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ARTICLE ORIGINAL / RESEARCH ARTICLE

Evaluating the conformity of Computed Tomography reports for pancreatic, gastric and colorectal cancers, with respect to standard practice at the Bafoussam Regional Hospital Centre.

Évaluation de la conformité des comptes rendus de tomodensitométrie des cancers pancréatiques, gastriques et colorectaux aux pratiques standards au Centre Hospitalier Régional de Bafoussam.

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***Mots*-clés :**
Compte rendu radiologique – Conformité – Cancer – Stadification – Qualité – Cameroun.

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ABSTRACT

Background: Gastrointestinal cancers, including pancreatic, gastric, and colorectal cancers, represent a significant health burden worldwide and in Cameroon. Computed Tomography (CT) plays a crucial role in the diagnosis and staging of these cancers, with radiology reports serving as the primary means of communication between radiologists and clinicians. However, concerns have been raised regarding the completeness and conformity of these reports to standardized guidelines.

Objective: This study aimed to assess the conformity of CT reports for pancreatic, gastric, and colorectal cancers at Bafoussam Regional Hospital Centre, and to determine whether report conformity varied according to the interpreting radiologist.

Methods: A descriptive cross-sectional study was conducted at Bafoussam Regional Hospital Centre between November 2021 and June 2024. We included radiology reports of patients who underwent thoraco-abdomino-pelvic CT scans for initial cancer evaluation. Reports were assessed for completeness based on established staging systems, including the TNM (Tumour-lymph Node-Metastasis) classification and National Comprehensive Cancer Network (NCCN) resectability criteria. Factors associated with non-conformity were sought using the Chi-square test, with statistical significance set at $p < 0.05$.

Results: We analysed 109 thoraco-abdomino-pelvic CT reports. Key deficiencies were noted in tumor staging, vascular invasion assessment, and pancreatic cancer resectability, with TNM classification reported in only a minority of cases. Contrast media details and radiation dosimetry

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were frequently omitted. No significant differences in reporting completeness were observed between radiologists, suggesting systemic rather than individual shortcomings.
Conclusion. This study reveals suboptimal completeness in radiology reports for pancreatic, gastric, and colorectal cancer evaluation at Bafoussam Regional Hospital, with no significant inter-radiologist differences, suggesting systemic issues. Structured reporting and standardized templates may improve clarity, consistency, and guideline adherence. Further research should explore their impact on clinical decisions and patient outcomes.

RÉSUMÉ

Introduction. Les cancers gastro-intestinaux, notamment pancréatiques, gastriques et colorectaux, constituent un fardeau sanitaire majeur au Cameroun et dans le monde. La tomodensitométrie (TDM) joue un rôle clé dans leur diagnostic et leur stadification, les comptes rendus radiologiques étant le principal moyen de communication entre radiologues et cliniciens. Cependant, des préoccupations subsistent quant à l'exhaustivité et la conformité de ces comptes rendus par rapport aux recommandations de bonnes pratiques.
Objectif. Évaluer la conformité des comptes rendus de tomodensitométrie (TDM) pour les cancers pancréatique, gastrique et colorectal au Centre Hospitalier Régional de Bafoussam, et à déterminer si cette conformité variait en fonction du radiologue interprétant l'examen.
Méthodologie. Une étude descriptive transversale a été menée entre Novembre 2021 et Juin 2024. Les comptes rendus de TDM thoraco-abdomino-pelvienne réalisées pour une évaluation initiale du cancer ont été inclus. L'exhaustivité des comptes rendus a été évaluée selon la classification TNM (Tumour-lymph Node-Metastasis) et les critères de résécabilité du National Comprehensive Cancer Network (NCCN). Les facteurs de non-conformité ont été analysés à l'aide du test du Chi-deux, avec un seuil de signification fixé à $p < 0,05$.
Résultats. Au total 109 comptes rendus de scanners thoraco-abdominopelviens ont été analysés. Des insuffisances ont été relevées dans la stadification tumorale, l'évaluation de l'invasion vasculaire et l'appréciation de la résécabilité du cancer pancréatique, la classification TNM n'étant mentionnée que dans une minorité des cas. L'omission des informations sur l'utilisation du produit de contraste et la dosimétrie des radiations était fréquente. Aucune différence significative entre les radiologues n'a été observée, suggérant des insuffisances systémiques plutôt qu'individuelles.
Conclusion. Cette étude révèle une complétude insuffisante des comptes rendus radiologiques lors de l'évaluation initiale des cancers pancréatiques, gastriques et colorectaux au Centre Hospitalier Régional de Bafoussam, sans différence significative entre les radiologues interprétant les examens, ce qui suggère un problème systémique. L'adoption de comptes rendus structurés et de modèles standardisés pourrait améliorer la clarté, la cohérence et la conformité aux recommandations cliniques. Des recherches supplémentaires sont nécessaires pour évaluer leur impact sur la prise de décision clinique et les résultats pour les patients.

