Do No Harm

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Provider's Resource Guide to the American Academy of Pediatrics Clinical Practice Guidelines for the Evaluation and Treatment of Children and Adolescents with Obesity

Overview

- The American Academy of Pediatrics (AAP) released Clinical Practice Guidelines for the Evaluation and Treatment of Children and Adolescents with Obesity on January 9, 2023.
- Each author of AAP Clinical Guidelines has financial ties to companies specializing in weight loss, pharmaceuticals, or bariatric surgeries. (1)
- Research methodology specifically excluded studies that focused on health outcome improvement regardless of weight change or came from a weight neutral perspective including those studies that incurred no weight loss. Therefore, only research studies that showed some weight loss were included. (2)
- These guidelines make a bold recommendation of using Body Mass Index (BMI) as a diagnostic tool. BMI has long been known as an unethical screening tool, rooted in race science, not making mathematical sense for assessing health and mortality risk of individuals or populations and yet through effective lobbying of eugenics supporters, pharmaceutical companies and diet industry it has become widely used as a screening tool in medical practices to the point where medical providers do not question the use of this tool nor the ethics and harm of using it in every day practice. (3)
- The context of how the authors laid out these guidelines makes evident their lack of ethical considerations and knowledge base regarding health outcomes related to weight stigma, fat phobia, weight bias, social determinants of health, the intersection of racism and weight bias, and the impact of weight stigma on eating disorder risk factors, depression and suicide rates of children. (4)
- The authors make several contradictory statements such as
  - Recommending weight loss surgery to prevent a child from being bullied for their weight. There is no situation in modern society where undergoing life risking, organ altering surgery to appease a bully/oppressor is ethical. (2)
  - Recommending interventions that will place a growing body into a state of malnourishment as well as disrupt absorption of nutrients in an effort to achieve minimal, short term weight loss.

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- Remarks on the significant impact of the social determinants of health yet all recommended solutions are individualized, expensive, time consuming solutions that do not address the systems causing harm.

- Recommending weight loss reinforces weight stigma, anti-fat bias and fatphobia. Being in a fat body does not equate to poor health outcomes. Weight stigma doubles allostatic load and is significantly associated with greater morbidity and mortality. (5, 6)

- Two diet industry tropes repeated throughout this document were originally marketing schemes to rebrand the data showing dieting in adults worsens health outcomes and increases weight. (7)
  - "Existing in a higher-weight body is a lifelong chronic health condition requiring lifelong treatment."
  - "Being in a larger body causes health issues."

Recommendations

Three forms of intervention have been recommended for children aged 2 or older who meet clinical criteria.

When considering using these guidelines in clinical practice please keep in mind that stigma is a fundamental cause of health inequalities and an added burden that affects people above and beyond any impairments they may have. (8)

Recommendation 1	Intensive Health Behavior & Lifestyle Treatment (IHBLT)

Intervention	Start at age 2

26 hours of nutrition, physical activity and behavior change lessons over 3-12 months. Repeat ongoing as many children will not experience BMI improvement.

How this Harms

- Utilizes the unethical and problematic diagnostic tool of Body Mass Index as a cut-off marker without considering growth patterns, genetically determined body shape and size, etc. (2)

- Time consuming, expensive and families are expected to rinse and repeat as long-term weight loss is not likely. (2)

- Ignores impact on families regarding intersection of socioeconomic status, race and weight stigma. (3)

- Behaviors taught in these programs meet qualifications for eating disorder diagnostic criteria. (9)

- The #1 trigger for eating disorders is dieting, even "moderate" dieting. (10)
- Eating disorders have the second highest mortality rate of all mental health disorders, surpassed only by opioid addiction. (11)
- Ignores the harm of weight cycling. (12)
- Recommending weight loss to a child may trigger a lifelong struggle with an eating disorder and increased risk of premature death as it is estimated that 28-74% of risk for eating disorders is through genetic heritability. (13)
- Reinforcing individual responsibility versus addressing systems causing harm is a pillar of white supremacy. In this context, medicalized weight stigma is the system that needs to be prioritized. (3, 14)
- Increases likelihood child will delay future medical care as an adult due to medicalized weight stigma received in childhood. (15)
- Recommendations are likely to disrupt normal growth and development.
- Reasonably Expected Harms of Weight Cycling in Children:
  - Accelerated growth/weight-for-age gains
  - Unexpected increased trajectory of growth
  - Increased autoimmune diagnoses
  - Increased cardiovascular issues
  - Increased mortality risk
  - Increased mental health disorders including depression, anxiety, general mood dysregulation
  - Increased nutritional deficiencies

Recommendation 2 | Pharmacotherapy

Intervention

Offer to children ages 8-11 years old if they have other health conditions (not defined) and live in a higher weight body in addition to IHBLT.

