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# The O&P EDGE

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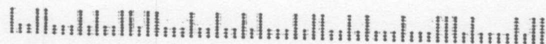

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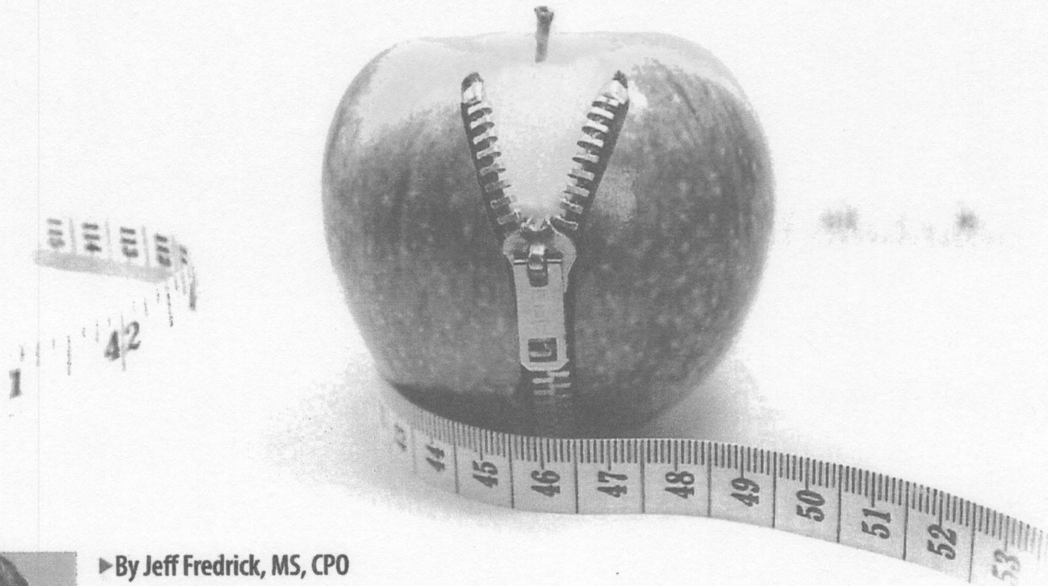
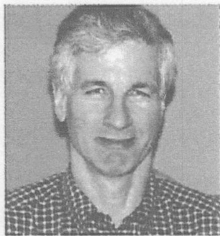
# Helping Obese Patients by Weight Management, *not* Diet





▶ By Jeff Fredrick, MS, CPO

*The same America that expects to attain viable longevity into its 80s has tallied up an unprecedented record of obesity. It comes as no surprise that booming obesity rates are correlated with an ever-skyrocketing appetite for junk food—often called "recreational consumption." Anyone with a genetic predilection for weight gain, who pursues a sedentary lifestyle, or is employed in a non-physical vocation, easily can become trapped in the deadly cycle of uncontrolled weight gain. The physically challenged patient is even more at risk.*

Sadly, healthcare providers, especially those who have never personally dealt with excessive weight gain, are often insensitive—even dismissive—toward the clinical presentation of chronic obesity. Too often, "You need to lose weight" is the curt clinical response to patients who present with an obvious inability to manage their weight.

We live in an information-driven culture, and the general public is well-informed about the hazards of obesity. The astute, sensitive clinician will recognize that obesity may indicate other equally serious issues such as depression, healthcare non-compliance, pharmaceutical dependence, an inability or reluctance to access medical care, or simply a failure to discipline the appetite. The fact that someone sustains obesity in a culture that puts such inordinate stress on physical beauty should be a wake-up call regarding the depth of the problem. If that's not serious enough, obesity can not only be physiologically detrimental, it can be psychologically humiliating as well.

So, how can clinicians sensitively address excessive weight gain and obesity in their patients regardless of their medical or rehabilitation specialty? More specifically, how can we factor in weight loss to increase the success of O&P functional outcomes?

