

Obesity Medications: An Interdisciplinary Panel Discusses Cases

Dan Bessesen, MD

Colleen Dawkins, FNP-C, RDN, CSOWM

Diana Isaacs, PharmD, CDCES, BC-ADM

Amy von Sydow Green, MS, MD, RD

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Welcome

Today's Moderator

Hope Warshaw, MMSc, RD, CDCES, BC-ADM

- Academy Foundation Board member, Chair, Past Chair, 2018 – 2024
- Academy Nominating Committee, 2024-2027
- Owner, Hope Warshaw Associates, LLC, diabetes and nutrition-focused consultancy, Asheville NC
- CDCES, freelance writer, consultant, book author specialized in diabetes care, weight management.



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Three-Part Webinar Series

New Anti-Obesity Medications and the Critical Role of Nutrition and the RDN

Webinar 1: *Obesity as a Chronic Disease and Treatment Using New Anti-Obesity Medications*

Webinar 2: *The Role of the RDN to Optimize Short- and Long-term Use of Anti-Obesity Medications*

Webinar 3: *Obesity Medications: An Interdisciplinary Panel Discusses Cases*



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Planning Committee

Julia Axelbaum, RD, CSOWM, Weight Management DPG representative

Linda Gigliotti, MS, RDN, CDCES, FAND, Academy Foundation Board member

Carrie Snyder, MPH, RDN, CDCES, Diabetes DPG representative

Hope Warshaw, MMSc, RD, CDCES, BC-ADM, Academy Foundation Past-chair



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Webinar Learning Objectives

- Apply knowledge gained from webinars #1 and #2 in series to interdisciplinary discussion of real-world cases and clinical practice.
- Discuss distinct presentations of individuals using obesity medications in clinical practice, along with corresponding strategies for successful management.
- List ways to work productively with interdisciplinary healthcare providers partners to achieve positive clinical outcomes for individuals using these medications.
- Identify tactics to promote referrals to RDNs for MNT for individuals taking obesity medications.

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Webinar Flow

- Webinar and speaker intros
- Speakers offer key points for RDNs
- Case presentation and development with interdisciplinary dialogue
- Q and A
- Speaker's conclusions
- Webinar conclusion

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Affiliations & Disclosures

Dan Bessesen, MD

- Professor of Medicine, Division of Endocrinology, Metabolism and Diabetes, University of Colorado, School of Medicine
- Program Director, U of CO Obesity Medicine Fellowship
- Disclosures: several industry sponsored clinical trials of new AOMs including Eli Lilly and Novo Nordisk



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Affiliations & Disclosures

Colleen Dawkins, FNP-C, RDN, CSOWM

- Owns Big Sky Medical Wellness, a telemedicine private practice focused on treating metabolic health for people in WA and MT
- Serves as vice chair, Commission on Dietetic Registration's Certificate of Training for Obesity and Weight Management for Adult and Pediatrics
- Disclosures: none to declare



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Affiliations & Disclosures

Diana Isaacs, PharmD, CDCES, BC-ADM

- ⑩ Employed at Cleveland Clinic, Cleveland
 - Endocrine Clinical Pharmacy Specialist
 - Director, Education and Training in Diabetes Technology
 - Diabetes and Obesity Center
- ⑩ Disclosures: Speaker/Consultant for Eli Lilly, Novo Nordisk, Dexcom, Abbott, Sanofi



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Affiliations & Disclosures

Amy von Sydow Green, MS, RD, MD

- Clinical Dietitian, Penn Metabolic Medicine at U of PA Health System
- Holds medical degree from Sahlgrenska Academy, Gothenburg, Sweden
- Disclosures: Nothing to declare



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Speakers' Key Points: Role of the RDN and Obesity Medications

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Dan's Key Points to RDNs

- RDNs should feel comfortable discussing all these FDA-approved meds with patients.
- No need to promote or discourage use of an incretin-based therapy, but rather provide accurate information and risks/benefits of each.
- Key points to convey on incretin-based therapy use:
 - Only work as long as taken, need to be open to long term therapy
 - Average weight loss and side effects vary between the different medications
 - Tremendous variability in medication response (wt loss, side effects, tolerability). Currently no good way to predict response.
 - Health plan/insurance often does not cover an incretin-based therapy, so cost may be an important factor in medication choice. Older incretin-based therapies may be an option for those with access issues.
 - A person could try a medicine for a few months and experience the benefits/side effects, then decide on long term therapy.
- Newer incretin-based therapies have demonstrated health benefits in addition to weight loss.

