

AHA Comments on Draft USPSTF Recommendation: Screening for and Management of Obesity in Adults

Draft Recommendation: The U.S. Preventive Services Task Force (USPSTF) recommends that clinicians screen adults for obesity. Clinicians should offer or refer patients with a body mass index (BMI) greater than 30 kg/m² to intensive, multicomponent behavioral interventions (B recommendation).

How could the USPSTF make this draft Recommendation Statement clearer?

According to the draft recommendation statement, clinicians should provide treatment to adults with “a body mass index (BMI) greater than 30 kg/m².” We do not understand why the recommendation only applies to individuals with a BMI *greater* than 30 kg/m². As the Task Force states in the Summary of Recommendation and Evidence, a BMI *equal to or greater* than 30 kg/m² is considered obese.

We recommend that the Task Force revise the recommendation to reflect the standard definition of obesity. The revised statement should apply to adults with “a body mass index (BMI) equal to or greater than 30 kg/m².”

In addition, as explained below, we believe that a BMI equal to or greater than 30 kg/m² should not be the only criteria to determine if a patient is obese and in need of treatment. BMI can serve as the initial screening tool, but clinicians should also consider waist circumference and abdominal fat when evaluating a patient’s weight, overall health, and risk for weight-related health outcomes.

What information, if any, did you expect to find in this draft Recommendation Statement that was not included?

The draft recommendation directs clinicians to screen for obesity using the BMI. While we support the use of the BMI to assess body weight, we would also like the Task Force to address the use of waist circumference and body composition, especially excess abdominal fat, to diagnose and assess an individual’s obesity and develop a weight loss plan.

It appears the Task Force decided not to address waist circumference because it had previously determined that BMI is an “acceptable measure” for identifying adults with excess weight, and therefore chose not to include a systematic evaluation of screening tests as part of this updated evidence review. We believe this is a significant oversight, particularly since the USPSTF acknowledges that recent evidence found waist circumference to be an “acceptable alternative” to BMI.

The accuracy of BMI for diagnosing obesity is especially limited for individuals in the intermediate BMI ranges, those with increased muscle mass, and in the elderly, and misses more than half of people with excess fat.ⁱ In addition, clinical and epidemiological evidence demonstrates that waist circumference is a better indicator than BMI of total body fat and intra-abdominal fat mass.ⁱⁱ Abdominal adiposity and visceral fat provide a more refined health indicator of the risk for cardiovascular death than BMI, especially in middle-aged adults.ⁱⁱⁱ For

example, one recent study found that individuals with a very large waist circumference had twice the risk of death. The study also found that risk of death increased in all individuals with a large waist, even if their BMI indicated a normal weight.^{iv}

Because waist circumference can help identify high risk individuals, it should be incorporated into the draft recommendation.

Finally, we are surprised that the draft recommendation focuses solely on obesity and does not address overweight patients. We encourage the USPSTF to also consider if individuals with a BMI between 25 and 29.9 would also benefit from behavioral interventions.

Based on the evidence presented in this draft Recommendation Statement, do you believe that the USPSTF came to the right conclusions? Please provide additional evidence or viewpoints that you think should have been considered.

The Task Force may have found it more appropriate to give obesity screening and management a stronger A-level recommendation if it had expanded its evidence review. It appears that the USPSTF's evidence reviews generally focus on clinically-designed studies. We believe this may result in the Task Force inappropriately excluding studies from the evidence review.

We encourage the Task Force to expand its search criteria to include epidemiological and population-based studies. Many prevention-related recommendations are based on epidemiological evidence that shows at least a correlation or relationship between the intervention and the health outcome. Although causality is not confirmed in these studies, the weight of evidence over time with multiple studies and significant cohorts can provide important consensus and foundation for assessing the evidence for the impact and efficacy of prevention-related initiatives. We recommend that the USPSTF look throughout the epidemiological literature to develop its level of evidence for each recommendation.

In addition, it is difficult to determine if the Task Force reached an appropriate conclusion, because the questions to be addressed and the inclusion criteria for the evidence review were not provided. We are therefore unable to determine if the Task Force covered the evidence base adequately. The USPSTF should continue to increase the transparency of the evidence review and provide the inclusion criteria and the dates of the searches.

What resources or tools could the USPSTF provide that would make this Recommendation Statement more useful to you in its final form?

Primary care clinicians are the intended audience of the draft recommendation. Yet, as the Task Force acknowledges in the Summary of Recommendation and Evidence, many primary care clinicians do not have experience providing intensive behavioral interventions. To help primary care clinicians provide this service, the USPSTF should provide guidance on the type of screening that should be performed, the frequency of the screening, and the type of intervention that should be provided. Ideally, screening would include both BMI calculation and waist circumference measurement. For patients who fall into the obese category based on BMI and waist circumference, the physician should follow-up with a metabolic-assessment. The provider must determine if there are other cardiovascular risk factors such as high triglycerides, low HDL

cholesterol, high LDL cholesterol, elevated blood pressure, or elevated glucose levels that put the patient at particular risk.

Screening should occur regularly, but at least once per year. And, for individuals identified as overweight or obese, BMI and waist circumference measurements should be performed at every follow-up visit to monitor progress.

With regard to the type of behavioral interventions that should be provided, the draft statement notes that a greater number of intervention sessions is associated with increased weight loss, as are behavioral interventions that are combined with pharmacologic treatment. The statement also describes intensive behavioral interventions as activities such as setting weight loss goals, improving diet, increasing physical activity, and addressing barriers to change. We agree that these activities are important components of effective weight loss interventions and encourage clinicians to provide these services to their patients. Not every provider, however, is prepared to deliver these services. To help primary care clinicians who wish to provide these services, the Task Force should offer additional guidance and resources about the types of interventions that have been shown to be effective. For example, a recent study found that three factors lead to weight loss success: 1) health coaches; 2) regular physician visits [the physicians receive progress reports from the health coaches to focus the visit and keep the patient progressing toward goals]; and 3) web-based support and email reminders. 40% of participants in this study were able to maintain a 5% weight loss over two years. (See www.nejm.org/doi/full/10.1056/NEJMoa1108660?query=featured_home).

In addition, the Task Force should reinforce the language in the recommendation that clinicians may want to refer patients to other providers or collaborate with other professionals with expertise in weight loss treatment and maintenance such as nutritionists, exercise physiologists, and behavior-change specialists.

ⁱ Romero-Corral A, Somers VK, Sierra-Johnson J, Thomas RJ, Collazo-Clavell ML, Korinek J, Allison TG, Batsis JA, Sert-Kuniyoshi FH, Lopez-Jimenez F. Accuracy of body mass index in diagnosing obesity in the adult general population. *International Journal of Obesity*. Advance online publication. February 19, 2008.

ⁱⁱ Guagnano MT, Manigrasso MR, Capain F, Davi G. The “problem obesity”: viewpoint of the internist. *Ann Ital Chir*. 2005; 76(5): 407-411.

ⁱⁱⁱ Cornier MA, et al. Assessing Adiposity: A Scientific Statement from the American Heart Association. *Circulation*. 2011.

^{iv} Jacobs EJ, Newton CC, Wang Y, Patel AV, McCullough ML, Campbell P, Thun MJ, Gapstur. Waist circumference and all-cause mortality in a large US cohort. *Archives of Internal Medicine*. 2010;170(15):1293-1301.

^v Sciamanna CN, et al. Practices Associated with Weight Loss Versus Weight Loss Maintenance. *Am J Prev Med* 2011;41(2):159–166

^{vi} See http://www.nhlbi.nih.gov/guidelines/obesity/ob_gdlns.htm.