/time entered for screening must be later than the staining date/time. If the staining date/time has not been entered yet, the information for screening cannot be entered.

### **Example:**

Select Workload, anat path Option: **CW** Cytology screening workload

Enter year: 1993// **<RET>**

Select Accession Number: **11** for 1993

Date/time slides examined: NOW//**<RET>** (APR 1,1993 15:09) OK? YES// **<RET>**  
(YES)

WASHINGTON,GEORGE 8888 Acc #: 11 Date: APR 1, 1993

	Slide/Ctrl	Date	Slides Examined
BRONCHIAL WASHING			
Smear Prep			
SMEAR PRE	Stain/Procedure		
	* 1) PAP STAIN, SMEAR PREP	2	APR 1, 1993 15:09
Cell Block			
CELL BLOC	Stain/Procedure		
	* 2) H & E STAIN	1	APR 1, 1993 15:09

Data displayed ok ? NO// **Y** (YES)

Select Accession Number: **<RET>**

### NOTES:

- Screening WKLD codes are captured based on the date/time entered for screening. However, if the data for the staining date/time has not been entered yet, the information for screening cannot be entered. The date/time examined **MUST** be later than the date/time stained.
- In the case of the codes for PAP smears, determination of the appropriate code may not be totally transparent since the selection of the code is based on whether the PAP smear result is negative or positive. Based on the PAP STAIN execute code, which is controlled by the REQUIRED COMMENT, the software will check the SNOMED morphology code. If the right codes have been entered for suspicious or positive (M69760 or M80013) or negative (M09460), the appropriate code will be selected. If the morphology code has not been entered or does not match, a prompt will be displayed to select the correct code.
- If an accession is reentered once the date/time screened has been entered, a prompt will appear to allow entry of a code for rescreening of negative GYN PAP smears for QA purposes. Previously accumulated workload cannot be edited using this option.



## Display Workload for an Accession [LRUWL]

During those times when verification of data capture is necessary, i.e., testing, software implementation or software changes, this can be accomplished by using this option. Keep in mind that this display reflects the last date/time entered for each test as it is based on data in File 68. In order to look at the actual date/time for workload for a given test where part of the work was done at one time and part of the work was done at a later time, it is necessary to look at File #64.1.

### **Example:**

```
Select Workload, anat path Option: DW Display workload for an accession
Select ACCESSION AREA: SP SURGICAL PATHOLOGY
Select SURGICAL PATHOLOGY Date: 1993// 91 1991
Select SURGICAL PATHOLOGY Accession Number for 1991: 11

TEST: XXSURGICAL PATHOLOGY LOG-IN          TECHNOLOGIST: GINS,RON
COMPLETE DATE: DEC 31, 1991@07:21
WKLD CODE: Surgical Path., Init. Handling
TEST MULTIPLY FACTOR: 1                    WKLD CODE COUNTED: YES
WKLD CODE TALLY: 1                         COMPLETION TIME: DEC 31, 1991@07:21
USER: GINS,RON                             INSTITUTION: REGION 5
MAJOR SECTION: SURGICAL PATHOLOGY          LAB SUBSECTION: SURGICAL PATHOLOGY
WORK AREA: SURGICAL PATHOLOGY

WKLD CODE: Transcription: File Search/Retrieve
TEST MULTIPLY FACTOR: 1                    WKLD CODE COUNTED: YES
WKLD CODE TALLY: 1                         COMPLETION TIME: DEC 31, 1991@07:21
USER: GINS,RON                             INSTITUTION: REGION 5
MAJOR SECTION: SURGICAL PATHOLOGY          LAB SUBSECTION: SURGICAL PATHOLOGY
WORK AREA: SURGICAL PATHOLOGY

TEST: EXTENSIVE GROSS SURGICAL             TECHNOLOGIST: GINS,RONALD
COMPLETE DATE: DEC 31, 1991@07:22
WKLD CODE: Tissue Preparation              TEST MULTIPLY FACTOR: 1
WKLD CODE COUNTED: YES                    WKLD CODE TALLY: 1
COMPLETION TIME: DEC 31, 1991@07:22      USER: GINS,RON
INSTITUTION: REGION 5                     MAJOR SECTION: SURGICAL PATHOLOGY
LAB SUBSECTION: SURGICAL PATHOLOGY        WORK AREA: SURGICAL PATHOLOGY
```

## EM Scanning and Photo Workload [LRAPWE]

This option allows recording workload for scanning and photography of EM grids and making of prints.

NOTE: In order to input workload associated with the scanning of the EM grids, the prompt "Ask 'Date/time grids scanned:' prompt for each accession ? NO//" must be answered "YES."

### **Example: Entry of only photography workload**

Select Anatomic pathology Option: **W** Workload, anat path

Select Workload, anat path Option: **EW** EM scanning and photo workload

Ask 'Date/time grids scanned:' prompt for each accession ? NO// **<RET>** (NO)

Enter year: 1992// **<RET>** ( 1992) 1992

Select Accession Number: **8** for 1992

Date/time prints made: NOW// **<RET>** (JAN 13, 1992@10:40) OK ? YES// **<RET>**(YES)

ADAMS,HOUSTON 3333 Acc #: **8** Date: JAN 13, 1992

BLOCK ID	GRIDS PREPARED	GRIDS SCANNED	PRINTS MADE	LAST DATE/TIME SCANNED	LAST DATE/TIME PRINTS MADE
SKIN					
*1) EPON 1	5	0	0		01/13/92 10:40
KIDNEY					
*2) EPON 1	5	0	0		01/13/92 10:40

Data displayed ok ? NO// **<RET>** (NO)

(If more than one block a selection must be made)

