#405: SGIM Obesity Medicine Update

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[The Curbsiders theme]

Matt: Welcome back to The Curbsiders. I'm Dr. Matthew Watto, here with my great friend, Dr. Paul Nelson Williams. Paul, how are you doing? How are you feeling? We've been traveling for three weeks together right now.

Paul: I'm real tired, dude. How are you?

Matt: I have some energy. I have a cup of coffee in me. So, I'm okay.

Paul: We're doing great.

Matt: We just had a great discussion with our guest, Dr. Kim Gudzune, and talking about obesity medicine, a lot of counseling around it, some medication stuff. We really went all over. Nice complement to some of the other obesity medicine shows that we've talked about. Paul, before I tell them a little more about our guest, can you tell me what is it that we do on this show, remind the audience what is it that we do on this show?

Paul: Sure. Hey, audience. A reminder, we are *the* Internal Medicine Podcast. We use expert interviews to bring you clinical pearls and practice-changing knowledge. Matt, as you mentioned, we talked to Dr. Kim Gudzune. Why don't I let you tell us all about her?

Matt: That's right. So, we had Dr. Kim Gudzune on the show. Kim Gudzune MD, MPH, FTOS. She is an internal medicine and obesity medicine physician. She is Medical Director of the American Board of Obesity Medicine and an associate professor of medicine at Johns Hopkins. She founded and directs the Johns Hopkins Healthful, Eating Activity & Weight Program. Her research focuses on how obesity influences the healthcare experience and contributes to health disparities as well as the efficacy of weight management interventions. A reminder that this and most episodes are available for CME through VCU Health at *curbsiders.vcuhealth.org*. And without further ado, let's get to the episode.

Kim, thank you so much for joining us. We've been back and forth emailing. I really appreciate you taking some time out of your busy conference to talk to us about this. Now, before we start talking about obesity medicine, I wanted to just ask you our standard question, they've heard your formal bio already, but tell them like a hobby or interest that you have outside of medicine.

Kim: Yeah, so these days, really, my hobby is pretending to be on HGTV. [Matt laughs] My husband and I bought a *FIXER UPPER* during the pandemic. And the term deferred maintenance, I wasn't really familiar with the term until we purchased the house, but as a result, there's been a lot of painting and spackling and electrical work, so I'm much handier now than ever before.

Matt: That's good.

Kim: So, yeah, that's my pastime these days, HGTV.

Matt: [laughs] Yeah.

Paul: So, I'm moving into a new place, and the landlord seems amazing. We'll see. I'll keep everyone updated. But the bathroom tile in one of the bathrooms is interesting and we'll just leave it at that. And when I was sort of touring the place with the landlord, they're like, it was COVID, [chuckles] we were trying some things, I was in a different headspace. I'm sorry. And I was like, okay, that's fair enough. So, the COVID renovations, I guess, is the point that I'm making seem to be a common thing.

Kim: Yeah. My husband might have torn up three or four layers of tile on our bathroom floor just from the 1960s, sort of continuing layer after layer after layer, which was sort of a blast to the past.

Matt and Paul: Yeah.

Kim: "Oh, yeah. I remember when that was popular." [laughs]

Paul: [crosstalk] -fun archaeologic project. That's nice.

Kim: Exactly.

Matt: It probably feels like you have higher ceilings now that you-

Kim: [chuckles] Exactly.

Matt: -took several layers out. Okay.

Paul: Another favorite question we like to ask. Tell us, if you don't mind, about your favorite failure and what you learned from it.

Kim: One of the most interesting failures personally was actually deciding to rent a car in Rome. So, I was traveling with my dad. We decided, "Oh, let's take a trip to Italy." And he was adamant we have to rent a car in Rome. Which led to a lot of getting lost, a lot of driving around the same loop over and over again, a lot of angry Italians [laughs] yelling at us. But really sort of came to the appreciation of not knowing where you're going sometimes leads to the most fun and the most adventure. And it's a time, even though in the moment I might have been insanely frustrated with both myself and with him, we still think back to that trip and the getting lost and all of the adventures that came with that. So ultimately a huge failure, don't recommend. [chuckles]

Matt: Yeah, driving on the other side of the road, to me that would be little anxiety provoking as well. I like to either walk, run, or bike around, that's another good way to get lost in a city, and if you're touring a new city, so the car thing is--

Kim: Yeah, that adds an extra dimension of sort of fear and death.

Paul: Sure.

[laughter]

Matt: Yes.

Paul: Kind of locks in the memory-- [crosstalk]

Kim: Exactly, exactly.

Paul: It's good.

Matt: All right, Paul. Well, we have a lot to get to, so why don't you bring us a case from Kashlak and let's get started talking about obesity medicine.

