

mandatory submission of FGM statistics by acute trusts (the monthly submission of data by hospitals relating to every case of FGM identified, irrespective of age, to the Department of Health); and (c) the proposed Enhanced Dataset collection. This matters in an environment where doctors risk prosecution for not reporting appropriately.

GPs should be aware that the proposed Enhanced Dataset contains patient-identifiable information. While GMC guidance states that 'personal information can be disclosed if it is required by law',⁴ the benefits of mandatory data submission do not automatically outweigh the potential harm to the patient-doctor relationship and public trust. Our concern is that without assurance of confidentiality, FGM survivors may avoid seeking medical help in general practice, even for non-gynaecological conditions. Either a greater case needs to be made that this patient-identifiable data will prevent FGM or changes must be made to maintain confidentiality.

The classification of labial or clitoral piercings as Type 4 FGM for the purposes of the monthly statistics adds further confusion.² This has the potential to undermine the validity and purpose of the data, notwithstanding the fact that many members of the general public and FGM survivors may find it objectionable that such piercings be considered equivalent to the crime of FGM.

Lastly, it was wrong for the authors to impugn the trainee in obstetrics and gynaecology recently exonerated of FGM when suturing after childbirth as 'claiming to be ignorant of FGM' as if it were untrue, and without declaring the interest that one author had advised the prosecution. The jury's rapid decision to acquit after hearing all the evidence must be respected. Interestingly, in public discussion the breach of patient confidentiality at the heart of the story seems to have been lost.

While government involvement in FGM prevention is welcome, greater caution is required. Inadequately-considered interventions alongside intrusive surveillance within the doctor-patient relationship have the potential to cause great harm.

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Competing interests

SB was a paid expert for the defence in the 2015 R v Dharmasena trial.

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Prevalence of comorbid depression and obesity in general practice

I read with great interest the article by Carey *et al.*¹ As a co-tutor of the master thesis related to a similar topic,² I would like to respond even at this late stage.

A cross-sectional study was carried out among 56 primary care patients, mean age 48.71 years \pm 10.78, 24 overweight women (BMI 25–<30 kg/m²) and 32 obese women (BMI \leq 30 kg/m²), in the city of Niš (south east part of Serbia). The Patient Health Questionnaire (PHQ-9) was used to assess depression.³ A score of \geq 10 on a 27-point scale was used to define clinically-relevant depressive symptoms. Body weight and height were measured to the nearest 0.1 kg and 0.1 cm, respectively, by using standardised equipment and body mass index (BMI) was calculated as weight (kg) divided by the square of height (m²).

The prevalence of depression in our study was similar among overweight and obese participants (48.4% and 51.6% respectively) and significantly higher compared to the prevalence of depression in the general population (between 16% and 34%). However, for only one-sixth (between 12% and 16%) of the participants, a diagnosis of depression has been confirmed. The

most common symptoms of depression were overeating (74.6%) and loss of energy (69.3%). The average PHQ-9 score was 9.967 ± 4.79 , represented mild form of depression. Univariate logistic regression analysis identified the duration of obesity as a risk factor for depression and every year duration of obesity increased the risk of depression for 7.7%.

We have to bear in mind the current social circumstances that have a strong influence on the prevalence of mental disease in the countries in transition. For example, depression is the leading cause of non-fatal disease burden in Serbia. In addition, mental illness is associated with stigma in these countries, so the symptoms of depression may often be overlooked and go untreated in the GP's practice.

To conclude, PHQ-9 is a really useful screening tool for depression for all obese patients attending ambulatory care. Further studies should focus on various socioeconomic and cultural environments and barriers.

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Increasing collaboration between GPs and dental practitioners

GPs, dentists, nurses, care workers, pharmacists, and many others¹ are at the forefront of primary care. Despite differences in working conditions and