Podcast Transcript

The GLP-1 Advantage - Optimizing Weight Management Strategies

Guest: Kathleen Wolz, DNP, NP

Dr. WOLZ is an advanced practice nurse who has had the opportunity to have served in multiple fields withing the nursing profession. She has been a tenured college professor in an Associate Degree Nursing Program, a hospital educator, a critical care nurse, and a leader in online and virtual reality education. She has served as a volunteer and board member of the local free and charitable medical clinic for over 20 years, as well as participating in three medical missions. Currently Dr. Wolz is co-owner of two primary/urgent care clinics and a comprehensive medical spa. She is fervent about providing access to medical care for those with limited access and mentoring and educating those entering or new to the nursing profession.

Host: Candace Pierce DNP, MSN, RN, CNE

Dr. Pierce is a nurse leader committed to ensuring nurses are well prepared and offered abundant opportunities and resources to enhance their skills acquisition and confidence at the bedside. With 15 years in nursing, she has worked at the bedside, in management, and in nursing education. She has demonstrated expertise and scholarship in innovation and design thinking in healthcare and education, and collaborative efforts within and outside of healthcare. Scholarship endeavors include funded grants, publications, and presentations. As a leader, Dr. Pierce strives to empower others to create and deploy ideas and embrace their professional roles as leaders, change agents, and problem solvers. In her position as the Sr. Course Development Manager for Elite, she works as a project engineer with subject matter experts to develop evidence-based best practices in continuing education for nurses and other healthcare professionals.

Episode 1: The GLP-1 Advantage - Optimizing Weight Management Strategies

Transcript

Candace Pierce: This is Dr. Candice Pierce with Elite Learning by Colibri Healthcare, and you are listening to our Elite Learning podcast where we share the most up-to-date education for healthcare professionals. Welcome to this series focused on a class of medication that is becoming increasingly popular for not only managing diabetes but also obesity, the GLP-1 receptor agonist. Over the last decade, GLP-1 agonists have gained prominence as effective treatments that not only improve glycemic control in type 2 diabetes, but they also promote weight loss through appetite suppressing effects. Major guidelines now recommend GLP-1 agonists as a routine part of diabetes management, but they are also popular now in weight management. So, we are going to take a deeper look into the mechanism of action of these

medications, and we are going to review extensive clinical evidence on their cardiac, metabolic, and weight loss benefits. And joining me for this podcast is Dr. Wolz. Kathleen, welcome. Thank you so much for joining us.

WOLZ: Thank you, I am excited to be here.

PIERCE: Yes, can you share a little about yourself?

WOLZ: I am a provider, an NP provider, and I currently co-own two medical clinics, primary care walk-in urgent-type clinics, and also, we own a medical spa. So, we use GLP-1s on both sides, diabetics, and non-diabetics for weight loss.

PIERCE: So, this would be a good conversation.

WOLZ: It is. Again, another passion, you know, so much of people, especially women, so much of their identity is tied up in their weight. And this is such an empowering drug for women that I just cannot tell you how it has been life-changing for most women that go on it. It is amazing.

PIERCE: Okay, well, let us start with, can you kind of give us an overview of the GLP-1 agonists, like how they work and their role that they play in weight management?

WOLZ: Yes. So, the GLPs are receptor agonists that were originally developed for the treatment of type two diabetes. Sorry, I got my notes here.

PIERCE: No, no, that is okay.

WOLZ: So, I am just going to be pulling up my notes just so that I stay on track. So, they mimic the effects of glucagon-like peptide one hormones. So, they increase the feelings of fullness, because they slow gastric emptying. So, food stays longer in your stomach. So, you are not hungry. And they also increase the incretin hormone. So that hormone makes you satiated. So, in your brain, it tells you are not hungry also. So those two things work. The nice thing about GLP-1 is it does not really affect your blood sugar. So, it only affects your glucagon stores. So, you wind up not having to worry about things like hypoglycemia, liver issues, those type of things, so it is kind of a safer drug and there are two of them, well, there are multiple on the market. They're GLP-1s and then they're GLP1s with a GIL which is the mounjaro, the Zepbound, the tirzepatide. So, it is like a GLP with a little added influence.

PIERCE: oomph to it. Okay, so what are the ones that are approved for weight loss?

WOLZ: So, for weight loss, the only ones that are approved currently are the semaglutides. which is Wegovy or Ozempic, and then the tirzepatide, which is Mounjaro. It was approved last August, October, somewhere like that, and that is ZepBound. And those are the only two that have really been approved. Rybelsus is an oral form of semaglutide, and Rybelsus works by

is an oral form. The problem with Rybelsus is it works really well in diabetics. In order for it to work in weight loss, it takes a lot more of the drug, because the drug is broken down in the stomach with the stomach acid. So, people are using oral semaglutides, but they are really not getting much of an effect for it for weight loss. It is a very, very good drug for diabetes, though.

PIERCE: So how did these drugs compare in terms of their efficacy and their side effect profiles?

WOLZ: They are actually, surprisingly, they are very safe drugs. They have a very good profile. So, what happens with, is that they, sorry, just trying to get my notes back. So, they have done a series of studies on these meds. I do not think people realize how well studied these medications have been. So originally, the first drug that came out was semaglutide or Ozempic, and they used it in diabetic patients. And what they found out was that not only did they get good control of their blood sugar without the risk of hypoglycemia and a lot of the side effects, but they also had a really significant weight loss of like 20%. Well, we all know the biggest underlying cause of diabetes type two is being overweight and becoming insulin resistant and all that. Well, now there was a drug that was going to address that, but also is addressing the weight. It is kind of like the Viagra. You know, Viagra was originally, you know, created for pulmonary hypertension, and then they had a side effect. Same thing happened here.

