FIRST, DO NO HARM: TREATING YOUTH WITH HIGHER BMIS

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CHLA Care Network Collaborative Town Hall

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DISCLOSURES

None

LEARNING OBJECTIVES

By the end of this presentation, participants will be able to:

1) Summarize the recommendations for screening and treating youth with higher BMIs outlined in the AAP's recent *Clinical Practice Guideline for Children and Adolescents with Obesity*

2) Evaluate potential harms of these recommendations related to weight stigma and disordered eating risk

3) Develop a weight-inclusive clinical approach to managing youth with higher BMIs that prioritizes health without increasing the risk of disordered eating

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Clinical Practice Guideline for the Evaluation and Treatment of Children and Adolescents With Obesity

Hampl, Hassink, Skinner, et al. Clinical Practice Guideline for the Evaluation and Treatment of Children and Adolescents With Obesity. *Pediatrics* February 2023; 151 (2): e2022060640. 10.1542/peds.2022-060640

SUMMARY OF SCREENING RECOMMENDATIONS:

Check height, weight, and BMI once a year and plot on a growth curve at least once a year

Screen those with BMI > 85th pc as appropriate for comorbidities: lipid abnormalities, abnormal glucose metabolism, NAFLD, hypertension

Consensus recommendations:

- Obtain sleep history and obtain polysomnogram in those with symptoms
- Evaluate for PCOS symptoms, MSK symptoms, symptoms of idiopathic intracranial hypertension
- Evaluate for depression

SUMMARY OF TREATMENT RECOMMENDATIONS:

"Overweight (>85th pc BMI) and obesity (>95th pc BMI) should be treated" – with or without comorbidities.

Treatment should start as early as possible, i.e. definitely by age **6 years**, and strongly consider as early as age **2 years**.

SUMMARY OF TREATMENT RECOMMENDATIONS:

How to treat?

"Intensive health behavior and lifestyle treatment" (IHBLT)

- Ideally >26 hours, face to face, family-based, over 3-12 months, multidisciplinary
- Health education + behavioral modification and counseling (i.e. nutrition and physical activity)
- Should provide/refer for 6 yrs and older, may provide/refer for kids 2-5 years

For kids 12 and older: should offer **weight loss pharmacotherapy** if BMI > 95th pc, as an adjunct to IHBLT

- Consensus statement: may offer pharmacotherapy to kids 8-11 years

For kids 13 and older: should offer **metabolic/bariatric surgery referral** if BMI is >120% of 95th pc

ACADEMY OF EATING DISORDERS RESPONSE

"In line with the Hippocratic oath of *first, do no harm*, the AED urges the AAP to revise their Guideline with input from key stakeholders including eating disorder professionals and individuals/families with lived experience in higher-weight bodies."

3 Main Concerns:

1. **"Although pediatricians are advised to approach the topic of weight with sensitivity, we are concerned that traditional medical training minimally equips healthcare providers with these skills."** Concern th… "explicit focus on weight loss" will perpetuate **weight stigma** → known association with poor menta… physical health outcomes.
2. **Only minimal reference to eating disorder treatment and referral.** "Eating disorders are potenti… illnesses that occur across the weight spectrum and individuals of higher weight are at especially hig… Guideline mentions screening, but no advice about what to do if an ED is suspected or identified.
3. **Concerns about long-term efficacy and safety of medications for children as young as 8 yrs, and surgery for teens as young as 13 yrs."**
   - "…we wonder about the independence of the AAP recommendations given the financial reliance on pharmaceutical companies that is often required to investigate medication efficacy."

