Provided by Clinical Care Options, LLC in partnership with
Practicing Clinician Exchange, Obesity Medicine Association and Smart Patients.

Practical Strategies for Applying Evidence and Patient Perspectives to Improve Obesity Management

Friday, November 10, 2023
Alpharetta, GA

Supported by an educational grant from Lilly.

Program Chairs

Jaime Almandoz, MD, MBA, FTOS
Associate Professor of Internal Medicine
Internal Medicine/Endocrinology
UT Southwestern Medical Center
Medical Director, Weight Wellness
Dallas, Texas

Angela Golden, DNP, FNP-C, FAANP, FOMA
CEO and Chief Clinical Officer
NP From Home, LLC
Munds Park, Arizona
Nurse Practitioner
Obesity Treatment Clinic
Flagstaff, Arizona

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Faculty

Krishna Doniparthi, MD
Clinical Education Coordinator
Doniparthi Neurogen Academy
Alpharetta, Georgia

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Angela Golden, DNP, FNP-C, FAANP, FOMA: *consultant/advisor/ speaker:* Acella, Currax, Gelesis, Lilly, Novo Nordisk, SetPoint.

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Krishna Doniparthi, MD, has no relevant financial relationships to disclose.

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Goal

The goal of this activity is to improve the knowledge, competence, and performance of learners in prioritizing obesity management, identifying patients who could benefit from pharmacologic treatment, and engaging patients in nonbiased discussions to achieve effective and sustained weight loss.

Target Audience

This activity is intended for primary care physicians, nurse practitioners, and physician associates involved in the treatment of obesity.

Learning Objectives

At the conclusion of this activity, learners should be able to:

- Apply tactics to patient care that demonstrate the value of prioritizing weight loss to reduce the risk of long-term complications from obesity-related comorbidities.
- Develop pharmacologic treatment plans for patients with obesity based on individual patient needs and preferences.
- Evaluate the effectiveness of strategies for engaging patients in successful long-term weight loss in the management of obesity.

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Designation of Credit

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To receive CME credit and/or MOC points, you MUST pass the posttest and complete the evaluation. For ABIM MOC points, your information will be shared with the ABIM through CCO's Joint Accreditation Program and Activity Reporting System (JAPARS). Please allow 6-8 weeks for your MOC points to appear on your ABIM records.

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ARS Interactive Questions

- **How to Vote**
- You will find a small card style remote located at your seat
  - The buttons are numbered 1 through 9 and 0
  - When the presenter asks you to vote on a question, please press the button that corresponds with your answer
  - If you change your mind or press an incorrect key, just press the correct button – the last button pressed will be accepted as your answer
  - At the end of the session, please leave the remote at the seat where you found it

Outcomes Analysis: What Did You Learn?

- Some questions in this activity will be presented twice: once before the content and then again later in the activity

- Discussion of the correct answers and a summary of your responses will appear only after the postactivity questions
- All responses will be measured only in aggregate (ie, your individual responses will not be identified)
- Thank you for helping us assess the impact of this educational activity

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Quick Survey

PCE CCO

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How many patients with obesity do you provide care for in a typical week?

A. 1-9

B. 10-25

C. 26-50

D. 51-100

E. >100

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Presurvey 1: A 40-yr-old man is seen in your clinic for routine follow-up. His current BMI is 40 kg/m^2, and he reports difficulty losing weight despite lifestyle changes over the last 3 mo, including diet and exercise. Which of the following would be the best approach for weight management in this patient?

A. Explain that obesity is a choice and can be overcome with discipline

B. Explain that obesity is a chronic disease and discuss options for weight loss

C. Explain that weight loss is based on decreasing calories and increasing energy expenditure

D. Recommend the patient continue to work on lifestyle changes and follow up in 3 mo

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Presurvey 2: A 38-yr-old woman with a BMI of 40 kg/m^2 and coexisting hypertension requests a medication to help her lose weight. Based on clinical trial data, which of the following agents is likely to be most effective for this patient?

A. Hydrogel

B. Naltrexone/bupropion SR

C. Orlistat

D. Semaglutide SC

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Presurvey 3: A 47-yr-old woman with obesity presents with difficulty losing weight. Her medical history includes hypertension, and her current weight is 215 lb, with a BMI of 34.7 kg/m^2. She has lost 10 lb since initiating lifestyle changes, including following a Mediterranean diet and exercising regularly, but her weight has plateaued over the past 3 mo. Which of the following would be the most appropriate option for this patient at this time?

A. Recommend increasing exercise to 7 days per wk

B. Recommend no changes because weight loss has been successful

C. Refer for bariatric surgery

D. Use shared decision-making strategies to discuss pharmacotherapy for weight loss

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Smart Patients Survey Results

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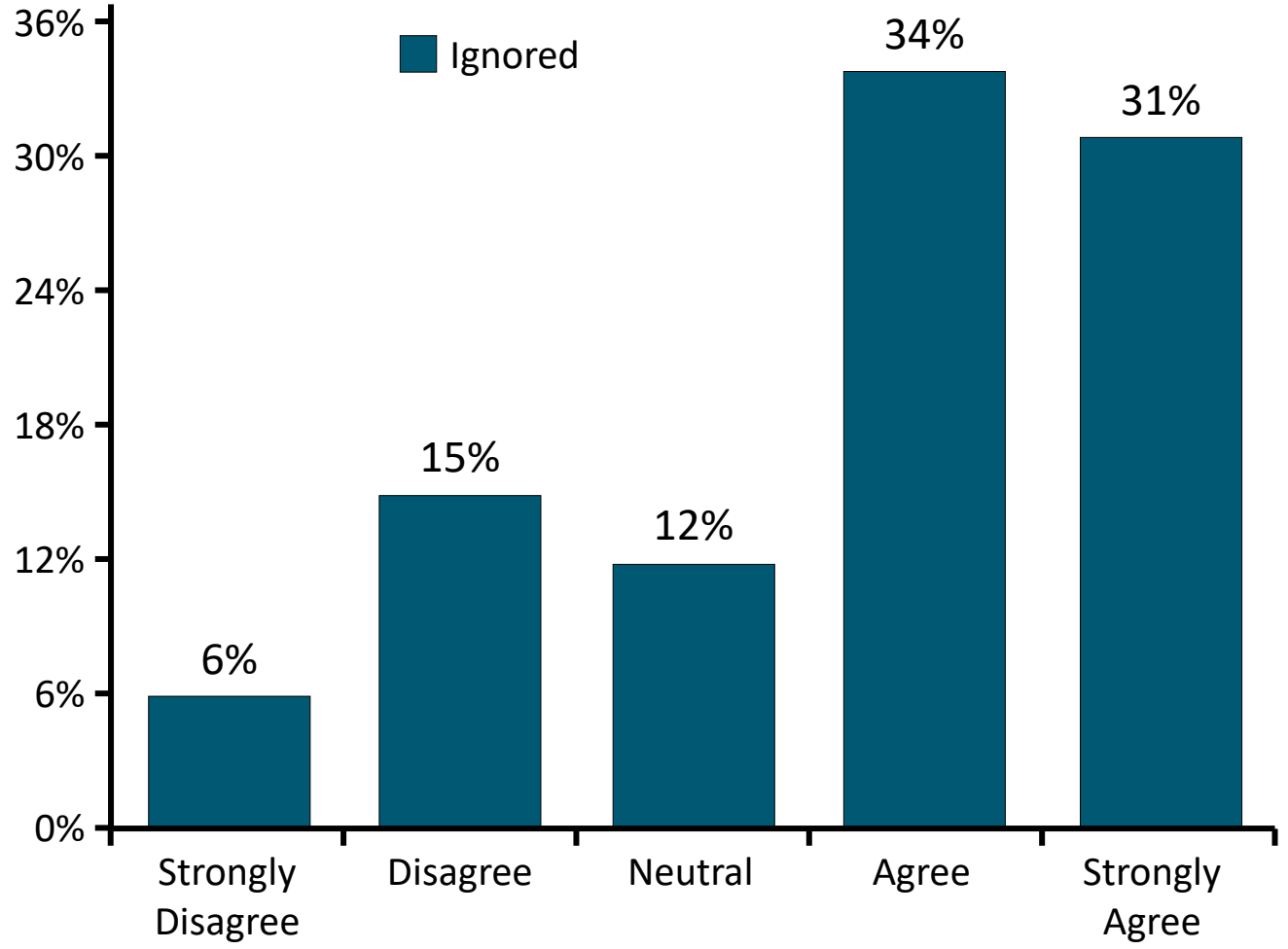
Why Patients Feel Hesitant or Reluctant to Discuss Their Weight-related Concerns With Their HCP: Ignored

- My HCP seldom mentions the issue of my weight (N = 64)



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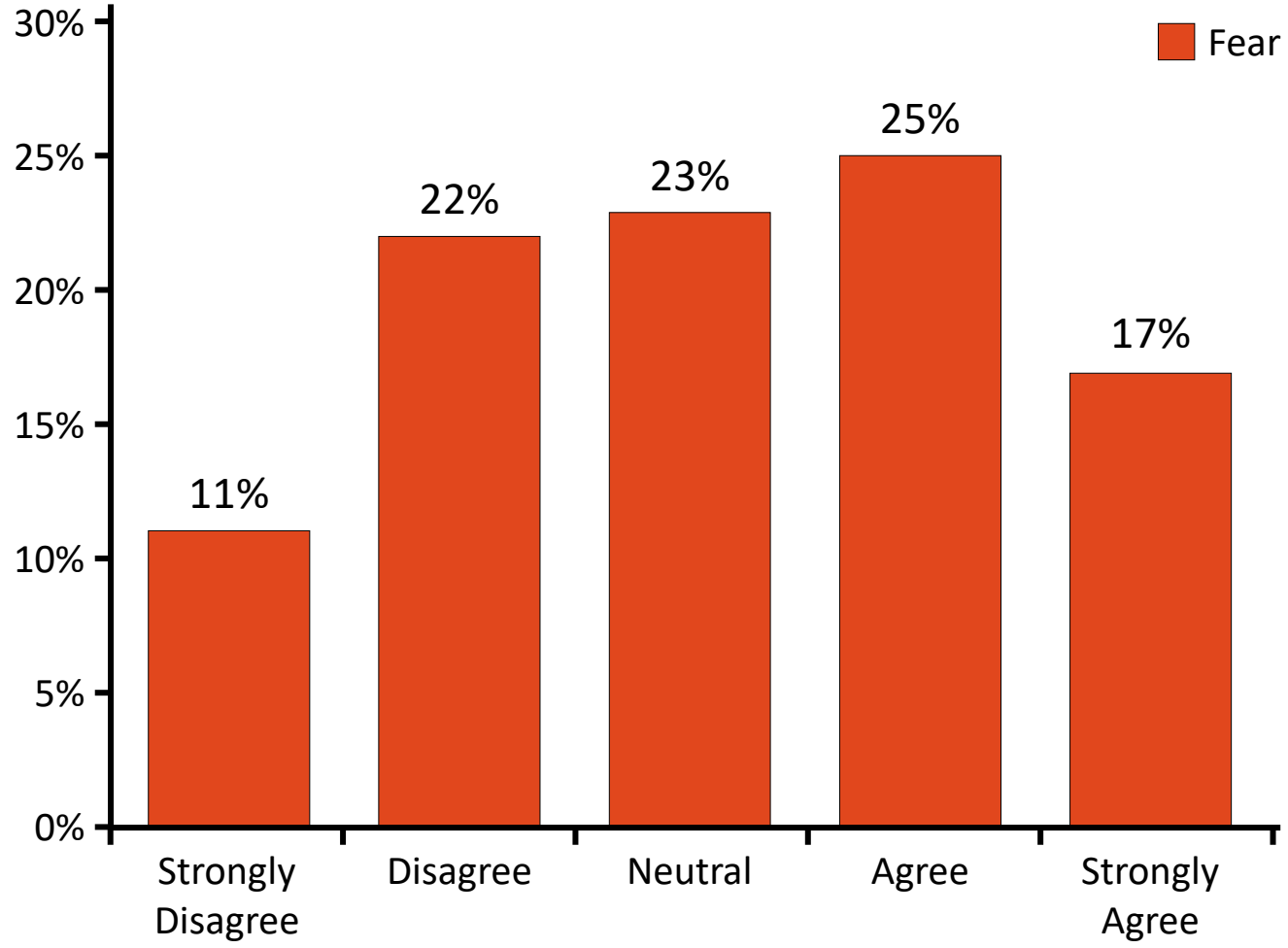
Smart Patients. Practical strategies for applying evidence and patient perspectives to improve obesity management. 2023.

Why Patients Feel Hesitant or Reluctant to Discuss Their Weight-related Concerns With Their HCP: Fear

- Fear of being judged or criticized (N = 68)



Slide credit: **clinicaleducationalliance**.com:

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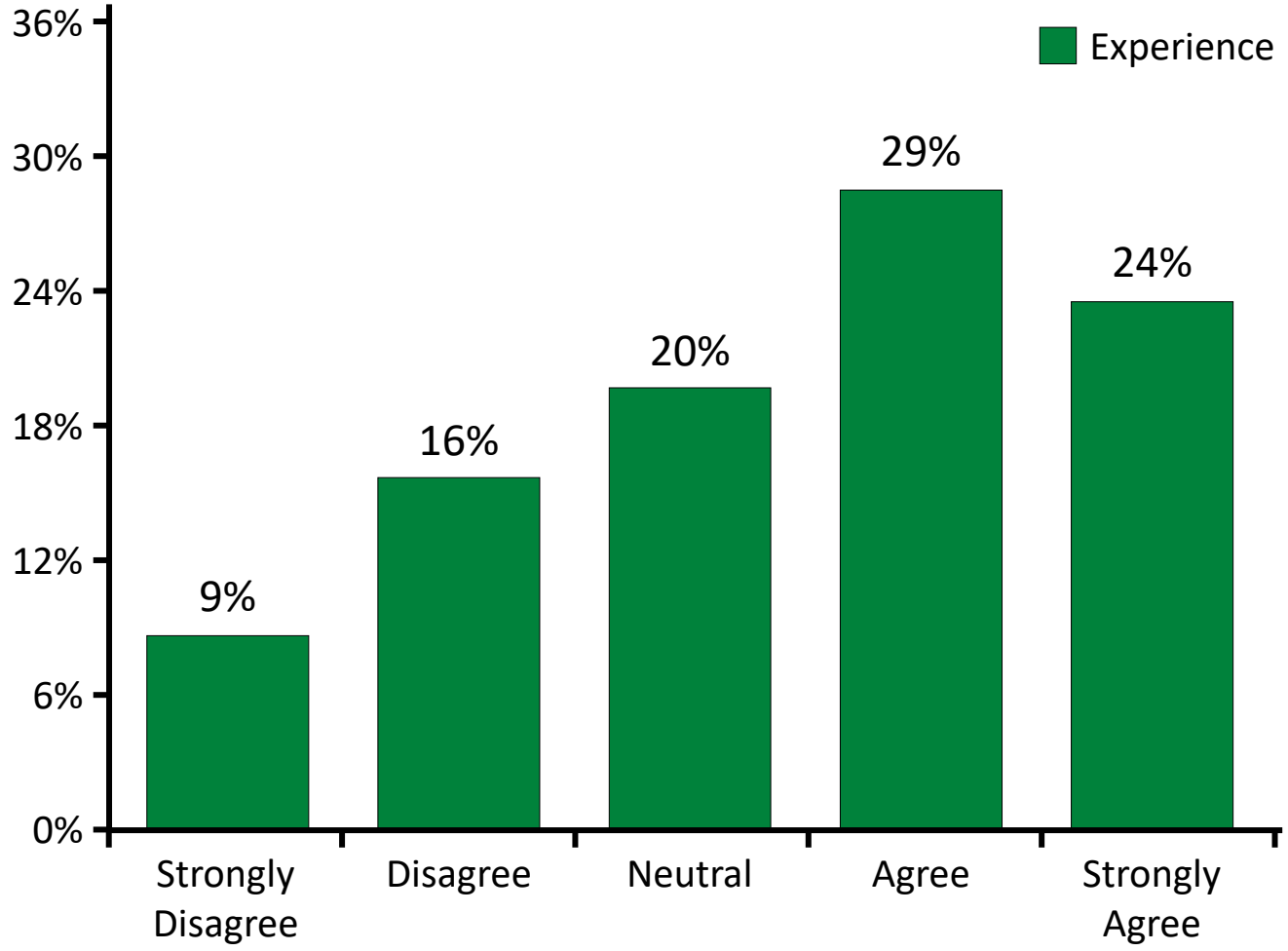
Why Patients Feel Hesitant or Reluctant to Discuss Their Weight-related Concerns With Their HCP: Experience

- Previous negative experiences with HCPs regarding weight (N = 65)



Slide credit: **clinicaleducationalliance**.com:

Survey Summary

Lack of Provider Engagement

Patients feel that their PCPs do not listen and dismiss their concerns about weight. Providers do not spend enough time discussing weight-related issues with patients. Some providers do not offer help, suggestions, or resources for weight loss.

