IFSO

XXIX IFSO World Congress

1-4 September 2026 | Toronto, Canada

PHARMACOTHERAPY FOR OBESITY: HOW, WHEN, AND WHO TO TREAT... AND WHEN TO COMBINE MEDICATIONS TO IMPROVE CLINICAL OUTCOMES

Dra Tarissa Beatrice Zanata Petry

Endocrinologista - Centro Especializado em Obesidade e Diabetes do Hospital Alemão Oswaldo Cruz

TORONTO 2026

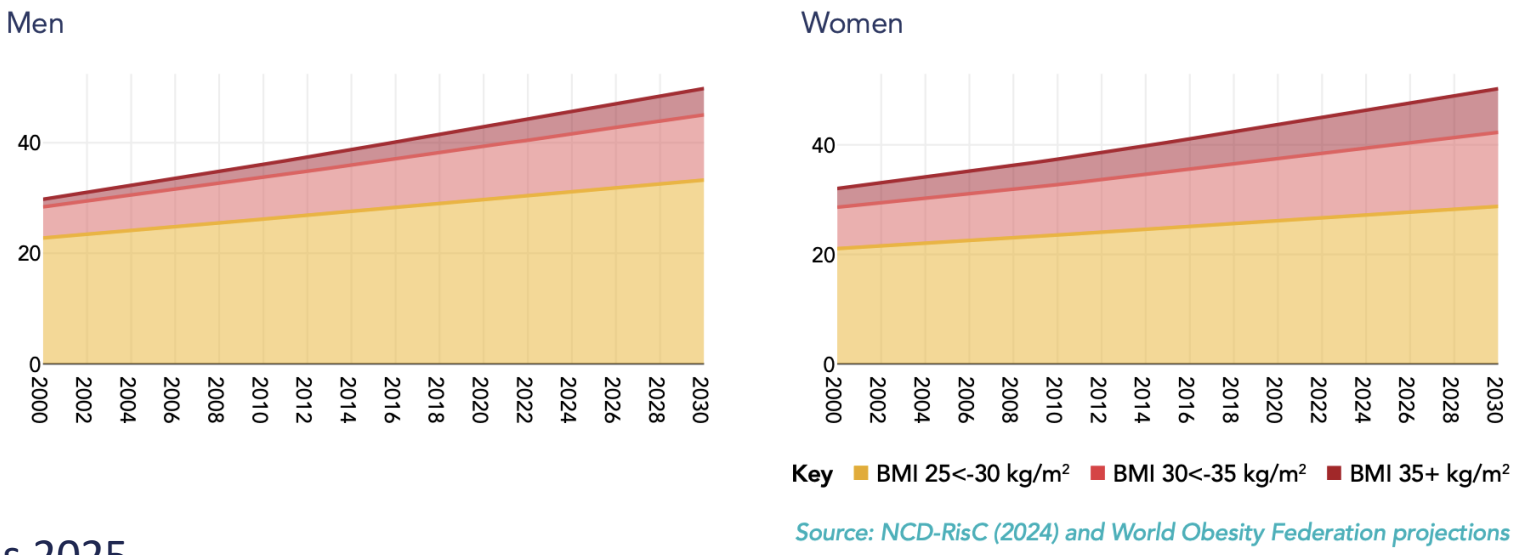
The Future of Obesity Management:
From Weight Loss to Health Gain

