EMBEDDING ANTI-STIGMA PRACTICES IN BARIATRIC CARE: A CLINICAL IMPERATIVE

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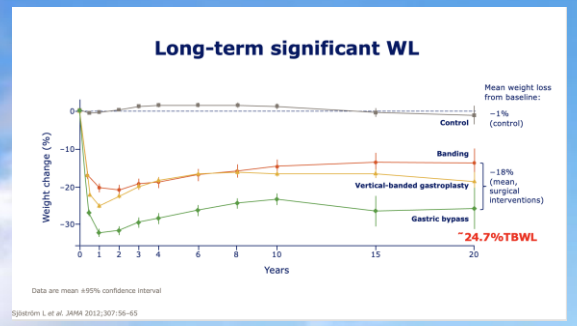
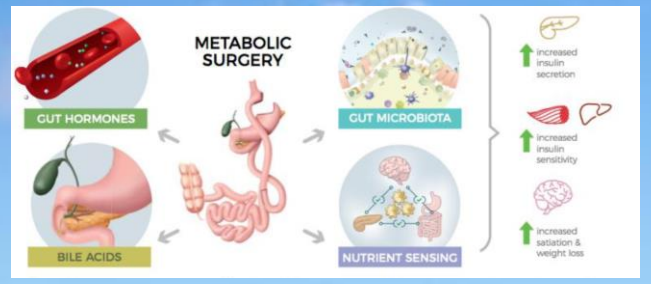
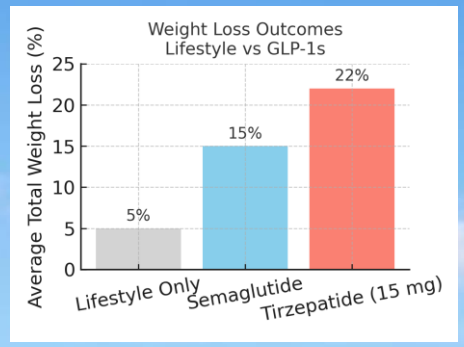
CENTRO ESPECIALIZADO EM OBESIDADE E DIABETES

