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Obese Father William Meets a Physician

"You are old, Father William," the young man said,
"And your hair has become very white;
And yet you incessantly stand on your head—
Do you think, at your age, it is right?" . . .

"You are old," said the youth, "as I mentioned before,
And have grown most uncommonly fat,
Yet you turned a back somersault in at the door—
Pray, what is the reason of that?"

Lewis Carroll’s fictional Father William (1) is an example of the most favorable stereotype of the obese person: a jolly fat man who seems to be exempt from the infirmity of obesity. Father William is a distinctive character who manifests among every group of people; he is Winston Churchill, Orson Wells, or, in Detroit, George Pierrot. His obesity does not burden his strong frame, nor wear out his indefatigable spirit, nor hinder the effectiveness of his opinions. Father William is bigger than life. He laughs at the potential adversity of his obesity. He may also laugh at his physician’s dire predictions—if he has a physician. The papers on obesity in this issue of the Journal shed little light on Father William; Father William violates the rule. Severe obesity is often accompanied by a morbid physiologic state. The Symposium on Obesity contains six papers authored by physicians and scientists from the diverse disciplines of psychology, hypertension research, biophysics, surgery, and internal medicine.

The first paper, "Minnesota Multiphasic Personality Profiles of the Morbidly Obese" by Lanziser et al (pp. 78-81), describes the personality profiles of 132 obese persons before they started a multidisciplinary weight control program. The subjects were severely obese (mean initial weight 118 kg [260 lb]) and middle-aged (mean age 40.4 years). Significant psychologic dysfunction was observed in less than half of these persons. The authors conclude that psychologic disturbance was not an important pathogenetic factor in the development of obesity in the psychologically normal subjects. While these results contradict the popular notion that severely obese persons are emotionally unstable, they are consistent with most published studies. The absence of a consistent psychologic profile does not disprove that psychologic factors play a role in abnormal eating behavior. The complex of social, psychologic, and physical factors may account for the failure of many severely obese persons to achieve the same level of socioeconomic status as the nonobese (2).

The second paper, "Obesity and Hypertension: A Review" by Imam and Sowers (pp. 82-87), reviews the extensive literature that includes considerable information from the hemodynamic and endocrinologic standpoint. The authors state that obesity contributes to hypertension by increasing cardiac output, sympathetic nervous system activity, sodium retention, and blood volume and by decreasing opioid peptides. Also, overfeeding stimulates insulin secretion and triiodothyronine production; both may increase sympathetic nervous system action. The hemodynamics of obesity and hypertension, essentially an increase in preload due to obesity and in afterload due to hypertension, greatly increase the risk for congestive heart failure. Weight reduction, regardless of sodium intake, will result in a fall in blood pressure. Ideal body weight need not be achieved to observe a reduction in blood pressure. The authors stress the need for adequate pharmacologic and dietary treatment of obese hypertensives, a very high risk group.

The third paper, "Blood Pressure Changes and Weight Changes in Hypertensive Patients in an Inner-City Clinic" by Goldberg et al (pp. 88-91), describes the effects on blood pressure of nonpharmacologic interventions: dietary sodium restriction, caloric restriction leading to weight reduction, and increased physical activity. All patients were ambulatory. Intensive contact (visits every two to six weeks) served to reinforce the changes in behavior. The authors observed a significant correlation between changes in blood pressure and changes in weight. Blood pressure levels fell in all patients who lost over 4.5 kg (10 lb) of weight; blood pressure increased in most patients (23 of 28 [82%]) who gained over 4.5 kg of weight. Dietary modification and increased physical activity are evidently important adjuncts to the pharmacologic treatment of hypertension.

The fourth paper, "Biophysical Methods for Estimating In Vivo Body Composition: The Determination of the Adipose Compartiment" by Preuss and Bolin (pp. 92-102), is an authoritative and comprehensive review of a subject that may seem arcane to the clinician, but the authors describe the methodology in simple, readable prose. The assessment of lean versus fat body mass may have clinical relevance in the following states: malnutrition, obesity, azotemia, lymphedema, muscle disease, among others. The authors have experience in assessing body composition in all these states. They first discuss anthropometry including skinfold measurement, height and weight index, body mass index, photogrammetric method, and the circumference method. Other topics include infrared spectroscopy, underwater...
weighing, water displacement, computed tomography, and magnetic resonance imaging. Electrical methods, based on the differential electrical conductivity of fat versus lean tissue, are gaining wide experimental application and are discussed in detail. Dual photon absorptiometry, where radioactive isotopes serve as photon sources to assess the density of bone and soft tissues, is also described. The authors rate the various methods according to safety, compliance, instrumentation, and cost, which is helpful. The application of biophysical methods to assess lean versus fat body mass may help to determine the safety of weight loss when the patient is given a very low calorie diet (3).

The fifth paper, “Surgery for Morbid Obesity: A Continuing Challenge” by Bivins et al (pp. 103-107), uses three cases of surgery for morbid obesity as the springboard for subsequent discussion of the indications, contraindications, and pitfalls of surgical treatment. The three most popular operative treatments, jejunoileal bypass, gastric bypass, and gastroplasty, receive the most attention. The gastric restrictive procedures, gastric bypass or gastroplasty, are indicated as treatment for the morbidly obese person who does not have illness that greatly reduces life expectancy (ie, cancer, symptomatic coronary artery disease, or end-stage renal disease). Successfully treated persons lose substantial amounts of weight and may experience improvement in obesity-related hypertension, diabetes mellitus, and pulmonary disease. The authors emphasize the need for careful patient selection, informed consent, and lifelong follow-up. Surgical treatment is more dangerous than diet alone. Consider surgery for diet-resistant, morbidly obese persons, especially those who may have the highest risk for death: young, morbidly obese males (4).

The sixth paper, “Morbidity and Treatment of Clinically Important Obesity: An Internal Medicine Perspective” (pp. 108-112), is well described by its title. Obesity is considered in terms of a differential diagnosis, and the associated morbidities are assessed. The dietary and exercise prescription is individualized. Severely obese persons often require a multidisciplinary, intensive program. The balanced-deficit diet and the very low calorie diet are described. James’ equations (5) to predict weight loss help to assess patient compliance. Obesity is incurable; the obese person needs chronic maintenance therapy to sustain weight loss. Poor patient compliance limits the long-term efficacy of obesity treatment (6).

These six papers describe manifold morbidity from obesity and modest benefit from medical or surgical treatment. They compel the conclusions that obesity is better prevented than treated or that severe obesity should afflict only protected hosts—like Father William.

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References