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Case Challenge in Obesity Medical Management

**Announcer:**
Welcome to CME on ReachMD. This activity, titled “Case Challenge in Obesity Medical Management,” is provided by Prova Education.

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**Dr. Vega:**
There are a number of barriers when treating and managing patients who have overweight or obesity. Effective strategies are necessary to provide long-lasting and positive outcomes. So how do we approach the issue of weight loss among patients? And who is considered at high risk for chronic obesity?

This is CME on ReachMD. And I'm Chuck Vega, MD.

**Dr. Ryan:**
And I'm Donna Ryan, MD.

**Dr. Vega:**
Welcome, Donna. Maybe you can start by giving us a case and explain what factors might put a patient at risk for high risk of chronic obesity.

**Dr. Ryan:**
Okay, I'd like to tell you about Annette. She's 42 years old. She's a home-based computer programmer. She's single. She has a history of hypertension, and let's say she's coming in for an annual medical visit. Her blood pressure is 130/80, okay. Her pulse is 75. Her weight is 202. Her BMI [body mass index] is 33.6. This is class I obesity. On physical exam she has acanthosis nigricans on her neck and arms. This is a sign of insulin resistance, and she has truncal obesity. On review of systems, she complains of daytime somnolence and of fatigue during the day. She's taking valsartan/hydrochlorothiazide 160/12.5 for her hypertension. And she's on omeprazole for GERD [gastroesophageal reflux disease]. Her chem survey is normal, including liver function tests, except her A1c is 6%. That's in the prediabetes range. Normal is less than 5.7%. Her lipid profile shows an HDL cholesterol of 45. That's right at the borderline. We don't want it to be lower than that. Her LDL is 90; her triglycerides are 175. We'd like them to be 150 or less.

So what I'm thinking about when I see this patient is that she has metabolic syndrome. And that is manifest by the dysglycemia, by the dyslipidemia, that high triglyceride, the low HDL, by evidence of increased waist circumference. We don't know what her waist circumference is, but she probably has an elevated one because of that truncal obesity. And so all of that put together is metabolic syndrome, which puts her at increased risk for developing diabetes and also for developing a cardiovascular disease. So it's a high-risk state that she's in. She also has other evidence of clinical obesity. She's got GERD and perhaps she even has obstructive sleep apnea. I sure am glad those liver function tests were normal. There's no evidence she had a fatty liver or NASH [nonalcoholic steatohepatitis].

So when I approach this patient, I say something like, “Oh, it's really good to see you. How have you been?” And she says, “I'm busy, and that's good. My blood pressure has been good. You know, I monitor it at home, and I feel fine.” So there's a discrepancy here. I'm worried about her health, but she's not. How do I sort of raise this as a subject for conversation with this patient? It's a real sensitive

topic; the last thing I want to do is lead with weight. I'm going to talk about her health. When patients hear that weight discussion, they believe you're judging them by how they look. So it's very important to express our concerns in terms of health. So I say, “I'm concerned about your health. Let's talk about some of your blood test findings. Your A1c is not normal. It's in the prediabetes range. And your other tests show what we call metabolic syndrome. So the very best thing we could do is to make some changes in your lifestyle that could improve your health.” Now, this is where I enter into the weight discussion. But we really need to be careful with our language. I don't ever use the term “obese.” In fact, I pretty much scrub that from my language. Patients have a disease, it's obesity, but most of the time I'm talking about their weight. I'm not talking about “fat.” Patients don't like those terms. So the most important thing in helping patients with weight management is to keep them coming back. And the last thing you want to do is drive patients away.

So with this patient, I need a lot more information. I need to know what her current diet is, what she's currently doing for physical activity, what's her weight history, what's driven her weight up in the past? What's worked in the past to help her lose weight? What's her level of motivation? Does she have confidence that she could succeed with weight loss right now? And what are her beliefs about diet, about sleep and stress? What are her beliefs about medications for weight loss? So it's a really long conversation that we need to be having.

The way I usually manage this is to schedule a visit just around exploring those things.

