



Hafernicks Perspectives

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THE ANATOMY OF AN AUTOPSY REPORT

Autopsy reports can be quite complex to navigate. Recently, Dr. Jesse Adame, formerly of the Galveston County Medical Examiner's Office, is the Director of Autopsy and Pathology Services, Inc., was asked to explain these reports in greater detail to the Greater Houston, Texas Chapter of the American Association of Legal Nurse Consultants. He explained that there was a great need for independent autopsies. An autopsy is a postmortem examination of the human body performed to determine the cause and manner of death. Causes of death include injuries such as gunshot wound, motor vehicle collision and disease processes such as pneumonia and myocardial infarction.

Causes of death are different from the mechanism of death. For example, sepsis might be the mechanism of death, while bronchopneumonia was the cause. The mechanism of a gunshot wound causes the patient to hemorrhage and die. A patient might die of a cardiac arrhythmia [cause], resulting in a myocardial infarction [mechanism].

The State of Texas recognizes (on a death certificate) the following manners of death:

- Natural
- Homicide
- Suicide
- Accident
- Undetermined

Natural causes of death include disease processes, as well as therapeutic or diagnostic complications. A patient that hemorrhages at the sheath insertion site after a cardiac catheterization would be considered a natural cause of death.

Hospital Laboratories; Autopsy and Pathology, Inc.; other private pathologists or pathology groups; and sometimes the Medical Examiner's Office usually generate private or hospital autopsy reports. Another type of autopsy report is a medicolegal autopsy report. It is important to know what type of report when attempting to obtain a copy of it.

There were many components of an autopsy report. The "history" or "investigative" would include the clinical scenario and circumstances surrounding the death. Every piece of clothing or evidence of medical intervention (i.e. NG, ETT, IVs) will be listed in detail. Multiple photos will be taken to document the autopsy from various angles and focusing on various aspects specific to the case. If the patient was wearing a medical identification tag, a close up picture will be taken as a means of identifying the body. The external examination will be extremely detailed and thorough, including pertinent negatives. The internal examination will outline cavity-by-cavity or organ-by-organ. Many illustrative slides and tissue blocks

will be frozen and available for future reference. Descriptions of all evidence saved will be detailed in the autopsy report. The report will conclude with the final diagnosis and findings of the pathologist, his opinion may also be included.

Another point is to be sure and specify all reports separately, such as toxicology, microbiology and pictures. Frozen sections will be saved for 6 months unless a written request is made. A private autopsy averages about \$1800 (in the Houston area) and the pathologist will generally invest anywhere from 10 – 15 hours with the case.

There is new technology available to identify cancer types, procedures for tissue procurement, exhumation of bodies for reexamination, etc. The *legal nurse consultant* is vital to deciphering these reports and determining what questions need to be asked and what information might be missing.

Deborah Hafernicks, RN, LNC

Hafernicks Legal-Nurse Consulting

League City, Texas

Deborah@HafernicksConsulting.com

www.HafernicksConsulting.com

ARE YOU ADDRESSING PAIN AND SUFFERING IN LONG TERM CARE CASES?

This is an area for deviation from the Standard of Care; these deviations are unexplainable and unacceptable. The nurse is the patient advocate for all but especially those who are unable to communicate their needs. Many residents in long term care facilities are unable to describe their pain or discomfort. This is usually due to the aging process or medical conditions such as prior cerebrovascular accident (CVA), traumatic brain injury (TBI), or Alzheimer's and the list goes on and is lengthy. Many conditions such as osteoarthritis, cancer, osteoporosis, rheumatoid arthritis and multiple neurological disorders cause more frequent pain and obviously, more intense pain. Osteoarthritis is the most prevalent pain syndrome in the long term care population. You cannot ask a resident who is unable to communicate verbally to describe their pain/discomfort in words. Residents who have/had CVA's, TBI or Alzheimer's may not be able to utilize the VAS (Visual Analog Scale) for rating their pain as they are not able to use the part(s) of the brain necessary for the Visual Analog Scale.

The nursing staff's responsibility is to identify the presence of pain and notify the physician; once the orders for the pain medication are received, the nurses' next responsibility is to evaluate the effectiveness of the medication. The resident may be in need of a stronger medication or need to receive the medication more frequently if possible; it is also possible that the resident may require

less medication. The physician relies on the nursing staff to assist in evaluating the residents' condition during the course of the resident's care in the long term care setting.

