ECVCP, Laboratory Standards Committee
Guidelines for Veterinary Clinical Pathology Reporting

Introduction

Veterinary cytology reports should provide clear communication to the clinician about the type of sample received, its condition/quality, and contents, as well as interpretation of the findings and comments regarding these findings.

Important aspects of non-interpretive sections of the report

It is recommended that all cytology reports include the following:

1. Identification of the animal, owner, and submitting veterinary clinic.
    Desirable but not required: identification of the submitting veterinary surgeon.

2. Age and species of animal.
    Desirable but not required: Breed of the animal. If there is not a field in the patient identification for breed, details of breed that may be relevant to the interpretation based on common breed-related findings and/or predisposition should be mentioned in the history or in the body of the report.

3. Date of collection and date of reporting

4. Type of specimen and method of collection

5. Additives (anticoagulant, fixative, other treatments)

6. Number and type of preparations evaluated (cytospin, direct smears, sediment smears, etc.)

7. If body fluid analysis is included in the cytologic submission, it is desirable (but not required) that the results of body fluid analysis be reported in conjunction with the report of the cytolopathologist/cytologist evaluating the cytologic preparations.

8. Identification of the laboratory and/or department from which the report is originating
    It is desirable but not required that this includes contact details for the laboratory (address, telephone, and/or e-mail)

Use of language in the cytology report

1. Use of a single tense for the entire report is encouraged. Present tense is preferred, but not required.

2. Use of stilted language, pompous wording or unnecessarily obtuse or complicated verbiage is discouraged. The sentences should be short, direct and clear.

The goal is to clearly communicate, not to try to ‘impress’ the reader.

Sections of the Cytology Report

Recommended sections of the cytology report include:

A. Clinical Summary
B. Description
C. Interpretation
D. Comment
E. Pathologist’s Signature/Identification

A. Clinical Summary

Some laboratories may not include this section in the report format. This section is strongly recommended since it provides valuable information about the setting in which the specimen collection is conducted and information that may be vital for interpretation, differential diagnoses and comments. Further, this section communicates to the submitting veterinary surgeon how the clinical context is appreciated or understood by the cytopathologist when assessing the case and specimen(s). It also documents the information that the clinical pathologist has at the time of assessment of the cytologic specimen.

B. Description

The description should provide a ‘word picture’ that allows anyone reading the report to picture the features of the cytology preparations that are examined. Some laboratories may offer cytology reports in an ‘abbreviated’ format with little or no description. This is not desirable from the point of training and/or quality assurance since subsequent audit or review for comparative reasons may not be able to determine if the smears available are likely to be those interpreted. The comparison of audit findings with those of the description provides confidence the correct smears have been evaluated. Mention of the quality of the preparations/submissions is indicated if these are not of good quality, with additional information about improvement of submissions/preparations provided in the Comment (see below). It is desirable but not required to acknowledge the presence of good quality submissions.

C. Interpretation

The interpretation may take the form of numbered items, or a few words or phrases. The interpretation section should be short and clear, providing a busy clinician with as succinct an interpretation as possible.

D. Comment

The comment may restate the interpretation of the findings, and should include (if needed or appropriate for the type of report) :
1.Elaboration with regard to the degree of confidence in the interpretation
2. Inclusion of differential diagnoses if a highly probable or conclusive interpretation is not possible
3, Information about other tests or investigations that may be of benefit for interpretation, diagnosis. prognosis and/or monitoring (if applicable)
4. Information about improving the quality of submission (if needed)
5. Information about the condition(s) intepreted to be present (aetiopathogenesis, expected biologic behaviour or clinical course, prognosis, etc.)
6. Treatment recommendations may be given if the reporting cytologist/.cytopathologists is knowledgeable and comfortable making such recommendations

E. Pathologist's Signature/Identification

This should include the name and credentials of the reporting cytologist/cytopathologist.