A Physician's Perspective Article

COMMENTARY

It's Not 'Reckless' to Consider Ozempic

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Caroline Messer, MD
DISCLOSURES

August 24, 2023

After nearly 20 years of practicing medicine with a focus on weight loss and preventive care, here is how I see the situation:

1. Ozempic is nothing new, people! Endocrinologists have been using this class of medication since Byetta hit the market in 2005. We have had 18 years to make informed risk-benefit analyses.

2. People are obsessed with the risk for pancreatitis. Any type of weight loss can cause gallstones, and this is what can trigger pancreatitis. Unless you're the type of person who worries that your balanced Weight Watchers diet is going to cause pancreatitis, you should probably remove this risk from your calculations.

3. Glucagon-like peptide 1 (GLP-1) receptor agonists are naturally occurring gut hormones that reduces inflammatory cascades and clotting risk. We are not giving a dangerous treatment (eg, fen-phen) that increases cardiovascular risk — quite the contrary, in fact.

4. Just because influencers are promoting a product doesn't mean the product is inherently worthless. One of my patients accused me of prescribing a medication which is the "laughingstock of America." Try telling that to the scores of cardiologists who send patients to my colleagues and me to start Ozempic to help lower their patients' risk for stroke and heart attack. Or tell this to my patient who survived an episode of rapid atrial fibrillation and was told by his cardiologist that he definitely would have died if he had not lost 30 pounds from Ozempic in the preceding year.

5. Sometimes it seems like society has become more judgmental about Ozempic than about plastic surgery for weight loss. If we have to choose between liposuction (which doesn't reduce visceral fat — the dangerous type of fat) or Ozempic, the latter clearly wins because of its real health benefits.

6. How does it make any sense to say that this medication should be reserved for patients who already have obesity and type 2 diabetes? Why should we penalize patients who have not yet reached those thresholds by denying access to preventive care? Don't we constantly hear about how our healthcare system would be much more efficient if we focused on preventive care and not just treatment?

7. Some people claim that we have to limit access to this medication because of drug shortages. Thankfully, the United States responds to supply and demand economics and will quickly adjust.

8. I've had more patients than I can possibly number with severe binge eating disorders (resistant to years of therapy and medication) who finally developed healthy relationships with food while taking these types of medications. Mounjaro, I'm talking about you…
9. I always hear the argument that it is immoral to give these medications to patients with a history of restrictive eating patterns. Although every patient needs to be carefully evaluated, often these medications remove food as both the enemy and primary focus of every waking thought. They allow patients to refocus on other aspects of their lives — such as family, friends, hobbies, work — and regain a sense of purpose. If anyone wants to run a trial on this little hypothesis of mine, please reach out to me.
10. Okay, I agree you might get a little constipated (most often described by patients as the "rabbit pellet phenomenon"), but it's small price to pay, no? I'll throw in a few prunes with the prescription.

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