OBESITY CARE
ADVOCACY NETWORK

March 19, 2018

USPSTF Coordinator
c/o USPSTF
5600 Fishers Lane
Mail Stop 06E53A
Rockville, MD 20857

Dear Task Force Members,

On behalf of the undersigned organizations of the Obesity Care Advocacy Network (OCAN), we are pleased to provide public comment regarding the United States Preventive Services Task Force (USPSTF) draft recommendations regarding "Weight Loss to Prevent Obesity-Related Morbidity and Mortality in Adults: Behavioral Interventions."

We are pleased that the USPSTF recognizes the significant evidence surrounding multicomponent interventions as effective obesity treatment requires a multidisciplinary approach. Intensive behavioral counseling services are a critical component of fostering quality and successful weight loss outcomes and can be used as a stand-alone treatment, or in conjunction with pharmacotherapy or bariatric surgery.

That being said, we believe that the Task Force should amend its formal recommendation statement to: "The USPSTF recommends that clinicians offer or refer adults with obesity for evidence-based treatments including: intensive multi-component behavioral interventions, obesity pharmacotherapy, and surgery."

Additionally, we question the appropriateness of using BMI as opposed to obesity in the language of the recommendation. We believe this statement should reflect treatment of the disease of obesity – not a singular measurement of the disease. Current Guidelines, based on a systematic evidence review (AHA/ACC/TOS 2013) emphasize that BMI is only a screening step. The World Health Organization defines overweight and obesity as abnormal or excessive fat accumulation that may impair health. Thus obesity is a clinical diagnosis, based on the observation of increased body mass coupled with increased waist circumference and/or other evidence of health risk.

<u>Intensive Multi-Component Behavioral Interventions</u>

The February 2018 request for public comment from the USPSTF marks the third time that the Task Force has evaluated possible treatment avenues for individuals identified with overweight or obesity

since 2003. The Task Force recommendations on high intensity behavioral treatment are similar to past recommendations from 2003 and 2012. We believe that the recommendations with regard to behavioral management of obesity are appropriate – particularly the evidence supporting a minimum of 12 high-intensity sessions a year.

That being said, we believe it would be extremely helpful – for patients, healthcare professionals and policymakers – if the Task Force would also emphasize its findings that "the evidence is insufficient to recommend for or against the use of moderate- or low-intensity counseling together with behavioral interventions to promote sustained weight loss in obese adults." Since the recommendations went into effect in 2013, we have observed that many health plans provide coverage for few if any sessions that would be considered high intensity.

Obesity Pharmacotherapy

While we are pleased that the USPSTF included obesity agents in its review, we are troubled by the assumptions and conclusions the Task Force has made regarding the effectiveness and durability of pharmacotherapy. Pharmacotherapy is only effective for sustained weight loss when used long-term. The argument that one should expect "maintenance of improvement after discontinuation of pharmacotherapy" is flawed as pharmacotherapy has been shown to double to triple the odds for chronic weight management when used long-term.[i]

We note that while the Task Force does discuss the multifactorial causes of obesity, it fails to address the nature of obesity as a chronic and complex metabolic disease, in which patients who lose only 5-10 percent of their starting body weight have automatic increases[ii] in hunger[iii] as well as automatic reductions in basal metabolic rate that predispose them to weight regain.[iv]

Because obesity is a disease, we would not expect medications to continue to be effective once stopped any more than an anti-diabetic or anti-hypertensive would offer benefit once discontinued. Further, pharmacotherapy is indicated only as an adjunct to the behavioral interventions.

Because of weight-bias, it is estimated that only 2% of patients with an indication for pharmacotherapy receive it.[v] Including pharmacotherapy in this statement would improve utilization of this important treatment, thus improving health outcomes and quality of life. The requirements of clinical trials mentioned in the USPSTF text ("selective inclusion criteria, show compliance with medication, meeting weight loss goals") would mirror real-world use.

Bariatric Surgery

Current studies clearly show that for the right individuals, surgery can improve comorbidities, quality of life, and improve life expectancy. While we recognize that primary care providers don't offer surgery, they are at the forefront of educating patients about the pros and cons of surgery. We feel the evidence is adequate to recommend surgery to the proper individuals, and that this should be communicated to primary care providers. It is estimated that 1% of those who may benefit from surgery receive it. While the primary care provider may not offer surgery, this would encourage proper referral to centers that do offer the procedure.

People-First Language

Finally, we are pleased that the USPSTF appears to be making a good faith effort to use people-first language when referring to individuals affected by overweight or obesity. While the Task Force followed this approach throughout the majority of the Draft Recommendation Summary, we did find two inappropriate mentions of the term "obese" in the summary document and numerous examples within the larger Draft Evidence Review.

Labeling individuals as obese creates negative feelings toward individuals with obesity, perpetuates weight bias, and must be avoided. Health care providers who use respectful communication with their patients, such as people-first language, create positive, productive discussions about weight and health. We urge the USPSTF and other authors and editors of scholarly research, scientific writing, and publications about obesity to use the same rules that are the norm for referring to individuals with other disabilities, diseases, and health conditions: the use of people-first language.

Thank you again for your consideration of these comments, should you have any questions, please contact OCAN Washington Office Director Christopher Gallagher at 571-235-6475 or via email at chris@potomaccurrents.com.

Sincerely,

Academy of Nutrition and Dietetics
American Academy of PAs
American Association of Clinical Endocrinologists
American Gastroenterological Association
American Society for Metabolic and Bariatric Surgery
Black Women's Health Imperative
Eisai, Inc.
Endocrine Society
Healthcare Leadership Council
Novo Nordisk, Inc.
Obesity Action Coalition
Obesity Medicine Association
SECA
The Obesity Society
The Redstone Center

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[i] N Engl J Med 2011;365: 1597-604. [demonstrates long-term hormonal changes resisting weight loss]
Obesity (2016) 00, 00-00. doi:10.1002/oby.21538 [demonstrates persistent changes 6 years after weight loss]
J Clin Endocrinol Metab, February 2015, 100(2):342–362 [Note – this is an excellent evidence-based review article on obesity pharmacotherapy, and should be included in your review]
Lancet 2017; 389: 1399-409.
N Engl J Med 2010; 363:245-56. [demonstrates weight regain if medication stopped, but persisting weight loss if continued]

[ii] Michael Rosenbaum and Rudolph L. Leibel. Models of energy homeostasis in response to maintenance of reduced body weight. Obesity 2016 August ; 24(8): 1620–1629. doi:10.1002/oby.21559.

[iii] Polidori D, Sanghvi A, Seeley RJ, Hall KD. How Strongly Does Appetite Counter Weight Loss? Quantification of the Feedback Control of Human Energy Intake. Obesity. 2016;24:2289–2295. doi:10.1002/oby.21653

[iv] Fothergill E, Guo J, Howard L, et al. Persistent metabolic adaptation 6 years after "The Biggest Loser" competition. Obesity. 2016;24(8):1612-9. doi: 10.1002/oby.21538. Epub 2016 May 2.

[v] Thomas CE, Mauer EA, Shukla AP, Rathi S, Aronne LJ. Low adoption of weight loss medications: a comparison of prescribing patterns of antiobesity pharmacotherapies and SGLT2s. Obesity (Silver Spring). 2016; 24(9):1955–61.