1. Introduction

GLOBOCAN (Global Cancer Statistics) 2022 data show that colorectal, gastric, and pancreatic cancers rank among the most prevalent and lethal worldwide [1]. Colorectal cancer is the third most common and second deadliest, with 1.9 million new cases and over 900,000 deaths. Gastric cancer ranks fifth in both incidence (968,350 cases) and mortality (659,853 deaths). Although less common, pancreatic cancer has a particularly high fatality rate, with 510,566 cases and 467,005 deaths, making it the sixth leading cause of cancer death [1, 2]. These cancers place a heavy burden on health systems, highlighting the need for improved prevention, early diagnosis, and treatment strategies.

In Cameroon, pancreatic, gastric, and colorectal cancers also pose a notable health burden. In 2022, colorectal cancer ranked 7th in both incidence (916 cases) and mortality (608 deaths). Gastric cancer was 9th in incidence (477 cases) and mortality (395 deaths), while pancreatic cancer ranked 16th in incidence (187 cases) and 13th in mortality (168 deaths) [3]. These figures highlight the significant impact of these cancers on the country's healthcare system.

Imaging, particularly computed tomography (CT), is central to diagnosing and staging pancreatic, gastric, and colorectal cancers. In pancreatic cancer, CT assesses tumour size, location, and vascular involvement for surgical planning. For gastric cancer, it evaluates local invasion, lymph nodes, and metastases, with accuracy comparable to endoscopic ultrasound in T-staging. In colorectal cancer, although diagnosis relies on colonoscopy, CT is key for staging and detecting distant

metastases, especially in the liver and lungs [4, 5]. CT's detailed anatomical insights are vital for treatment planning and improving outcomes.

Radiology reports are the primary means by which radiologists communicate CT findings to referring physicians, providing detailed interpretations of imaging results [6–8]. High-quality radiology reports are essential for safe and effective treatment planning. They must be clear, concise, and include key details for accurate staging, such as lesion size, location, vascular involvement, arterial variants, and the presence of nodal or metastatic disease [6, 9, 10].

Various tools have been developed to improve radiology reporting quality. Standardized instruments—such as the Fleischner glossary, Breast Imaging Reporting and Data System (BI-RADS), and TNM classification—enhance consistency and accuracy in describing pathology and disease progression. Structured reporting tools, including templates and guidelines, further improve report clarity, completeness, and uniformity, a practice commonly referred to as "structured reporting" [11, 12]. High quality radiology reporting ensures that essential information is consistently communicated to clinicians, facilitating accurate diagnosis, appropriate treatment planning, and timely intervention. Failure to clearly communicate results continues to be a leading cause of delayed diagnosis and resultant lawsuits worldwide [9].

