



2026 Family Medicine POP: Questions & Answers

Mastering Obesity Care: Evidence-Based Strategies from First Visit to Maintenance

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Related Outcomes

- Have there been more studies about improvement in joint pain (apart from knee OA)? I have heard this from several patients including my spouse early in use.

Joint pain beyond knee OA: The strongest evidence is still for knee OA — the STEP 9 RCT showed semaglutide reduced WOMAC pain by ~14 points more than placebo in people with obesity and moderate-to-severe knee OA (Bliddal et al., New England Journal of Medicine, 2024). Beyond the knee, preclinical and early clinical data suggest weight-loss-independent anti-inflammatory/chondroprotective effects and possible signals in RA/PsA and gout-associated cardiometabolic disease, but human joint-specific outcomes remain inconclusive; a recent meta-analysis did not confirm a pooled joint benefit outside dedicated OA trials (Karacabeyli & Lacaille, Nature Reviews Rheumatology, 2025; Beaudart et al., Drugs, 2026). So the patient reports of improved joint pain are plausible but not yet established beyond knee OA.

Diet

- Has there been any work in culturally relevant /tailored dietary recommendations for folks on GLP-1 medications?

Culturally relevant/tailored recommendations: There is not yet a robust evidence base for culturally tailored GLP-1 dietary guidance specifically, but the 2025 multi-society advisory offers adaptable, food-group-based principles (nutrient-dense, minimally processed foods; adequate protein and fiber) that can be mapped onto diverse cuisines and eating patterns (Mozaffarian et al., Joint Advisory — ACLM/ASN/OMA/The Obesity Society, 2025). A practical clinical framework is also in Mehrtash et al. (JAMA Internal Medicine, 2025).

- Do you follow micronutrient or vitamin levels while on GLPs?

Following micronutrient/vitamin levels: No formal consensus mandates routine screening, but a risk-based approach is reasonable — check vitamin D, B12, iron (and consider calcium) baseline and when weight loss is rapid/extreme or in higher-risk patients (older adults, menstruating patients, prior bariatric surgery), with a multivitamin as a pragmatic interim (Mozaffarian et al., Joint Advisory, 2025; Mehrtash et al., JAMA Internal Medicine, 2025).

Prescribing

- How to manage patients who are on max dose tirzepatide and they gain weight? This seems to highlight a caloric problem and not a "food portion" problem.

Weight gain on max-dose tirzepatide: First confirm adherence, technique, and injection timing, then reassess total energy intake, alcohol, sleep, and interfering medications — as you note, this usually reflects an energy-balance issue rather than portion size alone. Reinforce protein/resistance training and intensify behavioral support; if truly no response

(<5% at an adequate trial), guidelines advise avoiding treatment inertia and considering combination pharmacotherapy or metabolic surgery referral (American Diabetes Association, Standards of Care, 2026). Note ~9–17% of patients are low responders even at top dose (Saeed & Apovian, Current Atherosclerosis Reports, 2025).

- What recommendations do you have for tapering down if patients feel they have lost too much weight, for long term?

Tapering if too much weight is lost, for the long term: Obesity is chronic, so plan for maintenance rather than full stop. SURMOUNT-MAINTAIN showed continuing the maximum tolerated dose preserved ~96% of lost weight, reducing to 5 mg preserved ~68%, and switching to placebo only ~43% — supporting dose reduction to the lowest effective dose rather than abrupt discontinuation (Horn/Aronne et al., Lancet, 2026). If tapering, reduce dose or frequency gradually over ≥20 weeks with continued monitoring and reinitiate/up-titrate if regain exceeds ~5% (Mehrtash et al., JAMA Internal Medicine, 2025).

Insurance

- Have you had issues with naltrexone/bupropion ER getting covered and have you prescribed it as separate meds at a little higher doses and still have successful weight loss?

Naltrexone/bupropion ER coverage and prescribing as separate generics: Coverage of branded Contrave is often difficult; prescribing generic bupropion ER plus naltrexone separately is done in practice, but the FDA-approved efficacy data (~5–9% weight loss vs placebo) are for the fixed 32/360 mg combination, and separate dosing has not been studied for equivalence — titrate to the studied target dose and monitor blood pressure/heart rate (Gudzune & Kushner, JAMA, 2024; Nadolsky/Garvey et al., AACE Consensus Statement, 2025). Avoid in uncontrolled hypertension, seizure disorder, or chronic opioid use.

- Insurance will penalize patient for not picking up weight loss injection on time, what do you recommend when they go on vacation?

Vacation/late refill penalties: This is largely a plan-specific administrative issue rather than a clinical one; practical steps include documenting medical necessity, requesting a vacation override or 90-day supply from the pharmacy/PBM ahead of travel, and coordinating early refills. I don't have a literature resource here, as this falls outside the clinical evidence base.

Other

- Any thoughts on the use of unauthorized peptides for weight loss?

Unauthorized/compounded peptides for weight loss: I advise against non-FDA-approved compounded or "research" peptides. They are not reviewed for safety, potency, or purity; analyses have found inaccurate concentrations, impurities, and dosing errors leading to hospitalizations, and professional societies (AACE, ADA) explicitly advise against them (Nadolsky/Garvey et al., AACE Consensus Statement, 2025; Ruder, JAMA, 2025). The same caution applies to gray-market performance/recovery peptides, which lack rigorous human safety data (Mendias & Awan, Sports Medicine, 2026).

Medications or treatment methods suggested in this document should not be used by the practitioner without evaluation of their patient's condition(s) and possible contraindication(s) or danger(s).