number of air changes per hour in the PM room really diminish the hazard is another matter.

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References

- ¹ Whale K. The Howie Code; is the price of safety too high? *J (Letter) Clin Pathol* 1983;36:363.
- ² Innes JA. Non-respiratory tuberculosis. *J R Coll Physicians Lond* 1981;15:227-31.

I must take issue with Dr Whale¹ regarding the number of infectious TB cases likely to be encountered annually in the post-mortem room. The figures that she quotes are for those cases in which tuberculosis is given as the cause of death; they do not include the cases in which TB is either not the principal cause of death or is found incidentally. The latter cases, in which pulmonary TB unexpectedly turns up in a coroner's necropsy, usually in an elderly subject, are by no means uncommon; I have personally performed two such necropsies in the past 18 months, confirmed by positive cultures.

Professor Grist's continued survey² shows quite clearly that there is an increased risk of TB in morbid anatomists and mortuary technicians, and I am sure that I am not alone in being personally acquainted with cases of tuberculosis almost certainly contracted in the post-mortem room.

It is only recently that any interest at all has been taken in post-mortem room safety, and it is hardly surprising that mortuary ventilation systems are still relatively undeveloped. I would also add that, quite apart from the infection issue, adequate ventilation considerably reduces necropsy odours, which, contrary to popular belief,

are as offensive to the nostrils of morbid anatomists as to anyone else's.

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References

- ¹ Whale K. The Howie code. Is the price of safety too high? (Letter). *J Clin Pathol* 1983;36:363.
- ² Grist NR. Infections in British clinical laboratories 1980-81. *J Clin Pathol* 1983;36:121-6.

Dr Whale replies as follows:

I appreciate Dr Gubbay's concern that the OPCS figures do not include the cases in which tuberculosis is either not the principal cause of death or is found accidentally, leading to inaccuracies in the notification system for tuberculosis.

This problem was aired by Davies *et al.*,¹ who obtained unpublished OPCS data, and also data from the MRC Tuberculosis and Chest Diseases Unit (TCDU). They came to the conclusion, having regard to all possible sources or error, that the tuberculosis statistics published by OPCS have an impressively high (to within 10%) degree of accuracy, and that this is in the direction of overestimation. They point out that providing the under-notification of tuberculosis does not exceed by more than 15% the correct total, then the current overestimate provided by the notification statistics is nearer the truth than it appears.

As to his second point, regarding the incidence of tuberculosis in morbid anatomists and mortuary technicians, Professor Grist's² figures need to be examined in some detail. Seven of the 14 cases in whom occupational exposure seemed to be the cause were involved in post-mortem or mortuary work. Three of these cases were contacts of a medical morbid anatomist and some doubt must therefore exist as to whether their infection was contracted in

the post-mortem room. In addition, whilst it is accepted practice to give attack rates per 100 000, with such small figures, one must doubt the statistical validity of comparing attack rates in laboratory personnel and those in the general population. Perhaps it might be more useful to determine the incidence per person years of exposure. The figures as presented can give a misleading impression as significant differences will arise by the inclusion or otherwise of even one case. Furthermore, if the attack rates are to be believed, the incidence in porters, assistants, etc is extraordinarily high, though there is no reason to believe that they are particularly exposed to infection.

Ventilation of post-mortem rooms may well be desirable if only to contain the smell, but we should not delude ourselves that ventilation is necessarily going to reduce the risk of infection. Data on this will not be easy to acquire given the low figures of acquired infection in post-mortem rooms (pace Dr Gubbay) but the recently published work by Newsom *et al.*³ is a welcome indication that such data are now being sought. In the meantime, I maintain my plea for the observance of safe and careful working procedures rather than spending vast sums of money on installations the validity of which in relation to safety is questionable.

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- ¹ Davies PDO, *et al.* Ambiguities and inaccuracies in the notification system for tuberculosis in England and Wales. *Community Medicine* 1981;3:108-18.
- ² Grist NR. Infections in British clinical laboratories. *J Clin Pathol* 1983;36:121-6.
- ³ Newsom SWB, Rowlands C, Matthews J, Elliott CJ. Aerosols in the mortuary. *J Clin Pathol* 1983;36:127-32.