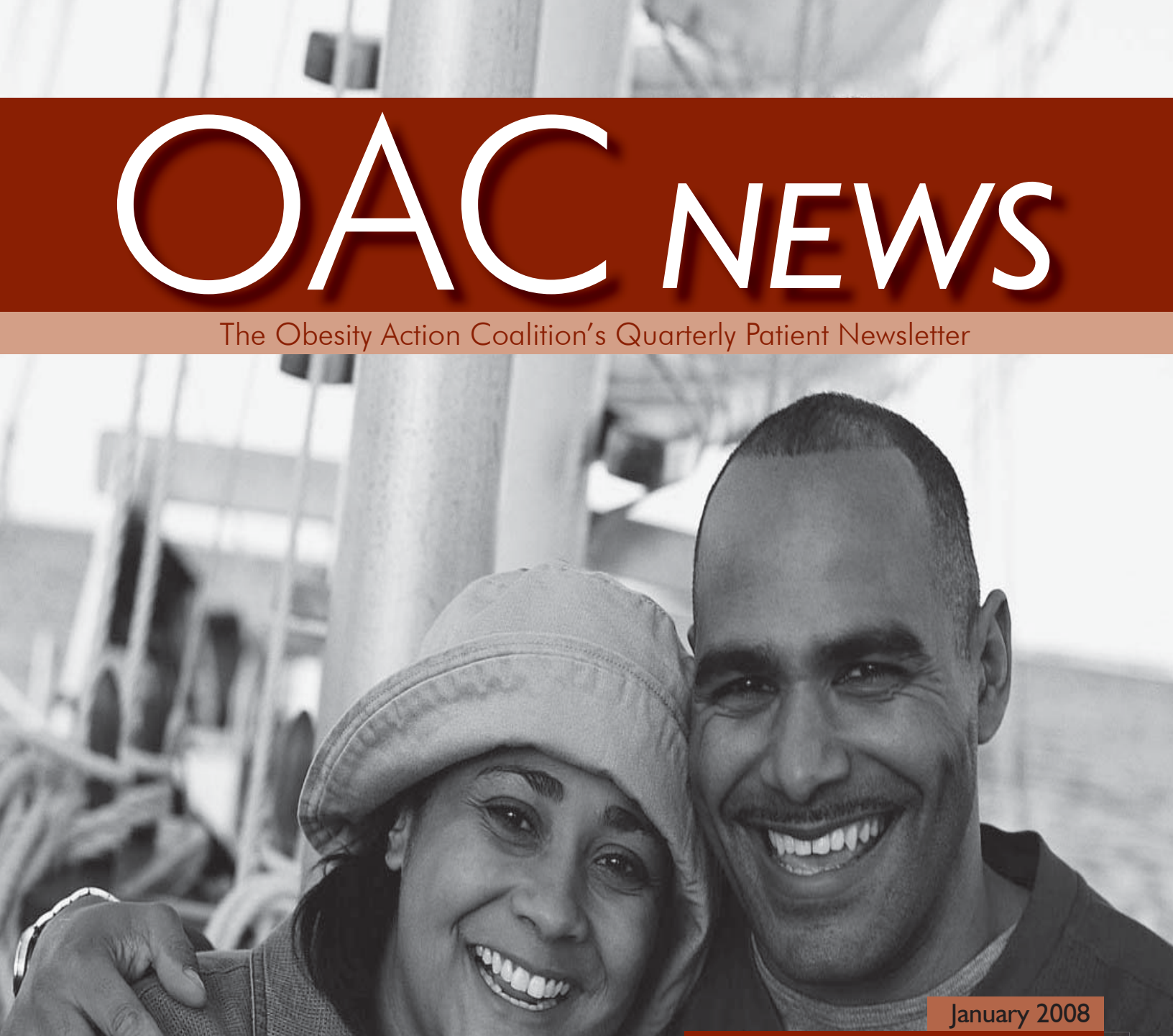
OAC NEWS

The Obesity Action Coalition's Quarterly Patient Newsletter



January 2008

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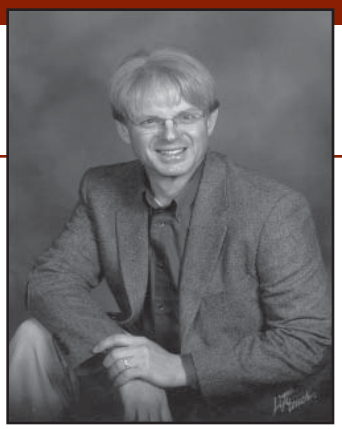
Obesity Action Coalition

A Message from OAC Chairman, Jim Fivecoat



In early November, the OAC National Board of Directors gathered in Tampa, Fla. for a full weekend of planning and to collectively develop a strategic plan for the next five years. While a weekend is not enough time to fully develop a complete long-term strategic plan, it was extremely beneficial in helping us focus our efforts for the next year.

We were able to produce an initial set of basic position statements, which are highlighted in this issue of *OAC News*. In addition, we explored and initiated projects to complete the following:

- Expand OAC membership
- Work collectively with legislative officials on various healthcare issues
- Educate employers on the importance of covering all types of weight-loss treatment
- Engage our members in proactive initiatives for the betterment of all those affected by obesity

I want to take this opportunity to personally thank each of the Board members for taking the time to attend the meeting and for all of their fantastic ideas toward improving our representation of all those affected by obesity.

In addition to the OAC's position statements, this issue of *OAC News* offers you a wide variety of articles focusing on many topics. In this issue, you will find articles discussing, high fructose corn syrup, self-monitoring, a Health Q&A on what to do as a bariatric patient if you relocate and need to continue your care, and much more.

As always, we strive to provide you, the reader, with the most up-to-date information in the obesity community and the latest news from the OAC. If there are any topics that you would like to see addressed in future issues of *OAC News*, please email them to **info@obesityaction.org** and we will be sure to consider them.

From everyone at the OAC, we wish you a Healthy and Happy 2008!

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

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

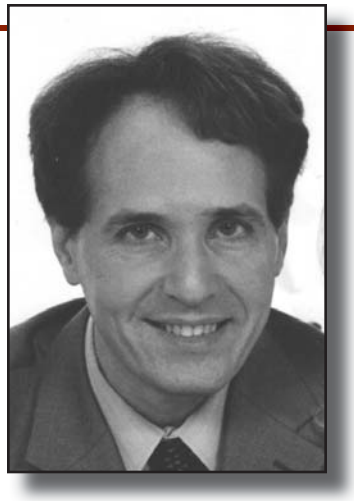
The OAC is governed under the authority of a National Board of Directors. Members of the OAC Board of Directors include: Jim Fivecoat, *Chairman*, Robin Blackstone, MD, Pam Davis, RN, CCM, Jacqueline Jacques, ND, Julie Janeway, BBA, MSA, JD, ABD/PhD, Georgeann Mallory, RD, Christopher Still, DO, FACN, FACP, and Barbara Thompson, MLS.

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.

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

Colon Cancer

Life-saving Strategies to Avoid this Preventable Cancer



By Edward Leigh, MA

"I am sorry to tell you this, but during the colonoscopy we found a tumor on your colon."

My doctor said those words to me in mid August 1999. My life would never be the same again. My wife, Beth, and I were enjoying our lives, when suddenly cancer decides to visit.

The colonoscopy revealed a large tumor on the right portion of my colon. I had surgery shortly thereafter, to remove one-third of my colon. On the last day of August 1999, I was informed that two out of 17 lymph nodes were positive, which put me in Stage III of the disease. I then began a year of chemotherapy, which was often debilitating.

Today, I am cancer free.

Before my diagnosis, I knew very little about colon cancer. I had actually been having abdominal problems for two and a half years. My family doctor attributed those issues to Irritable Bowel Syndrome. If I had known more about colon cancer, I would have realized that I needed to be further evaluated. Since experiencing my medical nightmare, I want people to know the facts about colon cancer, a very preventable illness.

First of all, we will use the term "colon cancer," however we are actually referring to cancer of both the colon and rectum, often referred to as "colorectal cancer." Colon cancer is the number one cancer killer among non-smoking adults. Ninety percent of cases are among people 50 years of age and older. The disease affects men and women in equal numbers. Also, more lives are lost each year to colon cancer than to AIDS and breast cancer combined.

Symptoms

Below are symptoms of colon cancer. However, these symptoms can be associated with other medical issues. Only a healthcare professional can determine the exact cause of the symptoms.

- Blood in or on the stool
- A change in bowel habits
- Stools that are narrower than usual
- Abdominal discomfort
- Frequent gas or indigestion
- Unexplained weight loss
- Chronic fatigue

Of course, everyone has a "stomach ache" now and then. However, the symptoms we are discussing are chronic. With the ongoing symptoms, an evaluation must be done. Unfortunately, as with my case, many people are not carefully evaluated and are told, "You have nothing to worry about." Be persistent in order to receive the proper care.

