

A PRACTICAL APPROACH TO THE PATIENT WITH OBESITY

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ABSTRACT

The prevalence of obesity and obesity-related comorbidities is rising in Singapore and across the globe. Primary care physicians are at the frontline of healthcare and play a central role in the management of obesity. In this article, we discuss the 5As framework (Ask, Assess, Advise, Agree, and Assist) as a practical framework for obesity counselling, focusing on how to initiate the conversation and assess the person with obesity. The assessment includes taking a weight history, excluding secondary causes, understanding lifestyle factors contributing to weight gain, and assessing for complications of obesity. This assessment then makes possible subsequent patient engagement, which would include advising, agreeing (goal setting), and assisting the patient on an individualised care plan.

Keywords: Obesity, weight management, clinical examination, patient-centred care

SFP2023; 49(9): 12-19

INTRODUCTION

Over the past four decades, the global prevalence of obesity has risen markedly from 7 percent in 1980 to 12.5 percent in 2015,¹ affecting all regions including Singapore.^{1,2} Obesity is not benign and it has been linked to many other health conditions, such as type 2 diabetes, cardiovascular disease, mood disorders, and certain cancers, resulting in reduced quality of life, higher healthcare costs, and increased mortality.³⁻⁶ Obesity has clearly become a major global and regional health problem,

However, according to international surveys and interviews, people with obesity may not perceive their weight to be a significant problem.⁷ Even if they do, it may take several years of struggling with excess weight before they finally consult a healthcare professional.⁸ Therefore, the primary care physician, being at the frontline of healthcare, has a key role in identifying the person with obesity and broaching the topic of weight management. Additionally, counselling delivered by primary care providers can positively impact their patients.⁹ In a meta-analysis of 12 studies involving

207,226 individuals, those who were provided with weight loss advice by their primary care provider were nearly four times more likely to attempt weight loss.⁹ However, observational and self-report evidence suggests that less than half of patients with obesity are advised by their physicians to lose weight.^{8,10} Primary care physicians often cite lack of motivation by the patient as the main reason for not discussing weight during consultations.^{7,8} Other barriers described include limited understanding of obesity care, concern about negative consequences of raising a sensitive topic, and limited time and resources.¹⁰

On the other hand, studies on patients with obesity suggest that patients do believe that it is the responsibility of their primary care physicians to initiate the conversation about weight management and would like them to do so.^{8,11} Only 3 percent were offended by such a conversation, according to an online survey conducted in 11 countries involving 14,502 participants.⁸ This survey also showed that nearly half of them said they were motivated to lose weight, with >80 percent of the total participants saying they had made at least one serious weight loss effort in the past.⁸ These results should reassure the primary care physician that a sizeable population with obesity is willing to receive help for their weight.

Hence, the purpose of this article is to reiterate the central role of the primary care physician in the management of obesity and discuss how to initiate the conversation and assess the person with obesity.

