OAC News

The Obesity Action Coalition's Quarterly Newsletter

Magic Pills:

The Marketing of Dietary Supplements for Weight-loss

By Jacqueline Jacques, ND

Everyone has seen the ads and the amazing promises they make: *Lose 30 Pounds in 30 Days! Safe, Natural and Effective! Melt Away Fat and Cellulite! Never Diet Again!* The promises of pills, patches, elixirs and creams that will lead to safe, effortless weight-loss are everywhere. The dietary supplement industry has long made millions off of the weight-loss consumer – and the worse the problem gets, the more products there are waiting to offer their magic.

According to AC Neilson, in 2005 alone, US consumers spent more than 322 million dollars on the category of weight-loss dietary supplements, shakes and bars, none of which are proven effective. A recent survey conducted by the Obesity Society (NAASO) concluded that more than two-thirds of Americans believe that dietary supplements sold for weight-loss must be tested for safety and efficacy. They also found that those with a serious need to lose weight were more willing to purchase and use these products than engage in medical programs that have been evaluated for safety and efficacy.

Can Dietary Supplements Really Help with Weight-loss?

There are many natural products that have been studied for weight-loss, but few, if any, have been studied to the degree of diet, drugs and surgery. The best-studied dietary supplement by far for weight-loss was Ephedra, which has been banned in the United States since 2003 for safety reasons. Others, by and large, are folk remedies, or substances that, while they may hold some promise, have not been adequately evaluated to demonstrate that they are either safe or effective. This is not to say that none are somewhat effective or that they may not help some people, only that there is not enough evidence to make claims for them.

These remedies go by many names. Some are nutrients like chromium; others herbs like hoodia, guarana, magnolia or kelp; there are food extracts from tea, beans and barley; even hormones like

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Inside This Issue:

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

Happy New Year! The OAC has made many great accomplishments in 2006, such as the release of its educational series on Understanding Obesity, which details obesity, childhood obesity, morbid obesity and much more. The OAC also played an integral role in educating the public about this disease and advocating for safe and effective treatment options.

This issue of "OAC News" is a unique issue as it addresses the impact of access to care by featuring a pre and post-operative patient profile. The first profile details Wayne Bolt, Defensive Coordinator for Iowa State University, and his success with weight-loss surgery. The second discusses the difficulty of access to treatment through Toni Andrews' story. Both stories provide readers with an understanding of the importance of access to safe and effective treatment options.

In addition, I also encourage you to visit the OAC's Web site at **www.obesityaction.org**. The OAC recently updated its Web site with a section devoted to education and awareness of the stigma associated with obesity, morbid obesity and childhood obesity. The section discusses topics such as discrimination in employment settings, weight bias in healthcare, bias in education and much more. The section also details ways to reduce the stigma associated with this disease.

As always, the OAC thanks you for your continued support of our efforts and the efforts of all patients who are getting involved and making a difference in the fight against obesity.

If you have any questions about the newsletter, would like to receive additional copies or would like more information on any of the OAC's activities, please do not hesitate to contact our National office at (800) 717-3117 or **info@obesityaction.org**.

Sincerely,

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.

Obesity Action Coalition
4511 North Himes Avenue, Suite 250
Tampa, FL 33614
(800) 717-3117
Fax: (813) 873-7838
www.obesityaction.org
info@obesityaction.org

Gastroesophageal Reflux Disease

GERD and the Obese Patient

By Julie Janeway, Karen Sparks, MBE, and Steven R. Hendrick, MD, FACS

Gastroesophageal Reflux Disease (GERD) is a digestive disorder that affects the lower esophageal sphincter (LES), and causes injury to the esophagus from chronic exposure to stomach acid. The LES is the muscle connecting the esophagus with the stomach, allowing food to pass from the mouth into the stomach.

The term gastroesophageal refers to the combination of both the esophagus and the stomach. The term reflux means to flow back or return. Therefore, gastroesophageal reflux is the return of the stomach's contents back up into the esophagus.

In normal digestion, the LES opens to allow food to pass into the stomach, and closes to prevent food and acidic stomach juices from flowing back into the esophagus. Gastroesophageal reflux occurs when the LES is weak or relaxes inappropriately allowing the stomach's contents to flow back up into the esophagus, and sometimes all the way into the mouth.

The severity of GERD depends on the LES dysfunction as well as the type, amount and frequency of fluid brought up from the stomach and the neutralizing effect of saliva.

When stomach acid refluxes back up into the esophagus, it creates a situation we refer to as heartburn or acid indigestion. Many people suffer from heartburn or acid indigestion, most prominently those who are overweight or obese.

Heartburn or acid indigestion is the most common symptom of GERD, and usually feels like a burning chest pain behind the breastbone that moves upward to the neck and throat. Many describe the sensation or feeling of food coming back into the mouth and leaving an acid or bitter taste.

Heartburn and GERD

With non-chronic heartburn, the burning, pain and pressure from heartburn can last as long as two hours and is often worse after eating. Lying down and bending over tend to worsen the symptoms, or cause the heartburn outright.

Heartburn pain can be mistaken for the pain associated with heart attack, but there are differences. Exercise may aggravate pain resulting from heart disease, and rest may relieve the pain. Heartburn pain is less likely to be associated with physical activity other than simply lying down or bending over. Additionally, many people find relief from their occasional heartburn by standing up, and by taking an antacid that clears the acid out or neutralizes the acid in the esophagus.

More than 60 million American adults experience heartburn and GERD at least once a month, and about 25 million adults suffer daily from heartburn. Occasional heartburn *does not* indicate that GERD exists, but increasing bouts with heartburn may be a sign that you should visit your doctor for an evaluation. GERD is more than just an annoyance and an uncomfortable situation. It is a serious disease that can cause esophagitis (inflammation of the esophagus) Barrett's esophagus (lesions and ulcers that may be in a pre-cancer state) and esophageal cancer.

Hiatal Hernia and GERD

GERD can also be caused by a condition known as a *hiatal hernia*. Hiatal hernia occurs when the upper part of the stomach moves up into the chest through a small opening in the diaphragm (*esophageal hiatus*). The *diaphragm* is the muscle separating the abdomen from the chest. Recent studies indicate that the diaphragm muscle

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Obesity-Related Diseases

Gastroesophageal Reflux Disease

***GERD** continued from page 3*

acts as an additional sphincter, or contracting structure, around the lower end of the esophagus to help keep food and other stomach contents from refluxing back up. When the stomach works its way out of position and the upper part gets above the diaphragm muscle, the combination of the muscle and the portion of the stomach above the opening in the muscle create retention of refluxed stomach contents above this opening. The retained or displaced stomach contents can then easily reflux back into the esophagus and the mouth.

Coughing, vomiting, straining or sudden physical exertion can cause pressure in the abdomen resulting in a hiatal hernia, as well as forcing stomach contents through the herniated opening into the upper part of the stomach if a hernia already exists. Hiatal hernia is very common in otherwise healthy people age 50 and over. Although often considered a condition of middle age, it can affect people of any age. Obese people and pregnant women, however, are most susceptible to this condition.

Hiatal hernia does not necessarily require treatment. It may become necessary if the hernia is in danger of becoming strangulated (twisted or otherwise contorted in such a way that blood supply will be cut off), or it is complicated by severe GERD or esophagitis. In cases such as these, surgery is the preferred treatment method.

Causes of GERD

Several factors contribute to the weakening of the LES. Certain foods and beverages, including chocolate, peppermint, fried or fatty foods, coffee, soda pop or alcoholic beverages, may relax the LES causing reflux and heartburn. Studies show that cigarette smoking also relaxes the LES. Pressure on the diaphragm from pregnancy is the cause for pregnant women, but one of the most common causes of GERD for both men and women is obesity.

Obesity and GERD are both highly prevalent diseases in Western societies. Recently, several research studies have begun to prove the link between obesity and GERD. A 2003 Scandinavian study, one of the largest to date on the causes of GERD, found that people who are overweight or obese may be up to six times more likely to have GERD than people who are of normal body weight. The study also concluded that the association between obesity and GERD was strongest among heavy, pre-menopausal women, and women who have used hormone therapy (including birth control pills), suggesting that estrogen may play a role in the development of the medical condition.

The researchers found that the higher the body mass index (BMI) of the patient, the worse the reflux symptoms were for both men and women, although the association was stronger in the female group. Severely obese men (those with a BMI more than 35) were 3.3 times more likely to have reflux symptoms than men of normal weight. Severely obese women, however, were 6.3 times more likely to have these same symptoms than women of normal weight.

Severely obese *pre-menopausal* women showed the highest risk, being 6.8 times more likely to have GERD than normal women. Severely obese *post-menopausal* women were 4.2 times more likely to have reflux symptoms than their normal weight sisters. Most shocking, however, were the results for those severely obese women who had taken hormonal therapy at some time in their lives. For these women, the risk of developing

Symptoms of GERD

- Heartburn
- Regurgitation (food and stomach contents backing up into esophagus, throat or mouth)
- Water brash (increased saliva production in response to acid reflux into the mouth)
- Laryngitis (hoarseness or loss of voice, especially in the morning)
- Difficulty swallowing
- Aspiration (passage of gastric fluid into the esophagus and then breathed into the lungs)
- Wheezing or asthma
- Night time awakening with choking
- Belching or burping more than normal (especially if accompanied by stomach contents)
- Flatulence (gas) more than normal (normal flatulence is 14 to 23 times per day)

GERD is 16 times increased over those women of normal weight who had never taken hormonal therapy. Worse than that, were the findings that severely obese women who had *estrogen only therapy* were 33 times more likely to develop GERD than normal weight women who had never had any hormone treatment of any kind. Researchers speculate that estrogen may predispose heavy women to GERD because it stimulates the production of nitrous oxide which relaxes smooth muscles such as the LES.

The New England Journal of Medicine published a May 2006 article that appears to confirm the Scandinavian study's link between BMI and GERD. Researchers in this study used 10,545 women, all nurses, who completed questionnaires about their GERD related symptoms or lack thereof. The study then examined the 3,419 nurses who reported moderate symptoms of GERD, and after controlling for smoking, alcohol use and medications that can affect LES pressure, the researchers observed a relationship between increasing BMI and the frequency of reflux symptoms. The relationship carried through for all BMI levels from below normal to super morbid obesity and beyond.

Additionally, the study noted that for those who had a reduction in BMI points of 3.5 or more, there was nearly a 40 percent reduction in their risk for frequent heartburn and GERD symptoms than for women who did not lose weight during the study.

