CARDIOMETABOLIC HEALTH CONGRESS

Webinar #6: How Much Can I Do in My Practice to Address Obesity?

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Faculty: Robert Kushner, MD; Holly R. Wyatt, MD

DR. ECKEL: Hi, again. I'm Bob Eckel again, one of the co-chairs of the Cardiometabolic Health Congress and also co-chair working with Donna Ryan on this program entitled Optimizing Long-Term Weight Loss in Patients with Type 2 Diabetes, this interface between two very common disorders, obesity and type 2 diabetes. This is a series of lectures or webinars entitled Advances and Expert Perspectives.

In the next slide, I'm going to introduce the program to follow. This is entitled How Much Can I Do in My Practice to Address Obesity? I'm the moderator. Our faculty is Bob Kushner, who've already met in the first presentation, the Approach to the Patient Living with Obesity in the Clinic, and Dr. Holly Wyatt, Professor and Vice Chair of Clinical Programs in the Department of Nutrition Sciences in the School of Health Professions at the University of Alabama, Birmingham.

Holly, it's all yours to present the patient that we're going to discuss today.

DR. WYATT: Okay. Thank you. Alright, guys, here is the case.

Laura is a 50-year-old dentist office receptionist. She's been in your practice for about 10 years. She scheduled an appointment today because she feels she's finally in a place in her life where she should prioritize her own health and wellness. She's recently divorced. Her kids are finally out of the house. They've gone back to college. She last saw you in person about three years ago, before COVID, and she reports that she gained around 15-20 pound during the pandemic. She recently weighed herself, and she found that she was over 200 pounds. This is a number she had vowed she would never see. So, she's not feeling good about herself. She's ready to do something to feel better, and she's coming to you to talk about her options and where she could start.

There are some statistics and things to know about her. Her BMI is 35. Her weight is 199 pounds on your scale. She's 5 ft. 3 inches tall. Her waist circumference is 40 inches. She was divorced six months ago. She has two boys who are 22 and 24. She works about five days a week, about 10 hours per day. She reports she gained between 15-20 pounds over the last three years, and she remembers weighing 180 pounds, and you have in your office notes that she weighed 180 pounds, which is a BMI of 32, when you saw her about three years ago.

Family history: Her mother had a stroke at age 55. No other family history of any cardiovascular disease, but colon cancer and dementia do run in her family.

Her past medical history is significant for type 2 diabetes and hypertension. She also reports having two bad knees. She's been told that one of them is actually bone-on-bone and will need to be replaced at some point in the future. Pain in both her knees limits her ability to walk for long distances. No history of heart problems. No history of chest pain.

Review of symptoms was positive for waking up feeling very tired when she gets plenty of sleep. She takes metformin and lisinopril. Her only additional exam finding is an elevated blood pressure at 135/85. Her EKG is normal. Labs are all within normal limits, except triglycerides of 200, HDL of 40, hemoglobin A1c of 7.2%.

Diet history reveals she eats out most weekdays. She now is home alone, and she doesn't think it makes much sense for her to cook just for herself, just for one. She routinely grabs something easy on her way home. She doesn't really enjoy vegetables. She orders lunch from a cafeteria downstairs in her office building every day. She doesn't report drinking full sugar sodas, but she does like to have some caffeine and an energy snack in the late afternoon. She reports 2-4 glasses of wine on the weekends.

Activity history reveals she sits at a desk for greater than eight hours per day. She does not do any planned activity, and she's too tired when she gets home to make that a priority. Her knees are also limiting her ability to walk and be active. An orthopedic surgeon told her he would like her to lose weight before considering get a total knee replacement.

She comes to you because she feels like she needs to do something, but she does not know where to start.

So, here is an audience poll question. This patient is sitting in front of you in your office. She wants to know where should I start? Here are some options. What do you think? What do you feel is her best option? A, she should lose weight, maybe in the range of 5-10%. B, stop the weight gain; just wherever she's at, that 199, let's just not gain any more. C, she should work on changing her diet, maybe the quantity, maybe the quality, but some kind of change in what she is taking in, her diet. Should she increase her activity level? Should she work on maybe not increasing her activity level, but maybe decreasing her sedentary time? Should you think about putting her on a weight loss medication? Should the first thing you, and her best option, be to go ahead and replace one of her knees, that one that's giving her so much problem. Should you order a sleep study? Or, at this point, would you do nothing?

