Medical, Surgical, Behavioral, Preventive Approaches to Address the Obesity Epidemic

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This issue of the *Rhode Island Medical Journal* deals with obesity and is meant for the practicing physician to get an up-to-date overview of available preventative community services from the State of Rhode Island and evidenced-based treatment modalities.

Obesity is a major personal health, society and economic problem in the United States, where, according to the Centers for Disease Control, more than one third (36.5%) of adults have obesity. In Rhode Island, about 25%, or about 200,000 persons, have obesity. Every practicing physician sees several obese patients per day. The most recent estimated annual medical cost of obesity in the U.S. was $147 billion in 2008 – $1,429 per obese person per year higher than for those of normal weight.[1]

Obesity has been considered a disease by the American Medical Association since 2013. A person's weight status is categorized by the Body Mass Index, BMI, which is an imperfect measure, but the one that is easiest and most widely accepted. A person with a BMI of 25–30 is considered overweight and a BMI above 30 is considered obese. Obesity itself is classified into Class 1 (BMI 30–35), Class 2 (BMI 35–40) and Class 3 (BMI above 40).

The importance of obesity lies in the systemic effects it has on almost all body systems. It creates an inflammatory state, increases insulin resistance, causes fat accumulation in organ systems such as heart and liver and causes mechanical problems such as back and lower extremity degenerative disease and obstructive sleep apnea. It affects the body from head (increased migraine) to toe (gout and diabetic foot).

The causes of obesity are multifactorial: genetic, societal, cultural, behavioral, and medical. In general, there is an oversupply of calories in proportion to energy expenditure. Over the years, the pendulum of opinion has swung from blaming too much fat intake to too much sugar intake. Although there certainly is a difference in the metabolic effects of various nutrients, there is not one single food group to blame.

The approach to overweight and obesity is also multifaceted because there is no single cause, there is no single symptom constellation and the overweight can range from a few to several hundred pounds. There is also no agreement among researchers about cause, effect and best treatment. In the primary care office the discussion about a person's weight is a sensitive issue and therefore not an easy one and requires more time than most physicians can afford. For that reason, it is a huge market for non-scientific approaches.

There are a number of scientifically well-researched and successful treatment options available. The choice of treatment option should be individualized to each patient.

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In this issue, **DIETER POHL, MD**, and **AARON BLOOMENTHAL, MD**, from the Metabolic and Bariatric Surgery Center at Roger Williams Medical Center, outline the surgical options for the treatment of obesity and the results on comorbidities.

STEPHANIE CURRY, MD, endocrinologist and obesity medicine specialist at CharterCARE Medical Associates and Roger Williams Medical Center, presents additional treatment options with a rapidly expanding field of weight-loss medications. The FDA has approved more than six medications over the past few years after a dormant period of more than a decade.

KAYLONI OLSON, MA; **DALE BOND, PhD** and **RENA WING, PhD**, from the Weight Control and Diabetes Research Center at The Miriam Hospital, describe the behavioral approaches to the treatment of obesity, including lifestyle, nutrition and activity modifications.

DORA M. DUMONT, PhD, MPH; **KRISTI A. PAIVA, MPH** and **ELIZA LAWSON, MPH**, from the Rhode Island Department of Health, explain the relevance of obesity, specifically for Rhode Island and the importance of prevention. In this article they provide information on how physicians can address the obesity epidemic with the help of the Community Health Workers program.

HOLLI BROUSSEAU, AGACNP, and **DIETER POHL, MD**, demonstrate the importance of quality-improvement programs for this high-risk population.

References

1. Finkelstein Eric A, Trogdon Justin G, Cohen Joel W, Dietz William. Health Affairs Estimates. Annual Medical Spending Attributable To Obesity: Payer-And Service-Specific. At the Intersection of Health, Health Care and Policy doi: 10.1377/hlthaff.28.5.w822 originally published online July 27, 2009 28, no.5 (2009):w822-w831.

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