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# LETTERS

## NHS REFORMS

### Wants and needs

Once people understand what the reforms will mean for NHS England,<sup>1</sup> and that Scotland, Wales, and Northern Ireland have refused to go down this path, enough backbench MPs might fear for their seats to defeat the bill on its third reading. Lansley got over 6000 responses to his “consultation.” Although these were overwhelmingly critical—and from virtually every representative professional body—the bill plunged even faster and deeper into privatisation than his draft.

All depends on public understanding of the relation between wants and needs. Market choice claims to give everyone access to what they want from competing providers. This is said to compel providers to work harder and more efficiently just to survive.

The nationalised NHS, on the other hand, aimed to meet not wants but needs. Needs were defined not by patients but by experts—doctors educated to know what’s good for people, better than they know themselves. Needs were assumed to be very much less than wants. The main reason the pre-Thatcher NHS could operate at less than half the cost per patient of that in the US, and provide care free for our whole population, was thought to be that NHS care was planned and provided according to professionally defined needs, not consumer wants.

Needs cannot be rationally defined by professionals alone. Unless patients contribute to the definition of needs, medical views reflect medical wants. Doctors like patients to have diseases they can name. Most patients’ real needs are only crudely, often misleadingly, reflected by wants as defined by patients alone or needs as defined by professionals alone. Both need time to talk, listen, and learn from each other, before needs can be rationally defined and efficiently dealt with.

The market may pretend to do some of this—the central function of GPs in primary care—but marketisation will put progress of this sort to

an end. It wouldn’t be profitable. Do you really want Wales, Scotland, and Northern Ireland to become the only parts of Britain where healthcare still advances to a more human future?

**Julian Tudor Hart** retired general practitioner and research fellow, Swansea University Medical School, Swansea SA2 8PP, UK [julian@tudorhart.freemove.co.uk](mailto:julian@tudorhart.freemove.co.uk)

**Competing interests:** None declared.

1 Godlee F. NHS reforms—why now? *BMJ* 2011;342:d552. (26 January.)

**Cite this as:** *BMJ* 2011;342:d984

### Where is the evidence, Mr Lansley?

Mr Lansley says “The evidence is that where there is effective competition, all producers are driven to raise their game. Competition is a tide that lifts every boat.”<sup>1</sup> I know of no evidence for this assertion, which is an echo from a US slogan defending tax cuts. The response to that from one of President Clinton’s advisers was “the rising tide will lift some boats, but others will run aground.”

Anna Dixon of the King’s Fund said:

“The truth is that competition works well in some types of healthcare markets but less well in others. In planned surgery where the episode of care is well defined, the outcomes easily measured, and where patients may have time to consider the options, competition may act as a spur for services to respond to the demands of patients.

“However, complex services such as those for trauma or cancer need a coordinated approach across providers. Quality has been demonstrably improved by focusing care within centres of excellence and creating networks of providers—an approach which necessarily reduces the extent of choice for patients. So, a market that encouraged multiple new entrants to ‘dabble’ in these services would not be good for patients.”<sup>2</sup>

**Sebastian Kraemer** consultant child and adolescent psychiatrist, Whittington Hospital, London N19 5NF, UK [kraemer@doctors.org.uk](mailto:kraemer@doctors.org.uk)

**Competing interests:** None declared.

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**Cite this as:** *BMJ* 2011;342:d981

### Is the NHS only a means of delivering healthcare?

I do not agree that the NHS “is only a means of delivering healthcare.”<sup>1</sup> The underpinning principle of the NHS, that the more fortunate (in terms of affluence and health) help those who are less fortunate, is an attractive one. It relies on the fact that all citizens are engaged with the NHS as patients, potential patients, or contributors; that receipt of NHS “benefits” varies with need; and that size of contribution varies with capacity to contribute. The NHS helps to promote civic virtue and contributes to the values of British society; it helps to reduce inequality (most obviously by preventing bankruptcy as a result of ill health) and promote social cohesion (the NHS being an institution where different groups mix and share). Because inequality and social cohesion are important determinants of health, the structure of our healthcare probably affects health and wellbeing independently of the direct effects of preventive and therapeutic interventions. In addition, the values inculcated by the NHS might spill over into other areas of life.

I don’t argue that the NHS doesn’t need reform or that it should not continually strive to improve quality and efficiency, but that the wider implications of reform must be considered—that is, that the design of our healthcare system contributes to the values and nature of our society.

