RCGP

Addressing an overweight child and an unaware parent in the General Practice Consultation

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KEY MESSAGES

- GPs can play a key role in tackling the current obesity epidemic, especially helping parents who may not realise their child is overweight
- In a ten-minute consultation, GPs should explore a parents ideas, concerns and expectations about food and exercise and build a picture of the home environment
- Exclude medical causes of overweight and plot height and weight on a growth chart
- Offer practical strategies, achievable goals, agree follow up and involve the multi-disciplinary team for support

WHY THIS MATTERS TO ME

Childhood obesity is a global epidemic that has significant impact on the physical and psychological health and development of children, and often persists into adulthood where the health sequelae are well known. Parents are key players in putting healthy living advice into practice but our recent systematic review showed that parents are poor at recognising overweight in their own children. We believe GPs are key in providing health promotion to this group. However, to approach this sensitive subject requires confidence and skills at one's fingertips and we hope this guide can provide this.

One in four children in the EU is overweight.[1] Public health policy makers and clinicians agree that there is a clear imperative to target primary prevention for the entire population in early childhood to curb the obesity epidemic,[1] and identify and treat overweight children at risk of becoming obese.[2,3] Whilst very recent data suggests the epidemic may be beginning to level off, the current trends of excess weight are still unacceptably high and we must not become complacent[4,5].

Primary care has a role in primary prevention and may be able to engage those families who have not yet responded to campaigns such as Change for Life and 5 a day.

Indeed our recent research has shown that parents are poor at recognising overweight in their children,[6] and in the absence of population based screening, GPs may need to identify those children at risk of obesity.

There is a wealth of research emphasising that childhood overweight is detrimental to a child's physical and psychological health,[7-9] and continues to make a significant impact in adulthood.[8, 10, 11] he challenge in primary

care is addressing this emotive subject within the time constraints of a consultation and balancing education with practical strategies and solutions, especially if paediatric obesity is not the parent's main objective.

The following case study provides a framework for use in a GP consultation to help address childhood overweight with an unaware parent.

CASE HISTORY

A mother brings her 4-year-old son Adam to your surgery. She is concerned about his poor eating. Mealtimes are a "battleground". You notice he is clearly overweight. During the consultation he throws a toy – his mother says "if you're good, I'll buy you sweets."

ISSUES TO COVER

- Tackle both her concern of poor eating and childhood overweight. Few interventions have proven benefit in treating childhood obesity and therefore it is critical to raise the issue of weight with Adam's mum before he becomes obese.
- Be curious about her worries with mealtimes. When does he eat? What does he eat and what are his portion sizes? How does he eat? Is this too fast or too slowly? How does this fit with her expectation? Listen carefully to her concerns.
- Ask about the family eating environment – Do they eat together, at a table, in front of the TV? Ask about Adam's and his family's activity levels.
- Check if he has met developmental milestones. Developmental delay and obesity may point to an underlying pathology e.g. hypothyroidism, Prader-Willi etc. If there are any symptoms or clinical signs check urine for glucose and blood tests including liver and thyroid function tests, fasting glucose and consider referral for further investigation.
- Ask about family and environmental factors including Adam's size in relation to his parents and siblings, or any family history of obesity, thyroid disease or diabetes.
- How does Adam fit in socially at nursery or school? Being overweight may result in social discrimination and may in turn impact negatively on self esteem
- Plot his body mass index on a growth chart. This provides an objective way of demonstrating to parents where their child lies on the bell curve. Ask mum if she thinks this could be a problem. Explain that this needs to be repeated after 3 months. If mother does not accept that Adam is overweight do not jeopardise a good relationship. Perhaps the health visitor could broach this again at a later opportunity.

