LABORATORY
ANATOMIC PATHOLOGY
USER MANUAL

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Preface

NOTE: The Veterans Health Information Systems and Architecture (**V***IST***A**) Laboratory Anatomic Pathology User's Manual released in October, 1994 has been edited to include an Appendix B section. The appendix contains file, fields, options changes, and examples created by the release of patch LR*5.2*248.

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 software application. It should be used in conjunction with other documentation of the Laboratory software application. 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 sections 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 <Enter> on some keyboards this is the key with the symbol ↵

Entering information	After you respond to a prompt, you must press <Enter>.
Accepting a default	If you want to accept the default value (the most likely response or a previously defined response, followed by //), just press <Enter>.
Skipping a prompt	If you do not want to enter any information in response to a prompt, you may press <Enter>, 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 the up arrow **(^)** to escape from the prompt but you will lose all information previously entered.

Delete	Deletes previous characters one at a time.
Control Key: (CTRL)	The CONTROL key, like the shift key, is held down while pressing another key.
CTRL/S	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.
CTRL/Q	causes printing or scrolling to resume after CTRL/S has been used.
CTRL/U	deletes current input line if <Enter> has not been pressed.
^ (up-arrow uppercase 6)	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.

Enter	the enter key on a computer keyboard 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.
Halt	entered at any point in an option will terminate your session immediately.
Continue	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.
Press	indicates one keystroke. **Example:** Press RETURN or <Enter> means press the RETURN key.
Press "^" to halt	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

- The Veterans Health Information Systems and Architecture (**V***IST***A**) Laboratory Anatomic Pathology User's Manual released in October, 1994 has been revised to included modifications created by Patch LR*5.2*248. Modifications and examples are listed in the Table of Contents section of this manual as "Modified Options". Side Bars used through out the manual to indicate when modifications were made to the options.

- 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// <Enter> Autopsy supplementary report
Select Accession Number/Pt name: 2 for 1990
LABPPATIENT, ONE  ID: 000-00-0001
Select SUPPLEMENTARY REPORT DATE: T SEP 12, 1990
   DESCRIPTION:
   1>Examination of brain shows no evidence of metastatic carcinoma.
   2><Enter>
EDIT Option: <Enter>
```

- 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: LABPROVIDER, ONE             : 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: The note box indicates that a special action may be recommended or required.

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 **V*IST*A** system or the Laboratory software applications.

PACKAGE OPERATIONS

Package Operations

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

Anatomic Pathology Menu

The Anatomic Pathology main 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.

Menu Item	Description
Data Entry	Used to enter descriptive or diagnostic data for Autopsy Pathology, Cytopathology, Electron Microscopy, or Surgical Pathology.
Edit/Modify Data	Used to edit entries in log-in data, descriptions or diagnoses in Autopsy, Cytopathology, EM, or Surgical Pathology.
Inquiries	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.
Log-in	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.
Print	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.

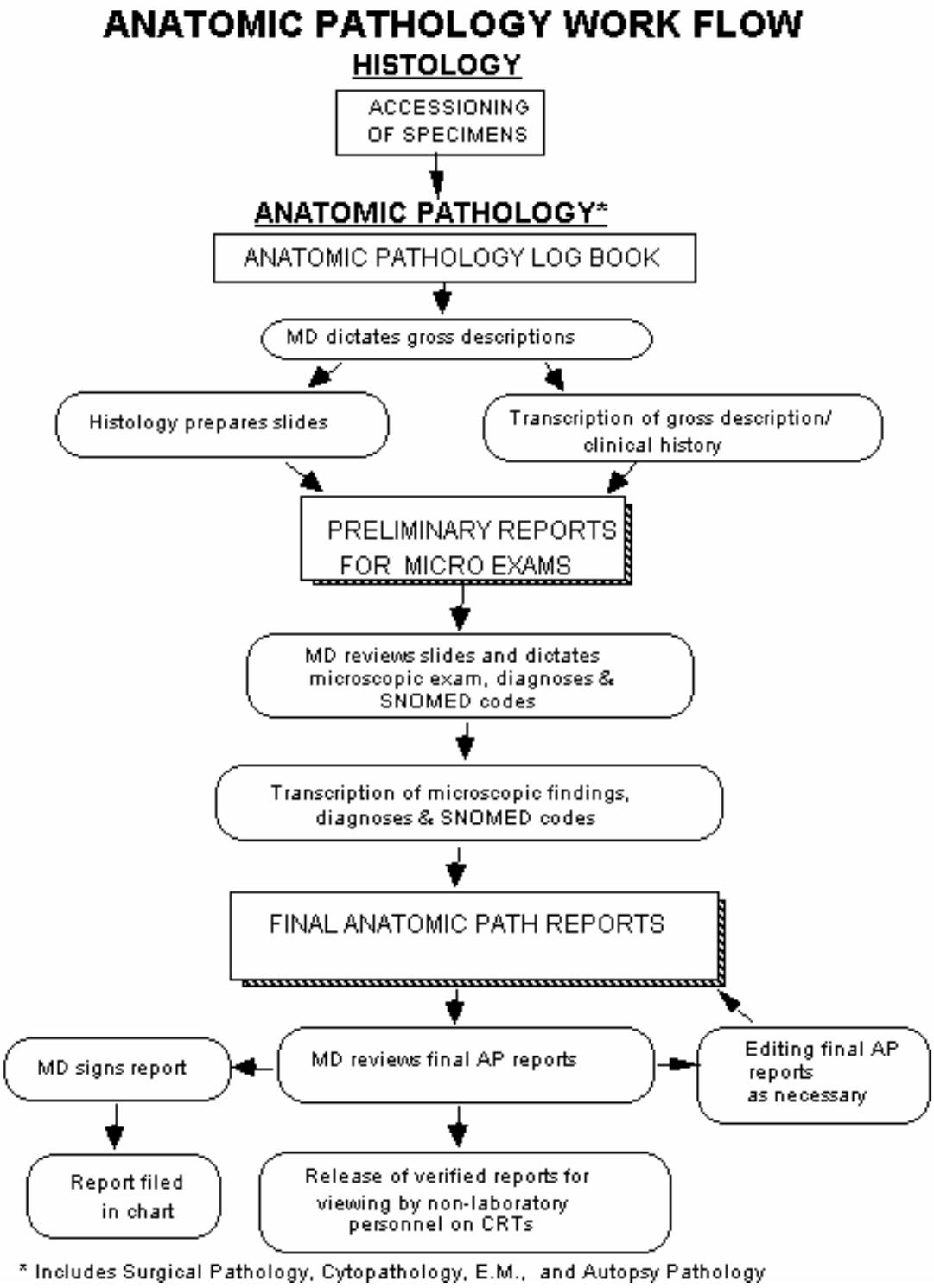
Menu Item	Description
SNOMED Field	Allows entering and editing of SNOMED references, file references, entering and editing of medical journal entries, and printing of medical journal references for a SNOMED file entry.
Supervisor	Includes options for printing topography counts, turnaround times, and 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.
Verify/Release Reports	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.
Clinician	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.
Workload	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 [LRAPAUFAD]
             SR   Autopsy supplementary report [LRAPAUSR]
             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 [LRAPAURV]
            AA   Alphabetical autopsy list [LRAPAUA]
            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
                    [LRAPAUL]
            CP   % Pos, Atyp, Dysp, Neg, Susp, Unsat cytopath [LRAPCYPCT]
            ST   Accession list with stains [LRAPSA]
            WS   Accession counts by senior pathologist [LRAPAULC]
      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]

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
ACCESSIONING OF SPECIMENS
ANATOMIC PATHOLOGY*
ANATOMIC PATHOLOGY LOG BOOK
MD dictates gross descriptions
Histology prepares slides
Transcription of gross description/ clinical history
PRELIMINARY REPORTS FOR MICRO EXAMS
MD reviews slides and dictates microscopic exam, diagnoses & SNOMED codes
Transcription of microscopic findings, diagnoses & SNOMED codes
FINAL ANATOMIC PATH REPORTS
MD signs report
MD reviews final AP reports
Editing final AP reports as necessary
Report filed in chart
Release of verified reports for viewing by non-laboratory personnel on CRTs
* Includes Surgical Pathology, Cytopathology, E.M., and Autopsy Pathology

Workflow

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: 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 sub options, 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 Micro glossary 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:

Special Studies	Supplementary Report
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:

TC Codes	QA Codes
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	QA Outcome Review cases

used to retrieve reports 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 is many code numbers in the codebooks 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 "Aden carcinoma, 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 that is close but with an identifying letter to indicate it is locally created. Another method is to start with your site station number, followed by three or four digits (including zeros), and write down the number and name in a logbook. 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 **2**0000 series is for the Respiratory system, **28**000 is for lung, **282**00 is for right upper lobe of lung and **2822**0 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// <Enter>
```

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 that 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 that 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:

Example:

```
------------------------------------------------------------------------
CLINICAL RECORD /AUTOPSY PROTOCOL                                  Pg 1
------------------------------------------------------------------------
Date died: NOV 4, 1986 12:30  / Autopsy date: NOV 4, 1986
Resident: LABPROVIDER6, EIGHT       / 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 [LRAPAUFAD] and Autopsy Data Review [LRAPAURV] expand the module's ability to provide data for various Quality Assurance monitors. When the autopsy has been completed, the [LRAPAUFAD] 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 that either clarified or contradicted the clinical diagnosis, the [LRAPAURV] 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 [LRAPAUFAD].

   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.

ANATOMIC PATHOLOGY MENU OPTIONS

Anatomic Pathology 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.

NOTE: The **V***IST***A** Laboratory Anatomic Pathology User's Manual released in October, 1994 has been edited to include Appendix B section. The appendix contains file, fields, options changes, and examples created by the release of patch LR*5.2*248.

Data Entry, Anat Path [LRAPD]

Descriptions

Option	Description
Data entry for Autopsies [LRAPAUDA]	
Provisional Anatomic Diagnoses [LRAPAUPAD]	Allows entering the preliminary autopsy diagnoses.
Autopsy Protocol [LRAPAUDAP]	Allows entry of clinical diagnoses (including operations) and pathological diagnoses for later printing of AUTOPSY PROTOCOL (SF 503).
Autopsy Protocol & SNOMED Coding [LRAPAUDAB]	Allows entry and editing of autopsy summary and SNOMED codes.
Autopsy Protocol & ICD9CM Coding [LRAPAUDAA]	Allows entry and edit of autopsy summary and ICD9CM codes.
Final Autopsy Diagnoses Date [LRAPAUFAD]	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 [LRAPAUSR]	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.

Option	Description
Blocks, Stains, Procedures, anat Path [LRAPSPDAT]	Allows entry of blocks, stains Surg Path and procedures used in surgical pathology.
Coding	
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 that 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// <Enter>  (YES)

Select Accession Number/Pt name: 4  for  1992
LABPATIENT, TWO ID: 000-00-0002

CLINICAL DIAGNOSES:
  1>1. Left CVA
  2>2. Recurrent UTI.
  3>3. Aspiration pneumonia.
  4>
EDIT Option: <Enter>
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 (areteriolonephrosclerosis)
 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: <Enter>
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// <Enter> (YES)

Select Accession Number/Pt name: 2 for 1990
LABPATIENT, ONE  ID: 000-00-0001

DATE AUTOPSY REPORT COMPLETED: 7 29 (JUL 29, 1990)
Select AUTOPSY COMMENTS: Carcinoma of right lung//<Enter>
CLINICAL DIAGNOSES:
      1>Carcinoma of right lung
      2><Enter>
EDIT Option: <Enter>
PATHOLOGICAL DIAGNOSES:
      1> I. Respiratory System
      2>   A. Adenocarcinoma, Right Upper Lobe
      3>   B. Atelectasis, Both lower lobes etc.
      4>   <Enter>
EDIT Option: <Enter>

Select Accession Number/Pt name: <Enter>
```

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// <Enter>

Data entry for 1989 ? YES// <Enter> (YES)
Select Accession Number/Pt name: 75 for 1989
LABPATIENT, THREE  ID: 000-OO-OOO3

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> <Enter>
EDIT Option: <Enter>

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 ABSCESSES
      6>                       AND EVIDENCE OF ASPIRATION, ALL RIGHT-SIDED
      7>                       LOBES AND LOWER LEFT LOBE.
      8>                   2. PULMONARY EMPHYSEMA
      9>                   3. CHRONIC BRONCHITIS
      10> <Enter>
EDIT Option: <Enter>

Select AUTOPSY ORGAN/TISSUE: HEART   32000
  . . . AUTOPSY ORGAN/TISSUE NUMBER: 1// <Enter>
      Select MORPHOLOGY: 54750  INFARCT,HEALED
      Select MORPHOLOGY: 52110 ARTHEROSCLEROSIS
      Select MORPHOLOGY: <Enter>
Select AUTOPSY ORGAN/TISSUE: 42000   AORTA  42000
AUTOPSY ORGAN/TISSUE NUMBER: 2// <Enter>
      Select MORPHOLOGY: 52110 ARTHEROSCLEROSIS
      Select MORPHOLOGY: <Enter>
Select AUTOPSY ORGAN/TISSUE: <Enter>
Select Accession Number/Pt name: <Enter>
```

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

NOTES:

- 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 verified/released, it **must** be unreleased prior to entry of the 'Final Anatomical Diagnosis' information. This is acceptable for the Autopsy accession area since there is NO chance for adverse patient outcome.

- Prior to the release of patch LR*5.2*248, this was accomplished using the "@" key at the `AUTOPSY RELEASE DATE/TIME//` prompt in the Verify/release reports, anat path [LRAPR] option.

- With the release of patch LR*5.2*248, the Verify/release reports, anat path [LRAPR] option has been **modified**. Unreleasing the report is now accomplished by answering 'YES' to the `Unrelease report?//` **`YES`** prompt.

```
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// <Enter>  (NO)

Data entry for  1992 ? YES// <Enter>  (YES)

Select Accession Number/Pt name: 5  for  1992
LABPATIENT, FOUR  ID: 000-00-0004
```

```
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><Enter>
1 line inserted...
EDIT Option: <Enter>
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// <Enter> to: 19// <Enter>

  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 <Enter>  Replace <Enter>
   PATHOLOGICAL DIAGNOSIS:
Edit line: 5
  5>    b.  Pericardial effusion
  Replace b.... With b.  Organizing pneumonia, right lung, with acute
bronchitis  Replace <Enter>
       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 <Enter>
       c.  Calcified granuloma, left upper lobe (gross)
Edit line: insert after line: 6
  7>    d.  Emphysema (bilateral) and focal atelectasis (left)
  8> <Enter>
1 line inserted.................
EDIT Option: list line: 1// <Enter> to: 20// <Enter>
  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 <Enter>  Replace <Enter>
       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 <Enter>
       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><Enter>
 25>CLINICO-PATHOLOGICAL CORRELATION
 26><Enter>
 27>Patient was an 81 year old Hispanic man ......
 28><Enter>
```

```
4 lines inserted......
EDIT Option: <Enter>
Select AUTOPSY ORGAN/TISSUE: 28000  LUNG        28000
   AUTOPSY ORGAN/TISSUE NUMBER: 1// <Enter>
  Select MORPHOLOGY: 36660  EDEMA, LYMPHATIC        36660
  Select MORPHOLOGY: 32800  EMPHYSEMA        32800
  Select MORPHOLOGY: 49000  FIBROSIS        49000
  Select MORPHOLOGY: <Enter>

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

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// <Enter> (YES)
Select Accession Number/Pt name: 2 for 1990
LABPATIENT, ONE  ID: 000-00-0001

Autopsy performed: July 28, 1990 Acc# 2
DATE AUTOPSY REPORT COMPLETED: 7 29 (JUL 29, 1990)
CLINICAL DIAGNOSES:
      1>Carcinoma of right lung
      2><Enter>
EDIT Option: <Enter>
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 ABSCESSES AND
      6>                        EVIDENCE OF ASPIRATION, ALL RIGHT-SIDED
      7>                        LOBES AND LOWER LEFT LOBE.
      8>                    2. PULMONARY EMPHYSEMA
      9>                    3. CHRONIC BRONCHITIS
      10><Enter>
EDIT Option: <Enter>

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

Select AUTOPSY ICD9CM CODE: 433.1   CAROTID ARTERY OCCLUSION
  . . . OK? YES// <Enter>
Select AUTOPSY ICD9CM CODE: 513.0   ABSCESS OF LUNG
  . . . OK? YES// <Enter>
Select AUTOPSY ICD9CM CODE: <Enter>
Select Accession Number/Pt name: <Enter>
```

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// <Enter> (YES)

Select Accession Number/Pt name: 2 for 1990
LABPATIENT, ONE: 000-00-0001

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: <Enter>
```

Autopsy Supplementary Report [LRAPAUSR]

NOTE: The Autopsy Supplementary Report [LRAPAUSR] option has been **modified** by the release of patch LR*5.2*248. This option now stores the 'Autopsy Supplementary' report audit information for any supplementary report that was modified (i.e., date/time the report text was modified, person name modifying the report text, and the original report text before it was modified) after the report had been released.

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// <Enter> Autopsy supplementary report

Select Accession Number/Pt name: 2 for 1990
LABPATIENT, ONE: 000-00-0001

Select SUPPLEMENTARY REPORT DATE: T SEP 12, 1990
      DESCRIPTION:
      1>Examination of brain shows no evidence of metastatic carcinoma.
      2><Enter>
EDIT Option: <Enter>

Select Accession Number/Pt name: <Enter>
```

NOTES:

The following 'Autopsy Supplementary' report may 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 specifying the desired report type.

The shaded areas shown on the following example indicate modifications made to the report.

Example: 'Autopsy Supplementary' report

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

SUPPLEMENTARY REPORT DATE: AUG 10, 1990 10:43
                            *** MODIFIED REPORT***
(Last modified: APR 26, 1990 12:00        typed by LABUSER, SEVEN
    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: LABPROVIDER, TWO                          jg| Date SEP 12, 1990

R5ISC                                          AUTOPSY SUPPLEMENTARY REPORT
LABPATIENT, FIVE        000-00-0005       SEX:M       DOB: FEB 1, 1901
MEDICINE          LABPROVIDER, ONE                   AGE AT DEATH: 51
```

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.

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// <Enter> (YES)

Select Accession Number/Pt name: LABPATIENT, SIX.  04-27-25   000000006   SC
VETERAN
LABPATIENT, SIX. ID: OOO-OO-OOO6 Physician: LABPROVIDER, THREE

             DIED JUN 1, 1990
Autopsy performed: JUN 2, 1990 Acc # 5

Select AUTOPSY ORGAN/TISSUE: LUNG//<Enter>
 AUTOPSY ORGAN/TISSUE: LUNG//<Enter>
 Select SPECIAL STUDIES: EM//<Enter>
  DATE: AUG 2,1990//<Enter>
  ID #: // 15
  DESCRIPTION:<Enter>
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//<Enter>
  DATE: AUG 11,1986//<Enter>
  ID #: P789-86//<Enter>
  DESCRIPTION: <Enter>
 1>Photographs of lung gram stains
 EDIT Option: <Enter>
 Select SPECIAL STUDIES:<Enter>
Select AUTOPSY ORGAN/TISSUE:<Enter>

Select Accession Number/Pt name: <Enter>
```

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) : <Enter>

Enter year: 1990//
```

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

LABPATIENT, SEVEN: 000-00-0007

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

LABPATIENT, SEVEN  0007 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// <Enter>  (NO)
Select SPECIMEN: PROSTATE CHIPS// <Enter>
Select SPECIMEN: PROSTATE CHIPS// <Enter>
  Select PARAFFIN BLOCK ID: A//<Enter>
    PARAFFIN BLOCK ID: A// <Enter>
    DATE/TIME BLOCK PREPARED: AUG 26,1994@13:21// <Enter>
    Select STAIN/PROCEDURE: H & E STAIN// <Enter>
      STAIN/PROCEDURE: H & E STAIN// B
      SLIDES PREPARED (#): 1// <Enter>
      CONTROL SLIDES (#): <Enter>
      DATE/TIME SLIDES STAINED: AUG 26,1994@13:21
         // <Enter>
    Select STAIN/PROCEDURE: <Enter>
  Select PARAFFIN BLOCK ID: <Enter>
Select SPECIMEN: <Enter>
```

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): <Enter>

Enter year: 1994// <Enter>  ( 1994)  1994
 Select Accession Number: 24  for 1994
 LABPATIENT, EIGHT  ID: 000-00-0008

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

LABPATIENT, EIGHT  0008 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// <Enter>  (NO)

Select SPECIMEN: LYMPH NODE// <Enter>
  Select FROZEN TISSUE ID: FS1
    DATE/TIME FROZEN PREPARED: AUG 26,1994@08:01// <Enter>  (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: <Enter>
       1        RUSH
       0        NOT RUSH

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

  Select FROZEN TISSUE ID: FS2
    DATE/TIME FROZEN PREPARED: AUG 26,1994@08:01// <Enter>(AUG 26,
1994@08:01)
    FROZEN TISSUE BLOCK TYPE: RUSH
    Select STAIN/PROCEDURE: FROZEN SECTION H & E// <Enter>
      SLIDES PREPARED (#): 1// <Enter>
      CONTROL SLIDES (#): <Enter>
      DATE/TIME SLIDES STAINED: AUG 26,1994@08:01// <Enter>(AUG 26
1994@08:01)

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

LABPATIENT, EIGHT  0008 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): <Enter>

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

Select Accession Number: 5  for 1994
LABPATIENT, NINE  ID: 000-00-0009

Date/time  slides stained: NOW// <Enter> (AUG 26, 1994@14:13) OK ?
YES//<Enter>(YES)
LABPATIENT, NINE 0009 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// <Enter>  (NO)
Select SPECIMEN: BRONCHIAL WASHING CYTOLOGY// <Enter>
  Select SMEAR PREP: SMEAR PRE// <Enter>
    SMEAR PREP: SMEAR PRE// <Enter>
    Select STAIN/PROCEDURE: PAP STAIN, SMEAR PREP
         // <Enter>
      STAIN/PROCEDURE: PAP STAIN, SMEAR PREP// <Enter>
      SLIDES PREPARED (#): 2// 4
      CONTROL SLIDES (#): <Enter>
      DATE/TIME SLIDES STAINED: AUG 26,1994@14:13
         // <Enter>
    Select STAIN/PROCEDURE: <Enter>
  Select SMEAR PREP: <Enter>
  Select CELL BLOCK: CELL BLOC// <Enter>
    CELL BLOCK: CELL BLOC// <Enter>
    Select CELL BLOCK STAIN: H & E STAIN// <Enter>
      CELL BLOCK STAIN: H & E STAIN// <Enter>
      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: <Enter>
  Select CELL BLOCK: <Enter>
Select SPECIMEN: <Enter>

LABPATIENT, NINE 0009 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 94-5 SMEAR PRE H & E VAMC578	CY 94-5 SMEAR PRE H & E VAMC578	CY 94-5 SMEAR PRE H & E VAMC578	CY 94-5 SMEAR PRE H & E VAMC578	CY 94-5 CELL BLOC H & E VAMC578	CY 94-5 CELL BLOC H & E VAMC578
CY 94-5 CELL BLOC H & E VAMC578	CY VAMC578	CY VAMC578	CY VAMC578	CY VAMC578	CY 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// <Enter>  ( 1992)  1992

 Select Accession Number: 7  for 1992
 LABPATIENT, TEN ID: 000-00-0010

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


 LABPATIENT, TEN 0010 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// <Enter>  ( 1992)  1992

 Select Accession Number: 3  for 1992
 LABPATIENT1, ONE  ID: 000-00-0011

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

 Select Accession Number: 3  for 1992
 LABPATIENT1, ONE  ID: 000-00-0011

 Date/time blocks prepared: NOW//T@1451   (JAN 08, 1992@14:51) OK ?
YES//<Enter>
 Date/time  slides/grids prepared: NOW// <Enter> (JAN 08, 1992@14:51)
       OK ? YES// N (NO)
 Date/time  slides/grids prepared: NOW//T@1450  (JAN 08, 1992@14:50)
       OK ? YES// <Enter> (YES)
 Date/time must not be before date/time blocks prepared
                                        (JAN 08, 1992@14:51).
 Select Accession Number: 3  for 1992
 LABPATIENT1, ONE  ID: 000-00-0011

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

LABPATIENT1, ONE  ID:0011  Acc #: 3 Date: JAN  8, 1992
                                     Count   Last stain/block date
 KIDNEY
 Epon Block
   EPON 1           Stain/Procedure             JAN  8, 1992  14:50
               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: <Enter>

Select Data entry, anat path Option: <Enter>
```