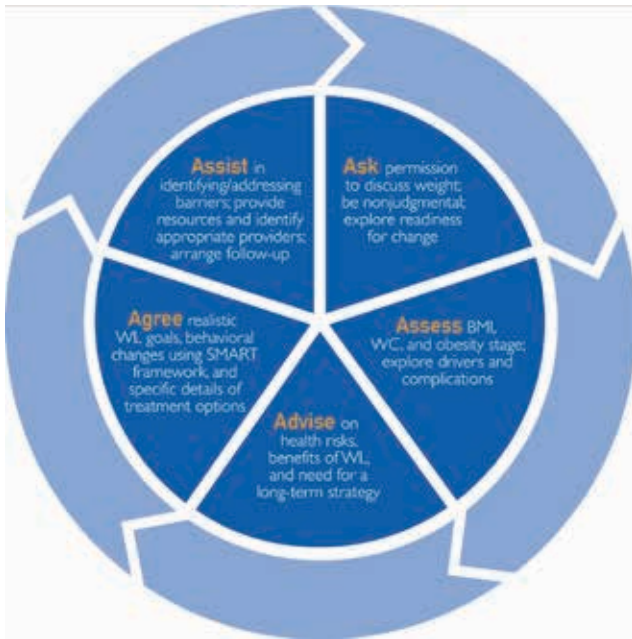
5AS FRAMEWORK FOR OBESITY COUNSELLING

A practical framework for obesity counselling is the 5As framework (*Ask, Assess, Advise, Agree, and Assist*), a universal approach to encouraging behaviour change, which was initially developed to support smoking cessation (refer to **Figure 1**).¹² This intervention strategy takes the individual's perceived need as the starting point, which then makes it possible to implement a process of care that is individualised and patient-centred.¹³ A 2014 study found that this framework was easy to implement, doubled the initiation of obesity management in primary care clinics, and resulted in positive behavioural health changes for patients.¹⁴ Another study found that patients managed by internal medicine residents trained in the 5As framework lost a mean of 1.53 kg at 12 months while those managed by non-trained residents gained a mean of 0.30 kg. This difference was statistically significant.¹⁵ However, while this approach seems simple, it should not be applied simplistically. The success of this framework rests on a strong therapeutic relationship between the physician and patient, where the physician can guide the patient through this journey of behaviour change at a pace that is suited to the patient's situation.¹³

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Figure 1: The 5 As framework for obesity counselling



BMI = body mass index

SMART = specific, measurable, achievable, relevant, time-based

WC = waist circumference

WL = weight loss¹²

Ask: Initiating the Conversation

Communication is a fundamental aspect of obesity management. The first A (Ask) involves seeking permission to talk about obesity and its management, especially if the “reason for encounter” is not related to weight. Based on a local qualitative study, primary care physicians tend to do this by presenting the patient’s anthropometric measurements and getting them to reflect on the weight instead of directly asking for permission.¹⁶ When a patient presents with a problem that could be attributed to weight, primary care physicians usually have no issues initiating the conversation.⁷ However, the physician should be cautious about focusing on the patient’s weight at the cost of neglecting to explore other possible causes of the problem.^{17,18}

Regardless, there are two main points to highlight regarding a successful conversation about obesity.¹⁷ First, the physician should communicate in a non-judgemental, respectful manner, with empathy, and without any bias, especially since evidence now suggests that obesity has a complex aetiology that may not fully be under voluntary control.^{17,18} Patients with obesity have been described as lazy, non-compliant, weak-willed, unintelligent, and even dishonest by healthcare professionals, and this stigmatisation only exacerbates the problem.¹⁷ Hence, the physician should take care not to use inappropriate or hurtful words and use people-first language (“patient with obesity”) as opposed to condition-first language (“the obese patient”). This is recommended for other medical conditions as well.^{12,17}

Second, in order to have a motivating conversation so that behaviour change can be elicited, the physician should employ motivational interviewing (MI).¹⁹ MI is a patient-centred, goal-directed counselling technique aimed at increasing intrinsic motivation for change by exploring and resolving ambivalence to change.¹⁹ MI’s core principles include expressing empathy, developing discrepancy (between patient’s goals and current behaviour), rolling with resistance, avoiding argumentation, and supporting the patient’s self-efficacy (empowerment); and involves open questions, affirming the patient’s perspectives, reflecting what was heard to ensure understanding, and summarising shared understanding to set specific goals (acronym OARS).¹⁹ In a meta-analysis of 11 Randomised Control Trials involving 1,448 participants, MI significantly enhanced weight loss in overweight and obese patients.²⁰ Hence, MI is an effective counselling approach, which can be used within the 5As framework for obesity counselling.

