

Table

	0–5 years (n 88)				P	5–8 years (n 24)			
	1st evaluation		5-year follow-up			5-year follow-up		8-year follow-up	
	Mean	SD	Mean	SD		Mean	SD	Mean	SD
Z-score BMI	4.6	2.0	2.9	1.6	<0.001*	3.2	1.4	2.8	2.1
%FM	38.7	7.6	34.0	9.0	<0.001*	36.0	9.0	35.2	12.0
TC ≥95th pc (%)	17.3		11.5		0.180**	23.1		7.7	
TG ≥95th pc (%)	7.3		8.2		1.000**	30.8		23.1	
HDL-c ≤5th pc (%)	17.1		18.0		0.687**	30.8		23.1	
LDL-c ≥95th pc (%)	15.9		11.7		0.344**	15.4		8.3	
SBP ≥95th pc (%)	32.1		15.6		0.035**	35.0		30.0	
≥2 CM-RF (%)	19.3		8.6			21.1		16.7	
HOMA-IR ≥3 (%)	24.1		29.2		0.503**	46.7		66.7	

%FM, %fat mass; TC, total cholesterol; TG, triglycerides; SBP, systolic blood pressure; CM-RF, cardiometabolic risk factors; HOMA-IR, homeostasis model assessment-insulin resistance.

Introduction: Cardiometabolic comorbidity of obesity is well documented, even in paediatric age.

Aim: Evaluate the tracking of cardiometabolic comorbidity in obese paediatric patients followed during 8 years.

Method: Data from eighty-eight children and adolescents (2–18 years; n 88) with nutritional obesity were collected including BMI Z-score, %fat mass (%FM) (bioelectrical impedance), lipid profile, blood pressure and HOMA-IR at baseline, 5-year (n 88) and 8-year (n 24) follow-up. Total

cholesterol (TC), triglycerides (TG), LDL-C, systolic (SBP) and diastolic blood pressure values above 95th percentile (pc), HDL-C values under 5th percentile and HOMA-IR ≥3 were considered cardiometabolic risk factors (CM-RF).

Conclusions: Even though the prevalence of CM-RF was high, a significative reduction in the magnitude of obesity and adiposity was associated with a medium-term improvement in all CM-RF, in particular SBP. HOMA-IR is an exception.

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62 – Eight years follow-up in the treatment of paediatric obesity: evaluation of success based on markers of nutritional status and body composition

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Introduction: BMI as well as percentage of fat mass (%FM) are usually used as markers of the result of intervention in obesity, even in paediatric age.

Aim: Evaluate the results of behavioural family-based intervention in obese children and adolescents (2–18 years) followed in an outpatient clinic during 8 years.

Method: A group of eighty-eight obese children and adolescents were characterized at 5-year, and twenty-four of them also at 8-year follow-up. BMI percentile, BMI Z-score, %FM (bioelectrical impedance) were collected. Reduction of BMI Z-score or %FM between evaluations was considered as success.

Table 5

	1st evaluation		5-year follow-up		P
	Mean	SD	Mean	SD	
BMI Z-score	4.6	2.0	2.9	1.6	<0.001
%FM	38.7	7.6	34.0	9.0	<0.001
BMI percentile ≥95 (%)		94		88	
Reduction of BMI Z-score (%)		–		90	
Reduction of FM (%)		–		71	
Reduction of BMI Z-score + FM (%)		–		70	

%FM, percentage of fat mass.

Results: Mean chronological age at baseline was 8.3 (SD 2.9) years with no differences between gender (male = 53%). Success rate expressed by decrease in BMI Z-score was greater in children (age ≤ 11 years) while when expressed by decrease in %FM was greater in adolescents. Considering only those with 8 years of follow-up (n 24),

trends of reduction persist between 5 and 8 years regarding BMI Z-score (3.2 (SD 1.4) *v.* 2.8 (SD 2.1)), %FM (36.0 (SD 9.0) *v.* 35.2 (SD 12.0)) and BMI percentile >95 (88% *v.* 63%).

Conclusions: Multidisciplinary family-based intervention, supported on behaviour changes, shows effective results in the treatment of paediatric obesity.

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63 – Therapeutic education as common tool in the prevention and early treatment of childhood obesity

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Introduction: Literature shows scarce evidence of primary care efficacy in treating obese children. Since 2008, Ferrara Hospital organized a training course on family therapeutic education (TE) as a tool to treat childhood obesity, attended by paediatricians and dietitians. Here the preliminary results are shown.

Method: The training course aims to develop families' efficient and positive communication, empowerment and to reduce their feeling of having done a wrong. The course has been attended by two primary care paediatricians (PCP), six paediatricians working in the hospital (HP) and six dietitians (D). The training course quality has been evaluated by questionnaires filled every 6 months and the clinical practice's improvement by children's BMI scores changes. In total 189 children have undergone treatment. The PCP treated ninety-one overweight/obese children aged 5.5 (SD 2) years,

the HP treated thirty-nine adolescents aged 13 (SD 1) years and the three D 59 children aged 12.3 (SD 3) years.

Results: Through the questionnaires all the professionals showed an improvement in motivation and communication techniques. The children treated by PCP showed a reduction of BMI Z-score of 0.15 (SD 0.5) after 2.2 years; the children treated by HP a reduction of 0.32 (SD 0.31) and those ones treated by the Ds -0.26 (SD 0.2) after 10 months.

Conclusions: Primary care paediatricians and dietitians, adequately trained, can efficiently treat obese children. Primary care treatment take advantage of an early, low-cost approach as compared with medical hospital centres. This pilot training courses has already given positive results and a multicenter study has started to better and deeper analyse the impact of such therapeutic approach.

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64 – Childhood perception and knowledge of traditional Italian Mediterranean diet: a quite surprising result

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Introduction: In 2009 and 2010, we asked a sample population of primary school of II degree in Bollate to do

a short game to assess their perception and knowledge of the traditional 'Mediterranean diet' (Md).