Risk Factors

There are a variety of factors that can put a person at increased risk for colon cancer, including:

- A personal or family history of colorectal cancer, colorectal polyps and certain hereditary syndromes
- Lack of regular physical activity combined with a diet low in fruits, vegetables and fiber, and a diet high in fat
- Being overweight or obese

Screening

Before discussing screening, there must be a clear distinction between screening and diagnosing. Screening is for people with no symptoms. If someone has ongoing symptoms, then they must be "diagnosed."

The best tool we have available is a colonoscopy. All healthcare professionals agree this is the best tool for a person with symptoms. The symptoms may indicate hemorrhoids, but we do not know until a colonoscopy is performed.

***Colon Cancer** continued on page 22*

Self-Monitoring

The Way to Successful Weight Management

By Stephanie F. Yeager, RD, LDN, Rose Heim, RD, LDN, Jamie Seiler, PA-C, and Holly Lofton, MD

One major and possibly most important behavioral interventional strategy for weight management and lifestyle change is self-monitoring.

Behavioral interventions are a central aspect in treatments to promote lifestyle changes that lead to weight-loss, prevent weight gain or weight regain and improve physical fitness.

In the past, self-monitoring has unfortunately been one of the least popular techniques for those in weight management programs, and in some cases it is even thought of as a punishment. Because self-monitoring is critical for success with lifestyle changes, it is important to look at the various self monitoring techniques.

What is Self-monitoring?

Self-monitoring refers to the observing and recording of eating and exercise patterns, followed by feedback on the behaviors. The goal of self-monitoring is to increase self-awareness of target behaviors and outcomes, thus it can serve as an early warning system if problems are arising and can help track success.

Some commonly used self-monitoring techniques include:

- Food diaries
- Regular self-weighing
- Exercise logs
- Equipment such as pedometers, accelerometers and metabolic devices

Food Logs and Diaries

One of the most common and important types of self-monitoring strategies in weight management programs is keeping a food log, in which individuals record foods, exercises or beverages as soon as they are consumed.

One important technique with food logs is individuals recording what they eat or drink as it is consumed; otherwise it may not

give an accurate account of the day's intake. A good "rule of thumb" for food logs is: "if you bite it, you write it!"

The minimum information for weight-loss that should be kept in food logs is type, amount and caloric content of food or beverage consumed. This provides the ability to track and balance the number of calories consumed throughout the day with the amount of calories expended throughout the day.

Other nutritional information that can be logged include: time of day of eating, fat content and carbohydrate grams. Disease-specific food logs can also be kept. For example: focusing on carbohydrate content instead of calories for patients with diabetes or insulin resistance.

Food Diaries

Another helpful tool in self-monitoring is keeping a food diary. Food diaries differ from food logs because they include more detailed information. They are useful if you are trying to find behavioral reasons or psychological aspects for eating.

Depending on the person and behavioral complexities involved, some food diaries could include the stress level, mood or feelings surrounding eating, activity or location or other environmental or emotional triggers for eating. The more complex or detailed, the better the feedback.

However, in today's society it is almost impossible for most people to keep highly detailed daily food records over the long-term, therefore, compliance is often very low with detailed food diaries. By suggesting that patients keep a detailed food record for a few days each week, perhaps major areas of focus for nutritional and behavioral intervention can be recognized.

Logging Your Food Online

Online food logs and diaries or computer software are quick and convenient ways to keep records of foods consumed in our technologically advanced world. Many Web sites are available for tracking of foods and calories throughout the day, some of which are free and very easy to use.

You can look up food choices and/or alternative choices in online databases of more than 50,000 foods. Internet-savvy loggers may choose to keep their journals online. Others may just choose to use these databases as a more convenient way of looking up nutritional value of foods. Some free online diaries include:

- www.myfooddiary.com
- www.sparkpeople.com
- www.my-calorie-counter.com
- www.myfitnesspal.com
- www.fitday.com

Free Web sites for searching nutritional information are available, an example is **www.calorieking.com**. These Web sites may also offer exercise tracking and ideas, support, motivational tips and chat or discussion rooms.

Hand-held Calorie Counters

Another option for those who are "on the go" are handheld devices for calorie counting. Some of the devices are stand-alone such as CalorieSmart® or HealthFitCounter®. Others need to connect to Web sites. Other devices are installed in your Palm or Pocket-PC such as Diet Diary by Calorie King. They let you download updates when nutrition facts change, however, some of them use a lot of memory.

Regular Weighing

Weighing yourself is an important and simple self-monitoring behavior to serve as reminder of one's eating and physical activity habits. Although it may be hard and sometimes discouraging to weigh yourself while losing weight, it is recommended to weigh yourself weekly, preferably outside of the home on the same scale.

Using the scale at the local gym or exercise facility or your doctor's office may be more accurate than home scales. However, if this is unrealistic, it is okay to use a home scale. Try to weigh yourself at the same time of day and the same day of the week.

Writing down your weekly weights on a table, graph or calendar can help you keep track of your success or to help you get back on track more quickly. It is important to note that weighing yourself more frequently than weekly is not recommended, as day to day fluctuations are not indicators of actual weight. Regular monitoring of your weight is also essential to help you maintain your weight after losing weight.

Exercise Logs

Another self-monitoring technique, along the same lines as food logs and diaries, is keeping an exercise log or diary. The number of minutes engaged and type and level of exertion of physical activity should ideally be recorded.

Self-monitoring *continued on page 6*

Self-monitoring *continued from page 5*

An important and often forgotten aspect of exercise logs is the level of perceived exertion. Walking for 30 minutes, at an easy compared to a hard pace, will result in different levels of calories burned and cardiovascular impact.

Typically, an easy physical activity that does not increase heart rate much, or alter breathing would usually be the pace that you walk around work or go shopping. Moderate level of physical exertion is when you are getting a mildly increased heart and breathing rate. Heavy or hard level of physical exertion would be sweating, increased heart rate (target heart rate range) as well as increased breathing.

Remember, physical activity can be done at one time or intermittently throughout the day. Logging exercise can be a positive feedback or a reminder to incorporate more exercise or physical activity into your daily routine.

Initial activities may be walking, riding a stationary bike or swimming at a slow pace. Other types of exercise that can be fun are dancing, exercise videos or chair exercises. You should try to aim for 30 minutes of exercise on most days of the week.

Many people try to start out with exercise on three or four days of the week. However, if you can get yourself exercising most to all days of the week, even if only for 10 or 15 minutes, it will become more of a routine for you.

Pedometers

Self-monitoring tools are becoming more and more popular and accurate. One of the simplest of these self-monitoring tools is a pedometer. Pedometers give objective data of physical activity throughout the day. Pedometers can be found in almost any consumer catalog or retail store.

Some of the more popular manufactures include Digi-Walker, Omron, Acumen, Bodytrend, Oregon Scientific, Sportline, Freestyle, Brookstone, AccuStep and many others. Garmin and Timex make pedometer of speedometer devices that calculate steps and speed using GPS. These clip-on devices are inexpensive, ranging from less than $15 up to $75.

Many people get an average of 3,000 steps per day with daily activity. In order to burn off extra calories for weight-loss, walking 10,000 steps per day is recommended. For regular health, a minimum of 6,000 steps per day is required. Research suggests that a deliberate walk of 4,000-6,000 steps will help with weight-loss. It is often a good idea to keep track of your daily steps taken in your exercise log.

Pedometers can be frustrating for those who are more interested in distance traveled. Focusing on the number of steps and ways to incorporate more steps throughout the day will make as much of a difference with weight-loss as actual distance does. Pedometers encourage people to find ways to add more steps throughout the day.

Because step counting is becoming more popular, advances are being made in the technology behind pedometers. New pedometers display steps and count them accurately. They are meant to be worn everyday and all day, as motivation to keep stepping, Most are small and comfortable to wear.

Pedometers sense your body motion, counting your footsteps usually by a turned pendulum technology, a coiled spring mechanism and a hairspring mechanism (which is the least accurate). The unit should be accurate in its count when you wear it correctly. You may need to experiment with where to wear it. You can measure your stride and then the pedometer can estimate distance traveled.

Some pedometers today offer multifunction options like calorie estimates, clocks, timers, stopwatches, speed estimators, seven-day memory or pulse rate readers, voice feedback and radios.

Accelerometers

Although pedometers are very cost effective, one of the main flaws in using pedometers, however, is that they do not record intensity (how hard) or duration (how long) or frequency (how often) movement occurs. Accelerometers are devices that can objectively measure frequency, duration and intensity of physical activity.

Accelerometers provide a high level of accuracy when assessing physical activity. There are a variety of commercially available accelerometers, or activity monitors, which come in a wide range of prices anywhere from $50 to $1,000. BioTrainer and Nike are examples of affordable accelerometers.

