"What is the Needed Wrap-Around Care When Treating Obesity with Pharmacotherapy"

Webinar Questions Answered by Jamy Ard, MD

Please note that these are brief answers to complex questions and are not meant as medical advice. For more complete information, please seek medical advice from your personal healthcare professional.

- Would you adjust the GLP-1 dose if the patient is not meeting nutrition requirements?
    - Yes, especially if the patient is experiencing a significant reduction in appetite that is driving the lack of nutrition.
- Do you see patients who are not supported by family members and friends and are told to increase their body weight?
    - Most commonly, we see that family and friends will suggest that someone has lost too much weight. This may challenge weight loss maintenance efforts for the patient because of limited support.
- I have seen remarkable weight loss with GLP1 medications, but where do we become concerned regarding malnutrition in these individuals, especially in the older adults or persons with diabetes, when they continue to be on this medication?
    - I think this is primarily about the quality of the intake. A lower intake is expected, and over time, we see that intake will increase from the lowest point. At that time, with counseling and support, optimizing nutrition is a goal. This could be easier for some people as they have fewer cravings for foods that might be less nutritious and typically displace healthier options.
- Although 30% of body weight lost with GLP1s is lean mass, does it typically result in abnormally low total % lean mass/abnormally high total % fat mass?
    - This all depends on the starting lean mass volume and % fat mass. For most people, this does not result in an abnormal outcome.
- Can you discuss some of the contraindications to these medications (e.g., comorbid conditions with a high risk of malnutrition)?
    - The main contraindications are a history of certain thyroid cancers and a family history of multiple endocrine neoplasia syndrome. Anyone who has a demonstrated intolerance would not be a good candidate. We tend to be cautious about use in those with a history of pancreatitis or gastroparesis
- What do we know about the body's production of endogenous GLP-1 hormone after bariatric surgery? I have heard that these medications may be contraindicated in the setting of prior bariatric surgery because that hormone may be increased.
    - These medications can be safely used in those with previous bariatric surgery. The effectiveness appears to be consistent with that seen in people who haven't had surgery.
- Would someone with CKD stage 3 be a candidate for GLP-1 intervention given the increased protein requirement? (1.5 gm/kg)
    - Yes, there are data now suggesting that GLP-1 based treatment can improve renal function/slow progression of CKD. In these instances, we can use a lower protein target.
- Can you discuss further how you manage GI side effects with food intake changes?
    - This includes reducing fatty foods, reducing portions, decreasing foods that are known to increase reflux symptoms (caffeine, spicy foods, tomatoes, etc),

- What are your thoughts on GLP-1 receptor activators?
    - GLP-1 receptor agonists have proven to be highly effective for weight management and metabolic health. Their ability to improve glycemic control, promote satiety, and support weight loss makes them a cornerstone in obesity pharmacotherapy. However, accessibility, side effects, and individual patient responses must be considered when selecting the appropriate agent.
- I see a lot of patients who want to lose weight with these new medications, but insurance won't cover them. Any thoughts?
    - The lack of insurance coverage is a significant barrier to obesity treatment. Advocacy efforts are needed to push for broader access, as these medications have demonstrated long-term health benefits. In the meantime, alternative strategies, including structured lifestyle interventions, lower-cost medications, and patient assistance programs, may help bridge the gap.
- Since ideally protein is utilized as a building block, not to meet energy needs, and since consuming 20-25g protein at a time is recommended, as my understanding is anything above this quantity is utilized for energy. That said, how concerned should one be about protein malnutrition if the patient is consuming significant protein in just one meal per day?
    - Protein distribution throughout the day is important for muscle preservation, especially during weight loss. While a single high-protein meal may not be ideal, the overall daily intake is the primary concern. Patients consuming most of their protein in one meal should be encouraged to spread intake more evenly across the day for optimal muscle protein synthesis.
- Are any assessments recommended to monitor metabolic health prior to recommending GLP1's or other meds?
    - Yes, a comprehensive metabolic assessment should include fasting glucose, HbA1c, lipid profile, renal function, liver enzymes, and baseline nutritional status. Additional assessments such as body composition and metabolic rate may be useful for tailoring treatment.
- Can you elaborate on the meal timing? What issues are you seeing?
    - Helping people establish a good structure of eating, such that they provide fuel and nutrition throughout the day helps to manage overall intake. Also, we know that eating within a timeframe that is consistent with circadian rhythms is more metabolically healthful for blood glucose, insulin, and metabolic flexibility.
- In patients with diabetes and on weight-loss Rx's, are whole foods recommended more than meal replacement options?
    - Whole foods are generally preferred for their nutrient density, fiber content, and satiety benefits. However, meal replacements can be useful for structured weight loss programs, portion control, and convenience. The choice should be individualized based on the patient's needs, social determinants (e.g., food availability) and adherence.
- It seems like some of these medications are available to people through online ordering, maybe without doctor supervision? Do you have any thoughts on the current access? Also, how is insurance coverage with these?
    - There are concerns about patient safety when medications are obtained without proper medical supervision. Side effects, contraindications, and dosing adjustments require professional oversight. Insurance coverage remains inconsistent, with many plans limiting access despite the demonstrated benefits.

