

# **The Australian Obesity Management Algorithm**

## **Introduction**

Obesity is a complex and multi-factorial chronic disease with genetic, environmental, physiological and behavioural determinants that requires long-term care. In 2014-15, 63.4% of Australians aged 18 years and over were above normal weight, with 27.9% being obese [1]. Obesity is associated with a broad range of complications including type 2 diabetes, cardiovascular disease, dyslipidaemia, sleep apnoea, osteoarthritis, and certain types of cancers, which significantly impair quality of life. Obesity and its related complications place a considerable financial burden on Australia. In 2014-15, the direct and indirect costs of obesity were estimated at \$ 8.65 billion [2].

This statement has been developed by a working group with representatives from the Australian Diabetes Society, the Australian and New Zealand Obesity Society and the Obesity Surgery Society of Australian and New Zealand. Membership of the working group is shown in Appendix 1.

The aims of the document are to:

- 1) Assist general practitioners (GPs) in treatment decisions for non-pregnant adults with obesity
- 2) Provide a practical clinical tool to guide the implementation of existing guidelines for the treatment of obesity in the primary care setting in Australia [3, 4]

Although the focus of this document is on weight loss interventions for the management of obesity, maintaining a healthy lifestyle and preventing weight gain in healthy weight or overweight individuals is an important and essential strategy to prevent a worsening of the current obesity epidemic in Australia.

## **Section1: Guiding principles**

### **1. The benefits of weight loss**

Weight loss in people with obesity has proven medical benefits in reducing the risk of diabetes and other obesity-related complications. For example, the 10 year follow-up of the US Diabetes Prevention Program showed that diabetes incidence was reduced by 34% in the lifestyle group and 18% in the metformin group, compared with placebo [5]. The weight loss required to achieve some of these medical benefits is relatively small. For example, the reduction in diabetes risk was achieved with weight loss in

the order of 5% [3]. However for some people with obesity, this degree of weight loss may not meet their cosmetic expectations, despite the potential medical benefits.

## **2. The role of primary care**

Primary care is critical to addressing Australia's obesity problem. Unfortunately there is a common view that little can be done to assist individuals with obesity. This document illustrates that there are viable and effective treatment options but it is important that these are considered in the context that obesity is a complex chronic disease that requires long-term ongoing care, with many similarities to managing diabetes. Management of obesity in primary care requires a personalised approach, often in a shared care arrangement, with regular monitoring and the application of a variety of weight loss strategies, intensified over time if weight loss and health targets are not achieved.

Routine and regular consideration and assessment of weight are essential initial steps that allow identification of:

- individuals whose weight is affecting their health and who may benefit from weight management interventions
- individuals who are gaining weight and require counseling and weight management interventions to prevent further weight gain

Available resources could be better utilised in the management of obesity. For example, individuals with obesity are eligible for Medicare funded enhanced primary care plans including reimbursed allied health visits. In addition, people with type 2 diabetes and Indigenous people are eligible for additional care plan services.

## **3. Weight bias**

Weight bias in obesity care is a common and important obstacle that can interfere with effective obesity treatment. Individuals with obesity face persistent societal stigmatisation, prejudice and discrimination. Unfair treatment or prejudice because of body weight is referred to as "weight bias" and translates into inequities in employment, education and also health-care. Common negative stereotypes include obese individuals being lazy, unmotivated, lacking in self-discipline, less competent and noncompliant. Weight bias negatively affects psychological well-being and physical health. Weight bias is common among healthcare providers with accumulating evidence that individuals with obesity are perceived as lacking self-control, unmotivated to improve health, noncompliant with treatment, and personally to blame for

their weight [6]. These attitudes affect outcomes and individuals with obesity who perceive bias from their healthcare providers have less trust in them, experience more difficulty losing weight and avoid preventive health services and medical appointments. Conversely, provider weight bias may result in less desire to help obese compared with thinner individuals. Healthcare professionals with obesity may also be reluctant to give weight loss advice to their patients with overweight and/or obesity. It is important for healthcare professionals to reflect on their attitude towards individuals who are obese and the potential for weight bias.

#### **4. A personalised approach**

Weight and weight loss are sensitive issues for many people and most individuals with obesity will have attempted multiple weight loss interventions and may not be ready to make another attempt. Poor body image, low self-esteem, psychological problems and eating disorders such as binge eating and food addiction are common and will impact the effectiveness of treatment options. Health professionals should be aware that measurement of weight may in itself be upsetting for some people. The objective of reducing weight should be discussed at the outset and differing expectations between medical and cosmetic benefits reconciled. This should be used to inform the setting of individual realistic and sustainable weight loss targets according to the treatment selected.

## **Section 2: Treatment options for obesity**

### **1. Lifestyle interventions**

Supervised lifestyle interventions are an essential component of all weight loss strategies. Treatment goals focus on reducing energy intake and increasing energy expenditure. General advice on healthy eating is defined in the Australian Dietary Guidelines and the Australian Guide to Healthy Eating [7, 8]. Similar weight loss can be achieved with diets of different macronutrient content [9, 10]. Involving a multidisciplinary team such as an accredited practicing dietitian, exercise physiologist, lifestyle coach or psychologist should be considered and can be accessed through a chronic care plan. For some individuals, established commercial programs may be appropriate.

#### **1.1 Reducing energy intake**

The following are options for reducing energy intake and achieving an energy deficit:

### **1.1.1 Reduced Energy Diet (RED)**

The aim of a RED is to produce a modest energy deficit of 2000-4000 kJ/day (480-960 kcal/day). This can be achieved by encouraging the intake of vegetables, fruit, wholegrains, legumes, nuts, seeds, lean meat, poultry, fish, eggs and low fat milk, cheese and yogurt and by minimising the intake of processed and energy dense foods such as biscuits, cakes, confectionary, pastries, pies, processed meats, commercial burgers, fried foods and chips. The intake of sugar-sweetened drinks, such as fruit juices, soft drinks, and energy drinks, as well as alcoholic drinks should be avoided. Snacking and portion sizes will also need to be reduced. A detailed review of the person's diet will help identify processed and energy dense foods that can be changed to healthier alternatives.