Weight Loss Resources and Support

Patients desire resources that can genuinely help them in their weight loss journey. They mention the need for free gym memberships, trial programs like Noom, and ongoing discussions for accountability and planning. Some patients feel that HCPs lack knowledge about weight loss and only label them as obese without assistance.

Weight Discussion Timing

Patients often bring up weight concerns when dealing with acute or chronic illnesses. Weight may not be the primary concern for patients, and they expect HCPs to address other health issues first.

Personal Feelings and Stigma

Patients feel reluctant or uncomfortable discussing weight-related concerns because they perceive it as a personal failing. Weight-related discussions may make patients feel judged, stigmatized, or blamed for their health conditions. Terms like “obesity” carry stigma and judgment, and patients prefer more neutral language like “overweight.”

Smart Patients. Practical strategies for applying evidence and patient perspectives to improve obesity management. 2023.

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Framing Obesity as a Chronic Disease

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Patient Video Vignette: Rebecca

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Poll 2: How often do you discuss obesity as a chronic disease with your patients who have overweight or obesity?

A. Never

B. Rarely

C. Sometimes

D. Frequently

E. Always

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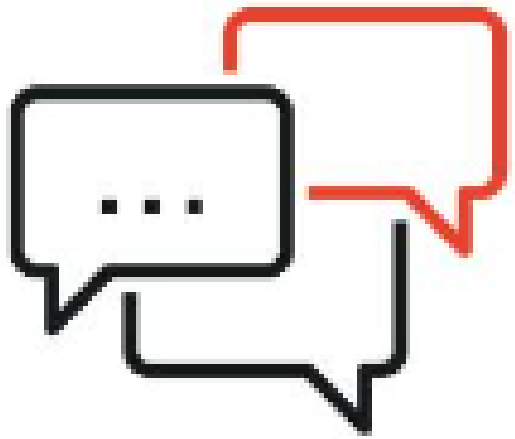
Small Group Breakout

- What are your thoughts about this patient vignette?
- Do you think Rebecca's experience is common?



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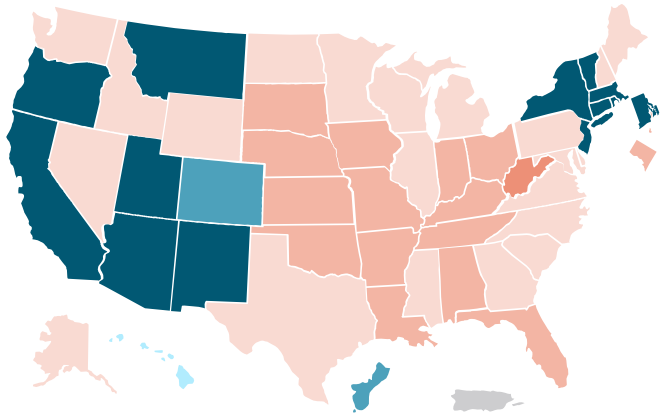
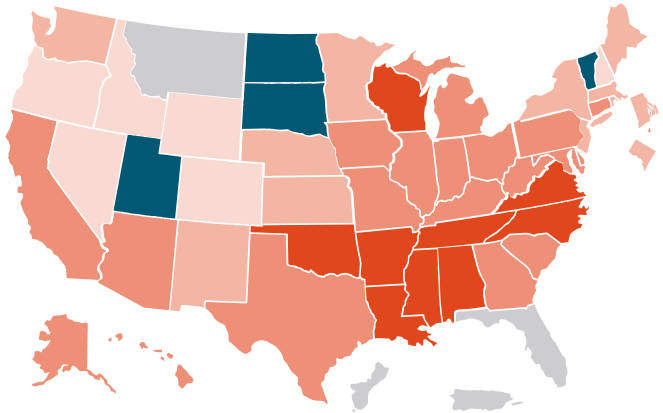
Obesity Prevalence Varies Across Race and Ethnicity (2020-2022)

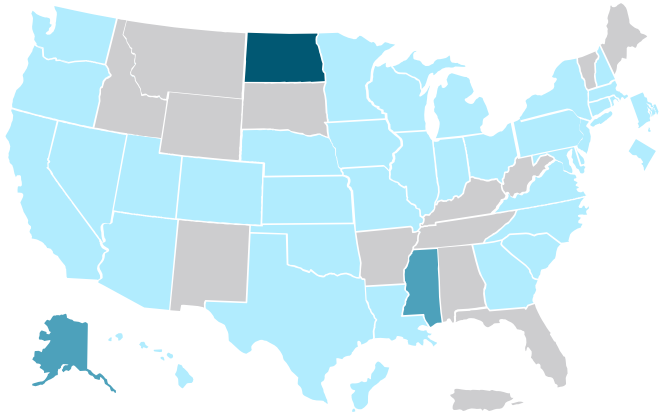
Non-Hispanic White



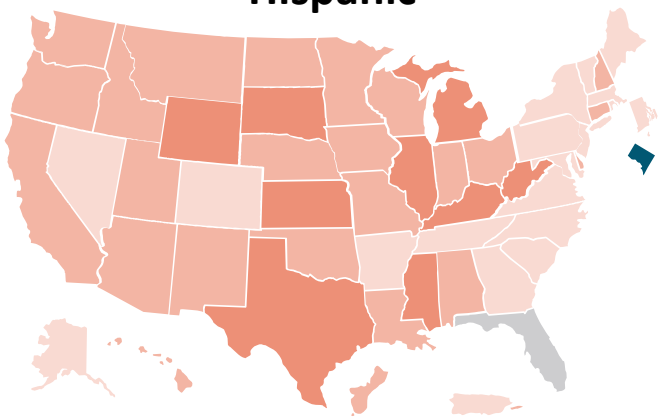
Non-Hispanic Black

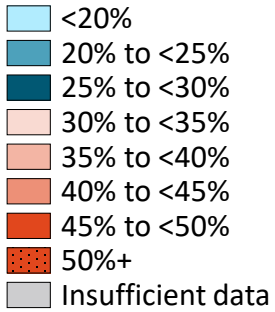


Non-Hispanic Asian

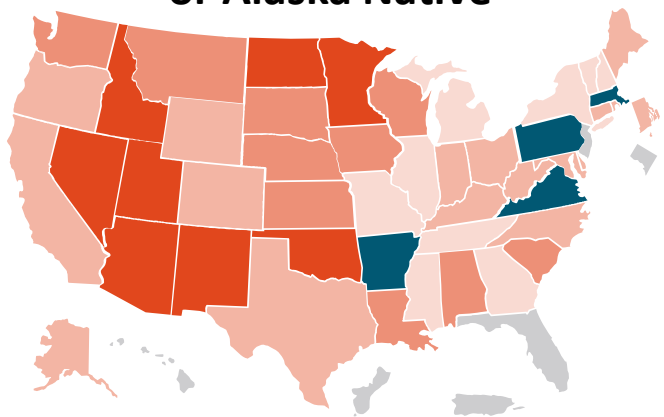


Hispanic





Non-Hispanic American Indian or Alaska Native



cdc.gov/obesity/data/prevalence-maps.html.

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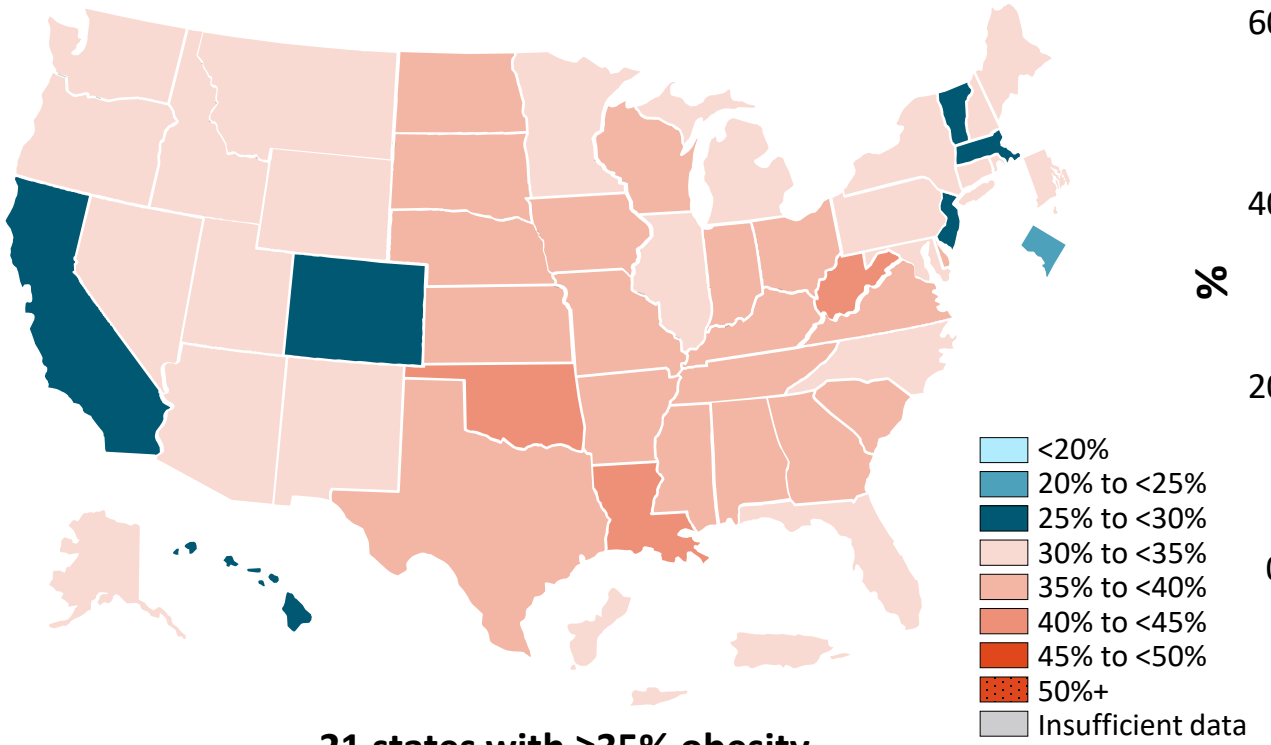
US Obesity Epidemic Grows

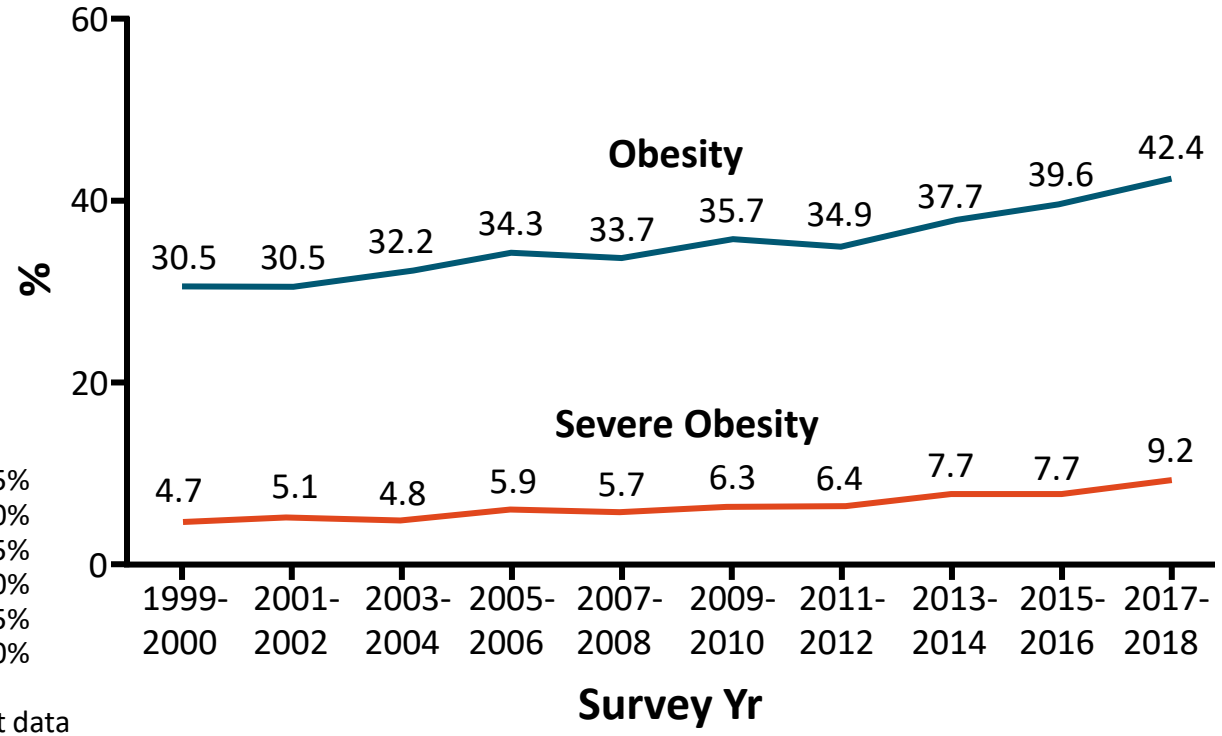
Non-Hispanic American Indian, Alaska Native, and Black patients, as well as Hispanic patients, are most affected

CDC Obesity Prevalence Map, Updated Sept 2023



21 states with ≥35% obesity

Trends in US Adults With Obesity 2000-2018



Obesity increased 30.5% to 42.4%
Severe obesity increased 4.7% to 9.2%

cdc.gov/obesity/data/prevalence-maps.html. cdc.gov/nchs/data/databriefs/db360-h.pdf.

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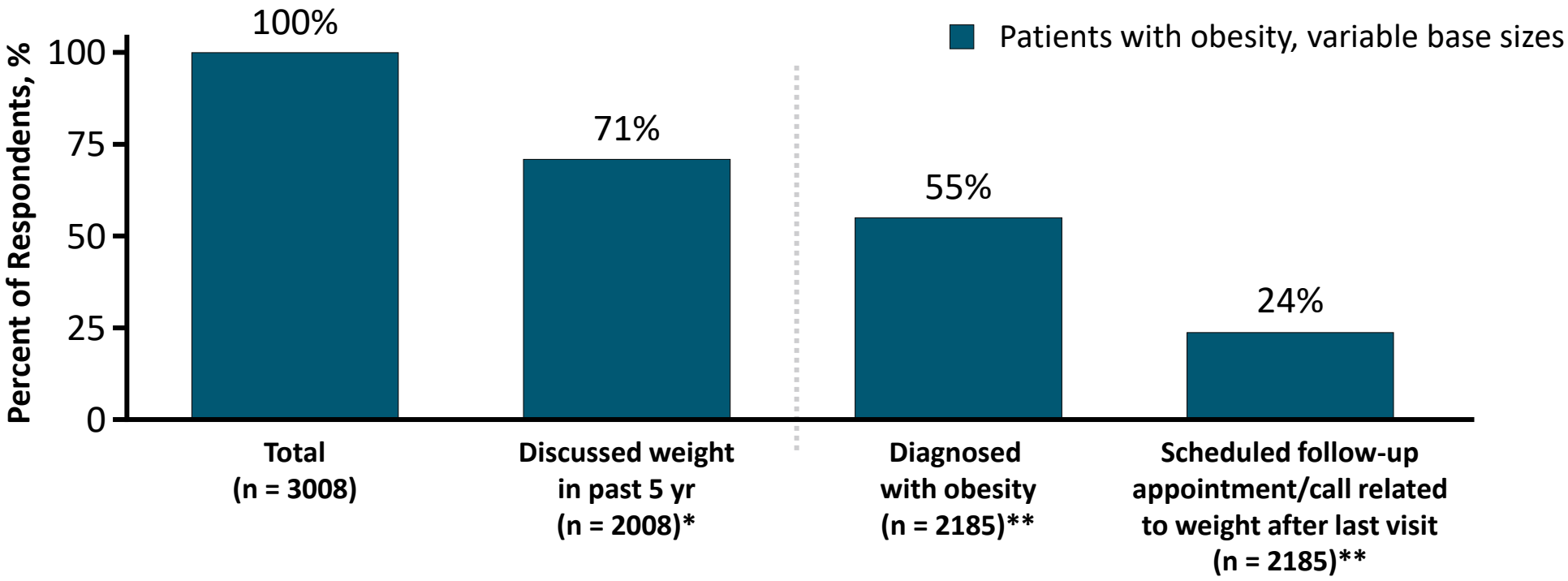
Few Patients With Obesity Receive a Diagnosis or Treatment



*Either "discussed being overweight" (68%) or "discussed losing weight" (64%) with their HCP.
**Among the 71% who have had a conversation in the past 5 yr. Dashed line indicates base size changes.

