PRACTISING RADIOLOGISTS INSIGHT REPORT

Incidental Findings in Radiology: When Is Follow-Up Really Needed?

A global radiologist perspective on incidental findings, ACR follow-up recommendations, defensive reporting, diagnostic cascades, AI over-detection, tracking ownership, patient portals, and the judgement required to decide what truly deserves surveillance.

Context → **Signal** → **Judgement** → **Action**

13	21	5	61.9%
complete responses	total survey records	countries represented	completion rate

WHY THIS REPORT

The hardest incidental finding is often not the one you see. It is the one you now have to manage.

Modern imaging makes it increasingly easy to detect small, asymptomatic abnormalities that were never the reason for the scan. For radiologists, every incidental finding creates a second diagnostic task: estimate its significance, choose the right language, and decide whether surveillance will help more than it harms.

This report follows that task through malpractice pressure, guideline deviation, downstream cascades, AI over-detection, communication with ordering clinicians, ED tracking, elective screening, report burden, patient cost, and immediate portal release.

The ACR has developed incidental-finding guidance and quality measures focused on closing the follow-up loop for actionable findings. That reflects the central radiology problem: over-testing and missed follow-up can coexist. The challenge is to make the recommendation appropriate enough to avoid unnecessary cascades and reliable enough that clinically important surveillance is not lost.

> **Survey lens:** 21 survey records, including 13 complete responses, across five countries. Core clinical question bases range from n=17 to n=15. Open-ended comments are interpreted qualitatively without unsupported counts.

EXECUTIVE SUMMARY

The pattern in six findings

FINDING 01

Borderline findings often get defensive movement

56.3% say malpractice pressure mildly pushes low-suspicion findings toward follow-up.

FINDING 02

Guideline intervals flex in the grey zone

81.3% say they occasionally move to earlier follow-up when context or ordering behavior raises concern.

FINDING 03

The cascade is visible from the reading room

81.3% say likely downstream testing at least occasionally gives them pause.

FINDING 04

AI is expected to add more noise

68.8% believe diagnostic AI will worsen the incidentaloma problem.

FINDING 05

Tracking is seen as a system job

56.3% prefer an automated institutional registry for ED incidental findings.

FINDING 06

The impression now has two audiences

73.3% add plain-language reassurance because patients may read reports immediately.

01

SECTION 01 · READING-ROOM REALITY

Incidental findings are part of the ordinary reading list, not an occasional exception

CONTEXT

The reporting dilemma begins with frequency. The more often asymptomatic findings appear, the more often radiologists must decide whether a detail deserves surveillance, reassurance, or no further action. Because cross-sectional imaging is so sensitive, the judgement repeats throughout the reading day. A single minor finding may take only seconds to describe, but its recommendation can create months or years of downstream surveillance.

WHAT THE DATA SHOWS

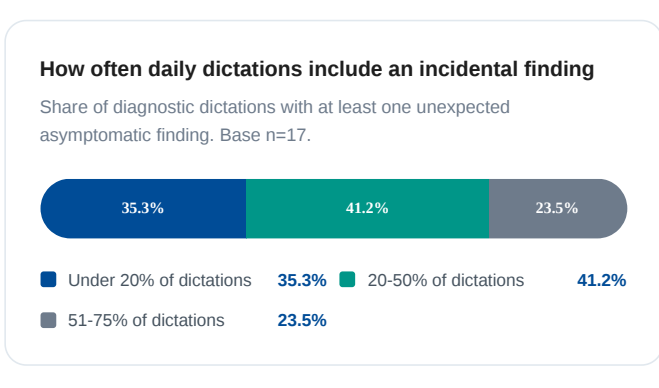
41.2% (7) report incidental findings in 20-50% of daily dictations; **35.3%** (6) report them in under 20%; **23.5%** (4) report them in 51-75%.

THE INSIGHT

Incidental findings are frequent enough to be a workflow issue. Each one consumes judgement even when it is clinically low risk. Incidental findings are therefore both a diagnostic and a workload phenomenon. The cumulative burden comes from repeatedly deciding significance, wording the recommendation, anticipating how it will be interpreted, and documenting why follow-up is or is not needed.

