IFSO Endorsement of Corporate Events (Meetings, Symposia, Conferences, Congresses, Courses, Workshops) in the field of Obesity and Metabolic Disorders

Requirements

Endorsement requests must be sent to IFSO Secretariat (info@ifso.com) together with the scientific program of the Course. IFSO relevant Committee will carefully review the concepts and objectives of the course as well as the faculty, the structure and content of the course, in deciding about the endorsement.
"Endorsement" does not in any way offer credentialing of grant approval to the participant regarding future skills and outcomes.

IFSO doesn't endorse events organized by a "parallel" society of a country where there is an "official" national society in IFSO.

The event/congress must be held at least six weeks before or after the IFSO World Congress and/or Chapter Meetings, when the event takes place within the relevant Chapter.

- **Single Endorsement**

  - Single Endorsement is only available for one event.
  - The complete application has to be received at latest 3 weeks prior to the event. Applications received less than 3 weeks before will be automatically rejected.
  - The event must be directed or coordinated by an IFSO member, or have as its primary faculty, at least one IFSO member
  - The Director must ensure that disclosure of conflict of interest are enforced
  - The Director must show in his presentation(s) the Case Mix Disclosure slide (see attached) and recommend its use to all the speakers.
  - Reduced registration fees must be granted to IFSO Members

The fee for single endorsement is $ **2.000,00**

- **Multiple Endorsement**

  - Multiple endorsement is meant for two or more events held per year at the same institution
  - The complete application has to be received at latest 3 weeks prior to the event. Applications received less than 3 weeks before will be automatically rejected.
  - The events must be directed or coordinated by an IFSO member, or have as its primary faculty, at least one IFSO member
  - The agendas and faculty lists of all events that will be held during the year must be submitted at the moment of application for annual review and approval
  - The institution/centre must be equipped with adequate facilities
  - The Director must ensure that disclosure of conflict of interest are enforced
  - The Director must show in his presentation(s) the Case Mix Disclosure slide (see attached) and recommend its use to all the speakers.
  - Reduced registration fees must be granted to IFSO Members

The fee for multiple endorsement is $ **5.000,00/year**

Please note that IFSO Corporate Partners benefit of a special discount:
Member Partner: 5%
Champion Partner: 10%

Benefits:

Endorsed events will be:

- listed on IFSO's Website on the "Endorsed meetings" page, with a link to the congress website
- included on IFSO's E-newsletter
- emailed twice to IFSO Members
- advertised once on IFSO Facebook and Twitter page
- the **IFSO** "***Endorsed by"*** **Logo** should be included on the promotional material

People's first language/ IFSO accepted nomenclature:

- Eliminate "recidivism" "non-compliant" "gold-standard" "last-resort" sort of language
- Imagery (no headless, stereotypical/stigma = takeaway boxes, fast food, ill-fitting clothes, etc.)

Not accepted Nomenclature	IFSO accepted Nomenclature
Mini Gastric Bypass (MGB)	**One Anastomosis Gastric Bypass (OAGB)**
Morbid Obesity	**Severe Obesity**
Obese/Diabetics	**Patient or individual with obesity/ diabetes**
Subject/s	**Patient/s or individual/s**
Weight loss surgery	**Metabolic Bariatric Surgery (MBS)**
Super or super-super obesity	**Please use Body Mass Index reference BMI>50 or BMI>60 to refer to this patient population respectively**
Gold standard	**Avoid using this term please**
Revision procedure	**'Revision or modification' for any procedure that does not encompass conversion to a new procedure with a new mechanism of action or reversal of the anatomy.** Revision or modification encompasses correction or an enhancement of the same procedure (revision of a gastric pouch, distalization of gastric bypass)
Conversion procedure	**'Conversion' entails converting one procedure to another with a different mechanism of action.** Revision is not accepted as a substitution anymore
Reversal procedure	**Term can still be used to describe reversing a procedure to the normal standard anatomy**

Insufficient or inadequate weight loss	**'Suboptimal clinical response' encompasses maximum total weight loss outcome (TWL%) <20%, while also covering no improvement or worsening of any obesity complication that was present preoperatively**
Weight loss failure	**Failure is not an acceptable term anymore. Use suboptimal clinical response if fits these criteria**
Adequate weight loss	**Optimal clinical response which follows the criteria of TWL% >20% and/or improvement of obesity complication/s**
Success	**This term is not acceptable anymore. Please use Optimal clinical response for primary procedures or optimal clinical response for other revision or conversion procedures**
Restrictive or Malabsorptive procedures	**These terms are not acceptable to use. Please describe procedures per their anatomic features, bypass, diversion, etc …**
Malabsorption/Hypoabsorption	Both are accepted, but it is **essential to report: Micronutrient for minerals and elements versus Macronutrient for protein/fact or carbohydrates**
Weight regain/ recurrence	**Recurrent weight gain**
Bariatric Surgery	**Metabolic Bariatric Surgery (MBS)**
Anti Obesity Medications	**Obesity Management Medications (OMMs)**
Comorbidities	**Obesity associated diseases/disorders**
Super Obesity, Super-Super Obesity, Extreme Obesity (please indicate the BMI instead)	**• BMI 30 <35kg/m2 Obesity I** **• BMI 35 <40kg/m2 Obesity II** **• BMI 40 <50kg/m2 Obesity III** **• BMI 50 <60kg/m2 Obesity IV instead of „Super Obesity"** **• BMI 60 <70kg/m2 Obesity V instead of „Super-Super Obesity"**

REPORTING DEFINITIONS

A suboptimal initial response to metabolic/bariatric surgery (MBS) is demonstrated either by inadequate weight loss OR by an unusually modest improvement in a significant obesity complication.