It is important for both physicians and nurses in the long term care setting to utilize the resources available to all including "Management of Cancer Pain." Evidence Report Vol. 1 & 2, October 2001 (AHRQ 02-E002) and "Management of Central Neuropathic Pain Following Traumatic Spinal Cord Injury." September 2001 (AHRQ 01-E062 & 01-E063); "Standards of Clinical Nursing Practice for Pain Management Nurses" from the American Society of Pain Management Nurses (1996); "Guidelines for Chronic Pain Management in Adults" (AHRQ – available online at www.ahrq.gov) and the "Core Curriculum for Pain Management Nursing," American Society of Pain Management Nurses (2002).

Cindy Brooke, RN, CLNC
Medical Legal Strategies
Hendersonville, North Carolina
CBrooke58@msn.com

ENDOVASCULAR GRAFTS FOR TREATMENT OF ABDOMINAL AORTIC ANEURYSMS

Endoluminal attempts to treat abdominal aortic aneurysms, amazingly date back centuries. In 1684, thrombosis of an aneurysm was attempted, with the introduction of large masses of intraluminal wire. This technique was modified in 1879 with attempts to pass electrical current along the intraluminal wire.

Despite the efforts of surgeons for hundreds of years to provide successful interventions in the treatment of these aneurysms, modern technological advances are not without risk and potential complications.

Both Medtronic's AneuRx Endovascular Graft, and Guidant's Ancure System received FDA approval in September of 1999. On April 27, 2001, the FDA issued a public health notification detailing problems with both manufacturers endovascular grafts. Specific problems identified included aneurysm ruptures, endoleaks, migrations of the grafts, and the device integrity or durability in view of reports of tears, suture breaks, etc.

Guidant temporarily suspended production, and announced a recall of all existing inventory on 3/16/01. The company voluntarily reported to the FDA that they had failed to report to the FDA many device malfunctions and adverse events.

Medtronic continued production. Manufacturing changes in the device included alteration of the design of the deployment mechanism utilized for placement of the graft during the aneurysm repairs. Training and education programs for surgeons were revised, as well as guidelines for exclusion criteria for patients that would be not suitable for endovascular repairs.

FDA later issued a recall for Medtronic's #Z-862-0. The product had the potential for detachment of a 21F tapered tip nosecone from the catheter during the deployment process. As this only involved the mechanism used during the placement of the graft, rather than the graft itself, this did not present a change in the post procedural surveillance of previous recipients of the graft.

Specific issues identified that must be considered for each patient, in evaluating the appropriateness of the various methods of abdominal aortic aneurysm repair:

- ◆ Size & expansion rate of the aneurysm.
- ◆ Specific exclusion criteria based upon anatomical measurements and factors.
(Tortuosity, degree of aorta-iliac angulation etc.)
- ◆ Smaller diameter of graft limb increases the risk of limb thrombosis.
- ◆ Learning curve & surgical skill of the physician.
- ◆ Surgical Technique
- ◆ Gender: Females are at increased risk of complications.
- ◆ Successful stent graft deployment is dependent upon complex interventional skills and accurate pre-procedural evaluation and planning.

Reported complications of endovascular stent repair include:

- ◆ Aneurysm rupture
- ◆ Endoleak
- ◆ Migration
- ◆ Limb ischemia or occlusion
- ◆ Graft Infection / Wound healing complications
- ◆ Arterial or Venous vascular occlusion
- ◆ Thrombosis & Thromboembolism
- ◆ Renal Failure
- ◆ Graft fracture or kinking
- ◆ Pulmonary, Cardiac, and Gastrointestinal Complications

Due to the questionable long term stability of the endoluminal endograft repairs versus open repairs, patients must agree to close post procedural surveillance. Prompt correction of complications are critical. This necessitates in psychological as well as physiological and anatomical determination of suitability. Although there are increased morbidity statistics with the open repair, it is recommended, that patients who are otherwise physically fit, and have an estimated lifespan of greater than 5 years, choose the open repair due to the benefit of long term durability. It is suggested that older patients or those with advanced co-morbidities that are anatomically suitable, may benefit from the endovascular procedure rather than the traditional method of open AAA repair.

Tamara Heptinstall RN, CLNC
Heptinstall & Associates
Lynn Haven, Florida
MedLegalAnalysis@aol.com



"I will help you win your cases!"

*Deborah Hafernick,
RN, LNC*

Deborah@HafernickConsulting.com
www.HafernickConsulting.com

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mobile: 281.734.4089
fax: 281.338.0933