Weight Management: preventing, assessing and managing overweight and obesity (update)

NICE National Institute for Health and Care Excellence

Consultation on draft guideline – deadline for comments 5pm on 28/1123

email: weightmanagement@nice.org.uk

Checklist for submitting comments

- Use this comments form and submit it as a **Word document (not a PDF)**.
- **Do not submit further attachments** such as research articles, or supplementary files. We return comments forms that have attachments without reading them. You may resubmit the form without attachments, but it must be received by the deadline. You are welcome to include links to research articles or provide references to them
- Complete the disclosure about links with, or funding from, the tobacco industry.
- Include **document name, page number and line number** of the text each comment is about.
- Combine all comments from your organisation into 1 response form. **We cannot accept more than 1 comments form from each organisation**.
- **Do not** paste other tables into this table – type directly into the table.
- Ensure each comment stands alone; **do not** cross-refer within one comment to another comment.
- **Clearly mark any confidential information or other material that you do not wish to be made public with underlining and highlighting. Also, ensure you state in your email to NICE, and in the row below, that your submission includes confidential comments.**
- **Do not name or identify any person or include medical information about yourself or another person** from which you or the person could be identified as all such data will be deleted or redacted.
- Spell out any abbreviations you use.
- **We do not accept comments submitted after the deadline stated for close of consultation.**

Note: We reserve the right to summarise and edit comments received during consultations, or not to publish them at all, if we consider the comments are too long, or publication would be unlawful or otherwise inappropriate. Where comments contain confidential information, we will redact the relevant text, or may redact the entire comment as appropriate.

Comments received during our consultations are published in the interests of openness and transparency, and to promote understanding of how recommendations are developed. The comments are published as a record of the comments we received, and are not endorsed by NICE, its officers or advisory Committees.

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	Please read the checklist above before submitting comments. We cannot accept forms that are not filled in correctly. We would like to hear your views on the draft recommendations presented in the guideline, and any comments you may have on the rationale and impact sections in the guideline and the evidence presented in the evidence reviews documents. We would also welcome views on the Equality Impact Assessment. In addition to your comments below on our guideline documents, we would like to hear your views on these questions. **Please include your answers to these questions with your comments in the table below.** 1. Would it be challenging to implement of any of the draft recommendations? Please say why and for whom. Please include any suggestions that could help users overcome these challenges (for example, existing practical resources or national initiatives. 2. Would implementation of any of the draft recommendations have significant cost implications? 3. [Insert any specific questions about the recommendations from the Developer, or delete if not needed] See Developing NICE guidance: how to get involved for suggestions of general points to think about when commenting.
Organisation name (if you are responding as an individual rather than a registered stakeholder please specify).	British Association for Nutrition and Lifestyle Medicine (BANT)
Disclosure (please disclose any past or current, direct or indirect links to, or funding from, the tobacco industry).	No links past or present to the tobacco industry.
Confidential comments (Do any of your comments contain confidential information?)	No
Name of person completing form	Dr Susan McGinty, BANT Policy Director

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Comment number	**Document** [e.g. guideline, evidence review A, B, C etc., methods, EIA]	**Page number** **'General'** for comments on whole document	**Line number** **'General'** for comments on whole document	**Comments** • Insert each comment in a new row. • Do not paste other tables into this table, because your comments could get lost – type directly into this table. • Include section or recommendation number in this column.
1	Dietary approaches: Dietary approaches for all ages	065	12-15	1.7.6 - The guideline suggests that people should be encouraged to eat a nutritionally balanced diet consistent with healthy eating advice as detailed in the NHS Eat Well advice. A significant proportion of people living with obesity have underlying metabolic dysfunction and insulin resistance with impaired glucose tolerance. As such, advice contained within the standard Eatwell guide[1] may not be suitable to those living with obesity with underlying metabolic health problems as it advises people to: *'Base meals on potatoes, bread, rice, pasta or other starchy carbohydrates. Starchy food should make up just over a third of the food we eat.'* Evidence suggests that high glycaemic index starchy foods may be unsuited to people with metabolic health conditions, as they lead to adverse post-prandial glucose responses which worsen metabolic health and increase risk of cardiovascular disease.[2-4] 1. NHS Eatwell Guide. https://www.nhs.uk/live-well/eat-well/food-guidelines-and-food-labels/the-eatwell-guide/ 2. Askari. M 2021.Glycemic index, but not glycemic load, is associated with an increased risk of metabolic syndrome: Meta-analysis of observational studies. *Int. Jnl of Clinical Practice.* https://doi.org/10.1111/ijcp.14295 3. van Zuuren EJ, Fedorowicz Z, Kuijpers T, Pijl H. Effects of low-carbohydrate- compared with low-fat-diet interventions on metabolic control in people with type 2 diabetes: a systematic review including GRADE assessments. Am J Clin Nutr. 2018 Aug 1;108(2):300-331. doi: 10.1093/ajcn/nqy096. PMID: 30007275. 4. Gjuladin-Hellon T, Davies IG, Penson P, Amiri Baghbadorani R. Effects of carbohydrate-restricted diets on low-density lipoprotein cholesterol levels in overweight and obese adults: a systematic review and meta-analysis. Nutr Rev. 2019 Mar 1;77(3):161-180. doi: 10.1093/nutrit/nuy049. PMID: 30544168.