So, the drug itself has been around for a while, used with diabetics. And as I always tell my patients, you have to understand, and anybody in healthcare gets it, nobody's body is more messed up than a diabetic. It affects every organ in their body. So, no matter what spot, it has been touched by diabetes. And there are a lot of complications for diabetes. As nurses and providers, we all know that, you know, they are their own complex patient. So, this is a drug that has made to be used for somebody with complex illness. So, first of all, it has to be a pretty safe drug because you have a lot of issues going on. The other thing is it has been very well studied. They have done a step study which looked at weight loss and in GLPs, the weight loss is usually around anywhere between 15 and 25%. It is significant. They looked at; they did a series study that looked at cardiovascular risk. They found out there is no higher risk in patients that are on a GLP-1 versus a patient who is not on a GLP-1. They looked at cancer risk. And they found there is no higher risk of cancer on a patient who has been on a GLP-1 versus someone who's not on a GLP-1. They are continuing to do huge studies on dementia, addiction, renal disease.

They just came out recently, Medicare did, and say they will pay for the GLP-1s and GLP-1s GILs to be used on patients that have diabetes and heart disease. So even if their diabetes is under control, we will pay for it, because of the protection of heart disease. It is a particularly good drug. There are indications though, where you cannot take this drug, okay? So, you cannot take this drug, of course, if you are pregnant or nursing, it is not going to happen for weight loss. That may change down the road, but right now that is a no-go. History of medullary thyroid cancer. So medullary thyroid cancer is a very rare form of thyroid cancer, but it does occur.

So, they did the initial studies to look at the safety and efficacy of GLP-1s, they reproduced it in rats. Okay, they never, nobody, there has never been a patient who has developed medullary

thyroid cancer. It has just been done on rats, and it was only one rat, but they had that warning on it. And then also if you have pancreatitis or if you have had pancreatic cancer, the pancreatitis though is loose, because we had a patient that was schizophrenic, that was on the antipsychotics, the Geodon, which gained tons of weight, okay, and on Depakote, which then the patient developed pancreatitis, because of the Depakote. We worked very closely with an obesity specialist. And so we called him and said, hey, can we use a GLP-1 even though this patient had pancreatitis? He said, absolutely, that was cause and effect. There is no reason you would reproduce this. So again, we did, and it was 100% successful. I also use it cautiously in other conditions. So if I have a patient who has lupus, or I had a patient that had chronic lymphocytic leukemia, or I have a patient who has IBS, I had a patient who had Crohn's, I had a patient who had a fundoplication, I will tell them because it affects the GI system, these are all issues that potentially could occur. And then what we do, or what I do in practice, is I send them back to their primary, or their GI, or their oncologist, or their surgeon to get clearance first. And I have never had anyone refuse the medication as a specialist. They have all approved it without any problem. So be aware that there are issues. I also will not treat anybody under the age of eighteen. I feel if you need to be treated with a GLP-1 either for obesity or diabetes, you need a specialist. You don't need me coming in. And of course you cannot use it for type one. It has to be type two diabetes.

PIERCE: Right, right, absolutely. So, you know, these are becoming more and more popular, more and more people are getting on them. And so, this is just a random question, but do you know like the cost of using these? Like what is the cost for the patient? Does insurance step in?

WOLZ: Interesting. Again, as we have talked earlier, we are in the market of disease fixing, not the market of disease prevention. So, unless your hemoglobin A1C is 6.5, and it does not matter if it is 6.4, you are three hundred pounds overweight, you have NASH, you have GERD. You have a 50% occlusion in one of your coronary arteries. You have PAD. You have everything. If your hemoglobin A1C is at 6.5, it can be 6.4, but if it is at 6.5, your insurance will not cover it. The cost without insurance, you can go on GoodRx and check it out. It is usually around $1,300. It is between $1,200 and $1,500. The tirzepatide, the mounjaro, the Zepbound are more expensive.

PIERCE: And that is for like a month. Oh, that is a lot.

WOLZ: So, what has happened? It is for a month. So, this is what has happened. So, when the shortage first came out, because the drug company was like, wow, we are sitting on a goldmine. And the FDA was like, hey, you are sitting on a goldmine, but there are a lot of people out here that need this drug for obesity. Just think if you cured obesity, what you would cure disease-wise. You would take out hypertension, diabetes, joint replacement. They predicted all joints, there will be no more joint replacements within five years if this drug was open to everybody in the United States. You are going to take away cancers. So many cancers are connected to obesity. I mean, just think of the diseases that go away when obesity goes away. So, the FDA came out and said, look, we cannot do this. You cannot hide this from all these people. You are years away from a generic. So, we are going to allow compounding pharmacies to create this drug. So, they took the medication. They took the recipe. They gave it to the compounding pharmacies and said, you have to create it, but you have to add

something, so it is considered a generic. So, what they did was they allow compounding pharmacies to create it. This, though, created a whole other problem in the area of weight loss. So, because of that, I have a whole thing that we do about compounding pharmacists. I do not know if you want to do this now.

PIERCE: Yes. Let's go.

WOLZ: Okay, because I also want to touch on this point really quickly, though. For people that are on Medicaid, public aid, sometimes it is a little bit harder to get this drug approved, even with a hemoglobin of 6.5. So, then we have to use a drug called Trulicity which is not as good weight loss wise as semaglutide or tirzepatide. Or we will use Saxenda, which is a daily shot. So trulicity is a weekly shot. Saxenda is a daily shot, the liraglutide. It's just not as good as the tirzepatide and the semaglutide, but insurance will always go with the least expensive one. So, I just wanted to put that out there. So, the way I do it is, and there are a lot of ways to do this, and you can make a whole lot more money than I do. So, if you are looking to make money, I am probably not the person to talk about, because that ship has sailed for me for some reason. But basically, the way we did it was, we decided we were going to do this in the most safe and efficacious way we could, okay? Money is nice and believe me, I would like a ton of it.