Many of the more expensive accelerometers are used only in research or as a part of a hospital-based program. These monitors are more complex than pedometers in that they display and store more complex data. Some are designed to download to a computer for analysis of intensity levels, movements and

Healthy Lifestyle Tip

All adults should set a long-term goal to accumulate at least 30 minutes or more of moderate-intensity physical activity on most to all days of the week.

Also, try to increase activities of daily living such as taking the stairs instead of the elevator, parking further away or walking to a bathroom that is further from your desk.

Reducing sedentary time is a good strategy to increase activity by undertaking frequent, less strenuous activities. With time, you may be able to engage in more strenuous activities.

physical activity patterns. They can also be used to estimate calories burned or energy expenditure.

Accelerometers have sophisticated sensors that convert physical movement into an electrical signal that is relative to the muscular force needed to produce the work. Accelerometers can be found in uniaxial or triaxial measures. Uniaxial accelerometers measure in a single plane and can be attached to the trunk or limbs. Triaxial accelerometers measure along three planes: vertical, medial-lateral and anterior-posterior.

Although accelerometers are a step up from pedometers in accuracy of physical activity, they cannot register resistance. Therefore, if you are strength training or adding resistance to your bike or treadmill or adding an incline to your walking, it will not be able to discern the added level of energy required to do that work.

Metabolic Devices

One of the most accurate and most expensive tools for self-monitoring are tools that have very sophisticated monitoring and interpreting sensors for calories burned. Many of these devices have options to subscribe to a Web-based calorie counter system that integrates the amount of calories burned measured by the equipment and your calories consumed that you enter in easy to use food logs.

These devices are more accurate in measurements of calories expended because they use not only accelerometer technology, but also heat flux sensors, galvanic skin response (to measure physical exertion and emotional stimuli) and skin temperature gauges. Some also include heart rate monitoring techniques. All of these technologies combined lead to a very accurate measurement of calories expended throughout the day.

These devices can determine if you are sitting, sleeping, jogging, walking, lifting weights or riding in a car. Many of these devices are very expensive and used primarily for research, however, some are available commercially.

This technology is also employed by hospital-based programs. Patients wear the hospital's armband and track their nutrition on the Web site or computer-based program for typically one to two weeks. When they return to the clinic, the information will be uploaded and the practitioners will be able to work with the patients with objective data on metabolic lifestyle patterns.

Practitioners can also monitor patients on integrated software applications to provide consultations without being face to face. Practitioners have the ability to set daily goals to tailor programs to the individual patient. These are great tools to help objectively monitor behavior and physical activity, as well as providing real time feed back to the patient. SenseWear® is one company that offers this technology.

Conclusion

Although specific diseases and treatments vary, behavior modification is the major key in weight-loss or prevention and decreases the risk of diseases. Self-monitoring is a key to behavior modifications, and there are a multitude of ways to self-monitor.

With technology advancements, self-monitoring techniques are changing and improving to help defeat some of the major barriers to compliance. The bottom line is that no matter how you do it, self-monitoring should be an important part of your weight-loss, weight maintenance or healthy lifestyle change. Then, the next step is to be sure the self-monitoring translates into positive behavior changes with regards to diet and exercise.

About the Authors:

Stephanie F. Yeager, RD, LDN, has been with the Center for Nutrition and Weight Management at Geisinger Health System since 2002. She completed her Bachelor's in Nutritional Sciences and Exercise Physiology at Penn State University in 2002 and her Dietetic Internship at Geisinger Medical Center in 2004. Stephanie is actively involved in multiple research studies on obesity and has authored and co-authored research publications and book chapters on topics such as behavior modification and outcome evaluation of vitamin and mineral requirements, genetics, metabolism and quality of life after bariatric surgery.

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Holly F Lofton, MD, is currently a fellow in the Bariatric Medicine/ Nutrition program at Geisinger Medical Center under the direction of OAC Board of Director Christopher Still, DO. Her primary interests are improving nutrition and activity profiles for overweight and obese patients and educating the public on the importance of preventing obesity.

Know Your Fats

By Jacqueline Jacques, ND

If you are confused about fats, you are far from alone. Now, all the talk is about "healthy fats" or avoiding "trans fats," but many do not fully understand these terms. Here are the basics.

Your diet contains three macronutrients that make up the building blocks of the foods we eat: protein, carbohydrate and fat. Also called lipids, fats can be broken down into sub-types based on their form and functions. Fats play many important roles in human health, including:

- Helping carry fat-soluble vitamins (like A, D, E and K) into your body
- Helping form the structure of your cells
- Supplying energy, the form of the backbone of many hormones
- Contributing to the health of your brain, eyes, skin, joints and much more

Types of Fats

Saturated – Saturated fats are those fats that are solid when they are at room temperature and turn into a liquid oil when heated. All fats are made up of carbon, hydrogen and oxygen.

In a saturated fat, all the carbon bonds are occupied by or saturated with hydrogen molecules. These fats are mostly found in meat, egg yolks and full-fat dairy foods. They are also found in few non-animal products such as coconut, cocoa butter and palm oil. Saturated fats are known to contribute to elevated cholesterol and are associated with heart disease risk when consumed in excess.

Monounsaturated – These fats tend to be solids when refrigerated and liquids at room temperature. Monounsaturated fats have one set of carbon atoms that are linked to each other by a double bond and not to hydrogen molecules. Thus "mono" – meaning "one" – for one site that is not saturated.

Though this sounds like a small change, the difference is quite large when it comes to health. Monounsaturated fats are known to be some of the healthiest around. These include olive oil, canola oil and peanut oil. Oils and foods that are high in monounsaturated fat help to decrease LDL or "bad" cholesterol levels.

They are also good choices for cooking, as they are much more stable than other oils and are not prone to being damaged by heat. Foods high in monounsaturated fat include avocado, peanuts, cashews, almonds, pumpkin seeds and sesame seeds.

Polyunsaturated – Polyunsaturated fats are primarily vegetable oils and some fish oils and are liquid both in the refrigerator and at room temperature. "Poly" means "many." As you can probably guess by now, they are called polyunsaturated because more than one set of carbon atoms are bound to each other instead of to hydrogen.

There are different kinds of polyunsaturated fats, and some are good, while others are not. In general, these fats are delicate and can be damaged by light and heat. They should be kept refrigerated to prevent rancidity and are not the best choice for sautéing or frying. These fats include oils such as corn, safflower, sunflower and cottonseed. Food sources include walnuts, fatty fish and soybeans.

Essential Fatty Acids or EFAs – As the word *essential* implies, this group of fats are a requirement for normal health and cellular function. The body cannot make these fats itself, so it must, as with essential vitamins and minerals, obtain them from an outside source such as a food or a dietary supplement.

Technically speaking, there are only two EFAs: the Omega-6 fatty acid Linoleic Acid (LA) and the Omega-3 fatty acid Alpha Linolenic Acid (ALA). From these, the body can derive the other four essential fatty acids: Gamma Linolenic Acid (GLA), Eicosapentaenoic Acid (EPA), Docosahexaenoic Acid (DHA), and Arachadonic Acid (AA). These four can also be ingested pre-formed.

Good sources of EFAs include fatty fish and fish oil, flax oil, borage oil, walnuts, vegetable oils and pumpkin seeds. The best health research, however, points primarily to the benefits of fish and fish oils, including sources such as anchovies, mackerel, salmon, tuna and halibut.

Hydrogenated and Partially Hydrogenated Fats – Hydrogenation is a process that literally adds more hydrogen to an unsaturated fat, making it more saturated, therefore more solid. A fat is partially hydrogenated if it still remains somewhat unsaturated. It is fully hydrogenated if it becomes fully saturated.

Hydrogenation can also generate the undesirable *trans fatty acids* (described below). Hydrogenated and partially hydrogenated fats are man-made. They are found in margarine, vegetable shortening, and many baked goods. They are frequently used in baked goods to extend the shelf life of a product.

Trans Fats – Trans fats or trans fatty acids are created when a fat is partially hydrogenated *(see above)*. Technically, the "trans" refers to the fact that the hydrogens are attached on opposite sides of the carbon molecules (versus on the same side, which would be "cis").

Trans fats have received a lot of attention lately in relation to their role in cardiovascular disease. It is believed that they act in the body more like saturated fats than unsaturated fats, and studies have shown that they both increase LDL (bad) and lower HDL (good) cholesterol.

In 1999, the United States Food and Drug Administration (FDA) wrote legislation proposing the mandatory labeling of trans fatty acid content of foods. This was passed in 2003, and labeling was required starting January 2006. In December 2006, New York City passed a law to ban artificial trans fats at all restaurants by July 2008. Other cities and states are considering similar legislation.

USDA Dietary Guidelines Recommend the Following:

- Consume less than 10 percent of calories from saturated fatty acids and less than 300 mg/day of cholesterol, and keep trans fatty acid consumption as low as possible.
- Keep total fat intake between 20 to 35 percent of calories, with most fats coming from sources of polyunsaturated and monounsaturated fatty acids, such as fish, nuts and vegetable oils.
- When selecting and preparing meat, poultry, dry beans, and milk or milk products, make choices that are lean, low-fat or fat-free.
- Limit intake of fats and oils high in saturated and/or trans fatty acids, and choose products low in such fats and oils.

