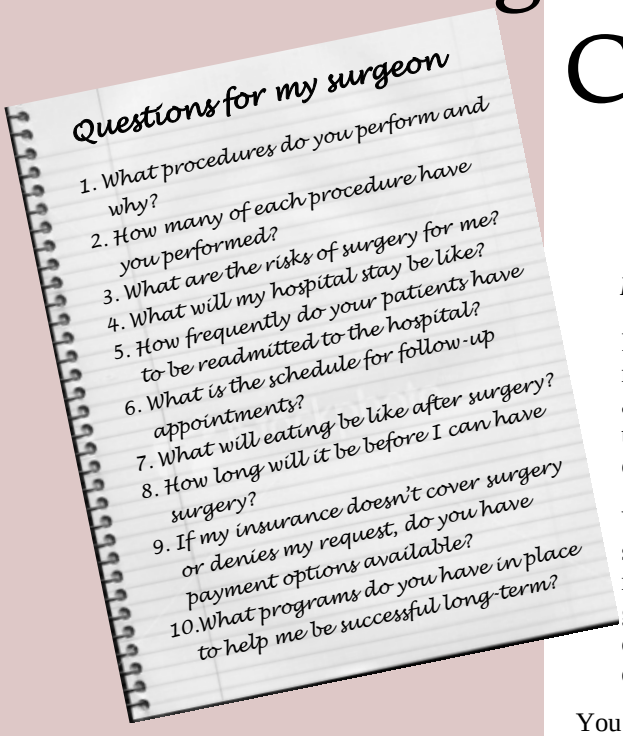
OAC News

The Obesity Action Coalition's Quarterly Newsletter

Choosing a Surgeon, Choosing a Program *What to Ask*



You've done a lot of soul searching. You've researched bariatric surgery on the Internet, you've talked to family, friends and co-workers, and you've decided that bariatric surgery is right for you. *Now what?*

By Pam Davis, RN, CCM

For most centers, the entry into their bariatric program is through a seminar. Seminars may be provided in a large or small group setting or over the Internet. I would encourage you to attend one or two or even 20. You should attend however many seminars it takes for you to find the surgeon and the center where you feel the most comfortable.

You may hear the phrase, "patient for life." Lifelong follow-up is crucial to optimal success after bariatric surgery and you do become our patient for life. Seminars are as much about you getting a feel for the surgeon and the center as they are for the surgeon and center to provide you with information about their program. If you are not comfortable asking questions in a group setting, ask about arranging a time for your questions to be answered privately.

You may be wondering, what do you need to ask? The following are some common questions you will want to ask if they were not answered at the seminar. Remember to trust your instincts.

1. What procedures do you perform and why?

Many surgeons perform multiple types of bariatric surgery and many prefer to perform a specific procedure. It is important to know if a surgeon has a preference for one procedure over another, and if so, that they explain to you why. Once a patient arrives at the decision to have bariatric surgery, they typically know which procedure they want and why. You will want to discuss the rationale for your surgery preference with your surgeon.

2. How many of each procedure have you performed?

A review of the literature will tell you that 100 procedures performed seems to be the magic number; the number at which a surgeon's death rate and complication rate dramatically decrease. For a surgeon to obtain a Center of Excellence (from the American Society for Bariatric Surgery) designation, they have to complete 125 cases with at least 50 of those performed in the prior 12 months.

This is not to say you should avoid a surgeon who is shy of the 100-125 range of cases. There are many excellent surgeons who have undergone the

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

As part of a recent interview, I was asked the question: "Is our government failing us by failing to address the obesity epidemic?"

In preparing to answer this question, I spent a great deal of time researching how our government is attempting to address the obesity epidemic. Literally hundreds of legislative bills and regulations have been introduced throughout the past several years at both the state and federal level.

Targets of such legislation included addressing nutrition in schools and in the general public, increasing physical activity in schools and in the public, improving access to obesity treatment, ending obesity discrimination and much more. The sheer amount of legislation, although the majority of it was not ultimately passed, was astounding.

There are brave and forward-thinking legislators out there who are trying to make a proactive difference. Is your legislator one of them? If you do not know the answer, please find out. If they are, share with them your experiences and encourage them to continue their efforts. If not, still share your experiences and educate them on the disease and its affects. Urge them to help make government a partner in the efforts to end the obesity epidemic.

In my opinion, it is too soon to fully answer the question originally posed to me, but as Americans, it is our duty to make sure the government does not fail in this important task.

To learn more about advocacy and how you can make a difference, please read "BlueCross BlueShield of Tennessee Rescinds IQ Testing Requirement for Those Seeking Weight-Loss Surgery" on page 20 of this issue.

OAC
Obesity Action Coalition

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.

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

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Depression

Obesity and Depression

By David Engstrom, PhD

What researchers know, and most people assume, is that individuals with excess weight often suffer from depression. What is less clear is which comes first. Could the effects of being seriously overweight directly lead to depression, or does depression itself cause excess weight gain in the first place? Probably, the answers are "yes" and "yes," and it may not matter in any practical sense. Depression and weight gain go hand-in-hand.

Certainly, increased appetite, reduced activity and weight gain can be symptoms of depression, and people with depression are more likely to binge eat and less likely to exercise regularly. Both depression and obesity have strong genetic links, so children of people with either or both problems are more predisposed to have them as well. In addition, many prescribed antidepressant medications cause weight gain as side effects.

One recent study found that overall, obese individuals have a 20 percent elevated risk of depression, and specifically for Caucasian college-educated people with obesity, the depression risk rises to as high as 44 percent. Although females with obesity have previously been found to suffer more depression, this study showed that there were no differences between sexes.

Obesity Defined

One standard measure of obesity is weighing more than 20 percent greater than the ideal body weight for a given height. Another definition is having a body mass index (BMI) of more than 30. (*To calculate your BMI, please visit the OAC Web site at* ***www.obesityaction.org***.) According to recent findings, approximately one third of the U.S. population is obese.

What is Depression?

Defining depression has always been a puzzle. Many people are depressed but don't know it. Others may seem depressed to friends but really aren't. It seems that we all have stereotypes of what depression is, but they aren't always accurate in reality.

One way to understand depression is to see it as consisting of two factors, or primary components. They are the psychological or "cognitive" component which affects mood, and the physical or "somatic" component which influences areas such as sleep and appetite. Viewing depression in this way sometimes helps to determine the primary cause of the problem. *To find out how depression is measured, please see the chart on the bottom of this page.*

A recent World Health Organization (WHO) report identified depression as "the number one cause of disability in the United States and the third largest, behind heart disease and stroke, in Europe."

What Could the Connection Be?

Stop and think about all the possibilities for depression to accompany obesity. To begin with, childhood obesity frequently leads to painful ridicule and exclusion from peer activities. Problems with body image, social isola-

Depression *continued on page 4*

How to Measure Depression

One of the most commonly-used and respected instruments to measure depression is the Beck Depression Inventory (BDI).

The <u>cognitive</u> subscale contains eight items:

- Pessimism
- Past failures
- Guilty feelings
- Punishment feelings
- Self-dislike
- Self-criticalness
- Suicidal thoughts or wishes
- Worthlessness

The <u>somatic</u> subscale has 13 items:

- Sadness
- Loss of pleasure
- Crying
- Agitation
- Loss of interest
- Indecisiveness
- Loss of energy
- Change in sleep patterns
- Irritability
- Change in appetite
- Concentration difficulties
- Tiredness and/or fatigue
- Loss of interest in sex

Although this test, like any self-report questionnaire, has its limitations, it does shed light on the commonly-accepted clinical definition of depression.

Obesity-Related Diseases

Depression

***Depression** continued from page 3*

tion and self-esteem might easily follow. Being seriously overweight at any age is a major source of dissatisfaction, sadness and frustration. Extra pounds often cause chronic joint and extremity pain, making individuals less able to get around, enjoy life or exercise.

Serious illness such as diabetes, hypertension and sleep apnea can threaten or shorten life. People with excess weight are often stereotyped and discriminated against by airlines, department stores, insurance companies and even doctors.

Depression after Weight-Loss

Several recent studies have found significant improvements in depression following major weight-loss. This finding has been reported in a large group of patients after gastric restrictive procedures. Younger patients, women and those with greater excess body weight loss after surgery had the greatest improvement on their BDI scores.

What Happens after Bariatric Surgery?

In a study of depression in our own bariatric surgical population at Scottsdale Bariatric Center, approximately 2,005 consecutive patients were evaluated for depression before and after surgery, as well as post-surgical weight loss. We defined improvement of depression in three areas:

- Cognitive (reduced thoughts of worthlessness, hopelessness and personal failure)
- Affective (reduced feelings of sadness, frequent crying and mood swings)
- Physiological (increased energy level and better sleep habits)

It was found that 24 percent of those patients were diagnosed with depression prior to surgery, a finding very consistent with national norms. Six months after surgery, there was a 62.5 percent decrease in excess body weight, accompanied by a 13 percent reduction of depressive symptoms, while at 12 months after surgery, there was a 76.9 percent loss of excess body weight, as well as an 18 percent resolution of depression. It may be surmised from our data that loss of excess body weight following bariatric surgery is accompanied by a reduction of depressive symptoms.

