

# The Lancet Commission – Redefining how we define obesity

## Implications for clinical practice: a physician's perspective

*IFSO, Melbourne, Sept 2024*

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[ ] I have the following potential conflict(s) of interest to report:

➤ Novo Nordisk

➤ ACTION Teens Steering Committee – honoraria, travel support

➤ Speaker fees

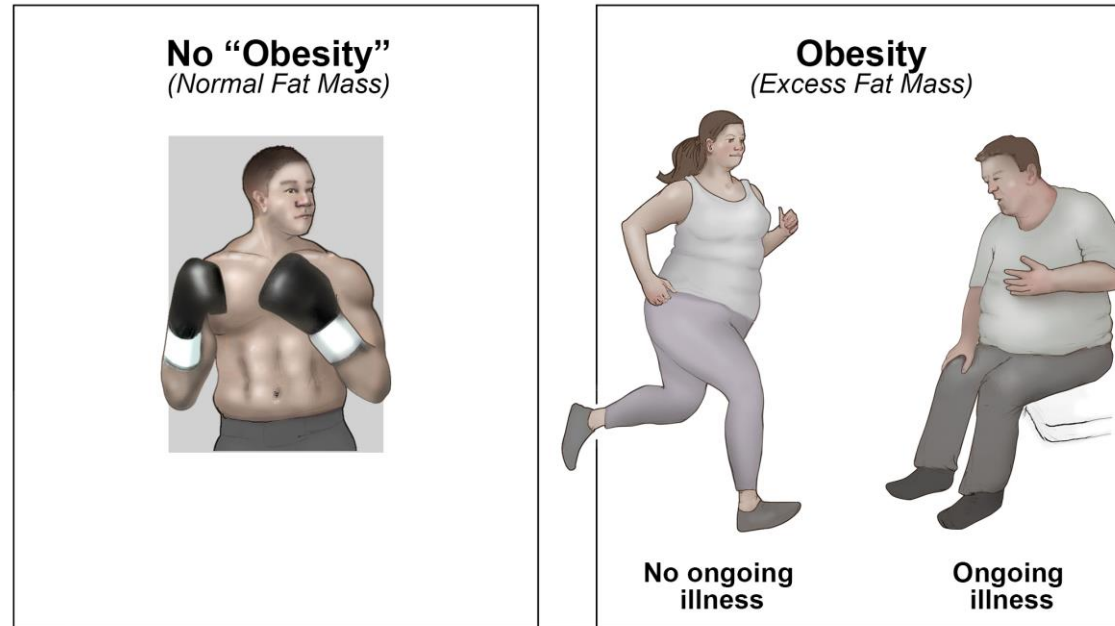
➤ Lilly

➤ Advisory Committee – honoraria, travel support

# Implications for clinical assessment

# *Can I still use BMI to assess a person with obesity? Does it measure body fatness and risk?*

## Limitations of BMI-Based Definition of Obesity



- Yes, do measure BMI - it is still a useful *screening tool*
- However, there are limitations to the blanket use of BMI to denote obesity

→ It is where assessment starts, not ends

# *Can I still use BMI to assess a person with obesity? Does it measure body fatness and risk?*

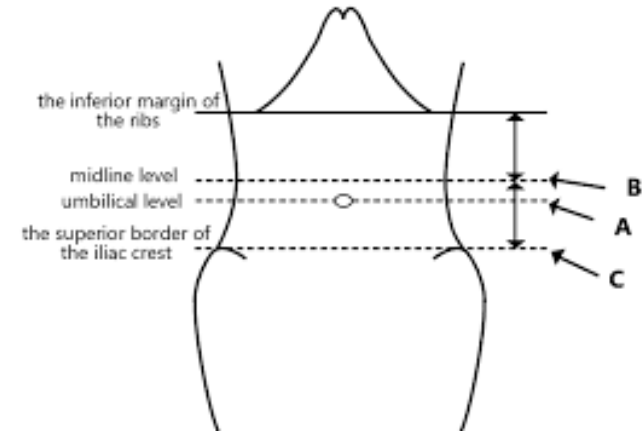
## Supplement BMI with:

