Is It Really Your Fault? The Science of Weight Loss Resistance in Women Transcript

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Opening and Guest Introduction

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You're constantly having insulin and they add to that insulin resistance. Interestingly, though, what I clearly saw when I started working with patients is most of my patients who were struggling with their weight would come in.

They were already eating in a small eating window. They were not eating breakfast. They often wouldn't eat till lunch. They'd eat something small for lunch.

And then somewhere around dinnertime, there would be a lot of overeating that would occur. So when people already have that pattern, encouraging them to do more of that isn't going to be helpful.

Have you made it past menopause, or are you going through it now? I'm Dr. Pat McShane, and on the Women's HealthSpan Voices podcast, I'll guide you through the health challenges of the menopausal years and beyond, guiding the way to thriving in this powerful era of your womanhood.

Hello and welcome. I'm Dr. Pat McShane, and this is Women's Health Spend Voices, where we explore ways to try to make your later years as healthy and productive as possible.

We're exploring different subjects in the medical literature that you might not come across in your everyday reading. So today we have a special guest with us, Dr.

Carolyn Frankavilla, who is a physician, a family practice physician, and she also has training and certifications in obesity medicine, which is a very particular kind of practice that we're going to explore today.

And in fact, Dr. Frankavilla won the Obesity Medicine Association William McCarthy Clinician of the Year Award in 2025. So I'm sure that was very well deserved.

And I'm delighted to have you with us today, Dr. Carolyn. Thank you. Thank you for the kind words and so excited to be here. So tell us a little bit about how you ended up in practicing around weight issues.

Yeah, so I always say I was kind of a weird medical student. I think most people show up at medical school and they want to see really sick people. They want to see giant tumors.

They're really excited to learn about all of that stuff. And I just wanted to figure out how to prevent as much of it as possible. I really wanted to see people be healthy, end up in the emergency room with less heart attacks, not have diabetic foot amputations.

I really wanted to see how much of this I could prevent. And so family medicine, of course, is a natural fit because we focus a lot on preventive health there.

And I really became clear that diet and weight were really affecting a lot of the underlying disease states. I saw like type 2 diabetes, cardiovascular disease, lung disease, foot amputations, and many other things.

How Obesity Medicine Fits Into Prevention

And so on my own, I started to pursue education there. And then I discovered there was a whole specialty that existed in that field and did additional training and became board certified in obesity medicine the same year I became board certified in family medicine.

So currently your practice is in Lakewood, Colorado, which is near where I live, but you also have remote access and you're going to tell us, and it'll be in the show notes, how to get in touch with you.

So how would people reach you if they wish to? Yeah, so our clinic is in Colorado. We can see people anywhere in Colorado through telehealth, though we are in the Denver metro area.

And our clinic is Green Mountain Partners for Health. And if you spell my name right, F-R-A-N-C-A, VIAs and Victor I-L-L-A, you will find me, my resources, and all the different things that I do out in the world.

It's an uncommon name, I think, yeah. Yeah. You mentioned how important the prevention of obesity is or the treatment of obesity in many cases. And it's estimated that over 40% of adult Americans are obese.

And in the over 50 age range, The prevalence in women is even higher than in men, although sometimes people kind of go down the other side of the curve in their late 70s and 80s, maybe from poor intake of nutrients and so on.

In any case, it's an enormous problem. Finally, for the last year or two, there's been a reduction in the number of people who are obese when measured in certain ways, and that may be because of people like yourself.

and patients who are undertaking various approaches to losing weight or not gaining it as well. So I think that's definitely a good thing. One thing just to talk about at the beginning is measuring obesity or where one is on the weight spectrum.

And we've been using the BMI body mass index criterion for many, many years, but it seems like there's a couple of other ways, waist circumference and waist to height ratio and so on.

So is there anything that you would like to tell our audience about measuring things? Absolutely. So BMI has been sort of the standard metric because it's very easy.

It's just a ratio of height to weight. So those are measurements that we already got for most of our patients. So it's very easy to calculate that. But really BMI was originally intended as more of a population screening tool.

And it's pretty useful in terms of big pictures of people, but it doesn't always tell us for any individual if their weight is actually a problem. Interestingly, BMI probably more often underestimates obesity than it overestimates obesity.

