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EMERGING CHALLENGES AND CLINICAL UPDATES IN PRIMARY CARE

Live Virtual Conference

AAPA | The Obesity Society

Obesity Management in Primary Care

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This activity is part of the ***Obesity Management in Primary Care Training and Certificate Program*** provided by the National Association for Continuing Education (NACE) and the American Academy of Physician Associates (AAPA) in collaboration with The Obesity Society (TOS).

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OBESITY MANAGEMENT IN PRIMARY CARE TRAINING AND CERTIFICATE PROGRAM

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- **Guest Patient 1**
  "Name not disclosed"

Disclosures

- **Angie Golden** has disclosed the following financial relationships*:
  - Advisory Boards and Consultant: Novo Nordisk, Gelesis, Currax
  - Speaker: Novo Nordisk
  - Royalties: Springer Nature
- **Robert Kushner** has disclosed the following financial relationships:
  - Advisory Boards and Consultant: Novo Nordisk, WW, Pfizer, Lilly
  - Speaker: none
  - Research Support: none
- **Karli Burridge** has disclosed the following financial relationships:
  - Consultant: Novo Nordisk
  - Advisor: Gelesis Biotechnology, Currax Pharmaceuticals, Vivus
  - Speaker's Bureau: Currax Pharmaceuticals, Vivus

Faculty for this educational activity not listed above have no relevant financial relationship(s) to disclose with ineligible companies whose primary business is producing, marketing, selling, re-selling, or distributing healthcare products used by or on patients.

*these are the disclosure relevant to this presentation.

All relevant financial relationships and potential conflicts of interest have been mitigated.

Learning Objectives

Recognize	Recognize obesity as a chronic, relapsing disease with unique, distinct pathophysiology that contributes to adiposity, comorbidities, and complications
Summarize	Summarize long-term pharmacotherapy to manage obesity, including new and emerging pharmacologic agents, based on efficacy and safety data
Develop	Develop individualized treatment plans for patients with obesity that incorporate evidence-based and clinical practice guidelines

Pre-test Questions

Pre-test Question 1

Pre-T1: Which of the following factors mediate the link between obesity and comorbidities such as dyslipidemia and insulin resistance?

1. Secreted adipocyte factors
2. Increased anorexigenic signaling
3. Reduced ghrelin production in gut
4. Reduced circulating levels of estrogen

Pre-test Question 2

Pre-T2: Which of the following medications have demonstrated an average of ≥ 15% weight loss in clinical trials?

1. Liraglutide
2. Naltrexone/bupropion
3. Phentermine/topiramate
4. Semaglutide

Pre-test Question 3

Pre-T3: 52 y/o man with obesity, T2D, hypertension, dyslipidemia.

Says he is concerned about weight gain over last 10 years (~25 lbs).

Workup: BMI 32.7 kg/m^2, BP 128/82 mmHg, A1C 6.9%, eGFR 52 mL/min/1.73m^2.

Meds: Metformin 1000 mg bid, canagliflozin 100 mg qd, lisinopril/hydrochlorothiazide 20 mg/25 mg qd, atorvastatin 80 mg qd.

Lifestyle: Walks briskly for 1 hour 6 days per week; follows a low-calorie, low-fat diet.

Notes that he hates needles and does not want injectable medications.

What would you do next for this patient?

1. Recommend bariatric surgery
2. Down-titrate obesogenic medications
3. Prescribe exenatide, lixisenatide, or dulaglutide
4. Discuss benefits of phentermine/topiramate or naltrexone/bupropion

Pre-test Question 4

Pre-T4: 38 y/o woman with history of T2D, hypertension, obesity.

Has gained 45 lbs in last 5 years.

Workup: BMI 34 kg/m^2, BP 142/86 mmHg, A1C 6.7%.

Meds: Lisinopril 20 mg qd, metformin 1000 mg bid, naltrexone/bupropion 2 tablets bid.

Lifestyle: Swims 45 min 5x week, lifts weights 2x week; goes to commercial weight-loss program.

Started naltrexone/bupropion 3 months ago; has lost 5 lbs (2.4% baseline weight) in that time.

What might be appropriate at this time?

1. Maintain naltrexone/bupropion for at least 6 months
2. Stop naltrexone/bupropion and refer for bariatric surgery
3. Continue naltrexone/bupropion and prescribe phentermine
4. Discontinue naltrexone/bupropion and prescribe liraglutide or semaglutide

Pre-test Question 5

Pre-T5: How confident are you in your ability to select long-term pharmacotherapy to manage patients with obesity?

1. Not at all confident
2. Slightly confident
3. Moderately confident
4. Pretty much confident
5. Very confident

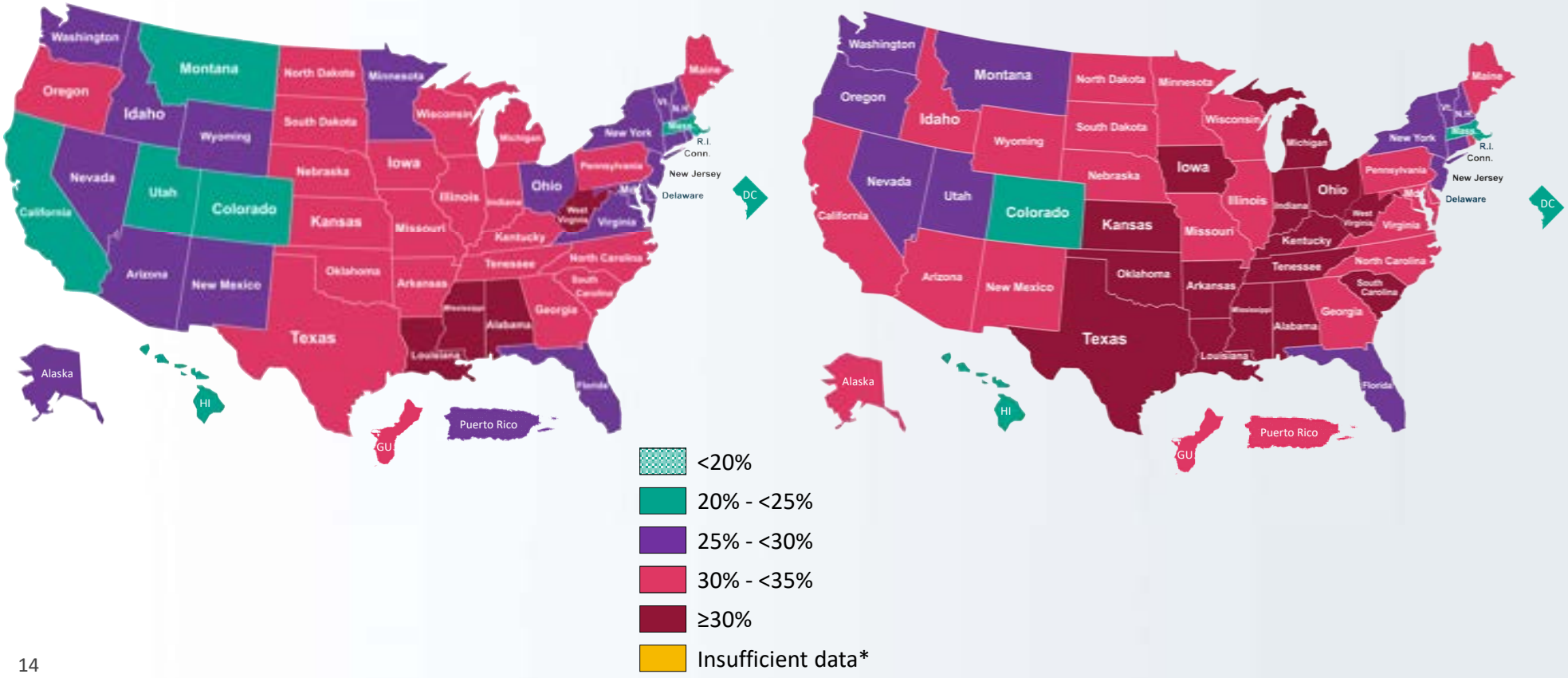
Pre-test Question 6

Pre-T6: How often do you assess comorbidities when considering anti-obesity therapies for patients with overweight/obesity?

1. Never
2. Rarely
3. Sometimes
4. Often
5. Always

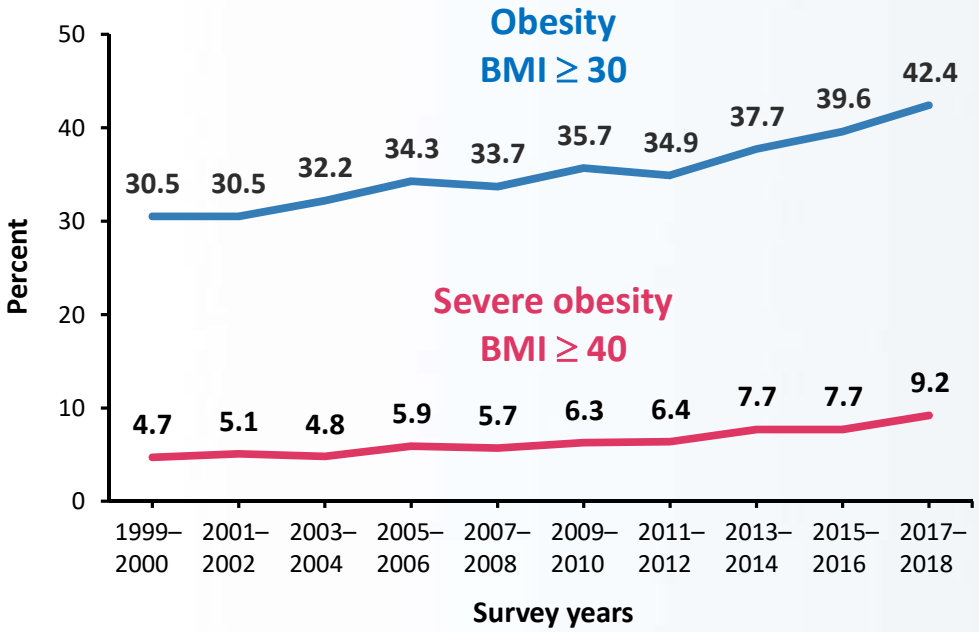
Understanding Obesity

Prevalence of Self-reported Obesity: U.S. Adults by State and Territory, BRFSS 2015—2020

