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PRF NEWS

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Covering Practice and Risk Management Issues for Physicians

ADDRESSING THE CHALLENGE OF OBESITY

Communicating with Overweight Patients

BY JOAN SAXTON, MD, FACP

The number of overweight children and adults in the United States has escalated so dramatically over the last two decades that it has become common to refer to an "obesity epidemic" as the nation's number one health problem. Obesity causes two-thirds of adult onset diabetes mellitus and increases the morbidity and mortality of most major health risks including cancer, hypertension, cardiovascular disease, and degenerative joint disease. Particularly sobering are the estimates that there are now over 10 million adults in the United States who are classified as morbidly obese and that obesity contributes to over 400,000 deaths per year. Yet from a medical industry perspective, physicians in general have been frustratingly ineffective in confronting this challenge even as the health care cost of treating obesity-related medical conditions approaches $70 billion a year.

Although as much as 40 percent of the tendency to be overweight is inherited, it appears that the environment plays the dominant contributory role. For example, the food industry's manufacture and marketing of "supersized" portions of calorically dense food has encouraged the consumption of more calories per day than ever before. At the same time, the cultural pervasiveness of television, computers, video games, and the Internet combined with the reduction in physical education programs in our schools and communities has led to an increasingly sedentary American lifestyle.

Although patients repeatedly remind us that communication is the single most important element in the doctor-patient relationship, a physician's attitudes about obesity can undermine effective communication even before the doctor and patient meet. For example, while most physicians believe that physical inactivity, overeating, and a high-fat diet are the most significant causes of obesity, the majority also view obese patients as awkward, unattractive, and noncompliant. Perhaps it is no surprise that physicians rate obesity treatment as being about as successful as treatment for drug addiction.

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The following suggestions can help primary care physicians improve their communication with obese patients:

- Assess preconceived notions about obesity. Avoid negative stereotypes. Educate yourself about the entire clinical spectrum of obesity causation and treatment.
- Prepare your office physically for large people. Increase their dignity and comfort with appropriate furniture, gowns, BP cuffs, and scales.
- Help patients recognize the problem. "Do you want to address your weight today?" is a useful question. If the answer is "no," you can avoid mutual frustration by moving on, even if you think the patient is in denial about their weight. It is OK to re-visit the subject again later, hoping to find more receptive response.
- Do not assume the patient's current weight is his or her highest weight. It is very embarrassing to be going on about how critical it is for the patient to lose

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Medical Management of Obesity[1]

Obesity is a chronic problem. At any one time, about half of American women and a third of American men are trying to lose weight. One reason why it is difficult to treat obesity is that people set unrealistic goals. For most individuals who are not contemplating surgery, an initial weight-loss goal should be between 5 percent and 10 percent of the starting weight. Clearly, for most people this could represent a very small amount; however, this strategy has the advantage of not only being achievable by most people, but also represents a weight loss associated with an amelioration of many medical problems.

MANAGEMENT REPORTS

In the event of an untoward incident with a patient (which may or may not give rise to a claim), it is highly recommended that the PRF Insured submit a Management Report (MR) outlining the relevant facts of the matter. **Management Reports are very important to the management of an incident/claim, and it is necessary that the MR contain sufficient information to provide a clear summary of your involvement in the incident, whether that involvement is incidental or significant.** In the near future, please watch for a special mailing to all PRF Insureds that will include a revised Management Report form. The form should be kept on file to copy as needed. ■

The evaluation should begin with the determination of the body mass index (BMI), the most commonly used indicator of excess body fat. Keep in mind that some individuals with increased muscle mass may have a BMI suggesting obesity while some people with BMI in the normal range may have reduced muscle mass and excess fat.

Table 1 shows the derivation of the BMI. However, it is much easier to use tables, wall charts, or calculations done on your personal digital assistants.

The management of obesity consists of the following interventions: diet, exercise, behavior modification, pharmacologic interventions, and surgery.

