



# OAC News

The Obesity Action Coalition's Quarterly Newsletter

## Medically Managed Weight-Loss: *A Treatment Option*



By Stephanie Yeager, RD, Shannon McShea, PA-C, Laura Smith, CRNP, and Christopher D. Still, DO

The Center for Nutrition and Weight Management at Geisinger Medical Center is designed to provide treatment to patients who are suffering from obesity with assistance, support and treatment for weight and weight-related problems such as heart disease and stroke, high blood pressure, sleep apnea, joint disease/limited mobility, high cholesterol, high triglycerides, low levels of HDL (high-density lipoprotein – the "good" cholesterol), and type 2 diabetes. Fortunately, even modest reductions in weight can help improve these conditions. A weight-loss of 5 to 15 percent of body weight may improve health and quality of life and prevent (or treat) these health problems. For a 200 pound individual, this would equate to a 10 to 30 pound weight-loss.

### The Initial Consult

Weight management is a partnership between the patient, their family and healthcare team; comprised of doctors, nurses and dietitians. This partnership is one that is developed on an individual basis with each patient. A phy-

sician, physician assistant or nurse practitioner, specializing in obesity treatment, provides the initial consultation. The initial consult involves a focused medical evaluation for diseases related to obesity, a weight history, including past diet attempts, and a thorough psychological history. Several blood tests are often drawn; many patients come to the clinic with undiagnosed diabetes, high cholesterol, thyroid disorders or abnormal liver tests.

Management of obesity includes diet, exercise, behavior modification and psychological counseling. In certain cases, medication for weight-loss (pharmacotherapy), supervised very-low calorie diets, full/partial liquid diets or weight-loss surgery may be options (surgery and liquid diets will be addressed in future articles).

### Diet and Behavior Modifications

After the initial assessment, many of the follow-up appointments are with registered dietitians or mid-level providers who are certified in obesity management, as well as exercise. Although many factors influence weight, the principal concept of the energy balance equation: "energy in, versus energy out," is the core of the program. To lose weight, you must consume fewer calories than you burn. This is, of course, easier said than done. No matter what weight-loss methods you

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# A Message from President and CEO, Joseph Nadglowski, Jr.

I hope you find this edition of *OAC News* to be informative and educational.

In February, Medicare, the government program that is the insurer of the elderly and disabled, implemented new rules expanding coverage for weight-loss surgery. Details and frequently asked questions regarding the new rules can be found on pages 12 and 13. Although not without some controversy, specifically around the Center of Excellence requirement, I view the new rules as a major step forward in our efforts to expand access to life-saving and life-changing weight-loss treatments and a major example of how patient advocacy can influence our healthcare.

## Why are the Medicare rules important?

As many of you are keenly aware, convincing insurance companies to pay for weight-loss surgeries has been an uphill battle. Too often, all forms of treating obesity and morbid obesity are specifically excluded. Medicare's extensive review of the safety and effectiveness of weight-loss surgery and their subsequent expansion of coverage is a strong signal to insurance companies to review and change their own policies. It is my hope that Medicare's decision will set off a chain reaction of private insurers adopting similar coverage.

## How did advocacy impact the decision?

In past months, the OAC and its members, called on patients, professionals and others to share their experiences with weight-loss surgery with Medicare. Many of you did just that, and it was through these advocacy efforts that the final rules greatly expand surgery options and those who may receive the surgery.

Like with many new rules, there have been some challenges. Many patients have had their surgeries cancelled because their surgeon/hospital is not a Center of Excellence. For those of you that have had your surgery cancelled, rest assured the OAC continues to share the impact the new rules have had on you and will continue to encourage programs to apply for Center of Excellence status and to accept Medicare patients.

If you have any questions about the Medicare issue, this newsletter or any of the OAC's activities, please do not hesitate to contact our National office at (800) 717-3117 or [info@obesityaction.org](mailto:info@obesityaction.org). Thank you.

Sincerely,



a National Board of Directors. Members of the OAC Board of Directors include: Robin Blackstone, MD, Jim Fivecoat, Julie M. Hill-Janeway, Georgeann Mallory, RD, Paulette Massari, LCSW, CAP, CS, Melissa Parish, Christopher Still, DO, FACN, FACP and Barbara Thompson, MLS.

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The Obesity Action Coalition (OAC) is an independent national non-profit patient organization dedicated to educating and advocating for those affected by obesity.

The mission of the OAC is to elevate and empower those affected by obesity through education, advocacy and support.

The OAC is governed under the authority of

OAC News is a quarterly educational and advocacy newsletter. OAC News is distributed in October, January, April and July. Subscription to OAC News is a membership benefit, however, anyone is welcome to request copies at any time.

Opinions expressed by the authors are their own and do not necessarily reflect those of the OAC Board of Directors and staff. Infor-

mation contained herein should not be construed as delivery of medical advice or care. The OAC recommends consultation with your doctor or healthcare professional.

If you are interested in contributing to this publication, or for reprint requests, please contact the OAC National Office.



# Sleep Apnea

## Sleep Apnea and the Obese Patient

By Randal S. Baker, MD, FACS

Loud snoring is a common sign of a breathing problem that can lead to other issues. According to the American Academy of Sleep Medicine, approximately 10 to 30 percent of adults snore. Loud snoring, however, is a sign of a serious disorder and affects about five in every 100 people.

When a person snores, it is because the breathing passages in the back of the throat are narrowed and not fully open, thus restricting the amount of air taken in while sleeping. It is like trying to breathe through a wet, sloppy noodle. When the body cannot get enough air, it signals the brain to breathe harder and force the air in (that terrible snoring sound), or if it cannot get any air in (and you stop breathing); it wakes the body up in order to correct the problem.

This can happen hundreds of times a night, and the cumulative effect can lead to chronic sleepiness, trouble concentrating and even depression. The body's repeated lack of restorative sleep over an extended period can also lead to more serious problems as well, including high blood pressure, heart attack and stroke.

### Different Types of Sleep Apnea

Those who experience loud snoring and breathing difficulties while sleeping are generally suffering from Obstructive Sleep Apnea Syndrome (OSAS). OSAS has two basic types. In some patients, the narrowing of the breathing passage is slight and the body can continue breathing, but only with increased effort (loud snoring or loud breathing). These patients still experience sleep disruptions and repeated sleep and wake cycles through the

night, although they may not remember any of it. This type of sleep disturbance is called *hypopnea*.

In other patients, the breathing passage can narrow so much that no air can get through and the patient stops breathing. The brain then wakes them up so they will breathe, and the cycle begins again. This is called *apnea*. Some patients actually experience both types of the disorder through the night as the muscles in the throat continue to relax and narrow the breathing passage. Both types of abnormal breathing drop the levels of oxygen in the blood which cause a number of other symptoms.

OSAS is caused by the natural relaxation of the throat muscles that happens in everyone when they begin to sleep. OSAS sufferers, however, often have additional factors that complicate things such as being overweight, having a smaller than normal jaw, having enlarged tonsils or other soft tissues that may partially block the breathing passage, or having a large tongue.

Additionally, those who drink alcohol before sleep or take sleeping pills or tranquilizers are causing the muscles in the throat to further relax and narrow, and therefore make the breathing passage more likely to close. Many take sleeping pills or tranquilizers in order to get better and more continuous sleep, and in fact the remedy makes the problem worse.

Sleep quality problems usually appear slowly, and may progress over years, especially if weight also increases at the same time. The patient may not even recognize the

Obesity-Related Diseases

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# Sleep Apnea

*Sleep Apnea continued from page 3*

symptoms, and most patients rarely remember the numerous times they sleep and wake over the course of a night. They often fail to recognize that a sleep problem even exists.

Many times those who suffer from the effects of poor sleep attribute it to aging, stress, medication, an old bed, or other causes. While these may actually be factors in the sleep quality experienced, if the symptoms listed above are present, they are most likely the real culprit of the sleep deprivation. In such cases, a sleep specialist can diagnose and treat these disorders in order to improve quality of sleep and quality of life.

