



OAC

NEWS

January 2009

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The Obesity Action Coalition's Quarterly Magazine for Patients

A Message from OAC Chairman, Jim Fivecoat

Happy New Year!

As I begin my third year as OAC Chairman, I cannot help but notice the immense progress the OAC and its members have made as the leading patient-focused organization. Last year, the OAC took part in monumental efforts, such as the *Walk from Obesity – Walk on the Capitol*, national and state-based advocacy issues, the annual *Walk from Obesity*, legislative briefings and much more. In addition, the OAC distributed more than 150,000 educational pieces in 2008.

Looking toward 2009, the OAC has many great initiatives and ideas in store for its members. On the educational front, in the first quarter of 2009, the OAC will release its brand new addition to its already popular *Understanding Obesity* series, titled *Understanding Your Weight-loss Options*. This brochure thoroughly discusses the various weight-loss options available to those battling obesity.

On the advocacy front, the OAC recently launched its OAC STAR (State Advocacy Resource) Program. The OAC STAR Program, is a new program where OAC members can sign-up to be an advocacy resource for their state. The purpose of the STAR Program is to support and communicate the mission and goals of the OAC before the state legislature and regulatory agencies. For more information on this program, please see page four.

This truly is a great time to be a member of the OAC. I encourage all of you that are already members to share your thoughts of the OAC with friends and family members and encourage them to join this ever-growing patient-focused organization.

In this issue of *OAC News*, we address topics such as, hypertension, diabetes, how to make cooking fun for kids, thyroid condition, the latest trend in exercising called “exergaming” and much more.

As always, we strive to provide you with the most up-to-date information in the obesity community and 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.



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OAC NEWS

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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 OAC is governed under the authority of a National Board of Directors. Members of the OAC Board of Directors include: James Fivecoat, MBA, *Chairman*; Barbara Thompson, MLS, *Vice-Chairman*; Georgeann Mallory, RD, *Treasurer*; Christopher Still, DO, FACN, FACP, *Secretary*; Pam Davis, RN, CBN, CCM; Jeff Haaga; Jacqueline Jacques, ND; Julie M. Hill-Janeway, BBA, MSA, JD, ABD/PhD; and Robin Blackstone, MD, *Director Emeritus*.

OAC News is a quarterly educational and advocacy magazine. OAC News is distributed in January, April, July and October. Subscription to OAC News is a membership benefit, however, individuals may request a copy.

Opinions expressed by the authors are their own and do not necessarily reflect those of the OAC Board of Directors and staff. Information contained herein should not be construed as delivery of medical advice or care. The OAC recommends consultation with your doctor or healthcare professional.

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

Exergaming? What is that?

By Laura M. Boyer, RN, CBN

There is an emerging trend in the home video gaming industry that allows for more physical interaction. A combination of exercise and video game technology is called "exergaming."

While home gamers have always had button-controlled sport themed games available, the addition of more physical participation is an exciting and attractive feature. The more recent breed of game controls sense movement and position of the player.

The level and mode of interaction varies. For example, mats and balance boards can simulate skateboards, skis and dance floors for a high level of exertion while handheld controls provide for more sedate interaction. Some games utilize a combination of both.

The goal of all of this – get the gamer moving!

These types of activities may be especially attractive to individuals with mobility limitations. Many of the games can be played by swinging and moving just the handheld controls. Activities for assisted living and nursing homes now include such sports as virtual bowling, golf and tennis. People who once enjoyed these sports find they are now able to enjoy the game once again, just at a different level.

The games can also be played with the full range of movements used to swing a racket or golf club, or roll a bowling ball. Recreational directors are using the Nintendo Wii tennis game for rainy day indoor play as an opportunity to teach rules and strategy and to work on form. In addition to the physical involvement, "exergaming" has a strong social component which encourages group interaction and friendships.

There is a growing variety of simulated sports and exciting activities available, such as snow and skate boarding, track and field competition, obstacle courses and dance contests. The idea of children spending time running, jumping and dancing sure beats the "couch potato" version of gaming. Clearly, the benefit here is that both adults and children are having fun, without realizing that they are exercising.

More than just exercise

Of course, as with exercise videos, the gamer only gets the benefit of a workout when truly participating. This became obvious to me when I was playing a simulated boxing match with my teenager. I was pulled into the excitement, punching and ducking with all my strength. I looked over at her and she



was calmly moving the handheld controls and getting the same results with just a flick of the wrist. My arms were tired and my heart rate was up, and she hadn't even broken a sweat!

So, if you want your family to move more than just their hands, the games with the interactive mat for running and dancing are a better choice.

The fitness aspect

There are a variety of programs designed specifically for fitness, some with specialized equipment. There are a few limitations such as the need for a television in a spot with the space to move around. The Wii Fit balance board has a weight limit of 330 pounds. The fitness programs offer some customization and feedback regarding weight, body mass index and fitness levels, but they are basic and not meant to replace professional guidance.

Avid and experienced gym patrons may be disappointed with this method of exercise, however those who would otherwise never pursue exercise instruction will likely see some benefit from the opportunity to learn at home and workout in a private setting. After a little confidence building, a trip to the gym might not be as intimidating.

Will "exergaming" be as big as the home exercise video movement? No one has a crystal ball, but we do know that any type of exercise is worth pursuing, whether it's a walk in the park or a virtual iron man competition. Just do something! As with any workout regimen, commitment and consistency are the keys to success.

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.

ADVOCACY NEWS

ADVOCACY ACTION

Calling All Advocates!

By Jim Fivecoat, OAC Chairman

Being Resourceful: OAC's New State Advocacy Resource (STAR) Program

In attempting to describe the Obesity Action Coalition's (OAC) new State Advocacy Resource (STAR) Program, I was reminded of a recent trip to Washington, DC. During my stay in the nation's capital, I made a side visit to the National Governors Association's Center for Best Practices.

My goal that day was to educate the members of the Center's Healthcare Division about the mission and the great work that is taking place at the OAC. At the end of this meeting, I was thanked for my time and efforts and also for my willingness to be a "resource" to the Center on obesity issues. I left feeling totally energized and excited.

The dictionary defines "resource" as a source of support, or source of information or expertise. When you stop and think, having someone call you a resource is a pretty cool thing. I believe all OAC members have been a resource at one time in their life – many on a continuing basis. We all have provided support to our family and friends throughout the years and we all can be a constant source regarding what it's like to be overweight or obese, or provide care for someone suffering from this disease. That's what the OAC's new STAR program is all about – stepping up in your state or territory to serve as the OAC's resource and representative at the local level.

We all have our radar up when we read or hear about new policies that unfairly discriminate or limit the rights of the overweight/obese. Those who live in their state's capital city surely receive a disproportionate amount of information about what the Governor and state legislature are up to. Keeping close tabs on changes in health insurance coverage policies for medical weight-loss management or bariatric surgery can be extremely helpful. What you do with this information can be of tremendous importance to the OAC.

The OAC is looking for a few good advocates. If you, or someone you know, would like to become an OAC STAR, please visit the "Advocacy" section of the OAC Web site. We'll help you make sure that access to care and the rights of the overweight/obese are protected in your state!



About the STAR Program

The purpose of the STAR program is to support and communicate the mission and goals of the OAC before the state legislature and regulatory agencies. The STAR program seeks individuals who are interested in volunteering their time and wish to make a strong impact in state advocacy initiatives. Responsibilities of STARs may include the following:

- Serve as OAC scouts at the local level in each state and territory of the United States – reporting back to the OAC when policy action is warranted in their respective state
- Voluntarily represent the OAC on state-based legislative and regulatory activities, such as monitoring legislation, meeting legislators and/or other elected or appointed officials, attending and/or testifying at legislative hearings
- Function as a local spokesperson for the OAC with the local media

Application to the OAC STAR program is an ongoing process. STARs are able to nominate themselves or be nominated by others. Applications are reviewed by the Board of Directors or a nominating committee designated by the Board. For more information on the STAR Program, visit the "Advocacy" section on the OAC Web site at www.obesityaction.org.

NEWS *from the OAC*

OAC Gives Groups a Way to Engage their Patients with New Program

The OAC is proud to announce a newly developed program that allows physicians and surgeons to get involved in the OAC's efforts and engage their patients in their care – the Discount Patient Membership Program for Groups.

