

# GLP-1 Hormones and Weight Loss

**Anna Barbieri :** [00:00:00] There are real physiological changes that happen to people in midlife, and here we're talking about women's health to... So let's name them. You know, we get to our, typically our early 40s and everybody goes, "What's happening? Something is different. I can't, you know, I can't figure out what's what. What I used to do doesn't work anymore."

What's very interesting to me is where is the line between a medical intervention that promotes health and the line between that and purely aesthetics?

**Joanne Stone:** Welcome to Herology, the podcast from Mount Sinai Health System dedicated to advancing women's health through the lens of cutting-edge science and compassionate care I'm your host for today, Dr. Joanne Stone, and our show is brought to you in part by the Carolyn Rowan Center for Women's Health and Wellness.

Today, we're focusing on a [00:01:00] really interesting topic that's gaining steam among medical practitioners and researchers: GLP-1 hormones. To walk us through all the details, including what GLPs are and what they're making- why they're making such an impact, I'm joined by two of my regular co-hosts of this show.

First, Dr. Anu Lalla, a premier cardiologist here at Mount Sinai, and Dr. Anna Barbieri, one of our most celebrated OBGYNs. So Anna and Anu, welcome to the show. So I'm so excited that we're g- here today to talk about GLP-1s, GLP. Um, you know, I live on the Upper East Side of, of Manhattan, and I walk down Madison Avenue and, like, in front of every pharmacy, there's, like, some kind of a big screen that says, you know, "We have Zepbound.

We have Mounjaro. We have this" You know, like, totally advertising it. So it's all over the place, and everywhere you look, you know, you, uh, you know, in the hospital here, you see the same people that you've known for 10 years, and all of a sudden they weigh, [00:02:00] like, 100 pounds less. You know, like, oh, th- you know.

They- And

**Anna Barbieri :** it's not their juice drink.

**Joanne Stone:** No. Uh, definitely not. It's totally not. Yeah. So let's... Why don't we start talking about it? Can you, um, Dr. Lalla, can you, um, let us know a little bit more about what GLP-1s actually are?

**Anu Lala:** Yeah, sure. I mean, it's the craze, right? It's the... Everybody wants to talk about these things, and I think this is so interesting because it's equally interesting to the public as it is to the scientific and medical world.

Um, so GLP-1s very, very simply are es- essentially just acting to enhance what you already have as a hormone in your gut, right? So we naturally have GLP-1s in our gut. You're enhancing that or you're, you're revving up that system, and that allows for your gut to speak to your brain to tell you, "Hey, listen, I'm full."

You know? And, uh, that's an oversimplification of it, but it also has so many other effects, right? It also helps [00:03:00] us have our pancreas secrete insulin in a smarter way, so we're more insulin sensitive rather than resistant. It slows down the transit of food in our gut, contributing again to the feeling of fullness.

And over time, what it does, which is really cool to the medical field, is it helps reduce the kind of fat that builds up over our organs. And so it's really... I mean, this, it used to be thought of as this diabetic shot, right? And now we've realized that it does so much more than that.

**Joanne Stone:** It's so amazing because the fact that it's like a hormone that we h- actually have and that's being utilized for better, better reasons is, is incredible.

**Anu Lala:** Yeah.

**Joanne Stone:** And I, I know that it's much more commonly prescribed, I think, to women. Um, so Dr. Barbieri, maybe you can let us know a little bit about why you think it's more prescribed for women.

**Anna Barbieri :** Sure. You know, I-- there are a number of reasons for that, and I would agree this [00:04:00] class of medications, so GLP-1s or GAGs, have been such a game changer in the area of health in general, and particularly in the area of metabolic health and weight management.

And I would say, you know, this would be an interesting topic to cover. Those two don't always go together, but they tend to go together. So, you know, as somebody who works in the space of midlife women's health, weight

management and weight gain, especially across the perimenopausal transition, is one of the top complaints that women have.

And we know from really well-established data, even one of the studies that our institution here, Mount Sinai, has been involved in, which is the, uh, study of women's health across the nation, pretty much seventy percent of women will experience pretty significant weight gain in midlife, and there are a number of reasons for that.

And that weight gain not only causes distress to a lot of women, and we can get [00:05:00] into that topic, that's very interesting to me, kind of all those social cultural aspects of it. Yeah. But often because of where the weight gain is located, and that's going to be mostly in the abdominal area, there's an increase in abdominal Uh, weight gain and visceral fat, it will carry metabolic consequences with it.

So I think lots of women are interested in these medications for their health effects and certainly for weight loss. And this midlife group, you know, traditionally, this is the group where the things that we are used to doing, you know, cutting out sugar, eating less, maybe exercise a little more. I mean, there used to be a time where I used to think of weight loss, and I would lose weight, right?

And those things no longer work because of certain age-related and hormonal processes that accompany this time. So we see this, we, we see a, a deep interest, um, in this, uh, [00:06:00] class of drugs.

**Anu Lala:** And yet half of all individuals living with obesity or overweight, which is 40% of the population, are men. But like you said, women are taking these drugs more, right?

Or these medications more. And I think so much of it has to do with that midlife sort of metabolic change that you talked about, but then also some of these social and cultural factors.

**Joanne Stone:** Well, it's, you know, especially I think during perimenopause, menopause, it's a time that people are feeling insecure about themselves.

