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Successful treatment of binge eating disorder with the GLP-1 agonist semaglutide: A retrospective cohort study

Jesse Richards [a], Neha Bang [a], Erin L. Ratliff [b], Maria A. Paszkowiak [a], Zhamak Khorgami [a], Sahib S. Khalsa [c], W. Kyle Simmons [b d]

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Abstract

Objective

Binge eating disorder (BED) is the most common eating disorder, and yet only one pharmacotherapy (lisdexamfetamine), which has known abuse-potential, is FDA-approved. Topiramate is also commonly prescribed off-label for binge eating but has many contraindications. In contrast, the glucagon-like peptide-1 (GLP1) analog semaglutide has profound effects on central satiety signaling leading to reduced food intake, and has been approved for the treatment of obesity based on its efficacy and safety profile. Semaglutide would thus seem to be a potential candidate for the treatment of BED.

Methods

This open-label study examined the effects of semaglutide on Binge Eating Scale (BES) scores in individuals with BED. Patients were divided into three groups: those prescribed semaglutide, those prescribed either lisdexamphetamine or topiramate, and those prescribed a combination of semaglutide with lisdexamphetamine or topiramate.

Results

Patients receiving semaglutide only exhibited greater reductions in BES scores compared to the other groups. Combined pharmacotherapy with both semaglutide and the other anti-obesity medications did not result in greater reductions in BES scores compared to the semaglutide-only group. Findings were similar in patients with moderate/severe BED, as well as the full sample.

Conclusion

The therapeutic effects of semaglutide in binge eating disorder warrant further investigation.

Previous Next

Keywords

Binge eating disorder; GLP-1 agonist; Semaglutide

1. Introduction

Binge Eating Disorder (BED) is the most common of eating disorders, with a lifetime prevalence of approximately 2.8% [1], and approximately 36% comorbidity with obesity [2]. Clinically, BED presents as a lack of control during binge episodes characterized by time-limited hyperphagia during which thousands of calories can be consumed [3]. These binge episodes are often psychologically disturbing, with patients experiencing significant embarrassment, guilt, or disgust associated with the episode. [4].

Lisdexamfetamine (Vyvanse®, Takeda), is the only FDA-approved pharmacotherapy for BED. It is a prodrug that is converted in the body to dextroamphetamine, causing the reverse transport of dopamine and noradrenaline into the synaptic cleft, thereby potentiating postsynaptic firing of catecholaminergic neurons [5,6]. Through mechanisms that are not fully understood, this results in a reduction in appetite. In addition to lisdexamfetamine, other medications are often prescribed for BED. Most notably, the antiepileptic topiramate (Topamax®, Janssen), has also been shown to be effective in randomized double-blind placebo controlled clinical trials, and is commonly prescribed off-label for binge eating [7], although it has many known contraindications including fatigue, cognitive impairment, metabolic acidosis, and interactions with other medications or alcohol. Because of their effects on appetite, both lisdexamfetamine and topiramate are commonly prescribed as anti-obesity medications [8].

In the past decade, glucagon-like peptide-1 (GLP-1) modulators have garnered attention for their efficacy in ameliorating type 2 diabetes and effectiveness as weight loss medications. In particular, semaglutide is an effective and FDA-approved treatment for obesity (Ozempic®, Novo Nordisk) and weight reduction (Wegovy®, Novo Nordisk). Delivered once weekly via subcutaneous injection, semaglutide alters gastric and hepatic function [9], but its most profound effects are on central satiety signaling. GLP-1 receptors are found in key appetite-regulating regions of the central nervous system, and pharmacological treatment with GLP-1 analogues modulates the downstream release of hunger and reward-related neurotransmitters in the hypothalamus and striatum in rodents [10]. Intraperitoneal administration of GLP-1 reduces hedonic feeding in a mouse-model of BED [10,11]. Likewise, in humans, treatment with semaglutide is associated with a significant reduction in emotional eating, which is a known contributor to BED [12].

Based on the extant pre-clinical and human data, Semaglutide would thus seem to be an excellent candidate for treating BED. As a first step in assessing this hypothesis, the present open-label study examined the effects of semaglutide on Binge Eating Scale (BES) scores in patients with moderate to severe BED. To contextualize the effects observed with this new pharmacological treatment, we compared changes in BES scores in the semaglutide treated group to a group of matched BED patients prescribed either lisdexamphetamine or topiramate, as well as a group that received both semaglutide and other anti-obesity medications.

2. Methods

A retrospective chart review identified 98 patients attending an obesity medicine and bariatric surgery clinic from June 2021 to December 2022. The study was inclusive of women and minorities. Forty-eight patients were identified as likely having moderate to severe BED as defined by intake visit with the Binge Eating Scale (BES), a validated psychiatric instrument [13]. The BES is a validated 16-item questionnaire that assesses binge eating severity, with scores > 16 indicating at least "moderate" binge eating symptomatology, and scores >26 indicating "severe" binge eating.

There were three groups of participants: patients receiving semaglutide only (n=19); patients receiving semaglutide

plus another anti-obesity medication (either topiramate or lisdexamphetamine) (n=13); or patients receiving the alternative anti-obesity medications (AOM) but not receiving semaglutide (n=16). Patients on other types of GLP-1 agonist medications were excluded from the analysis. The following data were collected via chart review: patient age, gender, medical history, medications, doses of medications, dates of initiation of medications, the amount of weight loss at 30, 90, and 180 days after treatment, and the starting and ending weight, BMI, and BES score with date and individual answers. The above information was also collected for patients with probable mild/minimal BED (BES scores <17), with their results included in supplemental figures. The retrospective study design was approved by the institutional review board of the University of Oklahoma Center for Health Sciences.

Based on our interest in identifying the impact of semaglutide on moderate to severe BED, a one-way analysis of covariance (ANCOVA) was initially conducted in the subsample of patients with a moderate or severe initial BES score (n=48). The independent variable had three levels: patients treated with semaglutide (SEMA_ONLY), a combination of semaglutide and other anti-obesity medications (SEMA+OAOM), and other anti-obesity medications only (OAOM). The dependent variable was mean change in BES score between baseline and follow-up. Covariates included the patient's self-reported gender, initial BES score, and time in days between baseline and follow-up. The ANCOVA was repeated for the full sample of patients that included those with a low initial BES score (N=98). Tukey's HSD post hoc analyses were used to determine which groups differed significantly. All analyses were conducted in R [14] using the *car* [15] and *multcomp* [16] packages.

3. Results

Descriptive statistics are presented in Table1 for the subsample of participants with moderate/severe BES score subsample (see Supplemental TableS1 for the full sample). In the moderate/severe BES score subsample, the ANCOVA revealed a significant effect of treatment type on BES: $F(2,42)=8.02$, $p<.01$. Tukey's HSD post hoc testing revealed a significant difference in the mean change in BES score between the SEMA_ONLY group and the OAOM group ($p<.01$) as well as between the SEMA+OAOM group and the OAOM group ($p<.01$) (see Fig.1). The mean change in BES score between the SEMA_ONLY group and SEMA_OAOM group was not significantly different. On average, BES scores decreased by 14 points in the SEMA_ONLY group, 12.9 points in the SEMA+OAOM group, and 5.9 points in the OAOM group. Fig.2A–C shows each patient's change in BES score from baseline to follow-up for each treatment group.

