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THE LATEST UPDATES IN OBESITY MANAGEMENT IN PRIMARY CARE

Obesity Clinical Practice Guidelines – What's New

The Canadian Obesity Clinical Practice Guidelines, published in 2020, have significantly shifted the dialogue around obesity management. These guidelines place substantial emphasis on patient-centered care, reducing stigma and bias, and recognizing obesity as a chronic disease, and have set a new global standard for obesity management. Most recently, Ireland and Chile have adapted these guidelines in their own countries.

The approach to obesity treatment has evolved from a linear model of lifestyle modification followed by medication and then considering bariatric surgery, to a three-pillar strategy.[1] This strategy is underpinned by medical nutritional therapy and physical activity which, although crucial for overall health, are not effective standalone tools for obesity and often fall short of success with long-term weight reduction.

Obesity is defined as a chronic, progressive disease caused by dysfunctional adipose tissue that increases hunger hormones and lowers metabolic rate (thermogenic adaptation) in response to weight loss. This biological defense mechanism explains why diet and exercise alone are often insufficient for managing this chronic condition.[2] This is also the reason why we have moved away from relying solely on the BMI calculation to diagnose obesity.

Obesity is now diagnosed using multiple characteristics including BMI, waist circumference and, most importantly, health consequences from excess adiposity. The three pillars of treatment for obesity include behavioural/psychological interventions, pharmacotherapy, and bariatric surgery **(Figure 1)**. These treatment modalities directly address the consequences of dysfunctional adipose tissue and are considered the only true long-term treatments for obesity.

Since its initial publication, the guidelines have updated the obesity pharmacotherapy chapter to include the newest addition of medication options, specifically, adding Wegovy (semaglutide 2.4 mg/week). There are now 4 Health Canada-approved medications for obesity: Orlistat, Saxenda (liraglutide 3 mg/day), Contrave (naltrexone/bupropion) and Wegovy (semaglutide 2.4mg/week) **(Table 1)**.

This update not only reviews the evidence for medication use and summarizes the efficacy of each agent but also introduces a new methodology for selecting the most appropriate pharmacotherapy option. The new recommendation suggests identifying the comorbidities related to obesity and choosing the pharmacotherapy agent based on this, amongst other patient and medication specific factors.

The GLP-1 RA class of medications, including liraglutide and semaglutide, has shown benefit in diabetes remission and HbA1c improvement, alongside Orlistat. Of medications used for the treatment of obesity, the GLP-1 RA class of medications is the only one beneficial for MASH (metabolic dysfunction-associated steatohepatitis) parameters. Liraglutide has been shown to improve the apnea-hypopnea index in those with obstructive sleep apnea, and Contrave has been shown to improve depression scores.[3] Both Contrave and Wegovy have shown an improvement in cravings. Wegovy is the only obesity medication that has demonstrated a cardiovascular mortality benefit in those with established cardiovascular disease, as seen in the SELECT trial.[5] Given these established improvements in adiposity-related health conditions, the choice of pharmacotherapy should take into consideration the desired health outcomes of the patient instead of focusing on weight loss alone.

The recommendation for choosing pharmacotherapy also emphasizes considering patient- specific factors such as cost/coverage, delivery method, medication interactions, contraindications, and efficacy, with a stronger focus on obesity-related health issues. There's also an important recommendation on prescribing medications as a long-term treatment for obesity, acknowledging that weight regain is likely once treatment is discontinued, regardless of treatment choice.[3] Prescribing medication also provides a valuable opportunity to discuss and educate patients about why obesity is considered a chronic disease, emphasizing the importance of medication compliance for long-term success.

Practical Tips For Obesity Management in Primary Care

Many primary care providers feel overwhelmed by the prospect of adding obesity treatment to their already extensive list of responsibilities. However, it's important to recognize that excess visceral fat increases a patient's risk of multiple health conditions, including metabolic conditions such as high blood pressure, fatty liver, high cholesterol, type 2 diabetes, heart disease, and cancer. It also increases the risk of mechanical health conditions such as sleep apnea and osteoarthritis, as well as mental health conditions including anxiety and depression. Addressing the main contributor of these conditions, obesity, is crucial for improved patient care and outcomes. Lastly, primary care professionals are best equipped to oversee chronic conditions such as obesity, due to established long-term therapeutic alliances with patients. Educating patients about the relationship between obesity and their mental and physical health in a truly

Medical Nutrition Therapy (MNT)

MNT is used in managing chronic diseases and focuses on nutrition assessment, diagnostics, therapy and counselling. MNT should:

a. be personalized and meet individual values, preferences, and treatment goals to promote longterm adherence
b. be administered by a registered dietitian to improve weight-related and health outcomes

