



Skal vi veje børn og unge i skoler eller ej?



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Vækst og udvikling er mange ting !

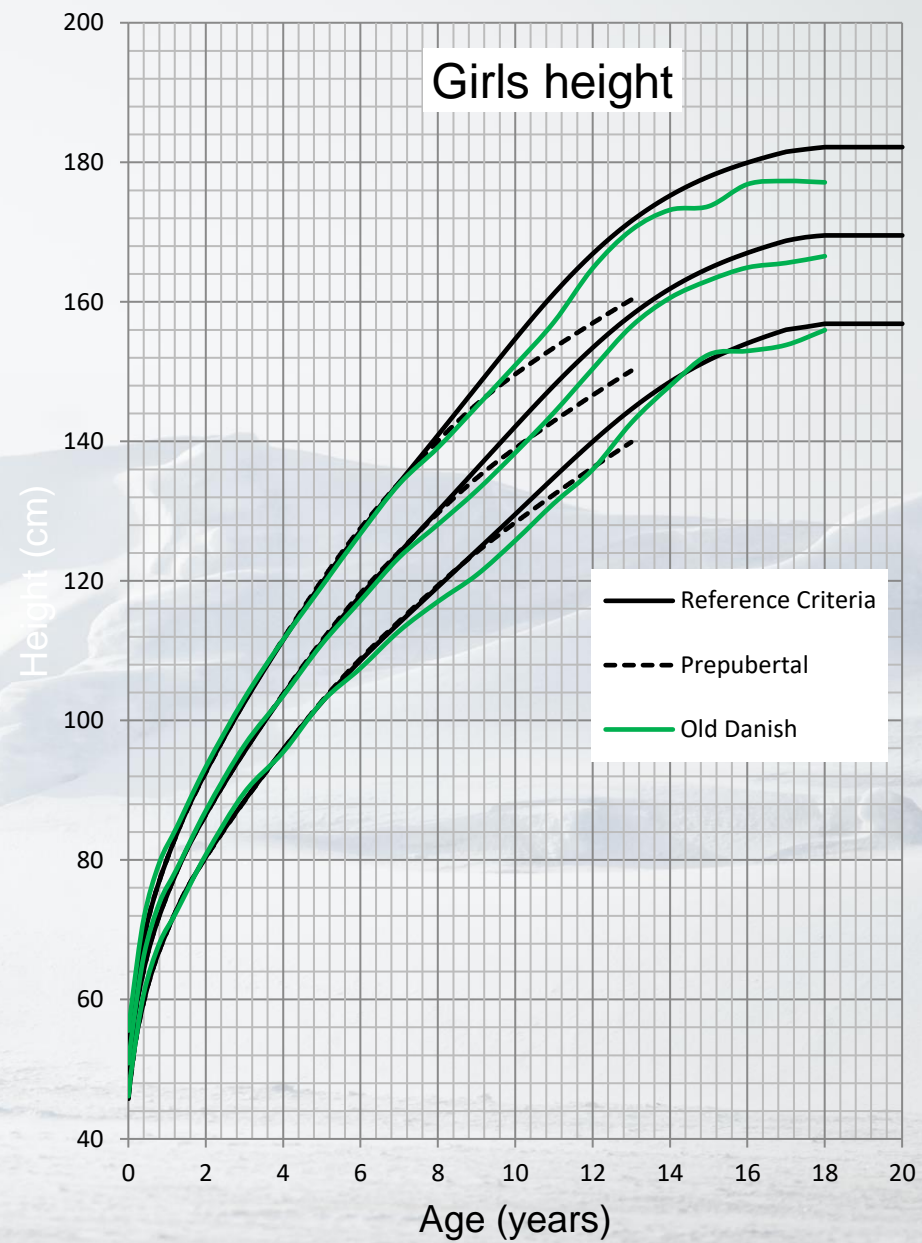
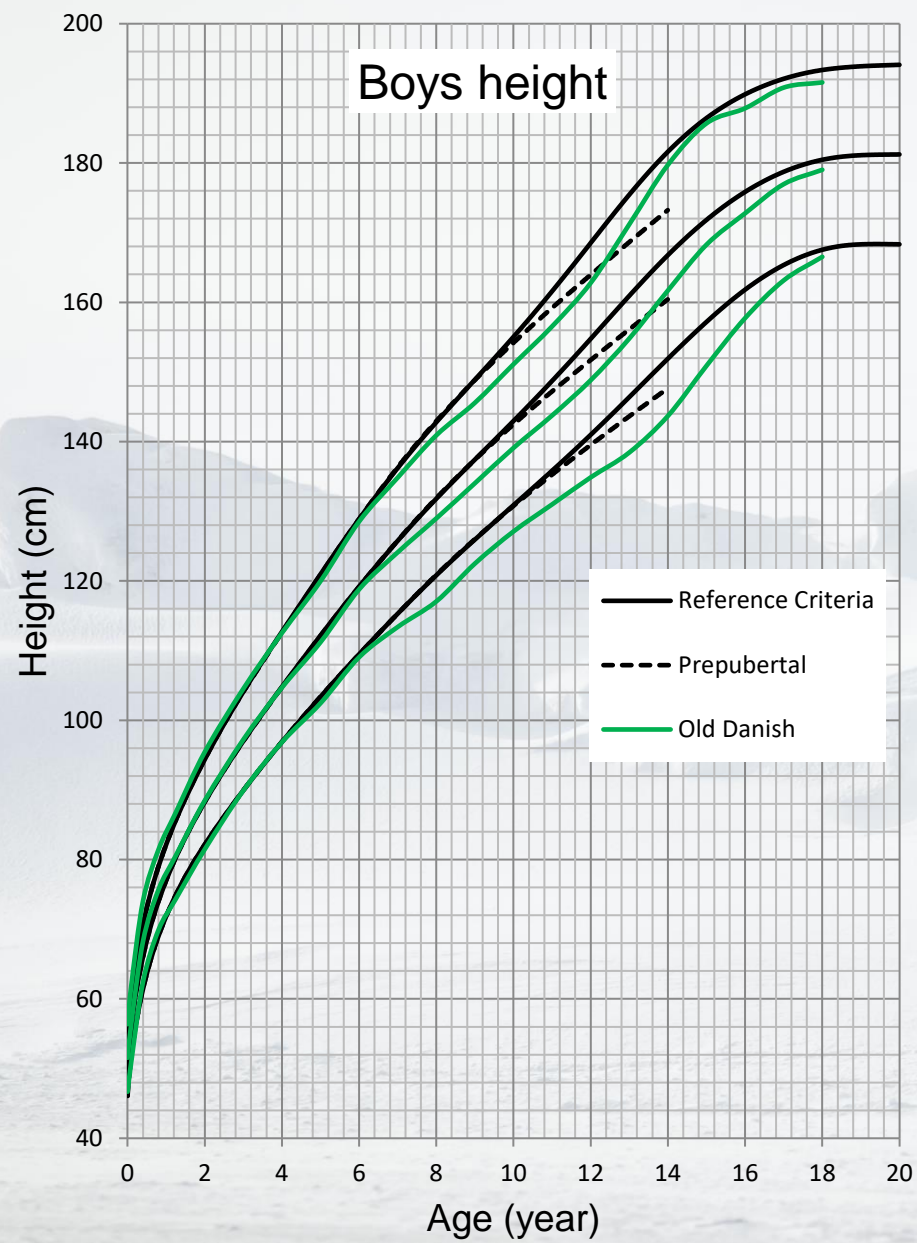


