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Letter to the Editor: Comment on “Pediatric obesity – assessment, treatment, and prevention: an Endocrine Society Clinical Practice Guideline” by Styne D.M., et al.

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We read with interest the recently published clinical practice guidelines for preventing and treating childhood obesity (1). The authors reported their evaluation of the quality of the evidence and assessment of the strength of recommendations according to objective criteria across a diverse literature; however, in our view, this excellent and comprehensive report does not mention two relevant issues: *attrition* and *enrollment*. These issues are likely to be of concern for clinicians, administrators, and researchers since they can have a substantial impact on clinical care.

Recent reviews showed that attrition from pediatric weight management is common (2,3), with estimates varying widely across studies (4 – 83%; median: 37%). It is apparent that a large number of children with obesity (and their families) choose to discontinue weight management prematurely, an occurrence that can lead to an inefficient use of clinical resources, be discouraging for families, and lead to frustration for clinicians who deliver services and interventions. Attrition has become increasingly well-characterized over recent years, which reinforces the importance of acquiring empirical data through randomized controlled trials and quality improvement initiatives as next steps to inform evidence-based strategies for retaining families so they achieve optimal benefits.

Comparatively, less data are available regarding treatment enrollment, but contemporary analyses are instructive. Shaffer *et al.* (4) found that of the 4,783 children referred to one multidisciplinary pediatric weight management clinic over a 4.4-year period, only 41.2% attended at least one appointment. In preliminary analyses of a provincial dataset of ~2,000 children referred to three different multidisciplinary weight management clinics over a 3-year period in Alberta, Canada, approximately two-thirds of families never attended a clinic appointment (5). These two reports are noteworthy since even the ‘best’ intervention for treating pediatric obesity will be of no benefit to families unless they are ready, willing, and able to enroll in care. In light of data suggesting that a minimum of 25 hours of clinical

contact is necessary to achieve weight loss that is clinically meaningful (6), there is clear value in helping children and their families to enroll and remain engaged in services and interventions for treating pediatric obesity and improving health-related outcomes. In our collective experience, only the vast minority of children ever receive this intervention dose.

We are confident that these new guidelines will have a positive influence on the prevention and treatment of pediatric obesity; they represent a meaningful and important step forward from the pre-existing guidelines. We are optimistic that by placing increased research and clinical attention on the imperative to mitigate attrition and enhance enrollment, services and interventions for preventing and treating pediatric obesity will be better able to optimize outcomes for children and families.

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