THE TRADITIONAL MODEL OF HEALTH AND WEIGHT

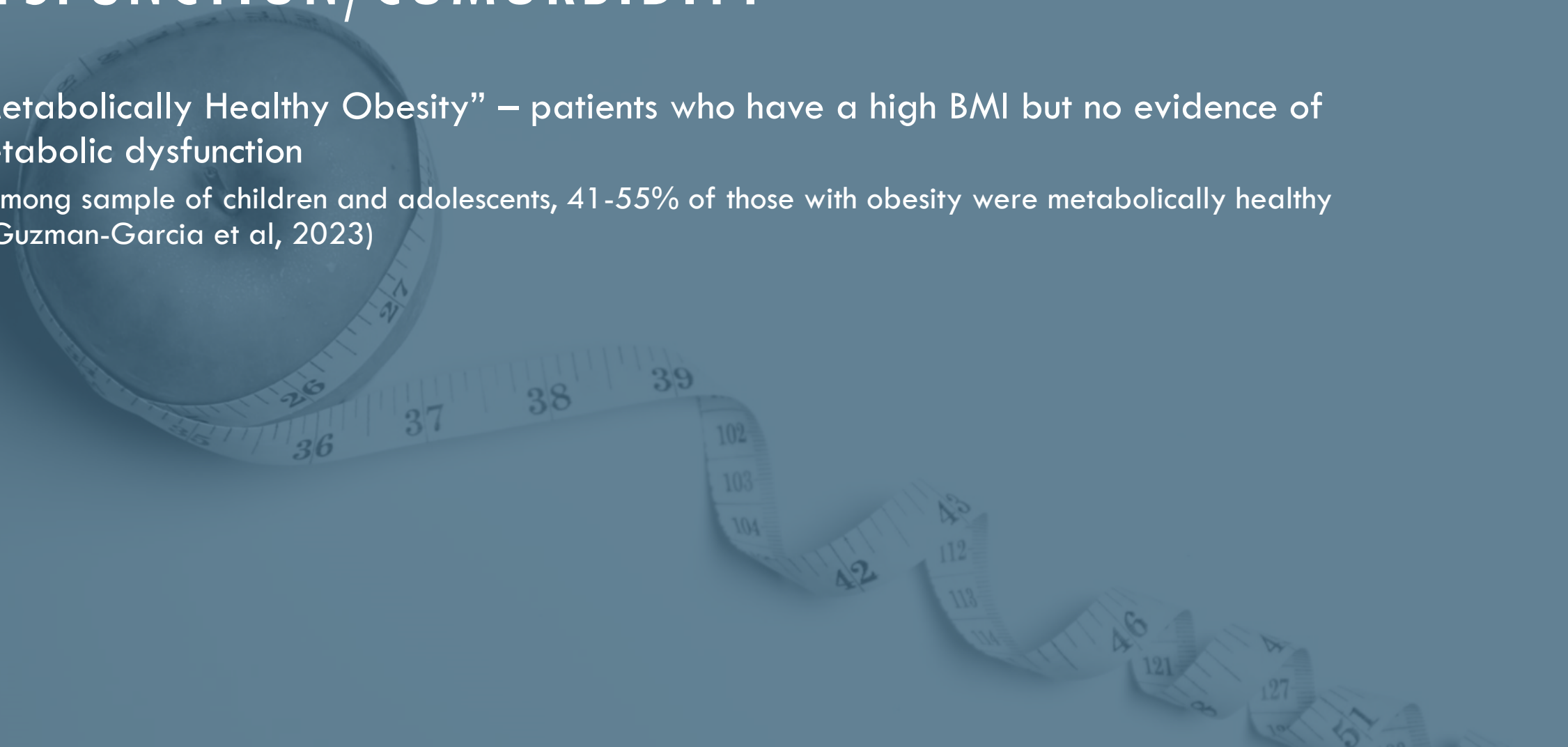
Weight Normative
Model of Health

Weight Stigma

PRESENCE OF METABOLIC DYSFUNCTION/COMORBIDITY

"Metabolically Healthy Obesity" – patients who have a high BMI but no evidence of metabolic dysfunction

- Among sample of children and adolescents, 41-55% of those with obesity were metabolically healthy (Guzman-Garcia et al, 2023)



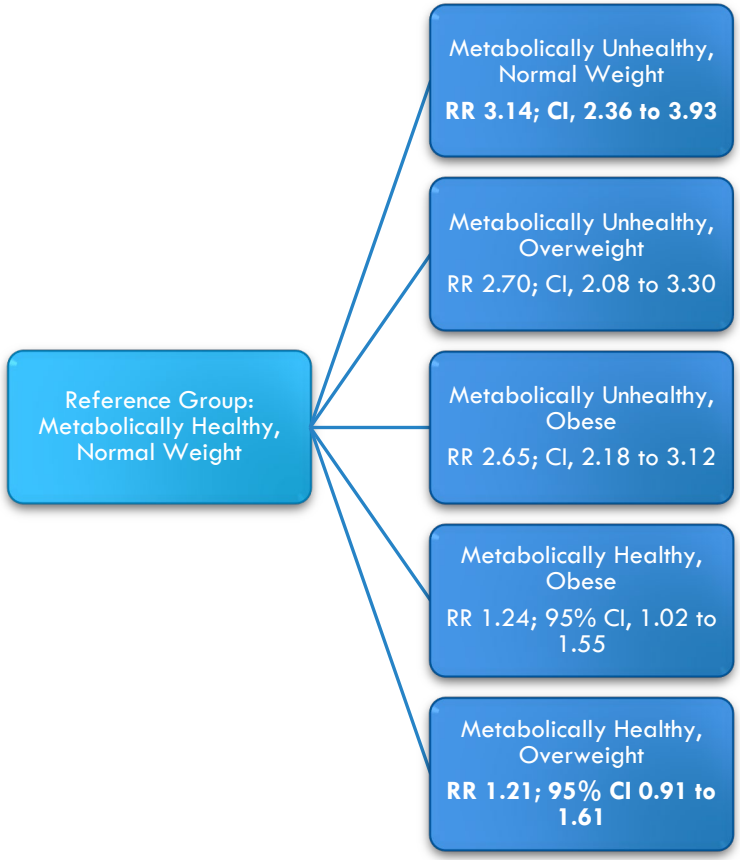
DIFFERENCES IN OUTCOMES?

All-cause mortality and/or cardiovascular event, at least 10 years of follow-up (Kramer et al, 2013)

6 groups:

- Weight status: normal, overweight, obese
- Presence/absence of any component of the metabolic syndrome

AT LEAST 10 YEARS OF FOLLOW-UP



CRITERIA FOR "METABOLICALLY HEALTHY OBESITY" IN CHILDREN? (ABIRI ET AL, 2023)

Consensus-based definition developed through a Delphi process involving an international panel of 23 experts.

Review included a total of 63 non-randomized studies, published between 2007 and 2022.

