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XXIX IFSO World Congress

1-4 September 2026 | Toronto, Canada

TORONTO2026

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

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Disclosure Slide

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Maintaining Health Gains Amidst Recurrent Weight Gain

Violeta Moizé Arcone. RDN, PhD
Hospital Clinic Barcelona
vmoize@clinic.cat

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Weight is a trajectory.
Health is a multidimensional outcome

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For example:

- **Health Markers** ----------►
  - **metabolic markers,**
  - **cardiovascular markers,**
  - **anthropometric measures,**
  - **quality of life indices,**
  - **inflammatory biomarkers,**
  - **renal and hepatic markers,**
  - **psychosocial and behavioural measures,**
  - **pulmonary function,**
  - **total mortality,**
  - **ovulatory function,**
  - **and muscle strength,**
  - **…**
- Can they walk further?
- Can they travel?
- Can they play with their children?
- Are they less breathless?
- Are they sleeping better?
- Are they eating comfortably?
- Are they socially engaged?
- Are they working?
- Do they feel more confident/ empowered?
- Are they less preoccupied with food/ desite to eat,…?
- **Calm, Capability, Comfort**

These are health gains worth protecting even when the trajectory of weight is imperfect.

Impact of low-level weight loss on health categories within the 70 studies

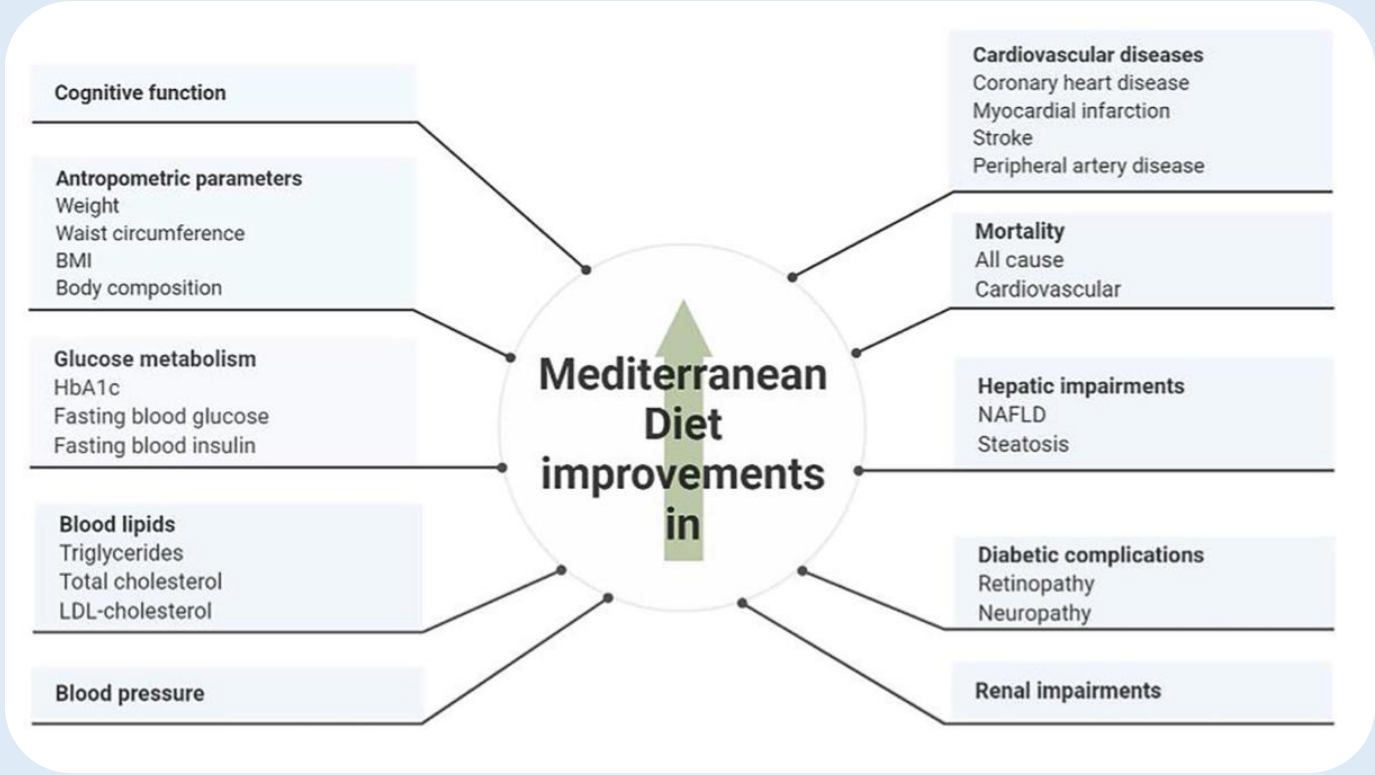
Health category	Improvement (%)	Worsening (%)	Mixed results (%)	No change (%)	Total health categories across included studies ($n = 137$)	Number of participants (loss < 5% body weight)
Metabolic	22 (52%)	3 (7%)	13 (31%)	4 (10%)	42	9389*
Cardiovascular	18 (56%)	1 (3%)	8 (25%)	5 (16%)	32	13,139*
Anthropometric	17 (89%)	–	–	2 (11%)	19	5004
Quality of life	6 (60%)	2 (20%)	2 (20%)	–	10	1222
Inflammatory biomarkers	6 (60%)	–	3 (30%)	1 (10%)	10	795*
Renal and hepatic	9 (100%)	–	–	–	9	1783*
Psychosocial and behavioural	4 (50%)	–	1 (12%)	3 (38%)	8	702
Pulmonary function	1 (33%)	1 (33%)	–	1 (33%)	3	774
Total mortality	–	1 (50%)	–	1 (50%)	2	642
Ovulatory function	1 (100%)	–	–	–	1	11
Muscle strength	–	–	–	1 (100%)	1	23

*Not all included studies provided a sample size for the <5% body weight loss category. Thus, the number may be underrepresented.

Intervention types that led to a change in health outcomes

Studies by intervention type	Improvement (%)	Worsening (%)	Mixed results (%)	No change (%)
Lifestyle ($n = 47$)	29 (62%)	2 (4%)	15 (32%)	1 (2%)
Pharmacological ($n = 2$)	2 (100%)	–	–	–
Both lifestyle and pharmacological* ($n = 21$)	11 (52%)	–	9 (43%)	1 (5%)
All studies / intervention types ($n = 70$)	42 (60%)	2 (3%)	24 (34%)	2 (3%)

D. Dhar et al. International Journal of Obesity (2025)



Muscogiuri G. Current Obesity Reports (2022)

