

Obesity

Identification, assessment and management of overweight and obesity in children, young people and adults

Partial update of CG43

Methods, evidence and recommendations

July 2014

Draft for Consultation

*Commissioned by the National Institute for
Health and Care Excellence*

Disclaimer

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3

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4 all their help and support throughout the guideline.

5

1 **Guideline update**

2 The guidance is a partial update of NICE clinical guideline 43 (published December 2006) and will
3 replace it.

4 NICE has a suite of guidance on obesity including the following guidance: PH45 BMI and waist
5 circumference – black, Asian and ethnic groups (July 2013), PH47 Managing overweight and obesity
6 among children and young people (October 2013), PH44 Overweight and obese adults – lifestyle
7 management (May 2014), Maintaining a healthy weight and preventing excess weight gain among
8 children and adults (due to be published in Feb 2015). This guidance will replace clinical section 1.2 in
9 CG43, we will advise stakeholders regarding signposting of the remaining public health
10 recommendation in Section 1.1., not updated at publication.

11 New and updated recommendations have been included covering very low calorie diets, bariatric
12 surgery in people with recent onset type 2 diabetes and follow up care after bariatric surgery.

13 Recommendations are marked to indicated the year of the last evidence review [2014] if the
14 evidence has not been updated since the original guideline, [2006, amended 2014] if the evidence
15 has not been updated since the original guideline, but changes have been made that alter the
16 meaning of the recommendation, [2014] if the evidence has been reviewed but no change has been
17 made to the recommendation and [new 2014] if the evidence review has been added or updated.
18 You are invited to comment only on the new and updated recommendations in this guideline.

19 Appendix Q contains recommendations from the 2006 guideline that NICE proposes deleting in the
20 2014 update. This is because the evidence has been reviewed and the recommendation has been
21 updated or because NICE has updated other relevant guidance and has replaced the original
22 recommendations. Where there are replacement recommendations, details are provided. Where
23 there is no replacement recommendation, an explanation for the proposed deletion is given. You are
24 invited to comment on the deleted recommendations as part of the consultation on the 2014
25 update.

26 The original NICE guidance and supporting documents are available from
27 <http://publications.nice.org.uk/obesity-cg43>.

28 Appendices M, N and P contain all the evidence and discussion that underpinned the original CG43
29 recommendations that are included in this guideline. Only evidence for the new reviews is contained
30 within this document.

1 Introduction

2 Overweight and obesity are increasing problems that lead to significant health and social difficulties
3 for people. Commonly defined by a measurement of Body Mass Index (BMI - calculated by dividing
4 body weight (kilograms) by height (metres) squared), the prevalence of overweight (adult BMI of
5 between 25 and 29.9) and obesity (BMI of 30 or over) is increasing. For children, these BMI standards
6 require adjustments for age and gender. Overweight and obesity are global problems and the World
7 Health Organization (WHO) predicts that by 2015 approximately 2.3 billion adults worldwide will be
8 overweight and more than 700 million obese. In the UK, obesity rates have nearly doubled in the
9 past 18 years from 13% of men and 16% of women in 1993, to 24% of men and 26% of women in
10 2011. In the same year, about 3 in 10 children aged 2–15 years were found to be overweight or
11 obese. Ethnic differences exist in the prevalence of obesity and the related risk of ill health. For
12 example, compared with the general population, the prevalence of obesity is lower in men of
13 Bangladeshi and Chinese family origin, whereas it is higher for women of African, Caribbean and
14 Pakistani family origin as reported by the National Obesity Observatory in 2011.

15 Obesity is directly linked to a number of different illnesses including type 2 diabetes, hypertension,
16 gallstones and gastro-oesophageal reflux disease, as well as psychological and psychiatric
17 morbidities. The Health and Social Care Information Centre reported that there were 11,740
18 inpatient admissions to hospitals in England with a primary diagnosis of obesity in 2011/2012, which
19 is 3 times as many as 5 years earlier in 2006/2007. There were 3 times as many women admitted as
20 men.

21 The cost of overweight and obesity to society and the economy was estimated to be almost £16
22 billion in 2007 (over 1% of gross domestic product). The cost could increase to just under £50 billion
23 in 2050 if obesity rates continue to rise, according to projections from the Department of Health. A
24 simulated model reported in the Lancet predicted that there would be 11 million more obese adults
25 in the UK by 2030, with combined medical costs for treatment of associated diseases estimated to
26 increase by £1.9–2 billion/year.

27 Treatment options for obesity include non-surgical treatment and bariatric surgery. Non-surgical
28 treatment usually takes a multicomponent approach, involving dietary changes to reduce calorie
29 intake, an increase in physical activity, behavioural modification, and rarely, pharmacotherapy.

30 NICE issued guidance on the prevention, identification, assessment and management of overweight
31 and obesity in adults and children in 2006 (CG43). This was a joint clinical and public health guideline
32 developed by the National Collaborating Centre for Primary Care (now merged as part of the
33 National Clinical Guidelines Centre) and NICE's Centre for Public Health Excellence. Despite the
34 guidance, there remain significant variations in existing service provision for people with obesity and,
35 in many places, the multicomponent programmes that are required for both prevention and
36 treatment are limited. The 2013 Royal College of Physicians report 'Action on obesity:
37 comprehensive care for all' reported that access to surgery for obesity in some areas of the UK did
38 not reflect the guideline recommendations.

39 The 2006 guideline was reviewed for update in 2011, leading to this partial update. This guideline
40 addresses three main areas - follow-up care packages after bariatric surgery; the role of bariatric
41 surgery in the management of recent onset type 2 diabetes; very low calorie diets including their
42 effectiveness, safety and effective management strategies for maintaining weight loss after such
43 diets.

44 The public health aspects of CG43 are not addressed here, but are in the process of being updated by
45 the Centre for Public Health Excellence. The public health recommendations that formed part of
46 CG43 have therefore been removed from this guidance. All other clinical recommendations from
47 areas not subject to update have been reviewed to ensure that they comply with the NICE policy on
48 non-discrimination and, where appropriate, have been amended or the wording changed in line with
49 current NICE house style (see Section 3.1).

2₁ Development of the guideline

2₂₁ What is a NICE clinical guideline?

3 NICE clinical guidelines are recommendations for the care of individuals in specific clinical conditions
4 or circumstances within the NHS – from prevention and self-care through primary and secondary
5 care to more specialised services. We base our clinical guidelines on the best available research
6 evidence, with the aim of improving the quality of health care. We use predetermined and
7 systematic methods to identify and evaluate the evidence relating to specific review questions.

8 NICE clinical guidelines can:

- 9 • provide recommendations for the treatment and care of people by health professionals
- 10 • be used to develop standards to assess the clinical practice of individual health professionals
- 11 • be used in the education and training of health professionals
- 12 • help patients to make informed decisions
- 13 • improve communication between patient and health professional.

14 While guidelines assist the practice of healthcare professionals, they do not replace their knowledge
15 and skills.

16 We produce our guidelines using the following steps:

- 17 • Guideline topic is referred to NICE from the Department of Health.
- 18 • Stakeholders register an interest in the guideline and are consulted throughout the development
19 process.
- 20 • The scope is prepared by the National Clinical Guideline Centre (NCGC).
- 21 • The NCGC establishes a Guideline Development Group.
- 22 • A draft guideline is produced after the group assesses the available evidence and makes
23 recommendations.
- 24 • There is a consultation on the draft guideline.
- 25 • The final guideline is produced.

26 The NCGC and NICE produce a number of versions of this guideline:

- 27 • the 'full guideline' contains all the recommendations, plus details of the methods used and the
28 underpinning evidence
- 29 • the 'NICE guideline' lists the recommendations
- 30 • 'information for the public' is written using suitable language for people without specialist
31 medical knowledge
- 32 • NICE Pathways brings together all connected NICE guidance.

33 This version is the full version. The other versions can be downloaded from NICE at www.nice.org.uk.

2₄₂ Remit

35 This is a partial update of Obesity (NICE clinical guideline 43). See Appendix A for details of which
36 sections will be updated.

37 An editorial review of all recommendations has also been carried out, for example to ensure that
38 they comply with NICE's duties under equalities legislation.

1 This update is being undertaken as part of the guideline review cycle.

2.3 Who developed this guideline?

3 A multidisciplinary Guideline Development Group (GDG) comprising health professionals and
4 researches as well as lay members developed this guideline (see the list of Guideline Development
5 Group members and the acknowledgements).

6 The National Institute for Health and Care Excellence (NICE) funds the National Clinical Guideline
7 Centre (NCGC) and thus supported the development of this guideline. The GDG was convened by the
8 NCGC and chaired by Dr Peter Barry in accordance with guidance from NICE.

9 The group met every 4 weeks during the development of the guideline. At the start of the guideline
10 development process all GDG members declared interests including consultancies, fee-paid work,
11 share-holdings, fellowships and support from the healthcare industry. At all subsequent GDG
12 meetings, members declared arising conflicts of interest.

13 Members were either required to withdraw completely or for part of the discussion if their declared
14 interest made it appropriate. The details of declared interests and the actions taken are shown in
15 Appendix B.

16 Staff from the NCGC provided methodological support and guidance for the development process.
17 The team working on the guideline included a project manager, systematic reviewers, health
18 economists and information scientists. They undertook systematic searches of the literature,
19 appraised the evidence, conducted meta-analysis and cost effectiveness analysis where appropriate
20 and drafted the guideline in collaboration with the GDG.

21 (a) What this guideline covers

22 The guideline covers the following populations:

- 23 • Adults, children and young people (aged 2 years and older) who are overweight and obese. This
24 includes those with established comorbidities, and those with or without risk factors for other
25 medical conditions.
- 26 • The following special groups, which have high rates of morbidity caused by obesity, will be
27 considered when there is good evidence of effectiveness of separate interventions targeted at
28 these groups:
 - 29 o black and minority ethnic groups
 - 30 o people from lower socioeconomic groups
 - 31 o young people
 - 32 o people with learning disabilities
 - 33 o older people
 - 34 o people with type 2 diabetes.

35 For further details please refer to the scope in Appendix A and review questions in Section 3.1.

36 ~~(b)~~(a) What this guideline does not cover

37 The guideline does not cover people of a healthy weight, pregnant women or children under 2 years
38 of age.

39 Relationships between the guideline and other NICE guidance

1 Related NICE Interventional procedures guidance:

- 2 • Laparoscopic gastric plication for the treatment of severe obesity. NICE interventional procedure
3 guidance 432 (2012).

4 Related NICE Clinical guidelines:

- 5 • Type 2 diabetes: the management of type 2 diabetes. NICE clinical guidance 87 (2009)
6 • Eating disorders. NICE clinical guideline 9 (2004).
7 • Preoperative tests. NICE clinical guideline 3 (2003).

8 Related NICE Public health guidance:

- 9 • Managing overweight and obesity among children and young people. NICE public health guidance
10 47 (2013).
11 • Assessing body mass index and waist circumference thresholds for intervening to prevent ill
12 health and premature death among adults from black, Asian and other minority ethnic groups in
13 the UK. NICE public health guidance 46 (2013).
14 • Physical activity: brief advice for adults in primary care. NICE public health guidance 44 (2013).
15 Obesity: working with local communities. NICE public health guidance 42 (2012).
16 • Preventing type 2 diabetes: risk identification and interventions for individuals at high risk. NICE
17 public health guidance 38 (2012).
18 • Walking and cycling. NICE public health guidance 41 (2012).
19 • Preventing type 2 diabetes: population and community level interventions. NICE public health
20 guidance 35 (2011).
21 • Prevention of cardiovascular disease. NICE public health guidance 25 (2010).
22 • Weight management before, during and after pregnancy. NICE public health guidance 27 (2010).
23 • Maternal and child nutrition. NICE public health guidance 11 (2008).
24 • Four commonly used methods to increase physical activity. NICE public health guidance 2 (2006).

25 Related NICE guidance currently in development:

- 26 • Overweight and obese adults: lifestyle weight management services. NICE public health guidance.
27 Publication expected May 2014.
28 • Maintaining a healthy weight and preventing excess weight gain among children and adults. NICE
29 public health guidance. Publication expected March 2015.

3₁ Methods

2 This chapter sets out in detail the methods used to review the evidence and to generate the
3 recommendations that are presented in subsequent chapters. This guidance was developed in
4 accordance with the methods outlined in the NICE guidelines manual 2012⁴⁰.

3₅1 Amendments to 2006 text

6 All text and recommendations from the previous guideline, CG43, that has not been updated
7 (therefore review questions have not been generated and evidence has not been searched for) has
8 been left unchanged. Amendments to recommendations are detailed in Appendix Q.

3₉2 Developing the review questions and outcomes

10 Review questions were developed in a PICO framework (patient, intervention, comparison and
11 outcome) for intervention reviews.

12 This use of a framework guided the literature searching process, critical appraisal and synthesis of
13 evidence, and facilitated the development of recommendations by the Guideline Development
14 Group (GDG). The review questions were drafted by the NCGC technical team and refined and
15 validated by the GDG. The questions were based on the key clinical areas identified in the scope
16 (Appendix A).

17 A total of 5 review questions were identified.

18 Full literature searches, critical appraisals and evidence reviews were completed for all the specified
19 review questions.

20 **Table 1: Review questions**

Chapter	Type of review	Review questions	Outcomes
6	Intervention	In people who are overweight or obese, what is the clinical and cost effectiveness of very low calorie diets (VLCD) in reducing weight?	<p>Critical outcomes:</p> <ul style="list-style-type: none"> • % weight change (kg) at final end score • Health related quality of life • Withdrawals <p>Important outcomes:</p> <ul style="list-style-type: none"> • BMI final score compared to start - % reduction • Weight change at end of VLCD to end of study - % kg • Weight change at end of diet to end of study - % BMI • Improvement in physical activity
6	Intervention	In people who are overweight or obese, what is the safety of VLCD when used to reduce and maintain weight loss?	<p>Critical outcomes:</p> <ul style="list-style-type: none"> • Disordered eating • Depression score • Postural hypotension <p>Important outcomes:</p> <ul style="list-style-type: none"> • Bone density • Constipation

Chapter	Type of review	Review questions	Outcomes
			<ul style="list-style-type: none"> • Gallstones • Gout • Diarrhoea • Hypoglycaemia
6	Intervention	What are effective management strategies for maintaining weight loss after VLCD in people who are overweight or obese?	<p>Critical outcomes:</p> <ul style="list-style-type: none"> • % weight change (kg) from end of VLCD to end of study • Health related quality of life • Drop-outs <p>Important outcomes:</p> <ul style="list-style-type: none"> • % weight change (BMI) from end of VLCD to end of study • % weight change from before VLCD to end of study (kg) • % weight change from before VLCD to end of study (BMI) • Improvement in physical activity
7	Intervention	In people with recent onset type 2 diabetes (T2D) who are also overweight and obese, what is the clinical and cost effectiveness of bariatric surgery for the management of diabetes?	<p>Critical outcomes:</p> <ul style="list-style-type: none"> • % weight change (BMI or kg) • Improvement (glycaemic control) • Health related quality of life <p>Important outcomes:</p> <ul style="list-style-type: none"> • Remission of type 2 diabetes • Mortality • Weight in BMI • Weight in kg • Reduction of diabetic medication
8	Intervention	What is the clinical and cost effectiveness to follow-up care packages after bariatric surgery compared with usual care?	<p>Critical outcomes:</p> <ul style="list-style-type: none"> • % weight loss at end of study • Development of at least one micronutrient deficiency • Health related quality of life <p>Important outcomes:</p> <ul style="list-style-type: none"> • Reoperation rate • Mortality • Reduction in medication use

Chapter	Type of review	Review questions	Outcomes
			• Psychological well-being

3.13 Searching for evidence

3.3.12 Clinical literature search

3 Systematic literature searches were undertaken to systematically identify all published clinical
4 evidence relevant to the review questions. Searches were undertaken according to the parameters
5 stipulated within The guidelines manual 2012.⁴⁰ Databases were searched using relevant medical
6 subject headings, free-text terms and study-type filters where appropriate. Studies published in
7 languages other than English were not reviewed. Where possible, searches were restricted to articles
8 published in English. All searches were conducted in MEDLINE, Embase, and The Cochrane Library. In
9 addition, PsycINFO was used for the questions on very low calorie diets and care packages after
10 bariatric surgery.

11 Search strategies were quality assured by cross-checking reference lists of highly relevant papers,
12 analysing search strategies in other systematic reviews, and asking GDG members to highlight any
13 additional studies. The questions, the study types applied, the databases searched and the years
14 covered can be found in Appendix F.

15 The titles and abstracts of records retrieved by the searches were sifted for relevance, with
16 potentially significant publications obtained in full text. These were assessed against the inclusion
17 criteria.

3.3.28 Health economic literature search

19 Systematic literature searches were also undertaken to identify health economic evidence within
20 published literature relevant to the review questions. The evidence was identified by conducting
21 searches using the population and intervention terms in the NHS Economic Evaluation Database
22 (NHS EED), the Health Technology Assessment database (HTA) and the Health Economic Evaluations
23 Database (HEED) from 2006 onwards. Additionally, the search was run on MEDLINE and Embase
24 using a specific economic filter, population and intervention terms, from 2006, to ensure recent
25 publications that had not yet been indexed by the economic databases were identified. Studies
26 published in languages other than English were not reviewed. Where possible, searches were
27 restricted to articles published in English.

28 The health economic search strategies are included in Appendix F.

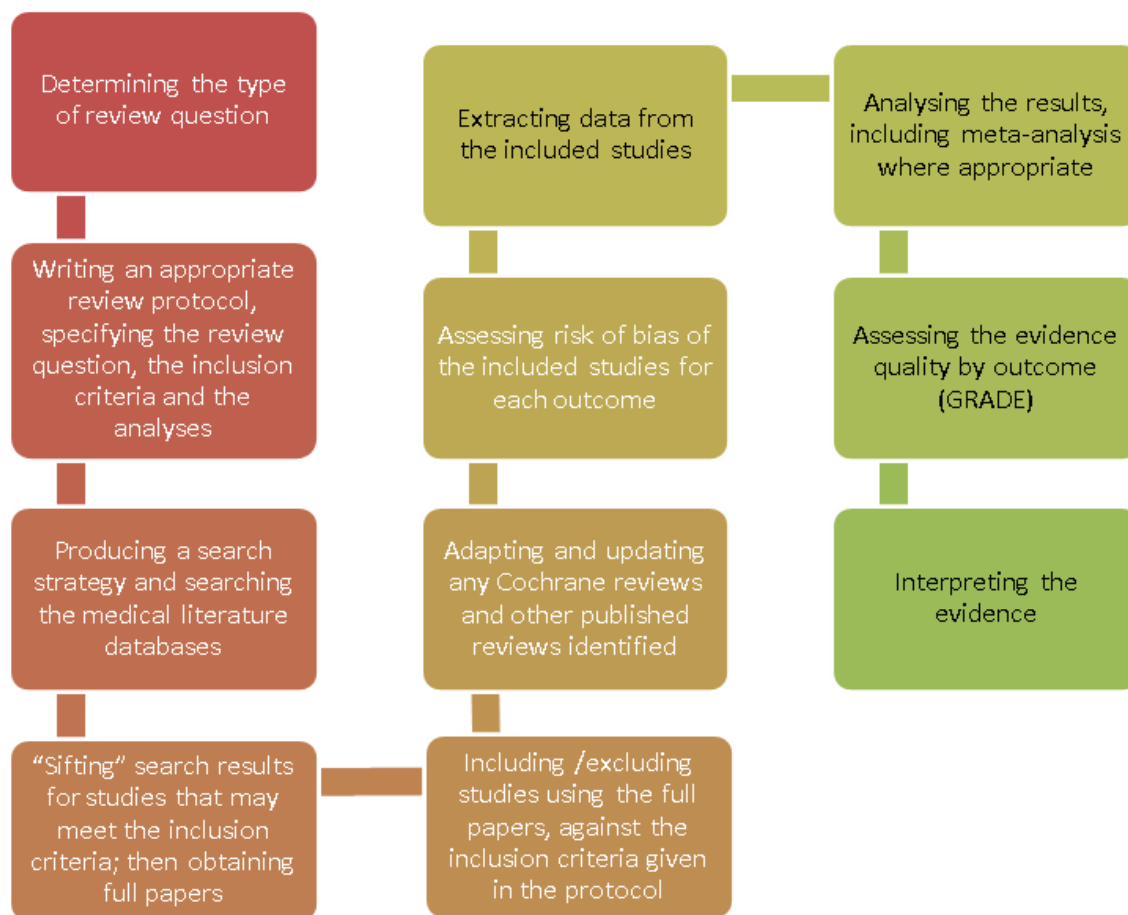
3.4 Evidence of effectiveness

30 The evidence was reviewed following the steps shown schematically in [Figure 1](#) ~~Figure 1~~:

- 31 • Potentially relevant studies were identified for each review question from the relevant search
32 results by reviewing titles and abstracts. Full papers were then obtained.
- 33 • Full papers were reviewed against pre-specified inclusion and exclusion criteria to identify studies
34 that addressed the review question in the appropriate population (review protocols are included
35 in Appendix C).
- 36 • Relevant studies were critically appraised using the appropriate checklist as specified in The
37 guidelines manual.⁴⁰
- 38 • Key information was extracted on the study's methods, PICO factors and results. These were
39 presented in summary tables (in each review chapter) and evidence tables (in Appendix G).

- 1 • Summaries of evidence were generated by outcome (included in the relevant review chapters)
- 2 and were presented in GDG meetings:
- 3 o Randomised studies: data were meta-analysed where appropriate and reported in GRADE
- 4 profiles (for intervention reviews).
- 5 A sample of the above stages of the reviewing process was quality assured by a second reviewer
- 6 to eliminate any potential of reviewer bias or error.

7 **Figure 1: Step-by-step process of review of evidence in the guideline**



8

3.4.19 Inclusion and exclusion criteria

10 The inclusion and exclusion of studies was based on the review protocols, which can be found in
11 Appendix C. Excluded studies by review question (with the reasons for their exclusion) are listed in
12 Appendix J. The GDG was consulted about any uncertainty regarding inclusion or exclusion.

13 The guideline population was people who are overweight defined as a BMI 25-29.9 (kg/m²) or obese
14 defined as a BMI over 30 (kg/m²). The review population included adults and children over two years
15 old. The only exception was for the question on follow-up care packages after bariatric surgery which
16 included adults and young people (post puberty) as prepuberty children would need different follow
17 up care.

18 For the review question on bariatric surgery in type 2 diabetes, the review population included
19 overweight and obese adults with recent onset type 2 diabetes. Recent onset type 2 diabetes was
20 defined as a duration of less than or equal to 10 years.

21 Literature reviews, posters, letters, editorials, comment articles, unpublished studies and studies not
22 in English were excluded.

1 The review protocols are presented in Appendix C.

3.4.2.2 Methods of combining clinical studies

3.4.2.1.3 Data synthesis for intervention reviews

4 Where possible, meta-analyses were conducted to combine the results of studies for each review
5 question using Cochrane Review Manager (RevMan5) software. Fixed-effects (Mantel-Haenszel)
6 techniques were used to calculate risk ratios (relative risk) for the binary outcomes: reoperation rate,
7 mortality, remission of type 2 diabetes, reduction of diabetic medication, withdrawals, depression
8 tendencies, constipation, gallstones and diarrhoea.

9 For continuous outcomes, measures of central tendency (mean) and variation (standard deviation)
10 were required for meta-analysis. Data for continuous outcomes [% weight change (kg or BMI), weight
11 change (kg or BMI), improvement in glycaemic control, use of diabetic medication, health related
12 quality of life, psychological well-being, improvement in physical activity, depression score and binge
13 eating] were analysed using an inverse variance method for pooling weighted mean differences and,
14 where the studies had different scales, standardised mean differences were used. A generic inverse
15 variance option in RevMan5 was used if any studies reported solely the summary statistics and 95%
16 confidence interval (95% CI) or standard error; this included any hazard ratios reported. However, in
17 cases where standard deviations were not reported per intervention group, the standard error (SE)
18 for the mean difference was calculated from other reported statistics (p values or 95% CIs); meta-
19 analysis was then undertaken for the mean difference and SE using the generic inverse variance
20 method in RevMan5. When the only evidence was based on studies that summarised results by
21 presenting medians (and interquartile ranges), or only p values were given, this information was
22 assessed in terms of the study's sample size and was included in the GRADE tables without
23 calculating the relative or absolute effects. Consequently, aspects of quality assessment such as
24 imprecision of effect could not be assessed for evidence of this type.

25 When reported time to event data was presented as a hazard ratio.

26 Stratified analyses were predefined for the review questions at the protocol stage when the GDG
27 identified that these strata are different in terms of biological and clinical characteristics and the
28 interventions were expected to have a different effect on subpopulations. Strata included:

- 29 • Different BMI categories
- 30 • People with learning disabilities
- 31 • Young people (puberty onwards)

32 For more information on strata refer to the protocols (see Appendix C).

33 Statistical heterogeneity was assessed by visually examining the forest plots, and by considering the
34 chi-squared test for significance at $p < 0.1$ or an I-squared inconsistency statistic (with an I-squared
35 value of more than 50% indicating considerable heterogeneity). Where considerable heterogeneity
36 was present, we carried out predefined subgroup analyses detailed in the protocols (see Appendix C).

37 Assessments of potential differences in effect between subgroups were based on the chi-squared
38 tests for heterogeneity statistics between subgroups. If no sensitivity analysis was found to
39 completely resolve statistical heterogeneity then a random-effects (DerSimonian and Laird) model
40 was employed to provide a more conservative estimate of the effect.

41 The means and standard deviations of continuous outcomes were required for meta-analysis.
42 However, in cases where standard deviations were not reported, the standard error was calculated if
43 the p values or 95% CIs were reported and meta-analysis was undertaken with the mean and
44 standard error using the generic inverse variance method in RevMan5. Where p values were

- 1 reported as 'less than', a conservative approach was undertaken. For example, if p value was
 2 reported as ' $p \leq 0.001$ ', the calculations for standard deviations will be based on a p value of 0.001. If
 3 these statistical measures were not available then the methods described in Section 16.1.3 of the
 4 Cochrane Handbook (September 2009) 'Missing standard deviations' were applied as the last resort.
- 5 For interpretation of the binary outcome results, differences in the absolute event rate were
 6 calculated using the GRADEpro software, for the median event rate across the control arms of the
 7 individual studies in the meta-analysis. Absolute risk differences were presented in the GRADE
 8 profiles and in clinical summary of findings tables, for discussion with the GDG.
- 9 For binary outcomes, absolute event rates were also calculated using the GRADEpro software using
 10 event rate in the control arm of the pooled results.

3.4.3.1 Type of studies

12 For most intervention reviews in this guideline, parallel randomised controlled trials (RCTs) were
 13 included because they are considered the most robust type of study design that could produce an
 14 unbiased estimate of the intervention effects. If there was limited evidence from RCTs, a conference
 15 abstract search was completed and authors were contacted for further information of any relevant
 16 studies. Please refer to Appendix C for full details on the study design of studies selected for each
 17 review question.

3.4.4.8 Appraising the quality of evidence by outcomes

19 The evidence for outcomes from the included RCTs and, where appropriate, observational studies
 20 were evaluated and presented using an adaptation of the 'Grading of Recommendations Assessment,
 21 Development and Evaluation (GRADE) toolbox' developed by the international GRADE working group
 22 (<http://www.gradeworkinggroup.org/>). The software developed by the GRADE working group
 23 (GRADEpro) was used to assess the quality of each outcome, taking into account individual study
 24 quality factors and the meta-analysis results. Results were presented in GRADE profiles ('GRADE
 25 tables'), which consist of 2 sections: the 'Clinical evidence profile' table includes details of the quality
 26 assessment while the 'Clinical evidence summary of findings' table includes pooled outcome data,
 27 where appropriate, an absolute measure of intervention effect and the summary of quality of
 28 evidence for that outcome. In this table, the columns for intervention and control indicate summary
 29 measures and measures of dispersion (such as mean and standard deviation or median and range)
 30 for continuous outcomes and frequency of events (n/N: the sum across studies of the number of
 31 patients with events divided by sum of the number of completers) for binary outcomes.

32 The evidence for each outcome was examined separately for the quality elements listed and defined
 33 in Table 2. Each element was graded using the quality levels listed in Table 3. The main criteria
 34 considered in the rating of these elements are discussed below (see Section 3.4.5 Grading of
 35 evidence). Footnotes were used to describe reasons for grading a quality element as having serious
 36 or very serious problems. The ratings for each component were summed to obtain an overall
 37 assessment for each outcome (Table 4).

38 **Table 2: Description of the elements in GRADE used to assess the quality of intervention studies**

Quality element	Description
Risk of bias ('Study limitations')	Limitations in the study design and implementation may bias the estimates of the treatment effect. High risk of bias for the majority of the evidence decreases confidence in the estimate of the effect
Inconsistency	Inconsistency refers to an unexplained heterogeneity of results
Indirectness	Indirectness refers to differences in study population, intervention, comparator and outcomes between the available evidence and the review question, or

Quality element	Description
	recommendation made, such that the effect estimate is changed
Imprecision	Results are imprecise when studies include relatively few patients and few events and thus have wide confidence intervals around the estimate of the effect. Imprecision results if the confidence interval includes the clinically important threshold
Publication bias	Publication bias is a systematic underestimate or an overestimate of the underlying beneficial or harmful effect due to the selective publication of studies

1 **Table 3: Levels of quality elements in GRADE**

Level	Description
None	There are no serious issues with the evidence
Serious	The issues are serious enough to downgrade the outcome evidence by 1 level
Very serious	The issues are serious enough to downgrade the outcome evidence by 2 levels

2 **Table 4: Overall quality of outcome evidence in GRADE**

Level	Description
High	Further research is very unlikely to change our confidence in the estimate of effect
Moderate	Further research is likely to have an important impact on our confidence in the estimate of effect and may change the estimate
Low	Further research is very likely to have an important impact on our confidence in the estimate of effect and is likely to change the estimate
Very low	Any estimate of effect is very uncertain

3.4.5.3 Grading the quality of clinical evidence

4 After results were pooled, the overall quality of evidence for each outcome was considered. The
5 following procedure was adopted when using GRADE:

- 6 1. A quality rating was assigned, based on the study design. RCTs start as High, observational studies
7 as Low, and uncontrolled case series as Low or Very low.
 - 8 2. The rating was then downgraded for the specified criteria: risk of bias (study limitations),
9 inconsistency, indirectness, imprecision and publication bias. These criteria are detailed below.
10 Evidence from observational studies (which had not previously been downgraded) was upgraded
11 if there was: a large magnitude of effect, a dose–response gradient, and if all plausible
12 confounding would reduce a demonstrated effect or suggest a spurious effect when results
13 showed no effect. Each quality element considered to have ‘serious’ or ‘very serious’ risk of bias
14 was rated down by 1 or 2 points respectively.
 - 15 3. The downgraded or upgraded marks were then summed and the overall quality rating was
16 revised. For example, all RCTs started as High and the overall quality became Moderate, Low or
17 Very low if 1, 2 or 3 points were deducted respectively.
 - 18 4. The reasons or criteria used for downgrading were specified in the footnotes.
- 19 The details of the criteria used for each of the main quality element are discussed further in the
20 following Sections 3.4.6 to 3.4.9.

3.4.6.1 Risk of bias

22 Bias can be defined as anything that causes a consistent deviation from the truth. Bias can be
23 perceived as a systematic error, for example, multiple replications of the same study would reach the
24 wrong answer on average.

- 1 The risk of bias for a given study and outcome is associated with the risk of over- or underestimation
- 2 of the true effect.
- 3 The risks of bias are listed in Table 5.
- 4 A study with a poor methodological design does not automatically imply high risk of bias; the bias is
- 5 considered individually for each outcome and it is assessed whether this poor design will impact on
- 6 the estimation of the intervention effect.

7 **Table 5: Risk of bias in randomised controlled trials**

Risk of bias	Explanation
Allocation concealment	Those enrolling patients are aware of the group to which the next enrolled patient will be allocated (this is a major problem in 'pseudo' or 'quasi' randomised trials with, for example, allocation by day of week, birth date, chart number)
Lack of blinding	Patient, caregivers, those recording outcomes, those adjudicating outcomes, or data analysts are aware of the arm to which patients are allocated
Incomplete accounting of patients and outcome events	Missing data not accounted for and failure of the trialists to adhere to the intention-to-treat principle when indicated
Selective outcome reporting	Reporting of some outcomes and not others on the basis of the results
Other risks of bias	For example: <ul style="list-style-type: none"> • Stopping early for benefit observed in randomised trials, in particular in the absence of adequate stopping rules • Use of unvalidated patient-reported outcomes • Recruitment bias in cluster-randomised trials

8

3.4.79 Inconsistency

10 Inconsistency refers to an unexplained heterogeneity of results. When estimates of the treatment
11 effect across studies differ widely (that is, there is heterogeneity or variability in results), this
12 suggests true differences in underlying treatment effect.

13 Heterogeneity in meta-analyses was examined and sensitivity and subgroup analyses performed as
14 pre-specified in the protocols (Appendix C).

15 When heterogeneity exists (chi-squared $p < 0.1$, I-squared inconsistency statistic of over 50%, or
16 evidence from examining forest plots), but no plausible explanation can be found (for example,
17 duration of intervention or different follow-up periods), the quality of evidence was downgraded by
18 1 or 2 levels, depending on the extent of uncertainty to the results contributed by the inconsistency
19 in the results. In addition to the I-squared and chi-squared values, the decision for downgrading was
20 also dependent on factors such as whether the intervention is associated with benefit in all other
21 outcomes or whether the uncertainty about the magnitude of benefit (or harm) of the outcome
22 showing heterogeneity would influence the overall judgment about net benefit or harm (across all
23 outcomes).

3.4.84 Indirectness

25 Directness refers to the extent to which the populations, intervention, comparisons and outcome
26 measures are similar to those defined in the inclusion criteria for the reviews. Indirectness is
27 important when these differences are expected to contribute to a difference in effect size, or may

- 1 affect the balance of harms and benefits considered for an intervention. In the bariatric surgery
- 2 review the population was overweight and obese people with recent onset of type 2 diabetes
- 3 (duration equal to or less than 10 years). Studies that had a mean duration less than ten years but
- 4 with wide standard deviation (including some patients with duration over 10 years) were included in
- 5 the review but downgraded for indirectness.

3.4.96 Imprecision

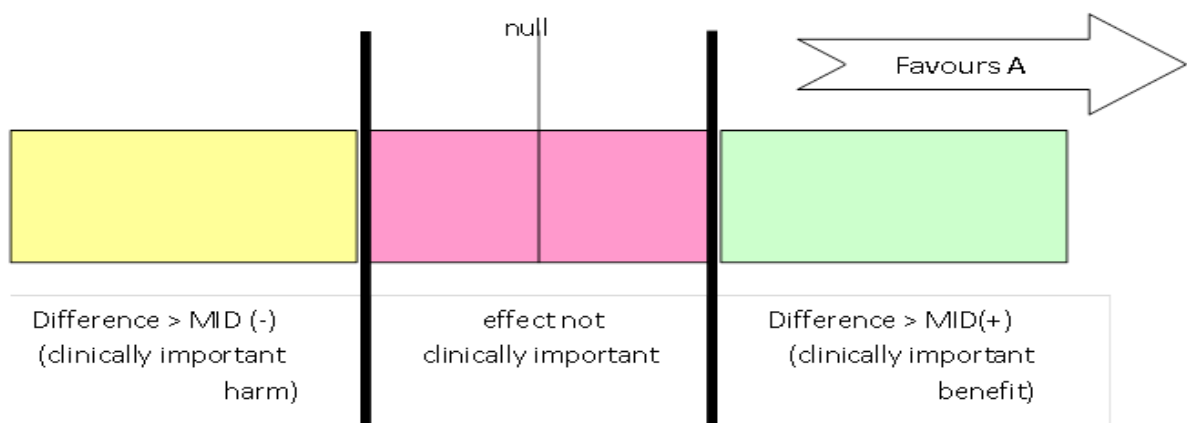
7 Imprecision in guidelines concerns whether the uncertainty (confidence interval) around the effect
8 estimate means that it is not clear whether there is a clinically important difference between
9 interventions or not. Therefore, imprecision differs from the other aspects of evidence quality in that
10 it is not really concerned with whether the point estimate is accurate or correct (has internal or
11 external validity); instead it is concerned with the uncertainty about what the point estimate is. This
12 uncertainty is reflected in the width of the confidence interval.

13 The 95% confidence interval (95% CI) is defined as the range of values that contain the population
14 value with 95% probability. The larger the trial, the smaller the 95% CI and the more certain the
15 effect estimate.

