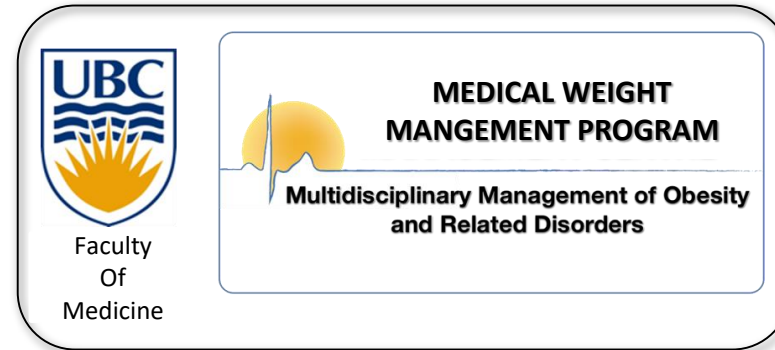


Michael R. Lyon, MD, ABOM
Diplomate of the American Board of Obesity Medicine
Clinical Instructor, Faculty of Medicine, Dept. Family Practice
University of British Columbia
Chair – Doctors of BC. Nutrition Committee



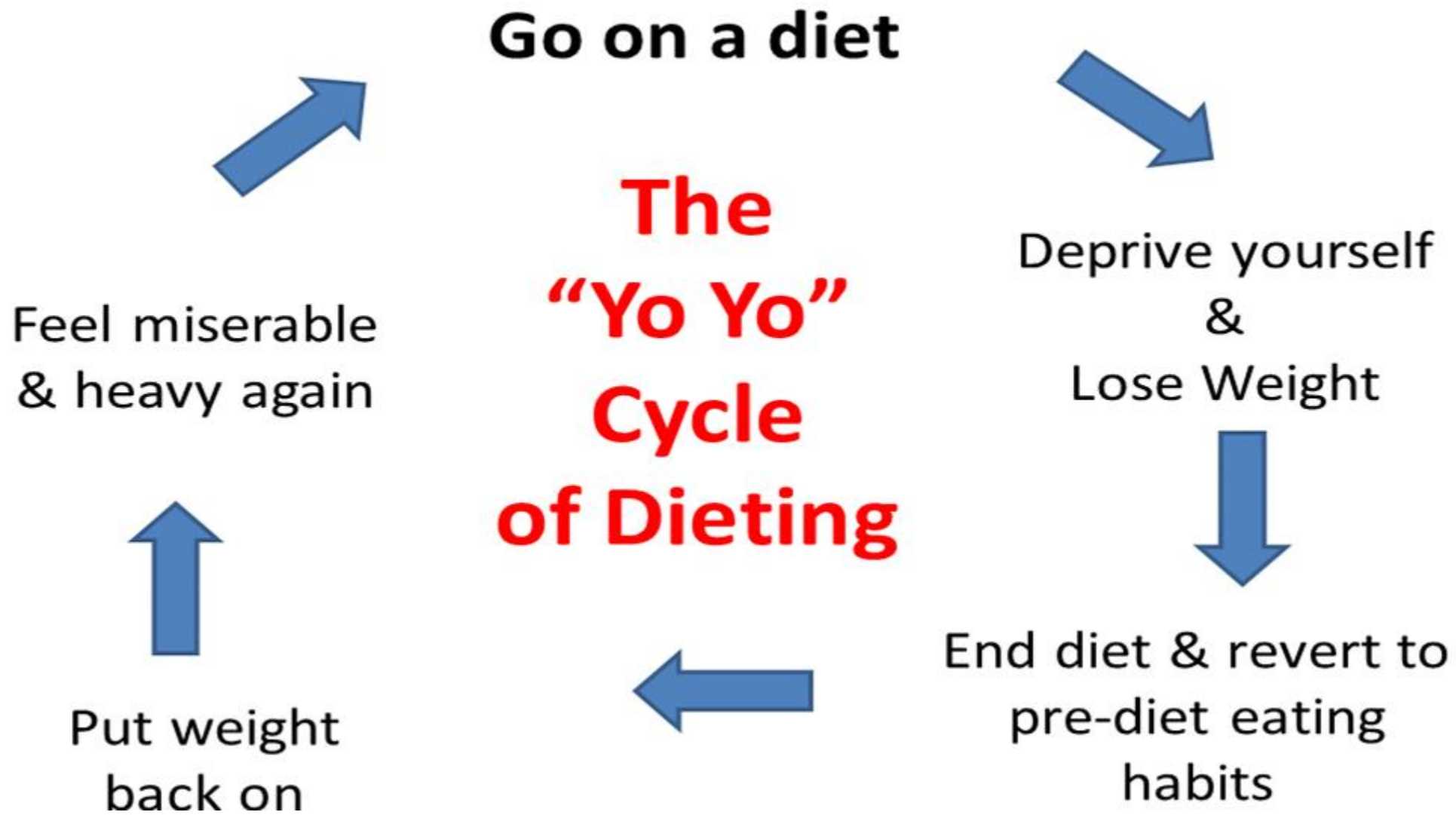
MedWeight.ca

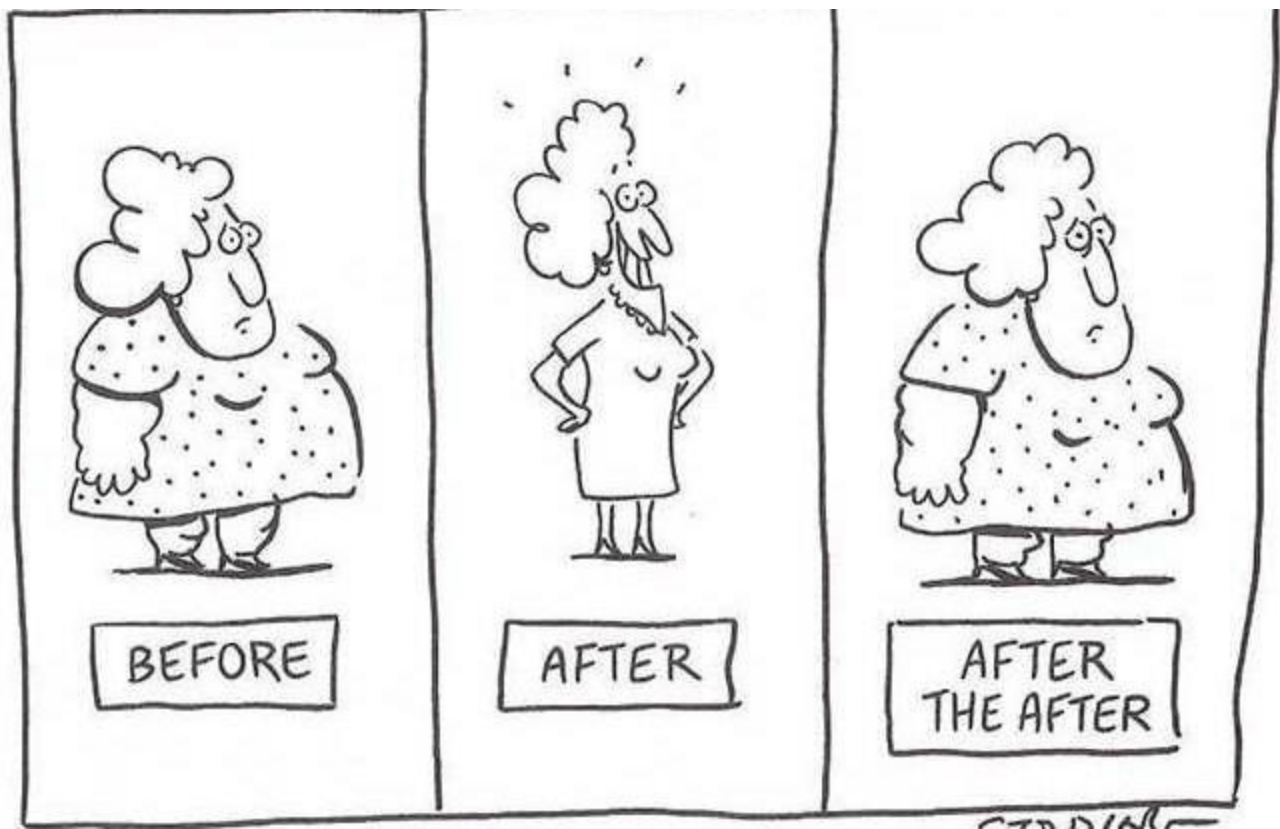


An Introduction to the Optifast Program

Overview

- Discuss the rationale behind the use of meal replacements in long-term obesity management and the concept of focused interval weight loss.
- Introduce the Optifast meal replacement program
- Discuss how to best utilize the Optifast program as a tool in conjunction with our program.
- Q &A



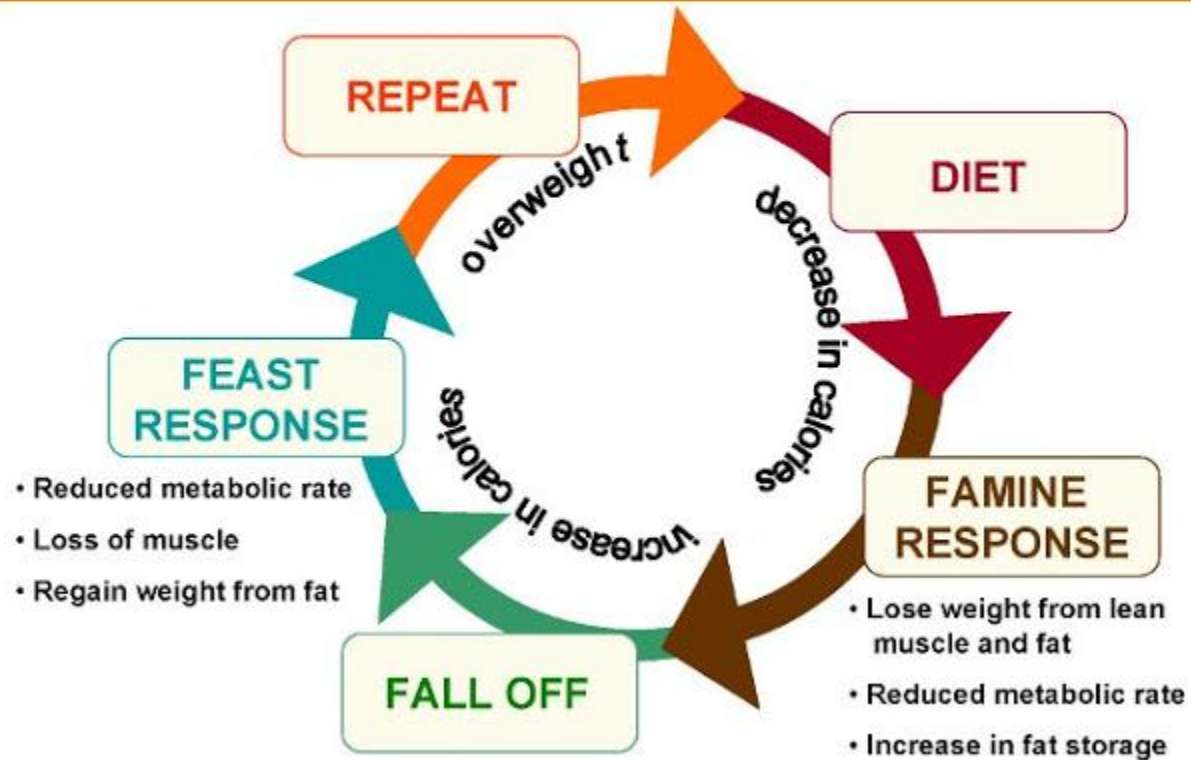


BEFORE

AFTER

AFTER
THE AFTER

THE VICIOUS DIET CYCLE



SPECIAL ARTICLE

Myths, Presumptions, and Facts about Obesity

Krista Casazza, Ph.D., R.D., Kevin R. Fontaine, Ph.D., Arne Astrup, M.D., Ph.D.,
Leann L. Birch, Ph.D., Andrew W. Brown, Ph.D., Michelle M. Bohan Brown, Ph.D.,
Nefertiti Durant, M.D., M.P.H., Gareth Dutton, Ph.D., E. Michael Foster, Ph.D.,
Steven B. Heymsfield, M.D., Kerry McIver, M.S., Tapan Mehta, M.S.,
