Weight Management
A VA Clinician’s Guide
to Weight Management (2019)
Background

**Obesity** is a chronic, complex disease requiring lifelong commitment to treatment and long-term maintenance.\(^1\) It is characterized by excessive fat accumulation that alters anatomy and physiology and results in unfavorable health consequences.\(^2\)

**Figure 1. Body Mass Index (BMI) categories\(^3,4\)**

<table>
<thead>
<tr>
<th>BMI</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>18.5 – 24.9 kg/m(^2)</td>
<td>NORMAL</td>
</tr>
<tr>
<td>25.0 – 29.9 kg/m(^2)</td>
<td>OVERWEIGHT</td>
</tr>
<tr>
<td>≥30 kg/m(^2)</td>
<td>OBESE</td>
</tr>
</tbody>
</table>

BMI is the best diagnostic tool available but does not distinguish between fat and lean body mass.\(^2\)

U.S. trend data from 1999-2000 to 2015-2016 indicates **rates of obesity have steadily increased** in youth and adults aged ≥20 years old.\(^3,5\)

**Risks associated with obesity**

People who have obesity, compared to those with a normal or healthy weight, are at increased risk for many serious diseases and chronic health conditions such as diabetes, hypertension, cardiovascular disease, anxiety, depression, osteoarthritis, pain, and sleep apnea.\(^4,6\)

- This is particularly true for those with central obesity, in whom increased abdominal fat is associated with elevated fasting glucose, hypertension, and dyslipidemia.
- The relationship of BMI to health outcomes is weaker in older adults because of changes in body mass due to muscle and bone mass changes; therefore, the optimal BMI for those over 65 may be slightly higher than for younger people.\(^4,7,8\)
Figure 2. Chronic medical conditions are more prevalent in patients who are obese\(^9\)

Prevalence of selected chronic conditions by weight class, 2010-2015

According to data from the Agency for Healthcare Research and Quality (AHRQ), adult obesity is associated with higher prevalence of chronic conditions. The data presented here illustrates the prevalence of selected chronic conditions by weight class (2010-2015).

There is strong evidence that achieving ~5-10% weight loss is associated with improvements in various adiposity-related conditions.\(^4,10,11\)

- Decreased risk of developing type 2 diabetes
- Decreased A1c in patients with type 2 diabetes\(^*\)
- Decreased LDL, triglycerides; increased HDL in patients with dyslipidemia
- Decreased systolic and diastolic blood pressure in patient with hypertension\(^*\)
- Decreased hepatic steatosis and liver function tests in patients with nonalcoholic fatty liver disease
- Decreased apnea-hypopnea index in patients with obstructive sleep apnea
- Improved joint function and symptoms in patients with osteoarthritis involving weight-bearing joint

\(^5\)-15% weight loss or more may be needed.\(^11\)

**A1c:** hemoglobin A1c; **LDL:** low-density lipoprotein; **HDL:** high-density lipoprotein
Acknowledging the unspoken

Health care staff attitudes about obesity, including weight stigma and pessimism about weight loss success, have been shown to negatively impact patient care by influencing clinical decisions, patient-centered communication, and willingness or ability to provide treatment.1,12-15

These negative effects and attitudes can result in:

- Discord, patient mistrust, reduced patient disclosure
- Patient not following-through
- Reduced patient willingness to seek the care they need
- Reduced patient weight loss

Figure 3. The challenges we face14-17

Obesity is often viewed as a behavioral problem or choice and associated with negative stereotypes and personal attributes.

Obesity was not classified as a disease by the American Medical Association until 2013.

Providers view obesity treatment as less effective than treatment of most other chronic conditions.

Less than 25% of physicians reported they would recommend evaluation for bariatric surgery in patients who met criteria.
Addressing one obstacle at a time

DISCONNECT BETWEEN PATIENT AND PROVIDER

Patients:
Often attribute their weight to uncontrollable factors such as hormonal disorders, slow metabolism, and stress.

Providers:
Often attribute obesity to controllable factors (such as over-eating) that can be solved through behavioral changes.

What can you do?
Consider and identify contributing factors for obesity.

