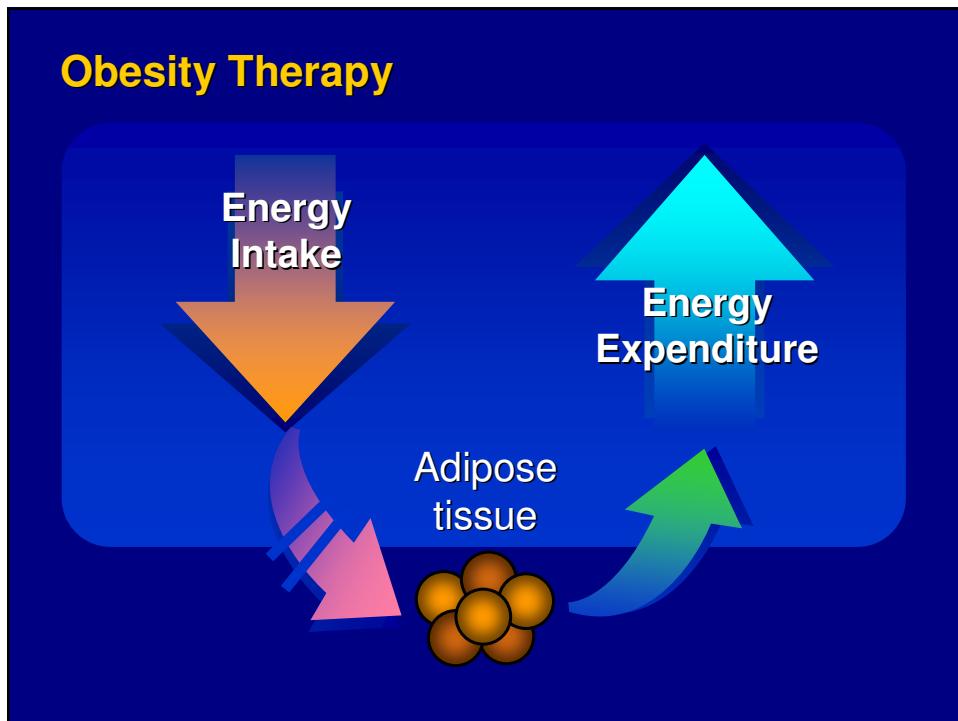


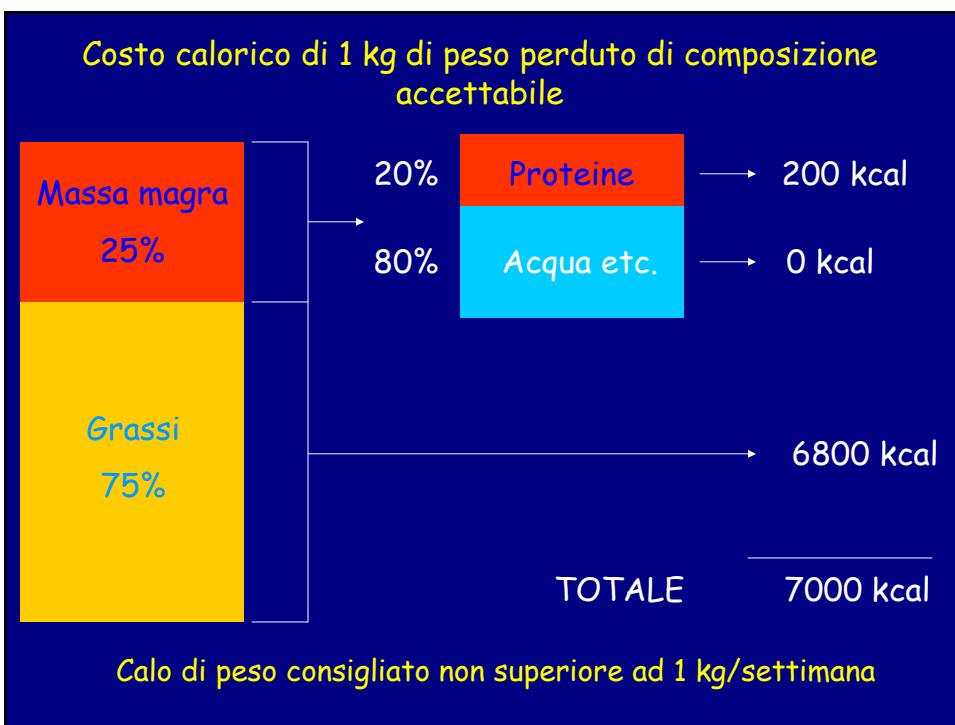
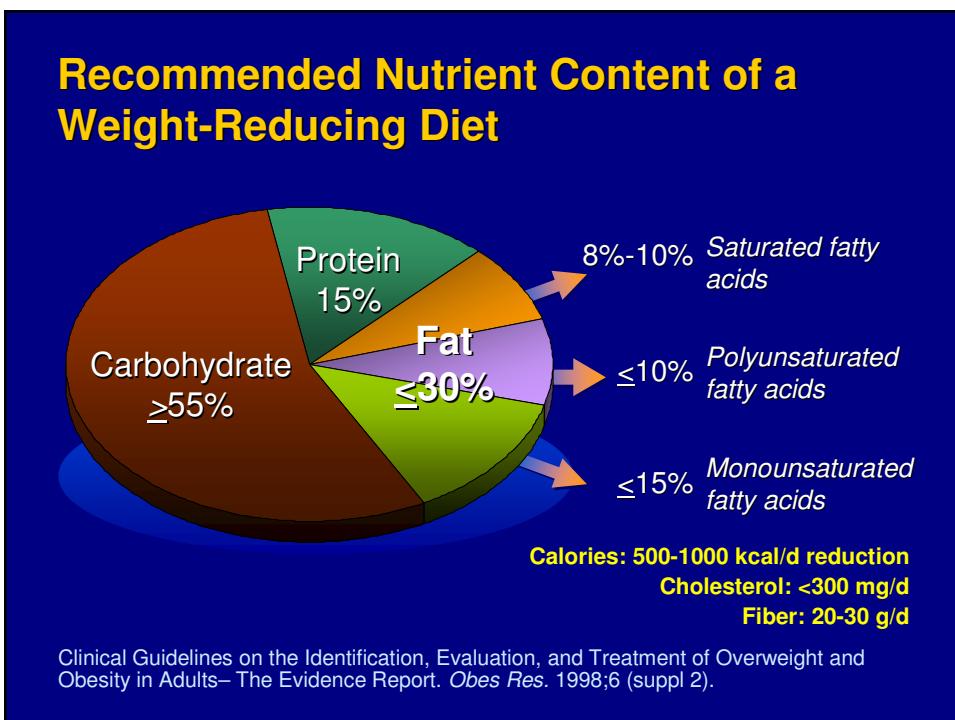


Diete diverse per dimagramenti diversi

Mauro Zamboni
Clinica Geriatrica
Servizio di Nutrizione Clinica
Università di Verona

Verona 25-26 Gennaio 2008





Suggested Energy Intake Based on Initial Body Weight

Body Weight (lb)	Suggested Energy Intake (kcal/d)	Approximate Initial Energy Deficit (kcal/d)
150-199	1000	500
200-249	1200	750
250-299	1500	1000
300-349	1800	1250
≥350	2000	≥1500

Reprinted from Klein S, et al. *Gastroenterology*. 2002; 123:882-932
with permission from Elsevier.

