

# OBESITY: KEYSTONES OF CARE IN PRIMARY CARE

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Northern Ireland PCDO

# Dr Eimear Darcy

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- NHS GP Partner
- MB BCH BAO DMH MRCGP (2017)
- PG Cert Diabetes (Distinction)
- SCOPE certified in Obesity Management (ongoing era of enlightenment)
- Disclosures:
- Eimear has received sponsorship for education events, or has received fees for educational speaking, travel or advisory board attendance from: AstraZeneca, Abbott, Bayer, Boehringer Ingelheim, Lilly, Novo Nordisk, Notovaris, Menarini, Napp and Daiichi Sankyo
- Claude AI was used in the preparation of this presentation

# Learning Objectives

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## OFFICIALLY..

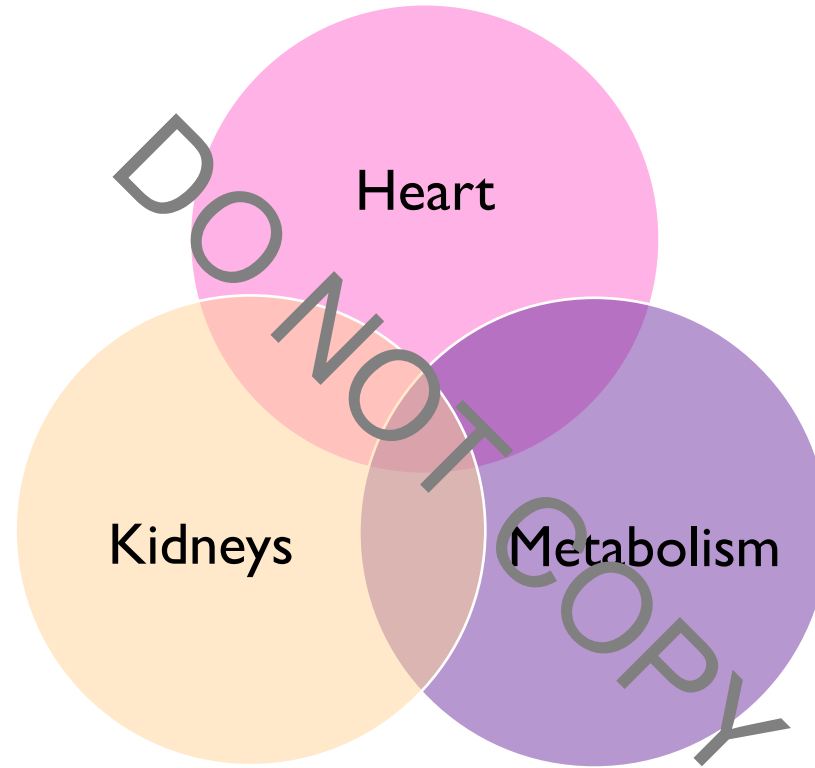
- Insights into the key components of the modern management of obesity in NHS General Practice
- in the context of obesity as a disease in the CKM syndrome and the broader obesity related complications

## PERSONALLY...

- Sharing learning to help each other build a new standard of care in General Practice



# CVRM = CKM = CAREME/CRM



## MULTIPLE LONG-TERM CONDITIONS (MTLCS)

**Obesity** is an **independent** disease state within the CKM syndrome that deserves **independent** attention....in **GENERAL PRACTICE**



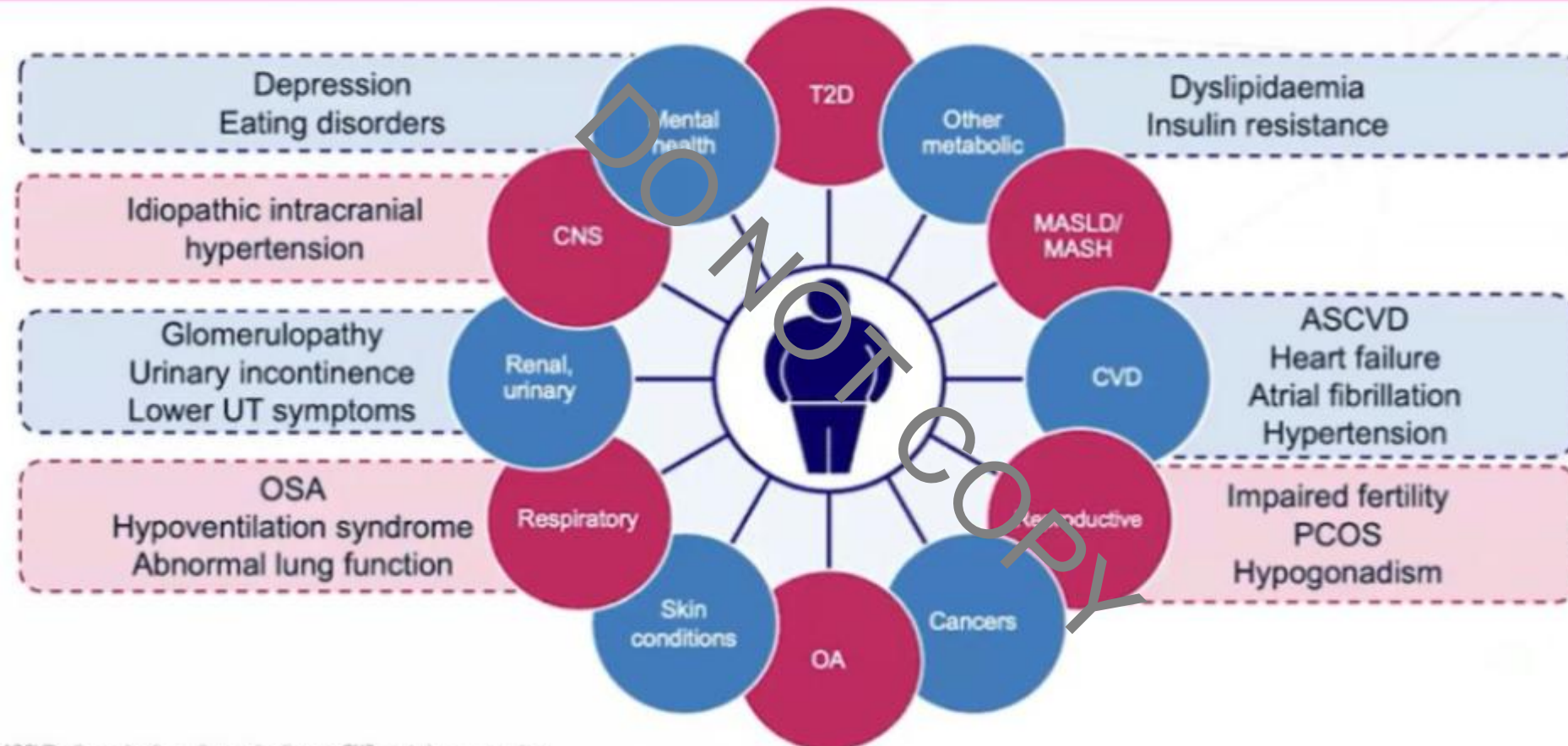
stage

sits

in

General Practice

# 200+ Obesity Related Complications, 13 different malignancies



ASCVD, atherosclerotic cardiovascular disease; CNS, central nervous system; CVD, cardiovascular disease; MASH, metabolic dysfunction-associated steatohepatitis; MASLD, metabolic dysfunction-associated steatotic liver disease; OSA, obstructive sleep apnoea; OA, osteoarthritis; PCOS, polycystic ovary syndrome; T2D, type 2 diabetes; UT, urinary tract. Icon: Obesity by Arif Hariyanto from [Noun Project](#) (CC BY 3.0).

Rubino F, et al. *Lancet Diabetes Endocrinol.* 2025;13:221–262.

