Letters to the Editor

To resuscitate or not?

Sir,

Potter and colleagues suggest that elderly hospital patients should routinely be asked their opinions about cardiopulmonary resuscitation,¹ but this is often unnecessary from an ethical viewpoint,² and might even be unwelcome to patients.^{3,4}

It may be appropriate to discuss cardiopulmonary resuscitation with patients where there is a reasonable chance that it will be successful, although many patients are excluded from resuscitation because the chances of survival are so poor that it is considered futile. Ethicists agree that doctors can legitimately make Do Not Resuscitate decisions in these patients without the need to obtain consent.² We have calculated morbidity scores, which have been shown to predict failure to survive cardiopulmonary resuscitation,⁵ for all our acute elderly inpatients, and have found that 30% of them were predicted not to survive by two separate scores (unpublished data). Discussing cardiopulmonary resuscitation with these patients seems unnecessary, and possibly counter-productive.

Potter and colleagues state that they gave patients a layman's explanation of cardiopulmonary resuscitation, without trying to predict the outcome for individuals, and found that almost all patients wanted resuscitation for themselves. Their results are in contrast with those of Murphy and colleagues,⁶ who found that very few elderly patients wanted cardiopulmonary resuscitation after they had been given a detailed explanation of their chances of surviving. Information on outcome is important in any discussion about treatment, especially when, as in the case of cardiopulmonary resuscitation, the success rate is low. Perhaps Potter's patients were inadvertently led to believe that cardiopulmonary resuscitation was nearly always successful whereas, of course, it is usually unsuccessful.

Even when it is appropriate to involve patients in these decisions, some may not wish to participate, and others may misunderstand what is being discussed. The Vice-President of the Patients' Association has been quoted in the national press as saying that a policy of discussing cardiopulmonary resuscitation with all elderly patients might be cruel or intrusive.³ Heller and colleagues implemented such a policy, but found that a patient's relative took exception to the practice, and they were misrepresented by the local media as running a covert euthanasia policy.⁴ They suggest that others proceed with caution before embarking on such policies.

If ethical guidelines² for making decisions not to resuscitate are followed then it is likely that only a minority of elderly patients will become involved in discussing cardiopulmonary resuscitation. Nearly half of Potter's patients (and 37% of ours, unpublished data) would be excluded because of cognitive impairment, and perhaps another third because of futility. We would expect that there would be others who would not wish to discuss the issue, would be too ill to discuss it, or in whom a senior clinician felt that discus-

Learning points

- many elderly patients may have Do Not Resuscitate decisions made on the basis of futility. Doctors do not need consent for these decisions
- if resuscitation is discussed with patients then they should be given realistic information about their chances of survival; this may affect their preferences
- patients may not want to discuss resuscitation, or may misunderstand what is being proposed
- many elderly patients will be unable to discuss resuscitation because of cognitive impairment

sion would be detrimental to their wellbeing. This is an acceptable ethical position.²

When discussions about cardiopulmonary resuscitation do take place, patients should be given realistic information about likely outcome, so as they can make a truly informed decision.

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- 3 Tomlin Z. A matter of life and death. *Guardian* 1994; 5 October.
- 4 Heller A, Potter J, Sturgess I, Owen A, McCormack P. Resuscitation and patients' views; questioning may be misunderstood by some patients. *BMJ* 1994; 309: 408.
- 5 O'Keefe S, Ebell MH. Prediction of failure to survive following in-hospital cardiopulmonary resuscitation: comparison of two predictive scores. *Resuscitation* 1994; 28: 21–5.
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Septic arthritis of the hip complicating pregnancy

Sir,

Septic arthritis of the hip joint in adults is uncommon. Patients often have predisposing factors and there is often a primary source of infection.¹ We have recently seen a patient with a group B streptococcal septic arthritis of the hip; it is rare to find this organism infecting a joint. The hip and sacroiliac joints seem to be particularly at risk from postnatal sepsis. Because of the variety of organisms and their differing antibiotic sensitivities a bacterial diagnosis should always be sought to ensure effective treatment.

A 43-year-old woman presented to our department three months following delivery of a healthy baby at full term. She had had a spontaneous vaginal delivery but there was an interval of 60 hours between rupture of the membranes and delivery. Pain had started in the left groin three days after delivery. At presentation all movements of the left hip were severely limited by pain, she was afebrile. Investigations were as follows: Hb 7.9 g/dl, platelets $463 \times 10^9/l$, WBC $9.8 \times 10^9/l$ (60% neutrophils), ESR 128 mm/h. Pelvic X-ray showed the left joint space to be reduced with some erosion of the superior acetabulum (see figure). The symphysis was also disrupted, presumably as a result of relaxation at the time of pregnancy followed by abnormal weight bearing.

The joint was aspirated under ultrasound control followed by arthrotomy and irrigation. A group B, β -haemolytic streptococcus which was penicillin sensitive was identified. Following surgical drainage and six weeks of antibiotics the patient's general health improved and the ESR returned to normal.

Group A streptococci (eg, *Streptococcus pyogenes*) were responsible for puerperal sepsis that was widespread during the middle of the last century. Now group B streptococci are recognised as important causes of neonatal and obstetric infections.² Group B streptococci are common commensals of the vagina in postpartum women and in those who have experienced prolonged rupture of the membranes (greater than 12 hours) colonisation exceeds 80%.³ Following prolonged rupture of the membranes the incidence of neonatal infection and maternal morbidity (fever, urinary infection, endometritis) increase.⁴

Septic infections of the knee⁵ and sacroiliac joints have also been described following pregnancy, the bacterial route of spread is likely to be haematogenous. The internal iliac veins are valveless and during episodes of raised intra-abdominal pressure, such as occurs in labour, blood is forced through the internal vertebral plexus of Batson. This route is via the lateral sacral veins and may explain the involvement of the sacroiliac joints in pregnancy. The vessels of the ligamentum teres drain into the obturator system and it is possible that the hip joint is also involved in this retrograde flow.

Figure Pelvic X-ray three months after the onset of symptoms