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2013 American Heart Association/American College of Cardiology/The Obesity Society Guideline for the Management of Overweight and Obesity in Adults: Implications and New Opportunities for Registered Dietitian Nutritionists

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IN 2005, THE NATIONAL HEART, LUNG, AND BLOOD Institute (NHLBI) of the National Institutes of Health recognized the need to update their guideline reports on cardiovascular disease (CVD) prevention and treatment. Stakeholder groups were convened to provide input on the process, including the Academy of Nutrition and Dietetics. These groups recommended the following integral and complementary steps[1]:

- Maintain risk-factor–specific cardiovascular clinical practice guidelines.
- Take a standardized and coordinated approach to the risk factor guidelines updates.
- Take a more evidence-based approach to [guideline] development and implementation.
- Give more attention to implementation issues and work closely with stakeholders in health care and community systems for translation and dissemination of the evidence base.
- Develop an integrated CVD risk-reduction guideline that addresses the realities of clinical practice where individuals often have multiple risk factors that interact in various ways to accelerate the development of CVD.

Based on this advice, the NHLBI established a series of expert panels in 2008 to develop updates to the existing guidelines on cholesterol, blood pressure (BP), and overweight/obesity. In addition, for the first time, three additional work groups comprised of selected expert panel members who were appointed by the NHLBI were convened to provide input to the panels and develop recommendations on overarching issues: risk assessment, lifestyle intervention, and guidelines implementation. A Guidelines Executive Committee, composed of panel and work group co-chairs and NHLBI staff, coordinated the work of the panels and work groups. Panels and work groups met to establish the scope and evidence-based approaches for examining critical research questions in each guideline topic area (eg, overweight and obesity, cholesterol). NHLBI contracted with two outside vendors with expertise in systematic, large-scale literature reviews to identify and rate the quality (good, fair, and poor) of thousands of peer-reviewed relevant abstracts, full-text original research articles, systematic reviews, and meta-analyses on each topic. The literature reviewed spanned the time frame from the last time the guidelines were updated in 1998 through 2011. During a 5-year period and at 23 meetings convened by NHLBI, the Obesity Panel utilized papers quality rated as "good" or "fair" to develop evidence tables; these tables included study design characteristics, methods, and key results. The available research was summarized in Evidence Statements rated as low, moderate, and high based on the quality of the research base. The Evidence Statements and their rationale were then used to make overall graded recommendations (The Overweight and Obesity Guideline report[2] maps the grading system used for the recommendations and Appendix 2 of the data supplement[3] provides a complete description of the research methods). In 2012, the NHLBI Advisory Council recommended that NHLBI consider partnering with other organizations to adopt and publish the recommendations.[4] Accordingly, in June 2013, the NHLBI worked with the American College of Cardiology (ACC) and American Heart Association (AHA) to publish four guidelines utilizing the evidence reviews: assessment of CVD risk, lifestyle modifications to reduce CVD risk, the treatment of blood cholesterol in adults, and the management of overweight and obesity in adults. The Obesity Society (TOS) also worked on the publication of the Overweight and Obesity Guideline.

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In this commentary, we summarize the development process for and the major findings and recommendations of the 2013 *Guideline for the Management of Overweight and Obesity in Adults: A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines and the Obesity Society*.[2] This Guideline is important for the registered dietitian nutritionist (RDN) because it provides a treatment algorithm for management of overweight and obesity; identifies evidence-based low-calorie dietary regimens; summarizes the expected impact of dietary, physical activity, and surgical interventions; recommends "nutrition professionals" for weight-loss counseling; and acknowledges their role on multidisciplinary teams that provide comprehensive lifestyle interventions for weight management. In our companion commentary, "2013 American Heart Association/American College of Cardiology Guideline on Lifestyle Management to Reduce Cardiovascular Risk: Practice Opportunities for Registered Dietitian Nutritionists,"[5] we report on the Lifestyle Guideline,[6] which examines the benefits of lifestyle intervention on CVD risk independent of weight loss.

