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ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

Breaking the Cycle: Prioritizing Weight Loss to Improve OSA Management

Announcer:
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Dr. Mokhlesi:
Again, we know obesity is ideologically complex, and there are many factors that affect it. You know, physiologic, of course, behavioral, there’s a genetic component, with epigenetics gaining more and more momentum, and, of course, important environmental factors. And many times, many of us have seen this in clinical practice, you know, the stigma about using anti-obesity agents in a variety of forms. I think there are so many different types of biases, the biases that start from us as physicians and providers, the biases that patients come in with after years of exposure to, you know, problems related to their weight management. So this is a complex issue, and the question is, how do we work with our patients to not augment the stigma, but encourage them to engage in weight loss strategies.

The interconnection between obesity and OSA, again, is, you know, I think they go hand in hand of course—I don’t need to convince this audience of that. Amongst people who have OSA, you know, 50% or more have a combination of both. So risk factors—again, we all know that aging is an important risk factor for developing OSA. Weight gain, of course, is an important risk factor. There are racial and ethnicity factors, postmenopausal status, and family history. These are all important in development of OSA.

But again, if you look at those individuals with obesity, particularly as you start looking at older cohorts, the prevalence of OSA is extremely high. I always put in the caveat that, you know, if you look at studies where fairly young women undergo evaluation for bariatric surgery, surprisingly, the prevalence of OSA tends to be on the lower side because they’re premenopausal and they have age going for them. But as they go through menopause and aging, the prevalence of OSA really catches up in women compared to men.

And again, we know about the anatomic factors as it relates to OSA and other pathophysiologic factors in terms of endotypes. But again, here you have a list of several anatomic factors, and you can see that if you’re born genetically with a relatively smaller airway, and you’re genetically predisposed to, you know, depositing fat more centrally, like we call apple shape versus pear shape, you can see how the upper airway can become crowded, where there is no space for the tongue to go, and it starts rolling back, obstructing your airway.

Similarly, one of the concerns with OSA is as it disrupts people’s sleep, that sleep disruption, and perhaps even sleep restriction, can create a neurohormonal environment which favors, you know, increase in appetite and reduction in satiety, particularly increase in appetite for food categories that are not as healthy and tend to be high caloric density and salty—all the good stuff, I guess.

So here is a relationship—this slide is trying to show the relationship between weight loss, change in weight in percentage versus change in the apnea hypopnea index. And of course, as you look at this, the bigger the degree of weight loss, the bigger is a reduction in AHI. With that said, there’s a lot of variability from patient to patient, but studies have shown that weight loss of even, you know, 5 to 10%, which many lifestyle modification trials have been able to demonstrate, that by itself can lead to some degree of improvement in OSA. But in addition to improvement in OSA, can also have a significant cardiometabolic impact. Of course, the greater the weight loss,

when you get to the categories of 10, 15, and 20%, the reduction in OSA severity becomes much more pronounced.

And here are two examples, the Sleep AHEAD study, which was more of a lifestyle intervention. You can see that the weight loss achieved was approximately 10%, and it led to OSA remission in close to 14% of patients compared to the group that was randomized to support and education as opposed to intensive lifestyle intervention. And bariatric surgery, you know, when patients can lose more than 30% of their body weight, the remission in OSA can be much more pronounced.

So the behavioral factors in obesity, and I will say, does create a feedback loop. If you think about it—and I talked about this a little bit—you know, laboratory studies and some epidemiologic studies suggest that when you restrict people's sleep, you create an environment where it leads to increase in appetite and reduction in satiety. So OSA, by itself, can also lead to some degree of maybe not necessarily sleep restriction, but sleep disruption. And that, I think, in itself, can also create problems with appetite control in terms of irritability, impact on mood swings, and that can also increase level of stress in some people. And that, by itself, can feed into this eating behavior, potentially, and becoming a vicious cycle.