U.S. Department of Health and Human Services and U.S. Department of Agriculture. Dietary Guidelines for Americans, 2005. 6th Edition, Washington, DC: U.S. Government Printing Office, January 2005.

The trans fat content of a food can be found in the Nutrition Facts box right under the saturated fat content. If the product has 0.5 g or less per serving, then the content can be listed as zero. Trans fatty acids are commonly added to commercial baked goods and processed foods to provide stability. Common sources are margarine, French fries, doughnuts, crackers, microwave popcorn, chips and cookies.

Cholesterol – Cholesterol is a fat-like substance that is both made by humans and found in fat-containing animal products in varying amounts. Cholesterol is important to the structure of all cells and is the precursor to the creation of steroid hormones like estrogen and testosterone.

Most of the cholesterol in your body is made by you, and often the amount of cholesterol a person makes (as well as the type) is greatly influenced by genetics. Daily cholesterol intake in excess of 300mg/day from dietary sources can raise blood cholesterol levels and contribute to heart disease.

All sources of dietary cholesterol are from animal products such as eggs, shellfish, dairy products, beef and poultry. Cholesterol can be further broken down into subtypes including LDL, HDL, VLDL and lipoprotein a [Lp(a)]. Your doctor may look at these "cholesterol fractions" and their ratios to determine your risk for cardiovascular disease.

So now you can see that there is both good and bad in the fats we eat. When we are looking at diet, there are some general guidelines that can help to simplify how you look at fat in your food.

***Fats** continued on page 11*

Health Q&A

I'm a Weight-loss Surgery Patient and I am Relocating.

Where should I go to seek care if I need it?

By Laura M. Boyer, RN, CBN

The decision to treat obesity with weight-loss surgery (WLS) includes making a lifetime commitment to follow-up care. This means the surgeon and the program team commit to providing care and guidance. You, the patient, commit to periodic appointments for evaluation and receiving that care and guidance. So what should you do when you relocate?

In the case of a well-planned move, you should start with a little research. Not all surgeons and programs accept outside patients. Your surgeon may refer you to a colleague in your new location. In this case, it should be easy to have records and important information forwarded as well as a referral letter describing your history and care.

Resources for locating bariatric surgeons and programs in the area can also be found on the Internet. The medical and professional organizations provide Web site information. I have included them at the end of this article. There are also many Web sites where WLS patients network. Ideally, before you actually make the move, you should locate a program that will "adopt" you. I recommend contacting them well in advance to ask for information.

Questions You Should Ask:

- Do you accept patients from outside programs? If so, what documents do I need to provide?
- What types of WLS procedures are done and how many have been done by your surgeon(s)?
- What resources are available, such as nutritional instruction, psychological support, support groups and exercise programs?
- What is the recommended follow-up schedule?
- Do you accept my insurance? *(If you do not have insurance coverage for bariatric surgery care, ask about cost and the care that is included in that cost.)*
- Are there any additional expenses or program fees involved with assuming my care?
- Do you use fluoroscopy for routine adjustments for adjustable gastric band patients? If so, is there an additional charge?
- Can you recommend a primary care physician in the area?

Laparoscopic Adjustable Gastric Banding Patients

If you have an adjustable gastric band, maintaining a regular schedule for adjustments is essential to your success, especially if you are still in the process of losing excess weight. The doctor who assumes your care needs information about the type and size of the band, as well as the operative technique.

For that reason it is a good idea to have a copy of the operative report from the original surgeon. Information about your health and illnesses, test results, previous adjustments and weight-loss is very helpful to develop a plan of care that picks up where you left off.

Although nutritional deficiency is uncommon in band patients, annual nutritional blood work should be a part of that plan. Anytime you have an implanted device, you should have specific information about the manufacturer, model and size.

Patients who Underwent a Malabsorptive Weight-loss Surgery Procedure

WLS patients who have had malabsorptive procedures, such as biliopancreatic diversion (BPD), duodenal switch (DS) or Roux-EN-Y gastric bypass, must obtain healthcare that includes periodic nutritional blood work. Lifetime nutritional supplements and annual blood work are essential to preventing malnutrition and potentially irreversible illnesses.

For this reason, it is important to find a physician with knowledge of your specific nutritional needs. There are a growing number of physicians who specialize in the treatment of obesity and the care of postoperative WLS patients called bariatricians. Very often they are associated with comprehensive weight-loss and surgery programs. To locate a bariatrician, please visit the American Society of Bariatric Physicians' Web site at **www.asbp.org**.

Weight-loss Surgery Patients and Follow-up Care

WLS patients often need less medical attention as their obesity-related illnesses, such as diabetes and high blood pressure, improve. However, it is important to remember that you should continue to monitor these conditions and find a primary care physician for proper care and medication adjustments as needed.

WLS patients, who develop abdominal symptoms that may be surgery-related, should always consult a surgeon who specializes in bariatric surgery. These symptoms might include vomiting, acid reflux, unexplained fever, change in bowel habits, blood in stool, abdominal pain or drainage from the port incision area. Establishing a relationship for follow-up care with a comprehensive program is the best way to prevent nutritional complications and to detect surgical complications before they are serious or life-threatening.

Finding a New Support Group

An important key to your weight-loss success is emotional support. Attend a support group as soon as you can. This will provide the support you may need during a potentially stressful event, as well as a network of friends in your new location. If you have contact with the program coordinator before the move, ask if there are any supportive patients who would be willing to communicate with you by email. This will provide a link to the group before you attend the meeting.

During an Emergency

One last area to discuss would be the situation when a WLS patient travels or finds themselves suddenly relocated; such as an evacuation due to a disaster. The motto, "always be prepared," comes to mind.

Always have your surgeon's contact information, including Web site or email address. It is a good idea to have a copy of the operative report that contains the procedure description. You can request this from the hospital or your surgeon's office within a month after your surgery.

If you have an adjustable gastric band, you should know the manufacturer, model and size. Make sure you have at least a two week supply of medications and vitamin/nutritional supplements that is handy and ready to travel at all times. In cases of emergency, always notify your caregivers that you are a WLS patient. It is best to consult a bariatric surgeon whenever an abdominal or pelvic condition is treated. At the very least, the doctor who is caring for you should call your surgeon for information and advice.

Recommended Resources:

- American Society for Metabolic and Bariatric Surgery **www.asmbs.org**
- American Society of Bariatric Physicians **www.asbp.org**
- American College of Surgeons **www.facs.org**
- Surgical Review Corporation **www.surgicalreview.org**

About the Author:

Laura M. Boyer, RN, CBN, has been Director of the Bariatric Surgery Program for The Surgical Specialists of Louisiana, serving the southern Louisiana area, since its inception in 2001. She has been a Registered Nurse for 25 years with experience in peri-operative and critical care.

***Fats** continued from page 9*

Some other general ideas for keeping a fat-healthy diet include:

- Read labels on prepared foods. Become familiar with foods that are high in fat, especially those high in trans fats, saturated fat and total fat content. Look at the ingredient list to see if products contain hydrogenated or partially hydrogenated fats.
- Choose healthy vegetable oils from olive, grape seed, corn, canola and sunflower.
- Try to include healthy sources of fats such as fish, nuts and seeds in your diet several times weekly.
- Limit your intake of fried foods and rich fatty foods such as cream sauces, ice cream and full-fat mayonnaise. Eliminate or reduce fried foods such as French fries, fried chicken, potato chips and most things that are "breaded." Choose baked, grilled, steamed or poached alternatives.
- Be wary of bakery good such as doughnuts, muffins, cookies and crackers that are frequently sources of hidden trans fats.
- Include a good variety of naturally low-fat and fat-free foods in your diet such as fruits, vegetables, whole grains, lean meat and poultry, low/non-fat dairy products and legumes (beans and peas).
- Practice portion control. Most fats are fine in moderation. Fats (9 per gram) have more than twice the calories as protein and carbohydrate (4 per gram). That means that the calories from fatty foods add up much faster. So it is fine to have peanut butter or use some half and half in your coffee so long as you don't use very much or use them all the time.

About the Author:

Jacqueline Jacques, ND, 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 National Board of Directors.

New Online Resource Identifies Healthier Choices at Restaurants

By Erica Bohm, MS

If you're like most Americans, more and more of your meals these days are being prepared by restaurants and other food service establishments. In fact, according to the National Restaurant Association, close to 50 cents of every food dollar is spent away from home – equating to four to five meals per week, on average.

When perusing a restaurant's menu, it isn't always easy to identify the healthier choices. But now, a recently launched Web site, developed by a team of health and nutrition professionals, has come to the rescue of those whose lifestyle or personal preference involves frequent visits to restaurants.

