

PROBLEMS AND VIEWS IN THE MANAGEMENT OF OBESITY

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Summary

This chapter illustrates four aspects from the specialist's point of view. The first aspect is the structure and the role of personnel in a successful weight management clinic and how success or failure in weight management can occur. Secondly, this chapter discusses the different approaches to improve compliance and adherence of patients to the weight loss program to achieve the best results. The chapter also includes the personal experience of the specialist in the use of the different prescription and over the counter medications available for weight loss in the market. It also deals with the components of lifestyle modification and how to get satisfactory results.

Aim of the chapter

This chapter aims at giving a detailed picture of how a weight loss program can lead to success or failure in obesity management. We are still far from being satisfied with our results, we still need to work hard to improve patients' compliance and adherence. By sharing knowledge and experience we might achieve more in this field. From this concept, the specialist sincerely wrote his 25 years of practice experience to be a starting point for those who are interested in the field to add better chances for our patients.

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Obesity has been recognized as a serious rising health problem. Management of obesity has been one of our big failures.¹ Currently, it is considered to be the second most prevalent health hazard, after smoking. Although people recognize its importance, most weight reduction attempts end in failure.

Individuals can be classified, into three categories, according to their success results in weight management and reduction²:

1. Category I: Those who are unsuccessful at maintaining a "normal" body weight. They account for 25% of individuals following a weight reduction program.
2. Category II: Those who are successful only with outside help, through nutrition education, exercise classes, therapy, commercial programs, etc. They account for another 25% of individuals following a weight reduction program.
3. Category III: Those who are successful by helping themselves through trial and error, reading self-help books, seeking information on their own, self monitoring, self imposed eating and/or exercise programs. This last category accounts for the remaining 50%.

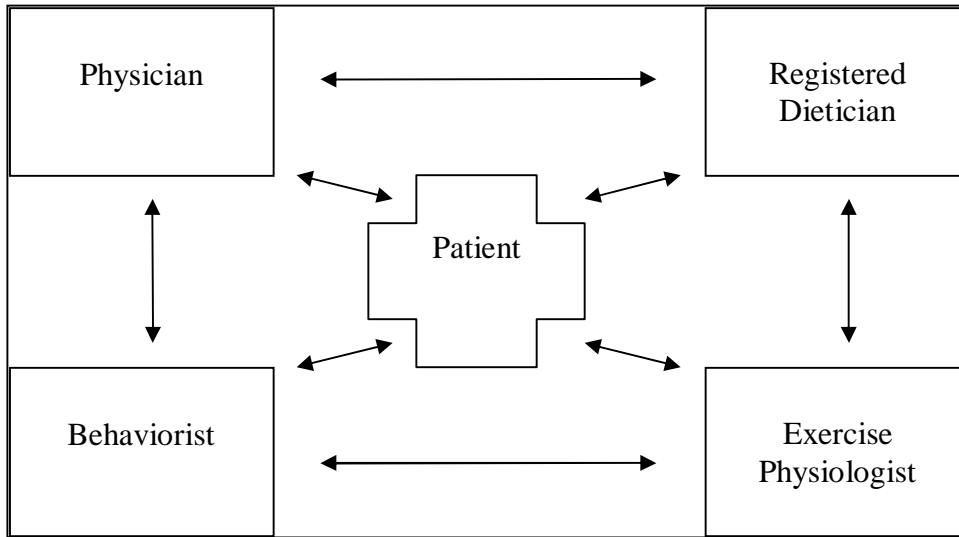
I. Causes of failure of weight reduction programs

To identify causes of failure we must first understand the structure of a weight reduction program. Ideally, any program should involve the following (diagram 1):

1. A physician whose role is to:
 - a. Identify the problem; assess weight, body mass index, waist measurements, , etc.
 - b. Assess general health, co-morbidities and risks.
 - c. Assess the need and readiness for treatment.
 - d. Devise goals and treatment strategy with the patient.

- e. Manage any detected co-morbidities.