Select \*BLOCK ID#: **1**

EPON 1

DATE/TIME prints made: JAN 13, 1992@10:40// **<RET>** (JAN 13, 1992@10:40)

TOTAL NUMBER of prints made:**10**

Select \*BLOCK ID#: **2**

EPON 1

DATE/TIME prints made: JAN 13, 1992@10:40// **<RET>** (JAN 13, 1992@10:40)

TOTAL NUMBER of prints made:14  
 Select \*BLOCK ID#: <RET>  
 ADAMS,HOUSTON 3333 Acc #: 8 Date: JAN 13, 1992

BLOCK ID	GRIDS PREPARED	GRIDS SCANNED	PRINTS MADE	LAST DATE/TIME SCANNED	LAST DATE/TIME PRINTS MADE
SKIN					
*1) EPON 1	5	0	10		01/13/92 10:40
KIDNEY					
*2) EPON 1	5	0	14		01/13/92 10:40

Data displayed ok ? NO// Y (YES)

Select Accession Number: <RET>

NOTE: The workload accumulated for only this portion of the data entry would be as shown in the following extract of information displayed by Display Workload for an Accession [LRUWL] option prior to the time the Nightly Cleanup [LRTASK NIGHTLY] option is run.

Select EM Accession Number for 1992: 8

```

TEST: EM PRINT/ENLARGEMENT          URGENCY OF TEST: WKLD
  TECHNOLOGIST: HOFF,LYNN           COMPLETE DATE: JAN 13, 1992@10:40
WKLD CODE: Photography Print Enlarge TEST MULTIPLY FACTOR: 14
  WKLD CODE COUNTED: NO             WKLD CODE TALLY: 0
  COMPLETION TIME: JAN 13, 1992@10:40 USER: HOFF,LYNN
  INSTITUTION: HINES, IL            MAJOR SECTION: EM
  LAB SUBSECTION: EM                WORK AREA: EM
  
```

Select EM Accession Number for 1992: <RET>

Select EM Date: <RET>

Surg Path Gross Assistance Workload [LRAPWRSP]

If the histology personnel, i.e., non-physicians, assist in the performance of the surgical pathology gross description, this workload can be recorded using this option. This option will allow entry of the date/time of the gross description/cutting and will allow designation of the type of assistance, i.e., routine gross, extensive gross or technical assistance. This will then automatically order the appropriate test and appropriate verify workload codes. Workload data entered through this option is tallied in the usual manner and is accession specific, i.e., it is **not** treated as MANUAL INPUT workload.

**Example:**

```
Select Anatomic pathology Option: W Workload, anat path
Select Workload, anat path Option: SW Surg path gross assistance workload
Enter year: 1991// <RET> ( 1991) 1991

Select Accession Number: 11 for 1991
ADAMS,SAM ID: 432-99-4321

Date/time Gross Description/Cutting: NOW// <RET> (DEC 31, 1991@07:22)
OK ? YES// <RET>
ADAMS,SAM 4321 Acc #: 11 Date: DEC 31, 1991
                                Date Gross Description/Cutting Type
STOMACH                                DEC 31, 1991@07:22

Data displayed ok ? NO// <RET> (NO)
Select SPECIMEN: STOMACH// <RET>
GROSS DESCRIPTION/CUTTING TYPE: ??
  Select 1 or "R" when the gross description and cutting of surgical
  tissue is performed by a nonphysician (e.g., a pathology assistant)
  Select 2 or "E" when extensive gross processing is required by
  technical assistants in addition to the usual dissection and
  description (e.g., orientation of a renal biopsy and splitting it
  for light and electron microscopy, and immunofluorescence)
  Select 3 or "T" when technical or clerical staff assist with
  gross processing.
CHOOSE FROM:
  1          ROUTINE GROSS SURGICAL
  2          EXTENSIVE GROSS SURGICAL
  3          TECHNICAL ASSISTANCE SURGICAL

GROSS DESCRIPTION/CUTTING TYPE: 2 EXTENSIVE GROSS SURGICAL
GROSS DESCRIPTION/CUTTING DATE: DEC 31,1991@07:22 // <RET>

Select SPECIMEN: ADAMS,SAM 4321 Acc #: 11 Date: DEC 31, 1991
                                Date Gross Description/Cutting Type
STOMACH                                DEC 31, 1991@07:22  EXTENSIVE GROSS SURGICAL

Data displayed ok ? NO// Y (YES)
```

# MICROFICHE OF PATH REPORTS



## Microfiche of Path Reports

The storage of Anatomic Pathology reports over a number of years requires a considerable amount of space for the bound volumes, whether they are all retained in the Pathology Service or stored off-site. Other methods of compact storage can greatly economize on use of this space. Such methods as microfilming and microfiche. Newer techniques such as compact laser discs are emerging, and may already be available, but at considerable expense. This section provides instructions for using microfiche within the Anatomic Pathology module of the Laboratory package.

Microfiche and microfilming are technologies well-developed at this time and are relatively inexpensive. Many hospitals are using these techniques in various departments on a daily basis—even for reports which are computerized. The equipment and service costs to microfiche anatomic pathology reports are reasonable and can be accommodated by almost any budget.

A microfiche reader-printer in the Anatomic Pathology department is an absolute necessity for using microfiche. Reader/printers range in cost from about \$550 - \$600 for the low usage installations, and about \$2500 for the higher volume pathology laboratories. A copy machine, which is accessible in most hospitals, is a helpful adjunct.

