Diagnosis and treatment of obesity in the elderly

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Record Status
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Citation

Authors' objectives
To examine the data for the effectiveness of obesity diagnosis and treatment in the elderly, we conducted a systematic review of policy-relevant obesity diagnosis and treatment options in this group.

Authors' conclusions
Body mass index (BMI) is an adequate measure of body fat percentage in the elderly. Waist circumference (WC) and waist-to-hip ratio (WHR) provide additional information, particularly for identifying people at high cardiovascular risk. Skinfold thickness is a less desirable measure.

While, currently, there are no data directly measuring the effect that weight loss intervention has on mortality, intentional weight loss can serve as a valid marker for certain improved cardiovascular-related endpoints. Diabetes and blood pressure control are also important health problems, independent of their link to cardiovascular disease. Possibly, additional benefits may be realized regarding cancer and functional disability. However, weight loss is also linked with adverse bone-related consequences.

The obese elderly most likely to benefit from weight loss are those with cardiovascular-related disease, or at high risk for these disorders. Those with high risk of cancer or functional decline may benefit as well. However, slowly developing disease processes and lack of reliable disease intermediaries makes evidence for cancer benefit difficult to establish. Intentional weight loss should be pursued with caution in the elderly with high osteoporosis risk. Among those with mixed risk patterns (e.g., cardiovascular and bone-related risk), relative benefits versus harms can only be individually assessed.

Overall, these findings reflect data from relatively healthy men and women; while race-specific data are limited, black participants’ cardiovascular-related benefit from intentional weight loss appears similar to that of white participants. Modulation by ethnicity or underlying health status is unclear. As the relationship between all-cause mortality risk and obesity recedes with age and is absent after about age 74, any potential all-cause mortality benefit of weight loss programs likely diminishes as well. The relationship between morbidity or disease-specific mortality and obesity has not been assessed for age-related change in older adults.

Dietary interventions can promote clinically significant weight loss (2-3 kg.) in the aged over 1-3 years. Data reflect low calorie, often relatively low-fat diets, delivered with behavioral theory approaches. While we did not evaluate physical activity as an independent variable influencing obesity in the elderly, all successful dietary interventions included physical activity components, and physical activity may help offset the risk of bone loss found with intentional weight loss programs. These conclusions are based on efficacy (rather than effectiveness) data. Minimal data assessed harms of such counseling-based treatment. Data are insufficient to assess the safety or efficacy of bariatric surgery in the obese elderly.

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