authority. I would hope that the consultant would escape involvement in any civil action that a patient might bring against the hospital (and possibly the general practitioner) if it could be shown that preventable damage had occurred because necessary drugs have been withheld.

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1 Wilkie P, Sibbald B, Raftery J, Anderson S, Freeling P. Prescribing at the hospital-general practice interface. I. Hospital outpatient dispensing policies in England. *BMJ* 1992;**304**:29-31. (4 January.)

Risk of Down's syndrome and amniocentesis rate

SIR,—Several articles on assessing the risk of Down's syndrome on the basis of maternal age and biochemical markers in maternal serum have emphasised the sensitivity and specificity (that is, true positive and false positive rates) that may be expected by offering amniocentesis to women whose risk of bearing a fetus with the syndrome exceeds a predefined cut off limit.[1-3] It seems to be assumed, firstly, that all or most obstetricians would be prepared to adopt the same limit for offering amniocentesis and, secondly, that most patients would accept such an offer. This second assumption has recently been questioned.[4]

We examined both these factors in Bristol, where assessment of the risks of Down's syndrome derived from maternal serum αfetoprotein concentration and maternal age has been available on request for women over 30 (based on the report by Murday and Slack[5]) since 1985. We examined the figures for 1989 as this was the first year for which results were available on computer, thus facilitating the analysis.

The study was in two parts. The first was a survey of stated policies on offering amniocentesis among the 15 consultant obstetricians practising in Avon. The second was an analysis of the numbers of estimates of risk in various numerical risk groups and the numbers of patients actually proceeding to amniocentesis within each risk group.

Three obstetricians stated that they would offer amniocentesis if the risk was ≥1:100, five if it was ≥1:200, one if it was ≥1:250, and two if it was ≥1:300, while four did not use a fixed figure. Thus most chose a level of risk ≥1:200. The table shows that only 14 (39%) of 36 patients with a reported risk ≥1:200 actually underwent amniocentesis and that only 34 (31%) of 110 with a reported risk ≥1:300 underwent amniocentesis. The reasons for this low uptake of amniocentesis could include lack of enthusiasm for the procedure among obstetricians and unacceptability to patients. Perusal of the notes of those patients not proceding to amniocentesis by one of us showed that in most instances the patient had declined the offer of amniocentesis. In a few cases this was related to a history of miscarriage.

Rates of amniocentesis associated with different risks of Down's syndrome

Reported risk	No of reports	No (%) of amniocenteses
≥1:100	8	4 (50)
<1:100-≥1:200	28	10 (36)
<1:200-≥1:300	74	20 (27)
<1:300-≥1:400	87	8 (9)
≥1:400	642	6 (1)

If these findings—that less than 40% of patients with a risk of bearing a fetus with Down's syndrome of ≥1:200 and less than a third of those with a risk ≥1:300 proceed to amniocentesis—are representative of the national position they have serious implications for the benefits likely to accrue from the introduction of population screening for the risk of Down's syndrome.

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1 Wald NJ, Cuckle HS, Densum JW, Nanchahal K, Royston P, Chard T. Maternal serum screening for Down's syndrome in early pregnancy. *BMJ* 1988;**297**:883-7.
2 Lewis M, Faed MJW, Howie PW. Screening for Down's syndrome based on individual risk. *BMJ* 1991;**303**:551-3.
3 Spencer K. Evaluation of an assay of the free β-subunit of choriogonadotrophin and its potential value in screening for Down's syndrome. *Clin Chem* 1991;**37**:809-14.
4 Keatinge RM, Williams ES. Screening for Down's syndrome. *BMJ* 1991;**303**:1063.
5 Murday V, Slack J. Screening for Down's syndrome in the North East Thames region. *BMJ* 1985;**291**:1315-8.

Auditing necropsies

SIR,—Lauder highlights the value of necropsy in audits of clinical practice.[1] The purpose and perceived value of necropsy will be different for the pathologist, clinician, relatives, and coroner. Thus the need to audit clinical practice may well be an insufficient reason for relatives to consent to a necropsy while an inadequate necropsy may deter clinicians from making further requests.

