

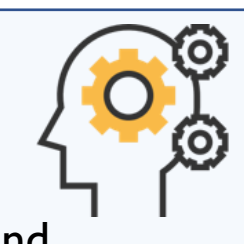
Identifying the Continuing Educational Needs of US Physicians in Managing Patients with T2D and Obesity

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Introduction and purpose

Most patients with type 2 diabetes (T2D) also have obesity, and the prevalence of both continues to increase. This study sought to understand approaches of endocrinologists and primary care physicians in managing patients with both T2D and obesity to identify areas where physicians may benefit from continued education.



Methodology

A survey presenting 2 patient case scenarios was developed in collaboration with an endocrinologist expert to assess current approaches to managing patients with T2D and obesity. Multiple choice, rating scales, and free text questions were included. The survey was pilot tested with an endocrinologist and a PCP.

The survey was fielded in October 2021 via an online survey platform to US-practicing endocrinologists and primary care physicians. Responses were collected from 181 endocrinologists and 350 family medicine and internal medicine physicians (comprising the PCP group).

Descriptive analyses and subanalyses were used to observe overall trends in the clinician and patient data.

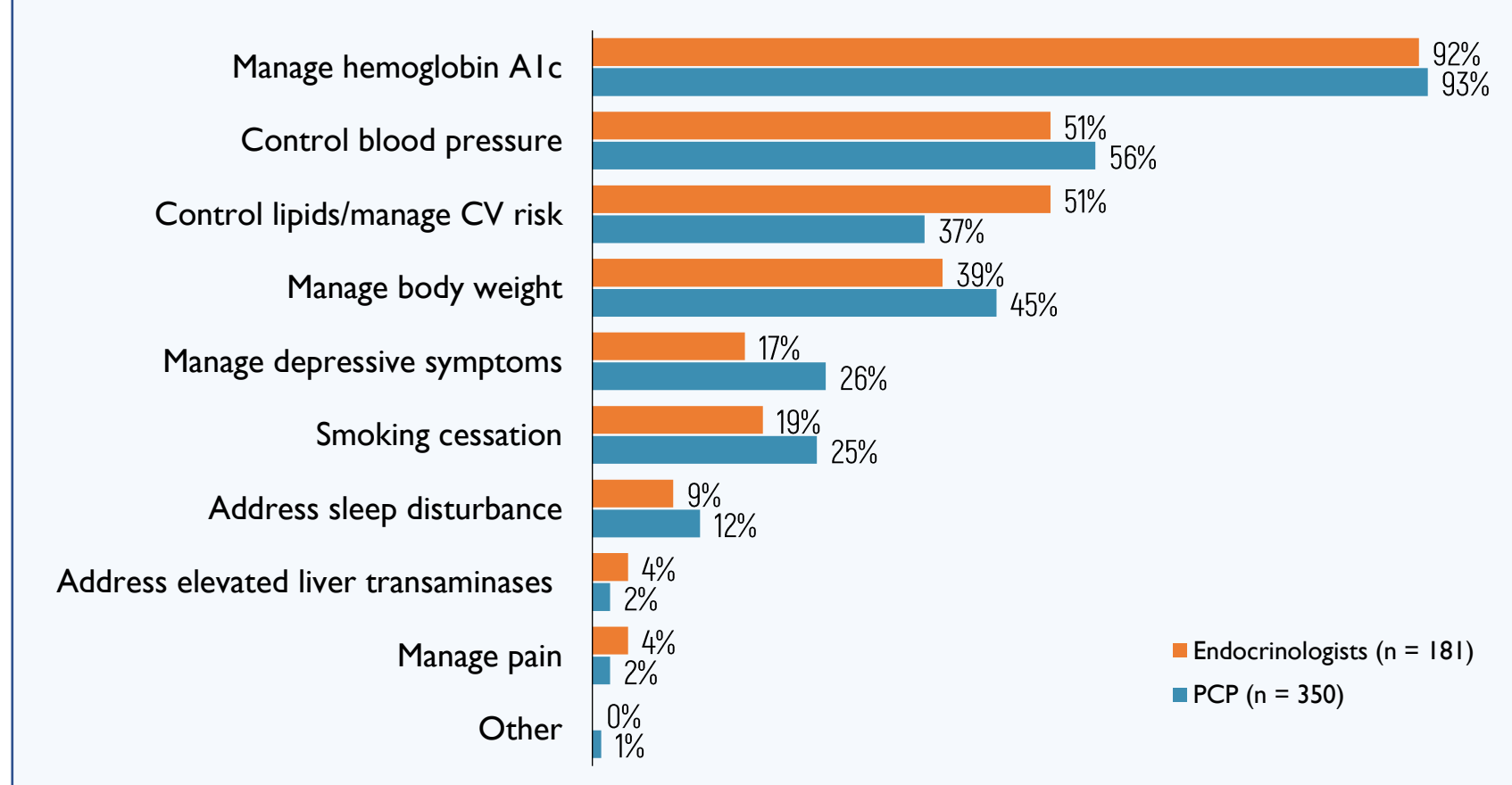
Study sample demographics

	Endocrinologists (n = 181)	Primary care physicians (n = 350)
Number of patients seen with type 2 diabetes, weekly (mean)	60 patients	51 patients
% of patients seen with a BMI of		
25 to 29.9 kg/m ²	28%	29%
≥ 30 kg/m ²	55%	51%
% academic affiliation	24%	12%
Number of years in practice (mean)	20 years	24 years
Practice location		
Urban	43%	35%
Suburban	54%	51%
Rural	3%	14%

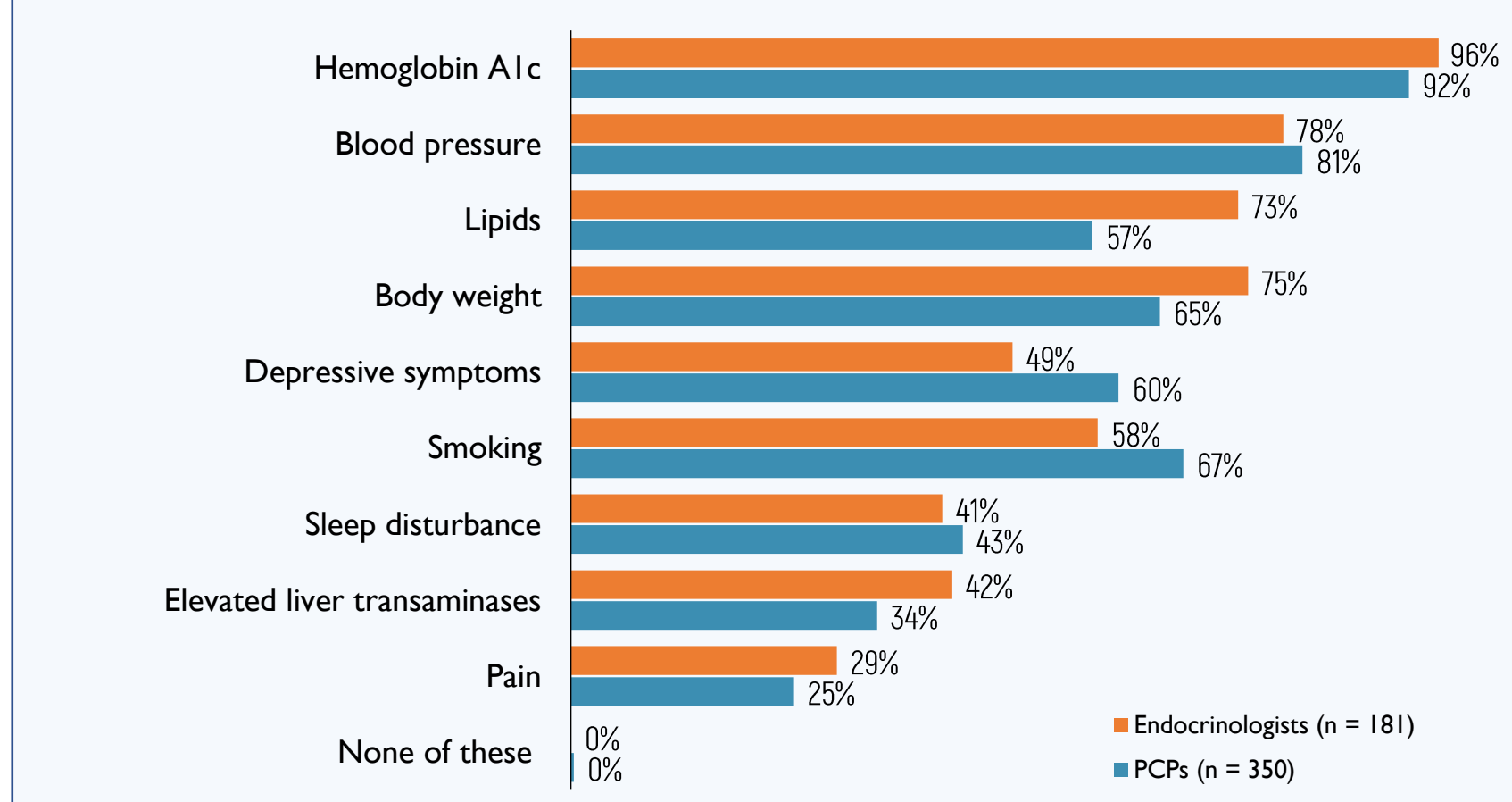
Management of a patient with multiple comorbidities

