

Editorial comment

Obesity in Spain: an open book that must be read

Obesidad en España: un libro abierto que debemos leer

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The growing frequency of obesity is a subject of debate, interest, and concern for governments, health professionals, companies from various sectors (eg, pharmaceutical, food, and fashion), and, therefore, society at large.

In an article published recently in *Revista Española de Cardiología*, researchers from the University of Santiago de Compostela reported changes in the prevalence of obesity in Spain and its autonomous communities between 1987 and 2020¹. Feijoo et al.¹ conclude by highlighting 4 messages. First, the prevalence of obesity in Spain doubled between 1987 and 2020 (7.3%-15.7%), increases with age, and is higher in men than in women (from 8.0%-15.3% vs 6.8-16.1%), although differences between the sexes have tended to disappear from 2003 onward. Second, if the study period is divided into 2 parts, ie, 1987 to 2009 (to 2001 for women) and thereafter, the increase during the second period does not generally seem significant. Third, trends differ by autonomous community: many follow the general, stable pattern during the second period, whereas others are characterized by upward and downward trends (Feijoo et al.¹; figure 1 in the appendix). Finally, among young adults aged 15 to 24 years, and especially among women, the increase is more pronounced, with a continuous, upward trend.

The article highlights obesity as a prevalent health problem that is important for the Spanish population. Although the prevalence values reported for the period 2009 to 2020 (15.7%-17.0%) are lower than those of similar studies (from 20% to 23% in the ANIBES,² ENPE,³ and ENRICA⁴ studies and from 26% to 28% in the Di@bet.es^{5,6} study), the disease clearly affects a very significant percentage of the population. The differences observed may result from estimates based on self-reported data (surveys¹) rather than on direct anthropometric measurements.²⁻⁶ Moreover, the estimates of international bodies with respect to Spain, eg, the World Health Organization (WHO 2022: prevalence of 23.8% based on data from 2016⁷) and the Organisation for Economic Cooperation and Development (OECD 2019: prevalence of 54% including overweight and obesity⁸), confirm that obesity is a cause for concern in terms of general health.

Beyond the snapshot of prevalence and the methodology applied for its calculation, 2 findings reported by Feijoo et al.¹ are of particular interest. First, while the prevalence of obesity remained stable during the latter period, it did not decrease, although other forecasts continue to expect an increase in prevalence, albeit perhaps less pronounced.⁹ Second, and perhaps more alarming, is the increase in the 15- to 24-year age group (from 0.9% in 1987 to 5.9% in 2017 and 3.7% in 2020) and the fact that this upward trend persisted throughout the period, more so among women (from 0.5%-3.9%) than among men (from 1.2%-3.6%). Although they overlap with findings from other European countries,¹⁰ these observations highlight the pressing need for new preventive methods. However, they do invite us to reflect on how the disease and its comorbid conditions are treated in order to prevent future complications. Most affected young adults will live with the disease for decades. The metabolic consequences of overweight and obesity in younger age groups have a marked impact—possibly even independently of their subsequent resolution—on the risk of premature cardiovascular events in the future and, therefore, may take the form of dramatically reduced life expectancy.¹¹⁻¹³

In contrast with the findings of these studies and even of the WHO and OECD, obesity should not be seen simply as a risk factor for specific diseases (eg, diabetes, hypertension, cardiovascular disease). Obesity per se is a disease, defined as excess adipose tissue. Despite the existing techniques for directly estimating body fat, technical complexity and high cost mean that body mass index is favored as an imperfect but easily applied approach. Without treatment, obesity gradually has a negative impact on the quality of life and life expectancy of affected individuals, with severe economic repercussions for society as a whole.¹⁴ The disease manifests in persons exposed to an environment where food is readily available and physical activity relatively unnecessary and affects the individual's biological and genetic mechanisms.¹⁵ At present, this conditioning favors accumulation of fat and powerful resistance to fat loss. The well-documented causes that contribute to the disease are more stressful living conditions, a sedentary lifestyle,¹⁶ loss of traditional dietary patterns,¹⁷ the elevated cost of a high-quality diet (based on fresh food and healthy eating habits), and unlimited access to high-energy foods and drinks (eg, sugars, saturated fats, precooked meals), which are more addictive and inexpensive. These factors render persons of a low socioeconomic and cultural level more vulnerable to the disease. In addition, this population is affected by a greater number of complications. All

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these factors, as well as genetic factors and demographic differences (eg, rural environment, population pyramid), help to create differences between populations and, to a large extent, are responsible for the differences between the autonomous communities recorded by Feijoo et al.¹. The highest prevalence of obesity in Spain has traditionally been recorded in regions such as Andalusia, Extremadura, the Canary Islands, and the southeastern provinces. However, data on changes reveal an upward trend in regions where the disease was previously less prevalent (eg, Murcia, Castile and León, Asturias, and Galicia).

For persons living with obesity, the traditional approach to the disease and its treatment, which is based on intensive lifestyle interventions, has proven to be, even under the best conditions possible, inefficient in the mid-term. Nonetheless, it continues to make sense and provides a clinical benefit.¹⁸ In the case of an adult with a decades-long history of the disease and its complications, we must look to strategies that also include drug therapy. The new options indicated for weight loss¹⁹ have proven to be potent, safe, and efficacious in maintaining weight loss. They offer affected individuals a wide range of benefits, such as improvement, remission, or prevention of specific diseases (eg, diabetes, metabolic liver disease, obstructive sleep apnea), as well as enhanced quality of life and fewer cardiovascular events.²⁰ As in other areas of medicine, it is always important to prioritize the use of these agents in groups or individuals where we expect to see a major benefit in terms of weight loss. At present, health professionals do not have access to these options to help patients (or they are only available to those with a high socioeconomic level).

If it is essential to start treating people living with obesity, it is even more important is the need for a determined effort to prevent the disease. In addition to health education strategies for the population at large, we require public health strategies that favor and—in specific cases—enable an individual to maintain a healthy lifestyle and eating habits. Taxing soft drinks, providing appropriate label information on supermarket products, and ensuring mandatory labeling of the nutritional content of food served in restaurants have proven useful as measures for keeping the problem in check.^{21,22} However, the evidence points to the need for more aggressive interventions that are broader in scope and include a social, environmental, and economic perspective based on clearly defined regulatory policies²³.

Finally, the most important aspect of the uncomfortable truth addressed by Feijoo et al.¹ is the authors' request for careful reading and critical reflection, and, above all, the need to act without delay.

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CONFLICTS OF INTEREST

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