Letters

Preventing obesity

Prevention starts in infancy

EDITOR—Crawford in his editorial on population strategies to prevent obesity has not mentioned an important factor in the aetiology of obesity: the method by which infants are fed.[1]

Von Kries et al found that a history of three to five months of exclusive breast feeding was associated with a 35% reduction in obesity at the age of 5 to 6 years, which was not accounted for by social factors, lifestyle, etc.[2] They discuss the evidence for a programming effect of breast feeding in preventing obesity and being overweight in later life. Gilman et al found that infants who were fed breast milk more than infant formula milk, or who were breast fed for longer periods, had a lower risk of being overweight during older childhood and adolescence.[3]

These results are consistent with those of the DARLING study, which showed that infants who received no milk other than breast milk in the first 12 months were lighter than formula fed infants, though of similar length and head circumference.[4] This study also found that energy intake of breastfed infants was lower than that of formula fed infants, even after the introduction of solids; the authors say that comparatively low energy intakes are a function of self regulation in breastfed infants.

Breastfeeding mothers also lose weight after pregnancy more effectively than those who feed artificially, an advantage seen over at least the first 12 months of breast feeding.[5]

Vigorous marketing of junk food is often implicated in the obesity epidemic. What about inappropriate marketing of infant formula milk? In the United Kingdom, with its limited legal restraints, manufacturers can and do actively promote infant feeding bottles, teats, and follow-on formula milk to the public in contravention of the international code of marketing of breast milk substitutes. This recently drew comment from the UN Committee on the Convention on the Rights of the Child. In its observations of 4 October 2002 the committee recommended that the United Kingdom takes all appropriate measures to promote breast feeding and adopt the international code of marketing of breast milk substitutes in light of its low rates of breast feeding.

Measures to promote and support breast feeding, including legislation and promotion of artificial feeding, seem to be a rational approach to preventing obesity.

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Hidden sugars in foods undermine strategies to reduce obesity and diabetes

EDITOR—In tackling the increasing obesity and diabetes problem described by Crawford in his editorial,[1] the focus needs to be on getting to the root of the problem, not on weight reduction programmes when the damage is already done. We need fundamental changes to food production, not just in labelling.

Trying to find sugar-free foods in shops and supermarkets is like running an obstacle course. It is easy to identify sweets as culprits, but what about the hidden danger of sugar in savoury foods and foods thought to be healthy, such as breakfast cereals, fruit juices, salad dressings, and yoghurts? I make my own fruit yoghurts as it is impossible to buy them unsweetened.

Sugar conditioning starts with baby foods and drinks, and once a child has acquired a sweet tooth, non-sweetened foods are not so attractive. The food industry needs to take more responsibility and have the courage to offer unsweetened products, and the government needs to encourage this practice.

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Doctors underestimate obesity

EDITOR—The hazards of excess body weight have been clearly established by epidemiological and clinical studies as reviewed by Hitchcock Noël and Pugh.[1] We agree that obesity can be easily identified and that patients who are mildly or moderately overweight may be overlooked. A recent study has shown that about a quarter of overweight patients were thought to be of normal weight by their primary care doctors.[2]

Despite its high prevalence,[3] obesity is documented by doctors only in a small proportion of patients, indicating that this life threatening condition is considerably under-reported in medical records.[4]

Similarly, a retrospective analysis found an apparently low rate of obesity in hospital outpatient departments treating conditions related to obesity (4% in cardiology, 5% in rheumatology, and 3% in orthopaedics) in comparison with the true prevalence (30% in cardiology, 20% in rheumatology, and 25% in orthopaedics).[5] The large disparity between apparent and true prevalence is evidence that opportunities for diagnosing and treating obesity are being missed.

