

## MINDFUL PRACTICE

## Old Is New: Turn Off TV to Combat Obesity

BY JON O. EBBERT, M.D., AND ERIC G. TANGALOS, M.D.

**The Problem**

A 56-year-old woman presents to you for peripheral edema. She has a history of asthma, diabetes mellitus type 2 on insulin, hypertension, and sleep apnea. She has a sedentary job and does not routinely exercise. She has a body mass index of 55 kg/m<sup>2</sup> and 1+ pitting pedal edema with an otherwise normal examination. She reports that she has not been adherent with her CPAP because of a poorly fitting mask. You set her up for mask refitting and recommend compression stockings and exercise. She contacts you 3 months later to tell you that she has been adherent with CPAP and compression stockings, and the peripheral edema has improved. She has been less fatigued and exercises more but has been frustrated by her inability to lose weight. She was deterred from bariatric surgery after taking the classes and quit orlistat due to side effects associated with dietary indiscretions. Her insurance will not cover sibutramine, and she does not want to pay for it out of pocket. In desperation, you search PubMed to see what nonpharmacologic interventions have demonstrated benefit for facilitating weight loss.

**The Question**

In patients with obesity, what nonpharmacologic interventions are effective for weight loss?

**The Search**

You log on to PubMed ([www.pubmed.gov](http://www.pubmed.gov)), search for "obesity," and limit the results to "randomized controlled trials." You find a relevant study. (See box.)

**Our Critique**

Watching television is the third most time-consuming activity for American adults after work and sleep. We were amazed to learn that the average U.S. adult watches 5 hours of TV per day and will spend more than 65 days in total hours in front of the TV over the course of a year. The authors point out that the short duration of the study may not have captured stabilization of behaviors, which may have increased observed differences between the two groups. Interestingly, TV viewing time also decreased in the control group, which may have been related to either seasonal variation (i.e., less TV in the summer) or the Hawthorne effect (being observed changes behavior). This was a well-conducted trial providing a practical and useful intervention to present to patients asking that we "fix" their obesity. Counseling overweight and obese patients on the positive impact of turning off the TV adds to our armamentarium facilitating transference of the "locus of control" back to the patient.

**Clinical Decision**

Upon further history taking, you discover that the patient watches about 4 hours of reality TV per day. You share the findings from the study with her and recommend that she decrease television consumption by 50%. She tells you that she is not certain that she can do this with the season finale of "The Amazing Race" coming up, and requests that you get back to her if you discover any other new ideas.

DR. EBBERT and DR. TANGALOS are with the Mayo Clinic in Rochester, Minn. They report having no conflicts of interest. To respond to this column, e-mail Dr. Ebbert and Dr. Tangalos at [imnews@elsevier.com](mailto:imnews@elsevier.com).

**The Evidence**

Otten J.J., et al. Effects of television viewing reduction on energy intake and expenditure in overweight and obese adults. *Arch. Intern. Med.* 2009;169:2109-15.

► **Design and setting:** Randomized clinical trial done in Vermont.

► **Patients:** Patients were eligible for enrollment if they had a BMI of 25-50, were aged 21-65 years, and reported watching television for 3-8 hours/day. Potential subjects were excluded if they had factors conflicting with study outcomes (e.g., pregnancy/breast-feeding, certain medications, or participation in another intervention related to energy balance or sleep), reasons rendering TV lockout impractical, conflicts interfering with the study, medical or pharmaceutical contraindications, or household members not agreeing to the intervention.

► **Intervention:** After a 3-week observation-only period (phase 1), subjects were randomized (phase 2) to either a 3-week TV reduction intervention or to an observation-only control group. The intervention consisted of reducing TV viewing by 50% from each participant's objectively measured phase 1 viewing time. Baseline TV viewing was assessed using electronic monitors (BOB TV Time Manager by Hopscotch Technology).

► **Outcomes:** Outcomes were energy expenditure (EE), energy intake (EI), weight, and sleep. EE was measured using a portable device (SenseWear Pro 3 Armband by Bodymedia). Sleep was measured using logs, and diet information was collected through dietary recalls administered by telephone.