2	Dietary approaches: Low-energy and very-low-energy diets for adults	066 067	9-21 9-29	1.7.9-12 - The guidelines state that **low-energy diets**, involving **800-1200 calories** per day should be considered for people: • living with obesity (with or without diabetes) or • living with overweight and with type 2 diabetes. It also states that very **low-energy diets**, of **less than 800 calories** per day, should be considered for people: • who are living with obesity, and • have a clinically assessed need to rapidly lose weight. **We recommend that low- energy diets and very low-energy diets be used only in very exceptional circumstances, and under close supervision for the following reasons:** a) ***Impact of severe caloric restriction on physical and mental well-being.*** The guideline (para 1.7.12) refers to potential side-effects of low and very low energy diets as including fatigue, constipation and hair loss. Such diets may also lead to a number of significant and potentially damaging effects, including severe hunger, which can be extremely uncomfortable, often intolerable. The effect of severely restricting caloric intake has previously been shown to produce a wide range of significant side-effects. The Minnesota Starvation Study, a landmark study of severe caloric restriction by Keys [5] (1950), used dietary restriction and increased exercise to reduce the body weight of participants by 25%. Three months of the study involved a semi-starvation diet of 1570 calories, which was low in nutrients. This diet led to chronic weakness, reduced aerobic capacity and severe painful lower limb oedema. It also led to various abnormal psychological behaviours, including emotional distress, confusion, apathy, depression, hysteria, suicidal thoughts and loss of sex drive. b) ***Severe caloric restriction and metabolic adaptation*** Research suggests that severe calorie restriction leads to a reduction in RMR (resting metabolic rate) and this metabolic adaptation can continue after the period of dietary restriction[6-7] A study [8] of participants from 'The Biggest Loser' competition, found that RMR, which had been 2607 calories per day at the beginning of the competition, fell to 1996 calories at the end of the 30-week competition. However, RMR remained very low well after the end of

				the competition and six years later the mean RMR was 1903 calories per day, and the majority of participants had regained most of the weight they had previously lost. **Severe caloric restriction is uncomfortable, potentially damaging to health and well-being, and unlikely to support sustained long term weight loss due to suppression of RMR.** 5. Keys AB, Brozek J, Henschel A, Mickelson O, Taylor A, 1950. The Biology of Human Starvation. University of Minnesota Press, Minneapolis. 6. Most J, Redman LM. Impact of calorie restriction on energy metabolism in humans. Exp Gerontol. 2020 May;133:110875. doi: 10.1016/j.exger.2020.110875. Epub 2020 Feb 11. PMID: 32057825; PMCID: PMC9036397. 7. Rosenbaum M, Hirsch J, Gallagher DA, Leibel RL. Long-term persistence of adaptive thermogenesis in subjects who have maintained a reduced body weight. Am J Clin Nutr. 2008 Oct;88(4):906-12. doi: 10.1093/ajcn/88.4.906. PMID: 18842775. 8. Fothergill, E *et al* 2016. Persistent metabolic adaptation 6 years after "The Biggest Loser" competition. https://doi.org/10.1002/oby.21538
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Insert extra rows as needed

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Data protection
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