Obesity is a complex disease that results from the interaction of biological, psychological, and environmental factors including:

- Endocrine, gut microbiome, metabolic, neuroendocrine effects
- Biologic adaptations to weight loss
- Genetics
- Lifestyle
- Co-morbidities
- Medications (both prescribed and over-the-counter)
- Socioeconomic status (affecting access to affordable, healthy food and safe places to walk or exercise)
Prevention

**Screen, document, and regularly assess for overweight and obesity.**

Routine screening should include measurement of height and weight to calculate body mass index (BMI) in all patients. Regular assessment increases the opportunity to identify unhealthy weight gain early and identify conditions and medications that promote weight gain and mitigate their effects. It also allows for discussions about the benefits of maintaining and striving for a healthy weight.

- If a psychiatric condition is present, encourage patient engagement or follow-through with mental health treatment to optimize its management.

**Encourage physical activity**

Physically active individuals sleep better, feel better, and function better.

Regular physical activity is recommended to reduce the risk of many chronic conditions, disability, and mortality.

New research indicates that bouts of any length of moderate-to-vigorous physical activity contribute to health benefits associated with the accumulated volume of physical activity.

**MODERATE INTENSITY EXERCISE:**

Walking briskly at a pace that makes you sweat, but at which you can still have a conversation (or at least 3 miles per hour).
Figure 4. 2018 Physical Activity Guidelines for Americans—Prevention²¹

Recommendations for adults

- 150-300 minutes a week of moderate-intensity aerobic physical activity or 75-150 minutes a week of vigorous-intensity aerobic physical activity
  - Additional health benefits are gained by engaging in >300 minutes of moderate-intensity physical activity a week
- Muscle-strengthening activities of moderate or greater intensity that involve all major muscle groups ≥2 days per week

SPECIAL POPULATIONS:

OLDER ADULTS

- Same key guidelines as adults for aerobic and muscle strengthening activities (directly above) plus balance training
- Understand if/how their conditions may affect their ability to do regular physical activity safely
- If unable to do 150 minutes a week, they should be as physically active as abilities and conditions allow

WOMEN DURING PREGNANCY/POSTPARTUM

- At least 150 minutes of moderate-intensity aerobic activity per week during pregnancy and postpartum period
- Adjustments in physical activity level may be needed during pregnancy and postpartum

ADULTS WITH DISABILITIES

- If able, adult aerobic activity recommendations apply (see above)
- If able, adult muscle-strengthening activity recommendations apply (see above)
- If not able to meet recommendations, regular physical activity according to abilities is recommended and inactivity should be avoided
Encourage a healthy diet

This can be as simple as discussing food portion control, monitoring, and label reading. Some key recommendations from the Dietary Guidelines for Americans include:

- Identifying the correct serving size is important for portion control.

<table>
<thead>
<tr>
<th>1 teaspoon</th>
<th>¼ cup</th>
<th>3 ounces of meat</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 tablespoon</td>
<td>½ cup</td>
<td>1 medium baked potato</td>
</tr>
<tr>
<td>1 ounce</td>
<td>1 cup</td>
<td>1 medium piece of fruit</td>
</tr>
</tbody>
</table>

See the MOVE! Program website for more detailed information: www.move.va.gov
**Review medications**

**Medication side effects can complicate issues with weight.**

Conduct a medication review to determine if medications are contributing to or causing weight gain and consider non-obesogenic alternatives when feasible.