### **1.1.2 Low Energy Diet (LED)**

The aim of a LED is to reduce total daily energy intake to 4200-5000 kJ (1000-1200 kcal). Generally, a more prescriptive diet is needed to achieve this energy deficit. Specific meal plans can be provided or prepared low energy meals can be obtained from commercial providers. LEDs can also be achieved by substituting one or two meals with one or two specially formulated meal replacements. For individuals who have unsuccessfully tried RED/LED, Very Low Energy Diets should be advised (See Section 1.1.3).

### **1.1.3 Very Low Energy Diet (VLED)**

The aim of a VLED is to reduce energy intake to less than 3300 kJ/day (800 kcal/day) by substituting meals with formulated meal replacements. VLEDs can be considered as an initial weight loss strategy, when supervised lifestyle interventions have been unsuccessful in reducing weight, or when rapid weight loss is required (e.g. prior to bariatric or general surgery conditional on weight loss). While following a VLED, physical activity should be encouraged. VLEDs are low in carbohydrate, inducing a mild ketosis after 2-3 days that has an anorexic effect. It should be stressed to the individual that VLEDs do not contain pharmacologically-active ingredients.

#### **VLED in practice**

VLEDs are often recommended for 12 weeks. However, VLEDs can be continued for 6-12 months under careful supervision [11]. The duration of the VLED depends on the person's weight at baseline and the target weight. Medical supervision is required while on a VLED (see section 1.1.3.1). Before starting a VLED, baseline blood tests should be taken and individuals reviewed every 4 to 6 weeks. Individuals may follow a partial or a complete VLED regimen. The partial regimen is the most common program

recommended and is based on 2 meal replacements per day (typically breakfast and lunch) and 1 serve of lean protein, usually for dinner, with vegetables (Appendix 2). A teaspoon of olive oil should be added to induce contraction of the gall bladder and reduce the risk of gallstones. Water, tea, coffee, and diet drinks are allowed. Milk (other than small quantities in tea or coffee) should be avoided. The complete VLED regimen is based on 3 meal replacements per day, plus vegetables. The choice of the program (partial vs. complete) depends on the target weight and the individual's ability to tolerate the VLED.

#### 1.1.3.1 Assessments while on a VLED

- **Baseline assessments:** weight and waist circumference; biochemistry (electrolytes, creatinine, liver function tests, fasting glucose, lipids, uric acid) and haematology (full blood count, iron studies) predominantly for comparison with subsequent tests after commencing the VLED.
- **Progress assessment:** weight and waist circumference; blood pressure (lying and standing); periodic biochemistry and haematology. Consider discontinuing VLED if abnormalities develop (eg electrolyte abnormality, anaemia).

#### 1.1.3.2 Contraindications to VLED

- Pregnancy or lactation
- Severe psychological disturbance (e.g. unstable anxiety disorders, major depression), alcoholism or drug dependence
- Recent myocardial infarction, cerebrovascular event or unstable angina
- Porphyria
- Age >65 years (VLED in this age group should be advised with caution)

#### 1.1.3.3 Special Groups

- **Diabetes on insulin or sulphonylureas:** Doses of sulphonylurea or insulin should be reduced by 50% on commencement of the VLED. Subsequent dosage adjustment (either increase or decrease) are based on frequent structured self-monitoring of blood glucose. It should be stressed that if hypoglycaemia occurs, it takes precedence over the diet and must be treated with appropriate carbohydrate ingestion.
- **Chronic kidney disease:** Individuals with an estimated glomerular filtration rate (eGFR)<60 mL/min/1.73m<sup>2</sup> need closer supervision and should have electrolytes assessed more frequently. Special precaution and consideration is needed in individuals with eGFR<30 mL/min/1.73m<sup>2</sup>.

- **Taking Warfarin:** The diet increases vegetable intake and may alter the international normalised ratio (INR). Individuals on Warfarin should be instructed to test INR one week after commencing the VLED in order to adjust the warfarin dose. The absolute quantity of green vegetables is not the issue, rather the level of intake must be kept constant throughout the VLED.

#### **1.1.3.4 Weight loss response and maintenance after a VLED**

Individuals are considered to be responding to the VLED if they lose on average 1.0 to 1.5 kg per week. Once the target weight is reached, individuals are weaned off the VLED and food is progressively re-introduced over a period of 8 weeks. For individuals following the complete VLED, the usual plan is to transition to 2 meal replacements and one meal of food per day for 4 weeks, followed by 4 weeks with 1 meal replacement and 2 meals of food per day. After 8 weeks, the individual should be following the standard healthy diet (refer to Australian Guide to Healthy Eating), but due to metabolic adaptation [12], caloric intake must remain lower than at baseline and physical activity maintained, otherwise weight will be rapidly regained. Weight should be monitored at monthly intervals. Weight loss maintenance may include intermittent periods of VLED (either 2 weeks every 3 months or triggered by reaching agreed action weight) or the use of commercial weight loss programs. Some weight regain is normal, expected and physiological, requiring continued intensive phases for most individuals. If more than approximately 3 kg of the weight lost is regained [3], consider restarting the VLED with the addition of pharmacotherapy [13].

#### **1.1.3.5 VLED non-responders**

If no weight is lost or less than 1.0 kg is lost per week over 4 weeks, review the person's adherence to the VLED or other factors that may be affecting weight loss. If there are no remedial factors, pharmacotherapy should be added to the VLED.

## **1.2 Increasing energy expenditure**

Regular physical activity is essential for well-being and to address obesity-related complications. All adults are recommended to follow the guidelines for physical activity [14, 15]. People with musculoskeletal problems may need alternative forms of exercise, such as water-based activities. Individuals with cardiovascular or respiratory disease may also need a gentler regimen. These people may benefit from seeing an exercise physiologist or engaging in community based programs.

## **2. Pharmacotherapy (Table 1)**

Weight loss pharmacotherapy may be useful in assisting with the initial weight loss, to maintain weight loss at the end of a VLED or to prevent weight regain. While weight loss pharmacotherapy will usually be required on a long-term basis, data on long-term safety and effectiveness of weight loss medication are limited. Only three drugs have been approved by the TGA for the treatment of obesity in Australia, Phentermine, Orlistat and Liraglutide.

