Clinical Nutrition Center
ETHAN LAZARUS, M.D.

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Address Block

Dear Doctor:

Thank you for all of your referrals to myself and the staff at Clinical Nutrition Center. There has been so much going on in the fields of obesity and bariatric medicine. I was hoping to spend a minute reviewing some of the latest developments. Below are some of the most frequent inquiries I receive from physicians - feel free to peruse the topics that interest you the most!

I have created a Physician Resources section on my website *(www.ClinicalNutritionCenter.com)* below the *Resources* tab. There you will find this and future letters, links to any documents referenced, useful web links, and links to keep you up to date with news feeds in the field of obesity medicine. Please also feel free to e-mail me anytime at **DrLazarus@clinicalnutritioncenter.com**, or to leave me a voicemail at 303-750-9454.

**Here are some common questions that physicians and patients ask that may be useful to you.**

**Q: Does HCG work? My patients are all talking about it!**
**A:** If only it were this easy. The short answer to this question is "No." A better answer can be found on the American Society of Bariatric Physicians (ASBP) web site. I've included a link to this on the physician resources tab mentioned above. HCG is a hormone normally secreted by the placenta during pregnancy. In 1954, Dr. Simeons developed a 500 cal/day meal plan and administered it in conjunction with 125 units of HCG injected 6 days per week for 8 weeks. The protocol became popular in the 1970's. A meta-analysis reviewing many studies found **insufficient evidence** to support the claims that HCG is effective in altering fat-distribution, hunger reduction or inducing a feeling of well-being. **The authors concluded that "the use of HCG should be regarded as an inappropriate therapy for weight reduction."**

Current evidence suggests that this is not a helpful treatment and it has unknown risks. Physicians employing the HCG or the diet recommended by Simeons may expose themselves to criticism from other physicians, from insurers, or from government bodies. **It is my practice NOT to recommend HCG to our patients at CNC, or to manage patients currently on HCG.**

7555 E. Hampden Avenue, Suite 301
Denver, Colorado 80231
Phone: (303) 750-9454
Fax: (303) 750-1996
www.ClinicalNutritionCenter.com

The American Society of Bariatric Physicians has adopted the following policy statements:
1. The Simeons method for weight loss is not recommended.
2. The Simeons diet is not recommended
3. The use of HCG for weight loss is not recommended.

**Q: Is Obesity Medicine or Bariatric Medicine a specialty recognized by the American Board of Medical Specialties (ABMS)?**
**A:** Not Yet. However, it appears likely that the Obesity Society (formerly NAASO - North American Association for the Study of Obesity) and the Bariatric Society (ABBM - American Board of Bariatric Medicine) will have a coming to terms and back a joint venture to get this type of medicine established as a medical specialty. Although ABBM has a board certification in place and the Obesity Society will likely have one in place within 1 year, neither has received recognition by the ABMS.

I have taken the position of remaining active in both organizations by regularly attending courses through the Obesity Society, the Harvard Obesity Course, and the ASBP, and will continue to do so until it becomes clear the best way to proceed.

**Q: I heard Meridia was withdrawn from the market. What happened? What's new in the medical treatment of obesity?**
**A:** A randomized placebo-controlled trial called SCOUT *(Sibutramine Cardiovascular Outcomes Trial)* was launched in 2002 and enrolled over 10,000 overweight or obese individuals with diabetes or a history of coronary or peripheral vascular disease or stroke, along with other CV risk factors. At the conclusion of the trial, an early analysis for the trial's primary end point, a composite of heart attack, stroke, resuscitated cardiac arrest, or death, found the rate to be 11.4% for patients receiving Sibutramine and 10% for those receiving placebo. *Please note that the label of Sibutramine specifically cautioned against the use of this medication in these situations.* This 1.4% increased risk led to Abbot labs voluntary withdrawal of Sibutramine from the market late in 2010.

Shortly after the Sibutramine withdrawal, the FDA ruled against 3 promising new drug candidates including a new combination of Phentermine with Topiramate (QNexa), a combination of Wellbutrin with Naltrexone (Contrave), and a new Selective Seratonin $5HT_{2c}$ agonist, Lorcaserin.

Many were disappointed with the FDA's decision. Since then, Ed Hendricks, MD, a respected bariatrician from California has been nominated by the FDA to serve on the Endocrinologic and Metabolic Advisory Committee (EMDAC). This is remarkable in that physicians in private medical practice are rarely selected to serve on the EMDAC committee. It is possible that Ed's expertise in long-term medical treatment of obesity will impact future FDA rulings.

**Q: Should I recommend that my patients achieve a normal BMI?**
**A:** BMI was never intended to set goals for weight loss. All too often I have patients who are told they must achieve a certain BMI to qualify for a joint replacement surgery or for a preferred rate on insurance. Often they are told to lose 30, 40, or even 50% of their total body weight.

Medically, this is not an appropriate recommendation. Even with gastric bypass surgery, a 50% weight loss is highly unusual. Obesity is a chronic disease and no medical authority that I am aware of recommends achieving a certain BMI as appropriate management. Most medical benefits from obesity treatment accrue with a loss of just 10% of the initial weight. I like to use as the definition of a successful obesity treatment program a weight loss of 10% maintained for at least a year.

