

It's time to consider pharmacotherapy for obesity

THE ARTICLE in this issue by Bersoux et al on pharmacotherapy to manage obesity¹ is apropos in light of a recent study² showing that patients are filling 15 times more prescriptions for antidiabetic medications (excluding insulin) than for antiobesity drugs. What makes this finding significant is that nearly 3 times more adults meet the criteria for use of antiobesity drugs than for antidiabetic drugs—116 million vs 30 million, respectively.

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This underuse of antiobesity medications has been noted in other studies. In 1 study,³ only about 2% of adults eligible for weight-loss drug therapy received a prescription. Conversely, about 86% of adults diagnosed with diabetes received antidiabetic medications.³

■ WEIGHT LOSS: IT'S IMPORTANT

This underuse of weight-loss drugs occurs despite our understanding that obesity is a risk factor for developing diabetes and that weight loss in obese patients reduces the risk.

The landmark Diabetes Prevention Program study found that even modest weight loss of 7% reduced the risk of developing diabetes by 58% in overweight and prediabetic individuals.⁴ Additionally, a 5% to 10% weight loss can lead to significant improvements in many comorbidities, including diabetes, hyperlipidemia, hypertension, sleep apnea, and fatty liver disease.

Antiobesity medications can help patients achieve weight-loss goals, especially if lifestyle and behavioral modifications alone have been unsuccessful. Data show that these drugs result in an average weight loss of 5% to 15% when added to diet and exercise.

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■ BARRIERS TO PRESCRIBING WEIGHT-LOSS DRUGS

Why are practitioners reluctant to prescribe these drugs despite the worsening obesity epidemic and despite knowing that obesity is a risk factor for diabetes? Many of us who practice obesity medicine believe there are several reasons.

One barrier is the misconception that obesity does not warrant treatment with weight-loss medications, even though most practitioners will readily admit that patients cannot achieve effective, durable, and meaningful weight loss with behavioral changes and lifestyle modifications alone.

Other barriers stem from issues such as time constraints in the office, lack of training to treat this condition, and not enough data on the newer chronic weight-loss medications. And there are stringent requirements for patient follow-up once a medication has been initiated. Finally, it's often difficult to obtain insurance coverage.

Addressing the barriers

Of these, I believe the biggest barrier for busy practitioners is finding the time and effort they need to devote to prescribing weight-loss medications. There are ways to address these issues.

Regarding time constraints, practitioners can discuss weight loss at follow-up visits and refer patients to obesity specialists. Regarding gaps in training and knowledge of obesity management, there are consensus guidelines for the identification, evaluation, and treatment of the overweight or obese individual.⁵⁻⁷ Guidelines provide extensive information on the pharmacologic treatment of obesity. These resources provide valuable evidence-based recommendations on how to manage this chronic disease.

■ ARMED WITH INFORMATION, PHARMACOLOGIC OPTIONS

Bersoux et al provide another valuable resource for clinical use of weight-loss drugs.¹ They accurately re-

view the available medications, their mechanisms of action, dosing, efficacy, side effect profiles, and clinical indications. Their review is comprehensive in every aspect of this drug class.

This is important information for practitioners to have when considering prescribing antiobesity medications. It is especially important for primary care practitioners because of the large number of obese or overweight patients they treat.

Drug options have expanded

We did not always have this many drugs to choose from. As Bersoux et al note, practitioners had limited options for weight-loss medications during the 1990s and early 2000s, and several of those had to be taken off the market because of serious side effects. Then between 2012 and 2014, the US Food and Drug Administration approved 4 new medications, giving us a total of 6 weight-loss drugs. Those approvals greatly increased the available drug treatments, giving us much-needed options beyond lifestyle and behavioral modifications.

Although it is widely accepted that antiobesity drugs are underused, the study by Thomas et al was the

first to quantify the extent of underuse, especially for the newer chronic weight-loss drugs.² Their data show that only about 19% of antiobesity prescriptions were for the newer drugs while 74% were for the older but short-term medication phentermine.

Bersoux et al seem to encourage primary care physicians, or anyone caring for overweight or obese patients, to consider prescribing these treatments if non-pharmacologic options are unsuccessful. I agree with this concept because there are not enough specialists to care for the more than 116 million individuals who are potential candidates for antiobesity medications.

THE TIME HAS COME

This new class of medications has been strongly endorsed by the most prestigious organizations and societies involved in developing treatment guidelines for the overweight or obese patient. It is time for everyone who sees overweight or obese patients in daily practice to consider adopting chronic weight-loss medications as adjunctive therapy if lifestyle and behavioral strategies are ineffective. ■

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