Primary Care on Front Line of Obesity Treatment

BY JANE SALODOF MacNEIL
Contributing Writer

LAS VEGAS — In theory, team management of obese patients makes a lot of sense.

But in the real world, it may not be possible, because the obesity epidemic is too big, trained specialists too few, and resources too scarce, Arthur Frank, M.D., said at the annual meeting of North American Association for the Study of Obesity.

Primary care physicians must diagnose and treat obese patients in their practices, according to Dr. Frank, medical director of the weight management program at George Washington University in Washington. Primary care physicians need to provide such care even if they have no special skills in managing obesity or access to the nutritionists, dietitians, behavioral counselors, and other specialists who make up weight management teams.

"In the United States, there are 220 million adults over age 18. If 65% are overweight or obese, we have 143 million adults who need care. How can any system care for 143 million people who are overweight or obese?" Dr. Frank asked, laying the problem at the front door of primary care practices.

His remarks opened a workshop on office management of obesity—a subject revisited several times during the meeting, cosponsored by the American Diabetes Association. Here are some practical suggestions from experts in the field:

Guidelines and Other Tools

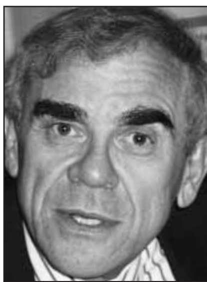
"The best way to describe the current management of obesity is clinical inertia," Robert E. Kushner, M.D., said. "If the patient doesn't lose weight, what does the doctor do? He talks louder."

Treatment guidelines are part of the problem, said Dr. Kushner, medical director of the Wellness Institute at Northwestern University, Chicago. There are too many of them—more than 2,000 at last count, including 135 at the National Guidelines Clearinghouse (www.guidelines.gov), he said—and even the best can be vague about treatment recommendations.

For example, he quoted an algorithm that concluded with a recommendation for the clinician and patient to determine goals and strategies for weight loss. "What is a clinician supposed to do with this?"

Putting aside such caveats, he recommended "The Practical Guide: Identification, Evaluation, and Treatment of Overweight and Obesity in Adults," available on the North American Association for the Study of Obesity (NAASO) Web site (www.naaso.org/information/practicalguide.asp). NAASO created the guide in cooperation with the National Heart, Lung, and Blood Institute, based on clinical guidelines from an NHLBI expert panel.

Still, "for managing obesity, guidelines are not enough. We really have to get down to tools," Dr. Kushner said.



To start, he suggested large blood pressure cuffs, gowns, office chairs, and scales that can accommodate a patient who weighs 350 lbs. Medical history forms should have questions focused on obesity. Patients can be given diet and activity diaries along with specific instructions on how to cut calories and exercise more.

Tell patients to get a pedometer; patients who keep track of how many steps they take each day will become more active over time. "The pedometer—it's not rocket science," he said. "It's not going to win a Nobel Prize, but what a useful tool to … get accountability."

Getting Started

First impressions count, advised Donald Schumacher, M.D. Attitude, body language, and the amount of time a physician spends listening as opposed to lecturing a patient are all important when an overweight person seeks help.

"The last thing someone overweight needs is one more lecture," said Dr. Schumacher, in private practice in Charlotte, N.C. Physicians must form a partnership with these vulnerable patients, and the role of the physician, staff, and patient should be established in the first visit.

Establishing the therapeutic bond is the most important first step, said Peter D. Vash, M.D., of the Lindora Medical Clinic of the University of California, Los Angeles. "Somehow the words, 'I can help you; please work with me,' to my mind set the stage for weight-loss success," he said, calling the 7-10 minutes when the patient is with the physician "a therapeutic window of opportunity."

The initial plan should go slow and be sensitive to the individual, Dr. Schumacher said. Ethnicity, work schedule, travel demands, and the obligations of motherhood are among the factors to consider.

Making too many changes too fast will lose the patient, he said. "Your patients have failed before. You do not want to set your patients up to fail once again."

'How can any system care for 143 million people who are overweight or obese?'

DR. FRANK

Some obese patients will ask their physicians to cite diabetes or hypertension or another condition as the primary diagnosis when billing for an office visit, Dr. Frank said. There is no code for obesity, and the cost might not be reimbursed if the real reason is stated.

Should the physician agree? Some clinicians argue that this is legitimate, because treating obesity can reduce metabolic syndrome, but Dr. Frank said not all physicians are comfortable with that solution. "This is a common ethical problem."

