LETTERS

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TACKLING OVERWEIGHT AND OBESITY

Early years support is crucial to reducing obesity

Howard and Davies note that "understanding of the complex causes of obesity has improved but remains incomplete."[1] One thing that is clear, however, is the stark association between growing up in poverty and the risk of being overweight or obese (figure).

Lifestyle choices—both food preferences and physical activity—have their roots in the early years.[2] Although a great deal of public expenditure currently goes on the consequences of adult obesity, with the cost to the NHS estimated at more than £5bn (€6bn; $8.4bn) a year, a more effective approach would be to tackle the "causes of the causes." Calls for a sugar tax are welcome,[1] but we also need to reaffirm a commitment to supporting children in the early years, reducing child poverty, and improving the conditions in which all children grow and live.

Unfortunately there are signs that the opposite is happening. For the first time in more than 17 years, child poverty in the UK has increased in absolute terms.[3] The poorest areas are being hit hardest by current austerity measures, with early years budgets and children's services facing severe cuts.[3 4] Nearly 600 children's centres have closed in recent years because of cuts in local authority budgets,[3] with several councils announcing further drastic reductions.[5]

A commitment to early years support is crucial and cost effective. These services must be protected. They are the basis on which healthy and thriving communities are built.

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Competing interests: None declared.

1 Howard SJ, Davies SC. Chief medical officer urges action to tackle overweight and obesity. *BMJ* 2014;348:g2375. (27 March.)
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Inactivity causes obesity

Howard and Davies skirt over the main reasons for the rise in obesity, preferring to blame gluttony over sloth.[1] As the Department for Environment, Food, and Rural Affairs' national food survey and family food datasets show,[2 3] calorie intakes peaked in the 1970s, declined until the 2000s, and have flattened out since.

Their commentary contained just one small paragraph about the real cause: inactivity. If our calorie intake has fallen, then our tendency to burn off calories must have fallen faster.[4]

It's easier to blame food companies and restaurants than change urban environments so that walking and cycling are encouraged, but the Netherlands and Denmark (the countries with the fewest obese people in Europe) have the same restaurant chains and food habits as us. They have invested heavily and have great expertise in how to build infrastructure that discourages the use of private cars and encourages active travel. Britain remains primitive in this respect.

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Competing interests: I do a lot of utility cycling. I'm used to the UK's roads, but I am aware that many of my patients would never consider cycling because they are too intimidated.

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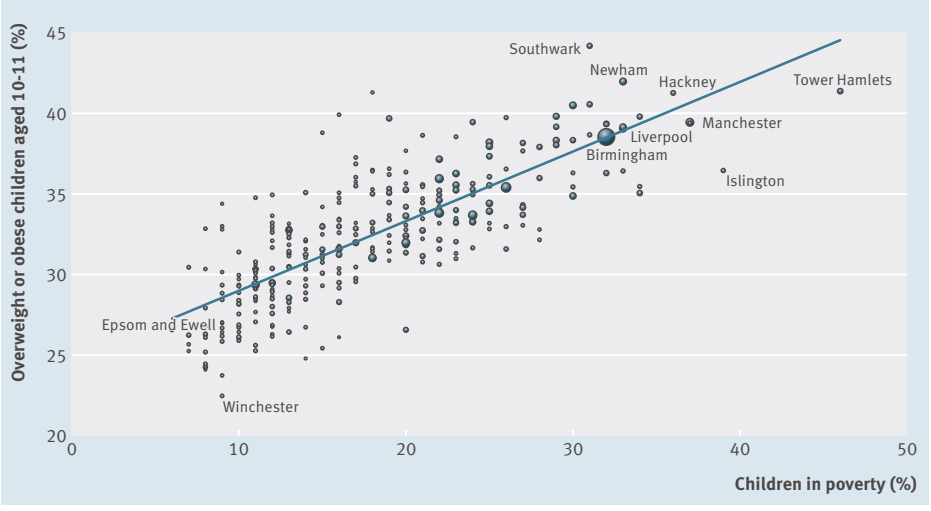

Percentage of overweight or obese children aged 10-11 years by percentage of children in poverty in English councils, 2012. Source: National Child Monitoring Programme (NCMP) and HM Revenue and Customs Children in Low-Income Families

GESTATIONAL DIABETES

Treating gestational diabetes reduces perinatal morbidity

The recent analysis of gestational diabetes summarises the ongoing debate about whether to screen for and treat this condition.[1] The authors conclude that mild glycaemia "does not carry anything like the same degree of risk" (as pre-existing type 1 or 2 diabetes) and imply that treating gestational diabetes has no clinically important benefit.

Two randomised controlled trials have established the benefit of treatment. One showed that treatment reduced a composite perinatal outcome (death, bone fracture, shoulder dystocia, and nerve palsy) from 4% to 1% (P=0.01).[2] The number needed to treat was 34. Fewer babies were admitted to the neonatal unit (71% *v* 61%). The other showed a significant reduction in mean birth weight (3302 *v* 3408 g), neonatal fat mass (427 *v* 464 g), frequency of large for gestational age infants (7.1% *v* 14.5%), birth weight

greater than 4000 g (5.9% *v* 14.3%), shoulder dystocia (1.5% *v* 4.0%), and caesarean delivery (26.9% *v* 33.8%). It also found reduced rates of pre-eclampsia and gestational hypertension (combined, 8.6% *v* 13.6%; P=0.01).[3]

To the individual woman, a fourfold reduction in the risk of her baby dying or sustaining nerve damage or bone fracture is certainly worthy of consideration, especially when the effective intervention can be as simple as blood glucose monitoring and maintaining a healthy diet. Reducing neonatal admission is beneficial in terms of bonding between mother and baby, and reducing cot occupancy and cost.