Kaplan. Obesity (Silver Spring). 2018;26:61.

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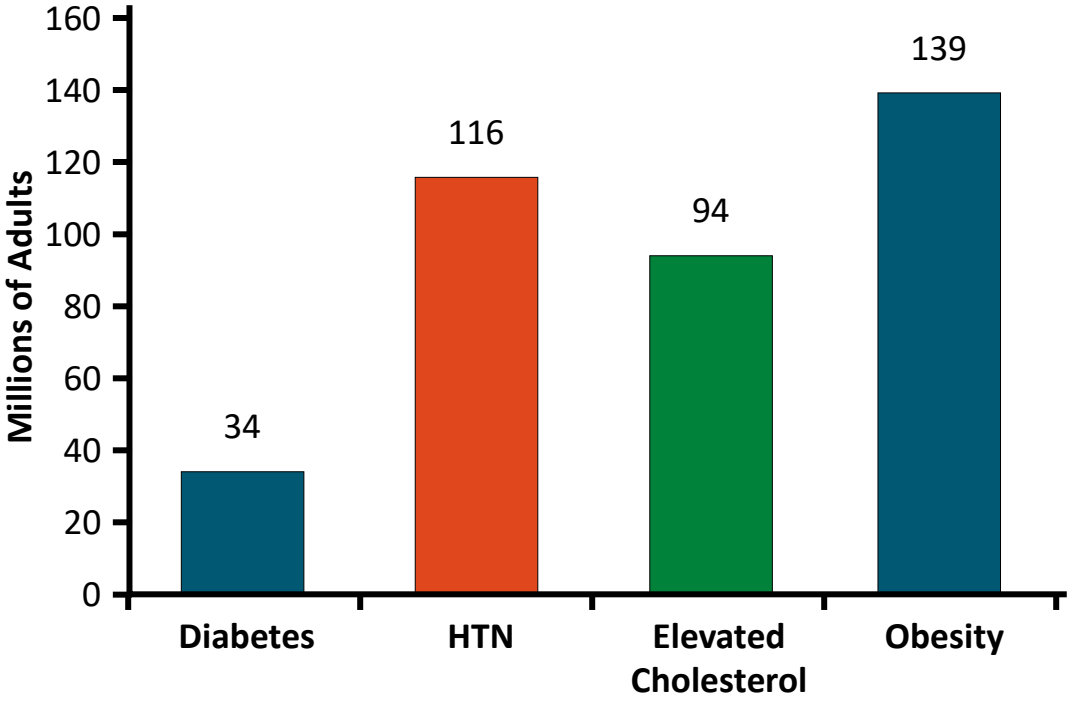
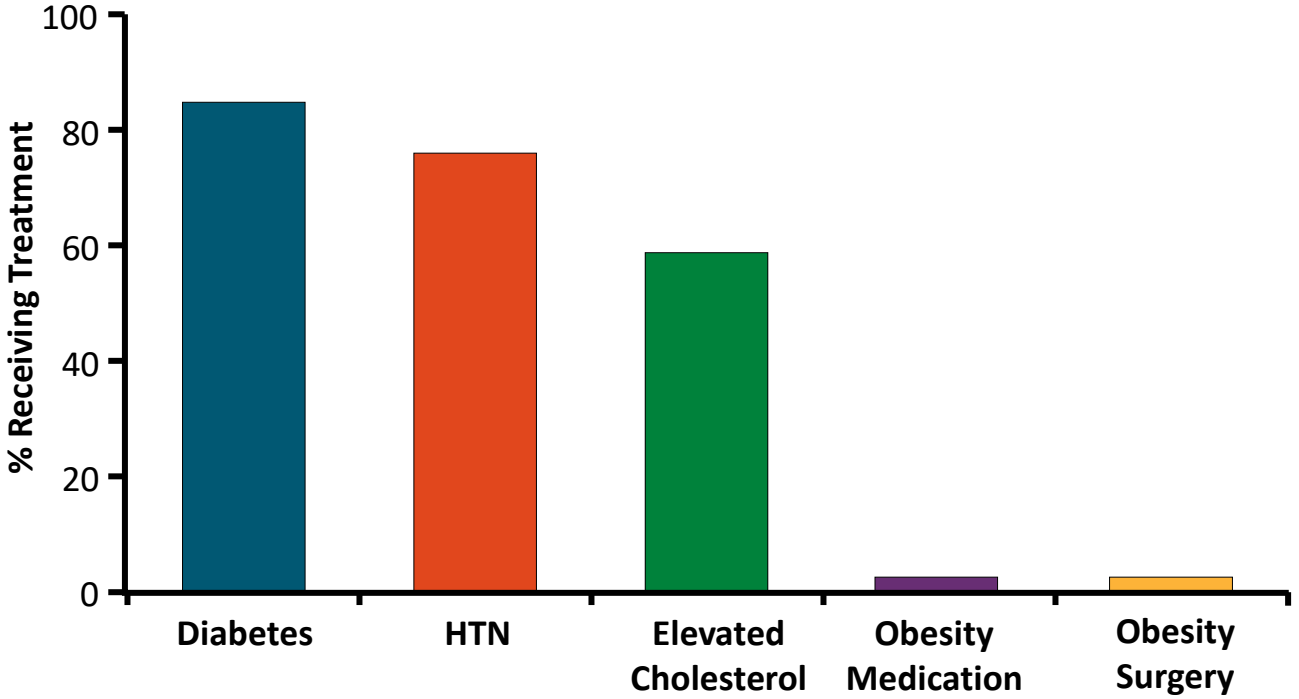
Do We Treat Obesity as a Chronic Disease?





Fang. NEJM. 2021;384:2219. Gasoyan. Surg Obes Relat Dis. 2019;15:146. Gjermeni. Biomolecules. 2021;11:1426. millionhearts.hhs.gov/data-reports/hypertension-prevalence.html. Saxon. Obesity (Silver Spring, Md). 2019;*27*:1975.

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Obesity results from **genetic and environmentally driven dysfunction** of the normal fat mass regulatory mechanisms ...
... leading to an **inappropriately elevated** defended body fat mass

Overeating does not cause obesity ...
... obesity causes overeating

Undereating does not fix obesity ...
... fixing obesity leads to undereating

nutrition.org/scientists-claim-that-overeating-is-not-the-primary-cause-of-obesity/. Schwartz. Endocr Rev. 2017;38:267.

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The Complex Etiology of This Chronic Disease[1-6]

Obesity

Physiologic[1-3]

- Altered levels of hormones and gastrointestinal peptides
- Altered homeostatic and reward system pathways
- Weight-positive medications
- Health conditions

Genetic[4]

- Epigenetics
- Mutations
- Single nucleotide polymorphisms

Behavioral[3]

- Diet
- Inactivity
- Emotional factors
- Lack of sleep
- Smoking cessation

Environmental[5,6]

- Socioeconomic status
- Access to/affordability of food
- Built/physical environment
- Cultures
- Sociocultural attitudes
- Endocrine-disrupting chemicals

1. Lean. Int J Obes (Lond). 2016;40:622. 2. Yu. Obes Rev. 2015;16:234. 3. nhlbi.nih.gov/health/overweight-and-obesity/causes. 4. Killi. North Clin Istanb. 2020;7:153. 5. Martínez. Public Health Nutr. 2007;10:1138. 6. Sharma. Obes Rev. 2010;11:362. 7. Chaput. Obes Rev. 2012;13:681.

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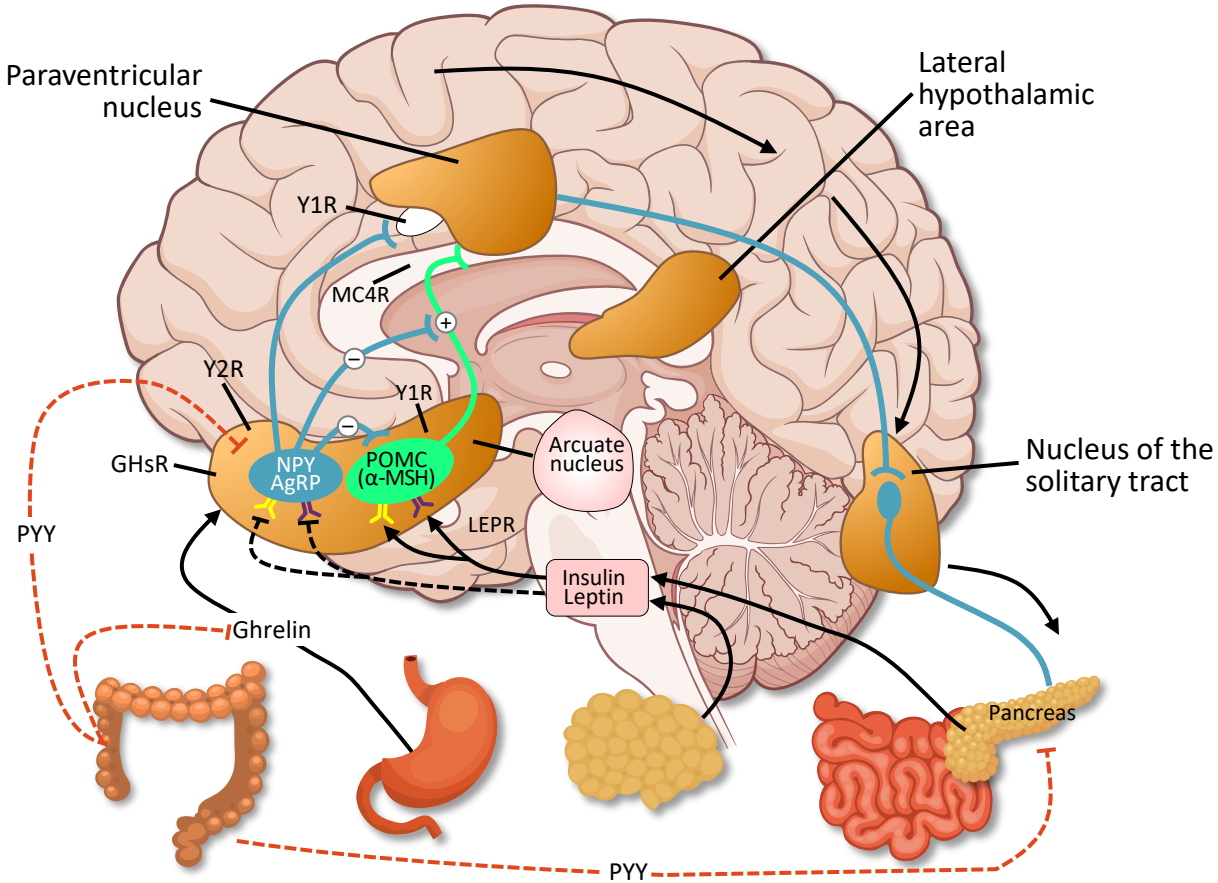
Dysregulation of Energy Regulation System

- Over time increase amount of adiposity
  - Intertwining of genetics, environment, and biology

- Biologic defense of the increased adiposity
  - Evolution: conserve body fat
  - Physiologic defense of higher body weight



Neuroendocrine disease

Figure 1 and 2: Servier Medical Art. CC BY 3.0. No changes made. Figure 3 adapted from Apovian. J Clin Endocrinol Metab. 2015;100:342. Schwartz. Endocr Rev. 2017;38:267.

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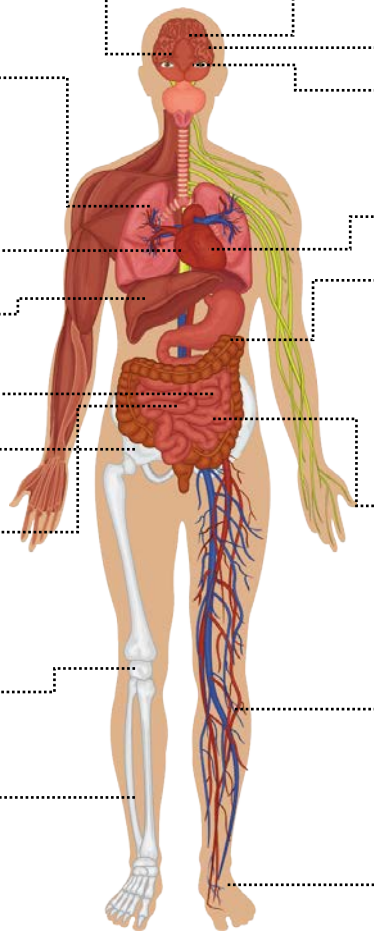
Understanding How Weight Can Impact Health



CNS
Depression

Pulmonary disease
- Abnormal function
- Hypoventilation syndrome
- OSA

Cardiovascular
Hypertension

NAFLD
- Steatosis
- Steatohepatitis
- Cirrhosis

Gallbladder disease

Genitourinary

Gynecologic abnormalities
- Abnormal menses
- Infertility
- PCOS

Musculoskeletal
Osteoarthritis

Skin

Other
Social stigmatization

Idiopathic intracranial hypertension

Stroke

Cataracts

Coronary heart disease

Renal
Chronic kidney disease

Endocrine
Metabolic syndrome,
T2D
Dyslipidemia

Phlebitis
- Venous stasis

Gout

Cancer: colorectal, postmenopausal breast, endometrial, gastrointestinal, liver

Infections: sensitivity to influenza and COVID 19

Garvey. Endocr Pract. 2016;22:1. Mechanick. Obesity. 2020;28:O1. Sarma. Diabetes Obes Metab. 2021;23:3.
Yin Ling. Int J Obes (Lond). 2021;45:1863. Tsai. Ann Intern Med. 2019;170:ITC33.

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How Much Weight Loss Is Needed to Improve Health?

- Blood glucose
- Triglycerides

-3%

- HDL-C
- Systolic and diastolic blood pressure
- Hepatic steatosis
- Measures of feeling and function
  - Symptoms of urinary stress incontinence
  - Measures of sexual function
  - Quality-of-life measures (IWQOL)

-5%

- NASH Activity Score measured on biopsy
- Apnea-Hypopnea Index

-10%

- Reduction in CV events, mortality, remission of T2D

-15% to -20%

cancer.gov/about-cancer/causes-prevention/risk/obesity/obesity-fact-sheet#does-losing-weight-lower-the-risk-of-cancer. Haase. Int J Obes (Lond). 2021;45:1249. rethinkobesity.global/global/en/cvd/weight-loss-and-benefits-for-cardiovascular-disease-cvd.html#section2. Ryan. Curr Obes Rep. 2017;6:187.