But we had to make sure we had patient safety as the center of all that we have done. So, what we did was, I went ahead, and I found compounding pharmacies that followed the recipe exactly. Because what has happened is, they are substituting things within the recipe. So one of it is salts. They're using salts and that changes the recipe. It is kind of like if you have a recipe for almond flour but then you use coconut flour, does it really change anything? I do not know, but it is not following the recipe, and we wanted to follow the recipe, because we have a lawyer that is one of our owners. The other thing we did was we vetted them. We went to compounding pharmacies and we vetted them and said, I want to see your solvency records, I want to see your potency records, I want to see your accreditation from your state, your board of pharmacy, and I want to see any FDA products you use. Because FDA does not approve or does not accredit compounding pharmacies. However, both of my compounding pharmacies only use FDA approved products. So, the chemicals are FDA approved, the vials are FDA approved, the hood is FDA approved, the manufacturing is FDA approved. So that is how we vetted ours. And so, we only use two, and they are not the most, they are not the cheapest by any means. But we are 100% convinced this is the safest and efficacious way for us to deliver the drugs to our patients. I think what we are seeing a lot of is a lot of people jumping on this bandwagon that have absolutely no reason to be on it. They are just looking to make money. Costco has just entered into the world of semaglutide. And so now you can just go to Costco and pick it up. So how they are doing it, they are really undercutting the price, how they're figuring it out, I have no idea.

But for me, my patients have a consultation. I sit down with them for one hour and go through a five-page list of things. And we will talk about more of that. I go through how to deal with the side effects, what are the side effects, how to dose it, what to do if you miss it, like frequently asked questions. I go through all the consents, and then when I am all done, I send them home. I tell them, I am going to email you all the information, take a week, think about it, make sure you're 100% committed to this. I give them the names of our compounding

pharmacies, their addresses, their contact information, tell them vet them yourself, call them, check with the College of Pharmacy in the state of Illinois where I am at in the Midwest, check it all out. And if you are comfortable, come see me. So currently what we charge a client is we charge $400 a month, or $400 a vial for semaglutide and $600 a vial for tirzepatide. You buy two ml vials, the vials come in 200 units per vial, and you dose according to units. So, the vials last according to your units. So, if you start on like five units or eight units, a very small dose, that initial vial will last as long as probably as 10 weeks. As you go up, by the time you are at 50 units, you are going through a vial a month. So, most patients do not get that high, but it is just kind of the number that we use. And we let them know all this upfront. And then if they, and I have had patients say to me, well, I can find it cheaper. Then find a cheaper. I would rather you be happy, and not be involved in it. I have had patients that have double dipped, because I will tell you, this is a very powerful drug. And the reason it is so powerful is that, I'm sorry, I am so passionate about this that if I'm getting over, then stop.

The reason why this is so powerful is, as women, our body image is so entwined with who we are. And I know it should not be, and I fuss about it every day, and I listen to my affirmations, and I tell myself all these wonderful things. And man, when I lost ten pounds, I thought I was hot. And then I lost twenty pounds, and then I am snatched. And then you lose, because you know what is happening is you are able to buy the clothes that you see everybody else wear. And you are all of a sudden, you can put them on, and you look good. And when you look good, you feel good, and when you feel good, you do good. Do you know what I mean? So, it has like tied up, I mean I have seen women just explode in confidence and in challenges and in moving mountains, and it is like, because they know on the outside finally reflects what they have believed on the inside, that people did not hear them. So, um but saying that, it is also a very powerful drug, and the effect that it gets highly addicting. Everybody comes in with the same thing. I only need to lose twenty-five pounds. If I can lose twenty-five pounds, I will be so happy. So, they come in and they lose twenty-five pounds. And then they are like, you know, another ten. I just think it is another ten. I think, you know, I am looking pretty snatched, but it is just another 10, just another 10. And then they get down to that other ten, then they say, you know, when I was in high school, I weighed 100. And then you are like, no, not going to happen. But it is just because the drug becomes so powerful. It stops the food noise. It just stops. So, you are not dealing with this, eat those cookies, get those chips, I am hungry. Oh, my goodness, there's some Reese's Pieces, I will eat the whole bag. It just all goes away, and you really focus on the more important things like how to eat well.

PIERCE: So how do you identify your candidates, the appropriate candidates for this?

WOLZ: Okay, so I have them come in. So, we use BMI, and we also use weight. Most of my patients that are coming in need to lose 30, 40 pounds. Some of them need to lose a couple hundred pounds. So normally what you would say is, if they are overweight, we try to use a BMI of 30. But there are a lot of other things that go in with that BMI besides a BMI of 30. And then we also will do a BMI of over 27. Twenty-seven or over if they have comorbidity. So, if they have hypertension, if they have some insulin resistance, if they have some PCOS, just if there are some other issues going on, we'll also use that. Rarely, you can identify if somebody's looking that may have some other underlying issues like an anorexia, excuse me, and you really just do not go down that road. Do you know what I mean? It is pretty simple too, most of

the patients really want to lose, you know, 20, 30, 40 pounds. So, I have had patients that wanted to lose ten pounds, so I told them this was not worth it. You do not want to do this for ten pounds, and so look at something else. Look at phentermine, look at Contrave, look at Topiramate. There are other drugs that you could use for five, ten pounds. You do not need this drug. So, it has to be more of a substantial weight loss. Again, we look at patients that have, really select clients that have the comorbidities. We make sure that they are not addicted to food. You know, because one of the things we have to think about is if they are addicted to food, and we remove that food addiction, we are going to get a massive depression. And we have to be very cognizant of that. And what is happening a lot, because this drug has such commercial value, we forget this is a drug. This is a definite prescription medication and needs to be treated as a prescription medication. So, our conversations with our patients have to be honest, they have to be forthright, and they have to know what the parameters are. You lose too much weight, or you do not follow my instructions of exercise, eating correctly, limit alcohol, you are off. And I even, my own sister's on the drug and she lost a lot of weight. And I said to her, I am taking you off this drug if you do not eat. Cause she said, “I have not eaten in three days”. I said, well, “then you are done”. She is like, “you cannot tell me that”. I said, “oh no, I can”. And because you can go for extended periods without eating, but then you are going to open another bunch of issues. So, we have to be good stewards of this medication. This is not just about commercial value. This is about safety. And so, I am very, I make my patients, I see them every month. I weigh them, I measure them, I have conversations with them. And I fired three people from my program. I have no problems firing you. If you are not going to follow the rules, you can go somewhere else and get it. I am not going to be responsible for your kidney failure or something else that is going to happen to you. I do not want to be that person.

