Obesity in Children: A Call to Action

Childhood obesity has become one of the biggest health problems in the United States. This, in turn, has led to increases in obesity-related complications.

A s a result, it is so important to recognize childhood obesity early and treat it before these complications arise. How do we determine whether a child is obese? The body mass index (BMI) compares a person’s weight in relation to their height and can be used for children 2 years of age and older. A child with a BMI between the 85th and 95th percentile for his/her age is considered to be overweight and those with a BMI ≥ 95th percentile are considered to be obese.

Almost one third of children and adolescents in the United States are either overweight or obese! The prevalence of obesity among children and adolescents tripled from the 1970s to 2000. Childhood obesity is more prevalent in American Indian, non-Hispanic black, and Mexican American populations. Having an obese parent also increases the risk of obesity in American Indian, non-Hispanic black, and Mexican American populations. Having an obese parent also increases the risk of obesity in children and adolescents to 2-3 times. Unfortunately, many obese children eventually become obese adults, but with proper education and changes in lifestyle, this can be prevented.

Causes of Obesity

Obesity in children can be caused by a variety of environmental as well as genetic factors. Increased availability of unhealthy food choices to children such as sugar-sweetened beverages, unhealthy snacks, and increased portion sizes can lead to excessive caloric intake above a child’s needs. A more sedentary lifestyle with decreased physical activity and increased screen time is also a factor. Decreased amount of sleep and even the presence of a TV in a child’s bedroom have been associated with higher rates of obesity. Interestingly, less than 1% of childhood obesity is caused by an endocrine disorder such as hypothyroidism, cortisol excess, or growth hormone deficiency.

Treatment

Treatment of obesity in children is challenging. Aggressive diet and exercise have always been the mainstay of therapy. Education about healthier choices, with complex carbohydrates instead of simple sugars, lean protein, increase in fruits and vegetables, as well as portion control, is the first step. Vigorous exercise of 45 minutes a day is essential. If diet and exercise alone are not successful, medications can be considered.

Metformin is the only medication approved for children older than 12 years of age—for those with insulin resistance, pre-diabetes, metabolic syndrome or polycystic ovarian syndrome. Metformin works by preventing the liver from making extra glucose (sugar). Medications such as Orlistat and Alli block fat absorption, but side effects are significant and include greasy stools, flatulence and malabsorption of fat-soluble vitamins. Locaserin is an appetite suppressant that also has concerning side effects of heart valve problems. Unfortunately, these medications are not approved in children.

Finally, bariatric surgery is now being offered to adolescents with severe obesity who have a BMI of 40 or greater, or those with BMI over 37 with comorbidities such as pre-diabetes, diabetes or polycystic ovarian syndrome. Specialized centers involve the family into a team of pediatric endocrinologists, surgeons, psychologists and dieticians to treat adolescents at highest risk. Laparoscopic adjustable gastric banding (LAGB) has been the procedure of choice, and in experienced centers has been successful. More recently, the vertical sleeve gastrectomy has been effective in adolescents, while maintaining proper nutrient absorption.

One of the main reasons we try to aggressively prevent and treat obesity is that it carries so many complications with it. Along with well-known risks such as Type 2 diabetes, heart disease, high blood pressure, joint problems, fatty liver disease, and obstructive sleep apnea, Slipped Capital Femoral Epiphysis (SCFE), an orthopedic emergency when the head of the femur bone slips off its shaft, is quite common in obese adolescents during their growth spurt, and requires surgical pinning.

Finally, the psychologic ramifications of obesity cannot be overemphasized, where bullying and depression can arise because of one’s weight, can lower a child’s self-esteem, and start a vicious cycle of poor eating choices, less exercise, and worsening obesity. It is very important to look for and recognize these psychological concerns, and seek counseling promptly if it’s needed. A team approach of physicians, family members, and school personnel can lead to success in combating obesity by encouraging healthier choices and a less sedentary, more active lifestyle.

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Prostatitis: Diagnosis & Treatment

WHAT IS THE PROSTATE?
The prostate is usually described as a walnut-sized gland that is situated below the bladder, surrounding and comprising the upper portion of the urethra, and responsible for producing the seminal fluid, in which the sperm are suspended during ejaculation. Physicians can examine the prostate manually only by performing a digital rectal examination, where the size, consistency, and symmetry of the prostate is assessed, as well as the presence of suspicious masses.

TYPES OF PROSTATITIS
Acute bacterial prostatitis refers to a true bacterial infection of the prostate and may include any or all of the following: high fevers, shakes, chills, fatigue, muscle aches, painful and frequent urination, cloudy urine. Treatment with antibiotics is mandatory, either orally at home, or in severe cases, with intravenous antibiotics in an inpatient setting. There are usually no long-term consequences, except chronic bacterial prostatitis may follow infrequently. If the common prostate blood test PSA is performed during this period it may very well be falsely elevated, and might incorrectly cause concern about prostate cancer.

Chronic bacterial prostatitis is the result of recurring bacterial infections from a source deep within the prostate. The symptoms are usually not as severe as those of acute prostatitis, and may resolve temporarily after a course of antibiotics, only to recur. The diagnosis is made by a characteristic history, and by the presence of positive urine cultures demonstrating the same bacterium time after time.

Antibiotics are the treatment of choice with a duration of perhaps 4-12 weeks, or by chronic, low-dose suppressive antibiotic therapy.

Chronic nonbacterial prostatitis/chronic pelvic pain syndrome is perhaps the most controversial, and is definitely the most common, accounting for approximately 90% of cases. It is not associated with bacteria and is not an infection. At the time of presentation the symptoms may have been present for 6-12 months; frustrated patients may have visited multiple physicians, and have been offered multiple trials of antibiotics in the mistaken assumption that this is a bacterial infection. A patient’s quality of life is usually diminished by the time he seeks care.

Symptoms are usually associated with pelvic or perineal (the area behind the scrotum) discomfort or pain; frequent or painful urination or ejaculation. The source of the symptoms is unclear, and may include inflammation of the nerves and tissues within and surrounding the prostate. Treating this entity may be challenging and usually includes a multi-modal approach, such as over the counter anti-inflammatories like ibuprofen or naproxen. Prescription medications of a variety of types are used: alpha blockers relax the smooth muscle in the prostate and bladder neck and will increase urinary flow; certain neurologic drugs like gabapentin may help in reducing the pelvic pain; bladder anti-spasmodics are helpful in decreasing the urinary frequency and urgency. Biofeedback or pelvic muscle rehabilitation may also be helpful. Many patients turn to herbal or homeopathic remedies.

Asymptomatic inflammatory prostatitis is a diagnosis established in patients without symptoms, usually by an examination of prostatic tissue during a prostate biopsy; or by detecting inflammatory cells in urine or semen. It is thought that this condition might falsely elevate the PSA, hence the need for a prostate biopsy. Usually no treatment is required if there are no other symptoms.

SUMMARY
The diagnosis of these conditions require a careful history and physical examination, as well as a thorough investigation of laboratory studies and x-rays when indicated. In many chronic cases, relief may be incomplete or fleeting. Deliberate physician-patient communication is required to help patients understand the array of options and controversies that exist, and to reassure patients who remain symptomatic even after long-term therapy.

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