So there are, of course, those people who have a higher BMI but do not have obesity. I always think of a patient I saw in residency who was a football player and his BMI was in the overweight category on his chart.

And I did his physical exam, I did his abdominal exam and he had a six pack. I was like, I don't need to do additional testing. I know you don't have obesity, right?

So the kind of newer thought though has always been my personal practice is that we shouldn't rely on BMI alone. BMI is a screening test. It might help us with populations, you know, when we look at like a whole country or a state or something like that.

But we want to figure out if weight is really affecting people's health. So we know that weight around your belly is going to have a bigger impact on your health, that visceral fat, that fat around your organs.

Why BMI Alone Is Not Enough

is what is really more of a predictor of things like type 2 diabetes and heart disease. And so one test that you recommended is that waist circumference.

That can be a helpful tool. And for women, especially older women, that is something that is a much more useful tool. What I'll see for a lot of my post-menopausal women is that they may be really frustrated by their weight and they feel like there's an issue, but they'll come in and their BMI is maybe 25 or 26, which is considered normal or really close to normal.

But if we do a waist circumference, they may have a waist circumference of 36, 38 inches, which is where we think that that weight may be a problem for them.

And they'll often have very low muscle mass in their arms or legs. They are under-muscled and then they have too much weight around their belly, the visceral fat.

And so that is someone who may benefit from a medical intervention. On the flip side, you may have someone who's very muscular, very fit, very healthy otherwise, and maybe their BMI is 26, 27, but their blood work looks great.

They're super active. They have a normal waist circumference. That patient may not need any intervention. So I think it's very important that it be customized and that we not just judge people by any number on the scale or a BMI.

I agree with that completely. One of the things that you talked about is, as we get older, our body kind of sinks downward. As women, men have this issue earlier in their lifespan than we do.

But let's back up a little bit and talk about what happens to our bodies as we go through menopause and some of the mechanisms, maybe, how that all happens.

Yeah. So of course, as we go through that menopausal transition, our estrogen levels are trending down over time to the point where they go very, very low to basically almost non-existent, right?

And estrogen is going to be very protective of our lean mass, meaning like our muscles and our bone health. And so again, that is a pattern that we'll see clinically as that women come in, they're really frustrated.

I actually just saw a woman this morning complaining about this, that they've gained weight just very specifically around their belly, even though they're doing all the same things they were doing a year ago.

So a lot of women I think get kind of gassed when they complain about this, and people will say, oh, well, surely you're not doing the same things, or maybe you're, you know, not exercising as intently, but it really does seem to be a phenomenon of menopause that body composition changes.

You gain more weight around the belly, muscle mass can decrease, and so the things you were doing, you know, at 35 may not be working as well at 45 or 50. Yeah, I've read a couple of things that the estrogen per se is instrumental in this change in our weight overall and in our weight distribution in particular.

And also muscle mass, as we tend to lose muscle mass over our lifetimes, that makes a big difference in how our bodies handle the same amount of calories that we may have been taking in when we were 35 versus 50. So maybe you could comment on that.

Yeah. And I think that affects how we feel too, right? Because the scale may not change that dramatically with that body composition, but all of a sudden pants that you were wearing don't fit anymore because of that change in where the weight is.

So yeah, certainly estrogen is playing a role there. The other thing that often happens around this time period for women is a change in insulin resistance.

And so many women around menopause will have increased insulin resistance, meaning that their cells are not responding to insulin as well. Their body has to make more insulin.

Menopause, Estrogen, and Body Composition Changes

Insulin does a few things. It makes you store fat more. It often makes you feel hungrier, makes your blood sugar go up. And so there can be these metabolic changes also that are occurring around this time period that make it harder to maintain your weight.

So let's now imagine that we have a woman who has come in to see you or is listening to this podcast today. And weight is an issue for her, both just the aesthetics of it, how she looks, how she feels, what she's able to do.

and maybe other things like her blood pressure or her glucose levels, her hemoglobin A1c, and her doc is saying, you know, we're not thrilled with where things are going with your weight.

How do you start to talk to such a woman? Yeah, first, I mean, we would have numbers, we'd have that BMI. But in our clinic, we use body composition testing.

So waist circumference is something we'll do. But body composition testing lets us find out a body fat percentage. And that can be very helpful to in making the diagnosis.

