The bad news—and the good—about obesity and COVID-19

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From the earliest days of the pandemic, it's been known that obesity is a risk factor for severe COVID-19, but a study recently released by the Centers for Disease Control and Prevention (CDC) demonstrated just how nonlinear this relationship is. The vast majority—78%—of U.S. patients hospitalized with COVID-19 were overweight or had obesity. The numbers for intensive care, invasive mechanical ventilation and death were nearly the same.

In a recent episode of the "AMA COVID-19 Update," an obesity medicine physician-scientist talked about how the COVID-19 pandemic has become an aha moment for patients struggling with overweight and what physicians can do both immediately and longer term to more effectively help them.

It cuts across ages

"If we look at the prevalence of obesity based upon 2018 numbers, which is the latest that we see from the CDC, we know that 42.4% of U.S. adults have the disease of obesity. That's almost half," said Fatima Cody Stanford, MD, MPH, assistant professor of medicine and pediatrics at Harvard Medical School. She added that many people have seen their weight increase during the pandemic, "so that 42.4% may actually be significantly closer to 50%."

In addition, it's often thought that kids are much less susceptible to COVID-19, but here again overweight plays a role. Children experiencing bad outcomes often have obesity, requiring ventilation or extracorporeal membrane oxygenation, or ECMO.

"This is an issue across the age spectrum," she said.

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Pandemic pushes patients to get help

Dr. Stanford said the vast majority of the patients she has been treating for chronic obesity during the pandemic—both adult and pediatric—have lost weight.

Part of that she attributes to a newfound sense of urgency among her long-term patients. Some had resisted metabolic and bariatric surgery for years before the pandemic but now want to sign up.

“I’m like, ‘Well, that's interesting. I've been trying to get you to surgery for five years,’” Dr. Stanford said. “And they say, ‘I'm seeing my family and friends die and I don't want to be that person. I know I should have done it back when you recommended it in 2015 or 2013 even, but here I am. I'm ready.’”

Why language matters

Given this golden opportunity to help patients, physicians should pay particular attention to their bedside manner, Dr. Stanford said.

“It's all about language, language, language, language,” she said, noting that the AMA House of Delegates adopted a resolution in 2017 discouraging the use of stigmatizing terms and amending language in the Association’s policy on obesity as a major public health problem. The AMA recognized obesity as a disease in 2013.

“Do not use the word obese. Obese is a label—it’s often highly stigmatizing,” Dr. Stanford said, adding that it’s better to instead say a patient has mild, moderate or severe obesity. In addition, it’s important to never use “morbid” in place of “severe.”

“We don't call it morbid COVID,” she noted. “We don't call it morbid cancer or morbid anything else.” Putting “morbid” in front of “obesity” is a demonstration of bias, according to Dr. Stanford.

But it also requires looking upstream of the problem. One approach is the Treat and Reduce Obesity Act, which was reintroduced with bipartisan support in the U.S. House and Senate this year. It would expand Medicare coverage to include screening and treatment of obesity, as well as Food and Drug Administration-approved medications for chronic weight management.

“Right now, if you have obesity but don't have diabetes, you still are paying quite a bit out of pocket to meet with a dietitian,” Dr. Stanford said. “Now, if you get diabetes, all of a sudden, that visit is covered. Hmm. That seems a little bit backwards. Why not treat the patient before they develop diabetes, which is obviously an even more severe risk factor sometimes than obesity itself?”

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