Though some pathologists may be reluctant to admit that inadequate necropsies are performed, few attempts have been made to access the quality of necropsies. The most notable exceptions have been the confidential inquiries into maternal deaths and the national confidential enquiry into perioperative deaths, which have identified considerable deficiencies.[2,3] Perinatal necropsies were audited in the West Midlands regional perinatal mortality survey[4]; only half attained what was a relatively low minimum standard. This is a matter of concern as the findings may influence the reproductive behaviour of the parents or the management of future pregnancies.

The coroner's necropsy raises further problems as there is rarely a perceived need for ancillary investigations. This is not helped by the response of coroners to requests for payments for investigations that may have to be met from laboratory budgets. These vary from no response (because the coroner believes that they are an integral part of the examination) to an arbitrary fee (irrespective of the work entailed) to acceptance of the Home Office rates as published by the BMA. There is also a lack of uniformity in the use of specialist pathologists. The Royal College of Pathologists has notified the Home Office of specialist paediatric pathologists on whom a coroner can call when appropriate. The use of this facility varies. The British Paediatric Pathology Association is surveying its members to assess the extent to which this facility is being used by individual coroners.

If we are to promote necropsy we must ensure that we are providing an adequate standard of service and can show that we are doing so. Although money for audit may be insufficient to fund the cost of ancillary studies for coroners' necropsies, it is adequate to allow the quality of services provided by pathologists to be assessed. Such audits must not be limited to the output of the pathology departments concerned but must also include an assessment by those receiving our reports of their quality and value. If our clinical colleagues are not convinced of the value of necropsy how can we expect to convince our hospital managers that it is worth funding?

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1 Lauder I. Auditing necropsies. *BMJ* 1991;**303**:1214-5. (16 November.)
2 Department of Health. *Report on confidential enquiries into maternal deaths in the United Kingdom 1985-7*. London: HMSO, 1991.
3 Campling EA, Devlin HB, Lunn JN. *The report of the national confidential enquiry into perioperative deaths 1989*. London: Royal College of Surgeons, 1990.
4 Rushton DI. West Midlands perinatal mortality survey 1987. An audit of 300 perinatal autopsies. *Br J Obstet Gynaecol* 1991;**98**: 624-7.

Communication of results of necropsies

SIR,—In their paper Paula Whitty and colleagues expose the inadequate provision of results of necropsy to clinicians; we support their recommendations regarding the provision of this information to general practitioners.[1]

Necropsy reports are needed to complete the picture of a patient's death, but lack of resources in local pathology departments, the expense of purchasing coroners' reports, and, indeed, the quality of coroners' necropsies (which has been questioned[2]) may be a serious obstacle. General practitioners should, surely, receive a copy of all relevant reports free of charge. Funding needs to be identified to implement these recommendations in the light of the report *The Autopsy and Audit*.[3]

Whitty and colleagues' paper concerns necropsies other than those done by coroners; such necropsies are performed after only 3% of all deaths, and the paper therefore addresses only a fraction of the problem faced by general practitioners when trying to obtain information on patients of theirs who have died. Knowledge of the time, place, and cause of death is essential for administrative purposes—for example, for cancelling appointments, following up relatives and carers, and auditing both the quality of care and the quality of death certification.

We know that general practitioners would like to receive this information routinely,[4] but presently no mechanism exists for its provision. The existing health service information systems do not permit the combination of general practitioner's name, patient's name, and cause of death. In Newcastle upon Tyne, with the help of the district health authority (supplying the patient's name and cause of death) and family health services authority (adding the general practitioner's name), we are preparing to create lists that include over 90% of deaths. We shall shortly circulate such lists to general practitioners and evaluate the benefits of providing them.

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1 Whitty P, Parker C, Prieto-Ramos F, Al-Kharusi S. Communication of results of necropsies in North East Thames region. *BMJ* 1991;**303**:1244-6. (16 November.)
2 Lauder I. Auditing necropsies. *BMJ* 1991;**303**:1214-5. (16 November.)
3 Joint Working Party of the Royal College of Pathologists, Royal College of Physicians, London, and the Royal College of Surgeons of England. *The autopsy and audit*. London: RCPath, RCP, RCS, 1991.
4 Van Zwanenberg TD. *Newcastle facilitators report*. Newcastle upon Tyne: Newcastle upon Tyne Family Practitioner Committee, 1989.

Hormonal manipulation of prostatic cancer

SIR,—In his summary of hormonal management of advanced prostatic cancer Fritz H Schröder urges that the concept of total androgen blockade should be questioned and that enthusiastic claims of