Obesity in Adults
Prevention and Management
Recommendations 2015

Canadian Task Force on Preventive Health Care

Putting Prevention
into Practice

Canadian Task Force on Preventive Health Care
Groupe d'étude canadien sur les soins de santé préventifs

Use of deck

- These slides are made available publicly as a another vehicle for dissemination of the practice guidelines.
- Some or all of the slides may be used with attribution in educational contexts.

- Guidelines were published online January 26, 2015

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Overview of Presentation

- Background on Adult Obesity Prevention and Management
- Methods of the CTFPHC
- Recommendations and Key Findings
- Implementation of Recommendations
- Other Guidelines on Adult Obesity
- Conclusions and Future Directions
- KT Tools
- Questions and Answers

Background

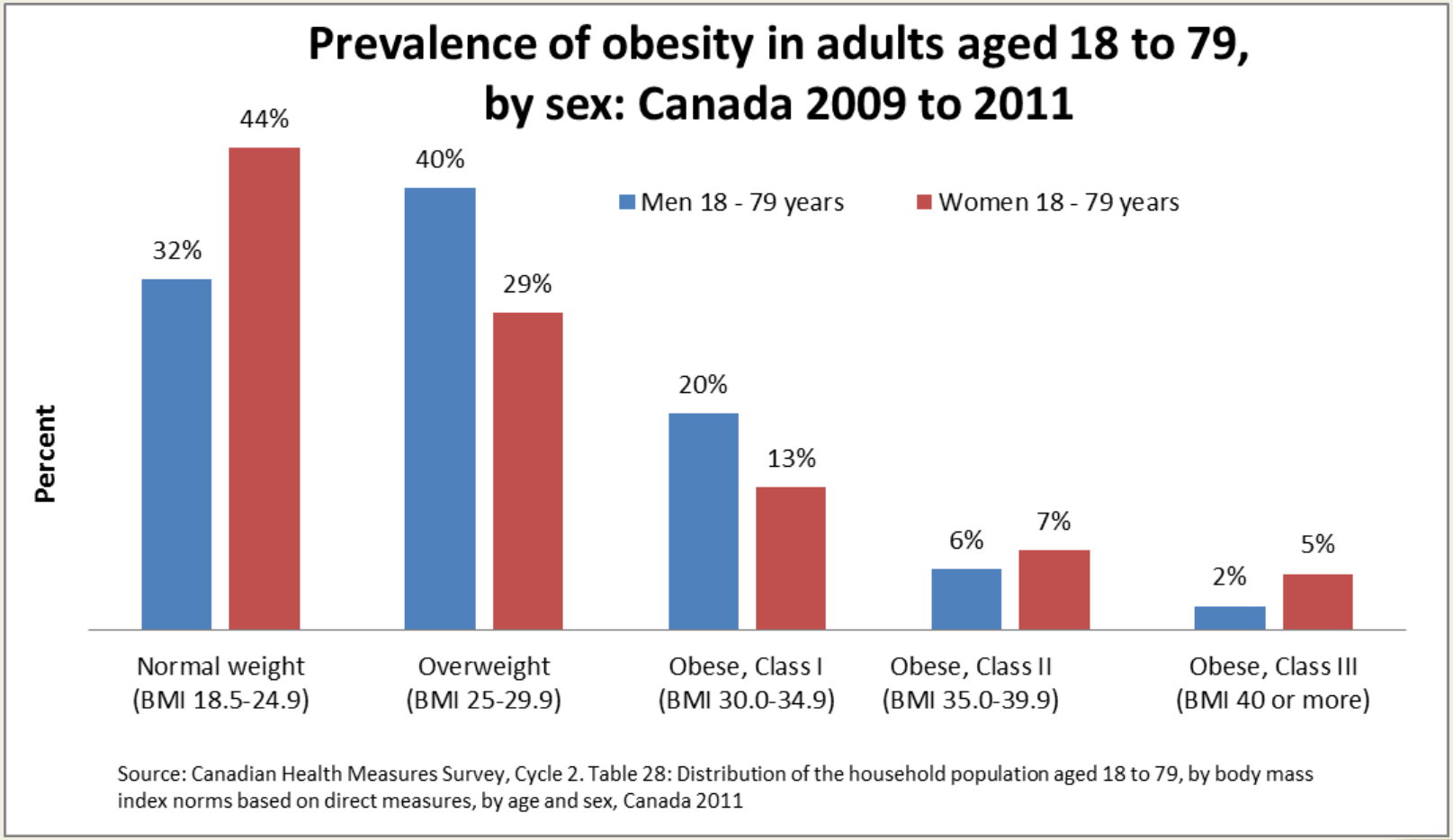
- Over two thirds of Canadian men (68%) and more than half of Canadian women (54%) are overweight or obese

- About two thirds of adults who are overweight and obese were in the healthy weight range as adolescents, but gained weight in adulthood (about 0.5-1.0 kg/2 years on average)

- The causes of obesity are complex (biological, behavioural, social and environmental factors interact)

- Excess weight is a well-recognized risk factor for several common chronic conditions

Prevalence of Obesity in Canada (2011)



Source: Canadian Health Measures Survey, Cycle 2. Table 28: Distribution of the household population aged 18 to 79, by body mass index norms based on direct measures, by age and sex, Canada 2011

Adult Obesity Prevention and Management Guidelines Objectives

Two separate guidelines were developed. These guidelines do not apply to those with a BMI >40 who may benefit from specialized services.

