BUSY PRACTICE, SO WHAT CAN BE DONE TO START AN EFFECTIVE WEIGHT-LOSS PROGRAMME?

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INTRODUCTION

Many patients who visit the Family Physician in a day are overweight and some are obese. Most of us shy away from treating these patients because of lack of time and resources. With the rising prevalence of obesity in Singapore, what little direct intervention that we can provide can result in positive outcomes for both the physician and the patient. Telling the patient to eat less and exercise more is not enough. Further, it belittles the complexity that lies behind the pathophysiology of obesity. Obesity is like any chronic disease; it requires long-term intervention and therapy. What is needed to start an effective program are strategies or "toolbox" that are easy to use and practical.

1. Get rid of myths

In Singapore being fat is still traditionally being associated with prosperity. A "towkay" must be fat to have an image of prosperity and success. Skinny children are often frowned upon and associated with the image that the family not having enough to eat. In many countries overweight and obesity are epidemic. Obesity is associated with an increase risk of a significant number of medical problems, including hypertension, dyslipidaemia, coronary artery disease, diabetes mellitus, gallbladder disease, sleep apnoea, osteoarthritis, infertility and several types of cancer. Such myths associating with overweight should be changed. The Family Physician can act as an agent of change and behaviour modification in this aspect.

2. Assessment and quantification of risk

The visit to the family Physician office should begin with an assessment and classification of the patient's weight and health risk. Three pieces of information are needed: body mass index (BMI), waist measurement, and established complication of obesity. An increasing BMI, waist measurement is associated with an increase health risk. These measurements will help to individualize the treatment option for the patients. For example, Linda has a BMI of 28; she has diabetes, hypertension, and dyslipidaemia. Cindy also has a BMI of 28 but no medical problems. Compared to Cindy, besides lifestyle changes, Linda will probably benefit from medication. Bariatric surgery may also need to be considered if her BMI is in the obese levels despite intervention.

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3. Assessment of lifestyle habits and factors affecting weight

In a busy practice, lifestyle habits can be assessed by asking the following simple questions:

a. What do you eat for breakfast, lunch, dinner and snacks?
b. How much vegetables, fruits and meat do you eat?
c. Do you exercise? How often? What type?
d. Anything else that you do? – Washing car, housework etc.

Factors such as sedentary job, steroid use and physical handicap should be elicited during history taking. Has the patient attempted to lose weight before? What has he tried? There are many weight loss supplements available as over the counter purchase in the market, has the patient tried them?

4. Individualized approach

After the assessment, choose a few items for the patient to work on. Help the patient to set realistic goals. Many patients have unrealistic weight-loss goals.

a. *Adjust the diet and keep records*
   The diet should involve an increase of vegetables and fruits, decrease intake of saturated fat and refined carbohydrates. This can also be achieved with low energy meal replacement such as the Cambridge Diet. Encourage the patient to keep a record of his or her diet. Referral to a dietician for proper counseling should be considered if one is available.
b. *Institute exercise and increase daily activity*
   Exercise regime should be tailored to the patient ability and physical conditioning. It should also be enjoyable. The activities should always be started slowly and gradually increase so that it is sustainable. Simple changes to a person's daily routine can greatly increase that person's energy expenditure. Examples include walking up the stairs instead of taking the lift and walking to a nearby market instead of driving.
c. *Set process goals for the patient*
   Setting the amount of weight to lose is an outcome goal. The wisdom is to avoid unrealistic goals and goals which are vague. Process goals such as eating one or more serving of vegetables, cutting down the intake of meat to half and taking 10 minutes of walk a day are more specific and achievable. Ultimately, by increasing such process will help the patient to achieve his outcome goal of losing weight.

5. Medications and Surgery

Weight-loss medications can be considered if patient's weight-loss falls short of the desirable weight despite lifestyle changes. Currently only two medications are recommended for long term use, Orlistat and Subitramine. The latter inhibits the

reuptake of Serotonin and Norepineprine in the brain resulting in increase satiety. The former inhibits intestinal lipase and reduce dietary fat absorption.

The patient with a BMI of 35-40, who fails despite intensive weight reduction treatment can be considered for bariatric surgery. There are three types of surgery: restrictive, malabsorption and combination. Bariatric surgey remains the most effective method to decrease weight and maintain weight in the morbid obese.

CONCLUSION

The important take home message is that despite limited time and resources, the Family Physician can still provide the patient with practical strategies to combat obesity. The key to success is to create an individualised plan based on each person's risk and habits. Patient should be empowered to be an active participant in their own program. Setbacks will occur in any program. We should help patients to expect this and formulate a plan to deal with them. They should be encouraged to accept a slow incremental progress towards weight loss. Even a 5% to 10% weight loss is associated with a reduction in disease risk.

REFERENCES

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