The study concluded that while obesity is linked to GERD, the more direct link is between GERD and BMI. Moderate amounts of weight gain may lead to development or exacerbation of GERD. The study also reported that the BMI link to GERD is stronger than the relationship between GERD and the waist-to-hip ratio or distribution of fat as well. Finally, the study did note that it was restricted to women, and therefore the findings may not necessarily be able to be extrapolated to men it their entirety.

Treatments for GERD

As a basic rule, doctors recommend lifestyle and dietary changes for most people with GERD. This includes stopping smoking, and avoiding foods and beverages than can weaken the LES like chocolate, peppermint, fatty foods, coffee, soda pop and alcoholic beverages. Foods and beverages that can irritate a damaged esophageal lining, such as citrus fruits and juices, tomato products and pepper, should also be avoided. Elevating the head of the bed six inches may also be helpful.

Diagram of the Gastrointestinal Tract

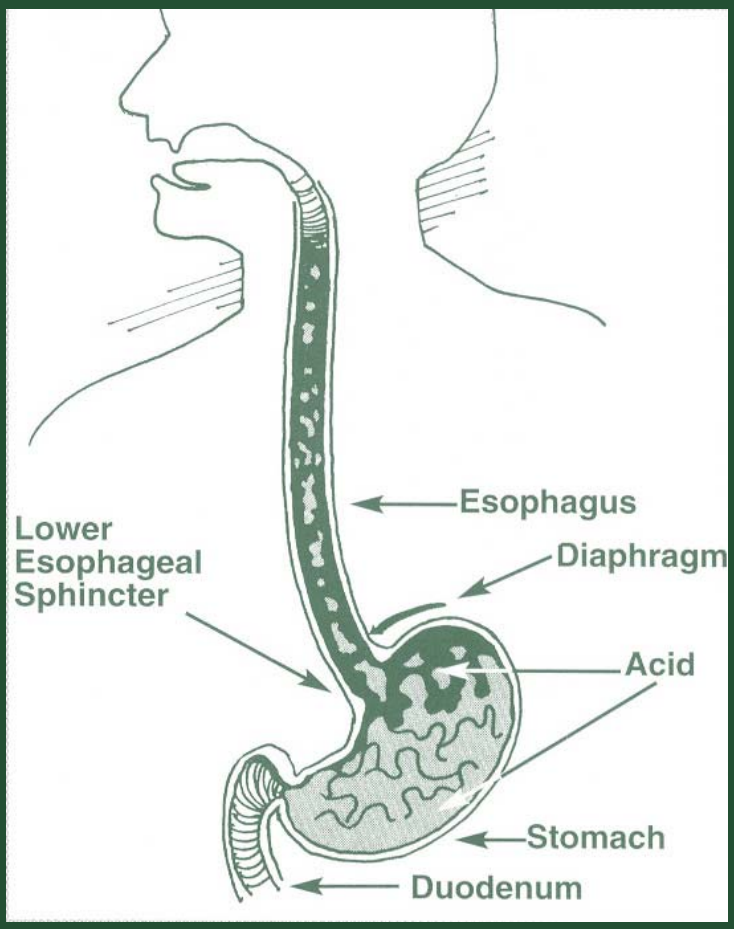


Photo from ***www.swgiassoc.com****.*

Decreasing meal portion sizes will also help control symptoms, and eating more than three hours before going to bed may lessen reflux by allowing the acid to decrease and the stomach to partially empty. Additionally, these lifestyle changes can assist in weight-loss which has been proven to reduce symptoms and incidence of GERD.

Those who suffer from occasional heartburn often benefit from the use of an antacid to neutralize the acid in the esophagus and stomach. Long-term use of antacids, however, can cause unwanted and potentially serious side effects. These side effects include diarrhea, altered calcium metabolism (a change in the way the body breaks down and uses calcium) and a build up of magnesium in the body. Having too much magnesium can be very dangerous for those with kidney disease. If antacids are needed for more than 3 weeks, a doctor should be consulted.

GERD *continued on page 6*

The general research consensus is that GERD is more of a problem for obese people because:

- Obese people are more sensitive to the presence of acid in the esophagus.
- Hiatal hernia is more common among the obese.
- Obese people have increased intra-abdominal pressure that displaces the LES and increases the gastroesophageal gradient (pressure differences)
- Vagal nerve function abnormalities associated with obesity may cause a higher output of bile and pancreatic enzymes which makes the refluxed stomach acids more toxic to the esophagus lining.

***GERD** continued from page 5*

For patients with more chronic heartburn and GERD symptoms, a doctor may prescribe medications to reduce acid in the stomach, allowing repair of any damage to the esophagus. These medicines include H2 blockers such as cimetedine, famotidine, nizatidine or ranitidine. Proton pump inhibitors (acid pump inhibitors), such as omeprazole, decrease or stop an enzyme necessary for acid secretion. Other medicines, including bethanecol and metoclopramide increase the muscle tone of the LES and quicken emptying of stomach contents by increasing the rate of movement in the gastrointestinal tract.

If symptoms persist despite these standard treatments, the patient may require a more complete diagnostic evaluation to determine if more advanced medical interventions may be necessary. In such cases, surgical treatment may become an option. Surgical treatments specifically meant for GERD issues exist, most particularly meant to repair the LES pressure. Fundoplication is such a surgical procedure that increases pressure in the lower esophagus. However, surgery should not be considered until all other measures have been tried.

Obesity Surgery and GERD

Studies are finding that among the obese and morbidly obese, however, that the surgical treatment for their obesity is proving to be a better intervention for their GERD than surgical procedures traditionally targeted at the GERD problem. Numerous studies have shown that gastric bypass procedures work very well to control, and even eliminate GERD, in both patients who have had a previous GERD surgery, and those who have not. A University of Pittsburgh School of Medicine study found that gastric bypass is effective in controlling GERD in patients who had previous anti-reflux surgery and who have subsequently gained significant weight, as well as in obese patients who have had previous anti-reflux surgery but have continued to have problems with GERD.

This is good news for those morbidly obese patients who are choosing gastric bypass to help control their weight. “Up to 55 percent of morbidly obese patients presenting for laparoscopic Roux-en-Y gastric bypass have symptoms of chronic GERD,” said Dr. James D. Luketich, professor of surgery, chief of the division of thoracic & foregut surgery, co-director of the Mark Ravitch/Leon C. Hirsch Center for Minimally Invasive Surgery at the University of Pittsburgh.

Other studies pre-dating the 2004 University of Pittsburgh study have come to similar conclusions, and many studies conducted since then confirm the findings. A 1999 study published in the medical journal *Obesity Surgery* concludes that the benefits of weight-loss surgery on GERD are not limited solely to gastric bypass operations. This study determined that the use of an adjustable gastric banding procedure (most commonly known by the brand name Lap-Band®) was effective in controlling the GERD symptoms and weight in the morbidly obese patients who participated in the study, even the three patients who were diagnosed with pre-surgery hiatal hernias.

But, gastric bypass surgery or adjustable gastric banding may not only be an option for the morbidly obese. According to a 1998 study performed by Dr. Ken Jones, a pioneer in gastric bypass surgery, Roux-en-Y gastric bypass performed in patients with chronic GERD, but who were less than 100 pounds over weight, or had a BMI less than 35, showed both a drastic drop in GERD symptoms and a reduction in weight into the normal weight ranges for each patient reported. This study concluded that esophagitis is truly a co-morbid condition of severe obesity and should be accepted as such, thus providing many morbidly obese with the medically necessary reason to have the surgery. It also concluded that use of Roux-en-Y gastric bypass to treat chronic esophagitis in the less than morbidly obese patient was a safe and effective treatment.

Conclusion

GERD is a common medical issue that is on the rise. For those who suffer from heartburn with one or more of the GERD symptoms, this is a wake-up call from your body to change your diet and lifestyle because your body isn't happy and it can't function properly given the current conditions. GERD can be treated and even eliminated.

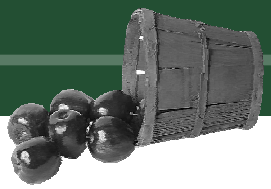
About the Authors:

Steven R. Hendrick, MD, FACS, is a bariatric surgeon with Henry Ford Health System, at the Wyandotte, Michigan Campus. He is a Board Certified general surgeon with an extensive practice in bariatric surgery.

Julie M. Hill-Janeway is the co-author of "The Real Skinny on Weight Loss Surgery: An Indispensable Guide to What You Can REALLY Expect!," and co-owns Little Victories Support Specialists and Little Victories Press. In October 2003, she underwent weight-loss surgery and to date has lost more than 180 pounds. Ms. Hill-Janeway is also a professor at Central Michigan University. She has taught for the past 12 years specializing in law, political science, social science, and public policy.

Karen Sparks, MBE, is a gastric bypass patient having had surgery in December 2003. She is a former Dean of Business Administration and Technology at Baker College and has been teaching for 15 years in business and technology. She is the co-owner of Little Victories Press and Little Victories Support Specialists serving both bariatric patients and medical professionals and the co-author of "The Real Skinny on Weight Loss Surgery: An Indispensable Guide to What You Can REALLY Expect!"

To view the references cited in this article, please visit the January 2007 issue of "OAC News" on the OAC Web site at www.obesityaction.org.



Grocery Shopping: Quicker, Smarter, Healthier!

By Chef Dave Fouts

Grocery store shopping does not have to be difficult. Believe it or not, the grocery store is set up in a way to get you to purchase what they want you to place in your cart. Whether you want to or not. Some of these items can be healthy but, unfortunately, most are not.

Grocery stores are paid to support a specific product line and to advertise. For instance, if Keebler is promoting a new cookie, they will market and pay the grocery store for space at the front of the store or on an end-cap (space at the end of the isle). This is where the food is most noticeable to the consumer. As for product placement on the aisles, it is about the grocery store making the most money. So anything within eyesight and where no reaching or bending is involved is where the most popular and most profitable items are located.

It is no mistake that cartoon characters on cereal boxes are located at your child's eye level while the healthier cereal is located at yours. Grocery stores spend money on research which proves that product placement is where most of the money is made. This article is going to give you the ammunition to shop quicker, smarter and healthier.

Let's Start with Quicker

Before stepping into your local grocery store, you need to make a list of items needed. This list should be made on a full stomach (pouch ... a little humor). When you are hungry, your list goes from being 40 items long to well over double the size because your cravings start to set in and somehow end up on the list. In addition, I recommend having a simple meal plan for each week and sticking to it. When you plan to eat sandwiches, salads and soups for lunch at work or school, and chicken, fish and beef dishes for dinner throughout the week, it will help you make your grocery list and keep it concise.

