The Royal College of Pathologists
Pathology: the science behind the cure

Guidelines on autopsy practice

Fetal autopsy after termination of pregnancy or fetal loss associated with congenital anomaly

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Series authors: Dr Esther Youd, Clinical Lead for Autopsy Guidelines
Dr Ben Swift, Forensic Pathology Services, Oxon

Specialist authors: Dr Tamas Marton, Birmingham Women's and Children's Hospital NHS Foundation Trust
Dr Beata Hargitai, Birmingham Women's and Children's Hospital NHS Foundation Trust
Dr Flora Jessop, Cambridge University Hospitals NHS Foundation Trust
Dr J Ciaran Hutchinson, Great Ormond Street Hospital NHS Foundation Trust
Professor Christoph Lees, Imperial College Healthcare NHS Trust
Dr Tracey Johnston, Birmingham Women's and Children's Hospital NHS Foundation Trust

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Produced by	The specialist content of this guideline has been produced by: Dr Tamas Marton MD, FRCPath, PhD, Consultant Perinatal Pathologist, Birmingham Women's and Children's Hospital Foundation Trust and Department of Obstetrics and Gynaecology, Semmelweis University, Faculty of Medicine; and Department of Pathology, Forensic and Insurance Medicine, Semmelweis University, Budapest, Hungary Dr Beata Hargitai, MD, Affiliate Member of RCPath, PhD, Consultant Perinatal Pathologist, Birmingham Women's and

	Children's Hospital Foundation Trust and Department of Obstetrics and Gynaecology, Semmelweis University, Faculty of Medicine; and Department of Pathology, Forensic and Insurance Medicine, Semmelweis University, Budapest, Hungary Dr Flora Jessop, Cambridge University Hospitals NHS Foundation Trust Dr Ciaran Hutchinson, Great Ormond Street Hospital NHS Foundation Trust Professor Christoph Lees, Imperial College Healthcare NHS Trust Dr Tracey Johnston, MD, FRCOG, Birmingham Women's and Children's Hospital NHS Foundation Trust
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The Royal College of Pathologists
6 Alie Street, London E1 8QT
Tel: 020 7451 6700
Fax: 020 7451 6701
Web: www.rcpath.org

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Contents

Foreword

The autopsy guidelines published by the Royal College of Pathologists (RCPath) are guidelines which enable pathologists to deal with non-forensic consent, coroner's and procurator fiscal post-mortem examinations in a consistent manner and to a high standard. They are intended primarily for the profession; some technical content may be distressing for the lay audience.

The guidelines are systematically developed statements to assist the decisions of practitioners and are based on the best available evidence at the time the document was prepared. Given that much autopsy work is single observer and one-time only in reality, it has to be recognised that there is no reviewable standard that is mandated beyond that of the FRCPath Part 2 exam or the Certificate of Higher Autopsy Training (CHAT). Nevertheless, much of this can be reviewed against ante-mortem imaging and other data. This guideline has been developed to cover most common circumstances. However, we recognise that guidelines cannot anticipate every pathological specimen type and clinical scenario. Occasional variation from the practice recommended in this guideline may therefore be required to report a specimen in a way that maximises benefit to the pathologist, coroner/procurator fiscal and the deceased's family.

At the time of drafting these guidelines, there is some uncertainty around workflow and the optimisation of patient pathways, despite great efforts by regional units to maintain service provision. Relevant additional material, including a parent pathway, is being drafted by NHS England, which aims to optimise the pathway and experience for parents at what is a very difficult time. Timely communication with parents via appropriate channels is critical to providing status updates regarding the examination and its findings, and providing answers for families experiencing great distress. Reference to these materials should be made, where required.

There is a general requirement from the General Medical Council (GMC) to have continuing professional development (CPD) in all practice areas and this will naturally encompass autopsy practice. Those wishing to develop expertise/specialise in pathology are encouraged to seek appropriate educational opportunities and participate in the relevant external quality assurance (EQA) scheme.

The guidelines themselves constitute the tools for implementation and dissemination of good practice.

The stakeholders consulted for this document were:

- British and Irish Paediatric Pathology Association (BRIPPA)
- Stillbirth and Neonatal Death Charity (Sands)
- The Royal College of Obstetrics and Gynaecologists (RCOG)
- Human Tissue Authority (HTA)
- The Coroners' Society of England and Wales
- Crown Office and Procurator Fiscal Service (COPFS) Scotland
- Coroner's Service for Northern Ireland
- The Home Office Forensic Science Regulation Unit and Forensic Pathology Unit and the British Medical Association.
- Pregnancy and Baby Charities Network.

