# Letters

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## Obesity and chronic disease in younger people

In your editorial on obesity,[1] Yates *et al* talk in apocalyptic terms about the rise in its prevalence. Their description of its 'devastating consequences' is amplified to an impressive degree by the repeated use of figures referring to relative rather than absolute risk. They propose an 'urgent need for high quality research' and go on to comment approvingly on the paper from the Bristol team,[2] concluding that it provides evidence that 'primary care can be used to engage effectively with, and manage, childhood obesity'.

To be honest, I'm not that good at analysing research papers but I felt it would be worthwhile seeing whether the paper delivered on this promise. Unless I am missing something, the main results I can see from this paper are as follows:

1. Of 152 eligible patients at the start of the trial, only 39 of them (25%) made it through to the end of the 12-month intervention period.
2. Reductions in body mass index (BMI) seen in those who did last the course (in both the primary and secondary care groups) were modest to say the least — and the authors comment that the mean change in BMI 'is too small to be certain of an improvement in metabolic health'.
3. There is no follow up beyond the 12-month trial period to see if there is any sustained reduction in BMI.

A more realistic conclusion, therefore, is that this model of an obesity clinic is equally ineffective in primary and secondary care. Something perhaps to bear in mind before we rush to provide such services as part of the 're-focusing of healthcare priorities' that your editorial recommends.

Roger Tisi,

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### REFERENCES

1. Yates T, Davies MJ, Khunti K. Obesity and chronic disease in younger people: an unfolding crisis. *Br J Gen Pract* 2012; **62(594):** 4–5.
2. Banks J, Sharp DJ, Hunt LP, Shield JPH. Evaluating the transferability of a hospital-based childhood obesity clinic to primary care. *Br J Gen Pract* 2012; DOI: 10.3399/bjgp12X616319.

DOI: 10.3399/bjgp12X629973

## Authors' response

Thank you for inviting us to reply to the letter from Dr Tisi who is concerned that our conclusions are not justified by our results. Taking the points he makes in turn:

1. There were not 152 eligible patients: 152 patients were referred by their GP for specialist obesity support. These children were screened for eligibility and 31 were not deemed suitable for the trial because of obesity related comorbidities. This left a further 45 who declined to participate in the trial for various reasons. These 76 patients did not provide trial data and will have received treatment in secondary care in the usual way. It is therefore erroneous to suggest that only 39 of 152 people made it through to the end of the trial. As we make clear in our consort diagram, 39 of the 76 who were randomised completed treatment but 52 provided outcome data and were included in an intention to treat analysis.
2. We have been explicit in our acknowledgement of the modest improvement in body mass index (BMI) standard deviation score (SDS) but as we point out this is still better than described in the recent Cochrane Review. However, the main aim of the trial was to establish the feasibility of running a fully powered trial in primary care and to this end we looked at a range of measures including: whether patients referred for obesity support were clinically suitable for primary care (121, 80% suitable); the willingness of families to be randomised to primary care (45, 30% declined trial participation); and the degree to which families randomised to primary care engaged with the service (measured with the main clinical outcome of BMI SDS change, patient satisfaction, and adherence rates, all of which are detailed in the article and comparable between the trial arms).
3. We recognise that in a full trial a longer-term outcome measure is essential but in a feasibility study such as this there were insufficient resources available and long-term efficacy was not an objective. However, this does not undermine the rationale for the study which was to assess the feasibility of running a specialist obesity service in primary care in order to proceed to a fully powered trial. Once such trials have been conducted and are open to scrutiny, we should be better placed to assess the value of realigning healthcare resources.

We hope that he will agree that our findings justify further research to develop interventions in the primary care setting that may assist families needing help with managing childhood obesity.

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DOI: 10.3399/bjgp12X629982

## How to afford a just health service

David Jewell suggests means-tested direct