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/m^2 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.

—Christopher R. Milburn MSc MD CCFP
Sydney, NS

Competing interests
None declared

References

1. Ladouceur R. Should we stop telling obese patients to lose weight? *Can Fam Physician* 2012;58:499 (Eng), 500 (Fr).
2. He M, Evans A. Are parents aware that their children are overweight or obese? Do they care? *Can Fam Physician* 2007;53:1493-9.

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

not arise from obesity itself, but from the chronic diseases associated with it.[5-7] As such, making the argument for prevention means not solely arguing for primary prevention of obesity but, more important, recognizing the important role obesity treatment has in the primary and secondary prevention of chronic disease outcomes.

Further, we know that the prevention of obesity is an incredibly complex phenomenon, requiring the interplay of different sectors, from government to industry to primary care providers. Based on existing evidence, the United States Preventive Services Task Force recommends screening for obesity and intensive counseling as a preventive service.[8] Treatment of obesity by health care providers surely represents one important piece to solving this puzzle.

Then, there is the critical issue of childhood obesity.[9] The arguments put forward by both discussants do not address this growing epidemic.[1,10] While our research base continues to develop, it stands to reason that obese children become obese adults. We know that this is a generation that could potentially see a lower life expectancy than that of its parents.[11] For many of these children, it is too late for primary prevention. However, that does not condemn them to a lifetime of obesity and resultant chronic disease. Treatment of obesity as a risk factor must be a mainstay of chronic disease prevention throughout their life course.

There is unfortunately a non sequitur in negating the need to treat obesity with an argument for the importance of prevention. The two simply cannot be separated: any argument for obesity and chronic disease prevention must consider counseling, education, and treatment opportunities. Otherwise, our chronic disease prevention efforts will indeed be doomed to futility.

—Lawrence C. Loh MD MPH CCFP
Toronto, Ont

Competing interests
None declared

References
1. Havrankova J. Is the treatment of obesity futile? Yes [Debates]. *Can Fam Physician* 2012;58:508, 510 (Eng), 512, 514 (Fr).
2. Hancock T. The Ottawa Charter at 25. *Can J Public Health* 2011;102(6):404-6.
3. Mensah GA, Dietz WH, Harris VB, Henson R, Labarthe DR, Vinicor F, et al. Prevention and control of coronary heart disease and stroke—nomenclature for prevention approaches in public health: a statement for public health practice from the Centers for Disease Control and Prevention. *Am J Prev Med* 2005;29(5 Suppl 1):152-7.
4. Guh DP, Zhang W, Bansback N, Amarsi Z, Birmingham CL, Anis AH. The incidence of co-morbidities related to obesity and overweight: a systematic review and meta-analysis. *BMC Public Health* 2009;9:88.
5. Withrow D, Alter DA. The economic burden of obesity worldwide: a systematic review of the direct costs of obesity. *Obes Rev* 2011;12(2):131-41. DOI: 10.1111/j.1467-789X.2009.00712.x.
6. Anis AH, Zhang W, Bansback N, Guh DP, Amarsi Z, Birmingham CL. Obesity and overweight in Canada: an updated cost-of-illness study. *Obes Rev* 2010;11(1):31-40. Epub 2009 Apr 21.
7. Office of the Surgeon General (US); Office of Disease Prevention and Health Promotion (US); Centers for Disease Control and Prevention (US); National Institutes of Health (US). *The surgeon general's call to action to prevent and decrease overweight and obesity.* Rockville, MD: Office of the Surgeon General (US); 2001.
8. United States Preventive Services Task Force [website]. *Screening for obesity in adults*. Rockville, MD: United States Preventive Services Task Force; 2003. Available from: **www.uspreventiveservicestaskforce.org/uspstf/uspsobes.htm**. Accessed 2012 May 23.
9. Dietz WH. Implications of the energy gap for the prevention and treatment of childhood obesity. *Am J Prev Med* 2012;42(5):560-1.
10. Garrel D. Is the treatment of obesity futile? No [Debates]. *Can Fam Physician* 2012;58:509-10 (Eng), 513-4 (Fr).
11. Olshansky SJ, Passaro DJ, Hershow RC, Layden J, Carnes BA, Brody J, et al. A potential decline in life expectancy in the United States in the 21st century. *N Engl J Med* 2005;352(11):1138-45.

Response

I thank Dr Loh for his comments. I agree on the importance of prevention of obesity and on the complex nature of that prevention.[1] The importance of problems secondary to obesity is unquestionable. But do not misunderstand me, please! It is not that I do not want to treat obesity, or not want to encourage others to do so, but after many years in practice I have to conclude that success is very limited. There are determined and courageous persons who succeed, but they are few. I reiterate: the treatment of obesity is generally a failure. Also, I am appalled by the multibillion-dollar business surrounding the issue of weight management that exploits people with weight problems. I would very much like to learn how to achieve lasting weight loss for my obese patients, most of whom have associated problems. If anyone knows the answer, he or she should share it with others.

—Jana Havrankova MD CSPQ
Saint-Lambert, Que

Competing interests
None declared

Reference
1. Havrankova J. Is the treatment of obesity futile? Yes [Debates]. *Can Fam Physician* 2012;58:508, 510 (Eng), 512, 514 (Fr).

Correction

In the research article "Natural procreative technology for infertility and recurrent miscarriage. Outcomes in a Canadian family practice,"[1] which appeared in the May 2012 issue, fetal age rather than gestational age was mistakenly reported in **Table 5.** The number of births at less than 32 weeks' gestational age was 3 (7%), the number between 32 and 37 weeks' gestational age was 8 (20%), and the number at 37 weeks' gestational age or later was 30 (73%).

Reference
1. Tham E, Schliep K, Stanford J. Natural procreative technology for infertility and recurrent miscarriage. Outcomes in a Canadian family practice. *Can Fam Physician* 2012;58:e267-74. Available from: **www.cfp.ca/content/58/5/e267.full.pdf+html**. Accessed 2012 Jun 6.