Review of the potential value of treatment targets in obesity management

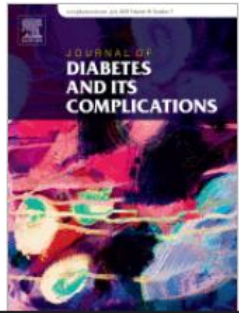
Faisal Almohaileb <sup>a,b</sup> and Carel W. le Roux<sup>b</sup>

<sup>a</sup>Department of Family and Community Medicine, College of Medicine, Qassim University, Buraydah, Saudi Arabia; <sup>b</sup>Diabetes Complications Research Centre, University College Dublin, Dublin, Ireland

**“obesity care will resemble modern diabetes care with pathways, targets, stepwise intensification....  
.....this will mark a change in...approach...obesity as a chronic, modifiable disease.”**

Obesity and its management in primary care setting

Mahmoud Ibrahim <sup>a</sup>  , Ebtesam M. Ba-Essa <sup>b</sup>, Jessica A. Alvarez <sup>c</sup>, Jason Baker <sup>d</sup>, Vincenzo Bruni <sup>e</sup>, Avivit Cahn <sup>f,g</sup>, Antonio Ceriello <sup>h</sup>, Francesco Cosentino <sup>i</sup>, Melanie J. Davies <sup>j,k</sup>, Francesco De Domenico <sup>l,m</sup>, Robert H. Eckel <sup>n</sup>, Allon N. Friedman <sup>o</sup>, Jonathan Goldney <sup>j,k</sup>, Omer Hamtzany <sup>p</sup>, Scott Isaacs <sup>c</sup>, Sehnaz Karadeniz <sup>q</sup>, Richard David Leslie <sup>r</sup>, Ildiko Lingvay <sup>s</sup>, Sue McLaughlin <sup>t,u</sup>, Omar Mobarak <sup>v</sup>...Guillermo E. Umperiez <sup>c</sup>



Journal of Diabetes and its Complications  
Date: July 2025  
Article: 109045  
Volume: Volume 39, Issue 7

# First - Do no harm

*Our weight bias is harming patients we are trying to help*

**1**

**Reduced healthcare  
use**

**2**

**Avoidance of physical  
activity**

**3**

**Low mood, reduced  
self-esteem**

**4**

**Increased binge  
eating**

**TAKEAWAY**

**Treat obesity as you would any other chronic disease.**

# Obesity Is Not A Choice

**Cause – complex , multi-factorial , not completely understood**



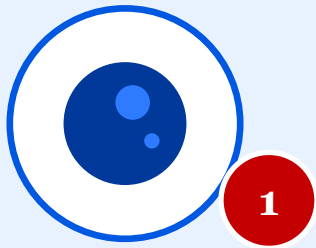
Adapted from Wharton S et al. CMAJ 2020;192:E875–91; Westbury S et al. Curr Obes Rep 2023;12:10–23.

**Treat obesity as a disease, not a behaviour. Stigma is a clinical harm.**

# BMI Doesn't Tell You Who's Actually Unwell

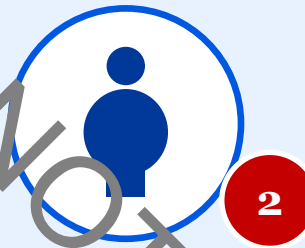
*It's a physical measurement — 3 things matter more.*

BMI does not consider:



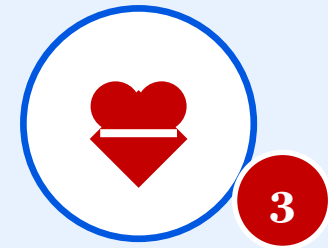
**Fat mass**

How much fat is present.



**Fat distribution**

Where the fat sits.



**Sick Fat & Impact on health**

If the adiposity is causing further disease.



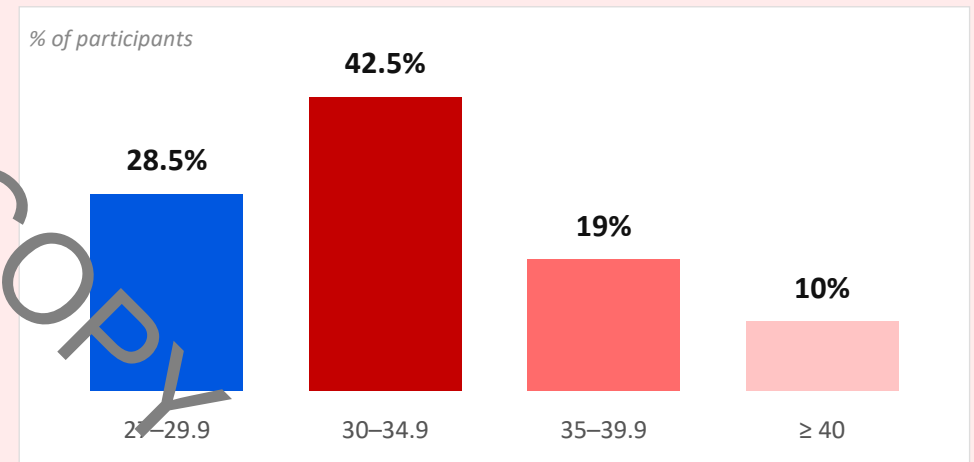
**BMI alone leads to both underdiagnosis & overdiagnosis.**

# Disease Often Occurs Below BMI Obesity Threshold

**BMI alone misses sick patients.**

## **SELECT trial — all had CVD**

*Baseline BMI of patients enrolled with established cardiovascular disease:*

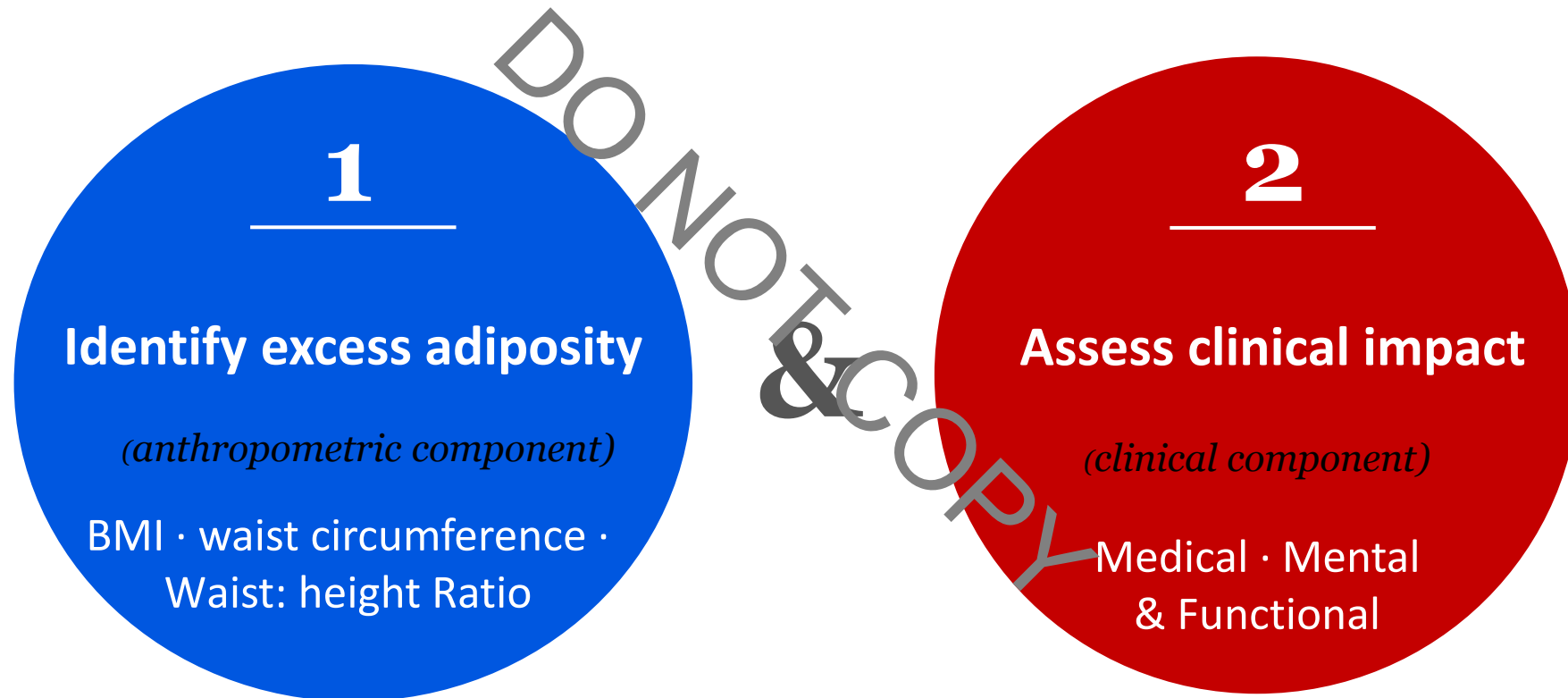


**71% had BMI < 35**

*All had established cardiovascular disease.*

# Rethinking How We Diagnose Obesity

*Diagnosis – measurement & clinical impact.*



**.Assessing both together will inform future obesity care.**

# Preclinical versus clinical obesity: *Lancet* Commission

Obesity: **excess adiposity**, *with or without* abnormal distribution or function of adipose tissue

**Preclinical obesity**



**Excess adiposity with:**

- Preserved function of other tissues & organs & ADLS, AND
- increased risk of developing clinical obesity / other non-communicable diseases

**Clinical obesity**



**Excess adiposity with:**

- Reduced organ & tissue function OR
- Limitations of ADLS due to obesity

# EASO Frame Work - *New diagnostic paradigm*

The Lancet Commission/EASO partially overlap but are not identical frameworks — EASO - more operationally usable for UK Primary Care

## Anthropometric & clinical components

- BMI  $\geq 30$  kg/m<sup>2</sup>

OR

- BMI  $\geq 25$  kg/m<sup>2</sup> AND WHtR  $\geq 0.5$

plus medical, functional or psychological complications.



**DIAGNOSIS** *of obesity*



**STAGING**



**DISCUSSION** *(personalised treatment)*



**INITIAL → INTENSIFICATION**

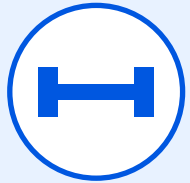
**Reminder.** Use ethnic-specific thresholds in adiposity assessment

# Assessing The Clinical Impact Of Obesity



## Medical history

Symptoms, signs, prior diagnoses.



