This led me to feel that the routine six week developmental physical examination, in its present form, is probably a waste of time.

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Trends in birth prevalence of cerebral palsy

We would like to add our comments to the correspondence arising from the recent publication of Professor Pharoah and colleagues on trends in birth prevalence of cerebral palsy.¹

There has been an interesting swing in thinking on the origins of cerebral palsy over the past few years. This has arisen mainly from the observations derived from registers which have been compiled of children with cerebral palsy within geographically defined populations. It has become increasingly clear when surveying the problem from this community perspective that although low birthweight infants are at increased risk of cerebral palsy, many infants who later manifest signs of cerebral palsy had neither a low birth weight nor a recognisable perinatal insult.

On the other hand there has been an increasing understanding of the associations between evolving neuro-pathological changes in the brain of the low birthweight infants, as detected by imaging techniques, and eventual clinical outcome.² This has led to the sort of claim made by Dr Barson that 'most infants with cerebral palsy have been admitted to a maternity hospital with a morphologically normal central nervous system whilst in utero and subsequently discharged to the community with pathological cavities in their brains.'³ This may be the perspective of those involved with immediate clinical care of low birthweight infants in a special care nursery but ignores the question of the aetiology of cerebral palsy in other babies.

Preliminary figures from the Oxford Region Child Development Project suggest a different view. This study has been establishing a register of infants with serious impairment, including cerebral palsy, born from 1984 onwards to mothers resident in the Oxford region at the time of delivery. Although the oldest infants on the register are now only 3½ years old, 58 infants from a total 1984 birth population of 31 811 have been diagnosed as having cerebral palsy. This gives a birth cohort prevalence rate of 1.82/1000 live births. Of the 570 infants with a birth weight of less than 2000 g, 17 have cerebral palsy. They represent only 29% of the 58 children with cerebral palsy.

We do not wish to minimise the risk of later motor impairment in the low birthweight population and the need

for continued monitoring of the outcome of the increasing numbers of extremely low birthweight survivors. At the same time we would support the view that the aetiological origins of most cases of cerebral palsy must be sought outside the immediate perinatal period.

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Carriage of penicillin resistant pneumococci

Sir,

While studying the pharyngeal colonisation by *Streptococcus pneumoniae* and the absence of penicillin resistance among pneumococci isolated from healthy Mexican children, we noticed the paper by Klugman *et al* that reported the relative penicillin resistance of *S pneumoniae* in 303 urban and 156 rural black children; this resistance was seen in 14% of urban carriers and 19% of rural carriers. The authors obtained those figures after screening isolated strains with methicillin discs and subjecting those organisms with halos of less than 25 mm in diameter to a quantitative antimicrobial test to confirm the resistance.²

The prevalence of such strains in South Africa may be even higher. Other investigators have shown that the methicillin discs can miss relatively resistant strains of *S pneumoniae* in 9% of cases, incorrectly identifying them as sensitive (that is with halos of greater than 25 mm in diameter).³ In addition, another paper by Klugman *et al* reported that when they were screening for resistance with methicillin discs they found 20% of falsely susceptible *S pneumoniae* strains, but they offered no explanation for this.

Consequently, if the limits of error given^{3 4} were used to calculate corrected figures, the results found¹ could be interpreted as showing resistant strains from 19% to 25% of the urban population and from 23% to 28% of the rural