Understand Healthy Weight Beyond BMI Transcript

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Introduction to Dr. Kelly Ruder and the topic

In this doctor talks, I have Doctor Kelly Ruder. She is the owner of Clearwater Family Medicine and Allergy in Clearwater, Florida, and she was an electrical engineer me before becoming a physician.

She practices family medicine, obesity medicine, and allergy medicine. I believe all of these things. And we are going to kind of take a big picture approach in this talk, talk about why weight loss is important and, what some of the basic things we need to do for weight loss are, but also a little bit of what who needs to lose weight.

And you know about BMI. Is that the key thing. So thank you doctor. So much for joining me. Yes. Thank you so much for having me. I'm excited to talk about this today.

And I'm using my standing desk so far very good. Getting some of your non exercise activity thermogenesis. And exactly and I might bring that up. So let's you know sort of with a basic healthy weight.

What is a healthy weight. How does someone know if they're at a healthy weight. We use this number BMI a lot in medicine, but we're, you know, kind of trying to move away from it.

How does someone know if they are at a healthy weight, if weight loss would be beneficial for them?

What BMI measures and its limitations

That's a awesome question. I think that sometimes when people come to me as a primary care or obesity doctor, they may have already been told, unfortunately, maybe by another provider that, you know, they they're their problem.

Like if they went to the cardiologist or the, orthopedist that they need to eat less, exercise more, and lose weight, right. To help their the whatever problem they're being seen for.

But when they come to me, I may be just doing an initial evaluation and deciding, okay, let's get a new patient. Let's what do we do when they walk in the door? Right.

So one of the things that we do when they walk in the door is take their height, right. And take a weight, maybe a blood pressure, maybe temperature and things like that.

So those are the vital signs, right? And this guy I'm going to read his name, Adolph Cue to lead is the one who developed the BMI. And the person who really instigated it into the United States was Ansel Keyes in 1972.

So the BMI is a body mass index and measurement of the height over. I'm sorry, the weight over height squared in, kilograms per meter squared. So we have these measurements that we use arbitrarily, and we have the different levels of the BMI which we consider abnormal overweight or obese.

And typically with a normal weight, we say that it's like 18.5 to 24.9 of the BMI. And then the overweight would be 25 to 29.9. And obesity is considered 30 and above.

And they break that down further with the classes of obesity. So class one obesity is considered 30 to 34.9. And then class two would be 35 to 39.9. And class three is anything greater than a BMI of 40.

So those are what we break it down for. And then BMI as you mentioned already has many limitations, right. So one is that the the race at ethnicity, gender, all of these things are not perfect with a BMI.

So in some races and ethnicities, for example, Asian population, there can be metabolic or comorbidities from weight, a lower BMI. So we have different cutoffs for those individuals.

And that would be usually I think it's less than 23, for Asians for normal weight. And then they cut off for obesity. Is at 27. And then there's also people who may be healthier at a higher weight.

And sometimes we see that in an African American female population. And they can have a BMI, you know, above 30 and have no metabolic dysfunction. So it really is not a great test to determine if someone needs to lose weight or anything.

But it is a pretty good screening tool and used in epidemiological studies. Right. So, other limitations would be someone who comes in the door that is, you know, very musculature.

Right? So they may have a higher BMI, but they're sorry. They would be. Yeah, higher BMI. But then very little body fat, right. Yeah, I remember I remember this patient.

I saw it when I was actually still in training. He was a football player. He was like 18 years old and on the chart, he, you know, was in the overweight kind of getting close to the obesity range.

And I went to do his exam and I did his belly exam. And he like he had a six pack like this guy had like no body fat. And I was like, so this is why BMI isn't always accurate, right?

Because he was very, very lean, very muscular individual. But the BMI just, you know, wasn't the way to measure body fat for him at all. Yeah, absolutely.

I mean, I have a couple powerlifters where, you know, they they definitely are high on the BMI chart, but they actually could have some may have some metabolic abnormalities and some may not.

So I will talk more about the metabolic stuff later. But we're just you know, focusing on BMI. There's also people who have a low BMI, kind of like I was mentioning with the Asian population.

I do have a lot of patients in that category, and they may have a normal BMI, but then they're at higher risk for diabetes and blood pressure and things like that, and definitely have several patients in that category.

And sometimes we have this. I don't know if it's a good term or not, but we call it toffee or toffee, which is thin on the outside but fat on the inside.

