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Behavioral Interventions for the Management Obesity

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Obesity is a complex, multifaceted condition. Increasing evidence suggests that obesity is not simply a problem of will power or self-control but a complex disorder involving appetite regulation and energy metabolism that is associated with a variety of comorbid conditions.

Overweight and obesity are major preventable and modifiable risk factors for disease, but research affirms that weight loss and maintenance can be accomplished only through a reduction in the number of calories a person consumes and an increase in exercise. To achieve long-term weight loss and maintenance requires a life-long commitment to behavioral change.

Many different approaches to obesity treatment interventions have been evaluated to achieve weight loss and weight maintenance. According to the findings, in order to achieve best treatment outcomes, it is recommended that the combination of dietary therapy with low-calorie diet, increased physical activity, and the inclusion of behavioral interventions should be incorporated.

Weight loss could be achieved by different weight loss programmes such as a one-year weight loss programme in health care centres and a one-year dietary based weight loss programme. Moreover, the attendance at weight loss sessions has been found to be more important in successful weight loss than the component of the diet.

Behavioral approachs are not used alone but in conjunction with other approaches like diet and exercise strategies, and they have been shown to be effective. The main strategies employed in behavioural therapy for weight control are self-monitoring, stress management, stimulus control, problem solving, cognitive strategies, and social support.*Self-monitoring. Keeping an extended food and exercise diary helps to give insight into personal behavior and to bring unrecognized behavior to light.

*Stress management. Stress can trigger dysfunctional eating patterns. Coping strategies, meditation, and relaxation techniques can be learned to reduce stress.

*Stimulus control techniques focus the patient's attention on changing the antecedents of overeating and underexercising.

*Problem solving. Patients engage in self-correction of problem areas related to their eating and physical activity.

*Cognitive strategies. Cognitive restructuring requires modifying negative thoughts, unrealistic goals, and inaccurate beliefs about weight loss and preparing in advance for relapses.

*Social support. A strong system of social support can facilitate weight reduction. Family members, friends, or colleagues can assist in maintaining motivation and providing positive reinforcement.

Finally, patients should be encouraged to take themselves, their health, and, thus, their weight seriously rather than attempting to lose weight so they can like themselves. Reaffirming the patient's self-worth, independent of body weight, is perhaps one of the most powerful interventions a health care provider can provide an obese patient.

Nuclear Cardiology

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Relation between Increased P Wave Duration Variability and Coronary Artery Disease with High Risk Parameters: Scintigraphic Evaluation

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Background: In this study, we aimed to investigate the relation between p wave duration variability and myocardial perfusion abnormality in stabil coronary artery disease.The predictions of increased p wave duration variability in coronary artery disease with high risks parameters were studied.
Methods: In our study, consecutively 96 patients with high suspected coronary artery diseases who were performed treadmill stress perfusion scintigrafi (Tc-99m sestamibi) were enrolled (mean age 55+9). The gated spect images evaluated with model of 17 segments and the subjects seperated to 4 groups as normal group (n=42) only seen reversible defect ischemic group (n=28), was not determined wall motion and systolic thickness in gated images only sen fixed scar group (n=12) and seen both reversible and fixed defects mixed group (n=14). Also the abnormal perfused subjects were divided to low-risk group (1-3 segment abnormal perfused subjects) and high-risk group (4 and above segment perfused subjects). The difference between rest and post exercise p wave duration defined as p wave duration variability (ΔPWD) in exercise stress testin the groups was researched. Above 20 msn accepted increased ΔPWD
Results: The value of average ΔPWD of normal, ischemic, fixed defect (scar group) and mixed group were 18±2.7msn, 21.7±5.6 msn, 26.1±7.5 msn ve 26.4±5.3 msn, respectively. There was a significant difference between normal group and the perfusion defect seen groups (p=0.007, p=0.005, p=0.0006), besides this only the ischemic group and tha mixed group were a difference in perfusion defect seen groups (p=0.001).The average delta pwd was 27.1+6.0 msn in high-risk group (4 and above segment defect) and the average delta pwd was 21.3+4.3 msn in low-risk group (1-3 segment defect).
Conclusıon: There is a significant relation between sintigrafic high risk parameters and increased p wave duration variability and myocardial perfusion defect. Therefore calculated ΔPWD with an ecg is considered that an early prognostic data in stabil CAD.

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