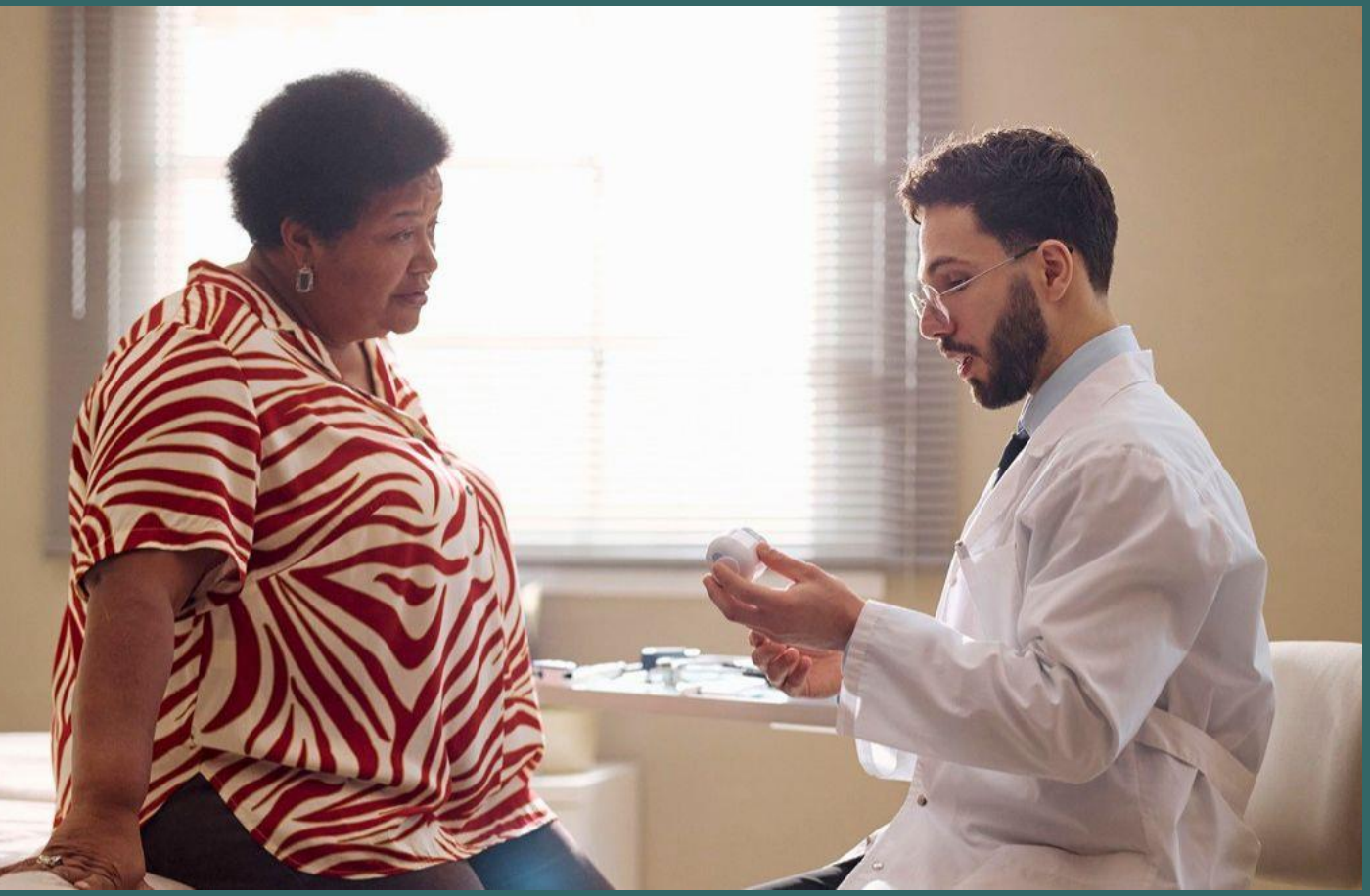
LIVING BEYOND
BREAST CANCER®



Hot topics in breast cancer care

Weight management, GLP-1s, and shared decision-making

Thank you to our speakers



Michelle Bronzo, MA, LPC, LCPC, LMHC, CT, FT
Psychotherapist, Michelle Bronzo Counseling, LLC



Neil M. Iyengar, MD

Co-Director, Breast Medical Oncology; Director, Cancer Survivorship Services; Associate Professor of Hematology and Medical Oncology, Winship Cancer Institute at Emory University



Learning Objectives

In today's program, you'll learn how to:

- Describe the relationship between weight gain, cancer treatment, and health-related outcomes.
- Explain the potential benefits, risks, and unknowns for GLP-1 use in patients with a history of breast cancer.
- Compare the benefits of exercise and other weight-management strategies.
- Explain patients' practical and emotional concerns about weight gain and the varied approaches to its management.
- Apply strategies for shared decision-making with patients.

Continuing education available

Earn up to:

- **1.0 *AMA PRA Category 1 Credit™* (Physicians)**
- **1.0 ANCC contact hour (Nurses)**
- **1.0 ASWB ACE continuing education credit (Social Workers)**

Live Learner Notification:

- **Accreditation details**
- **Disclosures**
- **Evaluation and certificate instructions (end of p.2)**
  - **Submit by 12/18/2026**

Questions? Contact us at hcp@lbbc.org.

This project is supported by Grant/Cooperative Agreement Number NU58DP007913 from the Centers for Disease Control and Prevention. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Centers for Disease Control and Prevention.



WEIGHT MANAGEMENT & BREAST CANCER

Neil M. Iyengar, MD

Co-Director, Breast Medical Oncology

Director, Cancer Survivorship Services

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Winship Cancer Institute at Emory University

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EMORY WINSHIP CANCER INSTITUTE
National Cancer Institute-Designated Comprehensive Cancer Center

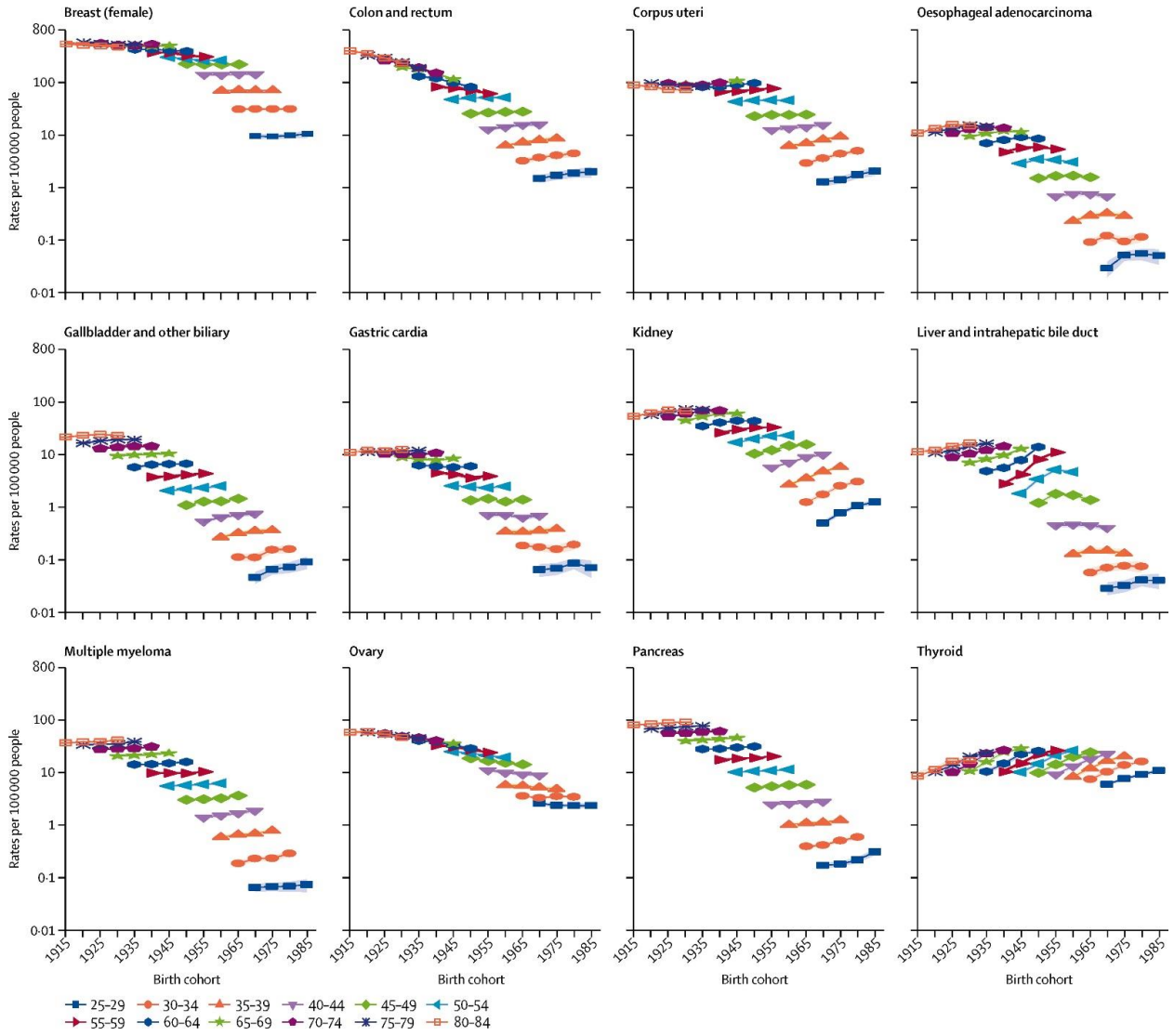
NCI Designated Comprehensive Cancer Center

Where Science Becomes Hope®

DISCLOSURES

- I have the following financial relationships to disclose:
  - Consultant/Advisor: Pfizer, Novartis, Seattle Genetics, AstraZeneca, Gilead, Boehringer Oncology, Amneal Pharmaceuticals, Arvinas, Daichii-Sankyo, Genentech/Roche, Bayer, SynDevRx, TerSera Therapeutics, BD Life Sciences, Menarini-Stemline, Puma
  - Speaker (Unbranded): MJH Life Sciences, CurioScience, IntrinsiQ Health, Community Health Media, Cardinal Health, DAVA Oncology
  - Editorial Positions: ONCOLOGY (Editor-in-Chief)
  - Equity / Ownership: The Bettering Company, Roon
  - Research Support (to institution): National Cancer Institute / National Institutes of Health, Breast Cancer Research Foundation, American Cancer Society, American Institute for Cancer Research, Conquer Cancer Foundation
  - Contracted Research (PI): Novartis, SynDevRx