**Case study:** Woman, age 25, suffering post-operative pain following a repaired fracture of a Charcot foot set in marked valgus. Conservative estimate: 100 lb. overweight. During my initial workup, she volunteers (more like apologizes) that she knows her weight is not helping her foot and ankle.

I respond, "May I discuss a few weight issues with you?"

She looks surprised that I even ask permission, and says, "Why not?"

I tell her about another patient. He suffers from post-polio syndrome and has gained more than 100 lb. in the 20 years I've provided unilateral KAFOs for him. One day he presents with complaints of hip and back discomfort that have pushed him to the

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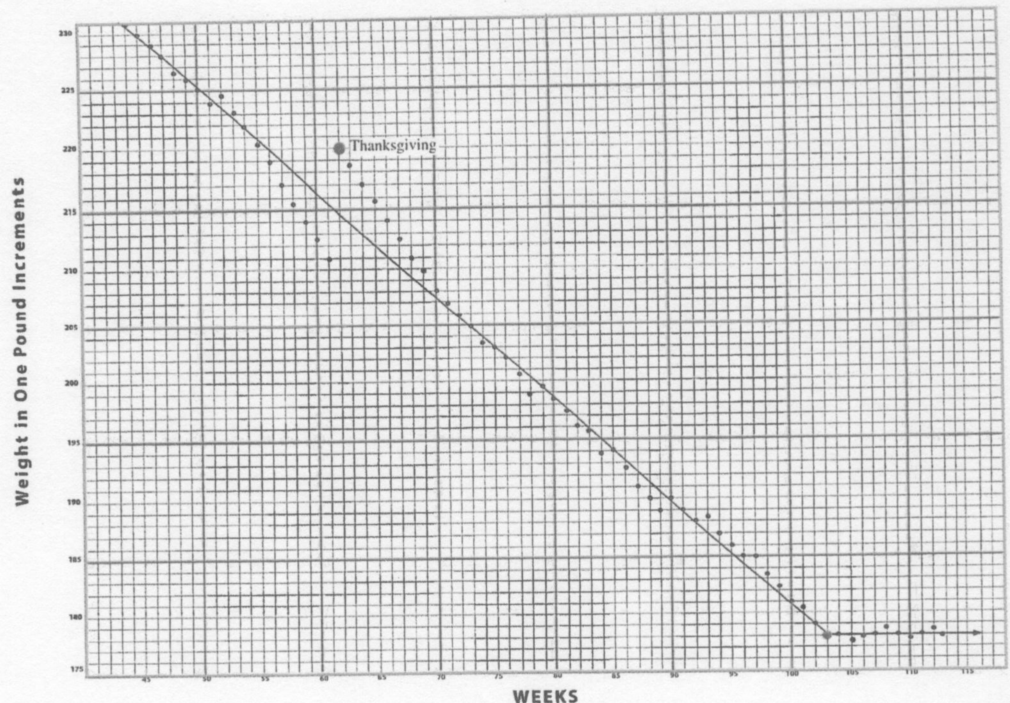
Figure 1




threshold of his pain tolerance. He wants me to adjust his orthosis to correct the problem. I respond with the suggestion that he conduct an experiment:

"Drop a 25-lb. barbell plate in one of your kids' book bags and wear it around for a few hours after work. Call and let me know how your back and hip feel."

He calls me a few weeks later.

"I did what you said and within an hour I hurt so bad I had to ditch the bag!"

I respectfully advise him that he is already wearing four flesh-and-blood 25-lb. barbell plates wrapped around his midriff. The only reason they aren't hurting four times as much is because he gained the weight slowly. However, the extra 100 lb. is no less a threat. The serial addition of excessive body weight to virtually any lower-extremity orthopedic etiology easily can cause further injury or deterioration.

Back to my patient: She was referred for an AFO. However, if I truly wish to provide competent rehabilitation care, her weight must be managed toward a steady decrease. But is this part of the O&P clinical repertoire? It is—if successful use of an AFO is the targeted functional outcome. That is, if the stability and healing of her ankle is the prescription rationale for orthotic intervention, and not simply to fit an AFO and have the patient sign the delivery paperwork.

