

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 \geq 85th percentile to $<$ 95th percentile), obesity (BMI \geq 95th percentile), and severe obesity (BMI \geq 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 \geq 85th percentile to $<$ 95th percentile) and obesity (BMI \geq 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 \geq 95th percentile) and for lipid abnormalities in children and adolescents with overweight (BMI \geq 85th percentile to $<$ 95th percentile).*

KAS 3.1. *In children 10 y and older with overweight (BMI \geq 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 \geq 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 \geq 85th percentile to $<$ 95th percentile) or obesity (BMI \geq 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 \geq 85th percentile to $<$ 95th percentile) and obesity (BMI \geq 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.

August

AAP Obesity Evaluation and Treatment Clinical Practice Guideline

Key Action Statement 7: Pediatricians and other PHCPs should evaluate for NAFLD by obtaining an alanine transaminase (ALT) test.

A great little pearl I received from my gastroenterology colleague, Stavra Xanthakos at Cincinnati Children's, was that ALT is the best marker for obesity-induced liver injury. Gamma GT can be a useful early indicator, but ALT is especially suggestive of weight status associated liver injury when it leads AST, which is often elevated with a viral illness. So, think L for liver when you see ALT leading AST in liver transaminases.

September

AAP Obesity Evaluation and Treatment Clinical Practice Guideline

Key Action Statement 8: Pediatricians and other PHCPs should evaluate for hypertension by measuring blood pressure at every visit starting at 3 y of age in children and adolescents with overweight (BMI \geq 85 to $<$ 95th percentile) and obesity (BMI \geq 95th percentile).

We all know that measuring BP is not easy in young children. We also know that unmanaged hypertension causes significant morbidity and mortality in our nation. The Obesity CPG is here to say that, in this case, the juice is worth the squeeze! We will uncover kids who need intervention for BP. Please make the effort to become good at measuring and interpreting it. And even if you are not comfortable with medical management of hypertension in young kids, learning that there is a problem is step one. There are resources out there for managing BP in children and adolescents. The AAP and our state children's hospital networks are also here to help. A great resource is at this link:

<https://publications.aap.org/pediatrics/article/140/3/e20171904/38358/Clinical-Practice-Guideline-for-Screening-and>

October

AAP Obesity Evaluation and Treatment Clinical Practice Guideline

Key Action Statement 9: Pediatricians and other PHCPs should treat overweight (BMI \geq 85th percentile to $<$ 95th percentile) and obesity (BMI \geq 95th percentile) in children and adolescents, following the principles of the medical home and the chronic care model, using a family-centered and non-stigmatizing approach that acknowledges obesity's biologic, social, and structural drivers.

Social determinants of health, institutional racism and implicit bias have profound impacts on obesity prevalence. Couple those challenges with societal weight bias and you have a toxic brew that our most vulnerable patients must deal with. Be alert to these factors and strive to make your office free of weight bias and weight stigma. A leader in this area which houses great resources is The Rudd Center at the University of Connecticut. I encourage you to check out their website: <https://uconnruddcenter.org/research/weight-bias-stigma/>

November

AAP Obesity Evaluation and Treatment Clinical Practice Guideline

Key Action Statement 10: Pediatricians and other PHCPs should use motivational interviewing (MI) to engage patients and families in treating overweight (BMI \geq 85th percentile to $<$ 95th percentile) and obesity (BMI \geq 95th percentile).

As a true believer in MI, I have to admit that I got all warm and fuzzy when this KAS was written. The evidence for MI has been building for a while and, personally, I have found it to be a game changer for those patients in the "moveable middle" with regard to positive behavior change. If you are ever looking for additional training in MI, I would recommend picking up Miller and Rollnick's new Fourth edition of "Motivational Interviewing: Preparing People for Change" or find an on-line or in-person class at <https://motivationalinterviewing.org/>

<https://publications.aap.org/pediatrics/article/151/2/e2022060640/190443/Clinical-Practice-Guideline-for-the-Evaluation-and->

December

AAP Obesity Evaluation and Treatment Clinical Practice Guideline

Key Action Statement 11: Pediatricians and other PHCPs should provide or refer children 6 y and older (Grade B) and may provide or refer children 2 through 5 y of age (Grade C) with overweight (BMI \geq 85th percentile to $<$ 95th percentile) and obesity (BMI \geq 95th percentile) to intensive health behavior and lifestyle treatment. Health behavior and lifestyle treatment is more effective with greater contact hours; the most effective treatment includes 26 or more hours of face-to-face, family-based, multicomponent treatment over a 3- to 12-mo period.

Intensive health and behavior lifestyle treatment (IHBLT) really works. Now the rub here in Kentucky, and really nationwide, is that there are not nearly enough programs for patients and families. So, what is the take-home message for this KAS? Basically, it is that “some is better than none and more is better than some.” Use what you have, refer when you can, and assist interested partners in your community to create more programs. Many hands make light work!

<https://publications.aap.org/pediatrics/article/151/2/e2022060640/190443/Clinical-Practice-Guideline-for-the-Evaluation-and->