Sydney National Obesity Forum 2017 – Audience Q&A – Dr Gary Kilov & Prof John Dixon

Question	Answer
How should we talk to children about healthy eating and weight? There are concerns that if you overemphasize it then that may cause issues with body image and predispose to eating disorders. The other concern is whether we are teaching our children to judge overweight people.	The approach should be informative, age appropriate and factual (much as we might have a chat about sex education!). Obesity represents the commonest form of disordered eating and is significant health hazard. Prof Dixon and others have shown that addressing obesity does not predispose to eating disorders such as anorexia and bulimia. Obese individuals are subject to extraordinary prejudice at all ages. Discussing obesity in a factual, non-judgmental way will educate and inform and help to strip away misconceptions and the stigma of obesity as it has for mental health.
Where do we find good resources on portion control for children and how much they should be served i.e. what is 1 portion for a child compared to an adult	GPs would be best advised to involve a dietitian skilled in this area. It is highly specialized. The needs of growing children are complex and vary according to age. We see the seemingly paradoxical dual pathology of obesity and malnutrition, particularly in low SES communities in first world countries and internationally in emerging economies. As was discussed at the forum children have excellent portion control and will not eat to excess unless coerced by adults or the type or food provided. Bring into the home only what you want your family to consume.
What pharmacological managements do you recommend for obesity what is the first line treatment and how do they compare in their efficacy?	We have so few agents that first choice for efficacy can be problematic. Contraindications, precautions, drug interactions, patient preference and cost all come into play. When a patient is a responder to any of the medications then there is real value in the long term. As we cannot predict responses it comes down to trying the agents that are available to an individual patient.
I understand the idea of parents giving the quality and children the quantity but talk to many parents whose children just always refuse meat or refuse vegetables long term. So what advise can we give those parent? Do you start to restrict the more popular food?	Children can go through very rigid patterns of eating behaviour. These tend to be transient and need to be differentiated from pathological behavior that might be seen in autism spectrum for example. Homo sapiens survived for the vast majority of human existence with far less variety that we now enjoy. What might seem a restrictive diet by today's standards is probably better and more varied than parents might think. However, when in doubt the child should be assessed by a dietitian skilled in this area. Alternatively, specialist referral may be indicated. Remember children will take time to learn to enjoy individual foods, especially vegetables, don't give up just continue exposure and limit the preferred foods.

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Prof Dixon what is your opinion on the evidence behind lower carbohydrate higher portion diets in the obese and in particular in diabetics?	I assume you are interest on the evidence for weight loss? Then there is glycaemic control, quality of life, preventing complications and increasing quality life years? The value of low CHO diets tend to favor better weight loss, improvement in some CV risk factors and glycaemic control in the short term. But there may be mixed effect over the longer term. The DASH diet and Mediterranean diet score best for overall diets. Also remember we need to think about the planet when considering a major reduction in CHO intake.
drug therapy metformin vs Duromine which is better? Can both be used together metformin use without insulin resistance?	Metformin is weight neutral in most people. In very few it may induce some weight loss. It is not TGA approved or PBS reimbursed for weight loss so would be off label. Phentermine is licensed and effective for weight loss. However, it is only approved for 3 months continuous use. Nevertheless, multiple courses can be administered over time.
How do you engage the overweight parent about the child's weight or risks when they are likely to have negative experiences with HCW and weight loss themselves? Is my approach to children different to adults? Especially when the parents control their environment	Many patients are sensitized by negative prior experiences with insensitive HCPs. However, if one is empathetic, sensitive to their distress patients will often be quite relieved to have a GP that not only 'gets it', but if going to offer some assistance and support.
If a child is on both the 90th centile for height AND weight does this mean that their weight is appropriate for their height or are they still obese?	This highlights one of the limitations of our ways of assessing obesity. The child just described is simply a big child but quite suitably proportioned. Remember to use BMI charts for assessing children for weight issues not weight and height tables separately.
If a toddler has a very healthy diet but is overweight is it still an issue? Should they have reduced portions even if they want to keep eating?	Healthy overweight is transient and comorbidities do accumulate in time. In this instance, the quality of food is right but the quantity needs tweaking. Provide the right food, water in my cup, be part of an active family, limit screen time, and be very careful with treats
Do you feel that infant formulas with a higher protein level may contribute to programming children's eating patterns in turn make them prone to being overweight adults?	The causes of obesity are complex and multifactorial. I am unaware of specific contributions from any infant formulae. However, as a rule and when possible, breast is best. This applies not only for prevention excess weight but for many other reasons. There is no evidence regarding infant milk formulas, or breast milk increasing the risk of overweight and obesity. It appears that the timing of introduction of to a broader diet increases risk. This is why it is suggested to stick to milk for 6 months.