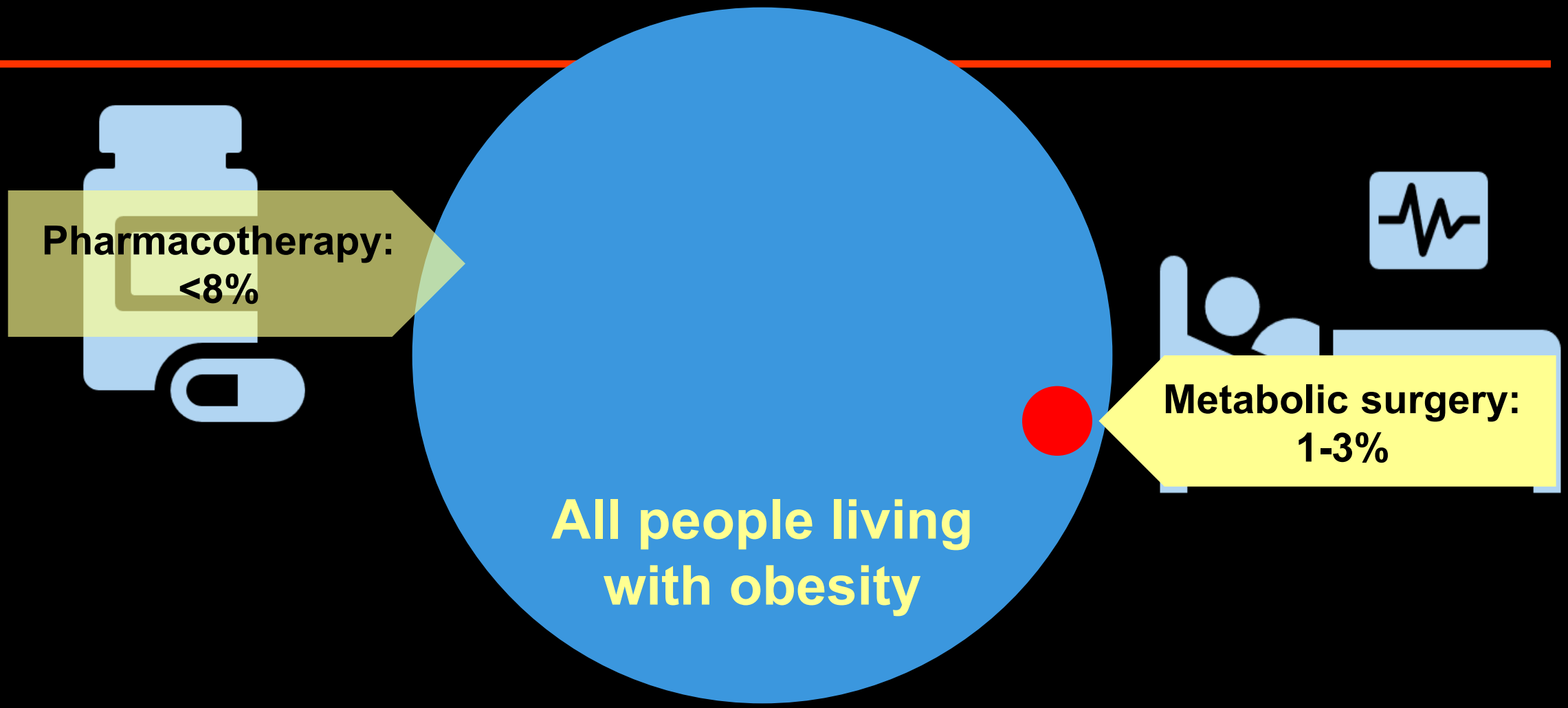
DISCLOSURES

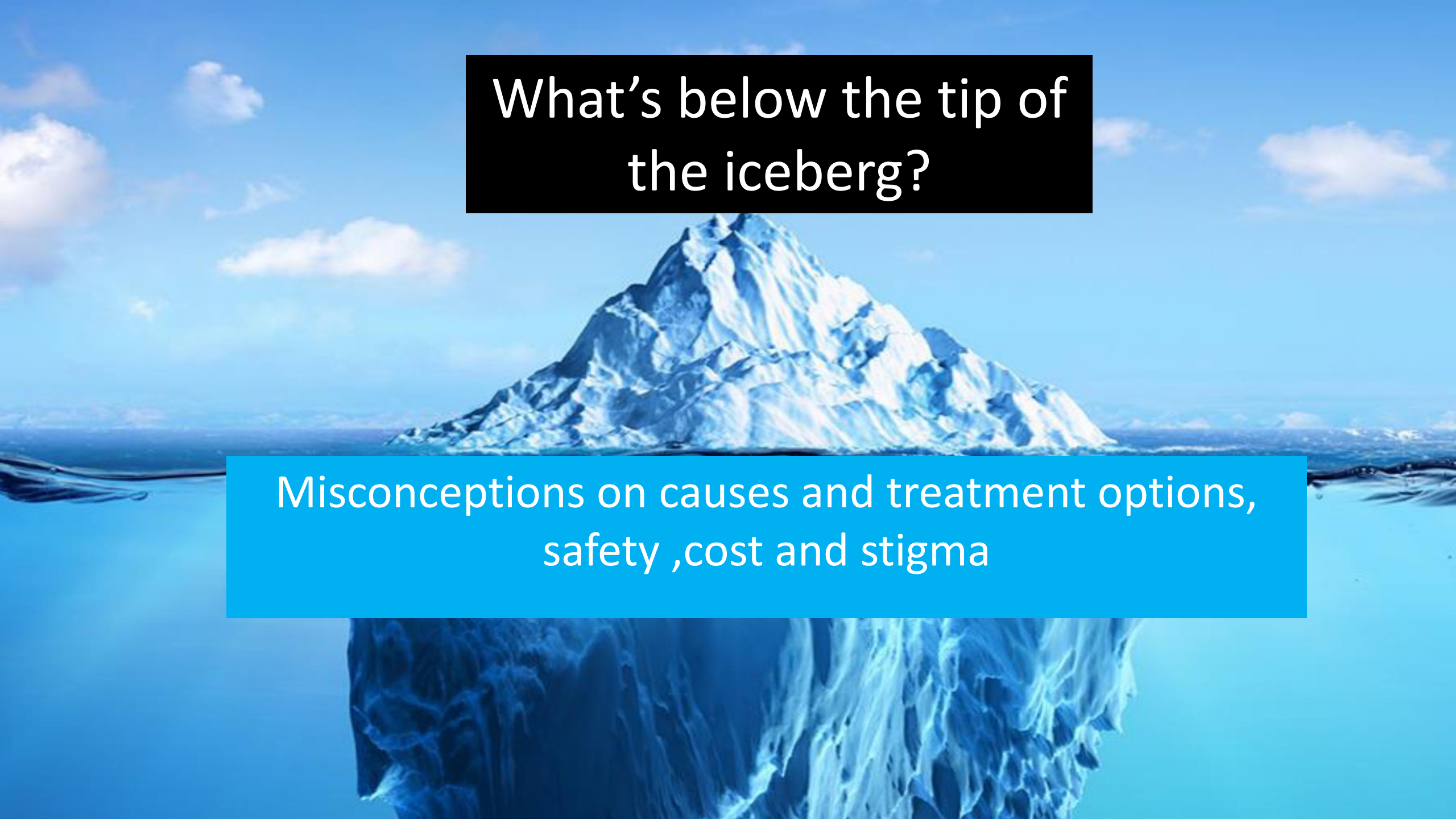
Nothing to disclose regarding this presentation


