INSIDE THE CLINIC: GLP-1S WITH DR. REKHA B. KUMAR

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Inside the clinic: GLP-1s with Dr. Rekha B. Kumar

Stephanie Sirota: Welcome to the RTW podcast. I'm your guest host, Stephanie Sirota, Partner and Chief Business Officer leading the Strategic Partnerships team at RTW Investments.

Today, I'm speaking with Dr. Rekha B. Kumar, endocrinologist, obesity medicine specialist, and Chief Medical Officer at Found.

Found's platform integrates the latest medical research and clinical practices, ensuring that users receive evidence-based, effective treatments. The first medical director of the American Board of Obesity Medicine, Rekha currently practices endocrinology in New York City. Rekha, thank you so much for joining us in the studio today.

Rekha Kumar: Thanks for having me here.

Dr. Rekha Kumar's journey into obesity medicine

Stephanie Sirota: Well, why don't we start with your fascinating background. Tell us why you went into medicine. You're an internist and endocrinologist focused primarily on female patients. I'd love to hear a little bit about your practice and what shaped your journey through school and then into clinical medicine.

Rekha Kumar: I would say my interest in medicine stemmed from my interest in endocrinology even as a teenager. I loved learning about exercise, muscle metabolism, and nutrition. I was a gymnast growing up. I was always intrigued by muscle mechanics, and that led me down a path of science, biology, and medical school.

Once in medical school I really knew I wanted to focus on a specialty that included every organ and understanding how the entire body functioned together. And I also wanted a field of medicine where lifestyle and behavior affected the disease states.

That landed me in endocrinology. I was finishing my training literally around the years that obesity was declared a disease, where the hormones that are involved in body weight regulation were just starting to be discovered, and it was a very exciting time to understand body weight regulation and metabolism.

It was sort of the right timing, where all my interests seemed to match this new emerging field of medicine.

Stephanie Sirota: People always say that obesity is so challenging because it's multifactorial. Did you think of it as a disease when you were really interrogating it and when you were studying it in so many different ways, before it was officially marked a disease?

Rekha Kumar: To call it a disease always felt bold, and I think some people still don't feel great about that because should we be saying that 40% of the U.S. population has a disease? I know that's still controversial despite the official terminology. I was aware of the dysfunction in the body, but I did not know that it was called a disease.

Stephanie Sirota: So being a clinician, what made you take this bold leap into entrepreneurship and how did that happen?

Rekha Kumar: So like many doctors, COVID created some creativity in my career path. I think for many physicians who experienced burnout or saw people get very sick during COVID, many of us reassessed our careers. I was a traditional academic doctor seeing patients, doing research, writing papers, writing textbook chapters, and then got pulled to work in the hospital during COVID as a COVID doctor.

During that period, I realized that what I loved was taking full care of patients, meaning doing their primary care, preventative health, metabolic health. A couple of years ago I said, "I'm just going to have a small women's health practice."

And then the question was, "Well, what am I going to do with the 12 years of academic obesity that I learned and that I had become a leader in the field in?" A great opportunity popped up when I met the former CEO of Found Health (which is a telehealth company that focuses on comprehensive weight care), and they were looking for a Chief Medical Officer.

I was thinking, "Well, this seems really too sophisticated for me, as a clinician," but it's a dream for an academic to know something so specific that I could be helpful to people outside of clinical medicine.

Stephanie Sirota: How did that impact your practice? And how did you make a decision as to what you would prioritize?

Rekha Kumar: I was making a transition from an academic practice to a smaller practice and was starting almost with an empty schedule. 20% of my patients followed me from the old practice to the smaller women's health practice, which gave me extra time.

My plan was to be a regular Upper East Side mom, and not ten days went by before I joined Found. Now the practice has picked up and it's more of a challenge, but I love doing both.

Establishing Found and treating obesity patients

Stephanie Sirota: Let's go back to Found and can you share the origins of the company and its mission? How has that evolved as new information hits the tape?

Rekha Kumar: Found started from a venture studio called Atomic Ventures that started Hims and Hers. It started out as a consumer company and has grown. Many people didn't have great access to obesity care despite the fact that the science was becoming more clear.

So Found was started to scale treatment to obesity care and expand access. And now we work with employers and health plans and continue on the consumer side.