### To Use at a VAX site

Using the Microfiche Path Reports option from the Anatomic Pathology Menu - VAX SITES

#### Example:

```
Select OPTION: PA (PRINT FINAL PATH REPORTS BY ACCESSION #)
Select ANATOMIC PATHOLOGY SECTION: SP SURGICAL PATHOLOGY
DATE: 1-90 (JAN 1990)
Start with accession #:1
Go to accession #: 900
```

```
DEVICE: MICROFICHE          INPUT/OUTPUT OPERATION: N
```

```
Do you want to queue this report ? No// N (NO)
```

## **To Use at a Non-VAX site**

1. Coordinate the procedure with your IRM office.

The IRM office will have to load the tape drive with tape and place it on line. Do not purge the text in the files until you have the fiche and are satisfied with the result.

Be sure to lock the Print Final Path Reports by Accession # [LRAPFICH] option with a security key to prevent accidental use by inappropriate users.

2. Enter the menu option, Print final path reports by accession #.

Follow the prompts as you would to print any list in the selected Laboratory AP section.

3. At the "Device" prompt, enter: "MICROFICHE/81."

This will now print to the magtape and also tie up your terminal until the job is complete. Thus, it is recommended that it be done during a known low-user time period.

4. When the job is completed, give the tape to a service bureau.

The service bureau will convert it into fiche. The service bureau will need to know the drive settings and how many frames per fiche, etc. The turnaround time is as short as overnight once they have the characteristics for your AP jobs. You may have to do several runs to fine-tune the fiche. We recommend practicing with about ten cases before doing the serious run.



Creating a Microfiche Tape**Example 1: Cytopathology, Electron Microscopy, and Surgical Pathology**

Select Print, anat path Option: ?

```

PQ   Print all reports on queue
DQ   Delete report print queue
LQ   List pathology reports in print queue
PS   Print single report only
AD   Add patient(s) to report print queue
AU   Autopsy administrative reports
AR   Anat path accession reports
CS   Cum path data summaries
LA   Anatomic pathology labels
LT   Edit/print/display preselected lab tests
PB   Print log book
PO   Prisoner of war veterans
PA   Print final path reports by accession #

```

Enter ?? for more options, ??? for brief descriptions, ?OPTION for help text.

Select Print, anat path Option: **PA** PRINT FINAL PATH REPORTS BY ACCESSION #

Select ANATOMIC PATHOLOGY SECTION: **SP** SURGICAL PATHOLOGY  
(or Cytopathology or Electron Microscopy)

DATE: **90** (1990)

Start with accession #: **1362**

Got to accession: **1735**

DEVICE: **MICROFICHE/81**

MICROFICHE MAGTAPE 81

```

This device is not a printer!
ARE YOU SURE you want to use it? NO// Y (YES)

```

Since you have not queued the report it will print immediately on the device selected.

But you will not be able to use your terminal during the printing.

Is this what you want? NO// **Y** (YES)

Select Print, anat path Option: **<RET>**

## Microfiche of Path Reports

### Example 2: Autopsy

Select ANATOMIC PATHOLOGY option: **P** PRINT, ANAT PATH OPTION

Select Print, anat path Option: **AD** ADD PATIENT(S) TO REPORT PRINT QUEUE

Select PATIENT NAME: **YOKUM, SALLY** 08-08-48 234567891 NON-VETERAN  
YOKUM, SALLY ID: 234-56-7891 Physician: STUHR, GARY

DIED JUL 27, 1990

Autopsy performed: JUL 28, 1990 08:00 Acc # 2

Select PATIENT NAME: **<RET>**

Select Print, anat path Option: **PQ** PRINT ALL REPORTS ON QUEUE

Select ANATOMIC PATHOLOGY section: **AU** AUTOPSY

1. Autopsy protocols
2. Autopsy supplementary reports

Select 1 or 2: **1**

#### Autopsy Protocols

(D)ouble or (S)ingle spacing of report(s): **D**

Print weights, measures and coding (if present): ? YES// **<RET>** (YES)

Save protocol list for reprinting ? NO// **<RET>** (NO)

DEVICE: **MICROFICHE/81**

MICROFICHE MAGTAPE 81

This device is not a printer!

ARE YOU SURE you want to use it? NO// **Y** (YES)

Since you have not queued the report it will print immediately on the device selected.

But you will not be able to use your terminal during the printing.

Is this what you want? NO// **Y** (YES)

Select Print, anat path Option,: **<RET>**

## **Enhancements to Reports on Microfiche**

A number of improvements are recommended to enhance reports on microfiche such as the following:

### **Data Pages:**

Double or triple size of data header with key index data on top of each page.  
Bold or italic data field anywhere in data--double size data available under some conditions.

### **Titling:**

Normal and reverse polarity. By title segments or portion of segments.  
Multiple number and variable size of characters by title segments.

### **Eyeball Pages:**

Eye readable data to highlight major changes within data.  
For example: new report, or change in departments. Data breaks can be used with the eyeball pages to advance to the top of the next column for quicker user access to their data.

### **Bypass Options:**

Ability to bypass selected data pages not meaningful to the end user.  
This could include system-generated data, banner pages, alignment pages or selected reports in multiple report file.

### **Data Break Options:**

Ability to break to the next microfiche or the next column whenever a significant change in data occurs. This allows selective grouping of specific reports to various user groups, or a selective breakdown of a large report to specific user areas.

### **Indexing Options:**

Standard page index in lower right corner of the microfiche.  
Column index at the bottom of each column.

The index page is enhanced by suppressing the printing of identical index values, which makes it easier and quicker to read and use.

## **Benefits:**

Information retrieval from microfiche becomes much easier and, as a result, user productivity will dramatically improve. User departments have reported retrieval time improvements of 25% to 50% with these techniques. User acceptance of microfiche will also dramatically improve as information retrieval becomes easier and quicker. Increased user productivity will result in direct dollar savings to VAMCs.

