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Workshop

(The following is a summary by the authors of their presentation)

Slimming diets

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The aims of a slimming diet for the treatment of obesity are to: provide essential nutrients to minimize lean tissue loss and maintain good health, but allow a negative energy balance; suit individual dietary preferences, financial circumstances and lifestyle; be part of a long-term approach to diet, behaviour and activity change to lose, then maintain, weight loss (Garrow & O'Kane, 1999).

Slimming diets used in the treatment of obesity always imply a compromise, limiting energy availability and diminishing sources of difficulty. Energy intake must be sufficiently low to widen the margin of utilization and to counter the fall in energy expenditure induced by low-energy diets (Leibel *et al*. 1995). This approach, however, can negatively affect N metabolism if the amount of the protein in the diet is too low (Dwyer & Lu, 1993).

The long-term effectiveness of low-energy diets, as highlighted in systematic reviews of the treatment of obesity published recently, is limited (Glenny *et al.* 1997; Douketis *et al.* 1999). We must include popular diets in the term 'slimming diets'. These diets are widely promoted in the media. Although popular diets are often reported to result in remarkable rates of weight loss, their true efficacy is rarely assessed by randomized controlled trials.

Furthermore, some popular diets may be nutritionally unsound because: (1) they have a very high or low protein content, or are generally nutritionally inadequate (Dwyer *et al*. 1993); (2) they cause rapid weight loss followed by rebound ('yo-yo' dieting) which may have deleterious effects on psychological health; they do not help to educate individuals about lifestyle changes needed for long-term weight control (Garrow & O'Kane, 1999).

Slimming diets need to supply enough of the nutrients we need to lose weight while staying healthy, but also be acceptable, satiate and give pleasure. They should ideally be designed and delivered to promote long-term compliance, using a client-centred educational and motivational approach. Slimming diets used in clinical practice include: low-fat high-carbohydrate; energy prescription based on a 2·5 MJ deficit of individual energy needs (Frost *et al*. 1991); milk diet (Summerbell *et al*. 1998); individually-negotiated changes to eating patterns and food choice. Different dietary approaches suit different individuals, and the composition of the slimming diet may need to change over time, e.g. include a novel approach, in order to achieve long-term goals (Garrow & O'Kane, 1999).

A thorough assessment, which includes eating behaviour (to identify disordered eating problems) is important to help develop the most appropriate dietary treatment for individual patients. The role of physical activity and its favourable impact on body composition, as well as long-term success with weight-loss programmes, should always be considered when planning slimming diets. Behaviour modification should also be part of any weight-loss programme (Glenny *et al*. 1997; National Institutes of Health, 1998). Pharmacotherapy and surgery are additional options for selected patients.

Setting realistic weight-loss goals, e.g. lose 10 % of the body weight and then maintain it (then re-negotiate further weight-loss targets), extending length of treatment and including post-treatment strategies to incorporate relapse prevention may also help to improve weight loss and long-term maintenance (Glenny *et al*. 1997; Garrow & O'Kane, 1999).

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