

# Impact on Outcomes: From Pre-operative Optimisation to Chronic Disease Management

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# A SURGEON'S CONCESSION

**The operation takes less than 60 minutes.**

**The outcome takes ten years.**

**The team owns the difference.**

1. Pre-operative optimisation
2. The peri-operative window
3. The first 24 months
4. Chronic disease management
5. What we should be measuring

Technique explains our complications. It does not explain our outcomes.

Everything that separates a good five-year result from a poor one happens outside the operating room — before it, and for years after it.

# One patient, four phases, one continuum

Each phase has a different team, a different lever, and a different outcome it moves.



*Programs are usually excellent at one phase, adequate at two, and absent at the fourth.*

# 1. PRE-OPERATIVE OPTIMISATION

The runway to intervention • Weeks to months before the procedure



**ASSESS → OPTIMISE → PREPARE → CONFIRM**

# Phase 1 — Optimization is not a waiting period

What the team does before surgery determines what the surgeon can achieve during it.

1

## Metabolic

Glycaemic control, lipids, BP and medication reconciliation.

2

## Respiratory

OSA screening, smoking cessation and conditioning.

3

## Nutritional

Correct micronutrient deficiencies before surgery.

4

## Psychological

Screening, stabilisation and behavioural assessment.

5

## Functional

Prehabilitation: mobility and strength are recoverable assets.

6

## Educational

Set expectations and prepare for long-term adherence.



### OUTCOMES MOVED

- Complication rate
- Cancellation / no-show
- Length of stay
- Anesthetic risk
- Early adherence
- Long-term retention

#### REVIEW

#### Open Access

Metabolic/bariatric surgery optimization: a position statement by Arabic association for the study of diabetes and metabolism (AASD)

Amin Roshdy Soliman<sup>1\*</sup>, Hesham Magd eldin Saleem<sup>2</sup>, Amr Abel Hady El Meligi<sup>3</sup>, Mervat Naguib<sup>4</sup>, Rasha Sobh Mohamed<sup>5</sup>, Ghada Rabie Abdelaziz<sup>6</sup>, Maha Rakha<sup>7</sup>, Shereen Abdelghaffar<sup>8</sup>, Abd ElKhalek Hamed<sup>9</sup>, Hany Abd El Rahman saeed Hammad<sup>10</sup>, Eman O Mahmoud<sup>11</sup> and Inass Shaltout<sup>12</sup>

#### POSITION STATEMENT

Diabetes management in people undergoing metabolic-bariatric surgery: A guideline from the Joint British Diabetes Societies for Inpatient Care (JBDS-IP) Group

Jeffrey W. Stephens<sup>1,2</sup> | Ketan Dhataria<sup>3,4</sup> | Andrew J. Beamish<sup>5</sup> | Dimitri J. Pournaras<sup>6</sup> | Alexander D. Miras<sup>7</sup> | Nader Raafat<sup>8</sup> | Georgia Noble-Bell<sup>9</sup> | Rachel Cadwallader Buckland<sup>10</sup> | Omar G. Mustafa<sup>8,10</sup>

# Evidence 1 — Glycaemia before surgery sets the outcome after

## Predicting Remission of Diabetes After RYGB Surgery Following Intensive Management to Optimize Preoperative Glucose Control

Thomas MacAndrew English · Samir Malkani · Rebecca L. Kinney ·  
Abdulkadir Omer · Mary Beth Dziewietin · Richard Perugini

Not fitness for anaesthesia. The pre-operative metabolic state predicts remission years later.

N=245 RYGB

68%

higher odds of diabetes remission for every 1% fall in HbA1c achieved before surgery, in a structured pre-operative glucose optimisation programme ( $p = 0.015$ ).

