UPCOMING ACTIVITIES

August 31, 2017, Thursday
PASOO 23RD ANNUAL CONVENTION
Theme: Save Organ Systems, Stop Obesity Swiftly (SOS)
EDSA Shangri-La Hotel, Mandaluyong City

September 1-7, 2016
Obesity Awareness and Prevention Week

September 22 , 2017
PASOO Exercise is Medicine (EIM)
Exercise Prescription Course for Primary Care Physicians
Monet, Novotel Araneta Center, Quezon City

October 4-6 , 2017
Asia-Oceania Conference on Obesity (AOCO) 2017
October 4-6, 2017, Adelaide Convention & Exhibition Center, Australia

October 11 , 2017
World Obesity Day

9th Obesity Workshop
Baguio / 1st Quarter 2018

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(Not in photo Dr. Celeste C. Tanchoco, RD, DrPh)

PASOO Secretariat:
Unit 2502, 25/F Medical Plaza Ortigas, San Miguel Avenue
Pasig City, Philippines 1600
Telephone Nos: (632) 632-1533 / 359-9268
Telefax: (632) 632-1533
Mobile No.: 09985145486
E-mail: sec@obesity.org.ph
Website: www.obesity.org.ph

OUR MISSION
Pioneer in the prevention & control of obesity & its complications through education, research & advocacy

OUR VISION
An obesity risk-free nation

Philippine Association for the Study of Overweight and Obesity
Member of the World Obesity Federation

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OBESITY ALERT NEWSLETTER
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Philippine Association for the Study of Overweight and Obesity
Member of the World Obesity Federation

PRESIDENT'S MESSAGE

EDGARDO L. TOLENTINO, JR, MD, FPPA
President, PASOO
Chairman, Dept. of Psychiatry & Mental Health
Quirino Memorial Medical Center

On the occasion of the 23rd anniversary of the Philippine Association for the Study of Overweight and Obesity (PASOO), what we do as an organization and what we envision with other like-minded organizations following a multi-disciplinary approach has become even more acutely relevant and urgent.Alarm bells have been sounded off as a joint report by the United Nations International Children's Emergency Fund (UNICEF), World Health Organization (WHO), and Association of Southeast Asian Nations (ASEAN) have found that: In the Philippines, overweight children below five years old has become rampant, listing a 400% percent increase from 1% in 1992 to 5 percent in 2013.

Meanwhile, wasting, being underweight, and stunting remain high at 8 percent, 20 percent, and 30 percent, respectively.

Middle-income countries including the Philippines, Indonesia, Malaysia, and Thailand face the "double burden of malnutrition." According to the same report, the rise in overweight and obese children is also blamed on the increased consumption of processed food that is high in sugar and fat, as well as physical inactivity and an idle lifestyle.

The National Nutrition Survey of the Food and Nutrition Research Institute (FNRI), on the other hand found that the number of obese Filipino adults increased by 14.5 percentage points, from 16.6 percent in 1993 to 31.1 percent in 2013. This means that three out of 10 Filipino adults are obese.

Over the last decade, the Philippines lost nearly P2.8 billion due to coronary heart disease, stroke, cancer, type 2 diabetes,and disease, stroke, cancer, type 2 diabetes, and musculoskeletal disorders.The estimate almost doubled by 2015, according to the report. The estimate almost doubled by 2015, according to the report. Thus, the theme for this annual convention is apt as it is timely: "Save Organ Systems, Stop Obesity Swiftly (SOS) underlining the urgency of fighting the modern scourge of overweight and obesity due to its dire consequences expressed in various diseases.

It is the stated mission of PASOO to be the pioneer in the prevention and control of obesity and its complications through education, research, & advocacy. Join PASOO in our vision for an obesity risk-free nation. Our future at stake!

EDGARDO L. TOLENTINO, JR, MD, FPPA
President, PASOO

member of WORLD OBESITY federation

What's inside?

What's Inside

MICHAEL D. ROSARIO, MD, FPSEDM
Board Member, PASOO

Empowering OBESITY Warriors

Obesity is a problem that literally keeps getting bigger. The numbers continue to rise and the affected groups are getting younger. In a joint report issued by UNICEF, WHO and ASEAN, the number of overweight children below 5 years old in our country has increased by 400% from 1% in 1992 to 5% in 2013. Obesity is a multi-faceted problem and the approach should be holistic and multi-disciplinary.

This approach to Obesity is what is being championed by PASOO. Last June 3, 2017, PASOO held an Intensive Obesity Workshop in Iloilo city, which exemplified this multi-pronged strategy. It started with the complete initial evaluation of an obese patient from measurements to diagnostic tests to nutritional evaluation and identifying barriers to lifestyle modifications. The second part focused on the management of obesity. This included lifestyle modifications such as dietary intervention and exercise prescription before ending with more advanced measures such as pharmacotherapy and bariatric surgery.

It is in this same spirit that we present to you Obesity Alert 2017. Our authors are experts from various disciplines involved in the management of Obesity. The topics are diverse ranging from intriguing concepts to helpful and practical interventions to possible future trends in this field. We do hope these articles will guide, educate and even inspire you to be more active in identifying and tackling this problem in your own ways.