Consensus (≥80% agreement):

HDL > 40 mg/dl

TGs < 150 mg/dl

Fasting glucose < 100 mg/dl

Measure of insulin

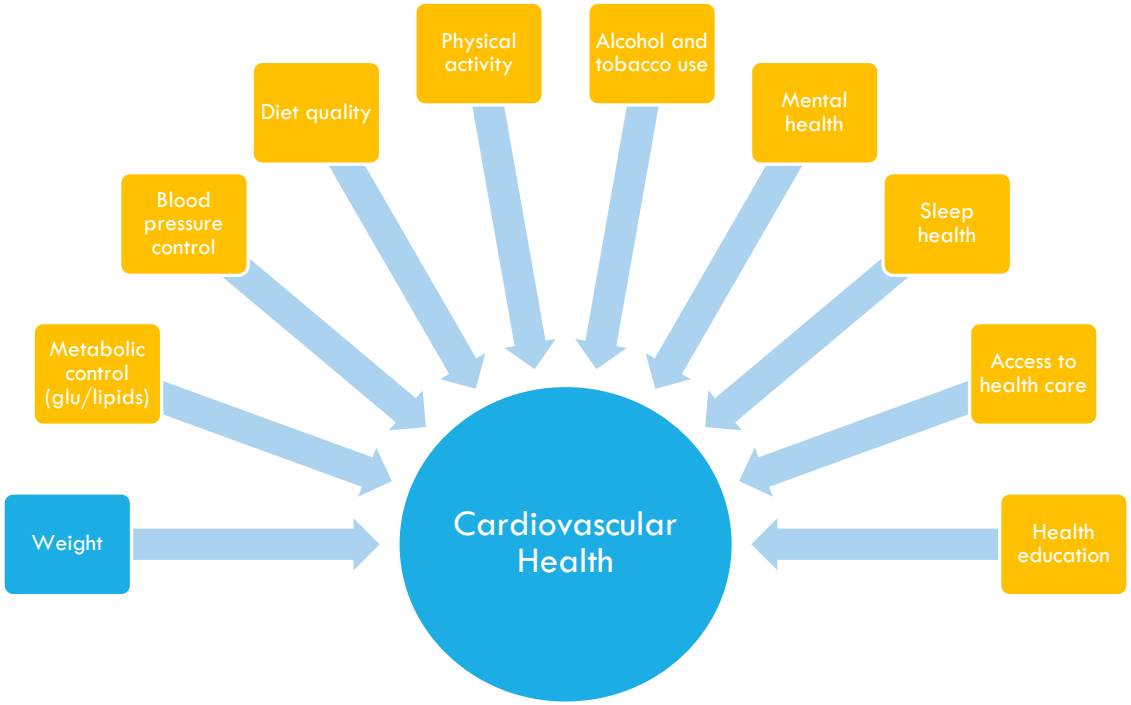
SBP/DBP ≤90th percentile

METABOLICALLY HEALTHY OBESITY

Concept of “Health at Every Size”™

Controversial, but makes the case for **risk stratification**

A HEALTH-FOCUSED MODEL



Adapted from Fawzy and Lip, 2021

WHAT IS WEIGHT BIAS/STIGMA?

Negative beliefs or experiences that we project onto people because of their weight (Puhl et al, 2018)

- Weight-related teasing or bullying
- Weight-related discrimination
- Social avoidance, prejudice, stereotyping, devaluing based onweight
- Belief that behavior is the only contributor to weight

Present in toddlers (before age 3 yrs) and influenced by maternal attitudes (Ruffman et al, 2016)

Highly prevalent among physicians, medical students, nurses, and systemically in health care settings (Phelan et al, 2014; Rubino et al, 2020; Puhl, 2014)

- Providers: poorer quality of care (Rubino et al, 2020)
- Patients: Less trust of providers, avoidance of follow-up care, poorer treatment adherence, poorer communication with providers, delay in preventive health screenings (Puhl et al, 2016)

OUTCOMES OF WEIGHT STIGMA

Physical: higher weight, higher A1c, higher BP, higher cortisol levels, higher CRP (Wu and Berry, 2017; Puhl et al, 2016)

Weight Bias Internalization: When people internalize the thin ideal and project negative beliefs onto *themselves* (Puhl et al, 2018).

In children and adolescents, WBI strongly associated with (Pont et al, 2017; Puhl et al, 2018; Haqq et al, 2021):

- Depression, anxiety, suicidality
- Substance use
- Poor body image and disordered eating behaviors: restriction, binging, unhealthy weight control behaviors
- Often more weight gain over time

