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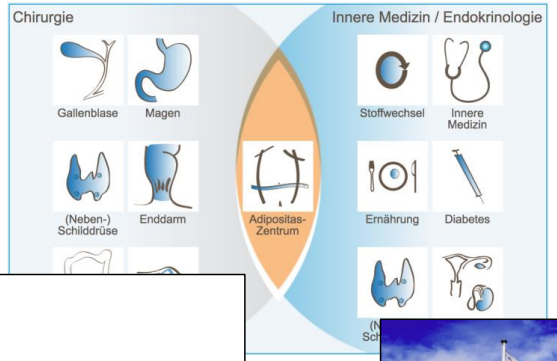
MEDICAL & SURGICAL CENTER

HIRSLANDEN
KLINIK STEPHANSHORN
40 JAHRE 1978/79–2019

WENN ÜBERGEWICHT ZUR KRANKHEIT WIRD

Dr. med. Christopher Strey PhD MRCP
Facharzt für Innere Medizin
Facharzt für Endokrinologie/Diabetologie

KURZ ÜBER UNS



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Adipositas – Zentrum

Chirurgie
Viszerale und endokrine Chirurgie

Diabetes – Zentrum
Endokrinologie
Innere Medizin

Ernährungsberatung

Leitung

Dr. med. Martin Thurnheer
Leiter Chirurgie
Facharzt für Chirurgie, FMH
spez. Viszeralchirurgie

Dr. med. Philipp Bisang
Facharzt für Chirurgie, FMH

Dr. med. Christopher Strey
Leiter Innere Medizin
Facharzt für Innere Medizin
Facharzt für Endokrinologie / Diabetologie

Ärzte

Dr. med. Andreas Zerz
Facharzt für Chirurgie
spez. Viszeralchirurgie

Dipl. Ärztin Tatjana Himmler
Fachärztin für Innere Medizin

Dr. med. Sabine Widerin
Praktische Ärztin

Dr. med. Andreas Mohl
Facharzt für Psychiatrie und Psychotherapie, FMH
Schwerpunkt Konsiliar- und Liaisonpsychiatrie

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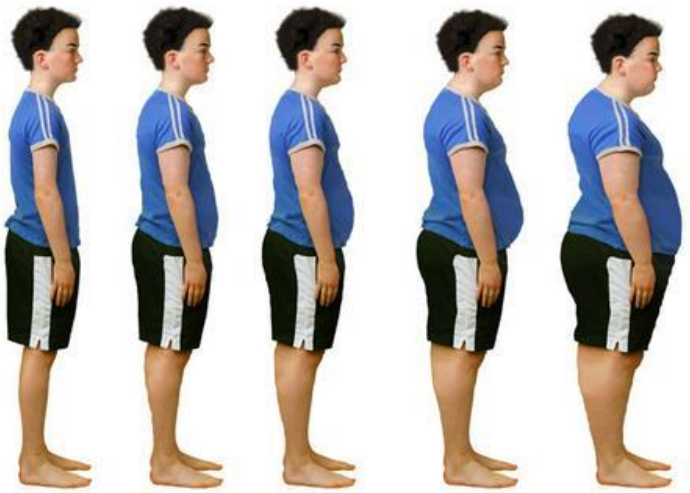
SCHON BEMERKT ....



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KLINIK STEPHANSHORN

WENN ÜBERGEWICHT ZUR KRANKHEIT WIRD

- Wie gross ist das Problem?
- Macht Übergewicht wirklich krank?
- Kann man durch Gewichtsabnahme gesünder werden?

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NÜTZLICH ZU WISSEN

- **BMI** = Body Mass Index = Gewicht/Grösse = kg/m^2

- BMI < 25 = kein Übergewicht
- BMI > 25 = Übergewicht
- BMI > 30 = Fettsucht = **Adipositas** = Obesity (engl.)

- **Bariatrische** Chirurgie = Chirurgie für Übergewicht

WENN ÜBERGEWICHT ZUR KRANKHEIT WIRD

- Wie gross ist das Problem?
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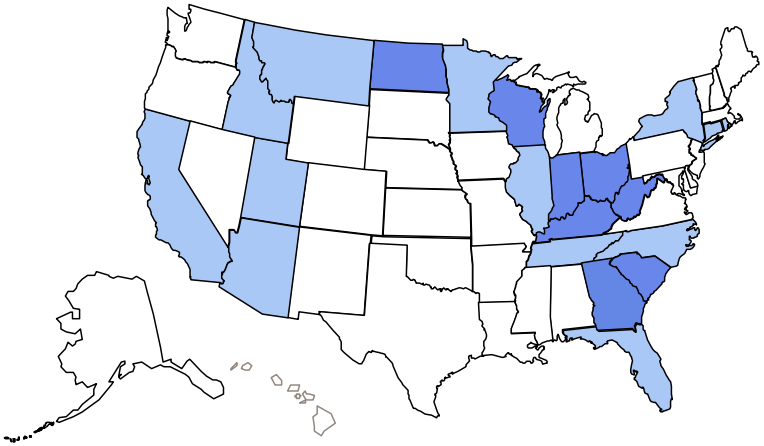
Obesity Trends* Among U.S. Adults
BRFSS, 1985

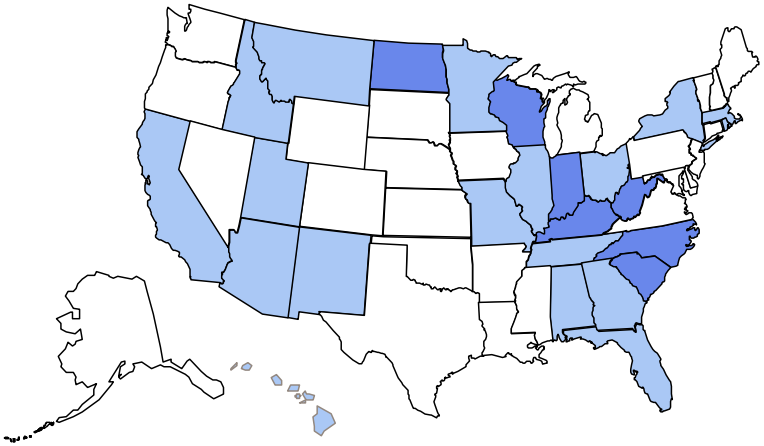
(*BMI ≥30, or ~ 30 lbs. overweight for 5' 4" person)



No Data | <10% | 10%–14% | 15%–19% | 20%–24% | 25%–29% | ≥30%

Obesity Trends* Among U.S. Adults
BRFSS, 1986

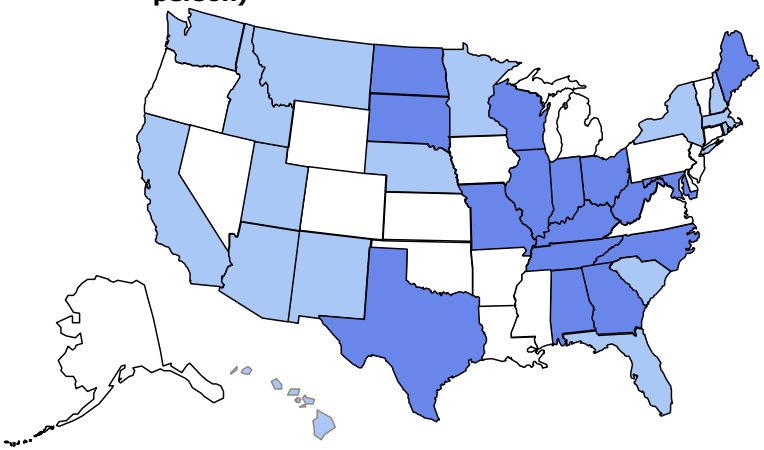
(*BMI ≥30, or ~ 30 lbs. overweight for 5' 4" person)



No Data | <10% | 10%–14% | 15%–19% | 20%–24% | 25%–29% | ≥30%

Obesity Trends* Among U.S. Adults
BRFSS, 1987

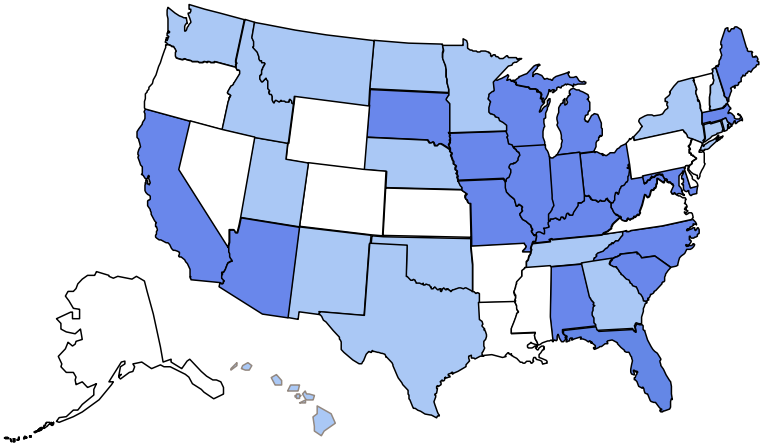
(*BMI ≥30, or ~ 30 lbs. overweight for 5' 4" person)



No Data | <10% | 10%–14% | 15%–19% | 20%–24% | 25%–29% | ≥30%

Obesity Trends* Among U.S. Adults
BRFSS, 1988

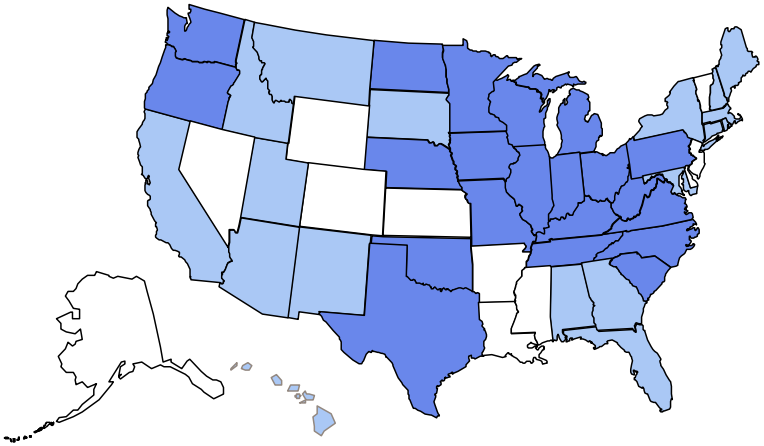
(*BMI ≥30, or ~ 30 lbs. overweight for 5' 4" person)