ifso2026.org

Global trends of high BMI in adults: *A Global Health Priority*

By 2030, over 2.9 billion adults are likely to be living with high BMI

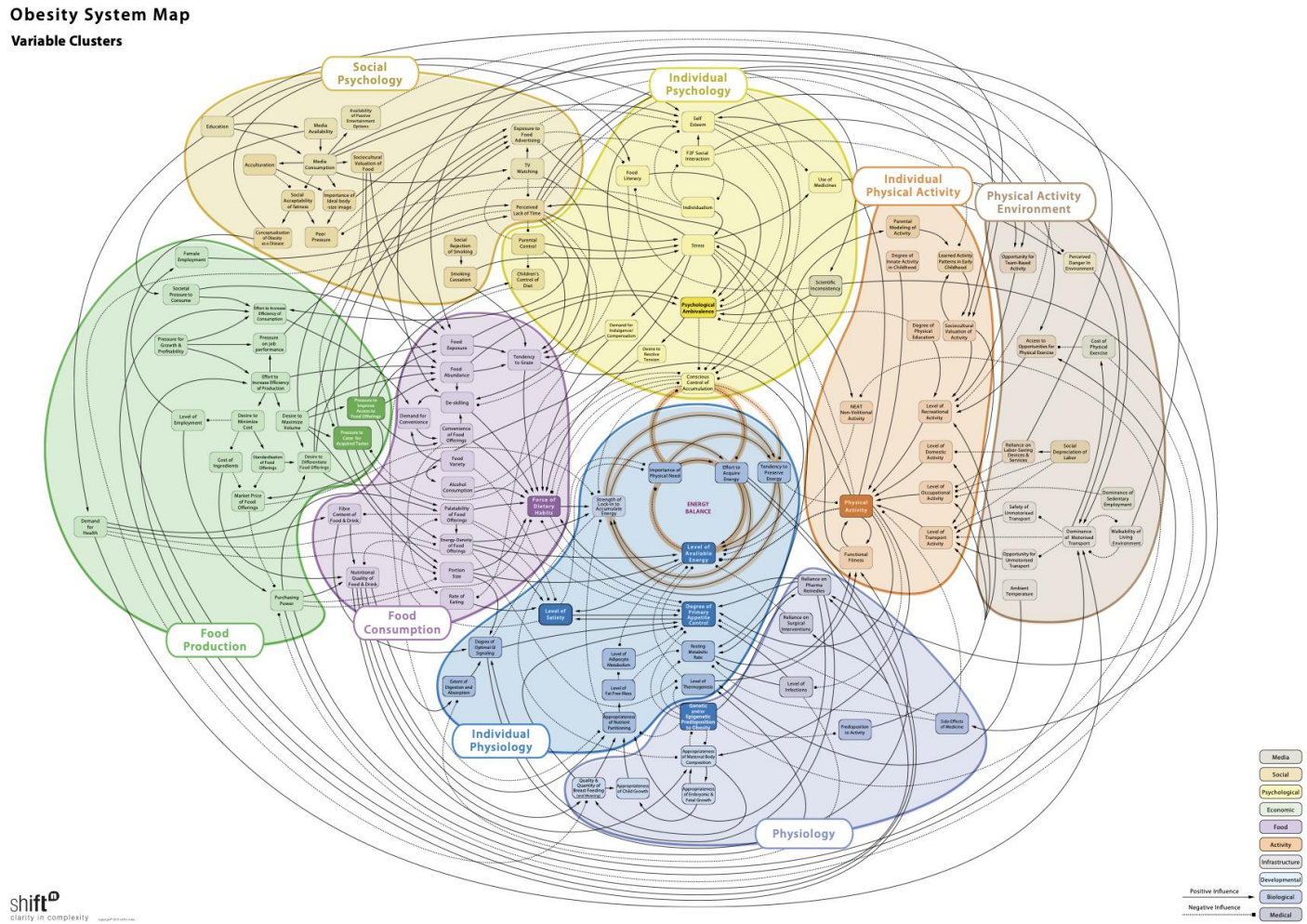
Figures 1.1 and 1.2: Percentages of men and women (aged 20+) living with high BMI, 2000-2030



