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# The whys and wherefores of who reads dermatopathology slides

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“Greed, for lack of a better word, is good.”

Gordon Gecko, *Wall Street*

Before exploring this topic, I must admit to my own financial bias. As director of an academic dermatopathology laboratory employing 4 dermatopathologists in addition to myself, I would prefer that all skin biopsy specimens be sent to our laboratory for processing and interpretation. Since this is not possible, I would settle for all skin specimens in the state of Connecticut. Since this is also unlikely, my next wish would be that all specimens in our state be sent to either Yale or the University of Connecticut. The reasons are both straightforward and simple: quality of care and economics. Dermatopathology laboratories are financially lucrative and help support not only the salaries of the highly qualified and dual and triple Board-certified faculty, but they are also often the financial engine that helps support academic department missions, including education and research. In addition, in this type of setting, there is a team approach to difficult and challenging cases. In our department we have the good fortune to have faculty who were trained by different, albeit all highly respected, mentors. As a result, in-house consultation by 5 dermatopathologists is a routine daily occurrence. When the 5 of us sit around the multiheaded microscope, there are 3 clinical dermatologists/dermatopathologists, 1 anatomic pathologist/dermatopathologist, and 1 anatomic pathologist/dermatopathologist/immuno-

pathologist, that is, 5 people, with 11 Board certifications!

The dispositive question is why would a clinical dermatologist sign out his or her own slides when there are specialized Board-certified dermatopathologists available, if not in your own community, then by courier, fax, and phone? I believe that these clinical dermatologists would tell you that they were exposed to a strong core curriculum in dermatopathology during their 3-year dermatology residency, that their dermatology Board certification included a significant amount of dermatopathology, that general dermatologists are, in fact, better trained in dermatopathology than anatomic pathology—trained physicians are in dermatopathology (see “The extent of dermatopathology education: A comparison of pathology and dermatology” by Singh et al in this issue [pages 694-7]), and that they can apply clinicopathologic correlation better than anyone else looking at the same slides since they have seen the patient. I would argue that although these clinical dermatologists did receive training in dermatopathology during their dermatology residency, a dermatopathologist is almost invariably better trained. Jean Bologna, an outstanding clinical dermatologist and original thinker, explained it best by a bell curve theory. At the far end of excellence is the dermatopathologist’s bell curve in ability and to the left is the dermatologist’s bell curve. A dermatologist who lies on the far right of his/her bell curve might be better than a poor dermatopathologist who falls to the far left of their curve. But in general, dermatopathologists are better. Who could argue with the fact that someone who spent 1 to 2 years obtaining additional training in dermatopathology, attends regular continuing medical education in dermatopathology, studied and passed specialty Board certification (and by definition is “double boarded”), and who is signing out slides every day would be more likely to recognize important pathologic changes even in what at first glance may look mundane?

Many clinical dermatologists who sign out their own slides will argue that they only sign out “the easy cases”. I would counter that among those

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so-called easy cases may be lurking a melanoma within the epidermis of a presumed seborrheic keratosis. It is always the so-called "easy" cases that frighten me the most! As for their clinical pathological correlation vantage, I would argue that there could be prejudice in the extreme to have the dermatopathology interpretation confirm what they have prejudged clinically.

Mohs micrographic surgical specimens present a somewhat different enterprise. The specimens are horizontally sectioned and immediately interpreted after frozen section preparation. The question is usually not histologically complex, but rather: is there any more neoplasm and, if so, in which portion of the specimen? Once again, in many academic settings, the Mohs surgeon has access to a dermatopathologist. In our clinical setting at UConn, we have insisted that the Mohs surgeon's operating rooms be geographically close to the dermatopathology laboratory so that consultations between our Mohs surgeon and any one of our dermatopathologists requires only a short walk down the hall. Finally, most Mohs surgeons will submit formalin-fixed specimens to a dermatopathology laboratory if there is any question regarding the nature of the disease;

these specimens can be handled as urgent "rush" cases, thereby allowing the patient to return to the Mohs suite the next day with a more definitive answer available from the laboratory. Mohs surgeons are required to comply with quality control regulations and are very adept at mapping specimens and at interpretation of horizontal sections of skin in the search for residual neoplasm.

So why do dermatologists sign out their own slides? I would contend that in many cases financial remuneration is the motivating factor. I would also contend that this kind of scenario will go the way of other similar settings that are now no longer considered legal, for example, physicians sending patients to their own physical therapy operation or chemistry laboratory. More rules and regulations in the ever-increasing managed care, government intervention medicine we practice will cause this practice to be disallowed. Finally, I would contend that in our malpractice-enriched environment, dermatologists signing out their own slides will find that the pain of one lost law suit or the emotional pain of dealing with an error that could have been avoided by the use of a dermatopathologist will cause this practice to go the way of the dinosaurs.