Necropsy organ weights are largely useless

In 1993 the Royal College of Pathologists published Guidelines for Post Mortem Reports.1 The guidelines may well have led to improvements in necropsy practice but were unfocused and their evidence base was unstated. They have been quoted as a gold standard for audit of necropsy reports,2 reiterated in an editorial in this journal.3

Most of the guidelines are sensible but I question the recommendation, in adult necropsies, of routine weighing of organs. Excluding the heart, the weighing of which can provide important information (particularly when the ventricles are weighed separately), organ weights are of little or no value. The apparent weight of an organ depends on dissection technique and on the accuracy of the weighing balance. In common with other branches of pathology, a numerical result should always be accompanied by the normal range, corrected for the patient’s sex, age, and body size. I suspect very few of us comply with this basic rule. However, even if we were to provide reproducibly accurate and referenced weights, they would not be of use to our clinical colleagues, who are accustomed to clinical evaluation of organs, supplemented by imaging techniques in which, at most, a single linear measurement of an organ is given. To be of use, our necropsy practice should reflect these assessments.

The purpose of the necropsy report is to communicate the findings of the necropsy to others, be they clinicians, coroners, or others. We should stop this ritualistic, pseudoscientific practice and concentrate on providing a relevant, meaningful service to our colleagues.

1 T H W BARKER
Department of Histopathology and Cytopathology, Norfolk and Norwich Hospital, Brunswick Road, Norwich, Norfolk

We obtained the following comments on this letter:
From Dr R D Start

Dr Barker is correct in his statement that the Royal College of Pathologists’ publication Guidelines for Post Mortem Reports has led to improvements in necropsy reporting.1 This is clearly evident within recent reports of the National Confidential Enquiry into Perioperative Deaths (NCEPOD).2 The necropsy report guidelines currently provide the only national audit standard for the quality of necropsy reports and I would agree that an appropriate evidence base is desirable. This was one reason behind my suggestion for national practice guidelines for necropsy.3

I am surprised that the routine weighing of organs is in question. Normal organ weight ranges, corrected for patient sex, age, and body size, are available and can be used if necessary. Some variation may occur with dissection technique but this would be consistent for individual pathologists and could be addressed in any national practice guidelines. Facilities for weighing bodies and organs are fundamental requirements for any mortuary and accuracy is simple to achieve. The suggestion that we stop this “ritualistic, pseudoscientific practice”3 in order to communicate relevant findings to our colleagues by way of other variables such as a single linear organ measurement is illogical and unacceptable. Linear measurements of focal abnormalities complement gross necropsy findings and allow comparative audit of modern imaging techniques, many of which now give measurements in three dimensions. Supplementary information can also be provided by the dissection of organs in the planes of examination typically seen in modern imaging techniques.

Most clinicians, coroners, and (possibly more importantly) relatives are able to comprehend the concept that organs are abnormal when organ weights are put in the context of normal ranges, particularly if the organ is several times the average normal weight for an individual of similar size, sex, and weight. Although I am unable to provide a specific evidence base to support the use of organ weights, the reasoning behind not providing them is difficult to comprehend, particularly when the most recent major regional audit of necropsy reporting in East Anglia (including Norwich!) found “all pathologists agreed the value of routine weighing of heart, lungs and brain.”4 I hesitate to suggest that organ weights may be an indirect measure of necropsy quality because through personal experience I have found not only that high quality necropsy reports can be generated from appalling necropsies but also that seemingly accurate organ weights can be determined without removal from cadavers.

More questionable than organ weight measurement is the reported desirability of histological examination in all necropsy cases. There is an increasingly vocal body of opinion within the profession which disagrees with this requirement and the same audit of necropsy reporting in East Anglia provided useful data in relation to the sensible use of histology in necropsy practice.5 Such evidence must be incorporated into any future national guidelines for necropsy practice in order that the guidelines reflect the views of most practising pathologists, rather than those of a few interested individuals who perform few, if any, necropsies.

Our principal aim should not be for more necropsies but for better quality necropsies, which are fully supported by a system of formal quality assurance. The Royal College of Pathologists has a major part to play in this process and in recent years has overlooked the necropsy in favour of diagnostic histopathology and cytopathology. The intermittent production of necropsy related guidelines has been useful but a complete reappraisal of all necropsy related matters is urgently required at a national level. Other countries have already addressed these issues6 and this is presumably one reason for the commissioning of a Royal College of Pathologists Working Party to examine the current status of necropsy in the United Kingdom.