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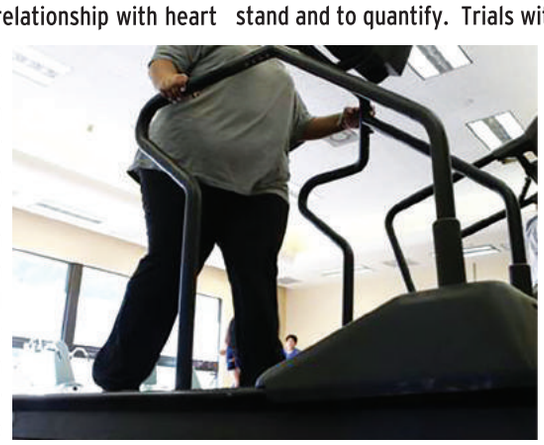
The OBESITY Paradox

Rogelio V. Tangco, MD
Cardiologist, Manila Doctors Hospital
Head, Cathlab, UP-PGH
Editor, The Filipino Internist

The obesity paradox in sum: obesity is a foe in health, but a friend in disease. We all know the harmful cardiometabolic effects of the hormones of fat cells, like angiotensinogen (hypertension), insulin like growth factors (diabetogenic), or leptin (proinflammatory). It is however observed that in certain disease, even malignancies, the obese and the overweight outlive those with normal weight and underweight. Indeed some are saying it is not a paradox but a paradigm.

In study after study, overweight and moderately obese patients with certain chronic diseases were often observed to live longer and fare better than normal-weight patients with the same ailments. The accumulation of evidence is inspiring some experts to re-examine long-held assumptions about the association between body fat and disease. It is well established that although obesity puts people at greater risk of developing kidney cancer, researchers found that among patients with kidney cancer, those with higher body mass index (BMI) had a longer survival. In the early 1980s, a team in France found that dialysis patients with advanced kidney disease had fewer cardiovascular complications and longer survival times if they were overweight. Still another study among patients undergoing non-bariatric general surgery, there was lower risk of death in the overweight and moderately obese patients. Even more astounding was an unadjusted analysis that found extremely obese critically ill patients in intensive care units had lower mortality. Boston University researchers discovered that overweight or mildly obese had better survival after stroke than normal weight participants and the survival benefit was strongest in males or in those younger than age 70. How does obesity enhance survival?

One of the first descriptions of the obesity paradox was when better outcomes was observed in overweight and obese patients undergoing percutaneous coronary intervention compared with normal-weight counterparts. Similarly, obese and severely obese patients after coronary artery bypass grafting had lower risk of reintubation, reexploration, prolonged stay in the intensive care unit, and 30-day mortality than patients with low BMI. In a 2014 meta analysis, cardiovascular mortality risk was lowest among overweight patients with a high BMI (25-30 kg/m2) compared to people with a normal BMI (20-25 kg/m2). Obese patients with acute venous thromboembolism have less than one-half the mortality in normal-weight subjects. In addition, in this cohort major nonfatal bleeding complications was more frequent among underweight patients. In the Digitalis Investigation Group Trial, data from 7,767 outpatients with stable heart failure followed up for 37 months, the risk of death was lower for both overweight and obese patients compared with normal-weight patients. On the other hand, among those with congestive heart failure, underweight patients (BMI < 18.5 kg/m2) were at increased risk of death. BMI, it appears, has a J curve relationship with heart failure risk and paradoxically an inverse relationship with heart failure related mortality. Importantly, one must distinguish between intentional weight reduction (as happens with diuresis and dietary modification) which results in improvement in cardiac indices, and nonintentional weight loss in heart failure, a harbinger of bad prognosis in heart failure -- the so-called state of cardiac cachexia. When nonintentional weight loss occurs in heart failure it is associated with high mortality and morbidity, more symptoms, deteriorating status and poor quality of life. How cardiac cachexia evolves remains unclear, but the role of tumor necrosis alpha from adipose tissue has been implicated in inducing a catabolic state. TNF has direct cytotoxic effects on the myocardium by virtue of its ability to trigger apoptosis directly or by enhancing the expression of proto-oncogenes. The J shaped curve between BMI and heart failure may be true for malignancy and chronic diseases as well. There may be reduced risk in those who are in the overweight category compared to the normal weight category, however when the maximum BMI or abnormally low BMI was reached, the paradox disappears.



Others have suggested that the obesity paradox is but a statistical illusion. They argue that any apparent obesity paradox might simply reflect "reverse causation" in which the normal weight sample is disproportionately composed of respondents who have experienced both rapid weight loss and elevated mortality risk from preexisting health conditions. Is it possible, some argue, that those who are obese and overweight are given more optimal medical therapy and thus have less mortality. A large observational study looked at body composition rather than BMI, they showed that higher lean body mass was associated with 29% lower mortality, and that although higher fat mass also exhibited survival benefits, this advantage disappeared after adjustment for lean body mass. Still another study discovered that a person's BMI had a bearing on the oncogene expression. In kidney cancer patients, they found lower expression of the gene FASN in people who were obese, and that the result of this altered gene expression is slower-growing kidney tumors. Research in tumor necrosis factor in heart failure is rather dated, maybe for a reason, it is a very complex cytokine to understand and to quantify. Trials with antagonists of TNF have failed to go beyond experimental levels. The current frontier in obesity research are interventions that aim to transform the harmful white fat of viscera to beige fat, a more metabolically active histotype.

For now, it is best not to encourage more obesity among our patients with heart disease, cancer or other medical illness. Better to observe for nonintentional weight loss, and to encourage fitness, if fatness cannot be curbed.

OBESITY: Sense of EMPOWERMENT ?

Acd. Ramon F. Abarquez, Jr. MD, NAST, EFACC, FAsCC, FPCP, FPCC, CSPSH
Professor Emeritus, College of Medicine, University of the Philippines
System Academician, National Academy of Science and Technology

Obesity is not only a 'stand-alone' risk, but also a major "metabolic syndrome" component. Mechanisms that contribute to the pathogenesis of Metabolic Syndrome remain under intense investigation including fetal programming, disharmony of the stress system and the development of a pro-inflammatory and pro-thrombotic state as a result of dysregulation from excessive adipose tissue1. Magnesium's effect on serum glucose, HDL-cholesterol, and triglycerides levels, on blood pressure, might play an important role in metabolic syndrome2.

