

Case report

Morbid Obesity with Complications

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Abstract :

Over weight technically refers to an excess of body weight. where as obesity refer to an excess of fat. The Body Mass Index (BMI) is the accepted standered measure of overweight and obesity BMI provides a guideline for weight in relation to height and is equal to the body weight divided by the height in meters squared. Adults with a BMI between 25 and 30 are considered overweight, those with a BMI of 30 are considered to be obese. In adults, a BMI threshed of 40 kg/m², distinguishes individuals with severe obesity and the high risks for co-morbidities. This category is sometimes termed as "Class III obesity" or "Super obesity" or "Morbid obesity". The term Morbid obesity is sometimes used to identify individuals with obesity related co-morbidities. The likelihood of persistence of childhood obesity into adulthood is related to age, parental obesity, and severity of obesity. In longitudinal studies, approximately those 50% of obese 6 years old children, and 80% of obese 10 to 14 years old children. who had an obese parent. Girls are more prone than boys to develop persistent obesity during adolescence. This is related to changes in body composition that occur at puberty, when body fat decreases in boys and increases in girls.

Case Report :

A thirty two years old fourth class Govt. employee, visited in DMCH. He was presented with snoring, sleep apnea, hypertension, palpitation, short ness of breath on exertion and chest pain and occasional feelings of vertigo. This Gentleman has three obese brothers and two normal sisters of normal size and shape. He has started gaining weight since his early childhood.

On General Examination :

This obese Gentle man looked anxious and obese. His weight was 129 kg and height was 1 meter 53 centimeters. His Body Mass Index (BMI) was 54.5. His ideal body weight for height should be 57 kg. To achieve target body weight he has to lose 72 kg body weight. He was cooperative and his decubitus was on choice. He was mildly anemic and Jaundice, clubbing, Koilonychias were absent. His respiration rate was 16 beats per minute, temperature was normal and Blood pressure, systolic 155 mmHg, Diastolic 100 mmHg. His neck veins could not be seen as they were buried under the thick fat pad in the neck. Both thyroid gland and lymph nodes were not enlarged.

On precordial examination :

On inspection, Apex beat was seen in left 6th intercostal space, 2.5 cm lateral to the left mid clavicular line. No other visible pulsation could be seen. On palpation, no thrill or palpable

heart sounds were felt. On auscultation, heart sounds were soft as if heard from distance. Bilateral basal creps were present. Examination of nose reveal hypertrophied inferior turbinate and nasal mucosa is congested. Nasal passage is narrowed. Examination of throat revealed tonsils are enlarged and respiratory passage is narrowed Examination of other systems revealed no abnormalities.

Electrocardiogram (ECG) :

ECG shows sinus rhythm with ventricular rate of 94 beats per minute. ECG was consistent with left ventricular hypertrophy with left atrial hypertrophy with high lateral ischemia.

Routine test :

CBC showed Hb% 11.20 gm/dl, ESR 80 mm in 1st hour. Urine RME showed plenty pus cells with trace albumin.

Special test :

FBS 6.2 mmol/L, total cholesterol 280 mg/dl, HDL 36 mg/dl, LDL 180 mg/dl, TG 360 mg/dl, Uric acid 7.9 mg/dl, Thyroid function test showed normal study.

Treatment plan :

As initial management of this obese person we planned for lifestyle intervention, a combination of diet, exercise and behavioral modification. In addition, antihypertensive, antilipid, weight reducing drugs are prescribed. As the patient

was poor, so, the patient was managed by medical therapy and our plan for Bariatric surgery could not be implemented.

Discussion :

Obesity is a curse for both the person individual as well for the society. Greater BMI is associated with increased rate of death from all causes and from cardiovascular disease. This is particularly true for those with severe obesity, although only being overweight also appears to be associated with decreased survival.

Conclusion :

Obesity is associated with significant excess morbidity and mortality. Secondary causes should be searched for and management of the patient has to be done accordingly. Familial genetic causes could be ruled out during prenatal check up by PCR in highly sophisticated centers and termination of pregnancy should be planned thereby. Meticulous weight reduction plan by strictly following life style modification, programme, lipid and weight reducing drugs should be the primary plan of treatment. Obesity related

complications should be treated of Bariatric Surgery could be planned if necessary.

References :

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