**Microfiche of Path Reports**

# GLOSSARY



## Glossary

Abbreviated Response	This feature allows you to enter data by typing only the first few characters for the desired response. This feature will not work unless the information is already stored in the computer.
Access Code	A code that allows the computer to identify you as a user authorized to gain access to the computer. Your code is greater than six and less than twenty characters long; can be numeric, alphabetic, or a combination of both; and is usually assigned by a site manager or application coordinator. (See the term verify code in the Glossary.)
Accession	A unique alpha-numeric (combination of letters and numbers) assigned to an individual patient specimen when it is received in the laboratory. The accession is assigned by the computer and contains the laboratory departmental designation, the date and an accession number. This accession serves as identification of the specimen as it is processed through the laboratory. (Example: HE 0912 1)
Accession Area	A functional area or department in the laboratory where specific tests are performed. The accession area defines the departmental designation contained in each accession.
Accession Date	The date of the accession, part of the total alpha-numeric accession of each specimen.
Accession Number	A unique number assigned to each accession.
ADP	Automated Data Processing
ADT	Admission, Discharge, Transfer. A component of the MAS software package .
AEMS	Automated Engineering Management Systems. This is the Engineering Service software package.
AFIP	Armed Forces Institute of Pathology; an external review board.

## Glossary

AMIE	Automated Management Information Exchange. A system that allows the Veterans Benefits Administration to use their WANG System to query medical centers via the VADATS network. See WKLD.
AMIS	Automated Management Information System; a method for tabulating Workload.
AMIS/CAP CODES	Numbers assigned to lab procedures by the College of American Pathology for compiling workload statistics.
ANSI	American National Standards Institute. An organization that compiles and publishes computer industry standards.
ANSI MUMPS	The MUMPS programming language, now officially called "M" Technology, is a standard; that is, an American National Standard. MUMPS stands for Massachusetts General Hospital Utility Multi-Programming System.
APP	Applications Portability Profile
Algorithm	A predetermined set of instructions for solving a specific problem in a limited number of steps.
Application	A computer program (e.g., a package) that accomplishes tasks for a user.
Application Coordinator	The designated individual responsible for user-level management and maintenance of an application package (e.g., IFCAP, Laboratory, Pharmacy, Mental Health).
ARG	Application Requirements Group. A designated group of applications experts who work with the developers of a software package to define and approve the contents of the package.
Array	An arrangement of elements in one or more dimensions. A MUMPS array is a set of nodes referenced by subscripts which share the same variable name.



ASCII	American Standard Code for Information Interchange. A series of 128 characters, including uppercase and lowercase alpha characters, numbers, punctuation, special symbols, and control characters.
Attribute Dictionary	See data dictionary.
Audit	An audit is a physical record of access to a file. The VA FileMan and Kernel provide audit tools that may be used to maintain a continuous audit trail of changes that are made to an existing database. Elements that can be tracked include, but are not limited to, fields within files and files themselves. Records are kept of the date/time and user making changes. In addition, the Kernel provides tools for auditing system access, option access, and device usage. Logs store the date/time of access, user identification and name of the option or device used.
Audit Access	A user's authorization to mark or indicate that certain information stored in a computer file should be audited.
Audit Trail	A chronological record of computer activity automatically maintained to trace the use of the computer.
Auto Instruments	Automated instruments used in the Lab that identify and measure tissue or other specimens.
Backup	The process of creating duplicate data files and/or program copies that serve in case the original is lost or damaged.
Baud (Baud rate)	A measure of times per second that switching can occur in a communications channel. Data transmission speed roughly equivalent to 1 bit per second (bps). Commonly used baud rates include 300, 1200, 2400, 3600, 4800, and 9600.
Bidirectional	Automated instruments that send and receive information from DHCP.

## Glossary

Boolean	A term used in computer science for data that is binary (i.e., either true or false).
Boot	To load instructions into main memory to get a computer operational.
Buffer	A temporary holding area for information.
Bug	An error in a program. Bugs may be caused by syntax errors, logic errors, or a combination of both.
Bypass Options	Ability to bypass selected data pages not meaningful to the end user. This could include system-generated data, banner pages, alignment pages or selected reports in multiple report file.
CAP	Numbers assigned to lab procedures by the College of American Pathology for compiling work statistics.
Caret	A symbol expressed as ^ (up caret), < (left caret), or > (right caret). In many MUMPS systems, a right caret is used as a system prompt and an up caret as an exiting tool from an option. The up caret is also known as the up-arrow symbol or “shift-6” key.
Checksum	The result of a mathematical computation involving the individual characters of a routine or file.
Cipher	A system that arbitrarily represents each character by one or more other characters.
Collection List	A listing of routine laboratory tests ordered for inpatients. The list is used by the Phlebotomy team during routine collection of specimens from the wards. The list is sorted by ward location, and includes both patient information (Name, SSN, and bed/room number) and test information, type of specimen to collect, amount needed, date and time tests were ordered, urgency status, order number, and accession number.

Command	A combination of characters that instruct the computer to perform a specific operation.
Computed Field	This field takes data from other fields and performs a predetermined mathematical function (e.g., adding two columns together). You will not, however, see the results of the mathematical calculation in the file. Only when you are printing or displaying information on the screen will you see the results for this type of field.
Computer	A device that processes information. A machine that has input, output, storage, and arithmetic devices plus logic and control units.
Control Key	The Control Key (Ctrl on the keyboard) performs a specific function in conjunction with another key. In some word-processing applications, for example, holding down the Ctrl key and typing an A will cause a new set of margins and tab settings to occur; Ctrl-S causes printing on the terminal screen to stop; Ctrl-Q restarts printing on the terminal screen; Ctrl-U deletes an entire line of data entry when the return key is pressed.
Core	The fundamental clinical application packages of DHCP. The original core of applications built on the Kernel and VA FileMan were Admission, Discharge and Transfer (ADT), Scheduling, Outpatient Pharmacy, and Clinical Laboratory. Additional software packages were added to implement Core+6 and Core+8 configurations.
CPU	Central Processing Unit. Those parts of computer hardware that carry out arithmetic and logic operations, control the sequence of operations performed, and contain the stored program of instructions.