OBESITY-RELATED CANCERS ON THE RISE IN YOUNG ADULTS



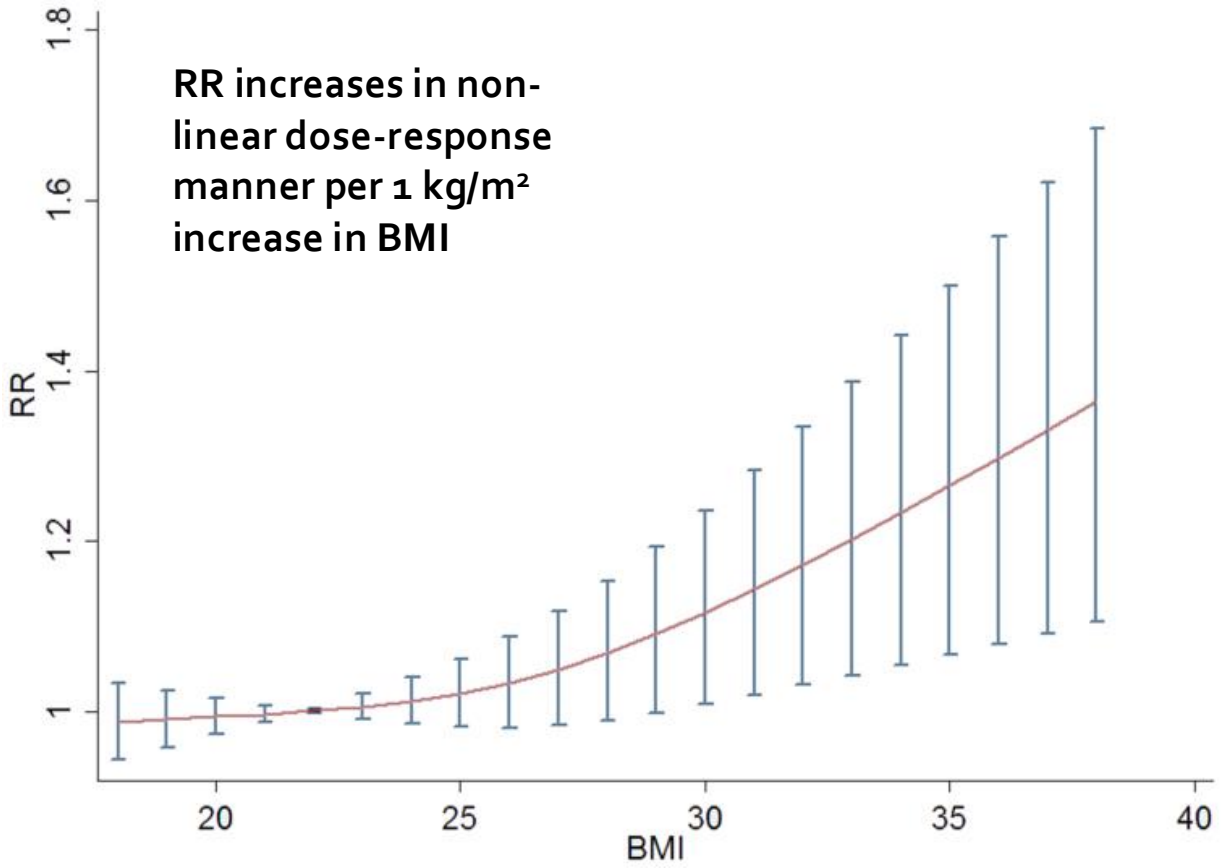
- Mouth, pharynx and larynx
- Esophagus (adenocarcinoma)
- Stomach (cardia)
- Pancreas
- Gallbladder
- Liver
- Colorectum
- Breast (postmenopause)
- Ovary
- Endometrium
- Prostate (advanced)
- Kidney
- Thyroid

Sung et al. Lancet Public Health. 2019

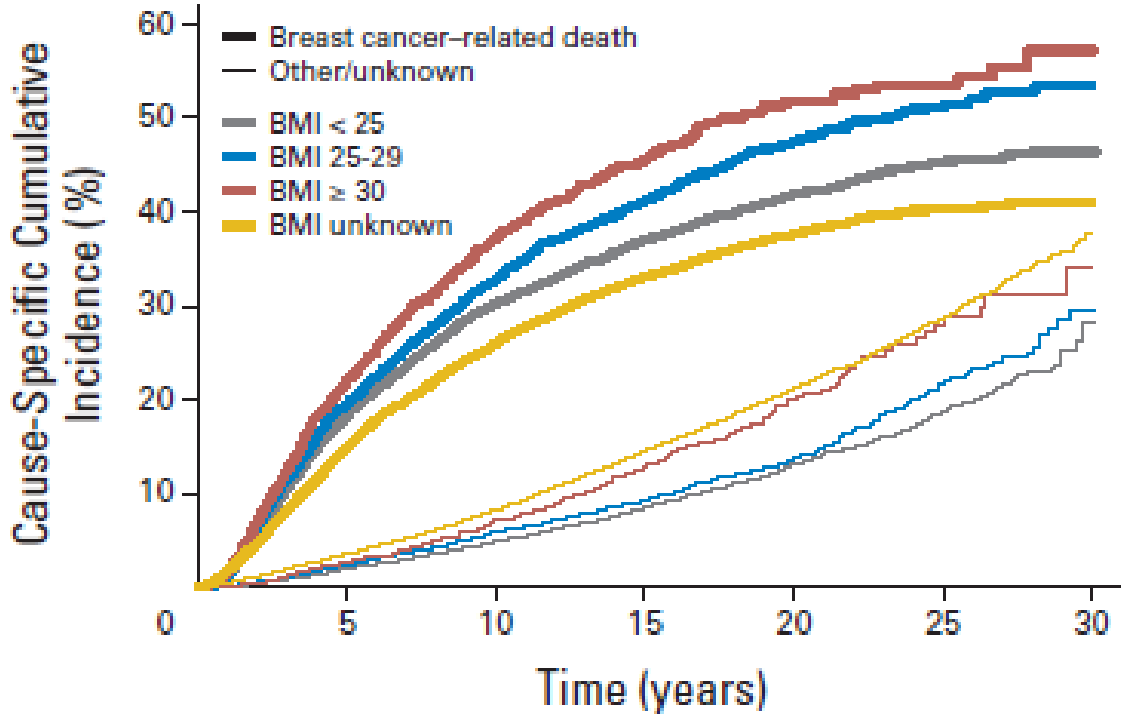
Body Mass Index & Breast Cancer Risk/Outcomes

Risk of ER+ postmenopausal breast cancer

RR increases in non-linear dose-response manner per 1 kg/m² increase in BMI



Breast cancer-related mortality



Xia et al. Scientific Reports 2004
Ewertz et al. JCO 2010

CASES



56yo postmenopausal woman with cT3N1M0 TNBC of R breast

- Planned to start neoadjuvant KEYNOTE522 regimen
- Co-morbidities: BMI 34, diabetes on metformin 1000 bid (Hb A1c 6.2%)

She was planning to start **tirzepatide** prior to TNBC diagnosis and asks if she could start with her breast cancer treatment.



42yo premenopausal woman with pT1cN0M0 HR+/HER2-neg IDC of L breast

- s/p lumpectomy + XRT, OncotypeDX RS 18
- planned to start adjuvant OS + AI
- Co-morbidities: BMI 29 on semaglutide (prior BMI 33)

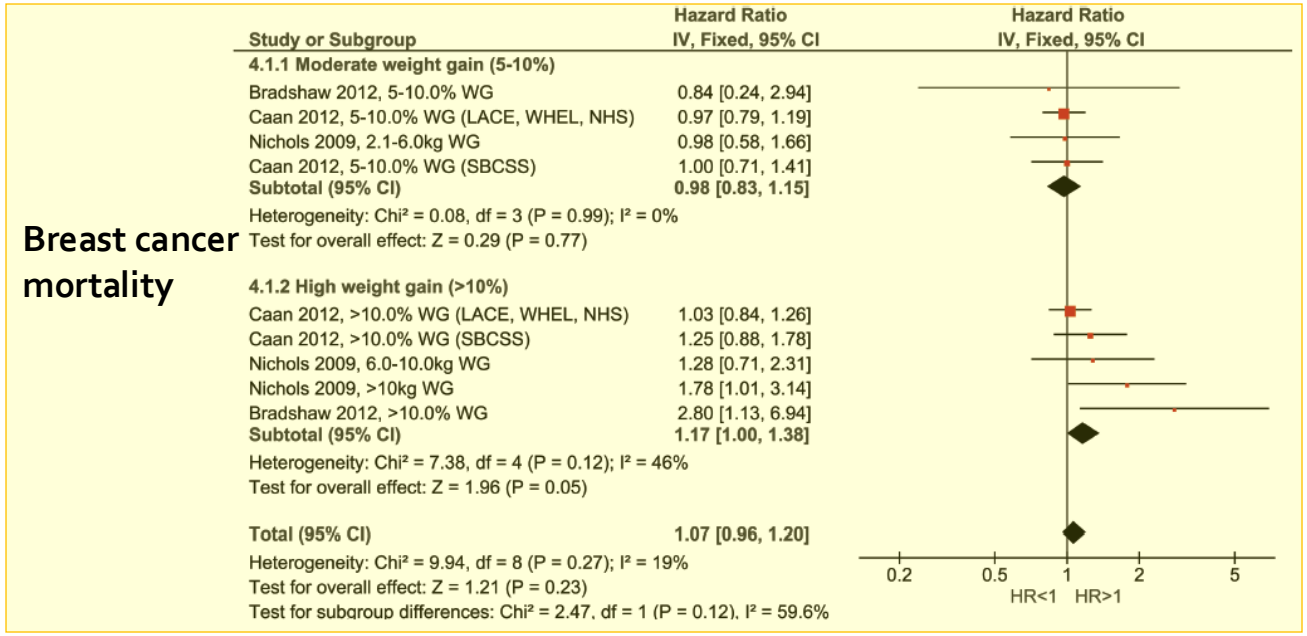
She asks if she could continue **semaglutide** with adjuvant endocrine therapy.

WEIGHT GAIN AFTER DIAGNOSIS

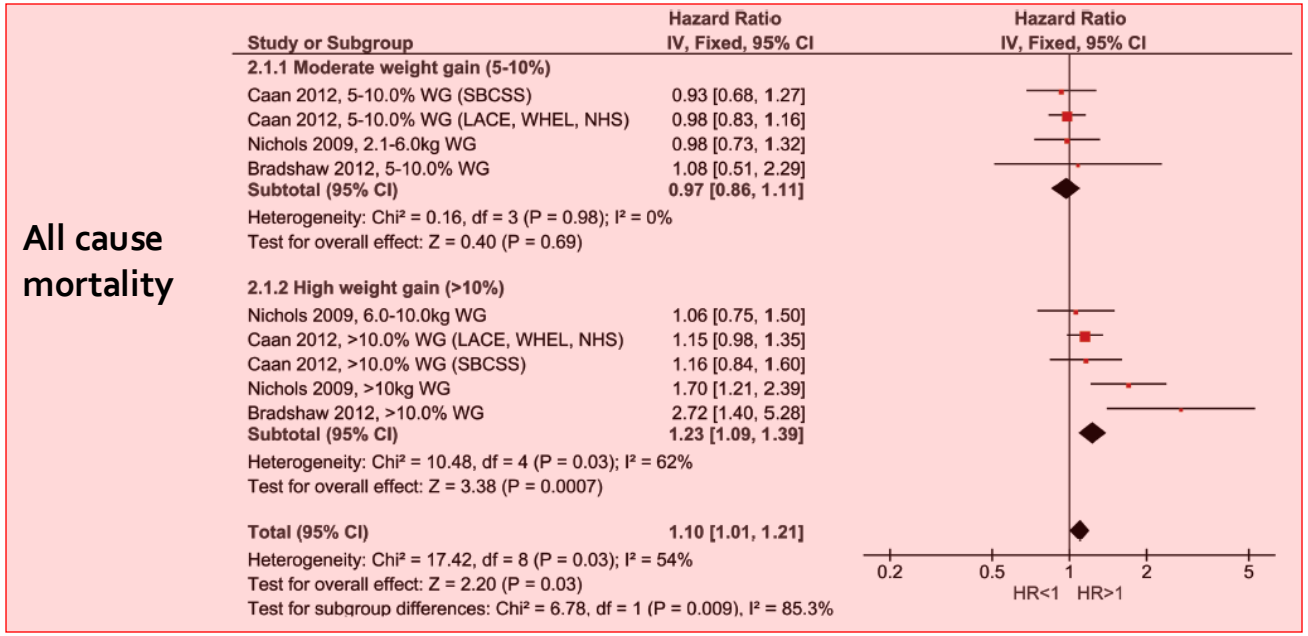
Meta-analysis:
12 studies published up to Dec 2014

Weight gain after diagnosis (over average of 1.5 years) is associated with increased mortality