Stages of Care

Physicians are doing a relatively good job of identifying and working with severely obese patients with comorbid conditions, but mildly overweight patients remain a missed opportunity, Dr. Kushner said.

"Everyone who is substantially obese was at one time a little bit overweight," Dr. Frank observed. He urged physicians to do more to identify and help patients "who have an early or mild form of the disease."

"Primary care physicians must treat obesity in an aggressive manner," Dr. Vash said, highlighting the relationships between obesity, diabetes, and hypertension. "If you don't deal aggressively with obesity, obesity will chew up and maim your patient."

Diet and physical activity remain the mainstay of weight-control programs, but pharmacotherapy also has a place, said Daniel H. Bessesen, M.D., of the University of Colorado, Denver.

Medication may not help people shed as much weight as they want or need to lose, but it can boost weight loss by about 5%. The is similar to what can be achieved with behavior modification. Pharmacotherapy and behavioral interventions together can be more effective than either strategy by itself, Dr. Bessesen said.

Yet many physicians refuse to prescribe weight-loss medications. Dr. Bessesen summed up their reasons: The drugs don't work for everyone, they cost too much, and they have side effects. Yet the same can be said of many widely used blood pressure drugs, and diets have side effects, too.

"Our mindset is completely different with other health problems. I think you have to ask yourself, why is that?" he said.

More weight-loss drugs "are coming down the pipe in the next 10 years," he added. "This is going to be a bigger issue in the future."

Dr. Schumacher suggested that clinicians prepare patients for weight gain, so they won't be too embarrassed or frustrated to come back. "You need to remind them that they will lapse, and that's not a personal flaw. That's life, and you will be with them if they lapse."

Gary D. Foster, Ph.D., said low-carbohydrate diets produce greater weight loss at 6 months than low-calorie, low-fat diets. The few studies to evaluate low-carbohydrate diets have reported remarkably consistent short-term results, he said, noting, however, that weight loss at one 1 year was the same as for low-fat regimens.

Dr. Foster, a psychologist and obesity researcher at the University of Pennsylvania in Philadelphia, urged patience when patients do gain back weight. "The patient needs to know we are going to be treating him in a nonjudgmental way," he said, recommending the clinician assume the reason is "lack of planning or skills, rather than a lack of motivation."

Figure out what got in the way of adherence, then come up with a plan for how the patient will deal with the same situation in the future, he advised. ■

Should You Counsel Your Patients Against Using Fad Diets?

BY JANE SALODOF MacNEIL
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LAS VEGAS — With great enthusiasm, an overweight patient announces plans to embark on a fad diet. The physician is skeptical and wants to steer the person to a nutritionally balanced, low-calorie, low-fat regimen. Does it matter which diet the person chooses?

Cathy A. Nonas, R.D., a dietitian, describes herself as "the original anti–Atkins diet person." She was so outspoken that the late Dr. Atkins refused to refer to her by name, she recalled at the annual meeting of the North American Association for the Study of Obesity.

Today Ms. Nonas, director of obesity and diabetes programs at North General Hospital in New York City, does not object to most of the fad diets her patients embrace. "I think the perfect short-term diet is anything that the patient is willing to adhere to that won't hurt the patient," she said.

Even the cabbage diet produces weight loss in the short term. "The truth is, all diets work as long as you can adhere to them," she said, describing long-term weight maintenance as a much tougher issue.

As for the nation's current diet craze, psychologist Gary D. Foster, Ph.D., said low-carbohydrate diets produce greater weight loss at 6 months than low-calorie, low-fat diets. The few studies to evaluate low-carbohydrate diets have reported remarkably consistent short-term results, he said, noting, however, that weight loss at 1 year was the same as for low-fat regimens.

Dr. Foster, clinical director of the Weight and Eating Disorders Program at the University of Pennsylvania, Philadelphia, described these trial results as encouraging but preliminary. So far, no effect has been seen on total cholesterol, he said at the meeting, cosponsored by the American Diabetes Association.

"We need fewer opinions and more data," he said, predicting that an ongoing National Institutes of Health study will be more rigorous in addressing safety and efficacy. "I've never seen a topic in science that inflamed so many opinions based on so little data."

Indeed, Holly R. Wyatt, M.D., warned that telling patients fad diets don't work could have the unintended effect of discouraging them from seeking medical advice.

"You have to be careful about saying, 'What you are doing is not working,' " said Dr. Wyatt, medical director of the Colorado Weigh program at the University of Colorado, Denver. "If you tell them that, and they just lost 10 pounds on the Atkins diet, they are going." ■