Paul: Sure. Happy to. So, we're going to talk about Ms. Jay. She is a 42-year-old female with Class 1 obesity with the BMI of 31, fatty liver disease, prehypertension, prediabetes, all the pres, coming to our primary care office as a new patient and asking for help with weight loss. Ms. Jay has struggled with cycles of weight gain and loss since her early 20s. She's tried multiple different diets, including paleo, keto, intermittent fasting, juicing and Weight Watchers. She exercises for 30 to 60 minutes, five days per week, and she doesn't seem to lose weight that way. She's been trying to do a good job of eating fruits and vegetables. She's trying to limit sweet desserts. And importantly, she does not drink sugar sweetened beverages, which is, like, my first line of attack. And without that, I don't even know where to go from here.

Matt: [laughs]

Paul: So, thankfully, we have you here to help guide us through the process. But before we even get to sort of the directive stuff, if maybe you could talk us through what barriers a primary care doctor might even perceive when having a conversation about obesity and weight loss in a primary care office.

Kim: One of the main barriers oftentimes stems from our own lack of education. I think back to when I was a medical student, when I was a resident, I really didn't learn much about obesity and how to treat it, yet it's a problem that affects the majority of our patients. And I think there was really a tide that turned in 2012 when obesity was stated as a chronic disease and thinking about, actually, this should be something that we treat, but then what do we do? And so, I think there's a lot of evidence out there showing that primary care physicians don't really know where to start, that lack of training, medicine is still very much an apprenticeship, and so it just is such an overwhelming body of information to try to synthesize and then distill and provide advice to a patient.

One of the other things is that a lot of our training is focused more on treating or managing the prediabetes or the prehypertension that we know what to do with that. And sometimes those seem a little bit in our wheelhouse, but also sometimes more of a priority. We're sometimes thinking about, "Can we get to the root cause of something?" But knowing oftentimes the intensivity that is required for the treatment of obesity, it just seems really overwhelming of, "Where do I start?" And so, I think it's sometimes just picking a place to start with folks is sometimes the most important first step.

Matt: The paper that you referenced in your talk was by Ashman, PLOS 2023. And they were talking about, I think, some people just there were all sorts of reasons that people weren't doing it, and it was like, "Well, I didn't think the patient was interested," or, "I didn't think I knew what to do." And I was like, those are reasons that we should teach ourselves what to do. So that's part of why we're doing this podcast, so our primary care audience can get some tips from you, and then you should ask the patient if they're interested.

Kim: Well, I think that there's an interesting situation where when we ask providers, they're oftentimes waiting for the patient to say something that I think the awareness of weight bias and stigma has really come to the forefront, so there's a dancing around that we don't want to bring up the issue for fear of actually alienating someone. At the same time, sometimes patients are waiting for the physician to bring it up to say, "Hey, it's actually okay to discuss this." I think it's really thinking about how do we begin that conversation. I oftentimes like to think about it, of asking permission, of saying, "Is it okay if we talk about your weight? Is that something you even want to talk about?" And giving the power to the patient to say yes or no. And if they say no, that's okay, you can circle back around to it. I think that's the luxury of having a long-term relationship with patients, but if they are interested, that opens that doorway for having that initial conversation, which I think is really important.

Matt: Have you ever had someone say no when you ask permission to talk about their weight? I can't remember a person yet, usually they're receptive.

Paul: I think that they may not want to address it necessarily, or it may not be a primary concern, but I think a lot of the times you expect it. I think people would hope that you at least bring it up. If not, that might not be the target to go after that visit.

Matt: Any other barriers that you thought were important, that you wanted to point out to the audience and maybe we can give them ways around them other than educating themselves, which we're doing by listening to this podcast?

Kim: Some of the things that were brought up in the paper related to issues with reimbursement, which that is actually a changing landscape. I think that we're holding on a little bit to these notions that you can't use a diagnosis code of obesity on a visit, which that's becoming less and less of a case. I think by not using that as a diagnosis code, it sometimes handicaps. If we're thinking about employers looking at, "Well, what is their population of employees and what benefits do they need to provide?" If we're not coding for things like obesity, they're using claims data to try to identify that they can't actually even see that as a need. And so, thinking about our own practices and how we can provide good data for things like insurance coverage of benefits, I think is really important in this area. And oftentimes something that we might not necessarily think about.

Matt: This patient has Class 1 obesity and we talked with Dr. Cody Stanford a while back and she was telling us, drop the term morbid obesity, Class 1 obesity, Class 2, it sounds like you're talking about it in the chronic disease model, and I think people should be coding that and addressing it.

Kim: I think the other thing is thinking about sometimes there's a challenge when patients now can see their own notes and see their diagnosis codes of when they get assigned a diagnosis that was never explained to them, which I think creates a lot of tension there for folks. So I do think before assigning a diagnosis into a chart, sometimes explaining to patients that this is a medical chronic condition,-

Matt: That's a great.