Stephanie Sirota: Are the patients coming to you asking for the drug? Have they tried other methods before asking to get on the drug?

"Ten years ago, when people came to me, they really felt like they had tried everything. They were often embarrassed to be there, felt like I was their last resort, and were very reluctant to take medicine because they felt like they had failed."

Stephanie Sirota: They had tried everything, meaning diet and exercise.

Rekha Kumar: Correct. I'd say what's different today is that people are asking for medicine. There aren't many medical conditions or disease states where people come to you asking for medicine, and people are seeing their friends and family have success on it.

So we're definitely seeing patient demand and, on the Found side, consumer demand. There's the people that have true diabetes and severe obesity, but we're seeing increased interest amongst people that have lesser degrees of weight concerns and health concerns that want to be on the medicine for prevention.

Stephanie Sirota: Are you tracking any of the other comorbidities that come with obesity?

Rekha Kumar: Both in my practice and at Found, we track the comorbidities that come along with excess body fat, such as diabetes, high blood pressure, high triglycerides, sleep apnea, and heart disease. We're also starting to gather anecdotal evidence about some of the other things that have been in the media, such as a reduction in desire for alcohol and some reduction in neurodegenerative diseases like Alzheimer's.

There's a lot of anecdotal data that's now leading to larger studies. These are all things that we follow.

Stephanie Sirota: I think anecdotally, I've also heard it reduces anxiety.

Rekha Kumar: Yes. And it seems that because these drugs are more anti-inflammatory than we ever thought, the body and the brain are helped in many ways.

Stephanie Sirota: It may also be that a huge amount of a person's time is spent focusing on weight loss, and this kind of relieves that pressure.

Rekha Kumar: Yeah, and a lot of people have been calling that reduction in "food noise." The effect of the GLP-1s on the brain is reducing food noise and making people feel less anxious or burdened by the constant decision-making around food and exercise.

Stephanie Sirota: What about people that suffer from pretty debilitating side effects? What has your experience been with your patients? How quickly do these side effects resolve? Do some patients get off the drug entirely because they can't handle the side effects?

Rekha Kumar: It's gotten better over the past ten years. The first FDA-approved GLP-1 for weight management came out in 2014, and that was Saxenda.

We probably saw a 60% response rate, meaning that 60% of people lost 5% of their body weight or more. On the newest product, which is Zepbound, Eli Lilly's dual agonist, we see 90% of patients losing 5% of their body weight or more.

In terms of efficacy across the population, the newer drugs are treating more people. That's still 33 million Americans, potentially 10% that don't respond.

In terms of side effects, a significant percentage of people will initially have gastrointestinal side effects, mild nausea, maybe vomiting, or maybe some acid reflux. These typically resolve over a few weeks, but there are some people that can't tolerate the medicine, and we have to stop.

Stephanie Sirota: What about "Ozempic face" and other concerns around losing body mass but not really targeted fat loss?

Rekha Kumar: "Ozempic face" can actually be seen with any kind of rapid weight loss. It seems to have taken on the name because we're seeing people lose weight faster than they typically would with just diet and exercise, and we're seeing people lose more weight than they typically would. But people are concerned about that. Plastic surgeons are busy.

Stephanie Sirota: Are you following some of the newer medications that might be more targeted for fat loss?

Rekha Kumar: So definitely following those compounds that are in clinical trials. Bimagrumab, which increases muscle and reduces fat, will probably first become a diabetes drug and then, hopefully, obesity.

There are some studies that show that Tirzepatide leads to less muscle loss than Semaglutide. Each generation of these drugs will likely get better in terms of preferential fat loss.

Telehealth and its impact on obesity treatment

Stephanie Sirota: I'd love to understand telehealth companies, where they fit into digital delivery care, and what you think is evolving in that space.

Rekha Kumar: During COVID, patients didn't want to come in. Most doctors' offices had a reduction in patient volume. And when doctors' offices went on to telemedicine because of lockdowns, many doctors' offices had very low volume partially because some doctors couldn't do their work.

Surgeons couldn't operate because they couldn't do it over telehealth. Endocrinology, obesity medicine, and psychiatry saw an increase in their number of visits.

There are some areas of medicine that just really lend themselves well to telehealth. Access to obesity care was very limited. You could get really great care in a handful of academic centers, but their waitlist can be a year or longer.