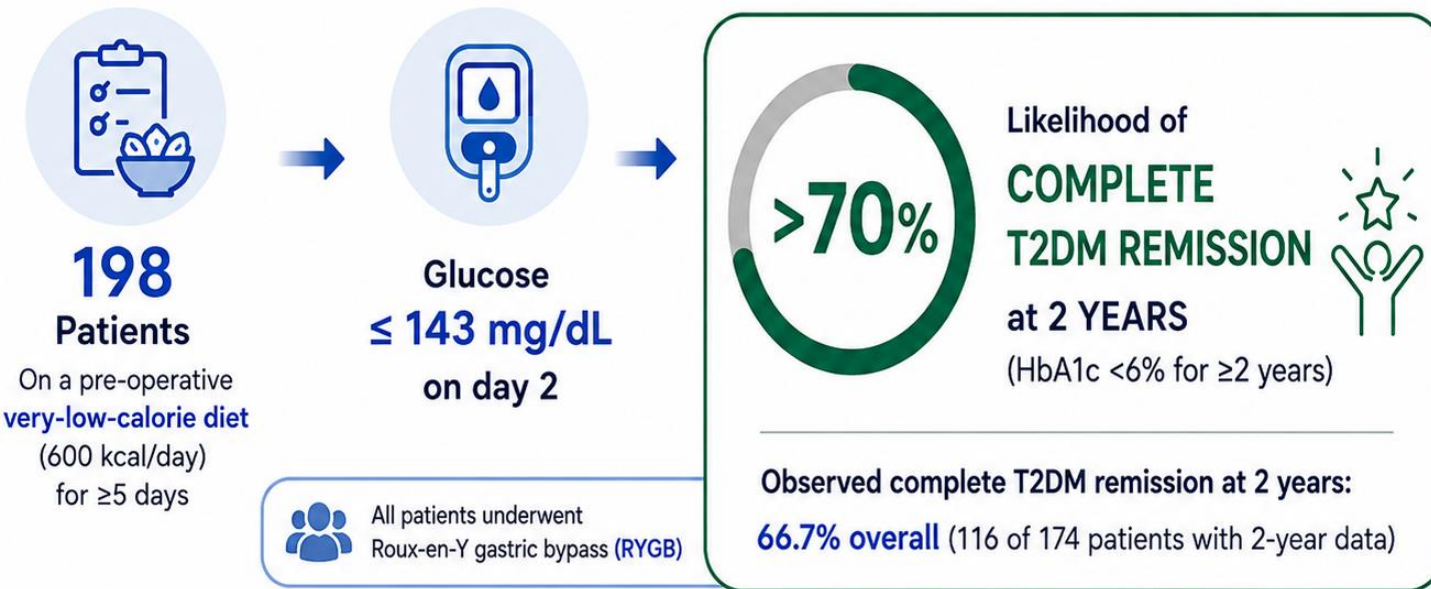
*Obesity Surgery, 2014*

Significant characteristics of patients who remitted include lower HbA1c prior to initiating the glucose optimization intervention (remit, 7.1 vs. no remit, 8.2  $p < 0.001$ )

|                                     | Remit (N=172)       | Non-remit (N=73)    | p value |
|-------------------------------------|---------------------|---------------------|---------|
| HbA1c prior to glucose optimization | 7.1 % (54 mmol/mol) | 8.2 % (66 mmol/mol) | <0.001  |
| HbA1c change prior to surgery       | 0.79 %              | 0.42 %              | 0.028   |
| HbA1c at surgery                    | 6.7 % (50 mmol/mol) | 7.4 % (57 mmol/mol) | <0.001  |
| HbA1c 1 year after surgery          | 5.6 % (38 mmol/mol) | 6.9 % (52 mmol/mol) | <0.001  |
| BMI                                 | 47                  | 45                  | 0.075   |
| Weight                              | 289                 | 282                 | 0.400   |
| Age                                 | 53                  | 56                  | 0.005   |
| White                               | 79 %                | 88 %                | 0.067   |
| Male                                | 32 %                | 44 %                | 0.086   |
| Diabetes duration over 2 years      | 54 %                | 93 %                | <0.001  |
| Insulin use at surgery              | 21 %                | 84 %                | <0.001  |
| Insulin use 1 year after surgery    | 0 %                 | 42 %                | <0.001  |
| DiaRem score                        | 6.65                | 14.99               | <0.001  |

# Pre-op Glycemic Response predicts T2DM Remission

## Evidence 2



Early glycemic response to a VLCD may predict long-term T2DM remission after bariatric surgery.