Because if we're talking about that visceral fat, right, the fat around the organs, that makes it metabolically unfavorable. So the BMI is kind of limited in that. Right?

So it's not really deciding between body, lean mass and fat mass. So we're limited by that respect with the BMI, but we still use it as a screening tool.

So also to make it a little bit better, we sometimes, recommend taking a waist circumference in addition to the BMI to get a little bit better understanding if there is that visceral fat around the organs on the stomach.

And that can give a better indication of whether someone might need to lose weight. But, I will say that not everybody does that. And guilty as charged.

We don't always take the waist circumference. I often feel personally awkward getting super close to the patient and taking that waist circumference. Other measurements we do, consider using, would be the waist to hip ratio.

And maybe like the skin, I forget what it's called, but the skin things which the calipers. Yeah, but we don't really use those anymore. But if you were to do a waist circumference greater than 35in for a male and 40in for women is considered, overweight, I'm sorry, I had I said it backwards, 40in for a male and 35in for a woman is considered, to

be obese.

Yeah. And so that goes to, I think, what you were saying about body composition and where that fat is the fat that may be in our legs or by our arms that maybe you don't like, probably doesn't have as much impact on your health as that visceral fat.

The fat you can't can't see that's inside your belly, around your organs. It has so much more impact on your health. And so that's where when we measure waist, we can get a little more information about where is that extra weight that someone has.

They may have a normal BMI. Like you said, their weight may may seem normal.

Body fat, waist measurements, and obesity staging

But the distribution of their fat or adipose tissue is in such a way that it's it's possibly causing harm to their health. Yeah. I mean, even just taking a look at the patient and seeing what sort of, you know, body shape and size they have, you know, pear shaped tends to be a little bit lucky, right?

Where the apple shape is not as lucky because of the abdominal, obesity that could be involved in those things. So even just, you know, looking at the patient, you can get some analysis of that too.

But then we mentioned, like, getting a more accurate picture of the body fat percentage. So luckily there's more and more tools to do this, which I think is really nice.

And we're all, I think, bringing it more into our clinics for those who practice obesity medicine. But there are many different ways to measure body fat, the gold standard being the Texas scan and then the you could do an MRI or CT, but clearly that's not cost effective and nobody's going to pay for that.

But the newer things like I don't I guess it's not that new, but the bioelectrical impedance analysis, like with an in-body scan or Sica scan, those are becoming more and more readily available and popular.

Many gyms have them, many offices are starting to get them too. And while it's not reimbursed by insurance, it's a really good, estimate of that body fat percentage that can tell us, you know, if they're at risk for metabolic problems and if they, you know, we would recommend maybe losing 3 to 5% of your weight.

So we could use that. There's also, the high density and I can't remember the, the full name of it, but the bod tod, which is something that I've, I remember using many years ago, but those are rare and far between these days either.

But this is a different way to assess body fat as well. I think the most common that we're going to see is these biological and Pinas analysis analysis ones.

And you can get like ones that don't do as good on the upper body, but you can get it off Amazon. And today's Prime Day, at least one where retorting.

And you could probably find a pretty good one, to get that up for your home scale as well. So those can give an indication of the body fat percentages, which is, you know, a better assessment rate.

So for, obesity, we typically say anything more than 25% for male and 32% for me, female for excess body fat from those things. So we've got all these new tools of, measuring, which is, you know, helpful.

So that I think gives us a better assessment on. Hey, okay, maybe we should think about, like, losing weight for your overall health rate. And then, we also have, obviously the comorbidities that are associated with obesity.

And another way that we kind of gauge and scale things is with this Edmonton obesity scale and that, or staging

system. I'm sorry. And that has based upon the risk factors and also incorporates like, activities of daily living if those are impacted and even just aches and pains right from having weight, excess weight on their joints.

So stage zero is really no risk factors. You may have, the BMI in the range, but you're really not, having any problems from it. Stage one is, basically prickling Nicole.

And I'm not sure if I like this term, but like the you're getting high blood pressure, but you maybe don't need treatment yet. So we call it borderline hypertension or borderline diabetes, which I'm assuming, you know, prediabetes.

And then, maybe like some aches and pains. And then stage two is having you know, diabetes, PCOS, high blood pressure and some impairment in those ADLs.

And then, stage three is actually having an organ damage. So heart attack, congestive heart failure, stroke, anything that might be, related to, you know, associated with obesity as well, and then some significant HDL, impact there.