The information used to develop this document was derived from current medical literature. Much of the content of the document represents custom and practice and is based on the substantial clinical experience of the authors. All evidence included in this guideline has been graded using modified SIGN guidance (see Appendix C). The sections of this autopsy guideline that indicate compliance with each of the AGREE II standards are indicated in Appendix D.

No major organisational changes or cost implications have been identified that would hinder the implementation of the guidelines.

A formal revision cycle for all guidelines takes place on a 5-year cycle. The College will ask the authors of the guideline to consider whether or not the guideline needs to be revised. A full consultation process will be undertaken if major revisions are required. If minor revisions or changes are required, a short note of the proposed changes will be placed on the College website for 2 weeks for members' attention. If members do not object to the changes, the changes will be incorporated into the guideline and the full revised version (incorporating the changes) will replace the existing version on the College website.

The guideline has been reviewed by the Professional Guidelines team, Death Investigation Committee, Forensic Pathology Specialty Advisory Committee and Lay Advisory Group. It will be placed on the College website for consultation with the

membership from 28 February to 27 March 2024. All comments received from the membership will be addressed by the author to the satisfaction of the Clinical Lead for Guideline Review.

This guideline was developed without external funding to the writing group. The College requires the authors of guidelines to provide a list of potential conflicts of interest; these are monitored by the Professional Guidelines team and are available on request. The authors of this document have declared that there are no conflicts of interest.

1 Introduction

This is a new guideline that complements *G160 Guidelines on autopsy practice: Fetal autopsy following antepartum or intrapartum death of non-malformed fetuses* and *G161 Guidelines on autopsy practice: Fetal autopsy of 2nd trimester fetal loss (excluding termination of pregnancy for congenital anomaly)* and focuses on fetuses with structural abnormalities of any gestational age.

Investigations following either planned delivery or termination of pregnancy for fetal abnormality identified in the antenatal period may take several forms. It is essential that the contribution from perinatal pathology services forms part of a multidisciplinary approach prior to and following delivery.

The voice of bereaved parents has been central to producing these guidelines. Many bereaved parents want to access a post-mortem examination for their baby, seeking the possibility of answers, even if only to rule out some underlying conditions rather than elicit specific positive findings. Bereaved parents have told us that the post mortem can become an important part of their path through their grief. The post-mortem report can support difficult decisions about another pregnancy. It is, of course, extremely common for parents to feel protective and strongly connected to their baby – the acute sensitivities and emotional context make perinatal post mortem unlike any other investigative procedure. The report authors have held the narrative of parents' vulnerabilities and wishes at the heart of the discussions involved in producing these guidelines.

This guideline is particularly relevant to cases which present with structural abnormalities for which there is no unifying diagnosis. In these circumstances, parents should be offered a full, detailed autopsy. Macroscopic, radiological or histologic findings at post mortem may well be additional to those identified antenatally and are key to providing as accurate

diagnosis/genetic counselling as possible.[1–3] Where possible, strong parental preferences (as documented on the consent form or in the referral documentation) should be taking into consideration by the responsible consultant.

The guidance provided in this publication is primarily directed towards supporting perinatal pathologists in undertaking what may be described as conventional, dissection-based autopsies. There is a considerable volume of evidence supporting less invasive autopsy, and imaging modalities such as ultrasound (US), micro-computed tomography (micro-CT), CT or magnetic resonance imaging (MRI) as effective investigations following termination of pregnancy for fetal anomalies.[4–7] Currently, UK-based perinatal pathologists are trained in a dissection-based approach to fetal autopsy and lack local resources to expand their practice into alternative methods. Should local resource permit, alternative approaches are not proscribed by these guidelines; the information from additional imaging should, in those circumstances, form part of the final post-mortem report.

In some cases, extensive prenatal investigation (US, MRI, comparative genomic hybridisation [CGH] microarray, whole-exome sequencing [WES] or whole-genome sequencing [WGS]) will have yielded a partial and/or differential diagnosis. In such circumstances, a detailed post-mortem examination can provide further valuable information and should again be offered.

Fetal autopsy also represents an opportunity to identify concomitant diseases, and fetal, maternal and placental conditions, particularly those with implications for subsequent pregnancies (e.g. fetal growth restriction, malformation, maternal diabetes).

In a minority of cases, prenatal diagnosis/screening has not been undertaken, with anomalies only identified following delivery and neonatal death. These guidelines also apply to this scenario, and parents should again be offered full post-mortem examination with genetic testing. Please note, however, that the clinicians providing care in these cases should initially discuss the case with their local medical examiner teams, to consider whether an MCCD (Medical Certificate of Cause of Death) should be issued or a referral to HM Coroner should be made. Perinatal pathologists should undertake a consented post-mortem examination only in circumstances where that discussion has been concluded and an MCCD has been issued. (The medical examiner team equivalent in Scotland is the Death Certification Review Service. In Northern Ireland, it is the Independent Medical Examiner Service.)