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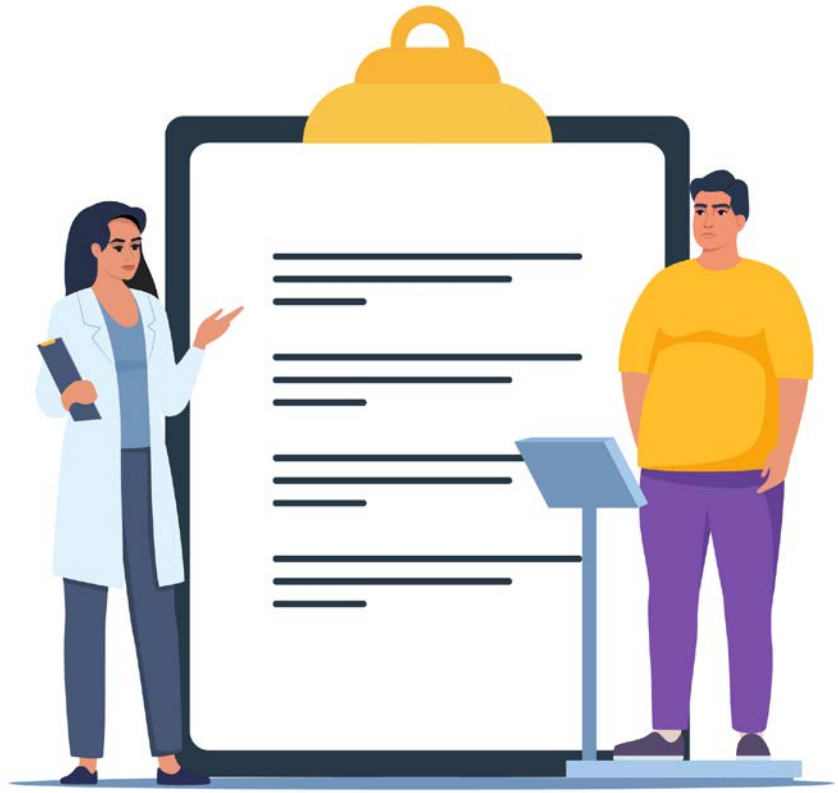
How to Start the Conversation

ASK
for permission to discuss weight and explore readiness



Ask

"Are you okay with discussing your weight today?"

followed by

"Would you be comfortable if I worked with you on a plan?"

- Assessing readiness establishes where the patient is in their weight management journey and helps the HCP engage in more effective and tailored communication

Auckburally. Curr Obes Rep. 2021;10:274. floridasphysicaltherapy.gov/pdfs/Talking_WPAWL_Handout.pdf.

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Strategies for Initiating Discussions About Weight Management

- Respectful language
- Explaining the disease and benefits of weight reduction
- Supportive counseling
- Patient-centered approaches
- Provide details of available treatment options: pros and cons/risks and benefits
- Discuss food as treatment and how to follow a plan of eating
- Provide information on different eating plan options with benefits and rules to follow a plan

Auckburally. Curr Obes Rep. 2021; 10:274. floridasphysicaltherapy.gov/pdfs/Talking_WPAWL_Handout.pdf.
Lindberg. Ugeskr Laeger. 2022;184:V04220264.

Slide credit: **clinicaleducationalliance**.com:
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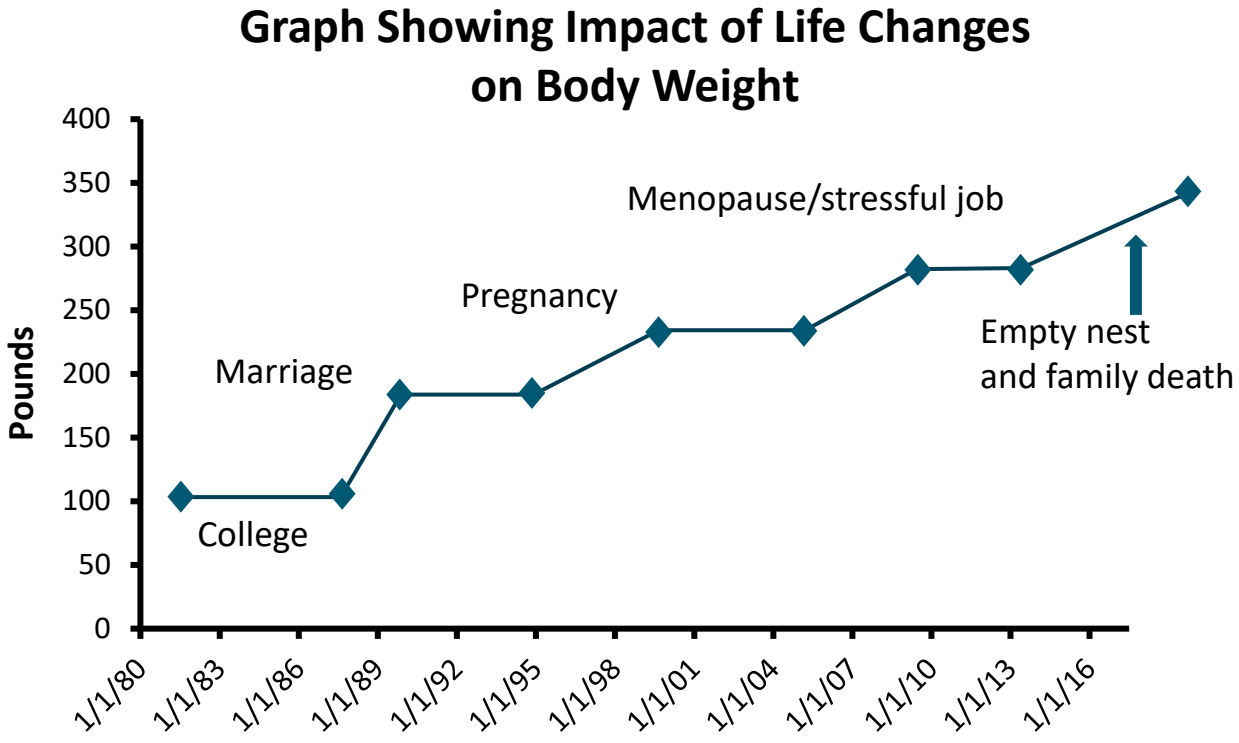
Obtaining a Weight History: How and Why

OPQRST Mnemonic	Sample Questions
Onset	"What did you weigh in high school, college, 20s, 30s, 40s?"
Precipitating factors	"How much weight did you gain when you stopped smoking?"
QoL	"At what weight did you feel your best?"
Remedy	"What have you tried in the past to control weight?"
Setting	"What was going on when you gained weight?"
Temporal pattern	"Did you gradually gain weight or was it more cyclic?"



Weight history may be helpful when discussing reasonable goals and expected outcomes for weight loss and maintenance

Slide credit: **clinicaleducationalliance**.com:

Kushner. Obesity (Silver Spring). 2020;28:9. Srivastava. Endotext: use of historical weight trajectory to guide an obesity focused patient encounter. 2022.

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Essential Standards of SDM: Provider Role

- Support for person’s values and preferences
- Use of language at patients' level of education
- Evidence sources
- Screening and necessary tests ordered
- Neutral presentation
- Recognize any ethnic or cultural eating trends
- Assure handouts are at 6th grade level and less if needed
- Provide patient with reliable online sources or handouts
- Likely not needed for selecting an eating plan
- Assure there is not provider choice in the presentation

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Essential Standards of SDM: Shared Role

- Discussion of patient decision
- Review cycle as appropriate
- Allow patient to guide this part of discussion
- Determine follow-up on patients' decision

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Shared Decision-making: Eating Plans Aids

How do I make an eating plan decision?
Options and choice for using eating plans to treat obesity

Patient decision aid (adapted from NICE)

I've been diagnosed with obesity. What does this mean for me?

- If you have obesity, your body has excess adipose tissue (fat mass) especially in the abdominal area. It is believed that obesity has something that turns on the genetic susceptibility for the disease. Obesity is in its essence a disruption in the body's ability to regulate fat mass.
- Obesity puts a person at risk for over 200 other diseases and disorders. This means that you may be at risk of cardiometabolic diseases like diabetes, heart attacks, and strokes
- The aim of treating obesity is to prevent obesity related complications or make those you might already have better.
- The actual benefit you might get from decreasing your weight and treating obesity may vary with the amount of weight lost.

How is obesity treated?

There are three basic components of treatment. Finding a way to change your eating as needed, increasing your physical activity and being in a program that is directed by your healthcare provider. Additionally, many patients will need the support of medications to help overcome the pathology of obesity. With more severe disease surgery may also be an option.

How does food play a role in treatment?

There is plenty of research demonstrating that changing the food eaten can provide an important role in treatment. Many guidelines recommend reducing calories, other experts recommend meal plans

Alternative to selecting an eating plan – selecting one of the following

- Minimize intake of highly processed foods
- Increase consumption of whole foods
- Increase consumption of high-fiber, complex, carbohydrates
- Read labels and use serving sizes

What are my options related to food plans?

- You can choose to **do nothing**.
- You can choose to make **choose an eating plan**.
- You can choose to **make individual changes** to your eating

This decision aid can help you and your healthcare professional decide together which is the best option for you. The table gives some information about each eating plan and the evidence for them for you to think about when choosing the best option for you.

Table: What are the options for an eating plan?

Do nothing	
What does this involve?	• Carrying on as I am.
Pros	• No changes to make.
Cons	• You are more likely to have no change in obesity and thereby stay at risk for the 200+ obesity related complications

Select an eating plan	
What does this involve?	• Selecting a pattern for eating
Pros	• Allows for a chance change eating as a part of the treatment plan and provide weight loss • Impact obesity related complications through weight loss
Cons	• Changing habits can be hard. • Requires time to plan, prepare and follow an eating plan • You'll have to remember to track your food each day

Decision aid adapted from nice.org.uk/about/nice-communities/nice-and-the-public/making-decisions-about-your-care/patient-decision-aids.

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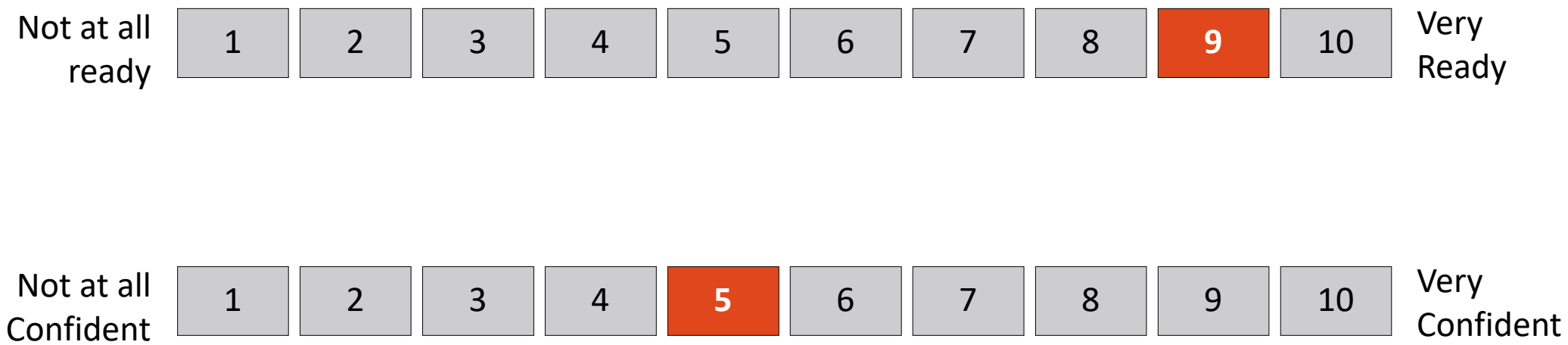
Next Visit at Obesity Clinic



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Goal Setting

S

Specific

I will increase my daily exercise

M

Measurable

To 30 min 3 days/wk

A

Attainable

Over the next 4 wk

R

Realistic

I will exercise prior to work

T

Timely

I will track this and report at my next appointment

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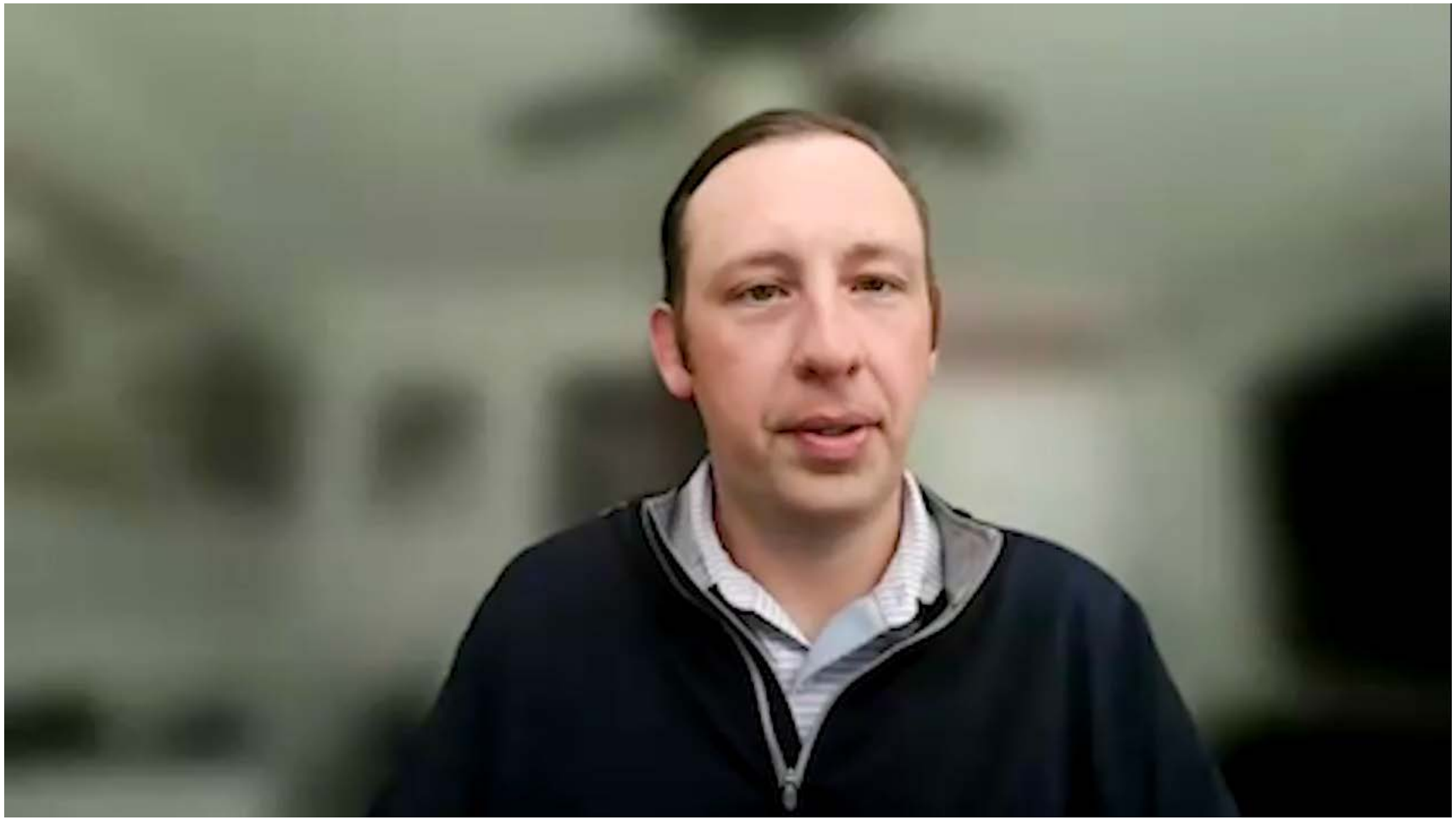
Identifying the Right Treatment for the Right Patient

PCE CCO
powered by cea

Patient Video Vignette: Alex



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Poll 3: How often do you discuss anti-obesity medications with your patients who have obesity?

A. Never

B. Rarely

C. Sometimes

D. Frequently

E. Always

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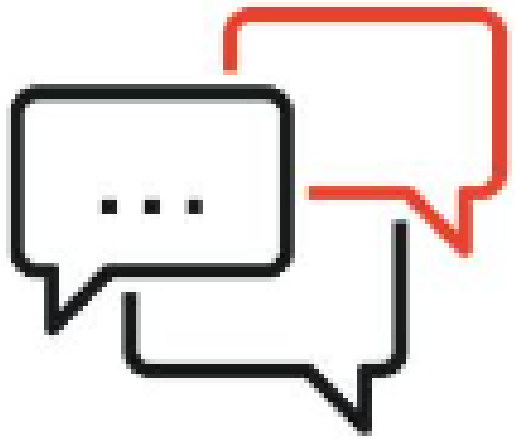
Small Group Breakout

- What are your thoughts about this patient vignette?
- Do you think Alex's experience is common?