Medications Recommended

- Metformin
- Orlistat
- Lisdexamfetamine (Vyvanse)
- Melanocortin 4 Receptor Agonist (MC4R)
- Vyleesi (bremelanotide)
- Scenesse (afamelanotide)
- Imcivree (setmelanotide)
- Glucagon-like peptide-1 Receptor Agonist (GLP-1 Agonists)
- Trulicity (dulaglutide)
- Bydureon bcise (exenatide extended release)
- Byetta (exenatide)
- Ozembic/Wegovy (semaglutide)
- Victoza (liraglutide)
- Saxenda (liraglutide)
- Adlyxin (lixisenatide)
- Rybelsus (semaglutide)
- Phentermine/Topirmate Combo

How this Harms

- Drug trials for weight loss across the decades for adults and children follow a similar trajectory. Participants may show weight loss up to 4-5% in the short-term, if any, then medication is stopped and weight gain occurs. Follow up is usually stopped as weight gain begins resulting in short term trials with no follow up on long term impact. Weight loss can reasonably be attributed to gastrointestinal side effects of the medication and dehydration. (7)
- Many of the well-known side effects and nutrient depletions caused by the recommended medications contribute to several of the same concerns that the AAP guidelines were designed to address – negative mental and physical health impact of weight stigma and metabolic risk factors for morbidity and mortality.
- A child's body size is not an ethical reason to prescribe medication for weight loss.
- Inducing diarrhea, nausea, vomiting and sudden onset fecal incontinence does not make someone in a fat body more comfortable in society. How might this impact school attendance and learning?
- Inducing malnutrition by way of malabsorption of vitamins and minerals, regardless of body size changes, does not support growth and development nor overall health and wellbeing.

Medication Side Effects (16)

- **Metformin**
  Diarrhea (53.2%), Nausea/Vomiting (25.5%)
- **Orlistat**
  50% experience the following for up to 4 weeks with some continuing beyond 6 months; oily spotting (26.6%), abdominal pain (25.5%)

  Increased risk of kidney stones, pancreatitis, increased liver enzymes and GI bleeding
  Nutrient depletions including fat soluble vitamins ADEK and beta carotene
- **Vyvanse (Lisdexamfetami ne)**
  Dry mouth (36%), Insomnia (27%)
- **Melanocortin 4 Receptor Agonists**
  Skin Hyperpigmentation (78%), Nausea (56%), Headache (41%), Diarrhea (37%), Back Pain (33%), Fatigue (30%), Depression (26%)
- **Trulicity(dulaglutide)**
  Increased risk of pancreatitis
- **Bydureon BCise/Byetta (exenatide)**
  Nausea (34%)
- **Wegovy /Ozembic/Rybelsus (semaglutide)**
  Nausea (44%), Diarrhea (30%)
  Increased risk of gallstones, Pancreatitis
- **Victoza/Saxenda (liraglutide)**
  Nausea (39.3%)
  Increased risk of gallstones, Thyroid C-cell tumors, Pancreatitis
- **Adlyxin (lixisenatide)**
  Nausea (26.5%)

- **Phentermine/Toprimate Combo**
  "Safety and efficacy not established; use not recommended. Serious adverse reactions including acute angle glaucoma, oligohidrosis and hyperthermia, metabolic acidosis, cognitive and neuropsychiatric reactions, hyperammonemia and encephalopathy, and kidney stones, reported in pediatric patients receiving topiramate."

- Of note, Wegovy by Novo Nordisk was approved by the FDA on 1/4/2023 (5 days prior to the release of these guidelines) on a 68 week study funded by Novo Nordisk that showed weight loss due to significant to severe side effects in children including nausea, vomiting, cramping, pancreatitis, gallstones, kidney failure, suicidal ideation, tachycardia, depression and tumors. Novo Nordisk's response was to recommend staying on this medication for life (17). This medication stimulates beta cells in the pancreas. When used for weight loss, the recommended prescription dose is double what is used for diabetes management. There is concern that this medication will exhaust beta cells faster and cause premature onset of diabetes, though no one knows the long term risks as this was only a 68 week study.

Recommendation 3 | **Weight Loss Surgery**

Intervention

Adolescents 13 yrs and up with BMI > 120% of 95th percentile for age and sex should be referred for metabolic and bariatric surgery.