With regard to live birth after termination of pregnancy, please see Chief Coroner Guidance No. 45, February 2023.[8]

In cases of known (prenatally diagnosed) aneuploidy, post-mortem examination is of doubtful value and should not routinely be offered.

1.1 Target users of this guideline

The target primary users of this guideline are UK consultant and trainee perinatal/paediatric pathologists. Recommendations will also be of value to pathologists working outside the UK, obstetricians, neonatal paediatricians, fetal medicine consultants and clinical geneticists, biomedical scientists and bereavement midwives.

2 Consent

Consent must always be obtained for the hospital post-mortem examination of a baby, whether born alive or dead, and at any gestation.

Consent is also required for all genetic testing, including of placental samples. Local protocols should be established between clinical genetics and histopathology departments. This will help to ensure that appropriate consent is in place prior to the release of tissue for any genomic investigation.

The only time when parental consent/authorisation for a post-mortem examination on a baby is not needed is when a coroner or procurator fiscal orders a post-mortem examination; this is unlikely to be relevant in the clinical context of these guidelines.

Regardless of the gestation, perinatal post-mortem examination may only be performed if informed consent has been given by the mother, unless there are exceptional circumstances, e.g. if she is too ill to consent. Wherever possible, in this situation, the partner's consent/authorisation should also be sought.[9]

The consent process should be compliant with the requirements of the HTA's Code of Practice: Code A: Guiding Principles and the Fundamental Principle of Consent.[10] In Scotland, Human Tissue (Scotland) Act 2006 is in force and the consent process should follow the legislation.[11]

The autopsy consent form should be compliant with the model 'Consent form for perinatal post mortem' developed by Sands, in conjunction with the HTA.[12] The pathologist performing the autopsy must see the completed consent form, either as a physical copy or

electronically, before commencing the autopsy. Any limitations on the scope of the autopsy must be complied with.

Any concerns regarding the validity of the consent should be resolved before commencing the autopsy.

The consent form indicates the maximal extent of the post-mortem examination that should be performed. For some patients, if the responsible consultant considers that a more limited examination can adequately answer the questions raised, the examination may not include some of the components, in keeping with the latest NHS guidance.[13] This depends on the specific features and history for each patient and is at the discretion of the consultant pathologist responsible for the examination.

[Level of evidence GPP – in line with statutory obligations.]

3 Clinical information relevant to the autopsy

The relevant clinical information (best obtained using structured request form, see Appendix A) includes:

- patient identification details
- maternal age/date of birth
- maternal height, weight and BMI
- relevant medical and family history, including consanguinity
- obstetric history, previous pregnancies/deliveries, including previous fetal and neonatal losses (if post-mortem examination had been carried out), malformation and growth restriction and other complications
- history of current pregnancy, including:
  - estimated delivery date (gestation by date and by scan)
  - antenatal infection screen results, including cytomegalovirus, toxoplasma, HIV
  - abnormal findings from US or other antenatal investigations (copy of the US report is highly desirable, mandatory with antenatally diagnosed structural abnormalities)
  - results of first trimester screening, non-invasive tests, chorionic villus sample (CVS) and amniocentesis
  - any concerns regarding fetal growth/fetal monitoring

- the presence of complications, such as pregnancy-induced hypertension/preeclamptic toxaemia
- events leading up to intrauterine death and/or delivery (membrane rupture, maternal pyrexia, antenatal bleeding, last evidence of fetal heartbeat).

[Level of evidence – B.]

4 The autopsy procedure

This guideline refers specifically to planned delivery or termination of pregnancy for fetal abnormalities identified in the antenatal period. [2,14–17]

- Whole body X-ray for gestational age assessment, malformation, etc. Recommended in all cases; mandatory for suspected skeletal dysplasia and multiplex developmental abnormalities. If available, this may be replaced or complemented by other imaging modalities e.g. CT, MRI.
- Photography is mandatory in all cases, particularly important to document external and internal abnormalities. Digital photography and secure storage should be available, in line with local trust/hospital information governance standards.
- Routine measurements should be taken (body weight, crown–heel length, foot length. Consider taking: crown–rump length, occipito-frontal circumference, inner and outer canthal measurements). Abdominal circumference has not been validated as a post-mortem measurement.
- Detailed external examination, including: fetal growth, soft tissue and muscle bulk, local/generalised oedema, pallor, dysmorphic features of the ears, eyes, facial proportions, patency of orifices (including choanae) and palatal fusion, limbs (positional abnormalities, skin webs), hands and feet (fingers, toes, nails and creases) and external genitalia. Recording of negative findings is not required unless clinically requested or relevant.
- Cases being submitted for MRI/US scan/micro-CT examination should be examined by a pathologist and then transferred to appropriate imaging facilities before returning for further assessment, ideally with any available interim imaging reports. At this time, follow up with dissection-based autopsy (in line with parental consent) is appropriate, but may be omitted at the discretion of the examining pathologist in line with their experience and expertise in these modalities.

