Sleep Apnea, GLP-1 Medications & Weight Loss Transcript

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Guest Introduction and Sponsor Messages

Treating my sleep apnea has renewed my appetite for life. What matters to me now is giving my family a little treat. Jerry, we have Dr. Mohammed Usama, who is triple board certified sleep and obesity physician and one of the leading voices in sleep medicine based in the greater Seattle area.

He also serves as an adjunct assistant professor of medicine at Still University School of Medicine. His clinical and research interests center on the intersection of obstructive sleep apnea, obesity, and metabolic health, with a particular focus on GLP-1 therapies like terzepatide that can shape outcomes for patients with OSA, Obesity and Cardio Metabolic Disease.

Well, we've got somebody with a lot of background coming at us today. It's going to be exciting, especially to talk about GLP-1s. I know that's been a hot topic for us a few times over.

So for someone who's boarded in sleep and obesity, I'd like to take a deep dive with that today Yep. Hey, Marimus, and I love to read some of the content that he will regularly post on LinkedIn where You know, he kind of gives his take on a certain new type of therapy or, you know maybe just a trend that he's seeing in the sleep medicine industry.

So excited to hear what he has to say. We met him last year at Seattle's influencer event and it was, that was great to meet him there. And we had talked about getting him on the podcast.

It's been a little bit, but we were able to pull it off. Happy to have him the show today. You guys ready to get started? Let's do it. Onto the show. Lights out.

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Dr. Usamau2019s Path Into Sleep Medicine

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Welcome, everyone, once again to another episode of Sleep Tech Talk, the Sleep Podcast with your hosts and friends, Emerson Kerr, Robert Miller, and me, Dr.

Gerald George Moneycrow. Folks, thank you so much, so, much for all the love, to share the likes, and the subscriptions that you have been providing us over all these years and it's because of you we keep going.

And so be sure to give yourselves a pat on the back because we sure do that for you, virtually of course. But a huge shout out to our sponsors without whom we can't keep doing this.

Be sure and check them out. We thank them so much for the love and support that they've provided us to help us keep growing and make us be able to do these things and provide really good content for each and every one of And once again, we have a fabulous show, and to tell you a little bit more about it, Emerson.

Thanks, Jerry. We have Dr. Mohammed Usama with us today. Dr Usma is triple boarded, And among the things he's triple-boarded in is obesity and sleep medicine.

He comes from the Seattle area. It's got an interesting history we want to ask him about. But Dr, Usam, welcome to the show. we are thrilled to have you with this today, Um, you know, one of the questions that we love to ask our guests is, how did you get here?

And how do you, did get into sleep medicine? So we know a little bit from our conversation earlier, but can you share with our audience, your journey from end to sleep and how you ended up in Seattle and what are you doing now?

Yeah, absolutely. Thank you so much for having me. So I'm working in greater Seattle area as a sleep in obesity physician. and happy to be here. So first to answer your first question, how did I get into sleep?

I got into to sleep accidentally, honestly. I did not plan to a sleep doctor, but during my residency training, I took an elective in sleep medicine and that made me realize that how much impact sleep has on metabolism, your health, energy, performance, all of that.

Obesity, GLP-1s, and Sleep Apnea

And then if we treat and address sleep disorder, first, the outcome is very quick as opposed to other chronic medical problems. You can see a day and night difference.

So there is that gratitude. Also, a lot of medical they get improved, which we are not expecting. And that's what brought me to, took that elective in the first place, because a lot of my patients, I was sending them to the sleep clinic and their high blood pressure was getting better.

Like, you know, their depression and mood was improving. Their sugars were improving and I like what magic is going on there. So I took it. The other reason is that I liked technology And I feel like sleep is a perfect mixture of mind and body medicine, as well as technology.

So there's a lot of technology in it. That's what brought me into sleep. But I think that was the best decision I ever made. I did my internal medicine training at Wayne State University in Detroit, Michigan, and sleep medicine Uh, at Cleveland clinic.

Um, and, um, after that I've been practicing for quite a while now. And, uh, for the past one and a half year, I'd been in Seattle area and enjoying it over here.

So you said you love the mix of, of technology and medicine. I think sleep tech talk is the right place to be right now, right? So, so what took you to Seattle though?

Uh well, you know, I did most of my training in Midwest and then I stayed in rural Wisconsin for a while. So my wife, she's a psychiatrist and she was doing her psychiatry residency over there.