About the Author:

David Engstrom, PhD, is a clinical health psychologist, board certified in Clinical Psychology. He practices in Scottsdale, Arizona and is a psychologist at Scottsdale Bariatric Center. Dr. Engstrom is an active member of the American Society for Bariatric Surgery and is a specialist in applying mindfulness techniques to long-term weight management. Dr. Engstrom currently serves on the OAC Advisory Board.

Tips for Avoiding Depression after Treatment

Exercise – There is no doubt that regular physical exercise and activity is the cheapest and most efficient way to control your mood. Not only does exercise release brain chemicals which fight depression, it also gives a person a greater sense of control over his or her life.

Get rid of anger – Remember, an old definition of depression is "anger turned inward." Unresolved resentment can damage both your relationships and health. Chronic anger and hostility can be your worst enemies. If anger is a problem, try taking an anger or stress management class to learn techniques to ward off long-standing angry feelings.

Keep a positive attitude – There is an entire field called "positive psychology," which has grown from research that indicates the people with positive attitudes fight disease better and live healthier lives. I know it's easier said than done, but remember the famous saying of Abraham Lincoln… "Most folks are about as happy as they make up their minds to be."

Don't take yourself too seriously – This is a tip that I've learned both from my own life and many of my patients. Humor is an important part of life. Some people have the ability to laugh at themselves, while others don't. And each day, everything changes anyway. Laughing is good for all of us. Seeing the silly parts of life may give you a fresh point of view and change your mood.

Stay motivated – Try to set a goal for yourself, and then develop a plan of simple, small steps to get to the goal. Perhaps exercise is a good place to start. The keys to motivation are to not get overwhelmed with a goal that is too big or unrealistic, and to write things down to keep track of progress.

Talk to someone – If you were seeing a mental health professional before treating your obesity, keep in touch with them after as well. Remember, treating your obesity has a major emotional impact, and your life will change. Although these changes are mostly for the better, it is a good idea to have someone other than family or friends to talk to as you adjust to your new life.

Use medications if prescribed – If you were taking prescribed antidepressant medication before treating your obesity, check with your doctor to see if you can remain on it. It may give you that "boost" you need during your recovery. Many of our patients have found that they can reduce or eliminate these medications after they see changes in their weight and quality of life.

Education, Research & Treatment of Obesity

WALK*from*OBESITY℠

Join Us for the WALK*from*OBESITY℠

September and October 2007

The Walk from Obesity is the nation's largest gathering of individuals affected by the disease of obesity. In September and October 2007 in cities all across the country, those living with the disease of obesity and survivors alike will join forces and walk to raise money for research, education, prevention and treatment of obesity.

To register for a Walk, locate a Walk site in your area or become a volunteer, please visit **www.walkfromobesity.com**.

Donating is a great way to help in the fight against obesity. If you are unable to participate in this year's Walk, please consider making a donation today. Giving makes a difference!

OUR OUTREACH: *Increasing*

OUR PURPOSE: *Expanding*

OUR DEDICATION: *Enduring*

ASBS American Society for Bariatric Surgery FOUNDATION

"Partnering to improve the lives of all of those affected by obesity through education, research and advocacy."

OAC Obesity Action Coalition

Someone to Talk to

By James Zervios, OAC Director of Communications

Ten years ago, Jude Milner weighed more than 430 pounds, was affected by diabetes, high blood pressure (HBP) and could barely walk.

Jude, a New York girl, grew up in an Italian and Irish household with an emphasis on food from the Italian side. "The Italian side always seemed to be the majority on food," said Jude. At the age of five, Jude was forced to live with her grandmother after her family home was badly damaged in a fire.

With her parents working during the day and fixing the house at night and her brother living with her aunt, it was a very stressful time for Jude. "I lived with my grandmother and at the time I was always given comfort food. You know, donuts, candy and other stuff that's not good for you," said Jude.

With this detrimental time and Jude's displacement, she began eating poorly. At first her parents always encouraged her with the eating, but then as time moved on and Jude began to gain weight, her parents discouraged the eating behavior. This discouragement overall led to Jude sneaking food.

"I would sneak-eat. It was when I was around seven or eight and my parents didn't want me having the candy and ice cream, so I would sneak the food and eat it," said Jude. As the "sneak-eating" magnified, Jude realized she was a compulsive eater.

"It took some time for me to realize this, but I knew it. I ate compulsively," said Jude.

As the years passed by, Jude constantly added weight to her body. Throughout her childhood, Jude attended private school and pretty much knew all the kids in her class. Jude, a witty girl, never put up with any wisecracks or comments about her weight.

"I was always quick to respond to any kids that had something to say. Not to mention, I had an older brother that attended school with me. He was a tough guy and nobody would mess with me because of him," laughed Jude.

Even though Jude was quick witted and had her brother's shield over her, she could have never prepared or protected herself from what was about to happen to her.

In the ninth grade, Jude left private school and attended public school. The kids didn't know her and the witty skin that once protected her, was beginning to thin. Jude weighed 250 pounds and was 5'9".

"I really had a difficult time. I felt like I had nobody to talk to. My family basically just told me not to eat and that didn't really help. I felt isolated, so isolated that I decided to run away from home," said Jude.

Running away from home, Jude, only 14-years-old, found herself on the way to Long Island. "I was walking down the road and a guy pulled over to offer me a ride. I took the ride," said Jude. What happened to Jude next would change her life completely. Jude was raped by the man offering her a ride down the road.

"I didn't stay away long. I was only gone four days. When I got home I couldn't tell anyone what happened to me. In my family, you just didn't say anything," sadly said Jude. For the second time in Jude's life she experienced a trauma affecting her greatly.

Throughout the next year, Jude added more than 100 pounds to her weight. By gaining weight, Jude felt as though she was protected. "I blamed myself for the weight and the rape. To me, it was all my fault. My life was over," said Jude.

Jude eventually attended college and enjoyed her collegiate experience. At this point, Jude was still keeping it all inside. She felt isolated in college. She was involved in things with friends, but never really felt like she was enjoying it completely.

"I blamed myself for the weight and the rape. To me, it was all my fault. My life was over."

"I feel good today about things. I am still not small, but I feel comfortable with my body. I think for those that weight-loss surgery is appropriate for, they need to do their homework and make a decision."

"Sexually I shut down completely. I loved college, but I always felt shut down. My experiences from childhood weighed heavily with me," seriously said Jude.

At the age of 21, Jude began to realize that she needed to do something about her weight. She began to research weight-loss surgery, but often found herself not interested.

"The operation seemed scary. Too many people were experiencing complications and I just didn't feel comfortable," said Jude. Jude became involved with overweight acceptance groups and was happy with her weight. She didn't feel the need to make a change – at that time in her life.

In her 20s and 30s, Jude needed to be in control. Thus far in her life, Jude had been the victim. "I wanted the control – the power. In life, people that are sexually abused usually take one of two routes. The first route people shut down completely. They don't want to have anything to do with anything sexual. The second, the route I took, they begin to express themselves overtly sexually. I became a phone sex operator because I wanted to be in control. I controlled the sexuality," said Jude.

Jude, acting out sexually, found herself working as a phone sex operator and frequenting clubs dressed provocatively. "I wanted the attention," said Jude. This was Jude's way of dealing with her past traumatic experiences.

Jude knew this was not the answer. She began therapy and slowly began to transition. Throughout all of this, Jude still continued to gain weight. "I was about 430 pounds and I could see the weight affecting me negatively," said Jude.

She began to exercise and diet. She found great success in this and eventually lost 120 pounds, which by any weight-loss standard is phenomenal through diet and exercise. "I enjoyed it. I started to lose weight and I knew I could do more," confidently said Jude. Unfortunately, Jude during training tore a tendon in her foot and blew out her knee on the leg-press machine.

"Combined with my compulsive eating, the injuries were of great magnitude to my weight-loss routine. I still exercised, but I knew I couldn't do it like I used to," said Jude.

The weight slowly began to increase again and so did Jude's co-morbidities. Jude, injured and seeking a solution, began to research weight-loss surgery again. "I used the Internet and did my homework on this stuff. I began to feel more comfortable with it and met with a surgeon about the procedure. I realized and he explained that the surgery had come a long way in 20 years. Jude, now 41-years-old decided to have weight-loss surgery.

In November 2001, Jude had gastric bypass Roux-En-Y surgery. "I had to make some very big changes in my life. My body changing has been the biggest change by far," said Jude. To date, Jude has lost more than 200 pounds and is continuing to lose weight.