Slide credit: **clinicaleducationalliance**.com:

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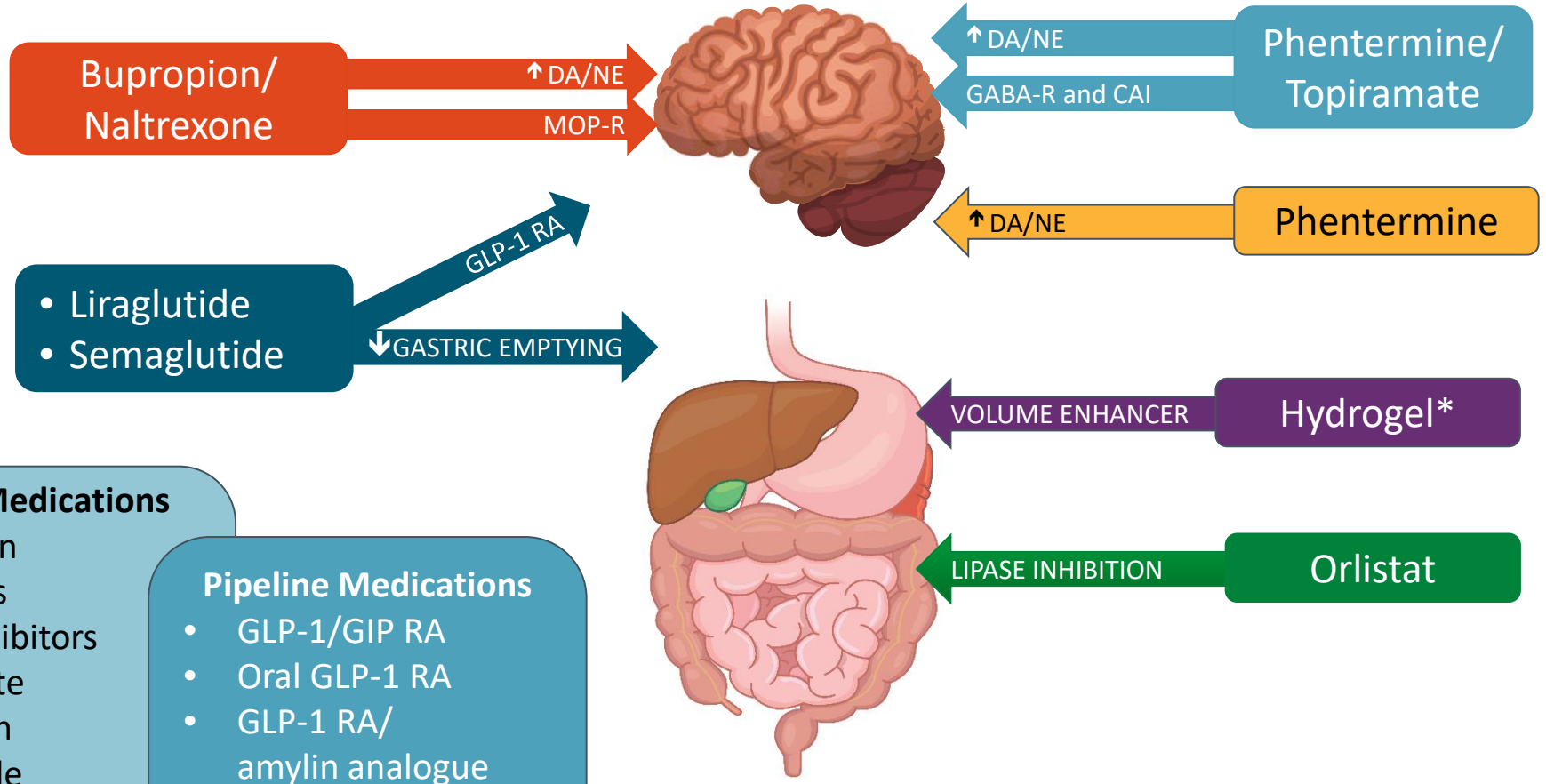
Why Use Medication With Obesity Treatment?

- Therapy aimed at the currently dysregulated weight-regulated biology
- Metabolic adaptation difficult to treat with diet and behavior modification alone
- Anti-obesity medications can assist in managing obesity-induced complications/comorbidities

health.clevelandclinic.org/weight-loss-drugs/. Mauer. Cleve Clin J Med. 2021;88:440.

Slide credit: **clinicaleducationalliance**.com:
cea clinical education alliance

FDA-Approved Anti-obesity Medications



Off-label Medications

- Metformin
- GLP-1 RAs
- SGLT2 inhibitors
- Topiramate
- Bupropion
- Tirzepatide

Pipeline Medications

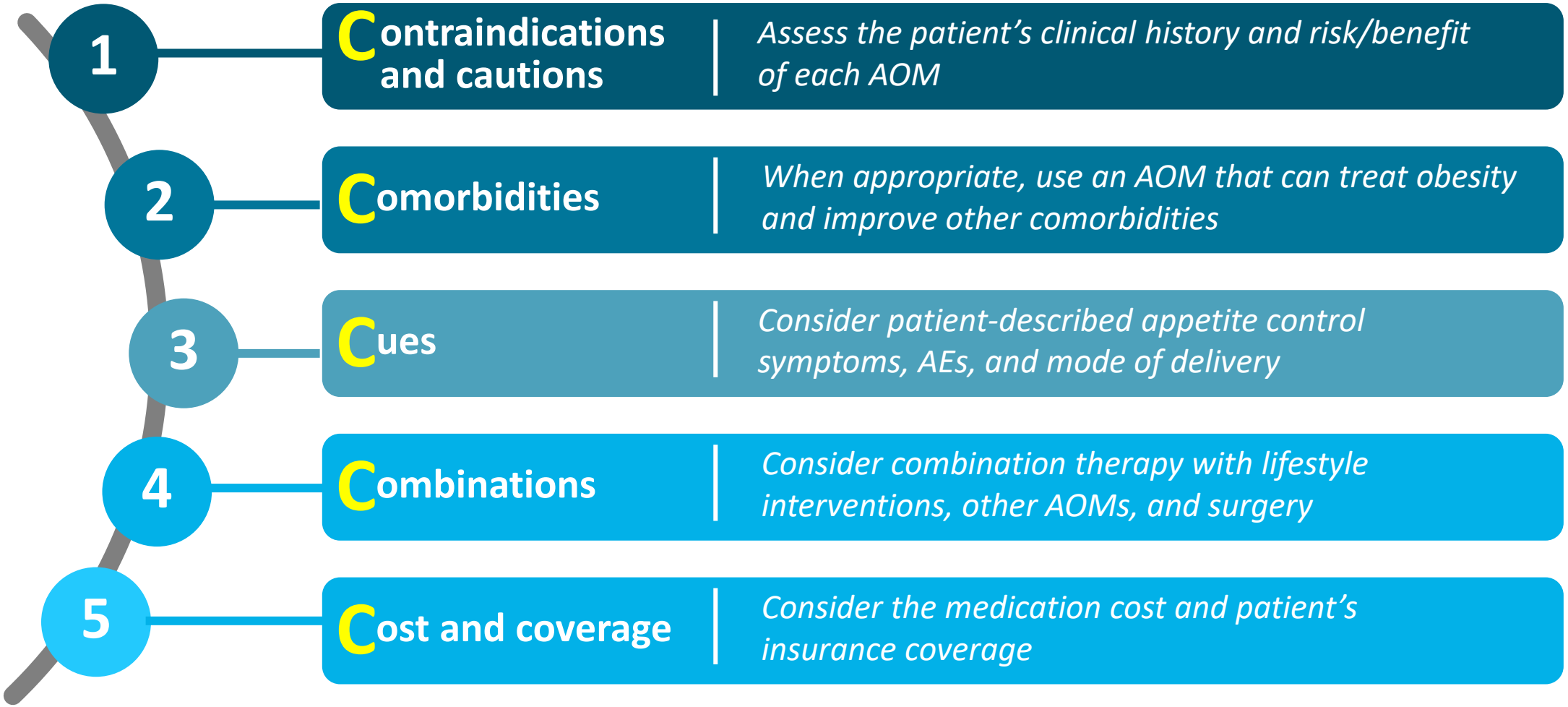
- GLP-1/GIP RA
- Oral GLP-1 RA
- GLP-1 RA/ amylin analogue
- PYY analogue
- GDF-15 analogue

*Considered a medical device.

Angelidi. Endocr Rev. 2022;43:507. Giruzzi. Clin Diabetes. 2020;38:313. Tak. Curr Obes Rep. 2021;10:14.

Slide credit: **clinicaleducationalliance**.com:
cea clinical education alliance

The 5 C's of Choosing an AOM

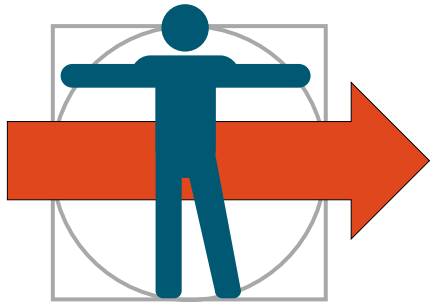


Adapted from Horn. Postgrad Med. 2022;134:359.

Slide credit: **clinicaleducationalliance**.com:
cea clinical education alliance

Ineffective Response to Therapy

- <5% weight loss at 12 wk of maximum dose
  - Medications with escalating doses could be 16 wk or longer
  - Unable to tolerate maximum doses
- <3% to 4% weight loss but with improvement in obesity related complications



1. **Decrease dose of existing AOM as appropriate**
2. **Switch to a different AOM**

Apovian. J Clin Endocrinol Metab. 2015;100:342. Bray. Lancet. 2016;387:1947.

Slide credit: **clinicaleducationalliance**.com:
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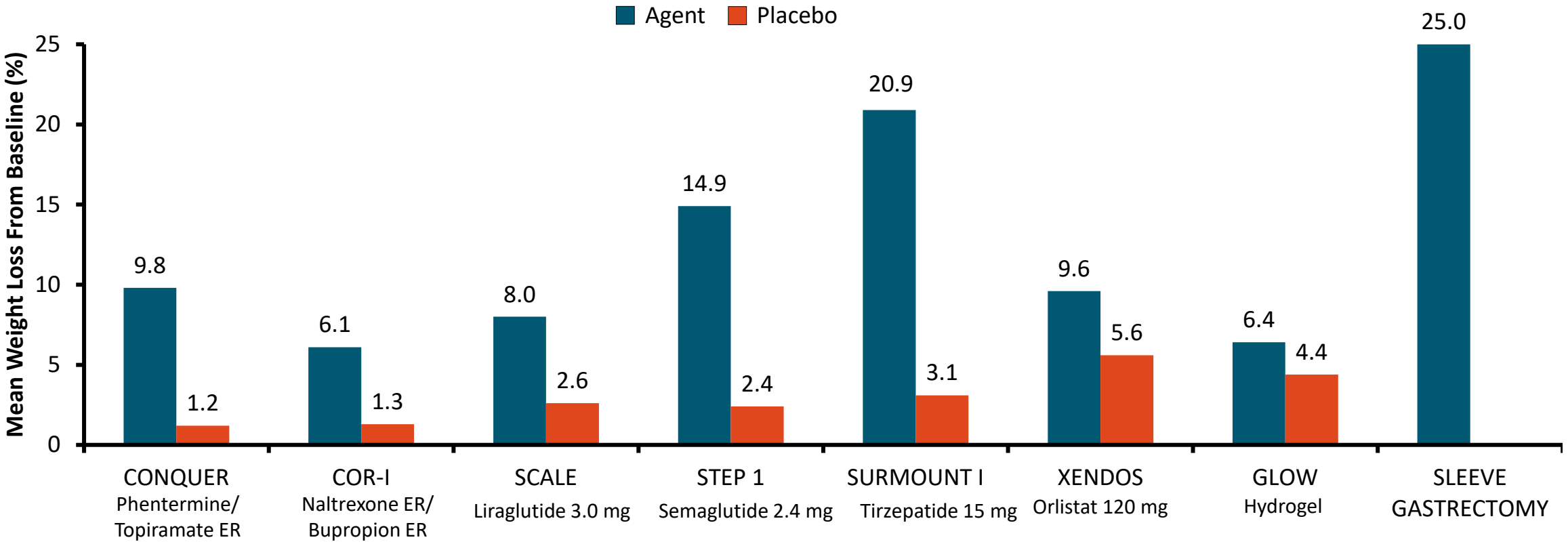
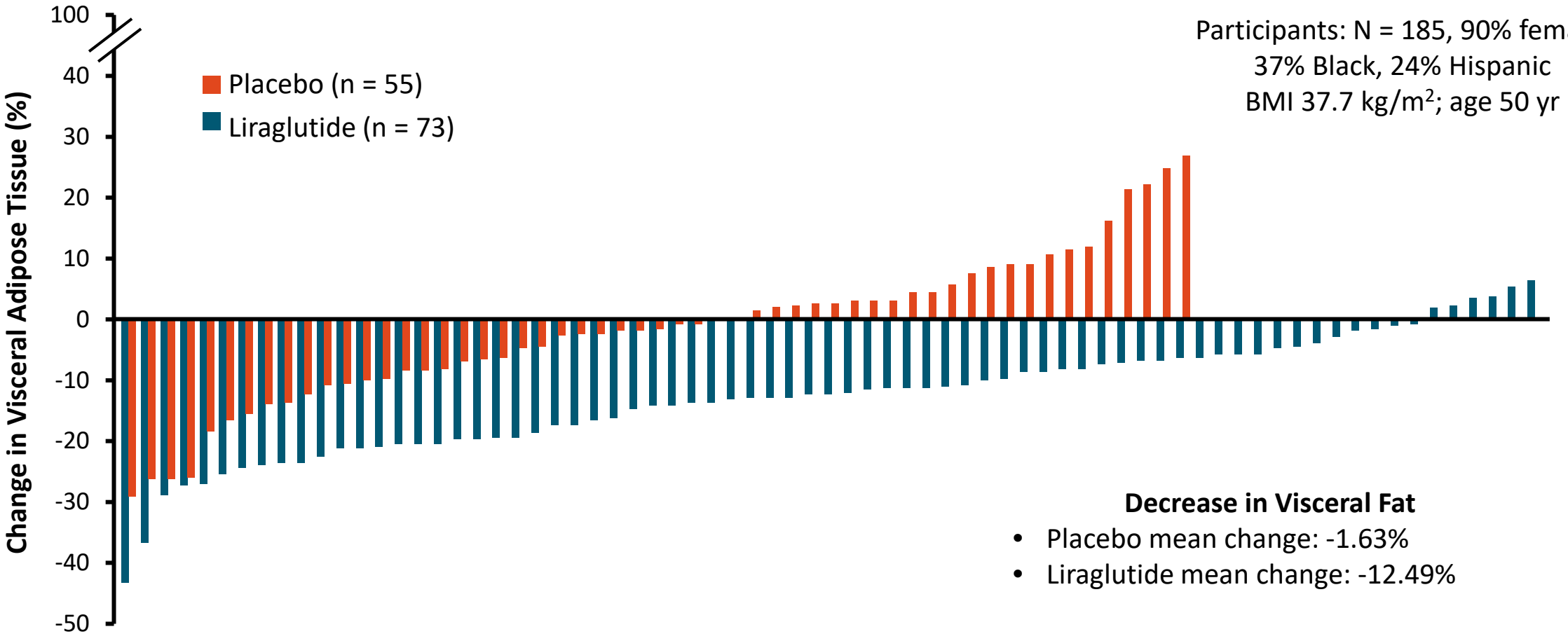
Weight Loss Percentage (Agent vs Placebo) for Weight Loss in Patients Without T2D



Gadde. Lancet. 2011;377:1341. Greenway. Obesity (Silver Spring). 2019;27:205. Greenway. Lancet. 2010;376:595. Jastreboff. NEJM. 2022;387:205. Mechanick. Surg Obes Relat Dis. 2020;16:175. Pi-Sunyer. NEJM. 2015;373:11. Torgerson. Diabetes Care. 2004;27:155. Wilding. NEJM. 2021;384:989.

