

## Use Weight-Loss Drugs Cautiously, Never Alone

BY SHERRY BOSCHERT  
San Francisco Bureau

SAN FRANCISCO — Medications for weight loss are little help as monotherapy, and it's questionable whether the benefits outweigh the risks, Dr. Robert Baron said at a diabetes update sponsored by the University of California, San Francisco.

Approved weight-loss medications such as sibutramine or orlistat produce an average 5% drop in weight beyond the weight loss achieved on placebo when used alone. Dieting alone leads to an average 8% weight loss beyond that achieved with placebo. The efficacy of drug and diet therapies are about the same, but medications carry potential side effects and cost more, said Dr. Baron, professor of medicine at the university.

He has no association with companies that make the drugs he discussed. His practice includes a small bariatric practice, but he chooses not to prescribe medications for weight loss.

There are no data to show that weight loss from medical therapy improves mortality. Trial end points are based on weight changes alone. Improving an intermediate end point such as weight doesn't necessarily reflect beneficial changes in mortality, "so be cautious with the use of drugs" for weight loss, he advised.

In the clinical trials that led to approval of some drugs for weight loss, the drugs were studied in combination with lifestyle modifications. The combination generally induces greater weight loss, and is the only way in which these medications should be used, he said.

National Institutes of Health guidelines recommend that drug therapy for weight loss may be considered in patients with a body mass index (BMI) of at least 30 kg/m<sup>2</sup> or in patients

with a BMI of 27 kg/m<sup>2</sup> plus comorbidity. In this framework, nearly every patient with type II diabetes would qualify for a weight-loss medication, but in practice few should use one, he believes.

Dr. Baron advised against prescribing weight-loss medications during the patient's first visit. Instead, he suggested, start motivated patients on the same strategy used in clinical trials for these medications by beginning with a run-in period of lifestyle modifications with a low-calorie diet, structured exercise, and behavioral therapy. After 1 month, only those who are adherent and who are losing weight should qualify for consideration for a weight-loss medication.

If you choose to use a weight-loss drug, prescribe no more than 1 month's worth initially. "The data are very clear that the outcome at 1 month correlates very well to the outcome at 12 months. If the patient hasn't lost weight at 1 month, you can stop the drug with impunity," he said. Counsel the patient about this strategy before beginning drug therapy.

Some medications used for other purposes can have weight-loss benefits. The most clinically useful of these is the antidepressant bupropion. In a randomized trial involving 327 obese patients, 5% of those on bupropion 300-400 mg lost modest amounts of weight, compared with 2% of those on placebo. "I would never prescribe this as a weight-loss drug," but for overweight or obese patients who are depressed, "I now use bupropion as my drug of first choice."

Dr. Baron cautioned against advertisements claiming that one drug is more effective than another based on the weight lost from baseline. Weight loss should be compared with the weight loss on placebo, he emphasized. ■

## Women Lose More Weight on Atkins Diet Than on Other Plans

BY MARY ANN MOON  
Contributing Writer

Overweight and obese premenopausal women lost more weight and showed more favorable metabolic changes after 1 year on the Atkins diet than did those who followed the Zone, LEARN, or Ornish diets, investigators have reported.

Women who followed the high-protein, high-fat, low-carbohydrate Atkins diet also showed no adverse changes in triglycerides, HDL cholesterol, blood pressure, or insulin resistance, as feared by some critics.

Although questions remain about long-term effects and mechanisms of action, "physicians whose patients initiate a low-carbohydrate diet can be reassured that weight loss is likely to be at least as large as for any other dietary pattern and that the lipid effects are unlikely to be of immediate concern," Christopher D. Gardner, Ph.D., and his associates in the A TO Z (Atkins, Traditional, Ornish, Zone) Weight Loss Study wrote in the journal of the American Medical Association.

They cautioned that the magnitude of weight loss was modest at best with all four diets, ranging from 2% to 5% of total weight, and the trajectories of weight loss during the 1-year study indicated that differences in weight loss among the diets would diminish over time.



Triglycerides and HDL cholesterol showed slightly more improvement in women in the Atkins group.