Case 1: 47-year-old woman presents to establish care. Review of her medical records indicate hyperlipidemia, hypertension, nonproliferative diabetic retinopathy, and T2D. She smokes 1/2 pack of cigarettes daily and was recently evaluated for excessive daytime sleepiness. Current medications: amlodipine, atorvastatin, gabapentin, losartan, and metformin at a maximally tolerated dose.
 BMI: 31.8 kg/m² BP: 150/90 mmHg HbA1c 9.5% AST 50 U/L ALT 70 U/L LDL 130 mg/dL HDL 50 mg/dL TG 350 mg/dL Pain level: 3 out of 10 (in her feet)
 PHQ-2 screening: Reports little interest or pleasure in doing things on several days and feeling down or depressed on several days over the last two weeks

UNAIDED What are your top three most important goals in managing the patient at this time? [open-ended]



AIDED Which would you address during this initial visit as part of your management of this patient? (select all that apply)

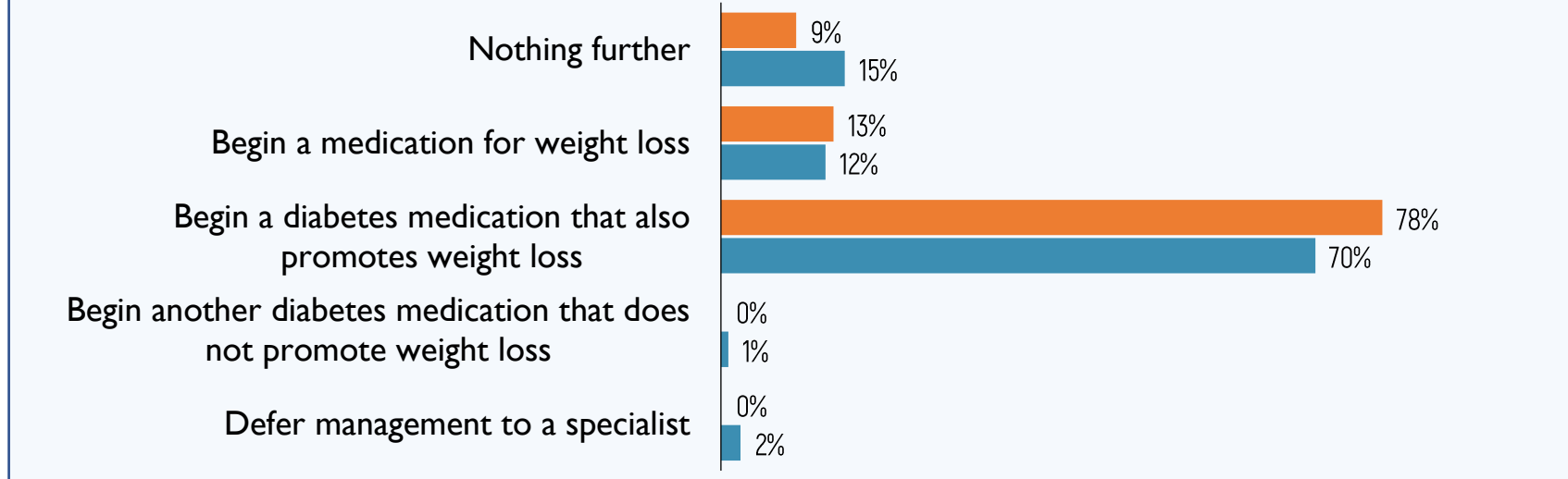


Respondents were asked to write in their top 3 most important goals in initial management of a patient with T2DM, obesity, and multiple obesity-related comorbidities. Almost all felt addressing the patient's HbA1c was important, but less than 1/2 considered managing body weight to be one of their 3 most important goals. When prompted with a list of items to address during the initial visit, the majority reported that they would address A1c, blood pressure, weight, smoking, lipids, and depression.

