Obesity Guidelines 2

Promise & Potential

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“Are we there yet?”
Obesity Guidelines 2: Context

- Most PCPs are not trained in obesity etiology, pathogenesis, diagnosis and treatment.
- Culture promotes supplements and dietary approaches that promise quick and easy weight loss.
- PCPs need authoritative recommendations for managing weight to improve their patient’s health.
Obesity 2 Guidelines

• Backed by stringent methodology
• Therefore, speak with authority
• But limited in scope:
  – Who needs to lose weight?
  – What are the benefits of weight loss and how much weight loss is needed?
  – What is the best diet?
  – What is the efficacy of lifestyle intervention?
  – What are the benefits and risks of the bariatric surgical procedures?
The Chronic Care Model of Weight Management by PCPs
Recommendation 1

To identify patients who might be at risk for obesity-related health problems

- Use BMI as an easily performed first screening step
- Use Waist Circumference as an indicator of risk for CVD, type 2 diabetes, and all-cause mortality
- Continue to use current BMI and WC cut points in common use
Recommendation 2

Counsel patients about the benefits of weight loss:

- Lifestyle changes that produce modest (3% to 5%) sustained weight loss result in clinically meaningful health benefits - improvements in TG, glucose, A1c and diabetes risk.
- Greater amounts of weight loss improve blood pressure, LDL-C, HDL-C and reduce the need for medications to control blood glucose, blood pressure and lipids as well as further reduce TG and glucose.

Note: most studies recommended a goal of 5-10% weight loss.

After 10-kg weight loss (85 kg, BMI 29)
Recommendation 3

In recommending a diet for weight loss

• there is no ideal diet for weight loss and no superiority for any of the myriad diets reviewed;

• Prescribe a diet to achieve reduced caloric intake, as part of a comprehensive lifestyle intervention.

• Choose diet composition considering the patient’s preferences and health status and preferably refer to a nutrition professional for counseling.
Recommendation 4

• Patients who need to lose weight should receive a comprehensive program (diet, physical activity and behavior modification) of 6 months or longer.

• The gold standard is on site, high intensity (>14 sessions in 6 months) comprehensive intervention delivered in group or individual sessions by a trained interventionist and persisting for a year or more.

• Other approaches (i.e., web-based, telephonic) may be used when patients can’t access the gold standard albeit though the amount of weight loss on average may be less.
Recommendation 5

• Advise your patients with BMI $\geq 35$ and a co-morbidity or $\geq 40$ that bariatric surgery may be an appropriate option to improve health and offer referral to an experienced bariatric surgeon for consultation and evaluation.
Gaps & Topics for Future Guidelines

• No Critical Question on pharmacotherapy
  – When Critical Questions developed only sibutramine and orlistat were on the market and sibutramine was removed shortly after.
  – The algorithm offers Expert Panel recommendations on pharmacotherapy + comprehensive lifestyle intervention.
• No Critical Question on physical activity protocols
• No Critical Question on weight gain with medications
• Evidence review required for WC and BMI as categorical variables to establish additional recommendations regarding cut points.
Conclusions

• High quality treatments are available and have been shown to result in medically important weight loss for patients who need to lose weight.
• Translation will depend upon
  – Providing primary care providers with information regarding success rates of the programs they work with for obesity treatment
  – Reimbursement practices for successful treatment programs, primary care physicians and specialists
  – Education of the primary care provider workforce, which will require great effort
• The Obesity Society, AHA, ACC and appropriate partners must address these translational needs.

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