

## Barriers to the Obesity Care

Raquel C. Lopes Assis Coelho<sup>1\*</sup> and Claudia Maria Andrade Fernandes Vieira<sup>2</sup>

<sup>1</sup>Institute of Education and Research Santa Casa BH, Brazil

<sup>2</sup>Ambulatório de Obesidade da Santa Casa de Belo Horizonte, Brazil

\*Corresponding author: Raquel C. Lopes Assis Coelho, Institute of Education and Research Santa Casa BH, Santa Efigênia, Belo Horizonte - MG, 30150-240, Brazil, E-mail: raquelassiscoelho@gmail.com

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### Editorial

Obesity is a chronic, progressive and highly prevalence disease associated with serious health consequences [1]. Despite increasing consensus about obesity as a serious and complex disease with considerable negative impact on individual health and quality of life, diagnosing and treating obesity within the standard medical context are uncommon.

Sustained weight loss has been shown to prevent the onset of and improve obesity-related comorbidities. Even weight loss of 3 to 5% can reduce triglycerides and hemoglobin A1c (HbA1c) [2]. Sustained weight loss >5% can reduce blood pressure, improve low- and high-density lipoprotein; and further decrease triglycerides, blood glucose, HbA1c, and need for pharmacotherapy for hypertension, diabetes, and lipid disorders [3]. The odds of achieving and maintain a clinically significant weight loss are low. However, there is still a stigma about indicating an anti-obesity medication.

In a recent study from Simon et al. (2018), only 24% and 33% of respondents discussed obesity medications with patients whose BMI was 30 to 39 and  $\geq 40$  kg/m<sup>2</sup>, respectively. The majority of respondents (81%) did not offer weight loss medications to patients with obesity. Common barriers to prescribing anti-obesity medications included limited experience and concern for adverse reactions, associated with lack of time to discuss treatment options [4].

Another issue in obesity care is the lack of a formal diagnosis of obesity. Awareness, Care, and Treatment in Obesity management (ACTION) study examined obesity-related perceptions, attitudes, and behaviours among people with obesity (PwO) and health care providers (HCPs). All interviewed patients had obesity according to self-related weight and height. However, only 50% of people with obesity saw themselves as obese, and only 55% reported receiving a formal diagnosis of obesity [5].

Limited time seems to be one of the most important barriers for not discussing weight loss [4,5], followed by the perception that discussion would not change patient behaviour, insufficient knowledge, and discomfort broaching the subject [4].

For the adequate management of obesity, current guidelines suggest frequent consultations (16/year), initially monthly and then every three months, for long periods.

Also, monitoring should preferably be done by a specialized multidisciplinary team, not only with knowledge of the disease obesity but also in the approach and willing to a good dialogue with the patient [6].

Communication problems may also be a barrier to obesity care. Communication problems in health care may arise as a result of healthcare providers focusing on diseases and their management, rather than people, their lives and their health problems. A Cochrane review concluded that even short period training for health care professionals may be effective in improving communication skills [7].

Although obesity perception as a chronic progressive disease is increasing, the management is still far away from other chronic diseases. Health care providers should not only be convinced about obesity as a disease, but tell their patients that and discuss with them about chronic management with lifestyle and pharmacological interventions for long periods.

Finally, we would like to reinforce the importance of prevention. Improving care for obese patients also requires prevention actions, such as encouraging breastfeeding, nutritional education of families, encouraging physical activity and continuous training for health care professionals.

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