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IMPORTANCE OF ALIGNING MEDICAL
OBESITY MANAGEMENT WITH SURGICAL
PATHWAYS

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TORONTO 2026

The Future of Obesity Management:
From Weight Loss to Health Gain



ifso2026.org

Disclosures

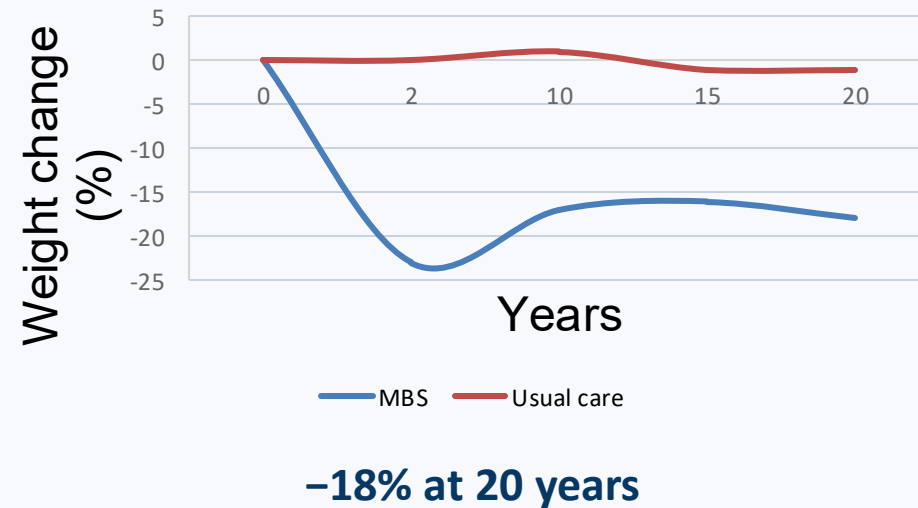
- **Speaker:** Novo Nordisk, Merck, Medtronic, Johnson & Johnson MedTech
- **Research Support/Grants:** Medtronic, Marlex



MBS delivers durable health gain

Long-term weight control is only part of the benefit.

DURABLE WEIGHT LOSS



METABOLIC CONTROL

**5–10
years**

Randomized trials
show superior
glycemic outcomes
versus medical
therapy alone.

SURVIVAL

+3.0

years of median life
expectancy

**23% lower all-cause
mortality**

MBS is not only a weight-loss intervention—it is a long-term disease-modifying treatment.

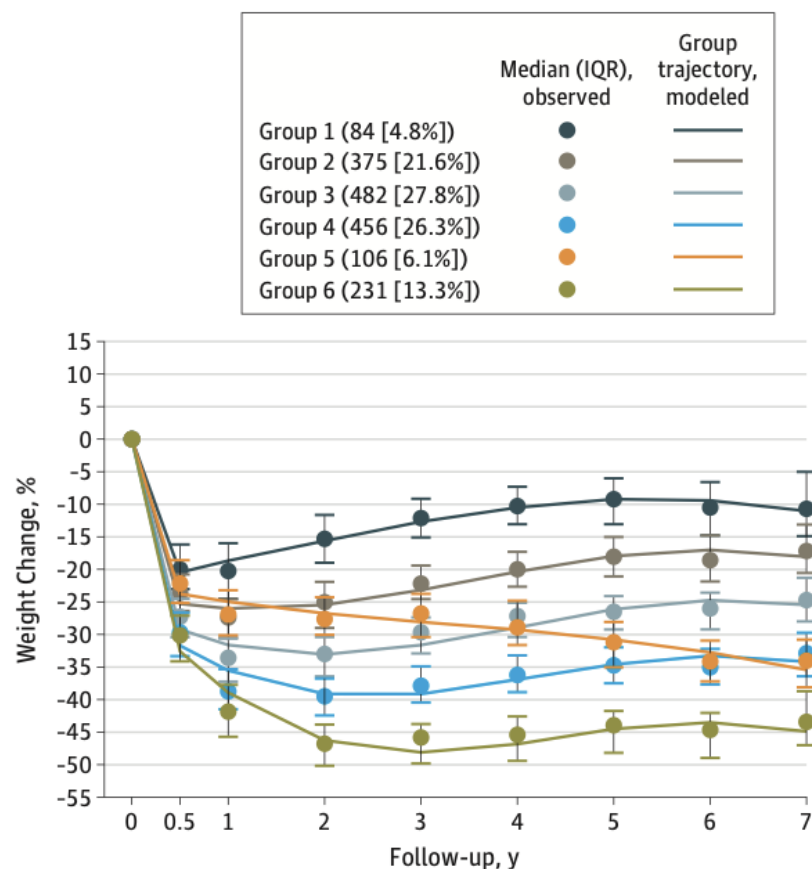
Tailoring Follow-Up: One Size Does Not Fit All