No Data | <10% | 10%–14% | 15%–19% | 20%–24% | 25%–29% | ≥30%

Obesity Trends* Among U.S. Adults
BRFSS, 1989

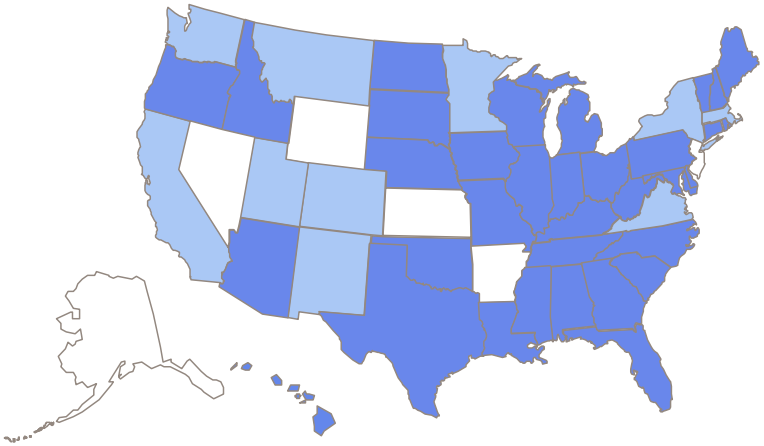
(*BMI ≥30, or ~ 30 lbs. overweight for 5' 4" person)



No Data | <10% | 10%–14% | 15%–19% | 20%–24% | 25%–29% | ≥30%

Obesity Trends* Among U.S. Adults
BRFSS, 1990

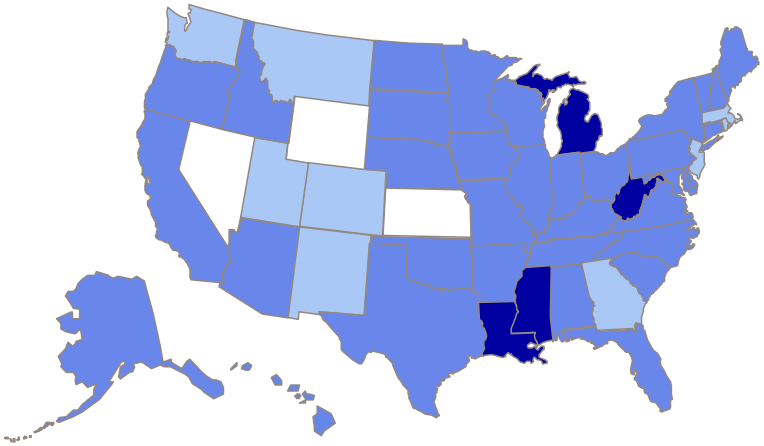
(*BMI ≥30, or ~ 30 lbs. overweight for 5' 4" person)



No Data | <10% | 10%–14% | 15%–19% | 20%–24% | 25%–29% | ≥30%

Obesity Trends* Among U.S. Adults
BRFSS, 1991

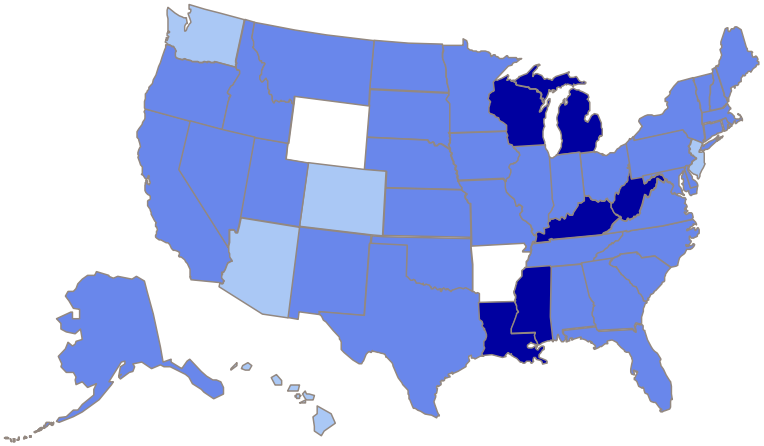
(*BMI ≥30, or ~ 30 lbs. overweight for 5' 4" person)



No Data | <10% | 10%–14% | 15%–19% | 20%–24% | 25%–29% | ≥30%

Obesity Trends* Among U.S. Adults
BRFSS, 1992

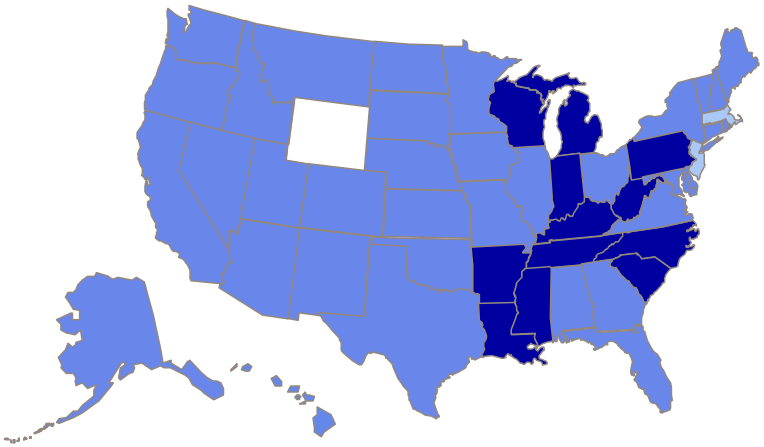
(*BMI ≥30, or ~ 30 lbs. overweight for 5' 4" person)



No Data | <10% | 10%–14% | 15%–19% | 20%–24% | 25%–29% | ≥30%

Obesity Trends* Among U.S. Adults
BRFSS, 1993

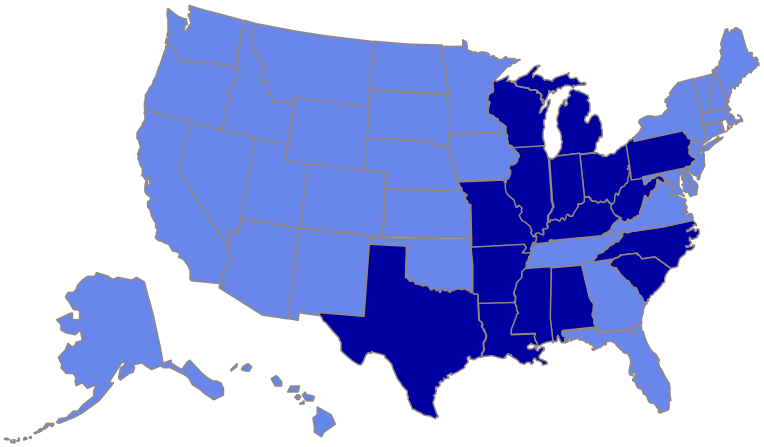
(*BMI ≥30, or ~ 30 lbs. overweight for 5' 4" person)



No Data | <10% | 10%–14% | 15%–19% | 20%–24% | 25%–29% | ≥30%

Obesity Trends* Among U.S. Adults
BRFSS, 1994

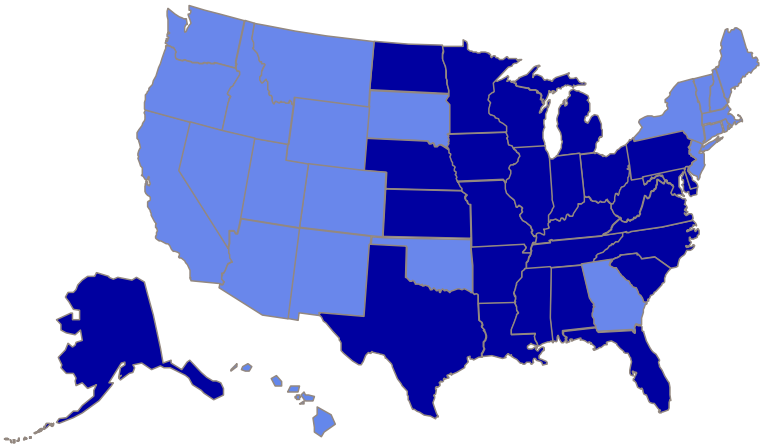
(*BMI ≥30, or ~ 30 lbs. overweight for 5' 4" person)



No Data | <10% | 10%–14% | 15%–19% | 20%–24% | 25%–29% | ≥30%

Obesity Trends* Among U.S. Adults
BRFSS, 1995

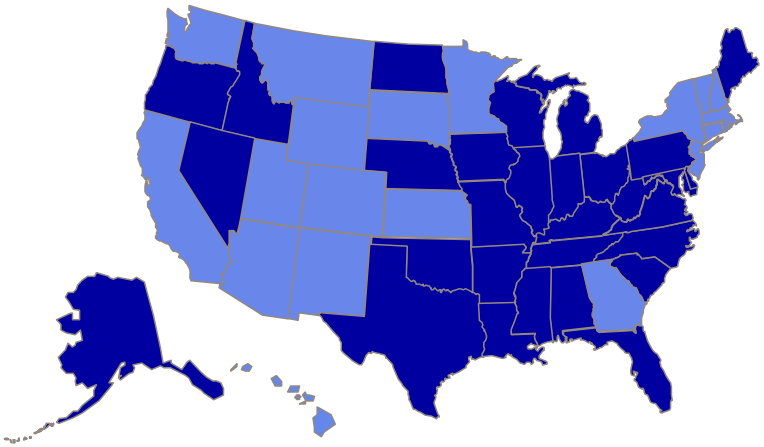
(*BMI ≥30, or ~ 30 lbs. overweight for 5' 4" person)