Table 1. Body Mass Index Calculation and Meaning

BMI = Weight (kg)/height^2 (m^2)
Overweight: BMI = 25.0-29.9
Obese: BMI ≥ 30

The management of obesity consists of the following interventions: diet, exercise, behavior modification, pharmacologic interventions, and surgery.[2]

DIET

Any weight-loss regimen must include a reduced calorie intake. There have been many controversies over the years about which "diet" is best.

Unfortunately, the jury is still out. Low carbohydrates compared with high carbohydrates or low-fat diets are now being more rigorously investigated, but the bottom line is the same — reduce the caloric intake to help lose weight. Referring patients to a registered dietitian can help direct them toward a better dietary plan.

EXERCISE

Exercise is an equally important component to any weight loss approach. For most individuals, walking is fine. Start slow, and gradually add time and increase the speed. If orthopaedic issues are a problem, then swimming or other low impact activities may be useful. It has been shown that adherence to an exercise program can predict the long-term maintenance of a person's weight loss. Availability of an exercise physiologist or personal trainer may be beneficial.

BEHAVIOR MODIFICATION

Behavior modification can be helpful in teaching patients why they turn to food for comfort or in teaching strategies for changing eating behavior. By itself, it may have a very small effect, but as part of a weight-loss program,

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[1] Adapted from "The Management of Obesity for the Primary Care Physician" by Donald F. Kirby, MD (www.medscape.com).

[2] See "Surgical Treatment of Obesity" on page 3.

Surgical Treatment of Obesity

BY GREGG H. JOSSART MD, FACS;
PAUL CIRANGLE, MD, FACS; AND JOHN FENG, MD

There is no cure for obesity. Numerous medications to control weight have been introduced over the years but many have been withdrawn from the market because of safety issues, unpleasant side effects, or ineffectiveness. Diet, exercise and behavioral changes are the initial and safest therapies for obesity and physicians who specialize in obesity management have found that a meal replacement regimen that is medically and behaviorally focused has good results. However this approach requires commitment on the part of the patient and a physician with the time and energy to be sure patients are engaging in the hard work of confrontation and lifestyle changes on a day-by-day basis. Nonetheless, consideration should be given for specialty referral for all patients with a BMI $\geq$ 40 or for patients with a BMI $\geq$ 35 with additional risk factors such as hypertension or diabetes.

For obese patients unable to maintain a significant, long term weight loss with these approaches, a more extreme alternative to diets and medical therapy is weight loss surgery. Surgical weight reduction, or bariatric surgery, is not cosmetic surgery. It is major surgery with associated risks that can even include death.

The surgical treatment of obesity is effective and leads to a long term weight loss of 60-70% of excess weight. This means that an individual who is 100 pounds overweight can maintain a 70 pound loss with surgery. In addition, obesity related diabetes, hypertension, hypercholesterolemia, sleep apnea and joint disease is cured or markedly improved in more than 90% of patients.

Guidelines for patients who may be a candidate for weight loss surgery include:

- A BMI > 40 (approximately >100 lbs overweight)
- Adequate health to undergo major surgery
- A commitment to long term follow-up including lifestyle changes, exercise and abstinence from tobacco and alcohol.

Most, but not all, insurance companies recognize that morbid obesity is a disease with associated medical problems and they will cover some or all of the expenses related to the surgical weight reduction. Recently, the Center for Medicare Services designated obesity as a disease.

Surgical weight reduction is accomplished by restricting how much an individual can eat by reducing the stomach volume and limiting how many calories are absorbed by bypassing a portion of the intestines The three main surgical weight reduction procedures performed are:

1. The Roux-en-Y gastric bypass procedure has been performed more than any other weight loss surgery. A very small stomach pouch is created at the top part of the stomach, reducing the stomach by about 95% and about 4 feet of small intestine is bypassed to reduce the amount of calories absorbed.

2. The Vertical Gastrectomy with Duodenal Switch procedure divides the stomach vertically. This makes the stomach about 85% smaller than normal restricting the amount that the stomach can hold but maintaining normal stomach function. A greater length of intestines is bypassed to create more malabsorption.

