Sydney National Obesity Forum 2017 – Audience Q&A – Dr Georgia Rigas

Question	Answer
You say that we use care plans. There is no MBS item number yet for obesity. Many patients only have obesity as their condition. How do we justify a care plan?	As you will see in The Dept of Health – Chronic care plan criteria**,** there is **NO** list of eligible conditions. The Dept of Health stipulates that "the condition needs to be present for at least 6 months… the patient requires a structured approach to their care…. and so would benefit from as MDT approach".
I have had patients who may need surgical intervention but for weight but do not have enough information to discuss the various options and costs. As a GP who do I refer to and what costs do I need to discuss?	The OSSANZ (Obesity Surgery Society of Australia & New Zealand) has a use friendly webpage and a tab for "health professionals". See The OSSANZ for free patient information sheets briefly explaining the different operations, mechanisms of action etc. Before I answer the question of cost, I want clinicians to also ponder and discuss with their patients the cost of **NOT** treating patients, or in this case, not referring for bariatric surgery where clinically indicated. PriceWaterhouseCoopers published a resource looking at the Cost of Obesity in Australia and Published in 2015. However, to answer this question, depending on the type of operation and clinic aftercare provided, a patient could expect to pay $15-$20,000 (uninsured; more if an unexpected complication arises and they need further surgery or ICU admission) or approx $4-$6,000 if their health insurance covers bariatric surgery.
What about the idea that you can be fat and healthy? Is this a barrier to a patient hearing what you have to say on weight loss?	Whilst I acknowledge that there are some patients with a high BMI who "appear healthy" they are a minority and if they truly are metabolically, cardiovascularly and functionally well, they *may* down the track develop premature wear and tear OA or other functional impairments as a result of being above a healthy weight. When working in a health care system with limited resources, obesity staging systems such as the Edmonton Obesity Staging System (EOSS) may help evaluate and identify those who need and are likely to benefit the most from treatment.
Do you think we should define obesity as a chronic disease? Would this improve the way general practitioners manage obesity in the community?	To be honest I am interested in what you think, especially whether you think it will break this therapeutic inertia, and encourage more clinicians to start treating patients with obesity. What do I think? You will have to attend or tune into the next HealthEd Obesity Forum lecture on Wednesday 24 May in Melbourne.

Sydney National Obesity Forum 2017 – Audience Q&A – Dr Georgia Rigas

At what age can one safely start metformin in a child young adult to prevent further weight gain treat insulin resistance?	Dr Louise Baur [paediatrician at Sydney's Westmead children's hospital Teenage & adolescent obesity clinic] *et al,* published a systematic review looking at the treatment of obesity in adults, adolescents & children. Note that pages 12-23 relate to children & adolescents.
drug therapy metformin vs Duromine which is better? Can both be used together metformin use without insulin resistance?	Weight loss with metformin is modest-a few kilos at most, however it does help improve insulin sensitivity despite this modest weight loss in patients with IGT. Given that metformin and phentermine work in different ways via different pathways, and have different indications, they could be co-prescribed. It goes without saying that it is important for patients to keep their fluids up so as to avoid unwanted side effects. Let's not forget how important it is for patients to participate in moderate intensity exercise; this itself helps improve insulin sensitivity independent of any weight loss.
What pharmacological treatments do you recommend for obesity Are there first line treatments and what is the efficacy compared to each other?	Unlike diabetes and other chronic diseases, at present there is NO tiered recommendation to treatment. I personally explain to patients that there are 3 medications that are TGA approved in Australia and also VLEDs, and ask them: 1) what, if anything, they have tried in the past and what their experience 2) ensure no contraindication due to patient's medical profile as this then eliminates 1 or 2 of the options. After this I discuss with the patients the VLEDs and medications we have as viable options, their mechanism of action, side effects, realistic weight loss expectations, "stopping rule" [at 3months on treatment dose to determine if patient is responding to therapy] etc, so as to assist patients in making an informed decision. We know that medications result in 5-10% weight loss (occasionally more), which is clinically meaningful. (see Cefalu et al.)

Sydney National Obesity Forum 2017 – Audience Q&A – Dr Georgia Rigas

	However as expected, upon discontinuation of the medication, a patient's weight usually drifts back upwards. Not surprising given that we see the same thing happen if a patient discontinues antihypertensive medication, cholesterol tablets etc.
With mental illness including eating disorders and body image issues on the rise and presenting earlier, how do you expect the talk of obesity and its impact son their future children to impact women's confidence and mental health? How do we balance physical and mental health?	You will have to attend or tune into the next HealthEd Obesity Forum lecture on Wednesday 24 May in Melbourne to hear Dr Marlene Tham.
What we can advise on women with PCOS?	1. Healthy lifestyle including no smoking 2. 30 mins of aerobic exercise daily 3. Aim for 5-10% weight loss achieved via lifestyle alone OR lifestyle and adjuvant therapy (medication, endoscopic therapies or bariatric surgery [results in 20-30% weight loss]) 4. Bariatric surgery if BMI ≥40 or BMI ≥35 & a weight related complication See RANZCOG guidance
If the waist hip ratio is 08 is there a different emphasis on weight loss?	The NHMRC guidelines for the Treatment of Obesity 2013, recommend waist circumference to be measured, midway between lowest rib and iliac crest, with one finger fitting between measuring tape and patient's skin. Measurement should be taken during expiration. In Caucasian women ≥88cm confers high risk of disease; in women of South Asian/ Chinese/ Japanese ancestry ≥80cm is the cut off. In Indigenous Australians, the cut off is lower than that of Caucasians, however the actual cut off level in this group has not been determined. Similarly, for women of Pacific Islander ancestry, the cut off is higher than that for Caucasians, however the actual cut off level in this group has not been determined.
Duromine vs Metformin, Which one is better is PCOS? Can they be used together?	Depends what you are trying to treat; one assists with insulin sensitivity especially if she has IGT; the other one directly reduces appetite with the intention the patient will lose weight.