Breast cancer mortality

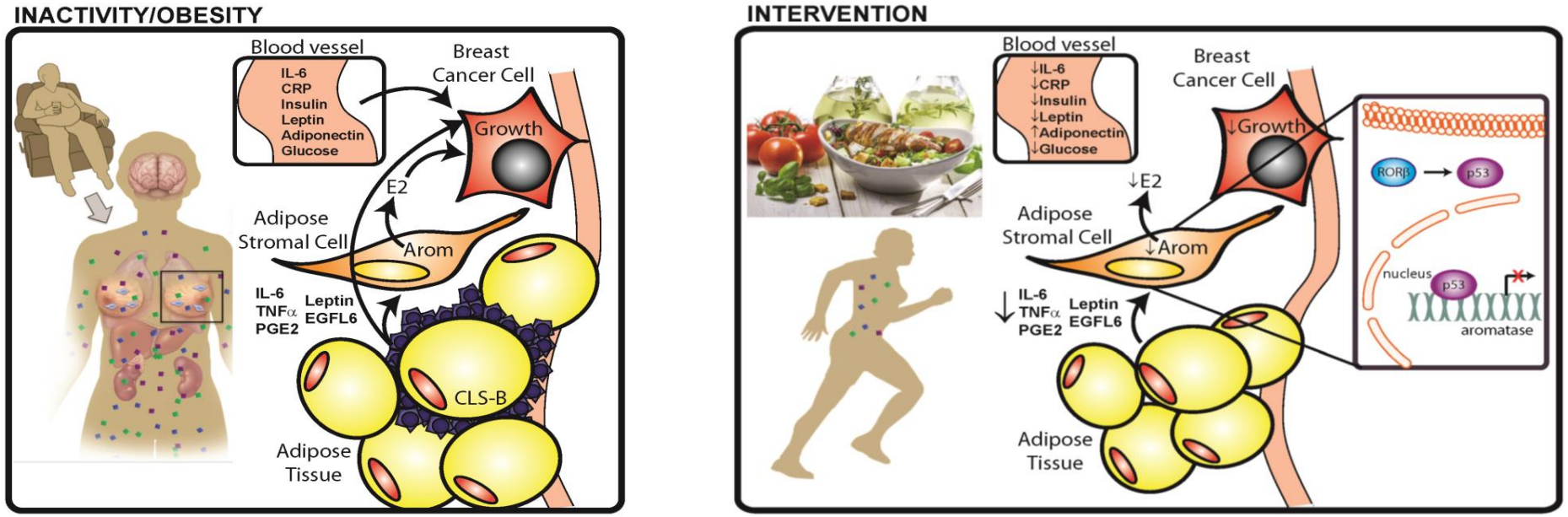


All cause mortality



Playdon MC et al. JNCI 2015.

WEIGHT LOSS TO IMPROVE TISSUE MICROENVIRONMENT AND BIOMARKERS



Iyengar et al. J Clin Oncol 2016

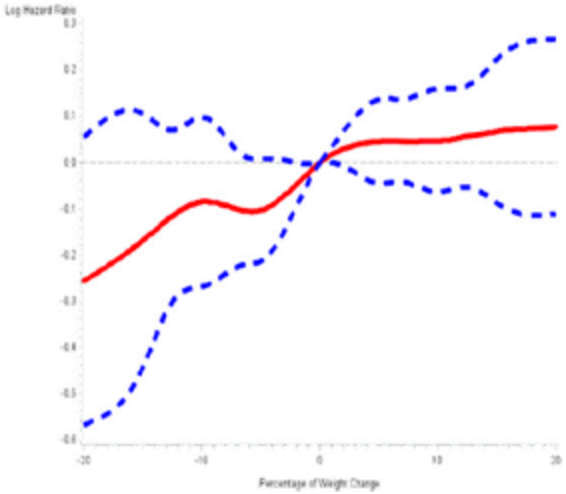
Breast Cancer Research and Treatment. 2013 November; 142:119-132

Favorable Modulation of Benign Breast Tissue and Serum Risk Biomarkers Is Associated with >10% Weight Loss in Postmenopausal Women

Carol J. Fabian, Bruce F. Kimler, Joseph E. Donnelly, Debra K. Sullivan, Jennifer Klemp, Carola Zalles, Gordon B. Mills and Stephen D. Hursting

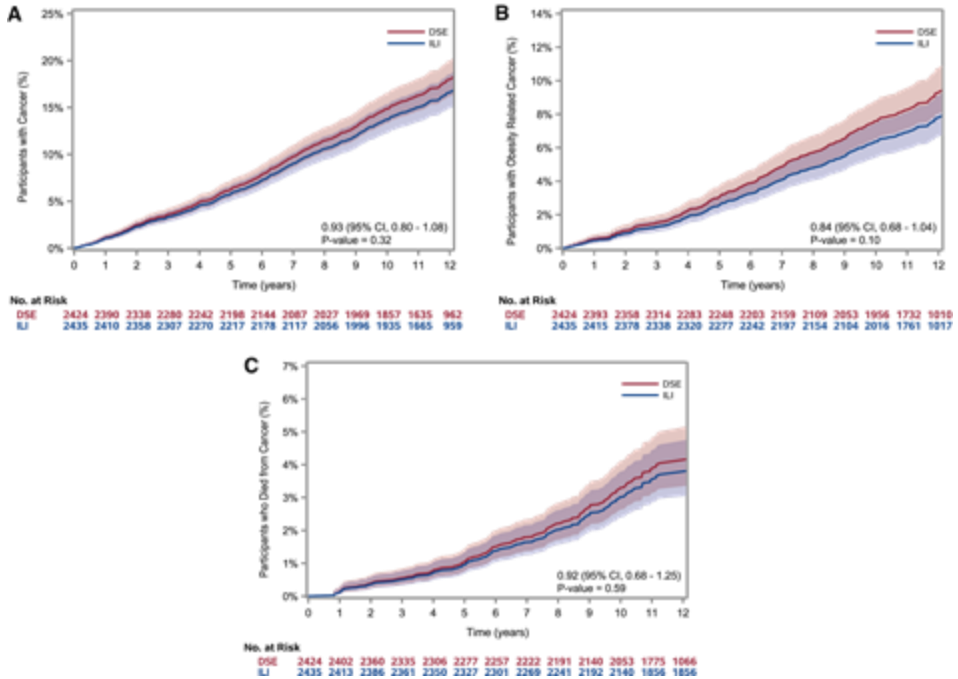
WEIGHT LOSS IS ASSOCIATED WITH REDUCED INCIDENCE OF OBESITY ASSOCIATED CANCERS WITH VARYING EFFECT SIZE

Women's Health Initiative:
- Prospective observational study
- N = 58,667 postmenopausal women
- 12 years median follow-up
- ≥5% weight loss associated with 12% reduction in Obesity Associated Cancers (HR 0.88; 95% CI 0.80 – 0.98)



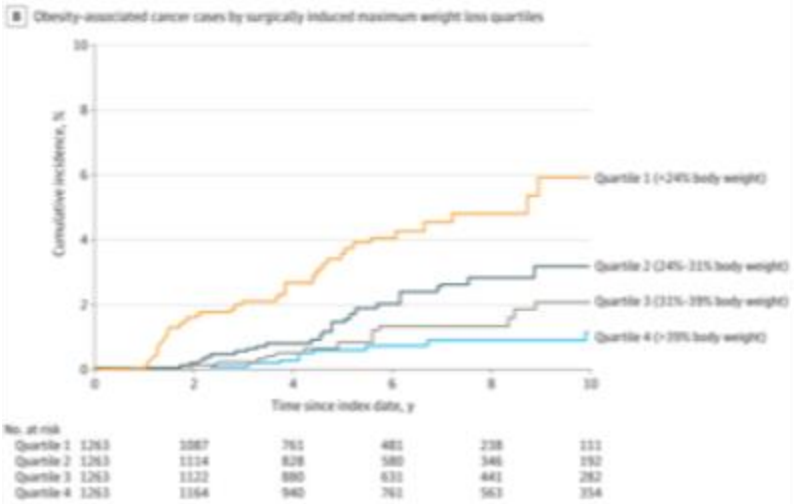
Luo et al. *JNCI Cancer Spectr* 2019

Look AHEAD RCT (post hoc analysis):
- Lifestyle weight loss intervention
- N = 4859 Ow/Ob with T2DM
- 11 years median follow-up
- 16% reduction in Obesity Associated Cancers (HR 0.84; 95% CI 0.68 – 1.04)



Yeh et al. *Obesity* 2020

SPLENDID matched cohort study:
- Bariatric surgery vs no surgery
- N = 30,318 (matched 1:5)
- 6.1 years median follow-up
- 32% reduction in Obesity Associated Cancers (HR 0.68; 95% CI 0.53 – 0.87)



Aminian et al. *JAMA* 2022

BREAST CANCER WEIGHT LOSS (BWEL) TRIAL

3136 Participants

Key Eligibility*

- Stage II-III Breast Cancer
- HR+/HER-2- or TNBC
- Diagnosed w/in past 14 months
- Completed with surgery and any chemotherapy and/or radiation
- BMI ≥ 27 kg/m2

*Patients planning on taking medications for the purpose of weight loss and/or undergoing a surgical weight loss procedure within 2 years were not eligible

Randomize

- **Health Education + 2-year Telephone-Based Weight Loss Intervention**
- **Health Education Alone**

Standardized Program:

- Telephone-based weight loss program
- Based on Social Cognitive Theory
- Adapted from Diabetes Prevention Program, Look AHEAD, LISA

Centralized Delivery:

- 42 calls over 2 years
- Each patient paired with a weight loss coach, based at Dana-Farber
- Weekly months 1-3
- Biweekly months 3-12
- Monthly months 13-24

Intervention Goals:

- 10% weight loss
- 500-1000 kcal/day deficit
- Increased physical activity
  150-225 minutes moderate-intensity activity/week



	CONTROL (n=1173)	WLI (n=1222)	P VALUE
Absolute Weight Change at 6-months	+ 0.2 kg	- 4.4 kg	<0.0001
% Weight Change at 6-months	+ 0.3%	- 4.8%	<0.0001
Absolute Weight Change at 12-months	+ 0.7kg	- 4.4kg	<0.0001
% Weight Change at 12-months	+ 0.9%	- 4.8%	<0.0001

Ligibel et al. ASCO 2023.

PHASE 2 RCT: NUTRITION + STRUCTURED EXERCISE FOR WEIGHT LOSS

Eligibility
- Stage I-III ER+ breast cancer
- Completed curative surgery, radiation, and cytotoxic treatment
- Current treatment with adjuvant aromatase inhibitor
- BMI ≥ 27
- Sedentary (< 90 min exercise / wk)

- **Breast biopsy**
- **DEXA**
- **Fasting blood**
- **CPET**
- **Stool**

Randomize

6 months

Structured Exercise + Plant-based diet (N=28)

Attention Control Telephone counseling + Treadmill (N=28)

Post-study Visit

- **Breast biopsy**
- **DEXA**
- **Fasting blood**
- **CPET**
- **Stool**

TECHNOGYM



Study Endpoints

Primary: Breast aromatase level
Secondary: Breast tissue gene expression changes, Blood markers, body composition, weight loss, adherence, microbiome, QOL / PROs