WHY IT MATTERS

Standardized language and follow-up rules matter because small decisions repeat across a reading day and can create large downstream volume. Consistency matters because small differences in wording can scale into large differences in downstream imaging volume across a practice.


How often daily dictations include an incidental finding

Share of diagnostic dictations with at least one unexpected asymptomatic finding. Base n=17.

02

SECTION 02 · DEFENSIVE FOLLOW-UP

Borderline follow-up decisions are not made in a liability-free room

CONTEXT

For a sub-centimeter, low-suspicion finding, the medical question may be simple while the legal question feels less settled. At the borderline, radiologists are balancing low pretest probability against the asymmetric fear of missing the rare important lesion. That is exactly where a small medicolegal nudge can produce a real follow-up recommendation.

WHAT THE DATA SHOWS

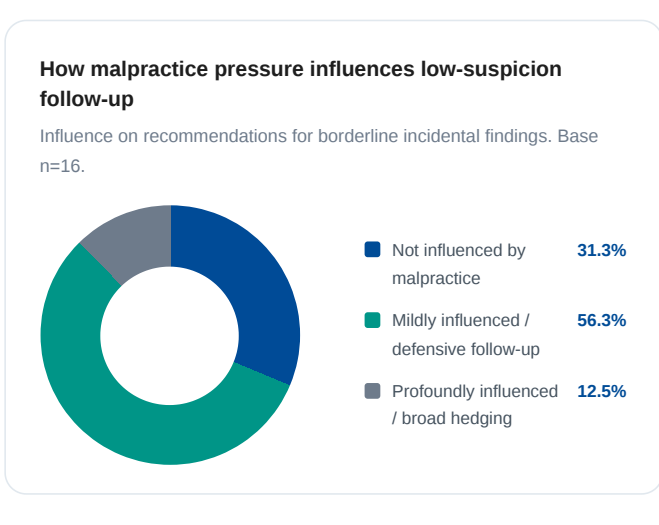
56.3% (9) say malpractice fear mildly influences follow-up recommendations; **31.3%** (5) say it does not influence them; **12.5%** (2) say it profoundly influences their reporting.

THE INSIGHT

The dominant response is not extreme defensive medicine. It is small defensive movement at the borderline, exactly where additional follow-up is easiest to justify. The survey suggests defensive medicine often operates subtly rather than dramatically. It appears as the extra interval scan, the broader correlation statement, or the preference to recommend rather than explicitly dismiss.

WHY IT MATTERS

Reducing unnecessary cascades requires more than guidelines. Radiologists also need confidence that guideline-concordant restraint is defensible. Reducing this pressure requires confidence that guideline-concordant restraint is professionally and legally defensible, not merely technically permitted.


How malpractice pressure influences low-suspicion follow-up

Influence on recommendations for borderline incidental findings. Base n=16.

03

SECTION 03 · GUIDELINE DEVIATION

Guideline intervals still bend when the clinical context feels less tidy

CONTEXT

ACR recommendations are designed to standardize incidental-finding management, but real-world reporting still includes patient context and the behavior of the ordering environment. Guidelines standardize common scenarios, but patients do not arrive as templates. Age, prior cancer history, smoking, symptoms, laboratory findings, and the anxiety of the ordering environment can all make a technically low-risk finding feel less straightforward.

WHAT THE DATA SHOWS

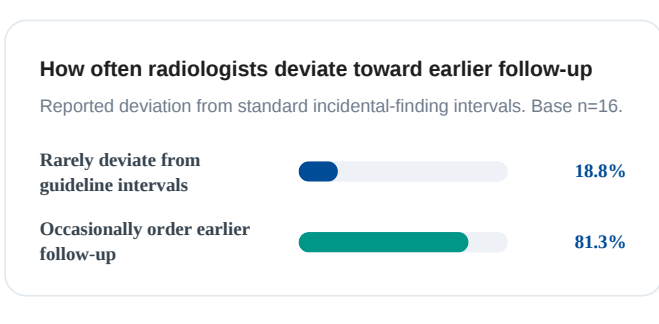
81.3% (13) say they occasionally deviate toward earlier follow-up when soft risk factors or an anxious ordering clinician are present; **18.8%** (3) say their practice rarely deviates.