### **2.1 TGA approved pharmacotherapy**

#### **Phentermine (Duromine®, Metermine®)**

Phentermine, delivered in a slow release resin complex, is a centrally acting adrenergic agonist that suppresses appetite [16, 17]. Side effects include tachycardia, hypertension, insomnia and dry mouth. Phentermine should not be used with anti-depressant drugs or in individuals with coronary artery disease, arrhythmias or uncontrolled hypertension because of its cardiac stimulant actions. Phentermine is registered for short-term use (12 weeks) as an adjunct to dietary management of obesity. In conjunction with a hypocaloric diet, weight reduction of 5-10% is achieved by 12 weeks of treatment [16]. The longer-term safety of phentermine has been evaluated in the SEQUEL trial in which combined phentermine and topiramate (Qysmia) was continued for 2 years [18].

#### **Orlistat (Xenical®)**

The primary action of Orlistat is to inhibit pancreatic and gastric lipase, reducing fat absorption by 30%. Side effects include steatorrhoea, oily spotting and flatulence if more than 30g of fat is consumed. Another potential complication of long-term use of this agent is deficiency of fat-soluble vitamins A, D, E and K, and the development of oxalate kidney stones. In conjunction with lifestyle intervention, results from the XENDOS study reported a weight loss of 10.6 kg at 1 year and 5.8 kg at 4 years in the Orlistat group compared to 6.2 kg and 3.0 kg weight loss in the placebo group, respectively. A 37% reduction in progression to type 2 diabetes was also reported in the Orlistat group [19]. The safety of Orlistat has been established over the 4 years of the XENDOS study.

#### **Liraglutide 3 mg (Saxenda®)**

Liraglutide is a once-daily glucagon-like peptide-1 (GLP-1) receptor agonist that slows gastric emptying and suppresses appetite. The starting dose is 0.6 mg daily by subcutaneous injection, with a weekly increment of 0.6 mg to minimise gastrointestinal side effects. While the recommended daily

dose is 3.0 mg, which is also the maximum dose, some patients may achieve good weight loss with lower doses. Since Liraglutide is a blood glucose-lowering medication, other glucose-lowering medications may need to be adjusted in people with diabetes. Common adverse effects include nausea, vomiting and diarrhoea, which can be reduced by slowing the dose escalation schedule. There is an increased risk of gall-stones and cholecystitis requiring cholecystectomy independent of weight loss. While occurring very rarely, there also appears to be an increased risk of pancreatitis [20]. Results from the SCALE trial, a 56-week placebo-controlled trial, demonstrated that treatment with Liraglutide 3 mg, in combination with lifestyle intervention, resulted in a mean weight loss of 8% compared to 2.6% in the placebo group [20]. Recent results from the LEADER Study, investigating the long-term effects of Liraglutide 1.8 mg in people with type 2 diabetes, demonstrated superior cardiovascular outcomes compared with placebo [21]. However, there are no hard outcome data for the weight loss recommended dose of 3 mg.

## **2.2 Off Label Pharmacotherapy**

Other medications not approved by TGA for weight loss therapy are being used off label in Australia for the management of obesity by experienced practitioners in obesity care.

### **Topiramate**

Topiramate is an anticonvulsant drug currently available in Australia on authority for difficult to control epilepsy and migraine. The drug has a powerful appetite suppressant effect, resulting in weight loss. A meta-analysis of 10 randomised controlled trials of at least 16 weeks duration concluded that the Topiramate-treated group had additional weight loss of 5.3 kg compared with the placebo-treated group [22]. An Australian trial program has established the use of Topiramate in the management of obesity [23]. Effective doses are between 25 and 100 mg per day. Side effects include depression, difficulty concentrating, paraesthesia (common) and closed angle glaucoma (rare). This medication can be considered for use “off label” in the management of individuals with obesity when other medications have been ineffective or are contraindicated. A thorough knowledge of side-effects, precautions and contraindications of Topiramate are essential and individuals need to be counselled appropriately.

### **Combined low dose Phentermine and Topiramate**

The combination of these two monotherapies is useful for weight loss maintenance. An Australian study investigating the safety, tolerability and efficacy of the combination showed that in about 40% of the subjects, the combination was not well tolerated predominantly due to Topiramate (25 mg mane) side effects. In those who tolerated the combination, the weight loss achieved with a VLED (10% weight loss) was maintained over a mean duration of pharmacotherapy of 10 months. A group of subjects who continued Phentermine-Topiramate for 22 months had a further mean weight loss of 6.7 kg [23].



**Table 1 Pharmacotherapy for the treatment of obesity**

Drug	Phentermine Duromine® Metermine®	Orlistat Xenical®	Liraglutide Saxenda®	Topiramate	Phentermine- Topiramate
<b>TGA status</b>	Approved	Approved*	Approved	Not Approved	Not Approved
<b>Available doses</b>	15 – 30 – 40 mg	120 mg	0.6 - 3 mg	25 – 50 – 100 mg	Phe. 15 mg Top. 12.5 – 25 – 50 – 100 mg
<b>Starting dose</b>	15-30 mg mane	120 mg tds	0.6 mg daily	12.5 mg mane	Phe 15 mg mane Top. 12.5 mg mane
<b>Dosage form</b>	Tablet	Tablet	Injection	Tablet	Tablet
<b>Maximal dose</b>	40 mg mane	120 mg tds	3.0 mg daily	50 mg bd	Phe. 15 mg mane Top. 50 mg bd
<b>Contraindications</b>	Severe hypertension Cardiac disease Glaucoma History of drug abuse MAO inhibitors SSRI use	Anorexia Pregnancy Vitamin deficiency	History of Pancreatitis or medullary cell thyroid cancer	Glaucoma Renal Stones Pregnancy (if used for weight loss)	Severe hypertension Cardiac disease Glaucoma History of drug abuse MAO inhibitors SSRI use Glaucoma Renal stones
<b>Side effects</b>	Hypertension Tachycardia Insomnia Restlessness Dry mouth Diarrhoea/ constipation	Steatorrhoea Fat soluble vitamin deficiency	Nausea Vomiting Diarrhoea Constipation Pancreatitis Cholecystitis	Paraesthesia Confusion Memory loss Glaucoma Renal stones Nausea Vomiting Pancreatitis	Hypertension Tachycardia Insomnia Restlessness Dry mouth Diarrhoea/ constipation Paraesthesia Confusion Memory loss Glaucoma Renal stones
<b>Cost of medication</b>					Phe. Top.
Dose	40 mg <sup>1</sup>	120 mg <sup>1</sup>	3 mg	50 mg <sup>1</sup>	15 mg <sup>1</sup> 50 mg <sup>1</sup>
No./day	1	3	1	2	1 2
Cost/month	\$125.0	\$107.20	\$387	\$28.0	\$119.50

Mane, in the morning; tds, 3 times per day; bd, twice a day; MAO, monoamine oxidase; SSRI, selective serotonin reuptake inhibitors. TGA, Therapeutic Goods Administration. \*Available through the veteran system. <sup>1</sup>Estimated price from pharmacy websites. The estimates of price per month are calculated by dividing the cost by the number of tablets per script, multiplied by the dose/day. Prices listed as July 2016.