## Physical assessment

Functional / ADLs



## Laboratory tests



## IDENTIFY

### What you're looking for:

- Organ/tissue dysfunction
- Physical limitations of ADLs

## IF FOUND

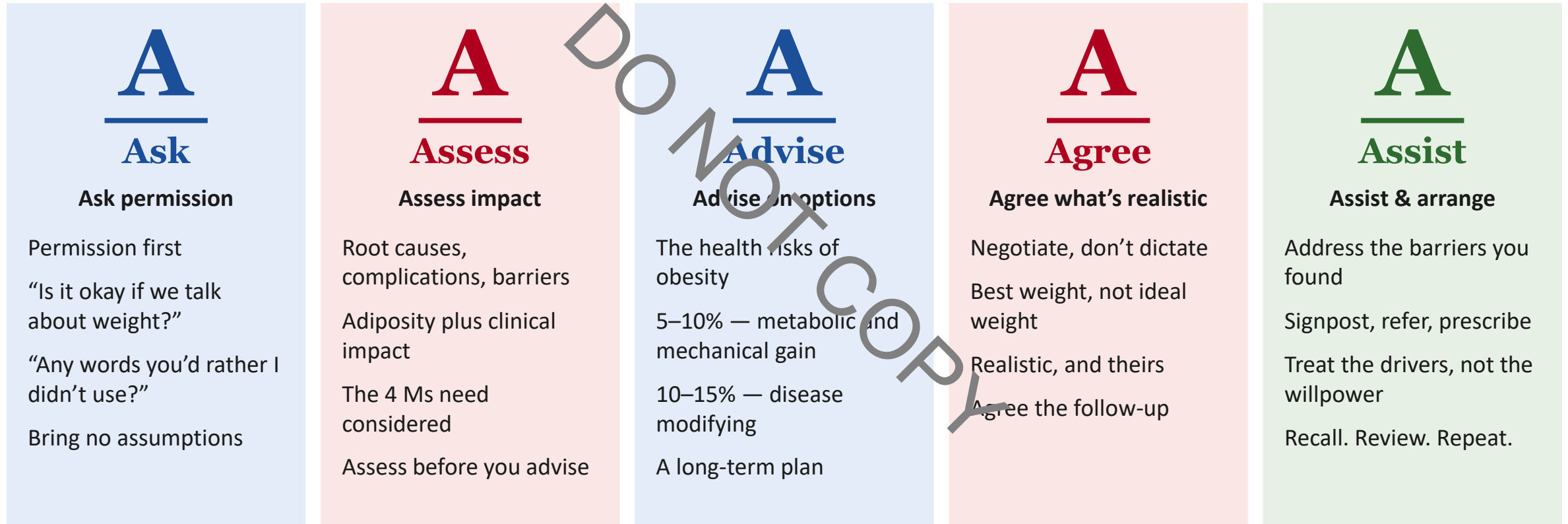
- Maximise health & Manage ORC
- NB DIAGNOSTIC OVERSHADOWING

**MOST OF THIS CONSULTATION YOU'RE ALREADY DOING — JUST FRAME IT AROUND OBESITY**

# The 5As – Consultation Framework

*The professional conversation is a tool.*

Obesity Canada · Rueda-Clausen et al., Clin Obes 2014 — with 5As training, initiation of obesity management doubled, 19% → 39%



**Episodic care fails obesity. Longitudinal care supports it.**

# Five Questions For A 10-minute Consultation

First — ask permission. *"Would it be okay if we talked about your weight today?"*

1

**"When did your weight start to change, and what was happening at the time?"**

**Listen for:** Childhood vs adult onset · pregnancy · medications started · life events · trauma

2

**"What have you tried before, and what helped or got in the way?"**

**Listen for:** Diets · gym · GLP-1s · meal plans · what worked short-term · why it stopped

3

**"How are you sleeping, and how is your mood?"**

**Listen for:** Sleep duration · snoring/OSA · shift work · low mood · binge eating · stress

4

**"Is your weight affecting your day — your joints, breathing, energy, life?"**

**Listen for:** Mobility · ADLs · breathlessness · pain · fatigue · social and work impact

5

**"What would you most like to be different — and what would help right now?"**

**Listen for:** Function vs scale · readiness to change · realistic targets · support needs

**Open-ended questions.**

# Taking The Obesity History

Open with permission

## 1 Weight history

- Age of onset; childhood vs adult weight gain
- Highest & lowest adult weight; current trajectory
- Pregnancy, menopause, life-event triggers
- Previous attempts — what worked, what didn't, why

## 2 Causes / Life Story / Barriers/Supports

- Meds (steroids, antipsychotics, insulin, gabapentin)
- Sleep — hours, OSA symptoms, shift work
- Mental health — mood, anxiety, eating patterns, trauma
- Endocrine **red flags**. Also hypothyroid, PCOS, Cushing's

## 3 Clinical impact

- CKM evidence
- OSA symptoms
- Joint pain, mobility, ADLS
- Mental health, body image, social/occupational impact

## 4 Readiness / goals

- What matters to them — function, symptoms, weight, health
- Readiness to change
- Realistic targets
- Social context — work, food access, family support

DONOT COPY

# Look For These In Every Consultation.

*The four common contributors to weight gain.*

| <div>COMMON</div> <div><b>1</b> Life Story</div> <div><ul style="list-style-type: none"><li>• Unhealthy diet / crash diets</li><li>• Sedentary lifestyle</li><li>• Chronic lack of sleep</li><li>• OSA</li><li>• Shift work</li><li>• Timing of meals</li><li>• Alcohol / smoking</li><li>• Cultural / socio-economic factors</li></ul></div> | <div>COMMON</div> <div><b>2</b> Mental</div> <div><ul style="list-style-type: none"><li>• Depression</li><li>• Chronic stress</li><li>• Child abuse (physical or emotional)</li><li>• History of sexual abuse</li><li>• Psychotrauma</li><li>• Eating disorders (binge, bulimia)</li></ul></div> | <div>COMMON</div> <div><b>3</b> Medication</div> <div><ul style="list-style-type: none"><li>• Corticosteroids</li><li>• Antihypertensives (<math>\beta</math>-, <math>\alpha</math>-blockers)</li><li>• Antidepressants (mirtazapine, paroxetine)</li><li>• Antipsychotics (olanzapine, lithium)</li><li>• Pain meds (pregabalin, amitriptyline)</li><li>• Insulin / sulphonylureas</li></ul></div> | <div>COMMON</div> <div><b>4</b> Hormonal</div> <div><ul style="list-style-type: none"><li>• Hypothyroidism</li><li>• PMOS</li><li>• Hypogonadism</li><li>• Postpartum weight retention</li><li>• Menopause</li><li>• Cushing's syndrome</li><li>• Growth hormone deficiency</li></ul></div> |
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Adapted from Van der Valk ES et al. Obesity Reviews 2019;20:795–804.

Most patients have contributors across all four categories — ask about all of them.

# Recognise These — Refer For Specialist input

Adapted from Van der Valk ES et al. Obesity Reviews 2019;20:795–804.

RARE

## 5 Hypothalamic

- Post-radiotherapy / surgery / trauma
- Hypothalamic tumour
- Craniopharyngioma
- Congenital malformation

RARE

## 6a Monogenic

- Early-onset obesity
- Increased appetite (hyperphagia)
- Striking weight difference vs family
- MC4R, POMC, leptin / leptin-receptor, PCSK1

RARE

## 6b Syndromic

- Early-onset obesity + hyperphagia
- Striking weight difference vs family
- Dysmorphic features / congenital abnormalities
- Mental or motor developmental delay
- Prader-Willi, Bardet-Biedl, Alström

**RED FLAGS** Onset <5 years · Striking hyperphagia · Family discrepancy · Dysmorphism · Developmental delay

Rare, but life-changing when found — refer if any red flag is present.