THE INSIGHT

The grey zone is where standardization loses some of its force. Most respondents describe occasional earlier follow-up rather than strict interval adherence. The high rate of occasional deviation shows that real-world judgement lives in the space between a white paper and an individual clinical context. The problem is not deviation itself, but whether that deviation is reproducible, explainable, and proportionate.

WHY IT MATTERS

Structured reporting can reduce variation, but the surrounding clinical and communication context still influences the final recommendation. Structured reporting can help by documenting why the recommendation differs from the standard interval, making the judgement visible rather than implicit.


How often radiologists deviate toward earlier follow-up

Reported deviation from standard incidental-finding intervals. Base n=16.

04

SECTION 04 · CASCADE BURDEN

Radiologists feel the downstream cascade even after the report leaves the workstation

CONTEXT

A benign variant can lead to another ultrasound, MRI, consultation, biopsy, or months of surveillance. The reader may not control that cascade, but they can anticipate it. Radiologists often know that a phrase in the impression may trigger another modality, a specialist visit, a biopsy, or repeated surveillance. Even when those decisions are made elsewhere, the initial wording can set the cascade in motion.

WHAT THE DATA SHOWS

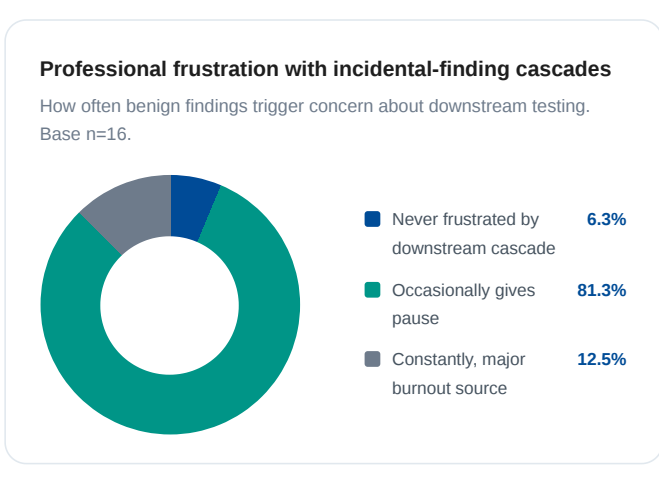
81.3% (13) say the likely downstream cascade occasionally gives them pause; **12.5%** (2) say it is a constant source of professional burnout.

THE INSIGHT

The dominant emotion is not constant burnout. It is repeated hesitation: the awareness that a low-risk phrase can become a high-burden pathway. That awareness creates a distinctive form of professional tension: the radiologist must avoid both under-calling a meaningful risk and over-medicalizing a benign variant. The survey suggests most respondents feel that tension intermittently rather than continuously.

WHY IT MATTERS

Good reporting should communicate both the finding and its urgency clearly enough to reduce unnecessary escalation without obscuring clinically meaningful risk. Risk-calibrated language can reduce unnecessary escalation when it states what is likely benign, whether follow-up is required, and how urgent the next step actually is.


Professional frustration with incidental-finding cascades

How often benign findings trigger concern about downstream testing. Base n=16.

05

SECTION 05 · AI

AI is expected to add signals faster than it removes uncertainty

CONTEXT

PACS-integrated detection can raise sensitivity, but every extra flag still has to be interpreted, documented, ignored, or acted on. AI adds another source of detections to a workflow that is already saturated with low-suspicion abnormalities. Every flag still needs to be accepted, rejected, documented, or reconciled with the radiologist's own interpretation.

WHAT THE DATA SHOWS

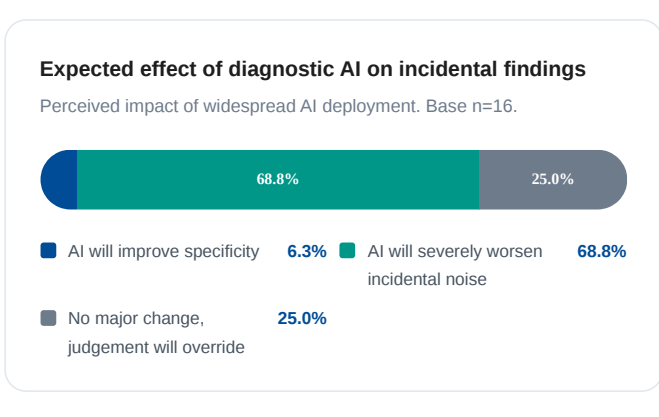
68.8% (11) believe AI will severely worsen the incidentaloma problem through hypersensitive detection; **25.0%** (4) expect no major change because radiologists will override over-calls; **6.3%** (1) expect AI to improve specificity.

