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The Ignored Medical Problem

by John Dwan

Obesity: The Ignored Medical Problem

A physician who doesn't recommend that a patient stop smoking is hard to find. Few, however, try to help patients lose weight, even though a recent National Institutes of Health (NIH) study showed that at least 300,000 deaths each year can be attributed to being overweight, obese or severely overweight.

"While being overweight is known to play a role in cardiovascular disease, diabetes, hypertension, coronary heart disease, arthritis and colon, breast, uterine and prostate cancer, and puts nearly every organ system at risk, medical schools provide practically no training in recognizing and treating the condition," said Christopher A. Gay, M.D., instructor in the Department of Family and Preventive Medicine at the School of Medicine. "I received a two-hour lecture in nutrition."

Unfortunately, this complex problem often is treated as depression and behaviorally based, so medical school professors may leave it for the psychologists and mental health providers to teach. Most inexperienced doctors, then, are unprepared to face the epidemic they see in the clinics and hospitals, according to Gay.

Chronic overweight or obesity is a disease that needs to be treated, says the family practitioner. "But I'm afraid it's just easier to focus on the patient's other medical problems."

According to the NIH study, nearly 60 percent of American males and more than 50 percent of women are overweight. The direct economic costs of overweight are "substantial," accounting for 5.7 percent of national health expenditures. Yet, "insufficient attention" is given to obesity "assessment and treatment" at the primary care level.

Why? The report cites lack of time, staff and financial resources available to the physician. Other reasons are limited training and access to patient-education materials; negative attitudes toward people with weight problems and the "high recidivism" rate among those treated; and underestimation of the prevalence and poor understanding of the condition.

"This is also a psychosocial problem, and there is little money

for mental health," said Gay. "It takes a lot of time to properly treat an overweight patient. There is an element of denial; even in the non-obese overweight, most patients tend to overreport their exercise and underreport their diet. There are no simple patterns to obesity, yet everyone wants a 'silver bullet': a pill. It's so much easier to swallow a pill than to get out and do something. We've learned to be lazy," he said.

Gay's approach to treating overweight patients varies, depending upon their degree of overweight and their attitude toward it. "When approaching the patient who desires weight loss, the first thing is to take a very careful history. When did the obesity first occur? In childhood, early or late adulthood, postpregnancy? Is it the result of use of steroids or antidepressants? What is the patient's diet and exercise history? Has he or she tried fad diets, heavy exercise or surgery?"

The next step is to set a "goal weight" with the patient. "This generally has to be modified, as most patients expect to weigh what they did in high school, or on their wedding day," Gay said. The National Heart, Lung and Blood Institute recommends a 10 percent weight-loss goal over six months, i.e., a 240-pound patient should start with a goal of losing 24 pounds.

The patient then is counseled, ideally by a nutritionist, about "sensible foods" and begins a gradually increased exercise program. Caloric intake is reduced by 500-1,000 calories a day with no more than 30 percent coming from fat.

"This, obviously, requires well-motivated patients, and they must make the diet and exercise lifestyle changes permanent, if they expect to keep the weight off," he said. The good thing is that all kinds of improvements happen when people get active and change their dietary habits. Cholesterol levels, exercise tolerance and heart conditions improve; blood sugar control is better. And, all of these things happen even when a patient isn't able to lose weight. So, any change is good.

"For patients of moderate or extreme obesity who are at significant risk of heart disease, a more aggressive approach is not unreasonable," Gay said. "Diet medications or even surgery may be required."

For patients who are obese but not interested in losing weight-and for doctors who are reluctant to address obesity issues with the patient-he recommends a "gentle but forceful repeated approach that points out the many risks of being overweight. Any diet changes will improve overall health and sense of well-being.

"Doctors can make a difference if we address the issue, if we tell

our patients that they should not let obesity happen to them. Gaining weight is a long, slow process, and losing it is even longer. But for those who are willing to know their bodies, recognize their habits and not let avoidance or denial enter in, there is great hope and reason for optimism that they will not become part of this epidemic," Gay said.

The recent Fen-Phen incident and the fact that health food stores, nutrition centers and drugstores are jammed with the latest herbal or natural substance thought to curb appetites, block absorption of fat or speed up metabolism show that America is searching for the quick-and-easy fix to the fat problem. It is estimated that $33 billion per year is spent on diet foods, products and programs.

The NIH study outlined three ways to lose weight: lifestyle changes, drugs or surgery. Lifestyle changes combine diet, physical activity and behavior modification. Weight-loss drugs should be used only as part of a "comprehensive" program that includes diet and exercise. Surgery is an option only for carefully selected patients: those severely overweight for whom other methods have failed and who are at high risk for overweight- or obesity-associated illness or death.

Gay and several of his colleagues recently surveyed Utah physicians to see who was more likely to prescribe anorexigenics (obesity medications). They found that family physicians, male physicians under 40 years old, and younger internists were more likely to attempt to treat their patients' weight with drugs. Female physicians reported a higher proportion of psychiatric problems among the patients for whom they prescribed obesity medications.

"We also found what might be described as a lack of understanding of the 'serotonin syndrome.' This is an excess of the compound caused when antidepressants and anorexigenics are taken together," he said. Serotonin, a neurotransmitter in the brain, affects appetite and mood. High levels are found in the gut, and future diet drugs probably will continue to work on these areas.

"The epidemic of overweight and obesity, and its implications in an increasingly economically driven medical field certainly will continue to challenge physicians," Gay wrote in his study. He believes physicians must become more aggressive in recognizing and treating weight problems in their patients, but there should be more financial reward for doing so. "It means taking much more time with the patient. It's considered mental health work, which means low or no compensation. And there are no assurances of success."

In any event, this modern-day epidemic can no longer be ignored.

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