Long-term significant WL
Mean weight loss from baseline:
−1% (control)
Control
Banding
Vertical-banded gastroplasty
Gastric bypass
−18% (mean, surgical interventions)
~24.7%TBWL
Weight change (%)
Years
Data are mean ±95% confidence interval
Sjöström L et al. JAMA 2012;307:56–65


METABOLIC SURGERY
GUT HORMONES
BILE ACIDS
GUT MICROBIOTA
NUTRIENT SENSING
increased insulin secretion
increased insulin sensitivity
increased satiation & weight loss


Weight Loss Outcomes
Lifestyle vs GLP-1s
Average Total Weight Loss (%)
25
20
15
10
5
0
5%
15%
22%
Lifestyle Only
Semaglutide
Tirzepatide (15 mg)


Pharmacotherapy:
<8%
All people living
with obesity
Metabolic surgery:
1-3%


What’s below the tip of the iceberg?
Misconceptions on causes and treatment options, safety ,cost and stigma

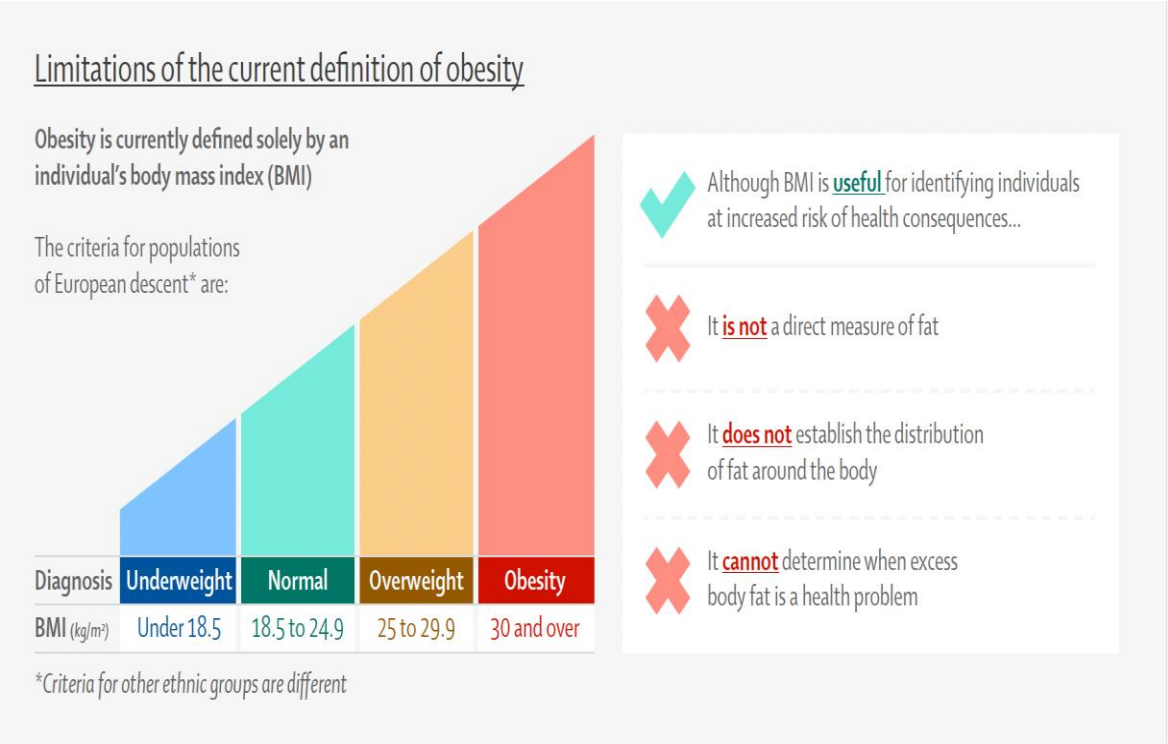
Current Definition: Obesity as a health risk

*"A condition of excess adiposity … that poses a **risk** to health"*

Physical phenotype

Health Impact

BMI Buckets ≠ Clinical Diagnosis.