VLCD

< 800 kcal per day, with fat less 15 g per day
and large amount of protein

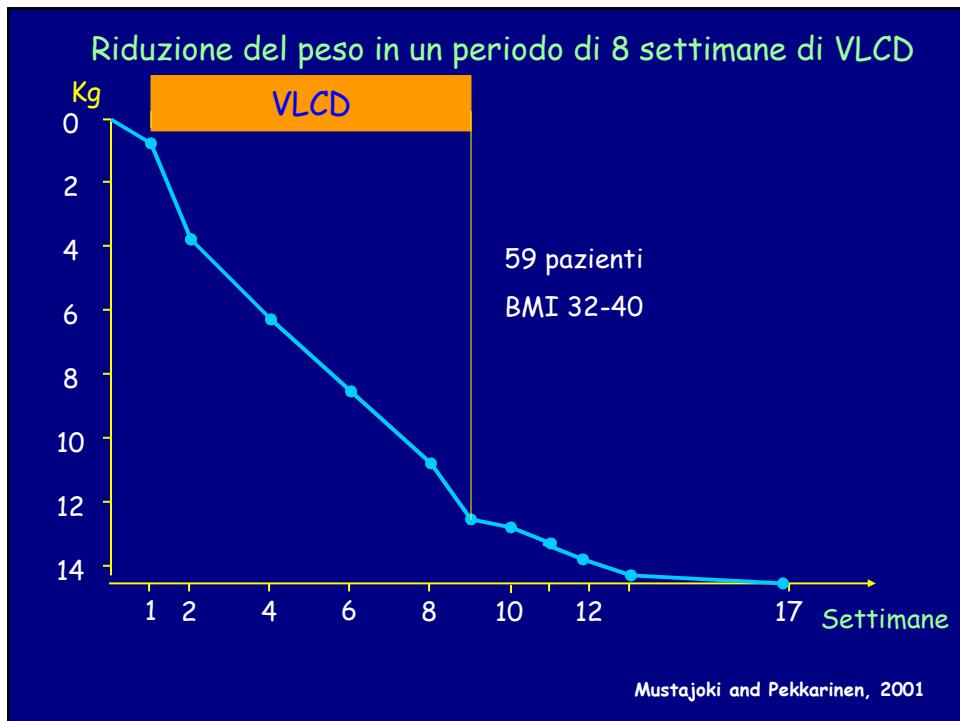
Klein S, 2002

**any diet that provides <50% of an individual's
predicted resting energy requirement**

Wadden TA and Berkowitz RI, 2003

VLCD

- introito calorico minimo: 400 kcal (F) 500 kcal (M)
- proteine ad alto valore biologico, minimo 50 g/die
- indispensabile stretta supervisione medica
- rischio elevato di colelitiasi se lipidi < 12g/die



**1000-1500 kcal/day LCD produces
about 8% loss of body weight
after 16-26 weeks**

**VLCD usually produces a loss of about
15-20% of body weight
after 12-16 weeks**

Klein S, 2002

- ... non vi è alcuna evidenza che le VLCD conducano a risultati a lungo termine migliori rispetto ai programmi ipocalorici moderati..”

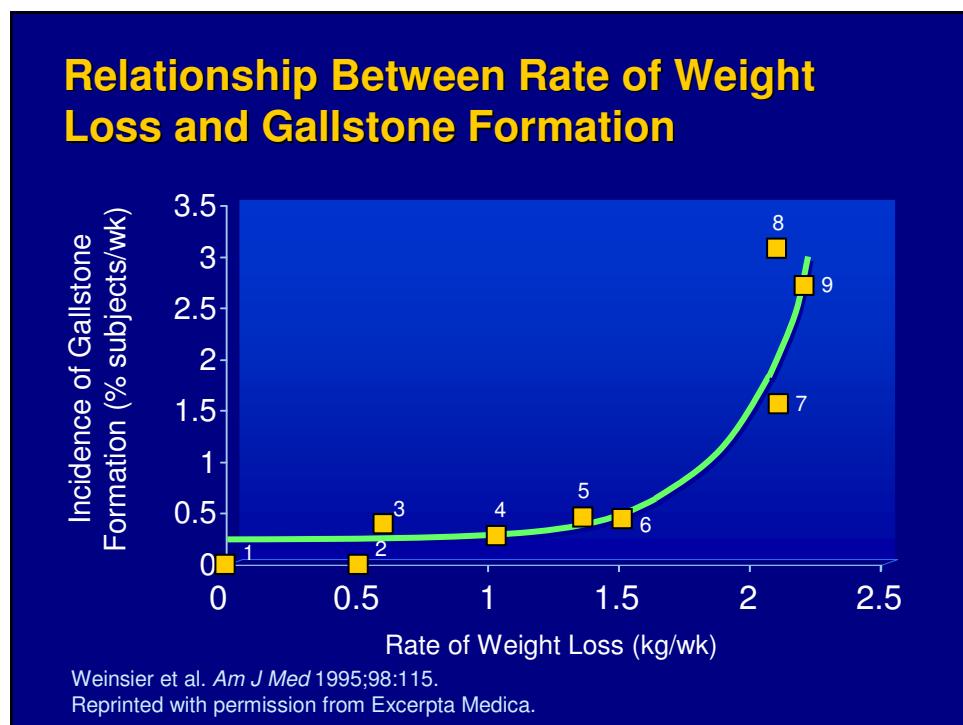
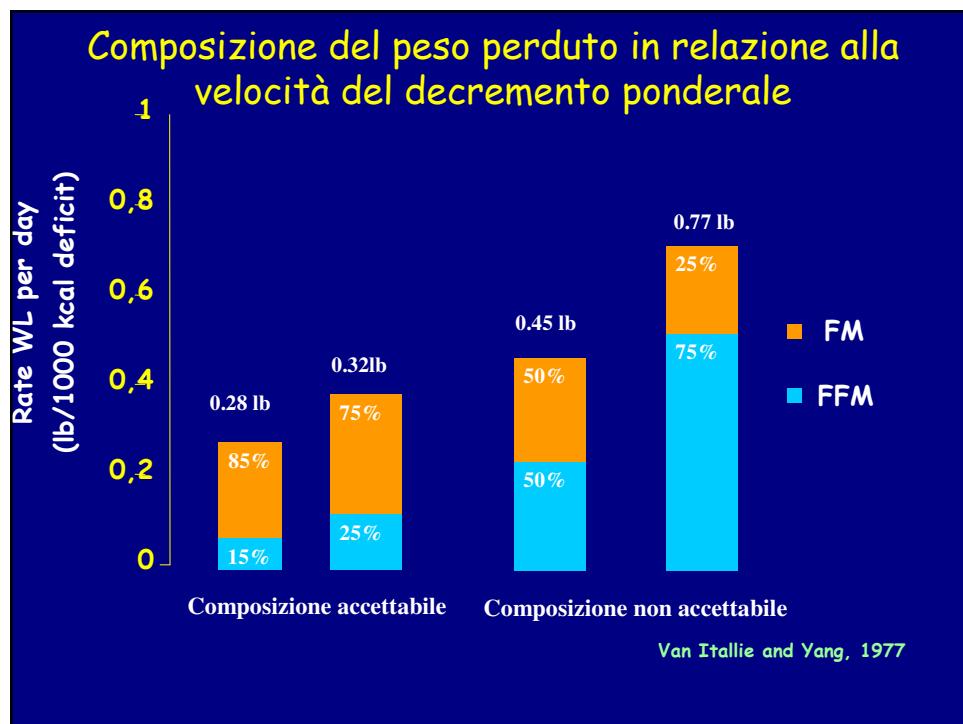
Klein S, 2002