Individuals in the fight against obesity need all the support they can get. Making that first commitment to addressing obesity is overwhelming and tough, and patients need to know they are not alone in this fight.

How the Program Works

This new program allows a physician or surgeon's practice to purchase OAC memberships for their patients at a discounted rate of \$10 each (regular Patient/Family membership is \$20/year). In addition, when making that commitment to purchase memberships for patients, the practice will automatically qualify as a member of the prestigious OAC Chairman's Council.

The program is easy to implement in your practice and only takes a few small steps to set-up and a limited time commitment by your staff.

Participating in the Program

The Discount Patient Membership Program for Groups is a great way to provide extra support to patients who are choosing to treat their obesity. Since this program was developed, we have seen practices participate for a variety of reasons.

Some practices want to engage their patients in advocacy activities, in order for them to make an impact on issues such as improving access to obesity treatments. Other practices see the value of their patients staying educated about obesity and long-term care by accessing the OAC's helpful resources and quarterly patient magazine, *OAC News*.

No matter what the motivation is, supporting patients is important - and OAC membership allows you to show your support.

More information about the program and how to join may be found in the "Membership" section on the OAC Web site at www.obesityaction.org. Or, contact Kristy Kuna, Director of Membership, at (800) 717-3117 or kkuna@obesityaction.org.

"We give the gift of OAC membership to our patients in order to give them a voice. By joining together, we will be heard as we fight obesity."

*Jaime Ponce, MD
The Gastric Band Institute –
Chattanooga, TN*

The OAC Thanks the Participants of the Discount Patient Membership Program for Groups

Bariatric Support Centers International;
Salt Lake City, UT

Gastric Band Institute; *Chattanooga, TN*

Geisinger Healthcare Center; *Danville, PA*

Premier Advanced Laparoscopic and
Weight Loss Surgery; *Knoxville, TN*

Scottsdale Bariatric; *Scottsdale, AZ*

The Wellborn Clinic; *Little Rock, AR*

***Thank You for Supporting the
OAC and Your Patients!***

OAC Announces 2009 National Board of Directors

The OAC is pleased to announce the 2009 National Board of Directors. The elected directors began serving their terms on January 1, 2009.

The OAC National Board of Directors are as follows: James Fivecoat, MBA, *Chairman*; Barbara Thompson, MLS, *Vice-Chairman*; Georgeann Mallory, RD, *Treasurer*; Christopher Still, DO, FACN, FACP, *Secretary*; Pam Davis, RN, CBN, CCM; Jeff Haaga; Jacqueline Jacques,

ND; Julie M. Hill-Janeway, BBA, MSA, JD, ABD/PhD; and Robin Blackstone, MD, *Director Emeritus*.

Formed more than three years ago, the OAC, governed by its National Board of Directors, continually succeeds as the leading obesity patient-focused organization. The OAC has been instrumental in many national and state-based issues throughout the past three years. Perhaps the most notable moment

in the OAC's history was the hosting, along with the ASMBS Foundation, of the *Walk from Obesity – Walk on the Capitol* where nearly 3,000 individuals walked on the national mall in Washington, DC, for obesity awareness.

For more information on the 2009 OAC National Board of Directors, visit our Web site at www.obesityaction.org.

The National Diabetes Goal: Turning the Tide of Pre-diabetes in America



By Manan Shah and Robert Moreschi

8 percent of the U.S. population has diabetes, while 57 million Americans have pre-diabetes.

Diabetes, especially type 2, is increasing at an alarming rate in the United States. This rapid rise is being fueled by an aging population, rising rates of obesity and more sedentary lifestyles. While genetics plays a role, we know that diabetes and its complications can often be delayed or prevented through lifestyle changes such as exercise and healthy eating. Preventing and managing diabetes may not be an easy task, but with improved awareness and action, it is possible.

Managing diabetes involves a balance of healthy eating, prescription medication and physical activity that can often be overwhelming. Many people who are newly diagnosed with diabetes don't know where to begin. People with diabetes must have access to information to help them make healthy choices, take control of their own care, and remain motivated to stay on track.

Prevalence of Diabetes and Pre-diabetes in America

Recently, the Centers for Disease Control and Prevention (CDC) reported new statistics on the prevalence of diabetes. While the headlines focused on the 23.6 million Americans, roughly 8 percent of the population who currently have diabetes, there is another number that poses a great risk and potential opportunity for the country: 57 million Americans have pre-diabetes, a

condition where a person's blood glucose level is higher than normal, but not yet high enough to be diagnosed as diabetes. Recent research shows that even in this condition, long-term damage to the body, including the heart and circulatory system, may already be occurring.

Additionally, there is also the growing economic burden of diabetes in America. In mid-November, research conducted by The Lewin Group and commissioned by the National Changing Diabetes® Program found that the cost of diabetes was an estimated \$218 billion in 2007 due to higher medical expenditures and lost productivity. Of that, \$25 billion was attributed to those 57 million Americans with pre-diabetes.

"In individuals with pre-diabetes, we observed a significant increase in ambulatory visits for a wide variety of medical conditions, including hypertension, endocrine, metabolic and kidney complications," said Tim Dall, vice president at The Lewin Group.

What the National Diabetes Goal Strives to do about the Diabetes and Pre-diabetes Epidemic

Diabetes does not have to be inevitable. People with pre-diabetes can take action to manage their blood glucose levels and reverse the course to diabetes.

That is why the National Diabetes Goal was established. The need for a National Diabetes Goal was highlighted in 2008 by the results of a Gallup survey funded by Novo Nordisk, titled *Public Knowledge, Perceptions and Behavior Regarding Diabetes and Diabetes Prevention: A Societal Barometer*. This survey brought to light the public's perception of diabetes and the amount of knowledge about the disease that exists among the general population.

Almost all survey respondents (94 percent) considered diabetes to be a serious health issue. The poll showed that one in four adults (24 percent) have either been diagnosed by a physician as having diabetes (9 percent) or as being at-risk for diabetes (15 percent).

The survey results revealed that high awareness about diabetes had not yet translated into action to prevent the disease, and it was this fact that led a coalition of diabetes stakeholders to develop the National Diabetes Goal: By 2015, 45 percent of American who are at risk for diabetes will know their blood glucose level and what actions to take.

In addition to calling on the American public to learn about the consequences of uncontrolled diabetes and the importance of being tested, the National Diabetes Goal emphasizes action. Blood glucose testing is only the first step in preventing diabetes; people who are at risk must also educate themselves on what the test results mean, and take the necessary next steps to stay in control of their health.

Risk Factors Associated with Type 2 Diabetes

The American Diabetes Association identifies several risk factors associated with type 2 diabetes. They include a family history of diabetes or heart disease, being overweight or obese, being physically inactive and having high blood pressure or triglycerides or low HDL cholesterol. African Americans, Hispanics, Native Americans, Asian

Americans and Pacific Islanders are also at higher risk for developing diabetes.

Confirming the important role that family history and genetics play in diabetes, a recent report in the *Journal of the American Medical Association*¹ estimates that one in three boys and two in five girls born in the year 2000 are at risk to develop diabetes in their lifetime; this number increases to one in two for minority children born that year. Diabetes is more common in African Americans, Latinos, Native Americans and Asian Americans/Pacific Islanders. This means these groups are also at increased risk for developing pre-diabetes.

Currently, the Goal is championed by the Obesity Action Coalition and more than 45 other health, advocacy, business and educational organizations across the country that are committed to reversing the diabetes epidemic in the United States.

Partnering Together

Some recent activities that these champions have taken to advance the National Diabetes Goal include the following:

- Bellwether Medical Center in Washington, Barton HealthCare System in California and the University of Missouri-Kansas City hosted multiple diabetes screening events in their local communities. Community members attended to learn about risk factors for diabetes and to get screened for the disease.
- The National Association of School Nurses has integrated Goal material into a variety of its programs, including School Nurse Childhood Obesity Prevention Education (S.C.O.P.E.), a training program for over 13,000 school nurses across the country.

Each organization that supports the National Diabetes Goal is working to reach out to its audience and constituents to spread the message of diabetes awareness and action. If you are interested in supporting the National Diabetes Goal or would like to learn more information about this initiative, visit www.NationalDiabetesGoal.com.

national Diabetes Goal

What is the National Diabetes Goal?