How this Harms

- Weight loss surgeries are taking a healthy, functioning organ (in this case, that of a growing and developing human) and surgically putting it into a permanent disease state that forces an underdeveloped brain to engage in anorexic eating disorder behaviors for the rest of their life.

- Medical prioritization of achieving short term possibility of thinness above overall mental, physical, emotional health of a child is unconscionable. "If this were to happen to a child it would be considered a tragedy. If it occurs to a child because of weight, it is considered healthcare." -Ragen Chastain

- Studies referenced had small participant sizes and all showed consistently similar results.
  - High rates of nutritional deficiencies (7).
  - High need for additional surgeries due to complications with the original surgery (7).
  - Weight regained to baseline by year 5, usually starting in year 2 post op (7).

- Reported "Benefits" of weight loss surgery are derived from short term studies where follow-up is not monitored after 4.5-5 years post op. (18) This is not an appropriate assessment range for children and adolescents who are still growing and developing.
- The recommendation does not address socioeconomic disparities that will put children at risk of not being able to follow through with taking expensive supplements and medications as well as special foods necessary to reduce risk of long term consequences such as dumping syndrome.
- Food restriction in any form and for any reason increases feelings of loneliness in children and adults. (19)
- The messages this recommendation sends to the public is
  - Fat people should be willing to risk their life and reduce their quality of life in an attempt to become thinner. (3)
  - Surgery will cure/prevent health problems that also happen at similar rates to thin people but are socially acceptable in thin bodies and therefore are not pathologized. (7)
- Known Risks associated with Bariatric Surgery (20)
  - Common Post Op:
    - Acid reflux
    - Anesthesia-related risks
    - Chronic nausea and vomiting
    - Dilation of esophagus
    - Inability to eat certain foods
    - Infection
    - Obstruction of stomach
    - Weight gain or failure to lose weight
  - Common Post Op:
    - Dumping syndrome
    - Low blood sugar
    - Malnutrition
    - Vomiting
    - Ulcers
    - Bowel obstruction
    - Hernias
    - Increased risk of substance use disorder
  - Risks of Gastric Bypass:
    - Breakage
    - Dumping syndrome
    - Gallstones (risk increases with rapid or substantial weight loss)
    - Hernia
    - Internal bleeding or profuse bleeding of the surgical wound
    - Leakage
    - Perforation of stomach or intestines
    - Pouch/anastomotic obstruction or bowel obstruction
    - Protein and/or calorie malnutrition
    - Pulmonary and/or cardiac problems
    - Skin separation
    - Spleen or other organ injury
    - Stomach or intestine ulceration
    - Stricture
    - Vitamin and/or iron deficiency
  - Risks of Gastric Sleeve:
    - Blood clots
    - Gallstones (risk increases with rapid or substantial weight loss)
    - Hernia
    - Internal bleeding or profuse bleeding of the surgical wound
    - Leakage
    - Perforation of stomach or intestines
    - Skin separation
    - Stricture
    - Vitamin and/or iron deficiency

Summary

The American Academy of Pediatrics' (AAP) Clinical Guidelines for the Evaluation and Treatment of Children and Adolescents with Obesity is unethical, will cause significant and severe harm to children, is contradictory to empirical evidence, reinforces weight stigma, reinforces systemic oppression of children in marginalized bodies, and upholds the pillars of white supremacy. Health care providers are sworn to First Do No Harm. These recommendations do nothing but harm on individual, familial and systemic levels.

Provider Considerations

- We must first acknowledge that medical training across all disciplines does not appropriately teach nor equip medical practitioners appropriately for weight inclusivity, the intersection of racism and weight science, the cycle of socialization, nor the social determinants of health and how these topics intersect with our day to day patient care. Due to industry funding the institutions charged with training medical professionals, it is up to us to demand a systemic shift with our accrediting agencies while simultaneously requesting and incorporating these trainings within our own organizations and individually.
- Diet culture has co-opted many provider's ability to treat fat patients with dignity and respect. If this statement is uncomfortable for you to accept, consider that discomfort a sign you have biases and unlearning to explore within yourself.
- Doing no harm, begins with the courage to do our own work. Every healthcare provider, with no exceptions, has internalized racism, weight stigma and fat-phobia. We unknowingly perpetuate harm with patients every single day.

