PRACTICE GUIDANCE: OBESITY

The role of community pharmacists in helping to tackle the problem of obesity is becoming more widely recognised. This guidance on best practice for pharmacists when advising on obesity has been prepared in the Royal Pharmaceutical Society's Practice Division

Royal Pharmaceutical Society of Great Britain

The Government's Public Health White Paper, "Choosing health" (2004) has a section on "Tackling obesity", as does the Department of Health's resource document "Choosing health through pharmacy: a programme for pharmaceutical public health 2005–2015 (2005; section 4.6).

Further information on obesity appears in another recent Department of Health publication, "Delivering choosing health: making healthier choices easier" (2005), which is backed by two new action plans entitled "Choosing a better diet: a food and health action plan" and "Choosing activity: a physical activity action plan".

A network of obesity services will be established by primary care trusts with additional funding from 2006. Community pharmacies will be commissioned to offer weight reduction programmes, with signposting to other services and the potential to refer to personal health trainers. Pharmacies will also be able to refer people directly on to Exercise on Prescription schemes, rather than indirectly through GPs.

WHAT ARE OVERWEIGHT AND OBESITY?

Obesity is defined as a body mass index (BMI) of 30kg/m2 or more, where a person's BMI is defined as their weight in kilograms divided by the square of their height in metres. Overweight is defined as a BMI between 25 and 30kg/m2.

The International Obesity Task Force classification of obesity is described below:

PRACTICE POINTS FOR PHARMACISTS

- Weight loss can be achieved only by reducing energy intake to a lower level than energy expenditure. The healthiest way to manage this is through a diet relatively low in saturated fat, and increased physical activity. There are no miracle diets.
- Return to ideal body weight may not be achievable. Sometimes a 10 per cent weight loss, and maintenance of that, is a more realistic goal.
- Changing eating habits is challenging. Individuals need to be involved and supported in food change decisions. Start with two or three specific changes (eg, fruit instead of a pudding; spreads high in monounsaturated fat such as olive oil, or in polyunsaturated fat such as corn oil or sunflower oil, instead of butter). Once these have been adopted, further changes can be agreed.
- Involve partners and families in the patient's attempts to lose weight and make healthier food choices.
- Dietary information should be given in terms of foods, not nutrients (eg, reduce intake of fried foods, not reduce fat).
- Consider and discuss financial and time constraints, cooking ability and facilities as well as making sure that the dietary change is enjoyable and sustainable.
- Patients need to understand that weight control will require a life-long change in eating habits and physical activity.
- Patients prescribed drug therapy must be counselled to discuss side effects.

IOTF Classification	BMI (kg/m²)
Underweight	<18.5
Normal range	18.5-24.9
Class I overweight	25-29.9
Class II obese	30-34.9
Class IIa obese	35-39.9
Class III obese	≥40

In addition to the determination of BMI, waist circumference presents another simple way of assessing someone's risk from being overweight, as fat around the waist is associated with a higher risk of developing cardiovascular and other diseases than fat in other parts of the body.

Waist circumference is measured midway between the lower margin of the ribs and the top of the iliac crest laterally.

	Increased health risk	Substantially increased health risk
Men	≥94cm	≥102cm
Women	≥80cm	≥88cm

HOW GREAT IS THE PROBLEM?

Obesity in adults in the UK has trebled in the past 20 years. The lives of many sufferers of obesity are being shortened by up to nine years.

- In 2002, 22 per cent of men and 23 per cent of women were clinically obese (BMI >30).
- 43 per cent of men and 34 per cent of women were overweight (BMI > 25-29.9).
- The problem also affects young people. In 2002 a health survey showed that one in 20 boys and one in 15 girls were obese.
- The prevalence of obesity in children is predicted to be more than 50 per cent by 2020.
- In disadvantaged social classes obesity is greater.
- The level of obesity is higher in Scotland and Wales than in England.
- People of differing ethnic backgrounds have different levels of obesity:
  - In England in 1999, black Caribbean women were 50 per cent more obese than average
  - Pakistani women were 25 per cent more obese than average
  - Obesity is four times more common in Asian children than in white children.

WHAT ARE THE CAUSES?