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// <Enter>  ( 1992)  1992

 Select Accession Number: 8  for 1992

LABPATIENT1, TWO  ID: 000-00-0012

 Date/time blocks prepared: NOW// <Enter> (JAN 13, 1992@10:39) OK ? YES//
<Enter> (YES)
 Date/time sections prepared: NOW// <Enter> (JAN 13, 1992@10:39) OK ?
YES//<Enter>(YES)
 LABPATIENT1, TWO  0012 Acc #: 8 Date: JAN 13, 1992

                                              Count     Last section/block
date
 SKIN
 Epon Block
   EPON 1            Stain/Procedure

                                                        JAN 13, 1992  10:39
               GRID EM                          5       JAN 13, 1992  10:39
               THICK SECTION EM                 2       JAN 13, 1992  10:39
 KIDNEY
 Epon Block
   EPON 1            Stain/Procedure                    JAN 13, 1992  10:39
               GRID EM                          5       JAN 13, 1992  10:39
               THICK SECTION EM                 2       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// <Enter> (NO)
Data entry for 1990 ? YES// <Enter> (YES)

Select Accession Number/Pt name: LABPATIENT, ONE  05-08-16  000000001
LABPATIENT, SEVEN ID: 3000-00-0007
AGE: 72 DATE OF BIRTH: MAY 8, 1916
PATIENT LOCATION: 1A// <Enter>


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// <Enter> (NO)
            Choose Count #(1-4): 3
 Accession #: 22  Date: JUN 4, 1990

DATE REPORT COMPLETED: JUN 4,1986// <Enter>
Select ORGAN/TISSUE: SKIN
      ORGAN/TISSUE: SKIN// <Enter>
      Select MORPHOLOGY: PSORIASIS
            MORPHOLOGY: PSORIASIS// <Enter>
      Select MORPHOLOGY: <Enter>
Select ORGAN/TISSUE: <Enter>

Select Accession Number/Pt name: <Enter>

Select Coding, anat path Option: <Enter>
```

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// <Enter> (YES)

Select Accession Number/Pt name: 22  LABPATIENT, SEVEN 05-08-16  000000007

Specimen(s):
BRONCH BRUSHINGS

DATE REPORT COMPLETED: JUN 4,1990// <Enter>

Select ICD9CM DIAGNOSIS: 491.2  OBSTRUCT CHR BRONCHITIS
      . . .OK? YES// NO

Select ICD9CM DIAGNOSIS: 491.9  CHRONIC BRONCHITIS
. . .OK? YES// <Enter>

Select ICD9CM DIAGNOSIS: <Enter>

Select Accession Number/Pt name: <Enter>

Select Coding, anat path Option: <Enter>
```

Clinical HX/Gross Description [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 <Enter> 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 <Enter> 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 a 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// <Enter> (YES)
Select Accession Number/Pt name: 22  for 1988
LABPATIENT, SEVEN ID: 000-00-0007
Specimen(s):PROSTATE CHIPS
Select SPECIMEN: PROSTATE CHIPS// <Enter>
      SPECIMEN: PROSTATE CHIPS// <Enter>
Select SPECIMEN: <Enter>
BRIEF CLINICAL HISTORY:
      1>Nocturia and difficulty voiding urine.
      2> <Enter>
EDIT Option: <Enter>
PREOPERATIVE FINDINGS:
      1>Same.
      2> <Enter>
EDIT Option: <Enter>
OPERATIVE FINDINGS:
      1>SAme.
      2><Enter>
Edit line: 1
      Replace A <Enter> With a <Enter> Replace <Enter>
       Same.
Edit line: <Enter>
EDIT Option: <Enter>
POSTOPERATIVE DIAGNOSIS:
      1>Same.
      2> <Enter>
EDIT Option: <Enter>
RESIDENT PATHOLOGIST: LABPROVIDER, FOUR.
GROSS DESCRIPTION:
      1>Specimen consists of * grams of prostate gland tissue.
EDIT Option: 1
      1>Specimen consists of * grams of prostate gland tissue.
      Replace * <Enter> With 25 <Enter> Replace <Enter>
       Specimen consists of 25 grams of prostate gland tissue.
Edit line: <Enter>
EDIT Option: <Enter>

Select Accession Number/Pt name: <Enter>
```

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// <Enter>  (YES)

Select Accession Number/Pt name: 26  for  1992
LABPATIENT1, THREE  ID: 000-00-0013
Specimen(s):
LEFT NOSE BIOPSY

Select SPECIMEN: LEFT NOSE BIOPSY// <Enter>
  SPECIMEN: LEFT NOSE BIOPSY// <Enter>
Select SPECIMEN: <Enter>
BRIEF CLINICAL HISTORY:
  1>Exc   BCC
  2> <Enter>
EDIT Option: <Enter>
PREOPERATIVE DIAGNOSIS:
  1>BCC
  2> <Enter>
EDIT Option: <Enter>
OPERATIVE FINDINGS:
  1>same
  2> <Enter>
EDIT Option: <Enter>
POSTOPERATIVE DIAGNOSIS:
  1>BCC
RESIDENT PATHOLOGIST: LABPROVIDER, FIVE
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: <Enter>
FROZEN SECTION:
  1>Basal cell CA, adequately excised.
  2>Reported to LABPROVIDER, ONE at x2420 at 10:55AM.
EDIT Option: <Enter>

Select Accession Number/Pt name: <Enter>
```

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), <Enter> at line one, <Enter> 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 that 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 <Enter> 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// <Enter> (YES)
Select Accession Number/Pt name: 23
LABPATIENT1, FOUR ID: 000-000-0014
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><Enter>
CYTOTECH:  LABPROVIDER, SIX
PATHOLOGIST: LABPROVIDER, SEVEN
DATE REPORT COMPLETED: TODAY// <Enter> (DEC 01, 1989)
REVIEWED BY PATHOLOGIST: YES
Select Accession Number/Pt name: <Enter>
```

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// <Enter>  (YES)

Select Accession Number/Pt name: 26  for  1992
LABPATIENT1, FIVE: 000-00-0015
Specimen(s):
LEFT NOSE BIOPSY

FROZEN SECTION:
  1>Basal cell CA, adequately excised.
  2>Reported to LABPROVIDER, SEVEN at x2420 at 10:55AM.
EDIT Option: <Enter>
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><Enter>
EDIT Option: <Enter>
MICROSCOPIC EXAM/DIAGNOSIS:
  1>Residual basal cell carcinoma in biopsy site.  Adequately excised.  See
  2>also S92-16.
  3> <Enter>
EDIT Option: <Enter>
PATHOLOGIST: LABPROVIDER, EIGHT// <Enter>
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 word-wrap unless a <Enter> and a space are entered. The maximum length of a word-processing field is 255 characters. When data is first entered, the line length is calculated, based on this limit. If you wish to use the <Enter> to control the appearance of the text on the screen, you may do so. However, when the report is printed, it will word-wrap 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 <Enter> 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 be 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// <Enter>
```

The second time around:

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

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// <Enter> (NO)
Data entry for 1990 ? YES// <Enter> (YES)
Select Accession Number/Pt name: 22 for 1990
LABPATIENT, SEVEN ID: 000-00-0007
Specimen(s) :
PROSTATE CHIPS

GROSS DESCRIPTION:
      1>Specimen consists of 25 grams of prostate gland tissue.
EDIT Option: <Enter>
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><Enter>
EDIT Option: <Enter>
PATHOLOGIST: LABPROVIDER, THREE// <Enter>
DATE REPORT COMPLETED: NOV 20, 1990
TC CODE: 1// ?
(ENTER: Numeric between 0 and 9.
TC CODE: 1// <Enter>
Select ORGAN/TISSUE: prostate  77100
            ORGAN/TISSUE NUMBER: 1// <Enter>
      WEIGHT (gm): 25
      Select MORPHOLOGY : WDA ??
      Select MORPHOLOGY: adenocarcinoma, well DIFFERENTIATED 814031
      Select MORPHOLOGY : hyperplasia    72000
      Select MORPHOLOGY: <Enter>
Select ORGAN/TISSUE: <Enter>
Select Accession Number/Pt name: <Enter>
```

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// <Enter>  (YES)

Select Accession Number/Pt name: 26  for  1992
LABPATIENT1, THREE  ID: 000-00-0013
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 LABPROVIDER, THREEat x2420 at 10:55AM.
EDIT Option: <Enter>
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>whichis inked in red.  Inferior margin is inked in green, anterior blue
  4>and posterior uninked.  Representative sections embedded.
EDIT Option: <Enter>
MICROSCOPIC EXAM:
  1>Residual basal cell carcinoma in biopsy site.  Adequately excised.  See
  2>also S92-16.
EDIT Option: <Enter>
SURGICAL PATH DIAGNOSIS: BASAL CELL CARCINOMA
PATHOLOGIST: LABPROVIDER, EIGHT// <Enter>
DATE REPORT COMPLETED: DEC 3,1992// <Enter>
TC CODE: 1// <Enter>
Select ORGAN/TISSUE: 02140  SKIN OF NOSE        02140
   ORGAN/TISSUE NUMBER: 1// <Enter>
  Select MORPHOLOGY: 80903  BASAL CELL CARCINOMA        80903
    Select ETIOLOGY: <Enter>
  Select MORPHOLOGY: 09400  SURGICAL MARGINS FREE OF TUMOR        09400
    Select ETIOLOGY: <Enter>
  Select MORPHOLOGY: <Enter>
  Select FUNCTION: <Enter>
  Select PROCEDURE: 1141  BIOPSY, EXCISION        1141
  Select PROCEDURE: 3082  FROZEN SECTION          3082
  Select PROCEDURE: <Enter>
  Select DISEASE: <Enter>
Select ORGAN/TISSUE: <Enter>
```

Example 3: 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// <Enter>  (YES)

Select Accession Number/Pt name: 26  for  1992
LABPATIENT, SEVEN  ID: 000-00-0007
Specimen(s):
BONE MARROW

GROSS DESCRIPTION:
  1 <Enter>

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><Enter>
EDIT Option: <Enter>
```

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
LABPATIENT, SEVEN  ID: 000-00-0007
Specimen(s):
BONE MARROW

GROSS DESCRIPTION:
  1 <Enter>

MICROSCOPIC EXAM/DIAGNOSIS:
1> BONE MARROW
```

```
18> DIAGNOSIS:*

19><Enter>

20> COMMENT:*
EDIT Option: E

EDIT Option: 2
2> Polys:*
 Replace * with 8 Replace <Enter>
    Polys: 8

Edit line: 3
3> Bands:*
  Replace * With 0 Replace <Enter>
    Bands: 0

Edit line: 4
4> Lymphs:*
  Replace * With 90 Replace <Enter>
   Lymphs: 90

Edit line: 5
5> Monos:*
  Replace * With 2 Replace <Enter>
   Monos: 2

Edit line: 6
6> Eosins:*
 Replace * With 0 Replace <Enter>
   Eosins: 0

Edit line: 7
7> Basos:*
 Replace * With 0 Replace <Enter>
   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 <Enter>

  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 <Enter>
     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><Enter>
2 lines inserted.........

EDIT Option: 20
20>DIAGNOSIS:*
  Replace * With Chronic lymphocytic leukemia (see comment) with extensive
diffuse bone marrow infiltrate. Replace <Enter>
  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 <Enter>
   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><Enter>
4 lines inserted.....
EDIT Option: <Enter>
PATHOLOGIST: LABPROVIDER, NINE.// <Enter>
DATE REPORT COMPLETED: JUN 28, 1988// <Enter>
```

[The final report is shown below]

```
------------------------------------------------------------------------
      MEDICAL RECORD  : SURGICAL PATHOLOGY     Pg 1
------------------------------------------------------------------------
Submitted by: LABPROVIDER, THREE    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: LABPROVIDER, THREE
========================================================================
                                          PATHOLOGY REPORT
Laboratory: VAMC              Accession No. 12
Gross description       Pathology Resident      LABPROVIDER, NINE
LABPATIENT1, TWO  LABPATIENT, TEN

      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)
LABPROVIDER, THREE                      rg: Date NOV 20,.1990
------------------------------------------------------------------------
LABPATIENT, SEVEN                     SURGICAL PATHOLOGY Report
ID:000-00-0007 SEX:M DOB:5/8/16 AGE: 74 LOC: 1A  LABPROVIDER, SEVEN
```

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// <Enter>  (NO)

Data entry for  1992 ? YES// <Enter>  (YES)

Select Accession Number/Pt name: 6  for  1992
LABPATIENT1, SIX  ID: 000-00-0016
Specimen(s):
CERVICOVAGINAL SMEAR

GROSS DESCRIPTION:
  1>Two smears received.
EDIT Option: <Enter>
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><Enter>
EDIT Option: <Enter>
```

[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
LABPATIENT1, SIX  ID: 000-00-0016
Specimen(s):
CERVICOVAGINAL SMEAR

GROSS DESCRIPTION:
  1>Two smears received.
EDIT Option: <Enter>
MICROSCOPIC EXAM/DIAGNOSIS:
  1>Statement on Specimen Adequacy
  2>   ( ) Satisfactory for interpretation
  3>   ( ) Less than optimal
  4>   ( ) Unsatisfactory
  5> <Enter>
  6> Explanation for less than optimal/unsatisfactory specimen:
  7>   ( ) Scant cellularity
  8>   ( ) Poor fixation or preservation
  9>   ( ) etc.
EDIT Option:<Enter>
```

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// <Enter> (YES)

Select Accession Number/Pt name: 1 for 1990
LABPATIENT, NINE: 000-00-0009
Specimen(s):
SPUTUM

GROSS DESCRIPTION:
 1>Specimen consists of 15 ml of serous milky fluid.
EDIT Option:<Enter>
MICROSCOPIC EXAM/DIAGNOSIS:
 1>No lower respiratory elements are found.
 2>
 3>DIAGNOSIS: SPUTUM: UNSATISFACTORY
 4> <Enter>
EDIT Option: <Enter>
CYTOTECH:  LABPROVIDER, TEN
PATHOLOGIST: LABPROVIDER1, ONE//<Enter>
DATE REPORT COMPLETED: MAY 12,1989//<Enter>
REVIEWED BY PATHOLOGIST: YES//<Enter>
Select ICD DIAGNOSIS: 786.4 786.4   ABNORMAL SPUTUM
     ...OK? YES// <Enter> (YES)
 ICD DIAGNOSIS: 786.4//<Enter>
Select ICD DIAGNOSIS:<Enter>
Number of slides: 4 //<Enter>
Number paraffin blocks: 1 //<Enter>
Select Accession Number/Pt name: <Enter>
```

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 straight-forwardly.

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// <Enter> (NO)

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

Select Patient Name: LABPATIENT, SEVEN  05-08-16  000000007
LABPATIENT, SEVEN  ID: 000-00-0007
AGE: 72  DATE OF BIRTH: MAY 8, 1916
PATIENT LOCATION: 1A// <Enter>

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: LABPATIENT1, SEVEN ID: 000-00-0017

Enter Accession number: 566
DATE REPORT COMPLETED: MAY 7, 1990// <Enter> (MAY 07, 1986)
PATHOLOGIST: LABPROVIDER1, TWO
Select ORGAN/TISSUE: SKIN   01000
      ORGAN/TISSUE NUMBER: 1// <Enter>
      Select MORPHOLOGY: 43000 CHRONIC INFLAMMATION  43000
      Select MORPHOLOGY: <Enter>
Select ORGAN/TISSUE: <Enter>
Select COMMENT: <Enter>

Date (must be exact) specimen taken: <Enter>

Select Patient Name: <Enter>

Select Data entry, anat path Option: <Enter>
```

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]

NOTE: The Supplementary Report, Anat Path [LRAPDSR] option was **modified** by the release of patch LR*5.2*248. This option stores audit information for any 'Supplementary' report that was modified after the report had been released. The audit information now being stored is the date and time the text was modified, the person's name modifying the text, and the original text before it was modified.

Any additional studies or supplemental information can be entered using the Spec Studies-EM;Immuno;Consult;Pic, Anat Path [LRAPDSS] option or the Supplementary Report, Anat Path [LRAPDSR] 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//<Enter>
Data entry for 1988 ? YES// <Enter> (YES)
Select Accession Number/Pt name: 23 for 1990
LABPATIENT, SEVEN ID: 000-00-0007
Specimen(s):
SKIN
```

```
DATE REPORT COMPLETED: NOV 21, 1990// <Enter>
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: <Enter>

Select ORGAN/TISSUE: <Enter>
Select Accession Number/Pt name: 23 for 1990
LABPATIENT, SEVEN ID: 000-00-0007
Specimen(s):
SKIN
DATE REPORT COMPLETED: NOV 21,1990// <Enter>
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><Enter>
EDIT Option: <Enter>
```

NOTES:

As mentioned on the prior page, with the release of patch LR*5.2*248, if a modification is made to a released 'Supplementary' report, audit information is now being stored. When printing the 'Supplementary' report using Print Single Report Only [LRAP PRINT SINGLE] option or Print All Reports on Queue [LRAP PRINT ALL ON QUEUE] option, the report will display the **new** 'MODIFIED REPORT' information (i.e., date and time the report text was modified, person's name that modified the report, and the original text before it was modified).

The shaded areas shown in the following example indicate modifications made to the report.

Example: 'Supplementary Final' report

```
------------------------------------------------------------------------------
      MEDICAL RECORD :        SURGICAL PATHOLOGY            Pg 1
------------------------------------------------------------------------------
Submitted by: LABPROVIDER, SEVEN          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: LABPROVIDER, SEVEN
==============================================================================
                                  PATHOLOGYY REPORT
Laboratory: R5ISC                                 Accession No. SP90 23
------------------------------------------------------------------------------
Gross description:              Pathology Resident: LABPROVIDER1, THREE
      3mm punch biopsy of skin

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

Supplementary Report:
      Date: NOV 21, 1990 11:00
                             *** MODIFIED REPORT***
(Last modified: NOV 21, 1990 11:00  typed by LABUSER, ONE
      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.
------------------------------------------------------------------------------
                                                              (End of report)
                                                     rg| Date NOV 21, 1990
------------------------------------------------------------------------------
LABPATIENT, SEVEN                                    STANDARD FORM 515
ID:000-00-0007 SEX:M DOB:5/8/16 AGE 72               LOC:1A
                                                     LABPROVIDER, SEVEN
```

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// <Enter> (YES)

Select Accession Number/Pt name: 23 for 1990
LABPROVIDER, SEVEN ID: 000-00-0007
Specimen(s):
SKIN

DATE REPORT COMPLETED: NOV 21,1990// <Enter>
Select ORGAN/TISSUE: SKIN// <Enter>
      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><Enter>
EDIT Option: <Enter>
      Select SPECIAL STUDIES:<Enter>
Select PROCEDURE: Y333 (ADMINISTRATION OF MEDICATION, EMERGENCY)
Select ORGAN/TISSUE: <Enter>

Select Accession Number/Pt name:<Enter>
```

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]

Description

Menu Item	Description
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 pre-modified 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 that 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// <Enter> (YES)

Enter SURGICAL Accession #: 23
LABPROVIDER, SEVEN ID: 000-00-0007   OK ? YES// <Enter> (YES)
Specimen date: NOV 21, 1990
Report released or completed. Cannot edit Log-in data.

Enter SURGICAL Accession #: 24
LABPATIENT1, EIGHT   ID: 000-00-0018  OK? YES// <Enter> (YES)
Specimen date: NOV 21, 1990

PATIENT LOCATION: 1A// <Enter>
SURGEON/PHYSICIAN: LABRPOVIDER1, FOUR// <Enter>
SPECIMEN SUBMITTED BY: LABRPOVIDER1, FOUR // <Enter>
Select SPECIMEN: HERNIA SAC// <Enter>
      SPECIMEN: HERNIA SAC// <Enter>
Select SPECIMEN: <Enter>
BRIEF CLINICAL HISTORY:
  1><Enter>
PREOPERATIVE DIAGNOSIS:
  1>
OPERATIVE FINDINGS:
  1><Enter>
POSTOPERATIVE DIAGNOSIS:dx
  1><Enter>
DATA/TIME RECEIVED: NOV 21, 1988@08:58// <Enter>
PATHOLOGIST: LABPROVIDER1,, TWO// <Enter>
RESIDENT PATHOLOGIST: PROVIDER1, FIVE// <Enter>
Select COMMENT: <Enter>

Enter SURGICAL Accession #: <Enter>
```

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// <Enter>  (YES)

Enter AUTOPSY Accession #: 4
LABPATIENT1, NINE ID: 000-00-0019 OK ? YES// <Enter>  (YES)

Edit Weights & Measurements ? NO// <Enter>  (NO)

Date Died: NOV 25, 1992

AUTOPSY DATE/TIME: NOV 26,1992// <Enter>
LOCATION: 1A// <Enter>
SERVICE: SURGERY// <Enter>
TREATING SPECIALITY AT DEATH: CRITICAL CARE UNIT// <Enter>
PHYSICIAN: LABPROVIDER, THREE// <Enter>
RESIDENT PATHOLOGIST: LABPROVIDER, EIGHT// LABPROVIDER1, SIX
SENIOR PATHOLOGIST: LABPROVIDER1, SIX // LABPROVIDER, EIGHT
AUTOPSY TYPE: FULL AUTOPSY// <Enter>
AUTOPSY ASSISTANT: LABPROVIDER1, FIVE LEE// <Enter>

Enter AUTOPSY Accession #: <Enter>
```

Modify Anat Path Gross/Micro/Dx/Frozen Sections [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// <Enter>  (YES)

Select Accession Number/Pt name: 2  for  1994
LABPATIENT1, TEN  ID: 000-00-0110
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><Enter>
EDIT Option: <Enter>
```

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 bypatient, not by date modified. These modifications remain in the system until the descriptions are purged using the Delete Anat Path Descriptions by Date [LRAPDAR] option.

Example 2: Surgical Pathology Final Patient Reports 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: LABPATIENT1, TEN 02-01-22    000000110    NO     NSC
VETERAN
LABPATIENT2, ONE ID: 000-00-0021 Physician: LABPROVIDER1, SEVEN

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: LABPROVIDER, SEVEN

Specimen(s)                   Count #   Accession #    Date Obtained
                              ( 1)            7        AUG 25, 1994 not
verified
LEFT LEG
                              ( 2)            6        AUG 25, 1994 not
verified
left hip chip
                              ( 3)            2        AUG 24, 1994
PROSTATE CHIPS
          Choose Count #(1-3): 3
 Accession #: 2    Date Obtained: AUG 24, 1994
Print SNOMED &/or ICD codes on report ? NO// <Enter>  (NO)
Select Print Device:  [Enter Print Device Here]
```

Example: 3 Surgical Pathology Final Patient Reports Printout

```
------------------------------------------------------------------------------
     MEDICAL RECORD |                   SURGICAL PATHOLOGY              Pg 1
------------------------------------------------------------------------------
Submitted by: LABPROVIDER1, EIGHT               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: LABPROVIDER1, FIVE 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 LABUSER, TWO)
    Glomerular basement membranes are thickenedd and there is increased
    mesangial matrix.  Also present are small prostatic infarts and foci
    of squamous metaplasia.  Another small infarts 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
------------------------------------------------------------------------------
                                                          (See next page)
LABPROVIDER1, EIGHT MD                                 ec | Date AUG 25, 1994
------------------------------------------------------------------------------
LABPATIENT1, TEN                                          STANDARD FORM 515
ID:000-OO-O110  SEX:F DOB:2/1/22 AGE:72 LOC:1 EAST
ADM:APR  8, 1993 DX:DIAGNOSIS                      LABPROVIDER1, EIGHT MD


------------------------------------------------------------------------------
     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.

------------------------------------------------------------------------------
                                                           (End of report)
LABPROVIDER1, NINE                                       ec | Date AUG 25, 1994
------------------------------------------------------------------------------
LABPATIENT1, TEN                                          STANDARD FORM 515
ID:241-22-0000  SEX:F DOB:2/1/22 AGE:72 LOC:1 EAST
ADM:APR  8, 1993 DX:DIAGNOSIS                      LABPROVIDER1, EIGHT 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// <Enter> (YES)

Enter SURGICAL Accession #: 22
LABPATIENT, SEVEN ID: 000-00-0007 OK ? YES// <Enter> (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: <Enter>
```

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.

