American Society of Bariatric Physicians®

2821 S. Parker Road
Suite 625
Aurora, CO 80014

Phone:303.770.2526
Fax:303.779.4834
Web: www.asbp.org

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Dear Consumer Reports Staff:

I am writing to you with regards to your article on the new anti-obesity medications. I have generally found Consumer Reports to do a great job of presenting both the good and bad on the issues they take on; unfortunately, that is clearly not the case in this article.

While the information presented is accurate, it is very one-sided. It suggests to people affected by obesity that if they simply eat less and exercise more it will take care of this difficult problem.

This is untrue.

Looking at the same studies quoted by the author (BLOOM, BLOOM-DM, BLOSSOM, CORE-I, CORE-II, CORE-DM, and CORE-BM, SEQUEL, EQUIP, CONQUER), and reviewing the guidelines issued by all of our major medical organizations we can arrive at a very different conclusion.

First, let's discuss obesity. Obesity is a chronic disease (American Medical Association, 2013). Treatment is recommended by the USPSTF with "multi-component treatment", evidence grade B. Once a patient has obesity, odds of successful treatment with behaviors alone are quite low. In fact, if you look at the placebo treated groups in the drug trials above, all received good supervision and counseling regarding how to eat less and exercise more. Even with professional help, those treated with placebo had less than 20% odds of achieving a 5% weight loss, and less than 10% odds of achieving a 10% weight loss (BLOOM - placebo treated patients had 17.9% odds of achieving 5%, 5.8% odds of achieving 10% vs. Lorcaserin treated patients, in whom those odds went up to 44.6% and 20.8%, respectively in completers, and in SEQUEL, patients treated with Qsymia had a 79.3% odds at achieving a 5% weight loss, 53.9% odds of 10%).

Anti-obesity medication more than doubles the odds of achieving and sustaining a 5-10% weight loss. The NHLBI recommends that a 5%-10% weight loss is both meaningful and valuable. The ADA recognizes that a 5% weight loss improves glycemic control for patients with diabetes.

The article further fails to note that in patients with type 2 diabetes, these medications lowered the Hemoglobin a1c number nearly as effectively as an anti-diabetic medication (Belviq lowered a1c 0.9, Contrave 0.6, Qsymia 0.4). It fails to recognize than in a recent study, Qsymia was found to be a cost-effective solution for long-term weight control (Obesity, June 2014).

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The very next article in this Consumer Reports edition promotes surgical intervention for obesity but fails to point out that the USPSTF recommends surgery for obesity with only a grade "C" evidence, vs. "multicomponent care" with a grade "B" evidence or that we have conflicting evidence regarding the cost-effectiveness of bariatric surgery.

It's time to stop blaming people with obesity for their weight. This bias and stigmatism further worsens their plight with this deadly disease reinforcing stereotypes that obesity is a disease of personal responsibility (simply "eat less and exercise more and you will successfully become thin like the rest of us" which is the message your article reinforces). It is akin to suggesting that an individual with depression "cheer up" or that an individual with knee pain "walk less."

Why don't we respect current science? We know that obesity is a chronic, progressive and deadly disease. In fact for patients with a BMI over 40, we expect them to live 5 to 8 years less than their normal BMI counterparts. We know that treatment with "eat less, exercise more" is effective for less than 1 in 5 who choose this approach. We know that prescription medications can double or even triple the odds at achieving AND maintaining medically meaningful weight loss, and that in extreme cases, even surgery may (and should) be considered.

Your article suggests that individuals with a medical disease treat it with do-it-yourself diets and goes against treatment recommendations from the USPSTF, The Obesity Society, the American Heart Association, the American Society of Bariatric Physicians, and even the Department of Defense. It goes against current thought leaders in Obesity Medicine as taught at courses like the George Blackburn "Practical Approaches to the Treatment of Obesity" (Harvard Medical School). It does not represent the current thinking of physicians specializing in the treatment of obesity.

Further, it fails to properly discuss the role of medical management of other diseases in a way that doesn't increase weight (many medications used for other problems contribute to weight gain), the role of an Obesity Medicine Physician to develop a proper assessment and treatment plan (same as all other medical problems), the use of Phentermine (which has been a safe, affordable and effective treatment in this country for 60 years, and remains the dominant anti-obesity medication being prescribed by physicians) and Diethylpropion, or that Saxenda is a new dosing of liraglutide, which is commonly used to treat type 2 diabetes. Obesity causes more deaths in America each year than diabetes. Both are major problems. But why would we recommend treatment for one but recommend against treatment for the other? Should we tell patients affected by diabetes to walk more and eat less sugar?

CR Staff, I urge you to present both sides to this difficult problem.

Thank you for your consideration.

Sincerely,

Ethan Lazarus, MD