Kim: -that were-- this is why I'm using this. It's not an assignment or a label of shame or blame. This is a chronic medical condition and normalizing that I think is important. And I agree with Dr. Cody Stanford of avoiding the morbidly obese term, but we now have all of these great ICD-10 codes that don't pigeonhole us into that one term.

Paul: If anything, they're too weirdly specific. The electronic health record that I use, the first one, is due to a medication that is not-- the diagnosis code is three lines long, and like, "No, no, the item is just--" [chuckles] You shouldn't have to scroll for one more common chronic disease issues.

Kim: [laughs]

Matt: Yeah, let's complain about electronic health records. Can I just select one diagnosis and not have to put, like, 25 modifiers on it?

Paul: I think people are going to love this episode. [crosstalk]

Matt: Yes.

Kim: [laughs]

Matt: So, Kim, this is a tough case for me. When you see somebody has tried a lot of things, is doing a lot of things, this person is really active and still struggling with their weight. So what might be your spiel? How might you talk to Ms. Jay at that first visit to just let her know what's coming as you work together on her weight?

Kim: I spend a lot of time talking about what is actually the physiology of weight regulation. So I think we have a lot of misconceptions that it's just eat less, move more. And for the vast majority of people, that's actually not the case for them, that folks like Ms. Jay can be successful in using a dietary strategy for a period of time, but then ultimately, our body sometimes works against us. And all of the hormonal regulation that comes into play in

thinking about getting back to that set point where you were before. And so both, I think physicians and patients don't really understand this concept that we have so much media out there that's really telling us that I should be able to do this, that it's just I stick to this and then all of a sudden I'm of a lower body weight, which is really not the reality.

And so I think it's sometimes diving in and understanding some of the eating habits, eating behaviors, drivers around what was working well, what happened when things started not going so well. Oftentimes factors like some type of life stressor maybe going on, emotional eating and diving into those eating habits, perceptions of hunger, which can then help lead to clues on where should we go actually treatment wise. And so her story is actually very common with the patients that I see in my own practice. And I think it's sometimes setting a new paradigm for folks that this is not just, I do keto for three months to lose weight and then I go back, that this is really a lifelong change, not only for lifestyle, but then thinking about the role of things like pharmacotherapy in actual weight management.

Matt: We talked about, this is years ago now, Paul. I think it was like one of our first 50 episodes. We talked about obesity, about the set point issue. I feel like the metabolic surgery and the newer weight loss drugs are maybe addressing it a little bit. But is it fair to say that if let's say her weight was 250 pounds or something like that, and her body anchors to that weight and says, "If I deviate from that weight, it's going to slow her metabolism and increase hunger to try to get back to it. Is that the gist of it?

Kim: Exactly. That as you lose that you can hold for a period of time, but then you're going to get triggers of slowly increasing appetite and not feeling satiated on what you once were. You combine that with the fact that as you lose weight, your metabolic rate is negatively impacted and so you actually need to maintain a lower caloric balance. When people try to go back to their normal that then you're just going [swoop] go right back to where you were. And a lot of folks will tell you, I actually went beyond where I was at that point in time. And so it's really thinking about with surgery, with the medications of trying to get you lower, but then hold is really the goal and that you can't as much as we would like to willpower against our physiology, that's not the way that your body works. And so we need to think about how do we use tools to augment and support someone on their journey.

Matt: I feel there're two messages that get mixed up, and Paul knows that I get on this a lot, but I think preventing patients from attaining a weight of 250, so their set point is 180 instead of 250, that should be one goal. But we have a huge amount of people in the country that are already at a higher set point. And those patients, we can't just tell them to just gut it out.

Kim: Exactly. We're really setting people up oftentimes for failure. There's so much obesity as an interesting condition in the fact that not only are people feeling bias and stigma from outside, but there's also a very strong internalized weight bias. And so an individual with obesity is much more likely to blame themselves and feel like this is their own failure, where it's not your failure. It's the fact that your body is doing what it's supposed to do. And so we need to help people disentangle that and really understand what is the role for the different treatments and why. And I do agree with you. I think there're two very different populations of those who were wanting to prevent weight gain to avoid getting to this, which is a totally different paradigm. For once you have developed obesity, it's never going to be the same.

Paul: Well, I think making sure that you're addressing the metabolic endpoints too, rather than focusing on absolute numbers as well. This is a patient with prehypertension and prediabetes and fatty liver disease, all things that can eventually progress and cause bad cardiovascular outcomes. So I think framing it in that way as opposed to an absolute number and so which feels anchored to some other-- I think the stigma is often tied into that. Like the number itself specifically can be helpful in the conversation.