► **Results:** No significant differences were observed between groups at baseline. Eleven men and 25 women aged 22-61 years were randomized to intervention (n = 20) or control (n = 16) groups. Daily TV viewing (mean, hours/day) decreased by more than the 50% goal in the intervention group (4.8 hours in phase 1 vs. 1.8 hours in phase 2). However, the control group also decreased their TV viewing (5.3 hours in phase 1 to 4.5 hours in phase 2). No significant differences were observed in EI between groups. Subjects in the intervention group significantly increased EE, compared with controls (119 vs. -95 kcal/day). The intervention group had a significant decrease in time spent in sedentary activities, compared with a nonsignificant increase in controls. The intervention group had a negative energy balance between phases (-244 kcal/day), compared with a positive energy balance for the control groups (57 kcal/day). The intervention group had a greater decrease in BMI (-0.25 vs. -0.06 kg/m<sup>2</sup>). Minimal change was observed in total sleep.

## Primary Care Physicians Need Weight-Loss Tools

BY JANE ANDERSON

Almost all primary care physicians want to help obese patients lose weight, but they say that no one in their practice knows enough to adequately deal with weight-related issues, a survey revealed.

The survey of 290 primary care physicians, conducted by Harris Interactive late in 2009 and sponsored by the STOP (Strategies to Overcome and Prevent) Obesity Alliance, indicated physicians agree that a 5%-10% weight loss would help their obese patients.

But a companion survey of American adults released at the same time by the STOP Obesity Alliance found that only 39% of obese adults (those with a body mass index of 30 kg/m<sup>2</sup> or greater) said that a physician ever told them they were obese.

Those adults whose physicians used the term obese also said that the physician recommended they lose weight. But about one in three of these said that their physicians never discussed the mechanics of how to go about losing weight, the survey of 1,002 adults reported.

This results in a disconnect between the information that obese patients need from their physicians and what physicians actually tell them about losing weight, according to presenters at a briefing on the results from the two surveys.

"Patients want more information about weight management. They're hungry for it, and they don't know what information to believe," said Roz Pierson, Ph.D., Harris Interactive vice president of health policy research. "But a lot of primary care physicians said they or no one in their office had been trained to discuss weight issues. If you don't feel like you have the training to deal with weight issues, you can see why there is a lack of willingness to have a dialogue."

Both physicians and patients agree that even a small amount of weight loss is beneficial, according to the surveys. In all, 80% of patients who consider themselves overweight or obese, along with 91% of physicians, agree that the risk of disease is reduced "a great deal" or "somewhat" following a weight loss of 5%-10%.

Physicians told surveyors that they recommended a variety of strategies to patients for

weight loss, including improving their diets, counting calories, and reading a book or visiting a Web site. Physicians also said they recommended that their overweight or obese patients see a weight-loss specialist, enroll in community-based organizations, consider clinical programs for weight loss, or even have bariatric surgery.

However, physicians told surveyors that they didn't have the training or tools to properly counsel patients on weight, and they also lacked the time needed with those patients to do the job right.

Former U.S. Surgeon General Richard Carmona, who serves as health and wellness chairperson of the STOP Obesity Alliance, said at the briefing that solving the problem of time to deal with obesity and other preventive health issues would require a health system overhaul.

Still, he urged physicians to take the time if possible under the current system. "You can say, 'I'd like to take the time, but I don't have the time.' But would you say that if patient walked in with chest pains? In diabetic acidosis? With a broken arm?" Dr. Carmona asked.

Dr. William Bestermann Jr., medical director of Holston Medical Group Integrated Health Services in Houston, one of the most obese areas in the country, agreed that a health system overhaul would be needed to give physicians ample time to counsel patients on weight loss.

"The system produces the results it was designed to produce," Dr. Bestermann said. "We do all this pricey stuff at the end of the game. We need to shift some of those resources from the end game" in order to help people lose weight and lower their risks of chronic and acute health issues from the beginning, he said.

The STOP Obesity Alliance recommended the following five strategies to improve the treatment of obesity within primary care:

- Monitor weight, health indicators, and risk.
- Assess patient motivation and readiness for change.
- Define success in terms of health improvement rather than looks.
- Increase integration and care coordination among providers.
- Implement electronic medical records.