

Letters to the Editor

Send letters to Kenny Lin, MD, Associate Medical Editor for *AFP* Online, e-mail: afplet@aafp.org, or 11400 Tomahawk Creek Pkwy., Leawood, KS 66211-2680.

Please include your complete address, e-mail address, telephone number, and fax number. Letters should be fewer than 500 words and limited to six references and one table or figure.

Letters submitted for publication in *AFP* must not be submitted to any other publication. Possible conflicts of interest must be disclosed at time of submission. Submission of a letter will be construed as granting the American Academy of Family Physicians permission to publish the letter in any of its publications in any form. The editors may edit letters to meet style and space requirements.

Pharmacotherapy Options for Weight Loss and Maintenance

Original Article: Weight Loss Maintenance

Issue Date: September 15, 2010

Available at: <http://www.aafp.org/afp/2010/0915/p630.html>

TO THE EDITOR: On behalf of the American Society of Bariatric Physicians (ASBP), I would respectfully like to address several shortcomings of the article by Drs. Grief and Miranda.

Primary care medicine has fostered a bias against the treatment of obesity, and the article in *AFP* perpetuates such a bias. Although there are numerous drugs available for the treatment of obesity, the article mentions only two: orlistat (Xenical) and sibutramine (Meridia). Since sibutramine has been withdrawn from the market, it is even more pertinent that the article should have included information about alternative anorexants. Medical bariatric experts routinely prescribe older anorectic drugs, including phentermine, diethylpropion, and phendimetrazine. These drugs are prescribed far more often than orlistat and sibutramine.¹ Topiramate (Topamax)—originally approved by the U.S. Food and Drug Administration (FDA) in 1996 to treat epilepsy, but known to be an effective anti-obesity drug—also is used more widely in bariatric clinics than orlistat or sibutramine.¹

Although none of these alternative anorexants have been approved by the FDA for long-term use, experts in obesity treatment have long acknowledged that if an anti-obesity drug is effective for a patient, it should be used long-term for maintenance.² Phentermine is the most widely used anti-obesity drug in the United States and is often used long-term for maintenance in medical bariatric programs.³ Approved in 1959, long before the FDA decided to require two-year clinical trials before approving a new anti-obesity drug,⁴ phentermine remains the

most popular anti-obesity drug. Its widespread use for the past 51 years is a far stronger testament to its effectiveness and safety than any long-term controlled trial. Clearly, obesity treatment experts believe phentermine should be considered as the first choice for any patient on long-term weight loss maintenance.

Long-term pharmacotherapy should be thoroughly considered for every patient during weight loss treatment and maintenance. The ASBP recently published *Overweight and Obesity Evaluation and Management guidelines*, which address various issues related to the treatment of obesity.⁵

LARRY A. RICHARDSON, MD, FASBP
Spring, Tex.

Author disclosure: No relevant financial affiliations to disclose.

REFERENCES

1. Hendricks EJ, Rothman RB, Greenway FL. How physician obesity specialists use drugs to treat obesity. *Obesity (Silver Spring)*. 2009;17(9):1730-1735.
2. Long-term pharmacotherapy in the management of obesity. National Task Force on the Prevention and Treatment of Obesity. *JAMA*. 1996;276(23):1907-1915.
3. Haddock CK, Poston WS, Foreyt JP, DiBartolomeo JJ, Warner PO. Effectiveness of Medifast supplements combined with obesity pharmacotherapy: a clinical program evaluation. *Eat Weight Disord*. 2008;13(2):95-101.
4. Colman E. Anorectics on trial: a half century of federal regulation of prescription appetite suppressants. *Ann Intern Med*. 2005;143(5):380-385.
5. American Society of Bariatric Physicians. Overweight and obesity evaluation and management. November 2009. http://www.asbp.org/siterun_data/about_asbp/position_statements/doc7270523281295654373.html. Accessed January 2, 2011.

IN REPLY: I thank Dr. Richardson for his letter about our article and his concerns regarding the information on pharmacotherapeutic options for weight loss maintenance. As Dr. Richardson points out, there are many non-FDA-approved medications available for treating weight loss.¹ The goal of our article was to provide an update on interventions that succeed in maintaining weight loss; a secondary goal was to share with the physician audience all FDA-approved medi- ►

Preferred and Alternative Regimens for First-Line HIV Therapy

Preferred regimens*

NNRTI-based regimen

Efavirenz + Tenofovir + Emtricitabine

PI-based regimens

Atazanavir + Ritonavir + Emtricitabine + Tenofovir

Darunavir + Ritonavir + Emtricitabine + Tenofovir

InSTI-based regimen

Raltegravir + Emtricitabine + Tenofovir

Alternative regimens†

NNRTI-based regimens

Efavirenz + Abacavir or zidovudine + Lamivudine

Nevirapine + Zidovudine + Lamivudine

PI-based regimens

Atazanavir + Ritonavir + Abacavir or zidovudine + Lamivudine

Fosamprenavir + Ritonavir + (Abacavir or zidovudine) + Lamivudine or Emtricitabine + Tenofovir

Lopinavir + Ritonavir + (Abacavir or zidovudine) + Lamivudine or Emtricitabine + Tenofovir

Key

- Integrase strand transfer inhibitor (InSTI)
- Non-nucleoside reverse transcriptase inhibitor (NNRTI)
- Nucleoside/nucleotide reverse transcriptase inhibitor (NRTI)
- Protease inhibitor (PI)

*—Preferred regimens for nonpregnant patients are arranged in order of approval by the U.S. Food and Drug Administration for components other than nucleosides (thus, by duration of clinical experience) and alphabetically within each class.

†—Regimens with potential disadvantages compared with preferred regimens; may be preferred for some patients.

Figure 1. Preferred and alternative initial regimens for antiretroviral therapy in patients with human immunodeficiency virus (HIV) infection.

Adapted from Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the use of antiretroviral agents in HIV-1-infected adults and adolescents. Rockville, Md.: U.S. Department of Health and Human Services; 2011. <http://www.aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf>. Accessed April 9, 2011.

cations that have been tested, studied, and confirmed to be of utility for long-term usage and for weight loss maintenance, defined as at least one full year of treatment. Off-label use of medications for weight loss was outside the scope of our article. A final goal of the article, albeit a tacit one, was to enhance the partnership and collaborative dialogue between primary care physicians and bariatric surgeons. Therefore, we consulted a bariatric surgeon at our affiliated institution in the preparation of our manuscript. We welcome continued dialogue as to best practices in treating patients for weight loss maintenance and encourage more research on this extremely important topic.

SAMUEL N. GRIEF, MD, FCFP

Chicago, Ill.

E-mail: sgrief@uic.edu

Author disclosure: No relevant financial affiliations to disclose.

REFERENCE

1. Haddock CK, Poston WS, Dill PL, Foreyt JP, Ericsson M. Pharmacotherapy for obesity: a quantitative analysis of four decades of published randomized clinical trials. *Int J Obes Relat Metab Disord*. 2002;26(2):262-273.

Correction

In the article “Common Adverse Effects of Antiretroviral Therapy for HIV Disease” (June 15, 2011, page 1443), there were several errors in Figure 1 (page 1445). In multiple locations, the word “or” was inserted between two drug names instead of a plus sign (+), which incorrectly implied that either of the two drugs listed should be administered, rather than both drugs needing to be administered. The online version of this figure has been corrected, and the corrected figure is reprinted above. ■