Epidemic within the Pandemic: Battling Obesity in a COVID-19 Climate

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Dr. Stéphanie B. Mayer, M.D. M.H.Sc. is an Associate Professor in the division of Endocrinology and Metabolism at the Hunter Holmes McGuire Veterans Affairs (VA) Medical Center and Virginia Commonwealth University, in Richmond Virginia. She trained at Brown Alpert Medical School for residency and Duke for her research fellowship in endocrinology, completing a masters in health science research at the Duke Clinical Research Institute (DCRI). She is a champion for the national VA/Department of Defense (DoD) 2020 update of the Clinical Practice Guidelines for the Management of Overweight and Obesity and co-champion for the Hunter Holmes McGuire VA MOVE! weight loss program. Her current clinical research focuses on outcomes of weight loss and weight regain in Veterans engaged in the McGuire VA MOVE! program. Dr. Mayer's passion is teaching the wonders and nuances of endocrinology to her students, trainees, fellow colleagues, and her patients. She also loves to dance and is an inveterate Francophile.

"Medically Ready Force...Ready Medical Force"

Navy Capt. Gordon Wisbach, M.D., M.B.A., F.A.C.S.





Navy Capt. Gordon Wisbach is a general surgeon in the United States Navy stationed at the Naval Medical Center San Diego (NMCSD), where he serves as Director of Metabolic and Bariatric Surgery as well as Surgical Director of the Simulation Center. He was awarded his medical degree from Jefferson Medical College in Philadelphia, Pa. and completed his residency training at NMCSD. CAPT Wisbach was fellowship trained in Advanced Laparoscopic/Bariatric Surgery at Brigham and Women's Hospital in Boston, Mass. He holds the title of Associate Professor of Surgery at the Uniformed Services University of the Health Sciences in Bethesda, Md.

CAPT Wisbach specializes in Minimally Invasive, Robotic and Bariatric Surgery and has an active interest in related research and surgical telementoring to enable surgical education using simulation. He serves as the inaugural current Chair and Navy Representative of the DHA Surgical Services Clinical Community.

"Medically Ready Force...Ready Medical Force"





- Dr. Stéphanie B. Mayer has no relevant financial or non-financial relationships to disclose relating to the content of this activity. She will discuss off-labeled uses of medications for purposes other than that for which the product(s) use was approved by the FDA.
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"Medically Ready Force...Ready Medical Force"

Objectives

At the end of this presentation participants will be able to:

- 1. Examine your patients struggling with obesity from a new perspective.
- 2. Select medications that promote weight LOSS versus GAIN.
- 3. Identify patients who qualify for a medication for weight loss and Comprehensive Lifestyle intervention (CLI), and who qualifies for bariatric surgery and CLI.

American Medical Association (AMA) Recognized Obesity as a Disease 5/16/2013

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 420 (A-13)

Introduced by:	American Association of Clinical Endocrinologists American College of Cardiology The Endocrine Society American Society for Reproductive Medicine The Society for Cardiovascular Angiography and Interventions American Urological Association American College of Surgeons
Subject:	Recognition of Obesity as a Disease
Referred to:	Reference Committee D (Douglas W. Martin, MD, Chair)

Defining Obesity: Body Mass index (BMI) (kg/m²) (Adults)

BMI classific	ation
Underweight	< 18.5
Normal range	18.5 - 24.9
Overweight	≥ 25.0
Preobese	25.0 - 29.9
Obese	≥ 30.0
Obese class I	30.0 - 34.9
Obese class II	35.0 - 39.9
Obese class III	≥ 40.0





https://www.huffpost.com/entry/realistic-beauty_b_870296

• Both healthcare providers and patients routinely underestimate BMI.

Obesity Trends US adults (>20 y.o.) 1999-2018



High Prevalence of Obesity in Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2)



Obesity and Coronavirus Disease 19 (COVID-19) Outcomes



Your Patient in Clinic

Mr. O is a 52 year-old man.

