The treatment of obesity: Past, present and future

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Welcome to the inaugural edition of the *British Journal of Obesity*, launched by the National Obesity Forum in conjunction with the Obesity Management Association. The journal can trace its ancestry back to *Obesity in Practice*, which existed until around 2008 and was dedicated to supporting clinicians in the day-to-day management of the condition. The Editorial Board will be looking for and requesting articles, for peer review, from those active in the field of obesity management who have experience to share, even if they have little or no experience in publishing papers. We warmly welcome commercial slimming groups, whose role is often undervalued, and would appreciate the support of pharmacists, who have an important responsibility in weight management.

NOF would also like to thank the Obesity Management Association for collaborating in this venture. OMA represents private slimming clinics in the UK and strives to ensure that best practice takes place, aligning private clinics with commercial groups and NHS efforts to ensure that everyone has access to top-quality care.

The history of obesity

Obesity has existed ever since civilisation has been recorded. The Venus of Hohle Fels, a crude statuette of a naked obese woman, is estimated to be 35 000 years old – 10 000 years older than her more famous cousin, the Venus of Willendorf. The recorded history of the treatment of obesity goes back thousands of years: in 500 BC, the ancient Indian surgeon Sushruta described "obesity, voracity, gloss of the body, increased soporific tendency and inclination for lounging in bed or on cushion" (Bhishagratna, 2006). Avicenna, the great Persian physician, prescribed an appetite suppressant for his obese patients, based on sweet almonds, beef suet, violets and marshmallow. Hippocrates said, "Men who are constitutionally very fat are more likely to die quickly than those who are thin." Galen of Pergamon, physician to several Roman Emperors, described the polysarkos phenotype, who "cannot walk without sweating, cannot reach when sitting at the table because of the mass of his stomach, cannot breathe easily, cannot give birth, cannot clean himself" (Papavramidou et al, 2004). Galen also produced an early case report:

> *"I reduced a huge fat fellow to a moderate size in a short time, by making him run every morning until he fell into a profuse sweat; I then had him rubbed hard, and put into a warm bath; after which I ordered him a small breakfast, and sent him to the warm bath a second time. Some hours after, I permitted him to eat freely of food, which afforded but little nourishment; and lastly, set him to some work which he was accustomed to for the remaining part of the day."* (Green, 2012)

Obesity in the present day

Clearly, obesity has been treated in primary care for many centuries. Although some of the dietary and activity advice has changed little since Galen's time, modern healthcare professionals might balk at rubbing fat people hard and then bathing them. Managing obesity has always been a challenge for primary care, but until the last 30 years obesity has been the exception rather than the rule. Now overweight and obese individuals outnumber their lean counterparts by two to one, people with a BMI of 40 kg/m^2 or more comprise almost 5% of the population and some with a BMI of 100 kg/m^2 are being encountered in specialist clinics. Obesity has become very common and highly complex; the number of comorbidities grows with an individual's size and the management needs for

diabetes, cardiovascular disease, sleep apnoea, skin rashes, etc., grow in parallel.

Our ostentatious "*British Journal*" title was chosen to mark the fact that obesity is almost entirely seen and managed in the community; therefore, the responsibility is greatest, and the knowledge most distilled, in the day-to-day management of the obese individual. Roughly a quarter of the population is obese, and almost two-thirds carry excess weight. Each obese person uses more time in primary care than lean individuals owing to the high chance of comorbidities. Primary care has the advantage of excellent access to the obese population: everyone – with only a few exceptions – attends primary care, maybe only for contraceptive advice or holiday jabs, but nevertheless they are in a situation where their general health should be a consideration, where identification and screening should naturally occur and where engagement and motivation should take place. This journal aims to assist at that doctor–patient interface as well as provide advice on using community services, setting up Tier 2 and 3 services, and managing obesity in the community.

There is a broad range of excellent obesity journals worldwide – the *International Journal of Obesity*, *Obesity Reviews*, *Clinical Obesity* and many more – which publish hifalutin research papers based on a tiny number of obese volunteers who enter study after study in attempts to lose weight and who have long ago forsaken primary care's efforts. The BJO will report these studies, if they apply to our Monday morning clinics, and will provide expert interpretations on how best to apply the evidence within. There will be no rat studies in this journal!

There is confusion within the world of commissioning: Tier 4 obesity management services are currently under the auspices of NHS England, whereas Tier 3 lies with the Clinical Commissioning Groups. What of Tiers 1 and 2? What are the roles of Local Authorities and Health and Wellbeing Boards, if any? And what does any of this matter if there is no political will or ring-fenced financial resource to make a difference anyway? Currently, there is a hopeless postcode lottery for Tier 3 services, and the Quality and Outcomes Framework is staggering along like a dying elephant. Whichever doomsday scenario occurs, however, obese individuals will continue to turn up to primary care in increasing numbers as the obesity trend translates into an epidemic of diabetes, heart disease, sleep apnoea and other diseases. The BJO will help equip primary care for this eventuality.

The role of primary care in obesity management is very broad and arduous, and the physiology of obesity and its relationship to metabolic syndrome and comorbidities is complex. The novel science of gut microbes, epigenetics, incretins and so on is daunting. Primary care is involved from the moment of identification of obesity, and the engagement of the individual, to the immediate post-bariatric surgery care of people whose diabetes is rapidly resolving only a few days after the procedure yet who are still on insulin. Primary care must embrace techniques such as motivational interviewing, behavioural and psychological interventions, diet and physical activity methods and pharmacotherapy, and clinicians should have a working knowledge of bariatric surgery. ■

Bhishagratna KK (2006) *The Sushruta Samhita: An English Translation Based on Original Texts*. Cosmo Publishing, Delhi, India

Green RM (2012) *A Translation of Galen's Hygiene: De Sanitate Tuenda*. Literary Licensing LLC, Whitefish, MT, USA

Papavramidou NS, Papavramidis ST, Christopoulou-Aletra H (2004) Galen on obesity: etiology, effects, and treatment. *World J Surg* **28**: 631–5

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