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// <Enter>  (NO)

Log book year:  1990 OK ? YES// <Enter>  (YES)
Start with Acc #: 22
Go    to   Acc #: LAST // <Enter>
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 LABPATIENT, SEVEN 8472  1 EAST LABPROVIDER1, NINE LABPROVIDER, SEVEN
Date specimen taken:10/24/90         Entered  by:LABUSER, TWO
                                     Released by: LABUSER, TWO
             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//  <Enter>
(YES)
```

```
Enter SURGICAL Accession #: 31
LABPATIENT2, TWO ID: 000-00-0022 OK ? YES//  <Enter> (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 #: <Enter>
```

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//  <Enter> (NO)

Log book year:  1993 OK ? YES//  <Enter> (YES)
Start with Acc #: 31
Go    to   Acc #: LAST // <Enter>
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  LABPATIENT2, TWO       0456 CARDIOLOG LABPROVIDER, ONE
LABPROVIDER, THREE
Date specimen taken:09/22/93         Entered  by:LABPROVIDER, EIGHT
             SKIN
    Specimen submitted in alcohol.
    Report delayed because of decalcification.
    Also there are many special stains
-------------------------------------------------------------------------
```

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:  LABPATIENT2, TWO 03-04-56     000000022      NSC
VETERAN
LABPATIENT2, TWO ID: 000-00-0022  Physician: LABPROVIDER1, TEN

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

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


Date Spec taken: SEP 22, 1993         Pathologist:LABPROVIDER, THREE MD
Date Spec rec'd: SEP 22, 1993  16:23  Resident:
REPORT INCOMPLETE                     Accession #: 31
Submitted by: LABPROVIDER, ONE        Practitioner:LABPROVIDER, ONE
------------------------------------------------------------------------

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

Inquiries, Anat Path [LRAPI]

Descriptions

Menu Item	Description
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.
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: LABPATIENT1, TEN 02-01-22 000-00-0110  NO  NSC VETERAN
LABPATIENT1, TEN 02-01-22 000-00-0110  Physician: LABPROVIDER1, SEVEN

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: LABPROVIDER1, SEVEN
PATIENT LOCATION: 1 EAST// <Enter>

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

Date Spec taken: AUG 25, 1994         Pathologist:LABPROVIDER1, FIVE MD
Date Spec rec'd: AUG 25, 1994  19:41  Resident:
Date  completed: AUG 26, 1994         Accession #: 7
Submitted by: LABPROVIDER2, ONE MD    Practitioner: LABPROVIDER2, ONE 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: LABPROVIDER2, ONE MD
Date Spec rec'd: AUG 25, 1994  19:36  Resident:
REPORT INCOMPLETE                     Accession #: 6
Submitted by: LABPROVIDER1, FIVE MD   Practitioner: LABPROVIDER1, FIVE MD
------------------------------------------------------------------------------



Report not verified
```

```
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: LABPROVIDER1, SEVEN MD  Practitioner: LABPROVIDER1, SEVEN 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 LABUSER, TWO)
  Glomerular basement membranes are thickenedd and there is increased
  mesangial matrix.  Also present are small prostatic infarts and foci of
  squamous metaplasia.  Another small infarts 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
```

NOTE: The Cytopath and EM reports work essentially the same way as the above example.

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: LABPATIENT, SEVEN   05-08-16  000000007   NO    NSC
VETERAN
LABPATIENT, ONE ID: 000-00-0001     Physician: LABPROVIDER2, TWO

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: LABPROVIDER2, TWO
PATIENT LOCATION: 1 A// <Enter>

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

LABPATIENT, SEVEN 0007 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: <Enter>
```

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: LABPATIENT2, THREE         08-18-27          000000023
LABPATIENT2, THREE ID: 000-00-0023   Physician: LABPROVIDER, SEVEN

AGE: 63 DATE OF BIRTH: AUG 18, 1927
PATIENT LOCATION: 1A// <Enter>
Is this the patient ? YES// <Enter> (YES)

SURGICAL PATHOLOGY  LABPATIENT2, THREE ID: 000-00-0023
Spec Date/time          Acc #       PHYSICIAN         SPECIMEN(S)

Spec Date/time  Acc #           PHYSICIAN       SPECIMEN(S)


08/25/94        SP94 7          LABPROVIDER2, TWO     LEFT LEG

08/25/94        SP94 6          LABPROVIDER1, NINE     left hip chip

08/24/94        SP94 2          LABPROVIDER2, THREE      PROSTATE CHIPS
```

Search Options, Anat Path [LRAPSEARCH]

The search options include SNOMED search options (MORPHOLOGY, DISEASE, ETIOLOGY, PROCEDURE, FUNCTION, and MULTIAXIAL) and 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// <Enter> AUG 30, 1994
Go    to   Date TODAY// -365  (AUG 30, 1993)
Select Print Device:  [Enter Print Device Here]
```

```
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


LABPATIENT2, FOUR  0024  F 62     5-94  SKIN OF NOSE       BASAL CELL ADENOMA
LABPATIENT2, FIVE  0025  M 83     3-94  LIVER              HYPERPLASIA
                                                          ADENOCARCINOMA
LABPATIENT2, SIX   0026  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  LABPATIENT2, FIVE  0025  M   83  8/24 LIVER             HYPERPLASIA

ADENOCARCINOMA
   5-94  LABPATIENT2, FOUR  0024  F   62  8/24 SKIN OF NOSE      BASAL CELL
ADENOMA
   8-94  LABPATIENT2, SIX   0026  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] option and ETIOLOGY code search, SNOMED [LRAPSE] option.

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: <Enter>

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 does not 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// <Enter> (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 #
 LABPATIENT, THREE  000-OO00003   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 <Enter> 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:<Enter>

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: <Enter>

DISEASE
      For all choices type “ALL”
DISEASE choice #1: Select 1 or more characters of the code: <Enter>

FUNCTION
      For all choices type “ALL”
FUNCTION choice # 1: Select 1 or more characters of the code: <Enter>

Start with Date TODAY// 10-1-90 (OCT 01, 1990)
Go  to   Date TODAY// <Enter> 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
```

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: <Enter>

PROCEDURE
Select only procedures with results ? NO// <Enter>  (NO)
     For all choices type 'ALL'
PROCEDURE   choice # 1: Select 1 or more characters of the code: <Enter>

DISEASE
     For all choices type 'ALL'
DISEASE     choice # 1: Select 1 or more characters of the code: <Enter>

FUNCTION
     For all choices type 'ALL'
FUNCTION    choice # 1: Select 1 or more characters of the code: <Enter>


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: <Enter>

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: LABPROVIDER2, Four
Taken    Patient              ID   Physician         LOC      Acc#
PATHOLOGIST
-------------------------------------------------------------------------------
06/29/89 LABPATIENT2, SIX  3454 LABPROVIDER, SEVEN   5N 2 LABPROVIDER2, FIVE
Specimen(s):   TOOTH
    AS ABOVE

     T-54010 TOOTH
          M-23350 IMPACTED TOOTH
          PHOTOGRAPHY 1 Date: JUN 29, 1989
-------------------------------------------------------------------------------
07/24/89 LABPATIENT2, SEVEN  0027 LABPROVIDER2, SIX  1E  3 LABPROVIDER2, NINE
Specimen(s):   GALLBLADDER
     T-57000 GALLBLADDER
          M-30010 LITHIASIS
-------------------------------------------------------------------------------
08/24/94 LABPATIENT2, FIVE 0027  LABPROVIDER, 2, SIX  1 EAST 3 LABPROVIDER1,
NINE

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: LABPROVIDER2, FOUR
Taken    Patient              ID   Physician         LOC      Acc#
PATHOLOGIST
-------------------------------------------------------------------------------
08/24/94 LABPATIENT2, FIVE 0027  LABPROVIDER, 2, SIX  1 EAST LABPROVIDER1,
NINE 3
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:LABPROVIDER2, FOUR
-------------------------------------------------------------------------------
                     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:LABPATIENT1, FOUR 02-01-12 000-00-0014
 NSC VETERAN
LABPATIENT1, FOUR 000-00-0014    Physician: LABPROVIDER2, EIGHT
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: LABPROVIDER2, EIGHT
PATIENT LOCATION: 1 EAST// <Enter>

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


LABPATIENT1, FOUR 000-00-0014    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   <Enter>


LABPATIENT1, FOUR 000-00-0014    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   <Enter>
```

```
LABPATIENT1, FOUR 000-00-0014    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   <Enter>
```

```
LABPATIENT1, FOUR 000-00-0014    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 890O8-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// <Enter> (1991)
Start with accession #: 1362
Go to accession #: 1735



Date Spec taken: JAN 11, 1991       Pathologist: LABPROVIDER2, TEN
Date Spec rec'd:  JAN 12, 1991      Resident:
Date Completed:  JAN 13, 1991 Accession #: 23
Submitted by: LABPROVIDER, ONE      Practitioner: LABPROVIDER, ONE
------------------------------------------------------------------
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]

Menu Item	Description
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.

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: LABPATIENT2, EIGHT
  ARE YOU ADDING ' LABPATIENT2, EIGHT' AS A NEW REFERRAL PATIENT (THE 19TH)?
Y  (YES)
   REFERRAL PATIENT DOB: 5-5-18  (MAY 05, 1918)
   REFERRAL PATIENT IDENTIFIER: 0028
LABPATIENT2, EIGHT ID: 0028
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.

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// <Enter> (YES)

Select Patient Name:  LABPATIENT, SEVEN  05-08-16  00-00-0007

LABPATIENT, SEVEN ID: 00-00-0007
AGE: 72 DATE OF BIRTH: MAY 8, 1916
PATIENT LOCATION: 1A// <Enter>

Checking surgical record for this patient...

No operations on record in the past 7 days for this patient.

Assign SURGICAL accession #: 22 ? YES// <Enter> (YES)
Date/time Specimen taken: TODAY// <Enter> (NOV 20, 1988)
SURGEON/PHYSICIAN: LABPROVIDER, SEVEN <Enter>
SPECIMEN SUBMITTED BY: LABPROVIDER, SEVEN MD// <Enter>
Select SPECIMEN: PROSTATE CHIPS
Select SPECIMEN: <Enter>
DATE/TIME RECEIVED: NOW// <Enter> (NOV 20, 1988@9:20)
PATHOLOGIST: LABPROVIDER, THREE
Select COMMENT: This comment will appear on the log book.
Select COMMENT: <Enter>
Select Patient Name: <Enter>
```

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// <Enter>  (YES)

Select Patient Name:  LABPATIENT1, FIVE       04-27-25     000000015     SC
VETERAN
LABPATIENT1, FIVE ID: 000-00-0015 Physician: LABPROVIDER, THREE

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// <Enter>  (YES)
Date/time Specimen taken: TODAY// <Enter>  (DEC 03, 1992)
SURGEON/PHYSICIAN: LABPROVIDER, THREE  LABPROVIDER, THREE
SPECIMEN SUBMITTED BY: LABPROVIDER, THREE MD// <Enter>
Select SPECIMEN: LEFT NOSE BIOPSY
Select SPECIMEN: <Enter>
DATE/TIME SPECIMEN RECEIVED: NOW// <Enter>  (DEC 03, 1992@10:45)
PATHOLOGIST: LABPROVIDER, EIGHT  LABPROVIDER, EIGHT
Select COMMENT: Call x3028 or x2420 with frozen results  (Call x3028 or x2420
          with frozen results)
Select COMMENT: <Enter>
FROZEN SECTION:
  1>Basal cell CA, adequately excised.
  2>Reported to LABPROVIDER2, TWO at x2420 at 10:55AM. .
  3><Enter>
EDIT Option: <Enter>
```

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// <Enter> (YES)

Select Patient Name:  LABPATIENT, SEVEN    05-08-16   000000007   NON-VETERAN
(OTHER)
LABPATIENT, SEVEN ID: 000-00-0007    AGE: 74 DATE OF BIRTH: MAY 8, 1916
PATIENT LOCATION: 1A// 11b
Assign CYTOPATHOLOGY accession #: 1 ? YES// <Enter> (YES)
Date/time Specimen taken: TODAY// <Enter> (AUG 28, 1990)
PHYSICIAN: LABPROVIDER. THREE
SPECIMEN SUBMITTED BY: LABPROVIDER, THREE//<Enter>
Select SPECIMEN: Prostate chips
Select SPECIMEN: <Enter>
DATE/TIME SPECIMEN RECEIVED: NOW// <Enter> (AUG 28, 1990@12:04)
PATHOLOGIST: LABPROVIDER3, ONE
Select COMMENT:<Enter>
GROSS DESCRIPTION:
 1>10 cc of tan viscous material submitted.
 2><Enter>
EDIT Option:
Select Patient Name:<Enter>
```

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// <Enter>  (YES)

Select Patient Name: LABPATIENT1, TWO       06-18-62     000-00-0012

 ADAMS,HOUSTON ID: 121-22-3333 Physician: LABPROVIDER3, TWO
 AGE: 29  DATE OF BIRTH: JUN 18, 1962
PATIENT LOCATION: 1B// <Enter>

 Assign EM accession #:  8 ? YES// <Enter>  (YES)
 Date/time Specimen taken: TODAY// <Enter>  (JAN 13, 1992)
 PHYSICIAN:    LABPROVIDER3, THREE
 SPECIMEN SUBMITTED BY: LABPROVIDER3, FOUR // <Enter>
 Select SPECIMEN: SKIN
 Select SPECIMEN: KIDNEY
 Select SPECIMEN: <Enter>
 DATE/TIME SPECIMEN RECEIVED: NOW// <Enter>  (JAN 13, 1992@10:39)
 PATHOLOGIST: LABPROVIDER, EIGHT  LABPROVIDER, EIGHT
 RESIDENT OR EMTECH: LABPROVIDER3, FIVE
 Select COMMENT: <Enter>
```

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// <Enter> (YES)

Select Patient Name: B9898  LABPATIENT, FOUR   12-18-25   000000004   NSC
VETERAN
LABPATIENT, FOUR   ID: 000-00-0004 Physician: LABPROVIDER, THREE

                                    DIED DEC  1, 1992


Assign AUTOPSY accession #:  5 ? YES// <Enter>  (YES)

Enter Weights & Measurements ? NO// <Enter>  (NO)

AUTOPSY DATE/TIME: T  (DEC 01, 1992)
LOCATION: 1A
SERVICE: MEDICINE
TREATING SPECIALTY AT DEATH: INTERNAL MEDICINE
PHYSICIAN: LABPROVIDER1, SIX
RESIDENT PATHOLOGIST: <Enter>
SENIOR PATHOLOGIST: <Enter>
AUTOPSY TYPE: F  FULL AUTOPSY
AUTOPSY ASSISTANT: <Enter>
```

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 <Enter> 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
LABPATIENT, SEVEN ID: 000000007 DOB: MAY 8, 1916

ACC # 22
Report completed &/or released, deletion not allowed.


Select Accession # : 24
LABPATIENT1, EIGHT ID: 000-00-0018 DOB: JAN 23, 1934

ACC # 24 DATE RECEIVED: NOV 21, 1990 08:58 OK to DELETE ? NO// <Enter> (NO)
      NOT DELETED


Select Accession # : 24
LABPATIENT1, EIGHT ID: 000000018 DOB: JAN 23, 1934

ACC # 24 DATE RECEIVED: NOV 21, 1990 08:58 OK to DELETE ? NO// Y
Select Accession # : <Enter>

Select Log-in menu, anat path Option: <Enter>
```

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// <Enter>

Log book year: 1991 OK ? YES// <Enter> (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   LABPATIENT1, FOUR    0014  1A      LABPROVIDER, THREE
       LABPROVIDER, THREE
Date specimen taken:11/07/90     Entered by:   LABPROVIDER3, SIX
           SKIN
-------------------------------------------------------------------------------
-
11/08   21   LABPATIENT1, FOUR    0014  1A      LABPROVIDER1, TWO
       LABPROVIDER, ONE
Date specimen taken:11/08/90     Entered by:   LABPROVIDER3, SIX
                                       Released by: LABPROVIDER3, SIX
           SNOMED codes:
            SKIN
                     Dx: PSORIASIS
                     Procedure: BIOPSY, PUNCH
            LIVER
                     Dx: CIRRHOSIS: HEMANGIOMA
                     Procedure: BIOPSY, NEEDLE
-------------------------------------------------------------------------------
11/20   22   LABPATIENT, SEVEN    0007  1A      LABPROVIDER, SEVEN
       LABPROVIDER, THREE
Date specimen taken:11/20/90     Entered by:   LABPROVIDER3, SIX
                                 Released by:LABUSER, THREE
           PROSTATE
                     Dx: ADENOCARCINOMA
                               Reviewed by LABPROVIDER3, SEVEN on 11/22/90
                               Notified LABPROVIDER, THREE 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

Option	Description
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.
Autopsy Administrative Reports:	
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.

Option	Description
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.

Anat Path Accession Reports:

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.
% 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.

Option	Description
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.
Anatomic Pathology Labels:	
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.
Edit/Print/Display Preselected Lab Tests:	
Print/Display Preselected Lab Tests Enter/Edit User Defined Lab Test	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.
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: The Print All Reports on Queue [LRAP PRINT ALL ON QUEUE] option has been **modified** with the release of patch LR*5.2*248.

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

Preliminary reports for SURGICAL PATHOLOGY
Add/Delete reports to/from print queue for 1990? NO//  N
Select Print Device:  [Enter Print Device Here]
```

Example 1: Surgical Pathology Preliminary Report *continued*

```
------------------------------------------------------------------
MEDICAL RECORD  :             SURGICAL PATHOLOGY            Pg 1
------------------------------------------------------------------
Submitted by:  LABPROVIDER, SEVEN         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:  LABPROVIDER, SEVEN
==================================================================
                              PATHOLOGY REPORT
Laboratory: R5ISC                          Accession No. SP90 22
------------------------------------------------------------------
                        ****  REPORT INCOMPLETE ****

Gross description:            Pathology Resident:  LABPROVIDER3, TWO

      Specimen consists of 25 grams of prostate gland tissue.

Microscopic exam/diagnosis:

------------------------------------------------------------------
                                                      (End of report)
 LABPROVIDER, THREE                        rg : Date
------------------------------------------------------------------
LABPATIENT, SEVEN                   SURGICAL PATHOLOGY Report
ID:000-00-0007  SEX:M  DOB:5/8/16  AGE:74  LOC:1A  LABPROVIDER, SEVEN
```

Example 1: Surgical Pathology Preliminary Report *continued*

```
NOV 20, 1990  09:27  ANATOMIC PATHOLOGY  R5ISC              Pg 2
------------------------------------------------------------------
LABPATIENT, SEVEN       SSN: 000-00-0007  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 Reports

You will 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 Final reports

                        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]
```

Example 2: Surgical Pathology Final Patient Reports *continued*

```
      MEDICAL RECORD :        SURGICAL PATHOLOGY                  Pg 1
------------------------------------------------------------------------------
Submitted by: LABPROVIDER, SEVEN          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:  LABPROVIDER, SEVEN
==============================================================================
                                          PATHOLOGY REPORT
Laboratory: R5ISC                        Accession No. SP88 22
------------------------------------------------------------------------------
Gross description:            Pathology Resident:  LABPROVIDER3, TWO

      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)
LABPROVIDER, THREE                       rg: Date NOV 20,.1990
------------------------------------------------------------------------------
LABPROVIDER, SEVEN                            SURGICAL PATHOLOGY Report
ID:000-00-0007  SEX:M  DOB:5/8/16  AGE: 74 LOC: 1A    LABPROVIDER, SEVEN
```

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// <Enter>  (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]
```

Example 3: Surgical Pathology Report with Frozen Section *continued*

```
------------------------------------------------------------------------------
     MEDICAL RECORD |                   SURGICAL PATHOLOGY          Pg 1
------------------------------------------------------------------------------
Submitted by: LABPROVIDER, THREE              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: LABPROVIDER, THREE
  ============================================================================
                                 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 LABPROVIDER, THREE 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




------------------------------------------------------------------------------
                                                        (End of report)
LABPROVIDER, EIGHT                                 lh | Date DEC  3, 1992
------------------------------------------------------------------------------
LABPATIENT1, FIVE                                      STANDARD FORM 515
ID:000-00-0015  SEX:M DOB:4/27/25 AGE:67 LOC:SURGERY      LABPROVIDER, THREE
```

Example 4: Change in Prompts if you select the Autopsy Section

NOTE: The Autopsy section for the Print All Reports on Queue [LRAP PRINT ALL ON QUEUE] option has been **modified** with the release of patch LR*5.2*248 as follows:

If any 'Autopsy supplementary report data has been modified after the report has been released the AUTOPSY SUPPLEMENTARY Modified Report audit information (e.g., `Last modified: Aug 16, 2000 09:54 and typed by SMITH, JOHN`) is now displayed. This information also appears for supplementary report data that appears on the Autopsy Protocol report.

The 'Autopsy Protocols Report' FOOTER has been modified by adding labels to the patient and physician names (i.e., `Patient:` and `Physician:`) of the report FOOTER to clearly distinguish between the two. The remaining data in the FOOTER has been realigned to allow for better readability.

The 'Autopsy Protocol Report' final page HEADER has been reformatted to allow for better readability. The report body displays the weights, measures, and SNOMED coding information.