**Gareth Forbes** general practitioner, Leadgate Surgery, Consett, County Durham DH8 6DP, UK [garethforbes@nhs.net](mailto:garethforbes@nhs.net)

**Competing interests:** None declared.

1 Hawkes N. Lansley had no choice but to make a full frontal assault. *BMJ* 2011;342:d470. (24 January.)

**Cite this as:** *BMJ* 2011;342:d983

## LIVING AND DYING WITH COPD

### End of life trajectories across conditions

The findings of Pinnock and colleagues’ study on the longitudinal perspectives of people with severe chronic obstructive pulmonary disease (COPD) have implications for other non-malignant

conditions.<sup>1</sup> Some of the findings echo strongly with the experience of people with advanced chronic kidney disease, although there are also notable differences.<sup>2</sup>

We need to understand more about the longitudinal perspectives and the similarities and differences between conditions. We also need to move away from considering end of life care mainly within disease specific groups. As the numbers of deaths in older people increase, a growing proportion of people are dying with multiple comorbid conditions. This is not reflected in death registration statistics, which still give one dominant cause and poorly reflect the realities of complex multiple conditions.<sup>3</sup>

Although only about 2% of all UK deaths are from end stage renal disease,<sup>4</sup> they provide a model for multiple comorbidities, because so many of these mostly older patients have cardiac or vascular disease (or both), diabetes, and other conditions. Whatever the condition or (increasingly) mix of conditions, there should be multiple entry points into palliative care; end of life care needs will only be met if there is proactive and timely assessment and reassessment of palliative care needs.

**Fliss E M Murtagh** clinical senior lecturer in palliative care, King's College London, Cicely Saunders Institute, London SE5 9PJ, UK [fliss.murtagh@kcl.ac.uk](mailto:fliss.murtagh@kcl.ac.uk)

**Katie Vinen** consultant nephrologist, King's College Hospital NHS Foundation Trust, London SE5 9RS, UK

**Ken Farrington** consultant nephrologist, Stevenage Lister Hospital, Stevenage, Hertfordshire SG1 4AB, UK

**Donal O'Donoghue** national clinical director for kidney care, Department of Health (England), London, UK

**Competing interests:** None declared.

- 1 Pinnock H, Kendall M, Murray SA, Worth A, Levack P, Porter M, et al. Living and dying with severe chronic obstructive pulmonary disease: multi-perspective longitudinal qualitative study. *BMJ* 2011;342:d142. (24 January.)
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Cite this as: *BMJ* 2011;342:d989

## What happens in neurological disease

Pinnock and colleagues highlight the difficulty, and often inappropriateness, of trying to identify a transition point to palliative care in non-malignant disease.<sup>1</sup>

Many patients seen in neurology services with non-malignant disease have incurable disease, and progression of illness may be associated (as in Parkinson's disease or multiple sclerosis) with impairment of cognition. This added consideration can complicate discussions on any change in emphasis of care.

In the preterminal phase, supportive multidisciplinary management of the patient

and family (or carers) in the clinic, and a "palliative care" approach, can overlap considerably. For these reasons, ongoing evaluation of the patient's needs may be more appropriate than a sharp transition in care.

**Peter Foley** neurology registrar, Western General Hospital, Edinburgh EH4 2XU, UK [peterfoley@nhs.net](mailto:peterfoley@nhs.net)

**Competing interests:** None declared.

- 1 Pinnock H, Kendall M, Murray SA, Worth A, Levack P, Porter M, et al. Living and dying with severe chronic obstructive pulmonary disease: multi-perspective longitudinal qualitative study. *BMJ* 2011;342:d142. (24 January.)

Cite this as: *BMJ* 2011;342:d994

## COPD EXACERBATIONS

### Anxious not to be breathless

I thought that the publication of the review on preventing exacerbations of chronic obstructive pulmonary disease (COPD) (from *Drug and Therapeutics Bulletin*; *DTB*) and the summary of National Institute for Health and Clinical Excellence guidance on the management of generalised anxiety disorder in adults in the same issue of the *BMJ* missed a trick.<sup>1 2</sup>

Although the *DTB* article stated, "patients with frequent exacerbations have high levels of anxiety and depression," it did not mention how the reverse could be true—that high levels of anxiety and depression result in patients presenting with frequent exacerbations. Although this may seem like a circular argument, it is a common finding in many emergency department and medical admissions units across the UK.

Neither did the article mention how treating anxiety and depression might reduce exacerbations, or at least hospital admission. Being breathless is frightening. Many of these patients are breathless chronically, so not surprisingly, many develop anxiety, but when assessed objectively such patients are often no (physiologically) worse than normal (for them).

Certainly, medical teams can offer a bed, reassurance, and regular medical and nursing assessment, but often these patients are discharged only to be readmitted on the next or the same day. Is there a longer term psychological crook we can offer?