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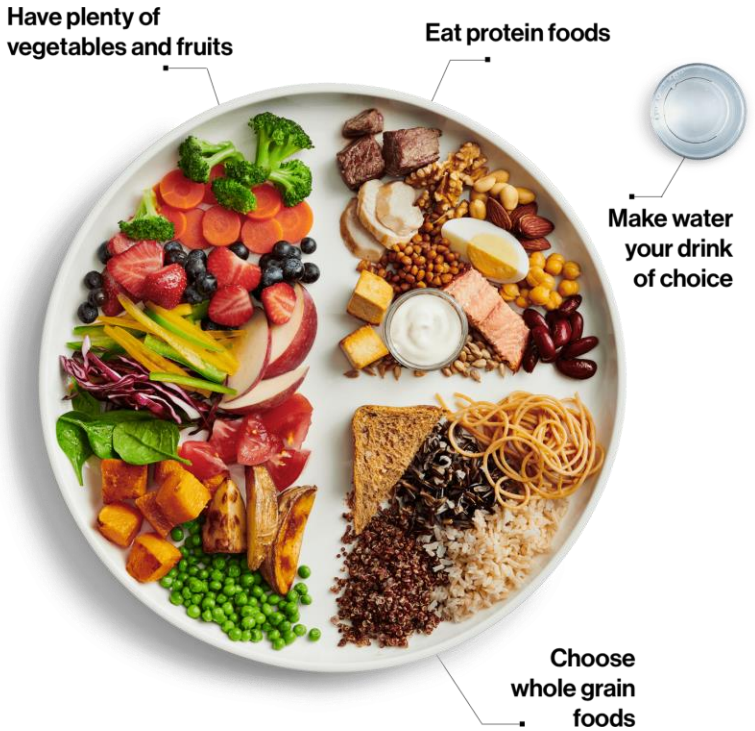
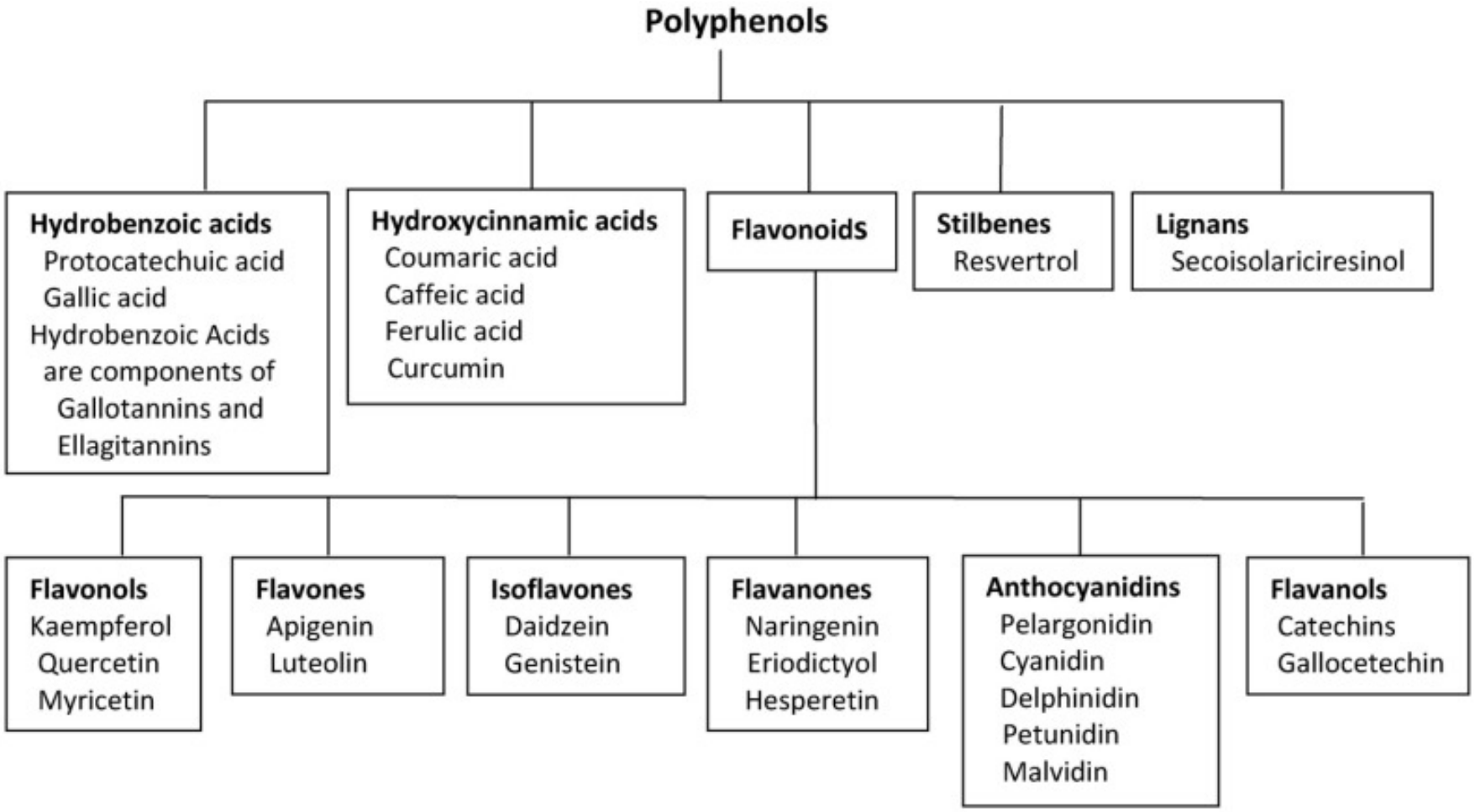
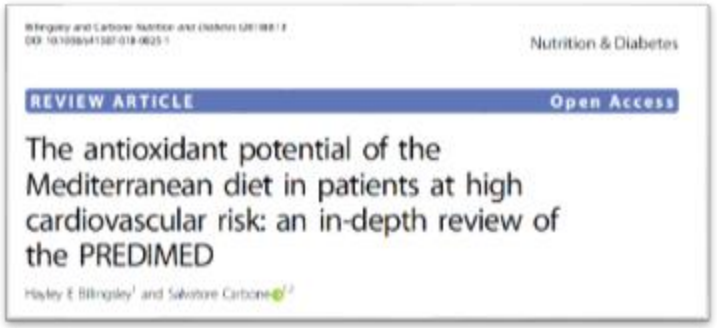


Polyphenols of the Mediterranean Diet





N= 7447 participants free of CVD at baseline, but at a high risk for CVD, who were randomized 1:1:1 to three groups

