Kılavuzlarla Obezite Tedavisi

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Obezitenin sınıflandırılması

- DSÖ-1995'de beden kütle indeksini obezitenin değerlendirilmesinde kullanılmasını önerdi
- BKİ'nin 'normal ağırlık' sınırlarına daha önce yapılan çalışmalarda yön verdi

✓*Enfeksiyonel hastalık sıklığı*
✓*Çalışma performansı*
✓*Kronik hastalık görülme*
✓*Mortalite*

World Health Organization (WHO). *Physical Status: the Use and Interpretation of Anthropometry*. Tech. Rep. Series 854, 1995. Geneva:

Table 1. BMI categories (WHO 1997)

Category	BMI, kg/m²
Underweight	<18.5
Healthy weight	18.5–24.9
Pre-obese state	25.0–29.9
Obesity grade I	30.0–34.9
Obesity grade II	35.0–39.9
Obesity grade III	≥40

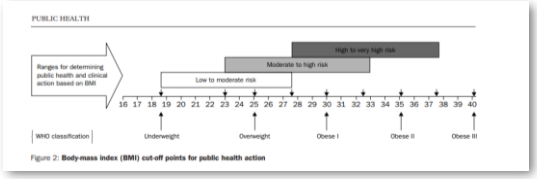

Figure 2: **Body-mass index (BMI) cut-off points for public health action**

Asyalılarda;
- <18.5- Zayıf
- 18.5- 22,9 Normal
- 23- 27,5 Hafif şişman- Artmış risk
- ≥27.5 Obez- Yüksek risk

WHO expert consultation
Lancet 2004; 363: 157–63

Obez bireyin klinik açıdan değerlendirilmesi:

- Hikaye
- Fizik muayene
- Laboratuvar testleri

European Guidelines for Obesity Management in Adults

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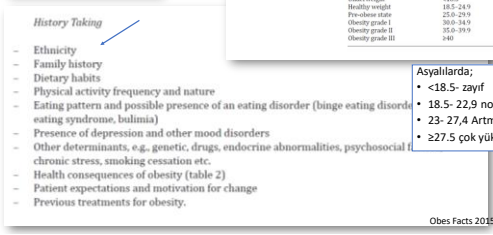


History Taking

- Ethnicity
- Family history
- Dietary habits
- Physical activity frequency and nature
- Eating pattern and possible presence of an eating disorder (binge eating disorde eating syndrome, bulimia)
- Presence of depression and other mood disorders
- Other determinants, e.g., genetic, drugs, endocrine abnormalities, psychosocial f chronic stress, smoking cessation etc.
- Health consequences of obesity (table 2)
- Patient expectations and motivation for change
- Previous treatments for obesity.

Asyalılarda;
- <18.5- zayıf
- 18.5- 22,9 normal
- 23- 27,4 Artmış risk
- ≥27.5 çok yüksek risk

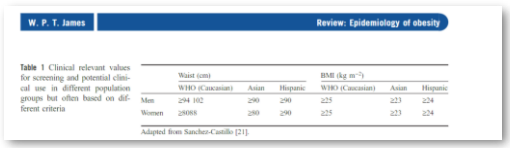
Obes Facts 2015;8:402–424

Obes Facts 2015;8:402–424

Fizik muayene

✓Boy uzunluğu, vücut ağırlığı, bel çevresi

✓Obezite komplikasyonu gelişmiş mi



W. P. T. James — Review: Epidemiology of obesity

Table 1 Clinical relevant values for screening and potential clinical use in different population groups but often based on different criteria

	Waist (cm)			BMI (kg m⁻²)		
	WHO (Caucasian)	Asian	Hispanic	WHO (Caucasian)	Asian	Hispanic
Men	≥94 102	≥90	≥90	≥25	≥23	≥24
Women	≥8088	≥80	≥90	≥25	≥23	≥24

Adapted from Sanchez-Castillo [21].