THE INSIGHT

Radiologists are more concerned about AI-generated noise than excited about AI as a filter. Sensitivity without calibrated clinical significance can simply move the burden downstream. Radiologists appear concerned that sensitivity may outpace clinical specificity. If software reliably finds more tiny abnormalities but cannot distinguish which ones matter, it can increase report burden and downstream testing even when technical detection metrics improve.

WHY IT MATTERS

AI tools should be evaluated not only on detection performance, but on how many additional findings they create that require documentation or follow-up. AI performance should therefore be assessed with measures such as false-positive burden, reporting time, follow-up volume, and clinically meaningful yield, not sensitivity alone.


Expected effect of diagnostic AI on incidental findings

Perceived impact of widespread AI deployment. Base n=16.

06

SECTION 06 · ORDERING CLINICIANS

The same report can be interpreted very differently outside radiology

CONTEXT

A carefully calibrated recommendation can become an urgent referral if the receiving clinician or patient reads descriptive uncertainty as danger. The same phrase can mean very different things to a radiologist, an emergency physician, a primary care clinician, and a patient reading the portal. Terms such as indeterminate, correlate clinically, or consider follow-up may carry more urgency outside the reading room than the radiologist intends.

WHAT THE DATA SHOWS

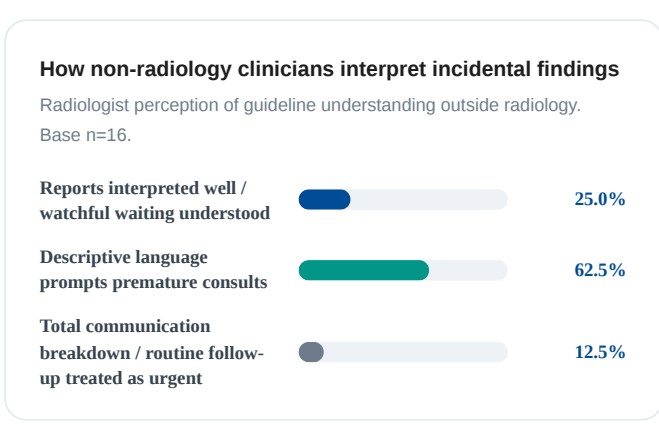
62.5% (10) say non-radiology clinicians often react with premature specialist referrals to descriptive language; **25.0%** (4) say reports are interpreted well.

THE INSIGHT

The reporting problem is partly a translation problem. Radiology thresholds do not always travel cleanly across specialties. The survey suggests a translation gap between radiology probability language and downstream action. That gap can be amplified when clinicians are unfamiliar with specialty-specific thresholds or are working in high-risk environments.

WHY IT MATTERS

Impressions that pair risk level with plain action language can reduce the gap between what the radiologist means and what the next clinician hears. Report impressions that pair the finding with a risk statement and a concrete time frame can make the intended action clearer without diluting diagnostic precision.


How non-radiology clinicians interpret incidental findings

Radiologist perception of guideline understanding outside radiology. Base n=16.

07

SECTION 07 · FOLLOW-UP OWNERSHIP

Follow-up ownership looks safer when it belongs to a system, not an individual inbox

CONTEXT

An incidental finding discovered during an ED CT may be unrelated to the acute reason for imaging, which makes ownership easy to lose during discharge and handoff. ED incidental findings are especially vulnerable because the acute problem is resolved before the non-acute recommendation becomes anyone's main responsibility. Discharge, shift changes, and lack of a known primary care clinician can all break the loop.

