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Should We Give Up on the Obese?

It's an uphill battle that must be fought.

Practice Perfect is a continuing every-issue column in which Dr. Shapiro offers his unique personal perspective on the ins and outs of running a podiatric practice.

Working with patients who are overweight or obese is a highly common theme in podiatric medicine. Many of the problems our patients face are caused or worsened by their increased weight. The most obvious example is plantar fasciitis/fasciosis. For so many of our patients, poor biomechanical function combined with excessive weight overloads the foot, leading to pain. Sometimes this occurs even with adequate foot structure. What should we expect when a 5 foot, 5 inch 250-pound person presents complaining of foot pain?

First, as a reminder, obesity is classified as follows based on BMI (body mass index).[1]

Most of our electronic medical records systems are capable of automatically calculating BMI, but for those of you who desperately want to calculate this by hand, here are two methods for you:

Metric: BMI = Kilograms/Meters2

US: BMI = (Pounds)(703)/inches2

This is a major problem for everyone in medicine and not only podiatrists. A meta-analysis from 2013 found some disturbing trends. Looking at a combined study sample size of more than 2.88 million people and 270,000 deaths, the authors found a significant increase in all-cause mortality in patients with all classes of obesity.[2]

Much research has gone into treating this difficult condition with a strong emphasis on counseling, including the five As (Assess, Advise, Agree, Assist, Arrange).[3] We are taught that if we take a patient-centered approach, counsel our patients thoroughly, and empower them to make life-altering changes, then we may be successful in reducing their weight and many of the potential complications that go with obesity.

What should we expect when a 5 foot, 5 inch 250 pound person presents complaining of foot pain?

TABLE 1:
BMI Classification

BMI	Classification
< 18.5	underweight
18.5–24.9	normal weight
25.0–29.9	overweight
30.0–34.9	class I obesity
35.0–39.9	class II obesity
≥ 40.0	class III obesity

Despite this, though, a new study from the *American Journal of Public Health* has found some disheartening results. The authors examined a United Kingdom database of obese patients from 2004 to 2014. Looking at 76,000 obese males and almost 100,000 obese females (excluding bariatric surgery patients), the authors looked at the probability of these patients attain-

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ing normal body weight or reducing body weight by 5% during a 9-year follow-up.

The chances of attaining a normal body weight was 1 in 210 for men and 1 in 124 for women for those with "simple" obesity (BMI 30.0—34.9 kg/m2). These numbers decreased to 1 in 1290 for men and 1 in 677 for those with morbid obesity (BMI >40.0 kg/m2). The numbers were more positive for attaining a 5% weight reduction, with 1 in 8 (13%) for men and 1 in 7 (14%) for women who were morbidly obese.

The authors conclude that current "non-surgical obesity treatment strategies are failing to achieve sustained weight loss for the majority of obese patients."[4] Not a hopeful study.

In the war against adipose tissue, we in the medical profession are not winning. If anything, we seem to be losing at a greater pace than in the past. This bodes ill for those in primary care, because we will continue to see an increase in diabetes, heart disease, and other obesity-related disorders. As podiatric physicians, we should anticipate an ever-increasing contribution of obesity to almost all of the disorders we treat.

In some cases, this will mean seeing a greater number of a certain diagnosis, and in others, we may need to adjust our current treatment regimens to maintain successful outcomes. For example, we should anticipate an increasing prevalence of adult acquired flatfoot, while also needing to adjust how we treat it. Orthosis therapy, for instance, may need to be more aggressive, while our surgical interventions may need to include a greater number of fusions to hold up against the increased ground-reactive forces.

The answer to my hypothetical title question is, of course, "no." We should not give up on our obese patients, though we should maintain a realistic outlook on their chances of weight loss. Until someone discovers a new method that helps our patients truly lose and maintain weight, we will have to live with the consequences of obesity. Perhaps this is the age of the bariatric surgeon. **PM**

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References

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