At HealthyDiningFinder.com, health and weight-conscious consumers can "search" for restaurants that offer a selection of healthier choices.

How it Works

You start by specifying your geographic location, preferred price range, and if desired, availability of take-out, delivery and catering. A list of "matched" restaurants will appear. Clicking on any of them links you to a list of that restaurant's healthier dishes – up to 10 of them – along with corresponding nutrition information: calories, fat, saturated fat, protein, carbohydrates, cholesterol, sodium, sugar, fiber and fruit/vegetable servings.

You'll find everything from fast food to upscale dining on the site. Restaurants don't need a reputation of being "healthy" to be included on HealthyDiningFinder.com. In fact, the program encourages all types of restaurants to join Healthy Dining and HealthyDiningFinder.com and offer a selection of *better for you* choices.

Menu items posted on the site must meet Healthy Dining's nutrition criteria (i.e., entrées or full meals must include lean protein, fruits and/or vegetables or whole grains, and they may not contain more than 750 calories, 25 grams of fat and 8 grams of saturated fat. Many of the featured dishes weigh in at much less.).

For appetizers, side dishes and desserts, the cut-offs are scaled down to 250 calories, 8 grams of fat and 3 grams of saturated fat. No fried foods are listed, aside from very small amounts, as in a garnish; and a maximum of two red meat dishes are listed for any restaurant. Healthy Dining's registered dietitians review and approve all the menu items before the items are posted on the site.

"Special Requests"

Some featured items include a "Special Request," a simple modification in the dish's preparation developed in collaboration with the restaurant, which reduces the amount of calories and fat. Examples include reductions in the amount of cheese, oil, sauce or dressing. Specific amounts are noted in a "Special Request."

About HealthyDiningFinder.com

HealthyDiningFinder.com was developed by California-based Healthy Dining. Its team of health and nutrition professionals has been dedicated to restaurant nutrition for almost two decades.

Since 1990, they have been providing computerized nutrition analysis and consultation to Southern California restaurants and

publishing a series of books that feature healthier menu choices and corresponding nutrition information.

In 2004, the Centers for Disease Control (CDC) and Prevention awarded Healthy Dining a grant to develop an online, nationwide version of their Southern California publication-based program.

HealthyDiningFinder.com launched in March 2007. Approximately 50,000 restaurant locations are participating to date, and more restaurants are joining regularly. The first phase of the project has focused on chain restaurants – both nationwide and regional. In the coming months and years, outreach to smaller and independent restaurants will ramp up.

Through HealthyDiningFinder.com, consumers have an easy way to identify the healthier choices at restaurants. And equally important, the Healthy Dining Program is a vehicle that guides, motivates and recognizes restaurants with respect to offering and promoting healthier choices.

About the Author:

Erica Bohm, MS, is vice-president and Director of Strategic Partnerships for Health Dining. Erica develops strategic partnerships within the restaurant industry and health community, coordinates restaurant enrollment and promotes the Web site to the media and the public. She has been with Healthy Dining since 1993.

7 MYTHS about Restaurant Dining and Nutrition

1. Chicken and fish are always good choices.

Sure, chicken (specifically white meat) and fish are lower in calories, fat and saturated fat than red meat. However, other factors play a role as well, such as portion size, preparation method, and sauces and other added ingredients, like oil or cheese.

2. Red meat dishes are not good choices for the health-conscious.

True, the less red meat in the diet, the better. However, those who enjoy red meat can do so, keeping four guidelines in mind:

- Select lean cuts (like sirloin).
- Trim the visible fat.
- Limit red meat to once or twice a week.
- Monitor portion size.

Since 3-4 oz. of protein is the recommended portion size per meal, consider the following options when restaurant dining:

- Share a red meat entrée with your dining companion and complement it with a white meat entrée or extra side dish.
- Take some of the dish home to enjoy the next day.
- "Bank" part of your protein allotment from other meals of the day to allow for a larger portion during your meal out.
- Try Asian dishes, which often combine protein with vegetables, as they provide a great way to limit the amount of red meat.

3. Vegetarian dishes are always healthy.

Americans are falling short of the recommended servings of fruits and vegetables – sources of good nutrition. That doesn't mean that all vegetarian dishes are good choices. Dishes that contain a lot of cheese, oil or nuts could be very high in calories, fat and even saturated fat (cheese). And some vegetarian dishes do not include many, or even any, vegetables. Be mindful, even when selecting vegetarian menu items.

4. Restaurant dining is for special occasions, so why not splurge a bit?

Decades ago, restaurant dining was, indeed, reserved for special occasions. But for many people today, restaurant dining is the norm, not the exception. Therefore, most people wouldn't want to make every restaurant occasion an opportunity to splurge.

5. A heart next to a menu item indicates a low-calorie selection.

Sometimes, perhaps, but not necessarily. The heart may have been placed there because the dish contains heart-healthy olive oil, lacks preservatives, contains omega 3 fatty acids or is vegetarian. The best policy is not to make assumptions. Restaurants that have joined the Healthy Dining program may display the Healthy Dining logo on their Web site or menu. Participating restaurants agree to offer a selection of healthier menu choices, which are reviewed and "approved" by Healthy Dining's dietitians.

6. Fast food restaurants do not have any good selections if you're watching your weight.

You can get some great selections at fast food establishments, including salads, grilled chicken and fish, fruit, yogurt and even whole grains. There are always choices that will meet your calorie and fat budget.

7. It is easy to spot the healthier choices on restaurant menus.

Restaurant menu descriptions are not always complete, so you just do not have all the information required to make an informed choice. A knowledgeable server can be helpful, but diners looking for nutrition information will be best served by checking the Web sites of individual restaurants or visiting HealthyDiningFinder.com for a centralized source of nutrition information for restaurant meals.

High Fructose Corn Syrup

By Jacqueline Jacques, ND

Increasing articles, both scientific and not, have been pointing fingers at this sweetener as a serious contributor to our rising rates of obesity here in the United States. So, what's the story?

If you haven't heard the growing controversy about high fructose corn syrup (HFCS), then you will.

Normal cornsyrup is 100 percent glucose, a simple sugar that is the primary sugar used by humans for energy. When someone refers to your blood sugar, they are referring to your blood glucose.

What is High Fructose Corn Syrup?

HFCS is not the same thing as simple corn syrup. It is made by using an enzyme to convert the glucose to fructose, a different simple sugar. A blend is then made between this new substance and regular corn syrup to create a standardized product with a precise ratio of fructose to glucose. The most common forms of HFCS are HFCS 42 (the common form used in baked goods), which is approximately 42 percent fructose and 58 percent glucose and HFCS 55 (the form used in soft drinks), which is approximately 55 percent fructose and 45 percent glucose.

How High Fructose Corn Syrup Evolved

Before 1970, most things in the U.S. that were sweetened were sweetened with cane sugar. Between the mid-70s and the mid-80s, much of the cane sugar used in the U.S. food industry was replaced with HFCS. There are several reasons for this.

One reason is that sugar became more expensive. Because of the laws to encourage the use of our own domestic sugar supplies (such as those from Hawaii), it is very expensive to import cheaper foreign sugar into the U.S. Conversely, because of farm subsidies, the price of corn in our country is artificially low. So sometime in the early 1980s, it became much cheaper for food companies to use HFCS than to keep using cane sugar (it was in 1984 that both Coke and Pepsi made the switch).

High Fructose Corn Syrup – What is the Link with Obesity?

As people search for a cause for the obesity epidemic, one place they look is changes in dietary habits. HFCS, as a relatively new ingredient in the American diet, and one that is found in many unhealthy foods and caloric drinks, has raised many eyebrows. Research has also looked at the possible connection, resulting in mixed messages.

If there is one connection that is obvious it is this: Calorie consumption in the U.S. has climbed steadily for many decades. One major source of "new" calories in the U.S. diet is sweet beverages such as sodas. (U.S. soft drink consumption grew 135 percent between 1977 and 2001.)[1]

Making the switch between cane sugar and HFCS in soda and other sweetened drinks made them cheaper, allowing for things like "super-sizing" to become possible, and increasing even more the calorie load from these sources.

For this reason, you will find some people who are concerned about obesity trying to make amendments to legislation such as the Farm Bill[2], with the hope that making corn products more expensive would ultimately reduce the consumption of HFCS-laden drinks.

So what about a scientific link between HFCS and obesity? Several scientific papers published in early 2000 theorized a direct connection between HFCS and obesity. These papers primarily argued along two lines of thought. One was the issue discussed above of increased consumption and super-sizing. The other is based on the metabolism of fructose.

Fructose and its Role

Fructose is metabolized differently in the body than glucose is. Glucose is transported into the cells of the body by the hormone insulin, fructose is not[3]. Therefore, its ingestion does not stimulate insulin release. This, in turn, means that fructose ingestion does not lead to the insulin-induced rise in leptin. As an increase in insulin and leptin are associated with satiety[4], some researchers theorized that perhaps ingesting fructose instead of glucose leads people to consume more calories because they do not get the right signals to feel full.

