

## LETTER TO THE EDITOR

## Approaching the obese patients in primary health care in the Czech Republic

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### Abstract

Statistical results of a study monitoring the occurrence of obesity in the Czech population between 1985 and 2000 were published by the Czech Society of General Practice, in the recommended diagnostic and treatment guidelines for general practitioners under the heading 'Obesity'. In these recommended guidelines, a collective of reputable authors characterize the illness, as well as review the epidemiological data and aetiology of this illness according to the latest know-how in contemporary science.

They recommend comprehensive therapeutic procedures in outpatient practice and assess the goals of weight-loss treatment. This comprehensive treatment of obesity is founded on 3 main pillars, namely on dietary measures, changes in physical activity using cognitive behavioural techniques, and the use of targeted pharmacotherapy.

In conclusion, a clear recommended algorithm for the diagnosis and treatment of obesity for general practitioners is provided (Ref. 3). Full Text (Free, PDF) [www.bmj.sk](http://www.bmj.sk).

Key words: obesity, guidelines, recommend, general practice, examination, metabolic syndrome, behavioural, pharmacotherapy.

In 2000, the results of a study monitoring the occurrence of obesity in the Czech population between 1985 and 2000 were published. The study shows that 45.9 % of monitored men and 32.4 % of monitored women are overweight. Obesity was discovered also in 29.5 % of examined men and 28.1 % of examined women. This shows that according to statistics, we can come across an overweight patient in the doctor's rooms in one third to one half of cases, and with obesity in one third of examined patients. This is a sizeable number, which we must comprehensively resolve today as part of our preventative programmes, as well as in our daily medical practice.

These statistics were published by the Czech Society of General Practice, in the recommended diagnostic and treatment guidelines for general practitioners under the heading 'Obesity', issued last year.

In these recommended guidelines, a collective of reputable authors characterize the illness, as well as epidemiological data and aetiology of this illness according to the latest scientific know-how. Furthermore, they detail diagnostic guidelines for GP's outpatient rooms, with recommendations on biochemical and overall examinations.

In the further section, they recommend comprehensive therapeutic procedures in outpatient practice and assess the goals of

weight-loss treatment. This comprehensive treatment of obesity is founded on 3 main pillars, namely on dietary measures, changes in physical activity using cognitive behavioural techniques, and the use of targeted pharmacotherapy.

The recommended guidelines contain clear BMI weight classification tables, the evaluation of fatty tissue and a table of health risks in relation to the distribution of body fat measured around the waist. In conclusion, a clear recommended algorithm for the diagnosis and treatment of obesity for general practitioners is provided.

What then can the general practitioner do for his obese patients at his rooms?

If we put aside the possibility of paying attention to this issue over and above one's practice and outside of health insurance as part of the GP's obesitology counselling centre, when

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one hardly has time for these activities with a waiting room overcrowded with patients, then most probably in this care of obese patients the GP's registered patients will be involved.

We can carry out the best obesity-related examinations of our patients mainly during our preventative checkups once every two years, in registered patients. This is where we can best resolve this problem. Thereafter, it is only up to us if either due to obesity or due to other comorbid diagnoses (in all probability as part of metabolic syndrome) we will continue to take care of our patient in the ensuing dispensarisation or invite a colleague to cooperate with us (a diabetologist, cardiologist, obesity-internal medicine specialist, surgeon).

Obesity should be understood as being an illness and at the same time as an important risk factor participating in the rise of a range of further illnesses, such as insulin-resistance, type 2 diabetes mellitus, ischemic heart condition, ictus, gout, dyslipidemia, hyperuricemia, hemocoagulation disorders, and others. The following can also be classified as further comorbidities in which excessive body weight plays a role: locomotive disorders, an increased risk in the rise of some cancers, cholelithiasis, gynaecological problems in women and other.

In order to be able to assess whether metabolic syndrome is involved, the patient should fit 3 or more criteria of the following: – abdominal obesity, namely waist measurement exceeding 102 cm (40.6 in) in men, exceeding 88 cm (34.65 in) in women, hypertriglyceridemia over 1.7 mmol/l, HDL below 1 mmol/l in men and below 1.3 mmol/l in women, arterial hypertension over 130 STK and/or over 85 DTK, – hyperglycemia on an empty stomach exceeding 5.6 mmol/l.

The anamneses of obese patients are set up somewhat differently from a regular preventative anamnesis. I recommend obtaining the following information during the first examination:

How long the obesity has persisted and the development of obesity;

- cause of increase in weight,

- aetiological factors – disease of glands with internal secretion – hypothyreosis, hypercortisolism with Cushingoid attributes, efficacy of drugs, hereditary diseases, i.e. the occurrence of obesity, diabetes, and high blood pressure in blood relatives,

- whether these factors persist to date.

Subjective obesity-related difficulties

Motivation to lose weight: health-related and other (risk factors – smoking)

Maximum weight in life (excluding pregnancy)

Weight reduction in the past: method of achievement and how long maintained

Eating habits: – typical day, – typical weekend, – shift work

Objective finding: with emphasis on the existence of goitres, discovery of striae, hernias and the dehiscence of primary stomach muscles.