- **Obesity Prevention:** Recommendations for prevention of weight gain among adults in primary care
  - ***Objective:*** *Provide evidence-based recommendations for structured interventions aimed at preventing weight gain in adults of normal weight*

- **Obesity Management**: Recommendations on using behavioural and/or pharmacological interventions to manage overweight and obesity in adults in primary care
  - ***Objective:*** *Provide evidence-based recommendations for behavioural and pharmacological interventions for weight loss and other indicators to manage overweight and obesity in adults, including those at risk of Type 2 Diabetes*

Structured Behavioural Interventions

- **Programs** focused on diet, exercise, or lifestyle changes, alone or in combination, that take place over weeks or months.
- **Lifestyle changes** include counseling, education or support, and environmental changes in addition to changes in exercise or diet.
- Offered in primary care settings or settings where primary care practitioners may refer patients, such as credible commercial or community programs.

Methods of the Task Force

- Independent panel of:
  - clinicians and methodologists
  - expertise in prevention, primary care, literature synthesis, and critical appraisal
  - application of evidence to practice and policy
- Adult Obesity Working Group
  - 5 Task Force members
  - establish research questions and analytical framework

Methods of the Task Force

- Evidence Review and Synthesis Centre (ERSC)
  - Undertakes a systematic review of the literature based on the analytical framework
  - Prepares a systematic review of the evidence with GRADE tables
  - Participates in working group and task force meetings
  - Obtain expert opinions

Task Force Review Process

- Internal review process involving guideline working group, Task Force, scientific officers and ERSC staff
- External review process involving key stakeholders
  - Generalist and disease specific stakeholders
  - Federal and P/T stakeholders
- CMAJ undertakes an independent peer review journal process to review guidelines

External Reviewers

Disease Specific Stakeholders

- Canadian Association of Gastroenterology (1)
- Canadian Cardiovascular Harmonized National Guidelines Endeavour (1)
- Canadian Obesity Network (1)
- Dietitians of Canada (1)
- Promoting Optimal Weights through Ecological Research (1)
- SIGN Obesity GL co-chair (1)

Generalist Organizations

- College of Physicians of Quebec (1)
- University of Waterloo (1)
- University of Alberta (1)
- University of Manitoba (1)

Federal and P/T Stakeholders

- Health Canada (1)
- PHAC (1)

Anonymous reviewers

- College of Family Physicians of Canada (6)
- CMAJ

Systematic Review Process

Pick topic and identify question

Decide what evidence counts

Develop protocol

Search for evidence

Screen citations for relevance

Full-text review for inclusion

Assess methodological quality of studies

Extract relevant data

Analyze data across studies

GRADE quality of evidence

Write report

Review Topics and Questions

	3 REVIEW TOPICS		
	Prevention of Overweight/Obesity	**Management of Overweight/Obesity**	**Maintenance of Weight Loss**
Adults	✓	✓	✓

KEY QUESTIONS: What are the benefits and harms of behavioural and/or pharmacological interventions (orlistat and metformin)

