‘Unhealthy Weight’ Term Promotes Weight Loss

BY BRUCE JANCIN

EXPERT ANALYSIS FROM A MEETING ON PRACTICAL PEDIATRICS SPONSORED BY THE AMERICAN ACADEMY OF PEDIATRICS

STEAMBOAT SPRINGS, COLO. – In discussing a child’s weight problem with the parents, it’s best for physicians to refrain from using the terms “fat,” “extremely obese,” and even “obese.”

“Parents find those terms undesirable. They’re stigmatizing, blaming, nonmotivating, and condescending,” Dr. Paul R. Stricker said at the meeting.

And that’s not just his personal opinion, either. He cited a recent groundbreaking study in which investigators at Yale University in New Haven, Conn., conducted a national online survey of the parents of 455 children aged 2-18 years. The purpose was to examine parental perceptions of language related to weight in order to improve the quality of physician-parent discussions about their child’s obesity. The underlying idea is that the likelihood of successful long-term weight loss is enhanced if the parents are committed to the proposed lifestyle modifications.

On a 5-point rating scale, most parents ranked “weight” and “unhealthy weight” as terms they preferred physicians to use in describing their child’s extra pounds. Moreover, the parents indicated they found the terms “unhealthy weight,” “overweight,” and “weight problem” to be the most motivating to lose weight, noted Dr. Stricker, a youth sports medicine specialist at the Scripps Clinic in San Diego.

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Parents are more motivated to help their children drop pounds when doctors avoid the words “fat” and “obese.”

On the other hand, parents perceived the terms “chubby,” “fat,” “obese,” and “extremely obese” quite negatively, rating them as the least motivating to encourage weight loss (Pediatrics 2011;128:e786-93).

These data cast doubt on the wisdom of the British public health minister’s 2010 declaration that U.K. health providers should call their obese patients “fat” to motivate them to lose weight.

As a pediatric sports medicine specialist, Dr. Stricker’s goal is to help overweight kids have a positive sports and exercise experience. He wants it to be “something they’ll want to pass along to their own children.” He combines his exercise guidance with dietary instruction in weight loss, with an emphasis placed on eating multiple small meals to keep the metabolic rate revved so more calories are burned.

But lifestyle interventions don’t always work, and Dr. Stricker highlighted a recent German study that’s eye-opening as to why.

The prospective study included 111 overweight and obese 7- to 15-year-olds and their parents. The youths were referred to a 1-year-long best-practice lifestyle intervention program.

Treatment success was defined as at least a 5% weight reduction at follow-up 1 year after completing the year-long intervention. The investigators found – consistent with their study hypothesis – that psychosocial familial characteristics were significantly predictive of long-term success or failure. This was true even after the researchers controlled for familial obesity in order to cancel out the impact of genetic factors.

The strongest predictor of long-term failure for the lifestyle intervention was maternal depression. Maternal attachment insecurity and family adversity also predicted long-term treatment failure (Pediatrics 2011;128:e779-85).

These findings point to the need for further research aimed at developing lifestyle interventions for pediatric weight loss that are tailored to a family’s psychosocial dynamics, Dr. Stricker observed.

He reported having no financial conflicts. ■

Weight Loss Higher After Roux-en-Y vs. Gastric Banding

BY MARY ANN MOON

FROM ARCHIVES OF SURGERY

Roux-en-Y gastric bypass surgery resulted in greater, more rapid, and more sustained weight loss compared with gastric banding, but also a higher number of complications in a matched-pair study.

The weight loss advantage achieved with Roux-en-Y leads to better correction of the comorbidities that accompany obesity, such as adverse lipid profiles and high fasting glucose levels, said Dr. Sébastein Romy of the department of visceral surgery, Centre Hospitalier Universitaire Vaudois, Lausanne, Switzerland, and his associates.

VITALS

Major Finding: Patients lost 78.5% of excess weight after Roux-en-Y gastric bypass vs. 64.8% after gastric banding; the treatment failure rate after 6 years was 2.5% vs. 38.9%, respectively.