At Bafoussam Regional Hospital Centre, multidisciplinary meetings have highlighted frequent concerns over incomplete CT reports for colorectal, gastric, and pancreatic cancers. Clinicians report that inadequate staging information hinders treatment planning, delays care, and compromises outcomes. Despite its clinical importance, no prior studies have assessed the quality of such reports in this setting. Addressing this gap is crucial to improve cancer management and decision-making.

We therefore conducted this study to assess the conformity of CT reports for pancreatic, gastric, and colorectal cancers at Bafoussam Regional Hospital Centre, and to determine whether report conformity varied according to the interpreting radiologist.

2. Materials and methods

2.1 Study design

We carried out a descriptive cross-sectional survey targeting patients received at the Bafoussam Regional Hospital Centre from November 1, 2021 to August 30, 2024.

2.2 Study setting

The Bafoussam Regional Hospital Centre, opened in October 2021, is a tertiary hospital serving as a referral facility for the West Region of Cameroon. It features a gastroenterology department with interventional endoscopy capabilities, a general surgery department, and a radiology department equipped with a Siemens Somatom.go® 16-slice computed tomography device. Furthermore, the hospital hosts a monthly multidisciplinary consultation meeting to provide care for cancer patients.

2.3 Study participants

The study population was made of patients with confirmed diagnosis of pancreatic, gastric or colorectal cancer who underwent CT scan at the Bafoussam Regional Hospital Centre during the study period.

We consecutively included all radiology reports of patients who underwent a thoraco-abdomino-pelvic (TAP) CT scan for the initial evaluation and/or staging of pancreatic, gastric or colorectal cancer, regardless of age or sex.

Reports of patients who underwent follow-up CT scans and incomplete reports lacking relevant data were excluded.

2.4 Data of interest

Our data of interest were:

- Protocol details: type and number of series;
- Contrast media details: volume, name, injection rate, concentration;
- Digestive tube marking (for gastric and colorectal cancers);
- Tumour description: size, location, dimensions, extension (local, locoregional, and distant), TNM classification (if applicable), resectability status (for pancreatic cancer);
- Identity of the radiologists.

The examination report data were extracted from the radiology department secretariat's database.

2.5 Data collection

All CT examinations were independently reviewed by two radiologists: a senior radiologist with 10 years of post-residency experience and a junior radiologist with 5 years of post-residency experience. Both radiologists completed their residency training at the same institution in Cameroon. Radiology reports were written freely by each radiologist. Although a few structured templates were available in the department, they were modified at the radiologist's discretion. At the time of the study, there was no standardized templates for interpreting CT scans in the evaluation of cancers.

The conformity of radiology reports was evaluated using the TNM staging system criteria for classifying the extent of colorectal and gastric cancer spread [13, 14], and the National Comprehensive Cancer Network (NCCN) resectability criteria for pancreatic cancer [15].

The conformity assessment was conducted using a standardized checklist. The evaluation was primarily made by a radiology master student. To ensure the accuracy of the extracted data, there was an independent verification by a second researcher, who reviewed the extracted data against the original radiology reports. Any discrepancies identified during these processes were resolved through discussion and consensus between the two researchers. If a consensus could not be reached, a third independent researcher adjudicated the discrepancy to ensure a consistent and unbiased evaluation.

2.6 Data analysis

Data were analysed with the IBM® Statistical Package for the Social Sciences (SPSS)® 21 software.

Qualitative variables were presented as counts and proportions. The association between the radiologist who interpreted the examination, and the completeness of the corresponding report was analysed using the Chi-square test. Statistical significance was determined using a p-value threshold of less than 0.05.

2.7 Ethical considerations

Ethical approval for the study was delivered by the Regional Ethics Committee for Human Health Research of the West Region of Cameroon (Number 784/29/05/2024/CE/CRERSH-OU).