But then we want to get a full history. So I consider obesity or weight gain like any other medical condition. I'm never going to jump to a conclusion about how to treat it.

So I like to compare it to like ankle pain. If a patient came in with ankle pain, I wouldn't just say, oh, you should take Tylenol, right? I would find out why they had ankle pain.

Was it broken? Was it sprained? Did they have gout? Do they have plantar fasciitis? Is it something that's been going on a long time? Is it something new?

I would get a whole history, maybe even an x-ray or blood work to figure out what was wrong with their ankle before I told them what their treatment options were.

So I believe weight deserves the same thing. What's been the history here? Have you struggled since you were a child? Did you struggle after your first pregnancy?

Did you start to struggle with menopause? Was it all of those things? Did you struggle when you had a bad injury? and had to decrease your activity level.

Like what happened? What is that person's story? Because that may direct us towards what treatments are going to make the most sense. And then we look at some of the things you mentioned.

What else is going on related to weight, if anything? What does the cholesterol panel look like? What does blood sugar look like? Is there pre-diabetes or diabetes going on?

Is liver health and kidney health good, or does that need to be optimized? Does this patient have hypothyroidism, which may be contributing? So we're going to do a very thorough workup for that person to figure out what else is going on.

Then we'll find out some lifestyle things. What's nutrition like? Does it make sense? Nutrition patterns often have to change over the course of our lifetime.

A lot of us can eat whatever we want as teenagers. Maybe in our 20s and 30s, we pay a little more attention, eat less fast food. But then as we get older, focusing more on protein often becomes really, really important.

So sometimes that diet that was healthy and working for you in your 30s and 40s, maybe even 50s, is not serving you as you get older. or have a different health change.

So figuring out that, getting an idea of what alcohol use is like, what exercise is like, what makes sense for this person exercise-wise. And then if there's any behavior things going on, is there a lot of stress in this person's life?

Is there poor sleep? Are they just really busy and they don't have any time to meal prep or even think about what they're eating? really looking at this comprehensive picture of why this person has experienced a change in their health or their weight and what makes sense for them.

That sounds like a marvelous approach to really get to the bottom of it with a plan that will work for more people than just, as you say, here, take some Tylenol for your ankle pain.

I love that analogy. Let's say the typical person who might have come in has been struggling for five or 10 years. They've been on multiple diets. They may have lost 20 pounds here or there, and they've tried to exercise, but that didn't really help them to lose weight.

Evaluating Weight Gain and Health Risks

I'm just making up a person whom I feel is probably typical. Sounds like most of the women I see. Let's say she's somebody who's like, oh, I don't want to think about taking medications or surgery.

What miracles do you have for me, Doc? I've tried fasting. I read something about fasting. What do you think? Do you think that might work for me? Yeah, well that was a lot of questions, but also very realistic of what people come in asking about.

The first question I really always start with is, do you need to lose weight? There is a lot of diet culture, a lot of pressure on women to always be thinner.

And actually one of the sadder things I sometimes see is when I have 60, 70 year old women come in and they're still so worried about losing five pounds that medically would not change their health trajectory.

But regardless of what age I am seeing, I'm always wondering, like, would losing weight actually change your health? Or is this just diet culture mentality, right?

Do you need to lose 10 or 20 pounds or not? And so that would be, again, looking at blood work, how the patient feels, you know, if they can't comfortably fly on an airplane, that may be a reason to lose weight, right?

So that's always the first thing. can't keep up with their grandchildren in the playground. Exactly. Is the weight causing a problem, whether that's on blood work or whether that's just in your daily living?

And if it's not, then maybe you don't actually, maybe you can let go of all that and just focus on healthy, balanced eating, activity that you enjoy, and live your life.

Most people do decide though that there would be a health benefit to weight loss. And so then really it's exploring what makes sense for this person. So getting that dietary history is helpful.

Sometimes there's a lot we can do there. Sometimes someone's already eating really healthy. And I want to take a step back because one of the most important things to understand is why it is so hard to lose weight.

So there's two things that happen when you go on a diet. And it really doesn't matter what diet it is, you're eating less on whatever diet that is, right?

So you're eating less. And when you eat less, your body does two things to respond. It decreases your metabolic rate. So this we have data on in animals, we have it in humans, and one of the kind of most interesting or most cited studies on this is from the Biggest Loser contestants.

