

# Practice guidance: obesity and overweight

The role of community pharmacists in helping to tackle the problem of obesity is becoming more widely recognised. This guidance on best practice for pharmacists when advising on obesity has been prepared in the **Royal Pharmaceutical Society's practice division**

The Public Health White Paper, "Choosing health", has a section on "Tackling obesity", as does the Department of Health resource document "Choosing health through pharmacy: a programme for pharmaceutical public health 2005-2015" (section 4.6).

Further information on obesity appears in another recent Department of Health publication, "Delivering Choosing health: making healthier choices easier", which is backed up by two new action plans entitled "Choosing a better diet: a food and health action plan" and "Choosing activity: a physical activity action plan"

A network of obesity services will be established by primary care trusts with additional funding from 2006. Community pharmacies will be commissioned to offer weight reduction programmes, with sign-posting to other services and the potential to refer to personal health trainers. Pharmacies will also be able to refer people directly on to Exercise on Prescription schemes, rather than indirectly through GPs.

## What are overweight and obesity?

Obesity is defined as a body mass index (BMI) of 30kg/m<sup>2</sup> or more, where a person's BMI is their weight in kg divided by the square of their height in metres. Overweight is defined as a BMI between 25 and 30kg/m<sup>2</sup>

The International Obesity Task Force classification of obesity is set out in Table 1.

In addition to the determination of BMI, waist circumference presents another simple way of assessing someone's risk from being overweight, as fat around the waist is associated with a higher risk of developing cardiovascular and other diseases than fat in other parts of the body.

Waist circumference is measured midway between the lower margin of the ribs and the top of the iliac crest laterally.

Table 2 indicates how health risk is assessed from waist measurement.

## How great is the problem?

Obesity in adults in the UK has trebled in the past 20 years. The lives of many people with obesity are being shortened by up to nine years.

- In 2002, 22 per cent of men and 23 per cent of women were clinically obese (BMI > 30)
- 43 per cent of men and 34 per cent of women were overweight (BMI > 25-29.9)
- The problem also affects young people. In 2002 a health survey showed that

**Table 1: International Obesity Task Force classification of obesity**

IOTF Classification	BMI (kg/m <sup>2</sup> )
Underweight	< 18.5
Normal range	18.5-24.9
Class I overweight	25-29.9
Class II obese	30-34.9
Class III obese	35-39.9
Class III obese	≥ 40

**Table 2: Assessment of health risk from measurement of waist circumference**

	Increased health risk	Substantially increased health risk
Men	≥ 94cm	≥ 102cm
Women	≥ 80cm	≥ 88cm



**Increased physical activity is a major contributor to weight loss**

## Main points to consider when advising on obesity

- Weight loss can only be achieved by reducing energy intake to a lower level than energy expenditure. The healthiest way to manage this is through a diet relatively low in fat and increasing physical activity. There are no miracle diets.
- Return to ideal body weight may not be achievable. Sometimes a 10 per cent weight loss, and maintenance of that, is a more realistic goal.
- Changing eating habits is challenging. Individuals need to be involved and supported in food change decisions. Start with two or three specific changes (eg, fruit instead of a pudding, low-fat spread instead of butter). Once these have been adopted, further changes can be agreed.
- Involve partners and families in the patient's attempts to lose weight and make healthier food choices.
- Dietary information should be given in terms of foods, not nutrients (eg, reduce intake of fried foods, not reduce fat).
- Consider and discuss financial and time constraints, cooking ability and facilities as well as making sure that the dietary change is enjoyable and sustainable.
- Patients need to understand that weight control will require a life-long change in eating habits and physical activity.
- Patients prescribed drug therapy must be counselled to discuss side effects.

one in 20 boys and one in 15 girls were obese

- The prevalence of obesity in children is predicted to be more than 50 per cent by 2020
- In disadvantaged social classes obesity is greater
- The level of obesity is higher in Scotland and Wales than in England
- People of differing ethnic backgrounds have different levels of obesity:
  - in England in 1999 Black Caribbean women were 50 per cent more obese than average
  - Pakistani women were 25 per cent more obese than average
  - obesity is four times more common

in Asian children than it is in white children

## What are the causes?

- Eating too much
- Lack of regular physical exercise. Up to two thirds of men and three quarters of women do not take the recommended amount of physical activity. Children are generally less active than the national guidelines
- These lower levels of daily activity by us all are caused by an increase in sedentary occupation and screen-based entertainment (ie, computers and television). Families are using their cars for ever shorter journeys. Children become

housebound as parents are worried about letting their children play outside

- School meals at present do not provide children with a healthy option. Overall standards for school meals will be introduced in 2006
- Increased snacking activity. There are far more retail food outlets than ever before providing high calorie snacks
- High fat diets
- Increased alcohol intake during the last decade, particularly in women and young men

### Health consequences

Being overweight or obese can seriously affect one's health and can manifest itself in any of the following conditions:

- Decreased life expectancy
- Development of type 2 diabetes (in adults and increasingly in young people)
- Cardiovascular disease
- Certain forms of cancer are more common in obese people:
  - colorectal and prostate in men
  - breast, endometrium and gall bladder in women
- A large number of associated conditions — osteoarthritis, breathing difficulties, gallstones, abnormalities of the reproductive system, including infertility and complications of pregnancy, sleeping problems and alterations in liver function — may lead to cirrhosis

### Prevention

- Maintaining the right energy balance, by ensuring that energy intake does not exceed energy expenditure
- A balanced diet, based on bread, other cereal and potatoes, but also rich in fruit and vegetables. There should be moderate amounts of milk and dairy products, meat, fish or protein alternatives and limited amounts of food containing fat and sugar. If weight needs to be lost, a balanced reduction across the different

food groups is advisable, rather than a diet that excludes certain food groups

- Regular physical activity helps control body weight and has significant benefits to physical and mental health. Current recommendations for adults are a total of at least 30 minutes of moderately intensive activity (eg, brisk walking) on at least five days a week. Children should have at least one hour of moderately intensive physical exercise every day

### Managing lifestyle change

Psychology has a lot to do with weight reduction. It is important to establish the reasons why a person wants to lose weight and their level of commitment. The return to an ideal body weight may not be an achievable target. A realistic goal is likely to be a loss of 5–10kg of body weight which may be maintained over a period of many years.

The diet for weight loss should provide fewer calories than the daily energy requirement, but should not involve drastic energy reduction because this can lead to lack of compliance and loss of lean tissue rather than body fat. The diet must be realistic and affordable. Before giving dietary advice, it is important to know the person's current eating habits, whether weight has been lost in the past and how long this was maintained. Asking the person to keep a food diary can be useful. Attendance at groups (eg, WeightWatchers) helps some individuals.

### Commercial diets

There are many popular commercial weight loss diets. Some promote a "quick fix" solution to obesity and may be nutritionally unsound.

- One food only – the grapefruit diet
- Banned foods – the no chocolate diet
- Food combining – the Hay diet
- Low carbohydrate intake – the Atkins diet
- Carbohydrate with a low glycaemic index — GI diets

Although they may result in weight loss in the short term, these diets may not encourage the change in eating habits necessary for long-term weight maintenance.

### OTC slimming products

Various over-the-counter slimming products are available and are heavily promoted in the press. Some are suggested to have effects on:

- Satiety — fibre products
- Absorption — chitosan
- Fat oxidation — carnitine, conjugated linoleic acid
- Metabolic rates — caffeine, ephedrine
- Lipogenesis — hydroxycitrate

There is little convincing evidence of benefit for any of these products.

### Drugs

Drugs licensed for the treatment of obesity are orlistat and sibutramine. They should be prescribed for individuals who have attempted seriously to lose weight by diet, exercise and other behavioural modification. Anti-obesity drugs should never be the sole element of treatment.

A proactive telephone support service called MAP (Motivation, Advice and Proactive Support) is available (in different forms) both to people who are trying to lose weight before being prescribed orlistat, and those who are on orlistat (<http://www.medicines-partnership.org/projects/current-projects/map-programme>).

### Information required for assessment

The following information is required before assessing a patient's predisposition towards obesity:

- Height (m) and weight (kg)
- Waist circumference (cm)
- Blood pressure (mmHg)
- Blood glucose (mmol/l)
- Total cholesterol

## Card version of practice guidance on obesity

The Royal Pharmaceutical Society's practice division intends to publish this guidance on obesity in the form of an A4-size card, which will be distributed with a future issue of *The Journal* to those members of the Society who are registered as practising pharmacists.

The card format version is already available as a PDF document that pharmacists can download from the practice section of the Society's website ([www.rpsgb.org/practice](http://www.rpsgb.org/practice)).

## Other guidance from the Society's practice division

The Society's practice division has been involved in the preparation of several further guidance documents for pharmacists:

- **Practice guidance on pharmacy services for clinical trials** This is being produced in co-operation with the Institute of Clinical Research and will be launched at a one-day conference to be held at the Society's headquarters on 19 May, "One year on: the impact of the EU clinical trials directive".
- **Cholesterol testing guidance** This is being produced jointly with the Medicines and Healthcare products Regulation Agency.

- **MAR chart guidance** New guidance on the provision of medication administration record charts has been developed in conjunction with a number of expert pharmacists and with input from the National Pharmaceutical Association. It was described in *Community Pharmacist* (centre pull-out, *PJ*, 2 April) and is available from the practice section of the Society's website ([www.rpsgb.org/practice](http://www.rpsgb.org/practice)).

- **Practice guidance on the care of people with mental health problems** The Society is working with various organisations to update its 2002 guidance on the

care of people with mental health problems, taking account of many developments in this area, and particularly the publication of "National Service Framework for Mental Health: modern standards and service models".

- **Helping smokers to stop: guidance for pharmacists** The guidance has been produced by the Health Development Agency (soon to become part of the National Institute for Clinical Excellence), the Pharmacy Health Link and the Society's practice division. The document has now been completed and has been sent out for consultation.