### 3. Bariatric surgery

Bariatric surgery remains the most efficacious weight loss intervention in individuals with obesity. Bariatric surgery should be considered as part of a comprehensive treatment delivered by a multidisciplinary team including GPs, physicians, surgeons, dietitians and psychologists. The potential benefits of surgery need to be assessed for each individual by suitably trained and experienced practitioners and balanced against the individual risk profile. Components of successful bariatric surgery care include an informed patient, tailored operation, committed multi-professional team care and long-term follow up. All individuals considered for bariatric surgery need a careful risk to benefit assessment and optimisation of health prior to surgery. Not all individuals in whom surgery is a potential treatment option will be suitable for surgery, especially if they have multiple and advanced complications. These people should be referred to multidisciplinary tertiary institutions for ongoing care. It is beyond the scope of this document to provide a detailed description of available bariatric surgical procedures, however these are available in the 2013 NHMRC Guidelines [3].

The NHMRC clinical practice guidelines for the management of overweight and obesity state that, taking into account the individual situation, bariatric surgery may be considered for adults with [3]

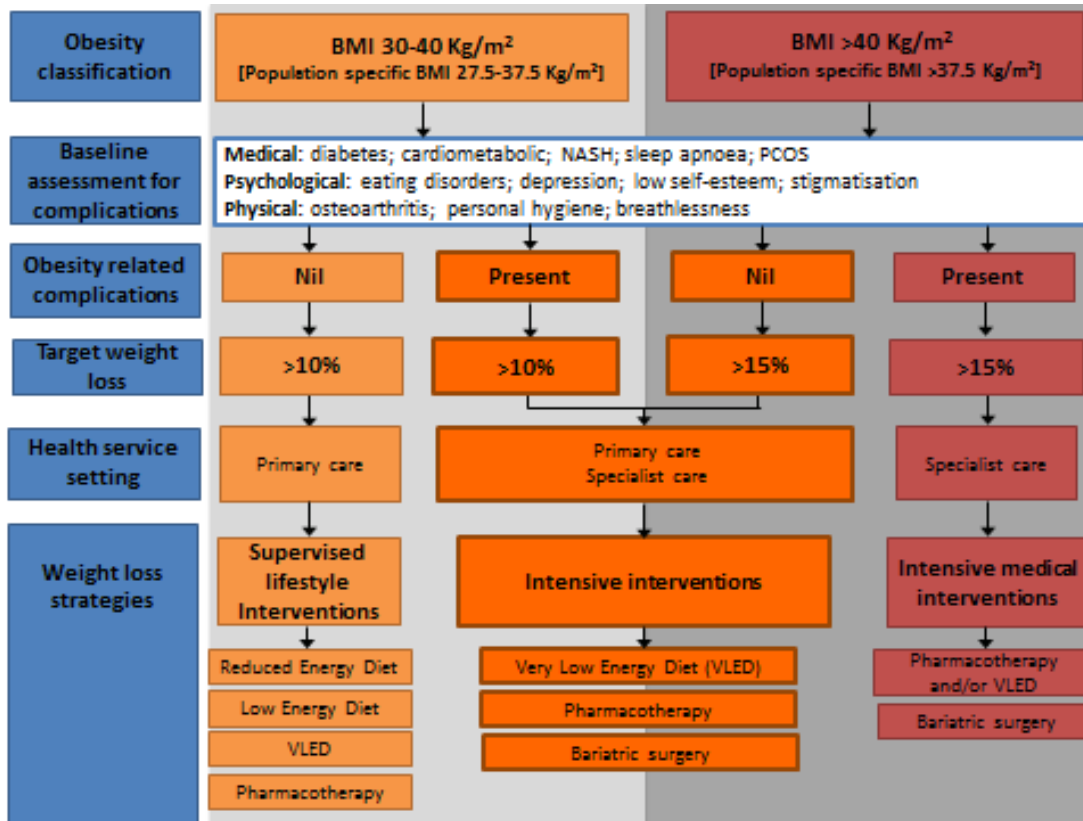
- BMI >40 kg/m<sup>2</sup>
- BMI >35 kg/m<sup>2</sup> and comorbidities that may improve with weight loss
- BMI >30 kg/m<sup>2</sup> who have poorly controlled type 2 diabetes and are at increased cardiovascular risk

Recently, the Australian Diabetes Society has endorsed the 2<sup>nd</sup> Diabetes Surgery Summit meeting guidelines [24] on metabolic surgery as a treatment option for individuals with type 2 diabetes which state that:

- Metabolic surgery is recommended for individuals with:
  - BMI ≥40 kg/m<sup>2</sup> regardless of the level of glycaemic control or complexity of glucose lowering regimens
  - BMI 35.0–39.9 kg/m<sup>2</sup> with inadequate glycaemia control despite lifestyle and optimal medical therapy
- Metabolic surgery should be considered in individuals with BMI 30.0–34.9 kg/m<sup>2</sup> with inadequately controlled hyperglycaemia despite optimal medical treatment by either oral or injectable medications (including insulin).

## Section 3: Algorithm for the management of obesity

Figure 1 Australian algorithm for the management of obesity



### Application of the algorithm

The first step in the application of the algorithm is a baseline assessment and categorisation of individuals for treatment guidance based on BMI and the presence of obesity-related complications.

#### 1. Baseline assessment

##### 1.1 Categorise the obesity

The algorithm considers two categories of BMI: BMI 30-40 kg/m<sup>2</sup> and BMI >40 kg/m<sup>2</sup>. While BMI has some limitations it remains a useful measure for guiding management decisions. It is well documented that the association between BMI and fat distribution differs across populations. Asian and Australian Aboriginal populations are characterised by higher adiposity for a given BMI [25, 26]. As such, the lower

BMI cut-offs for overweight and obesity recommended for Asian populations could also be considered for Aboriginal populations (Table 2).

