Correspondence

Circumcision ‘on the NHS’: is available in NHS Scotland and prioritized by the public

Paranthaman and colleagues’s paper on commissioning circumcision services (JPH 2011;33:280–283) for non-therapeutic indications in the NHS, tells us (repeatedly) that the NHS does not provide this procedure. The NHS choices website also says the same (http://www.nhs.uk/Conditions/Circumcision/Pages/Introduction.aspx, accessed 13/6/11). They are both wrong. The procedure is available in NHS Scotland and those interested can read the Scottish Government’s guidance (http://www.refhelp.scot.nhs.uk/index.php?option=com_content&task=view&id=537&Itemid=227, accessed 13/6/11).

It is too easy to make general recommendations for improvement in the NHS, rather than pointing to available policies and delivery options within the NHS. This lapse is all the more surprising given that the second author hails from Edinburgh, Scotland.

In an era where the patient’s voice and choice is supposed to drive service provision it is worth noting that a study done some years ago showed, unsurprisingly, that Pakistani patients in the northeast of England gave high priority to circumcision on the NHS.1 It is likely that such views are even firmer now given the kind of complications reported by Paranthaman and colleagues.

Reference


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The ‘Pounds for Pounds’ weight loss financial incentive scheme: an evaluation of a pilot in NHS Eastern and Coastal Kent

Reading the paper by Relton et al.1, I was surprised by the conclusion of the authors suggesting that money incentives could be an option to tackle obesity in light of the results of their study.

We already know from previous studies, as well as daily clinical practice observations, that a mean weight loss of most conservative therapeutic weight loss programmes is about 5–6 kg after 1 year.2 Therefore, we cannot consider as particularly successful a program that, according to the authors themselves, achieved a clinically significant weight loss—of 5% or more of body weight—in 45% of participants, and an estimated weight loss at 12 months of 4 kg.

Moreover, we know that for a person who has been obese it is difficult to maintain the weight loss. Also continuation of the programme cannot prevent a moderate weight increase in the follow-up year. A longer follow-up, 24 months in my opinion, would have been preferable, as it was chosen in the DIRTECT study.3

Also optimistic was working under the assumption of return-to-baseline weight for those who had left the programme before reporting a 12-month weight.

Most patients do progressively gain body weight and in fact we know that the mean BMI increases in both genders by age.

Thus, the assumption was probably wrong.

I would be particularly interested in seeing what has happened to the obese patients, particularly those with BMI >35, after 24 months.

In my opinion, weight reduction per se should not be our ultimate goal.

In fact, the best action plan would be limiting the number of people reaching the obesity threshold and when obesity is already established, we should aim to nothing less than achieving normal body weight limits, particularly in those patients without co-morbidities affecting their mobility.

There is no doubt that the lifestyle intervention required to keep patients away from obesity is far more likely to be successful, particularly in the long-term, than tackling established obesity. This is most obvious for morbid obesity.