Seven-Year Weight Trajectories and Health Outcomes in the Longitudinal Assessment of Bariatric Surgery (LABS) Study

Anita P. Courcoulas, MD, MPH; Wendy C. King, PhD; Steven H. Belle, PhD; Paul Berk, MD; David R. Flum, MD, MPH; Luis Garcia, MD; William Gourash, PhD, CRNP; Mary Horlick, MD; James E. Mitchell, MD; Alfons Pomp, MD; Walter J. Pories, MD; Jonathan Q. Purnell, MD; Ashima Singh, PhD; Konstantinos Spaniolas, MD; Richard Thirlby, MD; Bruce M. Wolfe, MD; Susan Z. Yanovski, MD

A Roux-en-Y gastric bypass



- One operation. Multiple responses.
- Trajectories separate early.
- Early recognition creates an opportunity to adapt care.

Variability should trigger personalized care—not blame or therapeutic inertia.



CONSENSUS ON DEFINITIONS AND CLINICAL
PRACTICE GUIDELINES FOR PATIENTS CONSIDERING
METABOLIC-BARIATRIC SURGERY

Name the clinical problem—not the patient as a “failure”

Suboptimal Initial Clinical Response: Total weight loss or BMI reduction < 20% or inadequate improvement of the complication that indicated the surgery

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

Late Postoperative Clinical Deterioration: Recurrent weight gain > 30% or worsening of the complication that indicated the surgery