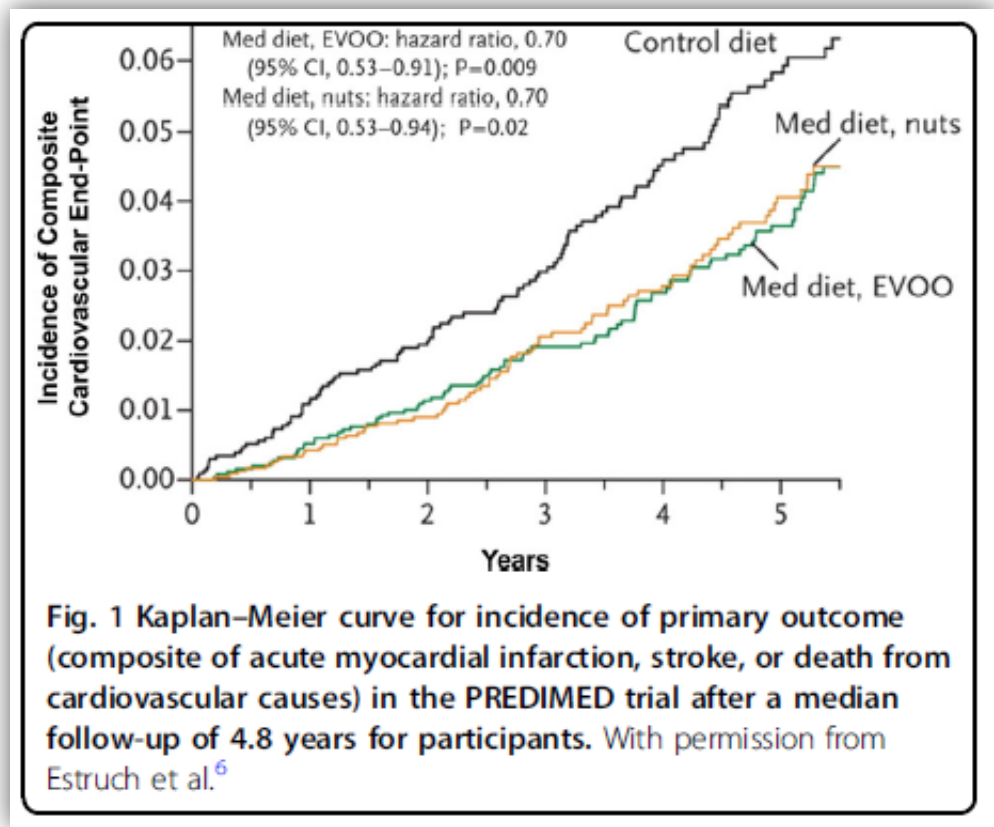
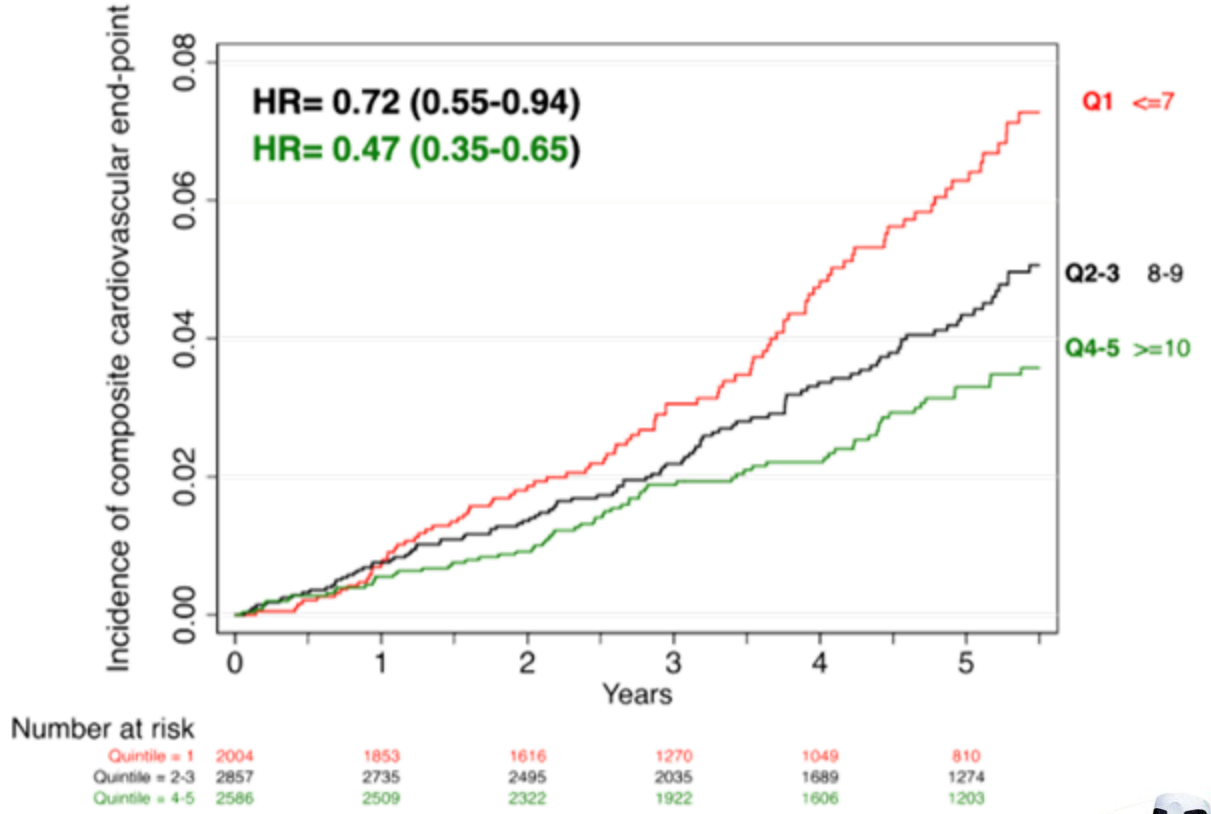


Fig. 1 Kaplan–Meier curve for incidence of primary outcome (composite of acute myocardial infarction, stroke, or death from cardiovascular causes) in the PREDIMED trial after a median follow-up of 4.8 years for participants. With permission from Estruch et al.[6]

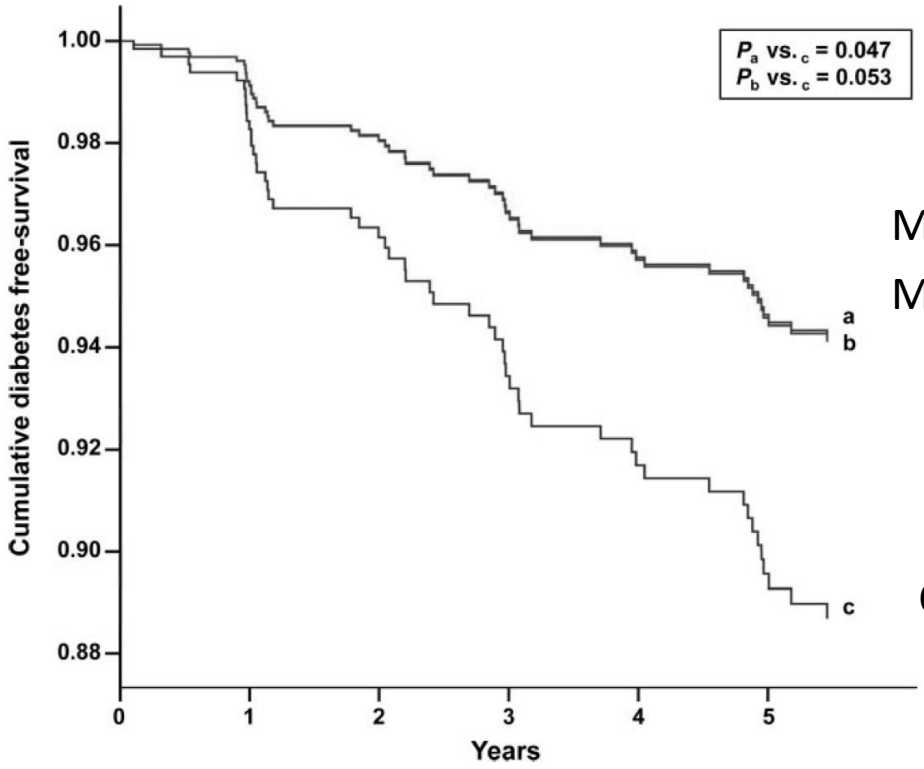


Baseline adherence to the MD (14-point MEDAS) and incidence of the primary end-point in the PREDIMED trial

Billingsley and Carbone Nutrition and Diabetes (2018) 8:13.