3. Results

3.1 Characteristics of study participants

Between November 2021 and June 2024, 487 thoraco-abdomino-pelvic (TAP) CT scans were performed at Bafoussam Regional Hospital Centre. Of these, 109 scans (22.4%) performed for initial staging of pancreatic, gastric, or colorectal cancer were included in this study (

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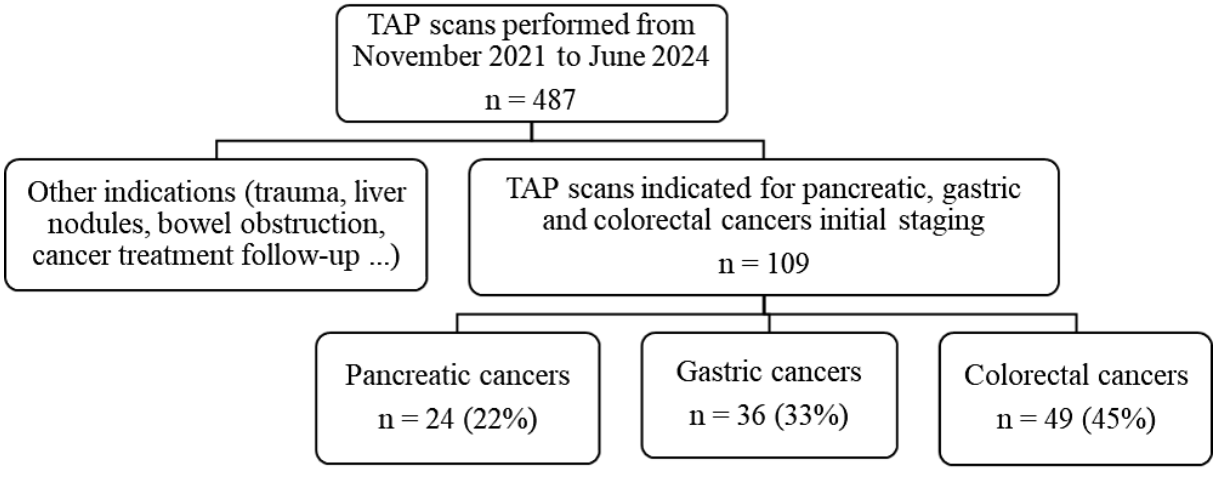

Figure 1: selection of study participants.

3.2 CT scan protocol

In the reports, key elements such as the name of the contrast media, its concentration, the quantity administered, and the precise delay time between injection and acquisition of the different series were consistently omitted. Also, the Dose Length Product was never mentioned in the reports.

However, details like the name of referring physicians, clinical data from the patient, the use or non-use of injected contrast media and the names of the imaging series performed were always reported.

Table I). While roughly half (44.5 – 55.1%) of the reports mentioned invasion of neighbouring organs and distant metastases for pancreatic, gastric and colorectal cancers, the documentation of vascular invasion and TNM classification varied considerably. Notably, TNM classification was reported in a minority of cases for all three cancer types (12.2% for colorectal, 2.8% for gastric, and 33.3% for pancreatic cancer).

The radiological reports mentioned the use of gastric marking in 63.9% (23/36) of gastric cancer cases, and the use of colorectal marking in 75.5% (37/49) of colorectal cancer cases.

3.3 Completeness of tumour evaluation in the radiology report

There was a low degree of consistency in documenting tumour spread and staging (

Concerning pancreatic cancer, the report never mentioned whether the cancer was resectable or not, regarding features of the tumour and its extension.

However, there was a high degree of completeness in documenting basic tumor location (100% for all three cancer types and locoregional lymph node involvement (95.8 - 100%) in radiology reports.

Table I : Frequency of reported characteristics in CT evaluation of pancreatic, gastric and colorectal cancer at the Bafoussam Regional Hospital Centre.