Vækst

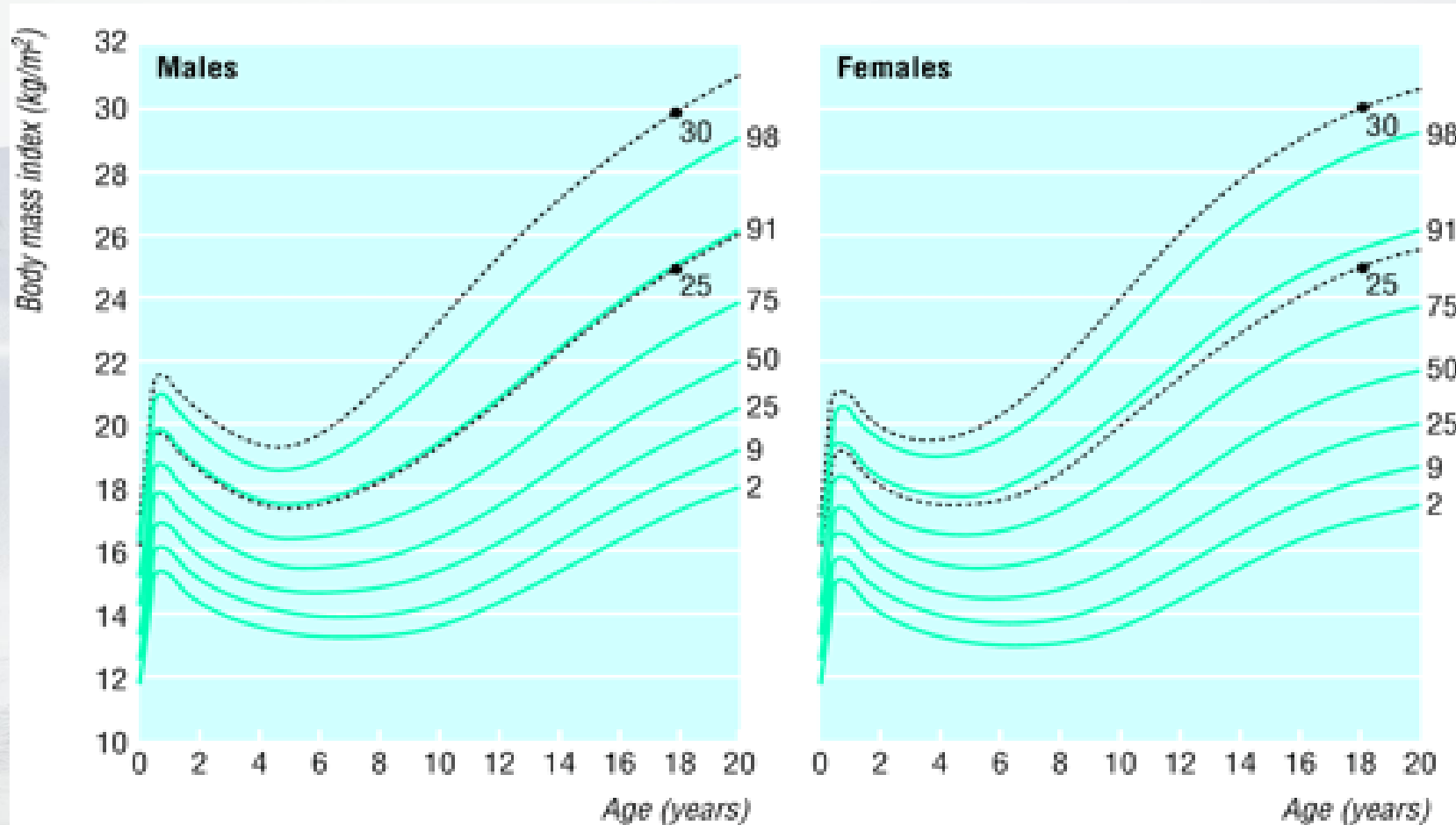
- Kontinuer, men ikke lineær proces
- Sunde børn vokser og udvikler sig normalt
- En måling er ikke nok. Vækst bør evalueres over tid, inkl vækst hastighed

Forudsætninger for normal vækst

- Godt intrauterint miljø og fødsel til termin
- Fravær af kronisk sygdom
- Gode psykosociale forhold
- Passende ernæring
- Normal hormon produktion
- Normal skelet (knogle udvikling) og bindevæv
- Gener



Underweight through to obesity



Take Home Message

- Vækst kurven – dit bedste redskab

Turner syndrom



Short stature

Low hairline

Shield-shaped
thorax

Widely spaced
nipples

Shortened
metacarpal IV

Small
fingernails

Brown spots (nevi)