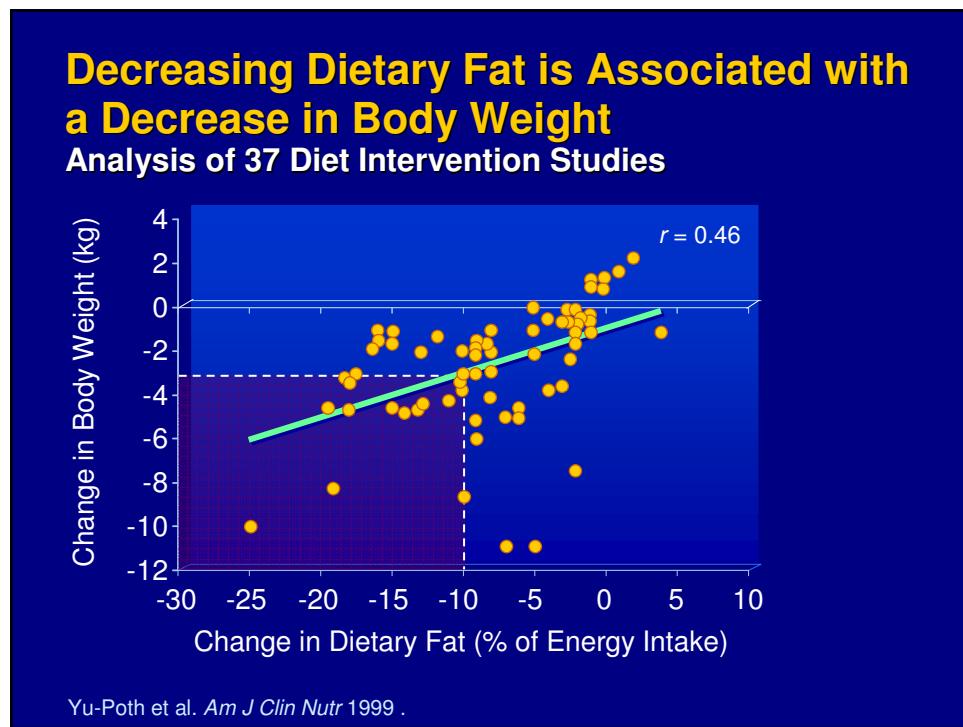
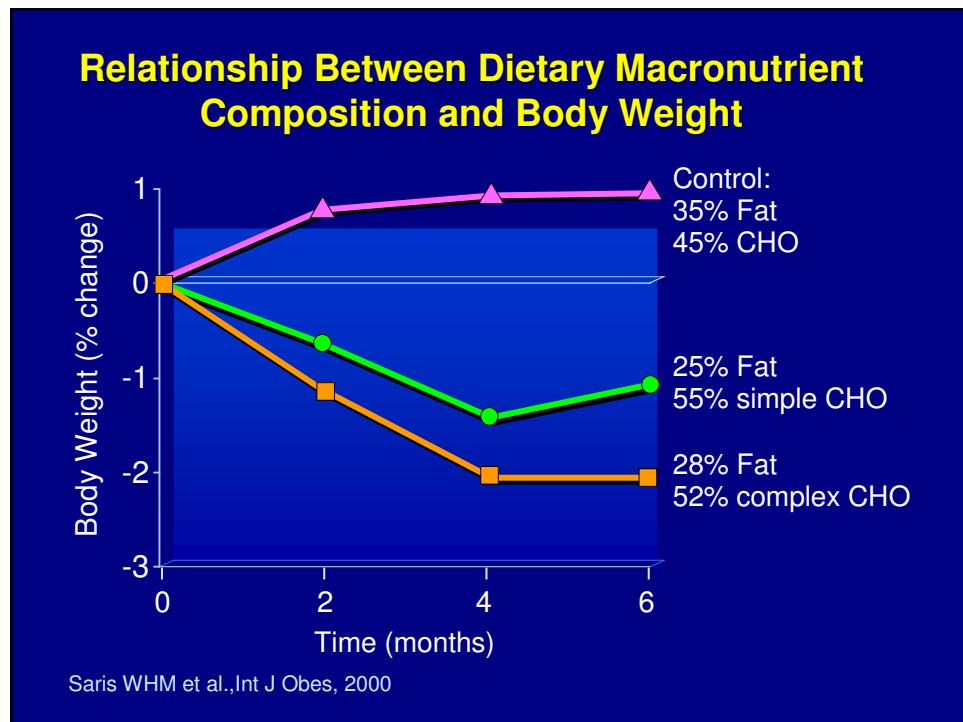
- “VLCD con follow-up attivo sembrano essere uno dei migliori trattamenti in relazione al risultato a lungo termine”

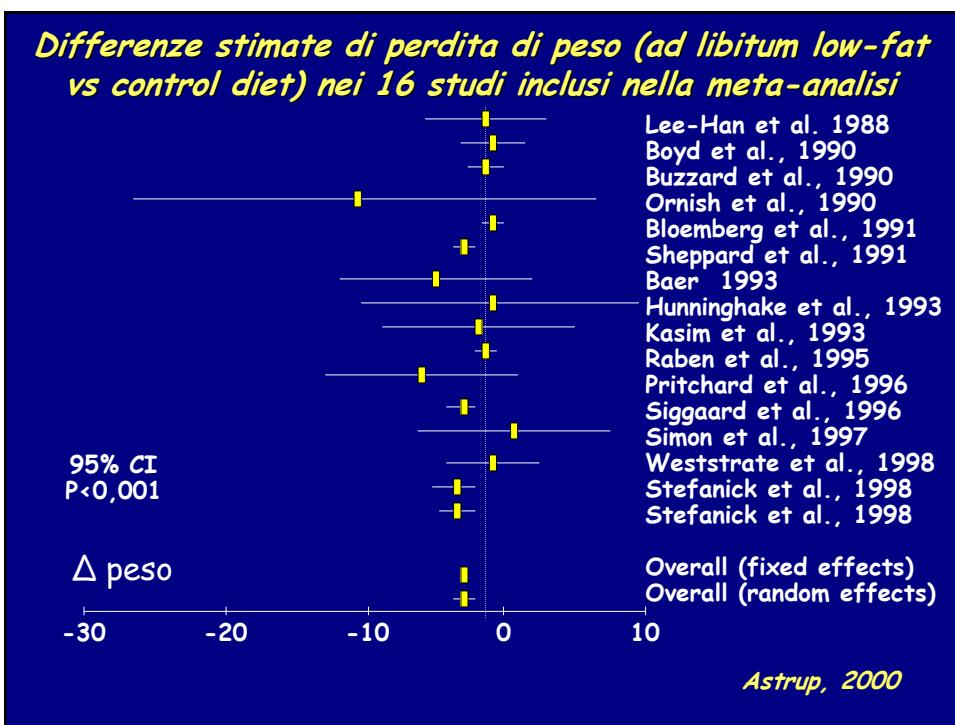
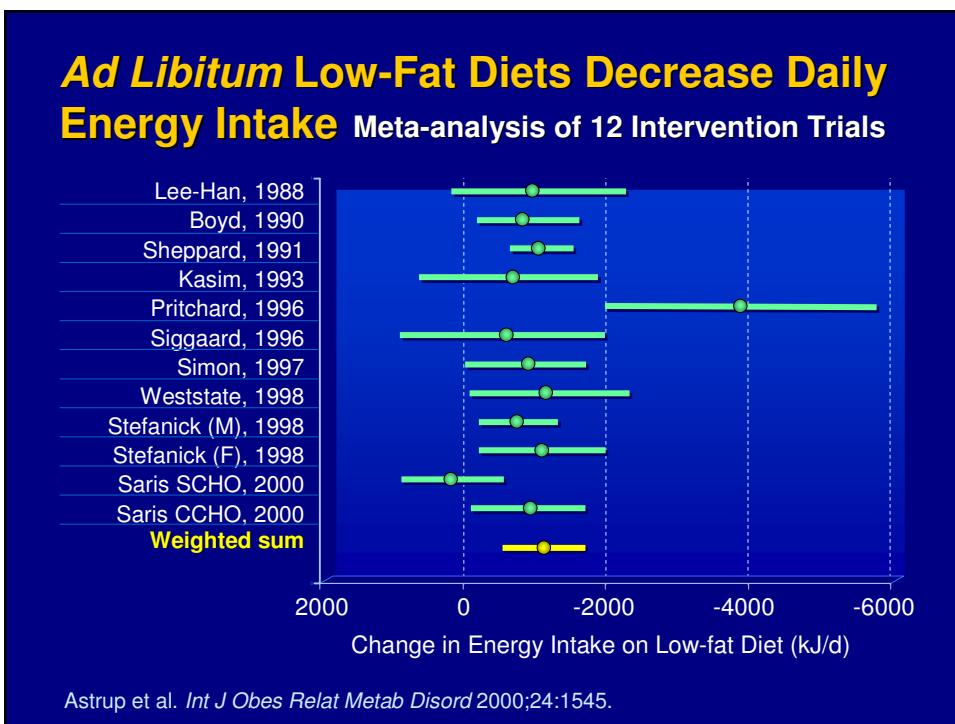
Saris WHm, 2001