The shaded areas display changes made in the 'Anatomic Pathology Report' HEADER and FOOTERS.

```
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<Enter>

                       Autopsy Protocols
(D)ouble or (S)ingle spacing of report(s): S<Enter>

Print weights, measures and coding (if present): ? YES// <Enter>  (YES)

Save protocol list for reprinting ? NO// Y  (YES)
Select Print Device:  [Enter Print Device Here]
```

Example 4: Change in Prompts if you Select the Autopsy Section *continued*

```
------------------------------------------------------------------------------
     CLINICAL RECORD |                  AUTOPSY PROTOCOL            Pg 1
------------------------------------------------------------------------------
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 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 mesangeal 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: LABPROVIDER, THREE                        lh| Date DEC  2, 1992
------------------------------------------------------------------------------
DALLAS ISC                                                  AUTOPSY PROTOCOL
Patient: LABPATIENT, FOUR     000-00-0004       SEX: M      DOB: DEC 18, 1925
BON-AHMED/OPC           Physician: LABPROVIDER, THREE       AGE AT DEATH:66
```

```
DEC 2, 1992   08:10     DALLAS ISC                                  Pg: 2
ANATOMIC PATHOLOGY
------------------------------------------------------------------------
LABPATIENT, FOUR  000-00-0004             DOB:DEC 18, 1925
Acc #: 5          AUTOPSY DATA            Age: 66
Date/time Died                            Date/time of Autopsy DEC 1, 1992
                  FULL AUTOPSY            DEC 1, 1992
Resident: LABPROVIDER6, SEVEN             Senior:LABPROVIDER, THREE



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: LABPROVIDER, THREE                     lh | Date DEC  2, 1992
------------------------------------------------------------------------
DALLAS ISC                                                AUTOPSY PROTOCOL
Patient: LABPATIENT, FOUR     000-00-0004       SEX: M    DOB: DEC 18, 1925
MEDICINE                Physician: LABPROVIDER, THREE     AGE AT DEATH:66
```

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          LABPATIENT, SEVEN                 000-00-0007
==============================================================================
```

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    LABPATIENT1, FOUR             000-00-0014
15    08/11/90    LABPATIENT2, NINE             000-00-0029
21    11/08/90    LABPATIENT1, FOUR             000-00-0014
22    11/20/90    LABPATIENT, SEVEN             000-00-0007
```

Print Single Report Only [LRAP PRINT SINGLE] option

This option prints pathology accessions in Cytopath report for 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: LABPATIENT1, FOUR. 02-01-12  0000000014  NO  NSC VETERAN
LABPATIENT1, FOUR ID: 000-00-0014 Physician: LABPROVIDER2, EIGHT

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: LABPROVIDER, SEVEN

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// <Enter>  (NO)
           Choose Count #(1-4): 1
 Accession #: 10   Date: JUL 28, 1990

Select Print Device:  [Enter Print Device Here]



MEDICAL RECORD |            EM                                  Pg 1
---------------------------------------------------------------------
Submitted by: LABPROVIDER1, TWO  Date obtained: JUL 28, 1990
---------------------------------------------------------------------
Specimen (Received JUL 28, 1990  12:35):
---------------------------------------------------------------------
Brief Clinical History:
---------------------------------------------------------------------
Preoperative Diagnosis:
---------------------------------------------------------------------
Operative Findings:
---------------------------------------------------------------------
Postoperative Diagnosis:
                          Surgeon/physician: LABPROVIDER3, EIGHT
=====================================================================
                                                   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)
LABPROVIDER2, ONE                              ec | Date SEP  2, 1994
------------------------------------------------------------------
LABPATIENT1, FOUR                                STANDARD FORM 515
ID:012-45-8762  SEX:M DOB:2/1/12 AGE:77 LOC:AMBULATORY SURGERY
                                               LABPROVIDER3, EIGHT

DEC  1, 1989  11:41   SIUG                                    Pg: 2
ANATOMIC PATHOLOGY
------------------------------------------------------------------
                              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                                  Pg: 3
ANATOMIC PATHOLOGY
-------------------------------------------------------------------
LABPATIENT1, FOUR              SSN:000-00-0014 DOB:2/1/12
                             CYTOPATHOLOGY
     Organ/tissue:       Date rec'd: 09/25/90      Acc #:    7
     SPUTUM
          CARBUNCLE
     Organ/tissue:       Date rec'd: 08/22/90      Acc #:    6
     Report not verified.
     Organ/tissue:       Date rec'd: 05/04/90      Acc #:    1
     SPUTUM
          NEGATIVE FOR MALIGNANT CELLS
     Organ/tissue:       Date rec'd: 08/04/89      Acc #:   35
     Report not verified.
     Organ/tissue:       Date rec'd: 08/03/89      Acc #:   34
     Report not verified.
     Organ/tissue:       Date rec'd: 08/03/89      Acc #:   33
     Report not verified.
     Organ/tissue:       Date rec'd: 07/31/89      Acc #:   14
     Organ/tissue:       Date rec'd: 07/31/89      Acc #:   15
     ABDOMEN
          ACQUIRED DIGITAL FIBROKERATOMA
     Organ/tissue:       Date rec'd: 07/31/89      Acc #:   30
     Report not verified.
     Organ/tissue:       Date rec'd: 07/31/89      Acc #:   29
     Report not verified.
     Organ/tissue:       Date rec'd: 06/10/89      Acc #:   24
     Organ/tissue:       Date rec'd: 06/10/89      Acc #:   23
     Organ/tissue:       Date rec'd: 06/10/89      Acc #:   22
     Organ/tissue:       Date rec'd: 05/06/89      Acc #:   12
     Report not verified.
     Organ/tissue:       Date rec'd: 03/05/89      Acc #:   11
     Report not verified.
    SPUTUM
          POSITIVE FOR MALIGNANT CELLS
     Organ/tissue:       Date rec'd: 08/20/88      Acc #:   10
     Organ/tissue:       Date rec'd: 07/21/88      Acc #:    9
     SKIN
          CARBUNCLE
          MALIGNANT MELANOMA
     Organ/tissue:       Date rec'd: 07/18/88      Acc #: 2319
     BRONCHIAL CYTOLOGIC MATERIAL
          ATYPIA, MILD
     Organ/tissue:       Date rec'd: 07/08/88      Acc #:    8
     SPUTUM
     Organ/tissue:       Date rec'd: 07/02/88      Acc #:    7
     BRONCHIAL BRUSHING CYTOLOGIC MATERIAL
```

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:  LABPATIENT2, TEN 07-06-84   000-00-0210
LABPATIENT2, TEN ID: 000-00-0210  Physician: LABROVIDER1, TWO

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: LABPROVIDER3, NINE
Specimen(s)             Count #     Accession # Date
                                    ( 1)              123   AUG 31, 1994
   Accession #: 123   Date: AUG 31, 1994

Select Patient Name: <Enter>

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:  LABPATIENT, SEVEN    05-08-16       000000007
LABPATIENT, SEVEN  ID:  000-00-0007
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: LABPROVIDER1, SEVEN

Specimen(s)             Count #           Accession # Date
                                  (  1)              22         SEP 6, 1994
PROSTATE CHIPS
                                  (  2)              22         JUN 4, 1989
                                  (  3)             567         APR 5, 1986
                                  (  4)              12         FEB 1, 1984
More accessions ? NO// <Enter> (NO)
            Choose Count #(1-4) : 1
  Accession #: 22   Date: SEPV 6, 1994

Select Patient Name: <Enter>
```

Autopsy Administrative Reports [LRAPAUP]

Autopsy Data Review [LRAPAURV]

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 [LRAPAUFAD] 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// <Enter> SEP 08, 1993
Go    to   Date  TODAY// 1/1/90  (JAN 01, 1990)

Count only in-patient deaths ? YES// <Enter>  (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)
                                  |DIAGNOSTIC         | CLINICAL DIAGNOSIS
|----------In-patient-------------|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)
                                  |DIAGNOSTIC         | CLINICAL DIAGNOSIS
|----------In-patient-------------|DISAGREEMENT       | CLARIFIED
# Deaths  # Autopsies    Autopsy% |#Yes      #No      | #Yes   #No
Verified
-------------------------------------------------------------------------
     10          8        80.0       7          1        8
```

Alphabetical Autopsy List [LRAPAUA]

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// <Enter> 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
 ------------------------------------------------------------------------
 LABPATIENT3, ONE            000-00-0031      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 // <Enter>
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  LABPATIENT, FIVE     0005  CCC   4/26/88     4/26/88     4/26/88
      4/26/88     LABPROVIDER2, TWO

                                                     LABPROVIDER, ONE
      2  LABPATIENT, ONE      0001  1A          7/28/88     7/29/88     7/29/88
      7/29/88     LABPROVIDER, ONE

                                                     LABPROVIDER3, TWO
```

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// <Enter> (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 LABPATIENT, SEVEN 0007  1A    LABPROVIDER, SEVEN      PROSTATE
        This comment will appear on the log book.
23          11/21 LABPATIENT, ONE   8472  1A    LABPROVIDER, SEVEN      SKIN
      %No SNOMED code
```

Example 2: Anat path accession reports

```
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// <Enter> 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)  0032 #LABPATIENT3, TWO        12 08/30  1 WEST  No SNOMED code
                                    14 08/30  2 EAST  No SNOMED code
  2)  0033 #LABPATIENT3, THREE      13 08/30  1 WEST  No SNOMED code
  3)  0021 LABPATIENT2, ONE          6 08/25  1 EAST  No SNOMED code
                                     7 08/25  1 EAST  LEG
  4)  0034 LABPATIENT3, FOUR        16 09/02  AMBULAT No SNOMED code
                                    17 09/03  AMBULAT No SNOMED code
  5)  0035 LABPATIENT3, FIVE        11 08/27  RED CLI TOE
  6)  0036 LABPATIENT3, SIX         10 08/26  1 EAST  No SNOMED code
  7)  0037 LABPATIENT3, SEVEN        2 08/24  1 EAST  PROSTATIC FASCIA
  8)  0038 LABPATIENT3, EIGHT        1 08/10  1 EAST  No SNOMED code
  9)  0039 LABPATIENT3, NINE         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// <Enter> (YES)
Start with Acc #: 1
Go    to    Acc #: LAST// 17
LIST BY PATIENT ? NO// <Enter> (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  LABPATIENT3, EIGHT     0038  P 1 EAS %     No SNOMED code
         2  LABPATIENT3, SEVEN     0037  1 EAS         PROSTATIC FASCIA
         3  LABPATIENT2, FIVE      0025  1 EAS         LIVER
         4  LABPATIENT3, NINE      0039  1 WES         PROSTATE
         5  LABPATIENT3, EIGHT     0038  1 NOR         SKIN OF NOSE
         6  LABPATIENT2, ONE       0021  1 EAS %       No SNOMED code
         7  LABPATIENT2, ONE       0021  1 EAS         LEG
         8  LABPATIENT2, SIX       0026  5 NOR         BONE MARROW
        10  LABPATIENT3, SIX       0036  1 EAS         No SNOMED code
        11  LABPATIENT3, FIVE      0035  RED C         TOE
        12  #LABPATIENT3, TWO      0032  1 WES         No SNOMED code
        13  #LABPATIENT3, THREE    0033  1 WES %       No SNOMED code
        14  #LABPATIENT3, TWO      0032  2 EAS %       No SNOMED code
        15  LABPATIENT2, SIX       0026  5 NOR %       No SNOMED code
        16  LABPATIENT3, FOUR      0034  AMBUL         No SNOMED code
        17  LABPATIENT3, FOUR      0034  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// <Enter> (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)  0032  #LABPATIENT3, TWO          12      No SNOMED code
  2)  0021  LABPATIENT2, ONE            6 %    No SNOMED code
                                        7      LEG
  3)  0035  LABPATIENT3, FIVE          11      TOE
  4)  0036  LABPATIENT3, SIX           10      No SNOMED code
  5)  0024  LABPATIENT2, FOUR           5      SKIN OF NOSE
  6)  0026  LABPATIENT2, FSIX           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// <Enter> 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// <Enter> NOV 21, 1990
Go     to    Date  TODAY// T-14  (NOV 07, 1990)
Select Print Device:  [Enter Print Device Here]

LABPATIENT, SEVEN                000-00-0007         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

LABPATIENT1, FOUR                000-00-014          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     LABPATIENT1, FOUR   0OOOOOO14                 REFERRAL PT
       21     LABPATIENT1, FOUR   0OOOOOO14
       22     LABPATIENT, SEVEN   000000007                 RESEARCH
       23     LABPATIENT, SEVEN   000000007
```

List of Path Cases by Resident, Tech, Senior or Clinicians [LRAPAUL]

This option provides a comprehensive listing, for 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// <Enter> 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  LABPATIENT2, THREE      000-00-0023
            PROSTATE
                        HYPERPLASIA, GLANDULAR AND STROMAL
2)    22                   11/20/90       LABPATIENT,SEVEN  000-00-0007
            PROSTATE
                        ADENOCARCINOMA, WELL DIFFERENTIATED
                        HYPERPLASIA
3)     23                     11/21/90    LABPATIENT,SEVEN  000-00-0007
            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 that 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 are no entries, the SNOMED codes that 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// <Enter> (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): <Enter>

Start with Date TODAY// <Enter> SEP 09, 1994
Go    to     Date TODAY// 1 1 90  (JAN 01, 1990)
Select Print Device:  [Enter Print Device Here]
```

```
SEP  9, 1994  07:23   DALLAS ISC, VERIFICATION ACCT                  Pg: 1
CYTOPATHOLOGY COUNTS From JAN  1, 1990 To SEP  9, 1994
     Location                    Location Count              Count
-------------------------------------------------------------------------


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// <Enter> (YES)
                          UNSATISFACTORY SPECIMEN
                          NEGATIVE FOR MALIGNANT CELLS
                          SUSPICIOUS FOR MALIGNANT CELLS
                          POSITIVE FOR MALIGNANT CELLS

Use topography category list? YES// <Enter>  (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.

```
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// <Enter>  (YES)
Start with Acc #: 20
Go    to     Acc #: LAST// <Enter>
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  LABPATIENT3, TEN  000-00-0310
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 "outlyers," 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                                        Pg: 1
Accession counts by Senior Pathologist
From JAN 1, 1990 to:SEP 09, 1993
------------------------------------------------------------------------------

                        SURGICAL PATHOLOGY
LABPATIENT4, ONE :            165
LABPATIENT4, TWO:              47
LABPATIENT4, THREE:            89
LABPATIENT4, FOUR:             72
LABPATIENT4, FIVE:             81
LABPATIENT4, SIX:              57
Unassigned accessions :         1
                           ------
                    Total     512

                        CYTOPATHOLOGY
LABPATIENT4, SEVEN:            38
LABPATIENT4, EIGHT:            71
LABPATIENT4, NINE:             41
LABPATIENT4, TEN:              53
                           ------
                    Total     203
```

```
                        ELECTRON MICROSCOPY
LABPATIENT5, ONE:                21
LABPATIENT5, TWO:                19
                               ------
                     Total       40

                        AUTOPSY PATHOLOGY
LABPATIENT5, THREE :              4
LABPATIENT5, FOUR:                3
LABPATIENT5, FIVE:                3
LABPATIENT5, SIX:                 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 autopy for screen dispaly 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 (flaggedto 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//  <Enter>  (1990)

Reprint slide labels?  NO// <Enter>   (NO)
Add/Delete slide labels to print?  NO// <Enter>   (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//  <Enter> (1993)  1993

Reprint slide labels ? NO// <Enter>  (NO)

Add/Delete slide labels to print ? NO// <Enter>  (NO)

Print CYTOPATHOLOGY slide labels for 1993

Start with accession number: 6
Go    to   accession number: LAST// <Enter>
Select Print Device:  [Enter Print Device Here]

There are no labels to print.

Select Anatomic pathology labels Option: <Enter>
```

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// <Enter>  (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: <Enter>
```

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// <Enter>  (1993)  1993

Reprint slide labels ? NO// <Enter>  (NO)

Add/Delete slide labels to print ? NO// <Enter>  (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
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// <Enter>
Select Print Device:  [Enter Print Device Here]



SURG  1120  22  Date taken:11/20/90
LABPATIENT, SEVEN       000-00-0007
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: ANAtomic 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// <Enter>  (1993)  1993

Enter Autopsy Case number: 1
Want labels for whole case? YES// <Enter>  (YES)
Enter total number of blocks :20
Want to enter additional stains :? NO// <Enter>
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//  <Enter>  (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: <Enter>


  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:<Enter>
```

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 LABPROVIDER, EIGHT
     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                                              Pg: 1
Test list for LABPROVIDER, EIGHT
------------------------------------------------------------------------------
     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 thee 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//<Enter> (NO)

      1)  LABPATIENT5, SEVEN

(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:  <Enter>

Print/display microbiology results instead of defined lab tests ? NO//
<Enter> (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                                              Pg:1
List for: LABPROVIDER3, TEN
------------------------------------------------------------------------------
089-48-5948        LOC:1 TEST               Patient: LABPATIENT1, THREE
                            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
------------------------------------------------------------------------------
```

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//<Enter>
(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  VAMC                                        Pg:1
List for: LABPROVIDER3, TEN                                      PT GRP:1
------------------------------------------------------------------------------
SSN:416-40-5800       LOC:RENAL  CONSULT          Patient: LABPATIENT5, EIGHT
==============================================================================
SSN:340-05-2342       LOC:11W                  Patient: LABPATIENT5, NINE
                                    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
```

Example 3: Retrieval of Microbiology Results

```
Select Edit/print/display preselected lab tests Option: PR  Print/display
preselected lab tests

Print/display tests for a single patient or group ? NO// <Enter>  (NO)



 1)  LABPATIENT5, TEN                  (2)  LABPATIENT1, FOUR

(R)emove a patient (A)dd/edit patients       (T)ransfer list to  another user
(D)elete 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 <CR> to accept list: <Enter>

           Print/display microbiology results (excluding antibiotics)
                         instead of defined lab tests? NO// Y  (YES)
Start with Date TODAY// <Enter> SEP  8, 1994
Go    to   Date TODAY// 5 20 94 (MAY 20, 1994)

New page for each patient ? NO// <Enter>  (YES)
Select Print Device:  [Enter Print Device Here]



SEP  8, 1994  10:49   VAMC                                                Pg:
1
List for: LABPROVIDER2, FOUR
------------------------------------------------------------------------------
SSN:111-11-1111    LOC:2 EAST              Patient: LABPATIENT5, TEN
Date         Site/specimen                 Collection sample Accession
number
05/20/94 14:38 NASAL BONE                  SWAB              MICRO 93 6
   Tests: PARASITE EXAM
PARASITE RPT DATE:MAY 20, 1994             FINAL REPORT
------------------------------------------------------------------------------
==============================================================================
```

Example 4: To Print a User's Patient List (new functionality)

```
 Print/display tests for a single patient or group ? NO// <Enter>  (NO)
 1)  PATIENT,FIRST               (HEM)   2) PATIENT,SECOND  (ONC)

(R)emove a patient (A)dd/edit patients (T)ransfer list to  another user
(D)elete 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 <Enter> to accept list: S

Select Print Device:  [Enter Print Device Here]


SEP  8, 1994  11:02   VAMC                                          Pg: 1
Patient list for: LABPROVIDER2, FOUR
------------------------------------------------------------------------------
 1)  LABPATIENT5, TEN.             (2)  LABPATIENT1, FOUR
```

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: LABPROVIDER, ONE                  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: LABPROVIDER, ONE
================================================================================
                             PATHOLOGY REPORT
Laboratory: SLC                                      Accession No. SP90 3
--------------------------------------------------------------------------------
Gross description:

--------------------------------------------------------------------------------
                                                         (See next page)
LABPROVIDER4, ONE                                    vtn| Date MAR 19, 1990
--------------------------------------------------------------------------------
LABPATIENT6, ONE                                 SURGICAL PATHOLOGY Report
ID:000-00-0061   SEX:M DOB:5/22/86 AGE:4 LOC:PHRENOLOGY
                                               LABPROVIDER, ONE
```

```
------------------------------------------------------------------------------
     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:

------------------------------------------------------------------------------
                                                          (See next page)
LABPROVIDER4, ONE                                   vtn| Date MAR 19, 1990
------------------------------------------------------------------------------
LABPATIENT6, ONE                                    SURGICAL PATHOLOGY Report
ID:101-05-2286  SEX: M DOB:5/22/86 AGE:4 LOC:PHRENOLOGY
                                              LABPROVIDER, ONE




------------------------------------------------------------------------------
     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.

------------------------------------------------------------------------------
                                                          (See next page)
LABPROVIDER4, ONE                                   vtn| Date MAR 19, 1990
------------------------------------------------------------------------------
LABPATIENT6, ONE                                     SURGICAL PATHOLOGY
Report
ID:101-05-2286  SEX:M DOB:5/22/86 AGE:4 LOC:PHRENOLOGY
                                              LABPROVIDER, ONE
```

```
-------------------------------------------------------------------------------
     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.

-------------------------------------------------------------------------------
                                                          (See next page)
LABPROVIDER4, ONE                                   vtn| Date MAR 19, 1990
-------------------------------------------------------------------------------
LABPATIENT6, ONE                                     SURGICAL PATHOLOGY
Report
ID:101-05-2286  SEX:M DOB:5/22/86 AGE:4 LOC:PHRENOLOGY
                                              LABPROVIDER, ONE




-------------------------------------------------------------------------------
     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

-------------------------------------------------------------------------------
                                                          (End of report)
LABPROVIDER4, ONE                                   vtn| Date MAR 19, 1990
-------------------------------------------------------------------------------
LABPATIENT6, ONE                                     SURGICAL PATHOLOGY
Report
ID:101-05-2286  SEX:M DOB:5/22/86 AGE:4 LOC:PHRENOLOGY
                                              LABPROVIDER, ONE
```

SNOMED Field References [LRAPREF]

Descriptions

Option	Description
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: <Enter>
Select TITLE OF ARTICLE: <Enter>
Select MORPHOLOGY FIELD NAME: <Enter>
```

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: LABPROVIDER, SEVEN                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:  LABPROVIDER, SEVEN
==============================================================================
                     PATHOLOGY REPORT
Laboratory: R5ISC                               Accession No. SP88 22
------------------------------------------------------------------------------
Gross description:            Pathology Resident:  LABPROVIDER4, TWO
      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: LABPROVIDER, THREE                       dg : Date NOV 21, 1990
------------------------------------------------------------------------------
LABPATIENT, SEVEN                          SURGICAL PATHOLOGY Report
ID:000-00-0007   SEX:M  DOB:5/8/16  AGE:74  LOC: 1A
                              LABPROVIDER, SEVEN
```

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//  <Enter>

FULL NAME:  JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION

CITY OF PUBLICATION: CHICAGO// <Enter>

NLM CALL NUMBER:  J11248

NLM TITLE CONTROL NUMBER:  12398767

COMMENT:
   1>  <Enter>
```

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

Option	Description
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. **OLD NAME was Edit Pathology Report Parameters.**
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	

Option	Description
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.
AP Quality Assurance Reports	
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." **NOTE:** This data is not included in any display or print option other than Tissue Committee review cases.

Option	Description
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.

Option	Description
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.

Option	Description
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.
AFIP Registries	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 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 that 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// <Enter>  (NO)

OK to delete Frozen Section Description entries ? NO// <Enter>  (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//  <Enter>
EXPANSION:  PROSTATE GLAND TISSUE  Replace <Enter>
SCREEN:  AP SURG//  <Enter>
SPECIMEN DESCRIPTION:
      1>Specimen consists of * grams of prostate gland tissue.
EDIT Option:  <Enter>

Select LAB DESCRIPTIONS NAME: <Enter>
```

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 test 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// <Enter>
EXPANSION: AU PRE/POSTMORTEM CORRELATION - Diagnosis confirmed/verified
SCREEN: AP GENERAL
SPECIMEN DESCRIPTION:
  1> <Enter>