By 2015, 45 percent of Americans who are at risk for diabetes will know their blood glucose level and what actions to take.


About the Authors:

Manan Shah is with the National Changing Diabetes Program and works on the National Diabetes Goal as well as the National Clinical Barometer, a project to analyze the current diabetes quality measurements in the United States. A graduate of American University, he is an avid runner and political writer.

Rob Moreschi recently joined the National Changing Diabetes Program (NCDP) and works on the NCDP newsletter as well as the National Diabetes Goal. Currently a senior at Rutgers University, he enjoys writing and is focusing on media and communications within the health care industry.

References:

- ¹2 K. M. Venkat Narayan, et. al. Lifetime Risk for Diabetes Mellitus in the United States. *JAMA*, Oct 2003; 290: 1884 - 1890.



Program Based on Alcoholics Anonymous Gives Real Hope to those Suffering with Food, Weight and Body Image Issues

Food Addicts in Recovery Anonymous Offers Solutions for 2009 and Beyond

According to Food Addicts in Recovery (FA) member Brian, until recently, New Year's Eve was no time for celebration. "For me, New Year's Eve used to be about isolation. I felt so bad about my body and the way I looked, I never wanted to show up to holiday parties. Instead, I would sit in my house, eat and feel sorry for myself. Ever since I found FA four years ago, I have happily attended all holiday parties I could. After a 140 pound weight-loss and freedom from food obsession, I feel self-confident and am happy to ring in the New Year."

Founded in 1998, FA is an effective, long-term solution to food addiction for many people who use food as a drug, whether they under-eat, overeat, are bulimic, or are otherwise obsessed with food or their weight.

Based on the Twelve Steps and Twelve Traditions of Alcoholics Anonymous (AA), is an international fellowship of individuals who, through shared experience and mutual support, are recovering from food addiction. FA is not affiliated with any public or private organization, political movement, ideology or religious doctrine. Membership in FA is free and is open to anyone who wants to recover from food addiction. The group is comprised of thousands of women and men diverse in age, ethnicity and socio-economic background who have experienced difficulty controlling the way they eat.

Before joining the program, many adult and teen members were overweight, some by as much as 250 pounds. Others were dangerously underweight or controlled their eating to the point of obsession through under-eating, bulimia, laxatives or over-exercising. Today, many lead fulfilling lives without abusing food, free of diabetes and other food-related medical problems. The program is free to all, sustained through nominal donations.

Much like alcoholics in AA, lives are reclaimed in FA when the despair brought on by constant thoughts of food and eating, or not eating, is lifted.

Food Addicts in Recovery – Helping Individuals

Case in point, Katie, an FA member for almost seven years says, "I can't believe how my life has changed. This is particularly noticeable to me around the holidays. One year, before FA, I recall having fun at a New Year's party for a short time, then something happened and I found myself at the buffet table eating all the goodies. That night I felt so disgusting that I hitched a cab and had the driver take me to my empty office building so I could go throw up. That's how I spent my New Year's Eve."

Now in recovery, Katie is able to truly enjoy her holidays in the company of others instead of in the throes of her bulimia. "Since joining FA, I also notice recovery changing my life in how I relate to my friends and family members at this time of year. I am more loving, tolerant, kind and just fun to be around. Instead of getting upset that I don't fit into my clothes or that I feel gross from eating too much sugar, I can be present for my friends and family."

Karen, 26, and a recent college graduate, suffered from a lifetime of food addiction and a top weight of 233 pounds at 5'4" before finding a solution in FA more than six years ago. She is now maintaining a 120 pound weight-loss and living a life free from the misery of food obsession. According to Karen, "I was completely hopeless when I walked through the doors of FA. I spent my junior high and teenage years miserably obese and looking for answers in unhealthy diets and exercise routines. I didn't know how to eat and live my life until I found this program. I came to FA looking for a thin body, but I found so much more – freedom from weight and food obsession and an end to my lifetime search of happiness."

Cassie, who started the program at age 14 recalls, "At first it was tough balancing school and FA meetings, but I had to put my recovery first. I watched my grades go way up and can now concentrate on what I'm studying, instead of obsessing about what I'm going to eat." As a result, Cassie, now a 23-year-old college student, is in a graduate medical school program in an area where she participates in the FA program long-distance.

Before joining the program, many members like Karen and Cassie were overweight. Others were dangerously underweight or controlled their eating to the point of obsession through under-eating, bulimia or over-exercising. Derrick, 33, experienced the first symptoms of his food addiction in high school which then carried over into college. Derrick remembers, "I was thin, but I was miserably obsessed with food. I found that 'thin' was not 'well.' I exercised constantly and had no peace until I found FA. At first I was one of the few guys, but there are more and more men coming into FA."

More about Food Addicts in Recovery

The number of FA members in 2008 is estimated at 3,700 worldwide. Membership spans 40 states in the U.S. and countries including France, Germany, Israel, Japan, Australia, Canada, Qatar and the United Kingdom. In the United States alone, there are more than 418 weekly FA meetings available for those looking for freedom from food addiction. While most members attend meetings locally in their region, some members follow the program long-distance.

For more information about FA, visit www.foodaddicts.org, or call the FA World Service Office at (781) 932-6300.

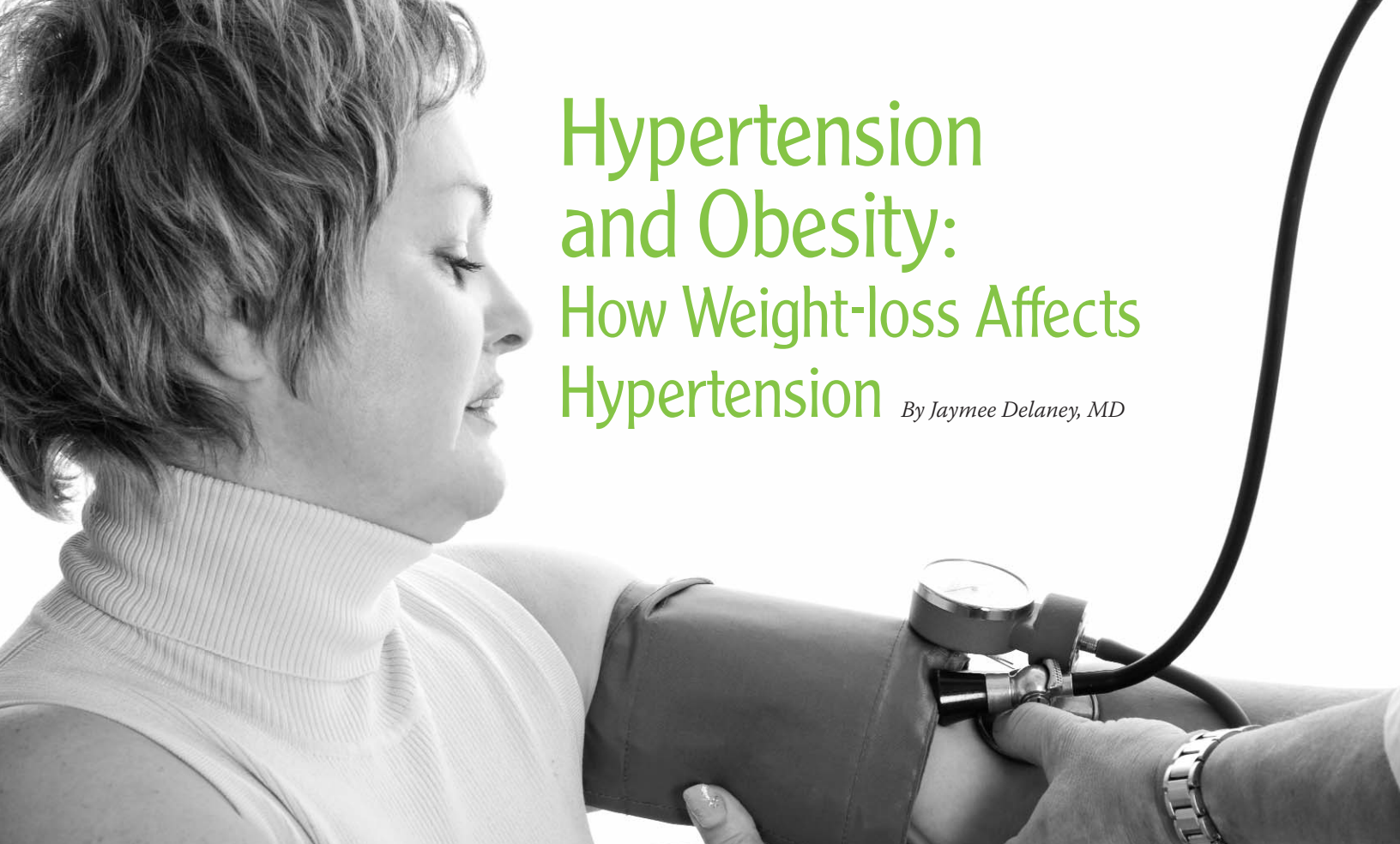
*Article provided by Food Addicts in Recovery Anonymous
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The 20 Questions *Are You a Food Addict?*

Ask yourself the following questions and answer them as honestly as you can.