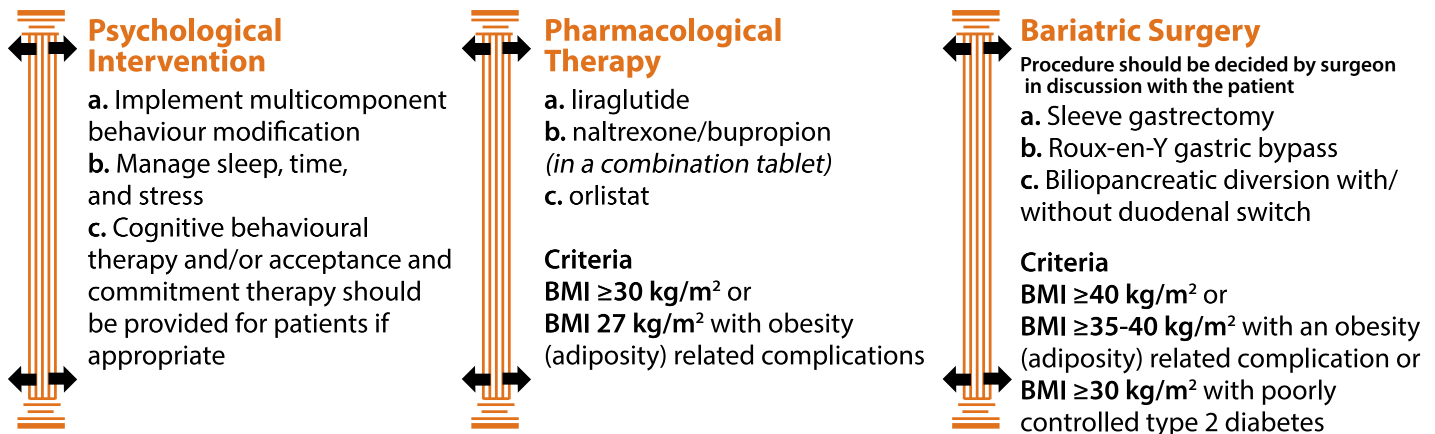
Physical Activity

30-60 mins of aerobic activity on most days of the week, at moderate to vigorous intensity, can result in:

a. small amount of weight and fat loss
b. improvements in cardiometabolic parameters
c. weight maintenance after weight loss

Remember nutrition and physical activity recommendations are important for all Canadians regardless of body size or composition

The Three Pillars of Obesity Management that Support Nutrition and Activity



Treating the root causes of obesity is the foundation of obesity management - refer to the 4M framework - *mechanical, metabolic, mental and social milieu*

Figure 1. The Three Pillars of Obesity Management that Support Nutrition and Activity; *adapted from CMAJ Appendix 2, 2020 Clinical Practice Guidelines: 5As Framework for Obesity Management in Adults*

empathetic manner is essential. The initial step is to explain why obesity is a chronic disease and to illustrate how even a modest reduction of 5-10% in weight can significantly help in managing their other medical conditions. It is vital to manage expectations to help with long- term treatment success as most patients expect to lose more than 20-30% (on average) of their weight, which is unrealistic with most treatment outcomes. Your best weight is the one you reach by enjoying the healthiest lifestyle possible, and it's important to celebrate this achievement despite any difference from your expected ideal weight, as positive health outcomes can occur with any amount of weight loss.[6]

Almost every individual grappling with obesity has dealt with criticism, attempted various dieting approaches, and faced setbacks. As patients internalize these adverse events as personal failures, a phenomenon referred to as internalized bias, the effectiveness of treatment tends to diminish. By addressing the bias and stigma associated with obesity, reviewing the pathophysiology behind the body's defence of its highest weight, and explaining that safe and effective treatments are available, we can shift the conversation from frustration caused by unrealistic expectations to hope and optimism arising from more realistic goals.

To assist our patients, it is valuable to explore simple and practical ways to support those living with obesity. To begin a conversation, it is best to ask if they are open to discussing their weight. If they agree, express that even modest weight loss could improve their health and manage related conditions. Then inquire, "On a scale of 0 to 10, how confident are you that you can lose weight at this time?" If they answer '4', probe further with, "I'm curious, why did you answer with '4' and not '5'?" Their response will offer deep insights into their challenges and perceived barriers. Review the three pillars of treatment (behavioural therapy, medications, and surgery) and inquire about their preference(s) for safe and effective treatment.

Arrange a follow-up visit to discuss this further, just as with any other chronic conditions like type 2 diabetes or hypertension. This gradual, empathetic approach also facilitates practical lifestyle changes in an efficient way. Patients are appreciative and responsive as this level of empathy and understanding regarding their struggles

with obesity is unfortunately rare.