So, take your best stab at what you think the best option is for her at this point.

DR. ECKEL: Well, Holly, lots of good options there. I think Bob would agree, but we're not going to try to select one at this time. Let's go ahead to the next slide, which I think we're using the audience poll question as a springboard in to our discussion among the three of us to follow.

DR. WYATT: Great. Here we go. Here are some discussion questions, but I think we can take this anywhere. There are so many questions that this case really opens up.

DR. ECKEL: Absolutely, and I think some of these questions may give rise to other questions to follow. So, we'll be very open, and this is very much a living room conversation. So, let's have fun with this and see what we can do to inform our listening audience.

Bob, to you, where are you going to start here and why, with this patient living with obesity and type 2 diabetes?

DR. KUSHNER: Holly, I think you've described one of my own patients in my own clinic. This is so darn common. I think everyone who's listening to this can think of a patient they recently saw just like this. I think what comes to my mind is that you want to make sure that your encounter is patient-centered with shared decision making. You took a good history, and there are so many targets to work with here. Your poll question, I think every one of this is something you want to be doing, but where do you start?

Part of it is asking her where she would like to start, even though she doesn't know where it is. But, what are you thinking of? Think of it in terms of giving her strategies and tactics, setting realistic practical goals, what we call SMART goals (specific, measurable, actionable, realistic, and so forth). So, when she walks out of your office, where you've had hopefully ample amount of time protected to talk to her, and not just lose weight, see you later. Then, she walks out with a very specific actionable plan, with a follow-up visit, so it's not like see you six months later. But, this is our agreed-upon plan, and tell me what I just said to you. I want to see you back in a short order.

Lastly, also remember that you're not the only game in town. I think of obesity treatment as a team sport. She may benefit, depending upon your inquiry, by joining a commercial program, seeing a registered dietician, maybe health psychologist. Maybe she's really in a funk because of COVID, divorce, two children, and so forth. Maybe she needs someone to talk to as a coach. There are so many directions you can go to, because you actually took a good history of all this information to work off of.

DR. ECKEL: So, Holly, don't you think it's important in the approach of this patient living with obesity and type 2 diabetes to have your ancillary personnel, maybe the nutritionist, someone who deals with the physical activity or behavior, to be on the same page you are? Often, I think what happens in primary care—I'm not going to be accusative here, but often they send the patient to a nutritionist or someone who deals with the physical activity component of their lifestyle rehab program, and they haven't talked to you, and you've not talked to them. Your thoughts about that?

DR. WYATT: Absolutely. You need to be on the same page. You need to be getting the same information. But, before I would even do that, I totally agree with what Dr. Kushner talked about, you've got to kind of meet them where they are. It might be appropriate to send them to a nutritionist, or that might not be the best option for them at this point.

So, before I jump to my ancillary staff, it is important that everybody is on the same page, for sure, with the same messaging. I would do a lot of what Dr. Kushner talked about, and be open ended and try to understand where some low-hanging fruit is, what she could do, what she wants to do. Allow her to kind of talk for a little bit and get some answers back.

I always talk about the art of medicine. To me, this is really the art of medicine at this point. There's a lot of science behind this, and I'm sure we'll talk about some of the evidence-based and the science involved in this patient and where the evidence-based options are. But, to me, this starts out with the art of medicine, and that communication and allowing her to kind of drive it a little bit with your guidance, but to see where she could move, where she would like to move. I think a lot of practitioners kind of come off sounding like you should do this, and it's your own personal opinion of what you think is important. But, instead, really learning to take that step back and trying to see what's important to her.

Also, you know I've talked about this before, allowing her to turn around and say here's what I could do, not what I should do. Here's what I could do, and there are many possibilities in allowing her to start setting that stage. And then, pulling in ancillary staff, once I kind of establish that. Then, talking about science and evidence-based options.

