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Insights from Obesity Canada: A Deep Dive into Guideline Updates

Dr. Buse:
Obesity Canada recently published new clinical practice guidelines that include updated recommendations for medications, subpopulations of care, comorbidities, and a decision tool for patients with obesity. What do these guidelines tell us about the role of pharmacotherapy in the treatment of obesity?

Welcome to *Diabetes Discourse* on ReachMD. I'm Dr. John Buse. And joining us to share guidelines updates is Dr. Sue Pedersen. Dr. Pedersen is a specialist in endocrinology and metabolism and practices in Calgary, Canada. She's also a Diplomat of the American Board of Obesity Medicine.

Sue, thanks so much for speaking with me today.

Dr. Pedersen:
Well, thanks for having me today, John.

Dr. Buse:
So, Sue, can you tell us why *Obesity Canada* developed new guidelines for pharmacotherapy in obesity management?

Dr. Pedersen:
Yeah. So, we actually had our previous guidelines chapter published in 2020, so it had only been two years since our last version, but, you know, so much has changed even in that short period of time. Obesity is really an exploding field with a whole bunch of new data coming out. We have semaglutide 2.4 mg now approved in Canada, so we felt that we needed to do an update to include recommendations for that medication. And we really realized there was a need to further emphasize the focus on treating comorbidities related to obesity as treatment goals, and there's really been an accelerated interest in this, particularly with new and emerging medications that can provide the degree of weight loss needed to improve many of these comorbidities.

Dr. Buse:
We could talk about all the details for hours, but why don't you give us some of the key issues regarding obesity pharmacotherapy that you thought were appropriately updated here?

Dr. Pedersen:
Sure. So one thing that we did is we broadened our search strategy, and we were looking for literature to identify data for obesity pharmacotherapy in specific subpopulations with obesity-related comorbidities. We could talk a little bit more about that. We of course recommended or updated our recommendations to include semaglutide 2.4 mg weekly. We have new recommendations now for pharmacotherapy for people with obesity and obstructive sleep apnea, with liraglutide, having data for that, and also for NASH, or nonalcoholic steatohepatitis, for which there's data for liraglutide and semaglutide, so that came out of that new broadened search strategy looking at specific subpopulations. We have a pharmacotherapy decision tool, which replaces our previous algorithm from two years ago, and a table as well to help guide healthcare providers on how to choose the most appropriate obesity medication for their patients. We have new sections on other health comorbidities, both where there is data and also to kind of point out where there isn't data. For example, for people with obesity and heart failure, now there are some medications that have studies ongoing there, but we don't yet have data in that important subpopulation. We also have new sections on cravings because that's a really important aspect that can impair control of eating in many patients with elevated weight and a specific section now on quality of life because we recognize that improvement in quality of life is one of the many parameters that is so important to look at and evaluate when we are treating with obesity pharmacotherapy.

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Dr. Buse:
Outstanding. You know, the big rub in the United States is that we have about half the population at least of adults that would qualify for treatment with a GLP-1 receptor agonist for obesity or overweight with comorbidities, but the drug is really expensive, and clearly, our society can't afford to treat everybody with these agents. How do your guidelines help thread the needle with regard to GLP-1 receptor agonists in obesity?

Dr. Pedersen:
Yeah. So I, I agree with you, and we struggle with access as well, and that's actually part of our pharmacotherapy decision tool is we have built-in highlighting the importance of advocating for access if a patient doesn't have access, for example, with insurance plans and, and so forth. As far as liraglutide and semaglutide in particular, both are recommended treatments with the standard BMI criteria for obesity, but we also point out that clinicians use their judgment in that BMI is not the be-all and end-all that defines obesity, of course—it doesn't reflect the burden of adiposity-related diseases—and that healthcare providers may like to interpret our recommendations with, for example, ethnic-specific criteria in mind. We had a recommendation for liraglutide for the prevention of type 2 diabetes. Both liraglutide and semaglutide are recommended in people with type 2 diabetes and obesity for weight loss and improvement in glycemic control, which of course is very well aligned with your outstanding ADA-EASD guidelines for which you, John, were the co-chair. And prioritizing weight management alongside glycemic control and cardiorenal protection, I just think that's such an important message, and I'm so glad those guidelines bring that to the forefront. We have, again, the new recommendation for liraglutide 3 mg for people with obstructive sleep apnea and obesity and then the NASH recommendations that I talked about already.

Dr. Buse:
Thank you. For those just tuning in, you're listening to *Diabetes Discourse* on ReachMD. I'm Dr. John Buse, and today I'm speaking with Dr. Sue Pedersen about updates from Canada's obesity pharmacotherapy guidelines.

Sue, I want to talk a bit about tirzepatide, a dual GIP and GLP-1 receptor agonist. I don't think it's available in Canada yet, and certainly, in the US it's approved for diabetes but not for obesity management yet, but the trial data suggests that it takes weight loss to a whole new level pharmacologically, and there are many new agents that are under development. What do you see as the future of obesity pharmacotherapy?