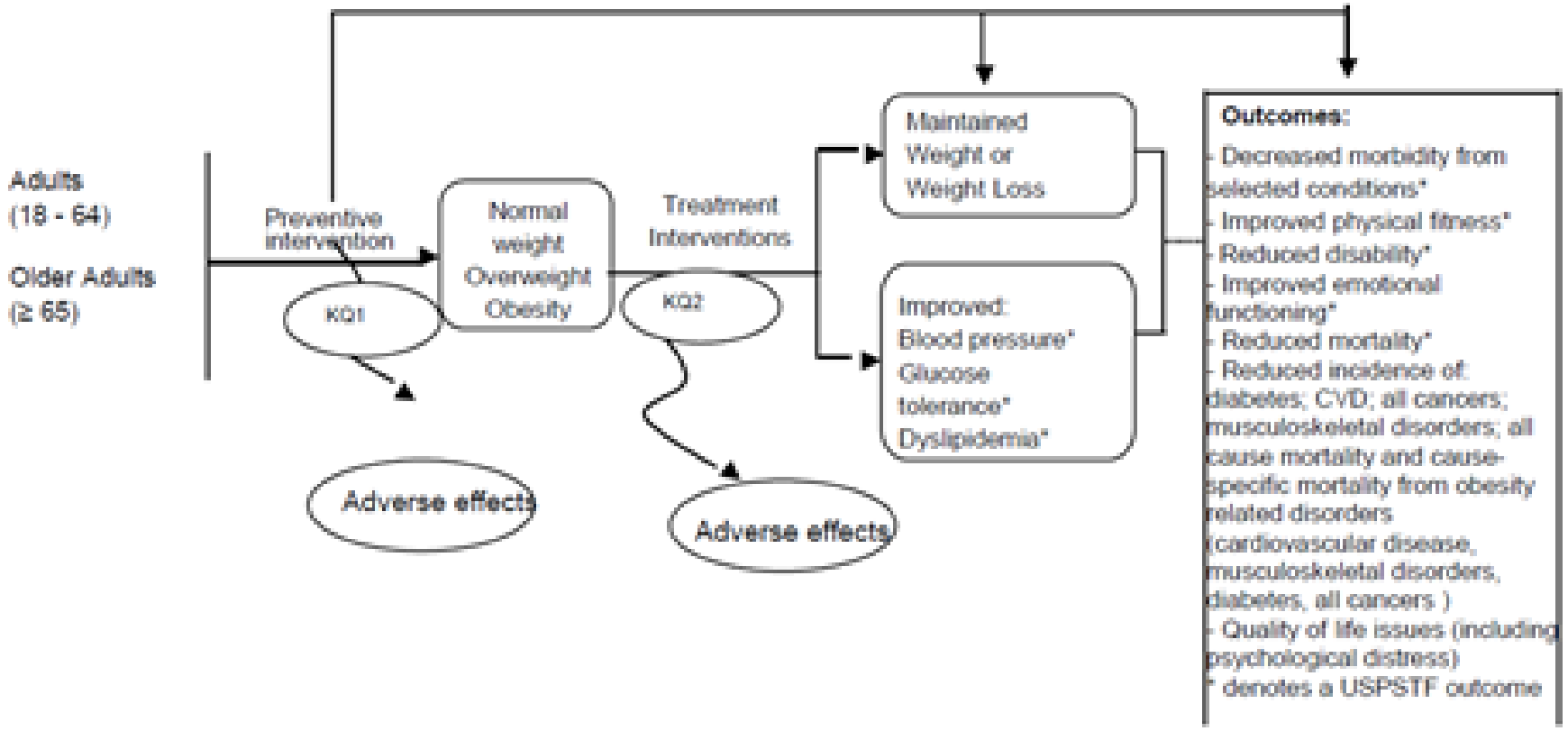
Key Research Questions

- The systematic review for prevention of obesity in normal weight adults included:
  - (1) key research question with (5) sub-questions
- The systematic review for management of overweight and obese adults included:
  - (1) key research question with (5) sub-questions
- The systematic review for both the prevention and management of obesity in adults included:
  - (6) Supplemental or contextual questions

For more detailed information please access the systematic review
www.canadiantaskforce.ca

Analytical Framework (initial)

Figure 1: Analytic framework: prevention and treatment interventions for normal weight, overweight and obese adults



Eligible Study Types

- **Population**: adults ≥ 18 years who are normal weight (prevention) or who are obese or overweight with a BMI<40 (management)
- **Language**: studies published in English and French (KQ 1. new review on prevention) and English-only (KQ 2. updated search of previous USPSTF review on treatment)
- **Study type:** Included randomized control trials (RCTs)

GRADE Methodology

The "**GRADE**" System:

- **G**rading of **R**ecommendations, **A**ssessment, **D**evelopment & **E**valuation

What are we grading?

1. Quality of Evidence

- Degree of confidence that the available evidence correctly reflects the theoretical true effect of the intervention or service.
- high, moderate, low, very low

2. Strength of Recommendation

- Quality of supporting evidence; the balance between desirable and undesirable effects; the variability or uncertainty in values and preferences of citizens; and whether or not the intervention represents a wise use of resources.
- strong OR weak

How is the Strength of Recommendations Determined?

The strength of the recommendations (strong or weak) are based on four factors:

- **Quality** of supporting evidence
- Certainty about the **balance between desirable and undesirable** effects
- Certainty / variability in **values and preferences** of individuals
- Certainty about whether the intervention represents a **wise use of resources**

Interpretation

Implications	Strong Recommendation	Weak Recommendations
For patients	• Most individuals would want the recommended course of action; • only a small proportion would not.	• The majority of individuals in this situation would want the suggested course of action but many would not.
For clinicians	• Most individuals should receive the intervention.	• Recognize that different choices will be appropriate for individual patients; • Clinicians must help patients make management decisions consistent with values and preferences.
For policy makers	• The recommendation can be adapted as policy in most situations.	• Policy making will require substantial debate and involvement of various stakeholders.

Adult Obesity Prevention and Management

RECOMMENDATIONS & KEY FINDINGS

Recommendations on Measuring Obesity

1. We recommend measuring height, weight and calculating BMI at appropriate primary care visits.

- Strong recommendation; very low quality evidence

Basis of the recommendation

- The CTFPHC placed a relatively high value on a low cost, clinically easily calculated measure with widely accepted cutpoints to base guidance for weight gain prevention and management.
- The strong recommendation implies that the CTFPHC is confident that the benefits of measuring BMI in primary care outweigh the potential harm.

Recommendations on Obesity Prevention

2. We recommend that practitioners not offer formal, structured interventions aimed at preventing weight gain in normal weight adults.

- Weak recommendation; very low quality evidence

Basis of the recommendation

- The CTFPHC placed a relatively lower value on the unproven possibility that obesity prevention programs offered to the normal weight population may reduce the long term risk for obesity in that group.
- The weak recommendation implies that uncertainty exists and that practitioners should use their judgement in determining whether some normal weight adults may benefit from being offered or referred to weight gain prevention programs (e.g., those highly motivated or at higher risk).

Summary of Findings

- Weight gain prevention interventions in mixed weight groups have minimal effect on weight (difference vs. controls of approximately 0.8 kg over 12 months)
- Effect was not sustained over time (measured 15 months after intervention).
- The current recommendations are based on examination of the evidence supporting interventions specifically aimed at preventing weight gain.
- The evidence for promoting healthy behaviours in primary care (such as increasing physical activity, healthy eating, and sleep) was not examined.

Recommendations on Obesity Management

3. For adults who are obese (30 ≤ BMI < 40) and are at high risk of diabetes, we recommend that practitioners offer or refer to structured behavioural interventions aimed at weight loss.

- Strong recommendation; moderate quality evidence

Basis of the recommendation

- The CTFPHC places a high value on the decreased risk of T2D among those who participated in a structured behavioural intervention aimed at weight loss.
- The strong recommendation implies that the CTFPHC is confident that the benefits of offering or referring obese patients at high risk of T2D to structured behavioural outweigh the potential harms.