Mm. Right? About how they look. All of a sudden maybe you're coloring your hair when you didn't used to color your hair. You're using whatever creams, Botox, you know, whatever you're doing to try to have this youthful appearance.

I mean, it's terrible, but that's like the culture, right? So and the weight gain is really part of it, you know.

Um, it was interesting 'cause I was watching Willy Geist, I think, recently, and, and they interviewed Jamie Lee Curtis, who's, like, amazing. She's like, "You know what?" My... Like, the [00:07:00] reason that her career continued cl- was because she didn't really give a crap about That was one way I could say it. Do it. Yeah. On, on, about, about how she looked and, like, maintaining some youthful appearance, you know?

And she's, like, proud of how she looks. But for most people, it's a time of, like, insecurity. I mean, I remember going through my closet going, "I have jeans that are, like, size 23, 24, 25, 26-" Right, right, right ... and the highest was 27. Like, what? Like, how did it get there?

**Anna Barbieri :** Right.

**Joanne Stone:** So I think it's, like, the societal pressure that people feel.

**Anna Barbieri :** I think it's really a combination of both. I think there are real physiological changes that happen to people in midlife, and here we're talking about women's health to- so let's name them. You know, we get to our, typically our early 40s, and everybody goes, "What's happening? Something is different. I can't, you know, I can't figure out what's what.

What I used to do doesn't work anymore, and now I can't sleep, and I'm gaining [00:08:00] weight, and I'm tired, and, and, you know, my mood is changing, and I can't make sense of it." And what's behind it is a really profound hormonal change and aging-related change, and we don't quite understand what's what there.

Certainly, with fluctuating, declining estrogen, we see a change in body composition, um, more fat accumulation, especially in the belly. With aging in general, we see loss of muscle mass. But these are really, really very definite physiologic processes that will happen, and they will happen no matter what. So then how do we respond to that?

And what's very interesting to me is where is the line between a medical intervention that promotes health and the line be- between that and purely aesthetics,

**Joanne Stone:** right?

**Anna Barbieri :** And, you know, how do we navigate that, right? I have patients, and I have been there myself, where, you know, even a gain of 10 pounds is [00:09:00] very uncomfortable and causes a lot of distress.

Um, and I have had patients who may have gained 30 pounds, and it doesn't do that, but clearly they are on a metabolic trajectory that's leading towards this higher risk for heart disease and diabetes and so on. So how do we really, you know, how do we really navigate that? It's, it's really interesting.

You know, for me, also as a mother of two young women, my daughters are in their late teens, early 20s- It's hard to know how to phrase this, right? Mm. How far do we go in order to achieve thinness for the sake of thinness and to satisfy certain societal expectations, rather than to use these medications for health or to decrease inflammation, or maybe to achieve some other long-term goals that we'll get into?

It's ve- it's a very interesting tension

**Joanne Stone:** that we have. I, I totally agree with you, and, you know, there's only a couple of real [00:10:00] indications for the use, right? The indications are-

**Anu Lala:** Yeah, I mean, I... For me, it's interesting to hear you say that. It's, for me, I'm so taken by the cardiovascular benefits, right? As a cardiologist, of course, this is-- I think this has done a number of things for us.

A, we thought this was just for diabetes, and now we recognize that there are actual cardiovascular benefits across a range of individuals, right? So there was a large, large clinical trial, the SELECT trial it's called, seventeen thousand patients, and these were patients who were, had some risk factor.

Some of them had established cardiovascular disease. And semaglutide, which is also known as Ozempic or Wegovy, depending on the dose and depending on the indication, reduced cardiovascular events by twenty percent.

**Joanne Stone:** That's huge, really.

**Anu Lala:** I mean, and this is over a period of three and a half years. Oh

**Joanne Stone:** my

**Anu Lala:** God.

That's remarkable, right? Uh, uh, so I think, [00:11:00] uh, to me, those, those numbers are what we s- strive to hear, right? We're constantly looking, "Oh, this is a mortality benefit. This will reduce your risk of, of cardiovascular events or heart failure hospitalizations," whatnot. And you have these medications that are conferring that benefit.

Now, what's the kicker here is that it's independent to a large extent of weight loss. So you're still seeing that clinical benefit Regardless of whether you're losing the 15 to 20% of weight loss that you, that the patient may want. Sometimes it's as low as 5 to 10%, if at all.

**Joanne Stone:** Oh, that's really interesting.

What, what is the pathophysiology for-

**Anu Lala:** Ha ...

**Joanne Stone:** the improvement when you haven't lost the weight?

**Anu Lala:** Yeah, that's the billion-dollar question. I think the... It's so complex, but you know, one of the really brilliant scientific minds, at least in the cardiovascular world, is a gentleman by the name of [00:12:00] Milton Packer, who actually used to work here and run the heart failure section at Sinai, and he, what I really like, has kind of put this idea forth that we can't ignore that fat in and of itself is kind of like its own organ that secretes hormones.

It really does. That's what it does. And, uh, you know, adipocytes, which is fat cells, secrete adipokines, which are essentially fat-related hormones that have effects on the rest of the hormones in the body and interact with the hormones in the body. And we know, just as you said, that as we develop more of that visceral fat, the fat that's on top of our organs- On top of our heart, on top of the organs in our belly, that tends to be the most metabolically active.

