The Physician Learning Program and the Office of Lifelong Learning

Championing Best Health: A Primary Care Series on Pediatric Obesity

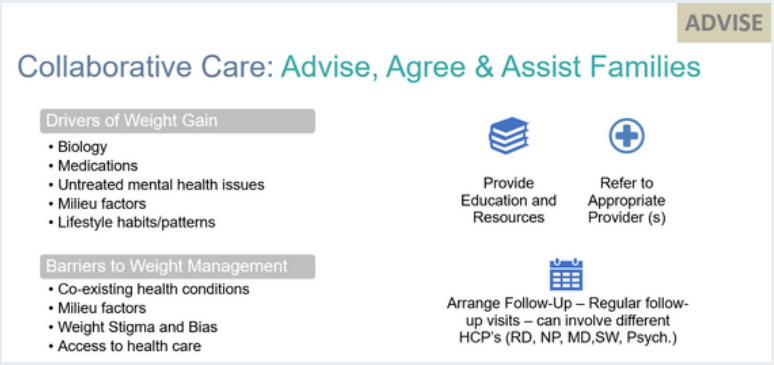
Exploring Treatment Options: What to Consider and When to Refer

Dr. Stasia Hadjiyannakis & Dr. Laurie Clark

Key Messages:

	Lifestyle	Medication	Surgery
Change in weight	1 to 5%	2 to 15%	20 to 40%

- Obesity is a heterogeneous, chronic, often treatment resistant disease
- There are 3 main types of weight management interventions: lifestyle management/health behaviour change, pharmacotherapy, and bariatric surgery.
- A comprehensive assessment of Obesity related complications, drivers and barriers is essential in order to guide an effective, meaningful management plan
- It is important to remember that not everyone with obesity needs to lose weight and not everyone with obesity will be healthier with weight loss
- The current available treatment options for children and adults living with severe complex obesity is limited. We need to be honest about what is possible through the interventions that we have available to us, much like we do with other chronic diseases.
- In establishing an intervention plan with families:
  - **AGREE** on desired health outcomes, sustainable and feasible goals, a care plan, and next steps.
  - **ASSIST** families in identifying and addressing drivers and barriers, provide education and resources, refer to appropriate providers, and arrange follow-up.



Mental Health	• Stress management • Body image • Self-confidence • Manage mood & mental health
Nutrition	• When, where & who we eat with • Hunger management – keeping our bodies fueled • Healthy relationship with food
Sleep	• Regular sleep & wake time • Good quantity & quality of sleep
Activity	• Opportunities for organized & free play • It's not about burning calories – it's about enjoyment, connection, feeling good in our bodies, & lifelong engagement in PA
Screen Time	• Decreasing recreational screen time

Behavioural and Psychological Interventions: Collaborative Care

- Individuals successfully engaged in lifestyle management efforts can experience improvements in physical and mental health, often in the absence of significant changes in weight
- Interventions should be family based - the whole family should engage in the changes rather than singling out one child in the family.
- Interventions should also be multicomponent, individualized, collaborative, and realistic

Talking About Lifestyle Change

- Normalize how difficult i is to have healthy behaviours in our current environment
- Normalize how difficult behaviour change can be - there will be ups and downs, and we may slip back into old habits at times
- Acknowledge the realities of living with obesity in our weight-obsessed society
- Use Motivational Interviewing techniques to elicit information on readiness for change, to guide intervention timing and managing expectations
- Choose long-term strategies & sustainable behaviours - Avoid quick fixes

The Physician Learning Program and the Office of Lifelong Learning

Championing Best Health: A Primary Care Series on Pediatric Obesity

Exploring Treatment Options: What to Consider and When to Refer

Dr. Stasia Hadjiyannakis & Dr. Laurie Clark

Behavioural and Psychological Interventions: Collaborative Care

1

Agree on Behaviour Change Outcomes

- Realistic Outcomes
- Parents & youth may have different health concerns and outcome goals
- Start with what we can all agree on – Can we agree to continue the conversation?