- An anthropometric measure of fat distribution eg waist, waist:height ratio

## AND/OR

- Where possible, a measure of body composition eg DXA

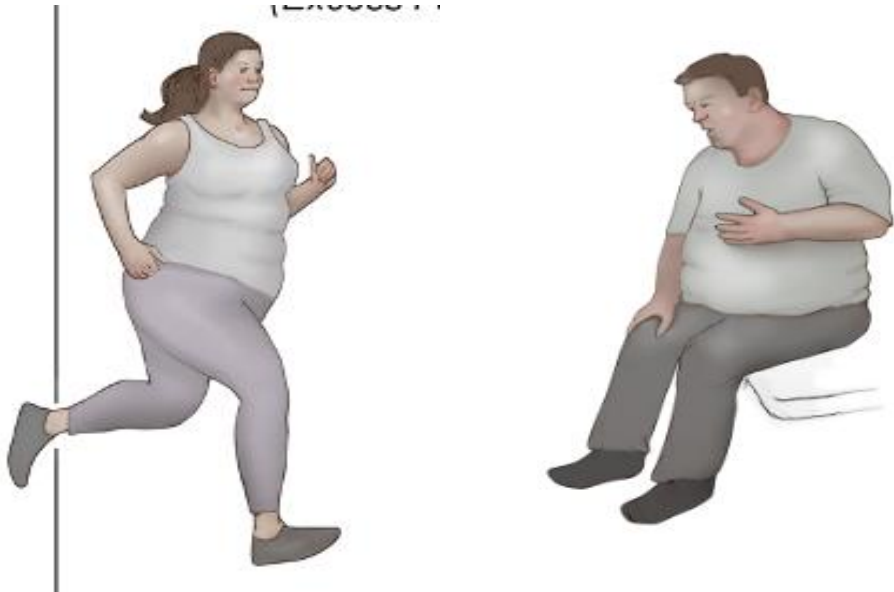
Where possible use validated methods and age-, gender- and ethnicity-appropriate cut-off points



## *Are there implications for other forms of assessment?*

As always – history, examination & investigation are vital.  
The new Clinical Obesity criteria will clarify further.





**What other health problems does your patient have?  
What distinguishes the person who just has *high BMI* from  
the person with *clinical obesity*?**