Nir Menachemi, Ph.D., P.K. Newby, Sc.D., M.P.H., Russell Pate, Ph.D.,
Barbara J. Rolls, Ph.D., Bisakha Sen, Ph.D., Daniel L. Smith, Jr., Ph.D.,
Diana M. Thomas, Ph.D., and David B. Allison, Ph.D.

ABSTRACT

From the Departments of Nutrition Sciences (K.C., M.M.B.B., D.L.S., D.B.A.), Health Behavior (K.R.F.), Pediatrics (N.D.), Medicine (G.D.), Health Care Organization and Policy (E.M.F., N.M., B.S.), and Biostatistics (T.M., D.B.A.) and the School of Public Health, Office of Energetics, Nutrition Obesity Research Center (A.W.B., D.B.A.), University of Alabama at Birmingham, Birmingham; the OPUS Center and the Department of Nutrition, Exercise, and Sports, University of Copenhagen, Copenhagen (A.A.); the Departments of Development and Family Studies (J.L.P.) and Nutritional

BACKGROUND

Many beliefs about obesity persist in the absence of supporting scientific evidence (presumptions); some persist despite contradicting evidence (myths). The promulgation of unsupported beliefs may yield poorly informed policy decisions, inaccurate clinical and public health recommendations, and an unproductive allocation of research resources and may divert attention away from useful, evidence-based information.