Sydney National Obesity Forum 2017 – Audience Q&A – Dr Georgia Rigas

What are the odds of success for long term weight loss 12 months and maintenance of a healthier weight?	Body weight is homeostatically controlled by a number of neuro hormonal pathways. Research by Sumithran et al, provided evidence that the body physiologically defends against weight loss. Patients with established overweight +/- established obesity, require long term regular follow up, and so setting up recall is important. Johannsen et al, performed a meta analysis of the literature looking at what things help patients maintain weight loss long term. They were: 1. Weight management medications 2. VLEDs 3. Meal replacements
In women who has had gestational diabetes postpartum follow up is often problematic. How do we as GPs address this issue?	When women make an appointment for the babies health check +/- vaccinations, inform them that this appointment is also to make sure that mother has her necessary reviews. Give women that facts and assist them to make an informed decision. Since such patients are at risk of developing type 2 diabetes, even more so if have overweight or established obesity, they require long term regular follow up, and so setting up recall is important.
Does a patient need certain BMI value to be suitable for a care plan?	Obesity is defined internationally by WHO as BMI ≥ 30. See The Dept of Health – Chronic care plan criteria. Make sure you feel confident that your peers would also agree that this patient, given their circumstances and health care needs, would benefit from a MDT approach.

Sydney National Obesity Forum 2017 – Audience Q&A – Dr Georgia Rigas

You spoke about obesity champions what about utilising local primary health network as a platform to initiate some of the discussion resources in weight management?	I really like your suggestion and agree that we need to opt for a multi-pronged approach. Given that different State Govts have different priorities wrt utilizing their health budget, having State networks of GPs, who are overseen by a State Champion makes sense. The vision is to further the dialogue with respect to resources in weight management with a number of appropriate bodies including PHNs, taking into account what local resources are available, and what local initiatives are already in place. Are you perhaps volunteering to be part of your State's working group network of GPs?
Would you recommend a bariatric surgery for a lady with BMI 30? She tried Duromine low calorie diet without success. She is 20 kg over her normal weight.	See NHMRC Obesity Guidelines 2013 which clearly indicates the criteria for bariatric surgery referral. In particular, for patients with a BMI ≥30 and diabetes, referral for surgery should be considered as part of the patient's treatment plan. Furthermore, laparoscopic adjustable gastric banding is now indicated for patients with a BMI ≥30.
Chronic inflammation and obesity cause or effect?	Still to be determined-it's one of the chicken & the egg scenarios
Is there a good resource to use as a guideline for obesity in pregnancy that outlines targets?	Yes the RANZCOG has published a great resource; See Management of Obesity in Pregnancy In particular page 10
Are there any restrictions on care plans as far as children go? Obese children are presenting with concerned parents	No age restrictions; see The Dept of Health – Chronic care plan criteria
Is there a role for measuring fasting insulin levels and is there a level which makes patients more responsive to metformin?	RANZCOG states that measuring insulin levels is not recommended; see Long term health consequences of PCOS

Sydney National Obesity Forum 2017 – Audience Q&A – Dr Georgia Rigas

What is the pharmacological agents recommended in obesity management in Australia?	• Orlistat 120mg tds (available over the counter); • phentermine slow release resin, dose as required (15mg & 30mg starting doses; maximum treatment dose 40mg) • Liraglutide 3mg s/c daily injection*(only one currently TGA approved which has been shown efficacious in t loss maintenance)
Can we use Metformin and Duromine together? Can Metformin be used even if there is no insulin resistance?	The RANZCOG specifies that insulin sensitizers are only recommended if a patient has IGT. The other question was answered earlier; see above
Still desperate to know WHAT WORKS	All therapies work to a degree, but let us not forget that *one size doesn't fit all*. Currently there is NO pre-intervention test a patient can do to determine if they will be a good responder vs partial or non-responder to any particular therapy. Therefore it is a bit of trial and error, just like which oral contraceptive pill you might initiate in a young lady. The literature might guide you as may your clinical experience, and other factors. See Summary of effects of weight management interventions Bariatric surgery is the most effective obesity management that we have at present, however I acknowledge that not all patients with obesity need nor want bariatric surgery. However it still needs to be discussed as a treatment option, and a referral made for a specialist opinion, where clinically indicated. A review of the dietary literature did not show one "diet" more superior to others in the long term; the "best diet" is the one that patients enjoy and can stick to. Exercise as a stand alone therapy has numerous health benefits eg cardiovascular, insulin sensitivity, preservation of lean body tissue, mental wellbeing etc. However as a stand alone therapy, it is unlikely to result in significant shifts in weight. What DOESN'T work, is trying to get a patient to do the same intervention which they have tried in the past and not responded to eg if they have tried VLED properly and didn't lose that much weight, then initiative a therapy with a different mechanism of action eg pharmacotherapy or bariatric surgery (if clinically indicated)

Sydney National Obesity Forum 2017 – Audience Q&A – Dr Georgia Rigas

	Watch this therapeutic space, as a number of endoscopic therapies have been utilized and a number of newer emerging endoscopic therapies are entering the bariatric (weight loss) arena.
Can Duromine be used in PCOS? Metformin vs Duromine which one is better? Can both be used together?	Answered above