



# Working together for best practice in obesity management



# Disclosures

Honoraria from Novo Nordisk for educational talks

**Weight loss is a cure for Obesity**

True or False?

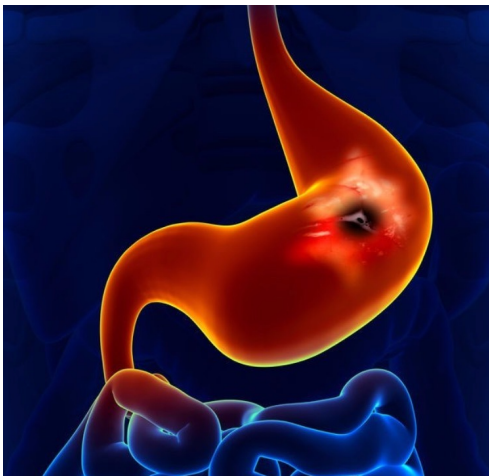
**People with depression just need to pull themselves together**

**People get stomach ulcers because they are 'highly strung'**

**People get seizures because they have demons inside them**

**You can catch HIV from shaking someone's hand**

**People with obesity just need to have more willpower**



## Personality pattern and emotional stress in the genesis of gastric ulcer<sup>1</sup>

M. H. ALP, J. H. COURT, AND A. KERR GRANT

*From the Gastroenterology Unit, The Queen Elizabeth Hospital, Woodville, South Australia, and the Department of Mental Health, The University of Adelaide, Adelaide*

**SUMMARY** In a group of 181 persons with a past history of chronic gastric ulcer, a greatly increased incidence of domestic and financial stress has been found, when compared with age- and sex-matched persons with no previous history of gastric ulcer. The consumption of aspirin, alcohol, and cigarettes was also significantly increased. Persons with chronic gastric ulcer were characterized by a personality pattern of independence and self sufficiency, and they are prone to anxiety and depression. This pattern was three times as common as in matched individuals without chronic gastric ulcer.

It is possible that internal conflict between a genetic and an environmentally induced sex role, together with an inability to externalize aggression, may be significant factors in the causation of chronic gastric ulcer.

In 1859, William Brinton suggested that privation, fatigue, and mental anxiety frequently coincided with the presence of gastric ulceration. Davies and Wilson (1937) found a significant correlation between the onset of symptoms of peptic ulcer and domestic upset, financial stress, or a long past history of 'tension'. Jones (1957) found that anxiety, frustration, resentment, and fatigue were important aggravating factors in the symptomatology of peptic ulceration. Alexander (1950) and Højer-Pedersen (1958) suggested that a psychological disturbance or emotional conflict might be transformed into an organic disease, eg, peptic ulcer.

We have recently completed a retrospective survey of 638 patients presenting with chronic gastric ulceration to two major public hospitals in South Australia between the years 1954 and 1963 (Alp and Grant, 1970). Emotional stresses which were present at the time of admission were documented. At the time of follow up, an assessment was made of the patient's basic personality. The results of this investigation suggest that an

identifiable personality pattern exists in patients with gastric ulcers and that emotional stress may play a part in the genesis of gastric ulcer.

### Patients and Methods

#### GROUP I

The case notes of 638 patients with proven gastric ulcer admitted to the Queen Elizabeth Hospital and the Royal Adelaide Hospital during the years 1954 to 1963 were studied. Criteria for acceptance have been described (Alp and Grant, 1970). Patients were circularized with questionnaires. Alcohol, aspirin, and cigarette consumption, together with domestic, financial, and other stress existing at the time of the patients' admission to hospital, were assessed from the inpatient notes or from completed questionnaires.

The questionnaire also included a neuroticism scale questionnaire (NSQ), a series of questions devised by Scheier and Cattell (1961). Of the 247 patients known to be still living, 181 completed the personality assessment.

<sup>1</sup>Received for publication 8 January 1970.

<sup>2</sup>Address requests for reprints to Dr A. Kerr Grant, Gastroenterology Unit, The Queen Elizabeth Hospital, Woodville, South Australia.

