In brief

GMC faces legal threat: Former patients of British gynaecologist Richard Neale, who was struck off the medical register in 2000, have threatened the General Medical Council with legal action, after the council told an inquiry that it was notified in 1985 of his being struck off in Canada. The GMC put his name on a "stop list" for immigrating doctors, without realising that he was already registered with the council in the United Kingdom.

Payments to be made for hepatitis C error: England's health secretary, John Reid, is to establish a financial assistance scheme for people who contracted hepatitis C as a result of being given infected blood products by the NHS. The details of the payments are yet to be worked out.

Dutch pharmacists to dispense cannabis: The Netherlands has become the first country to make medical cannabis available on prescription from pharmacists. The cannabis will be distributed through its ministry of health. Two firms will grow the cannabis exclusively for the government, which will be available for conditions such as multiple sclerosis and chronic neurological pain, and as palliative care for patients with cancer and AIDS.

Obesity report calls for advertising restrictions: The European Union should clamp down on food advertising to children, the International Obesity Task Force said in a report published this week. Philip James, the task force's chairman, told an EU conference in Milan that "hard sell" advertising contributed to growing rates of overweight or obesity in the region's children (*Waiting for a green light for health?* is available at www.iof.org).

Consultants decide to ballot: The BMA's Central Consultants and Specialists Committee has decided to ballot all consultants and specialist registrars in England over the proposed new consultant contract. The date of the ballot is still to be announced. Details of the proposals will be sent to the consultants, says the BMA.

US paediatricians call for checks for childhood obesity

Scott Gottlieb *New York*

The American Academy of Pediatrics has called on its members to make obesity screening and counselling a routine part of children's check ups, like testing reflexes or administering immunisations.

The report offers paediatricians procedures to identify patients and intervene before their weight problems start, rather than waiting until children are too heavy. After children have gained too much weight, the report says, it can be hard for them to lose it.

"Abundant opportunities exist for pediatricians to take a leadership role in this critical area of child health, including action in the following areas: opportunities for physical activity, the food supply, research, and third-party reimbursement," the report reads. "Change is desperately needed in opportunities for

Boy at fat people's festival, USA

physical activity in child care centres, schools, after-school programs, and other community settings. As leaders in their communities, pediatricians can be effective advocates for health-

and fitness-promoting programs and policies."

Dr Nancy Krebs, a paediatrician at the University of Colorado and a lead author of the report, said, "In the last five years, with both adults and paediatrics, there's certainly been a trend toward saying, 'Treatment success is so bleak, we've got to stop it because we can't treat it once it [obesity] occurs.'"

The authors of the report acknowledge that effective strategies for controlling weight in children are extremely limited. But they add that the scale of the obesity epidemic makes it urgent for paediatricians to start acting.

"If you look at the number of kids who are overweight or at risk," Dr Krebs said, "you are talking over 25% of our kids. If some infectious disease was affecting 25% to 30% of our children, you can be sure we'd be looking for some kind of vaccine." □

Prevention of Pediatric Overweight and Obesity is available at www.aap.org/policy/s100029.html

European society issues guidelines on cardiovascular disease

Susan Mayor *London*

New European guidelines extend recommendations for the prevention of coronary heart disease to cardiovascular disease and advise more aggressive interventions in high risk patients to reduce disability and premature deaths.

Announcing the guidelines at the European Society of Cardiology's annual congress in Vienna, Austria, last week, David Wood, professor of cardiovascular medicine at Imperial College, London, and a member of the guideline development task force, said: "The most important development in the new guidelines is that they cover atherosclerotic cardiovascular disease as a whole rather than focusing just on the prevention of coronary heart disease."

He explained that this

change recognised that atherosclerotic disease shares similar risk factors and benefits from interventions wherever it is expressed—in the heart, brain, or peripheral vasculature.

"Recent intervention trials have shown that several forms of therapy prevent not only coronary events and revascularisations but also ischaemic stroke and peripheral artery disease. Therefore, these new guidelines deal with cardiovascular disease prevention, not merely coronary heart disease," he noted.

The new guidelines aim to reduce the incidence of first or recurrent clinical events caused by coronary heart disease, ischaemic stroke, and peripheral artery disease (*European Heart Journal* 2003;24:1601-10).

The guidelines have introduced a new multifactorial risk model—the SCORE model, based on European data—to improve the accuracy of risk assessment for cardiovascular disease. Previous guidelines calculated coronary heart disease risk on the basis of US data, from Framingham, Massachusetts.

The new guidelines have also redefined priorities for prevention of cardiovascular disease and

tightened the goals for higher risk patients. The first priority for preventive measures remain patients with established cardiovascular disease, including those with cerebrovascular disease and peripheral artery disease, as well as coronary heart disease. The next priority is asymptomatic individuals at high risk of developing coronary heart disease because they have multiple risk factors.

Patients with type 2 diabetes or with type 1 diabetes with microalbuminuria have been moved up to the high risk group, in recognition that they have multiple risk factors.

The guidelines have set goals for most patients and for the normal population of <5 mmol/l for total cholesterol level and <3.0 mmol/l for low density lipoprotein (LDL) cholesterol.

However, for patients with atherosclerotic disease, including those with diabetes, they have tightened targets for total cholesterol (to <4.5 mmol/l) and for LDL cholesterol (to < 2.5 mmol/l).

Blood pressure targets have also been tightened, to less than 130/80 mm Hg for patients with established cardiovascular disease or diabetes. □