**What are the different clinical  
approaches for these two people?**

## Excess body fat with no ongoing illness

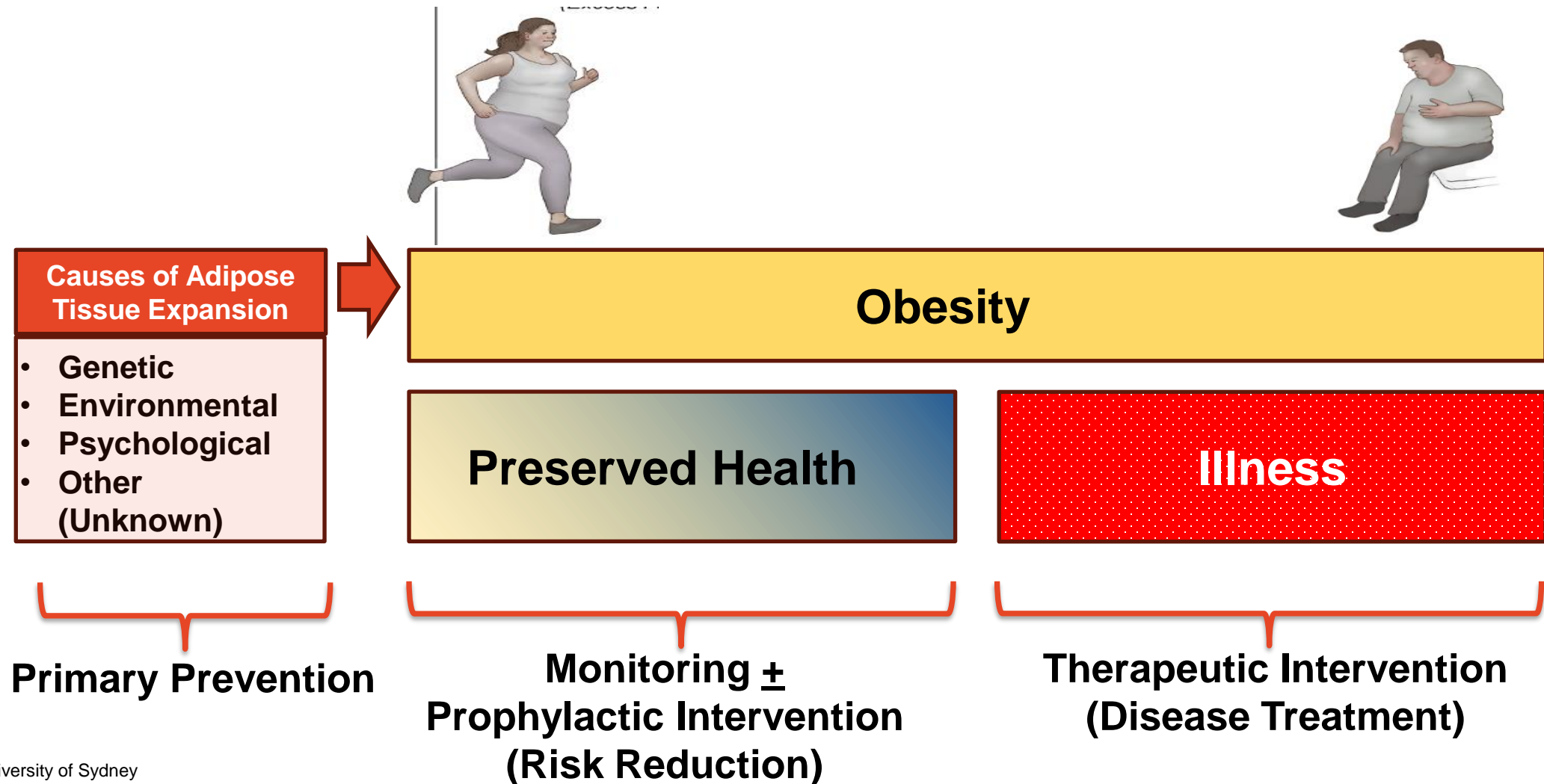
## Excess body fat with ongoing illness

<b>Excess Adiposity</b>		
<b>Pathophysiology</b>	Alterations of Cells & Tissue → Alterations of Organ Structure	Alterations of Organ Function → End-Organ Damage
<b>Clinical Manifestations</b>	Minor or Absent <i>(substantially preserved organ function)</i>	Signs & Symptoms    Alterations of day-to-day activities    Complications
<b>Diagnosis</b>	Anthropometrics, Medical History, Review of Systems and Further Diagnostic Assessment as Needed 	Signs & Symptoms, Alterations of day-to-day activities, Complications 