## Treating Sleep Apnea

When a patient is referred to a sleep disorders clinic, or sleep lab, the medical professionals will inquire about the patient's medical history, and may talk with the patient's sleep partner or other members of the household about the patient's daytime and sleeping behaviors. Patients are often asked to spend a night or two in a sleep laboratory in order to monitor and evaluate the sleep behaviors. This study is called a polysomnograph. If asked to spend the night at the lab for evaluation, a patient will be fitted with tiny sensors placed in different positions on the body to record brain waves, leg and arm movements, heart rhythms, muscle activity, respiratory rates, oxygen levels, and other body functions during sleep. Other devices may be used to monitor and assess breathing patterns as well. Occasionally x-rays and direct examination of the breathing passage are conducted to provide a better understanding of the architecture of the throat. There are generally no needles involved, and the testing is not uncomfortable or painful.

Some patients are asked if they can be studied during the day as well, and if so, they are monitored through a series of 20 minute naps offered at two-hour intervals. This type of study is known as a Multiple Sleep Latency Test (MSLT), and it measures daytime sleepiness for reference to results from the night time studies. The MSLT is also used to evaluate other potential causes of sleepiness such as narcolepsy or similar physical disorders of brain function.

If a patient is diagnosed with OSAS, there are several options for treatment. The first of which is a reduction in

## What To Do if You Think You Have Sleep Apnea



If you are experiencing any of the following symptoms more than twice a week, you should contact a medical professional who will refer you to a sleep disorders lab for evaluation:

- Excessively loud snoring which can be heard rooms away
- Mood swings, trouble concentrating or becoming forgetful, irritable, anxious or depressed
- Snoring that is interrupted by pauses, episodes of stopped breathing, gasps or a choking sensation
- Falling asleep at inappropriate times, such as at work or while driving
- Morning headaches, or unexplained nausea, and frequent trips to the bathroom to urinate at night
- Chronic dark circles under the eyes

*Note: It is not normal for children to snore loudly every night, or to have difficulty or labored breathing, squeak or gasp when breathing on a regular basis. Poor sleep can cause daytime hyperactivity which can then be misdiagnosed as Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD). If you observe your child exhibiting these warning signs, seek the help of a medical professional immediately.*

weight if the patient is in fact overweight. Even small amounts of weight-loss can significantly improve OSAS. For example, if a man who should weigh 165 pounds, and currently weighs 200 pounds reduces his weight by just 20 pounds, he may see a more improved sleep experience at night, reduced snoring and have better quality of life during the day.

The second treatment option, almost always combined with losing weight, is the use of a Positive Airway Pressure (PAP) device when sleeping. This light mask is worn over the nose during sleep. A small, quiet air pump is attached to the mask with a long tube, and air under pressure enters the nasal passages and goes into the throat and onto the lungs. This gentle air pressure holds the breathing passages open and reduces the amount of effort the body has to put forth in order to breathe during sleep. The body receives more oxygen,



works less, and thus experiences more restful and restorative sleep.

Other forms of treatment include oral appliances for those whose OSAS is affected by jaw shape, tongue size, or issues with the soft palate. Patients with mild to moderate OSAS generally have more benefit from this type of treatment than do severe sufferers. Surgery is a rare option, and certainly a last resort, unless the problem is being caused by an actual abnormal physical obstruction such as enlarged adenoids or tonsils, polyps or other growths.

OSAS is something that can be managed and even cured with the help of appropriate medical professionals. You don't have to sacrifice quality of sleep or life because you have OSAS. If you believe you may be suffering

from OSAS or any other type of sleep disorder, do yourself a favor and seek professional help – it doesn't hurt, and it is readily available. You deserve better sleep, and so do those who live with you!

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#### *About the Author:*



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### Patients with OSAS are encouraged to try the following to help in the treatment of their condition:

- Lose weight.
- Avoid alcohol within four hours of bedtime.
- Avoid sleeping pills as they relax the breathing passage too much. Talk to your healthcare professional if you are taking sleeping pills for any other sleep disruption other than those caused by OSAS.
- Consult a medical professional about all medication prescribed or taken for headaches, anxiety, and other common problems as they can affect sleeping and breathing.
- Sleep lying on one side or on the stomach. Some only suffer from OSAS when lying on their backs. Pinning a pillow or tennis ball to the back of the pajamas will prevent rolling over to the back during the night.
- Medications to reduce nasal stuffiness may be helpful in reducing snoring and may help OSAS slightly. Breathright<sup>®</sup> strips and other similar products can also be used to reduce nasal obstruction after consult with a medical professional.
- Avoid caffeine within four hours of bedtime. Caffeine is found in coffee, tea, soda, energy drinks, cocoa, chocolate and prescription and non-prescription medications. Excessive caffeine use during the day should be reduced.
- Stop smoking, or do not smoke within one hour of going to sleep.
- Regular exercise helps people sleep better, but do not exercise within six hours of bedtime. Consult a health care professional before beginning an exercise program.
- Maintain a comfortable sleeping environment including a quality bed appropriate for your body, constant comfortable temperature, and a dark, quiet room in which to sleep.
- Do not eat heavy meals before bedtime. Milk or other dairy products, or even a slice of turkey, are good before bedtime because they contain the natural sleep-promoting substance tryptophan.
- Manage stress during the day, and try engaging in a stress reducing activity for a half hour before bed such as reading, a warm bath, meditating, doing a crossword puzzle, etc.
- Maintain a regular sleeping and waking time, even on weekends and holidays.
- Maintain regular schedules for the other activities in your life such as taking medications, meals, chores and such.
- Use the bedroom only for sleeping, sex, and in times of illness.
- Do not permit yourself to fall asleep outside of the bedroom (i.e. the easy chair, the couch).
- Avoid napping during the daytime. If you must nap during the day, then do so at the same time.

# Understanding

## the Stigma of Obesity and its Consequences



By Rebecca Puhl, PhD

**Bias, stigma, and discrimination due to weight are frequent experiences for many obese individuals, which have serious consequences for their personal and social well being, and emotional health.**

The alarming rates of obesity have brought widespread attention to the medical consequences of this public health problem. Often ignored, however, are the social and personal obstacles that overweight and obese individuals face.

Bias, stigma, and discrimination due to weight are frequent experiences for many obese individuals, which have serious consequences for their personal and social well being and emotional health. Given that at least half of the American population is overweight, the number of people potentially faced with discrimination and stigmatization is immense.

### **Weight Stigma Plays a Role in Everyday Life**

#### At Work

There is clear evidence of weight stigma and bias in multiple aspects of daily life for obese individuals. Negative perceptions of obese persons exist in employment settings where obese employees are viewed as less competent, lazy and lacking in self-discipline by their co-workers and employers. These attitudes can have a negative impact on wages, promotions and decisions about employment status for obese employees.

Research studies also show that obese applicants are less likely to be hired than thinner applicants, despite having identical job qualifications. There are also increasing legal cases emerging where obese employees have been fired or suspended because of their weight, despite demonstrating good job performance and even though their body weight was unrelated to their job responsibilities.

#### In School

Multiple forms of weight stigmatization also occur in educational settings. Obese students face numerous obstacles, ranging from harassment and rejection from peers at school, to biased attitudes from teachers, lower college acceptances and wrongful dismissals from college.

The severity of this problem is highlighted by research which shows that stigma toward overweight students begins very early. For example, negative attitudes have been reported among pre-school children (ages three to five) who associated overweight peers with characteristics of being mean, stupid, ugly, unhappy, lazy and having few friends.

#### In Healthcare Settings

Unfortunately, weight stigma also exists in healthcare settings. Negative attitudes about overweight patients have been reported by physicians, nurses, dietitians, psychologists, and medical students. Research shows that even healthcare professionals who specialize in the treatment of obesity hold negative attitudes.

It is not yet known how bias among healthcare professionals affects the quality of care they provide to obese patients. However, some studies have indicated that obese patients are reluctant to seek medical care, and may be more likely to delay important preventative healthcare services and cancel medical appointments. One reason for these experiences may be weight bias in healthcare settings.

*Stigma continued on page 14*



**“The news is clear: we need to be eating more fat-free or low-fat dairy, whole grains, fruits and vegetables!”**

MyPyramid.gov is the new tool developed by the U.S. Department of Agriculture to assist Americans in selecting healthy diets. It is an update of the Food Guide Pyramid. Important updates incorporated into the new MyPyramid include recommendations for getting adequate nutrition from the food we eat while balancing caloric intake with energy expenditure for weight control. The tool stresses that one size does not fit all. An interactive Web site was developed at [www.mypyramid.gov](http://www.mypyramid.gov) to help people individualize their nutrition plan. The Web site gives advice on:

- Recommended portions from each food group
- Smart food choices within each food group
- Finding a balance between food and exercise
- Getting the most nutrition from your food choices

An interesting addition to the recommendations is the calculation of how many “extra” calories you can consume and still stay within your calorie range.