"I feel good today about things. I am still not small, but I feel comfortable with my body. I think for those that weight-loss surgery is appropriate for, they need to do their homework and make a decision," said Jude.

Currently, Jude is giving back to all those affected by this disease. She is a psychologist and a physical therapist for those affected by obesity. Additionally, Jude has written a book, titled Fat Free: Amazing All-True Adventures of Supersized Woman.

"I had put a great deal of my weight on because of my experiences in my life. I had nobody to talk to. Today, as a psychologist and trainer, I hope I can be someone for others to talk to," said Jude.

Jude Milner's book, Fat Free, is a graphic autobiography with illustrations by Mary Wilshire - a top Marvel Comics artist. Fat Free is the story of Jude's harrowing and hilarious adventures: freaking out in candy stores, following quack cures and diets, becoming a "Fat Is Beautiful" activist, working as a phone-sex fantasy girl with multiple personas and finally undergoing gastric bypass surgery.

For more information on Jude Milner, her book or to contact Jude, please visit www.fitnesstherapy.org.

Pregnancy *after* Weight-Loss Surgery

By John G. Kral, MD, PhD, FACS

Let's Start with a Brief Quiz!

Which mother has the greatest risk of giving birth to a child who will sooner or later become obese?:

a) own sister is obese
b) own father and grandfather are obese
c) diabetic during earlier pregnancy
d) diabetes and high blood pressure in family
e) being of a minority race
f) already has an obese child
g) gaining too much weight
h) doesn't breast feed
j) all of the above

If you guessed (j), all of the above, you were correct. Although the **lowest** risk is for (b).

According to some U.S. statistics 40-50 percent of pregnancies are unplanned, so it is difficult to warn obese young women to delay pregnancy until after weight-loss.

Taking into consideration that obesity causes earlier menarche and is more common among the poor and uneducated, and among African American and Hispanic women, it is obvious that huge educational, cultural and societal resources are required to limit the growing obesity epidemic.

Womens' health education in schools and homes should emphasize the importance of planning pregnancies and should encourage medical consultation while planning a pregnancy. This is especially important in the obese.

How Does Surgical Treatment of Obesity Fit into the Picture? Or Does It?

Not knowing the dangers of obese pregnancies is only part of the problem. The other part is lacking access to effective means of achieving weight-loss, or even maintaining a stable weight among those prone to weight gain. Regardless of reason(s) for undergoing weight-loss surgery, the fact is that rapidly increasing numbers of younger and younger women are having weight-loss operations. The majority of them are expected to become pregnant. In fact, obesity is a common cause of infertility, and weight-loss by surgery or other means often cures such infertility.

What should obese women considering surgery, or having undergone weight-loss surgery, know about its effects on pregnancy outcomes?

First, it is important to understand the differences between the two major types of operations. Most operations nowadays are (or should be) performed using a laparoscope and three or four instruments inserted through half-inch cuts in the belly wall, instead of one large cut eight to 12 inches long.

One type of operation is purely "gastric restrictive," creating a small stomach pouch by placing an adjustable band around the top of the stomach. The inflated band makes a very small opening for the food to pass into the large stomach below the band. This causes small amounts of solid food to stretch the stomach pouch wall creating a sense of fullness as well as slowing the emptying of solid food from the small pouch. Liquids and melting foods (chocolate, cookies, chips) go straight through unless solid food is blocking the opening.

The other type of operation combines restriction (a small pouch) with bypass of more than 95 percent of the stomach and the first portions of the small bowel. The restrictive sense of fullness disappears over the first 10-18 months because the pouch and the opening between the pouch and the small bowel stretch.

The bypass operations work better because the undigested solid food and liquids cause fullness even after the pouch and opening have stretched. Clearly the restrictive action of the operations can cause vomiting, especially if the patient eats quickly and chews poorly. Pills or capsules can similarly cause vomiting if they are sufficiently large.

Weight-loss operations are designed to cause rapid weight-loss which obviously is what the "customer" desires. I've already answered the question: "Will weight-loss surgery influence my ability to become pregnant?" But, what about the effects on the pregnancy, the fetus, the delivery and the developing infant on its way into childhood, adolescence and adulthood?

Effects on Pregnancy Outcomes

It is always recommended that young women, who have undergone weight-loss surgery and have the capacity to conceive, should take precautions to prevent pregnancy during the phase of rapid weight-loss, and at least for 18 months to two years after their surgery.

Pregnancy outcomes after all types of weight-loss surgery – even the problematic old intestinal bypass operations and the complex modern aggressive operations with the ability to cause deficiencies and other nutritional problems – are universally safer and better than outcomes of obese pregnancies. Even if mothers are still obese after their surgery, the outcomes are better than if they haven't had surgery.

Having said this, it is important to recognize that there are risks caused by weight-loss operations if the mother fails to follow recommendations about responding to vomiting, diarrhea or feelings of weakness. Patients must take recommended supplements, and blood levels of critical nutrients must be monitored as part of responsible prenatal care. As is the case for all patients who have had obesity surgery, the rules of eating and vomiting must be followed *(please see box at the bottom of this page).*

The most recent information about outcomes after obesity surgery suggests that guidelines for "healthy weight gain" should be revised. Commonly, normal-weight women with a body mass index (BMI) of 19.8-26 are recommended to gain 25-35 pounds, while those in the "high range" (BMI of 26.1-29) should have a "recommended target weight gain of at least 15 pounds" according to the Institute of Medicine of the National Academy of Sciences.

The dramatically increasing numbers of obese women have provided more statistics on pregnancy weight change in severely obese women (BMI greater than 35) allowing the development of new guidelines. Severely obese women often lose weight during pregnancy and the outcomes after weight-loss surgery, even during the non-recommended early rapid weight-loss phase, are healthy despite the absence of any weight gain.

Thus, it is important to "spread the word" that severely obese women (those with a BMI greater than 35) and those who have undergone weight-loss surgery can actually lose weight with a healthy outcome for the offspring. However, never forget that essential vitamins, minerals and other nutrients must be monitored and supplemented as needed to optimize pregnancy outcomes in the obese, before and after surgery.

Effects on the Child

Obese mothers give birth to small for age or underweight infants more often than lean mothers. After having weight-loss surgery, mothers do not have any increase in the numbers of small offspring compared to when they were obese. Only recently it has been recognized that small children are "healthy." In fact, it is dangerous for small (or even premature) infants to gain weight quickly. Rapid weight often leads to childhood

Pregnancy *continued on page 10*

Recommendations for Pregnant Women who have Undergone Gastric Restrictive Weight-loss Operations

Eating behavior
To reduce the risk of vomiting:

- Eat slowly with minimal stress and distraction.
- Progress your diet from liquids to semisolid food to solid food.
- Eat small portions.
- Chew well before swallowing.
- If you feel your pouch, stop eating.
- Do not drink with your food - wait at least one hour after eating.

Response to vomiting
If you vomit or regurgitate:

- Try to identify the reasons.
- Do not drink for four hours.
- Progress your diet slowly, starting with liquids.
- If nausea or vomiting during progression occurs, consume nothing by mouth for 12 hours.
- If you continue to vomit, despite above measures, contact your surgeon.

Pregnancy *continued from page 9*

obesity. It is important to realize that obese pregnancies and early rearing practices can cause many problems. No more, are the old expressions as acceptable: "cute baby fat," "she'll grow out of it." Round pudgy cheeks are not the signs of a "healthy baby."

Obese women do not breast-feed as commonly as non-obese women. When they do breast-feed, obese women do so for a much shorter period of time. Shorter breast-feeding practices are associated with greater post-natal body weight in the mother and increased obesity in the child. Everything must be done to encourage breast-feeding. It is a very healthy and rewarding practice, and it has a role in preventing obesity in the mother and child.

Conclusions

- Obese pregnancies are dangerous pregnancies.
- Pregnancies following weight-loss surgery are safer than obese pregnancies for mother and child.
- Pregnancies after weight-loss surgery, regardless of weight:
  a.) should be prevented during the first 18 months after surgery.
  b.) should be monitored for nutrient deficiencies to guide taking supplements.

About the Author:

John G. Kral, MD, PhD, FACS, received his M.A. degree in Psychology in 1961 from the University of Göteborg, Sweden, where he then attended medical school, completed specialty training in surgery and subsequently defended a Ph.D. thesis entitled, Surgical Reduction of Adipose Tissue in 1976. In 1980, Dr. Kral was recruited to St. Luke's Hospital Center, Columbia University College of Physicians and Surgeons, to develop a program of surgical metabolism and anti-obesity surgery where he investigated eating behavior and continued studies on severe obesity and effects of long-term maintenance of significant weight-loss on body composition after malabsorptive and gastric restrictive operations.

