Correspondence

Letter by Hendricks Regarding Article, “Obesity and Cardiovascular Disease”

To the Editor:

A recent Clinician Update by Apovian and Gokce,1 using a case report as an introduction, provides a succinct review of the relationship between obesity and cardiovascular disease, treatment of obesity, and the cardiovascular benefits of weight loss. The authors suggest that the only effective treatment for obesity is surgical and that current medical treatment is inferior, flawed by dangerous medicines. In their discussion of obesity drugs, Apovian and Gokce impugn phentermine. Readers of Circulation should be aware that a majority of American obesity treatment specialists do not share this negative view of current medical treatment for obesity nor do they share this view of the safety of phentermine.

Although it is not as effective as surgery for the extremely obese, medical treatment has been proven effective because even modest weight loss, if maintained, can reduce morbidity in the obese patient. These demonstrable reductions in morbidity can be expected to reduce mortality as well. Average weight loss approaches 20% at 1 year in some medical clinics treating patients with lifestyle, diet, and pharmacotherapy. Recently published data suggests long-term medical treatment that includes phentermine pharmacotherapy can achieve an average of 10% weight loss for as long as 7 years, with persisting declines in blood pressure among hypertensive and pre-hypertensive patients.2

If medical treatment is effective, why does such a small percentage of obese individuals seek medical care? One part of the answer to this question is that comments denigrating medical treatment and obesity drugs continually appear both in the peer-reviewed medical literature and in the public press. Such commentary typically ignores the real benefits of medically induced weight loss and places exaggerated emphasis on what are mostly theoretical risks of obesity drugs. The article by Apovian and Gokce is no exception. The authors suggest phentermine treatment was partly causal in a case of new-onset atrial fibrillation yet ignore the fact that a body mass index of 85 kg/m2 is a major risk factor for atrial fibrillation.3 There are no other reports suggesting any association between atrial fibrillation and phentermine.

Phentermine, the most widely used drug for treating obesity, is far safer than is commonly assumed. There are isolated anecdotes suggesting associations of phentermine with adverse cardiovascular events and that phentermine commonly raises blood pressure, but there is no published data to support either of these suppositions. Indeed, data from published reports more often show that phentermine lowers blood pressure.4–6 Clinical trials with topiramate and phentermine combined showed declines in blood pressure in hypertensive patients, and cardiovascular events were rare.5

Our patients desperately need new medicines, but as we await these, medical treatment with currently available medicines is appropriate for many millions of obese patients needing treatment. The risks associated with obesity itself far exceed any real risks associated with treatment with currently available medicines. Millions of untreated obese patients and most physicians will continue to eschew effective medical treatment until a more positive attitude is adopted by all involved in obesity treatment and research and this positive attitude is projected to the public.

Disclosures

Dr Hendricks has received honoraria from Citius Pharmaceuticals, Akrimax Pharmaceuticals, and Eurodrug Pharmaceuticals.

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References