Developed in conjunction with the release of the 2005 U.S. Dietary Guidelines, MyPyramid.gov provides science-based advice about diet and physical activity to promote health and reduce the risk of major chronic diseases. The guidelines are revised every five years.

Putting together dietary recommendations and meal plans for the general public is no small task. We are each unique in so many ways! But, the news is clear: we need to be eating more fat-free or low-fat dairy, whole grains, fruits and vegetables! We also need to balance our food intake with physical activity.

# The Food Pyramid in 2006



*By Stephanie Norris, MS, RD, LD/N*

## Extra Calories

Discretionary calories are to be considered once all food group recommendations are met. The MyPyramid.gov user is advised to use these calories to eat larger portions of recommended foods, add dressings or use higher fat versions of a recommended food, add sweeteners, or consume a food or beverage that is mostly fat or caloric-sweetener such as soda, or wine.

## Exercise

For the first time, as part of a food guidance plan, physical activity recommendations are made. Thirty minutes of moderate or vigorous activity is recommended daily. Examples of moderate to strenuous activity include walking at a pace of three and a half miles per hour, playing golf, hiking, gardening or bicycling less than 10 miles an hour. MyPyramid recommendations are designed for most Americans. It is not intended to overrule recommendations from health professionals who are familiar with personal needs.

MyPyramid.gov provides quite a bit of nutrition information in a manner that respects individual needs and population groups. It is based on current nutrition science and is sensitive to caloric and exercise needs. Although nothing can replace the important role of nutrition professionals in writing individual nutrition plans for unique personal and medical needs, MyPyramid.gov goes a long way to turn nutrition research into workable meal plans.

*Food Pyramid continued on page 8*



# Looking at the Food Groups

The food groups have remained basically the same (grains, fruits, vegetables, milk, meats and beans, oils), but there are some important differences in the message. The following is a synopsis of the most important changes from each food group:



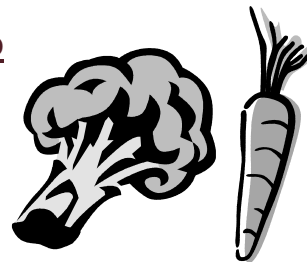
## Grain Group

The recommendation from the grain group is for at least one-half of your grain choices to be whole grain. This recommendation is supported with a definition of whole grains and gives examples, including 100 percent whole wheat bread, oatmeal, brown rice and barley. A portion size is – one ounce, the equivalent of one slice of bread, one cup of cold cereal or one-half cup of hot cereal, rice or pasta.

**TIP:** To increase whole grain consumption, try stocking the pantry with 100 percent whole wheat bread, whole grain pasta, brown rice and whole grain cereals. Substituting whole grains in recipes and asking for whole grains in restaurants, such as whole grain cereals, is recommended.

## Vegetable Group

Vegetables are divided into subgroups, including dark green, orange, dry beans and peas, starchy and others. The recommendation for how often you consume dark green, orange and dry beans and peas varies with personal plans. Servings vary, but a general rule is to consider one cup as a serving for most vegetables. Two cups is a serving for salad leaves. One medium-sized baked potato is considered one cup, but starchy vegetables are recommended to be consumed only three times a week.



**TIP:** To get more vegetables in your diet, look for vegetables that are in season and keep frozen and easy-to-prepare vegetables on hand. Pick up pre-washed vegetables and take them with you when you travel.

## Dairy Group

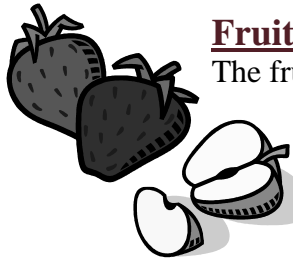


Americans ages nine and older need to consume three servings of fat-free or low-fat dairy everyday. The guidelines not only recognize dairy products as an important source of calcium, but also as nutrient-dense foods associated with overall diet quality and nutrient adequacy. For those who are lactose intolerant, recommendations from within the milk group are made, such as low-fat hard cheeses (cheddar, Swiss), yogurt or lactose-free milk. A serving is considered one cup of fat-free milk or yogurt. An equivalent for hard cheese, such as low-fat cheddar, is one and a half ounces. Dairy

foods such as milk, cheese and yogurt are rich in several nutrients that many Americans may be lacking, including calcium, potassium and magnesium.

**TIP:** To get more dairy in your diet, try having a glass of milk with meals, using milk in soups, hot cocoa or lattes and enjoying smoothies made with yogurt and fresh fruit. Yogurt also can be used to make dips for fruits or vegetables. You can also try adding low-fat cheese to casseroles as a tasty and nutritious touch to meals.





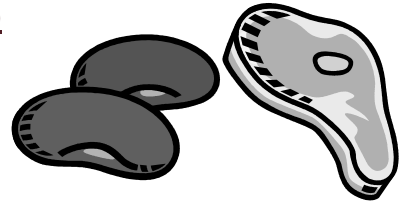
### Fruit Group

The fruit group recommendations vary widely between personal plans, and so does what constitutes a serving. Whole fruits are encouraged over juices for the benefit of the fiber. Also, high-potassium fruits such as bananas and oranges are encouraged.

**TIP:** To increase your fruit consumption, try things such as keeping a bowl of fruit on the table or keeping fresh fruit cut-up in the refrigerator.

### Meat and Bean Group

The meat and bean group has an interesting new difference from the past. Dry beans and peas are listed in the vegetable and the meat groups. Also, fish, nuts and seeds are encouraged as alternatives to meat and poultry. The portion sizes for this group vary quite a bit from the popular perception of what a portion should be. It is listed in one-ounce equivalents and although total recommendations for the day vary, most age, sex and activity levels typically recommend five or six equivalents.



**TIP:** Choose meat and poultry that are lean or low-fat. Processed meats such as ham, sausage, frankfurters, and luncheon or deli meats have added sodium. Check the ingredient and Nutrition Facts label to help limit sodium intake.

### Oil Group



There is now a separate group for oils. MyPyramid.gov recognizes the important nutrition contribution of oil in the overall diet. It also recognizes that most Americans get plenty of oil from nuts, fish, cooking oil and salad dressing. Recommendations vary widely for this group and are, once again, based on age, sex and activity level. Portions are generally listed in one-tablespoon equivalents.

**TIP:** If you are trying to watch your cholesterol, choose oils from plant sources (vegetable and nut oils). They do not contain any cholesterol. In fact, no foods from plants sources contain cholesterol.



#### **About the Author:**

*Stephanie Norris, MS, RD, LD/N, represents the Dairy Council of Florida in the promotion of quality nutrition education and research to health professionals, school food service and the media. For more than 15 years, Ms. Norris contracted with hospitals, nursing homes, assisted living facilities and an HMO to provide clinical nutrition services and programs. Ms. Norris has a Master's Degree in Health Care Administration from the University of Central Florida.*

## MEMBERSHIP

### Interested in Becoming a Member?

Did you know the OAC is a membership organization? Membership in the OAC is important in helping patients educate themselves about obesity and advocate for access to treatment. Whether a patient, family member, friend, professional or organization, the greater our membership the stronger our voice!

To join, please see page 23 for a membership application. For more information, call (800) 717-3117.



## What is dumping, and why am I experiencing it?

*Answer provided by:*

*Taghreed Almahmeed, MD, FRCSC, and Michel Murr, MD, FACS*

Dumping syndrome is a group of symptoms caused by rapid passage of undigested food into the small intestine. The stomach has a valve at the top and bottom, and serves as an acid-filled storage tank, breaking food intake down into small, component parts and passing it to the small bowel in small increments.

After gastric bypass, ingested food passes directly into the small bowel, mixed only with saliva, but not the stomach acid. The component parts of the undigested food remain fairly intact and therefore large.

The small intestine responds by diluting the ingested food through a process of “water recruitment.” The “richer” the food, in terms of sugar content, the more water will rush into the small intestine to dilute it. This is referred to as “early dumping.”

