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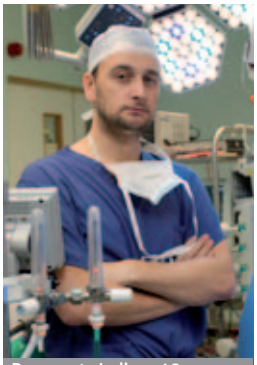
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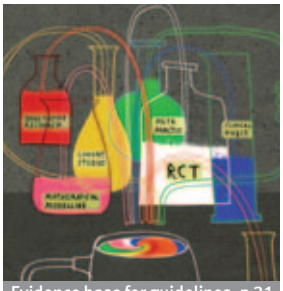

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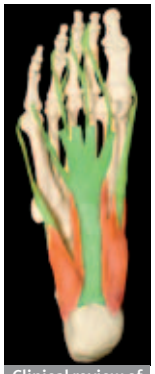
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THE CENTRAL SCOTLAND NEWS AGENCY

PICTURE OF THE WEEK

Illustration from the *De Hortus Sanitatis* or *Garden of Health* showing a consultation between two physicians in a sick room. This book is one of the earliest European medical texts and was first printed in Germany in 1491. It contains detailed writings and annotated illustrations on plants, herbs, animals, and minerals, and striking depictions of mediaeval medical practice.
It was once owned by George Peacock, an Aberdeen apothecary who taught at the Marischal College. The book is on display at the University of Aberdeen in the Pharmacopoeia exhibition, which runs until 1 December.

▶ **ANALYSIS**
Adapting clinical guidelines to take account of multimorbidity, p 22

RESPONSE OF THE WEEK

The excellent comprehensive article by Shields and colleagues has been written from the viewpoint of doctors and paramedical staff. Parents are often worried by their perception that their child's weight is faltering between the age of 10 months and two years. The child becomes thinner and there is a marked decrease in appetite. The change in shape from the infant to the child occurs at this time. BMI and skinfold thickness charts have a downward curve for all centiles during this period and show that the weight pattern is physiological.

Parents do not have this information and offer more tempting food which contains more sugar, fat and salt. A pattern of eating is started which may be permanent and lead to obesity.

Bernard Valman, emeritus consultant paediatrician, Northwick Park Hospital, Harrow, UK, in response to "Weight faltering and failure to thrive in infancy and early childhood" *BMJ* 2012;345:e5931

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Early fluid resuscitation in severe trauma
Diagnosis and management of headaches in young people and adults: summary of NICE guidance

BMJ.COM POLL

Our last poll asked:"Would a 'tan tax' on indoor tanning salons be an appropriate deterrent?"

55% voted yes (total 664 votes cast)

▶ Research (*BMJ* 2012;345:e4757 and *BMJ* 2012;345:e5909)
▶ Personal View (*BMJ* 2012;345:e6550)

This week's poll asks: "Is overtreatment an inevitable consequence of market based healthcare systems?"

▶ Feature (*BMJ* 2012;345:e6230)
▶ Vote now on bmj.com

EDITOR'S CHOICE

Depression and other things

Could it be that prevention programmes based on cognitive behavioural therapy don't work after all?

The prevalence of depression rises steeply in mid-adolescence, say Sally Merry and Karolina Stasiak in an editorial this week (p 8). This makes school a logical place for prevention programmes. The school based "resourceful adolescent programme" performed well in Australia and New Zealand, in a randomised trial on which Merry was an author. But Paul Stallard and colleagues have now tested the approach in eight schools in the UK and found no significant benefit compared with a placebo, despite good fidelity to the programme in the intervention groups (p 13). Their randomised trial found that adolescents who received the intervention reported more depressive symptoms.

Could it be, ask Merry and Stasiak, that prevention programmes based on cognitive behavioural therapy don't work after all? This latest trial is, they say, a timely reminder of the need for caution and for careful systematic research into this costly disorder.

Andrew Hill, the teenage author of this week's patient journey, knows the personal cost of depression. After what seems to have been successful and well coordinated treatment for non-small cell lung cancer (p 43), depression often leads him to hope for the disease to return, just to end the uncertainty, something that those around him find it hard to understand.

His story reminds us that depression is complex, not least because it rarely exists on its own. According to a recent analysis of electronic health records from UK primary care (*Lancet* 2012;380:37-43), only about a quarter of people with depression are free of other chronic conditions. As summarised in the figure in this week's Analysis (p 22), those aged under 65 years had on average 2.6 other conditions, with an average of 4.9 in those aged over 65. Pain is depression's most common bedfellow.

Building on these data, Bruce Guthrie and colleagues explore how clinical practice guidelines could do more to help clinicians and patients manage multimorbidity. Few guidelines take the leap beyond a single disease—the NICE 2009 guidelines on depression in adults with a chronic physical health problem are a notable exception. The authors propose more cross referencing between recommended treatments, and they give an example of how this might work for an elderly patient with hypertension, atrial fibrillation, osteoarthritis, and moderately severe depression.

Doing this across the whole of medicine and then keeping it up to date represents a sort of holy grail for healthcare. We must seek it, but even if we find it through new technology, it is unlikely ever to replace clinical judgment. Much the same can be said for efforts to integrate different types of evidence into guidelines, as Tuen Zuiderent-Jerak and colleagues report (p 31).

As for how clinicians handle multimorbidity, more time to talk to patients would surely help, though, as Umesh Kadam writes (p 10), there is little evidence to support this: most of the evidence for longer consultations in primary care has focused on patient satisfaction rather than clinical outcomes. Perhaps we need to think more radically. How can we best redesign consultations for patients with complex needs? Tell us what you are doing.

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