



# Midlife Weight Management

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**Women frequently become overweight or obese during the menopause transition years. Over 65% of women aged 45 to 55 years and 70% of women aged 55 to 75 years are overweight. Using body mass index classification, 40% of these women are considered obese.**



**H**ealth care providers and non-health care providers alike are well aware of the increasing number of Americans who are either overweight or obese. In fact, clinicians are reminded of this medical red flag during most non-emergent outpatient encounters. The electronic medi-

cal record, in addition to prompting for a number of patient behaviors, such as seatbelt use, limiting sun exposure, and smoking cessation, also prompts the clinician to counsel those patients whose weight is outside of the recommended body mass index (BMI). Electronic health records automatically calculate BMI once the weight and height are entered and remind the clinician to address weight with the small percentage of patients with a BMI below 18.5 (kg/m<sup>2</sup>) and the much larger percentage of patients whose BMI is above 25. The latter BMI is most often seen in the midlife and menopausal population of women who become overweight or obese during the menopause transition years.

Because of BMI awareness, today's practitioners often provide additional information and recommendations for targeted nutrition counseling, enrollment in programs such as Weight Watchers and Overeaters Anonymous, suggestions for healthy meal planning (eg, the Mediterranean diet), and referrals to obesity programs for those who may need pharmacologic or surgical intervention.

Unfortunately, despite awareness of their extra pounds and the accompanying counseling that takes place both in the office and as take-home printouts, Americans are still gaining weight. In addition to direct counseling in the

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health care setting, most Americans are not heeding the numerous obesity messages that are generated outside the provider's office either. Lay publications routinely address the topic and devote headline stories to this public health issue. It was difficult not to miss a *Newsweek* cover photo of a plump and happy toddler holding a bag of French fries, with the quote, "When I grow up, I'm going to weigh 300 pounds. Help!"<sup>1</sup> As reported to the public in this *Newsweek* article, society has had to adjust in subtle and obvious ways to the increasing weight of individuals. Examples drive this message home, such as one medical center needing to replace wall-mounted toilets with floor models so that persons tipping the scale at 250 pounds could be safely serviced or the need for the airline industry to spend \$5 billion more each year on fuel because of heavier passengers as compared to those flying in 1960.

Emerging research suggests that most strategies used in weight loss programs are not succeeding because obesity may not be solely a condition in which a person consumes more calories than expended, but rather is an addiction. It is possible that obese individuals should be viewed as having a chronic, relapsing problem of consuming too many calories for their energy needs due to a craving to achieve "a state of heightened pleasure, energy, or excitement."<sup>2,3</sup> Further, concentrated fats and sugars in foods possibly should be considered addictive substances similar to alcohol and nicotine.<sup>3</sup> As magnetic resonance imaging studies of the brain give us further understanding of food's addictive role, we may be able to pharmacologically turn off the neurologic mechanisms of food craving in the future.

### The Obesity Numbers

In the United States today, two-thirds of the adult population and one-third of children are either overweight or obese. As defined by BMI greater than 30 kg/m<sup>2</sup>, almost 41% of US adults are obese.<sup>4</sup> Those considered overweight have a

BMI greater than 25 and below 30. Although BMI is not an exact measurement of body fat, the correlation for most people is good, with the most obvious exception being athletes, whose muscle mass accounts for their increased BMI.

Data suggest that the population of obese individuals steadily increases until age 59, peaking in the decade from ages 50 to 59. Although some studies report that body weight decreases after ages 60 to 70, this trend is not seen in longitudinal data, which continue to point to either a stable

## FOCUSPOINT

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or a slight decrease in body weight in the aging population.<sup>5</sup> Additional weight in the older population, contrary to common folklore, is not protective. Rather, obesity—especially abdominal obesity—contributes to and increases the risk of cardiovascular and metabolic disorders, arthritis, respiratory problems, urinary incontinence, and some types of cancer. Physical and cognitive function may also be adversely affected.<sup>6</sup>

### Midlife Weight Gain

During the menopause transition, women often gain an average of approximately 5 pounds. The etiology of this weight gain may have several possible causes. One is the decline in serum estrogen. Menopause produces a hypoestrogenic state in the woman, which, in addition to being associated with menopausal hot flashes, vulvovaginal atrophic changes, and accelerated bone loss, may also include an increase in visceral adipose tissue and a decrease in muscle strength and muscle mass (ie, sarcopenia). However, the role of estrogen, as well as the role of lifestyle

(poor diet, lack of exercise, drinking excessive alcohol, and smoking), reduced protein consumption, increased oxidative stress, and aging need to be better defined by randomized, controlled trials before a direct cause and effect of estrogen loss can be postulated.<sup>7</sup>

If not directly related to estrogen, there are many indirect contributors to midlife and menopausal weight gain. For example, although physical activity is important in weight stability and weight loss, menopausal women outpace men in the prevalence of osteoarthritis after age 50.<sup>8</sup> Therefore, exercise regimens that were once enjoyable for younger women may no longer be possible if they become osteoarthritic in the post-reproductive years. Pain in

function should be encouraged to have a sleep study done.

#### Sedentary Lifestyle

A sedentary lifestyle—prevalent in the United States and other industrialized countries—is usually accompanied by unwanted weight gain. In 2000, the Centers for Disease Control and Prevention (CDC) reported that 26.2% of American adults met minimal standards for acceptable activities levels. In 2001, the CDC added lifestyle activities (eg, vacuuming, gardening, and walking) as part of physical activity and the number of adults not meeting minimal energy expenditure increased to 45.4%. With numerous opportunities for most adults to engage in physical activity, there are still approximately 27% of adults who are inactive and 70% who do not engage in exercise on a regular basis. This is also a public health issue because physical and mental health and weight are influenced by physical activity.