Kim: The other factors I like to focus in on is, for a lot of patients, the idea of cardiometabolic health and risk factors is so abstract. It's like, "Well, I don't have hypertension. I don't have diabetes yet. Why are you getting on me?" Where I think sometimes bringing in the more functional limitations and psychological impacts and thinking about how obesity affects not only the cardiometabolic health risk factors but those dimensions as well, where sometimes it's being able to go and play with my grandkids, that is a bigger personal motivator. And it's then something that the patient can really-- it's a very clear point where when you can do that, where you haven't been able to before, that's a clear goal. It's a major accomplishment and a win where I think sometimes seeing your A1c normalize [laughs] is a very special person-- [crosstalk]

Paul: Congratulations. You might not have a stroke in 20 years. You're welcome.

Kim: [laughs] And so I think balancing the whole constellation is really important in understanding what's motivating that one person is really important.

Matt: I guess we're going to jump around a little bit here, but--

Paul: I was hoping you're going to bring this up.

Matt: Well, actually, no. I don't think I'm going where you think. So what were you going to ask?

Paul: I was going to ask about the paper that you had in our outline specifically about motivational interviewing,-

Matt: Okay.

Paul: -which I am a tremendous fan of, obviously. I'm a primary care doctor. I think it has a lot of uses. But I guess there's one paper that looked at motivational interviewing specifically in weight loss and found it less efficacious, or not efficacious, I guess if I'm being very specific. I'm not sure there's even a question here. I guess how do you reconcile those two things, I guess might be the question.

Kim: Sure. So that systematic review was looking at motivational interviewing in the context of a behavioral weight loss program. So I think that's an important nuance to realize. And I think that motivational interviewing within the context of obesity treatment and programs has been a little bit controversial. There are some that have been like, "We must do MI," and others being like, "Well, do we really need to do MI?" And really, what this review in consolidating all the RCTs is suggesting is that MI is not necessarily better than a similar intensivity program. And so I think that that gives us latitude to think about when should MI actually be used.

I think MI is a good tool, particularly for primary care providers when you're one on one with the patient and the patient has a lot of ambivalence towards change, where I think it's a great tool to use things like a 1 through 10 ruler of, "What is your motivation to make changes in diet?" "Oh, I am of 3." "Well, why aren't you a 2?" And then working towards, "Okay. Well, we'll get you to a 5." I think that's a very helpful tool. I think, though, in the context of a behavioral weight loss program, a lot of times people who are coming into those programs have already resolved their ambivalence. So I think it's--

Paul: Interesting.

Kim: And thinking about the right tool at the right time with the right patient, I think MI is really helpful with that, where sometimes the intensivity is a more important factor in a

behavioral weight loss program. So if you are being seen once a week, every other week, it's that contact, that problem solving, that shared decision making. And so you don't necessarily need MI. It's not harmful. You can definitely use it, but it's not the be-all and end-all that, I think, sometimes has been promoted out there.

Paul: Right. Yeah, I guess that's the broader point. Motivational interviewing, I think, is a very specific technique, whereas I will never think it's the wrong thing to incorporate a patient's own motivations and barriers into their care. That's how you take care of patients. I don't think it's going to change my practice necessarily, but that's a very helpful comment. Thank you.

Matt: Yeah. I think something that we've talked about on this show, which is probably just the era that we've trained and come up as physicians in is that generally it works better if you're partnering with the patient, not just, like, [Kim laughs] telling them what to do. But I love the point that patients coming to your clinic, they're coming motivated to lose weight.

Kim: Yes.

Matt: So how much more can you add to that, but if it's the person you're like, "Hey, your A1c is 9, you have high blood pressure." And they're like, "Yeah, whatever. I'm not really ready to make changes." But then the stuff you talk about, "What about playing with your kids or your grandkids?" Trying to find some sort of way in to get them to start working with you, it seems like that would work better.

Kim: Yeah. Oftentimes, I really love the longitudinality of the relationship because I think it's something where setting the expectation that even if they're not ready to talk about it or make a plan now, letting them know that you're going to bring it up again, where I think sometimes, given that this is a topic that a lot of people feel uncomfortable with, it might be during the annual physical exam. And that's the one time when the patient knows that this is going to be brought up, where I think adding that in if you are seeing them more than once a year to say, "Hey, just want to check in on your weight." Just to have that reminder and keeping that door open for that conversation, I think can be really helpful because we have to be a little careful sometimes the messages that we give, sometimes unintentionally by not bringing things up again and while-- just always having that door open, so when someone is activated and ready and wanting to have that discussion, they know that they can turn to you I think is really important because if they feel like they can't, then they're going to go elsewhere.

There's so much in the commercial marketplace around weight loss. And making sure that they're really picking the best option for them that's evidence based, you're really the guide there.

Paul: Great. I did the same thing with tobacco cessation, whatever it's worth too. Maybe you can't spend the 15 minutes every single visit but I'm like, "I haven't forgot about it. We're going to talk about it next time. It's still important to me," but this is not the focus-- [crosstalk]

Kim: I think the other thing that I like to do is for folks where-- sometimes you only have 15-20 minutes if you're lucky, and that this sometimes takes a little bit of time to begin delving into some of these things of saying, setting an agenda that "I'd actually like you to come back in a month or two months just to specifically talk about this," which really emphasizes that priority, that this is not only important to them, it's important to you. And I think it's hard to tack it on.