Diagram 1: Ideal structure of a weight loss program



- f. Monitor the progress and encourage the patient.
 - g. Utilize adjunct therapies when indicated.
 - h. Have a comprehensive referral list with registered dietitians, exercise physiologists and behavioral therapists.
2. A registered dietician whose role is to:
 - a. Assess current diet and nutrition status as well as dietary behavior attitudes and habits.
 - b. Assess diet and weight management history.
 - c. Work with the patient and tailor appropriate dietary treatment.
 - d. Encourage food recording.
 - e. Educate on proper nutrition.
 - f. Counsel on appropriate strategies for making dietary changes.
 - g. Monitor adherence and encourage progress.
 3. A behaviorist. (Behavioral therapist or behavioral psychiatrist) whose role is to:
 - a. Establish a collaborative relationship with the patient.
 - b. Identify discrepancies between the patient's current behavior and the patient's desired health outcomes.
 - c. Work with the patient to help clarify his/her own reasons for change.
 - d. Discuss the patient's beliefs regarding obesity and treatment.
 - e. Assess the patient's treatment expectations.
 - f. Tailor behavior treatment strategies to patient's needs.
 - g. Address personal barriers to weight loss and how to overcome.
 - h. Monitor the progress and encourage the patient.
 4. Exercise physiologist whose role is to:
 - a. Assess the current levels of physical activity and exercise.
 - b. Assess the history of physical activity and exercise and possible reasons behind change, if any.
 - c. Assess the patient's attitude towards physical activity and exercise.
 - d. Evaluate current and potential barriers to increase physical activity and exercise.

- e. Work with the patient to develop the most suitable exercise programs and the ways to implement them.
 - f. Educate the patient on safe and effective exercise techniques and strategies to overcome the barriers.
 - g. Monitor adherence and encourage progress.
5. The overweight/ obese patient:
- a. The patient should always be playing an active role in the decision making.
 - b. Communication channels with all members of the team should always be open.
 - c. Implement the recommended lifestyle changes.
 - d. The patient should always seek social support from family members, friends and co-workers to keep him/her motivated.
 - e. Self-monitor lifestyle management.
 - f. Self- motivation.

Failure of any of the participants in the weight management team in achieving any of the designated tasks can lead to failure of the weight management program.

II. Approaches to improve compliance and adherence

Improving compliance and adherence of the patients to insure a successful weight management program can be accomplished by:

i. **Setting realistic goals:**

Goal setting is the specification of a behavior or a set of behaviors to be performed in a specified period of time. It is most effective when individuals set challenging, yet achievable goals. It was noted that goal setting strategies can increase initiation and maintenance rates.

It is important to distinguish the difference between what the patient wants, what he/she really needs, and what he can and cannot achieve. The difference between the patient's and physician's expectations in weight management must also be taken into account.

Patient's long term goals can be summarized as:

- a. A weight target.
- b. An amount of weight loss.
- c. Relief of symptoms.
- d. Improvement of medical condition/s, such as diabetes or hypertension.

Table 2: difference between the expectations of the patient and the physician in weight management

	Patient	Physician
Rate of weight loss	Quick	Progressive
Level of weight loss (% of initial body weight)	20%	5-10%
Diet Duration	Few weeks	Rest of the patient's life
Goals	<ul style="list-style-type: none"> • Weight loss • Cosmetic Purposes • Increase physical fitness 	<ul style="list-style-type: none"> • Weight maintenance to decrease obesity related risks. • Manage co-morbidities. • Improve metabolic fitness.

Certain aspects of the patient's goals may not be realistic and therefore, some vital points should be considered while setting the targeted weight loss:

- a. Substantial benefit can occur with 5-10% weight loss.

- b. Physiological responses often limit sustained weight loss. Clinical trials have shown that weight loss does not continue past 6 months in lots of cases.
- c. Repeated failures lead to depression and rebound of the lost weight.
- d. Long-term health benefits depend on limiting weight regain.

A physician should discuss the goals with the patient and set more realistic targets. Therefore, agreement should be reached on short-term achievable goals and the physician should always review the progress against short-term goals with the patient. For instance, some patients ask for 40 to 50 kg weight loss as quickly as possible. It is the role of the physician to fractionate this goal and make agreements with the patient on shorter term success points.

ii. Modifying the impact of information from other sources:

Dietary advice given by the health professionals is only a part of the information that the patient uses to change his/her dietary behavior. The compelling information on dieting from media, family and friends, influence the changes of eating behavior of patients^{3 4 5}. It is important for the health professional to address these claims seriously with the patient.

iii. Taking into consideration individual differences between patients:

It is crucial for health professionals to take into consideration the individual's habits, life style, needs and medical status and accommodate them into the weight loss program tailored to the individual rather than using a ready made template.

iv. Avoiding asking for sudden changes:

The health care professional should work on a gradual change of the patient's habits to a healthy eating system and increasing physical activity. A non-restrictive approach to dieting should be applied based on the internal regulation of food i.e. hunger and satiety.

III. Personal experience with pharmacologic therapy.

Pharmacologic diet products can be classified into:

A. Over the counter Products (OTC):

These products are generally preferred by patients since they are claimed to be natural products and they are available at relatively cheaper prices. They include chromium products, green tea, laxatives, fat burners, chitosan...etc. Some of these products have been tried by most patients but not prescribed by most physicians due to the lack of sufficient studies. Furthermore, it has to be mentioned that these products are not approved by the FDA.

