Hypnosis for the treatment of obesity

Hypnosis is increasingly used in the management of obesity. It involves the induction of a trance state and suggests that the patient can lose weight. Several case studies suggest that hypnosis may be effective in weight loss (McCammon et al., 1988; Gaskin et al., 1988; Swanson et al., 1990). One study found that patients who received hypnosis lost an average of 20 pounds over a six-month period (McCammon et al., 1988).

Studies have also shown that hypnosis can help reduce cravings for food and improve self-esteem (Marlatt and Gordon, 1970; Marlatt and Witkiewitz, 1984). However, hypnosis should not be considered a replacement for traditional weight loss therapy. It is important to combine hypnosis with other weight loss methods such as a healthy diet and regular exercise.

Hypnosis can be used in conjunction with other therapies such as行为 therapy and cognitive-behavioral therapy. It may also be helpful as a adjunct to medication for weight loss. However, more research is needed to determine the effectiveness of hypnosis in treating obesity.

In conclusion, hypnosis can be a helpful tool in the management of obesity. It is a non-invasive and safe intervention that can be used in combination with other treatment methods. Further research is needed to determine the best approach for using hypnosis in the treatment of obesity.

References

- McCammon et al., 1988
- Gaskin et al., 1988
- Swanson et al., 1990
- Marlatt and Gordon, 1970
- Marlatt and Witkiewitz, 1984
- UK CF Database, 2003

Dietary supplements

The Leeds Method of Management. April, 2008. Dietary supplements [online]. Leeds Regional Adult and Paediatric Cystic Fibrosis Units, St James’s University Hospital, Leeds, UK. Available from http://www.cysticfibrosismedicine.com

Introduction

If a patient’s weight gain is inadequate or appetite poor, dietary supplements may help to improve energy intake. A wide variety of supplements are available, including calorie only supplements e.g. Maxijul®, Polycal®, Duocal®; calorie and protein only supplements, e.g. Scandishake®, Calshake®; semi-complete supplements, e.g. Enlive® and Fortijuice® (fruit based), and nutritionally complete supplements e.g. Ensure Plus®, Entera®, Fortisip® (milk based). All are available on prescription.

The type and amount of supplement recommended depends on the patient’s age, preference and requirements, and should therefore be prescribed on an individual basis. Supplements should be taken in addition to normal food to increase total daily energy intake and should not replace a meal. Ideally they should be given with a snack between meals, as a drink after meals, or later in the evening. Multi-centre UK trials have shown that their use can promote significant weight gain (Skypala et al, 1998) and improvements in energy intake (Poustie et al, 2006). However, oral supplements should not be considered as an essential long term treatment in mildly malnourished children where dietary advice to optimise intake may be sufficient (Smyth & Walters, 2007). The efficacy of short term use of oral calorie supplements in the acute situation, or the long term use in adults or those with advanced lung disease, has not been fully assessed (Smyth & Walters, 2007). However, within our own adult clinic we have shown that use of supplements results in significantly greater energy and protein intakes (White et al, 2004).

Nasogastric and enterostomy feeds

Some patients, usually those with more severe chest involvement, may be unable to achieve or maintain an adequate energy intake and normal growth, even with a high fat diet and dietary supplements. Indications for more invasive forms of nutritional support include:

- Failure to achieve an adequate weight gain over a period of six months
- Weight-for-height below 90% (children)
- BMI less than 19 kg/m² (adults)
- Significant weight loss during an acute exacerbation
- Inadequate weight gain during pregnancy

Invasive nutritional support can be provided via a fine bore nasogastric tube (Holden et al, 1991) or a gastrostomy tube placed directly into the stomach (Steinkamp & von der Hardt, 1994). More rarely a jejunostomy tube (placed in the upper small bowel) may be required (Dalzell et al, 1992). The nasogastric tube can be left in place or passed each time a feed is given and feeding via this route has proved both effective and acceptable to patients (Bellwood et al, 1991). Gastrostomy feeding is now the preferred method of enteral tube feeding due to ease of endoscopic tube placement and the use of gastrostomy buttons. The incidence of gastrostomy feeding is reported as between eight and 20% of clinic populations (Bell et al, 1998; Richardson et al, 2000; Morton et al, 2000) and has increased steadily during the last 10 years. In Leeds, 13% of patients attending the paediatric unit and 12% of those attending the adult unit are currently tube fed, the majority via gastrostomies. This is double the incidence reported to the CF database from other centres in the UK (UK CF Database, 2003) and reflects our belief that optimising nutritional status is of paramount importance to help preserve lung function. Gastrostomy feeding has been shown to be more effective than nasogastric feeding in terms of resultant weight gain (Morton & Conway, 1996) and can stabilise lung function in the longer term (Morton et al, 2004; Efrati et al, 2006).
Figure 1. Enteral feeding routes
Early discussion and placement of a gastrostomy is an important factor in subsequent weight gain. Those with advanced disease may benefit less (Van Biervliet et al, 2004; Oliver et al, 2004). Although patients may express concerns regarding body image (Abbott et al, 2007) positive attitudes have also been reported to gastrostomy placement (Gunnell et al, 2005). Early discussion, allowing adequate time to make decisions regarding enteral tube feeding is therefore important.

Enteral tube feeds are usually administered overnight, allowing the patient to eat normally through the day. Our patients seem to tolerate lower volumes of more highly concentrated preparations such as the whole protein feeds e.g. Ensure Plus®, Ensure TwoCal®, Fresubin TwoCal®, Fresubin HP Energy® or Nutrison Concentrated®, rather than more dilute feeds given at a higher rate, as is often necessary with elemental feeds. Whatever the type of feed used, careful monitoring of the patient's blood glucose level is essential when feeds are first introduced. Hyperglycaemia (high blood glucose levels) requiring insulin therapy may occur in patients given night time enteral tube feeds (Smith et al, 1994), irrespective of the carbohydrate content (Kane & Black, 1989). This tendency is exacerbated if the patient is also receiving oral corticosteroids.

Orally administered pancreatic enzymes are necessary with all fat containing enteral tube feeds including elemental preparations and those containing medium chain triglyceride fat (Durie et al, 1980). As the feed is continuously administered over a long period of time, it is likely that the enzyme requirement is less than that calculated when comparing the fat content of the feed and the patient's usual enzyme dose with food.
**Key points**

- Individualised use of dietary supplements may help to improve the overall calorie (energy) intake and nutritional quality of the diet

- Enteral tube feeding may be required if dietary intakes are insufficient to achieve a good nutritional status

**References**


