

Ilene Fennoy, MD

We have not been outgrowing obesity amongst our children. We've only been seeing the prevalence increase and we have a significant group of about 6 to 7 percent of all children now are in the severe obesity group, in addition to the 20 percent in the 12-19-year-old age group that are in the obesity group. This is getting to be very detrimental.

LuAnn Heinen

That's Dr. Ilene Fennoy, a pediatric endocrinologist at Columbia New York Presbyterian with double board certification in obesity medicine and nutrition. Dr. Fennoy evaluates and treats hundreds of children and teens with obesity in her clinic, some who experience health problems seen in much older adults including hypertension, fatty liver disease, type 2 diabetes, and arthritis. She also conducts research focused on the comorbidities identified in children and adolescents with severe obesity and the impact of bariatric surgery on these conditions. Additionally, she's been involved in a school-based study to evaluate how nutrition education curriculum and exercise programs influence insulin resistance in middle schoolers.

I'm LuAnn Heinen and this is the Business Group on Health podcast, conversations with experts on the most relevant health and well-being issues facing employers.

Today, Dr. Ilene Fennoy and I talk about new guidelines from the American Academy of Pediatrics urging pediatricians to more quickly offer treatment for children with obesity. We also review the recommended treatments for youth and how to communicate care needs with parents, teens, and young children.

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Dr. Fennoy, welcome to the Business Group on Health podcast. I'm really excited to have you with us today.

Ilene Fennoy, MD

Thank you. I'm very happy to be here.

LuAnn Heinen

You know, the American Academy of Pediatrics, and I'm sure you remember, published its very first clinical guidelines for child obesity last year, 2023, in the journal, *Pediatrics*. Now, it's been 25 years since NIH designated obesity a chronic disease in adults, followed by the AMA 15 years later in about 2013, I think it was. It's taken a couple of decades to recognize the serious impact of obesity on our kids. 1998, obesity in adults is a disease. 2023, the very first guidelines. So what do you think precipitated the release of a 100-page clinical guideline describing in detail what should be done to evaluate and treat kids for obesity?

Ilene Fennoy, MD

Well, one of the major reasons that this guideline appeared at this time is that the prevalence of childhood obesity has been continuously increasing. The AAP did publish a prior guideline in about 2007, which suggested that pediatricians should pay careful attention to weight in children and that extreme weights should be evaluated. But a lot of detail was not present at the time, mostly because of lack of information. With the progressive rise in childhood obesity, an effort was made to make much more detailed and specific guidelines to affect the way providers interact with children.

LuAnn Heinen

Yes, there's a lot of detail and a lot about the why, not just the what should be done, but also the why. Why do you think there's this level of urgency in depth treatment right now?

Ilene Fennoy, MD

Part of the issue with obesity is that we have accepted in our society that obesity is only a cosmetic issue. What we have learned generally across all age groups is that obesity is a medical issue associated with a number of adverse health effects. To some extent, we've acknowledged that for the adult population, but we had not paid a lot of attention to that for children. And therefore, we're recognizing now as the

prevalence of obesity gets progressively worse in the pediatric population, that we are seeing serious medical complications that are secondary to the obesity.

LuAnn Heinen

And I guess the legacy approach, which I think a lot of parents thought and probably a lot of physicians as well, kids are going to outgrow obesity and it seems pretty resoundingly clear that that's not the case.

Ilene Fennoy, MD

Certainly that's true. We have not been outgrowing obesity amongst our children. We've only been seeing the prevalence increase and we have a significant group of about 6 to 7 percent of all children now are in the severe obesity group, in addition to the 20 percent in the 12-19-year-old age group that are in the obesity group. This is getting to be very detrimental.

LuAnn Heinen

I have an off-the-wall question. What drew you to medicine and, in particular, this area of practice? It doesn't sound like you took the easy road.

Ilene Fennoy, MD

My interest was always in child growth. Somewhat initially interested in birth weight. One, because children of African American heritage as a group have lower birth weights in general than the Caucasian population and have increased morbidity around infancy. So, the concern is, what is driving that? One of the issues over the course of my education and practice was learning about the social determinants of health and their contribution to the issue and the need to work on a broader approach. Part of that social determinant of health is recognizing that maternal health has an impact on the fetus and the child for the rest of their life. We see mothers with diabetes in pregnancy and mothers with obesity have children who have increased tendencies for diabetes and obesity compared to mothers who did not have those problems during the pregnancy. There is this generational effect that is also going on. However, as a pediatrician, I focus on the child mostly. I don't get to interact with the mother except as proxy for the child and to encourage the lifestyle changes that will benefit them both and families who support their children and help them tend to do extremely well with getting healthier behaviors in their children. The earlier the child has obesity, the less likely they're going to grow out of it. Certainly, children who are overweight, which is their weight is higher than ideal but not seriously increased, that group has a very good chance of growing out of it with lifestyle changes, increased exercise, dietary changes, things such as that. But the more severe the child becomes as a problem of weight, the less likely they're going to grow out of that.

