cardiomyopathy, 1 patient presented with alcohol intoxication and the other with an anxiety attack. Of 2 deaths due to congestive heart failure, both patients presented with abdominal pain. One death was due to giant cell myocarditis, and the reason for attendance was respiratory infection.

Time from medical consultation to death ranged from 2 to 72 hours, with a mean time of 22.64 hours. None of the patients were reviewed by a cardiologist.

Once the results of the additional requested tests (histology and toxicology) were analyzed and combined with the autopsy findings, we concluded that the definitive causes of death were: cardiac ischemic origin in 13 patients (48%); aortic aneurysm rupture in 4 patients (16%); hypertensive cardiopathy in 2 patients (12%); dilated cardiomyopathy in 2 patients (8%); congestive heart failure in 2 patients (8%); and giant cell myocarditis in 1 patient (4%).

Of the 25 deaths, 13 were of cardiac ischemic origin (48%), unrelated to the patient’s clinical treatment, since there are no clinical symptoms, electrocardiogram changes, or angiographic findings to suggest acute ischemia as the direct causal factor of death in almost 50% of sudden deaths. Most other cases of sudden death in patients with ischemic cardiomyopathy are probably caused by sustained ventricular tachycardia due to re-entry around an old infarct scar, triggering ventricular tachycardia or ventricular fibrillation.

In conclusion, the results from this descriptive study show that, despite the high number of medical acts carried out every day, in 2012 and 2013, only 25 cases of death were attributable to a cardiac cause undiagnosed at the time of recent medical review. This statement does not imply any diagnostic error, or any evaluation of clinical practice. In these cases, the complexity and seriousness of diagnostic cardiology should be taken into account, since the clinical picture of an aortic aneurysm, abdominal pain, or giant cell myocarditis hamper the initial diagnosis.

Despite concern about the negative consequences of the increasing number of professional liability claims against doctors, and, considering Gautier’s previous affirmation that within our time death would no longer be accepted as an inevitable fate, there were no records that relatives intended to file a medical complaint at the time of collection of the body. We acknowledge, however, the possibility that relatives may subsequently file a
professional liability claim after receiving definitive autopsy results.

However, there is little likelihood of such a claim being filed against a physician who has reviewed a patient a few days or hours previously and who then dies suddenly. The fundamental aim of judicial autopsy is to determine the cause of death, which is ascertained by macroscopic examination, histological and toxicological assessment, and, as of 2012, the genetic study of cardiac diseases causing sudden death, performed in the UdG-IDIBGI genetics laboratory, with repercussions for genetic counselling of relatives.4

Helena Martínez-Alcázar; Mercè Subirana-Domènech, and Josep Castellà-García

Servei de Patologia Forense, Institut de Medicina Legal de Catalunya, Barcelona, Spain

Corresponding author:
E-mail address: helena.martinez@xii.gencat.cat
(H. Martínez-Alcázar).

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