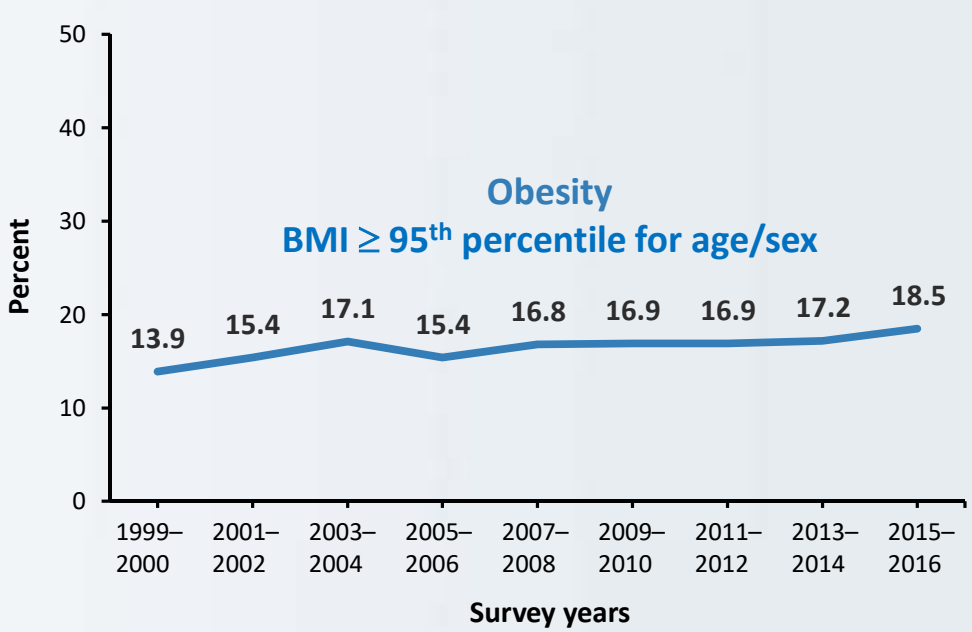


Trends in Obesity Prevalence, United States

Adults aged ≥20 years (age adjusted)[1]



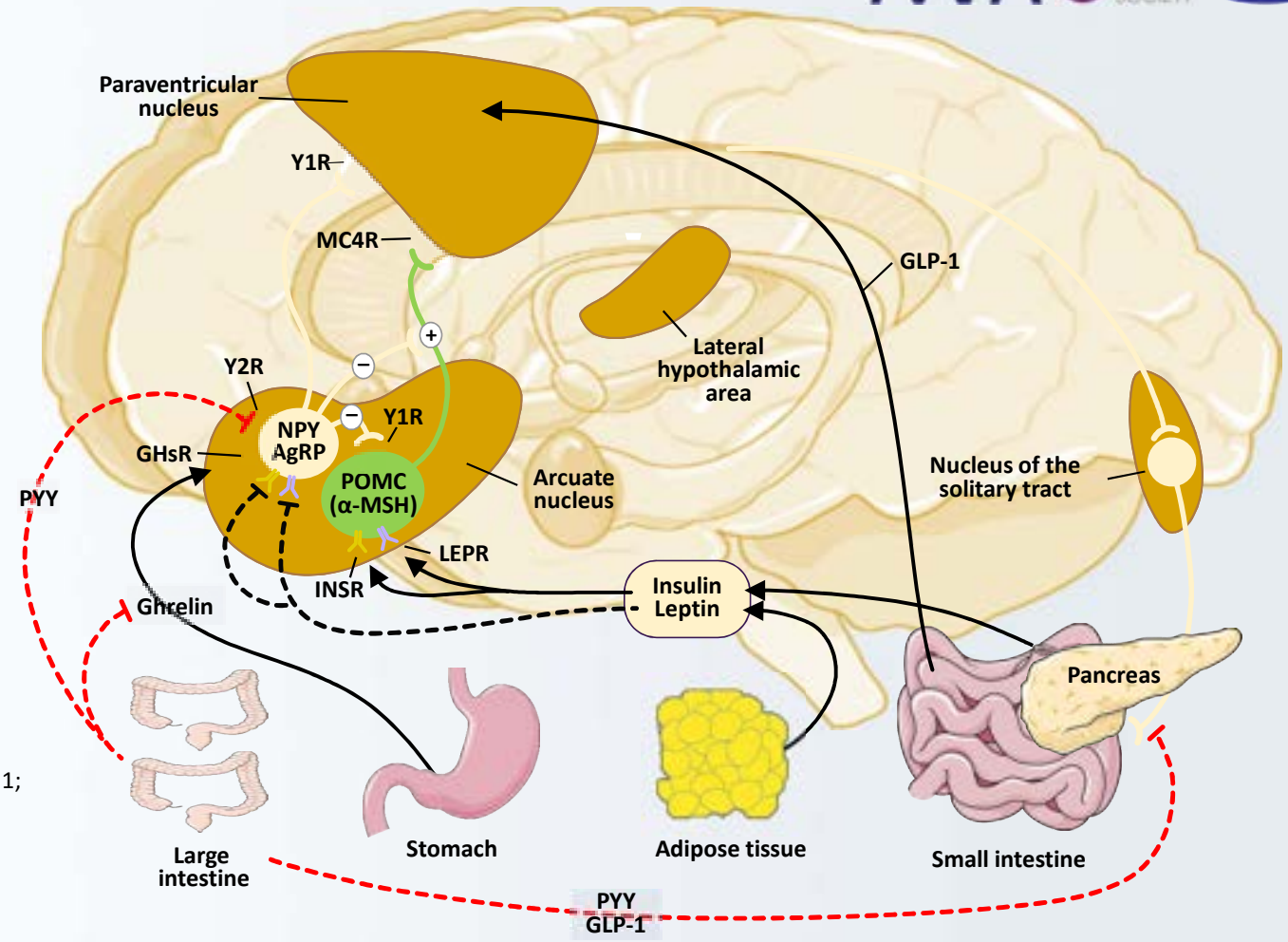
Youth aged 2–19 years[2]



1. NCHS Data Brief No. 360, Feb, 2020; 2. NCHS Data Brief, No. 288, October, 2017

Components of Appetite Regulation/ Dysregulation

Dysregulation of Biosignaling = Obesity



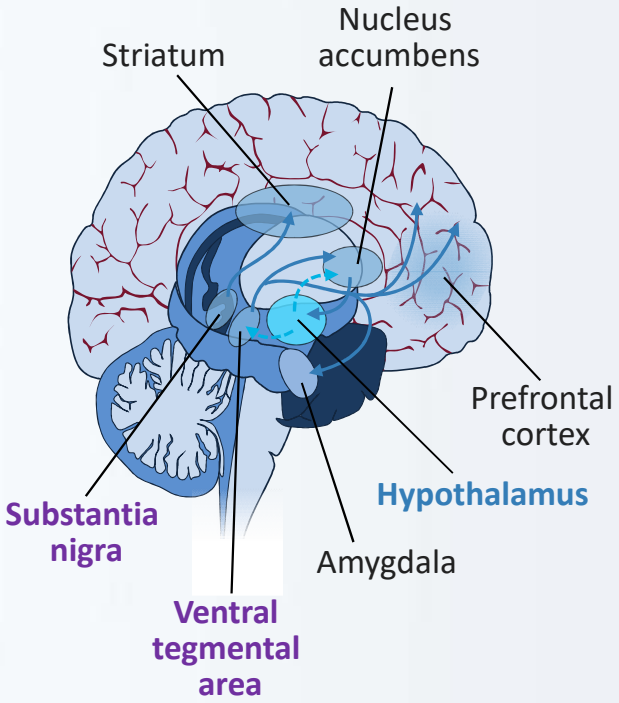
α-MSH, α-melanocyte-stimulating hormone; GHsR, growth hormone secretagogue receptor; INSR, insulin receptor; LEPR, leptin receptor; MC4, melanocortin-4 receptor; POMC, pro-opiomelanocortin; Y1R, neuropeptide Y receptor 1; Y2R, neuropeptide Y receptor 2.

Apovian CM, et al. J Clin Endocrinol Metab. 2015;100(2):342-362.

Integrated CNS Pathways Play a Key Role in Regulating Eating Behavior, Appetite, Cravings, and Weight

Homeostatic System
Hunger / Satiety

- Primarily driven by the arcuate nucleus of the **hypothalamus**
- Detection and integration of energy state information
  - Leptin, insulin
- Lateral hypothalamus projects to the VTA and receives input from the nucleus accumbens



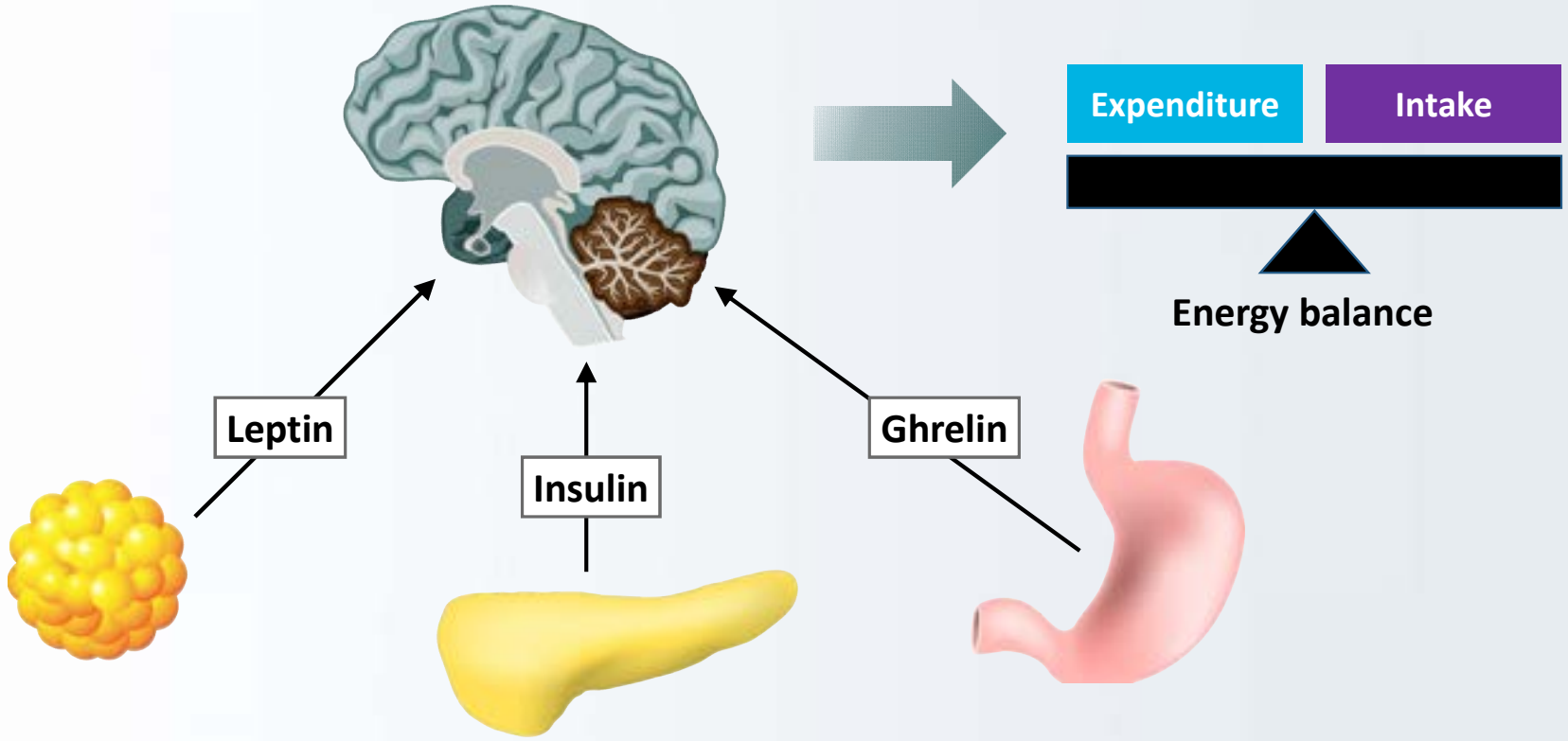
Hedonic or Reward System

- Dopaminergic pathways from the **VTA or substantia nigra** to regions such as:
  - Striatum (movement, reward salience)
  - Nucleus accumbens (reward, addiction)
  - Prefrontal cortex (decision making, executive function)
  - Amygdala (memory, emotion)