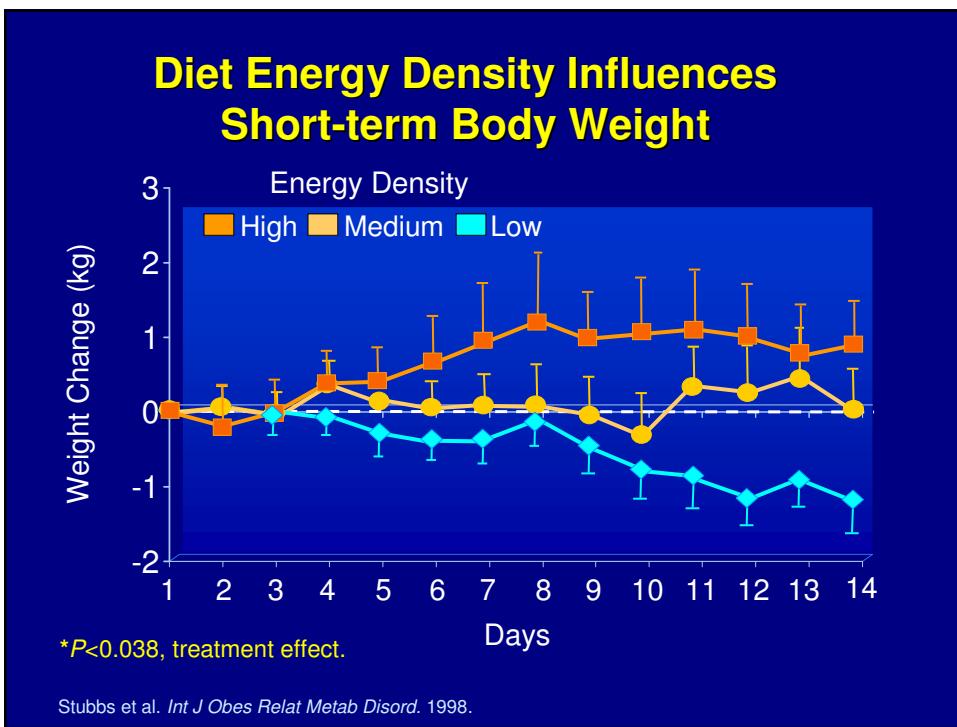
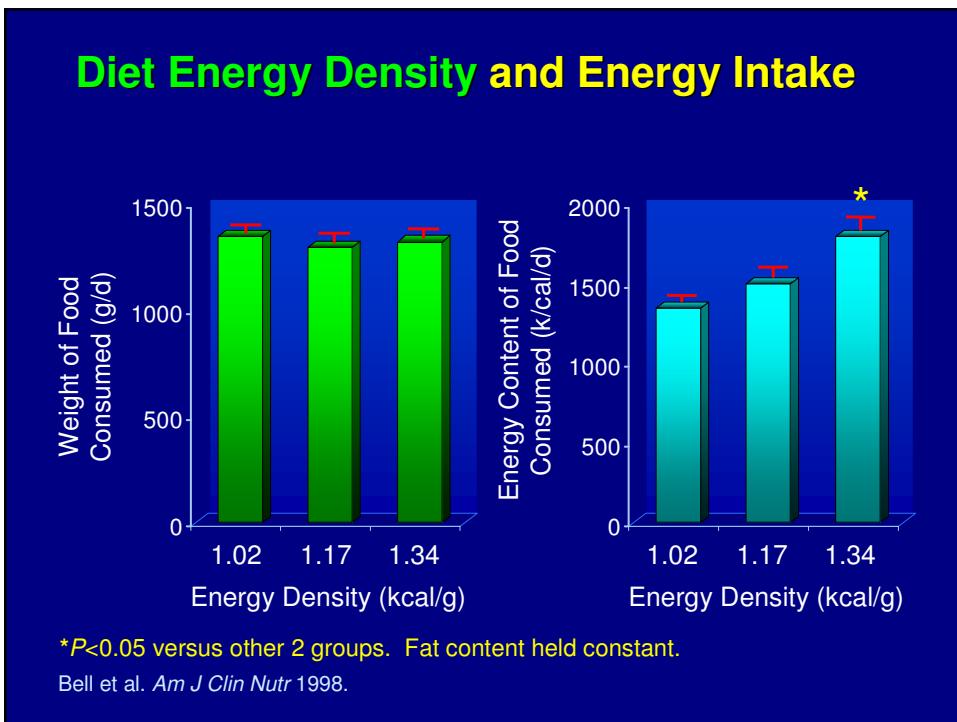
“la restrizione calorica inferiore alle 800 calorie conferisce solo marginali benefici..”

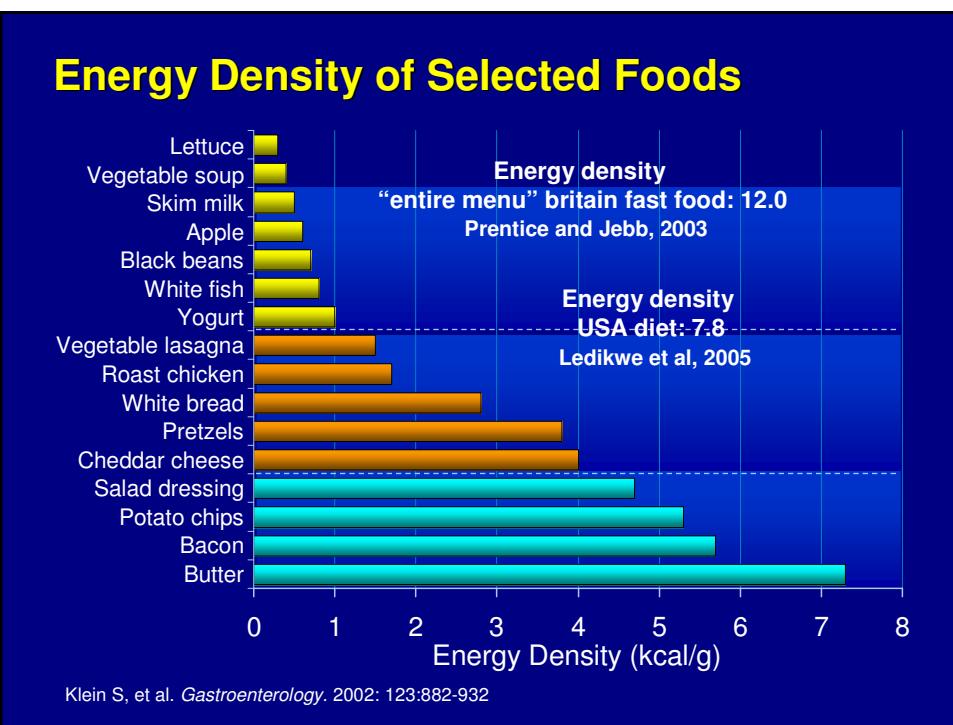
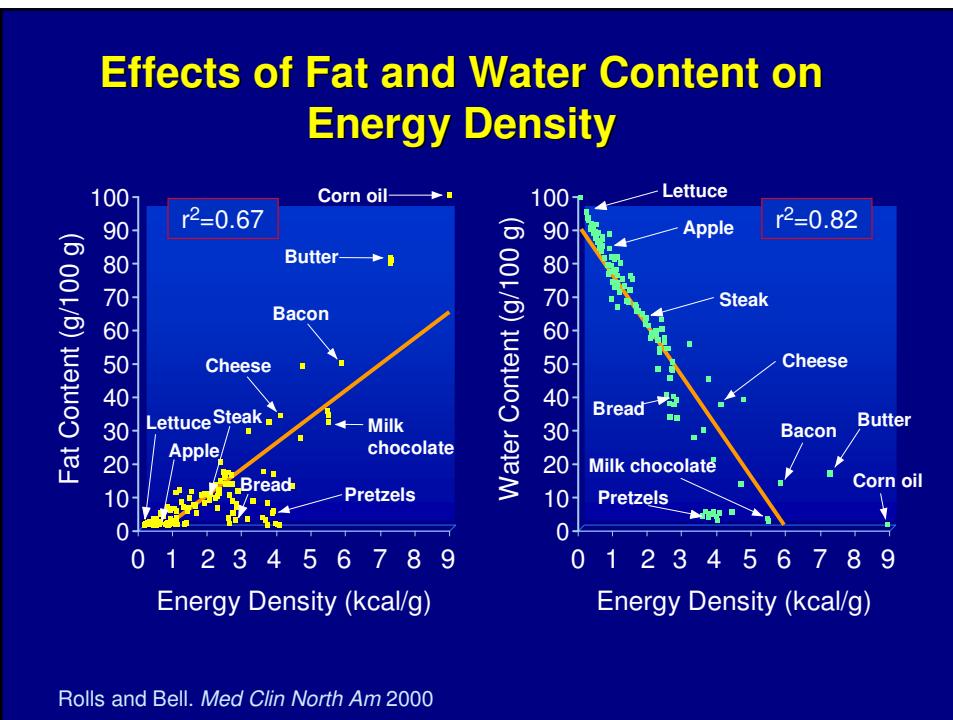
Wadden TA and Berkowitz RI, 2003



