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Core Principles for the Care of Patients with Obesity

Preamble. Obesity rates have risen progressively over the past 30 years, and this has created a global health crisis with profound impact on patient suffering and social costs^{1,2}. Based on a greater scientific understanding of pathophysiology, advances have been made in lifestyle interventions, pharmacotherapy, endoscopic devices, and surgical procedures to treat this disease. These advances have expanded effective therapeutic options, and thus necessitate the development of rational approaches for individualized and patient-centered care that optimize safety and effectiveness across a continuum of care³.

The authors represent a diverse assembly of 23 professional associations numbering 839,981 members, who encompass a broad spectrum of disciplines providing care to adult patients with obesity⁴. We strongly hold that the following declarations embody core principles that constitute a high quality of care for patients with

obesity, and will assure approaches to management that optimize health outcomes and safety. We believe that all patients seeking care for obesity should have access to care coverage that incorporates these Core Principles.

Core Principles for the Treatment of Obesity

- 1. Definition:** Obesity is a complex, progressive, adiposity-based chronic disease that is due to interactions among multiple genetic, biological, metabolic, social, and environmental factors, and is associated with weight-related complications that produce morbidity and mortality.
- 2. Prevention and Treatment:** As with other chronic diseases, therapeutic interventions must address primary prevention to avert the development of overweight and obesity, secondary prevention in patients with overweight or obesity to halt its progression and prevent the development of complications, and tertiary prevention to ameliorate or eliminate weight-related complications once they occur⁵. This three-phase paradigm for chronic disease aligns with the pathophysiology and natural history of obesity, and provides a rational framework for appropriate treatment at each phase of prevention.
- 3. Screening and Diagnosis:** Adults should be screened at least annually for overweight and obesity using, at minimum, the body mass index (BMI) guided by ethnicity-specific threshold values. The clinical evaluation required for diagnosis should include: (i) an examination to confirm that elevated BMI represents excess or abnormal adiposity, and (ii) an evaluation of patients for the risk, presence, and severity of weight-related complications. Potential factors that can worsen obesity including medications, environment and underlying health conditions should be assessed.
- 4. Therapeutic Goal:** The principal outcome and therapeutic target in the treatment of obesity should be to improve the health of the patient by stabilizing or reducing body fat and thus preventing or treating weight-related complications.
- 5. Follow-Up:** Patients with overweight or obesity should be monitored at regular intervals, as with any appropriate chronic disease management, based on severity and complexity of disease status to assess for and treat any changes in adiposity and adiposity-related complications over time.
- 6. Consequences:** Obesity-related complications may be ameliorated by weight loss therapy including: Prediabetes, Metabolic Syndrome, Type 2 Diabetes, Hypertension, Dyslipidemia, some forms of Cancer, Non-Alcoholic Fatty Liver Disease/Non-Alcoholic Steatohepatitis, Polycystic Ovary Syndrome, Male Hypogonadism, Female or Male Infertility, Adverse Birth Outcomes,

Obstructive Sleep Apnea, Asthma/Reactive Airway Disease, Osteoarthritis, Urinary Stress Incontinence, Gastroesophageal Reflux Disease, Immobility and Disability, Depression, Stigmatization, and diminished Quality of Life among many others. The risk, presence, and severity of these and other obesity and overweight complications should be considered in clinical decisions and the therapeutic plans for obesity treatment.

7. **Need for Intervention:** Initiating treatment for patients with obesity should begin prior to or in concert with other health interventions. Interventions should have credible evidence for efficacy and safety. Obesity may decrease the effectiveness of medical interventions in general and increase the risk of complications and cost of medical care. Health care professionals have an ethical and medical obligation to treat or refer patients with obesity for therapy.
8. **Lifestyle:** A structured lifestyle intervention program designed for weight loss (lifestyle therapy) should be available to patients who are being treated for overweight or obesity. Lifestyle therapy should consist of individualized care including a healthy eating pattern featuring a reduction in total caloric intake, reduced sedentary behavior that results in sufficient regular engagement of physical activity, adequate sleep, and behavioral interventions that promote adherence to the lifestyle prescription. Lifestyle changes such as physical activity are critical for weight maintenance as well as weight loss. Lifestyle intervention should be a component of all obesity interventions.
9. **Medications (Indications):** The approved use of pharmacotherapy should be considered in patients with obesity as an adjunct to lifestyle therapy. Based on clinical judgment, anti-obesity medications can be used for patients who have not achieved therapeutic goals on lifestyle therapy alone, or initiated concomitantly with lifestyle therapy in order to achieve and maintain sufficient weight loss in higher risk patients to treat or prevent weight-related complications.
10. **Medications (Management):** In selecting the optimal anti-obesity medication for each patient, clinicians should consider differences in efficacy, side effects, cautions, and warnings that characterize medications approved for chronic management of obesity, as well as the presence of weight-related complications and medical history; these factors are the basis for individualized anti-obesity pharmacotherapy. Clinicians and their patients with obesity should have available access to all approved medications to allow for the safe and effective individualization of appropriate pharmacotherapy.
11. **Endoscopic Interventions:** Utilization of endoscopic interventions such as intra-gastric balloons should follow FDA guidelines (e.g., BMI 30-40 kg/m²)

if applicable and be performed in concert with quality standards in place, established weight loss strategies, and a multi-disciplinary team.

12. **Surgery:** Patients with a BMI of ≥ 40 kg/m² without co-existing medical problems, and patients with a BMI of ≥ 35 kg/m² and one or more severe weight-related complications should be considered for a bariatric surgery at accredited centers. Consideration should be given to earlier referral in order to escalate care for lack of current therapy efficacy and/or comorbidity exacerbation particularly for diabetes. Selection of procedure is best made in an accredited center with an experienced bariatric surgeon in consultation with a multi-disciplinary team.
13. **Continuum of Care:** Obesity treatment should occur as a continuum of care with lifestyle intervention, pharmacotherapy, endoscopic therapy, and bariatric surgery available as needed to all patients with consideration for appropriateness, cultural competency, patient preference, safety, and effectiveness. The structure for obesity treatment should be patient-centered. This may include treatment in either a dedicated obesity treatment center or a primary care setting with access to components of a multi-disciplinary team who are committed to initiate and escalate therapy as needed, track outcomes, maintain standards of care, provide empathy, and evaluate patients for complications and the response of these complications to therapy.
14. **Professionalism:** All patients with obesity should be treated with respect, dignity, and sensitivity, and deserve an empathetic and supportive environment for the treatment of obesity. Facilities should maintain appropriate physical resources and staff training, and health care professionals should use patient-first language in their delivery of care. All patients are deserving of conscientious and comprehensive care for obesity as both a disease and a potential disability.
15. **Access:** The foremost component of medical prevention and treatment is access to evidence-based interventions. Federal, state and commercial insurance plans should provide all beneficiaries coverage for the full range of effective obesity treatments. As with other chronic diseases, patients with obesity should also have the same right to improve their health and welfare through access to prevention and treatment of their disease.

References

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