Or am I missing a trick?

**David R Warriner** clinical research fellow and honorary cardiology specialist registrar, University of Sheffield, Sheffield, UK [d.r.warriner@sheffield.ac.uk](mailto:d.r.warriner@sheffield.ac.uk)

**Competing interests:** None declared.

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Cite this as: *BMJ* 2011;342:d995

## JOINT HYPERMOBILITY SYNDROME

### Psychiatric manifestations



Ross and Grahame highlighted that hypermobility is just one visible feature of joint hypermobility syndrome.<sup>1</sup> The breadth of physical complications, including dysautonomia, premature osteoarthritis, and intestinal dysmotility, suggests a broader multi-system phenotype. Joint hypermobility is also commonly associated with psychiatric comorbidities. In particular, people with joint hypermobility syndrome are over-represented in panic and anxiety populations presenting to psychiatrists—people with joint hypermobility may have up to a 16 times greater risk than non-hypermobility controls. Joint hypermobility is more common in panic disorder, where the degree of hypermobility predicts the severity of anxiety.<sup>2</sup> Joint hypermobility is also linked to several psychosomatic disorders, including irritable bowel syndrome,<sup>3</sup> chronic fatigue syndrome,<sup>4</sup> and fibromyalgia.

People with joint hypermobility have similar autonomic cardiovascular abnormalities to those with postural tachycardia syndrome,<sup>5</sup> a defining characteristic of which, regardless of its association with joint hypermobility, is an abnormally reactive autonomic nervous system—particularly a sharp increase in heart rate on standing. A phenomenological overlap, if not direct association, is also seen between postural tachycardia syndrome and anxiety disorders.

These findings suggest that constitutionally determined brain-body interactions may underlie this psychosomatic vulnerability, and that joint hypermobility may represent a sub-phenotype of anxiety disorder.

**Jessica Eccles** specialist trainee year 2, academic clinical fellow in psychiatry, Sussex Partnership NHS Foundation Trust, Sussex Education Centre, Millview Hospital, Hove BN3 7HZ, UK [j.eccles@bsms.ac.uk](mailto:j.eccles@bsms.ac.uk)

**Neil Harrison** Wellcome Trust intermediate clinical fellow, psychiatry

**Hugo Critchley** professor of psychiatry, Brighton and Sussex Medical School, Brighton, UK

**Competing interests:** None declared.

- 1 Ross J, Grahame R. Joint hypermobility syndrome. *BMJ* 2011;342:c7167. (20 January.)
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Cite this as: *BMJ* 2011;342:d998

## Implications for obstetric care

Joint hypermobility syndrome and its wider clinical implications are poorly understood by health professionals, which can significantly compromise patient care.<sup>1</sup> Ross and Grahame mention the risk of uterine prolapse and uterine rupture, but the syndrome has a variety of other risks for childbearing women. These include a higher risk of premature rupture of the membranes,<sup>2</sup> precipitate delivery,<sup>2</sup> and bleeding.<sup>3</sup> Further risks are perineal trauma and subsequent poor wound healing<sup>4</sup> and later complications such as urinary and faecal incontinence.<sup>5</sup>

Hypermobile women with unstable hip, knee, or spinal joints are vulnerable to injury if placed in inappropriate positions during labour or operative delivery, and the use of regional or general anaesthesia may increase this risk by eliminating pain when joints sublux or dislocate. Careful, collaborative antenatal planning and clear documentation of risks and care plans can alert staff on duty when women present in labour and thus reduce the incidence of some of these complications.

**Malid Molloholli** specialty registrar in obstetrics and gynaecology, Horton General Hospital, Oxford Radcliffe Hospitals NHS Trust, Banbury, Oxfordshire OX16 9AL, UK  
malid@hotmail.com

Competing interests: None declared.

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Cite this as: *BMJ* 2011;342:d1003

## Urinary incontinence as presenting feature

We have noticed another common clue to the presence of joint hypermobility syndrome<sup>1</sup>—urinary stress incontinence in nulliparous women. Urinary stress incontinence is invariably the consequence

of pelvic floor trauma during childbirth so is rare in women who have not given birth.

In recent years we have seen several nulliparous women with urinary stress incontinence. All were referred for a geneticist's opinion and were found to have joint hypermobility syndrome or Ehlers-Danlos syndrome.

These women were all young when they presented to the urogynaecology clinic. We hope that early diagnosis, appropriate advice, and physiotherapy may delay, or even prevent, the pain and disability that can occur in people with this syndrome.

