

On July 4, 2003, the European Union granted approval for the use of a new drug in all 15 member states (Pfizer 2003). This drug, called Genotropin®, has been formulated to be given to children who were deemed small for gestational age at birth and who have not caught up by the age of four; on the basis that, if they haven't reached above the third percentile on the height chart by then, they probably never will. Pfizer estimate that this situation affects up to ten percent of babies who are diagnosed as small for gestational age at birth, and suggest that these babies are at higher risk of developing metabolic disorders. I can find little evidence that the long-term side effects of this drug have been evaluated, or that the wider context of this intervention has been considered.

This topic was first brought to my attention by a friend of mine, who attended a talk about the benefits of this drug and brought the relevant charts home, thinking it would be fun to put my measurements into the formulas suggested by the pharmaceutical company. Sure enough, at less than five feet, the charts defined me as pathologically short, despite the fact that my parents (whose heights were taken into account in the formulas) are not particularly tall either. If Genotropin® had been around when I was four years old, I would have been diagnosed with *persistent short stature* and deemed a prime candidate.

Yet I find myself wanting to protest that I am not so short that it causes my life to lack quality, and quite concerned about the idea that *persistent short stature* is now seen as a diagnosable medical condition, with the resultant label of abnormality attached. As I see it, some of us need to be on the extremes of any given range; by definition, we can't all fit the mean average. And who is to say that the mean average is the best way of defining normal anyway? As a teenager, I used to joke that I was actually of "normal" height, and that most other people had simply grown too tall. Normalcy, as we have been saying in relation to labour and birth for several years now, is really a matter of perspective.

Perhaps we need to think further about the issues surrounding babies who are considered growth-retarded or small for gestational age. Have we truly thought through the range of social, psychological, political, economic and spiritual issues involved in the causes of smallness, and the ways in which we can address these? Given that midwives spend thousands of hours each year estimating whether babies are growing within normal limits, there is little that we can do to alter the growth of a baby in utero. Is there a need to differentiate between physiological shortness and pathological shortness? (As far as I am aware, no one has talked about being physiologically short before now; the term only becomes necessary in response to the pathologisation of short stature, in an attempt to hold a space for that which is normal).

The relationship between smallness and metabolic disorders surely needs additional investigation; at the very least, it appears that breastfeeding could mitigate or prevent the risks cited as being linked with smallness. Do women know that breastfeeding these babies gives increased protection from some of the metabolic disorders which may manifest in later life, such as diabetes (Villalpando and Hamosh 1998)? Or that cholesterol production is different in babies who are fed breast and artificial milk (Orrhage and Nord 1999), with the former having increased protection against the coronary heart disease which seems more prevalent in adults who were small at birth? Are we offering extra support for women who are seeking to breastfeed their small babies? This must surely be a cheaper alternative to giving expensive injections with concomitant side effects to four-year old children, some of who may not be abnormal or at risk.

Finally, to what extent do we as midwives have the potential to affect whether a mother sees her baby as being simply small, abnormally small, positively small, or without any judgement about his size? It may be true that we live in a culture generally designed for the benefit of the person of above-average height. But I am not convinced that it is a good thing to attempt to medicate those children who

may not be reaching the required standard of elevation. Perhaps instead we could focus on finding out more about the issues before we jump to the use of relatively untested drugs to modify our babies, and focus on the celebration of difference.

References

Orrhage K and Nord CE. Factors controlling the bacterial colonization of the intestine in breastfed infants. *Acta Paediatr. Suppl.* 88 (430): 47-57

Pfizer (2003) www.pfizer.com/dg/236322.htm Accessed 25 July 2003

Villalpando S and Hamosh M (1998) Early and late effects of breast-feeding: does breast-feeding really matter? *Biol. Neonate.* 74(2): 177-91.