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CARDI·OH
Ohio Cardiovascular and Diabetes Health Collaborative

The Intersection of Weight Management and Diabetes Care:
Additional Webinar Questions and Answers

Answers from: Benjamin O'Donnell, MD, The Ohio State University Wexner Medical Center

Question **The availability of GLP-1s has been an issue. Are there any guidelines for transitioning between GLP-1s?**

Answer I find dulaglutide (for most people) has fewer gastrointestinal side effects, so I would consider the dulaglutide 3 mg dose equivalent to semaglutide 1 mg. For tirzepatide, I don't have as much working knowledge (due to shortages), but I have successfully moved a number of people from dulaglutide 1.5 mg to tirzepatide 5 mg and dulaglutide 3 mg to tirzepatide 7.5 mg. I haven't moved many people from semaglutide to tirzepatide.

Question **Is there a tolerance to the medication after a period of time?**

Answer Yes and no – I would refer to it as an adaptation rather than building a tolerance. Typically, around six months (after reaching the high dose), people seem to notice a "return of appetite" – though when I've asked more about this, they describe it as a noticeable appetite, but still less than what they were previously accustomed to and with a continued satiety impact (still have to stick with smaller portions).

Question **What are your thoughts on patients with baseline decreased caloric intake and using GLP-1 agonists? Is that not a good choice?**

Answer If someone can maintain a reduced calorie intake (relative to their needs) and maintain consistent weight loss without any trouble with hunger, there really isn't a need for medications.

Question **I saw a study recently that compared 3 mg of dulaglutide weekly compared to liraglutide 2.4 mg daily, showing greater efficacy for this dose of dulaglutide. I've observed a slightly higher approval for dulaglutide than for other GLP-1 RAs. Any thoughts on the use of dulaglutide?**

Answer I'm not familiar with this study – liraglutide 2.4 mg isn't a dose that was studied for weight loss or diabetes; dulaglutide hasn't been studied specifically for weight loss, though it has been reported in the phase 3 studies looking at higher doses (3 mg/4.5 mg) with modest increases in weight loss compared to lower doses (0.75 mg/1.5 mg). I have had patients with diabetes respond more favorably to the higher doses of dulaglutide, so if it's the only available GLP-1 RA (on their insurance formulary), I will use it.

Question **I often have patients who report thyroid cancer in the family but never know if it is medullary, which is understandable. Would that still make GLP-1 a hard no still?**

Answer The risk of medullary thyroid cancer is extremely low – hyperplasia of C-cells occurred in clinical trials utilizing rats (C-cells in the rat thyroid are much more susceptible to GLP-1 RA than human thyroid C-cells). If the person is unable to find out specifically what type of thyroid cancer is in the family, but the case is isolated to one relative (whether primary or distant), I think you should feel comfortable prescribing a GLP-1 RA. If a person has several family members with a history of thyroid cancer, particularly at younger ages, that would be a suspicious history for an inherited form of thyroid cancer (like familial medullary thyroid cancer or Multiple endocrine neoplasia type 2 [MEN2]).

Question **In the studies you presented, were changes in diet beyond the 500 kcal reduction, such as modifying intake of sweets, junk food, pasta, etc., part of the study protocol?**

Answer Not that they described in detail. They would include "education" sessions, which presumably would include descriptions of a healthy diet.impact (still have to stick with smaller portions).

Question **How do you address patients who really don't care about their weight? They have accepted that this is who they are and are not motivated to work on it.**

Answer This is a difficult situation, and some of it may be related to a patient's perception that their weight is not hindering them in any way. I've seen plenty of people with completely normal laboratory values who can run up four flights of stairs. I think the best strategy is to discuss the risk factors related to obesity (heart disease, diabetes, cancer, sleep apnea) but also allow the patient to guide the discussion. If they are clearly not ready to discuss or unwilling (thinking about the stages of readiness for change), you'll have little to no impact if the person is not ready to receive the information. In the instance when the patient comes to you saying that they are ready to start making changes, that is your opportunity to open a more in-depth conversation.