• He is worried about his weight: BMI is 36 kg/m2

 Patient Medical History (PMHx): high blood pressure, type 2 diabetes complicated by neuropathy, depression, and seasonal allergies

Next: Review medication list for Mr. O

 \rightarrow Look for culprit medications making weight loss harder

Med list:

- 1. Metoprolol tartrate 25 mg twice daily
- 2. Gabapentin 600mg three times daily
- 3. Cetirizine 10mg daily
- 4. Paroxetine 60mg daily
- 5. Glipizide 10mg 2 times/day (2xd)

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Don't make it harder than it already is!

Category	OBESOGENIC – CAUSE WEIGHT GAIN	Alternative to Consider
Antidepressants	TCAs (amitriptyline, nortriptyline, clomipramine, imipramine, doxepin, protriptyline*); Mirtazipine SSRIs (paroxetine, sertraline, citalopram*, escitalopram*, fluoxetine*); MAOIs (phenelzine)	Bupropion Desvenlafaxine Venlafaxine Duloxetine
Antipsychotics	Olanzipine; Quetiapine; Risperidone; Clozapine; Thioridazine	Aripiprazole; Haloperidol; Ziprasidone
Antiepileptics/ Mood Stabilizing	Gabapentin; Pregabalin; Divalproex; Valproic acid; Vigabatrin; Lithium; Carbamazepine	Topiramate; Lamotrigine; Zonisamide
Antiglycemics	Insulin Sulfonylureas (glipizide, glimepiride, glyburide etc) Thiazoledinediones (pioglitazone, rosiglitazone) Meglitinides (nateglinide, repaglinide)	Biguanides (metformin) SGLT2i (empagliflozin, canagliflozin, dapagliflozin etc.) GLP-1 (semaglutide, liraglutide, dulaglutide etc.) DPP4i (sitagliptin, saxagliptin, alogliptin etc.) alpha glucosidase inhibitors (acarbose or miglitol) Amylin analogs (pramlintide)
Antihypertensives	α Adrenergic Blocker (terazosin) β Adrenergic Blockers (especially nonselective metoprolol, propranolol, atenolol)	ACEi (lisinopril, ramipril etc) ARB (losartan, valsartan etc) CCB (amlodipine, verapamil, diltiazem) Diuretics
Steroid Hormones	Glucocorticoids (prednisone, hydrocortisone, methylpred) Contraceptives injectables >oral; any Progesterone based	NSAIDs; biologics; non-traditional therapies Copper IUD
Antihistamines	Cyproheptadine, Cetirizine, Fexofenadine	Decongestants, inhalers, nasal irrigation system

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The American Journal of Medicine (2007) 120, 610-615



CLINICAL RESEARCH STUDY

THE AMERICAN JOURNAL of MEDICINE ®



Body Weight Changes with β -Blocker Use: Results from GEMINI

Franz H. Messerli, MD,^a David S. H. Bell, MB,^b Vivian Fonseca, MD,^c Richard E. Katholi, MD,^d Janet B. McGill, MD,^e Robert A. Phillips, MD, PhD,^f Philip Raskin, MD,^g Jackson T. Wright, Jr., MD, PhD,^h Sripal Bangalore, MD,^a Fred K. Holdbrook, PhD,ⁱ Mary Ann Lukas, MD,ⁱ Karen M. Anderson, PhD,ⁱ George L. Bakris, MD,^j for the GEMINI Investigators

^aSt. Luke's-Roosevelt Hospital Center, New York City; ^bUniversity of Alabama, Birmingham; ^cTulane University, New Orleans, La; ^dSt. John's Hospital, Springfield, Ill; ^eWashington University School of Medicine, St. Louis, Mo; ^fUniversity of Massachusetts Memorial Medical Center and Medical School, Worcester; ^gUniversity of Texas, Dallas; ^hCase Western Reserve University, Cleveland, Ohio; ⁱGlaxoSmithKline, Philadelphia, Pa; ^jRush University Medical Center, Chicago, Ill

GEMINI study (n=1106)



GEMINI study (n=1106)



UK Prospective Diabetes Studies (N=1,148) Randomized Control Trial in patients with Diabetes Mellitus type 2 and (DM2) and Hypertension (HTN)

Atenolol gained more weight > Captopril

• (3.4 kg (7.5 lbs) vs. 1.6 kg (3.5 lbs) over nine years, p=0.020).