Slide credit: **clinicaleducationalliance**.com:
cea clinical education alliance

Liraglutide 3.0 mg Reduced Visceral Adipose Tissue Over 40 Wk



Participants: N = 185, 90% female,
37% Black, 24% Hispanic
BMI 37.7 kg/m^2; age 50 yr

Decrease in Visceral Fat

- Placebo mean change: -1.63%
- Liraglutide mean change: -12.49%

Neeland. Lancet Diabetes Endocrinol. 2021;9:595.

Slide credit: **clinicaleducationalliance**.com:
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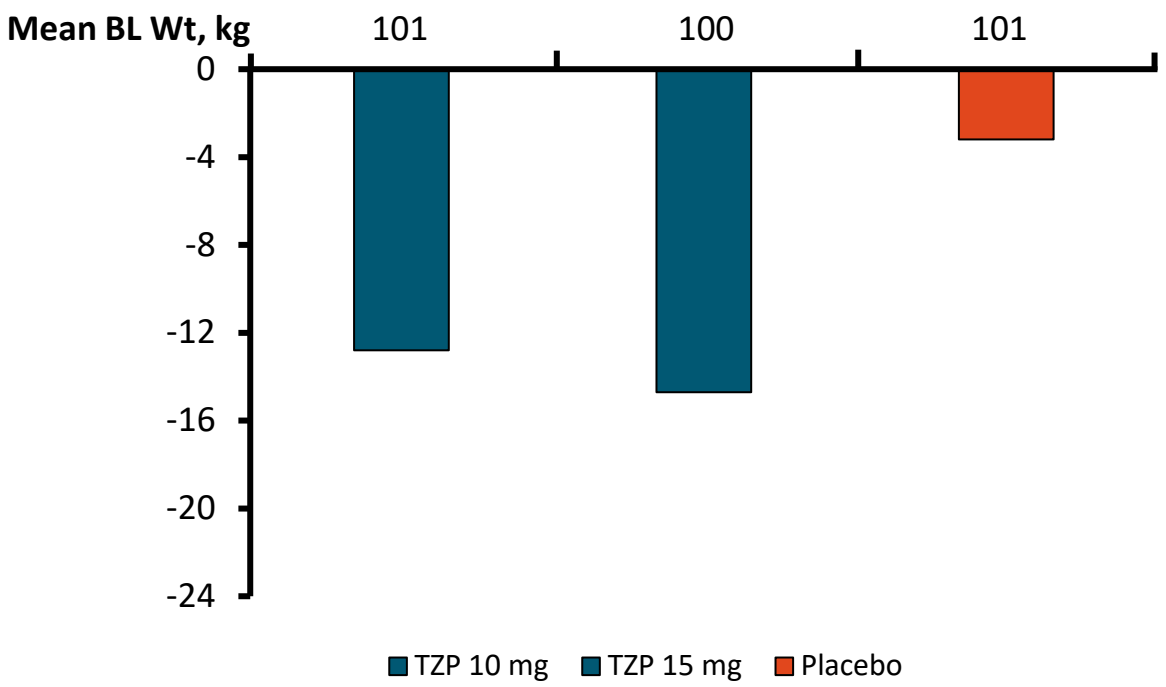
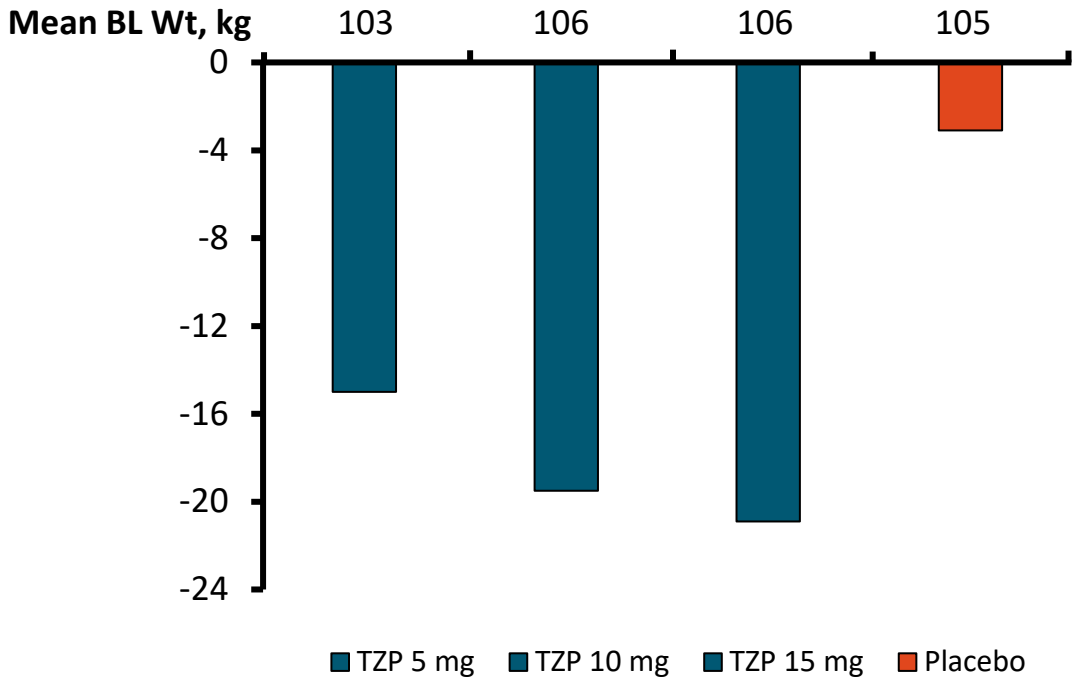
Tirzepatide Has Substantial Effects on Weight in Patients With or Without T2D

Tirzepatide is a GLP-1 RA/GIP dual agonist approved for T2D

SURMOUNT-2 (T2D), 72 Wk[1,a]



SURMOUNT-1 (No T2D), 72 Wk[2,b]



[a]Phase III, multicenter, double-blind, placebo-controlled study of tirzepatide monotherapy; N = 938, treatment-regimen estimand.
[b]Phase III, multicenter, double-blind, placebo-controlled study of tirzepatide monotherapy; N = 2,539, treatment-regimen estimand.
Tirzepatide PI. 1. Garvey. Lancet. 2023;[Epub]. 2. Jastreboff. NEJM. 2022;387:205.

Slide credit: **clinicaleducationalliance**.com:
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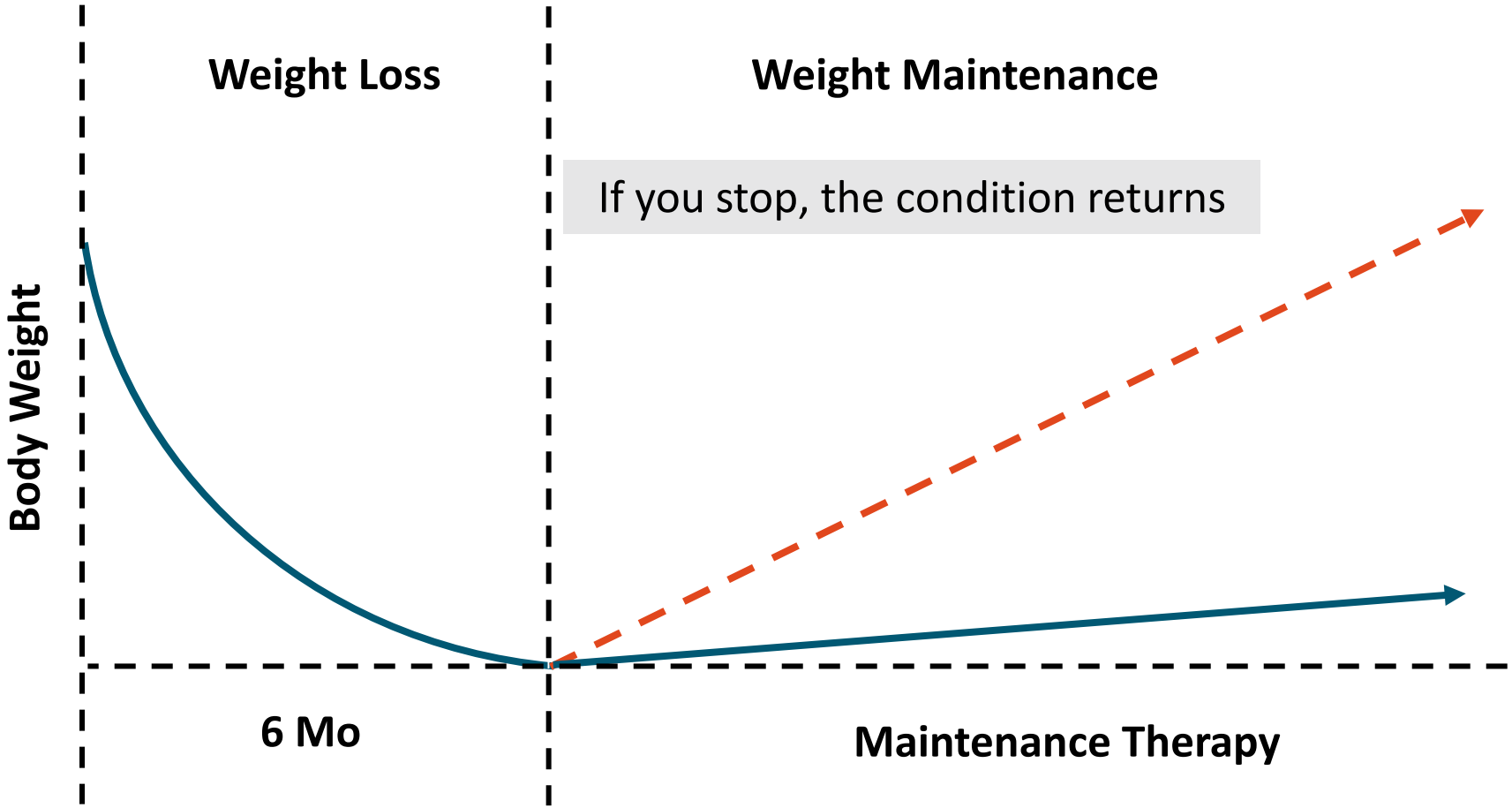
Think of Treating Obesity Like Hypertension



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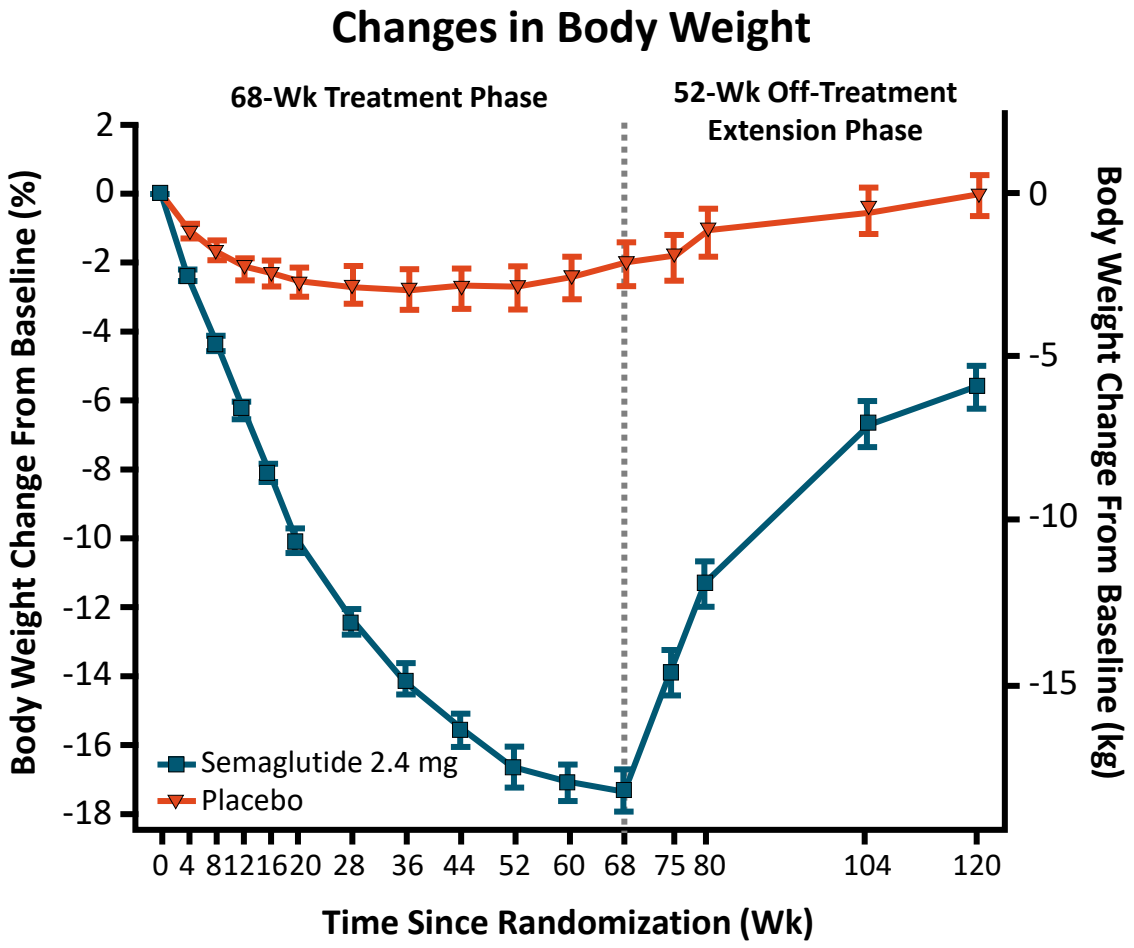
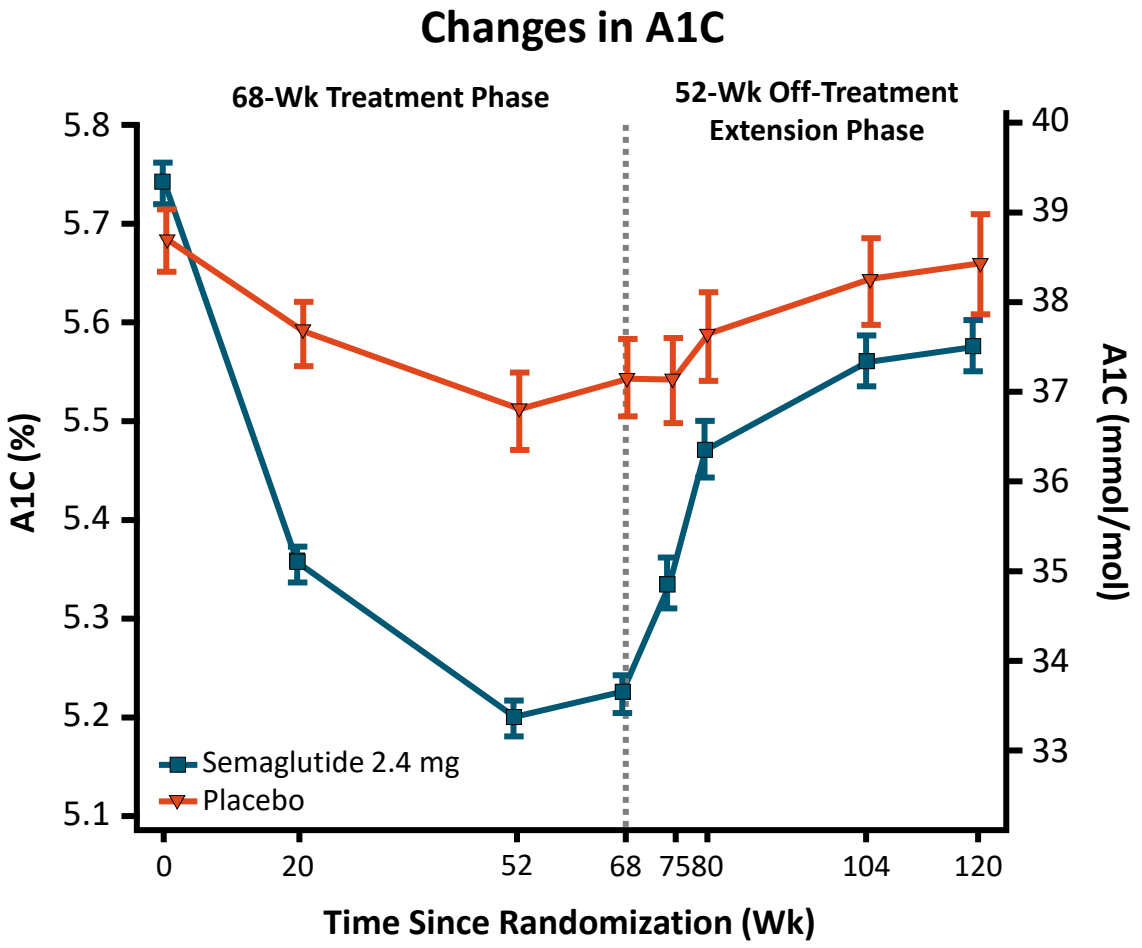
STEP 1 Study Extension: Semaglutide 2.4 mg