**Table 2 The classification of weight by BMI**

<b>Classification</b>	<b>General population BMI (kg/m<sup>2</sup>)</b>	<b>Population-specific BMI (kg/m<sup>2</sup>)*</b>
<b>Normal range</b>	18.5 – 24.9	18.5 – 22.9
<b>Overweight</b>	25.0 – 29.9	23.0 – 27.49
<b>Obese class I</b>	30.0 – 34.9	27.5 – 32.4
<b>Obese class II</b>	35 – 39.9	32.5 – 37.4
<b>Obese class III</b>	≥40	≥37.5

\* Cut-offs apply to Asian population but could be used for Australian Aboriginal populations

## 1.2 Assess for obesity-related complications

Assessment of obesity-related complications provides additional guidance for the treatment pathway. Complications are grouped under medical, psychological and those causing physical limitations. The majority of individuals with a BMI >40 kg/m<sup>2</sup> will have obesity-related complications. Some complications are more responsive to weight loss including type 2 diabetes, non-alcoholic steatohepatitis (NASH), polycystic ovary syndrome (PCOS) and hypertension and will benefit most from weight loss treatment. Although there are various systems to stage obesity, this algorithm adopts a simplified approach to obesity staging. Given the chronic nature of obesity, assessment of obesity-related complications needs to be ongoing and repeated at regular intervals.

## 2. Set weight loss targets

The algorithm provides a general weight loss target of >10% in individuals with BMI 30-40 kg/m<sup>2</sup> and >15% in individuals with BMI >40 kg/m<sup>2</sup>. These targets are indicative only and personalised weight loss targets should be set between the clinician and the individual with obesity. As noted earlier, lesser degrees of weight loss can still have medical benefits, especially in the prevention of diabetes.

### **3. Utilising Health Services**

The management of obesity requires a multidisciplinary team and a long-term chronic disease approach. The algorithm suggests that primary care is ideally placed to manage the care of individuals with BMI 30-40 kg/m<sup>2</sup> without obesity-related complications. Shared care arrangements between GPs and specialist services should be considered for people with BMI 30-40 kg/m<sup>2</sup> with complications or BMI >40 kg/m<sup>2</sup> without complications. Finally, individuals with BMI >40 kg/m<sup>2</sup> with complications should be considered for referral to specialist care.

### **4. Weight loss strategies**

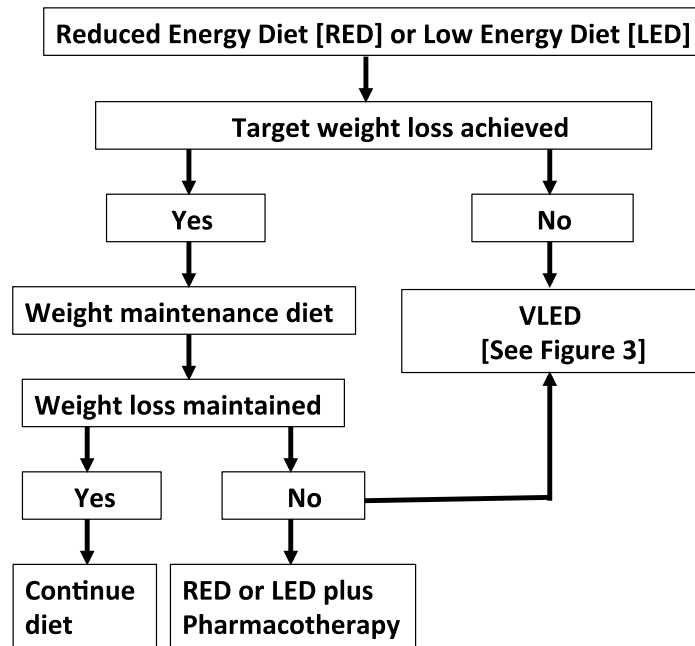
#### **4.1 Management of individuals with BMI 30-40 kg/m<sup>2</sup> without complications (Figure 2)**

Supervised lifestyle intervention is the mainstay of management for individuals with BMI 30-40 kg/m<sup>2</sup> without established complications. Initially this includes a reduced energy diet or a low energy diet, combined with a program to increase regular physical activity. Referral to multidisciplinary care such as an accredited practicing dietitian, exercise physiologist, lifestyle coach or an established commercial weight loss program can be considered.

If weight loss is insufficient or weight regain is experienced, a VLED can be considered or a RED/LED can be combined with pharmacotherapy.

Figure 2

**BMI 30-40 kg/m<sup>2</sup> without obesity-related complications**  
**Management Flow Diagram**



**4.2 Management of individuals with BMI 30-40 kg/m<sup>2</sup> with obesity-related complications  
OR BMI >40 kg/m<sup>2</sup> without complications (Figure 3)**

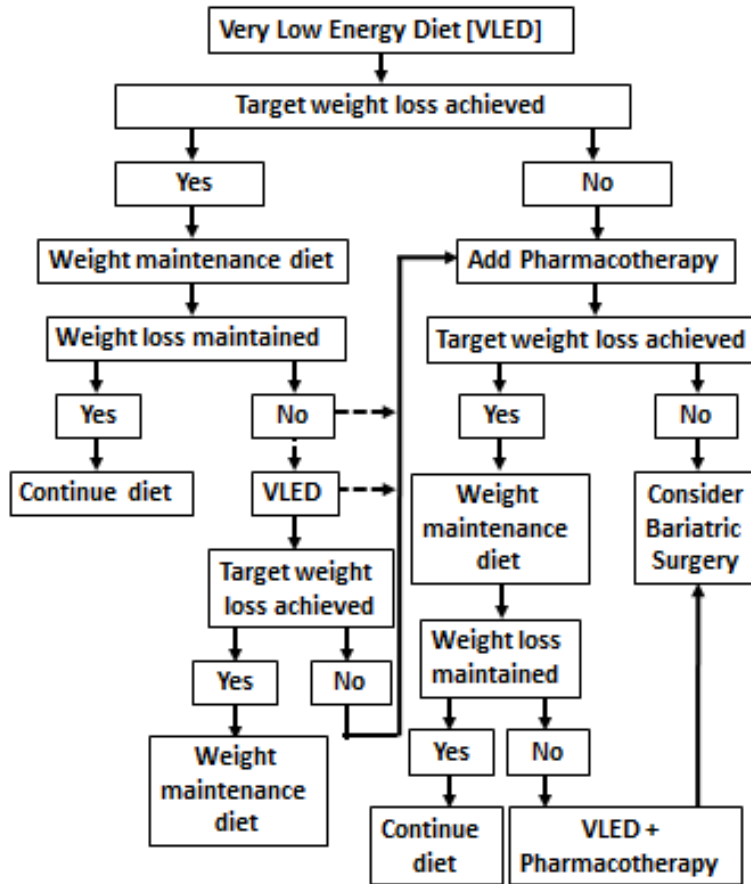
This group of individuals requires more intensive interventions. Three main options are available and the choice of therapies should be guided by previous weight loss interventions and response.