Your pantry should be treated like a commercial kitchen dry storage area with certain par levels (amounts that should always be in your cupboard) maintained. I always keep three cans of chicken stock, two jars of tomato sauce, two one pound packages of whole wheat pasta and so-on. When I go to make my grocery list, if I only have one can of chicken stock left, I know I need to get two more. This keeps me from over buying or not having it at all. This may take a few minutes to set up in your kitchen, but will save you time in the long run.

Next, on to Smarter

Now that you have your grocery list, don't be fooled by everything you see … meaning all the paid advertise-

ment spots I spoke about in the beginning of this article and the box fronts stating "low-fat, no fat, no sugar added, new formula," etc. Not everything is as it may seem. Remember, if they take fat out they normally replace it with another product that is probably not good for you, such as more sugar or even food additives I cannot pronounce. As a rule of thumb, if you can't pronounce the food additive, do you want to eat it?

Look up! Look down! This is where the healthier and a smarter consumers shop. It may require a step stool to get to or you may even have to get down on your knees, but the nutrition you get will certainly be worth it. This is where your whole grain and whole wheat items can be found.

Whatever you do, no matter how tempting it is, DO NOT deviate from your list. A grocery store is set up like a candy store for kids but with grown-ups at the top of the list.

Did you know that up to 25 percent of the grocery store profits can come from the deli and bakery area? These foods are marked up because they are considered convenient foods and can cost upwards of double the price of making it yourself. Not to mention the fact that they do not really have your health in mind.

Most of all, Healthier

Read, read and read the food labels on the back of the packing. Nutritional claims on the front of the package can be misleading. They are designed to make you buy products with their bottom line coming first.

The best advice I can offer was given to me by a great friend of mine, Chris Corcoran, MS, RD/LD of the WeightWise Bariatric program. "Choose foods that have the shortest ingredient list." A good example is peanut butter. One peanut butter may indicate it is low-fat but have more than six ingredients listed while another product may have only two – salt and peanuts. The choice is obvious.

Produce is another area where most will think fresh is better than frozen. This may have been true 10 years ago; however, now most produce and fruit is frozen within hours of being harvested and therefore keeping the nutrients within each item. Whereas the fresh produce may have been picked over two to three weeks ago and may not give you the same nutritional benefits. So, shop healthy without breaking the bank and check out the items in the frozen section… especially if they are not in season.

***Grocery** continued on page 31*

BBQ Scallops and Bacon

Serving Size: 16

16 large	sea scallops	1 tsp.	granulated garlic
½ lb.	turkey bacon slices		Walden Farms barbecue sauce
	salt and pepper, *to taste*		

Per Serving: 79 Calories; 6g Fat (64.4% calories from fat); 6g Protein; 1g Carbohydrate; trace Dietary Fiber; 29mg Cholesterol; 390mg Sodium. Exchanges: 0 Grain (Starch); 1 Lean Meat; 1/2 Fat.

In a small mixing bowl add scallops, garlic, salt and pepper and toss well. Next, take 8 slices of turkey bacon and cut in half giving you 16 pieces. Wrap each scallop with 1 piece of bacon and secure with a small tooth pick. Next, over medium high heat, sauté scallops on all sides for 5 to 7 minutes or until scallop is done in the center. A little oil may be needed to keep your scallops from sticking. Toss in BBQ sauce and serve. These also taste great grilled.

The Care and Feeding of Children:

Beating Childhood Obesity with Realistic Nutritional Recommendations

By Julie Janeway, Karen Sparks, MBE, and Randal S. Baker, MD, FACS

It's no secret that childhood obesity is the most recent bandwagon everyone is hopping on, but what good does it do to waive your arms, agree earnestly with experts and call loudly for change if no one puts forth a plan to actually make changes? Correct. It does no good at all. So, how do a mom and dad really understand the childhood obesity issue, and more importantly how do they actually acquire some skills to help change their kids' behaviors? Read on.

In the October 2006 edition of *OAC News*, Dr. Jacqueline Jacques did a fabulous job relating the causes and considerations of childhood obesity. If you missed the issue, please visit the OAC Web site and click on the *OAC News* tab located under the "Resources" link. This article will pick up where Dr. Jacques left off.

The Childhood Obesity Epidemic

As was correctly stated in the October article, approximately 9 million U.S. children over the age of six are now obese, and the numbers are on the rise. The U.S. Centers for Disease Control and Prevention state that the percentage of overweight young people in the United States has roughly tripled since 1980 to about 18 percent.

Children are less active than ever before, eat more processed food and have poorer eating habits. But this doesn't have to be a permanent condition. Parents can start by examining and understanding what their children are eating, where they are eating, when they are eating, why they are eating and how many extra calories a day they are consuming that can be cut out.

Consuming Extra Calories

According to the Harvard School of Public Health's Dr. Y. Claire Wang, kids today are suffering from an energy gap – meaning they take in more calories than they burn through growth and daily living. The average child takes in up to 165 extra calories per day which is about the amount in one can of soda. The heaviest children and teens are taking in as many as 1,000 calories more per day than needed, which is almost as much as two Big Macs.

From 1988 to 1994, children aged two to seven consumed between 110 and 165 calories more than they needed each day resulting in a weight gain (not related to growth) of almost one pound a year. Similarly, from 1999 to 2002, obese children 12 to 17 years old took in an average of 678 to 1,017 extra calories per day, amounting to an entire excess weight gain of 58 pounds.

The study, published in the December issue of the journal *Pediatrics*, concludes that prevention is the most important factor in reversing this trend. If government, community, schools, families and food and beverage industries don't start working together, we're going to see the first generation of children having a shorter life span than their parents.

"The heaviest children and teens are taking in as many as 1,000 calories more per day than needed, which is almost as much as two Big Macs."

According to a report presented at the American Heart Association meeting in Chicago in November 2006, children with risk factors for heart disease, including high cholesterol and diabetes, are showing signs of narrowing and hardening of the arteries, a condition normally associated with adults. The researchers from McMaster University in Hamilton, Ontario, Canada, concluded from a study of 3,630 children that an increasing number of children suffer from these and other risk factors for cardiovascular disease, including the risk factor of obesity.

Children's Diets and its Affects on the Body

So our children are not only heavy, out of shape, missing out on many of the wonderful things that come with childhood, having poor self-esteem and possibly having hardening arteries and seriously increased risk for cardiovascular disease, but their terrible diets may severely affect their learning opportunities as well. The junk food they eat during the day also alters the way they think, feel and react. It affects their entire emotional state.

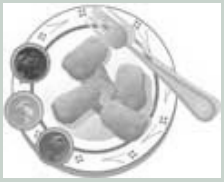
Changing Eating Habits

So how do we change what they eat? One way is to educate children so they understand their unique body. One child may eat large portions and their body stays slim. Others may eat less and be larger. The most difficult situation to manage is when siblings have different body types. Parents need to do a good job helping their child accept their body and instilling in the child a level of accountability for what they eat, as well as for the portions.

Children should also be active and sweat several times each week. Far too many children today are sedentary, which when coupled with poor nutrition habits, creates a recipe for weight issues.

To the right, we've provided you with a list of 10 foods you should teach your kids to consume with caution. We've also given you some realistic, tasty alternatives with which to replace them. Don't try to replace them all at one time. Start with one, and when you've worked that one into your routine, then select another to replace. One by one you'll be taking steps to healthier kids and a healthier family.

Healthy Alternatives



1. Chicken nuggets/tenders: These little tidbits are compressed fat, high-fructose corn syrup (HFCS), sodium and some form or parts of what might have been identified at one time as chicken. Many times the chicken nuggets are left over parts and skin pressed into a shape with the salt and HFCS to hold it together and then deep fried in hydrogenated oil. All this and we haven't even added in the HFCS or mayonnaise based dipping sauces that also includes more sodium, fat, and sugar.

- ***Alternative:*** Grill chicken breasts and cut them into dipping size pieces or one inch cubes. If you have time on your hands, pound the chicken to a thinner consistency and use basic shape cookie cutters to cut it after cooking. Use marinara sauce, mustard, homemade salsa, yogurt based sauces or ketchup that doesn't contain HFCS for dipping. You'll still have crunchy and delicious kid-friendly chicken, but without all the extra calories and fat.

2. Juice and juice flavored drinks: Yes, juice is good for children in moderation, and when it actually is 100 percent juice. It contains vitamins, antioxidants and other good things, but isn't as good for kids (or adults) as whole fruit because it doesn't have the fiber. The calories in juices are mostly from sugar and carbohydrates, and that can lead to obesity, tooth decay and other problems. Additionally, drinking calories rather than taking them in through foods does not satisfy hunger. It only adds to calorie counts. The American Academy of Pediatrics recommends four to six ounces of juice per day for kids under the age of six, and eight to 12 ounces for older kids. Juices that aren't 100 percent juice are full of HFCS and artificial colors and flavors. Just say, NO.

- ***Alternative:*** Water is always the best option for quenching thirst. To get kids to drink water, try adding no-sugar flavorings on occasion, or add just a small splash of fruit juice to get them started. Be

Childhood *continued on page 12*

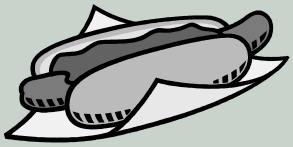
Healthy Alternatives

Childhood continued from page 11

a good role model and drink water yourself, and drink milk too. Low-fat milk is filled with nutrients, calcium and protein which are all good for growing kids as well as adults.

3. Chips: Cheesy curls, taco chips, ripply chips or whatever you might want to call them, they are nicely contained little bags of saturated fat, sodium and other chemicals. For the most part, leave them on the store shelf. Chips and their like have more sodium than any child should consume, and the low-fat and baked kind often contain olestra which may cause other health issues for children.

● ***Alternative:*** When kids want to snack and they want to snack on something crunchy, try cut up vegetables with a bit of cheese or peanut butter, air-popped popcorn, trail mix (no marshmallows and limited chocolate) and graham crackers. When you make your own popcorn you can control salt and butter additions, and you can experiment with other toppings like parmesan cheese, dill, red pepper and others. Homemade trail mix can also control salt, fat and sugar intake. A few chips here and there really isn't going to hurt your child. Just consider keeping them for special types of occasions.



4. Prepared lunchmeat and hot dogs: These processed meats are filled with saturated fats, poor quality proteins, potentially carcinogenic (cancer-causing) nitrates and nitrites, high levels of sodium, artificial colors and flavors and other types of fillers that scare us when we think about their origin. Better options exist.