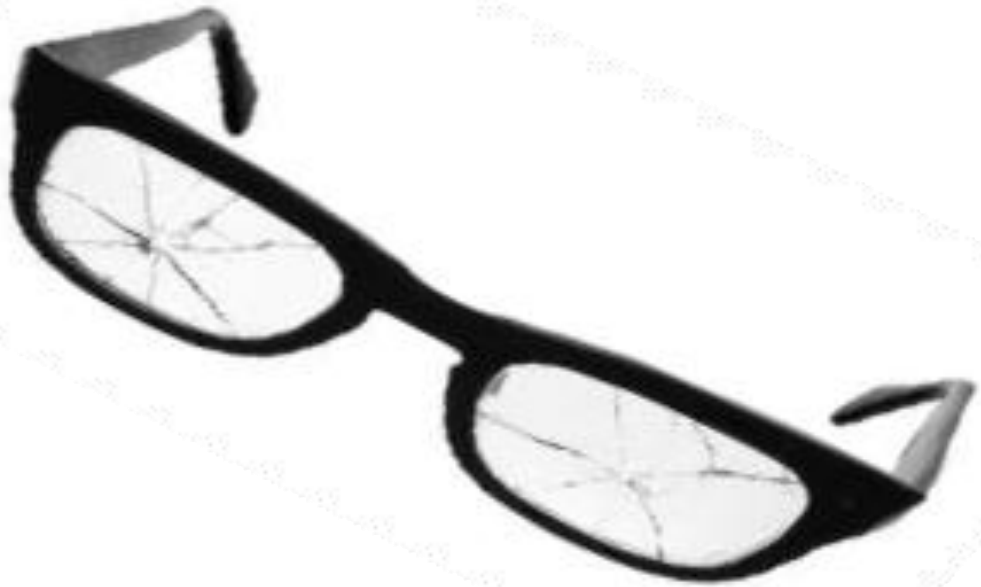
Body size

≠

Organ/Tissue Dysfunction

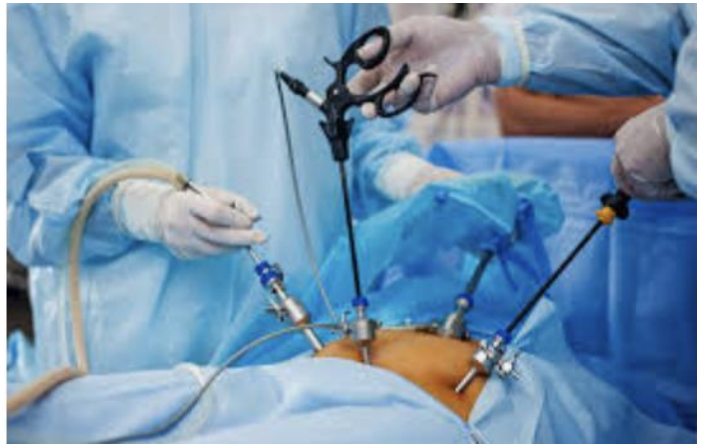
Functional Limitation

Misconceptions on prevention, treatments and causes



PREVENTION

DIFFERENT THAN TREATMENT



Would this be acceptable?

