



# With U.S. obesity rate over 40%, 3 treatment keys for doctors

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In 2013, the AMA recognized obesity as a disease, which was a huge step forward in the field of medicine. Yet about 42% of Americans now have obesity, which is up from one-third a decade ago. On top of that, obesity now costs the U.S. about \$1.72 trillion every year.

Additionally, nearly half of the cost of chronic disease can be attributed to obesity, according to an education session at the 2023 AMA Annual Meeting in Chicago. But treating obesity is *not* telling patients to “eat less” and “move more.”

“The modern treatment of obesity is this: The physician measures the body mass index, sees that it is high, tells the patient they are morbidly obese. We code it with an ICD-10 code that says morbid obesity due to excess calories, morbid deadly obesity because of eating too much. That’s our ICD-10 code,” said AMA member Ethan Lazarus, MD, a family physician and obesity medicine specialist in Greenwood Village, Colorado.

“It completely ignores the biology and the pathophysiology of obesity. We would never tell a patient you have morbid deadly cancer. Yet that is what we do with obesity,” said Dr. Lazarus, past president of the Obesity Medicine Association, noting “there are two types of obesity: There are people with obesity who are being properly treated and then there’s the 98% who are receiving no treatment at all.

“Treatment means they’ve been offered intensive lifestyle intervention, anti-obesity pharmacotherapy and, if they’re candidates, bariatric surgery. If we haven’t done those things, we haven’t addressed the obesity with the current standards of care,” he added, emphasizing that “obesity is a serious chronic and treatable disease.”

Here are some things to keep in mind when treating patients with obesity.

## Provide a diagnosis and follow up visit

Unfortunately, “one study—the ACTION study—showed that roughly half of patients affected by obesity don’t have a diagnosis. And nearly two-thirds aren’t offered a follow-up visit,” Dr. Lazarus said. “So, the patient goes in, they don’t know if they have obesity or not.” And the physician often fails to “offer a follow-up visit because they’re not sure what to do with that visit.”

“That’s a big problem,” he said, noting that physicians should “make a diagnosis, do it in a patient-friendly way, using person-first language and preferred terms—‘Can we talk about your BMI, which is in an unhealthy range,’ not ‘You are morbidly obese,’—and schedule a follow-up visit. This is no different than we would do for any other diagnosis.”

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## Offer intensive lifestyle interventions

Physicians ought to treat obesity as they do “everything else in medicine,” Dr. Lazarus said. “We offer patients the best evidence-based tools. For obesity, these tools are: intensive lifestyle intervention, medical management including anti-obesity pharmacotherapy, and bariatric surgery. That’s it. That’s all we need to know. These are the tools.

“What we’re going to think about is what’s the burden of disease for the patient. ... And start thinking about a percentage weight loss that would be appropriate for the patient,” he said. “Pick the right tools to get them there. Of course, as we move up the pyramid, we move up in terms of the risk, the complexity and the cost, but lifestyle intervention is the base of the pyramid.”

## Don’t ignore anti-obesity medication

“Medical management first involves making sure the patient is medically managed for all of their other problems and then it also involves adding pharmacotherapy,” Dr. Lazarus said, noting that one part of this is ensuring patients are not on medications for other conditions that cause weight gain if there are safe and effective alternatives. After that, physicians can look at anti-obesity medications such as glucagon-like peptide-1 (GLP-1) receptor agonists.

As explained in a *JAMA*<sup>®</sup> Medical News & Perspectives article, “GLP-1 receptor agonists mimic the GLP-1 hormone, which increases insulin production when blood glucose levels are elevated. The GLP-1 hormone also slows gastric emptying—in turn prolonging the feeling of fullness after eating—and works as an appetite suppressant by targeting parts of the brain responsible for hunger and cravings.”

Dr. Lazarus noted one study showing that with oral anti-obesity medication, patients “with overweight and obesity maintained an average weight loss of 10.6% and studies on GLP-1 receptor agonists show 15-20% or more.”