Surprisingly, doctors readily accept the need to treat the consequences of obesity (such as type 2 diabetes mellitus, hyperlipidaemia, hypertension, etc), but the disease itself, which is recognised as a diagnosis under ICD-9 code 278.0 (*International Classification of Diseases*, 9th revision), is often ignored. Body mass index defines differing degrees of obesity and being overweight, and clinical protocols can be adapted easily to record weight, height, and the resulting index. This simple measure could guide clinicians towards more appropriate referral.[5]

Doctors are called on to play a key part in successfully tackling the obesity epidemic through an early competent diagnosis accompanied by thoughtful and evidence based interventions. The gaps in screening,

recommending treatment, and appropriate referral need to be addressed.

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Patient centred approach may help in hypertension

Editor—Benson and Britten examined why patients choose to take drug treatment for hypertension and expose the ambivalence some people feel about pharmaceutical intervention for chronic disease.[1] We have recently completed a study looking at the reasons a notable proportion of diagnosed hypertensive patients does not return for follow up appointments.

We identified 35 such non-returners in populations from three general practices in Worcester, Droitwich, and Exmouth (approximately 5% of the hypertension registers). Eleven of these patients (age 30-75, median age 62, 6 male, 5 female) were interviewed in their homes and asked their views on their diagnosis, follow up, and treatment options. We analysed transcripts by using standard qualitative techniques.

Many of the themes we identified fit well with those described, notably the dislike of medication and fear of being labelled as sick. We also noted that many of the patients had wider concerns about how regular follow up would affect their perception by others. This includes worries that they would be seen as hypochondriacs not only by other patients ("Well, the other people in the waiting room might think, 'That silly old fool sitting there, there's nothing wrong with them'") but also by the general practitioner ("It may not be recorded that someone's told you to come in. They might think, 'He comes down here every three months and it's always normal, why does he do it? You know, he just likes to come in.'"). Concerns were raised that this might influence future treatment for other, more "serious" conditions ("If I was down there every week then she'd start thinking, you know, let's give him some placebo.")

None the less, all patients understood their diagnosis, although this was countered by varying degrees of denial, and agreed that medical intervention was appropriate given the severity of the possible consequences of untreated hypertension.

This study, along with that of Benson and Britten, highlights some of the dilemmas that patients face when attempting to resolve conflicting ideas regarding medical advice. Rather than considering such patients as non-compliant, it might be more constructive to think of them as sitting on a decision seesaw. The use of alternative consultation options and the adoption of more patient centred approaches, in particular having a greater understanding of health beliefs, may then be a way of tipping the balance towards regular follow up and effective treatment.

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The exiled tribe: don't forget overseas members of the BMA

Editor—I write to draw attention to the position of overseas members of the British Medical Association. The BMA's representative structures are based entirely on doctors who live in the United Kingdom. Without access to any of these, overseas members have no influence on the association's decisions and can't even find out about what is going on as they don't receive *BMA News*, the association's inhouse paper.

I am an overseas member and still registered with the General Medical Council. The BMA's actions can still have a major influence on my future. The GMC's plans for revalidation have been designed entirely around doctors working in the British NHS. Yet the association has ignored doctors registered with the GMC who live abroad, some of whom are BMA members, even though non-compliance will mean deregistration.

Members working abroad also have a stake in terms and conditions of service as they may return to the United Kingdom. The shortage of general practitioners and consultants there means that the views of overseas members should be particularly important. Decisions that don't take into account their perspective may have unforeseen consequences that deter them from coming home to work. Overseas members could also contribute to committees such as ethics, medical education, science, or even the international committee. It seems odd that the international committee currently consists entirely of doctors resident in the United Kingdom.

I can't raise the issue of the absence of democratic representation because I have no representation in the organisation. It is also impossible to assess the views of other overseas members through *BMA News* as they are not on the distribution list. I may be a lone voice or in a cast of thousands. I don't know, and neither does the BMA. If you are an overseas member, contact me.

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Involving patients can work in home blood glucose testing

Editor—According to the paper by Gray et al, the single biggest cost of implementing intensive control of blood glucose concentrations in type 2 diabetes relates to the use of home blood glucose monitoring.[1] This is surprising.

Firstly, currently evidence and agreement are lacking on the role of home blood glucose monitoring in type 2 diabetes.