WHAT THE DATA SHOWS

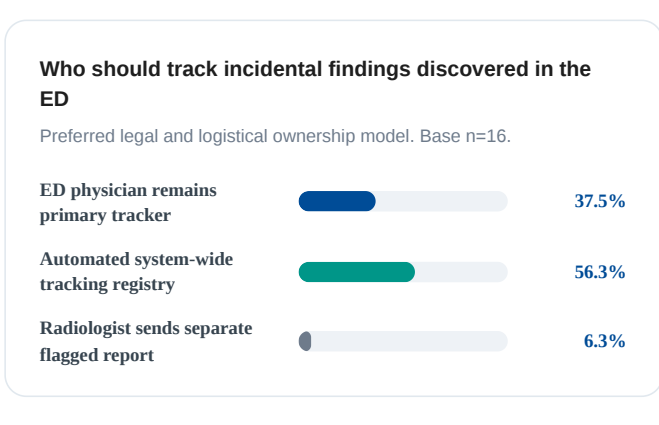
56.3% (9) prefer an automated system-wide institutional tracking registry; **37.5%** (6) place primary tracking responsibility on the ED physician; **6.3%** (1) place it on the radiologist through a separate flagged report.

THE INSIGHT

Most respondents favor infrastructure over person-dependent memory. The preferred solution is a registry that survives transitions between departments and clinicians. The preference for institutional tracking reflects a belief that safety should survive handoffs. A registry can assign ownership, generate reminders, record completion, and make the status of follow-up visible across departments.

WHY IT MATTERS

Closed-loop incidental-finding management should make ownership visible and auditable from discovery to completed follow-up. For actionable findings, reliability should not depend on whether one clinician remembers a line in a report weeks or months later.


Who should track incidental findings discovered in the ED

Preferred legal and logistical ownership model. Base n=16.

08

SECTION 08 · ELECTIVE SCREENING

Whole-body screening creates a second debate: who should own the downstream burden?

CONTEXT

Direct-to-consumer whole-body imaging can surface multiple low-specificity findings in asymptomatic people, transferring the follow-up problem into health systems that did not initiate the scan. Elective whole-body screening changes the context because the initial scan may have been performed without a clinical indication, yet the downstream findings enter conventional care. Radiologists then inherit uncertainty that the health system did not create.

WHAT THE DATA SHOWS

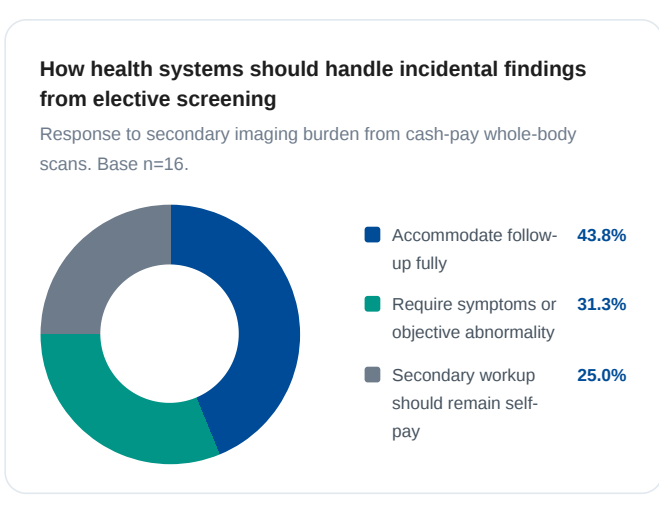
43.8% (7) would accommodate confirmatory care fully; **31.3%** (5) would require a corresponding symptom or objective abnormality before confirmatory imaging; **25.0%** (4) would keep secondary workup out-of-pocket.

THE INSIGHT

There is no dominant consensus. Radiologists are split between honoring any finding and protecting systems from cascades created by elective screening. The split responses show that this is both a clinical and policy problem. Some radiologists prioritize evaluating any discovered finding, while others want a threshold before the health system absorbs the secondary cascade.

WHY IT MATTERS

Health systems need explicit policies for outside screening findings so individual radiologists and clinicians are not forced to invent a pathway case by case. Institutions need explicit policies for outside screening findings, including how prior images are reviewed, when confirmatory imaging is appropriate, and who communicates uncertainty to the patient.


How health systems should handle incidental findings from elective screening

Response to secondary imaging burden from cash-pay whole-body scans. Base n=16.