Matt: It is.

Kim: And then, I think sometimes resort to the, "Oh, just start tracking your calories," or, "Oh, just do this," which then doesn't leave the right impression sometimes with patients. And so that intentionality I think is helpful, if that's possible, within folks' practice panels and things like that.

Matt: We're talking about contact with the patient and follow up. Telemedicine was another thing that you talked about. This was by Kahan and it was in Obesity in 2022, the Journal Obesity. Tell us about long-term weight management using telemedicine. Is that a valid thing? Does it work? Does it help?

Kim: Telemedicine really has, I think, revolutionized obesity medicine. It's not that we don't ever need to see patients in person, but really what we know is that the frequency of contact is really, really important, but it's really hard to ask a patient every single month or every two weeks to physically come in. People have jobs, they have lives, [laughs] they have things to do. And so telemedicine really allows an increase in accessibility to a provider and whether that be a dietitian or a psychologist or a physician or what have you, that we've learned that we don't actually need to see people in person, that most of what we do is counseling and shared decision making. And that can be very effective over a telemedicine platform. And then looking at outcomes with telemedicine during the pandemic, people are actually engaging in more visits than they were previous when we were requiring people or our only option was in person at that time.

We don't really see differences in use of medications in outcomes as far as weight loss. And so in trying to increase accessibility, I think that this is really the path forward. And if that can be incorporated, not just in obesity medicine, but I think primary care more broadly who's working in this space, I think it's a really useful tool.

Matt: What would Ms. Jay expect? You mentioned some potential team members in that response there. If she were to see you in your clinic, if you wanted to talk about what it's called and who's part of the team there, and then we can talk about how we might be able to do some of that in our primary care offices. We're probably definitely not going to have all the resources, but I want to hear what you have.

Kim: Sure. I've been practicing obesity medicine for almost 15 years now. Back in 2020, we worked to expand the obesity medicine offering called the Healthful Eating, Activity & Weight Program, and really thinking about having a space where providers from different disciplines can come together and provide collaborative care for patients. So, we have now eight obesity medicine physicians in the practice, along with two hepatologists who focus on nonalcoholic fatty liver disease, an endocrinologist, two of our bariatric surgeons practice with us. We have psychologists that are affiliated with the practice, as well as a health coach. We do group visits and our health coach is really key with that. And then we work closely with our dietitians. We launched this in 2020, so middle of COVID.

Matt: Great time to launch anything.

Kim: Yeah, it was perfect. And so we have a lot of close dietitian colleagues that we work with. They're not currently embedded with us, because we're all obesity medicine physicians, we actually have a lot of training in nutrition and so do a lot of that ourselves and rely upon our dietitians for very advanced cases and thinking about a cost-conscious model for care. A lot of folks don't have insurance coverage to see a dietitian and so we balance that of making sure the people get in who need to, but then handling a lot of the nutritional counseling ourselves in order to try to create a most cost-efficient care.

Matt: We talked with Dr. Michelle McMacken. She has a superfoods handout that she shared with us to give to patients. But do you have handouts or websites or things that are free or low cost that we can recommend to the audience to steer people towards?

Kim: Yeah. I think that there's some good references online through things like USDA as far as nutritional resources. There are some good recipes and meal planning websites out there, *eatingwell.com* is a really nice one that provides all the nutritional information for folks. And so we use those tools quite frequently. We're also a big fan of thinking about tracking apps. So I don't have necessarily this is my only tracking app that I use. But in thinking about what is really the point of tracking is really important. It's more the accountability and mindfulness rather than the precision around exactly what you're doing and what you're getting in. We use that as a tool in all of this rather than quite so dogmatic about you must get exactly [laughs] this balance, which never works out anyway and the estimates aren't that accurate anyway. Sometimes reframing that for folks--

Matt: So tracking steps, calories, sleep, what else?

Kim: Physical activity.

Matt: That's great. Okay. Paul, any other questions about this part of it? Health coach is probably hard to come by for most people. In my practice, you generally refer to a dietitian or a psychologist. I think the psychologists seem to be hard to come by. Are these psychologists specifically trained in food addiction or eating-related behaviors? I'm not sure what the right term would be.

Kim: The psychologists that we work with do have specific training in conditions, like binge eating disorder, night eating syndrome. I actually think out of all of the potential ancillary other staff having a psychologist in your area that you can identify to work with, I actually think is the most key. A lot of times I feel with nutrition, I sometimes advocate you don't need to know every single nutritional strategy out there, but if you get familiar with three of them, usually that will help most patients. So oftentimes a tracking situation, something like either Mediterranean or a DASH diet and then feeling comfortable talking about a low carb approach. That those three will work for the vast majority of people and get them going where they need to be nutritionally. But the psychologist, if someone really is having issues with, even if it's not diagnostic for an eating disorder, there's a whole gray zone before there in relation to emotional eating. And that spending a little bit of time doing some cognitive behavioral therapy with a psychologist can make all the difference in the world in thinking about this being a different weight loss experience than they've ever had before.