Biostatistical Design

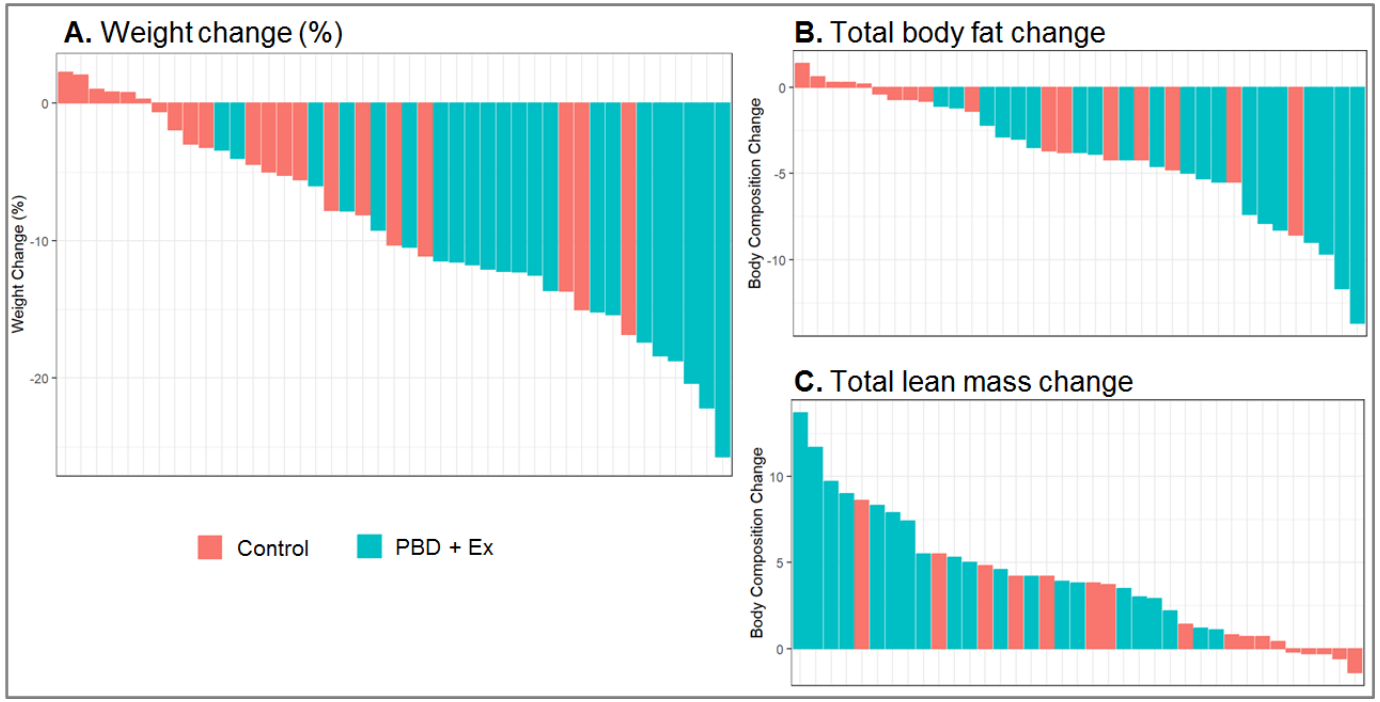
- 1 unit decrease in BMI = 0.06 mean reduction in aromatase (SD 0.81, log scale)
- Goal BMI reduction is 3 kg/m^2

NCT04298086

PHASE 2 RCT: PRECISION NUTRITION + STRUCTURED EXERCISE

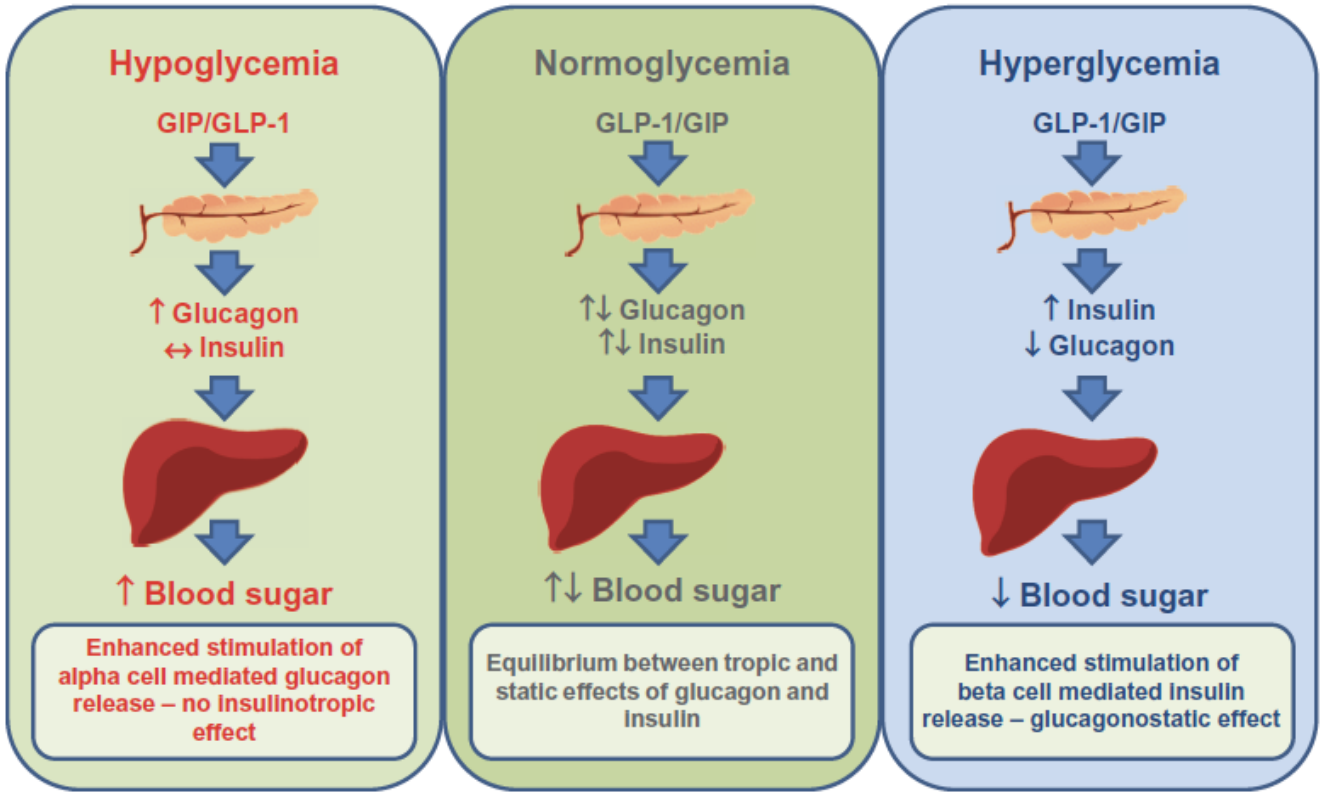
Characteristic	Control (N = 21)	PBD + Ex (N = 22)
Age at consent, mean (SD)	58 (7)	56 (7)
Race, number (%)		
White	16 (76%)	15 (68%)
Black	4 (19%)	3 (14%)
Other	0 (0%)	3 (14%)
Unknown	1 (5%)	1 (5%)
Ethnicity, number (%)		
Non-Hispanic	15 (71%)	18 (82%)
Hispanic	4 (19%)	4 (18%)
Unknown	2 (10%)	0 (0%)
BMI, mean (SD)	34.2 (4)	34.3 (5)
Smoking, number (%)		
Never	13 (62%)	14 (64%)
Prior/quit	8 (38%)	8 (36%)
Alcohol intake, number (%)		
Never	2 (9%)	4 (18%)
Prior/quit	1 (5%)	2 (9%)
Yes	18 (86%)	16 (73%)
Stage, number (%)		
I	11 (52%)	12 (55%)
II	7 (33%)	8 (36%)
III	3 (14%)	2 (9%)
Receptor status, number (%)		
ER+/PR–/HER2–	1 (5%)	1 (4%)
ER+/PR+/HER2–	19 (90%)	18 (82%)
ER+/PR+/HER2+	1 (5%)	3 (14%)
Chemotherapy, number (%)	6 (29%)	8 (36%)
Radiation, number (%)	18 (86%)	17 (77%)
Ovarian suppression, number (%)	5 (24%)	14 (64%)

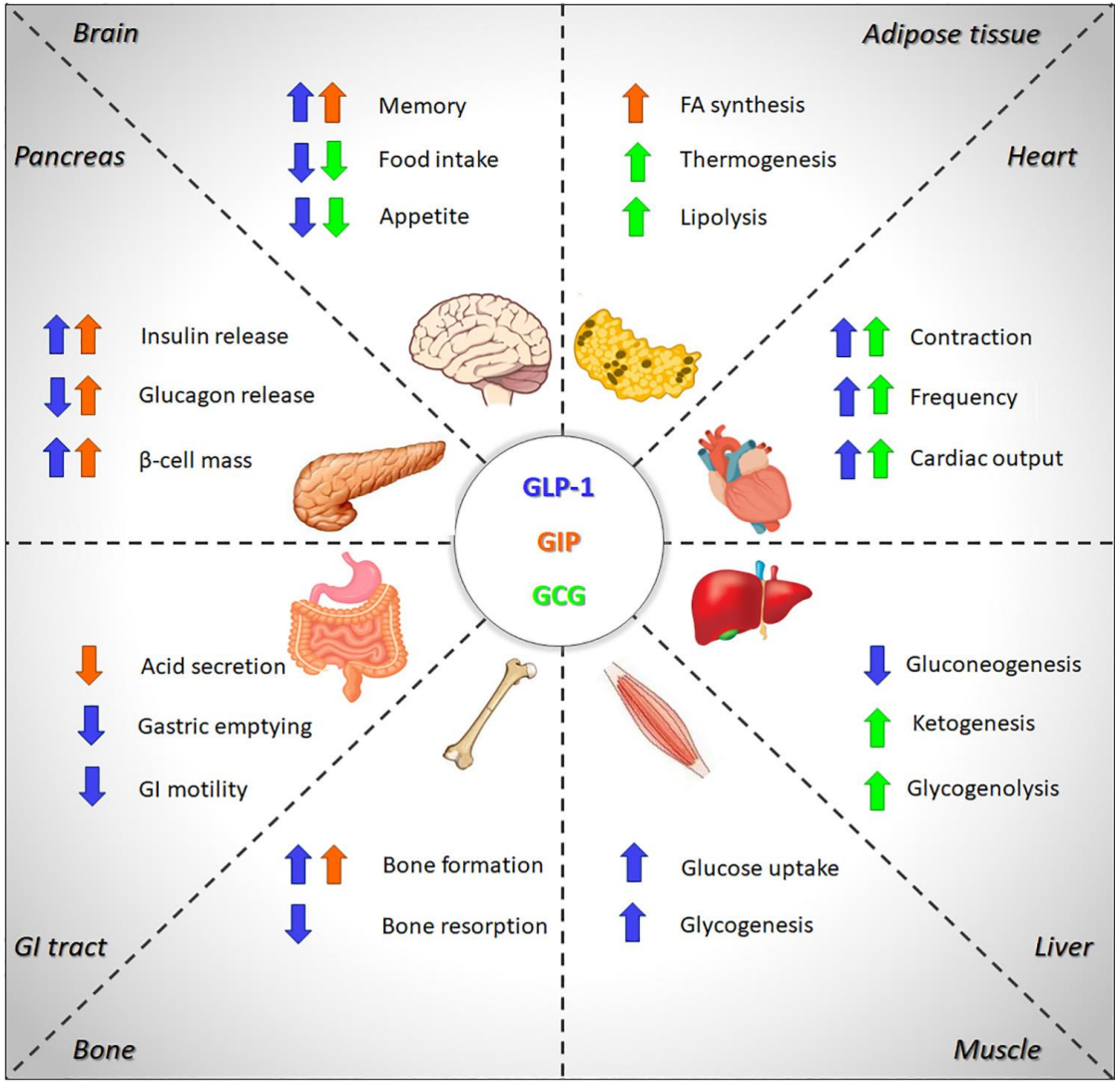
	Control (N=21)	PBD + Ex (N=22)	P
	Change (95% CI)	Change (95% CI)	
Weight (kg)	-4 (-6.6, -2.2)	-12 (-15, -9.4)	<0.001
Total body fat (kg)	-2 (-3.5, -0.71)	-6 (-7.3, -4.1)	<0.001
Trunk fat (kg)	-3 (-4.4, -0.73)	-7 (-8.9, -4.9)	<0.001
Total body lean mass (kg)	2 (0.71, 3.5)	6 (4.1, 7.3)	<0.001
Total body fat to lean mass ratio	-0.01 (-0.02, 0.00)	-0.02 (-0.03, 0.00)	0.4



Iyengar et al. ASCO 2024.