No Data | <10% | 10%–14% | 15%–19% | 20%–24% | 25%–29% | ≥30%

Obesity Trends* Among U.S. Adults
BRFSS, 1996

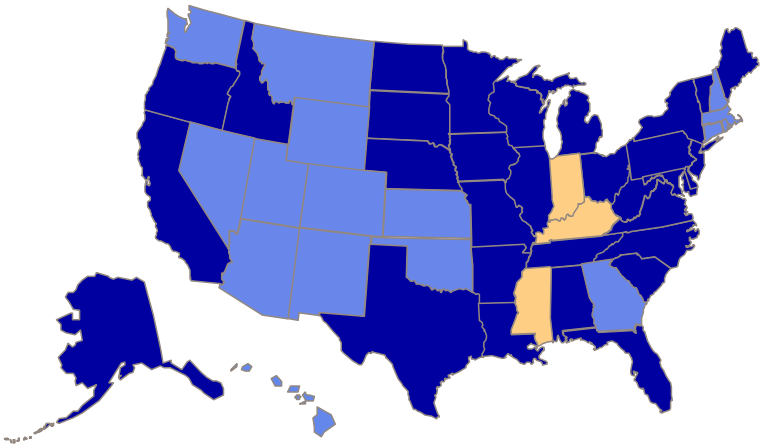
(*BMI ≥30, or ~ 30 lbs. overweight for 5' 4" person)



No Data | <10% | 10%–14% | 15%–19% | 20%–24% | 25%–29% | ≥30%

Obesity Trends* Among U.S. Adults
BRFSS, 1997

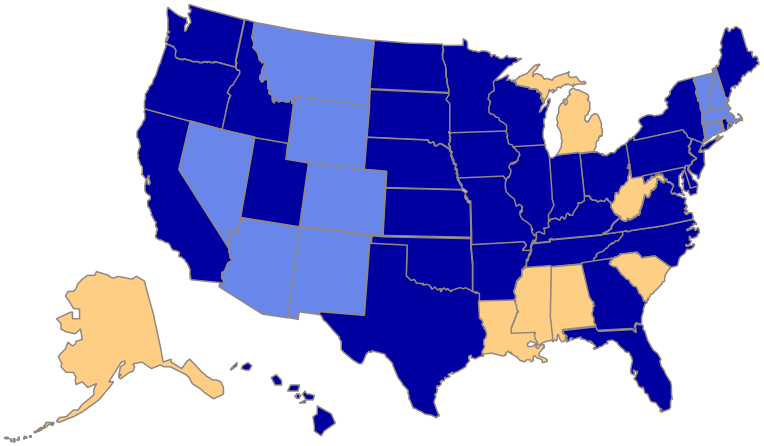
(*BMI ≥30, or ~ 30 lbs. overweight for 5' 4" person)



No Data | <10% | 10%–14% | 15%–19% | 20%–24% | 25%–29% | ≥30%

Obesity Trends* Among U.S. Adults
BRFSS, 1998

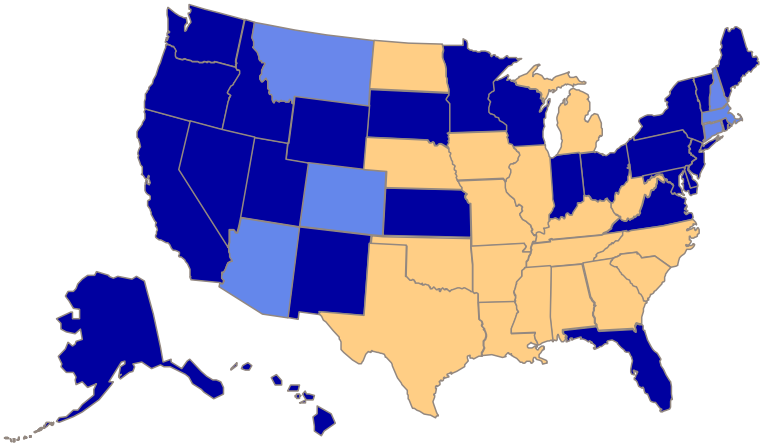
(*BMI ≥30, or ~ 30 lbs. overweight for 5' 4" person)



No Data | <10% | 10%–14% | 15%–19% | 20%–24% | 25%–29% | ≥30%

Obesity Trends* Among U.S. Adults
BRFSS, 1999

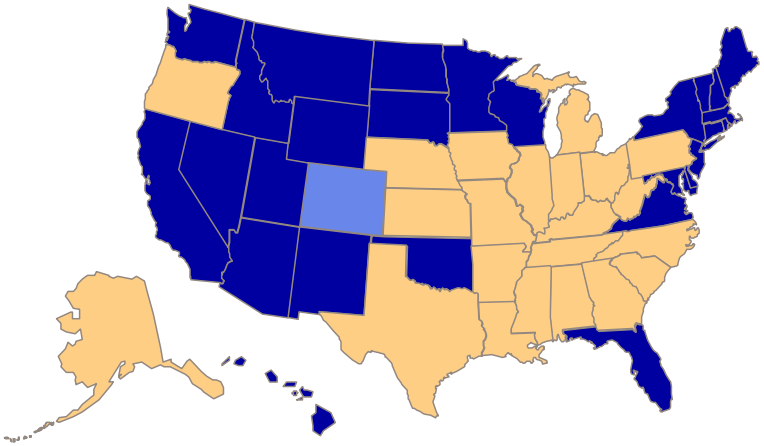
(*BMI ≥30, or ~ 30 lbs. overweight for 5' 4" person)

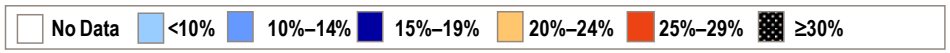


No Data | <10% | 10%–14% | 15%–19% | 20%–24% | 25%–29% | ≥30%

Obesity Trends* Among U.S. Adults
BRFSS, 2000

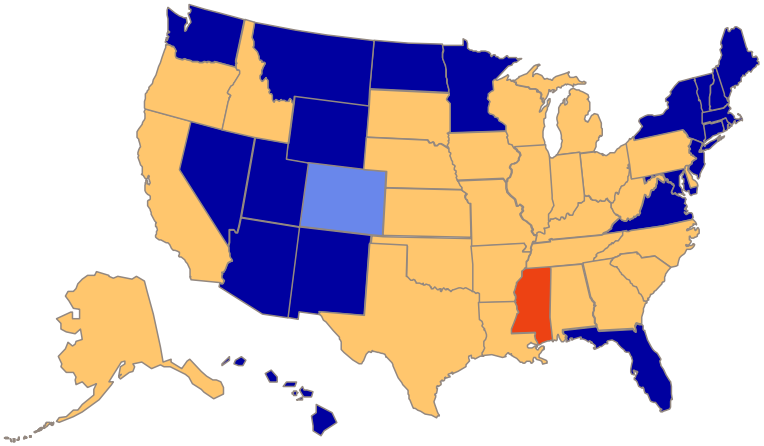
(*BMI ≥30, or ~ 30 lbs. overweight for 5' 4" person)





Obesity Trends* Among U.S. Adults
BRFSS, 2001

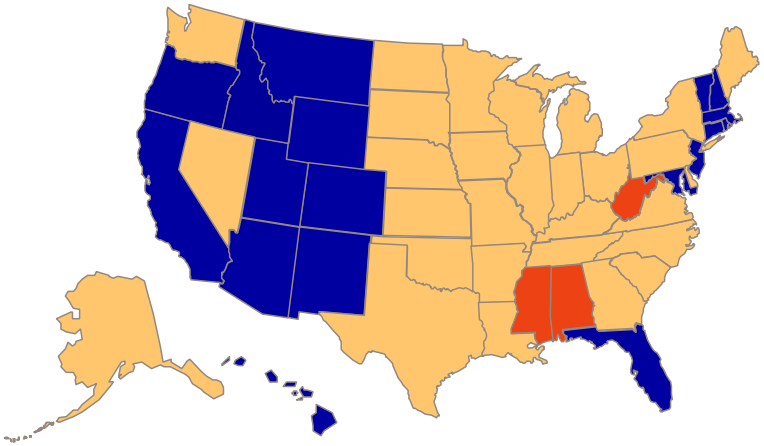
(*BMI ≥30, or ~ 30 lbs. overweight for 5' 4" person)



No Data | <10% | 10%–14% | 15%–19% | 20%–24% | 25%–29% | ≥30%

Obesity Trends* Among U.S. Adults
BRFSS, 2002

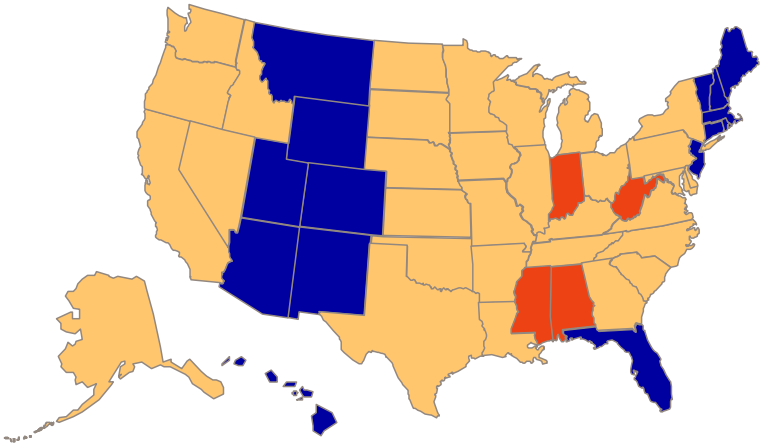
(*BMI ≥30, or ~ 30 lbs. overweight for 5' 4" person)



No Data | <10% | 10%–14% | 15%–19% | 20%–24% | 25%–29% | ≥30%

Obesity Trends* Among U.S. Adults
BRFSS, 2003

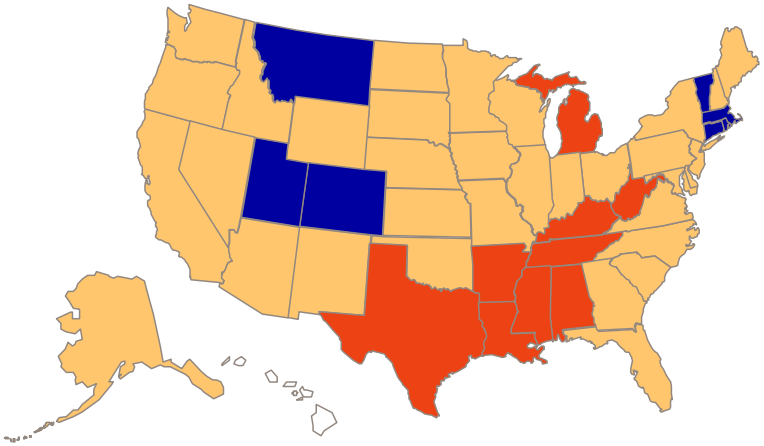
(*BMI ≥30, or ~ 30 lbs. overweight for 5' 4" person)