Oftentimes when you dive into, "Well, what happened? Why did you regain weight?" There are these certain triggers that we need to think about what is a contingency plan and that's where we're really working with a psychologist to have that plan in place, which is really hard to do as a physician. We're just not really trained in that. And not all psychologists are as well. And so trying to find one that you can partner with, so that if you do have a patient that seems like is potentially in this zone to have a different experience because some of the things we do, like tracking in someone who actually has an eating disorder that would actually be contraindicated. We wouldn't want someone to track that it's actually potentially harmful.

There're a few brief screeners, one called the SCOFF, which is five questions, and that if you score a certain score that that would be sort of a flag of, "Hey, this person should probably be evaluated by a psychologist or a counselor or social worker before really diving into a weight management plan."

Paul: Her initial question is, "Would you say that you have a complicated relationship with food?" I think it's like her initial screening question, which is like-- [crosstalk]

[laughter]

Paul: -being like, "Ooh." And I think that is a conversation start with me, and if someone can just say, "Nah." Then I think I'm done here. But if they say yes, then that might be a trigger to pursue and investigate a bit more completely.

Matt: Yeah. In my experience, most patients don't just say like, "I binge eat." I've had maybe one person I can remember that came to me with that concern. But usually you have to specifically ask about it.

Kim: Well, there's so much shame and guilt around all of these behaviors and so people don't want to come out and say that. Sometimes I think having these brief screening tools are a way to remove some of that judgment behind there and then get people to the right spot and care that they need.

Matt: Yeah. Well, okay, so we've talked-

[laughter]

Matt: -a bunch about Ms.- so we're going to bring it back to Ms. Jay a little bit here. Paul, I think we should read the second part of the case and maybe we could talk about maybe some of the medication stuff and other questions we had.

Paul: All right. Well, let's say we put together at least a lifestyle plan for Ms. Jay initially. And she comes to see us in three months via telemedicine, because we've read the studies, we feel good about things. She's made some tweaks to her diet and her exercise regimen, but her weight loss has plateaued, and maybe she's even gained three pounds relatively recently. She's understandably frustrated. Her A1c is 6.2%, her blood pressure is virtually in the 120s to 130s, systolic over 80s, and she's heard about these medications on TV. She might be interested in starting a GLP-1 agonist for weight loss. So she's ready for medication therapy and even broached the topic with you. So I guess we'd like to hear how you initially talk to patients who maybe don't have the success they were hoping for initially, and then we can sort of transition specifically into medication management.

Kim: Sure. So I start by normalizing the fact that what she's experienced is not necessarily totally unexpected and that just for her we need to find the right tool in order to treat her obesity, to really, again, remove some of that blame, shame, guilt that a lot of patients feel with this. And oftentimes that then is followed by a discussion around all of the anti-obesity medications that exist. Oftentimes when people come in specifically interested in the GLP-1, I take that as an opportunity to actually talk about all of them, because we do have quite a few now that are FDA approved. And I think sometimes I feel it's important to run through the whole spectrum with folks, because not everyone responds to a GLP-1. And sometimes if someone can't tolerate it or they are in that group that is a non-responder, again they say, "There's something wrong with me. Why can't I do this?" "Well, that's just not the right medication for you. We just need to find the right one." And so opening that up to have, "It's not you, we just need to find the right fit," I think is really helpful for folks in reconceptualizing this.

As far as a lot of people are interested in GLP-1s right now, given all of the press around that, and so oftentimes that's a starting point. I like to hear why they are specifically interested, what they know about the medications before really launching in. My discussions oftentimes center around the mechanism of action of how do each medication work, what

are the potential side effects, how do we manage them? And then, unfortunately, since we're in the US, there's also a conversation around cost has to be factored in and what does this cost if your insurance doesn't cover this medication?

And so that way we can really then go through and have a shared decision-making process. And some folks still end up saying, "Yeah, I'd like to go with the GLP-1," but sometimes they actually choose a different option than what they initially came in and started with.

Matt: I find that if they have type 2 diabetes, it's easy to get them on a GLP-1 or tirzepatide, but if they don't, then a lot of the time it's very hard, a lot of prior authorizations back and forth. So I am still using some of the-- I guess we can call them older agents now. We did talk about this on a prior episode, some of the older agents. So bupropion, naltrexone comes in a combination, phentermine and topiramate comes in a combination. There's orlistat which I believe is the generic, right?

Paul: Correct.