Source: NCD-RisC (2024) and World Obesity Federation projections

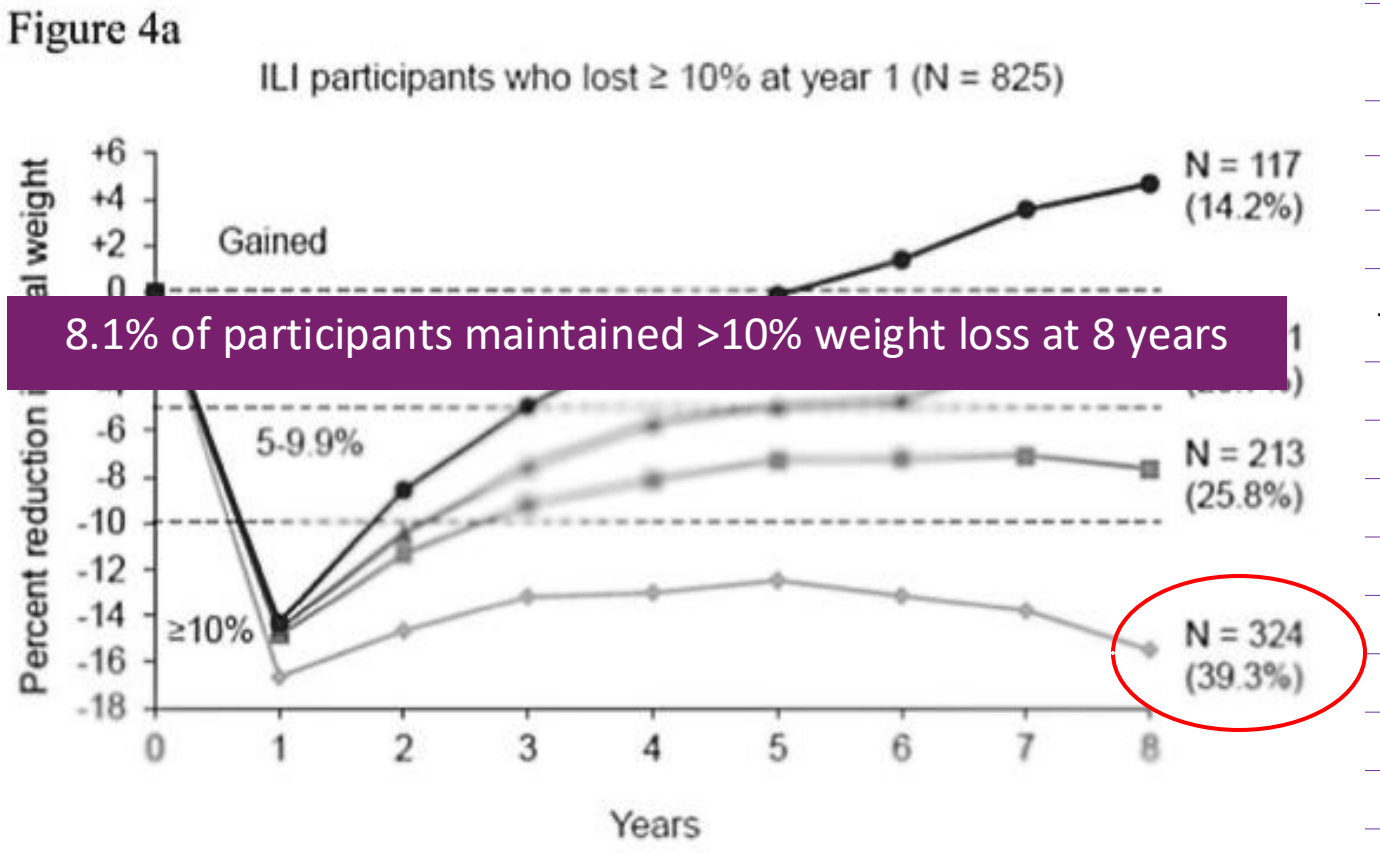
World Obesity Atlas 2025

Obesity is caused by a complex interplay of several factors



Magnitude of Weight Loss vs CV outcomes
Look AHEAD Study

		P Value
N (%)		
BMI (mean kg/m^2)		0.34
1-y Change in weight (mean %)		NA
Primary Outcome		**Test for Trend**
Events / person years		
Crude rate/100 person years		
Unadjusted HR (95% C.I.)		0.21
Adjusted HR ‡ (95% C.I.)		0.17
Secondary Outcome		
Events / person years		
Crude rate/100 person years		
Unadjusted HR (95% C.I.)		0.04
Adjusted HR ‡ (95% C.I.)		0.006



8.1% of participants maintained >10% weight loss at 8 years

Primary outcome: composite of death from cardiovascular causes, non-fatal AMI, non-fatal stroke, or admission to hospital for angina.
Secondary outcome: primary + CABG, carotid endarterectomy, PCI, hospitalisation for CHF, PVD, or total mortality.
‡Adjusted for sex, age, baseline weight, fitness, history of CVD, insulin use, diabetes duration, smoking status, LDL, blood pressure
*P< 0.05

Gregg *Lancet Diab Endocrinol* 2016

BMI opens the door—but it does not define the disease

The clinical decision and the access decision are related—but they are not the same

CLINICAL DECISION

Who needs treatment?