In practice, if the findings are discordant with the antenatal information, follow up dissection is recommended, where consent permits.

- Incisions on the body should be placed with due regards to the requirement for reconstruction. Standard incisions include typically T- or Y-shaped; an inverted Y-shaped incision of the lower abdominal wall can be considered for assessment of the internal lower abdominal wall.
- Detailed systematic examination of other internal organs, including:
  - in-situ examination of the thoracic cavity (thymus, lungs, heart and great vessels) with sequential segmental analysis of malformations
  - in-situ examination of abdominal organs and retroperitoneum; consider removing in continuity to assess abnormal structures crossing diaphragm; umbilical arteries and vein, ductus venosus
  - weights of internal organs (recommended: brain [if examined], lungs, liver; consider: kidneys, thymus, adrenals, spleen) to be compared with standard reference tables as required
  - sampling for histology if indicated by clinical and pathological findings. Routine histological examination of macroscopically normal organs (in the absence of a clinical indication to sample the organ) shows low diagnostic low yield[18] but is at the discretion of the responsible consultant.
  - any abnormally formed organ should be sampled for histological assessment (e.g. cystic kidney [with liver], lung)
  - muscle, if suspected fetal akinesia deformation sequence or another myopathy
  - appropriate samples for bone histology for suspected skeletal dysplasia: long bone (including growth plate), vertebral body – consider skull/rib if indicated.

[Level of evidence – C.]

- A record of the samples taken should be kept and tissue blocks and slides should be traceable within the laboratory, in line with the requirements of the HTA and the UK Accreditation Service (ISO 15189).
- Quantitative fluorescent PCR (QF-PCR) and array studies (if not undertaken antenatally). Freezing tissue for DNA extraction should be considered; lung and/or placenta may be preferable to autolysed liver (consider local consensus with the

genetic laboratory). Frozen tissue may be required in due course to support WES or WGS. The current Genomic Laboratory Hub (GLH) guidelines should be followed by the fetal medicine multidisciplinary team (MDT) collaborating with the pathologist. (Wales: All Wales Genomics Laboratory; Scotland: Scottish Strategic Network for Genomic Medicine [SSNGM] laboratories; Northern Ireland: Northern Ireland Genomics Medicine Centre [NIGMC]).

- Apply special dissection techniques where appropriate, photo-document the relevant findings, and consider dissection under the camera/under water/short-term formalin fixation.

[Level of evidence – GPP.]

4.1 Central nervous system examination

Examination of the central nervous system (CNS) is mandatory in termination of pregnancy for brain/CNS malformation or in cases of termination of pregnancy for syndromic disease without unifying diagnosis. Formal CNS examination should be considered in cases of incidental major internal anatomical abnormality.

- Median posterior or transverse scalp incision.
- Skull incisions to allow assessment of falx and venous sinuses.
- Observation of gyral pattern to assist gestational assessment.
- Consider removal under water (or direct in formalin) and perhaps in dura especially with marked autolysis: will permit weighing and assessment of gyral pattern.
- Consider referring the whole CNS for neuropathological examination in appropriate cases. This may include sampling peripheral nervous tissue (nerve root, peripheral nerve, muscle, etc). Consultation with an appropriately experienced neuropathologist may be helpful.

[Level of evidence – C.]

4.2 Placental examination

Placental examination is an integral part of the perinatal post-mortem examination. Submission to pathology with the baby is mandatory; non-conformances should be monitored in line with local policies. Guidance for detailed examination of the placenta is given in the *Tissue pathway for examination of the placenta*.[19]

[Level of evidence – B.]

5 Specific health and safety aspects

The pathologist should be informed as part of the referral if there is a potential biohazard risk.

Autopsy practice using universal precautions will significantly protect against accidental transmission of infection, including HIV, SARS CoV-2 and other blood-borne viruses.

6 Limited or less invasive post-mortem examination in the context of termination of pregnancy for fetal abnormalities

Where consent for a full autopsy is not given, limited or less-invasive examination may be of value. Consent takers should be competent to counsel bereaved parents on the benefits and limitations of this approach.

Examples of such examinations:

- autopsy limited to 1 or more body cavities
- examination excluding the brain or performing a CNS-only autopsy
- open or needle biopsy of specific internal organs (if available)
- external examination of the body with X-ray, photography and genetics (if indicated)
- placental examination only (with genetic testing if indicated)
- less/minimally invasive autopsy: external examination and imaging (CT, MRI – if available) alone or with targeted biopsies.[17]

[Level of evidence – C.]