Table1. Moderate/severe initial BES score patient characteristics.

	SEMA Only	SEMA+OAOM	OAOM
n	19	13	16
Female	17	10	14
Race/Ethnicity	White 15 Black 3 American Indian 1	White 5 American Indian 3	White 9 Black 1 American Indian 1 Multiracial 1
Age (yrs) *M [SD, range]*	43.5 *[13.6, 22-74]*	43.1 *[9.8, 32-64]*	39.6 *[12.8, 21-67]*
Initial weight (lbs) *M [SD, range]*	257.6 *[58.1, 162.4-360.6]*	327.1 *[127.6, 209.9-606.4]*	268.4 *[57.7, 179.5-358.2]*
Total body weight loss (lbs) *M [SD, range]*	22.5 *[14.3, 6.4-52.6]*	53 *[64.2, 1.3-224.9]*	13.2 *[20.1, -23.54-67.1]*
Baseline BES Score *M [SD, range]*	23.89 *[5.7, 18-36]*	22.7 *[6.3, 17-35]*	26.1 *[7.4, 17-44]*
Average Change in BES Score *M [SD, range]*	14 *[8.2, -2-25]*	12.9 *[8.9, 0-29]*	5.9 *[9.1, -7-24]*

	SEMA Only	SEMA+OAOM	OAOM
Prescribed Vyvanse	0	2	1
Prescribed Topiramate	0	13	12
Prescribed both Vyvanse and Topiramate	0	2	1

Abbreviations: M=mean; SD=standard deviation.

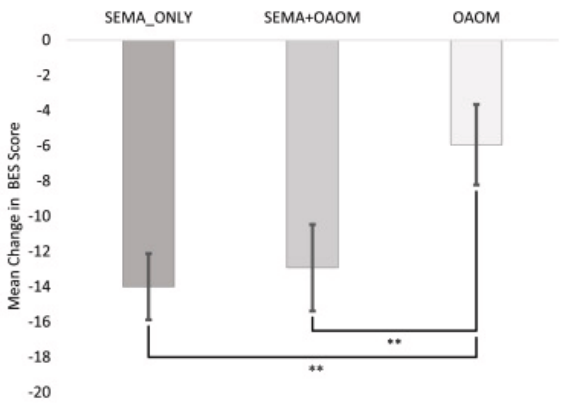

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Fig. 1. Mean change in BES score for patients with moderate or severe initial BES scores treated with semaglutide only (SEMA_ONLY, n=19), a combination of semaglutide and other anti-obesity medications (SEMA+OAOM, n=13), and other anti-obesity medications only (OAOM, n=16). n=48. $**p$ <.01. Error bars=standard error of the mean.

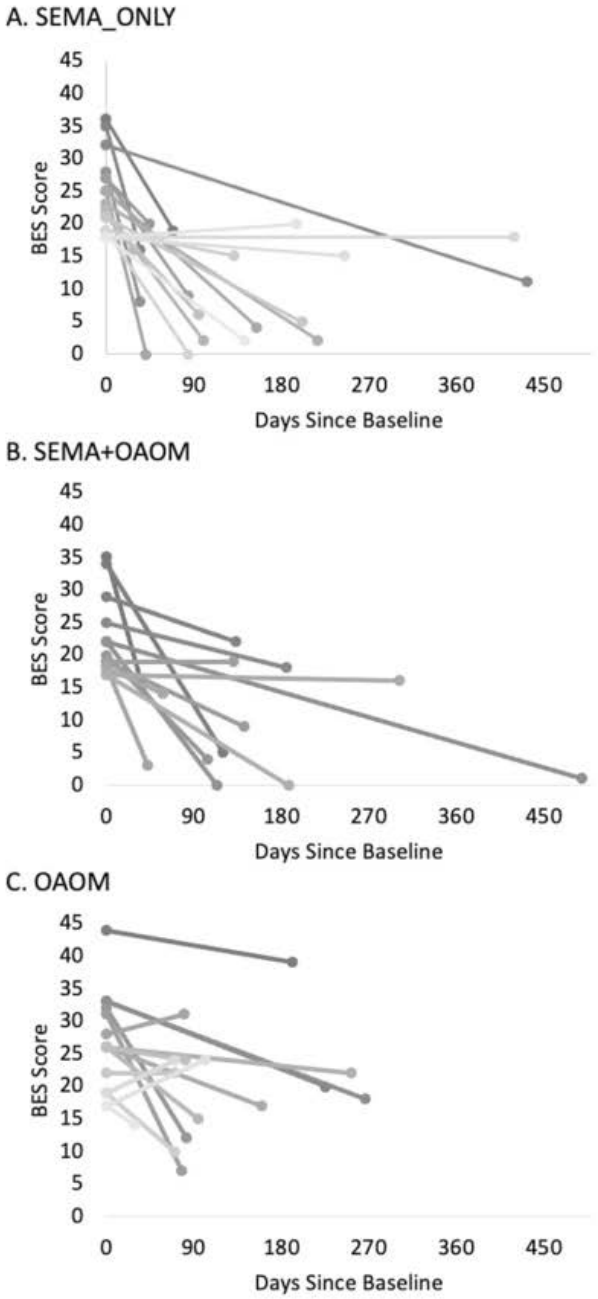

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Fig.2. Change in BES score from baseline to follow-up for patients with moderate or severe initial BES scores. (A) Patients treated with semaglutide only (SEMA_ONLY), (B) patients treated with a combination of semaglutide and other anti-obesity medications (SEMA+OAOM), (C) and patients treated with other anti-obesity medications (OAOM).

The second ANCOVA conducted using the full sample of patients showed findings that mirrored those observed in the subsample of moderate/severe BED patients, with a significant effect of treatment type on BES score: $F(2,92)=10.1$, $p<.001$. Similarly, Tukey's HSD post hoc analysis showed a significant difference in mean change in BES score between the SEMA_ONLY group and the OAOM group ($p<.001$) as well as a significant difference in mean change in BES score between the SEMA+OAOM group and the OAOM group ($p<.001$, see Supplemental Fig.S1). The mean change in BES score between the SEMA_ONLY group and SEMA+OAOM was not significantly different. On average, BES scores decreased by 7.9 points in the full sample of SEMA_ONLY patients, 8.8 points in the full sample of SEMA+OAOM patients, and 4.8

points in the full sample of OAOM patients. Individual changes in BES scores from baseline to follow-up are shown in Supplemental Figs.S2A–S2C.