METHODS

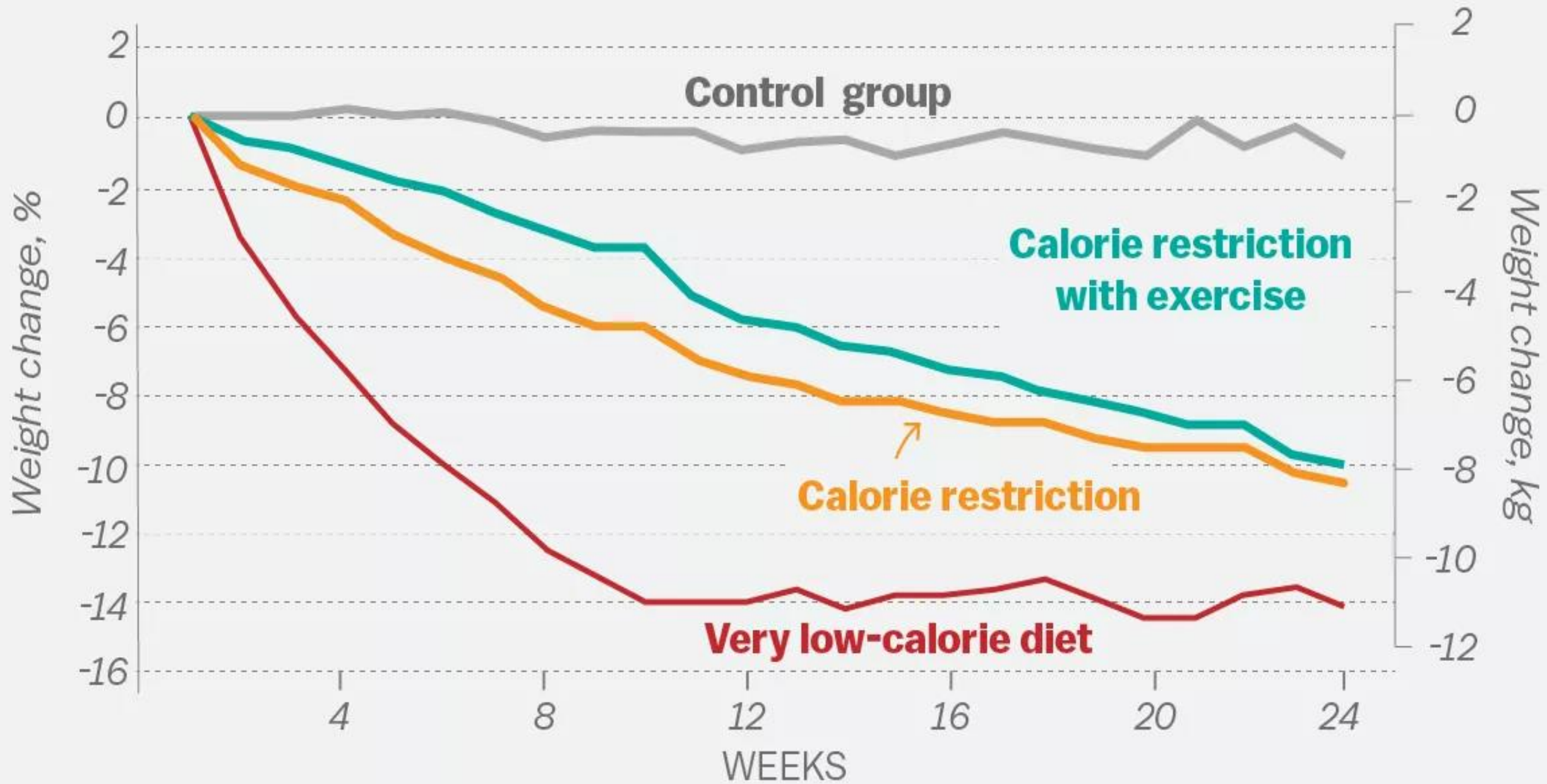
Using Internet searches of popular media and scientific literature, we identified, reviewed, and classified obesity-related myths and presumptions. We also examined facts that are well supported by evidence, with an emphasis on those that have

Table 1. Seven Myths about Obesity.*

Myth	Basis of Conjecture
Small sustained changes in energy intake or expenditure will produce large, long-term weight changes	National health guidelines and reputable websites advertise that large changes in weight accumulate indefinitely after small sustained daily lifestyle modifications (e.g., walking for 20 minutes or eating two additional potato chips)
Setting realistic goals in obesity treatment is important because otherwise patients will become frustrated and lose less weight	According to goal-setting theory, unattainable goals impair performance and discourage goal-attaining behavior; in obesity treatment, incongruence between desired and actual weight loss is thought to undermine the patient's perceived ability to attain goals, which may lead to the discontinuation of behaviors necessary for weight loss
Large, rapid weight loss is associated with poorer long-term weight outcomes than is slow, gradual weight loss	This notion probably emerged in reaction to the adverse effects of nutritionally insufficient very-low-calorie diets (<800 kcal per day) in the 1960s; the belief has persisted, has been repeated in textbooks and recommendations from health authorities, and has been offered as a rule by dietitians
Assessing the stage of change or diet readiness is important in helping patients who seek weight-loss treatment	Many believe that patients who feel ready to lose weight are more likely to make the required lifestyle changes
Physical-education classes in their current format play an important role in preventing or reducing childhood obesity	The health benefits of physical activity of sufficient duration, frequency, and intensity are well established and include reductions in adiposity
Breast-feeding is protective against obesity	The belief that breast-fed children are less likely to become obese has persisted for more than a century and is passionately defended
A bout of sexual activity burns 100 to 300 kcal for each person involved	Many sources state that substantial energy is expended in typical sexual activity between two adults

* We define myths as beliefs held true despite substantial evidence refuting them. A list of articles in which these myths are espoused is provided in the Supplementary Appendix.





SOURCE: JAMA



Published in final edited form as:

Int J Behav Med. 2010 September ; 17(3): 161–167. doi:10.1007/s12529-010-9092-y.

The Association Between Rate of Initial Weight Loss and Long-Term Success in Obesity Treatment: Does Slow and Steady Win the Race?