A late post-operative clinical deterioration is demonstrated either by recurrent weight gain OR by worsening of a significant obesity complication that occurs after an initially adequate post-operative clinical response.

The degree to which the clinical response to MBS is suboptimal or there is a late post-operative clinical deterioration can vary widely from patient to patient. The severity of the suboptimal response should guide clinical treatment.

The baseline weight for assessing weight loss after MBS should be a weight determined before starting preoperative weight reduction.

In patients who have been treated with AOM before undergoing MBS, who STOP it at the time of or shortly after surgery, the baseline weight for assessing the effect of surgery on bodyweight should generally be a weight determined BEFORE the AOM was started.

In patients who have been treated with AOM before undergoing MBS and CONTINUE this medication post-op., the baseline weight used to assess the effect of surgery on body weight should generally be measured on the day of surgery.

The initial surgical weight loss (defined as maximum weight loss within the first 2 years after MBS) should be determined in a manner that excludes any post-plateau weight loss caused by adding AOM, any endoscopic intervention, or any calorie-restricted diet.

Surgical or endoscopic procedures to convert to a new type of metabolic/bariatric operation (conversion surgery) and those to re-establish normal anatomy (reversal surgery) should be clearly distinguished and considered separately from procedures to modify or enhance the effects of a previous operation (revision or modification surgery).

Modification or revision procedures are typically designed to optimize the effectiveness of previous operations, while conversion procedures most commonly introduce additional mechanisms of therapeutic action.

The term "obesity complication" mostly describes diseases, conditions, and symptoms for which there is published evidence that obesity is a contributing cause or exacerbating factor. When such a causative relationship has not been established or accepted, the associated disorder is more accurately labelled an obesity comorbidity.

When considering the effects of MBS on intestinal nutrient absorption, diminished absorption (hypo-absorption or malabsorption) of micronutrients should be clearly distinguished from the hypo-absorption or malabsorption of macronutrients or ingested calories.

Characterization of the absorptive effects of an MBS procedure should not be used to imply that these effects are the mechanisms of action of weight loss associated with the operation. It is preferable to describe such procedures by their anatomical features (e.g., "bypass," "diversion," or more generally, "gastrointestinal") rather than by their inferred mechanism of action.

Characterization of the changes in the physical structure of the gut produced by an MBS procedure – including the size & shape of GI segments or anastomoses – should not be used to imply that these changes "restrict" food intake as a mechanism of associated weight loss. It is preferable to describe such procedures by their anatomical features (e.g., "gastrectomy," "banding" or, more generally, "gastric") rather than by their inferred mechanism of action.

REPORTING STANDARDS

In general, a suboptimal initial clinical response to MBS is demonstrated either by total body weight or BMI loss of less than 20% OR by inadequate improvement in an obesity complication that was a significant indication for surgery.

In general, a late post-operative clinical deterioration after MBS is demonstrated either by recurrent weight gain of more than 30% of the initial surgical weight loss OR by worsening of an obesity complication that was a significant

MBS = metabolic-bariatric surgery; AOM = anti-obesity medication; GI = gastrointestinal; BMI = body mass index.

Diversity statement:

IFSO encourages diversity such as gender, age and geographical representation. Therefore, we encourage to take into account diversity in selecting the faculty of your educational events.

Upcoming IFSO World Congress

The organizer of the endorsed meeting commits to:
1) Post on the meeting's website the digital flyer and the link to the website of the upcoming IFSO World Congress.
2) Display posters or flyers of the IFSO World Congress at the endorsed meeting's venue.

If you think your event fulfils the above mentioned requirements, please send your request to info@ifso.com by filling the following form together with a PDF file of the scientific program.
After the approval of the relevant Committee, the Applicant will receive further instructions about the payment of the endorsement fee.

APPLICATION FORM

EVENT DIRECTOR*:

INSTITUTION/SOCIETY:

TITLE OF THE EVENT*:

DATES and NUMBER OF EDITIONS/YEAR*:

TYPE OF EVENT:

WEBSITE OF THE EVENT*:

ADDRESS*:

CITY*: STATE: ZIP:

PHONE:

E-MAIL*:

WILL CME CREDITS BE OFFERED*? ☐ YES ☐ NO

IF YES, HOW MANY?*

IF NO, WHY?*

WHICH INSTITUTION PROVIDES THE CME CREDITS:

WILL THE EVENT BE DISCUSSING/DEMONSTRATING EXPERIMENTAL PROCEDURES,

TECHNOLOGY AND/OR THERAPIES: ☐ YES ☐ NO

IF YES: HAVE THE RIGHT APPROVALS AND CONSENTING BEEN SECURED: ☐ YES ☐ NO

ARE DISCLOURES OF CONFLICT OF INTEREST ENFORCED*? ☐ YES ☐ NO

DISCOUNT FOR IFSO MEMBERS (min 10%)*:

□ I have read and understood the IFSO Position Statement on Live Surgeries and informed the operator(s) accordingly. I declare that the answer to all points is in the affirmative for both the operator(s) and the organizer(s).*

***Mandatory field**

BILLING INFORMATION*

NAME (PERSON/COMPANY/INSTITUTION):

ADDRESS:

EMAIL:

DATE:

SIGNATURE EVENT ORGANIZER: