Treatment of Pediatric Overweight and Obesity Should Involve Nutrition Expertise in Diagnosis of These Diseases

To the Editor:

The article "Treatment of Pediatric Overweight and Obesity: Position of the Academy of Nutrition and Dietetics Based on an Umbrella Review of Systematic Reviews"[1] presents a comprehensive view of appropriate interventions and counseling for management of a complex chronic disease. Although timely, the review fails to present the fundamental role that credentialed cre cnutrition and dietetics practitioners play in diagnosing and managing these conditions. Disease treatment should be based on the correct diagnosis and identification of root causes of obesity along with any barriers to treatment.[2,3] As summarized by Styne and colleagues,[4] root causes of obesity include biological factors, such as genetics, epigenetics, neurohormonal mechanisms, associated chronic diseases, and obesogenic medications. In these situations, dietary and lifestyle management are appropriate but may be insufficient. Nutrition and dietetics practitioners are integral health care providers who can help identify the causes of obesity for appropriate disease management.

The critical importance of identifying the cause of obesity in those with early-onset obesity has been discussed recently.[5,6] As estimates of a genetic cause of obesity exceed 7% of cases presenting with early-onset obesity, it is likely that pediatric dietitians see cases that have a genetic cause.[7] The current "Pediatric Obesity—Assessment, Treatment, and Prevention: An Endocrine Society Clinical Practice Guideline" recommends genetic testing if a child's onset of obesity is before age 5 years or if the child has hyperphagia or a family history of extreme obesity.[4] Nutrition professionals are best suited for hyperphagia assessment, and routine practice should include considerations for further diagnosis of disease etiology if the assessment is suggestive and a root cause is unknown. One example that is often discussed is Prader-Willi syndrome. It should be noted that the developmental pattern for this disease is well-characterized and distinct, and thus should not be used as an example of other genetic obesity.

In addition to assisting with disease diagnosis, nutrition professionals play a significant role in clinical management of obesity and concomitant nutrition challenges. The limited publications to guide diet management of genetic obesity diseases should be addressed. The gaps in the critical knowledge that would be the basis of systematic reviews to establish practice guidelines present additional opportunities for nutrition professionals in both clinical and research settings. For example, Miller and Tan[8] provide suggestions for diet management in pediatric patients with Prader-Willi, but also highlight concerns about nutrient insufficiency that results from caloric restriction.

One scenario that highlights the difference in a patient's care trajectory could be a family that self refers to a pediatric dietitian. The dietitian could focus on dietary changes with limited success compared with a comprehensive assessment that indicates referral to a subspecialist team that identifies a genetic cause requiring a different approach to diet management, medication management, genetic counseling, and additional support.

In summary, treatment of pediatric and early-onset obesity requires consideration of the root cause, including those that may limit the effectiveness of traditional diet management approaches. Additional evidence to develop best practices for management of these conditions is necessary.

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STATEMENT OF POTENTIAL CONFLICT OF INTEREST Sylvia Poulos owns stock in Rhythm Pharmaceuticals, Inc, a company with interest in rare genetic diseases of obesity.
FUNDING/SUPPORT There is no funding to disclose.

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References

1. Kirk S, Ogata B, Wichert E, Handu D, Rozga M. Treatment of pediatric overweight and obesity: Position of the Academy of Nutrition and Dietetics based on an umbrella review of systematic reviews. *J Acad Nutr Diet*. 2022;122(4):848-861.
2. Luig T, Anderson R, Sharma AM, Campbell-Scherer DL. Personalizing obesity assessment and care planning in primary care: Patient experience and outcomes in everyday life and health. *Clin Obes*. 2018;8(6):411-423.
3. Wharton S, Lau DCW, Vallis M, et al. Obesity in adults: A clinical practice guideline. *CMAJ*. 2020;192(31):E875-E891.
4. Styne DM, Arslanian SA, Connor EL, et al. Pediatric obesity-assessment, treatment, and prevention: An Endocrine Society Clinical Practice Guideline. *J Clin Endocrinol Metab*. 2017;102(3):709-757.
5. Malhotra S, Sivasubramanian R, Srivastava G. Evaluation and management of early onset genetic obesity in childhood. *J Pediatr Genet*. 2021;10(3):194-204.
6. Dubern B, Mosbah H, Pigeyre M, Clément K, Poitou C. Rare genetic causes of obesity: Diagnosis and management in clinical care. *Ann Endocrinol (Paris)*. 2022;83(1):63-72.
7. Farooqi IS, O'Rahilly S. Mutations in ligands and receptors of the leptin-melanocortin pathway that lead to obesity. *Nat Clin Pract Endocrinol Metab*. 2008;4(10):569-577.
8. Miller JL, Tan M. Dietary management for adolescents with Prader-Willi syndrome. *Adolesc Health Med Ther*. 2020;11:113-118.

https://doi.org/10.1016/j.jand.2022.02.004