

Obesity must be addressed

I strongly disagree with much of what Dr Ladouceur had to say about obesity, other than his conclusion.¹ Here in Cape Breton, NS, only 1 in 3 people is of “normal” weight. I have a body mass index (BMI) of 23.5 kg/m² and am constantly told that I am “stick-thin” by people with BMIs well into the obese range.

Studies of parents of obese children show that many of them do not know their children are obese.² I practise injury rehabilitation, and most of my back pain patients are obese. They have often seen multiple specialists as well as their family doctors, and although their medical records often document their weight and the contribution of their weight problems to the back pain, the patients have not actually been told this. Family physicians assume the specialists will discuss it; specialists assume the family physicians have already discussed it. Contrary to Dr Ladouceur’s experience, I find that more and more overweight and obese patients consider themselves “normal” and are quite comfortable psychologically with their shape.

My approach to the topic of body weight during interviews is to ask patients what they think their current weight is, and then weigh them. I ask them if they are happy with their weight, if they think their weight is related to their medical condition, and what they think “a good weight for them” is. I continue to be shocked by the many patients who are more than 100 pounds over the weight that would give them a healthy BMI and think that they could stand to lose “20 or 30 pounds.” I am also amazed by the number of patients who underestimate their weight by dozens of pounds.

In my experience, most doctors do not routinely weigh their patients and calculate BMI; talk about current BMI versus healthy BMI; connect medical conditions to weight in discussions with patients; or reassure their patients that change is possible.

My take on the genetic research is that very few cases of obesity are “explained” by genes. People take on the shape of their parents because they think it is either normal or abnormal to walk to school rather than drive; to eat fried chicken and french fries and hate broccoli; and to be “big.”

Does Dr Ladouceur truly believe that his patients “already know” that they have weight problems and that their weight problems are related to their medical problems? Or is he just assuming this because it is a convenient way for him to avoid what is a very sensitive problem to approach, and a very difficult, complicated problem to resolve. It is much easier to just write prescriptions than to approach these complex problems.

I think physicians who truly take the time to talk to their patients in depth about weight, using a nonthreatening, question-and-answer approach, will be shocked by how many of their obese and overweight patients

are *not* attuned to the importance of weight control. That said, I do agree with Dr Ladouceur that, having explained to the patient that they *are* overweight and need to work on that problem, quickly focusing goals away from specific weight loss and toward diet and exercise modification is much more productive.

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Competing interests

None declared

References

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Obesity prevention is a continuum

I read with interest Dr Havrankova’s assertion that the treatment of obesity is futile, which emphasized that prevention is most important.¹ It is refreshing to see an emphasis on prevention rather than cure in a clinical argument. In fact, the paper correctly advocates for primary prevention of obesity through the tenets of the Ottawa Charter for Health Promotion—improving population health by reorienting health services, developing personal skills, strengthening community action, creating supportive environments, and building healthy public policy.² From a long-term societal change perspective, this holds the most hope for the greatest effect at the lowest cost.

However, we know that prevention is a continuum, involving primary, secondary, and tertiary prevention aimed at preventing the disease, preventing morbidity, and mitigating morbidity, respectively.³ We further know that obesity is not an issue on its own, but is a risk factor for cancer, cardiovascular disease, and diabetes. It is related to other chronic disease intermediates such as hypertension and hyperlipidemia, and it is associated with decreased mental health, osteoarthritis, and endocrine disruption.⁴

The author correctly points out that the “individual and collective cost of obesity is astronomical.”¹ This cost does

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