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Colleen's Key Points to RDNs

- Elicit what is important to the person, why weight loss is a goal.
- Improve the person's understanding of how medication works, titration, and long-term use
- Plan for road-blocks such as medication shortage, health plan/insurance coverage
- Advocate for the person and communicate with the prescribing provider about adverse side effects (ASE), tolerance, dose recommendations, etc.
- Focus on therapeutic interactions: non-scale victories, support, empowerment
- Connect with prescribing providers to increase awareness of RDN services
 - Pharma Reps know who is prescribing, and can help connect
 - Simplify referral process to you and your colleagues
 - Offer to present at local provider meetings

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Diana's Key Points to RDNs

- Educate clients on healthy eating, quality nutrition.
- Focus attention on sustainable weight loss.
- Offer food/nutrition-based approaches to reduce medication side effects.
- Provide practical tips on ways to preserve muscle mass with weight loss.
- Consider your role as an integral part of the interdisciplinary provider team –review labs (ex. kidney function), side effects, contraindications, concerns (ex. gastroparesis).
- Evaluate and re-evaluate is the treatment plan working? Address potential barriers.

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Amy's Key Points to RDNs

- Encourage reporting of ASE, assist in management of nutrition related side effects (nausea, constipation, diarrhea etc).
- Explain and discuss importance of healthy eating behaviors, such as eating slowly without distractions, being mindful of chewing, paying attention to feelings of fullness and satiety, and incorporating regular meals.
- Help improve the individual's nutrition quality to optimize health (maintaining and protecting muscle/bone mass is key). Be aware of hydration status.
- Develop collaboratively a sustainable healthy balanced nutrition plan that fits their needs (including comorbidities such as T2DM, personal and cultural preferences).
- Help develop strategies for managing challenges to healthy eating, such as holidays, traveling, and eating out.

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Introduce Today's Case



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Case Introduction (Dan)

- MJ is a 45 yo woman with a long history of living with obesity.
 - Hypertension for 5 years, treated with lisinopril.
 - Diagnosed with obstructive sleep apnea 6 months ago. Struggling to use CPAP regularly.
 - Diagnosed with prediabetes 2 years ago. Over that time A1C has risen from 5.9% to 6.1%.
 - History of depression that she used medication for 3 years ago. Not taking medication currently for depression but feels "a little low" because of her weight.
- Currently at her peak lifetime weight of 212 lbs (BMI of 35 kg/m²).
 - Multiple prior weight loss attempts with WW, a low carb diet and intermittent fasting. Some previous success but has regained the lost weight each time.
 - Currently eating a "healthy diet" and walking for 20 minutes twice a week.
- M.J. went to her physician asking for one of the new weight loss medications. He told her that she needed to "work on her diet" before he would prescribe one and referred her to an RDN.

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Case Discussion Questions

1. Does a person have to “fail lifestyle treatment” before being considered for an incretin-based therapy?
 - If so, what constitutes "failing lifestyle treatment"?
2. What should an RDN say to M.J. sent by her PCP after asking for a "weight loss medicine"?
3. What topics would be important to discuss with M.J. before she starts on a newer incretin-based therapy?

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Case Continued (Colleen)

- After a consult with the RDN regarding goals, screening questions, and lifestyle changes, M.J. returns to her prescriber.
- In her note, the RDN notifies the prescriber that M.J. is always hungry and distracted by constantly thinking about what she can eat next.
 - M.J. has heard that these new weight loss medicines can cause nausea and is worried about this. M.J. is prescribed tirzepatide (Zepbound) 2.5 mg sub-Q weekly.
- At follow-up M.J. has lost 10 lbs in the first 3 weeks with no ASE. However, she does feel dizzy moving from sitting to standing. Her BP is 105/65 today.
- M.J. is eager to titrate her dose of tirzepatide (Zepbound) to 15 mg weekly; however, with the first dose of 5 mg, she reports on follow-up to the RDN that she is having nausea and vomiting. She doesn't want to tell her prescribing provider so that she can stay on the medication. After all, it works so well!