Antropometrik ölçüm sonucuna göre tedavi planı

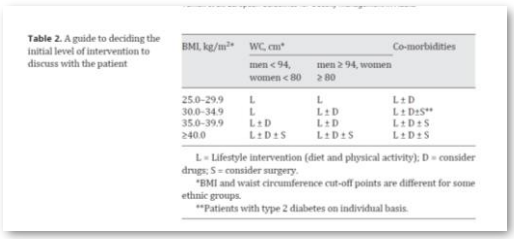


Table 2. A guide to deciding the initial level of intervention to discuss with the patient

BMI, kg/m²*	WC, cm*		Co-morbidities
	men < 94, women < 80	men ≥ 94, women ≥ 80	
25.0–29.9	L	L	L ± D
30.0–34.9	L	L ± D	L ± D±S**
35.0–39.9	L ± D	L ± D	L ± D ± S
≥40.0	L ± D ± S	L ± D ± S	L ± D ± S

L = Lifestyle intervention (diet and physical activity); D = consider drugs; S = consider surgery.
*BMI and waist circumference cut-off points are different for some ethnic groups.
**Patients with type 2 diabetes on individual basis.

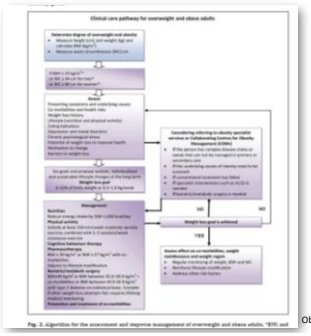
Obes Facts 2015;8:402–424

Laboratuvar Testleri

Laboratory Examinations

The minimum data set required will include (RBP):

- Fasting blood glucose
- Serum lipid profile (total, HDL and LDL cholesterol, triglycerides)
- Uric acid
- Thyroid function (thyroid-stimulating hormone (TSH) level)
- Liver function (hepatic enzymes)
- Cardiovascular assessment, if indicated (RBP)
- Endocrine evaluation if Cushing's syndrome or hypothalamic disease suspected
- Liver investigation (ultrasound, biopsy) if abnormal liver function tests suggest NAFLD or other liver pathology
- Sleep laboratory investigation for sleep apnoea.

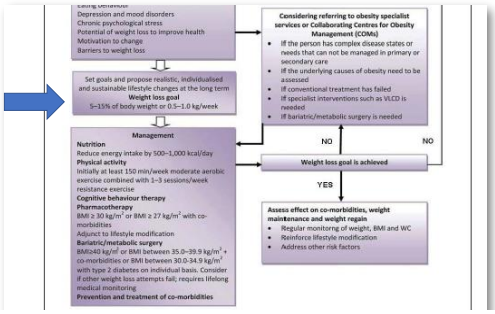


Obes Facts 2015;8:402–424

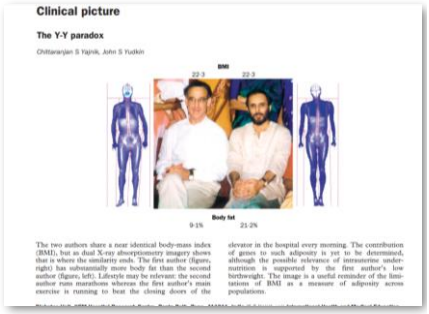
Tedavinin amacı ne?

Obezite tedavisinin amacı sadece ağırlık kaybı olmamalı

- *Dislipidemi*
- *DM'de glisemik kontrol*
- *HT'de kan basıncı*
- *Uyku apnesi*
- *Osteoartritte egzersiz vb*



BKİ yeterli mi?



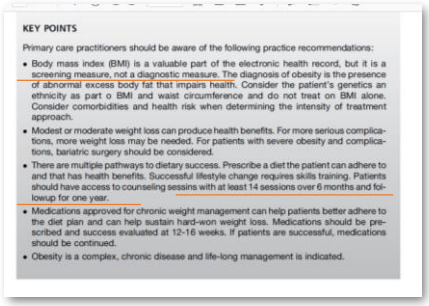
Clinical picture

The Y-Y paradox

Chittaranjan S Yajnik, John S Yudkin

The two authors share a near identical body-mass index (BMI), but as dual X-ray absorptiometry imagery shows that is where the similarity ends. The first author (figure, right) has substantially more body fat than the second author (figure, left). Lifestyle may be relevant: the second author runs marathons whereas the first author's main exercise is running to beat the closing doors of the elevator in the hospital every morning. The contribution of genes to such adiposity is yet to be determined, although the possible relevance of intrauterine undernutrition is supported by the first author's low birthweight. The image is a useful reminder of the limitations of BMI as a measure of adiposity across populations.