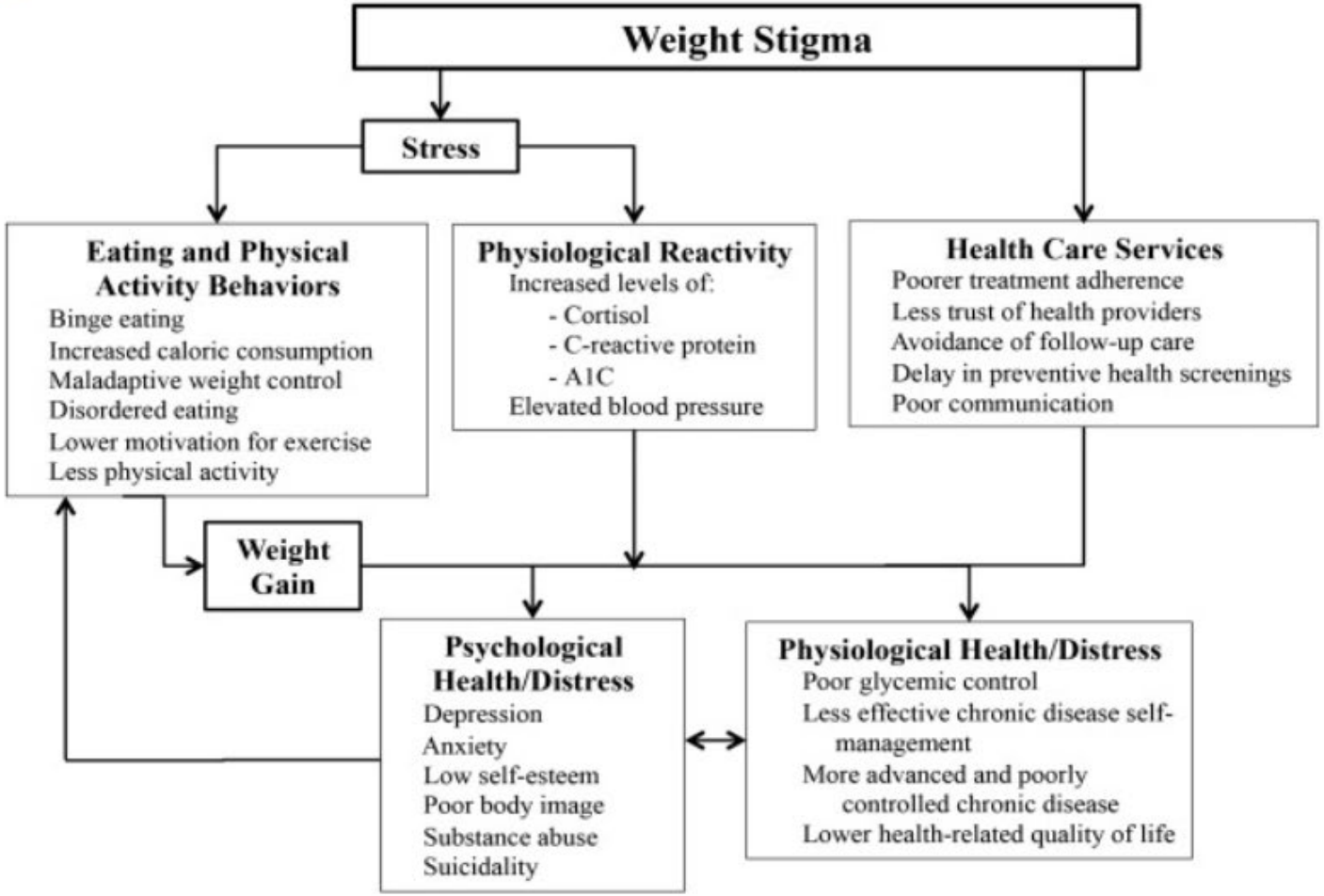


Figure 1 from Puhl et al, 2016

Health consequences resulting from experiences of weight stigma.

EATING DISORDER RISK

- Kass et al, 2015: Being identified as overweight by a nurse, doctor, or other health professional is an **independent risk factor** for increased eating disorder risk.
  - Even after adjustment for current BMI, weight-related teasing, history of an eating disorder, and family history of being identified as overweight.

DISORDERED EATING AMONG OVERWEIGHT YOUTH

- Patients and parents commonly misinterpret obesity prevention messages, eliminating foods that they perceive as "bad"[1]
- Disordered eating and unhealthy weight control practices are more common in overweight youth than normal weight youth[2-8]

[1]*Sim et al, 2013*
[2]*Neumark-Sztainer et al, 2002*
[3]*Neumark-Sztainer et al, 2007*
[4]*Flament et al, 2015*
[5]*Eaton et al, 2012*
[6]*Neumark-Sztainer et al, 2012*
[7]*Loth et al, 2015*
[8]*Kass et al, 2017*

INCREASED PREVALENCE OF ATYPICAL ANOREXIA NERVOSA

As common or more common than traditional AN (Harrop et al, 2021)