They studied these contestants seven years after they were on the show and found out that their average decrease

in calorie burning per day was 500. So these people who had lost a ton of weight years and years before were now burning 500 calories per day less than would be expected.

Very sad. Yes. So that's what we call metabolic adaptation. Your body sees weight loss as a bad thing. And as physicians, right, like if someone comes in and they have unexplained weight loss, that's a very concerning symptom to us, right?

We're like, do you have cancer? Do you have a severe infection? Do you have a rheumatologic condition? Like, do you have AIDS? Like, why are you losing a bunch of weight unexpectedly?

It's not normal. So Our body actually does a really good job of maintaining weight, and it errs towards gaining weight. That's protective. We want to store fat for if there's a famine or we get sick, right?

Most of us don't experience that in the modern world, but our body is still programmed to gain weight. So when you do something intentionally to lose weight, your body is going to try to adapt to that, and it does that by decreasing your metabolic rate.

Some people will even feel this. That's why they may have hair loss, they may have fatigue, they may feel colder, they may have brittle nails. These are all signs that your metabolic rate has gone down.

The second thing that happens is you're actually hungrier when you've gone on a diet. So when you have gone on a diet, you, you know, you stick with it for a few weeks, a few months, and then all of a sudden it kind of feels like you just can't do it anymore.

People will come in saying like, oh, I just didn't have the willpower anymore. But it wasn't willpower. It was physiology. They are actually hungrier.

So there's a hunger hormone called ghrelin. When people are on a diet, that hormone goes up. You are hungrier than you were before the diet. And then all the hormones, there's many hormones that make you feel full and satisfied with eating, including GLP-1.

And those hormones go down when you're on a diet. So it's like this double whammy. Your metabolic rate is lower and you're hungrier. You're less full when you eat and you feel like, oh, I just can't do this anymore.

And you blame it on yourself. Society blames it on you. The diet magazines blame it on you, but it was physiology. So I always explain that to people because we have to figure out how to overcome that.

So you mentioned fasting as a strategy. Personally, I'm not the biggest fan of fasting for many people because I think it can add to that sort of diet culture mentality of just restrict more, right?

I actually just had a family member text me earlier today, what do you think about a 72 hour water fast? You know, I think for most people it's probably a bad idea.

Why Dieting Often Fails Long Term

There is a cool fasting program called ProBon where it has been scientifically studied. You eat for five days on it, but it's very scientifically designed to get you into a fasted state and get the benefits of that.

Even in programs like that, what happens is you, let's say you lose five pounds during the fast, well, you probably regain three of it as soon as you start eating again, right?

So you might have a little weight loss and then there's always a risk of losing muscle. And we really don't, there's risk of that no matter what you do, but it's a little more intensified with fasting because you're not giving your body fuel for a much longer time.

It needs to get fuel from somewhere. So I don't love a really long fast for really anyone. How about intermittent fasting, which has kind of had its day?

Yeah, it does seem like it's kind of had its day, the intermittent fasting. The intermittent fasting had some good physiologic explanations, which is every time you eat, your body has to release insulin.

And so if you're eating a lot during the day and you're not having very long windows of not eating, you're constantly stimulating your body, you're constantly having insulin, and they add to that insulin resistance.

Interestingly, though, what I clearly saw when I started working with patients is most of my patients who were struggling with their weight would come in.

They were already eating in a small eating window. They were not eating breakfast. They often wouldn't eat till lunch. They'd eat something small for lunch.

And then somewhere around dinnertime, there would be a lot of overeating that would occur. So when people already have that pattern, encouraging them to do more of that isn't going to be helpful.

So again, just knowing what's working for that person is helpful. But I know your audience is a little bit more towards women who are later in life. And I do find intermittent fasting makes a little bit more sense for some of my older patients.

A lot of them already have decreased appetite. They don't feel that hungry throughout the day. And they've just been eating breakfast out of habit. And they're also able to spend more time maybe at home or have more time to eat intentionally.

So unlike my younger patients who are just running around, running to work, chugging a bunch of coffee all morning and then when they finally are done with the day they eat a bunch of stuff that's not great for them, if you can intentionally have your breakfast later and have a healthy balanced meal maybe at 11 and then you finish eating by five or six in the evening and you've eaten a balanced set of food throughout that time period, then intermittent fasting may be a strategy that can help a little bit with weight and with making healthier choices and having less of that insulin burden.