09

SECTION 09 · REPORT BURDEN

Report bloat is now a throughput problem as well as a communication problem

CONTEXT

Detailed follow-up language can protect clarity and consistency, but every additional qualifying phrase competes with the main diagnostic task. Longer reports can improve completeness, but they can also bury the primary diagnosis inside layers of template language. When every minor finding receives extensive qualifiers and follow-up wording, the report becomes harder to read and slower to produce.

WHAT THE DATA SHOWS

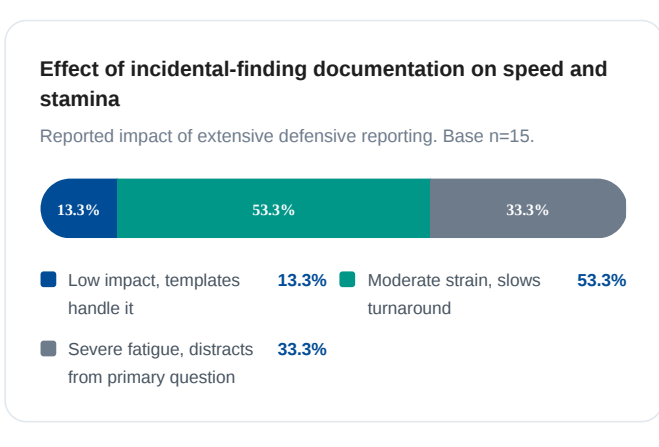
53.3% (8) report moderate strain from documenting minor findings; **33.3%** (5) report severe fatigue and distraction; **13.3%** (2) report low impact.

THE INSIGHT

Most respondents describe a measurable cognitive or turnaround cost from defensive documentation. The survey indicates that reporting burden is not merely annoyance. It consumes cognitive capacity that could otherwise remain focused on the indication for the study and the highest-risk findings.

WHY IT MATTERS

Structured language should make the report shorter and clearer, not simply add more mandatory text around every low-risk finding. The best templates should shorten the path to the right action by standardizing concise language, not simply add more defensive text.


Effect of incidental-finding documentation on speed and stamina

Reported impact of extensive defensive reporting. Base n=15.

10

SECTION 10 · FINANCIAL BURDEN

Patient cost matters, but usually does not overrule defensive or guideline logic

CONTEXT

Follow-up imaging can create deductibles, copays, time away from work, and further downstream testing. The radiologist may recognize that burden without being able to make it the primary decision rule. Radiologists are usually separated from the patient's deductible, copay, travel time, or time away from work, but they can still anticipate that repeated imaging carries real cost. The ethical tension is that financial burden should not lead to missed clinically important care.

WHAT THE DATA SHOWS

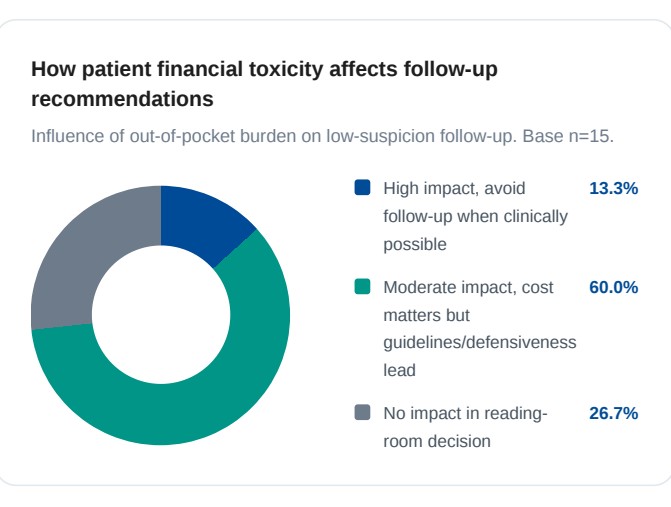
60.0% (9) say patient financial burden has moderate influence but does not override guideline or defensive considerations; **26.7%** (4) say it has no impact on the reading-room decision; **13.3%** (2) actively use clinical leeway to avoid low-value follow-up because of cost.

THE INSIGHT

Economic empathy is present, but it usually sits behind clinical and liability considerations in the final recommendation. The survey suggests cost acts mainly as a secondary consideration, behind evidence, guideline logic, and liability. That makes upstream appropriateness especially important because the reading room is not well positioned to solve affordability after a cascade has begun.