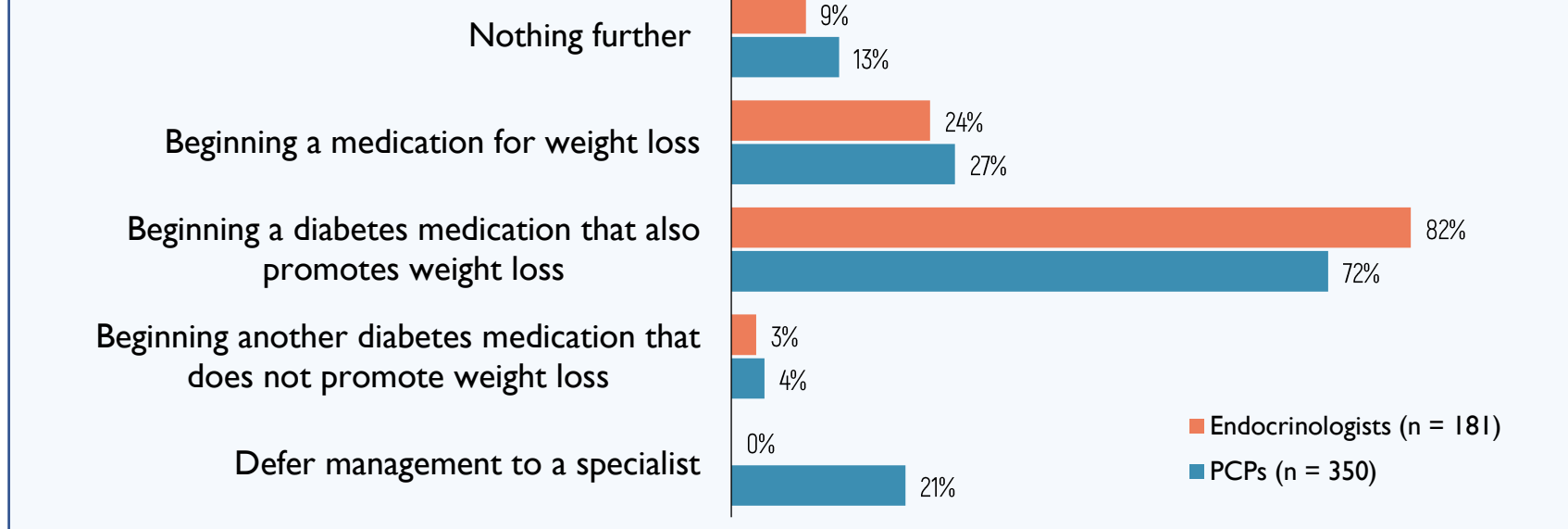
Management of a patient with T2D and obesity

Case 2: A previously healthy 43-year-old man was evaluated six months ago for complaints of tingling in his feet. He was found to have a BMI 37 kg/m² and HbA1c 7.5%. He was diagnosed with T2D and advised to lose weight, referred to a dietitian, and started on metformin, which was titrated to the maximally tolerated dose. He returns for follow-up. His HbA1c has decreased to 7%. His BMI has not changed. His BP, LDL, HDL, and TG are within target range. Renal and liver profiles are unremarkable.

Besides providing additional counseling on diet, exercise, and behavioral modification, which of the following would be part of your approach to managing the patient at this time? [select all that apply]



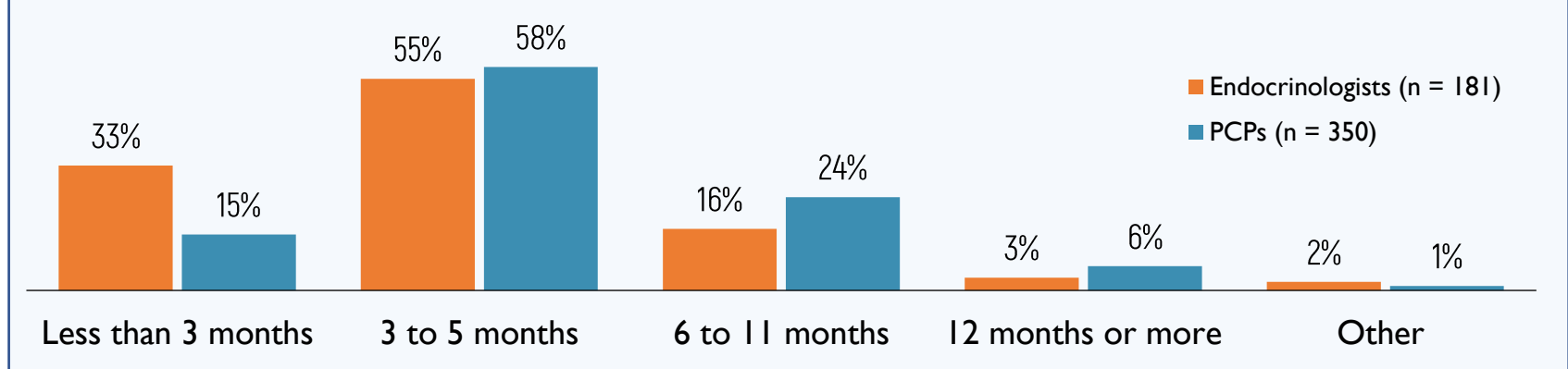
What would be your approach if the patient had a BMI of 47 kg/m²? [select all that apply]



