

## Opinion Article

# The Modern Obesity Treatment

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## Opinion

Obesity is nowadays a pandemic, the first non-infectious and one of the major public health challenges. If one wants to understand this chronic disease present in more than 600 million people all over the world, we need to recognize first the chronic inflammatory profile. Only then may we face the problem with the right view and be able to undertake successful strategies to control it.

Probably, obesity is the oldest metabolic disease as there are proofs of its existence already in the Paleolithic era. Hippocrates and his pupil Galeno, described it in the Ancient Greece, as a sickness condition, consequence of a lack of discipline in life. Unfortunately, nowadays, many people are thinking in the same way and looking at the disease carriers with prejudice and practicing a kind of social bullying on them.

Such a contemporary misunderstanding about discipline, slouch and flaw character, side to side with the beautiful, perfect and healthy body stereotype, implies a lot of social misfits to the obesity victims. So, these people are usually marginalized, discriminated and mistreated. The individual and social consequences of the disease are much stronger than the modern understanding and knowledge about the obesity as a chronic disease.

In 2007, the World Health Organization (WHO) has recognized "obesity" as a disease and defined it in terms of weight excess using the Body Mass Index (BMI) as a parameter to measure the morbidity and mortality risk. The highest degree defined, obesity grade III (BMI>40 Kg/m<sup>2</sup>), is known as "morbid obesity" as it causes at least some of the possible 227 comorbidities it may induce.

In Portugal 57% of the inhabitants have excess weight, 18.9% have obesity (Retrato de Saúde em Portugal- SNS 2018) and 3% are morbidly obese. Providing the unique effective treatment and getting good outcomes is only possible with bariatric and metabolic surgery.

The criteria for surgical treatment are very well defined by IFSO (International Federation for Surgery of Obesity). Although BMI is not a good predictor of severity of disease or comorbidities, it's a simple and quick parameter to achieve and hence universally used. Any patient with a BMI  $\geq 40\text{kg/m}^2$  or  $\geq 35\text{kg/m}^2$  with associated comorbidities (high blood pressure, type 2 diabetes mellitus,

dyslipidemia, osteoarthritis, obstructive sleep apnoea) are eligible to receive surgical treatment. Actually, other diseases were included in the indications criteria like depression, previous stroke, cardiac insufficiency, infertility and other. The three most common bariatric surgeries performed worldwide are sleeve gastrectomy, gastric bypass and gastric band. They are either restrictive procedures, malabsorption procedures or combinations of both.

It is common to hear about "surgery" being just a tool to allow patients to adapt to their lifestyle, eating more rationally and being physically more active. This is for sure true but, one should emphasize, surgery implies specific metabolic effects which are independent of the patient's rational decision. And this is the key for success. Those physiologic improvements are mediated through the digestive hormonal setup modification (incretin effect), biliary salts absorption and distribution, microbioma changes and neurophysiologic induction of a more convenient balance between hunger and satiety. Altogether, provided the patient remain compliant with the multidisciplinary team recommendations, these effects will always end in a significant weight loss, comorbidities control and better quality of life.

Bariatric and metabolic surgeries are not aesthetical procedures and surgeons should resist to perform these operations when very enthusiastic but not realistic patients ask for it. Specially, less obese patients should be managed to adjust their expectations according to their characteristics concerning weight loss, comorbidities control and mainly physical self image. A good discussion and agreement concerning the pretended goals to achieve in the future is really essential for a smooth and effective treatment. A strong commitment from both parts, patient and team, are naturally also necessary. It's worth remembering that metabolic teams should be organized, have a common policy under the surveillance of a leader, usually the bariatric surgeon. It should also include endocrinologists, nutritionists, psychologists, physiotherapists and physiologists.

Endocrinologists will evaluate and control possible diseases like type 2 diabetes mellitus, hypothyroidism, cushing syndrome, polycystic ovaries among others.

Psychologists have the mission of keeping the patient motivated. Awareness, reflection, self-determination and responsibility for caring for one's life are landmarks for all the team members to instill in the patient perspective.

The nutritionist has again a definitive importance because they are the one who will first teach patients about changing the alimentary pattern, to advice about the nutritional deficiencies symptoms and prescribe the supplements they need to take. The nutritionist will also promote methods and behavioural techniques driving people to the correct dietary habits as definitely important part of a lifestyle modification.

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The physiotherapist assists the patients with an appreciation of his/her physical capacity and has the mission to find new and interesting physical activity options.

If we want to have an effective treatment for obesity, then both patient and doctor need to build a skillful and empathetic communication where almost all aspects of the future advantages and disadvantages should be anticipated. With that point of view, it is wise to advise patients about issues like the sagging skin or the need for continuous supplementation schemes. And also to teach the few different medications people may need to avoid or minimize the use of.

The patients and all those practitioners will follow the same road for a long time. The destiny, a surgical success, relies on significant behavioural modifications which are not easy for majority of the patients to adopt.

Each person has its own capacity to build a new relation between healthy food and physical regular activities. It's a long lasting, time consuming and difficult process with advances and setbacks. Patients need to be pushed forward, emptied of guilt and misleading labels. They are not obese but patients with obesity, a terrible disease hitting all aspects of the physical and psychological structure.

Team support is necessary for a long time because chronic diseases needs a chronic treatment.

Obesity has no cure, but it has a treatment and we should strive to provide it in a serious effective pattern!