And in the case of women at least, which I-- this is where I get, like, so kind of excited, is it increases the risk of heart failure with preserved ejection fraction, [00:13:00] meaning the pump function can be normal, but you have this very increased risk of developing increased fluid, shortness of breath over time, et cetera, because of what you can call dysfunctional adipocytes or fat cells.

Mm. And so I think that, that's part of it. That's part of that benefit. We also know that it helps you become more sensitive to insulin, right? There's also this

profoundly interesting interaction with just psychological well-being that may be independent of weight loss, where you're more sort of self-regulated.

I think we've all seen data on how it helps in smoking cessation and addiction patterns. So I mean, I could talk about this for ages, which is - Well, that's why we're here. That's what we came for. That's

**Joanne Stone:** a good thing,

**Anu Lala:** right? Exactly. And I would just mention just really quick, Wegovy and Ozempic have the same active ingredient, which is semaglutide.

And then Zepbound and Mounjaro have the same active ingredient, which is tirzepatide. [00:14:00] And those are the main GLP-1s. In the case of tirzepatide, it's GLP-1 receptor agonist and a GIP, which is just another gut hormone that's interacting with our brain to do more of the same.

**Joanne Stone:** And it's, it's interesting 'cause you mentioned earlier the effect on the brain too, and, um, and we know that there are some studies that show, you know, less drinking, I think, less, you know, impact on reducing addiction.

N-- You know what? Do we see that with, like, sleep or any of the other sort of symptoms that perimenopausal or menopausal women, uh, have? Does that-- Do you think it makes a difference?

**Anna Barbieri :** So, you know, we do not have clear data looking at the use of G-GLP-1s for sleep. But, um, if you think about it, a lot of women, and men also, as they age and with weight climbing, experience sleep apnea, and that is one of the major reasons for sleep disruption.

And GLP-1s are now indicated by themselves for the treatment of sleep apnea. [00:15:00] Um, so we are starting to see the resolution of some of these symptoms with their use. Not to say that they are a magic bullet. There is no such thing, and it's not that, you know, the, the... Our systems are very complex. But we definitely are seeing in clinical practice, even without official data being published, certainly, you know, effect on weight loss, decreased inflammation.

Anecdotally, see less joint pain. And anecdotally for me, and we do need to distinguish between official published data and what we're talking about here, a- Easier use of hormone therapies. And what we don't understand yet, and where this should be studied formally, is how to include potentially the use of these medications as part of hormonal regimens that we're utilizing now.

Currently, the way that's done is really [00:16:00] the symptom profile and a patient's goals will dictate what gets started first. But we actually don't quite understand whether it would be beneficial to start with one arm of the treatment, meaning the metabolic treatment, including GLP-1s, versus hormone regimens.

So that's something that's, that will be very interesting to, uh, ascertain in the next few years. Going back to some of the aspects on fat as an organ specifically for women's health, the other really fascinating area of the use of GLP-1s is their impact on the risk of certain hormone-driven cancers.

There's a number of cancers, especially in women's health, where we know that obesity is a factor that drives that risk: breast cancer, colon cancer, for example, uterine or endometrial cancer. And we are starting to see papers coming out looking at the use [00:17:00] of GLP and potentially the effect on, uh, cancer risks in those areas.

**Joanne Stone:** It's, it's amazing 'cause it spans across so many, so many different areas. Also, like pregnant... I'm a maternal-fetal medicine specialist, that's my area, so we see it also in terms of, um, improving the chance of becoming pregnant with the weight loss, the effect on PCOS, right? Right. It has a huge effect on PCOS.

**Anu Lala:** And that's what I love, uh, you know, I, I love about these drugs, quite frankly, without endorsing them ubiquitously. I just like that it's forcing us as a field to recognize that we can't practice in our silos of care anymore. Like-Cardiovascular care is as linked to GYN as it is, quite frankly, to hepatology and liver medicine, where we're seeing so many women affected by fatty liver, right?

You go, and people think, "Oh, no, it's the statin I'm taking." Guess what? Statin is there to treat your fatty liver, right? [00:18:00] Uh, and the fatty liver is again a part of that visceral fat that GLP-1s have now in clinical trials shown to improve. Same thing with kidney disease, chronic kidney disease. These GLP-1s and this class of drugs broadly is improving kidney outcomes.

There's some emerging data to show it's improving neurologic outcomes. Prevention of dementia is something that's being sought after and studied. So what I like about the emergence of this class of drugs is that it's forcing us to be reminded of the fact that everything's connected and that we need to go back to the old school way of practicing medicine and recognizing that everything's our lane.

Like, this is all our lane. I can't just say, "Okay, you know what? Your kidney function's up, I'm gonna send you to nephrology. Your liver function's off, I'm gonna send you to hepatology," et cetera, et cetera, et cetera. And I, I have to say, I was guilty of doing that. I think these medications, this class of medications and [00:19:00] others, which we in the cardiology world are calling cardio kidney metabolic health-based medications, are helping us to work together, and I, I'm excited about that.

**Anna Barbieri :** I would agree with that, and I think this is one of these advancements in medicine that represent a root cause solution- Mm. -rather than treatment of a final symptom on that trajectory. And I, I think it's an incredible advancement and development, and that's not to say that we should forget certain basic interventions that apply other than these drugs.