7 Organ retention

Short-term retention of organs to allow fixation does not require specific consent, provided they are reunited with the body before release for burial/cremation.

Specific consent should be sought for long-term retention beyond the release of the body, for the purpose of examining the organs. Consider for extracranial organs with congenital malformations (particularly heart) if input is not available from a perinatal pathologist or cardiac morphologist on site at the time of examination, and the abnormality cannot be satisfactorily recorded by photography.

In practice, brain fixation for a minimum of 2–3 days in 20% formalin (± 5% acetic acid) will usually produce sufficient fixation to allow adequate sectioning and block sampling to allow the brain to be returned to the body before release for funeral. If there is doubt, consult the local neuropathology team.

[Level of evidence – GPP.]

8 Autopsy report

Units may choose, if resources allow, to issue a provisional report giving details of the macroscopic findings shortly after the examination of the body, followed by a final report when all histology and other tests have been completed. Alternatively, only a single, final report may be produced.

The report should include the following sections, where performed:

- demographic and identification data
- details of autopsy consent and limitations
- body weight
- body measurements with relevant reference values
- list of main findings
- clinicopathological summary (final report)
- summary of clinical history
- systematic description of external and internal findings and placental examination
- organ weights with relevant reference values and ratios
- details of ancillary tests taken (and results in final report)
- histology (final report)

- list of histology tissue blocks and retained organs and tissues, if applicable (final report).

[Level of evidence – GPP.]

8.1 Clinicopathological summary

The summary should include:

- reference to the gestational age at delivery (and death, if applicable)
- reference to previous losses/terminations of pregnancy, their outcome and relevance to the current pregnancy loss
- for termination of pregnancy, concordance or discordance of findings with the clinical history and prenatal testing, likely/possible unifying diagnosis and recommendation for genetic referral or further tests if appropriate
- identification of those cases with an increased risk of recurrence and requirement/possibility of additional testing
- results of MDTs, such as the clinical genetics MDT and its outcome, including molecular genetic diagnosis. In these cases, an addendum report or reports would be appropriate.

[Level of evidence – GPP.]

9 Coding

The autopsy procedure and principal findings should be coded according to the SNOMED CT system using appropriate body structure, finding, disorder and morphologic abnormality codes for SNOMED CT or appropriate T (topographic) and M (morphologic) for older versions of SNOMED (local protocols should be followed).

Of note, SNOMED ceased to be licensed by the International Health Terminology Standards Development Organisation from 26 April 2017; the authors recognise that NHS England aspires to fully transition to SNOMED CT.

The requirement to enable SNOMED CT content in secondary care systems is yet to be fully achieved, although it is known that many providers have SNOMED CT enabled EPR systems in place. SNOMED CT is used in many different healthcare settings internationally and an NHS-approved fundamental standard (SCCI0034). SNOMED CT

gives clinical IT systems a single shared language, making the exchange of information between systems easier, safer and more accurate. It contains all the clinical terms needed for the whole NHS, from procedures and symptoms through to clinical measurements, diagnoses, medications and pathological findings.

The NHS Digital SNOMED CT UK browser can be accessed for free.

A non-exhaustive list of autopsy-related SNOMED CT codes is provided in Appendix B.

10 Criteria for audit

The following standards are suggested criteria that might be used in periodic reviews to ensure a post-mortem examination report meets national standards. The phase of the autopsy examination (pre-analytical, analytical and post-analytical) assessed by the standard is included.

Supporting documentation:

- standards: supporting documentation was submitted with the body in 95% of cases [pre-analytical]. (NB: it is recommended that an autopsy should not be commenced in the absence of clinical information.)
- standards: 95% of submitted information is satisfactory, good or excellent [pre-analytical]
- standards: a correctly completed autopsy consent form, meeting national requirements is submitted with 95% of cases [pre-analytical]. (NB: an autopsy must not be commenced unless the pathologist has seen a physical copy of the consent form and it is correctly completed.)
- standards: 100% of autopsy reports must include all of the sections detailed in section 15, within the limits of parental consent and extent of the examination determined by the responsible consultant (above) [analytical]
- standards: in 100% of autopsy reports, the information documented is satisfactory, good or excellent [analytical]
- standards: in 100% of autopsy reports, the clinicopathological summary is clear and concise and, when appropriate, contains the information detailed above [analytical]
- standards: 80% of autopsy reports are completed within the turnaround times agreed with local clinical teams, excluding cases where turnaround time is compromised by

testing outside of the control of the responsible consultant (e.g. genetic array, neuropathological examination) [post-analytical]

- standards: 100% of autopsy reports are communicated to referring centres using secure email (e.g. nhs.net email) or encrypted email [post-analytical]
- standards: 100% of autopsy cases are coded appropriately according to local guidelines [post-analytical].