Recommendations on Obesity Management

4. For adults who are overweight or obese, we recommend that practitioners offer or refer to structured behavioural interventions aimed at weight loss.

- Weak recommendation; moderate quality evidence

Basis of the recommendation

- The CTFPHC places a high value on the small potential benefit of structured behavioural interventions and the low risk of harms
- The weak recommendation implies that uncertainty exists with respect to the lack evidence showing a clear net benefit, however, some overweight and obese results may still benefit from being offered or referred to weight loss interventions.

Recommendations on Obesity Management

5. For adults who are overweight or obese, we recommend that practitioners not routinely offer pharmacological interventions (orlistat or metformin) aimed at weight loss.

- Weak recommendation; moderate quality evidence

Basis of the recommendation

- The CTFPHC places a higher value on the potential harms of treatment with pharmacological interventions (e.g., adverse events and gastrointestinal disturbances)
- A weak recommendation against implies that uncertainly on the long term effectiveness of pharmacological interventions. Pharmacological therapy may be warranted in some situations.

Summary of Findings

- Weight loss interventions (behavioural and/or pharmacological) are effective in modestly reducing weight and waist circumference.
- For adults who are at risk of developing type 2 diabetes, weight loss interventions can reduce or delay onset.
- No important harms were identified for behavioural interventions, but pharmacological interventions increase the risk of harms such as gastrointestinal symptoms.
- Behavioural interventions are the preferred option, as the benefit to harm ratio appears more favourable than for pharmacological interventions.

Effect of Treatment Interventions on Incidence of T2D

Type 2 Diabetes Incidence	Relative Risk	No. of participants (studies)
Overall	RR 0.6	8,624 (9 studies)
Primary focus of intervention – behavioural	RR 0.6	3,198 (7 studies)
Primary focus of intervention – pharmacological + behavioural	RR 0.7	5,426 (3 studies)

Source: Peirson L, Fitzpatrick-Lewis D, Ciliska D, et al. Treatment of overweight/obesity in adult populations. Ottawa: Canadian Task Force on Preventive Health Care; 2014.

Effects of Treatment on Weight (Primary Outcome)

Outcomes	Treatment	
Critical Outcomes	Behavioural Interventions Compared to NO Intervention Controls *Mean Difference*	Pharmacological + Behavioural Interventions Compared to Behavioural Controls *Mean Difference*
Weight	-3.1 kg	-2.9 kg
BMI Change	-1.1 kg/m2	-1.3 kg/m2
Waist Circumference	-3.1 cm	-2.3 cm

Source: Peirson L, Fitzpatrick-Lewis D, Ciliska D, et al. Treatment of overweight/obesity in adult populations. Ottawa: Canadian Task Force on Preventive Health Care; 2014.

Number Needed to Treat

Behavioural

- To achieve one participant with ≥5% total body weight loss 9 must be treated
- To achieve one participant with ≥10% total body weight loss 12 must be treated

All studies

- To achieve one participant with ≥5% total body weight loss 5 must be treated

Effects of Treatment on Secondary Outcomes

Outcomes	Treatment	
Secondary Outcomes	Behavioural Interventions Compared to NO Intervention Controls *Mean Difference*	Pharmacological + Behavioural Interventions Compared to Behavioural Controls *Mean Difference*
Total Cholesterol	-0.1 mmol/L	-0.3 mmol/L
LDL cholesterol	-0.1 mmol/L	-0.3 mmol/L
Fasting glucose	-0.1 mmol/L	-0.4 mmol/L
Systolic blood pressure	-1.8 mmHg	-1.7 mmHg
Diastolic blood pressure	-1.6 mmHg	-1.2 mmHg

Source: Peirson L, Fitzpatrick-Lewis D, Ciliska D, et al. Treatment of overweight/obesity in adult populations. Ottawa: Canadian Task Force on Preventive Health Care; 2014.

Harms of Treatment

Behavioural Interventions:

- Few reported adverse effects
- Harms usually associated with injury from physical activity (number of reported events quite low)