Infertility and Obesity

By Karen Sparks, MBE, Julie M. Janeway, BBA, MSA, JD, ABD/PhD, and Steven R. Hendrick, MD, FACS

Infertility is a medical condition characterized by a diminished or absent ability to produce offspring. It does not imply (either in the male or the female) the existence of as serious or irreversible a condition as sterility. Although infertility is a common condition, it is often hard to pin down its source. Men and women may each have risk factors that can contribute to infertility, and those risk factors can be genetic, environmental or related to lifestyle. One of the most common and well documented risk factors for infertility in both men and women is obesity.

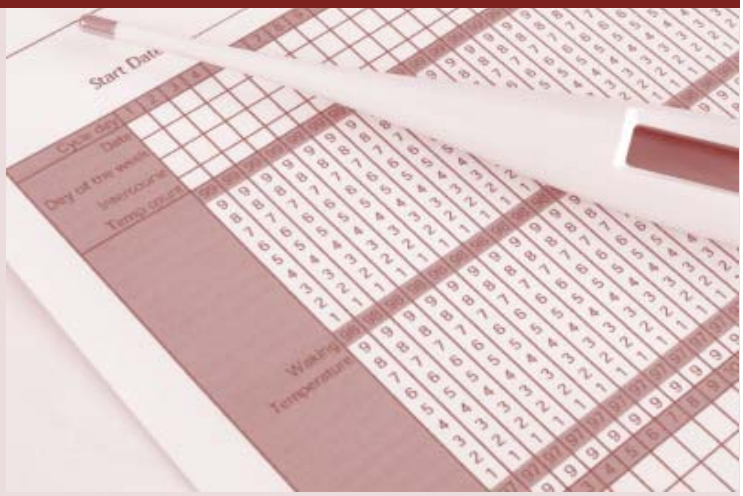
Obese Women and Infertility

Numerous studies report that women who are overweight or obese tend to have a more difficult time becoming pregnant than normal-weight women. Moreover, once pregnancy occurs, obese women have a higher rate of pregnancy loss.

Being overweight can also lead to abnormal hormone issues affecting reproductive processes for both women and men. Abnormal hormone signals, as a result of excess weight, negatively impact ovulation and sperm production. In women, it can cause the overproduction of insulin, which may cause irregular ovulation. There is also a link between obesity, excess insulin production and the infertility condition known as polycystic ovarian syndrome (PCOS). PCOS is a specific medical condition associated with irregular menstrual cycles, anovulation (decreased or stopped ovulation), obesity and elevated levels of male hormones.

Obese Men and Infertility

Obesity does not solely affect women's fertility though. Most recently, studies conducted at the U.S. National Institute of Environmental Health Sciences (NIEHS) are confirming that men with increased body mass indexes (BMI) are significantly more likely to be infertile than normal-weight men. The NIEHS data suggests that a 20-pound increase in a man's weight may increase the chance of infertility by about 10 percent.



Hormone irregularities in men affect stimulation of the testicles that inhibit sperm production. Excess fat actually causes the male hormone, testosterone, to be converted into estrogen, and those estrogens decrease testicle stimulation. Researchers from Reproductive Biology Associates report that a high BMI in men correlates with reduced testosterone levels. The study showed overweight men to have testosterone levels 24 percent lower than men of normal weight, and obese men to have levels 26 percent lower. Men with high BMIs typically are found to have an abnormal semen analysis as well.

Hormones

Excess body fat also impacts production of the gonadotropin releasing hormone (GnRH), which is essential to regular ovulation in women, and to the production of sperm in men. Specifically, GnRH triggers release of the luteinizing hormone (LH) and follicle-stimulating hormone (FSH), both critical to the development of eggs and sperm.

In Vitro Fertilization

When one or both of the partners suffer from infertility, whether or not related to obesity or hormonal imbalances, often they turn to in vitro fertilization (artificially assisted) for help in conceiving. A recent research study comparing the success rates of 5,800 in vitro fertilization attempts with the BMI of the female participants found that obese women with a BMI more than 35 had lower success rates compared with overweight (BMI of 25-30) or normal weight women (BMI of 20-25).

Additionally, obese women were found to have a lower rate of success with embryo implantation (13 percent vs. 19 percent among healthy weight women). They were also less likely to become pregnant after in vitro fertilization (22 percent became pregnant vs. more than 30 percent of normal weight women). Researchers suggest that doctors should encourage their patients to reach a healthy weight before attempting in vitro fertilization.

Keeping the Weight Off

Even when mild, obesity substantially increases poor pregnancy outcomes. Many patients seek to follow the advice of their physicians and lose weight before becoming pregnant. When one is 100 or more pounds overweight, however, the time frames involved in taking off such a significant amount of weight, and the fear of it returning with pregnancy are daunting at best. Many infertile individuals, especially women, turn to weight-loss surgery options to help them reduce their weight, and give them a tool to use along with newly learned skills to keep the weight off.

Weight-loss Surgery and Pregnancy

Women seeking surgical intervention for their obesity issues are advised not to become pregnant for at least 18 months following surgery. However, some women do become pregnant while still in the active weight-loss phase post-surgery.

After any weight-loss surgery that restricts food intake and/or has a malabsorptive component, some basic precautions should be taken before becoming pregnant. Severe iron deficiency anemia and vitamin B12 deficiency resulting from malabsorption can complicate pregnancy following gastric bypass surgery for morbid obesity. In general, vitamin B12 deficiency responds to parenteral treatment (IV or injection), and mild to moderate iron deficiency best responds to oral iron supplementation caused by the malabsorption component of the bypass.

Additionally, pregnant women should be aware of the levels of vitamin A in their post-surgical vitamin regimen. Women having had gastric bypass with a malabsorptive component should ask their doctors for a prescription for a non-acid dependent prenatal vitamin to ensure maximum absorbability.

While pregnancy is not recommended during the period of rapid weight-loss in the initial post-operative period, it can be managed effectively with the assistance of both the bariatric surgeon and OB/GYN who specializes in high risk pregnancies. Data indicates that a pregnancy which develops after the period of rapid postoperative weight-loss also shows that neither the mother nor the developing fetus is unduly endangered if appropriate precautions, monitoring and nutritional care are provided.

Conclusion

Obesity is a major health issue associated with infertility and many other co-morbid conditions. Studies show weight-loss is extremely valuable in the management of such patients, can enhance fertility, and lead to successful full term pregnancies.

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Nutrition Corner

Food Labels
A Primer

By Jacqueline Jacques, ND

If you are trying to eat a healthy diet and make good food choices, you will often get the advice: "become a label reader." This is said in reference to the Nutrition Label found on virtually all foods sold in grocery stores in the United States.

Food labels are required by the Food and Drug Administration (FDA) so that consumers can make an informed choice about the food they eat. When you know how to read them, you can understand valuable information about the ingredients in a food, its nutritional value as part of your diet and much more.

Nutritional labels on food are required by the FDA under the Food, Drug and Cosmetics Act and are regulated by the Office of Nutritional Products, Labeling and Dietary Supplements. The regulations set forth by this office literally regulate almost everything on a food label such as:

- What specific ingredients are called
- How the information is presented graphically
- What size type needs to be used
- How to use descriptive terms like "low," "reduced" and "free" for fat, salt and calories

What foods have to be labeled?

These days, most foods sold in your grocery store are required to have some sort of label. The obvious exceptions are fresh fruits and vegetables and fresh cuts of meat or fish. Foods like sandwiches made in the grocer's deli and those sold in bulk bins are also not required to be labeled.

Other foods that are exempt form labeling include:

- Foods sold in restaurants, hospital cafeterias and airplanes or sold by food service vendors (including vending machines)
- Food shipped in bulk – that which may be shipped to a restaurant for food preparation
- Medical foods
- Plain coffee, tea and spices
- Very small business - provided they inform the FDA and meet the criteria for this exemption

Nutrition Information that Should be Present in the Nutrition Facts Box

Mandatory Items

- Total calories
- Calories from fat
- Total fat
- Saturated fat
- Trans fat
- Cholesterol
- Sodium
- Total carbohydrate
- Sugars
- Protein
- Vitamin A
- Vitamin C
- Calcium
- Iron

SOURCE:
From Docket BG 99-5
U. S. Department of Health and Human Services
U. S. Food and Drug Administration
FDA Backgrounder
May 1999

Non- mandatory items that should be included

- Calories from saturated fat
- Polyunsaturated fat
- Monounsaturated fat
- Potassium
- Dietary fiber
- Soluble fiber
- Insoluble fiber
- Sugar alcohol (i.e. xylitol, mannitol and sorbitol)
- Other carbohydrate (difference between total carbohydrate and sum of dietary fiber, sugars, and sugar alcohol if declared)
- Percent of vitamin A present as beta-carotene
- Other essential vitamins and minerals

What should you look at when you look at a label?