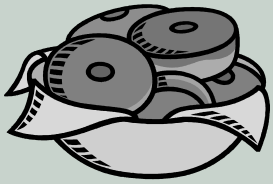
● ***Alternative:*** Buy real chicken, turkey, roast beef, tuna, salmon and other meats. Use whole wheat breads and crackers (low fat, low-sodium) and low-fat cheeses for sandwiches and homemade "lunchable" type eats. Make fun shapes and add crunchy veggies in to mix things up. If your kids are absolutely hotdog addicted then try switching to turkey dogs, but read ingredients closely as they can be just as full of chemicals and additives as regular hotdogs. Don't forget about peanut butter, grilled cheese (low-fat cheese) and other lunch time and quick dinner alternatives. The occasional hot dog at holiday festivities or backyard family BBQ is not the problem; it is the over consumption as part of the weekly dinner menu that can hinder overall dietary intake and cause medical problems for your child.

5. Typical sugary kids' cereals: Cereals contain exactly as much sugar and other junk as the labels say they do, such as: artificial colors, artificial flavors, sugar of every type and description, HFCS, sodium, overly processed grains without a hint of remaining nutrition, hydrogenated oils and fats, high amounts of carbohydrates and enough chemical preservatives to keep a child pickled through the year 3000. These cereals have virtually nothing to offer your child but a plastic toy that will keep the kid amused for a total of three minutes of his or her life. What they do offer is empty calories, unnecessary fat, tooth decay, upset tummies and arguments with siblings over those useless plastic toys with some added vitamins and minerals to try to compensate for the damage.

● ***Alternative:*** Look for cereals that are low in sugars (all of them, including HFCS, sucrose, fructose, dextrose,and any other thing that ends in "ose" or "tol"). Try and buy whole grains, but be aware of the fact that there is no regulation that requires any specific percentage of whole grain in the package. A box of cereal can have literally a speck of whole grain in the whole thing and legally label itself as whole grain cereal. Truly organic, whole grain cereals are best, especially with bananas, berries (good antioxidants), raisins, a splash of almonds and some good cold low-fat milk will make kids just as happy. Starting your day with a healthy breakfast high in fiber and protein, while low in sugar, can

"Parents can start by examining and understanding what their children are eating, where they are eating, when they are eating, why they are eating and how many extra calories a day they are consuming that can be cut out."

support better cognitive ability throughout the morning. It can also keep glucose and insulin levels more stable, which may positively impact body fat storage and utilization.

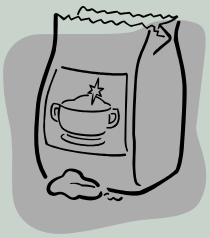


6. Doughnuts and sweet rolls: Speaking of things that are inappropriate for breakfast, especially for kids - doughnuts and sweet rolls top the list. Again, excessive amounts of sugars, starches, carbohydrates, preservatives and artificial everything, not to mention the hydrogenated oil in which they are deep-fried. This class of breakfast offenders also includes toaster pastries, muffins and other pastries. They may look good for breakfast but all they are is a pile of bad nutrition.

● ***Alternative:*** The old standbys are best: a piece of whole wheat toast with all- fruit spread or some quality peanut butter (not full of sugar); perhaps an egg or a whole wheat English muffin, and a small piece of cheese. Don't forget the milk – one gram of protein per ounce. Save doughnuts for the very occasional dessert treat, and place a general family ban on pastries and other bakery goods at the breakfast table or for snacks. These should be rare treats for everyone, indeed.

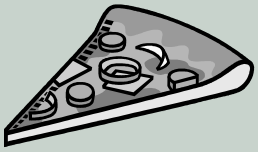
7. French fries: Although they are part of the American culture, they are high in calories, high in sodium and high in fat. Unfortunately, most American children think French fries are a "vegetable." Studies beginning in 2002 are now showing that French fries create a toxic substance called acrylamide. Acrylamide comes from heating starchy foods like potatoes at extreme temperatures (like deep-frying), and acrylamide is showing cancer-causing properties. In some tests, the amount of acrylamide in French fries was 300 to 600 times higher than the amounts the EPA allows in a glass of drinking water.

● ***Alternative:*** Potatoes are nutritious. They actually have some nutritive value in their own right, so take advantage of that. If fries are a requirement for some reason, then try baking them with a light brush of olive oil. Don't forget classic baked potatoes with yogurt sauce, or twice baked potatoes with yummy ingredients like salsa or chili and low-fat cheese. Also, don't feel like you're bound to using traditional white potatoes. Yams and sweet potatoes (yes, they are different things) can be made into baked fries, and other dishes as well, for a fun and colorful change of pace. Consuming traditional fast food or restaurant fries (also, school cafeteria fries) on a daily or near daily basis is not recommended, and certainly super-sizing is never the way to go.



8. Fruit naugahyde: This is the roll-up, bite size, stuff that contains a micro amount of fruit or fruit juice but is primarily comprised of HFCS, chemicals, multiple types of sugars and a lot of red dye. It really has nothing to do with fruit, and more to do with farm equipment upholstery fabric.

● ***Alternative:*** Give the kids fruit! It doesn't have to be in its right-from-the-tree or plant state, but you can do something to make it more fun and appealing. Try making a fruit cocktail, fruit kabobs, funny fruit faces, frozen grapes, freezing fruit pieces in ice cubes, dipping fruit in yogurt and freezing it, putting fruit in jello, putting fruit in homemade trail mix or making your own dried fruit snacks. Add raisins, cranberries, almonds, walnuts, apricots, star fruit or other berries. When you get home from shopping, precut the fruit into small pieces and place it in airtight containers. You may want to place the clear container at eye level in the refrigerator so when everyone in the family sees it, that's what they grab for a healthy, satisfying snack.



9. Pizza: In theory, not really a bad option. If you choose a good crust made with whole wheat flour; sauce that isn't full of sugar, HFCS and preservatives; low-fat cheeses; fresh veggies; and meats that aren't proc-

Childhood *continued on page 14*

Childhood *continued from page 13*

essed, pre-shaped, and filled with nitrates, you've got a great meal that can satisfy and make kids happy. Also, you have to know what the correct serving size is as well, and it's not half a pizza. Unfortunately, most pizza consumed by kids is processed, preservative-filled, fat-filled and lacking in real nutritive value.

● ***Alternative:*** Make your own pizza with your kids. Let them toss the crust around like an old time pizza chef, slop around in the sauce and sprinkle the cheese. Think about making kid-sized pizzas on whole wheat tortillas, English muffins, or toasted bread. Watch for the HFCS in sauces, and add toppings like chopped chicken, veggies and even pineapple. Once they buy-in to great tasting pizzas like this they'll choose to walk away from the greasy, slimy, cardboard kind.

10. Soda pop: Last, but by no means least, soda is one of the top three worst things a human being can put in their body. According to several studies, soda and other sugar-sweetened drinks have become the largest source of calories in the American diet, replacing white bread. Numerous studies have shown the strong link between consumption of soda pop and weight gain.

David S. Ludwig, MD, PhD, Director of the obesity program at Children's Hospital Boston states, "In my estimation, sugary beverages are one of the two leading environmental causes of obesity, perhaps second only to TV viewing in the magnitude of its effect."

Dr. Ludwig adds that people may be unaware of how these liquids make us fat. They do so because they pass through the stomach more quickly than food. As a result, people don't feel as full as those who consume the same amount of calories from solid food.

In addition, there's evidence that the HFCS used in most sodas fails to suppress the production of ghrelin, a hormone made by the stomach that stimulates appetite. HFCS doesn't seem to trigger the hormones that help you regulate appetite and fat storage, so the body never gets the message to stop eating. Soda pop not only contributes to obesity, but it also affects the body's ability to process sugar, and the links between soda pop and type 2 diabetes are becoming clearer as research continues.

At a pH of 2.5, the corrosive acid levels in soda are just slightly above that of battery acid at a pH of 1. For comparison, water comes in at a pH of 7. The lower the number, the more corrosive the substance. The pH levels in sodas inhibit the body's ability to absorb nutrients, essential for growing children. Several researchers are also looking at the link between soda pop and the interference from carbonation with the body's ability to absorb calcium, leading to more brittle bones, and later, to highly increased chances for osteoporosis. Phosphoric acid in many sodas also competes with calcium for absorption minimizing the calcium one does consume.

Finally, the caffeine in soda pop is completely unnecessary for children or adults. The sugar in soda is mixed with phosphates designed to speed it into your system. The carbonation and acid levels deplete oxygen in the blood which makes us feel like the caffeine is wearing off, and we head for the fridge for another soda to rev us back up.

The truth is it takes the better part of whole day to metabolize the caffeine in an entire can of soda pop out of the system. It's a terrible cycle that diet sodas don't correct. Diet sodas are not a realistic alternative and neither are the new "sports" drinks that are virtually repackaged soft drinks with different flavoring systems.

● ***Alternative:*** Water is always the healthiest alternative, followed by milk and appropriate amounts of real fruit juices. Children need to understand that they have a responsibility to take care of their bodies and that proper hydration is part of that responsibility. If you do one thing for your children, get them off soda. In the long run they'll be happier, be more attentive in school, they'll sleep better, have stronger bones, better check-ups at the dentist, breathe easier and absorb more of the good nutrition you're helping them take in.

Childhood *continued on page 30*

Food ADDICTION

and the Weight-loss Surgery Patient

By Katie Jay, MSW

For people with food addiction, the decision to overeat is not a conscious one, at least not in the early days of your addiction. You do not wake up and think, "Rise and shine! Let's get crackin'. Eat a box of donuts and lose some of that self esteem!"

No, it's usually more like, "I'm going to be so good today…is that an *OREO*?"

Food addiction is a daily struggle for many weight-loss surgery (WLS) patients. It may be a week, a month, a year after surgery; but for about 70 percent of those who undergo weight-loss surgery, it happens.

Of course, having the smaller stomach and/or rerouted intestines that come with WLS can be a great tool to help control your eating, but if you had trouble with food before surgery, there is high risk of eating compulsively, overeating or even just obsessing about food after surgery.

What exactly is food addiction?

Addiction is a loaded word that unfortunately holds a negative connotation for many people. That is why I prefer the term eating disorder, but even that term is viewed negatively by some.

The truth is, though, that food addiction is a complex problem for which there is no one cause and no simple solution. No matter what you call it, food addiction or an eating disorder, the basic definition is the same: an unhealthy relationship with food.

Sure, there are more clinical definitions, but it all boils down to one's relationship with food – how you think about it, how you use it, why you use it and what your behavior with food does to you (obesity, shame, preoccupation, illness, depression, etc.).