1. Have you ever wanted to stop eating and found you just couldn't?
2. Do you think about food or your weight constantly?
3. Do you find yourself attempting one diet or food plan after another, with no lasting success?
4. Do you binge and then "get rid of the binge" through vomiting, exercise, laxatives or other forms of purging?
5. Do you eat differently in private than you do in front of other people?
6. Has a doctor or family member ever approached you with concern about your eating habits or weight?
7. Do you eat large quantities of food at one time (binge)?
8. Is your weight problem due to your "nibbling" all day long?
9. Do you eat to escape from your feelings?
10. Do you eat when you're not hungry?
11. Have you ever discarded food, only to retrieve and eat it later?
12. Do you eat in secret?
13. Do you fast or severely restrict your food intake?
14. Have you ever stolen other people's food?
15. Have you ever hidden food to make sure you have "enough?"
16. Do you feel driven to exercise excessively to control your weight?
17. Do you obsessively calculate the calories you've burned against the calories you've eaten?
18. Do you frequently feel guilty or ashamed about what you've eaten?
19. Are you waiting for your life to begin "when you lose the weight?"
20. Do you feel hopeless about your relationship with food?

If you answered "yes" to any of the above questions, then you may be a food addict. You are not alone. FA offers hope through a real solution to food addiction.



Hypertension and Obesity: How Weight-loss Affects Hypertension

By Jaymee Delaney, MD

It is important to get both weight and hypertension under control to be healthy; both hypertension and obesity are major health issues in the United States.

The Incidence of Hypertension and Obesity

The Framingham Heart Study, a famous study for 44 years, estimated that excess body weight (including overweight and obesity), accounted for approximately 26 percent of cases of hypertension in men and 28 percent in women, and for approximately 23 percent of cases of coronary heart disease in men and 15 percent in women. Obese individuals have an increase in fatty tissue that increases their vascular resistance and in turn increases the work the heart has to do to pump blood throughout the body (6).

What is Hypertension?

Hypertension (high blood pressure) refers to the pressure that blood applies to the inner walls of the arteries. The diagnosis of high blood pressure cannot be given if the patient is ill or is already on blood pressure medicines.

High blood pressure is based on the average of two or more properly measured blood pressure readings at each of two or more visits after an initial screening. The definitions are based on The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure: The JNC 7 Report (7).

Physicians use the following classifications:

- *Normal blood pressure:* systolic (top number) greater than 120 mmHg and diastolic (lower number) greater than 80 mmHg
- *Pre-hypertension:* systolic 120-139 mmHg or diastolic 80-89 mmHg
- *Hypertension:*
 - Stage 1: systolic 140-159 mmHg or diastolic 90-99 mmHg
 - Stage 2: systolic greater than or equal to 160 mmHg or diastolic greater than or equal to 100 mmHg

Types of Hypertension

There are two types of hypertension: essential (primary) hypertension and

secondary hypertension. Most people with hypertension have essential hypertension.

Essential hypertension is poorly understood and may be due to a number of causes including inheritance, kidney problems (from hypoxia, drugs, nutritional deficiency, malnutrition, infection, genetic factors) and neural activity.

Secondary hypertension is less common and is the result of a different underlying medical issue, such as kidney disease, oral contraceptives, pheochromocytoma, primary hyperaldosteronism, Cushing's syndrome, sleep apnea syndrome and coarctation of the aorta.

Treating Hypertension

People with hypertension should be on blood pressure medications (antihypertensives). Those who are placed on medication for high blood pressure need to realize that everyone responds differently to these medications and two to three drugs may be required to achieve a normal blood pressure.

If weight-loss occurs and a normal blood pressure is achieved, then blood pressure medications may be tapered or stopped. No medical studies have found whether certain blood pressure medicines work better or are safer in obese patients. There are many types of medicines that can be used and physicians should discuss the risks and benefits of the choices that are available. Possible choices are:

- ACE inhibitors
- Low dose diuretic (12.5 to 25 mg of hydrochlorothiazide per day)
- Calcium channel blocker

Low-dose thiazide therapy is less expensive and should have little or no effect on glucose or lipid metabolism,

which may be an issue with other antihypertensive drugs.

Knowing Your Risk for Hypertension

Indicators for risk of hypertension include obesity, abdominal obesity and weight gain. Obesity is measured by body mass index (BMI), which is determined by weight and height. BMI is highly correlated with direct measures of body fat in most populations. Normal BMI is 20-25, overweight is 25-29.9 and obese is greater than 30 (5). Not only is BMI important for determining hypertension risk, but fat distribution is as well.

Fat distribution in the abdominal trunk is called abdominal obesity. Abdominal obesity is defined by a waist circumference greater than 102 cm (40in) for men and 88 cm (35 in) for women (9,10). Abdominal obesity has the greatest influence on whether someone will develop hypertension.

Weight gain was associated with increased risk of developing hypertension. The relative risks of hypertension in women who gained 10-22 pounds and those that gained over 55 pounds were 1.7 and 5.2, respectively. In other words, women that gained more than 55 pounds were three times as likely to become hypertensive as women who had gained less weight.

On the other hand, weight-loss can lead to a significant drop in blood pressure. One study showed that in a four year follow-up of 181 overweight hypertensive patients, a 10 percent weight-loss produced an average of a 4.3/3.8 mmHg fall in blood pressure.

Obese patients have other significant health risks, and patients with abdominal (central or upper body) obesity are at the greatest risk. Heart disease risk increases if a person has excess abdominal fat, high blood

Did You Know?

Obesity and hypertension (high blood pressure) is intimately connected. There are 58 to 65 million adults who have hypertension in the United States (1,2). Hypertension is the most common reason for office visits of non-pregnant adults to their physicians and for the use of prescription drugs (3), and obese people are more likely to have hypertension (5).

The percentage of obese people in the United States is increasing and in a survey from 1999 to 2000, the percentage of obese people in the United States was 33.5 percent (4). Other medical issues that are associated with obesity include reduced life expectancy, coronary heart disease, diabetes mellitus, gallstones, osteoarthritis, abnormal cholesterol (blood lipids), stroke, sleep apnea, cancer (colon and prostate in men; uterine and gallbladder cancer in women).

Hypertension continued on page 12

pressure, high levels of cholesterol in the blood, heart disease, a strong family history of diabetes, is a male or was obese before age 40.

The abnormalities in lipid and glucose metabolism appear to be related to fat distribution and to total body weight, and this is why obese patients have a higher rate of diabetes mellitus.

Obesity increases heart disease risk by increasing LDL-cholesterol levels (bad cholesterol) and reducing HDL-cholesterol levels (good cholesterol). This produces atherosclerosis (hardening of the heart arteries), which can cause myocardial infarction (heart attacks).

Obesity also increases the risk of diabetes by diminishing glucose tolerance and predisposing to the development of left ventricular hypertrophy (enlargement of the heart) (11,12). Left ventricular hypertrophy can be produced in obese patients because the heart is required to work harder to pump blood throughout the body. By some estimates, each pound of fat requires approximately a mile of extra blood vessels to supply nutrients and oxygen (13).