PIERCE: That is really good, to be good stewards of this medication. So, when you are counseling your patients, what are the potential side effects and how do you help them work through it? Because I know some of the ones I have heard are like nausea and just some really some GI issues.

WOLZ: Yes, it is mostly GI. So, what I do is, after I sit them down and I talk to them about, you know, this is what the drug does, this is the studies on the drug, this is what we are hoping to see from you, then we go through like frequently asked questions. So usually, their questions will start with side effects. One of the things is, you have to stick to yourself. You know, it is a self injection. I do have a patient that comes in once a week for an injection, and that is her choice, but we start with one injection. So, you get one injection, either in your abdomen or your thigh. You can do the back of your arm, but it is a little hard if you are doing it yourself. And then they say, well, you can get an irritation at the injection site. Some people will do it, or they will get a lot of side effects. So, then what we say is, then divide it into two shots. So far, nobody has done that yet. But you could take one shot and divide it into two shots. It will minimize irritation at the injection site, as well as also stopping some of the side effects. So, we try that, we offer that.

We talk about weight loss. Your weight loss should only be four to six pounds a month. It should not be more than that. If you lose too much weight too fast, it is going to throw you into a gallbladder attack. I mean, and that is true whether you are on Noon, Weight Watchers,

bariatric surgery, no matter what it is, you lose weight too fast, it throws you into gallbladder attack. So, we talk about gallbladder, we talk about if they are at risk, they have sludge or anything like that, it is going to make them more prone. We tell them no more than eight pounds a month, that slow and steady is the way to go with this drug. Do not think you are going to start this drug in May for your wedding in June. It is not going to work that way. So, we are very good about that conversation. We talk about, again, how the vials last. We talk about when they should see results. So, they will see some weight loss within two to four weeks, which then makes them feel a little bit better. We talk about the biggest side effects. The biggest side effect is going to be GI. You are absolutely right, nausea, vomiting, diarrhea, constipation, epigastric pain. The weird thing is anybody who has ever been on this drug, the nausea comes out of nowhere and it hits you like a ton of bricks. I mean, you are so nauseated, you think, oh my goodness, I am going to vomit right here and then. If you breathe through it for about 20 seconds, it will go away. Okay, it is very fast, but it is hard when it hits. My funny story is, I am a runner and I run races all the time. I have never thrown up in a race. Every time since I have started this drug, at the end of every race, I vomit. I have never done that before. And I think it is because the food sits so long in my stomach, where before it was empty, but it is like my, I come over the finish line, I vomit. So now I have come over the finish line. I just look for a garbage can. It is the weirdest thing ever.

PIERCE: That is, that is very interesting. Oh man. Gastroparesis, I have heard, like maybe on the news or you know, sometimes you see it on social media, gastroparesis talked about a lot with GLP-1. Is that a thing?

WOLZ: It is, it is occurred. The big side effects that we worry about are gastroparesis, we worry about ileus, and we worry about a bowel obstruction. Gastroparesis is how the drug works. It holds things in your stomach longer, which is technically gastroparesis. So, it is kind of the way it works. There has been evidence that showed that when you went off of it, that stayed. So that is an issue. The ileus and the obstruction have been found in a very minute number of clients. The most important thing is for everyone to realize that this drug is being used by more and more people. It has gone to the masses. I mean, it is estimated that there is like 300.,000-500,000 people on this medication, okay? Almost every nurse who knows on this medication, it is, you know, I know so many nurses that are on it, but you know, a lot of people are on this medication. So, as it keeps going to the public, we are not hearing anymore about side effects. So that is a good thing. And there are other side effects that we can talk about in the remainder of the next part of the podcast, because there are some other side effects that we need to talk about.

PIERCE: Absolutely. All right. Well, that is going to wrap up our first episode of this two-part series where we are exploring the important role of GLP-1 agonist medications and what they play in obesity management. We have covered a lot of ground. Just here, we are discussing, let us see, the mechanism of action of the drugs. We have talked about some patient selection criteria that Dr. Wolz used and really getting, kind of starting to get into the strategies for initiating therapy. So, in this next episode, we are going to continue this discussion on monitoring patients. And I think there are some more things to cover in initiating therapy too, do you think Dr. Wolz? All right, so thank you for listening and we look forward to continuing this important discussion on leveraging the full potential of these GLP-1 agonists.

WOLZ: Absolutely.

Episode 2: The GLP-1 Advantage - Optimizing Weight Management Strategies

Transcript

PIERCE: Welcome back to our series focused on the pivotal role of the GLP-1 receptor agonist in treating obesity. In the previous episode, we did a deep dive into the mechanisms of action and some clinical evidence supporting the use of this drug. We also covered strategies for starting to initiate GLP-1 agonist therapy in appropriate patients. So, we are going to pick up about right there with Dr. Kathleen Wolz and discuss best practices for initiating and monitoring and managing side effects and adherence. So, thank you, Kathleen, for continuing this discussion with me.

WOLZ: Thank you. I did want to add that one of the things we do prior to initiating is we review patients' labs. And the labs have to be within six months of the start date. So, if they have not had labs, as the provider, you can order their labs. You just have to be careful how you code them, because a lot of insurance will kick it out. So, just make sure that you code for either initiation of a medication, of a weight loss medication, or do an obesity code, or just be careful. If you just try to do like a well visit, you are not really a well visit, so it is going to kick the code out. So, we just do basic labs. I do not do all the vitamins and things. I just do basic labs, CMP, CBC, TSH, Lipid Profile. And then every six months to a year, I make them redo their labs. And of course, I always refer them back to their primary care. I am not their primary care, so they go back to their primary care if they have any issues, concerns, or problems. So, make sure you stay in touch with their primary care physician too, because you do not want to be taking care of them. It is a little trickier if you're in a med spa. If you are in a private practice, absolutely, absolutely. But in a med spa, you want to really make sure you are clear on those definitions of role.

PIERCE: Absolutely. So, you have initiated, you have done your labs, you've initiated treatment. So how do you continue to monitor your patient progress and determine those dosage adjustments that are needed?

