hypothesised advantages of bioresorbable stents were not readily detectable: neither vasemotion in the stented segment nor angina relief as reported by patients were superior to conventional stents. An increase in vessel dimensions due to positive remodelling as the scaffold degrades could also not be demonstrated. This finding suggests that in testing these scaffolds the well-established endpoints used in the evaluation of conventional stents remain the benchmark of choice. In this respect, antiplatelet efficacy, measured using late loss, was inferior to that of current generation drug-eluting stents. Moreover, the rate of stent thrombosis was significantly higher with bioresorbable scaffolds, with an excess of very late thrombotic events more than a year after stenting. This finding adds to concerns in relation to early outcomes in previous trials, and is in keeping with 2 year data from another recently reported clinical trial showing numerically more stent thrombosis after 1 year with bioresorbable scaffolds compared with standard stents.

Looking forward, two questions need to be answered. First, although the clinical outcome data from ABSORB II are concerning, it should be noted that the study was not powered for clinical endpoints. In particular, it remains to be seen whether the adverse safety signal is a real finding. For this reason, regardless of the follow-up protocol originally planned, ongoing large-scale trials with bioresorbable scaffolds should schedule additional evaluations and report 3 year outcomes for all patients. Ultimately, this represents the best chance to assuage concerns arising from the observations of Serruys and colleagues. Second, these data emphasise the need to redefine the optimal intensity and duration of dual antiplatelet therapy in patients treated with these devices. For although expectations regarding late performance have not been realised to date, the obvious advantage of a stent that disappears remains a goal worth pursuing.

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4 Serruys PW. Observations from the recent FDA Circulatory System Devices Panel meeting on bioresorbable vascular scaffolds. EuroIntervention 2016; 11: e1569–70.

Rethinking primary care systems for obesity

Paul Aveyard and colleagues, in The Lancet, provide optimistic news for the management of obesity in primary care. In this parallel, two-arm, randomised trial of screening and a brief intervention for obesity in primary care, Aveyard and colleagues identified a net weight loss benefit at 12 months from a 30 s active intervention by primary care physicians. A striking feature of the study was that patients with obesity (body-mass index of at least 30 kg/m² or at least 25 kg/m² if of Asian ethnicity) were invited to participate with no assessment of their readiness to change, yet the majority (2263 [83%] of...
2728 potentially eligible participants) were willing to do so, of whom 1882 individuals were eligible to enrol in the trial. 940 patients in the active intervention group were offered a specific appointment (made before leaving the clinic) to a weight management group (12 sessions of 1 h each, once per week) with follow-up support and advice, and 942 patients in the advice only (control) group were simply advised by the primary care doctor that their health would benefit from weight loss. At 12 months, mean weight change was 2·43 kg in the advice plus support group compared with 1·04 kg in the advice only group, giving an adjusted difference of 1·43 kg (95% CI 0·89–1·97). The number needed to treat to achieve a 5% weight loss (about 5 kg) at 12 months was 8·8, which is very good for a preventive intervention. By comparison, the number needed to treat for nicotine replacement therapy with respect to 12 month quit rate is about 15² and exercise prescriptions for 12 month achievement of physical activity guidelines have a number needed to treat of about ten.³

It is surprising that this is the first study in primary care to investigate a brief intervention for obesity, perhaps reflecting the nihilism about weight loss that pervades medical care. A survey of family physicians in the USA found that, of ten chronic disorders, obesity treatment was regarded as less effective than all but treatment for drug addiction.⁴ This finding supports our experience with physicians who report how difficult it is for patients to lose weight and keep it off. Physicians might see the task as being too complex, lack confidence in giving nutrition advice,⁴ or have become disillusioned with the poor outcomes. Clinicians might also fear insulting patients by raising the issue of obesity, yet in this study only four (<1%) of patients said the interventions were inappropriate and unhelpful. Clinicians’ own weight problems might also inhibit discussion, but Perri Klass⁵ suggests that health professionals must acknowledge their own weight struggles and “do the job effectively”. Effective resources are available in the form of commercial weight loss courses, but cost could be a barrier.⁶

Long-term behaviour change is hard and failed attempts at weight loss are ubiquitous. For some patients, such as those with a history of weight cycling, it could be time to move away from the sisyphean task of pursuing weight loss goals and onto achieving other valued health goals.⁷ The efforts needed to yet again break out of the metabolic, physical, psychological, and environmental vicious cycles that trap them in the state of obesity⁸,⁹ might be better directed at healthy eating and physical activity with no further weight gain.

However, far from giving up on weight loss entirely, Aveyard and colleagues’ results should trigger a rethink of the primary care approaches to obesity on two counts. First, the positive results of the 30 s active intervention signal a need for further such studies so that the evidence base for brief interventions for weight management matches that for quitting smoking,¹⁰ exercise prescriptions,⁷ and alcohol problems.¹¹ This brief intervention as part of a usual consultation capitalises on opportunities within the current systems of primary care practice.

The second, bigger rethink is how to work on the systems for primary care to achieve both clinical and population outcomes. The so-called control group in this study was in fact an intervention itself over and above current practice. This control intervention involved physician training on how to discuss weight with patients, addressing of weight bias, weighing of all patients, discussion of weight within the consultation, giving brief advice, and provision of follow-up phone calls and weight measurements. These are all systems changes at a practice level and they resulted in a 12 month weight loss of about 1 kg. Far from being trivial, a 1 kg weight loss or even no weight gain applied at the population level could help to reduce the enormous burden that obesity places on health systems.
Although mass, population-wide weight loss is not a plausible strategy, prevention of age-related weight gain in the adult population is, if primary care systems operated in line with the control condition in this study, they would contribute to progressively reducing adult obesity prevalence.

A primary care system that makes weight a vital sign by actively monitoring weight in all patients and communicating the benefits of normal growth trajectories for children and no age-related weight gain for adults would go a long way to fulfilling its population health potential to prevent the weight-related health problems that fill up its waiting rooms.

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6 year follow-up supports early autism intervention

There have been few large randomised controlled trials of early intervention for children with autism spectrum disorder, even fewer with follow-up data, and none with such a lengthy follow-up period as that reported by Andrew Pickles and colleagues in The Lancet. These researchers assessed long-term outcomes for children who had received a parent-mediated intervention versus treatment as usual nearly 6 years earlier. That earlier study from 2010 was notable for its rigorous methodology.1

The present follow-up study is also worthy of note. To appreciate its importance, some background is needed on the 2010 study. That study was a large randomised controlled trial in which young children (aged from 2 years to 4 years and 11 months) were assigned to receive treatment as usual (n=75) or treatment as usual plus the manual-based Pre-School Autism Communication Trial (PACT) programme (n=77). The PACT intervention is grounded in developmental principles and aims to increase parent sensitivity and responsiveness to child communication through various strategies such as improving parent observation, responsiveness, and focused communication. Compared with other early intervention approaches for young children with autism,2–4 the PACT intervention reported in 2010 was a relatively low-intensity programme. Parents received 2 h clinical sessions every 2 weeks for the first 6 months, followed by monthly booster sessions during the final 6 months. Parents were also asked to implement their newly acquired sensitivity and responsivity skills at home for 20–30 min each day.

The treatment effect was initially viewed as modest,2 but the updated analysis reported in this follow-up study reveals greater improvements in the intervention group than in the treatment-as-usual group. The improvements seen from the initial PACT trial are consistent with results from other randomised controlled trials of early autism interventions.4–6

The follow-up study sought to establish the long-term durability of these initial treatment gains. Follow-up was done at 5·75 years after the trial endpoint and included nearly 80% of the original sample. The resulting data, which were analysed with