2

Agree on Sustainable Behavioural Goals

- Parents & youth may differ in their levels of readiness for change and in what they want to work on
- Use SMART goals:
  (Specific, Measurable, Achievable, Relevant, Time-bound)

3

Agree on Management Plan

- Everyone's roles and responsibilities should be clear
- May need to be direct in what we can expect youth to complete on their own and what parents will need to do to support them

SMART Goal Examples

Mental Health	Nutrition	Physical Activity & Screen Time	Sleep
Call ABC agency to request to see a therapist	Aim for 3 food groups at each meal	Add 20 minutes of outside time after dinner – whole family	In bed by 10:30 pm each night, no electronics in bed
Parents to email the school tonight to request a meeting about peer bullying issues	Aim for 3 meals and 2 snacks each day	Turn screens off by 8 pm on weeknights	Wake up by 9 am on Saturdays and Sundays
State 2 things you like about yourself when brushing your teeth in the morning.	Eat something (Anything!) for breakfast each school day	Family games night on Fridays	No screens in the bedroom – they charge overnight in Mom's room
Dad will speak to Grandma this weekend about refraining from weight talk.	Mom to pack extra snack for the bus ride home.	Ice skating 2x/week with dad – Monday and Wednesday evenings	Plan for moving bedtime – 10:45 pm for 4 nights, then 10:30 pm the next 4 nights, continue by 15 minute intervals every 4 days
Mom to remove the bathroom scale from the home tonight	Family meals 2x/week – schedule them on Sundays	Maximum 3 hours of screen time per weekday	
	No screens at dinner 5x/week		

The Physician Learning Program and the Office of Lifelong Learning

Championing Best Health: A Primary Care Series on Pediatric Obesity

Exploring Treatment Options: What to Consider and When to Refer

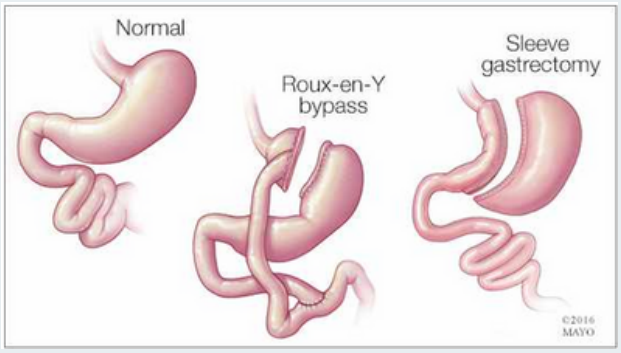
Dr. Stasia Hadjiyannakis & Dr. Laurie Clark

Pharmacotherapy

- **Setmelanotide/Imcivree** (FDA and Health Canada Approval)
  - ***Setmelanotide/Imcivree (FDA and Health Canada Approval)***
    - *Age 6 and older with:*
      - *POMC deficiency*
      - *PCSK1 deficiency (impaired POMC processing)*
      - *Leptin Receptor Deficiency*
      - *Bardet Biedl Syndrome*
      - *Outcomes: 80% lost more than 10% of their body weight*
- **GLP-1 Agonists**
  - **Liraglutide (*3mg sc daily*):**
    - Approved for 12 + years of age for weight management and for 10 + years for T2DM
    - Age 12-17, body weight of > 60 kg/m2 or > 27 kg/m2 with at least one weight related comorbidity
    - Reduction in BMI of at least 5% in 45% of patients
    - **Will be discontinued March 2026**
  - **Semaglutide(*2.4mg sc weekly*):**
    - Approved for 12 + years of age for weight management and 18 + years for T2DM
    - Age 12- 17, body weight of >60 kg; BMI > 30 kg/m2 or > 27 kg/m2 with at least one weight related comorbidity
    - Mean change in BMI 16.1%
    - A BMI reduction of at least 5% in 77% of patients
  - **Naltrexone-buproprion/Contrave**- Approved for 18 + years of age for weight management
  - **Orlistat/Xenical**- Approved for 12 + years of age for weight management
  - **Metformin**- off label use

Bariatric Surgery

- BMI greater than 40 kg/m2 OR BMI greater than 35 kg/m2 with clinically significant complications (OSA; T2DM; IIH, NAFLD, Blount Disease, SCFE, GERD, HTN)
- Outcomes (3 years): 29% reduction in weight (mean 8 year follow up); 95% resolution of T2DM; 74% resolution of HTN; 66% resolution of dyslipidemia
- Complications
  - Mortality – 0.3%
  - Minor surgical complications – 15%
  - Major surgical complications - 8%
  - Micronutrient deficiencies- (Fe – 66%; B12 8%; folate 6%)



Resources:

- **Clinical Practice Guidelines for Pediatric Obesity** - Obesity Canada
- Ball GD, et al. **Managing obesity in children: a clinical practice guideline.** CMAJ. 2025;197(14):E372-E389. DOI: https://doi.org/10.1503/cmaj.241456