WOLZ: Well, the nice thing is that on each vial of the product, it tells you how to dose. So, it will say, start off at five units for a month, and then ten units for a month or for four weeks. Everything is four weeks basis the way we do it. Now, sometimes we play with it. So, we may start on semaglutide, five units, five units, and then the patient is doing really well. So, we will go to ten units, ten units, and then we may do 15, 15, 15, and then we'll go to 20. So, we play with it a little bit. There is a lot of cost in it. So, I always want to make sure that the patient's aware the higher I dose it, the more cost you're going to have. So, we use that as one monitoring thing, how much weight loss they are experiencing. If they are not losing anything, then besides going over their diet and exercise, we also look at our dosing. So, to say like maybe you should dose higher, et cetera. We also look at side effects. So, some of the side effects, nausea is a big one. And we talked a little bit about it in the last episode. Nausea is

going to be their biggest complaint, because it is always going to be GI. The food sits there longer. It does not digest as quickly. So, nausea is the big thing. So, a couple of the ways that we can address that is we talk a lot about ginger chews. We talk about those anti-nausea bracelets that people use when they were pregnant. We talk about eating. One of the problems with this medication is you do not always eat. So, you can go a long period of time without eating. If you do, you are going to get nauseated. Okay. So, we tell people, have a hard-boiled egg, have some lunch meat rolled up. We really want to push protein and fiber vegetables, protein, fiber, protein, fibers, not carbs, protein, fiber, and water. You have to drink a lot of water. Because if you do not you have the potential to hurt your kidneys, because you are taking in all this protein. You can get dehydrated. So, we talk a lot about that too. So, a lot of water and most people that get nauseated will get nauseated initially. They may be nauseated for a couple weeks into a dose adjustment, and then they will start to feel better. Okay, so it is not uncommon. One person said to me, I am nauseated every morning, but when you talk to her, she eats dinner at five o'clock at night, and then she does not eat again till nine o'clock in the morning. It is probably too long of a span. So, then they say, well, you know, maybe at night have a hard-boiled egg, and when you get up in the morning, have a protein shake or something. So again, it is constantly looking at protein, fiber, water, trying to figure out what works best for them. Some people will just be nauseated the first couple of weeks they are on the med, and then it goes away. If they are really, really bad, I do send out Zofran, ondansetron. Not a lot, and I tell people I do not want you to be on this every day, but if it is super, super bad, we'll send out some Zofran initially.

PIERCE: That is good, because I do not like to feel nauseous at all.

WOLZ: Yes, and we have not had a lot of takers on it, but we always offer it. So, the other thing that is important is if you overeat. So, if you do overeat, you are going to get sick on this drug, because the food has nowhere to go. And so, we tell people you only overeat once, and it usually happens, you have lost ten pounds, you're at dinner. Usually there is a little alcohol involved. You have a cocktail, somebody orders dessert, you have dessert, and then you have another cocktail, and then you go home, and you are miserable. So, you have to be careful about that. Vomiting happens, but nobody really complains a lot about vomiting. I told you; I vomit after a race. Some people will occasionally vomit, but it is not like anything that is constant, like hyperemesis or anything. It is not like that. Some people will get constipated. If they do, if you are prone to constipation and not drinking enough water, you are probably going to get constipated. So again, we talk about fiber. We talk about magnesium; 600 milligrams over-the-counter magnesium citrate works perfectly. And we tell them you fixed it when you get diarrhea. Then you know to stop taking the magnesium. Other than that, we have not used anything more than that. People do really well. Sometimes they will put people on Metamucil just because they are more prone to it. Really, the key is increasing your fluid intake. You have to drink a lot of water. Increase your fiber in the diet. Avoid fatty foods. Avoid overly processed foods. Avoid eating too close to bedtime because if you are going to lay down with a full stomach, you are going to be miserable. And then do not go for long periods of time without eating. We tell patients to avoid alcohol. They do not have to, but we tell them to avoid alcohol because they are eating less. Your tolerance of alcohol is not very good anymore because it sits in your stomach longer. So, you may have been able to go out before and have two or three beers. You now can have one beer. You may have had a couple of Cosmos; you

can have one Cosmo. So, it really changes and we warn people about that. So, nobody is surprised, or nobody gets drunk, okay?

PIERCE: No drinking and driving.
So, we are very concerned about that. We talk about exercise.

WOLZ: Exactly. So, we are very concerned about that. We talk about exercise. Anytime you lose weight, and it does not matter again, if you are on weight watchers or Noon or a gastric bypass, you will lose lean muscle. It is just the way it goes. So, we tell our patients, you have to strength train. You have to lift weights. However you want to do that, we recommend three times a week, at least for 30 minutes, and you have to do weights. If you want to walk or do cardio, that is great. You do not have to do cardio. Walking is a great exercise. Weight bearing helps with osteoporosis, but definitely, definitely strength training. You have to strength train. No swimming does not count. Swimming is not going to count, but things like any lifting of weights, walking, absolutely perfect, but you have to do it. Some of the other side effects you are going to see is you're going to see hair loss. So, it is again, it is probably more of a nutritional thing. So, it is also probably a side effect of the medication. So, some people will experience hair loss, some people will not. If you do, we tell them to make sure they are eating enough calories. We always recommend a multivitamin supplement. And normally, I recommend prenatals for women. Seems to be a really good vitamin. And then, if they still lose weight, we can either put them on Rogaine 5%. We tell them just get Rogaine over the counter. Now my new thing is Nizoral shampoo, that ketoconazole shampoo. I started using it. It is amazing what it does for your hair.

PIERCE: Really? It helps with hair loss.

