Scott Kahan, MD, MPH - ABCDEF Approach to Obesity Management
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DISCLOSURES
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EVIDENCE-BASED OBESITY TREATMENT IN PRIMARY CARE: A PATIENT-CENTERED A-B-C-D-E-F FRAMEWORK
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Which of these best characterizes your beliefs about obesity treatment?

A. Obesity is a medical condition; it is the healthcare provider’s responsibility to ensure that patients are appropriately counseled and provided appropriate treatment for obesity, when indicated
B. Obesity is a personal issue; it is the patient’s responsibility to ensure that he/she gets the help they need
C. Obesity is both a medical and personal issue; the responsibility for addressing obesity is shared between healthcare providers and patients
D. Obesity is an issue of personal responsibility and willpower; patients should take better care of themselves and not burden the healthcare provider or the healthcare system


An Obesity Paradox


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An “ABCDEF” Approach to Weight Counseling

A: Ask “Permission”

“Over the last few years, your weight has been increasing, and I’m concerned that it may lead to diabetes and other health problems. Would it be okay if we started working on this together?”

B: Be Systematic in the Clinical Workup

- “Just less and exercise more” isn’t helpful
Elicit Weight History

Sample Questions
- **Onset**
  - "When did you first notice your weight increasing?"
  - "What was your lightest and heaviest weight as an adult? What did you weigh in high school, college, early 20s, 30s, 40s?"
- **Precipitating**
  - "Have you noticed specific life events causing weight gain, e.g., stressful new job, marriage, divorce, children, smoking cessation, financial stress, depression, illness?"
- **Quality of life**
  - "How does your weight affect your life?"
  - "At what weight did you feel your best?"
- **Remedy**
  - "What have you done or tried in the past to control your weight?"
- **Setting**
  - "What was going on differently in your life during times when you felt in control of your weight, versus times when it is more challenging to manage?"
- **Temporal pattern**
  - "What is the pattern of your weight gain, e.g., gradual, progressive gain, large, cyclic gain-loss ("yo-yo")?"

Weight History Informs Treatment

<table>
<thead>
<tr>
<th>Medications/Classes Associated With Weight Gain</th>
<th>Potential Alternatives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes medications</td>
<td>Insulin, sulfonylureas, TZDs</td>
</tr>
<tr>
<td>Hypertension medications</td>
<td>Beta-blockers, ACE inhibitors, CCBs, ARBs</td>
</tr>
<tr>
<td>Psychiatric medications</td>
<td>Antipsychotics, mirtazapine, TCAs, paroxetine (Bupropion), nefazodone, fluoxetine</td>
</tr>
<tr>
<td>Birth control</td>
<td>Progestational steroids, Barrier methods, intrauterine devices</td>
</tr>
</tbody>
</table>

An “ABCDEF” Approach to Weight Counseling

- **A**: Address weight loss expectations
- **B**: Counsel on benefits of modest weight loss
- **C**: Use evidence-based counseling strategies


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Guidelines For Intensive Behavioral Therapy

- Patients should receive a comprehensive behavior management program of at least 6 months (Level A)
- Gold standard is on-site, high-intensity (14+ sessions in 6 months), comprehensive intervention, delivered by trained interventionist (individual or group) and persisting for at least 1 year (Level A)
- Low intensity interventions may not be effective (Level A)
- Other approaches (web, phone) lead to less weight loss (Level B)

Behavioral Therapy for Obesity

Counseling
- Regular, frequent interaction via group or individual contact

Diet
- Reduced energy intake, regardless of macronutrient composition

Physical activity
- 150 minutes/week of moderate activity

Behavioral strategies
- Structured curriculum of behavior change education, including identifying target behaviors and building skills to achieve target behaviors
- Self-monitoring of food intake, physical activity, and/or weight
- Goal setting, problem solving, stimulus control
- Addressing barriers to change
- Behavioral resources (e.g., portion-controlled meals)
- Regular feedback and guidance from an interventionist
- Weight maintenance strategies and relapse prevention

Behavioral Therapy in Obesity/Diabetes

- % Weight Loss for Therapeutic Benefit

References
- Diabetes Prevention: 3% to 10% DPP (Lancet, 2009)
- SEQUEL (Garvey et al, 2013)
- Hypertension: 5% to >15% Look AHEAD (Wing, 2011)
- Dyslipidemia: 3% to >15% Look AHEAD (Wing, 2011)
- HbA1c: 3% to >15% Look AHEAD (Wing, 2011)
- NAFLD: 10% Assy et al, 2007; Dixon et al, 2004; Anish et al, 2009
- Sleep Apnea: 10% Sleep AHEAD (Foster, 2009) Winslow et al, 2012
- Osteoarthritis: 5-10% Christensen et al, 2007; Felson et al, 1992; Aaboe et al, 2011
- Stress Incontinence: 5-10% Burgio et al, 2007 Leslee et al, 2009
- GERD: 5-10% (women), 10% (men) Singh et al, 2013 Tutujian R, 2011
- PCOS: 5-15% (>10% optimal) Panidis D et al, 2008; Norman et al, 2002; Moran et al, 2013
**Normal Weight (BMI 19 to 24.9)**

**Obesity (Class I) (BMI 30 to 34.9)**

**Obesity (Class II) (BMI 35 to 39.9)**

**Obesity (Class III) (BMI 40 or more)**

**Increased complications/risk? Increased benefit? Increased risk acceptance?**


**Assess Health Status via Staging**

- Stage 0: Feels good
  - Physically active
  - No known RFs
  - No functional limitations
  - No mental health issues
  - Is aggressive treatment worth it?
  - Are less intensive options sufficient?
  - Is any treatment indicated?