Most people never get past the front of a food label when they are shopping – and that is what most manufacturers hope for. The front of a label is generally a modified ad for the food – maybe a picture that suggests a way to eat the food, catchy information like "low fat" or "part of a healthy diet," and perhaps a slogan that is familiar to consumers as part of a bigger advertising campaign.

If you are a health-conscious shopper, the front of a label generally tells you very little of what you need to know. There are, however, a few things that are required to be present in this area of the label under FDA guidelines. These things include the name of the food and the quantity of the product in the container (ounces, grams, etc.).

In some cases, the manufacturer also must describe the form of the food – meaning they should tell you if the milk is skim or whole, the cheese is sliced or shredded or the pineapple is sliced or in chunks, etc. Virtually everything else is there by the choice of the manufacturer.

TABLE 1

Start here to check serving size and calories in each serving

Cholesterol, fat and sodium are nutrients that you may need to limit

Many people want to know how much sugar and protein they are getting.

These are important nutrients that you need to get enough of from food.

This is general dietary information, and is not specific to the food in the package.

Nutrition Facts

Serving Size 1/2 cup (57g)
Servings Per Container 15

Amount Per Serving

Calories 230	Calories from Fat 100
	% Daily Value*
Total Fat 11g	**17%**
Saturated Fat 2g	**10%**
Trans Fat 0g	
Cholesterol 0mg	**0%**
Sodium 95mg	**4%**
Total Carbohydrate 32g	**11%**
Dietary Fiber 3g	**12%**
Sugars 18g	
Protein 5g	

Vitamin A 0% • Vitamin C 0%
Calcium 4% • Iron 10%

*Percent Daily Values are based on a 2,000 calorie diet. Your daily values may be higher or lower depending on your calorie needs:

	Calories	2,000	2,500
Total Fat	Less Than	65g	80g
Saturated Fat	Less Than	20g	25g
Cholesterol	Less Than	300mg	300 mg
Sodium	Less Than	2,400mg	2,400mg
Total Carbohydrate		300g	375g
Dietary Fiber		25g	30g

Calories per gram:
Fat 9 • Carbohydrate 4 • Protein 4

Reading the Food Label

Turn the package over!

If you really want to know about a food, the front of the label doesn't tell you what you need to know most of the time. The best place to start looking on a food label is the area – usually on the back or side of the package – called the Nutrition Facts Box. (If you are looking at a dietary supplement, this will be called a Supplement Facts Box.)

The Nutrition Facts Box

If you know what to look at, the Nutrition Facts Box actually provides a lot of information. Table 1 shows you an example of a box and the box on page 12 provides a list of the nutrition information that needs to be inside it.

From the top of the box, you can start by looking at the serving size and the number of servings in a container. For products like bread, where the serving is usually one slice, this is typically easy to understand. For foods that don't come in neat portions, consumers often do not use the serving size that the manufacturer recommends.

A great example is cereal. For many cereals, the serving size is 1/3 to 1/2 cup. That's about a medium handful for most adults – and it doesn't even come close to filling your cereal bowl. When pouring cereal, many of use three to four times the "serving" size. Same goes for foods like juice, pasta, chips, crackers, nuts, ice cream and other things where the serving size may differ a lot from what most people eat.

Two examples that I find bothersome are bottled drinks and nutrition bars. Many bottled drinks (from juice to soda) and packaged bars that look like single servings are actually 1 ½ to 2 servings per container. So, if you eat the entire contents of the package, you need to multiply the calories, fat content, etc by 1.5 or 2 to know what you are actually eating.

Everything else in the Nutrition Facts box is based on a single serving of the product – not on the amount that *you* typically eat. As you move through the box, keep this in mind. If you are trying to limit calories, fat, salt (sodium) or cholesterol, you can now much more easily know how much you are getting. If you want to make sure you get enough protein or fiber every day, you can see that as well.

Finally, you can also use the box to know how much iron, calcium, vitamin A and vitamin C you are getting each day. Other nutrients such as B-vitamins, vitamin E, D, K, and most minerals are not required, but can be listed voluntarily by the manufacturer.

You also see some percentages (%) in the Nutrition Facts box. These percentages tell you that for the listed nutrients how much of the Recommended Daily Value you get with a serving of that food.

Food Labels continued on page 14

Nutrition Corner

Food Labels *continued from page 13*

The Daily Value (DV) is the suggested amount of a nutrient (a vitamin, mineral, protein, fat, fiber or carbohydrate) that you should get each day. The Percent Daily Value (% DV) is the amount of that nutrient you should get based on an assumed calorie intake. For all nutrients, if they provide 5 percent or less of the DV, the food is low in that nutrient; if they provide 20 percent or more, they are high in that nutrient.

The FDA (Food and Drug Administration) generally assumes an intake of 2,000 calories for an average adult. Optionally, the manufacturer can show you percentages based on an intake of 2,500 calories as well. Also voluntary, but commonly shown, are the number of calories per gram of fat, carbohydrate and protein.

The Ingredients

The Nutrition Facts box is helpful, but the information in it is still limited. Foods are also required to have a complete listing of all the ingredients that they contain. This is required for all foods that have more than one ingredient. Usually this information is listed directly below or adjacent to the Nutrition Facts box. Ingredients are listed by weight.

While fewer ingredients don't always make a healthier food, it is not uncommon to find that foods with long, complicated ingredient lists contain more additive, more fillers and more non-nutritional ingredients.

By reading this list carefully, it can help you to compare not just the simple nutrition facts in the box, but also the quality of your food. You might be amazed when you start to compare foods like catsups, breads, soups and more just how much variation there is for individual types of foods.

Allergens

The newest label regulations require specific information for ingredients that have been identified as potentially harmful allergens. The allergens that must be declared on food labels are:

Comparing Ingredients

It's a good idea to read the entire ingredient list and really see what is in your food. This is especially helpful when you are trying to compare foods. The below samples show the ingredient lists from two kinds of strawberry low fat yogurt. It is pretty easy to see from the ingredients what the healthier choice is.

Strawberry Yogurt #1

Ingredients: cultured grade a reduced fat milk, sugar, strawberries, fructose syrup, high fructose corn syrup, modified corn starch, contains less than 1% of whey protein concentrate, kosher gelatin, natural flavors, citric acid, pectin, citric acid, sodium citrate, malic acid, potassium sorbate (to maintain freshness), monocalcium phosphate, red 40, blue 1. contains active yogurt cultures including l. acidophilus.

Strawberry Yogurt #2

Ingredients: milk, nonfat dry milk, strawberries, honey, guar gum, carrageenan, l. acidophilus, s. thermophilus, l. bulgaricus, l. casei, l. rhamnosis, b. bifidum cultures.

- Milk
- Eggs
- Fish (e.g., bass, flounder, cod)
- Crustacean shellfish (e.g., crab, lobster, shrimp)
- Tree nuts (e.g., almonds, walnuts, pecans)
- Peanuts
- Wheat
- Soybeans

Manufacturers can declare the source of the ingredient directly in the ingredient list, or they can place this information in a separate statement following the ingredient list. (This will usually be preceded by the phrase "This product contains…") While wheat is on this list, many medical authorities have commented that gluten is not, and perhaps should be. The FDA is currently reviewing the criteria for adding gluten to this list as well as looking to clearly define "gluten-free."

Nutrient Content Claims and Health Claims

It is becoming increasingly common for manufacturers to market health claims about their food. Whether it is margarine that helps your heart, cereal that lowers cholesterol or simply something that is "healthy" compared to the other choices on the shelf. You might be surprised at how regulated this language is by the FDA.

A *nutrient content claim* is one that tells you that compared to a similar food, the food from brand X is lower in something (like fat or sugar), free of something (like sodium or cholesterol) or provides a better than average source of a nutrient (like calcium or protein). Virtually every term from "light" to "high" has a strict definition that manufacturers must meet to use the term, or they risk serious penalties and fines. The table on the page 15 gives a list of common terms and their criteria.

Actual *health claims* for foods are extremely limited. To date, there are only 12 that the FDA has allowed, though they are considering others. In addition, there are two approved claims based on authoritative statements from scientific bodies that are allowed. One is for whole grains, heart disease and cancer and states:

> *"Diets rich in whole grain foods and other plant foods and low in total fat, saturated fat, and cholesterol may reduce the risk of heart disease and some cancers."*

The other is for potassium, high blood pressure and stroke, and reads:

> *"Diets containing foods that are a good source of potassium and that are low in sodium may reduce the risk of high blood pressure and stroke."*

How to Get More Information about a Food

One final thing that is required on all food labels is contact information. Food manufacturers and distributors are supposed to provide at least their name, address (if they are unlisted), city, state, country (if outside the U.S.) and zip code. While not required, many now provide a phone number and/or a Web site. If you have a question about a product that you can't find on the package, it can never hurt to ask at the source.

