

# Obesity Prevention and Screening



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## KEYWORDS

• Obesity • Screening • Prevention • Development

## KEY POINTS

- Screen for weight status at every primary care visit. Screening tools vary by age.
- Communicate appropriately and effectively with patients to maximize the success of prevention efforts. Motivational interviewing promotes patient willingness to engage in behavioral change.
- Prevention recommendations vary by age and stage of development, and cultural context is critical. Core behaviors include dietary intake, physical activity, and sleep.

## INTRODUCTION

Obesity is one of the most significant public health crises of our time. Between 5% and 10% of US health care costs are spent on the treatment of overweight, obesity, and associated comorbidities.<sup>1</sup> Obesity in adults is associated with increased risk for cardiovascular, metabolic disease, and cancer.<sup>2</sup> Overweight and obesity are also occurring in high rates in younger populations. In obese children, in addition to higher risk for cardiovascular and metabolic disease, there are also social and psychological difficulties,<sup>3</sup> such that the quality of life of obese youth has been compared with those with cancer.<sup>4</sup> Obese youth are likely to be overweight and obese adults, thus conferring a lifetime of risk for medical and psychosocial difficulties.<sup>5,6</sup> Obesity has a high

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Disclosures: The authors have no commercial or financial conflicts of interest or any funding sources to disclose.

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Prim Care Clin Office Pract 43 (2016) 39–51

<http://dx.doi.org/10.1016/j.pop.2015.08.009>

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individual and societal cost. For example, absenteeism is increased for obese children<sup>7</sup> and adults because of missed school, missed work, and increased health care use.<sup>8,9</sup>

## SCREENING AND PREVENTION

The lack of broadly effective treatments for obesity<sup>10</sup> highlights the importance of efficacious screening and prevention.<sup>11,12</sup> From a population health perspective, everyone should be screened for obesity and obesity risk, and targeted prevention applied. The risk for becoming obese is present across all ages. However, prevention targets differ by age group and cultural context so this must also be taken into account. Primary care practices should be aware of contextual considerations by age group and culture, have ready access to available screening tools, and be comfortable with approaches to prevention.

### INFANTS (BIRTH–12 MONTHS), TODDLERS (1–3 YEARS), AND PRESCHOOLERS (3–5 YEARS)

There is a unique opportunity for obesity prevention at very young ages.<sup>13</sup> The first 4 to 6 months of life (when birth weight typically doubles) can set the foundation for future weight trajectories. Infants who have excess fat at birth or who rapidly gain weight in the first 6 months of life are at risk for adult obesity.<sup>14–16</sup> Interventions to promote appropriate weight gain during the first 6 months of life have a substantial impact on future weight trajectories.

The toddler and preschool years also set the foundation for eating behaviors, physical activity patterns, and weight trajectories.<sup>17</sup> Timing of the introduction of solid foods, parental modeling of appropriate eating behaviors, sound sleep hygiene habits, limits on screen time, and encouragement of physical activity all develop during this time period.<sup>18</sup> These are critical target behaviors to help prevent the onset of obesity.

#### *Screening Tools*

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World Health Organization (WHO) measurements are used to classify obesity for infancy through preschool. WHO standards have shorter growth measurement intervals and provide the most accuracy for the rapid growth period between infancy and early childhood.<sup>19</sup> Obese infants are greater than or equal to the 95th percentile for weight for recumbent length.<sup>20</sup> As children age, standing height is included and clinicians typically switch to US Centers for Disease Control and Prevention (CDC) growth charts for weight-for-stature measurements for toddlers and preschoolers.<sup>20</sup>

The 95th percentile of the sex-specific CDC growth charts for body mass index (BMI) for age defines obesity in toddlers and preschoolers.<sup>21</sup> Weight and recumbent length measurements are an established element of routine well-child care. All measurements should be taken and recorded in a standard fashion. Attention should particularly focus on children who are at or greater than the 95th percentile, and on children who show significant or rapid movement up the growth chart (skipping curves) over time.<sup>22</sup> Electronic medical records often have automatic charting and tracking features for BMI percentile that can aid clinical practice by providing visual cues to initiate conversations about appropriate weight gain with parents and families.<sup>23</sup> Routine well-child care visits are also an excellent time to discuss individual family health behaviors, including family weight history, meal routines, food access, physical activity, sleep habits, and screen time.<sup>24</sup>

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