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Post-mortem cardiac MRI in deceased with a history of mental illness

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Background
The Danish Departments of Forensic Medicine have established a nationwide, cross-disciplinary study: “SURVIVE” for research in forensic autopsy cases involving mentally ill deceased. A major focus is CVD. Opposed to clinical cardiology the use of pmcMRI in forensic pathology is a fairly unknown area2-4.

Aim
The aim of this ongoing study is to implement pmcMRI in a forensic pathology setting and to describe cardiovascular morphological changes focusing on hypertrophy and presence of edema as it can occur in myocarditis and ischemia.

Material
So far 347 deceased with confirmed or suspected mental illness have been included in the SURVIVE study. 20 of these deceased, without signs of putrefaction on pmCT, were randomly included in this sub study (table 1).

Methods
Prior to autopsy a pmcMRI is performed (1T Siemens Harmony MRI-scanner). The image analysis is done using the software OSIRIX®. The wall thickness of the left ventricle and presence of edema on the pmcMRI are registered, measured and correlated to autopsy findings and histopathology results. For correct correlation the 17-segment classification of the American Heart Association® is used (figure 1). The papillary muscles are excluded when measuring the width of the segments (figure 2).

Preliminary results
The measurement of the left ventricular wall thickness shows varying agreement between the two methods (Bland-Altman Plot) with a mean bias between the measurement methods of 0.3 mm (SD 3.185 mm). The outliers are caused by difficulty to differentiate papillary muscle from ventricular wall on the pmcMRI.

Hypertrophy (ventricular wall thickness > 15 mm) is diagnosed more often on the pmcMRI than at autopsy (table 2). The correlation between the frontal, septal and posterior segments is good, but poor between the lateral segments (data not shown).

Edema (ventricular wall thickness > 15 mm) is diagnosed in 14 cases on pmcMRI (table 3). In 9 cases the area with the highest water content corresponded to the highest signal intensity on pmcMRI. Within the same case the lowest difference in water content between the segments was 1% and the highest 14% (mean 7.8%). There were 6 cases without edema with a mean difference of water content between all 4 areas in the same case of 4.9% (SD 1.9). There was no correlation between the distribution of lividity and high signal intensity.

Discussion
The preliminary results show a good correlation between the measurements of ventricular wall thickness regarding the anterior, posterior and septal segments. The measurement of lateral segments was generally too wide on pmcMRI compared to the autopsy results resulting in a too frequent hypertrophy diagnosis. The correlation between the diagnosis of edema and the results from the freeze drying were overall good. In a few cases the results did not match which needs to be elucidated further. The overall correlation between the macro- and microscopic findings with the pmcMRI was acceptable.

The results show good reason to continue the study and we believe that the use of pmcMRI in cardiovascular pathology is a useful adjunct to the forensic autopsy.

References:

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For further information on the SURVIVE study use the QR-code or visit the website http://retnedcin.dk/English/research/surveivestudy/