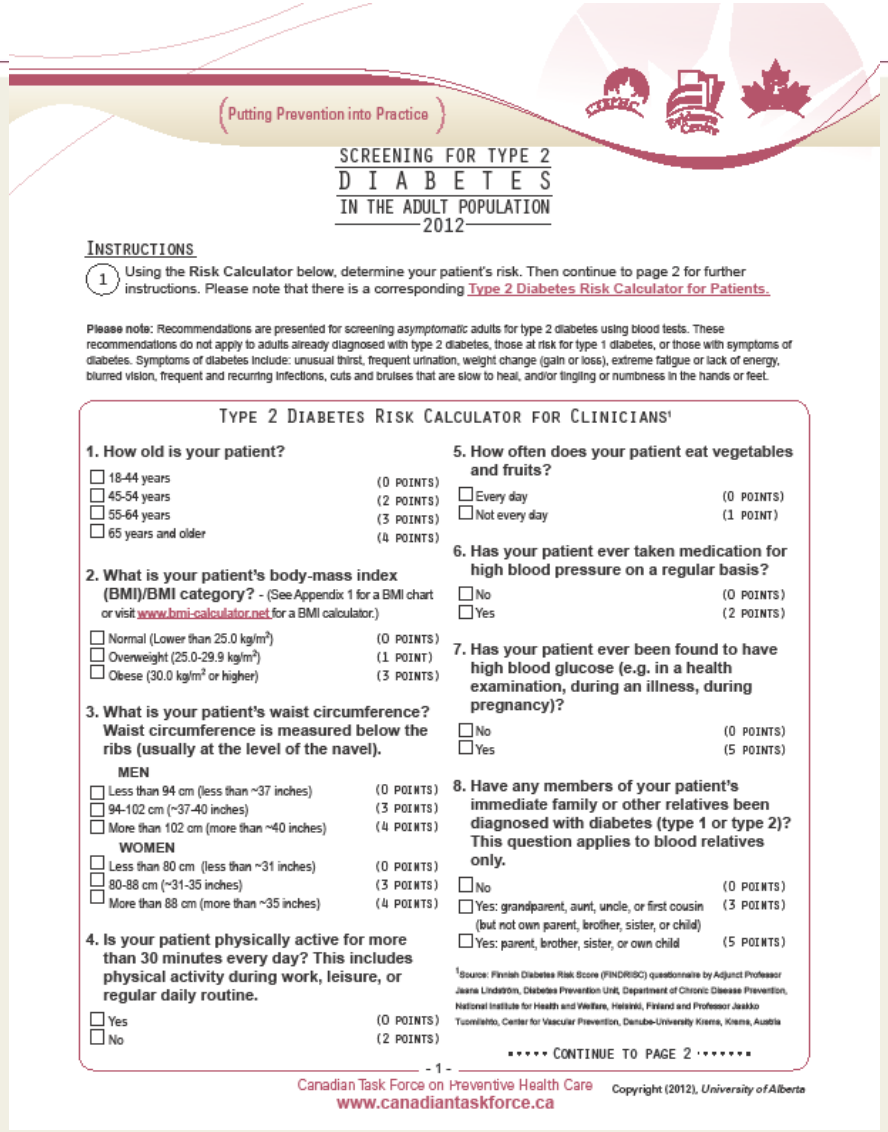
Pharmacological Interventions (Metformin and Orlistat):

- Adverse effects commonly reported
- Those with a high CVD risk at baseline were more likely to report at least 1 adverse event
- 80% of reported adverse events were in the category of mild to moderate gastrointestinal disturbance
- Other adverse events reported included: dizziness, headache, acute upper respiratory tract infection, hospitalization or required acute medical care

Adult Obesity Prevention and Management

IMPLEMENTATION OF RECOMMENDATIONS

Assessing Type 2 Diabetes Risk



Putting Prevention into Practice

SCREENING FOR TYPE 2 DIABETES IN THE ADULT POPULATION 2012

INSTRUCTIONS

1. Using the Risk Calculator below, determine your patient's risk. Then continue to page 2 for further instructions. Please note that there is a corresponding Type 2 Diabetes Risk Calculator for Patients.

Please note: Recommendations are presented for screening *asymptomatic* adults for type 2 diabetes using blood tests. These recommendations do not apply to adults already diagnosed with type 2 diabetes, those at risk for type 1 diabetes, or those with symptoms of diabetes. Symptoms of diabetes include: unusual thirst, frequent urination, weight change (gain or loss), extreme fatigue or lack of energy, blurred vision, frequent and recurring infections, cuts and bruises that are slow to heal, and/or tingling or numbness in the hands or feet.

TYPE 2 DIABETES RISK CALCULATOR FOR CLINICIANS[1]

1. How old is your patient?
- ☐ 18-44 years (0 POINTS)
- ☐ 45-54 years (2 POINTS)
- ☐ 55-64 years (3 POINTS)
- ☐ 65 years and older (4 POINTS)

2. What is your patient's body-mass index (BMI)/BMI category? - (See Appendix 1 for a BMI chart or visit www.bmi-calculator.net for a BMI calculator.)
- ☐ Normal (Lower than 25.0 kg/m²) (0 POINTS)
- ☐ Overweight (25.0-29.9 kg/m²) (1 POINT)
- ☐ Obese (30.0 kg/m² or higher) (3 POINTS)

3. What is your patient's waist circumference? Waist circumference is measured below the ribs (usually at the level of the navel).

MEN
- ☐ Less than 94 cm (less than ~37 inches) (0 POINTS)
- ☐ 94-102 cm (~37-40 inches) (3 POINTS)
- ☐ More than 102 cm (more than ~40 inches) (4 POINTS)

WOMEN
- ☐ Less than 80 cm (less than ~31 inches) (0 POINTS)
- ☐ 80-88 cm (~31-35 inches) (3 POINTS)
- ☐ More than 88 cm (more than ~35 inches) (4 POINTS)

4. Is your patient physically active for more than 30 minutes every day? This includes physical activity during work, leisure, or regular daily routine.
- ☐ Yes (0 POINTS)
- ☐ No (2 POINTS)

5. How often does your patient eat vegetables and fruits?
- ☐ Every day (0 POINTS)
- ☐ Not every day (1 POINT)

6. Has your patient ever taken medication for high blood pressure on a regular basis?
- ☐ No (0 POINTS)
- ☐ Yes (2 POINTS)

7. Has your patient ever been found to have high blood glucose (e.g. in a health examination, during an illness, during pregnancy)?
- ☐ No (0 POINTS)
- ☐ Yes (5 POINTS)

8. Have any members of your patient's immediate family or other relatives been diagnosed with diabetes (type 1 or type 2)? This question applies to blood relatives only.
- ☐ No (0 POINTS)
- ☐ Yes: grandparent, aunt, uncle, or first cousin (but not own parent, brother, sister, or child) (3 POINTS)
- ☐ Yes: parent, brother, sister, or own child (5 POINTS)