But I think it was just incredibly cold. And, you know, I don't have any issue with like, winter is a snow, but my life absolutely hates snow. So over here in Seattle area, the weather is much milder and much better.

Like, you know, in the winters it doesn't snow over there. If it does, it did once this year and the next day the rain washed it over. So it's much more better from climate-wise.

I like to hike a lot. A lot of outdoor stuff. Seattle is the only big metropolitan city in United States which has three national parks within one to one and a half hour.

drive distance from it. So I just love it over here. Yeah. Doc, you know, reading just your story, your boarded in obesity and sleep medicine. clearly giving you some really keen insights into how those overlap.

What have you seen, especially over the last few years, as we see more about GOP1s, where do you see that intersection with your specialties coming together?

How do those complement each other and really allow you to have a keen insight into those special patients? Yeah, that's a very interesting question. So actually as a sleep disorder, Major sleep disorder we treat in the sleep clinic, which is the most commonly seen in sleep clinics, is obstructive sleep apnea.

And one of the big underlying risk factors is obesity or weight gain. It's not the only risk factor, but it is one the major underlying this factor. I was always trying to address the underlying obesity in my patients who had sleep Apnea, so I sent them to our weight loss clinic and A lot of the patients, they wanted the care under one roof and a lot them did not want to go.

A lots of them were lost to follow up and I felt like I was not in control. And then, you know, my interest became in obesity kind of developed when I saw the results of GLP-1 therapy in obstructive sleep apnea.

And at that time, I decided that I'm going to treat these patients with GLP-1 therapy. And that is going address their weight as well. So might as we'll get some additional training and board certified in obesity medicine.

That's how I drew into obesity medicines. But at the same time I feel like obesity is not like it's on the diagnosis list.

Why Weight Loss Alone Doesnu2019t Cure OSA

It's not like a side conversation if you're talking about obstructive sleep apnea. So you cannot ignore the role of underlying obesity if someone has obstrative sleepapnea, so that is my journey into obesity medicine.

So, with that being said, the big, big conversation or the conversation that you hear all the time is, get rid of the obesity, your OSA is gone. And now with this miracle drugs that are out there, first injectables, and now we have the oral tablets for GLP-1 drugs.

People think it's like a magic bullet. I pop these pills. And I don't need to worry about OSA anymore. So what's the actual truth? What's, the myth behind these two things?

I think that's a big, big thing floating out there. Wouldn't you agree? Totally agree. Because, you know, whenever a new therapy comes out, we try to pitch it against established therapy, but that should not be the case.

But let's talk about first the role of obesity in obstructive sleep apnea. weight gain it worsens obstructive sleep apnea and if you lose weight it improves obstractive sleep Apnea so peppered and colleagues that did a study in which they showed that if You gain 10% body weight your sleep APnea get worsened by 32% But if your lose the same 10 percent bodyweight your Sleep Apnia only improves by 26% so it's easier to grow into Sleep apnia than to go out of Sleep APnia so You know, because once the disease is established, there are some changes that occur at pharyngeal level, at your cellular level that makes it difficult to get rid of obstructive sleep apnea.

So weight loss is not the only picture because obstrative sleep Apnea is Not one disease. And I'll come to that. underlying pathophysiology for obstructive sleep apnea, it is airway narrowing which could be due to obesity, which would be like extra fat in tongue or cheek or in your pharynx.

But at the same time, so that is one part, but at same, obstractive sleep Apnea could also be small mandible or low jaw. Obstructive sleep apnea could also be impacted by your arousal threshold, your ventilatory instability.

It can be affected by you muscle responsiveness. So all of these things, you know, interplace obstructive, sleep Apnea is not like, one monogenic disease.

There are multiple pathways to it. Losing weight, it always helps, but at the same time, We have a lot of data from meta-analysis and bariatric surgery cohort that showed us that people who underwent bariatic surgery lost a load of weight.

And, you know, the sleep apnea got improved, but majority of them, they did not get rid of obstructive sleep Apnea. Even the minute amount of patients who got rid obstractive sleep, there are some studies which have shown that after bariatric surgery, if they attained a healthy weight, and got rid of obstructive sleep apnea.

If we serially followed them in next three to four years with them maintaining the weight, the obstrative sleep Apnea came back, okay? Despite them being maintaining their weight because again, you know, it's not just due to the underlying obesity is not only the only factor.

