

Quintuplets

Quintuplets are back in the news with the report of A. C. Keast and G. Z. Cooper¹ that five children were born at one time to Mrs. Tukutese in East London, South Africa, in February 1966. At the time of the birth Mrs. Tukutese was 38 years old. It is well known that multiple pregnancy is commoner with the increasing age of the mother, and this is independent of the number of children she has had before. In fact Mrs. Tukutese had had two pregnancies previously and one of these had ended with the birth of twins. She is African, and it is known that Africans are far more likely to have dizygotic twins than Europeans. In Negroes from all parts of the world the dizygotic twinning rate per 1,000 maternities varies from 11.8 in the U.S.A. to 39.9 in Ibadan in Nigeria. In non-Africans in England the comparable rate is 8.9. The monozygotic twinning rate is, on the other hand, remarkably constant between about 3.0 and 5.0 per 1,000 pregnancies; for five Negro populations it is on average 3.6 and for five European countries it is 3.3² Hence it seems likely that Negro women are more prone to multiple ovulation than are Caucasian women.

The use of agents for inducing ovulation—pioneered mainly by C. A. Gemzell³ with pituitary and chorionic gonadotrophins, and more recently with the drug clomiphene—has often resulted in the birth or abortion of multiple foetuses. The first two of Gemzell's patients bore twins and the next ten who became pregnant produced one set of twins at term, another set of aborted twins, and one set of aborted quadruplets all from different ova. This seems to have been the experience of many who have induced ovulation by this method. G. C. Liggins and H. K. Ibberton⁴ have reported that quintuplets were born successfully after artificial induction of ovulation by gonadotrophins. With clomiphene given for a variety of conditions R. M. Kistner⁴ has found that twins occurred in 10.75% of 930 live births. This contrasts with the usually accepted figure that twins occur once in about every 90 births. Multiple pregnancies resulting from therapeutically induced ovulations always seem to be from separate ova.

The wastage rate in multiple pregnancy is high from abortion, stillbirth, death from prematurity, and congenital malformation. The greater the number of foetuses at birth the greater is the hazard. Keast and Cooper¹ point out that the Tukutese quintuplets are only the fourth set to have survived the neonatal period, the others being the Dionne quins of Canada in 1934, the Diligenti quins of Buenos Aires in 1943, and the Fischer quins of Aberdeen, South Dakota, in 1964. Estimates of the frequency of quintuplet births range from 1 in 8 million births to 1 in 54 million births.

The respective total birth weights of the above sets of quins were 10.61 lb., 14.08 lb., and 12.11 lb., and 23.52 lb. for Mrs. Tukutese. Most of the problems for the mother are occasioned by this enormous load, together perhaps with changes in the hormone balance. Thus pre-eclampsia, cardiac failure, oedema, varicose veins, breathlessness, hydramnios, and antepartum and postpartum haemorrhage are common. Nevertheless, Mrs. Tukutese had only mild cardiac failure just before labour. Fortunately the diagnosis had been made early in pregnancy by radiology, and she was kept in hospital for several weeks. Indeed for the last three

weeks she was almost entirely confined to bed as she could scarcely get about, and found difficulty in eating and sleeping.

As might be expected the quins were almost certainly all from different ova, and the total weight of the five placentas was 5.5 lb. Subsequently Mrs. Tukutese had produced dizygotic twins, when the quins were 20 months old. All these children were very well, having given no real cause for anxiety either at birth or since.

Size and Efficiency

The Annual Representative Meeting at Eastbourne is to be asked to approve further changes in the B.M.A.'s constitution, with a view to greater efficiency and economy. It is proposed that the Council should be reduced to 50 members, mostly elected by the A.R.M.; that the Council should appoint the Association's standing and special committees except the two autonomous committees; and that the Representative Body itself should be limited to 300. Along with this go recommendations that committees should be smaller, and that Council members should normally accept membership of standing committees. These proposals, which were agreed after a long debate in the Council last week, are set out at p. 54 of the *Supplement* this week.

At the moment the Council numbers 81 and the Representative Body may number as many as 584. Last year's revision of the constitution¹ introduced into both bodies a welcome measure of proportional representation between general, hospital, and other forms of medical practice. But the Council next session will have 82 members plus up to 15 additional *ex officio* committee representatives with no voting powers, making a possible total of 97; while at 538 there will be fewer members of the R.B.

Though conceived at a time of economic stringency, the Council's recommendations must be viewed in the light of their long-term effects. They will save money, and smallness in Councils and Committees usually spells greater efficiency. But the proposals will stand or fall on the test of whether they better enable the Association to pursue its principal objects—the promotion of the medical and allied sciences and the maintenance of the honour and interests of the medical profession. The situations of the Council and of the R.B. differ. The Council has executive functions in addition to its duty to debate and to examine major questions of policy as they arise. Its efficiency must to some extent be in inverse proportion to its size, and the same can be said of most of the committees. Nevertheless, B.M.A. members will want to look at the proposals in more detail to see what will remain of their direct representation at the centre of the affairs of the Association. They will wish to satisfy themselves that the electoral changes now recommended will not, as one speaker put it, turn a democracy into a "self-perpetuating oligarchy."

Traditionally and constitutionally the R.B. is the parliament of the Association, and while the Council had no doubts about cutting its own size its vote of 22 to 14 clearly reflected its reservations about reducing the R.B. from 538 to 300. Such a change might not greatly increase the efficiency of the R.B., though it would reduce its cost. Indeed, it could be argued that provided the Council and the committees are made more effective the R.B. would be better left alone until its new constitution has had a fair trial. However, if the B.M.A. is faithfully to discharge its duties to its members and the profession as a whole, few would dispute the need to consider some streamlining of its machinery.

¹ *Brit. med. J. Suppl.*, 1967, 3, 61, 72.

¹ Keast, A. C., and Cooper, G. Z., *S. Afr. J. Obstet. Gynaec.*, 1967, 5, 43.

² Bulmer, M. G., *Ann. Hum. Genet.*, 1960, 24, 1.

³ Gemzell, C. A., In *Modern Trends in Gynaecology*, ed. by Kellar,

R. J., Butterworths London, 1963, p. 133.

⁴ Kistner, R. W., *S. Afr. J. Obstet. Gynaec.*, 1967, 5, 25.

⁵ Liggins, G. C., and Ibberton, H. K., *Lancet*, 1966, 1, 114.