INCRETIN MIMETICS – DUAL- AND TRI-RECEPTOR AGONISTS





Von Websky et al. Vasc Health Risk Manag 2013
Folli et al. Am J Physiol Endocrinol Metab 2023

GLP-1 RECEPTOR AGONISTS AND CANCER

Key findings from the 2026 ASCO Annual Meeting – Dr. Iyengar's Highlights

TAKE-HOME MESSAGE

Across multiple real-world cohorts, GLP-1RA exposure was associated with lower cancer incidence, less metastatic progression, and improved survival. These observational findings are hypothesis-generating, not causal.

CANCER PREVENTION / INCIDENCE

High-risk women with obesity (BMI ≥30)

Breast cancer incidence: 2.95% vs 3.01%
HR 0.844 (95% CI 0.779–0.915)

Abstract 10520 • Gotera et al.

Community oncology cohort

1,121 GLP-1RA users; 69% had BMI ≥30
Semaglutide was the most common agent (64%).

74% initiated GLP-1RA after cancer diagnosis; breast (27%) and prostate (13%) were most common.

METASTATIC PROGRESSION AFTER DIAGNOSIS

Stage I–III cancer • GLP-1RA vs DPP-4 inhibitor • TriNetX

NSCLC	10.0% vs 22.3%	**HR 0.50 (0.43–0.59)**
Breast	10.2% vs 20.1%	**HR 0.57 (0.46–0.71)**
Colorectal	13.4% vs 22.2%	**HR 0.69 (0.54–0.88)**
HCC	18.9% vs 28.4%	**HR 0.62 (0.44–0.89)**

Significant reductions in 4 of 7 tumor types; 12,112 patients in the final propensity-matched analysis.

Abstract 3143 • Orland et al.

OVERALL SURVIVAL

Adjusted HR

0.58

95% CI 0.40–0.84

24-mo OS was higher among GLP-1RA users in breast and prostate cancer.

Adjusted for age, BMI, stage, and cancer type.

Abstract 11017

Sruti et al.

POPULATIONS

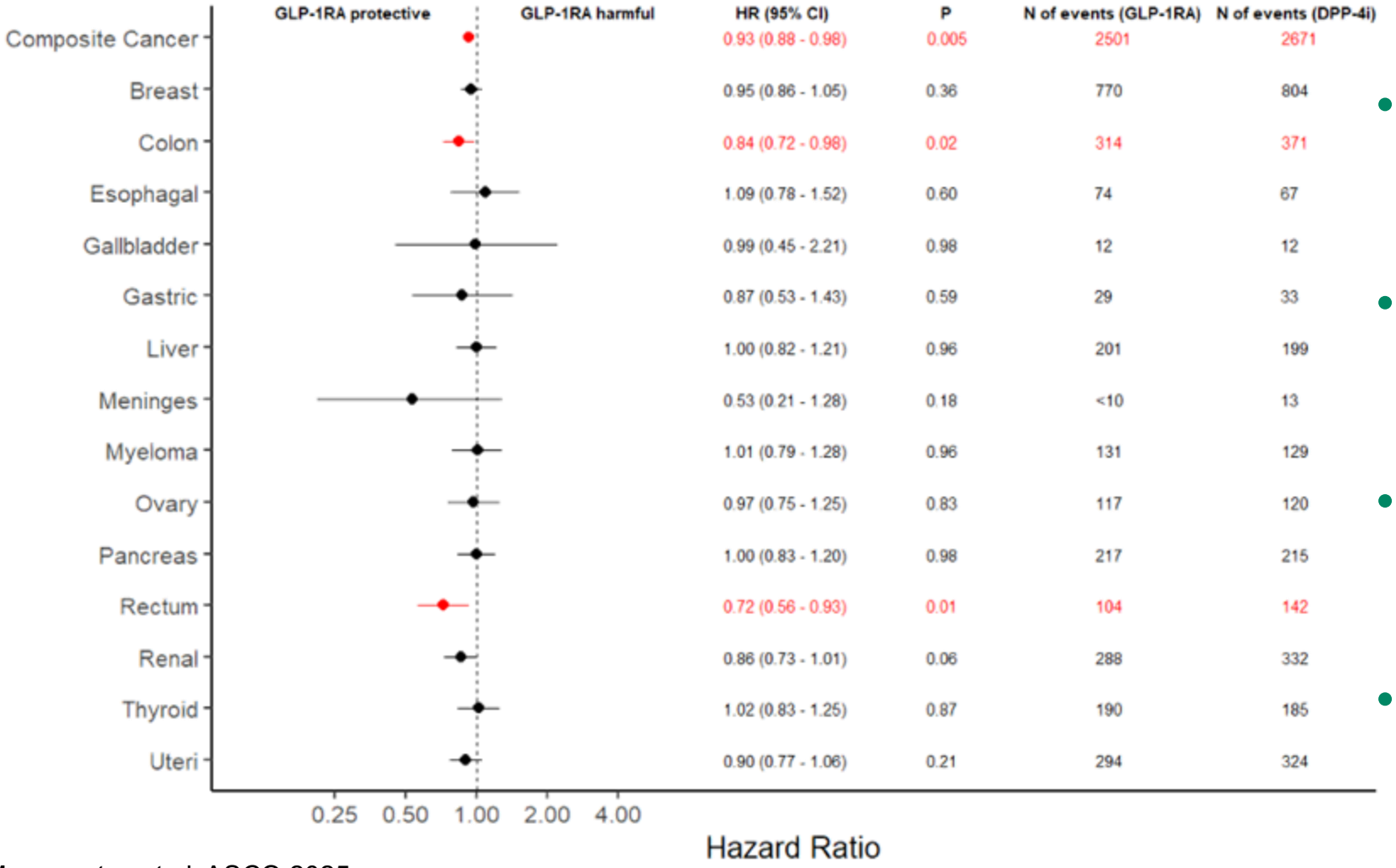
- Obesity / high breast-cancer risk (BMI ≥30)
- Cancer cohorts enriched for obesity and metabolic disease
- Stage I–III solid tumors after diagnosis
- Comparators included non-users and DPP-4 inhibitor users

LIMITATIONS

Retrospective real-world analyses • residual confounding • exposure misclassification • heterogeneous populations and follow-up • association ≠ causation • randomized trials needed

Selected ASCO 2026 abstracts: Gotera et al., #10520; Orland et al., #3143; Sruti et al., #11017. Data shown are as reported in the meeting abstracts.

IN PATIENTS WITH TYPE 2 DIABETES, GLP-1RA USE WAS ASSOCIATED WITH 7% LOWER CANCER INCIDENCE VS DPP4I USE

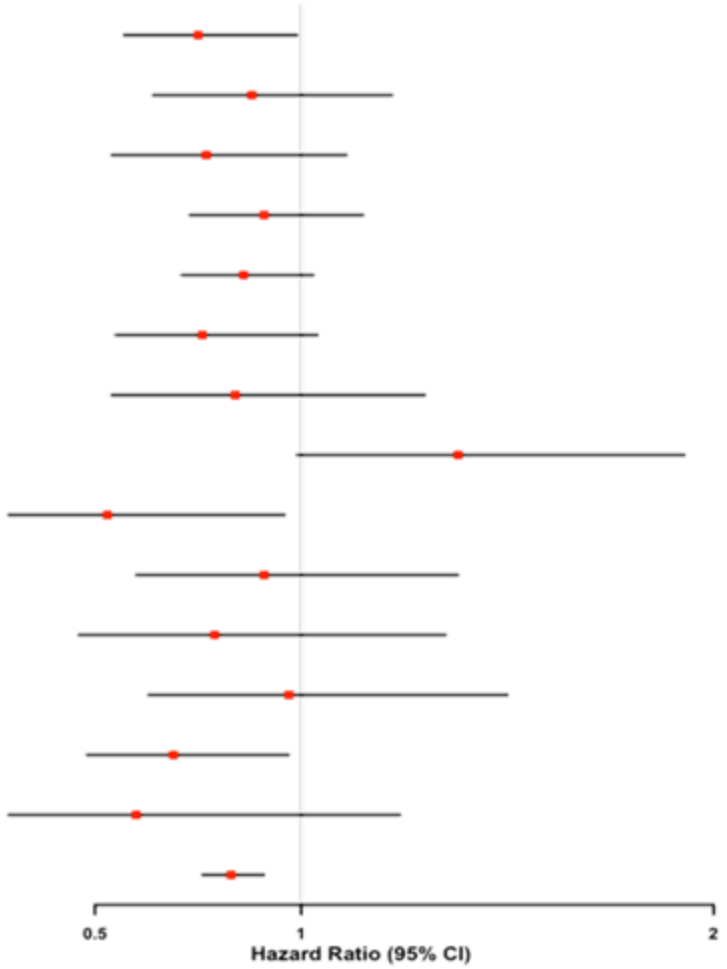


- 7% lower cancer incidence rate HR 0.93 (0.88–0.98)
- 8% lower all cause mortality rate HR 0.92 (0.87–0.97)
- Benefit driven by colorectal cancer risk reduction
- No signal for increase in specific cancers

Mavromatos et al. ASCO 2025.

IN PATIENTS WITH OR WITHOUT DIABETES, GLP1-RA USE WAS ASSOCIATED WITH 17% LOWER CANCER INCIDENCE

Outcome	GLP-1RA, n/N (IR)	non-GLP-1RA, n/N (IR)	Hazard ratio (95% CI)
Endometrial cancer	86/29379 (2.93)	115/29741 (3.87)	0.75 (0.57, 0.99)
Colorectal cancer	70/43317 (1.62)	76/43315 (1.75)	0.88 (0.64, 1.22)
Thyroid cancer	54/43317 (1.25)	67/43315 (1.55)	0.77 (0.54, 1.11)
Prostate cancer	151/13938 (10.91)	145/13561 (10.69)	0.91 (0.73, 1.15)
Breast cancer	200/29379 (6.81)	234/29741 (7.87)	0.86 (0.71, 1.03)
Lung cancer	70/43317 (1.62)	88/43315 (2.03)	0.76 (0.55, 1.04)
Pancreatic cancer	37/43317 (0.85)	42/43315 (0.97)	0.84 (0.54, 1.30)
Kidney cancer	83/43317 (1.92)	58/43315 (1.34)	1.38 (0.99, 1.93)
Ovaries cancer	17/29379 (0.58)	32/29741 (1.08)	0.53 (0.29, 0.96)
Liver cancer	44/43317 (1.02)	46/43315 (1.06)	0.91 (0.60, 1.38)
Multiple myeloma	24/43317 (0.55)	29/43315 (0.67)	0.79 (0.46, 1.35)
Bladder cancer	41/43317 (0.95)	40/43315 (0.92)	0.97 (0.63, 1.50)
Meningioma	55/43317 (1.27)	76/43315 (1.75)	0.69 (0.48, 0.97)
Upper gastrointestinal cancer	12/43317 (0.28)	19/43315 (0.44)	0.60 (0.29, 1.24)
Overall cancer	891/43317 (20.5)	1022/43315 (23.6)	0.83 (0.76, 0.91)



Dai et al. ASCO 2025.

