

Algorithm for the Assessment and Management of Childhood Obesity in Patients 2 Years and Older

This algorithm is based on the 2007 Expert Committee Recommendations,¹ new evidence and promising practices.

Assess Behaviors

Assess healthy eating and active living behaviors

Provide Prevention Counseling

5 (fruits & vegetables) 2 (hours or less of screen time) 1 (hour or more of physical activity) 0 (sugary drinks) every day!

Determine Weight Classification

Accurately determine weight and height, calculate and plot Body Mass Index (BMI) and determine BMI percentile.

Healthy Weight
(BMI 5-84%)

- Family History
- Review of Systems
- Physical Exam

Risk Factors Absent

Routine Care

- Provide ongoing positive reinforcement for healthy behaviors.
- For patients in the *healthy weight* category, screen for genetic dyslipidemia by obtaining a non-fasting lipid profile for all children between the ages of 9-11 and again between 18-21.²
- For patients in the *overweight* category, obtain a lipid profile.
- Maintain weight velocity:
 - Crossing 2 percentile lines is a risk for obesity⁴
 - Reassess annually
- Follow up at every well-child visit.

Overweight
(BMI 85-94%)

Augmented (obesity-specific)¹

- Family History
- Review of Systems
- Physical Exam

Determine Health Risk Factors*

Lab Screening

- The 2007 Expert Committee Recommendations¹ state that a fasting glucose and fasting lipid profile along with ALT and AST should be obtained.
- Additionally, guidelines from the ADA and Endocrine Society recommend using A1C, fasting glucose or oral glucose tolerance to test for diabetes or pre-diabetes. The ADA notes that there are presently limited data supporting A1C for diagnosing diabetes in children and adolescents; however, they are continuing to recommend A1C at this time.³
- For patient convenience, some providers are obtaining non-fasting labs.
- Clinical judgment, local preferences and availability of testing should be used to help determine the timing of follow up of abnormal labs.
- Of note, some subspecialty clinics are screening for Vitamin D deficiency and insulin resistance by obtaining labs for Vitamin D and fasting insulin. The clinical utility and cost effectiveness of such testing is yet to be determined.
- Currently, there are no guidelines on when to start laboratory testing for patients with obesity. Based upon the patient's health risk, some experts may start screening patients at 2 years of age.

Obesity
(BMI ≥ 95%)

Augmented (obesity-specific)¹

- Family History
- Review of Systems
- Physical Exam

Risk Factors Present

Obesity-related conditions: The following conditions are associated with obesity and should be considered for further work-up. Additional lab tests may be warranted if indicated by the patient's clinical condition.⁵ In 2014, consensus statements from The Children's Hospital Association described the management of a number of these conditions.^{6,7}

Dermatologic:

- Acanthosis nigricans
- Hirsutism
- Intertrigo

Endocrine:

- Polycystic ovarian syndrome (PCOS)
- Precocious puberty
- Prediabetes: Impaired fasting glucose and/or impaired glucose tolerance as demonstrated during a GTT
- Premature adrenarche
- Type 2 Diabetes

Gastrointestinal:

- Cholelithiasis
- Constipation
- GERD
- Nonalcoholic fatty liver disease or steatohepatitis

Neurologic:

- Pseudotumor cerebri

Orthopedic:

- Blount's Disease
- Slipped capital femoral epiphysis (SCFE)

Psychological/Behavioral Health:

- Anxiety
- Binge eating disorder
- Depression
- Teasing/bullying

*Based on behaviors, family history, review of systems, and physical exam, in addition to weight classification.

Management and Treatment Stages for Patients with Overweight or Obesity

- Patients should start at the least intensive stage and advance through the stages based upon the response to treatment, age, BMI, health risks and motivation.
- An empathetic and empowering counseling style, such as motivational interviewing, should be employed to support patient and family behavior change.^{8,9}
- Children age 2 – 5 who have obesity should not lose more than 1 pound/month; older children and adolescents with obesity should not lose more than an average of 2 pounds/week.

Stage 1 Prevention Plus

Where/By Whom: Primary Care Office/Primary Care Provider

What: Planned follow-up themed visits (15-20 min) focusing on behaviors that resonate with the patient, family and provider. Consider partnering with dietician, social worker, athletic trainer or physical therapist for added support and counseling.

Goals: Positive behavior change regardless of change in BMI. Weight maintenance or a decrease in BMI velocity.⁴

Follow-up: Tailor to the patient and family motivation. Many experts recommend at least monthly follow-up visits. After 3 – 6 months, if the BMI/weight status has not improved consider advancing to Stage 2.

Stage 2 Structured Weight Management

Where/By Whom: Primary Care Office/Primary Care Provider with appropriate training

What: Same intervention as Stage 1 while including more intense support and structure to achieve healthy behavior change.

Goals: Positive behavior change. Weight maintenance or a decrease in BMI velocity.

Follow-up: Every 2 - 4 weeks as determined by the patient, family and physician. After 3 – 6 months, if the BMI/weight status has not improved consider advancing to Stage 3.

Stage 3 Comprehensive Multi-disciplinary Intervention

Where/By Whom: Pediatric Weight Management Clinic/Multi-disciplinary Team

What: Increased intensity of behavior changes, frequency of visits, and specialists involved. Structured behavioral modification program, including food and activity monitoring, and development of short-term diet and physical activity goals.

Goals: Positive behavior change. Weight maintenance or a decrease in BMI velocity.

Follow-up: Weekly or at least every 2 – 4 weeks as determined by the patient, family, and physician. After 3 – 6 months, if the BMI/weight status has not improved consider advancing to Stage 4.

Stage 4 Tertiary Care Intervention

Where/By Whom: Pediatric Weight Management Center/Providers with expertise in treating childhood obesity

What: Recommended for children with BMI \geq 95% and significant comorbidities if unsuccessful with Stages 1 - 3. Also recommended for children $>$ 99% who have shown no improvement under Stage 3. Intensive diet and activity counseling with consideration of the use of medications and surgery.

Goals: Positive behavior change. Decrease in BMI.

Follow-up: Determine based upon patient's motivation and medical status.

References

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