Cross Reference	A cross reference on a file provides direct access to the entries in several ways. For example, the Patient file is cross referenced by name, social security number, and bed number. When asked for a patient, the user may then respond with either the patient's name, social security number, or bed number. Cross reference speeds up access to the file for printing reports. A cross reference is also referred to as an index or cross index.
CRT	Cathode Ray Tube. A piece of computer hardware that looks something like a television screen. The CRT and keyboard collectively are called your terminal. A vacuum tube that guides electrons onto a screen to display characters or graphics. Also called VDT for video display terminal.
Cumulative	A chartable patient report of all data accumulated on a patient over a given time period.
Cursor	A flashing image on your screen (generally a horizontal line or rectangle) that alerts you that the computer is waiting for you to make a response to an instruction (prompt).
Data	In the generic sense, data is information that can be processed and/or produced by computers.
Data Attribute	A characteristic of a unit of data such as length, value, or method of representation. VA FileMan field definitions specify data attributes.
Database	A set of data, consisting of at least one file, that is sufficient for a given purpose. The Kernel database is composed of a number of VA FileMan files. A collection of data can be about a specific subject (e.g., the Patient file). A data collection has different data fields (e.g., patient name, SSN, date of birth).

Database Management System	A collection of software that handles the storage, retrieval and updating of records in a database. A Database Management System (DBMS) controls redundancy of records and provides the security, integrity, and data independence of a database. VA FileMan is the Database Management System for the DHCP software.
Databreak options	Ability to break to the next microfiche or the next column whenever a significant change in data occurs. This allows selective grouping of specific reports to various user groups, or a selective breakdown of a large report to specific user areas.
Data Dictionary	A Data Dictionary (DD) contains the definitions of a file's elements (fields or data attributes); relationships to other files; and structure or design. Users generally review the definitions of a file's elements or data attributes; programmers review the definitions of a file's internal structure.
Data Dictionary Access	A user's authorization to write/update/edit the data definition for access computer file. Also known as DD Access.
Data Dictionary Listing	This is the printable report that shows the data dictionary. DDs are used by users, programmers, and documenters.
Data Processing	Logical and arithmetic operations performed on data. These operations may be performed manually, mechanically, or electronically. Sorting through a card file by hand would be an example of the first method; using a machine to obtain cards from a file would be an example of the second method; and using a computer to access a record in a file would be an example of the third method.
DBA	Within the VA, the Database Administrator oversees package development with respect to DHCP Standards and Conventions (SAC) such as name-spacing, file number ranges, and integration issues.

## Glossary

Debug	To correct logic errors and/or syntax errors in a computer program. To remove errors from a program.
Default	A response the computer considers the most probable answer to the prompt being given. It is identified by double slash marks (//) immediately following it. This allows you the option of accepting the default answer or entering your own answer. To accept the default, you simply press the enter (or return) key. To change the default answer, type in your response.
Delete	The key on your keyboard (may also be called D or backspace on some terminals) which allows you to delete individual characters working backwards by placing the cursor immediately after the last character of the string of characters you wish to delete. The @ sign (the "shift-2" key) may also be used to delete a file entry or data attribute value. The computer will ask "Are you sure you want to delete this entry?" to insure you do not delete an entry by mistake.
Delimiter	A special character used to separate a field, record, or string. VA FileMan uses the " character as the delimiter within strings.
Device	A terminal, printer, modem, or other type of hardware or equipment associated with a computer. A host file of an underlying operating system may be treated like a device in that it may be written to (e.g., for spooling).
Device file	A DHCP file (in VA FileMan) where devices (printers or terminals) are defined.

DHCP	The Decentralized Hospital Computer Program of the Veterans Health Administration (VHA), Department of Veterans Affairs (VA). DHCP software, developed by the VA, is used to support clinical and administrative functions at VA medical centers nationwide. It is written in MUMPS and, via the Kernel, will run on all major MUMPS implementations regardless of vendor. DHCP is composed of packages which conform with name spacing and other DHCP standards and conventions.
Disk	The medium used in a disk drive for storing data.
Disk Drive	A peripheral device that can be used to “read” and “write” on a hard or floppy disk.
Documentation	User documentation is an instruction manual that provides users with sufficient information to operate a system. System documentation describes hardware and operating systems provided by a system vendor. Program documentation describes a program’s organization and the way in which the program operates and is intended as an aid to programmers who will be responsible for revising the original program.
DRG	Diagnostic Related Group
DSCC	The Documentation Standards and Conventions Committee
DSS	Decision Support System
E3R	Electronic Error Enhancement Reporting System
Electronic Signature	A code that is entered by a user which represents his or her legally binding signature.

## Glossary

Encryption	Scrambling data or messages with a cipher or code so that they are unreadable without a secret key. In some cases encryption algorithms are one directional; they only encode and the resulting data cannot be unscrambled (e.g., access/verify codes).
Enter	Pressing the return or enter key tells the computer to execute your instruction or command or to store the information you just entered.
Entry	A VA FileMan record. It is uniquely identified by an internal entry number (the .001 field) in a file.
EP	Expert Panel
Extended Core	Those applications developed after the basic core DHCP packages were installed (e.g., Dietetics, Inpatient Pharmacy). Also referred to as Core+6 or Core+8.
Eyeball pages	Eye readable data to highlight major changes within data; for example: new report, or change in departments. Data breaks can be used with the eyeball pages to advance to the top of the next column for quicker user access to their data.
Field	In a record, a specified area used for the value of a data attribute. The data specifications of each VA FileMan field are documented in the file's data dictionary. A field is similar to blanks on forms. It is preceded by words that tell you what information goes in that particular field. The blank, marked by the cursor on your terminal screen, is where you enter the information.
File	A set of related records treated as a unit. VA FileMan files maintain a count of the number of entries or records.
FileManager	See VA FileMan.



