2023 KACO Posts

January

Buckle Up! The new AAP Obesity Clinical Practice Guideline is Here!

If you haven't already, you will soon hear that the new AAP Obesity guidelines have been released. The news is being picked up in a variety of settings on the local, state, national and even global levels. You can access the document and a ton of supporting materials at this site from the AAP Institute for Healthy Childhood Weight. Obesity Guideline and supporting materials

The document is broken down into five basic sections with Key Action Statements (KAS's) for each of the areas of Evaluation, Comorbidities, Intensive Behavioral Therapy, Pharmacologic Treatment and Metabolic/Bariatric Surgery. We will be going over each of the KAS's in the coming months of the KACO newsletter. There are a couple take-home messages to know about. First, weight bias is real, causes a lot of suffering and needs to be out of our practices. Next, we should continue to talk supportively with our families about good nutrition and healthy activity and treat obesity as a chronic disease. And lastly, treatment works, and we all should be able to help our patients access therapy as we are able, and they are ready.

Like any document that advocates for change, there will be controversy and healthy debate. And like many AAP recommendation statements, there will be the usual response that I often have which is "You expect me to do WHAT?!?!?!!?" As one of many authors of this clinical practice guideline, I encourage you to not get too bogged down by the various "shoulds", "mays" and "cans" in the KAS's. That terminology is the product of some agonizing work looking at strength of evidence. Additionally, the statement is written to let public and private funders know what the evidence says. Bottom line, the statement is there to empower pediatricians to provide evidence-based care to the level at which they are comfortable.

Your Kentucky chapter and KACO look forward to helping you provide the best care to your patients who suffer from the chronic disease of obesity. Let us know how we can help! And buckle up as we start our journey in the coming months.

February

AAP Obesity Evaluation and Treatment Clinical Practice Guideline

Key Action Statement 1: BMI is Still Important!

KAS 1. Pediatricians and other PHCP's should measure height and weight, calculate BMI, and assess BMI percentile using age- and sex-specific CDC growth charts or growth charts for children with severe obesity at least annually for all children 2 to 18 y of age to screen for overweight (BMI ≥85th percentile to <95th percentile), obesity (BMI ≥95th percentile), and severe obesity (BMI ≥120% of the 95th percentile for age and sex).

This KAS states that there is good data that BMI is a good place to start when evaluating weight status. BMI is especially helpful when it comes to studying populations and is helpful when you think about it like other vital signs. That is, put it in context. Some of our elite athletes will have a high BMI due to higher muscle mass and there are other times that BMI breaks down, but it is
the language we speak and should be measured accurately and discussed in context for each family.

March

AAP Obesity Evaluation and Treatment Clinical Practice Guideline

Key Action Statement 2: Complete H&P is the First Step After Identification

**KAS 2.** Pediatricians and other PHCPs should evaluate children 2 to 18 y of age with overweight (BMI ≥85th percentile to <95th percentile) and obesity (BMI ≥95th percentile) for obesity-related comorbidities by using a comprehensive patient history, mental and behavioral health screening, SDoH evaluation, physical examination, and diagnostic studies.

When you identify children and adolescents with obesity or overweight, the evidence is strong that a good history and physical with appropriate diagnostic studies will uncover important medical conditions. Fine tune your history and physical for those areas that are specifically related to weight status. You can see more on this here: The Detailed H &P. And don’t forget behavioral health and social determinants of health. Our kids with overweight and obesity have higher rates of behavioral diagnoses and adverse childhood experiences, and they are both causes and effects of obesity and overweight.

April

AAP Obesity Evaluation and Treatment Clinical Practice Guideline

Key Action Statement 3: Evaluate for Liver and for Glucose & Lipid Metabolism Abnormalities in Patients at Risk

**KAS 3.** In children 10 y and older, pediatricians and other PHCPs should evaluate for lipid abnormalities, abnormal glucose metabolism, and abnormal liver function in children and adolescents with obesity (BMI ≥95th percentile) and for lipid abnormalities in children and adolescents with overweight (BMI ≥85th percentile to <95th percentile).

**KAS 3.1.** In children 10 y and older with overweight (BMI ≥85th percentile to <95th percentile), pediatricians and other PHCPs may evaluate for abnormal glucose metabolism and liver function in the presence of risk factors for T2DM or NAFLD. In children 2 to 9 y of age with obesity (BMI ≥95th percentile), pediatricians and other PHCPs may evaluate for lipid abnormalities.

While there is a little less evidence for younger kids and kids with only overweight but not obesity, it is worthwhile to screen for lipid and glucose metabolism abnormalities. And in kids with obesity, be on the lookout for liver disease. You can learn more here.

May

AAP Obesity Evaluation and Treatment Clinical Practice Guideline

Key Action Statement 4: Pediatricians and other PHCPs should treat children and adolescents for overweight (BMI ≥85th percentile to <95th percentile) or obesity (BMI ≥95th percentile) and comorbidities concurrently.
So, what does this really mean? Put simply, it means to think holistically. Our patients with obesity and severe obesity DO have co-morbidities and do often have multiple ones. Be complete. Ask about things you would not necessarily with patients without obesity, like sleep apnea. And look for physical findings that are associated with obesity, like tibial bowing. You can learn more about these obesity-related co-morbidities at https://publications.aap.org/pediatrics/article/151/2/e2022060640/190443/Clinical-Practice-Guideline-for-the-Evaluation-and.

June

AAP Obesity Evaluation and Treatment Clinical Practice Guideline

**Key Action Statement 5:** Pediatricians and other PHCPs should evaluate for dyslipidemia by obtaining a fasting lipid panel in children 10 y and older with overweight (BMI ≥85th percentile to <95th percentile) and obesity (BMI ≥95th percentile) and may evaluate for dyslipidemia in children 2 through 9 y of age with obesity.

Our routine screening for lipid abnormalities is very helpful as was stated in other AAP guidelines and in KAS 3. But lipid abnormalities are much more common in patients with obesity. Be alert to them even in your younger patients. Be looking for high LDL, high triglycerides, and the frequently overlooked low HDL.

July

AAP Obesity Evaluation and Treatment Clinical Practice Guideline

**Key Action Statement 6:** Pediatricians and other PHCPs should evaluate for prediabetes and/or diabetes mellitus with fasting plasma glucose, 2-h plasma glucose after 75-g oral glucose tolerance test (OGTT), or glycosylated hemoglobin (HbA1c).

This is kind of a vague recommendation, but really it just means to stay alert for diabetes and insulin resistance in your patients with obesity, and especially severe obesity. It happens! And it is happening more frequently these days due to the sheer prevalence of obesity and severe obesity. Your lab will help you with interpretation of an OGTT but think of insulin resistance and Type II DM in your patients with obesity who have a fasting glucose over 110 or a HgbA1c of 5.7 or greater.