But, this first conversation, to me, is important to be able to have that dialogue to direct where you want to go.

DR. ECKEL: Alright. Your comments, and Bob's too, are a springboard in to questions 3 and 4. How would you help her decide her next best step? And, is there anything you would not suggest she do? Bob, your thoughts on some of those question?

DR. KUSHNER: I want to circle back and make sure that we cover the medical issues that may not have been revealed at this point. She made a point that she is tired, despite sleeping. Tiredness, of course, is the tip off for does she have sleep apnea? Does she have sleep insufficiency? Does she have depression? So, you want to explore that. Probably a better understanding about her knees and what she could do better. Holly, she's 50. Is she perimenopausal? Is that part of her weight gain and issues?

As medical providers, not that we want to blame everything on obesity, that's the wrong thing to do. But, equally so, we want to explore what other medical problems may you have that may be contributing to your weight or getting in the way of losing weight or being caused because of the weight indirectly. I want to make sure that we want to go ahead and do that.

One thing to mention is, and, Bob, you and I talked about it a while ago on the very first conference or webinar that we did together, we talked about monitoring herself and getting data and getting more information about she's actually doing, and having her track her diet. Those types of things can be very, very powerful.

DR. ECKEL: I think, essentially, very importantly, answering question number three, how would you help her decide her next step. It may relate to the medical evaluation. Right? Is she depressed? Does she have sleep apnea? Could she be hypothyroid? Of course, for years and decades, people blamed their weight excess on hypothyroidism, which is, of course, rarely a cause of much weight gain, but should probably checked. She's fatigued. I don't know if she's cold intolerant, constipated, or anything else. But that's all part of the medical evaluation. Holly, some additional thoughts?

DR. WYATT: I agree. I think that point you're making about the thyroid, I check it. I always have people check it, but rarely is it really the cause, although we do know that if someone is hypothyroid, you do want to treat it. It can be harder for them to lose weight if they're not treated appropriately. There's good data about that. But I think so many times that's all the practitioners or the healthcare providers know to do is check a thyroid, and that's what they do.

So, that is usually not the issue, and that's usually checked at some point. But it's always good to think about everything, so you have all that data. Then, if there is something, like she is depressed, yes, you want to start dealing with that. I think the perimenopausal idea, you do want to think about that.

Then, to me, it's about really turning to her and saying what do you want to work on? What is motivational? So, really getting to what's going to motivate her. We know that we can tell someone what to do. We can give them options. They can even choose it. But, if they're not motivated, if it's really not important to them, if you haven't really linked the

want to do to the why they're going to do it, they won't do it for very long.

DR. ECKEL: Let me raise another issue that may need consideration. She's been gaining weight. She has type 2 diabetes. She has systolic hypertension, albeit stage 1. It's not severe. But, ultimately, does she require a work-up for excess adrenal corticoid production? Is this a Cushing kind of patient?

DR. WYATT: I would look for other signs and symptoms of that. I don't know that that's what I would go to right away. It doesn't bring like a huge red flag. Obviously, if she had purple striae, if the fat distribution, when I saw her, was more consistent with that, we could definitely consider that. It's not probably the first thing that I thought of in this patient. I don't know, Dr. Kushner, how you feel about that?

DR. KUSHNER: Well, I think we want to think about evidence-based medicine and pre-test probability. There's no stigma or anything in this case that I'm thinking she has Cushing's syndrome. Something that's rare, and you test for it, something that's rare, you're not likely going to find it. So, always think about it in your differential, but this does not present as someone who's presenting with Cushing's syndrome.

DR. ECKEL: Yes, that's the point I'm trying to bring up here.

So, let's get now to some of the other questions that relate to maybe bullet points four and five. What are the odds of her losing weight? She wants to lose weight. And what are the odds of her keeping it off? Now, that's assuming that all of these medical work-up issues have been completed and she's been evaluated for all these related issues. Patient is living with obesity and type 2 diabetes, probably with a sleep disturbance, at least she thinks she sleeps well, but she doesn't feel well in the morning. She's fatigued. Sleep study is probably indicated. But let's say you've worked all that up, and now you've found nothing definitive, or have found something that needs therapeutic intervention, what are her odds of losing weight, and how much does she need to lose? Then, to follow that, can she keep it off?

