The changing landscape of obesity care

Jane Diggle
Specialist Diabetes Nurse Practitioner, West Yorkshire

It is issue 2 of 2025 already, and we are finally seeing some welcome sunshine and lighter evenings. I hope you are enjoying the sunny spring weather. I am preparing myself for a busy couple of months of face-to-face meetings.

This weekend I have been adding the final touches to a presentation I shall be delivering on early-onset type 2 diabetes at our PCDO Society Smart Update series. It is several years since the Society has run the Smart Updates, and I am very much looking forward to being involved. The focus is on the diagnostic dilemmas and difficult decisions in type 2 diabetes we face every day in clinical practice across different ages and generations. There are five half-day meetings taking place in Leicester, Leeds, Crawley, Bristol and Birmingham. It would be great to see you there – just click here for more details and to register.

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I am still getting used to the Society's change of name (you may recall our Chair, Naresh Kanumilli, explaining why we felt the Society needed to expand its remit); however, at the journal we are also endeavouring to reflect this change in our content, as you will see. To this end, we have invited the Society's new obesity faculty to also join the journal's Editorial Board, to offer their helpful insights and ensure we are covering the key areas within obesity and weight management. If you have any suggestions of topics of interest, we'd love to hear from you at dpc@omniamed.com.

In the last issue, I discussed how the way we define obesity is changing, and in this issue we include an *At a glance factsheet* summarising the new NICE (2025) NG246 guideline on overweight and obesity management. This is such a complex area and, interestingly, this new guideline both updates and replaces several previous related guidelines. I am all for this if it simplifies things and reduces time-consuming searching through multiple documents for advice and guidance on various aspects of management!

Something that features strongly in the new guideline is language. Those of us working within diabetes are no strangers to the impact of the language we use (NHS England, 2023), and this is something we have covered previously in the journal (Bateman, 2021; Christie, 2024). Many people living with diabetes describe being stigmatised by the condition, and I believe this is often bound up with perceptions and beliefs about the link between excess weight and the development of type 2 diabetes, not only in society at large but also among many healthcare professionals. The NG246 guideline reinforces the need for non-stigmatising, person-first language.

This prompted me to reflect on a recent consultation I had with a young woman newly diagnosed with type 2 diabetes and living with obesity (and a particularly high BMI). We spent a long time talking about her weight (she expressed a willingness to do so) and she expressed a real interest in the NHS Type 2 Diabetes Path to Remission programme. Regrettably, her HbA_{1c} exceeded the referral threshold, so instead we focused on her diet and lifestyle, and changes she felt able to make. I did, however, suggest a slightly earlier repeat HbA_{1c} (at 6 weeks rather than 3 months) in the hope that within this time it would have reduced sufficiently for referral onto the programme.

I enjoy having lifestyle discussions and have learned, over the years, never to underestimate their impact, but it isn't always easy to know how well your interpersonal (and I hope non-judgmental) style is received. On this occasion, at the end of our consultation, she asked me for a hug – so I guess I got it right! Six weeks later, she had managed to lose 5 kg and was feeling much better, and her HbA_{1c} had fallen below the threshold to allow for referral to the Path to Remission programme. I am really optimistic that she will do well.

Incretin mimetics have transformed obesity care and do feature – alongside lifestyle approaches – in the NG246 obesity guidance. While tirzepatide has been approved for use in

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Volume 27 | Issue 2

Click to view the full table of contents

primary care for weight management (NICE, 2024), we are still waiting to see how this is implemented across the country. NHS England has recently published interim commissioning guidance to answer some of the questions raised by this approval, and our new Editorial Board member, Satish Durgam, summarises the guidance and reviews who will be eligible to receive tirzepatide for weight management and when.

A recent audit of tirzepatide prescribing in my practice identified more people being prescribed the drug privately for weight loss than by the practice as part of their type 2 diabetes management. I suspect that comprehensive counselling prior to incretin mimetic initiation (which is effectively mandated in the NICE Technology Appraisal) varies considerably, and one aspect that I doubt is covered is the concomitant loss of muscle mass. Any weight loss is likely to comprise loss of both fat and lean mass. In *Diabetes Distilled*, Pam Brown discusses this in detail and offers some useful advice on how to preserve muscle when using incretin mimetics.

Diabetes and associated long-term conditions

My regular references to the incretin-based therapies reflect the abundance of emerging evidence of their benefits. One such example is the recently published cardiovascular outcomes trial for oral semaglutide – SOUL – which demonstrated a 14% reduction in major adverse cardiovascular events in people with type 2 diabetes aged ≥50 years and at high risk of cardiovascular disease (CVD), summarised here. It is, however, important to note that the participants in this study had a higher cardiovascular risk than the general type 2 diabetes population (with one third having established CVD and 25–40% having chronic kidney disease [CKD]), so the results may not be directly applicable to lower-risk populations.

On the subject of CKD, given the substantial evidence base to support their use, SGLT2 inhibitors are now advocated as "the new standard of care for cardiovascular, renal and metabolic protection in type 2 diabetes" (Seidu et al, 2024). With respect to renal benefit, incretin mimetics are running a bit behind SGLT2 inhibitors in the evidence base, though clinical trials designed to show their renal benefits are well underway. Our interactive case study in this issue focuses on CKD and provides more detail on the current evidence underpinning the use of SGLT2 inhibitors and the incretin mimetics in diabetic kidney disease.

Of course, blood pressure (BP) management is an important element in the management of both CKD and diabetes. The optimal BP target for those with type 2 diabetes is not that clear and varies across different guidelines. According to NICE (2023) NG136, BP targets are the same for people with and without diabetes (and/or CVD) and only differ for those with co-existing CKD (see my *Need to know guide* for a quick reference). However, results from the BPROAD trial, summarised in *Diabetes Distilled*, raise the question as to whether it is time to consider lower BP targets in people with type 2 diabetes.

Diabetes rarely exists in isolation and, therefore, any review should take a broader, more holistic approach. Nicola Milne's *How to* in this issue provides comprehensive and practical guidance on how to undertake a multiple long-term conditions review, with links to many of the practical guides we have published all in one place.

While our need to focus on preventing and managing CVD and CKD in people with type 2 diabetes is well established, these are by no means the only comorbidities with diabetes. One less-considered comorbidity we should be mindful of is cancer, and Tahseen Chowdhury summarises the potential links between diabetes and cancer in his *At a glance factsheet*, also providing some practical recommendations on management of hyperglycaemia in patients undergoing cancer therapy.

All of this content is pertinent to our practice, and I hope you enjoy this issue!

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