**1. VLED** is an initial option for individuals who have not tried this previously and are willing to use meal replacements. If effective in achieving adequate weight loss, the meal replacements can be reduced and the diet can be replaced with a weight maintenance diet. If weight is regained the VLED can be reintroduced.

**2. Pharmacotherapy** can be considered in individuals who do not have an adequate initial response to the VLED, or who regain weight once the VLED is relaxed.

**3. Bariatric surgery** is an option for individuals who do not respond to the VLED plus pharmacotherapy, or who have previously tried this approach without success, or who have type 2 diabetes.

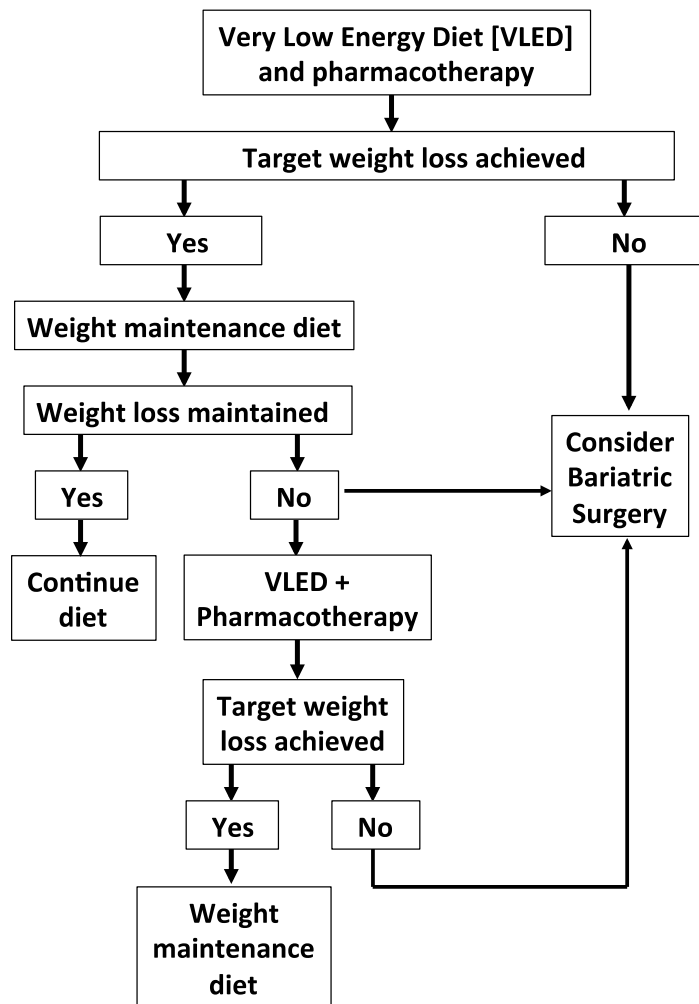
**Figure 3**                    **BMI 30-40 kg/m<sup>2</sup> with obesity-related complications or**  
**BMI >40 kg/m<sup>2</sup> without obesity-related complications**  
**Management flow diagram**



### 4.3 Management of individuals with BMI >40 kg/m<sup>2</sup> with obesity-related complication (Figure 4)

These individuals should be considered for intensive medical interventions and are best managed in specialist care. Initial treatment should consider combining a VLED and pharmacotherapy. Subsequent management is guided by response. Bariatric surgery should be recommended especially in the presence of weight responsive complications or when previous interventions have not resulted in sustainable weight loss or health improvements.

**Figure 4** BMI >40 kg/m<sup>2</sup> with obesity-related complications  
Management flow diagram





## **Section 4: Special clinical situations**

### **1. Age**

The nadir for lowest mortality associated with weight is not constant and varies with age, ethnicity and the presence of other disease. Obesity defined by BMI  $\geq 30$  kg/m<sup>2</sup> does not carry the same mortality risk in older adults (>65 years) as in younger adults. With ageing, lowest mortality is associated with a BMI higher than the normal range [27]. Thus, the mortality risk associated with weight loss (including intentional) increases with age generating an altered risk to benefit ratio. Healthy ageing should therefore focus on lifestyle, quality nutrition and physical activity to improve cardiovascular fitness, optimise functional independence and quality of life.

#### **1.1 Young adults (18-35 years)**

Adolescence and early adulthood are often associated with a decrease in physical activity and rapid weight gain. Particular attention should be given to early detection and management of individuals on a positive weight trajectory and with high cardio-metabolic risk. Interventions should be initiated early to prevent weight gain, complications and end-organ damage.

#### **1.2 Older adults (>65 years)**

There is no clear BMI target in this age group. The main goal in older adults with obesity is to improve physical function and minimise the impact of obesity-related complications. In individuals with BMI 30-40 kg/m<sup>2</sup> and BMI  $\geq 40$  kg/m<sup>2</sup> without complications, the aims of treatment are to maintain health and physical function, prevent weight gain, and generate a more moderate intentional weight loss. In individuals with a BMI  $\geq 40$  kg/m<sup>2</sup> with obesity-related complications, more intensive therapies are indicated, but the importance of maintaining physical function, body composition, and quality nutrition may require specific lifestyle programs. When engaging older adults in intensive therapies, cardiovascular fitness should be considered.

### **2. Pregnancy**

Obesity during pregnancy is associated with an increased risk of obstetric complications, hypertension, gestational diabetes, fetal macrosomia and increased risk of obesity in the offspring. In women with BMI  $>30$  kg/m<sup>2</sup>, a total weight gain not exceeding 9 kg is recommended [28, 29]. Gestational weight gain (GWG) should be closely monitored in women with obesity, as well as in women with a healthy pre-pregnancy weight, as excessive GWG is associated with poorer maternal and neonatal outcomes. In women with excessive weight gain, weight management strategies should be implemented. If indicated,

bariatric surgery should be considered 12 to 18 months prior to pregnancy. All medications available for weight loss in Australia (either on-label or off-label) are category B for use in pregnancy.