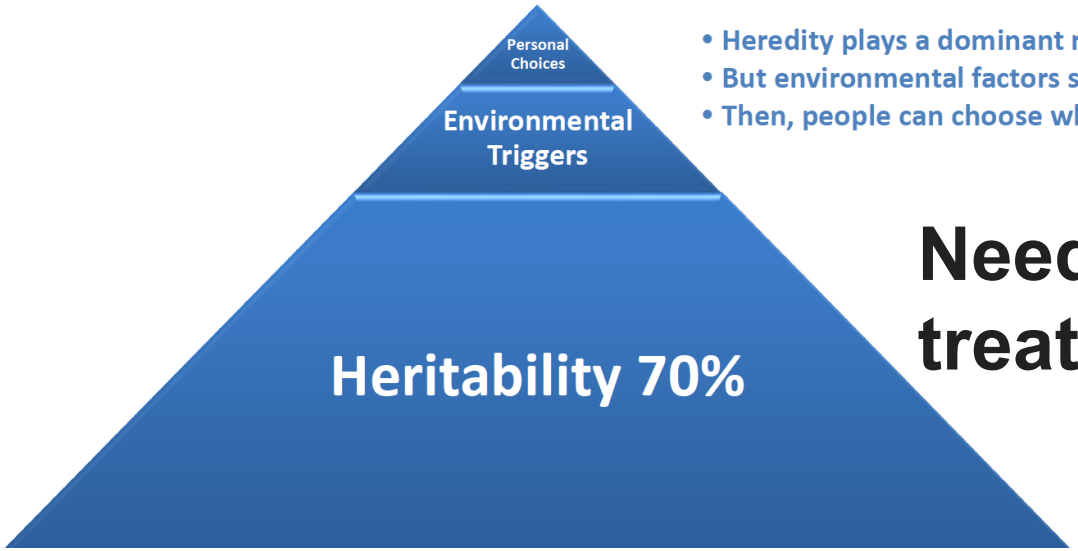
"**AIDS** should be prevented, not treated"

Isn't Obesity Just the Result of Eating More Calories Than You Burn?

Misconceptions on the causes of obesity

The Truth Is That

Obesity Is a Highly Heritable Chronic Disease



- Heredity plays a dominant role in obesity risk
- But environmental factors serve to activate it
- Then, people can choose what to do about it

Needs treatment

Scientific blindness leads to misconceptions

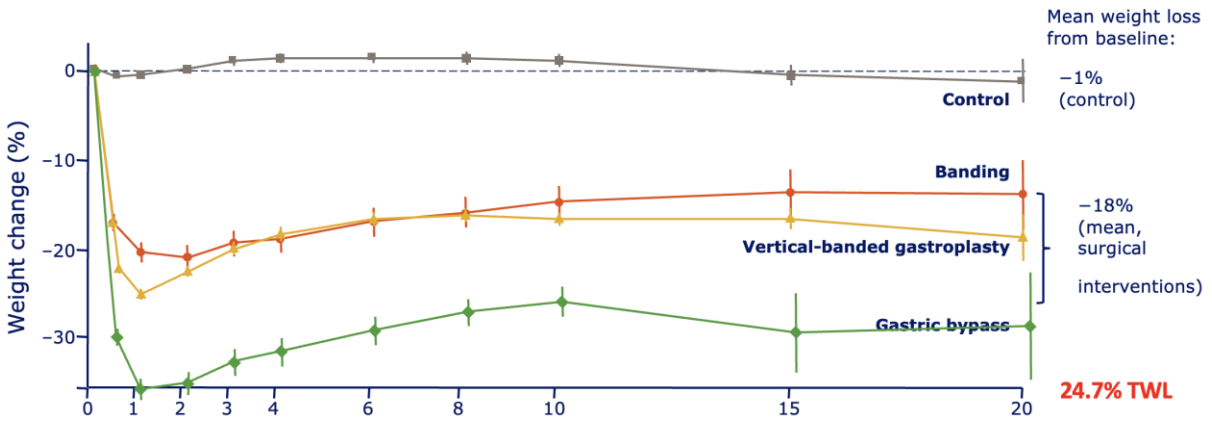
Glucocentric outcomes RCTs, at least 2 years of follow-up