# The 4 M's

**BMI tells you the size of a person. The 4 Ms tell you what's wrong.**

## M

### Mental

- Depression
- Eating disorders
- Sleep quality
- Trauma, ACEs
- Addictions

## M

### Mechanical

- OSA
- OA / chronic pain
- GORD
- Urinary incontinence
- Intertrigo
- Plantar fasciitis
- Idiopathic intracranial HTN

## M

### Metabolic

- T2D, hyperinsulinaemia
- Dyslipidaemia
- HTN
- MASLD / MASH
- PMOS, infertility
- Gout
- Obesity-related cancers

## M

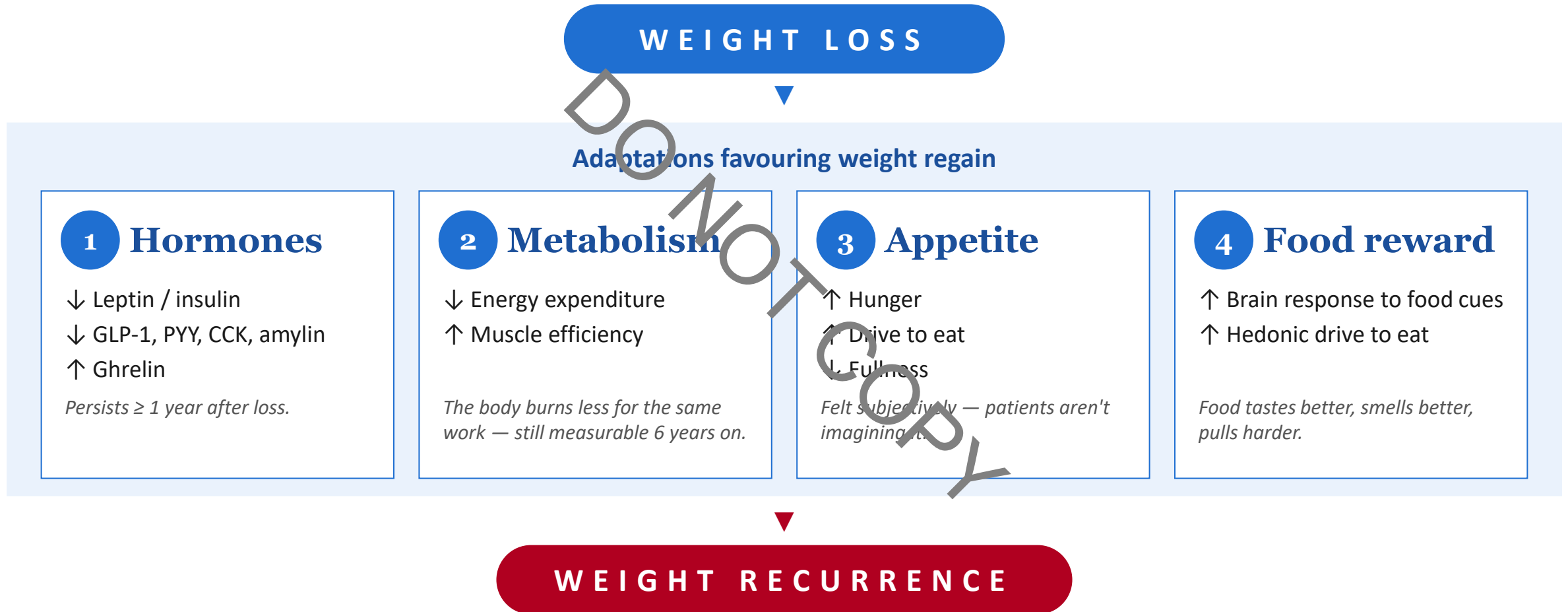
### Milieu

- Income, employment
- Food security/ £
- Housing, neighbourhood
- Education, health literacy
- Caring responsibilities
- Social support
- Access to services

**ST3 TAKEAWAY The 4 Ms describes whole person care to whole person care General Practice teams.**

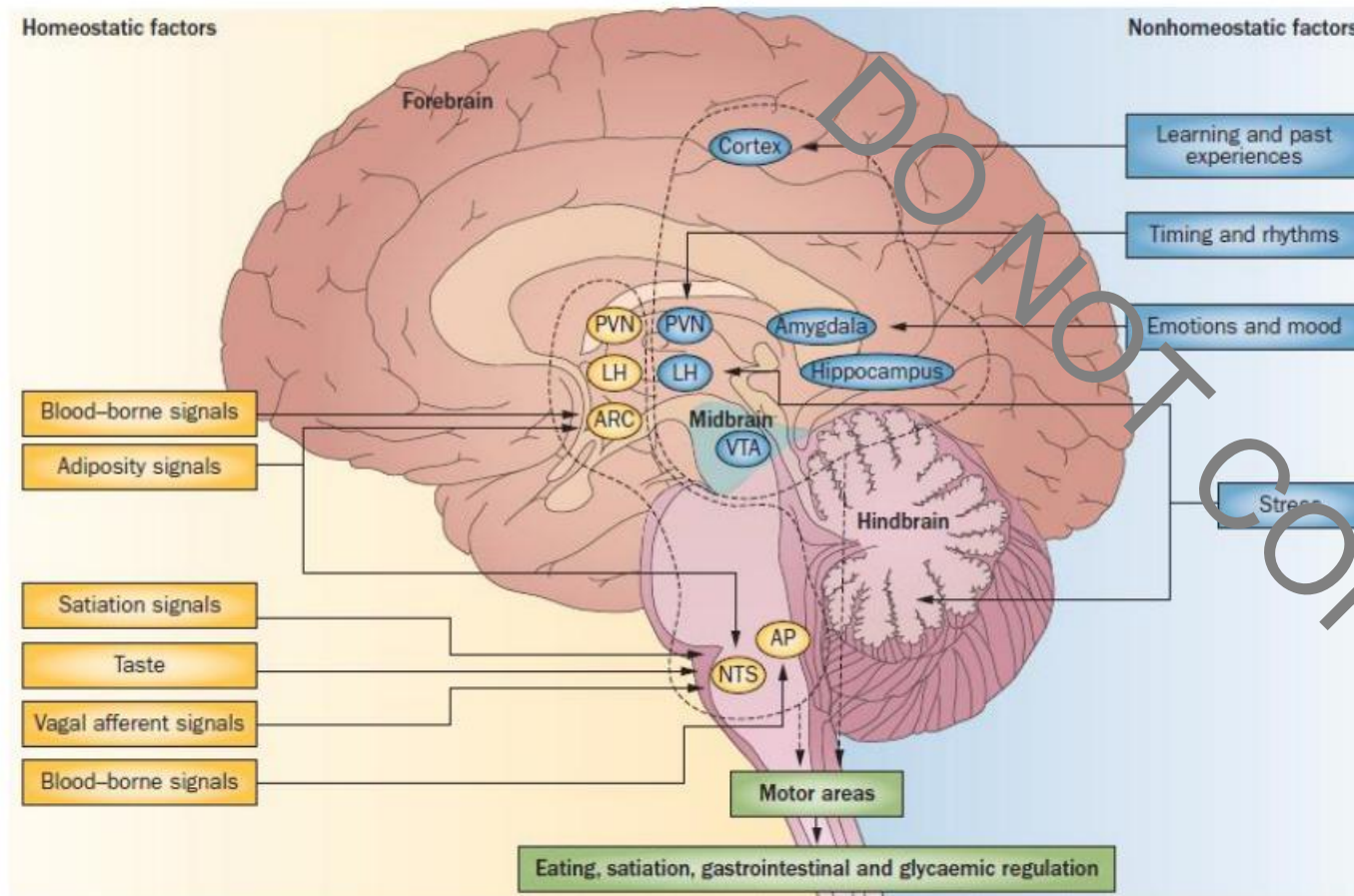
# Explain – Why Weight Comes Back – Normal Physiology

After lifestyle-induced weight loss, four physiological adaptations **push back**.



**This isn't willpower failing — it's biology defending a set point.**

# Explain People With Obesity Have Pathophysiology, Not Poor Will Power



- Hypothalamus – energy homeostasis
- Mesolimbic system – reward seeking behaviour
- Pre frontal cortex – executive functioning

# Don't forget - Weight Regain - A Hard Problem

## WHAT WE HAVE TRIED

↑ Physical activity / ↑ Protein intake / meal replacement

Continued support/monitoring

LIMITED-TO-NO SUSTAINED SUCCESS FOR MOST

## WHAT WE'VE BEEN MISSING

Medication

Surgery

*Both target biology that drives regain.*

**REALITY CHECK:  
IF NO ACCESS , MITIGATION OF PROGRESSION & MAXIMISING ORC MANAGEMENT MAY BE ALL YOU  
CAN DO.... FOR NOW.**

# Obesity treatment: what is the goal?

## Treat-to-target and (vs) treat-to-benefit

- Type 2 diabetes (prevention) and A1C
  - Systolic blood pressure
  - Triglycerides
  - PCOS and infertility
- 
- HDL-C
  - Diastolic blood pressure
  - Measures of feeling and function
    - Symptoms of urinary stress incontinence
    - Sexual function, QoL measures
    - Osteoarthritis, mobility
- 
- MASH activity
  - Depression<sup>3</sup>
  - Apnoea-Hypopnoea Index
  - Reduction in CV events and mortality
  - Type 2 diabetes (remission)

Weight loss<sup>1,2</sup>

2.5%

5% to  
10%

10% to  
20%

A1C, glycated haemoglobin; CV, cardiovascular; HDL-C, high-density lipoprotein cholesterol; MASH, metabolic dysfunction-associated steatohepatitis; PCOS, polycystic ovary syndrome; QoL, quality of life.

