

# YOUR HEALTH TOOLKIT

Obesity Medicine  
Supportive Care Guide

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Bloom Health — Evidence-based obesity and survivorship care

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Evidence-based guidance from VA/DoD 2025, current FDA labeling,  
CDC, NHLBI, ASMBS/IFSO, and clinical obesity medicine materials

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## Welcome

Obesity is a **chronic, relapsing, multifactorial disease** — not a character flaw, not a lack of willpower, and not something you should expect to fix with a short burst of dieting. In practice, treatment should look more like long-term management of hypertension or diabetes than a temporary restriction.

This guide contains the evidence-based strategies we use to help patients achieve lasting weight loss, improve metabolic health, and sustain results. **Read it. Follow it. Ask questions.**

### What We Assess Up Front

- **BMI plus waist circumference** or waist-to-height ratio
- **Weight trajectory:** prior weight-loss attempts and pattern of regain
- **Complications:** diabetes/prediabetes, MASLD/MASH, OSA, hypertension, dyslipidemia, osteoarthritis, GERD, infertility, functional impairment
- **Sleep apnea screen:** snoring, witnessed apneas, morning headaches, daytime sleepiness
- **Disordered eating:** binge eating, night eating, emotional/reward-driven eating
- **Food insecurity and access:** ability to obtain and prepare recommended foods
- **Obesogenic medications:** beta-blockers, insulin, sulfonylureas, certain antidepressants, antipsychotics, corticosteroids
- **Secondary causes:** hypothyroidism, Cushing syndrome, hypothalamic injury (brain tumor, cranial irradiation, TBI)
- **Sleep, stress, mood:** depression, anxiety, trauma history

### The Treatment Frame

The most useful clinical approach is **complications-centric treatment**: identify what excess adiposity is doing to the body, estimate how much weight loss is needed to change that outcome, and choose the intervention most likely to get there.

Measure	Useful Clinical Anchor
<b>Waist circumference</b>	Common thresholds: $\geq 40$ in (102 cm) men, $\geq 35$ in (88 cm) women; lower Asian thresholds: $\geq 35$ in men, $\geq 31$ in women
<b>Waist-to-height ratio</b>	A ratio $\geq 0.5$ is a practical marker of excess central adiposity
<b><math>\approx 5\%</math> weight loss</b>	Often improves glycemia, blood pressure, triglycerides, and HDL
<b><math>\approx 10\%</math> weight loss</b>	Often needed for larger OSA, liver, and functional benefits
<b><math>&gt;15\%</math> weight loss</b>	More likely to produce major metabolic benefit and sometimes diabetes remission

## The Golden Rules

### 1. Obesity Is a Chronic Disease — Treat It Like One.

If effective therapy is withdrawn, regain is common. The target is better health, function, and durability — the number on the scale matters, but it is not the whole story.

### 2. Protein First, Every Meal.

About 1.0 g/kg/day is a strong practical target. Many patients preserving lean mass do well near 1.0–1.2 g/kg/day. Spread protein across the day rather than saving most of it for dinner.

### 3. Sleep 7+ Hours — It's Not Optional.

Poor sleep increases hunger, cravings, fatigue, and insulin resistance. Untreated obstructive sleep apnea makes long-term weight management harder. Ask about it.

### 4. Structure Is Treatment.

A good obesity plan reduces decision fatigue. That may mean planned meals, meal-prep, protein shakes, logging, accountability visits, or all of the above. Shame is not treatment — curiosity, planning, accountability, and repetition work better.

## Section 1 — Nutrition Foundation

No single perfect diet works for everyone. The strongest long-term pattern for many patients is a **Mediterranean-style approach**: protein-forward meals, produce, fiber, legumes, olive oil, nuts, seeds, and whole-food carbohydrate choices in portions that fit the target calorie range.

### Practical Starting Targets

Target	Practical Starting Point	Why It Matters
<b>Calories</b>	A 500–1,000 kcal/day deficit often leads to ≈1–2 lb/week of weight loss	Useful evidence-based pace for many adults
<b>Women</b>	≈1,200–1,500 kcal/day in many structured plans	Starting point only; individualize for size, age, activity, and medical context
<b>Men</b>	≈1,500–1,800 kcal/day in many structured plans	Starting point only; adjust for lean mass, work demands, and activity
<b>Protein</b>	≈1.0 g/kg/day; many patients do well near 1.0–1.2 g/kg/day	Helps satiety and protects muscle during weight loss
<b>Fluids</b>	Usually ≥64 oz/day	Appetite control, constipation prevention, medication tolerance

### If You Can Only Change a Few Things

- Build meals around **protein first**, then add vegetables or fruit, then add carbs and fats intentionally
- Minimize liquid calories, routine alcohol calories, and unplanned grazing
- Keep ultra-processed snack foods out of the default environment when possible
- Use a plate or bowl on purpose instead of eating from the package