Yet, a significant number of subjects reported a family history of hypertension (8.0%), obesity (5.4%), diabetes (3.3%) and stroke (1.4%), with 14.6% NCDs with higher diastolic BP, cholesterol, uric acid and obesity. Familial obesity begets higher BMI while familial diabetes begets higher BMI, glucose, cholesterol, triglycerides and uric acid3.

Compared to a control group, subjects who had a family history of Metabolic Syndrome had a higher mean daytime Systolic Blood Pressure (121.5 mmHg vs. 113.3 mmHg, $p < 0.035$), mean-daytime diastolic blood pressure (79.0 mmHg vs. 74.5 mmHg, $p < 0.045$), and mean nighttime DBP (64.0 mmHg vs. 59.5 mmHg, $p < 0.019$). It was also observed that in the group with the family history of Metabolic Syndrome, more than 50% had excess weight or a lipid disorder as well4. Familial Metabolic Syndrome begets higher daytime mean SBPs, (8.2 mmHg) affecting BP control. Overall, it affects endothelial function and as a risk factor it results in control problems.

Treated hypertensive individuals with a positive Family History of Coronary Heart Disease reported similar longitudinal BP reduction compared to those with a negative Family History. Yet their all-cause and CV mortality independent of baseline risk factors were worse. Inclusion of Family history of CVD did not improve mortality risk discrimination over and above traditional risk factors5.

SHOULD WE PRIORITIZE SCREENING THEN, IN THOSE WITH 'FAMILIAL RISK CLUSTER HISTORY?

LIFESTYLE MODIFICATION:

Lifestyle modification has been shown to benefit cognitive function and school achievement in children of normal weight. To see if this also applied to overweight or obese children, a systematic review was done. No evidence suggested an effect of any lifestyle intervention, among youngsters, on reading, vocabulary and language achievements, attention, inhibitory control and simultaneous processing. Heterogeneity was present within some meta-analyses6.In another systematic review, the effects of diet, physical activity and behavioral interventions for the treatment of overweight or obese children were assessed. It showed that in may help in achieving small, short-term reductions in BMI, BMI z score and weight.

The quality of the evidence was low or very low. The heterogeneity observed across all outcomes was not explained by subgrouping7. Where is the evidence for Lifestyle Modification?

Yet, Lifestyle Modifications are likely to be more effective when delivered to the whole family than to individuals, encouraging communication among the family unit, addressing common structural and environmental conditions8. However, "how cardiovascular interventions can be developed in a culturally appropriate manner in family settings has not been explored in a systematic way"9. Does individual motivation and compliance matters?

SENSE OF EMPOWERMENT:

Participants value the recruitment strategy wherein their "own risk assessment" and not merely "to whom – it- may – concern" format was a strong motivator. "Learning new skills" is a "sense of empowerment." Receiving regular progress reports was a means of self-assessment, accomplishment and a motivator to continue compliance commitment. 'Generic' strong family and community support contributed to personal motivation and sustained practice10. The six-minute-walk test is an objective self-progress assessment of functional capability which can assess the effectiveness of Lifestyle Modifications intervention, rather than dependence on 'too-late' subjective symptom interpretations, since 'silent-functional deterioration' does occur. Even with the use of implanted acute heart attack sensor, the positive predictive value was only 37% and the FDA estimated a false-negative rate of 40%11. Modern technology has its limitations.

CONCLUSION:

If merely 37% symptomatic acute coronary attack can be detected at best using implanted sensors while missing 40%, the Six-minute-walk test may be or should be an 'obesity-empowerment'. Lifestyle Modifications with usually symptomless Metabolic Syndrome is a challenging clinical enigma.

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PROTEIN QUALITY, NOT QUANTITY:

A NEW DIRECTION TO SLOWING PROGRESSION OF CKD

CELESTE C. TANCHOCO, RND, MPH, DrPH
Past President, Nutritionist-Dietitians Association of the Philippines'
Board Member, PASOO
Consultant, Food and Nutrition and Research Institute

Researches have shown that controlling diabetes, hypertension, and obesity can help prevent CKD. Dietary modifications are important to addressing these risk factors.Studies have shown that protein balance may also be the key up preventing progression in those already showing signs of kidney damage.

PROTEIN IN CKD

The major end products of protein metabolism are non-protein nitrogen such as urea, uric acid as well as sulfate, creatinine, organic acids, carbon dioxide and water which are normally eliminated through the kidneys.When the kidneys are not functioning normally, these waste products are not excreted properly and nitrogen accumulates in the blood and tissues, causing anorexia, nausea, and vomiting, drowsiness and a general feeling of ill health. Thus, in renal patients, the protein intake must be restricted.

Protein restriction has long been a major and controversial issue in CKD management. Current recommendations vary, but generally it's recommended that CKD patients restrict protein intake to 0.8 g/ kg body weight per day, the Recommended Dietary Allowance. According to Michael Conrad , MD of the Center for Kidney Care in New Jersey " In the past, severe restriction (less than 0.6 g:/kg) was believed to slow progression but the diet was very restrictive and there were complications associated with it, including malnutrition ". Then in 1994, the Modification of Diet in Renal Disease study was published in The New England Journal of Medicine. Two large clinical trials found that reducing total protein intake made very little difference in kidney disease progression, and a very low- protein diet didn't slow further progression.

One of the reasons dietary proteins are restricted in CKD patients is its effect on renal acid load.The kidneys remove acid fromthe blood and excrete it in the urine. In a study of Donald E. Wesson, MD of Texas A & M College of Medicine, in rats, the more acidic the diet, the worst its effect on kidney functions. Metabolic acidosis is known to contribute to GFR decline and is associated with a furtherincrease in the already high rate of CVD- related mortality in CKD patients.In animal models of kidney disease, bicarbonate administration has been found to slow progressive GFR decline even if the animals don't have acidosis.

These findings suggest that high dietary acid load itself might contribute to kidney disease progression.