Matt: And then lorcaserin is gone. That one is some sort of increased cancer risk or something. So anything I'm missing there? How do you quickly go through those with a patient in a visit? Probably your new first patient visits are an hour or 30, something like that.

Kim: Yeah, initial patient visits for me are an hour, which is a luxury that I know not everybody has. And so usually during that time I'll run through all of the medication options with them. So usually I actually start with phentermine just by itself. So there's a number of medications, phentermine, diethylpropion that are still available on the market that can be used as monotherapy, predominantly work by suppressing appetite. There is some data to suggest that they may increase metabolic rate a little bit, although that is a little bit controversial. These have been approved for so long, the studies and the quality of the studies are a little bit different and were originally only FDA approved for short term use, which is typically considered somewhere around three months. There's a lot of variability though, from state to state and prescribing practices around phentermine. And actually the Endocrine Society in 2015 actually put in their guideline statement that phentermine could be considered to be used off label long term, that there are some large cohort studies looking at people taking long-term phentermine for two plus years without increased risk of cardiovascular effects and risks. And thinking about it is in Qsymia, which is approved for long-term use. And so that's always a judgment by each individual physician from state to state. And then side effects with this typically dry mouth, constipation.

I think one of the things with something like a phentermine is a lot of physicians think about kind of that maximum dose of 37.5 milligrams and starting people there, but they're actually formulations that are lower doses. And most people don't actually need 37.5, that over suppresses them where they're not eating anything, which is not the goal. And so starting very low is oftentimes just what folks need. And then with phentermine-topiramate combination, I think this is really helpful in folks who have like a sweet tooth or crave carbonated beverages.

There is a taste aversion that is listed as a side effect, but a lot of patients actually find it beneficial that they're no longer interested in eating and drinking those things.

Matt: Is that the topiramate component of it?

Kim: The topiramate component does that. And it also creates a little bit more of an early satiety rather than just pure appetite suppression, which is also a nice feature. With that, generally well tolerated, I think it's really the birth defects risk. And so always counseling women of reproductive age there on that is really important.

Matt: I've run into the kidney stone thing with topiramate. And after Roux-en-Y bypass, that was something that came up, I think, in some discussion we were having the other day. Do you worry about it in those patients too, if they've had a prior bypass?

Kim: Not too much. Again, starting low and going slow. I think where some of the misconception out there is oftentimes this advocacy of ramping all the way up to max dose per the titration schedule on the package. And I think this is interestingly being reinforced actually through some of the prior authorization. Now where if you have a patient who needs to titrate up slower that then they're coming in and saying, "Well, why didn't you increase?" You need to increase, which doesn't really make a lot of sense. It's used with caution and just each individual patient there.

Matt: And then the others, bupropion, naltrexone.

Kim: With that one, I think it's very helpful in people who have a lot of issues with cravings or some of those more emotional eaters usually respond well. Again, a lot of the side effects are similar with all of these as far as constipation, dry mouth, headache. And then we have our newer agents. And then orlistat is still available. I know sometimes not a very popular one, but there are some folks that really do feel a benefit from them. And for folks who have issues with elevated cholesterol, you can actually get a cholesterol reduction benefit with that, which can also be a motivator. I think the one that you didn't mention is not technically FDA approved as a medication, but it's actually approved as a device. It's a hydrogel that you take three capsules before lunch and dinner. It's like you ate five cucumbers before you eat a meal, and then when you eat you feel full on smaller portions. So, it's a little bit more of a subtle effect there.

The nice part is for folks who have interactions with some of the other medications that you can use this one, it's like fiber on steroids, [chuckles] it's like how you got to think about it. And so that can be a nice option for folks who can't really tolerate or have contraindications to the other options.

Matt: I'll have to look into that one more because that's not one that I am familiar with. I think maybe it was very briefly mentioned on a previous episode, but I don't even know if that made it to air because-- Anyway.

Kim: [laughs]

Matt: With the last few minutes, Paul and I have been talking about this a bunch lately and some of my colleagues have too. Sometimes the GLP-1 agonist or the GIP/GLP-1 agonist works so well, the patients are just almost not eating and the weight is just coming off and I'm worried about them almost becoming frail. Is this a concern for you? Tell us how you're monitoring soft tissue or lean mass when you're monitoring patients or following patients.

Kim: The first thing to realize is that it is always normal to lose a little bit of muscle mass when you lose weight, that will happen regardless. This is usually more of a concern for me in patients who are a little bit older, so 60, 70 plus who are needing to lose weight. And in those patients, I really monitor carefully body composition. So, in my own clinic, I use bioelectric impedance analysis to really be able to monitor what is their fat mass, what is their lean mass over the course of weight loss treatment. And am really very much advocating, particularly for an older population to make sure that they're incorporating resistance training in early. So that then we can really work to preserve as much of the muscle mass as possible. And you can be successful in doing this with actually people on the GLP-1s losing weight and they're predominantly losing fat mass, and that we can really

preserve that muscle mass with monitoring as well as the incorporation of the resistance training. So it can be done safely. We just need to be a little bit cautious.