ABCD Arq Bras Cir Dig  
2025;38:e1919  
<https://doi.org/10.1590/0102-67202025000050e1919>

ORIGINAL ARTICLE

### Preoperative glycemic response to a very low-calorie diet predicts long-term type 2 diabetes remission after bariatric surgery

Resposta glicêmica à dieta de muito baixa caloria no pré-operatório como preditor de remissão tardia do diabetes tipo 2 pós-cirurgia bariátrica

Mariana Fior Frias Thomaz BORTOLAN<sup>1</sup>, Roberto DE CLEVA<sup>2</sup>, Leandro FERREIRA<sup>2</sup>, Denis PAJECKI<sup>2</sup>, Marco Aurelio SANTO<sup>2</sup>

# Nutritional Pre- optimization

## RAPID RESPONSE TO 2-WEEK PRE-OP DIET



T2DM REMISSION  
AT 6 MONTHS

**RAPID  
RESPONDERS**

(n = 29)

**44%**

(13/29)

**NON-RESPONDERS**

(n = 22)

**13.6%**

(3/22)

T2DM REMISSION  
AT 12 MONTHS

**72.7%**

(16/22)

**5.9%**

(1/17)

*Biro et al., Journal of Surgical Research, 2013*

## Diabetes remission and glycemic response to pre-bariatric surgery diet

Steven M. Biro, MS<sup>a</sup>, Diane L. Olson, RD<sup>a</sup>, Michael J. Garren, MD<sup>a</sup>, and Jon C. Gould, MD<sup>b,\*</sup>

<sup>a</sup>Department of Surgery, University of Wisconsin School of Medicine and Public Health, Madison, Wisconsin

<sup>b</sup>Department of Surgery, Division of General Surgery, Medical College of Wisconsin, Milwaukee, Wisconsin

**Rapid responders:** patients who achieved a  $\geq 50\%$  reduction in their total daily insulin dose while still maintaining appropriate blood glucose control during the preoperative diet.

**Non-rapid responders:** patients who did not achieve a  $\geq 50\%$  reduction in total insulin requirement during the diet.

# Hypertension Evidence 1

## Duration of Hypertension Matters



Each additional year of hypertension before surgery

↓ **15%** lower odds of hypertension remission



**n = 100**  
Patients with obesity undergoing RYGB



**39%** achieved complete hypertension remission at **3 YEARS**



Shorter duration of hypertension before surgery predicts higher remission rates. **Early intervention** leads to lasting benefit.

## GATEWAY Trial – 5 YEAR Outcomes



**RYGB** vs. Medical Therapy

≥30% reduction in antihypertensive medications with BP <140/90 mmHg

**80.7%**  
RYGB  
(n=100)

VS

**13.7%**  
Medical Therapy  
(n=100)

Complete hypertension remission

**46.9%**  
RYGB  
(n=100)

VS

**2.4%**  
Medical Therapy  
(n=100)

Obesity Surgery (2023) 33:2485–2492  
<https://doi.org/10.1007/s11695-023-06711-2>



### ORIGINAL CONTRIBUTIONS

#### Shorter History of Hypertension as a Predictor of Hypertension Remission after 3-years of Bariatric Surgery: Data from the GATEWAY Trial

Juliana D. Oliveira<sup>1,2</sup> · Carlos A. Schiavon<sup>2,3</sup> · Julia S. Oliveira<sup>2</sup> · Renato N. Santos<sup>2</sup> · Lucas P. Damiani<sup>4</sup> · Dimas Ikeoka<sup>2</sup> · Eliana V. Santucci<sup>2</sup> · Rachel Helena V. Machado<sup>2</sup> · Luiz A. Bortolotto<sup>5</sup> · Otavio Berwanger<sup>4</sup> · Alexandre B. Cavalcanti<sup>2</sup> · Luciano F. Drager<sup>1,5,6</sup>



