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.

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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.

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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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May

AAP Obesity Evaluation and Treatment Clinical Practice Guideline

Consensus Recommendations on Treatment:

Deliver the best available intensive treatment to all children with overweight and obesity.
Build collaborations with other specialists and programs in their communities.
May offer children ages 8 through 11 y of age with obesity wt. loss pharmacotherapy, according to medication indications, risks, and benefits, as an adjunct to health behavior and lifestyle treatment.

The Consensus Recommendation on treatment reiterates points from the Key Action Statements of the Clinical Practice Guideline. That is, deliver treatment to all, do it with your community and layer on therapies. Don't forget the basics of good nutrition even when you need to pursue more aggressive therapy.

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June

AAP Obesity Evaluation and Treatment Clinical Practice Guideline

Implementation and Barriers to Care Recommendations:

Promote supportive payment and public health policies that cover comprehensive obesity prevention, evaluation, and treatment. The medical costs of untreated childhood obesity are well-documented and add urgency to provide payment for treatment.119 There is a role for AAP policy and advocacy, in partnership with other organizations, to demand more of our government to accelerate progress in prevention and treatment of obesity for all children through policy change within and beyond the health care sector to improve the health and well-being of children. Furthermore, targeted policies are needed to purposefully address the structural racism in our society that drives the alarming and persistent disparities in childhood obesity and obesity-related comorbidities.
Public health agencies, community organizations, health care systems, health care providers, and community members should partner with each other to expand access to evidence-based pediatric obesity treatment programs and to increase community resources that address social determinants of health in promoting healthy, active lifestyles.

EHR vendors, health systems, and practices implement CDS systems broadly in EHRs should provide prompts and facilitate best practices for managing children and adolescents with obesity.
Medical and other health professions schools, training programs, boards, and professional societies should improve education and training opportunities related to obesity for both practicing providers and in preprofessional schools and residency/fellowship programs. Such training includes the underlying physiologic basis for wt dysregulation, MI, wt bias, the social and emotional impact of obesity on patients, the need to tailor management to SDoHs that impact wt, and wt-related outcomes and other emerging science.

Whenever I speak on the Obesity Clinical Practice Guideline, I always talk about the CPG's aspirational aspects. Data exists for certain therapies, and we are morally obligated to get that information out to our patients. However, we know that the infrastructure and the institutional will to deliver intensive health behavior and lifestyle treatment, pharmacotherapy and bariatric surgery to patients who need it does not yet exist. Former AAP President and my mentor, Sandy Hassink, has a great analogy. When we have a new effective therapy for cancer, we don't say "It's too expensive" or "We can't do this for poorer neighborhoods". We figure out how to deliver it. This Consensus Statement speaks to that aspirational aspect. We need to hold payers, communities, public health, EHR's and training programs to account.

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