Bob, to you on that first one.

DR. KUSHNER: Well, I have to say I don't think I have ever used the phrase giving people the odds of treatment.

DR. ECKEL: Holly asked the question. She asked the question.

DR. WYATT: I wouldn't tell her this. This is just me, us discussing it. This is what I want you to tell me, Dr. Kushner. What do you think the odds are? I wouldn't say that to her.

DR. KUSHNER: I know the statistics very well, which I'll mention in a minute for all of our listeners. But the point I want to make is that when we're talking to patients, we want to be as supportive and empathetic as possible, but be realistic. I would rarely say you know you can take it off, but you know you're going to gain it back. None of us would do that.

First of all, we know that obesity is a chronic relapsing disease. It is very hard in someone who's gained weight slowly over time, because of modern society and inactivity and eating out all the time, to take weight off and keep it off. That is very, very challenging. We know from the literature that average weight loss in aggressive, in intensive lifestyle treatment

is about 8%, something like that. With a slow weight regain over time, because of the biologic forces that kind of cause our weight to go back up. So, it is very difficult.

I would start working with her, nonetheless, on lifestyle treatments. I think there's a lot we can do to help her through diet, physical activity, mental health, sleep hygiene, dealing with the medical issues, and so forth. I consider weight loss a process. It's a dynamic process. By continuing to work with them, what's working, what's not working, what are the challenges? If they start slipping, what can we do to problem solve? Very different than a surgeon who goes in and takes a gallbladder out and you're one. This is a chronic relapsing disease, like diabetes, that we have to continue to work with them.

DR. WYATT: I agree with all that. Kind of the reason I put the question in, and Dr. Eckel, you probably know this, is I like to think about weight loss and weight loss maintenance as separate entities. It's not just one long continuum. Yes, you've got to continue to treat it, either in the weight loss phase or the weight loss maintenance phase, or they will regain. But I like to think about specifically trying to lose weight and the tools and strategies and what I'm going to be talking about in terms of lifestyle change will be slightly different than when she gets to weight loss maintenance. So, I like to kind of think of them as weight loss moving in to weight loss maintenance. I'm always preparing them for weight loss maintenance, but two distinct entities, that we lose weight, and then we move in to weight loss maintenance.

For me, in my practice, and this is mostly anecdotal, that is a helpful way, that we don't lose weight forever. I think so many people are constantly trying to lose weight, and that doesn't seem to work either, but we concentrate on weight loss, and then we concentrate on weight loss maintenance.

DR. ECKEL: Well, the busy clinician in the clinic can refer to well-done studies on clinical research centers where, in fact, all three components, physical activity modification, at least changing sedentary behavior, reduced caloric intake, and finally behavioral intervention is greater than any two together or any one alone. But, in the outpatient clinic, busy clinicians don't have a lot of time or don't have access, ultimately, particularly in certain socioeconomic groups, to be able to intervene with all three components.

Now, the next question, my paradigm in the outpatient clinic in a cardiology clinic, despite being an endocrinologist, my clinic has been in the heart center for a number of years, I focus on caloric intake for the initial part of the weight reduction, not really working on physical activity initially. So, ultimately, what you've shown, Holly, you've written about this a lot over the years, is the physical activity paradigm is much more important in weight maintenance than it is in losing weight. So, your thoughts about that, and Bob's comment to follow.

DR. WYATT: Yes, so that's definitely, if I can only start with one or two things, and they're wanting to lose weight, she has decided, yes, that is something I want to do and she's motivated to do that, then I'm definitely going to have a nutritional piece to this that's going to restrict calories. There are many different ways we can go about it. I don't believe there's one diet or one tool or one way to do it. But we're going to be doing something that can restrict the calories, the energy coming in, because I do think that's the most important

piece. Other pieces play a role. I'm not saying they're not important. But, it has to be there.

I always say nutrition and restriction of calories is driving the bus for weight loss, and if you don't have a bus driver, the bus isn't going anywhere. A lot of people on the bus, a lot of other things on the bus, but the bus isn't going anywhere without the driver, and the driver is nutrition.