**JACC**

#### Randomized Trial of Effect of Bariatric Surgery on Blood Pressure After 5 Years

Carlos A. Schiavon, MD,<sup>a,b</sup> Alexandre B. Cavalcanti, MD,<sup>a</sup> Juliana D. Oliveira, CN,<sup>a,b</sup> Rachel H.V. Machado, CN,<sup>a</sup> Eliana V. Santucci, Pr,<sup>a</sup> Renato N. Santos, STAT,<sup>a</sup> Julia S. Oliveira, STAT,<sup>a</sup> Lucas P. Damiani, STAT,<sup>a</sup> Débora Junqueira, MD,<sup>a</sup> Helio Halpern, MD,<sup>c</sup> Frederico de L.J. Monteiro, MD,<sup>c</sup> Patricia M. Noujaim, MD,<sup>b</sup> Ricardo V. Cohen, MD,<sup>d</sup> Marcio G. de Sousa, MD,<sup>e</sup> Luiz A. Bortolotto, MD,<sup>f</sup> Otavio Berwanger, MD,<sup>g</sup> Luciano F. Drager, MD<sup>h,i,j</sup>

# THREE PRE-OP FACTORS THAT SHAPE LONG-TERM OUTCOMES

Evidence 2

Tobacco • Micronutrients • Fitness



## TOBACCO

- Smokers had higher 30-day overall morbidity: 4.3% vs 3.7% (P=.04)
- Associated with marginal ulceration and internal hernia after RYGB.
- Smoking cessation is a modifiable pre-op target.

Haskins IN, et al. Surg Obes Relat Dis. 2017;13:810-816.  
PMID: 28420587



## MICRONUTRIENTS

- Multivitamin use fell from 92.6% at 1 year to only 37% at 4 years after LSG.
- Low vitamin D, B1 and albumin may persist after surgery.
- Screen and correct deficiencies before surgery.

Ben-Porat T, et al. Surg Obes Relat Dis. 2017;13:1138-1144.  
PMID: 28416186



## FITNESS

- Systolic BP fell 23.8 mmHg (P=.007) and 6-minute walk distance improved 69.8 m (P<.0001), showing better pre-op functional capacity.
- Exercise before surgery may shorten recovery.
- Build mobility and strength before intervention.

Marcon et al. data summarized in:  
Perioperative Exercise Therapy in Bariatric Surgery.  
2020.

PRE-OP OPTIMISATION: STOP SMOKING • CORRECT DEFICIENCIES • BUILD FITNESS

# SMOKING RAISES RISK. STOP BEFORE BARIATRIC SURGERY.

133,417

bariatric surgery patients

Large NSQIP bariatric cohort • LSG + RYGB



## RESPIRATORY COMPLICATIONS

**0.8% vs 0.5%**

smokers vs non-smokers

**OR 1.69**

95% CI 1.34-2.14

## WOUND COMPLICATIONS

**2.0% vs 1.4%**

smokers vs non-smokers

**OR 1.44**

95% CI 1.24-1.68

## 30-DAY READMISSION

**4.9% vs 4.1%**

smokers vs non-smokers

**OR 1.21**

95% CI 1.10-1.33

## INTERNAL HERNIA AFTER RYGB

n = 401

**2.4×**

**higher hazard**

HR 2.4 (95% CI 1.3-4.5)

p = 0.005

Adjusted HR 2.2 (1.2-4.2)

**TAKE-HOME:** Current smoking is associated with worse 30-day bariatric outcomes and higher internal-hernia risk after RYGB.



# OPTIMISATION ≠ MANDATED PRE-OP WEIGHT LOSS

Clinical risk reduction should not become an administrative delay.



## CLINICAL OPTIMISATION

- **Targets a real risk**  
e.g., diabetes, smoking, OSA, nutrition
- **Has a clinical endpoint**  
BP/HbA1c control, deficiency correction
- **Runs alongside scheduling**  
prepares the patient without arbitrary delay



## MANDATED WEIGHT PROGRAM

**+57 DAYS**

RYGB: 178 vs 121 days

**+74 DAYS**

SG: 169 vs 95 days

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### NO SIGNIFICANT LONG-TERM BENEFIT

%TWL, %EWL and follow-up were not different through 60 months.