16 Imprecision in the evidence reviews was assessed by considering whether the width of the 95% CI of
17 the effect estimate is relevant to decision-making, considering each outcome in isolation. Figure 3
18 considers a positive outcome for the comparison of treatment A versus B. Three decision-making
19 zones can be identified, bounded by the thresholds for clinical importance (minimal important
20 difference – MID) for benefit and for harm. The MID for harm for a positive outcome means the
21 threshold at which drug A is less effective than drug B by an amount that is clinically important to
22 patients (favours B).

23

24 **Figure 2: Illustration of precise and imprecise outcomes based on the confidence interval of**
25 **outcomes in a forest plot**



26 When the confidence interval of the effect estimate is wholly contained in one of the 3 zones (for
27 example, clinically important benefit), we are not uncertain about the size and direction of effect
28 (whether there is a clinically important benefit, or the effect is not clinically important, or there is a
29 clinically important harm), so there is no imprecision.

30 When a wide confidence interval lies partly in each of 2 zones, it is uncertain in which zone the true
31 value of effect estimate lies, and therefore there is uncertainty over which decision to make (based
32 on this outcome alone). The confidence interval is consistent with 2 decisions and so this is
33 considered to be imprecise in the GRADE analysis and the evidence is downgraded by 1 level
34 ('serious imprecision').

1 If the confidence interval of the effect estimate crosses into 3 zones, this is considered to be very
2 imprecise evidence because the confidence interval is consistent with 3 clinical decisions and there is
3 a considerable lack of confidence in the results. The evidence is therefore downgraded by 2 levels in
4 the GRADE analysis ('very serious imprecision').

5 Implicitly, assessing whether the confidence interval is in, or partially in, a clinically important zone,
6 requires the GDG to estimate an MID or to say whether they would make different decisions for the
7 2 confidence limits.

8 The literature was searched for established MIDs for the selected outcomes in the evidence reviews
9 but none were found. The GDG were asked whether they were aware of any acceptable MIDs in the
10 clinical community but there were none known. Therefore, the GDG agreed that default values
11 stated in GRADEpro were appropriate for the outcomes. The default thresholds suggested by GRADE
12 are a relative risk reduction of 25% (relative risk of 0.75 for negative outcomes) or a relative risk
13 increase of 25% (risk ratio 1.25 for positive outcomes) for dichotomous outcomes. For continuous
14 outcomes, the default approach of multiplying 0.5 by the standard deviation (taken as the median of
15 the standard deviations across the meta-analysed studies) was employed.

3.4.106 Assessing clinical importance

17 The GDG assessed the evidence by outcome in order to determine if there was, or potentially was, a
18 clinically important benefit, a clinically important harm or no clinically important difference between
19 interventions. To facilitate this, binary outcomes were converted into absolute risk differences
20 (ARDs) using GRADEpro software: the median control group risk across studies was used to calculate
21 the ARD and its 95% CI from the pooled risk ratio.

22 The assessment of benefit, harm, or no benefit or harm was based on the point estimate of absolute
23 effect for intervention studies in relation to the comparison (or control) event rate.

24 This assessment was carried out by the GDG for each critical outcome, and an evidence summary
25 table was produced to compile the GDG's assessments of clinical importance per outcome, alongside
26 the evidence quality and the uncertainty in the effect estimate (imprecision).

3.4.117 Evidence statements

28 Evidence statements are summary statements that are presented after the GRADE profiles,
29 summarising the key features of the clinical effectiveness evidence presented. The wording of the
30 evidence statements reflects the certainty or uncertainty in the estimate of effect. The evidence
31 statements are presented by outcome and encompass the following key features of the evidence:

- 32 • the number of studies and the number of participants for a particular outcome
- 33 • a brief description of the participants
- 34 • an indication of the direction of effect (if one treatment is beneficial or harmful compared to the
35 other, or whether there is no difference between the 2 tested treatments)
- 36 • a description of the overall quality of evidence (GRADE overall quality).

3.5 Evidence of cost effectiveness

38 The GDG is required to make decisions based on the best available evidence of both clinical and cost
39 effectiveness. Guideline recommendations should be based on the expected costs of the different
40 options in relation to their expected health benefits (that is, their 'cost effectiveness') rather than the
41 total implementation cost.⁴⁰ Thus, if the evidence suggests that a strategy provides significant health
42 benefits at an acceptable cost per patient treated, it should be recommended even if it would be
43 expensive to implement across the whole population.

- 1 Evidence on cost effectiveness related to the key clinical issues being addressed in the guideline was
- 2 sought. The health economist:
- 3 • Undertook a systematic review of the published economic literature.
- 4 • Undertook original health economic analyses where appropriate.

3.5.15 Literature review

- 6 The health economist:
- 7 • Identified potentially relevant studies for each review question from the economic search results
- 8 by reviewing titles and abstracts. Full papers were then obtained.
- 9 • Reviewed full papers against pre-specified inclusion and exclusion criteria to identify relevant
- 10 studies (see below for details).
- 11 • Critically appraised relevant studies using the economic evaluations checklist as specified in The
- 12 guidelines manual.⁴⁰
- 13 • Extracted key information about the studies' methods and results into evidence tables (included
- 14 in Appendix H).
- 15 • Generated summaries of the evidence in NICE economic evidence profiles (included in the
- 16 relevant chapter for each review question) – see below for details.

3.5.1.17 Inclusion and exclusion criteria

- 18 Full economic evaluations (studies comparing costs and health consequences of alternative courses
- 19 of action: cost–utility, cost-effectiveness, cost–benefit and cost–consequence analyses) and
- 20 comparative costing studies that addressed the review question in the relevant population were
- 21 considered potentially includable as economic evidence.
- 22 Studies that only reported cost per hospital (not per patient), or only reported average cost
- 23 effectiveness without disaggregated costs and effects, were excluded. Literature reviews, abstracts,
- 24 posters, letters, editorials, comment articles, unpublished studies and studies not in English were
- 25 excluded.
- 26 Remaining studies were prioritised for inclusion based on their relative applicability to the
- 27 development of this guideline and the study limitations. For example, if a high quality, directly
- 28 applicable UK analysis was available, then other less relevant studies may not have been included.
- 29 Where exclusions occurred on this basis, this is noted in the relevant section.
- 30 For more details about the assessment of applicability and methodological quality see the economic
- 31 evaluation checklist (Appendix F of The guidelines manual.⁴⁰ and the health economics review
- 32 protocol in Appendix C).
- 33 When no relevant economic studies were found from the economic literature review, relevant UK
- 34 NHS unit costs related to the compared interventions were presented to the GDG to inform the
- 35 possible economic implications of the recommendations.

3.5.1.26 NICE economic evidence profiles

- 37 The NICE economic evidence profile has been used to summarise cost and cost-effectiveness
- 38 estimates. The economic evidence profile shows an assessment of applicability and methodological
- 39 quality for each economic evaluation, with footnotes indicating the reasons for the assessment.
- 40 These assessments were made by the health economist using the economic evaluation checklist from
- 41 The guidelines manual.⁴⁰ It also shows the incremental costs, incremental effects (for example,
- 42 quality-adjusted life years [QALYs]) and incremental cost-effectiveness ratio for the base case

- 1 analysis in the evaluation, as well as information about the assessment of uncertainty in the analysis.
- 2 See [Table 6](#) for more details.
- 3 If a non-UK study was included in the profile, the results were converted into pounds sterling using
- 4 the appropriate purchasing power parity.⁴³

5 **Table 6: Content of NICE economic evidence profile**

Item	Description
Study	First author name, reference, date of study publication and country perspective.
Applicability	An assessment of applicability of the study to the clinical guideline, the current NHS situation and NICE decision-making ^(a) : <ul style="list-style-type: none"> • Directly applicable – the study meets all applicability criteria, or fails to meet one or more applicability criteria but this is unlikely to change the conclusions about cost effectiveness. • Partially applicable – the study fails to meet one or more applicability criteria, and this could change the conclusions about cost effectiveness. • Not applicable – the study fails to meet one or more of the applicability criteria, and this is likely to change the conclusions about cost effectiveness. Such studies would usually be excluded from the review.
Limitations	An assessment of methodological quality of the study ^(a) : <ul style="list-style-type: none"> • Minor limitations – the study meets all quality criteria, or fails to meet one or more quality criteria, but this is unlikely to change the conclusions about cost effectiveness. • Potentially serious limitations – the study fails to meet one or more quality criteria, and this could change the conclusions about cost effectiveness. • Very serious limitations – the study fails to meet one or more quality criteria, and this is highly likely to change the conclusions about cost effectiveness. Such studies would usually be excluded from the review.
Other comments	Particular issues that should be considered when interpreting the study.
Incremental cost	The mean cost associated with one strategy minus the mean cost of a comparator strategy.
Incremental effects	The mean QALYs (or other selected measure of health outcome) associated with one strategy minus the mean QALYs of a comparator strategy.
Cost effectiveness	Incremental cost-effectiveness ratio (ICER): the incremental cost divided by the incremental effects.
Uncertainty	A summary of the extent of uncertainty about the ICER reflecting the results of deterministic or probabilistic sensitivity analyses, or stochastic analyses of trial data, as appropriate.

6 (a) *Applicability and limitations were assessed using the economic evaluation checklist in Appendix G of The guidelines*
7 *manual (2012)*⁴⁰

3.5.2.8 Undertaking new health economic analysis

- 9 As well as reviewing the published economic literature for each review question, as described above,
- 10 new economic analysis was considered by the health economist in selected areas. Priority areas for
- 11 new health economic analysis were discussed with the GDG after formation of the review questions
- 12 and consideration of the available health economic evidence. It was agreed by the GDG that for the
- 13 review question concerning bariatric surgery for early onset type-2 diabetes the cost-effectiveness
- 14 evidence that existed was sufficient to base recommendations on. For very low calorie diets and
- 15 follow up care after surgery the GDG agreed that the long-run data needed to populate a model does
- 16 not exist. Therefore as the results on any model would be largely driven by assumptions rather than
- 17 clinical evidence no original economic analysis was conducted. To fully consider cost-effectiveness

- 1 quality of life studies were incorporated into threshold analysis to see how effective interventions
- 2 would need to be to be considered cost effective.

3.5.3.3 Cost-effectiveness criteria

4 NICE's report 'Social value judgements: principles for the development of NICE guidance' sets out the
5 principles that GDGs should consider when judging whether an intervention offers good value for
6 money.³⁹ In general, an intervention was considered to be cost effective if either of the following
7 criteria applied (given that the estimate was considered plausible):

- 8 • the intervention dominated other relevant strategies (that is, it was both less costly in terms of
9 resource use and more clinically effective compared with all the other relevant alternative
10 strategies), or
- 11 • the intervention cost less than £20,000 per QALY gained compared with the next best strategy.

12 If the GDG recommended an intervention that was estimated to cost more than £20,000 per QALY
13 gained, or did not recommend one that was estimated to cost less than £20,000 per QALY gained,
14 the reasons for this decision are discussed explicitly in the 'Recommendations and link to evidence'
15 section of the relevant chapter, with reference to issues regarding the plausibility of the estimate or
16 to the factors set out in 'Social value judgements: principles for the development of NICE guidance'.³⁹

17 If a study reported the cost per life year gained but not QALYs, the cost per QALY gained was
18 estimated by multiplying by an appropriate utility estimate to aid interpretation. The estimated cost
19 per QALY gained is reported in the economic evidence profile with a footnote detailing the life-years
20 gained and the utility value used. When QALYs or life years gained are not used in the analysis,
21 results are difficult to interpret unless one strategy dominates the others with respect to every
22 relevant health outcome and cost.

3.5.4.3 In the absence of economic evidence

24 When no relevant published studies were found, and a new analysis was not prioritised, the GDG
25 made a qualitative judgement about cost effectiveness by considering expected differences in
26 resource use between options and relevant UK NHS unit costs, alongside the results of the clinical
27 review of effectiveness evidence.

3.6 Developing recommendations

29 Over the course of the guideline development process, the GDG was presented with:

- 30 • Evidence tables of the clinical and economic evidence reviewed from the literature. All evidence
31 tables are in Appendices G and H. Excluded evidence can be found in Appendices J and K.
- 32 • Summary of clinical and economic evidence and quality (as presented in Chapters 6-8).
- 33 • Forest plots (Appendix I).

34 Recommendations were drafted on the basis of the GDG interpretation of the available evidence,
35 taking into account the balance of benefits, harms and costs between different courses of action.
36 Firstly, the net benefit over harm (clinical effectiveness) was considered, focusing on the critical
37 outcomes. When this was done informally, the GDG took into account the clinical benefits and harms
38 when one intervention was compared with another. The assessment of net benefit was moderated
39 by the importance placed on the outcomes (the GDG's values and preferences), and the confidence
40 the GDG had in the evidence (evidence quality). Secondly, it was assessed whether the net benefit
41 justified any differences in costs.

42 When clinical and economic evidence was of poor quality, conflicting, or absent, the GDG drafted
43 recommendations based on their expert opinion. The considerations for making consensus-based

1 recommendations include the balance between potential harms and benefits, the economic costs
2 compared to the economic benefits, current practices, and recommendations made in other relevant
3 guidelines, patient preferences and equality issues. The GDG also considered whether the
4 uncertainty was sufficient to justify delaying making a recommendation to await further research,
5 taking into account the potential harm of failing to make a clear recommendation (see Section 3.6.1
6 below).

7 The wording of recommendations was agreed by the GDG and focused on the following factors:

- 8 • The actions health professionals need to take.
- 9 • The information readers need to know.
- 10 • The strength of the recommendation (for example the word 'offer' was used for strong
11 recommendations and 'consider' for weak recommendations).
- 12 • The involvement of patients (and their carers if needed) in decisions on treatment and care.
- 13 • Consistency with NICE's standard advice on recommendations about drugs, waiting times and
14 ineffective interventions.

15 The main considerations specific to each recommendation are outlined in the 'Recommendations
16 and link to evidence' sections within each chapter.

3.6.17 Research recommendations

18 When areas were identified for which good evidence was lacking, the GDG considered making
19 recommendations for future research. Decisions about inclusion were based on factors such as:

- 20 • the importance to patients or the population
- 21 • national priorities
- 22 • potential impact on the NHS and future NICE guidance
- 23 • ethical and technical feasibility.

24

3.6.25 Validation process

26 This guidance is subject to a 4-week public consultation and feedback as part of the quality assurance
27 and peer review of the document. All comments received from registered stakeholders are
28 responded to in turn and posted on the NICE website after publication of the guideline.

3.6.39 Updating the guideline

30 A formal review of the need to update a guideline is usually undertaken by NICE after its publication.
31 NICE will conduct a review to determine whether the evidence base has progressed significantly to
32 alter the guideline recommendations and warrant an update.

3.6.43 Disclaimer

34 Health care providers need to use clinical judgement, knowledge and expertise when deciding
35 whether it is appropriate to apply guidelines. The recommendations cited here are a guide and may
36 not be appropriate for use in all situations. The decision to adopt any of the recommendations cited
37 here must be made by practitioners in light of individual patient circumstances, the wishes of the
38 patient, clinical expertise and resources.

39 The National Clinical Guideline Centre disclaims any responsibility for damages arising out of the use
40 or non-use of this guideline and the literature used in support of this guideline.

3.6.5.1 Funding

- 2 The National Clinical Guideline Centre was commissioned by the National Institute for Health and
- 3 Care Excellence to undertake the work on this guideline.

4

4₁ Guideline summary

4₂₁ Algorithm

Figure 3: Very- low- calorie diets (VLCD)

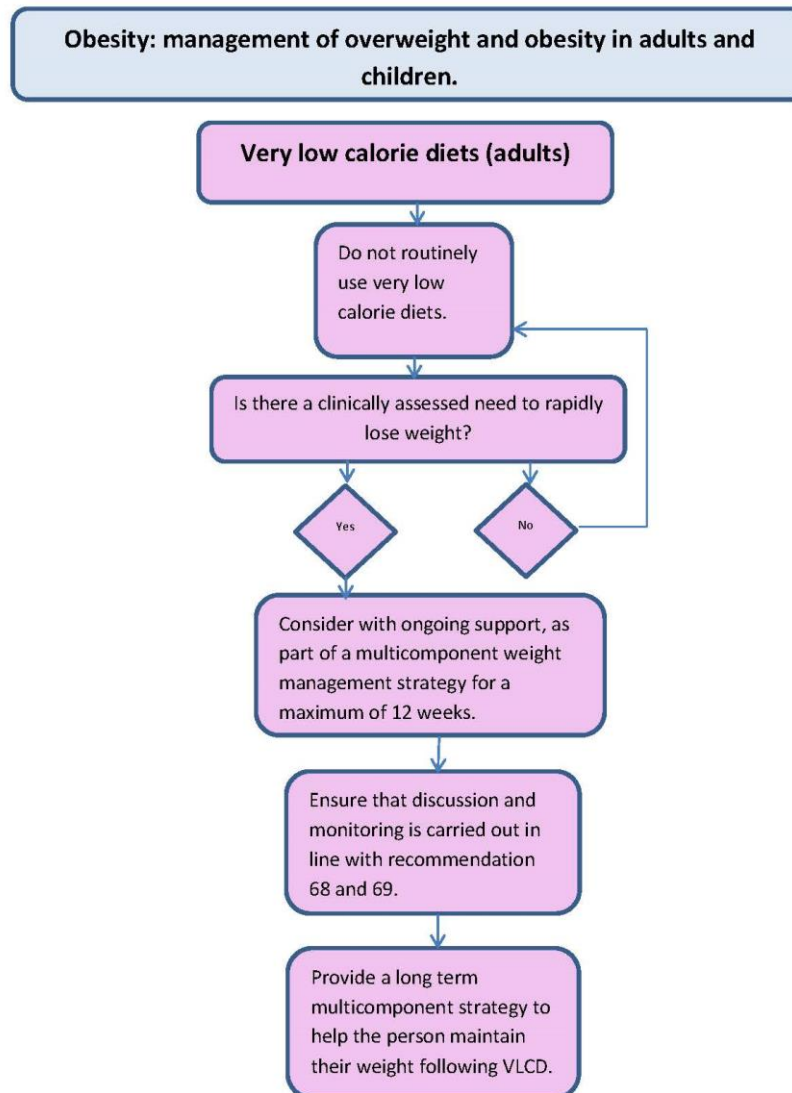
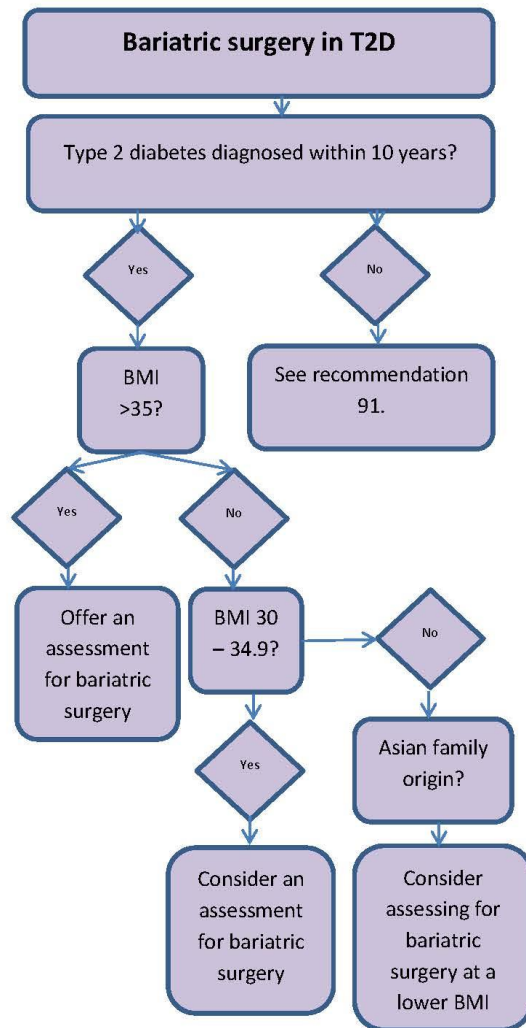
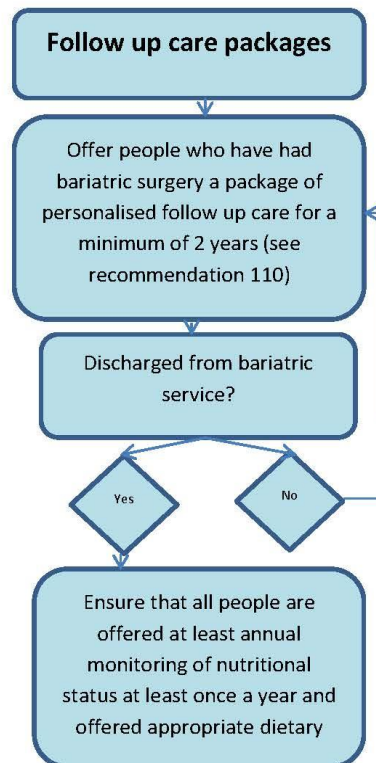


Figure 4: Bariatric surgery in people with type 2 diabetes



1

Figure 5: Follow-up care packages after bariatric surgery



1

Figure 6: 2006 recommendations

See full guideline for recommendations relating to:

- General principles of care
- Identification and classification of overweight and obesity
- Assessment
- Lifestyle interventions
- Pharmacological interventions
- Surgical interventions.

5.1 Full list of recommendations

5.1.2 Generic principles of care

5.1.2.1 Adults and children

- 4 1. Offer regular, non-discriminatory long-term follow-up by a trained professional. Ensure
5 continuity of care in the multidisciplinary team through good record keeping. [2006]

5.1.2.2 Adults

- 7 2. Equip specialist settings for treating people who are severely obese with, for example,
8 special seating and adequate weighing and monitoring equipment. Ensure hospitals have
9 access to specialist equipment – such as larger scanners and beds –when providing general
10 care for people who are severely obese. [2006]
11
12 3. Discuss the choice of interventions for weight management with the person. The choice of
13 intervention should be agreed with the person. [2006]
14
15 4. Tailor the components of the planned weight management programme to the person's
16 preferences, initial fitness, health status and lifestyle. [2006]

5.1.2.3 Children

- 18 5. Coordinate the care of children and young people around their individual and family needs.
19 Comply with national core standards as defined in A Call to Action on Obesity in
20 England^a. [2006, amended 2014]
21
22 6. Aim to create a supportive environment^b that helps a child who is overweight or who has
23 obesity, and their family, make lifestyle changes. [2006, amended 2014]
24
25 7. Make decisions about the care of a child who is overweight or has obesity (including
26 assessment and agreeing goals and actions) together with the child and family. Tailor
27 interventions to the needs and preferences of the child and the family. [2006]
28
29 8. Ensure that interventions for children who are overweight or have obesity address lifestyle
30 within the family and in social settings. [2006]
31
32 9. Encourage parents (or carers) to take main responsibility for lifestyle changes in children who
33 are overweight or obese, especially if they are younger than 12 years. Take into account the
34 age and maturity of the child, and the preferences of the child and the parents. [2006]

5.2.5 Identification and classification of overweight and obesity

- 36 10. Use clinical judgement to decide when to measure a person's height and weight.
37 Opportunities include registration with a general practice, consultation for related conditions
38 (such as type 2 diabetes and cardiovascular disease) and other routine health checks. [2006]

^a Recommendations on the management of overweight and obesity in children and young people can be found in 'Managing overweight and obesity among children and young people: lifestyle weight management services' (NICE Public health guideline 47).

^b The GDG noted that 'environment' could include settings other than the home, for example, schools.

5.3.1 Measures of overweight and obesity

- 2 11. Use body mass index (BMI) as a practical estimate of adiposity in adults. Interpret BMI with
3 caution because it is not a direct measure of adiposity. [2006, amended 2014]
4
5 12. Think about using waist circumference, in addition to BMI, in people with a BMI less than 35
6 kg/m^{2c}. [2006, amended 2014]

5.3.1.1 Children

- 8 13. Use BMI (adjusted for age and gender)^d as a practical estimate of adiposity in children and
9 young people. Interpret BMI with caution because it is not a direct measure of adiposity.
10 [2006, amended 2014]
11
12 14. Waist circumference is not recommended as a routine measure. Use it to give additional
13 information on the risk of developing other long-term health problems. [2006]

5.3.1.2 Adults and children

- 15 15. Do not use bioimpedance as a substitute for BMI as a measure of general adiposity. [2006]

5.4.6 Classification of overweight and obesity

5.4.6.1 Adults

- 18 16. Define the degree of overweight or obesity in adults using the following table:

Classification	BMI (kg/m ²)
Healthy weight	18.5–24.9
Overweight	25–29.9
Obesity I	30–34.9
Obesity II	35–39.9
Obesity III	40 or more

- 19 17. Interpret BMI with caution in highly muscular adults as it may be a less accurate measure of
20 adiposity in this group. Some other population groups, such as Asians and older people, have
21 comorbidity risk factors that are of concern at different BMIs (lower for Asian adults and
22 higher for older people). Use clinical judgement when considering risk factors in these
23 groups, even in people not classified as overweight or obese, using the classification in
24 recommendation 35. [2006]
25

- 26 18. Base assessment of the health risks associated with being overweight or obese in adults on
27 BMI and waist circumference as follows:
28

BMI classification	Waist circumference		
	Low	High	Very high
Overweight	No increased risk	Increased risk	High risk
Obesity I	Increased risk	High risk	Very high

^c Further information on the use of BMI and waist circumference can be found in 'BMI and waist circumference – black, Asian and minority ethnic groups' (NICE Public health guideline 46).

^d Where available, BMI z-scores may be used to calculate BMI in children and young people

BMI classification	Waist circumference		
			risk
For men, waist circumference of less than 94 cm is low, 94–102 cm is high and more than 102 cm is very high For women, waist circumference of less than 80 cm is low, 80–88 cm is high and more than 88 cm is very high			

1 19. Give adults information about their classification of clinical obesity and the impact this has
2 on risk factors for developing other long-term health problems. [2006]

3

4 20. Base the level of intervention to discuss with the patient initially as follows:

5

BMI classification	Waist circumference			Comorbidities present
	Low	High	Very high	
Overweight	1	2	2	3
Obesity I	2	2	2	3
Obesity II	3	3	3	4
Obesity III	4	4	4	4

6

1	General advice on healthy weight and lifestyle
2	Diet and physical activity
3	Diet and physical activity; consider drugs
4	Diet and physical activity; consider drugs; consider surgery

7 The level of intervention should be higher for patients with comorbidities (see section 5.5 for
8 details), regardless of their waist circumference. Adjust the approach as needed, depending on
9 the person's clinical need and potential to benefit from losing weight. [2006]

5.4.2 Children

11 21. Relate BMI measurement in children and young people to the UK 1990 BMI charts^e to give
12 age- and gender-specific information^f. [2006, amended 2014]

13

14 22. Tailored clinical intervention should be considered for children with a BMI at or above the
15 91st centile, depending on the needs of the individual child and family. [2006]

16

17 23. Assessment of comorbidity should be considered for children with a BMI at or above the
18 98th centile. [2006]

5.5.9 Assessment

5.5.9.1 Adults

21 24. Make an initial assessment (see recommendations 29 and 31), then use clinical judgement to
22 investigate comorbidities and other factors to an appropriate level of detail, depending on

^e The Guideline Development Group considered that there was a lack of evidence to support specific cut-offs in children. However, the recommended pragmatic indicators for action are the 91st and 98th centiles (overweight and obese, respectively). Since the 2006 clinical guideline was published, more recent growth charts have become available (see Making a referral to a programme from healthcare services | 1).

^f Where available, BMI z scores may be used to calculate BMI in children and young people.

- 1 the person, the timing of the assessment, the degree of overweight or obesity, and the
2 results of previous assessments. [2006]
3
- 4 25. Manage comorbidities when they are identified; do not wait until the person has lost weight.
5 [2006]
6
- 7 26. Offer people who are not yet ready to change the chance to return for further consultations
8 when they are ready to discuss their weight again and willing or able to make lifestyle
9 changes. Give them information on the benefits of losing weight, healthy eating and
10 increased physical activity.[2006]
11
- 12 27. Recognise that surprise, anger, denial or disbelief about their health situation may diminish
13 people's ability or willingness to change. Stress that obesity is a clinical term with specific
14 health implications, rather than a question of how people look; this may reduce any negative
15 feelings.
16
- 17 During the consultation:
- 18 o Assess the person's view of their weight and the diagnosis, and possible reasons for weight
19 gain
20 o Explore eating patterns and physical activity levels
21 o Explore any beliefs about eating, physical activity and weight gain that are unhelpful if the
22 person wants to lose weight
23 o Be aware that people from certain ethnic and socioeconomic backgrounds may be at greater
24 risk of obesity, and may have different beliefs about what is a healthy weight and different
25 attitudes towards weight management
26 o Find out what the person has already tried and how successful this has been, and what they
27 learned from the experience
28 o Assess the person's readiness to adopt changes
29 o Assess the person's confidence in making changes. [2006]
30
- 31 28. Give people and their families and/or carers information on the reasons for tests, how the
32 tests are done and their results and meaning. If necessary, offer another consultation to fully
33 explore the options for treatment or discuss test results. [2006, amended 2014]

5.1.2 Adults

- 35 29. Take measurements (see recommendations in section 5.2) to determine degree of
36 overweight or obesity and discuss the implications of the person's weight. Then, assess:
37 o any presenting symptoms
38 o any underlying causes of being overweight or obese
39 o eating behaviours
40 o any comorbidities (for example type 2 diabetes, hypertension, cardiovascular disease,
41 osteoarthritis, dyslipidaemia and sleep apnoea)
42 o any risk factors (assess using lipid profile preferably done when fasting, blood pressure
43 measurement and HbA_{1c} measurement)
44 o the person's lifestyle (diet and physical activity)
45 o any psychosocial distress
46 o any environmental, social and family factors, including family history of overweight and
47 obesity and comorbidities

- 1 o the person's willingness and motivation to change lifestyle
- 2 o the potential of weight loss to improve health
- 3 o any psychological problems
- 4 o any medical problems and medication
- 5 o the role of family and paid carers in supporting individuals with learning disabilities to make
- 6 lifestyle changes. [2006, amended 2014]
- 7
- 8 30. Consider referral to tier 3 services if:
- 9 o the underlying causes of being overweight or obese need to be assessed
- 10 o the person has complex disease states and/or needs that cannot be managed adequately in
- 11 tier 2 (for example, the additional support needs of people with learning disabilities)
- 12 o conventional treatment has been unsuccessful
- 13 o drug treatment is being considered for a person with a BMI more than 50 kg/m²
- 14 o specialist interventions (such as a very low-calorie diet) may be needed
- 15 o surgery is being considered. [2006, amended 2014]
- 16

5.5.3 Children

- 18 31. Take measurements to determine degree of overweight or obesity and raise the issue of
- 19 weight with the child and family, then assess:
- 20 o presenting symptoms and underlying causes of being overweight or obese
- 21 o willingness and motivation to change
- 22 o comorbidities (such as hypertension, hyperinsulinaemia, dyslipidaemia, type 2 diabetes,
- 23 psychosocial dysfunction and exacerbation of conditions such as asthma)
- 24 o any risk factors (assess using lipid profile preferably done when fasting, blood pressure
- 25 measurement and HbA_{1c} measurement)
- 26 o psychosocial distress, such as low self-esteem, teasing and bullying
- 27 o family history of being overweight or obese and comorbidities
- 28 o the child and family's willingness and motivation to change lifestyle
- 29 o lifestyle (diet and physical activity)
- 30 o environmental, social and family factors that may contribute to being overweight or obese,
- 31 and the success of treatment
- 32 o growth and pubertal status.
- 33 o any medical problems and medication
- 34 o the role of family and paid carers in supporting individuals with learning disabilities to make
- 35 lifestyle changes[2006, amended 2014]
- 36
- 37 32. Consider referral to an appropriate specialist for children who are overweight or obese and
- 38 have significant comorbidities or complex needs (for example, learning disabilities or other
- 39 additional support needs. [2006, amended 2014]
- 40
- 41 33. In tier 3 services, assess associated comorbidities and possible causes for children and young
- 42 people who are overweight or who have obesity. Use investigations such as:
- 43 o blood pressure measurement
- 44 o lipid profile, preferably while fasting

- 1 o fasting insulin,
- 2 o fasting glucose levels and oral glucose tolerance test
- 3 o liver function
- 4 o endocrine function.
- 5
- 6 Interpret the results of any tests used in the context of how overweight or obese the child is, the
- 7 child's age, history of comorbidities, possible genetic causes and any family history of metabolic
- 8 disease related to being overweight or obese. [2006, amended 2014]
- 9
- 10 34. Make arrangements for transitional care for children and young people who are moving from
- 11 paediatric to adult services.[2006]
- 12

5.6.3 Lifestyle interventions

14 General

5.6.1 Adults and children

- 16 35. Multicomponent interventions are the treatment of choice. Ensure weight management
- 17 programmes include behaviour change strategies (see recommendations 48-50) to increase
- 18 people's physical activity levels or decrease inactivity, improve eating behaviour and the
- 19 quality of the person's diet, and reduce energy intake.[2006]
- 20
- 21 36. When choosing treatments, take into account:
- 22 o the person's individual preference and social circumstance and the experience and outcome of
- 23 previous treatments (including whether there were any barriers)
- 24 o the person's level of risk, based on BMI and, where appropriate, waist circumference (see
- 25 recommendations 18-20)
- 26 o any comorbidities.[2006]
- 27
- 28 37. Document the results of any discussion. Keep a copy of the agreed goals and actions (ensure
- 29 the person also does this), or put this in the person's notes.[2006, amended 2014]
- 30
- 31 38. Offer support depending on the person's needs, and be responsive to changes over
- 32 time.[2006]
- 33
- 34 39. Ensure any healthcare professionals who deliver interventions for weight management have
- 35 relevant competencies and have had specific training.[2006]
- 36
- 37 40. Provide information in formats and languages that are suited to the person. Use everyday,
- 38 jargon-free language and explain any technical terms when talking to the person and their
- 39 family or carers. Take into account the person's:
- 40 o age and stage of life
- 41 o gender
- 42 o cultural needs and sensitivities
- 43 o ethnicity
- 44 o social and economic circumstances

- 1 o specific communication needs (for example because of learning disabilities, physical disabilities
2 or cognitive impairments due to neurological conditions).[2006, amended 2014]
- 3 41. Praise successes – however small – at every opportunity to encourage the person through
4 the difficult process of changing established behaviour.[2006]
5
- 6 42. Give people who are overweight or obese, and their families and/or carers, relevant
7 information on:
- 8 o being overweight and obesity in general, including related health risks
9 o realistic targets for weight loss; for adults the targets are usually:
10 - maximum weekly weight loss of 0.5-1 kg^g
11 - aiming to lose 5-10% of original weight
12 o the distinction between losing weight and maintaining weight loss, and the importance of
13 developing skills for both; advise them that the change from losing weight to maintenance
14 typically happens after 6-9 months of treatment
15 o realistic targets for outcomes other than weight loss, such as increased physical activity and
16 healthier eating
17 o diagnosis and treatment options
18 o healthy eating in general^h
19 o medication and side effects
20 o surgical treatments
21 o self-care
22 o voluntary organisations and support groups and how to contact them.
- 23 Ensure there is adequate time in the consultation to provide information and answer
24 questions. [2006, amended 2014]
25
- 26 43. If a person (or their family or carers) does not feel this is the right time for them to take
27 action, explain that advice and support will be available in the future whenever they need it.
28 Provide contact details so that the person can get in touch when they are ready.[2006]
29

5.3.2 Adults

- 31 44. Encourage the person's partner or spouse to support any weight management
32 programme.[2006]
33
- 34 45. Base the level of intensity of the intervention on the level of risk and the potential to gain
35 health benefits (see recommendation 20).[2006]

5.3.3 Children

- 37 46. Be aware that the aim of weight management programmes for children and young people
38 can vary. The focus may be on either weight maintenance or weight loss, depending on the
39 person's age and stage of growth.[2006]
40

^g Based on the British Dietetic Association 'Weight Wise' Campaign (www.bdaweightwise.com). Greater rates of weight loss may be appropriate in some cases, but this should be undertaken only under expert supervision

^h Further information on healthy eating can be found on NHS Choices <http://www.nhs.uk>.

