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American Academy of Pediatrics Clinical Practice Guideline for the Evaluation and Treatment of Children and Adolescents with Obesity: What we can learn versus what we can apply in clinical practice

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Abstract

The American Academy of Pediatrics released its first guideline for the evaluation and treatment of children and adolescents with obesity, which was negatively received by eating disorders experts and anti-weight stigma activists around the world. As a primary care physician and an eating disorders practitioner, dealing with the devastating effects of both excess weight and eating disorders in kids and teens, I read with great interest the recently published guideline. A large section was dedicated to the complexity of the problem at hand, from the multifactorial causes to the long list of obstacles to treatment including the significant harm caused by weight stigma in healthcare. The main proposed management, Intensive Health Behavior and Lifestyle Treatment seemed inclusive of multifaceted components needed by kids and their families, unfortunately the feasibility, availability and affordability of such treatment are very problematic. On the other hand, the benefit-harm assessment used was quite confusing especially when it comes to eating disorders risk, and the evidence used to back up the strategies proposed was very weak. While we can learn a lot from AAP clinical practice guideline for the evaluation and treatment of children and adolescents with obesity, there is very little we can apply in clinical practice because of lack in resources and risk of doing harm.

Introduction

Despite decades of combating obesity, kids and teenagers are still getting bigger.

In its latest guideline for evaluation and treatment of children and adolescents with obesity, The American Academy of Pediatrics (AAP) did a very good job at shedding the light on the complexity of the problem when it addressed the following (Hampl et al., 2023):

1. The role of exposure to adversity as a risk factor for alterations in immunological, metabolic and epigenetic processes that can alter energy regulation.
2. The role of health inequity in promoting obesity in childhood and how as a result "practice standards must evolve to support an equity-based practice paradigm".
3. The positive link between obesity and low socio economical status, food insecurity, lack of green space, violence and unsafe environments.

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4. The role of weight stigma in healthcare as a risk factor for obesity, and the need for healthcare professionals to uncover and address their own attitudes toward children with obesity and their parents for more empathetic and effective care.
5. The importance of an intensive physical, psychological, social and cultural assessment before giving any advise or starting any treatment, requiring an intensive training for all involved providers, primary health care practitioners in particular, to offer a non-biased, culturally competent care.
6. The importance of acknowledging obesity as a chronic disease requiring life long treatment with a multidisciplinary team, requiring a preparation for a proper transition into adult care.
7. The significant barriers to treatment including an obesogenic environment and a significant disparity in access to such a long, multifaceted care among other obstacles.
8. The need for more studies to advance our knowledge and understanding of obesity, requiring a certain level of humility when attending to the patients and their families.
9. Last but not least, the importance of promoting evidence-based recommendations with particular focus on a good aggregate evidence quality after evaluation of benefits, risks, harms and cost for a good benefit-harm assessment.

The confusion around the benefit-harm assessment

The benefit-harm assessment started with calculating BMI. Under benefits, AAP stated "easy to use, reproducible, improved identification of severe obesity, and improved ability to monitor improvements in weight status of youth with severe obesity."

Under risks, harms and costs, the following was mentioned: "screening tool with both false negatives and false positives… may confer stigma associated with obesity; interpretation and explanation for families might be challenging." The conclusion was "benefits outweigh harm."

To summarize, as per AAP, BMI is an easy-to-use tool to identify obesity but has false negatives and false positives, its interpretation might be challenging and it may contribute to weight stigma in health care, nevertheless, the benefits of calculating it and using it outweigh any harm, a very surprising conclusion to say the least.

A similar scenario is found in the aggregate evidence quality of evaluation of Obesity and co-morbidities by "using a comprehensive patient history, mental and behavioral health screening, social determinants of health evaluation, physical exam and diagnostic studies."

Under benefits, the following is stated: "early detection and treatment can reduce further serious sequelae, detection of comorbidity may motivate treatment engagement."

Evidence based treatment of obesity treatment as per AAP, is an Intensive Health Behavior and Lifestyle Treatment IHBLT, with a multidisciplinary trained team, a minimum of 26 hours of face-to-face interaction with child and family over 3 to 12 months, in addition to medications, metabolic and bariatric surgery in high-risk patients.

The academy acknowledges the chronicity of the condition and the importance of continuity of treatment and transition of care into adulthood while admitting the scarcity of IHBLT teams, the low compliance of children and adolescents to such chronic care and the absence of long term studies assessing the feasibility of such proposal.