Characteristic
facial features

Fold of skin

Constriction
of aorta

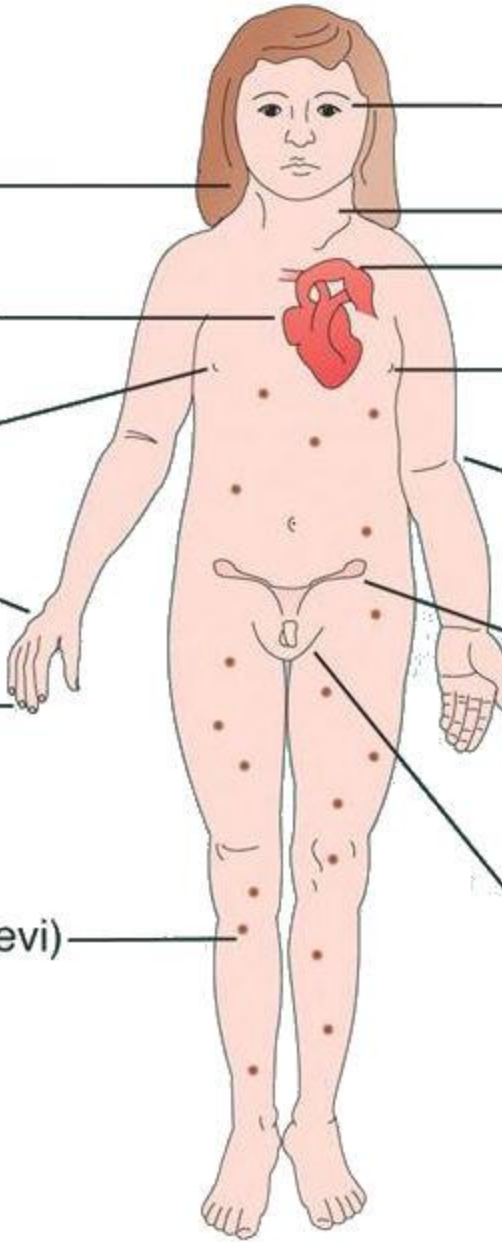
Poor breast
development

Elbow
deformity

Rudimentary
ovaries

Gonadal streak
(underdeveloped
gonadal
structures)

No menstruation



Tall stature



Marfan Syndrom



ORIGINAL ARTICLE

Change in Overweight from Childhood to Early Adulthood and Risk of Type 2 Diabetes

Lise G. Bjerregaard, Ph.D., Britt W. Jensen, Ph.D., Lars Ångquist, Ph.D.,
Merete Osler, D.M.Sc., Thorkild I.A. Sørensen, D.M.Sc.,
and Jennifer L. Baker, Ph.D.

CONCLUSIONS Childhood overweight at 7 years of age was associated with increased risks of adult type 2 diabetes only if it continued until puberty or later ages.

N Engl J Med 2018;378:1302-12.
DOI: 10.1056/NEJMoa1713231

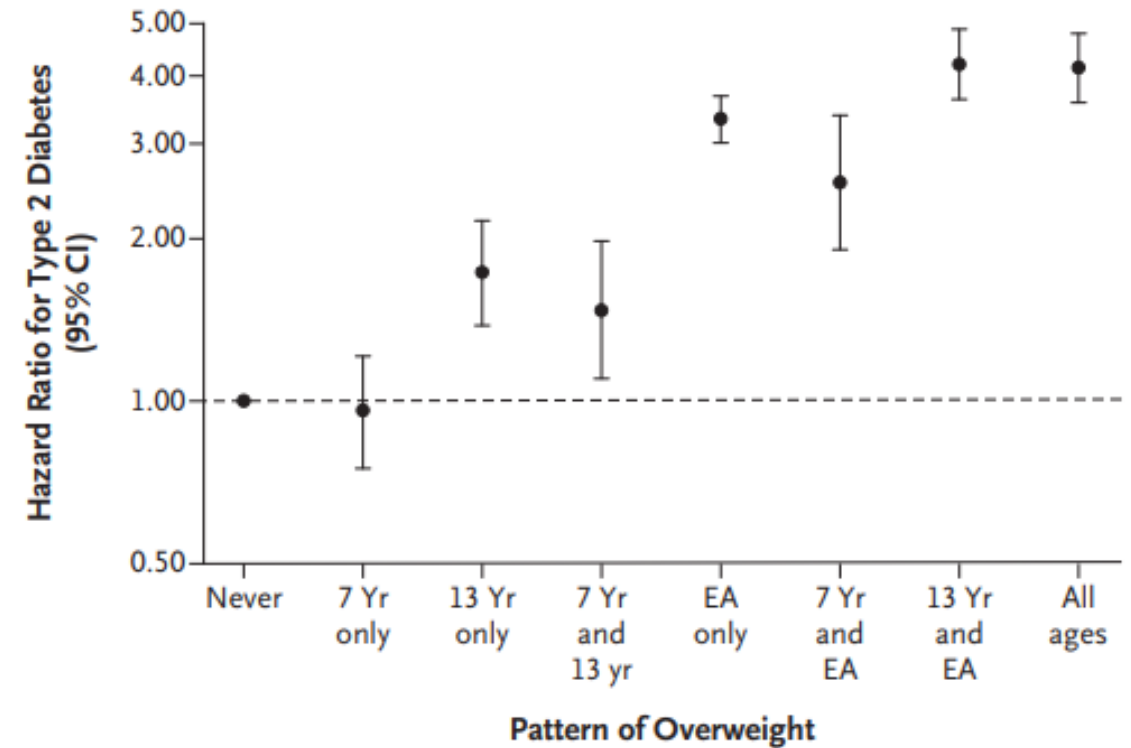


Figure 1. Patterns of Overweight at 7 Years of Age, 13 Years of Age, and Early Adulthood (EA) and the Risk of Type 2 Diabetes at 30 to 60 Years of Age.