- Eating too much.
- Lack of regular physical exercise. Up to two thirds of men and three quarters of women do not take the recommended amount of physical activity. Children are generally less active than the national guidelines.
- These lower levels of daily activity by us all are caused by an increase in sedentary occupation and screen-based entertainment (computers and television). Families are using their cars for ever shorter journeys. Children become housebound as parents are worried about letting their children play outside.
- School meals at present do not provide children with a healthy option. Overall standards for school meals will be introduced in 2006.
- Increased snacking activity. There are far more retail food outlets than ever before providing high-calorie snacks.
- Diets high in saturated fats.
- Increased alcohol intake during the past decade, particularly in women and young men.

HEALTH CONSEQUENCES

Being overweight or obese can seriously affect one's health and can manifest itself in any of the following conditions:

- Decreased life expectancy.
- Development of type 2 diabetes (in adults and, increasingly, in young people).
- Cardiovascular disease.
- Certain forms of cancer are more common in obese people:
  - colorectal and prostrate in men
  - breast, endometrium and gall bladder in women.
- A large number of associated conditions:
  - osteoarthritis, breathing difficulties, gallstones, abnormalities of the reproductive system including infertility and complications of pregnancy, sleeping problems and alterations in liver function
  - may lead to cirrhosis.

PREVENTION

- Maintaining the right energy balance, by ensuring that energy intake does not exceed energy expenditure.
- A balanced diet rich in fruit, vegetables, and lower-glycaemic index (GI) carbohydrates. The GI is a ranking system for carbohydrates based on their immediate effect on blood glucose levels: low-GI foods include beans and pulses, porridge, bran cereals and some fruit (apples, oranges, pears); high-GI foods include bread, rice, potatoes and cornflakes. There should be moderate amounts of milk and dairy products, meat, fish or protein alternatives, and limited amounts of food containing sugar and fat – with the emphasis on reducing saturated fats and increasing mono- and polyunsaturated fats. If weight needs to be lost, a balanced reduction across the different food groups is advisable, rather than a diet that excludes certain food groups.
- Regular physical activity helps control body weight and has significant benefits for physical and mental health. Current recommendations for adults are a total of at least 30 minutes of moderately intensive activity (eg, brisk walking) on at least five days a week. Children should have at least one hour of moderately intensive physical exercise every day.

MANAGING LIFESTYLE CHANGE

Psychology has a lot to do with weight reduction. It is important to establish the reasons why a person wants to lose weight and their level of commitment. The return to an ideal body weight may not be an achievable target. A realistic goal is likely to be a loss of 5–10kg of body weight which may be maintained over a period of many years.

The diet for weight loss should provide fewer calories than the daily energy requirement. Drastic energy reduction, below the daily levels can lead to dietary non-compliance, with a loss of lean tissue rather than body fat. The diet must be realistic and affordable.

Before giving dietary advice, it is important to know the person's current eating habits, whether weight has been lost in the past and how long this was maintained. Asking the person to keep a food diary can be useful. Attendance at groups (eg, WeightWatchers) helps some individuals.

COMMERCIAL DIETS

There are many popular commercial weight loss diets. Some promote a "quick fix" solution to obesity and may be nutritionally unsound.

- One food only — the grapefruit diet.
- Banned foods — the no-chocolate diet.
- Food combining — the Hay diet.
- Minimal carbohydrate intake — the Atkins diet.

OTC SLIMMING PRODUCTS

Various over-the-counter slimming products are available and are heavily promoted in the press. Some are suggested to have effects on:

- Satiety — fibre products.
- Absorption — chitosan.
- Fat oxidation — carnitine, conjugated linoleic acid.
- Metabolic rates — caffeine, ephedrine.
- Lipogenesis — hydroxycitrate.

There is little convincing evidence of benefit for any of these products.

DRUGS

Drugs licensed for the treatment of obesity are **orlistat** and **sibutramine**. They should be prescribed for individuals who have attempted seriously to lose weight by diet, exercise and other behavioural modification. Drugs should never be the sole element of treatment.

A proactive telephone support service called MAP (Motivation, Advice and Proactive Support) is available (in different forms) to both people who are trying to lose weight before being prescribed orlistat, and those who are on orlistat (www.medicines-partnership.org/projects/current-projects/map-programme).

INFORMATION REQUIRED FOR ASSESSMENT

The following information is required before assessing a patient's predisposition towards obesity:

- Height (m) and weight (kg).
- Waist circumference (cm).
- Blood pressure (mmHg).
- Blood glucose (mmol/l).
- Total cholesterol.

This guidance on best practice when advising on obesity has been prepared by the Practice Division of the Royal Pharmaceutical Society of Great Britain

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