[1]Source: Finnish Diabetes Risk Score (FINDRISC) questionnaire by Adjunct Professor Jaana Lindström, Diabetes Prevention Unit, Department of Chronic Disease Prevention, National Institute for Health and Welfare, Helsinki, Finland and Professor Jaakko Tuomilehto, Center for Vascular Prevention, Danube-University Krems, Krems, Austria

CONTINUE TO PAGE 2

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www.canadiantaskforce.ca

- Strong recommendation for treatment when people at high risk of diabetes (1/3 chance of developing diabetes in next 10 years)
- Diabetes screening is recommended at age > 18 where risk factors exist and every 3-5 years
- Different tools available (e.g., CANRISK, FINRISK)
- See CTFPHC guidelines for diabetes screening: http://canadiantaskforce.ca/ctfphc-guidelines/2012-type-2-diabetes/

Values and Preferences

Obesity Prevention

Practitioners should discuss the evidence showing minimal short-term benefit from weight gain prevention interventions, as some individuals of normal weight may benefit from being offered or referred to these programs including:

- Individuals with metabolic risk factors, high waist circumference, family history of Type 2 Diabetes and of CVD.
- Individuals who are gaining weight and motivated to make lifestyle changes

Values and Preferences

Obesity Management

Practitioners should discuss the evidence showing the potential benefit of structured behavioural interventions aimed at weight loss, as some overweight and obese adults may benefit from being offered or referred to these programs including:

- Individuals who are highly motivated to lose weight and make lifestyle changes

Values and Preferences

Obesity Management

Practitioners should discuss the potential benefits and harms of pharmacological therapy, in advising those patients who may benefit from the addition of pharmacological therapy to behavioural change including:

- Individuals at risk for diabetes
- Individuals who are highly motivated to lose weight
- Individuals who prefer medications and are less concerned about potential harms

Facilitators and Barriers

Practitioners should be aware of facilitators and barriers to participation in weight gain prevention and loss interventions:

- Family and work schedules
- Unrealistic expectations
- Hunger
- Knowledge and/or skills
- Socio-cultural factors
- Psychological problems
- Past stigmatizing experiences
- Environmental factors

Adult Obesity Prevention and Management

KT TOOLS

Adult Obesity Recommendation 2014

Canadian Task Force on Preventive Health Care

Your Patient's BMI Matters

The Canadian Task Force on Preventive Health Care (CTFPHC) recommends measuring height and weight and then calculating Body Mass Index (BMI) at appropriate primary care visits (strong recommendation, very low quality evidence*).

- Recommendations apply to most adults ≥ 18 years of age
- Recommendations do not apply to pregnant women or people with health conditions where weight loss is inappropriate
- Recommendations do not apply to people with BMI ≥ 40, who will benefit from specialized bariatric programs

WHAT IS YOUR PATIENT'S BMI?

Calculate BMI by measuring height and weight AND using BMI Chart

BMI < 18.5 UNDERWEIGHT	This category is outside the scope of this guideline
18.5 ≤ BMI ≤ 24.9 NORMAL WEIGHT	Do not offer formal, structured behavioural interventions aimed at preventing weight gain in adults (*weak recommendation; very low-quality evidence*)
25 ≤ BMI ≤ 29.9 OVERWEIGHT	Have a discussion with your patient, and offer or provide referral to structured behavioural interventions aimed at weight loss (*weak recommendation; moderate-quality evidence*)
30 ≤ BMI ≤ 39.9 OBESE	Have a discussion with your patient, and offer or provide referral to structured behavioural interventions aimed at weight loss (*weak recommendation; moderate-quality evidence*)
30 ≤ BMI ≤ 39.9 OBESE AND AT HIGH RISK OF DIABETES†	Offer or refer the patient to structured behavioural interventions aimed at weight loss (*strong recommendation; moderate quality evidence*)
BMI > 40 SEVERELY OBESE	This category is outside the scope of this guideline

What are "appropriate primary care visits"?

- Routine visits, visits for medication renewal, and other visits where the primary care practitioner deems it appropriate.

What are "structured behavioural interventions"?

- Programs focused on behaviour modification that involve several sessions over a period of weeks to months.

- **Recommended programs should focus on:**
  - Modifying diet
  - Increasing exercise
  - Making lifestyle changes
  - Any combination of these

- **Programs for obesity management may also include:**
  - Counselling
  - Education or support
  - Environmental changes (e.g., use of a smaller plate)

