The decline in autopsy rates in the past four decades in developed countries (to less than 5% in the USA) has paralleled continued discrepancies between clinical and autopsy diagnoses of up to 20–30%.

The interconnected causes of low autopsy rates include absence of predictable funding, clinical overconfidence in diagnostic modalities, reluctance to request and undertake autopsies, decreased expertise in autopsy, a scarcity of auditable standards and mandated autopsy rates, and reluctance of families to consent to autopsy.

The need for mortality data based on accurate post-mortem diagnosis of disease and identification of cause of death has increased in minimally or less-invasive procedures to replace or augment conventional autopsy. However, uncertainty about the accuracy of less-invasive diagnostic techniques for post mortems and about integration with conventional autopsy has raised concerns about whether reliable population-based determination of cause of death can be maintained.

In The Lancet, Sudhin Thayyil and colleagues report on the first large, prospective, validation study of fetuses, infants, and children comparing post-mortem MRI with conventional autopsy and a uniquely defined minimally invasive autopsy. The MRI protocol, optimised to acquire non-contrast T1-weighted and T2-weighted images of the brain, spine, and body on a 1.5 Tesla magnet, needed about 90 min scan time in fetuses and 60 min in children, and used three-dimensional sequences for image reconstruction in different planes. The conventional autopsy complied with UK national guidelines, including in-situ, macroscopic, and histological assessment of the brain and internal organs, and ancillary assessments, consisting of clinical history; ante-mortem diagnostic studies; post-mortem plain-film radiography; external examination; placental histopathological examination for fetuses; and laboratory tests, including genetic, metabolic, and microbiological studies. The minimally invasive autopsy consisted of these common ancillary assessments and post-mortem MRI, with no post-mortem sampling of tissues or body fluids other than blood, and no histological assessments.

MRI alone versus conventional autopsy was concordant in 222 (55.5%, 95% CI 50.6–60.3) of 400 cases for identification of cause of death or major pathological change. By contrast, minimally invasive versus conventional autopsy was concordant in 357 (89.3%, 85.8–91.9) cases. However, concordance varied substantially by age. A high concordance for fetuses
(95–96%), and relatively high rates for newborn babies (81%) and infants (85%), contrasted with that of only 53·6% for children aged between 12 months and 16 years. Concordance between fetuses and infants was substantially greater than that reported in several previous smaller series, with one reporting that a minimally invasive autopsy provided information of at least equivalent clinical significance to that of conventional autopsy in 32 (73%) of 44 fetuses.7 Post-mortem MRI is particularly valuable for delineation of anatomical abnormalities, and might be better than autopsy for identification of structural brain abnormalities, especially when substantial post-mortem autolysis restricts pathological assessment.8 The high concordance in fetuses and infants shows the importance of common ancillary studies in this age group.

Conversely, the low concordance in older childhood deaths reflects the different processes that caused those deaths. In children, acquired natural diseases were frequently missed, especially myocarditis, pneumonia, and sepsis. Identification of such diseases usually requires macroscopic and histopathological assessment; specific diagnosis would not be expected from imaging or a blood test. This poorer concordance in children was similar to a large series of adult deaths referred for coroner’s autopsy,9 in which the major discrepancy rate for cause of death between consensus MRI studies and conventional autopsy was 43% and post-mortem MRI frequently missed common natural disease processes, particularly ischaemic heart disease, pulmonary embolism, pneumonia, intra-abdominal abnormalities, deep venous thrombosis, and malignancy, also confirmed in other studies.10,11

Although minimally invasive autopsies have been defined by the UK Human Tissue Act as those in which “needle biopsies through the skin are taken to sample internal organs and tissues, and examinations...[that] use an endoscope or laparoscope to provide internal access to the gastrointestinal tract and the abdominal cavity”,1 a standard protocol and criteria for adequacy of assessment have not been universally accepted. Identification of when a minimally invasive autopsy is likely to provide an accurate cause of death is crucial to the success of any system of death investigation that uses less invasive techniques. In the present study, predefined criteria were used for a retrospective collaborative review of the minimally invasive autopsies by a pathologist and a radiologist who were masked to the conventional autopsy results. They concluded that a full autopsy might not have been needed in 41% of deaths and, in those cases, there was near-perfect concordance (99·4%) between minimally invasive and conventional autopsy. This assessment resulted in an algorithm that could provide a basis for a collaborative system for death investigation using various diagnostic modalities, both invasive and non-invasive.