### Mediterranean Pattern in Plain English

- Protein each meal: fish, poultry, eggs, Greek yogurt, cottage cheese, tofu, tempeh, beans, lentils
- High-fiber plant foods most days: vegetables, fruit, legumes, and whole grains
- Fats that help: olive oil, nuts, seeds, avocado
- Limit sugar-sweetened beverages, routine desserts, large restaurant portions, and heavily processed snack foods

*Practical protein note: Many patients do better when they spread protein across the day rather than saving most of it for dinner.*

## Section 2 — Meal Structure, Shakes & Behavior Tools

**Structure is treatment.** A good obesity plan reduces decision fatigue. That may mean planned meals, meal-prep, protein shakes, meal replacements, logging, accountability visits, or all of the above.

### Protein Shakes & Meal Replacements

- They are tools, not failures and not gimmicks
- Best use: replacing a meal or snack **intentionally**, not adding liquid calories on top of the same intake
- Higher-protein products are usually more useful for satiety and lean-mass preservation
- Especially useful when mornings are chaotic, appetite is low, or patients need structure to stop repeated impulsive eating

Helpful Use	Less Helpful Use
<b>Breakfast replacement when mornings are rushed</b>	Using a shake and then still eating a full second breakfast
<b>Planned post-workout protein</b>	Using shakes as uncounted liquid calories
<b>Short-term structured meal-replacement phase with follow-up</b>	Very-low-calorie plans without supervision

## Stress, Mood & Emotional Eating

- Stress, grief, depression, anxiety, trauma, and food insecurity all affect weight-management success
- Ask directly about binge eating, night eating, and reward-driven eating
- SMART goals, self-monitoring, stimulus control, and relapse planning still matter
- Useful question: *What feeling is the food trying to solve right now?*

**Behavior-change pearl:** *Shame is not treatment. Curiosity, planning, accountability, and repetition work better.*

## Section 3 — Sleep, Stress & Physical Activity

Sleep, stress, and movement are not side topics. They directly affect appetite, insulin resistance, fatigue, body composition, blood pressure, and the durability of weight loss.

### Sleep

- Most adults need **7 or more hours of sleep** per night
- Poor sleep increases hunger, cravings, fatigue, and insulin resistance
- Ask about snoring, witnessed apneas, dry mouth, morning headaches, nocturia, and daytime sleepiness
- Untreated obstructive sleep apnea makes long-term weight management harder

### Physical Activity

Type	Starting Goal	Practical Note
<b>Aerobic activity</b>	Build toward $\geq 150$ min/week moderate activity	Walking counts. Consistency matters more than intensity at the beginning.
<b>Strength training</b>	$\geq 2$ sessions/week	Essential for lean-mass preservation and body composition.
<b>Daily movement</b>	Reduce long sedentary stretches	Steps, stairs, short walks after meals, and standing breaks all help.
<b>HIIT</b>	Optional	Use only after a base is built and if joints, conditioning, and symptoms allow.

## Stress Management

- Stress is a common driver of cravings, emotional eating, and poor sleep
- The goal is not to eliminate stress. The goal is to stop stress from repeatedly dictating food choices
- Common tools: planned walks, therapy, mindfulness, journaling, support groups, resistance training, and tighter evening structure

## Section 4 — When Medication Should Enter the Plan

Medication is not a shortcut and not a last resort. It is appropriate when biology keeps overpowering a solid plan or when the complication burden is high enough that lifestyle therapy alone is unlikely to reach the needed degree of weight loss.

- A common threshold is BMI  $\geq 30$ , or  $\geq 27$  with a weight-related complication
- If effective and tolerated, medication is usually continued long term
- FDA-approved obesity medications and indications are preferred when possible

## Current Incretin Options

Medication	How It's Taken	Typical Result	Most Important Cautions
<b>Wegovy (semaglutide 2.4 mg)</b>	Weekly injection	≈15% body weight loss	GI effects, gallbladder, pancreatitis warning, gastroparesis caution; stop $\geq 2$ months before planned pregnancy
<b>Zepbound (tirzepatide)</b>	Weekly injection	≈15–21% body weight loss	Same class GI issues; OCP interaction for 4 weeks after initiation and dose changes; pregnancy planning required
<b>Foundayo (orforglipron)</b>	Daily pill (no food/water timing restriction)	≈10–15% body weight loss	GI effects, reflux, hair loss reported; OCP backup for 30 days after initiation and dose escalation; CYP3A4 interactions; simvastatin restriction; thyroid C-cell precautions

**■ IMPORTANT FOR ALL INCRETIN MEDICATIONS: Tell your surgeon, anesthesiologist, or endoscopist if you take Wegovy, Zepbound, or Foundayo. All three labels warn about rare pulmonary aspiration during general anesthesia or deep sedation. Your care team may need to adjust timing around procedures.**