**GASTROENTEROLOGICAL SOCIETY OF AUSTRALIA**

145 Macquarie Street,  
SYDNEY. 2000

Telephone 27 3288

17th March, 1983

Dear Dr. Marshall,

I regret that your research paper was not accepted for presentation on the programme of the Annual Scientific Meeting of the Gastroenterological Society of Australia to be held in Perth in May, 1983.

The number of abstracts we receive continues to increase and for this Meeting 67 were submitted and we were able to accept 56.

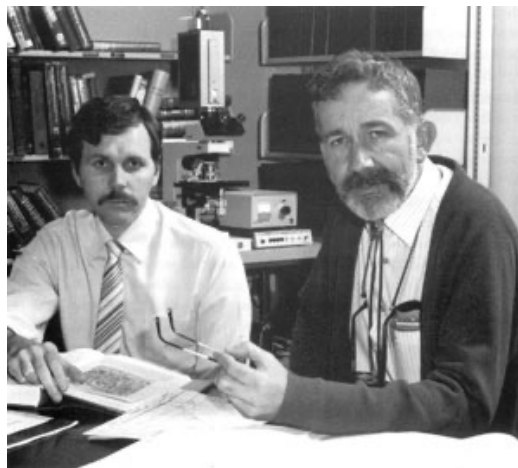
There were a large number of high quality abstracts which made it extremely difficult to choose those which should be accepted for presentation, and as you know, this is now done by a National Abstract Selection Committee which reviews the abstracts without knowledge of the Authors concerned.

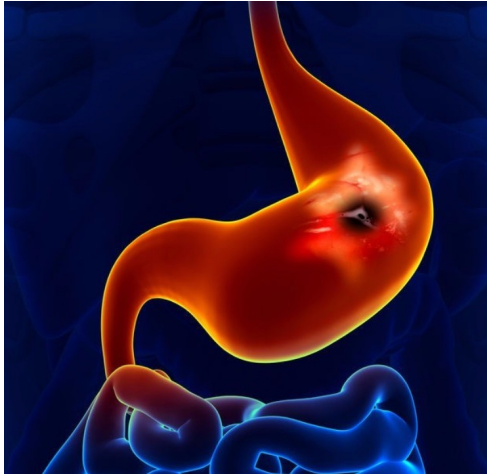
The National Programme Committee would like to thank you for submitting your work, and would hope that this might be re-submitted in the future, perhaps following critical review from your colleagues.

My kindest regards,

Yours sincerely,

for Terry D. Bolin,  
Honorary Secretary.





## The Spectrum of *Helicobacter*-Mediated Diseases

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### Keywords

*Helicobacter pylori*, gastric adenocarcinoma, duodenal ulcer, gastric ulcer, gastritis, MALT lymphoma, reflux esophagitis, antimicrobial resistance

### Abstract

*Helicobacter pylori* is the leading cause of peptic ulcer disease. The infection has been implicated in more than 75% of duodenal ulcer cases and 17% of gastric ulcer cases. *H. pylori* has been classified as a human carcinogen, since it is the main cause of distal gastric adenocarcinoma and B cell mucosa-associated lymphoid tissue lymphoma. Evidence also links *H. pylori* with extragastric conditions including iron deficiency anemia, idiopathic thrombocytopenic purpura, and vitamin B<sub>12</sub> deficiency. Studies indicate that *H. pylori* may be protective against other conditions of the gastrointestinal tract (e.g., reflux esophagitis and related pathologies) and elsewhere in the body (e.g., asthma). The infection is asymptomatic in the vast majority of cases; more serious outcomes occur in only 10–15% of infected individuals. Despite extensive research over the past 3 decades, there is no effective vaccine, and the circumstances leading to disease development remain unclear. In addition, there is now a growing prevalence of antimicrobial resistance in *H. pylori*. This review discusses these important issues.

Losing weight is simple....