- 1 47. Encourage parents of children and young people who are overweight or obese to lose weight
2 if they are also overweight or obese. [2006]
3

5.7.4 Behavioural interventions

5.7.1 Adults and children

- 6 48. Deliver any behavioural intervention with the support of an appropriately trained
7 professional. [2006]

5.7.2 Adults

- 9 49. Include the following strategies in behavioural interventions for adults, as appropriate:
10 o self-monitoring of behaviour and progress
11 o stimulus control
12 o goal setting
13 o slowing rate of eating
14 o ensuring social support
15 o problem solving
16 o assertiveness
17 o cognitive restructuring (modifying thoughts)
18 o reinforcement of changes
19 o relapse prevention
20 o strategies for dealing with weight regain. [2006]
21

5.7.3 Children

- 23 50. Include the following strategies in behavioural interventions for children, as appropriate:
24 o stimulus control
25 o self-monitoring
26 o goal setting
27 o rewards for reaching goals
28 o problem solving.
29 Give praise to successes and encourage parents to role-model desired behaviours. [2006]

5.8.0 Physical activity

5.8.1 Adults

- 32 51. Encourage adults to increase their level of physical activity even if they do not lose weight as
33 a result, because of the other health benefits it can bring (for example, reduced risk of type 2
34 diabetes and cardiovascular disease). Encourage adults to do at least 30 minutes of
35 moderate or greater intensity physical activity on 5 or more days a week. The activity can be
36 in 1 session or several sessions lasting 10 minutes or more.[2006]
37

- 1 52. Advise that to prevent obesity, most people may need to do 45–60 minutes of moderate-
 2 intensity activity a day, particularly if they do not reduce their energy intake. Advise people
 3 who have been obese and have lost weight that they may need to do 60–90 minutes of
 4 activity a day to avoid regaining weight. [2006]
 5
- 6 53. Encourage adults to build up to the recommended activity levels for weight maintenance,
 7 using a managed approach with agreed goals.
 8
- 9 Recommend types of physical activity, including:
- 10 o activities that can be incorporated into everyday life, such as brisk walking, gardening or
 - 11 cycling
 - 12 o supervised exercise programmes
 - 13 o other activities, such as swimming, aiming to walk a certain number of steps each day, or stair
 - 14 climbing.
- 15
- 16 Take into account the person's current physical fitness and ability for all activities. Encourage
 17 people to also reduce the amount of time they spend inactive, such as watching television, using a
 18 computer or playing video games. [2006]

5.8.2 Children

- 20 54. Encourage children and young people to increase their level of physical activity, even if they
 21 do not lose weight as a result, because of the other health benefits exercise can bring (for
 22 example, reduced risk of type 2 diabetes and cardiovascular disease). Encourage children to
 23 do at least 60 minutes of moderate or greater intensity physical activity each day. The
 24 activity can be in 1 session or several sessions lasting 10 minutes or more. [2006]
 25
- 26 55. Be aware that children who are already overweight may need to do more than 60 minutes'
 27 activity. [2006]
 28
- 29 56. Encourage children to reduce inactive behaviours, such as sitting and watching television,
 30 using a computer or playing video games. [2006]
 31
- 32 57. Give children the opportunity and support to do more exercise in their daily lives (for
 33 example, walking, cycling, using the stairs and active play). Make the choice of activity with
 34 the child, and ensure it is appropriate to the child's ability and confidence. [2006]
 35
- 36 58. Give children the opportunity and support to do more regular, structured physical activity,
 37 (for example football, swimming or dancing). Make the choice of activity with the child, and
 38 ensure it is appropriate to the child's ability and confidence. [2006]
 39

5.9.0 Dietary

5.9.1 Adults and children

- 42 59. Tailor dietary changes to food preferences and allow for a flexible and individual approach to
 43 reducing calorie intake. [2006]
 44
- 45 60. Do not use unduly restrictive and nutritionally unbalanced diets, because they are ineffective
 46 in the long term and can be harmful. [2006]

- 1
2 61. Encourage people to improve their diet even if they do not lose weight, because there can be
3 other health benefits. [2006]
4

5.9.2 Adults

- 6 62. The main requirement of a dietary approach to weight loss is that total energy intake should
7 be less than energy expenditure. [2006]
8
9 63. Diets that have a 600 kcal/day deficit (that is, they contain 600 kcal less than the person
10 needs to stay the same weight) or that reduce calories by lowering the fat content (low-fat
11 diets), in combination with expert support and intensive follow-up, are recommended for
12 sustainable weight loss. [2006]
13
14 64. Consider low-calorie diets (800–1600 kcal/day), but be aware these are less likely to be
15 nutritionally complete.[2006, amended 2014]
16
17 65. Do not routinely use very-low- calorie diets (800 kcal/day or less) to manage obesity (defined
18 as BMI over 30).[new 2014]
19
20 66. Only consider very-low-calorie diets, with ongoing support, as part of a multicomponent
21 weight management strategy for a maximum of 12 weeks (continuously or intermittently) in
22 people who are obese who have a clinically-assessed need to rapidly lose weight (for
23 example, people who require joint replacement surgery or who are seeking fertility
24 services).[new 2014]
25
26 67. Before starting someone on a very-low-calorie diet as part of a multi-component weight
27 management strategy:
28 o Consider counselling and assess for eating disorders or other psychopathology to make sure
29 the diet is appropriate for them
30 o Discuss the risks and benefits with them.
31 o Tell them that this is not a long-term weight management strategy, and that regaining weight
32 is likely and not because of their own or their clinician's failure
33 o Discuss the reintroduction of food with them.[new 2014]
34
35 68. Provide a long-term multicomponent strategy to help the person maintain their weight after
36 the use of a very-low-calorie diet. (See recommendation 38).[new 2014]
37
38 69. Encourage people to eat a balanced diet in the long term, consistent with other healthy
39 eating advice.[2006, amended 2014]

5.9.3 Children

- 41 70. A dietary approach alone is not recommended. It is essential that any dietary
42 recommendations are part of a multicomponent intervention.[2006]
43
44 71. Any dietary changes should be age appropriate and consistent with healthy eating
45 advice.[2006]
46

- 1 72. For overweight and obese children and adolescents, total energy intake should be below
2 their energy expenditure. Changes should be sustainable.[2006]

5.10~~3~~ Pharmacological interventions

4 General

5.10~~1~~ Adults

- 6 73. Consider pharmacological treatment only after dietary, exercise and behavioural approaches
7 have been started and evaluated.[2006]
8
9 74. Consider drug treatment for people who have not reached their target weight loss or have
10 reached a plateau on dietary, activity and behavioural changes.[2006]
11
12 75. Make the decision to start drug treatments after discussing the potential benefits and
13 limitations with the person, including the mode of action, adverse effects and monitoring
14 requirements, and the potential impact on the person's motivation. Make arrangements for
15 appropriate healthcare professionals to offer information, support and counselling on
16 additional diet, physical activity and behavioural strategies when drug treatment is
17 prescribed. Provide information on patient support programmes.[2006]
18
19

5.10~~2~~ Children

- 21 76. Drug treatment is not generally recommended for children younger than 12 years. [2006]
22
23 77. In children younger than 12 years, drug treatment may be used only in exceptional
24 circumstances, if severe comorbidities are present. Prescribing should be started and
25 monitored only in specialist paediatric settings.[2006, amended 2014]
26
27 78. In children aged 12 years and older, treatment with orlistatⁱ is recommended only if physical
28 comorbidities (such as orthopaedic problems or sleep apnoea) or severe psychological
29 comorbidities are present. Treatment should be started in a specialist paediatric setting, by
30 multidisciplinary teams with experience of prescribing in this age group. [2006, amended
31 2014]
32
33 79. Do not give orlistat to children for obesity unless prescribed by a multidisciplinary team with
34 expertise in:
35 o drug monitoring
36 o psychological support
37 o behavioural interventions
38 o interventions to increase physical activity
39 o interventions to improve diet [2006, amended 2014]
40

ⁱ At the time of publication (October 2014), orlistat did not have a UK marketing authorisation for use in children for this indication. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's (Good practice in prescribing and managing medicines and devices | 1) for further information.

- 1 80. Drug treatment may be continued in primary care for example with a shared care protocol if
2 local circumstances and/or licensing allow.[2006, amended 2014]

5.11 3 Continued prescribing and withdrawal

5.111 Adults and children

- 5 81. Pharmacological treatment may be used to maintain weight loss rather than to continue to
6 lose weight.[2006]
7
8 82. If there is concern about micronutrient intake adequacy, a supplement providing the
9 reference nutrient intake for all vitamins and minerals should be considered, particularly for
10 vulnerable groups such as older people (who may be at risk of malnutrition) and young
11 people (who need vitamins and minerals for growth and development).[2006]
12
13 83. Offer support to help maintain weight loss to people whose drug treatment is being
14 withdrawn; if they did not reach their target weight, their self-confidence and belief in their
15 ability to make changes may be low.[2006]

5.112 Adults

- 17 84. Monitor the effect of drug treatment and reinforce lifestyle advice and adherence through
18 regular review. [2006]
19
20 85. Consider withdrawing drug treatment in people who have not reached weight loss targets
21 (see recommendation 88 for details).[2006]
22
23
24 86. Rates of weight loss may be slower in people with type 2 diabetes, so less strict goals than
25 those for people without diabetes may be appropriate. Agree the goals with the person and
26 review them regularly. [2006]
27 87. Only prescribe orlistat as part of an overall plan for managing obesity in adults who meet one
28 of the following criteria:
29 o a BMI of 28 kg/m² or more with associated risk factors
30 o a BMI of 30 kg/m² or more.[2006]
31
32 88. Continue orlistat therapy beyond 3 months only if the person has lost at least 5% of their
33 initial body weight since starting drug treatment. (See also recommendation 86 for advice on
34 targets for people with type 2 diabetes.)[2006]
35
36 89. Make the decision to use drug treatment for longer than 12 months (usually for weight
37 maintenance) after discussing potential benefits and limitations with the person.[2006]
38
39 90. The co-prescribing of orlistat with other drugs aimed at weight reduction is not
40 recommended.[2006]

5.11.3 Children

- 2 91. If orlistat^j is prescribed for children, a 6-12 month trial is recommended, with regular review
3 to assess effectiveness, adverse effects and adherence.[2006, amended 2014]
4

5.12.5 Surgical interventions

- 6 92. Bariatric surgery is a treatment option for people with obesity if all of the following criteria
7 are fulfilled:
8 o they have a BMI of 40 kg/m² or more, or between 35 kg/m² and 40 kg/m² and other significant
9 disease (for example, type 2 diabetes or high blood pressure) that could be improved if they
10 lost weight
11 o All appropriate non-surgical measures have been tried but the person has not achieved or
12 maintained adequate, clinically beneficial weight loss
13 o The person has been receiving or will receive intensive management in a tier 3 service^k
14 o The person is generally fit for anaesthesia and surgery
15 o The person commits to the need for long term follow-up.
16 See recommendations 103 and 104 for additional criteria to use when assessing children, and
17 recommendation 98 for additional criteria for adults.[2006, amended 2014]
18
19 93. The hospital specialist and/or bariatric surgeon should discuss the following with people who
20 are severely obese if they are considering surgery to aid weight reduction:
21 o the potential benefits
22 o the longer-term implications of surgery
23 o associated risks
24 o complications
25 o perioperative mortality.
26 The discussion should also include the person's family, as appropriate.[2006]
27
28 94. Choose the surgical intervention jointly with the person, taking into account:
29 o the degree of obesity
30 o comorbidities
31 o the best available evidence on effectiveness and long-term effects
32 o the facilities and equipment available
33 o the experience of the surgeon who would perform the operation.[2006]
34
35 95. Provide regular, specialist postoperative dietetic monitoring, including:
36 o information on the appropriate diet for the bariatric procedure
37 o monitoring of the person's micronutrient status
38 o information on patient support groups

^j At the time of publication (October 2014), orlistat did not have a UK marketing authorisation for use in children for this indication. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's (Good practice in prescribing and managing medicines and devices | 1) for further information.

^k For more information on tier 3 services, see NHS England's report on Joined up clinical pathways for obesity.

- 1 o individualised nutritional supplementation, support and guidance to achieve long-term weight
 2 loss and weight maintenance.[2006]
 3
- 4 96. Arrange prospective audit so that the outcomes and complications of different procedures,
 5 the impact on quality of life and nutritional status, and the effect on comorbidities can be
 6 monitored in both the short and the long term^l. [2006, amended 2014]
 7
- 8 97. The surgeon in the multidisciplinary team should:
 9 o have had a relevant supervised training programme
 10 o have specialist experience in bariatric surgery
 11 o submit data for a national clinical audit scheme^m. [2006, amended 2014]
 12

5.12.1 Adults

- 14 98. In addition to the criteria listed in 92, bariatric surgery is the option of choice (instead of
 15 lifestyle interventions or drug treatment) for adults with a BMI of more than 50 kg/m² when
 16 other interventions have not been effective.[2006]
 17
- 18 99. Orlistat may be used to maintain or reduce weight before surgery for people who have been
 19 recommended surgery as a first-line option, if it is considered that the waiting time for
 20 surgery is excessive.[2006]
 21
- 22 100. Surgery for obesity should be undertaken only by a multidisciplinary team that can
 23 provide:
 24 o preoperative assessment, including a risk-benefit analysis that includes preventing
 25 complications of obesity, and specialist assessment for eating disorder(s)
 26 o information on the different procedures, including potential weight loss and associated risks
 27 o regular postoperative assessment, including specialist dietetic and surgical follow-up (see 112)
 28 o management of comorbidities
 29 o psychological support before and after surgery
 30 o information on, or access to, plastic surgery (such as apronectomy) when appropriate
 31 o access to suitable equipment, including scales, theatre tables, Zimmer frames, commodes,
 32 hoists, bed frames, pressure-relieving mattresses and seating suitable for people undergoing
 33 bariatric surgery, and staff trained to use them.[2006]
 34
- 35 101. Carry out a comprehensive preoperative assessment of any psychological or clinical
 36 factors that may affect adherence to postoperative care requirements (such as changes to
 37 diet) before performing surgery.[2006]
 38
- 39 102. Revisional surgery (if the original operation has failed) should be undertaken only in
 40 specialist centres by surgeons with extensive experience because of the high rate of
 41 complications and increased mortality.[2006]

^l The National Bariatric Surgery Registry is now available to conduct national audit for a number of agreed outcomes
www.nbsr.co.uk

^m The National Bariatric Surgery Registry is now available to conduct national audit for a number of agreed outcomes
www.nbsr.co.uk

5.12.2 Children

- 2 103. Surgical intervention is not generally recommended in children or young
3 people.[2006]
- 4 104. Bariatric surgery may be considered for young people only in exceptional
5 circumstances, and if they have achieved or nearly achieved physiological maturity. [2006]
6
- 7 105. Surgery for obesity should be undertaken only by a multidisciplinary team that can
8 provide paediatric expertise in:
- 9 o preoperative assessment, including a risk-benefit analysis that includes preventing
10 complications of obesity, and specialist assessment for eating disorder(s)
 - 11 o information on the different procedures, including potential weight loss and associated risks
 - 12 o regular postoperative assessment, including specialist dietetic and surgical follow-up
 - 13 o management of comorbidities
 - 14 o psychological support before and after surgery
 - 15 o information on or access to plastic surgery (such as apronectomy) when appropriate
 - 16 o access to suitable equipment, including scales, theatre tables, Zimmer frames, commodes,
17 hoists, bed frames, pressure-relieving mattresses and seating suitable for children and young
18 people undergoing bariatric surgery, and staff trained to use them.[2006]
19
- 20 106. Coordinate surgical care and follow-up around the child or young person and their
21 family's needs. Comply with national core standards as defined in A Call to Action on Obesity
22 in England.[2006, amended 2014]
23
- 24 107. Ensure all young people have had a comprehensive psychological, educational,
25 family and social assessment before undergoing bariatric surgery.[2006]
26
- 27 108. Perform a full medical evaluation, including genetic screening or assessment before
28 surgery to exclude rare, treatable causes of obesity.[2006]
29

5.13⁰ Bariatric surgery in people with recent onset type 2 diabetes

- 31 109. Offer an assessment for bariatric surgery to people who have recent-onset type 2 diabetesⁿ
32 and who are obese (BMI of 35 and over).[new 2014]
- 33 110. Consider an assessment for bariatric surgery to people who have recent-onset type 2
34 diabetesⁿ with a BMI of 30–34.9.[new 2014]
- 35 17. Consider assessing people who have recent-onset type 2 diabetes^o and are of Asian family
36 origin for bariatric surgery at a lower BMI (see recommendation 36).[new 2014]
37

ⁿ The GDG considered that recent onset type 2 diabetes would include those people whose diagnosis has been made within a 10 year time frame.

^o The GDG considered that recent onset type 2 diabetes would include those people whose diagnosis has been made within a 10 year time frame.

5.14 **1 Follow up care**

- 2 112. Offer people who have had bariatric surgery a follow-up care package for a minimum of 2
3 years within the bariatric service. This should include:
- 4 • monitoring of nutritional intake (including protein and vitamins) and mineral deficiencies
 - 5 • monitoring for comorbidities
 - 6 • medication review
 - 7 • dietary and nutritional assessment, advice and support
 - 8 • physical activity advice and support
 - 9 • psychological support tailored to the individual
 - 10 • information about support groups.[new 2014]
- 11 113. After discharge from bariatric surgery service follow-up, ensure that all people are offered at
12 least annual monitoring of nutritional status and appropriate supplementation according to need
13 following bariatric surgery, as part of a shared care model of chronic disease management.[new
14 2014]
- 15

5.15 **Key research recommendations**

17 The Guideline Development Group has made the following recommendations for research, based on
18 its review of evidence, to improve NICE guidance and patient care in the future.

19 **Post-operative care after bariatric surgery**

20 Do post-operative lifestyle intervention programmes (exercise, behavioural or dietary) improve
21 weight-loss and weight-loss maintenance following bariatric surgery?

22

23 **Long-term outcomes of bariatric surgery on people with type 2 diabetes**

24 What is the long-term effect of bariatric surgery on diabetes-related complications and quality of life
25 in people with type 2 diabetes compared with optimal medical treatment?

26

27 **Bariatric surgery in children and young people**

28 What are the long-term outcomes of bariatric surgery in children and young people with obesity?

29

30 **Obesity management for people with learning disabilities**

31 What is the best way to deliver obesity management interventions to people with particular
32 conditions associated with increased risk of obesity (such as people with a learning disability or
33 enduring mental health difficulties)?

34 **Long term effect of VLCDs on people with a BMI of 40kg/m² or more**

- 1 What are the long-term effects of using very-low-calorie diets (VLCDs) versus low-calorie diets (LCDs)
- 2 on weight and quality of life in patients with a BMI of 40 kg/m² or more, including the impact on
- 3 weight cycling?

5.16⁴ How this clinical guideline was updated

- 5 Methods used to develop recommendations from CG43, as well as the accompanying text from
- 6 CG43, can be found in Appendices M and N.

- 7 Appendix Q contains details of the amendments to recommendations from the original guideline. All
- 8 recommendations have been updated to ensure that they comply with the NICE policy on non-
- 9 discrimination and, where appropriate, have been amended or the wording changed in line with
- 10 current NICE house style.

- 11 Appendix Q also contains details of recommendations which have been deleted from the current
- 12 guideline and an explanation as to why these recommendations have been removed.

6₁ Very low calorie diets

6₂₁ Introduction

3 Obesity is a serious public health issue and the most common interventions are diet and exercise.
4 The use of very-low-calorie diets (VLCDs) is sometimes considered for weight management in the
5 NHS and in commercial programmes. There is a need for long term comparison with conventional
6 dietary interventions to assess clinical effectiveness. VLCDs are defined as hypocaloric diets which
7 provide between 450 to 800 kcal per day and are relatively enriched in protein of high biological
8 value. They must contain the full complement of vitamins, minerals, electrolytes and fatty acids. They
9 are usually in a liquid formulation and are intended to completely replace other food intake in a
10 weight loss programme for a specific period of time.

11 NICE CG43 (2006) reviewed and approved the short term use of VLCDs in treatment of the obese
12 person. The provision of very low calorie diets on the NHS is an emerging intervention option, and
13 often used by people with a high BMI, despite a lack of published literature on the use of VLCDs in
14 this group. However, it is noted that a large number of individuals purchase these limited calorie
15 meal replacement options from commercial providers.

16 CG43 recommended the use of VLCDs in people who are obese and have reached a plateau in weight
17 loss. The care and management of these people is likely to be delivered within specialist services.
18 Moreover, the GDG recognise that attendance at NHS care will vary but that it is likely that people
19 with comorbidity would attend at a GP surgery. It is important to assess whether the provision of
20 VLCDs in this population is of added benefit compared to the usual care provided at this level.

21 The GDG wished to determine the long term efficacy of VLCDs as it is currently unknown. The
22 potential increased use of VLCD in the NHS requires evidence of improved patient outcomes without
23 compromising patient safety and quality of care. This includes assessing evidence of reduction in
24 comorbidities with long term maintenance of weight loss and the impact on the patient's quality of
25 life.

26 To this end the GDG posed 3 questions that aimed to provide the evidence for effectiveness and
27 safety of VLCDs as well as establishing what maintenance strategies maximised weight loss in the
28 longer term. Each of these questions and the evidence are presented in this chapter. The GDG
29 interpretation of the body of evidence considered, together with recommendations made, conclude
30 the chapter. This guidance amended the definition of VLCD to ≤ 800 calories per day in line with
31 current practice, whereas the previous guideline had used a definition of 1000 calories or less. The
32 search for this review question was repeated without any date cut-offs to ensure that no relevant
33 evidence was missed.

6₄₂ Review question: In people who are overweight or obese, what is the clinical and cost effectiveness of very low calorie diets in reducing weight?

37 For full details see review protocol in AppendixC.

38 **Table 7: PICO characteristics of review question**

Population	Adults (18 years old and over) Children (over 2 years)
Intervention(s)	Very-low-calorie diet (≤ 800 calories per day) – these should be nutritionally complete. Includes intermittent diets (for example VLCD meal replacements just 2 days a week –

	which may follow a period of daily VLCD (usually 8 weeks and then intermittent)).
Comparison(s)	Standard dietary advice defined as: low-calorie (regular) diet (LCD) 800-1200 calories per day or 500/800 deficit diet.
Outcomes	<ul style="list-style-type: none"> • % weight in kg change (from start of study to end of maintenance period) • Health related quality of life • Withdrawals • Weight in BMI, change (from start of study to end of maintenance period) - % reduction IMPORTANT • Weight change at end of VLCD to end of maintenance period - % kg • Weight change at end of VLCD to end of maintenance period - % BMI • Improvement in physical activity
Study design	RCT or systematic review of RCTs.

6.2.1 Clinical evidence

2 Seven studies were included in the review.^{47,58-60,62,63,65} Evidence from these studies is summarised in
3 the clinical evidence summary below (Table 8). See also the study selection flow chart in Appendix D,
4 study evidence tables in Appendix G, forest plots in Appendix I, GRADE tables in Appendix O and
5 excluded studies list in Appendix J.

6 Three studies reported on specific populations: 1 with all male participants in an occupational setting
7 ⁴⁷ and 2 with all female participants.^{59,60} Furthermore, 3 studies reported on people with type 2
8 diabetes.^{58,62,65}

9 All included studies compared VLCD to standard dietary advice, but the length of VLCD (8-50 weeks),
10 the number of calories included (400-800 kcals), and the length of treatment and follow-up (6
11 months-24 months), varied. Three papers^{58,59,63} reported intermittent VLCD Six studies^{47,59,60,62,63,65}
12 included behavioural therapy (or educational sessions) as part of the treatment in both arms and 4 of
13 these studies included an exercise component as well.^{47,59,60,65}

14 No studies reported the weight change outcomes in the GDG preferred units of percentage loss of
15 initial weight. However, the studies did report BMI or kg change so this was used instead. One study
16 did report percentage 'ideal' weight loss, which was included.⁴⁷

17 None of the studies reported weight change (BMI or kg) from end of VLCD to end of maintenance
18 period. However, studies reported weight change from start of study to end of VLCD and from start
19 of study to end of maintenance period which indirectly provided the same information, so this was
20 reported instead.

21 Numbers of participants withdrawing from the study was extracted for all 7 studies. None of the
22 included studies reported on the following outcomes from the protocol: health -related quality of life
23 and improvement in physical activity.

24

25

26

1 **Table 8: Summary of studies included in the review**

Study	Intervention/comparison	Population	Outcomes	Comments
Pavlou 1989 ⁴⁷	<p>Treatment (8 weeks)</p> <p>Randomly assigned to 1 of 4 diet groups, and either exercise (90 min supervised, 3 times a week) or non-exercise group</p> <p>VLCD + exercise (n= 57):</p> <ul style="list-style-type: none"> • DPC-70, a 420 kcal powdered protein-carbohydrate mix • DPC-800, an 800 kcal diet provided in powder form <p>Standard dietary advice + exercise (i.e. LCD, n= 53)</p> <ul style="list-style-type: none"> • Balanced caloric-deficit diet, 1000 kcal • Protein-sparing modified fast, ~1000 kcal <p>All participants attended weekly educational sessions</p> <p>Follow-up 6 + 18 months</p>	<p>Moderately obese men (22% above ideal body weight), 26-52 yr.</p> <p>Initial weight: Treatment 101.9 kg (4.585) Comparator 101.5 kg (3.853)</p>	<p>% weight loss ('ideal')</p> <p>Withdrawals</p> <p>Weight in kg, change (start of study to end of maintenance period)</p>	<p>All male sample</p> <p>Combined VLCD and LCD groups have comparable baseline weights. However, separate groups had wide range (96.1 – 105.7 kg)</p> <p>Unclear follow-up period "final weight", assume 18 month follow-up</p> <p>Measure of physical activity, unable to extract data in any useful way</p>
Simonen 2000 ⁵⁸	<p>Run in (6 weeks)</p> <p>Participants consumed an ad libitum diet at home</p> <p>Treatment (3 months)</p> <p>VLCD (n= 10):</p> <ul style="list-style-type: none"> • Daily 3 servings of a VLCD (97 kJ/d, Cambridge diet; Howard Foundation, Cambridge, UK – 14.2 g protein, 15.0 g carbohydrates, 2.7 g fat) <p>Standard dietary advice (i.e. LCD, n= 6)</p>	<p>Obese (>30 BMI) patients with recently diagnosed (<2yr) T2D</p> <p>Initial weight: All participants 93.2 kg (3.74)</p>	<p>Withdrawals</p> <p>Weight in kg, change (start of study to end of maintenance period)</p>	<p>Small sample</p> <p>Unclear calorie total in either arm (GDG noted that VLCD was likely to be 97 kJ/d per kilo)</p> <p>Serum and metabolic variables were not significantly different between treatment groups,</p>

Study	Intervention/comparison	Population	Outcomes	Comments
	<ul style="list-style-type: none"> Advised to consumed a low-fat, low-cholesterol diet <p>Weight maintenance diet (up to 2 years)</p>			therefore, participants were analysed in aggregate – results taken from HTA
Viegener 1990 ⁵⁹	<p>Treatment (6 months)</p> <p>Behavioural therapy + exercise + diet (intermittent diet, n= 42):</p> <ul style="list-style-type: none"> VLCD - 800 kcal/day, low fat diet, used 4 days a week (3 days: 1200 kcal/day) <p>Behavioural therapy + exercise + diet (standard deficit diet, N= 43)</p> <ul style="list-style-type: none"> 1200 kcal/day <p>Treatment also included exercise component (i.e. programmed aerobic exercise, target goal 30 minutes per day, 6 days a week)</p> <p>During treatment, participants received 26 weekly group sessions, each 2 hours in duration</p> <p>Weight maintenance (6 months)</p> <p>During maintenance, participants undertook therapist-led “maintenance” sessions, held twice a month</p>	<p>Females, 21-59 years of age, 25-99% overweight (based on the height-weight tables of the Metropolitan Life Insurance Company, 1983)</p> <p>Initial weight: Treatment 98.6 kg (15.9) Comparator 94.6 kg (12.6)</p>	<p>Withdrawals</p> <p>Weight in kg, change (start of study to end of VLCD period)</p> <p>Weight in kg, change (start of study to end of maintenance period)</p>	<p>All female sample</p> <p>Difference in baseline weight</p> <p>Intermittent VLCD</p>
Wadden 1994 ⁶⁰	<p>Treatment (52 week programme + 26 week follow-up)</p> <p>Behavioural therapy + exercise + short-term use of a VLCD (n = 28):</p> <ul style="list-style-type: none"> Week 1: 1200 kcal/day Week 2-17: liquid formula VLCD (OPTIFAST 70, provided 420 kcal/day (70 g protein, 30 g 	<p>Obese women, mean age 39 years, 106.33 kg, 39.46 BMI</p> <p>Recruited by newspaper advertisements seeking persons at least 25 kg</p>	<p>Withdrawals</p> <p>Weight in kg, change (start of study to end of VLC period)</p> <p>Weight in kg, change</p>	<p>All female sample</p> <p>Short term VLCD (16 weeks)</p> <p>Assuming numbers at end of treatment, i.e. week 17 (report number of</p>

Study	Intervention/comparison	Population	Outcomes	Comments
	<p>carbohydrate, 2 g fat))</p> <ul style="list-style-type: none"> Week 8-23: conventional foods gradually reintroduced and amount of liquid formula reduced so that by week 23 consuming 1000 kcal/day diet of conventional foods Week 24-52: consume conventional reducing diet of 1200 kcal/day <p>Behavioural therapy + exercise + a balanced-deficit diet (n= 21)</p> <ul style="list-style-type: none"> 1200 kcal/day 15-20% of calories derived from protein, no more than 30% from fat, and the remainder from carbohydrates <p>Participants in both conditions began exercise program at week 8, which mostly consisted of walking (exercise for 10-20 min, 2-3 times a week, at 40-60% of estimated maximum heart rate – by week 52: 20-40 min, 3-5 times a week, 60-70% maximum heart rate)</p> <p>All participants participated in weekly group treatment sessions for first 52 weeks (instruction in traditional behavioural methods of weight control, e.g. controlling stimuli associated with eating, slowing the rate of eating, etc.) and biweekly sessions for an additional 26 weeks (6-9 participants, 90 min)</p>	<p>overweight, as determined by the height-weight tables of the Metropolitan Life Insurance Company (1983).</p> <p>Initial weight: Treatment 107.85 kg (14.89) 40.01 (5.73) Comparator 105.43 kg (13.68) 38.80 BMI (5.39)</p>	<p>(start of study to end of maintenance period)</p>	<p>participants at week 9, 26, and 78)</p> <p>% weight loss from fat, at 17 weeks: VLCD (n= 16) -72.11 (11.06) BDD (n= 15) -81.75 (53.75)</p>
Wing 1984 ⁶³	<p>Pre-treatment assessment (10 days)</p> <p>Treatment (10 weeks) Intermittent low-calorie regimen (i.e. VLCD, N= 25):</p> <ul style="list-style-type: none"> Given individualised goals to follow for 5 days/week. 	<p>Obese participants, age 20-65, ≥20% overweight</p> <p>Initial weight: Treatment 91.8 kg (13.4)</p>	<p>Withdrawals</p> <p>Weight in kg, change (start of study to end of VLCD period)</p>	<p>15 month study</p> <p>Weekly meetings for 10 weeks, each lasting 60-90 minutes; consisting of weigh-in, review, and collection of</p>

Study	Intervention/comparison	Population	Outcomes	Comments
	<ul style="list-style-type: none"> For the other 2 days, participants advised to practice 'self-control' by restricting intake to below 750 kcal/day <p>Standard behavioural condition (i.e. LCD, N= 23)</p> <ul style="list-style-type: none"> Goal (based on initial weight x 12 – 1000 kcal) of at least 1000 kcal/day <p>Booster sessions (6 months) Massed (four of the six meetings held during the third month) or spaced (6 x monthly intervals) booster sessions</p> <p>Follow-up (6 months)</p>	<p>Comparator 92.9 kg (18.5)</p>	<p>Weight in kg, change (start of study to end of maintenance period)</p>	<p>food diaries</p> <p>Intermittent VLCD</p> <p>Results combined: VLCD (massed + spaced groups) LCD (massed + spaced)</p>
Wing 1991 ⁶⁵	<p>Treatment 20 weeks</p> <p>Behavioural therapy + exercise (n= 19)</p> <ul style="list-style-type: none"> 1000-1500 kcal/d <p>Behavioural therapy + exercise + VLCD (n= 17)</p> <ul style="list-style-type: none"> 4-week LCD (1000-1500 kcal) 8-week VLCD (400 kcal/d) 4 weeks of gradual introduction of other foods 4-week LCD (1000-1500 kcal) <p>Weekly meetings – included instruction of diet, exercise and behaviour modification</p> <p>Exercise goals – increase walking and given weekly exercise goals, starting at 210 J/week (equivalent to walking 0.5 mile for a 67.5 kg person) and increasing to 4200 J/week (approx 10 miles per week)</p> <p>Weight maintenance (52 weeks)</p>	<p>10 men/26 women, 35-70 years of age, 30% or more above ideal body weight, type 2 diabetes</p> <p>Initial weight: BT alone 104.5 kg (21.5) 38.10 BMI (5.7) VLCD 102.1 kg (11.7) 37.34 BMI (4.7)</p>	<p>Withdrawals</p> <p>Weight in kg, change (start of study to end of VLCD treatment)</p> <p>Weight in kg, change (start of study to end of maintenance period)</p> <p>Weight in BMI, change (start of study to end of maintenance period)</p> <p>Weight in BMI, final (start of study to end of maintenance period)</p>	

Study	Intervention/comparison	Population	Outcomes	Comments
Wing 1994 ⁶²	<p>Treatment 50 weeks</p> <p>Behavioural therapy + diet (N= 48)</p> <ul style="list-style-type: none"> 1000-1200 kcal/d <p>Behavioural therapy + VLCD (N= 45)</p> <ul style="list-style-type: none"> Week 1-12: 400-500 kcal/d Week 13-23: increase to 1000-1200 kcal/d Week 24-36: 400-500 kcal/d Week 37-48: increase to 1000-1200 kcal/d <p>Behavioural treatment (weekly group meetings) occurred over 1 year. Meetings consisted of individual weigh-in, review of self-monitoring records, and a lecture and discussion concerning a topic related to nutrition, exercise or behaviour modification.</p>	<p>Obese patients with T2D (diagnosis of diabetes for an average of 6.8 years (SD 6.2))</p> <p>Initial weight: VLCD 105.8 kg (19.4) 37.42 BMI (6.13)</p> <p>Standard dietary advice 107.7 kg (18.7) 38.31 BMI (6.52)</p>	<p>Withdrawals</p> <p>Weight in kg, change (start of study to end of VLCD period)</p> <p>Weight in kg, change (start of study to end of maintenance period)</p> <p>Weight in BMI, change (start of study to end of VLCD period)</p>	

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1 **Table 9: Summary of studies included in the review: weight in kg**

Study	Mean kg - baseline	Mean kg – end of VLCD period	Mean kg – end of weight maintenance period
Pavlou 1989	VLCD: 101.9 kg (4.585) LCD: 101.5 kg (3.853)	8 weeks: Unable to extract data from graph	18 months: VLCD: 89.8 kg (5.56) LCD: 90.77 kg (4.281)
Simonen 2000	Overall: 93.2 kg (3.7)	12 weeks: Unable to extract data from paper	24 months: Overall: 87.2 kg (3.2)
Viegner 1990	VLCD: 94.6 kg (12.6) Standard diet: 98.6 kg (15.9)	26 weeks: VLCD: -10.2 kg (5.1) [84.4 kg] Standard diet: -8.9 kg (5.6) [89.7 kg]	12 months: VLCD: -9.0 kg (6.7) [85.6 kg] Standard diet: -8.9 kg (7.3) [89.7 kg]
Wadden 1994	VLCD: 107.85 kg (14.89) Standard diet: 105.43 kg (13.68)	17 weeks: VLCD: -20.50 kg (7.29) [87.35 kg] Standard diet: -9.14 kg (6.17) [96.29 kg]	18 months: VLCD: -10.94 kg (9.97) [96.91kg] Standard diet: -12.18 kg (8.23) [93.25 kg]
Wing 1984	VLCD: 91.8 kg (13.4) Standard diet: 92.9 kg (18.5)	10 weeks: VLCD: -8.4 kg (1.4) [90.96 kg] Standard diet: -7.8 kg (1.5) [85.1 kg]	12 months: VLCD: -2.7 kg (2.4) [89.1 kg] Standard diet: -3.0 kg (2.3) [89.9 kg]
Wing 1991	VLCD: 102.1 kg (11.7) Standard diet: 104.5 kg (21.5)	20 weeks: VLCD: 83.5 kg (9.5) Standard diet: 94.4 kg (19.8)	12 months: VLCD: 93.5 kg (10.4) Standard diet: 97.7 kg (17.4)
Wing 1994	VLCD: 105.8 kg (19.4) Standard diet: 107.7 kg (18.7)	52 weeks: VLCD: -14.2 kg (10.3) [91.6 kg] Standard diet: -10.5 kg (11.6) [97.5 kg]	24 months: VLCD: -7.2 kg (8.0) [98.6 kg] Standard diet: -5.7 kg (7.9) [102 kg]

2
3

1 Table 10: Summary of studies included in the review: withdrawals

Study	Baseline	End of VLCD period	End of weight maintenance period	Explanation for withdrawals	Other measures of adherence
Pavlou 1989	Treatment: n= 80 Comparator: n= 80	8 weeks: Not specified	18 months: Treatment: n= 57 Comparator: n= 53	None given	
Simonen 2000	Treatment: n= 10 Comparator: n= 6	12 weeks: Paper reports no withdrawals	24 months: Paper reports no withdrawals	Not applicable	
Viegener 1990	Treatment: n= 42 Comparator: n= 43	26 weeks: Treatment: N= 31 Comparator: N= 32	12 months: Treatment: n= 30 Comparator: n= 30	Paper states “conservative assumption of assuming that each client who dropped out of treatment had relapsed to pre-treatment weight...”. No other details given.	Attendance at treatment group sessions and twice a month maintenance sessions Self-reported adherence to behavioural weight loss strategies
Wadden 1994	Treatment: n= 28 Comparator: n= 21	17 weeks: Treatment: N= 28 Comparator: N= 21 *assumption	18 months Treatment: n= 21 Comparator: n= 16	Reasons reported overall only: of 12 who dropped out overall (including 3 during maintenance), 2 were because of illness or death in the family, 1 moved, 1 started a job conflicting with treatment, but the rest felt that they did not have time for the program or were unhappy with their weight losses or both	Withdrawals reported at: week 9 (VLCD: n= 28, LCD: n= 21)* week 26 (VLCD: n= 26, LCD: n= 17) week 52 (VLCD: n= 23, LCD: n= 17) week 78 (VLCD: n= 21, LCD: n= 16) Treatment sessions: Attendance high in both condition during first 26 weeks, averaging 24.03 visits Fell during next 26 weeks to a mean of 17.76 Attendance during weeks 53-78 was low in both conditions, averaging

Study	Baseline	End of VLCD period	End of weight maintenance period	Explanation for withdrawals	Other measures of adherence
					only 6.51 of 13 possible visits.
Wing 1984	Treatment: n= 25 Comparator: n= 23	10 weeks: Treatment: n= 24 Comparator: n= 22	12 months: Treatment: n= 23 Comparator: n= 21	Paper states “the 2 dropouts (one from each condition) were assumed to have lost no weight”. No other details given.	Number of days participants reported eating <750 kcal during 10 week treatment Number of weeks participants reported eating <750 kcal for 2 days/week during 10 weeks. Total calorie intake
Wing 1991	Treatment: n= 17 Comparator: n= 19	20 weeks: Treatment: n= 17 Comparator: n= 16	72 weeks: Treatment: n= 17 Comparator: n= 16	None given	Self-monitoring records of caloric intake Eating behaviour
Wing 1994	Treatment: n= 45 Comparator: n= 48	52 weeks: Treatment: n= 38 Comparator: n= 41	24 months: Treatment: n= 36 Comparator: n= 37	None given	Attendance

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1 **Table 11: Clinical evidence profile: VLCD versus standard dietary advice for overweight and obese people**

Outcome	Number of studies	Imprecision	GRADE rating	Absolute Difference	Control event rate (per 1000)	Control event rate for continuous outcomes
% (ideal) weight loss	1	Serious	Very low	MD 2.1% higher (3.4 lower to 7.6 higher)	-	65.4%
Health related quality of life	0	-	-	-	-	-
Withdrawals	7	Serious	Very low	32 fewer per 1000 (from 85 fewer to 41 more)	229 per 1000	-
Weight in kg, change (from start of study to end of VLCD period)	5	Serious	Very low	MD 4.3 kg lower (5.99 lower to 2.62 higher)	-	-9.14 kg
Weight in kg, change (from start of study to end of weight maintenance period)	7	None	Low	MD 0.96 kg lower (1.66 to 0.25 lower)	-	-6.8 kg
Weight in BMI, change (from start of study to end of VLCD period)	2	Serious	Low	MD 2.09 BMI lower (3.29 to 0.9 lower)	-	-3.69 BMI
Weight in BMI, final (from start of study to end of weight maintenance period)	1	Serious	Very low	MD 1.26 BMI lower (4.17 to 1.65 lower)	-	35.4 BMI

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6.2.2 Economic evidence

6.2.2.12 Published literature

- 3 No relevant economic evaluations were identified.
- 4 See also the economic article selection flow chart in Appendix E.