Assess: History

History – An Obesity-Focused History

Once the patient is ready to engage in conversation about his or her weight, the physician can initiate an obesity-focused history taking. An obesity-focused history taking has the following aims:

- Assessing for secondary obesity and contributing factors of obesity
- Assessing for obesity-related comorbidities
- Gathering information to formulate a treatment plan

Weight History

In taking a weight history, the mnemonic “OPQRST” may be used to evaluate weight. This includes onset, precipitating events, quality of life, remedy, setting, and temporal pattern (refer to **Table 1**).^{21,22} In addition, comprehensive history-taking also includes delving into the pattern of weight changes, duration of obesity, highest weight, previous weight loss attempts, and response to these attempts. If time permits, graphing the patient’s weight over time and inserting events or treatments that they feel were temporally related to weight changes may be useful. This weight chart may reveal significant events that cause changes in weight trajectory, such as physiological changes (e.g., puberty, pregnancy, menopause), medical factors (e.g., diagnosis of medical disorders, initiation of medications), and social factors (e.g., change of job, marriage, divorce, grief, etc). By using open-ended questions, the physician permits the patient to express their own weight journey and challenges. This also enables the physician to understand the patient’s knowledge, attitude, and motivation, which would provide a basis for formulating a treatment plan.

Table 1: Using the mnemonic OPQRST to take a weight history^{21,22}

	Sample Questions
O nset	“When did you first begin to gain weight?” “Have you struggled with your weight since childhood?” “What did you weigh in school, in college, in your early 20s, 30s, 40s?” “Did the weight gain begin when you started taking a certain medication?”
P recipitating	“What life events may have led to your weight gain – such as work stress, marriage, divorce, financial loss, a period of depression, the onset of an illness?” “How much weight did you gain with pregnancy?” “How much weight did you gain when you stopped smoking?” “How much additional weight did you gain when you started insulin?”
Q uality of life	“At what weight did you feel your best?” “What is hard to do at your current weight?” “How does your weight affect how you feel and function?”
R emedy	“What have you tried in the past to control your weight?” “Which medications, if any, have you taken to help control your weight?” “What have you found to be particularly helpful when trying to lose weight?”
S etting	“What was going on in your life when you last felt in control of your weight?” “What was going on when you gained your weight?” “What role has stress played in your weight gain?” “Which people in your life, if any, have been helpful to support your efforts to control your weight?”
T emporal pattern	“What is the pattern of your weight gain?” “Did you gradually gain your weight over time?” “Are there large swings in your weight, and if so, what is the weight change?” “What was your lightest and heaviest weight as an adult?”

Assessing for Secondary Obesity and Contributing Factors

Secondary Causes

The physician should be aware of secondary causes of obesity. Secondary causes can be elicited in the history, physical examination, and initial investigations. Certain clinical features such as the early or sudden onset of obesity, temporal relationship to an event, or associated signs and symptoms of another medical condition (e.g., Cushing’s syndrome, hypothyroidism) may suggest an underlying medical disorder. The onset of weight gain after initiating a medication may suggest drug-induced weight gain. Paediatric patients with extreme early-onset obesity (<five years of age), severe hyperphagia, developmental delay, and/or dysmorphism will warrant a referral to a paediatrician.²³ The causes of obesity are summarised in **Table 2**.²⁴

Table 2: Causes of obesity²⁴

Causes of Obesity
Primary Genetic and epigenetic causes Monogenic disorders (e.g., MC4R mutation, Leptin deficiency, POMC deficiency) Syndromes (e.g., Prader-Willi syndrome, Bardet-Biedl syndrome)
Secondary Neurological Brain injury Brain tumour Cranial irradiation Hypothalamic obesity Endocrine Hypothyroidism ^a Cushing’s syndrome Hypogonadism Psychological Depression ^b Eating disorders Drug-induced Anti-depressants Anti-psychotics Anticonvulsants Sulphonylureas Insulin Thiazolidinediones Steroids Oral contraceptives
^a Controversial whether hypothyroidism causes obesity or exacerbates obesity ^b Depression associated with overeating or bingeing

