



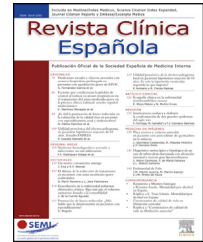
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EDITORIAL

Recognizing obesity as a disease: A true challenge[☆]

Reconocer la obesidad como enfermedad: todo un reto



The current coronavirus disease 2019 (COVID-19) pandemic has laid bare both the strengths and the weaknesses of our public health system.

In 1998, the World Health Organization defined obesity as an epidemic disease that was a significant public health problem not only for the enormous impact it has on morbidity and mortality and quality of life, but also for the significant costs, both direct and indirect, that this pathology generates.¹ Therefore, the most efficient possible prevention and treatment strategies must be established. In addition, obesity is one of the main comorbidities that greatly increase the risk and severity of COVID-19 in patients who have it.²

In this issue of the Revista Clínica Española, the Spanish Society of Internal Medicine's (SEMI, for its initials in Spanish) Diabetes, Obesity, and Nutrition working group's position paper on an approach to individuals with obesity is published.³ In addition to its timely nature in these circumstances, it is a very necessary document. It sheds light on the level of knowledge that internal medicine physicians have regarding the diagnosis and clinical control of obesity. Of those surveyed, 93.8% and 83% considered obesity and overweight as a chronic disease, respectively. These results have led us to make a series of reflections.

Recognizing obesity as a disease allows for improving access to treatment and spurs advances in new therapeutic strategies. However, the term obesity is associated with a high degree of stigma from both the public and the patient him or herself. Medicalizing obesity, which confers the condition of "ill" on millions of adults and children, puts them at risk of dependence on costly medical treatment and ignores healthcare policy's preventative measures for addressing the social determinants that underlie obesity.⁴

The World Obesity Federation defines obesity as a "chronic disease." The American Association of Clinical

Endocrinology (AACE) and the American College of Endocrinology (ACE) consider obesity as a *chronic disease based on adiposity*. This last definition incorporates the idea that the health impacts could be related to both the quantity and the distribution and/or function of adipose tissue.^{5,6}

It is important to take into account that in our setting, obesity is in large part the product of an obesigenic environment, which consists of hypercaloric diets mainly promoted by commercial sources accompanied by little physical activity in the context of a poor food culture and significant shortcomings in dietetics.

The lack of precise metrics for classifying obesity can lead to doubt about the utility of defining it as a disease in order to improve health outcomes. The most widely accepted and established measurement of obesity is the body mass index (BMI) scale, developed by Adolphe Quetelet at the end of the 19th century.⁷ However, despite its ability to be used as a screening tool to estimate adiposity, this scale has limitations as a predictor of health and sole guideline for making clinical decisions, as it is an anthropometric measurement.^{6–12} For example, BMI tends to overestimate adiposity in athletes who have more lean body mass and underestimate it in the elderly, who have less lean mass.^{5,6}

Among the less universal methods for measuring body composition, those which merit mention are waist circumference, the waist/hip ratio or height, triceps skinfold thickness, and bioimpedance (dual energy X-ray absorptiometry). Other more sophisticated techniques to determine the degree of obesity or excess body fat are the subject of investigation. Their main objective is to determine greater risk of morbidity and mortality in individuals with this pathology.^{5,12}

The document from the SEMI's Diabetes, Obesity, and Nutrition working group³ wisely ends with a series of recommendations, the fourth of which states: "It is recommended to weigh, calculate BMI, and measure abdominal circumference in all patients attended to in outpatient clinics as well as hospitalized patients whenever it is possible, either directly or by using the alternative formulas available for this purpose."

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In regard to the approach to lifestyle in patients with obesity, the initial management is similar in all cases and group consultations can be held to improve the efficiency of the system.

We believe that the decision to declare obesity as a disease *per se* is a well-intentioned effort both to legitimize the ailment as well as to change the public discourse of shame and stigma with regard to the medical treatment of this pathology. The fact that it is recognized as a disease entails combining lifestyle modifications with costly treatment in the form of drugs, medical technology, or even bariatric surgery.

Considering obesity as a disease means taking into account the existing limitations in measurement tools and their consequent impact on the prognosis and management of the pathology.⁷ The lack of knowledge and use of antiobesity drugs and of the indications for bariatric surgery on the part of those surveyed in the study merit mention.³ In addition to adiposity screening (BMI) and adipose tissue distribution screening (abdominal circumference), classifying patients with obesity based on the complications they present with is of great importance (class 0: no complications; class 1: minor complications; class 2: major complications such as diabetes or cardiovascular disease).⁵

Knowing the obesity class and the distribution of adipose tissue allows us to evaluate whether the patient requires drug treatment and/or surgery in addition to lifestyle modifications. We cannot forget that obesity is a very heterogeneous disease. The consensus document confirms that “every person with obesity is different” and treatment response can vary greatly. Therefore, multidisciplinary functional units such as morbid obesity-bariatric surgery units have been created in tertiary hospitals or similar centers. These groups include all healthcare professionals who participate in managing obesity.

A multidisciplinary care model must ensure continuity of care for patients with prevalent chronic diseases with the goal of optimizing healthcare resources, improving clinical control upon discharge, and avoiding unrealistic expectations on the part of patients.

Recently, the Spanish Obesity Society (SEEDO, for its initials in Spanish) and the Spanish Society of Primary Care Physicians (SEMERGEN, for its initials in Spanish) have created a consensus document on continuity of care for obesity between primary care departments and specialized hospital units.¹³ This joint approach to obesity is highly efficient, as it allows for characterizing and identifying an important group of patients.¹⁴

In addition, the significant repercussion obesity has both psychologically and on patients’ quality of life as well as its influence on the control of other cardiovascular risk factors such as glucose levels, hypertension, or lipid levels cannot be ignored.¹⁵

As it is a social and a healthcare problem, a proper approach to it would require both social and political reforms to increase preventative and therapeutic efforts, especially among children and adolescents.

In conclusion, to be able to correctly approach obesity, it must be addressed jointly by patients, healthcare personnel, and healthcare institutions, with proper coordination between all levels of care and society being key.

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