WOLZ: So yes, because it stimulates, it actually increases blood flow to the hair follicles. So, it is just a side effect of the ketoconazole shampoo. So besides not getting dandruff, it actually helps with hair follicle and hair regrowth. So, I use it now, that's my hair, that's my shampoo, Nizoral, get it from Amazon, works perfect. Also, Nutri-Full, if you want to use any of the Nutri-Full products, they are amazing. We kind of stay away from minoxidil and stuff because minoxidil is going to cause hair everywhere. And most women are not interested in growing beards. So, we try to shy away from that and just do topicals at this point. Usually, your hair does not get horribly thin, you lose some hair, it starts to go back, you're okay. May take a couple of months for you to adjust. So, we talked a little bit about the gastroparesis. We talked about the ileus. We talked about the bowel obstruction. They have been known to occur. I do not have; I've never had a patient that had it. I did have a patient that had vomiting. We took her off the med. She is fine, but she had some underlying issues. She had gastric ulcer disease. Again, anything that you question, send them back to their primary for clearance. I have done all kinds of medications, but I still question them. And a patient who had a fundoplication, and my concern was, well, what if she starts to vomit? Because she said to me, well, I cannot vomit. OK, well, that is going to be a problem if a medication is going to cause you to vomit. Sent her back to her gastroenterologist. He said, no, it is absolutely fine. So again, just get clearance. Again, safe, and efficacious. Just get clearance. I have never had a doctor tell me not. And I actually had a doctor last week, because I had a patient with elevated liver enzymes, and I said, you have got to go back to your doctor. It has got to be cleared through your

primary care. He told her, he said “you have a good provider.” He said, “I do not know who she is”, but he said, “she's absolutely doing it the way you should be doing it.” And he said, “I like her name. I would like to refer her to some clients”. So again, there is so much not the best way out there doing it. You have got to really think about safety with these patients. We do see some depression. Again, if food is your go to, I said to somebody, you can't smoke, can't eat, can't drink, what's left? And somebody said, well, you could read a book. I said, seriously, read a book. I have to have one bad habit. So hopefully it is exercise. You maybe become addicted to exercise. I am sure you can become addicted to shopping. But if you do have a tendency that food was your coping mechanism, we have now taken that away from you. So, we monitor depression very closely.

PIERCE: Oh, that’s good. Yes.

WOLZ: Visual side effect, there has been one published report that said diabetic patients on GLP-1s develop some visual issues. They were self-limiting, and they were clear, but I always tell my patients, if you have vision issues, follow up with your ophthalmologist if you notice any changes. You know that there is a side effect of that. So, we are very careful about that. We talk about supplements, talk about multivitamins, talk about omega-3s, we talk about D3s. The best advice I can give my patients is eat when you are hungry. Stop when you are full. Increase your protein and drink lots of water. We also address the area of social media, so we talk a lot about what's available on Tik-Tok and Instagram. So, I follow a couple obesity Specialists. I follow this Dr. Cortina out of Canada, and she is an obesity specialist, and she takes every study that is done on these GLPs and GLP-1-GILs, and she breaks it down. And she goes through every part of the study. She talks about the validity, the reliability, the specificity, the sensitivity. So, I tell my patients, go on Facebook, sign up and follow her. She is amazing. I also include a website, and I can send you that, that has all of the current research in one spot on these drugs. So, they literally will go to this site, and every research article that has been published is on this website. It ishttps://diabetes.medicinematters.com., and you can scroll through, and it has the step, it's got select, it's got the series trials, it's got everything right there in it. So, I make sure that I empower them with websites and tools and resources that are accurate and up to date and also scientific. We talk a lot about the wrong that is out there. We talk a lot about things like you need to be educated. You need to be informed. This is not a decision you should take lightly. Everything I just went over with you in these two podcasts, I also send my patients in written forms and have them review it all, sign it, keep a copy with them. We give them a diet, healthy eating, a whole diet on what foods are acceptable, which foods, the protein counts in foods. We talk about, you know, my fitness friends. We talk about macros, which I have to tell you, I cannot wrap my head around macros. I cannot figure it out. So, I have tried all those apps, and I cannot figure it out. But we talk to our patients about macros and MyFitnessPal and some other websites. We talk about myplate.gov. We give them websites. We try to give them every tool I come across. Any research article I find out or any new breaking thing on these medications, I quickly look at the validity and efficacy and specificity and sensitivity of the trial to make sure it is appropriate or not. I am constantly updating my information, making sure it's current, making sure that, and I tell my patients, I am telling you everything we know today. That is all I'm telling you. I do not know what we're going to know tomorrow, but as of today, I can guarantee you this is everything we know. I also tell them that this medication is in the masses. It is estimated 300,000 to 500,000 people in

the United States are on this medication. It is in the masses, which means we have a great sample size, and we are not seeing any more problems. Okay, and that is really great because if we like fen-phen only went to the masses in a very small study before we had big issues. So, it is great that the more we see about these meds, the less we're seeing issues with them. We have no long-term studies. The medications maybe been used in diabetics for 10 years at the max, so we do not have any data that talks about further than that. Every data, all the studies that have been done have been very positive. And again, as the new studies come out, I go out and I vet them before I will share them with any of my patients, just to make sure that we're all kind of knowing that the information is scientific. So yes, that's kind of it in a nutshell. I mean, we cover a lot of, yes, we do. And I will tell you, I always have patients say to me, they are appalled when they go back and talk to their friends that are on the drugs, how little they know about it. They said, I pull out my paper and I say, “well, according to Dr. Wolz, you are supposed to”, and they are like, “well, nobody told me that. Nobody told me that.” I just really believe the more informed they are, the more empowered they are to do this in a safe manner.

PIERCE: Right. Absolutely. And that is so much information for them. I mean, that is a lot to take in. So, I love that you give it to them paper as well so that they can just be like, I just need to judge this. That is a lot.

WOLZ: Right. I want them to listen in the first visit, then I want them to read it, and then on their subsequent visit, I want to discuss any concerns that they have.

PIERCE: Absolutely. All right. So, you have educated your patient. They decided to start it. You are, you know, working through how to do their adjustments. Now, what about when they lose that weight that they are looking to lose? How do you transition them to like a weight maintenance rather than a weight loss?

