



**UK National Screening Committee
Screening for obesity in children –an evidence review**

Consultation comments pro-forma

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Do you consent to your name being published on the UK NSC website alongside your response?			
Yes			
For which evidence summary are you submitting comments?			
<ul style="list-style-type: none"> • Screening in children between 7 and 11 years of age 			
Section and / or page number	Text or issue to which comments relate	Comment	
		<i>Please use a new row for each comment and add extra rows as required.</i>	
Findings and gaps in the evidence p 6	'Child obesity may be a clear risk factor for adult obesity...'	The consistent evidence from large prospective cohort studies that child obesity in 7-11 years increases risk of adult obesity suggests that screening in this age group may be beneficial. The clear evidence that adult obesity impacts negatively upon	

		<p>numerous health outcomes therefore suggests that screening in children aged 7-11 years should be promoted.</p>
<p>Findings and gaps in the evidence p 6</p>	<p>'It is estimated that about 30% of obese adults would have been obese as children'</p>	<p>We accept the uncertainties within the data, and that this analysis did not include screening in adolescents. A higher proportion of obese adults may have been obese as adolescents than as children. Nonetheless 30% is a substantial proportion of adults exposed to the potential harms of excess adiposity over decades, and there are no doubts about the health risks associated with adult obesity. In addition, recently published data which included >50,000 children demonstrated that tracking of obesity from children aged as young as 3 years of age into adolescence was the norm (https://www.nejm.org/doi/full/10.1056/NEJMoa1803527). We would also like to draw attention to the current consultation on mandatory calorie labelling for foods and drinks in the out-of-home sector (https://www.gov.uk/government/consultations/calorie-labelling-for-food-and-drink-served-outside-of-the-home). Part of the stated evidence base for this is that 'obese children tend to remain overweight and become obese adults. Moreover, the more obese the child is, the higher the chance of them becoming an obese adult'. We urge that this new evidence is taken into account.</p>
<p>Basis for current recommendation p8</p>	<p>Point 3: 'Without evidence for a safe effective treatment that gives long term benefit, the value of obesity detection would be questionable'</p>	<p>No evidence of effect is not the same as evidence of no effect. No harm of multicomponent behavioural treatments has been demonstrated, and a gap in the literature with regard to long term follow up of interventions should not be a reason for not identifying those at risk. In addition some multicomponent interventions commissioned are linked to improved self-esteem and quality of life.</p>

Basis for current recommendation p9	'Primary prevention of obesity in children was likely to be the most cost effective step...'	We agree that primary prevention is ideal and support the current work being undertaken in particular by PHE and SACN in this regard. However primary prevention even if effective will not address the issue in those children already carrying excess body fat, and it is those children who may be missed without screening. Given the higher prevalence of overweight and obesity with deprivation, this could result in further disadvantage to an already vulnerable group.
Discussion of question 1 evidence, Simmonds et al HTA p16	"Additionally the cohorts commenced many decades ago. There are differences in terms of environmental and lifestyle factors between children today and those born 30 to 60 years ago.'	We agree and this is a significant problem inherent in long term cohort studies. However the environmental and lifestyle risk factors for excess weight are much greater now than they were 30 to 60 years ago, thus it is our view that cohort studies may well underestimate any such associations.
Discussion of Simmonds findings in relation to risks of adult morbidity p19	"High child BMI is associated with statistically significant increased risks of adult CHD and type 2 diabetes'	Although we accept that the limitations within the data make a definitive answer difficult, the previous point is also relevant here. There appears to be more clarity with regard to type 2 diabetes and the costs of type 2 diabetes are substantial in terms of individual, health and social care costs.
Summary p21	'Most children who are obese between these ages will be obese adults' and 'This means that treatment/preventative interventions targeted at obese children may have limited impact in tackling adult obesity'	Limited impact does not mean no impact. This data suggests that identifying obese children between 7-11 years will be effective in identifying many obese adults of the future. This suggests that <u>in addition</u> to identifying these children, how the 70% of obese adults who were not obese as children can be identified also needs to be addressed. BOTH cohorts need to be identified.
Discussion p35	'The BMI reduction compared with control is statistically significant but whether the difference would have meaningful clinical effect is unclear and was not reported by the studies.....Whether interventions could reduce risk of cardiometabolic morbidity such as type 2 diabetes or hypertension is	A small reduction in BMI in a large group of children may well have significant public health impact, particularly if it was maintained in the longer term. The Foresight report of 1998 was clear that doing nothing was not an option, and evidence should be gathered alongside interventions. Small reductions in BMI in obese children occurring where increasing efforts

	also unclear”	are being made to address environmental cues which encourage underactivity and overconsumption may well be clinically significant but this is data which needs to be gathered prospectively.
Summary: criterion 10 not met p37	‘There is limited follow-up available beyond 12 months....’	No evidence of longer term impact is not evidence of no effect. This data is needed.
Conclusions p38	‘Therefore identifying and treating obese children may be of limited value for identifying all those who may be at risk in adulthood and reducing the overall prevalence of obesity’	We do not agree that this is a reason not to act. In our view this suggests that in addition to screening in children aged 7-11 years, additional screening opportunities to identify the 70% of obese adults who were not obese as children is needed. Exactly when this should occur needs to be ascertained.
Limitations of the rapid review process p39 & 40		We agree that this process results in significant limitations and attempts to address these have been made. However the age groups appear somewhat arbitrary, in that some 6 year old children have been included in this review and others in the sister review (screening in children ≤ 5 years). Data from some 12 year old children has been included in this review. It is not clear why this review was not for children aged 6-12 years. However whether or not this would impact on the findings of the review is not clear. While we accept that BMI alone is not the most reliable weight measurement tool for individuals, it remains the most practical screening tool available.
		We note the publication of the recent report on child health from the Royal College of Paediatrics and Child Health (https://www.rcpch.ac.uk/resources/state-child-health). The recommendations of the report include ‘opportunistic recording of weight and BMI of all children (2-18 years) once a year’. The findings and recommendations of this rapid review are in stark contrast to that of experts and practitioners in the area of child health.

		We strongly disagree with the recommendations of the committee for the reasons above. In our view, <u>more</u>, not less, screening is needed. We urge the committee to reconsider their proposal and in particular to take newly published evidence into account.
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Please return to the Evidence Team at screening.evidence@nhs.net by 21 October 2019