DIET



Energy In



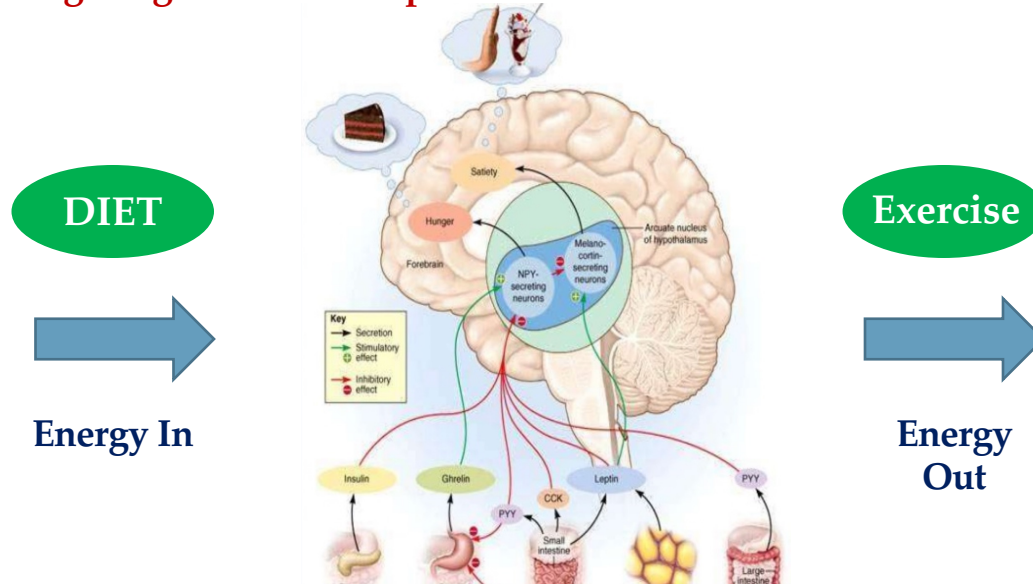
Exercise

