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Choose the single best answer.

Reducing weight bias in obesity management, practice and policy

1. When managing patients living with obesity (PLWO), weight bias and weight stigma in health care settings may lead to all of the following, except:

A. Inadequate routine screening procedures for PLWO.
B. An increased risk of depression and anxiety in PLWO.
C. An improvement in motivation to lose weight.
D. An increased risk of eating disorders in PLWO.

Epidemiology of adult obesity

2. What best describes the patterns of change in obesity prevalence in South Africa from 2009 to 2017?

A. National increase in obesity of 38%, with men more affected than women (44 v. 20%).
B. National increase in obesity of 38%, with women more affected than men (44 v. 20%).
C. National obesity rate remained stable, with a decrease in obesity of 7% in women, while men remained stable.
D. National obesity rate remained stable, with an increase in obesity of 9.6% in men, while women remained stable.

The Science of Obesity

3. Effective weight loss for primary obesity requires which core cause, as opposed to contributors, to be addressed:

A. Dietary changes
B. Increased exercise
C. Appetite reduction
D. Reduced stress and improved sleep.

Prevention and Harm Reduction of Obesity (Clinical Prevention)

4. A 28-year-old woman presents to your clinic for a routine check-up. She has a BMI of 23 kg/m² and is concerned about weight gain, as both her parents live with obesity. She works night shifts as a nurse, often feels tired, and reports difficulty maintaining a regular sleep schedule. She asks what she can do to prevent weight gain in the future.

Which of the following approaches would be MOST appropriate as a primary prevention strategy for this patient?

A. Recommend daily self-weighing and prescribe a strict 1 200-calorie diet to prevent any future weight gain.
B. Address her sleep patterns and shift work schedule as potential underlying contributors to weight gain, while discussing nutrition and physical activity.
C. Reassure her that since her current BMI is normal, no intervention is needed until she starts gaining weight.
D. Prescribe pharmacological agents approved for weight gain prevention to use prophylactically.

Enabling participation in activities of daily living for people living with obesity

5. What is the most significant predictor of mobility disability in people living with obesity?

A. Body mass index (BMI) alone.
B. Central versus lower body fat distribution.
C. Muscle strength, particularly bilateral hand grip strength.
D. Age of the patient.

Assessment of people living with obesity

6. Which of the following statements BEST describes the relationship between Body Mass Index (BMI) and Waist Circumference (WC) in assessing health risks?

A. BMI is a superior measure of body fat compared to WC because it accounts for muscle mass.
B. WC is a better predictor of visceral fat and cardiometabolic risk than BMI, although BMI is a widely used indicator of excess body fat.
C. BMI and WC are interchangeable measures, providing similar information about an individual's health risk.
D. Neither BMI nor WC are useful in assessing health risks, as they do not account for individual variations in metabolism.

The role of mental health in obesity management

7. Please identify the false statement out of the following 4 sentences:

A. Though still poorly understood, there is a complex bi-directional link between obesity and mental illness and all people living with obesity should be screened for mental illness.
B. Interventions to limit weight gain in those taking antipsychotic medications are most effective when instituted early and in those with a first episode of serious mental illness.
C. Low-dose prescribing of antipsychotics for off-label indications such as sleep and personality disorders is unlikely to cause significant weight gain.

A maximum of 3 CEUs will be awarded per correctly completed test.

INSTRUCTIONS

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D. Though there is some evidence to support the use of lisdexamfetamine and topiramate to reduce the frequency of binge episodes in binge eating disorder, these are not licenced for this indication in South Africa and non-pharmacological interventions may be more effective.

Medical nutrition therapy in obesity management

8. The Health Promotion Levy, introduced in April 2018 as a sugar-content-based tax, aimed to curb rising rates of obesity and diabetes in South Africa by incentivising the reformulation of sugar-sweetened beverages. While this policy led to measurable changes in product composition, it also appeared to influence consumer behaviour. One year post-implementation, to what extent can the observed reduction in sugar intake within low-income communities be attributed to shifts in consumer behaviour rather than solely to beverage reformulation?

A. 9%
B. 14%
C. 22%
D. 24%

Physical activity in obesity management

9. A 52-year-old patient with obesity (BMI 34 kg/m²) and type 2 diabetes asks about starting an exercise program. They have heard conflicting advice about whether aerobic exercise or resistance training is better for people with obesity. Based on current evidence-based guidelines, which statement regarding physical activity recommendations for adults with obesity is MOST accurate?

A. High-intensity interval training (HIIT) should be avoided in obesity management as it poses cardiovascular risks and provides no additional benefits over moderate-intensity exercise.
B. Resistance training is contraindicated for people with obesity as it may increase body weight through muscle gain and worsen insulin resistance.
C. Aerobic physical activity (30 - 60 minutes of moderate to vigorous intensity most days) can reduce abdominal visceral fat and improve cardiometabolic risk factors even without weight loss, while resistance training promotes muscle mass maintenance.
D. Physical activity benefits in obesity are primarily psychological (mood, body image) and have minimal impact on cardiometabolic parameters unless significant weight loss is achieved.

