

Weight management and weight stigma: Why these are everyone's responsibility

Attending this year's *European Congress on Obesity* (ECO) from Maastricht, as a virtual delegate with colleagues on the Royal College of General Practitioners GP Leadership in Obesity and Weight Management (GLOW) Programme, was a wonderful opportunity to network, update my knowledge, and to refocus and reflect on obesity and weight management.

It has been 25 years since the World Health Organization recognised obesity as a chronic disease, defining it as "excess or abnormal adipose tissue that causes a deterioration in health". In March 2021, obesity was defined by the European Commission as a "chronic relapsing disease which acts as a gateway to a range of other non-communicable diseases", identifying it as a non-communicable disease in its own right.

A recently published UK and Finnish cohort study (Kivimaki et al, 2022), reminds us that obesity is associated with at least 21 non-overlapping conditions, including type 2 diabetes, and therefore could serve as an important target for preventing or managing multimorbidity, instead of trying to manage the individual diseases one by one. In her opening plenary at the conference, Rachel Batterham (Professor of Obesity, Diabetes and Endocrinology, UCL Division of Medicine, London) summarised these chronic conditions associated with obesity into metabolic, mechanical and psychological, and highlighted the impact that obesity had on severity of COVID-19. She discussed how precision medicine (delivering the right treatment to the right patient at the right time) can harness science to decide who to manage and to inform our decisions about how to manage obesity.

Time to rethink reliance on BMI?

I have long been an advocate for using waist circumference rather than BMI (Brown, 2009),

as I believe it better conveys risk and is more motivational for people as they lose weight, since visceral fat, and hence waist circumference, usually decrease faster than subcutaneous fat. In his session highlighting the deficiencies of BMI in the diagnosis and management of obesity, Carel le Roux (Professor of Experimental Pathology, University College Dublin) reminded us that we should instead rely on the pathognomonic symptoms of obesity (being hungry all the time and lack of satiety when eating) – symptoms that disappear when obesity has been effectively managed with lifestyle, drugs or surgery. He stressed that we should use the presence of obesity-related health conditions to identify who needs obesity treatment, especially drug treatment or surgery, rather than relying on BMI.

When assessing obesity-related conditions and their impact and making management decisions, Professor Batterham reminded us that the Edmonton Obesity Staging System (EOSS), available since 2009 (Sharma and Kushner, 2009), is a good predictor of mortality (Padwal et al, 2011), while BMI is not. So although BMI, along with diabetes and hypertension, has proven to be a useful marker for risk of severe COVID-19 disease, hospitalisation and death, we should perhaps rethink our reliance on it for deciding where to focus our attention in managing obesity. EOSS ranges from Stage 0 (no obesity-related comorbidities and no physical or functional limitations), where our goal is to help people avoid weight gain, to Stage 4 (end-stage organ failure from obesity-related chronic diseases and severe disabling physical symptoms, functional limitations and impairment of well-being), where we should be pursuing obesity management options as aggressively as the person living with obesity prefers. If you have not used it previously, please take a look [here](#).



Pam Brown
GP in Swansea

Citation: Brown P (2022) Weight management and weight stigma: Why these are everyone's responsibility. *Diabetes & Primary Care* 24: 29–32

“We have a duty to help people understand that since obesity is a relapsing, chronic, lifelong disease, weight regain is to be expected.”

The weight-reduced state

Throughout the conference, it was agreed that double-digit weight loss is now achievable using modern drugs soon to be available in specialist centres in the UK, and with bariatric/metabolic surgery, but that weight maintenance is the key challenge both for people living with obesity and for us as healthcare professionals (HCPs) assisting with management. We all have inbuilt physiological mechanisms that increase hunger (thanks to increased ghrelin), decrease satiety hormones, increase brain reward-centre responses to food cues (increasing interest in food) and reduce energy expenditure – all designed to protect us from starving and remaining in the weight-reduced state. These are powerful, unconscious, primitive drivers over which we have no control and that lead not just to weight regain but often to weight increasing to levels above baseline, the classic yo-yo dieting pattern.

