

VI. Standards of Care for the Patient with Overweight and Obesity

Some aspects of care of patients with overweight and obesity, although clinically important and part of the generally accepted standard of care, do not have sufficient high-quality evidence to support stand-alone recommendations. In some cases, clinical studies assessing the efficacy of these standards of care do not exist because they are determined to be routine actions (e.g., measurement of weight and calculation of BMI). In other cases, the standards are based on expert opinion, as was the case for several of the recommendations found in the previous version of this CPG.

A. Screening and Assessment for Overweight and Obesity

a. Screening

Calculating BMI is a practical screening tool to determine overweight and obesity in adult populations. The BMI is easily calculated, reliable, and is the basis for mortality risk estimates.^[41] BMI is defined as a person's weight in kilograms divided by the square of the person's height in meters (kg/m^2). When weight is measured in pounds and inches, the BMI is calculated as $(\text{weight [in pounds]}/\text{height [in inches]}^2) \times 703$. The optimal frequency for calculating BMI in the clinical setting has not been evaluated and is a matter of clinical discretion.^[42] Screening at least annually provides an opportunity for patients and providers not only to identify overweight and obesity, but also to engage in productive discussions about the benefits of maintaining a healthy weight.

Although BMI is the most common way to identify overweight and obesity, there are questions regarding its accuracy in distinguishing between some individuals with and without obesity. For example, the optimal BMI for those over 65 may be slightly higher than for younger people.^[40,43] Moreover, the use of BMI alone may lead to misclassification of highly fit individuals who have increased lean body mass, impacting assessments of fitness for duty. Measurement of body fat has been suggested as an alternative to BMI for screening for obesity, as truncal obesity may be an important indicator of risk for obesity-associated conditions, especially in people with a BMI below $30 \text{ kg}/\text{m}^2$.^[44] Waist circumference (WC) is the most practical and reproducible anthropometric measurement for assessing a patient's level of abdominal fat and is an indicator of increased disease risk for patients with overweight.^[45] Measurement of WC is less relevant in individuals with $\text{BMI} \geq 35 \text{ kg}/\text{m}^2$ because the WC will likely be elevated and will add no additional risk information.^[26] We recommend cutpoints ($>88 \text{ cm}$ [$>35 \text{ in}$] for women and $>102 \text{ cm}$ [$>40 \text{ in}$] for men) as indicative of increased cardiometabolic risk.^[26] The WC measurement should be made with a tape measure placed around the bare abdomen just above the iliac crest. The tape should be snug, but should not compress the skin and the measurement should be obtained while the patient is standing at the end of normal exhalation.^[46] Measuring an individual's waist-to-hip ratio may be useful in identifying increased cardiometabolic risk associated with central obesity, especially among those with smaller body frames.^[47] Though there are several other ways to estimate body fat (e.g., skin-fold caliper measurement, hydrodensitometry, dual-energy X-ray absorptiometry, magnetic resonance imaging [MRI], and bioelectrical impedance [BEI]), most of these methods are not readily available or convenient in clinical settings. The introduction of scales that feature BEI technology to measure percent body fat in clinical settings may enhance the assessment of overweight and obesity, particularly among Service Members.