Secondly, for newly diagnosed patients, home blood glucose monitoring does not offer any particular advantage compared with urine testing.[2]

Thirdly, actual usage of blood glucose strips by patients is much less than the reality of the situation.[3]

Fourthly, suggestions have been made of an inverse relation between the frequency of blood testing in type 2 diabetes and achieved concentrations of glycated haemoglobin.[4]

We have adopted a new approach in Bournemouth for patients with type 2 diabetes in whom home blood glucose monitoring is indicated (patients with altered renal threshold for glucose, those at risk of hypoglycaemia, and those who prefer blood testing). The patients test a fasting value on a Wednesday. If this is above the ideal value (for the individual), they test again on the Thursday, and (if still above ideal) again on Friday. If the value is still above ideal, patients are taught to self titrate their dose of oral agent, and the cycle is repeated until agreed concentrations are achieved. In a pilot study this seems to work and is acceptable for patients.[5]

When this approach is used together with urine testing, the costs of monitoring may be less than anticipated. The worst scenario occurs when patients test at unstructured times and no one does anything with the information—worse still, if no one bothers to even look at the results.

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Violence as a public health problem

ZEFREX

Combined approach is needed

EDITOR—Although treating violence as a public health issue is not new,[1] the World Health Organization's report on violence and health is an important reminder of the suffering we inflict, intentionally, on each other.[2] In the United Kingdom the Crime and Disorder Act 1998 places a statutory obligation on health services to work with the police and local government to tackle crime. So far, however, the police and local authorities in England and Wales have found the NHS difficult to engage, probably because the reasons to contribute are not widely understood.

A great deal of violence that results in treatment is not reported to or recorded by the police. This means that health services have substantial opportunities to collect unique information about the circumstances of violence, which, combined with police data, can be used to target violence prevention resources at particular locations, times, and vulnerable individuals and groups.[3] Since most injured people are treated by emergency services, they should be a major focus of preventive effort.

Tackling violence as a problem of intentional injury provides both a rational framework for prevention and existing local expertise, which has much to offer statutory partnerships for reducing local crime.

Injury rates due to assault as provided by emergency departments are proving objective and unique local, regional, and national measures of violence.[4] These correlate with measures of unemployment, poverty, and expenditure on alcohol, for example. Data can be collected without extra resource by clerical staff in emergency units and have successfully been used to target local police activity. They also have potential as evidence relevant to alcohol licensing: a recent study found a correlation between capacity of licensed premises and injury sustained in local street violence.[5]

Heath draws attention to the perspective of human rights.[1] Nowhere is this more important than in relation to the rights of the many victims of violence who come to the attention of health services only. Health professionals must therefore develop services for victims. These range from links with local victim support schemes, through initiating permanent protection, orders which reduce the risk of repeat domestic violence, to the provision of liaison psychiatry services.

What is needed is a combined approach in which public health, accident and emergency and mental health services; primary care; the police; and other components of the criminal justice system collaborate. This will help to develop communities that are both safe and just.

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Report misses association of violence with pregnancy

EDITOR—The world report on violence and health issued by the World Health Organization unfortunately does not pay attention to the growing body of evidence that shows that violent deaths among women are often associated with pregnancy events.[1] Homicide is a leading cause of death among pregnant women and recently pregnant women.[2 3] According to one study of battered women, the target of battery during their pregnancies shifted from their face and breasts to their pregnant abdomen.[4] This redirection of the assault implies hostility toward the woman's fertility.

Many women are coerced, pressured, or battered to submit to unwanted abortions by men who are opposed to birth.[5] This may be a clue as to why a history of abortion is an important marker for increased risk of death from violence.[2 3]

A major record linkage study in Finland found that in the first year after a pregnancy event,women who had given birth were half as likely to die as women who had not been pregnant whereas women who had abortions were 76% more likely to die.[2] The largest discrepancy was due to deaths from violence. The odds ratio of death for women who had abortions compared with women who had given birth was 4.24 for accidents, 6.46 for suicide, and 13.97 for deaths resulting from homicide.

