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We may return unduly long letters to the author for shortening so that we can offer readers as wide a selection as possible. We receive so many letters each week that we have to omit some of them. Letters must be signed personally by all their authors. We cannot acknowledge their receipt unless a stamped addressed envelope or an international reply coupon is enclosed.

Too few necropsies

SIR,—In writing of his difficulty in elucidating the long-term behaviour of sarcoid heart disease (25 August, p 501), Dr H A Fleming criticises the inadequacy of some necropsies. He also complains of the falling rate of necropsies, and suggests that this may be attributable to the lack of help given to clinicians by inadequate postmortem examinations. I wish to make some personal observations on these matters and also to comment on behalf of the Royal College of Pathologists.

In my experience there is considerable variation in the interest of individual clinicians in the necropsy. Among clinical units served by the same department of histopathology, I know of one which achieves a necropsy rate of over 90%; the clinicians (including consultants) attend necropsies on their patients and give the pathologist a full clinical account of the patient's illness, stressing points of particular concern. In such cases a thorough necropsy is performed with extensive histological and often biochemical studies, to the mutual benefit of clinicians, pathologists, and students. By contrast, there are some clinical units in which the necropsy rate is low, the history supplied to the pathologist is quite inadequate, and the clinicians are reluctant to attend necropsies. In these instances examination is often inadequate because the pathologist is not fully aware of the clinical problems relating to the case. In general, the benefit of a necropsy to the clinician is related directly to the interest he takes in it. It is certainly difficult and disheartening to try to maintain a high quality of service without clinical interest, and the educational value of a necropsy, which should be a clinicopathological conference, is greatly diminished when the clinical presentation is based on a few words scribbled on a request form.

I do not wish to suggest that pathologists are blameless for deficiencies in the necropsy service. This college has noted complaints of various clinical specialty groups, particularly in cases of perinatal, infant, and maternal deaths and also in deaths following anaesthesia. The college is emphasising the importance of adequately supervised necropsy work during training and has made obligatory the performance of a necropsy in the MRCPath final examination in histopathology.

Another reason for inadequate necropsies is, as Dr Fleming notes, the shortage of pathologists. Staffing levels are well below those recommended by the college[1] and inevitably the surgical pathology and cytology services take priority over the necropsy service. The college is making strenuous efforts to improve recruitment. It is perhaps worth noting also that the necropsy rate has not fallen in all hospitals and where it has that this may be due to the increased numbers of deaths in hospital and not necessarily to a decline in the number of necropsies performed.[2,3] Postmortem examinations requested by coroners present a particularly difficult problem, for they are often performed by a busy pathologist trying to provide a satisfactory hospital service; accordingly the examination is often restricted to ascertaining the cause of death. This problem is also receiving the college's close attention.

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[1] Royal College of Pathologists, *Staffing and Workload*. London, Royal College of Pathologists, 1972.
[2] Cameron, H M, *et al*, *British Medical Journal*, 1977, **1**, 1577.
[3] *British Medical Journal*, 1977, **1**, 1560.

Reactions to whooping cough vaccine

SIR,—In his letter on reactions to whooping cough vaccine Dr J S Robertson (22 September, p 735) rightly points out that the liability to brain damage cannot be assessed by statistical studies on the part played by coincidence in apparent time relationships between immunisation and convulsions. But the alternative he proposes does not go to the root of the problem.

Above all we need to establish whether whooping cough vaccine ever has caused brain damage, however rarely—and in some of the case reports of Werne and Garrow,[1] Byers and Moll,[2] and Brody[3] coincidence is clearly out of the question. Next we have to determine the full range of the manifestations of this brain damage; the constituents of the vaccine giving rise to it; the likely pathological mechanisms, toxic or allergic; and why only a few children suffer while most escape. We