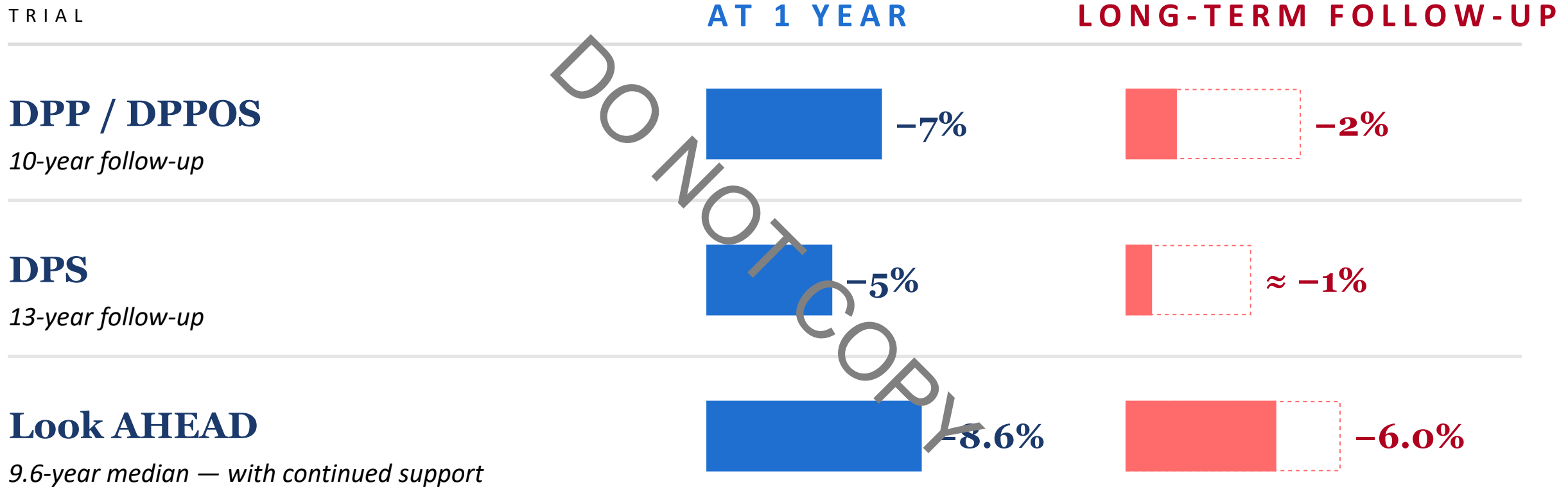
1. Ryan DH, Yockey SR. *Curr Obes Rep.* 2017;6:187–194;

2. Horn DB, et al. *Postgrad Med.* 2022;134:359–375;

3. Silverii GA, et al. *Diabetes Obes Metab.* 2025;doi.org/10.1111/dom.70202.

# What Can We Expect From Healthy Living Interventions?

*The landmark trials — and what happens to the weight loss over time.*



**The pattern.** <10% at 1 year — substantial regain follows. Even a decade of resourced support holds 6%.

# Obesity Treatment Pillars

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**We have two lives, and the second begins when we realise we only have one – help them live their best life.**

**Healthy Living**

**Psychological**

**Medications**

**Surgery**

**ALL TREATMENTS SHOULD BE TAILORED TO THE INDIVIDUAL — AND MOST PATIENTS NEED MORE THAN ONE PILLAR.**

# Behavioural Support

# Planning the change - Behavioural Support

*Goals are behaviours, not numbers on a scale.*

## S

### Specific

What exactly will the patient do?  
Name the behaviour

*"Walk for 30 minutes after work, Mon–Fri."*

## M

### Measurable

How will we both know it's happening? Quantify and track

*"Tick the days walked on the kitchen calendar."*

## A

### Achievable

Is this realistic given the patient's current life and capacity?

*Start with 3 days, not 7. Build*

## R

### Relevant

Does this matter to the patient — not just to the clinician?

*"I want energy to play with my grandkids."*

## T

### Timed

When will we review? A specific date holds the plan in place.

*Review 6 wks.*

**PRACTICE POINT** *Self generated goals work best.*

# Motivational interviewing in the Obesity Consultation

1

Express empathy

"That sounds exhausting. You've been carrying this on your own for a long time"

2

Develop discrepancy

*"You want to be healthy for your children — how does that fit with how things are now?"*

3

Avoid argumentation

*"No problem if that idea wouldn't work for you, I understand it's really difficult. Talk me through the barriers in your life."*

4

Roll with resistance

*"Ok I understand that won't work for you, no problem, what would work better for your lifestyle?"*

5

Support self-efficacy

*"You are the expert in you, tell me what you know works for you?"*

**OARS** Open questions · Affirmations · Reflective listening · Summarising

# Food Strategy

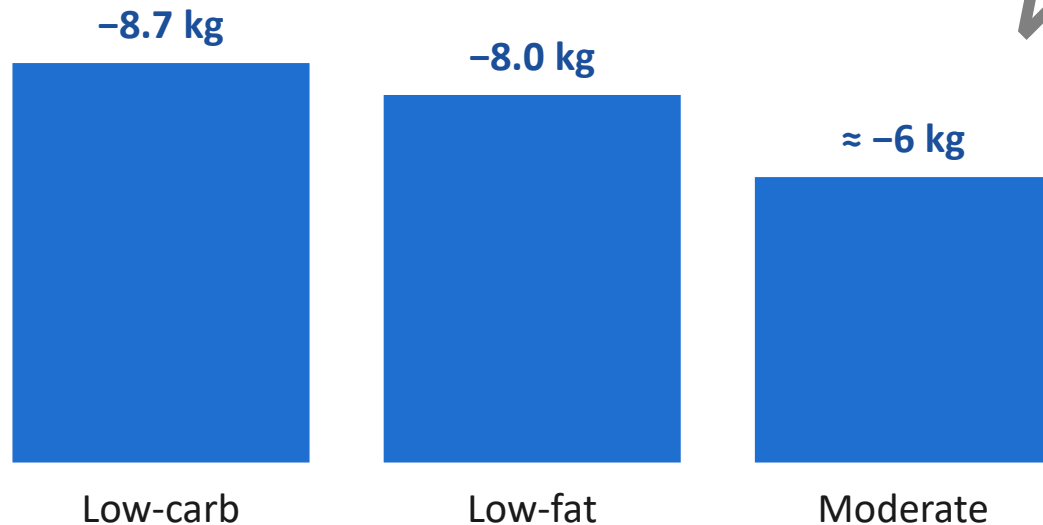
# Is there a “best” diet for weight management?

Two network meta-analyses, same group · Johnston, JAMA 2014 (48 RCTs · 7,286) · Ge, BMJ 2020 (121 RCTs · 21,942)

At 6 months · Johnston 2014

## All the diets worked.

Weight loss vs no diet. Differences between diets small to trivial.



At 12 months · Ge 2020

## The benefit faded.

Weight loss vs usual diet, all macronutrient patterns.

4–5 kg → ~3 kg

at 6 months                      at 12 months

Blood pressure and lipid gains: **gone by 12 months** — except the Mediterranean diet for LDL.

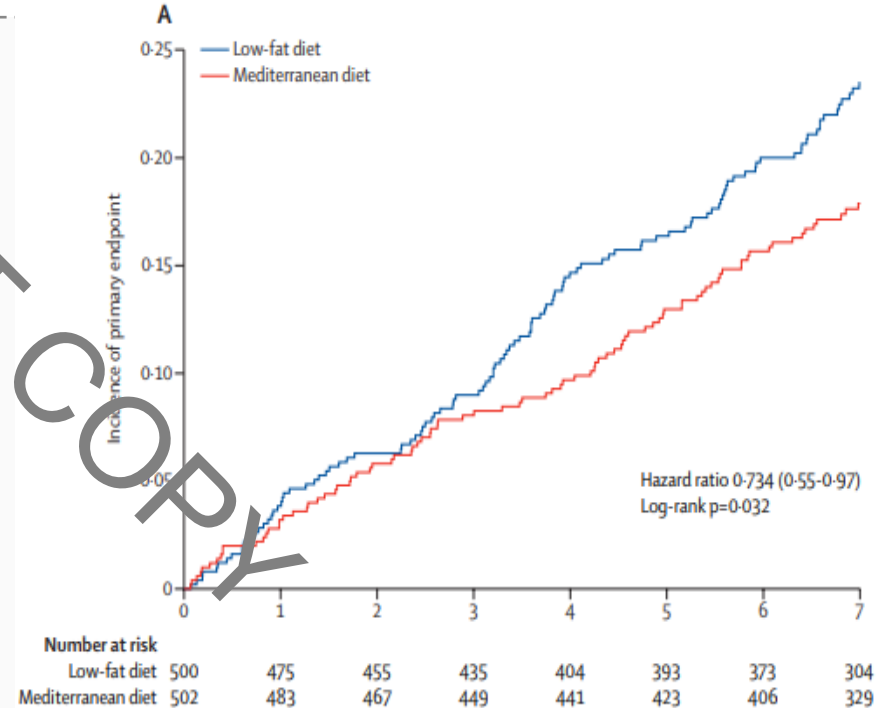
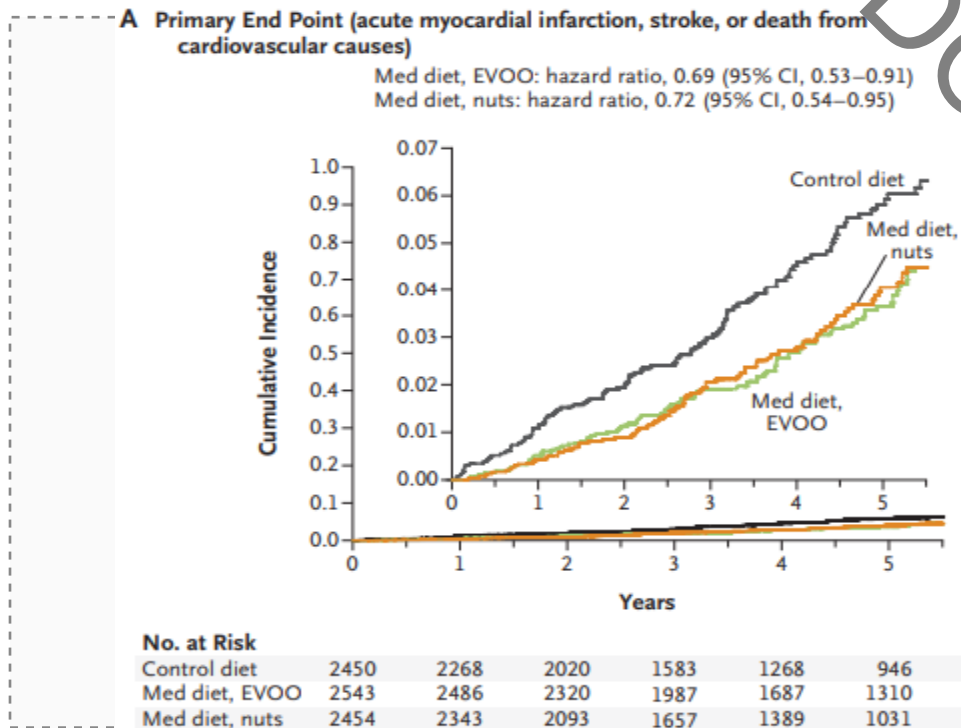
12-month data: fewer trials, low certainty.