Select LAB DESCRIPTIONS NAME: <Enter>
```

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><Enter>
  6> Explanation for less than optimal/unsatisfactory specimen:
  7>   ( ) Scant cellularity
  8>   ( ) Poor fixation or preservation
  9>   ( ) etc.
 10><Enter>
EDIT Option: <Enter>

Select LAB DESCRIPTIONS NAME: <Enter>
```

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 label. 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://  <Enter>
REPORT HEADER 2:  Microscopic exam:  Replace  <Enter>
REPORT HEADER 3:  Frozen section diagnosis:// <Enter>
REPORT HEADER 4:  Diagnosis:// <Enter>
PRINT SNOMED/ICD CODES:  LOWER CASE//  <Enter>
GROSS DESCRIPTION SPACING:  DOUBLE//  <Enter>
LINES IN A LABEL:  7//  <Enter>
ACCESSION PREFIX:  SP//  <Enter>
PRINT SF-515 LINES:  YES//  <Enter>
NEW PG FOR SUPPLEMENTARY RPT: YES// NO  [New]
ASK TC CODES: YES// <Enter>
SNOMED & QA CODING:
1)**************************************************************************
2)**************************************************************************
3)<SPACE><Enter>
4)PLEASE CIRCLE ALL APPROPRIATE CODES & INDICATE A TOPOGRAPHY & MORPHOLOGY:
5)<Enter>
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><Enter><Enter>
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><Enter>
27)   0654001     AFIP consultation 0654004  Internal (intradepartmental)
28)<SPACE><Enter>
29)   0656  Outside case, slides returned
```

```
EDIT Option: <Enter>
```

[Edit pathology parameters (Example 1 cont'd)]

```
Select TOPOGRAPHY CATEGORY: <Enter>
Select MORPHOLOGY ENTRY: <Enter>
ASK FROZEN SECTION: YES// <Enter>
ASK SURG PATH DIAGNOSIS: YES// <Enter>
```

Example 2: Cytopathology

```
Select Supervisor, anat path Option: ER  Edit pathology parameters
Select LAB SECTION PRINT NAME: CY  CYTOPATHOLOGY
REPORT HEADER 1: Gross Description// <Enter>
REPORT HEADER 2: Microscopic description  Replace <Enter>
REPORT HEADER 3: <Enter>
REPORT HEADER 4: Diagnosis:// <Enter>
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// <Enter>
  SLIDE LABEL: SMEAR PREP// <Enter>
  PRINT NAME: SMEAR// ?
     Answer must be 1-9 characters in length.
  PRINT NAME: SMEAR// <Enter>
Select SLIDE LABEL: <Enter>
PRINT SNOMED/ICD CODES: LOWER CASE// <Enter>
GROSS DESCRIPTION SPACING: SINGLE// <Enter>
LINES IN A LABEL: 7// <Enter>
ACCESSION PREFIX: CY// <Enter>
PRINT SF-515 LINES: YES// <Enter>
NEW PG FOR SUPPLEMENTARY RPT: YES// <Enter>
ASK TC CODES: YES// <Enter>
SNOMED & TC CODING: <Enter>
13)                    09010 Unsatisfactory Specimen
14)<Enter>
15)              Also: _____________________________________
16)                    _____________________________________
17)<Enter>
18)Common procedures:  1149  Fine needle aspiration (FNA)
19)                    1143  Biopsy, needle (NB)
20)                    0654004 Internal consultation (intradepartmental)
21)                    0654001  AFIP consultation
EDIT Option:<Enter>
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// <Enter>
Select TOPOGRAPHY CATEGORY:  1Y010
            TOPOGRAPHY CATEGORY COMMENT: SYNOVIAL FLUID
      COMMENT: SYNOVIAL FLUID//<Enter>
Select TOPOGRAPHY CATEGORY:  2Y030
            TOPOGRAPHY CATEGORY COMMENT:  SPUTUM
      COMMENT: SPUTUM//<Enter>
Select TOPOGRAPHY CATEGORY:  2Y410
            TOPOGRAPHY CATEGORY COMMENT: BRONCHIAL MATERIAL
      COMMENT: BRONCHIAL MATERIAL//<Enter>
Select TOPOGRAPHY CATEGORY:  2Y610
            TOPOGRAPHY CATEGORY COMMENT: PLEURAL FLUID
      COMMENT: PLEURAL FLUID//<Enter>
Select TOPOGRAPHY CATEGORY:  3X110
            TOPOGRAPHY CATEGORY COMMENT: PERICARDIAL FLUID
      COMMENT: PERICARDIAL FLUID//<Enter>
Select TOPOGRAPHY CATEGORY:  6X210
            TOPOGRAPHY CATEGORY COMMENT: ESOPHAGEAL
      COMMENT: ESOPHAGEAL//<Enter>
Select TOPOGRAPHY CATEGORY:  6X310
            TOPOGRAPHY CATEGORY COMMENT: GASTRIC
      COMMENT: GASTRIC//<Enter>
Select TOPOGRAPHY CATEGORY:  6X940
            TOPOGRAPHY CATEGORY COMMENT: PERITONEAL FLUID
      COMMENT: PERITONEAL FLUID//<Enter>
Select TOPOGRAPHY CATEGORY:  7X100
            TOPOGRAPHY CATEGORY COMMENT: URINE
      COMMENT: URINE//<Enter>
Select TOPOGRAPHY CATEGORY:  8X330
            TOPOGRAPHY CATEGORY COMMENT: VAGINAL/CERIVICAL
      COMMENT: VAGINAL/CERVICAL//<Enter>
Select TOPOGRAPHY CATEGORY:  8X210
            TOPOGRAPHY CATEGORY COMMENT: VAGINAL
      COMMENT: VAGINAL//<Enter>
Select TOPOGRAPHY CATEGORY:  X1010
            TOPOGRAPHY CATEGORY COMMENT: CSF
      COMMENT: CSF//<Enter>
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: <Enter>
```

[Edit pathology parameters (Example 2 cont'd)]

```
Select MORPHOLOGY ENTRY: <Enter>
ASK CYTOPAH DIAGNOSIS: <Enter>
```

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 // <Enter>
 REPORT HEADER 2: MICROSCOPIC DESCRIPTION // <Enter>
 PRINT SNOMED/ICD CODES: // <Enter>
 GROSS DESCRIPTION SPACING: // <Enter>
 LINES IN A LABEL: // <Enter>
 ACCESSION PREFIX: CY// <Enter>
 PRINT SF-515 LINES: // <Enter>
 NEW PG FOR SUPPLEMENTARY RPT: YES// NO  [New]
 ASK TC CODES: // YES
 SNOMED & TC CODING:
  1><Enter>
Select TOPOGRAPHY CATEGORY: 7// <Enter>
  TOPOGRAPHY CATEGORY: 7// <Enter>
  COMMENT: GU// <Enter>
Select TOPOGRAPHY CATEGORY: <Enter>
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: <Enter>
```

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// <Enter>
REPORT HEADER 2: Microscopic Description  Replace <Enter>
REPORT HEADER 3: <Enter>
REPORT HEADER 4: Diagnosis:// <Enter>
PRINT SNOMED/ICD CODES: LOWER CASE// <Enter>
GROSS DESCRIPTION SPACING: <Enter>
LINES IN A LABEL: <Enter>
ACCESSION PREFIX: EM// <Enter>
PRINT SF-515 LINES: <Enter>
NEW PG FOR SUPPLEMENTARY RPT: YES
ASK TC CODES: YES
SNOMED & TC CODING:
  1><Enter>
Select TOPOGRAPHY CATEGORY: <Enter>
Select MORPHOLOGY ENTRY: <Enter>
ROUTINE PROCEDURE 1: 2// <Enter>
ROUTINE PROCEDURE 2: 5// <Enter>

ASK EM DIAGNOSIS: YES// <Enter>
```

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// <Enter>
REPORT HEADER 2: Anatomic Diagnoses// <Enter>
REPORT HEADER 3: <Enter>
REPORT HEADER 4: <Enter>
PRINT SNOMED/ICD CODES: LOWER CASE// <Enter>
GROSS DESCRIPTION SPACING: <Enter>
LINES IN A LABEL: <Enter>
ACCESSION PREFIX: A// <Enter>
PRINT SF-515 LINES: <Enter>
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// <Enter>
ASK TC CODES: <Enter>
Select GENERIC LABEL: PROSTATE// <Enter>
  GENERIC LABEL: PROSTATE// <Enter>
Select GENERIC LABEL: <Enter>
SNOMED & TC CODING:
  1><Enter>
Select TOPOGRAPHY CATEGORY: <Enter>
Select MORPHOLOGY ENTRY: <Enter>

Select Supervisor, anat path Option:<Enter>
```

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: <Enter>
   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 <Enter>
SNOMED CODE:  814032// <Enter>
ABBREVIATION:  MDA
Select SYNONYM:  MODERATELY DIFFERENTIATED ADENOCARCINOMA// <Enter>
Select TITLE OF ARTICLE: <Enter>
Select MORPHOLOGY FIELD NAME:  MDA  ADENOCARCINOMA, MODERATELY DIFFERENTIATED
814032
NAME:  ADENOCARCINOMA, MODERATELY DIFFERENTIATED  Replace  <Enter>
```

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// <Enter> 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    LABPATIENT1, FOUR 8762   1A   LABPROVIDER, THREE
```

Print Path 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!

NOTE: The Print Path Modifications [LRAPMOD] option was **modified** by the release of patch LR*5.2*248. This option will print audit information for any 'Supplementary Report' that was modified after its release.

Example: Print Pathology Report Modifications

```
Select Supervisor, anat path Option: MR  Print path modifications

               Print pathology report modifications

Select ANATOMIC PATHOLOGY section: SP  SURGICAL PATHOLOGY

Select Patient Name: LABPATIENT1, TEN    02-01-22   000-00-0110     NO
NSC VETERAN
LABPATIENT1, TEN ID: 000-00-011 Physician: LABPROVIDER4, THREE

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

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

Example: Print Pathology Report Modifications *continued*

```
------------------------------------------------------------------------------
     MEDICAL RECORD |                   SURGICAL PATHOLOGY               Pg 1
------------------------------------------------------------------------------
Submitted by: LABPROVIDER4, THREE             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: LABPROVIDER4, FOUR
==============================================================================
                              PATHOLOGY REPORT
Laboratory: VAMC                                      Accession No. SP 94 2
------------------------------------------------------------------------------
                               Pathology Resident: LABPROVIDER1, FIVE
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 LABUSER, TWO)
Date modified:AUG 27, 1994  17:19 typed by LABUSER, TWO    Glomerular
basement membranes are thickenedd and there is increased
    mesangial matrix.

Date modified:AUG 27, 1994  17:30 typed by LABUSER, TWO
    Glomerular basement membranes are thickenedd and there is increased
    mesangial matrix.  Also present are small prostatic infarts and foci
    of squamous metaplasia.
             ==========Text below appears on final report==========
    Glomerular basement membranes are thickenedd and there is increased
------------------------------------------------------------------------------
                                                              (See next page)
LABPROVIDER4, FOUR                                  ec | Date AUG 25, 1994
------------------------------------------------------------------------------

LABPATIENT1, TEN                                      STANDARD FORM 515
ID:00-00-0110  SEX:F    DOB:2/1/22   AGE:72      LOC:1 EAST
ADM:APR  8, 1993 DX:ACCIDENT                      LABPROVIDER4, THREE
```

Example: Print pathology report modifications *continued*

```
------------------------------------------------------------------------------
     MEDICAL RECORD |                   SURGICAL PATHOLOGY              Pg 2
------------------------------------------------------------------------------
                              PATHOLOGY REPORT
Laboratory: VAMC                                        Accession No. SP 94 2
------------------------------------------------------------------------------
    mesangial matrix.  Also present are small prostatic infarts and foci
    of squamous metaplasia.  Another small infarts 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
                              ***MODIFIED REPORT***
(Last modified: AUG 26, 1994  18:19 typed by LABUSER, FOUR)
Date modified: AUG 26, 1994  18:19 typed by LABUSER, FOUR
    This is another supplementary report.

            ==========Text below appears on final report==========

   This is another supplementary report.  When the supplementary report was
    released, this line was added to the 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









------------------------------------------------------------------------------
                                                            (End of report)
LABPROVIDER4, FOUR                                     ec | Date AUG 25, 1994
------------------------------------------------------------------------------

LABPATIENT1, TEN                                    STANDARD FORM 515
ID: 00-00-0110  SEX:M DOB:2/1/22     AGE:72       LOC:1 EAST
ADM:APR  8, 1993 DX:ACCIDENT                      LABPROVIDER4, THREE
```

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: <Enter>

Start with Date  TODAY// <Enter>
Go    to     Date  TODAY// 1 1   (JAN 01, 1988)
Select Print Device:  [Enter Print Device Here]



------------------------------------------------------------------------------
                      LABORATORY SERVICE R5ISC
NOV 22, 1990  08:26   SURGICAL PATHOLOGY TOPOGRAPHY COUNTS       PG:1
Topography  Count     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:

TC Codes	QA Codes
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// <Enter>  (YES)
Select Accession Number/Pt name:  5630 for 1990
LABPATIENT6, TWO.  ID: 000-00-0062
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: <Enter>

Select Accession Number/Pt name: <Enter>
```

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.

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//  <Enter> (YES)

Select Accession Number/Pt name: 63  for  1992
LABPATIENT6, THREE   ID: 000-00-0063

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: <Enter>

Select Accession Number/Pt name: <Enter>
```

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, and 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

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): <Enter>

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

LABPATIENT6, FOUR 0064   M    92   284-89  PROSTATE       SERS EXTERNAL REVIEW
LABPATIENT6, FIVE 0065   M    62    95-89  PROSTATE       SERS EXTERNAL REVIEW

LABPATIENT6, SIX  0066   M    61   205-89  COLON          SERS EXTERNAL REVIEW
LABPATIENT6, SEVEN0067   M    42    23-89  ESOPHAGUS      SERS EXTERNAL REVIEW
LABPATIENT6, EIGHT0068   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   LABPATIENT6, FOUR 0064M 92   PROSTATE            SERS EXTERNAL REVIEW
 95-89   LABPATIENT6, FIVE 0065  M    62   PROSTATE        SERS EXTERNAL REVIEW
205-89   LABPATIENT6, SIX  0066  M    61   COLON           SERS EXTERNAL REVIEW
 23-89   LABPATIENT6, SEVEN0067  M    42   ESOPHAGUS       SERS EXTERNAL REVIEW
518-89   LABPATIENT6, EIGHT0068  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  vamc                                        Pg: 4
                  SURGICAL PATHOLOGY CONSULTATIONS
------------------------------------------------------------------------------
LABPATIENT6, SEVEN                000-00-0067
      Organ/tissue:               Date rec'd: 01/04/89   Acc #:   23
      ESOPHAGUS
         SERS EXTERNAL REVIEW
         ACUTE INFLAMMATION
      CONSULTATION AFIP#2249480-1 Date: OCT 20, 1989
------------------------------------------------------------------------------
LABPATIENT6, FIVE                                 000-00-0065
      Organ/tissue:               Date rec'd: 01/09/89   Acc #:   95
      PROSTATE
         SERS EXTERNAL REVIEW
         HYPERPLASIA, GLANDULAR
------------------------------------------------------------------------------
LABPATIENT6, SIX                                            000-00-0066
      Organ/tissue:               Date rec'd: 01/13/89   Acc #:   205
      COLON
         SERS EXTERNAL REVIEW
         ADENOMATOUS POLYP
      CONSULTATION AFIP#2249395-1 Date: OCT 18, 1989
------------------------------------------------------------------------------
LABPATIENT6, FOUR                                           000-00-0064
      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
------------------------------------------------------------------------------
LABPATIENT6, NINE                                           000-00-0069
      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]
```

```
OCT 16, 1989   11:45                        VAMC            Pg 1
ANATOMIC PATHOLOGY
CYTOPATHOLOGY QA from JAN  1, 1989 to JAN 31, 1989
------------------------------------------------------------------------------
LABPATIENT6, TEN              SSN:000-00-0610 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// <Enter> (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): <Enter>
Start with Date TODAY// <Enter> 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.

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//<Enter>

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// <Enter> (NO)

Select AP quality assurance Option: <Enter>
```

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
 to print following search ? NO// <Enter>  (NO)

---------------------------------------------------------------------------
 Start with Date TODAY// <Enter> 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.

```
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
LABPATIENT7, ONE  0071  M    31    435-92   LYMPH NODE OF NECK   FROZEN SECTION
                                             PIRIFORM RECESS      FROZEN SECTION
LABPATIENT7, TWO  0072  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  LABPATIENT7, ONE   0071  M     31     LYMPH NODE OF NECK   FROZEN SECTION
443-92  LABPATIENT7, TWO   0072  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: LABPROVIDER, SEVEN           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:  LABPROVIDER, SEVEN
==============================================================================
                              PATHOLOGY REPORT
Laboratory: R5ISC                                      Accession No. S92 435
------------------------------------------------------------------------------
GROSS DESCRIPTION:            Pathology Resident: LABRPOVIDER4, FIVE

      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.
      LABPROVIDER4, SIX, hematopathologist, Southwestern University, concurs
with the
      diagnosis.
------------------------------------------------------------------------------
                                                                   (End of
report)
LABPROVIDER, SEVEN                                     rg: Date MAR 17,.1992
------------------------------------------------------------------------------
LABPATIENT7, ONE0071                              SURGICAL PATHOLOGY Report
ID:000-00-0071  SEX:M  DOB:5/8/59  AGE: 31 LOC: 1A
                                        LABPROVIDER, SEVEN
```

Print path gross/micr/dx/fr.sect 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.

NOTE: The Print Path Micro Modifications [LRAPQAM] option has been **modified** to include 'Supplementary Report' changes with the release of patch LR*5.2*248. Use the [LRAPQAM] option to print 'Surgical Pathology Reports' that have microscopic descriptions and/or 'Supplementary' reports modified from one date to another.

Example: 'Surgical Pathology Report'

```
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]
```

Example: 'Surgical Pathology' report *continued*

```
------------------------------------------------------------------------------
   MEDICAL RECORD  :                          SURGICAL PATHOLOGY       Pg 1
------------------------------------------------------------------------------
Submitted by:  LABUSER, FIVE                  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)
LABPROVIDER4, SEVEN                              nr  : Date JUN 7, 1990
------------------------------------------------------------------------------
LABPATIENT7, THREE                            SURGICAL PATHOLOGY Report
ID:000-00-0067  SEX:M  DOB:7/14/19  AGE: 73 LOC: MHC
                                                    LABPROVIDER, SEVEN
```

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// <Enter>
              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// <Enter>  (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           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
LABPATIENT7, ONE  0071    M    31    435-89  VERTEBRA      CARCINOMA, METASTATIC
LABPATIENT7, TWO  0072    M    58    443-89  KNEE JOINT    CARCINOMA, METASTATIC

------------------------------------------------------------------------------


DEC 27, 1989  07:05                          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   LABPATIENT7, TWO  0072  M    58   11/01   KNEE JOINT     CARCINOMA,MET
435-89   LABPATIENT7, ONE  0071  M    31   11/28   VERTEBRA       CARCINOMA,MET

------------------------------------------------------------------------------


DEC 27, 1989  07:05                          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.

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// <Enter>
              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// <Enter>  (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// <Enter>
Select Print Device:  [Enter Print Device Here]
```

```
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: LABPROVIDER4, EIGHT
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: LABPROVIDER4, NINE.
F1   FROZEN SECTION- QA review-no disagreement
2423  05/04/90
2488  05/09/90
                  Number of cases:  2
                  Total cases:            2
Pathologist: LABPROVIDER4, TEN
M1   MALIGNANCY QA REVIEW- minor disagreement (no Dx or Rx change)
2559  05/11/90
                  Number of cases:  2
                  Total cases:            2
Pathologist: LABPROVIDER5, ONE
F1   FROZEN SECTION- QA review-no disagreement
2338  05/01/90
                  Number of cases:  2
                  Total cases:            2
Pathologist: LABPROVIDER5, ONE
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   VAMC                                    Pg: 1
QA CODES for AUTOPSY From: OCT  1, 1991  To: OCT 31, 1991
Acc #     Date      Pathologist
------------------------------------------------------------------------------

A1   AU PRE/POSTMORTEM CORRELATION - Diagnosis confirmed/verified
122       10/21/91  LABPROVIDER, THREE
128       10/31/91  LABPROVIDER5, TWO
Total QA Codes: 2

A4   AU PRE/POSTMORTEM CORRELATION - major unsuspected/additional Dx
115       10/11/91  LABPROVIDER, THREE
126       10/25/91  LABPROVIDER, THREE
Total QA Codes: 2

D1   DEATH CLINICAL FACTORS- unremitting course of disease
122       10/21/91  LABPROVIDER, THREE
128       10/31/91  LABPROVIDER5, TWO
Total QA Codes: 2

D3   DEATH CLINICAL FACTORS- complication or therapeutic proc.
126       10/25/91  LABPROVIDER, THREE
Total QA Codes: 1

D4   DEATH CLINICAL FACTORS- unrecognized diagnosis w/ premortem evidence
115       10/11/91  LABPROVIDER, THREE
126       10/25/91  LABPROVIDER, THREE
Total QA Codes: 2

D8   DEATH - NO PRONOUNCEMENT DOCUMENTED
124       10/23/91  LABPROVIDER5, THREE
128       10/31/91  LABPROVIDER5, TWO
Total QA Codes: 2

Total cases reviewed: 5
```

```
DEC  3, 1992  11:57    VAMC                                              Pg: 2
QA CODES by SERVICE, TREATING SPECIALTY and CLINICIAN
From OCT  1, 1991 To OCT 31, 1991
------------------------------------------------------------------------------

A1   AU PRE/POSTMORTEM CORRELATION - Diagnosis confirmed/verified

     SERVICE: MEDICINE
       TREATING SPECIALTY: HEMATOLOGY/ONCOLOGY
          CLINICIAN: LABPROVIDER5, FOUR
             Autopsy: 128  Date: 10/31/91
       TREATING SPECIALTY: INFECTIOUS DISEASE
          CLINICIAN: LABPROVIDER5, FIVE
             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: LABPROVIDER5, SIX
             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: LABPROVIDER5, FOUR
             Autopsy: 128  Date: 10/31/91
       TREATING SPECIALTY: INFECTIOUS DISEASE
          CLINICIAN: LABPROVIDER5, FIVE
             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: LABPROVIDER5, SIX
             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: LABPROVIDER5, SIX
             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: LABPROVIDER5, FOUR
             Autopsy: 128  Date: 10/31/91
       TREATING SPECIALTY: INFECTIOUS DISEASE
          CLINICIAN: LABPROVIDER5, FIVE
             Autopsy: 124  Date: 10/23/91
Total QA Codes for D8: 2




DEC  3, 1992  11:58    VAMC                                          Pg: 3
AUTOPSY DATA REVIEW (OCT  1, 1991-OCT 31, 1991)

                                  |----------In-patient-------------|
Treating Specialty                | #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: <Enter>
```

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// <Enter>  (NO)
 Start with Date TODAY// <Enter> 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  LABPATIENT7, FOUR                    000-00-0074
     LIVER
          CIRRHOSIS, MICRONODULAR
-------------------------------------------------------------------
    7-91  LABPATIENT7, FIVE                    000-00-0075
     APPENDIX
          INFLAMMATION, ACUTE FIBRINOUS
     SKIN
          POLYP, FIBROEPITHELIAL
-------------------------------------------------------------------
    1-92  LABPATIENT7, SIX                     000-00-0076
     RIGHT LUNG
          CARCINOMA, SQ CELL
          INFLAMMATION, GRANULOMATOUS
-------------------------------------------------------------------
    5-92  LABPATIENT, EIGHT                    000-00-0008
     LYMPH NODE OF NECK
          HODGKIN'S DISEASE, NODULAR SCLEROSIS
-------------------------------------------------------------------
    6-92  LABPATIENT7, SEVEN                   000-00-0077
     SKIN OF FACE
          WOUND, ABRADED
     TOE
          WOUND, CONTUSED
     AUDITORY CANAL, OSSEOUS PORTION
          INSPISSATED CERUMEN
-------------------------------------------------------------------
   10-92  LABPATIENT7, EIGHT                   000-00-0078
     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//  <Enter>
```

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 (#62.5).

