Management of Obesity: Summary of Recommendations

The following practical recommendations were selected from SIGN guideline. They could be applied in Saudi Arabia at all health care levels (primary, secondary and tertiary care) in order to improve the quality of health care for individuals with overweight/obesity.

1. Prevention of overweight and obesity in children and young people.
   - Sustainable school based interventions to prevent overweight and obesity should be considered by and across agencies. Parental/family involvement should be actively facilitated (Evidence-C).

2. Prevention of overweight and obesity in adults
   - Individuals consulting about weight management should be advised to reduce (Evidence-B)
   - Intake of energy-dense foods (including foods containing animal fats, other high fat foods, confectionery and sugary drinks) by selecting low energy-dense foods instead (for example wholegrains, cereals, fruits, vegetables, and salads).
     - Consumption of "fast foods" (e.g. "take-aways")
     - Alcohol intake.
   - Individuals consulting about weight management should be encouraged to be physically active and reduce sedentary behavior, including television watching (Evidence-B).

3. Diagnosis and screening of obesity in children and young people
   - BMI centiles should be used to diagnose overweight and obesity in children (Evidence-C).

4. Assessment in adults
   - Health-care professionals should discuss willingness to change with patients and then target weight loss interventions according to patient willingness around each component of the behavior required for weight loss, e.g. specific dietary and/or activity changes (Evidence-D).

5. Weight management in adults
   - Weight management programs should include physical activity, dietary change, and behavioral components (Evidence-A).

6. Dietary interventions in adults
   - Dietary interventions for weight loss should be calculated to produce a 600 kcal/day energy deficit. Programs should be tailored to the dietary preferences of the individual patient (Evidence-A).

7. Physical activity in adults
   - Overweight and obese individuals should be prescribed a volume of physical activity equal to approximately 1,800-2,500 kcal/week. This corresponds to approximately 225-300 min/week of moderate intensity physical activity (which may be achieved through 5 sessions of 45-60 min/week, or lesser amounts of vigorous physical activity) (Evidence-B).

8. Pharmacological treatment in adults
   - Orlistat should be considered as an adjunct to life-style interventions in the management of weight loss. Patients with BMI ≥28 kg/m^2 (with comorbidities) or BMI ≥30 kg/m^2 should be considered on an individual case basis following assessment of risk and benefit (Evidence-A).

9. Bariatric surgery in adults
   - Bariatric surgery should be included as part of an overall clinical pathway for adult weight management. Bariatric surgery should be considered on an individual case basis following assessment of risk/benefit in patients who fulfill the following criteria: (Evidence-C)
     - BMI ≥35 kg/m^2
   - Presence of one or more severe comorbidities, which are expected to improve significantly with weight reduction (e.g. severe mobility problems, arthritis, type 2 diabetes).

10. Treatment of obesity in children and young people
    - Treatment programs for managing childhood obesity should incorporate behavior change components, be family based, involving at least one parent/carer and aim to change the whole family's lifestyle. Programs should target decreasing overall dietary energy intake, increasing levels of physical activity and decreasing time spent in sedentary behaviors (screen time) (Evidence-B).
    - In most obese children (BMI ≥98th centile) weight maintenance is an acceptable treatment goal (Evidence-D).
    - Weight maintenance and/or weight loss can only be achieved by sustained behavioral changes, (Evidence-D), e.g.,
      - Healthier eating, and decreasing total energy intake.
      - Increasing habitual physical activity (e.g. brisk walking). In healthy children, 60 min of moderate-vigorous physical activity/day is recommended.
      - Reducing time spent in sedentary behavior

(e.g. watching television and playing computer games) to <2 h/day on average or the equivalent of 14 h/week.

- The following groups should be referred to hospital or specialist pediatric services before treatment is considered: (Evidence-D).
- Children who may have serious obesity-related morbidity that requires weight loss (e.g. benign intracranial hypertension, sleep apnea, obesity hypoventilation syndrome, orthopaedic problems and psychological morbidity).
- Children with a suspected underlying medical (e.g. endocrine) cause of obesity including all children under 24 months of age who are severely obese (BMI ≥99.6th centile).
- Orlistat should only be prescribed for severely obese adolescents (those with a BMI ≥ 99.6th centile) with comorbidities or those with very severe to extreme obesity (BMI ≥3.5 SD above the mean) attending a specialist clinic. (Evidence-D).
- There should be regular reviews throughout the period of use, including careful monitoring for side-effects. Bariatric surgery can be considered for post pubertal adolescents with very severe to extreme obesity (BMI ≥ 3.5 SD above the mean on Saudi Growth Charts) and severe comorbidities (Evidence-D).

REFERENCE

1. Scottish Intercollegiate Guidelines Network (SIGN). Management of Obesity. A National Clinical Guideline February 2010. Page 4-6