

Forensic Identification of Early Hospital Deaths among Nigerians



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Abstract

A British group advocated that the establishment of a histopathology data pool facilitates epidemiological analysis. Therefore, what forensic evidence can be obtained with such a pool when patients die during early hospitalization? The answer was sought personally as the pioneer pathologist at the Reference Pathology Laboratory set up by the Eastern Region Government at the Capital City, Enugu, for the Igbo Ethnic Group. Seven cases were identified including those involving renal failure in cholera and death during tracheostomy.

Keywords: Forensic pathology, Hospitalization, Early death, Pattern, Developing community, Igbos

Introduction

A Birmingham (UK) group appreciated that the establishment of a histopathology data pool facilitates epidemiological analysis [1]. This opportunity became available when the Government of the Eastern Region of Nigeria established a Reference Pathology Laboratory at the capital city, Enugu, with me as the Pioneer Pathologist. It has served the Igbo Ethnic Group [2]. In this context, forensic pathology was involved. Accordingly, this paper considers cases of deaths during the second or third days of admission for hospital treatment.

Results

These may be tabulated hereunder as follows: (Table 1).

Table 1: Age and sex distribution of the pathological appearances.

No	Initials	Age	Sex	Pathological findings
1	SN	14	F	Renal failure in cholera
2	ME	21	M	Gastric erosion
3	CO	28	F	Tracheal cancer with death at tracheotomy
4	SI	30	M	Cirrhosis and ruptured carcinoma
5	AM	19	F	Bronchopneumonia
6	ON	11	F	Purulent pericarditis
7	CO	43	M	Lung cancer with metastasis in liver and diaphragm

Discussion

It was during a cholera epidemic that death occurred, acute kidney injury being responsible. This is in keeping with the published work [3] which described it thus: "Tragically, people continue to die in large numbers in low-resources settings as a result of this disorder, which in many cases is preventable and potentially treatable with simple measures." In this context, an Israeli man aged 72 years recovered despite severe dehydration with profound hypovolemia and infection [4]. Gastric erosion or ulcer caused death. Among 1905 patients, there were 235 such deaths in the survey of Bonnevie [5].

Tracheotomy has potentially lethal complications. These have been spelt out by workers in Australia [6], USA [7], and Germany [8,9]. Perhaps, the last review may be cited thus: "Tracheotomy-related deaths can be avoided in several ways: by thorough training under the leadership of experienced physicians, by the use of the World Health Organization's Surgical Safety Checklist regardless of where the tracheotomy is performed, and by the continuous vigilance of nursing staff."

Liver cancer rupture had been publicized personally including its historical dimensions [10]. Bronchopneumonia of the *endogenous lipoid* type is what is deemed to be important [11], as well as the *eosinophilic* type [12]. Purulent pericarditis was reviewed by Shiber [13]. As he put it, bacterial pericarditis has a high mortality rate with the majority of deaths being due to cardiac tamponade. It was not so in our locality. Lung cancer

has also been looked at from the historical angle in terms of papillary adenocarcinoma [14]. Incidentally, the epidemiology of lung cancer itself in this community was reviewed a decade ago [15].

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