

Obesity Management in Cardiology Practice to Improve CV Outcomes

Identifying Patients Who Have Obesity

Screen with BMI – confirm with direct body fat measurement or ≥ 1 anthropometric measure (confirmation not necessary for BMI >40 kg/m²)

BMI Category, kg/m ²	European	Asian
Overweight	25 to <30	23 to <25
Obesity	≥ 30	≥ 25
Anthropometric Measures	European	Asian
Waist circumference, in (cm)	Women: ≥ 35 (90), Men: ≥ 40 (102)	(South Asian, Chinese) Women: ≥ 31.5 (80), Men: ≥ 35.5 (90) (Japanese) Women: ≥ 35.4 (90), Men: ≥ 33.5 (85)
Waist-to-height ratio	≥ 0.50	
Waist-to-hip ratio	Women: ≥ 0.85 , Men: ≥ 0.90	

Discussing Obesity Management With Patients

Ask permission: “Would it be OK to discuss your weight?”

Avoid shaming: Obesity is disordered biology; focus on improving health.



Share decision-making: Your patient will be the one doing the work.

Language matters!
Patient first: “Patient with obesity” instead of “obese patient”
More acceptable: “Weight,” “excess weight,” “elevated BMI”

Treatment Options

Lifestyle management: Core intervention—diet, activity, and behavior change associated with improved CV risk factors; accessible in cardiology practice ($\approx 5\%$ - 10% weight loss)

Bariatric surgery: Can improve CV outcomes; not an optimal choice for all patients ($\approx 25\%$ - 30% weight loss)

Anti-obesity medications: Accessible in cardiology practice; NuSH therapies show CV benefits, and semaglutide and tirzepatide are associated with greater weight loss ($\approx 10\%$ - 20%)

Placebo-Controlled CV Studies With NuSH Therapies

Patients with overweight or obesity and established CVD

- Semaglutide 2.4 mg: 20% reduction in MACE risk, benefits in HF and all-cause mortality, and 22% reduction in composite kidney outcome in patients with BMI ≥ 27 kg/m² and no diabetes

Patients with obesity and HFpEF

- Semaglutide 2.4 mg: Significantly improved symptoms and function and greater weight loss in patients with BMI ≥ 30 kg/m² and HF with ejection fraction $\geq 45\%$
- Tirzepatide: Significantly improved function, symptoms, CV death/worsening HF, and HF hospitalization in patients with BMI ≥ 30 kg/m² and HF with ejection fraction $\geq 50\%$

Obesity Management in Cardiology Practice: Overview of NuSH Therapies

Discussions to Have With Patients Before Starting NuSH Therapy for Obesity Management

- Contraindications/precautions: Personal or family history of medullary thyroid carcinoma or multiple endocrine neoplasia syndrome type 2, risk of thyroid C-cell tumors, discontinuation in pregnancy, and other warnings/precautions
- Accessibility/coverage and need for long-term treatment of obesity as a chronic disease
- Lifestyle/behavioral counseling and instruction on injection technique and missed doses
- Managing AEs: Dietary changes to avoid GI AEs (eg, plan smaller meals, eat slowly, avoid high-fat foods), adequate hydration

Monitoring and Long-term Follow-up

- Weight loss and cardiometabolic goals (eg, A1C, lipids, blood pressure): Consider treatment alternatives/obesity specialist referral if goals are not met
- Tolerability/AEs: Consider dose adjustment (eg, slower escalation) per prescribing information to minimize GI AEs

NuSH Approved for Obesity Management: Descriptions, Indications, and Doseage

Agent	Indication(s)	Target Dose/Titration
<u>Liraglutide</u> (peptide; GLP-1 analog/GLP-1 RA)	Reduce excess body weight and maintain reduction long term [†] • Patients aged ≥ 12 yr with weight >60 kg and obesity • Adults with overweight and ≥ 1 weight-related comorbid condition	• Target: 3.0 mg daily • Initiation dose: 0.6 mg • Increase weekly until maintenance dose is reached
<u>Semaglutide</u> (peptide; GLP-1 analog/GLP-1 RA)	Reduce risk of MACE in adults with established CVD and obesity or overweight [†] Reduce excess body weight and maintain reduction long term [†] • Patients aged ≥ 12 yr with weight >60 kg and obesity • Adults with overweight and ≥ 1 weight-related comorbid condition Treat noncirrhotic MASH with moderate to advanced liver fibrosis in adults [†]	• Target: 2.4 or 1.7 mg once weekly • Initiation dose: 0.25 mg • Increase every 4 weeks per recommended schedule
<u>Tirzepatide</u> (peptide; dual GIP and GLP-1 RA)	Reduce excess body weight and maintain reduction long term [†] • Adults with obesity • Adults with overweight and ≥ 1 weight-related comorbid condition Treat moderate to severe OSA in adults with obesity [†]	• Target: 5, 10, or 15 once weekly for obesity, 10 or 15 mg for OSA • Initiation dose: 2.5 mg • Increase by 2.5 mg every 4 weeks

[†]With reduced-calorie diet and increased physical activity.