**OPTIMISE CLINICAL RISK — DON'T DELAY SURGERY FOR AN ARBITRARY WEIGHT TARGET**

# Phase 2 — The peri-operative window belongs to nursing

Thirty days in which the team, not the technique, determines readmission.

1

## Enhanced recovery

Nurse-led ERAS protocols, early mobilisation and structured analgesia — the physiotherapist starts on day zero.

2

## Hydration and nausea

The commonest cause of early readmission is not a surgical complication. It is dehydration.

3

## Structured discharge

Teaching that is documented, teach-back verified, and followed by a scheduled contact — not a leaflet.

*In a high-volume program, same-day and next-day discharge is not a surgical achievement. It is a nursing protocol, an anaesthetic pathway and a telephone call at 48 hours.*

# PHASE 2 - The peri-operative window belongs to nursing



## ENHANCED RECOVERY

ERAS protocols support safer recovery and earlier discharge in bariatric surgery.

### EVIDENCE



ERAS Society recommends a multimodal pathway including:

- ✓ Opioid-sparing analgesia
- ✓ Optimized fluid management
- ✓ Early oral intake
- ✓ Early mobilization
- ✓ Standardized discharge criteria



These measures are associated with fewer postoperative complications, shorter lengths of stay, and improved patient outcomes.

**Source:** Stenberg E, et al. ERAS® Society guidelines for metabolic and bariatric surgery: 2022 update. *World J Surg.* 2022;46(4):729–751.



**KEY TAKEAWAY:** High-volume bariatric programs achieve safe same-day or next-day discharge through multidisciplinary ERAS pathways, with hydration and nausea management being critical to reduce early readmissions.

2



## HYDRATION AND NAUSEA

Dehydration, nausea and vomiting are among the leading causes of early readmission after bariatric surgery.

### EVIDENCE



Nausea, vomiting and dehydration are among the leading causes of 30-day readmission.

**6.62%**

30-day readmission rate

(n = 736 patients)

AbuAlsel A, et al.

*Obes Surg.* 2024;34:2561–2568.

**3.3%**

30-day readmission rate

(n = 161,141 patients)

Palacios Argueta P, et al.

*Dig Dis Sci.* 2022;67:834–843.

*World J Surg* (2022) 46:729–751  
<https://doi.org/10.1007/s00268-021-06394-9>

SCIENTIFIC REVIEW

## Guidelines for Perioperative Care in Bariatric Surgery: Enhanced Recovery After Surgery (ERAS) Society Recommendations: A 2021 Update

Erik Stenberg<sup>1</sup> · Luiz Fernando dos Reis Falcão<sup>2</sup> · Mary O’Kane<sup>3</sup> · Ronald Liem<sup>4,5</sup> · Dimitri J. Pournaras<sup>6</sup> · Paulina Salminen<sup>7,8</sup> · Richard D. Urman<sup>9</sup> · Anupama Wadhwa<sup>10</sup> · Ulf O. Gustafsson<sup>11</sup> · Anders Thorell<sup>12,13</sup>

Observational Study

Medicine

OPEN

## Predictive factors for readmission after bariatric surgery

### Experience of an obesity center

Mohammad Rashdan, MD<sup>a</sup> · Lana Al-Sabe, MD<sup>a</sup> · Mohammad Salameh, MD<sup>a</sup> · Shahed Halaseh, MD<sup>a</sup> · Bana Al-Mikhi, MD<sup>a</sup> · Shereen Sha’bin, MD<sup>a</sup> · Lina Alqireh, MD<sup>a</sup> · Tabarak Alsaadi, MD<sup>a</sup> · Jood Ahmad, MD<sup>a</sup> · Aseel Sabbagh, MD<sup>a</sup> · Faris Haddad, MD<sup>a</sup> · Yasser Algharawi, MD<sup>a</sup> · Laith Alghazawi, MD<sup>a</sup> · Mohammad N. Nofal, MD<sup>a</sup>

ERAS • HYDRATION • EARLY MOBILISATION • STANDARDIZED DISCHARGE • FOLLOW-UP

# Phase 3 — The first 24 months set the trajectory

This is the window in which behaviour, body composition and adherence are still modifiable.