In fact, shame and self loathing are such major factors in obesity and food addiction that I feel compelled to remind you that a food addiction is not a moral issue. It is not an affliction of weak-willed, lazy people. It is something that occurs in people of all ages, income levels, races and sexes. It has a strong genetic component, a relationship to brain chemistry and a cultural component (can you say, "Supersize me?").

You do not set out to be addicted to food, or to be obese. Food addictions can develop over time, and are not always obvious in the early stages.

How do you know for sure you are "addicted" to food?

Food addiction is a vicious cycle of unhealthy eating, which brings on a sense of being hopelessly out of control, which brings on a desire to eat more food to numb the uncomfortable feelings.

The amount of food eaten, the types of food and the manner in which the unhealthy eating occurs varies from person to person.

Some people drive through a fast food restaurant and eat "in private" in their car. While others will get up at night to eat when no one else will observe them and criticize their behavior. Still, others hide food to sneak when the opportunity presents itself.

Food Addiction *continued on page 16*

Food Addiction *continued on page 15*

Some people binge by eating as much food as possible in a short period of time. Others will eat more food than normal over the course of the day but never eat a large quantity at one sitting.

Some people obsess about certain foods, like sugary, salty, fatty or refined foods. Many people who use food in an addictive manner also obsess about their body and/or their weight.

You do not have to search far on the Internet to find a list of food addiction symptoms. Numerous quizzes exist to help a person determine whether or not they have a food addiction (see sample quiz on the next page).

What if you are a food addict?

As trite as it may sound, if you self diagnose a food addiction, you have taken an important first step. After all, if you do not know what your problem is, it is pretty hard to fix it. Research shows the number one reason people do not seek help with an addiction is they do not believe they can stop their self-destructive behavior.

I see that dynamic in my coaching practice every day. The number one reason most of my coaching clients avoided seeking help for so long is they did not believe they could stop obsessing about their eating, body and/or weight. They had such a track record of failure with weight-loss and weight control they felt absolutely hopeless.

If you feel hopelessly trapped by addictive behavior and you have decided not to seek help, remember that time and time again people who struggle with food addiction turn a corner and make real, permanent changes. It happens every day.

A Food Addiction is an Unhealthy Relationship with Food

A <u>healthy</u> relationship with food includes:

- Eating when you are hungry
- Stopping when you are full
- Eating without shame
- Eating to live (rather than living to eat)
- Not obsessing about food
- Not feeling guilty about eating
- Not eating secretively

An <u>unhealthy</u> relationship with food, or a food addiction, includes:

- Compulsive eating
- Overeating
- Obsession with food
- Secretive eating
- The feeling of being out of control with your eating
- Eating when you're not hungry
- Eating to numb emotions
- Eating past full, etc.

The secret to healing from food addiction is to not keep it a secret. If deep down you know you have a food addiction, you will find relief when you start to talk about it. You must seek help.

Many people who struggle with their weight never lose obsessive thoughts about food, but that is partly because they are not seeking help, trying strategies to find what will work for them and living in the solution.

The people most successful at breaking free from the burden of unhealthy eating have transitioned from being rebellious (reactive) to responsible (proactive). They stop looking for whose fault their food addiction is to whose responsibility it is.

Many factors will affect the treatment of your food addiction. I encourage you to leave no stone unturned as you search for solutions to your problem.

Action Steps for those Suffering from Food Addiction:

- Get help
- Seek counseling with an experienced eating disorder specialist of some kind
- Find an experienced life coach
- Attend support groups that focus on food addiction,
- Do whatever you have to do to make the necessary changes in you and your environment

You may have an undiagnosed and untreated depression or anxiety disorder that, if left untreated, makes your food addiction much harder to deal with. There may be foods you could avoid that trigger you to overeat or obsess about food.

Maybe you have not learned how to nurture yourself in healing ways so that you do not use food to manage your emotions.

Food addiction is very common and nothing to be ashamed of. But, it is hard to get rid of it in isolation. Get help if you are struggling. And keep in mind, any addiction left untreated absolutely will control your life.

About the Author:

Katie Jay, MSW, is a nationally recognized expert on weight-loss and weight-loss surgery, CTA Certified Life Coach, and the director of the National Association for Weight-loss Surgery and author of Dying to Change: My Really Heavy Life Story, How Weight-loss Surgery Gave Me Hope for Living.

MEMBERSHIP

Membership in the OAC is important in helping those affected by obesity become educated 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 31 for a membership application. For more information, call (800) 717-3117.

Food Addiction Questionnaire ?

Do you see yourself in some of these questions?

1. Has anyone expressed concern about your thoughts and/or behavior around your eating, body or weight?
2. Do you think or obsess about food, your eating, your body and/or your weight much of the time?
3. Do you binge on a regular basis, eating a relatively large quantity of food at one sitting?
4. Do you eat to relieve unpleasant emotions?
5. Do you eat when you are not hungry?
6. Do you hide food for yourself or eat in secret?
7. Can you stop eating without difficulty after one or two bites of a snack food or sweets?
8. Do you often eat more than you originally planned to eat?
9. Do you have feelings of guilt, shame or embarrassment when you eat – or afterwards?
10. Do you spend a lot of time calculating the calories you ate and the calories you burned?
11. Do you feel anxious about your weight, body or eating?
12. Are you fearful of gaining weight?
13. Do you tell yourself you'll be happy when you achieve a certain weight?
14. Do you feel like your whole life is a struggle with food and your weight?
15. Do you feel hopeless about your behavior with food, and/or your obsession with your body and weight?
16. Do you entertain yourself with thoughts of food and what you are going to eat next?
17. Do you weigh yourself once, twice or more daily?
18. Do you exercise excessively to control your weight?
19. Do you avoid eating or severely limit the amount of food you will eat?
20. Being totally honest with yourself, do you think you have a problem with food?

Total Change

By James Zervios, OAC Director of Communications

Iowa State University Defensive Coordinator, Wayne Bolt, shares his struggles with his weight in a sport dominated by size.

At 500 pounds, Wayne Bolt was larger than your average individual – much larger. But in Wayne's profession "large" is well, "in charge."

Wayne Bolt is the new defensive coordinator for Iowa State University. As he grew up around the sport and eventually played ball himself, size, strength and endurance were no stranger to Wayne. In fact, today he may seem like the "stranger" if any of his former coaching buddies were to see him.

In January of 2006, Wayne's weight skyrocketed to 500 pounds. Mostly due to the original weight Wayne packed on during his football career and a lack of diet and exercise once his playing days ended. "It was January 23, 2006 and I could barely move. I couldn't walk and everything hurt. I knew I had to do something about my weight," said Wayne.

After reaching this overwhelming realization, Wayne decided to see his doctor about his weight. Wayne eventually consulted with a bariatric surgeon and decided to seek out Roux-En-Y gastric bypass surgery. "After speaking with my doc, I decided that this surgery would be best for me," said Wayne. Upon seeing his surgeon, he told Wayne that he needed to lose 50 pounds before he would perform the surgery. "I knew I had to lose some. By the time of surgery, I had lost 45 pounds with diet and exercise," proudly said Wayne.

The extra weight Wayne carried is very common among athletes in today's fast-paced, competitive society. Everyone wants to be bigger than the other guy and is willing to do whatever it takes. Quite often, athletes find themselves no longer participating in the sport that required the bulkiness, but now doing very little to readjust to life without the sport.

"It really is something that needs to be addressed. I worry about some of these guys and old friends. They have to know that once they're done with the game, the sport, they have to lose the weight. Otherwise, down the road, there's going to be much more to lose than weight – if you know what I mean," said Wayne.

Not only did Wayne's surgeon require him to lose weight prior to surgery, he also wanted Wayne to understand the entire process of weight-loss surgery. He wanted him to know that his life would change – totally change. "He said to me, 'Wayne, are you ready to make a complete lifestyle change?' I said 'yes.'" Wayne knew he would have to change his eating, exercise and lifestyle habits completely.

Prior to the surgery, Wayne was affected by many co-morbid conditions due to his morbid obesity, such as high blood pressure (HBP), diabetes, high cholesterol and sleep apnea. Total, Wayne took eight pills a day for these conditions. "I couldn't take it anymore. I wanted to do it and do it right. I've always said if you're going to do something, do it RIGHT," strongly said Wayne.

On April 4, 2006, Wayne had gastric bypass. "It's been a challenge, a contest to lose the weight. I had to learn how to eat again, what to eat again and how to exercise. You know, the basics," said Wayne.

Today Wayne weighs 270 pounds. To date, he has lost more than 230 pounds. Wayne Bolt is a true story of success. The 500 pound Wayne ate three eggs and three slices of bacon for breakfast, wore a size six extra large shirt, wore a size 66 pant, didn't exercise and hadn't ever enjoyed walking in the mall with his wife Linda – more on that in a bit.

"Surgery is a tool. It's only a tool. Some people try to tell me it's a crutch for weight-loss. That's not true. You have to want to do it. I can tell the kids I coach that they need to watch their weight, but in the end, they have to WANT to do something about it," insightfully said Wayne.

Today, Wayne has made a total change. He eats one egg and one slice of bacon for breakfast, wears a size extra large shirt and a 42 pant, swims and walks every day and most importantly enjoys time with his wife Linda.

"This past Thanksgiving my wife said she was going to the mall and wanted to know if I wanted to go along. She always went to the mall – you know it's kind of a woman thing, but I thought I'd go too. It was the day after Thanksgiving. Some big shopping day she said. I can't even begin to tell you how much I enjoyed the mall with her. It was great," laughed Wayne.

Oh, and I forgot to mention that today Wayne takes ZERO pills and has controlled his HBP, cholesterol and diabetes. He stills uses his sleep apnea machine, but hopes to be off of that soon.

Linda is Wayne's true support. During the entire process of the weight-loss, Linda has remained his support – maybe even his "coach." "Linda is great to me. She never asked me to have the surgery. She always supported me through it all. This entire process has truly been a Godsend," said Wayne.

Nowadays, Wayne finds himself very busy as the defensive coordinator for Iowa State University. "The people here don't know the 500 pound Bolt. They know the 270 Bolt. Hopefully, soon, they'll know the 250 pound Bolt. I am going to keep doing this 'til I can't do this anymore," said Wayne.

In his spare time, Wayne enjoys spending time with his wife Linda, walking in the park, swimming and most of all – trips to the mall. Even though, "it's a woman thing."

Above: Wayne Bolt, with his wife, pre-surgery

Right: Wayne Bolt (230 pounds lighter) poses with his wife for their Christmas 2006 family photo.