WOLZ: Most patients will almost do it on their own. So whatever dose they are on, you are always looking at what their weight is. So, let us say you are on 40 units, okay? You have been on 40 units for two or three months and you are maintaining your weight. You are not gaining, you are not losing, but you're maintaining. We will keep them on that dose. Then it is up to them to make the decision whether they want to continue, or they want to start weaning themselves down. You do not stop the medication abruptly; you wean them down. And again, hopefully through the course, because the average person is on this drug about 18 to 24 months. So, on a short-term course for this medication, it is not like three months, six months, and you're off. They really do recommend that you stay on the drug for at least 18 months. This Dr. Sandra Cortina says, eventually we are going to see this medication used for their whole life. She said, it is going to be just like hypertension, diabetes. Once you are diagnosed with this obesity, you are going to be taking an obesity drug for the rest of your life. It is going to be the management of obesity. So, she really believes that we are eventually going to transition to that. She also believes that eventually, insurance companies will recognize obesity as a disease, because in the United States, besides the state of Massachusetts, which has Harvard Obesity Center, we still consider obesity a psychological process that you can stop at any time if you would just stop eating. Just stop it. And again, it is mostly women. So that is a whole other lecture. So just kind of be aware that we have done nothing to improve how we

are dealing with this medication. So maybe eventually we will get there. So, it is really up to the individual. So, we tell them, you can maintain on it. It is an expense. You have to determine how much money you want to put into that. And I have had patients that have been on it for a while, lost their weight, weaned off of it, and had been highly successful. I have had patients that have been on it for a while, weaned off of it, and gained some of their weight back. But there are also, I have had patients that have had bariatric surgery that have come to me, and now have started the med because it is safe to use after bariatric surgery, which is amazing. So again, I have patients that have been through weight loss their whole life. And the more and more research are being done on weight loss you are starting to identify that it really is a genetic component, that you cannot eat anything and still be morbidly obese. This is not something that it is because you ate too much McDonald's. There is a genetic component to this. So, I think as we kind of navigate it and look at more research, we are getting into a better field. And now the drugs being studied to look at addiction, look at addiction for alcohol, look at addiction for drug use. So again, this is going to be a far-fetching, reaching type of medication. It is, if used appropriately, you know, you can wind up with a whole antibiotic overuse if we are not careful. It has to be appropriate.

PIERCE: Absolutely. Well, I want to quickly kind of talk about the special populations and patient factors to really consider that can cause contraindication for use or maybe require some extra caution.

WOLZ: Right, so there are some. So, when we talked about the pancreatitis, if you have a straight causative effect like a Depakote use or something, then that patient, again, once cleared by their PCP, all of this would be cleared by their PCP. They could actually then take the medication. I have had patients that have thyroid nodules. The majority of us probably have thyroid nodules, and until they get big enough, we do not know, or we have a scan. I checked with all the obesity specialists I know. I have looked at the research. Thyroid nodules that are not growing is not a contraindication, okay? Hashimoto's is not a contraindication. So, we need to educate ourselves, because some of the things we think, oh, this is going to be a contraindication is not. Mental illness of anorexia, bulimia, to me is a contraindication, or to me needs to go to an obesity specialist. It is beyond my scope of practice. So, there are things that we as practitioners will decide for this group. I really believe, under the age of eighteen, you need to be with a specialist. I am not a specialist for that age group. Birth control pills, if you take birth control pills, this will affect your absorption of birth control pills every time you increase your dose. So, you kind of got to tell people, you can get pregnant on this drug. If you get pregnant, it is contraindicated. So, it does not affect thyroid levels, and it just seems to right now to be birth control pills. So, every patient I have that conversation with, and there was a study published on too long ago that said increasing birth rates related to Ozempic, and it's because if they are on birth control pills, they are now going to get pregnant So something to think about, surgery, any exposure to anesthesia, it used to be 24 hours fasting. This drug keeps food in your stomach much longer than that. A colonoscopy is a week or two, depending on your anesthesiologist. So, I always tell my patients, you have to inform everybody you are on this drug. And it is really a slippery slope. People are very embarrassed by obesity. They are very embarrassed that they cannot control their intake. And then they become very embarrassed, or they suffer from shame, because they are on this medication. I yell that I am on this medication from the rooftops. If you want to judge me, you go right ahead. I also use

Botox and filler. I exercise five days a week at the gym. There is plenty to judge me for. Stand in line. And it is okay because there is always going to be somebody who's going to judge. So, patients sometimes will be very reluctant to share this, but they have to share it with every provider. Your risk of vomiting and aspiration is so great on this medication. So, I always tell them, as soon as you have that initial appointment for your colonoscopy or for any other surgery, one thing you have to say is, I take this medication. Most providers, anesthesiologist, want you off at least one to two weeks.

PIERCE: Ok so, it's not just a couple of days.

WOLZ: No, no, it is one to two weeks. So, if you know someone is going to have surgery, then take them off of it. The other really interesting thing that we just went through that I was not even aware of until it just happened to me was Ramadan. So, I have a Muslim population. And so, I had patients that wanted to start this medication a week before Ramadan. And it was like, no, we cannot do it, because my fear was the renal side effects due to the fact that they were going to be so dehydrated. Now I understand people that fast, they know how to do it, they can go all day without eating, they can handle it beautifully. If they were diabetic, they would still be on the drug. My thought was, why go down that road if we do not have to, if we can just wait the 30 days of Ramadan, and then start you on the medication. So, I talked to several people that were members of the mosque. I talked to several people that were outside the mosque, experts in the area, and we kind of just decided that for safety reasons, we will not do it. Now, of course, if they were diabetic, that is entirely different. So again, that was a population I did not even expect to be an issue. And there will be other ones. There are people that genetically get rashes from the medication, something about their back feels like they are on fire. It is not a reaction. It is just kind of waiting it out. It gets better. Some people get hives. I do not know. I am more cautious. If you have some funky side effects, I kind of take you off of it. I am a little more nervous. But I think as more studies come out, we will get better at it. But right now, I do not want anybody to have anaphylaxis. There is also a certain population that will never respond to this medication. It is like 1 to 5% of the population. So, you need to tell them that. You may not respond to this medication. It may not change your life at all.

PIERCE: Now is that response for weight loss or the role it plays in diabetes management?