4. Discussion

The present open-label retrospective cohort study evaluated the effects of semaglutide on binge eating symptoms in patients with moderate to severe levels of binge eating. Treatment with semaglutide resulted in a significantly greater reduction in Binge Eating Scale (BES) scores compared to compared to those receiving lisdexamfetamine and topiramate, two common anti-obesity medications used to treat BED. Combined pharmacotherapy with both semaglutide and other anti-obesity medications did not result in greater reductions in BES scores compared to semaglutide-only group.

These findings are consistent with previous studies showing that GLP-1 agonists, including semaglutide, have an effect on central satiety signaling, which may play a role in reducing binge eating symptoms. [17] A study by Da Porto and colleagues [18] found that treatment with the GLP-1 analogue dulaglutide was associated with a greater reduction in BES scores relative to gliclazide, a sulfonylurea compound that increases insulin but is not known to affect brain reward circuitry or appetite. Additionally a short term 3 month pilot study of liraglutide by Robert etal. has shown promise in reducing BED symptoms [19]. The present findings thus make the important contribution of providing the first evidence in humans that GLP-1 analogue Semaglutide may be effective in reducing binge eating symptomatology, and possibly more effective than other commonly prescribed medications known to alter reward neurocircuitry and appetitive behaviors.

The results of this study have important implications for future neuroscientific studies on the mechanism of action of GLP-1 agonists in the treatment of BED. Neurons with GLP-1 receptors are found throughout the mesolimbic dopamine pathway and hypothalamic sub-nuclei [20], and extensive preclinical research demonstrates that GLP-1 analogues such as semaglutide have their effects on eating behavior primarily through modulation of these central nervous system targets [21]. We expect that the reductions in binge eating symptomatology observed here likely arise from semaglutide's effects on these CNS circuits, but further research is needed to determine the precise mechanism by which GLP-1 agonists reduce binge eating symptoms. Future studies should investigate the optimal dosing and duration of treatment with semaglutide, as well as potential interactions with other medications commonly prescribed for BED and/or obesity.

5. Conclusion

BED is a common psychiatric condition that can affect cardiovascular mortality of patients with obesity, with limited current treatment options. The findings from this study provide a rationale for future randomized clinical trials to assess the efficacy and safety of semaglutide in the treatment of BED. Overall, the present study adds to the growing body of evidence supporting the use of GLP-1 agonists, including semaglutide, in the treatment of BED. Semaglutide may be a promising pharmacological treatment option for patients with moderate to severe BED, and further research is needed to fully elucidate the mechanisms underlying its therapeutic effects.

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Declaration of competing interest

Dr Richards is on Speaker Bureau for Rhythm Pharmaceuticals and Novo Nordisk and is on Advisory Board for Rhythm Pharmaceuticals. The other authors report no disclosures to declare.

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Appendix A. Supplementary data

The following is the Supplementary data to this article:

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Multimedia component 1.

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How Ozempic Can Aid Binge Eating Disorder Recovery

July 7, 2023 // Admin

Binge eating disorder (BED) is a complex and distressing condition characterized by recurrent episodes of uncontrollable overeating, often accompanied by guilt, shame, and loss of control. Ozempic, developed initially to address diabetes, has demonstrated remarkable efficacy in reducing binge eating disorder (BED) episodes and promoting sustainable weight loss.

Ozempic offers hope to those struggling with BED, providing a potential path towards regaining control over their eating habits and ultimately improving their overall well-being.

Key Takeaways

It is essential to consult with a qualified healthcare professional to determine if Ozempic or any other treatment suits your specific situation and to receive personalized medical advice.

- Ozempic has gained popularity for its potential to control binge eating episodes and reduce food intake.
- Off-label use of Ozempic can cause several side effects, including nausea, vomiting, diarrhea, and decreased appetite.
- Ozempic should only be used under the supervision and guidance of a qualified healthcare provider.

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What is Binge Eating Disorder?

Binge eating disorder (BED) is characterized by recurring episodes of uncontrollable overeating, often marked by consuming large amounts of food rapidly and to the point of discomfort. Individuals with BED feel a lack of control during these episodes and may experience guilt and distress afterward. Unlike bulimia, BED episodes are not followed by compensatory behaviors like purging.

According to recent data, BED affects individuals worldwide, with a prevalence of approximately 1-3 percent globally. In the United States, it is estimated that 2.8 million people have BED. Binge Eating Disorder can lead to significant physical and psychological consequences, including obesity, diabetes, depression, and low self-esteem.

Ozempic Role in Treating Diabetes and Weight Management

Ozempic, a medication developed for diabetes treatment and weight management, is crucial in managing these conditions. As a once-weekly injectable glucagon-like peptide-1 (GLP-1) receptor agonist, Ozempic helps control blood sugar levels by stimulating insulin production and reducing glucagon secretion.

It also slows down digestion and lowers appetite, aiding in weight loss. In the treatment of type 2 diabetes, Ozempic offers significant benefits. It not only lowers A1C levels but also reduces the risk of cardiovascular events.

The drug promotes weight loss, making it an ideal choice for individuals with diabetes who struggle with obesity. Moreover, its once-weekly dosing regimen ensures convenience and better compliance.

When it comes to weight management, Ozempic has shown promising results.

make healthier food choices and adopt a more active lifestyle.

Connection Between Diabetes and Binge Eating Disorder

The connection between diabetes and binge eating disorder is complex and multifaceted. Research suggests that individuals with BED may be at a higher risk of developing type 2 diabetes due to the potential weight gain resulting from binge eating behaviors.

Binge eating can lead to obesity and insulin resistance, increasing the likelihood of developing diabetes. Moreover, managing diabetes while dealing with BED can be challenging, as irregular eating patterns and excessive consumption of high-sugar foods can disrupt blood sugar control.

How Ozempic Works for Binge Eating Disorder

Ozempic helps regulate hormones and curb binge eating behaviors, offering hope to individuals struggling with this disorder.

Regulate Hormones

Ozempic regulates hormones, specifically glucagon-like peptide-1 (GLP-1), in the body. GLP-1 plays a crucial role in appetite control and satiety. By increasing GLP-1 levels, Ozempic helps regulate insulin release, stabilizing blood sugar levels and reducing food cravings.

Curb Binge Eating Behaviors

Ozempic curbs binge eating behaviors. It promotes a feeling of fullness and reduces the urge to overeat. By activating the GLP-1 receptors in the brain, Ozempic helps individuals with BED gain better control over their eating habits and reduces the

Clinical studies have demonstrated the effectiveness of Ozempic in reducing binge eating episodes and improving overall eating disorder symptoms. However, Ozempic should only be used under the guidance of a healthcare professional, as it may have side effects and requires close monitoring.

Side Effects of Ozempic

Ozempic can be an effective treatment option for many individuals with binge eating disorders, be aware of potential side effects that may occur.