3. The Inamed Lap-Band® adjustable gastric band is a silastic balloon that is wrapped around the top of the stomach and can be inflated with saline to restrict the rate of emptying from the pouch. The band limits the amount of food that is consumed and delays the emptying of the new stomach pouch.

The laparoscopic approach with several small punctures rather than a large abdominal incision has the advantage of less pain, smaller scars and a faster recovery.

These procedures are effective at achieving weight loss but are associated with a serious complication rate of up to 10% and a mortality rate of up to 1%. Complication rates are dependent on an individual's weight, medical problems and surgeon experience. The first 3-6 months after surgery are the most difficult as individuals are struggling to adapt to their new anatomy. Vomiting, dehydration and fatigue can occur and anyone considering weight loss surgery should know this is not the "easy way out." It is also important to know that the surgical procedure is only a tool to help individuals lose weight initially. Commitment to a diet and exercise plan as well as lifelong vitamins and follow up are necessary to maintain long term health. Individuals considering weight loss surgery should spend considerable time educating themselves about the indications, the procedures, and the results. This can be done by research on the Internet, attending local seminars or support groups, consulting with physicians experienced in the treatment of obesity and talking with other individuals who have undergone weight loss surgery. ■

The authors are members of Laparoscopic Associates of San Francisco Medical Group, Inc.

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Communicating with Overweight Patients *(continued from page 1)*

weight, only to be told that he or she has already lost 50 pounds and is working hard in Weight Watchers, still on the way down.

- Beware of the trap of blaming everything on the obesity. This makes patients angry. They know that thin people have some of the same problems they have, and they think that physicians are not seeing anything but their weight and are taking the easy way out.
- Keep expectations realistic. Being thinner is not a panacea. A smaller body can bring with it challenges in self-image, mood, and interpersonal relationships that are not expected. Besides these psychological effects, not all physical problems are ameliorated. For example, it is often expected that hip and knee pain will get better with weight loss, yet if those joints are worn out, reducing the load may not erase the pain.
- Praise patients for addressing their weight and for being willing to work on it. Reassure them that small successes in weight loss (5 to 10 percent of body weight) can result in 90 percent of the health benefits, e.g., lower insulin, glucose, and cholesterol levels, lower blood pressure, less sleep apnea. Encourage patients to attain reasonable short term goals while being prepared to cheer them on over the long term. ■

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Medical Management of Obesity *(continued from page 2)*

behavior modification can have a more additive effect.

PHARMACOLOGIC INTERVENTIONS

The pharmacologic treatment of obesity is limited to very few specific medications. Table 2 lists the current medications that are FDA-approved for the treatment of obesity. Of these medications, only two, sibutramine and orlistat, are FDA-approved for up to two years of use. The other medications that are effective—phentermine, phendimetrazine, and diethylpropion—are labeled for short-term use, meaning up to 12 weeks. This equates to a short-term fix for a long-term problem.

Table 2 lists the current medications that are FDA-approved for the treatment of obesity.

Side effects for all of the drugs listed in Table 2 except orlistat commonly include elevation of blood pressure, tachycardia, central nervous system overstimulation, dry mouth, and, rarely, memory loss. Their use should be avoided in patients with advanced arteriosclerosis and uncontrolled hypertension, as myocardial infarctions and strokes can occur. Also, avoid these medications within 14 days of taking monoamine oxidase (MAO) inhibitor medications. Phentermines have been used very successfully in helping to reduce weight, but their long-term use must be readdressed. Orlistat is unique in that it is a lipase inhibitor and will block about one third of ingested fat. Its mode of action thereby leads to GI side effects such as oily discharge or loose stools. These can be minimized by the use of psyllium. ■

Table 2. Current Pharmacologic Options

DEA Schedule	Generic Name	Brand Name(s)
CIV	Phentermines	*Adipex-P, Ionamin*
CIII	Phendimetrazine tartrate	*Prelu-2, Bontril*
CIV	Diethyproprion hydrochloride	*Tenuate*
CIV	Sibutramine	*Meridia*
NS	Orlistat	*Xenical*