And here, there's a slide summarizing how OSA could potentially lead to cardiometabolic disruption, combination of OSA, sleep restriction, you know, increase in appetite and decrease in satiety, all of those ultimately leading to beta cell dysfunction, insulin resistance, and creating this kind of loop—positive loop, I should say—in terms of hypertension, risk of type 2 diabetes, and whatnot.

So the approaches to weight loss for these patients, of course, you know, lifestyle modification is critical. Easier said than done, but, you know, in terms of what the patient can achieve in terms of their socioeconomic conditions, where they live, what they have access to. But again, these are critically important portions of management of these patients, as opposed to just pharmacotherapy alone. It has to be a multimodal approach.

You know, we're lucky that we are practicing now in an era that there are increasingly more and more medications that can help our patients lose weight effectively, particularly incretin-based therapies. And of course, bariatric surgery, in my opinion, remains a very important modality that many of our patients will ultimately benefit from.

So, you know, when you listen to your patients, you can see here in these quotes from a variety of patients, many of them are similar to what I hear from my patients, challenges that they face, frustrations that they have. And I think what we're hoping to do today is to discuss some of those with you when we do our group discussions.

Now, weight regain is also a major problem. You know, as many of us here have gone through periods where we try to implement lifestyle changes and eating and dieting, and, you know, do the yo-yo dieting, so to speak. You know, as you start losing weight, your metabolic rate goes down. And patients tell you this, that 'I eat less, but I'm no longer losing weight.' Hunger goes up, satiety gets worse, and it just creates a bad cycle. And this is one of the problems that many of our patients run into when it comes to weight loss maintenance. Of course, it's quite frustrating for them.

So, and when you look at the ATS guidelines, the good news—well, these guidelines that came out by the ATS several years ago was before the incretin-based therapies. And I think, as far as I know, ATS is currently working on updating these guidelines, actively they're working on this. But again, we do need updated guidelines from our societies—and I know other societies are working on them as well so that it can guide us as clinicians on, you know, best approaches and best practices to dealing with these problems that our patients have, because it is a chronic condition and has to be treated as such.

So let's do a question here. A 36-year-old man with obesity presents with complaints of daytime sleepiness, difficulty concentrating in work, loud snoring at night. BMI 43. Sleep study confirms diagnosis of OSA. How comfortable are you with educating this patient about the pathophysiologic connection between obesity and OSA? Again, this is like your post-test, right? We talked about this. Hopefully you're feeling a little bit more comfortable. But not comfortable, somewhat not comfortable, neutral, somewhat comfortable, and very comfortable.

All right, I'll stop there, and I'll let Dr. Breaden take it over.

Dr. Breaden:
All right, thank you. So with that, let's go to section 2, patient-centered conversations, building trust and supporting sustainable change for our patients. So poll 3, who do you think should be in charge of long-term obesity management for patients with OSA? The endocrinologist, obesity specialist, primary care provider, pulmonologist, or sleep specialist? Very interesting. All right, with that, let's listen to a patient perspective from Bill. I think we're getting some audio issues here.

Dr. Mokhlesi:
Practice this part to make sure the video comes on.

Bill:
That was it. I never saw a sleep doctor. I didn't really talk to my primary care physician much after that about my sleep apnea, except he confirmed that I had it. And I came home with the machine and with the knowledge that I had sleep apnea. Whatever I knew about sleep apnea, I learned on my own by just going on the internet and searching. I discovered there that some people believed that sleep apnea was caused primarily by being overweight, which I was overweight, not morbidly so, but overweight, and that you might be able to cure it by losing weight. But no one ever told me that. I didn't, you know, talk to a doctor, whether it was a sleep doctor or any other kind of doctor, who ever made a point of letting me know what caused sleep apnea or how I might prevent it or make it better. Just here's the machine, use the machine, and that's what you've got to do for the rest of your life.

It was only recently, about, well, 4 years ago, I was diagnosed with multiple myeloma, and I started taking my sleep apnea quite a bit more seriously, because I decided that if I was going to die of something, I didn't want to die of something that I could prevent. And so I started wearing my mask every night and trying to be much more careful about my sleep apnea, because I knew from my studies that it was a serious condition, and that, you know, in fact, it could have serious consequences if I didn't use my CPAP. So I started using it more.

