Obesity
GP Update, 2024

Frequently Asked Questions, with Dr Simone Gonzo

Q: What counts as "discretionary foods"?
A: All the "extras" outside core meals: morning-tea cakes/pastries, sugary/carbonated drinks (including juices), and other high-calorie, low-nutrient items.

Q: Does obesity alone qualify a patient for a GP Management Plan (GPMP)?
A: Yes — obesity is a chronic disease. If present ≥6 months, it meets GPMP criteria; use this to access subsidised dietitian/EP/physio support.

Q: How long can we keep a patient on naltrexone/bupropion? Can it be used with SSRIs?
A: There's no fixed limit. You can co-prescribe with SSRIs; start low and up-titrate slowly while monitoring for mood changes. If adverse effects emerge, reduce dose to a tolerable level that still achieves loss, or switch.

Q: How long can patients stay on Wegovy/semaglutide?
A: No defined maximum (diabetes patients use semaglutide long-term). In real-world primary care, people often cycle (on/off) or reduce to a maintenance dose once a target is reached.

Q: Post-bariatric surgery: how long should we follow patients? What should we monitor?
A: Specialist follow-up can extend 5–10+ years; in general practice, continue annual bloods and monitor fat-soluble vitamins and nutritional markers. Ongoing dietitian input improves outcomes.

Q: Is bariatric surgery covered publicly? Why do the guidelines feel "treatment-heavy" given real-world barriers?
A: Public access is limited (often private pathways). Allied-health costs are real barriers. The presented guideline section focuses on management once obesity exists; broader prevention sits in separate strategy work. In general practice, use GPMP/TCA to offset costs and keep care realistic.

Q: If a patient is steadily losing weight with good habits but hasn't reached a healthy range, how long can we continue pharmacotherapy?
A: Indefinitely, provided it's tolerated. Some patients use meds for weight maintenance. For diabetics on semaglutide, doses can be reduced to maintain weight while preserving glycaemic benefits.

Q: Practical VLED points?
A: Typically ≤3,000 kJ/day, two meal replacements + lean protein, supervised monthly; add 1 tsp olive oil to lower gallstone risk; avoid in pregnancy/lactation, severe psych illness, recent MI/CVA/unstable angina, porphyria; caution in >65 yrs, insulin/SGLT2/CKD/warfarin—adjust or monitor accordingly.

Q: GLP-1 side effects and tips?
A: Nausea, vomiting, constipation/diarrhoea are common. Go slow with titration; consider gallstone and pancreatitis risk; in diabetics, rapid HbA1c falls can transiently worsen retinopathy — keep optometry reviews current.

Q: Can medication be used just for maintenance?
A: Yes. Some patients use low-dose, ongoing pharmacotherapy (e.g. weekday phentermine or reduced-dose semaglutide) to stabilise weight after initial loss.

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**