For reference, the NHS specifications (from the 2013/2014 standard contract for perinatal pathology[20]) are as follows:

> *60% of final reports for routine post-mortem examination will be issued to referrers within 42 days of examination and 90% should be issued within 56 days. This will exclude those cases in which there may be a specialist referral opinion required (e.g. neuropathology) or very complex metabolic or genetic testing required.*

These are mandatory contractual requirements of units commissioned to provide perinatal pathology services and are important measures of service quality and outcomes. The authors recognise that paediatric and perinatal pathology services have ongoing staffing and associated operational challenges and where services are shorthanded or otherwise under provisioned, or are providing mutual aid to other units, specific audit targets will be agreed between commissioners and clinical teams, but with the view that all units should be working towards the standards set out in the service specification.

The authors recognise that many units are inadequately staffed with either pathologists or anatomical pathology technologists. Failure to achieve targets is unlikely to reflect the performance of individual pathologists but may indicate the need for a managerial review of local systems in place to ensure timely reports, and measures such as mutual aid should be considered. Where services are shorthanded or otherwise under provisioned, temporary audit targets should be agreed with clinical teams and outsourcing of reporting or other measures should be considered.

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Appendix A Exemplar autopsy request form

CLINICAL INFORMATION FOR FETAL / PERINATAL POST MORTEM

Mother (sticker if available)	**Fetus / Infant (sticker if available)**
Family Name:……. First Name:……. D.o.B.: / / Reg No……	Family Name:……. First Name:……. D.o.B.: / / D.o.D: / / Reg No……

Please carefully complete this form. Any missing information could potentially delay or alter the findings.
Parts 1, 2 and 3 ALL require completion for EVERY referral made.
REFERRING HOSPITAL:_____ Ward: _____
HOSPITAL OF BIRTH (if different): _____
(Please include history / notes from previous hospitals)
CONSULTANT OBSTETRICIAN: _____
CONSULTANT PAEDIATRICIAN: _____

Part 1. MOTHER'S DETAILS
(ALL fields for this section are MANDATORY for ALL requests please)

Ethnic origin: _____ Father's ethnic origin (if known) _____

Consanguinity between parents? Y/N Blood group: _____

Maternal height: cm	Booking weight: kg	BMI:

Obstetric History:
PREVIOUS PREGNANCIES

	Date	Gestation	Delivery	Sex	Outcome
1.					
2.					
3.					
4.					
5.					
6.					
7.					

Were there any complications with any previous pregnancies (this current pregnancy excluded)?*
Yes / No / Not known – if yes, specify

*Further space for writing is provided on p4 of this form.

This form consists of 4 pages. All require your attention.

Please carefully complete this form. Any missing information could potentially delay or alter the findings.

Part 2. CURRENT PREGNANCY DETAILS
(ALL fields for this section are MANDATORY for ALL requests please)

Booked/Unbooked LMP : _____ EDD: _____

Gestation: by dates: _____/40 by scan:_____/40 weeks

Is there any relevant past medical history? (If yes, what?) _____
Were there any abnormal screening results? (If yes, what? Fetal growth issues and uterine artery Doppler results?) _____
Medications (if any): _____
USS findings (please send report if abnormal):

	Date	Indication (e.g. dating / anomaly, etc.)	Gestation	Findings (please include report if abnormal)
1.				
2.				
3.				
4.				

Antenatal diagnostic procedures (please include results if available / known):
(e.g. CVS sampling or other invasive techniques / fetal MRI)
_____
_____
_____
Additional antenatal history:

Was this a twin pregnancy?	Y/N	If so, MCDA/ MCMA/ DCDA?
Any history of reduced fetal movements?	Y/N	If so, how many episodes for how long?
Was there antenatal bleeding?		Y/N If so, when and how much?
Was there hypertension?	Y/N	BP = mmHg
Was there pre-eclampsia?	Y/N	BP = mmHg
Was there anaemia?	Y/N	

Is there anything else of relevance regarding the pregnancy that you would like to tell the pathologist? Labour and delivery details are detailed in the following section*.
*Further space for writing is provided on p4 of this form.

N.B. Would this PM examination be classed as an infection risk to relevant staff? Y/N

This form consists of 4 pages. All require your attention.

Please carefully complete this form. Any missing information could potentially delay or alter the findings.

Part 3: LABOUR & DELIVERY DETAILS
Have you completely filled part 1 & 2? Any missing information can alter the findings.