### **Early Dumping and Late Dumping**

Early dumping occurs a few minutes to 45 minutes after eating. Symptoms are not life-threatening, but can be frightening to the unsus-

pecting patient. Symptoms of early dumping are:

- Weakness and fainting
- Sweating
- Irregular and rapid heartbeat
- Low blood pressure
- Flushing of the skin
- Dizziness
- Shortness of breath
- Vomiting
- Diarrhea and cramps

Late dumping occurs two to three hours after eating. It is caused by excess insulin produced in response to rapid entry of food and fluids into the small intestine. The high insulin levels lower low blood glucose level and cause symptoms including:

- Perspiration
- Hunger
- Shakiness
- Anxiety
- Difficulty to concentrate
- Exhaustion
- Faintness

The diagnosis of late dumping syndrome can often be confirmed through frequent blood sampling to measure blood glucose.

You can prevent early and late dumping by avoiding the foods that cause dumping. In other words – sugars, starches and fried foods. Eat at least five to six small, evenly spaced meals a day. Take meals dry (i.e. without water or beverages, and drink fluids only between meals). Because carbohydrate intake is restricted, protein and fat intake should be increased to fulfill energy needs. Examples include meats, cheeses, eggs, nuts, toast, potatoes and rice crackers. Milk and milk products are generally not tolerated and should be avoided.

Each person has a different tolerance, and you will discover what your personal safe foods might be throughout your post surgery life. Person “A” might have no problem with strawberries and person “B” might experience dumping every time a few strawberries are eaten and person “C” might be able to eat strawberries only if they are a little unripe. You will learn what your own trigger foods might be. Be aware that these may change over time as your bypass matures.

## General Measures to Treat Dumping

For early dumping, lie down for 45 minutes until symptoms pass to minimize the chances of fainting. For late dumping, eat small amounts of sugar candy or drink sweetened juice until the symptoms of low blood sugar resolve. Additionally you can supplement food with dietary fibers such as fruit, vegetables and grain products. Many medical therapies have been tested, including pectin, guar gum and glucomannan. These dietary fibers form gels with carbohydrates, resulting in delayed glucose absorption and therefore avoiding a sharp increase in insulin. However in 3 to 5 percent of instances, severe symptoms of dumping can continue despite dietary changes. This results in marked weight-loss, fear of eating and outdoor activities, or even an inability to maintain full time employment.

Medical management of dumping includes acarbose or octreotide. Acarbose delays absorption of food and maintains an even blood glucose level. Octreotide is an analog of a hormone in the digestive system that can alleviate dumping by inhibiting insulin release and by slowing transit of food in the small intestine.

## Dumping is Common

Dumping syndrome is a common post-surgical complication after gastric surgery. The symptoms of dumping

may cause considerable morbidity. If medical management fails to provide adequate symptom relief, remedial surgery should be offered with the understanding that even surgical intervention may not be successful. Normally most patients have a spontaneous recovery as the digestive system adapts after surgery. Early dumping syndrome usually occurs for three to four months after surgery. Late dumping syndrome can occur for an entire year, but may persist for many years. If you experience any of these symptoms, contact your health provider to review your food diary and implement changes to help you.

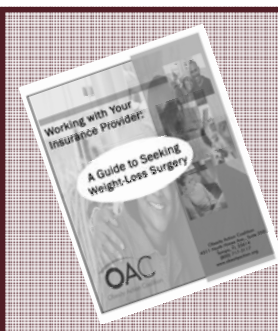
### About the Authors:



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*Michel Murr, MD, FACS, is an Associate Professor of Surgery at the University of South Florida and a leading authority in bariatric surgery nationwide. He pioneered laparoscopic gastric bypass in the Tampa Bay area and has done extensive research on obesity and its surgical treatment. His comprehensive multi-disciplinary bariatric team performs more than 300 surgeries yearly.*



## Order Your OAC Insurance Guide!

The OAC is excited to offer its insurance guide, designed to provide individuals with the knowledge to successfully work with their insurance provider. It

offers readers information discussing the effects of obesity and morbid obesity, tips for working with your insurance provider, how to read your insurance policy, detailed information concerning the treatment options available for morbid obesity and much more.

To order free copies of “Working with Your Insurance Provider: A Guide to Seeking Weight-Loss Surgery,” please visit [www.obesityaction.org](http://www.obesityaction.org) or contact us at (800) 717-3117 or [info@obesityaction.org](mailto:info@obesityaction.org).



# AdvocacyNews AdvocacyAction



## Medicare National Coverage Decision



### *Frequently Asked Questions about Medicare's New Rules Regarding Obesity Surgery and Why the Rules are Causing Some Cancellations.*

*On February 21, 2006, Medicare, the federal program that provides health coverage for the elderly and disabled, announced and immediately implemented new rules for the coverage of obesity surgery. These FAQ's are based on the new rules as currently implemented.*

#### **What do the rules say?**

The new rule, adopted after nearly one year of review, states that Medicare will cover open and laparoscopic gastric bypass, laparoscopic adjustable gastric banding (the LAP-BAND SYSTEM) and open and laparoscopic biliopancreatic diversion with duodenal switch **as long as the procedure is performed at a Center of Excellence as designated either by the American Society for Bariatric Surgery (ASBS) or the American College of Surgeons (ACS).**

#### **Who does this apply to?**

The new rule applies only to Medicare beneficiaries who are morbidly obese (body mass index (BMI) of 35 or greater) with any obesity-related condition or disease, and the patient has been previously with medical treatment of obesity. There are no age restrictions. Patients who are covered by their employer's health plan are not affected by Medicare's new rule.

#### **Why did Medicare adopt new rules?**

Under most circumstances, decisions regarding covered procedures under Medicare are made at the local and regional level. The challenge with obesity surgery coverage under the previous rules was that surgery coverage and the criteria to access surgery varied widely across the country. Under the old local rules, some states had great access to surgery while others had little or no access. At the request of ASBS and others, Medicare went through a national coverage decision process to adopt rules making coverage consistent across the country. In addition, Medicare has become more focused in recent

years on quality outcomes for Medicare beneficiaries and it is believed that this directly contributed to the inclusion of the Center of Excellence requirement.

#### **Why has this ruling caused cancellations?**

Due to the immediate implementation of the rule, some surgery practices were caught off-guard and have been forced to cancel procedures if they have not yet received designations as a Centers of Excellence. Medicare has informed hospitals that the rules have been implemented immediately and that they will not pay bills associated with the surgery for a Medicare patient unless they are performed at a Center of Excellence.

#### **What are my options if my surgery was cancelled?**

1. Find a Center of Excellence and contact them regarding their criteria for surgery. A list of Centers of Excellence can be found at [www.surgicalreview.org](http://www.surgicalreview.org) or [www.facs.org/viewing/cqi/bcen/fullapproval.html](http://www.facs.org/viewing/cqi/bcen/fullapproval.html). Keep in mind that Medicare is a national program, so you often can travel to another state for your procedure. The Centers for Medicare & Medicaid Services Web site also lists the facilities that are approved Centers of Excellence at <http://www.cms.hhs.gov/MedicareApprovedFacilities/BSF/list.asp>.
2. Talk to your existing surgery practice to see if they have applied for Center of Excellence status and if they have been advised when their application will be reviewed. With this information, you

can make the decision whether to wait for your existing practice to receive the appropriate Center of Excellence status or choose a new practice which is already designated as a Center of Excellence.

### **What is required for a hospital to be designated as a Center of Excellence?**

To become certified as an ASBS Center of Excellence, the hospital or institution must:

- Perform at least 125 bariatric surgeries per year collectively.
- The surgeon must have performed at least 125 bariatric surgeries by him or herself over a lifetime and perform at least 50 per year.
- The center must also report long-term patient outcomes and have an on-site inspection to verify all data.
- The center must have a dedicated multi-disciplinary bariatric team that includes surgeons, nurses, medical consultants, nutritionists, psychologists and exercise physiologists.
- The center must meet a variety of other requirements detailed at [www.surgicalreview.org/r\\_provisional.html](http://www.surgicalreview.org/r_provisional.html).

Requirements from the ACS are similar. For information on ACS requirements, visit [www.facs.org](http://www.facs.org).

### **Why is Medicare requiring Centers of Excellence status?**

For a variety of reasons including:

- A wide variety of data suggests that surgeon experience is an important factor in better outcomes and reducing deaths and complications.
- Data also suggests that comprehensive programs, those with pre-op and post-op care, also report better outcomes.
- The requirement of data collection (outcomes, mortality and complications) under the Centers of Excellence programs provides important information for future rulings.

### **How many Centers of Excellence are there?**

As of March 21, 2006, there are 123 in 33 states.

### **There isn't a Center of Excellence near my home. What can I do?**

You have a couple of options. The first is to be patient. The ASBS and ACS continually certify new surgeons/hospitals.