# Implications for treatment?



# *Scope of care in obesity: Primary prevention, risk reduction and disease treatment*

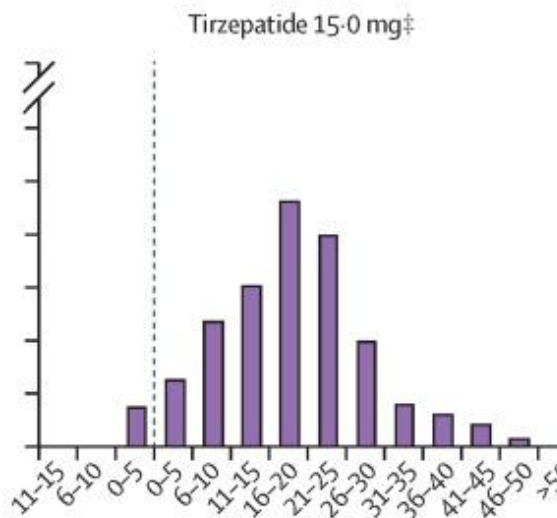
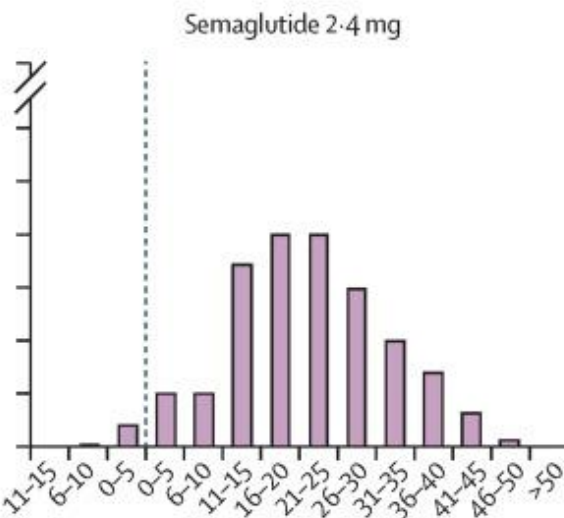
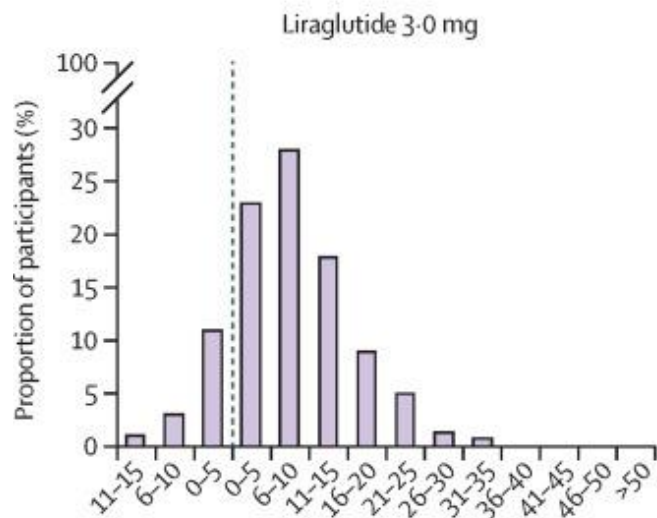
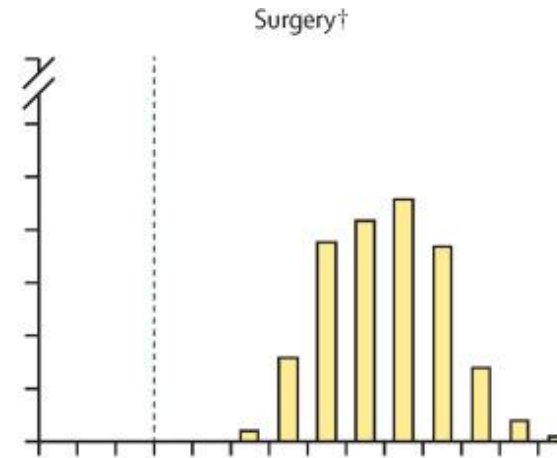
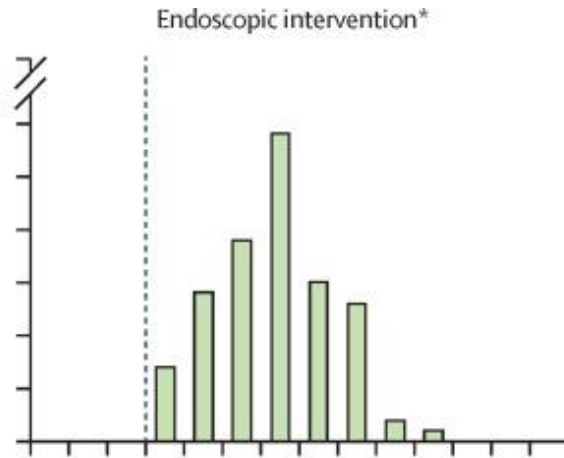
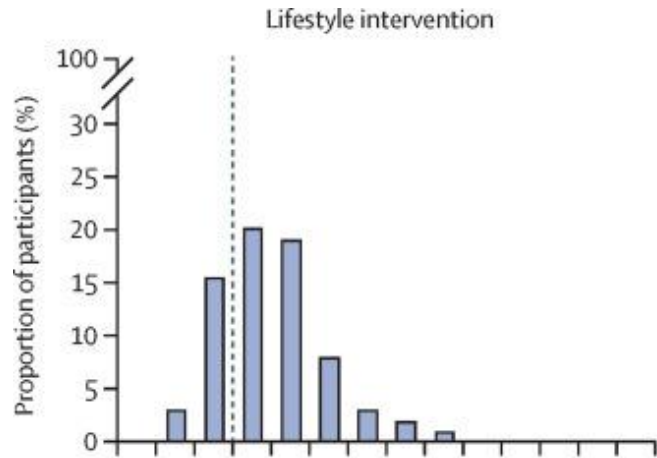