Nutrient Content Claims and Their Requirements

Claim	Requirements
Fat Free	Less than 0.5 grams of fat per serving with no added fats or oils
Low Fat	3 grams of fat or less per serving
Less Fat	25% or less fat than a comparable food
Saturated Fat Free	Less than 0.5 grams of saturated fat per serving and less than 0.5 grams of trans fat per serving
Cholesterol Free	Less than 2 mg of cholesterol per serving and 2 grams or less of saturated fat per serving
Low Cholesterol	20 mg or less of cholesterol per serving and 2 grams or less of saturated fat per serving
Reduced Calorie	At least 25% fewer calories than a comparable food
Low Calorie	40 calories or fewer per serving
Extra Lean	Less than 5 grams of fat, 2 grams of saturated fat, and 95 mg of cholesterol per 100 grams serving of a meat, poultry or seafood
Lean	Less than 10 grams of fat, 4.5 grams of saturated fat, and 95 mg of cholesterol per 100 grams serving of a meat, poultry or seafood
Light (Fat)	50% less fat (or more) than a comparable food
Light (Calories)	1/3 fewer calories (or less) than a comparable food
High Fiber	Containing 5 grams of fiber or more per serving
Sugar Free	Less than 0.5 grams of sugar per serving
Sodium Free	Less than 5 mg of sodium (salt) per serving
Low Sodium	140 mg or fewer of sodium per serving
Very Low Sodium	35 mg or fewer of sodium per serving
Healthy	A food that is low in fat, saturated fat, cholesterol, and sodium that contains at least 10% of the Daily Value for Vitamin A, Vitamin C, Iron, Calcium, Protein or Fiber
High, Rich in, or Excellent Source	20% or more of the Daily Value for a given nutrient per serving
Less, Fewer or Reduced	At least 25% less of a given nutrient or 25% lower in calories than a comparable food
Low, Little, Few or Low Source of	Compared to comparable foods, the food can be consumed frequently without exceeding the Daily Value for a given nutrient
Good Source of, More or Added	The food provides 10% more of the Daily Value for a given nutrient than a comparable food

In Conclusion

Food labels may look complicated, but once you begin to look at them regularly you will start to see that the information they provide is useful in maintaining a healthy diet. If you are new to reading and comparing labels, allow yourself some extra, unhurried time at the market to read and compare.

To obtain more consumer information about reading and using food labels, visit the FDA Web site at **www.cfsan.fda.gov/~dms/foodlab.html** or contact the FDA at (888) 463-6332.

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Dr. Jacqueline Jacques is a Naturopathic Doctor with more than a decade of expertise in medical nutrition. She is the Chief Science Officer for Catalina Lifesciences LLC, a company dedicated to providing the best of nutritional care to weight-loss surgery patients. Her greatest love is empowering patients to better their own health. Dr. Jacques is a member of the OAC Board of Directors.

Childhood Obesity and Stigma

By Rebecca Puhl, PhD

Studies indicate that about 1/3 of overweight girls and 1/4 of overweight boys report being teased by peers at school.

Societal prejudice against obesity is widespread, even toward children and adolescents. Given the high rates of childhood obesity and the expected continued increase of overweight among youth, there is considerable reason to be concerned about the vulnerability of so many children to the negative consequences of weight bias and stigma. These consequences may have immediate and long-term effects on their well-being.

How is weight bias experienced by youth?

In general, weight bias refers to weight-related attitudes and beliefs that are expressed as stereotypes, rejection and prejudice toward children and adolescents because they are overweight or obese.

Youth who are overweight are vulnerable to multiple forms of weight bias. Often, these children encounter verbal teasing by peers (such as name calling, derogatory remarks, being made fun of), physical bullying (such as hitting, kicking, pushing, shoving), and social exclusion (such as being ignored or avoided, excluded from peer activities or the target of rumors).

Thus, some expressions of weight bias are more subtle, whereas other attitudes are expressed in a direct and public manner. Very often, children face these obstacles on a daily basis.

Who are the sources of weight bias toward youth?

Not surprisingly, peers are frequent critics of obese children, and school is a common setting where weight bias occurs. Research shows that negative attitudes toward obese children begin as early as preschool age, from three to five years old. Preschoolers report that their overweight peers are mean and less desirable playmates compared to non-overweight children, and they believe that overweight children are mean, stupid, ugly, unhappy, lazy and have few friends.

As children enter elementary school, attitudes become worse, with children reporting that obese peers are ugly, selfish, lazy, stupid, dishonest, socially isolated and subject to teasing. In contrast, non-overweight children are described as being clever, healthy, attractive, kind, happy, socially popular and a desirable playmate.

A concerning consequence of these attitudes and stereotypes is peer victimization, such as teasing and bullying. Obese children are highly susceptible to victimization from peers. Studies indicate that about 1/3 of overweight girls and 1/4 of overweight boys report being teased by peers at school.

In addition, among those children who have the highest level of obesity, rates increase to approximately 60 percent of girls and boys who report peer victimization. This problem has become so pervasive that research now shows that future peer victimization can be predicted by a child's weight.

In addition to bias from peers in the classroom or on the schoolyard, obese youth are also vulnerable to negative attitudes from teachers. As an example, one study that surveyed teacher attitudes found that some teachers believed that obese persons are untidy, more emotional, less likely to succeed at work and more likely to have family problems.

Forty-six percent of teachers agreed that obese persons are undesirable marriage partners for non-obese people. One can imagine that

such attitudes could influence teaching practices with obese students.

Other research has demonstrated that educators report lower expectations for overweight students than normal weight across a variety of performance areas, and that physical educators perceive overweight students to have worse social, reasoning, physical, and cooperation abilities than non-overweight students. Thus, it is important to recognize that teachers are not immune to societal attitudes and may perpetuate bias unintentionally or through differential treatment of overweight students.

An unexpected source of weight stigma toward youth is parents. Several large studies have examined weight-based teasing and victimization in adolescents, and show that parental bias is common.

For example, in one study, weight-based teasing by family members was reported by as many as 47 percent of overweight girls and 34 percent of overweight boys. Our own research indicates that family members are often reported as the most frequent sources of weight bias.

My colleagues and I studied experiences of weight stigmatization and sources of bias in a sample of over 2,400 overweight and obese adult women. These women reported family members to be the most frequent source of stigma, with 62 percent reporting that family members had stigmatized them on multiple occasions because of their weight. Mothers and fathers were frequently reported in descriptions of their worst stigmatizing experiences.

What are the consequences of weight bias for youth?

Taken together, children face weight bias from multiple sources – from peers, educators and even parents. The impact of weight bias on children is significant, and has negative consequences for their psychological, social and physical health.

Studies show that overweight and obese children who are victimized because of their weight are more vulnerable to depression, anxiety, lower self-esteem and poor body image. In addition, some research has found that obese youth who are victimized by their peers are two to three times more likely to engage in suicidal thoughts and behaviors than overweight children who are not victimized.

Weight bias also has consequences for children's social relationships. Obese children are rejected more often by their peers than non overweight students. They are more likely to be socially isolated, and are less likely to be nominated by their peers as friends than non-overweight students.

Finally, weight bias can lead to impairments in children's physical health. Several studies have demonstrated that weight bias leads to unhealthy eating behaviors. For example, overweight girls and boys who are targets of frequent weight-teasing are more likely to engage in unhealthy weight control and binge eating behaviors than overweight girls and boys who were not teased about their weight.

There is also evidence to suggest that obese children are less likely to engage in physical activity because of weight stigma.

***Stigma** continued on page 18*

What can parents do to help reduce weight bias?

Parents have a critical role to play in reducing bias and improving the lives of overweight children. The following suggestions highlight parental strategies that can be helpful toward these goals.

1. Increase awareness of personal attitudes about weight.

As a parent, it's important to become aware of your own weight-based assumptions, as these are often communicated to children – even if unintentionally. Here are some questions to consider:

- *Do I make assumptions based on a person's weight about their character, intelligence, or lifestyle?*
- *What are my views about the causes of obesity? Does this affect my attitudes toward obese persons?*
- *What are common stereotypes about obese persons? Do I believe these to be true or false? Why?*

2. Use sensitive and appropriate language about weight.

Children are very perceptive of parental attitudes. Thus, it's important for parents to avoid making negative comments about their own or other people's weight in front of their child. Avoid making negative associations with being overweight (e.g., that overweight people are lazy), and be careful not to use pejorative terms to describe body weight. Talk to your child to learn what words they feel comfortable using when talking about weight.

3. Intervene to reduce weight-based teasing.

Parents need to look for signs of peer harassment, teasing, or victimization if their child is overweight. It's important for parents to talk to children if there is a problem and to find ways to intervene and provide support in dealing with these difficult experiences.

