Atoms

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IS BMI THE RIGHT MEASURE?

The House of Commons Select Committee on obesity and the American Academy of Pediatrics advise schools (UK) and paediatricians (US) to measure the body mass index (BMI) of their patients. David Hall and Tim Cole, in an erudite and forceful perspective, raise numerous concerns about measuring BMI. Interestingly, investigators from Leeds report on the TRENDS Project. The primary purpose of this study was to develop a methodology for monitoring a representative sample rather than a whole population with respect to obesity. They employed the standard deviation of the BMI in their project.

Why is there so much controversy over the use of the BMI in children? Clearly, government and paediatricians feel a responsibility to respond to the epidemic of obesity. As children have become heavier and heavier, frustration has mounted. But as Hall and Cole point out, there are few data that measuring BMI helps individual children lose weight. It may be an effective measure of the ''weight of a population,'' but from an individual standpoint we know little about how parents relate to this measure, or how paediatricians can effectively use it to counsel families. Unfortunately, unlike advising parents to place infants on their back for sleep, or restraining ourselves when it comes to writing a prescription for an antibiotic, impacting on an outcome like weight gain, which reflects complex lifestyle choices—exercise, diet, TV viewing—is something we have never done very well in medicine.

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INTENSIVE TREATMENT FOR DIABETES

A recent report in *NEJM* found that intensive control of type 1 diabetes reduced the risk of any cardiovascular disease event during the 17 years of follow-up by 42%.[1] Added to the data that near normoglycemia reduces the risk of microvascular and neurological complications of this disorder, there is little doubt that children with diabetes should pursue normoglycemia. This is far easier said then done. Adherence remains a struggle and the changing requirements for insulin as children grow and pass through puberty represent another hurdle. Science may help with the latter problem, but a better understanding of children with diabetes is necessary to help with the former. Alderson, Sutcliffe, and Curtis from the University of London describe how 24 children with type 1 diabetes share in managing their medical and healthcare with adults. Although descriptive in nature, and limited in generalisability because of sample size, more qualitative studies are likely necessary if we are to improve adherence to drug therapy for children with chronic disease.

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USE THE CORRECT SEATBELT

The widespread use of child safety seats over the past two decades has led to increased recognition that it is important that the correct type of restraint for children is necessary. For example, we have always known that infants must be placed in an infant car seat. However, as children get older, the appropriate age and weight when they can safely transition to an adult seat belt is controversial. In an analysis of 1033 children less than 15 years of age injured in car accidents, Javouhey and colleagues from France found that more children than adults were likely to be unrestrained and that children between 5 and 9 years were almost three times as likely to sustain an abdominal injury. They suggest that this may be related to the type of restraint.

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SIDS – MORE DATA, MORE RECOMMENDATIONS

Vennemann and colleagues from Münster present data indicating that in East Germany active monitoring of infant and child mortality led to the recognition of the association between prone sleeping and sudden infant death syndrome (SIDS) almost 20 years before this was discovered as a risk factor in West Germany. Investigators from Children's University Hospital, Dublin, report that the association between bed-sharing and SIDS varies depending upon birth weight, gestational age, and tog value of the clothing of the infant and bedding. Blair *et al* recently reported on the changing epidemiology of SIDS in Avon over 20 years.[2] They found that a greater percentage of deaths now occur in families who are from deprived socioeconomic backgrounds, and that the proportion of children who die from SIDS while co-sleeping with their parents has risen from 12 to 50%. Li reported a recent case-control study from California, done after full-implementation of the ''Back to Sleep'' campaign in the US, and found that the use of a dummy was significantly related to a dramatic reduction in the risk of SIDS (the letters to the editor make for an interesting read).[3] Where do these data lead? Peter Fleming will tell us in a few months in a perspective.

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ELECTRONIC AND PRINT LETTERS

As you are aware, you can comment on what we publish through electronic letters. I review everything that is submitted; and post electronically virtually all material. I select for print publication letters that raise controversial issues, or contain data about the relevant article. We have received a number of letters regarding the perspective last month by Professor Hall and Dr Renfrew on tongue tie. These letters and a response by Dr Hall will be published shortly.

REFERENCES

1 **Nathan DM**, Cleary PA, Backlund JY, *et al*. Diabetes Control and Complications Trial/Epidemiology of Diabetes Interventions and Complications Study Research Group. Intensive diabetes treatment and cardiovascular disease in patients with type 1 diabetes. *N Engl J Med* 2005;**353**:2643–53.
2 **Blair PS**, Sidebotham P, Berry PJ, *et al*. Major epidemiological changes in sudden infant death syndrome: a 20 year population-based study in the UK. *Lancet* 2006;**367**:314–9.
3 **Li De-Kun, Willinger M, Petitti DB, et al**. Use of a dummy (pacifier) during sleep and risk of sudden infant death syndrome (SIDS): population based case-control study. *BMJ* 2006;**332**:18–21.