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 are turned on for that area.

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): <Enter>

 Start with Date TODAY// <Enter> MAR 19, 1992
 Go    to   Date TODAY// 1 1  (JAN 01, 1992)

 Also print cumulative path data summaries ? NO// <Enter>  (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
LABPATIENT7, NINE                    000-00-0079        9  MAR  7, 1992
LABPATIENT2, TEN                     000-00-0210        2  JAN  7, 1992
LABPATIENT7, SIX                     000-00-0076        1  JAN  7, 1992
LABPATIENT, EIGHT                    000-00-0008        4  JAN  7, 1992
LABPATIENT, EIGHT                    000-00-0008        5  JAN  8, 1992
LABPATIENT7, TEN                     000-00-0710        3  JAN  7, 1992
LABPATIENT7, EIGHT                   000-00-0078       10  MAR  7, 1992
LABPATIENT8, ONE                     000-00-0081        7  JAN 13, 1992
LABPATIENT7, SEVEN                   000-00-0077        6  JAN 13, 1992

TC Code: NONE
LABPATIENT, SIX                      00-00-0006         8  JAN 14, 1992
LABPATIENT6, ONE                     00-00-0061        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
LABPATIENT8, TWO.                  000-00-0082     12  MAR  8, 1992
LABPATIENT8, THREE                 000-00-0083     13  MAR  8, 1992
LABPATIENT8, FOUR                  000-42-0084     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
```

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// <Enter> NO PROBLEM
 Select a number from 0 to 9 (Choice# 2): <Enter>

 Start with Date TODAY//  <Enter> MAR 26, 1992
 Go    to   Date TODAY// 1 1  (JAN 01, 1992)

 Also print cumulative path data summaries ? NO// <Enter>  (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
 LABPATIENT8, TEN               000000810          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// <Enter> NO PROBLEM
Select a number from 0 to 9 (Choice# 2): <Enter>

Start with Date TODAY// <Enter> MAR 26, 1992
Go    to   Date TODAY// 1 1  (JAN 01, 1992)

 Also print cumulative path data summaries ? NO// <Enter>  (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
 LABPATIENT, EIGHT                   000000008         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 **<Enter>** 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 LABPATIENT3, EIGHT          0114P  ec   LABPROVIDER5, SEVEN

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
```

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// <Enter> DEC  3, 1992
Identify cases exceeding turnaround time limit ? NO// <Enter>  (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 LABPATIENT8, SIX       0086   lab                 COUGAR
    1 F 05/11/92 LABPATIENT8, SEVEN     0087
    1 F 08/24/92 LABPATIENT2, FIVE      0025   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:  Supervisor, 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
 LABPATIENT, SIX  ID: 00-00-0006
 File: REFERRAL PATIENT
 Move accession to
 Select Patient Name: LABPATIENT, SIX         04-27-25     0000000006
 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: LABPATIENT, SIX         04-27-25     0000000006
 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// <Enter> (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
------------------------------------------------------------------------------
LABPATIENT1, TWO                        JUN 18, 1962        000-00-0012
     POW  PERIOD WORLD WAR II - EUROPE
Specimen date: 02/01/94                Accession number: 4
------------------------------------------------------------------------------
LABPATIENT1, THREE                     APR 27, 1925         000-00-0013
     POW  PERIOD KOREAN
Specimen date: 03/31/94                Accession number: 17
Specimen date: 03/18/94                Accession number: 14
Specimen date: 02/24/94                Accession number: 6
------------------------------------------------------------------------------
```

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// <Enter> 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
------------------------------------------------------------------------------
LABPATIENT1, THREE                      APR 27, 1925         000-00-0013
     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: LABPATIENT1, THREE          04-27-58
089485948
NAME: LABPATIENT1, THREE // <Enter>
SEX: MALE// <Enter>XXXXXXXX
DOB: 04/27/58// <Enter>
MARITAL STATUS: <Enter>
RELIGION: <Enter>
IDENTIFIER: 089485948// <Enter>
REFERRAL SOURCE: <Enter>
PROVIDER: <Enter>
STREET ADDRESS: <Enter>
STREET ADDRESS 2: <Enter>
STREET ADDRESS 3: <Enter>
CITY: <Enter>
STATE: <Enter>
ZIP CODE: <Enter>
PHONE: <Enter>
OFFICE PHONE: <Enter>
PHONE #3: <Enter>
PHONE #4: <Enter>
DATE OF DEATH: <Enter>
```

Verify/Release Menu, Anat Path [LRAPVR]

Descriptions

Option	Description
Verify/Release Reports, Anat Path	Allows displaying and printing of reports after they are verified by the pathologist. **Note:** The report release prompt has been changed to a yes/no question.
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, persons outside the laboratory can view the information with the necessary access. The information can be extracted either by the Health Summary software or the [LRAPSPCUM], [LRAPCYCUM], [LRAPEMCUM] options in the Clinician options, anat path [LRAPMD] 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.

NOTE: The Verify/Release Reports, Anat Path [LRAPR] option was **modified** with the release of patch LR*5.2*248. The REPORT RELEASE DATE/TIME prompt has been changed to a YES/NO question.

Changes to the Verify/Release Reports, Anat [LRAPR] option are indicated in the shaded areas of the following example.

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: SUR  SURGICAL PATHOLOGY

                     SURGICAL PATHOLOGY (SUR)

Data entry for 1994 ? YES//<Enter>   (YES)

Select Accession Number/Pt name: 7  for 1994
LABPATIENT1, TEN  ID: 000-00-0110

Release report? NO// YES<Enter>

Report released...

Select Accession Number/Pt name:<Enter>
```

NOTE: If an attempt is made to release a report that has already been released, the following is displayed.

```
Report released JUN 26, 1994@16:52:57 by LABPROVIDER5, EIGHT
```

```
Select Accession Number/Pt name:
```

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// <Enter>  (NO)
Log book year:  1994 OK ? YES// <Enter>  (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  LABPATIENT1, TEN     0110  1 EAST   LABPROVIDER2, ONE;
                                                  LABPROVIDER1, FIVE
Date specimen taken:08/25/94         Entered  by: LABUSER, TWO
                                     Released by: LABUSER, SIX
```

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, Date Report Completed field (#.03) and Release Report field (#.11) 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

NOTE: The Verify/Release Reports, Anat Path [LRAPR] option has been **modified** with the release of patch LR*5.2*248. The "AUTOPSY RELEASE DATE/TIME" prompt has been changed to YES/NO question.

Changes made in the Verify/Release Reports, Anat Path [LRAPR] option are indicated in the shaded areas of the following example.

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//<Enter>   (YES)

Select Accession Number/Pt name: 5 for 1992
LABPATIENT, FOUR  ID: 000-00-0004

Release report? NO// YES<Enter>

Report released...

Select Accession Number/Pt name:<Enter>
```

NOTE: For Autopsy, it may be necessary to unrelease a report. This occurs when a Provisional Anatomical Diagnosis was verified/released for viewing by the clinicicians but the pathologist does not want the final report accessible to the clinicians until that portion has once again been verified/released. Therefore, it must be unreleased prior to entry of the Final Anatomical Diagnosis information. Since there is no chance for adverse patient outcome, this was done prior to the release of LR*5.2*248 by using the "@" key at the "AUTOPSY RELEASE DATE/TIME" prompt. With the release of patch LR*5.2*248, this was replaced by a YES/NO question as follows:

```
Select Anatomic pathology Option: V  Verify/release menu, anat path

   RR     Verify/release reports, anat path
   RS     Supplementary report release, anat path
   LU     List of unverified pathology reports

Select Verify/release menu, anat path Option: RR  Verify/release reports, anat path
                            RELEASE PATHOLOGY REPORTS

Select ANATOMIC PATHOLOGY SECTION: AU  AUTOPSY

                     AUTOPSY (AU)

Data entry for 1992 ? YES// <Enter>   (YES)

Select Accession Number/Pt name: 1  for 1992
LABPATIENT8, EIGHT  ID: 000-00-0088

Report released SEP 18, 1992@13:11:20 by LABPROVIDER5, NINE
Unrelease report? NO// YES <Enter>
Report unreleased...
```

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// <Enter>  (YES)

Select Accession Number/Pt name: 1  for  1990
LABPATIENT8, NINE  ID: 000-00-0089
Specimen(s):
SKIN

Select SUPPLEMENTARY REPORT DATE:1-7-1990@10:00:00// <Enter> JAN 7,1990
@10:00
RELEASE SUPPLEMENTARY REPORT ? NO// Y  (YES)

Select Accession Number/Pt name: <Enter>
```

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// <Enter>
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                  LABPATIENT8, TEN               000-00-0810
08/16/90      5                  LABPATIENT, NINE               000-00-0008
```

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// <Enter> SEP 24, 1990
Go    to   Date TODAY// <Enter> 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        LABPATIENT8, NINE             000-00-0089
```

Clinician Options, Anat Path [LRAPMD]

Descriptions

Option	Description
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.

Option	Description
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.

Display Surg Path Reports for a Patient [LRAPSPCUM]

Display Cytopath Reports for a Patient [LRAPCYCUM]

Display EM Reports for a Patient [LRAPEMCUM]

These options 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 Print Surgical Pathology Report for a Patient [LRAPSPSGL] or other print options.

HINTS:

1. Display Cytopath Reports for a Patient [LRAPCYCUM] option and Display EM Reports for a Patient [LRAPEMCUM] option work essentially the same as this option.

2. The "Date Spec Taken" listed at the top of this report has also been inserted after the "Microscopic exam/diagnosis" heading to prevent confusion if the report is more than one page in length.

Example:

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

               SURGICAL PATHOLOGY PATIENT REPORT(S) DISPLAY

Select Patient Name: LABPATIENT1, TEN     02-01-22   000000110    NO   NSC
VETERAN
ARDEN,TOM ID: 241-22-0000 Physician: LABPROVIDER5, TEN

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: LABPROVIDER3, NINE
PATIENT LOCATION: 1 EAST// <Enter>

Is this the patient ? YES// <Enter>  (YES)
```

```
Date Spec taken: AUG 25, 1994         Pathologist: LABPROVIDER1, FIVE
Date Spec rec'd: AUG 25, 1994  19:41  Resident:
Date  completed: AUG 26, 1994         Accession #: 7
Submitted by: LABPROVIDER2, ONE    Practitioner: LABPROVIDER2, ONE
------------------------------------------------------------------------------
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: LABPROVIDER2, ONE
Date Spec rec'd: AUG 25, 1994  19:36  Resident:
REPORT INCOMPLETE                     Accession #: 6
Submitted by: LABPROVIDER1, FIVE        Practitioner: LABPROVIDER1, FIVE
------------------------------------------------------------------------------
Report not verified


Date Spec taken: AUG 24, 1994         Pathologist: LABPROVIDER1, SEVEN
Date Spec rec'd: AUG 24, 1994  10:37  Resident: LABPROVIDER1, FIVE
Date  completed: AUG 25, 1994         Accession #: 2
Submitted by: LABPROVIDER1, SEVEN     Practitioner: LABPROVIDER1, SEVEN
------------------------------------------------------------------------------
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 CASUGAY,ELSIE)
 Glomerular basement membranes are thickenedd and there is increased
 mesangial matrix. Also present are small prostatic infarts and foci of
 squamous metaplasia. Another small infarts 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
```

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 [LRAPCYSGL]

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 [LRAPCYSGL] 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: LABPATIENT1, FOUR     02-01-12   0000000014
 NSC VETERAN

LABPATIENT1, FOUR ID: 000-00-0014    Physician: LABPROVIDER2, EIGHT
AGE: 77  DATE OF BIRTH: FEB  1, 1912
PATIENT LOCATION: CARDIOLOGY// <Enter>

Specimen(s       Count #   Accession #    Date
                 ( 1)        9        MAR 28, 1990 not verified
SKIN
                 ( 2)        21       NOV  8, 1989
                 ( 3)        20       NOV  7, 1989 not verified
SKIN
                 ( 4)        12       AUG  1, 1989
TOENAIL
More accessions ? NO//  <Enter> (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: LABPROVIDER1, TWO            Date obtained: NOV  8, 1989
------------------------------------------------------------------------------
Specimen (Received NOV  8, 1989  13:31):
------------------------------------------------------------------------------
Brief Clinical History:
------------------------------------------------------------------------------
Preoperative Diagnosis:
------------------------------------------------------------------------------
Operative Findings:
------------------------------------------------------------------------------
Postoperative Diagnosis:
                        Surgeon/physician: LABPROVIDER2, EIGHT
==============================================================================
                               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                                   (End of report)
LABPROVIDER, ONE                                        rg | Date NOV  8,
1989
------------------------------------------------------------------------------
LABPATIENT1, FOUR                          WORK COPY ONLY !!
ID:000-00-0014  SEX:M DOB:2/1/12 AGE:77 LOC:CARDIOLOGY
                                              LABPROVIDER2, EIGHT
```

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: LABPATIENT1, THREE      04-27-25     000000013     SC
VETERAN

LABPATIENT1, THREE ID: 000-00-0013 Physician: LABPROVIDER, EIGHT

AGE: 68  DATE OF BIRTH: APR 27, 1925
PATIENT LOCATION: 1 TEST// <Enter>

Is this the patient ? YES//  <Enter> (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: <Enter>
```

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: LABPATIENT9, ONE     04-27-25     000000091     SC
VETERAN

LABPATIENT9, ONE ID: 000-00-0091       Physician: LABPROVIDER, EIGHT

AGE: 68  DATE OF BIRTH: APR 27, 1925
PATIENT LOCATION: 1 TEST// <Enter>
Is this the patient ? YES// <Enter>  (YES)

Another patient: ? NO// Y  (YES)

Select Patient Name: LABPATIENT9, TWO     05-23-52     000000092P     NSC
VETERAN

 Pat Info: VERY SICK
LABPATIENT9, TWO ID: 000-00-0092P Physician: LABPROVIDER6, ONE

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: LABPROVIDER6, ONE
PATIENT LOCATION: PSYCH// <Enter>
Is this the patient ? YES// <Enter>  (YES)

Another patient: ? NO// N  (NO)
Select Print Device:  [Enter Print Device Here]
```

```
APR 18, 1994  10:28  VAMC                              Pg: 1
ANATOMIC PATHOLOGY
------------------------------------------------------------------------------
LABPATIENT9, TWO              SSN:00-00-0092   PDOB: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
------------------------------------------------------------------------------
LABPATIENT1, THREE                    SSN:000-00-0013 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
```

```
APR 18, 1994  10:28    VAMC                              Pg: 2
ANATOMIC PATHOLOGY
------------------------------------------------------------------------------
LABPATIENT1, THREE                   SSN:000-00-0013 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    VAMC                              Pg:    3
ANATOMIC PATHOLOGY
------------------------------------------------------------------------------
LABPATIENT1, THREE                   SSN:000-00-0013 DOB:APR 27, 1925

                              ELECTRON MICROSCOPY
     Organ/tissue:       Date rec'd: 12/17/91      Acc #:    1
     Report not verified.
```

Autopsy Protocol/Supplementary Report [LRAPAUPT]

NOTE: The Autopsy Protocol report [LRAPAUPT] option has been **modified** with the release of patch LR*5.2*248. The "Autopsy Protocol Reports" FOOTER has been reformatted to include new information. The final page HEADER has been reformatted for better readability.

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: LABPATIENT, FOUR       12-18-25     000000004     NSC
VETERAN
 LABPATIENT, FOUR ID: 000-00-0004 Physician: LABPROVIDER, THREE


                                  DIED DEC  1, 1992

Autopsy performed: DEC  1, 1992  Acc # 5
Select Print Device:  [Enter Print Device Here]
```

Example: Autopsy Protocol Report

NOTE: The "Autopsy Protocol Report" FOOTER has been modified to include the **new** Physician and Patient labels to clearly distinguish between the patient and physician names.

The shaded areas in the following example display changes made to the footer:

```
------------------------------------------------------------------------------
     CLINICAL RECORD |                  AUTOPSY PROTOCOL               Pg 1
------------------------------------------------------------------------------
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: LABPROVIDER, THREE                wty| Date DEC  1, 1992
------------------------------------------------------------------------------
DALLAS CIOFO                                                AUTOPSY PROTOCOL
Patient: LABPATIENT, FOUR          000-00-0004 SEX:M        DOB:DEC 18, 1992
Bon-AHMED/OPC          Physician: LABPROVIDER6, TWO         AGE AT DEATH: 75
```

NOTE: The Autopsy Protocol/Supplementary report [LRAPAUPT] option has been **modified** with the release of patch LR*5.2*248. The "AUTOPSY PROTOCOL REPORT" final page header and footer were reformatted to allow for better readability. The report can be generated by using the [LRAPAUPT] option.

The shaded areas in the following example display the changes made in the final page header and footer:

```
DEC 2, 1992 07:49       DALLAS CIOFO                                    Pg:2
ANATOMIC PATHOLOGY
------------------------------------------------------------------------------
LABPATIENT, FOUR        000-00-0004       DOB:DEC 18, 1925
Acc #:5                 AUTOPSY DATA      Age: 66
Date/time Died                            Date/time of Autopsy
DEC  1, 1992 1700       FULL AUTOPSY      DEC  1, 1992 1801
Resident: LABPROVIDER6, NINE              Senior: LABPROVIDER, THREE
```

```
------------------------------------------------------------------------------

Pathologist: LABPROVIDER, THREE                          wty| Date DEC  2,
1992
------------------------------------------------------------------------------
DALLAS CIOFO                                             AUTOPSY PROTOCOL
Patient: LABPATIENT, FOUR     000-00-0004       SEX:M    DOB: DEC 18, 1925
MEDICINE                Physician:  LABPROVIDER6, TWO    AGE AT DEATH: 66
```

Workload, Anat Path [LRAPW]

Descriptions

Option	Description
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//  <Enter>

Select Accession Number: 11  for 1993

Date/time slides examined: NOW//<Enter> (APR 1,1993 15:09)   OK? YES//
<Enter> (YES)

LABPAIENT1, FOUR 0014 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: <Enter>
```

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: LABPROVIDER, EIGHT                        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: LABPROVIDER, EIGHT          INSTITUTION: REGION 5
  MAJOR SECTION: SURGICAL PATHOLOGY     LAB SUBSECTION: SURGICAL PATHOLOGY
  WORK AREA: SURGICAL PATHOLOGY
 TEST: EXTENSIVE GROSS SURGICAL         TECHNOLOGIST: LABPROVIDER, EIGHT
  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// <Enter>  (NO)

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

 Select Accession Number: 8  for 1992
 Date/time prints made: NOW// <Enter> (JAN 13, 1992@10:40) OK ? YES//
<Enter>(YES)

LABPATIENT1, TWO 0012 Acc #: 8 Date: JAN 13, 1992


               GRIDS    GRIDS   PRINTS  LAST DATE/TIME      LAST DATE/TIME
     BLOCK ID PREPARED SCANNED   MADE       SCANNED           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// <Enter>  (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// <Enter> (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// <Enter> (JAN 13, 1992@10:40)

 TOTAL NUMBER of prints made:14
 Select *BLOCK ID#: <Enter>
LABPATIENT1, TWO 0012   Acc #: 8 Date: JAN 13, 1992


               GRIDS    GRIDS   PRINTS  LAST DATE/TIME      LAST DATE/TIME
    BLOCK ID PREPARED SCANNED   MADE       SCANNED           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: <Enter>
```

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 NIGHTY] option is run.