The Incidence of Type 2 Diabetes With the Mediterranean Diet Results of the PREDIMED-Reus nutrition intervention randomized trial

Cumulative diabetes free-survival by group of intervention.



MD VOO n=139

MD Nuts n=145

Control group n=134

Salas-Salvadó J et al. Diabetes Care 2011

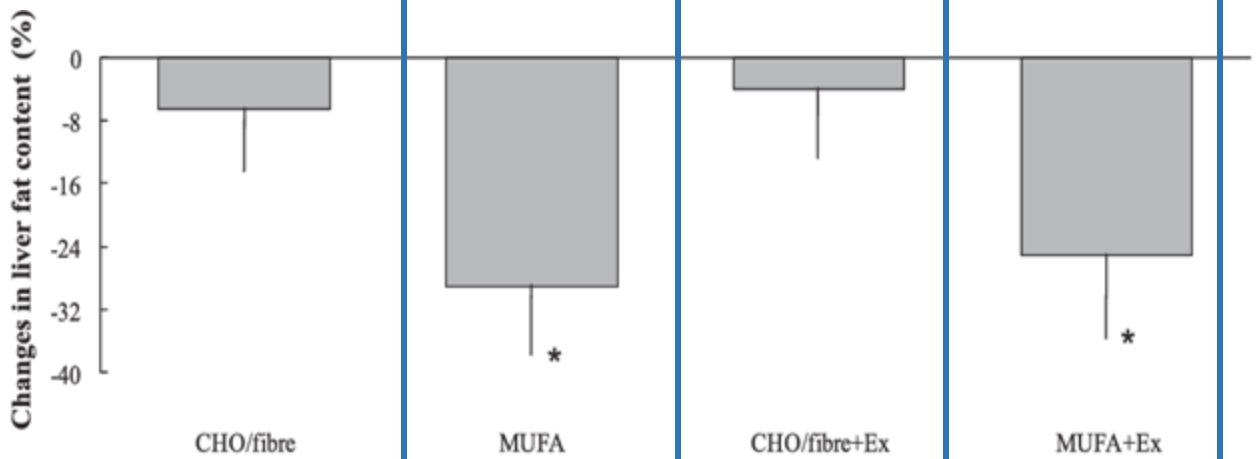
Liver Fat Is Reduced by an Isoenergetic MUFA Diet in a RCT (8w intervention) in patients with Type 2 Diabetes

@37 ♂ and 8 ♀
Aged 35 –70 years

The benefits of MD are independent of WL.

	CHO/fiber		MUFA		CHO/fiber+Ex		MUFA+Ex	
	Baseline	End	Baseline	End	Baseline	End	Baseline	End
Body weight (kg)	85 ± 13	85 ± 13	79 ± 13	79 ± 13	83 ± 13	83 ± 13	87 ± 13	87 ± 13
Waist circumference (cm)	103 ± 6	104 ± 6	100 ± 8	99 ± 8	101 ± 8	101 ± 8	104 ± 11	103 ± 10
Plasma total cholesterol (mg/dL)	157 ± 38	164 ± 46	167 ± 25	166 ± 23	175 ± 39	176 ± 36	171 ± 37	168 ± 39
HDL cholesterol (mg/dL)	37 ± 8	37 ± 7	35 ± 6	36 ± 4	44 ± 11	49 ± 21	40 ± 7	39 ± 6
LDL cholesterol (mg/dL)	98 ± 29	107 ± 40	110 ± 20	109 ± 21	116 ± 36	121 ± 35	110 ± 29	111 ± 30
Plasma triglycerides (mg/dL)	110 ± 68	131 ± 106	122 ± 37	114 ± 33	90 ± 26	100 ± 30	126 ± 104	102 ± 70
Plasma glucose (mg/dL)	137 ± 15	138 ± 25	145 ± 37	141 ± 21	133 ± 27	142 ± 32	136 ± 15	143 ± 31
Plasma AST (UI)	18 ± 5	20 ± 5	21 ± 13	21 ± 8	20 ± 11	18 ± 5	19 ± 3	17 ± 3*
Plasma ALT (UI)	22 ± 8	23 ± 6	34 ± 34	30 ± 17	26 ± 22	24 ± 13	28 ± 8	25 ± 6
HbA_{1c} (%)†	6.3 ± 0.3	6.3 ± 0.4	6.6 ± 0.8	6.2 ± 0.7*	6.5 ± 0.7	6.5 ± 0.8	6.9 ± 0.6	6.8 ± 0.5
Plasma insulin (μU/mL)	17 ± 8	16 ± 5	11 ± 6	11 ± 5	16 ± 6	16 ± 8	12 ± 3	11 ± 3
HOMA-IR	4.8 ± 1.8	5.2 ± 1.2	3.6 ± 1.5	3.9 ± 2.0	5.1 ± 1.6	5.4 ± 2.9	4.2 ± 1.2	4.0 ± 1.6
Peak VO_2 (mL/kg/min)	16 ± 4	16 ± 4	15 ± 3	15 ± 4	14 ± 4	14 ± 4	17 ± 2	18 ± 2*
Liver fat (%)†	17.7 ± 9.7‡	16.1 ± 6.8	7.4 ± 2.8	5.2 ± 2.7*	8.8 ± 4.9	8.9 ± 5.7	11.6 ± 8.0	9.1 ± 7.4*

Data are means ± SD. †$P < 0.05$ for diet × time effect by repeated-measures ANOVA; *$P < 0.05$ vs. baseline; ‡$P < 0.05$ vs. MUFA baseline values.



