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LETTERS

GH IN IDIOPATHIC SHORT STATURE

What illness is being treated?

Albertsson-Wikland overstates the case for treating idiopathic short stature with growth hormone.[1] The studies may, for example, have been confounded by including small for dates babies. She also states that child growth is an integral marker of health but not whether this applies to normal children.

Children with idiopathic short stature are normal but small. By definition they do not have a recognisable disease as generally understood. Their "illness" seems to be wholly defined by statistics and parental over-expectations. I do not see children with idiopathic tall stature being given growth hormone antagonists. I therefore have serious doubts about the ethics of "treatment" for a poorly defined "illness."

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Competing interests: None declared.

1 Albertsson-Wikland K. Growth hormone in children with idiopathic short stature. *BMJ* 2011;342:d1248. (14 March.)

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Aren't there better ways of spending the money?

Deodati and Cianfarani found an average gain in height of 4 cm in children with idiopathic short stature given injectable growth hormone (GH).[1] Such treatment has unknown later risks to health and is of questionable benefit to the individual.[2 3]

I calculate that the cost of growth hormone for 4 cm in one child would provide 200 000 doses of measles vaccine or 28 village pumps for sub-Saharan Africa. Shouldn't global ethics be considered?

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Competing interests: JKW prescribes growth hormone from all current UK manufacturers for current licensed indications detailed in the *BNF for Children*.

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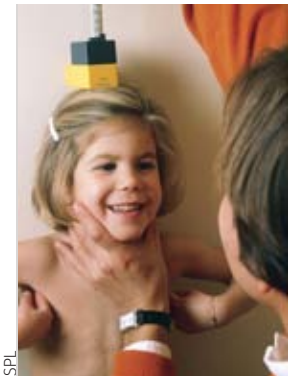
SACN IRON RECOMMENDATIONS

Pregnancy is a special case

The recent Scientific Advisory Committee on Nutrition (SACN) report recommends reducing red and processed meat consumption to 70 mg/day because of links with colorectal cancer.[1 2] This recommendation is largely based on evidence from prospective studies in middle aged and elderly participants.

Around 25% of women of reproductive age in Western societies have iron deficiency anaemia,[3] which during early pregnancy increases the risk of preterm birth, low birth weight, infant mortality, and iron deficiency.[4] Around 41% of women under 34 years have dietary iron intakes less than the lower reference nutrient intake of 8 mg/day according to the national diet and nutrition survey in Great Britain, and this was true of one in four women in our study of around 1300 pregnant women in Leeds.[5]

The National Institute for Health and Clinical Excellence antenatal guidelines recommend investigating haemoglobin <110 g/L in the first trimester or 105 g/L at 28 weeks and considering iron supplementation. The problem arises when supplements are abandoned because of common side effects such as nausea and constipation. Current UK antenatal care does not provide specific dietary advice in relation to iron intake during pregnancy. Recommending meat as the source of the readily absorbed haem iron during the limited span of pregnancy is unlikely to have adverse effects in relation to lifetime risk of colorectal cancer. A public health approach towards increasing dietary iron intake and optimising iron absorption from non-haem sources, whether from diet or supplements, during pregnancy is needed.



SPL

We recommend considering iron intake during pregnancy separately from lifelong recommendations for red meat intake.

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Competing interests: None declared.

1 News. In brief. *BMJ* 2011;342:d1338. (1 March.)
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Cite this as: *BMJ* 2011;342:d1783

ATYPICAL ANTIPSYCHOTIC DRUGS

Two points of clinical interest

Two points of clinical interest add to Mackin and Thomas's summary of the indications for and use of atypical antipsychotic drugs.[1]

Firstly, up to 5% of patients with schizophrenia commit suicide,[2] which is similar to the rates in major depression and considerably higher than those in the general population. Suicidal ideation at initial presentation is thought to predict suicide attempt in the near future.[3] Clozapine is the only antipsychotic drug with an anti-suicidal effect,[4] so it may be useful in clinically significant suicidal ideation, especially secondary to psychotic symptoms.

Secondly, recent long term follow-up data suggest that antipsychotic use may be an independent risk factor for generalised and specific reduction in grey matter volume.[5] This effect was dose dependent, the changes were subtle, and atypical antipsychotics were milder than typical antipsychotics. Antipsychotic use must therefore be judicious and the minimal effective dose tailored to each patient.

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Competing interests: None declared.

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OSTEOARTHRITIS EXCESS MORTALITY

Painful limping and early death

If people with a painful limp would take more exercise, they would live longer; that is the perverse conclusion of a cohort study and accompanying editorial.[1 2] Most people with a painful limp would find this suggestion unhelpful.

Neither article makes much of the overwhelming dominance of age as a risk factor: an effect 20 times more powerful than any other in this study.