6.2.2.25 Unit costs

- 6 Relevant unit costs are provided below to aid consideration of cost effectiveness.
- 7 The sections below detail the costs borne by the NHS for providing a VLCD diet. Note that the level of
- 8 care provided as part of a VLCD varies across the UK, therefore the following costs are intended to
- 9 provide only an example of the costs faced; local costs will vary. This analysis focuses on NHS-run
- 10 VLCDs, though consideration is given to commercially run VLCDs. Two costs analyses were
- 11 conducted:
 - 12 • VLCDs that individuals with and without comorbidities with a BMI over 40 kg/m² may receive.
 - 13 • VLCDs that individuals with no comorbidities and a BMI 30 - 40 kg/m² may receive.

14 Tier 3 service VLCD costs (individuals with and without comorbidities with a BMI over 40 kg/m²)

15 The following represents the costs per individual for undertaking a VLCD for 1 year. Where
16 appropriate, separate costs are displayed for individuals with comorbidities, such as hypertension
17 and type-2 diabetes. These individuals are likely to receive a different level of care to ensure their
18 comorbidities are properly monitored and controlled.

19 Initial medical assessment

20 When an individual first undertakes a VLCD they undergo an initial assessment in which their
21 suitability is assessed, and they receive advice on how to undertake the diet properly. The individual
22 is also discussed at a separate multi-disciplinary-team (MDT) meeting which comprises of medical
23 professionals who will be involved in the VLCD. The costs of these assessments are shown in [Table](#)
24 [12: Initial medical assessment](#).

25 **Table 12: Initial medical assessment**

Item	Description	Cost	Source
Medical consultant assessment	1 x 45 minute assessment	£74	GDG estimate, PSSRU ¹⁰
Dietitian (band 7) assessment ^(a)	1 x 30 minute assessment	£24	GDG estimate, PSSRU ¹⁰ , NHS pay and conditions circular ⁴²
Blood tests and time taken to review results ^(b)	Including: FBC, Ues, LFTs, bone, Vit D, iron studies, B12, folate, fasting lipidse and HbA _{1c} .	£178	GDG estimate, PSSRU ¹⁰
10 minute MDT	1 x dietitian 1 x psychologist 1 x physiotherapist 1 x medical consultant	£41	GDG estimate, PSSRU ¹⁰

26 (a) In some centres this assessment may be completed by a clinical nurse specialist instead; however the cost difference is
27 small

1 (b) This is based on the assumption that it takes 5 minutes for a medical consultant to review blood results

2 Undertaking the diet

3 After the initial medical assessment the individual undergoes the diet for 12 weeks. During this
4 period they are likely to receive intense monitoring to identify any medical or compliance issues.
5 Individuals with comorbidities are likely to receive additional monitoring from different healthcare
6 professionals to ensure their comorbidities are being correctly treated. They may also receive
7 additional telephone support from a clinical nurse specialist. Monitoring costs for individuals with no
8 comorbidities are shown in [Table 13](#)~~Table 13~~, and monitoring costs for individuals with comorbidities
9 are shown in [Table 14](#)~~Table 14~~.

10 **Table 13: Costs of undertaking the diet for individuals with no comorbidities**

Item	Description	Cost per assessment	Cost	Source
Monitoring	12 x 30 minute assessments with dietitian (band 7)	£24	£288	GDG estimate, PSSRU ¹⁰ , NHS pay and conditions circular ⁴²

11 **Table 14: Costs of undertaking the diet for individuals with comorbidities**

Item	Description	Cost per assessment	Cost	Source
Monitoring	2 x 30 minute assessments with physician; 2 x 30 minute assessments with CNS; 8 x 30 minutes with dietitian	£50 per physician appointment £26 per CNS appointment £24 per dietitian appointment	£344	GDG estimate, PSSRU ¹⁰ , NHS pay and conditions circular ⁴²
CNS monitoring during 12 weeks the individual is on the diet	17 x 15 minute phone calls ^(a)	£13 per phone call	£221	GDG estimate, PSSRU ¹⁰

12 (a) Once every other day in the first two weeks, then once a week until the diet is complete.

13 End of programme

14 After the diet has been completed the individual will have their blood tested again and undertake a
15 final medical assessment to discuss a follow up plan. It is assumed that if the individual has
16 comorbidities then this final assessment will take place with a medical consultant, the costs of which
17 are shown in [Table 15](#)~~Table 15~~. If the individual has no comorbidities then the final assessment takes
18 place with a dietitian, the costs of which are shown in [Table 16](#)~~Table 16~~.

19 **Table 15: Final medical assessment for individuals with comorbidities**

Item	Description	Cost	Source
Medical consultant assessment	1 x 60 minute assessment	£99	GDG estimate, PSSRU ¹⁰
Blood tests and time taken to review results	Including: FBC, Ues, LFTs, bone, Vit D, iron studies, B12, folate, fasting lipidse and HbA _{1c}	£178	GDG estimate, PSSRU ¹⁰

1

2 **Table 16: Final medical assessment for individuals with no comorbidities**

Item	Description	Cost	Source
Dietitian assessment (band 7)	1 x 60 minute assessment	£48	GDG estimate, PSSRU ¹⁰ , NHS pay and conditions circular ⁴²
Blood tests and time taken to review results	Including: FBC, Ues, LFTs, bone, Vit D, iron studies, B12, folate, fasting lipidse and HbA _{1c}	£178	GDG estimate, PSSRU ¹⁰

3 **Follow-up**

4 It is assumed that after the diet the individual will continue to receive regular monitoring, in the form
5 of monthly follow up visits with a dietitian, to ensure weight is maintained and any medical issues are
6 identified and addressed. These costs are shown in [Table 17](#) ~~Table 17~~.

7 **Table 17: Follow-up**

Item	Description	Cost per appointment	Cost	Source
Follow-up visits	9 x 30 minute assessments with dietitian (band 7)	£24	£216	GDG estimate, PSSRU ¹⁰ , NHS pay and conditions circular ⁴²

8 **Additional costs**

9 During the time the VLCD is being undertaken there are additional pressures placed on the service to
10 accommodate people undertaking a VLCD. This includes additional time spent by an administrator
11 and longer MDT meetings. Individuals on a VLCD will be seen more and therefore more time will be
12 spent by an administrator making appointments, entering additional information into a database and
13 sending more letters to the individual's GP. MDT meetings are weekly meetings which are used to
14 discuss the progress and issues of patients on the service, and individuals who are undertaking a
15 VLCD will require more time to discuss any safety or compliance concerns. Individuals with
16 comorbidities will have an even longer MDT discussion to discuss issues related to medication
17 titration for example. The additional costs for patients with no comorbidities are shown in [Table](#)
18 ~~18~~ [18](#) ~~Table 18~~, and the additional costs for patients with comorbidities are shown in Table 19. Note that
19 transport costs have been excluded from this analysis as most services do not cover transport costs
20 and this cost is not specific to VLCDs.

21 **Table 18: Additional costs borne by the centre for individuals with no comorbidities**

Item	Description	Cost per week	Cost	Source
Additional 5 minutes a week at MDT for the twelve weeks the individual is undertaking the VLCD	Individuals involved in MDT: 1 x dietitian 1 x psychologist 1 x physiotherapist 1 x medical consultant	£21	£246	GDG estimate, PSSRU ¹⁰
Additional 15 minutes a week for	Band 4 administrator	£7	£78	GDG estimate, NHS pay and conditions

Item	Description	Cost per week	Cost	Source
twelve weeks for additional database entry work				circular ⁴²

1 **Table 19:** Additional costs borne by the centre for individuals with comorbidities

Item	Description	Cost per week	Cost	Source
Additional 10 minutes a week at MDT for the twelve weeks the individual is undertaking the VLCD	Individuals involved in MDT: 1 x dietitian 1 x psychologist 1 x physiotherapist 1 x medical consultant	£41	£491	GDG estimate, PSSRU ¹⁰
Additional 15 minutes a week for twelve weeks for additional database entry work	Band 4 administrator	£7	£78	GDG estimate, NHS pay and conditions circular ⁴²

2

3 The comparator

4 In this analysis VLCDs are compared to a tier 3 weight management service. This decision was made
5 given that:

- 6 • The majority of people placed on VLCDs in the NHS are those already on a tier 3 weight
7 management service
- 8 • These individuals have a BMI over 40 kg/m², therefore they are likely to receive intensive
9 treatment.

10 Some of the costs detailed above would be incurred as part of a tier 3 weight management service,
11 even if the patient had not gone on the VLCD. The cost components that are unique to a VLCD are
12 identified in the following section.

13 Incremental costs

14 The incremental cost of providing a VLCD in comparison to a tier 3 weight management service is
15 calculated in [Table 20](#). This assumes:

- 16 • After 1 year people who underwent a VLCD will receive the same standard of care as those on a
17 tier 3 service.
- 18 • People undertaking a VLCD will also receive the level of care provided within a tier 3 service, for
19 example the same number of physiotherapist and psychologist visits.

20 **Table 20:** Incremental costs for undertaking a VLCD

Item	Cost
Additional time spent at MDT	£246
Additional time taken to complete database	£78
Additional 5 hours of dietitian time (assuming a standard tier 3 service would provide 7 hours of	£240

Item	Cost
dietitian time per year).	
Blood tests	£356
Initial medical assessment by medical consultant	£74
Additional costs for individuals with comorbidities: 2 additional hours with medical consultant, 5.25 hours with CNS, additional 5 minutes per week at MDT however 3 hours less with dietitian.	£573
Total for patients with no comorbidities	£994
Total for patients with comorbidities	£1567

1 Sensitivity analysis

2 To reflect the differential level of care patients may receive, sensitivity analyses were run on the
3 costs by considering the following additional scenarios.

4 Firstly, in some centres, an MDT may not be run to discuss individuals with no comorbidities on a
5 VLCD. Instead, medical support may be offered to these patients if they choose to access it. An
6 assumption was made, based on GDG opinion, that 20% of individuals would access this additional
7 medical support. The cost of this additional support is calculated in Table 21, and would be instead of
8 the additional MDT cost calculated in [Table 18](#) for people with no comorbidities. For people
9 with co-morbidities it was assumed in this sensitivity analysis that the MDT would last the same
10 amount of time as in a tier three service.

11 **Table 21: Cost of additional medical support**

Item	Description	Cost	Source
Additional medical support	12 x 30 minute assessments with a medical consultant for 20% of patients	£40	PSSRU ¹⁰ , GDG estimate

12 Secondly, in some centres, blood tests may also be taken for people as part of the tier 3 service, and
13 therefore do not represent an incremental cost.

14 **Table 22: Incremental costs for undertaking a VLCD (low end estimate)**

Item	Cost
Additional medical support (no MDT)	£40
Additional time taken to complete database	£78
Additional 5 hours of dietitian time (assuming a standard tier three service would provide 7 hours of dietitian time per year).	£240
Initial medical assessment by medical consultant	£74
Additional costs for individuals with comorbidities: 2 additional hours with medical consultant, 5.25 hours with CNS, however 3 hours less with dietitian.	£327
Total for patients with no comorbidities	£432
Total for patients with comorbidities	£759

1 **Primary care VLCD costs (individuals without comorbidities with a BMI 30 – 40 kg/m²)**

2 The GDG also recognised that a small group of individuals with a BMI between 30 – 40 kg/m² with no
3 comorbidities may receive a much less intensive care package during their VLCD. These individuals
4 would only receive an initial medical assessment from a dietitian, then weekly monitoring visits
5 during the time the individual is on the diet. They would have access to medical support, provided by
6 a GP, and an assumption was made that only 20% of patients would access this service. The costs of
7 this service are provided in Table 23.

8 **Table 23: Costs of reduced care package VLCD in people with no comorbidities**

Item	Description	Cost	Source
Initial medical assessment	1 x 60 minute visit with band 5 dietitian	£31	GDG estimate, PSSRU ¹⁰
Monitoring during the diet	12 x 30 minute visits with dietitian (band 5)	£186	GDG estimate, PSSRU ¹⁰
Medical support	30 minutes with GP assuming 20% of patients access this service	£19	GDG estimate, PSSRU ¹⁰
Total		£236	

9

10 As these people will not require intense treatment the relevant comparator is standard dietary
11 advice. This consists of visits with a dietitian the costs of which are provided in Table 24.

12 **Table 24: Cost of standard dietary advice**

Item	Description	Cost	Source
Initial visit	1 x 60 minute band 5 dietitian appointment	£31	GDG estimate, PSSRU ¹⁰
Follow-up	3 x 30 minute dietitian appointments	£47	GDG estimate, PSSRU ¹⁰
Total		£78	

13 Therefore the incremental costs of providing a VLCD for these people is £158.

14 **Commercially run VLCD**

15 A number of people choose to fund their own VLCD and complete this outside of NHS care. Even
16 though the individual pays for the service, there are still costs borne by the NHS. These costs are
17 mainly relevant to individuals with comorbidities and are related to medical assessments that are
18 required by the commercial providers before and during the diet. The NHS will incur the cost of a
19 professional assessment to ensure the VLCD is safe to complete and also the cost professional
20 monitoring via telephone to alter medication and ensure no complications arise. Finally, the costs of
21 any adverse effects that arise from undertaking the VLCD will also fall on the NHS.

22 **Economic considerations**

23 Using the incremental cost of providing a VLCD, the QALY increase which would be required for
24 VLCDs to be considered cost effective at a £20,000 per QALY threshold can be calculated like so:

$$\text{Change in QALYs} = \frac{\text{Change in cost}}{\text{£20,000}}$$

- 1 The change in BMI required to achieve this increase in QALYs can then be calculated using data on
- 2 the health related quality of life (HRQoL) increase expected from a one point reduction in BMI:

$$BMI \text{ change needed} = \frac{\text{Change in QALYs}}{\text{HRQoL increase per one unit reduction in BMI}}$$

3

4 Evidence from the literature^{14,30} suggests that HRQoL increases between 0.0079- 0.0164 per unit
5 decrease in BMI. Therefore if a unit decrease in BMI was sustained for a year this would mean an
6 increase of 0.0079 – 0.0164 QALYs. It is worth noting that the estimate of 0.0164, derived from Dixon
7 et al,¹⁴ is unadjusted for age and whether or not the individual has type-1 or type-2 diabetes. The
8 estimate of 0.0079, derived from Lee et al,³⁰ is for non-diabetics and adjusted for age. Therefore we
9 would expect the true value to be closer to 0.0079 for patients without diabetes.

10 Using the information above, the BMI changes needed for VLCDs to be cost effective at a £20,000 per
11 QALY threshold are displayed in Table 25 taking into account the range of costs and quality of life
12 values.

13 **Table 25: BMI change needed for VLCD to be cost-effective at a £20,000 per QALY threshold (no**
14 **comorbidities)**

Cost/Effect	0.0079 (lower estimate for quality of increase per BMI unit change)	0.0164 (upper estimate for quality of increase per BMI unit change)
£432 (lower estimate for tier 3 VLCD)	2.73 kg/m ²	1.32 kg/m ²
£994 (Base case estimate for tier 3 VLCD)	6.29 kg/m ²	3.03 kg/m ²
£158 (Cost for primary care VLCD)	1 kg/m ²	0.48 kg/m ²

15 Literature suggests that the HRQoL improvements associated with BMI reductions may be higher for
16 individuals with type-2 diabetes (T2D).³⁰ Using the T2D specific estimate detailed in Lee et al,³⁰ Table
17 26 details the BMI change needed for VLCDs to be cost effective at a £20,000 per QALY threshold for
18 individuals with T2D.

19 **Table 26: BMI change needed for VLCD to be cost-effective at a £20,000 per QALY threshold**
20 **(people with T2D)**

Cost/Effect	0.01 (lower estimate for quality of increase per BMI unit change)	0.0164 (upper estimate for quality of increase per BMI unit change)
£759 (lower estimate for tier 3 VLCD)	3.80 kg/m ²	2.31 kg/m ²
£1567 (Upper estimate for tier 3 VLCD)	7.84 kg/m ²	4.78 kg/m ²

21 Other considerations:

22 Firstly, this analysis only considers the costs associated with the VLCD, and only HRQoL changes
23 associated with weight change. In reality the probability of a person experiencing comorbidities is
24 likely to decrease as they lose weight. By reducing these comorbidities the individual will achieve a
25 higher HRQoL, for example weight loss may improve osteoarthritis related knee pain or improve
26 obesity related sleep apnoea, and costs to the NHS will fall. For example reducing BMI results in
27 lower prescriptions costs as outlined in a study by the counterweight project team.⁸ The study
28 showed that unit BMI decreases from 40 kg/m² can reduce prescription costs by £5 - £8 per year.

- 1 Secondly, in this analysis, the HRQoL increases per unit change in BMI reflect an assumed linear
- 2 relationship between BMI and HRQoL. A study by Hunger et al¹⁹ shows that HRQoL is sensitive to
- 3 changes in BMI between 30 – 40 kg/m² however is fairly unresponsive to changes between a BMI of
- 4 40 – 45 kg/m². If the weight change from a VLCD was the same for all BMI values then this analysis
- 5 would suggest that they are less likely to be cost effective for individuals with a BMI above 40 kg/m².
- 6 Finally the above analysis does not take into account any adverse effects that could arise from a
- 7 VLCD. These could reduce HRQoL and increase costs to the NHS.

6.2.3 Evidence statements

6.2.3.19 Clinical

- 10 • Low to very low quality evidence showed that there may be no clinical difference between VLCD
- 11 and standard dietary advice in:
 - 12 o % ideal weight loss (1 study, n=110)
 - 13 o Withdrawals (7 studies, n=487)
 - 14 o Weight in BMI change from start of study to end of weight maintenance period (1 studies,
 - 15 n=33)
 - 16 o Weight in kg change from start of study to end of weight maintenance period (7 studies,
 - 17 n=373)
 - 18
- 19 • However, low to very low evidence showed that there may be a clinical benefit for VLCD in:
 - 20 o Weight in kg change from start of study to end of VLCD period (5 studies, n=265)
 - 21 o Weight in BMI change from start of study to end of VLCD period (2 studies, n=112)
 - 22
- 23 • No evidence was found for health related quality of life outcome.

6.2.3.24 Economic

- 25 • No relevant economic evaluations were identified.
- 26 • An original comparative cost analysis showed that:
 - 27 o For obese individuals with co-morbidities:
 - 28 o Using the lowest cost estimate for VLCDs and the highest quality of life estimate for unit
 - 29 decreases in BMI, a VLCD would need to reduce BMI by 2.31 kg/m² and sustain this for one
 - 30 year, to be considered cost effective at a £20,000 per QALY threshold.
 - 31 o Using the highest cost estimate for VLCDs and the lowest quality of life estimate for unit
 - 32 decreases in BMI, a VLCD would need to reduce BMI by 7.84 kg/m² and sustain this for one
 - 33 year, to be considered cost effective at a £20,000 per QALY threshold.
 - 34 o For obese individuals without co-morbidities:
 - 35 o Using the lowest cost estimate for VLCDs and the highest quality of life estimate for unit
 - 36 decreases in BMI, a VLCD would need to reduce BMI by 0.48 kg/m² and sustain this for one
 - 37 year, to be considered cost effective at a £20,000 per QALY threshold.
 - 38 o Using the highest cost estimate for VLCDs and the lowest quality of life estimate for unit
 - 39 decreases in BMI, a VLCD would need to reduce BMI by 6.29 kg/m² and sustain this for one
 - 40 year, to be considered cost effective at a £20,000 per QALY threshold.
 - 41 o This analysis was considered directly applicable with potentially serious limitations.

6.2.4 Review question: In people who are overweight or obese, what is the safety of very-low-calorie diets when used to reduce weight and maintain weight loss?

3 For full details see review protocol in Appendix C.

4 Table 27: PICO characteristics of review question

Population	Overweight or obese people
Intervention(s)	Very-low-calorie diet (≤800 calories per day)
Comparison(s)	Standard dietary advice: - low-calorie diet (>800-1200 calories per day) - 500-800 calorie deficit diet
Outcomes	Critical: 1. Disordered eating at latest follow up 2. Depression score at latest follow up 3. Postural hypotension at latest follow up Important: 4. Bone density at latest follow up 5. Constipation at latest follow up 6. Gall stones at latest follow up 7. Gout at latest follow up 8. Diarrhoea at latest follow up 9. Hypoglycaemia at latest follow up
Study design	RCT or systematic review of RCTs

6.2.5 Clinical evidence

6 Six studies were included in the review.^{4,17,52,60,61,64} These are summarised in Table 28 below.

7 Evidence from these studies is summarised in the clinical evidence summary below (Table 29). See
8 also the study selection flow chart in Appendix D, study evidence tables in Appendix G, forest plots in
9 Appendix I, GRADE tables in Appendix O and excluded studies list in Appendix J.

10 Mean BMI ranged between 31.9 and 39 kg/m² in most studies^{4,17,52,60,64} but 1 study⁶¹ had mean BMI
11 of 40 and 44 kg/m² in VLCD and LCD arms, respectively. Two studies reported on specific populations:
12 1 on participants with type 2 diabetes,⁶⁴ and another on participants with osteoarthritis.⁵²

13 All included studies compared VLCD to LCD but the length of VLCD varied (from 8 to 12 weeks) as
14 well as the number of calories included (ranging from 400-520 kcal/d). The range of calories included
15 for a LCD varied from 810 kcal/d to 1500 kcal in 1 study. The studies also varied in whether or not
16 the VLCD treatment period included some time on a LCD (before or after the VLCD).

17 Furthermore, 4^{52,60,61,64} studies included behavioural therapy as part of the treatment in both arms
18 and 2 of these studies included exercise as well.

19 One study reported on binge eating scores (with the Binge Eating Scale), 1 aspect of disordered
20 eating scale⁶⁰. However, no studies reported on other aspects of disordered eating such as night
21 eating syndrome and bulimia nervosa.

22 Three studies^{60,61,64} reported final depression scores on Beck's Depression Inventory at different time
23 points ranging from 4 months to 1 year. Since depression scores were expected to be different
24 sooner after treatment when patients have achieved the most weight loss (18 weeks as in one study)
25 than at 1 year when they may have gained back some weight (as in another study), results were
26 presented separately for different time points.

- 1 One study⁵² reported the proportion of people with depressive tendencies at the end of the study
- 2 but it was not clear how many of these individuals had depressive tendencies at the start of the
- 3 study.

- 4 One study each reported on gallstones¹⁷, uric acid levels (gout)⁴, diarrhoea⁵², and constipation⁵² (an
- 5 additional study⁶⁴ reported levels of uric acid but only in the VLCD group).

- 6 However, none of the included studies reported comparative data from the following outcomes from
- 7 the protocol: postural hypotension, bone mineral density, or hypoglycaemia.

- 8

1 Table 28: Summary of studies included in the review

Study	Intervention/comparison	Length of intervention (length of follow-up)	Population	Outcomes	Comments
Arai 1992 ⁴ Japan	-4 to 8 week VLCD (419 kcal) (n=20) - 4 to 8 week LCD (839-1199 kcal) (n=25)	4-8 weeks	Obese adults (n=45) Mean BMI: 37 kg/m ² (SD 4) VLCD 36 kg/m ² (SD 6) LCD	Serum uric acid Marked serum uric acid (dichotomous)	No details on whether patients also received behavioural treatment. No comment on the incidence of clinical gout.
Gebhard 1996 ¹⁷ USA	-12-week VLCD (520 kcal) (n=6) -12-week LCD (900 kcal) (n=7) (both were then gradually transitioned from liquid to solid 1000 kcal/d at 18 weeks and 1500 kcal/d at 24 weeks)	24 week program	Obese adults (n=13) Mean BMI: 37 kg/m ² (SD 4) VLCD 36 kg/m ² (SD 6) LCD	Gallstones (dichotomous)	24-week program included weekly meetings, diary and compliance review by an experienced dietitian and periodic evaluation by a physician.
CAROT study (Rieke 2010) ⁵² Denmark	-8-week VLCD (415 kcal) (n=96) -8-week LCD (810) (n=96) (+behavioural therapy for both) (both followed by 8-week LCD [1200 kcal/d])	16 weeks	Obese adults with knee osteoarthritis (n=192) Mean BMI: 37.3 kg/m ² (SD 4.8, range 30.1-54)	Constipation (dichotomous) Depression tendencies (dichotomous) Diarrhoea (dichotomous)	Nutritional instructions and behaviour therapy by an experienced dietitian at weekly sessions through 16 weeks (1.5 hours).
Wadden 1990 ⁶¹ USA	1200 kcal/d for 4 weeks then randomisation to: -8-week VLCD (400-500 kcal/d) then 10-week LCD (1200 kcal/d) -18-week LCD (1200 kcal/d) (+behavioural therapy for both)	18 weeks	Obese women (n=15) Mean BMI: 40.7 kg/m ² (SD 10) VLCD 44.6 kg/m ² (SD 9) LCD	Depression score (continuous)	Behavioural therapy consisted of weekly group sessions (1.5 hours) of 4-7 subjects led by a doctoral-level clinical psychologist.

Study	Intervention/comparison	Length of intervention (length of follow-up)	Population	Outcomes	Comments
Wadden 1994 ⁶⁰ USA	-12-week VLCD (420 kcal/d) then LCD (1200 kcal/d) for 48 weeks -52-week LCD (1200 kcal/d) (+ behavioural therapy and exercise programme for both)	52 weeks (+26 weeks follow-up)	Obese women (n=49) Mean BMI: 39.46 kg/m ² (40.01 kg/m ² [SD 5.73] VLCD, 38.80 kg/m ² [SD 5.39] LCD)	Binge eating score (an aspect of disordered eating) (continuous) ^a Depression score (continuous) ^a	Behavioural therapy consisted of weekly group sessions 6-9 subjects led by a doctoral-level clinical psychologist or a psychology graduate student. Exercise programme started at week 8; it consisted mostly of walking (increase from 10-20 minutes for 2-3times/wk to 20-40 min 3-5 times/wk at week 52).
Wing 1991 ⁶⁴ USA	-20-week VLCD program: - 4-week LCD (1000-1500 kcal) - 8-week VLCD (400 kcal/d) - 4 weeks of gradual introduction of other foods - 4-week LCD (1000-1500 kcal) -20-week LCD (1000-1500 kcal/d) (+ behavioural therapy and exercise for both)	20 weeks (+1 year follow-up)	Obese adults with type 2 diabetes (n=36) Mean BMI: 37.34 kg/m ² (SD4.7) VLCD 38.10 kg/m ² (SD 5.7) LCD	Depression score (continuous) ^b Levels of uric acid 'Marked' uric acid levels ^c	Behavioural therapy consisted of weekly group sessions for the treatment period led by a team of therapists around diet, exercise and behaviour modification. Exercise was recommended and subjects given weekly goals (starting from 210 J/wk [~50 kcal] to 4200 J/wk [~1000 kcal]). No subjects developed clinical symptoms of gout. Only 1 patient had a uric acid level greater than 594 umol/L.

- 1 (a) These outcomes were only reported at 52 weeks of treatment (not after the additional 26-weeks of follow-up)
- 2 (b) The study states that the outcome was reported at '4 and 5 months' (not otherwise explained)
- 3 (c) Unclear how this was defined in the study

1 Table 29: Clinical evidence summary: VLCD versus LCD (both with or without behavioural and/or exercise therapy) for overweight and obese people

Outcome	Number of studies	Imprecision	GRADE rating	Absolute Difference	Control event rate (per 1000)	Control event rate for continuous outcomes
Binge eating a	1	Serious	Very low	MD 6.32 higher (1.68 to 10.96 higher)	n/a	12
Depression score at 4 to 5 months b, c (continuous)	2	Very serious	Very low	MD 2.03 lower (11.09 lower to 7.03 higher)	n/a	5.95
Depression score at 1 year b (continuous)	1	Serious	Very low	MD 3.32 higher (1.22 lower to 7.86 higher)	n/a	5
Depressive tendencies (dichotomous)	1	Very serious	Very low	36 more per 1000 (from 16 fewer to 238 more)	34 per 1000	n/a
Postural hypotension	-	-	-	-	-	-
Constipation	1	Very serious	Very low	45 more per 1000 (from 73 fewer to 230 more)	281 per 1000	n/a
Gall stones	1	Serious	Low	670 more per 1000 (from 270 fewer to 1060 more)	0 per 1000	n/a
Serum uric acid (continuous)	1	Serious	Very low	MD 23.6 lower (72.17 lower to 24.97 higher)	-	306.8 µmol/L
'Marked' d serum uric acid concentration	1	Serious	Very low	350 more per 1000 (from 140 higher to 560 higher)	0 per 1000	-
Diarrhoea	1	Very serious	Very low	13 more per 1000 (from 23 fewer to 170 more)	34 per 1000	n/a

2 (a) One aspect of disordered eating which was the outcome specified in the protocol (no other data found); measured with Binge Eating Scale.

- 1 (b) Beck's Depression Inventory
- 2 (c) Includes a study reporting this outcome at 18 weeks and another at '4 to 5 months'; the later appears to be an average of results through these months
- 3 (d) The level considered 'marked' was not described in study

4

5

6.2.6 Economic evidence

- 2 See review on the effectiveness of VLCD for economic evidence.

6.2.7 Evidence statements

6.2.7.14 Clinical

- 5 • VLCDs may result in more binge eating after one year compared to LCDs (1 study, n=45, very low
6 quality).
- 7 • It is unclear if depression is worse after VLCDs than after LCDs (3 studies, n=100, very low quality).
- 8 • There were more participants with 'depressive tendencies' after VLCDs than after LCDs (1 study,
9 n=192, very low quality).
- 10 • Constipation (1 study, n=192, very low quality) and diarrhoea (1 study, n=192, very low quality)
11 may be more frequent after VLCDs than LCDs.
- 12 • Gallstones occurred in some people during or after VLCDs but not with LCDs; however this was
13 only symptomatic in 1 individual (1 study, n=13, low quality).
- 14 • There were similar serum uric acid levels in VLCDs and LCDs; however, more participants with
15 VLCDs had 'marked' increases in serum uric acid at some point during treatment but these were
16 not correlated with episodes of gout (1 study, n=45, very low quality).
- 17 • There was no evidence on postural hypotension, bone density, or hypoglycaemia.

6.2.7.28 Economic

- 19 • No relevant economic evaluations were identified.

6.2.8 Review question: What are effective management strategies for maintaining weight loss after very low calorie diets in people who are overweight or obese?

22 For full details see review protocol in Appendix C.

23 Table 30: PICO characteristics of review question

Population	Adults (18 years old and over) Children (over 2 years)
Intervention(s)	All participants have a lead-in period on a very low calorie diet (VLCD; ≤800 kcal) for 6-12 weeks before randomisation. Intervention: maintenance strategy: <ul style="list-style-type: none"> • Anti-obesity drugs • Exercise • Diet • Behavioural therapy • Combinations of above
Comparison(s)	Standard dietary advice (control) Placebo Other maintenance strategies
Outcomes	% weight change (kg) from end of VLCD to end of study Health related quality of life Withdrawals % change in body mass index (BMI) from end of VLCD to end of study

	% weight change from before VLCD to end of study (kg)
	% change in BMI from before VLCD to end of study
	Improvement in physical activity
Study design	RCT or systematic review of RCTs

- 1 A minimum study duration of 1 year was required for study inclusion because that was considered
- 2 necessary to assess long-term maintenance of weight loss.

6.2.9 Methods summary

4 The protocol included a range of interventions (behavioural therapy, anti-obesity drugs, diet), which
5 should not be combined in a meta-analysis and were reported separately. The protocol also treated
6 separately comparisons with no treatment and placebo.

7

8 The various interventions were clustered into 6 main comparisons:

- 9 1. behavioural therapy and different re-feeding techniques [Agras 1996]
- 10 2. hypocaloric diet (1600 kcal/day), with additional 238 kcal VLCD diet (total 1838 kcal/day)
11 [Ryttig 1997] or including VLCD sachet (total 1600 kcal/day) [Ryttig 1995]
- 12 3. dietary counselling with exercise versus dietary counselling only [Borg 2002, Fogelholm 2000]
- 13 4. Orlistat with or without dietary and lifestyle counselling versus dietary and lifestyle
14 counselling or meal replacement [LeCheminant 2005, Richelsen 2007]; and, Orlistat with
15 dietary and lifestyle counselling versus dietary and lifestyle counselling only [Richelsen 2007]
- 16 5. high protein diet versus high carbohydrate diet [Delbridge 2009]
- 17 6. interventions compared to no treatment: Sertraline versus placebo [Wadden 1995], high
18 protein diet versus no treatment [Lejeune 2005], fibre diet versus no treatment [Pasman
19 1997]

20

21 The duration of VLCD varied from 1 to 6 months and this may influence the effectiveness of
22 maintenance regimens. Similarly, the length of maintenance regimen and follow-up also varied (1
23 year was inclusion criteria, maintenance ranged up to 3 years).

24

25 The protocol specified the outcomes, % weight change (kg) from end of VLCD to end of study and %
26 change in body mass index (BMI) from end of VLCD (called 'baseline') to end of study. The GDG
27 considered as alternative outcomes, the weight at the end of the study or the weight change from
28 before VLCD to the end of study or from the end of VLCD to the end of study. The GDG considered
29 the outcomes in relation to the weight at baseline (that is, at the end of VLCD), end of treatment and
30 end of follow-up. Another protocol outcome was withdrawals at baseline, end of treatment and end
31 of follow-up. It was important to distinguish between withdrawals due to maintenance strategy or
32 due to other circumstances.