FOIA	The Freedom Of Information Act. Under the provisions of this public law, software developed within the VA is made available to other institutions, or the general public, at a nominal charge that covers the cost of reproduction, materials, and shipping.
Free Text	The use of any combination of numbers, letters, and symbols when entering data.
FTAM	File Transfer, Access, and Management
GKS	Graphic Kernel Standard
Global	In the MUMPS language, a global is a tree-structured data file stored in the common database on the disk.
Global Variable	A variable that is stored on disk (MUMPS usage).
GOSIP	Government Open Systems Interconnection Profile
GUI	Graphic User Interface
Hacker	A computer enthusiast; also, one who seeks to gain unauthorized access to computer systems.
Handshake	A method for controlling the flow of serial communication between two devices, so that one device transmits only when the other device is ready.
Hardware	The physical equipment pieces that make up the computer system (e.g., terminals, disk drives, and central processing units). The physical components of a computer system.
Header	Information at the top of a report.
Help Prompt	The brief help that is available at the field level when entering one or more question marks.

## Glossary

HINQ	Hospital Inquiry. A system that permits medical centers to query the Veterans Benefits Administration systems via the VADATS network.
HIS	Hospital Information Systems
HOST	Hybrid Open Systems Technology
IFCAP	Integrated Funds Distribution, Control Point Activity, Accounting and Procurement
IHS	Indian Health Service
IHS	Integrated Hospital System
Interactive Language	The dialogue that takes place between the computer and the user in the form of words on the screen of the user's CRT.
Initialization	The process of setting variables in a program to their starting value.
Input Transform	An executable string of MUMPS code which is used to check the validity of input and converts it into an internal form for storage.
IRAC	Information Resources Advisory Council
IRM	Information Resource Management
ISC	Information Systems Center
JCAHO	Joint Commission for the Accreditation of Health Care Organizations.
Jump (also called Up-Arrow Jump)	The Up-Arrow Jump allows you to go from a particular field within an input template to another field within that same input template. You may also Jump from one menu option to another menu option without having to respond to all the prompts in between. To jump, type an up-arrow (^) - the "shift-6" key on most keyboards - and then type the name of the field in the template or option on your menu you wish to jump to.

Kernel	<p>A set of DHCP software routines that function as an intermediary between the host operating system and the DHCP application packages such as Laboratory, Pharmacy, IFCAP, etc. The Kernel provides a standard and consistent user and programmer interface between application packages and the underlying MUMPS implementation. Two Kernel components, VA FileMan and MailMan, are self-contained to the extent that they may stand alone as verified packages. Some of the Kernel components are listed below along with their associated namespace assignments.</p> <p style="padding-left: 40px;">VA FileMan DI  MailMan XM  Sign-on Security XU  Menu Management XQ  Tools XT  Device Handling ZIS  Task Management ZTM</p>
Key	A security code that is assigned to individual users that allows access to options.
Lab Sub-section	Refers to the subdivision of lab major sections. If your lab uses this system, your reports will be printed and totaled by lab sub-section as well as lab section.
LAYGO access	A user's authorization to create a new entry when editing a computer file. (Learn As You GO, the ability to create new entries).
Line Editor	This is VA FileMan's special line-oriented text editor. This editor is used for the word-processing data type.
LMIP	Laboratory Management Index Program
Local Variable	A variable that is stored in a local partition.

## Glossary

Load List	Used for organizing the workload in various accession areas of the laboratory. A load list is generated for each automated instrument, and is used to arrange the order in which standards, controls and patient specimens are to be run on the specific instrument.
Log In/On	The process of gaining access to a computer system.
Log Out/Off	The process of exiting from a computer system.
Looping	A set of instructions in a program that are repeatedly executed. When set up correctly, VA FileMan allows you to loop through groups of entries in a file without having to select each entry individually.
LSI	Large Scale Integrating Interface also known as Laboratory System Interface, an instrument for translating data between DHCP and auto instruments.
Magnetic Tape	Plastic or mylar tape on reels or cassettes used for data storage (also called mag tape).
MailMan	An electronic mail system that allows you to send and receive messages from other users via the computer.
Major Section	Refers to the grouping of lab sub-sections into major groups within the lab. A lab may consist of the following major sections: General Clinical (may include hematology, toxicology, serology, chemistry, etc.), Blood Bank, Microbiology, and Anatomic Pathology. If your lab uses this system, your workload report will be reported by major section ("Section Workload Report").
Mandatory Field	This is a field that requires a value. A null response is not valid.
MAS	Medical Administration Service
Menu	A list of options you are authorized access to and may select from.