What to Remember with Hypertension and Obesity

The most important issue to remember is that obesity is associated with hypertension, and hypertension is associated with numerous other diseases that can affect overall health and life expectancy. Anti-hypertension medications should be started if hypertension is diagnosed. But, with weight-loss, a significant fall in blood pressure may permit a decrease in the number of medications taken or decrease the amount of medication taken. Prevention would be better than any drug.

Use lifestyle changes with weight reduction (maintaining BMI 18.5 to 24.9 kg/m²), DASH diet (eating fruits, vegetables, and low-fat dairy products with reduced content of saturated and total fat), a decrease in dietary sodium (2.4 g sodium or 6 g sodium chloride), an increase in physical activity (for 30 minutes per day) and moderate consumption of alcohol. Weight-loss is the most important step in reducing hypertension and improving quality of life.

About the Author:

Jaymee Delaney, MD, is an Internal Medicine Physician in Tualatin, Oregon. She received her medical degree from Oregon Health Sciences University and did her residency at Legacy Hospital Program. She is a member of the Oregon Medical Association, which advocates and supports legislation on obesity issues. She is also an Advisory Board and Chairman's Council member of the OAC.

Her personal and professional interest lies with both adult and childhood obesity. Dr. Delaney has successfully influenced numerous patients on changing their lifestyles and to pursue healthier habits.

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I cannot count the times I have had a patient with weight gain come into my office certain they have thyroid disease. The conversation often starts like this, “I have had tests before, and they have been normal, but I have read all about low thyroid and I am sure mine must be low...”

Sometimes it is, and sometimes it isn't. In this article, we will review what the thyroid gland is, its role in metabolism and what happens when it malfunctions.

What is the thyroid gland?

Your endocrine system is a group of glands in your body (such as the pituitary, thyroid, pancreas, ovaries and testes) that secrete hormones (like growth hormone, thyroid hormone, insulin, estrogen and testosterone) that regulate functions such as metabolism, growth, development and reproduction.

The thyroid gland is the largest gland in the endocrine system. It is a butterfly-shaped organ that sits roughly in the middle of the neck, just below where the Adam's apple is in men. In your physical exam, when your doctor places a hand on the front of your neck and asks you to swallow, they are doing so to feel your thyroid gland.



The Role of Your Thyroid in Metabolism and Weight Control

By Jacqueline Jacques, ND

What does the thyroid gland do?

The thyroid gland produces three hormones: Thyroxine (T4), Triiodothyronine (T3) and Calcitonin. T4 and T3 are what most people think of as “thyroid hormones.” These hormones play a significant role in your metabolism and in energy regulation in the body. T4 and T3 are made in the thyroid gland from using the building blocks iodine (a trace mineral) and tyrosine (an amino acid). T3 has three molecules of iodine, and T4 has four. You make about four times the amount of T4 as you do T3.

After T4 and T3 are made, they are released by the thyroid gland into circulation. This release happens in response to stimulus from a part of your brain called the pituitary that makes a substance called Thyroid Releasing Hormone (TRH). TRH tells the thyroid gland to release thyroid hormones into your blood stream.

Thyroid hormones act on almost every kind of cell in your body to increase cellular activity or metabolism. If there is too much or too little thyroid hormone, the metabolism of your entire body is impacted.

Calcitonin, which this article will not focus on, is a hormone that reduces the amount of calcium and phosphate in the blood and promotes the formation of bone by signaling the body to absorb more calcium into the bone matrix.

Thyroid continued on page 14

Diseases of the thyroid

There are numerous things that can go wrong with the thyroid gland, but mostly they fall into three categories:

1. *Overactivity or Hyperthyroidism* – when the body makes too many of the thyroid hormones
2. *Underactivity or Hypothyroidism* – when the body makes too little of the thyroid hormones
3. *Growths* – this can include benign cysts, nodules or cancers of the thyroid gland

Thyroid disease is extremely common. According to the American Association of Clinical Endocrinologists, 27 million Americans have an over or underactive thyroid gland. Thyroid disease is much more common in women – 8 in 10 thyroid patients are female and women are between five and eight times more likely than men to develop a problem with the gland. One part of this gender imbalance is the strong tie between pregnancy and thyroid disease. Approximately 18 percent of pregnant women will develop a post-partum thyroid problem. In a quarter of these, the problem will be permanent.

Thyroid disease is also strongly linked to diabetes. People with diabetes and their close relatives are approximately three to five times more likely to develop thyroid disease as compared to the general population.

Hypothyroidism, metabolism and obesity

Because the thyroid hormones T3 and T4 control cellular metabolism throughout the body, when there is not enough of them for any reason, this metabolic function slows and becomes impaired. The most common causes of hypothyroidism are autoimmune failure (Hashimoto's Thyroiditis) and surgical removal or destruction of the gland. These latter treatments are usually done for thyroid cancer to treat hyperthyroidism or goiter (an enlargement of the thyroid gland). Outside of the United States, hypothyroidism is often caused by iodine deficiency. When there is not enough iodine to make thyroid hormones, the body cannot produce them. Iodine is added to salt in the US, which has eliminated almost all iodine deficiency.

Since thyroid hormone are important to all the cells of the body, symptoms can appear very general and may often be seen as vague in mild cases.

Signs and symptoms of hypothyroidism (underactive thyroid) include:

- **Fatigue**
- **Sleepiness**
- **Mood swings**
- **Forgetfulness**
- **Weight gain**
- **Depression/irritability**
- **Muscle cramping and aching**
- **Weakness**
- **Decreased perspiration**
- **Changes in blood pressure**
- **High cholesterol**
- **Swelling in legs**
- **Blurred vision**
- **Cold intolerance**
- **Hoarse voice**
- **Heavy menses**
- **Coarse, dry hair and skin**
- **Hair loss (on head and/or body)**
- **Constipation**

How is thyroid disease linked to weight and BMI?

While weight gain or difficulty losing weight is strongly associated with hypothyroidism, the connection with body mass index (BMI) and obesity is still not well understood. Several new studies have examined this and we are beginning to gain more knowledge.

A study published in the *International Journal of Obesity* in 2006 compared BMI and TSH levels in 6,164 adults from 1995 to 2001¹. In this study, higher BMI was associated with higher TSH (TSH is higher in hypothyroidism), and increases in BMI throughout the six-year period was positively correlated with increases in TSH. In a 2004 study of obese patients referred for evaluation at a sleep disorder clinic found previously undiagnosed subclinical hypothyroidism in 11.5 percent of patients². They also found a strong correlation with BMI and neck circumference.

In a group of 72 patients preparing for gastric bypass surgery, 25 percent were found to have undiagnosed subclinical hypothyroidismⁱⁱⁱ. They concluded that overall, morbid obesity was associated with elevated TSH and that weight-loss after surgery generally resulted in decreasing TSH. It is important to note that this study, however, did not find a direct association between TSH and BMI.

Several studies have found changes in TSH in obesity with normal levels of T4 and T3^{iv,v}. This has led some researchers to believe that there is another cause of the elevation of TSH that is not related to low levels of circulating thyroid hormones. Currently, a popular theory is that insulin resistance leads to changes in the thyroid that can result in changes in the gland and possibly in TSH levels of thyroid hormone levels^{vi}. Other things being examined are associations with leptin and adiponectin.

How do I get my thyroid checked?

There is enough evidence for undiagnosed thyroid disease in obesity, that if you are overweight or obese, it is probably a good idea to have your thyroid checked with your annual labs. This is even truer if you are female or know that you have insulin resistance or diabetes, because of the increased risk. The most common tests used to evaluate the thyroid are:

1. *TSH*: TSH is the most common screening test for thyroid disease. Levels of TSH rise when levels of thyroid hormone decrease. What constitutes “normal TSH” has been much debated in the past decade.

While the most recent consensus statement issued by a joint committee of the American Association of Clinical Endocrinologists (AACE), the American Thyroid Association (ATA) and the Endocrine Society (TES) stated that the upper limit of TSH should be 4.5 mIU/L, the AACE issued their own follow-up statement saying that “AACE uses an upper limit of normal for TSH of 3.0mIU/L established in a population of patients carefully screened for thyroid disease by the National Academy of Biochemistry in 2002.” Thus, if you have a TSH that is between 3 and 4.5, you may want to ask your doctor about repeat testing or further tests to explore for thyroid disease.