But I really wish that through all of this that someone had told me more about the role of weight and sleep apnea. I wish that they would have challenged me, perhaps, to lose weight. I feel like sometimes physicians these days are afraid of offending their patients, and so even when I would say, you know, 'I know I'm fat,' or make a joke about being fat, the doctors would usually just kind of play it off. 'Oh, you're fine. It's no trouble. You know, don't worry about it.' I wish that they would have said, 'Yeah, you are. You could just lose some weight, and that would have a dramatic impact on your health.' I wish that I had been given more information, you know, not just given a machine and told how it works, but actually given information about sleep apnea and about the consequences of not treating it. But I didn't have that. I had to learn all that on my own.

So my experience has been kind of negative in general, because I didn't get much information. But overall, I'm still alive, and thankfully, I've learned enough to take my illness or my condition much more seriously these days.

Dr. Breaden:
So let's talk a little bit about those experiences. Is that how we talk to patients about sleep and about weight? Do we say, you know, just lose weight, or do we just avoid the topic? I think, as we all know, talking about weight is a pretty sensitive topic, and many providers do try to avoid it. So we need to really talk about how we can set that up for success.

One of the things we really need to do is to lay that groundwork across visits, and especially in sleep medicine or in pulmonology, it may be difficult, you know, because we do have limited time and we do have limited visits with the patients. But we really do need to build that rapport and trust with our patients and assess their readiness to talk about sleep and weight with relationship to that.

One of the biggest things that I always do with all of my patients when I talk about weight is I really ask them, may we talk about weight? And that is the thing that I always ask every time before I broach that topic. And I find that that really sets the tone for the visit, and it sets the tone for whether the patient is ready to talk about weight and whether they are ready to talk about weight today. And that helps me see their readiness to see if they are contemplating a change at this time.

And then the second question I ask is, can you tell me a little bit about your weight over time? And patients who are ready to talk about their weight will then be very open to telling you their weight history. They'll tell you about whether they were an athlete in high school and that they have gained their weight because they had an injury and became more sedentary. They'll tell you about the weight gain that they had after the death of their spouse. They'll tell you about weight gain that they had after depression that they experienced after a job loss. They'll be able to tell you about yo-yo dieting, or whether they've been having obesity issues since they were a child. But they will tell you everything about their weight if you ask them in a respectful way and you listen actively to their concerns and then clarify their goals and help them set realistic expectations for their weight management.

One of the things we do when we do this is to really use neutral, nonjudgmental language, as Dr. Mokhlesi was saying, you know, we really need to understand obesity is a chronic disease, as opposed to some of the paradigms we've had around weight as, you know, kind of an issue around a person's being able to control themselves or anything of that sort. So we really have to be very nonjudgmental in our speech with them, and then we really meet patients where they are.

So many patients are aware of motivational interviewing, Grolnick and Miller, and this is often used in smoking cessation. It is also often used with any health behavior change, and this is very valid to use within weight management as well.

So as we talk to our patients, we want to express empathy. We want to roll with any resistance, really avoid any confrontation, and develop a discrepancy between what the patient is doing right now and their current behaviors and their long-term goals, and then

support their self-efficacy, reinforce their confidence as they're looking at their behavior changes.

Again, interrogate your own assumptions. This is what I was saying before. So don't assume that there's a lack of willpower there. Make sure that you're not focusing just on weight. Make sure that you're focusing on their overall health and their health goals. As with Bill, he was focusing on his overall health as well. And then consider those biological, psychological, social factors that are going on in a patient's life.

So approach each patient with curiosity, not with judgment around them. You know, patients who come in thinking that you're going to say, 'You should lose weight,' are the patients that are not going to take that very well. And just really understand their own context and values and challenges.