**Table 1. Select medications associated with weight gain[^23-27]**

<table>
<thead>
<tr>
<th>Drug class</th>
<th>Specific medications</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Anticonvulsants</strong></td>
<td>• Carbamazepine</td>
</tr>
<tr>
<td></td>
<td>• Valproic acid</td>
</tr>
<tr>
<td></td>
<td>• Pregabalin</td>
</tr>
<tr>
<td></td>
<td>• Gabapentin</td>
</tr>
<tr>
<td><strong>Antidepressants</strong></td>
<td>• Amitriptyline</td>
</tr>
<tr>
<td></td>
<td>• Mirtazapine</td>
</tr>
<tr>
<td></td>
<td>• Paroxetine</td>
</tr>
<tr>
<td><strong>Antipsychotics</strong></td>
<td>• Clozapine</td>
</tr>
<tr>
<td></td>
<td>• Olanzapine</td>
</tr>
<tr>
<td></td>
<td>• Quetiapine</td>
</tr>
<tr>
<td></td>
<td>• Risperidone</td>
</tr>
<tr>
<td></td>
<td>• Thioridazine</td>
</tr>
<tr>
<td><strong>Antidiabetic agents</strong></td>
<td>• Insulin</td>
</tr>
<tr>
<td></td>
<td>• Meglitinides: nateglinide, repaglinide</td>
</tr>
<tr>
<td></td>
<td>• Sulfonylureas: chlorpropamide, glimepiride, glipizide</td>
</tr>
<tr>
<td></td>
<td>• Thiazolidinediones: pioglitazone, rosiglitazone</td>
</tr>
<tr>
<td><strong>Beta-blockers</strong></td>
<td>• Atenolol</td>
</tr>
<tr>
<td></td>
<td>• Metoprolol</td>
</tr>
<tr>
<td></td>
<td>• Propranolol</td>
</tr>
<tr>
<td><strong>Glucocorticoids</strong></td>
<td>• Prednisone</td>
</tr>
<tr>
<td><strong>Contraceptives</strong></td>
<td>• Medroxyprogesterone acetate depot injection</td>
</tr>
<tr>
<td><strong>Mood stabilizers</strong></td>
<td>• Lithium</td>
</tr>
</tbody>
</table>
Identify and diagnose obesity when it is present and include other members of the healthcare team to manage when needed.4

Assess for the presence of obesity-associated conditions among patients who are obese or overweight:

- Perform a targeted assessment on patients who are overweight and obese.
- In addition to the basic medical history and physical examination, assess for factors contributing to obesity.
- Consult with or refer to members of the healthcare team regarding weight management opportunities.
  - Examples: clinical pharmacists, MOVE! Weight Management Program for Veterans (MOVE!), registered dietitians, obesity medicine providers, bariatric surgery providers

ANNUAL SCREENING should include a review of medications as well as medical and mental health conditions that may be contributing to weight gain.

Challenges starting the conversation1,28

Discussing obesity can be challenging not only due to provider time limitations and demands for co-morbidity management, but also due to concerns or unease about approaching the topic in a way that will be impactful and acceptable to the patient.

Other challenges may include clinician misperceptions regarding the potential impact of discussions about weight management on patient behavior (including participation in weight management interventions) or misperceptions of the impact of effective weight management (e.g., MOVE!, medications, bariatric surgery) on health, well-being, and other outcomes.
Veterans who are obese, as well as those who are overweight with an obesity-associated condition, can benefit from weight loss and should be engaged in a process of shared decision-making. The recommended process for achieving shared understanding is based on evidence-based principles of health education, health behavior counseling, shared decision-making, and motivational interviewing.4

**Figure 5. Tips for discussing weight with Veterans**

Use medically appropriate words and phrases

- Large size
- Heaviness
- Fat
- Overweight status

Remain non-judgmental

- Unhealthy weight
- Weight
- Unhealthy body weight
- Unhealthy BMI

Show genuine interest, support, and compassion

**Veterans who are obese**, as well as those who are overweight with an obesity-associated condition, can benefit from weight loss and should be engaged in a process of shared decision-making. The recommended process for achieving shared understanding is based on evidence-based principles of health education, health behavior counseling, shared decision-making, and motivational interviewing.4

- **Discuss risks of unhealthy weight** as well as the potential benefits of participating in an effective weight management intervention.
- **Discuss relative potential obstacles** to participation in a weight management program, considering an individual’s coexisting medical conditions.
- **Emphasize, if needed, the value of viewing unhealthy weight as a chronic disease** that requires lifelong management.
Motivational interviewing has been shown to significantly improve weight loss in patients who are overweight or obese, resulting in a 3.3 pound (1.5 kg) higher weight loss than control treatments in weight loss studies.²⁹

To increase patient engagement and action, use motivational interviewing to examine and address ambivalence to change.³⁰

1. Why would you want to lose weight and exercise?
2. What success have you had with weight management in the past?
3. What are your reasons for working on your weight?
4. How important is it for you to make this change, and why?

Summarize the patient’s responses and then ask:
So, what would you like to do?