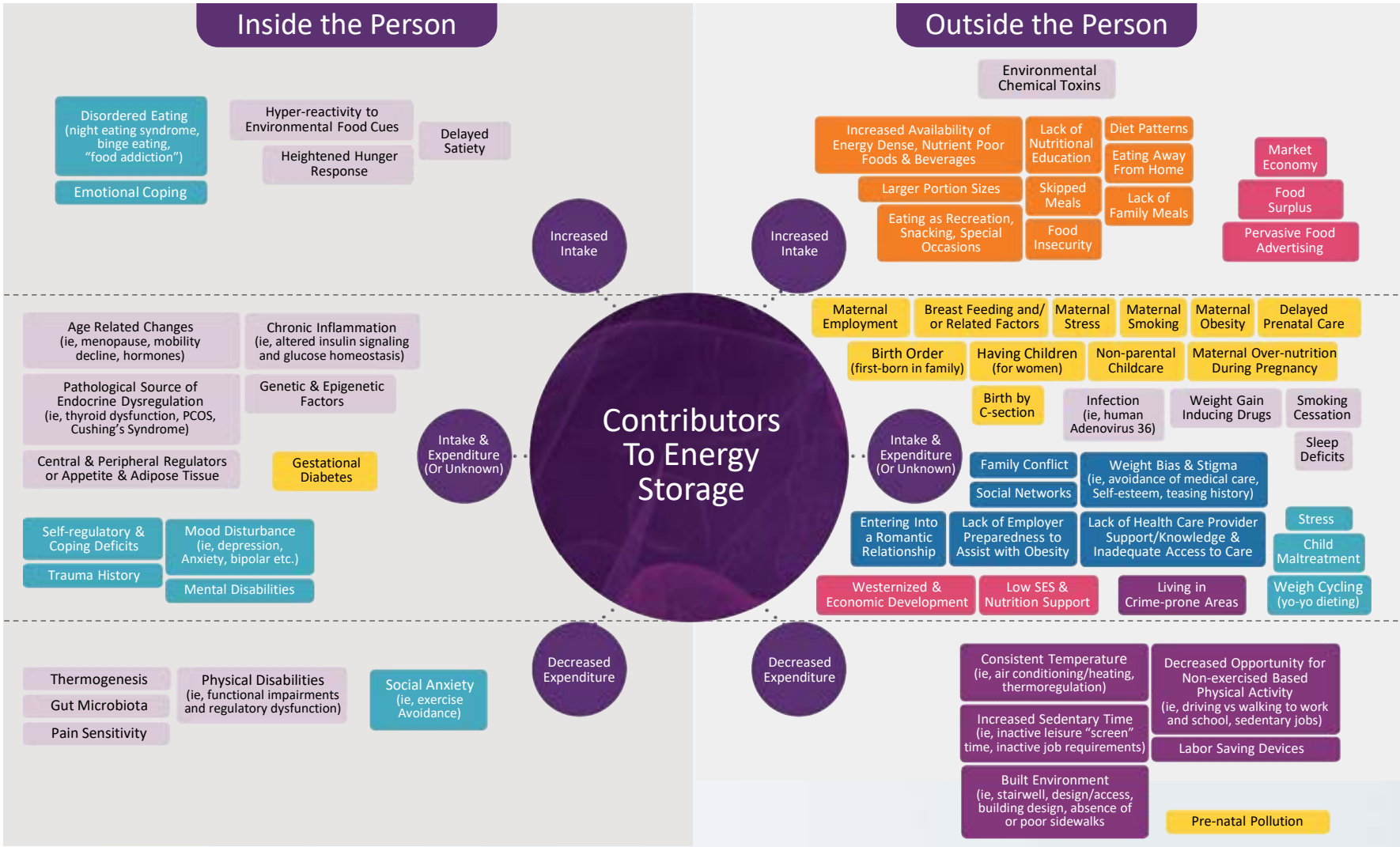
CNS, central nervous system; VTA, ventral tegmental area.

Billes SK, et al. *Pharmacol Res*. 2014;84:1-11.

