In other words

A pathologist's phrasebook

Pathology is not generally viewed as the most sociable medical specialty. And yet the greatest tool of the pathologist is none other than the ability to communicate: the power to describe pathology in a manner so compelling that the clinician will be galvanized into action. And so we pathologists have cultivated certain habits of speech.

Although many of us have a natural predisposition to brevity, the changing times are driving us to lengthy descriptions of microscopic subjects. Some of my professional seniors tell me that verbosity is the only way to hoodwink our clinical brethren into believing that we do more than drink English tea over slides and smoke the finest Cuban cigars over decomposing corpses. In simpler times, when a total mastectomy was the standard of care for breast cancer, "invasive ductal carcinoma" rendered on a breast biopsy report would have been sufficient. Not these days. A multitude of prognostic factors have to be included. From tumoral necrosis to estrogen receptors to resection margins to lymphovascular invasion, and so on. Not to mention what is required for melanomas. Mitoses, tumour-infiltrating lymphocytes, distance of tumour from the edge ... It's clear that pathologists are the victims of successful medical research. The oncologist is definitely not our friend.

Our ally the surgeon, on the other hand, usually wants the report distilled to one of two things: "Is this tumour benign, or is it malignant?" Pathologists worth their weight in freshly prepared formalin know that sometimes it is just not possible to be so definitive. Hence the use of nuanced statements intended to convey uncertainty without stupidity.

Take, for example, the case of our stressed imaginary colleague staring with despair at the pile of cervical biopsies a colposcopy-happy gynecologist has provided him. He comes across a slide from a 14 year old with enough atypia to confound him but not enough to make him firmly committal. What does he write in his report? "Findings compatible with koilocytotic atypia." Read instead: "It's probably a condyloma, but I'm not sure." Now he sees similar changes in a 23 year old with a history of high-grade dysplasia. This time he takes a different tack, choosing instead to say, "Findings consistent with koilocytotic atypia." This time, read: "Because of the patient's history, I'm pretty sure it's a condyloma."

To make matters even more subtle, features can be diagnosed as being "not inconsistent with." For this version, read: "If you think it's a brain tumour, it probably is." It then becomes the clinician's problem to decide what to tell the patient. I would imagine that delivery of the dreaded news frequently goes like this: "Mr. A, I'm afraid the pathologist does not really know what disease you have but *I* think it is — ."

How many times have you read the expression, "Clinical correlation required"? Is it *really* necessary to remind clinicians that they need to make sure that what they are *told* and what they *think* a patient's tumour is, are one and the same thing? I mean, do they really need to spend 5 years of residency fine-tuning their clinical-pathologic correlation skills? Of course clinical correlation is always required!

Some are also confused over the term "excised." I suspect a strict constructionist would assume that when something is reported as excised it means just that: excised. Not to some folks. Fast-forward to letter from surgeon: "Is it completely excised, or incompletely excised?"

So, to be on the safe side, one should occasionally report, "Benign fibroadenoma, completely excised." Good for a giggle at the lunch table.

One of my favourites is "Supplementary report to follow." To follow what? Indecision, or ignorance? Still, it is a nice cop-out when you and your colleagues are royally stumped. Buys time and shifts more of the diagnostic responsibility to someone more willing to take on some of the legal risks for a small fee.

> No matter how well you phrase a diagnosis, there is always a human being at the other end of that slide.

In all this it can be very easy to forget one thing. You guessed right. The patient. No matter how delicately or elegantly you phrase a diagnosis, no matter how thick your microscopic description, no matter what diagnostic algorithm is applied, there is always a human being at the other end of that slide. Not some abstract slide set reviewed at a medical conference in a frantic attempt to fulfill CME requirements, but a living, breathing organism with emotions, a family, hopes and aspirations. Not the one who is gunning to sue you at the drop of an acronym, but the one whose world is turned upside down at the confirmation of that "wonderful looking" stage-IV melanoma. The one faced with potentially life-threatening chemotherapy, radical surgery or perhaps only a few weeks to live.

It does put things into perspective does it not? So much for nomenclature.

Ken Obenson
Attending Pathologist
Saint John Regional Hospital
Saint John, NB

DOI:10.1503/cmaj.051217