Data Source: A retrospective matched-pair study of 221 Roux-en-Y gastric bypass patients and 221 gastric banding patients at a single center who were followed for at least 6 years.

Disclosures: No financial conflicts of interest were reported.

Although there are more early complications with the Roux-en-Y procedure, they are outweighed by “the much higher long-term major morbidity seen after gastric banding, leading to a large number of major reoperations and their risks,” the investigators noted.

The sharp rise in bariatric surgeries performed in recent years in the United States has occurred predominantly in gastric banding procedures. “This is probably because gastric banding is perceived both by doctors and patients as a simple, safe, and reversible operation but also because of a huge industry-driven marketing campaign,” they said.

Dr. Romy and his colleagues performed a matched-pair analysis of patients who underwent the two procedures in 1998-2005. The study subjects, who had failed to lose weight with more conservative approaches, all had a body mass index of 40 or more, or a BMI of 35 plus at least one severe comorbidity. A total of 221 patients who underwent Roux-en-Y gastric bypass were matched for age, sex, and BMI with 221 who underwent gastric banding. Follow-up rates after 6 years were about 92% in both groups. The same team performed the operations at the same two hospitals.

Maximal weight loss was achieved at a mean of 18 months after Roux-en-Y gastric bypass, compared with 36 months after gastric banding. The percentage of excess weight lost was significantly higher after Roux-en-Y (78.5%) than after gastric banding (64.8%), and the mean nadir in BMI was significantly lower (26.7 vs. 29.4, respectively). After 6 years, only 5 patients (2.4%) in the Roux-en-Y group had a BMI greater than 40, compared with 21 patients (13.8%) in the gastric banding group.

As a result, significantly more patients who had Roux-en-Y surgery were rated as having excellent or acceptable results at all time points during follow-up, Dr. Romy and his associates said (Arch. Surg. 2012 Jan. 16 [doi:10.1001/archsurg.2011.1708]).

Treatment failures were defined as a weight loss of less than 25% of baseline weight or the need to reverse the surgery or convert to a different bariatric procedure. At the 3-year mark, there were no treatment failures among Roux-en-Y patients, compared with 39 treatment failures (18.2%) among gastric banding patients. After 6 years, failure rates were 2.5% and 38.9%, respectively, in Roux-en-Y and gastric banding patients.

Improvement in lipid profiles was significantly greater after Roux-en-Y than after gastric banding. Total cholesterol, LDL cholesterol, and triglyceride levels decreased after Roux-en-Y but not after gastric banding. Fasting glucose levels also were lower after Roux-en-Y (89.55 mg/dL vs. 92.79 mg/dL).

There were significantly more early complications after Roux-en-Y (17.2%) than after gastric banding (5.4%), most of which required only conservative treatment. In contrast, gastric banding was associated with significantly more long-term complications than was Roux-en-Y (41.6% vs. 19%) and required more than twice as many reoperations (26.7% vs. 12.7%). ■

VIEW ON THE NEWS

Still a Few Caveats for Roux-en-Y

“I personally agree” with Romy et al. that Roux-en-Y gastric bypass is the better procedure, but “before we make from this conclusion a paradigm, a few caveats remain,” said Dr. Jacques Himpens.

A case-control study such as this one may be biased. Even though a prospective randomized trial comparing the two surgeries isn’t feasible, a prospective rather than retrospective comparison of matched patients would yield better evidence, as would a multicenter rather than a single-center study.

In addition, a growing number of Roux-en-Y patients are showing neuroglycopenia and diabetes recurrence several years after surgery, which is concerning.

Dr. Himpens *is at the European School of Laparoscopy at Saint Pierre University Hospital, Brussels. He reported being a consultant for Ethicon Endo-Surgery, Covidien, and Gore. These remarks were taken from his invited critique that accompanied Dr. Romy’s article (Arch. Surg. 2012 Jan. 16 [doi:10.1001/archsurg.2011.1855]).*