Obesity management in cardiovascular disease – a view from primary care

Even before the National Service Framework for Coronary Heart Disease[1] (NSF for CHD) was published, GPs and Primary Care Teams throughout the UK had been working very hard to reduce mortality from cardiovascular disease. The establishment of diabetes and hypertension clinics in primary care, screening for hypertension and diabetes, together with wider application of lipid-lowering therapies for primary and secondary prevention, was already widespread.

The NSF for CHD legitimised this process. It emphasised the value of lifestyle change, particularly stopping smoking, eating healthily, increasing physical activity, and the importance of reducing overweight and obesity. It also gave us a timescale in which to achieve results (see table 1).

Since the year 2000, many Health Authorities and Primary Care Organisations have set up groups to help people stop smoking. Some have created exercise and walking initiatives. Data received by the National Obesity Forum, a primary care group working to improve the understanding and management of overweight and obesity, indicate that a significant number are working on healthy eating and weight loss projects.

Nevertheless, action is not universal, due more to lack of available resources than lack of desire for action. If attendance at meetings on the subject is an indicator, primary care nurses are particularly keen to support weight loss programmes and are supported by nutritionists and dietitians. GPs and Primary Care Organisations (PCOs) who bear responsibility for balancing the financial implications of the government's competing initiatives, seem less persuaded that this is an area worthy of significant investment.

The approval of two new therapies, orlistat and sibutramine, by the National Institute for Clinical Excellence[2,3] has provided a welcome opportunity for pharmaceutical companies to resource the education which is needed. If they are to help patients lose weight, both GPs and nurses will need to learn new skills which will enable them to identify motivated patients, build upon patient ideas, utilise accumulated knowledge and empower patients to take control of their lifestyles. On the evidence of the clinical trials, both orlistat and sibutramine work. Both are suitable in diabetic patients, who constitute the most important group of at-risk obese patients in primary care.[4,5] Used appropriately, either drug should at least double our success in enabling obese patients to lose that magical 10% body weight which will result in measurable cardiovascular benefit.[4,6]

Nurse-led clinics

It seems likely that primary care teams will focus their initial weight management programmes within their existing nurse-led clinics – notably the diabetes, cardiovascular and stop-smoking clinics. While these populations are undoubtedly very much at risk and many newly diagnosed patients are sufficiently motivated to lose significant amounts of weight, those who do not do so initially can retain it most stubbornly. Clinical trials demonstrate the increased difficulty which diabetic patients have compared with non-diabetic patients.[5] Primary care teams who focus all their activity in clinics and with patients who have tried to lose weight several times before may not see the most encouraging results.

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Table 1. Timetable for lifestyle change[1]

- By April 2001, Health Authorities, Local Authorities, Primary Care Groups/Primary Care Trusts and NHS Trusts will have agreed and will be contributing to the delivery of the local programme of effective policies on:
  – reducing smoking
  – promoting healthy eating
  – increasing physical activity
  – reducing overweight and obesity
- By April 2002 these same bodies will have quantitative data no more than 12 months old about implementation of these policies

In comparison with doctors, the nurses, community dietitians and nutritionists are keen to involve patients with lower body mass index levels (25-30 kg/m^2) who have not yet developed complications. They argue that prevention is better than cure; that other community resources like Weight Watchers, sports facilities and workplaces can be more easily involved; and that group work is more easily managed in otherwise healthy patients. Post-natal groups, groups for men and groups for retired people are all practical possibilities. Meetings can be held in public houses, gyms, workplaces or even supermarkets. Success is more likely and this encourages staff to continue their efforts. Movement in this direction, however, is hampered by lack of staff, finance and by other pressing PCO imperatives.

'The average practice will have around 200-250 adults who are obese - similar to the number with hypertension'

Weight maintenance

Weight loss is, in many ways, easier to achieve than maintenance of weight loss. For many patients whose weight would otherwise drift inexorably upwards, weight maintenance is, in itself, a success. NICE has imposed a limit of one year on the time for which both orlistat and sibutramine can be taken,[2,3] despite the fact that orlistat has a licence for two years of therapy. Clinical trials with both products have demonstrated similar modest, although clinically significant, weight loss when used in conjunction with a weight management programme. Data from two-year studies[7,8] illustrate that, in suitably selected patients, weight loss of about 10% can be maintained. More studies are needed to determine the optimum duration of use of these products if patients are not to yo-yo between obesity and a more healthy body mass index. It seems a little illogical to stop treatment with a successful anti-obesity agent at the arbitrary point of one year if this results in the need for long-term lipid-lowering, hypoglycaemic or antihypertensive therapy.

There is no doubt that primary care will need major assistance if it is to make significant progress in weight loss. The average practice with 1,800 patients will have around 200-250 adults who are obese – similar to the number with hypertension and about twice the number who present each year with depression. It will also have around 500 who are overweight.

Personal experience suggests that only half of these patients will be motivated to begin weight loss programmes. Nevertheless we will need to pace our efforts and to involve the private and voluntary sectors if we are to be successful. Primary care needs to innovate and to see itself as a focus for patient advice. Some patients will be managed in general practice, others will need to be referred elsewhere. It would be inappropriate for our under-resourced GP practices to take on the whole task.

Finding sufficient resources to manage obesity is a major concern for primary care since many overweight and obese patients are regular attenders at our surgeries for the management of the related co-morbidities. Treatment with these anti-obesity agents may require even more regular attendance at the surgery eg. for blood pressure monitoring. Furthermore, we have to recognise that most trials have been performed with highly motivated hospital populations in which defaulters and poorly motivated patients were excluded from the analysis.

If we are to extend a belief in the success of therapy into primary care then further studies are necessary. These do not have to be high-powered: it is more important that they reflect reality. All patients will need dietary advice, changed behaviour and increased exercise. Some will benefit from drug therapy or even surgery. We need to know which groups of patients respond best to which approach and which service method can best deliver results for the numbers involved. Primary Care Organisations will need to develop 'champion practices' in their area and to audit their success. Only when they see the success of local initiatives will PCOs recognise that obesity is a problem worthy of significant investment.

References

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