

C A S E R E P O R T

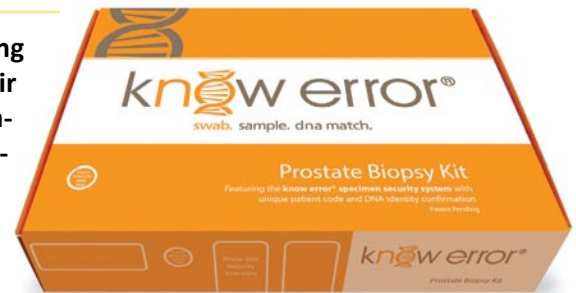
DNA Confirmation of Mislabeled Biopsy Specimens

OVERVIEW

In this case, the pathology laboratory received two specimen kits containing prostate core biopsies from two separate patients. These patients had their biopsy procedures on the same day in the same building. However, one patient was downstairs in the surgery center, while the other patient was upstairs in the office.

The first kit (Kit #1) contained six specimen jars labeled with the name of Patient A. The second kit (Kit #2) contained 14 specimen jars. However, 12 jars from Kit #2 were labeled with the name of Patient B and two jars were labeled with the name of Patient A.

Upon receipt of the kits, the laboratory staff discovered the labeling error and potential specimen mislabeling.



MATERIALS AND METHODS:

When the potential error was identified, the laboratory followed their policy of notifying physicians and staff. The lab requested new specimens which would require a repeat biopsy for both patients.

After additional consultation with the laboratory's pathologist, it was agreed to process and report the histology for Patient B. This was done using the biopsy kit's unique bar code number as the primary identifier rather than the patient name listed on the specimen jars.

The histology report from Kit #1 revealed five BPH specimens and one PIN specimen. The histology report from Kit #2 revealed all 14 specimens consistent with BPH.

RESULTS:

The specimen identification was verified with DNA confirmation testing. The single PIN specimen from Kit #1 was sent for DNA matching with a reference buccal

smear from Patient A. Three specimens in Kit #2 (two labeled with the name of Patient A, and one labeled with the name of Patient B) were also sent for DNA confirmation testing with a reference buccal smear from Patient B.

Results of the DNA testing confirmed the PIN biopsy from Kit #1 was from Patient A, as it had been labeled. The DNA confirmation testing also confirmed that the tested specimens from Kit #2 belonged to patient B. Therefore, the two specimen containers in Kit #2 (labeled with Patient A) were mislabeled.

CONCLUSIONS:

DNA testing confirmed the sources of mislabeled prostate biopsy specimens without subjecting patients to repeat biopsies.

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For more information about the **know error® specimen security system** with unique patient code and DNA identify confirmation, please visit: www.knowerror.com

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