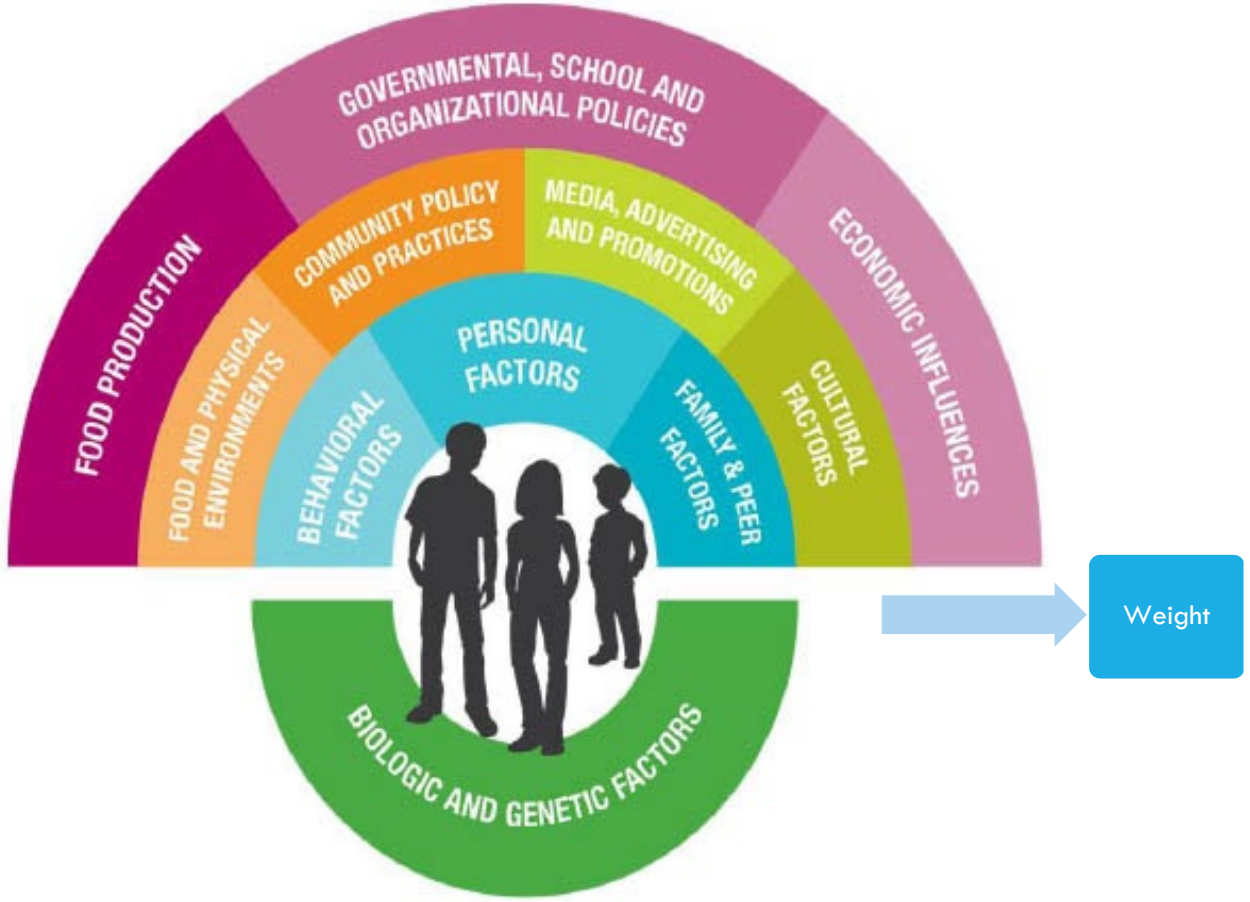
Account for an increasing proportion of seriously ill eating disorder patients who require hospital admission (Whitelaw et al, 2014; Lebow et al, 2015)

DEGREE OF WEIGHT LOSS MATTERS MORE THAN ABSOLUTE WEIGHT/BMI

Greater rate of weight loss, duration of weight loss, and magnitude of weight loss are associated with: (Garber et al, 2019; Whitelaw et al, 2014; Whitelaw et al, 2018; Sawyer et al, 2016; Peebles et al, 2010; Swenne, 2016)

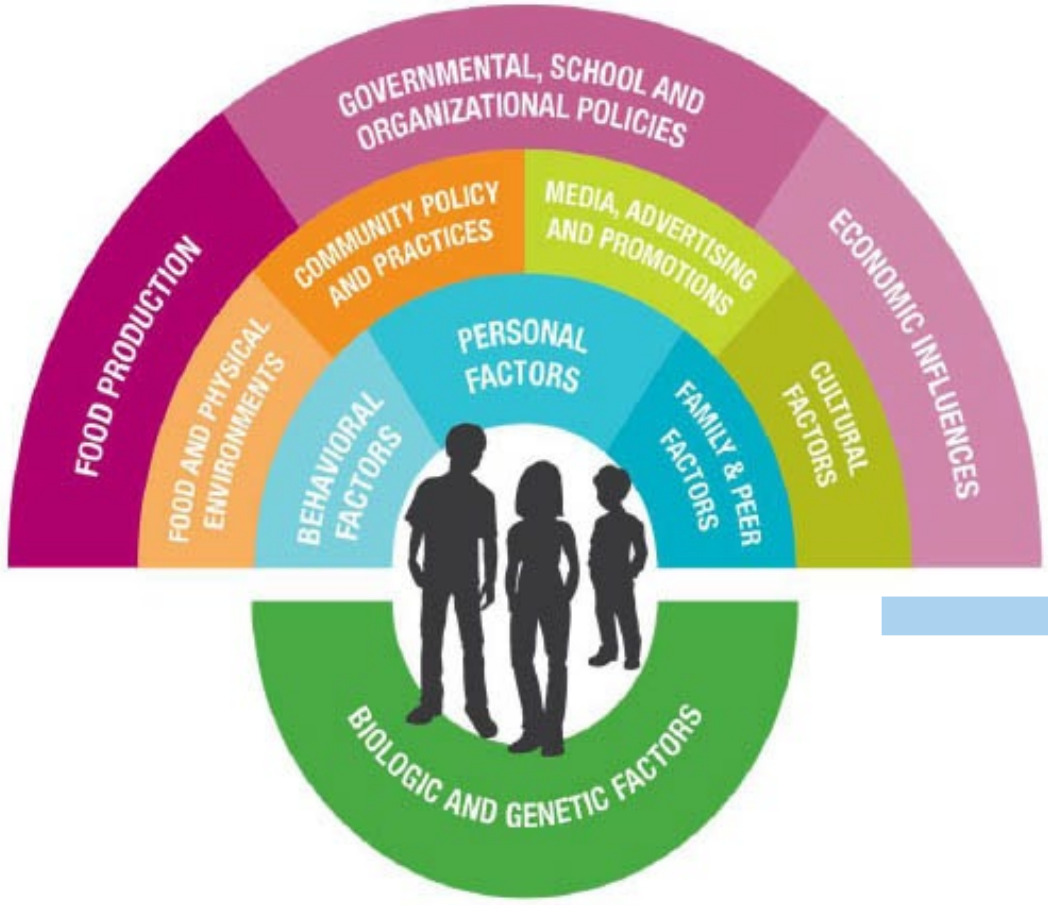
- More severe cardiac outcomes (e.g. bradycardia, orthostasis)
- Higher risk of refeeding syndrome
- More cognitive dysfunction and severity of ED thoughts