Research by Wesson et al, suggests that the issue may be not the quantity of protein but the quality. While animal proteins increase acid load , the metabolism of plant-sourced proteins, yields base (alkali). Wesson and colleagues in a 2013 study, found the alkali-producing fruit and vegetable intake improved metabolic acidosis and reduced kidney injury in stage 4 CKD. A comparison group that received sodium bicarbonate had similar outcomes but sodium bicarbonate supplements can raise blood pressure, which may further damage the kidneys.

Fruits and vegetables may contribute potassium and lead to hyperkalemia in patients with CKD.Thus, increasing fruits and vegetables in CKD stages 1 to 3 may help slow disease progression by lessening renal acid load but this approach is not recommended for patients in stages 4 or 5 at this time.

A 2017 meta-analysis in the Clinical Journal of the American Society of Nephrology concluded that dietary patterns higher in fruits and vegetables, fish, legumes, cereals, whole grains, and fiber and lower in red meat, salt, and refined sugars were associated with lower all- cause mortality in patients with CKD.

KIDNEY FUNCTIONS AND PATHOPHYSIOLOGY

The three major functions of the kidneys are to excrete the waste products of protein breakdown; to regulate the blood levels of electrolytes and maintain fluid and acid/ base balance in the body and to produce renin and erythropoietin which affects blood pressure and stimulates the production of red blood cells, respectively .

When the kidneys are diseased, they become less able to rid the body of waste products of protein metabolism, excess electrolytes and fluid. These waste products accumulate in the tissues and blood and uremia - the final common pathway of chronic progressive kidney disease -develops. CKD typically is a progressive disease, but advancement to kidney failure is not inevitable. Medications, diet, and other lifestyle changes can slow progression.

DIETARY MODIFICATIONS

The purposes of dietary modifications in CKD are to maintain or improve nutritional status; minimize uremic toxicity; retard progression of renal failure; and promote patient's well being.
Dietary changes are essential to the management of CKD, and dietary restrictions become more complex as kidney function declines.As the kidneys become less able to maintain balance in the body, dietary intake of sodium, potassium, phosphorus, and calcium may need to be adjusted and fluid restriction may become necessary in later stages.

ENJOY EATING RIGHT AND LIGHT

Eating smarter doesn't mean avoiding tasty meals. Losing weight can still be attained in a number of tasty ways.

Sanirose S. Orbeta, MS, RD, FADA
Board Member, PASOO
Consulting Clinical and Sports Nutriotionist

"I want to lose weight but I don't want to fast. Is that possible?" That is the usual question that pops into the minds of people when they hear the words "losing weight." Some also think that elimination of some foods is the key such as eliminating Rice completely in their diet and replacing them with other Foods. For starters, losing weight is as simple as keeping balance between your food intake and your physical output. In other words, you need to eat smarter and move more.

1. Eat the right amount of Carbohydrates – 50-55% Daily

It is true that cutting carbs can help you lose weight. However, totally avoiding rice, bread or pasta or noodles will not. We need carbs for energy. The healthier way to cut your carbs is to cut your intake on sugar sweetened beverages like regular sodas; candies; pastries; sweet & creamy desserts; and other foods with added sugars. Those foods are loaded in calories but have low nutritional value. To secure your energy level without loading up on calories, choose whole grains, root crops/tubers, fruits, and vegetables.

2. Add Protein to your Meals – 20-25% Daily

Make sure to include some lean protein to your meals to add more satiety to your stomach. Choose low-fat dairy foods, eggs, lean meats, poultry without skin, fish & other sea foods, and legumes.

3. Minimize Saturated and Trans Fatty Acids as Much as You Can

Fries, Donuts, Cakes, Pies, Cookies, Pizzas, Bacon, and other creamy foods sound tasty but will you still enjoy eating them when you hear their negative effects on your cholesterol profile? Consuming too much Saturated Fats and Trans fatty acids can clog your arteries by elevating your cholesterol levels. Choose a more heart friendly type of fats which are the monounsaturated and polyunsaturated fats that are found in nuts, avocado, plant oils, olives, salmon or tuna.

4. Make conscious effort to trim down your portions

Try using smaller plates and bowls to help you reduce your food intake, as we all tend to fill up the dish that we're using and then eat everything therein. So if we use a smaller dish, it's like eating up only half of what we used to eat when using big dishes. Another way to cut your intake is to share your foods with friends, classmates or co-workers. That way you are not only cutting your food intake but you also get the joy of not eating alone.

5. Relish and Enjoy your Food Choices

Eat slower to help yourself consume only what your body needs to feel satisfied. Eating in a haste, in about less than 20 - 30 minutes, can lead to overeating and feeling disturbingly stuffed right after.

6. Make your Beverage Count
Drink 8 – 10 glasses of water or more daily.

Water is zero calorie and helps to make your stomach feel full. If you're going for a drink other than water, choose low calorie drinks such as diet sodas.

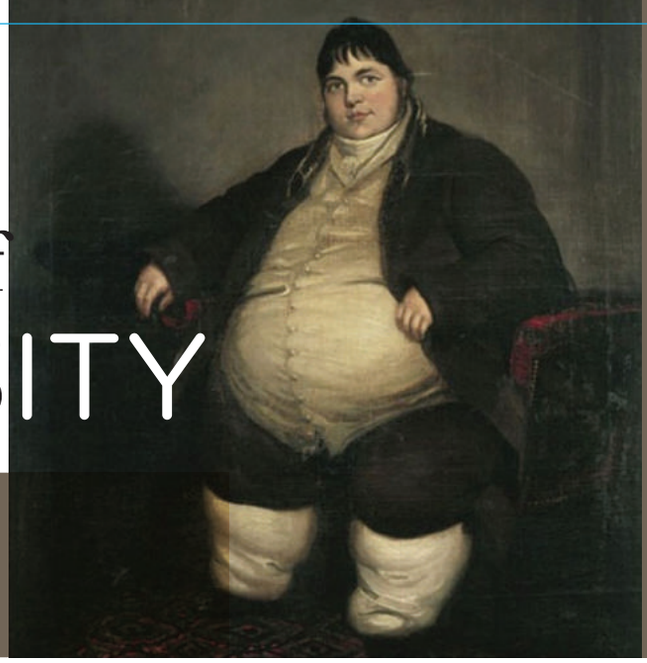
7. Wisely Select your Food Orders

Resist ordering big, deluxe or supersize portions. Order grilled, steamed, stewed or Choose fresh fruits as your dessert. Make sure to check out the nutrition facts panel when doing your groceries to make sure you're getting the right food for you.