B. Prescription anti-obesity medication:

Currently, there are 3 prescription anti-obesity medications in the Egyptian market. Those are:

1. Orlistat (Xenical):

It is both FDA and EMEA approved for weight loss. Patients know that it has a good safety profile. Most patients use Orlistat in a wrong way taking only one capsule a day with the fat-laden meal. This tremendously reduces its efficacy since the dose is 3 capsules a day. Patients have been found to stop using the drug due to its side effects, high cost and lack of confidence in its efficacy. Most patients, so far, do not know that it can be used starting at the age of twelve^{6 7}.

2. Sibutramine (Meridia/Reductil):

It is also approved by both FDA and EMEA as a medication for weight loss. Sibutramine acts centrally on the brain enhancing satiety and the feeling of fullness and reducing the post-weight loss decline in metabolic rate⁸. Patients refrain from taking it due to its central mechanism of action. Some of the patients wrongfully think of Sibutramine as an appetite suppressant hence their claim it is ineffective. The difference between an

appetite suppressant, which helps patients not to start eating, and a satiety enhancer, that makes patients stop eating earlier, should be explained to the patients. Egyptians claim that the leaflet is filled with anticipated side effects. Patients resort to the cheaper generics. It's worth noting that lately, Sibutramine is gaining popularity among Egyptian obese patients⁹.

3. Rimonabant (Acomplia):

This is the newest anti-obesity medication to be introduced to the market. It has been approved by EMEA only and is yet to be officially available in the Egyptian market. Rimonabant is also a centrally acting drug by selective cannabinoid type 1 receptor blockade. Very few patients have started using Rimonabant recently. Those who can get it from foreign countries are fairly satisfied with its action as a weight loss adjunct therapy.

IV. Best approach to lifestyle modification

Lifestyle modification should include:

1. Dietary management.
2. Physical activity.
3. Behavior modification.

To obtain better results, lifestyle modification should start early in life with the help of professional behaviorists. It should also involve all family members. Support should be available in school classes. Media campaigns should encourage healthy lifestyles. This should involve policy makers by controlling stimuli and taxing. Religious support should be available in mosques and churches.

- Counseling for lifestyle modification should be frequent, available and inexpensive. Patients should be encouraged to self monitor their progress by documentation.
- To encourage healthy eating habits, the pricing of food items should be reconsidered. Adding more taxes to high fat products, while subsidizing healthy foods like fruits and vegetables. Shelving schemes may be used such as making high fiber low calorie food items more accessible than the high fat items¹⁰. For example, removing chocolates, chips and doughnuts from the front of shops and replacing them with the high fiber low calorie food items especially in supermarkets near schools. Giving fresh fruits either as a reward or to all students can help promote healthier dietary habits.
- To encourage physical activity, we should recommend that the governments must add in future plans for cities and districts more walking and bicycle paths and reducing car lanes at all streets. They should also ensure more parks and playgrounds. Allocating car parking areas relatively away from shopping malls and living areas will make people resort to walking more¹¹.
- Behaviorists should be given more time and space in the media and schools to explain and promote healthy lifestyle forms and patterns. Giving talks, lectures and seminars about healthy living parameters by talented specialized behavior therapists at work places, clubs ...etc will help people adopt a healthier living style¹².

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⁴ Ornish, D. *Eat More, Weigh Less*. New York: Harper Collins. 1993

⁵ Hill, J. Four Keys to Weight Loss Success. Online. June 3, 2004.

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⁶ FDA Approves Labeling For Use of Xenical (Orlistat) in Management of Obesity in Adolescent Patients Aged 12-16 Years. Roche Laboratories Inc. 2003. Online. September 5, 2004. <<http://www.roche.com/inv-update-2003-12-16a>>

⁷ Hauptman, J. Lucas, C. Boldrin, M.N. et al. Orlistat in the Long Term Treatment of Obesity in Primary Care Settings. Arch Fam Med. 2000; 9 (2): 160-167.

⁸ Clinical Pharmacology – Mode of Action of Sibutramine. Online. September 5, 2004. <
http://www.rxlist.com/cgi/generic/sibutramine_cp.htm>

⁹ Meridia (Sibutramine Hydrochloride Monohydrate) Package Insert. Online. September 4, 2004. <
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¹⁰ Putnam, J.J. Allshouse, J.A. Food Consumption, Prices, and Expenditures. 1970, 1997. Washington DC: US Department of Agriculture. 1999.

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¹² National Task Force on the Prevention and Treatment of Obesity. Arch Intern Med. 2000. 160: 898-904.