Mike Fitzpatrick

Obesity — not a child protection issue

The return to school after the summer holidays has already produced the first request from the child protection authorities for information about an overweight 15-year old boy, whose family is now threatened with statutory proceedings.

It is only a few weeks since David Rogers, public health spokesman for the Local Government Association, declared that 'parents who allow their children to eat too much could be as guilty of neglect as those who did not feed their children at all'.[1] The LGA's conviction that overweight children should become the subject of child protection procedures was reported under the headline 'Fat children "should be taken from parents" to curb obesity epidemic'. It seems that the Fat police are already on the rampage.

I first encountered the facile presentation of obesity as a form of child abuse at a case conference about a teenage girl some years ago. Social workers accepted that her parents were devoted and there was no hint of neglect. Nevertheless, they cited a recent case in the US in which authorities had been blamed over the death of a morbidly obese young woman and insisted that drastic action had to be taken.

I pointed out the inappropriateness of the parallel between the situation of an under-nourished and neglected infant and an over-weight and pampered adolescent. In the former case, actual bodily harm is the direct result of parental abuse and is, at least in physical terms, readily susceptible to intervention. The dramatically improving growth chart of the 'failing-to-thrive' infant following admission to hospital can be found in every child health textbook. In the latter case, long-term risks to health are the result of a complex (and poorly understood) combination of factors, including the wider 'obesogenic' environment (of cheap, fast and fattening food, sedentary lifestyles and leisure activities) as well as the behaviour of both the young person and her parents.

A paediatrician told the case conference that there was only weak and contradictory evidence supporting the efficacy of any particular treatment for childhood obesity.[2] She argued against the proposal for coercive action, putting the view, recently restated by the Royal College of Paediatricians, that obesity is 'a public health problem, not a child protection issue'.[3]

I was concerned that imposing stigmatising statutory measures on the family would alienate them from both health and social services without providing any benefit for the child. However, it seemed that the anxieties of the child protection authorities to avert blame outweighed their concerns for the welfare of the child, who was duly placed on the 'at risk' register.

'Did it do any good?' I recently inquired of the subject of these proceedings. 'No' was her candid response. The only benefit of being on the register was that she was enrolled in an exercise course at the local swimming pool. But, as she recalled with some bitterness, this ceased on her 16th birthday when she was no longer the responsibility of the child protection authorities. However, since enrolling on a college course and joining a local gym, she had managed to lose several stones in weight.

Apart from being threatened with legal action, parents will shortly be receiving official warnings if their children are overweight and instructions from the government about healthy eating and physical activity (despite the abundant evidence that such exhortations are utterly useless). In their crusade against childhood obesity, public health zealots would do well to heed the wise words of paediatric experts in this field, who recently observed that 'it is also important to remember that obesity remains extremely difficult for professionals to treat, thus criticising parents for what professionals are frequently unable to do smacks of hypocrisy.'[4]

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Top Tips in 2 minutes

Being a guardian of the interface between illness and disease is a challenging and active process. What do the stories of babies Toby, Tyla, and their 20 or so friends, all of whom have been treated for skull asymmetry, tell us about this?[1]

According to their parents, they were all born 'beautiful' with a lovely rounded head but at the age of a few weeks this became misshapen. The parents consulted health professionals and were reassured that the head shape would get better and was simply related to the baby being put 'back to sleep'. The evidence of the parents eyes however, was that things were getting worse with time. The treatment for skull asymmetry with orthotic devices, according to the narratives, does produce results. Treatment for what is usually regarded as a self-correcting condition is not available on the NHS and parents often go to huge lengths to fund raise.

There is a lack of evidence that helmet moulding for positional skull asymmetry does work and is better than simple positioning measures or doing nothing at all. Equally there is a lack of evidence that helmet moulding does not work.[2]

There are some important things we should be doing in primary care. There are preventative measures. There are also occasional children where the condition does herald significant pathology; not all skull asymmetry is positional and benign, so a thorough assessment is needed. Perhaps most of all what we need to be doing is offering parents an explanation, including an honest account of the evidence, and of course, taking the parent's concerns seriously.

Ruth Bastable

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Common conditions of the normal child: skull asymmetry in a 4-month old child.

Why:

Up to 50% of children have some degree of skull asymmetry.

- ▶ Brachiocephaly = symmetrical posterior flattening acquired postnatally and usually caused by 'Back to Sleep'.
- ▶ Plagiocephaly asymmetrical posterior flattening, there at birth (usually related to intrauterine position), but accentuated by 'Back to Sleep'.
- ▶ Greatly increased incidence of skull asymmetry since 'Back to Sleep' campaign (although this has been hugely successful in reducing 'cot death' incidence).
  - Parental worry; will head be normal shape?
  - Professionals worry as there are occasional serious conditions associated with skull asymmetry.
  - In most cases purely a cosmetic problem with no impact on brain development.

How:

History:

- Obstetric/birth history — intrauterine moulding can be related to mal presentation. Children who are floppy tend to have malpresentation. Birth trauma moulding tends to resolve in first few weeks of life. Prematurity predisposes to plagiocephaly and babies have higher risk of associated central nervous system problems such as hydrocephalus.
- Developmental history.
- Ask about how much time baby spends on tummy/back.

What next and when:

Examination:

- General development
- Look for dysmorphism (premature synostosis of cranial suture +/- syndrome, for example, Crouzon's)
- Head size; can be difficult to measure largest circumference. Record head (= brain) growth in parent held record and monitor this.
- Head exam; check for fontanelle and any ridging of cranial sutures.
- Look at ears. In plagiocephaly accentuated by sleeping position, the head resembles a parallelogram: the ear ipsilateral to flattening moves forward and is associated with cranial bossing on affected side. In craniostenosis; the ear is pushed back (not forward).
- Eye movements: if the baby has a squint, he/she will preferentially look one way and so encourage plagiocephaly. Check for other visual problems for example, hemianopia.
- Neck movements; exclude torticollis, traumatic sternomastiod tumour.
- Shoulder and upper limb; examine for muscular symmetry.
- Muscle tone — babies with general floppiness will tend to develop plagiocephaly/brachiocephaly as they move less, so do query underlying neurological or metabolic problem.
- Hips — limited movement in one hip will encourage baby to lie one way.

If all normal, then spend more time on tummy or side if awake and playing — that is: 'Back to sleep and over again'.

- If torticollis refer to physiotherapy.
- Refer if abnormal findings — especially note: developmental delay; weakness or hypotonic; suspected craniostenosis (neurosurgical referral); head circumference crossing centiles; head circumference out of keeping with weight and/or height; abnormal hip position.

Head helmets; (popular in the US and here!) to give baby a perfectly round head. Problems: cost thousands of pounds! Positional skull asymmetry improves with age anyway; helmets have to be worn 23 or more hours a day; treatment should start <7 months age, lasts months. Potentially not tolerated by child, applied and monitored by non-medical practitioner in most cases.

Monitor the situation/review!

Patient information:

Information sheet for parents on plagiocephaly/brachiocephaly:
http://www.nhsdirect.nhs.uk/articles/article.aspx?articleId=1892
Exercises for torticollis (parent information sheet): http://www.orthoseek.com/articles/congenmt.html

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