**Malcolm John Dickson** consultant obstetrician and gynaecologist [mjdickson@btinternet.com](mailto:mjdickson@btinternet.com)  
**Mari Isdale** specialist trainee year 1, obstetrics and gynaecology  
**Sarah Davies** specialist trainee year 1, obstetrics and gynaecology, Rochdale Infirmary, Lancashire OL12 0NB, UK  
Competing interests: None declared.

- Ross J, Grahame R. Joint hypermobility syndrome. *BMJ* 2011;342:c7167. (20 January.)

Cite this as: *BMJ* 2011;342:d1002

## GUN CONTROL

### Australian and US gun deaths compared

The myopic parochialism of US debate on gun control astonishes many who live overseas.<sup>1</sup> The population of the US is 14.4 times that of Australia; the US has 141 times as many deaths from firearms as Australia (31 224 in 2007 v 221 in 2008) and 238 times Australia's firearm homicide or manslaughter rate (12 632 in 2007 v 53 in 2008). In 1996, our government introduced massively supported gun laws that banned citizens' access to semi-automatic rifles and pump action shot guns; a temporary tax levy funded the buyback of the banned guns. In the 18 years before the gun law reforms, there were 13 mass shootings (five or more people killed) in Australia. In the 14.6 years since, there have been none.

**Simon Chapman** professor of public health, University of Sydney, Sydney, Australia [simon.chapman@sydney.edu.au](mailto:simon.chapman@sydney.edu.au)

Competing interests: None declared.

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Cite this as: *BMJ* 2011;342:d1005

## WHEN TO WEAN

### Analysis article was misleading

Fewtrell and colleagues' analysis article on the evidence for six months' exclusive breast feeding<sup>1</sup> hit the headlines—negative comment on breast feeding in professional and scientific journals usually does. It has resulted in confusion among families and health professionals internationally about the relative merits of breast feeding and

formula feeding. It has put at risk years of large scale collaborative international work to promote breast feeding and support women,<sup>2,3</sup> already a hard task in cultures that are antagonistic to breast feeding.<sup>4,5</sup> It is important therefore to consider whether the paper that prompted this media interest offers a worthwhile contribution to knowledge.

As a review, this piece fails on all quality criteria. In an area that potentially affects the health of millions of babies and women, the principles of systematic reviewing, developed to protect professionals and the public from incomplete and biased information, have been disregarded. Two examples illustrate the consequences.

Firstly, Fewtrell and colleagues challenge the findings of the 2002 review of optimal duration of exclusive breast feeding by the World Health Organization (in fact updated in 2009<sup>6</sup>). Instead they cite a Nestle supported review that says that it “found no compelling evidence to support change” from four months to around six months of exclusive breast feeding. A quick appraisal of this review shows several factual errors and misrepresentation of its conclusions in Fewtrell and colleagues' summary.

Secondly, they list catastrophic consequences of iron deficiency as potential sequelae of exclusive breast feeding, yet the study they cite in support is not relevant. They omit to mention important related factors, including the increased bioavailability of iron in breast milk and increased infection in infants who are not breast fed.

Why choose to examine this topic? The optimum duration of exclusive formula feeding is a more pressing public health question. International recommendations on the timing of introduction of solids are based only on evidence on exclusive breast feeding, and evidence on the health consequences of exclusive formula feeding after four months is completely lacking.

This paper has not advanced knowledge but confused and misled; it is also likely to have increased international sales of formula milk. Peer review by those with knowledge of the field should have prevented that.



**Mary J Renfrew** professor of mother and infant health, and director, Mother and Infant Research Unit, Department of Health Sciences, University of York, Area 4, Seebohm Rowntree Building, York YO10 5DD, UK [mary.renfrew@york.ac.uk](mailto:mary.renfrew@york.ac.uk)

**William McGuire** professor of child health, Hull York Medical School, John Hughlings Jackson Building, University of York, York YO10 5DD, UK

**Felicia M McCormick** research fellow, Mother and Infant Research Unit, Department of Health Sciences, University of York, Area 4, Seebohm Rowntree Building, York YO10 5DD, UK

**Competing interests:** None declared.

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Cite this as: *BMJ* 2011;342:d987

## Infection more important than anaemia or allergy

It seems extraordinary that concern about possible effects on iron deficiency and coeliac disease should lead Fewtrell and colleagues to suggest shortening the recommended duration of exclusive breast feeding, when they acknowledge that longer durations of exclusive breast feeding are associated with substantial reductions in infectious diseases.<sup>1</sup> Excellent research evidence suggests that this effect applies to children in affluent as well as deprived societies.<sup>2-3</sup> Visit any UK paediatric ward and you will find it teeming with infants with infections, not iron deficiency and coeliac disease. Inevitably harms as well as benefits are associated with deferring solids, and the World Health Organization determined the age at which equipoise between the two was reached.