Then, when we get to weight loss maintenance, though, they flip-flop, and physical activity suddenly gets in the driving of the bus seat, and we see that most people who are successful at losing and then keeping it off have higher levels of physical activity. So, while they're losing weight, I'm still working on physical activity, because you can't flip a switch and suddenly take somebody to where they need to be. But my goal is a little bit different. I'm slowly increasing that physical activity.

So, when the weight loss stops, and now we need to maintain, and no one's ever ready to do that, that's a whole other topic. But, when that happens, that physical activity hopefully is at a level that we have greater odds that we have stacked the deck in our favor, where we're more likely to be able to maintain the weight that she's lost.

DR. ECKEL: Bob?

DR. KUSHNER: Holly's absolutely right. It's evidence based. It is nutrition that drives weight loss, just like she said. I'll just add, though, that we all see patients every day, and you ask them where is it in your lifestyle that's modifiable, something you can change that you think will make a difference? Many of them don't come up with it's my diet. They'll say I need to be more physically active. So, they come in to the office setting thinking they've got to be more physically active. They have to join a gym. They have to start seeing a trainer, and that's where their head is at. I never discourage that. I think Holly's saying the same thing.

However, I always add education at that point. I say I think that's great, but we know that it's the change in the diet where you're likely to be more successful, so please pay attention to that as well. In fact, I'm going to give you more tips and strategies on the diet side, and you go ahead and be as physically active as you'd like to be at this point.

DR. ECKEL: Well, I think the important point here is she's sedentary. This woman has no physical activity at all. I think changing sedentary behavior, at least using a step counter or some other way to give a metric being more physically active is an important strategy to consider.

DR. KUSHNER: Absolutely. I'll just add that may be very motivating for her because we all know that when you're tired, and you go for a walk, you could become refreshed, and you're maybe not as tired or less depressed. It's great for coping and stress reduction. So, we would always help our patients be less sedentary, reduce sedentarism and be more physically active. But, the biggest bang for the buck, like Holly said, the driver in the bus—that's a good one—the biggest bang for the buck is focusing in on your diet. That's where the weight loss happens, and evidence is very clear about that.

DR. ECKEL: So, Holly, how do you have your patient living with obesity and type 2 diabetes focus on their diet?

DR. WYATT: Well, that's, once again, I think this is important for practitioners, you don't just have one thing you do. I always say you have a bag of tools. You have a bunch of different ways that you could go, or at least several that you could pull out. That's where I start to kind of do that, that history. Once again, start talking to her about what things she may want to change. Is she willing to really work on not going out as much, or does she still want to go out to eat, but change what she's eating? Is she ready to maybe log her calories? We know that logging the calories, there's a lot of good data behind success in logging. But, she may say, you know what, that seems overwhelming to me. That's way too much, so I'm not going to do that. Is she potentially in, could we do some meal replacements with her for a couple of meals?

So, I'm really going to look at what she's willing to do, what makes sense. I have multiple tools that I know I can kind of pull out that have evidence behind them, but I'm really trying to match her with what she is willing to do and where I can meet her, and then provide her some concrete things she can do, because she's asking me for that. But, multiple options, I guess. I wouldn't come out with here is the diet you have to be on, because we know that's not the case. There's not one diet for that.

DR. ECKEL: Reminds me of a very important paper by Dansinger et. al. in JAMA a number of years ago that ultimately showed it is adherence to the program, and that's where meeting her needs where she's at in terms of dietary choices, and ultimately other lifestyle modifications, are going to prove move successful. It's not one diet versus another. It's ultimately compliance to the program that you set out and establish with her to fit her best. Bob?