High fructose diets also have been shown to lead to a more direct formation and storage of fat[5]. Additionally, despite not having the same impact on insulin secretion as glucose, fructose ingestion is strongly tied to the development of insulin resistance[6] and Type-II Diabetes. This appears to occur because ingestion of a high-fructose diet leads to more fat production, including increased production of circulation triglycerides (a kind of fat)[7].

How this All Compares

All of this sounds pretty bad for HFCS. But remember, most HFCS is only a little more than half fructose. While it accounts for a lot of calories in the human diet, on average 132 calories/day for each person over the age of two[8], only 55 percent of those are fructose calories.

By comparison, normal unsweetened apple juice is about 64 percent fructose[9]. Studies comparing weight gain from HFCS products and other sweeteners do not really exist. A recent review conducted by the United States Center for Food, Nutrition and Agriculture Policy found that while overall calories from fructose in the U.S. diet have increased, the ratio of fructose to glucose in the U.S. diet has stayed constant since roughly the 1960s[10].

Additionally, there is no evidence that weight gain is more likely to occur from the ingestion of foods and drinks sweetened with HFCS as compared to drinks using other caloric sweeteners or naturally caloric drinks such as fruit juice.

What Does this All Mean?

So what do you need to know? Right now, the current evidence does not really indicate that HFCS is any more responsible for obesity than any other sources of sugar. It may be that some of the metabolic issues we have discussed will eventually be shown to be a serious contributor to obesity, but right now, we do not have enough data to say.

What we do know is that consuming sweet drinks, whatever the source, does appear to contribute to weight gain and obesity. A recent systematic review of 30 studies examining the link between sweet beverages and weight found significant evidence that excess calories from soda, fruit drinks, fruit juice and other drinks all had some association with body weight[11].

Remember, many sweet drinks are not sold in 12 ounce servings, but in 16, 20 or larger sizes. Until more is known, the best advice for the weight-conscious is to try to minimize consumption of sweet, caloric drinks. If you do include caloric beverages in your diet, opting for nutrient-rich drinks like 100 percent juice or milk instead of sodas or juice-flavored drinks may be wise, as is limiting serving size.

Is Soda the Main Culprit in *Weight Gain?*

As more studies examined soda than any other drink, there is more evidence for a link between obesity and soda. Regardless of what they are sweetened with, drinks of this kind provide no nutritional value and are primarily a source of empty calories.

As noted by Vasanti S Malik, Matthias B Schulze, and Frank B Hu in their article, "Intake of sugar-sweetened beverages and weight gain: a systematic review:"

> *"In the U.S., on average, a 12 oz serving (12 oz = 1 can of soda =1 serving) of soda provides 150 calories and 40–50 grams of sugar in the form of high fructose corn syrup (45 percent glucose and 55 percent fructose), which is equivalent to 10 teaspoons of table sugar. If these calories are added to the typical U.S. diet without reducing intake from other sources, 1 soda per day could lead to a weight gain of 15 lb, or 6.75 kg in 1 year[12]."*

In other words, this many extra calories from anything is likely to cause you to gain weight.

About the Author:

Jacqueline Jacques, ND, 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 National Board of Directors.

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Advocacy News
Advocacy Action

What is being done about the rising *childhood obesity* epidemic?

- The OAC details two important advocacy initiatives and encourages each of you to get involved to help drive change.

In today's society, the awareness of childhood obesity has become more and more apparent. Perform a simple Google News or Yahoo! News search with the term "childhood obesity," and you will receive thousands of results featuring articles discussing this disease. But, what is being done about childhood obesity? Well, that's a good question.

As awareness builds, more and more organizations, states and well, just about everyone else, are beginning to target this disease with more passion and dedication. The Obesity Action Coalition (OAC), for instance, has been involved in many childhood obesity activities and initiatives. It has always been the OAC's school of thought that "you must first educate before you advocate." The OAC has taken great pride in developing its childhood obesity resources, all available online at **www.obesityaction.org**. Okay, so we have the first part of the equation, the educational materials, finished. But, what about the advocacy?

Harkin/Murkowski School Nutrition Amendment to the Farm Bill

Recently, the OAC signed on to the Harkin/Murkowski School Nutrition Amendment to the Farm Bill, which tried to establish the types of food and beverage products that may be offered for sale in schools. The Amendment sought to ensure that healthier food and beverages were offered for sale in schools across the country.

Unfortunately, the school nutrition standards through the Harkin/Murkowski School Nutrition Amendment were not included in the Farm Bill.

More than 100 organizations and thousands of individuals across the country signed on to support the school nutrition amendment. The dedication and persistence of all those involved created a strong consensus of support throughout the Senate and House of Representatives for future efforts and initiatives. It is our hope that this legislation will be passed during a future legislative session.

Fitness Integrated with Teaching Kids Act (FIT Kids Act)

In addition, the OAC also signed on to the American Heart Association's (AHA) FIT Kids Act. The Federal legislation would integrate regular physical education into the No Child Left Behind Act.

In early August, AHA endorsed federal legislation that addresses the nation's childhood obesity epidemic by putting more emphasis on quality physical education (PE) and physical activity for all public school children. The FIT Kids Act would better integrate PE into the No Child Left Behind Act by encouraging schools to work towards the national goal of 150 minutes of PE per week for elementary school students and 225 minutes per week for students in middle and high schools.

It would also require that all schools, districts and states include the quantity and quality of PE in the "report cards" currently sent to parents. The FIT Kids Act was introduced in the House by Representatives Ron Kind (D-WI), Zach Wamp (R-TN) and Jay Inslee (D-WA).

The FIT Kids Act would also amend existing federal programs to get all parents, educators, counselors and administrators involved in teaching children healthy lifestyles. The bill also supports professional development for teachers and principals to promote children's healthy lifestyles and physical activity and would fund research and a pilot program to study effective ways to improve healthy living and physical activity for all children.

As you can see, childhood obesity is a serious issue, and education, advocacy initiatives and legislation are all part of combating this disease; however, this fight requires proactive participation on the part of you – the parent, the caregiver, the school teacher, the doctor, the dentist… all of us. After all, if we cannot ensure the quality of health and life of **OUR** children, then **OUR** future is at stake.

*To learn more about the AHA's FIT Kids Act, please visit the association's Web site at **www.americanheart.org.** To learn more about childhood obesity or keep up to date on the latest childhood obesity initiatives and activities, please visit **www.obesityaction.org**.*

Obesity Action Coalition Develops Position Statements

As the OAC is the leading non profit patient-focused obesity organization, we are continually asked our position on a variety of obesity-related topics both general and specific. The OAC Board of Directors developed OAC Position Statements in order to provide the general public with a foundational basis of the OAC's viewpoints and positions.

It is our hope that these statements reflect the ideals, needs and thoughts of those affected by all forms of obesity. The OAC will continue to evaluate these statements and modify them as topics arise in the obesity and healthcare communities. It is vitally important for the OAC and its constituents to stay up-to-date on the latest obesity-related topics and represent all those affected.

OAC Position Statements

1. Obesity is a complex, multifactoral, and chronic disease that requires a comprehensive medical approach to care. It is the second leading preventable cause of death in the U.S., and is associated with a large number of co-morbid conditions. Care should therefore not be seen as simply having the goal of reducing body weight, but should additionally be focused on improving overall health and quality of life.

2. Efforts should be made to both prevent and treat obesity at all stages, and in all age groups. This may include, but is not limited to treatments such as surgery; physician supervised programs; drug, diet and lifestyle interventions; educational programs; and school and community-based programs.

3. Health insurance should cover care for obesity as a standard benefit. Insurance should cover the most appropriate and proven treatments to treat the given stage of overweight or obesity. Recognizing obesity as a chronic condition, insurance should also cover necessary long-term follow-up care for obesity treatment. Access to care needs to be both mandatory and reasonable, and should not require undue tests or prerequisites on the part of the patient.

4. Obesity is a condition that is currently having and continues to have an impact at all levels of our society. As such, action is needed at the levels of the individual, community, government, healthcare and insurance.

5. Obesity is not a condition of personal choice. Obese individuals frequently struggle with not only the health and physical consequences of their disease but also with professional and social consequences. Discrimination against obese individuals occurs in schools, workplaces, doctors' offices and more. No person should be discriminated against based on their size or weight. Individuals with obesity should be legally protected against such discrimination.

6. Obesity is often misunderstood, which contributes to both discrimination and care issues. It is important to educate the public, health professionals, and policy makers about obesity as a disease, the issues impacting obese individuals and the treatments available to help.

The OAC welcomes your comments on these position statements. To comment, email the OAC at ***info@obesityaction.org***.

