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CORRESPONDENCE

Expectant management of twin pregnancy with single fetal death

Sir,

We wish to comment on the antenatal monitoring of the surviving co-twins in the study of Santema *et al.* (Vol 102, January 1995). In their study fetal condition was assessed serially with ultrasound scan and cardiotocogram (CTG) and no neurological morbidity was recorded.

Despite this result, it is important to recognise the limitation of these antenatal surveillance tests. Biophysical profile and CTG monitor biophysical events regulated by the brainstem, and this part of the brain may be spared during neurological insult.

In one of the cases reported by D'Alton *et al.* (1984) severe neurological damage occurred in the surviving co-twin, despite normal ultrasound and reactive antenatal CTG. Postnatal computerised tomographic scan revealed an intact brainstem.

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References

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Santema J. G., Swaak A. M. & Wallenburg H. C. S. (1995) Expectant management of twin pregnancy with single fetal death. *Br J Obstet Gynaecol* **102**, 26–30.

Authors' Reply

Sir,

We are grateful for the interest showing in our study by Drs Arayomi and Pereira. We agree that a reactive cardiotocogram does not exclude major fetal cerebral damage in the presence of an intact brainstem. At present we have no accurate method to diagnose the development or existence of such fetal neurological damage. Because our data suggest that it may be a relatively rare event, we feel that it does not constitute an argument against expectant management of twin pregnancy with single fetal death unless the fetal cardiotocogram is suggestive of fetal compromise.

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Local research ethics committees: hindrance or help?

Sir,

We sympathise with the frustrations of Penn and Steer (Vol 102, January 1995) in their attempts to obtain approval from various local ethics committees for a multi-centre trial, and we share their disappointment that the preterm breech trial failed. As consumer representatives, we are in favour of well-designed randomised trials, and we have lost an important study.

Inefficiency and ignorance of the kind they describe are inexcusable. However, they do not make out a case for the drastic proposal to bypass local committees, leaving them only with the power of veto. Proposals are rarely turned down, but they are often usefully amended and improved by committee members, whose knowledge and experience is increasing now that training is available.

The fact that two committees insisted on longer term follow up of babies involved in the study shows that changes suggested were far from trivial or unimportant. The AIMS policy for research on pregnancy, childbirth and the newborn requires keeping names of research subjects so that long term follow up is possible (Robinson 1994). It would be helpful if Penn and Steer were to share with us information on other changes requested, so that we may judge their ethical value.

A national committee is not necessarily the fount of all wisdom. One of us (J. R.) while sitting on the GMC Professional Conduct Committee, was concerned about ethical problems revealed in a trial approved by one national committee, and as a result the President wrote to the body concerned. AIMS' criticisms of a multi-centre trial show that serious ethical problems can be missed if there is inadequate consultation (Robinson 1994). Wider consideration can be valuable protection for researchers, since it reduces the likelihood of ethical criticisms after publication. There are also often local factors (e.g., ethnicity, culture, availability of staff) affecting research which the district committee will be aware of but the national committee will not.

Hindrances from local ethics committees can be reduced or avoided. There might even be a case for prioritising multi-centre trial applications, but the help and valuable experience which many local committees offer should be thrown aside.

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Penn Z. J. & Steer P. J. (1995) Local research ethics committees: hindrance or help? *Br J Obstet Gynaecol* **102**, 1–2.

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Interleukin-6, tumour necrosis factor and soluble tumour necrosis factor receptors in women with pre-eclampsia

Sir,

We were interested to read this paper by Vince *et al.* (Vol 102, January 1995) because their conclusions were similar to those we drew from an investigation of tumour necrosis factor-alpha (TNF-α) and soluble E-selectin in pre-eclampsia (Meekins *et al.* 1994). E-selectin was studied because it is expressed by endothelium in response to TNF-α and interleukin-1 (IL-1); like interleukin-6, it is an indirect measurement of the activity of these cytokines.

Maternal blood samples were collected from singleton pregnancies at different gestational ages: TNF-α and soluble E-selectin were measured by sandwich ELISA techniques. The women studied included 10 normal pregnancies who later developed pre-eclampsia, nine with established PET, and 22 controls whose pregnancies were clinically normal throughout and whose babies were of normal birthweight. Pre-eclampsia was defined according to the criteria of Davey and MacGillivray (1988) as a diastolic blood pressure greater than 90 mmHg on two or more consecutive occasions more than 4 h apart and with more than 300 mg of protein in a 24 h urine collection, or 2+ proteinuria detected on reagent strip on two occasions more than 4 h apart.

In the 10 women who later developed pre-eclampsia, TNF-α was below the immunoassay limit of detection (< 80 pg/ml) one