Other therapies

The current clinical management of paediatric obesity involves behavioural therapy. There is little information to guide the use of other treatment approaches (for example, very low calorie diets, obesity surgery, drug therapy or hospitalisation), although there may be a role for their use in morbidly obese patients. Experience from adult studies suggests that they need to be used in the context of a behavioural management program. No drugs are currently approved for the treatment of paediatric obesity, although therapeutic trials are underway with drugs such as orlistat and sibutramine. Such therapy, if used at all, should only be given in a specialist setting.

Conclusion

Obesity is increasingly prevalent in childhood and adolescence. Family doctors are well placed to manage this problem. Effective management of obesity in this age group will include:

- having a family-focused approach, especially with pre-adolescent patients
- setting small, achievable goals for behaviour change
- targeting sedentary behaviour
- helping families and young people to make healthier food choices
- providing ongoing support as families and young people make sustainable lifestyle changes.

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Conflict of interest: none declared

Self-test questions

The following statements are either true or false (answers on page 47)

1. The management of childhood obesity should involve the whole family.
2. An obese child with short stature requires further investigation.

Your questions to the PBAC

Availability of bulking and osmotic laxative agents as pharmaceutical benefits

During my research for a presentation on managing constipation and the use of laxatives in the aged-care setting for our local nursing home, I consulted published guidelines and other references for information. My search also included the Schedule of Pharmaceutical Benefits. It was then that I became aware just how difficult it is for prescribers to follow guidelines in this area. Stimulant laxatives (such as bisacodyl) are covered quite comprehensively, despite being considered as third- or fourth-line agents by the guidelines. Bulking agents and osmotic agents are poorly covered in the Schedule, but are listed as first- or second-line treatments in most of the references I consulted. This anomaly has resulted in the common use of stimulant laxatives at our facility (and, I suspect many others) when non-pharmacological interventions have failed. Can the PBAC consider widening the restrictions on these agents, particularly lactulose, to include residents of aged-care facilities? Ease of use makes lactulose especially attractive. A laxative-free nursing home may be a dream, but a stimulant-free one may be achievable!

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PBAC response:

The Pharmaceutical Benefits Advisory Committee (PBAC) is legally required, in evaluating applications for Pharmaceutical Benefits Scheme (PBS) subsidy, to take into account the clinical effectiveness, safety and cost-effectiveness (value for money) of the medication concerned compared to other available therapies.

Importantly, a medicine cannot be subsidised via the PBS unless the PBAC makes a positive recommendation. In other words, a decision by the Committee not to recommend a medicine be subsidised is binding on the Government.

The PBAC has considered the listing of lactulose for the treatment of patients in domiciliary or nursing home care in the past. However, the PBAC was of the opinion that lactulose is an expensive synthetic disaccharide which is no more effective than other cheaper osmotic laxative preparations, and it is associated with abdominal discomfort in a number of patients. The Committee felt that further widening the indication would encourage unnecessary and definitely non-cost-effective use.

The PBAC is reluctant to recommend laxative products for listing on the PBS and considers that other measures such as modification of diet can be used in the treatment of constipation in most patients.