2. *T3 and T4 levels*: T3 and T4 are your circulating thyroid hormones. These may be checked on an initial screen or only if TSH is found to be abnormal. These tests should be done using a method called radioimmunoassay (RIA).



3. *Thyroid antibodies*: As Autoimmune destruction of the thyroid gland is the most common cause of hypothyroidism, sometimes your doctor will look at antibody levels. These include thyroid peroxidase antibody (TPO), thyroglobulin antibody (TgAb) and thyroid stimulating hormone receptor antibody (TRAb).
4. *Other tests*: Other tests that your doctor may use to look at your thyroid function include: TRH (thyroid releasing hormone), thyroid ultrasound and thyroid scan (radioactive iodine uptake test).

To learn more about thyroid disease, you can talk to your doctor or visit the following Web sites for more information:

- The American Thyroid Association: www.thyroid.org
- The American Association of Clinical Endocrinologists: www.aace.com
- The Endocrine Society: www.endo-society.org
- The Thyroid Disease Center at About.com: www.thyroid.about.com

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.

To view the references for this article, please visit the OAC Web site.

"I did it for the health of it"

By Angela Farley



I've struggled with my weight all of my life. Throughout school, I was bothered by the fact that I was overweight and it greatly impacted my high school years. I never had a date, went to any dances or to my prom. I didn't have many friends.

As a teenager and young adult, I tried several fad diets - Cambridge Diet, grapefruit diet, diet pills, laxatives, diuretics, cabbage soup diet, etc. Many I concocted on my own and always managed to lose weight. However, once I returned to my unhealthy eating habits I would immediately gain back all the weight I lost and more.

In my mid-thirties, after numerous years of physical, emotion and mental defeat, I finally decided to try a "structured" means to lose weight and it began with finding something I could do the rest of my life.

At my highest, I weighed 278 lbs. By utilizing the tools listed below, I was able to lose more than 130 pounds and have kept that off for five years. At times it's difficult to maintain my weight-loss, but it was more difficult living my life morbidly obese.

"I Am Not on a Diet"

The difference between losing weight this time and other times is that I realize I must do this the rest of my life. All my other "diets" were temporary things that I did until I lost weight. I am not on a "diet;" I am living a healthy lifestyle. This involves exercising regularly as well as added lifestyle activity such as taking the stairs whenever possible, mowing the lawn myself, running nearby errands on foot, etc.

I think all of these things are a recipe for success: eating sensibly, exercise 4-6 days a week, drinking water, an active lifestyle, recording my food intake and group support.

My source of group support is Take Off Pounds Sensibly (TOPS) Club, Inc. I think that group support is vitally important to long-term weight-loss success. Group support is also critically important to my continued success. It means I have a group of people I can turn to when I am presented with challenges and struggles. There are people that believe in me when I don't believe in myself. Someone is always there with pats on the back when I do well but, more importantly, they are there with hugs when I'm not doing well.

When I was nearing 100 pounds lost, one of my friends from my TOPS chapter arranged a “card shower” for me. Throughout that week, I received 65 cards from my TOPS friends encouraging me to stay on track and letting me know they were behind me. Cards were scattered everywhere; on the kitchen table to remind me to make good choices when I was preparing my meals; in the bathroom when I got ready for work as a positive way to start the day; on my desk to help me resist the challenges such as vending machines and donuts at the office; and even in my car to help me avoid temptations on the road.

It wasn't a matter of me not wanting to let them down as much as it was me wanting to make them proud! I did reach my 100 pound milestone that week and waiting for me was a large banner that they placed across the room that announced my success!

It's All about Support

The friend that arranged the card shower joined TOPS about the same time I did, and we were both about the same weight. After suffering a bit of a backslide, she is still on her health and wellness journey. However, to this day she is my biggest supporter. She's the person I'm able to turn to when I'm struggling, and she's always there for me. Someone that can be so supportive and encouraging despite their own trials and tribulations is a true friend and she's the epitome of a TOPS pal. That's the essence of TOPS!

It helps to surround yourself with people that are seeking the same outcome as you – a healthier, happier life! Whether male or female, young or old, any race or religion... we're all fighting the same battle. It's one we must continue to fight day in and day out. We might not win every battle, but if we never give up we can win the war on obesity!

In January of 2008, I was selected to be a TOPS Area Captain. The duties of the Area Captain are primarily to assist the chapters in a defined area with membership or general questions, field calls and emails from prospective members, participate in chapter events and visit the chapters throughout the year.

Being an Area Captain allows me to get personally involved in the lives of other TOPS members. I would love to see them succeed in their health and wellness goals and will do whatever possible to see that happen. I try to make myself readily

available via email and phone, and I believe the members in my area recognize that I'm as committed to seeing them achieve their goals as I was to reaching my own.

Whenever I visit a chapter, I always tell them that you never hear of someone that's morbidly obese dying of natural causes. It's always due to complications related to their weight: high blood pressure, heart attacks, some cancers, diabetes. It breaks my heart the number of lives that will be cut short because of obesity and the number of lives it will impact. People don't realize that their lives touch many other people. Think of the child that doesn't go to the park because their parents aren't as mobile as they should be; the parents that have to bury a child that died too young; the children that don't meet their grandparents because they died before their birth; or the kids that aren't learning healthy habits because their parents don't practice them. The list is truly endless.

A Different Life

If my life prior to 2001 (when I joined TOPS) was compared to my life today, people would probably believe that they were peering into the lives of two different people. The difference is remarkable. I went from wearing a size 28 to a size 8 or 10, and from a 3X shirt to a medium. When I began exercising, I completed a mile in 1 1/4 hours. My normal pace now is 4 miles or more per hour, and I'm planning on running a half marathon later this year. A few years ago, I went bike riding for the first time in many years. My

husband and I now average more than 200 miles each summer and biked as many as 50 miles on a single bike-riding trip.

My cholesterol, which was once more than 230, is now below 200. I have a resting heart rate in the 50's; at one time it was as high as 92. I once dreaded doctor appointments because I was sure eventually I was going to get the dreaded news that I had diabetes, but now I look forward to them because I'm anxious to see how my health has improved from one year to the next.

By far, the greatest change in my life has been my degree of happiness. While I'm still faced with the everyday pressures of life, they are much easier to deal with because I'm a much happier person. I'm also more open and will now say “Hi!” or “Have a good day!” to a stranger. Someone asked me once if people treat me differently since I've lost weight. My initial response was, yes. Then I realized, after self-examination, that a happier person is more approachable than someone that appears unhappy.

“I think all of these things are a recipe for success: eating sensibly, exercise 4-6 days a week, drinking water, an active lifestyle, recording my food intake and group support.”

Angela Farley continued on page 20



Healthy Kids Start at Home

By Chef Dave Fouts and Vicki Bovee, MS, RD

Make menu planning a fun learning experience. Plan themed dinners for once a week or once a month. Decide on your theme for the meal and sit the kids down for some help planning the meal. You may end up with some strange food combinations, but that is part of the fun. Here are some suggestions to get you started with a theme:

ABC Menu

Plan a meal with all foods starting with a letter of the alphabet. Everyone gets to pick a food for the letter of the meal. If the letter of the meal is “r,” you could include radishes, ribs, rhubarb, red peppers, rye bread, raisins, ravioli, raspberries or rolls. Have the kids get out the dictionary to look up foods for some of the more difficult letters. The ABC theme can give you at least 23 meals since you may have to combine some of the letters like q, x and z into another meal.

Color Menu

Plan the meal with all the foods the same color. It may not look exciting on the plate, but the planning is the fun part. Just keep in mind that there are no naturally occurring blue foods since blueberries are really purple.

Shape Menu

Plan your meal with all the foods the same shape. The foods can be naturally the shape you have chosen or you can cut them into the shape. If you are having a square meal, you can make hamburger patties into squares, trim the buns and make fruit cubes.

Four Course Meal

Design your menu around the following “courses:” salad, fruit or vegetable, entrée, side dish and dessert. Decide who gets to choose which course and then rotate courses for the next four course meal.

Getting Your Ingredients

The theme has been decided, the menu has been planned and now it is time for a trip to the market. Have the kids help find the recipes, check for ingredients on hand, and make out the shopping list. Give the list a double check to prevent a meal preparation emergency.

