# Screening and Interventions for Childhood Overweight: Evidence Synthesis: Evidence Synthesis Number 36

*U. S. Department of Health and Human Services, Agency for Healthcare Research and Quality*

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**Screening and Interventions for Childhood Overweight: Evidence Synthesis: Evidence Synthesis Number 36** U. S. Department of Health and Human Services, Agency for Healthcare Research and Quality This review examines the evidence for the benefits and harms of screening and earlier treatment of child and adolescent overweight in clinical settings. It summarizes the current state of the evidence for primary care clinicians and identifies key evidence gaps relating to clinical identification and treatment of childhood overweight. Obesity and overweight develop when there is a mismatch between energy intake and expenditure, and are related to health risks and problems in children. The genetic survival advantage for individuals whose bodies use calories more slowly has become a disadvantage in a society where abundant food and inactivity predominate. Obesity and overweight are multifactorial problems rooted in the interaction of the host (susceptibility due to genetics and learned behaviors), agent (energy imbalance), and environment (abundant food; reduced lifestyle activity; and economic, social, and cultural influences). Obesity/overweight has been declared an epidemic and a “public health crisis” among children in the United States and around the world due to alarming upward trends in its prevalence. Overweight in children aged two and older has at least doubled in the last 25 years. The age- and sex-specific mean BMI and the proportion of children with BMI greater than 95th percentile increased markedly in children from the mid-1970s through the 1990s, with almost all of this increase occurring in children in the upper half of the BMI distribution. Thus, about 50% of children appear to have “obesity susceptibility genes” that have been acted upon by environmental changes in the last 25 years. Health consequences of childhood overweight and obesity have been reviewed recently and include pulmonary, orthopedic, gastroenterological, neurological, and endocrine conditions, as well as cardiovascular risk factors. Perhaps the most significant short-term morbidities for overweight/obese children are psychosocial, including issues of social marginalization, self-esteem, and quality of life. In a recent study, 10- to 11-year-old children rated same-sex obese children the least likeable, compared with children with various physical disabilities or normal healthy children. This finding suggests that prejudice against obese children has not improved, and may have increased. Risk factors for developing childhood overweight have also been recently reviewed and include parental fatness, low parental education, social deprivation, and, perhaps, infant feeding patterns, early or more rapid puberty, extremes of birth weight, gestational diabetes, and various social and environmental factors, such as childhood diet or time spent in sedentary behaviors. Key Questions addressed include: KQ1. Is there direct evidence that screening for overweight in children/adolescents improves age-appropriate behavioral or physiologic measures, or health outcomes? KQ2a. What are appropriate standards for overweight in children/adolescents and what is the prevalence of overweight based these? KQ2b. What clinical screening tests for overweight in childhood are reliable and valid in predicting obesity in adulthood? KQ 2c. What clinical screening tests for overweight in childhood are reliable and valid in predicting poor health outcomes in adulthood? KQ 3. Does screening have adverse effects, such as labeling or unhealthy psychological or behavioral consequences? KQ4. Do interventions (behavioral counseling, pharmacotherapy, or surgery) that are feasible to conduct in primary care settings or available for primary care referral lead to improved intermediate behavioral or physiologic measures with or without weight-related measures? KQ5. Do interventions lead to improved adult health outcomes, reduced childhood morbidity, and/or improved psychosocial and functional childhood outcomes? KQ6. Do interventions have adverse effects, such as stigmatization, binging or purging behaviors, eating disorders, suppressed growth, or exercise-induced injuries?

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