	Surgical intervention	Follow-up duration, years	Glycaemic target	Proportion reaching glycaemic target (surgical intervention *vs* current medical treatment), %	Total bodyweight loss (surgical intervention *vs* current medical treatment), %
Dixon et al[37]	AGB	2	FPG <126 mg/dL and HbA_{1c} <6·2% (44·3 mmol/mol), without glucose-lowering agents	73% *vs* 13%	20% *vs* 1%
Cohen et al[23]	RYGB	2	HbA_{1c} <6·5% (47·5 mmol/mol), regardless of glucose-lowering agents	71% *vs* 51%	26% *vs* 5%
Simonson et al[38]	RYGB	3	FPG <126 mg/dL and HbA_{1c} <6·5% (47·5 mmol/mol) regardless of glucose-lowering agents	42% *vs* 0%	25% *vs* 5%
Ikramuddin et al[39]	RYGB	5	HbA_{1c} <7% (53·0 mmol/mol), regardless of glucose-lowering agents	55% *vs* 14%	22% *vs* 10%
Courcoulas et al[40]	RYGB *vs* AGB	5	HbA_{1c} <6·5 (47·5 mmol/mol) or FPG <126 mg/dL, without glucose-lowering agents	30% (RYGB) *vs* 19% (AGB) *vs* 0%	25% (RYGB) *vs* 15% (AGB) *vs* 6%
Wentworth et al[41]	AGB	5	FPG <126 mg/dL and 2 h blood glucose concentration <200 mg/dL (75 g glucose oral challenge test)	23% *vs* 9%	12% *vs* 2%
Schauer et al[42]	RYGB *vs* sleeve gastrectomy	5	HbA_{1c} <6% (42·1 mmol/mol), regardless of glucose-lowering agents	29% (RYGB) *vs* 23% (sleeve gastrectomy) *vs* 5%	23% (RYGB) *vs* 19% (sleeve gastrectomy) *vs* 5%
Mingrone et al[43]	RYGB *vs* biliopancreatic diversion	10	FPG <100 mg/dL and HbA_{1c} <6·5% (47·5 mmol/mol), without glucose-lowering agents	25% (RYGB) *vs* 50% (biliopancreatic diversion) *vs* 5%	37% (RYGB) *vs* 42% (biliopancreatic diversion) *vs* 7%

HbA_{1c}=glycated haemoglobin. FPG=fasting plasma glucose. AGB=adjustable gastric banding. RYGB=Roux-en-Y gastric bypass.

Table 1: **Randomised controlled trials with follow-up duration of at least 2 years comparing bariatric surgery with current medical treatment**