Your second option is to contact the closest Center of Excellence to you. Medicare is a national program so beneficiaries often have the option to travel out of state to receive medical care.

### **I thought my hospital was a bariatric surgery Center of Excellence. Why isn't it on the list?**

Many commercial insurance companies and others use the Center of Excellence designation. In addition, some centers may have indicated they have applied for Center of Excellence status, but have not received a final review. Medicare specifically required that surgeons/hospitals be designated as a Center of Excellence by either the ASBS or ACS.

### **Do all Centers of Excellence accept Medicare?**

No. You will need to contact the center directly to see if they accept Medicare and/or have any other financial requirements.

### **I'm a Medicare beneficiary with surgery scheduled soon, but haven't heard from my surgeon. What should I do?**

Contact your surgeon's office to see if they are a Center of Excellence. Remember, if you have the surgery and they are not a Center of Excellence, you may be personally liable for the surgery and hospital fees.

### **Does this ruling affect my private insurance or my state Medicaid coverage?**

No. The rules apply only to Medicare beneficiaries. It is hoped that the rules encourage commercial insurers and Medicaid programs to expand their coverage.

### **I heard media reports a few months ago about Medicare eliminating coverage of obesity surgery for those 65 years of age and older. Will the rules allow me to have surgery?**

Yes. There are no age restrictions in the new rules. There is a great deal of confusion on this issue. As part of the process of adopting new rules, Medicare originally proposed limiting surgery to those under the age of 65. This proposed rule was removed from the final decision when the obesity surgery community provided additional data on the safety and effectiveness of obesity surgery in older Americans.

### **Do all Centers of Excellence accept patients 65 years of age or older?**

No. Individual surgeons/hospitals set their own age requirements. You will need to contact the center directly to determine their patient requirements.



## **How Obesity is Perceived Impacts the Negative Stigma**

Perceptions about the causes of obesity may be partially responsible for this stigma and bias. Assumptions that obesity can be prevented by self-control, that patient non-compliance explains failure at weight-loss, and that obesity is caused by emotional problems, are all examples of attributions that contribute to negative attitudes. Additional research suggests that beliefs about the causality and stability of obesity are also important factors contributing to negative attitudes. For example, studies show that obese individuals are more likely to be stigmatized if their overweight condition is perceived to be caused by controllable factors compared to uncontrollable factors (e.g., overeating versus a thyroid condition), and if obesity is perceived to be personally changeable rather than an irreversible condition.

Taken together, the consequences of being denied jobs, rejected by peers, or treated inappropriately by health-care professionals because of one's weight can have a serious and negative impact on quality of life. Obese individuals suffer terribly from this, both from direct discrimination and from more subtle forms of bias and stigma that are frequently encountered.

## **What Can be Done to Eradicate the Problem of Weight Bias?**

Given how pervasive and acceptable weight stigma is in our society, transforming societal attitudes and enacting laws that prohibit discrimination based on weight are needed in order to eliminate the problem of stigma toward obese individuals. Although this requires enormous efforts, there are other important steps that can be taken by both patients and their healthcare providers to help improve the daily functioning and well-being of obese individuals.

### **Strategies to Deal with Weight Stigma**

- Educate others about the stigma of obesity to help challenge negative attitudes.
- Obtain social support from others who are struggling with weight stigma, or from friends and family members who are supportive.
- Instead of avoiding enjoyable activities because of negative feelings about your weight, set goals to ease these restrictions and participate more fully in these experiences.
- Rather than feeling inferior, practice positive self-talk strategies that emphasize self-acceptance and positive self-esteem.
- Be vocal about individual needs and positively assert these to appropriate individuals (e.g., requesting larger-sized medical gowns from a healthcare provider).
- Communicate to the perpetrator of bias that his or her comments were inappropriate and hurtful, and that nobody deserves such unkind remarks, regardless of their weight.
- Participate in public groups to protest weight stigmatization. The National Association for the Advancement of Fat Acceptance (NAAFA) is one such advocacy group which promotes size acceptance, fights weight discrimination, and publicly campaigns to challenge stigma.
- Talk to a therapist to help identify effective ways to cope with stigma and to replace self-defeating thoughts or self-blame with healthier ways of coping.

### ***Patients as Advocates***

Patients who are struggling with weight stigma can begin to approach this problem by becoming advocates for themselves. This includes identifying situations in which they have been stigmatized because of their weight and deciding how best to handle the situation to achieve positive emotional health to help prevent additional stigma from occurring.

### ***An Important Role for Healthcare Professionals***

Healthcare can easily become a negative and shaming experience for obese patients because of weight stigma. Therefore, healthcare professionals have an extremely important role to play in addressing the problem of weight bias. Encouraging patients to share their experiences of stigma and to help them feel less isolated in these experiences is an important first step. Clinicians can also help patients identify ways to effectively cope with stigma, such as using positive "self-talk," obtaining social support from others and participating in activities that they may have restricted due to feelings of shame about their weight.

***It is important to note that there are many different strategies of coping with weight stigma and some strategies may be more or less effective with different types of stigmatizing situations.***



These tools can help reduce the tendency of obese individuals to internalize negative stereotypes of obesity and blame themselves, both of which can negatively impact emotional well-being.

A second role for healthcare professionals is to address the issue of weight bias within themselves, their medical staff, and colleagues. In order to be effective and empathic with obese patients, this requires honest self-examination of one's own attitudes and weight bias. Education can help increase awareness among healthcare professionals about the pervasiveness and consequences of weight bias and can also encourage providers to adopt a more accurate and empathic understanding of their obese patients.

Finally, healthcare professionals can do a great service to their obese patients by improving the physical and social environment of healthcare settings. This means having bathrooms that are easily negotiated by heavier patients, sturdy armless chairs in waiting rooms, offices with large exam tables, gowns and blood pressure cuffs in appropriate sizes and reading materials for patients that are appropriate and "weight-friendly" (rather than fashion magazines with thin supermodels).

Healthcare professionals can also improve their interpersonal interactions with obese patients by being sensitive to situations of embarrassment for patients, such as weighing patients in a private and sensitive matter, without judgmental commentary. Providers can also help by emphasizing goals of health and fitness behaviors (rather than only the number on the scale) and celebrating positive health behavior changes made by patients.

**For more resources on weight bias, including research papers and assessment tools, please visit [www.yaleruddinstitute.org](http://www.yaleruddinstitute.org).**

#### ***About the Author:***

*Rebecca Puhl, Ph.D., is the Coordinator for Community and Weight Stigma Initiatives at the Rudd Center for Food Policy and Obesity at Yale University. Dr. Puhl is responsible for identifying and evaluating promising community nutrition programs and coordinating research and policy efforts aimed at reducing weight bias. Dr. Puhl received her Ph.D. in Clinical*

*Psychology from Yale University. In addition to seeking ways to reduce weight bias, Dr. Puhl's research examines societal and behavioral contributors to obesity.*

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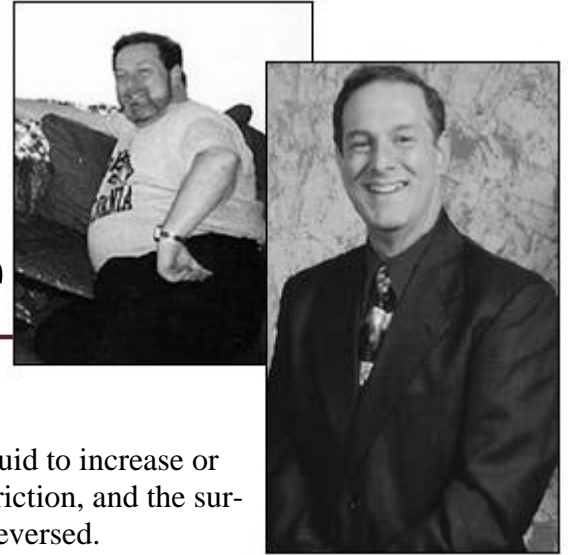


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## Doctor and Patient – *One in the Same*



By James Zervios, OAC Director of Communications

“I need a volunteer. You come up here. Okay, do me a favor and tie your shoe.”

“You see that. Did you see the leg lift?”

If you happen to find yourself at Pasco Regional Medical Center, these are the types of things you might hear being said by a doctor, but not just any doctor. Lee Grossbard, MD, is a bariatric surgeon and also a patient.