Another large study in the United States showed that the higher risk of death associated with a history of abortion persists for at least eight years.[3] After controlling for age and prior psychiatric history, a history of abortion was a significant marker for 3.12 times higher the risk of death from suicide and 1.93 times higher the risk of death from homicide over the entire eight years examined. The increased risk of death from violent causes was highest in the first four years after the pregnancy outcome.

While much attention is paid to the problem of unwanted pregnancies, comparatively little has been paid to the violent conflicts that erupt when pregnancies are wanted by women but not their partners. Other causes of unwanted abortions—pressure from parents, medical staff, or circumstance—can also result in grief, guilt, and loss of desire to live,[5] which may play a part in the increased risk of deaths due to suicide and accidents among women with a history of abortion. One important step in addressing this public health crisis is to expand screening and counselling programmes for women with a history of abortion.

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All together now, again

EDITOR—I welcome the approach taken by Heath in her editorial.[1] I have long noted just how many of the psychological and physical symptoms of distress seen by general practitioners and at emergency departments have their roots in violence. Classically, men get upset, angry, and end up in jail for fighting, whereas women get upset, sad, and end up seeing doctors with depression.

I have long wanted a frame of thinking that would allow these two needless streams of human misery to be turned off at source. I no longer regard the case by case treatment of individuals as a sufficient response to these problems. Heath is careful to look at the roles of both individual agency and societal structures in contributing to the problem of violence. The idea of taking the soil away from the seeds of violence is highly appealing.

Heath says that electorates, and so governments, are unwilling to allocate more resources to poor areas and families. A similar point was made by Watt in 1996.[2] There is a moral argument to ask the richer classes to fund the poorer classes, but this on its own cuts little ice with the middle class voter. What strikes me about the apparent refusal of wealthier classes to fund redistribution is

how short sighted a policy that is. What is the use of a large private house if you need closed circuit television to vet all your visitors before opening the security gates?

The middle classes are paying the high costs of inequality in their fears of being a victim of crime and the cost of insuring their cars and their property. Perversely, whatever money they are saving in tax they are probably paying out for insurance and security, and still not feeling very secure after paying this. A more ecological approach to give a better outcome for all sections of society could trade off higher tax as a worthwhile investment in reducing crime and violence by reducing inequality.[3]

Reducing inequality would also be an investment for the health not just of poorer people, but of rich people too. Have we reached the stage where we as individuals could back a political party that tried to sell us such a policy that could benefit us all? Or do we still think our insurance policies are a better buy?

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Inequality fuels terrorism globally

Editor—As an Australian, deeply affected by last October's massacre in Bali, I found Heath's editorial to be especially prescient in calling our attention to the links between all forms of violence and the extent to which the perceived injustices of economic inequality drives violent acts such as terrorism.[1]

As inequality grows between the wealthiest countries of the developed world and those of the developing world, and while inequality thrives in many developing countries, the seeds are sown for the expression of anger, hatred, and resentment by some of the most disaffected at those they perceive to be their oppressors. This inevitably gives rise to the kind of appalling events directed at wealthy Westerners that we have seen over the past 16 months.

Those of us who are convinced of the effects of experiences and environments during the early years on the rest of our lives, worry about the messages that young children who grow up in those environments are being given, as well as what that might mean for the future of relationships between the different tribal groups who inhabit this planet.

A sustainable future must mean more than one in which exploitation of the physical environment out of avarice is ceased: all forms of exploitation of the weak by the powerful must be lessened. The war against terrorism will be lost unless the West, in partnership with the exploited developing world, grapples with this issue and devises effective ways of reducing socioeconomic inequality. Sadly, the history of our capacity as humans to make the sacrifices required in acting out of what is ultimately going to be enlightened self interest does not fill me with confidence. History shows that we often just go on blaming and attacking the victims.

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Vaccine induced protection against hepatitis B

Editor—Whittle et al report one of the few long term follow up studies of children vaccinated against hepatitis B.[1] The reported reduction in the rate of carriers of hepatitis B surface antigen in two villages in the Gambia, from 13% to 1% and from 35% to 2% respectively, represents a major achievement in public health.