Many providers find that the 5A model of weight loss is very helpful in remembering what to do: ask, advise, assess, assist, and arrange. This is all, as Dr. Mokhlesi mentioned, available on the slides that you have available to look at in detail. But basically ,assessing the patient's readiness for change, providing clear, nonjudgmental recommendations, setting collaborative goals, and then offering those resources and support, and then scheduling those follow-ups. So making sure that you do all of those things. But we do these things all the time without labeling those 5As.

As we set goals with patients, we really try to avoid looking at the number on the scale but looking at behavior changes that are sustainable for patients. So a patient who may not be active, coming up with a behavior change that says they're going to be more active 3 days a week, or a patient who may not be eating fruits and vegetables, saying, 'I'm going to integrate, you know, 2 fruits and vegetables every day.' Things like that. So coming up with those type of goals are going to be more effective overall and lead to success for patients that are going to be sustainable, as opposed to just coming up with numerical weight loss goals.

And then really celebrate non-scale victories with patients. When patients are able to do things that they weren't able to do before, when they feel better, those are things really to celebrate with patients as you help them with weight management.

So key takeaways as you are supporting your patients in weight management, really build that trust with your patient as you have these discussions, focus on overall health, not weight, use evidence-based strategies like motivational interviewing, the 5A model, and then really help patients identify those achievable goals that really align with their values and their readiness for change.

And with that, we will go to shifting tides, pharmacotherapy with Dr. Sepulveda.

Dr. Sepulveda:
Thank you so much. All right, so I get the fun part. So let's talk about pharmacotherapy and OSA management. So how do we get to an incretin-based therapy? So the SCALE OSA trial was the first trial done for an incretin-based therapy with liraglutide. This trial did a 32-week randomized trial with 359 patients, where they placed patients on liraglutide plus lifestyle modifications and had a control group, a placebo group, with just lifestyle modifications alone.

Now, what this resulted in was a reduction of AHI. Even though it was modest, it was around 6.1 events per hour in comparison to placebo, but it gave us the idea that this potentially could be a therapy to help patients improve OSA. There was a higher percentage of weight loss in the liraglutide group, and cardiometabolic changes in the A1c and systolic blood pressure also were significantly lower in the liraglutide group.

Now, that takes us down to the SURMOUNT-OSA trial, which was tirzepatide versus a placebo group. So in this one, we actually saw a 52-weeks total body weight loss of around 18.1% and a decrease in AHI of around 27.4, averaging around 25.3 in most subjects. Now, this led to the FDA approval, since the baseline severity of AHI in those patients was around 51.5. So this exceeded that 50% mark that the FDA requires for approval of a medication.

Now, how do we compare tirzepatide with semaglutide? So basically, as you can see in the graph, the orange is the semaglutide, the blue is tirzepatide. You can see that at 52 weeks, they're pretty much causing around 15% for semaglutide, around 17 to 18% for tirzepatide. But prolonged use of both, in terms of semaglutide, the average total body weight loss is around 15.4, which kind of stays a little bit still around that total body weight loss, in comparison to tirzepatide, that has 2 to 3% more total body weight loss from that 52-week trial.

Now, how do we compare tirzepatide and semaglutide in terms of weight reduction and waist circumference? So as you can see in the change in waist circumference, you can see a bigger decrease in centimeters of waist circumference in the tirzepatide group, and a higher group of patients that have more than 15, 20, and 25% weight loss with tirzepatide in comparison to semaglutide.

Now, titration schedules with semaglutide and tirzepatide for chronic weight management. So semaglutide, it starts at a dose of 0.25. It's a weekly injection and is usually escalated monthly, obviously increasing as tolerated until the optimal dose of 2.4. In terms of

tirzepatide, the titration starts at 2.5 mg, weekly injections with increases as tolerated monthly, up to a maximal dose of 15 mg. However, we have to think that beginning this therapy, the main important thing is to titrate slowly and based on the individual's tolerance, because we want sustained and long-lasting care for their weight management. So we're not focusing on achieving the highest dose, but the most functional dose.

Practical considerations in terms of administration and dosing. So as I mentioned, weekly injections with tirzepatide, titrate slow and based mostly on tolerance, educate patients on the duration of treatment. Most of these patients are going to be using this medication long term, so they need to understand that this is a lifestyle change as well.

