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Obesity management: General practitioners need support

I congratulate Dr Duns for his interesting editorial on obesity in the July 2017 issue of *Australian Family Physician*.¹ I agree that many lifestyle-dependent and lifestyle-independent factors play a major part in the development and treatment of multi-risk factor obesity. There is one 'physician' aspect worth mentioning.

In one study in the US, for example, 79% of patients who attended a family medicine practice did not have overweight or obesity included in their medical problem list.² The ability of general practitioners (GPs) to recognise patients who are overweight or obese is also not always correct. An analysis by the Bettering the Evaluation and Care of Health (BEACH) research program in Australia showed that GPs underestimated 36% of their patients who were overweight as having a normal weight or being underweight, and 40% of patients who were obese as being overweight or having normal weight.³ This could be improved by routine monitoring of body mass index (BMI) and waist circumference in general practice, as recommended by Australian guidelines for the management of adult patients who are overweight and obese in primary care.^{3,4} However, recent studies of routine general practice data in Australia concluded that of the patients in the studies, 22–31% had a BMI recorded and only 4–8% had a waist circumference recorded in their electronic medical records.^{5,6}

If we then examine the rare data prevalence of overweight and obesity among GPs, it becomes clear that about half of the doctors are overweight or obese.⁷ This also means that physicians themselves do not look after their own physical health or manage their obesity adequately, which can adversely affect

documenting obesity or initiating a weight loss conversation (ie nutrition, physical activity, lifestyle counselling practices) with their patients who are obese.⁶ Training and support for lifestyle behavioural principles and techniques would be desirable for GPs and very valuable in the long-term management of obesity.^{8,9}

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Weight loss and appetite suppressants at menopause

We question how the approach to weight loss proposed by Professor Proietto (*AFP* June 2017)¹ is applicable to general practice and what overall harm it is purporting to address.

It is certainly true that weight gain occurs at menopause and that this weight is centrally deposited, which may affect a patient's cardiovascular risk profile. However, this gain is in the order of only 2.5–5 kg. It is difficult to know how much of this change in risk is related to weight gain in isolation or the overall physiological changes associated with menopause. It is also important to note that there is some evidence that weight gain at menopause may in fact be protective.²

The author describes weight gain and loss to be a matter of energy in and out. There is a growing body of evidence to suggest it isn't that simple.³ A good general practitioner must consider a patient in context, including their relationship to food and individual stressors that may have caused weight gain. If these complexities are not addressed, restrictive dieting will not solve the problem in the long term.

Restrictive diets can be associated with the development of eating disorders. The evidence also shows that, long term, they cause weight gain, not loss.^{4–6} There is little evidence around long-term use of appetite suppressants, as suggested by the author. However, the potential side effects suggest such a practice should not be entered into lightly.^{7,8} We worry that the failed use of appetite suppressants due to intolerable side effects could, paradoxically, lead to weight gain. The competing interests of the author has not escaped our notice.

Menopause is a time of great change, adjustment and, not infrequently, great vulnerability. The potential damage (harms

of appetite suppression, development of disordered eating, damage to self-esteem) during an already emotional change for an average weight loss of only 2.9 kg strikes us as being of dubious benefit.

We advocate for consideration of potential significant harms to a vulnerable patient population, and a more holistic, patient-centred approach in line with the aims of general practice.

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Reply

I thank Drs Roxburgh and Riley for commenting on my article (*AFP* June 2017).¹ They make several points.

The first is that weight gain at menopause is only 2–5 kg and may be protective. However, the reference they have cited clearly says that the benefit was seen only in women with BMI <25 kg/m² and that weight gain increased mortality risk of men and middle-aged women.²

The second point is that weight gain is not simply a matter of energy in and

energy out. Fat is stored energy, and energy cannot be created or destroyed (laws of thermodynamics). Any weight gain can only be the result of changes in either energy intake or energy expenditure. All of the mechanisms proposed by McAllister et al,³ whose article Drs Roxburgh and Riley cite, can only work through change in either energy intake or energy expenditure.

The most baffling comment from Drs Roxburgh and Riley, citing references 4–6, is that restrictive diets can lead to weight gain.^{4–6} For example, Neumark-Sztainer et al⁵ conclude that adolescents who dieted were heavier five years later when compared with those that did not diet. However, the study by Neumark-Sztainer et al⁵ was not a randomised study. The explanation for their data is that, as obesity is genetic,^{7–10} young people struggling to avoid weight gain because of their genetic make-up went on a diet, while those who were naturally lean did not. This is the reason why, five years later, the dieters were heavier than the non-dieters.

The comments about medication do not take into account the fact that nearly everyone regains weight and that this is due to the powerful defence of weight by hormone and energy changes (as discussed in my paper).¹

If serious consideration of restrictive diets was avoided by most general practitioners, there would be no hope of making a dent in the obesity epidemic, with untold harm to the community. Fortunately, this is not the case.

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