And then stage four is end stage, I guess obesity with limitations and severe ADL impact. So these are all the different ways that we can classify obesity and decide, you know, what's the overall picture of a person presenting to us.

And whether we want to broach that discussion of, you know, should should this person lose weight? And then the next step would be, you know, getting bloodwork.

So do you have any comments or questions? No. I think that's really, really helpful information. I know in my clinic we've used in body for, for like a decade to, help assess that particular in our patients that have those lower BMI, but they're worried about their weight or they have, you know, the next thing we'll talk about some metabolic markers that come back concerning high cholesterol or something like that.

And we're able to make that diagnosis of obesity and offer treatment for that and offer medical weight loss based on a body fat percentage instead of just the scale, which just doesn't tell us the whole story.

So, so I think that was a very, helpful outline of how much more detail we can go into for this, because, again, it is more than just the number. And so, yeah, let's talk about that second part, which is the metabolic markers and the other factors that go into determining if we think that weight loss would be helpful for someone's health.

So tell us about these metabolic markers okay. Before I do, let me go back and also say that with the body fat percentage, if we're not doing that, you can also miss someone who has really low body.

Sorry, muscle mass, like with sarcopenia. So I didn't mention that. But that's important to because that's not going to get picked up from the BMI, right?

They might have a normal BMI, but like no muscle. So that's going to impact their health. Yeah, it's actually interesting because people are critiquing the BMI more and more.

And the American Medical Association, the AMA, which I'm really involved in, has, made a lot of policy to sort of like reverse BMI, and kind of concerns a lot of time about BMI over estimating obesity.

Metabolic markers and lab work for weight health

But really, what the data shows is we're under diagnosing obesity because there are these people that have sarcopenia, obesity, meaning they have low muscle mass.

And so the BMI is missing more people actually than it's over diagnosing. So, even though the BMI is not a perfect tool, it actually looks like if anything, it's missing more people than than over diagnosing.

If we're really looking at the science, that is probably I mean, that's very accurate. I always want to question also in my older population, whether I want to get them on their body scale and say, hey, this is why you need to, you know, move more, lift some weights or lift your body weight and do some more exercises because you may be a good weight, but you are at risk for, you know, impairment of the ideals if you were to fall or anything like that.

Yeah, yeah. We want to keep those strong muscles as functional muscles and have that, that lean mass, that muscle mass. Yeah. Okay. But to answer your question about the metabolic markers.

So typically when you go to your primary care doctor they're going to order some standard panels. And I guess I'll go over those ones first. So one would be a cholesterol profile.

One would be a complete metabolic panel. We usually use a complete blood count, but I don't use that much on my analysis for metabolic health. And then also a hemoglobin A1, C although, you know, I have to fight Medicare sometimes to order that one.

But so those are probably the most standard ones. And then I would say there's some advanced stuff that I also tried to order. If the patient agrees or, you know, we think it will be covered or other things like that. So those are the basic ones.

And from those basic ones, we can get things like a fasting glucose, because that's in the metabolic panel. We can get obviously the hemoglobin A1, C.

And those are both going to be, you know, detecting, you know, prediabetes, diabetes and seeing if there is insulin resistance. So one step further might be for to investigate insulin resistance would be, you know, getting a fasting insulin and perhaps also quest offers this something now called insulin resistance score.

I'm not sure if you're familiar with that, but I've started using it more and, that both of these methods can help us calculate a number that would determine if the person has insulin resistance, which is going to be like pre pre diabetes, if you will, and kind of get those markers in place sooner.

So we can get these habits change so we can prevent you know disease from coming on. Right. So showing how we can assess other markers of metabolic health.

And in the complete metabolic panel we also can look at kidney function. And I'd like to look really closely at liver function when that would be the AST and the Alt and when those are elevated.

Sometimes we're thinking about a comorbidity called fatty liver disease. And they have changed the name multiple times. But I forget what the new one is.

But nonalcoholic fatty, the liver disease is the one that we typically associate with a, metabolic problems associated with weight. So you can get that picture just from the metabolic panel.

And then I also mentioned how we assess cholesterol in the metabolic, analysis here. And one thing I like to look closely at is a triglyceride to HDL ratio.

So we do look at the whole cholesterol panel in general and the LDL, which is the quote bad cholesterol. But the HDL to regulate the triglyceride to HDL ratio gives us a little bit more assessment of impact.