## Other Options Still Matter

Medication	Best Fit	Main Avoid / Caution Points
<b>Qsymia (phentermine/topiramate ER)</b>	When appetite and grazing are major issues and stimulant/teratogenicity concerns are low	Pregnancy; glaucoma, kidney stones, tachyarrhythmia, insomnia, CAD, uncontrolled HTN
<b>Contrave (naltrexone/bupropion ER)</b>	When cravings or reward-driven eating are prominent and incretins are not a fit	Seizure disorder, uncontrolled HTN, chronic opioid use, anorexia/bulimia, abrupt ETOH/benzo withdrawal
<b>Saxenda (liraglutide)</b>	When weekly GLP-1 products are not available or patient has prior liraglutide success	Same class GI, gallbladder, pancreatitis, and thyroid C-cell precautions
<b>Orlistat</b>	Limited modern role	Modest efficacy with frequent GI issues and fat-soluble vitamin concerns
<b>Setmelanotide (IMCIVREE)</b>	Bardet-Biedl syndrome, POMC/PCSK1/LEPR deficiency, or acquired hypothalamic obesity	Not a general obesity medication; reserved for specific genetic or acquired syndromes with confirmed diagnosis

## Section 5 — Medication Safety & Side Effects

**Most GLP-1 and GIP/GLP-1 side effects are gastrointestinal and manageable** with slower eating, smaller meals, better hydration, and careful titration. The goal is to anticipate them instead of being surprised by them.

### Common Early Effects

- Nausea, early fullness, constipation, diarrhea, reflux, and reduced appetite
- Practical response: protein first, smaller portions, slow eating, hydration, and early constipation management

### Pregnancy & Contraception

- Weight-loss medications are **not used during pregnancy**
- Semaglutide should be stopped at least **2 months** before a planned pregnancy
- Tirzepatide and orforglipron can reduce oral contraceptive effectiveness — use backup contraception for **4 weeks** (tirzepatide) or **30 days** (orforglipron) after starting and after each dose escalation

### Drug Interactions (Orforglipron/Foundayo)

- Orforglipron can affect absorption of other oral medications; take narrow-therapeutic-index drugs (e.g., warfarin) with monitoring
- **Simvastatin restriction:** do not exceed simvastatin 20 mg/day while on orforglipron
- CYP3A4 interactions: discuss all current medications with your prescriber before starting

### Cancer-Relevant Note

For patients with prior brain tumor, traumatic brain injury, or cranial irradiation, **hypothalamic obesity** should remain on the differential.

## Section 6 — Surgery, Insurance & Access

### When to Refer for Surgery or Endoscopy

- Bariatric surgery remains the most effective and durable treatment for obesity
- Per 2022 ASMBS/IFSO guidelines: surgery is recommended for BMI ≥35 regardless of comorbidity, and should be considered for BMI 30–34.9 with metabolic disease
- Surgery can also be considered starting at BMI ≥30 when nonsurgical methods have not achieved substantial or durable benefit
- Endoscopic options can help selected patients who want something between medication and surgery
- A surgery referral is not a commitment to surgery. It opens an informed discussion.

### Insurance & Manufacturer Support

Program	What to Expect Right Now
<b>Wegovy / NovoCare</b>	Commercially covered eligible patients may pay as little as \$25 for a 1-month supply. NovoCare can help with benefits investigation, prior authorization, and appeals.
<b>Zepbound / Lilly</b>	Commercially covered eligible patients may start as low as \$25. Current published self-pay options can still be several hundred dollars per month depending on dose and program.
<b>Foundayo / LillyDirect</b>	At approval on April 1, 2026, Lilly announced launch pricing for commercially covered and self-pay patients. Coverage rules are still evolving because the approval is new.

- Medicare generally excludes weight-loss-only medications

- A good prior authorization usually documents BMI criteria, weight-related complications, prior lifestyle intervention, and why cheaper options are not appropriate
- Savings programs change often; every prescription still needs a real-time coverage check
- Avoid casually using compounded or unapproved GLP-1 products; the FDA continues to express safety concerns about unapproved GLP-1 drugs used for weight loss

## Section 7 — Your Practical Action Plan

Start with the smallest set of actions you can actually sustain.

1. **Know your starting point.** Weight, waist, and the health target that matters most.
2. **Create a calorie deficit you can live with** — not just tolerate briefly.
3. **Hit your protein target most days.** ≈1.0 g/kg/day, spread across meals.
4. **Fix your sleep.** Aim for 7+ hours and evaluate for sleep apnea if symptoms fit.
5. **Move your body.** Build toward 150 min/week aerobic + ≥2 strength sessions.
6. **Use structure.** Shakes, meal replacements, logging, and accountability if they help.
7. **Add medication or surgery referral** when needed weight loss exceeds what lifestyle alone is likely to achieve.
8. **Follow up early** and adjust instead of waiting for regain.