In terms of safety, the main adverse effects that we encounter with these medications is gastrointestinal effects that are usually mild in most patients and can be mitigated. So nausea, vomiting, diarrhea, and constipation. A lot of that is triggered by a slowing in the gastric emptying with the medication.

So how do we mitigate that? So usually trying to do titration slower than what the regular titration schedule is, modifying their intake of nutrients, and in some cases that are more severe, we can use anti-nausea medications. All through this process of weight loss, we should also, besides monitoring the weight, be should be monitoring A1c, lipids, liver and renal function, as well as their mental health, and adjust the doses of any kind of medications as we lose the weight.

All right, nutritional considerations. So we have to think that most adults in the US do not meet the healthy diet recommendations. As Dr. Mokhlesi mentioned, for women, it's around 1200 to 1500 calories per day. For men, it's around 1500 to 1800 kilocalories per day. And when we're on an incretin-based therapy, we're looking in terms of macronutrient recommendations to prioritize higher protein intake of at least a little bit over 1.5 g/kg/day, and also increasing fiber intake.

Very, very important as well to consider ingestion of fluids, water of 2 to 3 L per day. Avoiding any kind of sugar-sweetened beverages, caffeine, and alcohol is extremely important because since we are blocking hunger, we are also blocking thirst. So a lot of patients can potentially have some renal problems because of dehydration. And also adding a multivitamin has been associated with reducing risk for deficiencies. So supplementation should be encouraged, especially during a low-calorie diet.

So how do we do individualize treatment? So as Dr. Breaden mentioned, discuss preferences, goals, and values, consider any kind of comorbid conditions and psychological factors in patients, and educate on the expectations with the use of this therapy and enforce that long-term commitment might be needed.

All right, so let's go to post-test number 2. How confident are you with initiating and managing pharmacotherapy for the management of obesity in your patients with obstructive sleep apnea? A, not confident. B, somewhat not confident. C, neutral. D, somewhat confident. E, confident.

All right, very good.

All right, so let's go to post-test number 3. A 49-year-old woman with a BMI of 41 and an AHI of 33 on CPAP presents to your clinic. She has prediabetes, controlled hypertension, and no history of cardiovascular disease. She's highly motivated to lose weight to improve her OSA. Based on the SURMOUNT trial, which of the following statements best describes the goal of tirzepatide in this patient's care? A, it can improve OSA but may cause blood pressure to increase, limiting its use in patients with hypertension. B, it is only effective for treatment of OSA in patients who also have type 2 diabetes. C, it can decrease her AHI primarily through weight loss and offers additional cardiometabolic benefits. And D, it will decrease her BMI by up to 20% and increase her AHI by up to 15%.

All right, very good. All right, so the rationale for this is the answer is C, it can decrease her AHI primarily through weight loss and offers additional cardiometabolic benefits. So the rationale is individualized treatment planning for a patient with obesity and obstructive sleep apnea should address both conditions at the same time, simultaneously, considering the latest evidence and the patient's preference. Tirzepatide has demonstrated significant efficacy in weight loss and improvement of OSA severity by reducing the AHI, and combining pharmacotherapy with ongoing lifestyle modification enhances long-term success.

All right, post-test number 4. A 55-year-old man, BMI of 37 with moderate obstructive sleep apnea, managed on CPAP, presents for follow-up. His blood pressure is well controlled with medications. He has been adherent to CPAP but remains fatigued and is frustrated with minimal weight loss. He asks what additional steps could help his OSA and improve his energy level. Which of the following strategies best address his long-term obesity management as part of his obesity OSA care? A, continue CPAP and add lifestyle interventions to improve weight loss. B, use a short course of phentermine to accelerate initial weight loss and then taper after 12 weeks. C, focus on CPAP adherence, weight loss medication should be reserved until OSA improves. D, initiate an incretin-based therapy to promote sustained weight loss and improve OSA severity.

All right, very good. All right, so the answer is D, initiate an incretin-based therapy to promote sustained weight loss and improve OSA

severity.