And I think, you know, I think it would behoove us to say that these should not be a cheat code to losing weight without paying attention to proper nutrition and sleep and movement, right? The rapid weight loss that occurs on these is often accompanied by loss of muscle mass. [00:20:00] Muscle, just like fat, is an organ that can, that can be hormonally active, and we do need to protect it.

Right. So to me, GLP-1s are an incredible tool, but they are one tool in the toolbox. And, and I am excited also 'cause I think it's really the, the seemingly endless benefits that these drugs have is not because they are some magical substance. Right. It's because they address a really basic cellular process that ties a lot of outcomes together.

**Anu Lala:** That's so important.

**Joanne Stone:** It to- totally, and, uh, you know, a couple things that come to mind. One is that I think it takes away, like, obesity or being overweight from, like, having that fat-shaming thing, like, to make it more of a chronic disease, like we're treating a, you know, we're treating a chronic disease here.

Yeah. And it's not, you know, because, oh, you just are so out of control. I mean, there are other reasons that people gain weight, as you [00:21:00] just, you know, as you just talked about. Um, one thing when you mention the muscle loss, though, you know, we don't have, I don't think, a lot of long-term data on outcomes, so do you, you know...

But, and there's also bone loss that occ- can occur as well. Mm-hmm. So it's important, I think, for people to balance, who are on the GLP, GLP-1s, to

balance with some sort of exercise regimen. Would you, do you tell your patients that? Oh,

**Anu Lala:** gosh, yeah.

**Anna Barbieri :** Yeah, 100%. I mean, we, you know, when we use GLPs in practice, it goes along with nutritional counseling, uh, counseling and education on proper movement and strength training, adequate micronutrient support, all of that.

So it's not just a... A- and this is, I guess, what my beef would be with certain Types of prescribing where basically you can call up, you know, you can check a box and get your shot, and that's it, and you could go on eating, you know, three Tic Tacs, um, a day. [00:22:00] So, um, to me, certainly, you know, as a tool, GLP-1s should be combined with other types of counseling, other behavioral interventions, and developing habits that are sustainable long term.

And what we see actually with them is for many women, I'll say women here 'cause I take care of women, um, we see the development and sustaining of habits to a greater degree than without them. Because if you think about it, right? Tell somebody to exercise, or how many times have we done, like, the January going to the gym?

If I'm not seeing effects, I'm just not going to do it. Like, we are a reward-based organism. That's

**Joanne Stone:** true.

**Anna Barbieri :** So when we, um, help our patients understand their habits and help them see effects sooner with the use of GLP-1s, we see them be sustained longer, and I think [00:23:00] that's also really, really great use of them in terms of starting up somebody on their health journey.

**Anu Lala:** Yeah, I wanna s- stress that. So, my-- I don't want my enthusiasm- ... for this class of drugs to be, you know, delivered with the wrong message. It is so crucial. Like, if I had my way, I would issue that prescription in the right clinical scenario with literally a prescription for exercise, diet, nutritional counseling, really.

I, I wish it could come in a bundle, and it could be something that would, you know, the, the payer world out there would see as valuable because I think that's the tricky part of these medications, is that I don't know if they're always being

administered, prescribed in the right way. You know, I, I, as we're talking actually, I have this dear patient of mine who lost sixty pounds, needed to, absolutely appropriate, probably didn't keep up with the exercise, the [00:24:00] weight-bearing activity in particular as much as she could have, and Has just felt progressive muscle weakness, tripping more, sprained her ankle, these kinds of things, 'cause you lose the laxity with which your muscles are able to hold the tendons that connect to the bones.

You know, I literally feel like I'm c- you know, singing that, like, the hip bone is connected to the- But it, it, it's true, really. And I think if we don't take the time out to counsel and to really say that, "Listen, if you're getting this prescription, you're getting it in tandem with a prescription for weight-bearing activity."

And we don't-- that doesn't always mean that everybody has access to go to the gym. This can mean exercise snacks, as, you know, are, are frequently called, walking up the stairs, squatting at home. There's so many things that you can do, and I think that our field in general is going to need, and I do see this happening in some s- [00:25:00] some spaces, to deliver really practical advice for patients to take home when they get that prescription.

**Joanne Stone:** I mean, what you're talking about sort of is what we're doing in, in the Wellin Center, right? Mm-hmm. Like, with the clinical pathways that people may be going on GLP-1s, and, and but, but along with the nutritional counseling, the physical therapy, the diet, the exercise, and all that, and it's, it's being, you know, it's being addressed in that way.

So I think you're so right. I mean, you-- it should be absolutely part of the sort of provision of this medication.

**Anu Lala:** Yeah. Sure. And I always tell our patients, "I'm not looking for a particular weight loss goal here. That's not what this is." This is about getting you as an individual... I think it's, like, really the ideal form of personalized medicine.

This is about getting you to the weight where you are metabolically healthiest. What does that mean? Where your [00:26:00] sugar is in an ideal zone, right? Where your blood pressure is ideally less than one twenty over eighty. Where your cholesterol is well controlled, and that may be with or without other medications, and of course, diet, exercise, lifestyle changes.