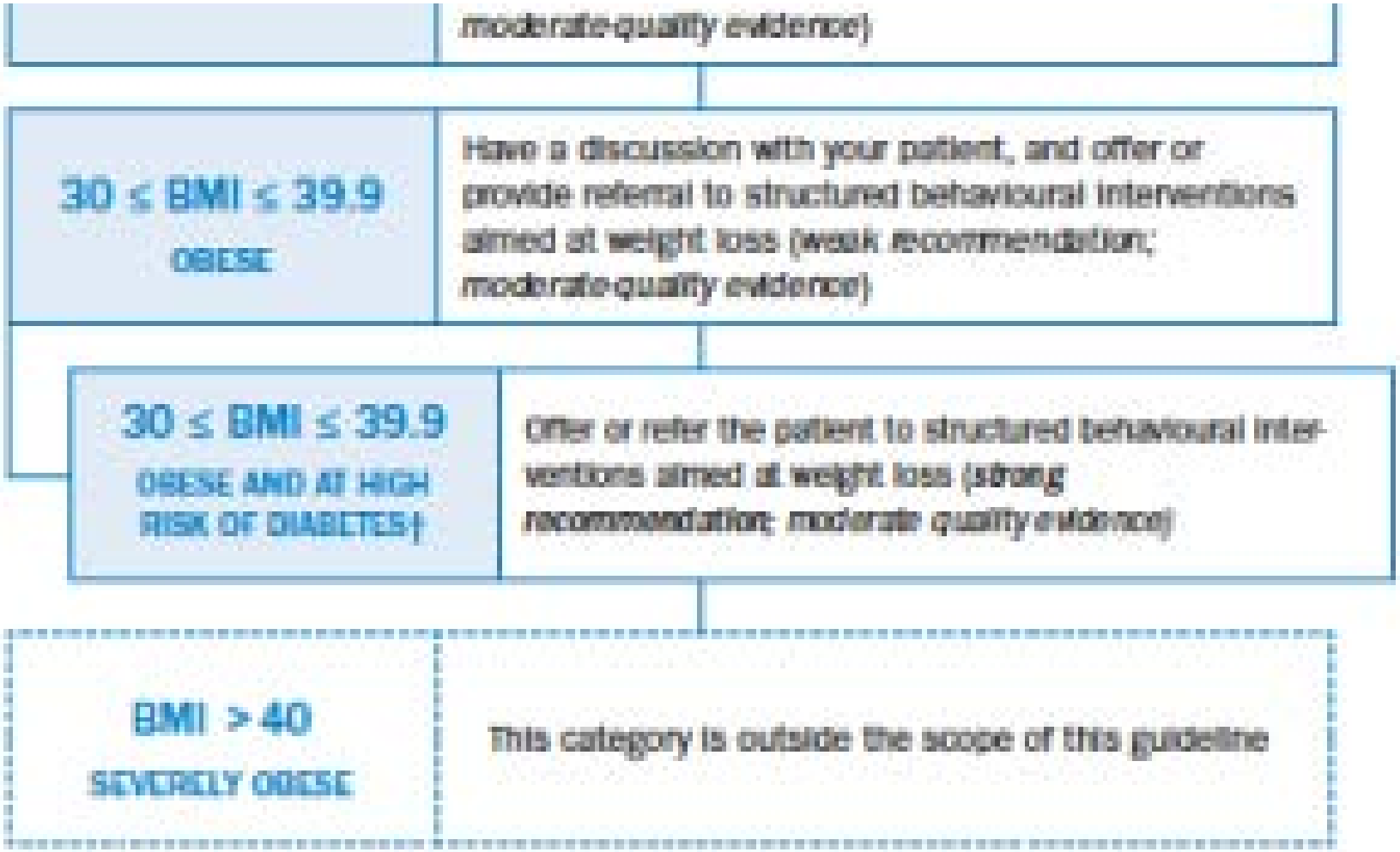
Can I instruct my patients to calculate their own BMI? Or can I estimate it?

- We recommend that physicians (or another member of the health care team) measure weight and height to calculate the patient's BMI.
- Adults tend to overestimate their own height and underestimate their own weight.
- Visual estimation by clinicians is often inaccurate and will not detect the relatively small gains occurring among most adults.

* For explanation of GRADE categories of recommendations and quality of evidence, please see: www.canadiantaskforce.ca/methods/grade/

† High-risk status is defined by 10-year risk of diabetes of ≥33%, which can be assessed using the CANRISK or FINDRISC risk assessment tool available at: www.canadiantaskforce.ca/ctfphc-guidelines/2012-type-2-diabetes/

PLEASE VISIT WWW.CANADIANTASKFORCE.CA FOR ADDITIONAL INFORMATION


moderate-quality evidence)
30 ≤ BMI ≤ 39.9
OBESE
Have a discussion with your patient, and offer or provide referral to structured behavioural interventions aimed at weight loss (weak recommendation; moderate-quality evidence)
30 ≤ BMI ≤ 39.9
OBESE AND AT HIGH RISK OF DIABETES†
Offer or refer the patient to structured behavioural interventions aimed at weight loss (strong recommendation; moderate quality evidence)
BMI > 40
SEVERELY OBESE
This category is outside the scope of this guideline

Canadian Task Force on Preventive Health Care

Prevention and Management of Adult Obesity: FAQs for Primary Care Practitioners

PREVENTION

1. What are the CTFPHC's recommendations for preventing weight gain?

- We do not recommend offering programs aimed at preventing weight gain for healthy adults with a Body Mass Index (BMI) between 18.5 and 24.9, as evidence for such programs is limited.

2. How do I implement this recommendation?

- This is a weak recommendation, so clinicians should use their judgment in determining whether a particular patient might benefit from being offered or referred to a program.
- For example, if an individual expresses concerns about weight gain or is motivated to make lifestyle changes, the clinician should consider referral to a program consistent with the person's values and preferences.

MANAGEMENT

3. What are the CTFPHC's recommendations for managing weight gain?

- We strongly recommend that patients who are obese ($30 \leq BMI < 40$) and who are at high risk of type 2 diabetes be referred to a formal diabetes prevention program.
- Such programs can reduce the risk of diabetes for some people who make lifestyle changes (modified diet and increased physical activity).
- We also recommend offering overweight and obese patients referral to programs aimed at weight loss. This is a weak recommendation.
- We don't recommend offering pharmacological therapies, such as orlistat or metformin, to overweight or obese patients for the purpose of weight loss. This is a weak recommendation.