Characteristic mentionned or not	Colorectal Cancer (n=49)	Gastric Cancer (n=36)	Pancreatic Cancer (n=24)
Tumor location within the organ			
Yes	49 (100%)	36 (100%)	24 (100%)
No	0	0	0
Invasion of neighboring organs			
Yes	27 (55.1%)	16 (44.4%)	12 (50%)
No	22 (44.9%)	20 (55.6%)	12 (50%)
Vascular invasion			
Yes	NA	5 (13.9%)	12 (50%)
No	NA	31 (86.1%)	12 (50%)
Locoregional lymph node			
Yes	49 (100%)	36 (100%)	23 (95,8%)
No	0	0	1 (4.2%)
Presence or absence of distant metastases			
Yes	27 (55.1%)	16 (44.4%)	12 (50%)
No	22 (44.9%)	20 (55.6%)	12 (50%)
TNM classification			
Yes	6 (12.2%)	1 (2.8%)	8 (33.3%)
No	43 (87.8%)	35 (97.2%)	22 (66.7%)
NA* : Not Applicable			

3.4 Association between the completeness of tumour evaluation and the reporting radiologist

Table II : reporting practices of the two radiologists regarding key characteristics of pancreatic, gastric and colorectal cancer evaluation at the Bafoussam Regional Hospital.

	Mentioned Characteristics		**Khi 2 – test (p)**
	Yes	No	
Vascular invasion			
Radiologist 1	54 (77.2)	13 (22.8)	0.899
Radiologist 2	52 (80.8)	10 (19.2)	
Invasion of Neighboring Organs			
Radiologist 1	26 (45.6)	31 (54.4)	0.445
Radiologist 2	28 (53.8)	24 (46.2)	
Metastases			
Radiologist 1	51 (89.5)	6 (10.5)	0.445
Radiologist 2	49 (94.2)	3 (5.8)	
TNM Classification			
Radiologist 1	51 (89.5)	6 (10.5)	0.493
Radiologist 2	49 (94.2)	3 (5.8)	

Although the proportions reported for individual characteristics exhibited some variation, the **Table II**).

4. Discussion

4.1 Summary of Key Findings

This study aimed to assess the conformity of CT reports for pancreatic, gastric, and colorectal cancers at Bafoussam Regional Hospital Centre, and to determine whether report conformity varied according to the interpreting radiologist. Our study revealed consistent omissions of key elements in CT reports, including contrast media related protocol details (agent, concentration, volume, delay time) and Dose Length Product. Tumor staging, particularly TNM classification, was also underreported, and resectability of pancreatic tumors was never explicitly addressed. No significant differences in reporting completeness was observed between the two radiologists.

4.2 Cancer staging and resectability were badly reported

A significant finding of this study is the incomplete reporting of critical information required for accurate tumor staging, particularly TNM classification, vascular invasion and pancreatic cancer resectability, in a substantial proportion of the examined CT reports.

analysis revealed no statistically significant differences in the radiologists' reporting of these critical features (

In colorectal cancer, imaging is essential for staging, surgical planning, assessing the resectability of metastatic disease, and evaluating response to neoadjuvant therapy [12, 16]. The TNM system remains the standard for diagnosis, management, and prognosis [10, 12].

Gastric cancer staging requires precise documentation of tumour site, extent, and size. The report should also detail the relationship with adjacent structures, lymph node involvement and distant metastasis.-[17, 18]. The TNM classification also helps to summarise these findings in a comprehensive and clinically relevant way.

Successful pancreatic cancer surgery requires radiology reports to provide more than metastatic status, detailing tumour size, location, vascular involvement, and possible perineural spread. Such information is essential for surgical planning and treatment decision-making [19]. Accurate staging of pancreatic cancer—distinguishing resectable, borderline resectable, and locally

advanced/unresectable cases—is vital for guiding treatment, maximizing survival, avoiding unnecessary surgery, and supporting clinical trial enrollment and analysis. [10].