Table 3: STOP-BANG Questionnaire²⁹

Snoring	Do you SNORE loudly (louder than talking or loud enough to be heard through closed doors)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tired	Do you often feel TIRED, fatigued, or sleepy during the daytime?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Observed	Has anyone OBSERVED you stop breathing during your sleep?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pressure	Do you have, or are you being treated for high blood PRESSURE?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
BMI	BMI of more than 35 kg/m ² ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Age	AGE over 50 years old?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Neck	NECK circumference >40 cm?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Gender	GENDER: Male?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p><u>Scoring criteria:</u> Low risk of OSA: Yes to 0-2 questions Intermediate risk of OSA: Yes to 3-4 questions High risk of OSA: Yes to 5-8 questions</p>			

Lifestyle and Social Factors

Taking a dietary and physical activity history will enable the physician and patient to identify areas where they can start making changes to improve their health. Energy intake from self-reported dietary history is frequently underestimated, but it is an important starting point for awareness and self-reflection. A 24-hour diet recall may be used. Assessing the type of food, portion size, the timing of meals, and location of meals is useful in dietary assessment since disordered eating patterns such as night eating or emotional eating may be uncovered.

Physical activity is an important factor in weight loss maintenance. Furthermore, physical activity is also associated with decreased mortality independent of weight.^{25,26} During the assessment of a person’s baseline physical activity, the physician should also assess for any medical limitations for exercise (e.g., cardiovascular disease, respiratory disease, musculoskeletal problems) as this will influence exercise prescription. The use of smartphone apps and fitness devices for food and physical activity tracking might help patients monitor their dietary intake and physical activity, and their usage should be noted so that an individualised plan can be formulated.

Disordered sleep patterns are associated with weight gain. Shift workers who have disrupted circadian rhythms have an increased risk of weight gain.²⁷ Disrupted sleep or poor sleep quality may also be due to obstructive sleep apnoea (OSA), which has a high prevalence in patients with obesity.²⁸ A useful tool in assessing for OSA is the STOP-BANG questionnaire to screen for OSA (refer to **Table 3**).²⁹

Past Medical History

Many medical conditions are caused or contributed to by obesity. These include type 2 diabetes mellitus (T2DM), hypertension, dyslipidaemia, non-alcoholic fatty liver disease (NAFLD), polycystic ovarian syndrome, OSA, ischaemic heart disease, etc. The presence and control of these obesity-related complications (refer to **Table 4**) will

influence treatment options and urgency of treatment of obesity. Many medications used to manage obesity-related comorbidities may contribute to weight gain. Psychological history including history of depression, anxiety, eating disorders, and the use of psychiatric medications are important to note and would impact the management of obesity.

Table 4: Complications of obesity

<p>Metabolic</p> <ul style="list-style-type: none"> Diabetes mellitus Hypertension Dyslipidaemia Gout Non-alcoholic fatty liver disease Polycystic ovarian syndrome Coronary artery disease Cancer – breast, endometrial, colon, cervical, oesophageal, kidney, prostate, etc.
<p>Mechanical</p> <ul style="list-style-type: none"> Obstructive sleep apnoea Gastroesophageal reflux disease Osteoarthritis Venous stasis
<p>Mental or Psychological</p> <ul style="list-style-type: none"> Depression Eating disorders Stigma and discrimination

Assess: Examination and Further Investigations

Assessment of Obesity

Obesity is abnormal or excessive fat accumulation that presents a risk to health. The most utilised marker for classifying weight is the body mass index (BMI), which is calculated from weight (kg) divided by height (m) squared. Overweight is defined by a BMI of ≥ 25 kg/m² and obesity is defined by a BMI of ≥ 30 kg/m², where the severity of

obesity increases with increasing BMI (refer to **Table 5**). In Asians, a BMI of >23.0 kg/m² is considered overweight and the BMI cut-offs for intervention for obesity categories are lowered by 2.5 kg/m² as Asians have higher adiposity for a given BMI and metabolic risk.³⁰