Since so many of our diabetes-related goals – prevention, remission, tight glycaemic control – ideally require weight loss, we need to better understand this weight-reduced state and these mechanisms (Laughlin et al, 2021). Perhaps most importantly, as clinicians, Professor Batterham reminds us we have a duty to help people understand that since obesity is a relapsing, chronic, lifelong disease, weight regain is to be expected and people should not beat themselves up when it occurs. Rather, we need to use the science to find and explore ways to reduce the weight set point, helping achieve weight maintenance in the longer term. Look out for more discussion on this interesting topic in a future issue.

Time to end weight stigma

My most important take-home messages from the sessions so far relate to weight stigma. Although aware of weight stigma, I was unaware of the detrimental physiological impact this can have on people living with obesity. According to Professor Batterham, experiencing a weight-stigma event triggers an immediate acute stress response, elevating cortisol levels and blood pressure, and associated with increased energy intake, a preference for high energy foods, as well as psychological distress.

I was also surprised to hear that HCPs are perceived to be the biggest source of weight stigma. Weight stigma results in confused and incorrect medical and media messages, and can prevent people accessing evidence-based treatments. People who experience weight stigma are less likely to seek and receive appropriate care, and are more likely to cancel healthcare appointments and not seek medical care when this is needed. We need to really understand that obesity is not a choice and cannot be reversed simply by choosing to eat less or exercise more. The International Weight Stigma Consensus Panel highlights (Rubino et al, 2020), and Professor Batterham stressed in her address, that weight stigma is one of the major obstacles in our efforts to effectively prevent and treat obesity, and hence reduce type 2 diabetes. Quoting the panel, “Tackling stigma is not only a matter of human rights and social justice, but also a way to advance prevention and treatment of these diseases.” The consensus document provides a sobering read about the impact of stigma on people living with obesity and our significant role as HCPs both in perpetuating it and in taking steps to reduce it. Surely, therefore, it is time for us to take notice, reflect and review what we are doing and what we can change?

So what can we do right now to manage obesity and impact diabetes?

We can ask for permission to raise the topic of weight more often, and follow the lead of the person sitting beside us as to whether the time is right for further discussion or action. We can recognise and share that weight regain is normal, and is a direct consequence of primitive mechanisms designed to protect us from starvation. We can learn from those who lose weight and manage to maintain it.

We know from studies such as Look AHEAD (Look AHEAD Research Group, 2010) that initial weight loss predicts long-term weight loss and, therefore, by 2–3 months into a weight loss programme, we should be able to pick out those who would benefit from additional support – referring to our dietitian colleagues, health coaches, exercise on prescription and weight management programmes. To do this effectively,

we need to know exactly what is available in our area and how to refer or signpost. The fastest growing group developing overweight and obesity in the UK are young men aged 18–24 years (Kattsoulis et al, 2021), people we rarely see in our surgeries, so we need to work with colleagues to find innovative ways to reach them.

We now have a clear idea how much weight loss will have beneficial impact on chronic conditions: 0 to 5% weight loss will help with blood pressure and glucose levels; 5 to 10% can prevent type 2 diabetes, improve dyslipidaemia, fatty liver and asthma, and reduce urinary incontinence; and 10–15% can impact on NASH, obstructive sleep apnoea, reflux and knee osteoarthritis. Finally, achieving >15% loss may begin to reverse NASH with fibrosis, reduce cardiovascular disease risk, heart failure, death from heart disease and stroke, and allow more than 80% to achieve type 2 diabetes remission. But we should also remember that any weight loss is likely to be beneficial.

Since most bariatric/metabolic surgery services and Tier 3 weight management clinics are reopening their doors, the time may be right for referrals. Once-weekly injectable semaglutide is pending NICE approval for use in specialist weight management clinics, early data on cagrilintide in combination therapy has been published and data on weight loss with tirzepatide was presented at the conference. All demonstrate that double-digit weight loss may soon be achievable for those who can access treatment.

However, for people to access the help they need, we in primary care need to discuss weight more often and raise it sensitively. How many of us can honestly say we make time to discuss weight whenever it is acceptable to the person sitting beside us in surgery? How often do we refer or signpost, and how often do we seek the help of our dietitian and other colleagues who can provide the support that we believe we do not have the time to provide?

In this issue

This year's hybrid *Diabetes UK Professional Conference* in London was a wonderful opportunity for people to meet face-to-face after the pandemic. We share [breaking news stories](#) from the conference and devote our *Conference*

over Coffee to [key take-home messages](#) on NAFLD and NASH from the conference.