But if you think just cutting down your eating window to eight hours a day and eating whatever you want in that time period is gonna solve problems, that's where intermittent fasting doesn't really work.

So you have to be really intentional and focus on eating healthy balanced food in that eight hour window or whatever your eating window is if you're going to do intermittent fasting.

Good, good. So we've kind of moved past typical dieting. We've kind of thought that fasting or intermittent fasting wasn't a very good approach for most people, so that leaves us with A couple of options as I see it.

One is the marvelous medications that we have now. And the other is surgery, which we've had for, I don't know, 30 or 40 years, probably different kinds of surgeries.

So maybe you could walk us through how you make that decision with- Like a medication. Yeah. And so I think when we explain that physiology of why it's so hard to lose weight and why those previous diets didn't work forever for people, then people become more open to something that will assist them in sticking with a healthy diet, like a medication or surgery.

Both surgery and medication are always meant to complement healthy eating and increased movement. So they are not meant to replace that, but they make it more possible for people to do that.

So before we had GLP-1s, we did have some older medications that I used because I've been doing this before GLP-1s were a thing, but those meds mostly just made people think about food less.

They worked more at the brain level and they took the edge off. They made sticking to a healthy eating plan easier, but the average weight loss was maybe like 10% at best.

And some people had pretty minimal weight loss on our older meds. But then four years ago now, almost five, we had Wigobi enter the market as an option, as an injectable weight loss med.

It was actually the second injectable weight loss med, but the first one wasn't that good, so it never got that popular. But Wigobi came out and people had an average of a 15% weight loss.

And then about a year and a half later, ZetBound came out and ZetBound has a more than 20% average weight loss. So these started to be really significant tools.

And what's so powerful about these meds is they really let most people achieve what they've been trying to. So people who are like, you know, had this idea of what a healthy breakfast and lunch would be, but either stuck to that and ate a bunch of snacks in between or just never felt full from it and ate, you know, really large portions.

Now we're able to eat healthy, balanced meals, feel full, satisfied, not think twice about it and just move on with their lives. So they really have been very, very helpful tools for people.

Intermittent Fasting: When It Helps and When It Doesn't

It's been a miracle, I think, for a lot of people and has been probably the major reason why the amount of obesity in the U. S. at least has seemingly leveled out.

I did just recently read, though, a study about people stopping the GLP-1 medications and a number of side effects. Cost is one big thing, and I don't know if you're aware of a movement to try to get them covered on Medicare as soon as this spring.

So maybe you could tell us about that and then also tell us about… Well, that's been my passion for years. So we have had a bill in Congress for more than a decade called the Treat and Reduce Obesity Act to try to get these medications covered.

So this was way before Wigoby even was available. But there was announcements this fall that certain patients will have coverage of these medications for the treatment of obesity with Medicare.

Medicare actually has a specific rule that says it cannot cover weight loss medications. And so this is a huge step in the right direction. It does look like only a certain amount of people are going to have access to it.

So it is not going to be as broad as everyone who medically qualifies for the medication. There will be a lot of other caveats about who can get it. So unfortunately, it's not going to completely open access, but it is a huge step in the right direction for Medicare patients.

Also a huge step in the right direction is the pharmaceutical companies do have direct pay options for patients. A lot of times Medicare patients are excluded from these sorts of plans because it's a coupon and it violates whatever Medicare contracts are out there.

But these cash pay direct options don't include any coupon. You can be anyone and have those same rates. So that's also been a really good step in the right direction.

And they are supposed to have even improved cash rates through the Trump Rx. So even if Medicare is not covering it for you, the cash price has gone down quite substantially.

While we're on the subject of new things in the marketplace, could you talk about the oral medications? Because the injections, once a week injection isn't the end of the world for most people, although I'm sure it's kind of off-putting for some people and the oral approach might be more amenable to some people.

Yeah, so it'll be interesting to see. I think the first one that has come out is oral Wigobi. That just came out the beginning of January 2026. And what the data shows is that the pill version works just as well as the injection version.

