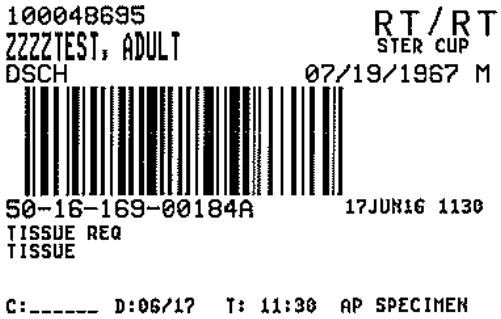
RANCHO LOS AMIGOS
NATIONAL REHABILITATION CENTER

Anatomical Pathology Collection Guide

PATHOLOGY

All Pathology orders must be placed in Orchid/Cerner PowerChart application. On the patient home page, go to Orders - Add and type “path” in the orders search box. Select the appropriate order from the drop down menu, Pathology Tissue Request, Pathology Non-Gyn Cytology Request, Pathology GYN Cytology Request or Pathology Bone Marrow and provide the required Information. When the order is placed, a specimen label will be printed. Place the label on the specimen container and send to the Laboratory. All specimens must have a SPECIMEN label and cannot be processed without it.



A. SURGICAL PATHOLOGY

All tissue, teeth, hardware, foreign bodies, etc., removed from patients in the operating rooms, on the units, or in the clinics must be submitted for pathological examination unless prior arrangement is made with the pathologists.

Pathology orders must be placed in the Cerner system through the PowerChart application for each specimen. To place an order, go to PowerChart>ORDERS>+ADD>PATH>. Select Surgical Pathology, Gyn Cytology or Non-Gyn Cytology and enter the Specimen Description. Once entered, a specimen label will be printed. Affix the SPECIMEN label to the specimen container and send to Pathology department.

Unlabeled specimens or specimens without a SPECIMEN label cannot be processed and may result in significant delays until the issue is resolved.

Any specimen sent in red biohazardous waste bags or containers will not be accepted.

10% formalin is the fixative routinely used for fixation. Other fixatives are available. Fixatives can be obtained from the pathology department by calling x 58994 or going to JPI room B165.

All foreign bodies placed in the body by accident or intention such as orthopedic hardware, bullets, knife blades, needles, which may have medical-legal implications, will be kept by the Pathology Department and identified by number for at least one year.

Pathology specimens are disposed of 2 weeks after the report has been finalized, unless previous arrangements have been made.

Routine specimens are processed daily. Generally, a final report will be available within 5 days for uncomplicated cases and 8 days for complicated cases unless a weekend or holiday intervenes or a case requires outside consultation or additional studies (immunohistochemical stains, molecular studies, etc).

Request for a copy of the surgical report by the patient must be done in writing. Patient requests must be made through the Health Information Management Department.

Pathological reports may not be quoted in published articles without written permission from the Chairman of the Pathology Department.

ELECTRON MICROSCOPY

For electron microscopic examination, **consult with the pathologist prior to biopsy/tissue sampling**. Arrangements need to be made with the reference laboratory to obtain the fixative (may take several hours) and to place the order/request. A small piece of tissue, no larger than l mm, should be placed immediately in the fixative and transported to the Histology Laboratory for sendout.

MUSCLE BIOPSIES
Make prior arrangements with the Pathology department (562-385-8994-Histology) to arrange for a STAT courier to send-out specimen to Harbor-UCLA. Muscle biopsies must be submitted fresh, wrapped in a saline moistened gauze. **DO NOT place in formalin.** Send the specimen immediately to the Pathology department.

FLUORESCENCE MICROSCOPY
For fluorescence microscopy frozen tissue is needed. (Arrange with Pathology department prior to biopsy).

MICROBIOLOGICAL CULTURES
If microbiological culture is desired on tissue, the specimen must be placed into a sterile container and sent immediately to the Laboratory with an order for microbiology culture.

FROZEN SECTION AND STAT GRAM STAINS
Arrangement for frozen sections and stat gram stains at time of surgery must be made through the Pathology Office (562-385-8994). It would be helpful to give advance notice.

B. CYTOPATHOLOGY

All cytology specimens received must be ordered by a physician, a physician assistant or nurse practitioner with privileges at Rancho Los Amigos National Rehabilitation Center.

The specimen container must have the specimen label affixed that is generated at the time the order is placed in Cerner.

Specimens must be submitted in the appropriate specimen container with an adequate amount of the proper fixative to avoid decomposition of cellular materials.

The following information must be on all slides submitted:
a. Patient name
b. Complete unique patient identifier

If specimen container identification is incomplete:
The floor or ward supervisor will be notified or the specimen will be returned if it is impossible to complete the necessary information or if the container is not identified.

Criteria for rejection of specimens
Specimens that are received in the pathology laboratory for processing may be rejected based upon the following criteria for rejection of specimens:

1. Inadequate or incorrect patient identification and information on the specimen container
2. Inadequate or lack of fixative or preservation
3. Fluid specimen is clotted
4. Improperly obtained and/or source of request is unauthorized:

If the specimen has been rejected, the submitting physician and the requesting service is notified so corrective action may be taken. Notification is documented in the PathNet General Lab: Pending Inquiry Appbar.