LuAnn Heinen

When children have excess weight at a young age, a very early age, what are the impacts of that across the lifespan?

Ilene Fennoy, MD

Unfortunately, children that develop obesity in their adolescent age almost never outgrow it and they get into comorbidities that we used to identify in 40-50-year-olds, now in 20-30-year-olds. So, with the beginning of the 2000s, we started seeing an increase in the number of children with type 2 diabetes. That's the type of diabetes that we previously called adult onset, and all the screening was targeted to 45 and above years of age. We start seeing large numbers of children developing this as they developed signs of puberty. We then followed those and tried to intervene and we're seeing that those children who develop this type 2 diabetes in adolescence get into complications of diabetes very rapidly. We used to say the middle-aged person, 45, 50, who developed type 2 diabetes would develop complications of that diabetes in 10, 15, 20 years. With these children, we're seeing them develop those complications in 5 to 10 years. So, we're talking about creating populations of children with serious complications of a chronic disease in their 20s and 30s. All of these things we associate with middle age, we're now seeing in the younger population.

LuAnn Heinen

Presumably, we do have treatments that we believe are effective. Starting some of these treatments sooner is believed to have an impact.

Ilene Fennoy, MD

Well, that is the other really nice thing about what has happened. Not only are we recognizing that there is an increasing problem, we also have had research develop interventions that are more effective than they used to be. The idea of watchful waiting when you know the problem is getting worse and you have an effective intervention seems to be poor planning. We now want to more aggressively deal with the problem and minimize the adverse effects to our children.

LuAnn Heinen

Let's recap the range of treatments recommended now by age group.

Ilene Fennoy, MD

Well, first of all, for everyone no matter what age group, with overweight or obesity, lifestyle interventions are recommended, that is making dietary and physical activity changes to your life to improve your overall health. Once you start becoming more severely obese, then medications may be added to the lifestyle interventions for those children over the age of 10. But before you go to interventions, you have to screen these children for comorbidities or complications related to obesity. Now with these new guidelines, we're focused on screening children whose BMI, so weight in relationship to height, is greater than the 95th percentile for their age group, screening them for complications associated with obesity, like hypertension, like high cholesterol triglyceride, like diabetes, like fatty liver disease. All of these become issues that need to be addressed.

LuAnn Heinen

Wow. Did you say when they're 10 and older medications are a potential treatment and does that depend on the results of the screening for comorbidities?

Ilene Fennoy, MD

In general, yes. Most of the medications are approved 12 and up. Some are approved 6 to 12, but it depends on the comorbid condition. A patient with diabetes in the 10 to 12 age, medication would definitely be approved and it's the medications that are appropriate for the type of diabetes they have. These children who have diabetes as a result of obesity are most often children with the type 2 variety. We frequently have to try and separate what types of diabetes children have and we can't just use weight alone and the treatments are different according to the type you have. What we're seeing is this 10 to 12 where puberty is beginning, the development of type 2, the adult type that we no longer call the adult type, and in that group there are a variety of medicines that are now useful and we offer them.

LuAnn Heinen

If an 11-year-old with obesity has hypertension or high cholesterol numbers, would they potentially be treated with hypertension medicine or with a GLP-1 kind of obesity type medicine?

Ilene Fennoy, MD

Possibly both. Okay, both the hypertension and the GLP-1 depends on the level and the seriousness of their hypertension. It also depends on the state that they live in and the type of insurance that they have. This is one of our bigger limitations now. We still at the political level frequently think of obesity as cosmetic, and in many places Medicaid and/or Medicare do not pay for weight loss medications. So, a child with obesity and hypertension may have no other option but to receive antihypertensive medicines and diet and lifestyle intervention, but no weight loss medication.

LuAnn Heinen

Could an 11-year-old get lipid-lowering medication, a statin?