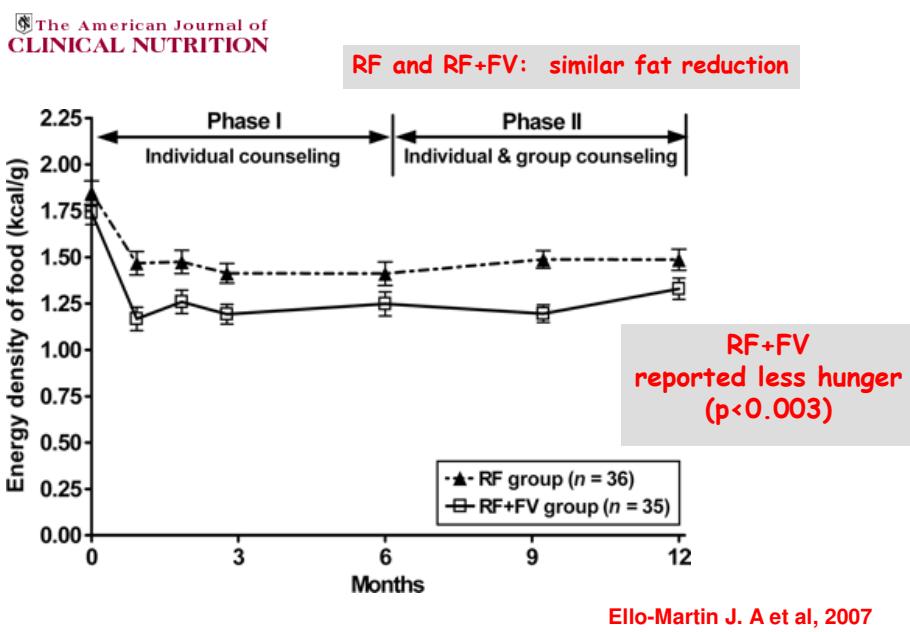
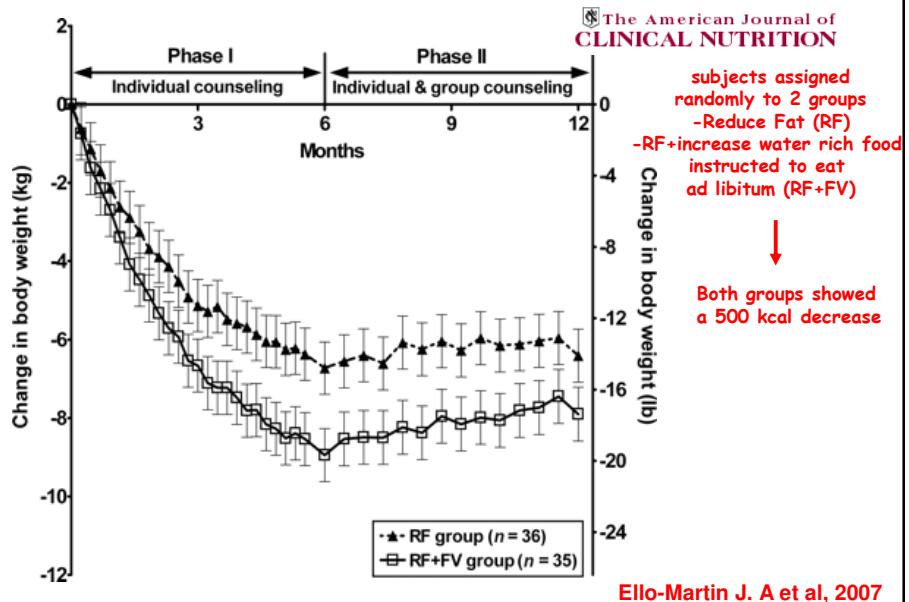