Age is a fair but imperfect surrogate for "miles on the clock," as any car dealer will confirm. This leads to a simpler conclusion that does not rely on a chronic inflammatory or osseovascular conjecture. Joints usually wear out through overuse. This fatigue failure is associated with overuse of other structures such as heart valves, arteries, and veins, which share the same barely measureable metabolic rates and minimal ability to heal.

The implications of this more physical explanation are the exact opposite of those proposed, but are true for any mechanical mode of transport—that wearing out can be delayed by careful use or accelerated by overuse, overloading, or faulty materials. If a knee does start to wear out, the timely partial replacement of the worn out part may not prolong the life of a body that is already wearing out, but it will enhance the quality of life in a highly cost effective way.[3] Preventing humans from wearing out painfully while trying to maintain a healthy and fulfilling lifestyle is a much tougher proposition.

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Competing interests: None declared.

1 Nüesch N, Dieppe P, Reichenbach S, Williams S, Iff S, Jüni P. All cause and disease specific mortality in patients with knee or hip osteoarthritis: population based cohort study. *BMJ* 2011;342:d1165. (8 March.)
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Cite this as: *BMJ* 2011;342:d2137

NEW MENTAL HEALTH STRATEGY

Uncosted, unrealistic strategy

Thornicroft is right to criticise the new mental health strategy for being uncosted and lacking an implementation plan.[1] The overarching theme of the strategy represents a misguided, somewhat soft headed, utopianism, focused on wellbeing and mental good health, as though a happy society and a reduction in serious mental illness are directly connected. They are not. Events and circumstances, often unavoidable, play a large part in the origins of serious disorders, but only a part.

The broader public health issue of mental wellbeing and the aim to intervene to prevent the experience of distress are legitimate national strategic objectives. Emotional human misery and minor psychiatric morbidity cost England around £105bn (€119bn; $168bn) every year. National wellbeing should therefore influence our approach to economics, but this document will largely be read by health and social care providers for whom it is largely irrelevant.

The wider availability of psychological treatments is welcome, but again I have doubts about what Marjorie Wallace at SANE recently referred to as the "therapy for the nation" strategy, which comes across as a panacea for the whole spectrum of mental health conditions and is being launched against a background of active planning for cost improvements of about £20bn in the NHS, with local authorities shamelessly slashing community services.

Mental health strategy should focus primarily on people whose lives are so often wrecked by serious mental illness. It has to be fit to be translated into measurable outcomes for the new Commissioning Board and turned easily into commissioning intentions by GP consortiums.

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Competing interests: EM is secretary to the All Party Parliamentary Group on Mental Health.

1 G Thornicroft. A new mental health strategy for England. *BMJ* 2011;342:d1346. (18 March.)

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EVIDENCE BASED POLICY MAKING

How can it be achieved?

Politicians consider their policies to be evidence based,[1] so why are clinicians so dissatisfied with the level of evidence that underpins policies?[2]

Clearly clinicians and politicians mean different things by "evidence" and "evidence based." In medicine, expert opinion is derided as level 5 evidence,[3] yet the Cabinet Office recommends consulting experts or consultants as one of four key points of evidence based policy making,[4] along with reviewing and commissioning research and considering a range of properly costed and appraised options.

Policy makers are attempting to practise evidence based policy without the underlying processes for assessing evidence having been fully developed or utilised.

There is a distinction between practising evidence based medicine—making decisions on the basis of the available evidence—and the discipline of evidence based medicine—the development of processes by which evidence is created, collated, and appraised. Thanks to the evolving discipline we have methods and processes for finding, assessing, and disseminating evidence. It is only the robustness of these underlying processes that allows the practice to be successful.

A parallel discipline of evidence based policy must be developed to assess the extent, weight, and quality of available evidence before using it in practice. Until then clinicians will be rightly suspicious of evidence based policies that may be built on sand.

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Competing interests: None declared.

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NATIONAL ALCOHOL PLANS

New Zealand's alcohol plan is less than "half hearted"

We are not surprised that experts have walked out of working with the government in England to reform alcohol policies.[1]

In New Zealand, where a new Alcohol Reform Bill is currently before a select committee, the government showed similar signs of being influenced by vested interests by ruling out changes to "excise tax" even before the select committee process began. This was despite the importance of price being highlighted in a major recent report reviewing New Zealand's alcohol laws,[2] and the increasing affordability of alcohol.[3]

Similarly, the government refuses to reduce the country's comparatively high blood alcohol limits for driving, despite popular support for this measure. In addition, the proposed reforms hardly touch the issue of advertising and sponsorship of alcohol, despite such controls for tobacco being pioneered in New Zealand in 1990.

If governments are to reduce the harm from alcohol they must focus on public health and societal wellbeing—and stop trying to keep the alcohol industry happy.

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Competing interests: None declared.

1 O'Dowd A. BMA and others walk out of "half hearted" national alcohol plan. *BMJ* 2011;342:d1659. (14 March.)
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Cite this as: *BMJ* 2011;342:d2147