8. Always Stay Physically Fit

Of course, the journey to a leaner you goes with being active physically. Just like sticky rice cake that can't be pulled apart, Diet and Exercise are a couple that has to work together for life to achieve your healthy weight. You don't need to go intense with your workout. What matters more is the regularity and length of your exercise. Choose a form of exercise that you will surely enjoy. Try achieving a total of 150 min. of exercise per week for health but go as much as 300-350 min. per week for weight loss.

The ART of OBESITY



Ariel S. Torres, M.D.

Philippine Delegate, International Congress on Obesity, IASO Specialist Certification of Obesity Professional Education, WOFGraduate, OBESITY Summer School, Réseau Canadien en Obésité

Weight Loss Definitions, Obesity as a Disease, Quetlet Index with subsequent Classifications, & 5 A's of Obesity Management

Weight Loss is defined as the ability to lose weight and maintain it for a year. You see it's so easy to lose weight. But if you cannot maintain it, then it's as if you never lost it. So, when you unintentionally gain back the weight that you intentionally lost, that's called Recidivism. Sometimes, you even gain more than what you lost and that's called the Rebound Phenomenon. Even in Liposuction wherein we literally remove subcutaneous fat, if the patient cannot maintain weight before the surgical procedure was done; fat will be re-deposited in the visceral area which is bad if not worse. So, what is the secret to achieving weight loss ..., weight maintenance first.

The International Classification of Diseases (ICD) has its origins in 1860 during the International Statistical Congress. Unknown to most medical professionals, Obesity was already classified as a disease as early as ICD-8 that was implemented in 1965. It was listed as #277 – Obesity not specified as of Endocrine in origin. This was followed by ICD-9 that was created immediately after that but implemented in 1978. It was listed as #278 but you cannot be admitted for that reason only. There must be other reasons for your Obesity for it to be covered by the Federal government. At present starting October 1, 2015, we're now using ICD-10 (for Insurance Coverage). So, Obesity is E65, E66, E67, or E68. It's under Endocrine which is why it starts with E. E65 is simply localized adiposity. E66 means generally obese (and not localized anymore). E67 is due to Hyperalimentation while E68 is a sequela of hyperalimentation.

The "old method" of determining obesity is by computing for Ideal Body Weight (IBW). If you are 10% over your IBW, you are Overweight. If you are 20% over your IBW, you have too much excess fat with a risk of suffering from Obesity (meaning developing metabolic disease). So, for women, the IBW can be estimated using this equation: the first 5 feet is 100 lbs and every inch thereafter is 5 lbs. And for men, the equation is: the first 5 feet is 106 lbs and every inch thereafter is 6 lbs. But like I said earlier, that's the "old method". The latest one that we use for computation in Obesity is the Quetlet Index. It was originally formulated by Adolph Quetlet, hence the name, but the one that made it famous is Ancel Keys who renamed it as Body Mass Index or BMI.

Different regions and countries use the BMI in various ways with independent cut-offs. For Caucasians, the value considered Obese is 30 kg/m2 while for Asians it is lower at 25 kg/m2. Now each country has different Obesity Classifications. In Singapore, they give the a "Risk" category according to BMI. So, it's either you have Low Risk (18.5-22.9), Moderate Risk (23-27.4), or High Risk (27.5 and above). In Japan, once you are above Normal (BMI > 25), then you are automatically Obese and they just grade you as either Class 1 (25-29.9), Class 2, Class 3, or Class 4 (40 and above).

Lately, it has been noted that the Waist Circumference and Waist-Hip Ratio is more pathognomonic and more specific in determining excess Visceral Fat. This was correlated with CT Scan and MRI results. So, what they did was the next best thing which is to combine the BMI and Waist Circumference in a Table and assign disease risk at certain cut-off points. So, for example a Male with a Waist Circumference of more than 102 cms with a BMI of 32 kilograms per meter squared would have a Very High Risk of developing diseases associated with Metabolic Syndrome like Hypertension, Hypercholesterolemia, Heart Disease, and Diabetes. But if he can lose some Visceral Fat and therefore decrease his Waist Circumference and at the same time lose weight and therefore decrease his Body Mass Index, then he would improve his classification and lower his risk.

So there are 5 A's in Obesity Management. The first A is Ask. You have to ask permission to discuss a patient's weight because weight is a very sensitive issue for patients suffering from Obesity. So you have a sit down with the patient. Then ask, "May I talk to you about your weight?" If she replies, "Yes it's okay to talk about my weight. I'm glad you asked.", then that's a good thing. You then follow it up and say, "I'd like to offer my help. Is it okay if I help?" Hopefully, she says, "Yes please. I would appreciate any help you can offer." The second A is Assess. You need to determine if there are any health conditions that led to excess fat or the reverse, if excess fat has led to any health condition. So you normally do a Complete Physical Exam. And you also draw blood to determine if she has diabetes where excess sugar is stored as fat, or hypothyroidism where metabolism slows down, or rheumatoid factor which led to immobility, etc. The third A is Advise. So you tell the patient, "Now that we know your health situation, let's make plans on improving it. The fourth A is Agree. You have to agree on goals that are S-M-A-R-T. So they should be Specific, Measurable, Achievable, Rewarding, and Timely. And the fifth A is Assist. Facilitators are there for motivation and support to confront barriers that can be challenging. So those are the 5 A's in Obesity Management and without one of them, there are less chances of success.