33

34 In addition to the forest plots for each individual pairwise comparison, 2 forest plots summarising all
35 comparisons in the literature were presented to the GDG: 1 including all head-to-head trials and 1
36 including all trials with interventions against either no treatment or no placebo.

37

6.2.10 Clinical evidence

39 10 papers were included in the review.^{2,5,11,16,29,31,46,51,54,55}

40

41 4 studies reported on sub populations: 3 with all female participants (Agras 1996, Fogelholm 2000,
42 and Pasman 1997) and 1 with male participants (Borg 2002). Furthermore, 5 studies did not have a
43 minimum weight loss for inclusion in the maintenance phase of the study. There were differences in
44 weight (kg) at baseline between treatment arms; for example, Ryttig 1995 reported a 12 kg
45 difference between the 2 separate intervention arms.

1

2 Only 1 study reported the protocol % change outcomes,⁴⁶ and the rest reported the alternative
3 outcomes. Most studies reported withdrawals from maintenance; however, it was often unclear
4 whether they were withdrawals due to maintenance strategy or due to other circumstances. None of
5 the included studies reported on health-related quality of life. Two studies reported physical activity
6 as an outcome^{5,16} but as both studies were exercise interventions and this outcome was only
7 reported during the study, the results are more about adherence to the exercise regimen rather than
8 improved physical activity after the maintenance programme had completed.

9

1 Table 31: Summary of studies included in the review

Study	Intervention/comparison	Population	Outcomes	Comments
Agras1996 ²	<p>Weight loss phase: 3 months, 800 kcal (n=201) Included in maintenance if ≥5% weight loss Randomised into one maintenance strategy (n= 194):</p> <ul style="list-style-type: none"> • behaviour therapy + standard food re-feeding (time dependent) • behaviour therapy + standard food re-feeding (weight dependent) • behaviour therapy + pre-packaged re-feeding (time dependent) • behaviour therapy + pre-packaged re-feeding (weight dependent) 	Overweight women (unclear definition)	Weight change in kg, withdrawals	All had concurrent behaviour therapy (modifying their own food intake, increased physical activity levels, eating slower) weekly for first 3 months, fortnightly for the next 3 months and then monthly for the last 3 months of treatment.
Borg2002 ⁵	<p>Weight loss phase: 2 months: 1 week LCD 1200, 6 week VLCD 500, 1 week LCD 1200 (n=90) (no minimum weight loss for inclusion in maintenance reported) Randomised into one maintenance strategy (n= 82):</p> <ul style="list-style-type: none"> • dietary counselling + walking • dietary counselling + resistance training • control (dietary counselling) 	Men (BMI >30 kg/m ²), between 35-50 year	Weight in kg (final value, adjusted ANCOVA), withdrawals	All patients attended weekly meetings in small groups where problems with diet and prevention of relapses were discussed. Patients were instructed to follow a low-fat and high carb diet. They received written educational material monthly.
Delbridge2009 ¹¹	<p>Weight loss phase: 3 months, ~500-550kcal (n= 180) Included in maintenance if ≥10% weight loss Randomised into one maintenance strategy (n= 141):</p> <ul style="list-style-type: none"> • High protein diet • High carbohydrate diet 	Obese patients (BMI ≥30 or ≥27 with comorbidities), ≥18-to ≤75 yr	Weight change from before VLCD to end of weight maintenance period (kg), weight change (kg) from end of VLCD period to end of weight maintenance period, withdrawals	Both groups advised to reduce fat intake to <30% of their intake, monthly counselling sessions, encouraged to practice healthy behaviours such as aerobic exercise ≥3 times/wk.

Study	Intervention/comparison	Population	Outcomes	Comments
Fogelholm2000 ¹⁶	Weight loss phase: 2 months: 1 wk LCD 1200, 6 wk VLCD 500, 1 wk LCD 1200 (n= 85) (no minimum weight loss for inclusion in maintenance reported) Randomised into one maintenance strategy (n= 82): <ul style="list-style-type: none"> • dietary counselling + exercise (target 1000kcal) • dietary counselling + exercise (target 2000kcal) • control (dietary counselling) 	Pre-menopausal women (BMI 30-45 kg/m ²), between 30-45 yr	Weight in kg (final value), adjusted ANCOVA), withdrawals	
LeCheminant2005 ²⁹	Weight loss phase: 3 months: 520 kcal (n= 157) (no minimum weight loss for inclusion in maintenance reported) Randomised into one maintenance strategy (n= 147): <ul style="list-style-type: none"> • Meal replacement • Orlistat 	Overweight or obese (≥28 BMI), 19-70 yr	Weight in kg (final score), withdrawals	
Lejeune2005 ³¹	Weight loss phase: 1 months: ~500 kcal (n= 140) Included in maintenance if 5-10% weight loss Randomised into one maintenance strategy (n= 120): <ul style="list-style-type: none"> • Protein • Control 	Moderately overweight (25-35 BMI), 18-60 yr	Weight change (kg), withdrawals	
Pasman1997 ⁴⁶	Weight loss phase: 2 months: ~477 (n= 48) Included in maintenance if >5kg body weight Randomised into one maintenance strategy (n= 41): <ul style="list-style-type: none"> • Fibre diet • No treatment (control) 	Obese female (no further details of inclusion)	Weight in kg (final score), weight in BMI (final score), withdrawals	
Richelsen2007 ⁵¹	Weight loss phase: 8 wk, 600-800 kcal (n= 383) Included in maintenance if >5% weight loss	Obese (BMI >30 and <45), 18-65 yr	Weight change from start of study to end	Instructed to follow a standard energy-restricted diet (600 kcal

Study	Intervention/comparison	Population	Outcomes	Comments
	Randomised into one maintenance strategy (n= 309): <ul style="list-style-type: none"> • Dietary and lifestyle counselling with orlistat • Dietary and lifestyle counselling with placebo 		of weight maintenance period (kg), weight change (kg) from end of VLCD period to end of weight maintenance period, withdrawals	daily deficit) during maintenance phase. Dietician provided dietary and lifestyle counselling. Advised to reduced fat to ~30% of total energy and engage in daily physical activity.
Rytigg1995 ⁵⁵	Weight loss phase: 3 months, 330 kcal (n= 114) (no minimum weight loss for inclusion in maintenance reported) Randomised into one maintenance strategy (n= 60): <ul style="list-style-type: none"> • Hypocaloric diet (1600 kcal) with VLCD (220 of the 1600 kcals) • Standard hypocaloric diet (1600 kcal) 	Obese (>30 BMI), 19-65 yr	% weight change from start of study to end of weight maintenance period (kg), weight in kg (change score), withdrawals	Standard hypocaloric diet group had higher baseline weight, both before VLCD (120.1 (22.5) vs. 108.1 (15.8)) and after VLCD (97.6 (19.1) vs. 85.7 (14.7)).
Rytigg1997 ⁵⁴	Weight loss phase: 2 months, 420 kcal (n= 81) (no minimum weight loss for inclusion in maintenance reported) Randomised into one maintenance strategy (n= 81): <ul style="list-style-type: none"> • Hypocaloric diet (1600 kcal) with VLCD (238 kcals) • Standard hypocaloric diet (1600 kcal) 	Obese (≥30 BMI), 21-64 yr	% weight change from start of study to end of weight maintenance period (kg), weight in kg (final score), withdrawals	

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1 Table 32: Summary of studies included in the review: weight in kg

Study	Mean kg - baseline	Mean kg – end of VLCD period	Mean kg – end of weight maintenance period
Agras 1996	Baseline, overall: <ul style="list-style-type: none"> • 100.3 kg (14) • 36.6 BMI (4.4) 	After treatment, 12 weeks: <ul style="list-style-type: none"> • time-dependent regular food condition: -15.2 kg (4.8, n= 47) • weight-dependent regular food condition: -15.0 (4.8 n= 45) • time-dependent stimulus narrowing condition - 14.9 (4.5, n= 38) • weight-dependent stimulus narrowing condition: - 14.2 (4.1, n= 44) 	Last follow-up, 18 months: <ul style="list-style-type: none"> • time-dependent regular food condition: -8.2 kg (12.3, n= 45) • weight-dependent regular food condition: -8.6 (11.8, n= 41) • time-dependent stimulus narrowing condition -6.0 (11.1, n= 34) • weight-dependent stimulus narrowing condition: - 2.8 (18.3, n= 42)
Borg 2002	Baseline: <ul style="list-style-type: none"> • All: 106.0 kg (9.9) 	At 8 weeks (post lead in): <ul style="list-style-type: none"> • All: 91.7 kg (9.4) • Control: 92.3 kg (10.5) • Walking: 91.9 kg (9.3) • Resistance: 90.8 kg (8.6) 	At 8 months (post intervention): <ul style="list-style-type: none"> • Control: 99.9 kg (11.1) • Walking: 93.7 kg (10.7) • Resistance: 91.1 kg (8.0)
Delbridge 2009	Baseline: <ul style="list-style-type: none"> • Treatment HC: 109.4 kg (2.6) • Comparator HP: 114.0 kg (3.0) 	After 12 week lead in: <ul style="list-style-type: none"> • All: -16.5 kg (0.5) • Treatment HC: -17.6 kg (0.8) [91.8 kg] • Comparator HP: -17.4 kg (0.7) [96.6 kg] 	12 month follow-up: <ul style="list-style-type: none"> • Treatment HC: -14.3 kg (2.0) [95.1 kg] • Comparator HP: -14.8 kg (1.5) [99.2 kg]
Fogelholm 2000	Baseline: <ul style="list-style-type: none"> • All: 92.0 kg (9.8) <p>(weight loss after 12 week weight reduction phase was 13.1 kg (3.5))</p>	Start of weight maintenance program: <ul style="list-style-type: none"> • Control: 80.0 kg (9.5) • Walk 1: 78.0 kg (8.8) • Walk 2: 78.2 kg (11.6) <p>End of weight maintenance program (40 weeks):</p> <ul style="list-style-type: none"> • Control: 82.0 kg (10.2) • Walk 1: 77.3 kg (10.7) • Walk 2: 77.6 kg (11.1) 	End of follow-up (24 months): <ul style="list-style-type: none"> • Control 89.7 kg (9.6) • Walk 1: 83.9 kg (12.2) • Walk 2: 87.4 kg (15.3)
Lejeune	Baseline:	After 26 week weight maintenance:	Weight loss at 6 month follow up:

Study	Mean kg - baseline	Mean kg – end of VLCD period	Mean kg – end of weight maintenance period
2005	<ul style="list-style-type: none"> • Protein: 83.1 kg (11.1) • Carbohydrate: 83.4 kg (10.4) <p>After 4 week VLED:</p> <ul style="list-style-type: none"> • Protein: 76.7 kg (9.9) • Carbohydrate: 77.3 kg (9.9) 	<ul style="list-style-type: none"> • Protein: 77.5 kg (11.8) • Carbohydrate: 80.3 kg (11.6) 	<ul style="list-style-type: none"> • Protein: -5.5 (0.9) [77.6 kg] • Carbohydrate: -2.6 (1.2) [80.8 kg] (calculated from graph)
LeCheminant 2005	<p>Weight loss from baseline to end of 16 week VLCD:</p> <ul style="list-style-type: none"> • Meal replacement: -22.8 kg (6.1) • Orlistat: -22.3 kg (6.1) <p>(from text, actual baseline weights not reported)</p>	<p>At week 16, randomisation to treatment arm:</p> <ul style="list-style-type: none"> • Meal replacement: 85.4 kg (14.3) • Orlistat: 85.7 kg (17.9) 	<p>12 months, end of treatment:</p> <ul style="list-style-type: none"> • Meal replacement: 88.1 kg (16.5) • Orlistat: 88.5 kg (20.3)
Pasman 1997	<p>Baseline:</p> <ul style="list-style-type: none"> • All: 88.7 kg (10.4) • Fibre: 88.4 kg (9.559) • Control: 89.4 kg (12.6) 	<p>End of VLCD, 8 weeks:</p> <ul style="list-style-type: none"> • Fibre: 77.95 kg (8.429) • Control: 78.3 kg (10.6) 	<p>End of study, 14 months:</p> <ul style="list-style-type: none"> • Fibre: 87 kg (11.78) • Control: 85.0 kg (12.0)
Richelsen 2007	<p>Baseline:</p> <ul style="list-style-type: none"> • Orlistat: 110 kg (75-162) • Placebo: 112 kg (78-152) 	<p>End of VLED, 8 weeks:</p> <ul style="list-style-type: none"> • Placebo: -14.3 kg (12) [95.7 kg] • Orlistat: -14.5 kg (13) [97.5 kg] 	<p>36 month follow-up:</p> <ul style="list-style-type: none"> • Placebo: -7.2 kg (6.3) [102.8 kg] • Orlistat: -9.4 kg (8.3) [102.6 kg]
Ryttig 1995	<p>Baseline:</p> <ul style="list-style-type: none"> • All: 112.4 kg (19.8) • Hypocaloric diet: 108.1 kg(15.8) • Control: 120.1 kg (22.5) 	<p>Start of weight maintenance (12 week VLCD):</p> <ul style="list-style-type: none"> • Hypocaloric diet: 85.7 kg (14.7) • Control: 97.6 kg (19.1) 	<p>End of weight maintenance (12 months):</p> <ul style="list-style-type: none"> • Hypocaloric diet: +8.0 kg (8.2) • Control: +12.3 kg (9.7)
Ryttig 1997	<p>Baseline:</p> <ul style="list-style-type: none"> • Hypocaloric diet: 116.2 kg (21.0) • B) VLCD run in, hypocaloric only & C) VLCD run in, hypocaloric, plus VLCD: 113.2 kg (17.7) 	<p>VLCD run in (8 weeks):</p> <ul style="list-style-type: none"> • Hypocaloric diet: 109.0 kg (18.9) • B) VLCD run in, hypocaloric only & C) VLCD run in, hypocaloric, plus VLCD: 94.0 kg (13.9) 	<p>End of the programme (26 months):</p> <ul style="list-style-type: none"> • Hypocaloric diet: 110.7 kg (17.4) • VLCD run in, hypocaloric only: 107.3 kg (15.1) • VLCD run in, hypocaloric, plus VLCD: 107.5 kg (16.9)

1 Table 33: Summary of studies included in the review: withdrawals

Study	Baseline	End of VLCD period	End of weight maintenance period	Explanation for withdrawals	Other measures of adherence
Agras 1996	Entered study, n= 201 6 dropped during run in VLCD 1 did not meet entry criteria (i.e. 5% reduction)	n= 194 (stratified on BMI and % weight loss during VLCD and allocated to one of four groups) • 12 dropped during treatment	Post-treatment, n= 182 • 5 dropped during follow-up • incomplete data, n= 3 Final n= 174	Of the 17 dropped post-randomisation: • time-dependent regular food condition • weight-dependent regular food condition • 7 time-dependent stimulus narrowing condition • weight-dependent stimulus narrowing condition	Attendance at treatment sessions post-randomisation, 3-month reintroduction of food phase, and treatment.
Borg 2002	Completed weight reduction phase (2 months), n= 90	Completed weight maintenance phase (6 months), N= 82 • Control: n= 29 • Walking: n= 25 • Resistance: n= 28	Measured at the end of follow-up (23 months), N= 68 • Control: n= 22 • Walking: n= 20 • Resistance: n= 26	Due to lack of time or interest None due to illness or injuries related to the intervention program. No difference in dropout rates between study groups.	Physical activity Energy intake (food diary)
Delbridge 2009	Entered study, n= 180 During 3-month lead in: • 1 failed screening criteria (diagnosis of hemochromatosis •	Started 12 month treatment, n= 141 • High Carbohydrate: n= 70 • High Protein: n= 71	High Carbohydrate: n= 40 • 29 withdrew • 1 did not proceed (decided not to continue after randomisation)		Compliance with dietary recommendations assessed with food diaries and by the objective measures of urea excretion and weight maintenance Attrition

Study	Baseline	End of VLCD period	End of weight maintenance period	Explanation for withdrawals	Other measures of adherence
	<ul style="list-style-type: none"> • 14 failed to lose $\geq 10\%$ body weight • 4 lost $\geq 10\%$ body weight but withdrew 		High Protein: n= 42 <ul style="list-style-type: none"> • 26 withdrew • 3 excluded (poor compliance with protocol; did not attend a sufficient number of study visits) 		
Fogelholm 2000	Entered study, n= 85 <ul style="list-style-type: none"> • dropped during 12 week weight reduction run in Randomised to 40 week weight maintenance phase, n= 82 <ul style="list-style-type: none"> • Control: 29 • Walk 1: 26 • Walk 2: 27 	Completed 40 week program, n= 80 <ul style="list-style-type: none"> • Control: 28 • Walk 1: 25 • Walk 2: 27 	Completed 2 year follow up, n= 74 <ul style="list-style-type: none"> • Control: 27 • Walk 1: 24 • Walk 2: 23 		
Lejeune 2005	n= 140 recruited to study <ul style="list-style-type: none"> • 20 did not start study due to relocation, a change of job or inability to fulfil schedule • 7 dropped out because of difficulty maintaining the diet n= 113 began 4 week	Randomised to weight maintenance phase, 6 months, n= 113 <ul style="list-style-type: none"> • Protein: n= 53 • Carbohydrate: n= 60 	Follow-up, 6 months, n= 70 <ul style="list-style-type: none"> • Protein: n= 31 • Carbohydrate: n= 39 	No reason given for drop of 43 participants between entering weight maintenance phase and end of follow-up	

Study	Baseline	End of VLCD period	End of weight maintenance period	Explanation for withdrawals	Other measures of adherence
	VLCD run-in <ul style="list-style-type: none"> No report of dropouts 				
LeCheminant 2005	Enrolled in the study, 12 week VLED, n= 157 <ul style="list-style-type: none"> Meal replacement: N= 90 Orlistat: N= 67 	Randomised at week 16, n= 147 <ul style="list-style-type: none"> Meal replacement: N= 86 Orlistat: N= 61 	Completed all testing (36 weeks treatment), at week 52, n= 92 <ul style="list-style-type: none"> Meal replacement: N= 56 Orlistat: N= 36 	Failure to comply with study protocol, job-related conflicts, illness, and injury not related to the investigation.	Prescribed number of meal replacements: <ul style="list-style-type: none"> Women: 121 per week (86%) Men: 16.1 per week (>100%) Prescribed medication: <ul style="list-style-type: none"> Women: 12.6 pills per week (90%) Men: 13.4 pills per week (96%)
Pasman 1997	Entered study, n= 48 <p>Completed the 2 month VLCD run-in: n= 41</p> <ul style="list-style-type: none"> 7 unable to follow the strict VLCD regime <p>Entered the treatment phase, n= 39</p> <ul style="list-style-type: none"> 2 lost less than 5kg of body weight 	Randomly assigned to treatment arm, n= 39 <p>Fibre supplement, n=25</p> <p>Non-treatment group, n= 14</p> <ul style="list-style-type: none"> 1 not able to come for test at month 10 1 became pregnant 1 spinal cord operation 5 dropped out due to personal circumstances 	Completed treatment (complete data for), n= 31	Total drop, n= 17	Compliance of fibre intake (questionnaire): <ul style="list-style-type: none"> Consumed more than 80% of supplement amount of fibre, n= 10 Consumed between 50-80% of required fibre, n= 10 Control, n= 11
Richelsen 2007	Met eligibility criteria and started VLED treatment, n= 383	Achieved ≥5% weight loss after 8 weeks VLED, n= 309 <ul style="list-style-type: none"> Orlistat: n= 153 Placebo: n= 156 	No specific mention of how many participants completed the treatment and had data at follow-up (36 months).		Premature withdrawals were similar in the orlistat (33.3%) and the placebo group (37.2%) during the 3-year trial.

Study	Baseline	End of VLCD period	End of weight maintenance period	Explanation for withdrawals	Other measures of adherence
Ryttig 1995	<p>Entered study, n= 60</p> <p>Failed to complete VLCD (12 weeks), n= 8 (all female)</p> <ul style="list-style-type: none"> • became pregnant • could not accept the VLCD and discontinued after 6 weeks • 2 did not show up • 1 became depressed • 1 hospitalised due to myocarditis • (also, during VLCD, due to severe hunger feelings, 2 patients received transiently one extra sachet of the Cambridge diet per day) 	<p>Entered study, n= 52</p> <p>Discontinued prematurely (5 females, 2 males), n= 7</p> <ul style="list-style-type: none"> • became pregnant • 1 due to a gastroplastic obesity operation • 4 did not show up 	<p>Completed trial, n= 45</p> <p>Hypocaloric diet with VLCD, n= 23</p> <p>Control, n= 22</p>		<p>Compliance: 75% of all patients remained in the whole 64-week programme.</p>
Ryttig 1997	<p>Started study, n= 81</p> <ul style="list-style-type: none"> • Hypocaloric diet: n= 27 • B) + C) VLCD run-in, n= 54 • VLCD run-in: • Hypocaloric only: n= 27 • C) Hypocaloric, plus VLCD: n= 27 	-	<p>Completed treatment, n= 42</p> <ul style="list-style-type: none"> • Hypocaloric diet: n= 16 • Hypocaloric only: n= 11 • C) Hypocaloric, plus VLCD: n= 15 	<p>4 patients in the VLCD groups discontinued the treatment prematurely during the first two months:</p> <p>2 due to side-effects of the VLCD preparation</p> <p>1 moved abroad</p> <p>1 due to epileptic seizure not related to the</p>	-

Study	Baseline	End of VLCD period	End of weight maintenance period	Explanation for withdrawals	Other measures of adherence
				treatment 39 patients discontinued the treatment before the 2-year follow-up (note – number completed and number discontinued do not match. Figures as reported in paper)	

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1 Table 34: Clinical evidence summary: head-to-head trials

Comparison	Number of studies	Length of maintenance period + follow-up	Weight in kg			Withdrawals		
			GRADE rating	Absolute Difference (GRADE rating)	Control quantity	GRADE rating	Withdrawals: Absolute Difference (GRADE rating)	Control event rate (per 1000)
Time dependent re-feeding vs. weight dependent re-feeding (all with behavioural therapy) (after 3 month VLCD)	1 ²	9 months maintenance + 6 month follow-up	VERY LOW	MD 0.9 higher (3.11 lower to 4.9 higher)	2.8 or 8.6 kg	VERY LOW	77 fewer per 1000	72 per 1000
Standard vs. pre-packaged re-feeding (all with behavioural therapy) (after 3 month VLCD)	1 ²	9 months maintenance + 6 months follow-up	VERY LOW	MD 3.59 higher (0.47 lower to 7.65 higher)	6 or 2.8 kg	VERY LOW	77 fewer per 1000	129 per 1000
Dietary counselling + exercise (1000 kcal or 2000 kcal burn) vs. dietary counselling only (after 3 month VLCD)	1 (but 2 arms) ¹⁶	~9 months maintenance + 24 month follow-up	VERY LOW	MD 4.25 lower (9.59 lower to 1.08 higher)	89.7 kg	VERY LOW	43 more per 1000	69 per 1000
Dietary counselling + exercise (1200 kcal or resistance) vs. dietary counselling only (after 2 month VLCD)	1 (but 2 arms) ⁵	6 months maintenance + 23 months follow-up	VERY LOW	MD 0.02 higher (6.18 lower to 6.22 higher)	100.7 kg	VERY LOW	106 fewer per 1000	241 per 1000
Orlistat vs meal replacement (after 3 month VLCD)	1 ²⁹	~ 8 months maintenance including follow-up	VERY LOW	MD 0.4 lower (8.32 lower to 7.52 higher)	88.5 kg	VERY LOW	83 fewer per 1000	463 per 1000
Orlistat + dietary and lifestyle counselling vs. dietary and lifestyle counselling only (after 2 month VLCD)	1 ⁵¹	36 months maintenance including follow-up	LOW	MD 2.4 lower (4.16 to 0.64 lower)	7 kg	MODERATE	40 more per 1000	333 per 1000

Comparison	Number of studies	Length of maintenance period + follow-up	Weight in kg			Withdrawals		
			GRADE rating	Absolute Difference (GRADE rating)	Control quantity	GRADE rating	Withdrawals: Absolute Difference (GRADE rating)	Control event rate (per 1000)
Hypocaloric diet (1600kcal) vs. meal replacement diet (1600kcal + 238kcal VLCD) vs. (after 2 month VLCD)	1 ⁵⁴	24 months maintenance including follow-up	VERY LOW	MD 0.2 lower (12.56 lower to 12.16 higher)	107.5 kg	LOW	147 more per 1000	444 per 1000
Hypocaloric diet (1600kcal) including 220 VLCD vs. Hypocaloric diet (1600kcal) (after 3 months VLCD)	1 ⁵⁵	12 months maintenance including follow-up	VERY LOW	MD 3 lower (7.92 lower to 1.92 higher)	12.3 kg	VERY LOW	92 more per 1000	69 per 1000
High protein vs high carbohydrate (after 3 month VLCD)	1 ¹¹	12 months maintenance	LOW	MD 1.3 lower (1.85 to 0.75 lower)	4.3 kg	VERY LOW	83 fewer per 1000	463 per 1000

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1 Table 35: Clinical evidence summary: intervention versus no treatment

Comparison	Number of studies	Length of maintenance period + follow-up	Weight in kg			Withdrawals		
			GRADE rating	Absolute Difference (GRADE rating)	Control quantity	GRADE rating	Withdrawals: Absolute Difference (GRADE rating)	Control event rate (per 1000)
Fibre vs no treatment (after 2 months VLCD)	1 ⁴⁶	14 months maintenance including follow-up	VERY LOW	MD 2 higher (6.77 lower to 10.77 higher)	85 kg	VERY LOW	15 fewer per 1000	214 per 1000
High protein diet (18-20% of energy/day) vs no treatment (after 1 month VLCD)	1 ³¹	6 months maintenance + 6 months follow-up	LOW	MD 2.9 lower (3.39 to 2.41 lower)	-2.6 kg	LOW	67 more per 1000	350 per 1000

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6.2.11 Economic evidence

- 2 See review on the effectiveness of very-low-calorie diets for economic evidence.

6.2.12 Evidence statements

6.2.12.14 Clinical

- 5 • Behavioural therapy and re-feeding: maintenance strategy did not result in clinical benefit, with
6 greater weight regain (1 study, n= 201, very low quality)
- 7 • Orlistat: when compared with both meal replacement and dietary and lifestyle counselling only,
8 the use of orlistat resulted in less weight regain (2 studies, n= 540, moderate to very low quality)
- 9 • Dietary counselling with or without exercise: dietary counselling, plus exercise (100 kcal or 200
10 kcal burn) was a more effective weight loss maintenance strategy than dietary counselling alone
11 (2 studies, n= 175, very low quality)
- 12 • Diet, including:
- 13 o Hypocaloric and meal replacement: when compared with a hypocaloric diet only, hypocaloric
14 diet which included a 220 kcal VLCD diet resulted in greater weight loss over the course of the
15 weight maintenance phase; meal replacement (hypocaloric diet, with an additional 238 kcal
16 VLCD) when compared to hypocaloric diet only, resulted in less weight regain also but this was
17 not considered to be of clinical benefit (2 studies, n= 195, low to low quality)
- 18 o High fibre versus no treatment: more weight regain during the high fibre maintenance
19 strategy, when compared to no treatment (1 study, n= 48, very low quality)
- 20 o High protein versus no treatment: less weight regain during the high protein maintenance
21 strategy, when compared to no treatment (1 study, n= 140, low quality)
- 22 o High protein versus high carbohydrate: high protein weight maintenance strategy resulted in
23 great weight loss than the high carbohydrate weight maintenance strategy(1 study, n= 180,
24 very low quality)
- 25 • There was no evidence on 'health related quality of life' and 'improvement in physical activity'
26 outcomes.

6.2.12.27 Economic

- 28 • No relevant economic evaluations were identified.

29

30

6.2.13 Recommendations and link to evidence

	<p>65. Do not routinely use very-low-calorie diets (800 kcal/day or less) to manage obesity (defined as BMI over 30). [new 2014]</p> <p>66. Only consider very-low-calorie diets, with ongoing support, as part of a multicomponent weight management (See recommendation 35) strategy for a maximum of 12 weeks (continuously or intermittently) in people who are obese who have a clinically-assessed need to rapidly lose weight (for example, people who require joint replacement surgery or who are seeking fertility services). [new 2014]</p> <p>67. Before starting someone on a very-low-calorie diet as part of a multicomponent weight management strategy:</p> <ul style="list-style-type: none"> • Consider counselling and assess for eating disorders or other psychopathology to make sure the diet is appropriate for them • Discuss the risks and benefits with them • Tell them that this is not a long-term weight management strategy, and that regaining weight is likely and not because of their own or their clinician's failure • Discuss the reintroduction of food with them. [new 2014] <p>68. Provide a long-term multicomponent strategy to help the person maintain their weight after the use of a very-low-calorie diet. (See recommendation 35). [new 2014]</p>
<p>Recommendations</p> <p>Relative values of different outcomes</p>	<p>VLCD effectiveness</p> <p>When considering the effectiveness of VLCDs, the critical outcomes identified were % weight change (kg) at end of maintenance period, health related quality of life, and withdrawals (to assess adherence).</p> <p>VLCD safety</p> <p>The GDG considered that, for the safety of VLCDs, the most critical outcomes were disordered eating, depression and postural hypotension. They were particularly concerned from their clinical experience that the dramatic calorie reduction in diet with VLCD, even though for a short period, may create or worsen pre-existing unhealthy eating patterns, or disordered eating, such as binge eating, bulimia nervosa, or night eating syndrome. They were also particularly concerned with the development of or worsening of depression in people who initially lose weight but then later gain it back. Postural hypotension was considered to have a significant impact upon an individual's life.</p> <p>Whilst it was noted that a proper VLCD with vitamin/mineral supplementation may actually improve a person's vitamin D and iron levels; the GDG identified other important outcomes which may cause a number of problems. These were reduction in bone density, constipation, gallstones, gout, diarrhoea, and hypoglycaemia. Reduction in bone density may occur because of insufficient calcium in the diet and may result in fragility and fracture. Constipation, which may be caused by insufficient fibre in the diet, is particularly troubling for individuals. The GDG considered that gallstones (the result of inactivity of the gallbladder from low fat in VLCD diets) and gout (associated with rapid weight loss) were very painful experiences for people. As gout will be rarely reported, raised serum uric acid levels, which are associated with gout, were felt to be an</p>

	<p>appropriate surrogate outcome of gout. Diarrhoea is an important outcome for patients and may be caused by several factors, including undiagnosed lactose intolerance. Hypoglycaemia, while rare, is a serious adverse event that may result from lower energy intake without concomitant review of diabetic medication.</p> <p>VLCD maintenance</p> <p>The GDG considered, with respect to strategies for maintaining weight loss after VLCD, the most critical outcomes to be % weight change (kg) from end of VLCD to end of study, health related quality of life, and withdrawals. The GDG were particularly interested in weight change from end of VLCD to end of study, because their clinical experience indicated that initial weight loss in people using VLCDs was not sustained.</p>
<p>Trade-off between clinical benefits and harms</p>	<p>The GDG noted the recommendation from CG43 which indicated that the main requirement of a dietary approach to weight loss is that total energy intake should be less than energy expenditure. They also recognised the challenges in engaging people with long term behavioural change strategies to support and maintain weight loss.</p> <p>Clinicians and people wishing to lose weight may find the benefit offered by immediate and rapid weight loss when adhering to a very-low calorie diet (a maximum of 12 weeks continuously or intermittently with a low-calorie diet) attractive. The GDG were very much aware that these diets are also available to individuals delivered by the commercial sector (at a cost to the individual). They also noted from their clinical experience that weight regain following a VLCD was common, although weight regain may be slower with proper support in returning to a balanced diet and change in lifestyle. Weight regain in people who have tried VLCDs may cause depression and perpetuate a sense of failure in those people who are trying to manage weight. If weight increases following a VLCD then this may also cause harm to the individual.</p> <p>The GDG noted that a safety review had previously not been clearly available from the evidence considered in CG43 and wished to identify any concerns associated with such a restricted calorie intake. The GDG noted that early formulations of VLCDs, used in lower BMIs and with limited associated support, had previously been linked to some incidences of mortality in the past. The GDG felt however that the current formulations and associated support made such an outcome unlikely, and therefore did not prioritise this as an outcome in the safety review.</p> <p>Gathering and interpreting this evidence would allow the GDG to determine whether the benefit of any rapid initial weight loss, offset against safety and maintenance of weight loss (and consequently any harms), would require any changes to the existing CG43 recommendation for the NHS.</p>
<p>Trade-off between net health benefits and resource use</p>	<p>No relevant economic evaluations were identified.</p> <p>The incremental cost of providing a VLCD relative to a tier 3 service without a VLCD (standard dietary advice) was estimated to be £432 - £994 for individuals without comorbidities and a BMI over 40kg/m². This cost increases to £759 - £1567 for individuals with comorbidities. At this cost, individuals without comorbidities would need to reduce their BMI by 1.32 – 6.29 kg/m² and sustain this for a year for a VLCD to be considered cost effective at a £20,000 per QALY threshold. Individuals with comorbidities would need to reduce their BMI by 2.31 – 7.84 kg/m² and sustain this for a year to be considered cost effective at a £20,000 per QALY threshold. The GDG felt that it was unlikely that this level of</p>

	<p>weight loss, relative to a tier 3 service without a VLCD, would be achieved or sustained, and therefore agreed that VLCDs are unlikely to be cost-effective for this population. Note that no clinical evidence was available for VLCDs in this population. The GDG did not consider that it was appropriate to extrapolate the effectiveness of a VLCD from one BMI population to another.</p> <p>For individuals with less complex clinical issues (those with no comorbidities and a BMI between 30 – 40 kg/m²), the incremental costs of using VLCDs are estimated to be lower, with an additional cost of £158 compared to standard dietary advice alone. Using these costs, it was estimated that an individual would need to reduce their BMI by 0.48 – 1 kg/m² and sustain this for one year for the VLCD to be considered cost-effective at a £20,000 per QALY threshold. The clinical evidence showed that at the end of the clinical trials individuals are expected to lose a very small amount of weight relative to standard dietary advice. This small decrease in weight is unlikely to provide any quality of life benefits. Therefore the GDG agreed that it was unlikely that VLCDs would be cost-effective in this population at a £20,000 per QALY threshold.</p> <p>The GDG also noted that the small weight loss achieved from a VLCD measured at the end of the clinical studies was unlikely to result in any improvements in comorbidities. Therefore no additional cost savings or health benefits would be realised (note that such additional benefits have not been incorporated into this analysis).</p> <p>The GDG noted that the evidence on adverse events was weak and that there could be other adverse events which would increase costs and reduce quality of life, making VLCDs even less likely to be cost-effective.</p> <p>It is assumed that weight loss achieved through the VLCD will have no long-term impact on quality of life unless it is sustained. The GDG felt that, in some cases, rapid initial weight loss may be of increased clinical benefit to some individuals, particularly those who need to meet clinical requirements for further medical or surgical interventions, for example, orthopaedic surgery and fertility treatment. Therefore a VLCD may be cost-effective for this group of individuals as there will be a large benefit derived from the rapid initial weight loss which has not been captured in this analysis. For individuals seeking sustained long term weight loss, the initial fall and then subsequent rise in weight often seen with VLCDs will not offer sustained improvements in quality of life, therefore use of VLCDs is not considered to be cost-effective for long term weight loss.</p>
<p>Quality of evidence</p>	<p>VLCD effectiveness</p> <p>The evidence for the effectiveness review was low to very low quality evidence. Evidence was typically downgraded for risk of bias or imprecision.</p> <p>Most of the studies did not report allocation concealment. There were differences in weight (kg) at baseline between treatment arms which would warrant caution when interpreting the weight change outcomes.</p> <p>The GDG felt it important to note that most of these included studies looked at populations with BMIs that the GDG would consider too low to warrant the use of VLCD on the NHS. There was only evidence in some BMI categories and it was not clear that the data would be relevant to the people with higher BMIs who, in practice, are the most likely to be using VLCDs under NHS care.</p> <p>The GDG discussed that there were no recent studies on effectiveness and the most recent was from 2000. It was also noted that 4 of these 6 studies were from the United States which had carefully selected population inclusion and this</p>

could lead to selection bias.

The outcome weight in kg change from start of study to end of weight maintenance period had heterogeneity but this was explained by sub-grouping studies by intermittent versus non-intermittent VLCD diets. The GDG believed that this was clinically appropriate and sufficiently explained the heterogeneity.

No studies reported on percentage weight loss, but one study did report percentage 'ideal' weight loss. Data on weight change in kg and BMI (from start of study to end of VLCD and start of study to end of maintenance period) was extracted and presented to the GDG.