Atenolol required additional antiglycemic treatment > captopril

• (81% vs 71%, p=0.029)

Atenolol had worse Hemoglobin A_{1c} over the first 4 years

• (7.5% vs 7.0%, p=0.0044)

2017 ACC/AHA/AAPA/ABC/ACPM/ AGS/APhA/ASH/ASPC/NMA/PCNA Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults

Recommendation for Choice of Initial Medication References that support the recommendation are summarized in Online Data Supplement 27 and Systematic Review Report.

COR LOE RECOMMENDATION



1. For initiation of antihypertensive drug therapy, first-line agents include thiazide diuretics, CCBs, and ACE inhibitors or ARBs. (S8.1.6-1,S8.1.6-2)

2015 EMPA-REG OUTCOME study – Weight in kg, (n=7020)



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> PLoS One. 2017 Dec 6;12(12):e0187982. doi: 10.1371/journal.pone.0187982. eCollection 2017.

The cardio-metabolic impact of taking commonly prescribed analgesic drugs in 133,401 UK Biobank participants

Sophie Cassidy ¹, Michael I Trenell ¹, Kirstie N Anderson ²

Affiliations + expand

PMID: 29211804 PMCID: PMC5718411 DOI: 10.1371/journal.pone.0187982

Free PMC article



Dr. Mayer's approach to Neuropathy; Treatment Options that are LESS Obesogenic

1. Topiramate (OFF label; Avoid if CI: nephrolithiasis and acute closed angle glaucoma, also teratogenic)

OR (sometimes AND)

2. Duloxetine (FDA indication for diabetic neuropathy)

- + 3. Capsaicin cream (usually not monotherapy)
- 4. Lidocaine patches / cream
- 5. NSAID gel /cream ex. Voltaren
- 6. Alpha Lipoic Acid (OTC antioxidant) 600mg daily
- All of the above + improving BG control with a more narrow SD
- Referral to pain clinic +/- neurologist

Sleep! (7-8 hours every night)



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Antihistamine use and Obesity National Health and Nutrition Examination Survey (NHANES)

Measure	H1 Antagonist	Control	Significance
Weight (kg)			
Males	97.03 ± 24.40	87.52 ± 19.83	.000**
Females	$\textbf{79.96} \pm \textbf{21.07}$	75.59 ± 23.82	.037*
BMI (kg)			
Males	30.87 ± 7.57	27.93 ± 5.56	.000**
Females	$\textbf{30.49} \pm 7.70$	28.75 ± 8.77	.024*
Waist Circumference (cm)			
Males	106.47 ± 15.92	98.49 ± 14.31	.000**
Females	96.81 ± 16.64	93.25 ± 17.90	.028*
Insulin (pmol/L)			
Males	113.52 ± 94.41	64.65 ± 60.23	.000**
Females	66.68 ± 47.58	66.48 ± 64.10	.981

N=268 H1 antagonist users and 599 controls

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Weight Change with Chronic Antidepressant Use



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† Actioned whenever these become new clinical considerations regardless of background glucose-lowering medications.