WOLZ: It may potentially be both. And there is no rhyme or reason. I had a patient who was on every med, every dose, never lost an ounce. And we went over her diet. We went over her exercising. We did everything. Sometimes, you can supplement if they are at the top of their dose, we can supplement them with metformin. We may try some Phentermine. We may do Topiramate. Sometimes we play a little bit to see if we get a better reaction. And sometimes, they just do not respond. And the problem is once you buy, we individualize our vials, we do not buy like a gallon. We buy them per patient so we can track lot numbers in case there are any outcomes. And I would encourage everyone to do that. It is a little more expensive, but if something bad happens, and you are not accessing a vial 100 times, kind of causing any bacteria, I don't care how good your technique is. So, we do individual vials.

PIERCE: You can trace it back.

WOLZ: If they bought the vial, they are out six hundred bucks. Do you know what I mean? So sometimes that is another little issue that, but I always give them the vial and say, you can give it to whoever you want. I just cannot be responsible for it. So yes, it is kind of, for some patients, there's always going to be those few.

PIERCE: What about adherence? What are some tips that you have to help with improving your motivation of use, which it seems like if you're seeing results, you're not going to have issues with motivation, but you do have some that are just forgetful, you just forgot to use it, or they're just not persistent in using it correctly.

WOLZ: They usually will quit on their own. I had one person who bought a vial, did one month of shots, and decided she did not like it. She just was not going to do it. She did not like it. She would rather be on Phentermine. She wanted that amphetamine component, which this medicine does not have. You are not going to feel this surge of energy. If anything, you may feel a little fatigue, we give you vitamin B12. So, some people will feel fatigue more than anything. So, I told you, some people I can give their vial and their medication if their healthcare, and they will do their own. Some people I give them four syringes. They come in. I weigh them every month. I give them four syringes, adjust their dose, accordingly, monitor them and they go home for a month and come back, and I do have one patient who comes in every week, and I give her a shot. So, I am all over the place, you know it just depends on what works best for the client. That is what we tell you, what works best for you. I have they are fairly good about following their diet, where I really have to stay on them is the exercise. It is really encouraging them all the time about the exercise. My sister has this term called fat skinny, and she is always like, well, you know her problem is she is fat skinny. And she is right, you can be fat skinny. So, we talk about that, and the importance of exercise to prevent that. And usually what happens is they see that they are fat skinny, and then that scares them into following the exercise guidelines, but they usually probably are the thing they are least compliant on is the exercising.

PIERCE: So, we are titrating up, but now if I want to quit, am I titrating down?

WOLZ: Yes, I would titrate you down depending on your dose. If you are only at five units, not a big deal, because that is the initial start. But if you are at like 40 units, we'd probably go 40, 30, 20, 10. We may do it over six or eight weeks. It may not be a month for each one, but we definitely would do a good two weeks to titrate you down. And then your body is not thrown into, from not eating at all to now wanting to eat everything.

PIERCE: So, you are going to have to plan that out if you are going to have surgery, right? So, if you are going to be put under anesthesia.

WOLZ: Normally for surgery, they will just stop it for two weeks. They will just stop it. Again, you just have to be aware that you may be really hungry during those two weeks, but for surgery, they just stop it. They do not care what your doses. You are off that meds, so. Yes, you're done. And some people play, you know, sometimes I play with it, you know, like instead of doing it every week, I do it every 10 days, because, you know, it was Easter. So, and you are not supposed to do that. I am not sanctioning that in any way. I am just saying, you have got to

look at this in the real world also. And I can tell you, this is exactly, it is kind of like health literacy. This is exactly the way you are supposed to do it. We are hoping you do it for 75%. So, know what the side effects are for that 50%. So that you can address them in your clients when they present with them because they will present with them. Travel is another issue. It has to be kept in the refrigerator or freezer, depending on the product. So, we talk a lot about traveling with syringes. No problem, but we have to talk about it, you know, because they don't really have a vial. They just have four syringes, and they have to be kept cold, so we talked about thermoses and those kinds of things. So, there's just some things that you have to have in conversation with patients so that they're aware that these are medications. We talked about the Ozempic face. We talked about Botox and fillers. You're not going to be happy, and we're running a special on Botox. No, just kidding! Being a med spy, you know, you can kind of like, you know feed into like the next thing but it's true, I told you, we all need little enhancements.

PIERCE: It is a lot so much to cover, so many pieces to this. So, as we are kind of running out of time here for episode two. Is there anything that you just want to make sure you emphasize to our listeners?

WOLZ: Education. Make sure you are educating your patients. Make sure they are informed. They know exactly what they are getting into. Make sure you have covered the safety and efficacy of this drug. Do not look at just the reward, even though we all want to be millionaires. Look at how to do it safely. Vet your own people. Make sure your products are as safe as they can be. It may not be the cheapest, but I probably have 25, 30 weight loss clients in a couple of months. And it is just because I am very safe with people like that. You know, I am as safe as you could be today. So really make sure safety, advocacy, education, and monitor, I mean, really, it is like any, it wouldn't be any different if they were a diabetic. You know, and that is what you have to think about. This is a prescription medication. It should be respected as such.

PIERCE: Absolutely, that is such great advice. Thank you so much. Dr. Kathleen Wolz for joining us for this series.

WOLZ: Thank you. I loved it. And if anybody has questions, they can always reach out to me. I will be happy to mentor, help people, share all my information with you, anything I can do to help you be successful.

PIERCE: Girl, you packed so much into these. I didn’t even have to talk much. I was just like; I need to take notes! So much information here!

WOLZ: It is! I told you I spent at least an hour consulting with each patient prior to even starting the drug. I just want them to be informed about it.

PIERCE: Absolutely. Well, thank you so, so much for sharing such a wealth of information because know I am, and I hope our listeners are also walking away with such a comprehensive understanding of how to leverage these drugs as part of really an evidence-based treatment approach for patients and looking at weight management and treating obesity. So, these medications have definitely emerged as powerful tools, and they are just such a wonderful

way to help really with that dual challenge of elevated blood sugar its effect is on weight loss. I mean, they go hand in hand, and a lot of times we do not realize that. So, thank you so much for opening this up for us and it was great to meet you, and discuss this with you. And to our listeners, I encourage you to explore many of the courses that we have available on elitelearning.com to help you grow in your careers and earn CEs.