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Patient Case Study: Obesity

**Announcer:**
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**Dr. Lopes:**
Hello. This is CME on ReachMD, and I am Dr. Renato Lopes. And I'm here today with Dr. Valeria Caso. Welcome, Valeria.

**Dr. Caso:**
Hello.

**Dr. Lopes:**
So, Valeria, do you have a patient case which you would like to present to us?

**Dr. Caso:**
Yes. Thank you, Renato. And I have a young patient, relatively young patient, a 64-year-old lady. And she has a long history of AF diagnosed for 2 years, but she always refused to be treated. She had a of problems with compliance and she never was really adherent to her treatment. Her BMI is 41. She weighs more than 100 kg. And her medical history, you can imagine, also, to the obesity is hypertension, obstructive sleep apnea. She's treated with CPAP, but again, her compliance is not the best one.

And she has a history of diabetes mellitus, and you know diabetes mellitus always changes the risk profile of a patient because it's not only doubling but increased the risk of having a stroke in an important way.

And another two points, she had already a minor stroke without neurological sequelae, but there is a lesion. So we have a patient who is really, despite her age, in a very strong condition for having stroke recurrence.

She is on metoprolol, losartan, semaglutide. However, we know that when there's obesity, we have alternate drug observation. We have the different distribution of the drug. We know that there's a reduced plasma concentration patient who have BMI over 40 or weigh more than 120.

So in these cases, how can we, again, use the best drug for lady, Renato? Because we really want her to be protected from stroke recurrence.

**Dr. Lopes:**
Yeah, Valeria. I think you brought up a challenging case. And of course, we don't have tremendous amount of data on obese patients, although we have some data. A subgroup analysis from the major trials and also some other studies on obese patients. But as we start going up in the BMI, then we start having less and less data.

I think that when we look at the weight per se, when we have reasonable amount of data up to 140 kg in terms of DOACs, in terms of the efficacy and safety of DOACs compared to warfarin. The reason ACC/AHA/ACCP/HRS guidelines also recommend as reasonable to use DOACs over warfarin with a 2A recommendation for patients with obesity Level 3. So, again, when we have this patient population

greater than 40 of BMI, it seems reasonable to use NOACs compare to warfarin. Of course, we might have more data with similar NOAC versus the other, but I think we have enough to reasonably chose NOACs over warfarin. The problem is when you start getting in the stage 4 or level 5, above 50 or 60 of BMI, then I think we have very minimal data. But we also don't have a lot of data with warfarin. The only thing is that, with warfarin, we have a way to monitor the level of drug that we need to give. But that's a zone that we're going to have to really customize, individualize, and look at overall patient profile to be able to choose the right agent, the right dose for this very challenging group of patients.

Would you agree?

**Dr. Caso:**
Absolutely. No, I think it's a very important message. Again, we have some data on DOAC, and as you said, I think the point that you made about buffering because we don't have so many data. Okay, we have the possibility to monitor, but how close can we monitor? And we know there's often more buffering resistance, so we want patient to continue the drug without knowing this is a fixed dose which makes life much more easy. So I think this is a very good message to say. We have space in these patients for being treated with NOAC.

**Dr. Lopes:**
Well, this has been a great discussion, Valeria. I think we continue to try to do new trials and try to close the gaps on those challenging group of patients, and hopefully continue to advance the field of stroke prevention in atrial fibrillation.

Thank you very much for listening.

**Announcer:**
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