Telehealth has democratized obesity care. People that live in all parts of the country can get care, coaching support, lifestyle advice, but also access to a doctor that can prescribe if appropriate.

Stephanie Sirota: And how comprehensive is the care?

Rekha Kumar: There's a range of levels of care in telemedicine. I think it depends on the field of medicine. I think it depends on what the patient/consumer wants. There's this tendency in telehealth for everyone to want price, speed, and convenience.

If it's something relatively straightforward, like a sore throat or a stye on your eye that doesn't require a lot of hands-on doctoring, then telehealth is great.

Obesity and metabolic health are unique because there's a shortage of trained doctors in the brick-and-mortar practices. It affects a huge portion of the population, it requires a lot of compassionate doctoring, and so telehealth's a great platform for it.

But you need clinicians that really still want to engage with the patient because there's so much of the art in addition to the science of medicine.

Stephanie Sirota: Is that doctoring integrated with a patient's internal medicine and their normal primary care doctor?

Rekha Kumar: In an ideal scenario, these telehealth platforms have easy communication with the primary care doctor. Primary care doctors are completely overwhelmed, and there are conditions like obesity and menopausal health that patients really want access to, but their primary care doctor doesn't have the time, resources, or support to provide, and those seem to be going towards telehealth.

And so, if primary care doctors had the ability to easily see the records from the telehealth company, I think that would be a great model. But I hear you that there are some very transactional platforms out there that aren't giving care.

Stephanie Sirota: What do you think is going to become the norm in telemedicine over the next decade?

Rekha Kumar: I think that we will continue to see more telehealth usage amongst patients. I think larger institutions will outsource certain conditions to telehealth visits to be more efficient in their own businesses.

Stephanie Sirota: Have you seen an increase in patients being inspired to holistically address their weight through one of these brand-new drugs but also incorporating changes to their diet?

Rekha Kumar: I've seen people have new interest in their overall health and well-being because these medicines have helped them feel better about themselves. Their joints feel better, and they want to go to the gym; they try new things. They just feel more confident in their healthier bodies. But I've also seen the opposite, where there are people that want to rely on these drugs and don't want to do the other stuff.

Stephanie Sirota: And in your practice, do you say, "Look, this is what we recommend to support your experience on the drug. We also recommend that you make some modifications to your diet or you incorporate certain exercises into your life and your daily regimen?"

Rekha Kumar: We focus on the medical diagnostic side to see if there's any complications of excess body fat, and we treat those. But also, we are very focused on the lifestyle side, on nutrition, exercise, sleep, stress, and alcohol intake. And that's why my visits take a long time because I like to ask all those questions.

Understanding how GLP-1s work

Stephanie Sirota: We talked a little bit about some of the different drugs. Can you talk a little bit about the mechanism of action of each? How do they do what they do?

Rekha Kumar: The mechanism of action of GLP-1s, or glucagon-like peptide receptor agonists, is that they mimic a hormone that we naturally make in our intestines. When we eat a meal, we make GLP-1 in our intestines. It's released into our bloodstream.

It signals fullness to the brain. It lowers blood sugar and delays stomach emptying.

The medications are longer-acting analogs that enhance all of those effects, which is why people feel full faster, longer, and they have better blood sugar control.

The difference between the version in your body versus the drugs is that the drugs are longer-acting. The second generation was even longer-acting, so you could only take them weekly.

Then the molecule was tweaked slightly, and it penetrated the blood-brain barrier better. We started hearing more about the brain effects. The future looks like there's going to be many different combinations of gut hormones that work in different ways: agonists, antagonists, and antibodies. Hopefully, we reach a point where there are so many options that we can help even those 33 million right now that I say have been non-responders.

Stephanie Sirota: What should one do to optimize the benefits of the medication?

Rekha Kumar: So what I always remind people when we start a GLP-1 is I say, "If you are not hungry or your appetite is suppressed, use that newfound control to make good choices." The point isn't to not eat. Some people love that they don't have to think about anything they're eating or doing because they naturally lose weight so quickly on the medicine because it works so well at the beginning.

But then eventually the body starts to compensate a bit. You could even totally go back to having cravings and food preference. So I ask people to use the appetite control to make good choices and, because the medicines work so well, to really focus on protein intake and weight training to maintain the muscle mass.

