

Table 29-5 Setting Explicit Goals to Prevent or Treat Obesity

FIGHT OBESITY EFFECTIVELY	AMBIGUOUS GOALS	SPECIFIC GOALS
Keep it simple	Walk or bike more	Walk or bike to school 2 days a week
Countable goals/unambiguous	Watch less TV	Watch no TV on school days
2 short-term goals/time		
Be able to count	Decrease size of serving	Small bowls (parent palm)
Aim to change behaviors		Avoid eating from the box
Don't focus on consumption of carbohydrates, fat, protein	Decrease to 20 g of fat	Eat fish once a week
Focus on specific categories	Decrease sugars	Avoid sweetened foods
Focus on healthier preparation methods		Avoid frying
Focus on eating patterns		Avoid double dinner
Focus on portion size		Portion parent's palm size
Eating fast food	Eat less junk food	Limit trips to McDonalds to once a week
Sweetened beverages	Avoid soda/juices	No soda or juices
Healthy beverages		Drink only milk or water
Fruits	Buy fewer juices Increase eating fruits	Have no juices in the refrigerator Keep a bowl of fruits in the kitchen
Vegetables	Increase eating veggies	Have a bowl of veggies in the refrigerator Cooperation, competition, and social interaction such as building a house of veggies
Physical activities	Walk more	Family hikes every Sunday Specific activity time for activities and sedentary behavior
	Increase walking from school	Parents picking up from school 2 days a week

a systematic approach that promotes multidisciplinary brief, office-based interventions for obese children as well as reducing weight. Before enrolling any patient in a weight-loss program, the clinician must have a clear idea of that individual's expectations. Patients with unrealistic expectations should not be enrolled until these are changed to realistic and attainable goals. Using the mnemonic described, the clinician should guide the patient who seeks weight reduction to create **SMART** goals: Specific, Measurable, Attainable, Realistic, and Timely.

Surgical treatment may be advocated as a preferred and cost-effective solution for certain children and adolescents. The role of bariatric surgery in the treatment of obese children or adolescents is controversial. The concerns about surgery to treat obesity in young populations include whether or not surgery is cost effective; how to ensure healthy growth through to adulthood; what support services are needed after surgery; compliance with the postoperative nutrition regimen; and attendance at appointments for long-term follow-up and care. There is very limited evidence available to adequately estimate long-term safety, effectiveness, cost effectiveness or durability of bariatric surgery in growing children. The existing evidence suggests that bariatric surgery in severely obese adolescent results in significant weight loss and improvements in comorbidities and quality of life. Postoperative complications (both physical and psychological), compliance, and follow-up may be more problematic in adolescents than adults, and long-term data on safety, effectiveness, and cost remain largely unavailable.

Chapter 30

PEDIATRIC UNDERNUTRITION

Pediatric undernutrition is usually the result of inadequate food supply, access, or utilization; poor access to health and sanitation; and/or inappropriate feeding or child care practices. The greatest risk of undernutrition is in utero through age 2. Various guidelines can be used to classify pediatric malnutrition (Table 30-1). International references are established that allow normalization of anthropometric measures in terms of *z* scores. Other measurements include height and weight for age, weight for height, BMI, and mid-upper arm circumference. The greatest consequence of undernutrition is death, but significant intellectual and physical disability exists in many who survive.

Protein-energy malnutrition (PEM) is a spectrum of conditions caused by varying levels of protein and calorie deficiencies. Primary PEM is caused by social or economic factors that result in a lack of food. Secondary PEM occurs in children with various conditions associated with increased caloric requirements (infection, trauma, cancer) (Fig. 30-1), increased caloric loss (malabsorption), reduced caloric intake (anorexia, cancer, oral intake restriction, social factors), or a combination of these three variables. Protein and calorie malnutrition may