That means where you are feeling energetic and well, and then you don't feel sick and nauseous all the time. So it's, it's not at all about-- I have a lot of people

where I'll actually go down on the dose and say, "You know what? That amount of weight loss is not good for you. This wasn't where you were your healthiest or your best."

So I think it's, it's... For me, it's much less about the weight, quite frankly. It's more about getting patients in a zone that is metabolically healthy for them on an individual level.

**Anna Barbieri :** And I definitely agree with that. You know, I think that's such an important statement to make, and, um, I think both of you know me well enough that I, I am always opposed to the very [00:27:00] extremes- Mm-hmm

and I think this is what we're seeing with these medications. You know, on one hand, I'd be so curious to actually hear your opinion on this. We have the current FDA indications, right? Mm-hmm. So you can get them approved by insurance if your body mass index-- We can talk about that, how that's a very crude measurements of, of your health.

If your ma- body mass index is over thirty, or if it's over twenty-seven, but you have one of the other kind of metabolic, uh, conditions that may be associated with poor metabolic health, high blood pressure, um, hyperlipidemia, metabolic syndrome, and so on. What about the women that have gained twenty, thirty pounds over their baseline, mostly in the abdominal area?

Their fasting glucose, fasting insulin is creeping up. Maybe they're already pre-diabetic. Their blood pressure is rising- Mm ... their cholesterol is rising, but they don't meet those criterias. Would they not benefit? [00:28:00] We don't know a good answer to that, and we should study that, but that means we're intervening earlier in that metabolic trajectory, right?

The other extreme is what you were just saying, is when do we-- You know, these drugs are written on a very specific basis of dose escalation, and it's probably was developed like that to ensure adequate weight loss and a rapid response. That may not be optimal for the individual in front of us, and also maybe getting down to that, like, prom weight is actually not what we want at fifty.

That may not be the right thing, and we see it. I mean, I think all of us have our, you know, favorite media personalities that seem to be taking this to an extreme, right? But maybe every extra five, ten, twenty pounds is not conducive to your best health at a given point in life. So I think that's, you know...

[00:29:00] I, I really like that middle, rational, kind of thoughtful approach to the use of these medications and staying away from the extremes. Yeah.

**Anu Lala:** I completely one hundred percent agree.

**Joanne Stone:** So, so- What do you do, you know, with the person that maybe doesn't fit one of these approved, you know, FDA-approved indications, right?

But I, I agree. I mean, there's gotta be some benefit to treat somebody before they actually meet that criteria, right? 'Cause then, then they're sick. They... Then they're in the disease state. But it does make sense when you're watching somebody's trajectory of, you know, they gained 15 pounds over the last four years, and they're...

Like, why not

**Anna Barbieri :** intervene and- Yeah. I see it all the time. Yeah. You know, patients are coming in, and you can, you can see in their lab work that year after year, their cholesterol is going up, their hemoglobin A1C is going up, and they are told, "Oh, they are still in the normal range. [00:30:00] Everything is fine."

Meanwhile, there's a massive difference, I think, between having, you know, hemoglobin A1C, which is kind of the screening test for diabetes, and it's an indicator of your, um, insulin glucose status. Massive difference between being at 5.0 and a 5.5, for example. Mm-hmm.

**Joanne Stone:** Mm-hmm.

**Anna Barbieri :** So, um, but I think it also gets to that question of, you know, given that by 50, about 30% of women are pre-diabetic and close to 50% by age 65, does that mean eventually we are, you know, half the population is going to be on these medications?

Where these are staggering numbers. Yeah. So while, again, this is this amazing tool, we also have to ask ourselves, what are some of the other drivers of this epidemic, and what are we doing about our food supply? What are we doing [00:31:00] about the epidemic of not moving, you know? What did I do today? I walked my dog, and I walked from the parking lot here.

Embarrassed to say. Like, that's not- Better,

**Anu Lala:** better

**Anna Barbieri :** than me right now. Not great.

**Anu Lala:** No, but I think that's exactly it. Like, we are so desperate, myself included, for a quick fix. My A1C's up, my cholesterol is up, I've gained 10 pounds. Give me the shot. I'll see you next- Yep ... you know, I'll see you in two weeks when I need to go up on the dose.

And it cannot be that way. There is no quick pill for good health. Even this whole longevity s- you know, space that is so hot right now, there's no quick magic pill. It is about sleeping well. It is about having adequate movement and weight-based training or exercise. It is about good food and h- natural food that's not so processed.

It is about this holistic approach to health- And being proactive [00:32:00] rather than reactive, which is how a lot of us are ...

**Anna Barbieri :** especially in midlife, do you think a lot of us struggle with just the fact that our aging is so obvious and staring us in the face? Mm-hmm. And whether that is a higher jean size or, you know, the freak-out I have over my face in the morning, like, it is very uncomfortable, and I think this sort of spot in life, this, you know, age 50-ish, 40s, 50s, 55, it's actually a good opportunity to maybe think about how we relate to this whole process.

So I would also call for a little bit of self-compassion and- Yeah ... self-acceptance of some changes. Yes, being proactive. Yes, being involved in our health. Yes, reaching out for these tools to make us healthier, but not in an effort to deny certain [00:33:00] biologic realities, not in effort to feed the societal expectation that so many of us have an issue with rationally, but really to be very thoughtful, um, about how we use these for ourselves or for our patients.