Ilene Fennoy, MD

Yes, statins are approved for the sort of early pubertal age or the peripubertal age, so 10 and above, if the cholesterol is high enough, but they have to have serious elevations of them. By and large, when we're using medications in these younger children, we're choosing to give medications to children who are more severely affected. At the overweight category, it's lifestyle at greater than the 95th percentile BMI to about 120 percent of the 95th percentile, which is sort of class 1 obesity. Lifestyle plus weight loss medications would be primary, even if they have comorbidities, as long as their comorbidity is not seriously abnormal.

Once you go above 120 percent of the 95th percentile, then people start considering weight loss medications, whatever medications they need for their comorbidity, be it statins, be it antihypertensives, and even depending on how severe their problem is, bariatric surgery may be considered.

LuAnn Heinen

Oh my goodness. It's really hard to hear that so many kids are struggling in this way and they're needing some of these medicines or injectables and are on regular schedules of pill-taking. That's a lot.

Ilene Fennoy, MD

Yes, it's very much for children to have to deal with. Our goal would be to try and recognize problems as they develop and do the preventative approach with the overweight child to prevent progressing to obesity. So here, lifestyle, family therapy, exercise activities, all of that are critical to preventing the child from progressing on to a greater need.

LuAnn Heinen

It's pretty clear that a lot of those activities and programs have been around for the last many decades and haven't put a stick in the spokes, so to speak, haven't stopped the dramatic 3, 4-fold increase in child obesity.

Ilene Fennoy, MD

We need to recognize that the programs have not been around very much at all. The concept has been around, the recommendations have been around, but there's limited access to such programs. The programs themselves require significant intensity, that is participation from families, which depending on your life circumstances may be difficult to accomplish between work and school and then an additional after-school program. Many of the groups most affected by increased weight do not have after-school programs that focus on physical activity, maybe not even on education, but certainly not on physical activity. They are very sedentary. Gyms in many schools are not as active as you'd like. Many children have 2 to 3 times per week, some have 5 times per week, but there are schools that have almost no physical education except recess, which is not organized physical activity. Programs are not as commonplace as one might think. The recommendation is very commonplace, but programs are difficult to access.

LuAnn Heinen

There's always challenges with implementing guidelines, but you've already flagged a big one here for that guideline of family support intervention on the lifestyle side. How's that going to happen?

Ilene Fennoy, MD

That's particularly difficult. The studies on the lifestyle really suggest that you need 26 hours of intervention time with family to have a significant impact on their weight loss. It's over a 6-12-month period, but still, 26 hours would at least be one hour every week. That's very difficult for many people to organize. That is a barrier right there.

LuAnn Heinen

I'm speaking with Ilene Fennoy, board-certified pediatric endocrinologist specializing in treating obesity and its complications in children and teens. We'll be right back.

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LuAnn Heinen

Just for any listeners who may be thinking about where to look, CDC has recognized family healthy weight programs that meet certain criteria, that they're based on adequate evidence, include the contact hours that you mentioned, at least 26 hours with families, and some of these are in the YMCA system, although not every Y offers the program, some are more clinic-based. There is on the CDC website a link to at least

take a look and access some of these programs. It's not a long list, but it's a good list, and we'll provide that in the show notes.

Ilene Fennoy, MD

Yes, it's very helpful to have that available to families. I wish we had more programs to add to that list.

LuAnn Heinen

Let's talk about bariatric surgery. What's the receptivity to bariatric surgery versus drugs? I have a hypothesis, but what do you see?

Ilene Fennoy, MD

I think it's variable. We have definitely been adversely affected in New York State by the limitation of Medicaid, so we have no access to weight loss medications for patients who are on Medicaid. We definitely use them where we can for patients who have other insurance and some patients are using them in preparation for their bariatric surgery. Then they go on to bariatric surgery with the intent of not returning to the weight loss medication. So we're seeing a variety of combinations and one of the new areas of investigation is whether we should be using weight loss medications in patients who regain after weight loss surgery.

LuAnn Heinen

In the adult population, a very small percentage of those who qualify, something like 20 percent of adults would qualify for bariatric surgery, and maybe 2 percent get it. Is it different in the adolescent population?

Ilene Fennoy, MD

I don't think it's really different. We see a limited number of places that offer bariatric surgery to the adolescent population and many of those skew it towards the older adolescent, excluding the younger adolescents, so they have 17, 18-year-olds, but no one younger than that. That can be an issue for access. There's a percentage of children who come for bariatric surgery and who don't qualify primarily based on their inability to make lifestyle changes. Many of our bariatric programs require that there are diet and activity changes as a part of it. They don't require necessarily weight loss, but they often require stabilization of weight, stopping of weight gain, before they will do bariatric surgery. Patients don't get it because they're unwilling to make certain changes. Patients don't get it because their insurance refuses to approve them. There are patients who want it and patients whose families want it for them. We really want patients to want it for themselves before we move forward.