And sometimes because it was harder cardiovascular disease of stroke and heart attack. So I have to calculate this out alone. But when we do that we usually are aiming for a ratio under two and a half to two.

And those. That's because it's better outcomes are associated with those numbers. So really we want a lower triglyceride. And a higher HDL. So HDL is a high density lipoprotein or the better cholesterol.

And then there are more, advanced studies that your doctor could order on the cholesterol profile, which would

include a LP, little A and B, and it also may include a CRP or high, high sensitivity, blinking all of a sudden.

Probably because not the power, but, C-reactive protein, sorry, high sensitivity C-reactive protein. And these all can, if they're elevated, can be associated with more metabolic risk factors that we will look at.

And that panel would also break down the size of the LDL particle. And the smaller LDL particles are the ones that are considered to be dangerous and can cause heart attack and stroke, whereas the bigger ones we kind of think are neutral.

So you can get more advanced studies. But sometimes these aren't always covered by insurance. But a basic cholesterol profile using the triglyceride HDL ratio can be really helpful.

And there are other studies that we could add on to that aren't in these standard panels. And that might be something like a uric acid or a vitamin D.

Most patients who have overweight or obesity often have a vitamin D deficiency. And we do sometimes check that as well. And you know, this all these measures and markers of everything kind of give us an assessment of what these comorbidities could be and whether it's a good idea to try to lose like 3 to 5% of your body weight, because that could improve some of these markers.

And then, you know, likely we would retest and see how everything is on that. Yeah. So I think the kind of, you know, summarize some of what you said is BMI screening tool.

And, we can get more information based on where people have body fat, how much body fat they have. And then we also can pair that with any health conditions related to weight, things like sleep apnea or heart disease.

Fatty liver disease, any diagnoses they may have. And then that bloodwork also is giving us, some information as well. If you come in and you have no health diagnoses and your bloodwork looks picture perfect, then you may not have, a compelling medical reason that you need to lose weight.

You're welcome to. Right? Like you, you might be able to safely lose weight, but there may not really be a medical reason why you need to do that. And then you might just be able to, like, take this weight off your shoulders about your weight.

You may not need to worry about it. It may not be a problem for you. And I think that that's important to realize, too, is that not everyone needs to lose weight.

We kind of obsessed with that in our culture sometimes. And that can cause a lot of stress to people who constantly feel like they need to lose weight.

Sometimes. Sometimes people don't have to. Sometimes you don't need to. You may not have a big health benefit from that. Yeah. I mean, so these metabolic markers, they they're not going to pick up, you know, joint problems. Right.

So if you're having aches and pains then that might be a reason to lose weight. And they also may just not pick up what your emotional. And you know your moods are right.

If you have anxiety or depression and it's about your weight because you don't like your physical appearance, that may be a reason for you to lose weight.

So I really talk about being at a healthy weight and a happy weight. Right? So there's got to be the merging of the two to see whether the patient should be trying to pursue losing weight, right?

Yeah, yeah, I think that's really powerful. And, a lot of people will come to me and they say they were most comfortable, had a certain weight. Right. That they just they felt better.

They felt that they were able to do all the activity they wanted to do. They slept better. They had good energy, they felt more comfortable in their own skin.

When weight loss is medically helpful

And those are important as well. Right. So we're really, you know, when you see someone like doctor I, we're trying to like take this comprehensive approach to how much weight would be beneficial, how much is it needed.

And then of course, like, what are your goals? What would make you feel your best, in this process as well? Yeah, absolutely. I'll add in. Also, sometimes you may breathe better at a certain way because I like to focus on allergy and asthma.

And sometimes those things can be impacted by weight as well. Yeah. And so you know I imagine you're the same. But one of the things I like to check in with for my patients as they're losing weight is what things are feeling better. Right.

And so those can be reasons to keep doing what you've done, whether it was a nutrition strategy or a medication or whatever your strategy was to lose weight, if now you are breathing better and sleeping better and your joints feel better, you have less reflux, whatever those things may be, those are really important to remember that that you're seeing that improvement when you're when you're on that weight loss journey.

That's a great point. Reflux doesn't come in on a metabolic analysis doesn't know. And that can be definitely related. Yeah. So what are your some of your top tips around nutrition.

You know if we're looking at the big picture here, what are some of the most important nutrition changes you recommend for your patients. Yeah. So I you know, there's obviously you got to meet the patient where they are and what they're currently doing.