It worsens with age, right? And I explained to you there are other things, other pathophysiologic mechanism, which can cause it. So that was a reason, because not everyone responds the same way to the weight loss.

And then the rate loss, it's a chronic process. Losing weight, I say that it is the easy part, but it s the maintaining weight or chronic, like in a long term weight management, that is really an art.

And so that was the reason why American Academy of Sleep Medicine in their latest guideline for treatment of obstructive sleep apnea, they did not say that bariatric surgery is a treatment option for obstrative sleep Apnea.

Which a lot of bariatic surgeons, They tell my patient that I will do this bariotic surgery. You will lose your weight and you know, you will, I'll cure your obstractive sleep.

Apneas. So they are probably wrong in saying that. That is why I'm at the Academy sleep medicine said that weight loss should be addressed in all of the patients.

have obstructive sleep apnea, but it's an adjunctive treatment option. It's not the primary treatment options. So these patients still need to be some sort of primary therapy, whether that is CPAP or oral appliance or mandibular advancement device or hypoglossal nerve stimulator.

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Endotypes and Combination Therapy

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Choose Solesh. One selfie. Better sleep. Scan the QR code to know more. So Jerry's going to eye roll when I bring this up. He's already smiling, knowing what I'm going say.

But you mentioned the endotypes. And when we begin to talk about those, I think it's such an important subject because I've bring it up a lot on this show.

How does that factor as you look into the future and the ability to see those from sleep studies emerges, how do you feel like that's gonna influence your decisions in therapy and in ongoing care for your patients?

So I think we should take some lesson from heart failure management. So if someone has heart failures, they're not on a single therapy. It's not like, you know, one drug to rule them all.

You know they are on beta blocker. They are own ACE or ARB therapy, They're on Aldosterone antagonist. And so they don't on different form of therapies which are hitting different pathways, right?

So similar is the case with obstructive sleep apnea. It's not one machine to cure it all, or one pill to win it, all of one injection will cure at all.

The future is gonna be a lot like heart failure, because these therapies, they work in conjunction. Maybe it's gonna to be PAP therapy plus GLP-1 therapy.

May be in some patients, it is going to to mandibular advancement device plus positional therapy, maybe in patients it will be you know, hypoglossal nerve stimulator plus GLP-1 therapy.

Or maybe down the road, we know there is a pill coming for obstructive sleep apnea as well. It's gonna be that in combination with oral appliance. So, you now, it's going to be in conjunction because first of all, its good to have multiple therapies with different pathways because if a patient is not tolerating one therapy, they have more option to stick to.

At the end of the day, our goal is to treat the patient. And regardless of how effective the therapy is, CPAP is more than 99% efficacious, but if someone is not using it, then the efficacy does not matter.

It's about reducing the mean disease burden. How many nights they're using, how regularly they are using how many hours they were using. If something else reduces the main disease burdens, then that's good and that the way we should go towards.

So again, the answer is more nuanced and we need to have more holistic care while treating the patients and kind of take it as a, just like as I said for heart failure, we have so many therapies, so similar will be the, I think future with obstructive sleep apnea treatment So I do read your content on LinkedIn a good bit.

I know that you've got this substack blog that also write articles and put content out.

Innovation, Screening, and Rural Sleep Care

You seem to be a student of the industry because I feel like I'm sort of in a similar position where I love all of new diagnostic tools, but I don't want to just know about them, I want know how they work, the nuances and the differences to understand the capabilities and what is good science, what's not so good, science and then also with the different therapy options that are out there.

I do love the fact that you're thinking about things from a phenotyping standpoint and we certainly need that broader approach to sleep therapy. So tell us a little bit about your desire to know about all things sleep.

So I think, personally I that we provide medical care to patients in sort of a very epileptic way and very archaic or Jurassic way. So, I'm always trying to come up with ways which are sort disruptive or out of the box solution.

Because 80% of patients who have obstructive sleep apnea, they're not diagnosed. And there are probably one billion people on planet Earth who have obstructive sleep apnea.

So that's a big disease burden. In order to really diagnose these patients, we need to come up with novel, new, innovative pathways, just like we cannot solve the problem of traffic congestion by building more highways.

Similarly, we cannot solve the epidemic of obstructive sleep apnea by building more sleep labs, like home sleep studies here to stay, and we need to come up with some innovative and novel pathways to meet the patients where we are.