In recent data collected on 5,145 overweight or obese adults (ages 45-74) with type 2 diabetes, those in an intensive lifestyle intervention group had greater weight loss, improved physical fitness, and fewer participants with severe disability as compared to the group who only received diabetes support and education.<sup>10</sup> Implications for midlife and older women suggest that counseling should address the woman's physical limitations when encouraging physical activity.

An unhealthy lifestyle has been linked not only to obesity but recently also to increasing cancer rates, especially lung, colon, and breast.<sup>11</sup> These data suggest that one-third to one-half of future cancers could be avoided by encouraging people to eat healthier, not smoke, and exercise.

#### Calorie Restriction

When other risk factors are eliminated, the issue of overconsumption of calories in industrialized countries (due to fast food, large portions, insufficient fruits and vegetables) continues to be a major contributor to excessive weight. Most

#### FOCUSPOINT

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joints, stiffness, loss of range of motion, and joint deformity and swelling will make several physical activities either not possible or painful. Another area that appears to impact weight is lack of sleep. Menopausal women have poorer sleep quality and more insomnia when compared to reproductive-aged women. Inadequate sleep has been linked to increased appetite, less physical activity, and altered thermoregulation, which can lead to weight gain and obesity.<sup>9</sup> Addressing and correcting sleep problems in midlife and older women should have a positive impact on maintaining ideal weight. Women who are resistant to interventions for insomnia and sleep dys-

diets address ideal caloric consumption for the individual. Restricting calories appears to not only lower body weight and whole body and visceral fat but also improve fasting insulin levels and cardiovascular disease markers, improve the ratio of total cholesterol to high-density lipoprotein cholesterol, and decrease C-reactive protein levels. No decreases in bone density have been noted.

### Counseling Midlife Women

Health care providers should encourage a support system of friends and family as well as such groups as Weight Watchers that help in maintaining weight loss and recommend separating food intake from other activities, such as watching television, listening to music, using a computer, or driving. People may not be as conscious of what they are eating if they are engaged in another activity and may not consider the caloric content of what they had just consumed. The act of providing nutrients along with excessive calories may not be recognized when distractions occur at meal and snack times.

### Conclusion

*Maintenance of an ideal body weight* should be a priority for midlife and older women. A hypocaloric diet that utilizes foods with low fat, salt, and sugar and high fiber is required. Care providers should discuss the addictive properties of high fat, sugar, and salt as well.

*Exercise and physical activity* also can contribute to weight loss in women who start to put on extra pounds during peri- and postmenopause. For those who are entering the menopause transition and are neither overweight nor obese, exercise and physical activity should be first-line interventions for weight maintenance. Lean body mass is often preserved by keeping physically active and exercising.

*Correcting sleep problems* is another way to assist older women in maintaining weight.

*Weight issues should be prioritized* in

the same manner as blood pressure control, diabetes management, and routine screenings. At this time, there is no ideal way for midlife women to lose weight and keep off the extra pounds. Ideal caloric needs, physical activity, food selection, and individual support systems should be addressed regularly, especially with women with an increased BMI. Weight-loss diets that promise quick and lasting results usually do not live up to their promises in the long run.

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For a **PATIENT HANDOUT** on midlife weight management, see page 49.

## Coding for Midlife Weight Management

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There are several ICD-9 codes for body mass index (BMI) values. I recommend that you create a graph of your patient's BMI so that you can discuss weight management at each visit. It is more likely to have an impact on the patient when you inform them that according to medical definitions they are either overweight or obese. The BMI codes are as follows:

<b>V85.0</b>	Body Mass Index less than 19, adult
<b>V85.1</b>	Body Mass Index between 19–24, adult
<b>V85.21 – V85.25</b>	Body Mass Index 25.0–29.9, adult (Overweight)
<b>V85.31 – V85.39</b>	Body Mass Index 30.0–39.9, adult (Obese)
<b>V85.41 – V85.45</b>	Body Mass Index 40 and over, adult (Morbid Obesity)

These are the ICD-9 codes to use with the BMI codes:

<b>278.00</b>	Obesity, unspecified
<b>278.01</b>	Morbid obesity, severe obesity
<b>278.02</b>	Overweight

Use additional code to identify BMI (V85.0 – V85.45)

There are codes to describe sleep symptoms:

<b>627.2</b>	Symptomatic menopausal or female climacteric states (symptoms, such as flushing, sleeplessness, headache, lack of concentration, associated with the menopause)
<b>780.50</b>	Sleep disturbance, unspecified
<b>780.52</b>	Insomnia, unspecified

A very important sentence in this article gives the physician incentive to spend time counseling their patients. “Weight issues should be prioritized in the same manner as blood pressure control, diabetes management, and routine screenings.”

To quote from the AMA CPT book\*:

*Counseling is a discussion with a patient and/or family concerning one or more of the following areas:*

*Risks and benefits of management (treatment) options  
Instructions for management (treatment) and/or follow-up  
Importance of compliance with chosen management  
Risk factor reduction  
Patient and family education*

*For coding purposes, face-to-face time for these services is defined as only that time spent face-to-face with the patient and/or family. This includes the time spent performing such tasks as obtaining a history, performing an examination, and counseling the patient.*

The physician may utilize the Established Patient codes, 99212 – 99215, when counseling is performed in conjunction with their visit. You would choose the appropriate code based on face-to-face time. Or, there are four codes for preventive medicine counseling that could be used for a visit to just discuss diet and exercise:

<b>99401</b>	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes
<b>99402</b>	approximately 30 minutes
<b>99403</b>	approximately 45 minutes
<b>99404</b>	approximately 60 minutes

\* From the CPT 2013 Professional Edition. Chicago, IL: American Medical Association; 2012.

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