Another useful clinical measurement of obesity is waist circumference, widely recognised as a measure of central adiposity. An increased waist circumference is associated with increased visceral adiposity and increased risk of cardiometabolic disease.^{31,32} The waist circumference is measured at the midpoint between the iliac crest and lower border of the ribs. A waist circumference of >80 cm and >90 cm in Asian females and males, respectively, indicates increased metabolic risk. Another marker is the waist-hip ratio, which is calculated from waist circumference divided by hip circumference. A ratio of >0.90 in men and >0.85 in women is indicative of an increased risk of metabolic complications.³³ However, waist circumference is preferred

because it is a better marker of abdominal fat content and is easier to measure and interpret.³⁴ Neck circumference has also been associated with visceral adiposity and is used in the STOP-BANG score for OSA.^{29,35}

The rest of the physical examination and investigations should be guided by the patient’s history, suspicion of secondary causes, and the screening for obesity-related complications, especially cardiovascular- and metabolic-related complications. Acanthosis nigricans, a dark velvety discoloration of the skin on the neck and armpits, may be seen and is a sign of insulin resistance. If secondary causes of obesity are suspected (refer to **Table 2**), further investigations or appropriate referrals may be required. The physician should screen for obesity-related complications (refer to **Table 4**) in the clinical examination and investigations as obesity management is now more “complications-centric” instead of being based on BMI classification alone. **Table 6** suggests investigations to consider in patients with obesity.

Table 5. BMI classification for obesity and waist circumference threshold for increased metabolic risk

BMI Classification	WHO cut-off for BMI (kg/m ²)	BMI cut-off for action in Asians* (kg/m ²) ³⁰
Obese	>30.0	
Class I obesity	30.0-34.9	27.5-32.4
Class II obesity	35.0-39.9	32.5-37.4
Class III obesity	>40.0	>37.5
*BMI threshold for action is lowered by 2.5 kg/m ² in Asians		
Waist circumference (WC) for increased metabolic risk	WC threshold (cm) ³³	WC threshold in Asians (cm) ⁴⁰
Female	>88	>80
Male	>108	>90

Table 6. Investigations in a patient with obesity

<p><u>To investigate underlying causes</u></p> <p>Thyroid function test</p> <p>Cushing’s work up if clinically indicated (overnight dexamethasone suppression test, 24-hour urinary free cortisol, late-night salivary cortisol, or referral to an endocrinologist)</p>	<p>Exclude hypothyroidism</p> <p>Exclude Cushing’s syndrome</p>
<p><u>Screening for complications of obesity</u></p> <p><i>Clinical</i></p> <p>Blood pressure</p> <p>STOP-BANG score</p> <p><i>Laboratory investigations</i></p> <p>Fasting glucose and HbA1C</p> <p>Lipid panel</p> <p>Renal panel</p> <p>Liver panel</p> <p>Others (e.g., Mammogram, pap smear, referrals as required)</p>	<p>Screen for hypertension</p> <p>Screen for OSA</p> <p>Screen for DM, IFG and IGT</p> <p>Screen for dyslipidaemia</p> <p>Screen for abnormal renal function</p> <p>Screen for NAFLD</p> <p>Screen for cancers</p>
<p>OSA: Obstructive sleep apnoea</p> <p>DM: Diabetes mellitus</p> <p>IFG: Impaired fasting glucose</p> <p>IGT: Impaired glucose tolerance</p> <p>NAFLD: Non-alcoholic fatty liver disease</p>	

In the assessment of obesity, there are new staging systems for obesity that are more comprehensive and predictive of outcomes than BMI alone. One staging system is the Edmonton Obesity Staging Scale (EOSS).³⁶ The EOSS has five stages from Stage 0 to Stage 4, depending on the presence of obesity-related comorbidities, their severity, and functional limitations (refer to **Table 7**). It is superior to BMI classification in predicting mortality for people who are overweight and with obesity.^{36,37} The presence of obesity-related comorbidities and a higher EOSS stage may suggest more urgent action required to address obesity. For example, a patient with obesity with T2DM, NAFLD, and OSA would require more urgent and aggressive weight management than a patient with similar BMI without any obesity-related comorbidities. Thus, it is useful to consider the staging and the impact of obesity on health when assessing a patient.