Stephanie Sirota: What happens when a patient does plateau?

Rekha Kumar: I always remind people that they're not going to keep losing weight. Why does that happen? The body is so good at protecting its fat mass, and that's how we are adapted for survival.

That plateau will happen in different places for different people at different times. If it's at a healthy weight, meaning that somebody's joints feel good, they feel good in their body, and there's no blood sugar, cholesterol, or blood pressure issues, that can be a healthy weight for them.

According to BMI, that might still look like a high number, but I try to reassure people that the goal isn't to be as skinny as possible, it's to be as healthy as possible.

If somebody hits a plateau where they still have health-related complications, we might have to increase the dose, change medicines, or add medicine.

If people continue to plateau or to have rebound weight gain, bariatric surgery is still an option.

Stephanie Sirota: Is the expectation that this is going to be a short or medium-term fix? Are some patients thinking about it as a lifestyle change and they will be on these drugs forever?

Rekha Kumar: So nobody wants to be on a medicine forever. And unfortunately, what the science shows us on these medicines is that when they're prescribed appropriately (meaning for people with a body mass index that's quite high with weight-related comorbidities), and they stop the medicine, two-thirds of the weight is regained in the first year.

But what we're seeing is a little out-of-the-box prescribing: people of lower body weights and healthier people taking the medicine.

I do believe that some percentage of those people will come off the medicine at least for stretches of time. And then if they notice weight regain, they can go back on it.

Stephanie Sirota: Does the medical community see this as a new statin or a new blood pressure medication, that someone could in theory just take it for the rest of their life and be great?

Rekha Kumar: The science would support thinking about it like a statin or a high blood pressure medicine. When somebody takes a statin and reaches their goal cholesterol, people don't typically say, "Well, can I stop my Lipitor now?"

Yet because of weight stigma and how we think about weight, not just patients but even doctors want to stop these medicines on people. If we see a cohort of patients that can come off the medicine and maintain their weight loss, I suspect it's a group of people that didn't have a lot of metabolic disease to begin with.

Obesity as an area of study in medicine

Stephanie Sirota: Do you see obesity attracting a lot of med school students, and is it an area that's pulling people in?

Rekha Kumar: Historically, it pulled people in mid-career—so people that had already been practicing for 10 to 15 years and started to realize that the real issue in their patient population was how obesity and chronic disease were affecting their health.

We're seeing an earlier interest in people right out of med school and residency wanting to have this knowledge. What is still tricky is that the business model of somebody practicing in this field is a challenge.

If you look at the billing codes and the reimbursement for treating obesity, it's a lot of time and a lot of effort without great reimbursement. For people with loans (the average medical student has around $200,000 of debt when they come out of med school), some may be discouraged from pursuing it.

I would encourage them to pursue it, and hopefully a lot of this will be rectified if Medicare and Medicaid start covering these medicines and we go in that direction.

Stephanie Sirota: What's your biggest worry?

Rekha Kumar: My biggest worry is the possible health equity concern that is coming up with the cost of these meds.

If we're talking about a 20% reduction in heart disease, reduction in neurodegenerative disease, fatty liver, all of these health benefits—and only wealthy people have access while poor people don't—I fear the country would be going in two different directions.

Stephanie Sirota: At least until they go off patent.

Rekha Kumar: Correct.

Thoughts on the future of obesity medicine

Stephanie Sirota: Looking into your crystal ball, tell us about your hopes for the future of obesity medicine.

Rekha Kumar: I think the future is very bright in terms of drug development and research, understanding the neurohormonal regulation of body weight, and the drugs that are coming.

What I still have questions about is how we are going to improve the food supply, get people to continuously be active, redesign our cities, and encourage mobility and walking. My hope is that we can actually prevent what has happened in the United States in developing countries.

The whole metabolic disease epidemic in the United States occurred when our food supply changed rapidly, and we became sedentary.

What we see in the developing world is actually malnutrition and obesity existing together, which really happens with rapid urbanization.

My hope for the future is that we can recognize these patterns and, in certain areas of the world, as urbanization happens, encourage those populations to focus on preventative health.

Stephanie Sirota: We can look back to history to learn and hopefully create a much brighter future. Rekha, thank you so much for joining us today. This was really fascinating.

Rekha Kumar: Thank you so much for having me here.

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