**Diet alone won't hold the weight — and the risk-factor gains go with it. Durable obesity care needs more than diet.**

# Diet For The Heart, Not The Scale

*Mediterranean diet reduces major cardiovascular events – without weight loss.*

**25–30% reduction in major cardiovascular events. Both primary and secondary prevention.**



**PREDIMED · primary prevention** **HR 0.69** (95% CI 0.53–0.91)

**CORDIOPREV · secondary prevention** **HR 0.73** (95% CI 0.55–0.97)

Estruch R et al. NEJM 2018;378:e34 (PREDIMED). | Delgado-Lista J et al. Lancet 2022;399:1876–85 (CORDIOPREV).

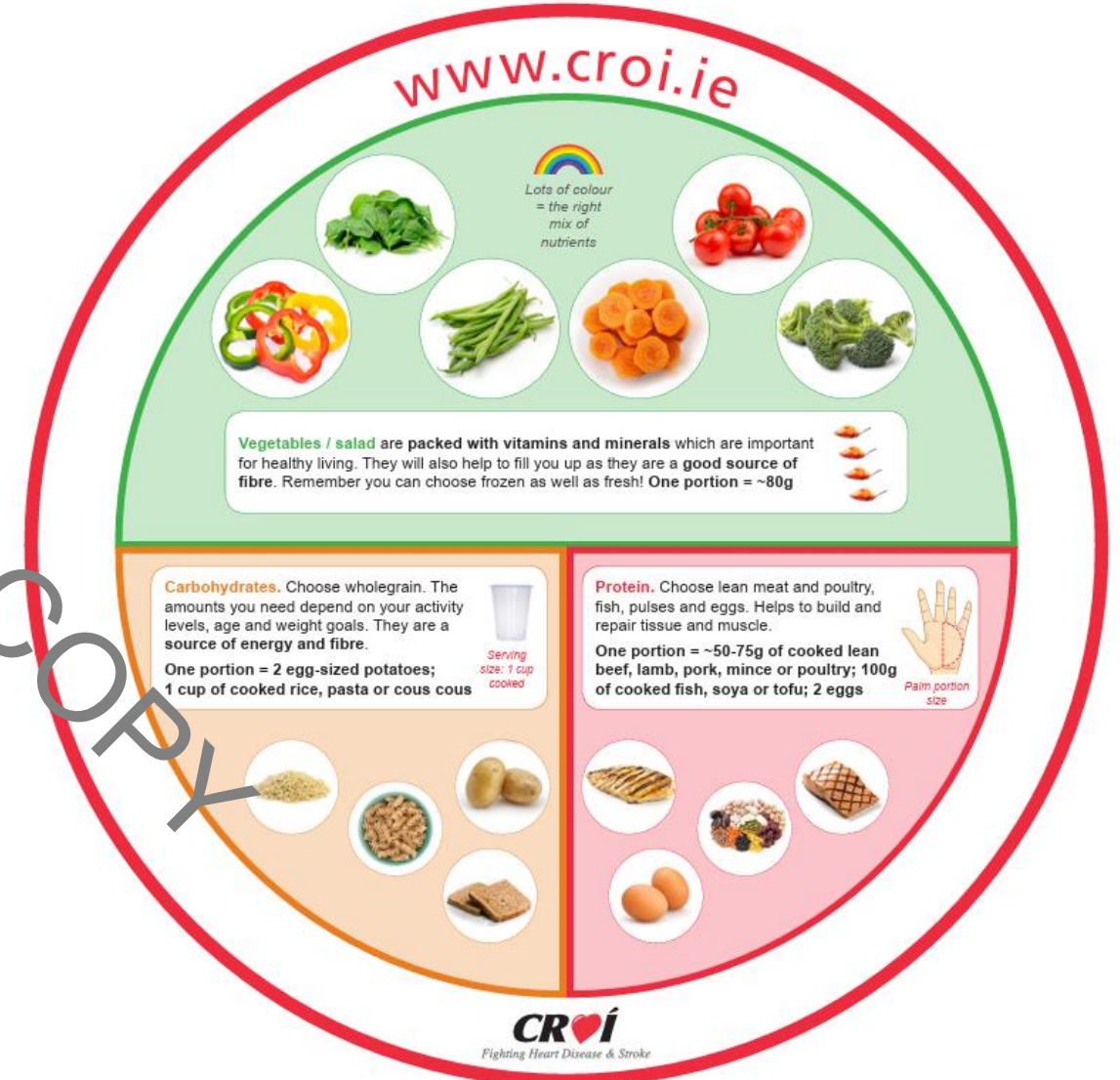
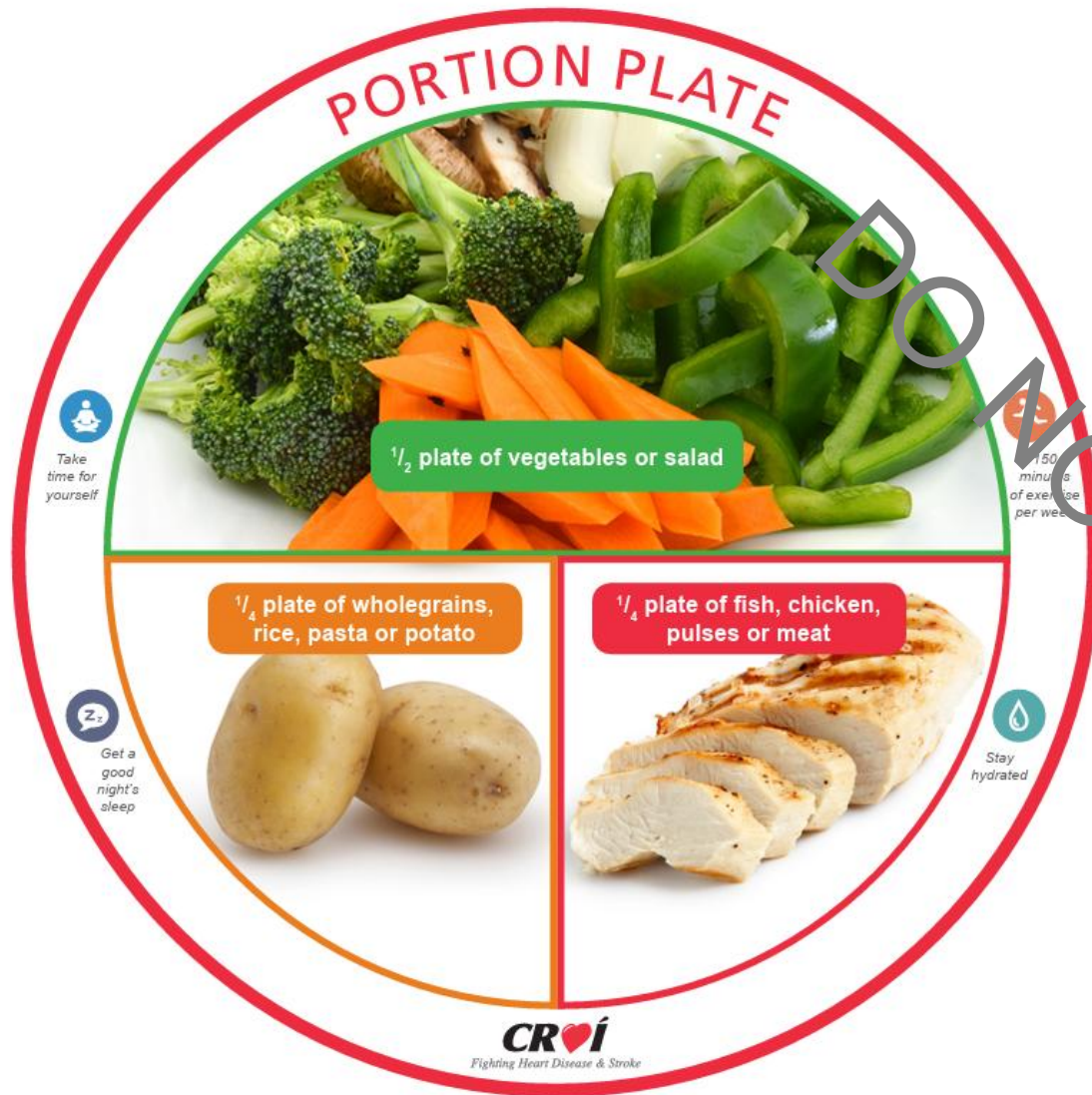
**Diet's most durable benefit isn't on the scale — it's on heart attacks, strokes, and deaths.**