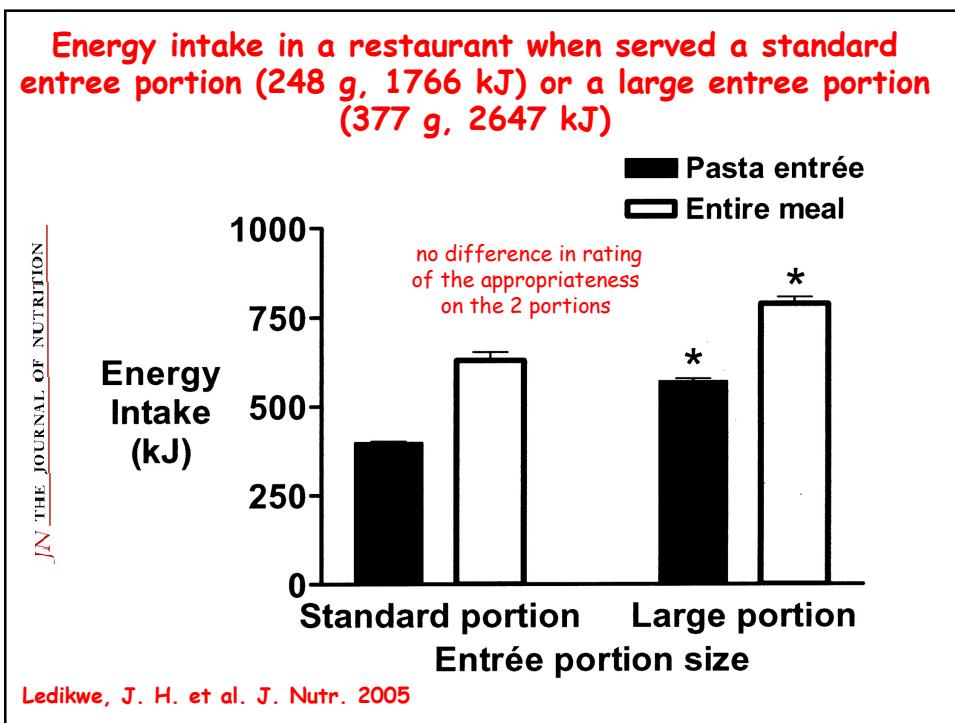
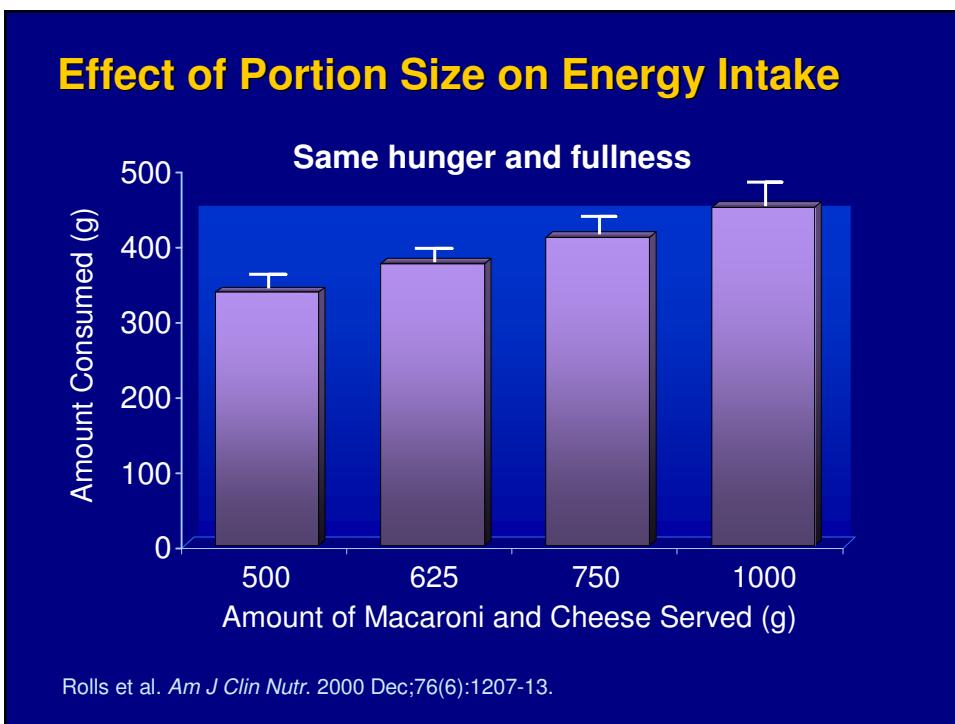


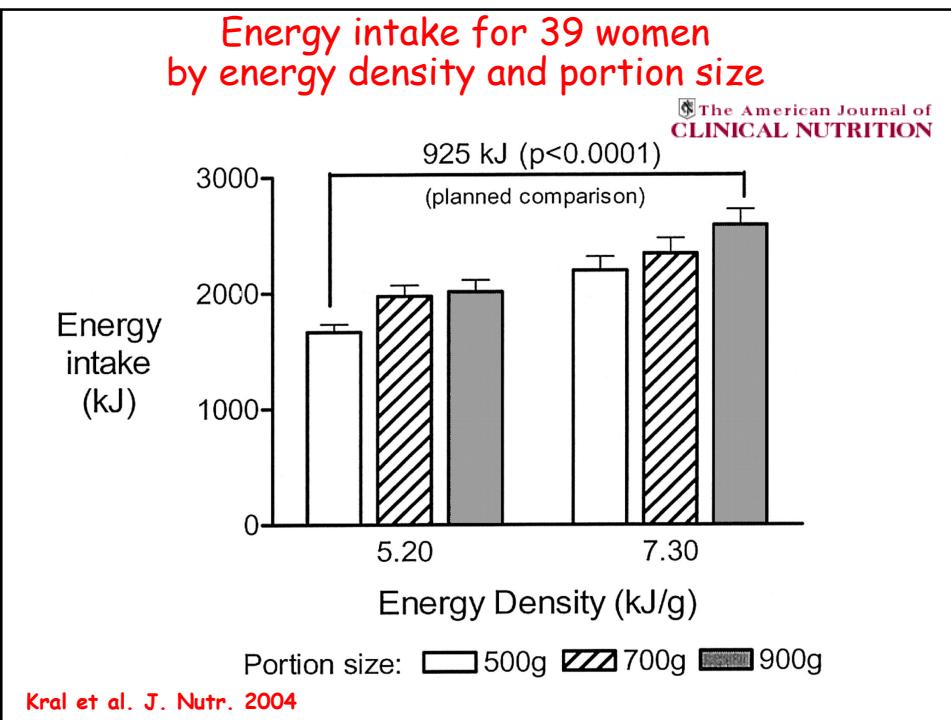




Dietary density in the treatment of obesity: a year-long trial comparing 2 weight-loss diets







JN THE JOURNAL OF NUTRITION

Telling people to simply "eat less" is not likely to be an effective solution, because it is not just large portion sizes that increase energy intake, but rather large portions of energy-density foods.

Ledikwe, J. H. et al. J. Nutr. 2005

Low-calorie portion controlled diets

Investigators have focused on the calorie content of LCD and VLCD and overlooked the form and the manner in which the diets are consumed

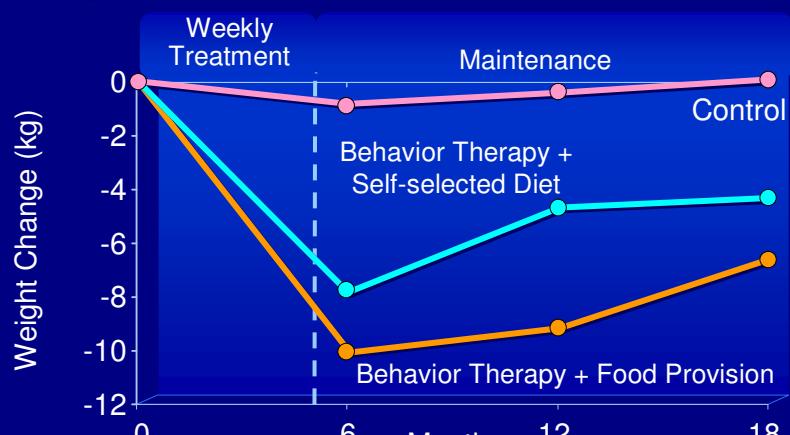
Liquid supplements facilitate dietary adherence...., provide patients a precise estimate of their calorie intake...

From this perspective, it is the provision of portion-controlled serving, not the restriction of energy

that is primarily responsible for the efficacy of VLCD

Wadden TA and Berkowitz RI, 2003

Providing Prepackaged Meals Enhances Weight Loss

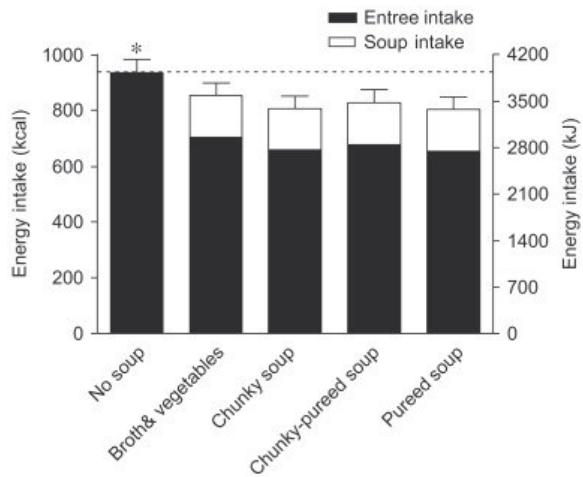


P=0.0001 treatment vs control.

P=0.0002 behavior therapy + self-selected diet vs behavior therapy + food provision.

