The following is from a question-and-answer session that followed the live presentation between the participants and the presenter. The questions and answers have been edited for length and clarity.

Question: How do you determine the dosing of Metformin for an individual? The first case example the patient had early pre-diabetes. Would the appropriate dose be the max or would the clinical benefit occur at a lower dose?
Answer: There is not necessarily a clear guidance when using metformin to treat obesity. The rule of thumb is to start with the lowest dose and slowly increase it to effect with patient toleration. Tolerating metformin can be challenging for a lot of people with gastrointestinal side effects, nausea, and such. If a patient is tolerating 500 of metformin, that may be enough to get improvement in insulin resistance. The optimal dose when using it for obesity treatment is typically going to be 2000 a day.

Question: During the cases study it was mentioned using phentermine hydrochhloride in the mid-morning or early afternoon. What is the benefit with this dosing versus the impact of dosing in the morning?
Answer: The first patient was getting cravings after lunch and up into the evening. She didn't necessarily need any help with cravings earlier in the day. Some people don't have much of an appetite earlier in the day and if their appetite is too suppressed early, then they don't eat, and then they could get rebound hunger. The recommendation is to dose for effect and get the maximum benefits with the least amount of medication. One caution is to assure there is plenty of time to wear off before patients go to bed.

Question: How can we move individuals when they are in pre-contemplative stage to increasing their activities? Any tips or tricks for helping individuals to engage in increasing their activity level?
Answer: The clinician likely can't motivate someone else. A clinician can appeal to a patient's motivations. For someone who is in a pre-contemplative mode, not ready to make a change, don't push them but instead help them get things out of their way. For example, a patient with knee pain, could recommend use of physical therapy. Another example is when environmental issues are the problem, helping the patient problem-solve can help. Removing barriers can often move the patient out of pre-contemplative stage. This is what motivational interviewing is entirely about.

Question: For the first case could the patient evaluated for PCOS?
Answer: This patient's metabolic profile and infertility would be perfect reasons for doing an evaluation for PCOS. This would not have done much to change her treatment plan.

Question: This question is focusing on the management of female's post-pregnancy. Once a patient is done breastfeeding is there anything different in creating a treatment plan?
Answer: Post-pregnancy and lactation is treated the same as other patients with obesity. Some people are quite eager to start anti-obesity meds and others are very reluctant. The first thing when treating obesity is preventing further weight gain. And then move to induce weight reduction, and finally help people to maintain it their weight loss. This is the totality of obesity treatment and anti-obesity medications can be a part of any patient's treatment plan. Talking to patients at an early stage in your practice and defining the goal of overall health for the rest of their lives. During the pregnancy and/or the breast-feeding period, there's limitations on using medications. After that, evaluate obesity just as any other patient.

Question: What about the issues of patients using gabapentin for orthopedic pain and its obesogenic nature?
Answer: This is a really challenging situation. First check to see if the gabapentin is even working. Often patients in primary care end up "collecting" medications over time and it is important to do a medication review on a regular basis. Gabapentin is the same as other medications, a process of risk stratification. A patient getting incredible, life-changing benefits from being on the medication in terms of improving their pain, even if it affects their weight negatively in some ways, may be a perfectly fine tradeoff for them. On the other hand, there will be plenty of people that are getting minimal to no benefit from the gabapentin, so it's an easy decision to take them off it. These are challenging cases so having a consult may be beneficial with an obesity specialist. When tapering gabapentin (or any medication), do so slowly and monitor.

Question: Are these terms used interchangeably; anti-obesity medications, appetite suppressants and weight loss drugs? Is there a difference between an appetite suppressant and an anti-obesity medication?
Answer: This of anti-obesity medication as the broadest term. Appetite suppressant applies to some of the anti-obesity medications, but not all of them use appetite suppression as the primary mechanism of action. Examples: Orlistat doesn't impact appetite at all and GLP1 agonists increase satiety. So, if we look at the class, they're truly anti-obesity medications. Within the class, there are some that might help with that pathophysiology of suppression of appetite. The class is anti-obesity medications, some impact appetite, some cravings, some other components. From a language perspective recognizing obesity as a disease, referring to the medications as anti-obesity medications, adds some legitimacy to their use. "Weight loss drugs" sounds like it's treating just the scale not the disease. There is not a "blood sugar drug", they are anti-diabetes medications

Question: What are tips for starting the discussion of bariatric surgery?

Answer: Using terms of the data. Example; the data shows that bariatric surgery can be an effective addition to an obesity treatment plan, and in particular for people with Type II Diabetes or other metabolic issues. Discussing benefits outweighing the risks.

Many things in the world of obesity are presented in a black and white way or in a sensationalist way. Example: “Bariatric surgery is such a miraculous thing or bariatric surgery is terrible”. Bariatric surgery could have miraculous effects for some people, but less or even no long-term benefits effect for others. Be open and honest with patients, know the data, the risks, and the benefits.