## **Section 5: Implementation in primary care and linkage with specialist care**

Obesity is a chronic disease that requires lifelong management. GPs play a key role in identifying individuals with obesity and implementing appropriate interventions to support weight loss and/or prevention of weight regain. Primary care should assist individuals to access obesity support services that address the social complexity surrounding obesity. General practices can strategically improve services for these individuals and carers through personal education, education of practice staff, development of obesity focussed practice resources (e.g. weighing scales to monitor individuals across the obesity ranges as a matter of routine), and development of a referral network of specialist services or multidisciplinary teams able to address obesity and weight-related complications. Practice systems that exist for chronic disease management can be utilised for weight management such as recall systems and reviews focussing on high risk individuals with complications and bariatric surgical assessment [15, 30-33].

## **APPENDIX 1 – Membership of working group**

### **Australian Diabetes Society representatives:**

A/Professor Sof Andrikopoulos, Department of Medicine, University of Melbourne, Melbourne

Professor Stephen Colagiuri (Convenor), Boden Institute, University of Sydney, Sydney

Dr Gary Deed, Mediwell, Brisbane

Professor Joe Proietto, Department of Medicine, University of Melbourne, Melbourne

### **Australian and New Zealand Obesity Society representatives:**

Professor John Dixon, Baker IDI Heart and Diabetes Institute, Melbourne

A/Professor Tania Markovic, Metabolism & Obesity Services, Royal Prince Alfred Hospital, Sydney

### **Obesity Surgery Society of Australian and New Zealand representatives:**

Professor Jeffrey Hamdorf, School of Surgery, University of Western Australia, Perth

Dr Georgia Rigas, University of New South Wales, Sydney

### **Project Officer:**

Dr Nathalie Kizirian, Boden Institute, University of Sydney, Sydney

**APPENDIX 2: Foods allowed and to avoid while on a VLED**

Allowed			Avoid
<b>Low starch vegetables</b>			
Alfalfa sprouts	Celery	Radishes	Corn
Asparagus	Cucumber	Shallots	Green peas
Bean Sprouts	Eggplant	Silverbeet	Legumes
Bok Choy	Endive	Snow peas	Lentils
Broccoli	Green beans	Spinach	Potatoes
Brussels sprouts	Konjac noodles	Squash	Sweet potato
Cabbage	Lettuce (all types)	Tomatoes	Parsnip
Capsicum	Leeks	Watercress	Pumpkin
Carrots	Mushrooms	Zucchini	Turnip
Cauliflower	Onions		
<b>Soups</b>			
Stock cubes	Vegetable soups made from allowed vegetables		All other soups
Bonox (in moderation)	Miso soup		
<b>Sauces and condiments</b>			
Lemon & lime juice	Soy sauce	Mustard	Cream High calorie simmer sauces and dressings
Vinegar	Chilli	Tomato paste	
Worcestershire sauce	Diet, oil free or fat free salad dressings		
Tabasco sauce			
<b>Herbs and spices</b>			
All spice	Curry powder	Oregano	
Basil	Dill	Paprika	
Celery flakes	Fennel	Parsley	
Chilli	Garlic	Pepper	
Chives	Ginger	Rosemary	
Cinnamon	Lite salt	Sage	
Cloves	Mint	Thyme	
Coriander	Mustard seed	Tumeric	
Cumin	Nutmeg	Taragon	
<b>Others</b>			
Low joule jellies Artificial sweeteners Tea, coffee, diet drinks			Fruit and fruit juice Alcohol Milk Sugary drinks Flavoured mineral waters Discretionary foods

### APPENDIX 3: Summary of weight loss interventions<sup>1</sup>

Intervention	Summary of effect
<p><b>Lifestyle change</b></p>	<p>&gt;10% weight loss in few studies; weight loss difficult to maintain for many individuals.</p> <p>Study results:</p> <ul style="list-style-type: none"> <li>• Dietary change: average weight loss 3-5 kg at 12months; 0 kg at 5 years</li> <li>• Dietary change and exercise: average weight loss 5-10 kg at 12 months; 0-3 kg at 5 years</li> <li>• Lifestyle change and psychological intervention: average weight loss 3-4 kg at 5 years</li> </ul>
<p><b>Combined lifestyle change and pharmacotherapy</b></p>	<p>&gt;10% weight loss in some but not all studies; weight loss maintained &gt;5 years in some but not all participants.</p> <p>Study results:</p> <ul style="list-style-type: none"> <li>• Orlistat and dietary change: average weight loss 6-10 kg at 12 months; 2-3 kg at 5 years</li> <li>• Phentermine and dietary change: average weight loss 6.4 kg 12 weeks [16]</li> <li>• Liraglutide and lifestyle change: average weight loss 8% at 56 weeks [20]</li> </ul>
<p><b>Bariatric surgery with maintained lifestyle changes</b></p>	<p>&gt;10% weight loss consistently across studies; weight loss likely to be maintained &gt;5 years</p> <ul style="list-style-type: none"> <li>• Laparoscopic adjustable gastric banding: average weight loss 20% at 12 months; 12% at 10 years</li> <li>• Vertical gastrectomy: average weight loss 25% at 12 months; 16% at 10 years [34]</li> <li>• Roux-en-Y gastric bypass: average weight loss 33% at 12 months; 30% at 10 years</li> </ul>

<sup>1</sup> Adapted from the 2013 NHMRC table 6.4 [3].