LVH = Left Ventricular Hypertrophy; HFrEF = Heart Failure reduced Ejection Fraction UACR = Urine Albumin-to-Creatinine Ratio: LVEF = Left Ventricular Ejection Fraction

FIRST-LINE Therapy is Metformin and Comprehensive Lifestyle (including weight management and physical activity)





(Pharmacologic Approaches to Glycemic Treatment: *Standards of Medical Care in Diabetes*—2021)

Lab Review: Consider Treating Pre-Diabetes A1c ≥ 5.7%

American Diabetes Association (ADA) recommends considering metformin therapy in patients with prediabetes, BMI ≥35kg/m2, <age 60, women with Gestational Diabetes Mellitus (GDM)

(grade A evidence)

Physical Exam (PE): Look for signs of Insulin Resistance → check sugar/insulin/energy conversion and diabetes risk (HgbA1c)



https://dk.intelligentlabs.org.jpg

BMI >30kg/m² consider screening: diabetes mellitus, dyslipidemia, hypertension (HTN), cardiovascular disease (CVD), obstructive sleep apnea (OSA), non-alcoholic fatty liver disease (NAFLD), osteoarthritis (OA), major depression, and cancer screening as indicated.





Recommendations for Obesity

1. Screen all adults for obesity.

2. BMI \ge 30 kg/m² \rightarrow refer to intensive, multi-component behavioral intervention program, a **Comprehensive Lifestyle intervention** (B recommendation)

DoD: Military OneSource Command Fitness Evaluation Program



(http://uspreventativeservicestaskforce.org)

Behavior Modification Therapy

- Goal of long-term changes
- Identification and control of stimuli that trigger eating
- Setting SMART goals (Specific, Measurable, Action-oriented, Realistic, Time-sensitive)
- Modification and then monitoring (emphasis on self-monitoring) eating behavior and activity level
- Mindful eating, slowing down the process, eating with intent
- Social support, encourage family engagement
- Cognitive restructuring, problem solving, assertiveness training, behavioral contracting, reinforcement of success and stress reduction also may be helpful

(Voils et al. 2009) (Apovian et al. 2015) (https://pictures.abebooks.com/isbn/9780446825672-us.jpg)



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Diet: Goal of Negative Energy Balance

- Many dietary programs studied: Low carbohydrate/ketogenic (modified-Atkins), DASH, Mediterranean, low fat (LEARN or Ornish), low glycemic index (South Beach, Zone), and intermittent fasting:
- Low carbohydrate more effective than low fat at 6 mos only, <u>not</u> <u>different</u> 12 mos.
- Meal replacement (shake or bar) can be helpful
- Degree of adherence, and perhaps frequency of intervention, key

Dietary Recommendations: Good for ALL!

- NO sugar-sweetened beverages (NO juice –including cranberry, no sweet tea, no Gatorade, no Koolaid, no Lemonade, no soda/ginger ale)
- MORE non-starchy vegetable servings per day
- MORE lean proteins
- Minimize or avoid alcohol –diuretic, calories, brain misinterprets thirst for hunger Green Giant







ZUCCHINI SPIRALS

COOKED

FRESH



Sugar synonyms:

- Agave syrup
- Maple syrup
- Molasses
- Brown sugar
- Sugar in the raw
- Honey
- Turbinado

Physical Activity: Goal is to Move More

• We suggest choosing one or more of the following as the physical activity component of a comprehensive lifestyle intervention: aerobic, resistance, and/or lifestyle physical activity.

• "Every minute and Every step Counts"

Back to our patient in clinic

"Is there a medication I can take to help me to lose weight?"

Pharmacologic Management of Obesity

FDA cites indicated for:

 Patients with BMI 27 kg/m² + an obesity related comorbidity: type 2 DM, HTN, dyslipidemia, OA and OSA (consider with NAFLD, and Gastroesophageal Reflux Disease [GERD])

• Any patient with BMI >30 kg/m²

FDA Approved Obesity Medications (more in pipeline)

1. Phentermine and Diethylpropion (Short term only)

- 2. Orlistat (Xenical, Alli)
- 3. Topiramate ER + Phentermine (Qsymia)
- 4. Liraglutide (Saxenda)
- 5. Bupropion + Naltrexone (Contrave)
- 6. NEW! Semaglutide (Wegovy) approved 6/4/2021

Weight loss in general is contraindicated in pregnancy. Most Pregnancy class X.