DR. KUSHNER: I just want to add something because we're thinking about resources here. You really want to understand where your patient is at, their personality and their world view. This is a patient who is divorced, children are off to school, living by herself. She may benefit from the social interaction and social support, so she's not doing it alone. So, although we all agree the primary care provider needs to be part of the solution and part of guiding the patient, this is something where I'd ask, what do you think about joining a commercial program, where you're not by yourself, and you have the benefits of socialization, social interaction, a coach. If you're savvy using apps, you can, through digital media, be involved with other affinity groups, and so on. That may be very positive for her. Or, she'll say, you know what, I'm a private person. That wouldn't work for me. But, asking that kind of question is very important, and you don't have to do it alone, but you need to help guide the patient towards a successful treatment.

DR. WYATT: I love that, because then that gets in to the social environment, and we know how important that social environment is in our behaviors. We tend to take on the behaviors of the people we hang around. So, who she starts hanging around may make those behaviors easier. If it's normal to bring your lunch to work, and you're hanging around people who bring their lunch to work, you're more likely to bring your lunch to work. If you're hanging out with people that go out, you're more likely to go out to lunch.

So, starting to increase your social environment or social circle, rubbing elbows with people that are doing some of the behaviors that she wants to try to do, is not only going to make her feel connected and may help her with her situation, also is a behavioral tactic that will work, that will help. So, I love that for a couple reasons.

DR. ECKEL: We focused on lifestyle a lot here, and behavior modification. But, now, the question fourth from the bottom, is she a good candidate for weight loss meds or other diabetes medications? That really is an important question. When do you have lifestyle up to a certain point, and then consider a medication? Or, should a medication be considered earlier for a patient like this, living with obesity and type 2 diabetes?

Bob, let's start with you on that one.

DR. KUSHNER: So, there's a very important observation you just made or a recommendation I'm going to give. I think a lot of primary care providers think a patient has to fail lifestyle treatment before you accelerate and become more aggressive. That's absolutely not true. What you're looking for is a patient who is engaged in self-care, maybe tracking their diet, aware of what they're eating, being more physically active, making appointments with you for touch points. If that is insufficient, then I would become more aggressive earlier, rather than later.

I think this is an excellent patient, once you've done the ground work of foundational changes, to think about a pharmacotherapy. We now have pharmacotherapy that will treat both diabetes and obesity using a GLP-1 receptor agonist, and hopefully soon, a dual agonist, GLP-1/GIP, in the near future for obesity as well.

These medications, that work pharmacologically through different integrated systems in the brain, change behavior. They change appetite, hunger, fullness, thoughts of food, cravings. We have all seen patients that have had difficulty following a diet, and you put them on a medication, and they become more adherent, because they don't have the noise going on in their head about I'm hungry, I'm not full, I'm thinking about food. If you can quiet the noise and give them a sense of control, they could very, very successful. So, Bob, the bottom line is: I would absolutely be thinking about a medication for this patient earlier rather than later in the course.

DR. ECKEL: Holly?

DR. WYATT: Totally agree, and I love that comment. One of the things I always say is: think about your hypertensive patient. Do you make them fail a low sodium diet or some type of diet before you would consider adding medication? I think for most people that's no. So, same thing. I would be thinking of this simultaneously. I think that this makes sense in her. So, depending on her feelings about it, obviously, I would definitely be thinking about that.

I also love the comments, and this is one thing I talk to my patients about sometimes, when I'm talking about medication, is kind of the two-way street between physiology and behaviors. They tend to separate them and think, well, my metabolism or my physiology is this way, and I talk about medications definitely work on that physiology.

But I also talk about how physiology is hooked to and impacts behaviors, and how behaviors

can impact physiology, and that they're really not as separate as we sometimes like to think of them. They are intertwined. So, yes, we're going to work on the behavior side, and that can impact your physiology. We can do medications that work on physiology that's going to impact your behaviors. So, they really work together. It's not like you have to choose one or the other. You can use them successfully together, and yes, it is about your metabolism and physiology. Let's optimize that. And let's use behaviors to allow the medications to work the best they can. Let's do both things to have them work together.

DR. ECKEL: Bob, it reminds of the slide you showed on stigma and how they impact the psychosocial environment and cause stress to make the patient ultimately not favorably influenced by anything you're going to do. So, a very important point, Holly.