Lisa M. Nackers,

Department of Clinical and Health Psychology, University of Florida, PO Box 100165, Gainesville, FL 32610-0165, USA

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Lisa M. Nackers: lnackers@php.ufl.edu

Abstract

Background—Controversy exists regarding the optimal rate of weight loss for long-term weight management success.

Purpose—This study examined whether gradual initial weight loss was associated with greater long-term weight reduction than rapid initial loss.

Methods—Groups were drawn from participants in the TOURS trial, which included a sample of middle-aged (mean =59.3 years) obese women (mean BMI =36.8) who received a 6-month lifestyle intervention followed by a 1-year extended care program. Participants were encouraged to reduce caloric intake to achieve weight losses of 0.45 kg/ week. Groups were categorized as “FAST” (≥ 0.68 kg/week, $n=69$), “MODERATE” (≥ 0.23 and < 0.68 kg/week, $n=104$), and “SLOW” (< 0.23 kg/week, $n=89$) based on rate of weight loss during first month of treatment.

Results—The FAST, MODERATE, and SLOW groups differed significantly in mean weight changes at 6 months (−13.5, −8.9, and −5.1 kg, respectively, $ps < 0.001$), and the FAST and SLOW groups differed significantly at 18 months (−10.9, −7.1, and −3.7 kg, respectively, $ps < 0.001$). No significant group differences were found in weight regain between 6 and 18 months (2.6, 1.8, and 1.3 kg, respectively, $ps < 0.9$). The FAST and MODERATE groups were 5.1 and 2.7 times more likely to achieve 10% weight losses at 18 months than the SLOW group.

Conclusion—Collectively, findings indicate both short- and long-term advantages to fast initial weight loss. Fast weight losers obtained greater weight reduction and long-term maintenance, and were not more susceptible to weight regain than gradual weight losers.



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Lessons from obesity management programmes: greater initial weight loss improves long-term maintenance

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Summary

It is a common belief that weight loss achieved at a slow rate is better preserved than if the weight is lost more rapidly. However, the literature shows that initial weight loss is positively, not negatively, related to long-term weight maintenance. There is evidence from randomised intervention trials to support that a greater initial weight loss induced without changes in lifestyle (e.g. liquid formula diets or anorectic drugs) improves long-term weight maintenance, providing it is followed by a 1–2 years integrated weight maintenance programme consisting of lifestyle interventions involving dietary change, nutritional education, behaviour therapy and increased physical activity. In conclusion, we find evidence to suggest that a greater initial weight loss as the first step of a weight management programme may result in improved sustained weight maintenance.

Keywords: Obesity, pharmacotherapy, sibutramine.

obesity reviews (2000) **1**, 17–19

Greater initial weight loss is associated with better long-term weight maintenance

Among both laymen and professionals it is commonly thought that weight loss achieved at a slow rate is better preserved in the long term than a rapid weight loss. However, against this notion speak numerous *post hoc* analyses of weight loss intervention studies showing that a greater initial weight loss, usually achieved in the first 2–4 weeks of treatment, is associated with a better long-

programme in obese women (5), and found that patients in the upper 50-percentile vs. lower 50-percentile of attained weight loss week 36 (Upper vs. Lower 50-percentile: –17.7 kg vs. –9.8 kg ($P < 0.02$)) had maintained more weight loss at follow-up 2.5 years later (–7.1 kg vs. +2.8 kg, $P < 0.01$). Although correlational rather than experimental, these results do not support the hypothesis that obese patients should be encouraged to set lower weight-losing goals.

Very-Low-Calorie Diets and Sustained Weight Loss

Wim H.M. Saris

Abstract

SARIS, WIM H.M. Very-low-calorie diets and sustained weight loss. *Obes Res.* 2001;9:295S–301S.

Objective: To review of the literature on the topic of very-low-calorie diets (VLCDs) and the long-term weight-maintenance success in the treatment of obesity.

Research Methods and Procedures: A literature search of the following keywords: VLCD, long-term weight maintenance, and dietary treatment of obesity.

Results: VLCDs and low-calorie diets with an average intake between 400 and 800 kcal do not differ in body weight loss. Nine randomized control trials, including VLCD treatment with long-term weight maintenance, show a large variation in the initial weight loss regain percentage, which ranged from -7% to 122% at the 1-year follow-up to 26% to 121% at the 5-year follow-up. There is evidence that a greater initial weight loss using VLCDs with an active follow-up weight-maintenance program, including behavior therapy, nutritional education and exercise, improves weight maintenance.

Conclusions: VLCD with active follow-up treatment seems to be one of the better treatment modalities related to long-term weight-maintenance success.

Key words: very-low-calorie diet, low-calorie diet, dietary treatment, weight loss, weight maintenance

Introduction

Nearly half a century ago Stunkard and McLaren-Hume (1) characterized the efficacy of the treatment of obesity as follows: “Most obese persons will not stay in treatment of obesity. Those that do stay in treatment, most will not lose

or fewer calories per day, has contributed significantly to this progress. Whether the above observation is outdated is not clear. This article reviews the long-term effectiveness of VLCDs in the treatment of obesity compared with other dietary treatments such as low-calorie diets (LCDs), ranging from 800 to 1200 kcal, or other types of treatment such as behavior treatment (BT) or physical activity (PA).

Definition of VLCD

Over the years the definition of VLCD and LCD have changed with regard to the energy-restriction level. In the early days more emphasis was given on the very-low-calorie level with values of 250 kcal/d or less. With the introduction of the international CODEX standardization and legislation by the U.S. Food and Drug Administration and the European Union on this type of food restriction, VLCDs are now defined as total diet replacements with <800 kcal and >400 to 450 kcal/d. Diets consisting of between 800 and 1200 kcal/d are classified as LCDs, whereas meal replacements are limited to 200 to 400 kcal. These types of definitions and regulations using fixed energy levels for all users ignore individual differences in body size and thus energy requirements. Therefore, the use of VLCDs and LCDs results in significantly different weight loss for different groups, for instance, between men and women.

Historical Perspective

The history of VLCDs goes back to 1929 when Evans and Strang (2) published their results of a diet, which is not too different in composition from those used today.

This diet made from food ingredients comprising ~ 400

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2020

January							February							March							April						
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Over the Long Haul

- Weight management involves consistently applying the many skills and routines of a healthier lifestyle
- These skills and routines may take years to fully develop
- Weight regain may be an inevitable part of your struggle with weight even if you successfully lose a lot of weight
- Focussing on weight loss from time to time may have to be considered a normal part of your long term weight management strategy.

Successful Weight Loss Requires...