**Joanne Stone:** I mean, I, I totally agree with everything you're saying, and I feel like... Well, two things. One is it's a little unfair 'cause I don't think men feel that same sense of pressure. I mean, they, they age, too. They get gray hair, but, oh, doesn't, doesn't George Clooney look- It's salt and pepper ... gorgeous with that?

It's salt and pepper. Yeah. Exactly. Like, no salt and pepper here for me, you know? But, um, so, so I think there's, you know, cultural norms that exist that are so hard to overcome, and that's why when I brought up Jamie Lee Curtis's interview, I was so, you know, delighted to hear the celebrity who's achieved so much success in her life, and especially the la- latter part of life.

The other thing I wanted to mention is, you know, what about [00:34:00] the inequity or disparities that the GLP-1s, you know, that we see? Because, you know, you have to have certain indications, and certain insurances are not gonna cover it, and I don't know that Medicaid covers, uh, the GLP-1s. And, and, you know, when we talk about some of the, you know, food insecurities and poor, you know, poor health and the lower socioeconomic, um, uh, um, patients, you know, who may not have access to, you know, a gym or eating, you know, the healthiest of foods 'cause they're expensive, you know.

What, what do we do? Like, how do we, how can we change that?

**Anu Lala:** It is such an important point. I think- Oh, it like kind of breaks my heart, honestly, um, because I think there's, there's two parts that are somewhat heartbreaking. One is this, this lack of self-compassion that we do have for ourselves during this phase of life broadly.

I think that's so [00:35:00] spot on. Um, it makes me wanna just tell you both that you look very beautiful, and I'm very honored to be with you right now. Um, and I think with respect to equity, this is so glaringly obvious when we talk about not just these medications, but like you're getting at, what does it cost to be healthy in America in twenty twenty-five, twenty twenty-six?

You know, like half the patients I'm seeing who may be, you know, uh, in socioeconomically disadvantaged areas, it's not that easy to get healthy produce and eat a salad for lunch while they're working night shifts. And, you know, it's, it's-- we have to be practical. Um, and I think it's, it's a hu- it's a much bigger issue than certainly we're gonna be able to solve at this table today.

But I think it starts with recognition, it starts with acknowledgement, and it starts [00:36:00] with meeting people where they are, right? So you can't get to a gym? Fine Where do you live to? What subway do you live near? Can you go up and down those subway stairs 10 times a day, and that's your exercise for a little bit?

Can you do that maybe twice a day? You know, do you have stairs in your building that you can use when it's cold outside, like on a day like today? I think it's, and these are just tiny examples, but I wasn't doing that, at least in my own practice, as much as I am now, which is, "Tell me a little bit about where you live.

Tell me who buys the food in your house. What are you eating? What does it look like? Can we keep a food diary?" Things that seem kind of like, "Oh, I'm

never gonna be able to get to that in 20 minutes," I think that these are some of the proactive, um, pieces of information that we need to be able to best serve the patients that we're seeing.

**Joanne Stone:** I love that, and I love, you know, when you said meeting patients where [00:37:00] they're at, because it means listening, right? Mm. Asking the right questions and listening and seeing how can we achieve some degree of success with improving health, given whatever the circumstances, you know, somebody has, and whether they're working at night, whether they are taking care of children, whether they're taking care of their parents or whatever it is, whatever we can do to help them in their current situation, so, so critical.

**Anna Barbieri :** I, I agree. I think those, you know, even very small changes are really incremental, um, and can lead to real and sustained change. But I would argue that for somebody who is struggling with obesity, hyperlipidemia, um, you know, pre-diabetes, high blood pressure, who has limited resources and cannot pay \$400 out of pocket every month for these [00:38:00] medications, the, you know, the road to Faster change is through change of policy-

**Joanne Stone:** Yeah

**Anna Barbieri :** and through change of coverage. And I think it's, it's great to walk an extra subway stop. It's great to make, um, choices in the moment that are better for us, but these drugs are really powerful. We know their benefits. The data is out there, and coverage policies, policies should follow. Otherwise, we're going to...

We already have this here, and it's going to get even worse. We're going to have a two-tiered, not as a healthcare system, but a two-tiered health system.

**Joanne Stone:** Yeah.

**Anna Barbieri :** So.

**Joanne Stone:** So totally. I mean, you're right, and we, we can't solve it all, you know, the, everything in this room. But I think bringing awareness to this, having people advocate, you know, getting, going to the representatives, you know, to really push for healthcare reform for, for these, well, we're talking [00:39:00] about GLP-1, so f- specifically for this, would be really s- you know, in- incredibly essential, you know?

Yeah. Because it's, it's criminal to hold back medication- Yeah ... that we know works, right? Absolutely. 100%. So, yeah.

**Anu Lala:** And sometimes getting on these medications are kind of the jumpstart people need to be able to engage, like you were saying before- With this. That's exactly right. Yeah ... in healthier habits, 'cause they feel like there's some hope.

**Joanne Stone:** Yeah.

**Anu Lala:** You know?

**Joanne Stone:** Do, do you think that people have to stay on these forever? Like, what, what do we know about that? Do they have to stay on them forever? Because you hear stories when they come off, then all of a sudden they gain the weight back, you know? So what... Is it a li- is it a lifelong prescription?