Here are some common side effects associated with Ozempic:

- **Gastrointestinal Issues:** One of the most commonly reported serious side effects of Ozempic is gastrointestinal discomfort. This may include nausea, vomiting, diarrhea, or constipation. These symptoms are usually mild and improve over time as the body adjusts to the medication.
- **Hypoglycemia:** Ozempic lowers blood sugar levels, occasionally resulting in hypoglycemia or low blood sugar. Symptoms of hypoglycemia include dizziness, sweating, confusion, and shakiness. It is important to monitor blood sugar levels regularly and be prepared with a source of glucose, such as candies or glucose tablets, in case of a hypoglycemic episode.
- **Injection Site Reactions:** Since Ozempic is administered via subcutaneous injections, some individuals may experience injection site reactions. These can include pain, redness, itching, or swelling at the injection site. Proper injection techniques and rotating injection sites can help minimize these reactions.
- **Thyroid Tumors:** In rare cases, Ozempic has been associated with thyroid tumors in rodents during preclinical studies. However, the significance of this finding in humans is still unclear, and further research is needed to determine the potential risks in humans.
- **Allergic Reactions:** Although rare, allergic reactions to Ozempic can occur.

immediate medical attention should be sought.

Risks of Off-Label Use

Ozempic was approved by the U.S. Food and Drug Administration (FDA) for treating type 2 diabetes. However, when medications are used for purposes other than those approved by regulatory authorities, it is known as off-label use. Off-label use of Ozempic can carry certain risks and potential side effects.

Here are some important considerations regarding the risks of the off-label use of Ozempic:

- **Lack of Scientific Evidence:** Off-label use means that the medication is being used in a manner not specifically studied or approved by the FDA. As a result, there may be limited or no scientific evidence regarding the safety and efficacy of Ozempic for the specific off-label purpose. It is challenging to accurately determine the potential risks and benefits without proper clinical trials and research.
- **Adverse Reactions:** The side effects of off-label use of Ozempic may differ from those observed according to approved indications. Certain patient populations or medical conditions may be more susceptible to experiencing adverse reactions when using the medication off-label. It is crucial to consult a healthcare professional before considering off-label use to understand the potential risks.
- **Drug Interactions:** When Ozempic is used off-label with other medications, drug companies claim that there is an increased risk of drug interactions. These interactions can lead to unpredictable effects on the body and potentially result in adverse events or reduced effectiveness of one or both medications. It is essential to inform your clinical education specialists about all the medications you are taking to minimize the risk of drug interactions.
- **Safety Concerns:** Off-label use may involve higher doses, different dosing

developing serious adverse effects and health risks like kidney and heart disease. Without proper monitoring and guidance from a healthcare professional, the safety of the off-label use of Ozempic may be compromised.

- **Legal and Ethical Considerations:** While off-label use of medications is legal and sometimes necessary, healthcare professionals and experts must carefully evaluate the risks and benefits before prescribing medications off-label. The decision to use Ozempic off-label should be based on sound medical judgment, consideration of the available evidence, and a thorough understanding of the patient's individual needs.

Proven Treatments for Binge Eating Disorder

BED affects millions worldwide and can have significant physical and psychological consequences. Studies have shown its efficacy in weight loss, making it a promising option for those seeking weight-loss medications.

Fortunately, several proven treatments have shown effectiveness in addressing this disorder.

Cognitive Behavioral Therapy (CBT)

CBT is a widely recognized and evidence-based treatment for BED. It focuses on identifying and changing the negative thoughts and behaviors associated with binge eating. CBT helps users develop coping strategies, manage triggers, and establish healthier eating patterns.

Therapists work with patients to challenge distorted beliefs about food and body image, ultimately promoting long-term recovery.

Dialectical Behavioral Therapy (DBT)

personality disorder. It combines individual therapy, group skills training, and phone coaching to enhance emotional regulation and mindfulness.

DBT teaches patients, especially young people, to tolerate distress and manage emotions without resorting to binge eating. It empowers individuals to develop healthy coping mechanisms and build a more balanced life.

Inpatient Treatment

An inpatient treatment facility may be recommended for people with binge eating disorder. This involves round-the-clock care in a specialized facility, providing a structured environment and a multidisciplinary approach.

Inpatient programs focus on medical stabilization, nutritional rehabilitation, individual and group therapy, and ongoing monitoring. They offer a comprehensive treatment plan to address the complex needs of individuals struggling with BED.

Support Groups

Support groups are crucial in providing individuals with BED a sense of community and understanding. These groups bring together people with similar experiences and offer a safe space to discuss challenges related to health issues, share strategies, and gain support.

Peer support can alleviate isolation, provide motivation, and encourage accountability.

Frequently Asked Questions (FAQ)

Can you overeat on Ozempic?

appetite and promoting weight loss. However, it is still possible to overeat while taking Ozempic. It's important to follow a healthy diet and portion control to maximize the benefits of the medication and maintain a balanced lifestyle.

Can Ozempic be combined with other treatments or therapies for binge eating disorder?

Ozempic is not approved for treating binge eating disorder (BED). It is primarily indicated for treating type 2 diabetes. However, the best treatment for BED often involves a multimodal approach that may include psychotherapy, medication, and lifestyle changes.
Consult a doctor or health care professional for the most up-to-date information and personalized recommendations.

How does Ozempic work in controlling binge eating episodes and reducing food intake?

Ozempic activates specific receptors in the brain that regulate appetite and food intake. By stimulating these receptors, Ozempic helps control binge eating episodes and reduces food intake.
It promotes feelings of fullness, reduces cravings, and improves the overall regulation of eating behavior, reducing binge eating episodes.

Break Free from Binge Eating at Indiana Center for Recovery

Embark on the path to recovery and reclaim your life at Indiana Center for Recovery. Our dedicated team of professionals is here to guide you on your journey toward overcoming mental health issues and achieving lasting mental wellness.

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AMERICAN PSYCHIATRIC ASSOCIATION

What are Eating Disorders?

Eating disorders are behavioral conditions characterized by severe and persistent disturbance in eating behaviors and associated distressing thoughts and emotions. They can be very serious conditions affecting physical, psychological and social function. Types of eating disorders include anorexia nervosa, bulimia nervosa, binge eating disorder, avoidant restrictive food intake disorder, other specified feeding and eating disorder, pica and rumination disorder.

Taken together, eating disorders affect up to 5% of the population, most often develop in adolescence and young adulthood. Several, especially anorexia nervosa and bulimia nervosa are more common in women, but they can all occur at any age and affect any gender. Eating disorders are often associated with preoccupations with food, weight or shape or with anxiety about eating or the consequences of eating certain foods. Behaviors associated with eating disorders including restrictive eating or avoidance of certain foods, binge eating, purging by vomiting or laxative misuse or compulsive exercise. These behaviors can become driven in ways that appear similar to an addiction.

Eating disorders affect several million people at any given time, most often **women between the ages of 12 and 35**. There are several types of eating disorders. The most common are anorexia nervosa, bulimia nervosa, binge eating disorder, avoidant restrictive food intake disorder (ARFID) and other specified feeding and eating disorder (OSFED).