COVID-19 has had a huge impact on all diabetes services and, in this issue, Rose Butler and colleagues share how their team adapted, to continue to deliver [diabetes structured education](#) throughout the pandemic. Indirect effects of the pandemic include delayed diagnoses of type 2 diabetes, delays in reviews for those with existing type 2 diabetes and potentially unhealthy changes in lifestyle. All of these appear to have contributed to the perception that we are seeing more people with high HbA_{1c} levels. These can be complex consultations as not only do we have to ensure appropriate prioritisation and safety netting in case the person needs urgent assessment or admission, but we also need to decide whether another condition, such as pancreatic malignancy, could be underlying a significant HbA_{1c} deterioration in someone previously well-controlled or in someone newly diagnosed. Jane Diggle and I prepared and field-tested "[How to manage high HbA_{1c} in people with type 2 diabetes](#)", a resource to help guide ourselves through the preparation for and execution of such consultations. We presented and discussed this at the [All Ireland Conference of the PCDS](#) earlier this year and discussed it as part of the [PCDS Question Time](#) programme, and it is included in this issue. We are grateful to the members of the original LEAD GPs group who helped develop the original idea. We hope you find it useful and welcome feedback on how we can further improve it.

Joseph Henson and colleagues guide us on how to encourage appropriate [physical activity](#) in people living with diabetes in our *At a Glance* factsheet. We commissioned Patrick Wainwright to address our questions on lipids gathered from our day-to-day practice. The [first part](#), focusing on measuring lipids and lipid targets, is included in this issue, with further Q&As to follow. Our case study, focusing on "[Managing type 2 diabetes during Ramadan](#)" was live and provided useful learning throughout Ramadan, and will remain available for teams to prepare for next year.

In *Diabetes Distilled*, Kevin Fernando shares a concerning cohort study suggesting those suffering COVID-19, even if not hospitalised,

“People who experience weight stigma are less likely to seek and receive appropriate care, and are more likely to cancel healthcare appointments and not seek medical care when this is needed.”

“How many of us can honestly say we make time to discuss weight whenever it is acceptable to the person sitting beside us in clinic?”

may be at [increased risk](#) of developing diabetes during the 12 months following their acute infection. We also share a study demonstrating the association of both tight early glycaemic control in those newly diagnosed with type 2 diabetes and subsequent [glycaemic variability](#) on cardiovascular risk, and explore the association between both [weight loss and weight gain](#) with adverse cardiovascular events in people with type 2 diabetes. Finally, we summarise the key recommendations of an international consensus group on diagnosis and management of [diabetic sensorimotor polyneuropathy](#).

I hope that you will all manage to make some time to rest, relax and recharge your batteries this summer and will emerge re-energised to continue coping with the high workload. ■

- Brown P (2009) Waist circumference in primary care. *Prim Care Diab* **3**: 259–61
- Katsoulis M, Lai AG, Diaz-Ordaz K et al (2021) Identifying adults at high-risk for change in weight and BMI in England: a longitudinal, large-scale, population-based cohort study using electronic health records. *Lancet Diabetes Endocrinol* **9**: 681–94
- Kivimaki M, Strandberg T, Pentti J et al (2022) Body-mass index and risk of obesity-related complex multimorbidity: an observational multicohort study. *Lancet Diabetes Endocrinol* **10**: 253–63
- Laughlin MR, Osganian SK, Yanovski SZ et al (2021) Physiology of the Weight-Reduced State: a report from a National Institute of Diabetes and Digestive and Kidney Diseases Workshop. *Obesity Silver Spring* **29**: S5–8
- Look AHEAD Research Group (2010) Long-term effects of a lifestyle intervention on weight and cardiovascular risk factors in individuals with type 2 diabetes mellitus: four-year results of the Look AHEAD trial. *Arch Intern Med* **170**: 1566–75
- Padwal R, Pajewski N, Allison D et al (2011) Using the Edmonton obesity staging system to predict mortality in a population-representative cohort of people with overweight and obesity. *CMAJ* **183**: E1059–66
- Rubino F, Puhl RM, Cummings DE et al (2020) Joint international consensus statement for ending stigma of obesity. *Nat Med* **26**: 485–97
- Sharma AM, Kushner RF (2009) A proposed clinical staging system for obesity. *Int J Obes (Lond)* **33**: 289–95