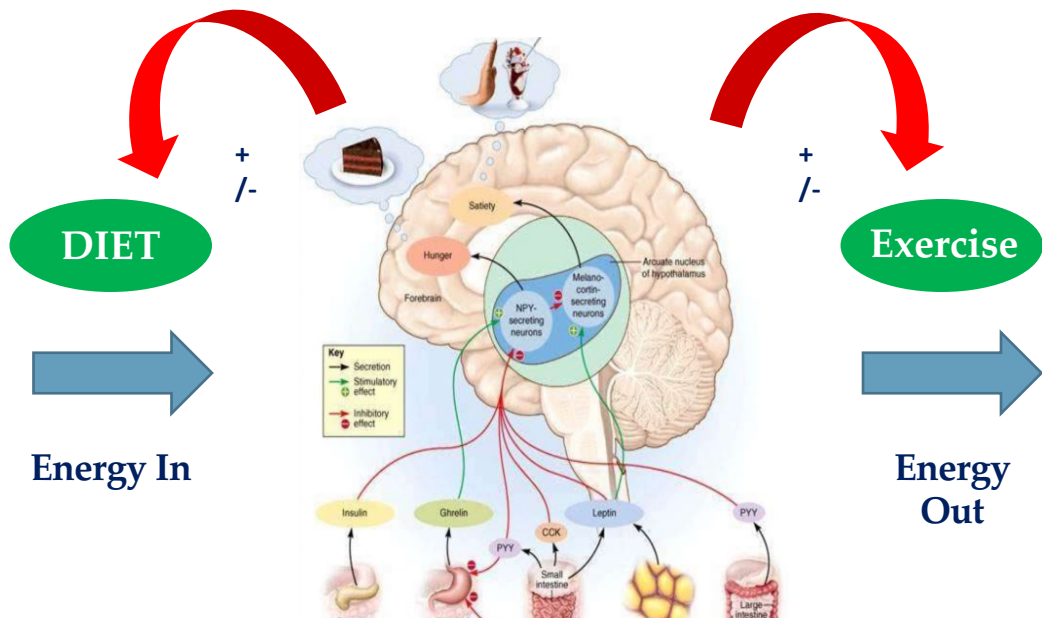


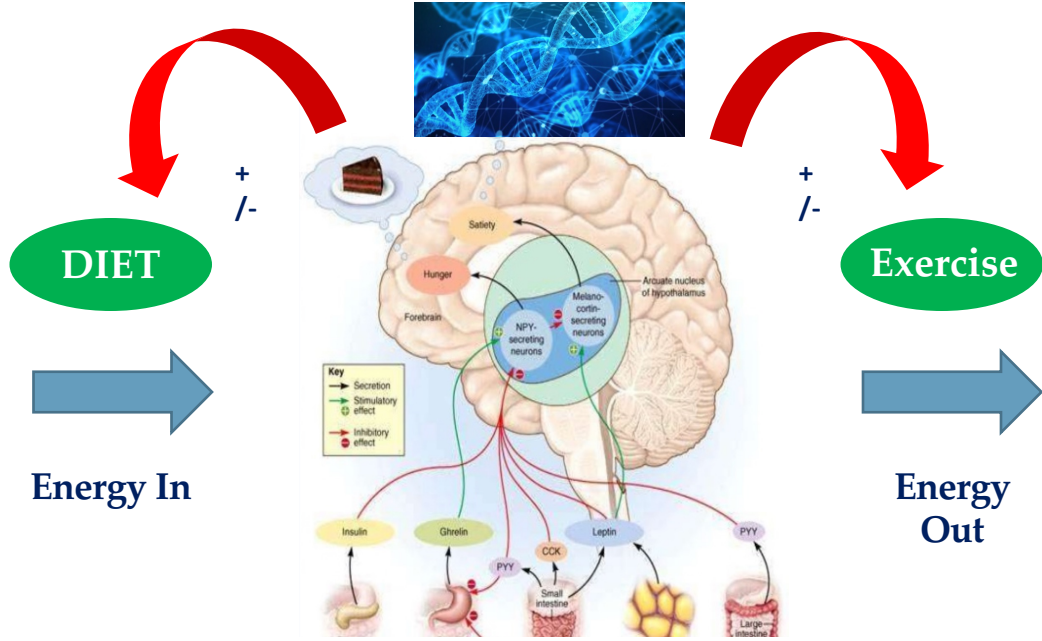
Energy Out