In the calculation of hazard ratios for the development of type 2 diabetes, men who had not been overweight at any of the ages examined were used as the reference group. When Bonferroni corrections were applied, overweight only at the ages of 7 and 13 years was no longer significantly associated with an increased risk of type 2 diabetes (unadjusted $P=0.01$; number of tests, 7; $P=0.07$ with Bonferroni correction applied [7×0.01]), whereas all other significant associations remained significant. CI denotes confidence interval.

Tendenser

- Stigmatisering!
- Ikke måle højde og vægt!
- Spiseforstyrrelser
- Bio hacking
- Vægtneutral adgang
- Intuitiv spisning
- Fødevareindustrien
- Sikre optimal vækst og udvikling?

Kolding kommune

- Kvalitative undersøgelse viste at børnene følte sig forkerte
- På hvor mange? Er det en repræsentativ undersøgelse?
- Hvorfor er konklusionen at ophøre med at veje og måle, hvad med kommunikation?
- Hvem har ansvaret for monitorering af diverse vækstproblematikker, endsige overvægt?
- Sundhedsstyrelsen er meget uenig.

Konsekvenser ved ikke at måle

- Viden om flere hundrede pædiatriske sygdomme med potentiel påvirket vækst, udvikling og trivsel (fysisk, mentalt og socialt) bliver mindre tilgængelig!
- At vurdere vækst, udvikling, væksthastighed, familær prædisposition er i princippet en specialistopgave.
- Neglegt, omsorgssvigt, seksuelt misbrug!
- 100 års opbygget sygdomsprofylakse og sundhedsfremme!
- Generel omsorg!
- Overvægt, forværring uden monitorering?!

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PEDIATRIC OBESITY/TREATMENT

WILEY **obesity**reviews

Treatment of obesity, with a dietary component, and eating disorder risk in children and adolescents: A systematic review with meta-analysis

Hiba Jebeile^{1,2}  | Megan L. Gow^{1,2}  | Louise A. Baur^{1,2}  | Sarah P. Garnett^{1,2}  |
Susan J. Paxton³  | Natalie B. Lister^{1,2} 

Summary

This review aimed to investigate the impact of obesity treatment, with a dietary component, on eating disorder (ED) prevalence, ED risk, and related symptoms in children and adolescents with overweight or obesity. Four databases were searched to identify pediatric obesity treatment interventions, with a dietary component, and validated pre-post intervention assessment of related outcomes. Of 3078 articles screened, 36 met inclusion criteria, with a combined sample of 2589 participants aged 7.8 to 16.9 years. Intervention duration ranged from 1 week to 13 months, with follow-up of 6 months to 6 years from baseline. Prevalence of ED was reported in

follow-up of 6 months to 6 years from baseline. Prevalence of ED was reported in five studies and was reduced post-intervention. Meta-analyses showed a reduction in bulimic symptoms (eight studies, standardized mean difference [SE], -0.326 [0.09], $P < 0.001$), emotional eating (six studies, -0.149 [0.06], $P = 0.008$), binge eating (three studies, -0.588 [0.10], $P < 0.001$), and drive for thinness (three studies, -0.167 [0.06], $P = 0.005$) post-intervention. At follow-up, a reduction in ED risk (six studies, -0.313 [0.13], $P = 0.012$), emotional eating (five studies, -0.259 [0.05], $P < 0.001$), eating concern (three studies, -0.501 [0.06], $P < 0.001$), and drive for thinness (two studies, -0.375 [0.07], $P < 0.001$) was found. Structured and professionally run obesity treatment was associated with reduced ED prevalence, ED risk, and symptoms.