Numbers of participants withdrawing from the study was extracted for all seven studies; however, it was often unclear whether they were withdrawals due to individual patients unable to tolerate the VLCD or due to other circumstances. None of the included studies reported on the following outcomes from the protocol: Health Related Quality of Life and improvement in physical activity.

Three studies reported on specific populations: 1 with all male participants and 2 with all female participants. Furthermore, 3 studies reported on people with type 2 diabetes. All included studies compared VLCD to standard dietary advice but the length of VLCD, the number of calories included, the length of treatment, and the length of follow-up, varied. Four papers reported intermittent (3 papers) or short-term (1 paper) use of VLCDs. Six studies included behavioural therapy (or educational sessions) as part of the treatment in both arms, and 4 of these studies included an exercise component as well; however it was not possible to extract any useful data.

No evidence was found to inform recommendations in the pre-specified subgroups from the protocol: type 2 diabetes, ethnicity, diet and men and women with learning disabilities, people with osteoarthritis, sleep apnoea, and those giving up smoking or BMI thresholds. .

VLCD safety

There was very low to low quality evidence on the safety of VLCDs compared to LCDs. Six RCTs were identified which reported on the pre-specified safety outcomes for VLCDs, with many of the outcomes considered critical or important to decision-making only being reported by 1 study. Most of the studies did not report allocation concealment and some included participants with different baseline characteristics (for example, in depression scores and baseline weight) which may indicate inadequate randomisation or be an indication that allocation was not concealed appropriately. Participants and most of the assessors in the studies did not appear to be blinded and this may have had an impact on the more subjective outcomes, for example depression or binge eating. Furthermore, some of the outcomes such as 'depressive tendencies' and 'marked' serum uric acid levels were not well-defined and the results were very imprecise.

Heterogeneity was found and investigated for the one outcome where meta-analysis was possible, final depression scores at 4 and 5 months. One study⁶¹ which showed higher (worse) depression scores for VLCD than LCD was a very small study and there were problems with using the final values for the later study⁶⁴ which reported higher values for VLCD at follow-up. For the later study, baseline values were also higher for VLCD. Consequently, change scores for this study (not reported) are likely to have shown no difference between VLCD and

LCD. There was a similar problem with the results in final depression score reported at 1 year⁶⁰ where baseline values were also different and, if change scores were reported, may show little difference between VLCD and LCD. Another possible reason for this heterogeneity could be that the study favouring VLCD was reported at 18 weeks follow-up, whereas the studies favouring standard dietary advice were one year follow up. The GDG agreed that a period of rapid initial weight loss during the first phase (at 18 weeks) would be more likely to lead to reduced depression, whereas by the later follow-up times, individuals could have experienced weight regain, as they transition to solid food, and would be more likely to have higher depression scores in the VLCD group.

The GDG highlighted that the majority of evidence identified was in an indirect population of people who would be unlikely to receive a VLCD in NHS clinical practice (that is, the evidence is in people with a BMI less than 40). No evidence was identified on the use of VLCDs in people with a BMI over 40 with complex comorbidities.

There was evidence from one study to suggest that binge eating may be worse in those who have VLCD compared to LCD at 1 year. However, the GDG noted that final binge eating scores were better than at baseline; which was considered to be likely due to the psychological support element of the treatment that the patients received. However, there were no outcomes reported related to other aspects of disordered eating, such as bulimia nervosa or night eating syndrome.

Regarding other possible adverse events, one study reported on gallstone formation detected by ultrasound. However, this was a small study which specifically looked at biliary physiology during VLCDs and LCDs and reported a very high rate of (asymptomatic) gallstone formation associated with VLCDs, leading to the study terminating early.

One study reported on constipation and diarrhoea, reporting that there was a slightly higher occurrence of these effects with VLCDs compared to LCDs but there was little certainty in the results.

No studies reported on the occurrence of gout but one small study reported the proportion of participants with 'marked' serum uric acid levels. As the study did not define this, it was difficult to draw any conclusions. The same study reported the mean levels of serum uric acid to be similar between VLCDs and LCDs.

VLCD maintenance

Most of the evidence for the maintenance review was very low to low quality evidence. The GDG noted that the studies also consisted of small sample sizes. Evidence was typically downgraded for risk of bias or imprecision and outcomes on weight (change or final scores) were downgraded for indirectness as they were not reported in the GDG's preferred way, % change from baseline. Most of the studies did not report allocation concealment. Some outcomes had very wide confidence intervals reflecting large levels of uncertainty in results. There were differences in weight (kg) at baseline between treatment arms. The GDG noted that the evidence presented was not applicable for relevant patients with a BMI above 50 as the majority of the studies included populations with lower BMIs.

Only one study presented % change: the remaining studies reported the alternative outcomes. There was no clinical evidence found relating to health related quality of life. It was possible to determine withdrawals for all included

	<p>studies; however once again, it was often unclear whether they were withdrawals due to the maintenance strategy or due to other circumstances. Two studies reported physical activity as an outcome but as both studies were exercise interventions and this outcome was only reported during the study, the results are more about adherence to the exercise regimen rather than improved physical activity after the maintenance programme had completed.</p> <p>Four studies reported on sub populations: three with all female participants and one with male participants. Furthermore, five studies did not have a minimum weight loss for inclusion in the maintenance phase of the study.</p> <p>No evidence was found to inform recommendations in the pre-specified subgroups (type 2 diabetes: expected weight maintenance strategies following VLCD to have different outcomes in people with T2DM; ethnicity (white (over 80%); Asian (over 80%); black (over 80%): expected maintenance strategies following VLCD to have different outcomes in different ethnicities; learning disabilities; adherence to weight maintenance strategies following VLCD may be challenging for men and women with intellectual disabilities; and, diet: expected weight maintenance strategies involving diet to work better in those who followed a supervised diet) or strata (BMI thresholds - intervention thought likely to have a different effect on different BMI thresholds) in the protocol.</p>
<p>Other considerations</p>	<p>The GDG considered the applicability of these studies and discussed the challenges in maintaining weight loss following very-low-calorie diets</p> <p>Overall, the GDG felt that there was little evidence of effectiveness of VLCDs compared to LCDs (standard dietary advice) in the long-term, but they are relatively safe. The GDG noted that there was some evidence that VLCD worked in the short term, but outcomes for weight loss at end of maintenance periods found no difference between VLCD and standard dietary advice. Evidence demonstrated that VLCDs achieve slightly greater weight loss over the short period of the intervention compared to LCDs, however this loss is not likely to be maintained. This was also supported by evidence to suggest a benefit in weight reduction at the start of a VLCD which was not however maintained over a long period of time.</p> <p>The GDG noted that the provision of VLCDs is relatively new in the NHS (other than pre-surgery); however they are provided extensively by commercial providers at cost to individuals. It is outside the remit of this guideline to consider issues related to the use of VLCDs purchased by the individual, although the GDG recognise that commercial companies advise their customers to seek medical advice or monitoring in certain conditions (such as hypertension or type 2 diabetes) and as such are not without cost to the NHS as it is usual for people to get this advice from their NHS general practitioner.</p> <p>The GDG agreed that VLCDs showed a clinical benefit over harms in the initial phase of the diet but felt that these benefits were rarely evident long-term. They also noted from their experience that many patients regain the weight lost during the initial VLCD period and often end up gaining weight. The GDG discussed the harmful nature of weight cycling and associated morbidity as well as the potential dissatisfaction and sense of failure this weight regain may cause the individual.</p> <p>The GDG observed that there was no difference in withdrawals which was being used to determine adherence to the VLCD, and as such were unable to highlight any supportive measures to encourage adherence to any VLCD.</p>

The GDG noted with interest the incidence of gall stones in the VLCD population. The size of this study was acknowledged as a particular weakness, but the GDG were not particularly surprised by the high incidence. It was the opinion of the GDG that gallstones are common after rapid weight loss, but they were unsure whether this was increased in VLCD compared to rapid weight loss by other means. They also noted that they would expect other studies which actively looked for gallstones to discover high rates of gallstones associated with VLCDs. Whilst in practice, their experience demonstrated that the incidence of gall stones in the population was generally increasing probably caused by rapid changes in weight (increase or decrease), there was little evidence to suggest that these were a particular safety issue, especially as, in the evidence reviewed, only one case of gallstones was symptomatic. For these reasons, the GDG did not choose to make a research recommendation to further investigate the cause and association and impact of gall stones in the population of people using VLCDs.

The GDG considered the evidence related to depression. While the study showed that those with a VLCD may have higher (worse) depression scores than those with a LCD, scores were also higher in this group at baseline. Given this, the GDG did not feel able to make any conclusions about this.

The GDG did not consider overall that there were benefits to providing VLCDs to the majority of obese people who wish to lose weight and recommended that it should not be routinely offered. However, the GDG considered that there were likely to be some benefits to providing VLCDs to selected people who need to lose weight quickly for clinical reasons, for example, those people who are being considered for surgical procedures such as orthopaedic surgery or women who wish to conceive. The GDG recommended the use of VLCDs in patients clinically assessed by the health care professional as likely to benefit from rapid weight loss in these or analogous circumstances.

The GDG reported that from personal experience there is a group of individuals who may do very well on a VLCD despite the poor evidence. The GDG agreed that patient choice would also be very important as some patients may not want to try a VLCD while others would be very keen. They also indicated in their recommendation a set of activities that should take place before a VLCD was offered that reflects the importance of ensuring that people are aware of the challenges with ensuring long term sustained weight loss with this type of diet. They felt it important to ensure that the use of VLCDs was only used as part of a multicomponent intervention to ensure weight loss (as already recommended in CG43), and chose to highlight this in their recommendations.

The GDG also discussed the evidence related to disordered eating. The GDG felt from their clinical experience that individuals without a previous history of disordered eating behaviours may be more at risk of developing these after use of a VLCD, although no evidence that fit the criteria specified in the protocol was found. They agreed by consensus that careful review and screening of people being considered for a VLCD diet for binge eating and other disordered eating behaviours was necessary as from their clinical experience, VLCDs may trigger these behaviours and they chose to include this specifically in their recommendation. They particularly wished to ensure that the re-introduction of food was carefully discussed to ensure that the person was reintroduced to a balanced diet rather than return to previous eating habits to maximise the chance to maintain weight loss following the intervention. Although no formal review of the evidence to identify the support that an individual should receive

before initiating a VLCD, the felt that it was important to highlight that individuals being considered for a VLCD as part of a multi component weight strategy should be considered for counselling and assessed for eating disorders and other psychopathology. The GDG also wished to highlight that a discussion regarding the risks and benefits of VLCDs, the reintroduction of food and the concept of VLCD as a short term weight strategy should take place before initiation of the diet. The GDG used informal consensus to develop a recommendation to reflect this.

The GDG wished to highlight that all people who are being given a VLCD should be monitored and reviewed regularly and provided with support to help maintain weight loss. The duration of this support should be tailored to individual need as outlined in recommendation 38.

The GDG noted that the review did not consider evidence on the use of VLCD prior to bariatric surgery and believed this to be a separate issue. The GDG wanted to highlight that they did not want standalone VLCDs to be linked to the use of VLCD as a 2 week pre-surgery treatment. It was the opinion of the GDG that these diets should not be seen as a way to avoid surgery as although they do work for some people they are in general not as effective as bariatric surgery. The GDG were concerned that clinicians would use VLCDs routinely instead of bariatric surgery, and that the patient's treatment may be delayed as a consequence. The GDG also discussed the importance of highlighting that the use of VLCDs should not be considered as an alternative to surgery or a gateway to surgery.

It was also noted that the definition of a VLCD diet has been amended since CG43 (see Glossary) which defined them as 1000 calories or less. This guideline has clarified and defined them as 800 calories or less, which is an accepted definition within current practice.

The GDG selected adults and children over 2 years to be included within these VLCD reviews. However, no evidence was found for children for any of the VLCD reviews on effectiveness, safety or maintenance. VLCDs are not used on children in current practice and the GDG did not believe the evidence on adults could be extrapolated to make any recommendations on children. Similarly, it was not possible to make recommendations for any other of the identified sub-groups or groups warranting special consideration. In line with advice from the co-opted expert for learning disabilities, the GDG noted that people with learning disabilities across the lifespan and carers supporting them should have access to specialist advice on overweight and obesity. They also felt that clinicians undertaking health checks for people with learning disabilities should be aware of referral pathways to services for individuals with obesity and that educational programmes for health, education and social care staff should include training on assessing and managing overweight and obesity in people with learning disabilities.

7.1 Bariatric surgery in people with recent onset type 2 diabetes

7.1.3 Introduction

4 Approximately 3 million people in the UK have type 2 diabetes (T2D); over a 500% rise since 1960.
5 More than one hundred thousand people are diagnosed with the condition each year and it is likely
6 that another million patients have yet to be discovered. Treatment already costs the NHS almost 10
7 billion a year which is 10% of its total budget.

8 The epidemic of obesity and T2D has been termed as “diabesity”; in most people the condition is
9 managed with lifestyle advice and medication³⁷, but in some individuals with obesity, bariatric
10 surgery has been used to aid weight loss. This often results in dramatic improvement in glycaemic
11 control that may be partly independent of weight loss leading to the term ‘metabolic surgery’ as a
12 descriptive term for the procedures used. In the most severely obese, it has been suggested that
13 metabolic surgery may have the potential effect of putting diabetes into ‘remission’ in people who
14 are obese. This is particularly pertinent as a potential ‘treatment’ option in those who have recent
15 type 2 diabetes (within 10 years) as it may be possible to intervene before the impact of diabetes
16 causes long term damage to other organs.

17 The duration of T2D in adults who are obese is known to affect outcomes after surgery. Given the
18 very high numbers of people with type 2 diabetes who are obese and the resulting health economic
19 impact, the GDG wished to determine: “In people with recent onset type 2 diabetes who are also
20 overweight or obese, what is the clinical and cost effectiveness of bariatric surgery for the
21 management of diabetes?”

7.2.1 Review question: In people with recent onset type 2 diabetes (T2D) who are also overweight or obese, what is the clinical and cost effectiveness of bariatric surgery for the management of diabetes?

25 For full details see review protocol in Appendix C.

26 **Table 36: PICO characteristics of review question**

Population	Adults, young people and children with recent onset type 2 diabetes (duration of less than or equal to 10 years) who are overweight or obese.
Intervention(s)	Bariatric surgery
Comparison(s)	Non-surgical management (including diet and exercise diabetes medication)
Outcomes	% weight loss (in BMI or kg) Use of diabetic medication Health related quality of life Remission of type 2 diabetes Improvement in glycaemic control Mortality Weight measured with BMI Weight measured in kg
Study design	RCTs or systematic reviews of RCTs

27 Studies that had less than 1 year follow-up were excluded as the longer term outcomes after
28 bariatric surgery were considered the most important.

- 1 The definition of recent-onset diabetes of a duration of less than or equal to 10 years was
- 2 determined by discussion with the GDG that indicated that 'remission' from diabetes following
- 3 surgery was possible up to 10 years after an initial diabetes diagnosis.

7.12 Clinical evidence

5 We searched for randomised trials comparing the effectiveness of surgical interventions versus non-
6 surgical management for people with recent onset T2D and obesity. Recent onset T2D was defined as
7 within 10 years of diagnosis. Six studies^{13,21,26,32,33,36,44,56,57} were included in the review; and are
8 summarised in [Table 37](#) below. Evidence from these studies is summarised in the clinical
9 evidence summary below ([Table 29](#)). See also the study selection flow chart in Appendix D,
10 study evidence tables in Appendix G, forest plots in Appendix I, GRADE tables in Appendix O and
11 excluded studies list in Appendix J.

12 Three studies^{21,44,57} included people with a mean duration of T2D that was less than 10 years but with
13 very large standard deviations which shows that there were a large proportion of patients who had
14 T2D for longer than 10 years. These studies were considered to have indirect populations since they
15 included a large proportion of people without recent onset diabetes.

16 All outcomes were reported in at least 1 study. However, only 1 study^{25,26,33,56,57} reported health-
17 related quality of life after at least 1 year of follow-up. The study reported results from the RAND-36
18 questionnaire before and after treatment for each of the individual domains, but the study did not
19 report composite scores across all domains. The study reports that there were significant
20 improvements over conventional therapy in 5 of the 8 mental and physical domains among people
21 treated with gastric bypass and 2 of the domains among people treated with sleeve gastrectomy.

22 The way diabetic medication usage was reported in the studies varied. Two studies^{13,56} reported the
23 proportion of participants who were still taking diabetic medication at follow-up (dichotomous) and
24 2 other studies^{21,56} reported the number of diabetic medications being taken at follow-up
25 (continuous). Consequently, both dichotomous and continuous outcomes were presented
26 separately. Two of the other papers^{32,36} reported this outcome in the surgery group only so it was not
27 possible to include the results from these studies.

28 'Remission' of type 2 diabetes is often used as an outcome but there is controversy over the term as
29 it is defined by hyperglycemia which may change over time⁷. The American Diabetes Association⁷
30 has defined partial and complete remission. Complete remission is defined as a return to normal
31 glycemic measures (HbA_{1c} in the normal range, fasting glucose less than 100 mg/dl [5.6mmol/l]) of
32 at least 1 year's duration in the absence of active pharmacological therapy or on-going procedures.
33 Partial remission is sub-diabetic hyperglycemia (HbA_{1c} not diagnostic of diabetes [less than 6.5%],
34 fasting glucose 100-125 mg/dl [5.6-6.9 mmol/l]) of at least 1 year's duration in the absence of active
35 pharmacologic therapy or on-going procedures.

36

37 Normal range of HbA_{1c} is typically defined as less 6% [less than 43mmol/mol].

38 Remission of T2D was reported in a number of studies but the definition was different across the
39 included studies. The different definitions are presented in Table 38.

40 As per the protocol, presentation of the results into the following four strata were explored: BMI 25-
41 29.9 kg/m² at baseline, BMI 30-34.9 kg/m² at baseline, BMI 35-39.9 kg/m² at baseline, and BMI 40-
42 49.9 kg/m². All of the studies included patients from more than one of these strata, but none of the
43 studies performed subgroup analyses. Consequently, the results were separated by mean BMI and
44 explored using sub-group analysis in the forest plots.

1 Table 37: Summary of studies included in the review

Study	Intervention/comparison	Population	Outcomes	Comments
Dixon 2008 ¹³ Australia N=60 2 year follow-up	Intervention: Laparoscopic adjustable gastric banding with conventional diabetes care (n=30) Comparison: conventional diabetes care (with a focus on weight loss by life-style change) (n=30)	Obese patients (BMI >30 - <40 kg/m ²) with recently diagnosed (<2 years) type 2 diabetes Age: 20-60 years Mean BMI: 37.0 (SD 2.7) vs 37.2 (SD 2.5) kg/m ² Mean HbA _{1c} : 7.6 and 7.8% (60 and 62 mmol/mol)	% weight loss Use of diabetic medication (dichotomous) Remission of diabetes ^a Glycaemic control (HbA _{1c} <6.2%) Mortality Weight in kg	Patients in the intervention group received all aspects of the conventional therapy program
Liang 2013 ³² China N=108 1 year follow-up	Intervention: Laparoscopic Roux-en-Y gastric bypass (n=36) Comparison: usual conventional treatment plus Exenatide treatment (GLP-1 therapy) (n=36) or conventional treatment (medication, reduction in fat intake and physical exercise) (n=36)	Obese patients (BMI >28 kg/m ²) with type 2 diabetes (between 5 and 10 years) Age: 30-60 years Duration of T2D: 7.4 (SD 1.7) vs 7.2 (SD 1.8) vs 7.2 (SD 1.6) years Mean BMI: 30.5 (SD 0.9) vs 30.3 (SD 1.4) vs 30.3 (SD 2.0) kg/m ² Mean HbA _{1c} : 10.47 – 10.88% in arms (90.9-95.4 mmol/mol)	Remission of diabetes ^a Mortality Weight in BMI	Study conducted in China. In accordance with the WHO Asia-Pacific classification for obesity, BMI >28 kg/m ²
Mingrone 2012 ³⁶ Italy N=60 2 year follow-up	Intervention: patients assigned to undergo either gastric bypass (n=20) or biliopancreatic diversion (n=20) Comparison: conventional treatment (medication, programs for diet and lifestyle modification (i.e. reduction in fat intake and physical exercise)) (n=20)	Obese patients (BMI ≥35 kg/m ²) with type 2 diabetes (>5 years) Age: 30-60 years Duration of T2D: 6.0 (SD 1.2) vs 6.0 (SD 1.3) vs 6.1 (SD 1.2) years Mean BMI: 44.9 (SD 5.1) vs 45.1 (SD 7.8) vs 45.6 (SD 6.2) kg/m ² Mean HbA _{1c} : 8.5 – 8.9% in arms (69.4 – 73.8 mmol/mol)	% weight loss Remission of diabetes ^a Mortality Weight in BMI Weight in kg	

Study	Intervention/comparison	Population	Outcomes	Comments
Palikhe 2013 ⁴⁴ India N=31 Mean 12.5 months follow-up	Intervention: laparoscopic sleeve gastrectomy (n=14) Comparison: intensive medical therapy with exenatide and low calorie diet (1000 kcal/day) (n=17)	Patients with type 2 diabetes and BMI ≥ 27 kg/m ² Age: 20 to 75 years Duration of T2D: 8.5 (SD 6.1) years Mean BMI: 40.5 (SD4.6) vs 35.8 (SD5) kg/m ² Mean HbA _{1c} : 8.5 and 8.7% (69.4-71.6 mmol/mol)	% weight loss Remission of diabetes ^a Glycaemic control (HbA _{1c} <7%) Mortality Weight in BMI Weight in kg	Follow-up was mean 12.5 months; study is ongoing and only 20 patients had completed 12 months of follow-up
STAMPEDE trial (Schauer 2012/2014) ^{25,26,33,56,57} USA N=150 3 year follow-up	Intervention: patients assigned to undergo either gastric bypass (n=60) or sleeve gastrectomy (n=60) and intensive medical therapy Comparison: intensive medical therapy (n=60)	Obese patients with BMI 27-43 and type 2 diabetes Age: 20 to 60 years Duration of T2D: 8.2 (SD 5.5) vs 8.5% (SD 4.8) vs 8.9 (SD 5.8) years Mean BMI: 37.0 (SD 3.3) vs 36.2 (SD 3.9) vs 36.8 (SD 3.0) kg/m ² Mean HbA _{1c} : 9.0 – 9.5% in groups (74.9-80.3 mmol/mol)	% weight loss Use of diabetic medication (continuous and dichotomous) Remission of diabetes ^a Health-related quality of life ^b Glycaemic control (HbA _{1c} <6%, 6.5%, & 7%) Mortality Weight in kg	
The Diabetes Surgery Study 2013 (Ikramuddin 2013) ²¹ USA Taiwan N=120 1 year follow-up	Intervention: Roux-en-Y gastric bypass with lifestyle and medical management (n=60) Comparison: lifestyle and medical management only (n=60)	Patients with type 2 diabetes and BMI between 30.0 and 30.9 kg/m ² Age: 30 to 67 years Duration of T2D: 8.9 (SD 6.1) vs 9.1 (SD 5.6) years Mean BMI: 34.9 (SD 3.0) vs 34.3 (SD 3.1) kg/m ² Mean HbA _{1c} : 9.6% (81.4 mmol/mol)	% weight loss Use of diabetic medication (continuous) Remission of diabetes ^a Glycaemic control (HbA _{1c} <6% and <7%) Mortality Weight in BMI Weight in kg	

[Table 38](#)

1

- 1 (a) [Table 38](#).
- 2 (b) *This is presented narratively only as composite scores were not available from the study*
- 3
- 4

1 Table 38: Definition of remission of diabetes among included studies

Study	Remission definition
Dixon 2008	Fasting plasma glucose levels < 126 mg/dL HbA _{1c} < 6.2% No oral hypoglycaemics or insulin.
Liang 2013	No definition given
Mingrone 2012	Fasting plasma glucose < 100 mg/dL (5.6 mmol per litre) Glycated haemoglobin < 6.5% for at least 1 year No active pharmacologic therapy.
Palikhe 2013	Fasting blood glucose < 100 mg/dl HbA _{1c} < 6% on at least 2 occasions including the last follow-up visit No anti-diabetic medications
STAMPEDE 2014 (Schauer 2012/2014)	Glycated haemoglobin < 6% No anti-diabetic medications
The Diabetes Surgery Study 2013 (Ikramuddin 2013)	HbA _{1c} < 7% LDL cholesterol level < 100 mg/dL Systolic blood pressure less than 130 mm Hg

2 Accepted definition: glycated haemoglobin (HbA_{1c}) less than 6% and fasting blood glucose less than 100 mg/dL off diabetic medications.

3

1 **Table 39: Clinical evidence summary: Surgical versus non-surgical management of people with T2D and obesity**

Outcome	Number of studies	Imprecision	GRADE rating	Absolute Difference	Control event rate (per 1000)	Control event rate for continuous outcomes
% weight loss (BMI or kg)	5	No serious imprecision	Very low	20.54 lower (22.13 to 18.96 lower)	-	4.73%
Use of diabetic medication (dichotomous)	2	No serious imprecision	Moderate	16 fewer per 1000 (from 13 to 18 fewer)	25 per 1000	-
Use of diabetic medication (continuous)	2	No serious imprecision	Very low	MD 2.14 lower (2.48 to 1.80 lower)	-	Mean 2.6 medications used
Health-related quality of life	0 ^a	-	-	-	-	-
Remission of type 2 diabetes	6	No serious imprecision	Very low	401 more per 1000 (from 234 to 663 lower)	64 per 1000	-
Improvement in glycaemic control (continuous)	5	No serious imprecision	Low	MD 1.32 lower (1.60 to 1.04 lower)	-	7.69% HbA _{1c}
Mortality	6	No serious imprecision	Very low	N/A	0 per 1000	-
Weight measured with BMI (final score)	4	No serious imprecision	Low	MD 4.19 lower (4.62 to 3.76 lower)	-	Mean 31.8 kg/m ²
Weight measured in kg (final score)	5	No serious imprecision	Low	MD 19.48 lower ((22.61 24.2 to 16.36 lower)	-	Mean 104.8 kg

2 (a) One study did report quality of life but it did not report composite scores across all domains and it was not possible to analyse the results in the above table. There is a narrative summary
3 in the clinical evidence section above

4

5

7.1.3 Economic evidence

7.1.3.12 Published literature

3 Four economic evaluations were identified with the relevant comparison and have been included in
4 this review.^{18,27,49,50} These are summarised in the economic evidence profiles below (Table 40 and
5 Table 41) and the economic evidence tables in Appendix H.

6 Eight economic evaluations relating to this review question were identified but were excluded due to
7 a combination of limited applicability, methodological limitations and the availability of more
8 applicable evidence.^{1,3,9,15,20,28,34,48} These are summarised in Appendix K, with reasons for exclusion
9 given.

10 See also the economic article selection flow chart in Appendix E.

11

12

1 Table 40: Economic evidence profile: laparoscopic adjustable gastric banding (LAGB) versus conservative care for type-2 diabetes (T2D)

Study	Applicability	Limitations	Other comments	Incremental cost	Incremental effects	Cost effectiveness	Uncertainty
POLLOCK2013 ⁵⁰ (UK)	Directly applicable ^(a)	Potentially serious limitations ^(b)	The economic evaluation was conducted using the CORE diabetes model. This model comprises of seventeen inter-dependent semi-Markov sub models each modelling a diabetes related complication. Patients with early onset type 2 diabetes and a baseline BMI of 37.1 kg/m ² are modelled over a lifetime horizon. LAGB is compared to standard medical management comprising of normal diabetes care with a focus on weight loss through lifestyle change.	£3298	0.92 QALYs	£3602 per QALY gained	One way sensitivity analyses were conducted under 21 different scenarios. The ICER only increased above £20,000 to £36,377 in 1 scenario in which Hb1A1c, SBP and BMI benefits were lowered to 1 standard deviation below the mean.
PICOT2012 ⁴⁹ (UK)	Directly applicable ^(c)	Potentially serious limitations ^(d)	The economic evaluation was conducted using a Markov model with a 20 year time horizon. The population was patients who have early onset type 2 diabetes and a BMI between 30 and 40 kg/m ² . LAGB is compared to a non-surgical weight loss program.	£1792	1.10 QALYs	£1634 per QALY gained	One way sensitivity analyses were run but results were not reported. The analysis was also run using a 2 and 5 year time horizon. At a £20,000 threshold LAGB was not cost effective at 2 years with an ICER of £20,159 but was cost effective at 5 years with an ICER of £4969. At a 2 year time horizon LAGB had an 11% probability of being cost effective at a £20,000 per QALY threshold. At a 20 year time horizon LAGB had a 100%

Study	Applicability	Limitations	Other comments	Incremental cost	Incremental effects	Cost effectiveness	Uncertainty
KEATING2009 ²⁷ (Australia)	Partially applicable ^(e)	Potentially serious limitations ^(f)	The economic evaluation was conducted using a Markov model with a lifetime horizon. The population was patients with early onset type 2 diabetes and a BMI between 30 and 40 kg/m ² . LAGB was compared to conventional therapy for the management of type 2 diabetes.	-£1088	1.20 QALYs	LAGB dominated conventional therapy	probability of being cost effective at a £20,000 per QALY threshold One way sensitivity analyses were conducted. LAGB remained dominant or cost effective in all but 1 scenario in which the relative risk of diabetes remission was reduced to the lower 95% CI and annual probability for relapse to type 2 diabetes increased to the upper bound of the 95% CI. Under this scenario the ICER increased to £21,449 per QALY gained.

1 Abbreviations: BMI: body mass index; HbA_{1c}: glycated haemoglobin; LAGB: Laparoscopic adjustable gastric band; SBP: systolic blood pressure

2 (a) UK cost utility study

3 (b) Study was funded by Allergan Ltd, the manufacturer of the LAP-BAND LAGB product. Unclear whether the model accounts for future weight re-gain. Mortality and loss of HRQoL from
4 surgical complications are also not modelled.

5 (c) UK cost utility study

6 (d) Does not look at mortality and loss of HRQoL associated with surgical complications. The study does not measure HRQoL using EQ-5D and a lack of long run clinical data has necessitated
7 long term extrapolation of clinical data based on assumptions.

8 (e) Australian cost utility analysis

9 (f) Study was funded by Allergan Ltd, the manufacturer of the LAP-BAND LAGB product. The study employs a basic model structure, which ignores obesity comorbidities other than T2D and
10 mortality associated with surgery. Also the model does not take into account the effects of potential weight re-gain years after surgery.

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1 **Table 41: Economic evidence profile: gastric bypass versus standard care for T2D**

Study	Applicability	Limitations	Other comments	Incremental cost	Incremental effects	Cost effectiveness	Uncertainty
HOERGER2010 (USA)	Partially applicable ^a	Potentially serious limitations ^(b)	The economic evaluation was conducted using the CDC-RTI Diabetes Cost-Effectiveness Model. This is a Markov model with a lifetime horizon that simulates diabetes-related complications. The population was patients with early onset diabetes and a BMI ≥ 35 kg/m ² . Gastric bypass is compared to standard care for type-2 diabetes.	£9884	2.21 QALYs	£4472 per QALY gained	A variety of one way sensitivity analyses were conducted. These included reducing the quality of life gain from a BMI reduction to zero. The ICER did not increase above £20,000 per QALY in any of the one way sensitivity analyses. At a £20,000 per QALY threshold gastric bypass had a 98% probability of being cost effective.

2 (a) US cost utility study

3 Model does not explicitly account for weight re-gain, however there is a probability that the patient could relapse after diabetes remission. Although the study is based on the US healthcare
 4 system the costs detailed in the study, such as the cost of bypass surgery and post-surgical follow-up care, are far greater than UK costs. This means the study's results will bias away from the
 5 intervention. The study does not use EQ5D for HRQoL values.

6

1 Unit costs

2 To further help the GDG consider the cost-effectiveness of bariatric surgery the following costs for
3 bariatric surgical procedures were identified using the NHS reference costs.¹²

4 **Table 42: Bariatric surgery costs**

Procedure	HRG code	Cost (£) ^(a)
Stomach Bypass Procedures for Obesity	FZ84Z	£5,410
Restrictive Stomach Procedures for Obesity	FZ85Z	£2,473

5 (a) Average total HRG costs

7.1.4 Evidence statements

7.1.4.17 Clinical

- 8 • Surgical intervention is more clinically effective than non-surgical management at:
 - 9 o Increasing percentage weight loss from baseline (5 studies, n=417; very low quality)
 - 10 o Reduction of use of diabetic medication (4 studies, n=306; moderate quality)
 - 11 o Increasing remission of diabetes (6 studies, n=503; very low quality)
 - 12 o Improving glycaemic control (5 studies, n=370; low quality)
 - 13 o Reducing weight as measured by BMI (4 studies, n=303; low quality) or kg (5 studies, n=398;
 - 14 low quality)
- 15 • These changes were considered as clinically important differences.
- 16 • Mortality rates did not appear to differ between groups (6 studies, n=503; very low quality).
- 17 • One study reported improvement in quality of life across 5 domains in the gastric bypass
- 18 procedure and 2 domains in the gastric sleeve procedure using a RAND 36 questionnaire.

7.1.4.29 Economic

- 20 • Two cost-utility analyses found that LAGB was cost effective compared to non-surgical
- 21 management for treating obese patients with early onset type 2 diabetes (ICERs: £3602 per QALY
- 22 gained, £1634 per QALY gained). These studies were assessed as directly applicable with
- 23 potentially serious limitations.
- 24 • One cost-utility analysis found that LAGB was dominant (less costly and more effective) compared
- 25 to non-surgical management for treating obesity in obese patients with early on-set type 2
- 26 diabetes. This analysis was assessed as partially applicable with potentially serious limitations.
- 27 • One cost-utility analysis found that gastric bypass was cost effective compared to non-surgical
- 28 management for treating obese patients with early on-set type 2 diabetes (ICER: £4472 per QALY
- 29 gained). This study was assessed as partially applicable with potentially serious limitations.
- 30

7.1.5 Recommendations and link to evidence

<p>Recommendations</p>	<p>107. Offer an assessment for bariatric surgery to people who have recent-onset type 2 diabetes^p and who are obese (BMI of 35 and over).[new 2014]</p> <p>108. Consider an assessment for bariatric surgery in people who have recent-onset type 2 diabetes^o with a BMI of 30–34.9.[new 2014]</p> <p>109. Consider assessing people who have recent-onset type 2 diabetes^o and are of Asian family origin for bariatric surgery at a lower BMI (see recommendation 36).[new 2014]</p>
<p>Relative values of different outcomes</p>	<p>The GDG considered the following outcomes to be critical for this review: Percentage weight loss; use of diabetic medication, and health-related quality of life at latest follow-up. The GDG also noted that the following were important outcomes: remission of type 2 diabetes, improvement in glycaemic control, mortality, and weight as measured in either BMI or kg (all at latest follow-up).</p> <p>The GDG felt that the most valuable way of measuring weight loss was one that took into account baseline values. Change values and final values of weight do not take into account the changes from baseline for each patient, so the GDG chose percentage weight loss (that is the average of percentages of weight loss) as the most critical outcome to decision making when determining the effectiveness of bariatric surgery. However, as some studies do not report weight in this way, weight in BMI and kg were also included as important outcomes.</p> <p>The GDG felt that a reduction in diabetic medication was a crucial measure of how well bariatric surgery affected a patient's diabetic status as it assumes that the diabetes is well controlled.</p> <p>Other aspects of the patient experience after bariatric surgery were felt to impact greatly on the patient so health-related quality of life was an outcome the GDG found was critical to decision making.</p> <p>While the GDG noted that the use of the term 'remission' of diabetes may be a misnomer since people are not 'cured' of diabetes, they felt this composite measure (as defined in the studies) was however, a useful measure of the effect of bariatric surgery on diabetes. This outcome is typically defined as improvement in glycaemic control ($\leq 6\%$ HbA_{1c}) and fasting blood glucose (less than 100 mg/dL), as well as no further need for diabetic medication. Acknowledging that some papers would not report the composite value of remission, but that an improvement in glycaemic control was a helpful measure on its own for the effect of bariatric surgery on remission, the GDG chose this as an important outcome to consider.</p> <p>While rare, the GDG were also interested in the difference in mortality rates between surgery and non-surgery.</p>
<p>Trade-off between clinical benefits and harms</p>	<p>Any intervention carries risk to the individual. Surgical intervention in overweight or obese people carries an increased risk of complications, for example, in relation to anaesthesia. However, this risk needs to be considered in terms of the potential benefits that can be achieved by surgically treating the condition of overweight or obesity creating, a 'remission' of diabetes in this population and thereby avoiding</p>

^p The GDG considered that recent onset type 2 diabetes would include those people whose diagnosis has been made within a 10 year time frame.