**Anna Barbieri :** It's a great question.

Oh, yeah. Yeah. So I, I think it depends, you know? W- from the data that we have, it does seem that this is a really long-term medication, [00:40:00] and for people who have been struggling for years or decades, you can't just turn it on and off. You know, like, the, the way I describe it to patients, it's not like if you're getting older and need glasses all of a sudden, you wear your glasses for six months, oh, and then you take them off and you're good.

Doesn't work like that. What we try to do with patients who want to be on these temporarily is when we start them, we institute a pretty intensive plan of lifestyle change and habit sustainability and support them in that, and try to then, like you said, pull back on the dose or even... And again, this is not an FDA-approved way of using these medications, but potentially space out the dosing.

Mm-hmm. And you can see that in a small sample of our patients, they are able to come off and maintain the weight loss. We don't see that in the larger population, especially of people who w- have been struggling for a while. [00:41:00] And when you stop it, there's a rebound weight gain, and a lot of that weight that's gained back is going to be fat gain rather than muscle gain, and that's an issue.

That's an important

**Anu Lala:** point. Yeah. I think that's a... Especially if you haven't kept up with the weight building, maintaining aspect of exercise and movement, that, I think, is, is really challenging, and I certainly have seen that. We've also seen that in clinical trial settings.

**Anna Barbieri :** What do you think of the plateau that we're seeing at about two years in sometimes?

**Anu Lala:** You know, again, for me, it's not about the weight. It's really about where they are metabolically healthy. So I, I... And I prescribe these medicines every day. I'm seeing patients all day long yesterday, today, this morning right before this. I think... You know, and I have such a variety, as I'm sure you do too, in terms of the experiences that our patients are having.

Some saying, like, "I felt terrible on it. I was super [00:42:00] nauseous-" Mm-hmm. "... then I pulled back, way back." And then we start at the baby dose again, if at all, because I know I saw improvements in blood pressure, cholesterol, diabetes that were not conferred with other medications, right? It's not like these are the only medications to treat diabetes, meta- metabolic syndrome, et cetera, but we certainly know that they are very effective, um, and perhaps getting at this root cause issue.

I think this plateau at two years, for me- Matters less than the habit building and forming that I hope that this will afford the vast majority of patients, which I really am seeing, and a, a, a hold, so to speak, on their cardiometabolic health. Uh, can we move in general in our medical world from preserving cardiometabolic health rather than reacting to and treating disease?

Um, [00:43:00] and so there's a fine line, but I am much less concerned with the weight itself and more concerned with their habits and their metabolic health and, and the markers that we have at least of metabolic health.

**Anna Barbieri :** Yeah. And it's a... I would say it's a conversation- Mm ... that's ongoing in the practice, and I think with our patients.

It's certainly a conversation I keep having with myself because I think as women, circling back to kind of the social culture, we are so conditioned to think about weight. We are so conditioned to think that less weight is better- Right ... it's prettier, that to reframe that thinking takes a while. It's, it's not an overnight switch.

**Joanne Stone:** Yeah.

**Anna Barbieri :** Yeah.

**Joanne Stone:** I just had one, I just had one other question to ask you guys. You know, sometimes when I'm, you know, li- listening to the radio and commercials come on about, you know, [00:44:00] if you wanna lose weight and, like, there are certain companies out there, I think, that prescribe compounded formulas. Mm. What do you th- what do you think about those?

**Anu Lala:** Whew. You know, for me- Had to ask. Yeah. For me personally, I would prefer that they go through the traditional prescription route. I just don't know what... These are unregulated bodies that are putting out compounded forms of semaglutide and tirzepatide, quite frankly. How they are compounded, preservatives, additives, preparation, we can't vouch for it, and they're not regulated.

I mean, that's why we have the FDA, right? It's, it's a, it's a body that we have in place, not perfect, but it's an, a body that is meant for the regulation of medications and substances, and I feel like w- we owe it to our patients to be able [00:45:00] to at least tell them, "This is what we know about this medication because it has been studied in this fashion, in this preparation, in these doses."

Um, so I think we owe it to our patients to offer informed choice rather than fear or free reign and misinformation. I don't know, what do you think, Emma?

**Anna Barbieri :** Um, I agree. You know, I think it makes me very wary to, um, know that so many people are using compounded, not well-regulated injectable medications. Um, and I think what a lot of people don't realize is the difference between FDA-approved and compounded, especially injectables.

And I think- Um, a lot of people should also realize that it is the actual business model of some companies to push these medications specifically towards women- Mm ... [00:46:00] because they make a lot of money on that. And part of it is, sure, these GLP-1s have health benefits, but part of it is also the push of these products towards women specifically to achieve a thinner frame for a more desirable aesthetic.

**Anu Lala:** Right.

**Anna Barbieri :** Capitalizing on vulnerability. Um, capitalizing- Yeah ... 100%. Yeah. 100%. I think the nuanced situation is, and, and I certainly have been there as a prescriber, for someone who loses coverage on a medication that has

been there, um, for them and has had significant benefits, and they cannot afford to buy an FDA-approved version of it, but a compounded version may be 50% cheaper.

**Joanne Stone:** That's what I was gonna ask. Yeah. Uh, because they're less expensive, so for those that can't afford it, is it- Mm ... you know, a reasonable option? I don't... You know?