Eating disorders often co-occur with other psychiatric disorders most commonly, mood and anxiety disorders, obsessive-compulsive disorder, and alcohol and substance use disorders. Evidence suggests that genes and heritability play a part in why some people are at higher risk for an eating disorder, but these disorders can also afflict those with no family history of the condition. Treatment should address psychological, behavioral, nutritional and other medical complications. The latter can include consequences of malnutrition or of purging behaviors including, heart and gastrointestinal problems as well as other potentially fatal conditions. Ambivalence towards treatment, denial of a problem with eating and weight, or anxiety about changing eating patterns is not uncommon. With proper medical care, however, those with eating disorders can resume healthy eating habits, and recover their emotional and psychological health.

Types of Eating Disorders

Anorexia Nervosa

Anorexia nervosa is characterized by self-starvation and weight loss resulting in low weight for height and age. Anorexia has the highest mortality of any psychiatric diagnosis other than opioid use disorder and can be a very serious condition. Body mass index or BMI, a measure of weight for height, is typically under 18.5 in an adult individual with anorexia nervosa.

Dieting behavior in anorexia nervosa is driven by an intense fear of gaining weight or becoming fat. Although some individuals with anorexia will say they want and are trying to gain weight, their behavior is not consistent with this intent. For example, they may only eat small amounts of low-calorie foods and exercise excessively. Some persons with anorexia nervosa also intermittently binge eat and or purge by vomiting or laxative misuse.

There are two subtypes of anorexia nervosa:

- **Restricting type**, in which individuals lose weight primarily by dieting, fasting or excessively exercising.
- **Binge-eating/purging type** in which persons also engage in intermittent binge eating and/or

purging behaviors.

Over time, some of the following symptoms may develop related to starvation or purging behaviors:

- Menstrual periods cease
- Dizziness or fainting from dehydration
- Brittle hair/nails
- Cold intolerance
- muscle weakness and wasting
- Heartburn and reflux (in those who vomit)
- Severe constipation, bloating and fullness after meals
- Stress fractures from compulsive exercise as well as bone loss resulting in osteopenia or osteoporosis (thinning of the bones)
- Depression, irritability, anxiety, poor concentration and fatigue

Serious medical complications can be life threatening and include heart rhythm abnormalities especially in those patients who vomit or use laxatives, kidney problems or seizures.

Treatment for anorexia nervosa involves helping those affected normalize their eating and weight control behaviors and restore their weight. Medical evaluation and treatment of any co-occurring psychiatric or medical conditions is an important component of the treatment plan. The nutritional plan should focus on helping individuals counter anxiety about eating and practice consuming a wide and balanced range of foods of different calorie densities across regularly spaced meals. For adolescents, the and emerging adults, most effective treatments involve helping parents to support and monitor their child's meals. Addressing body dissatisfaction is also important but this often takes longer to correct than weight and eating behavior.

In the case of severe anorexia nervosa when outpatient treatment is not effective, admission to an inpatient or residential behavioral specialty program may be indicated. Most specialty programs are effective in restoring weight and normalizing eating behavior, although the risk of relapse in the first year following program discharge remains significant.

EATING DISORDERS

Guidance for Patients, Families, and Friends

AMERICAN PSYCHIATRIC ASSOCIATION

View the Patient/Family Guide

Bulimia Nervosa

Individuals with bulimia nervosa typically alternate dieting, or eating only low calorie “safe foods” with binge eating on “forbidden” high calorie foods. Binge eating is defined as eating a large amount of food in a short period of time associated with a sense of loss of control over what, or how much one is eating. Binge behavior is usually secretive and associated with feelings of shame or embarrassment. Binges may be very large and food is often consumed rapidly, beyond fullness to the point of nausea and discomfort.

Binges occur at least weekly and are typically followed by what are called "compensatory behaviors" to prevent weight gain. These can include fasting, vomiting, laxative misuse or compulsive exercise. As in anorexia nervosa, persons with bulimia nervosa are excessively preoccupied with thoughts of food, weight or shape which negatively affect, and disproportionately impact, their self-worth.

Individuals with bulimia nervosa can be slightly underweight, normal weight, overweight or even obese. If they are significantly underweight however, they are considered to have anorexia nervosa binge-eating/purging type not bulimia nervosa. Family members or friends may not know that a person has bulimia nervosa because they do not appear underweight and because their behaviors are hidden and may go unnoticed by those close to them. Possible signs that someone may have bulimia nervosa include:

- Frequent trips to the bathroom right after meals
- Large amounts of food disappearing or unexplained empty wrappers and food containers
- Chronic sore throat
- Swelling of the salivary glands in the cheeks
- Dental decay resulting from erosion of tooth enamel by stomach acid
- Heartburn and gastroesophageal reflux
- Laxative or diet pill misuse
- Recurrent unexplained diarrhea
- Misuse of diuretics (water pills)
- Feeling dizzy or fainting from excessive purging behaviors resulting in dehydration

Bulimia can lead to rare but potentially fatal complications including esophageal tears, gastric rupture, and dangerous cardiac arrhythmias. Medical monitoring in cases of severe bulimia nervosa is important to identify and treat any possible complications.

Outpatient cognitive behavioral therapy for bulimia nervosa is the treatment with the strongest evidence. It helps patients normalize their eating behavior and manage thoughts and feelings that perpetuate the disorder. Antidepressants (e.g. fluoxetine) can also be helpful in decreasing urges to

binge and vomit. Eating disorder focused family based treatment which involves providing caregivers with information on how to assist an adolescent or young adult to normalize their eating pattern may also be helpful in the treatment of young people with bulimia nervosa.

Binge Eating Disorder

As with bulimia nervosa, people with binge eating disorder have episodes of binge eating in which they consume large quantities of food in a brief period, experience a sense of loss of control over their eating and are distressed by the binge behavior. Unlike people with bulimia nervosa however, they do not regularly use compensatory behaviors to get rid of the food by inducing vomiting, fasting, exercising or laxative misuse. Binge eating disorder can lead to serious health complications, including obesity, diabetes, hypertension and cardiovascular diseases.

The diagnosis of binge eating disorder requires frequent binges (at least once a week for three months), associated with a sense of lack of control and with three or more of the following features:

- Eating more rapidly than normal.
- Eating until uncomfortably full.
- Eating large amounts of food when not feeling hungry.
- Eating alone because of feeling embarrassed by how much one is eating.
- Feeling disgusted with oneself, depressed or very guilty after a binge.

As with bulimia nervosa, the most effective treatment for binge eating disorder is either individual or group-based cognitive behavioral psychotherapy for binge eating. Interpersonal therapy has also been shown to be effective, as have several antidepressant medications and lisdexamfetamine..

