

Is the treatment of obesity futile?

Dominique Garrel MD

NO

Gula plures occidit quam gladius—Gluttony kills more than the sword.

In Ancient Rome, obesity was considered a fatal condition caused by incurable gluttony. Today, many physicians are tempted not to intervene with their obese patients. They are not weighed and the subject of body weight is never raised with them. Recently, obesity has been termed a disease, to the great joy of the experts. However, if obesity is considered an incurable disease, I worry that many physicians will decide not to waste their precious time trying to treat it.

I would argue that obesity must be treated and that, as physicians, we have an essential role to play. What is more, the treatment of obesity is simple and need not be time-consuming.

Treat the patient, not his weight. Telling an obese patient to lose weight is about as effective as telling an asthmatic patient to breathe better! Care consists of assessing the risks of excess weight to a patient's health. The Edmonton Obesity Staging System recently proposed by Kuk et al is an interesting tool designed for this point of view.¹ This system includes recommendations for each level of intervention, ranging from simply recommending that the patient maintains his weight, to recommending bariatric surgery. This assessment is extremely important because the consequences of excess weight vary among patients. For example, it is possible for an obese patient to be metabolically healthy.² The Edmonton system consists of a clinical examination, the measurement of biochemical parameters, and in some cases an investigation of possible comorbidities such as sleep apnea. This process takes time; it is not possible to assess an obese patient in a single session. However, for physicians, this is familiar territory: approach obesity as you would any other chronic disease.

Treat any comorbidities. Comorbidities will create considerable roadblocks to any attempt on the part of the patient to lose weight. Severe sleep apnea and depression are examples of comorbidities that are frequently seen in men and women with a body mass index of greater than 40 kg/m²; however, neither is rare in less severe cases of obesity.³

Set a reasonable objective and period of time for weight loss. Few patients realize they can improve their health considerably by losing even a small percentage of their weight. For example, to prevent type 2 diabetes (at least temporarily), a patient need only lose 5% to 10% of his weight. These goals should be set with the physician, who will provide medical follow-up.

Inform the patient of the tools at his disposal for losing weight. This part of the treatment might take longer, but there is no reason it cannot be delivered over several visits. At this stage, a physician might feel ill-equipped without his usual box of tools: drugs. Yet, the history of treating obesity with drugs reads like a long list of catastrophes. Today, the only drug at our disposal is orlistat, which inhibits the absorption of fats in the intestine. Recently, glucagon-like peptide-1 analogues were brought to market for the treatment of diabetes; they are a new development because they cause weight loss. However, there are no long-term data for these drugs. Weight management remains a matter of education and permanent lifestyle changes. These changes are not part of the field of medicine and must be introduced by a multidisciplinary team of nutritionists, psychologists, and kinesiologists. Ideally, this team will be working in the same location as the physician. Long-term maintenance of weight loss by a professional working alone has a success rate of 5%; weight management by a multidisciplinary team has a success rate of 25% to 40%.⁴ The role of the physician is to refer the patient to this team and then provide medical follow-up. The cost of seeing a multidisciplinary team once a week or every 2 weeks for 6 months to a year is about \$2000 to \$3000, which can represent an insurmountable financial barrier. If this is the case, the patient can be referred to an organization in the community such as Weight Watchers or Choisir de maigrir.

Physicians have a responsibility to warn their patients about ineffective weight loss methods that can be dangerous such as high-protein fasts, natural products, and liposuction.


The surgical treatment of obesity is very popular and increasingly simple and safe.⁵ Physicians must be able to identify good candidates for this surgery and to refer them to reputable bariatric surgery centres. It should be noted that this surgery requires very close follow-up care for a period of 2 years, with an annual review thereafter.⁶

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Prevention, first and foremost. There is very little evidence that the treatment of obesity works. As a result, we should be focusing on prevention. Efforts at prevention involve some degree of telling people what to do, and some people will criticize this. Screening and monitoring excess weight from early childhood, ensuring that physical activity is part of the curriculum right up to university, creating neighbourhoods that encourage people to get out and walk, and teaching people how to prepare healthy meals are just a few suggestions. Would these efforts at prevention cost much? What we really need to remember is that the individual and collective cost of obesity is astronomical.

For every individual who wants to lose weight, I maintain hope. For society, however, what gives me hope is prevention. 

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Competing interests

None declared

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∴ **CLOSING ARGUMENTS**

- Even though we should continue to encourage individual patients to lose weight, clinical experience teaches us that the long-term success of non-surgical treatment of obesity is limited.
- Prevention efforts beginning in childhood provide the best hope for public health.

∴ **NO** *continued from page 509*

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∴ **CLOSING ARGUMENTS**

- Assess the health risks of excess weight and treat any comorbidities.
- Organize multidisciplinary support for lifestyle changes.
- If necessary, refer the patient for bariatric surgery.

The parties in these debates refute each other's arguments in rebuttals available at www.cfp.ca. Join the discussion by clicking on Rapid Responses at www.cfp.ca.