SCOPE OF THE PROBLEM

Since 1998, when the last clinical NHLBI guidelines on overweight and obesity were published,[7] the prevalence of overweight (body mass index [BMI; calculated as kg/m^2] 25 to 29.9) and obesity (BMI $\geq$30) among US adults has risen dramatically. In addition, although the annual trajectory of increases in obesity may have slowed in certain segments of the population[8,9] and overall population rates of overweight have plateaued,[8,9] the combined prevalence of overweight and obesity has reached a new high. Data from the National Health and Nutrition Examination Survey 2009-2010 indicate that overweight and obesity affect more than two in three US adults, and the age-adjusted rates of overweight and obesity are about 33% and 36%, respectively.[9] Recent updates from the National Health and Nutrition Examination Survey 2011-2012 confirm that obesity now affects >78 million American adults, and women aged 40 to 59 years have the highest rates (39.5%).[10] The epidemic of obesity is associated with a "twin epidemic" of type 2 diabetes, and together these conditions threaten to reverse the gains in CVD mortality reduction observed during the last half-century.[3] Obesity is also associated with other serious biological and psychological consequences that severely impact the health of the public and put additional pressures on health care delivery costs. The current direct and indirect costs of treating overweight and obesity and their related comorbidities are estimated to be nearly $150 billion annually and are expected to increase dramatically if overweight and obesity are not stemmed.[11]

CRITICAL APPRAISAL OF THE SCIENTIFIC EVIDENCE: QUESTIONS AND RECOMMENDATIONS

The 2013 AHA/ACC/TOS Guideline for the Management of Overweight and Obesity in Adults[2] represents a state-of-the-art critical appraisal of the scientific evidence in five major areas: risks of obesity and overweight, benefits of weight loss, and three treatment modalities for achieving weight loss—dietary modification, comprehensive lifestyle change, and bariatric surgery. The expert Obesity Panel, convened in 2008 by NHLBI, chose these five topic areas based on an assessment of their importance and relevance to primary care providers and the availability of quality research in each topic area. The Panel also identified five Critical Questions as the focus of their in-depth reviews of the research evidence. The first two Critical Questions address weight-related CVD health risks and measurable benefits of weight loss associated with improvements in CVD risk factors/events; the other three address treatments for overweight and obesity. The five Critical Questions were:

1. Among overweight and obese adults, does weight loss produce CVD health benefits and what health benefits can be expected with different degrees of weight loss?
2. What are the CVD-related health risks of overweight and obesity and are the current cut points for overweight (BMI 25 to 29.9), obesity (BMI $\geq$30), and waist circumference (>102 cm [>40 in] in men and >88 cm [>35 in] in women) appropriate for population subgroups?
3. Which dietary strategies are effective for weight loss?
4. What is the efficacy/effectiveness of a comprehensive lifestyle-intervention program (ie, diet, physical activity, and behavior therapy) in facilitating weight loss or maintaining weight loss?
5. What is the efficacy and safety of bariatric surgery? What is the profile (BMI and comorbidity type) of patients who might benefit from surgery for obesity and related conditions?

The Panel decided not to address pharmacotherapy for chronic obesity management with a specific Critical Question, given that, at the time of their reviews, only two medications were available and approved for weight loss (ie, orlistat and sibutramine); neither was widely prescribed in primary care, and sibutramine was removed from the market in 2010. The Panel did, however, address the effect of orlistat on weight loss and CVD risk factors in Critical Question 1 since several meta-analyses on this topic were identified for review.

In developing recommendations for clinical management and treatment of overweight and obesity, most of the research reviewed was invariably based on data from epidemiological studies of large populations or from randomized clinical trials (RCTs) in smaller study samples. These aggregated data do not consider the unique profiles or circumstances of individuals. The panel faced the difficult task of making recommendations appropriate to the needs of individual patients seen in clinical practice settings. The Overweight and Obesity Guideline is intended to help guide practitioners in their assessment and treatment of patients in order to achieve "best practices" in clinical settings.

Overweight and Obesity Guideline Recommendations

The following is a summary of the AHA/ACC/TOS Guideline Recommendations that utilized the systematic evidence report and recommendations of the Panel. AHA/ACC reviewed and evaluated the strength of evidence for each recommendation and, for comparison purposes, provided their ratings alongside those of the Panel (Table 1 in the Guideline[2] describes the classification of recommendations and level of evidence system used by AHA/ACC). A treatment algorithm that accompanies the recommendations is found in the Guideline report.[2]

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