Recurrent weight gain is usually multifactorial

BIOLOGY

Hunger/satiety
signaling
Neuroendocrine
adaptation
Hypoglycemia

ANATOMY

Pouch or sleeve
changes
Anastomotic
dilation
Fistula or reflux

BEHAVIOR & CONTEXT

Eating patterns
Mental health ·
alcohol
Social
determinants

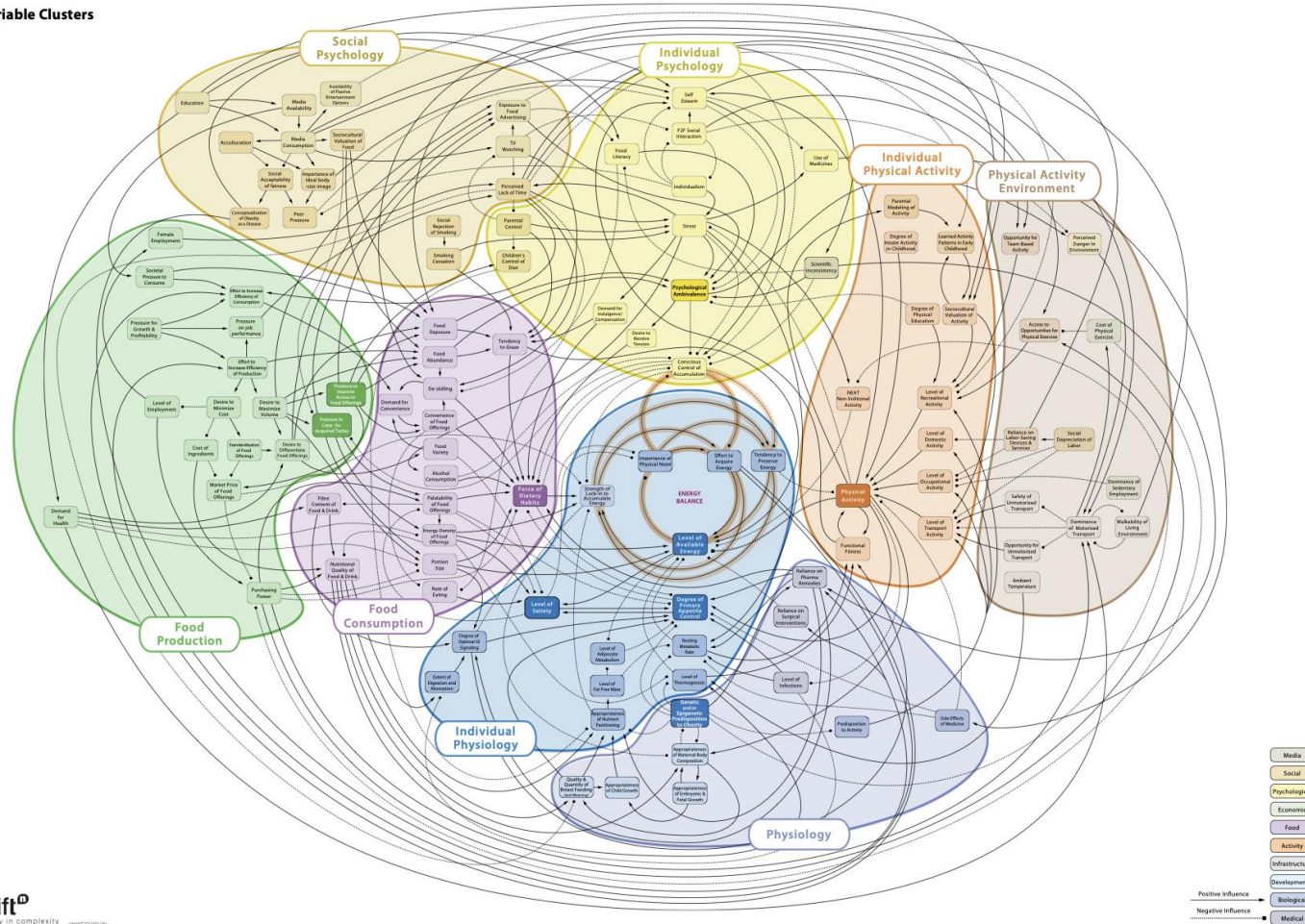
FOLLOW-UP

Nutrition and
activity
Medication access
Continuity of care

Usually, more than one driver is present

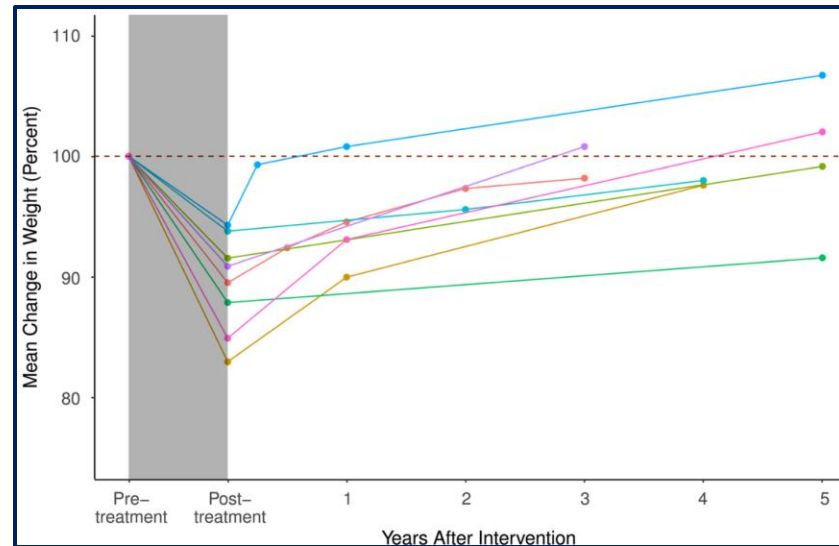
Obesity is caused by a complex interplay of several factors