Most would start a diabetes medication that promotes weight loss or a medication for weight loss for a patient who achieves glucose control but remains at a BMI of 37 kg/m²; however, 15% of PCPs and 9% of endocrinologists would only continue to counsel on diet, exercise, and behavioral modifications. If the patient had a BMI of 47 kg/m² instead of 37 kg/m², more would begin a medication for weight loss, while over 20% of PCPs would defer management to a specialist.

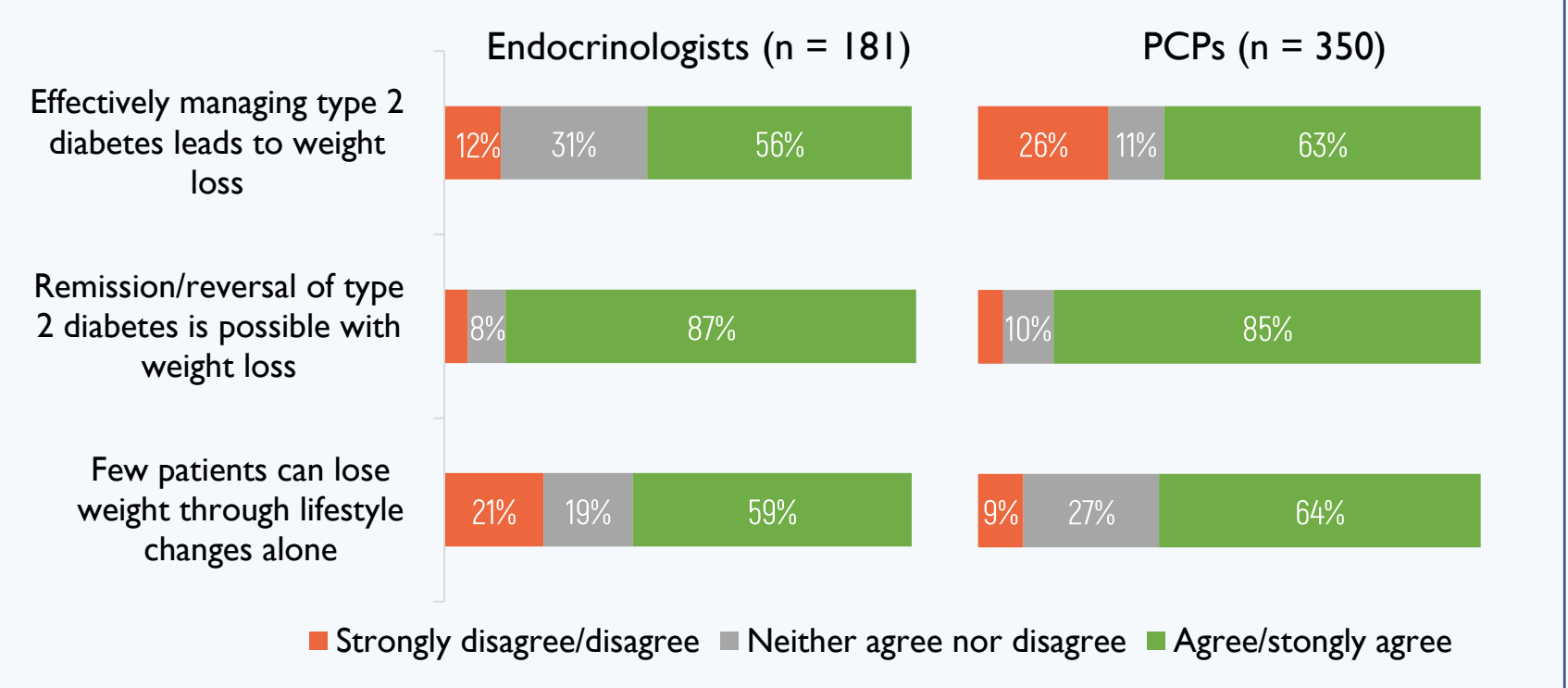
Length of trialing diet and lifestyle modification