The Pathology of Obesity
Energy Balance Dysregulation

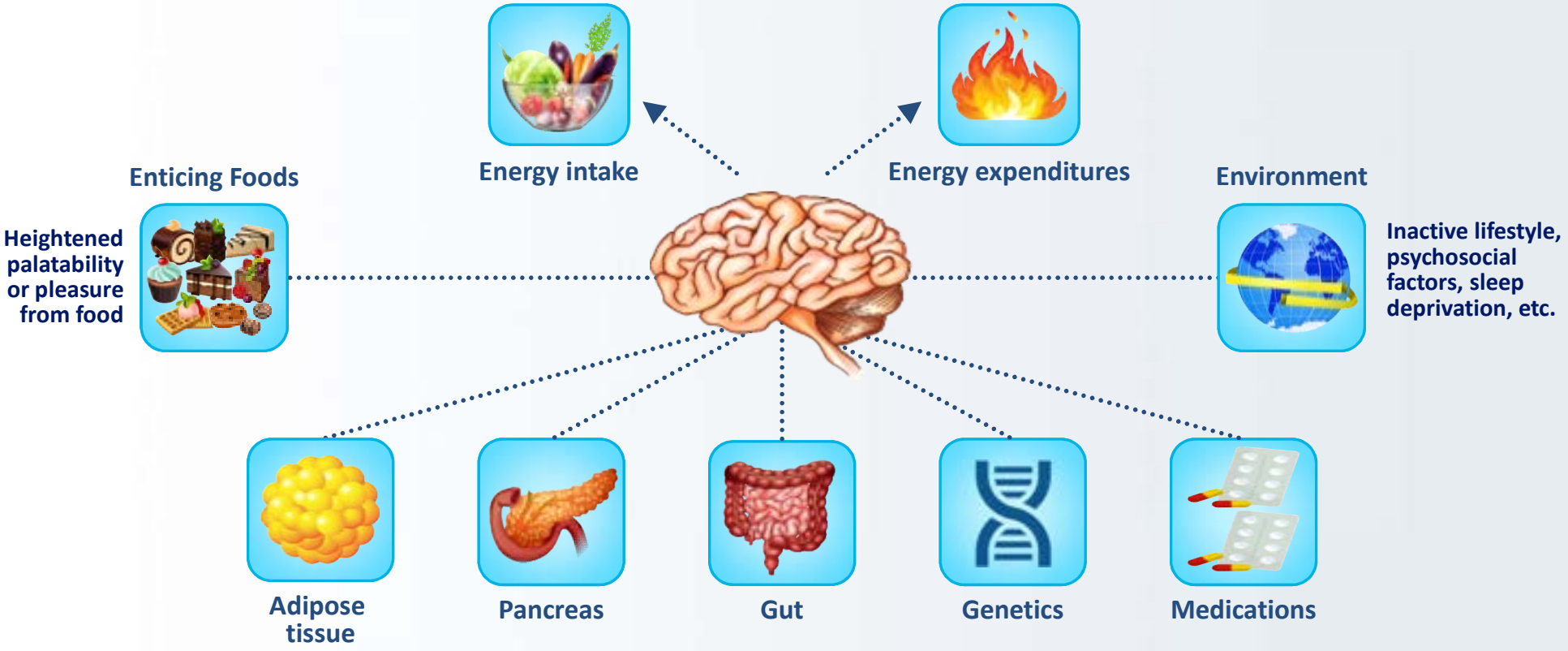


Potential Contributors to Obesity 2015



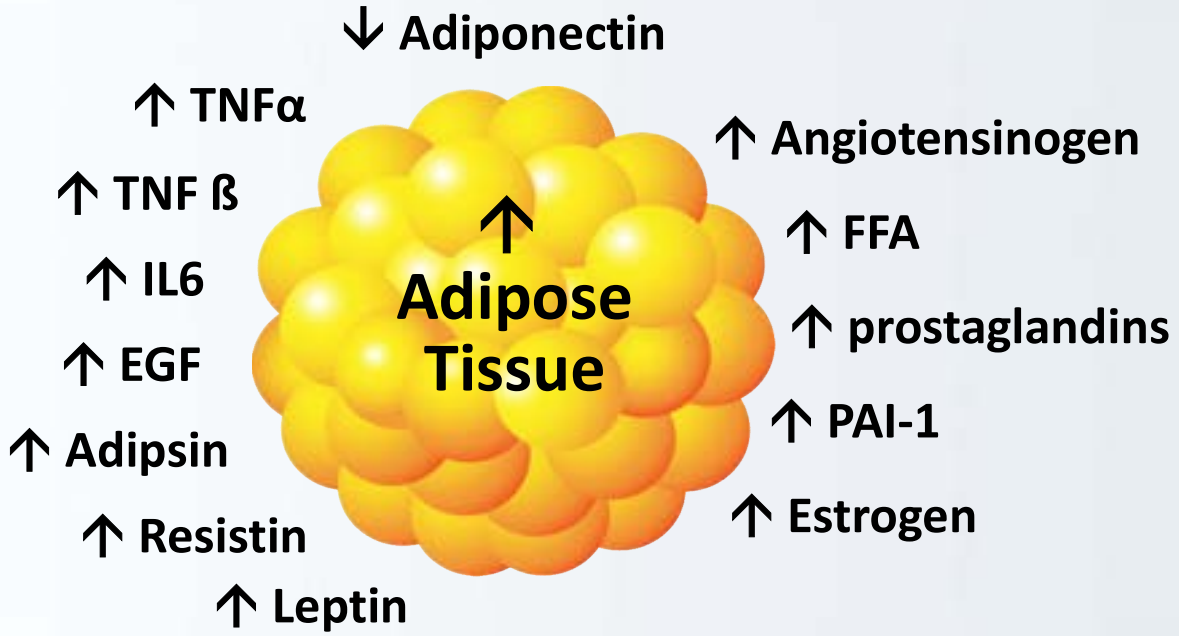
Adapted from The Obesity Society

Energy Balance Dysregulation



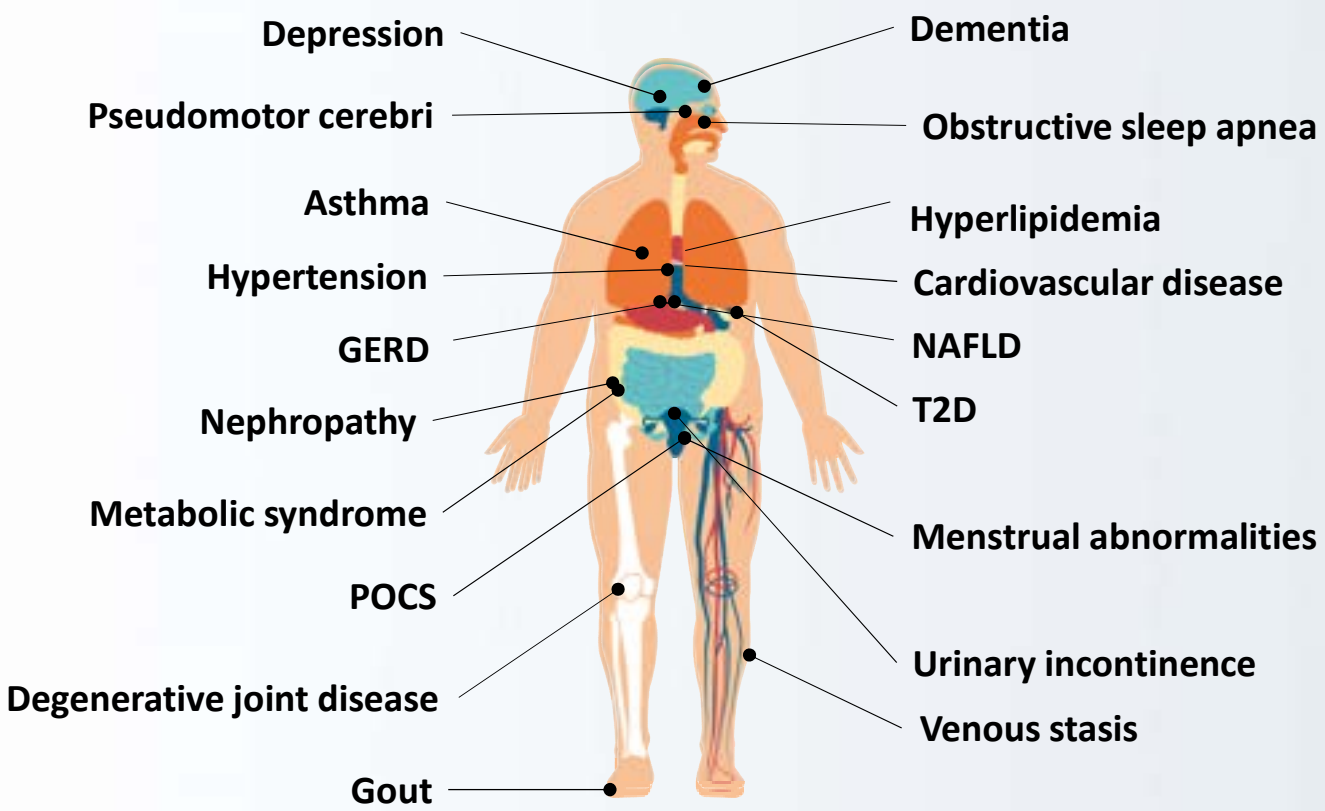
1. Badman, Flier. Science 2005;307:1909–14; 2. US Department of Health and Human Services, 1998. NIH Publication No. 98-4083

The Pathology of Obesity
Organ System Impairment



LIPOTOXICITY

Obesity-Related Diseases



Link Between Pathophysiology of Obesity and Comorbid Conditions

Central Adiposity

Secreted Adipocyte Factors

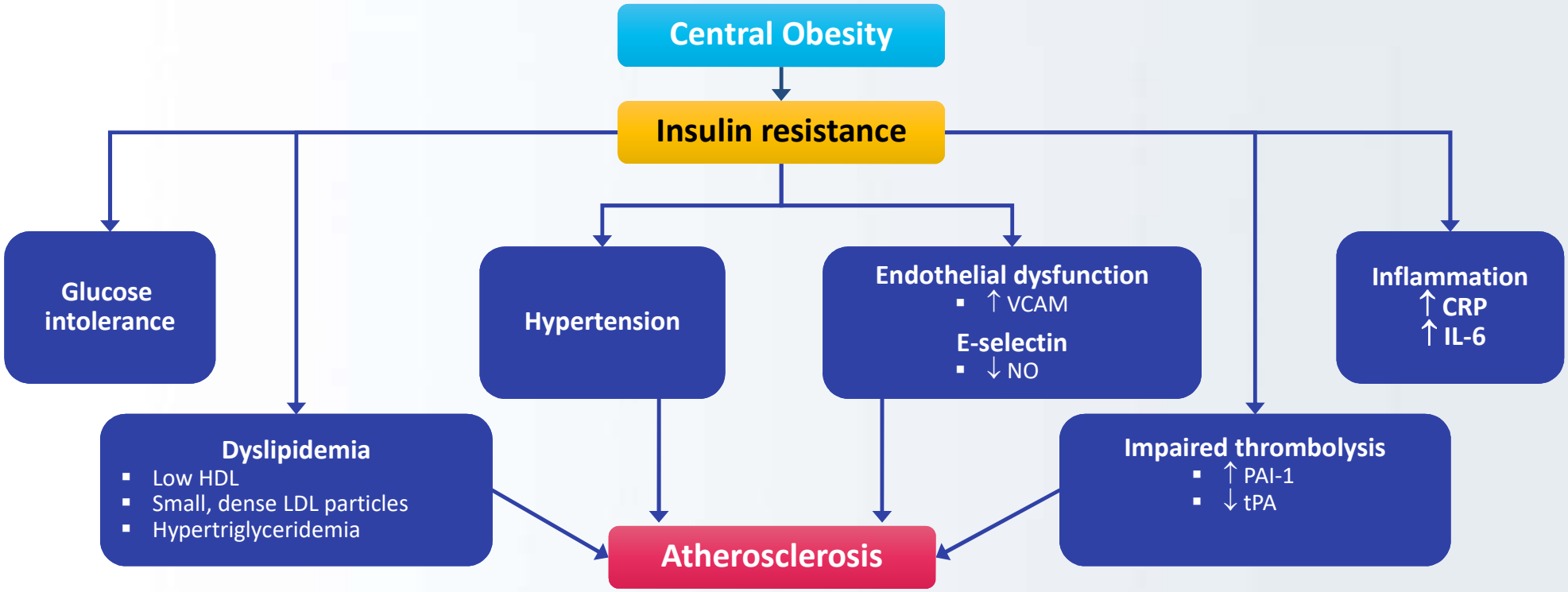
DYSLIPIDEMIA
- Increased large VLDL
- Increased small LDL
- Increased LDL particles
- Decreased large HDL

VASCULAR DYSFUNCTION
- Vascular reactivity
- Dysfibrinolysis
- Inflammation
- Foam cell

INSULIN RESISTANCE
- Glucose intolerance

Allende-Vigo MZ. Endocr Pract. 2010;16(4):692-8.

Association of Insulin Resistance With Cardiovascular Risk Factors and Atherosclerosis



CRP, c-reactive protein; HDL, high-density lipoprotein; LDL, low-density lipoprotein; NO, nitric oxide; PAI-1, plasminogen activator 1; tPA, tissue plasminogen activator; VCAM, vascular cell adhesion molecule

McFarlane SI, et al. J Clin Endocrinol Metab. 2001;86(2):713-718.

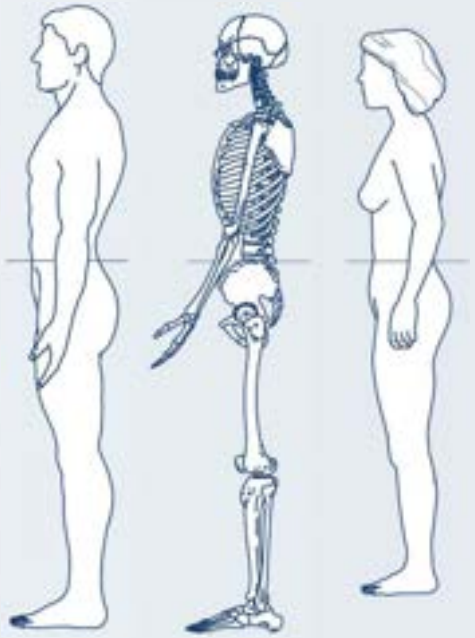
How Do We Define Obesity?

- A condition characterized by excessive accumulation and storage of fat in the body
- Excess adiposity resulting in reduced health and longevity
- An abnormal or excessive fat accumulation that presents a risk to health.