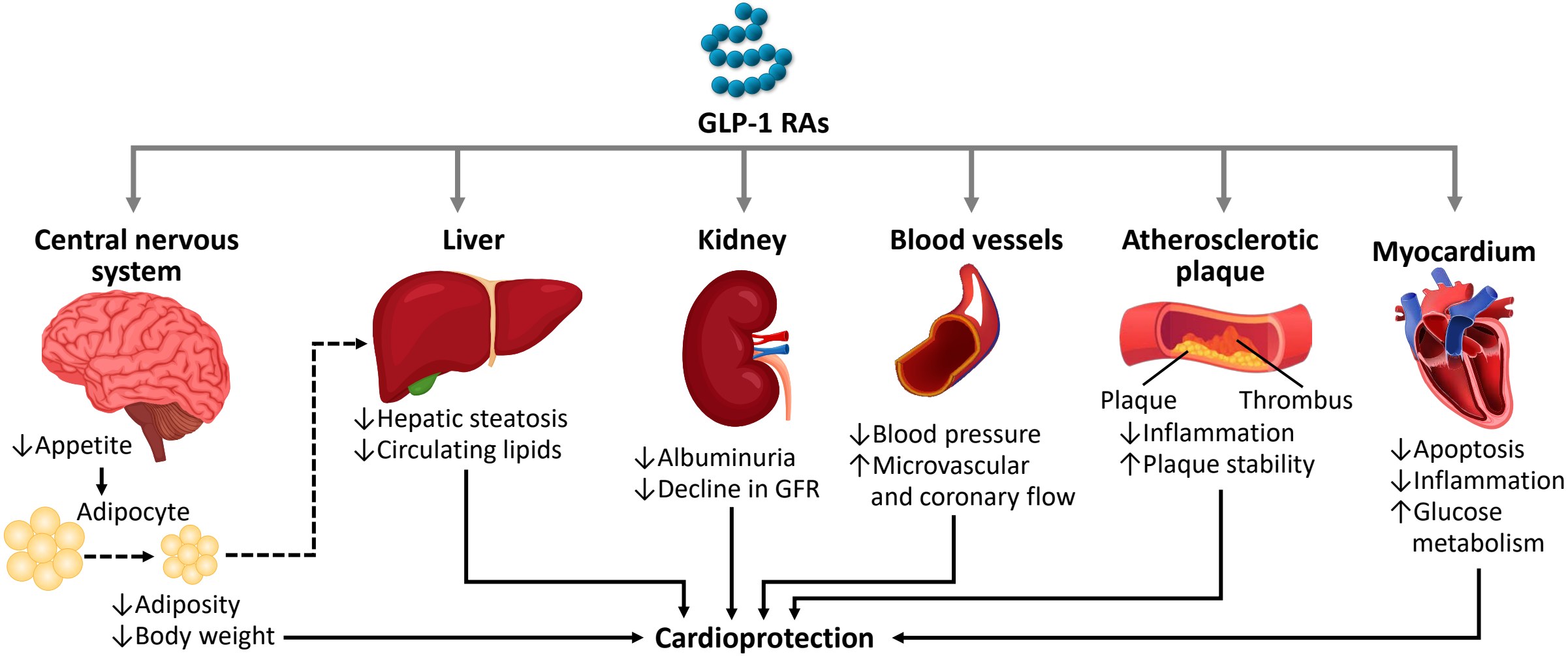


Slide credit: **clinicaleducationalliance**.com:

cea clinical education alliance

Wilding. Diabetes Obes Metab. 2022;24:1553.

Direct and Indirect GLP-1 RA-Mediated Cardioprotection



Ussher. Nat Rev Cardiol. 2023;20:463.

Slide credit: clinicaleducationalliance.com:
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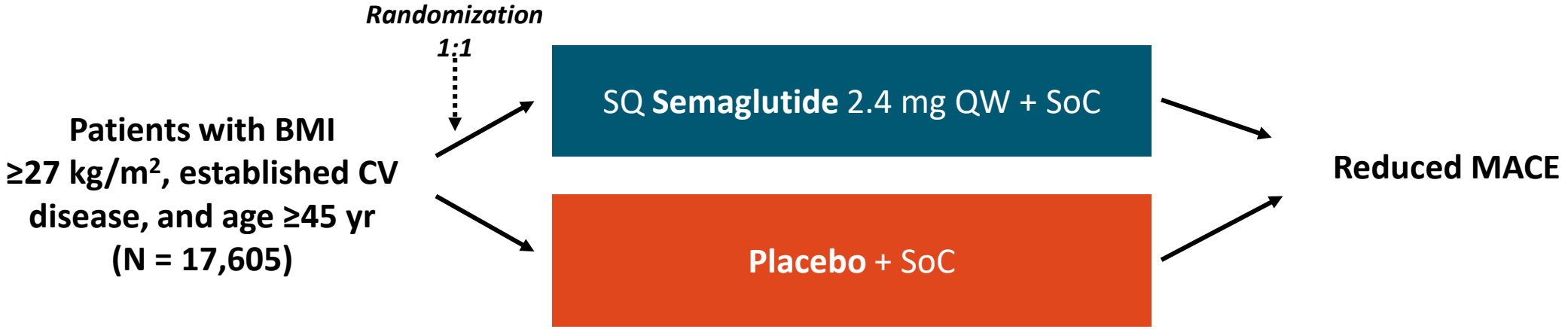
SELECT: Semaglutide Impact on MACE in Patients With Overweight or Obesity

- Global, randomized, double-blind, placebo-controlled, phase III trial



- Primary endpoint: Time to first MACE (ie, CV death, nonfatal MI or stroke)
- Secondary endpoint: Time to CV death, all-cause death, expanded MACE

NCT03574597. Ryan. Am Heart J. 2020;229:61.

Semaglutide for Cardiovascular Event Reduction in People With Overweight or Obesity: SELECT Study

Study population
17,605 participants (72.5% male)
Age: 61.6 yr
BMI: 33.34 kg/m^2
Non-Hispanic White: 84%

Prior CV events and other demographics
Myocardial infarction: 76.3%
Stroke: 23.3%
Peripheral artery disease: 8.6%

Heart failure diagnosis: 24.3%
Prediabetes: 66%
Tobacco history: 65.2%

20% reduction in MACE in people treated with semaglutide 2.4 mg vs placebo

Primary endpoint
Composite outcome of the first occurrence of MACE
- Cardiovascular death
- Nonfatal myocardial infarction
- Nonfatal stroke

All 3 components contributed
1270 first MACEs were accrued

acc.org/Latest-in-Cardiology/Articles/2023/08/10/14/29/SELECT-Semaglutide-Reduces-Risk-of-MACE-in-Adults-With-Overweight-or-Obesity.
Lingvay. Obesity 2023;31:111.

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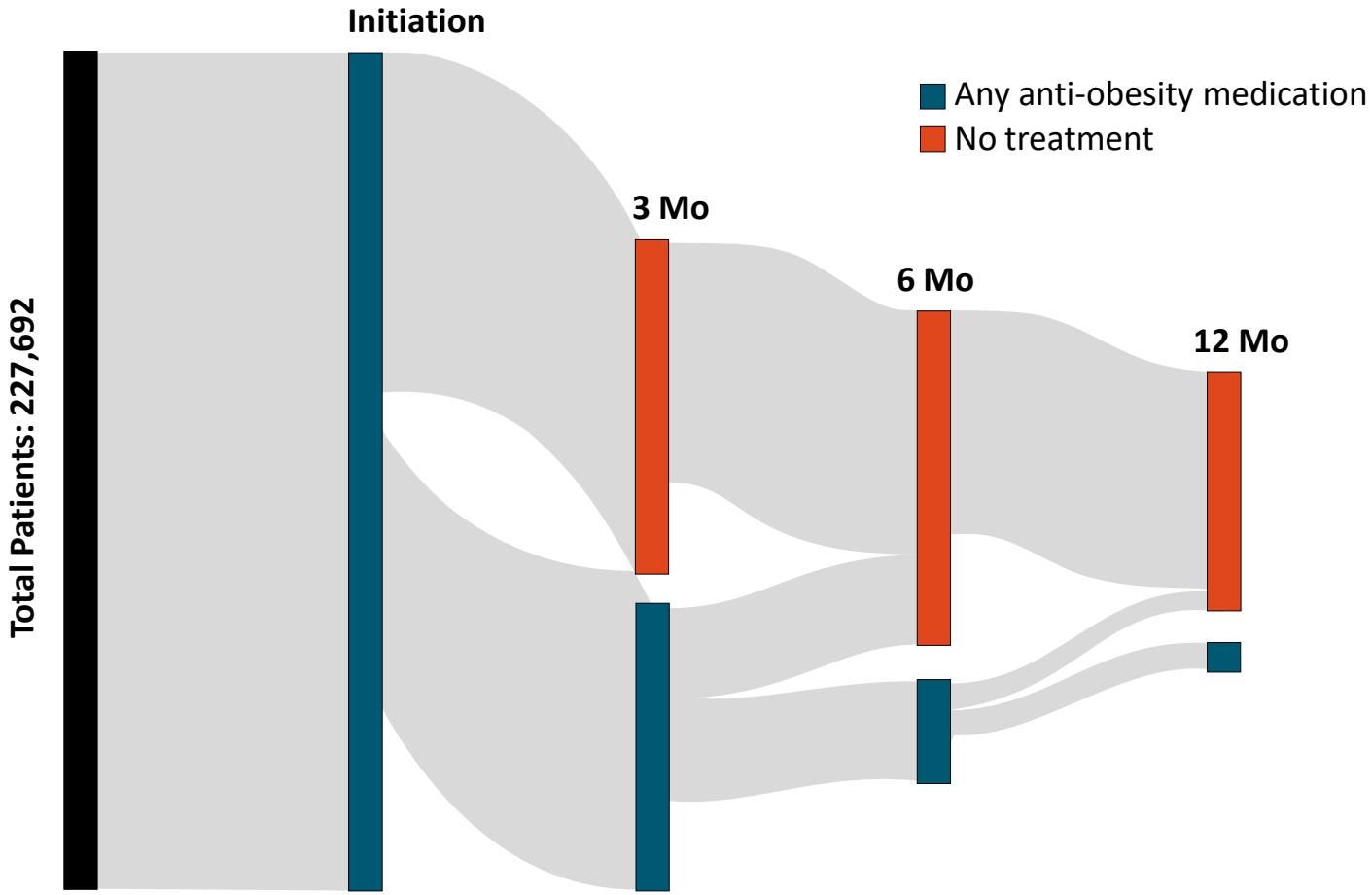
Use of Anti-obesity Medications Short-Lived in United States: Discontinuation and Switching 2015-2018

- Phentermine 51%
- Naltrexone/bupropion 19%
- Liraglutide 3.0 mg 13%

Mean treatment: 81 days



Suissa. Diabetes Obes Metab. 2021;23:1542.

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Bariatric Surgery Criteria and Weight Reduction

Bariatric Surgery BMI Criteria

NIH Consensus Statement

BMI <35

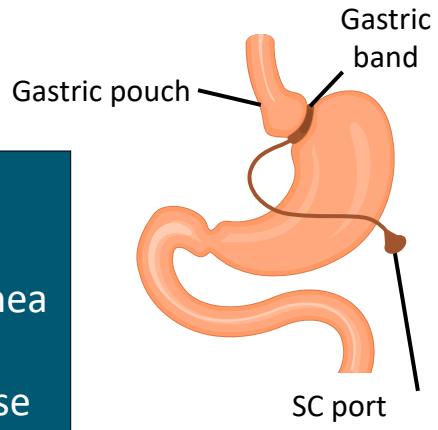
BMI 35-39
+1 comorbidity

BMI >40

Comorbidities
Type 2 diabetes
Obstructive sleep apnea
Hypertension
Atherosclerotic disease
Hyperlipidemia
Fatty liver disease

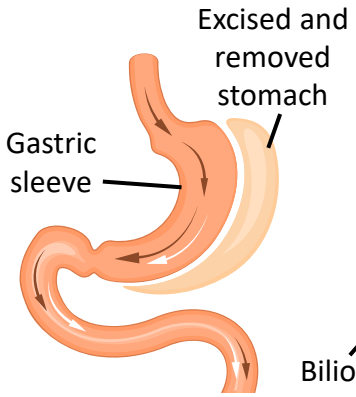
Weight Loss Outcomes

Adjustable Gastric Banding



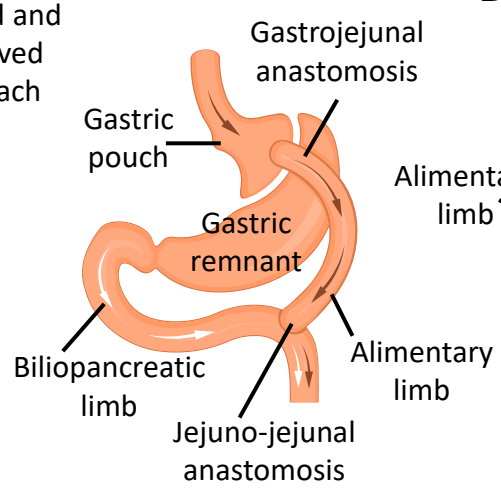
15%

Sleeve Gastrectomy



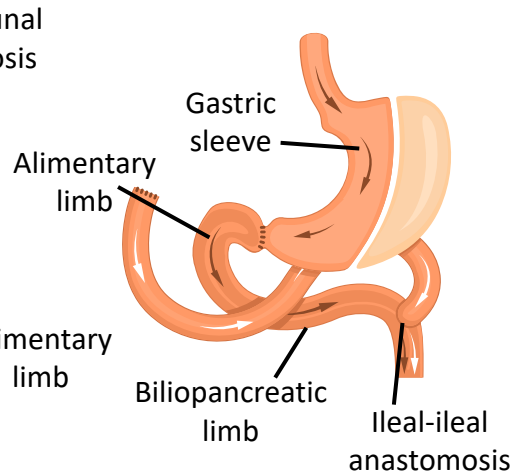
21.1%

Roux-en-Y Gastric Bypass



24.5%

Biliopancreatic Diversion With Duodenal Switch



33.82%

Abboud. Front Endocrinol (Lausanne). 2022;13:946870. Courcoulas. JAMA Surg. 2015;150:931.
Mingrone. NEJM. 2012;366:1577. Schauer. NEJM. 2014;370:2002.