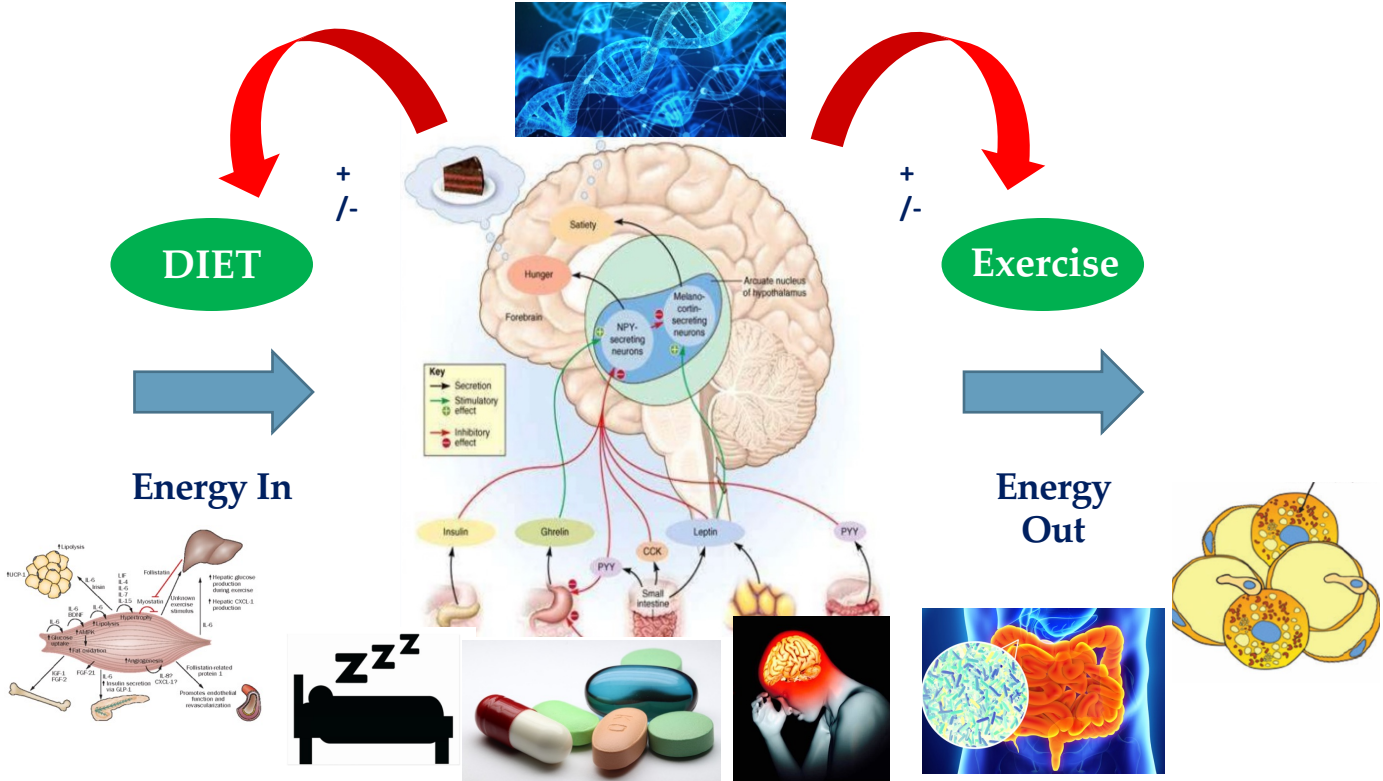


Losing weight is NOT simple....