AVOIDING WEIGHT STIGMA

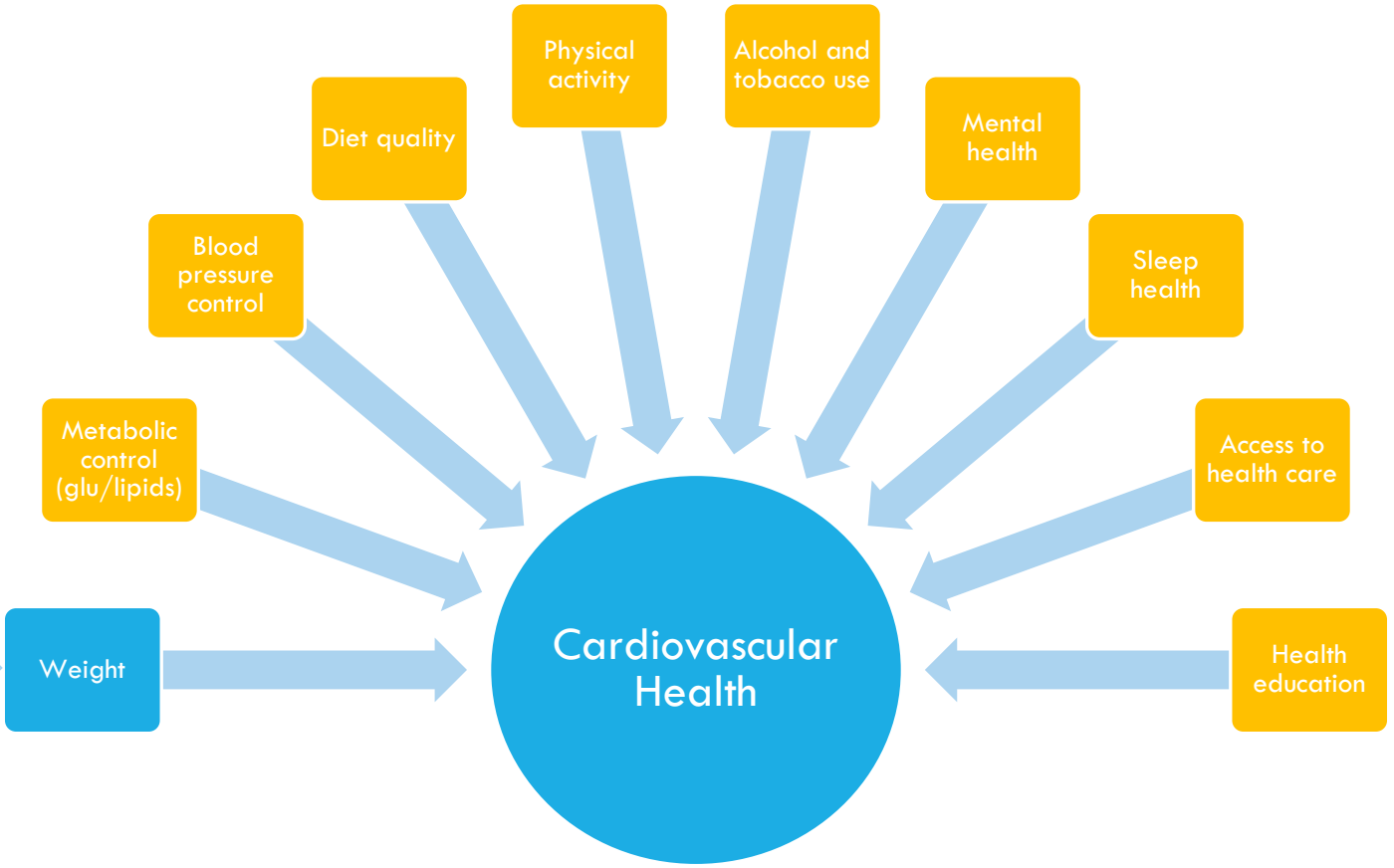


Perry et al, 2015

PUTTING IT TOGETHER: A WEIGHT-INCLUSIVE APPROACH TO CARDIOVASCULAR HEALTH



Perry et al, 2015



Adapted from Fawzy and Lip, 2021

A WEIGHT-INCLUSIVE APPROACH

Recognition that contributors to higher BMIs are not just behavioral – avoiding blame or shame

