

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.

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Competing interests

None declared

References

- Havrankova J. Is the treatment of obesity futile? Yes [Debates]. *Can Fam Physician* 2012;58:508, 510 (Eng), 512, 514 (Fr).
- Hancock T. The Ottawa Charter at 25. *Can J Public Health* 2011;102(6):404-6.
- 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.
- 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.
- 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.
- 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.
- 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.

- 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.
- Dietz WH. Implications of the energy gap for the prevention and treatment of childhood obesity. *Am J Prev Med* 2012;42(5):560-1.
- Garrel D. Is the treatment of obesity futile? No [Debates]. *Can Fam Physician* 2012;58:509-10 (Eng), 513-4 (Fr).
- 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.

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Competing interests

None declared

Reference

- 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

- 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.