# Behavioural therapy – why we eat

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- **Increasing self monitoring** – daily records of intake, activity.
- **Setting Goals** – keeping it simple ‘three changes’.
- **Social Support Mobilisation and Social Saboteur Assassination** – needed for modifying behaviours.
- **Relapse Prevention** – expecting set backs , be prepared, view them as temporary.
- **Stress Management – Hedonic Hyperphagia.**

# Nutrition Therapy – Key Concepts For A Brief Intervention



**Pattern** – Regular meals

**Content** - Hydration / Protein / Fibre.

**Dinner Plate Rule** - Balanced / Food Groups

# Movement Strategy

*‘Benefits exist across the continuum of human movement’*

# Physical activity is a Metabolic tool — **not a weight-loss tool.**

*"Eat less, move more" - not an effective obesity treatment for the majority*

## THE EVIDENCE

Pontzer et al. (2012) found Hadza hunter-gatherers

— walking 10–15 km daily —

burn roughly the **same** total daily energy as sedentary Western adults.

The body compensates.

## THE HADZA

THEY ARE LIVING A HUNTER-GATHERER EXISTENCE THAT IS LITTLE CHANGED FROM 10,000 YEARS AGO. WHAT DO THEY KNOW THAT WE'VE FORGOTTEN?



PHOTOGRAPHS BY MARTIN SCHOELLER

WHY IT STILL MATTERS

*Activity protects health on its own.*

# Movement matters. **For health gain, not weight loss**

Frame activity around mood, energy, and long-term health — not weight loss.

**1** **Start small**  
5–10 minutes a day.

**2** **≥150 min/week moderate**  
Walking, cycling, swimming. MOVING.

**3** **Resistance 2× weekly**  
Protect muscle mass

**4** **Reframe the goal**  
Activity for mood, energy, sleep, cardiovascular risk

Movement is medicine — even when the weight doesn't move.

# Some Is Good More Is Better — **Every Minute Counts.**

## Physical activity for adults and older adults

|                          |                            |      |
|--------------------------|----------------------------|------|
| Benefits health          | Type II Diabetes           | -40% |
| Improves sleep           | Cardiovascular disease     | -35% |
| Maintains healthy weight | Falls, depression etc.     | -30% |
| Manages stress           | Joint and back pain        | -25% |
| Improves quality of life | Cancers (colon and breast) | -20% |

Reduces your chance of

Some is good, more is better    Make a start today: it's never too late    Every minute counts

### Be active

at least **150** minutes moderate intensity per week  
increased breathing able to talk

OR

at least **75** minutes vigorous intensity per week  
breathing fast difficulty talking

**Build strength**  
to keep muscles, bones and joints strong  
on at least **2** days a week

Gym    Yoga    Carry heavy bags    Stairs    Sport

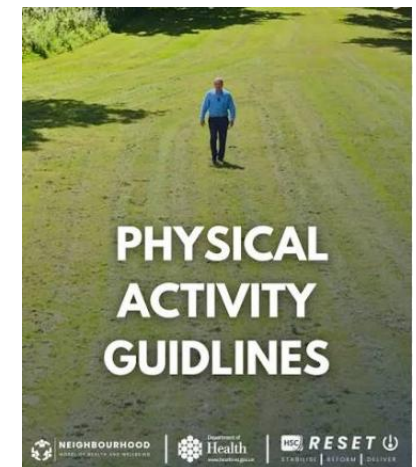
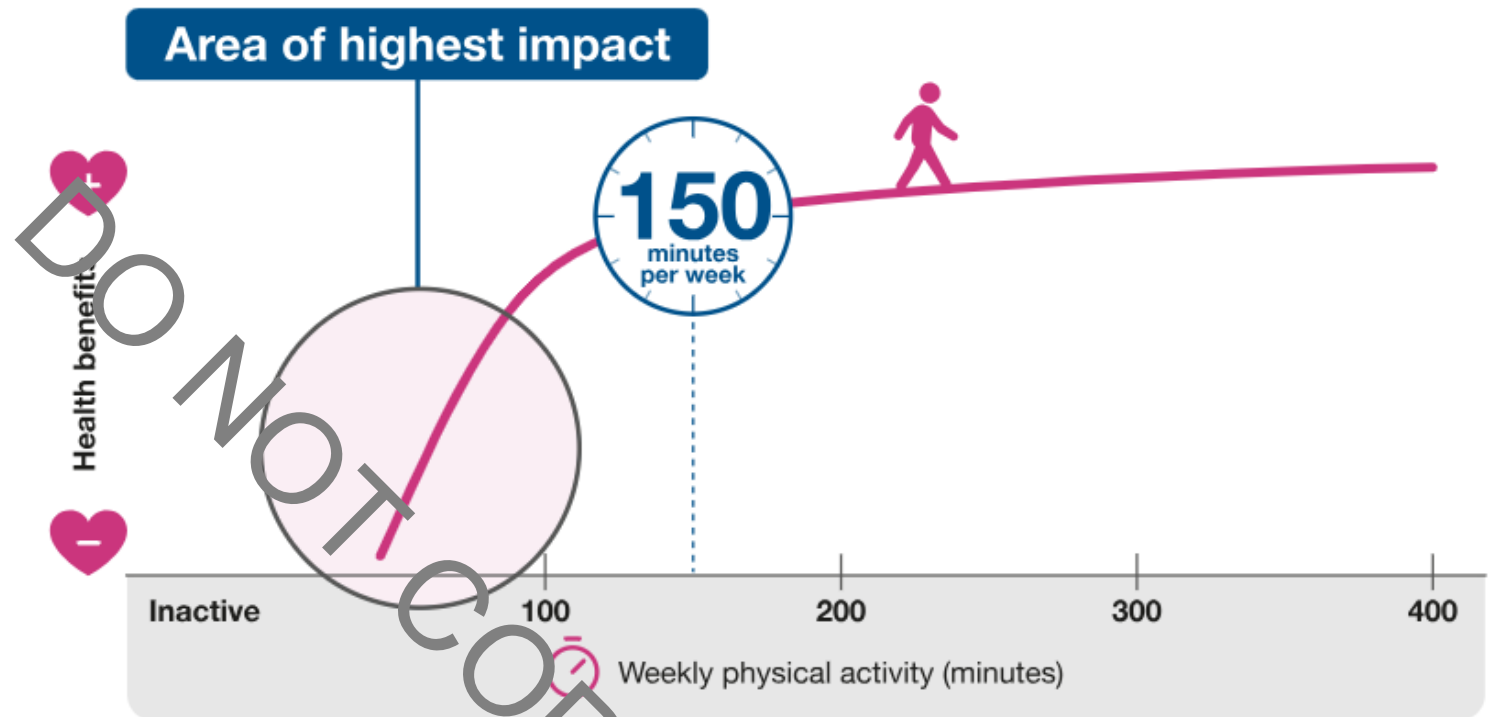
**Minimise sedentary time**  
Break up periods of inactivity



**Improve balance**  
For older adults, to reduce the chance of frailty and falls  
2 days a week

Dance    Bowls    Tai Chi

UK Chief Medical Officers' Physical Activity Guidelines 2019



# TYPE 2 DIABETES: PHYSICAL BEHAVIOUR TIPS

## SITTING/BREAKING UP PROLONGED SITTING

Walking around or doing simple resistance exercises every 30 minutes breaks up prolonged sitting and improves glucose metabolism.