Patient Profile
Inspiring Stories from Inspiring Patients

By James Zervios, OAC Director of Communications

"I am Getting Where I Want to Go"

Toni's story is like so many others. Being denied coverage for weight-loss surgery is a reality that many suffering from obesity are facing. But, Toni has kept the fight going and still fights for coverage.

By the age of 17, Toni was already affected by obesity, but even more life threatening was her diagnosis of FacioScapulo-Humeral Muscular Dystrophy (FSHD). Unfortunately, genetically Toni was predisposed to both FSHD and obesity. Toni's At 5'7" and 240 pounds, Toni Andrews has a body mass index (BMI) of 37, which statistically puts her in the mid-range of the obesity scale. Some bariatric surgeons may not even consider Toni a candidate for weight-loss surgery; however, in Toni's case, it is not so much a consideration as it is a necessity.

entire family has been affected by obesity and nearly every bloodline relative also exhibits some form of Muscular Dystrophy.

The disease has basically taken over her life. In 2003, Toni had to leave her business of a bail bonds company due to her illness. "I never wanted to have to quit work. I am a doer. I want to provide for my children. It hurts when I can't," said Toni.

One of Toni's closest relatives, her sister, was also affected by Muscular Dystrophy and obesity. Her sister underwent Roux-En-Y gastric bypass, but unfortunately died due to complications after the surgery.

With as devastating a loss as her sister passing away due to complications, Toni still seemed determined to have weight-loss surgery because this surgery may provide her with the much needed medical treatment for her FSHD.

Toni has found herself in a "Catch-22." Either way she looks for treatment, she is being denied or turned down. "My FSHD doctor has told me that I cannot receive treatment for my Muscular Dystrophy unless I lose weight," said Toni.

Toni has tried every weight-loss product, program and wonder drug to no avail. "I've done it all. Nothing works. I guess I am just genetically made not to lose weight. This is why I think the Laparoscopic Adjustable Gastric Banding (LAGB) procedure can help me. It's reversible and I think it's the best way to go," strongly said Toni.

On the surface, this may seem logical. The FSHD process requires weight-loss and the LAGB would give her the tool to lose the weight. Unfortunately, for Toni and many others, it is not that easy.

The Mississippi Medicaid program does not cover weight-loss surgery. In fact, Toni has been told on numerous occasions that Medicaid sees this procedure as purely cosmetic. "I honestly just don't get it. Medicare covers the surgery under certain guidelines, but Medicaid doesn't. It just doesn't make sense," said Toni.

Toni has explored the lengthy appeals process and even sought out legal advice but has been told that there really isn't much that can be done. Toni's FSHD doctor has sent letters to Medicaid stating that this procedure is crucial for her to receive treatment for her FSHD. Unfortunately, Medicaid has not responded.

The word "frustration" can best describe Toni's current state of emotion. Toni has two children and desperately wants to provide for them; however, she knows without proper treatment things will only get more difficult.

"My kids help me now. They help me wash my hair as I can only lift my arms to a certain point. I love my children. They are my support and I'll do anything for them," said Toni.

Even with all the obstacles currently facing Toni, she remains determined and dedicated. She is currently studying law and one day hopes to become a lawyer to help those like her gain access to treatment. "I want to help people. The whole country needs to know about obesity and what it can do to somebody's life emotionally and physically," said Toni.

" I want to help people. The whole country needs to know about obesity and what it can do to somebody's life emotionally and physically."

When I asked Toni why she kept on fighting even though she seems to have hit a stopping point, she replied "I am getting where I want to go. I will make a difference in my life and lives of others affected by disease."

Toni, I couldn't agree more. With your determination and heart, you will most certainly make a difference.

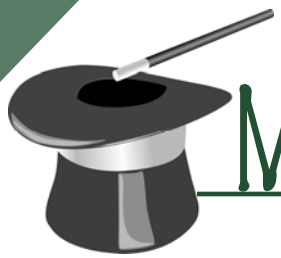
As of the publishing date of this issue of "OAC News," Toni Andrews still has not found a solution to her situation. If you or anyone you know of may be able to assist Toni, please contact the OAC National Office at (800) 717-3117 or ***info@obesityaction.org*** *for more information.*

Are you having difficulty accessing treatment for obesity?

Unfortunately, many are facing the same challenges as Toni when trying to access treatment for obesity. The OAC has several beneficial advocacy tools to help you in your journey to accessing care.

One of the most popular educational pieces produced by the OAC is the Insurance Guide - "Working with Your Insurance Provider: A Guide to Seeking Weight-loss Surgery." This guide is designed to provide the knowledge needed to successfully work with your insurance provider and become and advocate for change.

The OAC Web site also has a comprehensive advocacy section, providing visitors several valuable resources to get involved in advocacy efforts. Patients are encouraged to visit the OAC Web site at **www.obesityaction.org** to learn more and view the many ways that they can impact change.



Magic Pills

Magic Pills continued from page 1

DHEA. Some claim to accelerate fat burning, others to target specific areas of fat, still others claim to suppress appetite. And while there may be pieces of truth in any of this, often companies are simply aiming to sell hope to those who are desperately seeking to find a solution to being overweight or obese.

Why can companies market these products?

In the U.S., it is relative easy to bring a dietary supplement to market. Unlike drugs, dietary supplements do not have to go through clinical trials; they do not have to be proven safe or effective for anything.

As far as safety goes, the FDA currently treats dietary supplements more like foods than drugs. Safety does not have to be established in clinical trials, but is assumed because the products are dietary (just like you do not need to demonstrate the safety of bananas). Companies selling dietary supplements are ultimately responsible for their safety; the FDA is responsible for demonstrating that a product is *unsafe* before it can restrict use or recall the product from the market.

It is currently not required for manufacturers or distributors of dietary supplements to collect or report adverse events to the FDA. Consumers or health professionals can file voluntary Adverse Event Reports (AERs) through Med Watch (**www.fda.gov/medwatch**).

Advertising Issues

The issue of claims made about dietary supplements is perhaps most irritating to physicians and confusing to consumers. Ads, especially for weight-loss products, seem to make remarkable claims. How can they do that?

Quite simply, a great deal of the advertising for dietary supplements is illegal – companies simply bank on not being caught, or on making enough money before they do get caught that the fines will pale in comparison to profits.

The Food and Drug Administration (FDA) and the Federal Trade Commission (FTC) technically work together to regulate what is said about dietary supplements. Where the FDA has primary jurisdiction over things that are on the product – the label, the packaging, inserts and appended literature – the FTC has oversight of everything else such as commercials, Internet marketing, print media, catalogs, testimonials and direct marketing materials.

The issue of claims made about dietary supplements is perhaps most irritating to physicians and confusing to consumers. Legally, a dietary supplement cannot be used to, or claim to diagnose, cure, mitigate, treat or prevent a disease – substances that do this, or claim to do so, are drugs by definition.

As stated above, the FDA and the FTC both have some oversight over claims, packaging and label information. However, it seems that between these two agencies they still struggle to maintain control over inconsistent, unproven

How Dietary Supplements are Defined

It helps to start by understanding what a dietary supplement is and is not. Dietary supplements were defined in 1994 by Congress under the Dietary Supplement Health and Education Act (DSHEA). Under DSHEA, a product is a dietary supplement if:

1. It is intended to supplement the diet
2. It contains dietary ingredients such as vitamins, minerals, herbs (other than tobacco), amino acids, other natural substances and/or their constituents
3. It is ingested orally in the form of a pill, capsule, tablet or liquid
4. It is labeled on the front panel of the product as a dietary supplement
5. It was sold and marketed as a dietary ingredient before October 15, 1994 or has been approved by the FDA as a *new dietary ingredient* (NDI)
6. Its intended use is as a dietary supplement, not as a food or a drug

As long as a substance meets these criteria, it can be sold to the public without being tested or investigated as is required for substances sold as drugs.

and just plain false information being distributed to consumers. This problem has clearly been compounded by the Internet, which we now know is used by approximately 16 percent of the U.S. adult population to seek information on health.

In the September 17, 2003 issue of the *Journal of the American Medical Association*, Morris and Avorn of Harvard Medical School conducted a survey of health claims made on the Internet about the most common dietary supplements. The reviewers looked at 443 Web sites and applied FDA criteria to classify claims as "disease" or "non-disease" in nature. Of the surveyed sites, 76 percent were retail sites either selling products or directly linked to a vendor. Of this 76 percent, 81 percent (338 sites) made one or more health claims, with 55 percent of these claiming to treat, prevent, diagnose or cure specific diseases.

Moreover, 52 percent of retail sites failed to include the mandated federal disclaimer for dietary supplement sales. Only 12 percent of sites provided any reference materials to support claims. Thus, the authors concluded that despite supposed FTC authority to regulate these materials, the current enforcement of claims (at least on the Internet) is quite poor and likely to mislead consumers.

By law, allowable claims for dietary supplements are supposed to meet both FDA and FTC criteria. The FDA offers general guidelines for structure-function claims, language for approved health claims (very limited), and required disclaimers (such as those that caution use in pregnancy and nursing).

The FTC further offers guidelines for advertising that are designed to assure that materials are truthful and not misleading in nature. They further require claims to be adequately substantiated by solid scientific data. The FTC laws even apply to personal or health professional testimonials – including those often amazing pictures showing miraculous weight-loss and body sculpting.

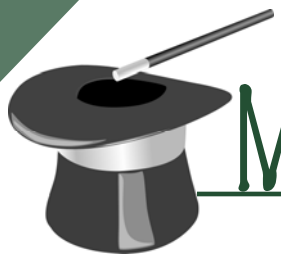
***Magic Pills** continued on page 24*

What Can you Do as a Consumer?

As a consumer, you need to be smarter than the companies that market to you. Let's face it: if any of these companies had the real miracle cure for weight-loss we would not be facing obesity at near epidemic levels in our country. More likely than not, a major pharmaceutical company would snap up the product, and it would be making headlines. The miracle solution for obesity does not yet exist. The best proven long-term results are from weight-loss surgery, followed by diet and exercise, behavior modification and some pharmaceutical agents. That does not mean that some natural substance might not have value – but you should look critically before you buy.