Obesity System Map
Variable Clusters



Lifestyle intervention

Weight change



Study

- Cooper (2010)
- Hensrud (1994)
- Olszanecka - Glinianowicz (2012)
- Pekkarinen (1997)
- Schwarzfuchs (2012)
- Stalonas (1984)
- Vogels (2005)
- Wadden (1989)

Nordmo *Obes Rev* 2020

Physiological response

Appetite hormone profile

↑ hunger: ghrelin
↓ satiety: leptin,
PYY, CCK, amylin

Appetite

↑ hunger, desire to eat

CNS activation

↑ mesolimbic reward pathway

Energy expenditure

↓ SNS activity, T3,
TEE, REE, NREE
300-500 kcal per day



Energy in

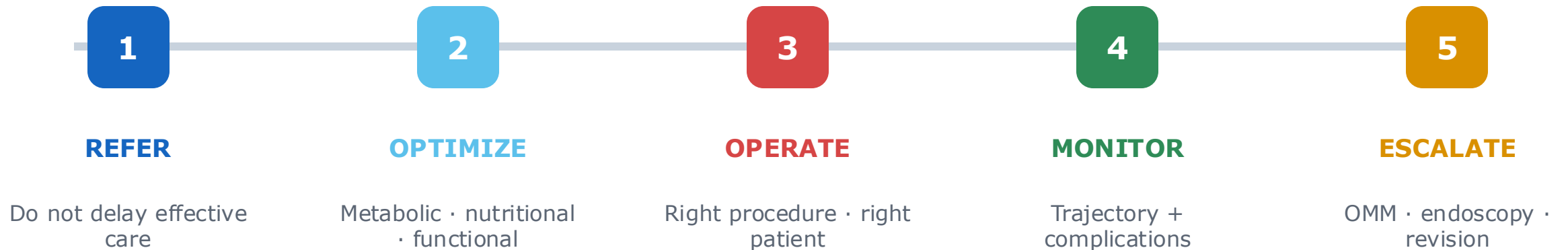


Energy out

Courtesy of Prya Sumithran

Sumithran *NEJM* 2011
Rosenbaum *Am J Clin Nutr* 2008
Fothergill *Obes* 2016

Every phase needs a clinical and a surgical lens



Recurrent weight gain requires multidisciplinary care



Prevention and management

Behavioral

Cognitive behavioral therapy, remote acceptance-based behavioral intervention, lifestyle counseling [87–90]

Dietary

Counseling with dietitian, structured dietary intervention [91–94]

Pharmacological

FDA approved: phentermine, phentermine–topiramate extended release, liraglutide, bupropion/naltrexone

Off label: metformin, topiramate, zonisamide, bupropion [95–98]

Surgical (management only)

After failed LAGB

Conversion to LSG, RYGB, BPD/DS [99]

After failed LSG

Conversion to RYGB, BPD/DS [17]