On October 17, 2002, Dr. Grossbard himself underwent bariatric surgery and had the Lap-Band procedure. Since then, he has lost more than 100 pounds.

“I went down to visit one of my daughters in college. I think she was in medical school at the time. So, I am down in Miami helping her put together a piece of furniture, and when I am done, I can’t get up off the floor,” said Dr. Grossbard. Being morbidly obese, at a weight of 275 pounds, Dr. Grossbard knew he had to do something to improve his health.

This experience was the breaking point for him. He knew he had to make a decision. “For me, the hardest part about the surgery was making the decision to have it. I chose the Lap-Band because of its low mortality rates,” said Dr. Grossbard.

The Lap-Band procedure, or Lap Adjustable Gastric Banding (LAGB), is when a band is placed around the upper most part of the stomach; therefore, separating the stomach into one small and one large portion. Digestion and absorption is normal. The band can be ad-

justed with fluid to increase or decrease restriction, and the surgery can be reversed.

Prior to surgery, Dr. Grossbard tried many diets, and each time only losing 10 pounds or so and then eventually putting the weight back on again. “My problem was that I loved food. I still love food today, but I watch what I eat more,” said Dr. Grossbard. Today, Dr. Grossbard enjoys appetizers instead of entrees, soups and “fancy” salads. “I used to be a meat person, but now I just don’t care for it,” said Dr. Grossbard.

“I’ll be out to eat with other surgeons, and they’ll just look at me and know I’ve had enough to eat. One more bite, and it’s all coming up,” laughs Dr. Grossbard.

Some may think that with Dr. Grossbard being a bariatric surgeon himself, the choice of surgery was an easy one; however, this is not true. Dr. Grossbard thought long and hard about his procedure choice. “Today, my patients have to pass a test, an actual test on a computer, before I’ll operate on them. The information available today is much better than what was available in the past. The Internet is a great place for information, but people need to be careful because there is also a lot of disinformation out there. If you’re looking for a surgeon, ask them their mortality numbers. Don’t be afraid to ask the hard questions, and if they don’t answer, get up and walk out,” said Dr. Grossbard.

In addition to patients educating themselves about the different types of treatment options available, Dr. Grossbard also stressed that patients have their surgeries in the

**“To me, post-op care is even more important for a band patient, than any other weight-loss surgery. The average LAGB surgeon sees their patients 10-12 times in the first year.”**

United States. “People think they’ll save money by going out of the country. This is wrong. In fact, it’s going to cost them more in the long run,” said Dr. Grossbard.

By costing them more, Dr. Grossbard is referring to the importance of post-operative care. “To me, post-op care is even more important for a band patient, than any other weight-loss surgery. The average LAGB surgeon sees their patients 10-12 times in the first year,” said Dr. Grossbard. A significant and important part of the post-operative care is the adjustment of the band. With a LAGB, patients may need to adjust the amount of fluid in the band from time to time.

Because he knows what it is like to be a Lap-Band patient, many of Dr. Grossbard’s patients feel a connection with him. “I would say that there is an emotional and physical connection with me being a patient. It still amazes me to this day that surgeons can adjust patients’ bands without having a band themselves,” said Dr. Grossbard.

Being a patient has given Dr. Grossbard a renewed pride for his work. “Having the patient perspective not only helps me with my patients, it also helps me when working with my colleagues. I absolutely enjoy proctoring other surgeons,” said Dr. Grossbard.

If you have never met or spoke with Dr. Grossbard, you really cannot appreciate the energy, enthusiasm and passion he portrays for his work. “I don’t ever regret having this surgery. I feel much healthier and enjoy life a lot more,” he said.

“If there’s one thing I want to get across, it is that people who need bariatric surgery must be able to get it. It is life changing,” said Dr. Grossbard.

*Dr. Grossbard has been involved with bariatric surgery for 20 years. He is the President of Florida Surgical Obesity Associates, currently practicing approximately 20 miles northeast of Tampa, Fla. He has been performing Lap Adjustable Gastric Banding surgery since June 2001, when the FDA approved this procedure and is one of the most experienced lap-band surgeons in the United States. For more information, please call (813) 788-5569.*



*Dr. Grossbard, 100 pounds lighter, poses with an old pair of pants post-surgery.*

### **About the Lap-Band**

The Lap-Band procedure is when a band is placed around the upper most part of the stomach; separating the stomach into one small and one large portion. Digestion and absorption is normal. The band can be adjusted with fluid to increase or decrease restriction.

### **Facts about the Lap-Band**

- More than 120,000 bands placed worldwide
- Lower mortality risk than other obesity surgery procedures
- Least invasive surgical option
- Removable at any time
- No intestinal re-routing
- No cutting or stapling of stomach wall or bowel
- Reduced patient pain, length of hospital stay and recovery period
- No "dumping syndrome" related to dietary intake restrictions
- Supports pregnancy by allowing stomach outlet size to be opened for increased nutritional needs

*Information obtained from INAMED Health*



# Treating

By Janet E. Mohrman, MS, RD, LDN

## Childhood Obesity



According to [www.actionforhealthykids.org](http://www.actionforhealthykids.org), 19 million children between the ages of six and 19 are overweight. In the last 20 years, the incidence doubled for children and tripled for adolescents. About 80 percent of overweight children will be obese as adults. Of those who are overweight, many also have medical complications such as high blood pressure. Obese adults and children can develop co-morbid conditions, such as high blood pressure, Type 2 diabetes and heart disease.

### Treatment Methods for Childhood Obesity

Lifestyle changes, such as healthy eating, exercise, and behavior modification are the accepted methods for weight-loss.

The general dietary recommendations for children are:

- No more than 30 percent (and no less than 20 percent) of total energy from fat
- Less than 10 percent of energy from saturated fat
- Less than 300 mg of cholesterol per day

The average daily energy intake for children ranges from 1,200 kcal for toddlers to 3,000 kcal for male teenagers; the total daily fat intake of 40 to 100 gr. (13 to 33 gr. of saturated fat) translates into approximately 30 percent and 10 percent of energy from total fat and saturated fat, respectively. General guidelines state that the child's diet include a wide variety of foods, provide adequate energy

for growth and development and achieve and maintain a desirable body weight.

### Dietary Modifications

Soluble fiber is known to have a mild to moderate cholesterol lowering effect in adults with high cholesterol. Sources of soluble fiber are fruits, dry beans and peas, oat bran and vegetables such as broccoli and carrots. Studies using soluble fiber to lower cholesterol in children are limited, according to the American Dietetic Association (ADA). Very high fiber diets may limit the energy density (calories) and the absorption of vitamins and minerals—all necessary for growing children. The recommended daily amount of fiber, for children over the age of two, is the number five plus the child's age. For example, a child of 11 plus five should eat approximately 16 grams of fiber each day.

### Herbal Products for Weight Control in Children

Herbal products are a popular form of weight control. However, the DSHEA Act (Dietary Supplement and Health Education Act) of 1994, states that dietary supplements, including herbals, are not classified to prevent or treat disease.

Herbal companies follow good manufacturing practices (GMP) that outline the quality of an herbal product, but does not assure the *safety* of the ingredients. GMP regulates good sanitation during processing, purity (no unnecessary ingredients) and standardization (identical amounts of active ingredients per batch). Also, on the dietary supplement label you may find "USP-Verified," which assures that the product meets GMP standards. The term "natural" does not imply safe or harmless. For example, ephedra or ma huang, which was used as an appetite suppressant or as an energy booster, has side effects such as headaches, insomnia, high blood pressure, which could lead to seizures or strokes and a fatal heart valve disease. The Food and Drug Administration (FDA) banned the sale of ephedra as of April 2004.

Germander, which has been used for weight-loss, can cause liver death. Bitter orange, which is increasing in popularity since the ban on ephedra, may cause increased heart rate and blood pressure or trigger migraine headaches. The use of herbal products, especially with children, is generally not recommended due to limited long-term studies on most herbal supplements and not knowing the effect of these products on the growth and development of a child.

### **Fad Diets and Weight-Loss in Children**

All foods fit. However, fad diets are another way many try to lose weight. Most quick weight-loss diets eliminate or almost eliminate entire food groups, such as the ever-popular high protein, low carbohydrate diet. Carbohydrates such as whole grains, fruits, and vegetables, contain most of the fiber that we need to avoid constipation. In addition, carbohydrates are the main source of energy for the body, which children need for growth. So, if any diet severely limits or eliminates a food group, no one, especially children should follow it for any reason.