Plan the trip to the market when the kids (and you) are fed and have enough time. Avoid shopping with the kids right after school and activities. They will probably be tired and hungry and that combination does not make for an enjoyable shopping trip. For whatever theme you have selected, look for other foods that fit the theme, but didn't make it to the menu. As you go through the store ask the kids to look for other foods that start with the letter, color, or shape of the meal.

Preparing Your Themed Meal

Once you have been to the store, it's now time to prep and prepare your meals. Prep time should be fun, and inviting your children to help with the meal prep will reinforce great food choices. Different shapes and sizes of food is an easy way to keep your kids interested in healthy foods. Here are a few examples of easy food prep ideas:

- Using a sharp vegetable peeler, take a peeled carrot and run the peeler from the top of the carrot to the bottom. This makes a long thin strip which can be rolled to make carrot curls. This also works with cucumbers, zucchini, yellow squash, sweet potatoes and parsnips.
- Purchase a crinkle cutter (they are inexpensive) from your local kitchen gadget store. Take any washed vegetable and using your crinkle cutter cut your vegetable into thin strips. The crinkle cutter can also be used to cut cheeses as well.
- Cookie cutters are great for making premade sandwiches into fun shapes.
- Use food coloring to change the color of your food. Green oatmeal, yellow milk, red cream of wheat, blue mashed potatoes, etc.
- Using a sharp knife, cut vegetables into small cubes, triangles, rectangles and diamond shapes. This also works well with meat, chicken, fish and cheeses.
- Take peeled boiled eggs and using a cheese grater, shred your boiled eggs. These shredded boiled eggs can then be used on top of fresh salads, on top of a baked potato and even on top of cheese pizza.

Cook Smart...

Chef Dave Fouts

Eat Smart...

Vicki Bovee, MS, RD

Keeping meal time fun is easy. Here is a perfect "circle" meal to get your started.

Main Entrée:

Stuffed Cannelloni

- 8 kid size servings
- 8 cannelloni pasta tubes, cooked
- 2 cups part skim ricotta cheese
- 1 cup part skim mozzarella cheese, shredded
- 1 egg
- 1/2 teaspoon granulated garlic
- 1/2 teaspoon salt
- 1 teaspoon dried basil
- 2 cups jarred spaghetti sauce

Directions:

1. Mix cheeses, egg and spices together into a small bowl.
2. Divide cheese mixture into 8 equal parts.
3. Using a teaspoon, fill each pasta tube with cheese mixture.
4. Pour 1 cup spaghetti sauce into bottom of a 9x13 baking pan.
5. Next, place stuffed cannelloni on top of sauce.
6. Pour remaining sauce over stuffed cannelloni.
7. Place in preheated 350F degree oven and bake for 30 minutes and serve.

Per Serving: 230 calories, 15 grams protein, 9 grams fat (4 grams saturated), 40mg cholesterol, 21 grams carbohydrates, 2 grams fiber, 600mg sodium

Side Dish:

Sliced carrot rounds with peas steamed until tender

Dessert:

Bananas cut into thin rounds and blue berries mixed together, placed into a small bowl.

About the Authors:

Chef Dave Fouts is known as the world's premier culinary expert for weight-loss surgical patients. Chef Dave can be found speaking around the country on the importance of culinary techniques and cooking methods to ensure the weight-loss patient's success. For more information please visit www.chefdave.org.

Vicki Bovee, MS, RD, has been working in the field of weight management for more than 20 years. She has worked with thousands of patients in clinical and research practices. She is the clinical dietitian for Western Bariatric Institute in Reno, Nevada, conducting counseling sessions and teaching classes for pre-operative and post-operative patients.

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The Chairman's Council is the OAC's most prestigious membership level. As a Chairman's Council member, you make a commitment to improving education and advocacy efforts for the 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.

Angela Farley continued from page 17

A lot of people are under the misconception that I've overcome my food addiction. I haven't overcome it; I've learned to manage it. There are still backyard barbeques, buffets at weddings and showers, cake and ice cream at birthday parties and bagels and donuts at work. But, I've learned to never go to a party hungry, always have a healthy snack available and that everything can be enjoyed in moderation. The first bite of cake tastes the same as the last bite, so eating the whole cake is no longer necessary. The first spoonful of ice cream has the same flavor as the last, so a small bowl can satisfy me as much as the whole container. A single-serving bag of potato chips accompanied by a diet soda brings the same gratification as a large bag of chips with a regular soda.

It's hard work – there's no question about that! But, the trade-off between long-term health and happiness outweighs the short-term enjoyment derived from food. And, when all else fails, my TOPS friends are there to pick me up, dust me off and set me back on the right track!

The Ultimate Reward

Some of the ways that other people's lives are affected aren't immediately apparent. Other times, they are. In October of 2006, I was found to be a donor match for a friend needing a kidney. I was able to donate in August of 2007. I knew that losing weight would prolong my life. I never dreamt it would help me to prolong the life of another.



TAKE OFF POUNDS SENSIBLY

If you would like to speak with Angela Farley about her weight-loss journey or the TOPS organization, please email amfarleytopsac@aol.com.

Measuring Obesity in Children

By Shirley Schantz, RN, EdD, ARNP

Overweight and obesity are serious health concerns for children and adolescents. Almost 32 percent of children in the United States between the ages of two to 19 are overweight or obese. The number of overweight children has more than tripled throughout the past three decades. Overweight and obesity are the result of too many calories taken in for the amount of calories used (activity) and is influenced by heredity and family, dietary patterns, environment, lack of physical activity, socioeconomic status and health.

Obese children and adolescents are more likely to become obese as adults. About 80 percent of children who are overweight at ages 10-15 will be obese adults at age 25. If overweight begins before eight years of age, obesity in adulthood is likely to be more severe. As a result of obesity in children, it is estimated that this generation of young people will be the first expected to not live as long as their parents, and for children born in 2000, the lifetime risk of developing diabetes is estimated to be 30 percent in girls and 40 percent in boys if nothing is done.

Causes of Obesity in Children

The causes of overweight and obesity in children and adolescents are a combination of unhealthy eating patterns, a lack of physical activity, genetics, lifestyle, behavioral, psychological, socio-cultural and environmental influences. Childhood obesity can lead to various additional health risks, including type 2 diabetes, high blood pressure, coronary heart disease, high cholesterol, joint disorders, mental health issues and asthma. A family history of diabetes and being African American, Hispanic or Native American increases the risk of children and adolescents getting diabetes.

To prevent and manage overweight in children and adolescents, those who are overweight or obese must be correctly identified. One way to identify if a child or adolescent is overweight or obese is body mass index (BMI).

What is BMI?

BMI is a number calculated from a child's weight and height. BMI does not measure body fat directly but is a reliable indicator of body fatness for most children and teens and connects to direct measures of body fat. BMI is an accepted screening tool for a first assessment of body fat.