You know, I think most of the time, Chuck, when physicians would see this patient, they were prescribed metformin and advocate for lifestyle—a healthy diet, healthy physical activity—and they'd see the patient back in 6 months. But to me, this is a window of opportunity to really engage the patient in a more intensive weight-loss effort.

**Dr. Vega:**
Well, Donna, I very much appreciate, you know, your approach, which is really patient centered. And I see those principles and motivational interviewing there towards the end, where you're really looking forward to, you know, trying to help patients find their own motivation for weight loss, because ultimately, they're going to be the ones who need to walk down that road. We're here to help them and guide them. And so with that in mind what would you recommend? You mentioned treatment with lifestyle and metformin could be considered. Other treatments that you might consider for this patient? And how do you continue to provide that motivation for patients so they adhere to it?

**Dr. Ryan:**
Yeah, you know, Chuck, I think that we've been too complacent about metabolic syndrome and prediabetes. The prediabetes is not pre anything. Patients are at risk for cardiovascular disease. Not the same risk as if they have established diabetes, but they are at higher risk than they would be if they were euglycemic or normal glycemic.

So for me, the ideal treatment here is to engage this patient in an intensive weight-loss effort. And I would like to see this patient lose about 15%. I never talk about the percent with the patients; it's always pounds. So I would interpret that as 30 pounds. That's a goal that I would like the patient to achieve.

But to achieve that goal, it really takes an intensive effort, and the patient has to be part of that. But if we could get her to that 30 pounds weight loss, we would really move her upstream in that diabetes disease process. And we would be treating not just prediabetes; we would be treating hypertension, GERD, obstructive sleep apnea, all of the complications that are associated with excess abnormal body fat, the clinical diagnosis of obesity.

So I explain this to her and recommend that we aim for enough weight loss to normalize the A1c to improve her symptoms, her sleep apnea, and her daytime sleepiness and to improve her lipids. And I tell her, “I think 30 pounds would be a good goal.” But there are other options. I tell her that she has to be part of that decision-making process. And I say, “What's important to you?” I want patients to set their single most important outcome of a weight-loss effort. I want them to set that for themselves. So it might be that she wants to feel better about herself. And the patient has to really embrace what it is to do it. So I'm going to send her home with some homework to evaluate medications, to evaluate different diets, to evaluate different approaches. And we're going to come back and meet again to set that goal.

**Dr. Vega:**
So I agree, and that's great, you know, 15% weight loss could have a real disease, you know, even a curative effect when we think about things like prediabetes or even hypertension. 5% weight loss will help reduce blood pressure, can help reduce dysglycemia. So those are great goals, but hard to achieve with just lifestyle alone, especially with the maintenance. So I'm sure you're also thinking about medications possibly for this patient.

For those just tuning in, you're listening to CME on ReachMD. I'm Dr. Chuck Vega, and here with me today is Dr. Donna Ryan. We're discussing everything you need to know about the medical management of our patients who are overweight and obese.

Can you go into some of the process for choosing a medical treatment for obesity?

**Dr. Ryan:**
I think our best chances of achieving that 30 pounds or 15% weight loss in this patient is with a medication along with lifestyle. So the way to choose the medication is I run through, in my head, contraindications. Fortunately, this patient has none for any of the medications that are available for a chronic weight management. I think about dual benefits. I'd like not just improvement in weight; I'd like improvement in glycemia. And we do have 2 medications that are GLP-1s [glucagon-like peptide-1] that have an independent effect on glycemia. Those will be preferable to me. Cost and availability are key. The patient has to be able to afford the medication for them to be able to get it in their bodies and for it to be able to work. So this patient is going to be evaluating what her health plan will pay for. And that will define what medications are open to her.

And then also, and my last consideration, is the likelihood of achieving robust weight loss. So we know our most effective, efficacious medications in terms of weight loss right now would be semaglutide 2.4 mg. But second most efficacious, the best odds of achieving that would be with a combination of phentermine/topiramate. But really, with any of our medications, patients can achieve this amount of weight loss, and they do help patients achieve more weight loss than they would with lifestyle alone.