### **Calcium and Weight-Loss in Children**

The recent study on calcium and weight-loss shows promise. According to [www.naturaldatabase.com](http://www.naturaldatabase.com), adults and children with low calcium intake are more likely to gain weight, or be overweight or obese compared to people with a high calcium intake. Several studies show that increasing calcium intake of 900-1000 mg per day (about three to four servings) from dairy products seems to be associated with an 18-20 pound weight-loss.

### **Pharmacotherapy and Weight-Loss in Children**

In some cases, medications are prescribed for weight-loss, but always in addition to healthier eating and physical activity. According to the June 2005 issue of the *Journal of the American Dietetic Association*, all of the currently available drugs for treating obesity result in a five to 10 percent weight-loss. With this weight-loss, while there is an improvement in the blood pressure in children with high blood pressure, improved blood sugar control in children with Type 2 Diabetes, etc., these medications, as with medications in general, are not without side effects. Common side effects include:

- Dry mouth
- Constipation
- Nausea
- Difficulty sleeping
- Diarrhea

In addition, cost of the medication is a concern. Since

most medical insurance plans will not cover the cost of obesity treatment medications, the out of pocket expense may be \$100-\$150 per month.

### **Behavior Modification**

In addition to healthier eating and increased physical activity, also changing habits in regards to food is necessary to ensure better health. Many struggle with emotional eating, which is eating in response to anger, loneliness, sadness, boredom, etc. The process of learning how to eat when hungry and not to an emotional cue can be relearned.

### **Psychological Effects**

According to *Circulation 2005*, published by the American Heart Association, the relationship of psychological problems and obesity in youth has not been widely studied. However, studies of adults who had been diagnosed with depression in their youth had a greater body mass index (BMI) than adults without the diagnosis of depression in their youth. Other studies have confirmed this association. Conversely, one other study has shown that depression scores are the highest in children with the greatest increase in BMI. For BMI calculations please refer to [www.cdc.gov/growthcharts](http://www.cdc.gov/growthcharts).

*Circulation 2005* also reports that overweight children have fewer friends, and have more isolated relationships. Overweight children are often teased about their weight, which leads to emotional suffering.

### **Conclusion**

First and foremost, the overweight child should have a physical exam by his or her physician, especially when family members are obese, have diabetes and/or heart disease. Second, ask for a referral to a Registered Dietitian who can provide nutrition advice in regards to childhood obesity. In addition, a healthier lifestyle should involve all family members, as diabetes, heart disease, etc, tends to run in families. Find out what your child's school can do to help. Lastly, investigate the resources below, and others that you can find, to support a healthier life.

**To view additional childhood obesity resources, please visit the "Childhood Obesity" section on the OAC Web site at [www.obesityaction.org](http://www.obesityaction.org).**

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### ***About the Author:***

*Janet E. Mohrman, MS, RD, LDN, is a registered dietitian at St. Joseph Medical Center in Bloomington, Illinois.*


may employ (diet, exercise, medication or surgery), the principle of energy balance is unavoidable.

Caloric expenditure is a key component to the energy balance. In general, calorie estimation equations are not as accurate for patients who are obese or those who have lost and gained weight with dieting for many years. We offer an objective test with the use of an indirect calorimeter called MedGem®, which actually determines how many calories are burned at rest throughout the day. This is a true measurement of caloric expenditure and, thus, supplies an objective value from which the dietitian and patient can develop a realistic meal plan, which should result in weight-loss.

Getting a handle on eating behaviors is key to making significant long-term change. While no one likes to keep food logs that require writing down all food eaten, this exercise has been shown to be important for long-term success. With all the variation in serving sizes, most individuals do not have a good understanding of how many calories are actually consumed in one day. Therefore, it is recommended that, for at least the first six to eight weeks, individuals keep a complete food log. This will also help dietitians get a better handle on areas of the diet to focus at follow-up visits.

Dietitians also work with patients using individualized meal plans for various lifestyles and medical conditions. Many medical conditions, such as insulin resistance, can make it difficult to lose weight on traditional low fat diets. The dietitian can work individually with the patient to find a meal plan that will work for him or her. Also, the dietitians teach patients how to actually make the changes such as: how to shop; cooking ideas such as easy preparation methods or healthy recipes; and how to eat out at restaurants.

Our approach to weight-loss is focused more on teaching and reinforcing the importance of behavior and lifestyle changes than on “following a diet.” Many people can follow a diet and lose weight, the challenge, however, comes in maintaining the weight-loss. Our belief is that teaching behavior change facilitates lifelong success with weight-loss. Any changes in eating and exercising behaviors must become habitual, which takes time. We offer monthly visits that provide behavior modification help (strategies to help change habits) that encompass



***“Weight management is a partnership between the patient, their family and healthcare team; comprised of doctors, nurses and dietitians”***

things such as record keeping; eating behavior and associated activities; eating slowly and portion control; vitamins, minerals, fiber and water; enhancing exercise; attitudes, self-esteem and quality of life; holiday eating; and stress eating.

### **Follow-up Visits**

Patients are given the opportunity to revisit a topic or obtain more information on an area of interest during follow-up visits. The frequency of and interval between follow-up visits is determined on a patient-by-patient basis. We encourage monthly visits until initial weight-loss goals (5 to 20 percent) are achieved. At that point, we encourage every three, six or 12-month follow-up visits as needed for individual patients.

Many studies have shown that accountability is one of the major factors influencing the ability of individuals to maintain long-term weight-loss. For this reason, patients are offered and encouraged to follow-up in our clinic indefinitely. Obesity is not a disease that’s conquered in a day, month or year. It is a disease that must be fought everyday for the rest of one’s life. This combination of specialized healthcare professionals and individualized treatment plans ensures that each patient’s health is improving with steady weight reduction and weight maintenance.

Weekly weigh-ins are a useful tool to hold individuals accountable. Patients are frequently given a meal and exercise plan by their healthcare provider and told to return in two to three months. However, getting weighed on a weekly basis, at the same time and day of the week and using the same scale helps to keep dieters on track. Just knowing there will be a weekly weigh-in decreases caloric consumption. On the other hand, daily weigh-ins are not recommended since small, incremental changes often cause frustration and result in failure. It is also recommended (if possible) that the weekly weigh-in occur outside of the home. Being weighed in the presence of an-



other person increases accountability and has been shown to decrease caloric intake per week by nearly 20 percent.

## Dealing with Plateaus

We also will use the MedGem® in the case of a plateau of weight. Unfortunately, as we lose weight, our metabolism decreases. Having the ability to actually test caloric needs can be very useful in these instances. Body composition is also tested to determine actual muscle mass. This enables patients to focus on muscle mass as an objective or goal rather than the weight on the scale.

Another way we deal with plateaus is to encourage an increase in both cardiovascular and muscle building exercises. The only safe and effective way to maintain one's metabolism is by increasing or maintaining lean body mass. The most beneficial way to do this is through modest, regular exercise.

If one is able, simple walking is very beneficial. Not only does this maintain lean body mass and maintain metabolism, but it also increases bone density. Individuals who are unable to walk (due to arthritis or other problems) can use upper body exercises while seated. A simple exercise such as repetitively raising two cans of soup over the head is an exercise that can help to maintain lean body mass while burning calories.

It is important to start an exercise program slowly and build gradually. For some patients, walking two to three minutes several times each day, and then gradually increasing to 10 minutes three times a day (or 30 minutes over 24 hours) is very helpful. This 150 minutes over a seven-day period is the recommended



amount of physical activity to maintain lean body mass and increase calories burned.

## Medications (Pharmacotherapy)

Currently there are three medications that are FDA approved for weight-loss: sibutamine (Meridia®), orlistat (Xenical®) and noradrenergic products. All are to be used in conjunction with a reduced-calorie diet, exercise and behavior modification. Pharmacotherapy should be reserved for patients with a body mass index (BMI) greater than 30 or a BMI greater than 27 with at least one cardiac risk factor (high blood pressure, high cholesterol, diabetes). A novel medication (rimonabant) has just been approved for weight-loss by the FDA in February of this year. This medication is aimed at improving cardiometabolic risk factors and assisting with

*Medically Managed continued on page 22*

## Does My Insurance Cover Medically Managed Weight-Loss?

Most insurance companies will cover office visits with providers (i.e. physician, physician assistant and nurse practitioners). It is important for the provider to document co-related medical problems caused by obesity.

