

Who reads our radiology report?

The radiological report is the final result of the radiologist's diagnostic exercise, regardless of the imaging modality used.

The request for an imaging study is made by a treating physician, who hopes that the image will confirm a diagnostic impression, find a pathological diagnosis for his patient's clinical problem, rule out pathologies to narrow the differential diagnosis, control the evolution of a known disease or use the image to adequately plan a surgical treatment.

But this report, issued by the radiologist, is not only read by the treating physician; first of all, it is the patient himself or his family member who reads it as a medical opinion that will tell him that he has a new disease or that his known disease is improving or worsening, that the cause of his ailments has not yet been found or that instead of the suspected disease a different lesion has been discovered.

Therefore, the language used to prepare this report should be clear enough so that not only the treating physician, but also any non-medical person can understand it. The conclusion, which is the paragraph that will be read the most, must answer the implicit question in the medical request related to the symptoms. If the patient had a trauma and an image of his spine was requested, clearly in the conclusion it should be written whether or not there is a traumatic injury —for example, a fracture—, even if the main findings are others —for example, disc disease, scoliosis and osteoarthritis. It should have a probable diagnosis or diagnoses if there is one and not only a description of the findings with a recommendation for an additional study, which will reflect our knowledge of the semiology of the image, which allows us to establish the most probable diagnosis. Where possible, with a language of certainty rather than doubt. It is unnecessary to raise doubts about findings that are possibly very clear and easy to diagnose. Therefore, it is preferable to avoid terms such as "it could be… cholelithiasis". If we use eponyms or signs in the description, which in my opinion should be avoided, they must be clarified below, since not all doctors —and even less patients— will be familiar with them. If the reported finding is fortuitous, it is better to describe it that way and even better if the severity or lightness of said finding is added. Surely, the patient will be reassured when reading that they have found a tonsillar ectopia that does not affect other structures of his brain and that has no pathological significance. Even if the report mentions that an aneurysm has been found, additional stability findings of the same or small size should be included to guide management or simply continue observation of such a chance finding. If the finding is normally expected after an event, a treatment or a previous condition, it is desirable that it be so described. For example, if the diagnosis is "replacement to fatty bone marrow", its pathological implication will be different if it is added that it is an expected change after the radiotherapy that the patient has received.

Grammar and spelling errors or unexpected dictation errors should be actively searched for and corrected before they end up in the report. Reading through digital dictation often "translates" the dictation in the wrong way. If we start the dictation without giving a few seconds to wait, words can be omitted and this can be so serious that phrases such as "metastatic lesions are demonstrated" are written in the conclusion instead of "no metastatic lesions are demonstrated".

Patients today can quickly read their radiological report and this almost always generates some degree of anxiety in them. Medical language is often not understood by the common people, but they have access to look up the terms on the internet. Of course, it is usually the attending physician who explains his findings to the patient and correlates them with the clinical data he has, in order to make recommendations. But a lot of time can pass between the patient's reading of his radiological report and the appointment with his doctor, who really knows this language. Meanwhile, the patient or his family may feel very confused, anxious or pessimistic about what they have understood when reading their own radiology report. Although it is not widely used in daily practice, the possibility that the patient can speak with his radiologist is a good alternative.

The invitation is that when preparing the reports of the imaging studies we think not only of issuing a sophisticated diagnosis, but also about the patient, who will surely read it first hand and for whom said report represents a very important opinion of his state of health.

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