Provider Recommendations

- Screen children for eating disorders annually, beginning at age 8.
- Educate yourself and your staff on eating disorder prevention and treatment.
- Call on the AAP to retract the entirety of this Guideline. Do this publicly and through emails and phone calls.
- Call upon the AAP to make it mandatory for all pediatric primary care providers to obtain recurrent continuing education on social determinants of health, weight inclusive care and internalized weight bias.
- Call upon the AAP to abandon the use of BMI-for-age calculations for children.
- Require the AAP to work with multidisciplinary teams who have no affiliations with diet industry, weight loss clinics, pharmaceutical industry, lobbying, wellness industry and who do primarily work with the pediatric population in the disciplines of primary care including registered dietitians, mental health providers and patient advocates. It is imperative that 50-100% of this team also be experts in the field of eating disorders.
- Make time to do your own work. Connect with other weight inclusive healthcare providers, seek out your own training and consultation regardless if CME's are offered.

Learn how to Help without Harming Virtual Trainings

- Annual Weight Stigma Conference https://weightstigmaconference.com
- Association for Size Diversity and Health Annual Conference: https://asdah.org/conference/
- Weight Stigma Training by Asher Larmie, GP https://www.fatdoctor.co.uk/training/
- Feeding & Eating for Kids: Challenges, Disordered Eating, and Our Approach & Biases by Sanity Iyer, ND, LM. https://tinyurl.com/2p8t4fteV
- Trauma-Informed Care for the Fat Body by Lily Stokely, ND & Tara O'Brien, ND. https://tinyurl.com/2p8t4fte
- Management of Eating Disorders for Primary Care Providers by Kara Menzer, ND. https://tinyurl.com/4wxa4xmz
- What are We Going to Do about the Weight?: Weight Stigma in Health Care by Amelia Mitchell, LMP, CLS. https://tinyurl.com/44avfs65h
- Responsive Feeding Therapy Virtual Trainings, https://responsivefeedingpro.com/webinars/
- Body Trust Professional Training by The Center for Body Trust, https://centerforbodytrust.com/offerings
- Feeding With Love and Good Sense VISION Workshop, https://www.ellynsatterinstitute.org/product-category/selfstudy/

Trainings for Individuals and Organizations

- BIPOC Eating Disorder Conference: https://bipoceatingdisorders.showit.site
- The Gaudiani Clinic: https://www.gaudianiclinic.com/trainings
- The Adaway Group: https://adawaygroup.com
- Every Level Leadership: https://everylevelleadstraining.com
- Training & Consulting by Sonya Renee Taylor: https://www.sonyareneetaylor.com/training-and-consulting
- Jessica Wilson, RD: https://www.jessicawilsonmsrd.com/consulting
- Ellyn Satter Institute: https://www.ellynsatterinstitute.org/what-we-do/
- Lindo Bacon: https://lindobacon.com/speaking/

Books

- Sick Enough: A Guide to the Medical Complications of Eating Disorders by Jennifer Guadiani, MD, CEDS, FAED
- Belly of the Beast: The Politics of Anti-Fatness as Anti-Blackness by DaShaun Harrison
- Fearing the Black Body: The Racial Origins of Fat Phobia by Sabrina Strings, PhD
- It's Always Been Ours: Rewriting the Story of Black Women's Bodies by Jessica Wilson, MS, RD

- Decolonizing Wellness by Dalia Kinsey, RD
- Anti-Diet by Christy Harrison, MPH, RD, CEDS
- How to Raise an Intuitive Eater: Raising the Next Generation with Food and Body Confidence by Sumner Brooks, MPH, RDN and Amee Severson, MPP-D, RDN
- Helping Your Child with Extreme Picky Eating: A Step-by-Step Guide for Overcoming Selective Eating, Food Aversion, and Feeding Disorders by Katja Rowell, MD, Jenny McGlothlin, MS, SLP
- A Clinician's Guide to Gender-Affirming Care: Working with Transgender and Gender Non-Conforming Clients by Sand Chang, PhD
- Man Up to Eating Disorders by Andrew Walen, LCSW-C

Popular Articles, Podcasts & Resources Your Clients Are Already Consuming

- Weight and Healthcare by Ragen Chastain, https://weightandhealthcare.substack.com
- Burnt Toast by Virginia Sole Smith, https://virginiasolesmith.substack.com
- Health At Every Size Health Sheets: Blame Free, Shame Free Explanations of Common Medical Conditions, https://haeshealthsheets.com/
- Katja Rowell, MD, https://www.thefeedingdoctor.com/resources
- Lindo Bacon, PhD. https://lindobacon.com/resources
- Maintenance Phase Podcast by Aubrey Gordon and Michael Hobbes
- Food Psych Podcast by Christy Harrison
- The Appetite Podcast by Opal: Food + Body Wisdom
- Men Unscripted Podcast by Aaron Flores
- All Fired Up Podcast by Louise Adams

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