放射線診斷報告修改之原因分析：以某醫學中心為例

Analysis of Revised Imaging Reports in Diagnostic Radiology: An Example from a Medical Center in Taiwan

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摘要

本研究目的以某醫學中心為例收集放射線判讀報告修改事件並予以統計分析。自2004年9月至2006年6月前瞻性收集某醫學中心所有放射線報告發生修改的事件共297例，並將修改原因分為「閱片太快」、「行政疏忽」、「配合臨床」、「獲得其他資訊」與「不良影像」五大類。結果顯示報告平均修改率為0.06%，其中138份是一般X光檢查，119份為CT/MRI檢查，其他類別的檢查佔40份。一般X光檢查因「閱片太快」修改報告比例最高（佔38.4%），CT/MRI報告修改最主要的原因是「獲得其他資訊」（佔41.2%），其他類別的檢查中以「行政疏忽」最常見（佔37.5%）。 本研究結果的修改率與過去文獻結果(0.07%)相當，透過調查報告修改次數並回饋予報告醫師，如此持續於修正中學習將能促增報告品質的提升。

Abstract

To analyze revised imaging reports in diagnostic radiology from a medical center in Taiwan, we prospectively collected revised imaging reports from one institution between September 2004 and June 2006. A total of 297 revised reports was recruited and divided into five types: missed diagnosis, transcription errors, requested by clinicians, obtained additional information, and suboptimal films. Results showed that the rate of revised reports was 0.06%. Of these 297, plain x-rays had 138 reports, CT/MRI had 119, and other special procedure examinations had 40. The most frequent reason for revision of plain x-rays was missed diagnosis (38.4%), whereas obtained additional information was the main reason for revision of CT/MRI reports (41.2%). Transcription errors accounted for most of the revision in other special procedure examinations (37.5%). In this study, the rate of revised reports was correlated well with previous literature (0.07%). Radiologists can learn from such feedback and revision to enhance quality of our imaging reports.