Obesity poses a serious risk to health. This review gives an introduction to, and taster of, our newly launched Nursing Times Learning unit on obesity management in adults.

**Obesity is measured by body mass index (BMI), calculated by weight (kg)/height (m²). Having a BMI of >35.0 does not mean an individual is necessarily at less risk of obesity-related diseases (Table 1); for these people, adding waist circumference to assessment should be considered, as abdominal fat is an important risk factor (National Institute for Health and Clinical Excellence, 2006).**

Weight loss of 5-10% has health benefits. In patients with a BMI of >35.0, weight loss of >15-20% will be required to obtain a sustained improvement in comorbidity (Scottish Intercollegiate Guideline Network, 2010). The usual weight loss target is 0.5-1kg a week (NICE, 2006).

**Assessment**

Obesity management is complex, as energy intake and expenditure are influenced by physical, social, emotional and environmental factors. Working in partnership with patients encourages them to develop confidence, a sense of control and self-management skills. They usually know broadly what influences their weight, but may need help to identify specific factors.

After motivation and barriers to losing weight are identified, individualised SMART (specific, measurable, attainable, realistic and time-bound) goals and actions should be agreed and provided in written format (NICE, 2006).

**Weight history**

Obesity tends to run in families. Although genetics play a part, the greatest influence is family structure, roles and relationships. Individuals with a history of repeated dieting may believe they will never succeed; they tend to have unrealistic expectations and opt for “quick-fix” diets. Addressing these beliefs is important if long-term weight management is to be achieved.

**Motivation**

Our reasons for intervening may be to improve health, but those who are obese may have different reasons for wishing to lose weight, such as being able to play with their children.

**Eating**

A food and drink diary is a useful tool and should cover 24 hours a day. People with obesity often skip breakfast and eat late in the day; the diary will help identify those who snack at night or who may have night-eating syndrome. Quantities of food and high-calorie drinks, including alcohol, should be identified, as should convenience foods and take-away meals.

**Physical activity**

The SIGN guideline on obesity states that international consensus guidelines recommend 45-60 minutes of moderate-intensity physical activity per day for adults (SIGN, 2010a). While this may be the eventual aim, it is important to assess current activity so appropriate goals can be set. Inactivity, such as watching television, should be addressed.

**Emotional/psychological aspects**

Emotional wellbeing can be affected by cultural values. There is a general belief that obesity is the fault of the individual (Puhl and Brownell, 2003). Obese people often take on these prejudices, which result in self-blame, guilt and shame.

**Social support**

Identifying sources of support among family, friends and colleagues is important for people with obesity. Different types of support may come from different people.

**Additional options**

Various supportive additional options are recommended if they are based on principles including healthy eating and realistic targets, focus on long-term lifestyle changes and have ongoing support (NICE, 2006). This includes weight-loss interventions such as formula diets and diet plans.
As an example, for those at moderate risk of diabetes, NICE (2012) guidance suggests slimming clubs or structured weight-loss programmes. People with certain medical conditions – such as type 2 diabetes, heart failure, uncontrolled hypertension or angina – should check with their GP or hospital specialist before starting a weight-loss programme.

Very-low-calorie diets (defined in legislation as <800kcal/day or less) may be used for a maximum of 12 weeks continuously by people with obesity and a medical condition requiring greater amounts of weight loss, for example obstructive sleep apnoea (Johansson et al, 2011) and diabetes (Snel et al, 2012). Programmes that follow a diet of <600kcal/day should only be carried out under clinical supervision (NICE, 2006).

Patients following commercial or self-help weight-management programmes should be monitored and supported by health professionals (NICE, 2006).

Medication
As well as lifestyle interventions, the drug orlistat (Xenical) may be prescribed for those who have a high fat intake. They should have a BMI of >28.0 and comorbidities, or a BMI of >30.0. If, after at least six months’ intervention, there has been no beneficial weight loss, referral to a specialist clinic may be considered (SIGN, 2010).

Treatment may include bariatric surgery. As well as lifestyle interventions, the drug orlistat (Xenical) may be prescribed for those who have a high fat intake. They should have a BMI of >28.0 and comorbidities, or a BMI of >30.0. If, after at least six months’ intervention, there has been no beneficial weight loss, referral to a specialist clinic may be considered (SIGN, 2010).

Conclusion
Nurses are in an ideal position to discuss obesity with patients. Assessment and intervention should not be limited to eating and physical activity but should include: comorbidity risk; weight history; expectations of weight loss; motivation; and psychological, emotional, social and environmental issues. Obesity management is complex and requires a holistic and person-centred approach.

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References

TABLE 1. BODY MASS INDEX (BMI) CLASSIFICATION

<table>
<thead>
<tr>
<th>Classification</th>
<th>BMI (kg/m²)</th>
<th>Risk level of obesity-related diseases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal range</td>
<td>18.5-24.9</td>
<td>No increased risk</td>
</tr>
<tr>
<td>Overweight</td>
<td>25.0-29.9</td>
<td>Increased</td>
</tr>
<tr>
<td>Class I</td>
<td>30-34.9</td>
<td>Moderate</td>
</tr>
<tr>
<td>Class II</td>
<td>35.0-39.9</td>
<td>Severe</td>
</tr>
<tr>
<td>Class III (severe obesity)</td>
<td>&gt;40.0</td>
<td>Very severe</td>
</tr>
</tbody>
</table>

BMI classification for South Asian, Chinese and Japanese people should be lower: a BMI of >23.0 is overweight and of >27.5 is obese (SIGN, 2010).

TEST YOUR KNOWLEDGE
Can you answer these questions? To check if you are correct go to our learning unit at nursingtimes.net/obesity

1 It is estimated that in England, 47% of males and 36% of females will be obese by 2025. What are the two estimated figures for 2050?
A. 60% male
B. 56% male
C. 45% female
D. 50% female

2 Which of the following comorbidities is associated with obesity?
A. Coronary heart disease
B. Obstructive sleep apnoea
C. Type 2 diabetes
D. Impaired fertility

3 Waist measurement is sometimes recommended to help assess comorbidity risk factors in obesity. How is it measured?
A. Standing with feet 25-30cm apart
B. Over indoor clothing
C. From the front
D. At umbilicus level

4 What minimum percentage of weight loss is required before health benefits are gained in those with a BMI of 25.0-35.0?
A. 1-2%
B. 5-10%
C. 15-20%
D. 25-30%

5 Which of the following issues should be addressed in obesity management?
A. Energy intake
B. Emotional issues
C. Social issues
D. Inactivity

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