Obesity problems go beyond excess mass!

Obesity is the common denominator of many conditions presented to the GP in his daily practice. In most instances, however, the patient's complaint is not one of weight.

Common conditions experienced by the overweight individual include hypertension, injuries sustained by accidents through immobility, diabetes, ischaemic heart disease, respiratory discorders, and to a degree, cancer.

In a National Heart Effort pilot study currently being undertaken in the Western Cape, overweight is shown to be particularly prevalent in both White males and females over the age of 36.

According to Prof Jacques Rossouw, director of the S.A. Medical Research Council's National Research Institute for Nutritional Diseases, weights rise dramatically in particularly females in the age group 36-45.

'In our Western Cape study we have found that the cut-off point for obesity (20 per cent above the ideal weight) among White females is exceeded by 41 per cent in this age group. The equivalent male excess is 28 per cent.

Prof Roussouw stressed that diet control should become an essential function of the GP in his treatment of the obese patient, regardless of the clinical condition presented.

'Take respiratory disorders, for example. Lung function tests on obese individuals have shown respiratory deficiencies caused by adipose tissue restricting the lungs [1]. Such individuals are therefore more prone to respiratory infections such as pneumonia, brochitis, as well as pulmonary embolism.

'Many GPs fail to connect such disorders with the patient's weight.'

In the case of mild to moderate hypertension, Prof Roussouw issued a warning: 'Practitioners should rather treat the patient's overweight than the presenting hypertension.

Though true hypertension is associated with obesity, a falsely elevated reading of up to 25 per cent may be obtained. Therefore, introduction of the otherwise appropriate blood pressure reducing chemotherapy ie: beta blocking agents, could in turn result in problems of hypotension.

'In obese patients where BPs do not exceed 170/100, it is estimated that they have an 85 per cent chance of becoming normo-tensive as a direct result of lifestyle adjustment; for example, reducing salt intake down to 3 to 5 g daily, weight control, and of course stopping smoking.

Lifestyle adjustments largely represents dietary control. The GP has a number of measures to select when introducing weight reduction to his therapeutic regimen.

'Popular diets,' said Prof Roussouw,' include the broad calorie counting procedure, the prudent diet ie: restricting energy intake to less than energy expenditure, one-food dients, and adhering to high protein/low carbohydrate consumption.

The prudent diet is the only one which can be recommended since it will provide the necessary nutrients even if energy is restricted to 1 200 k/cal (5 000 kj) for women, or 1 500 k/cal (6 300 kj) for men. It is important to note that there are basic principles to safe and effective dietary control. Calorie intake, for example, must be one third less than normal intake, but if reduced lower, the 'law of diminishing returns' comes into play to the detriment of the patient. Energy conservation is aggravated. On the other hand the increased energy expenditure resulting from exercise has a direct effect on appetite and actually helps the patient to adjust his food intake to his real needs.'

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- Diets of specific interest to the medical profession are available form: Nutritional Services, Department of Health, Pvt Bag X88, Pretoria 0001; 2) National Research Institute for Nutritional Diseases, P.O. Box 70, Tygerberg 7505.

REFERENCE:

1. Burwell, C.S., Robin E.D., Whaley, R.D., and Bickelman, A.G., Amer J. Med. 21:811,1956.