Elderly patients who survive out-of-hospital cardiac arrest to be admitted seem to have much the same prospect of being discharged alive as do younger patients, and most survivors are discharged to their own home or families. We believe, on the basis of our findings, that a decision to resuscitate must be made in the context of the patient’s previous quality of life and current illness rather than on the basis of age alone.

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Population variation in ovarian function

SIR—Ovarian function can be modulated by several factors, including age, parity, intensity of lactation, exercise, nutritional status, energy balance, and diet.¹ Such modulation may have an appreciable impact on individual variance in fecundity and may also be important in the cause of breast, ovarian, and uterine cancers within individuals.² Yet despite the importance to women’s health and reproductive capacity, scant information exists on natural variation in ovarian function at the population level.

We have done comparative studies of ovarian function in four populations of distinct genetic, geographical, ecological, and cultural backgrounds: middle-class women in Boston, USA; Lese horticulturalists in the Ituri Forest of Zaire; Tamang agro-pastoralists in central Nepal; and Quechua Indians in highland Bolivia. We collected serial saliva samples from adult women with regular menstrual cycles in each of these populations for the analysis of progesterone content with standardised protocols in both the field and the laboratory.³ The results indicate that considerable inter-population variance exists in this index of ovarian function (figure). Differences between the four populations in average progesterone profiles are highly significant by repeated-measures analysis of variance (p<0-001).


Table: Outcome by age in patients admitted after out-of-hospital cardiac arrest during 3 years from April, 1990

<table>
<thead>
<tr>
<th>Age (y)</th>
<th>Total no admitted</th>
<th>Patients surviving to discharge</th>
<th>Deaths during index admission</th>
<th>Mortality (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>15-59</td>
<td>67</td>
<td>50</td>
<td>14</td>
<td>21.2</td>
</tr>
<tr>
<td>60-79</td>
<td>68</td>
<td>55</td>
<td>24</td>
<td>35.3</td>
</tr>
<tr>
<td>&gt;79</td>
<td>67</td>
<td>50</td>
<td>17</td>
<td>25.3</td>
</tr>
<tr>
<td>Overall</td>
<td>200</td>
<td>165</td>
<td>114</td>
<td>57.0</td>
</tr>
</tbody>
</table>

Differences between groups are not significant.
The cause of this inter-population variation in progesterone is unclear. It may result from acute differences in health, diet, energy balance, or other factors, or may be the result of chronic differences in such factors during development. Whether such differences in average ovarian steroid profiles contribute to population differences in fecundity or to the epidemiology of breast and reproductive tract cancers at the population level is also unclear. These questions deserve attention. The average ovarian hormone concentrations in developed western populations may represent one extreme of the global distribution of ovarian function rather than an ideal normal.

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Pre-emptive analgesia: sufficient to change practice?

Str—We would like to believe that there is a pre-emptive effect of analgesics, so that preoperative analgesia reduces postoperative pain. Unfortunately your commentary (July 10, p 65) is less than systematic in reviewing the evidence. We have to consider 3 types of intervention: local anaesthetic, non-steroidal anti-inflammatory drugs (NSAIDs), and opioids. The commentary dismisses lack of pre-emptive effect with local anaesthetics by saying that the patients had all had opioids. Preoperative caudal blocks, however, showed no more benefit than the same procedure done after surgery, and no opioid was given. The NSAIDs are not mentioned in the commentary. Of the 3 studies comparing preoperative and postoperative NSAIDs none showed any difference;1-4 2 of the 3 were not “contaminated” by use of opioids. Preoperative and postoperative paracetamol (with no opioid premedication) showed no pre-emptive effect.5

The evidence for a pre-emptive effect with opioids rests on two papers.6,7 Neither is clear-cut: in the intravenous study there is conflict within and between the three outcomes; in the epidural study there was a significant advantage for the preoperative over the postoperative dose at only one of 6 sample times. The evidence does suggest that there may be a pre-emptive effect of opioids. This is an “almost” answer to an academic question rather than grounds for changing clinical practice. We hope that the evidence to convince us will emerge.

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Transmission of Pseudomonas cepacia by social contact in cystic fibrosis

Str—Govan and colleagues1 (July 3, p 15) suggestion that transmission of Pseudomonas cepacia in patients with cystic fibrosis (CF) is mainly by social contact concurs with our experience. Routine culture of all sputum samples from CF patients attending our clinic began in March, 1991, with the use of selective medium (Mast Diagnostic, Bootle, UK). In the 3 weeks following the introduction of routine culture an organism was isolated from 6 patients which proved to represent one type of P cepacia. P cepacia was typed by pyrolysis mass spectrometry.1

From May, 1991, all CF patients known to be colonised with P cepacia were admitted to another ward in the hospital so that they had no contact with non-colonised patients. Outpatients were not segregated. However, during the next 4 months this type of P cepacia was found as a new isolate in 2 further CF patients who had previously been negative with selective media. These patients had extensive social contact with other patients colonised with this type of P cepacia. In August, 1991, the Adult Cystic Fibrosis Association discontinued its meetings in the Liverpool area and patients colonised with P cepacia had much less social contact with non-colonised patients. After this change, there were no new isolates of this type of P cepacia in our clinic.

2 patients became colonised with P cepacia in April, 1993. 1 of these is an infant who has been admitted to neither of our CF wards and who has attended our clinic on one occasion only. The other is a child who had little social contact with