Dr. Gardner and his associates of Stanford (Calif.) University conducted the A TO Z study to compare the effects of four well-known diets representing a spectrum of carbohydrate intake. The Atkins diet is very low in carbohydrates; the Zone diet is low in carbohydrates; the LEARN (Lifestyle, Exercise, Attitudes, Relationships, and Nutrition) diet, is high in carbohydrates; and the Ornish diet is very high in carbohydrates.

Subjects were 311 women aged 25-50 years, with body mass indices of 27-40 kg/m<sup>2</sup>, who were randomly assigned to read one of the four diet books and attend eight 1-hour weekly classes during which the books and diets were discussed by a dietitian, and to follow one of the diets. The attrition rate was about 20% and did not differ significantly between diets.

Total energy intake did not differ among the four groups either at baseline or at any point during follow-up, even though two diets (Zone and LEARN) called for caloric restriction and the other two did not. There was a modest increase in physical activity in all groups.

The mean weight loss at 1 year was 4.7 kg for the Atkins diet, 1.6 kg for the Zone diet, 2.2 kg for the LEARN diet, and 2.6 kg for the Ornish diet (JAMA 2007;297:969-77).

There were no significant differences among the groups in percentage of body fat or in waist-to-hip ratio, nor in fasting insulin or fasting glucose levels. The decrease in blood pressure levels paralleled that in weight, with the Atkins group showing slightly larger decreases than the other groups. Triglycerides and HDL cholesterol showed slightly more improvement in the Atkins group, but LDL cholesterol did not.

"The reported effects of the current study should be interpreted as resulting from the combination of macronutrient changes that occur when following low- vs. high-carbohydrate diets, not changes in carbohydrates alone. Greater satiety from the higher protein content of the Atkins diet may have contributed to the benefits observed for that group," the authors noted. ■

## Weight Maintenance, Not Loss Alone, Should Be the Real Goal

BY SHERRY BOSCHERT  
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SAN FRANCISCO — Helping patients, even overweight patients, to avoid gaining more weight is an important therapeutic goal by itself, Dr. Robert Baron said at a diabetes update sponsored by the University of California, San Francisco.

"It's very, very hard to get people to lose weight. Our priority in a large number of our patients should be to prevent further weight gain," said Dr. Baron, professor of medicine at the university. "In our society, the default position is to gain weight. You need to have a strategy to maintain your

weight, especially [with age]."

Recent data support the classic goals of being as fit as possible at one's current weight, preventing weight gain, and then considering attempts at weight loss, he emphasized. Being overweight by itself is not necessarily a risk factor for mortality, other data show. The presence or absence of metabolic syndrome plays a key role in level of risk.

A 2005 meta-analysis of three National Health and Nutrition Examination Surveys (NHANES I, II and III) found no increased risk for mortality in people who fit the conventional definition of overweight for white people (a body mass index [kg/m<sup>2</sup>] of at

least 25 but less than 30), although the mortality risk did increase among the obese.

Although the prevalence of obesity has increased, the mortality risk associated with obesity decreased between the first of the three surveys, NHANES I, and the more recent NHANES III, although this could be because of methodologic differences.

Data from a separate study in 2005 of 19,173 men showed that the presence of metabolic syndrome doubled the risk for mortality in normal-weight people, added about 50% in absolute risk for death in overweight people, and increased risk for death by 13% in obese people.

Overweight patients may not be at increased risk if they are metabolically normal, but the presence of the metabolic syndrome or other signs of insulin-resistance changes the clinical picture, Dr. Baron said. "Your BMI is your initial screening test, and evaluation of metabolic syndrome becomes your more accurate, second-level test to sort out which patients in the overweight category and Class I obese [BMI of at least 30 but lower than 35] need more particularly aggressive interventions."

Data on 3,000 successful dieters (mostly white women) who enrolled in the National Weight Control Registry and maintained

a 30-pound or greater weight loss for 1 year showed three key steps to keeping the pounds off: high levels of physical activity; diets low in fat and high in fiber, and regular self-monitoring of weight.

Most of the patients did an hour a day of moderately intense exercise, 6-7 days a week, to burn 2,545 kcal/week for women or 3,293 kcal/week for men. Most checked their weight daily or weekly.

Their "grazing" diets consisted of five meals or snacks a day, providing 1,381 kcal/day from foods made up of 24% fat, 19% protein, and 56% carbohydrates. The calorie levels of their weight maintenance diets were similar to those during their weight loss. ■