7. Setmelanotide (Imcivree)*

 *For use only in patients with obesity due to proopiomelanocortin (POMC), proprotein convertase subtilisin/kexin type 1 (PCSK1), or leptin receptor (LEPR) deficiency confirmed by genetic testing

Net meta-analysis

Medication	Mean weight loss vs placebo	> 5% weight loss	Discontinuation due to an adverse event
phentermine/ topiramate	-8.80 kg	75%	10%
liraglutide	-5.24 kg	63%	12%
naltrexone/ bupropion	-4.95 kg	55%	13%
orlistat	-2.63 kg	44%	8%

Dr. Mayer's Approach to Pharmacotherapy Considerations for Obesity

Obtain history:

- If premenopausal female: Conception goals?
- Kidney stones
- Acute closed angle glaucoma
- Seizure
- Uncontrolled HTN or heart rate
- Any current or future need for opiates
- Diarrhea or constipation/GI concerns, gastroparesis
- Medullary thyroid cancer, MEN2, ? pancreatitis, ? family history of pancreatic cancer
- Mental health history

-Insomnia-Migraine headaches

-Trying to quit smoking

Provider Weight loss Medication TOOL: 2020 CPG

Prescribing Information for Chronic Weight Management Medications ^a			Prescribing Information for Cl	hronic Weig	ht Management Medications ^a (cont.)		
Phentermine/Topiramate ER (Qsymia®) C-IV [3.75 mg/23 mg; 7.5 mg/46 mg; 11.25 mg/69 mg; 15 mg/92 mg capsules]		Orlistat (Xenical®, Alli®) [120 mg; 60 mg (OTC) capsules]					
Dosing: 3.75 mg/23 mg daily for 14 days; increase to 7.5 mg/46 mg for 12 weeks Goal: 3% weight loss within 12 weeks. If unsuccessful, increase to 11.25 mg/69 mg for 14 days; increase to 15 mg/92 mg daily for 12 weeks. If 5% baseline weight loss is not achieved, discontinue by slow taper. <u>Renal/Hepatic Impairment</u> (CrCl <50 mL/min or Child-Pugh 7-9): Max dose: 7.5 mg/46 mg daily	Contraindications: Pregnancy; REMS; glaucoma; MAOI use during or within 14 days; hyperthyroidism Warnings: Increased heart ratemood & sleep disorders; suicidal behavior/ ideation; increased creatinine; metabolic acidosis; cognitive impairment; drug abuse; nephrolithiasis; hypokalemia. • Taper slowly to discontinue (1 dose every other day for ≥1 week) to prevent seizure. Discontinue if glaucoma or myopia develop.		 Dosing: Xenical®: 120 mg 3 times dail containing meal (up to 1 hour meal); omit dose if meal is occ missed or contains no fat Alli® OTC labeling: 60 mg 3 times with a fat containing meal <u>Renal/Hepatic Impairment</u>: No ac provided by manufacturer 	Contraindications: Pregnancy; chronic malabsorption syndrome; cholestasis Warnings: Hepatotoxicity; cholelithiasis; increased urine oxalate and nephrolithiasis; decreased absorption of fat-soluble vitamins, cyclosporine, thyroid hormone, and anticonvulsants; adjust hypoglycemic drugs to avoid hypoglycemia			
Naltrexone/Bupropion ER (Co	ntrave®) [8 mg/90 mg tablet]	i I	Liraglutide (Saxenda®) [6 r	ng/mL, 3mL	injection for subcutaneous use]		
 Dosing: Week 1: 1 AM tablet; Week 2: 1 AM tablet, 1 PM tablet; Week 3: 2 AM tablets, 1 PM tablet; Weeks 4-12: 2 AM tablets, 2 PM tablets Goal: 5% weight loss within 12 weeks. Discontinue if unsuccessful. Renal Impairment (moderate/severe): Max dose: 1 tablet twice daily Not recommended for use in patients with ESRD. Hepatic Impairment: Max dose: 1 tablet in the morning. 	Contraindications: Opioid use; pregnancy; uncontrolled hypertension; seizure disorder; bulimia & anorexia nervosa; abrupt stop of alcohol; acute opioid withdrawal; MAOI's Warnings: Suicidal thinking/behavior [Boxed Warning]; seizures; increased heart rate & blood pressure; neuropsychiatric symptoms; hepatotoxicity; may precipitate withdrawal if receiving opioids; adjust hypoglycemic medications to avoid hypoglycemia		Dosing: Initiate 0.6 mg daily for 1 week; increase by 0.6 mg per week to target dose of 3 mg; slow titration may improve tolerability Goal: 4% weight loss within 16 weeks. Discontinue if unsuccessful. <u>Renal Impairment</u> : Use with caution	Contraind family histo MEN2 [Box Warnings: Warning]; (discontinu impairment the risk for secretagog 50%) or ins	ications: Pregnancy; Personal or ory of medullary thyroid carcinoma or xed Warning] Thyroid C-cell tumors [Boxed gallbladder disease; pancreatitis e); increased heart rate; renal t; suicidal behavior/ideation; to reduce hypoglycemia, decrease concomitant ue (i.e., sulfonylureas) dose (e.g., by sulin		