They may have already changed some habits. So starting, you know, with what they're currently doing is really important, like getting an assessment. But then the, the most thing I tried to do is kind of focus on eating whole foods, you know, foods that came from the ground, foods that we haven't done anything to.

And that is meaning get rid of these ultra processed foods that are, you know, manufactured in a facility. They do much, much testing on these products to get to make them at this quote bliss point.

So they taste so good that you can't just eat just one, right, can't eat just one, and that they you know, they you become addicted to them. So kind of trying to eliminate ultra processed foods, I mean, maybe not 100%.

Right. But being reasonable about it, obviously cut back on it. And that's probably the first place I would say I want you eating real food and you know, where your old, your grandmothers used to eat right?

I would say that has been one of the most consistent things from many of the experts I have interviewed in this doctor Talk summit is, you know, those ultra processed foods, really watching those in the diet, being intentional about them, right?

It doesn't mean you can never have them, but they should be, either a treat or a rare convenience. They really should be a minimal amount of of what we are eating.

So I think you're you're emphasizing what we've heard from so many of our experts. That's because I think, sorry to interrupt the, every diet out there, you name the type of diet, the pattern of eating, whatever it is, they're all doing the same thing, and they're all kind of get rid of getting rid of ultra processed foods, and they all work, and you stick to them, but they're all doing the same thing, doing getting rid of ultra processed foods.

Yeah.

Nutrition basics and reducing ultra-processed foods

And then will you tell us a little bit about the role of weight loss or anti-obesity medications in your practice, what you see for patients, how does someone know if it's time to consider something like that.

So usually I think, you know, looking at if they've plateaued or they've struggled for such a long period of time, if they're overly hungry, if they aren't ever full, if they are struggling with the cravings, the food addictions, if they can't just get themselves to, you know, not want these foods all the time that are inhibiting their weight loss.

So typically those are the kind of times where, you know, they've tried everything and they would like to have some more support in that. And that's where the medications can really play a role, because that ghrelin, that hunger really comes in heavily when people are starting to lose weight.

And usually they've come to me trying everything already. Right? So they are wanting, you know, help and advice with that. So that's where an eye start to think okay.

Yeah. This is might be a good idea to implement medication. And not only that we talked about the insulin resistance. And that also is another reason for me to maybe think about medication.

Because when you're insulin resistant, it's harder to lose weight in the first place. So kind of trying to get those cells more sensitive to insulin so that you can bring the sugars and the insulin down is another reason why we might start using medications, even if it's like off label usage.

So, with that, you know, we sometimes think about using metformin and then with the increased hunger that people, really have trouble with, that's when we also start to use something like that phentermine or these appetite suppressant.

And then there's the combination with Venture Brain and topamax and topiramate and topiramate. Also can help with that, that some of the cravings as well.

Medications for weight loss and closing remarks

So I think that combination can work really well for someone who is overly hungry and having trouble with cravings for things. So we often implement that.

And then another one that works well with cravings is the control or the original naltrexone. And we often use that as well to help, people who have, cravings.

But as you know, I'm sure and everybody else knows all these new or the injectable medications, the GOP ones and Gib, GLP, they are all helping with these same things, right?

They're helping reduce cravings. They're reducing satiety. They're, sorry, increasing satiety and reducing hunger. And it's just helping with everything at the same time.

So it's also in turn reducing their cravings and want and need for these ultra processed foods. So I think, you know, it's a win win. But of course there's limitations with all of the medicines.

You have to make sure the patient has doesn't have any risk factors. And contraindications for these medications as well. So yeah, like a wide range of options and working with an expert who can help navigate, you know which of those may be a best fit, I think is a really important part of this process.

Absolutely. Yeah. I don't know if you want me to go in any more detail on anything or. Well, I think you've been really generous with your time. Especially, you know, with some technical difficulties we had during this recording.

If people want more information about what you do, where can they find you? Yeah. So I am on, you know, all the

social things, usually at Kerry, MD or at Clearwater Family Medicine and Allergy on Instagram or, or family medicine.

And our website is CMA, Dot health. Because we like to keep everybody healthy and, yeah, it can reach out to me there and I'm sorry, you know, due to the power in the storm, we got cut a little short.

But I'm, you know, very thankful for being here today. And I hope this helps everybody who's listening. Thanks so much, Doctor Eller. For.