Correspondence

fibronectin concentrations will not contrib-
ute to the differential diagnosis in complicat-
ed clinical settings where definite proof by
potive CSF cytology should be sought.
However, a few cancer patients in our study
had a completely normal routine CSF exam-
ination including cytology, glucose, lactate,
albumin, IgG, and IgM, but they had increased
CSF fibronectin and later turned out to have leptomeningeal metastases, as
shown by cytology. Therefore, determination
of CSF fibronectin may be a useful diagnostic
and monitoring tool in the staging and follow up
of patients with disseminated cancer.

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Results over the past 12 months indicate
that the INRs have shown a consistent
improvement. The figure shows that the mean
INR for each patient group has pro-
gressively moved nearer to the mid point of
the therapeutic ranges—3—7.5 for the range
3—0-4-5 and 2-5 for the range 2-0-3-0, there
being too few patients in the range 2-0-2-5 to
analyse. The percentage of patients within the
therapeutic range each month for these two
groups has increased from 50% to 70% and
from 48% to 65%, respectively.

As a result of the improved anticoagulant
control the average recall between visits has
also increased from 26 to 36 days and from
21 to 33 days for the two groups. The results
have been achieved without any apparent
increased risk of serious bleeding complica-
tions. All episodes of bleeding have been
recorded on each patient’s computer record
which allows the number of such episodes to be
monitored.

The use of this computer program for
determining the dose of oral anticoagulants
has improved our therapeutic control. The
clinic is now also run by a staff pharmacist
acting under the direction of a consultant
haematologist, thus freeing up medical
time.

Among other benefits which have ensued
is the improved advice given to new patients,
which is part of the program. This part of the
program consists of a series of questions for
all new patients. As directed by the com-
puter, the pharmacist will question the
patients to ensure that they know why they
have been given warfarin, the dose and
colour of their tablets, the side effects of
warfarin together with which drugs should be
avoided. This ensures that each patient is
fully counselled regarding their anticoagu-
tion. This program will allow comparisons of
performance to be made between centres.

Use of computers in anticoagulant
clinics

The guidelines on oral anticoagulation pub-
lished by the British Society for Haematology
(BSH) acknowledged that computers may
have a role in both the analysis of therapeutic
quality control and in the clerical support of
an anticoagulant clinic. Their use in the
production of dose schedules for individual
patients was not recommended until reliable
patient database programmes had been
developed.

Until August 1990 our anticoagulant clinic
had been performed by either a consultant
haematologist or a medical senior house
officer. Each patient had been allocated a
target International Normalised Ratio (INR)
range according to the BSH guidelines. In an
attempt to improve our anticoagulant control
we introduced a previously reported com-
puter programme for determining the dose of
oral anticoagulant.

Audit of necropsies in a British district
general hospital

In response to the recent article about audit
of necropsies we were prompted to carry out a
retrospective study of the past 200 adult
necropsies performed at the Mayday Hospi-

Our criteria for grading diagnostic dis-
crepancies between the clinical cause of
death and the post mortem findings differed
from Harris and Blundell’s study, as we used
a single category for additional major pathol-
ogy without “feed-back on tests” group.

The data were derived from the clinical and
necropsy diagnoses obtained from post mortem
request forms and necropsy reports.

The diagnoses were then independently
graded by three histopathologists (TPM, MJG,
and SMT) using up to three of the criteria
given below. The grades were then
together compared and only those agreed by at least
two of the pathologists were accepted for each
case. Results were later presented at the
hospital clinical audit meeting (table).

The feedback from our study indicated that
necropsies have a central role in clinical audit,
yet despite this the necropsy rate continues to fall in this era of audit.

Our study differs from that of Harris and Blundell in several ways. Both studies never-
theless emphasise the significant discrepancy between clinical and necropsy diagnosis.
This discrepancy is sufficiently high to question the use of mortality statistics as derived from
death certificates in the distribution of medi-
cal resources.

Many clinicians still question the relevance and validity of necropsy results. Our study,
however, shows that most necropsies provide considerable information in diagnostic,
terminal pathological process as well as revealing important findings that may not
directly contribute to the cause of death.

The feedback from our study indicated that a summary of the main post mortem
findings was desired by the clinicians even
more than a full necropsy report. Despite the
lack of resources in many hospitals it would
not be too much of an extra effort for us to
provide a summary of findings and a concise necropsy
report which would be included in fuller the
Intercollegiate Working Party’s recommenda-
tions on necropsies.

In conclusion, necropsies must be con-
sidered as an essential part of clinical man-
agement and audit. Therefore, we actively
support the use of necropsy and encourage our
clinical colleagues in this matter. We also
feel that additional resources—for example,
secretarial and technical personnel—should
be provided so that the underresourced
pathology laboratories can provide the quan-
tity and quality of necropsies as laid out by the
Intercollegiate Working Party recommend-
ations.

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Table Comparison of necropsy findings between Harris and Blundell’s study and ours

<table>
<thead>
<tr>
<th>Findings</th>
<th>Harris and Blundell study</th>
<th>Mayday hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major discrepancy in diagnosis</td>
<td>13%</td>
<td>32%</td>
</tr>
<tr>
<td>Major unsuspected diagnosis</td>
<td>30%</td>
<td>46%</td>
</tr>
<tr>
<td>Important clarification in diagnosis</td>
<td>63%</td>
<td>38%</td>
</tr>
<tr>
<td>Confirms presence of main diagnosis</td>
<td>86%</td>
<td>60%</td>
</tr>
<tr>
<td>No contribution</td>
<td>2%</td>
<td>7%</td>
</tr>
<tr>
<td>Major additional pathology</td>
<td>51%</td>
<td>47%</td>
</tr>
</tbody>
</table>

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Audit of necropsies in a British district general hospital.

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