(VA/DoD Clinical Practice Guidelines, 2020)

STEP 1: Semaglutide 2.4mg weekly



A Body Weight Change from Baseline by Week, Observed In-Trial Data

Reassess Response

- Reassess!
- "Effective" is often defined as 5% loss of body weight at three months.
- Ineffective = < 5% weight loss at three months, or if side effects
 →discontinue (may need to taper back down) consider switch or
 referral
- Weight loss effects are sustained only while taking these agents.
- Cross-over trials demonstrate weight regain once off of the obesity treatment agent →Long-term use required.

Surgical Treatment Options for Obesity

Bariatric surgery is indicated:

- BMI \geq 30 kg/m² with type 2 Diabetes
- BMI ≥35 kg/m² + an obesity-related comorbidity (could include HTN, OSA, OA, GERD)
- BMI \geq 40 kg/m² (without additional comorbidity presence required)

Metabolic Surgery vs. Lifestyle Intervention Sessions



Surgical Treatments for Obesity



(BPD-DS)

Space Occupying Systems for weight loss

• Endoscopically placed balloons

Short-term six month use only



TOOLS for you to use TODAY!

<u>Management of Adult Overweight and Obesity (OBE)</u> (2020) - VA/DoD Clinical Practice Guidelines

https:/www.healthquality.va.gov/guidelines/CD/Obesity

Medication Weight Effect Poster for Your Clinic Rooms



(VA/DoD Clinical Practice Guidelines, 2020)