Several factors may contribute to the incomplete reporting of staging information observed in this study. A potential factor is a lack of awareness or a misunderstanding of the established staging guidelines among radiologists. Time constraints and heavy workloads, common in busy clinical settings, could also lead to abbreviated reports where crucial staging details are omitted [20]. In some cases, technical limitations inherent in CT imaging might hinder the clear visualization of certain tumour features necessary for accurate staging, particu

in the assessment of vascular invasion or s metastatic deposits [21]. The absence of standardized reporting templates or checklists could further exacerbate the issue, as radiologists may not have a consistent framework to ensure the inclusion of all essential staging elements in their reports [22]. Incomplete radiology reports can have several detrimental consequences for patient care. Inaccurate or missing staging information can lead to suboptimal treatment planning, potentially resulting in the administration of inappropriate therapy or the omission of necessary interventions [9]. This can negatively impact patient outcomes, including decreased survival rates and increased morbidity. Furthermore, incomplete reports can hinder communication between healthcare providers, leading to delays in diagnosis and treatment. They can also create challenges for clinical trials and research, as incomplete data compromises the validity and reliability of study findings [22]. From a medico-legal perspective, incomplete reports can increase the risk of malpractice claims and legal disputes. Finally, the lack of essential information can necessitate repeat imaging studies, increasing healthcare costs and exposing patients to additional ionising radiation.

4.3 Protocol details and radiation dose were insufficiently reported

Details on the contrast media used for the examination and the dosimetric index were never reported. A compliant CT radiology report must include the type, volume, and concentration of the contrast agent administered, as well as the radiation dosimetry [6, 23]. The inclusion of these parameters ensures standardized reporting, facilitates comparison between examinations, and promotes quality control in radiological practice. Additional technical criteria, such as the specific scanner model and acquisition parameters, are also relevant for comprehensive reporting[6, 24].

In a 2014 evaluation of 49 healthcare institutions conducted by the French High Authority for Health, reporting rates for key contrast-related and dosimetric parameters in CT scans were found to be suboptimal. Specifically, the type of contrast agent was reported in 73.9% of cases, the volume in 62%, the concentration in 68.3%, and the dosimetry in 86.7% [23].

4.4 Radiologist experience did not influence conformity of the report

This study found no statistically significant difference in the completeness of radiology reports between the two radiologists assessed despite the difference of five years of experience between them. The omission rate of relevant details about vascular invasion, invasion of neighbouring organs, metastases or TNM Classification were consistently comparable between the two radiologists.

Several factors may explain the lack of a statistically significant difference in reporting completeness between the two radiologists. The fact that they shared training background at the same institution could have instilled similar reporting styles and practices. Furthermore, the presence of standardized reporting protocols within their department, while potentially contributing to consistency, may themselves be incomplete, thus perpetuating similar deficiencies in both radiologists' reports. Unstructured narrative reporting in radiology introduces variability in language, length, and style, hindering clarity and completeness, thereby impacting optimal patient care [8, 25, 26].

The limited sample size of this study may also have reduced the statistical power to detect a true difference, warranting further investigation with a larger cohort. Finally, the case mix itself could have played a role; a homogenous set of cases, lacking in complexity or diversity of presentation, might limit the opportunities for variation in reporting completeness to emerge.

4.5 Perspectives

Radiology reports for the initial evaluation of pancreatic, gastric and colorectal cancers at Bafoussam Hospital Centre are suboptimal in their completeness. Updating radiologist training on evaluating these cancers and implementing standardized structured reporting could effectively address this issue.

Standardised reporting involves enhancing the uniformity of report content through standardisation tools (e.g: RADS collection, RECIST, TNM nomenclature…). In contrast, structured reporting entails utilising dedicated tools to properly construct, organise, or populate the radiological report [11].

