MASSACHUSETTS
GENERAL HOSPITAL

HARVARD
MEDICAL SCHOOL

Heather M. Downs, B.S.
Laboratory Manager
275 Charles St./Warren 310
Boston, Massachusetts 02114
Tel: 617.726-0260
Fax: 617.726.0473

Anne Louise Oaklander, M.D., Ph.D.
Laboratory Medical Director
Associate Professor of Neurology, HMS
Associate in Neurology, MGH
Assistant in Pathology, MGH

Registration:

Patients must have MGH registration numbers; ask unregistered patients to call +1-866-211-6588 to obtain an MGH medical record number. There is no cost to register and obtain a medical record number.

Referring physicians must submit the form on Page 3 if they wish to be sent Pathology reports.

Performing skin biopsy for diagnosing small-fiber polyneuropathy:

A. The site is 10 cm above the lateral malleolus (less for children), from the more-affected leg. The distal thigh can be biopsied as a second site, 20 cm below the iliac spine. Skin innervation density varies with location so standard sites must be used to get accurate results.
B. For anesthesia, inject about 1 cc of lidocaine w/epinephrine 1:100,000, using a tiny gauge needle, eg an insulin syringe. To reduce pain, buffer this with up to 10% bicarbonate solution. It is critical to inject below the skin (subcutaneous), not into the skin (intradermal), which damages skin cells and renders the biopsy unusable.
C. Perform a 3 mm biopsy (2 mm for small children) using a standard sterile skin biopsy punch. Place this on the skin and twirl it gently without applying pressure until you penetrate the full skin thickness and have loss of resistance. Pressure will stretch the skin and yield a too-small biopsy that will generate inaccurate results.
D. To remove the biopsy, grip the subcutaneous fat with a sterile forceps and sever it with a sterile scissor or scalpel. Never touch or pinch the skin itself during removal or the cells will be crushed which makes the biopsy uninterpretable.
D. Immediately place the biopsy into the vial of Zamboni fixative. Make sure that the biopsy is submerged and then tighten the vial cap completely. Use a Sharpie or other permanent ink to label the vial with the patient's name, date of birth, and biopsy site.
E. A nearby biopsy can be taken and placed in a separate vial of 8% formalin if routine dermatopathology is requested as well.

Handing and shipping skin biopsy:

Fill out the Page 2 requisition form and place it and the biopsy in a sealed plastic specimen transport plastic bag. Pack the bagged specimen in a foam container containing ice or frozen gel packs to maintain cool temperature. Do not use dry ice or freeze the specimen at any time as this will render the biopsy uninterpretable.

Tape the container securely and ship it to: Heather Downs
Warren Building room 310
Massachusetts General Hospital
70 Blossom Street Receiving
Boston, MA 0211

The laboratory is open Monday - Friday and specimens cannot be received on a weekend, so please ship the specimen accordingly.

Email to "hdowns@mgh.harvard.edu" to provide the tracking number, number of specimens and arrival date.

MASSACHUSETTS GENERAL HOSPITAL

MGH Nerve Unit
Lab Director: Anne Louise Oaklander MD PhD
Laboratory Manager: Heather M. Downs BS
Phone (617) 726-0260; Fax (617) 726- 0473

Patient Name:
DOB:
MRN:

THIS WORKSHEET MUST ACCOMPANY SKIN BIOPSY

Patient Information: Sex: ☐ M ☐ F Patient Age: _____ Previous biopsies by us? ☐Y ☐N

Hispanic: ☐Y ☐ N Race: ☐ Asian ☐ Caucasian ☐ Black ☐ Other _____

Indication for requesting biopsy: ☐ Small-fiber polyneuropathy ☐ Other _____

Any additional information? _____

Name of physician to whom report should be sent: _____

Affiliation:_____ Phone: _____

Address:_____ Fax: _____

Specimen(s) submitted:

Date of Biopsy: _____ Performed by:_____

Purpose of Biopsy: ☐ Clinical ☐ Research Study? Which _____

Type of Fixative: ☐ Zamboni's ☐ Other: _____ Size of punches: ☐ 3mm ☐ 2mm

First biopsy site:

☐ Standard distal leg (10 cm above lateral malleolus)	Side of body:	☐ **R**	☐ **L**
☐ Thigh (20 cm below iliac crest)	Side of body:	☐ **R**	☐ **L**
☐ Dorsum of Foot	Side of body:	☐ **R**	☐ **L**
☐ Other: _____	Side of body:	☐ **R**	☐ **L**

Second biopsy site (if applicable):

☐ Standard distal leg (10 cm above lateral malleolus)	Side of body:	☐ **R**	☐ **L**
☐ Thigh (20 cm below iliac crest)	Side of body:	☐ **R**	☐ **L**
☐ Dorsum of Foot	Side of body:	☐ **R**	☐ **L**
☐ Other: _____	Side of body:	☐ **R**	☐ **L**

FOR MGH LABORATORY USE:

MGH case # _____ Punch Biopsy #:_____

Technical Quality: ☐Poor ☐Fair ☐Good ☐Excellent ☐Other _____

1st biopsy morphology impression: ☐Abnormal ☐Borderline ☐Normal Comment:_____

Morphometry: Density: _____ Centile: _____

2nd biopsy morphology impression: ☐Abnormal ☐Borderline ☐Normal Comment:_____

Morphometry: Density: _____ Centile: _____

*Pathologist:*_____ *Date of report:*_____

Pathology Provider Add/Update Request Form.

Important Directions For Additions:
1. Fill out the appropriate fields in the BOXED AREA below Provider Number and indicate the subspecialty/s.
2. Submit with copies of original docTouments that identify the contact information etc. for this physician.

Important Directions For Updatesa
1. Please fill out the Provider Number and Name Fields for all updates.
2. For name changes, give us the new name on the line and the old name underneath it.
3. Only fill in s (other than name and provider number) that contain changes.

Always fill in Submitted by and Date Sent

Provider Number: _____

Provider Type: (check one**) MD** ☐ **Resident** ☐ **Other (**indicate type)

NPIN#: _____

Last Name: _____ **First Name:** _____ **M.I:** ____

Office Name: _____

Office Street Address: _____

_____ **State** _____ **Zip:** _____

Office Phone Number #1: _____ **Office Fax:** _____

Office Phone Number #2 _____ **Fax Reports Default = Yes ☐ No ☐**

Email: _____

_____

UPIN: _____

Specialty/s (If more than 1, indicate as 1, 2, 3):

___ANE (Anesthesia)	___OPH (Ophthalmology)	___RAD (Radiation Oncol)
___DER (Dermatology)	___ORA (Oral Surgery)	___RAI (Radiology)
___ENT (Ear, Nose, Throat)	___ORT (Orthopedic Surgery)	___SUR (Surgery)
___GYN (Gynecology)	___PAT (Pathology)	___URO (Urology)
___MED (Medicine)	___PED (Pediatrics)	___OTH (Other)
___NEU (Neurology)	___PSU (Pediatric Surgery)	
___NSU (Neurosurgery)	___PSY (Psychiatry)	

Accession Number/s: _____

Update of Existing Entry ☐ **YES**

Billing Contact Name: _____

Billing Contact Telephone Number: _____

Key Contacts - Fax Numbers
Deborah Mills: 726-5306
Marianna Sanchez: 726-5306

Submitted By (your name)

Date Submitted _____
*Date Entered*_____
*Date Edited*_____