So, interesting thing is when I was in Wisconsin, I working in a rural community hospital, in that hospital I designed a program of inpatient sleep-apnea screening and screening diagnosis and management.

So what happened was that, and this was the first rural hospital in the United States in which that kind of program was implemented. We know big academic centers which have such programs such as West Virginia University,

Cleveland Clinic, where I trained at and University of Pennsylvania and some other more academic programs.

Just to give you a brief overview that, you know, every patient who got admitted to that hospital in the ER, they got a stop bank score. And when they get admitted, and if their stop-bank score was three or higher, it sent an alert to the admitting team.

in the inpatient site that this patient is at high risk of obstructive sleep apnea. So a sleep medicine consultation is recommended. And then they consulted me.

I went in patient in, in in hospital and did a complete sleep evaluation while they were admitted. Then right before their discharge, we did portable sleep study while there in because we wanted them to be more physiologic, near their point of discharge.

And they left the hospital with a CPAP machine. So the concept was just like the concepts of everyone who get admitted into the hospitals during the flu season, they got influenza shot before they get discharged.

The point-of-contact the patient has with the healthcare system, we need to do the most in that. And also with that novel inpatient sleep apnea screening and diagnosis program, when we track the data down the road, we saw that those patients, they were more compliant to therapy because they came to the hospital usually with a health scare like a heart attack or heart failure or COPD exacerbation.

And when their cardiologist told them that you need to use your machine and we need treat the sleep apnea, otherwise your atrial fibrillation will keep coming back.

Your heart health is not going to be good. You will have increased readmission due to heart failure. They listened and they were more motivated. And so we needed to come up with innovative pathways like this.

So it was that discovery. That is why I'm very interested in new developments so I can implement them somehow into my practice and see how it can help my patients.

Well, Doc, we are really getting really close to time. And first off, I think it's really awesome to hear your interests, your depth of interest in the field.

It is really cool that you implemented such things. I just took down some notes. Yeah. there of obstructive sleep apnea moving in the direction of just like we have with congestive heart failure, how we're moving that direction now where there are different options.

Also understanding that you can't just simply open more sleep labs to do this. This is just trying to alleviate congestion and the roads just by adding more roads.

It's not going to help you. So we really appreciate the insight, but we are close to time. Where can people get more information? You have a sub stack.

Could you give us a shout out what your sub-stack is, and so that people can look at it? Yeah. So people find me on LinkedIn with handle SleepWarriorMD, on Twitter, LinkedIn, Instagram.

I'm most active on Linkedin. That is the best place if you want to reach out to me. But in addition to that, I have my substacks as well, which we can include in the show notes.

It's sleepphysician.substack.com. Got it. And you heard it here, folks. Sleepphysisian. Substac. Com. We'll make sure to have that in the show notes. So, Doc, thank you so much for joining us.

Thank you. Thanks for having me.

Closing Thoughts and Where to Find Dr. Usama

and thank y'all once again for joing us, it's been a pleasure. Be sure to check out our clinical sponsor, Sleep Review Magazine. More details in show notes.

Alright, that was another show and that's quite a bit. What did you guys think? Jerry, I think it's fascinating to hear someone talk about just all that goes into thinking about the GLP-1, the sleep patient.

I mean, there's so many moving parts and for someone like that to really take that deep dive was so interesting today and I really appreciate Dr. Osama's perspective on the complexities of these types of patients.

I agree, I mean, GLP-1s are still being talked about this day and age, well, at this time. It's interesting, especially because when the pill came out in January, it became hot once again.

So it's good to hear his take on it and alleviating some of the myths. Yeah, you know, I think that one of the things that I'm I loved hearing from him today is just his more holistic approach and treat, to treating patients who have issues with sleep apnea, for instance, where maybe it's a combo therapy or The idea that a GLP-1 is the magic bullet that may treat sleep apnea by itself.

Love his take on that and the phenotyping models that he talked about. That's always sort of a funny topic, I think, for us, but just love his perspective.

I'd think in a world where there seems to be some form of practice where it's just diagnostic study, CPAP, diagnostic, study CPAT, that, you know, having these trendsetters who are willing to sort of think outside the box and treat patients a little more comprehensively is, is certainly great for the field.

And I love the fact that he said, we now have options for patients. That's the, probably the biggest thing out there. Absolutely. Well, I think this is a great place to stop.

Folks out there, thank you all so much. Until next time, cheers.