Obesity
GP Update, 2024

Your shortcut to the latest clinical guidelines for the management of obesity in primary care.

Expanded area	Clinical focus you can apply tomorrow
Risk framing	Assess BMI and waist; screen for complications; tailor to severity.
Energy-restricted diet	RED/LED: ~2,000–5,000 kJ/day deficit or total intake; dietitian plans or commercial programs; meal replacements for 1–2 meals/day.
Very low energy diet (VLED)	<3,000 kJ/day, usually 2 meal replacements + lean protein; 1 tsp olive oil to reduce gallstone risk; max ~12 weeks (longer only with supervision); contraindicated in pregnancy / lactation, severe psych illness, recent MI/CVA/unstable angina, porphyria; caution in >65 yrs, insulin users (↓ dose ~50%), SGLT2 users (monitor/withhold), CKD, warfarin (keep intake steady).
Physical activity	Prioritise what patients enjoy; add resistance work to limit sarcopenia; consider hydrotherapy / EP / physio via GPMP.
Pharmacotherapy (TGA-approved)	Phentermine, Orlistat, Liraglutide (Saxenda) daily SC, Naltrexone/Bupropion (Contrave), Semaglutide (Ozempic/Wegovy) weekly SC. Start low, go slow; watch GI effects, gallstones / pancreatitis risk with GLP-1s; adjust other glucose-lowering meds to avoid hypos.
Off-label options discussed	Topiramate (appetite suppressant; cognitive/mood side effects), low-dose Phentermine + Topiramate, Tirzepatide (Mounjaro) (costly vial in AU).
Bariatric surgery	Most efficacious for sustained loss; consider BMI >40, BMI 35–39 with comorbidities, BMI 30–35 with poorly controlled T2DM/CV risk. Multidisciplinary prep (psych/dietitian/EP), optimise comorbidities, often pre-op VLED; long-term follow-up (labs incl. fat-soluble vitamins).
Special groups	18–35 yrs: rapid gain common—early intervention. >65 yrs: focus on function, falls, independence; moderate losses. Pregnancy: avoid excessive gain; GLP-1s are category D; plan 12–18 months between bariatric surgery and conception.
Equity & access	Limited public access to surgery; allied-health costs are barriers — use GPMP/TCA if possible.

Clinical pearls

- Make weight/height routine at visits (normalise the conversation, track trends).
- Combine strategies (diet + activity + meds ± VLED), and expect cycling. Support re-starts without judgement.
- GLP-1 dose titration prevents GI drop-out; retinopathy can transiently worsen with rapid HbA1c falls. Keep optometry reviews up to date.
- After surgery, patients still need annual bloods and ongoing lifestyle support; some will later need weight-maintenance pharmacotherapy.

How to use new algorithm

- Stratify by BMI and waist and check complications.
- Set realistic targets:
  - BMI 30–40 → aim 10–15% loss.
  - BMI >40 → aim >15% loss.
- Interventions are combined and stepped.

Where to next

🎓 Explore our short CPD **Micro-Course** in obesity, or our university-assured, structured **Certificate Courses** pathway in Chronic Disease & Conditions: **www.healthcert.com/cdc**