It also seems extraordinary that the *BMJ* published this highly subjective article in the same issue in which it repeatedly castigated the *Lancet* for its behaviour in relation to MMR.<sup>4</sup> Many children will lose the protective benefit of breast milk as the result of the *BMJ*'s inflammatory publicity and become ill as a consequence. Will the *BMJ* next mount an exposé of its own irresponsibility?

**Charlotte M Wright** professor of community child health, University of Glasgow, Glasgow, UK [charlotte.wright@glasgow.ac.uk](mailto:charlotte.wright@glasgow.ac.uk)

**Competing interests:** None declared.

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Cite this as: *BMJ* 2011;342:d1000

## RESPONSE Scientific Advisory Committee on Nutrition replies to Mary Fewtrell and colleagues

Fewtrell and colleagues selectively reviewed evidence on the appropriate age at which to introduce complementary food into the diet of breastfed infants.<sup>1</sup> We comment on several of their statements about the role of the Scientific Advisory Committee on Nutrition (SACN) in advising UK governments on this issue. SACN is a committee of independent experts appointed under Nolan principles to advise these governments.

It is incorrect that SACN "was not asked to formally consider the scientific evidence" supporting the World Health Organization's revised recommendations on breast feeding in 2001. The issue was initially considered in 2000 at a meeting chaired by the inaugural chair of SACN. It concluded: "There is sufficient scientific evidence that exclusive breast feeding for six months is nutritionally adequate." SACN endorsed this view in 2001, acknowledging the need for flexibility since mothers may introduce complementary foods earlier than this for personal, social, and economic reasons. It nevertheless stated these should not be given before the end of four completed months.<sup>2</sup>

SACN has subsequently published reports and commentaries on several topics relevant to Fewtrell and colleagues' review. All have been published and most were open to public consultation. Thus "broad professional consultation" has always been part of the SACN process. Fewtrell and colleagues did not acknowledge three reviews:

- In 2007 SACN recommended adoption of the 2006 WHO international growth standard for children up to 5 years old.<sup>3</sup> This describes the growth of exclusively or predominantly breastfed infants receiving complementary foods at an average age of 5.4 months<sup>4</sup>; this pattern of growth is internationally acknowledged as compatible with both short term and longer term infant health. This work was conducted collaboratively with experts nominated by the Royal College of Paediatrics and Child Health
- SACN will endorse the adequacy of iron and energy supply during exclusive breast feeding in forthcoming reports that were open for public consultation in 2010.<sup>5</sup> These examine the issues in depth and do not support the views of Fewtrell and colleagues
- SACN and the Committee on Toxicity (COT) have reviewed evidence relating the risk of coeliac disease and type 1 diabetes to the age at which gluten is introduced into an infant's diet.<sup>6</sup> The committees do not consider evidence sufficient to support introduction of gluten between 4 and 6 months of age. Fewtrell and colleagues suggest that changes to infant feeding policy should

be subject to audit but fail to acknowledge that infant feeding policy has long been evaluated closely in the UK. Quinquennial surveys of infant feeding have documented trends since 1975, and a government funded national survey of the diet and nutritional status of infants and young children is in progress. Following changes to policy in 2003, the proportion of mothers in the UK introducing solids before 4 months of age fell to 51% from 85% in 2000.<sup>7</sup> The proportion introducing solids before 3 months more than halved. SACN believes that these changes will benefit infant health<sup>8</sup> and does not share the concerns of Fewtrell and colleagues.

Interpreting evidence relating infant feeding to health poses many challenges, but these are common to many areas of public health nutrition. SACN combines evidence from a range of sources to provide balanced advice to government.<sup>9</sup> Fewtrell and colleagues thus suggest nothing new in asking for "a synthesis balancing the risks and benefits of the proposed intervention, accounting for a range of possible outcomes."

SACN's advice to government on the nutritional adequacy of exclusive breast feeding for six months remains unchanged. The committee continues to review all new evidence and in September 2010 started investigating the scope of a detailed review of the scientific evidence underpinning infant and young child feeding policy.

**Anthony F Williams** chair, SACN Subgroup on Maternal and Child Nutrition (SMCN)

**Ann Prentice** chair, Scientific Advisory Committee on Nutrition (SACN), SACN Secretariat, Department of Health, London SE18UG

**Competing interests:** None declared.

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Cite this as: *BMJ* 2011;342:d980