- Collaborate on an action plan—What would be a realistic next step?³¹
- Address barriers to adherence³²,³³
- Peer/social support—particularly in low health literacy patients³⁴,³⁵
- Health care team checks in regularly and applauds progress³²-³⁵

Personalized Action Planning³²,³⁶,³⁷

✓ Include the use of daily weighing and integrate into daily routines. Daily weighing has been associated with significantly greater weight loss and less weight regain.

For example, by placing the scale near the toothbrush, daily weighing is encouraged.

✓ Emphasize the value of peer, provider, or social support, and addressing barriers for adhering to an action plan.
**Figure 6. Shared decision-making approach to discussing overweight and obesity and the MOVE! Program**

<table>
<thead>
<tr>
<th>Ask permission to discuss weight management</th>
</tr>
</thead>
<tbody>
<tr>
<td>• “May I talk with you about strategies to help you manage your weight?”</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Explore readiness and experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>• “How does gradual weight loss fit in with your life mission?”</td>
</tr>
<tr>
<td>• “What successes have you had in managing your weight in the past?”</td>
</tr>
<tr>
<td>• “How important is it for you to work on your weight?”</td>
</tr>
<tr>
<td>• “What do you know about the benefits of weight loss?”</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Support and affirm any interest, benefits, and current/past successes</th>
</tr>
</thead>
<tbody>
<tr>
<td>• “It’s good you have (interest in, knowledge about) weight management.”</td>
</tr>
<tr>
<td>• (if applicable) “I’m glad you have had some success in managing your weight.”</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Share information about MOVE! and/or the value of weight loss (with permission)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• “Would it be okay if I shared some information about how losing some weight would improve your health?”</td>
</tr>
<tr>
<td>(if the Veteran spontaneously expresses readiness to participate in weight management strategy, go directly to next step)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Confirm next steps</th>
</tr>
</thead>
<tbody>
<tr>
<td>• “Would you like to participate in the MOVE! program?”</td>
</tr>
<tr>
<td>• If yes, connect Veteran to MOVE! program</td>
</tr>
<tr>
<td>• If no, ask about interest in learning more about other weight management programs (e.g., community-based, eating healthy, being active)</td>
</tr>
</tbody>
</table>
Responding to Veterans’ perceived barriers to weight loss

Table 2. Objections and responses

<table>
<thead>
<tr>
<th>Example objections voiced by Veteran</th>
<th>Example provider responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>“I don’t have time to work out (or make a healthy meal).”</td>
<td>“Many Veterans have challenges with time. The MOVE! program and our VA dietitians can help you identify ways to address time concerns.”</td>
</tr>
<tr>
<td>“I tried the MOVE! program and it didn’t work for me.”</td>
<td>“It’s great you tried MOVE!. What parts of MOVE! were helpful?” OR “It’s great you tried MOVE!. For some Veterans, participating in MOVE! doesn’t lead to significant weight loss. It’s challenging to lose weight, so we may want to consider how to boost your chance of success.” (Consider offering to review the patient’s medications to identify those that may contribute to obesity.)</td>
</tr>
<tr>
<td>“My knees have arthritis so I can’t exercise.”</td>
<td>“If you are interested, we can discuss how you can increase your activity in ways that don’t affect your knees. What is your understanding of how losing some weight might help your arthritis?”</td>
</tr>
<tr>
<td>“Eating healthy is too expensive.”</td>
<td>“It’s good that you are thinking about how you might eat healthier. The MOVE! program and our VA dietitians can help you identify ways to eat healthier without spending more.”</td>
</tr>
<tr>
<td>“I’ve tried several medications before and they didn’t work for me.”</td>
<td>“If you are interested, we can look at the medications you’ve tried in the past to see if there is a reason they may not have worked for you, or if there are others you haven’t tried yet.”</td>
</tr>
</tbody>
</table>
Frustrations with management of obesity

PATIENTS:
Many patients who are overweight or obese initially lose weight through dieting; however, maintenance of weight loss is challenging for many reasons, including the long-term reduction in resting metabolic rate that accompanies weight loss.

PROVIDERS:
Perceive that responsibility for weight loss lies with the patient or that the availability of evidence-based treatments for obesity are limited.

What can you do?