Anthropometry = Science of measuring human body

- ✓ Skinfold thickness and circumferences
- ✓ Bioelectrical impedance analysis (BIA)
- ✓ Dual-energy x-ray absorptiometry (DXA)
- ✓ Air displacement plethysmography
- ✓ Computed Tomography (CT scan)

Measuring tape position for waist (abdominal) circumference



Plethysmography

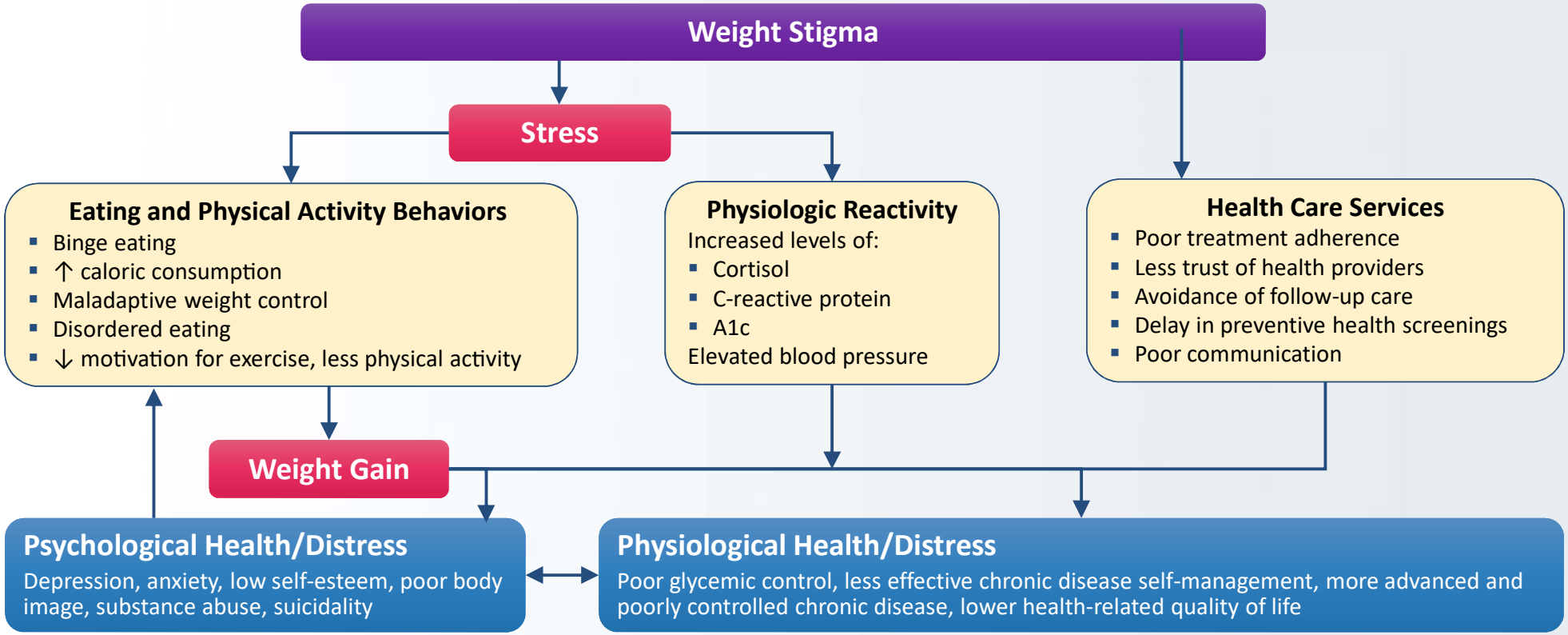
NHLBI Obesity Education Initiative Expert Panel on the Identification, Evaluation, and Treatment of Obesity in Adults (US). Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. Bethesda (MD): National Heart, Lung, and Blood Institute; 1998 Sep. Chapter 4, Treatment Guidelines.

Patient Speaker – Perspectives on Bias

What Is Weight Bias?

- Negative attitudes toward individuals with obesity
- Stereotypes leading to:
  - Stigma
  - Rejection
  - Prejudice
  - Discrimination
- Verbal, physical, relational, cyber
- Subtle and overt

Weight Bias Internalization



Puhl RM, et al. *Clin Diabetes*. 2016;34(1):44-50.

The Approach to Obesity

Screening and Diagnosis

BMI

- Non-Asian
  - ≥ 25 kg/m^2 pre-obesity (overweight)
  - ≥ 30 kg/m^2 obesity
- Asian
  - ≥ 23 kg/m^2 pre-obesity (overweight)
  - ≥ 25 kg/m^2 obesity

Waist circumference

- Non-Asian
  - > 40 inches in men
  - > 35 inches in women
- Asian
  - > 35 inches in men
  - > 31.5 inches in women

Fat percentage

- Men > 30% obesity; 25%—29% pre-obesity
- Women > 35% obesity; 30%—34% pre-obesity

	BMI ranges (kg/m^2)	
Category	**Non-Asian descent**	**Asian descent**
Underweight	< 18.5	< 18.5
Normal	18.5—24.9	18.5—23.0
Pre-obesity/ overweight	25—29.9	23—27.5
Obesity	≥ 30	≥ 27.5

Fitch, A. et al. *Obesity Pillars*, Volume 1,2022.

Staging: Identifying High-Risk Patients

	AACE Staging System	
Stage	**BMI (kg/m^2)**	**Complications**
0	≥ 25-29.9 OR ≥ 30	No identified complications
1	≥ 25	≥ 1 mild-to-moderate complications that may be treated effectively by treating obesity
2	≥ 25	≥ 1 severe complication and may require more aggressive treatment

	Edmonton Obesity Staging System			
Stage	**Obesity-related risk factors**	**Physical symptoms**	**Psychological symptoms**	**Functional limitations**
0	None	None	None	None
1	Subclinical	Mild – no medical treatment needed	Mild	QoL not impacted
2	Established ORC with medical intervention	Moderate	Moderate psychological sx (depression, anxiety, eating disorder)	Moderate – QoL is being impacted
3	Significant ORC with end organ damage (MI, heart failure, diabetes with complications)	Significant (incapacitating OA)	Significant (reduced mobility, unable to work or complete ADLs)	Significant – QoL is significantly impacted
4	Severe	Severe	Severe	Severe

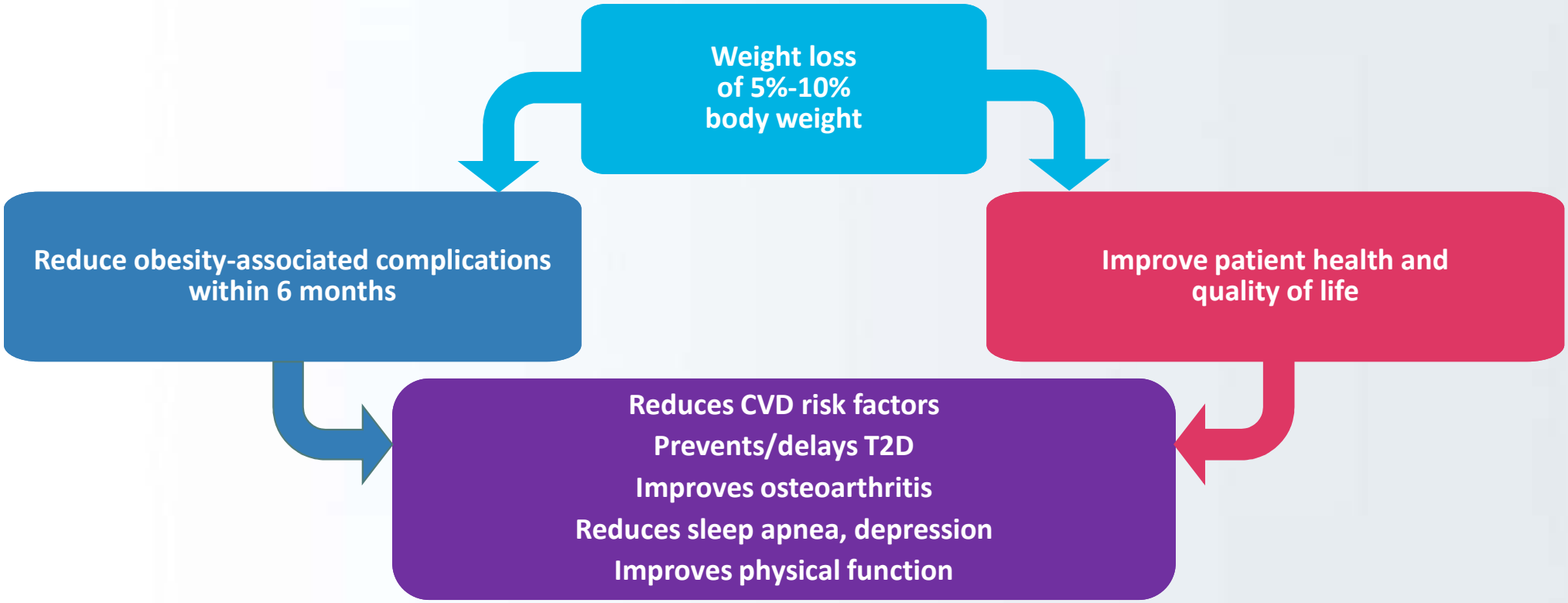
ORC, obesity-related complication; MI, myocardial infarction; OA, osteoarthritis; ADLs, activities of daily living; QoL, quality of life ; AACE, American Association of Clinical Endocrinologists

APPROACH: The 5As

ASK	Ask the patient's permission "Would you be willing to discuss your weight and the treatment options?"
ASSESS	Usual PMH/SH including weight history, family history of obesity, obesogenic medications; review food intake, current activity, sleep duration and stressors
ADVISE	Advise on treatment options
AGREE	Utilize motivational interviewing and shared decision making to develop a plan of treatment from the options discussed
ASSIST	During follow-up visits assist the patient in staying on track, reassessing for needed changes in treatment; referrals and resources

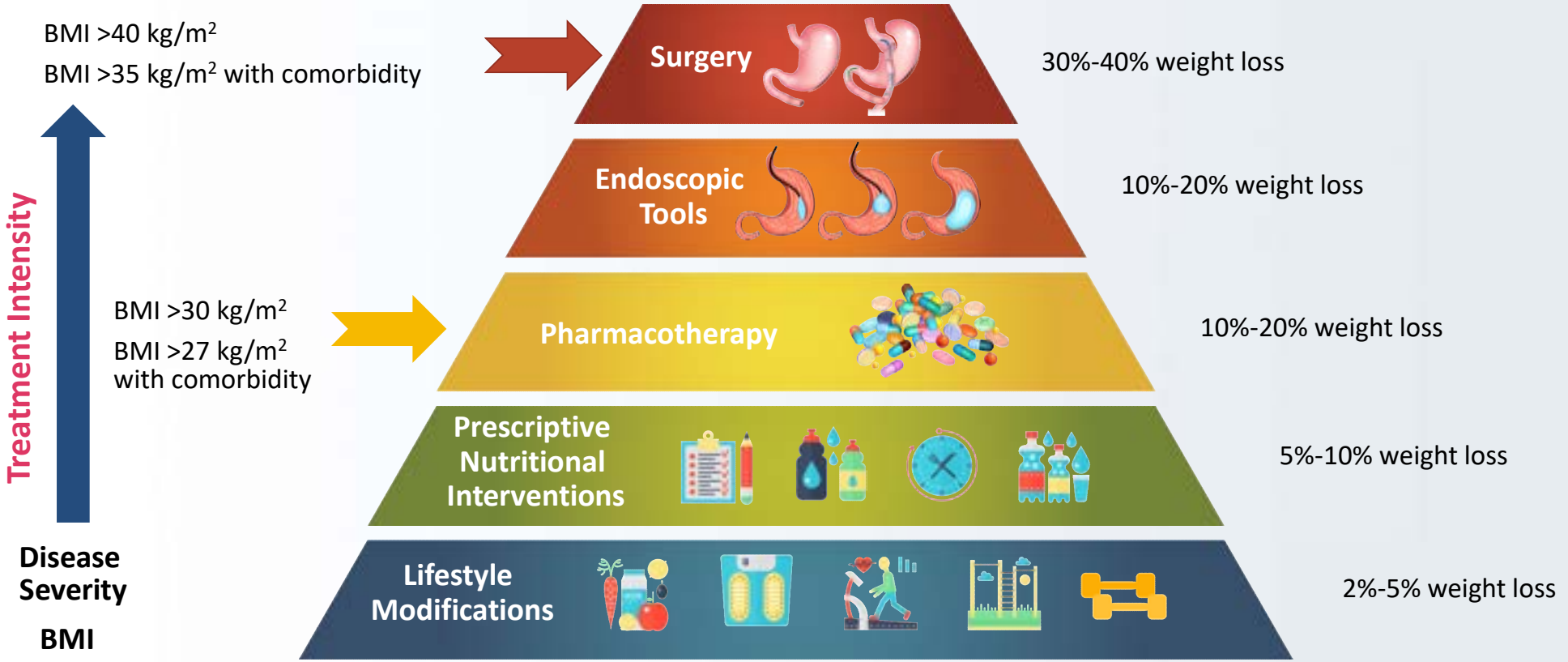
Patient Speaker – Perspectives on the Approach to Obesity Management

Obesity Management: Therapeutic Goals



Jensen MD, et al. *Circulation*. 2014;129:S102-S138; Garvey WT, et al. *Endocr Pract*. 2016;22 Suppl 3:1-203; Yanovski SZ, et al. *JAMA*. 2014;311:74-86; Apovian CM, et al. *J Clin Endocrinol Metab*. 2015;100:342-362.