Identifying **Cardiometabolic Risks** in Obese Children and Adolescents

Sioksan Chan - Cua, MD, MSc
Chief, Pediatric Endocrinology Section
Associate Professor, College of Medicine, UP - PGH
Past President, PASOO and PSPME

Obesity is a medical condition in which excess body fat has accumulated to the extent that it may impair health. When defining overweight and obesity in children, age needs to be considered. For children <5 years of age: overweight is weight-for-height >2 standard deviations (SD) above WHO Child Growth Standards median; and obesity is weight-for-height >3 SD. For children aged between 5-19 years: overweight is BMI-for-age >1 SD above the WHO Growth Reference median; and obesity is >2 SD. Clinicians should use growth and BMI charts to identify children who are overweight or obese.

The worldwide prevalence of obesity more than doubled between 1980 and 2014. The prevalence of overweight and obesity is now on the rise in low- and middle-income countries, particularly in urban settings. In 2014, an estimated 41 million children under 5 years were overweight or obese. Nearly half of the under 5 years children who were overweight or obese lived in Asia. Although the prevalence of obesity among children has been lower than that among adults, the rate of increase in childhood obesity in many countries has been greater than the rate of increase in adult obesity. Middle-income countries including the Philippines, face the "double burden of malnutrition," according to a joint report by the United Nations International Children's Emergency Fund (UNICEF), World Health Organization (WHO), and Association of Southeast Asian Nations (ASEAN). In 2006, the Philippines lost nearly P2.8 billion due to coronary heart disease, stroke and diabetes. The estimate almost doubled by 2015, according to the report.

Obese children and adolescents have increased risks of insulin resistance and early onset of type 2 diabetes mellitus, dyslipidemia, hypertension, non-alcoholic fatty liver disease, breathing difficulties, obstructive sleep apnea, knee and back pain or fractures, menstrual irregularities in females, and psychological effects. Childhood obesity is associated with a higher risk of adult obesity, premature death and disability. In the local setting, Pediatric Endocrinologists have encountered a 9-year-old obese boy diagnosed to have type 2 diabetes with acute complication, diabetic ketoacidosis, at the Emergency Room, and an obese adolescent with hypertension and dyslipidemia who developed strokes at age 14 years. A 12 year-old obese adolescent was admitted for treatment of slipped capital femoral epiphysis (SCFE).

A total of 350 overweight and obese Filipino adolescents (aged 10 to 18 years, 206 males and 144 females) referred to pediatric endocrine clinics in Metro Manila were included in a study. Ninety-eight percent of them had abdominal adiposity, 25% hypertension, 24% hypertriglyceridemia, 17% low HDL and 12% hyperglycemia; 67% had hyperinsulinemia (>15 uU/ml) and 70% had insulin resistance based on HOMA-IR (≥3).

Overweight and obesity, and their related non-communicable diseases (NCDs), are largely preventable. The American Academy of Pediatrics (July 2017) recommends that pediatricians focus on clusters of cardiometabolic risk factors that are associated with obesity. Identifying cardiometabolic risk factors in obese children and early intervention can help to prevent chronic health problems such as heart disease and type 2 diabetes.

At the individual level, limit energy intake from sugars and trans-fat, increase consumption of fruit and vegetables, as well as legumes, whole grains and nuts; and engage in regular physical activity (60 minutes a day for children).

At the societal level, it is important to sustain implementation of evidence based and population based policies that make regular physical activity and healthier dietary choices available, affordable and easily accessible to everyone, particularly to the poorest individuals. An example of such a policy is a tax on sugar sweetened beverages

The food industry can play a significant role in promoting healthy diets by:

- reducing the fat, sugar and salt content of processed foods;
- ensuring that healthy and nutritious choices are available and affordable to all consumers;
- restricting marketing of foods high in sugars, salt and trans-fats, especially those foods aimed at children and teenagers; and
- ensuring the availability of healthy food choices and supporting regular physical activity practice in the workplace.

After the Seoul Declaration 2007
(To be presented in the KSSO annual meeting August 31,2017)

PASOO: MOVING FORWARD IN THE FIGHT AGAINST OBESITY IN THE PHILIPPINES

Rosa Allyn G. Sy, MD, FPCP, FPSEDM
Philippine Association for the Study of Overweight and Obesity
Past President and Founding Member

Obesity is on the rise, sparing not even a third world country like the Philippines. When PASOO was organized in 1994, the prevalence of overweight / obesity in the country was 16.6%. In 2011, when AOCO was held in Manila, Philippines, the NNHes (National Nutrition Heath Examination Survey) 2011 reported a prevalence of 28.4%. In the most recent survey (2013), the prevalence rose to 31.1% wherein three (3) out of 10 Filipino adults are overweight / obese, affecting female adults more than male adults.

The challenge to fight obesity is an enormous task. PASOO, in its earlier years, being the pioneer in the prevention and control of obesity and its complication through education, research and advocacy, lobbied for government's support. It was appointed together with the Department of Health to spearhead annual health promotion and awareness regarding obesity in the country by former President Estrada. By the Proclamation no. 162 dated August 21, 1999, the former president declared the first week of September of every year as the Obesity Prevention and Awareness week in the Philippines. Different awareness campaigns for both the medical community and the public through nationwide education and obesity summits were carried out. After the successful AOCO in 2011 held in Manila, Philippines, hosted by the PASOO, its Voice in the field was heard and recognized.

