Obesity Medical Therapy: It Is Time to Take the Bull by the Horns

Obesity is the largest public health threat, affecting 42.4% of US adults. In this issue of Mayo Clinic Proceedings, Claridy et al report that although there have been minor increases in the use of Food and Drug Administration (FDA)—approved medications to treat obesity, the prescribing of antiobesity medications (AOMs) remains very low. The aim of this report was to evaluate the utilization of pharmacotherapy in obesity treatment in the United States from 2011 to 2016. Using data from the National Ambulatory Medical Care Survey, they evaluated 3 types of visits: patients with obesity and an AOM mention, patients with obesity and no AOM mention, and patients without obesity and with AOM mention. They noticed there was a slight increase in AOM mentions, from 0.26% in 2011 to 0.28% in 2016, but only 1% of office-based visits for patients with obesity received a prescription for an AOM.

This study corroborates previous findings obtained from electronic medical records from 11 million patients demonstrating that only 1.3% of patients who were eligible for treatment with AOMs received a prescription for one of these medicines during a 6-year period. Claridy et al also confirm what health care providers (HCPs) who take care of patients with obesity know: weight loss medications are rarely prescribed to eligible patients who suffer obesity.

THE SEVERITY OF THE PROBLEM

Obesity is the most prevalent disease and is projected to increase to 48.9% by 2030. Obesity is the primary reason that many of the patients seen in our clinics develop type 2 diabetes (T2D), hypertension, dyslipidemia, sleep apnea, cardiovascular disease, and cancer. Obesity is also associated with increased mortality and is the largest contributor to chronic disease burden in the United States. The estimated cost of obesity in the United States was $480.7 billion in direct health care costs and $1.24 trillion in indirect costs due to lost productivity in 2016.

WHERE DID WE GO WRONG?

In 2013, obesity was recognized as a complex chronic disease by the American Medical Association, yet its treatment continues to be challenging. There is still a significant bias against obesity and patients who suffer from it. In addition, well before there is even consideration of treatment, there is an underrecognition of obesity by HCPs; less than half of patients who have obesity according to body mass index receive a formal diagnosis by International Classification of Diseases, Ninth Revision or Tenth Revision documentation when they are seen in the clinic. If a condition is not appropriately diagnosed, rarely will it be treated.

Many HCPs still have the perception that obesity is a question of willpower and not a disease. There are several reasons that HCPs may be reluctant to prescribe AOMs: insufficient training in obesity medicine, lack of understanding of the role of the appetite set-point and changes in basal metabolic rate during weight loss, low expectations for success, lack of time to provide advice regarding nutrition, societal stigma, concerns with high cost or lack of insurance coverage of medications, denials of payment for services, and limited therapeutic tools. The limited use of therapeutic tools is not just restricted to AOMs as only approximately 1% of patients with severe obesity end up undergoing bariatric surgery. These observations occur despite specific recommendations by the Endocrine Society and the American Association of Clinical Endocrinology regarding the use of AOMs and bariatric surgery to treat obesity.
RELUCTANCE TO CHANGE

The way we manage patients with obesity has not changed much over time (it may have actually worsened). The first successful medical treatment of obesity was documented in the 10th century in Spain. According to the chronicles of the time, Sancho I of León had developed obesity because of food transgressions and limited exercise.10 His subjects felt that his obesity made him unfit to rule, and they thereby deposed him. He consulted with a well-known physician in Córdoba Caliphate, Hisdai ibn Shaprut, to treat this condition. The treatment involved long walks (he was pulled with ropes by slaves), a nutritional program (infusions combining salt water, boiled with vegetables), stress reduction (he was obliged to take endless steam baths), and medications (theriacs were a group of compounds that contained opiates). As a result of the treatment, Sancho lost weight and his throne was restored.

Not all HCPs are as innovative as Dr Hisdai, and there is considerable inertia in the care of patients with obesity, who in many circumstances consult for consequences of their obesity while their weight continues to increase without being addressed. A referral to specialized care (obesity medicine, endocrinology, bariatric surgery) is warranted for many of these patients. The very high prevalence of obesity and the concern of collapsing our specialized care with referrals should not be a deterrent.

WHAT CAN WE DO NOW?

The obesity epidemic has reached dramatic proportions, and its impact on the cost of our health budget has become unbearable. Patients with obesity need to receive a long-term, interdisciplinary, and personalized approach. It is important to identify the cause of obesity and to develop a therapeutic plan addressing nutrition, physical activity, and appetite control as well as sleep habits and psychological factors such as stress, anxiety, and depression.

We currently have 5 FDA-approved AOMs for long-term use: orlistat, phentermine-topiramate, naltrexone-bupropion, liraglutide, and, most recently, semaglutide. The use of these AOMs can be successful in causing clinically meaningful weight loss in a real-world setting.11

There is a crucial need for our politicians to support the treatment of obesity in all its dimensions, including access to AOMs. Third-party payers need to increase coverage for AOMs and leave aside the shortsighted concerns of the upfront cost when they are already covering treatment for T2D and other costly comorbidities associated with obesity. We need to stop blaming patients for a disease that they have little control over, provide them with the tools to improve their health and lifestyle, and strongly consider the use of AOMs. We also need to work on national campaigns devoted to remove the bias against individuals with obesity.

The fact is that obesity is a disease that affects almost half of the country, and our current approach to treatment is obviously not effective. The FDA has approved several medications to treat obesity; however, HCPs do not readily prescribe them. If this circumstance were to be applied to other chronic diseases, such as T2D, heart failure, or ulcerative colitis, we would be referring to such behavior as medical malpractice.

The time has come to take the bull by the horns. It is imperative that we change the therapeutic obesity paradigm. Every patient deserves to be treated with respect while the disease is appropriately evaluated and treated with the full spectrum of therapeutic options. The need to refer patients with obesity to an interdisciplinary team involving dietitians, exercise physiologists, psychologists, and a sleep apnea specialist should always be considered, and AOMs have to be part of the therapeutic armamentarium.

In many circumstances, the use of AOMs will be the only way to reset patients’ appetite set-point to a lower level to help them be successful in maintaining weight loss for the long term. Last, even a small amount of...
weight loss can provide a significant impact on improving the quality of life of our patients and their comorbidities while affording the opportunity to reduce the long-term cost burden of obesity on the health care system.

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**REFERENCES**