COLLECTION PROCEDURES:

Vaginal and cervical smears

1. Scrape lateral vaginal wall and exocervix with a spatula and make smears on slides. Use cotton tipped applicator for insertion in the endocervical canal. No lubricants should be used on instruments for vaginal or cervical specimens.
2. Patient's name and MR# must be written on the frosted slide with a pencil.
3. Fix specimen slide immediately, without drying, in 99% isopropanol.

ThinPrep PAP Test

Endocervical Brush/Spatula Protocol

1. Obtain an adequate sampling from the ectocervix using a plastic spatula.
2. Rinse the spatula into the PreservCyt Solution vial by swirling the spatula vigorously in the vial 10 times.
3. Obtain an adequate sampling from the endocervix using an endocervical brush device.
4. Insert the brush into the cervix until only the bottom-most fibers are exposed.
5. Slowly rotate 3 or 2 turn in one direction. DO NOT OVER ROTATE
6. Rinse the brush in the PreservCyt Solution by rotating the device in the solution 10 times while pushing against the PreservCyt vial wall.
7. Swirl the brush vigorously to further release the material.
8. Discard the brush.
9. Specimen vial must be labeled with the patient's name and MR#.
10. Tighten the cap on the vial so that the torque line on the cap passes the torque line on the vial.
11. Label container with patient name and unique identifier.

Broom-like Device Protocol

Obtain an adequate sampling from the cervix using a broom-like device.

1. Insert the central bristles of the broom into the endocervical canal deep enough to allow the shorter bristles to fully contact the ectocervix.
2. Push gently, and rotate the broom in a clockwise direction five times.
3. Rinse the broom in the PreservCyt Solution vial by pushing the broom into the bottom of the vial 10 times, forcing the bristles apart.
4. As a final step, swirl the broom vigorously to further release the material
5. Discard the collection device.
6. Specimen vial must be labeled with the patient's name and MR#.
7. Tighten the cap of the vial so that the torque on the cap passes the torque line on the vial.
8. Label container with patient name and unique identifier.

Body cavity fluids (pleural, peritoneal, synovium)

1. Collect body fluids in clean container and add 1 ml. of 1:1000 heparin for each 10 ml. of fluid.
2. Label container with Patient name and unique identifier.
3. Bring to Clinical Laboratory immediately, or refrigerate.

Bronchial, esophageal or gastric washings

1. The organ lumen is rinsed with normal saline solution and washings are collected into 2 oz. bottles with 50% ethanol.
2. Brushings should be smeared onto slides and immediately placed in 99% isopropanol. Slide must be labeled with patients name and Rancho number.
3. Label container with patient name and unique identifier.

Urine

1. Early A.M. urine samples are recommended for collection.
2. Urine should be collected in 2 oz. bottles with 50% ethanol and sent to the laboratory.
3. Label container with patient name and unique identifier.

Sputum

1. Encourage deep cough (not saliva). Early morning is usually best; do not use 24-hour collections.
2. Place collection material in an equal amount of 50 percent ethyl alcohol.
3. Label container with patient name and unique identifier.

Cerebrospinal fluid

1. This must be submitted fresh, immediately.
2. Label container with Patient name and unique identifier.
3. Refrigerate if transport to the lab is delayed.

Aspiration Specimens

1. Label glass slides clearly and legibly with the patient's name and other unique and complete identifier.
2. Label containers with patient name and unique identifier.
3. After cleaning of the skin with disinfectant, the lesion site is aspirated with a 22 gauge needle attached to a plastic syringe which has been rinsed with heparin.
4. Apply vacuum pressure to the syringe while moving the needle in the lesion at different angles. Stop the aspiration when sample is noted in the syringe.
5. Withdraw needle from the site without vacuum pressure on the syringe.
6 The syringe is filled with air after detaching the needle. After detaching the needle the specimen is expressed as a small drop onto glass slides. A second slide is inverted over the sample slide and pull smears are made.
7. The slides are immediately fixed in 99% isopropanol and any remaining material in the syringe is added to a bottle with 10% formalin for cell block processing.

Breast- nipple secretions

1. Nipple secretions should be obtained after manipulation of the breast.
2. The sample should be expressed onto a slide and pull smears are made and submitted immediately in 99% isopropanol.
3. Label container and slide with patient name and unique identifier.

Buccal smears for sex chromatin

1. After patient rinses his mouth, the lateral buccal mucosa should be scraped with a wooden tongue blade.
2. Smears are made on slides and immediately placed in 99% isopropyl alcohol.
3. Label container and slides with patient name and unique identifier.

C. BONE MARROW ASPIRATIONS

The Hematology Laboratory (x-58993) should be notified in advance when a bone marrow is scheduled.

1. Bone marrow smears are made by the clinician.
2. Label glass slides clearly and legibly with the patient's name and other unique and complete identifier.
3, Bone marrow particles are smeared on glass slides. Any remaining aspiration material is put in

freshly mixed B-5 solution (fixative obtained from Histology Laboratory).
4. Bone biopsies are placed in buffered 10% formalin.
5. Label container and slides with patient name and unique identifier.