```
Select EM Accession Number for  1992: 8

TEST: EM PRINT/ENLARGEMENT              URGENCY OF TEST: WKLD
  TECHNOLOGIST: LABPROVIDER6, THREE     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: LABPROVIDER6, THREE
  INSTITUTION: HINES, IL                MAJOR SECTION: EM
  LAB SUBSECTION: EM                    WORK AREA: EM


Select EM Accession Number for  1992: <Enter>

Select EM Date: <Enter>
```

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// <Enter>  ( 1991)  1991

 Select Accession Number: 11  for 1991
LABPATIENT1, EIGHT  ID: 000-00-0018

Date/time Gross Description/Cutting: NOW// <Enter> (DEC 31, 1991@07:22)
OK ? YES// <Enter>
 LABPATIENT1, EIGHT  0018 Acc #: 11 Date: DEC 31, 1991
                                 Date  Gross Description/Cutting  Type
 STOMACH                       DEC 31, 1991@07:22

 Data displayed ok ? NO// <Enter>  (NO)
 Select SPECIMEN: STOMACH// <Enter>
  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 // <Enter>

Select SPECIMEN: LABPATIENT1, EIGHT 0018  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: <Enter>
```

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: LABPATIENT, ONE      08-08-48    000000001         NON-
VETERAN
LABPATIENT, ONE ID:000-00-0001 Physician: LABPROVIDER2, EIGHT

DIED JUL 27, 1990

Autopsy performed: JUL 28, 1990 08:00  Acc # 2

Select PATIENT NAME: <Enter>

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// <Enter> (YES)

Save protocol list for reprinting ? NO// <Enter> (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,: <Enter>
```

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.

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.
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.
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 files.
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 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.
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) that 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.
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.
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	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.

VA FileMan	Dl
MailMan	XM
Sign-on Security	XU
Menu Management	XQ
Tools	XT
Device Handling	ZIS
Task Management	ZTM

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.

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	A device for connecting a terminal to a telephone line, allowing it to communicate with another modem. Modems include the following types. Direct Connect —The modem is directly hooked into the phone line. Acoustic—The modem is connected to the telephone through the handset. Auto Answer—When it detects a ring signal, the modem will "answer the phone." Auto Dial—The modem, upon command from the terminal or the computer, will dial another modem.
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

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).

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).
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.
Terminal	See CRT. May be either a printer or CRT/monitor/visual display terminal.
Titling	Methods of displaying titles on microfiche. - Normal and reverse polarity. - By title segments or portion of segments. - Multiple number and variable size of characters by title segments.
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 that 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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APPENDIX A
ANATOMIC PATHOLOGY USER MANUAL NOTES FOR PATCH LR*5.2*72

Appendix A

Anatomic Pathology User Manual Notes for Patch LR*5.2*72

This section of the AP manual contains a list of files, fields, new options, and options changes created by the release of patch LR*5.2*72.

Patch LR*5.2*72 enhancements allow a facility to operate Anatomic Pathology and Blood Bank modules in a multidivisional mode. All data is resident in a single primary Laboratory database, but is now identifiable by division. For those sites that are not multidivisional, but wish to have multiple accession areas in Anatomic Pathology, the changes to accommodate multidivisional functionality will also provide this functionality. A few additional changes unrelated to multidivisional functionality have also been included.

This appendix includes **only portions** of the Release Notes and Installation Guide. For additional details, including post-installation instructions for the Laboratory Information Manager regarding necessary file changes which apply to all types of facilities using the Anatomic Pathology software, consult the Laboratory LR*5.2*72 Patch Release Notes and Installation Guide.

Overview of Multidivisional Functionality

In order to accommodate multidivisional functionality, it is necessary to clearly identify the primary site as defined by VA FileMan, the associated divisions for which data is being entered and accessed as defined in the INSTITUTION file (#4) and the associated divisions to which individual users may be assigned as defined by the NEW PERSON file (#200), DIVISION field (#16). Based on the data dictionaries, the primary site is assigned a numeric code (3 digits) and the associated divisions are defined based on suffixes attached to that numeric code.

To minimize confusion, the term institution is used in conjunction with the word primary to indicate the parent facility at which the software and the database reside, i.e. the one with the straight numeric in INSTITUTION file (#4). The other facilities are referred to as divisions and will have a suffix appended to the numeric portion for their entry in the INSTITUTION file (#4).

For purposes of reports and other items with medicolegal implications, the name of the primary institution will be utilized; however, reference to the specific division will be included whenever possible and appropriate. For the pathology reports and the microscopic slide labels, the name of the primary institution will be used and will not reflect the division.

Whenever possible, the accession area or division to which the user is currently assigned is displayed to minimize confusion for those users who may be assigned to more than one division. For Anatomic Pathology, this functionality is utilized in conjunction with a new variable LRDICS which is called by many routines.

Because searches of data in LAB DATA file (#63) are done by accession area, and access to the accession area is limited by the DUZ(2), it will be necessary for the pathologists to be assigned to all of the divisions in order for them to have access to search all of the AP data; however this will **not** be necessary for the clinicians since the clinicians menu options allow the clinicians to access Anatomic Pathology reports for a patient, regardless of the division of the accession area for the specimen.

Anatomic Pathology Data Dictionary and Functionality Changes

1. The name and the input transform for LAB DATA file (#63), AUTOPSY ACC # field (#14) were **changed** from a numeric field to a free text field (5-15 characters) with a specific format determined by the input transform. The AUTOPSY ACC # field (#14) now includes the abbreviation for the accession area, concatenated with the year of the accession, concatenated with the accession number. This accommodates multidivisional functionality.

2. The name and the input transform in LAB DATA file (#63), EM subfile (#63.02), EM ACC # field (#.06) were **changed** from a numeric field to a free text field (5-15 characters) with a specific format determined by the input transform. The EM subfile (#63.02), EM ACC # field (#.06) now includes the abbreviation for the accession area, concatenated with the year of the accession, concatenated with the accession number. This accommodates both multiple accession areas within the "EM" subscript in a single division and multidivisional functionality.

3. The name and the input transform in LAB DATA file (#63), SURGICAL PATHOLOGY subfile (#63.08), SURGICAL PATH ACC # field (#.06) were **changed** from a numeric field to a free text field (5-15 characters) with a specific format determined by the input transform. The field now includes the abbreviation for the accession area concatenated with the year of the accession concatenated with the accession number. This accommodates both multiple accession areas within the "SP" subscript in a single division and multidivisional functionality.

4. The name and the input transform in LAB DATA file (#63), CYTOPATHOLOGY subfile (#63.09), CYTOPATH ACC # field (#.06) were **changed** from a numeric field to a free text field (5-15 characters) with a specific format determined by the input transform. The CYTOPATHOLOGY subfile (#63.09), CYTOPATH ACC # field (#.06) now includes the abbreviation for the accession area, concatenated with the year of the accession, concatenated with the accession number. This accommodates both multiple accession areas within the "CY" subscript in a single division and multidivisional functionality.

5. A **new** field was added to ACCESSION file (#68). The **new** DIV field (#26) is a subfield of the ACCESSION NUMBER field (#1), which is a subfield of the DATE field (#2). The **new** DIV field (#26) is a pointer to the INSTITUTION file (#4) which captures the division of the log-on person based on the DUZ(2). The data is then subsequently stored in the ACCESSION file (#68), in TEST field (#11), WKLD CODE subfield (#6), INSTITUTION subfield (#3) which has an associated "AC" cross reference.

6. The input transform was changed for LAB DATA file (#63), AUTOPSY RELEASE DATE/TIME field (#14.7) to prevent entries of a previous date/time and a future date/time.

7. The input transform was changed for EM subfile (#63.02), REPORT RELEASE DATE/TIME field (#.11) to prevent entries of a previous date/time, and a future date/time.

8. The input transform was changed for SURGICAL PATHOLOGY subfile (#63.08), REPORT RELEASE DATE/TIME field (#.11) to prevent entries of a previous date/time, and a future date/time.

9. The input transform was changed for CYTOPATHOLOGY subfile (#63.09), REPORT RELEASE DATE/TIME field (#.11) to prevent entries of a previous date/time, and a future date/time.

10. A **new** field was added to the ACCESSION file (#68). The **new** ASSOCIATED DIVISION subfile field (#1) of the ASSOCIATED DIVISION field multiple (#.091) **must** be completed even if there is only a single division. In the majority of the Anatomic Pathology menu options, the division of the user is assessed. Only those accession areas assigned to the same division as the user can be accessed.

Anatomic Pathology Option, Functionality, and Other Changes

1. In the Log-in, anat path [LRAPLG] option of the[LRAPL] menu, the routine was **changed** to eliminate the error caused if the user attempted to log in an autopsy on a referral patient who did not have a date of death entered. (NOIS call MEM-0595-70138)

2. By **changing** the data dictionaries for the anatomic pathology accession numbers in LAB DATA file (#63), SURGICAL PATHOLOGY subfile (#63.08), SURGICAL PATH ACC # field (#.06), EM subfile (#63.02), EM ACC # field (#.06), CYTOPATHOLOGY subfile (#63.09), CYTOPATH ACC # field (#.06), and AUTOPSY ACC # field (#14), it is now possible to have multiple accession areas for a single "AP" subscript (regardless of whether the facility is multidivisional).

Example: You may wish to have a separate accession area for Bone Marrows, which is associated with the LR subscript "SP", in addition to the Surgical Pathology accession area.

NOTE: The abbreviation for the accession area now controls the format of the accession number on the report, instead of it being based on the entry in the Edit pathology report parameters [LRAPHDR] option.

3. In the Verify/release reports, anat path [LRAPR] option of the Verify/Release Anat Path Menu [LRAPVR] submenu has been **changed**. The date/time of the release has been limited to current time only.

NOTE: The ability to enter a previous date/time has been removed for all of the anatomic pathology subscripts, in an effort to increase the validity of the data.

4. The FS/Gross/Micro DX/SNOMED coding [LRAPDGS] option of the Data Entry, Anat Path [LRAPD] submenu has been **changed**. The ability to use the LAB DESCRIPTIONS file (#62.5) for rapid entry of standardized text has been expanded to include the LAB DATA file (#63), SURGICAL PATHOLOGY DIAGNOSIS field (#8), SURGICAL PATH DIAGNOSIS subfield (#1.4).

5. For the Autopsy protocol [LRAPAUPT] option in the Clinician option, Anat path [LRAPMD] menu, a variable was **reset** to eliminate the error which occurred if the option was moved to another menu. (NOIS HOU-0196-715 and LIT-0895-72013)

6. For the Prisoner of War Veterans [LRAPDPT] option in the AFIP Registries....[LRAPAFIP] submenu of the Supervisor, anat path [LRAPSUPER] menu, the problem created by Patch LR*5.2*114 in which additional patients who should not have been included in the report were included is fixed. (NOIS MAD-0596-41915)

Instructions for Anatomic Pathology for Multidivisional Sites and Multiple AP Accession Areas

NOTE: The asterisk (*****) indicates changes that **must** be done before the software will run as multidivisional OR before the software will accommodate multiple AP accession areas (not necessarily immediately).

1. Now that the LRAPFIX conversion routine has been run, make the necessary changes in the ACCESSION file (#68) in the primary site to reflect the desired setups. Do **NOT** make these changes before the conversion routine is run or the accession numbers for the previous data will not be converted properly.

NOTE: At this point, the AREA field (#.01) can be edited; however, for those entries which already exist, the ABBREVIATION field (#.09) **cannot** be edited!

a. If you have multiple AP accession areas in non-multidivisional site, you might have a setup such as:

NOTE: These are examples only; therefore, the facility IDs may **not** be correct.

AREA field (#.01): SURGICAL PATHOLOGY
LR SUBSCRIPT field (# .02): SURGICAL PATHOLOGY
ABBREVIATION field (#.09): SP
ASSOCIATED DIVISION field(#.091), subfield (#.01): Long Beach (600)
LAB DIVISION field (#.19): Anatomic Pathology

AREA field (#.01): BONE MARROW
LR SUBSCRIPT field (#.02): SURGICAL PATHOLOGY
ABBREVIATION field (#.09): BM
ASSOCIATED DIVISION field(#.091), subfield (#.01): Long Beach (600)

LAB DIVISION field (#.19): Anatomic Pathology
AREA field (#.01): CYTOLOGY
LR SUBSCRIPT field (#.02): CYTOLOGY
ABBREVIATION field (#.09): CY
ASSOCIATED DIVISION field (#.091), subfield (#.01): Long Beach (600)
LAB DIVISION field (#.19): Anatomic Pathology

AREA field (#.01): AUTOPSY
LR SUBSCRIPT field (#.02): AUTOPSY
ABBREVIATION field (#.09): AU
ASSOCIATED DIVISION field (#.091, subfield (#.01): Long Beach (600)
LAB DIVISION field (#.19): Anatomic Pathology

b. If you are a multidivisional site, there are a variety of ways in which the file can be setup to produce the desired effect.

NOTE: Remember, at this point, the AREA field (#.01) can be edited; however, for entries that already exist in the ABBREVIATION field (#.09) **cannot** be edited!

NOTE: If you wish to use an alpha suffix to annotate the abbreviation, rather than an alpha prefix, this will not confuse the users during accessioning as the users will only be able to access those areas assigned to the appropriate division.

☛**WARNING:** If data is being merged from more than one site, such as is planned for those sites who are consolidating, it is absolutely **critical** that each of the anatomic pathology accession areas which existed in the site of origin be added to the site into which the data is being merged. **If this is not done, users will not be able to access that data** through the search or print options. See (#4) below for details.

(1) IF both sites process and report their own surgical path work, but only the Seattle site does bone marrow procedures

Comments:
Primary site = 663 (Seattle); American Lake Division = 663A
The cum path summary and health summary show all of the accession areas, still split by subscript.

Access to enter/edit data is controlled by the assignment of divisions in the NEW PERSON file (#200).

AREA field (#.01): SEATTLE SURG PATH
LR SUBSCRIPT field (#.02): SURGICAL PATHOLOGY
ABBREVIATION field (#.09): SSP
ASSOCIATED DIVISION field (#.091), subfield(#.01): Seattle (663)
LAB DIVISION field (#.19): Anatomic Pathology
AREA field (#.01): AMER. LAKE SURG PATH
LR SUBSCRIPT field (#.02): SURGICAL PATHOLOGY
ABBREVIATION field (#.09): ASP
ASSOCIATED DIVISION field (#.091), subfield (#.01): American Lake (663A)
LAB DIVISION field .(#19): Anatomic Pathology

AREA field (#.01): SEATTLE BONE MARROW
LR SUBSCRIPT field (#.02): SURGICAL PATHOLOGY
ABBREVIATION field (#.09): SBM
ASSOCIATED DIVISION field (#.091), subfield (#.01): Seattle (663)
LAB DIVISION field (#.19): Anatomic Pathology

(2) IF cytology specimens are obtained at both sites, but are processed/reported at one site

Comments:
Accessioning can be done by each facility, but only a single number sequence will be utilized.
The division logging in the specimen will be captured and displayed on the log book. The header for the log book will be based on the division printing it, but the accession area is also included.

AREA field (#.01): CYTOLOGY
LR SUBSCRIPT field (#.02): CYTOLOGY
ABBREVIATION field (#.09): SCY
ASSOCIATED DIVISION field (#.091, subfield (#.01): Seattle (663)
ASSOCIATED DIVISION field (#.091, subfield (#.01): American Lake (663A)
LAB DIVISION field (#.19): Anatomic Pathology

(3) IF surgical pathology specimens are obtained at both sites, but only accessioned, processed and reported at one site,

AREA field (#.01): CYTOLOGY
LR SUBSCRIPT field (#.02): CYTOLOGY
ABBREVIATION field (#.09): TCY
ASSOCIATED DIVISION field (#.091), subfield (#.01): Temple
LAB DIVISION field (#.19): Anatomic Pathology

NOTE: It will **not** be possible to tell which division submitted the specimen because the accession area is the same and the division logging in the specimen will be captured and displayed on the log book.

(4) IF data is being merged from more than one site, such as is planned for those sites who are consolidating, it is absolutely **critical** that each of the anatomic pathology accession areas which existed in the site of origin be added to the site into which the data is being merged.

Comments:
Access to the accession area is controlled by the entry in the ASSOCIATED DIVISION field (#.091). If the site which is usually doing the accessioning for the new specimens received after the consolidation is **NOT** included, this accession area will not be available as a choice. Users will only be able to access the 'OLD' data through the search or print options if they can designate that division upon sign-on.

AREA field (#.01): WACO CYTOLOGY
LR SUBSCRIPT field .(#02): CYTOLOGY
ABBREVIATION field (#.09): WCY
ASSOCIATED DIVISION field (#.091, subfield (#.01): Waco
LAB DIVISION field (#.19): Anatomic Pathology

2. For those sites, which are multidivisional, a new option has been created, (i.e. Change to new division [LRUCHGDIV]). This option allows the user to change from one associated division to another, as appropriate based on the entry(ies) for DIVISION field (#16) for that user in the NEW PERSON file (#200), without having to log out and sign back in. It appears in the Blood bank patient [LRBLP] menu; however, if the process flow and task assignments are such for anatomic pathology that users need to input or view data from more than one division, it may be appropriate to assign this option to that user's secondary menu or to one of the AP submenus.

DATA MERGER Information for the Consolidation Sites

NOTE: Data merger routines will be available for both Blood Bank and Anatomic Pathology data in File 63; however, these will be issued as a s separate patch.

LAB DATA file (#63)

Laboratory data on the legacy systems will be available for a long period of time and all Lab data that is normally available through a health summary component IS going to be viewable on the primary system; however, for Anatomic Pathology, this is not adequate. It is imperative that historic records be available for to the pathologist, particularly when trying to make a rapid diagnosis on a specimen submitted for frozen section.

For Anatomic Pathology, this includes the following fields:

field 2 EM (subfile 63.02)
field 8 SURGICAL PATHOLOGY (subfile 63.08)
field 9 CYTOPATHOLOGY (subfile 63.09)
field 11 AUTOPSY DATE/TIME
field 12 DATE/TIME OF DEATH
field 12.1 PHYSICIAN
field 12.5 AGE AT DEATH
field 13 DATE AUTOPSY REPORT COMPLETED
field 13.01 AUTOPSY TYPIST
field 13.1 DATE FINAL AUTOPSY DIAGNOSES
field 13.5 RESIDENT PATHOLOGIST
field 13.6 SENIOR PATHOLOGIST
field 13.7 AUTOPSY TYPE
field 13.8 AUTOPSY ASSISTANT
field 14 AUTOPSY ACC #
field 14.1 LOCATION
field 14.5 SERVICE
field 14.6 TREATING SPECIALTY AT DEATH
field 14.7 AUTOPSY RELEASE DATE/TIME
field 14.8 AUTOPSY RELEASED BY
field 14.9 PROVISIONAL ANAT DX DATE
field 16, BODY HEIGHT (in)
field 17 BODY WT (lb)
field 18 LUNG,RT (gm)
field 19 LUNG,LT (gm)

field 20 LIVER (gm)
field 21 SPLEEN (gm)
field 22 KIDNEY,RT (gm)
field 23,KIDNEY,LT (gm)
field 24 HEART (gm)
field 25 BRAIN (gm)
field 25.1 PITUITARY GLAND (gm)
field 25.2 THYROID GLAND (gm)
field 25.3 PARATHYROID, LEFT UPPER (gm)
field 25.4 PARATHYROID, LEFT LOWER (gm)
field 25.5 PARATHYROID, RIGHT UPPER (gm)
field 25.6 PARATHYROID, RIGHT LOWER (gm)
field 25.7 ADRENAL, LEFT (gm)
field 25.8, ADRENAL, RIGHT (gm)
field 25.9 PANCREAS (gm)
field 25.91 TESTIS, LEFT (gm)
field 25.92 TESTIS, RIGHT (gm)
field 25.93 OVARY, LEFT (gm)
field 25.94 OVARY, RIGHT (gm)
field 26 TRICUSPID VALVE (cm)
field 27 PULMONIC VALVE (cm)
field 28 MITRAL VALVE (cm)
field 29 AORTIC VALVE (cm)
field 30 RIGHT VENTRICLE (cm
field 31 LEFT VENTRICLE (cm)
field 31.1, PLEURAL CAVITY, LEFT (ml)
field 31.2 PLEURAL CAVITY, RIGHT (ml)
field 31.3 PERICARDIAL CAVITY (ml)
field 31.4 PERITONEAL CAVITY (ml)
field 32 AUTOPSY ORGAN/TISSUE
field 32.1 AUTOPSY COMMENTS
field 32.2 CLINICAL DIAGNOSES
field 32.3 PATHOLOGICAL DIAGNOSES
field 32.4, AUTOPSY SUPPLEMENTARY REPORT
field 33 AUTOPSY SPECIMEN
field 80 AUTOPSY ICD9CM CODE
field 83.1 MAJOR DIAGNOSTIC DISAGREEMENT
field 83.2 CLINICAL DIAGNOSIS CLARIFIED
field 99 AUTOPSY QA CODE

Post DATA MERGER Instruction for the Consolidation Sites

The ability to merge Anatomic Pathology data from sites, which are consolidating so that critical data stored before the consolidation will still be accessible through the usual options, will be released in a separate patch. The LRAPFIX2 conversion routine will be included in this separate patch and will redo the appropriate cross-references ("ASPA", "ACYA', "AEMA", and "AAUA") for LAB DATA file (#63) for the SP, CY, EM, and AU subscript accessions.

APPENDIX B
ANATOMIC PATHOLOGY
PATCH LR*5.2*248 CHANGES

APPENDIX B

Anatomic Pathology Patch LR*5.2*248 Changes

The Anatomic Pathology User Manual Appendix B section contains a list of files, fields, and option changes that occurs with the installation of patch LR*5.2*248.

LAB DATA file (#63) Changes

LAB DATA file (#63) has been **edited** to add **new** audit trail functionality. The audit trail will display changes made to the Electron Microscopy, Surgical Pathology, Cytopathology, and Autopsy Supplementary reports that are edited after previously being released for review. The modified Supplementary reports will display the name of the person modifying the report, date and time the report was modified, and the report original text at release, and currently modified text.

New Fields

LAB DATA file (#63) Modified Fields	LAB DATA file (#63) New Fields
EM (Electron Microscopy) field (#2), subfile (#63.02) SUPPLEMENTARY REPORT field (#1.2), subfile (#63.207), was **edited** to create four **new** fields. These fields are used to add the **new** audit trail functionality to the EM Electron Microscopy supplementary reports.	SUPPLEMENTARY REPORT MODIFIED field (#2) multiple, subfile (#63.2072). This is the date/time in which this supplementary report was modified. This information is stored for audit trail purpose. It is updated by the software and can only be modified from programmer mode. SUPPLEMENTARY REPORT MODIFIED field (#.01). This is the date/time in which this supplementary report was modified. PERSON MODIFYING TEXT field (#.02). This is the DUZ of the person who modified the supplementary report. It is updated by the software and can only be modified from programmer mode. PREMODIFICATION TEXT field (#1), subfile (#6320721). This is the text of the supplementary report, as it existed before it was modified. It is updated by the software and can only be modified from programmer mode.

Continued

LAB DATA file (#63) Modified Fields	LAB DATA file (#63) New Fields
SURGICAL PATHOLOGY field (#8), subfile (#63.08) SUPPLEMENTARY REPORT field (# 1.2), subfile (#63.817) were **edited** to create four **new** fields. These fields are used to add the **new** audit trail functionality to the Surgical Pathology supplementary report.	SUPPLEMENTARY REPORT MODIFIED field (#2), subfile (#63.8172). This is the date/time in which this supplementary report was modified. This information is stored for audit trail purpose. It is updated by the software and can only be modified from programmer mode. SUPPLEMENTARY REPORT MODIFIED field (#.01). This is the date/time in which this supplementary report was modified. This information is stored for audit trail purpose. It is updated by the software and can only be modified from programmer mode. PERSON MODIFYING TEXT field (#.02). This is the DUZ of the person who modified the supplementary report. It is updated by the software and can only be modified from programmer mode. PREMODIFICATION TEXT field (#1), subfile (#6381721). This is the text of the supplementary report, as it existed before it was modified. It is updated by the software and can only be modified from programmer mode.

Continued

LAB DATA file (#63) Modified Fields	LAB DATA file (#63) New Fields
CYTOPATHOLOGY field (#9), subfile (#63.09) SUPPLEMENTARY REPORT field (#1.2), subfile (#63.907) were **edited** to create four **new** fields. These fields are used to add the **new** audit trail functionality to the Cytopathology supplementary reports.	SUPPLEMENTARY REPORT MODIFIED field (#2), sub-file (#63.9072). This is the date/time in which this supplementary report was modified. This information is stored for audit trail purpose. It is updated by the software and can only be modified from programmer mode. SUPPLEMENTARY REPORT MODIFIED (#.01). This is the date/time in which this supplementary report was modified. This information is stored for audit trail purpose. It is updated by the software and can only be modified from programmer mode... PERSON MODIFYING TEXT field (#.02). This is the DUZ of the person who modified the supplementary report. It is updated by the software and can only be modified from programmer mode. PREMODIFICATION TEXT field (#1), subfile (#63.90721). This is the text of the supplementary report, as it existed before it was modified. It is updated by the software and can only be modified from programmer mode.

Continued

LAB DATA file (#63) Modified Fields	LAB DATA file (#63) New Fields
AUTOPSY SUPPLEMENTARY REPORT field (#32.4), subfile (#63.324) was **edited** to create four **new fields** used to add the audit trail **new** functionality to the Autopsy supplementary report audit trail.	SUPPLEMENTARY REPORT MODIFIED field (#2), subfile (#63.3242). This is the date/time in which this supplementary report was modified. This information is stored for audit trail purpose. It is updated by the software and can only be modified from programmer mode. SUPPLEMENTARY REPORT MODIFIED field (#.01). This is the date/time in which this supplementary report was modified. This information is stored for audit trail purpose. It is updated by the software and can only be modified from programmer mode. PERSON MODIFYING TEXT field (#.02) stores the user DUZ that modified an Autopsy supplementary report. PREMODIFICATION TEXT field (#1), subfile (63.32421). This is the text of the supplementary report, as it existed before it was modified. It is updated by the software and can only be modified from programmer mode.

Anatomic Pathology Option Changes

The following Anatomic Pathology options were changed with the release of patch LR*5.2*248:

Enhancements

Supplementary Report, Anat Path [LRAPDSR] option

The Supplementary Report, Anat Path [LRAPDSR] option has been enhanced to include the audit trail **new** functionality. The audit trail information contains the name of the person editing the report, date and time the report was edited, and the original text before the report was changed. **E3R:** 3687. **NOIS:** SAM-0599-21489, DAY-0499-40904, SLC-1199-52531, SLC-1199-51746.

Note: The shaded areas shown in the following example indicate modifications made to the "Supplementary" report.

Example: Supplementary report

```
------------------------------------------------------------------------------
      MEDICAL RECORD :        SURGICAL PATHOLOGY            Pg 1
------------------------------------------------------------------------------
Submitted by: LABPROVIDER, SEVEN    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: LABPROVIDER, SEVEN
```

```
================================================================================
                                PATHOLOGYY REPORT
Laboratory: R5ISC                                  Accession No. SP90 23
--------------------------------------------------------------------------------
Gross description:              Pathology Resident: LABPROVIDER6, FOUR
      3mm punch biopsy of skin


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

Supplementary Report:
      Date: NOV 21, 1990 11:00
                           *** MODIFIED REPORT***
(Last modified: NOV 21, 1990 11:00  typed by LABUSER, ONE
      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.
--------------------------------------------------------------------------------
                                                              (End of report)
                                                     rg| Date NOV 21, 1990
--------------------------------------------------------------------------------
LABPATIENT, SEVEN                                    STANDARD FORM 515
ID:366-61-8472 SEX:M DOB:5/8/16 AGE 72               LOC:1A
                                                     LABPROVIDER, SEVEN
```

Autopsy supplementary report [LRAPAUSR] option

The Autopsy supplementary report [LRAPAUSR] option has been **enhanced** to include an audit trail. The audit trail information contains the name of the person editing the report, date and time the report was edited, the report original text and currently modified text. **E3R:** 3687. **NOIS:** SAM-0599-21489, DAY-0499-40904, SLC-1199-52531, SLC-1199-51746.

Note: The shaded areas shown in the following example indicate modifications made to the "Autopsy Supplementary" report.

Example: Autopsy Supplementary report

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

SUPPLEMENTARY REPORT DATE: AUG 10, 1990 10:43
                           *** MODIFIED REPORT***
(Last modified: APR 26, 1990 12:00        typed by DUCK,JOE
    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: LABPROVIDER, THREE                          jg| Date SEP 12, 1990
------------------------------------------------------------------------------
R5ISC                                          AUTOPSY SUPPLEMENTARY REPORT
LABPATIENT, FIVE  000-00-0005       SEX:M      DOB: FEB 1, 1901
MEDICINE          LABPROVIDER, ONE             AGE AT DEATH: 51
```

Modifications

Show List of Accessions for a Patient [LRUPT] option

The Show list of accessions for a patient [LRUPT] option has been **modified** with the following changes:

- This option now displays the accession number when the Autopsy section is selected to generate a report.
- Some tests were missing on the report for accessions in which the user enters a collection date for the previous year but the order date is in the current year. This option was modified to use the correct year so that the missing tests will now appear. NOIS: AUG-0398-32638, SYR-0193-10004.