Because perinatal mortality is at an all time low, reducing perinatal morbidity becomes increasingly important. Advancement may necessitate treating larger groups of women for relatively smaller benefit. This is common to almost all obstetric conditions. However, the women—who potentially live with the consequences of non-intervention—should be given the choice, not the medical profession, which takes a global, rather than individual, view of worthiness.

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1 Cundy T, Ackermann E, Ryan EA. Gestational diabetes: new criteria may triple the prevalence but effect on outcomes is unclear. *BMJ* 2014;348:g1567. (11 March.)
2 Crowther CA, Hiller JE, Moss JR, McPhee AJ, Jeffries WS, Robinson JS. Effect of treatment of gestational diabetes mellitus on pregnancy outcomes. *N Engl J Med* 2005;352:2477-86.
3 Landon MB, Spong CY, Thom E, Carpenter MW, Ramin SM, Casey B, et al. A multicenter, randomized trial of treatment for mild gestational diabetes. *N Engl J Med* 2009;361:1339-48.

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Authors' reply

We agree with Hodson and colleagues that women should be given a choice about intervention in gestational diabetes. However, terms fraught with emotion such as "risk of her baby dying" are inappropriate in this setting and unhelpful to the debate.

Firstly, let us correct some factual errors. In the ACHOIS study, the risk of babies in the treatment group being admitted to the special nursery was increased, not decreased, as Hodson states.[1] Population studies and the other major intervention trial show no increased risk of stillbirth with gestational diabetes.[2-5] The ACHOIS study, with five stillbirths/neonatal deaths in the untreated group versus zero in the treated group, is at odds with other studies, and at least two of the deaths could not plausibly be related to gestational diabetes (lethal congenital anomaly, intrauterine growth restriction).[1] The improved outcomes seen with treatment in the MFMU study were all secondary outcomes—treatment did not change the primary composite outcome.[5]

Secondly, and most importantly, both randomised controlled trials used a two step process for diagnosing gestational diabetes, something that the newly proposed international criteria suggest dropping—a procedural change that will fuel a huge increase in prevalence of gestational diabetes.[1 5] The proposed criteria will double or triple prevalence by capturing women with lower levels of glycaemia than those in the randomized controlled trials. Hodson and colleagues advocate a recipe for overdiagnosis: "Treating larger groups of women for relatively smaller benefit." We disagree. There is no evidence that women diagnosed by the newly proposed criteria will benefit, but ample evidence that interventions and costs will increase. A more rational and less emotional approach to the definition and management of gestational diabetes seems desirable.

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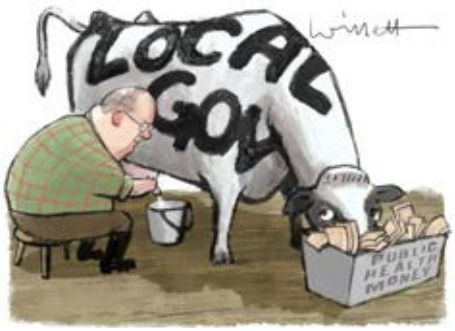
RAIDING THE PUBLIC HEALTH BUDGET

Some local authorities fund public health programmes

I commend *The BMJ* for highlighting concerns that, in some areas of the country, funds earmarked to improve public health are not being used by local authorities for this purpose.[1] However, I think that the article lacks balance and should have included examples of areas where public health is flourishing and finances are being managed appropriately.



In my local authority area of Wiltshire, the council has put public health at the heart of its business and has used its own funds to supplement public health programmes, such as free swimming for schoolchildren during all school holidays. I would have expected this activity, which promotes health and wellbeing, to have been paid for out of public health funds, but the council funded it through its leisure budget. The council has also promoted successful campaigns to engage the wider community in health and wellbeing initiatives, such as making a "big pledge" to improve personal health or the health and wellbeing of others. Raising awareness is one step, engaging hundreds of people to make a difference is clear evidence that in Wiltshire we take public health integration and matters seriously.

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1 Iacobucci G. Raiding the public health budget. *BMJ* 2014;348:g2274. (27 March.)

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BRONCHIAL THERMOPLASTY FOR ASTHMA

Evidence is lacking

Minerva seems less than overwhelmed by the thought of a tube heated up to 60°C being introduced into the lungs to treat asthma.[1] I cannot help but share her misgivings.

It is therefore surprising that the NHS Commissioning Board, in its service specification for centres treating severe asthma, insists that bronchial thermoplasty is a necessary requirement rather than a possible area of future research.[2]

I presume this cannot be because the authors of this document have an interest in this relatively new technique, in which Cochrane seems to have little confidence as yet.[3]

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