Menu Tree	A series of menus you sequence through in order to get to the specific option you desire.
Microfiche	A device for microfilming for data storage.
Microscan	An automated instrument used for organism identification and for measuring antibiotics within the Microbiology module.
MIRMO	Medical Information Resources Management Office in the Department of Veterans Affairs Central Office in Washington, DC.
MIS	Management Information Systems
Modem	<p>A device for connecting a terminal to a telephone line, allowing it to communicate with another modem. Modems include the following types.</p> <p>Direct Connect —The modem is directly hooked into the phone line.</p> <p>Acoustic—The modem is connected to the telephone through the handset.</p> <p>Auto Answer—When it detects a ring signal, the modem will “answer the phone.”</p> <p>Auto Dial—The modem, upon command from the terminal or the computer, will dial another modem.</p>
Multiple-valued	More than one data value is allowed as the value of a data attribute for an entry.
MUMPS	Massachusetts General Hospital Utility Multi-Programming System
Name spacing	A convention for naming DHCP package elements. The DBA assigns unique character strings for package developers to use in naming routines, options, and other package elements so that packages may coexist. The DBA also assigns a separate range of file numbers to each package.
NAVAP	National Association of VA Physicians

## Glossary

NCD	National Center for Documentation, located at the Birmingham ISC.
NIST	National Institute of Standards and Technology
NOAVA	Nationwide Office Automation for Veterans Affairs
Node	In a tree structure, a point at which subordinate items of data originate. A MUMPS array element is characterized by a name and a unique subscript. Thus the terms node, array element, and subscripted variable are synonymous. In a global array, each node might have specific fields or "pieces" reserved for data attributes such as name. In data communications, the point at which one or more functional units connect transmission lines.
Numeric field	A response that is limited to a restricted number of digits. It can be dollar valued or a decimal figure of specified precision.
OE/RR	Order Entry and Results Reporting
On-line	A device is on-line when it is connected to the computer.
On-the-fly	A term given to the process of not permanently storing data in the data dictionary but having a computation performed at run time.
Operating System	A basic program that runs on the computer, controls the peripherals, allocates computing time to each user, and communicates with terminals.

Order number	A number generated by the computer each time a test is ordered - unique for each patient's order - starting at midnight JAN 1 with order number 1. The order number provides identification of patient specimens both during transport to the laboratory and until accession numbers have been assigned to the specimens. Generally used by non-laboratory personnel; e.g., ward, section, number.
OS/M	Occurrence Screen/Monitor
Output Transform	An executable string of MUMPS code which converts internally stored data into a readable display.
PACS	Picture Archiving and Communications Systems
Package	The set of programs, files, documentation, help prompts, and installation procedures required for a given software application. For example, Laboratory, Pharmacy, and MAS are packages. A DHCP software environment composed of elements specified via the Kernel's Package file. Elements include files and associated templates, name spaced routines, and name spaced file entries from the Option, Key, Help Frame, Bulletin, and Function files. Packages are transported using VA FileMan's DIFROM routine that creates initialization routines to bundle the files and records for export. Installing a package involves running the installation routines that will recreate the original software environment. Verified packages include documentation. As public domain software, verified packages may be requested through the Freedom of Information Act (FOIA).

## Glossary

Password	A user's secret sequence of keyboard characters, which must be entered at the beginning of each computer session to provide the user's identity.
Pattern Match	A preset formula that includes any one of the following types: 1) letters, numbers, or symbols; 2) letters, numbers, and symbols; 3) letters and numbers; 4) symbols and letters; 5) numbers and symbols. If the information entered (does not match the formula exactly, the computer rejects the user's response).
Peripheral Device	Any hardware device other than the computer itself (central processing unit plus internal memory). Typical examples include card readers, printers, CRT units, and disk drives.
Pointer	Points to another file where the computer stores information needed for the field of the file in which you are currently working. If you change any of the information in the field in which you are working, the new information is automatically entered into the "pointed to" file.
POSIX	Portable Operating System Interface for Computing Environments
Printer	A printing or hard copy terminal.
Program	A list of instructions written in a programming language and used for computer operations.
Programmer Access Code	An optional three-to-eight character code that allows the computer to identify you as a user authorized to enter into programmer mode (see also access code). Once in programmer mode, you will use Standard MUMPS, DHCPs official programming language, to interact with the computer. Programmer access is very tightly restricted to authorized, qualified individuals.



Programmer Access	Privilege to become a programmer on the system and work outside many of the security controls of Kernel.
Prompt	The computer interacts with the user by issuing questions called prompts, to which the user issues a response.
QA	Quality Assurance
RAM	Random Access Memory
Read Access	A user's authorization to read information stored in a computer file.
Reader-printer	A device for displaying and printing microfiche.
Record	A set of related data treated as a unit. An entry in a VA FileMan file constitutes a record. A collection of data items that refers to a specific entity. For example, in a name-address-phone number file, each record would contain a collection of data relating to one person.
Required Field	A mandatory field, one that must not be left blank. The prompt for such a field will be asked until the user enters a valid response.
RMEC	Regional Medical Education Center
ROM	Read Only Memory. A type of memory that can be read but not written.
Routine	A program or a sequence of instructions called by a program, that may have some general or frequent use. MUMPS routines are groups of program lines which are saved, loaded, and called as a single unit via a specific name.
SAC	Standards and Conventions. Through a process of verification, DHCP packages are reviewed with respect to SAC guidelines as set forth by the Standards and Conventions Committee (SACC). Package documentation is similarly reviewed in terms of standards set by the Documentation Standards and Conventions Committee (DSCC).

## Glossary

SACC	Standards and Conventions Committee of the Decentralized Hospital Computer Program.
Screen (Noun)	The display surface of a video terminal.
Screen (Verb)	The process of checking a user's input for a pre-defined format or condition (e.g., date within a permitted range).
Screen Editor	This is VA FileMan's special screen-oriented text editor. This editor is used for the word-processing data type.
Scroll/no scroll	The scroll/no scroll button (also called hold screen) allows the user to "stop" (no scroll) the terminal screen when large amounts of data are displayed too fast to read and to "restart" (scroll).
SERA	Systematic External Review of Autopsies.
SERS	Systematic External Review of Surgical Pathology.
Set of codes	Usually a preset code with one or two characters. The computer may require capital letters as a response (e.g., M for male and F for female). If anything other than the acceptable code is entered, the computer will reject the response.
Site Manager/IRM Chief	At each site, the individual who is responsible for managing computer systems, installing and maintaining new modules, and serving as liaison to the ISCs.
SIUG/ARG	Special Interest User Group/Application Requirements Group. A designated group of applications experts who work with the developers of a software package to define and approve the contents of the package.
SNOMED	Systematized Nomenclature of Medicine, developed to standardize the coding of information regarding specific diseases.