THINGS TO DO

- Congratulate Adam's mother on recognising the problem and ask her what input she would like from you.
- Discuss need for clear boundaries around mealtimes. Focus on eating behaviours (eat breakfast, lunch and dinner, stop snacking). Ask his mother to identify times when she is able to achieve this and how the family might support her. Encourage family meals. If they can't eat together every day suggest a special effort at least once a week, building up over time. This allows children to see parents trying different things and avoids focusing on food.
- Discuss healthy lifestyle behaviours for the whole family.[1] Don't focus on weight loss or the difficult eater (see box).
- Discuss definitions[3] and health consequences for overweight and obesity e.g. raises the chances of cardiovascular disease and diabetes.
- Involve the dietician and health visitor. Refer to a paediatrician if suspicious about underlying pathology. Consider community psychology for management of mealtimes or eating behaviours.
- Be a healthy role model yourself.Calculate your own BMI today and do something if you are overweight. Promote healthy living in your surgery – healthy recipes, community activities. Show your activities in your consultation room e.g. the fun run you participated in.
- Arrange a time to meet again to discuss progress, successes and difficulties. Be positive about changes made. Plot weight and height after 3 months but don't focus on weight loss as a measure of success before this.

Useful reading:

www.nhs.uk/change4life/
www.nationalobesityforum.org.uk
International reference ranges for child obesity: Cole TJ, Bellizzi MC, Flegal M, Dietz WH. *Establishing a standard definition for child overweight and obestiy worldwide: international survey*. **BMJ** 2000; 320:1240-3 (http://www.bmj.com/cgi/content-nw/full/320/7244/1240/TA2)

Healthy Lifestyle Ideas:

- Find creative ways to ensure everyone in the family eats five portions of fruit/vegetables a day.
- Clear the house of calorie dense foods (e.g. crisps, sweets).
- Decrease sedentary behaviour by restricting computer and television time and increase lifestyle physical activity (e.g. walking to shops and school).
- Set quantifiable goals together and invite parents to monitor the family's positive changes e.g. using a star chart for low, medium (e.g. walking to school) and high energy activities (football, running in the park). Aim for 60 minutes activity per day.
- Reward children for good behaviour by spending time with them and praise e.g. story time rather than with food.

REFERENCES

1. Lobstein, T., Baur, L., & Uauy, R., for the IOTF Childhood Obesity Working Group. Obesity in children and young people: A crisis in public health. Obesity Reviews. 2004; 5, 4–85.
2. Dehghan, M., Khtar-Danesh, N., & Merchant, A. (2005). Childhood obesity, prevalence and prevention. Nutrition Journal. 2005; 4, 24.
3. Muller, M. J., Mast, M., Asbeck, I., Langnase, K., & Grund, A. Prevention of obesity—Is it possible? Obesity Reviews. 2001; 2, 15.
4. McPherson K, Brown M, Marsh T and Byatt T. Obesity Recent Trends in Children Aged 2-11 and 12-19. National Heart Forum. Accessed 09/11/09. Available from http://www.heartforum.org.uk/
5. McPherson K, Brown M, Marsh T and Byatt T. Obesity Trends for Children Analysis from the Health Survey for England 1993-2007. National Heart Forum. Accessed 09/11/09. Available from http://www.heartforum.org.uk/
6. Parry, L.L., Netuveli, G., Parry, J., Saxena, S. A systematic review of parental perception of weight status in children. JACM. 2008; 31(3), 252-267
7. Dietz, W. H. Health consequences of obesity in youth: Childhood predictors of adult disease. Pediatrics.1998; 101, 518–525.
8. Reilly, J. J., Methven, E., Mcdowell, Z. C., Hacking, B., Alexander, D., Stewart, L., et al. Health consequences of obesity. Archives of Disease in Childhood. 2003; 88, 748–752.
9. Zametkin, A. J., Zoon, C. K., Klein, H. W., & Munson, S. Psychiatric aspects of child and adolescent obesity: A review of the past 10 years. Journal of the American Academy of Child and Adolescent Psychiatry. 2004; 43, 134–150.
10. American Diabetes Association. Type 2 diabetes in children and adolescents: Consensus statement. Diabetes Care. 2006. 23, 381–389.
11. Serdula, M. K., Ivery, D., Coates, R. J., Freedman, D. S., Williamson, D. F., & Byers, T. Do obese children become obese adults? A review of the literature. Preventative Medicine. 2003; 22, 167–177

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