4. Increase awareness of weight bias at school.

Parents can be powerful advocates of change in schools. It can be helpful to talk to teachers or the principal in your child's school to promote awareness of weight bias. You have the right to express your concerns about this problem and to ask what the school can do to address bias and promote weight tolerance.

5. Find role models to build confidence and self-esteem.

It is important for children to see examples of positive role models who *aren't* thin. Teach your child that overweight individuals can be successful and accomplish important goals. Look for examples of individuals who challenge common weight-based stereotypes, and share these with your child.

6. Emphasize health rather than thinness.

Most parents of overweight children want their child to lose weight. But be sure that your focus is on your child's health – and not just on their appearance or how much they weigh, which can place added pressure on your child and communicate that health is not as important as appearance.

For more resources on weight bias, including research papers, assessment tools and PowerPoint presentations, please visit **www.yaleruddinstitute.org**.

Stigma *continued from page 17*

For example, weight bias expressed by physical education teachers leads overweight students to avoid participating in physical education classes.

Some research has also found that weight bias can negatively impact cardiovascular health outcomes in youth. A recent study found that adolescents who reported unfair treatment because of their physical appearance had higher blood pressure, even after accounting for typical determinants of blood pressure including body weight, gender, race, physical activity, posture, consumption and mood.

These consequences of weight bias can substantially reduce a child's quality of life. Not surprisingly, research shows that obese youth have much lower scores on quality of life compared to non-obese children, including physical health, psychosocial health, emotional and social well-being and school functioning. This research concluded that obese children have a quality of life comparable to children with cancer.

About the Author:

Rebecca Puhl, PhD, 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 coordinating research and policy efforts aimed at reducing weight bias. Dr. Puhl received her Ph.D. in Clinical Psychology from Yale University. Dr. Puhl is the co-chair of the Weight Bias Task Force of NAASO, and is an editor of the book Weight Bias: Nature, Extent, and Remedies (Guilford Press, 2005).

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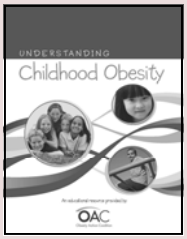
An Inside Look at the OAC's Resources

Visit the OAC Web site at www.obesityaction.org

The OAC provides valuable educational resources and advocacy guides to those who are affected by the disease of obesity. As a non profit, the OAC offers these resources free of charge. Individuals and organizations are welcome to request any of the below materials. Materials are also able to be sent in bulk. To make a request, visit the OAC Web site or contact us at (800) 717-3117 or **info@obesityaction.org**

***Are You Living with Obesity?* Brochure**
This is the OAC's membership/introductory brochure. This brochure explains the OAC's education and advocacy efforts and also explains why it is important to become a part of the OAC.

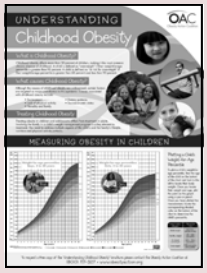
***Understanding Obesity* Brochure**
This educational piece is part of the *Understanding Obesity* series. This brochure provides a comprehensive introduction to obesity and details the causes, effects and co-morbid conditions of the disease. It also contains an adult BMI chart with a key to indicate the range of BMI and its classification.



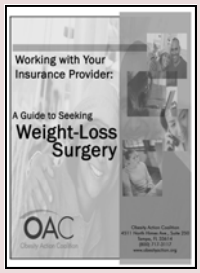
***Understanding Childhood Obesity* Brochure**
This educational piece is part of the *Understanding Obesity* series. This brochure offers information on childhood obesity, such as causes, treatment options, stigma and much more. In addition, the brochure contains a Weight-for-Age chart for both boys and girls, which is used to determine a child's weight percentile.

***Understanding Morbid Obesity* Brochure**
This educational piece is part of the *Understanding Obesity* series. This brochure provides a comprehensive overview of morbid obesity and details the causes, effects and co-morbid conditions of the disease. It also contains an adult BMI chart with higher levels of weight, in addition to a key to indicate the range of BMI and its classification.

***Understanding Obesity* Poster**
This 18x24 color poster is part of the *Understanding Obesity* series and features quick information on obesity as well as a large BMI chart. It is a great resource for healthcare professionals, doctors' offices, community centers, fitness centers, etc.



***Understanding Childhood Obesity* Poster**
This 18x24 color poster is part of the *Understanding Obesity* series and features quick information on childhood obesity as well as the Weight-for-Age charts for boys and girls. It is a great resource for schools, healthcare professionals, doctors' offices, community centers, fitness centers, etc.



Working with Your Insurance Provider: A Guide to Seeking Weight-Loss Surgery
This insurance guide helps patients work with their insurance provider when seeking weight-loss surgery. It provides patients with an understanding of their insurance policy, helpful tips for working with their provider, tips for reading their policy and much more.

OAC Advocacy Primer:
Your Voice Makes A Difference
Developed to educate readers on the effects of obesity and how to advocate for access to safe and effective treatments, this brochure is a great resource for those wanting to learn more about advocacy.

Sign up to Receive the *Obesity Action Alert* The OAC's Monthly FREE E-newsletter

Three Reasons Why You Need to Subscribe to the *Obesity Action Alert*:

- Current information on obesity, such as treatment options and advancements
- Latest advocacy news helping you become a proactive advocate for change
- Up-to-date information on the OAC and its efforts in the fight against obesity

Name: _____

E-mail Address: _____

Zip Code: _____

Register online by visiting www.obesityaction.org!

Please return to:
OAC • 4511 North Himes Ave, Suite 250 • Tampa, FL 33614
Or Fax to: 813-873-7838

AdvocacyNews AdvocacyAction

BlueCross BlueShield of Tennessee Rescinds IQ Testing Requirement for Those Seeking Weight-Loss Surgery

Often, people ask, "Does advocacy work?"
The answer, YES!

A recent example of advocacy in action can be seen in relation to BlueCross BlueShield of Tennessee (BC/BS of Tenn.) and their IQ testing requirement for those seeking weight-loss surgery. This issue was brought to the OAC's attention by a patient who was attempting to gain access to treatment for their obesity and was asked to take an IQ test prior to treatment.

Requiring an IQ test to access any medical procedure is wrong and by implementing such a requirement, BC/BS of Tenn. set a dangerous precedent of denying healthcare based on intelligence testing. Furthermore, this decision further perpetuated the negative stigma often associated with obesity.

In late 2006, the OAC issued multiple letters to BC/BS of Tenn. requesting that they rescind their decision for IQ testing. Unfortunately, BC/BS of Tenn. did not respond.

As the story began to gain interest, the OAC issued a national news release asking BC/BS of Tenn. to rescind their decision to administer IQ testing in order to gain access to treatment for weight-loss surgery. In addition, the OAC called on its constituents to take action and raise their voice.

Soon after the news release received national media attention by Fox News and many other media outlets, BC/BS of Tenn. decided to stop all IQ testing and removed the requirement from their insurance policy.

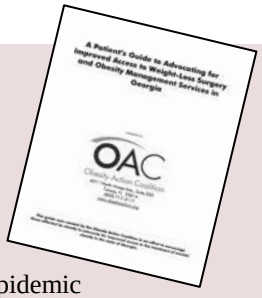
The elimination of the IQ testing requirement was a proactive step in the right direction for those seeking to access the much needed medical care of obesity.

Conclusion:
The success of the elimination of the IQ testing is a clear example of advocacy in action. The OAC and its constituents quickly addressed an issue that clearly affected and discriminated against all those affected by obesity trying to access care. This victory made it very apparent that your letters, phone calls and e-mails make a tremendous difference.

In recent weeks, the OAC has put a call out to all patients to provide the OAC with some of the more unusual experiences with accessing

treatment. Do you know of an insurance provider's policy that contains an unusual requirement? If so, please send a copy of the policy with the requirement highlighted to the OAC National Office. Once we receive the policy, the OAC will research the policy for further information. For more information please, contact the OAC National Office at (800) 717-3117 or visit **www.obesityaction.org**.

Are you having state-based access to care issues?



From its inception, the OAC has targeted different states facing access to care issues for the obese and morbidly obese. The OAC developed state-specific guides to further educate citizens about the obesity epidemic and provide them with the tools needed to begin advocating for access to treatment. Thus far, the OAC has guides for the following states:

- Alaska
- Arizona
- Connecticut
- Florida
- Georgia
- Indiana
- Illinois
- Kansas
- Louisiana
- Massachusetts
- Missouri
- Nebraska
- Oklahoma
- South Carolina
- Tennessee
- Texas
- Virginia
- Wisconsin

NEWS from the Obesity Action Coalition

OAC Welcomes Jim Fivecoat as Newly Elected OAC Chairman

The OAC is excited to announce the election of Jim Fivecoat as chairman of the OAC.