After failed RYGB

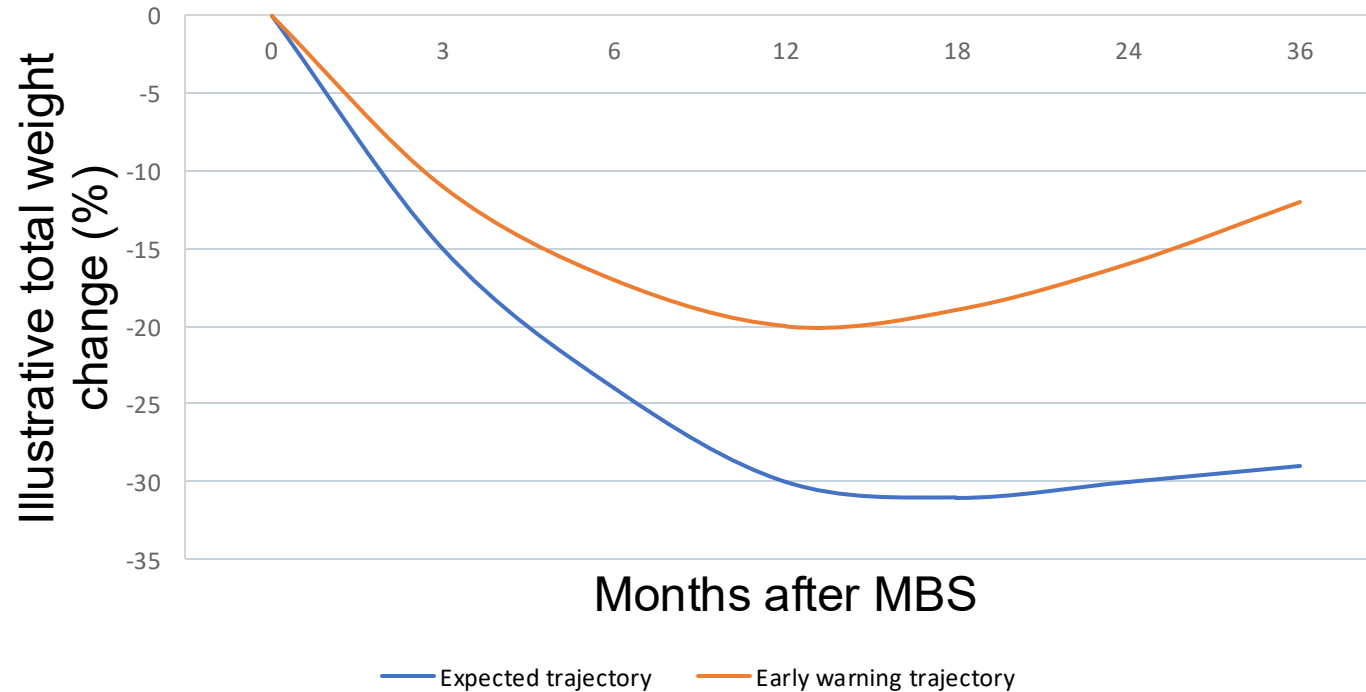
Conversion to DRYGB or to BPD/DS; or revision of gastric pouch and anastomosis, revision with gastric band [100]

Preoperative treatment should optimize—not obstruct—access to MBS

- Control hyperglycemia, sleep apnea, blood pressure and cardiovascular risk
- Identify nutritional deficiencies, sarcopenia risk and eating disorders
- Use OMMs selectively when a clinical objective is clear
- Continue shared decision-making about procedure, expectations and lifelong follow-up

Optimization and surgical evaluation should run in parallel.

Act on the trajectory—before deterioration becomes established



Trigger review when the slope changes—not only after an arbitrary kilogram threshold.

Also track diabetes, sleep apnea, liver disease, function, nutrition, mental health and quality of life.



Collaborative Research

BJS, 2024, znae283

<https://doi.org/10.1093/bjs/znae283>

Collaborative Research Proceedings

International consensus position statement on the role of obesity management medications in the context of metabolic bariatric surgery: expert guideline by the International Federation for the Surgery of Obesity and Metabolic Disorders (IFSO)

Ricardo V. Cohen^{1,*} , Luca Busetto² , Randy Levinson³, Carel W. Le Roux⁴, Paulina Salminen^{5,6}  and Gerhard Prager⁷ on behalf of the experts of the International Consensus on the Role of Obesity Management Medications in the Context of Metabolic Bariatric Surgery



