2024 KACO Posts

January

AAP Obesity Evaluation and Treatment Clinical Practice Guideline

Key Action Statement 12:

Pediatricians and other PHCPs should offer adolescents 12 y and older with obesity (BMI ≥95th percentile) weight loss pharmacotherapy, according to medication indications, risks, and benefits, as an adjunct to health behavior and lifestyle treatment.

No KAS has garnered more attention or controversy than KAS 12. The meaning of the word "should" here is critical. In the Clinical Practice Guideline, "should" does NOT imply an obligated or mandatory action. Providers need to use clinical judgment to determine when an option like medication is appropriate. Furthermore, providers should only provide therapy that they are comfortable with. As we learned to use SSRI's in practice over the past few years, we eased in with a single med and then learned more sophisticated management as we moved along. Medications should also never be prescribed in isolation. It should always be accompanied by intensive health behavior and lifestyle treatment.

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

February

AAP Obesity Evaluation and Treatment Clinical Practice Guideline

Key Action Statement 13:

Pediatricians and other PHCPs should offer referral for adolescents 13 y and older with severe obesity (BMI ≥120% of the 95th percentile for age and sex) for evaluation for metabolic and bariatric surgery to local or regional comprehensive multidisciplinary pediatric metabolic and bariatric surgery centers.

KAS 13, like the KAS on pharmacotherapy, garnered a lot of controversy even though it was preceded by a similarly worded AAP Policy Statement two years ago. Also, like pharmacotherapy, bariatric surgery should always be accompanied by intensive health behavior and lifestyle treatment. In Kentucky, expect to see increasing options for bariatric surgery for our patients.

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

March

AAP Obesity Evaluation and Treatment Clinical Practice Guideline

Consensus Recommendations on Risk Factors:

Perform initial and longitudinal assessment of individual, structural, and contextual risk factors to provide individualized and tailored treatment of the child/adolescent with overweight/obesity.

First a word about Consensus Recommendations (CR). Up to this point, we have been discussing Key Action Statements, which are recommendations made when sufficient evidence exists to support a clear course of action. CR's exist for those areas where subject matter experts feel guidance is appropriate but either evidence is lacking because it has not been done yet or would be impossible to obtain.

The Consensus Recommendation on Risk Factors may sound just like good common sense, but is an important reminder to think about the environment our patients live in. We are all products of our genetics, our family upbringing, our education, and our environment. How we help our patients manage their weight status should be tailored taking these factors into account.

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

April

AAP Obesity Evaluation and Treatment Clinical Practice Guideline

Consensus Recommendations on Comorbidities:

Obtain a sleep history, including symptoms of snoring, daytime somnolence, nocturnal enuresis, morning headaches, and inattention, among children and adolescents with obesity to evaluate for OSA.
Obtain a polysomnogram for children and adolescents with obesity and at least one symptom of disordered breathing.
Evaluate for menstrual irregularities and signs of hyperandrogenism (ie, hirsutism, acne) among female adolescents with obesity to assess risk for PCOS.
Monitor for symptoms of depression in children and adolescents with obesity and conduct annual evaluation for depression for adolescents 12 y and older with a formal self-report tool.
Perform a musculoskeletal review of systems and physical examination (eg, internal hip rotation in growing child, gait) as part of their evaluation for obesity.
Recommend immediate and complete activity restriction, non–wt-bearing with use of crutches, and refer to an orthopedic surgeon for emergent evaluation, if SCFE is suspected. PHCPs may consider sending the child to an emergency department if an orthopedic surgeon is not available.
Maintain a high index of suspicion for IIH with new-onset or progressive headaches in the context of significant wt gain, especially for females.

Comorbidities really are why we worry about weight management in the first place. The Clinical

Practice Guideline writing group acknowledges that in this Consensus Recommendation. And the writing group sought to leverage existing AAP policy to reinforce the message that managing obesity is part of managing co-morbidities. They should be done together!

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