COVID-19 pandemic: unexpected problems in pathological reporting

The COVID-19 pandemic saw a dramatic reduction in patient referrals for investigation and management of cancers and other conditions in the UK and elsewhere. One of the most immediate effects was a 'downturn' in the number of specimens submitted to pathology laboratories. Following this, many clinical teams, in conjunction with their managerial colleagues, put in place plans to see and manage patients and to undertake surgical procedures in various hospitals where they would not normally do this, including independent non-National Health Service (NHS) institutions. In most, but not all, cases this involved the clinicians travelling to undertake the work in these institutions. While this practice undoubtedly alleviated some of the pressures and allowed other NHS institutions to be devoted to dealing with the pandemic, there have been unexpected consequences for the reporting of pathology specimens.

One major issue is that some pathological specimens, including cancer resections, have been reported in different laboratories (NHS and non-NHS) and by different pathologists than those familiar to the clinicians. Some of these laboratories have been in completely different geographical locations within different cancer centre regions. In my experience, this has resulted in suboptimal reporting in some cases and more importantly major consequences regarding access to pathology reports, slides and tissue blocks. This has the potential to result in serious consequences for patients.

A significant problem in this scenario is that pathology reports are typically not available on the local laboratory information system or patient electronic care record, with consequences for the pathologist and the clinical team in accessing the reports. Reports need to be available on the local laboratory information system not just to facilitate timely patient treatment and discussion at multidisciplinary team meetings but also in the future, for example should the tumour recur. In such a scenario, the reporting pathologist may not be aware of a history of a neoplasm and will have no access to the report or the histological slides or blocks. Another problem is that blocks are not readily available for additional studies (immediate or in the future), for example further immunohistochemistry, mismatch repair studies, tumour *BRCA* testing or other molecular studies. Although the local institution can request the slides and blocks, this results in increased secretarial and pathologist work and inevitable delay. This also results in problems for cervical screening programmes, where routine correlation of cytology and histology is necessary. As another example in gynaecological pathology, in many institutions the chemotherapy response score (CRS) is routinely reported in postchemotherapy tubo-ovarian high-grade serous carcinomas. However, in my experience such specimens reported in other laboratories have not had the CRS recorded on the report. It is also unfortunately the case that some pathologists, especially in private laboratories, may report specimens which they would not normally report.

In summary, the COVID-19 pandemic has resulted in some unexpected and unfortunate consequences regarding the pathological reporting of specimens. Although herein this is highlighted with regard to gynaecological pathology, undoubtedly this also happens in other organ systems. Managers and clinicians must be aware of this and when embarking on similar undertakings in the future should liaise with their local pathology team and take steps to ensure that pathology samples are directed to their local institutions for reporting.

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