Editorial

Family physicians and obese patients

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Obesity has reached alarming levels throughout the world. According to a joint report of the Public Health Agency of Canada and the Canadian Institute for Health Information published in 2011, the Canadian prevalence of obesity nearly doubled in 30 years, from 14% in 1981 to 25% in 2007 to 2009.[1] Almost two-thirds (62%) of adults aged 18 to 79 years are overweight or obese (body mass index [BMI] of ≥25 kg/m^2).[2] How can this be possible? It defies all understanding! One could be forgiven for wondering whether the tool used to define obesity is still valid or whether the remaining one-third of Canadians are too thin!

However, there is general agreement that several factors contribute to obesity, including genetic and phylogenetic factors, better living conditions, ready access to calorie-rich foods, and sedentary lifestyles. And there is general agreement that prevention and education are important, yet these interventions do not seem to be working. In fact, the numbers show they are not working.

How should family physicians respond to this global epidemic, and what can they do to help their obese patients?

The role of the physician has been clearly defined in the recommendations of various advisory groups. The Canadian Task Force on Preventive Health Care (CTFPHC) has provided definitions of what we should do, and should not do, for our obese patients.[2] According to the CTFPHC, we should be offering, or providing a referral for, a structured behavioural intervention for weight loss to all of our obese patients. This is a strong recommendation for adult patients (≥18 years) who are obese (BMI 30 to 39.9 kg/m^2) and at high risk of diabetes. It is a weak recommendation for all other patients who are overweight or obese (≥18 years; BMI of 25 to 39.9 kg/m^2).

These recommendations are laudable, but are they realistic and effective? There are so many overweight and obese Canadians that we would be referring most of our adult patients. What's more, the structured behavioural interventions described by the CTFPHC are not benign; they involve programs of diet, exercise, and lifestyle changes over weeks or months. Will all of our obese patients comply with these programs and pay for them?

The CTFPHC also recommends that pharmacologic treatment (orlistat or metformin) not be offered systematically to overweight or obese patients (weak recommendation), despite the fact that it results in an additional loss of 2.9 kg, on average, among participants who receive it in addition to behavioural interventions. The CTFPHC justifies the recommendation by citing adverse events and higher dropout rates among participants receiving pharmacologic treatment.

This position is somewhat surprising. Careful consideration of the meta-analysis on which the CTFPHC's recommendation is based[3] reveals that structured behavioural interventions lead to an average weight loss of 3.1 kg and that with the addition of pharmacologic treatment, a patient might lose an additional 2.9 kg on average. Thus, a person who is 1.8 m tall, who weighs 127.0 kg (with a BMI of 38.0 kg/m^2), and who has been told to lose 5% of his or her weight should lose 6.4 kg. (The 5% weight loss is considered clinically meaningful because it leads to an improvement in several risk factors for cardiovascular disease, including hypertension, elevated blood glucose level, and dyslipidemia.) According to Peirson and colleagues, structured behavioural intervention would lead to weight loss of 3.1 kg and adding pharmacologic treatment would lead to a further loss of 2.9 kg. The total is close to the recommended 6.4 kg!

The CTFPHC bases its recommendation on the side effects of pharmacologic treatment. Yet, Peirson and colleagues state in their meta-analysis that "most (about 80%) adverse events that occurred in orlistat trials (and some in metformin trials) were gastrointestinal disturbances. Commonly reported symptoms across studies were fatty or oily stool, increased defecation, increased urgency, abdominal pain, soft stools, oily spotting and flatulence. Most studies reported that the gastrointestinal events were typically mild or moderate in intensity and occurred only once or twice in the participants, usually near the beginning of treatment."[3] The authors indicate that the studies did not reveal more serious adverse events with pharmacologic treatment.

Could the CTFPHC recommendations be wrong?

We invite you to read the debate published this month in *Canadian Family Physician* on **page 102**, entitled "Should family physicians prescribe medication for obesity?"[4,5]

Cet article se trouve aussi en français à la **page 93.**

References

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