10% weight loss provides real and tangible medical benefits, even for the extremely obese. I had a young man last year who came in to see us at 400 pounds. He had no primary care or health insurance and at his first visit, had a blood pressure of 170/110, triglyceride count over 1000, and fasting blood sugar in the 200's. Over 3 months, he lost 40 pounds (10%), and then he did not visit our office for almost a year. When he next saw me, he maintained the 40 pound loss. He was still quite heavy at 360 pounds but had normal blood pressure, normal triglycerides, and normal blood sugar. *Always encourage your patients that health benefits of even modest weight loss are substantial!* Remember that in the Diabetes Prevention Program (a link to this important program is on my web site for you) a *weight loss of just 7% reduced diabetes risk by two-thirds.*

Many of our patients successfully lose 20-30%, and occasionally 40% of their total weight. This compares favorably with surgical approaches (average weight loss with lap band is 20%, with gastric bypass surgery 35%). However, obesity is a chronic illness and relapse is likely. Patients with obesity need long-term follow up and an active management plan to address relapse early and effectively.

**Q: Okay - so if there are no new medications, what is CNC doing to help address obesity treatment?**
**A:** At CNC, our registered dietitians have always been the cornerstone of our treatment programs. This really differentiates us from other options. Registered dietitians I believe are the best resource for not only individualized weight loss programs, but for behavior modification, accountability, and long-term maintenance.

We have continued to innovate and improve our meal plans. There is plentiful evidence these days that the Very Low Calorie Diets are not necessarily the best approach for many individuals. While these dominated our treatment approach as recently as 8 years ago (and still offer them to appropriate individuals), these days the majority of our patients pursue non-ketogenic diets. We utilize our new **Advanced Program** with great success, and even have a high success rate at getting diabetics off of many medications including insulin through better management of carbohydrate intake and optimizing the protein amount.

We launched the full suite of **Optifast Programs** this year too. These are extremely easy and safe full meal replacement programs that unlike other "fasting" programs do not put an individual into ketosis. In clinical studies the typical Optifast patient (average BMI 39) loses 52 pounds over 22 weeks before transitioning to a long-term maintenance program. Some patients go on to lose 75 pounds, 100 pounds

or even more. It is my opinion that this approach to safe, quick and large volume weight loss compares favorably with Lap-Band surgery for a fraction of the cost.

Improved medical management options are also helpful. I actively provide consultation to our patients regarding their medical situation and how optimizing it can help enhance odds for long-term weight control. When you refer your patients to me I send you a consultation note to help you manage your patient's co-morbidities in a fashion that may enhance long-term weight outcomes. A simple switch from Lantus to Victoza, from Glipizide or Actos to Januvia, from Paxil to just about anything else, from Elavil to Trazadone, or from Depo-Provera to an oral contraceptive can really enhance weight loss and long term weight control.

**Q: Great! So, with all these benefits, are insurance companies paying for obesity treatment?**
**A:** Insurance coverage remains a significant issue; however, we have seen tremendous improvements in coverage over the past several years. Most patients are successful using their HSA or Flex dollars towards treatment. Also, many PPO's cover all or part of a treatment program. We re-coded all of our medical billing last year which has further improved reimbursement options.

With obesity management, many patients actually recoup the money spent. We see patients qualifying for preferred rates on life and health insurance, lowering their direct medical expenses through needing less medications and fewer hospitalizations and ER visits. In a study published last year by the George Washington University School of Public Health, it is estimated that among the severely obese, annual direct health care expenditure increases by over $6500 / year for men, $8300 / year for women (I put a link to this article on the web site for you). Most medical weight loss programs cost far less than this, and thus on average pay for themselves in high risk individuals.

**Q: What can I do in MY practice to help patients with obesity?**
**A:** Even with very little time and no training in obesity medicine, the following tips can be very helpful:

1) **DO** Encourage and support rather than blame, threaten or pressure.
2) **DO** suggest realistic rather than unattainable goals (5-10% is realistic, but even this can be incredibly challenging).
3) **DO** treat this seriously. Trivial responses like "Don't eat so much" or "Read such and such book" are not appropriate responses to one of the most challenging medical questions a patient with obesity can ask you. These sorts of responses can alienate the patient from you and strain the relationship.
4) **DO** encourage eating regular meals (especially breakfast), eliminating calories in liquids, drinking 16 ounces of water BEFORE breakfast, lunch, and dinner, pedometer use and recording steps, offer weekly or monthly weigh-ins, and recording a food journal (lots of examples available for free -download under resources at our web site).
5) **DO** CONTINUE TO SUPPORT YOUR PATIENT **WHEN** RELAPSE OCCURS. **Weight gain is a normal and expected part of the chronic disease of obesity.** Individuals need an incredible amount of support during these tough times to get back on track.

6) **DO** EDUCATE YOURSELF ON OBESITY. Options include:
   a. A very good book on the topic is "Best Weight" by Freedhoff and Sharma, available on Amazon.
   b. CME - Harvard Obesity Course, American Society of Bariatric Physicians course, or The Obesity Society Course.
   c. Call me and I can meet with you personally to discuss this.
7) **DO** TREAT OTHER MEDICAL PROBLEMS WITH SENSITIVITY TO WEIGHT. Within class, choose medications that can promote weight loss rather than weight gain. I have posted a handout I developed for my Grand Rounds talk at the Hospitals of drugs most likely to promote further weight gain and treatment alternatives to the physician resources tab on our web site.

**In Summary**

Thanks for taking the time to read through these updates. I hope you'll calculate BMI on all of your patients, and that you'll keep us in mind if an individual needs help with their obesity problem. Patients generally respond very well when asked if they've thought about addressing their weight, especially if you have useful treatment options. If you'd like more information, or help with a particular individual, you can always e-mail me at **DrLazarus@clinicalnutritioncenter.com**, or call me at **303-750-9454**. Also, if you'd like me or a member of my staff to stop by your office and bring materials, referral cards, BMI cards, brochures, etc., please just let me know. I am always happy to help!

Thank you again for all of your referrals over the years, and I promise to do the best I can to help your patients achieve long-term freedom through better control of their weight, and to do this with a scientifically proven, medically appropriate and safe treatment approach.

Sincerely,

Ethan Lazarus, MD