## *Those with obesity and ongoing illness*



- **Require timely access to comprehensive care and evidence-based treatments, and individualised decision-making**
- ***Goals of therapy:***
  - **improvement or remission of clinical manifestations of obesity**
  - **prevention of progression to further complications or end-organ damage**
- **Different clinical manifestations of obesity may require different intensities of treatment and/ or weight reduction**
- **Clinical care has a corrective intent**

# Treatment options: Different mean weight loss at 12 months with different types of obesity treatment



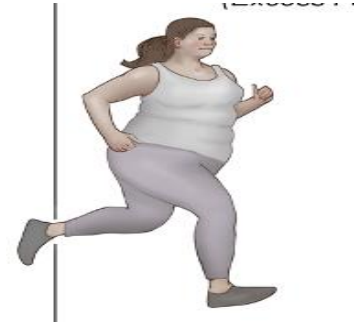
**Personalised treatment pathways – including use of combinations of different therapies**

Weight gain (%)    Weight loss (%)  
The University of Sydney

Weight gain (%)    Weight loss (%)

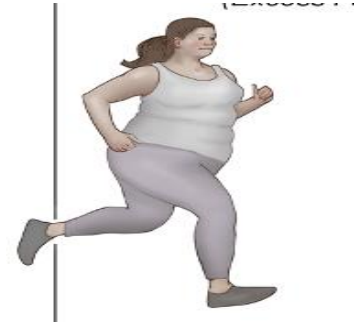
Weight gain (%)    Weight loss (%)

## *Those with high BMI but no, or minimal, associated health problems*



- **Have a variable level of health risk but with substantially preserved health at present**
- **Such people require *individual risk/benefit assessment* based upon:**
  - **Severity of excess or abnormal adiposity**
  - **Presence/ absence of other risk factors and co-existing diseases or disorders that will benefit from specific treatment**
- **Clinical care aims at risk reduction**

## *Those with high BMI but no, or minimal, associated health problems*



- In those with ***low risk for health problems***
  - Health counselling, reassurance may be sufficient
- In those with ***higher risk***
  - Other interventions may be warranted eg MAY benefit from pharmacotherapy or even surgery
  - Generally requires less urgency and intensity of care than in those with clinical obesity

# Some adolescent case examples

# *14 year old boy, BMI 39.9 kg/m<sup>2</sup>, waist:height ratio 0.70 – Case 1*

- **Maori ethnic origin**
- **Strong family history of obesity & T2DM**
- **No evidence – as yet! - of cardio-metabolic risk, OSA**
- **Good mental health, no experience of bullying**
- **Loves rugby training and games. Wants to “keep up with my mates” on the rugby field but knows he is not fit enough**

## **Treatment approach**

- **Engagement of young person & family with multidisciplinary team**
- **Exercise scientist assessment – gym & training plan given; liaised with coach**
- **Frequent dietetic review with the aim of helping him to be “match fit” - and also decrease longer-term risk of T2DM**
  - **Opted for an intermittent energy restriction plan**

**A risk reduction approach**

## *14 year old boy, BMI 39.9 kg/m<sup>2</sup>, waist:height ratio 0.70 – Case 2*

- Anglo-Australian ethnic origin
- Strong family history of T2DM & obesity (mother - sleeve gx)
- OSA: CPAP - variably adherent
- Some depression, bullying at school, some school refusal
- Immersed in screens and gaming
- Acanthosis nigricans, abnormal LFTs, dyslipidaemia, no diabetes (as yet), c/o joint pains
- Limping