Obesity Treatment Pyramid



Tchang BG, et al. *Med Clin North Am*. 2021;105(1):149-174.

Lifestyle Interventions


Keto


Paleo


Vegetarian


Vegan

EATING PLANS


Mediterranean


Low Carb


DASH


No Sugar

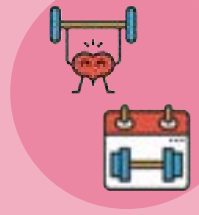
Aerobic exercise

During obesity treatment:
150 min per week

Maintain Weight Loss:
300-400 min per week

ACTIVITY

Resistance Training
Twice per week to maintain lean mass




Motivational interviewing

BEHAVIORAL TECHINQUES

Cognitive-behavioral therapy


Sleep / Circadian enhancement

OTHER HEALTH FACTORS

Stress reduction

Obesity Pharmacotherapy

What Is the Primary Purpose of Adjunctive Medications Used in Obesity Treatment?

The primary purpose of anti-obesity medications is to

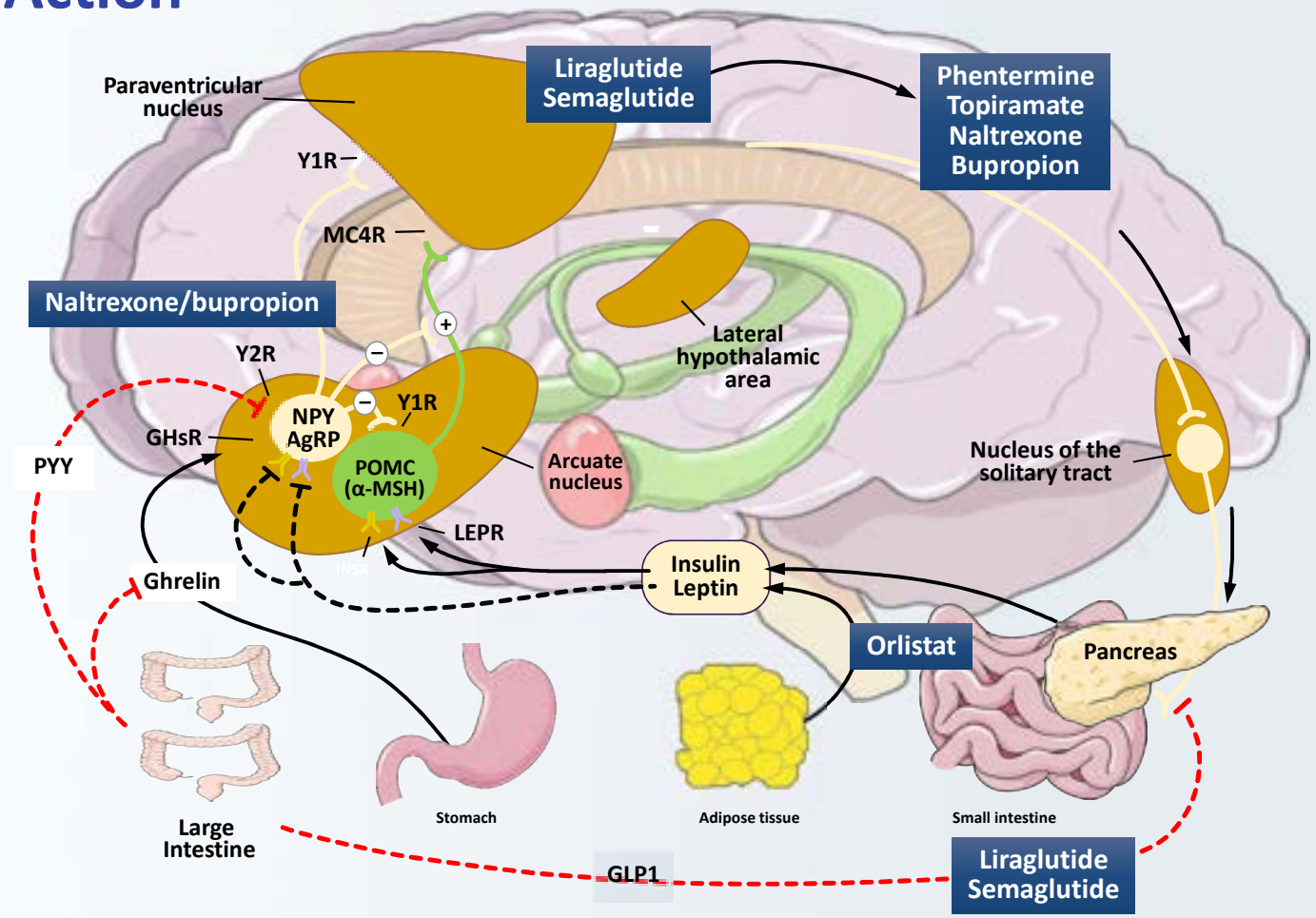
- Impact the pathophysiology of the disease,
- Facilitate weight loss and health improvements, and
- Support adherence to lifestyle interventions by helping patients change their relationship with food.

Indicated for patients with BMI ≥30 kg/m^2 or BMI ≥27 kg/m^2 with a comorbidity

FDA-Approved Medications for Obesity

Agent	Mechanism of Action	Effect	Approval Date
Phentermine (Lomaira/Adipex)	Sympathomimetic	Appetite regulation	1959
Orlistat (Xenical or Alli)	Pancreatic lipase inhibition	Reduces fat absorption	1999
Phentermine/topiramate ER (Qsymia)	Sympathomimetic, anticonvulsant (GABA receptor modulation, carbonic anhydrase inhibition, glutamate antagonism)	Appetite regulation	2012
Naltrexone/bupropion SR (Contrave)	Opioid receptor antagonist Dopamine/noradrenaline reuptake inhibitor	Appetite regulation	2014
Liraglutide (Saxenda)	GLP-1 receptor agonist	Appetite regulation	2014
Setmelanotide (IMCIVREE)	Melanocortin 4 (MC4) receptor agonist *[Indication: Obesity due to POMC, PCSK1, or LEPR deficiency]*	Appetite regulation	2020
Semaglutide (Wegovy)	GLP-1 receptor agonist	Appetite regulation	2021

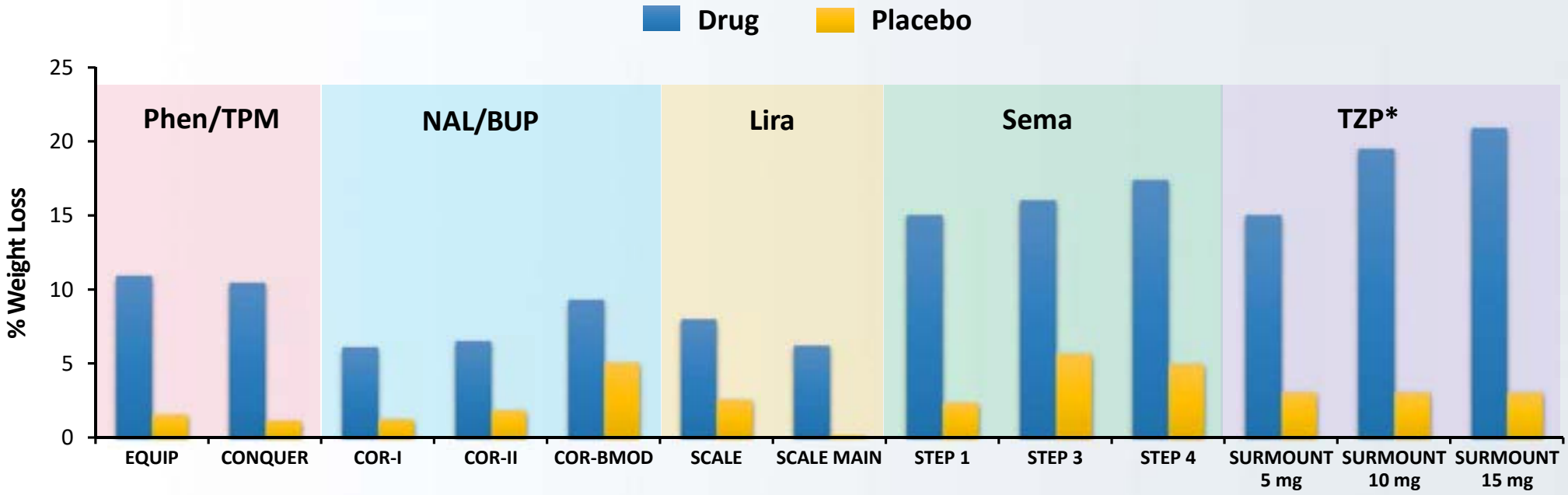
Medication Sites of Action



α-MSH, α-melanocyte-stimulating hormone; GHsR, growth hormone secretagogue receptor; INSR, insulin receptor; LEPR, leptin receptor; MC4, melanocortin-4 receptor; POMC, pro-opiomelanocortin; Y1R, NPY Y1 receptor; Y2R, NPY Y2 receptor.

Apovian CM, et al. *J Clin Endocrinol Metab.* 2015;100(2):342-362.