Plausible molecular determinants of the beneficial effect of the Mediterranean diet on NAFLD

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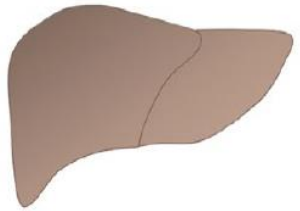
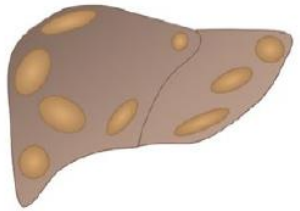
HEALTHY LIVER



WESTERN DIET

MEDITERRANEAN DIET

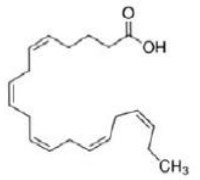
FATTY LIVER



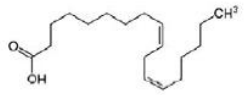
- ↓ de *novo* lipogénesis
- ↑ fatty acids β-oxidation
- ↓ Insulin resistance
- ↓ Oxidative stress
- ↓ Inflamation
- ↓ fibrogenesis

Oleic acid

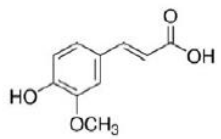
Docosahexaenoic acid



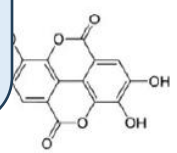
Eicosapentaenoic acid



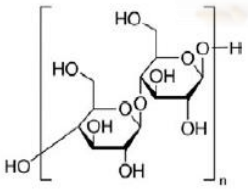
Linoleic acid



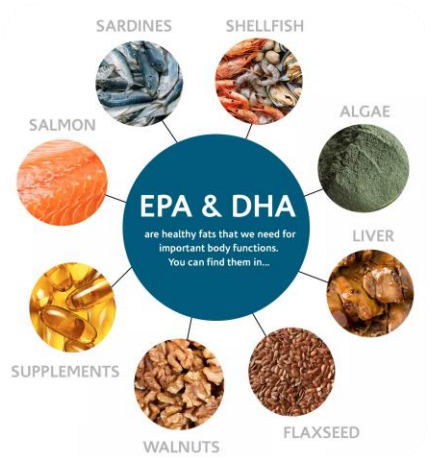
Ferulic acid

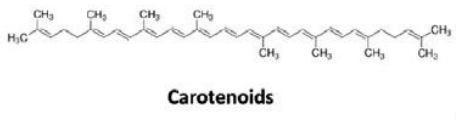


Flavonoids



Fibers



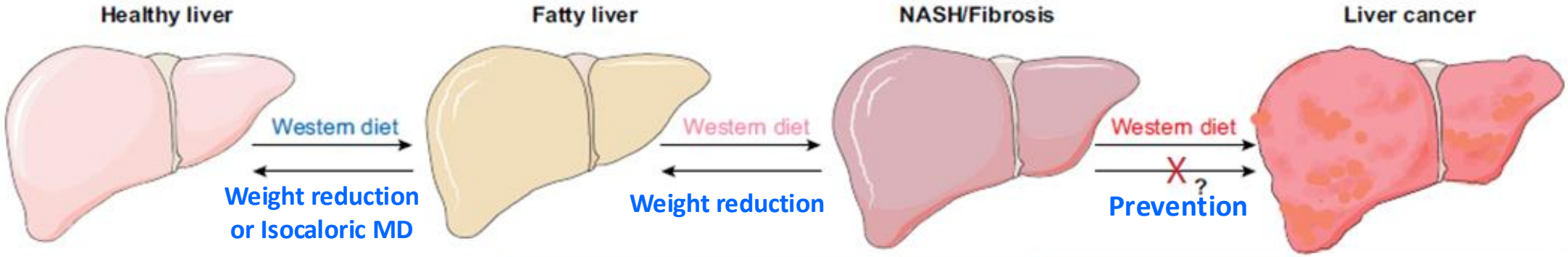


Carotenoides

Cafein

Polifenoles

A summary of the nutritional treatment options through the course of MAFLD



Hypocaloric or isocaloric - Mediterranean diet

Aerobic or resistance excercise
(Clinical trials)

≥7-10% Weight reduction
by energy deficit of 500-750 kcal/day through either diet:
- low fat
- low carb
- Mediterranean

(Clinical trials)

Dietary composition modification
Reduced fructose
Mediterranean diet
(Observational studies)

Mediterranean diet
- High fibres
- High fish
- High vegetables
- Low cholesterol
- Low sugar

Drinks
- Coffee ≥2-3 cups/day
- No alcohol in cirrhotics

(Observational studies)

Nutritional Intervention + moderate physical exercise

→ offered to patients with obesity and NASH cirrhosis managed **on the liver transplant waiting list** to support weight loss and improve muscle mass*.

*Grade B - strong consensus 100% agreement

Impact of lifestyle on blood pressure levels and the risk of hypertension.