1

## Nutrition

Protein adequacy, supplementation adherence and eating competence — dietetic contact frequency is a modifiable predictor of outcome.

2

## Behaviour and mental health

Eating behaviour, mood, alcohol and the psychological adjustment that follows rapid change in body and identity.

3

## Physical activity

Preserving lean mass is the difference between weight loss and health gain. Resistance training is a clinical intervention, not a lifestyle suggestion.

4

## Follow-up attendance

The most consistently reported modifiable predictor of long-term outcome across the literature — and the one we manage worst.

*We invest heavily in selecting patients and very little in retaining them.*

# Multidisciplinary Member Roles

| Provider                      | Activity                                                                                 | Details                                                                                                                                                                           | Role             |
|-------------------------------|------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|
| <b>Dietitian</b>              | Nutritional assessment and counseling                                                    | Assess dietary patterns, preferences. Set family-based nutrition plans, goals and monitoring                                                                                      | <b>Essential</b> |
| <b>Bariatric Nurse</b>        | Measurements/clinic routine                                                              | Anthropometric measurements, vital signs, routine laboratory workup request, clinic routine                                                                                       | <b>Essential</b> |
| <b>Clinical Coordinator</b>   | Medical record, case report forms, educational workshop, appointments, laboratory workup | Case report forms, file summary, research blood sample, patient picture, booking educational workshop, appointment scheduling, issue routine predefined laboratory workup request | <b>Essential</b> |
| <b>Physical therapist</b>     | Musculoskeletal, activity assessment and counseling                                      | Assess musculoskeletal and physical activity; education, develop exercise and activity plan                                                                                       | Optional         |
| <b>Behavioral therapist</b>   | Psychologic assessment and counseling                                                    | Counsel patient and family; structure a cognitive behavioral therapy program, identify behavior issues that might be affecting weight, screen for psychiatric disorders           | Optional         |
| <b>Internist/Primary Care</b> | Medical assessment                                                                       | Medical assessment, ordering non-routine investigations, preoperative assessment, medical follow-up                                                                               | <b>Essential</b> |
| <b>Anesthesiologist</b>       | Preoperative and operative preparations                                                  | preoperative assessment, anaesthesia administration, continuous monitoring of vital signs, managing pain, responding to emergencies, and collaborating with the surgical team.    | <b>Essential</b> |
| <b>Bariatric Surgeon</b>      | Bariatric surgery, surgical follow-up                                                    | Counsel child and family on bariatric surgery, perform the procedure, postoperative follow-up                                                                                     | <b>Essential</b> |

# Surgery induces remission — not immunity

Obesity remains a chronic disease. Long-term surveillance is part of the treatment, not an optional follow-up.



**The endpoint is not discharge. The endpoint is durable disease control.**

# Five domains can quietly re-emerge after surgery

A high-volume program actively searches for recurrence, deficiency and late complications.

01

## Metabolic relapse

T2DM • dyslipidemia • hypertension

10-y RYGB: T2DM remission  
declined from 74% → 53%

02

## Nutritional deficiency

Iron • B12 • vitamin D • thiamine • protein

Annual  
long-term  
monitoring

03

## Bone & lean mass

BMD loss • sarcopenia risk

Bone loss  
persists beyond  
weight loss

04

## Mental health

Depression • disordered eating • alcohol use

AUD risk  
↑ later after  
surgery

05

## Reproductive health

Contraception • pregnancy • maternal nutrition

Plan before  
conception;  
monitor closely

SURVEILLANCE DELIVERABLE → Detect • stratify • replace • refer • escalate

# Recurrent weight gain is a pathway — not a failure

Detect the phenotype, identify the driver, then escalate treatment.

**>30%**

of lost weight regained  
from nadir

2026 international  
Delphi consensus threshold

→ investigate, don't blame

1

**REASSESS**

Behavior • medication • anatomy • endocrine

2

**PHARMACOTHERAPY**

AOM / incretin-based therapy when appropriate

3

**ENDOSCOPIC  
REVISION**

TORe / revisional endobariatric therapy

4

**SURGICAL REVISION**

For selected anatomy or refractory disease

Chronic disease model: intensify treatment when disease activity returns.