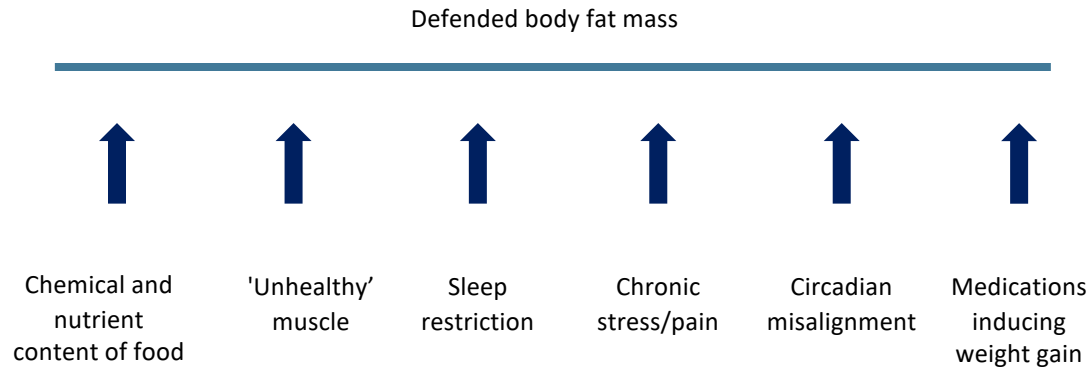


# Defended fat mass / energy storage 'set point'

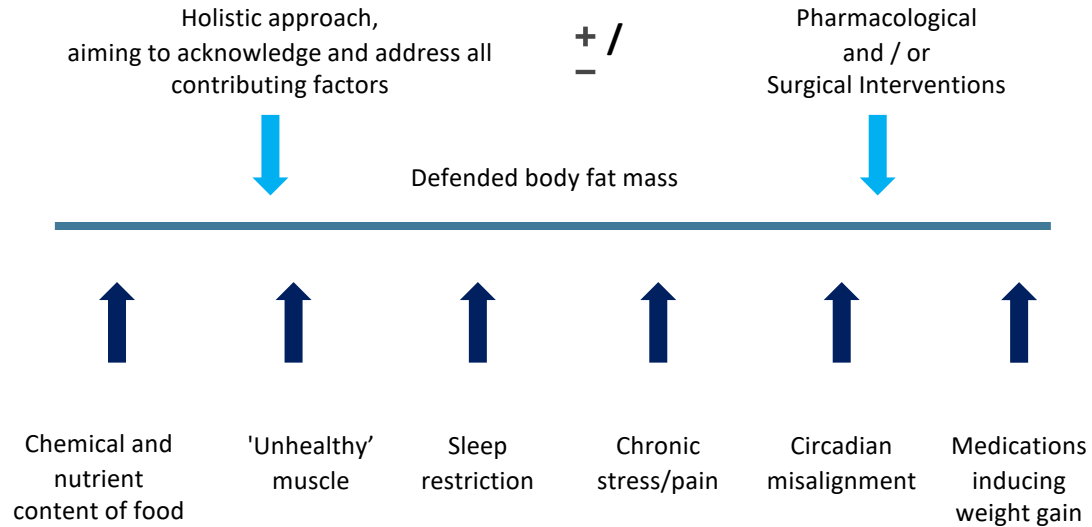
Defended body fat mass

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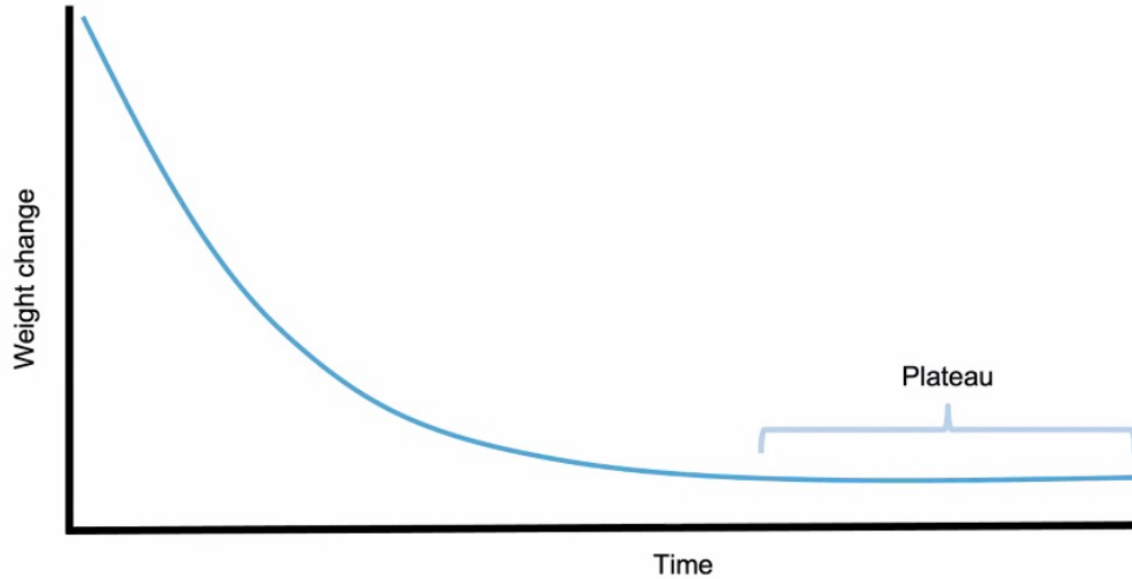
# Defended fat mass / energy storage 'set point'



# Defended fat mass / energy storage 'set point'



# Weight Loss Curve





# “Best Weight” versus “Ideal Weight”

Your best weight is the weight you can achieve while living the healthiest life you can truly enjoy