So how do you recommend a particular diet when the higher domains of nutritional science are generally beyond our training as O&P practitioners? There is a plethora of diet chatter reverberating throughout the pages and airwaves of our culture. The latest successes flash onto the fad stage and then fade away at an alarming rate. Alarming rate, that is, if there really are any scientific "diet" absolutes out there. Why is the crash rate of most "miracle" diets so high? It's simple really. Most diets demand a sudden, inflexible disconnect from a person's lifestyle and comfort zone.

A diet, to be successful, must evoke a significant reduction in the quantity of foods ingested, eliminate sweets, junk carbs, and most other enjoyable, recreational foods. The typical dieter has worked up the motivation needed to begin withdrawal, loses a significant amount of weight to reward his/her motivation, and then suddenly binges out of the process. Why? Because he or she has lost a primary means of escape and enjoyment, and the resulting sense of well-being recreational foods and their celebrated occasions provide.

So, what are the reasonable clinical options? First, recognize a diet per se may not be the best option for your patient, especially if he/she has a history of failed attempts to lose and maintain weight loss. Perhaps a more clinically reasonable strategy is a *weight management program* with protracted, easily attainable results—results that will not demand a sudden and catastrophic change of lifestyle.

## E Scale: A Practical Program

Toward meeting the challenge of weight management, especially among my patients who present with physical dysfunction that excessive weight clearly exacerbates, I have developed a practical weight management program. The approach is simple and guides the patient toward weight loss and long-term maintenance of healthy body weight. It is a simple model that can provide realistic and sustainable outcomes for your patients. Best of all, it does not require any sudden dietary restrictions, special foods or cooking, reductions in recreational foods, or calorie counters. It is a simple management plan that *enables* patients to track and adjust their eating habits via a very low impact, i.e., gradual, form of change.

Let's pursue my patient as an example. What is my response when she volunteers that she is 100 lb. overweight?

"Well, you're planning on being alive two years from now, right?" I ask, mitigating the import of the question with a teasing smile.

"I'm planning to be," she smiles back, but with a question in her eyes.

"Then you could lose one pound a week for the next 24 months—since you plan to be around that long anyway, right?"

"Only one pound a week?' she laughs, "I've lost that much in the first morning of at least a dozen diets!"

"Yep, just one pound a week. Why not settle for an easy-to-

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lose one pound a week for the next 100 weeks? Best of all, you'll lose it slowly, naturally, just like you gained it, not starving down and then binging back up again."

"Tell me more," she asks, taking the first step toward a healthier, more disease- and stress-resistant body.

**Figure 1** is a chart we provide for patients interested in adding a reasonable and potentially successful weight management program to their rehabilitation regime. I call it the **Emily** or **E Scale** after my daughter who has successfully used it to manage her fashion-critical five-lb. weight fluctuation. The E Scale is never suggested without mention that we are not dieticians. It presupposes there are no medical conditions that might be aggravated, and we include a recommendation that patients ask their physician for permission before they begin.

## How It Works

In Figure 1, the X axis is incremented in weeks, and the Y axis weight in pounds. My patient has charted her present weight of 275 lb., and her ideal or target weight of 175 lb., 100 weeks later. A patient could settle for a half-pound per week target or even less to minimize culinary trauma, but I feel any long-term increase over a single pound per week negates the psychology of the concept.

The two weights are connected with a Weight Management Line (WML). On the same day of every week, the patient records his/her weight. A successful E Scale reduction actually mimics a descending stock market graph. A dinner with Aunt Martha leaves us a pound heavy as recorded on week three, so two lb. are required over the next week or two to achieve correlation to the WML. Obviously any fluctuation can be spread over time to soften recovery and ease trauma—but only by small, easily manageable increments to plan ahead or recover. Staying on top of management is the critical issue.