• **Work with the patient to set reasonable weight loss goals.** Consider an initial goal of 5% weight loss over 6 months. This is a reasonable goal and in line with what the MOVE! program is focused on—achieving clinically meaningful (~5%) weight loss.

• **Gain a better understanding of evidence-based prevention** and management of overweight and obesity.¹⁵

• **Support weight management opportunities** available for Veterans within VHA and the community.

• **Integrate weight management** into Veteran care.

• **Consider treatment strategies such as pharmacotherapy** and **bariatric surgery** when applicable.

*Weight loss is not a milestone, it’s part of a dynamic process.*³⁸
Management

Offer or refer the patient to evidence-based weight loss interventions based on their obesity-associated conditions and BMI.

Obesity is a chronic disease that generally requires long-term management. When considering management options, it is important to take a complications-centric approach with the primary therapeutic endpoint being improvement in adiposity-related complications. Treatment selection should be aligned with the severity of overweight, associated chronic conditions, functional limitations, and patient values and preferences. Three evidence-based treatment options include:

1. **Comprehensive lifestyle intervention** (in VHA, the MOVE! Weight Management Program for Veterans)
2. **Pharmacotherapy**
3. **Bariatric surgery**

**Figure 7. Treatment recommendations using BMI (kg/m²) as a guide**

<table>
<thead>
<tr>
<th>BMI Range</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>18.5–24.9*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25.0–29.9</td>
<td>Comprehensive lifestyle intervention</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30.0–34.9</td>
<td>Comprehensive lifestyle intervention</td>
<td>Consider drug therapy</td>
<td></td>
</tr>
<tr>
<td>35.0–39.9</td>
<td>Comprehensive lifestyle intervention</td>
<td>Consider drug therapy</td>
<td>Consider surgery</td>
</tr>
<tr>
<td>≥40.0</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

† with obesity-associated condition(s)

*Note: Patients at a healthy weight may be offered information and counseling about a healthy lifestyle and maintaining a healthy weight.
Level 1: Comprehensive lifestyle intervention (CLI)

Comprehensive lifestyle intervention (CLI) should be offered to all obese patients and overweight patients with one or more obesity-associated chronic health conditions. In VHA, the MOVE! Weight Management Program for Veterans is the CLI of choice.

The foundation of treatment for overweight and obesity should include at least 12 contacts over a year of an intervention that combines the following components:

- Dietary
- Behavioral
- Physical activity

Diet and physical activity together must create an energy deficit of 500-1,000 kcal/day for effective initial weight loss (adherence to any calorie-deficit diet is more important than choice of a specific diet).

Moderate or vigorous physical activity, through short bursts of activity or a single longer episode, typically must accumulate to at least 150 minutes per week.

People who want to lose a substantial amount of weight (more than 5% of body weight) and people who are trying to keep off a significant amount of weight once it has been lost may need to do more than 300 minutes of moderate-intensity activity or 150 minutes of vigorous activity a week to meet weight-control goals.

MOVE! WEIGHT MANAGEMENT PROGRAM FOR VETERANS

MOVE! is an evidence-based, population-focused weight management program that has helped thousands of Veterans to lose weight and improve their health. Comprehensive lifestyle intervention is the foundation of MOVE!

- Goal is to assist Veterans in achieving clinically significant weight loss (~5%)
- Guided by national policy, aligned with VA/Department of Defense Obesity Clinical Practice Guidelines
- Led by facility MOVE! coordinators and provider champions, VISN MOVE! Coordinators
Flexible MOVE! Program participation options

Comprehensive lifestyle intervention offered via various modalities for Veterans:

- Group sessions
- Individual sessions
- Telephone lifestyle coaching
- Clinical Video Telehealth (CVT)
- TeleMOVE!—home telehealth
- MOVE! Coach mobile app
- MOVE! Coach with Care—mobile app + clinical contacts
- Be Active and MOVE!—physical activity adjunct
- Annie text messaging app
Level 2: 
**Drug therapy**

- Although lifestyle changes alone can result in weight loss for some, **many patients who are overweight and obese need additional interventions** for weight reduction.

