POST MORTEM

Why do we do them?
Can we do more?

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Perinatal death –
the loss of an expected life

- Why did the baby die?
- When did the baby die?
- Was something missed or did someone fail to act?
- Was it something that ‘I’ (the mother) did/ate?
- Will it happen again?

- What measures can you take to answer these questions?
Why is postmortem requested?

- To establish cause of death
- To confirm antenatal diagnosis
- To confirm discontinuation of intensive care was justified
- To identify risk factors for future pregnancies
- To inform parents, LMCs, obstetricians and paediatricians
Post mortem investigation options

- Full Autopsy + Placenta and cord (gold standard)
- Limited autopsy confined to area of interest
- Placenta and cord alone
- Radiology: X-ray, CT, MRI, USS
- Microbiology / virology
- Infant photos and external examination
- Genetics
The most useful limited examination (of anatomically normal babies) is the **placenta and cord** with external examination of baby (measurements + photos)
Autopsy rates

- Perinatal autopsies declining since mid 80’s (UK figures) at rate of 2.8% / year
- Decline attributed to improving diagnostic techniques and imaging.
- Change in public willingness to consent
- Clinician reluctance to ask (most often NND)
The request

- Takes time
- Do not rush into discussion
- Parents need time alone to consider
- Keep negative personal opinions to yourself
- How do you respond if parents decline?
Who should request

- No difference between senior or junior doctor
- Parents influenced by nursing staff

*Khong TY Obstet.Gynaecol 2001;97:994-8*
Parental consent - decision affected by

- Other fetal / newborn loss
- Gestational age
- Cause of death
- Transport to another centre
- Limited exposure to value of autopsy
- Perceptions gained from media
- Variable skills of requester
- Personal bias of requester
Barriers to consent - professionals

• Emotional distress (parents and professionals)
• Long wait for results

• Workload
• Negative publicity
• Religion and cultural issues
The placenta

• The placenta and umbilical cord are an integral part of the perinatal postmortem examination

• **Placentas are still being discarded – ? thoughtless / ignorant**

• 70% of IUD >36 weeks have significant placental pathology
A surprise – the placental side of T1 looks abnormal and T2 looks ‘normal’

Cord insertion of T1

Following formalin fixation
Term IUD – the answer was in the placenta
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<th>Offered autopsy</th>
<th>Optimal investigations</th>
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<td><strong>Offered autopsy</strong></td>
<td>11/20 &gt;90%</td>
<td>8/20 &gt;50%</td>
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<td><strong>Lowest</strong></td>
<td>66.7%</td>
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PMMRC report – 20 DHB figures
Can we do more?

- High autopsy ‘offer’ rate – variable uptake
- Low autopsy numbers in NND and intrapartum death - ?failure to ask because of emotional nature of case.
- Many studies indicate that some parents who decline regret that decision.
The PM informs us about the living

- Most babies are liveborn
- Antenatal screening allows for recognition of problems and need for possible early delivery
- Many of those babies will have similar placental pathology to that of the SB/END population.
- Twins
The autopsy is an invasive procedure. It remains the gold standard examination of deceased persons.

Have you attended an autopsy?