Other Specified Feeding and Eating Disorder

This diagnostic category includes eating disorders or disturbances of eating behavior that cause distress and impair family, social or work function but do not fit the other categories listed here. In some cases, this is because the frequency of the behavior does not meet the diagnostic threshold (e.g., the frequency of binges in bulimia or binge eating disorder) or the weight criteria for the diagnosis of anorexia nervosa are not met.

An example of other specified feeding and eating disorder is "atypical anorexia nervosa". This

category includes individuals who may have lost a lot of weight and whose behaviors and preoccupation with weight or shape concerns and fear of fatness is consistent with anorexia nervosa, but who are not yet considered underweight based on their BMI because their baseline weight was above average.

Since speed of weight loss is related to medical complications, individuals with atypical anorexia nervosa who lose a lot of weight rapidly by engaging in extreme weight control behaviors can be at high risk of medical complications, despite appearing normal or above average weight.

Avoidant Restrictive Food Intake Disorder (ARFID)

ARFID is a recently defined eating disorder that involves a disturbance in eating resulting in persistent failure to meet nutritional needs and extreme picky eating. In ARFID, food avoidance or a limited food repertoire can be due to one or more of the following:

- Low appetite and lack of interest in eating or food.
- Extreme food avoidance based on sensory characteristics of foods e.g. texture, appearance, color, smell.
- Anxiety or concern about consequences of eating, such as fear of choking, nausea, vomiting, constipation, an allergic reaction, etc. The disorder may develop in response to a significant negative event such as an episode of choking or food poisoning followed by the avoidance of an increasing variety of foods.

The diagnosis of ARFID requires that difficulties with eating are associated with one or more of the following:

- Significant weight loss (or failure to achieve expected weight gain in children).
- Significant nutritional deficiency.
- The need to rely on a feeding tube or oral nutritional supplements to maintain sufficient nutrition intake.
- Interference with social functioning (such as inability to eat with others).

The impact on physical and psychological health and degree of malnutrition can be similar to that seen in people with anorexia nervosa. However, people with ARFID do not have excessive concerns about their body weight or shape and the disorder is distinct from anorexia nervosa or bulimia nervosa. Also, while individuals with autism spectrum disorder often have rigid eating behaviors and sensory sensitivities, these do not necessarily lead to the level of impairment required for a diagnosis of avoidant/restrictive food intake disorder.

ARFID does not include food restriction related to lack of availability of food; normal dieting; cultural practices, such as religious fasting; or developmentally normal behaviors, such as toddlers who are picky eaters.

Food avoidance or restriction commonly develops in infancy or early childhood and may continue in adulthood. It can however start at any age. Regardless of the age of the person affected, ARFID can impact families, causing increased stress at mealtimes and in other social eating situations.

Treatment for ARFID involves an individualized plan and may involve several specialists including a mental health professional, a registered dietitian nutritionist, and others.

Pica

Pica is an eating disorder in which a person repeatedly eats things that are not food with no nutritional value. The behavior persists over at least one month and is severe enough to warrant clinical attention.

Typical substances ingested vary with age and availability and might include paper, paint chips, soap, cloth, hair, string, chalk, metal, pebbles, charcoal or coal, or clay. Individuals with pica do not typically have an aversion to food in general.

The behavior is inappropriate to the developmental level of the individual and is not part of a culturally supported practice. Pica may first occur in childhood, adolescence, or adulthood, although childhood onset is most common. It is not diagnosed in children under age 2. Putting small objects into their mouth is a normal part of development for children under 2. Pica often occurs along with autism spectrum disorder and intellectual disability, but can occur in otherwise typically developing children.

A person diagnosed with pica is at risk for potential intestinal blockages or toxic effects of substances consumed (e.g. lead in paint chips).

Treatment for pica involves testing for nutritional deficiencies and addressing them if needed. Behavior interventions used to treat pica may include redirecting the individual from the nonfood items and rewarding them for setting aside or avoiding nonfood items.

Rumination Disorder

Rumination disorder involves the repeated regurgitation and re-chewing of food after eating whereby swallowed food is brought back up into the mouth voluntarily and is re-chewed and re-

swallowed or spat out. Rumination disorder can occur in infancy, childhood and adolescence or in adulthood. To meet the diagnosis the behavior must:

- Occurs repeatedly over at least a 1-month period
- Not be due to a gastrointestinal or medical problem
- Not occur as part of one of the other behavioral eating disorders listed above
- Rumination can also occur in other mental disorders (e.g. intellectual disability) however the degree must be severe enough to warrant separate clinical attention for the diagnosis to be made.

Physician Review

Angela Guarda, M.D.
February 2023

Additional Resources

- National Eating Disorders Association (NEDA)
- Centers for Disease Control and Prevetion - Growth charts
- Families Empowered And Supporting Treatment for Eating Disorders
- Academy for Eating Disorders

Medical leadership for mind, brain and body.

One woman lost 30 pounds in 4 months on semaglutide. The drug ended years of binge-eating and weight cycling.

Rachel Hosie Apr 13, 2023, 8:20 AM MST

Lana Rodriguez before (left) and after losing 20 pound with semaglutide. Lana Rodriguez

Lana Rodriguez had struggled with binge eating for years, regularly turning to food for comfort.

It hasn't been a problem since she started taking weight loss drug semaglutide, she said.

She lost 30 pounds in four months and says the drug is the best thing that's ever happened to her.

Lana Rodriguez loved food. It was how she coped with stress, happiness, or sadness.

"I find comfort in food," the 37-year-old who works in real estate told Insider.

But Rodriguez, from Colorado Springs, struggled with binge eating for seven years, which caused her to gain and lose weight repeatedly.

After a particularly bad binge in September 2022, she wondered if the buzzy new weight loss drug semaglutide, which her friend had

told her about a month prior, could help.

Known by the brand names Ozempic for diabetes and Wegovy for weight loss, semaglutide is usually taken as weekly injection and works by suppressing appetite. It originated as a diabetes medication but was FDA-approved to treat obesity in 2021 and has become so popular there have been shortages and rumors that celebrities are taking it.

Confusingly, Ozempic has become the byword for the once-weekly shot regardless of which version of the drug they are taking.

Rodriguez did some research, contacted a doctor, and "never looked back."

"It's the best thing that's happened to me," she said.

Rodriguez started taking semaglutide as a weekly injection in September 2022. By January 2023, she had lost 30 pounds and was happy in her body so has since transitioned to one shot every two weeks with the hope of maintaining her weight.

Rodriguez no longer eats for comfort

In her first week on the drug, Rodriguez experienced anxiety and nausea and still felt hungry, but this faded when she stopped taking a vitamin B12 supplement she was using at the same time. There is no evidence that vitamin B12 supplements interact with semaglutide.

Not long after, she was eating some leftover mac and cheese and noticed it stopped tasting good after after four or five mouthfuls.

"It tasted like rubber" and was the "weirdest feeling ever," she said, adding that semaglutide has made everything taste different.