	<p>longer term harm from that condition.</p> <p>People with T2D having surgery at different BMI thresholds may respond differently. For example, effectiveness may be less or greater in people with a higher or lower BMI. If evidence is available about effectiveness at different BMIs, the trade-off between benefits and harms may also differ.</p>
Trade-off between net health benefits and resource use	<p>Four economic studies were identified which evaluated the cost-effectiveness of bariatric surgery in individuals with recent on-set T2D. Three studies looked at laparoscopic adjustable gastric bands (LAGB) compared to medical management of T2D. Of these studies 2 found that LAGB was cost effective compared to non-surgical management for treating obese patients with recent on-set T2D (ICERs: £3602 per QALY gained and £1634 per QALY gained). Both of these studies used a UK NHS perspective and are therefore directly applicable to the UK NHS. One further study found that LAGB dominated (less costly and more effective) non-surgical management of T2D, however this was conducted using an Australian healthcare perspective and is therefore only partially applicable to a UK setting. The GDG agreed that, despite the limitations of these studies, the evidence to suggest that LAGB is cost-effective in this population was convincing. Robust sensitivity analyses conducted within the studies supported this conclusion.</p> <p>One study looked at gastric bypass compared to standard medical management of T2D. The study showed that gastric bypass was cost-effective at a £20,000 per QALY threshold, with an ICER of £4472 per QALY gained. However the study was conducted using a US healthcare perspective and was therefore only partially applicable. The GDG noted that although the costs of surgery used in the model were much higher than UK surgery costs the costs of diabetic care were also likely to be higher, meaning the cost savings from reduced diabetic medication were also likely to be overestimated. Despite this, the GDG noted that addressing this limitation would not substantially change the model results as the sensitivity analyses revealed that the model was very robust to drastic changes in parameter values.</p> <p>Based on the existing evidence and consideration of the cost of surgery in the UK, the GDG agreed that bariatric surgery is highly likely to be cost-effective for obese individuals with recent onset T2D. The GDG noted that some individuals with a BMI between 30-35 kg/m² could achieve similar outcomes as those identified in the clinical review with a BMI over 35 kg/m². This was demonstrated in 1 study found in the clinical review. Such individuals may be identified through assessment as recommended above. One study identified in the economic literature search by Picot et al⁴⁹ found that bariatric surgery may be cost-effective at a £20,000 per QALY threshold, for individuals with an 'identifiable obesity-related comorbid condition' and a BMI between 30 – 35 kg/m² (ICER: £13,701 per QALY gained). The authors note however how the result is based on weak evidence. Therefore for these individuals bariatric surgery may also be a cost-effective treatment.</p>
Quality of evidence	<p>Overall, most of the evidence was of low or very low quality. Four of the outcomes were downgraded due to indirectness as the majority of the studies included a large proportion of people with diabetes for more than 10 years. While the GDG acknowledged that evidence on individuals with duration of T2D of 10 years or less would be ideal, they felt that the results from these studies were likely to reflect, if not underestimate, the results in people with more recent onset diabetes. This was informed by the GDG experience of observational data from the latest National Bariatric Surgery Registry, which suggests that people with more established diabetes may be less likely to respond to bariatric surgery.</p> <p>There was also a high risk of bias in a large number of the included studies. This was due to a number of reasons including a risk of selection bias: only 1 study had adequate allocation concealment while none of the other studies reported about allocation concealment, 2 studies did not report about generation of randomisation</p>

	<p>sequence and in a few studies, people in groups were up to 10 kg higher or lighter in the surgery groups. Furthermore, there was also a lack of blinding, which, while it is not easily possible for the treatments, can still affect more subjective outcomes. Some studies had either differential dropout rates or no information reported about dropout rates.</p> <p>Some outcomes were imprecise and this was largely due to small sample sizes in some of the included studies.</p> <p>The body of evidence considered, which was based on 6 studies, showed that bariatric surgery consistently improved weight and diabetic outcomes compared to non-surgery in people with recent-onset T2D (less than 10 years). Most of the evidence considered included people who had diabetes for less than 10 years but some studies included also included individuals who had diabetes for more than 10 years.</p> <p>It was not possible to assess differential mortality since no deaths were reported for either surgery or non-surgery in any of the included studies.</p> <p>Quality of life was only reported in 1 study⁵⁶ from the RAND-36 questionnaire but was presented narratively only because results were reported for each domain, rather than as a composite outcome.</p> <p>As specified in the protocol, evidence was presented separately by mean BMI. However, with few studies for many strata, it was difficult to comment about differential effect on different BMIs. Two studies had a mean BMI from 30 to 34.9 kg/m² (though only 1 reported many of the outcomes of interest), 3 had mean BMI 35-39.9 kg/m², but only 1 study had mean BMI between 40 and 49.9 kg/m². While some studies included some people with a BMI of less than 30 kg/m², there were no studies where the mean BMI was less than 30 kg/m².</p> <p>Areas where it was thought that the results might differ (and to examine if there was heterogeneity in the results) included gender, diabetes treatment (particularly use of insulin), ethnicity, use of VLCD, exercise (supervised or advice only), and type of surgery. However, the heterogeneity in all but 1 of the analyses was not important since all studies showed significant benefits for the surgery arm.</p> <p>Many of the studies did not report the ethnicity of the participants or present the results separately by ethnicity. While there were a few studies in Asian countries which included participants at lower BMIs (1 in India, 1 in China and 1 with centres in both the US and Taiwan), the GDG did not feel they could draw conclusions from the evidence about the appropriateness of different BMI thresholds for surgery in these individuals.</p>
Other considerations	<p>The GDG felt that the evidence supported and strengthened the existing recommendation from CG43 for people with T2D and a BMI of 35 or above being offered surgery. They chose to remove the original reference to diabetes from within the existing recommendation relating to surgery in CG43 and made a separate recommendation for the population of obese (BMI 35kg/m² or over) people with recent onset diabetes reflecting the evidence considered in this review.</p> <p>There was only 1 study with a mean BMI of 30-35 kg/m² and the GDG felt that this was not sufficient to support the routine use of bariatric surgery in this population. The GDG felt that bariatric surgery in this group should only be considered in exceptional circumstances (for example, people with other obesity related issues or where diabetes is not being sufficiently managed with alternative measures such as diet, exercise and pharmacological treatments). Because, bariatric surgery may be of some benefit to some individuals, the GDG considered that it was important that healthcare professionals at least considered offering an assessment for individual patients with BMI less than 35 kg/m² on a case-by-case basis and made a weaker</p>

recommendation in this regard reflecting the evidence considered.

While there was limited data on quality of life reported in the included studies, the GDG felt, from their experience, that the improvement in quality of life from treating diabetes would outweigh possible harms from bariatric surgery. The GDG highlighted the importance of collecting data on quality of life in this population in the future. The GDG felt that, from a patient perspective, an improvement of quality of life following surgery would be significant. The GDG noted that there were additional effects of conducting bariatric surgery on other obesity related conditions (for example, joint pain or stress incontinence), as well as diabetes, which can have significant impact upon an individual's quality of life.

The GDG noted that diabetes tends to occur at lower BMIs in Asian patient due to greater abdominal adiposity. The GDG felt that it might be appropriate to consider bariatric surgery at lower thresholds in these individuals. The GDG did not consider that it was possible to specify an exact BMI threshold for this population but noted that the International Diabetes Federation recommends that for people of Asian origin, BMI should be reduced by 2.5 BMI points. They made a consensus recommendation in the absence of any evidence in this review in ethnic minorities recognising the established evidence elsewhere for this group. The GDG noted that NICE public health guidance (PH46 BMI and waist circumference - black, Asian and minority ethnic groups) had identified that these groups are at an equivalent risk of diabetes, other health conditions or mortality at a lower BMI than the white European population. It also noted that the guidance had not found sufficient evidence to make recommendations on the use of new BMI and waist circumference thresholds to classify whether members of these groups are overweight or obese.

The GDG also noted that while most studies included both male and female patients, the results were not reported separately by gender so it was not possible to comment about any differences of bariatric surgery by gender. The GDG considered that women are more likely to have a BMI of over 40 and more likely to access services and felt that it was important that men were encouraged to access services so that they also have opportunities to benefit from effective treatments. They did not wish to make a recommendation in this area.

The GDG acknowledged that different procedures may have different effectiveness and safety profiles but the limited evidence prevented the GDG making any specific comment about differential effect of different procedures. Evidence on biliopancreatic diversion was reported in 1 study and included in the review despite the fact that it is only very rarely used in the UK. The results tend to be slightly better than other types of surgery as it is the most invasive surgery used but there are concerns about the safety of the procedure and people who receive this procedure usually require life-long follow-up. However, the results from this study were removed from the outcome 'improvement in glycaemic control' as it was felt that the results were skewed because of this study. The study reported HbA_{1c} levels less than 5% in the group that received this treatment; the GDG felt that it was very unlikely that HbA_{1c} would be this low for any other type of surgery.

With regards to the other factors which may have differentially affected the results presented in this review (see Appendix C), the GDG noted that most were not reported adequately enough in the studies to consider, and would have been limited by the small number of included studies. These included the use of a VLCD, concomitant supervised exercise versus advice on exercise only, and the use of insulin. Most studies included a mix of participants who did and who did not use insulin but studies did not report the results separately for these individuals. However, the GDG felt, from their clinical experience, that it was likely that people

with insulin resistance were more likely to benefit from bariatric surgery and that people who have poor beta cell function are less likely to benefit. Consequently, it may be important to consider measuring c-peptide as an index of beta-cell function in individuals who are being considered for surgery

The GDG also wished to highlight that bariatric surgery does not result in the cure of diabetes, despite that this is how this is often referred to in the literature. The term 'remission' has been used throughout the document to reflect the terminology used in the studies, despite the fact that the definition often varied slightly among the included studies. The GDG were aware that this concept is often misunderstood by patients and that a perception that diabetes has been cured can mean that some people choose not to continue to access services that are appropriate and important for their health.

The GDG debated the timing of bariatric surgery noting from the evidence that having surgery within 3 years of the onset of diabetes could avoid complications although the long term impact on microvascular disease remains unknown. They discussed the fact that the chances of getting any individual into a bariatric pathway within a 2 year diagnosis of T2D with current commissioning guidelines is very challenging. However, the group felt that surgery within 10 years of diabetes onset could also reduce or delay the need for diabetic medication. The GDG noted that this reduction in medication may be temporary because, as the disease progresses, there is often a need to reintroduce medications. They agreed however that surgery was still worthwhile in this group as the improvement was beneficial as there was improved glycaemic control and reduction in medication usage. For these reasons the GDG did not wish to indicate a specific time frame in their recommendations.

The GDG noted that for patients, the referral to a tier 3 service, including for consideration of bariatric surgery is often seen as a failure on their part. The GDG felt it was important to emphasise to people that this is not the case but represented another treatment option that may be appropriate for the individual.

The GDG highlighted that it was also important for healthcare professionals to optimise HbA_{1c} levels prior to any surgery but did not feel that this required a recommendation as it was considered current practice, as per the British Obesity and Metabolic Surgery Society Tier 3 commissioning guidance.

The GDG chose not to amend the recommendation on bariatric surgery in children and young people with type 2 diabetes as no evidence was identified.

The GDG were aware from expert opinion that there remained challenges in relation to people with learning disabilities accessing services. They felt it was important that people with learning disabilities do have access to specialist advice and that clinicians undertaking health checks for people with learning disabilities should be aware of referral pathways to services for individuals with obesity. They recognised that surgery in this group was rarely considered as an option because of the difficulties with gaining informed consent and because there may be challenges with compliance to advice following surgery. They did note, however, that educational programmes for health, education and social care staff should include training on assessing and managing overweight and obesity in people with learning disabilities.

The GDG wished to highlight that further guidance on tier 3 Obesity services can be found in the NHS England report on Joined up clinical pathways for obesity.

8₁ Follow up care packages

8.1.2 Introduction

3 A post- bariatric surgery care package is ideally provided by a multi-disciplinary team (MDT) offering
4 a multicomponent approach, with some variation in local models of care. It is believed that multi-
5 disciplinary evaluation is vital to providing best patient care and in current NHS arrangements, the
6 follow up team includes bariatric physicians, dietitians, psychologists or psychiatrists, specialised
7 nursing staff, physiotherapists or exercise specialists, and surgeons. The individual's general
8 practitioner (GP) may be involved in requesting annual blood tests or review appointments via a local
9 shared care weight gain agreement. All practitioners recognise that after all procedures there is a
10 minimum level of life-long follow up needed to support good clinical care with variation depending
11 on the type of surgery and individual needs of the patient.

12 Current practice is that initial outpatient follow up should be offered by the tier 4 surgical team to all
13 individuals at 4-6 weeks post-surgery. The surgical aftercare period in the current Commissioning
14 Policy A05⁵³ is 2 years at the surgical centre with recommended life-long nutritional follow up by tier
15 3 or 4 services. Individuals need long term follow up as nutritional and vitamin deficiencies occur at a
16 significant rate³⁵ requiring micro-nutrient monitoring and access to specialist services as needed. The
17 extended period of surgical aftercare is generally considered important to optimise outcomes,
18 supervise long term nutritional and dietary replacement and to identify issues that may require
19 referral back to the medical and surgical MDTs. This may include treatment of comorbidities
20 investigation and treatment of medical and surgical complications (for example, hypoglycaemia,
21 dumping syndrome) and where there are clear surgical or medical indications, addressing weight
22 regain. Ideally, bariatric physicians and surgeons should liaise closely with local tier 3 services and
23 GPs after surgery and consider a shared care model of chronic disease management that arranges for
24 each patient to be reviewed (including nutritional screening) at least annually, indefinitely, with clear
25 protocols for the management of different complications and nutritional deficiencies if they arise.⁵³

26 Reasons for long term follow up were reviewed by the National Confidential Enquiry into Peri-
27 operative Death after bariatric surgery.³⁸ This report emphasised the importance of offering the full
28 range of multi-disciplinary input pre and post-surgery and supporting the individual's needs including
29 improving access to psychological assessment and screening and dietetic education and support.
30 Clear contact details for referral back into the specialist weight management service are required for
31 specialist treatment for example in the event of pregnancy or where plastic surgery is indicated.⁶

32 The current professional standards in the UK include a commitment to long-term follow up with
33 appropriate level of surgical, dietetic, psychology or psychiatric, medical and nursing input. The latest
34 commissioning guidance mandated long term data collection of patients' outcomes with local and
35 national audit results which should be publically available. The challenge in the NHS currently is
36 ensuring that people who have had bariatric surgery have access to such long-term follow-up. Local
37 tier 3 services still do not exist in the majority of areas and the provision of what might be considered
38 standard follow up post bariatric surgery is also variable. Given the importance of minimising harm
39 from unidentified micronutrient deficiencies, suggested improvements in access to psychological
40 follow-up and the importance of maximising outcomes, the GDG wished to identify which
41 components of a follow up care package optimised patient outcomes.³⁸

8.1.2.1 **Review question: What is the clinical and cost effectiveness of follow-up care packages after bariatric surgery compared with usual care?**

44 For full details see review protocol in Appendix C.

1 **Table 43: PICO characteristics of review question**

Population	Adults (18 years and older) and young people (post-puberty) who are overweight or obese and who have undergone bariatric surgery
Intervention(s)	Follow-up care package after bariatric surgery that includes nutritional monitoring and 1 of the following: - problems associated with excess weight loss - avoiding weight regain - specialist psychological, educational, and social support Note: support for becoming pregnant post-bariatric surgery may also be part of the care package
Comparison(s)	Usual care (defined as nutritional monitoring only – not a package; nutritional monitoring includes assessment of dietary history, weight measurements, blood tests, and face to face review)
Outcomes	Critical: 1. % weight loss at latest follow-up (in BMI or kg) (or % excess weight loss) 2. Development of at least 1 micronutrient deficiency (i.e. iron, selenium, zinc, vitamin A, calcium, vitamin B12, vitamin B1) at latest follow-up 3. Health related quality of life / Obesity related quality of life at latest follow-up Important: 4. Reoperation rate at latest follow-up 5. Mortality at latest follow-up 6. Reduction in medication use at latest follow-up 7. Psychological well-being at latest follow-up
Study design	RCTs or systematic reviews of RCTs (conference abstracts if no evidence)

2 People with learning difficulties may be at a higher risk of complications and require additional follow
3 up or support and may be at greater risk of continued excess food intake despite having the
4 procedure. This group may also be at greater risk of nutritional deficiencies. Any evidence on people
5 with learning disabilities would be presented separately, as the evidence allows.

6 In addition, it was felt that absolute minimum study duration of 1 year was required for study
7 inclusion since less than 1 year of follow-up would provide insufficient information on patients after
8 bariatric surgery that require long-term follow-up.

9 The search was conducted from 2006 onwards as it was felt that care after bariatric surgery before
10 this date was unlikely to be applicable to current practice.

8.11.2 Clinical evidence

12 We searched for randomised trials looking at the use of follow-up care packages after bariatric
13 surgery. We considered those which compared usual care, defined as nutritional monitoring only,
14 with follow-up care packages including nutritional monitoring and 1 or more additional component
15 that was aimed at avoiding problems associated with excess weight loss, avoiding weight regain, or
16 providing specialist psychological, educational and social support.

17 Two studies were included in the review^{23,45} and are summarised in Table 28 below.

18 One study⁴⁵ was on a very specific population of severely obese women (greater than 40 kg/m²) after
19 undergoing vertical banded gastroplasty (VBA), which is not currently used in the UK. This study
20 considered a lifestyle intervention compared with usual care. Usual care consisted of 30 sessions
21 over 3 years with a dietitian aimed at giving general information on adopting healthier eating and
22 increasing physical activity (this is more comprehensive than current UK care). The lifestyle
23 intervention consisted of an additional 40 minutes of individualised sessions during their 30 visits
24 with the dietitian and was aimed at helping people overcome barriers and regulate their body

- 1 weight, adopting healthier eating habits and being less sedentary, using a patient-centred
2 collaborative approach and behaviour modification techniques.
- 3 The other study²³ recruited participants that had undergone bariatric surgery 3 or more years
4 previously and had lost less than 50% excess weight. The comparator in this study was wait list
5 control. No additional information was given about what this included. However, the GDG agreed it
6 was acceptable to assume that they had received some element of nutritional monitoring as this was
7 usual care. Outcomes were measured at 12 months.
- 8 Evidence from these studies are summarised in the clinical evidence summary below (). Of the
9 outcomes specified in the protocol, the included studies only reported percentage excess weight
10 loss. As the studies did not report any of the other outcomes in the protocol, actual weight in kg at
11 the end of the study was also reported. Outcomes 1 year after surgery were expected to be different
12 from outcomes 3 years after surgery so it was felt inappropriate to pool results from these studies
13 and they are presented separately.
- 14 See also the study selection flow chart in Appendix B, study evidence tables in Appendix E, forest
15 plots in Appendix D, GRADE tables in Appendix G and excluded studies list in Appendix H.

16 **Table 44: Summary of studies included in the review**

Study	Intervention/ comparison	Population	Outcomes	Comments
Kalarchian 2012 ²³ US	Behavioural programme to help weight loss with dietary and physical activity delivered in groups and with telephone support versus wait list control group	n=36 patients with a BMI of 30 or more who had undergone bariatric surgery at least 3 years before and had less than 50% excess weight loss	Percentage weight loss at 12 months, change in weight in kg at 12 months	Drop outs: 5 in intervention and 2 in control arm Any treatment received by the wait list control group was not described
Papalazarou 2010 ⁴⁵ Greece	Usual care plus additional behavioural support focusing on nutrition education, dietary intake, and physical activity delivered by dietitian versus usual care (dietary advice and nutritional monitoring only) (both over 3 years)	n=30 severely obese women (BMI > 40 kg/m ²) who underwent vertical banded gastroplasty	Percentage weight loss at 3 years, weight in kg at 3 years	Study does not report how many participants were randomised to each arm; it is assumed that it is 15 per arm

1

1 **Table 45: Clinical evidence summary: Usual care (nutritional monitoring only) versus usual care plus specialist educational support, and avoiding weight regain**

Outcome	Number of studies	Imprecision	GRADE rating	Absolute Difference	Control event rate (per 1000)	Control event rate for continuous outcomes
% weight loss (excess) at 3 years	1	Serious	Very low	MD 26% higher (15.26 to 36.74% higher)	n/a	49.1%
% weight loss (excess) at 1 year	1	No serious imprecision	Low	MD 4.9% higher (2.43 to 7.37% higher)	n/a	0.9%
Weight loss at 3 years	1	Serious	Very low	MD 18.30 kg higher (from 27.73 to 8.87% lower)	n/a	102.5 kg
Mean change in weight loss at 1 year	1	Serious	Very low	MD 3 kg higher (from 9.17 lower to 3.17% higher)	n/a	-0.6 kg
Development of at least 1 micronutrient deficiency (iron, selenium, zinc, vitamin A, calcium, vitamin B12, vitamin B1)	0	-	-	-	-	-
Health related quality of life	0	-	-	-	-	-

2

3

8.1.3 Economic evidence

8.1.3.12 Published literature

- 3 No relevant economic evaluations were identified.
- 4 See also the economic article selection flow chart in Appendix E.

8.1.3.25 Unit costs

- 6 Relevant unit costs are provided below to aid consideration of cost effectiveness.

7 Nutritional monitoring (standard care)

- 8 Nutritional monitoring has 3 components; follow-up visits, nutritional supplementation, and blood
- 9 tests. The costs of these components are detailed in the following sections. The costs below
- 10 represent the majority of costs that are likely to be incurred however regional costs may vary.

11 Follow-up visits

- 12 The costs associated with follow-up visits are displayed in Table 46. For the initial 2 years after
- 13 surgery these visits are likely to take place with a dietitian or bariatric physician. It is assumed that in
- 14 the first year the person has 3 visits, then in subsequent years the individual has 1 follow-up visit per
- 15 year. After the initial 2 years, follow-up is likely to take place with either a dietitian, or with the GP
- 16 within a locally agreed shared care protocol. These annual visits will take place for the remainder of
- 17 the individual's life.

18 **Table 46: Cost of follow up visits**

Health care professional	Number of annual visits	Length of visit (minutes)	Cost per visit	Source
First year post surgery				
Dietitian	3	20 minutes	£31	PSSRU ¹⁰
Second year post surgery				
Surgical consultant	1	20 minutes	£33	PSSRU ¹⁰
Subsequent years				
Dietitian ^(a)	1	15 – 60 minutes	£8 - £31	PSSRU ¹⁰

19 (a) In some cases this appointment may take place with a GP

20

1 Nutritional supplements

2 Table 47: Cost of nutritional supplements shows the costs of the nutritional supplements a patient
3 may take during follow up. Note that some individuals may require additional nutritional
4 supplements and individuals who receive a gastric band or a sleeve gastrectomy may not require
5 these supplements. The exact nutritional supplements provided will be individualised to meet the
6 person's requirements, the following costs represent an average.

7 Table 47: Cost of nutritional supplements

Supplement	Frequency	Cost per dose	Cost per year	Source
Ferrous sulfate (Tablets, coated, dried ferrous sulfate 200 mg (65 mg iron))	Once daily	£0.04	£14	NHS drug tariff ⁴¹
Folic acid (Tablets, 400 mcg)	Once daily	£0.03	£11	NHS drug tariff ⁴¹
Vitamin B12 injection (hydroxocobalamin)	Once every 12 weeks	£3.92	£17 ^(a)	PSSRU ¹⁰ & NHS drug tariff ⁴¹
Multivitamin and mineral (Forceval)	Once daily	£0.16	£58	BNF ²²
Adcal-D3 (calcium carbonate 1.5 g (calcium 600 mg or Ca ²⁺ 15 mmol))	Once daily	£0.07	£27	BNF ²²
	Total		£127	

8 (a) Cost per injection includes 5 minutes of GP practice nurse time¹⁰ and cost of injection (£1)⁴¹

9 Blood tests

10 To monitor potential deficiencies after bariatric surgery, people will require a blood test before their
11 follow up visit so that results can be discussed during the appointment. Examples of blood tests used
12 are full blood count (FBC) tests, and liver function tests (LFTs), which would both be performed 3
13 times in the first year post surgery and then once annually. Different tests are required depending on
14 the type of bariatric surgery which has been carried out; therefore the annual cost of blood tests will
15 also depend on the type of bariatric surgery. The GDG estimated that the annual cost of conducting:
16 Full blood count (FBC), Urea and electrolytes (U and Es), Liver function tests (LFTs), bone tests
17 (calcium and parathormone), Vitamin D, iron studies, B12, folate, fasting lipids and HbA_{1c} would be
18 £178 including 5 minutes of physician time to review the results. The total annual costs of nutritional
19 monitoring are summarised in Table 48: Total cost for minimal follow-up.

20
21

1 **Table 48: Total cost for minimal follow-up**

Years after surgery	Visits	Supplements	Blood tests	Total
1	£31	£127	£178	£336
2	£33	£127	£178	£338
3 onwards (with dietitian)	£8 - £31	£127	£178	£313 - 336

2 **Economic considerations**

3 Using the incremental cost of providing two years of follow up, relative to nothing, the QALY increase
4 which would be required for two years of follow-up to be considered cost effective at a £20,000 per
5 QALY threshold can be calculated like so:

$$\text{Change in QALYs} = \frac{\text{Change in cost}}{\text{£20,000}}$$

6

7 Therefore if 2 years of follow-up post-surgery costs £674 then it will need to produce 0.0337 QALYs
8 to be considered cost-effective at a £20,000 per QALY threshold.

9

$$0.0337 = \frac{\text{£674}}{\text{£20,000}}$$

8.2 Evidence statements

8.2.11 Clinical

8.2.1.12 Immediately post-surgery:

- 13 • Evidence from 1 RCT of 29 participants showed that a post-bariatric follow-up care package may
14 have a clinical difference over usual care in terms of % excess weight loss after 12 months. (Low
15 quality).

8.2.1.26 At least 3 years post-surgery:

- 17 • Evidence from 1 RCT of 30 participants showed that a post-bariatric follow-up care package may
18 have a clinical benefit over usual care alone in terms of % excess weight loss after 3 years. (Very
19 low quality).

8.2.20 Economic

- 21 • No relevant economic evaluations were identified.
22 • An original comparative cost analysis showed that:
23 o Two years of post-bariatric follow-up would need to produce 0.0337 QALYs to be considered
24 cost-effective at a £20,000 threshold.
25 o This analysis was considered directly applicable with potentially serious limitations.

26

8.2.3 Recommendations and link to evidence

<p>Recommendations</p>	<p>110. Offer people who have had bariatric surgery a follow-up care package for a minimum of 2 years within the bariatric service. This should include:</p> <ul style="list-style-type: none"> • monitoring nutritional intake (including protein and vitamins) and mineral deficiencies • monitoring for comorbidities • medication review • dietary and nutritional assessment, advice and support • physical activity advice and support • psychological support tailored to the individual • information about support groups.[new 2014] <p>111. After discharge from bariatric surgery service follow-up, ensure that all people are offered at least annual monitoring of nutritional status and appropriate supplementation according to need following bariatric surgery, as part of a shared care model of chronic disease management.[new 2014]</p>
<p>Relative values of different outcomes</p>	<p>The GDG considered the following outcomes to be critical for this review: Percentage weight loss at latest follow-up; development of at least 1 micronutrient deficiency at latest follow-up and health-related quality of life at latest follow-up. The GDG also noted that the following were important outcomes: re-operation rate; mortality; reduction in medication use and psychological well-being (all at latest follow-up).</p> <p>The GDG felt that the most valuable way of measuring weight loss was one that took into account baseline values. Change values and final values of weight do not take into account the changes from baseline for each patient, so the GDG chose percentage weight loss (that is the average of percentages of weight loss) as the most critical outcome to decision making when determining the adequacy of follow-up care packages. However, as one study did not report any other outcomes specified in the protocol, final weight scores were also reported. The GDG were concerned with people not receiving an adequate diet after bariatric surgery so felt micronutrient deficiency as another critical outcome in their decision-making.</p> <p>Other aspects of the patient experience after bariatric surgery were felt to impact greatly on the individual so health-related quality of life was an outcome the GDG found to be critical to decision making. Reoperation rates were thought to be particularly important measure of the adequacy of a care package after bariatric surgery. While rare, the GDG were interested in the difference in mortality rates between different care packages after bariatric surgery.</p> <p>The GDG found the requirement for medication (particularly for comorbidities such diabetes or hypertension) in the follow-up period after bariatric surgery to be a useful outcome to consider when comparing a care package with usual care. While this was considered to be part of health-related quality of life, the GDG felt that the psychological well-being of people after bariatric surgery is particularly important so felt it was important to look for any evidence of differences in psychological well-being resulting from different care packages.</p>

<p>Trade-off between clinical benefits and harms</p>	<p>One study (Papalazarou 2010⁴⁵) found post bariatric care packages to be more clinically effective than usual care at increasing % weight loss. However, the GDG interpreted this evidence of benefit with caution for a number of reasons.</p> <p>Usual care in this study (Papalazarou 2010⁴⁵) was not representative of usual care in the UK. The GDG considered it above the level of care given in the UK with extensive follow up appointments.</p> <p>The GDG also discussed the fact that the higher baseline weight in the intervention arm (4-5 kg based on difference of 1.5 kg/m² BMI) could have influenced the outcome. They also felt mistrustful of the data given the lack of information on withdrawals and the small study size. After bariatric surgery, there is likely to be at least some withdrawals, particularly in those people with poorer outcomes and over 3 years of follow-up. Given the uncertainty in the number of participants included in the final outcomes reported, there was very little confidence in the results.</p> <p>Another study²³ compared post bariatric care packages to usual care in people that had undergone bariatric surgery 3 or more years prior to the study and had less than 50% excess weight loss. Post bariatric care packages were found to be more clinically effective than usual care at 12 months follow-up.</p> <p>However, the GDG felt that there are particular needs with people who have had bariatric surgery. They felt that current practice in the UK was not consistent and, in their experience, people are often lost to follow-up after bariatric surgery. From their experience, the GDG felt that an active level of follow-up care was necessary in order to give patients support with the different aspects of the patient experience (see 'Other considerations' below).</p> <p>The GDG did not consider there to be any harms associated with the provision of a follow up package of care but recognised the very real harm to the individual if nutritional deficiencies were not appropriately identified or managed in a timely manner.</p>
<p>Trade-off between net health benefits and resource use</p>	<p>No economic evaluations were identified in the literature. It was estimated that providing the minimal level of care would cost approximately £674 for the first two years post-surgery. At this cost follow-up care would need to produce 0.0337 QALYs to be considered cost-effective at a £20,000 per QALY threshold.</p> <p>The GDG recognised that the consequences of not providing this level of care can be severe: high probability of weight regain, depression, nutritional deficiencies, osteoporosis, anaemia, and even death. There would also be significant costs involved in treating these outcomes. Therefore the GDG agreed that follow-up as specified is highly likely to be cost-effective, at a £20,000 per QALY threshold, as not only will it provide significant health improvements but it will also reduce future NHS costs.</p>
<p>Quality of evidence</p>	<p>Two studies^{23,45} were included in the clinical review. One study⁴⁵ reported on a small and very specific population of 30 severely obese women who had undergone vertical banded gastroplasty, a procedure not currently used in the UK. Of the outcomes of interest to the GDG (and specified in the review protocol), the study only reported percentage excess weight loss at end of study.</p> <p>No information was given in the study about how many participants were in each arm of the trial so it was assumed that it was a 50-50 divide. No information was given on study withdrawals, a common problem in post-bariatric care, particularly for people with poor outcomes. As a result, the results are likely to overestimate the effectiveness of the intervention.</p> <p>Overall, the study was found to be at very high risk of bias. There were no details of the randomisation sequence or if there was allocation concealment (selection bias), no details on how the outcome was calculated (measurement bias), issues related to</p>

	<p>lack of blinding, and, as described above, there were no details of drop-outs so there is a high risk of incomplete outcome bias.</p> <p>The other study²³ was a small and selective population comprising of people who had bariatric surgery 3 or more years previously and had less than 50% excess weight loss. Usual care was defined as a wait list control without any further information given. The GDG felt that it was acceptable to assume that this included nutritional monitoring.</p> <p>Both studies reported 1 critical outcome (% excess weight loss) which was very low quality. The GDG agreed that the evidence for this question was limited and of poor quality and made consensus recommendations on the experience and opinion of the GDG.</p> <p>No relevant evidence was available for consideration from the conference abstracts identified in the search for this review question.</p> <p>No evidence was found to inform recommendations in the pre-specified subgroups or strata in the protocol including for young people (from post-puberty to 18 year), by surgery type, for different ethnicities, for people with T2D, or for people with learning disabilities.</p>
Other considerations	<p>The GDG considered the applicability of these studies and discussed the challenges in providing care in this area. Current practice is variable and the GDG felt that, while research into different care packages for a longer period of follow up would be valuable, it was important to provide advice for the NHS now to mitigate against poor care and to encourage longer term sustainable positive outcomes. Consequently, the GDG chose to make a number of consensus recommendations.</p> <p>The GDG noted the limited poor quality evidence and therefore the recommendations were drafted based on the experience and opinion of the GDG. The GDG felt that their draft recommendations were applicable to adults and children and felt that the detail contained within them could apply to those population sub-groups where they had looked for evidence but not found any (for example, people with learning disabilities or individuals from different ethnic minorities).</p> <p>For the purposes of this review, the GDG chose nutritional monitoring as a comparator as this is assumed to be the very minimum level of care that should be provided post-bariatric surgery (although current practice is variable in terms of quality). The GDG felt that a number of areas would be important to consider as part of a follow-up care package to ensure safety and wellbeing after bariatric surgery. These included specific interventions and also a clarification of a time frame regarding the follow-up.</p> <p>The GDG noted that the nature and quality of follow up care varied around the UK. The GDG were unanimous that that follow up care needs to be provided by the surgical team (tier 4) for a minimum of 2 years in the first instance. They noted that this 2 year time frame was also in line with the Tier Commissioning Guidance recommendations.⁵³ They made a strong recommendation about this on the basis that it would be unethical not to offer this follow-up care. The responsibility for follow up thereafter usually takes place within tier 3 services. As such, the recommendations drafted re-iterate what should be considered routine practice following bariatric surgery.</p> <p>As well as specifying that nutritional status should be monitored at least annually after discharge from a bariatric surgery service for all patients with no time limit, the</p>

GDG chose also to include this in a package of follow-up care to allow screening for and replacement of nutritional, vitamin and mineral deficiencies to sit alongside appropriate dietetic assessment, advice and support after surgery. The GDG felt that, from their experience, up to a third²⁴ of people having bariatric surgery would have good weight loss initially but then experience weight regain. The provision of appropriate dietary advice and support with behavioural change and access to tailored psychological support as necessary was considered important in order to mitigate against this wherever possible.

The GDG noted the importance of monitoring comorbidities, such as T2D, since some individuals may ultimately have relapse of diabetic symptoms such as a lack of glycaemic control after initial improvements following surgery. The GDG highlighted the need to continue screening for retinopathy in these individuals, given the potential risk of missing sight threatening problems.

The GDG also noted that many people who have had bariatric surgery have not previously been in a position to exercise because the degree of their obesity limited physical activity. The GDG felt that providing specialist physical activity and support would be an important component of any follow-up care package and that this should be tailored to the person to ensure that any barriers to exercise or increased physical activity after surgery were removed for example, lack of knowledge or understanding of the benefits of exercise.

The group discussed the importance of providing access to psychological screening and support following surgery and were aware that the need for and the degree of psychological intervention required would vary between individuals and over time. CG43 made recommendations regarding pre-operative psychological support including the availability for such support after surgery by a multidisciplinary team (original rec 1.2.6.9 adults and 1.2.6.14 children). Psychological needs after bariatric surgery can vary enormously and can include issues such as adjusting to changes in the relationship with food and body size, managing the impact on social relationships as well as dealing with excess skin including consequent difficulties with hygiene, activity and self-image. The patient members of the group identified clearly with the challenges that this may bring, reporting that a number of people may require 'body-contouring' plastic surgery to remove excess skin in order to maximise opportunities for physical activity, sexual function and psychological health.

The GDG discussed the issue regarding the provision of follow up social support and noted the value that social support and local peer support groups (including online and local groups) can offer in supporting the delivery of some of the elements of a follow-up care package and in helping to maintain weight loss. It was particularly noted that people can discharge themselves from services following surgery as all seems to be going well and they have lost the weight intended through surgical measures. It was noted that a follow-up care package has the additional benefit of keeping people engaged in a programme of activity that can ensure that the initial benefits of surgery are maximised and the potential harms of nutritional deficiency are minimised. It was noted from GDG experience that patients often value support and advice from professionals after surgery (including dietary, physical activity and psychological support) and feel there should be more clear guidance for their primary care physicians about monitoring after surgery and about the provision for surgery for excess skin.