As you think about weight loss medications, including patients living with obesity and type 2 diabetes, our keynote lecturer at the annual cardiometabolic health congress this year is given by a Chicago colleague, who you know probably well, Bob. That's Lou Phillipson. A topic called therapeutic inertia. Sometimes, we so delay therapeutic decision-making beyond the time when evidence suggests we have been too delayed in intervening, particularly in patients with positive family history for cardiovascular disease, modestly hypertensive, type 2 diabetes, excess body weight. Ultimately, the indication for a GLP-1 receptor agonist is pretty well there at the very beginning.

So, Bob, your thoughts about that.

DR. KUSHNER: I agree completely. The GLP-1 receptor agonists, to me, is this harmony called syndemic or diabesity in the previous program that you and I did, Bob. It's looking at a patient with two diseases that both interact, obesity worsening the diabetes. And, we now have a common medication to tackle both of these diseases, with the GLP-1 receptor agonist. So, that would be something I would thinking of. It's very powerful in changing or regulating appetite.

I'll also mention, though, Bob, that there are many other anti-obesity medications, or medications for chronic weight management, that will also improve her diabetes. They just don't work in an incretin fashion, like a GLP-1 receptor agonist. But she's a candidate for many medications here, depending upon her blood pressure and other side effects.

DR. ECKEL: So, Holly, to you, I think one of the questions you're posting here, and we're going to end with this, actually, she doesn't want to be on more medication. So, how can you influence a therapeutic decision, such as tirzepatide, by the way which is already approved for type 2 diabetes; it's not approved for obesity independent of type 2 diabetes. But, tirzepatide could be a choice here, or high-dose semaglutide, or even moderate-dose semaglutide would be helpful. How can you convince a patient who doesn't want more medication about a very effective medication, not only for losing weight, but also potentially modifying her cardiovascular disease risk?

DR. WYATT: I guess I wouldn't use the word convince her, but I would definitely make sure I would educate her. I would start planting the seeds. It might not be at this visit. If she is really resistant to that, then I'm not going to try to push that. But, I might start planting the seeds and make sure she understands and is thinking of the medication. She may in her

mind think of a medication as a cheating, or they're not effective, or she may not know a lot of things that made her feel that way. So, we're going to start talking about that, planting the seed, not pushing her in any direction, not trying to change her mind, but just trying to lay some groundwork.

I think the other thing, though, and I'd be interested to hear what Dr. Kushner thinks about this, is so many of these patients, when it comes to these for diabetes/obesity, it's really more for the obesity, but now, when you have the combination, don't want to be on them long term. They're okay with being on diabetes medications long term. For some reason, that sits well. But, being on obesity drugs long term doesn't sit well. What are your thoughts on that? How do you handle that?

DR. KUSHNER: You're absolutely right. People still have this notion that their weight is their fault. It's their personal responsibility to tackle, and I shouldn't have to be medication the rest of my life. Similarly, I shouldn't have to have an operation for my weight, because it's my responsibility.

It gets back to the education that you were just mentioning, Holly. It's that we need to educate them that obesity is a—I don't use the word disease often. I use chronic relapsing condition. I kind of soften the blow on that. But, I tell them that, just like diabetes and hypertension, we think of obesity as a chronic long-term problem, for which medication is going to be helpful. And it takes more than one session, typically, to do that education.

DR. ECKEL: Alright. Well, I want to thank both Drs. Kushner and Wyatt for their participation in this webinar. Just to summarize, we've got a fairly complicated patient who's continued to gain weight. She's reached the point where she's not satisfied with that weight gain, and she's asked your advice. I think addressing her clinically relates to the fact that she's asking you. So, we're asking her further whether we get next steps really identified and outlined, so that she can successfully achieve weight reduction, if that's her goal, and likely, it's your goal, too.

There may be some medical work up that's needed on the side. But, once that's complete, we've really discussed the steps in terms of bonding with her, educating her, and working with a program that she can buy into, that can be individually successful to follow.

So, I'm going to end by thanking Holly and Bob again for an outstanding discussion about a very complicated patient, but this one's a very common type of patient we all see in our practices, isn't it? So, thanks, Holly and Bob, again. Thank you for being part of the program today. Hopefully, this has been beneficial to you in your practice going forward.