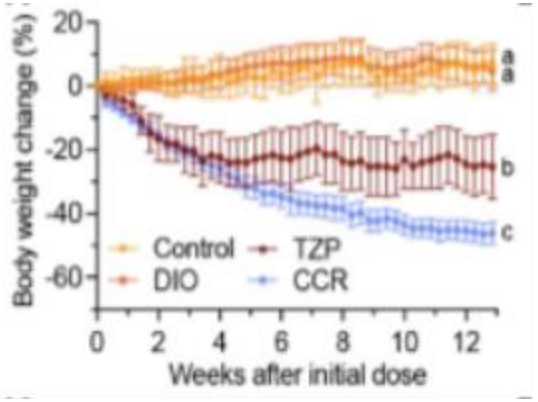
INCRETIN MIMETICS ATTENUATE TUMOR GROWTH: PRECLINICAL EVIDENCE

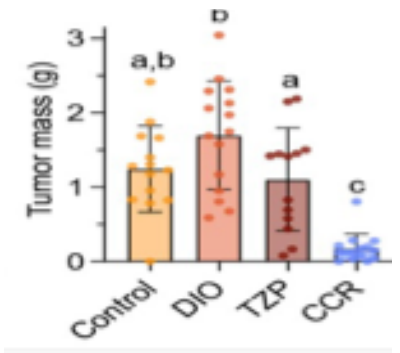
Tirzepatide attenuates mammary tumor progression in diet-induced obese mice

Elaine M. Glenny, Alyssa N. Ho, Violet A. Kiesel, Fangxin Chen, Claire E. Gates, Evan M. Paules, Ruihan Xu, C. Alex Holt, Michael F. Coleman, Stephen D. Hursting

doi: https://doi.org/10.1101/2024.01.20.576484







Analyte	Control	DIO	TZP	CCR
Adiponectin (µg/ml)	20.0 (7.5)†	23.1 (6.8)†	28.7 (13.4)†	95.0 (40.0)*#
Ghrelin (ng/ml)	15.5 (6.5)†	10.7 (3.0)†	16.2 (5.1)†	27.4 (12.1)*#
GIP (ng/ml)	1.9 (0.4)	1.8 (0.6)	2.0 (0.5)	2.0 (0.3)
GLP-1 (pg/ml)	124.2 (66.2)	108.8 (48.6)	100.8 (48.2)	130.2 (36.7)
Glucose (mg/dl)	127.6 (15.0)†	149.5 (18.5)*†	124.5 (15.5)	107.6 (18.8)#
Glucagon (pg/ml)	847.6 (279.7)	702.0 (185.3)†	696.3 (94.0)†	972.2 (252.7)#
IGF-1 (ng/ml)	30.5 (5.3)	53.8 (18.2)*††	49.0 (10.3)	36.5 (7.9)
Insulin (ng/ml)	2.6 (0.9)	4.5 (1.2)*††	2.6 (0.5)	3.1 (1.6)
Leptin (ng/ml)	0.6 (0.2)†	11.9 (4.4)*††	3.8 (2.5)*†	1.6 (1.2)
PAI-1 (ng/ml)	2.6 (1.4)††	1.7 (0.6)	1.1 (0.5)*	1.9 (0.4)#
Resistin (ng/ml)	89.8 (25.2)	65.5 (15.3)*†	69.0 (17.7)	90.0 (16.5)

Glenny et al. bioRXiv 2024.

INCRETIN MIMETICS IN POST-DIAGNOSIS SETTING

Shen et al:

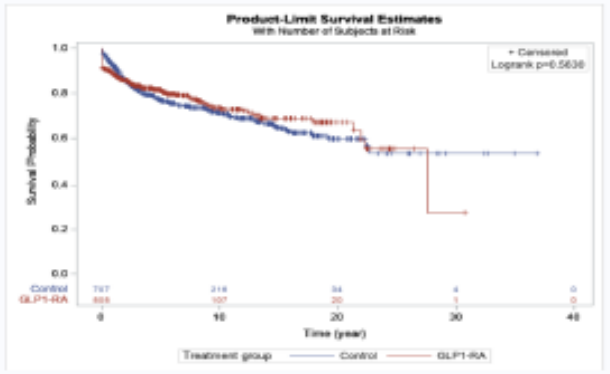
- Retrospective observational study at MSK
- N = 75 women with stage 0-4 breast cancer
- Median GLP-1a duration: 20 months (6 – 111)
- Mean weight change: -6.2 kg (95% CI -6.2 – -2.1)
- Mean relative weight change: -5% (SD 6%)

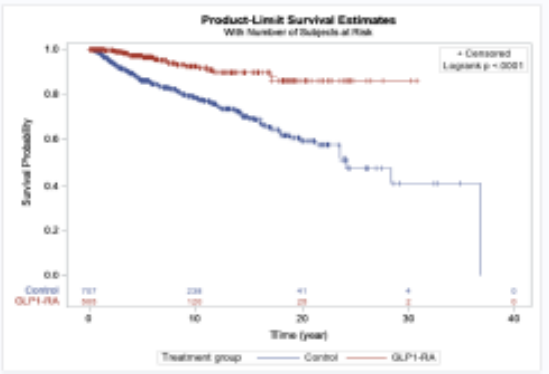
Variable		N	Odds ratio		p
BMI at GLP Start		46		0.95 (0.85, 1.05)	0.30
Race	White	22		Reference	
	Black Or African American	14		0.69 (0.13, 3.58)	0.66
	Asian, Other/No Response	10		0.10 (0.01, 0.90)	0.06
Ethnicity	Not Hispanic	40		Reference	
	Hispanic Or Latino	6		2.17 (0.24, 28.00)	0.50
Stage	0-1	13		Reference	
	2	19		0.92 (0.17, 5.24)	0.92
	3	10		2.45 (0.35, 21.11)	0.38
	4	4		10.20 (0.65, 360.22)	0.13
Receptors	HR-Positive	33		Reference	
	HER2-Positive	9		0.62 (0.09, 3.77)	0.61
	Triple-Negative	4		0.67 (0.02, 11.10)	0.78
Concurrent Endocrine Therapy	No	16		Reference	
	Yes	30		1.65 (0.31, 9.76)	0.56
Menopause	Post	41		Reference	
	Pre	5		0.54 (0.04, 6.04)	0.62

Shen et al. ONCOLOGY 2025.

Sukumar et al:

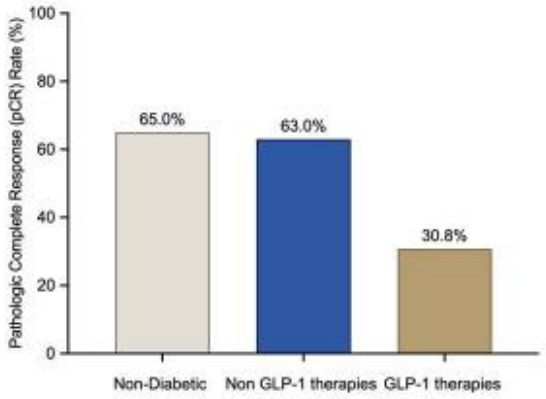
- Retrospective observational study at MDACC
- N = 1,022 patients with stage 0-3 breast cancer
- Median follow-up 4.7 years (0 – 30.9)
- 38.1% (n=389) received semaglutide or tirzepatide; Median weight loss:
  - 3 months: -2.1% (-13.2%-14.9%)
  - 6 months: -2.9% (-20.2%-19.0%)
  - 12 months: -3.1% (-27.8%-11.5%)
- Tamoxifen or AI use associated with weight gain (+2.3kg; p=0.037)
- DFS: Median 27.53 years (0-30.7) GLP-1RA vs not reached (0-36.08) control
- OS: Median not reached (0-30.7) GLP-1RA vs 24.1 years (0-36.8) control, p<0.0001