In patients with BMI higher than 30 or more than 27 with a comorbidity who fail to achieve sufficient weight loss through lifestyle modification, pharmacotherapy with anti-obesity medication is highly recommended. GLP-1 receptor agonists and dual GIP/GLP-1 agonists produce clinically significant sustained weight loss to improve cardiometabolic outcomes. Short-duration sympathomimetics produce a transient weight loss but lack evidence in terms of OSA improvement. Long-term agents with cardiometabolic benefits are preferred, and weight loss should be pursued concurrently with CPAP, not sequentially. Early integration of obesity treatment enhances OSA remission rates and reduces CPAP dependence.

All right, so poll number 4. What is your biggest barrier to using pharmacotherapy for managing obesity in your patients with OSA? If you can just type your response in your tablet.

All right, so we're going to go to section 4. This is the small group case discussions. So we're going to read the case. There's going to be two different cases. We're going to split the room, in the left side of the auditorium and then the right side for both cases. So read the case with your table and write down your answers, discuss your answers between each other, and we will have our faculty go around if you have any questions. And I'll be with the virtual attendees going through the cases.

Gastrectomy 10 years ago for weight loss. He initially achieved significant… Oh, it's this lower—okay. So yes, initially achieved significant weight loss but had experience with regain over the past—check, check, check 1, 2. Nothing, nothing.

So is there another student. Yes, he's getting—all right.

So case number 1, Mr. Anderson, so he has a diagnosis of moderate obstructive sleep apnea—had moderate obstructive sleep apnea with a BMI higher than 30. He already had undergone a procedure, a sleeve gastrectomy for weight loss, which, you know, is not a real contraindication to using any alternative therapy for weight loss. He is basically using his CPAP, so he is dissatisfied with it, but he's continuing to use therapy and he would like an alternative treatment. So basically, he's looking for a treatment that will help support his OSA. So in general, he would have a good outcome in terms of his OSA treatment if we would consider, you know, weight loss as well.

Now, in case 2, Ms. Smith, so she's 57 and presents with newly diagnosed moderate obstructive sleep apnea diagnosis with AHI of 23, so moderate, and her BMI is 41. She's currently using her CPAP and, you know, tolerating it well. During today's visit, Ms. Smith says that she feels tired much of the time and is having trouble babysitting her grandchildren. Ms. Smith also cares for her husband, who has heart disease and needs help with managing his medications and medical appointments. So in this case, the main thing is we have a patient with moderate obstructive sleep apnea, a BMI of 41, she's already tolerating what we could consider mechanical therapy for obstructive sleep apnea. The main challenge for this patient is functionality. So she's tired, she has to do different types of labor during the day, and you know, babysit her grandchildren, as well as taking care of her husband. So in terms of commitment, we have to think about how much adherence would be in this patient. But at a BMI higher than 30, you know, considering weight loss should be improving her outcome overall with the CPAP.

All right, we will resume the case discussion soon.

Let's wrap up the case discussions so we can discuss a little bit up here for Breaden. So we've got some interesting questions to go over hopefully.

Dr. Breaden:
Hopefully this was the number one discussion, so we had to talk about insurance.

Dr. Sepulveda:
All right. So any feedback from the different cases? Do we want to go over it really quickly?

Dr. Mokhlesi:
Let's do it. I don't know if they've sent you questions or not yet.

Dr. Breaden:
Yeah.

Dr. Sepulveda:
All right. So let's go over a few of the questions from the group.

So does tirzepatide have the same contraindications as semaglutide? Personal or family history of medullary carcinoma of the thyroid? So I can take over this one. So yes, the contraindications for tirzepatide are basically almost the same one as semaglutide. So basically, a history or family history of medullary cancer of the thyroid, also pregnancy, pediatrics, severe gastroparesis. Keep in mind that in our

case, for example, a sleeve gastrectomy or bariatric surgery is not a contraindication to use tirzepatide in patients, and also severe anaphylaxis to the medication. Those are basically kind of the main ones.