Standardized reporting templates, such as the one proposed by the Society of Abdominal Radiology and the American Pancreatic Association [27], promote uniform, comprehensive, and reproducible reporting to enhance treatment decisions and facilitate clinical trials. Adopting such templates improves patient management, particularly for conditions like pancreatic ductal adenocarcinoma, by ensuring complete and accurate disease staging for optimized treatment recommendations [10]. Studies demonstrate that template-based reporting, using defined criteria, yields more complete and precise reports [8, 24, 26]. Consequently, structured reporting, is advocated as a key method for improving the overall quality of radiology reports [25]. Furthermore, clinicians tend to prefer structured reports than free-narrative reports [24].

Despite promising advancements and inclusion in some guidelines and certifications, structured reporting has yet to achieve widespread adoption in routine clinical practice [8]. Several factors may explain the limited use of structured reports. While structured reporting is increasingly utilized in radiology, particularly for abdominal and neuroradiological CT and MRI reports, the level of supporting evidence remains low [11]. Barriers to structured reporting adoption also include radiologist resistance to change, workflow disruptions due to new reporting styles, potential for increased errors (forgetting to delete standard phrases), and the possibility of including irrelevant information that hinders report coherence [25]. Furthermore, the limited applicability of structured templates to complex cases, the predominance of english-language templates, and their heterogeneous quality pose significant challenges to widespread implementation [8].

4.6 Implications for Future Research and Practice

This research suggests the need for a shift towards structured reporting in radiology to improve the quality, completeness, and clarity of reports at Bafoussam Regional Hospital Centre. Future research should focus on developing and evaluating standardized templates adaptable to various clinical scenarios, addressing language barriers, and integrating these templates into existing workflows. Furthermore, investigating the impact of structured reporting on diagnostic accuracy, inter-observer variability, and patient outcomes is crucial.

Practical implications include developing training programs for radiologists to support the adoption of structured reporting, educating clinicians on standardized radiology terminology, and creating user-friendly software solutions that streamline reporting while allowing flexibility for complex cases. Investigating the optimal balance between structured templates and free-text narratives for different imaging modalities and clinical contexts is also essential for maximizing the benefits of structured reporting.

4.7 Strengths and Limitations

A key strength of this study lies in its real-world setting within a tertiary referral hospital, providing insights into the practical aspects of radiology reporting. The inclusion of all consecutive CT examinations for the specified cancers during the study period minimizes selection bias and enhances the representativity of the findings in the study site. Furthermore, the independent review of all reports by two investigators strengthens the assessment of reporting practices. Finally, to the best of our knowledge, this is the first study to assess to conformity of reports on pancreatic, gastric and colorectal cancers in our context.

However, the study is limited by its single-center design, which may not reflect practices in other healthcare settings. The relatively small sample size for certain cancer types could limit the statistical power to detect subtle differences in reporting practices. Additionally, the retrospective nature of the study relies on the available data within the reports and does not allow for clarification of

missing or ambiguous information. Finally, while the study focuses on the content of radiology reports, it does not assess the impact of reporting practices on patient outcomes.

5. Conclusion

This study highlights the suboptimal completeness of radiology reports for the initial evaluation of pancreatic, gastric, and colorectal cancers at Bafoussam Regional Hospital Centre, with no significant difference in conformity between the two radiologists—indicating a systemic issue rather than an individual one. Introducing structured reporting could significantly improve the quality and consistency of cancer-related radiological assessments. However, successful implementation will require addressing key challenges, including radiologist training, integration into existing workflows, and the development of context-appropriate templates. Future research should explore the impact of structured reporting on clinical outcomes, inter-observer agreement, and referring physician satisfaction in this specific healthcare setting.

6. Conflicts of interest

The authors declare no conflict of interest.

7. Funding

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8. Authors' Contributions :

MTJR conceptualized the study, designed the methodology, and drafted the initial manuscript. MMPG collected and analyzed the data and contributed to data interpretation. JT, YRO, AAA, and MMF assisted with the literature review and critically reviewed the manuscript. MB and NGM co-developed the methodology and provided critical revisions. All authors read and approved the final version of the manuscript.

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