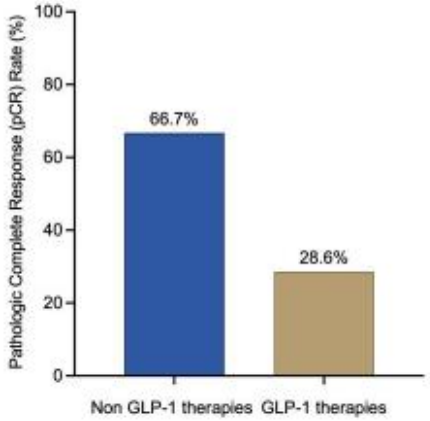


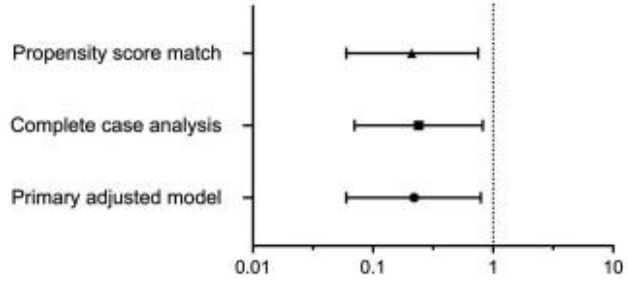


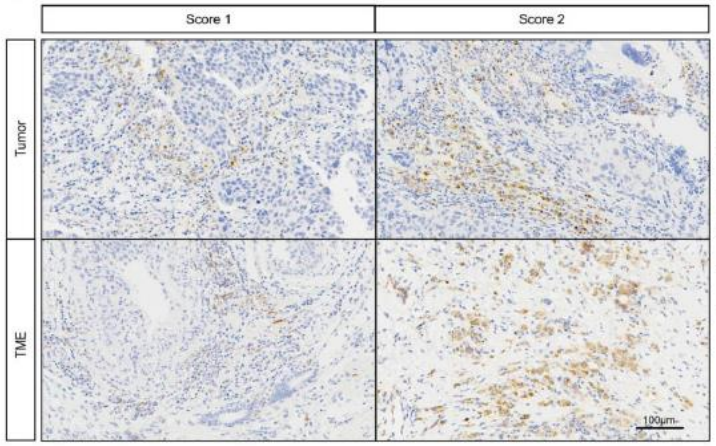
Sukumar et al. SABCS 2024

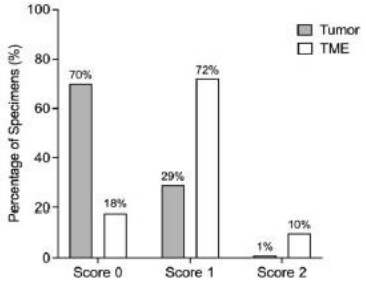
A NOTE OF CAUTION: GLP1-RA USE DURING NEOADJUVANT KEYNOTE522

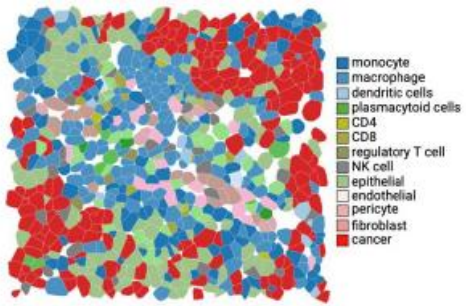


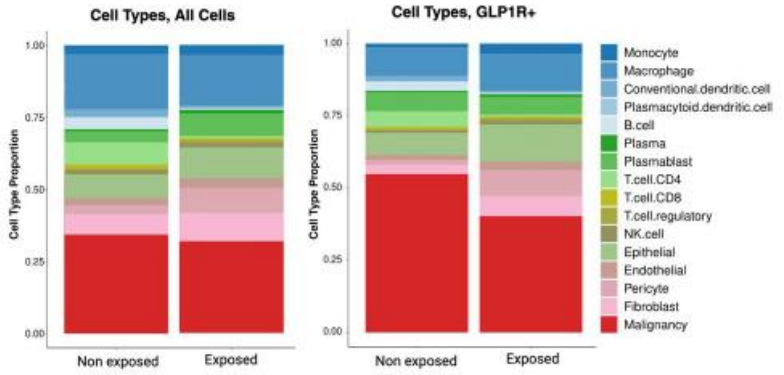






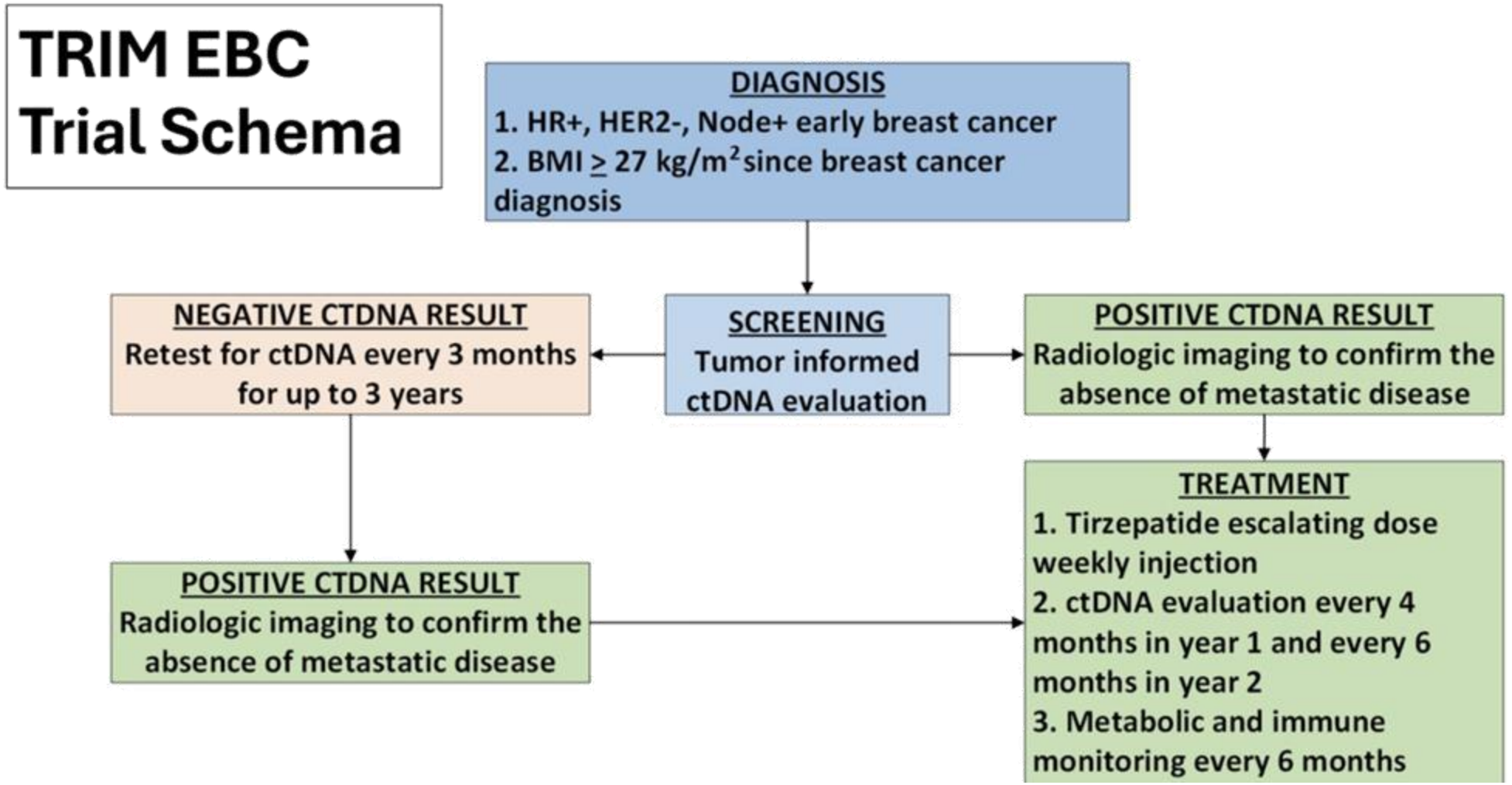






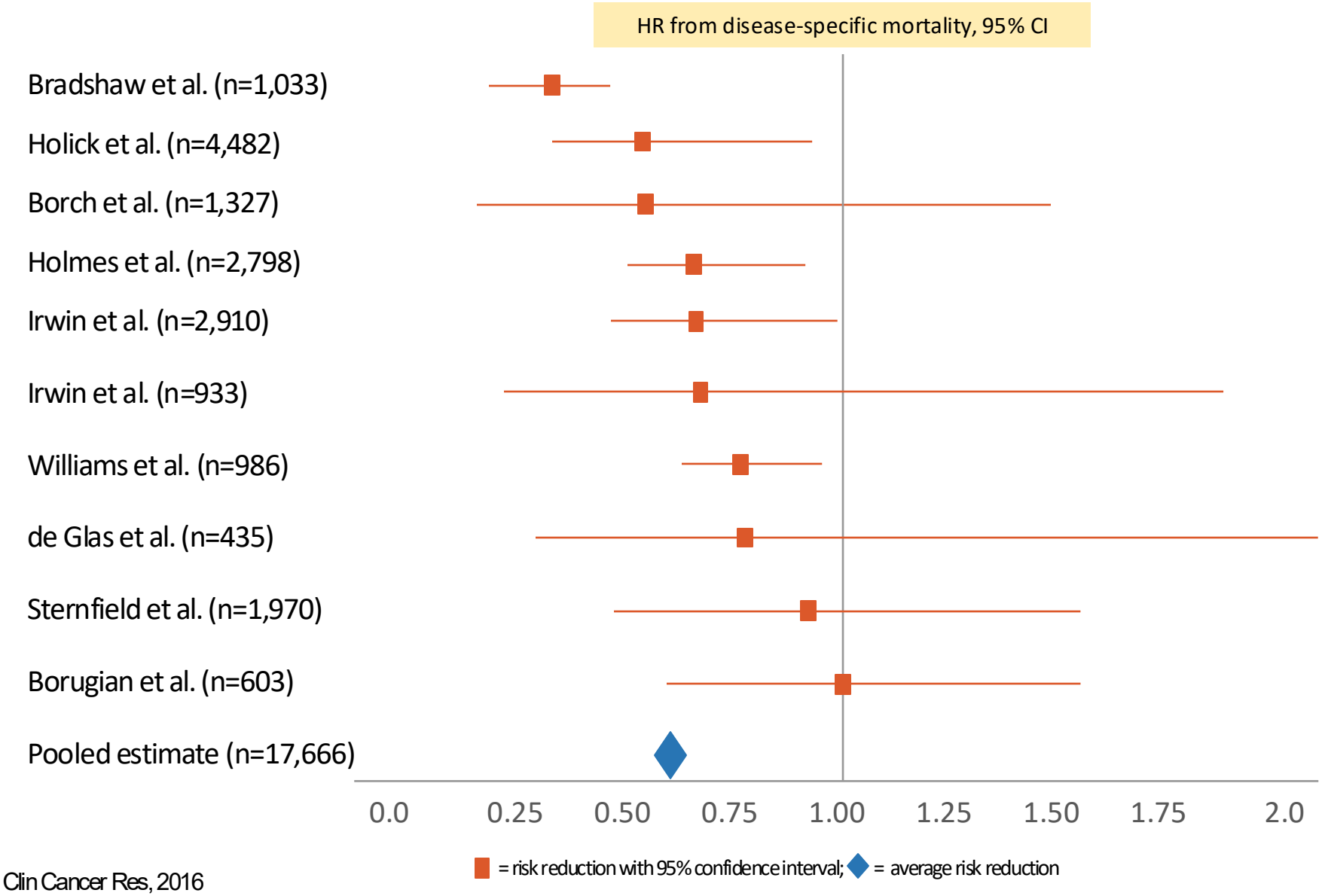
Santos B, *Marção* et al. Preprint. *Research Square.* 2026.

CLINICAL TRIAL - ADJUVANT



O'Shaughnessy et al.

EXERCISE AND BREAST CANCER MORTALITY

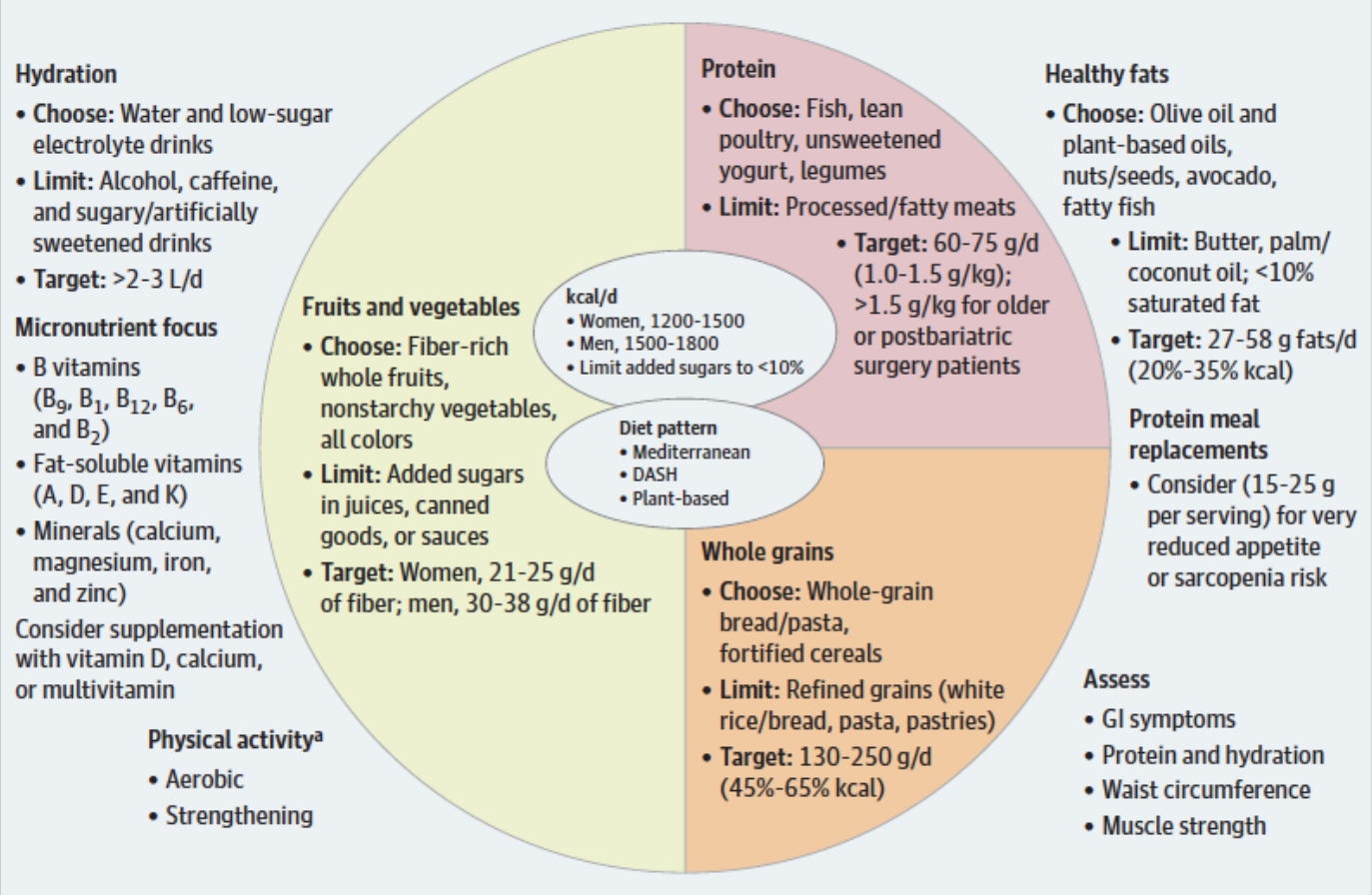


Friedenreich et al. Clin Cancer Res, 2016

Integrating Diet and Physical Activity When Prescribing GLP-1s—Lifestyle Factors Remain Crucial

Farhad Mehrtash, MPH; Jody Dushay, MD, MMSc; JoAnn E. Manson, MD, DrPH

JAMA Internal Medicine September 2025 Volume 185, Number 9



- **7-12% weight rebound** after GLP-1RA discontinuation
- Consider dose taper over at least **20 weeks**
- Increase dose or reinitiate if **>5% weight regain**

CASES - REVISTED



56yo postmenopausal woman with cT3N1M0 TNBC of R breast

- Planned to start neoadjuvant KEYNOTE522 regimen
- Co-morbidities: BMI 34, diabetes on metformin 1000 bid (Hb A1c 6.2%)

She was planning to start **tirzepatide** prior to TNBC diagnosis and asks if she could start with her breast cancer treatment.