From 2011 to 2016, several partnerships were formed and the establishment of EXERCISE IS MEDICINE further emphasized PASOO's advocacy for an active and healthier lifestyle. To date, PASOO has achieved the following:

1. Partnered with fitness/exercise professionals to promote exercise as a means of treating chronic illnesses beyond obesity
2. Partnered with schools to educate parents and teachers on diet and exercises to prevent and treat obesity
3. Educated GP's and FP's on ways to identify and measure obesity and the importance of properly managing this disease thru weekend courses in different regions of the country.
4. Promoted local nutrition guidelines and discussed its importance for the lay.
5. Compiled a compendium of locally done research outputs on obesity in order to focus on a proper research agenda to address our country's growing number of obese individuals.

Recently, the congress has proposed the bill on Sugar-Sweetened Beverage Tax (SSB Tax) and the Bill for Tax Reform for acceleration and Inclusion (TRAIN) to promote intake of healthier beverages. This new development led the Society to partner with other stakeholders to discourage sugar sweetened beverages by increasing its tax and making sure that revenues will be earmarked for projects promote proper nutrition for the malnourished (both under- and overweight).

Our fight continues...

Petition for **PRO - HEALTH** and **PRO - POOR** Tax Reform for Acceleration and Inclusion **(TRAIN)**

Petition signed by: Edgardo L. Tolentino, Jr, MD

On behalf of PASOO Board 2017

There are 14.5 M Filipino smokers and 1.2 M more are expected by 2022, mostly from the lowest 2 quintiles of wealth. Tobacco exposes these smokers to 49 life-threatening diseases including stroke, heart attack, lung cancer and chronic lung disease, resulting in 150,000 deaths a year and 210 B pesos in annual losses. In addition, tobacco predisposes to a major health problem, illicit drug use. Of 4.5 M Filipinos who have ever tried drugs, 1.5 M used tobacco as the gateway.

14 million Filipinos experienced involuntary hunger in the last quarter of 2016, and 12.5 M suffer chronic undernutrition. This is the underlying cause of persistent health problems such as pneumonia, diarrhea, and tubeculosis, which remain among the top 10 cuases of death in Filipinos.

To address these pressing health problems, we urge that the comprehensive tax reform bill be converted to a version that is overwhelmingly pro-poor. We strongly appeal the following ammendments:

1. We urge that taxes on tobacco be increased by 60% in 2018,, and by 10% yearly thereafter with the following goals:

   a. To decrease the number of current smokers from 14.5 to 13.5 million

   b. To reduce annual financial losses of at least 210 B pesos from smoking related diseases

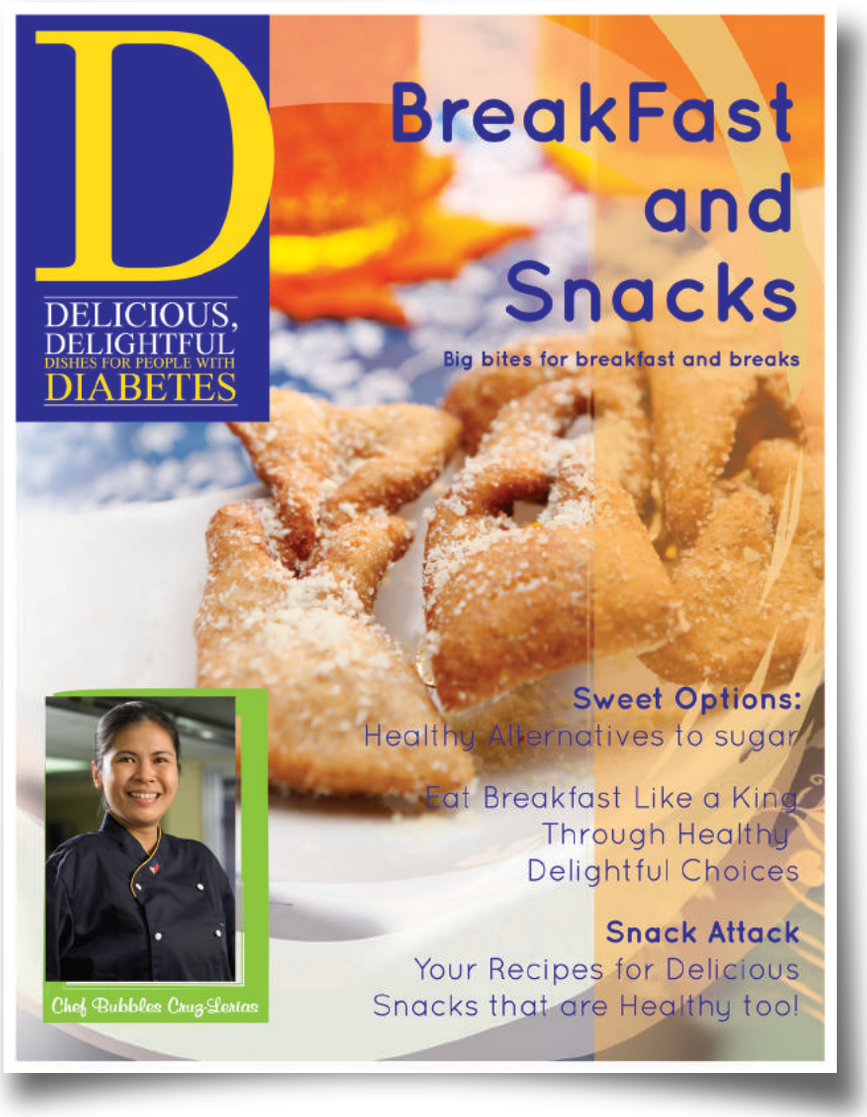
   c. To augment funds for universal healthcare, government infrastructure projects, and crop diversification by tobacco farmers

   d. To institute tobacco control as a preventive measure against use of illicit drugs

2. We further propose that ALL income from taxes on sugar sweetened beverages be used to finance measures to reduce the cost of healthy food to increase accessbility, especially for the poor and near poor, and to curtail the potential increase in the incidence of undernutrition.

