Obesity Management in **Primary Health Care**

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Abstract: Obesity is a **key public health problem** across the world. Easy solutions are unlikely, given the complex interaction between the abundant availability of energy dense food, and the ever decreasing demand for energy expenditure in the **modern world**. This review paper addresses the issues of **weight gain** and **obesity** in primary health care.

INTRODUCTION

Obesity is a key public health problem across the world. It is a persistent state that is multifactorial in origin, intricate to treat, and is a key contributor to multiple diseases including heart disease, type II diabetes, hypertension, stroke and some cancers. Simple solutions are improbable knowing the multifaceted interaction between the copious accessibility of energy dense food, the decreasing demand for energy expenditure in the modern world, and the effect of our genetic make up. Many physicians do not tackle the question of weight gain and obesity with their patients who fulfill the criteria for obesity or overweight, or with persons that are at risk of becoming obese.

MANAGEMENT OF OBESITY

Systemic management of weight gain and obesity is the key to a successful approach. It is important to pin point patients who would benefit from nutritional counseling, since the behaviors that increase a patient's risk for related morbidity and mortality are seldom the reasons for a patient visiting the physician. A detailed examination of physical activity and nutrition history is a critical step in helping overweight and obese patients identify and implement healthier behaviors.

Primary care physicians should follow the steps below:

ASK IF THE PATIENT READY TO MAKE A CHANGE?

As frequently as is appropriate, family physicians should ask every patient who is at risk of becoming overweight whether he or she is willing to make one or more health behavior changes.

ADVISE

There is at least value in simply notify a patient that his or her BMI is harmful. For patients who express an interest in making one or more changes, advice about nutrition and physical activity must be clear, exact and geared tailored to the patient's lifestyle, experience and capabilities.

ASSESS BMI

The first step in assessing the excessive weight of the patient is calculating the BMI. BMI is similar to blood pressure as a vital sign. It must be used to establish health risks and to direct discussion with patients about health behavior changes.

A BMI of 25.0 to 29.9 kg per m2 is defined as overweight; a BMI of 30.0 kg per m2 or more is defined as obesity.

WAIST CIRCUMFERENCE

Waist circumference is a significant independent risk factor for cardiovascular disease, type 2 diabetes, dyslipidemia and hypertension. The waist must be taken around the smallest area below the rib cage and above the umbilicus.

Waist circumference measurements greater than 40 inches (102 cm) in men or 35 inches (89 cm) in women indicate an increased risk of obesity-related co-morbidities.

METABOLIC SYNDROME

The metabolic syndrome consists of five criteria, three of which must be present to make the diagnosis. Table 1 lists these criteria.

Telling a patient that he or she has the metabolic syndrome may create a precious counseling chance.

HEALTH IMPLICATIONS

There is little support from prospective studies revealing that weight loss by obese individuals ameliorate long-term morbidity and mortality. Strong evidence insinuates that obesity is linked

» The introduction of molecular testing to the diagnosis of PH allows more secure diagnosis of other family members «

to increased morbidity and mortality and that weight loss in obese persons reduces important disease risk factors.

In adults, elevated disease risk increases separately with increasing BMI and excess abdominal fat. Cardiovascular and other obesity-related disease risks increase markedly when BMI exceeds 25.0 kg per m2. Overall mortality starts to increase with BMI levels greater than 25 kg per m2 and increases most considerably as BMI levels surpass 30 kg per m2. Waist circumference measurements greater than 40 inches (102 cm) in men and 35 inches (89 cm) in women also point to an increased risk of obesity-related co-morbidities.

MANAGEMENT

There is discord concerning whether the known dangers of being obese cause a greater health risk than the possible hazards of treatment. It is preferable to treat patients with a BMI of 25.0 to 29.9 kg per m2 or a high waist circumference, and two or more risk factors. Treatment is also preferable for patients with a BMI of 30 or more kg per m2 regardless of risk factors. Successful management embrace dietary therapy, physical activity, behavior therapy, pharmacotherapy and amalgamation of these methods. Drugs must be used as part of a comprehensive plan. Currently, an appetite suppressant, sibutramine (Meridia), and a lipase inhibitor, orlistat (Xenical), are labeled by the U.S. Food and Drug Administration for long-term use and may be helpful in the treatment of suitable high-risk patients.

Pharmacotherapy is used in patients with a BMI of 30 or more kg per m2 and no associated obesity-related risk factors or diseases, or patients with a BMI of 27 or more kg per m2 with associated obesity-related risk factors or diseases (i.e., hypertension, dyslipidemia, coronary heart disease, type 2 diabetes [formerly noninsulin-dependent diabetes] and sleep apnea).

Surgery may be entertained for difficult cases where the patients do not respond to medical treatment because such individuals are at high risk for the comorbidities associated with obesity. Surgical treatment of clinically severe obesity are normally done to restrict caloric intake (e.g., vertical banded gastroplasty) or to combine caloric restriction with some degree of malabsorption (e.g., Roux-en-Y gastric bypass, biliopancreatic bypass).

SPECIAL CONSIDERATION IN CHILDREN

Currently children normally eat more calories than they burn up in physical activity. This discrepancy results from several recent alterations at home, school, and neighborhood environments. A study by The Institute of Medicine (IOM) called Food Marketing to Children and Youth: Threat or Opportunity gives a scary report of how this influences children's health. Food marketing, the IOM says, deliberately targets children who are too young to differentiate advertising from genuineness and leads them to eat high-calorie, low-nutrient "junk" foods. Companies succeed so well in this endeavor that business-as-usual must not be allowed to persist.

The IOM report gives enough evidence to maintain extra policy actions. Restrictions or bans on the use of cartoon characters, celebrity endorsements, health claims on food packages, stealth marketing, and marketing in schools, along with federal actions that promote media literacy, better school meals, and consumption of fruits and vegetables should be encouraged.

In the pediatric patients, clinical evaluation must include determination of the BMI percentile (for age and sex) and vigilant assessment to pinpoint potential complications of obesity such as hypertension, dyslipidemias, orthopedic disorders, sleep disorders, gallbladder disease and insulin resistance. Treatment must be considered in children with a BMI higher than the 85th percentile and complications of obesity, or a BMI higher than the 95th percentile with or without complications.

■ References available on request (jenna.wilson@iirme.com)

TABLE ONE

NCEP ATP III Diagnostic Factors for the Metabolic Syndrome*

Risk Factor Defining Level

- Abdominal obesity Men: >102 cm (40 inches), (waist circumference) Women: >88 cm (35 inches)
- Triglycerides 150 mg per dL (1.69 mmol per L)
- High-density lipoprotein Men: <40 mg per dL (1.04 mmol per L), (HDL) cholesterol Women: <50 mg per dL (1.29 mmol per L)
- Blood pressure 130/85 mmHg
- Fasting glucose 110 mg per dL (6.1 mmol per L)

**Diagnosis is established when three or more of these risk factors are present.*

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