Mr. Fivecoat is a weight-loss surgery patient and underwent gastric bypass surgery in 2003. Mr. Fivecoat brings knowledge of how the benefit process works with major employers and an immense passion to help others affected by all forms of obesity to the OAC.

Prior to weight-loss surgery, Mr. Fivecoat weighed more than 300 pounds and was affected by back aches, sore knees, high cholesterol and blood pressure. Today, Mr. Fivecoat has been tremendously successful with his chosen obesity treatment option and continues to educate others seeking information on obesity-management services.

For information on Mr. Fivecoat or the OAC, please visit the OAC Web site at **www.obesityaction.org** or contact the National Office at (800) 717-3117 or **info@obesityaction.org**.

"I am very pleased and excited to accept the position of OAC chairman. I look forward to working with the other board members to implement new initiatives and goals we set forth during my term. Together we, the OAC and its constituents, will continue to educate and advocate for the millions of Americans affected by all forms of obesity, improve access to safe and effective treatment options and strive to eliminate the negative stigma associated with this disease."

- Jim Fivecoat, OAC Chairman

OAC Partners with the ASBS Foundation to host Annual *Walk from Obesity*

This year, the Obesity Action Coalition (OAC) has partnered with the ASBS Foundation to host the *Walk from Obesity* in cities across the country. This partnership expands the reach of the Walk, as funds raised will now benefit patient-based education and advocacy efforts, in addition to research and professional education.

Last year, thousands of people joined forces and walked to raise money for research, education, prevention and treatment of the life-threatening disease of obesity.

The annual *Walk from Obesity* (in September and October) welcomes all types of individuals to participate in this special event. Participants include those who have successfully treated their obesity, family members, friends of patients, those who continually struggle with obesity and members of the public who are interested in advancing the cause of fighting obesity.

How We Raise Money for the *Walk from Obesity*

Participants raise money by asking friends, family and co-workers to sponsor them in the Walk. A large portion of funds are raised through sponsorship, matching gifts, corporate contributions and other fundraising activities.

To date, the *Walk from Obesity* has raised more than $1.6 million to support research and educational programs on behalf of those affected by obesity.

Participate in the Walk this Year

The ASBS Foundation and OAC's *Walk from Obesity* was established to give hope to those needing it most.

We encourage you to show your support, as well as support others, in the cause of obesity and participate in a Walk this year. For more information on the Walk *from* Obesity, please visit **www.walkfromobesity.com**.

What to Ask continued from page 1

proper training and have been appropriately proctored (supervised by an experienced bariatric surgeon); they just haven't met the volume requirements yet.

Do your research! Attend a support group, talk to their patients, and ask for patient references.

3. What are the risks of surgery for me?

General mortality rates are typically quoted in seminars. The surgeon should be able to provide you with his mortality rate and his complication rate. After reviewing your case, he will discuss potential risks specific to you. For each individual, you have to consider, is the risk of remaining extremely obese greater than the risk of undergoing surgery.

- Are you able to perform most surgeries laparoscopically (minimally invasive with several small incisions as opposed to one large open incision)?
- What is your rate for having to convert a laparoscopic surgery to an open one?
- What are my specific risk factors for having an open procedure?

Laparoscopic surgery has many advantages over an open procedure: smaller incisions mean less pain, less likelihood of developing a hernia, a shorter hospital stay and a quicker return to your pre-surgery activity level.

Men, who tend to have more fat tissue overlying their abdominal organs; those with central obesity (apple shaped) and those who have had previous abdominal surgery (increased likelihood of scar tissue), may be at a higher risk for an open procedure.

It is also important to remember that any time you are scheduled for a laparoscopic procedure (whether it's to have your gallbladder or appendix removed, or to have bariatric surgery), there is always some risk of your surgery needing to be converted to an open procedure.

That being said, please keep in mind having an open procedure is not the end of the world. It does increase the risk of issues with wound healing and the risk of developing a hernia, it may increase your hospital stay by a couple of days and it will likely delay your return to work.

4. What will my hospital stay be like?

Your length of stay in the hospital will vary depending on which procedure you have and your response to that procedure. A patient undergoing laparoscopic adjustable gastric banding may go home the same day or stay overnight in the hospital whereas a patient having a laparoscopic gastric bypass may be in the hospital two to four days. Patients who have open procedures may be in the hospital up to one week or longer.

You should also ask about who will be providing your care while in the hospital. Do all bariatric surgery patients go to a designated unit in the hospital where the staff has been trained specifically in the care/needs of the bariatric surgery patient?

The facility may not have a unit that has only bariatric surgery patients; however, there should be a designated unit or floor with staff specifically trained to care for bariatric surgery patients.

Your surgeon should be one part of a whole bariatric surgery program. The program should include (at minimum) access to a/an:

- Registered dietitian
- Nurse
- Exercise specialist
- Mental health counselor

5. How frequently do your patients have to be readmitted to the hospital?

This can vary a great deal depending on the procedure you choose; at what point you are originally discharged from the hospital and how compliant you are with the discharge instructions you are given. Some readmissions are unavoidable. Careful adherence to the discharge instructions, specifically the diet recommendations, will help you to decrease the likelihood of having to return to the hospital.

6. What is the schedule for follow-up appointments?

The schedule will vary depending on the procedure and the surgeon. In general, you should expect to have your first follow-up appointment within two weeks of surgery. Bariatric surgery is not like getting your gallbladder out. You don't just see the surgeon once before surgery and once after surgery. There should be an established routine for when you will be seen in follow-up, for when laboratory tests will be drawn and for continued dietary counseling.

7. What will eating be like after surgery?

Your surgeon should be one part of a whole bariatric surgery program. The program should include (at minimum) access to a/an:

- Registered dietitian
- Nurse
- Exercise specialist
- Mental health counselor

All of these people are there to help you transition your diet before surgery and to educate you regarding how to make the appropriate lifestyle changes to ensure success after surgery.

8. How long will it be before I can have surgery?

Each program will have a variety of steps you will go through prior to surgery. Typically, attending a seminar, undergoing a psychiatric evaluation, participating in a support group and receiving dietary counseling are all a part of the preparatory process. Much of this will need to be completed prior to submitting your request to your

insurance company. Frequently, the greatest time variance is the insurance approval process. Depending upon your carrier, approval can take as little as 24 hours or up to eight weeks or longer.

9. If my insurance doesn't cover surgery or denies my request, do you have payment options available?

Few surgeons will offer direct financing through their office or center. Many do participate with financial institutions that offer healthcare financing. Other possible options are home equity loans, borrowing against your retirement fund or a personal loan.

At first glance, it may seem that surgery is cost prohibitive, however when you consider many people spend a similar amount on a new automobile and five years later have little to show for it, five years after surgery you will have improved health.

10. What programs do you have in place to help me be successful long-term?

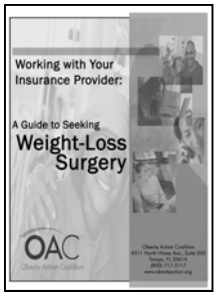
As mentioned earlier, your bariatric surgeon is but one component of your success. A Center of Excellence program will provide you with access to support groups, dietary counseling, and continued education specific to your needs.

About the Author:
Pam has been a registered nurse for 13 years and certified case manager for seven years. Pam is currently employed as the bariatric program coordinator for Baptist Metabolic Surgery Center in Nashville. In 2001, Pam had laparoscopic gastric bypass surgery and has since developed a passion for working with the morbidly obese. Pam also co-authored a resource path on morbid obesity for CMSA (Case Management Society of America). Pam is a member of the OAC Board of Directors.

Reference:

1. ***www.surgicalreview.org/pcoe/tertiary/tertiary_provisional.aspx***

Having Difficulty with Working with Your Insurance Provider?



The OAC encourages you to request a free copy of its Insurance Guide, which provides patients with the tools to successfully work with their insurance provider when seeking bariatric surgery. To make a request, please contact the OAC at (800) 717-3117 or **info@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
- *OAC News* - the OAC's quarterly newsletter
- Subscription to *Obesity Action Alert* - a monthly e-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** or contact the National Office at (800) 717-3117.

OAC Resources

The OAC provides several beneficial resources for patients, as well as professionals. 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**.

Brochures/Guides

- *Are you living with Obesity?*
- Advocacy Primer: *Your Voice Makes a Difference*
- BMI Chart
- *Understanding Obesity* Series
  - *Understanding Obesity* Brochure
  - *Understanding Obesity* Poster
  - *Understanding Morbid Obesity* Brochure
  - *Understanding Childhood Obesity* Brochure
  - *Understanding Childhood Obesity* Poster
- OAC Insurance Guide: *Working with Your Insurance Provider*
- State-specific Advocacy Guides
- Support Group Kit

Newsletters

- *Obesity Action Alert* - *the OAC's free monthly electronic newsletter*
- *OAC News* - *OAC's quarterly education and advocacy newsletter*

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