WHY IT MATTERS

The best way to reduce financial toxicity is to reduce low-value cascades upstream through clearer thresholds, risk language, and reliable follow-up governance. Reducing low-value follow-up through better thresholds is one of the few ways radiology can reduce financial burden without asking clinicians to ration necessary surveillance.


How patient financial toxicity affects follow-up recommendations

Influence of out-of-pocket burden on low-suspicion follow-up. Base n=15.

11

SECTION 11 · PATIENT PORTALS

Immediate portal access is turning the radiology impression into a dual-audience document

CONTEXT

Patients may read the report before a clinician explains it. That means the same sentence has to work for an ordering professional and a person searching unfamiliar terms online. Immediate portal release means patients may search an unfamiliar term before the referring clinician has seen the report. A technically accurate phrase can therefore generate anxiety even when the intended recommendation is routine or non-urgent.

WHAT THE DATA SHOWS

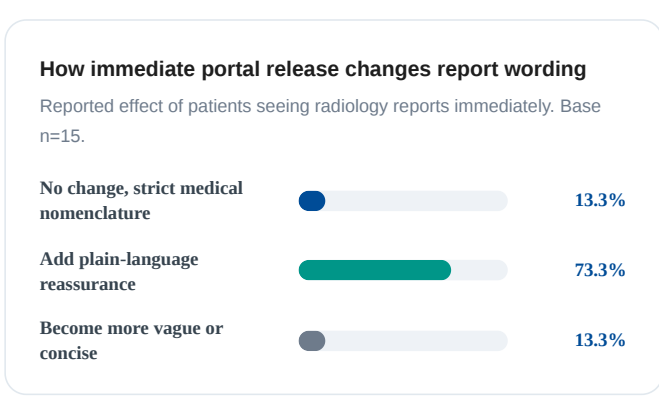
73.3% (11) say they add plain-language reassurance to reduce patient panic; **13.3%** (2) keep strict objective terminology unchanged; **13.3%** (2) become more vague or concise.

THE INSIGHT

The impression is increasingly doing two jobs: communicating diagnostic meaning to clinicians and managing immediate patient interpretation. The strong use of plain-language reassurance shows radiologists are already adapting to a dual audience. The challenge is to reassure without minimizing uncertainty and to be precise without making every descriptive term sound alarming.

WHY IT MATTERS

Plain-language risk framing can reduce anxiety without weakening professional precision if it clearly distinguishes urgency from uncertainty. Clear statements such as no urgent action, likely benign, or follow-up at a defined interval can help distinguish uncertainty from urgency for both clinicians and patients.


How immediate portal release changes report wording

Reported effect of patients seeing radiology reports immediately. Base n=15.

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SECTION 12 · PEER VOICE

The open responses call for thresholds, tracking, and clearer clinical significance

WHAT WAS ASKED

Radiologists were asked what structural change would help early detection save lives without turning healthy people into lifelong imaging patients. The open responses repeatedly return to thresholds, standardization, tracking, and communication. Respondents also describe the need for AI that triages clinically meaningful abnormalities instead of simply increasing the number of visible signals.

WHAT THE RESPONSES SHOW

Responses call for stricter evidence-based thresholds, standardized reports, consistent ACR-aligned recommendations, stronger PCP follow-up, automated tracking registries, better research, AI triage that filters benign noise, and continued clinical judgement.

THE INSIGHT

The qualitative signal does not ask radiology to see less. It asks the system to distinguish clinically meaningful findings from detectable noise more reliably. Taken together, the comments argue for a system that is comfortable saying both follow this and no follow-up is needed. That balance is essential because over-investigation and missed surveillance are opposite failures of the same follow-up process.

WHY IT MATTERS

The future of incidental-finding management is likely to depend on a combination of evidence thresholds, communication, and system-level follow-up rather than sensitivity alone. A mature incidental-finding program should make both decisions traceable: why surveillance was recommended, and why additional imaging was intentionally not recommended.

> Several comments ask for evidence-based size thresholds, standardized recommendations, and consistent use of guideline logic.
>
> EVIDENCE THRESHOLDS

> Respondents mention a PCP follow-up path and automated institutional registries so findings do not disappear between settings.
>
> CLOSED-LOOP TRACKING

> Comments argue for AI and reporting that prioritize biological or clinical significance rather than simply detecting ever smaller structures.
>
> CLINICAL SIGNIFICANCE OVER RESOLUTION

?