Approximately how long do you trial diet, exercise, and behavioral modification before considering pharmacotherapy for overweight/obesity in your patients with diabetes?



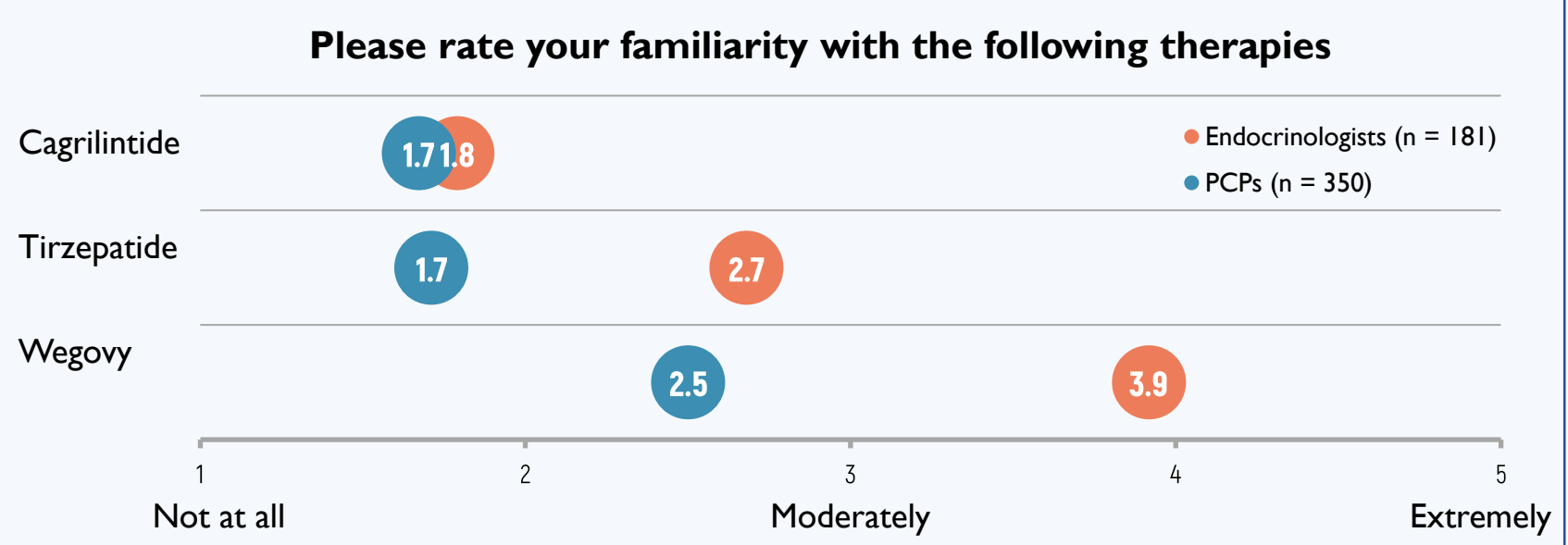
While 1/3 of endocrinologists are trialing diet and lifestyle modifications for patients with overweight/obesity and T2D for less than 3 months, most are waiting 3-5 months, and 1/4 of PCPs are waiting at least 6 months, and a handful one year or more.

Attitudes towards managing weight in patients



Most agree that remission/reversal of T2D is possible with weight loss and that few patients can lose weight through lifestyle changes alone; however, fewer agree that effectively managing T2D leads to weight loss.

Familiarity with new and emerging therapies for weight management



Conclusions

The findings from this study point to potential areas where future educational focus can be beneficial, including:

- Approaches to addressing weight, in addition to A1c, blood pressure, and lipids, at the initial visit for patients with T2DM, obesity, and other obesity-related comorbidities.
- Data on new and emerging therapies for weight management.
- The role of current and emerging pharmacotherapy in addition to counselling on diet, exercise, and behavioral modifications for patients with T2D and obesity.

Acknowledgements and Disclosures:

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