## References

1. Australian Bureau of Statistics, *Australian Health Survey: First Results, 2014-15*. 2015.
2. PWC, *Weighing the cost of obesity: A case for action*. 2015.
3. National Health and Medical Research Council, *Clinical practice guidelines for the management of overweight and obesity in adults, adolescents and children in Australia*. 2013, National Health and Medical Research Council: Melbourne.
4. Royal Australian College of General Practitioners, *Guidelines for preventive activities in general practice, 8th edition*. 2012: East Melbourne.
5. Diabetes Prevention Program Research, G., et al., *10-year follow-up of diabetes incidence and weight loss in the Diabetes Prevention Program Outcomes Study*. *Lancet*, 2009. **374**(9702): p. 1677-86.
6. Obesity Australia, *Rethink Obesity: A media guide on how to report on obesity*. 2015.
7. National Health and Medical Research Council, *Australian Dietary Guidelines*. 2013, National Health and Medical Research Council: Canberra.
8. National Health and Medical Research Council. *Australian Guide to Healthy Eating*. Available from: <https://http://www.eatforhealth.gov.au/guidelines/australian-guide-healthy-eating>.
9. Sacks, F.M., et al., *Comparison of weight-loss diets with different compositions of fat, protein, and carbohydrates*. *N Engl J Med*, 2009. **360**(9): p. 859-73.
10. Hu, T., et al., *Effects of low-carbohydrate diets versus low-fat diets on metabolic risk factors: a meta-analysis of randomized controlled clinical trials*. *Am J Epidemiol*, 2012. **176 Suppl 7**: p. S44-54.
11. Sumithran, P. and J. Proietto, *Safe year-long use of a very-low-calorie diet for the treatment of severe obesity*. *Med J Aust*, 2008. **188**(6): p. 366-8.
12. Fothergill, E., et al., *Persistent metabolic adaptation 6 years after "The Biggest Loser" competition*. *Obesity (Silver Spring)*, 2016. **24**(8): p. 1612-9.
13. Johansson, K., M. Neovius, and E. Hemmingsson, *Effects of anti-obesity drugs, diet, and exercise on weight-loss maintenance after a very-low-calorie diet or low-calorie diet: a systematic review and meta-analysis of randomized controlled trials*. *Am J Clin Nutr*, 2014. **99**(1): p. 14-23.
14. Australian Government, *More than half of all Australian adults are not active enough*, Department of Health, Editor. 2014.
15. The Royal Australian College of General Practitioners, *Smoking, nutrition, alcohol, physical activity (SNAP): A population health guide to behavioural risk factors in general practice, 2nd edn*. 2015: Melbourne.
16. Kang, J.G., et al., *Randomized controlled trial to investigate the effects of a newly developed formulation of phentermine diffuse-controlled release for obesity*. *Diabetes Obes Metab*, 2010. **12**(10): p. 876-82.
17. Munro, J.F., et al., *Comparison of continuous and intermittent anorectic therapy in obesity*. *Br Med J*, 1968. **1**(5588): p. 352-4.
18. Garvey, W.T., et al., *Two-year sustained weight loss and metabolic benefits with controlled-release phentermine/topiramate in obese and overweight adults (SEQUEL): a randomized, placebo-controlled, phase 3 extension study*. *Am J Clin Nutr*, 2012. **95**(2): p. 297-308.

19. Torgerson, J.S., et al., *XENical in the prevention of diabetes in obese subjects (XENDOS) study: a randomized study of orlistat as an adjunct to lifestyle changes for the prevention of type 2 diabetes in obese patients*. *Diabetes Care*, 2004. **27**(1): p. 155-61.
20. Pi-Sunyer, X., et al., *A Randomized, Controlled Trial of 3.0 mg of Liraglutide in Weight Management*. *N Engl J Med*, 2015. **373**(1): p. 11-22.
21. Marso, S.P., et al., *Liraglutide and Cardiovascular Outcomes in Type 2 Diabetes*. *N Engl J Med*, 2016.
22. Kramer, C.K., et al., *Efficacy and safety of topiramate on weight loss: a meta-analysis of randomized controlled trials*. *Obes Rev*, 2011. **12**(5): p. e338-47.
23. Neoh, S.L., et al., *Combination phentermine and topiramate for weight maintenance: the first Australian experience*. *Med J Aust*, 2014. **201**(4): p. 224-6.
24. Rubino, F., et al., *Metabolic Surgery in the Treatment Algorithm for Type 2 Diabetes: A Joint Statement by International Diabetes Organizations*. *Diabetes Care*, 2016. **39**(6): p. 861-77.
25. Piers, L.S., et al., *Relation of adiposity and body fat distribution to body mass index in Australians of Aboriginal and European ancestry*. *Eur J Clin Nutr*, 2003. **57**(8): p. 956-63.
26. World Health Organization Expert Consultation, *Appropriate body-mass index for Asian populations and its implications for policy and intervention strategies*. *Lancet*, 2004. **363**(9403): p. 157-63.
27. Dixon, J.B., et al., *'Obesity paradox' misunderstands the biology of optimal weight throughout the life cycle*. *Int J Obes (Lond)*, 2015. **39**(1): p. 82-4.
28. Institute of Medicine (US), *Weight gain during pregnancy: Reexamining the Guidelines*. 2009, National Academy of Sciences:: Washington DC.
29. Get Healthy NSW. *Weight gain during pregnancy*. Available from: [http://www.gethealthynsw.com.au/assets/pdf/resources/GHS\\_Fact\\_Sheet\\_Weight\\_Gain\\_During\\_Pregnancy\\_online\\_Final.pdf](http://www.gethealthynsw.com.au/assets/pdf/resources/GHS_Fact_Sheet_Weight_Gain_During_Pregnancy_online_Final.pdf).
30. Australian Family Physician, *Recommendations for management in general practice and beyond*. 2013. **42**(8): p. 532-541.
31. Welbourn, R., et al., *NICE-Accredited Commissioning Guidance for Weight Assessment and Management Clinics: a Model for a Specialist Multidisciplinary Team Approach for People with Severe Obesity*. *Obes Surg*, 2016. **26**(3): p. 649-59.
32. Mechanick, J.I., et al., *Clinical practice guidelines for the perioperative nutritional, metabolic, and nonsurgical support of the bariatric surgery patient--2013 update: cosponsored by American Association of Clinical Endocrinologists, the Obesity Society, and American Society for Metabolic & Bariatric Surgery*. *Endocr Pract*, 2013. **19**(2): p. 337-72.
33. Allied Health Sciences Section Ad Hoc Nutrition, C., et al., *ASMBS Allied Health Nutritional Guidelines for the Surgical Weight Loss Patient*. *Surg Obes Relat Dis*, 2008. **4**(5 Suppl): p. S73-108.
34. Sjostrom, L., et al., *Effects of bariatric surgery on mortality in Swedish obese subjects*. *N Engl J Med*, 2007. **357**(8): p. 741-52.