Provider Pocket Reference Card

VA/DoD CLINICAL PRACTICE GUIDELINES														June 2020
The Management of				Sidebar 1: Comm	on Obesity-	Associated Conditions	Sidebar 2:	Select Med	Icationa	and the	ir Poteri	dial Effec	cts on Weig	ht" (cont.)
Adult Overweight and Obesity	J		- HTN			OA/degenerative joint disease		Medic	ations w		_	Medicat	iona that r	any be
Algorithm Module			 Dyslipidem 		- 6	ERD	Classes	100	ight Cair			w	leight Loss	
1 Adults enrolled in the VA	/DoD health systems]	OSA	yndrome*	- 0	Cancer"	Hormonal	medicinyp	s (e.g., rogester:	one or	method	da da	on, conside	r albernative
+			 See Nation available of 	al Cholesterol Edu	cation Progr	am definition of metabolic syndrome,	agents	megestrol	acetate)	,	(e.g., c	opper IU	D)	
 Obtain height and weight Calculate BMI to access for our puricht and 	d chasik at madical visite		Source: Bh	eskaran et al. JAM	A, 2014, 384	4(9945) 775-765. PMID: 29340665	1	 Sulforry 	luneas		inag	lutide, ex	sts (e.g., se e natide, du	lagiutide.
3 1	a county at mean at wards		Sideba	r 2: Select Medical	tions and the	eir Potential Effects on Weight*		(e.g., d glimepi	ride, glipi	ride.	 SGL 	T2 inhibi	tors (e.g., e	mpagi fozin,
Is the patient's BM	/II ≥25 kg/m ² ?*		Medication	Patent	al for	Weight Neutral or have	Ans	 glyburid Meglitin 	ides		enter	eglifficatin, glifficatin)	dapagi ficz	m.
No	Yes		Alpha-	Veigh	tGan	For EPH (e.g., doxazosin,	hyperglycemic agents	(e.g., n	ateglinide ride (۰ I	- Meth	Cormain Ministrate		
4	5		blockers	- Mintacapine		 Bupropion 		- T2Ds	-	_	 Alph In a 	a glucos	idase inhibi as midibil	tors
 Other guidance about healthy diet and physical activity to maintain a healthy weight^b 	screen for overweight- and obe	s (Sidebar 3) and esity-associated		 SSRs (e.g., pa settaline, cital; 	roxetine,	 Desventafazine Vantafazine 		resights	(and the		 DPP 	-4 inhibit	tors (e.g., al	ogiptin,
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medications (see Sidebar 1) and obesogenic medications (see Sidebar 2)			depressants	 TCAs (e.g., am 	itriptyline,			- Atemolo	si i		 Netsi 	ivalal		
	6 Is patient ready to engage	ege with a Yes		imipramine, nor	triptyline,			- Proper			antihyp	pertenaiv	e medicatio	na may be an
7 • Offer counseling on putrition, physical activity, and	weight management pro	rogram?	L	 Gabapentin 		- Topinamate	Deta-blockers	1			(e.g., e	depende ingina, he	ig on the in eart failure,	HTN.
behavior change	No		Antiepileptic drugs or	 Pregabalin Carbamazepine 		 Lamotrigine Zonisamide 		1			blocker	ne). Cons n. ACEh	ader calciur s, ARBs, an	d thiazide or
visits. (see Sidebar 4)	8 A Offer a CLU/Sidabar 4)		mood stabilizing	 Divelproex Lithium 			⊢	- Cettrici	-	_	bop di	ding on a	is indicated	L.
9 Has patient achieved weight	 Continue to monitor and reassess 	is the patient (see	agents	 Valproic acid Vicabatrin 			Anti	 Cyproh 	eptedime	· · · ·	ipratrop	pium nas	al spray, de	congestants,
management goals?	 Standards of Care in the full CPC Consider observace/becary and/or 	PG)		Quefiapine		 Aripiprazole 	hatamanaa				-	nes (e.g.	nasal irriga	ation)
	concurrently with CLI (Sidebar 6)	i)	Arti psycholics	 Olanzapine 		 Ziprasidone 	 The information 	tion provide	ad in the l	table is r	not to be	e conside	ared all-ind	usive and is
 Continue a CLI and any additional therapy for uniable mainteened. 	 For patients of Asian descent: is BMI ≥23 kg/m Mat. 2014. 00:01.875 8000. East anti-sets 265 m 	m ² ? (Winter, et al. Am. J. Clin.		 Reperidone Thioridazine 			meta-analys	es, subgro	up analys	sis of dir	nical tria	ils, coho	rt studies, r	eviews).
 Reassess periodically including for 	assessment (WHO Tech. Rep. Ser. 2000;894 i	Li-eii, 1-253. PMID: 11234459)	(3m)	 Hydrocortisone 		Alternatives for rheumatologic disorders:	based on le	ngth of folio	w-up, be	seline v	weight, p	atient co	morbidities	, etc.;
pharmacotherapy and follow-up for long-term post-bariatric procedure management	 See, for example, 2015-2020 Detary Godeline evelable at: <u>https://health.gov/dietaryguideline</u> 	es/2015/ and Physical	corticoida	 Methyl-predmiss 	andia	 NSAIDs Biologics/DMARDs 	events, post	-marketing	and case	e reports	solect pr s).	roduct int	formation (a	adverse
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Three Videos for your Patient Waiting Room!



