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HEIGHT AND WEIGHT CHECKS FOR CHILDREN IN PRIMARY CARE

I still remember the day my mother took me to see my GP. It was the year 1975, 35 years ago, and I had just started primary school. I saw a locum GP instead.

He checked my weight and height, even though no one had asked him to do so. He looked at me and my mother with a perplexed gaze, and said: 'your son is obese, he has to eat less and exercise more'.

I hadn't a clue what obesity was. Previously I was told that if I carried on growing up that way I could have joined the Army by the age of 10. Everybody in the family had perceived that comment as a compliment rather than a suggestion to control my weight. Not surprisingly the advice of the locum GP did not go down well among my family members. However, my upset mother decided that it was worthwhile following his recommendation in spite of my grandmother's objections. The change meant less pasta on my plate and watching less TV, 1 hour per day at the most. What was at that time application of common sense, gave the expected results.¹

Very soon I took pride in looking after my fitness levels. I still do.

I moved to the UK from Liguria, Italy, in 2002 and I was bewildered by the prevalence of obesity. I rarely saw it documented in the medical records as an active significant medical problem. Very often I was the first doctor to check and make a written record of a patient's weight.

Now we have an obesity register, but I am still often the first to check body weight and height, particularly in youngsters.

On a few occasions patients or their parents left my consulting room upset as they did not expect to attend the surgery and have their weight checked. Sometimes they refuse altogether to get on the scale. In all those cases, the BMI is clearly above 30.

Tackling established obesity is one of the greatest challenges in general practice and long-term results for morbid obesity are disappointing. The stigma is still there, 35 years later.

We know that normal individuals maintain body weight at a remarkably steady 'set point'. Unintentional weight loss may be more

alarming than obesity. We should make sure to identify that set point.

I believe that the beginnings of morbid obesity are often already identifiable in children. Growth charts are widely available, but weight and height are plotted rarely after the first few months of life. From the first year of age to the fourth, anthropometric checks do not take place unless there is suspicion of a medical problem, generally a failure to thrive. In England there are several schemes in place, but rigorous evaluation is rare.²

Progression from childhood overweight to obesity in adolescence is well documented.³

My professional experience strongly suggests that at best, the obesity trend may have reached a plateau, but its prevalence is epidemic. My view is shared by epidemiological studies.⁴

There is a failure of the system to monitor weight in childhood and adolescence. There are data supporting a link between elevated BMI in children and body weight after puberty.⁵ GPs have been given an educational and disease prevention role. Body weight, height, and BMI are fundamental data that should and could be gathered at any GP consultation. I think it would make sense to introduce annual anthropometric checks in children in a primary care-based setting, particularly in the pre-school phase, when such data is not even gathered by a school nurse. Most young obese patients are potentially healthy adults and their disbelief, when the stigma of obesity is thrown at them from nowhere, should not come as a surprise.

Edoardo Cervoni

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