No Data | <10% | 10%–14% | 15%–19% | 20%–24% | 25%–29% | ≥30%

Obesity Trends* Among U.S. Adults
BRFSS, 2004

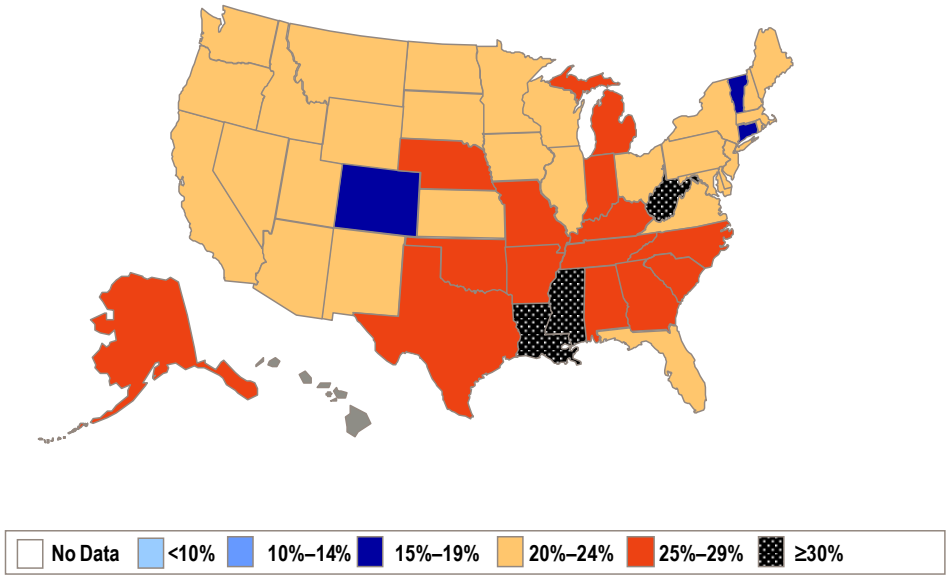
(*BMI ≥30, or ~ 30 lbs. overweight for 5' 4" person)



No Data | <10% | 10%–14% | 15%–19% | 20%–24% | 25%–29% | ≥30%

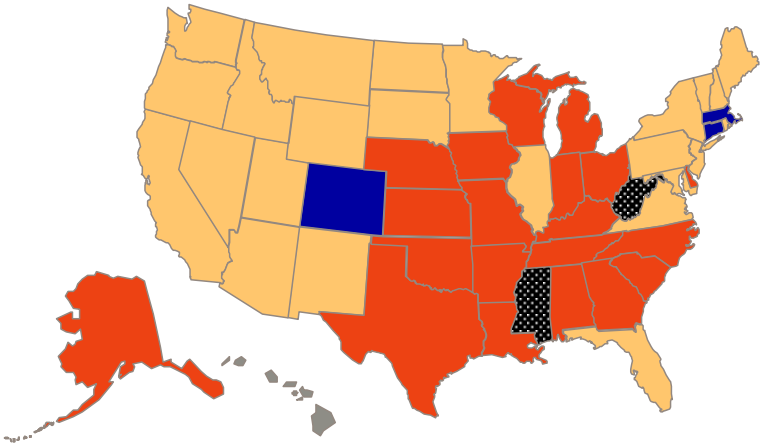
Obesity Trends* Among U.S. Adults
BRFSS, 2005

(*BMI ≥30, or ~ 30 lbs. overweight for 5' 4" person)



Obesity Trends* Among U.S. Adults
BRFSS, 2006

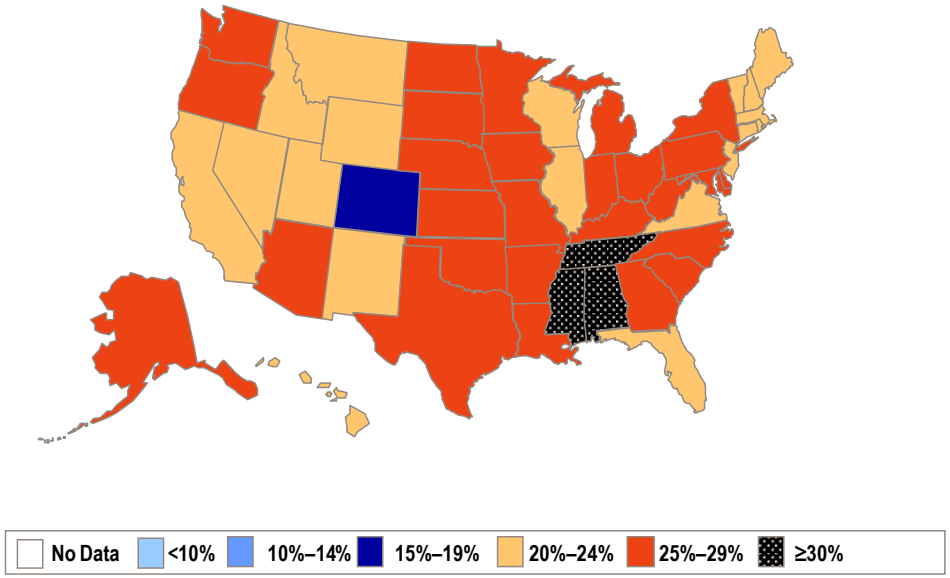
(*BMI ≥30, or ~ 30 lbs. overweight for 5' 4" person)



No Data | <10% | 10%–14% | 15%–19% | 20%–24% | 25%–29% | ≥30%

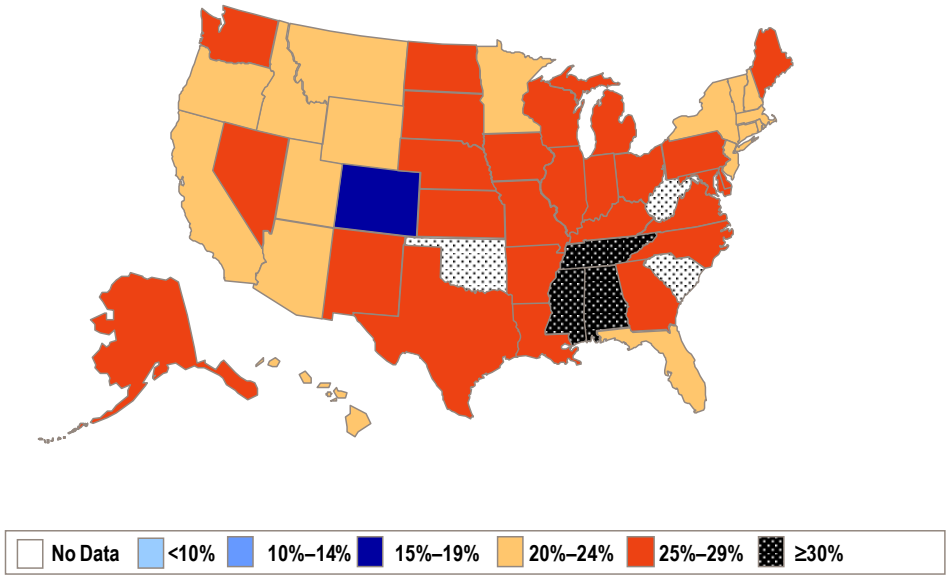
Obesity Trends* Among U.S. Adults
BRFSS, 2007

(*BMI ≥30, or ~ 30 lbs. overweight for 5' 4" person)



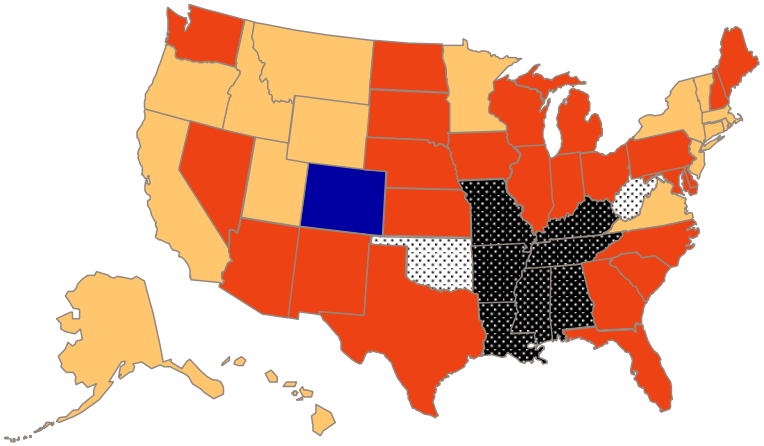
Obesity Trends* Among U.S. Adults
BRFSS, 2008

(*BMI ≥30, or ~ 30 lbs. overweight for 5' 4" person)



Obesity Trends* Among U.S. Adults
BRFSS, 2009

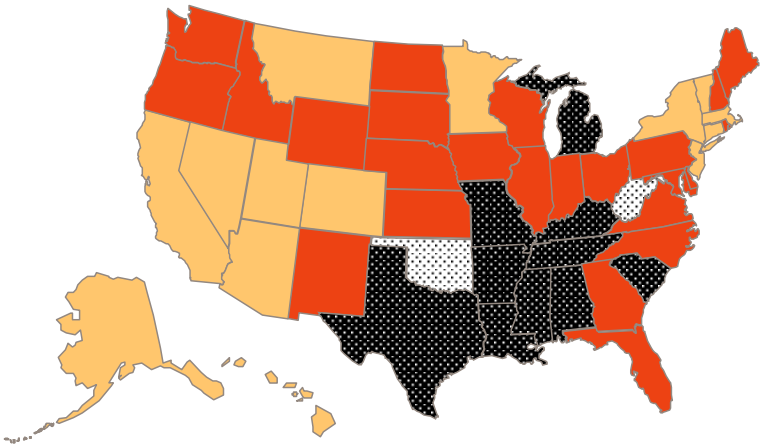
(*BMI ≥30, or ~ 30 lbs. overweight for 5' 4" person)