Surgery for Obesity and Related Diseases 22 (2026) 753–761

Original article

International expert consensus on definitions and management of weight recurrence and suboptimal response after metabolic and bariatric surgery: a Delphi study

SURGERY FOR OBESITY  
AND RELATED DISEASES

RESEARCH

Metabolic Outcomes and Recurrent Weight Gain 10 Years After Roux-en-Y Gastric Bypass, a Longitudinal Cohort Study

Monica Chahal-Kummen<sup>1</sup> · Stephen Hewitt<sup>1</sup> · Torgeir Thorson Søvik<sup>1</sup> · Jon Kristinsson<sup>1</sup> · Tom Mälä<sup>1,2</sup>



# From weight loss to health gain: change the endpoint

If the team's contribution is invisible in the outcome data, it will be invisible in the budget.

## WHAT WE HAVE COUNTED

- Percentage total weight loss
- Percentage excess weight loss
- Complication and reoperation rate
- Length of stay
- Binary remission at one year

## WHAT HEALTH GAIN REQUIRES

- Medication burden — deprescribing as an endpoint
- Comorbidity remission and relapse over time
- Body composition, not body weight
- Functional capacity and quality of life
- Nutritional and mental health status
- Retention in follow-up

*A dietitian cannot be funded by a percentage. She can be funded by a deprescribing rate.*

**14% → 2%**

insulin use at baseline → 10 y;  $p < 0.001$  (n=95)

**31%**

complete T2DM remission at 10 y

**24.6%**

mean total body weight loss at 10 y; SOReg n=29,578

# How we built it — Riyadh

A single high-volume center running surgical, endoscopic and medical pathways with one team.

## 1 One intake

Every patient enters through the same modality-agnostic assessment, seen by nutrition and psychology before a procedure is chosen.

## 2 One MDT

Surgery, endoscopy, endocrinology, dietetics, psychology, nursing and physiotherapy review the same patient list.

## 3 One escalation ladder

Pharmacotherapy, endoscopic revision and surgical revision are pre-defined steps — not separate services.

## 4 One dataset

All modalities report to a single outcome registry with common definitions, including IFSO recurrent weight gain terminology.

The adolescent program taught us this first: with a growing patient and a family, no single discipline can carry the outcome.

## SAID PLAINLY, BY A SURGEON

1

### We treat the team as support

The team is not supporting the operation. The operation is one intervention inside the team's program.

2

### We measure ourselves at one year

One-year data flatters the surgeon and hides the phase where the team's work becomes visible.

3

### We call escalation failure

Recurrent weight gain is disease behaviour, not patient behaviour — and not a verdict on the operation.

4

### We discharge

There is no discharge from a chronic disease. There is only a handover, and usually to no one.

**24%**

late diabetes recurrence despite initial remission at 10 y

**56.7%**

clinically relevant weight regain at 10 y

**–12.9%**

12-mo weight change with semaglutide for post-MBS recurrence  
(n=115)

# What to build on Monday morning

Four commitments a program can make without new funding.

1

## Write the protocol

A documented, phase-by-phase pathway with named discipline ownership at every step — including year five.

2

## Appoint retention

Someone owns attendance. Missed appointments trigger contact, not discharge.

3

## Add two metrics

Medication burden and follow-up retention, reported alongside weight, at every audit.

4

## Pre-define escalation

Agree the thresholds and the options for recurrent weight gain before the patient is in front of you.

*None of these require a new post. All of them require a decision.*



# **4<sup>th</sup> IFSO MENAC Meeting**

3-5 December 2026

Gulf Convention Hotel, Manama, Bahrain

## **Registrations are Open**



# XXX IFSO WORLD CONGRESS

"Advancing Multimodal Obesity Care"

24-27 August 2027

[ifso2027.org](https://ifso2027.org)



IFSO  
PARIS 2027

*See you in*

PARIS