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OMMs **after** MBS

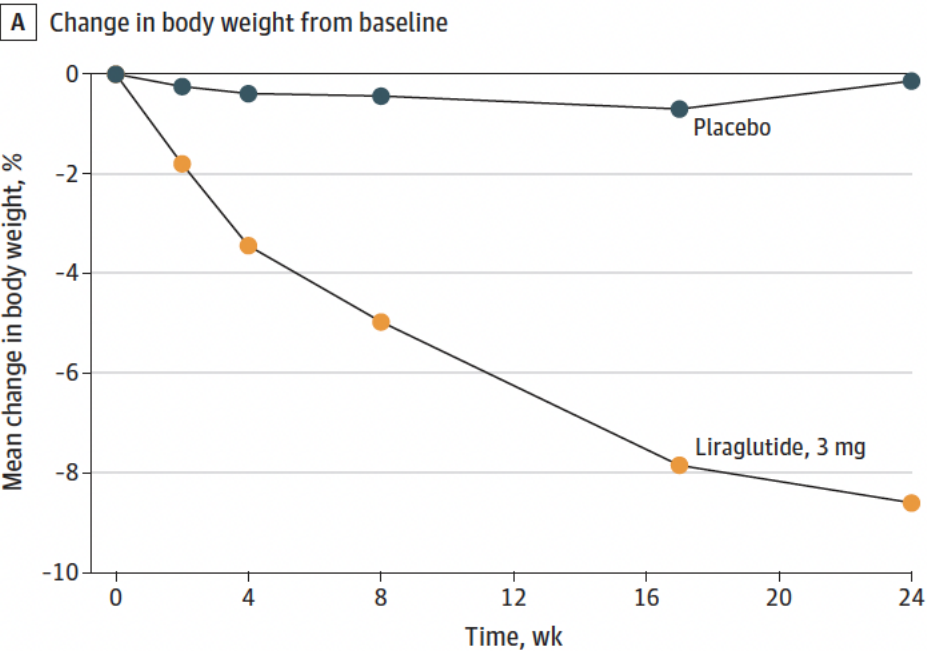
	Grade	Consensus (%)	Nr.of rounds	Nr.of total votes
Emerging evidence indicates that the weight loss induced by OMMs is similar among people who have or have not undergone MBS	A+	100	2	36



Safety and Efficacy of Liraglutide, 3.0 mg, Once Daily vs Placebo in Patients With Poor Weight Loss Following Metabolic Surgery

The BARI-OPTIMISE Randomized Clinical Trial

Jessica Mok, BMBS, MPhil; Mariam O. Adeleke, PhD; Adrian Brown, PhD; Cormac G. Magee, MBBChir, MA; Chloe Firman, MRes; Christwishes Makahamadze, MRes; Friedrich C. Jassil, PhD; Parastou Marvasti, PhD; Alisia Carnemolla, PhD; Kalpana Devalia, MBBS, MS; Naim Fakihi, MD; Mohamed Elkalaawy, MRCSEd, MS, MD; Andrea Pucci, MD, PhD; Andrew Jenkinson, MBBS, MS; Marco Adamo, MD; Rumana Z. Omar, PhD; Rachel L. Batterham, MBBS, PhD; Janine Makaronidis, MRChB, PhD