Average Percent Weight Loss (Drug vs. Placebo) from Randomized, Controlled Trials



*Not FDA approved for obesity

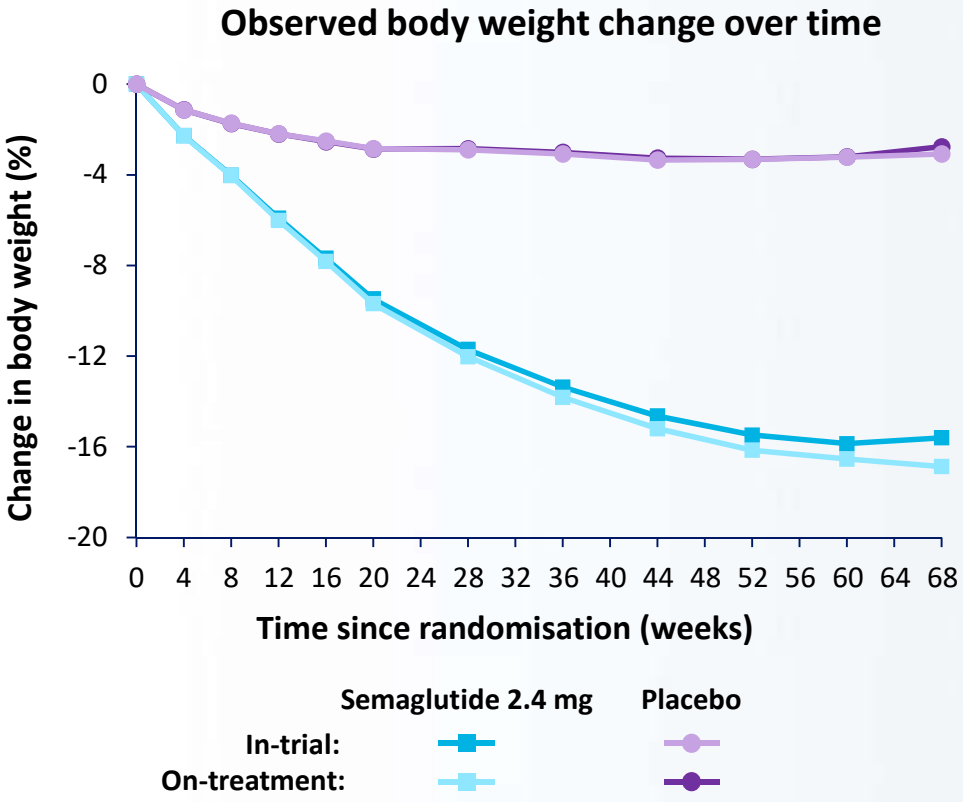
Phen/TPM, phentermine + topiramate; NAL/BUP, naltrexone + bupropion; Lira, liraglutide; Sema, semaglutide; TZP, tirzepatide

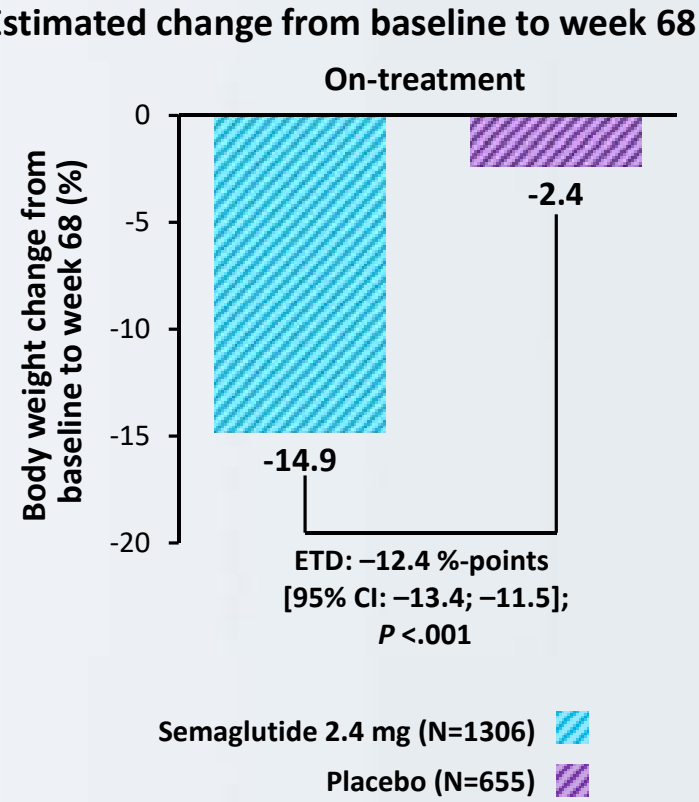
Allison DB et al. *Obesity* (Silver Spring). 2012;20(2):330-42; Gadde KM et al. *Lancet*. 2011;377:1341-52; Greenway FL et al. *Lancet*. 2010;376: 595-605; Apovian CM et al. *Obesity* (Silver Spring). 2013;21(5):935-43; Wadden TA et al. *Obesity* (Silver Spring). 2011;19(1):110-20; Davies MJ et al. *JAMA*. 2015;314(7):687-99; Wilding JPH et al. *N Eng J Med*. 2021;384(11):989-1002; Wadden TA et al. *JAMA*. 2021;325(14):1403-13; Rubino D et al. *JAMA*. 2021;325(14):1414-25; Jastreboff AM et al. *N Eng J Med*. 2022 Jun 4. doi: 10.1056/NEJMoa2206038.

Emerging Anti-obesity Pharmacological Therapies

Category	Mechanism	Drug	Stage of Development
Hormonal	**GLP-1 RA**	**Semaglutide**	**Approved 2021**
	GLP-1/GIP RA	Tirzepatide	Approved for T2D 2022
	GLP-1/glucagon RA		Phase 2
	GLP-1/GIP/glucagon		Phase 2
	Amylin analogue	Cagrilintide	Phase 2
	GLP-1/amylin analogue		Phase 1
	Ghrelin antagonist		Phase 1
	PYY analogue		Phase 1
	GLP-1 small molecule RA	Danuglipron	Phase 1
Neuropeptide	Melanocortin-4 RA	Setmelanotide	Approved 2020 for rare genetic conditions
Enzyme inhibition	Sodium-glucose transporter-1 and 2 (SGLT1, SGLT2 inhibitor)	Licoglifloxin	Phase 2
Monoamine receptor uptake inhibition	Noradrenaline, dopamine, serotonin update inhibitor	Tesofensine	Phase 3
Monoclonal antibody	Activin type II RA	Bimagrumab	Phase 2

Semaglutide: STEP 1 Trial



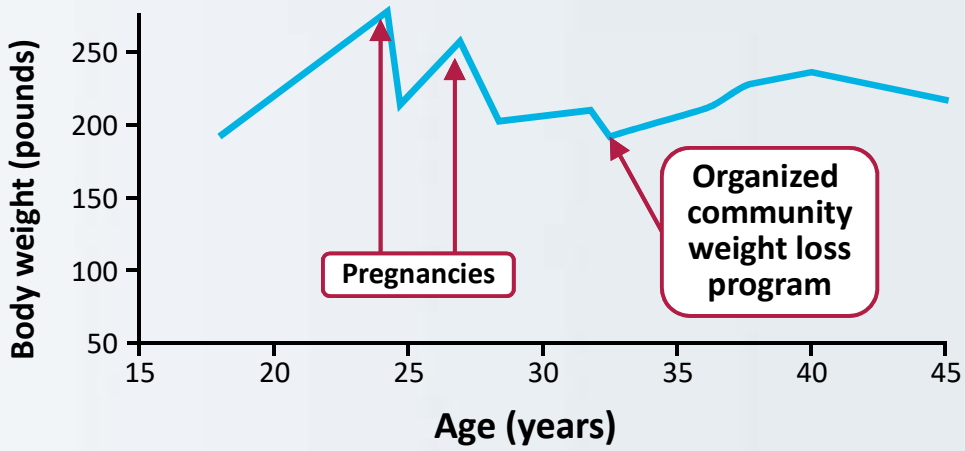


Wilding JPH, et al. N Engl J Med 2021;384:989-1002.

Individualizing Obesity Management

ARS Question 1
Case 1: Ms. York

- 44 y/o female presents for well-woman visit.
- **PMH:** GERD, hypertension, depression, NAFLD, insulin resistance.
- **Meds:** Metoprolol 20 mg qd, omeprazole 20 mg qd, vortioxetine 20 mg qd, metformin 1000 mg bid.
- **Ask:** Patient gives permission to discuss her weight.
  - Reports 30-lbs weight gain in past 3 years.
- Assess:
  - Body-weight graph (above right)
  - Walks 20 min/day, 6 days/week
  - Tries to eat carefully everyday
  - Sleeps 7 hours most nights
  - Two teenage children at home



ARS QUESTION:

ARS-T1: What obesogenic medication is this patient taking?

1. Metformin
2. Metoprolol
3. Omeprazole
4. Vortioxetine

ARS Question 2
Case 1: Ms. York, Cont'd

- **Vitals:** BP 126/72 mmHg, HR 82 bpm, RR 16 bpm.
- **Biometrics:** Height 5'6", weight 216 lbs, BMI 34.86 kg/m2, waist circumference 42".
- **Screening tools:** PHQ9 (score 4), BED7 (negative), STOP-BANG (score 2).
- **Shared decision making:**
  - Eating plan: Discuss very low calorie diet (VLCD) with meal replacement plan.
  - Activity: Increase steps to 7500 per day, add resistance training 2x per week.
- **Replaced metoprolol with ACE inhibitor.**
- Follow-up visit in 2 weeks.

ARS QUESTION:

ARS-T2: You are considering whether to start anti-obesity medication (AOM). What are the criteria for starting pharmacotherapy?

1. Initiate AOM only for adults with BMI ≥30 kg/m^2
2. Initiate AOM for adults with BMI ≥30 kg/m^2 or ≥27 kg/m^2 with comorbidities
3. Initiate AOM for adults with BMI ≥35 kg/m^2 or ≥30 kg/m^2 with comorbidities
4. Initiate AOM for adults with BMI ≥25 kg/m^2 who are unable to lose weight with lifestyle changes

Case 2: Mr. Alves

- 52 y/o male presents for diabetes and hypertension follow-up and medication refill.
- **PMH:** T2D, hypertension, dyslipidemia, osteoarthritis in both knees, NAFLD, OSA.
- **Family Hx:** Obesity, CVD, T2D.
- **Social Hx:** No tobacco or alcohol use, no drug abuse.
- **Meds:** Canagliflozin/metformin 50 mg IR/1000 mg ER qd, lisinopril 40 mg qd, lovastatin 80 mg qd, ibuprofen 400 mg prn (up to tid).
- **Ask:** Patient gives permission to discuss his weight.
  - Responds: “Will it get me off any of my meds?”

ARS Question 3
Case 2: Mr. Alves, Cont'd

- **Vitals:** BP 138/78 mmHg, HR 82 bpm, RR 16 bpm.
- **Biometrics:** Height 6'1", weight 248 lbs, BMI 32.72 kg/m2, waist circumference 43".
- **Screening tools:** PHQ9 (score 0), BED7 (negative), using CPAP every night.
- **Shared decision making:**
  - Eating plan: Rejoined community program
  - Activity: Joined a gym, swims 3 days/week
  - Patient reluctant to injectable medications
- No obesogenic medications noted.
- Follow-up in 2 weeks.