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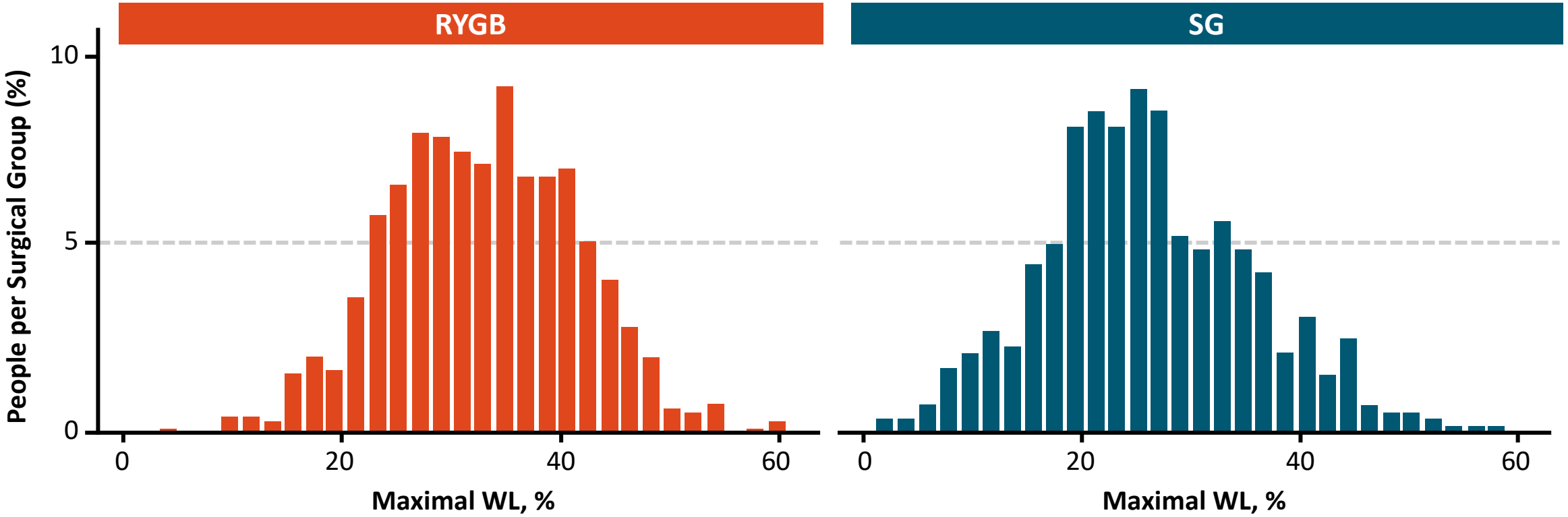
Weight Loss Is Highly Variable After Surgery



Manning. Surg Endosc. 2015;29:1484.

Slide credit: **clinicaleducationalliance**.com:
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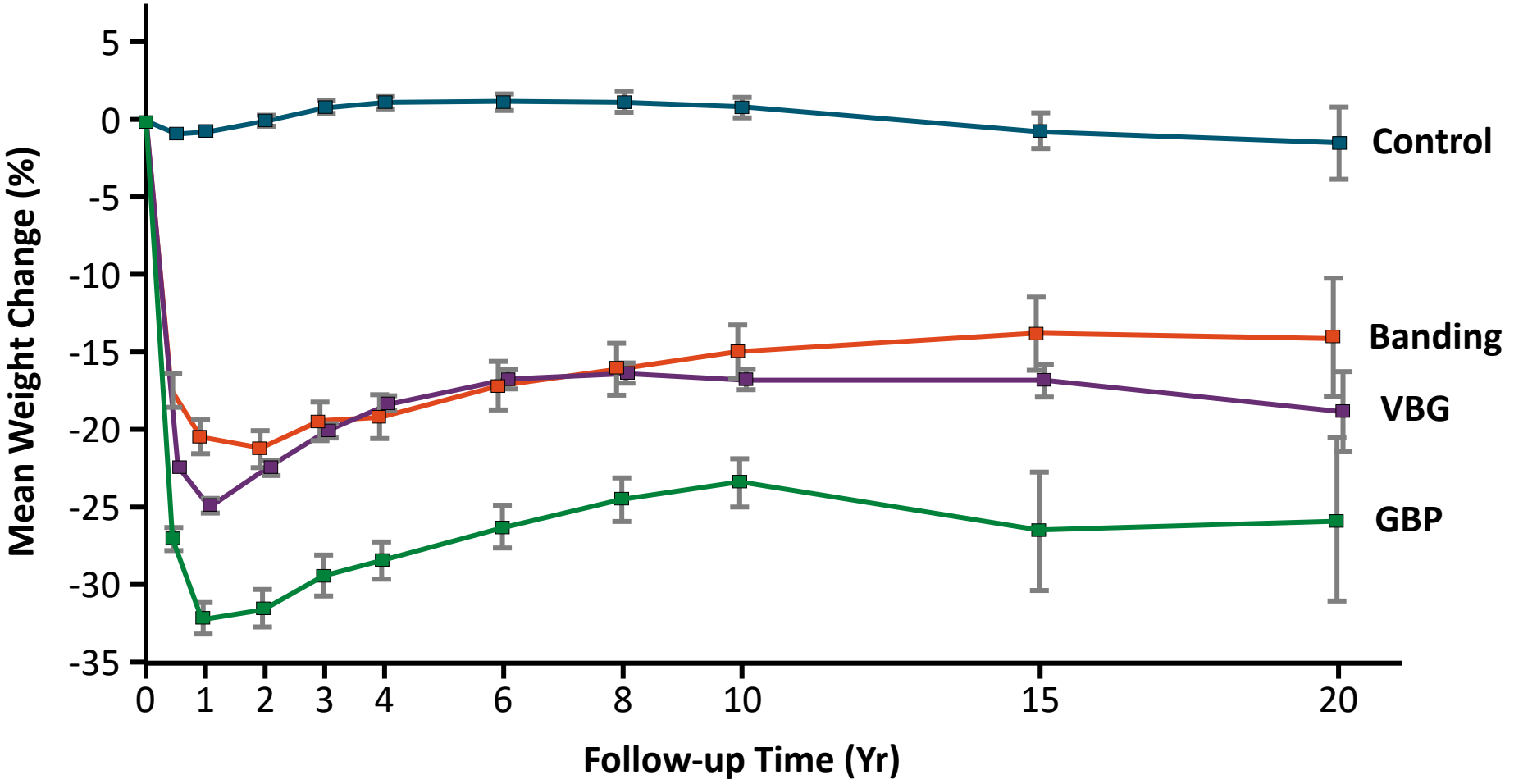
Post-Bariatric Weight Recurrence Is Expected



Sjöström. JAMA. 2012;307:56.

Slide credit: **clinicaleducationalliance**.com:
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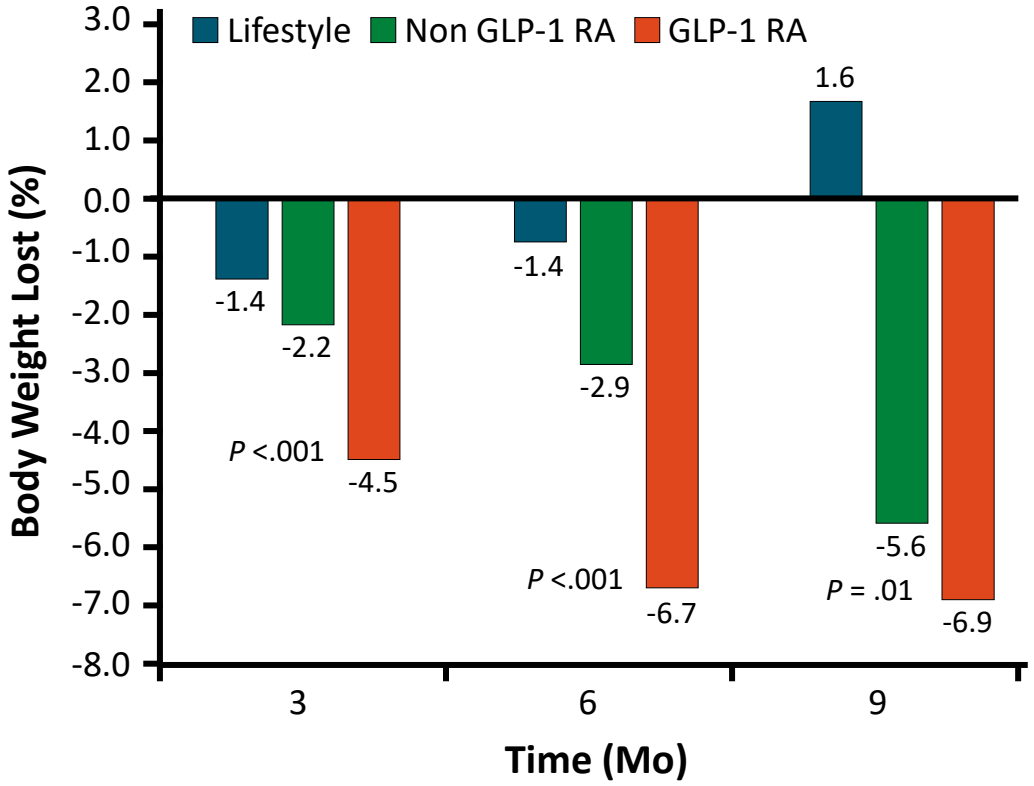
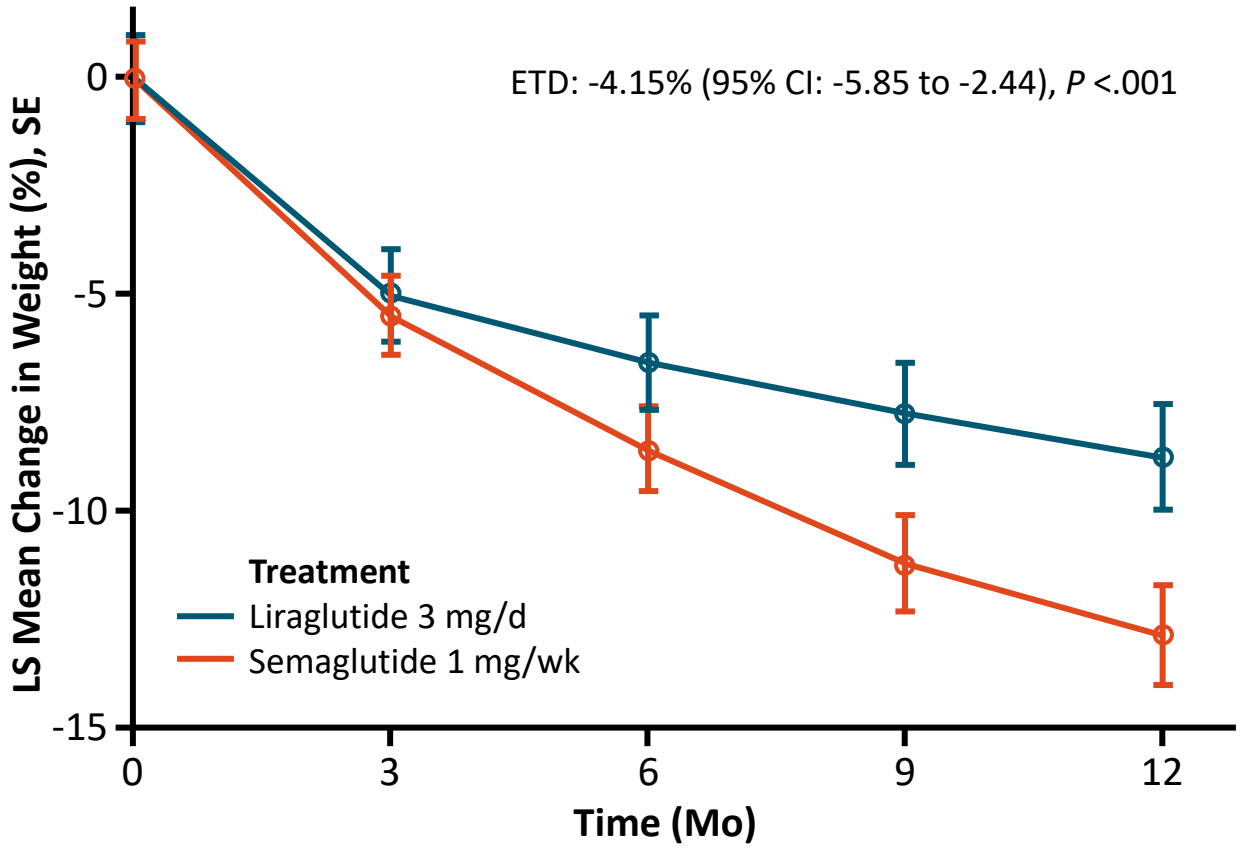
Anti-obesity Medications Support Long-Term Weight Loss After Surgery

GLP-1 RA–based Therapies More Effective for Long-term Weight Loss Following Bariatric Surgery[1]



Change in Weight After Treatment Post-Bariatric Surgery[2]



1. Gazda. Obesity. 2021;29:829. 2. Murvelashvili. Obesity. 2023;31:1280.

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Summary

- Obesity is a growing epidemic in the United States
- Obesity is a chronic disease and should be treated as such
- Even modest weight loss of 5% to 10% is beneficial in improving health outcomes
- Shared decision-making and other counseling strategies can help HCPs more effectively address weight management with their patients
- Anti-obesity medications are effective tools in helping patients achieve significant weight loss

Assessment 1: A 40-yr-old man is seen in your clinic for routine follow-up. His current BMI is 40 kg/m^2, and he reports difficulty losing weight despite lifestyle changes over the last 3 mo, including diet and exercise. Which of the following would be the best approach for weight management in this patient?

A. Explain that obesity is a choice and can be overcome with discipline

B. Explain that obesity is a chronic disease and discuss options for weight loss

C. Explain that weight loss is based on decreasing calories and increasing energy expenditure

D. Recommend the patient continue to work on lifestyle changes and follow up in 3 mo

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D. Recommend the patient continue to work on lifestyle changes and follow up in 3 mo

RATIONALE

Although diet and exercise are important to weight loss, decreasing calories and increasing energy expenditure are only 2 components of weight management. A and C are not correct because they oversimplify the pathophysiology behind weight gain and fail to provide actionable recommendations for the patient. B is correct because obesity is a chronic disease, and patients with overweight or obesity should be offered treatment options if they qualify. D is not correct because the patient has already initiated lifestyle changes over a 3-month period and has not been successful.

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Assessment 2: A 38-yr-old woman with a BMI of 40 kg/m^2 and coexisting hypertension requests a medication to help her lose weight. Based on clinical trial data, which of the following agents is likely to be most effective for this patient?

A. Hydrogel

B. Naltrexone/bupropion SR

C. Orlistat

D. Semaglutide SC

Slide credit: **clinicaleducationalliance**.com:
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D. Semaglutide SC

RATIONALE

There currently are no head-to-head trials comparing the effectiveness of all antiobesity agents. Placebo-controlled trials cannot be directly compared, but based on estimated results derived from these trials, semaglutide 2.4 mg weekly appears to be the most effective of these agents, with up to 16.9% of body weight lost in trial participants. This is more than twice as effective as hydrogel (6.4%) and naltrexone/bupropion SR (6.1%) and nearly twice as effective as orlistat (9.6%). D is correct. In addition, naltrexone/bupropion SR can cause elevated blood pressure, making it less preferred for patients with existing hypertension.

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Assessment 3: A 47-yr-old woman with obesity presents with difficulty losing weight. Her medical history includes hypertension, and her current weight is 215 lb, with a BMI of 34.7 kg/m^2. She has lost 10 lb since initiating lifestyle changes, including following a Mediterranean diet and exercising regularly, but her weight has plateaued over the past 3 mo. Which of the following would be the most appropriate option for this patient at this time?

A. Recommend increasing exercise to 7 days per wk

B. Recommend no changes because weight loss has been successful

C. Refer for bariatric surgery

D. Use shared decision-making strategies to discuss pharmacotherapy for weight loss

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RATIONALE

Because this person's BMI is ≥30 kg/m^2, she qualifies for weight loss pharmacotherapy. The current recommendations for exercise in adults are 150 minutes per week and at least 2 days per week of muscle-strengthening activities. She may benefit from adding strengthening exercises if they are not already incorporated into her routine but increasing exercise to 7 days per week likely is not sustainable for most patients and may lead to injury. She has successfully lost weight with her current lifestyle changes, but because her weight has plateaued over the past 3 months, she likely will need additional intervention to maintain and continue her weight loss. She does not qualify for bariatric surgery because her BMI is below 35 kg/m^2.

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Question and Answer Session

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