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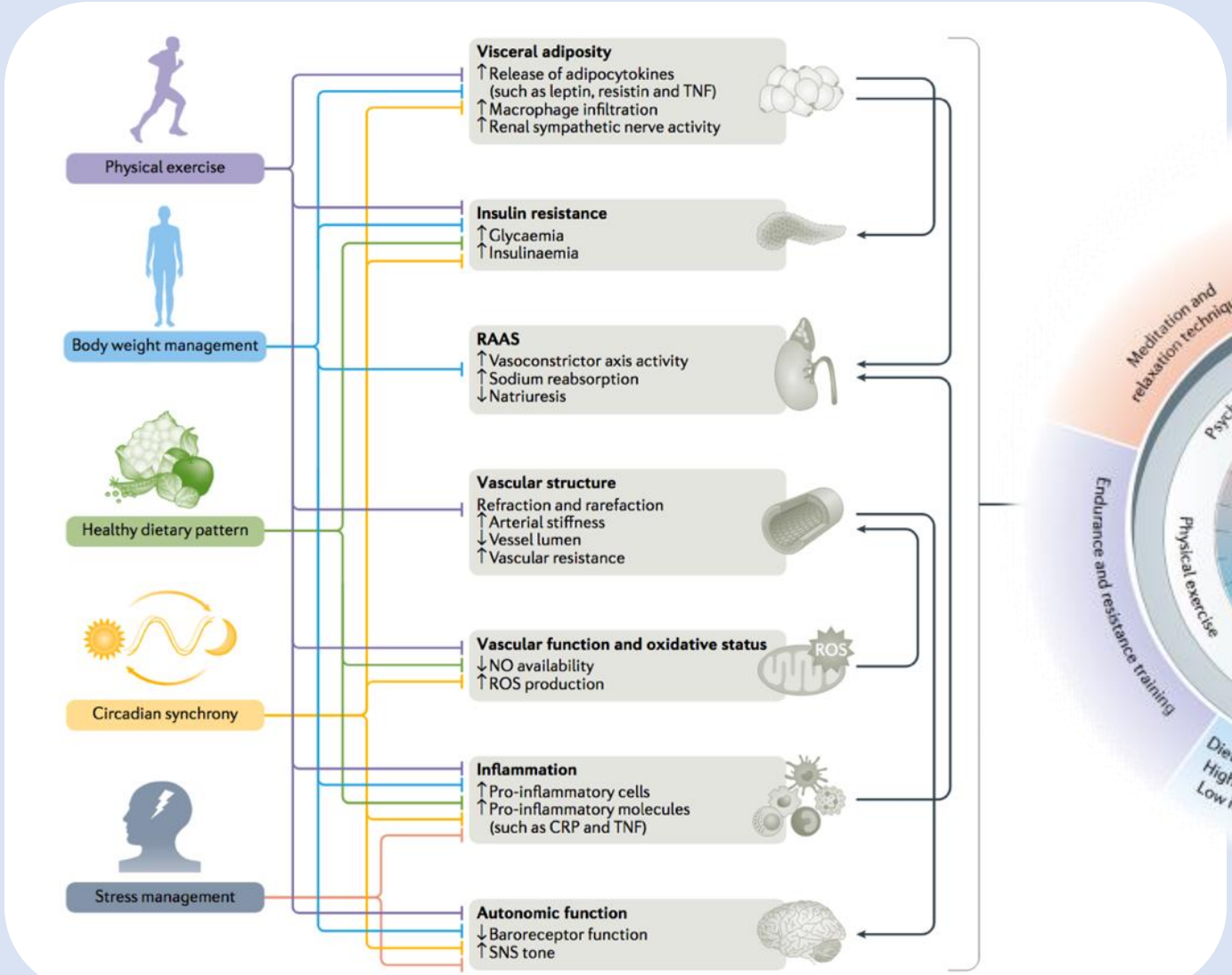
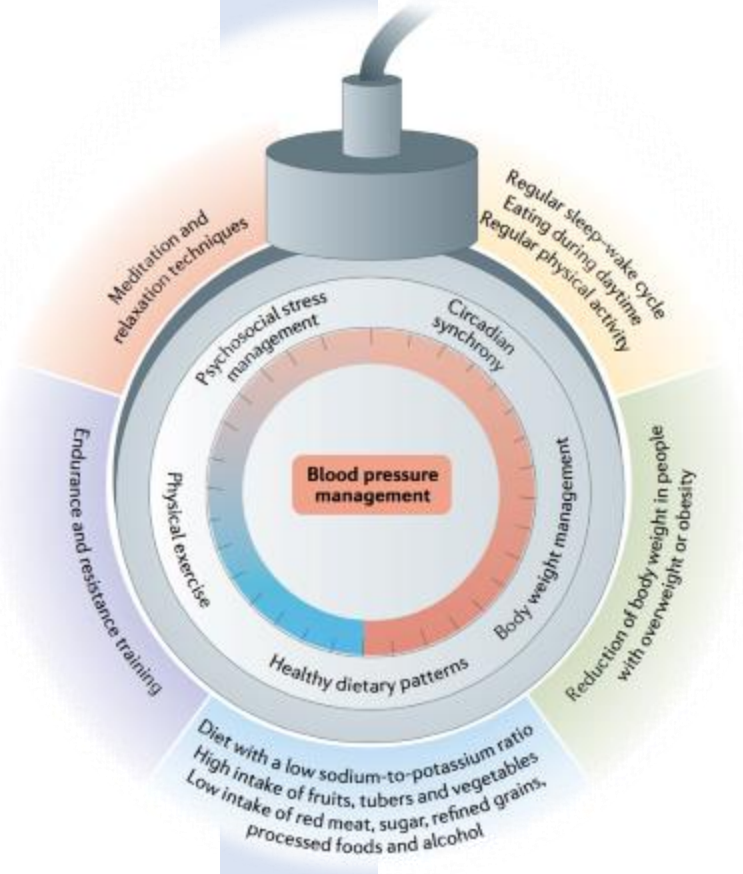
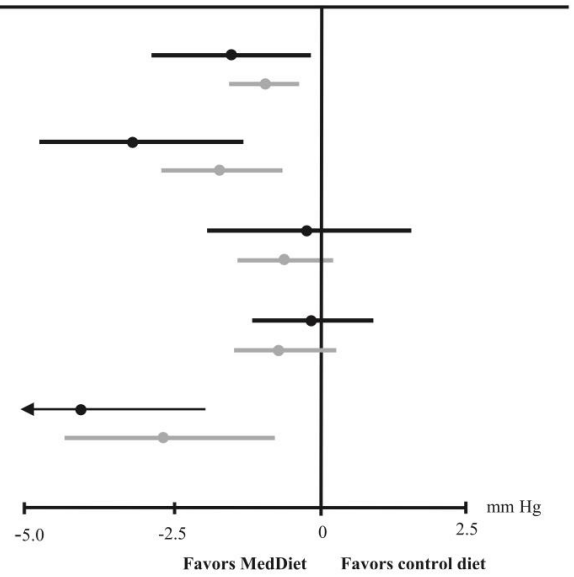




Valenzuela PL et al. Nature Reviews Cardiology (2021)

BP-lowering effect of the MedDiet in adults with and without hypertension: SR and MA of RCT

Outcome	RCTs, N	Subjects, N		SBP		DBP		Difference in means (95% CI), mm Hg	
		MedDiet	Control diet	*I*-squared	P	*I*-squared	P	SBP	DBP
All trials	35	8,250	5,806	56%	<0.001	12%	0.270	-1.5 (-2.8, -0.1)	-0.9 (-1.5, -0.3)
MedDiet versus usual diet	15	1,908	1,871	33%	0.110	10%	0.340	-3.1 (-4.8, -1.3)	-1.6 (-2.6, -0.6)
MedDiet versus other active diets	20	6,342	3,935	52%	0.003	8%	0.360	-0.2 (-1.9, 1.5)	-0.6 (-1.3, 0.1)
Sensitivity MedDiet versus low-fat diet	12	5,449	3,083	0%	0.636	0%	0.990	-0.1 (-1.1, 0.9)	-0.7 (-1.5, 0.1)
Sensitivity MedDiet versus usual diet with equal lifestyle changes	7	1,333	1,299	24%	0.245	28%	0.211	-4.1 (-6.3, -1.9)	-2.6 (-4.4, -0.7)



None of the selective effect modi ers (baseline SBP and DBP levels, BMI, male sex, duration of the follow-up period) was neither a positive nor a negative determinant of SBP or DBP reduction

Christina D. Filippou et al. Clin Nutr 2021

Patient-reported outcomes should be part of follow-up

PROMs/PREMs alongside clinical outcomes.

Patient-reported outcomes measures [PROMs]

What the patient tells us about their health:

- Quality of life
- Physical functioning
- Eating-related quality of life
- Body image
- Psychological wellbeing
- Symptoms
- Treatment burden

Patient-reported experience measures [PREMs]

What the patient tells us about the care:

- Did I feel heard?
- Was my experience respected?
- Did clinicians involve me in decisions?
- Was information understandable?
- Did I feel judged or stigmatized?
- Was care coordinated?
- Could I access help when I needed it?