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What age would you use the BMI chart in children? Is 2 yo too young? Is there a role for WC given they tend to have more evenly distributed fat?	The CDC BMI charts begin at 2 yrs. so, this is appropriate. However monitoring weight trajectories earlier than two years may be necessary if the infant is gaining weight rapidly and crossing percentile lines or if there is significant discordance between weight and length (height)
How do you deal with teenagers who continue to buy the junk foods and soft drinks at school and at the local supermarkets and have cravings they can't control and parents can't control them? Can you use medications in these kids? What is the minimum age?	Engaging teens is challenging. The WIFM principle might apply. What 'hook' might engage the teen? Being more attractive to the opposite sex? Being able to perform better on the footy field? Concerns about future health issues tend to be a low priority in this age group!
I found the children quite challenging to talk to. They are often more defensive than the parent. Any suggestions?	The approach should be informative, age appropriate and factual (much as we might have a chat about sex education!). It may take some time to get their trust. They might be defensive because the feel they're 'in trouble'. If we make it clear that we realise how challenging this can be for them and that we are there to help, not admonish, the attitude might change.
If a patient is on a weight loss drug but continues an unhealthy diet and is physically inactive is the drug still effective? Are there any harmful side effects of these drugs in the absence of diet and exercise?	If the patient continues an unhealthy lifestyle they are not engaged in the management plan. The medication will still work but the results will be suboptimal. It may be worth reconsidering the treatment approach at this stage. Drugs control appetite and satiety and therefore are great enablers for improved lifestyle – control can now assist in following a diet!
How do we approach the issue of obesity with parents?	Obesity is a health issue and should be treated as such. Using BMI charts to show the parents that their child is obese and then address the health issues. (Showing them a copy of the diagram depicting health issues for obese children, such as the one used in one of my slides, is an effective visual representation of the health data in summary form)
Parents are often defensive when their child's obesity is addressed particularly regarding cooked meals grocery purchases etc. How do you suggest we approach it?	Obesity is a health issue and should be treated as such. Using BMI charts to show the parents that their child is obese and then address the health issues. (Showing them a copy of the diagram depicting health issues for obese children, such as the one used in one of my slides, is an effective visual representation of the health data in summary form)
The portion size of Core Food groups for children are available on the Eat For Health Website	Thank you. These are useful guidelines but would need to be individualised

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Where are the public places pts can have bariatric surgery at lower costs and what are the average costs for bariatric surgery where indicated?	Most bariatric surgery is performed in the private sector. Whilst this is a highly effective treatment it is invasive, expensive and not scalable to population levels. Costs vary considerably according to the procedure being performed and the surgeons billing practice, but would be around 15K, a variable amount covered by private health funds. Access to public bariatric surgery varies by state, city and region. It is woefully inadequate in the best serviced areas and not available at all to many in real need. Learn what is available in your area and how it can be accessed.
Childhood obesity is getting worse while out of school sport programs are getting more expensive. Cheaper out of school sports can help fix this. What about government rebates for out of school sports? Do you think this would help how do we make it happen?	This is a whole of society problem requiring a whole of society solution. You suggest initiatives that seem very reasonable. How to make this happen in the more challenging question. Local community initiatives can be very successful if they resonate with the population. One such example is the popularity of Park Runs. I commend the idea. However, we need evidence based interventions and sadly data is thin on the ground for out of school interventions or negative. Governments have wasted millions of dollars on thoughtful initiatives that have not worked. Walking school buses is but one example.
The odds of an obese adult maintaining weight loss over the long term is fairly poor, what are the odds for children?	The weight trajectory for children is more variable than for adults with similar percentage (~9%) becoming obese from a healthy weight range as those reverting to healthy weight from being overweight or obese. The majority however, have fairly predictable trajectories with most obese and most lean individuals tracking along this same course. Certain ethnicities and those of lower SES are at higher risk of unhealthy weight trajectories. Age is also a major determinant prior to puberty obesity as an adult is strongly predicted by parental weight, after it is largely driven by the individual's weight.

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For How long we can give duromine? Do we have to stop after 3 months what is the maximum duration we can give can we increase the dose from 15 mg up to 30 after 3 months Can we treat pts on SSRIs with Duramine?	Phentermine is licensed and effective for weight loss. After 3 months the decision to continue phentermine is made on an individual basis between the patient and the doctor. The decision should be based on efficacy, absence of major side effects and signals of CV risk for example raised blood pressure. It is now approved for continuous use in the US in combination with topiramate. We need to be very careful with SSRIs as there is a very small serotonergic effect with phentermine. It should be considered a precaution and the 15 mg starting dose chosen, monitor the patient and warn the patient about symptoms of the serotonin syndrome. There is some data around the efficacy of Fluoxetine in weight loss, so this might be an SSRI to consider.
Would early intervention in preventing Obesity lead to more Eating Disorders? How can we promote health weight without shame and guilt from a young age? Are there any studies looking at the 10 who never get fat no matter what they do? Is there a skinny gene we can harvest?	The approach should be to provide informative, age appropriate advice. (much as we might have a chat about sex education!). Obesity represents the commonest form of disordered eating and is significant health hazard. Prof Dixon and others have shown that addressing obesity in children does not predispose to eating disorders such as anorexia and bulimia. Obese individuals are subject to extraordinary prejudice at all ages. Discussing obesity in a factual, non-judgmental way will educate and inform and help to strip away misconceptions and the stigma of obesity as it has for mental health.
What is the maximum duration to use duromine if working?	The PI allows for 3 months. This can be repeated at patient and HCP discretion
As a GP registrar I find it difficult to decide between Duromine and Orlistat. Due to supervisor preference I lean towards Duromine but what considerations do you use to choose?	Both agents are effective when used correctly and in combination with lifestyle modification. However, both have potential tolerability issues and it may well be that the patient will need to trial each agent to determine suitability. Pulse therapy may involve alternating between courses of different therapies as treatment needs to be ongoing to maintain weight loss. Patient preference should ultimately dictate the choice of agent. Phentermine is possibly more efficacious. Should the phentermine/topiramate combination become available in Australia, this would be the better choice. (Currently available in the US and hopefully in Australia in the not too distant)
Public Health Units should be funded to target low SES and other at risk groups to allow clinicians to even open discussion	This is a whole of society problem requiring a whole of society solution. You suggest initiatives that seem very reasonable. How to make this happen in the more challenging question.