1) Was this a TOP? Y/N
a) If TOP – Feticide Y/N If so, method and date of feticide:
2) Was this a miscarriage (i.e. pregnancy loss <24 weeks' gestation)? Y/N
3) Was this an IUD > 24 weeks' gestation (i.e. macerated stillbirth)? Y/N
If so, when was the last documented evidence of fetal / infant viability / fetal heart beat?
4) Was this an intrapartum or neonatal death (i.e. fresh stillbirth / live birth)? Y/N
What was the presenting part? Vertex / Breech / Other
b) Rupture of membranes: date _____ time_____ Augmentation (Syntocinon): Y/N
c) 1st stage __h __min 2nd : __h __min
d) Abnormal fetal monitoring or suspected fetal compromise: Y/N If yes, please specify signs:
_____
e) DELIVERY: Spont. / Assisted (forceps / ventouse) / CS (elective / emergency). Date _____ Time_____
f) Apgars: 1st min ____ 5th min ____ 10th min ____
Did labour commence spontaneously / did it require induction?
Date of induction, if applicable: Date of delivery:
Liquor: Normal / reduced volume / increased volume. Abnormal liquor colour?
Was there antepartum haemorrhage? Was there maternal pyrexia, concerns re: maternal infection?

The infant or fetus			Any notable abnormalities in the fetus / infant at time of delivery*:
Male ♂	Female ♀	Indeterminate	
Birth Weight (g):			

*Further space is provided for writing on p4 of this form.

Part 4: For LIVEBORN infants ONLY (i.e. Neonatal deaths):
Have you completely filled parts 1, 2 & 3?
RESUSCITATION procedures employed: Surfactant: Y/N
NEONATAL PROBLEMS & PROCEDURES:
_____
BRIEF SUMMARY OF LATER SYMPTOMS / TREATMENTS AND MAJOR INVESTIGATIONS (including CPAP / ventilation, IV therapy, fits, episodes of collapse, pneumonia, pneumothorax, bleeding problems, type of feeding, etc.)
_____
_____
*Further space for writing is provided on p4 of this form.

Attention please: If this was a complex course, please consider sending YOUR summary and interpretation of events. Sending photocopies of the notes or the complete set of notes may be acceptable, but not advisable for optimal practice.

SUSPECTED CAUSE(S) OF DEATH:
DEATH REGISTERED AS (if applicable):

ANY OTHER RELEVANT INFORMATION / SPECIAL POINTS TO BE NOTED AT POST MORTEM:
*Further space for writing is provided on p4 of this form.

This form consists of 4 pages. All require your attention.

Please carefully complete this form. Any missing information could potentially delay or alter the findings.

Please do not hesitate to contact us should you have any queries regarding the completion of this form.

Person completing form: _____ Contact number / bleep No_____

(Please PRINT)

Copy of report to be sent to:

Consultant obstetrician: (Mr/ Ms/ Mrs/ Dr) _____ and/or
(Please PRINT)

Consultant paediatrician: _____
(Please PRINT)

Thank you for carefully completing all relevant parts of this form. Parts 1, 2 and 3 all require your attention please.
May we remind you that any missing information could potentially delay or alter the findings.

Notes for any further relevant information and short narrative of the clinical synopsis:

_____

_____

_____

_____

_____

_____

_____

ALL BABIES AND PLACENTAS SHOULD BE SENT FRESH IN LEAKPROOF, OPAQUE CONTAINERS UNLESS THERE IS AN INFECTIOUS HAZARD (in this case phone to discuss whether the specimen should be fixed in 10% formalin before transportation)

IT IS ESSENTIAL TO SEND THE PLACENTA WITH A FETUS / INFANT.

This form consists of 4 pages. All require your attention.

Appendix B Autopsy-related SNOMED CT codes

The following codes are suggested for centres with SNOMED CT capabilities. Local coding procedures should be followed where SNOMED CT has yet to be implemented. The suggested lists below are not exhaustive but highlight examples of codes that could be used. The NHS Digital SNOMED CT UK browser can be accessed for free.

General autopsy codes

29240004	|	Autopsy examination (procedure)
702692002	|	Coroner's autopsy (procedure)
5785009	|	Forensic autopsy (procedure)
430339001	|	Pediatric autopsy (procedure)
308375000	|	Report for Procurator Fiscal (record artifact)

Specimen codes

309502007	|	Fetus specimen (specimen)
725957005	|	Formalin-fixed placenta tissue specimen (specimen)

Post-mortem imaging

717193008	|	Cone beam computed tomography (procedure)
699581005	|	Post mortem magnetic resonance imaging (procedure)
713599004	|	Post mortem ultrasonography (procedure)

Fetal findings

85811006	|	Autolysis (morphologic abnormality)
248200007	|	Dysmorphic facies (finding)
87309006	|	Death of unknown cause (event)
22033007	|	Fetal growth retardation (disorder)
289448000	|	Fetus normal (finding)
198901003	|	Macerated fetus (disorder)
85728002	|	Morphologic description only (finding)