She also no longer craves things she used to, like Sprite or alcohol. And while she used to eat her own meals and finish her kids', she's now "full and content" after eating half of her own.

Rodriguez no longer looks forward to food like she used to, which is both a blessing and a curse, she said. She neither has the excitement, nor the stress or guilt, associated with eating. Going out to eat is now more about socializing than the food, she said.

"The best thing this medication has done is cutting the emotional attachment to food," she said.

Lana Rodriguez before and after losing weight with semaglutide. Lana Rodriguez

Semaglutide side effects included constipation, nausea, and headaches

Side effects of semaglutide include bloating, nausea, and stomach cramps. In Rodriguez's case, she got a dry mouth and tasted bitterness after each injection

For the first month, Rodriguez had nausea, headaches, and constipation so started taking a probiotic to help her bowel movements. The FDA approved a 2.4mg weekly dose of semaglutide, but you start at a much lower dose and gradually build up over months. When Rodriguez increased the dosage too quickly, she was "sick as a dog" and threw up every day, but then went back down briefly and was OK, she said.

Drinking a protein shake in the morning helps with the nausea, Rodriguez said.

She noticed she had less of an appetite within a day or two of taking the weekly shot, she said.

Her hunger returns as the drug wears off

Semaglutide has been "amazing" for Rodriguez. She's scared of her hunger coming back and notices it returning when the drug wears off towards the end of each biweekly injection.

"I don't like that feeling, I don't miss that feeling," she said.

Rodriguez pays $200 per shot. She admits this is expensive, but feels safe in the knowledge that she gets her medication from an in-person doctor who is there to answer any questions, unlike her friends who've ordered the drug online for less don't have that, she said.

Rodriguez hopes to gradually reduce the frequency of her doses further, going down to once every three weeks then hopefully four — provided she can maintain her weight. She's waiting to see, however, how she feels and whether her urges to comfort eat return.

"I'm in a much better place and I would like to do whatever it takes to stay here," Rodriguez said.

Read next

Watch:

People on Drugs Like Ozempic Say Their 'Food Noise' Has Disappeared

For some, it's a startling side effect.

By Dani Blum

June 21, 2023

Until she started taking the weight loss drug Wegovy, Staci Klemmer's days revolved around food. When she woke up, she plotted out what she would eat; as soon as she had lunch, she thought about dinner. After leaving work as a high school teacher in Bucks County, Pa., she would often drive to Taco Bell or McDonald's to quell what she called a "24/7 chatter" in the back of her mind. Even when she was full, she wanted to eat.

Almost immediately after Ms. Klemmer's first dose of medication in February, she was hit with side effects: acid reflux, constipation, queasiness, fatigue. But, she said, it was like a switch flipped in her brain — the "food noise" went silent.

"I don't think about tacos all the time anymore," Ms. Klemmer, 57, said. "I don't have cravings anymore. At all. It's the weirdest thing."

Dr. Andrew Kraftson, a clinical associate professor at Michigan Medicine, said that over his 13 years as an obesity medicine specialist, people he treated would often say they couldn't stop thinking about food. So when he started prescribing Wegovy and Ozempic, a diabetes medication that contains the same compound, and patients began to use the term food noise, saying it had disappeared, he knew exactly what they meant.

As interest has intensified around Ozempic and other injectable diabetes medications like Mounjaro, which works in similar ways, that term has gained traction. Videos related to the subject "food noise explained" have been viewed 1.8 billion times on TikTok. And some of the people who have managed to get their hands on these medications — despite persistent shortages and list prices that can near or surpass a thousand dollars — have shared stories on social media about their experiences.

When food noise fades

Wendy Gantt, 56, said she first heard the term food noise on TikTok, where she had also learned about Mounjaro. She found a telehealth platform and received a prescription within a few hours. She can remember the first day she started taking it last summer. "It was like a sense of freedom from that loop of, 'What am I going to eat? I'm never full; there's not enough. What can I snack on?'" she said. "It's like someone took an eraser to it."

For some, the shortages of these medications have provided a test case, a way to see their lives with and without food noise. Kelsey Ryan, 35, an insurance broker in Canandaigua, N.Y., hasn't been able to fill her Ozempic prescription for the last few weeks, and the noise has crept back in. It's not just the pull of soft-serve each day, she said. Food noise, to Ms. Ryan, also means a range of other food-related thoughts: internal negotiations about whether to eat in front of other people, wondering if they'll judge her for eating fried chicken or if ordering a salad makes it look like she's trying too hard. Ozempic is more of a way to silence the food noise than anything else, she said.

"It's a tool," she said. "It's not like a magic drug that's giving people an easy way out."

What causes food noise?

There is no clinical definition for food noise, but the experts and patients interviewed for this article generally agreed it was shorthand for constant rumination about food. Some researchers associate the concept with "hedonic hunger," an intense preoccupation with eating food for the purpose of pleasure, and noted that it could also be a component of binge eating disorder, which is common but often misunderstood.

Obesity medicine specialists have tried to better understand why a person may ruminate about food for some time, said Dr. Robert Gabbay, chief scientific and medical officer of the American Diabetes Association. "It just seems to be that some people are a little more wired this way," he said. Obsessive rumination about food is most likely a result of genetic factors as well as environmental exposure and learned habits, said Dr. Janice Jin Hwang, chief of the division of endocrinology and metabolism at the University of North Carolina School of Medicine.

Why some people can shake off the impulse to eat, and other people stay mired in thoughts about food, is "the million-dollar question," Dr. Hwang said.

How does medication suppress food noise?

The active ingredient in Ozempic and Wegovy is semaglutide, a compound that affects the areas in the brain that regulate appetite, Dr. Gabbay said; it also prompts the stomach to empty more slowly, making people taking the medication feel fuller faster and for longer. That satiation itself could blunt food noise, he said.

There's another theoretical framework for why Ozempic might quash food noise: Semaglutide

activates receptors for a hormone called GLP-1. Studies in animals have shown those receptors are found in cells in regions of the brain that are particularly important for motivation and reward, pointing to one potential way semaglutide could influence cravings and desires. It's possible, although not proven, that the same happens in humans, Dr. Hwang said, which could explain why people taking the medication sometimes report that the food (and, in some cases, alcohol) they used to crave no longer gives them joy.

Researchers are continuing to investigate how semaglutide works, how it may influence aspects of the brain like food noise and the potential it has for other uses, like treating addiction.

Ms. Klemmer said she worried about the potential long-term side effects of a medication she might be on for the rest of her life. But she thinks the trade-off — the end of food noise — is worth it. "It's worth every bad side effect that I'd have to go through to have what I feel now," she said: "not caring about food."

Dani Blum is a reporter for Well. More about Dani Blum

A version of this article appears in print on , Section D, Page 6 of the New York edition with the headline: Drugs to Help Quiet 'Food Noise'

Who Can Perform Semaglutide Treatments?