Note: The shaded areas shown in the following example indicate the modifications made in the 'Show list of accessions for a patient [LRUPT] option".

Example of report for Chemistry:

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

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

Select ACCESSION AREA: CH CHEMISTRY

Select Patient Name: LABPATIENT9, THREE   08-18-27    000000093
LABPATIENT2, THREE ID: 000-00-0023  Physician: LABPROVIDER, SEVEN

AGE: 63 DATE OF BIRTH: AUG 18, 1927
PATIENT LOCATION: 1A// <Enter>
Is this the patient ? YES// <Enter> (YES)

CHEMISTRY           LABPATIENT9, THREE ID:000-00-0093   TESTS ORDERED
Spec Date/time  Acc #           Site/specimen              Tests
01/15/93 10:11  CH 0115 9       SERUM                     1)CALCIUM
12/26/92 11:00  CH 0115 8       SERUM                     1)GLUCOSE
11/13/92 16:14  CH 1113 6       SERUM                     1)GLUCOSE
```

Example of report for Autopsy:

```
Select Anatomic pathology Option: I  Inquiries, anat path
Select Inquiries, anat path Option: PA Show list of accessions for a patient
Select ACCESSION AREA: AU  AUTOPSY
Select Patient Name: LABPATIENT9, FOUR

LABPATIENT9, FOUR  ID: 000-00-0094 Physician: LABPROVIDER6, FIVE.

                                  DIED FEB  5, 1996

Is this the patient ? YES//   (YES)

AUTOPSY             LABPATIENT9, FOUR  ID: 000-00-0094

Autopsy date/time  Autopsy #

JUL 31, 1997           10
```

Modify anat path gross/micro/dx/frozen section [LRAPM] option

The Modify anat path gross/micro/dx/frozen section [LRAPM] option was **modified** with the following changes:

- This option was **modified** to allow queuing and printing of a "COMPLETED" report when the patient is a male.

- This option was **modified** to prevent a report from becoming "UNRELEASED" even though no changes were made to the report. NOIS: BHS-0600-12155.

Verify/Release Reports, Anat Path [LRAPR] option

The Verify/Release Reports, Anat Path [LRAPR] option has been **modified** with the following changes:

- The REPORT RELEASE DATE/TIME// prompt has been changed from allowing entry of a future date and time response to a Release report? // YES or NO question response. If the user response is YES, the current date and time stored.

- The Autopsy verified/released report previously required using the @ sign to unrelease a report. This option was changed to require a YES/NO prompt response to unrelease a report. NOIS: REN-0197-61357

Note: Changes made to the Verify/Release Reports, Anat [LRAPR] option is indicated in the shaded areas of the following example.

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: SUR  SURGICAL PATHOLOGY

                     SURGICAL PATHOLOGY (SUR)

Data entry for 1994 ? YES//<Enter>   (YES)

Select Accession Number/Pt name: 7  for 1994
LABPATIENT1, TEN  ID: 000-00-0110

Release report? NO// YES<Enter>

Report released...

Select Accession Number/Pt name:<Enter>
```

NOTE: If an attempt is made to release a report that has already been released, the following is displayed.

```
Report released JUN 26, 1994@16:52:57 by LABPROVIDER6, SIX

Select Accession Number/Pt name:
```

Example 2: Release of '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//<Enter>   (YES)

Select Accession Number/Pt name: 5 for 1992
LABPATIENT,  FOUR    ID: 000-00-0004

Release report? NO// YES<Enter>

Report released...

Select Accession Number/Pt name:<Enter>

Select Anatomic pathology Option: V  Verify/release menu, anat path

   RR     Verify/release reports, anat path
   RS     Supplementary report release, anat path
   LU     List of unverified pathology reports

Select Verify/release menu, anat path Option: RR  Verify/release reports,
anat path
                            RELEASE PATHOLOGY REPORTS

Select ANATOMIC PATHOLOGY SECTION: AU  AUTOPSY

                     AUTOPSY (AU)

Data entry for 1992 ? YES// <Enter>   (YES)

Select Accession Number/Pt name: 1  for 1992
LABPATIENT8, EIGHT.  ID: 000-00-0088

Report released SEP 18, 1992@13:11:20 by SMITH,DOE
Unrelease report? NO// YES <Enter>
Report unreleased...
```

Enter old anat path records [LRAPOLD] option

The Enter old anat path records [LRAPOLD] option used for entering certain pathology historical data was **modified** to correct an undefined variable error. **NOIS:** OKL-0799-72578, FAV-0999-71182, AUG-1299-32707, ANN-0200-42620, WRJ-0500-10974.

Log-in, anat path [LRAPLG] option

The Log-in, anat path [LRAPLG] option has been **modified** with the following changes:

- A five second time-out has been put on record locking to prevent system hang time when logging-in with this option. **NOIS:** MUS-0395-70386, SHR-0595-70238.

- FileMan look-up call (DIE) will not store three question marks (???) as data for patient location. The three question marks (???) have been replaced with UNKNOWN, which is FileMan compatible. **NOIS:** DUB-0895-32241, LEB-0899-22335, SAM-0499-22281, WRJ-0298-11480, SAM-0598-20421.

Autopsy protocol/supplementary report [LRAPAUPT] option

The autopsy protocol/supplementary Report [LRAPAUPT] option has been **modified** to correct the following:

- Printing of unnecessary form feeds for Autopsy Protocol and Supplementary reports. NOIS: WPB-0696-30073, IND-1097-41646.

- The Autopsy Protocol report header and footer have been reformatted for better readability. Labels have been added before the physician and patient names (i.e., “Physician:” and “Patient:”)

Note: The shaded areas in the following example display changes made to the footer.

```
------------------------------------------------------------------------------
     CLINICAL RECORD |                  AUTOPSY PROTOCOL                Pg 1
------------------------------------------------------------------------------
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: LABPROVIDER, THREE                        wty| Date DEC  1, 1992
------------------------------------------------------------------------------
DALLAS CIOFO                                                  AUTOPSY PROTOCOL
Patient: LABPATIENT, FOUR     000-00-0004 SEX:M       DOB:DEC 18, 1992
Bon-AHMED/OPC           Physician: LABPROVIDER6, TWO        AGE AT DEATH: 75
```

Clinical Hx/Gross Description/FS [LRAPDGD] option

The Clinical Hx/Gross Description/FS [LRAPDGD] option has been **modified** to correct re-entering a patient's name at the Accession Number/Patient Name prompt and a second prompt within this option. The option now performs the patient name lookup at the first prompt, thereby eliminating the need for the second prompt.

FS/Gross/Micro/Dx [LRAPDGM] option

The FS/Gross/Micro/Dx [LRAPDGM] option has been **modified** to correct re-entering a patient's name at the Accession Number/Patient Name prompt and a second prompt within this option. The option now performs the patient name lookup at the first prompt, thereby eliminating the need for the second prompt.

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

The FS/Gross/Micro/Dx/SNOMED Coding [LRAPDGS] option has been **modified** to correct re-entering a patient's name at the Accession Number/Patient Name prompt and a second prompt within this option. The option now performs the patient name lookup at the first prompt, thereby eliminating the need for the second prompt.

FS/Gross/Micro/Dx/ICD9CM Coding [LRAPDGI] option

The FS/Gross/Micro/Dx/ICD9CM Coding [LRAPDGI] option has been **modified** to correct re-entering a patient's name at the Accession Number/Patient Name prompt and a second prompt within this option. The option now performs the patient name lookup at the first prompt, thereby eliminating the need for the second prompt.

Supplementary Report, Anat Path [LRAPDSR] option

The Supplementary Report, Anat Path [LRAPDSR] option has been **modified** to correct re-entering a patient's name at the Accession Number/Patient Name prompt and a second prompt within this option. The option now performs the patient name lookup at the first prompt, thereby eliminating the need for the second prompt.

Spec Studies-EM;Immuno;Consult;Pic, Anat Path [LRAPDSS] option

The Spec Studies-EM;Immuno;Consult;Pic, Anat Path [LRAPDSS] option has been **modified** to correct re-entering a patient's name at the Accession Number/Patient Name prompt and a second prompt within this option. The option now performs the patient name lookup at the first prompt, thereby eliminating the need for the second prompt.

Provisional anatomic diagnoses [LRAPAUPAD] option

The Provisional anatomic diagnoses [LRAPAUPAD] option has been **modified** to correct re-entering a patient's name at the Accession Number/Patient Name prompt and a second prompt within this option. The option now performs the patient name lookup at the first prompt, thereby eliminating the need for the second prompt.

Autopsy protocol [LRAPAUDAP] option

The Autopsy protocol [LRAPAUDAP] option has been **modified** to correct re-entering a patient's name at the Accession Number/Patient Name prompt and a second prompt within this option. The option now performs the patient name lookup at the first prompt, thereby eliminating the need for the second prompt.

Autopsy protocol & SNOMED coding [LRAPAUDAB] option

The Autopsy protocol & SNOMED coding [LRAPAUDAB] option has been **modified** to correct re-entering a patient's name at the Accession Number/Patient Name prompt and a second prompt within this option. The option now performs the patient name lookup at the first prompt, thereby eliminating the need for the second prompt.

Autopsy protocol & ICD9CM coding [LRAPAUDAA] option

The Autopsy protocol & ICD9CM coding [LRAPAUDAA] option has been **modified** to correct re-entering a patient's name at the Accession Number/Patient Name prompt and a second prompt within this option. The option now performs the patient name lookup at the first prompt, thereby eliminating the need for the second prompt.

Final autopsy diagnoses date [LRAPAUFAD] option

The Final autopsy diagnoses date [LRAPAUFAD] option has been **modified** to correct re-entering a patient's name at the Accession Number/Patient Name prompt and a second prompt within this option. The option now performs the patient name lookup at the first prompt, thereby eliminating the need for the second prompt.

Autopsy supplementary report [LRAPAUSR] option

The Autopsy supplementary report [LRAPAUSR] option has been **modified** to correct re-entering a patient's name at the Accession Number/Patient Name prompt and a second prompt within this option. The option now performs the patient name lookup at the first prompt, thereby eliminating the need for the second prompt.

Special studies, autopsy [LRAPAUDAS] option

The Special studies, autopsy [LRAPAUDAS] option has been **modified** to correct re-entering a patient's name at the Accession Number/Patient Name prompt and a second prompt within this option. The option now performs the patient name lookup at the first prompt, thereby eliminating the need for the second prompt.

SNOMED coding, anat path [LRAPX] option

The SNOMED coding, anat path [LRAPX] option has been **modified** to correct re-entering a patient's name at the Accession Number/Patient Name prompt and a second prompt within this option. The option now performs the patient name lookup at the first prompt, thereby eliminating the need for the second prompt.

ICD9CM coding, anat path [LRAPICD] option

The ICD9CM coding, anat path [LRAPICD] option has been **modified** to correct re-entering a patient's name at the Accession Number/Patient Name prompt and a second prompt within this option. The option now performs the patient name lookup at the first prompt, thereby eliminating the need for the second prompt.

Modify anat path gross/micro/dx/frozen section [LRAPM] option

The Modify anat path gross/micro/dx/frozen section [LRAPM] option has been **modified** to correct re-entering a patient's name at the Accession Number/Patient Name prompt and a second prompt within this option. The option now performs the patient name lookup at the first prompt, thereby eliminating the need for the second prompt.

Verify/release reports, anat path [LRAPR] option

The Verify/release reports, anat path [LRAPR] option has been **modified** to correct re-entering a patient's name at the Accession Number/Patient Name prompt and a second prompt within this option. The option now performs the patient name lookup at the first prompt, thereby eliminating the need for the second prompt.

Supplementary report release, anat path [LRAPRS] option

The Supplementary report release, anat path [LRAPRS] option has been **modified** to correct re-entering a patient's name at the Accession Number/Patient Name prompt and a second prompt within this option. The option now performs the patient name lookup at the first prompt, thereby eliminating the need for the second prompt.

Print path gross/micr/dx/fr.sect modifications [LRAPQAM] option

The Print path gross/micr/dx/fr.sect modifications [LRAPQAM] option was **modified** to include report changes in the 'Supplementary' reports modified after their release. **E3R**: 3687. **NOIS:** SAM-0599-21489, DAY-0499-40904, SLC-1199-52531, SLC-1199-51746.

Print path modifications [LRAPMOD] option

The Print path modifications [LRAPMOD] option has been **modified** to print the audit trail new information for supplementary reports. The audit trail information contains the name of the person editing the report, date and time the report was edited, and the original text before the report was changed. **E3R:** 3687. **NOIS:** SAM-0599-21489, DAY-0499-40904, SLC-1199-52531, SLC-1199-51746.

Note: The shaded area in the following examples display changes made in the report.

Example: Print Pathology Report Modifications

```
Select Supervisor, anat path Option: MR  Print path modifications

               Print pathology report modifications

Select ANATOMIC PATHOLOGY section: SP  SURGICAL PATHOLOGY

Select Patient Name: LABPATIENT1, TEN: 000000110 NO     NSC VETERAN
LABPATIENT1, TEN: 000-00-0110 Physician: LABPROVIDER4, THREE

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


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

```
------------------------------------------------------------------------------
     MEDICAL RECORD |                   SURGICAL PATHOLOGY               Pg 1
------------------------------------------------------------------------------
Submitted by: LABPROVIDER4, THREE              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: LABPROVIDER4, FOUR
==============================================================================
                              PATHOLOGY REPORT
Laboratory: VAMC                                      Accession No. SP 94 2
------------------------------------------------------------------------------
                               Pathology Resident: LABPROVIDER1, FIVE
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)
Date modified:AUG 27, 1994  17:19 typed by PEREZ,ELSIE
    Glomerular basement membranes are thickenedd and there is increased
    mesangial matrix.

Date modified:AUG 27, 1994  17:30 typed by PEREZ,ELSIE
    Glomerular basement membranes are thickenedd and there is increased
    mesangial matrix.  Also present are small prostatic infarts and foci
    of squamous metaplasia.
             ==========Text below appears on final report==========
    Glomerular basement membranes are thickenedd and there is increased


LABPROVIDER4, FOUR                                  ec | Date AUG 25, 1994
------------------------------------------------------------------------------
LABPATIENT1, TEN                                  STANDARD FORM 515
ID:000-00-0110  SEX:F    DOB:2/1/22   AGE:72      LOC:1 EAST
ADM:APR  8, 1993 DX:ACCIDENT                      LABPROVIDER4, THREE
```

```
------------------------------------------------------------------------------
     MEDICAL RECORD |                   SURGICAL PATHOLOGY              Pg 2
------------------------------------------------------------------------------
                              PATHOLOGY REPORT
Laboratory: VAMC                                        Accession No. SP 94 2
------------------------------------------------------------------------------
    mesangial matrix.  Also present are small prostatic infarts and foci
    of squamous metaplasia.  Another small infarts 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




                              ***MODIFIED REPORT***
(Last modified: AUG 26, 1994  18:19 typed by DOE,SUE)
Date modified: AUG 26, 1994  18:19 typed by DOE,SUE
    This is another supplementary report.



           ==========Text below appears on final report==========
    This is another supplementary report.  When the supplementary report was
    released, this line was added to the 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



------------------------------------------------------------------------------
                                                              (End of report)
LABPROVIDER4, FOUR                                  ec | Date AUG 25, 1994
```

```
LABPATIENT1, TEN                                          STANDARD FORM 515
ID:000-00-0110  SEX:M DOB:2/1/22     AGE:72       LOC:1 EAST
ADM:APR  8, 1993 DX:ACCIDENT                      LABPROVIDER4, THREE
```

Print final path reports by accession # [LRAPFICH] option

The Print final path reports by accession # [LRAPFICH] option has been **modified** to correct the following:

- The Print final path reports by accession # [LRAPFICH] option has been **modified** to correct printing of unnecessary form feeds for the Final Pathology Report by Accession Number. **NOIS:** WPB-0696-30073, IND-1097-41646

- The Print final path reports by accession # [LRAPFICH] option has been **modified** to display audit trail new information on the supplementary report. **E3R:** 3687. **NOIS:** SAM-0599-21489, DAY-0499-40904, SLC-1199-52531, SLC-1199-51746

Print all reports on queue [LRAP PRINT ALL ON QUEUE] option

The Print all reports on queue [LRAP PRINT ALL ON QUEUE] option has been **modified** as follows:

- Corrected the printing of unnecessary form feeds and accession number that are entered to long for Anatomic Pathology reports (i.e., Surgical Pathology, Cytopathology and Electron Microscopy Preliminary, Final and Supplementary, and Autopsy Protocol and Supplementary reports). **E3R:** 3687. **NOIS:** WPB-0696-30073, IND-1097-41646 NOIS: SAM-0599-21489, DAY-0499-40904, SLC-1199-52531, SLC-1199-51746, MAR-0398-22377.

- The Autopsy Protocol report header and footer have been reformatted for better readability. Labels have been added before the physician and patient names (i.e., “Physician:” and “Patient:”).

- The option has been modified to display audit information on supplementary reports. **E3R:** 3687. **NOIS:** SAM-0599-21489, DAY-0499-40904, SLC-1199-52531, SLC-1199-51746

Note: The shaded areas display changes made in the 'Autopsy Protocol Report' HEADER and FOOTERS.

```
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<Enter>

                        Autopsy Protocols
(D)ouble or (S)ingle spacing of report(s): S<Enter>

Print weights, measures and coding (if present): ? YES// <Enter>  (YES)

Save protocol list for reprinting ? NO// Y  (YES)
Select Print Device:  [Enter Print Device Here]
```

Example 4: Change in Prompts if you Select the Autopsy Section *continued*

```
------------------------------------------------------------------------------
     CLINICAL RECORD |                 AUTOPSY PROTOCOL            Pg 1
------------------------------------------------------------------------------
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 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 mesangeal 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: LABPROVIDER, THREE                    lh| Date DEC  2, 1992
------------------------------------------------------------------------------
DALLAS ISC                                                AUTOPSY PROTOCOL
Patient: LABPATIENT, FOUR        000-00-0004         SEX: M DOB: DEC 18, 1925
BON-AHMED/OPC       Physician: LABPROVIDER2, TWO     AGE AT DEATH:66
```

```
DEC 2, 1992   08:10     DALLAS ISC                                  Pg: 2
ANATOMIC PATHOLOGY
------------------------------------------------------------------------------
LABPATIENT, FOUR          000-00-0004        DOB:DEC 18, 1925
Acc #: 5                        AUTOPSY DATA      Age: 66
Date/time Died                                    Date/time of Autopsy DEC 1,
1992                      FULL AUTOPSY      DEC 1, 1992
Resident: LABPROVIDER6, SEVEN                     Senior: LABPROVIDER, THREE



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: LABPROVIDER, THREE                        lh | Date DEC  2, 1992
------------------------------------------------------------------------------
DALLAS ISC                                                  AUTOPSY PROTOCOL
Patient: LABPATIENT, FOUR       000-00-0004        SEX: M   DOB: DEC 18, 1925
MEDICINE                Physician: LABPROVIDER2, TWO        AGE AT DEATH:66
```

Print single report only [LRAP PRINT SINGLE] option

The Print single report only [LRAP PRINT SINGLE] option has been **modified** as follows:

- Corrected the printing of unnecessary form feeds and accession number that are entered to long for Anatomic Pathology reports (i.e., Surgical Pathology, Cytopathology and Electron Microscopy Preliminary, Final and Supplementary, and Autopsy Protocol and Supplementary reports). **E3R:** 3687, SAM-0599-21489, DAY-0499-40904, SLC-1199-52531, SLC-1199-51746. **NOIS:** WPB-0696-30073, IND-1097-41646, MAR-0398-22377.

- The Autopsy Protocol report header and footer have been reformatted for better readability. Labels have been added before the physician and patient names (i.e., "Physician:" and "Patient:").

- The option has been **modified** to display audit trail new information on supplementary reports. **E3R:** 3687. **NOIS:** SAM-0599-21489, DAY-0499-40904, SLC-1199-52531, SLC-1199-51746

Laboratory Option Modifications

Accession List by Date [LRUPAD]

The Accession List by Date [LRUPAD] option report is incorrectly displaying a numeric value that has no meaning to the user in the 'Tech' column. The option has been **modified** to print the initials of the technologist who verified the report. **NOIS:** ALN-0395-10067

Lab orders by collection type [LRRP5] option

The Lab orders by collection type [LRRP5] option was **modified** to resolve the reporting of incorrect tests as being ordered if a particular test has a SYNONYM field (#2) multiple, Synonym sub-file (#60.1), of the LABORATORY TEST file (#60) that is identical to the internal entry number (IEN) of the look-up test. The correct tests (instead of the synonyms) are now displayed on the report. **NOIS:** IND-0797-40657.