We believe these amendments wil transform the proposed tax reforms into a package that is clearly pro-poor. We commit to strongly support a version of this bill that includes these provisions.

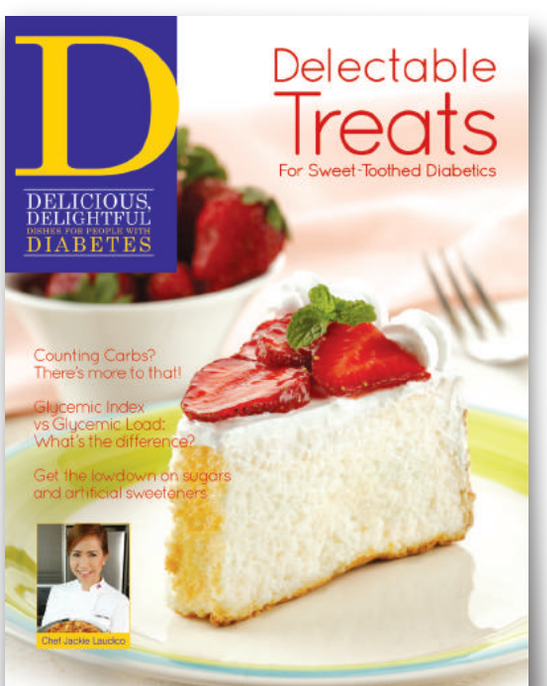
Edgardo L. Tolentino, Jr, MD
President
Philippine Association for the Study of Overweight and Obesity

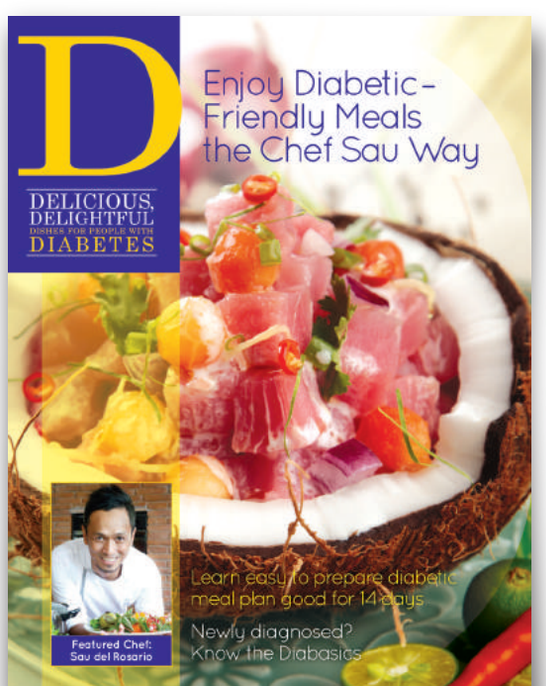


COMING SOON

Cookbook 1&2 available for **DOWNLOAD** at the **PASOO** website

www.obesity.org.ph





Weight loss – the formoline L112 advantages

formoline L112

Lipid adsorbent to:

- support reduce excess weight
- support long-term weight control
- lower cholesterol intake from diet

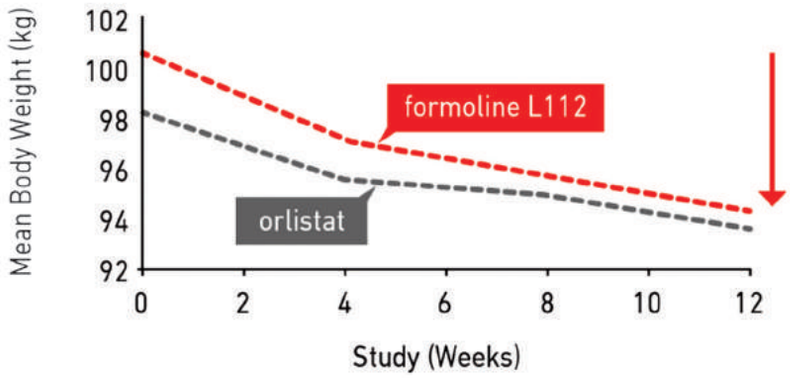
Product key facts

- The No. 1* slimming tablet in Germany
- Multiple award and prize winner
- Successfully launched in more than 40 countries worldwide
- Good tolerability and low side effect profile
- Medical Device Class III certified by a designated Notified Body in Germany

Average weight loss 6.7 kg

The randomised, double-blind, clinical study with 64 patients shows that the medical device polyglucosamine (formoline L112) is significantly more effective than non-prescription drug orlistat 60 mg in weight reduction. With formoline L112 (polyglucosamine) subjects lost 6.7 kg on average during three months.

Stoll M., et al. (2016): Randomised, double-blind, clinical investigation to compare orlistat 60 mg and a customized polyglucosamine, two treatment methods for the management of overweight and obesity. BMC Obesity (2017) 4:4.



Weight loss by treatment with polyglucosamine (L112)

FLF1702EN

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www.certmedica.de

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PASOO IN ACTION

KIDS
LECTURE
SERIES

July 25, 2017
Rafael Palma Elem. School,
Makati City

PASOO IN ACTION

2016

Induction of New officers & Board of Directors 2016-2018
November 29, 2016
Discovery Suites, Ortigas, Pasig, City

Thanksgiving & Christmas Party
November 29, 2016
Discovery Suites, Ortigas, Pasig, City

2017

PASOO Lay Forum
June 2, 2017
Sarabia Manor Hotel & Convention Center, Iloilo City

8th Intensive Obesity Workshop
June 3, 2017
Sarabia Manor Hotel & Convention Center
Iloilo City

22nd Annual Convention
August 23, 2016
EDSA Shangri-La Hotel, Mandaluyong City