KARNATAKA STATE OBSTETRICS AND GYNECOLOGY ASSOCIATION
ETHICS AND MEDICOLEGAL COMMITTEE

MEDICOLEGAL BULLETIN

Week 31:Missed or Delayed Follow-Up of an Abnormal Endometrial Biopsy: Cancer Diagnosis and Medicolegal Accountability

1.REAL LIFE CASE SCENARIO(ILLUSTRATIVE)

A 58-year-old woman with postmenopausal bleeding undergoes outpatient endometrial sampling. The pathology report, uploaded several days later, reads "atypical endometrial hyperplasia / endometrial intraepithelial neoplasia (EIN); exclude concurrent carcinoma." The patient assumes she will be called if anything is serious. The treating clinic assumes she will return with the report. Neither a documented review nor a recall occurs.

Six months later, she presents with recurrent bleeding and is diagnosed with endometrial carcinoma. A complaint alleges that the initial abnormal result was not communicated or acted upon. This is a hypothetical teaching scenario, not a reported judicial case.

Core question: Who owned the result, how was the patient informed, and what action and follow-up were documented?

2.MEDICOLEGAL RISKS IN SUCH CASES

- Failure to review a report that the clinician ordered.
- Failure to distinguish benign findings from EIN/atypical hyperplasia or suspected malignancy.
- No documented communication of a significant result or recommendation for further evaluation.
- No tracking of missed appointments or unsuccessful contact attempts.
- False reassurance from a technically inadequate or insufficient sample.
- Failure to investigate persistent bleeding despite a benign initial result.
- Alteration or backdating of notes after a complaint.

3. WHAT THE CLINICAL STANDARD REQUIRES

Postmenopausal bleeding requires appropriate assessment. Endometrial sampling may be indicated according to presentation and imaging findings; a thin endometrial stripe on ultrasound is reassuring in selected initial presentations, but persistent or recurrent bleeding still requires evaluation.

EIN/atypical endometrial hyperplasia is a premalignant diagnosis associated with a substantial possibility of concurrent endometrial cancer. In patients who have completed childbearing, hysterectomy is generally definitive treatment; gynecologic oncology input is appropriate when cancer is suspected or staging may be required.

If a specimen is insufficient, the result must not be treated as a negative cancer test. Further assessment depends on symptoms, ultrasound findings and clinical risk.

4.DOCUMENTATION – THE DOCTOR'S STRONGEST DEFENSE

- Record indication for biopsy, bleeding history, relevant risk factors and findings.
- Record the sampling method, specimen labeling and pathology request.
- Date/time of receipt and clinician review of the pathology report.
- Record the exact diagnosis, its significance, and the recommended next step.
- Record how the patient was contacted, what was explained, and the patient's response.
- Document referral, appointment date, attendance, and any unsuccessful contact attempts.
- Preserve original reports and contemporaneous entries; correct errors with dated, attributable addenda, never silent overwriting.
- Sample entry: "Histopathology dated __ reviewed on __: EIN/atypical hyperplasia. Discussed risk of concurrent carcinoma and need for prompt definitive assessment. Patient informed by __ on __; referral arranged to __; appointment __. Safety-net advice given." Use only when these actions actually occurred.

5.PRACTICAL SAFE PRACTICE – CLOSED-LOOP RESULTS SYSTEM

- Assign responsibility for reviewing every ordered pathology report, including during leave or staff turnover.
- Maintain an abnormal-result register or electronic work queue with acknowledgment and closure.
- Flag EIN, atypia, suspicious carcinoma and inadequate samples requiring further assessment.
- Communicate important results directly and promptly; document contact and a clear action plan.
- Use reasonable repeat contact and escalation procedures for non-response, consistent with confidentiality.
- Confirm that high-risk referrals have been received and that follow-up is arranged.
- If the patient declines further investigation, document informed refusal, alternatives, risks and safety-netting.
- In low-resource settings, a numbered pathology register with columns for report received, reviewed, patient informed, next action and completion can prevent avoidable failures.

6.COMMON MISTAKES TO AVOID

- "The patient was supposed to collect the report" as the only follow-up system.
- Assuming an abnormal report will automatically trigger action by the laboratory.
- Treating an insufficient sample as proof of no malignancy.
- Reassuring a woman with persistent postmenopausal bleeding solely on one prior benign test.
- Sending an unclear message without confirming that the patient understands the urgency.
- Backdating documentation after a missed result is discovered.

7.CLINICAL–LEGAL PEARL

Ordering a test creates a clinical responsibility to have a reliable process for receiving, reviewing, communicating and acting on its result. It does not mean a clinician can guarantee every patient will comply, but reasonable follow-up efforts should be demonstrable.

"Test ordered" is not the end of care. "Result reviewed → patient informed → action arranged → outcome tracked" is the safer sequence.

8.REAL COURT CASE INSIGHTS – APPLY PRINCIPLES CAREFULLY

- In Jacob Mathew v. State of Punjab (2005) 6 SCC 1, the Supreme Court explained that medical negligence is assessed against the standard of an ordinarily competent professional exercising reasonable skill and care; a poor outcome alone does not prove negligence. This judgment did not decide an endometrial-biopsy follow-up dispute.
- In Kusum Sharma v. Batra Hospital (2010) 3 SCC 480, the Supreme Court reiterated that doctors are not liable merely because a treatment outcome is adverse, provided their conduct meets the applicable professional standard. Again, this is a general negligence principle, not a ruling that every missed result constitutes negligence.
- Whether delayed follow-up is legally negligent depends on the clinical urgency, reasonable systems, communication, causation, evidence and facts of the individual case.

9.TAKE-HOME MESSAGE

- An abnormal endometrial biopsy is not just a laboratory report; it is a clinical decision point.
- Protect the patient and the practice with five habits: identify the report owner, review the result, explain its significance, arrange the next step, and document completion or reasonable follow-up attempts.
- Good documentation cannot replace good care. It should accurately demonstrate that good care occurred.

SELECTED REFERENCES

- ACOG Clinical Consensus No. 5 (2023): Management of Endometrial Intraepithelial Neoplasia or Atypical Endometrial Hyperplasia.
- ACOG Committee Opinion No. 734 (2018; reaffirmed): The Role of Transvaginal Ultrasonography in Evaluating the Endometrium of Women With Postmenopausal Bleeding.
- Jacob Mathew v. State of Punjab (2005) 6 SCC 1; Kusum Sharma v. Batra Hospital (2010) 3 SCC 480.

NEXT WEEK-WEEK 32:Failure to Diagnose and Manage Ovarian Torsion – Emergency Surgery, Ovarian Preservation and Medicolegal Liability

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