*Bottom line: The best obesity plan is not the most intense one. It is the one that matches your biology, your complication burden, and what you can realistically sustain.*

## Section 8 — Red Flags: When to Call Us

Call the prescribing team or seek care immediately if you experience any of the following:

Symptom	Why It Matters
Severe abdominal pain, especially with persistent vomiting	Could represent pancreatitis, gallbladder disease, bowel obstruction, or another urgent process
Unable to keep down fluids or dehydration symptoms	Medication side effects can become dangerous if dehydration develops
Jaundice or dark urine	Raises concern for gallbladder or liver problems
Chest pain, major shortness of breath, or fainting	Do not assume every symptom is from the medication
Pregnancy while taking an obesity medication	Treatment plan needs urgent review

Symptom	Why It Matters
Major new mood change or suicidal thoughts	Urgent mental-health evaluation matters no matter what medication is on board
Rapid weight loss (>3 lb/week sustained)	May indicate excessive restriction or underlying illness
Persistent severe constipation	Can become dangerous — may need medication adjustment

## Recommended Products

Below are commonly recommended products for supporting your weight-management plan. These are suggestions, not endorsements — equivalent brands work fine. Dietary supplements are not weight-loss therapy (VA/DoD 2025 recommends against nutraceuticals for clinically meaningful weight management).

Category	Product	Cost	Notes
Protein	Ensure Max Protein (30g)	~\$28/12pk	150 cal, 1g sugar; strong macro profile
Protein	Fairlife Core Power (42g)	~\$36/12pk	Highest protein per bottle
Protein	Orgain Organic Shake	~\$30/12pk	Plant-based option, 16g protein
Calorie Density	Boost VHC (530 cal/8 oz)	~\$55/27pk	Special circumstances only: rapid weight loss, post-surgical, or calorie needs exceed intake
Kitchen	Digital food scale	~\$12–20	Essential for accurate portion learning
Kitchen	Meal prep containers (set)	~\$15–25	Glass or BPA-free, portion-sized
Exercise	Resistance bands (set)	~\$15–25	Home strength training, portable
Tracking	Food logging app (free tier)	Free	MyFitnessPal, Cronometer, Lose It!
GI Relief	MiraLAX (polyethylene glycol)	~\$15	OTC; for GLP-1 constipation
GI Relief	Ginger chews / ginger tea	~\$5–10	OTC; helps GLP-1 nausea
Supplement	Daily multivitamin	~\$10–15	Basic coverage during calorie deficit; not a weight-loss treatment

*Prescriptions (GLP-1 medications, phentermine, etc.) will be provided by your care team. Savings programs (NovoCare, Lilly) should be checked at every refill — terms change frequently.*

## Selected Source Families

This guide was built from local Bloom Health obesity materials, the 2025 VA/DoD obesity guideline, current FDA labeling for Wegovy/Zepbound/Foundayo (reviewed April 2026), 2022 ASMBS/IFSO bariatric surgery guidelines, CDC sleep and physical-activity guidance, and NHLBI calorie-deficit education.

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# My Treatment Journal

A place to notice patterns, remember questions, and track what helps.

*You do not need to fill this out perfectly. Even a few notes can help you see patterns, remember what worked, and tell your care team what is actually happening at home.*

## This Week

Week of / goals / anything I especially want help with

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## Daily Check-In

Day / Date	Energy (0-10)	Pain (0-10)	Eating / Drinking	Sleep	Main note
Mon					
Tue					
Wed					
Thu					
Fri					
Sat					
Sun					

## Symptoms I Want to Watch

<input type="checkbox"/> Hunger / cravings	<input type="checkbox"/> Fullness / nausea	<input type="checkbox"/> Protein / fluids
<input type="checkbox"/> Movement	<input type="checkbox"/> Sleep	<input type="checkbox"/> Mood / stress
<input type="checkbox"/> Other: _____		

## What I Tried / What Helped

Use this page to test small changes and keep track of what helps, what does not, and what you want to ask about next.

Problem or symptom	What I tried	Did it help?	Next step / question

*Examples: taking pain medicine before meals, changing skin care timing, drinking earlier in the day, using a humidifier, adjusting fiber, walking after treatment, or asking for a refill.*

## Questions for My Care Team

Bring this page to visits. Small questions are worth writing down, especially when treatment days start to run together.

Symptoms or side effects I want to mention

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Medication, refill, or product questions

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Eating, drinking, bowel, bladder, skin, sleep, or activity questions

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Logistics: appointments, transportation, work, family, forms

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One thing I keep forgetting to ask

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