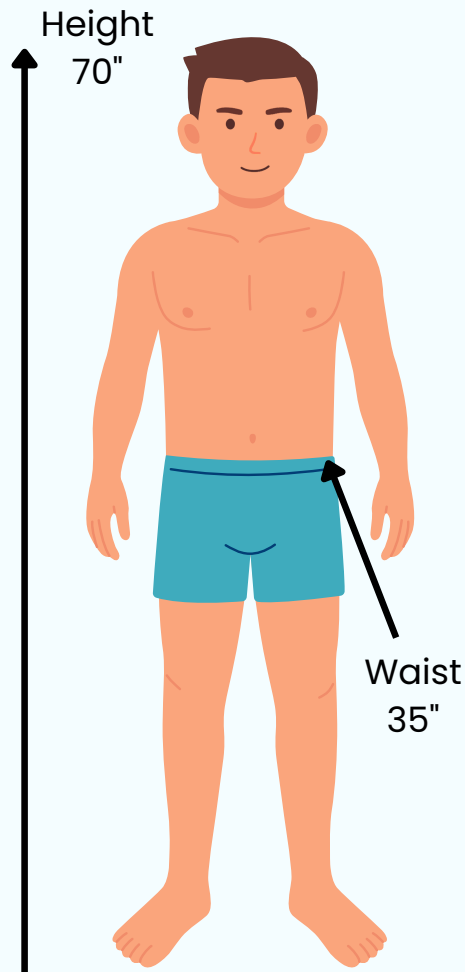


# MANAGING OBESITY

Historically, obesity was diagnosed using Body Mass Index (BMI), which calculates weight relative to height. (Overweight: BMI 25–29.9, Obesity: BMI  $\geq 30$ ). While BMI is easy to use, it doesn't account for fat distribution or individual health impacts.



## A BETTER APPROACH: TWO-PART DIAGNOSIS

### ANTHROPOMETRIC COMPONENT

Goes beyond BMI to include fat distribution, especially abdominal fat (visceral fat):

- Uses the **waist-to-height ratio** (WtHR)  $>0.5$  as a better indicator of **cardiometabolic risk**
- Even patients with "normal" BMI but high abdominal fat are at increased risk

### CLINICAL COMPONENT

Evaluates actual or potential impairments:

- **Medical:** diabetes, hypertension, heart disease, sleep apnea, cancer risk
- **Functional:** MSK pain, mobility issues, muscle loss (especially in older adults)
- **Psychological:** depression, disordered eating, low quality of life

# SUPPORTIVE THERAPY

## WHO BENEFITS?

People with BMI  $\geq 25$  and WtHR  $>0.5$  plus any physical, functional, or mental health complications, should be considered for treatment, even if they don't meet traditional obesity cut-offs.

## TREATMENT TOOLS



### Lifestyle Therapy

Nutrition, exercise, stress reduction, sleep support



### Behavioral Support

Coaching and psychological therapy



### Functional Outcomes

Better mobility, less pain, and more daily function



### Medications

Not limited to BMI  $\geq 30$  if other risk factors are present



### Surgical/Endoscopic Options

For appropriate clinical stages

## MANAGEMENT CONSIDERATIONS

Therapy should be matched to disease stage, severity, patient goals, and treatment barriers. One-size-fits-all doesn't work.

Goals should include improved health conditions, mental well-being, quality of life, and physical and social function.

Repeating ineffective care delays progress. If goals aren't met, escalate treatment—just like with other chronic conditions.