- I have a patient who is using this medication and is of a larger weight (350lbs) and in 2 months has lost nearly 30 lbs. She is having constipation issues and is eating about 1000 kcal/day. Also has challenges with the cost of the medication. How do I address the extreme low-calorie consumption when she is unwilling to increase more than 1000 calories?
    - As long as the nutritional intake is adequate, including with mineral/vitamin supplementation, the reduced caloric intake is not a major concern. I would focus on ensuring an adequate protein intake within the 1000 kcal. The rate of weight loss is fast but it is within the range of expected at about 1% of initial weight per week. For comparison, if this person had metabolic/bariatric surgery, they would be consuming around 600 kcal immediately post op.
- I am wondering what you would say to Dietitians who think that medical obesity treatments may increase risk of eating disorders/disordered eating no matter the history of the patient and past disorders?
    - While concerns about eating disorders are valid, evidence does not support the notion that all patients using obesity medications are at risk. These medications can actually reduce binge eating episodes by regulating appetite and cravings. However, careful screening and monitoring are necessary to identify and address disordered eating behaviors.
- How do you advise patients when they reach a plateau and haven't reached their weight loss goal?
    - Plateaus are common and may require adjustments to diet, activity, or medication. Strategies include reassessing caloric intake, ensuring adequate protein, increasing physical activity, and optimizing medication dosage. Psychological support can also help patients stay engaged and prevent frustration. Additionally, we also have a conversation about why they chose a particular weight loss target; if health improvements have been achieved, additional weight loss may not be necessary.
- Any data on patient outcomes after GLP 1 treatments that have stopped pharmacotherapy?
    - Studies show that weight regain is common after discontinuing GLP-1 receptor agonists, underscoring the chronic nature of obesity. Some patients who maintain lifestyle changes tend to regain less weight, but for many, ongoing pharmacologic support may be necessary.
- Is it true that tirzepatide can make your blood sugar appear higher than it is?
    - No- there is no evidence of this.
- BMI use is controversial. To my understanding, it was never meant to classify weight issues. Why is it still being used in your opinion?
    - BMI is easy to calculate and is still a reasonable screening tool. It is not intended to diagnose the disease of obesity alone. There are several guidelines that identify how to evaluate the patient beyond BMI to establish the diagnosis.
- Is a mental health or counseling strategy tried before medical management?"
    - It is part of the treatment strategy; in some cases, when we identify significant mental health conditions that need to be addressed before treatment can be done safely or effectively, mental health treatment will be initiated first.
- Do you check vitamin and mineral labs before starting the patient on a medication? I know you mentioned the need for MVI, Calcium, and vitamin D supplementation, but can you get insurance to cover lab draws as we do in bariatric surgery patients?

    - We don’t routinely check these labs as we can assume that most people will have a low vitamin D level. The use of the MVI and calcium supplements are not to address known deficiencies but to account for lower expected intake. It’s more prophylactic than treatment of a deficiency.
- What are the risks of using AOMs in pregnancy? For example, a woman is using an AOM and then becomes pregnant but doesn't know it for a few months.
    - These medications have not been studied in pregnancy, so we don’t know. Obviously, we would discontinue the medication as soon as pregnancy is known.
- Does risk of significant adverse events increase with longer duration of GLP1 medications? (biliary, pancreatitis, cancer, etc) Is it realistic to use long term?
    - In fact, the rate of adverse events goes down over time because the most common ones (e.g., nausea, vomiting, diarrhea, constipation) tend to improve with ongoing usage.
- Are there guidelines for those that have IBD (Crohn’s or UC) who are on these meds?
    - There are no universal guidelines, but caution is advised due to potential GI side effects. Patients with active IBD should be monitored closely for worsening symptoms, and alternative weight management strategies should be considered if intolerances develop.
- Any advice for patients in the 10% group who aren't seeing a response?
    - Patients who lose less than 10% of their body weight on GLP-1s may need a reassessment of their treatment plan. This could involve medication adjustments, ensuring adherence, addressing potential metabolic barriers, and reinforcing behavioral strategies. Some patients may require combination therapies for better outcomes.
- Are you seeing issues with gastroparesis? If so, does this continue even if stopping the GLP-1 medication?
    - Delayed gastric emptying is an expected outcome with these medications. If people have significant persistent nausea, vomiting, and belching/bloating this can be a sign of potential gastroparesis. When this occurs, it typically resolves with discontinuation of the medication.
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