ARS QUESTION:

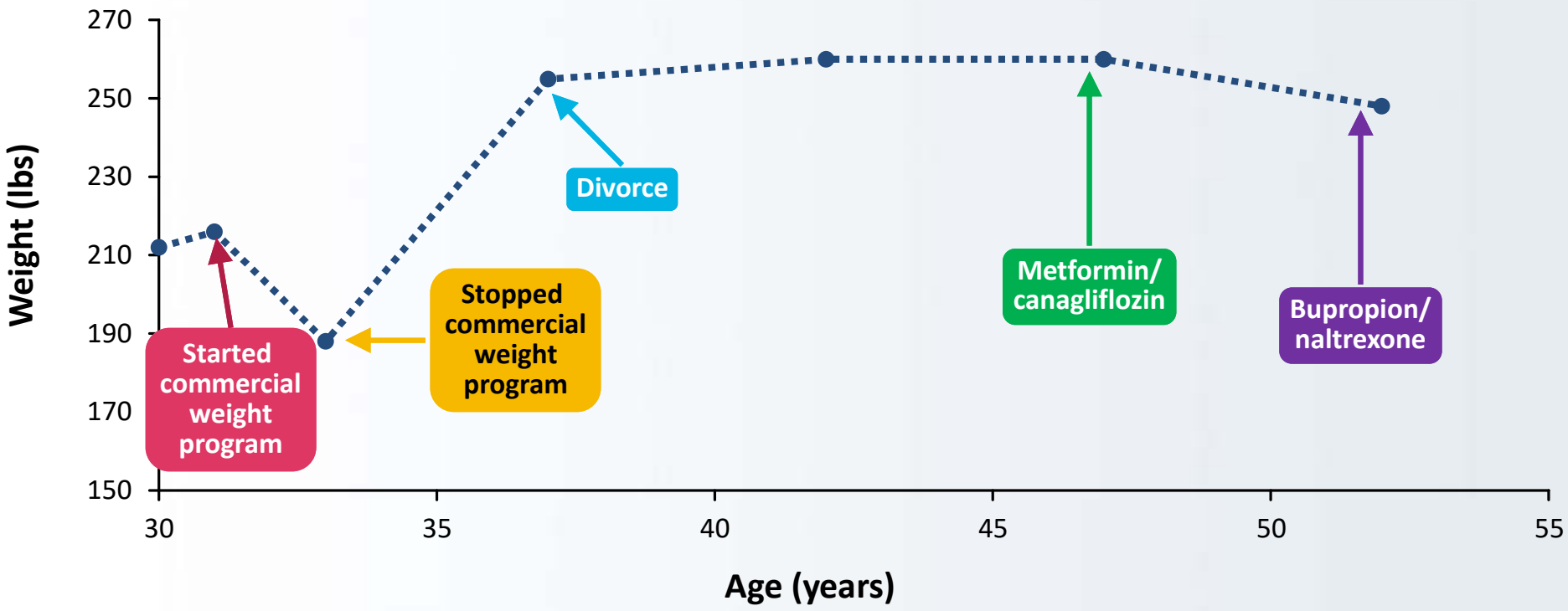
ARS-T3: Which anti-obesity medication would be appropriate for this patient?

1. GLP1-RA
2. Lipase inhibitor
3. Sympathomimetic with GABA receptor modulator
4. Opioid antagonist combined with norepinephrine dopamine reuptake inhibitor

Case 2: Mr. Alves, Cont'd

- **Eating plan:** Showed record of attending community commercial weight program.
- **Activity:** Over past 3 weeks has attended gym for weight lifting 2x week and swimming 3x week.
- **Behavior:** Completed education on obesity as a disease.
- **Medication:** During shared decision making, patient declines an injectable agent and decides to start bupropion/naltrexone.

Mr. Alves: Body-Weight Graph



ARS Question 4
Case 2: Mr. Alves, Cont'd

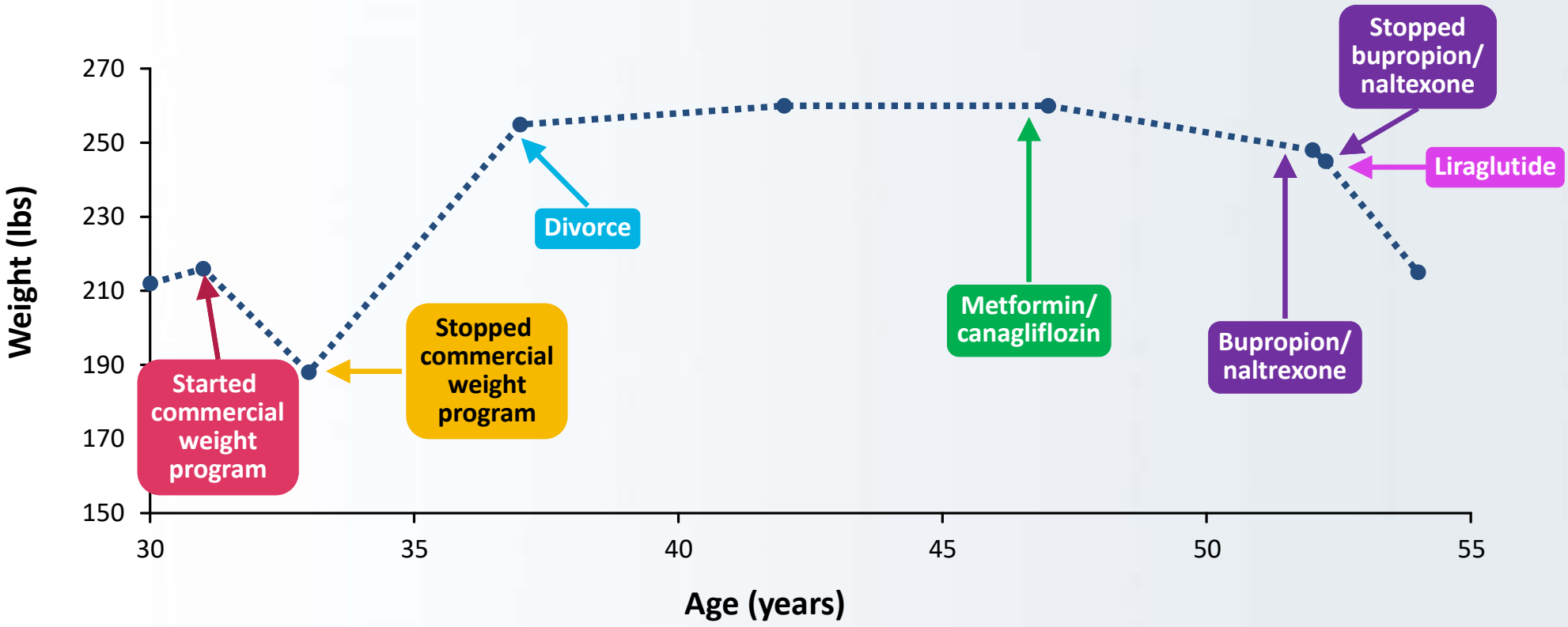
- 3 months later.
- Patient has lost 5 lbs (2% baseline weight).
  - Weight now 243 lbs.
  - BMI 32.3 kg/m^2.
- Reports consistent exercise and participation in commercial weight program.
- Reports adherence to bupropion/naltrexone.

ARS QUESTION:

ARS-T4: What would you recommend now for this patient?

1. Add lipase inhibitor
2. Maintain current therapy for 1 year
3. Switch from bupropion/ naltrexone to GLP-1 RA
4. Switch from bupropion/ naltrexone to sympathomimetic with GABA receptor modulator

Mr. Alves: Body-Weight Graph



Post-test Questions

Post-test Question 1

Post-T1: Which of the following factors mediate the link between obesity and comorbidities such as dyslipidemia and insulin resistance?

1. Secreted adipocyte factors
2. Increased anorexigenic signaling
3. Reduced ghrelin production in gut
4. Reduced circulating levels of estrogen

Post-test Question 2

Post-T2: Which of the following medications have demonstrated an average of ≥ 15% weight loss in clinical trials?

1. Liraglutide
2. Naltrexone/bupropion
3. Phentermine/topiramate
4. Semaglutide

Post-test Question 3

Post-T3: 52 y/o man with obesity, T2D, hypertension, dyslipidemia.

Says he is concerned about weight gain over last 10 years (~25 lbs).

Workup: BMI 32.7 kg/m^2, BP 128/82 mmHg, A1C 6.9%, eGFR 52 mL/min/1.73m^2.

Meds: Metformin 1000 mg bid, canagliflozin 100 mg qd, lisinopril/hydrochlorothiazide 20 mg/25 mg qd, atorvastatin 80 mg qd.

Lifestyle: Walks briskly for 1 hour 6 days per week; follows a low-calorie, low-fat diet.

Notes that he hates needles and does not want injectable medications.

What would you do next for this patient?

1. Recommend bariatric surgery
2. Down-titrate obesogenic medications
3. Prescribe exenatide, lixisenatide, or dulaglutide
4. Discuss benefits of phentermine/topiramate or naltrexone/bupropion

Post-test Question 4

Post-T4: 38 y/o woman with history of T2D, hypertension, obesity.

Has gained 45 lbs in last 5 years.

Workup: BMI 34 kg/m^2, BP 142/86 mmHg, A1C 6.7%.

Meds: Lisinopril 20 mg qd, metformin 1000 mg bid, naltrexone/bupropion 2 tablets bid.

Lifestyle: Swims 45 min 5x week, lifts weights 2x week; goes to commercial weight-loss program.

Started naltrexone/bupropion 3 months ago; has lost 5 lbs (2.4% baseline weight) in that time.

What might be appropriate at this time?

1. Maintain naltrexone/bupropion for at least 6 months
2. Stop naltrexone/bupropion and refer for bariatric surgery
3. Continue naltrexone/bupropion and prescribe phentermine
4. Discontinue naltrexone/bupropion and prescribe liraglutide or semaglutide

Post-test Question 5

Post-T5: After completing this activity, how confident are you in your ability to select long-term pharmacotherapy to manage patients with obesity?

1. Not at all confident
2. Slightly confident
3. Moderately confident
4. Pretty much confident
5. Very confident

Post-test Question 6

Post-T6: After completing this activity, how often do you intend to assess comorbidities when considering anti-obesity therapies for patients with overweight/obesity?

1. Never
2. Rarely
3. Sometimes
4. Often
5. Always

Post-test Question 7

Post-T7: Approximately how many patients with obesity do you see on a weekly basis, in any clinical setting?

1. None
2. 1-5
3. 6-10
4. 11-15
5. 16-20
6. 21-25
7. >25

Q&A