No Data | <10% | 10%–14% | 15%–19% | 20%–24% | 25%–29% | ≥30%

Obesity Trends* Among U.S. Adults
BRFSS, 2010

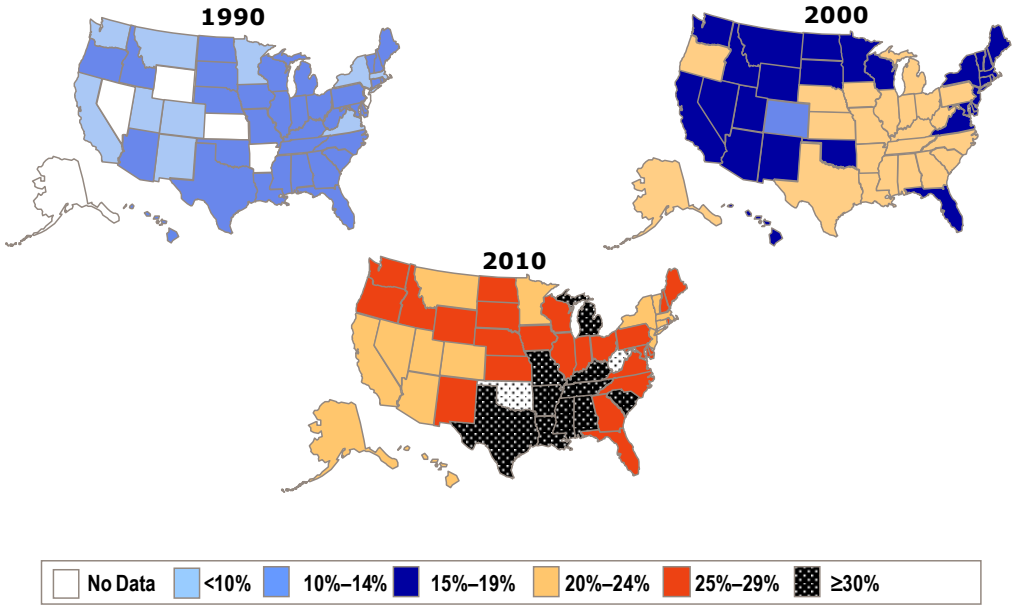
(*BMI ≥30, or ~ 30 lbs. overweight for 5' 4" person)



No Data | <10% | 10%–14% | 15%–19% | 20%–24% | 25%–29% | ≥30%

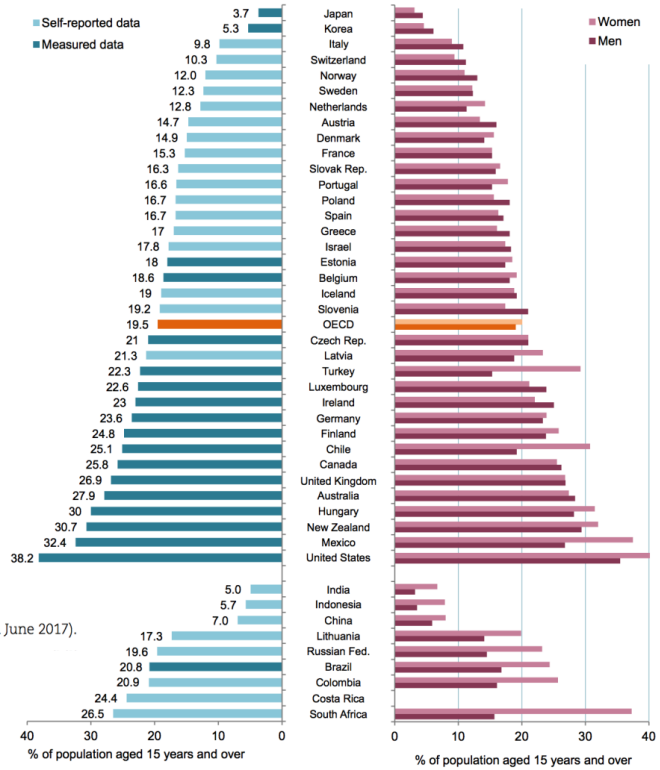
Obesity Trends* Among U.S. Adults
BRFSS, 1990, 2000, 2010

(*BMI ≥30, or about 30 lbs. overweight for 5'4" person)



EIN GLOBALES PROBLEM

Figure 1: Obesity among adults, 2015 or nearest year



Source: OECD (2017), OECD Health Statistics 2017 (Forthcoming in June 2017).
www.oecd.org/health/health-data.htm

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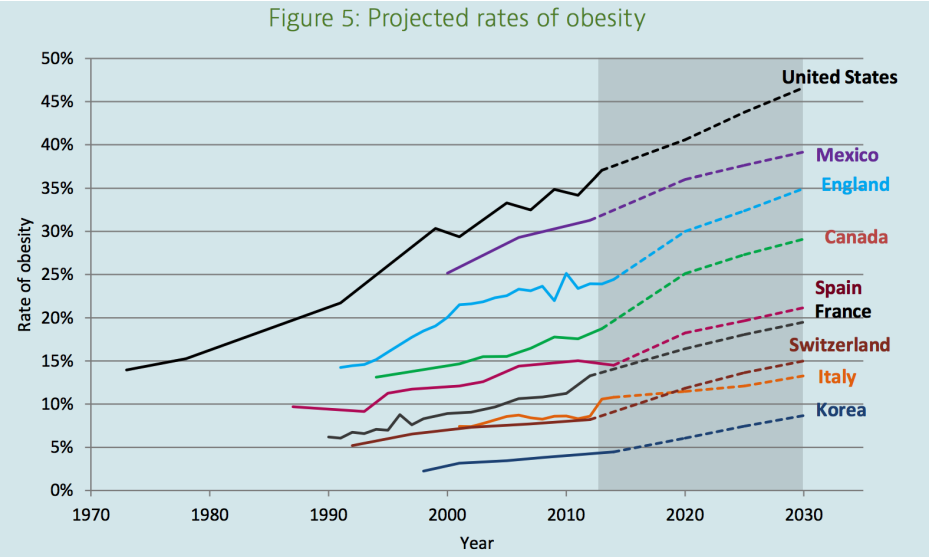
EIN GLOBALES PROBLEM



Source: OECD (2017), OECD Health Statistics 2017 (Forthcoming in June 2017).
www.oecd.org/health/health-data.htm

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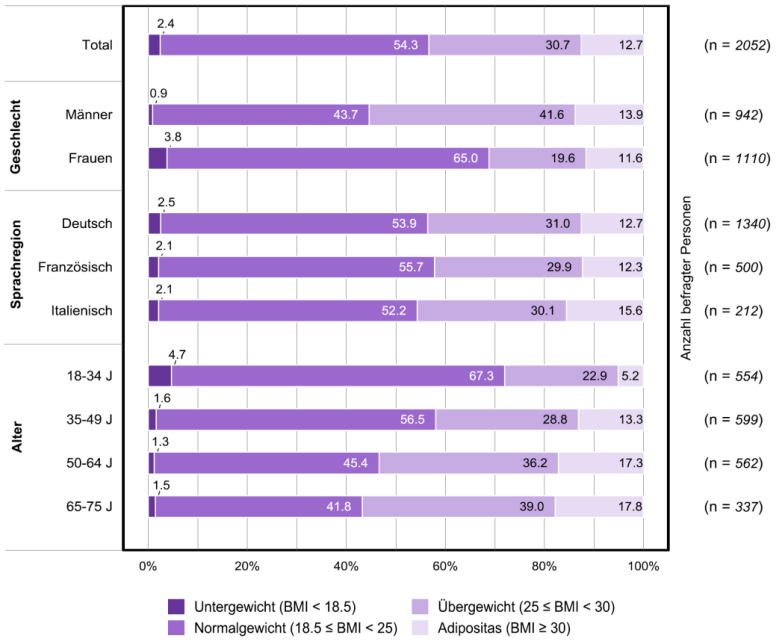
ADIPOSITAS IN DER SCHWEIZ 2014/2015

BMI-VERTEILUNG BEI DER ERWACHSENEN BEVÖLKERUNG DER SCHWEIZ (IN PROZENT)



https://www.blv.admin.ch › blv › Fachinformation_menuCH_BMI_def_DE

WENN ÜBERGEWICHT ZUR KRANKHEIT WIRD

- Wie gross ist das Problem?
- Macht Übergewicht wirklich krank?
- Kann man durch Gewichtsabnahme gesünder werden?

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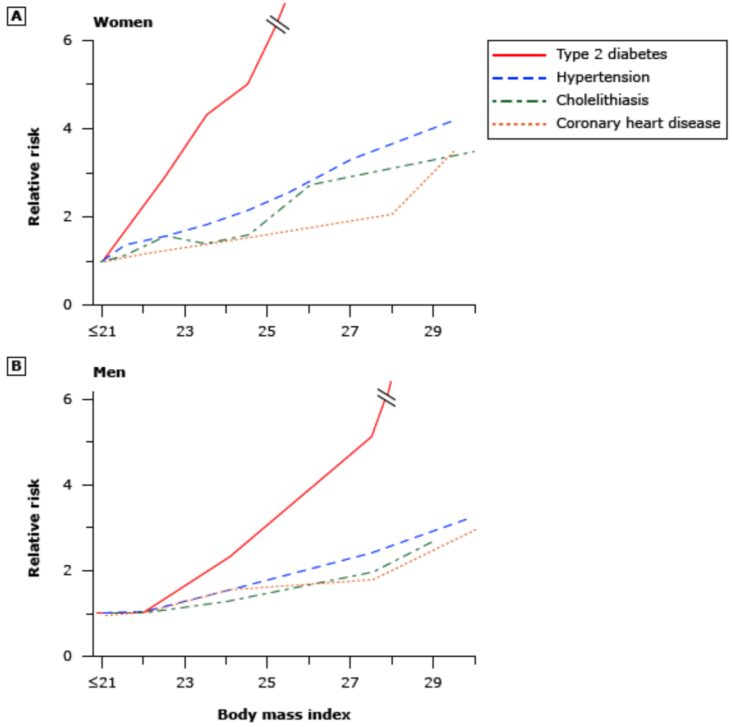
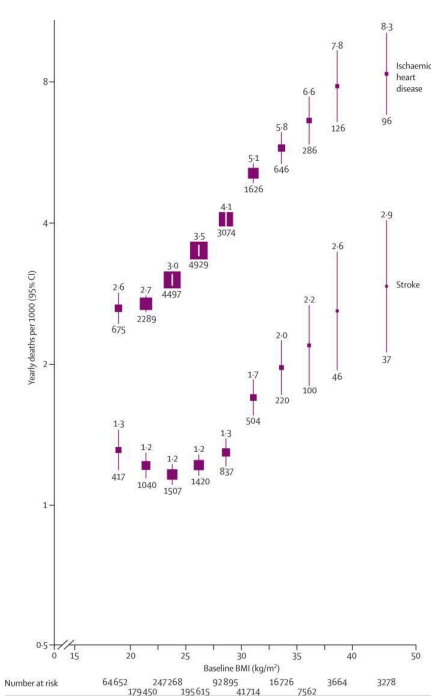
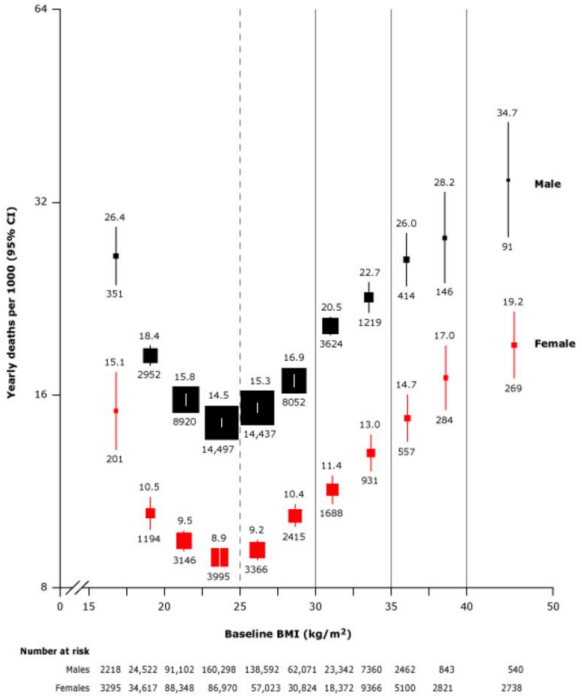
HIRSLANDEN KLINIK STEPHANSHORN

