AUTOPSY RATES

Key point

Deaths following therapeutic endoscopy are under-reported to coroners - only 24% - and are then less likely to be examined at autopsy (only 30%) compared with the national average.

In England & Wales in 2002, more than 90% of autopsies of patients outside the perinatal age group were authorised by a coroner[4 5]. These follow reports from clinicians who consider that the death comes into one or more of the categories that by custom, though not by law, should be reported to a coroner; the commonest of these is uncertainty over the actual cause of death.

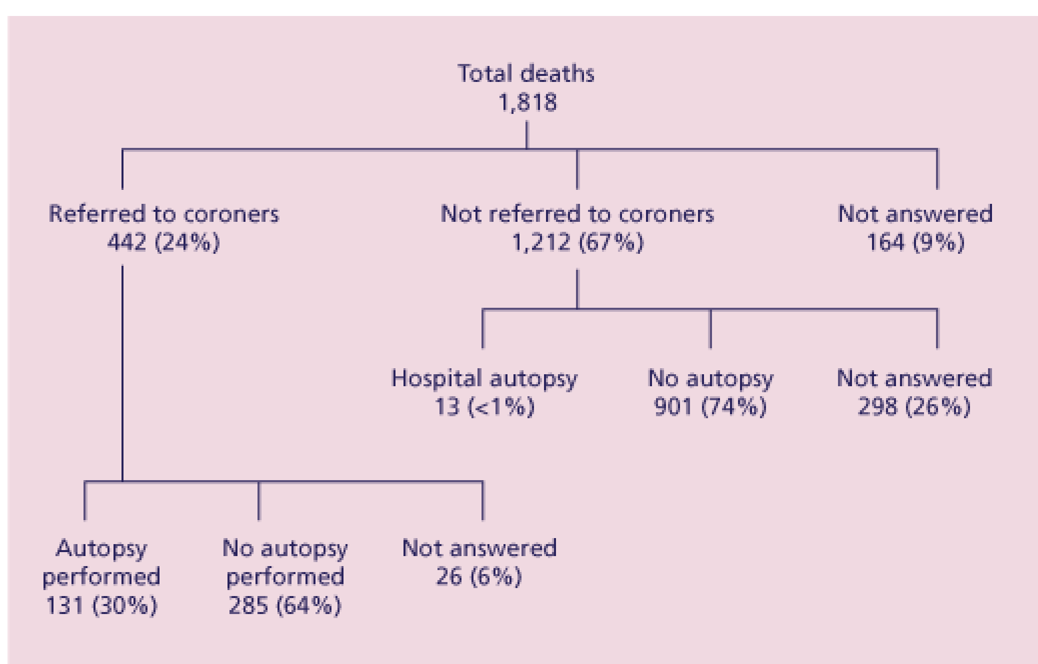

Figure 21. Deaths and autopsy rates

Of the 1,818 deaths that occurred amongst patients who had undergone an endoscopic procedure within 30 days, only 27% (442/1,654) were definitely known to have been reported to a coroner (Figure 21); physicians reported a smaller proportion of deaths (22%) compared with surgeons (36%) (Table 78). These are a small proportion of the possible 100% rate of reporting, since in the standard instructions provided for doctors and bereavement affairs staff on the cases that should be reported to a coroner, it is clearly stated that deaths following procedures in hospital qualify[6]. Even if the 164 unanswered cases are included, where it is unclear whether or not they were reported to a coroner (but the coroner might not have accepted the case), only a maximum of 33% (606/1,818) of these deaths were reported. In 2002, the overall proportion of deaths in England & Wales reported to a coroner was 38%[5], so the reporting rate in this sample is low.

Table 78. Cases reported to a coroner, by senior endoscopist specialty			
	Total deaths	Number reported to a coroner	*(%)*
Physician	1,365	294	*(22)*
Surgeon	334	120	*(36)*
Radiologist	34	9	*(26)*
Nurse practitioner	8	1	*(13)*
General practitioner	7	0	*(0)*
Other (not specified)	4	0	*(0)*
Sub-total	**1,752**	**424**	
Not answered	66	18	*(4)*
Total	**1,818**	**442**	

Of those cases known to have been reported to a coroner, only 30% (131/442) were accepted as cases and an autopsy authorised. This contrasts with the overall average in 2002 in England & Wales, when 58% of cases reported were accepted and had an autopsy[5].

In addition to the known 131 coronial autopsies amongst these patients, a further 13 had a consented autopsy, where the medical certificate of cause of death (MCCD) had been completed and the clinicians requested an autopsy examination with the agreement of the relatives. Therefore only 9% (131+13 = 144/1,654) of this sample had an autopsy. Nationally, in 2002, about 23% of deaths resulted in an autopsy[7], the great majority for a coroner. So this category of patient deaths is significantly under-investigated by autopsy after death compared with the national average for all causes of death. Had the average 23% of these deaths been so examined, a potential 400 cases for review would have been available, instead of one third of this number (144/400).

The median age overall of the patients in the study was 78 years. Of the deaths following a percutaneous endoscopic gastrostomy (PEG), where the median age was 80 years, only 21% (140/653) were reported to a coroner. It suggests that deaths in the very elderly may be under-reported to the coroner when they occur in hospital, despite the fact that they follow operative procedures.

The rate of consented autopsies was only 0.8% (13/1,654), which appears to be even lower than the usual current low autopsy rate for UK in-hospital deaths (~5%[8]) that are not reported to a coroner.

The lack of interest of clinicians in the use of autopsies as part of the follow-up of their patients is probably multifactorial:

- The advanced age of the patients
- The knowledge that the endoscopic procedure was in many cases a palliative procedure (e.g. PEG insertion in 40% (719/1,818 patients in the study) in a patient with known advanced and probably terminal disease
- The impression that the patients had already ‘had enough medical interventions’.