**Anna Barbieri :** Um, this may be controversial to say, um, you know, [00:47:00] I think there are compounding pharmacies, and there are compounding pharmacies. Right. Um, some of them follow all the different, you know, licensing, um, regulations, third-party testing, and frankly, have better techniques than some others.

So having a relationship with a compounder that is a better, more honorable player in these, in this space is important. Um, we do work with a, a certain company that helps patients exactly in that situation, but it is done with full counseling on the potential risks of compounded medications.

**Anu Lala:** Right. It's an informed-

**Anna Barbieri :** Yeah

**Anu Lala:** choice. One thing I wanted to ask actually both of you is what do you think of this construct of the BMI? I mean, you're-- this comes up even, you know, when you're talking about high-risk pregnancy or women who are getting pregnant. We, it's a- across our lifespan, it's almost a vital sign. Where, where are [00:48:00] y- where are your thoughts on, on practice?

How do you implement it?

**Joanne Stone:** It's true. It's like everything that you read, every study that you do, you know, in pregnancy, it's, uh, what's the pre-pregnancy BMI? How does that increase the risk? But, but you're right, it's like height and weight. What d- what does that tell us about the body composition? It does-- tells us nothing.

Like, how much of your weight is 'cause you're, like, a b- you know, bodybuilder, and so have, you know, have a heavier weight 'cause you're all muscle, right? Right. So it's, it's really such an interesting question, and I think we have used it, you know, and continue to use it, but this needs to be m- absolutely better studied.

**Anna Barbieri :** There, um, are, I think, efforts to develop kind of a more of a biologic BMI using markers and a combination thereof that I think would be such a more precise and personalized way of assessing metabolic health than BMI.

**Anu Lala:** Waist circumference, all that [00:49:00] stuff, but

**Joanne Stone:** Yeah, no, f- ab- absolutely. All right, well, so, um, maybe as we close, any, um, advice that you would give somebody that is asking you, you know, what to do, you know, let's say you...

this person is, you know, 52, has noticed this 15-pound weight gain, but maybe she went from 105 to 120. She's 5'4", so clearly not overweight, um, according to BMI Anyway, according to BMI, what we just talked about. Um, doesn't have any markers, but isn't really feeling great about herself, you know, and, and her esteem is down, and she's sort of- Mm

anxious and depressed and feeling, you know, awful, and she thinks she's gonna, you know, break... her relationship is gonna break up because she's just feeling so miserable. What do you, what... Well, other than send her to a psychiatrist I don't know what, what do

**Anna Barbieri :** you say? I, I don't, I don't think a GLP-1 will solve all of those issues.

I think that is [00:50:00] a quick fix. That's a Band-Aid on some complicated stuff that's going on with her. Mm. So I, you know, I would, um, vote for really spending some time with this person, examining the causes of why she's feeling that way. We can introduce the... 'Cause a lot of people come in asking about GLP-1s.

That doesn't mean that's what we're reaching for first. Mm. There's a lot to be said about circadian rhythm, sleep, self-compassion, your own relationship with yourself, hormonal management, you know, especially at this point in life, examining the relationship before we go to a, you know, tirzepatide or semaglutide for- Mm

15 pounds.

**Anu Lala:** Could not agree more. I think it's really, can we get at root causes? Can we understand who this person is? [00:51:00] Where-- can we create a personalized trajectory for this individual to allow for her to have healthy habits

moving forward, and feel well, and be healthy from a cardiometabolic standpoint?

And that may be independent of weight loss.

**Joanne Stone:** Yeah. I mean, and I think what you said, you know, self-compassion, self-care, and making it, you know, normalizing the, what this person's going through, I think is so important, and treating it-

**Anna Barbieri :** Less judgment- Yeah ... of ourselves and of each other too. Yeah. Yeah. You know?

Right. Yeah. It's like, "Oh, she lost all that weight cheating with a GLP-1." Exactly. There is judgment, versus- Right ... "Oh, she let herself go." Judgment. Where, doesn't she know about GLP-1s? Right. Like,

**Joanne Stone:** we're

**Anna Barbieri :** two extremes again. Exactly. So yes, less judgment.

**Joanne Stone:** Yeah. Yes. I mean, 'cause I do feel that way, right? Like, people like, "Oh, this person was on a GLP-1.

That's how they lost all that weight." Yeah. Right. That's them cheating. But, like, you know, it's, it's like th-th-there's a shame either [00:52:00] way. Yes. You know? So- Less judgment.

**Anu Lala:** Would we not-

**Joanne Stone:** Less judgment ...

**Anu Lala:** and personalized care.

**Joanne Stone:** All right. Love it.

**Anu Lala:** Love

**Joanne Stone:** it. Well, thank you, guys, for, um, being part of this incredible podcast today on Herology.

And, um, just looking forward to, to talking more about this. I think we're gonna have another episode maybe in the future talking more about this as well. Ah, this is

**Anna Barbieri :** fascinating.

**Anu Lala:** I love it. This was great. Yeah. Thank you so much for

**Joanne Stone:** having us. Thank you.

**Anna Barbieri :** Thank you.

**Joanne Stone:** So that's it for this episode of Herology.

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[00:53:00] below.