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Low Utilization of Obesity Medications: What are the Implications for Clinical Care?

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In a new analysis of dispensed prescriptions for obesity medications, Thomas et al. (1) quantify the extent of a problem that until now has only been described qualitatively. Prescribing of obesity medications, and especially obesity medications approved by the FDA in the past 4 years, is at a low level that appears to be incongruous with the extent of the unmet need for clinical care in obesity. By comparing the rate of adoption of the newer obesity medications with the rate of adoption for the newest medications for type 2 diabetes (SGLT2 inhibitors), the investigators provide a benchmark that suggests systematic barriers may be at work to limit the adoption of new pharmacotherapies in the treatment of obesity.

This analysis serves to confirm low rates of utilization and adoption for new obesity medications that have previously been reported (2), but it does not answer two important questions about the causes and implications of these low rates.

The first task is to quantify the benefit of the therapies in real clinical settings, as measured by objective outcomes that they provide. While efficacy data from randomized, controlled studies of obesity medications show that the therapies have the potential for clinical benefits, published data on real-world effectiveness are needed for obesity pharmacotherapy (3). Woloshin and Schwartz cite limited outcomes data as a reason for caution in adopting these new agents (4). Physicians prescribing obesity medicine have direct access to outcomes in the large populations of patients that they treat, but few publications of such data can be found in peer-reviewed literature. Thus, the perspective of physicians prescribing obesity medicine on outcomes of pharmacotherapy is not widely shared in the medical community.

In addition to more robust outcomes data, a better understanding of the systematic barriers to adoption of obesity pharmacotherapy is necessary. Thomas et al. cite several factors that may contribute (1). These factors include inadequate training of providers, reluctance to

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recognize obesity as a chronic disease that requires medical care, limited coverage of obesity treatment by health plans, provider biases regarding patients with obesity, a gap between expected and actual effectiveness of treatment, and concerns about the safety of obesity drugs. While each of these factors may contribute to the slow adoption rates for these drugs, they are unlikely to be of equal importance. A better understanding of the most important factors will be essential for overcoming the problem that Thomas et al. describe.

The unmet need for better obesity care is considerable. Meeting that need will require more work to quantify the outcomes that current therapies can deliver in real-world settings and a deeper understanding of the most important barriers to their adoption.

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