- **Pharmacotherapy should always be used in combination with CLI.**
  - The addition of pharmacotherapy produces greater weight loss and weight-loss maintenance compared with lifestyle interventions alone.\(^\text{11}\)

- **Weight loss medications can be used long-term** in individuals who are obese or overweight with at least one weight-associated co-morbidity (e.g., type 2 diabetes, hypertension, dyslipidemia, metabolic syndrome, obstructive sleep apnea, or degenerative joint disease [osteoarthritis]).\(^\text{39}\)

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**Table 3. Pharmacotherapy options**

<table>
<thead>
<tr>
<th>Weight management medication</th>
<th>REMS*</th>
<th>Controlled substance schedule</th>
<th>Boxed warning</th>
<th>Administration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phentermine/topiramate ER (Qsymia(^\text{®}))</td>
<td>Yes**</td>
<td>CIV</td>
<td>No</td>
<td>Oral, titration to dose given once daily</td>
</tr>
<tr>
<td>Naltrexone/bupropion ER (Contrave(^\text{®}))</td>
<td>No</td>
<td>None</td>
<td>Yes (suicidal thoughts/behaviors)</td>
<td>Oral, titration to twice daily</td>
</tr>
<tr>
<td>Lorcaserin (Belviq(^\text{®}))</td>
<td>No</td>
<td>CIV</td>
<td>No</td>
<td>Oral, twice daily <strong>XR</strong>: Oral, once daily</td>
</tr>
<tr>
<td>Lorcaserin ER (Belviq XR(^\text{®}))</td>
<td>No</td>
<td>None</td>
<td>No</td>
<td>Oral, three times daily</td>
</tr>
<tr>
<td>Orlistat (Xenical(^\text{®}), Alli(^\text{®}))</td>
<td>No</td>
<td>None</td>
<td>No</td>
<td>Oral, three times daily</td>
</tr>
<tr>
<td>Liraglutide (Saxenda(^\text{®}))</td>
<td>No</td>
<td>None</td>
<td>Yes (thyroid C-cell tumors)</td>
<td>Injection (SC), titration to dose given once daily</td>
</tr>
</tbody>
</table>

Please see Quick Reference Guide for more information. Criteria for use of the individual agents for chronic weight management are available in VA PBM Criteria for Use. VA Formulary information at: www.pbm.va.gov/apps/VANationalFormulary

*REMS: Risk Evaluation and Mitigation Strategy
**REMS: Phentermine/topiramate ER—to prevent unintended exposure during pregnancy, as topiramate is associated with oral clefts in newborns exposed during the first trimester; requirements for provider and pharmacy certification

ER: extended-release; SC: subcutaneous; XR: extended release
According to a 2016 systematic review and network meta-analysis reviewing 28 randomized clinical trials with over 29,000 patients, pharmacotherapy agents—when added to a comprehensive lifestyle intervention—were associated with achieving significant excess weight loss versus placebo at one year.

**MEDICATION PEARLS**

- Weight loss from clinical interventions will likely plateau around 6-9 months.
- Weight is usually regained after the medication is stopped.
- Longer durations of treatment do not typically lead to greater weight loss, but instead help to maintain weight.
There is no one drug that fits all. A number of factors must be considered, including drug efficacy, side effects, cautions and warnings, and patient comorbidities. Selection should be a shared decision between patient and provider.

Consider pharmacotherapy as an adjunct to CLI for patients who are overweight or obese or if other interventions have not resulted in desired weight loss.

*See Guidance on Selecting Weight Management Medication for more information

**Clinically significant: at least 3% to 5% of baseline weight
Level 3:
Surgical interventions

Surgical interventions for obesity have consistently demonstrated profound and sustained weight loss.\textsuperscript{40} Surgical options for weight loss should be offered as an adjunct to comprehensive lifestyle interventions for the following patient populations:\textsuperscript{4}

- BMI 35.0-39.9 kg/m\(^2\) with obesity-associated conditions
- or
- BMI \(\geq 40\) kg/m\(^2\)

There is insufficient evidence to suggest offering bariatric surgery as an adjunct to comprehensive lifestyle intervention for weight loss or to improve some obesity-associated conditions in patients over age 65 or with a BMI <35 kg/m\(^2\).