Under risks, harm and costs, come a serious concern: anxiety, over-testing with false positives and negatives, lack of time needed for counseling and cost, with intentional vagueness (lack of evidence) when it comes to frequency of evaluation and the definition pa patients at risk.

And once again, despite all the limitations listed above, the benefit-harm assessment is considered shockingly positive in high-risk patients, knowing that stratification of risk is not well determined yet.

On the other hand, immediate referral to an intensive program was recommended by AAP while acknowledging that IHBLT availability, affordability, practicality (time off school for kids, and time off work for parents) are very problematic, and that no treatment should be started before assessing and respecting patients and parents readiness to change. The importance of taking permission from patients and parents to even discuss the calculated body mass index (BMI), is clearly mentioned.

One can only hope that clinicians would take into consideration the whole message rather than focus on advising immediate action regardless of the huge obstacles.

The controversy around the risk of developing or triggering eating disorders

When it comes to the risk of eating disorders eating disorders in this population, especially when this population is dieting, AAP consensus finds IHBLT different from other

weight loss approaches as it is similar to eating disorders treatment in terms of focus on general wellbeing, improving self-efficacy, self-esteem and body image.

The guideline relies on a review study showing that specialized obesity clinics interventions, reduce the risk of disordered eating up to 6 years after completing the treatment (Jebeile et al., 2019).

This same review as well as a proposal to reduce the dichotomy between treating obesity and treating eating disorders (Cardel et al., 2022), acknowledge that maintaining long term engagement with an obesity treatment appears to be to most important contributor to the reduction of eating disorders risk, and that no study offered any feedback on the high number of children and teens who withdraw from treatment, making further research mandatory "to better understand the relationship between dieting and eating disorders risk in the context of obesity treatment for children and adolescents" (Jebeile et al., 2019).

The Academy for Eating Disorders released a statement urging the AAP to review the guideline based on the above mentioned risk, the absence of representation of parents of kids in larger body in the committees leading to the consensus and a high risk of serious bias when many studies reviewed by AAP were sponsored by pharmaceutical companies with weight loss products (Newswise, 2023).

Similarly, The Collaborative of Eating Disorders Organizations (CEDO) (2023) has released the following statement: "The guidelines speak extensively about complex genetic, physiologic, socioeconomic, and environmental contributors to obesity, yet all suggested interventions focus on individual behavior changes within an obesogenic environment. Acknowledging that factors such as racism, poverty, and cultural variances play a role in obesity while still pressuring individuals to change behavior does harm to children and further contributes to the misconception that obesity is based on individual choices. The AAP expresses its concern about weight bias while simultaneously publishing recommendations based on, and very likely to exacerbate, weight bias."

Conclusion

As a family physician with 25-year experience in a cosmopolitan city, I have witnessed firsthand the significant distress excess weight can cause to kids, teens and their families and the heartbreaking discrimination they have to deal with in the current healthcare system. Failing them time after time was what got me into further training in eating disorders, weight related issues and the devastating consequences of weight stigma.

As a CBT-ED (Cognitive Behavioral Therapy for Eating Disorders) accredited medical doctor, working with a multidisciplinary intensive outpatient unit for eating and weight related disorders, and as an active member of the international community of eating disorders specialists, I would agree with AAP regarding the importance of including many components of eating disorders management in weight management (Cardel et al., 2022) to bridge the gap between the eating disorders world and the weight management world.

This would be possible when experts from both worlds meet to design studies with the methodology and long term follow up needed to answer many pending questions and eventually offer our patients the evidence-based treatment they deserve while respecting the oath we took to do no harm. This should be followed by serious effort to train health care professionals and to make the treatment available and affordable to all.

In conclusion, after offering valuable lessons to clinicians in listing all the complexities of obesity, the obstacles to treatment, the importance of not biased empathetic and humble approach, the necessity of training healthcare practitioners and the utmost importance to address obesogenic factors unrelated to the child or the family, the AAP guideline for evaluation and treatment of obesity in youth seem to be based on experts' opinion rather than evidence.

Therefore, while they could be considered as a good road map for further studies, policies and strategies, when it comes to clinical practice, the solution offered is impractical to say the least, putting a lot of pressure on health care providers with no training nor resources and on patients and families who, in the absence of access to proper care, are going to be subject once more to shame and discrimination, making it very hard for the benefits to outweigh the harms.

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