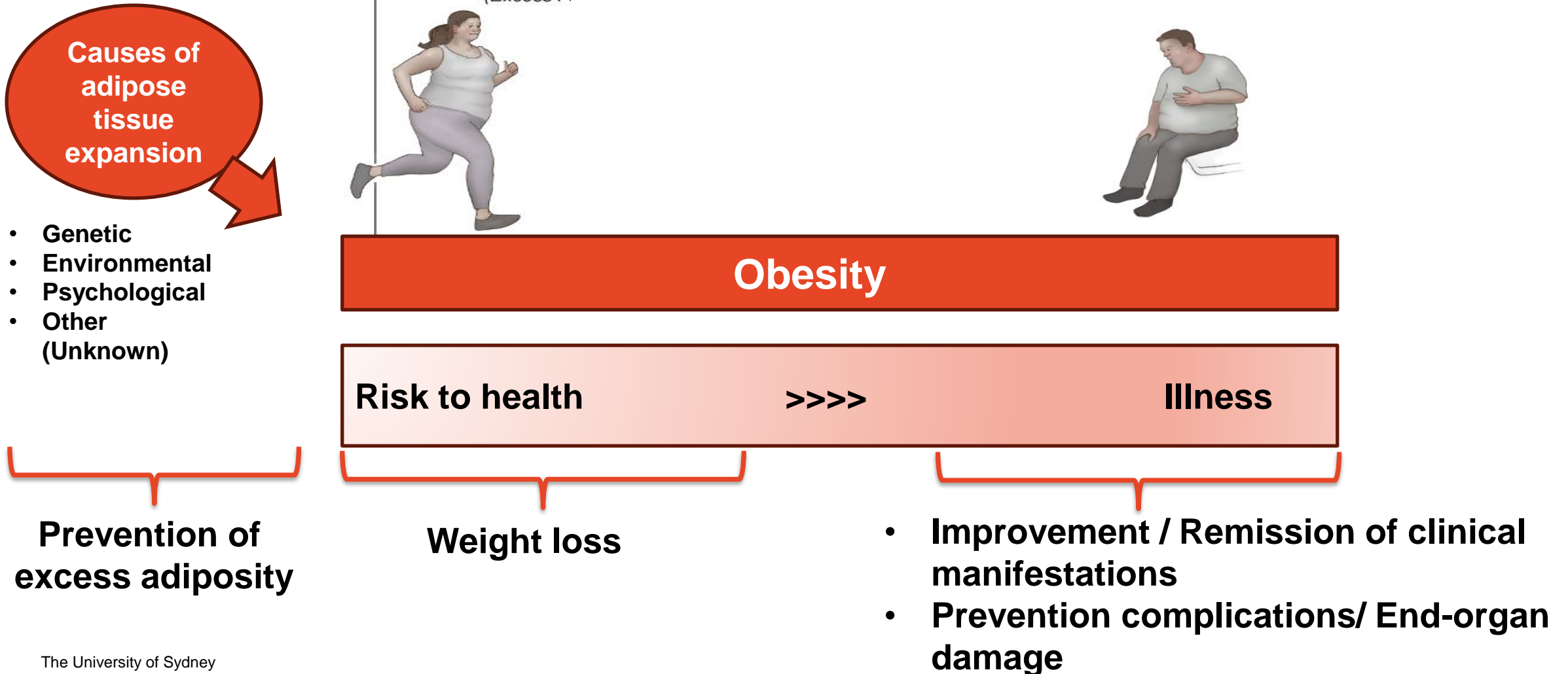
### Treatment approach

- Engagement of young person & family with multidisciplinary team
- SCFE diagnosed – orthopaedic Sx, with rehab to increase mobility
- Clinical psychology review/ support for depression
- School liaison; clinical teams liaison
- Frequent dietetic review
- Commenced on semaglutide (off-label, provided by hospital)
- *May* be a candidate for MBS in the future

**A corrective approach**



# Redefining treatment outcomes in obesity



# Summary

# *Summary*

- **People with confirmed excess obesity should be assessed for health problems to rule out clinical obesity**
- **Goals of treatment – improvement or remission of the clinical manifestations of obesity and prevention of progression to further complications**
- **Intervention principles – require an individual risk/benefit assessment; should aim to improve clinical manifestations of obesity and quality of life, or reduce risk of disease progression/mortality**

**Thank you!**