- Stage 2: Hypertension
  - Diabetes
  - Sleep apnea
  - Osteoarthritis
  - Depression
  - Consider:
    - Intensive counseling
    - Referral
    - Pharmacotherapy
    - Bariatric surgery


- Stage 3: Higher co-morbidity
  - Is aggressive treatment worth it?
  - Are less intensive options sufficient?
  - Is any treatment indicated?

- Stage 4: Highest co-morbidity
  - Follow on regular and manage complications


**Staging Better Predicts Outcomes**

- Baseline weight
- Baseline height
- Baseline BMI

**2 Patients of Same Age and Weight/BMI**

**An “ABCDEF” Approach to Weight Counseling**

- **A**: Aspiration to lose weight
  - Overweight
  - Obesity
  - Higher co-morbidity
  - Is aggressive treatment worth it?
  - Are less intensive options sufficient?
  - Is any treatment indicated?

- **B**: Benefits of weight loss
  - Improved quality of life
  - Reduced risk of chronic diseases

- **C**: Co-morbidities
  - Diabetes
  - Hypertension
  - Sleep apnea
  - Osteoarthritis

- **D**: Determining the approach
  - Non-surgical
  - Surgery

- **E**: Evaluation
  - Baseline weight
  - Baseline height
  - Baseline BMI

- **F**: Follow-up
  - Regular visits
  - Monitoring progress

E: Escalate Treatment When Appropriate

- Specialist referral
- Medically-monitored structured diets
- Obesity pharmacotherapy
  - BMI >27 kg/m² with comorbidities
- Medical devices/endoscopic procedures
  - Generally BMI 30-40+ kg/m²
- Bariatric surgery
  - BMI >35 kg/m² with comorbidities

Medically-Monitored Structured Diet/Counseling

- Comprehensive, high-intensity, specialist-led, on-site lifestyle interventions
- May include a medically supervised low-calorie or very-low-calorie-diet utilizing meal replacement products (Level A)
- Average weight loss of 14-21 kg over 11-14 weeks (Level A)

Effect of Weight Loss on Satiety

Obesity Pharmacotherapy

- 5 FDA-approved short-term medications
  - Phentermine and noradrenergics
- 4 FDA-approved long-term medications
  - Orlistat
  - Phentermine/topiramate ER
  - Naltrexone/Bupropion SR
  - Liraglutide 3.0 mg

Obesity Pharmacotherapy

- Use pharmacotherapy as adjunct to diet, exercise, and behavioral counseling for adults… (Level 1 evidence)
  - with BMI 30+; or 27+ with comorbidity;
  - who are unable to lose and successfully maintain weight;
  - who meet label indications
- Assess efficacy/safety monthly for three months, then at least quarterly thereafter (Level 2)
  - At three months, if ≥5% weight loss, continue; if not, discontinue and seek alternative approaches (Level 1)
- Use medications to promote long-term weight loss maintenance (Level 2)
Pharmacotherapy Improves RFs and Prevents Comorbid Conditions

<table>
<thead>
<tr>
<th>Drug</th>
<th>Orlistat</th>
<th>Phentermine/topiramate SR</th>
<th>Naltrexone/bupropion SR</th>
<th>Liraglutide 3.0 mg</th>
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<td>A1C</td>
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</table>

Pharmacotherapy Improves RFs and Prevents Comorbid Conditions

Outcomes by Responder Status

Short versus Long-Term Use

Combination Therapy

Devices and Endoscopic Procedures

Gastric Band
Gastric Balloons
Plenty Hydrogel
Endoscopic Sleeve Gastrectomy

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Guidelines For Bariatric Surgery

- Advise patients with BMI >40 (or >35 with comorbidity) that bariatric surgery may be an appropriate option to improve health (Grade A)
- Offer referral to an experienced bariatric surgeon for consultation and evaluation (Grade A)
- Insufficient evidence to recommend for or against surgery for BMI <35
- No clear guidance for medical devices


Bariatric Surgery Outcomes


F: Follow Up Regularly, Leverage Resources

F: Follow Up Regularly, Leverage Resources

An “ABCDEF” Approach to Weight Counseling


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Follow up, Leverage Resources: Don’t Do It All At Once

- Weight management is a chronic process
- Don’t expect to impact long-term behavioral change during a single episode of care


Follow up, Leverage Resources: Don’t Do It All On Your Own

- Utilize a team-based approach
- Clinical and non-clinical staff
- Referrals and specialists
  - RDNs, Obesity Medicine physicians, CDEs, psychologists, etc
- Community-based programs
  - Diabetes prevention programs, others
- Online/virtual programs


Long-Term Benefits (Generally)
Require Continued Management


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A-B-C-D-E-F FRAMEWORK

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Upcoming FREE Continuing Education Webinar
Early life risk factors for obesity in children with Autism Spectrum Disorder

Villanova.edu/cope

Presented by:
Tanja Kral, Ph.D.
Associate Professor of Nutrition Science
University of Pennsylvania School of Nursing & Perelman School of Medicine

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QUESTIONS & ANSWERS

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