The E Scale does not impose a rigorous regime of deprivation in place of favorite foods or the meaningful social occasions when they are enjoyed. Rather, it substitutes low-impact management for forced caloric reductions, and consequently preserves the psychologically uplifting moods and comforting social life that are inarguably associated with food in our culture.

**E SCALE ALERT:** Our patient's two sisters (also chronically overweight) are coming to town to celebrate a good, old-fashioned family Thanksgiving. Our patient usually gains ten lb. before her sisters pack up the leftovers and head out of town. But this time she is prepared. Since she has been using the E Scale for 20 weeks for a sum loss of 20 lb., her lifestyle and caloric intake/dependence already has begun to diminish. (And yes, the argument can be made that for some, food—its effect—is an addictive drug!) Planning ahead for her yearly Thanksgiving food fest (or, should I say, *managing* ahead), she opts to lose an extra half-pound per week over the ten weeks preceding the holiday. **Figure 2** illustrates that Thanksgiving arrives and she is five lb. under scale going into the weekend. This is an example of successful weight management.

**Figure 2**

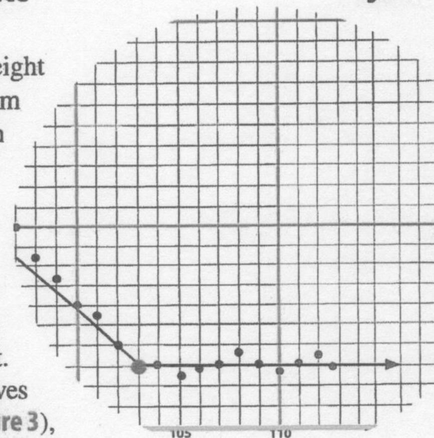
Thanksgiving

The following Monday (her regular chart day) she records only a five-lb. spike above the WML which she will manage over another ten-week period in the same manner she prepared for the much-anticipated gain. This ability to retain the recreational component of eating while effectively managing weight toward health is the heart of the E Scale philosophy. This represents its advantage over traditionally harsh modes of dieting.

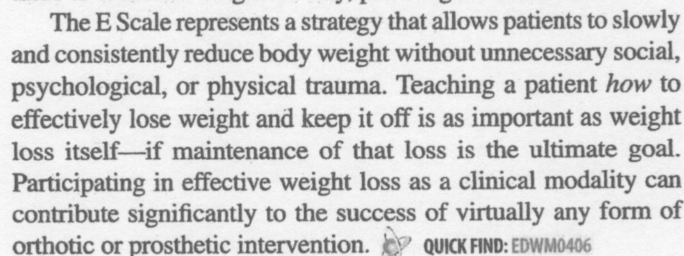
What about eating the *wrong* foods, the need for a well-balanced meal, and the danger of too many carbs? The fact that weight gain has become a problem for some is not a function of their ignorance of nutrition, but the lack of a successful strategy to address the problem. The E Scale is managerial, not nutritional, in its approach. It bases success on a low-impact reduction in portions and frequency of intake, not the termination of any particular food type or understanding of correct nutritional balance. Most obese Americans understand which foods cause excessive gain, and which are healthier. Comprehension is not the issue, but rather the need for a realistic strategy to gain control over unmanaged excess in overall caloric intake.

## Lifelong Maintenance for Health

**Figure 3**




The success of any weight management program should be based on maintenance of the loss—not short-term, diet-driven or artificial reductions. This is, perhaps, the key to effective, long-term weight management. Once our patient achieves her 175-lb. target (**Figure 3**), the Weight Management Line becomes a Weight Maintenance Line tracking a horizontal course for the rest of her life. She will continue to chart her weight weekly, planning for fluctuations.



The E Scale represents a strategy that allows patients to slowly and consistently reduce body weight without unnecessary social, psychological, or physical trauma. Teaching a patient *how* to effectively lose weight and keep it off is as important as weight loss itself—if maintenance of that loss is the ultimate goal. Participating in effective weight loss as a clinical modality can contribute significantly to the success of virtually any form of orthotic or prosthetic intervention. **QUICK FIND: EDWM0406**

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