Effective psychological and behavioural interventions in obesity management

10. Which of the following statements about the use of behavioural interventions in the management of obesity is false?

A. Classical conditioning explains how people can learn to associate eating with environmental cues, such as watching TV, even when they are not hungry.
B. Self-monitoring strategies, such as keeping food diaries and regular self-weighing, are associated with improved weight control in the medium to long term.
C. Physical activity or dietary interventions alone are usually sufficient to support long-term weight loss in people living with obesity.
D. Digital interventions, such as apps and web-based platforms, can be effective adjuncts to in-person behavioural interventions for obesity, but more research is needed.

Pharmacotherapy for obesity management

11. According to the guideline, which of the following is an indication to initiate pharmacotherapy for obesity?

A. BMI ≥25 kg/m², regardless of complications.
B. BMI ≥27 kg/m² with at least one adiposity-related complication.
C. BMI ≥27 kg/m² without adiposity-related complications.
D. Any BMI if the patient requests medication.

Bariatric and surgery: Selection and preoperative work-up

12. Metabolic and bariatric surgery can be considered in the following patients:

A. A patient with a BMI of more than 35, with or without co morbidities associated with obesity.
B. A patient with a BMI of 30 to 35 with type 2 DM or with another co morbidity associated with obesity.
C. A patient with a BMI above 30 with failed medical weight loss.
D. All of the above.

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Metabolic and bariatric surgery: Surgical options and outcomes

13. A 45-year-old patient with BMI 42 kg/m² is considering MBS and asks about surgical safety and expected outcomes. Which statement about MBS outcomes and approach is MOST accurate according to current evidence?

A. Open surgical approach is preferred over laparoscopic due to better long-term weight loss outcomes, despite higher complication rates.
B. MBS provides modest weight loss benefits but has minimal impact on obesity-related comorbidities compared to intensive medical management.
C. Laparoscopic MBS should be standard practice and is associated with low mortality (<0.1%) and serious complication rates (<5%), while providing superior long-term outcomes compared to medical management.
D. MBS outcomes are primarily short-term, with most patients regaining significant weight within 2-3 years and requiring repeat procedures.

Metabolic and bariatric surgery: Postoperative management

14. A 42-year-old patient presents to your primary care clinic 18 months after undergoing sleeve gastrectomy at a metabolic and bariatric surgery (MBS) centre. She was recently discharged from the MBS centre. Which of the following is the MOST appropriate ongoing management approach?

A. Arrange follow-up in 5 years, as she is now past the critical post-operative period
B. Conduct annual reviews including nutritional intake, activity levels, supplement compliance, weight monitoring, comorbidity assessment, and laboratory tests for nutritional deficiencies
C. Focus only on weight monitoring and discontinue vitamin supplementation if weight loss goals are achieved
D. Order laboratory tests only if the patient develops symptoms suggestive of nutritional deficiencies

Primary care and primary healthcare in obesity management

15. Which structured approach is recommended for primary healthcare providers (PHPs) to guide respectful, patient-centred conversations with people living with obesity?

A. The 4Cs of Care (Counsel, Challenge, Correct, Continue)
B. The 5As of Obesity Management (Ask, Assess, Advise, Agree, Assist)
C. The ABC Model (Assess, Balance, Control)
D. The 3Rs of Health (Recognise, Recommend, Reassure)

Commercial products and programmes in obesity management

16. When advising an adult living with obesity about commercial weight-loss programmes in South Africa, which ONE of the following is the most appropriate recommendation?

A. They can be used to reliably achieve long-term weight loss and sustained HbA1c reduction.
B. They are recommended to improve blood pressure and lipid control.
C. They may achieve mild-to-moderate short-term weight loss compared with usual care.
D. They should always be recommended in conjunction with other interventions.

Emerging technologies and virtual medicine in obesity management

17. Which technology-based platforms may be offered in addition to conventional (face-to-face) management of PLWO (People living with obesity)?

A. Wearable devices (e.g. mobile phones, watches),
B. Integrated software platforms (e.g. websites/applications),
C. Artificial intelligence-based multidisciplinary integration of computer science and linguistics (e.g. ChatGPT).
D. All of the above.

Weight management over the reproductive years for adult women living with obesity

18. Which of the following statement is correct regarding the management of weight during pregnancy

A. Metformin is recommended for the management of gestational weight gain.
B. Physical activity should be avoided.
C. Health care practitioners should avoid discussing weight gain targets during pregnancy .
D. Nutritional counselling is recommended for the management of gestational weight gain.

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