The following are some resources that consumers can use to both evaluate dietary supplements and report fraud:

- **ftc.gov/bcp/conline/edcams/ojo/cases_health.htm#weight** - this Web site has a list of companies that have recently been cited for fraudulent weight-loss claims by the FTC.
- **rn.ftc.gov/pls/dod** - If you feel you have been the victim of fraud from a company marketing or selling weight-loss products or services, you can file a complaint here.
- **www.ftc.gov/redflag** - The homepage for the FTC's Operation Red Flag. This informative site gives great information for both consumers and companies on how to avoid false advertising of weight-loss products and services.
- **ods.od.nih.gov/index.aspx** - The National Institutes of Health Office of Dietary Supplements. Contains a lot of information on popular dietary supplements and has an informative page on avoiding health fraud (http://www.fda.gov/fdac/features/1999/699_fraud.html)
- **www.umm.edu/altmed** - The alternative medicine database at University of Maryland Medical Center. This is one of the best on the Web. Evidenced-based reviewed articles on hundreds of natural ingredients.
- **www.cfsan.fda.gov/~dms/supplmnt.html -** The Office of Dietary Supplements at the FDA. You will find a page here of FDA warnings and advisories against dietary supplements, information on being a smart consumer, and the link to report an adverse event or reaction to a dietary supplement. You can also look at warning letter such as those issued to companies marketing Ephedra.



Magic Pills

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Details of what the FDA requires can be viewed at **www.cfsan.fda.gov/~dms/ds-labl.html**; FTC requirements are detailed at **www.ftc.gov/bcp/conline/pubs/buspubs/dietsupp.htm**.

Specific Guidelines for Weight-loss Products

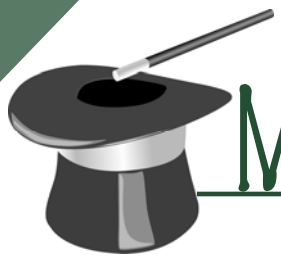
The FTC has had ongoing campaigns to halt false advertising in the weight-loss category since the mid-90s. To that effect, they have issued both advertising and consumer guides to try to diminish fraud. Generally, guidance for dietary supplements states that they should not claim or promote an ability to produce weight-loss in the absence of dietary restriction and exercise, and they should not claim weight-loss of greater than one to two pounds per week (the amount that can be claimed for diet and exercise alone).

The following chart outlines the most common supplements for weight-loss and the specifics for each product:

Ingredient	Claims	Mechanism, Safety, Efficacy
Hoodia	Suppresses appetite, increases energy	Hoodia contains a chemical constituent known as "p57" which is supposed to be the active ingredient in appetite suppression. P57 was patented by a company in England called Phytopharm, LTD, who then licensed it to Pfizer. Pfizer dropped the product after early trials, for vague reasons. Reports later circulated that the levels of Hoodia required to suppress appetite in rats and dogs was extremely large and produced severe liver damage. It may have also caused kidney damage. Whatever the actual reason, if it had worked at all, they would have developed it, as a viable weight-loss drug would be a verifiable gold mine for any drug company.
Green Tea	Burns fat	Green tea contains polyphenolic antioxidants and limited amounts of caffeine. While some animal studies have demonstrated small increases in metabolism, there have been no studies actually demonstrating weight-loss in overweight or obese individuals. One small study of 10 patients did find increased 24-hour energy expenditure and fat oxidation, but did not look at weight-loss. On the positive side, green tea is high in antioxidants, and is considered to be quite safe. It should not be used by those with heart or liver disease, pregnant or nursing women unless advised by a doctor. Anyone sensitive to caffeine should also be cautious about green tea use, though the caffeine content is quite low.
Chitosan	Blocks fat absorption	Also called chitin, this is an extract from the shells of crustaceans like shrimp and lobster. Chitin is not absorbed by the body. Rather it forms a gel in the intestine. While limited study shows that this gel can bind cholesterol, fats soluble vitamins (A, E, D and K), calcium, and some fats in the gut, studies have not demonstrated an over all change in fat excretion or absorption. One meta-analysis of human trials did show an increased weight-loss of about seven pounds over placebo, however other studies have failed to support this. There is

Ingredient	Claims	Mechanism, Safety, Efficacy
		some support for chitosan lowering cholesterol, although trials are very limited. There have been warnings from the FDA to manufacturers of Chitosan products for making false product claims. Chitosan is not absorbed by the body, which does make it relatively safe. *Because it comes from shellfish, those with shellfish allergy should avoid it.* As it also binds to calcium and fat-soluble vitamins, use in pregnancy, breast feeding or by those with nutritional concerns should be avoided. It can also cause digestive problems including gas and constipation.
White Kidney Bean Extract	Blocks carbohydrate absorption, called "starch blockers"	Kidney beans and a few other foods contain substances that inhibit the enzyme alpha-amylase, which digests some carbohydrates. These products were very popular about 20 years ago and had a recent resurgence with the rise of low carb diets. It is interesting to note that in the 1980s the FDA actually shut down many companies making these products, but under new regulations like DSHEA, they were allowed to re-emerge. In the past couple of years, the FDA has been busy once again sending warning letters to companies manufacturing and marketing "starch blockers." The science also does not appear to hold up. While the ingredient may be able to inhibit some enzyme function in lab studies, human trials have shown no effect at all[i] . The safety of these products has also been questioned, especially for diabetics.
Yerba Mate/ Guarana (caffeine)	Increases metabolism/ Burns fat	Yerba Mate and Guarna are both caffeine containing herbs which have seen increased popularity since the Ephedra ban. They do not contain ephedra alkaloids. All reported claims are based on the functions of caffeine. Caffeine is a central nervous system stimulant. Caffeine also increases metabolism and acts as a diuretic. This said, caffeine, even at doses that would really give you the jitters, has never been shown to produce significant weight-loss. One study of 18,417 men and 39,740 women over 12 years did show that those who used 100mg of caffeine regularly gained less weight than those who used less. One study using a combination of these two herbs in 47 overweight patients did demonstrate increased satiety and delayed gastric emptying, and very small, but not significant weight-loss. Overall, there is just not substantial evidence for caffeine impacting body weight. All caffeine can result in anxiety, insomnia, tremor and palpitations. If you really want caffeine, coffee (with about 75 mg per cup) may be less exotic, but can be had for a lot less money.
Chromium	Regulates blood sugar, promotes weight-loss, increased muscle mass	Chromium is an essential trace element involved in the regulation of blood glucose by enhancing the action of insulin at the insulin receptor. In deficiency states, abnormal insulin response, glucose metabolism and blood lipids are seen. At least a dozen studies have looked at the relationship between chromium supplementation and body composition in humans, most without significant results. For fat loss, a few studies have shown small, mostly statistically insignificant weight-loss with chromium supplementation[j] . On the up side, there is some evidence that chromium can improve blood sugar and insulin regulation in diabetics[j] , and it appears to lower LDL cholesterol in those with

***Magic Pills** continued on page 26*



Magic Pills

Magic Pills *continued from page 25*

Ingredient	Claims	Mechanism, Safety, Efficacy
		high LDL. As an essential nutrient, chromium is very safe at levels up to the Daily Value of 120 mcg, and here is good evidence that levels up to 400 mcg per day are quite safe. There have been a few reports of kidney damage in very high-dose (1000 mcg or more), long-term (3 months or longer) supplementation. Individuals taking insulin or medications to lower blood sugar should be careful as theoretically chromium may have an additive effect.
Hydroxycitrate (Garcinia cambogia, HCA)	Suppresses appetite, promotes weight-loss	Hydroxycitrate is an extract from the Indian tamarind fruit that has been promoted for weight-loss. It has been suggested that the primary mechanism is through increasing brain serotonin, and decreasing appetite. Most studies have been done in animals, but there are a few in humans, and some have been positive for both reduced calorie intake and weight-loss. One 12-week trial in 135 patients did not produce significant results. However, another 12 week trial in 89 patients did product a small weight-loss (just under 3 pounds) compared to placebo. Participant taking the hydroxycitrate also lost slightly more body fat – but neither result was statistically significant. Safety assessments are limited to some animal data and reported side effects from clinical trials, but there are no glaring adverse events. It is noteworthy that back in the mid-1990s hydroxycitrate was being researched by Roche as a weight-loss drug, but never made it past animal trials. Again, if it looked really effective, it's hard to believe a pharmaceutical company wouldn't develop it.
Kelp	Improves thyroid function, stimulates metabolism	Kelp (Laminaria species) is often found in multi-ingredient weight-loss products. Kelp contains variable levels of iodine which is a part of thyroid hormones, and thyroid hormones are important for metabolism. However, in the absence of an iodine deficiency, there is no evidence that additional iodine will improve thyroid function or metabolism. Conversely, excessive iodine may suppress thyroid function. Some kelp products have been shown to have as much as 1000 mcg of iodine – nearly seven times the RDA. Ultimately, there is no support for weight-loss. Those with thyroid disease or iodine allergy should be careful of supplements containing kelp.
5-HTP, Tryptophan	Suppresses appetite	Tryptophan and 5-hydroxytryptophan (5-HTP) are both amino acid precursors to the neurotransmitter serotonin. Low tryptophan and low serotonin have been linked to overeating, cravings and weight gain. Small trials have shown some promise, but large scale trails are really wanting. A 12-week study did show 11 pound weight-loss over placebo, along with decreased food intake. Another study of 28 obese women had similar results. Clinical trials have shown side effects including fatigue, nausea and headache. There have been concerns about a con-

Ingredient	Claims	Mechanism, Safety, Efficacy
		taminant known as "Peak X" in tryptophan and 5-HTP supplements. A number of years ago, this resulted in a temporary ban of all products. For this reason, anyone purchasing these products should be sure to obtain them from a reputable manufacturer. Tryptophan and 5-HTP should not be taken with any medications that modify serotonin including anti-depressants, migraine medications, and some weight-loss drugs. Those with autoimmune disease, anxiety, liver disease as well and pregnant and breast feeding women should not take these products.
DHEA	Weight-loss, improved body composition	DHEA is an over-the-counter steroid hormone. In the body, it is made by the adrenal gland, and can be converted to estrogen, testosterone and other hormones. Studies on DHEA and weight-loss/body composition are really mixed. A one year trial of 15 patients with a topical cream showed no change in weight, but a significant reduction in fat mass along with increased lean body mass. A 10-week study in morbidly obese teens showed no benefit; ditto for a small study in obese men. DHEA is a hormone, so the safety – and whether it should even be sold over-the-counter- really needs to be questioned. Many side effects including breast tenderness, menstrual irregularities, mood changes and acne have been reported. Moreover, as it is a precursor to other hormones, there has to be a caution regarding cancer. There is not enough knowledge in this area to make self-medication with DHEA truly risk-free.
Conjugated Linoleic Acid (CLA)	Lose weight, burn fat, increase lean body mass	Conjugated Linoleic Acid or CLA is a conjugated or hydrogenated derivative of essential fat Linoleic Acid (LA). CLA has not been shown to cause people to lose weight, but has clearly been shown to cause loss of fat in people with excess body fat. Studies have shown that at one year, overweight people may lose up to nine percent of excess body fat, while conserving lean muscle. Other, mostly shorter, studies have largely shown similar results. One study of 40 overweight adults did show a small (2.2 pound) weight-loss compared to placebo after six months, as well as prevention of "holiday weight gain." Studies have generally shown that side effects are similar to placebo, and include gastrointestinal upset and fatigue. However, doses greater than three grams per day (which are commonly used in studies) may produce changes in serum lipids including decreases in HDL, LDL, and total cholesterol as well as possible elevation of Lp (a), so it may be wise for those using CLA to have their blood fats monitored by a physician.