LEIDER JA!
UND WIE!



N Engl J Med 1999; 341:427.





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Lancet 2009; 373:1083

HIRSLANDEN KLINIK STEPHANSHORN

ERSTAUNLICH SCHÄDLICH

Stoffwechsel: Diabetes, Fettstoffwechselstörungen

Herz-Kreislauf: Bluthochdruck, Herzkrankheit, Schlaganfälle, Thrombosen

Gelenk und Muskel: Osteoarthrose, Gicht

Verdauungstrakt: Leberverfettung, Refluxerkrankungen, Gallensteine

Reproduktion: Unfruchtbarkeit, Geburtskomplikationen

Nieren- und Blasenfunktion: Nierenschwäche, Nierensteine, Inkontinenz

Atmung und Lunge: Schlaf Apnoe Syndrom, Asthma

Haut: Striae, Acanthosis nigricans, vermehrter Haarwuchs

Krebs: Uterus, Nieren, Speiseröhre und Mageneingang, Dickdarm, Gallengänge Gallenblase, Brust, Pankreas, Eierstöcke, Leber

Psychosozial: Depression, Demenz, Gefühl der Minderwertigkeit und Ausgrenzung, gesellschaftliche Diskriminierung

Erhöhte Infektionsanfälligkeit

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ZUR VERDEUTLICHUNG

- Mit einem BMI Anstieg um 1 kg/m^2 steigt das Risiko für Herzversagen um 5% für Männer und 7% für Frauen
- 80% von Typ 2 Diabetes ist durch Adipositas verursacht
- 40% der Krebserkrankungen in den USA entstehen durch Übergewicht
- Mit einem BMI Anstieg um 5 kg/m^2 steigt die allgemeine Sterblichkeit um 30% (wegen Gefässerkrankungen um 40%, wegen Diabetes um bis zu 120%, wegen Krebs um 10%, wegen Lungenerkrankungen um 20%)

WIESO?

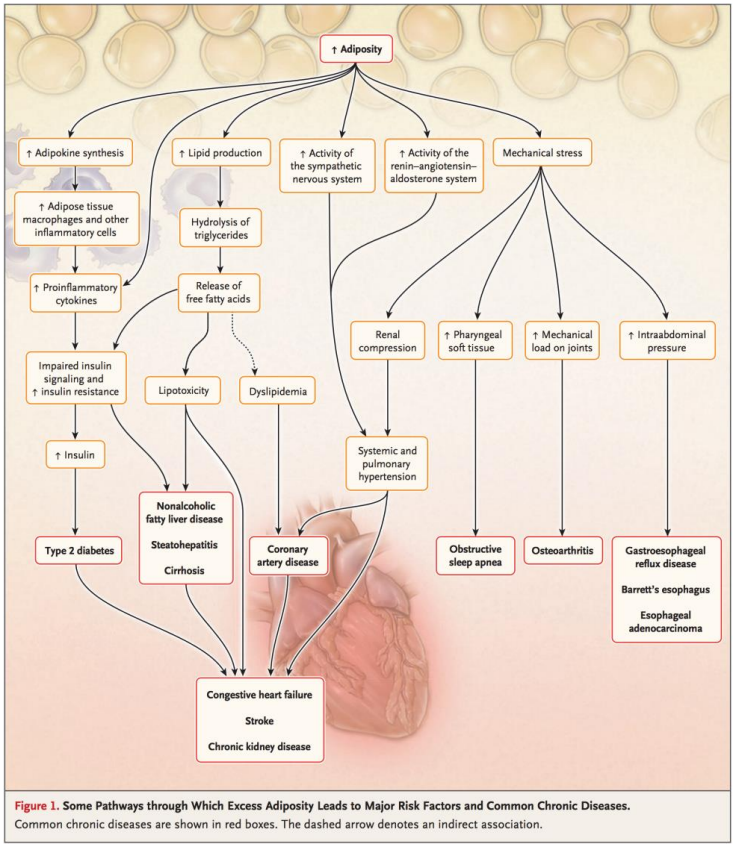

Figure 1. Some Pathways through Which Excess Adiposity Leads to Major Risk Factors and Common Chronic Diseases.
Common chronic diseases are shown in red boxes. The dashed arrow denotes an indirect association.

N Engl J Med 2017;376:254-66

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WENN ÜBERGEWICHT ZUR KRANKHEIT WIRD

- Wie gross ist das Problem?
- Macht Übergewicht wirklich krank?
- Kann man durch Gewichtsabnahme gesünder werden?

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WAS TUN?

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THERAPIE OPTIONEN

- Modifizierung der Lebensweise
  - Diäten und Fitnessprogramme
  - Verhaltenstherapien
  - «Comprehensive Lifestyle Interventions»

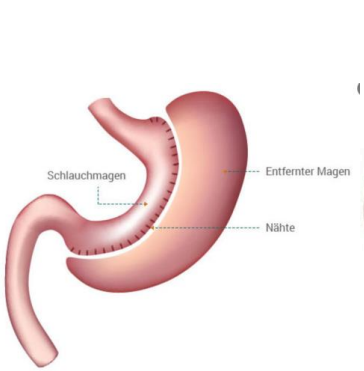
- Spezifische Behandlung
  - Medikamente: Xenical, Saxenda
  - Hilfsmittel: Bänder, Ballone, Neurostimulatoren, Aspiration, Gels
  - Bariatrische Chirurgie: Schlauchmagen, Magenbypass, BPD

MODIFIZIERUNG DER LEBENSWEISE

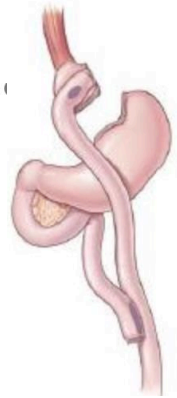
HIGH INTENSITY COMPREHENSIVE LIFESTYLE INTERVENTION

Component	Weight Loss	Weight-Loss Maintenance
Counseling	≥14 in-person counseling sessions (individual or group) with a trained interventionist during a 6-mo period; recommendations for similarly structured, comprehensive Web-based interventions, as well as evidence-based commercial programs	Monthly or more frequent in-person or telephone sessions for ≥1 yr with a trained interventionist
Diet	Low-calorie diet (typically 1200–1500 kcal per day for women and 1500–1800 kcal per day for men), with macronutrient composition based on patient's preferences and health status	Reduced-calorie diet, consistent with reduced body weight, with macronutrient composition based on patient's preferences and health status
Physical activity	≥150 min per week of aerobic activity (e.g., brisk walking)	200–300 min per week of aerobic activity (e.g., brisk walking)
Behavioral therapy	Daily monitoring of food intake and physical activity, facilitated by paper diaries or smart-phone applications; weekly monitoring of weight; structured curriculum of behavioral change (e.g., DPP), including goal setting, problem solving, and stimulus control; regular feedback and support from a trained interventionist	Occasional or frequent monitoring of food intake and physical activity, as needed; weekly-to-daily monitoring of weight; curriculum of behavioral change, including problem solving, cognitive restructuring, and relapse prevention; regular feedback from a trained interventionist

