CONCLUSION

Our QI project resulted in an improved and sustained lesion diameter reporting rate.

• Barriers to implementing guidelines were addressed, including lack of awareness, inertia of previous practice, and external barriers (eg, lack of a reminder system).

• A peer orientation successfully educated a new resident in implementing lesion diameter reporting in his practice.

• Several limitations were encountered in this QI project.

  • Lesions may not have been classified correctly during data collection, as the determination of a neoplasm vs eruption was made from the clinical impressions recorded on SBRFs by a single dermatologist.

  • There was limited, but some, crossover between the control and intervention groups secondary to scheduling of staff. This may have resulted in the miscategorization of some data.

  • In retrospective chart reviews, missing data can result in a hidden or non-response bias in the results. As some SBRFs were not accessible, the data set is incomplete.

• Future directions of this project may include:

  • Examining the downstream effect from SBRFs received by dermatopathologists including lesion diameter vs. non-inclusion.

  • In one study, 90% of dermatopathologists viewed medical decision-making guidance as part of their role in addition to providing pertinent histopathologic findings and specific diagnoses.

  • Inclusion of detailed information in SBRFs improves diagnostic accuracy of the consulted dermatopathologist.

  • Examining the impact of the electronic medical record (EMR).

• The use of clinicians’ EMRs by pathologists may enhance access to clinical information not otherwise included on the SBRFs.

• Some authors have proposed a modified SBRF that includes lesion size. However, SBRFs are increasingly generated by EMRs, resulting in incomplete SBRFs that omit vital clinical information (eg, lesion size) for interpreting dermatopathologists.

REFERENCES


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