



COMMENT ON HINNOUHO ET AL.

Metabolically Healthy Obesity and Risk of Mortality: Does the Definition of Metabolic Health Matter? Diabetes Care 2013;36:2294–2300

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Wolfram Doehner¹
and Andreas F.H. Pfeiffer²

Hinnouho et al. (1) demonstrate in their recent article that the category of metabolically healthy obese subjects does not carry a prognostic benefit over metabolically abnormal obese subjects. This holds true across a variety of methods used to define so-called metabolically healthy obesity. In other words, those more complex criterion clusters and indices to specify an adverse metabolic balance provide no additional prognostic information that could not be obtained with similar validity from a simple measurement of BMI. This report seems to challenge the clinical relevance of the widely discussed concept of metabolically healthy obesity that has been defined above and beyond the mere condition of overweight and obesity.

These data, however, should not be understood to speak against a more differentiated approach to target overweight and obesity. On the contrary, weight changes and weight management should be viewed with strong consideration of clinical and individual conditions. Two factors are of utmost importance with regard to the prognostic relevance of overweight and obesity: advanced age and the concomitance of a chronic disease.

Multiple epidemiologic studies have shown that the impact of excess body weight on outcome is steadily diminishing with increasing age (2). In fact, in a recent meta-analysis including 2.88 million individuals and 270,000 deaths, it was confirmed for subjects aged ≥ 65 years that overweight conveyed a survival benefit

compared with normal weight subjects. Moreover, obesity, even of grade 2 and 3, was not any more predictive of increased mortality (3).

The second major area, where the primary prevention wisdom to fight excess body weight without condition may not be applicable, is in patients with established chronic diseases. A recent study by Pocock et al. (4) may serve as a prime example to underscore the inverse epidemiology of obesity and prognosis in patients with established cardiovascular disease. In a combined analysis including 39,000 patients with heart failure, a risk score was developed and validated to predict prognosis. Among the 13 independent variables identified to predict outcome in these patients, body weight was identified to predict a stepwise increased survival with each higher BMI category up to the BMI of ≥ 35 kg/m². The further analysis above this point was omitted.

With the increasing bulk of data such as the study by Pocock et al. (4), the discussion for an adequate weight management under varying conditions is gaining momentum. To add further to the confusion about weight-management recommendations, some current guidelines recommend weight reduction for all subjects above a BMI of 25 kg/m² regardless of age and primary or secondary prevention, while more recent guidelines start to reconsider this doctrine and to propose a more differentiated weight management even in diabetic patients (5).

Clearly, the mantra in primary prevention to reverse overweight and obesity by all means may not hold true in patients with preexisting chronic disease and in patients with advanced age. These individuals are a considerable proportion of the patients we see in our daily clinics. A more differentiated approach on weight management in those patients is overdue.

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¹Center for Stroke Research Berlin, Charité-Universitätsmedizin Berlin, Berlin, Germany

²Department of Endocrinology, Diabetes, and Nutrition, Charité-Universitätsmedizin Berlin, Berlin, Germany

Corresponding author: Wolfram Doehner, wolfram.doehner@charite.de.

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