We are concerned, however, that those who are influential in deciding policy of hepatitis B vaccination may not appreciate that relevant information is missing in the printed version compared with the electronic one. The electronic version says that several vaccines, different vaccine dosages, and different routes (including intradermal) were used, most differing from recommendations for childhood vaccination programmes. Thus, despite the use of low dose hepatitis B vaccines intradermally, and without mentioning whether the results of the study might have been influenced by malnutrition, infection with HIV or other underlying disease, the overall vaccine efficacy against carriage of hepatitis B surface antigen was 94%, which fulfils the objective of a universal hepatitis B vaccination programme admirably.

Distinction between protection against hepatitis B core and surface antigen seroconversion needs to be appreciated.[2] Eight out of 10 vaccinated subjects who had a hepatitis B surface antigen seroconversion had a peak antibody response of less than 10 mIU/ml. Only a concentration at or above this one can be regarded as an indicator of immunological priming or immunocompetence.[2] In addition, although no breakthrough infections due to hepatitis B escape mutants have been observed in successfully vaccinated individuals so far, the possibility of such infections was not ruled out in this study.

Seroconversions of hepatitis B core antigen have also been reported in other studies, but these infections do not result in persistent carriage with its attendant risk of chronic liver disease. The observations reported in the paper are therefore consistent with a Chinese 15 year follow up study and with data from other studies showing the persistence of immune memory after the disappearance of humoral antibody responses.[3–5] These data provided the basis for the recent European consensus statement which concluded that, as immunological memory lasts for at least 15 years in immunocompetent people, hepatitis B booster doses are not recommended in those who have responded to a completed primary vaccination course.[2]

What remains important in assessing protection is that attention is given to monitoring immunological memory in those whose antibody responses, although initially present, have declined to undetectable levels.

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Case report showed Muehrcke's nails, not Beau's lines

Editor—The patient in the case presented by Moule et al in Minerva had several narrow transverse white bands on her nail plates after receiving five cycles of combined chemotherapy for non-Hodgkin's lymphoma.[1] We studied the clinical photograph thoroughly. We did not detect any transverse grooves or furrows on the nail plate, which are characteristic of Beau's lines.[2] In contrast, the band-like ungual discolorations resemble closely the clinical manifestations of leukonychia striata, or Muehrcke's nails.

Leukonychia is a common finding in nails of fingers and toes.[3] Grossman and Scher listed over 70 different causes of this nail plate discoloration.[4] Apart from conditions of chronic hypoalbuminaemia, Muehrcke's nails can develop after the use of chemotherapeutic agents.[2 5] These abnormalities are due to incomplete keratinisation, so that nuclei or nuclear debris are retained in the nail plate.[2] In contrast, Beau's lines are due to temporary interference with nail plate formation and become visible on the proximal nail surface as a transverse depression some weeks after administration of the drug.[2]

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Referees make journal clubs fun

EDITOR—Gibbons described how to make a journal club experience potentially more successful.[1] His highly structured approach to the traditional journal club format is certainly a necessary ingredient for success. Many of the problems with the traditional approach, such as monopolisation of the discussion by a few individuals, failure to read the article, and incredibly dry and boring Microsoft PowerPoint presentations are not, however, solved by this approach.

We have organised our journal club around a debate team format.

Firstly, we provide instruction on literature evaluation and use the articles by Trisha Greenhalgh in the *BMJ* as background reading.[2 3]

Secondly, two interns pick an article of choice, and a senior resident approves the selections. The senior resident is also the referee of the debate. He or she comes to the journal club equipped with a referee shirt, whistle, and stopwatch. The attendees are randomly assigned to one of two teams. We have pro and con sides for each article and two debatable questions per article. These questions are carefully chosen to ensure that all skills necessary to evaluate literature are taught. The teams meet briefly to develop their strategies, and then the fun begins. Of course the referee with his whistle and stopwatch ends deliberations promptly.