723745006 | Morphological description only, with differential diagnosis (finding)

41962002 | Oligohydramnios sequence (disorder)

Placental findings

4532008 | Acute inflammation (morphologic abnormality)

84499006 | Chronic inflammation (morphologic abnormality)

396343006 | Funisitis (disorder)

65396000 | Histiocytic infiltrate (morphologic abnormality)

125563001 | Hyalinized fibrosis (morphologic abnormality)

55641003 | Infarct (morphologic abnormality)

73728008 | Maturation acceleration (morphologic abnormality)

50353005 | Maturation deceleration (morphologic abnormality)

309162003 | Normal histology findings (finding)

415105001 | Placental abruption (disorder)

268585006 | Placental infarct (disorder)

237292005 | Placental insufficiency (disorder)

448485001 | Specimen satisfactory for evaluation but limited by cellular degeneration (finding)

27696007 | True knot of umbilical cord (disorder)

75798003 | Twin dichorionic diamniotic placenta (disorder)

83787007 | Twin monochorionic diamniotic placenta (disorder)

388604008 | Villitis (disorder)

1155707008 | High histologic grade

1155708003 | Low histologic grade (qualifier value)

1155705000 | Histologic grade cannot be assessed (qualifier value)

Appendix C Summary table – Explanation of grades of evidence

(modified from Palmer K *et al. BMJ* 2008; 337:1832)

Grade (level) of evidence	**Nature of evidence**
Grade A	At least 1 high-quality meta-analysis, systematic review of randomised controlled trials or a randomised controlled trial with a very low risk of bias and directly attributable to the target population or A body of evidence demonstrating consistency of results and comprising mainly well-conducted meta-analyses, systematic reviews of randomised controlled trials or randomised controlled trials with a low risk of bias, directly applicable to the target cancer type.
Grade B	A body of evidence demonstrating consistency of results and comprising mainly high-quality systematic reviews of case-control or cohort studies and high-quality case-control or cohort studies with a very low risk of confounding or bias and a high probability that the relation is causal and which are directly applicable to the target population or Extrapolation evidence from studies described in A.
Grade C	A body of evidence demonstrating consistency of results and including well-conducted case-control or cohort studies and high- quality case-control or cohort studies with a low risk of confounding or bias and a moderate probability that the relation is causal and which are directly applicable to the target population or Extrapolation evidence from studies described in B.
Grade D	Non-analytic studies such as case reports, case series or expert opinion or Extrapolation evidence from studies described in C.
Good practice point (GPP)	Recommended best practice based on the clinical experience of the authors of the writing group.

Appendix D AGREE II guideline monitoring sheet

The guidelines of the Royal College of Pathologists comply with the AGREE II standards for good quality clinical guidelines. The sections of this guideline that indicate compliance with each of the AGREE II standards are indicated in the table.

AGREE standard	Section of guideline
Scope and purpose	
1 The overall objective(s) of the guideline is (are) specifically described	Introduction
2 The health question(s) covered by the guideline is (are) specifically described	Introduction
3 The population (patients, public, etc.) to whom the guideline is meant to apply is specifically described	Foreword, Introduction
Stakeholder involvement	
4 The guideline development group includes individuals from all the relevant professional groups	Foreword
5 The views and preferences of the target population (patients, public, etc.) have been sought	Foreword
6 The target users of the guideline are clearly defined	Introduction
Rigour of development	
7 Systematic methods were used to search for evidence	Foreword
8 The criteria for selecting the evidence are clearly described	Foreword
9 The strengths and limitations of the body of evidence are clearly described	Foreword
10 The methods for formulating the recommendations are clearly described	Foreword
11 The health benefits, side effects and risks have been considered in formulating the recommendations	N/A
12 There is an explicit link between the recommendations and the supporting evidence	Throughout
13 The guideline has been externally reviewed by experts prior to its publication	Foreword
14 A procedure for updating the guideline is provided	Foreword
Clarity of presentation	
15 The recommendations are specific and unambiguous	Throughout
16 The different options for management of the condition or health issue are clearly presented	Throughout
17 Key recommendations are easily identifiable	Throughout

Applicability		
18	The guideline describes facilitators and barriers to its application	Foreword
19	The guideline provides advice and/or tools on how the recommendations can be put into practice	All appendices
20	The potential resource implications of applying the recommendations have been considered	Foreword
21	The guideline presents monitoring and/or auditing criteria	10
Editorial independence		
22	The views of the funding body have not influenced the content of the guideline	Foreword
23	Competing interest of guideline development group members have been recorded and addressed	Foreword