Use of weight-inclusive language

Risk stratification of patients with higher BMI to determine the degree of intervention required

WEIGHT-INCLUSIVE LANGUAGE

Puhl, 2020

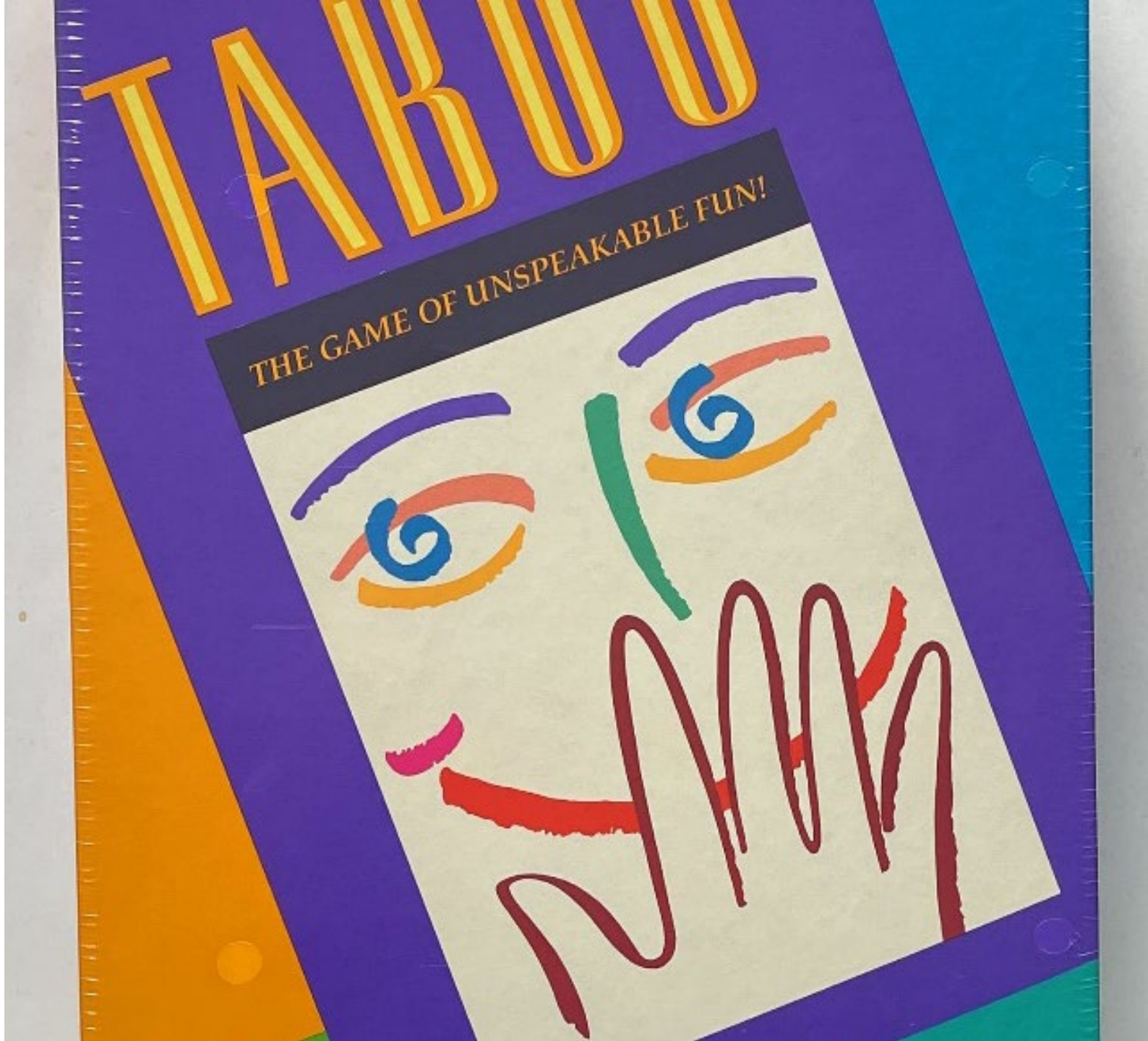
- Varies among different cultural/racial/ethnic groups
- Preferred terms are "higher weight" or "higher BMI".
- People prefer to discuss BEHAVIORS than weight
- Try not to use the **"O-Words"**

Ample evidence that ideal body weight/shape varies among ethnic and cultural groups

Self-reflection on our own weight stigma/bias

CAN YOU ASSESS AND COUNSEL A PATIENT WITH A HIGHER BMI WITHOUT MENTIONING THE WORD "**WEIGHT**"?

Challenge



NEVER PRAISE RAPID WEIGHT LOSS.

Never set weight goals – the goal is HEALTH.

Praise increases in healthful behaviors, not changes in weight

Closely monitor rate of weight loss

- Maximum 2 lbs per week, ideally 0.5-1 lb per week
- EXPRESS CONCERN if weight loss is too rapid, and intervene

Ensure linear growth and pubertal development are not compromised by weight loss

ADDRESS BODY IMAGE PRO-ACTIVELY.