Long term WL after bariatric surgery



Data are mean ±95% confidence interval

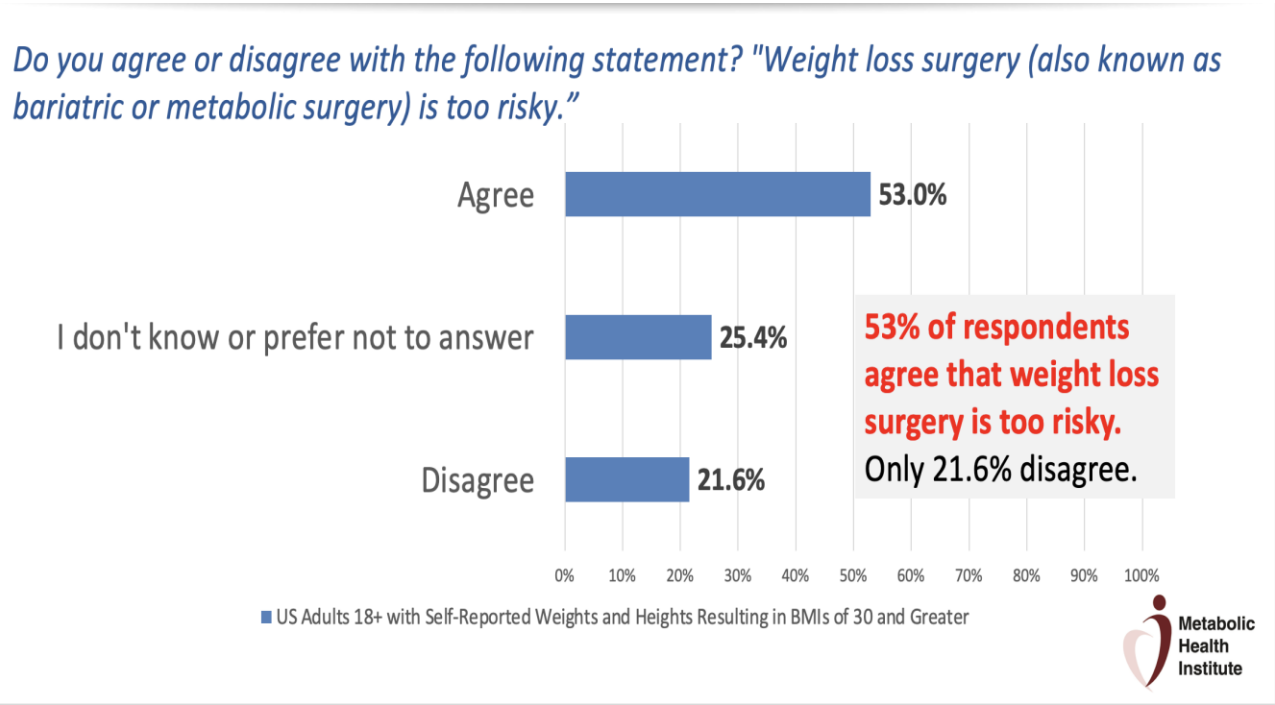
Sjöström L *et al. JAMA* 2012;307:56–65

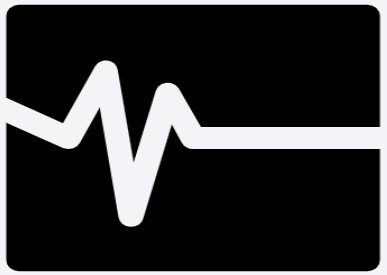
Lingvay, Sumithran, Cohen, LeRoux- Lancet 2021

MISCONCEPTIONS ABOUT SAFETY

Bariatric/Metabolic Surgery Continues to be Seen as “Too Risky”

Do you agree or disagree with the following statement? "Weight loss surgery (also known as bariatric or metabolic surgery) is too risky.”



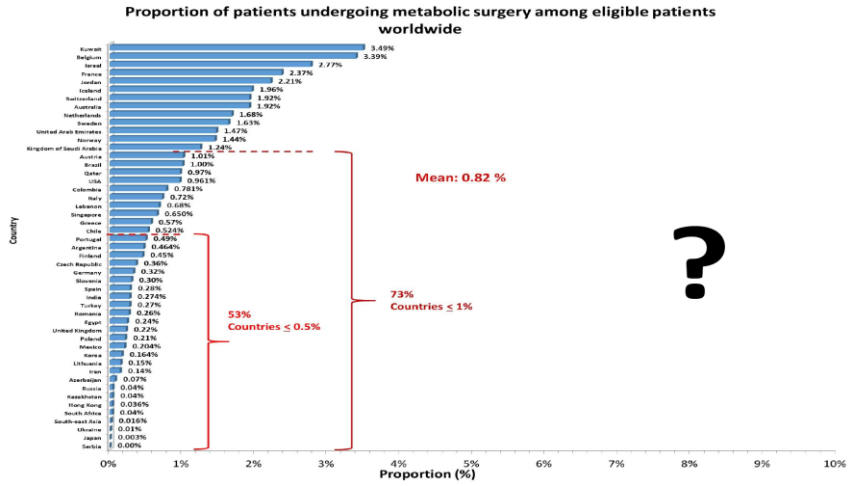


RYGB mortality is comparable to a knee arthroplasy **3/1000, 1/10 of the mortality rate of cardiac surgery**

MISCONCEPTIONS ABOUT COST

Health Insurance and Bariatric/Metabolic Surgery

- ~~Long-term cost-effectiveness~~
- ~~Quality of Evidence~~
- ~~Return of Investment~~
- Upfront Costs
- "Fear of Opening the Flood Gates"



?

Stigma holds evidence-based MBS

"You will be treated if you show you want it!"

You'll be operated only if you lose weight

The ophthalmologist does not ask for “more will power” to individuals with myopia.

They treat the person with glasses/contacts.


