

*Manitoba Health, Healthy Living & Seniors (MHLS) supports reporting and learning from patient safety events. The focus of a patient safety review is to closely look at the health care system that surrounds and interacts with those giving and receiving care. The goal is to identify risks to patient safety and recommend the most effective ways to minimize risk and improve the delivery of healthcare.*

## **Patient Safety Learning Advisory**

### **Discrepancy between Pathology Specimens on Two Occasions**

A physician submitted pathology samples from a patient on two separate occasions. On the first occasion, the sample was reported as benign. On the second occasion, the sample was reported as a carcinoma.

After our system correlated the cases and caught the error, the cases were reviewed again.

It was determined that carcinoma should have been reported on the first occasion.

The incorrect diagnosis on the first occasion caused a delay in initiating treatment.

**Keywords:**

Discrepancy in diagnosis, pathology

**Device Name (if applicable):**

**Drug/Name/Fluid Name: (if applicable):**

**Type of Analysis:** single event

**Topic:** Specimen/Laboratory

**Findings of the Review:**

No systemic issues were identified as contributing factors to the error.

The review deemed human error as the cause for the incident.

**System Learning:**

Have the pathologists involved in the case submit an amended report following their review of the cases.

Present a case review of the incident in a clinical education setting for all pathologists.