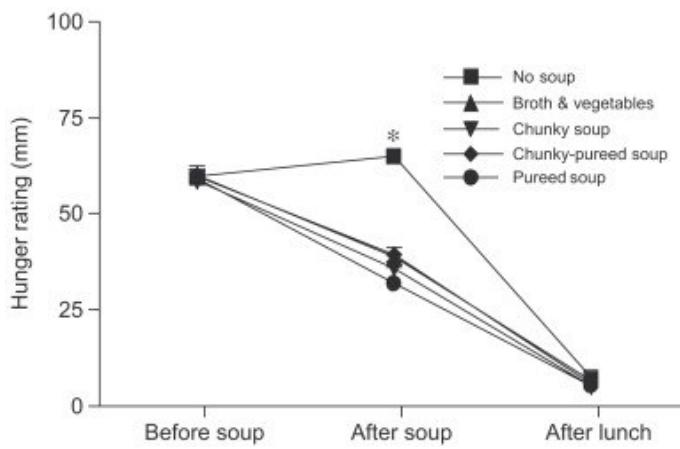
Jeffery et al. J Consult Clin Psychol 1993

Energy intake at lunch (soup and entrée intake) for women and men combined ($n = 60$)



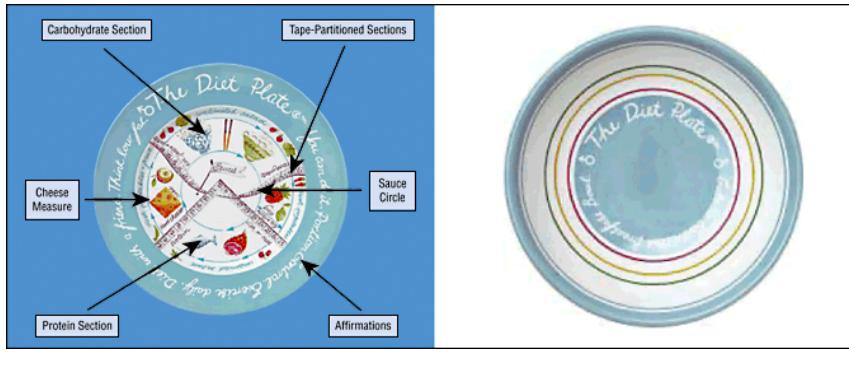
Flood JF and Rolls BJ, Appetite 2007

Hunger ratings "before soup" "after soup" and "after lunch" across experimental conditions.



Flood JF and Rolls BJ, Appetite 2007

130 obese patients with type 2 Diabetes randomly assigned to the daily use of a commercial portion plate for 6 months vs usual care in the form of dietary teaching



Dinner portion plate:
800 kcal in men
650 kcal in women

Cereal Bowl:
200 kcal in men
and in women

ARCHIVES OF
INTERNAL MEDICINE
Pedersen et al, 2007

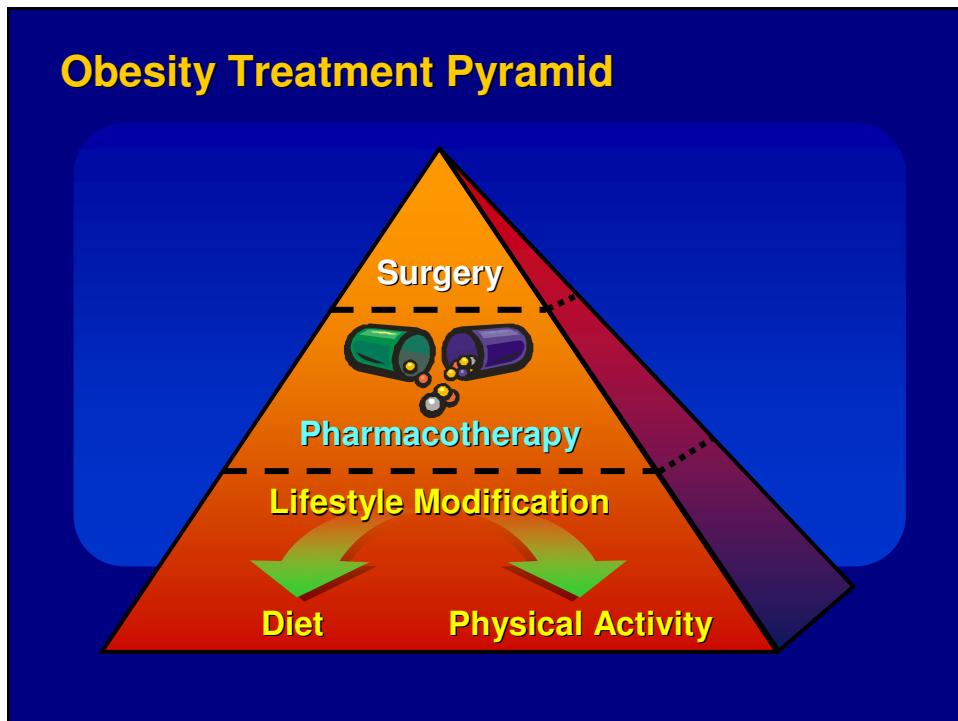
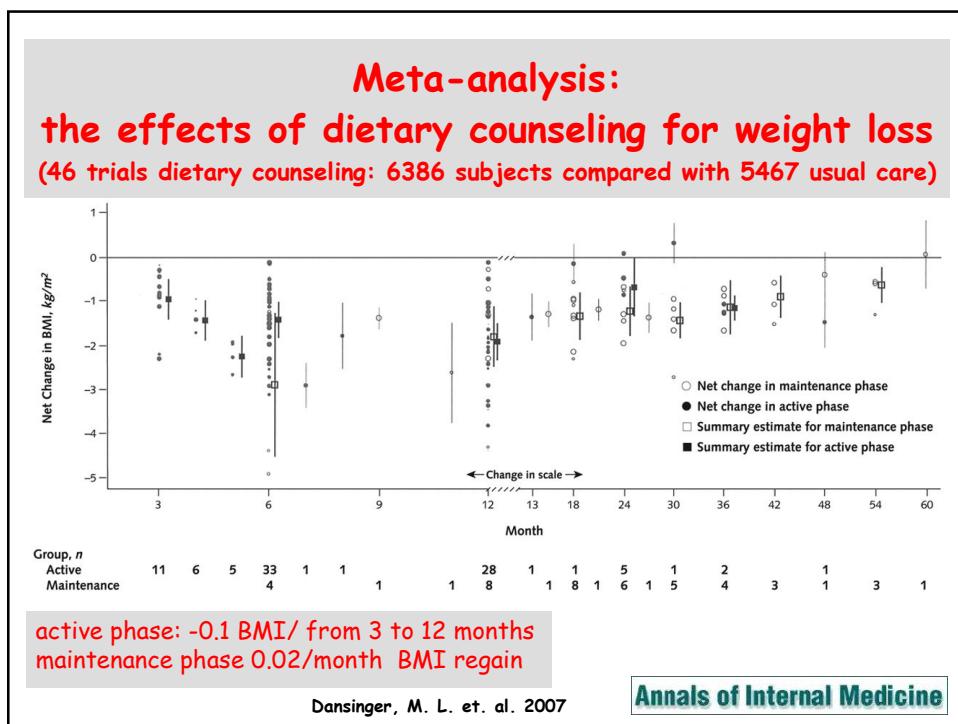
Table 2. Absolute and Proportional Weight Loss*

Variable	Intervention Group	Control Group	P Value†
Percentage change in weight			
Entire group	-1.8 ± 3.9 (65)	-0.1 ± 3.0 (65)	.006
Subgroup taking insulin	-2.6 ± 4.3 (26)	0.1 ± 3.0 (25)	.01
Subgroup not taking insulin	-1.3 ± 3.7 (34)	-0.2 ± 3.2 (37)	.16
Absolute change in weight, kg			
Entire group	-2.1 ± 4.9 (65)	-0.1 ± 3.5 (65)	.01
Subgroup taking insulin	-3.2 ± 5.9 (26)	0.01 ± 3.40 (25)	.02
Subgroup not taking insulin	-1.2 ± 3.8 (34)	-0.1 ± 3.8 (37)	.23
Proportion of each group achieving ≥5% weight loss			
Entire group	11/65 (16.9)	3/65 (4.6)	.048
Subgroup taking insulin	6/26 (23.1)	1/25 (4.0)	.099
Subgroup not taking insulin	5/34 (14.7)	2/37 (5.4)	.25

*Data are given as mean ± SD (number of patients) or as number/total number (percentage).
†For differences between the 2 groups.