KEYWORDS

dieting, disordered eating, pediatrics, weight loss

3.6 | Eating disorder-related symptoms

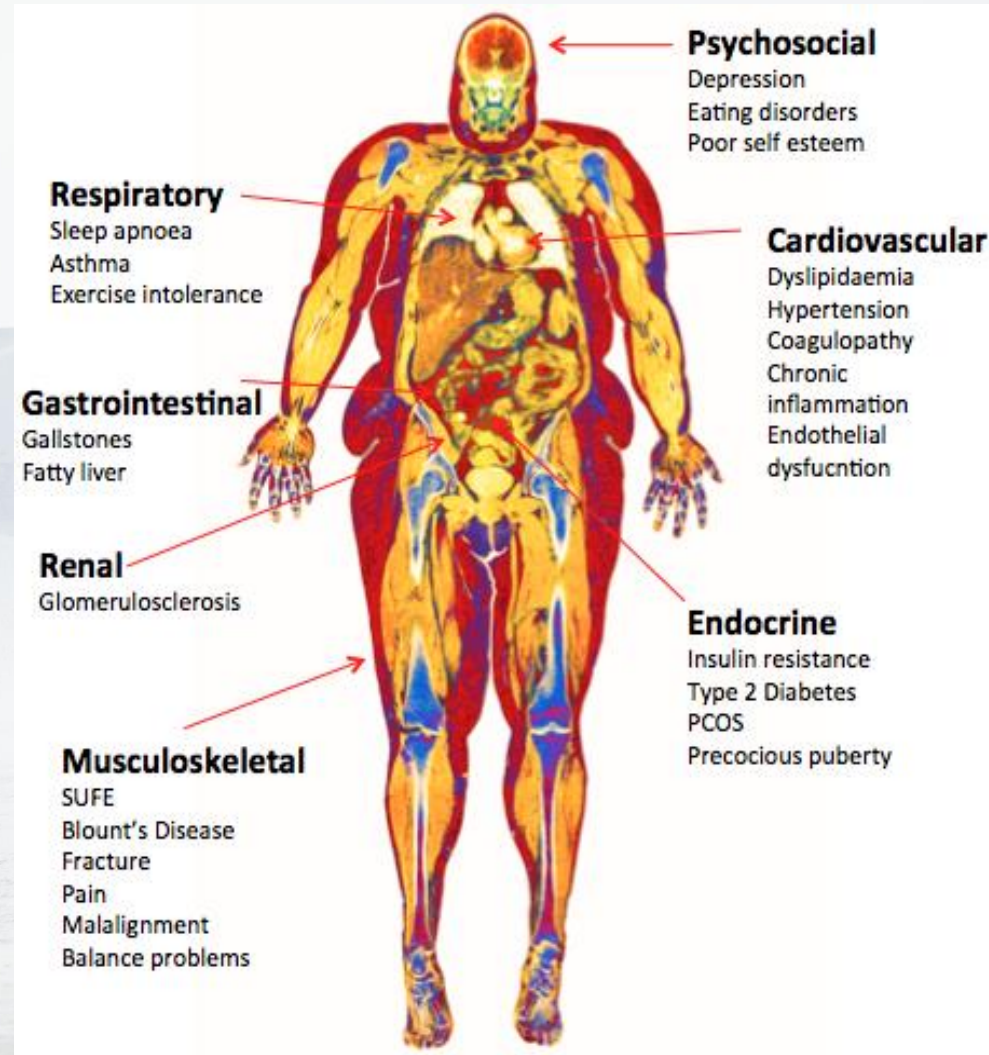
3.6.1 | Bulimic symptoms

The change in bulimic symptoms was measured using six different assessment tools^{56,66,67,70,71,74} reported in eight studies^{24,25,28,30,34,37,39,41} at post-intervention only, two studies^{22,44} at follow-up only, and one study³⁶ at both timepoints. Eight studies^{22,24,25,28,34,36,41,44} reported a significant reduction in bulimic symptoms, and three studies^{30,37,39} reported no change post-intervention. Meta-analysis of the intervention arm from eight studies,^{25,28,30,34,36,37,39,41} with a combined sample of 375 participants, found a reduction in bulimic symptoms post-intervention (Figure 3A;

5 | CONCLUSION

This review demonstrates that structured and professionally run obesity treatment leads to a reduction in the prevalence of ED, ED risk, and ED-related symptoms for most participants. Maintained longer term engagement with the program appears to be an important contributor to the reduction in ED risk. However, further research is required to better understand the relationship between dieting and ED risk in the context of obesity treatment for children and adolescents and in those who withdraw from treatment.

Obesity related Complications



Courtesy of Grace O'Malley, PhD, The Children's University Hospital, Dublin, Ireland





Disclosures

- Lecture fees and honoraria from Novo Nordisk and Rhythm Pharmaceuticals
- Board member; Danish Association for the Study of Obesity
- Member Obesity Committee; Danish Paediatric Society
- Co-chair; The Childhood Obesity Task Force EASO
- Ex-Officio Executive Committee EASO
- Dr Holm provides training and treatment



Thank you very much for your attention



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