Quick Nutrition Tips: Is There a Best Diet?

There is no single best diet that suits everyone. The most effective diet is one that an individual can maintain long term. As we lose weight, our body naturally increases our appetite and control of eating becomes challenging which is why, in general, the recommendation is to avoid highly restrictive diets as they are rarely sustainable. Advising people to follow a diet that worked for you, a family member, or another patient is not beneficial, as individuals have different lifestyles and dietary preferences. A one-size-fits-all approach should be avoided.[4] Focusing on nutrition that keeps patients full and satisfied, with a healthy balance of macronutrients and a positive relationship with food should be emphasized.

Using motivational interviewing, as previously described, to identify the specific challenges a patient is facing, is helpful when establishing nutrition-based goals. Whether they are overeating due to lack of satiety, emotional eating, or cravings, it is important to work together on strategies to address challenges in a patient-centered way. Understanding high-risk times of the day or triggers for their cravings can significantly reduce their overall intake in a more sustainable manner. Remind them that while this approach may result in slower and possibly less weight loss initially, it reduces the likelihood of weight regain. If possible, referring patients to a dietitian or a certified bariatric educator can be helpful for creating individualized nutrition plans.

Managing Obesity in Patients Who Cannot Afford Obesity Medications

The cost of obesity medications presents a significant challenge. Currently, obesity medications are not covered by any provincial drug plan and are often not covered by private insurance. However, discussing the benefits of modest weight loss—including the need for fewer medications overall, increased energy, improved mental health, less joint pain, and better sleep—may persuade patients who are initially deterred by the cost to consider them. Many patients have spent significant amounts of money managing their weight through commercial programs, which can be redirected toward evidence-based treatments that have been shown to have long-term success.

Nevertheless, some individuals simply cannot afford these medications. In such cases, optimizing behaviours and overall health is still a valuable outcome. Inquire if they have access to a dietitian or other allied healthcare

Agent	Populations Showing Weight Loss Benefit in Clinical Trials*	Average Weight Loss at 1 year	Benefits in adiposity related health parameters	Cost	Provincial Coverage for Obesity Pharmacotherapy
Liraglutide 3 mg SC daily	Overweight and Obesity PreDM T2DM NASH OSA	-8.6% vs -2.6% placebo	Remission of PreDM A1C NASH parameters apnea-hypopnea index BP QoL	$$$$	None
Naltrexone-Bupropion 8/90 mg 2 tabs PO BID	Overweight and Obesity T2DM	-6.1% vs -1.3% placebo	A1C Depression scores Cravings QoL	$$$	None
Orlistat 120 mg PO tid	Overweight and Obesity PreDM T2DM	-10.2% vs -6.1% placebo	Remission of PreDM A1C	$$	None
Semaglutide 2.4 mg SC weekly	Overweight and Obesity PreDM T2DM NASH	14.9% vs -2.4% placebo	A1C NASH parameters BP Cravings QoL	TBD	None

Table 1. Medications Approved in Canada; *adapted from Pharmacotherapy in obesity management, Pedersen, SD et al., 2022*

*Clinical trials conducted in populations with overweight and obesity, and trials conducted in populates with overweight/obesity and specific comorbidities (PreDM, T2DM, MASH, OSA)

Abbreviation: preDM = prediabetes; **T2DM** = type 2 diabetes mellitus; **NASH** = nonalcoholic steatohepatitis**; OSA** = obstructive sleep apnea; **A1C** = hemoglobin A1C; **BP** = blood pressure; **QoL** = quality of life

support and consider the other two pillars of treatment (behavioural change and bariatric surgery). Importantly, review if they are taking weight gain promoting medications and consider alternatives where appropriate. Antipsychotics and insulin are the most prescribed medications that cause weight gain. Where possible, alternative options such as SGLT2 inhibitors or GLP-1 RA should be considered for patients with type 2 diabetes. Consider using metformin to prevent weight gain caused by anti-psychotic medications as recommended in the Obesity Canada Clinical Practice Guidelines pharmacotherapy chapter.[3]

Finally, focus on optimizing lifestyle changes through behavioural support. Educate patients on modulators of the appetite system and the importance of stress management, high-quality sleep, and the role of their environment in weight management.

It is important to remind patients that the goal of the above-mentioned treatment modalities isn't solely weight loss but improving how they feel and their overall health. Often, re-defining success with behaviour goals (e.g., walking 5 blocks without shortness of breath) is more effective than emphasizing a number on the scale. Addressing these issues can often enhance patients' well-being and improve overall satisfaction with treatment.

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