The quality of current services vary with the GDG reporting that often the basic service of annual monitoring of nutritional status is being implemented to varying degrees. The GDG felt that the absence of this care in a coherent and consistent manner represented significant risk to the individual who may suffer from long term

harm because of unidentified nutritional deficiencies (such as, Wernicke's encephalopathy, peripheral neuropathy, anaemia, osteoporosis, night blindness, or death) because of a lack of expertise within primary care interpreting blood tests that determine nutritional status. Because of this risk of harm, the GDG chose to make a consensus recommendation in this area.

Finally, the GDG wished to note that it was their experience that women who have had bariatric surgery have enhanced fertility compared to pre-surgery and that pregnancy (intended or not) is often identified within a 12 month follow-up period in tier 4 services. This group require specialist support so the GDG felt it was important to highlight this potential to all services to manage the risks to mother and baby if access to follow up care is not taken up.

1

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10₁ Acronyms and abbreviations

ABV	Alcohol by volume
BMEG	Black and minority ethnic group
BMI	Body mass index
BT	Behavioural therapy or behavioural treatment
CBA	Controlled before-and-after study
CC	Collaborating centre
CCT	Controlled clinical trial
CHD	Coronary heart disease
CEA	Cost-effectiveness analysis
CG	Clinical guideline
CI	Confidence interval
CPHE	Centre for Public Health Excellence
CUA	Cost-utility analysis
CVD	Cardiovascular disease
DH	Department of Health
EBQ	Evidence-based question
EQ5D	EuroQol 5 dimensions
FBC	Full blood count
GDG	Guideline development group
GP	General practitioner
GPP	Good practice point
GRP	Guideline review panel
HC	High carbohydrate
HDA	Health development agency
HDL	High-density lipoprotein
HP	High protein
HR	Hazard ratio
HRQoL	Health-related quality of life
HTA	Health technology assessment
ICER	Incremental cost-effectiveness ratio
IOTF	International Obesity Taskforce
ITT	Intention to treat
kcal	Calories
LAGB	Laparoscopic (adjustable) gastric banding
LCD	Low-calorie diet
LDL	Low-density lipoprotein
LED	Low-energy diet
LFT	Liver function test
LSP	Local strategic partnership
LYG	Life year gained
MD	Mean difference
MDT	Multi-disciplinary team

MID	Minimal important difference
mo	Months
NCC-PC	National Collaborating Centre for Primary Care
NHMRC	National Health and Medical Research Council (Australia)
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
NR	Not reported
NSF	National service framework
NSP	Non-starch polysaccharides
OR	Odds ratio
PCT	Primary care trust
PICO	Framework incorporating patients, interventions, comparisons, and outcomes used for the development of evidence-based questions
PSMF	Protein-sparing modified fast
QALY	Quality-adjusted life year
RCT	Randomised control trial
RDA	Recommended daily allowance
RR	Risk ratio or relative risk
SBP	Systolic blood pressure
SD	Standard deviation
SE	Standard error
SEG	Socioeconomic group
SES	Socioeconomic status
SIGN	Scottish Intercollegiate Guidelines Network
VBG	Vertical banded gastroplasty
VLCD	Very-low-calorie diet
VLED	Very-low-energy diet
WC	Waist circumference
WHR	Waist-to-hip ratio
WHO	World Health Organisation
wk	Week
yr	Year

11₁ Glossary

Abdominoplasty	Plastic surgery of the abdomen in which excess fatty tissue and skin are removed, usually for cosmetic purposes.
Abstract	Summary of a study, which may be published alone or as an introduction to a full scientific paper.
Active play	What children and young people do when they follow their own ideas and interests, in their own way and for their own reasons – such as 'play active games, run about, ride a bike, kick a ball around'(based on Department for Culture Media and Sport definition of play and Health Survey for England 1997 definition of active play).
Active transport/travel	A form of transport that requires physical activity e.g. walking or cycling.
Adiposity	Body fat
Ad libitum diet	No dietary or calorie restrictions
Adult	For the purposes of this guideline, adult is defined as an individual >18 years.* *However it is not considered helpful to have absolute cut offs for ages of children/young persons since the facilities available for the transition of care from child to adult centres can vary between specialities e.g. mental health, endocrinology.
Algorithm (in guidelines)	A flow chart of the clinical decision pathway described in the guideline, where decision points are represented with boxes, linked with arrows.
Allocation concealment	The process used to prevent advance knowledge of group assignment in an RCT. The allocation process should be impervious to any influence by the individual making the allocation, by being administered by someone who is not responsible for recruiting participants.
Anthropometry	Measures of the human body
Applicability	How well the results of a study or NICE evidence review can answer a clinical question or be applied to the population being considered.
Arm (of a clinical study)	Subsection of individuals within a study who receive one particular intervention, for example placebo arm.
Association	Statistical relationship between 2 or more events, characteristics or other variables. The relationship may or may not be causal.
Balanced caloric-deficit diet	A mixed diet containing protein, fat and carbohydrate and providing less energy than energy requirements.
Bariatric surgery	Surgery on the stomach and/or intestines to help the person with extreme obesity lose weight.
Baseline	The initial set of measurements at the beginning of a study (after run-in period where applicable), with which subsequent results are compared.
Behavioural intervention	Refers to the use of the common components of behavioural treatment (self-monitoring, goal setting, stimulus control).
Behavioural treatment	Behavioural treatment (or behaviour therapy) draws on the principles of learning theory (stimulus–behaviour contingencies or behaviour–reward contingencies). Consists of assessment (identifying and specifying problem behaviours and the circumstances in which they are elicited), treatment (including setting specific, measurable and modest goals that are continually revised) and monitoring. Behaviour change processes include stimulus control, graded exposure, extinction and reward.
Beta cells	Produce insulin in response to rising blood glucose levels and mainly regulate the metabolism of carbohydrates, but also of proteins and fats.
Bias	Influences on a study that can make the results look better or worse than

	they really are (bias can even make it look as if a treatment works when it does not). Bias can occur by chance, deliberately or as a result of systematic errors in the design and execution of a study. It can also occur at different stages in the research process: for example, during the collection, analysis, interpretation, publication, or review of research data. For examples see selection bias, confounding factor, and publication bias.
Bilo-pancreatic diversion	A type of weight loss surgery that is similar to a gastric bypass (see below) except that a much larger section of the small intestine is bypassed.
Binge eating disorder (BED)	A syndrome in which an individual experiences repeated uncontrolled episodes of overeating but does not use extreme compensatory weight-control behaviours. Current definitions recognise that this becomes a disorder when binge eating episodes are occurring at least twice a week for a period of 6 months or more. Usually individuals with this disorder feel a compulsion to eat, usually binge eat in private and experience high levels of distress and shame about these behaviours.
Bio-electrical impedance analysis	A way to estimate the amount of body weight that is fat and non-fat. Non-fat weight comes from bone, muscle, body water, organs and other body tissues. BIA works by measuring how difficult it is for a harmless electrical current to move through the body. The more fat a person has, the harder it is for electricity to flow through the body. The less fat a person has, the easier it is for electricity to flow through the body. By measuring the flow of electricity, one can estimate body fat per cent.
Blinding	A way to prevent researchers, doctors and patients in a clinical trial from knowing which study group each patient is in so they cannot influence the results. The best way to do this is by sorting patients into study groups randomly. The purpose of 'blinding' or 'masking' is to protect against bias. A single-blinded study is one in which patients do not know which study group they are in (for example whether they are taking the experimental drug or a placebo). A double-blinded study is one in which neither patients nor the researchers/doctors know which study group the patients are in. A triple blind study is one in which neither the patients, clinicians or the people carrying out the statistical analysis know which treatment patients received.
Body mass index (BMI)	Commonly used to measure whether or not adults are a healthy weight or underweight, overweight or obese. It is defined as the weight in kilograms divided by the square of the height in metres (kg/m ²).
BMI z score	<p>BMI z score is a measure of how many standard deviations a child or young person's BMI is above or below the average BMI for their age and gender (this is based on a reference population known as a child growth reference). For instance, a z score of 1.5 indicates that a child is 1.5 standard deviations above the average value, and a z score of -1.5 indicates a child is 1.5 standard deviations below the average value.</p> <p>The advantage of using BMI z scores, instead of BMI, is that it allows direct comparison of BMI (and any changes in BMI) across different ages and by gender. This term is sometimes used interchangeably with 'BMI standard deviation score' (BMI SDS). See the National Obesity Observatory's A simple guide to classifying body mass index in children.</p> <p>Care is needed when interpreting BMI z scores using the UK 1990 centile charts for black, Asian and other minority ethnic groups. There is evidence to suggest that adults from these groups are at risk of obesity-associated conditions and diseases at a lower BMI than the white population.</p>
Bulimia nervosa	A syndrome characterised by recurrent episodes of binge eating and by compensatory behaviour (vomiting, purging, fasting or exercising) in

	order to prevent weight gain. Binge eating is accompanied by a subjective feeling of loss of control over eating. This is a normal weight syndrome in which the body mass index (BMI) is maintained above 17.5 kg/m ² .
Calorie value	The number of calories (kcal) in any given food or drink. Fat provides 9 calories per gram, alcohol provides 7 calories per gram, carbohydrates and proteins provide 4 calories per gram. 1 kcal = 4.2 kilojoules (kJ).
Carer (caregiver)	Someone who looks after family, partners or friends in need of help because they are ill, frail or have a disability.
Case series	Report of a number of cases of a given disease, usually covering the course of the disease and the response to treatment. There is no comparison (control) group of patients.
Child	For the purposes of this guidance, child is defined as an individual aged <18 years* *However, it is not considered helpful to have absolute cut-offs for ages of children/young persons since the facilities available for the transition of care from child to adult centres can vary between specialties e.g. mental health, endocrinology.
Cholelithiasis	See gallstones
Clinical effectiveness	How well a specific test or treatment works when used in the 'real world' (for example, when used by a doctor with a patient at home), rather than in a carefully controlled clinical trial. Trials that assess clinical effectiveness are sometimes called management trials. Clinical effectiveness is not the same as efficacy.
Clinician	A healthcare professional who provides patient care. For example: a doctor, nurse, or physiotherapist.
Cochrane Review	The Cochrane Library consists of a regularly updated collection of evidence-based medicine databases including the Cochrane Database of Systematic Reviews (reviews of randomised controlled trials prepared by the Cochrane Collaboration).
Cohort study	A retrospective or prospective follow-up study. Groups of individuals to be followed up are defined on the basis of presence or absence of exposure to a suspected risk factor or intervention. A cohort study can be comparative, in which case two or more groups are selected on the basis of differences in their exposure to the agent of interest.
Comorbidities	Comorbidities are diseases or conditions that someone has in addition to the health problem being studied or treated. Some comorbidities, such as type 2 diabetes, are associated with being overweight or obese, because the risk of developing them increases with an increasing BMI.
Complex obesity	Complex obesity occurs when someone who is obese has additional and related diseases or conditions, for example, type 2 diabetes. It can also occur when obesity results from an underlying condition, for example, an endocrine disease or condition, or when it is associated with various syndromes (such as Prader-Willi syndrome). Complex obesity can occur regardless of how obese the person is, although it is more likely as BMI increases.
Confidence interval (CI)	There is always some uncertainty in research. This is because a small group of patients is studied to predict the effects of a treatment on the wider population. The confidence interval is a way of expressing how certain we are about the findings from a study, using statistics. It gives a range of results that is likely to include the 'true' value for the population. The CI is usually stated as '95% CI', which means that the range of values has a 95 in a 100 chance of including the 'true' value. For example, a study may state that 'based on our sample findings, we are 95% certain that the 'true' population blood pressure is not higher than 150 and not lower than 110'. In

	<p>such a case the 95% CI would be 110 to 150.</p> <p>A wide confidence interval indicates a lack of certainty about the true effect of the test or treatment - often because a small group of patients has been studied. A narrow confidence interval indicates a more precise estimate (for example, if a large number of patients have been studied).</p>
Confounding factor	<p>Something that influences a study and can result in misleading findings if it is not understood or appropriately dealt with.</p> <p>For example, a study of heart disease may look at a group of people that exercises regularly and a group that does not exercise. If the ages of the people in the 2 groups are different, then any difference in heart disease rates between the 2 groups could be because of age rather than exercise. Therefore, age is a confounding factor.</p>
Consensus methods	<p>Techniques used to reach agreement on a particular issue. Consensus methods may be used to develop NICE guidance if there is not enough good quality research evidence to give a clear answer to a question. Formal consensus methods include Delphi and nominal group techniques.</p>
Constipation	<p>A term to describe the subjective complaint of passage of abnormally delayed or infrequent passage of dry, hardened faeces often accompanied by straining and/or pain.</p>
Control group	<p>A group of people in a study who do not receive the treatment or test being studied. Instead, they may receive the standard treatment (sometimes called 'usual care') or a dummy treatment (placebo). The results for the control group are compared with those for a group receiving the treatment being tested. The aim is to check for any differences.</p> <p>Ideally, the people in the control group should be as similar as possible to those in the treatment group, to make it as easy as possible to detect any effects due to the treatment.</p>
Cost–benefit analysis (CBA)	<p>Cost-benefit analysis is one of the tools used to carry out an economic evaluation. The costs and benefits are measured using the same monetary units (for example, pounds sterling) to see whether the benefits exceed the costs.</p>
Cost-effectiveness analysis (CEA)	<p>Cost-effectiveness analysis is one of the tools used to carry out an economic evaluation. The benefits are expressed in non-monetary terms related to health, such as symptom-free days, heart attacks avoided, deaths avoided, or life years gained (that is, the number of years by which life is extended as a result of the intervention).</p>
Cost-effectiveness model	<p>An explicit mathematical framework which is used to represent clinical decision problems and incorporate evidence from a variety of sources in order to estimate the costs and health outcomes.</p>
Cost–utility analysis (CUA)	<p>Cost-utility analysis is one of the tools used to carry out an economic evaluation. The benefits are assessed in terms of both quality and duration of life, and expressed as quality-adjusted life years (QALYs). See also utility.</p>
C-peptide	<p>Biologically inactive part of pro-insulin molecule, secreted in equal molar quantities with insulin. C-peptide level gives information on endogenous insulin secretion.</p>
Depression	<p>Depression is a broad and heterogeneous diagnosis. Central to it is depressed mood and/or loss of pleasure in most activities. A chronic physical health problem can both cause and exacerbate depression: pain, functional impairment and disability associated with chronic physical health problems can greatly increase the risk of depression in people with physical illness. Depression can also exacerbate the pain and distress associated with physical illnesses and adversely affect outcomes, including shortening life expectancy.</p>
Diabesity	<p>A popular term for the association of type 2 diabetes mellitus and obesity.</p>

Diabetes mellitus	Chronic condition characterised by elevated blood glucose levels. Diabetes is of diverse aetiology and pathogenesis, and should not be regarded as a single disease. Predominant types are Type 1 diabetes and Type 2 diabetes, diabetes secondary to other pancreatic disease or other endocrine disease, and diabetes of onset in pregnancy.
Diarrhoea	A condition in which the sufferer has frequent and watery or loose bowel movements (from the ancient Greek word διαρροή = leakage; lit. "to run through").
Diet	The habitual food intake of people or animals or A plan of food and drink set down for the loss of weight, or a prescribed plan for medical reasons.
Disordered eating	Refers to a range of irregular eating behaviours that have not been given a specific diagnosis of eating disorder such as anorexia nervosa or bulimia nervosa.
Drop-out	A participant who withdraws from a trial before the end.
Dumping syndrome	A set of symptoms that can affect people after a gastrectomy. It is caused when particularly sugary or starchy food moves suddenly into the small intestine.
Duodenal switch	A type of weight loss surgery in which the size of the stomach is reduced, leaving in place the pylorus and a little of the duodenum which is anastomosed (or joined to the ileum).
Economic evaluation	An economic evaluation is used to assess the cost effectiveness of healthcare interventions (that is, to compare the costs and benefits of a healthcare intervention to assess whether it is worth doing). The aim of an economic evaluation is to maximise the level of benefits - health effects - relative to the resources available. It should be used to inform and support the decision-making process; it is not supposed to replace the judgement of healthcare professionals. There are several types of economic evaluation: cost-benefit analysis, cost-consequence analysis, cost-effectiveness analysis, cost-minimisation analysis and cost-utility analysis. They use similar methods to define and evaluate costs, but differ in the way they estimate the benefits of a particular drug, programme or intervention.
Effect (as in effect measure, treatment effect, estimate of effect, effect size)	A measure that shows the magnitude of the outcome in one group compared with that in a control group. For example, if the absolute risk reduction is shown to be 5% and it is the outcome of interest, the effect size is 5%. The effect size is usually tested, using statistics, to find out how likely it is that the effect is a result of the treatment and has not just happened by chance (that is, to see if it is statistically significant).
Effectiveness	How beneficial a test or treatment is under usual or everyday conditions, compared with doing nothing or opting for another type of care.
Efficacy	How beneficial a test, treatment or public health intervention is under ideal conditions (for example, in a laboratory), compared with doing nothing or opting for another type of care.
Energy-dense food	Food and drinks which provide relatively high amounts of calories per gram, millilitre and/or serving. The World Health Organization (2003) states that energy-dense foods 'tend to be processed foods that are high in fat and/or sugar. Low energy-dense (or energy dilute) foods such as fruit, legumes, vegetables and whole grain cereals are high in dietary fibre and water.'
EQ-5D (EuroQol 5	A standardised instrument used to measure health-related quality of life. It

dimensions)	provides a single index value for health status.
Evidence	Information on which a decision or guidance is based. Evidence is obtained from a range of sources including randomised controlled trials, observational studies, expert opinion (of clinical professionals or patients).
Exclusion criteria (literature review)	Explicit standards used to decide which studies should be excluded from consideration as potential sources of evidence.
Exclusion criteria (clinical study)	Criteria that define who is not eligible to participate in a clinical study.
Exercise	Planned bouts of physical activity usually pursued for personal health and fitness goals. Exercise is a subset of physical activity, which is planned, structured, and repetitive. It is aimed at improving or maintaining any aspect of fitness or health.
Extrapolation	An assumption that the results of studies of a specific population will also hold true for another population with similar characteristics.
Fast foods	No specific definition but commonly used slang term for foods which are generally sold in retail outlets and which are high in calories, fat, saturated fat, sugar and/or salt.
Fatty acids	Organic acids containing carbon, hydrogen, and oxygen. Fatty acids are an important component of lipids (fat-soluble components of living cells).
Fatty foods	Foods high in total fat and/or saturated fat. The Food Standards Agency (FSA) provides the following guidance: 20g fat or more per 100g is a lot of fat 5g saturates or more per 100g is a lot 3g fat or less per 100g is a little fat 1g saturates or less per 100g is a little fat.
Follow-up	Observation over a period of time of an individual, group or initially defined population whose appropriate characteristics have been assessed in order to observe changes in health status or health-related variables.
Gallstones	Small stones, usually made of cholesterol, that form in the gallbladder.
Gastrectomy	Surgical removal of all or part of the stomach.
Gastric balloon	A soft silicone balloon that is surgically implanted into the stomach. The balloon is filled with air or saline solution (sterile salt water), and so takes up some of the space in the stomach.
Gastric band	A type of weight loss surgery that reduces the capacity of the stomach using an adjustable band.
Gastric bypass	A type of weight loss surgery that reduces the size of the stomach and shortens the length of the small intestine that food passes through.
Gastrostomy	Enteral tube inserted through the abdominal wall into the stomach for the purpose of nutrition support.
Glucose	Glucose comes from digesting carbohydrate and is also produced by the liver. Carbohydrate comes from many different kinds of food and drink, including starchy foods such as bread, potatoes and chapatis; fruit; some dairy products; sugar and other sweet foods (Diabetes UK 2010).
Glycaemic control	The regulation and maintenance of blood glucose levels within normal ranges.
Glycated haemoglobin (HbA1c)	Forms when red cells are exposed to glucose in the plasma. The HbA1c test reflects average plasma glucose over the previous eight to 12 weeks. Unlike the oral glucose tolerance test, an HbA1c test can be performed at any time of the day and does not require any special preparation such as fasting. HbA1c is a continuous risk factor for type 2 diabetes. This means there is no fixed point when people are or are not at risk. The World Health Organization recommends a level of 6.5% (48 mmol/mol) for HbA1c as the

	cut-off point for diagnosing type 2 diabetes in non-pregnant adults.
Gout	A type of arthritis where crystals of sodium urate form inside and around joints.
GRADE, GRADE profile	A system developed by the GRADE Working Group to address the shortcomings of present grading systems in healthcare. The GRADE system uses a common, sensible and transparent approach to grading the quality of evidence. The results of applying the GRADE system to clinical trial data are displayed in a table known as a GRADE profile.
Harms	Adverse effects of an intervention.
Health economics	Study or analysis of the cost of using and distributing healthcare resources.
Health-related quality of life (HRQoL)	A measure of the effects of an illness to see how it impacts upon someone's day-to-day life.
Healthy diet	<p>A healthy diet contains plenty of fruit and vegetables; is based on starchy foods such as wholegrain bread, pasta and rice; and is low in fat (especially saturated fat), salt and sugar.</p> <p>Specific dietary recommendations (UK) (Population average intakes; apply to children aged 5 years and over)</p> <p>Total fat: maintain at 35% of food energy Saturated fat: reduce to 11% of food energy Added sugar: reduce to 11% of food energy Fibre: increase to 18g/day Salt: reduce to no more than 6g/day*</p> <p>Fruit and vegetables: increase consumption of a variety of fruit and vegetables to at least five portions per day.</p> <p>*1The maximum amount of salt recommended for children is less than that for adults – see www.eatwell.gov.uk for specific recommendations.</p>
Healthy weight	A person who has a body mass index (BMI) 18.5-24.9.
Heterogeneity or Lack of homogeneity	The term is used in meta-analyses and systematic reviews to describe when the results of a test or treatment (or estimates of its effect) differ significantly in different studies. Such differences may occur as a result of differences in the populations studied, the outcome measures used or because of different definitions of the variables involved. It is the opposite of homogeneity.
Hypertension	High blood pressure
Hypoglycaemia	Low blood glucose level
Impaired glucose tolerance	This is a risk factor for future diabetes and/or other adverse outcomes. The current WHO diagnostic criteria for impaired glucose tolerance are: a fasting plasma glucose of less than 7.0 mmol/l and a 2-hour venous plasma glucose (after ingestion of 75 g oral glucose load) of 7.8 mmol/l or greater, and less than 11.1 mmol/l.
Imprecision	Results are imprecise when studies include relatively few patients and few events and thus have wide confidence intervals around the estimate of effect.
Inclusion criteria (literature review)	Explicit criteria used to decide which studies should be considered as potential sources of evidence.
Incremental cost	The extra cost linked to using one test or treatment rather than another. Or the additional cost of doing a test or providing a treatment more frequently.
Incremental cost-effectiveness ratio (ICER)	The difference in the mean costs in the population of interest divided by the differences in the mean outcomes in the population of interest for one treatment compared with another.
Indirectness	The available evidence is different to the review question being addressed,

	in terms of PICO (population, intervention, comparison and outcome).
Insulin	Insulin is the hormone produced by the pancreas that allows glucose to enter the body's cells, where it is used as fuel for energy. It is vital for life (Diabetes UK 2010).
Intermediate outcomes	Results or outcomes of action that must occur prior to the final outcome and in order to produce the final outcome. Within the context of this work, relevant changes in diet or activity levels may be considered intermediate outcomes for the assessment of interventions to prevent weight or manage obesity.
Intervention	In medical terms this could be a drug treatment, surgical procedure, diagnostic or psychological therapy. Examples of public health interventions could include action to help someone to be physically active or to eat a more healthy diet.
Laparoscopic sleeve gastrectomy	See sleeve gastrectomy
Life-long learning	A continuum of the learning process that takes place at all levels - formal, non-formal and informal - utilizing various modalities such as distance learning and conventional learning.
Lifestyle activity	Activities that are performed as part of everyday life, such as climbing stairs, walking (for example, to work, school or shops) and cycling. They are normally contrasted with 'programmed' activities such as attending a dance class or fitness training session.
Life years gained	Mean average years of life gained per person as a result of the intervention compared with an alternative intervention.
Long-term	For the purposes of this guidance, long-term is considered 1 year or more.
Low-calorie diet	A weight loss diet containing less energy than an individual's energy needs – typically 1000-1500 kilocalories per day.
Low-fat diet	A diet where 30% or less of the total daily energy is derived from fat.
Markov model	A method for estimating long-term costs and effects for recurrent or chronic conditions, based on health states and the probability of transition between them within a given time period (cycle).
Meta-analysis	A method often used in systematic reviews. Results from several studies of the same test or treatment are combined to estimate the overall effect of the treatment.
Metabolic equivalent (MET)	1 MET = a person's metabolic rate (rate of energy expenditure) when at rest. MET values are assigned to activities to denote their intensity and are given in multiples of resting metabolic rate. For example, walking elicits an intensity of 3–6 METs, depending on how brisk the walk is, and more strenuous activity such as running would have an intensity of 7–10 METs.
Multicomponent intervention	An intervention that aims to address a range of factors which may influence the outcome measure of interest. Sometimes referred to as 'multifaceted'.
Night eating syndrome (NES)	Primarily characterises a persistent and ongoing pattern of late-night eating, with more than 25% of a person's calorific intake occurring after the evening meal and associated nocturnal awakening and food ingestion occurring at least 2 or 3 times per week .
Observational study	An epidemiological study that does not involve any intervention, experimental or otherwise. Nature is allowed to take its course with changes in one characteristic being studied in relation to changes in other characteristics.
Oral glucose tolerance test (OGTT)	Involves measuring the blood glucose level after fasting, and then 2 hours after drinking a standard 75g glucose drink. Fasting is defined as no calorie intake for at least 8 hours. More than one test on separate days is required for diagnosis in the absence of hyperglycaemic symptoms.

Outcome	The impact that a test, treatment, policy, programme or other intervention has on a person, group or population. Outcomes from interventions to improve the public's health could include changes in knowledge and behaviour related to health, societal changes (for example, a reduction in crime rates) and a change in people's health and wellbeing or health status. In clinical terms, outcomes could include the number of patients who fully recover from an illness or the number of hospital admissions, and an improvement or deterioration in someone's health, functional ability, symptoms or situation. Researchers should decide what outcomes to measure before a study begins.
P value	The p value is a statistical measure that indicates whether or not an effect is statistically significant. For example, if a study comparing 2 treatments found that one seems more effective than the other, the p value is the probability of obtaining these results by chance. By convention, if the p value is below 0.05 (that is, there is less than a 5% probability that the results occurred by chance) it is considered that there probably is a real difference between treatments. If the p value is 0.001 or less (less than a 1% probability that the results occurred by chance), the result is seen as highly significant. If the p value shows that there is likely to be a difference between treatments, the confidence interval describes how big the difference in effect might be.
Perioperative	The period from admission through surgery until discharge, encompassing the pre-operative and post-operative periods.
Physical activity	The full range of human movement, from competitive sport and exercise to active hobbies, walking, cycling or activities of daily living. Physical activity varies by: Volume or quantity (total quantity of physical activity over a specified period, usually expressed as kcal or METs per day or week); Frequency of participation, typically expressed as number of sessions per day or week; Intensity, usually expressed as light, moderate or vigorous. Commonly used approximations are: light intensity = less than 4 METs, for example, strolling; moderate = 4 – 6 METs, for example, brisk walking, vigorous = 7+ METs for example, running; Duration – time spent on a single bout of activity; Type or mode – qualitative descriptor such as brisk walking, dancing or weight training.
Physical literacy	Motivation, confidence, physical competence, understanding and knowledge to maintain physical activity at an individually appropriate level, throughout life.
Placebo	A fake (or dummy) treatment given to participants in the control group of a clinical trial. It is indistinguishable from the actual treatment (which is given to participants in the experimental group). The aim is to determine what effect the experimental treatment has had over and above any placebo effect caused because someone has received (or thinks they have received) care or attention.
Postoperative	Pertaining to the period after patients leave the operating theatre, following surgery.
Postural hypotension	Condition (also known as orthostatic hypotension) in which a marked fall in blood pressure is provoked by a change in posture from lying to sitting or from lying or sitting to standing. This may cause lightheadedness ("dizziness"), a fall, or transient loss of consciousness (blackout).
Preoperative	The period before surgery commences.

Primary care	Healthcare delivered outside hospitals. It includes a range of services provided by GPs, nurses, health visitors, midwives and other healthcare professionals and allied health professionals such as dentists, pharmacists and opticians.
Protein-sparing modified fast	A diet which is relatively high in protein (0.8-1.5g/kg of ideal body weight (IWB) per day), low fat and low carbohydrates. It is hypocaloric and generally contains fewer than 800 kilocalories per day. It contains supplements to meet the dietary reference values for vitamins and minerals. Often recommended only for short-term use in individuals who are obese.
Psychosocial	Involving aspects of social and psychological behaviour or experience
Publication bias	Publication bias occurs when researchers publish the results of studies showing that a treatment works well and don't publish those showing it did not have any effect. If this happens, analysis of the published results will not give an accurate idea of how well the treatment works. This type of bias can be assessed by a funnel plot.
Quality of life	See 'Health-related quality of life'.
Quality-adjusted life year (QALY)	A measure of the state of health of a person or group in which the benefits, in terms of length of life, are adjusted to reflect the quality of life. One QALY is equal to 1 year of life in perfect health. QALYS are calculated by estimating the years of life remaining for a patient following a particular treatment or intervention and weighting each year with a quality of life score (on a scale of 0 to 1). It is often measured in terms of the person's ability to perform the activities of daily life, freedom from pain and mental disturbance.
Quasi-experimental study	A study in which some subjects receive an experimental prevention or therapeutic product or intervention and are compared with subjects who do not, but allocation to each of the groups is not random.
Randomisation	Assigning participants in a research study to different groups without taking any similarities or differences between them into account. For example, it could involve using a random numbers table or a computer-generated random sequence. It means that each individual (or each group in the case of cluster randomisation) has the same chance of receiving each intervention.
Randomised controlled trial (RCT)	A comparative study in which participants are randomly allocated to intervention and control groups and followed up to examine differences in outcomes between the groups.
RCT	See 'Randomised controlled trial'.
Recent-onset diabetes	Defined for the purposes of this guideline as within 10 years of diagnosis.
Red food	From Epstein and coworkers' traffic light diet. Consists of high in calories, low in nutrient density foods.
Relative risk (RR)	The ratio of the risk of disease or death among those exposed to certain conditions compared with the risk for those who are not exposed to the same conditions (for example, the risk of people who smoke getting lung cancer compared with the risk for people who do not smoke). If both groups face the same level of risk, the relative risk is 1. If the first group had a relative risk of 2, subjects in that group would be twice as likely to have the event happen. A relative risk of less than one means the outcome is less likely in the first group. Relative risk is sometimes referred to as risk ratio.
Review question	In guideline development, this term refers to the questions about treatment and care that are formulated to guide the development of evidence-based recommendations.

Revisional surgery	Bariatric procedure performed to correct or modify a previous bariatric procedure.
Selection bias	Selection bias occurs if: a) The characteristics of the people selected for a study differ from the wider population from which they have been drawn, or b) There are differences between groups of participants in a study in terms of how likely they are to get better.
Sensitivity	How well a test detects the thing it is testing for. If a diagnostic test for a disease has high sensitivity, it is likely to pick up all cases of the disease in people who have it (that is, give a 'true positive' result). But if a test is too sensitive it will sometimes also give a positive result in people who don't have the disease (that is, give a 'false positive'). For example, if a test were developed to detect if a woman is 6 months pregnant, a very sensitive test would detect everyone who was 6 months pregnant, but would probably also include those who are 5 and 7 months pregnant. If the same test were more specific (sometimes referred to as having higher specificity), it would detect only those who are 6 months pregnant, and someone who was 5 months pregnant would get a negative result (a 'true negative'). But it would probably also miss some people who were 6 months pregnant (that is, give a 'false negative'). Breast screening is a 'real-life' example. The number of women who are recalled for a second breast screening test is relatively high because the test is very sensitive. If it were made more specific, people who don't have the disease would be less likely to be called back for a second test but more women who have the disease would be missed.
Sensitivity analysis	A means of representing uncertainty in the results of economic evaluations. Uncertainty may arise from missing data, imprecise estimates or methodological controversy. Sensitivity analysis also allows for exploring the generalisability of results to other settings. The analysis is repeated using different assumptions to examine the effect on the results. One-way simple sensitivity analysis (univariate analysis): each parameter is varied individually in order to isolate the consequences of each parameter on the results of the study. Multi-way simple sensitivity analysis (scenario analysis): 2 or more parameters are varied at the same time and the overall effect on the results is evaluated. Threshold sensitivity analysis: the critical value of parameters above or below which the conclusions of the study will change are identified. Probabilistic sensitivity analysis: probability distributions are assigned to the uncertain parameters and are incorporated into evaluation models based on decision analytical techniques (for example, Monte Carlo simulation).
Serum uric acid level	The amount of uric acid in the blood.
Short-term	For the recommendations in this guidance, short-term is defined as less than one year.
Significance (statistical)	A result is deemed statistically significant if the probability of the result occurring by chance is less than 1 in 20 ($p < 0.05$).
Skinfold thickness	A measure of the amount of fat under the skin; the measurement is made with a calliper. Measurements at several sites are normally required as the per cent of fat at each site varies with age, sex and ethnicity. Skinfold measurements are usually taken at the triceps, subscapular and supra-iliac sites.
Sleeve gastrectomy	Also known as laparoscopic sleeve gastrectomy or gastric sleeve, sleeve gastrectomy is a type of weight loss surgery in which a section of the

	stomach is removed.
Snack	No specific definition. Foods consumed between meals or instead of a main meal.
Social marketing	The application of commercial marketing technologies to the analysis, planning, execution, and evaluation of programmes designed to influence the voluntary behaviour of target audiences to improve their personal welfare and that of their society.
Stakeholder	An organisation with an interest in a topic that NICE is developing a clinical guideline or piece of public health guidance on. Organisations that register as stakeholders can comment on the draft scope and the draft guidance. Stakeholders may be: manufacturers of drugs or equipment national patient and carer organisations NHS organisations organisations representing healthcare professionals.
Sugary foods and drinks	Food and drinks high in added sugars. The FSA provides the following guidance: 10 g sugar or more per 100 g is A LOT of sugar 2 g sugar or less per 100 g is A LITTLE sugar.
Systematic review	A review in which evidence from scientific studies has been identified, appraised and synthesised in a methodical way according to predetermined criteria. It may include a meta-analysis.
Tiered services	Different tiers of weight management services cover different activities. Definitions vary locally but usually tier 1 covers universal services (such as health promotion or primary care); tier 2 covers lifestyle interventions; tier 3 covers specialist weight management services; and tier 4 covers bariatric surgery.
Time horizon	The timespan over which costs and health outcomes are considered in a decision analysis or economic evaluation.
Traffic light diet	This is a calorie-based food-exchange system created by Epstein and coworkers. Foods are divided into five groups (fruits and vegetables, grains, proteins, dairy and other foods), and the foods in each group are colour coded according to nutrient density: green for 'go', yellow for 'eat with care', and red for 'stop'. Green foods are foods containing less than 20 calories per serving, yellow foods are the staple of the diet and provide most of the basic nutrition and red foods are those foods high in fat and simple carbohydrates. All sweets and sugared beverages are classified as red foods. Families are then instructed to count calories and cannot have more than four red foods a week.
Travel plan	Department for Transport definition: A travel plan is a package of measures produced by employers to encourage staff to use alternatives to single-occupancy car use. Such a plan could include: car sharing schemes; a commitment to improve cycling facilities; a dedicated bus service or restricted car parking allocations. It might also promote flexible working practices such as remote access and video conferencing.
Type 1 diabetes	Insulin-deficiency disease, developing predominantly in childhood, characterized by hyperglycaemia if untreated, and with a consequent high risk of vascular damage developing over a period of decades.
Type 2 diabetes	Diabetes generally of slow onset mainly found in adults and in association with features of the metabolic syndrome. Carries a very high risk of vascular disease. While not insulin-dependent, many people with the condition eventually require insulin therapy for optimal blood glucose control.

Utility	In health economics, a 'utility' is the measure of the preference or value that an individual or society places upon a particular health state. It is generally a number between 0 (representing death) and 1 (perfect health). The most widely used measure of benefit in cost-utility analysis is the quality-adjusted life year, but other measures include disability-adjusted life years (DALYs) and healthy year equivalents (HYEs).
Very-low-calorie diet	Hypocaloric diets which provide between 450 to 800 kcal per day and are relatively enriched in protein of high biological value. They must contain the full complement of vitamins, minerals, electrolytes and fatty acids. They are usually in a liquid formulation and intended to completely replace food intake in a weight loss programme for a specific period of time.
Vulnerable groups	Populations who face a greater than average risk of weight gain due to a range of factors largely beyond their control. Some of these factors may be inherent, while others may relate to the social, economic and environmental circumstances in which they live.
Waist-to-hip ratio	Waist circumference (cm) divided by hip circumference (cm). Provides a proxy measure of central distribution of fat (intra-abdominal fat).

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