Clinical Design & Innovation
Person-centred, co-ordinated care

PAEDIATRICS

FACULTY OF PAEDIATRICS
ROYAL COLLEGE OF PHYSICIANS OF IRELAND

Child Obesity

BACKGROUND

- Prevalence in children in Ireland estimated to be 20%, greater prevalence in girls and disadvantaged children.
- Complex, chronic, multi-factorial disease requiring a comprehensive multi-disciplinary approach to care.
- Weight based stigma and obesity discrimination must be challenged in our health care response.

DEFINITIONS

BMI thresholds are different in children to adults as their bodies undergo physiological changes.

For children > 2 yrs sex specific growth reference percentile charts are used UK-WHO

< 2nd centile – underweight

> 85th centile – overweight

> 95th centile – obese

CONSEQUENCES

Children who are greater than a healthy weight are at significant risk of many adverse health consequences e.g obstructive sleep apnoea (OSA), hypertension (HTN), cardiovascular disease (CVD), type 2 diabetes, certain cancers, osteoarthritis.

Children's quality of life may also be impacted substantially by psychosocial aspects such as exclusion, low mood and anxiety.

HISTORY

- Detailed neonatal and developmental history
- Social and environmental history
- Medical history to rule out other important causes of obesity – hypothyroidism, pseudoparahypoparathyroidism, Cushing syndrome, Prader Willi, Bardet-Biedl or other syndromes
- Complications/comorbidities associated with obesity – headache, obstructive sleep apnoea, hip pain, abdominal pain, polyuria/polydipsia, polycystic ovary syndrome
- Medications likely to exacerbate weight gain
- Psychosocial impact of weight
- Patterns of eating

EXAMINATION

- Observe for features consistent with relevant syndromes
- Skin for ancanthosis nigricans, hirsuitism, acne, striae
- Abdominal palpation for hepatomegaly
- Tanner staging and pubertal assessment
- Weight, height, BMI centiles
- Blood pressure

INVESTIGATIONS

As indicated by examination

- Urine dip for glucose and protein
- Fasting glucose, HbA1C, lipids, Cholesterol
- LFTs and TFTs
- Cortisol, calcium, phosphate and parathyroid hormone (PTH)
- Pituitary hormones
- Imaging - organomegaly, bone pain, gonads
- Consider genetics if unexpected findings e.g. short stature

TREATMENT

- Policy
- Prevention
- Lifestyle modification
  - Diet: Discuss healthy eating and portion size. Consider dietitian referral
  - Exercise: Discuss increasing daily exercise
  - Behaviour therapy
  - Discuss co-morbidities
- Pharmacotherapy
- Bariatric Surgery

  Post pubertal adolescents with severe obesity with co-morbidities

KEY OUTCOMES

https://childhoodobesity.ie/

Improve social participation, patient centered and functional outcomes

Depending on child's age, agree weight loss targets with multidisciplinary team

MODEL OF CARE - REFERRAL

Level 0 – health promotion and community

Level 1a – GP and primary care

Level 1b – Community specialist MDTs

Level 2 – Hospital specialist MDTs

Level 3 – Tertiary care MDT https://w82go.ie

Ref: Child Obesity 10/23. CDI/0067/2.0/2023