Furthermore, careful measuring of height, weight, pressure and waist, BMI calculation, and a fatty tissue calculation in % and kilograms should ensue as well as the taking of a blood sample for biochemical examination carried out in accord with the recommended guidelines, as well as the assessment thereof.

In the next part of our examination of obese patient, we should conduct an educational interview as part of the treatment, particularly highlighting the recommendations as follows: reduction of energy balance in the first month at least by 500 to 1000 KJ, in the next month by 1500 to 2000 KJ, maintaining the reduction routine. The care should include guidance and advice on the suitable selection of food and dishes, the restriction of the amount of food by their energy value, maintaining more portions daily, not leaving out morning meals, not shifting evening portions to afternoons, finding time for eating. We should talk about the causes and severity of obesity, the need of walking at a quicker pace, taking the dog for a walk, work in the garden or riding a bicycle, swimming, exercises for the supporting joints, finding a suitable activity. The general practitioner should provide behavioural support by helping in self-development and setting out realistic goals. The level of weight loss should be discussed and regular checkups with proven measurements should be conducted.

If we fall within the criteria for possible pharmacotherapy application, we should consider what drug type to apply (Sibutramine, Orlistat or Phentermine). It is necessary to concentrate on eliminating the health risks accompanying such drugs accordingly. We should determine the contraindications of these drugs according to package leaflet information approved by SUKL (State Institute for Drug Control). Rimonabant (inhibitor CB1 receptors) is not registered in Czech Republic now.

Due to the central mechanism of efficacy, Sibutramine inhibits serotonin and noradrenalin reuptake on synaptic clefts, thereby physiologically extending their action time and reducing the intake of energy by increasing the feeling of saturation and increasing the expenditure of energy by stimulating the thermogenesis. We must however be careful when administering Sibutramine by making ourselves sure that the patient has not been using similarly acting preparations (IMAO, SSRI – as described in the contraindications) as serotonin syndrome can be evoked. Serotonin syndrome clinically manifests itself through gastrointestinal symptoms (nausea, vomiting, diarrhoea, and abdominal spasms), neurological symptoms (tremors, myoclonus, hyperreflexia, and increased muscle tension), cardiovascular effects (tachycardia, hypertension, and collapse), perspiration, mydriasis, hyperpyrexia, agitation, and manic syndrome.

We do not administer Sibutramine in decompensated and insufficiently controlled hypertension, however it is not a problem to administer it in treated, regularly controlled and compensated hypertension.

When administering Sibutramine – the starting dosage is 10mg daily, in the morning on an empty or full stomach. In patients whose response to treatment is insufficient (weight loss is less than 2 kg in 4 weeks), the dosage can be increased to 15mg daily, provided that the 10mg dosage was well tolerated.

In patients whose weight loss was less than 5 % of their previous weight, therapy should be terminated after three months. Therapy should also be terminated if they do not respond suitably to the 15 mg dose and lose less than 2 kg in 4 weeks. Therapy should be discontinued in patients who have gained weight by 3 or more kg, even if they did lose weight previously.

If there is a disease occurring concurrently and the clinical benefit is proven by improved lipid profile and modified glycaemia in Type 2 DM, the treatment should be continued. Treatment should not exceed one year.

It is also good to know that Sibutramine causes neither valve disorders, nor respiratory hypertension, it is neither neurotoxic, nor addictive, its adverse reactions are usually not serious, do not lead to treatment interruption and are reversible. During treatment a slight increase in blood pressure (2–3 mmHg) and heart rate (3–7 beats/min) can occur. For this reason it is recommended to monitor the blood pressure when commencing the treatment and during the course thereof.

Orlistat inhibits intestinal lipases, whereby the absorption of fat from foods is restricted by approximately 30 %. The restriction of resorption of fatty acids leads to a negative energy balance, which is a prerequisite for weight loss.

It is administered in a dose of 3x1 tablets daily containing 120 mg of active substance, at mealtimes. Primarily steatorrhea, accompanied by diarrhoea, is one of the adverse reactions in patients consuming excessive amounts of fat. Upon long-term administration, the adverse reactions subside.

When administering Orlistat, the contraindications are chronic malabsorption syndrome, cholestasis, allergy to preparation components, pregnancy, breastfeeding and it is not intended for children.

Phentermine is an anorectic drug with a psycho-stimulating effect and was used as an adjuvant in maintaining reduction diets. It is only for short-term administration of 4–8 weeks, but is nowadays not at all analysed by all experts in our recommended procedures due to the possible risk of adverse reactions (solitary

cases of irreversible respiratory hypertension and the onset of valve defects) and mainly due to the risk of addiction.

Today, these drugs (Sibutramine, Orlistat) do not burden the health system or outpatient costs as they are not covered by the insurance companies (partial cover is possible upon the meeting of strict criteria in diabetics stated in the Code List). Due to the fact that as of this year the price of these drugs has dropped down by one third of the original price when compared to the past year, there is now a chance for many other obese patients for whom the option of obesity pharmacotherapy was limited by these high prices.

It can be seen from the above that if we are going to take care of our patients in a comprehensive manner, i.e. care also for obese patients in line with the above cited recommended guidelines for general practitioners, patients will profit from this approach by reducing their obesity-related health complications and risks. In addition to this they will find more satisfaction in their lives, which will be beneficial not only to them but also to the members of their families. Ultimately also the health personnel will profit from such approach.

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