

Orbital Tumor of an eye enucleated previously: Legal responsibility of the Pathologist

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Article History

Received: 22.11.2017

Accepted: 26.11.2017

Published: 30.11.2017

DOI:

10.36347/sjmc.2017.v05i11.026



Abstract: The input of the pathologist in the diagnosis of tumors is essential. An accurate diagnosis is needed by the clinician to carry out the right surgical procedure in order to minimize the consequences on the prognosis. Any error in the diagnosis by the pathologist may end up with inappropriate treatment that can threaten the life of the patient. The current case report is about a 10-year-old child enucleated for tumoral proptosis with a recurrence 3 months later despite the normal report given by the pathologist.

Keywords: Orbital Tumor, tumoral proptosis, prognosis.

INTRODUCTION

A wrong diagnosis by a clinical pathologist could lead to delay or inappropriate treatment and may result in a legal action from the patient who suffered damages [1]. Diagnosis errors, defined as missed, delayed, or wrong diagnoses, are a frequent cause of medical errors in the United States [2].

A pathologic diagnostic error or discrepancy is defined as « when one pathologist renders a diagnosis and another pathologist looks at the same materials and renders a different opinion or diagnosis » [3]. The diagnosis of many disease processes depends to a large extent on the pathologic assessment of tissues. The majority of cancer diagnoses are made on the basis of histologic or cytologic evaluation. Consequently, diagnostic pathology errors may lead to incorrect patient management plans, including delay in treatment or the implementation of incorrect treatment regimens [4]. We report a case that points out a wrong diagnosis rendered by the pathologist with serious consequences on the prognosis.

CASE REPORT

A 10-year-old school boy presented with extra-ocular mass of the left eye following a previous enucleation. On history, his left eye was enucleated 3 months back for “proptosis with painless blind eye”. The enucleated tissue was examined by the pathologist who noticed no sign of malignancy in his report. Clinical findings were as following:

Visual acuity: 6/6 in the right eye and NPL (non perception of light) in the left eye. On physical examination, the socket of the enucleated eye was filled with a swelling that protruded through the palpebral fissure. Computed Tomography (CT-Scan) showed a tumoral mass that filled the left orbital cavity. The legal guardians of the patient disagreed to let him undergo a new surgical procedure despite our endeavor to persuade them; so we referred him to the oncologist.



Fig-1: showing the mass through the palpebral fissure

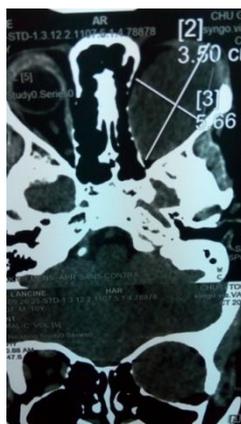


Fig-2: CT-Scan showing the mass filling the left orbital cavity

DISCUSSION

Diagnosis errors are not common in anatomic pathology. These errors may be classified into no-fault errors, system errors and cognitive errors [5]. No fault errors refer to uncertainty about the state of the world and the limitations of medical knowledge. System errors consist of technical and/or organizational failures and also require investigation of organizational factors. Cognitive errors are the most common source of diagnostic errors; they may consist of misinterpretation of microscopic slides due for instance to human limitation in competence [6, 7]. In the case reported here, the pathologist may have committed a cognitive error; since the time frame from his report that found no malignancy and the recurrence of the tumor was short.

Histopathological diagnosis is a vital link in patient management. Accurate as well as in time diagnosis is vital for the success of any treatment. Diagnostic errors in surgical pathology and cytology range from 0.25 to 6% [8]. Diagnostic errors may lead to an unnecessary surgery or organ removal, chemotherapy or early death due to therapeutic complication as a result of over diagnosis. An under diagnosis may lead to delay in inappropriate treatment and sometimes disease may progress so rapidly and leading to increase in mortality and morbidity [9]. In the current case, there is an under diagnosis that led to insufficient treatment. The patient may have undergone additional chemotherapy or exenteration in case the pathologist's report was right.

Diagnostic pathology error frequency and effect are poorly characterized, partly because of the lack of uniform measurement processes, a lack of understanding of when an error has occurred, and fear of disclosure. Anatomic pathology errors are detected by several methods [10]. The most commonly used method is secondary review, in which a second pathologist reviews slides previously examined by a first pathologist [4].

Oftentimes, surgeons are blamed by patients when an error occurs during the process of healthcare

even when it is committed by the pathologist. Legal proceedings against pathologists are rare because their errors are not obvious for the layman.

CONCLUSION

Orbital tumors have sometimes a fatal prognosis; their diagnosis has to be performed with accuracy by a qualified pathologist. An under diagnosis may lead to the death of the patient. Some pathologists are careless particularly in Africa, because they are rarely prosecuted. The law enforcement is necessary in order to compel this category of practitioners to cope with the standards of good healthcare.

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