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Case Continued (Colleen)

- Titration and dosing
 - Start lowest dose weekly, titrate every 4 weeks if tolerated
 - Can slow titration or reduce the dose when needed; not advisable to skip doses
 - Highest dose is not necessarily the therapeutic dose needed for all patients
 - If daily injection medication, can titrate every 7 days
 - Oral semaglutide is titrated monthly
 - Dispose of pens or needles in sharps containers

- Potential Adverse Side Effects (ASE)
 - Nausea, vomiting, constipation, diarrhea, bloating, headache, fatigue
 - Relationship with food, disordered eating
 - Serious ASE: cholecystitis, pancreatitis, hypoglycemia, renal impairment (r/t unmanaged nausea/vomiting), mood changes

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Case Discussion Questions

1. How would/should a prescriber select an incretin-based therapy for M.J.?
2. If the RDN hears about one or more ASE from their client, what is their responsibility to report these to the prescriber?
3. What lifestyle interventions should the RDN address with M.J. early in her use of an incretin-based therapy?

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Case Continued (Diana)

- It's 5 years later. M.J. is now 50 years old.
- M.J. was off the incretin-based therapy for the last few years due to changes in health insurance coverage.
- M.J. reached a lower body weight (191 lbs, BMI 32) but has regained back to her starting weight (212 lbs). M.J. is now perimenopausal and was diagnosed with type 2 diabetes a year ago.
 - Most recent A1C = 7.8%
- M.J. takes the following glucose-lowering medications: metformin 1000 mg 2x/day, glimepiride 8 mg/day.
- M.J. takes for lisinopril 40mg daily and HCTZ 25mg daily for hypertension which is well-managed.
- M.J. started a new job. New health insurance plan covers several incretin-based therapies.

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Case Discussion Questions

1. When adding an incretin-based therapy, which of M.J.'s glucose-lowering medications may need to be decreased or stopped?
 - How would/should a prescriber approach this?
2. Can M.J. be started at a higher dose since she has taken an incretin-based therapy in the past?
3. How should you as one of her clinicians talk to M.J. about her potential response to this incretin-based therapy and expectation for weight loss?

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Case Continued (Amy)

- It is 1 year later. M.J. is now 51 years old.
- M.J. restarted an incretin-based therapy one year ago.
- In the first 9 months M.J. reached a weight loss of 16%. She has now been maintaining her lower weight of 178 lb (BMI = 30) for 3 months.
- Most recent A1C = 6.8%
 - Metformin 1000 mg twice daily (glimepiride discontinued)
- Hypertension continues to be well-managed with lisinopril 40mg daily and HCTZ.
- Physical activity: walking for 20 minutes twice per week.
 - M.J. asks the RDN about guidelines for physical activity.
- M.J. is busy with work and describes sometimes struggling with maintaining a regular mealtime routine.

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Case Discussion Questions

1. How can an RDN discuss the long-term use of an incretin-based therapy with clients?
2. What are several key behaviors for successful long term weight management?
3. What is the scope of practice for a RDN regarding physical activity?

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Questions?



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Speaker's Conclusions

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Moderator's Conclusions

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- Available now:
 - Archived 3-part webinar series available at <https://www.eatrightpro.org/aom>
 - Education materials on Diabetes DPG's website: <https://www.dce.org/resources/education-handouts>
 - Education materials on Weight Management DPG's website: <https://www.wmdp.org/wm-resources>
- On the Way:
 - Resources and publications developed by subject matter experts with Academy's Research, International and Scientific Affairs (RISA) team

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- [NewsFlash](#) is a peer reviewed newsletter published three times a year by Diabetes DPG
- [FREE webinars](#) for members on hot topics

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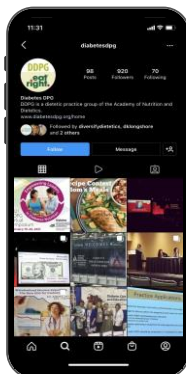
- [DDPG reproducible patient educational handouts](#) are produced annually and maintained in the DDPG publication area of the website.

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