- Structure and focus





SORRY
OUT OF
SERVICE

The Concept of Focussed Intervals of Weight Loss

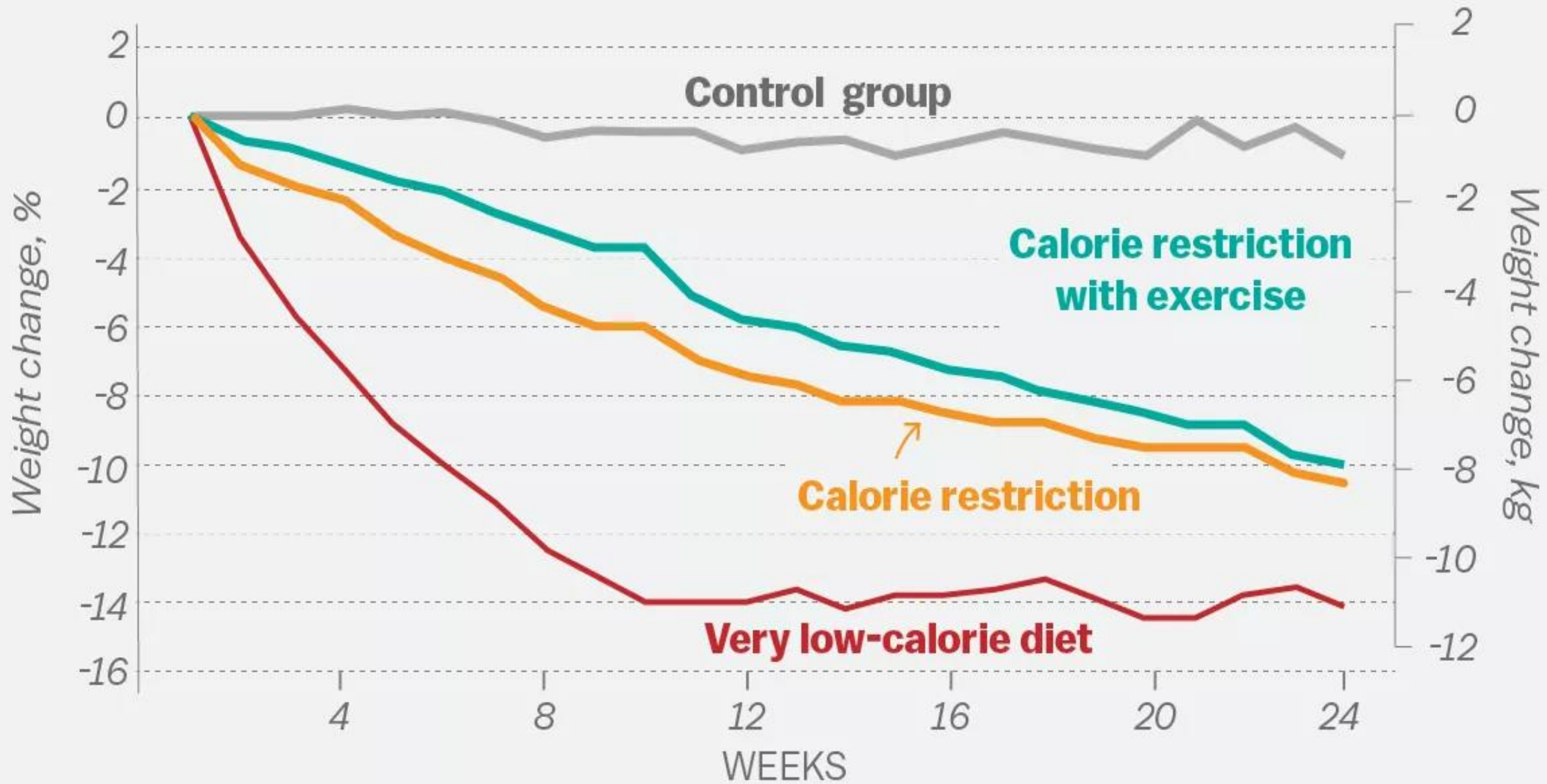


2020

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27	28	29	30	1	2	3	25	26	27	28	29	30	31	29	30	1	2	3	4	5	27	28	29	30	31	1	2

Which Diet for Weight Loss?

- Low Fat?
- Low Carbohydrate/Ketogenic Diet?
- Low Glycemic Index?
- The Zone Diet?
- The Mediterranean Diet?
- The DASH Diet
- Weight Watchers
- Partial meal replacement diet (LCD)?
- Full meal replacement diet (VLCD)?



SOURCE: JAMA

The Role of Meal Replacements

Meal replacements help aid this process by:

- Making initial weight loss more accessible
 - Less cooking skills required
 - Less meal planning
 - Provide a balanced/low-calorie food plan option that meets nutrient requirements
 - Provide a cost-effective healthy alternative for weight management



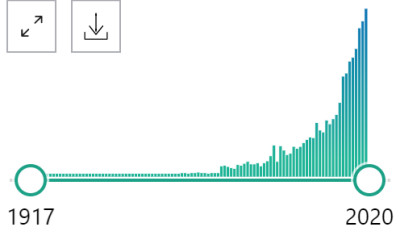
Financial Disclosure

The clinic does not sell meal replacements and does not obtain any profits from the sale of any product under any circumstance.

MYNCBI FILTERS

2,790 results

RESULTS BY YEAR



TEXT AVAILABILITY

- Abstract
- Free full text
- Full text

ARTICLE ATTRIBUTE

- Associated data

ARTICLE TYPE

- Books and Documents
- Clinical Trial
- Meta-Analysis
- Randomized Controlled Trial
- Review
- Systematic Reviews

1 Individualized **Meal Replacement** Therapy Improves Clinically Relevant Long-Term Glycemic Control in Poorly Controlled Type 2 Diabetes Patients.

Kempf K, et al. *Nutrients* 2018 - *Clinical Trial*. PMID 30081574 Free PMC article.

During the follow-up period, all of the participants were asked to continue **replacing** one **meal** per day until the 52-weeks follow-up. ...Furthermore, the initiation of a weight loss program with one week of full **meal replacement** (three **meals** per day) resulted in a clinically relevant long-term HbA1c reduction, as compared to an observational control group that had standard care....

“ Cite Share

2 Randomized Trial of a High Protein, Partial **Meal Replacement** Program with or without Alternate Day Fasting: Similar Effects on Weight Loss, Retention Status, Nutritional, Metabolic, and Behavioral Outcomes.

Bowen J, et al. *Nutrients* 2018 - *Clinical Trial*. PMID 30142886 Free PMC article.

Higher-protein diets, **meal replacements**, and greater early weight loss have separately been associated with greater weight loss. ...This study supports the use of higher protein, **meal replacement** programs with or without ADF in weight management....

“ Cite Share

3 Effect of a balanced nutrition **meal replacement** diet with altered macromolecular composition along with caloric restriction on body weight control.