Software	The set of instructions and data required to operate the computer. One type is called operating system software - fundamental computer software that supports other software. The second type is called applications software - customized programs that tell the computer how to run applications (e.g., Pharmacy, Laboratory).
Spacebar Return Feature	You can answer a VA FileMan prompt by pressing the spacebar and then the return key. This indicates to VA FileMan that you would like the last response you were working on at that prompt recalled.
Spooling	Procedure by which programs and output can be temporarily stored until their turn to print.
SQL	Structured Query Language
Stop Code	A number assigned to the various clinical, diagnostic, and therapeutic sections of a facility.
Sub-routine	A sequence of MUMPS code that performs a specific task, usually used more than once.
Subscript	A symbol that is associated with the name of a set to identify a particular subset or element. In MUMPS, a numeric or string value that is enclosed in parentheses; is appended to the name of a local or global variable; identifies a specific node within an array.
Syntax	A term for the rules that govern the construction of a machine language.
Template	A means of storing report formats, data entry formats, and sorted entry sequences is the opposite of "On-the-Fly." A template is a permanent place to store selected fields for use at a later time.

## Glossary

Terminal	See CRT. May be either a printer or CRT/monitor/visual display terminal.
Titling	Methods of displaying titles on microfiche. <ul style="list-style-type: none"><li>- Normal and reverse polarity.</li><li>- By title segments or portion of segments.</li><li>- Multiple number and variable size of characters by title segments.</li></ul>
Treating Area	The section or service of the hospital that requests a test. Some hospital systems have an embedded code that determines if the ordered test is for an inpatient or outpatient.
Tree Structure	A term sometimes used to describe the structure of a MUMPS array. This has the same structure as a family tree, with the root at the top, and ancestor nodes arranged below, according to their depth of subscripting. All nodes with one subscript are at the first level, all nodes with two subscripts at the second level, and so on.
Trigger	A trigger is an instruction that initiates a procedure. In VA FileMan, a trigger can be set up when entry of data in one field automatically updates a second field value.
Truncate	Truncating is a process that drops characters of text or numbers (without rounding) when the text or numbers are limited to a specific location to store or print them. For example, the number 5.768 is truncated to 5.76 when stored or printed in a location that holds only four characters.
Uneditable Field	This is a status given to fields to prevent any editing of data in the field.
Up Arrow	A character on your keyboard that looks like this: “^” character is used mainly for exiting or opting out of answering VA FileMan prompts and jumping to other fields in VA FileMan. The “^” character is the “shift-6” key on most keyboards.

User Access	Access to a computer system. The user's access level determines the degree of computer use and the types of computer programs available. The systems manager assigns the user an access level. (See also access code and programmer access code.)
Utility Routine	A routine that performs a task that many programmers utilize.
VA	The Department of Veterans Affairs, formerly called the Veterans Administration.
VACO	Department of Veterans Affairs Central Office
VADATS	Veterans Administration Data Transmission System (replaced by IDCU about two to three years ago).
VA FileMan (also called VA FileManager)	A set of programs used to enter, maintain, access, and manipulate a database management system consisting of files. A package of on-line computer routines written in the MUMPS language which can be used as a stand-alone database system or as a set of application utilities. In either form such routines can be used to define, enter, edit, and retrieve information from a set of computer-stored files.
VA MailMan	A computer-based message system
VAMC	Department of Veterans Affairs Medical Center
Variable	A character or group of characters that refer to a value. MUMPS recognizes three types of variables: local variables, global variables, and special variables. Local variables exist in a partition of main memory and disappear at sign off. A global variable is stored on disk, potentially available to any user. Global variables usually exist as parts of global arrays. The term "global" may refer either to a global variable or a global array. A special variable is defined by system operation (e.g., \$TEST).

VAX	Virtual Address Extension
VDT	Video Display Terminal (See CRT)
Verification (data verification)	The process by which technologists review data in the computer for a specific patient and verify (validate) that it is accurate before releasing the data to the physician.
Verification (package verification)	A process of internal and external package review carried out by a DHCP verification team (people who were not involved in the development of the package. Software and associated documentation are reviewed in terms of DHCP Standards and Conventions.
Verify Code	An additional security precaution used in conjunction with the access code. Like the access code, it is also 6 to 20 characters in length and if entered incorrectly will not allow the user to access the computer. To protect the user, both codes are invisible on the terminal screen. The code must be a combination of alphabetic and numeric characters.
VHA	Veterans Health Administration
VITEK	An automated instrument is used for organism identification and for measuring antibiotics within the Microbiology module.
WKLD	Abbreviation for workload. The Department of Veterans Affairs off shoot of CAP workload reporting. Also used for LMIP applications. See LMIP.
WKLD Code	Numbers assigned to lab procedures by the Laboratory program for compiling work statistics.

Work List	Used for collecting and organizing work in various accession areas of the laboratory. A work list is generated for manual or automated tests (singly or in batches) and can be defined by number of tests and/or which tests to include. It can also be used as a manual worksheet by writing test results directly on the worklist.
Wrap-around mode	Text that is fit into available column positions and automatically wraps to the next line, sometimes by splitting at word boundaries (spaces).
Write Access	A user's authorization to write/update/edit information stored in a computer file.





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