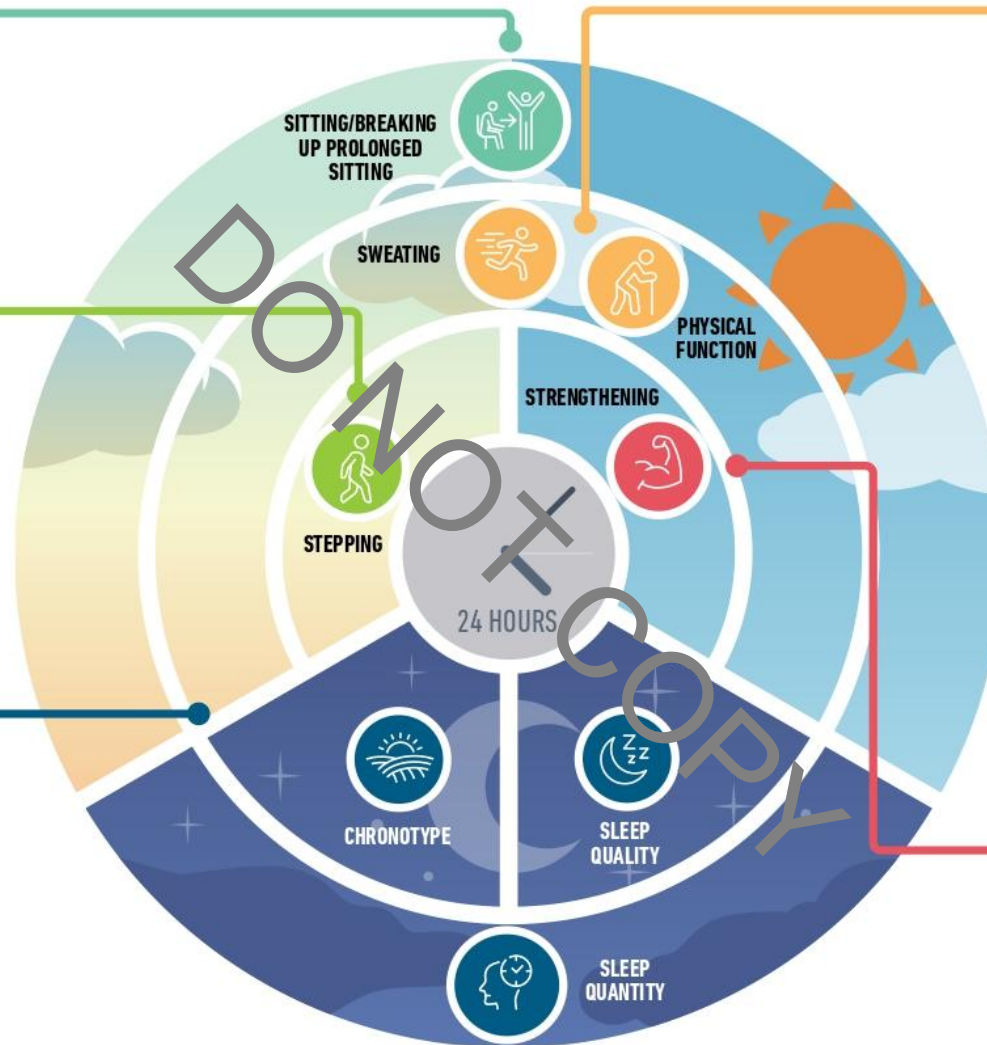
## STEPPING

- An extra 500 steps a day can reduce risk of cardiovascular morbidity and all-cause mortality by 2-9%.
- Brisk walking for 5/6 minutes every day can add 4 years to life expectancy

## SLEEP

Aim for consistent, uninterrupted sleep.

- More than 8 hours and less than 6 hours of sleep negatively impacts HbA1c
- Irregular sleep results in poorer glycaemic levels – this could be due to insomnia, obstructive sleep apnoea and restless leg syndrome
- 'Night owls' who go to bed late and get up late may be more susceptible to inactivity and poorer glycaemic levels compared to 'early birds' who go to bed early and get up early.



## SWEATING

Aim for:

- 150 minutes or more of moderate-intensity exercise every week

OR

- 75 minutes or more of vigorous-intensity exercise spread over three days or more, every week.

Avoid no more than 2 consecutive days of inactivity and supplement with 2/3 resistance, flexibility and/or balance sessions.

The ability of people with type 2 diabetes to undertake simple exercises in middle-age is similar to that in people over a decade older.

Just 30 minutes of moderate-intensity physical activity a week improves metabolic profiles.

## STRENGTHENING

Resistance exercise such as tai chi and yoga improves insulin sensitivity and glucose levels



# Sleep and Stress Strategy

# Sleep is not a lifestyle choice. **It's A Physiological Driver Of Weight.**

Each hour below 7 hours of sleep raises BMI by 0.35 kg/m<sup>2</sup>.

HORMONAL

**Hunger goes up.**

METABOLIC

**Insulin resistance  
rises.**

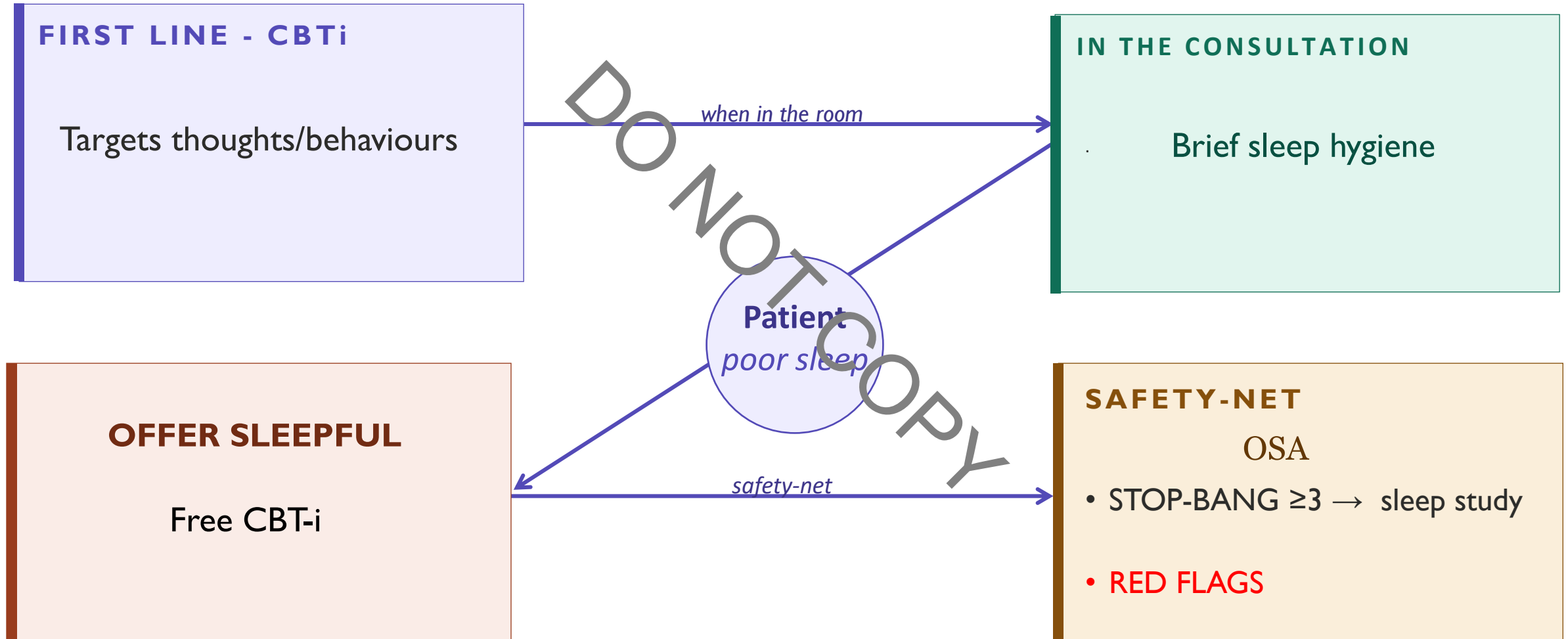
CIRCADIAN

**Timing matters  
too.**

**Take Home** – *Sleep is an evidence-based, modifiable target in obesity care.*

# Treating Sleep In General Practice

Frame : "Your sleep & weight are connected. Improving sleep is part of your treatment."



**Offer CBT-I before — or instead of — hypnotics.**

# Medication Strategy

*They were **never** just 'weight loss drugs'*

# Nutrient-Stimulated Hormone (NuSH) Therapies

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**Most adverse events come from excess dose — not the medication!**

**Titrate slowly. Counsel proactively. Don't just stop . STRATEGISE first.**

# Gastrointestinal Side Effects

## Nausea / Indigestion/Vomit/Diarrhoea/Constipation

- Nausea - usually first sign dose escalation too quick
- GI side effects do NOT predict better weight loss – mechanisms are distinct.
- Slower titration = good practice — does not compromise weight loss or glycemic efficacy.

Figure: Dr Mick Crotty, My Best Weight (mybestweight.ie)



ALWAYS EDUCATE ON  
Pancreatitis – Gallstones - Food & Movement Strategy –  
Muscle Mass preservation –Contraception  
NAION – recent data reassuring but be careful.

# Conclusion And Call To Action

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**Obesity care is relational.**

**It is longitudinal.**

**It is respectful.**

**Make your change in practice from tomorrow onwards be the legacy of your learning today**