

Reply to Letter to: Reference values of waist circumference and waist/hip ratio in children and adolescents of Mérida, Venezuela: Comparison with international references[☆]



Respuesta a Carta a: Valores de referencia de la circunferencia de la cintura e índice de la cintura/cadera en escolares y adolescentes de Mérida, Venezuela: comparación con referencias internacionales

Sir,

We have carefully read the comments in the letter to the editor on our recently published article.¹ The study was indeed conducted in Municipio Libertador of the state of Mérida, as stated in the Materials and Methods section, and was part of a project called "Assessment of growth, development, and cardiometabolic risk factors in schoolchildren and adolescents of Mérida, Venezuela (CREDEFAR)". We agree with the comments in the letter to the editor that any confusion should be avoided from the start of any article. This recommendation will therefore be taken into account, and the title of future CREDEFAR reports will state that data were collected in Municipio Libertador, Mérida, Venezuela.

Our study was observational and cross-sectional. We confirm that both the educational centers and the schoolchildren and adolescents participating were randomly selected following a rigorous plan, as stated in the article: "The sample was selected using proportional stratified, multistage random sampling that guaranteed adequate participation by sex, public or private institution (socio-economic level), and geographical location". The study population consisted of approximately 4000 children and adolescents for each year of age, in accordance with information provided by the educational area of the state of Mérida. As regards sample size, this was estimated based on the mean waist circumference of 58 cm and a standard deviation of 10 cm, as measured in a prior study conducted in our city,² with an alpha error of 5%, a beta error of 20%, a 2% precision, and an a priori power of 80%. Sample size was 94 participants per year of age, i.e. a total of 846 children and adolescents aged 9 to 17 years. This sample size was exceeded, as 919 students were enrolled into our study. Post hoc power was 96.63%. Calculations were also made to ensure that this sample size was adequate to obtain reference values of other anthropometric, clinical, and biochemical measurements, which will be reported soon. As

in other publications,³⁻⁵ such detailed information was not included in the article. However, it was reported in detail in the work project submitted for evaluation to funding agencies, both academic (Consejo de Desarrollo Científico, Humanístico, Tecnológico y del Arte de la Universidad de Los Andes-CDCHTA-ULA) and governmental (Fondo Nacional de Ciencia, Tecnología e Innovación del Ministerio del Poder Popular para la Ciencia, Tecnología e Innovación-FONACIT-MCTI).

The article recommends the use of our references at regional level, because they come from a population in Mérida, in the Andes region, and although some differences exist in its population, our references are undoubtedly closer to reality than those used to date, coming from other countries⁶ where the population is clearly different. As stated in the letter to the editor, national references are available in Venezuela for the vast majority of anthropometric variables, although references for waist circumference are not available yet.

Unfortunately, the literature review made could not find the reference of Hidalgo et al. reference⁷ entitled *Measurement of cut-off points for waist circumference through ROC curves in pediatric population from three Venezuelan regions assessed at the SENACREDH* referred to in the letter to the editor, which would have been worth discussing in our study. This journal has a year's delay in its publications, and was therefore not available at the time of writing our study. It should be noted that as of the current date, October 2013, the most recent number available is the one issued in October 2012.

We hope that the questions posed have been clarified. Research should be stimulated, particularly in training young people. The more that studies of this type, adequately and responsibly designed, are conducted, the greater the knowledge obtained about the behavior of the different anthropometric, clinical, and biochemical variables in our population, so allowing for the establishing of potential differences between the different geographic areas.

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Comments on the «Clinical practice guidelines for the assessment and treatment of transsexuality» issued by the sexual identity and differentiation group of the SEEN (GIDSEEN)[☆]



Comentarios sobre las «Guías de práctica clínica para la valoración y tratamiento de la transexualidad», emitidas por el Grupo de identidad y diferenciación sexual de la SEEN (GIDSEEN)

Sir,

Moreno-Pérez and Esteva de Antonio have recently claimed, on behalf of the Sexual Identity and Differentiation Group of the Spanish Society of Endocrinology and Nutrition (GIDSEEN),¹ that we need a coordinated action protocol to provide integral health care to transsexual people in the framework of the benefits of the National Health System (SNS), i.e. throughout Spain. It is true that such national care to transsexual people does not exist (yet), and it is indeed desirable, particularly in order to harmonize and provide equal health care in all the regions.²

The new 2012 version of the «Clinical practice guidelines for the assessment and treatment of transsexuality»¹ was published in full awareness of the Standards of Care (SOC)-7,³ quoted by Moreno-Pérez and Esteva de Antonio.¹ In the scientific opinion of the author, however, this new version of the Spanish guidelines¹ lacks clarity and topicality in several aspects and demands unnecessary care systems and environments, not to mention some conditions some-

times counterproductive which are mentioned and discussed below:

- 1) The authors state that adequate care to transsexual people may only be provided at the so-called “functional units”. i.e. that the three PES components (clinical psychiatry and/or psychology, endocrinology and surgery) should be concentrated at a single gender identity disorder unit (GIDU) of the same hospital, preferably a teaching hospital. This option may be challenged by arguing that new technologies allow for excellent and fast communications between the different members of the multidisciplinary PES team. If this team does not work at the same clinic, which is very common in other European countries and the United States, transfer of the required information between the psychologist and the endocrinologist, or between these and the plastic surgeon, should suffice. Only a confirmation phone call, which would hardly impair the efficacy of care to transsexual patients, would be required. The same considerations apply to useless patient referrals (e.g. from Asturias to the Malaga GIDU, a trip of 2000 km, just for blood sampling and testing). Instead of this, mutual recognition of clinical test results may be used, because laboratories from all hospitals, not only teaching hospitals, are integrated in a quality control system.
- 2) Moreno-Pérez and Esteva de Antonio¹ emphasize that diagnosis of GID or transsexualism should be a «prolonged and complex process under rigorous, extensive control». Exactly the same definition is found in the Madrid GIDU guidelines, which, unlike those of the Malaga GIDU, do not consider transsexualism to be a mental disease,⁴ while the Barcelona GIDU applies international standards more flexibly, particularly as regards individualized diagnostic times (E. Gomez-Gil, personal information). In the related literature, many authors from other countries have stated that transsexualism, which does not require psychotherapy in most cases, may be diagnosed after only 4–5 appointments of 40–45 min.⁵ SOCs require an accurate, but not necessarily long, evaluation. By contrast, comprehensive evaluation is needed for diagnosis in minors and adolescents, or in patients with some psychopathology.

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