WHO expert consultation
Lancet 2004; 363: 157–63



KEY POINTS

Primary care practitioners should be aware of the following practice recommendations:

- Body mass index (BMI) is a valuable part of the electronic health record, but it is a screening measure, not a diagnostic measure. The diagnosis of obesity is the presence of abnormal excess body fat that impairs health. Consider the patient's genetics an ethnicity as part o BMI and waist circumference and do not treat on BMI alone. Consider comorbidities and health risk when determining the intensity of treatment approach.
- Modest or moderate weight loss can produce health benefits. For more serious complications, more weight loss may be needed. For patients with severe obesity and complications, bariatric surgery should be considered.
- There are multiple pathways to dietary success. Prescribe a diet the patient can adhere to and that has health benefits. Successful lifestyle change requires skills training. Patients should have access to counseling sessins with at least 14 sessions over 6 months and follow-up for one year.
- Medications approved for chronic weight management can help patients better adhere to the diet plan and can help sustain hard-won weight loss. Medications should be prescribed and success evaluated at 12-16 weeks. If patients are successful, medications should be continued.
- Obesity is a complex, chronic disease and life-long management is indicated.

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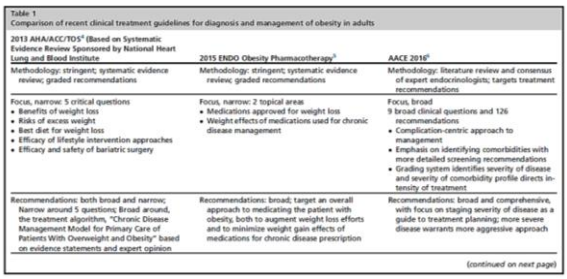

Table 1
Comparison of recent clinical treatment guidelines for diagnosis and management of obesity in adults

2013 AHA/ACC/TOS[4] (Based on Systematic Evidence Review Sponsored by National Heart Lung and Blood Institute	2015 ENDO Obesity Pharmacotherapy[5]	AACE 2016[6]
Methodology: stringent; systematic evidence review; graded recommendations	Methodology: stringent; systematic evidence review; graded recommendations	Methodology: literature review and consensus of expert endocrinologists; targets treatment recommendations
Focus, narrow: 5 critical questions • Benefits of weight loss • Risks of excess weight • Best diet for weight loss • Efficacy of lifestyle intervention approaches • Efficacy and safety of bariatric surgery	Focus, narrow: 2 topical areas • Medications approved for weight loss • Weight effects of medications used for chronic disease management	Focus, broad 9 broad clinical questions and 126 recommendations • Complication-centric approach to management • Emphasis on identifying comorbidities with more detailed screening recommendations • Grading system identifies severity of disease and severity of comorbidity profile directs intensity of treatment
Recommendations: both broad and narrow; Narrow around 5 questions; Broad around, the treatment algorithm, "Chronic Disease Management Model for Primary Care of Patients With Overweight and Obesity" based on evidence statements and expert opinion	Recommendations: broad; target an overall approach to medicating the patient with obesity, both to augment weight loss efforts and to minimize weight gain effects of medications for chronic disease prescription	Recommendations: broad and comprehensive, with focus on staging severity of disease as a guide to treatment planning; more severe disease warrants more aggressive approach

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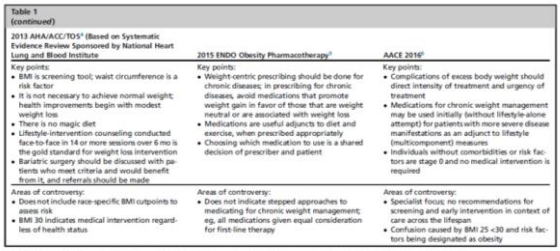

Table 1
(continued)