It gets to the same level in the bloodstream and also has very similar weight loss results with tiny bit more side effects in terms of nausea and vomiting, but not very much more.

So really, we can think of that medicine as equivocal to the injectable wagovi. However, it's a bit of a finicky oral medication. It does have to be taken just right or it will not absorb and will not work.

So that oral wagovi does have to be on an empty stomach with no more than four ounces of water for 30 minutes for it to absorb in the bloodstream. So the main people who probably are not a good candidate for the oral version of wagovi are people who are on another medicine that needs to be taken on an empty stomach.

So levothyroxine being a common one, it is possible to change when you take the levothyroxine or take them sequentially, but that's a big challenge if you're on another medicine that needs to be on an empty stomach.

It may not be a good fit. Also, if someone has had any surgery on their stomach, It has to hit the right spot in the stomach. So if your anatomy is different in your stomach because of a surgery or otherwise not a good fit, but otherwise for most people, as long as you can take it daily on an empty stomach for 30 minutes, it should work as well as the injection.

GLP-1 Medications and New Oral Options

It'll be interesting to see what people prefer. A lot of people do like that ease of the weekly injection, but I am been surprised that a lot of my patients have been interested in considering a daily pill instead of the shot.

Is it about the same expense out of pocket if you don't have coverage? Right now in January 2026, things change quickly and I think it will change as these Medicare plans roll out $50 cheaper to do the pill right now.

Okay. So that's something. That's something. Yes. Yeah. There is another pill that's anticipated to come out maybe late spring. Definitely we're expecting it by the summer called Orphlipatron.

Don't know what the brand name will be yet. That one doesn't have maybe quite as dramatic of weight loss. I think that one, the data is around 12% weight loss, but it is not a finicky pill.

You can take it however you need to. So that will be a really convenient option I think for some people as well. We didn't talk about why people stop the meds.

Yeah, that was going to be my next question. You mentioned in passing the side effect of gastrointestinal stuff, constipation, nausea, bloating, yeah.

Yeah, so the side effects, if we look at the study trial, the people who took it in studies, they only like, depending on which med we're talking about, which trial, the vast majority of people, 90% plus, were able to continue the medication.

So most people do not stop these medications from side effects in clinical trials where they're getting support, maybe they're getting their side effects handled.

And so there are maybe around 10% of people who will stop the medication from a side effect. The side effects are most intense in the beginning. And so I think one of the challenges, a lot of these people are just getting medications online, maybe from someone who is not available to coach them through side effects, or maybe getting it from their busy primary care physician who doesn't have time to see them monthly and check in on how they're doing.

So at our clinic, we see our patients monthly when they're getting used to the medicine. They can message us anytime so that we can give them an anti-nausea medicine if needed.

We can help them troubleshoot constipation. We can give them dietary advice on how to reduce those GI symptoms that's customized to them. So I think that's really important is that patients know how how to eat on the medication, get the support that's individualized to deal with side effects.

Because if you just start this medicine without any direction, it's just not intended to be that way. There's some medicines that are easy enough. They can be over the counter.

You don't need special directions or counseling. I really don't believe that's the case with these medications. People should be seeing their doctor monthly for the first few months they're on them.

And the dosages are ramped up is the recommended dosage, right? Correct. We ramp up over the course of, you know, several months. And so some people don't need to get to the highest dose of the medicine.

So that can be a problem, too, if people are just expecting, oh, I have to go up every month, or they were just given six months of scripts and told to keep increasing.

Some people only need those lower doses or need to go slower to get to the higher dose to minimize side effects. Yeah, let's chat about muscle loss as well because you've mentioned dietary or nutritional counseling during the course of therapy and that's very, very important for avoidance of losing muscle mass.

Yeah. So this has been, I think, one of the most overblown concerns with these medications. So we know no matter how you lose weight, you are likely to lose at least some muscle.

We see this with bariatric surgery. We see this with intense nutrition or diet protocols or very low calorie diets. And we see this with the medications.

The medications have, you know, a couple percentage more weight loss, muscle mass loss than those other interventions, but otherwise it's pretty similar to what we see from large weight loss from other things.

It also is not factoring in quality of your muscle. I frequently have people come in, I get them on my in-body, I see their muscle mass that have a hundred plus pounds of muscle.