Appointments with registered dietitians are not always covered by health insurance. If a patient has obesity with diabetes or kidney failure, the dietitian visits are covered by most insurers, but usually limited to how many visits are allowed per year. If a patient does have to pay for a visit, a typical dietitian

appointment costs approximately \$50-\$75 for an initial appointment and \$15-\$30 dollars for a return visit.

If the patient has psychology coverage through their health insurances, then psychology visits are covered. If uncovered, this again could be an out of pocket cost to the patient. An initial psychology visit may cost around \$200. Medicare/Medicaid and many other insurances carriers have the availability of covering psychology related visits.

weight-loss and possibly smoking cessation.

## Referrals to Other Services

### Psychology

Obesity is a disease that affects more than just blood pressure, blood sugar and knee pain. It can be an enormous contributor to psychological issues, including low self-esteem, depression and relationship difficulties. Including a psychologist in the “weight management team” can be priceless. A psychologist can help patients with behavior modification and goal setting such as: finding other coping measures and alternatives to stress/emotional eating, enlisting social support, self-monitoring, relapse prevention and body image issues.

### Support Groups

Support groups focusing on lifestyle, quality of life and behavior rather than food are ideal for success with weight-loss. Because our clinic is in a rural area and many patients travel hours to come to our clinic for support, we encourage joining a support group system such as Overeaters Anonymous and Take Off Pounds Sensibly (TOPS) that are usually closer to home. We also encourage the use of online support groups particularly those that are “monitored-loosely” by our staff members.

## Realistic Expectations

Unrealistic goals of a comprehensive weight management program often result in failure. Therapy should not be expected to achieve the “ideal” body weight often set as a measure of success. A modest weight-loss can offer profound benefit in preventing or delaying the onset of co-morbid medical problems and should be viewed as a success. This realistic goal of a 10 to 15 percent weight-loss from initial weight will keep one focused, as well as improve their quality of life and help manage any obesity co-morbid medical problems.

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### *About the Authors:*

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## Types of Weight-Loss Medications

### **Noradrenergics**

Phentermine is the most commonly prescribed amphetamine-like medication for weight-loss. Phentermine is only approved for short-term use (less than 12 weeks) in adults; at that point the majority of the patients may have developed a tolerance for the drug and it is no longer as effective. This class of medications are mild stimulants that suppress appetite by altering chemical signals in the brain. Common side effects include jitteriness, dry mouth, constipation, elevated blood pressure and increased pulse rate. It should not be used in people with a history of heart disease, uncontrolled high blood pressure, seizures, or anxiety disorders.

### **Sibutamine**

Sibutamine has been FDA approved for adults since 1999 for weight-loss and maintenance of weight-loss. It also works with brain chemicals (serotonin and norepinephrine) to help patients feel full quicker and decrease cravings for food. Similar side effects are seen with sibutamine and phentermine (listed above). Patients with poorly controlled blood pressure, heart disease, arrhythmias, heart failure, and stroke should not use sibutamine. Medications may interact with sibutamine including many antidepressants, pain medications, some antibiotics and herbal remedies. It is important that the patient tells his or her provider all medications they are taking, including over-the-counter medication and supplements.

### **Orlistat**

In 1998, orlistat was FDA approved for weight-loss in adults and the next year was approved in teens (ages 12 and older). Orlistat is the first non-centrally acting medication that works by decreasing the absorption of fat from the intestines. Orlistat “blocks” approximately 1/3 of fat from the food eaten. Overall, Orlistat is a safe medication. It interacts with few medications (caution with warfarin and cyclosporine) and can be used in most every patient. Patients should be advised to take a multivitamin with chronic use of orlistat due to a potential decreased absorption of fat-soluble vitamins. Side effects of orlistat include diarrhea, gas, oily stools, and fecal incontinence. These side effects lessen over time and can be avoided by following a low-fat diet.



city and her masters from DeSales University. She is part of a multidisciplinary team that treats the morbid obese and their co-morbid medical problems through diet, exercise and/or pharmacotherapy and bariatric surgery.

Laura Smith, CRNP, is a Nurse Practitioner at Geisinger Medical Center in Danville, Pennsylvania. She has worked within the Center of Nutrition and Weight Management for the last year. She earned her bachelor's degree in nutrition science from Purdue University and her masters from Bloomsburg University. She is part of a multidisciplinary team that treats the morbid obese and their co-morbid medical problems through diet, exercise, and/or pharmacotherapy and bariatric surgery

Christopher D. Still, DO, FACP, FACN, has been studying developments in nutrition support and obesity for nearly a decade. He serves as principal investigator on a rural elderly nutrition and aging study of some 22,000 individuals. Dr. Still's interest in weight-loss comes from his personal experiences with obesity. Dr. Still once weighed 365 pounds, and losing the weight was a life and

career changing experience. Dr. Still is certified by the American Board of Internal Medicine, the American Board of Nutrition and the American College of Nutrition, among others. He is also a member of the OAC Board of Directors.

Stephanie F. Yeager, RD, LDN, is a Registered Dietitian at Geisinger Medical Center in Danville, Pennsylvania. She has worked within the Center for Nutrition and Weight Management for the last four years. She received her bachelor's degree in nutrition science from Penn State University. She specializes in weight management and exercise. She is part of a multidisciplinary team that treats the morbid obese and their co-morbid medical problems through diet, exercise, and/or pharmacotherapy and bariatric surgery.

**Please note: Treatment success varies from person to person. It is important for patients to know all of the available treatment options for obesity. For more information on obesity treatments, please visit the "All About Obesity" section on the OAC Web site at [www.obesityaction.org](http://www.obesityaction.org).**

## OAC membership

Membership in the Obesity Action Coalition allows the patient voice to be heard in the fight against obesity. By building a coalition of members, consisting of patients, family members and professionals, the OAC strives to educate and advocate on behalf of the millions who are affected by obesity. Membership benefits include:

- Official charter membership card/certificate
- Subscription to *Obesity Action Alert* - a monthly e-newsletter
- OAC News - the OAC's quarterly newsletter
- Representation through advocacy in addition to information on advocacy issues concerning patients

### Membership Application

Name: \_\_\_\_\_

Company Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

E-mail: \_\_\_\_\_

- Patient/Family Member: \$20
- Allied Health Professional Member: \$50
- Physician Member: \$100
- Surgeon Member: \$150
- Institutional Member: \$500 (Bariatric surgery centers, weight-loss management centers, etc.)\*
- Chairman's Council: \$1,000 and up\*

\* Different benefits apply. Contact the OAC National Office for more info.

### Payment Information

Enclosed is my check made payable to the Obesity Action Coalition for \$\_\_\_\_\_.

Please charge my credit card for my membership fee of \$\_\_\_\_\_.

Discover®  Mastercard®  Visa®  American Express®

Credit Card #: \_\_\_\_\_

Expiration: \_\_\_\_\_ Name on Card: \_\_\_\_\_

Signature: \_\_\_\_\_

Please mail to: Obesity Action Coalition  
4511 North Himes Ave, Suite 250  
Tampa, FL 33614

Or fax to: (813) 873-7838 If you have questions about OAC membership, please contact the National Office at (800) 717-3117.



The mission of the Obesity Action Coalition is to elevate and empower those affected by obesity through education, advocacy and support.



## About the OAC

The Obesity Action Coalition is a non profit patient organization dedicated to educating and advocating on behalf of the millions of Americans affected by obesity. By strictly representing the interests and concerns of obese patients, the OAC is a unique organization with a patient-focused approach to obesity. To learn more about the OAC, visit [www.obesityaction.org](http://www.obesityaction.org) or contact the National Office at (800) 717-3117.

## OAC Resources

Through education and advocacy, patients need to get involved to help drive change in the obesity community. The OAC provides several beneficial resources for patients, as well as professionals.

- OAC Introductory Brochure
- Obesity Action Alert
- OAC News
- State-specific Guides to Advocating for Improved Access to Obesity Treatments
- *Your Voice Makes a Difference. A Guide on How You Can Help Fellow Patients Affected by Obesity*
- *Working with Your Insurance Provider: A Guide to Seeking Weight-Loss Surgery*
- The OAC Web site: [www.obesityaction.org](http://www.obesityaction.org)

All OAC resources are complimentary and may be ordered in bulk. To request materials or an order form, please contact the OAC National Office at (800) 717-3117 or send an email to [info@obesityaction.org](mailto:info@obesityaction.org).



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