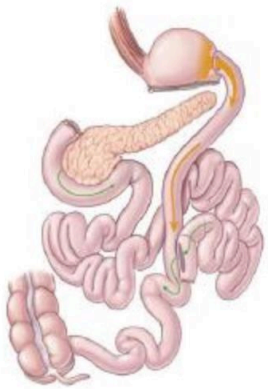
SPEZIFISCHE BEHANDLUNG
BARIATRISCHE CHIRURGIE

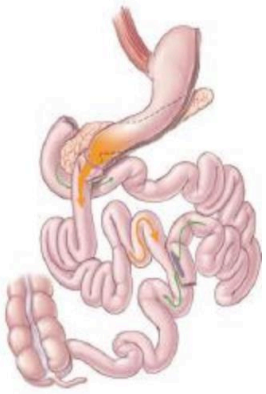


Schlauchmagen



Magenbypass





Biliopankreatische Diversion

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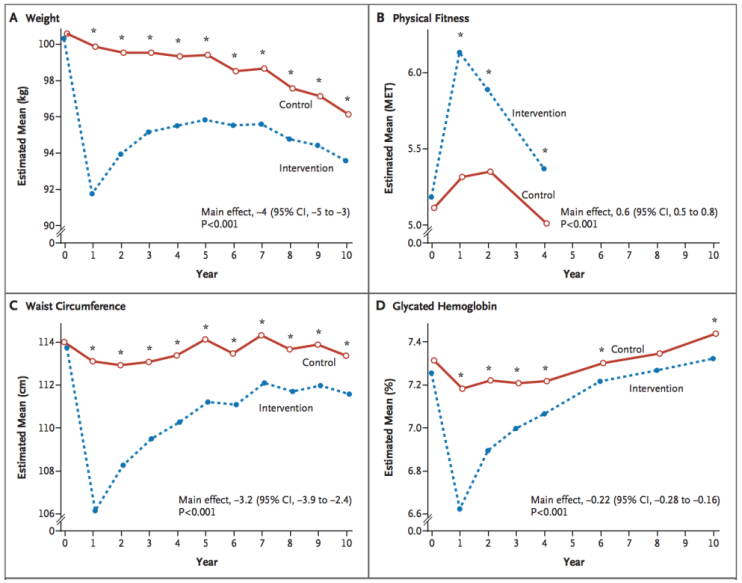
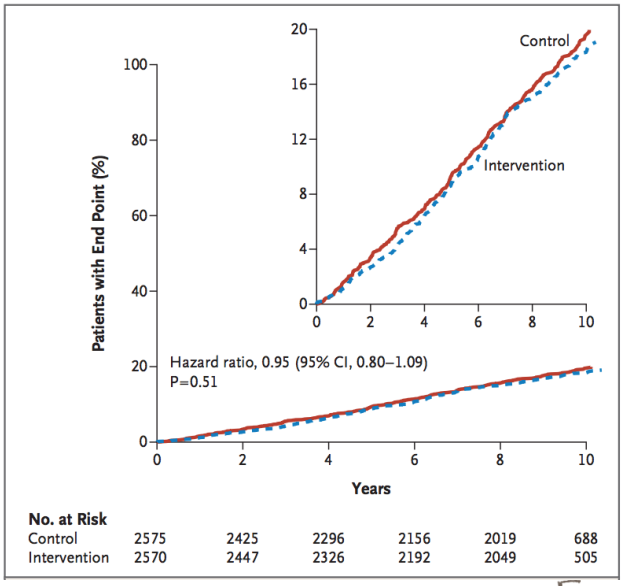
MODIFIZIERUNG DER LEBENSWEISE

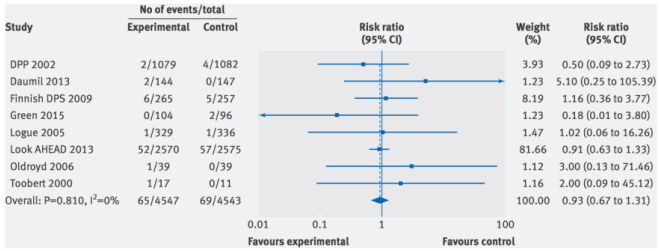
THERAPIE EFFEKTE: „LOOK AHEAD“ STUDIE





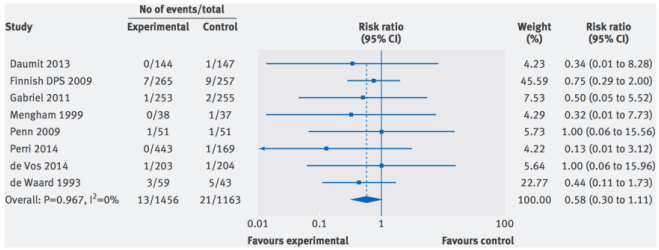
NEJM. 2013;369:145–154.

MODIFIZIERUNG DER LEBENSWEISE THERAPIE EFFEKTE – META-ANALYSE



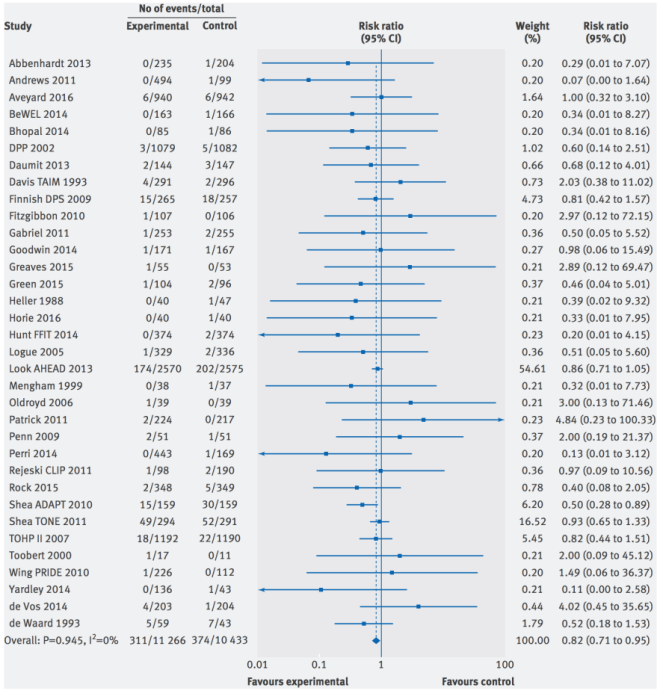
Study	No of events/total: Experimental	Control	Risk ratio (95% CI)	Weight (%)	Risk ratio (95% CI)
DPP 2002	2/1079	4/1082		3.93	0.50 (0.09 to 2.73)
Daumit 2013	2/144	0/147		1.23	5.10 (0.25 to 105.39)
Finnish DPS 2009	6/265	5/257		8.19	1.16 (0.36 to 3.77)
Green 2015	0/104	2/96		1.23	0.18 (0.01 to 3.80)
Logue 2005	1/329	1/336		1.47	1.02 (0.06 to 16.26)
Look AHEAD 2013	52/2570	57/2575		81.66	0.91 (0.63 to 1.33)
Oldroyd 2006	1/39	0/39		1.12	3.00 (0.13 to 71.46)
Toobert 2000	1/17	0/11		1.16	2.00 (0.09 to 45.12)
Overall: P=0.810, I^2=0%	65/4547	69/4543		100.00	0.93 (0.67 to 1.31)

Fig 3 | Random effects meta-analysis of the effects of weight loss interventions on cardiovascular mortality. DPP=diabetes prevention program; DPS=diabetes prevention study.



Study	No of events/total: Experimental	Control	Risk ratio (95% CI)	Weight (%)	Risk ratio (95% CI)
Daumit 2013	0/144	1/147		4.23	0.34 (0.01 to 8.28)
Finnish DPS 2009	7/265	9/257		45.59	0.75 (0.29 to 2.00)
Gabriel 2011	1/253	2/255		7.53	0.50 (0.05 to 5.52)
Mengham 1999	0/38	1/37		4.29	0.32 (0.01 to 7.73)
Penn 2009	1/51	1/51		5.73	1.00 (0.06 to 15.56)
Perri 2014	0/443	1/169		4.22	0.13 (0.01 to 3.12)
de Vos 2014	1/203	1/204		5.64	1.00 (0.06 to 15.96)
de Waard 1993	3/59	5/43		22.77	0.44 (0.11 to 1.73)
Overall: P=0.967, I^2=0%	13/1456	21/1163		100.00	0.58 (0.30 to 1.11)

Fig 4 | Random effects meta-analysis of the effects of weight loss interventions on cancer mortality. DPS=diabetes prevention study.



Study	No of events/total: Experimental	Control	Risk ratio (95% CI)	Weight (%)	Risk ratio (95% CI)
Abbenhardt 2013	0/235	1/204		0.20	0.29 (0.01 to 7.07)
Andrews 2011	0/494	1/99		0.20	0.07 (0.00 to 1.64)
Aveyard 2016	6/940	6/942		1.64	1.00 (0.32 to 3.10)
BeWEL 2014	0/163	1/166		0.20	0.34 (0.01 to 8.27)
Bhopal 2014	0/85	1/86		0.20	0.34 (0.01 to 8.16)
DPP 2002	3/1079	5/1082		1.02	0.60 (0.14 to 2.51)
Daumit 2013	2/144	3/147		0.66	0.68 (0.12 to 4.01)
Davis TAIM 1993	4/291	2/296		0.73	2.03 (0.38 to 11.02)
Finnish DPS 2009	15/265	18/257		4.73	0.81 (0.42 to 1.57)
Fitzgibbon 2010	1/107	0/106		0.20	2.97 (0.12 to 72.15)
Gabriel 2011	1/253	2/255		0.36	0.50 (0.05 to 5.52)
Goodwin 2014	1/171	1/167		0.27	0.98 (0.06 to 15.49)
Greaves 2015	1/55	0/53		0.21	2.89 (0.12 to 69.47)
Green 2015	1/104	2/96		0.37	0.46 (0.04 to 5.01)
Heller 1988	0/40	1/47		0.21	0.39 (0.02 to 9.32)
Horie 2016	0/40	1/40		0.21	0.33 (0.01 to 7.95)
Hunt FFIT 2014	0/374	2/374		0.23	0.20 (0.01 to 4.15)
Logue 2005	1/329	2/336		0.36	0.51 (0.05 to 5.60)
Look AHEAD 2013	174/2570	202/2575		54.61	0.86 (0.71 to 1.05)
Mengham 1999	0/38	1/37		0.21	0.32 (0.01 to 7.73)
Oldroyd 2006	1/39	0/39		0.21	3.00 (0.13 to 71.46)
Patrick 2011	2/224	0/217		0.23	4.84 (0.23 to 100.33)
Penn 2009	2/51	1/51		0.37	2.00 (0.19 to 21.37)
Perri 2014	0/443	1/169		0.20	0.13 (0.01 to 3.12)
Rejeski CLIP 2011	1/98	2/190		0.36	0.97 (0.09 to 10.56)
Rock 2015	2/348	5/349		0.78	0.40 (0.08 to 2.05)
Shea ADAPT 2010	15/159	30/159		6.20	0.50 (0.28 to 0.89)
Shea TONE 2011	49/294	52/291		16.52	0.93 (0.65 to 1.33)
TOHP II 2007	18/1192	22/1190		5.45	0.82 (0.44 to 1.51)
Toobert 2000	1/17	0/11		0.21	2.00 (0.09 to 45.12)
Wing PRIDE 2010	1/226	0/112		0.20	1.49 (0.06 to 36.37)
Yardley 2014	0/136	1/43		0.21	0.11 (0.00 to 2.58)
de Vos 2014	4/203	1/204		0.44	4.02 (0.45 to 35.65)
de Waard 1993	5/59	7/43		1.79	0.52 (0.18 to 1.53)
Overall: P=0.945, I^2=0%	311/11 266	374/10 433		100.00	0.82 (0.71 to 0.95)

Fig 2 | Random effects meta-analysis of the effects of weight loss interventions on all cause mortality. ADAPT=arthritis, diet, and activity promotion trial; CLIP=community level interventions for pre-eclampsia; DPP=diabetes prevention program; DPS=diabetes prevention study; FFIT=football fans in training; Look AHEAD=look action for health in diabetes; PRIDE=program to reduce incontinence by diet and exercise; TAIM=trial of antihypertensive interventions and management; TOHP=trials of hypertension prevention; TONE=trial of nonpharmacologic intervention in the elderly.