The study also confirmed that post-mortem diagnosis of many common diseases presently requires conventional autopsy. As in living patients, histological or cytological assessment is mandatory for specific diagnosis of many neoplastic, infectious, and inflammatory diseases. Histopathological findings might not be uniform; therefore, accurate diagnosis often needs macroscopic assessment of the organs and tissues, and sampling of various sites. Suspicious deaths and other unnatural deaths, including those related to asphyxiation, toxins, or drugs, need complete autopsy to assess natural disease processes accurately and reliably. Multispecialty guidelines to assess possible opiate-related deaths require complete autopsy for possible drug-related deaths, because the toxicological results have to be interpreted in the context of all available information, including autopsy findings.12 Complex diseases, treatment sequelae, immunosuppression, and emerging infections will increase the importance of tissue procurement, preservation, and assessment, to assess new therapeutic and disease-prevention strategies.

Despite limitations, Thayyil and colleagues have presented a starting point for development of a robust system for post-mortem diagnosis using various modalities (ie, pathology, radiology, laboratory testing) and a system of interdisciplinary consultation and collaborative diagnosis, mimicking systems for optimum diagnostic assessment of living patients. Some deaths could be assessed with minimally invasive autopsy, but some investigations will mandate use of conventional autopsy. Family members could participate in the decision process. Crucial to success of an integrated post-mortem diagnostic programme will be clear performance standards, regular audits, physician training, and sufficient and stable funding to attract, train, and retain specialists and provide state-of-the-art resources for radiology and pathology. Centres of excellence will provide sufficient resources and interdisciplinary consultation among subspecialty pathologists, radiologists, and clinicians,
Caesarean section: in good surgical skills we trust

No fewer than 18.5 million caesarean sections are undertaken annually worldwide,¹ making up 9–33% of all births in Africa, Latin America, and Asia.² ⁴ In The Lancet, the CORONIS Collaborative Group⁵ present a well thought out randomised controlled trial that included 15 935 women from 19 sites in Argentina, Chile, Ghana, India, Kenya, Pakistan, and Sudan, and that assessed the effects of five elements of the caesarean section surgical procedure on short-term outcomes. The comparisons undertaken in the CORONIS trial were as follows: (1) blunt versus sharp abdominal entry; (2) exterior versus intra-abdominal repair of the uterus; (3) single-layer versus double-layer closure of the uterus; (4) closure versus non-closure of the pelvic and parietal peritoneum; and (5) chromic catgut versus polyglactin-910 for uterine repair. No statistically significant differences were noted in the primary outcome, which was a composite of death, maternal infectious morbidity, further operative procedures, or blood transfusion of more than 1 unit of whole blood or packed cells up to the 6-week follow-up visit; the risk ratio was 1.03 (95% CI 0.91–1.17) for blunt versus sharp entry, 0.96 (0.84–1.08) for exterior versus intra-abdominal repair, 0.96 (0.85–1.08) for single-layer versus double-layer closure, 1.06 (0.94–1.20) for closure versus non-closure, and 0.90 (0.78–1.04) for chromic catgut versus polyglactin-910. Among the secondary maternal and neonatal outcomes assessed, the use of chromic catgut compared with polyglactin-910 was associated with a lower risk of a mother receiving a blood transfusion of more than 1 unit (risk ratio 0.53, 95% CI 0.30–0.93).

The CORONIS trial was funded by the UK Medical Research Council and WHO, and was inspired by the CAESAR study—a study done in the UK and Italy in 2000 that investigated the association between three caesarean section surgical factors (only one of these was repeated in CORONIS) and the risk of maternal infectious morbidity.¹ CORONIS used a fractional, factorial design—ie, only three of the five possible intervention pairs were allocated to each woman by the randomisation procedure, whereas the two remaining factors were undertaken at the discretion of the surgeon. By this approach, more than 9000 women were available for the analysis of each comparison.

CORONIS was well planned, well managed, and had unprecedented focus on clinical practice in low-income settings, and will facilitate continued research on translation of multispecialty diagnostic modalities used in living people to the post-mortem setting.

*Corinne L Fligner, Manjiri K Dighe
Departments of Pathology and Laboratory Medicine, University of Washington, Seattle, WA 98195, USA (CLF); and Department of Radiology, University of Washington Medical Center, Seattle, WA, USA (MKD)
fligner@u.washington.edu

We declare that we have no conflicts of interest.