Annual Walk*from*Obesity℠ Develops New Community Grant Program

The *Walk from Obesity* is proud to announce the formation of the Bryan G. Woodward Community Grant Program. The program was founded to support local initiatives to address the obesity epidemic in cities that host an OAC and American Society for Metabolic and Bariatric Surgery (ASMBS) Foundation *Walk from Obesity*.

Only those organizations located in a Walk city may apply (for a list of Walk cities, visit **www.walkfromobesity.com**). Preference is given to those who participated in the *Walk from Obesity*. Awarding of grants will be in amounts of $5,000 or less, and approximately 10 projects will receive funding annually.

This past October, Bryan Gerard Woodward died following a courageous battle with Chronic Lymphocytic Leukemia. Bryan served as the Chief Bariatric Officer at Nashville's Baptist Hospital. A member of the ASMBS, his life's work was for the care and counseling of the morbidly obese.

To date, the Walk has provided nearly $2.3 million to support prevention, education, advocacy and research efforts. With Bryan's persistence and dedication, the initial steps of the first Walk lead to a vigorous future for individuals who may not have thought it a possibility in their lifetime.

In September and October, in more than 70 cities across the United States, those affected by the disease of obesity join forces and walk to raise money for education, research, advocacy, prevention and treatment of obesity in the Annual *Walk from Obesity*. In 2007, more than 16,000 participated in the event and raised more than $750,000 nationwide.

For more information on the Bryan G. Woodward Community Grant Program, please visit the "Community Grants" section of the OAC Web site at **www.obesityaction.org**.

Turning My Life around

By James Zervios, OAC Director of Communications

"Welcome! Thank you for flying with us today. Here is your ticket."

You all know the drill. You wait in the long lines, get through security, get to the gate, scan your ticket and head on down to your plane – hoping it will be a smooth ride and maybe you'll get an empty seat next to you to stretch out.

Well, for Tim Liebmann, just like any other guy, he was thinking the same things – until he boarded the plane.

"I remember at the time I weighed more than 500 pounds and I was on a flight back from Alabama when I got on the plane. It was a small plane, and there were only a few seats.

Immediately, a man stood up and went over to the flight attendant and said, "Please do not sit that man near me.' For me, that was the wake up call," said Tim.

Gaining the Weight

Growing up in the 1970s, it was a different world for Tim than it is today. He told me stories of always having food in the house. Whether it was doughnuts, candy or whatever you could think of; Tim had it in his house to eat.

"You could say that my household wasn't the best to grow up in for eating purposes," laughed Tim. Even though his house may have had junk food in it, Tim wasn't necessarily an overweight kid.

All throughout his childhood, Tim stayed fit. It wasn't until he began his career that he started noticing the pounds. "You know, as I got into my career, I just began

> *I was doing this with only* ***diet and exercise****, and boy was it tough. My wife came to me one day and gave me this little ceramic angel, and I put it on my sink. I remember saying to that thing, 'Today is going to be a hard day, but I am going to tell you all about it tomorrow.' It was helpful to me," said Tim.*

seeing the weight. Somewhere in my mid-twenties I just started to gain about a pound a week, and you figure a pound a week for 52 weeks. It eventually added up," said Tim.

For the next 15 to 20 years of his life, Tim continued to gain weight. Becoming involved in his career, Tim didn't notice the weight or the effects it was having on his body. From his mid twenties until the summer of 2006, Tim felt his mind tricked him.

He told me stories of not being able to breathe while walking, sweating profusely and the diagnosis of high blood pressure. "It was like I was addicted to food. I feel food is an addiction and you have to treat it as one. I knew I was eating bad things, but I couldn't help it. I was addicted," strongly said Tim.

Turning his Life around

After Tim's airplane incident, he knew he had to turn his life around. With the help of his wife, Rori, and inspiration of his daughter, Sarah, he did just that. On Labor Day of 2006, Tim and his wife began a diet.

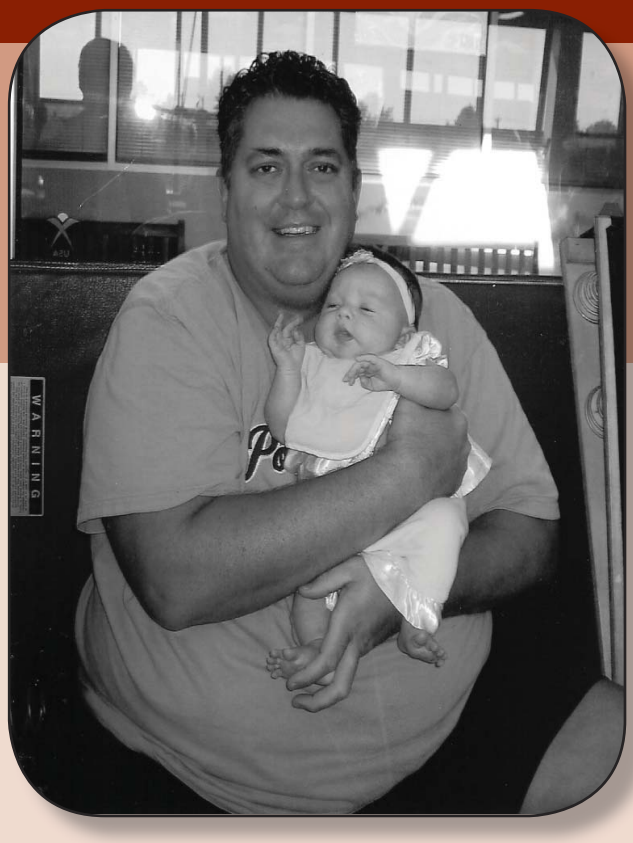
"Ah, the first few weeks are tough. I remember this one time we were having a party at our house and Rori ordered all these pizzas. And oh boy, pizza was my favorite food. I went to reach for a slice, and bam! I thought she was going to rip my hand off. My wife actually embarrassed me. But, you know what? I needed that," laughed Tim.

For the first three months, Tim used a commercial weight-loss plan to get started. But, soon after that, he and Rori were well on their way to a healthy lifestyle. Tim expressed to me the times when it was a struggle and how his wife inspired him to continue with the program.

"I was doing this with only diet and exercise, and boy was it tough. My wife came to me one day and gave me this little ceramic angel, and I put it on my sink. I remember saying to that thing, 'Today is going to be a hard day, but I am going to tell you all about it tomorrow.' It was helpful to me," said Tim.

With Tim's weight decreasing, so was his high blood pressure. He told me of a time when he visited his cardiologist and literally broke down into tears. "I remember she put me on the scale and for the first time in my life, I didn't max it out. I began to cry. The nurse looked at me like I was crazy until I explained why I cried," laughed Tim.

That day Tim also received the great news that his blood pressure was lower than before and could possibly go off of medications completely.



Before losing weight through diet and exercise, Tim was on high blood pressure medication and found it difficult to play with his daughter.

Changes while Losing the Weight

As the pounds began to fade, Tim noticed many differences in his life. He explained to me, in an interesting fashion, what it was like to be on the other side.

"As a kid, I used to look at people that were big, and I'd chuckle. When I was at my heaviest, I started to think to myself that people were now laughing at me. Today, when I walk through an airport or somewhere, I hope somebody says, 'hey, that guy looks good.' For me, it would be an accomplishment," said Tim.

Well for Tim, those thoughts of people looking at him different have certainly come to fruition. To date, Tim has lost more than 240 pounds, and his wife Rori has lost more than 40 pounds.

"I know I still got some more to go, but I am proud of myself. I did this with diet and exercise and that is hard to do. I am proud of my wife too. She was my inspiration throughout it all," proudly said Tim.

I asked Tim what he would tell somebody that is trying to lose weight. His response was enlightening and inspiring. "Take it one step at a time. Don't look at it as climbing a mountain. Just take one step each day and you'll get there," said Tim.

Well Tim, I think you have most certainly arrived one step at a time. Today, Tim can often be found working out, jogging, enjoying time with his five-year old daughter and living out one his family's favorite pastimes – horseback riding.

How to Deal with Jealousy of Loved Ones after You Have Lost Weight

By Barbara Thompson, MLS

"I have a sister-in-law who has treated me terribly since I got into a smaller pant size than her. She is not obese. She is about a size 14.

She never knew me as a thin person. She has always been a person who competes for friendship and attention. My weight-loss brought all of that out.

Many have said that my personality changed. I guess I am much more self-confident now. I am comfortable in my own skin and very self assured. I am also confident in my womanhood and not afraid that someone will steal my husband away like I was before.

It feels good to be confident and I will not change that for anyone. I also will not gain weight back to make anyone else happy."

- Tracy Baker
Erie, PA

It is a familiar scenario. Jealousy can cause many relationships to crumble. According to a survey done by sparkpeople.com, 31 percent of exercisers would be jealous if a friend lost more weight than they did. In a perfect world, we would all applaud the successes of others and not see those successes as a sign of our own failure.

But jealousy from others is a human emotion that we often have to deal with as we lose a significant amount of weight.