*Freedhoff & Sharma, 2010, 'Best Weight'*



# Chronic diseases

Hypertension

Asthma

COPD

Type 2 diabetes

Arthritis

Heart failure

# Chronic diseases

Obesity

Hypertension

Asthma

COPD

Type 2 diabetes

Arthritis

Heart failure

**Weight loss is NOT a cure for Obesity**



National Clinical  
Programme for  
Obesity



ROYAL COLLEGE OF  
PHYSICIANS OF IRELAND

# Model of Care for The Management of Overweight and Obesity

ICT & EMR | Education & Training | Monitoring & Surveillance

Policy, legislation &  
cross sectoral action  
to support healthy  
environments





# Clinical Practice GUIDELINE

for the Management of  
Obesity in Adults in Ireland

<https://asoi.info/guidelines>

## Obesity Facts

## Review Article

Obes Facts  
DOI: 10.1159/000527131

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## Obesity in Adults: A 2022 Adapted Clinical Practice Guideline for Ireland

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# Clinical Practice GUIDELINE

for the Management of  
Obesity in Adults in Ireland

<https://asoi.info/guidelines>



## Reducing Weight Bias in Obesity Management, Practice and Policy

Heary C<sup>1</sup>, Ryan L<sup>1</sup>, Birney S<sup>1</sup>, Arthurs N<sup>1</sup>, O'Connell J<sup>1</sup>. Chapter adapted from: Kirk SFL, Ramos Salas X, Alberga A, Russell-Mayhew S. Canadian Adult Obesity Clinical Practice Guidelines: Reducing Weight Bias in Obesity Management, Practice and Policy (version 1, 2020). Available from: <https://obesitycanada.ca/guidelines/weightbias> ©2020 Obesity Canada

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### Cite this Chapter

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### KEY MESSAGES FOR HEALTHCARE POLICY MAKERS



- **Policy makers developing obesity policies should assess and reflect on their own attitudes and beliefs related to obesity<sup>1</sup>.**
- **Public health policy makers should avoid using stigmatising language and images.** It is well established that shaming does not change behaviours. In fact, shaming can increase the likelihood of individuals pursuing unhealthy behaviours and has no place in an evidence-based approach to obesity management<sup>2,3</sup>.
- **Avoid making assumptions in population health policies that healthy behaviours will or should result in weight change.** Weight is not a behaviour and should not be a target for behaviour change. Avoid evaluating healthy eating and physical activity policies, programmes,

and campaigns in terms of population-level weight or body mass index outcomes. Instead, emphasise health and quality of life for people of all sizes. As weight bias contributes to health and social inequalities, advocate for and support people living with obesity. This includes supporting policy action to prevent weight bias and weight-based discrimination<sup>2,8</sup>.

- **Policy makers should know that most people living with obesity have experienced weight bias or some form of weight-based discrimination.** Public health policy makers should consider weight bias and obesity stigma as added burdens on population health outcomes and develop interventions to address them. To avoid compounding the problem, we encourage policy makers to do no harm, to develop people-centred policies that move beyond personal responsibility, recognise the complexity of obesity, and promote health, dignity and respect, regardless of body weight or shape.

# Impact of weight bias and stigma

Poor body image and  
body dissatisfaction

Low self-esteem and  
self-confidence

Feelings of worthlessness  
and loneliness

Suicidal thoughts  
and actions

Depression, anxiety,  
other psychological  
disorders

Stress-induced  
pathophysiology

Maladaptive  
eating patterns

Avoidance of  
physical activity

Avoidance of healthcare



# This is an exciting time in obesity management

- Model of Care – funding and resourcing of hospital and community-based treatment centres
- National Clinical Practice Guidelines
- Equality of access to care improving
  - reimbursement
  - expansion of surgical centres
- More effective medications
- Recognition of synergies of medical and surgical therapy
- Peer support available (ICPO – [www.icpobesity.org](http://www.icpobesity.org))
- Increased awareness of harms of weight stigma



# 30<sup>th</sup> EUROPEAN CONGRESS ON OBESITY

17-20 May 2023 | The Convention Centre Dublin | Dublin, Ireland

17 MAY 2023, WEDNESDAY

## ECO2023 Teaching Workshops