Quality of life should be an outcome, not an afterthought

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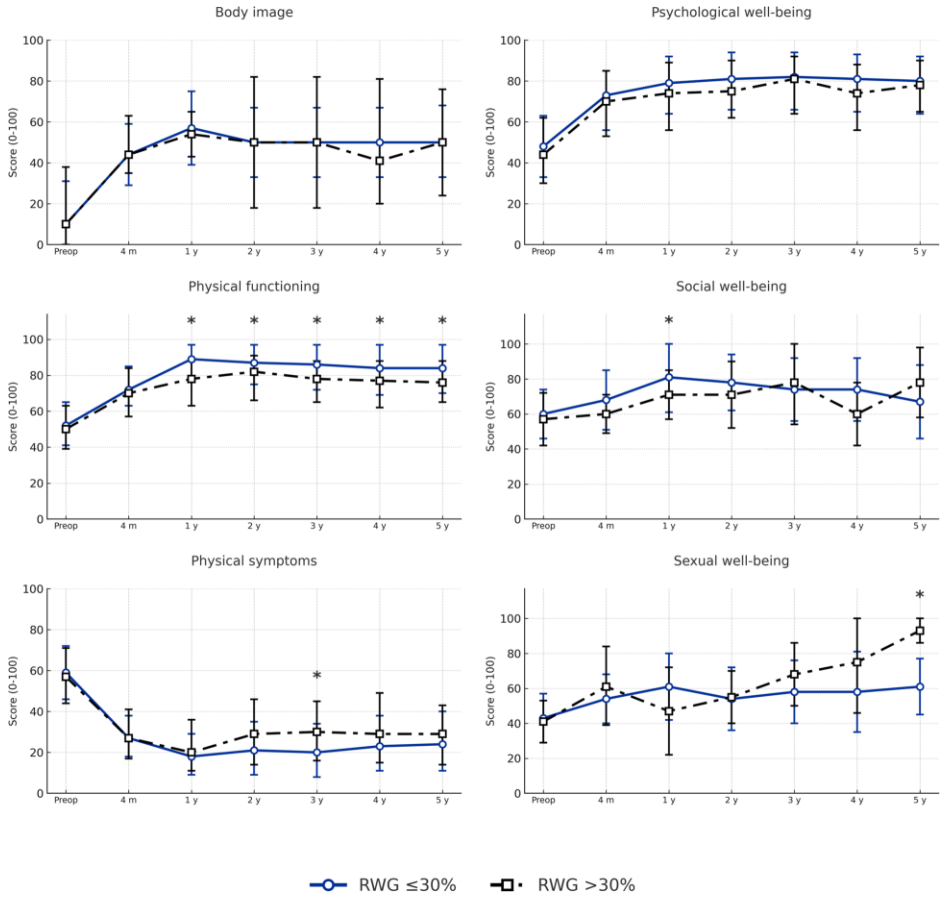
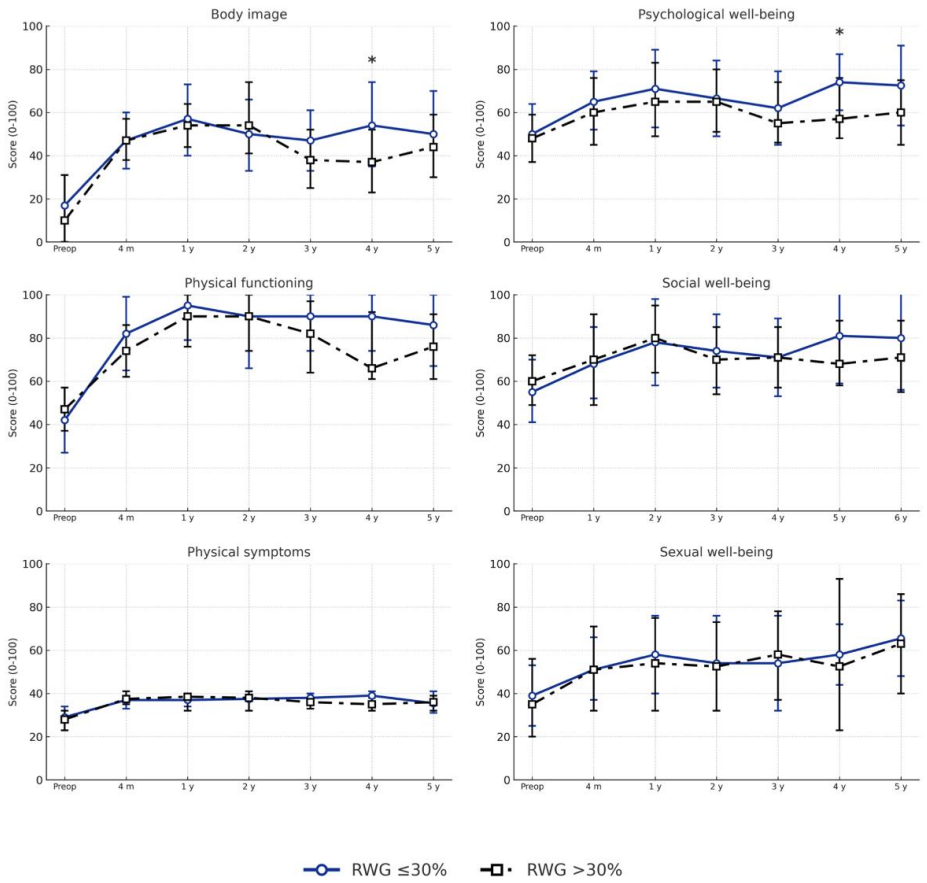
Sustained Quality of Life:





n=337

LRYGB: 206 < 30% vs 19 ≥ 30%

LSG: 81 < 30% vs 31 ≥ 30%.

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Stans B van Gelder et al. Obes Surg 2026.

Weight recurrence can change the patient experience

For many patients, seeing the number on the scale increase can trigger:

Fear → shame → self-blame → restrictive eating → loss of control → disengagement from care

This is where language matters enormously.

Instead of:

“You have regained 12 kg.”

Try:

“Your weight trajectory has changed. Let's understand what's happening and what we can do together to protect the health you've gained.”

Obesity Science & Practice

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Obesity Science and Practice

REVIEW OPEN ACCESS

Motivational Interviewing (MI) in Obesity Care: Cultivating Person-Centered and Supportive Clinical Conversations to Reduce Stigma: A Narrative Review

Violeta Moizé[1,2,3,4,5] | Yitka Graham[5,6,7,8] | Ximena Ramos Salas[9,10] | Mercè Balcells[4,11,12]

[1]Obesity Unit, Endocrinology and Nutrition Department, Hospital Clinic Barcelona, Barcelona, Spain | [2]Department of Medicine, University of Barcelona, Barcelona, Spain | [3]Translational Research in Diabetes, Lipids and Obesity, Consortium August Pi i Sunyer Biomedical Research Institute (IDIBAPS), Barcelona, Spain | [4]Grupo en Español de Trabajo de Entrevista Motivacional (GETEM), Barcelona, Spain | [5]Faculty of Health Sciences and Wellbeing, Helen McArdle Nursing and Care Research Institute, University of Sunderland, Sunderland, UK | [6]Bariatric Surgical Unit, Sunderland Royal Hospital, South Tyneside and Sunderland NHS Foundation Trust, Sunderland, UK | [7]Faculty of Psychology, University of Anahuac, Mexico City, Mexico | [8]Faculty of Biomedical Science, Austral University, Buenos Aires, Argentina | [9]Bias 180, Ontario, Canada | [10]Replica Communications, Kristianstad, Sweden | [11]Addictive Behavior Unit, Psychiatry and Psychology Service, Clinical Institute of Neurosciences (ICN), Hospital Clinic Barcelona, Barcelona, Spain | [12]Addiction Research Group, Consortium August Pi i Sunyer Biomedical Research Institut (IDIBAPS), Barcelona, Spain

Correspondence: Violeta Moizé (vmoize@clinic.cat)

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ABSTRACT

Background: Patients perceive high levels of weight prejudice, stigma, and discrimination within health systems, affecting their ability to manage their obesity and related chronic conditions. Scientific and patient obesity associations worldwide have prioritized the reduction of weight stigma to improve patient experiences in health systems and overall health outcomes. Since a significant proportion of the population is now living with multiple chronic diseases related to obesity, healthcare systems must shift toward multi-disease management frameworks incorporating person-centered and non-stigmatizing clinical conversations. Motivational Interviewing (MI) has the potential to transform clinical interactions by using non-stigmatizing language, communication, and practices. Studies using MI in obesity management have solely focused on weight loss outcomes, while other patient experience related outcomes would also be relevant to evaluate.