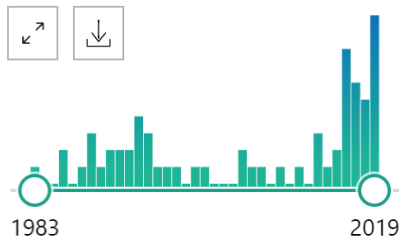
Lu TM, et al. *Food Funct* 2019 - *Clinical Trial*. PMID 31161182

Obese subjects (BMI > 27; n = 50, male 23, female 27) were recruited and requested to **replace** two **meals** per day (breakfast and lunch or dinner) with the balanced nutritional **meal replacement** diet (equal to 240 kcal) for 8 weeks with one regular **meal** and make sure that the daily target calorie limit (caloric restriction) was less than 1500 kcal day⁻¹ for men and 1200 kcal day⁻¹ for women. After eight

MYNCBI FILTERS

64 results

RESULTS BY YEAR



TEXT AVAILABILITY

- Abstract
- Free full text
- Full text

ARTICLE ATTRIBUTE

- Associated data

ARTICLE TYPE

- Books and Documents
- Clinical Trial
- Meta-Analysis
- Randomized Controlled Trial
- Review

- 1 [A health economic model to assess the cost-effectiveness of **OPTIFAST** for the treatment of obesity in the United States.](#)

Nuijten M, et al. *J Med Econ* 2018. PMID 29678127

The objective of this study is assess potential cost-savings of the **OPTIFAST** program in the US, as compared to "no intervention" and pharmacotherapy. ...Moreover, **OPTIFAST** has additional clinical and economic advantages through very low complication and adverse events rates....

“ Cite Share

- 2 [Efficacy of commercial weight-loss programs: an updated systematic review](#)

Gudzune KA, et al. *Ann Intern Med* 2015 - Review. PMID 25844997 Free PMC article.

Very-low-calorie programs (Health Management Resources, Medifast, and **OPTIFAST**) resulted in at least 4.0% greater short-term weight loss than counseling, but some attenuation of effect occurred beyond 6 months when reported. ...

“ Cite Share

- 3 [Effectiveness of a Total Meal Replacement Program \(**OPTIFAST** Program\) on Weight Loss: Results from the OPTIWIN Study.](#)

Ard JD, et al. *Obesity (Silver Spring)* 2019. PMID 30421863 Free PMC article.







OBJECTIVE: The aim of this study was to test the effectiveness of the **OPTIFAST** program (OP), a total meal replacement dietary intervention, compared with a food-based (FB) dietary plan for weight loss. ...

“ Cite Share

- 4 [Treatment with **Optifast** reduces hepatic steatosis and increases candidacy rates for living donor liver transplantation.](#)

How we've incorporated these treatment options into our approach

1) Partial Meal Replacement Plan

Breakfast	AM Snack	Lunch	PM Snack	Dinner
Meal Replacement Shake 	Protein & Fibre 	Meal Replacement Shake 	Protein & Fibre 	Frozen meal up to 380 kcal, 18-25 g protein + extra veggies  
				OR Portioned Balanced Healthy Meal

2) Full Meal Replacement Plan



4 Meal Replacements per Day
No other food for the duration of the program

So what is the Optifast Program?

The **OPTIFAST.** *Program*

The science-based program that delivers
weight loss for health gains

[LEARN MORE](#)



What is the Optifast Program?

- Optifast is a medically-supervised weight loss program
- The program utilizes a meal replacement that transitions to self-prepared meals through comprehensive education and support
- The goal is to help patients achieve sustainable weight loss by working with them to develop the self-management skills necessary for long-term weight maintenance.



Optifast Meal Replacements

Flavours: chocolate & vanilla



Ingredients

Chocolate

MILK PROTEIN ISOLATE, CORN MALTODEXTRIN, COCOA, HIGH OLEIC SUNFLOWER OIL, CANOLA OIL, ACACIA GUM, OLIGOFRUCTOSE, INULIN, SALT, SODIUM CASEINATE, VITAMINS (VITAMIN A PALMITATE, VITAMIN D3, DL-ALPHA-TOCOPHERYL ACETATE, ASCORBIC ACID, THIAMINE HYDROCHLORIDE, RIBOFLAVIN, NIACINAMIDE, CALCIUM D-PANTOTHENATE, PYRIDOXINE HYDROCHLORIDE, BIOTIN, FOLIC ACID, CHOLINE BITARTRATE), MINERALS (DIPOTASSIUM PHOSPHATE, POTASSIUM CITRATE, MAGNESIUM OXIDE, FERROUS SULPHATE, ZINC SULPHATE, MANGANESE SULPHATE, COPPER GLUCONATE, POTASSIUM IODIDE, SODIUM SELENITE, SODIUM MOLYBDATE), MONO- AND DIGLYCERIDES, SUCRALOSE, NATURAL AND ARTIFICIAL FLAVOUR, STEVIA EXTRACT. CONTAINS MILK. GLUTEN FREE. LACTOSE FREE*. *Not for individuals with Galactosemia.

Vanilla

MILK PROTEIN ISOLATE, CORN MALTODEXTRIN, HIGH OLEIC SUNFLOWER OIL, CANOLA OIL, ACACIA GUM, OLIGOFRUCTOSE, INULIN, SALT, SODIUM CASEINATE, VITAMINS (VITAMIN A PALMITATE, VITAMIN D3, DL-ALPHA-TOCOPHERYL ACETATE, ASCORBIC ACID, THIAMINE HYDROCHLORIDE, RIBOFLAVIN, NIACINAMIDE, CALCIUM D-PANTOTHENATE, PYRIDOXINE HYDROCHLORIDE, BIOTIN, FOLIC ACID, CHOLINE BITARTRATE), MINERALS (DIPOTASSIUM PHOSPHATE, POTASSIUM CITRATE, MAGNESIUM OXIDE, FERROUS SULPHATE, ZINC SULPHATE, MANGANESE SULPHATE, COPPER GLUCONATE, POTASSIUM IODIDE, SODIUM SELENITE, SODIUM MOLYBDATE, CHROMIUM TRICHLORIDE), MONO- AND DIGLYCERIDES, NATURAL AND ARTIFICIAL FLAVOUR, SUCRALOSE, STEVIA EXTRACT. CONTAINS MILK. GLUTEN FREE. LACTOSE FREE*. *Not for individuals with Galactosemia.

