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Food choices are about values not virtues

Helena Popovic

Winning at Slimming, Burleigh Waters, QLD, Australia

The language people use around food choices often carries a moralistic tone. My patients frequently tell me: 'I've been good all month because I've been going to the gym.' Or 'I was bad last week because I ate a lot of junk.' They are shocked when I tell them that people who exercise on a regular basis are no more virtuous or self-disciplined than people who don't exercise. People who exercise simply put exercise higher up on their list of priorities than people who don't exercise. We always make time for the things that are most important to us.

Negative self-judgement leads to poor self-image and a greater likelihood of self-soothing with food. The result is a self-perpetuating negative spiral. When people recognise that their food choices — in fact every decision they make — are a reflection of their values, rather than their virtues, it relieves much of the guilt and stress around eating and enables them to start the journey to self-compassion.

Most people in the Western world are living back to front: trying to fit healthy choices into a busy schedule rather than fitting a busy schedule around health choices. How can we bring about a shift in perspective that assists people in giving greater priority to their health? Not just through lip service but also through the way they live their lives?

This presentation examines how teaching people to live in alignment with their deepest values can have a profoundly positive impact on their health and lifestyle choices.

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Pilot Study: The impact of substantial pre-conception weight loss in obese women on glucose control at 26—28 weeks of pregnancy

Sarah Price [1,*], Priya Sumithran [1], Alison Nankervis [2,3], Michael Permezel [4], Jeffrey Craig [5], Luke Prendergast [6], Joseph Proietto [1]

[1] *Department of Medicine, University of Melbourne, Heidelberg, VIC, Australia*
[2] *Department of Diabetes and Endocrinology, Royal Melbourne Hospital, Melbourne, Victoria, Australia*
[3] *Royal Women's Hospital, Melbourne, Victoria, Australia*
[4] *Department of Obstetrics and Gynaecology, University of Melbourne, Heidelberg, VIC, Australia*
[5] *Early Life Epigenetics, Murdoch Childrens Research Institute, Flemington, VIC, Australia*
[6] *Department of Mathematics and Statistics, LaTrobe University, Bundoora, VIC, Australia*

Background: In Australia, 1 in 3 women of reproductive age are obese, but no pre-pregnancy weight loss interventions have been shown to reduce the risk of obesity-related pregnancy complications for both mother *and* child. The HAPO study (NEJM 2008;358:1991—2002) observed that small changes in maternal glucose at 26—28 weeks gestation are associated with significant changes in the rate of adverse pregnancy outcomes.

Aim: To determine if substantial pre-conception weight loss (10—15% body weight) in obese (BMI > 30 kg/m^2) women reduces fasting glucose at 26—28 weeks gestation by ≥10% compared with modest (≤3%) weight loss.

Method: 78 women were randomised to either a lifestyle program expecting modest weight loss (MWL; ≤3% body weight; $n = 38$), or a modified VLED program expecting substantial weight loss (SWL; 10—15% body weight; $n = 40$). Attrition over the 12-week program was 20% (MWL 10/38 (25%), SWL 6/40 (15%)). Only completers were considered in the preliminary analysis. Subjects were followed for 12 months and if pregnancy occurred, maternal plasma glucose was measured at 26—28 weeks

gestation. Of the 24 subjects who were >6 months post-intervention, 10 were pregnant and had completed 28 weeks gestation.

Results: Weight loss in the MWL ($n = 28$) and SWL ($n = 34$) groups was 2.1% and 13.1% respectively. Mean reduction in plasma glucose after 12 weeks was 1.24% (SE 1.40) in MWL and 9.12% (SE 1.83) in SWL group. Of those who achieved pregnancy (MWL = 3, SWL = 7), mean decrease in plasma glucose between the start of the weight loss program and 26—28 week gestation was 1.85% (SE 1.83) and 11.51% (SE 3.17) in the MWL and SWL groups respectively.

Conclusion: This pilot data suggests that, in obese women, pre-conception weight loss results in a decrease in fasting plasma glucose which is maintained into pregnancy. The reduction in plasma glucose is greater when substantial pre-pregnancy weight loss is achieved.

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Liraglutide 3.0 mg in obese/overweight adults with or without prediabetes with baseline BMI <35 vs ≥35 kg/m^2 in the SCALE Obesity and Prediabetes 56-week randomized, double-blind, placebo-controlled trial

Joseph Proietto[1], Xavier Pi-Sunyer[2], Luc van Gaal[3], John P.H. Wilding[4], Carel W. Le Roux[5], Søren K. Lillløre[6], Birgitte Claudius[6], Frank Greenway[7], Cilla Haywood[1,*]

[1] *University of Melbourne, Melbourne, Vic, Australia*
[2] *Columbia University, New York, NY, USA*
[3] *Antwerp University Hospital, Antwerp, Belgium*
[4] *University of Liverpool, Liverpool, UK*
[5] *University College, Dublin, Ireland*
[6] *Novo Nordisk A/S, Søborg, Denmark*
[7] *Pennington Biomedical Research Center, Louisiana State University, Baton Rouge, LA, USA*

Background: SCALE Obesity and Prediabetes (NCT01272219) randomized 3731 subjects (mean age 45 years, male 22%, mean BMI 38 kg/m^2, 61% with prediabetes) 2:1 to liraglutide 3.0 mg or placebo (PBO) as adjunct to diet and exercise (D&E) for 56 weeks.

Methods: This post-hoc analysis compared efficacy and safety results for subjects with BMI < vs ≥35 kg/m^2 at baseline. The treatment effect of liraglutide across baseline BMI subgroups was evaluated by statistical testing of interaction between treatment and baseline BMI subgroup.

Results: Baseline characteristics were similar between liraglutide and PBO subgroups (BMI< vs ≥35 kg/m^2) except for body weight (90.1 and 89.9 kg; 115.1 and 115.0 kg) and prevalence of prediabetes (54.0 and 51.1%; 65.3 and 66.1%); both were higher with BMI ≥35 kg/m^2. At 56 weeks, greater mean and categorical weight loss were seen with liraglutide vs PBO in both subgroups (mean: −8.2 and −7.9%; −2.7 and −2.6%) as well as greater improvements in systolic BP, FPG, and IWQoL-Lite total score. These treatment effects of liraglutide were all independent of baseline BMI (< vs ≥35 kg/m^2; $p > 0.05$), except for the IWQoL-Lite physical function sub-score, which improved more with BMI ≥35 kg/m^2 ($p = 0.04$).

Adverse events (AEs) and serious AEs were generally comparable across BMI subgroups. In both liraglutide subgroups (BMI< or ≥35 kg/m^2), more subjects reported nausea (40 vs 40%) than PBO (15 vs 15%). Gallbladder disorders were similar in liraglutide subgroups (18 [2.1%] vs 37 [2.3%] subjects) but higher than PBO (3 [0.7%] vs 7 [0.9%] subjects). Similar results were seen for adjudicated events of acute pancreatitis (liraglutide: 2 [0.2%] vs 5 [0.3%] subjects; PBO: 0 vs 1 [0.1%] subject).

Conclusions: The effects of liraglutide 3.0 mg, as adjunct to D&E, on body weight, metabolic control and safety were similar in subjects with baseline BMI < and ≥35 kg/m^2.

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