R D START

Guidelines for Post Mortem Reports
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impressed by the many tables and flow charts, which can be used as aids to decision making.

All aspects of pathology are covered and it is very easy to find the specific information one needs; the first page of each chapter has its own index, there are summaries of topics at the top of each page, and the general index is detailed and comprehensive. Each subject is clearly introduced with relevant background information. Practical details are easy to follow and alternative methods discussed. Attention is paid to the interpretation of results and to the use of quality controls. At the end of each chapter future directions are covered and there is a useful further reading list. The unifying theme to the book is the application of similar methods to different disciplines. Microscopy and molecular techniques are referred to frequently and it is obvious that a common language is developing between pathologists. This welcome situation will be helped considerably by this work, which should be on the bookshelf of every laboratory. The availability of a version on CD-ROM will increase its appeal.

D M BARNES


Immunologists may well wonder whether there is any need for another volume to complement the many excellent texts that already exist on clinical immunology. Gavin Spickett explains why he wrote the book, saying it was for selfish reasons in that the book that he would like to have had was not available when he was a trainee. Therefore the volume has to be assessed from two points of view: first, does it fill a need in the market, and second, does it meet Dr Spickett’s own requirements?

In my opinion the answer to both questions is yes. The volume is up to date, comprehensive, and easily referenced. The text includes information on both clinical and laboratory immunology and has useful appendices on quality and managerial issues which laboratory trainees will find particularly valuable. Skipping through the volume, I find it is generally very up to date, for example the section on X-linked lymphoproliferative disease identifies the cloned gene, information about which was only published in Nature in October 1998.

In a volume such as this, one’s attention tends to get drawn to areas of one’s own particular interest and not surprisingly not all contributions are similarly up to date. I found it surprising that the section on HIV infection did not mention combination antiretroviral therapy, particularly protease inhibitor therapy, or viral load testing in any detail, and also indicated that there was no value in sequential monitoring of CD4 counts once they had fallen below 0.05—information that is clearly incorrect following the advent of new treatments.

However, such criticisms are minor in what is otherwise an excellent volume, and I applaud Dr Spickett’s omission of fundamental immunology which has little or no place in such a book. I think that immunology trainees will find this volume invaluable, as will most of their trainers, but whether the market will be larger than the 150 or so individuals that this group comprises remains to be seen. I certainly cannot see many SHOs in general medicine carrying this book along-side the many other small slim volumes that currently sit in RMO’s pockets, but I may be proved wrong on this too.

GRAHAM BIRD

Correction

Because of an error in the publishing process, Dr Ibrahim’s Best Practice article in the February issue (Guidelines for handling oesophageal biopsies and resection specimens and their reporting, vol 53, no 2, pp 89–94) has been numbered 155 instead of 156. Reprints of this article will be numbered correctly, as will references to the article in our in-house Best Practice advert that appears at the end of each issue. We apologise for this error.

Notice

St Mary’s Hospital Campus of ICSM, London

Haematology Courses, Spring 2000

1. Two day course in haematology morphology
St Mary’s Hospital, 3–4 April 2000 Suitable for consultants and career grade post holders in haematology. Also valuable for trainees in haematology. CME approved (6+7 CME credits)
Cost £140 including light lunch

2. One day course in histopathology of the bone marrow
St Mary’s Hospital, 5 April 2000 Suitable for consultants, career grade post holders, and trainees in haematology and histopathology. CME approved (7 CME credits)
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Inquiries in writing or by fax only, to: The Postgraduate Course Organiser Academic Surgical Unit 10th Floor, QEQM Wing St Mary’s Hospital London W2 1NY Fax No +44 (0)171 886 6314.
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Receipt of manuscripts will be acknowledged (see the following media: zipped or unzipped files on floppy disks, compact disks, or optical disks. A hard copy of the image should be provided).

If any tables or illustrations submitted have been published elsewhere, written consent to republication should be obtained by the author from the copyright holder (usually the publisher) and the authors. A copy of the letter giving consent must be included.

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When a manufacturer's method is used in a study with a particular item of equipment or kit of reagents, the method, manufacturer, and reference to the scientific literature on which it was based should be given.

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3 References in the text should be identified by Arabic numerals in brackets—for example, [1] [2].

4 Information from manuscripts not yet accepted, or personal communications may be cited only in the text and not included in the references. References are not checked by us; authors must verify references against the original documents before submitting the article.


Manuscript checklist:

- Is there an abstract?
- Are the abbreviations spelled out?
- Are the measurements in SI units?
- Are the references in Vancouver style?

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