Change

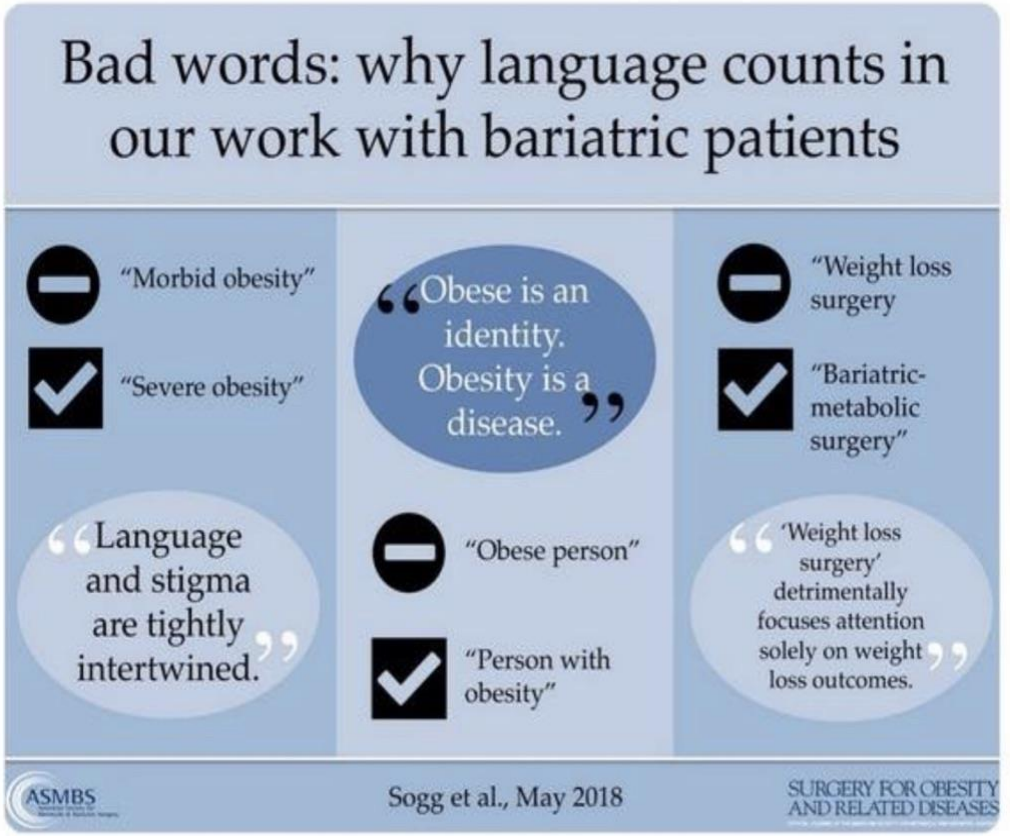
Use adequate wording

People-first language.

People live with obesity and are NOT OBESE!

Is a person cancerous?

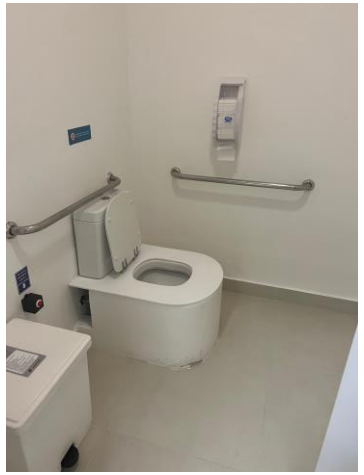
Aidetic?

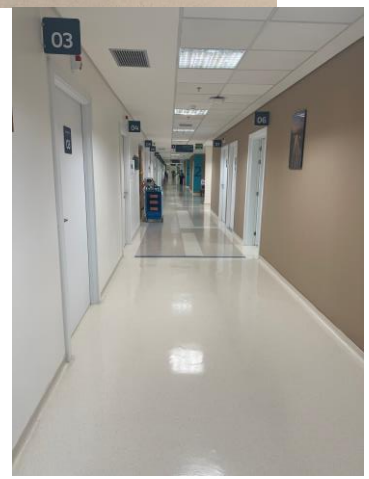



Aidetic


OBESO
In the OR???

Appropriate facilities





- ✓ **Surgery is not the “last resort”**
- ✓ **It’s not the “easy ” way**
- ✓ **Is the best treatment when well indicated**

Science & obesity

- Overeating **DOES NOT** cause obesity
- Obesity **IS NOT** an eating disorder
- Obesity **IS NOT** a mental disease (addiction or vice)
- Obesity **IS** primarily a metabolic illness,with **alterations in the function of tissues, organs or the entire individual, due to excessive and/or abnormal adiposity**

Obesity Surgery
https://doi.org/10.1007/s11695-025-07869-7

IFSO GLOBAL STATEMENT

The Venice Declaration: Obesity as a Disease—A Call to Action for Diagnosis, Multimodal Treatment, and Policy Change

Maurizio De Luca[1] · Amanda Belluzzi[1] · Giuseppe Navarra[2] · Tarissa B. Z. Petry[3] · Scott Shikora[4] · Nicola Di Lorenzo[5] · Ricardo V. Cohen[3]

Accepted: 9 April 2025

1.Obesity is a complex, chronic disease that must be recognized across a spectrum from pre-clinical to clinical stages.

2.Diagnostic and therapeutic inertia must be urgently countered through education, guidelines, policy prioritization, and societal reframing.

3.Weight bias and stigma must be actively eliminated in healthcare, policy, and society.

4.Global access to comprehensive, multimodal obesity care should be significantly expanded **and including medical, endoscopic, surgical and combined strategies**

5.Health systems need integrated obesity-care pathways to ensure consistent, effective management.


Thank you
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