



Best practice recommendations

Communication of unexpected

findings, urgent reports, delayed

reports and the use of alert systems in

diagnostic cellular pathology

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Foreword

Best practice recommendations (BPRs) published by the Royal College of Pathologists should assist pathologists in providing a high standard of care for patients. BPRs are systematically developed statements intended to assist the decisions and approach of practitioners and patients about appropriate actions for specific clinical circumstances. They are based on the best available evidence at the time the document was prepared. It may be necessary or even desirable to depart from the advice in the interests of specific patients and special circumstances. The clinical risk of departing from the BPR should be assessed and documented.

A formal revision cycle for all BPRs takes place every 5 years. The College will ask the authors of the BPR to consider whether the recommendations need to be revised. A review may be required sooner if new developments arise or changes in practice necessitate an update. A full consultation process will be undertaken if major revisions are required. If minor revisions or changes are required, a short note of the proposed changes will be placed on the College website for 2 weeks for members' attention. If members do not object to the changes, a short notice of change will be incorporated into the document and the full revised version will replace the previous version on the College website.

This BPR has been reviewed by the Professional Guidelines team. It was placed on the College website for consultation with the membership from 22 September to 20 October 2025. All comments received from the membership were addressed by the author to the satisfaction of the Clinical Director of Quality and Safety.

This BPR was developed without external funding to the writing group. The College requires the authors of BPRs to provide a list of potential conflicts of interest. These are monitored by the College's Professional Guidelines team and are available on request. The author of this document has declared that there are no conflicts of interest.

1 Introduction

1.1 Key changes to previous guideline

Key changes made to the previous guideline are outlined in the table below.

Section	Explanation
1	A cross reference to guideline G158 has been included.
3	An example of a pathway that may be suitable for the communication of urgent reports or unexpected findings has been given. The fact that an urgent communication that has taken place should ideally be documented within the report has been added. The advice relating to pathologists coding reports to indicate a positive cancer diagnosis or a negative biopsy, for the purposes of managing a patient pathway, has been updated.
3	The fact that alert systems for the communication of urgent reports or unexpected findings are generally for communication between the pathologist and requester only, has been added.

1.2 Target users and health benefits of this guideline

The target primary users of this guideline are consultant and trainee histopathologists and cytopathologists. The recommendations will also be of value to other members of cellular pathology laboratories.

2 Purpose of guidance

Laboratory-based work is dependent not just on the issuing of a report in which there is a description of histological findings, but also on interpreting their relationship to the clinical setting. This requires the application of clinical judgment. The General Medical Council has issued guidance in Good Medical Practice that indicates a clinical duty to make appropriate communications to clinical teams, placing the care of patients as a first priority (Paragraphs 25 and 44a).¹

This document provides advice in relation to concerns around implementation of systems designed to draw attention to laboratory reports, here termed 'alert systems'. Advice is also given in relation to working with service users to establish pathways for the communication of urgent reports or reports in which there is an unexpected finding. Advice is also given around communication when it is anticipated that the issue of a written report will be significantly delayed.

An alert system may be implemented as part of a laboratory reporting system. An alert system is defined as any management system designed to highlight or code laboratory reports such that they are specially drawn to the attention of the clinical team. They are usually used to expedite the referral of patients through care pathways.

Please also see [G158 BPR: The communication of critical unexpected pathology results](#).²

2 Systems should ensure that reports are available to service users promptly

Cellular pathology departments should ensure that systems are in place within the laboratory so that reports are routinely sent in a timely manner to meet clinical needs. This should include the appropriate use of technology to create written reports and electronic transmission to service users.

Pathologists should work with service users to optimise the service so that those who have requested a laboratory investigation receive reports upon which they can make clinical decisions. Reports should be written to comply with [guidance issued by the College](#). The use of SNOMED-CT codes for reports can aid identification of cancer patients for multidisciplinary team meetings.

Service users sending specimens should have systems in place to ensure that all histopathology reports are read by someone who is suitably trained and qualified to read and interpret them correctly, in the context of the patient's clinical details. Systems established with service users should ensure that histopathology/cytology reports are available promptly.

3 Urgent communication of a report or unexpected finding

In addition to routine reporting systems, a report may sometimes need to be communicated urgently, in the opinion of a pathologist. Pathologists should work with service users to define a communications pathway that allows for such a report to be communicated securely and reliably and with as little time and effort required for the pathologist.

Systems will need to be specified that are appropriate for local use, but could include, for example, the use of a secure email message. There may be some benefit in choosing a communication system that is auditable. The ability to send a communication in this setting

will partly depend on the inclusion of the identity of the individual who would be most appropriately placed to receive such a communication, in the request.

In some instances, a diagnostic finding is encountered that may be urgent or unexpected and where the pathologist believes, based on their clinical judgment, that harm may come to a patient by the delay implied in the routine reporting system. In such circumstances, the pathologist should communicate the report using a locally defined pathway for communicating urgent reports, as long as an appropriate means of secure communication is available. It is stressed that the pathologist cannot be held responsible for a report not being acted upon.

Alert systems for the communication of urgent reports or unexpected findings are generally for communication between the pathologist and requester only.

The fact that an urgent communication has taken place should ideally be documented within the report.

4 Coding reports for alert systems

Pathologists may be asked to code reports as part of alert systems. The following principles should apply.

- Pathologists should support the implementation of alert or coding systems as they may draw timely attention to a report to expedite a subsequent clinical management decision.
- In participating in the use of a coding or alert system, pathologists and their employing authorities should make it clear that it is the responsibility of the requesting clinician to have systems in place to ensure timely reading and acting upon of a laboratory report. It must be clear that the alert or coding system does not remove this primary responsibility.
- Coding reports requires clinical information about a case that may be lacking from a laboratory request. Pathologists must, therefore, inform those implementing and using an alert system that no reliance should be placed on such a system to prevent harm coming to a patient, for example through missing reading a report, as subjective interpretation is required for the coding.

5 Informing service users when a delay is anticipated in issuing a report

If a diagnostic finding is encountered and it is anticipated that there will be a significant delay in the preparation of a final written report (for example, in waiting for additional investigations, referral to another colleague or referral to another centre), an interim report summarising the current position should be issued promptly to the relevant clinical team. This can then be noted in the patient record.

The decision of when to issue an interim report is one of clinical judgment, based upon the context of the case. The case should be tracked in the laboratory to flag that a final report is still outstanding and a final written report should be issued as soon as possible.

6 References

1. General Medical Council. *Good medical practice*. Accessed June 2025. Available at: <https://www.gmc-uk.org/professional-standards/the-professional-standards/good-medical-practice>
2. The Royal College of Pathologists. *The communication of critical and unexpected pathology results*. Accessed August 2025. Available at: <https://www.rcpath.org/profession/guidelines/cross-specialty-publications.html>