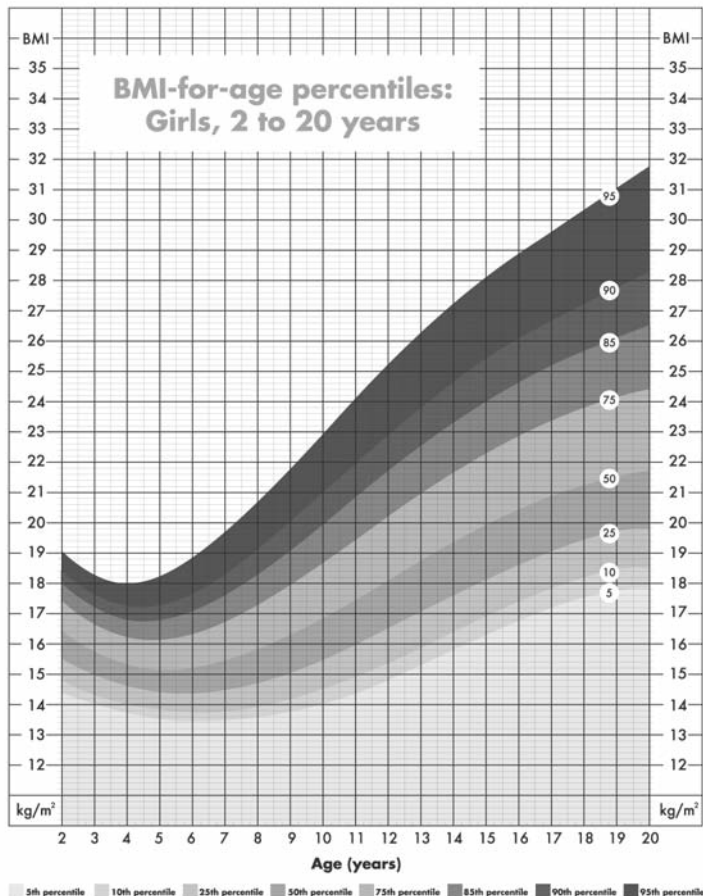
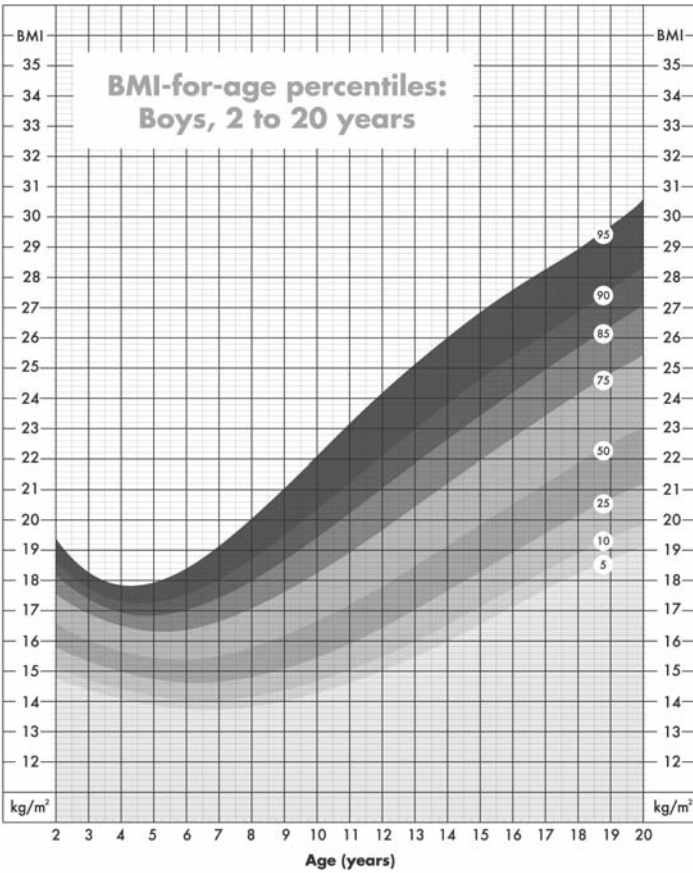
BMI is the screening tool used by the doctor or school nurse to identify overweight and obese children and adolescents who need further assessment or tests for health risks. It also indicates possible treatment and provides parents with information to help them take appropriate action. All parents should be provided with a clear and respectful explanation of the BMI results and a list of appropriate follow-up actions.

The CDC and the American Academy of Pediatrics (AAP) have recommended the use of BMI to screen for overweight and obesity in children beginning at two years old. When BMI is calculated, the age and sex of the child is taken into consideration and is referred to as BMI-for-age.

A percentile is a number that indicates where the child is compared to other children of the same age and sex. For example: What does it mean if my child is in the 60th percentile? The 60th percentile means that compared to children of the same age and sex, 60 percent (or 60 out of a hundred) have a lower BMI. Or, a 9-year-old girl at the 95th percentile has a higher BMI than 95 out of every 100 9-year-old girls. A youth's weight status is then identified from his or her BMI-for-age percentile.

The CDC has developed an online youth BMI calculator to compute BMI and the corresponding BMI-for-age percentile and weight status category. The site provides an interpretation of the result and can display it on the appropriate growth chart. To calculate your child's BMI visit www.apps.nccd.cdc.gov/dnpabmi/Calculator.aspx.

Obesity in Children continued on page 22



Importance of Measuring Obesity in Children

BMI measurement increases awareness for children and families about possible health risks for children and adolescents, and families may be motivated to take action after receiving their child's BMI results. Parents are encouraged to share the BMI results with physicians or primary health care providers. The best person to say whether your child's measurements are within a healthy range is your child's healthcare provider.

Emerging school-based efforts have focused on improving the quality of food sold in schools, limiting sales of less nutritious foods, improving physical education and health education, and encouraging increased physical activity either within the school day or through extracurricular activities. Parents have the power to change things at home and at school.

Further information about childhood overweight and obesity can be found on the OAC Web site at www.obesityaction.org, the CDC Web site at www.cdc.gov, and at the National Diabetes Education Program (NDEP) site for children and adolescents -Tips for Teens - Lower Your Risk for Type 2 Diabetes at www.ndep.nih.gov.

Determining a Child's BMI-for-age Percentile.

To plot your child's BMI-for-age percentile, you must first calculate his/her BMI. Once you calculate his/her BMI, find the age of your child on the bottom of the BMI-for-age percentile chart and look to the left or right to locate their BMI. Plot the point on the graph using a pen or pencil. Once you have plotted the measurement locate the corresponding shaded color on the bottom of the chart to determine your child's BMI-for-age percentile. You are then able to find your child's weight status by viewing the Weight Status Category table located on the right.

Weight status category	Percentile range
Underweight	Less than 5th percentile
Healthy weight	5th - 85th percentile
Overweight	85th - 95th percentile
Obese	95th percentile and greater

About the Author:

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<http://www.cdc.gov/growthcharts>





Membership



Building a Coalition of those Affected

About OAC Membership

The OAC is a grassroots organization and was created to bring together individuals impacted by the disease of obesity. One of the first steps to getting involved and making a difference is to become a member of the OAC.

Membership allows the OAC to build a Coalition of individuals impacted, bringing a unified voice in obesity. These are the individuals that make up OAC's membership:

- Those who are currently struggling with their weight, whether obese or morbidly obese
- Those who are seeking treatment for their obesity
- Individuals who have successfully and/or unsuccessfully treated their obesity
- Friends, coworkers and family members of patients
- Professionals whose work is dedicated to those affected
- Organizations that support efforts in obesity

You probably find yourself fitting into one of the categories above. This is because obesity affects just about every person in the U.S. and directly impacts more than 93 million Americans. With this number continuing to grow, so must our voice. And that is where **YOU** become an important part in what the OAC strives to do.

Membership Categories and Benefits

The OAC wants **YOU** to be a part of what we do. No matter how you're impacted, having individuals join our efforts who believe in making a difference is essential. That's why the OAC offers various member categories, so you can get involved at your desired level.

Several valuable benefits also accompany your OAC membership, including an annual subscription to OAC News. Each membership category offers something different. To learn more about membership benefits, please visit the OAC Web site at www.obesityaction.org.

Not ready to join the OAC as a paid member?

You can become a "Friend of the OAC" and still have your voice be heard. When joining the OAC in this category, you can get involved in our efforts while receiving electronic benefits. There is no charge to become a "Friend of the OAC." To sign-up, check the box below and complete the application.

- Sign me up as a "Friend of the OAC."

Membership Application

Yes! 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
(Doctors' offices, weight-loss centers, surgery centers, etc.)
- OAC Chairman's Council: \$1,000 and up

Mail to: OAC
4511 North Himes Ave.
Suite 250
Tampa, FL 33614

Or Fax to: (813) 873-7838

Name: _____

Company: _____

Address: _____

City: _____ State: ____ Zip: _____

Phone: _____ Email: _____

Payment Information

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

Please charge my credit card for my membership fee:

- Discover® MasterCard® Visa® Amex®

Credit Card Number: _____

Expiration Date: _____ Billing Zip Code: _____

Signature: _____

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.



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 resources for patients, as well as professionals. OAC resources are complimentary and members of the OAC can request materials in bulk. To request materials, please contact the OAC National Office at (800) 717-3117 or send an email to info@obesityaction.org.

Magazine

- OAC News - OAC's quarterly education and advocacy publication for patients

E-newsletter

- Obesity Action Alert - the OAC's free monthly electronic newsletter

Brochures/Guides

- BMI Chart
- OAC Insurance Guide
- State-specific Advocacy Guides

- More than 100 obesity-related topics located on the OAC Web site
- 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
 - Understanding Your Weight-loss Options Brochure



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