BMJ 2017;359:j4849

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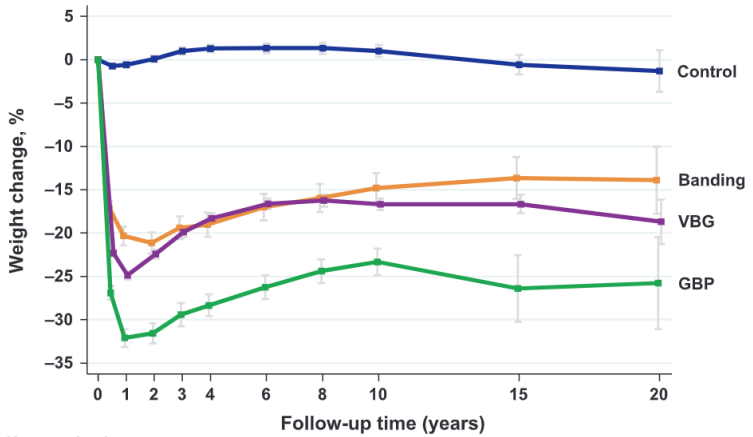
„SOS“ STUDIE



No. examined

Control	2037	1490	1242	1267	556	176
Banding	376	333	284	284	150	50
VBG	1369	1086	987	1007	489	82
GBP	265	209	184	180	37	13

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J Intern Med. 2013 Mar;273(3):219-34

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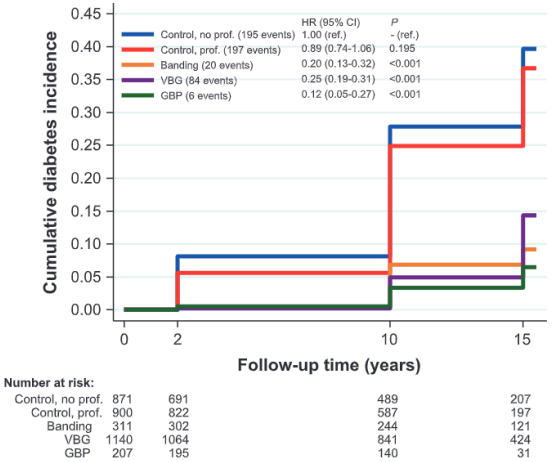

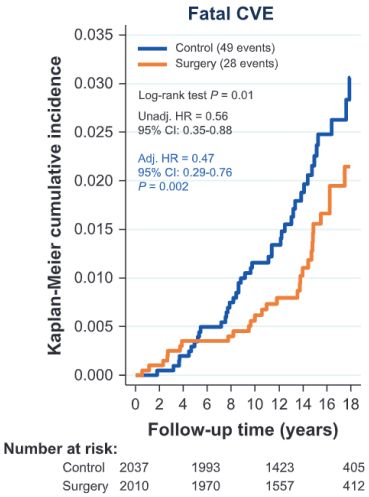

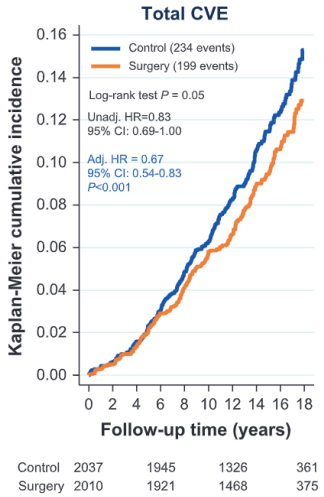

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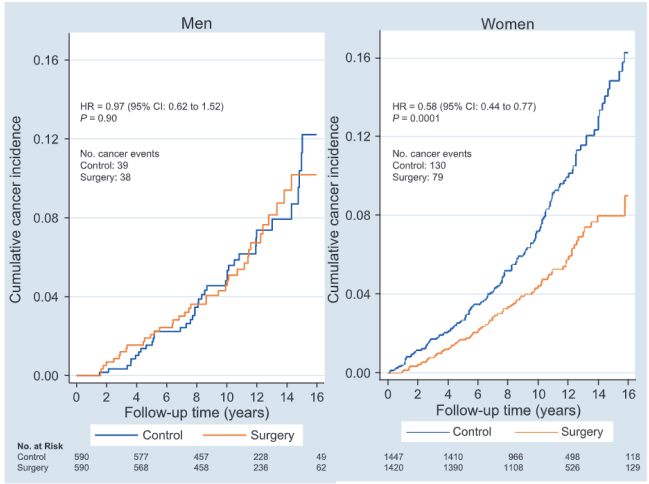

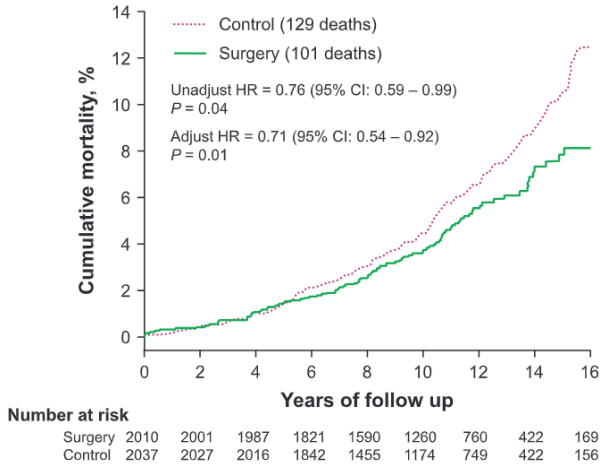

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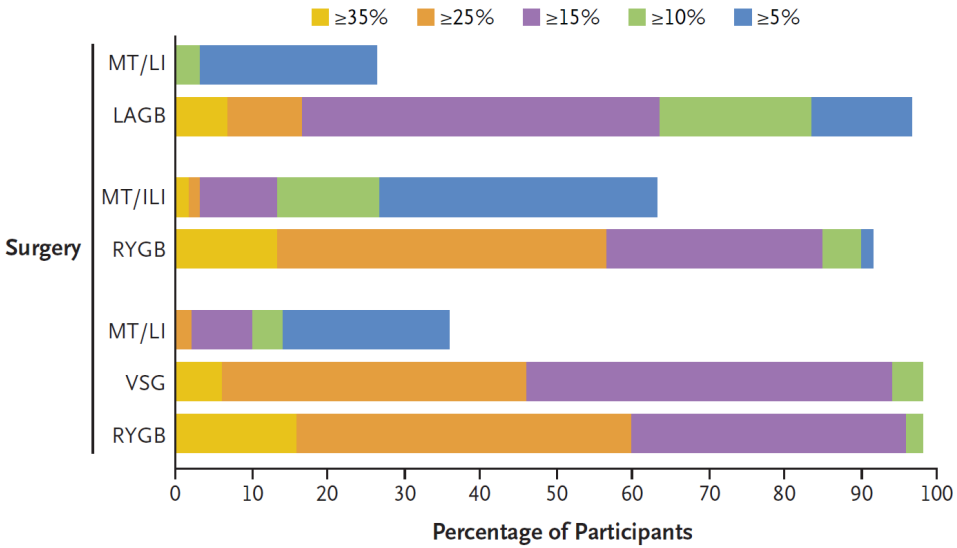
GEWICHTSVERLUST IM VERGLEICH



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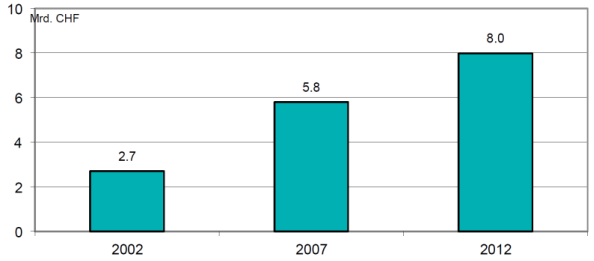
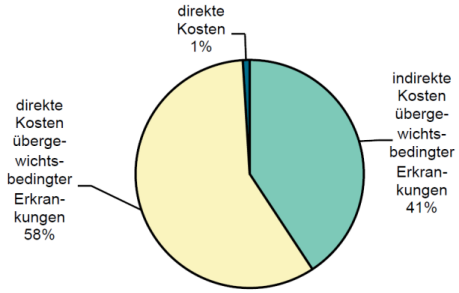
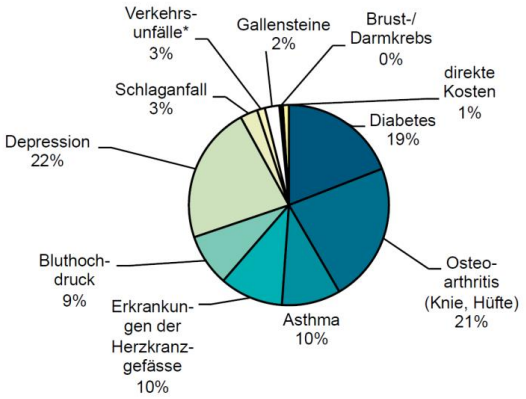
KOSTEN VON ÜBERGEWICHT IN DER SCHWEIZ





	2007	2012
Medikamente	25	24
Operationen	19	50
Konsultationen	3	3
Total	*47*	77



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Schneider und Venetz (2014)

WENN ÜBERGEWICHT ZUR KRANKHEIT WIRD

- Fettsucht wird weltweit normal oder normaler, auch in der Schweiz.
- Übergewicht verursacht viele Krankheiten und erhöht die Sterberate.
- Gewichtsabnahme verhindert Krankheiten und verlängert die Lebensdauer.
- Massnahmen zur Gewichtsabnahme sind unterschiedlich effektiv.
- Fettsucht verursacht hohe Kosten. Davon entfallen nur ca. 1% auf die Therapiekosten für die Fettsucht selbst.

VIELEN DANK FÜR IHRE AUFMERKSAMKEIT!

- Noch Fragen?

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