Methods: A narrative review was undertaken to critically analyze the potential impact of MI on obesity and chronic disease management practices and experiences.

Findings: An analysis and contextualization of the MI theoretical framework for obesity management, based on the philosophy of motivational spirit, was reviewed, assessing micro skills or strategies.

Conclusion: MI may assist healthcare professionals conduct non-stigmatizing clinical conversations in accordance with basic principles of collaborative therapeutic alliances. A proposal for research considerations that can help illuminate the potential for of MI in obesity management is also outlined.

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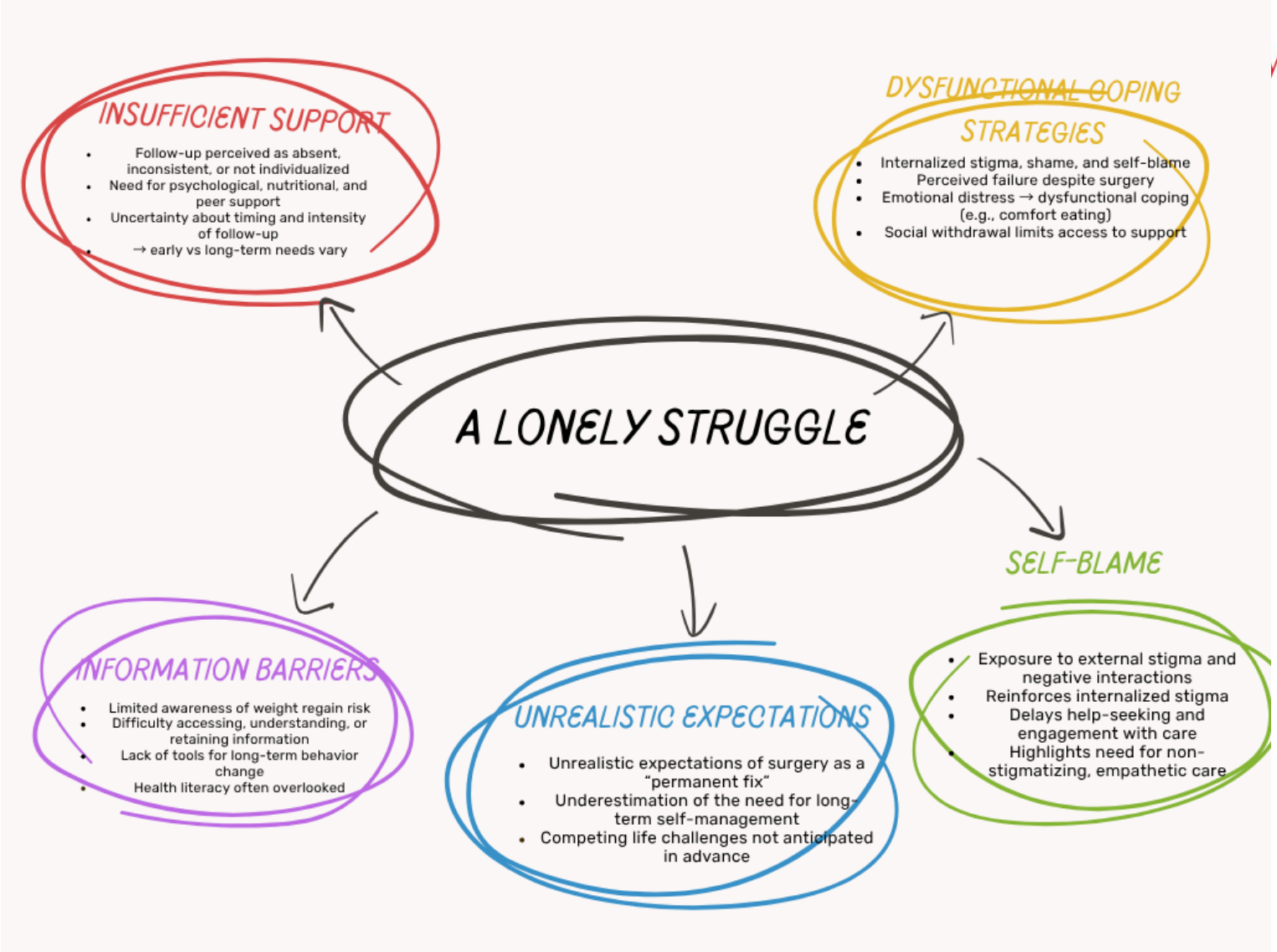
Perceived and Preferred Social Support in Patients Experiencing Weight Regain After Bariatric Surgery—a Qualitative Study



Tolvanen L et al. Obes Surg 2021

Expressing emotions and needs through drawing

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People lived Experience after metabòlic and bariatric surgery

1

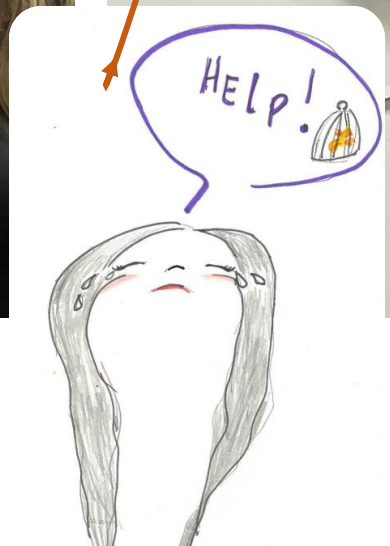
"How do you think the people around you see you?"

2

"How do you feel when you didn't reach therapeutic goals in relation to physical activity, healthy diet, or activities of daily living?"

Clínic Barcelona


BARCELONA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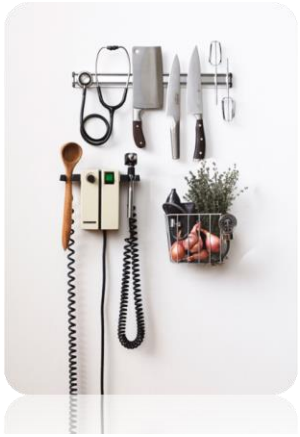

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https://diabetesalacarta.org/recetas/hamburguesa-de-sardina/

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Thank you for your atention!

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vmoize@clinic.cat
@violetaMoize