taneously, produces cerebral impairment in the other. Alternatively, an insult may lead to fetal death in one twin which in turn affects the development of the second twin. If this latter mechanism is responsible, monozygous twins, in which one dies, are likely to be at greater risk than dizygous twins. This is of relevance to the treatment of fertility where multiple birth is common and both mono- and dizygous rates are increased, and if selective fetocide is used. Whether the difference observed between the Mersey and Western Australian series is real or is an artefact of survival, or of differences in twin classification and registration, requires further investigation. Unfortunately, few data are available worldwide to examine the comparative risks of singleton and multiple births. The lack of routine data sources for determining the prevalence of cerebral palsy means a continuing dependency on registers which are population based. Such registers are of relevance to health service provision, to outcomes of the treatment for infertility, and may provide clues to aetiology.

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Commentary

There has been much media coverage recently about multiple births and their risk to mother and children. It is therefore timely to be able to review two separate papers (cerebral palsy and multiple births; cerebral palsy: effects of twinning; birthweight and gestational age) which both discuss the association of cerebral palsy with multiple births.

There is a great public awareness about the implications for the provision of services to families where a child has cerebral palsy. A study from North East Thames Regional Health Authority confirms the importance of twinning as a risk factor for cerebral palsy. Other factors include gestational age and fetal growth. These three factors act independently of each other. It must be remembered, however, that these risk factors only account for a minority of cases of cerebral palsy. A study from Liverpool shows an increased risk of cerebral palsy within a twin pair if the co-twin was a fetal death. Multiple births run a greater risk of cerebral palsy than a singleton birth. This is partly due to their lower birthweight distribution and partly to a higher risk among normal birthweight infants. Currently, the number of multiple births is increasing, largely as a result of infertility treatment. Thus an increased risk of disability and mortality for twins and higher order births is important for both the potential parents and professionals who would have to provide care for the surviving children. We therefore need to be able to identify and quantify the risk factors.

The number of cases covered in both these studies is small so it is welcome that a multicentre study is in progress which combines data from cerebral palsy registers in Britain, the USA, and Australia. It is unfortunate, however, that we have no United Kingdom based data of child morbidity to answer questions on cerebral palsy. A report in July 1995 to the NHS Central Research and Development Committee stated that routine information systems, including morbidity data, for child health are at present inadequate. [1] The Advisory Group recommended that integrated and accessible information systems should be developed to identify accurately the health and healthcare needs of mothers and children. The Office for National Statistics (ONS) is starting a trial which brings together data from different local child health systems. We recognise that cerebral palsy is one of the issues that we will be able to examine with such a database. In addition to the new child health system, we have recently begun to set up a register of twins at ONS. It is in its very early stages, dependent on funding through research proposals. Nevertheless, the long term potential of such a register is that these morbidity issues could be investigated using a much larger register of multiple births than has been possible with the studies published here. The Liverpool study also suggests that long term follow up of children born as a result of infertility treatment is needed. We have only limited data from which we can measure any increased risk for the children born as a result of these treatments. The data available are for techniques of gamete manipulation rather than drugs taken to stimulate ovulation.

It is only by long term follow up of babies born as a result of a complete range of all these procedures that we can begin to have a complete understanding of the long term outcome for these births. I therefore welcome these papers which take forward our knowledge and understanding of the epidemiology of cerebral palsy. I hope that the issues they raise can be developed further using data from a longer time period and larger sample sizes.

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