42yo premenopausal woman with pT1cN0M0 HR+/HER2-neg IDC of L breast

- s/p lumpectomy + XRT, OncotypeDX RS 18
- planned to start adjuvant OS + AI
- Co-morbidities: BMI 29 on semaglutide (prior BMI 33)

She asks if she could continue **semaglutide** with adjuvant endocrine therapy.

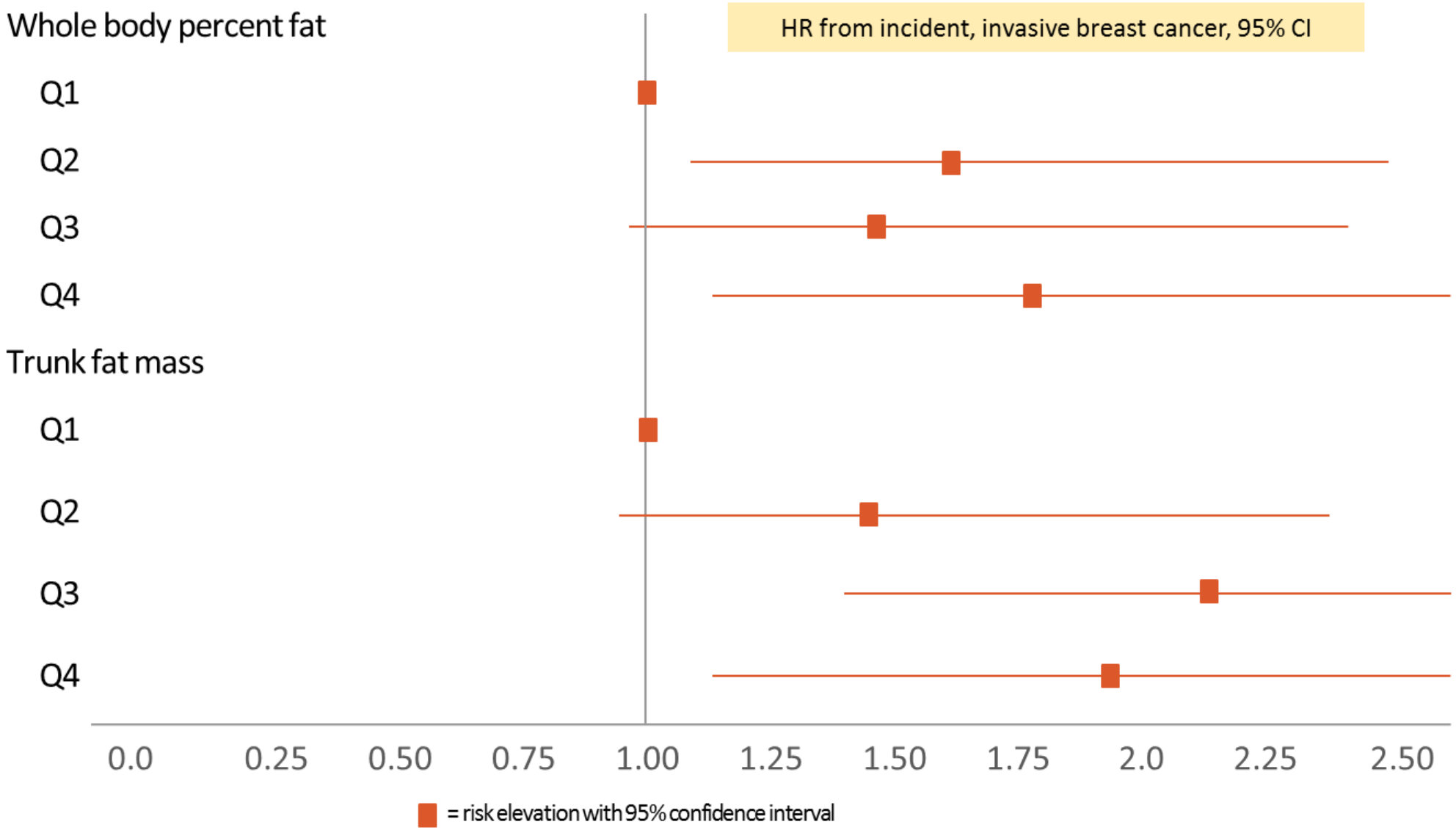
UPCOMING ESMO GUIDELINES STATEMENT

DRAFT STATEMENT:

- GLP-1 RAs may be considered for weight-loss in patients who have completed cancer therapy and may be considered with caution for patients on stable endocrine-based cancer therapies based on limited observational safety data.

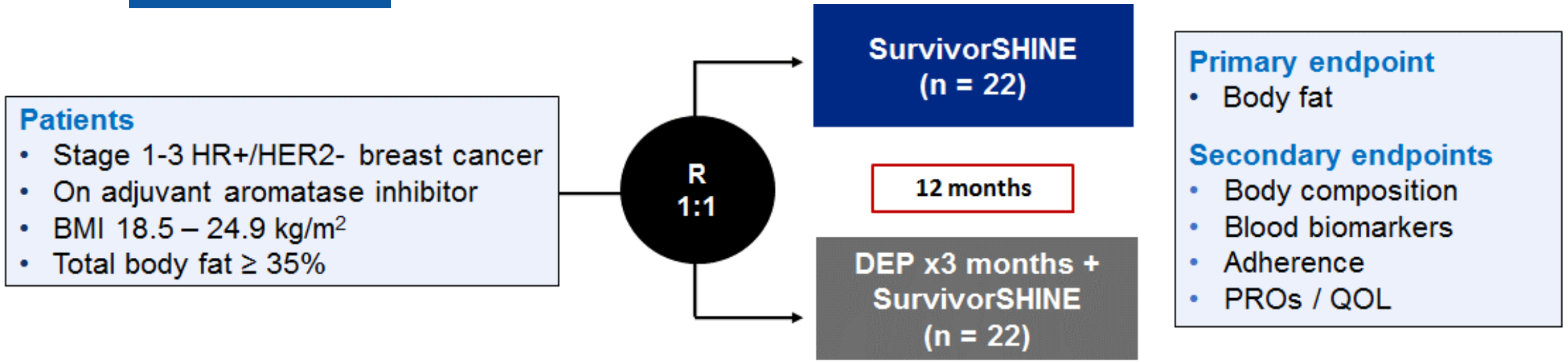
- GLP-1 RAs cannot be recommended currently for patients receiving or initiating chemotherapies and/or immunotherapies due to lack of safety and outcomes data.

Normal Weight Hyperadiposity and Postmenopausal Breast Cancer Risk



Iyengar et al., JAMA Oncol 2018

PHASE 2 RCT IN NORMAL WEIGHT OBESITY AND BREAST CANCER



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Breast Cancer and GLP-1s: Mental Health Considerations

Michelle Bronzo, MA, LPC, LCPC, LMHC, CT, FT

LIVING BEYOND BREAST CANCER®

Why Mental Health Matters

- Weight and appetite are emotionally loaded
- Cancer impacts body control and identity
- GLP-1s alter hunger, reward and self perception

GLP-1s: Cultural Framework

- Framed as “miracle” drug
- Influence of social media and celebrity use of GLP-1s
  - Before/ after transformations
  - Reinforces thin ideals and “diet culture”
  - Re-emergence of the “heroin chic” trend of the 90s
- Persistent weight stigma in healthcare
  - Size-based biases can lead to misdiagnosis and reduced quality of care
- Tension between body positivity/ fat liberation movement and medicalized weight loss

GLP-1s: Appetite and Reward Changes

- Reduced hunger cues and less food preoccupation (“food noise”)
- Altered dopamine/ reward pathways
  - Less pleasure from food
  - Can reduce cravings for highly processed food and alcohol
- Changes in eating patterns – eating much less and possibly at different times
- Can intensify treatment side effects (e.g., nausea)
- Changed social interactions
  - E.g., Going out to dinner
- Loss of a coping mechanism

GLP-1s: Motivations for Cancer Patients

- Desire for control post-cancer
  - Body has already changed in so many ways that are out of control
  - History of weight fluctuation due to treatment
- Fear of recurrence linked to weight
- Body image distress
  - As identity can be closely connected with appearance, changes in body can lead to significant distress
    - Mastectomy, steroid use, treatment-induced menopause, lymphedema

GLP-1s: Oncology-Specific Concerns

- Risk of poor nutrition and muscle mass loss
  - Reduction in protein and other critical nutrients/ minerals found in food
- Overlap with treatment side effects
  - Many cancer patients are already dealing with taste changes (e.g., metallic taste), GI symptoms, fatigue that influences meal prep, etc.
- Comments by others about how one looks reinforce focus on weight
- Conflict between survival, overall health and appearance
  - Feeling shame about body concerns when survival is prioritized

Provider Role

- Ask what the patient already knows about GLP-1s: side effects, challenges, and their feelings about them in general
- Help clients make informed, self-aware decisions while protecting their mental health and relationship with food
- Avoid reinforcing stigma
- Avoid reinforcing thin ideals
- Approach the topic in a non-judgmental way
    - Be mindful of your tone as patients can pick up on subtle cues

At-Risk Populations

- History of eating disorders
- Adolescents and young adults
- Anxiety/ OCD/ perfectionism traits

Framing the Conversation

“Because medications like GLP-1st can affect appetite, weight, and how we relate to food, I’d like to learn a bit about your personal history with eating and body image, as well as your future goals. There are no right or wrong answers.”

Screening Questions

1. Can you tell me what a typical day of eating looks like for you right now?
2. How has your relationship with food changed since your cancer diagnosis?
3. How do you usually decide when and what to eat?
4. Have there been times in your life when eating was a source of stress?
5. What has your weight journey looked like over time?
6. What do you imagine might change in your body if you start a medication like a GLP-1?
7. How important is weight loss compared to other health goals right now?

Screening Questions (Cont.)

8. How do you feel about your body in general, especially after cancer treatment?
9. How much does your body shape or weight influence how you feel about yourself?
10. What messages have you received about your body during or after treatment (from others or yourself)?
11. Have there been times when you've felt out of control around food, like eating more than you planned to or in a way that didn't feel good afterwards?
12. Have you ever restricted food, skipped meals, or tried to "make up" for eating certain things (e.g., exercising a lot afterwards)?

Screening Questions (Cont.)

13. Have you ever been diagnosed with an eating disorder or wondered about your eating?
14. What concerns, if any, do you have about changes in appetite or weight?
15. How has your energy level, strength, or nutritional status been affected by your treatment?
16. How comfortable do you feel making sure your body gets enough nourishment even if you’re not feeling hungry?
17. How do you see a medication like this fitting into your overall cancer care?

Disordered Eating Red Flags

- Meal skipping beyond the typical reduction in appetite seen with this medication
- Rapid weight loss
- Fear of eating or weight regain
- Excessive focus on number (e.g., weight, calories)
- Rigid food rules or extreme guilt after eating certain foods
- Avoidance of eating socially
- Continued restriction of food despite medical concerns

What You're Listening For (Clinically)

- Restriction, binge eating, or behaviors to compensate for food intake
- Over-valuing weight or shape in regards to self-worth
- Fear of weight gain vs. focus on health
- Difficulty maintaining adequate nutrition (which can increase other side effects – e.g., fatigue, brain fog)
- Unrealistic expectations of GLP-1s
- Increase in anxiety, depression or suicidal thoughts

Coping and Support

- Psychoeducation on nutrition
  - Refer to registered dietitian to help maintain nutrition goals
- Encourage flexibility
  - May need to pause or reduce GLP-1 use during treatment to mitigate side effects, muscle mass loss, and nutrition changes
- Refer to specialists when needed
  - Hx of eating disorders or food restriction during GLP-1 use
  - Significant distress around use

If challenges come up while taking this medication, how would you want support?

Conclusion

- GLP-1s have both physical and psychological effects
- Cancer patients can be vulnerable
- Screening for motivation and assessing if the patient is in an at-risk population is essential in determining if GLP-1s are a good fit
- Holistic care approach
    - We are treating the whole person, not just the medical part
    - How will quality of life be impacted for this specific individual if they choose to add in a GLP-1?