-8.03%
estimated treatment
difference

70 adults ≥ 1 year after RYGB or SG
Poor weight loss + suboptimal GLP-1 response

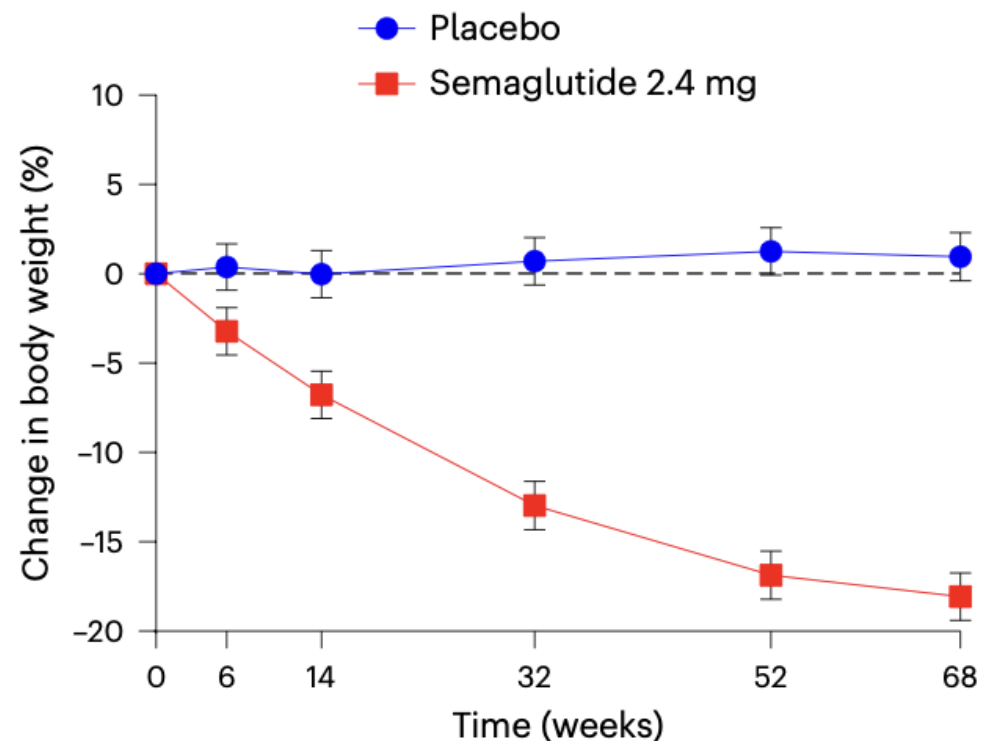
Event	Participants who experienced an AE, No. (%)		
	Placebo (n = 35)	Liraglutide (n = 35)	Total (N = 70)
Total	20 (57)	28 (80)	48 (67)
Total AEs, No. ^b	75	37	112
Gastrointestinal events			
Nausea	7 (20)	18 (51)	25 (36)
Diarrhea	2 (6)	2 (6)	4 (6)
Constipation	2 (6)	9 (26)	11 (16)
Vomiting	1 (3)	1 (3)	2 (3)
Abdominal pain	1 (3)	2 (6)	3 (4)
Abdominal bloating	0	1 (3)	1 (1)
Dyspepsia	0	1 (3)	1 (1)

Semaglutide versus placebo in individuals with poor weight loss after bariatric surgery: a double-blinded, randomized, placebo-controlled trial

70 participants
≥1 year after RYGB or
SG
Suboptimal clinical
response

–19.1%

treatment difference at week
68



The scale is one signal—not the definition of success

METABOLIC

HbA1c · BP · lipids
MASLD · sleep
apnea

FUNCTION

Mobility · strength
pain · participation

NUTRITION

Micronutrients
lean mass · eating
tolerance

LIVED EXPERIENCE

Quality of life
mental health ·
patient goals

Integrated care converts weight loss into durable health gain.



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

Maurizio De Luca¹ · Amanda Belluzzi¹ · Giuseppe Navarra² · Tarissa B. Z. Petry³ · Scott Shikora⁴ · Nicola Di Lorenzo⁵ · Ricardo V. Cohen³

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- ✓ **Obesity is a disease—not just weight.**
- ✓ **Barriers delay care and worsen outcomes.**
- ✓ **Integrated, multimodal treatment must become standard.**

Surgery changes obesity biology. It does not end obesity care.

- 01 Do not delay access with fragmented prerequisites.
- 02 Monitor trajectories and health—not weight alone.
- 03 Use OMMs as complementary escalation tools.
- 04 **Keep one integrated team accountable for long-term care.**

The strongest treatment is not a procedure or a drug—it is a pathway that does not abandon the patient.

XXX IFSO WORLD CONGRESS

"Advancing Multimodal Obesity Care"

24-27 August 2027

ifso2027.org



IFSO
PARIS 2027

See you in

PARIS





Thank you

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