That's a lot of muscle. Some people only weigh a hundred pounds, right? If they lose some muscle, I'm not worried, right? They have plenty of muscle. And so that's one of the things I'll look at when we start the medicine.

Are you someone who's starting out with average muscle? Are you someone who's starting out with plenty of muscle? Or are you on that low side to begin with?

We need to watch you a lot more closely. And that is going to be oftentimes our older patients. Especially women or either way, men or women. Yes, it can be either way.

Yeah, definitely can be either way, but definitely a concern, especially for post-menopausal women who have had that muscle loss. The other big thing though is muscle function, okay?

So there's the amount of muscle you have, but most of my patients have more muscle than me when they have obesity, and I am not worried about my muscle mass.

What is your muscle strength? So two ways that we measure this quickly in clinic. One is grip strength. There's a little machine. You can buy them online for like 30 bucks.

You squeeze it as hard as you can. We can measure your grip strength. That has become sort of a proxy for overall strength. The other thing that we'll do is have people stand up and down from their chair with their arms

crossed so that they're not using arms to support themselves getting out of the chair and see how many times you can do that in like 10 seconds or 30 seconds.

We can time them do that if they are having sarcopenia, which is not enough muscle and weak muscle, that's what we're worried about, then that's a struggle for them, right?

Maybe they can't even stand up without using handrails or maybe it takes them a really long time. So tests like that are more valuable than just measuring muscle because we're not just worried about the amount of muscle, but is it functional?

So I think that's been an overblown concern and we can usually mitigate it with exercise and getting enough protein in. Yeah, protein's very important for older women in general, in particular, but certainly if they're trying to lose weight and calorie restricting in any way.

Let's shift gears for a second, talk about surgery, because when people stop the GLP-1 medications, they regain the weight as they would if they had stopped a diet.

Most people, yes. Most people will regain if they stop the medication. You know, I think we're still looking at what our approach is. Can they transition to another medicine?

Which people will have success off the medication? Because some will, but, you know, we expect most people to regain if they stop the medicine. Okay.

Side Effects, Muscle Loss, and Follow-Up Care

So it's a lifelong decision, essentially, if you're, certainly if you're doing it for a medical reason, like, you know, borderline diabetes or high blood pressure or something of that nature.

You should expect to continue it, but I always tell people there's new meds coming, right? So if you don't like this one, there's a few available now.

It may not be this exact medicine forever, but if you need a medicine to help you lose weight, you're likely to keep needing a medicine. Okay. So surgery is a one-time deal for almost everybody, and people tend to lose a higher percentage than the 15 or 20% of their body weight that we've been talking about.

Would you reserve this for people who have higher weight issues or? Yeah. By nature, people who've come to see me usually are not wanting surgery. So it is something I'll bring up at a first appointment.

But most of my patients historically have kind of wanted to try everything else, including a GLP-1 before they go on to surgery. And many times they are able to find success with a different medication or option.

But yes, I think there's a couple people that I, when I first see them, I might more quickly, you know, suggest surgery as an option. Type 2 diabetes.

So type 2 diabetes is often reversed by bariatric and metabolic surgery. That's why they changed their name to bariatric and metabolic surgery because they cure metabolic conditions.

So if you have type 2 diabetes, you might want to consider surgery. It's truly pretty transformative. And then the other thing with type 2 diabetes is it's really hard to lose weight.

So ZetBound or Monjaro, same drug but for diabetes, is our most powerful weight loss drug right now. But about 20% of people with type 2 diabetes really will not have significant weight loss on that medication.

And the average weight loss, I think, is more like 15% versus the 20% if you don't have type 2 diabetes. And so maybe you have taken Monjaro or you have taken a Zempik and your diabetes is well controlled, but you really

didn't lose that much weight, that may be a time to consider surgery.

Um, the other people are, you know, if a 20% weight loss is not going to be enough to have a significant impact on your health, maybe you have, um, you know, you weigh 450 pounds and you know, if you lose a hundred pounds, you still weigh 350 pounds and you still feel really uncomfortable and life is still.

very challenging. Maybe you're going to need surgery and then maybe you'll go on to a GLP-1 afterwards. And then I just had a patient this month who had done okay with the GLP-1, but her insurance company stopped covering it.

I said, you know, like, what do you think about surgery? Your insurance covers it. I think you're a great candidate. You have all the right health behaviors.