Proactive anticipatory guidance about pubertal changes

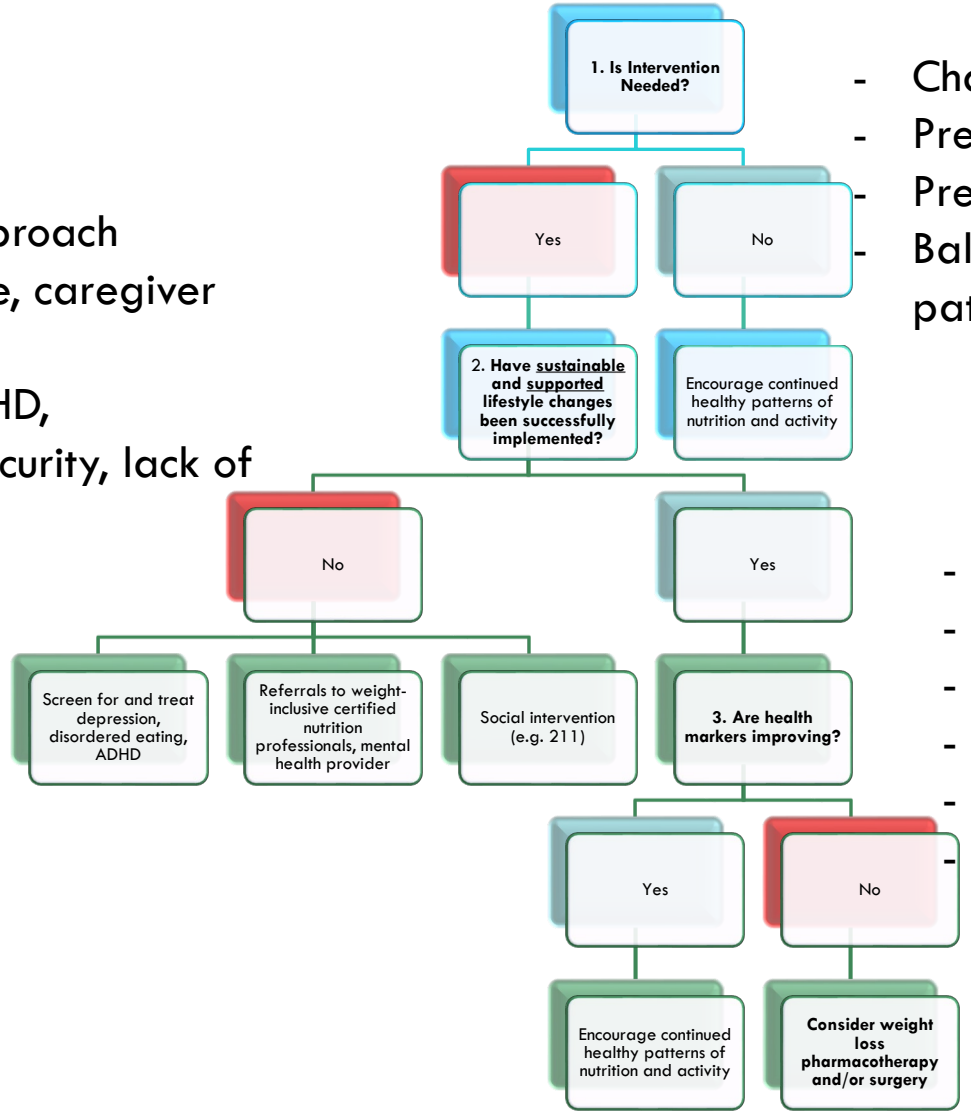
Depersonalize and neutralize weight – and encourage families to do the same

- "Weight is just a vital sign"

Dog analogy

AN APPROACH TO RISK STRATIFICATION

- Sustainable = Total Diet Approach
- Supported = weight-inclusive, caregiver support
- Roadblocks: depression, ADHD, disordered eating, food insecurity, lack of safe spaces to be active



- Change in growth curve?
- Presence of metabolic dysfunction?
- Presence of comorbidity?
- Balanced nutrition and physical activity patterns?

- Glucose, A1c, insulin
- Lipid panel
- Liver enzymes
- Waist-height ratio
- Improvement of comorbidity
- Cardiovascular fitness

EFFECTIVE LIFESTYLE CHANGES

NO FAD DIETS

Sustainable: Total Diet Approach (Freeland-Graves et al, 2013) + Enjoyable Physical Activity

- **There are no good or bad foods.**
- Pattern = more important than individual foods
- Variety of food groups combined in appropriate proportions
  - E.g. Plate model (1/3, 1/3, 1/3)
- Choose nutritionally dense foods
- Nutrition should be obtained from food as often as possible, not supplements or vitamins.
- **In general: have as few rules as possible**

SCREEN REGULARLY FOR DISORDERED EATING BEHAVIORS (PATIENTS AND PARENTS!)

Fad dieting

Restrictive eating

Fasting

Binge eating

Emotional eating

Night eating

Vomiting

Laxatives

Detox/weight loss/"cleanse" products

Excessive use of protein products

SCREEN REGULARLY FOR DISORDERED EATING BEHAVIORS (PATIENTS AND PARENTS!)

Provide education and discourage fads/dieting

Teach media literacy

Refer to eating disorder mental health providers/dietitians

ENCOURAGE KIDS (AND FAMILIES) TO…

Be flexible and spontaneous

Be social

Make room for celebration eating

ENGAGE FAMILIES

Assess family culture around food and eating

Advise against (and gently call out) weight-related criticism or teasing

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THANK YOU!

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