PEOPLE ALSO ASK · TOPIC FAQ

Frequently asked questions about incidental findings and radiology follow-up

What is an incidental finding in radiology?

An incidental finding is an unexpected abnormality discovered on imaging performed for another reason. Many are benign, but some require additional characterization or surveillance depending on the organ, imaging features, patient age, and risk factors.

Does every incidental finding need follow-up imaging?

No. Many incidental findings can be safely ignored or require no further imaging when established guidance and the clinical context indicate very low risk.

Why can incidental findings lead to unnecessary testing?

Uncertainty, defensive medicine, patient anxiety, fragmented follow-up, and overly sensitive detection can turn a low-risk finding into repeated imaging, specialist referrals, or invasive testing.

How can radiology practices reduce missed follow-up?

Clear action-oriented report language, standardized recommendations, automated registries, assigned ownership, patient notification, and closed-loop confirmation can reduce lost or delayed follow-up.

Will AI reduce incidental findings?

AI may help characterize findings, but high-sensitivity tools can also increase the number of low-value flags. The clinical benefit depends on specificity, relevance, and how the system handles false-positive or low-significance detections.

Why does report wording matter for incidental findings?

Wording influences how ordering clinicians and patients interpret urgency. Clear risk language and explicit follow-up intervals can reduce overreaction while preserving appropriate surveillance.

READING-ROOM LENS

What the incidental-finding problem looks like from the workstation

Four recurring tensions explain why a technically small finding can create a large operational footprint.

Detection versus significance

The threshold lens

Higher resolution and AI can reveal more anatomy than the care pathway can use.

Focus: Tie detection to clinical significance, not visibility alone.

Guideline versus liability

The judgement lens

Standard intervals reduce variation, but borderline cases still carry defensive pressure.

Focus: Make guideline-concordant restraint easier to defend.

Report versus interpretation

The communication lens

Ordering clinicians and patients may hear more urgency than the radiologist intended.

Focus: Pair descriptive precision with plain action language.

Finding versus follow-through

The system lens

Incidental findings can be lost across ED discharge, referral, and primary care handoffs.

Focus: Use registries and explicit ownership to close the loop.

CLOSING PERSPECTIVE

Better detection only helps when radiology can separate actionable risk from incidental noise.

Incidental findings are now part of routine radiology, which means the quality problem is no longer simply whether a finding is detected. It is whether its significance is communicated proportionately, whether the recommended action matches evidence, and whether the patient who genuinely needs surveillance is reliably followed. The survey shows that liability, ordering-clinician behavior, patient portals, and AI can all push that decision away from the image itself.

The most sustainable response is system design rather than individual vigilance. Clear ACR-aligned thresholds, concise risk language, structured reporting, closed-loop registries, and AI tools evaluated for downstream workload can help radiologists be both sensitive and selective. The aim is not fewer findings by default, but fewer low-value cascades and fewer important recommendations that disappear after the report is signed.

1. **Standardize the grey zones**
   Use consistent evidence-based thresholds and report macros that state both risk and recommended action.
2. **Design AI for clinical relevance**
   Measure whether detection tools reduce or increase low-value downstream work.
3. **Close the follow-up loop**
   Route actionable incidental findings into automated registries with visible ownership.
4. **Write for two audiences**
   Keep diagnostic precision while making urgency understandable to patients who see reports immediately.

What are incidental findings doing to your reading day?

Join the MDForLives Panel and share how radiology teams are balancing detection, follow-up, and patient impact.

Discover · Share · Shape

Join the Panel

DATA SOURCE AND CONTEXT

1. MDForLives Radiology Insight Survey_July, SGID 8918829. Survey export: 21 total records, 13 complete, 8 partial, 61.9% completion rate. Question-level bases vary by completion depth.
2. American College of Radiology. Incidental Findings resources and Incidental Findings Committee recommendations. https://www.acr.org/Clinical-Resources/Clinical-Tools-and-Reference/Incidental-Findings
3. American College of Radiology. Incidental Findings Committee goals include balancing patient risks and benefits and reducing unnecessary additional examinations. https://cs.acr.org/Clinical-Resources/Incidental-Findings

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