Sharing information with patients who want to lose weight
A crib sheet for NHS healthcare professionals

- Permission – is the information wanted?
- Ask – what do they know already?
- Provide – tailored information, without telling people what to do
- Ask – how they will use the information

Dietary advice

There is strong evidence that people don't stick to crash diets for long and that they end up feeling bad about themselves as their weight goes up and down.

The NHS recommends manageable changes that patients can stick to for life. These changes include:

- How and when you eat, such as having regular meals away from the TV, eating with the whole family, and avoiding snacking;
- What you eat, so that you eat all the food groups in the right proportions and avoid soft drinks;
- How much you eat, through portion control. Some people find it helpful to use their hand as a guide to portion sizes. A clenched fist being an appropriate portion of carbohydrate (rice, pasta, bread) to have with each meal. [Eatwell plate with portion control].

Aim for modest weight loss of up to 10% (average is 3%) at a rate of 0.5kg to 1kg per week, and then maintenance as a goal. Even slowing the rate of weight gain could be a helpful goal for some patients.

Notes:

Exercise advice

The NHS recommends 150 minutes of moderate exercise or 75 minutes of vigorous exercise each week. This is equivalent to 30 minutes moderate exercise 5 days a week, or 15 minutes vigorous exercise 5 days a week, plus strengthening exercises.

Try to be specific about how often, when, where and for how long you intend to exercise. [Exercise prescribing pad]

Low impact exercise is beneficial for patients with wear-and-tear arthritis of their knees and hips. This can be explained as any exercise where no noise is made from impact e.g. cycling, swimming, yoga, pilates, rowing etc.

Notes:

Complex cases

Binge Eating Disorder (BED) is a condition that can be caused by many things, including low self-esteem or low confidence. People who have this disorder frequently eat uncontrollably until they feel unwell and may have feelings of guilt and shame. Many people get better after seeing a specially trained counsellor. Here is a leaflet / website.

The prevalence of BED is 2% in the general population but around 30% in populations seeking help for their weight and may be linked to a history of depression or abuse.

Consider BED where there are three or more of the following:

- Eating much faster than normal during a binge
- Eating until uncomfortably full
- Eating a large amount of food when not hungry
- Eating alone or secretly due to being embarrassed about the amount of food consumed
- Feelings of guilt, shame or disgust after binge eating

Treatment involves addressing the psychological issues (through self-help e.g. www.b-eat.org.uk , psychological therapies such as CBT, and/or starting an SSRI) as well as a standard weight-loss plan once they are in control of their eating habits. BED has a good rate of remission with 50% responding to CBT treatment.

Health benefits

There is strong evidence that losing a small amount of weight, or increasing the amount of exercise that you do can help to protect you from dementia / heart disease / cancer / diabetes / stroke etc. Here is a leaflet / website.

Most patients lose weight to look and feel healthier, and may be unaware of the health risks of obesity, or the benefits of modest weight loss. If your patient is already motivated, it may not be necessary to educated them, but if you feel they would benefit from understanding the health risks and benefits, tailor the advice to the areas of health that they are concerned about, perhaps due to family members with diabetes, arthritis, heart disease, or cancer. Try to couch this as education rather than advice ('people who lose weight can significantly reduce their risk of many types of cancer', rather than 'you must lose weight to reduce your risk of cancer').

Joint osteoarthritis

There is a strong and weight-related link with patients of BMI 35 have 14 times the risk of patients with normal BMI. Losing weight and low impact exercise has been shown to be as effective as surgery in symptom control. Useful patient leaflet

Type two diabetes

There is a strong weight-related link, with obese patients, and patients from some ethnicities (in particular the Indian subcontinent and some Afro-Caribbean populations) having dramatically higher levels of diabetes. Use this personalised risk calculator to illustrate your patient's current level of risk and how losing weight could modify their risk.

Hypertension

About 16 million adults (30% of adults) have hypertension in the UK with 60 to 70% of hypertension attributable to adiposity.

Advice for parents

The NHS normally recommends that children don't try to lose weight, just to stop putting it on until they grown into a healthy weight for their height. Children can stop gaining weight by improving what they eat, eating child-sized meals, swapping snacks and sweet drinks for healthier options, and getting at least an hour running around every day. It helps if the whole family make changes together. Here is a helpful website.

Many parents are unaware that their children are overweight. It can help to be objective and to show where their child is on their height and growth chart (they should be in a similar centile for both). BMI tends to underestimate a child's level of obesity, and a specialist paediatric healthy weight calculator should be used.

Young children should generally aim to 'grow into their weight' rather than lose weight. However as children approach their adult height, they will need to lose weight as an adult would.

Dietary change (e.g. cutting snacks and soft drinks) is the key intervention for severely overweight children as it has been shown that obesity causes inactivity rather than the other way around.

Notes:

Causes of obesity

Weight gain is determined by a balance of energy in (food and drink) and energy out (exercise plus background metabolism). If people consume more than they expend, they put on weight. The reasons for excess calorie intake and inadequate calorie expenditure are complex and include differences in appetite, availability of food and snacks, unseen calories and some medical conditions. The evidence shows that it is difficult to exercise enough to lose weight, unless you are controlling how much you eat at the same time. If exercise is difficult for someone, they can still lose weight by improving their diet, and reducing the amount that they eat.

Some medications can have a profound impact on appetite (e.g. valproate, lithium, olanzapine, risperidone, clozapine, amitriptyline, mirtazapine, cetirizine). Some medications cannot be withdrawn for clinical reasons, but others may be swapped for alternatives with less obesogenic effects.

According to the FOA the average UK calorie intake is 3,440 kcal while the recommended calorie intake is only 2,000kcal for women or 2,500 kcal for men. One hour's vigorous exercise (more than most people do) consumes only about 500 kcal.

People that believe that lack of exercise is the main cause of obesity tend to be heavier than people that think that excess dietary intake in the main cause of obesity.

Notes:

Orlistat

Orlistat works by preventing the body from digesting fat. It therefore commonly causes faecal incontinence if fat is ingested. It is helpful if patients are able to stick to a fat-free diet, but many patients are intolerant of this side effect.

Some patients have the misconception that Orlistat will allow them to eat as much fat as they like without putting on weight. Orlistat effectively forces patients to adopt a fat-free diet.

Orlistat can be prescribed to patients with a BMI>30 (or 28 with risk factors), to be discontinued if the patient has not successfully lost 5% of their weight in 3 months.

Notes:

Surgery for weight loss

Surgery is the most effective treatment for obesity, however there are capacity issues (it is estimate that 5% of the UK population meets the current NHS criteria for surgery, but only 7,000 procedures are currently performed annually, creating a theoretical backlog of around 300 years). Newer therapies such as gastric balloons can be inserted gastroscopically as a day case but need to be removed 6-12 months later, but this service may not be available on the NHS in all areas.

Some patients have the misconception that surgery will allow them to eat as much as they like without putting on weight. Surgery effectively forces patients to eat smaller portions. Patients are referred to a tier 3 obesity service before being considered for surgery, where they receive coordinated exercise, dietary and psychological interventions.

Patients can be referred to this service if other treatments have failed if they have BMI >40 (or BMI>35 with comorbidities). It is used as a first line treatment if BMI >50.

Patients have to commit to life-long changes, and may develop nutritional deficiencies without life-long supplementation.

Notes:

- This information is intended for NHS healthcare professionals and trainees
- It is part of the KHP e-learning module Addressing Obesity
- The information was accurate at time of press (June 2015)
- For feedback please contact kay.leedham-green@kcl.ac.uk