4. How do I implement the weak recommendations?

- A weak recommendation implies that many overweight and obese individuals may benefit from formal diabetes prevention programs, but others may not (e.g., individuals who do not value the short-term benefits of these programs).
- Similarly, pharmacological therapy may not be appropriate for most individuals, but it may be suitable for some (e.g., individuals who are less concerned about the harms of medication).
- Management decisions should be consistent with patients' values and preferences.

5. Which features should I look for when selecting a commercial or community program?

- Commercial programs are largely unregulated, unless they include supplements that fall under Health Canada's *Natural Products Act*. The most effective interventions vary substantially, and availability of programs may vary from province to province. Therefore, physicians should seek out local expertise to find reputable programs.
- According to our review, the most effective programs included the following elements:
  - were over 12 months in duration
  - focused on diet, physical activity, and lifestyle changes and were tailored to meet individual needs
  - included combinations of goal-setting and/or active use of self-monitoring
  - used multiple modes of delivery, such as a combination of group and individual sessions or a combination of individual sessions and technology-based components

STRUCTURED BEHAVIOURAL INTERVENTIONS
Programs focused on behaviour modification that involve several sessions over weeks to months.

6. What are realistic weight loss goals for overweight or obese patients?

- On the basis of the evidence review, we found an average weight loss of 3 kg over 12 months in mixed-weight populations.

RECOMMENDATION

7. To whom do these recommendations apply?

- These recommendations apply to adults ≥ 18 years of age.
- They do not apply to pregnant women and people with health conditions where weight loss is inappropriate.
- They do not apply to people with BMI ≥40, who will benefit from specialized bariatric programs.

BMI

8. Why does the CTFPHC recommend calculating BMI?

- We recommend routinely measuring height and weight and then calculating BMI at appropriate primary care visits.
- Calculation of BMI is feasible, and there is evidence showing that it is the body composition measure most strongly associated with mortality.
- BMI can be used as a basis for weight management but should be considered in the context of a patient's overall health to inform clinical decision-making; it should not be used in isolation.
- For some patients, measurement of waist circumference will also be required as part of risk assessment for diabetes and/or cardiovascular risk.

9. Are there different BMI cut-points for different racial or ethnic groups?

- Currently, there is no strong evidence to support using different BMI cut-points for different groups.

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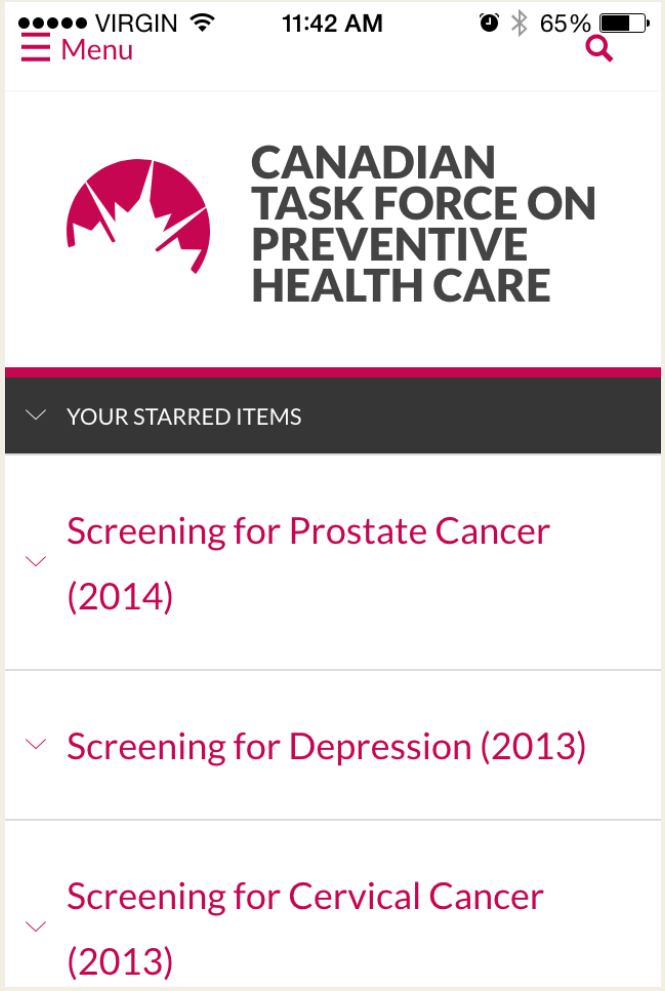
Update: CTFPHC Mobile App Now Available



- The app contains guideline and recommendation summaries, knowledge translation tools, and links to additional resources.
- Key features include the ability to bookmark sections for easy access, display content in either English or French, and change the font size of text.

Conclusions

- Measuring BMI (height/weight) is important for weight monitoring.
- People at high risk of diabetes should be offered or referred for treatment.
- Treatment directed to weight loss is only modestly effective and prevention of obesity would be preferable if there was evidence of effectiveness.
- Some individuals may still benefit from being offered or referred to formal programs.
- Primary care practitioners have an important role to play in overweight and obesity prevention and management.
- Resources and strategies to better support primary care practitioners in implementing the guidelines are needed.
- Research is urgently needed about how best to prevent weight gain in normal weight adults.

More Information

For more information on the details of this guideline please see:

- Canadian Task Force for Preventive Health Care website: http://canadiantaskforce.ca/?content=pcp