Posted By *Madilyn Moeller*, **Thursday, August 3, 2023**

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By Patrick O'Brien, JD, General Counsel, American Med Spa Association (AmSpa)

With the great popularity of weight loss treatments using GLP-1 receptor agonists such as semaglutide, AmSpa has received a number of questions regarding what rules to follow in offering these treatments. Although a few states do have rules on appropriate practice for weight loss

treatments, for the most part, states do not have special rules on policies and procedures for specific medications (controlled substances being the major exception). However, that doesn't mean that there aren't any rules involved. These are still FDA-approved drugs requiring a prescription to provide to a patient, and licensed prescribers—such as physicians, physician assistants (PAs) and advanced practice registered nurses (APRNs)—must still adhere to their professional ethical obligations and the standard of practice for their profession. Here is the basic framework for providing weight loss medical treatments.

In general, a prescriber-patient relationship must be established, the prescriber must perform an appropriate examination of the patient (commonly called a **good faith exam**), and then the prescriber must develop a diagnosis of the patient's condition and order an appropriate treatment. After the patient has given their informed consent to the treatment, the actual provision of the treatment can usually be delegated to others.

Licensed health care professionals owe a special duty to those they have undertaken to treat. This special duty applies when certain elements are met and a prescriber-patient relationship is established. The rules on what elements are needed vary between states, but, in general, there needs to be a person seeking health care and a health care provider who agrees to treat the person. This may seem obvious, but it is critical to understand that if the physician, APRN or PA has never met or interacted with the person in a sufficient way, they can't prescribe them treatments or medication.

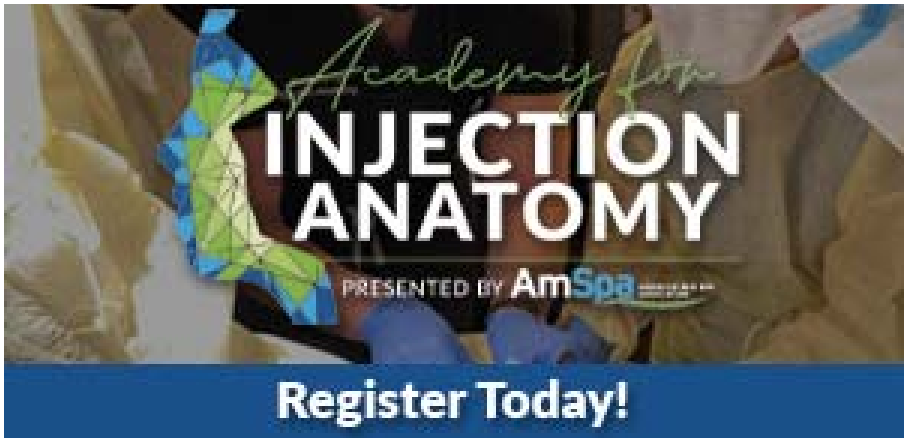
We next have to consider the good faith exam. It is important to understand that "good faith exam" is jargon; it's a term for the larger patient assessment/examination concept that is present in all states. At this step, the practitioner owes this special duty to the patient and must gather pertinent data and evidence about the patient's condition. This can and should include taking a medical history and assessing the patient's current physical state. It also should include any tests or diagnostic procedures, including blood work, that are appropriate to get a more complete picture of the patient's condition. Again, this may seem obvious, but is also critical to the treatment process. If the patient is seeking treatment for obesity, the methods selected to treat them could be different if they also have liver, kidney or other endocrine issues, or if their body composition warrants a certain treatment. To put it another way, would it be appropriate to give penicillin to someone without first checking to see if they had an allergy?

Most states allow physicians and other health professionals to provide services remotely via telehealth or telemedicine. Of course, requirements differ between states, but most require that telehealth services meet the same **standard of care** as in-person services. So, if there is a test or measurement or observation that is appropriate if the patient was being seen in-office, it is likely that will need to be adequately replicated when using an audio/video telehealth system.
Now that evidence and data about
the patient and their symptoms have [redacted]

been gathered, the practitioners bring their professional training, knowledge and judgement to bear by diagnosing the patient's condition and considering appropriate methods of treatment. While conceptually this is a discrete step, it is often overlooked or lumped in with other parts of the process. In practice, this makes complete sense, as we naturally form an early hypothesis and then refine and test that hypothesis through the observation and testing stage before drawing a conclusion (the diagnosis).

For weight loss treatments, the patient may come in with an expressed desire to start semaglutide treatment to lose weight, and that may initially appear like a viable option. But, at this point, this is just a theory or hunch—not enough to base a professional judgement on. However, with a review of their medical history, examination of their current state of health, and search for indications and contraindications, there is a concrete basis to determine what the patient's condition is and if they may be helped by this semaglutide treatment. With that, the practitioner can discuss the risks of the treatment with the patient and obtain their informed consent.

Once all the above steps have been taken. the actual rendering of the



treatment—i.e., injecting the medicine—can likely be delegated to a trained staff member. State rules vary on what licensing and training is needed for this person and the rules under which they may perform the task. Some states limit administering medications to only licensed registered nurses (RNs) or practical/vocational nurses (LPNs/LVNs), but many states allow unlicensed medical assistants to perform this task, as well. All states require that the delegated person act under the supervision of the prescribing practitioner and may additionally need to be guided by standardized procedures or protocols if the practitioner is not present. Additionally, many states require that prescribers provide the option of issuing a written or electronic prescription as an alternative to directly administering the medication. State rules usually favor patient choice on filling prescriptions and dislike requiring they be locked into any one source.

While specific state rules governing these treatments are rare, they do exist and are important for practitioners to be aware of. For example, the Florida Board of Medicine has rules on prescription obesity treatments. Under these, the physician, PA or APRN must perform an initial evaluation that includes a physical and complete history, tests related to medical treatment for weight loss, and medical referrals as indicated by the physical examination, history and testing. Re-evaluations are needed every three months. Practitioners may only prescribe medication for weight loss if the patient has a body mass index (BMI) over 30 or a BMI of 27 or above and at least one comorbidity. The patient's informed consent must be obtained prior to prescribing treatment. There are additional rules about what types of drugs are permitted, advertising standards, and notices and documentation.

In essence, offering medication-assisted weight loss, such as semaglutide, is not all that different from treating a patient's condition with any other prescription medication. Likewise, it is important not to skip over the requirements, steps and standards needed in prescribing these medications. This is especially true because of the ubiquity of the symptoms. Nearly everyone wishes they could lose a few pounds or be slimmer. But, even with extremely common conditions the physicians, PAs, and APRNs must still adhere to their professional duties and responsibilities when treating patients.

Compliance issues such as these are covered in detail at AmSpa's Medical Spa Boot Camps. Make plans to attend one today.

Discover more about compounding pharmacies, legal issues at play and prescriber perspectives when you visit AmSpa's Medical Aesthetic Semaglutide Resource Center at https://americanmedspa.org/med-spa-semaglutides.

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224 N Desplaines, Ste. 300

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