*Optifast is gluten-free and lactose free

*Optifast contains milk protein and soybean

*Optifast contains 4g of dietary fibre

NUTRITIONAL INFORMATION

Vanilla Flavoured	Units	340 ml**(54 g packet)
Energy	Cal (kJ)	225 (940)
Protein	g	22.5
Fat	g	7.5
Linoleic Acid	g	1
Linolenic Acid	g	0.25
Saturates	g	0.8
Carbohydrate	g	18.8
Fibre	g	4
Sugar	g	0.6
Sucralose	mg	31
Sodium	mg	450
Potassium	mg	565
Chloride	mg	415
Manganese	mg	1.1
Copper	mg	0.55
Selenium	mg	0.014
Molybdenum	mg	0.022
Chromium	mg	0.011
Biotin	mg	0.025
Choline	mg	25
Calcium	%	25
Phosphorus	%	25
Magnesium	%	42
Iron	%	25
Zinc	%	39
Iodide	%	31

Vitamin A	%	37
Vitamin D	%	25
Vitamin E	%	25
Vitamin C	%	33
Thiamine	%	26
Riboflavin	%	29
Niacin	%	42
Pantothenic Acid	%	26
Vitamin B6	%	28
Folacin	%	33
Vitamin B12	%	25



Who is Optifast Appropriate For?

The Optifast program can be helpful for patients with a BMI > 30 or a BMI > 27 with weight-related co-morbidities.





NOTE:

Patients on insulin & sulphonylureas need to be monitored more carefully to adjust their medication requirements on a low-calorie meal plan.

This is important to avoid episodes of hypoglycemia

Additionally, if you have any other medical conditions requiring specific dietary requirements, please check with a physician before starting on the Optifast plan.

How Does Optifast Work?

- Optifast has 3 phases

Active Weight Loss Phase

12 to 16 weeks of total meal replacement

Transition Phase

4 to 6 weeks transitioning to a healthy and balanced food-based diet

Maintenance Phase

Up to 52 weeks with diet and lifestyle support for weight maintenance

How we run Optifast:





Session	Topic
1	Introduction To Optifast
2	Navigating the Plan
3	Transitioning to Partial MR Plan
4	Transitioning to Solid Foods

*These sessions are spread out over a 3 month period.

Participants may be on the Optifast meal plan for 8 -12 weeks or less, depending on how long they want to be on the meal replacement before transitioning off.

Phase I: The Active Weight loss Phase

(4 shakes per day for a total of 900cal/day)

Breakfast	
Snack	
Lunch	
Snack	
Dinner	

Try to spread your shakes out every 3-4hrs.

When doing the full meal replacement plan you need to consume 4 shakes.

Consuming less than 4 shakes can result in muscle loss & malnutrition

Additional Support

GROUP MEDICAL VISITS PASSPORT			
CORE	√	LIVING LIFE TO THE FULL COURSE (OPTIONAL)*	√
Core 1		Session 1	
Core 2		Session 2	
Core 3		Session 3	
Core 4		Session 4	
Core 5		Session 5	
Core 6		Session 6	
Core 7		Session 7	
Core 8		Session 8	
NUTRITION EDUCATION		BUILDING A HEALTHY OUTLOOK	
Session 1		Session 1	
Session 2		Session 2	
Session 3		Session 3	
Session 4		Session 4	
FOOD PLANNING & COOKING SKILLS		BUILDING RESILIENCE	
Session 1		Session 1	
Session 2		Session 2	
Session 3		Session 3	
Session 4		Session 4	

BUSTING BARRIERS	√	GETTING ACTIVE 101	√
Session 1		Session 1	
Session 2		Session 2	
Session 3		Session 3	
Session 4		Session 4	
MAYO CLINIC ADVANCED STRESS MANAGEMENT COURSE (OPTIONAL)**		ADDITIONAL GROUPS	
Session 1			
Session 2			
Session 3			
Session 4			
Session 5			
Session 6			
Session 7			
Session 8			

Cost:

MWM participants can purchase Optifast at the wholesale price for the cost of \$81 per week (after tax, free shipping via Canada Post expedited, receive within 1 week)



Cost of the Partial MR Diet

Cost of diet	In store	Commissary
2 servings of SlimStyles	\$6.60	\$4.65
Average frozen meal	\$3.43	\$3.49
Average cost of snack foods per day	\$1.92	\$1.92
5 grams of PGX	\$1.32	\$0.48
TOTAL cost per day	\$13.27	\$10.54

Low cost version of diet

2 servings of PC Nutri-Total	\$2.39
Meal Replacement	
Average frozen meal	\$3.43
Average cost of snack foods per day	\$1.92
TOTAL cost per day	\$7.74

Logistics: How do I order?

Optifast is only available through Optifast online store
(Please refer to ordering card for more information)

You are required to provide the shopping code every time you are placing an order.

You are not allowed to share your code with family and friends. Optifast is a medically supervised weight management program and the code is only for patients who have been cleared by an authorized physician or authorized program.

MWM Optifast Screening Form

Please check 'yes' or 'no' to the following questions as they apply to you.

Yes No

 Are you planning on starting the Optifast program?

 Do you have diabetes and are on any of the following medications:

- Insulin
 - (e.g. Lantus, Levemir, Toujeo, Tresiba, Basaglar)
- Glyburide (name brands: Glynase, Glycron, Micronase)
- Gliclazide (Diamicron)
- Glimepiride (Amaryl)
- Chlorpropamide (Diabinese)
- Tolazamide (Tolinase)
- Tolbutamide (Tol-Tab)

 Do any of the following apply to you?

- I am over the age of 70 and have lost a lot of my muscle mass
- I am pregnant or breastfeeding
- I am currently dealing with a severe or unstable disease state (e.g. systemic infections, malignancy, unstable cardiac or cerebrovascular disease, porphyria, congestive heart failure)
- I have advanced kidney disease
- I have an inflammatory bowel disease such as Crohn's or ulcerative colitis
- I have had gastrointestinal cancer and have undergone a colectomy
- I have recently undergone bariatric surgery
- I am on a significant number of medications that need to be taken both with and without food
- I have a serious or unstable psychological or psychiatric disorder
- I have struggled with a significant eating disorder in the past or now

If you checked 'yes' to either of the last two questions you need to follow up with a physician for further guidance before starting the Optifast program.

How to set yourself up for success when starting a low-calorie meal plan



Precautions to take into consideration



Know your why & what?



Set specific behavior based goals and make time to give yourself feedback on those goals.



Reach out to your support system

Precautions to take into consideration



Self-monitoring during the active weight loss phase

Non Exercise Activity Thermogenesis (NEAT)

This is the amount of calories your body uses for everything that's not eating, exercise, BMR or sleeping. Based on activity & can make up 10-40% of your total caloric burn - Based on activity level!

Walking Fidgeting Standing Doing the dishes or cooking

A small infographic box with a white background and a thin black border. It has a title 'Non Exercise Activity Thermogenesis (NEAT)' in bold black text. Below the title is a short paragraph explaining NEAT. At the bottom, there are four icons with labels: an orange stick figure for 'Walking', a red fidget spinner for 'Fidgeting', a blue stick figure for 'Standing', and a stack of dishes for 'Doing the dishes or cooking'.