And so she did go on to get surgery because again, she'd had an okay response to her injectable med. but now it wasn't even being covered anymore and she really didn't want to regain all that weight.

So yeah, I think those are some of the people that I have those conversations with. Great, great. That's great information. Strength training, you mentioned it as part of your approach to maintenance of muscle for people who are on the GLP-1s.

I guess I would say that everyone should be doing strength training and probably you're going to say the same thing as a primary care doctor. Yes, I can't emphasize that enough, but especially for us as women and women as we get older, strength training is so key.

It is the best way to stimulate bone health. It is the best way to have that muscle strength to be able to continue doing the things we want to do as we get older, right?

So I like to normalize exercise. I never want exercise to feel like a punishment or something extra my patients with weight have to do. We all should be doing it regardless of our weight.

So I love that point. We actually don't have evidence yet that strength training is more beneficial than other exercise for preserving muscle and people on these medications.

So we do know that really any exercise you're doing, walking, biking, dancing, Pilates, Any of that is probably going to help preserve your muscle mass.

So my first step with people is exercise, whatever you like to do. But we do have a recommendation that we've had for many years from the federal government that we should all do strength training twice a week.

I think it's a good recommendation for all of us. And certainly we know the only way to get more strength and build bigger muscles is strength training, right?

So although we don't have proof, which people keep saying that this works on GLP ones, it's logical to assume that if we want to build strength, that we should do strength training.

Uh-huh. Makes a lot of sense to me. And it will take time for the trial to A, be planned, B, be executed, and C, be published for us to get the information.

And somebody's probably out there doing it as we speak. I'm sure. I hope. It would be good to know. But again, you just said you think this is kind of an overblown concern that's made it into the popular press.

When Bariatric Surgery Makes Sense

Yes. I mean, it's something we should be aware of and we should be monitoring our patients. I have had a couple patients where, you know, they've lost more muscle than I'd like to see because we track that.

Usually they're people who are not exercising at all, right? Like they're not going on a walk or doing anything. And they're also not eating at all. They're the people who take the med, their appetite's suppressed, and they're like, great, I'm just going to eat as little as possible.

and they're eating a couple hundred calories a day, and so we really have to regroup and get them eating. But the people who are nourishing their bodies and really doing any amount of, you know, recommended movement, any type, we are not seeing that in our clinic.

Another reason to have the monthly follow-up visits until things get kind of established to find those people who aren't eating anything because they're going to have a bunch of metabolic and physical problems ultimately if they're not eating anything.

Yeah. Exactly. Yep. Yep. Excellent. Well, you have given us so much fabulous information today based on your experience as a clinician and obviously your training and keeping up with what's new, the latest, greatest.

Anything else you think that our audience of older women would be wanting to hear from us today? You know, I think the body image thing is something I see.

And so I would just encourage any woman at any age to focus on your health. So our bodies are going to change as we get older and we're not going to always look the same.

And let's not make it about that. Let's focus on what our health goals are. Do we have blood sugar or blood pressure or other health issues that would be improved by changing our weight, by taking a medication?

Do we have a way that weight is getting in the way of us, like you said, playing with grandkids or traveling? Then let's address it. But if you're just frustrated by a little bit of belly fat, but you are playing pickleball every day and going on hikes and traveling the world and your blood work looks great, I would encourage you to let it go and focus more on your health than those five pounds.

Strength Training, Health Goals, and Body Image

Or have a little plastic surgery to one or two little areas. Sure, yes. If it makes you feel better. But it's also okay to let it go. If you've been trying to lose that same five pounds for 20 years, You can let it go.

You mean we're not going to look like those celebrities who have hair stylists, makeup artists, and have had plastic surgery for the last 50 years? We're not going to look like them?

Yeah. How disappointing. We don't need to look like them. Well, that's good to hear. Well, Dr. Carolyn, thank you so very much. I hope that much of our audience have found things that are helpful for them.

If this is the kind of information that you value, please like and subscribe and tell your friends, and we hope to see you again here soon. Thank you, Dr.

Carolyn. Bye. Bye-bye. Thanks for listening to the Women's Health Span Voices Podcast. If today's episode spoke to you, follow the show and share it with a friend ready to take charge of her health.

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