(https://www.qmo.amedd.army.mil/obesity/OverweightAndOBesity_SugarsandSaltVideoFINALCC13Apr2021.mp4)

Metabolic/Bariatric Procedure Comparisons



Gastric Balloon

- Daily Multi-Vitamin
- Eat slowly stop when full
- · FDA approved for only six (6) months



For more information on the VA/ DoD Clinical Practice Guideline for the Management of Adult Overweight & Obesity, visit https://www.healthquality. va.gov/guidelines/cd/obesity/

Lap Band

- Requires commitment to life-long follow-up
- · Three meals per day (high protein/low carb) -
- initially liquids with gradual transition
- Will require periodic band adjustments
- Eat slowly, chew well, and stop when full
- Daily Multi-Vitamin
- 64 oz. of water throughout the day
- Avoid high calorie drinks, carbonated drinks, and alcohol
- Avoid stringy vegetables, sticky foods, large chunks of meat, crunchy foods such as popcorn and nuts

Sleeve Gastrectomy - Gastric Bypass - Duodenal Switch

- Requires commitment to life-long follow-up
- Avoidance of carbohydrates/refined man-made sugars and alcohol
- Diet of high protein, low fat, and low carb avoid carbonated beverages
- Eat slowly and stop when full
- No drinks 30 minutes before or after a meal. Aim for at least 64 oz. of water throughout the day.
- Lifelong Multi-Vitamin Supplementation: Folate, B12, B1, Iron, Calcium, Vitamins D, A, E, K, Zinc, and Copper

- Three small meals per day/avoid drinking immediately before/during/after meals
- Avoidance of ALL ulcerogenic drugs and No smoking
- Proton Pump Inhibitors (PPIs) initially in the post-operative period
- Gallstone prophylaxis with ursodiol for six (6) months post-operatively
- Close post-operative follow up for de-escalation of diabetes/hypertensive meds
- Weight-based medication doses will likely decrease over time
- Avoidance of pregnancy for the first year

(VA/DoD Clinical Practice Guidelines, 2020)

Treatment Pearls from an Endocrinologist to consider:

- Am I making weight loss harder for my patient? <u>Review their medication list</u>. Consider getting help from a pharmacist. Ask the patient to review their list with pharmacist and discuss next visit.
- Ask for <u>permission</u>: "I am concerned about how your weight might be affecting your health. Is this something you feel comfortable discussing today?"
- Consider screening for diabetes: BMI >30kg/m2; OR signs of insulin resistance: acanthosis, or metabolic type lipid pattern (low high-density lipoprotein [HDL] + high triglycerides [TG]).
- Assess where your patient is in their desire for change
- Start with lowest hanging fruit: NO LIQUID SUGAR!



Next: Review medication list

 \rightarrow Look for culprits making weight loss harder

Med list:

- 1. Metoprolol tartrate 25 mg twice daily
- 2. Gabapentin 600 mg three times daily
- 3. Cetirizine 10mg daily
- 4. Paroxetine 60mg daily
- 5. Glipizide 10mg 2xd

Don't make it harder than it already is!

Key Takeaways:

1. Obesity is chronic condition requiring lifelong management.

2. Don't prescribe medications that promote weight gain and warn prescribing providers.

3. Comprehensive lifestyle Intervention is all 3 components (behavior, diet, and exercise) and is foundational to other interventions.

4. Several dietary approaches can be successful. Adherence is most important.

5. We have many tools for you to use with your patients! Use them all!



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