Table 7. Edmonton obesity staging scale (EOSS)³⁶

Stage 0	No signs of obesity-related risk factors No physical symptoms No psychological symptoms or functional limitations
Stage 1	Subclinical obesity-related risk factors (e.g., Borderline hypertension, impaired fasting glucose, impaired glucose tolerance, elevated liver enzymes, etc.) Mild physical symptoms Mild obesity-related psychopathology, functional limitations, and/or mild impairment in well-being
Stage 2	Established obesity-related comorbidities (e.g., Type 2 diabetes mellitus, hypertension, OSA, PCOS) Moderate obesity-related functional limitations and/or moderate impairment of well-being
Stage 3	Significant obesity-related comorbidities (e.g., Myocardial infarction, heart failure, diabetes complications, incapacitating osteoarthritis) Significant obesity-related psychopathology, functional limitations, and/or impairment of well-being
Stage 4	Severe (potentially end-stage) disabilities from obesity-related comorbidities Severe disabling obesity-related psychopathology, functional limitations, and/or severe impairment of well-being

Advise

The next step would be to provide advice. This entails informing the patient about the results of the assessment and treatment options. Advice should include the health risks of obesity, weight loss benefits, and discussion of strategies for weight loss.

Agree: Discussing a Management Plan and Goal-Setting

Assessing readiness for change is important before discussing a management plan with the patient. When confronted with any potential change, ambivalence is expected. The physician can help the patient to resolve the patient’s ambivalence through MI techniques, before progressing further in the discussion.

Discussing a management plan should be patient-centred and collaborative. Patient-centred care encourages active collaboration and shared decision-making between patients and providers. Apart from clinical considerations, the patient and provider would need to consider emotional, mental, social, and financial perspectives.³⁸ Patients who share their perspectives achieve better outcomes.^{22,39} As lifestyle modification requires changes in a person’s daily behaviours, each person’s treatment needs to be tailored and personalised. To facilitate this process, the physician may need to start by setting realistic weight loss expectations and clarifying misconceptions. A modest target of 5-10 percent weight loss can have significant benefits on obesity-related comorbidities.³² For some patients, preventing further weight gain may be a realistic initial target.

In formulating a management plan, focusing on behavioural goals where patients have more locus of control may be more beneficial, rather than only concentrating on weight loss outcomes. These behavioural goals may be related to healthy eating, physical activity, or other psychosocial behavioural goal. Examples include intake of fruits and vegetables, avoidance of sugar-sweetened beverages, self-monitoring of dietary intake, self-monitoring of weight, reducing sedentary time, increasing steps, or exercise sessions per week. Patients should choose their own behavioural goal to work on. Ideally, this goal should be sustainable and one that the patient believes is important and is confident in carrying out. In collaborating with the patient to form behavioural goals, one may use the SMART (specific, m measurable, achievable, relevant, time-based) goals as a guide.

Assist

To conclude the consultation for obesity, the patient should be assisted in further management. This may include prescription of medications for weight management and/or adjustment of medications that contribute to weight gain by adjusting doses or using weight-friendly alternatives, if possible. It is also important to assist the patient in further management by providing educational resources, arranging follow-ups, or referral to other community resources or healthcare providers.

CONCLUSION

The role of the primary care physician is central to the management of obesity. The 5As framework (Ask, Assess, Advise, Agree, Assist) is a useful tool for guiding consultations. The clinical assessment of obesity is an important skill to learn. It is important to exclude secondary medical causes and understand lifestyle factors contributing to weight gain. The use of motivational interviewing and focusing on behavioural goals may be useful during the consultation. Lastly, the management of patients with obesity should be patient-centred and collaborative.

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LEARNING POINTS

- **Initiate a collaborative conversation about weight management with patients in a non-judgemental and respectful manner with empathy.**
 - **The 5As framework is a useful and practical framework for obesity counselling.**
 - **Motivational interviewing is an effective counselling approach that can be used within this framework.**
 - **A comprehensive clinical assessment should be performed for the patient with obesity, aiming to assess for secondary causes, contributing factors of obesity, and obesity-related comorbidities.**
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