Matt: You talk about protein intake for those folks too.

Kim: When someone's appetite is so altered, I oftentimes talk with folks to really think about, it's even more critical now to think about what you're eating and how you're fueling your body. And so we want to make sure that you have adequate lean protein, fiber, that whatever you're putting in now, because it is a smaller amount, needs to be the best possible stuff that you can put in there. And so while I may not have people track forever, particularly when they're getting into the groove of things, ensuring that they are doing a little tracking to see, "Well, how much protein intake are you actually getting in?" Because sometimes people will shift what they're eating, and not make always the best choices and just supporting them to make the shift, so they are doing that in a positive way.

Matt: Paul, did you have any other questions about the GLP-1 agents?

Paul: No. I mean, the lean mass loss is the big one. I think that was addressed thoroughly and thoughtfully. So, I think I'm good.

Matt: I'm having success for weight loss, not personally, but for my patients when I'm using-- some patients on semaglutide 0.25, 0.5, I'm not having to push everybody up to the 2.4, which is the max, the largest dose. Can you talk about the titration a little bit?

Kim: In my own clinical practice, I think it's really important to titrate to effect, that the goal actually is not to suppress someone's appetite so much where they're not eating anything, we need to eat. [chuckles]

Matt: I would agree.

Kim: It is sort of a critical life function.

Matt: Plus it's fun, it's social, it's great.

Paul: It's all I got left.

Kim: [laughs] And so really, being mindful of taking people to where they need to be, that there are some folks that do need 2.4. There are others, though, that 0.25 is exactly where they need to be. And so it's really just having that follow up with folks. I think the other thing is managing the side effects with the GLP-1s. I oftentimes counsel people when they're starting to think about what your normal portion size is and to cut it in half, because that feeling of knowing when to stop, that's a learning curve. And so instead of having people feel miserable for a few weeks when they're trying to figure that out on their own, knowing to cut in half, and you'll actually feel satiated on that. "Okay, if you're still a little hungry, then have a little bit more." But that gives people a framework because otherwise people will come back and say, "I'm feeling nauseous constantly, I feel miserable, I can't do this." Well, yeah, it's because you're trying to eat what you normally would. And so just to anticipatorily let them know that. The other thing is constipation. Big issue.

Matt: Oh, that-- I-- That’s a--

Kim: [laughs] I knew where you're going.

Matt: Yes.

Kim: And so I advocate that when you reduce your portions in thinking about, "Okay, well, what are you eating?" That it really needs to be a lot of fiber in there, along with the lean protein. And for folks who have a little bit of a difficulty getting in the fiber, I do use like a psyllium-based fiber supplement to help and really to start at the outset. Not until we wait till, "Oh, my gosh, I haven't gone in four days. What do I do now?" To do that from the get go. And psyllium-based fiber has lots of other health benefits to it, and so it really works together very nicely. And, again, anticipating what people are going to experience before it actually happens, smooths that transition and then increases the tolerability. And then the more you can stick with it, the better the outcomes will be.

Matt: I think it's going to be smoother for my patients, pun intended, Paul,-

Kim: [laughs]

Matt: -going forward, because I have not been counseling eat half portion sizes. There are a couple of patients, I was like, "This must be a thing," because several patients have been like, "I was so constipated, I almost went to the ER," in the first few months that I was prescribing a lot more semaglutide.

Kim: I tell them, "One of the ways that the medication works is it slows down your digestive system. Understanding that when your stomach is slow and you eat a big meal, oop, you're going to be nauseous, and that's why the constipation happens." I think that understanding for folks of why they're experiencing what they're experiencing makes it a little less scary of like, "Oh, my God, what is happening to me?" And so I think that having those really brief conversations to let them know that this is a normal part of the experience, but then also when it is gone too far and kind of what can we do to prevent that from happening.

Matt: All right. Well, last question is, can you give the audience one or two take-home points if they only remembered one or two things from this talk that you want them to internalize and bring to their practice?

Kim: The first thing would be the asking permission for folks to actually talk about this, to not be scared to bring this up. I think patients want to talk about it. And then to think about finding some partners in your area, whether that's a dietitian, a psychologist, that this is really a team sport, obesity medicine. And so to really work together and you can really accomplish amazing things for your patients. And so they are running around with their grandkids and their A1c is normal and all of those great things. So it's a really rewarding field to practice in. And I hope that others can really experience that same joy.

Matt: Fantastic. That's a great spot to end on. Thank you.

[music]

Paul: This has been another episode of The Curbsiders, bringing you a little knowledge food for your brain hole.

Matt: Yummy.

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Paul: Matt, as always, I remain Dr. Paul Nelson Williams. Thank you and goodbye.

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