

evening support group led by a non-clinical member of the practice staff (SH) who has previous experience in the conduct and process of self-help groups and personal experience of successful weight reduction. During the initial half of each session the patient is weighed alone by the therapist and given individual feedback and advice. During the second session there is a group interactive discussion referring to a relevant topic. Each cycle lasts 12 weeks and we have completed three cycles.

Patient questionnaires indicated a high level of patient satisfaction. Throughout the 12 weeks there is a minimal regular attendance of 76%. The age-sex distribution was 16–29 years = 1 female; 30–39 years = 10 females; 40–49 years = 12 females; 50–59 years = 1 male, 9 females; and ≥60 years = four males, 17 females.

At the end of the three 12-week cycles the total weight loss was 207.5kg with an average weight loss of 4.0kg for those starting and 9.1kg for those completing the 12 weeks. The maximum weight loss was 11kg (9%) and the minimum was 2 kg (4%).

Participation in this group removes responsibility from the healthcare professional referring the patient and encourages patients in their belief that reducing their obesity is their responsibility. We believe this type of group offers effective support and encouragement to obese patients, which may reduce the frustration described by everyone in their management, and also that a more detailed evaluation is indicated, ideally taking into account the recorded difficulties of such evaluation.³

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Childhood obesity

Scott Brown is right to draw attention to the absence of primary care involvement in the problem of childhood obesity.¹ In our flagship university-linked research & teaching practice, awarded Beacon status for clinical excellence, we are barely registering the extent and seriousness of obesity in children, let alone responding to it. In August 2006 we had 2748 patients aged 0–16 years, with BMI measurements recorded for just 128 (4.6%). In 2005 13 children had obesity documented in their records as an active problem, of whom five were brought by parents because of their weight, and four others presented with problems potentially linked to their weight — asthma, joint pains, snoring. Five were referred to a paediatrician or a dietician, and nine were followed up during the year by their usual doctor. Nine had one parent with a BMI over 25 (three were obese), and in six both parents were overweight.

While GPs are described as having ‘a pivotal role’ in tackling an epidemic that, on conservative estimates, will result in a fifth of boys and a third of girls in this country being obese by 2020,² there is little evidence that interventions based in primary care work.³ The SIGN guidelines recommend that weight maintenance is the most realistic goal for most obese children (rather than weight reduction), and that weight management programmes for those not ready to change are likely to be time consuming, futile and possibly even harmful. Our apparent unawareness of obesity in children may not be so negligent after all.

One problem is that obesity is not as easy to understand as a risk factor as, say, smoking or hypertension. Its epidemiology varies according to socioeconomic and cultural conditions, with obesity a feature of the rich in poor

countries and the poor in rich countries, while in many middle-ranking economies almost half of all households have both obese and thin members.⁴ Obesity looks set to be one aspect of the polarisation of UK society, with the potential for interventions (however complex, multifaceted and social) being ineffectual or possibly even counterproductive. Before QOF targets are set in stone for childhood obesity, we must be sure that we are not being set up to fail.

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4. Department of Health. Foresight. Tackling obesity: future choices project. <http://www.foresight.gov.uk/Obesity/Obesity.htm> (accessed 9 Nov 2006).

Correction

Malignancy and deep vein thrombosis [letter]. *Br J Gen Pract* 2006; **56**: 886. The first author of the letter is Jacqueline Barrett. She is a researcher at Caper Research Unit, now based at The Dairy, Stoke Hill Farm, Exeter EX4 5BW.