So in this case, I'm really drawn to semaglutide. We know that that drug has shown to produce about 15% to 17% weight loss, on average, in a little over 1 year of treatment. And we know that half of the patients achieved 15% weight loss or more. So it's pretty good odds that we'd be able to do that with it. When I would start this medication, or really any medication, I make sure that I'm starting it with a clear plan for diet and physical activity. It has to be her plan, not my plan.

**Dr. Vega:**
Those are great points. And, yeah, definitely we are living in, I think, a paradigm shift in terms of treatment of obesity with medications. So it’s a really exciting time to be in this space because this is a chronic illness. This is not something that, you know, we're going to treat for 6 months and expect to raise a banner and things are done.

So how do you involve the patient in a treatment plan that can create real, meaningful outcomes over time, over 12 months and beyond?

**Dr. Ryan:**
Oh, Chuck, you raise such a good point. You know, our patients haven’t been used to seeking support from their providers for weight-loss effort. It's been something they've managed on their own. We have to signal them that we want to help them with their weight-loss efforts, and that we are going to be with them over the long term. So, you know, developing the treatment plan and how to do that is absolutely key. The patient is part of the shared decision about what to do. They have to know what their insurer is going to support. They have to commit to the lifestyle changes. They have to know what the goal is.

In this case, I'd like about 30 pounds. I think we can do that in a year. And I'm going to follow that patient at 6 weeks, 12 weeks, and then 6 months to make sure we're on track. I'd like the patient to lose at least 15 pounds by 6 months. And I would like the patient to lose at least 5 to 10 pounds within 12 weeks to know that we're on the right track. If not, I'm going to modify what we're doing.

So in discussing what this patient needs to know about the treatment plan, I think that first we have to address the patient's understanding of what the medications are and what they do. If it's an injectable, they need to see the pen, and they have to see a demonstration of how it works. This is really going to help them with their acceptance and their adherence to the treatment plan. They have to know that we're going to start at a low dose, that we're going to escalate slowly. They need to know the side effect profile. They need to know in advance that this drug is going to affect their appetite; they cannot fill their plates like they used to before taking the medication. They should try to eat different foods. Low-fat foods are more likely to be tolerated better, and high-fat foods are more likely to promote that nausea and vomiting. I always give them some tips on how to handle nausea and vomiting in advance.

And they need to know that their individual journey is just for them. They're not average; I can't predict what their weight loss is going to be. But we're going to have to see how that particular patient responds. And remember, we're treating to the patient's outcomes and health outcomes. That's number one. It's not really so much about a number on the scale, but it's about the patient's goals. And we should always try to make those goals health goals.

**Dr. Vega:**
Thank you, Donna, for those tremendous insights. It’s clear you really care about the subject material and, maybe more importantly, you really care about the patients you see in our communities. That's great.

Before we wrap up, I want to give the opportunity to just share a take-home message for our audience today.

**Dr. Ryan:**
You know, Chuck, I think my take-home message would be that obesity is a chronic disease. If we're going to manage it and help our

patients, we've got to keep our patients coming back.

**Dr. Vega:**
Yeah, absolutely. And I think that using that patient-centered language and continuing to use their motivations, particularly I look at functional outcomes, things they want to achieve, you know, maybe even down the line, like, “I want to see another grandchild being born,” “I want to take this big trip somewhere,” you know, those things matter. And unfortunately, obesity and cardiometabolic disease can very much stand in the way of those goals. So when we keep ourselves focused on that, you know, maybe a little bit more motivated to continue that follow-up, to continue those lifestyle changes and the medications which can make such a big difference.

Unfortunately, that's all the time we have today. So I want to thank you, our audience, for listening in and thank you, Dr. Donna Ryan, for joining me and sharing your valuable insights as well. It was great speaking with you today.

**Dr. Ryan:**
Thank you, Chuck.

**Announcer:**
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