The evaluations from residents and attendees on this format have been overwhelmingly positive. We have seen increased participation from formerly silent individuals, and the club is not only educational but fun.

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Cycle of abuse goes on

Remember referral for imaging is referral for an opinion

EDITOR—Your author, anonymous to us and his radiologist, demanded magnetic resonance imaging and got short shrift.[1] The radiologist was probably reporting magnetic resonance—numerous images, taking concentration and time to influence treatment. Because disturbance breaks concentration, increasing error, she was probably as irritated as he would be if disturbed during a ward round. Would he expect to make a surgical referral by a personal appearance in theatre?

We have half the number of radiologists we need. The need for diagnosis and staging demanded by the Cancer Plan is increasing: surgeons wish to image before operating; we need to police the use of radiation and manage the demands of training if more national training numbers are to allow us to dig ourselves out of the manpower hole. Is it surprising that radiologists feel tetchy?

The Royal College of Radiologists asserts that we are clinical radiologists—referral for imaging is a referral for an opinion, clinical information allowing the radiologist to select the method of imaging. Would he or she refer his patient for surgery by demanding hypophysectomy or by asking the surgeon's advice? The appropriate use of limited resources in imaging is where radiologists can help. We want to provide clinically based services but demands for imaging based on ill conceived clinical strategies only frustrate us. The constant flow of juniors sent to demand imaging and intervention but unable to provide clinical information tests our patience.

Your author needs some humility. He should find his colleague and apologise for his arrogance in disturbing her while she was busy, not introducing himself, treating her as a technician rather than a fellow clinician, and making the assumption that his own view of this encounter is the only tenable view. He will find that she is only too willing to provide his patients with the imaging service they need.

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1 The cycle of abuse goes on. *BMJ* 2002;325:831. (12 October.)

We are all on the same side

EDITOR—It is a shame that some of the responses to the anonymous article on the cycle of abuse seem to imply an ongoing battle between radiologists and people who ask for their help.[1–2] The original article was not an attack on radiologists but on bullying. It could just as easily have been written about a surgeon, rheumatologist, or geriatrician.

The important point is the fact that the radiologist (in this case) behaved so differently when informed that she was talking to a consultant. If she felt that the request for magnetic resonance imaging was inappropriate or rudely made then she could have felt quite justified in telling the author so, whatever his rank. The fact that she did not do this implies, as the author says, that she was perfectly happy to abuse trainees in a way that she felt unacceptable for consultants. It is also important that the author made sure that he talked to junior doctors on his firm before making a complaint and established that this was not an isolated occurrence—after all, we all have bad days when we are irritable.

There is no justification for being rude or unhelpful to those more junior than yourself, just because you think you have the power to do so. We are all supposed to be on the same side.

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1 The cycle of abuse goes on. *BMJ* 2002;325:831. (12 October.)
2 Electronic responses. The cycle of abuse goes on. bmj.com 2002. bmj.com/cgi/eletters/325/7368/831 (accessed 2 Jan 2003).

Why are miraculous cures mainly of cancer?

EDITOR—In his personal view Westcott asks whether miracles can happen.[1] Many of the apparently well authenticated cases of miraculous cures seem to be of cancer. Occasionally cases of spontaneous remission of cancer occur outside a religious context. This implies that in certain rare circumstances an effect, probably immune mediated, can happen that results in complete remission. The psychological state of the patient is undoubtedly relevant through well known connections between the nervous system and the immune system.

The claim that this is evidence of divine intervention is harder to sustain. If this were the case we would presumably hear convincing accounts of cures in cases where spontaneous recovery does not occur. This need not be as dramatic as regrowth of an amputated limb: recovery of the integrity of the optic nerve in a patient with visual loss from glaucoma would do.

Such cases do not seem to occur, which suggests to me that the cancer cures, no matter how impressive and gratifying, are events that can be accommodated in the framework of the natural world.

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1 Westcott R. Can miracles happen? *BMJ* 2002;325:553. (7 September.)