D. AUTOPSY REQUEST/RELEASE OF DECEDENT

All patient deaths must be reported at the time of death to the Medical Records office (x57129) and the Pathology office (x58994) during weekdays from 0800 to 1700. During all other times, weekends and holidays, notify the Laboratory at x 58991 immediately. Please be prepared to give the following information: patient name, Medical Record Number, time of death, unit, autopsy consent status, (i.e. unknown, obtained, denied). When the body is ready to be picked up from the ward, call the Lab at x 58991 to make arrangements for the morgue to be opened.

1. Coroner's Autopsy (Fill out Coroner's "Form 18"):

Any person who does not notify the coroner as required by this section is guilty of a misdemeanor.

a. A physician and surgeon, physician assistant, funeral director, or other person shall immediately notify the coroner when he or she has knowledge of a death that occurred or has charge of a body in which death occurred under any of the following circumstances:

i. Without medical attendance.
ii. During the continued absence of the attending physician and surgeon.
iii. Where the attending physician and surgeon or the physician assistant is unable to state the cause of death.
iv. Where suicide is suspected.
v. Following an injury or an accident.
vi. Under circumstances as to afford a reasonable ground to suspect that the death was caused by the criminal act of another.

B. Cases of possible but not diagnosed contagious disease, such as, possible meningitis or possible pulmonary tuberculosis when an autopsy is not contemplated, shall be referred to the coroner for diagnosis following which notification of proper authorities will be made.

C. Listed below are types of deaths which have been difficult to evaluate and should be referred to the Coroner for decision:

i. Aspiration
ii. Suffocation
iii. Drug addiction
iv. Exposure
v. Pneumoconiosis
vi. Poisoning
vii. Heat prostration
viii. All fractures should be evaluated by the Coroner except SPONTANEOUS PATHOLOGICAL fractures.
ix. Therapeutic misadventure
x. Operative Deaths (result of surgery or anesthesia)

2. Non-Coroner's Autopsy (PERFORMED AT HARBOR-UCLA):

a. Please call the RLA Anatomic Pathology Department at x58994 (during business hours) or at X58993 (after hours) to make arrangements for the autopsy. The autopsy order must be submitted using the RLA Laboratory Computer Downtime

form. In addition, Harbor-UCLA requires its forms to be filled out to perform the autopsy (e.g. Harbor-UCLA post-mortem consent form, Harbor UCLA Notice of Patient Death form and Harbor-UCLA Information for death certificate form). The autopsy will not be performed without evidence of valid consent. The consent verbiage must be read word for word from the Harbor- UCLA post-mortem consent form for the consenting process to be considered valid. Signatures of the physician and a witness must be documented directly on the Harbor UCLA Post-mortem consent form.

b. It is the policy and goal of the Medical Center to obtain postmortem examinations on all patients who die during the course of treatment at the Medical Center. Staff members shall attempt to secure consent for autopsies in all deaths except coroner's cases. If possible, contact should be made with relatives who are present at the time of death. Any discussion with family members regarding the postmortem examination must be documented in the chart. If consent is not obtained for a postmortem examination, refusal shall be documented in the medical record.

c. In compliance with state regulations, the patient's attending physician shall be advised by the pathologist or designee of the date, time and place of the autopsy. The provisional anatomic diagnoses will be recorded in Orchid Powerchart upon completion of the autopsy and the completed protocol shall be made a part of the record within sixty days.

3. When the next of kin is not at the bedside, it is preferable to obtain permission Telephonically, with a witness listening and signing the consent from as a witness.

4. When the next of kin desires a report of an autopsy, a written report will be sent upon request to the physician of their choice. Autopsy front sheets may be sent directly to next of kin. Upon insistence of next of kin, the Freedom of Information Act does not permit withholding the reports therefore, a copy of the report may be sent directly to the family.

5. Pathology reports may not be quoted in published articles without the written permission of the Chairman of the Department.

E. SHOWING BODIES IN THE MORGUE

The family should be gently, but strongly discouraged from viewing the body after it comes to the morgue because there are no proper facilities in the morgue for viewing the remains. However, if the family insists, it is, of course, their right and the Pathology office should be notified. The pathology personnel will do their best to make the body presentable to the family. Staff is available for this service from 08:30 to 16:30 during regular workdays only (Monday to Friday).

The following procedures should be followed when showing bodies in the morgue:

a. The nursing or pathology personnel will accompany the family to the morgue and remain there until the viewing is completed.
b. The nurse or pathology personnel accompanying the family should have spirits of ammonia or other appropriate agents available for family members who do feel faint.

F. RELEASE OF BODIES AND BODY PARTS:

Bodies and body parts can only be released to the County Coroner or to licensed facilities, such as organ donor agencies, funeral homes, and crematoriums. No bodies or body parts will be released to family members, friends or acquaintances. In addition, the release of all bodies or body parts will be done only upon completion of the proper release document.