To view the references cited in this article and chart, please visit the January 2007 issue of "OAC News" on the OAC Web site at www.obesityaction.org.

About the Author:

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 Advisory Board.

AdvocacyNews AdvocacyAction

Obesity and Stigma

Obesity discrimination is one of last forms of acceptable discrimination in today's society. Quite often obese individuals find themselves the target of discrimination in a variety of settings such as employment, healthcare, education and much more.

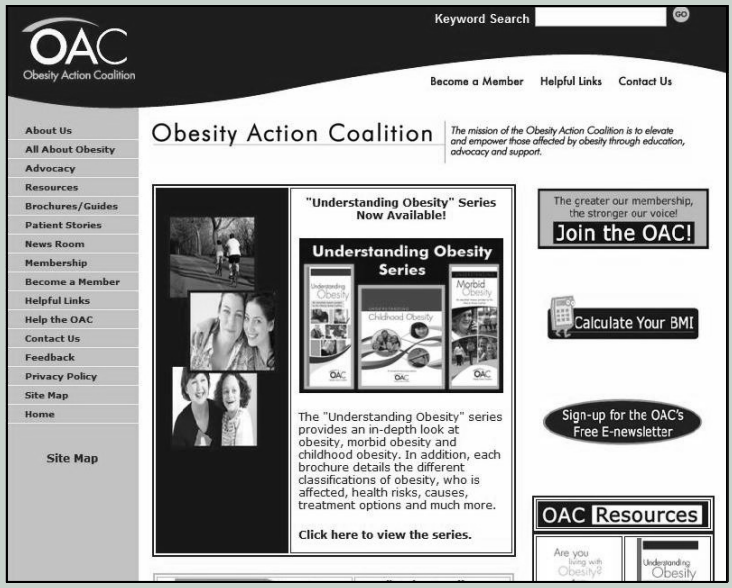
Consequences of Weight Bias

Taken together, the consequences of being denied jobs, rejected by peers, or treated inappropriately by healthcare 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.

Weight bias can have psychological, social and physical health consequences on those affected by this disease. Psychological outcomes can include depression, anxiety, low self-esteem, poor body image and much more. The social effects can be social rejection by peers, poor quality of interpersonal relationships and potential negative impact on academic outcomes. The physical health outcomes can include binge-eating and unhealthy weight-control practices.

Reducing the 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. 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.



Visit the new Obesity Stigma page, located under the "All About Obesity" section of the OAC Web site, at **www.obesityaction.org.**

How You Can Help

The OAC has recently developed a stigma section devoted to education and awareness of the stigma associated with obesity, morbid obesity and childhood obesity. The section discusses the negative stigma often associated with obesity and details ways to reduce the stigma associated with this disease.

If you see any examples of the negative stigma associated with obesity portrayed in your daily life, we encourage you to share them with the OAC by e-mailing **info@obesityaction.org**.

NEWS from the Obesity Action Coalition

OAC Releases "Understanding Obesity" Series

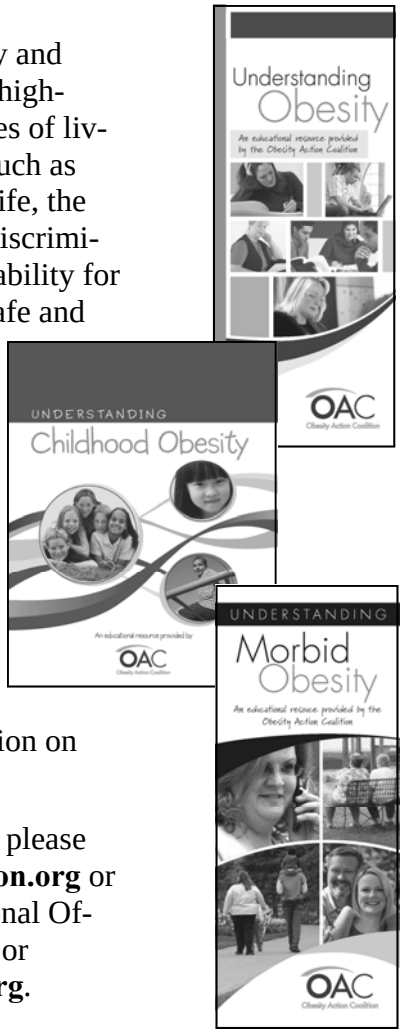
The OAC is excited to announce the release of its *Understanding Obesity* series. The *Understanding Obesity* series is comprised of three brochures, titled *Understanding Obesity*, *Understanding Childhood Obesity* and *Understanding Morbid Obesity*, and two 18x24 full color posters.

The brochures each separately provide an in-depth look at obesity, morbid obesity and childhood obesity. In addition, they detail the different classifications of obesity, who is affected, health risks, causes, treatment options and much more.

The *Understanding Obesity* poster compliments the brochure and features quick facts about obesity and its health risks. It offers readers a body mass index (BMI) chart to calculate their BMI and determine if they are underweight, normal weight, overweight, obese or morbidly obese.

The *Understanding Childhood Obesity* poster briefly explains childhood obesity, its causes and treatment options. In addition, it features a colorful boys and girls Weight-for-Age chart to determine a child's weight percentile range and category.

This series is an excellent tool for people wanting to have a better overall understanding of obesity, morbid obesity and childhood obesity and highlights the daily struggles of living with this disease, such as diminished quality of life, the impact of stigma and discrimination, the lack of the ability for individuals to access safe and effective care and much more.



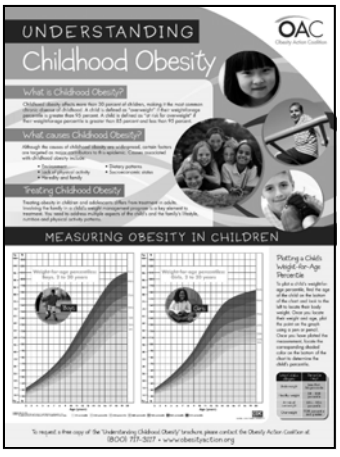
The *Understanding Obesity* series is an excellent resource for the general public, healthcare professionals, schools, community centers, fitness centers and others seeking more information on this disease.

To request free copies, please visit **www.obesityaction.org** or contact the OAC National Office at (800) 717-3117 or **info@obesityaction.org**.

"Understanding Childhood Obesity" Poster Now Available

The OAC's newest poster is designed to provide individuals with a basic knowledge of childhood obesity, its affects, the health risks associated with it and much more. The poster also features a weight-for-age chart that allows individuals to calculate a child's percentile and determine if they are classified as underweight, healthy weight, at risk of overweight or overweight.

This poster is an excellent resource for parents and healthcare professionals. The OAC encourages healthcare professionals, community centers, fitness centers, schools and others to order this poster. For more information or to order the poster free of charge, please visit the OAC Web site at **www.obesityaction.org**.



Childhood *continued from page 14*

When your children come face to face with less nutritious foods, it is important for them to learn to make choices to take care of their own bodies because they want to, and not because the parental "food police" say so. Be a good role model and display a balanced approach with creative alternatives. The occasional poor food choice is not a problem for a person who consumes a balanced, healthful food intake and exercises as part of their daily life. Helping children create sensible, healthy relationships with food is the key to ending the childhood obesity cycle, and moving us back toward a nation of healthy kids.

About the Authors:

Randal S. Baker, MD, FACS, is a bariatric surgeon at the Center for Health Excellence in Grand Rapids, Michigan. Dr. Baker served for several years as the Medical Director of the Surgical Intensive Care Units at Spectrum Hospital and is an Assistant Professor of Surgery at Michigan State University. He is a member of the American Society for Bariatric Surgery, the American Medical Association and the Society of Critical Care Medicine. He is also a member of the OAC Advisory Board.

Julie M. Hill-Janeway is the co-author of "The Real Skinny on Weight Loss Surgery: An Indispensable Guide to What You Can REALLY Expect!", and co-owns Little Victories Support Specialists and Little Victories Press. In October 2003, she underwent weight-loss surgery and to date has lost more than 180 pounds. Ms. Hill-Janeway is also a professor at Central Michigan University. She is a member of the OAC Board of Directors.

Karen Sparks, MBE, is a gastric bypass patient having had surgery in December 2003. She is a former Dean of Business Administration and Technology at Baker College, and has been teaching for 15 years in business and technology. She is the co-owner of Little Victories Press and Little Victories Support Specialists serving both bariatric patients and medical professionals and the co-author of "The Real Skinny on Weight Loss Surgery: An Indispensable Guide to What You Can REALLY Expect!"

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Grocery continued from page 9

When dealing with meats that are packaged for cold and hot sandwiches such as cold cuts and hotdogs, they need to be chosen carefully. Cold cuts should resemble the meat it came from not round or square. Also, note that items such as salami and bologna contain a lot of processed materials and have very little protein in them. Hot dogs are processed as well, so choose the ones that are made of all beef or turkey.

In Closing

I recently filmed a two part CookWise with Chef Dave grocery shopping video with dietitian Chris Corcoran, MS, RD/LD. The first is called "The Outer Limits." While I give you cooking tips and advice about how to pick the freshest melon, Chris explains how the foods are nutritionally beneficial.

The second, "The Inside Scoop," takes you on a guided tour of the inside aisles where the cookies, candy, breads, soda, juices, frozen and canned foods are located. The second show gives you the healthy scoop on what foods are best for you. These videos can be found online at **www.chefdave.org**.

About the Author:

Chef David Fouts received his Culinary Degree in 1994 from the Florida Culinary Institute in West Palm Beach, Florida. Soon thereafter he was hired by the prestigious 5 Star Diamond Hotel "The Breakers" in West Palm Beach, where he worked for several years. He currently is a key member on the staff at Foundation Surgery Affiliates as their Director of Bariatric Culinary Services.

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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