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Pedersen et al, 2007



Obesity Treatment Guidelines

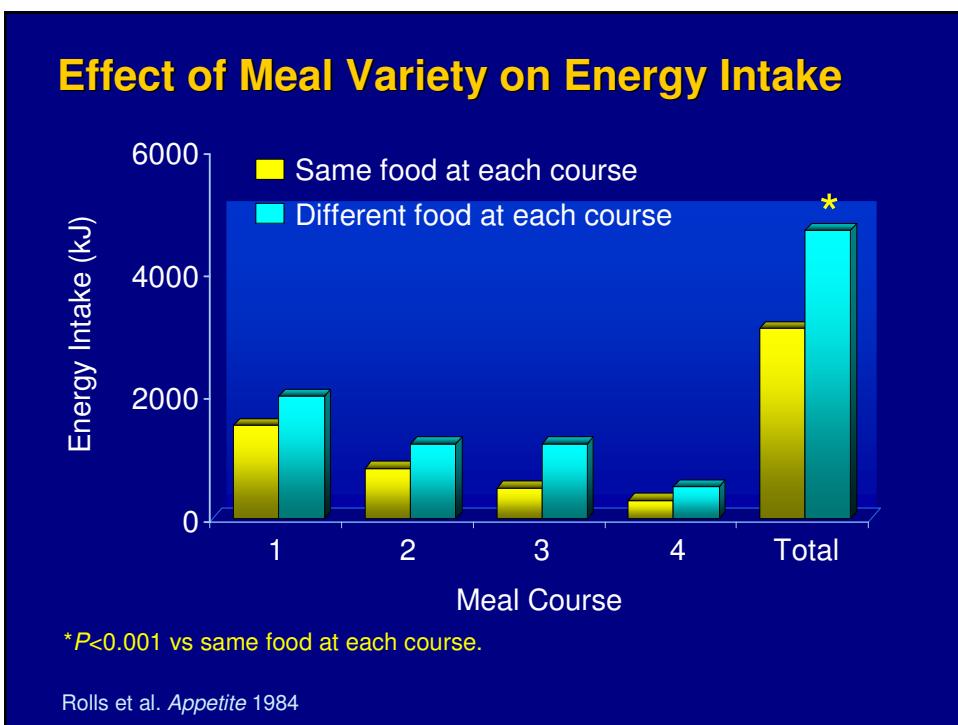
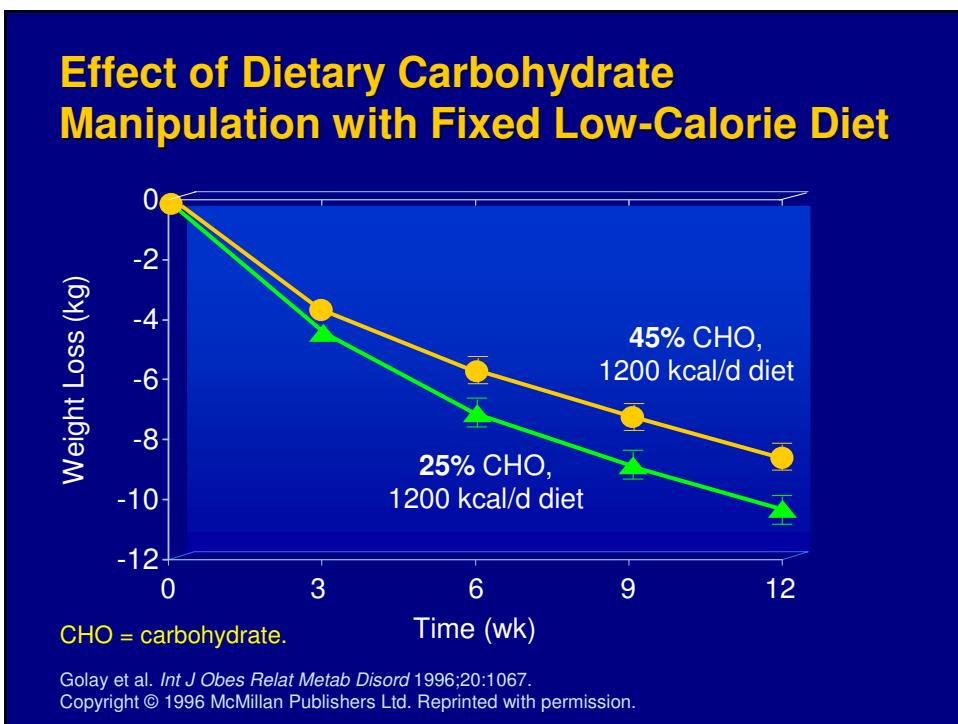
**The Practical Guide
can be found at:**

NHLBI web site:
www.nhlbi.nih.gov

NAASO web site:
www.naaso.org

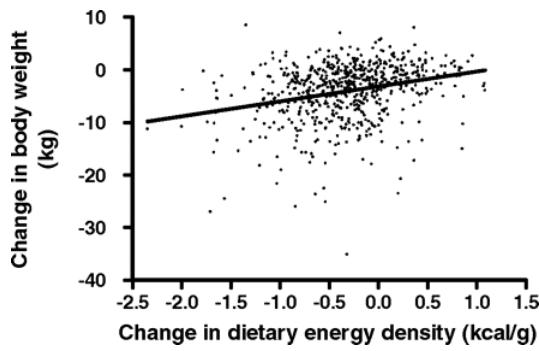
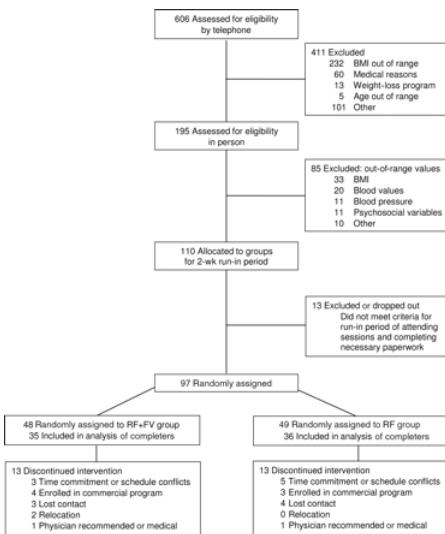


Slide Source:
www.obesityonline.org





Ello-Martin J. A et al, 2007



Percentuale di successo per gruppi di studio, suddivisi secondo il trattamento iniziale, valore energetico della dieta iniziale ed intensità del follow-up			
	Numero di pazienti	Numero di gruppo di studio	% mediana di successo
Percentuale di successo complessiva	2131	21	15% (0-49%)
Influenza del trattamento iniziale:			
solo dieta	1337	10	15% (6-28%)
dieta+terapia di gruppo	487	4	27% (14-31%)
dieta+modif comportam	307	7	14% (0-49%)
Influenza del valore energetico:			
VLCD (300-600 kcal/24h)	304	8	14% (6-49%)
LCD (800-1000 kcal/24h)	1827	13	18% (0-31%)
Influenza dell'intensità del follow-up:			
passivo	597	10	10% (0-31%)
attivo	1534	11	19% (13-49%)

Ayyad, Andersen, 2000