Dr. Pedersen:
Yeah. So tirzepatide is approved in Canada, but we don't have it on shelves yet because of some challenges with shortages and so forth on a global level. These new and emerging hormone-based therapies are so exciting, and not only in their efficacy for weight management but also importantly to treat weight-related comorbidities. You know, our natural biology of obesity and natural biology of weight management has so many hormonal defenses in place that defend our body weight when we try to lose weight or keep weight off, so it makes sense that we would approach this natural biology with multiple hormonal treatments or combination treatments like these dual agonists or tri agonists. Also, we're studying semaglutide with cagrilintide, which is an amylin analog, so that's really where I see obesity medicine going. I foresee more people achieving targets of treatment, those being improvement in health parameters and with, of course, superior weight loss efficacy. I also foresee targeted treatment, with specific indications for obesity with specific comorbidities for medications, so it's really nice to see that these medications are now being studied in these specific subpopulations like NASH, like heart failure, and so on and so forth.

Dr. Buse:
Right. I agree. You know, the precision medicine approach also gives us the opportunity to make sure that that investment that we make in these expensive medications is going to pay off for the people in whom the intervention is being attempted. With these guidelines in mind, Sue, I think it's only about 2 percent, maybe 3 percent of people with obesity are currently being managed either with drugs or with weight loss surgery. You know, most people have had multiple attempts at lifestyle management. Is it time to readjust our approach overall? How do we completely reset medical thinking about what to do for the patient that's overweight or obese with comorbidities?

Dr. Pedersen:
Yeah, it's so true, the small proportion of people who actually are on treatment, and it's so different from other chronic diseases like diabetes or hypertension. We couldn't imagine having only 2 percent of people with type 2 diabetes on treatment, for example. So I think there's really three points here. One is education for healthcare providers, and that's why I was so thrilled to be invited to speak with you today, John, because it's just such an important aspect to educate about obesity as a chronic disease, that lifestyle change is not the intervention, and it does not help our patients to advise them just simply to eat less and move more. That doesn't work. Rather, treatments such as psychological support, pharmacotherapy, and/or bariatric surgery, these actually are treatments that support adherence to healthier lifestyle choices, so the healthier lifestyle is actually the dependent variable or the outcome of treatment.

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The second point is educating patients on treatment options and on availability. We're seeing a lot of patients now proactively asking especially with you know, there's a lot of social media attention to new obesity pharmacotherapies and so forth, so we also need to help patients understand the appropriate use of these medications to treat a chronic disease and not what we're seeing as like a very brief transient treatment on social media and things like that, so educating patients is the second point.

And then as we've already touched on, so important is advocating for access. So, with more data on benefit to comorbidities, we hope that insurers will become more attuned and accepting of the need to cover obesity pharmacotherapy. And public reimbursement as well is something, and in Canada, we have zero public reimbursement for pharmacotherapy for obesity, and we really need to really press all of these payers to be interested and be engaged in supporting treatment for obesity. I think one of the potentials, what I like to call TSN turning points, is if we can show that obesity pharmacotherapy can reduce cardiovascular risk, that can—could really be a stimulus to start to get some coverage. So, semaglutide and tirzepatide are currently both under study in obesity populations without diabetes to see if they are capable of reducing cardiovascular risk in people with obesity.

Dr. Buse:
Yeah, I agree. That will help a lot.
All right. Well, before we close, Sue, you get the last chance to provide some final thoughts.

Dr. Pedersen:
So, the message I think I would like to leave us with today is what I call the three Ts, and that is treat, treat early, and treat long-term. So, as you pointed out, John, obesity medications are prescribed far less frequently than meds for other chronic medical conditions. Adoption rates of new medications is much slower. We need to be much more proactive in treating patients with obesity. We want to treat early, so obesity pharmacotherapy and actually any treatment for obesity should be considered early in the natural history of obesity because if we treat it earlier, then we can reduce the risk of developing health complications related to obesity rather than waiting six or seven years down the road which is what our study shows about the time from when a person actually develops obesity to even having a conversation with their healthcare provider for the very first time. So talk about it early with your patients. Ask permission to talk about weight and open up that conversation. And then the third T is treating long-term. So we must remember that any treatment for obesity is intended as a long-term strategy. clinical trials consistently demonstrate weight regain when a treatment is stopped, so we do need to think about it. Just like we think about diabetes or hypertension, other chronic diseases, it's a long-term treatment strategy.

Dr. Buse:
That's a great note to end on. I'd like to thank my guest, Dr. Sue Pedersen, for sharing her insights on new obesity pharmacotherapy guidelines from Canada.

Sue, it was wonderful to speak with you today.

Dr. Pedersen:
Likewise, John. Thanks so much.

Dr. Buse:
For ReachMD, I'm Dr. John Buse. To access this episode and others from our series, visit ReachMD.com/DiabetesDiscourse where you can be Part of the Knowledge. Thanks for listening.

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