Dr. Mokhlesi:
And what's your thought on personal history of pancreatitis, for example, if they have pancreatitis?

Dr. Sepulveda:
Yeah, so I personally haven't seen it, and I've been using this medication for a while now with patients. But gallstones and pancreatitis is something that is also mentioned in the literature as well.

So why are there insurances that won't cover incretin therapy? And what lobbying or education is being provided to make that illegal as it withholds FDA-approved therapy for patients in a discriminatory manner?

Dr. Breaden:
Wow.

Dr. Mokhlesi:
That's a thought. Well, just because something is FDA-approved doesn't mean insurance has to cover it. And that's a common theme with many of the medications, unfortunately, for better or for worse. So my hope is that over time, more insurances will come on board. The FDA approval happened in late December 2024, so my hope is as time goes by, more and more insurances will come on board, but maybe that's wishful thinking.

Dr. Breaden:
Right. Well I think it's—I hate to say, but it's a little bit of an arms race when it comes to the insurance companies so I'm always trying to find strategies that will get things approved. The thing that I found to be the most successful is a letter of medical necessity that I have a template of that summarizes the SURMOUNT-OSA data that says very clearly in very bold letters that this is being used for obstructive sleep apnea, it is not being used for weight loss, and that any denial based on weight loss would therefore be incorrect. And I just make that very clear in the first paragraph. And then I have kind of blanks where I put in the patient's medical history where I put in the AHI, their BMI, and all of the other things that support that it is consistent with SURMOUNT-OSA. And I have found this to be a bit more successful than just sending the chart notes because at least this seems to get past maybe a little more of that immediate letter that says we don't cover this for weight loss. So I have found that to be a little bit more successful, you know, in fighting that fight.

Dr. Sepulveda:
One last question. So there's a question about how to—well when the patient loses the weight that they're comfortable with, how do we manage that portion once they have already lost the weight? Do we keep them on the medication? Do we decrease the medication dosage? Or do we change to any kind of oral anti-obesity medications? How would you approach that?

Dr. Breaden:
I mean, we would expect this to be a lifelong medication, and so we usually reduce the medication dose to a dose at which they're maintaining. And, you know, that varies significantly from person to person but, you know, most of the patients that I have to maintenance are at, you know, 2.5 or 5 or something of that sort, you know, and that's what they're going to be on lifelong.

Dr. Sepulveda:
So in my experience, the main thing is I look for a constant weight loss of 0.5 to 2 pounds a week in a steady manner. Now, if they're, for example, let's say, on a 10-mg dose and I notice that they start going on their way then I start kind of titrating down the dose as long as they're able to maintain their healthy body weight. And in some cases, you can consider depending on tolerance or financial matters as well, you know, consider oral medications as well but that's a discussion to have with the patient and see what their goals are. Most patients in practice actually stay on the medication even at a lower dose but long term it provides a better outcome.

One last question is how frequently do you monitor labs?

Dr. Breaden:
So there are no strict recommendations on labs but I always get baseline labs. I always get baseline, you know, CBC, lipids, hemoglobin A1c, complete metabolic panel. And then I usually monitor at least a limited number of those quarterly. And then, you know, depending on if they're on maintenance, I might do that semiannually just, you know, in the beginning especially if I'm titrating more aggressively I make sure that they get them quarterly.

Dr. Sepulveda:
Yeah. Yeah. One question that I always get as well is when do you retest for obstructive sleep apnea? So labs I do it twice a year. Some of the time that's taken over by the primary care in my community. But if we don't have labs every 6 months, I try to get, you

know, A1c, CMP, and lipid panel as well. Very rarely get special vitamins unless they have bariatric surgery.

In terms of sleep testing, usually either when they have lost at least 10 to 15% of their total body weight you can consider retesting again for severity. Most of the time patients want to get to their weight that they feel healthy at before they repeat their study. Especially the ones that want to repeat testing more often are the ones that are not comfortable with their CPAP for example or their other sleep treatment but basically every 10 to 15% you can kind of try to retest with a sleep study.

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