Figure 11. Types of bariatric surgical procedures

<table>
<thead>
<tr>
<th>Restrictive techniques</th>
<th>Malabsorptive techniques</th>
<th>Both restrictive and malabsorptive techniques</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gastric banding</td>
<td>Biliopancreatic diversion</td>
<td>Roux-en-Y gastric bypass</td>
</tr>
<tr>
<td>Adjustable gastric banding</td>
<td>Biliopancreatic diversion with duodenal switch</td>
<td>(Most common in the U.S.)</td>
</tr>
<tr>
<td>Sleeve gastrectomy</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Weight loss expectations with bariatric surgery\textsuperscript{10,41}

The amount of weight loss depends on several factors including exercise, diet, lifestyle, and overall commitment to changing old habits.

After one year, patients on average lose 15-30% of their body weight depending on the type of surgical procedure.\textsuperscript{10}

It is important to note that patients are reported to regain \(~5-10\)% from their lowest weight at 10 years of follow-up after a bariatric surgical procedure.\textsuperscript{10}

Figure 12. Surgical procedures achieve 15-30% weight reductions\textsuperscript{10}
After bariatric surgery

After bariatric surgery, pronounced clinical improvements can be seen in most obesity-related health issues.\textsuperscript{10,42}

**Figure 13. Surgical procedures improve hemoglobin A1c\textsuperscript{42}**

![Bar chart showing percent of patients with glycated hemoglobin level 6.0% or less for medical therapy, gastric bypass, and sleeve gastrectomy.]

A 2017 study in 134 patients compared 5-year outcomes from bariatric surgery versus intensive medical therapy in patients with diabetes. At baseline, the study participants had a mean glycated hemoglobin level of 9.2±1.5%, and a mean duration of diabetes of 8.4±5.2 years, with 44% of patients requiring insulin. According to the results, 2 of 38 patients (5%) in the medical therapy group, 14 of 49 patients (29%) in the gastric-bypass group, and 11/47 patients (23%) in the sleeve-gastrectomy group achieved a glycated hemoglobin level of 6% or less (unadjusted p=0.01, adjusted p=0.03, p=0.08 in the intention-to-treat analysis).

There are approximately 20 VHA Bariatric Surgery Programs currently—contact them to learn their policy for bariatric surgery. An example of the requirements may be:

- Participation in MOVE! or other comprehensive lifestyle intervention
- Providing a physical and labs 30 days before bariatric surgery
- Addressing emergent conditions (complications) post-surgery

**Use this link to locate VA bariatric surgery programs:** [http://vaww.dushom.va.gov/DUSHOM/surgery/NSOMaps.asp](http://vaww.dushom.va.gov/DUSHOM/surgery/NSOMaps.asp)

**Refer**

Refer patients who meet criteria for weight loss surgery to MOVE! and ensure they receive an evaluation for surgical intervention.
Summary

1. **Screen, document, and regularly assess** for overweight and obesity.

2. **Identify and diagnose obesity** when it is present and include other members of the healthcare team to manage when needed.

3. **Engage Veterans** in shared decision-making regarding weight loss and treatment options.

4. Offer or refer the patient to **evidence-based weight loss interventions** based on their obesity-associated conditions and BMI.

5. **Consider pharmacotherapy** as an adjunct to CLI for patients who are overweight or obese or if other interventions have not resulted in desired weight loss.

6. **Refer patients** who meet criteria for weight loss surgery to MOVE! and ensure they receive an evaluation for surgical intervention.
Important resources

- **Office of Disease Prevention and Health Promotion**: https://health.gov
- **MOVE! Program**: www.move.va.gov
- **Pharmacy Benefits Management Services SharePoint site**: https://vaww.pbmnat.va.gov/sites/PBM/Pages/Home.aspx
- **Iowa City VA Bariatric Surgery Resources**: www.vapulse.net/groups/hpdp-program-planning/blog/2018/07/17/bariatric-resources-attachments

**REFERENCES**


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This reference guide was created to be used as a tool for VA providers and is available to use from the Academic Detailing SharePoint.

These are general recommendations only; specific clinical decisions should be made by the treating provider based on an individual patient’s clinical condition.

**VA PBM Academic Detailing Service Email Group:**
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**VA PBM Academic Detailing Service SharePoint Site:**
https://vaww.portal2.va.gov/sites/ad

**VA PBM Academic Detailing Service Public Website:**
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