Jealousy Can Show up with Many of the People in Our Lives:

Spouse

If your spouse has known you only in a heavy state, losing weight might be especially frightening. You are more attractive to the opposite sex and you may be getting far more attention, making your spouse feel insecure.

You may want to be more social than before you lost weight, adding to his or her insecurity. Your spouse may have also seen your weight as a way of controlling you. If your weight caused health or mobility problems, or if you had such low self-esteem that you never wanted to go out, that meant that you were home for your spouse. And there is safety in that.

People Who Have Had Weight-loss Surgery at the Same Time

It is common to strike up a friendship with people that we meet in a support group or in the hospital. As soon as the surgery is over, it seems like the race is on, especially in support groups where people stand up and announce their weight-loss. The numbers are hard to argue. Not everyone loses at the same rate, but it is difficult for the other person to not feel like a failure.

Friends

If you were the largest person in your group (or in your family for that matter) and you lose weight, that means that someone is going to have to take your place. And that person doesn't like it! That person may have rationalized their weight by thinking, "At least I'm thinner than she is!" Now that you are losing weight, that person is reluctantly claiming your role and could very well resent you for it.

You may have heard from friends that you have changed – you are not the same person anymore. They are right, you have changed. You cannot experience tremendous weight-loss without that happening. You are the same person in your core, but that weight-loss affects the way people treat you and the way you feel about yourself.

Do not feel guilty about your success. Relish it, but do it quietly.

About the Author:

Barbara Thompson, MLS, is the author of Weight-loss Surgery: Finding the Thin Person Hiding inside You, and co-author of Weight-loss Surgery for Dummies which can be found at her patient Web site ***www.WLScenter.com*** *. Her free newsletter is available at www.wlscenter.com/E-Newsletter.htm. Check out her blog at* ***WeightLossSurgeryBlog.net****. Barbara is also a member of the OAC National Board of Directors.*

Tips for Dealing with Jealousy after Weight-loss

Tip #1
Soften your voice, maintain eye contact, tell the person how you feel and ask them to express their feelings. See if you can understand the root of their problem. Be open and honest and try to dispel their fears without negating their feelings.

Tip #2
Understand that jealousy is a human emotion. It has much more to do with how the person feels about him or herself than about you. It can be very flattering that someone recognizes your success to that degree, but be gentle with the person. They are truly hurting.

Tip #3
Compliment the person on something they are especially successful with. Everything is not about weight. A comment like "I wish I could bake as well as you do," or "You look great in that color," can go a long way to making someone feel less insecure.

Tip #4
Reassure your spouse that he or she is the only love in your life. Try to swallow your hurt and show him or her as much affection as you can. Compliment your spouse and support them in building their self-esteem. If the situation is very serious, seek couples' counseling. Ask your doctor for a referral to a therapist who has dealt with these issues.

Tip #5
Do some self examination. Could it be true that perhaps you are acting in a way that might be hurtful to others? Could your elation about your shrinking size be insensitive to the feeling of others?

Tip #6
Above all, be yourself. Do not feel pressured to regain weight because someone is feeling insecure. Watch out for those who might try to sabotage your weight-loss.

Chairman's Council

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The Chairman's Council is the OAC's most prestigious membership level. Membership in the Council is accompanied with several exclusive benefits. By joining as a Chairman's Council member, you are making a commitment to improving education and advocacy efforts for the obese and morbidly obese. Most importantly, your membership strengthens the voice of patients in the obesity community.

To add your name to this list, please visit **www.obesityaction.org** or contact us at (800) 717-3117.

Colon Cancer *continued from page 3*

Assuming no symptoms are present, we are in a screening scenario. There are many options. You need to begin screening at age 50, then continue getting screened at regular intervals. After turning 50, if your doctor does not think you need to be screened – find another doctor.

Screening tests can find precancerous polyps (abnormal growths) in the colon and rectum; polyps can be removed before they turn into cancer. Screening tests for other types of cancer may find cancer in the early stages, such as mammograms.

However, with screening for colon cancer, we can find the polyp before it can turn into cancer. In this case, we are actually preventing the cancer from developing.

This is a list of some commonly used tests.

- **Colonoscopy-** During the exam, the doctor uses a narrow, flexible, lighted tube to look at the inside of the rectum and the entire colon. During the exam, the doctor may remove polyps (abnormal growths) and collect samples of tissue or cells for closer examination. Also, during the test, sedatives are given; most people experience no pain during the test.

- **Flexible Sigmoidoscopy-** The doctor (or other specially-trained healthcare professional) uses a narrow, flexible, lighted tube to look at the inside of the rectum and the lower portion of the colon. During the exam, the doctor may remove polyps (abnormal growths) and collect samples of tissue or cells for closer examination. This is only a partial colon exam. About 2/3 of the colon is not viewed and polyps and tumors can be missed.

- **Fecal Occult Blood Test-** This test checks for occult (hidden) blood in the stool. Blood in the stool does not mean cancer is present. Blood can result from hemorrhoids or other conditions. However, further testing must be done to evaluate the cause of the bleeding.

- **Double-Contrast Barium Enema-** This is an x-ray of the rectum and colon. The barium coats the lining of the intestines so that polyps and other abnormalities are visible on the X-ray.

What is the best screening test for you? Any test is better than no test at all; however, the gold standard is considered the colonoscopy.

Colon Cancer *continued on the next page*

Obesity and Colon Cancer Risk

According to an article publish on the WebMD Web site, obesity more than doubles a woman's risk of developing colon cancer or growths that can lead to colon cancer.

The findings emphasize the need for obese women to be screened for colorectal cancer, says the American College of Gastroenterology (ACG) President David A. Johnson, MD, a gastroenterologist at Eastern Virginia Medical School in Norfolk. "If a woman is reluctant about being screened, she needs to consider that her risk is a lot higher than that of women of normal weight," he says.

The time to act is now! Colon cancer screening saves lives. Today, make plans to get tested. This may just be the most important decision of your life.

About the Author:

Edward Leigh, MA, is a health educator, professional speaker and seminar leader focusing on creating positive workplace environments. His expertise put him in the national spotlight through interviews on MSNBC News, The Today Show, Discovery Health Channel and the Learning Channel. Sign up for his fun and informative complimentary electronic newsletter, "Joy on the Job," at ***www.edwardleigh.com****.*

Interested in Learning about Other Obesity-Related Diseases?

The OAC has addressed numerous topics on co-morbid conditions associated with obesity. These topics include:

- Obesity and Type II Diabetes
- Sleep Apnea and the Obese Patient
- Cardiovascular Disease- Obesity and the Heart
- How Obesity Affects Arthritis
- GERD and the Obese Patient
- Gallbladder Disease
- Obesity and Depression

All above articles and many others may be viewed, downloaded and printed by visiting the "OAC News" section on the OAC Web site at www.obesityaction.org.

OAC Membership

The OAC was founded as the "patient voice" in obesity. As a membership organization, the OAC exists to represent the needs and interests of those affected by obesity and provide balanced and comprehensive education and advocacy resources. Membership in the OAC is integral in strengthening the voice of the millions affected by obesity. Various membership levels are available and each is accompanied with several valuable benefits such as:

- Official membership card/certificate
- Annual subscription to *OAC News* – OAC's quarterly educational and advocacy newsletter
- Subscription to *Obesity Action Alert* – monthly e-newsletter distributed on the 1st of each month
- Access to valuable educational resources and tools
- Patient representation through advocacy, in addition to information on advocacy issues concerning patients

Yes! I would like to join the OAC's efforts. I would like to join as a/an:

- ❑ Patient/Family Member: $20
- ❑ Professional Member: $50
- ❑ Physician Member: $100
- ❑ Surgeon Member: $150
- ❑ Institutional Member*: $500 *(Surgery centers, doctors' offices, weight-loss centers, etc.)*
- ❑ OAC Chairman's Council*: $1,000 and up

** These membership levels have exclusive benefits.*

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Enclosed is my check (payable to the OAC) for $ _____.

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www.obesityaction.org

About the OAC

The Obesity Action Coalition (OAC) is a non profit patient organization dedicated to educating and advocating on behalf of those affected by obesity, morbid obesity and childhood obesity. The OAC distributes balanced and comprehensive patient educational materials and advocacy tools.

Obesity Action Coalition

The OAC believes that patients should first be educated about obesity and its treatments and also encourages proactive patient advocacy. The OAC focuses its advocacy efforts on helping patients gain access to the treatments for obesity. As a membership organization, the OAC was formed to bring patients together to have a voice with issues affecting their lives and health. To learn more about the OAC, visit **www.obesityaction.org** or contact us at (800) 717-3117.

OAC Resources

The OAC provides numerous beneficial resources for patients, as well as professionals. All OAC resources are complimentary and may be ordered in bulk. To request materials, please contact the OAC National Office at (800) 717-3117 or send an email to **info@obesityaction.org**.

Newsletters

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

Brochures/Guides

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

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