2013 AHA/ACC/TOS[4] (Based on Systematic Evidence Review Sponsored by National Heart Lung and Blood Institute	2015 ENDO Obesity Pharmacotherapy[5]	AACE 2016[6]
Key points: • BMI is screening tool; waist circumference is a risk factor • It is not necessary to achieve normal weight; health improvements begin with modest weight loss • There is no magic diet • Lifestyle-intervention counseling conducted face-to-face in 14 or more sessions over 6 mo is the gold standard for weight loss intervention • Bariatric surgery should be discussed with patients who meet criteria and would benefit from it, and referrals should be made	Key points: • Weight-centric prescribing should be done for chronic diseases; in prescribing for chronic diseases, avoid medications that promote weight gain in favor of those that are weight neutral or are associated with weight loss • Medications are useful adjuncts to diet and exercise, when prescribed appropriately • Choosing which medication to use is a shared decision of prescriber and patient	Key points: • Complications of excess body weight should direct intensity of treatment and urgency of treatment • Medications for chronic weight management may be used initially (without lifestyle-alone attempt) for patients with more severe disease manifestations as an adjunct to lifestyle (multicomponent) measures • Individuals without comorbidities or risk factors are stage 0 and no medical intervention is required
Areas of controversy: • Does not include race-specific BMI cutpoints to assess risk • BMI 30 indicates medical intervention regardless of health status	Areas of controversy: • Does not indicate stepped approaches to medicating for chronic weight management; eg, all medications given equal consideration for first-line therapy	Areas of controversy: • Specialist focus; no recommendations for screening and early intervention in context of care across the lifespan • Confusion caused by BMI 25 <30 and risk factors being designated as obesity

BMI 25 <30 means BMI at least 25 and up to 30 kg/m2. This is usually classified as overweight, but in this guideline, it can be "obesity".

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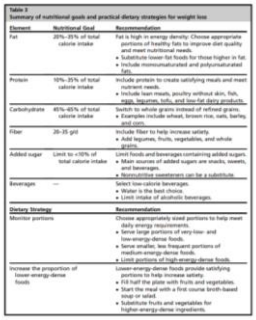

Table 2
Summary of nutritional goals and practical dietary strategies for weight loss

Element	Nutritional Goal	Recommendation
Fat	20%–35% of total calorie intake	Fat is high in energy density. Choose appropriate portions of healthy fats to improve diet quality and meet nutritional needs. • Substitute lower-fat foods for those higher in fat. • Include monounsaturated and polyunsaturated fats.
Protein	10%–35% of total calorie intake	Include protein to create satisfying meals and meet nutrient needs. • Include lean meats, poultry without skin, fish, eggs, legumes, tofu, and low-fat dairy products.
Carbohydrate	45%–65% of total calorie intake	Switch to whole grains instead of refined grains. • Examples include wheat, brown rice, oats, barley, and corn.
Fiber	20–35 g/d	Include fiber to help increase satiety. • Add legumes, fruits, vegetables, and whole grains.
Added sugar	Limit to <10% of total calorie intake	Limit foods and beverages containing added sugars. • Main sources of added sugars are snacks, sweets, and beverages. • Nonnutritive sweeteners can be a substitute.
Beverages	—	Select low-calorie beverages. • Water is the best choice. • Limit intake of alcoholic beverages.
Dietary Strategy		**Recommendation**
Monitor portions		Choose appropriately sized portions to help meet daily energy requirements. • Serve large portions of very-low- and low-energy-dense foods. • Serve smaller, less frequent portions of medium-energy-dense foods. • Limit portions of high-energy-dense foods.
Increase the proportion of lower-energy-dense foods		Lower-energy-dense foods provide satisfying portions to help increase satiety. • Fill half the plate with fruits and vegetables. • Start the meal with a first course broth-based soup or salad. • Substitute fruits and vegetables for higher-energy-dense ingredients.

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Table 2
Energy density categories and examples of foods in each category

Energy Density Category	Energy Density Range (Calories per Gram)	How to Eat	Examples of Foods
Very low energy density	0.0–0.6	Free foods to eat anytime	Most fruits and vegetables, broth-based soups, nonfat milk
Low energy density	0.6–1.5	Eat reasonable portions	Cooked grains, low-fat meats, beans and legumes, low-fat mixed dishes, such as chili and pasta
Medium energy density	1.5–4.0	Manage portions	Meats, cheese, bread, snack foods such as popcorn and pretzels, mixed dishes such as pizza and macaroni and cheese
High energy density	4.0–9.0	Carefully manage portions and frequency of eating	Crackers, chips, cookies, nuts, butter, oils

Adapted from The Ultimate Volumetrics Diet Smart, Simple, Science-Based Strategies for Losing

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