LuAnn Heinen

It reminds me a little bit of, it's been a few years now, the research on transplants in young adults, older teens and young adults, and how difficult compliance was post-transplant when taking immunosuppressive drugs was literally life-saving, and they somehow were surprisingly non-compliant.

Ilene Fennoy, MD

Yes, adolescents are having many stressors as they negotiate their own separation from family and what is appropriate and inappropriate and how to be like their friends but still be themselves. All of that is a major developmental stage of life, which can make serious disease or medical complications more difficult to handle.

LuAnn Heinen

Now, there's been some concern and pushback from the eating disorder community, experts who feel that perhaps obesity shouldn't even be a disease and we shouldn't have such specific guidelines focused on BMI and weight and so on. What are your thoughts about that?

Ilene Fennoy, MD

One of the issues is that eating disorders exist frequently amongst obese individuals. Obesity itself in our society is a medical problem that is stigmatized. People are bullied, they're teased, they're discriminated in terms of job hiring because of their weight. So obesity itself can be a serious problem that leads a person to become depressed, to choose to eat food in isolation, to binge eat, to develop bulimia without them even trying weight loss programs or products. Part of the issue is knowing how much of our population is

involved in eating disorders as a product of their obesity versus how much developed their eating disorder after the treatment for obesity with significant weight loss.

LuAnn Heinen

Where does that leave us with the guidelines? Do you feel that there's anything more that should be done to minimize the risk of pushing someone into an eating disorder or not understanding where they are vis-a-vis disordered eating?

Ilene Fennoy, MD

Well, one of the things these guidelines nicely do is they discuss eating disorders and suggest that individuals actually as a part of the evaluation process and assessment of their overweight be evaluated for eating disorders. This is really an important activity to take place because if the child is presenting with an eating disorder, that needs to be addressed right then and there before you go to more aggressive things. Or as a part of combination therapy, you're treating the eating disorder as well as you're treating the weight problem itself. That's one of the issues that makes programs for children with obesity extremely difficult to manage. Mental health services for adolescents are already shortchanged. Many of the mental health services themselves are focused on other areas of mental health with adolescents and not on eating disorders. And there are practitioners who do not feel that that is an area that they are comfortable dealing with, they're not trained for, etc. It can be hard to have a child get the requisite services for their eating behaviors, but it's definitely an important thing to evaluate. We're not seeing so much eating disorder after bariatric surgery. There are some studies, not a lot. Many show remission or resolving the eating disorder associated with the weight loss. So, addressing it as a part of the whole treatment plan and not just expecting it to magically go away because you treat the obesity seems to be the most helpful approach to dealing with eating disorders.

LuAnn Heinen

Thank you for that. This whole conversation is making me wonder about how pediatricians are going to respond and how they're going to be able to respond to the guidelines. Really, there's a fair amount of nuance and complexity to all of this and they've got busy practices. What do you think about implementation of these guidelines?

Ilene Fennoy, MD

I think the guidelines present many problems for the general practice, but they also address the fact that pediatricians may not be able to address it all in their practice, and looking for resources that they can align with, refer to, can be extremely helpful. There are clear statements in the guidelines about screening for instance, eating disorders, and making that referral, not trying to deal with it yourself. But the guidelines do suggest that it's not totally the pediatrician's responsibility to do it all. It's the role of the pediatrician to identify, to perform screening of any complications and associated problems, to coordinate care wherever possible so that the patient gets the optimal outcome, and to provide some level of care that is appropriate within their expertise. Surprisingly, when one tries to break it up and begins to work on it, one can make some headway. It's not necessarily perfect, and that's why we'd like more of the healthy children's weight programs available to us, but at the same time, it definitely helps a large number of children.

LuAnn Heinen

Dr. Fennoy, thank you so much for this conversation. I so appreciate everything I've learned and your commitment to your patients.

Ilene Fennoy, MD

Thank you. I'm glad to have had this opportunity and I hope our listeners find it useful.

LuAnn Heinen

I've been speaking with Dr. Ilene Fennoy, a pediatric endocrinologist specializing in obesity medicine and nutrition. She's the medical director of Columbia Presbyterian's Comprehensive Adolescent Bariatric Surgery Program. In her practice, she routinely cares for children with obesity, some who experience health problems seen in much older adults, including hypertension, fatty liver disease, diabetes, and arthritis.

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