Reduce physical activities to daily/NEAT activities



If you have an active job you may want to incorporate some extra healthy snacks.

Precautions to take into consideration

What if I experience increased hunger?



Spread your shakes throughout the day
(e.g. every 3-4 hrs)



Add PGX granules or another soluble fiber
source to your shake



Incorporate zero calorie snacks into your diet

Practically Zero Calorie Snack Options

- Bell Peppers
- Boom Chicka Pop Popcorn (35 calories per cup)
- Broccoli
- Brussel Sprouts
- Cabbage
- Cauliflower
- Celery
- Cucumber
- Leafy greens (arugula, bok choy, collard greens, kale, Swiss chard, spinach, lettuce, etc.)
- Pickles, sauerkraut, kimchee

Vegetables can be eaten with any no calorie herbs, seasonings (such as Spike), vinegars, salt and pepper but no oils.

Incorporate a fibre supplement when on a liquid meal replacement plan



Feel free to add a dietary fibre supplement such as Metamucil to help with your bowel movements while taking the shakes.

Precautions to take into consideration

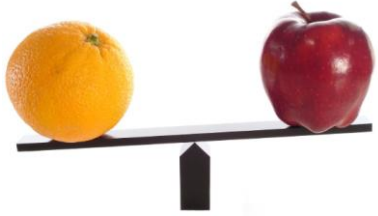


Stay well hydrated (2L or 8 cups of water per day)



Get creative and use the Optifast recipe handouts to mix up the shakes. These will be emailed.

Precautions to take into consideration



Avoid comparison with other participants and focus on your own journey.



Listen to your body



Plan ahead for high risk situations

If you have diabetes and are on:

- Insulin
- Sulphonylureas:
 - Glyburide (name brands: Glynase, Glycron, Micronase)
 - Gliclazide (Diamicron)
 - Glimepiride (Amaryl)
 - Chlorpropamide (Diabinese)
 - Tolazamide (Tolinase)
 - Tolbutamide (Tol-Tab)



Precautions to take into consideration

Understand what hypoglycemia is:

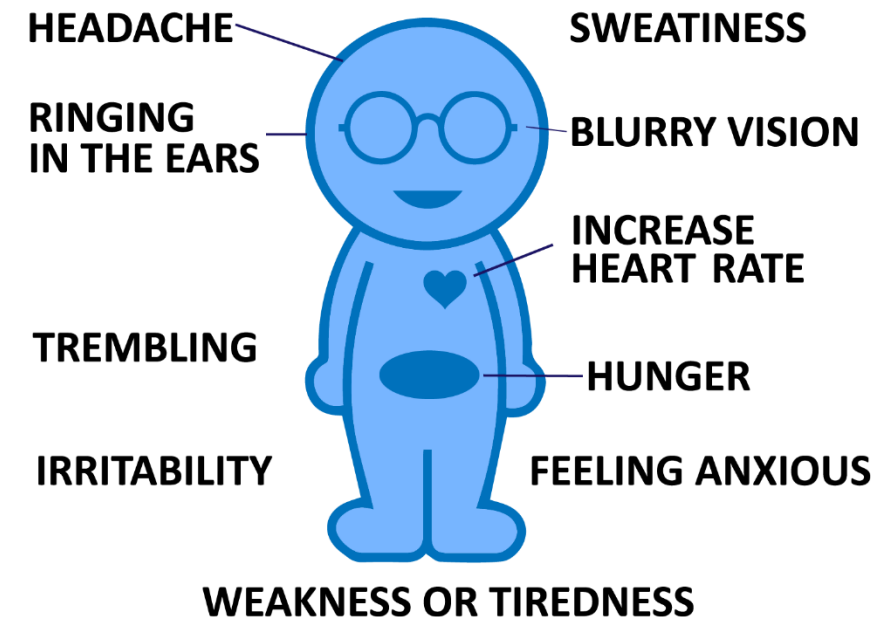
Hypoglycemia can be defined by a low plasma **glucose level <4.0 mmol/L** and most often occurs in people with type I diabetes, followed by people with type II diabetes treated with insulin, and people with type II diabetes treated with sulfonylureas

*Hypoglycemia is often accompanied with clinical symptoms.

Precautions to take into consideration

Know the common signs and symptoms of hypoglycemia

- Trembling/muscle weakness
- Sweating, palpitations, tingling
- Confusion, drowsiness, vision changes
- Difficulty concentrating
- Difficulty speaking
- Nausea, headache, dizziness
- Fatigue, hunger
- Anxiety



*Not all symptoms will be present and some individuals may have other or no symptoms.

Precautions to take into consideration

Check your blood sugars when symptomatic or before taking medication?



Precautions to take into consideration

Know how to treat hypoglycemia

- Carry a source of fast-acting carbohydrate with you at all times, such as glucose tablets or a juice box
- Hypoglycemia should be treated by the oral ingestion of 15g carbohydrate, preferably as glucose or sucrose tablets or solution. These are preferable to orange juice or glucose gels. People with diabetes should retest BG in 15min and re-treat with another 15g carbohydrate if BG level remains $<4\text{mmol/L}$

Table 4

Examples of 15 g of carbohydrate for the treatment of mild-to-moderate hypoglycemia

- 15 g of glucose in the form of glucose tablets
 - 15 mL (3 teaspoons) or 3 packets of table sugar dissolved in water
 - 5 cubes of sugar
 - 150 mL of juice or regular soft drink
 - 6 Life Savers™ (1 = 2.5 g of carbohydrate)
 - 15 mL (1 tablespoon) of honey
-



Reach out to us or your GP if experiencing low blood sugars.

Email:

soosan@medweight.ca

OR

Clinic phone: 604-777-5500

Dr. Lyon: 604-805-6183 (cell)

Diabetes Educator



Soosan Davis, IMG, MAS
(Global Health and Human Services Administration)

How to best utilize Optifast in conjunction with our program:

- Attend the follow up sessions
- Continue to participate in the program modules to prepare for your transition to weight maintenance
- Reach out for support if needed

*Remember: going on a full liquid meal replacement plan without having the proper support or emphasis on long-term weight management skills will most likely result in weight regain. We want to avoid this trend of yo-yo dieting and help you be able to sustain the weight loss that you achieve with the Optifast program.

NEXT STEPS

- The **Optifast code** will be provided to you after the physician has reviewed your screening form (please give us ~1 week to review the forms)
- **Please note that these groups will not be on the calendar as they are just for people who are already on Optifast. If you check “yes” to the starting the program a reminder email will be sent to you one week before the follow up group.**