- Excess adiposity and its distribution
- Medical, functional or psychological impairment
- Current complications and future risk
- Individual therapeutic goals

ACCESS DECISION

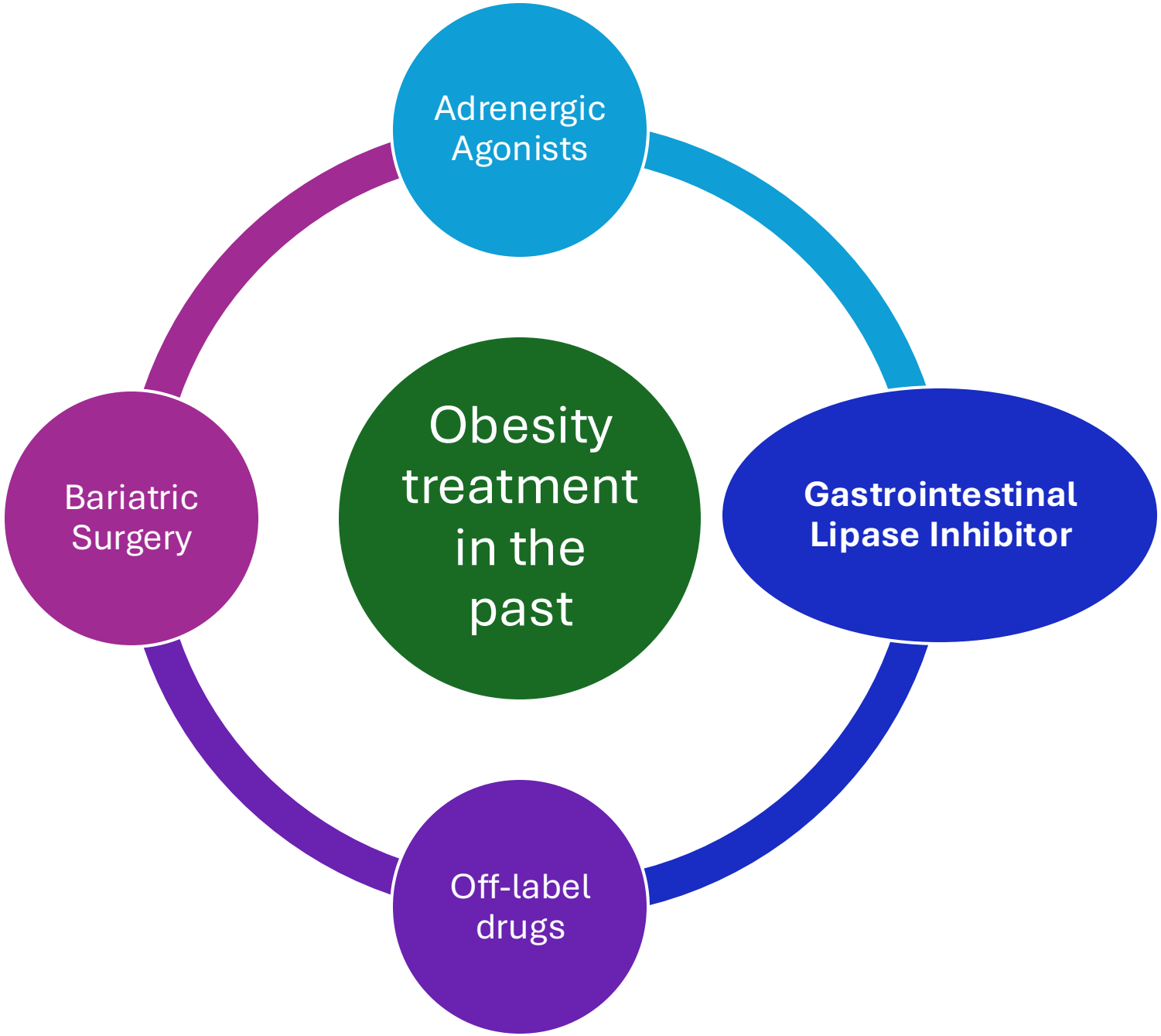
Who gains access?

- Regulatory indication
- Payer eligibility criteria
- Frequently BMI ≥30 kg/m²
- Or BMI ≥27 kg/m² with a weight-related complication

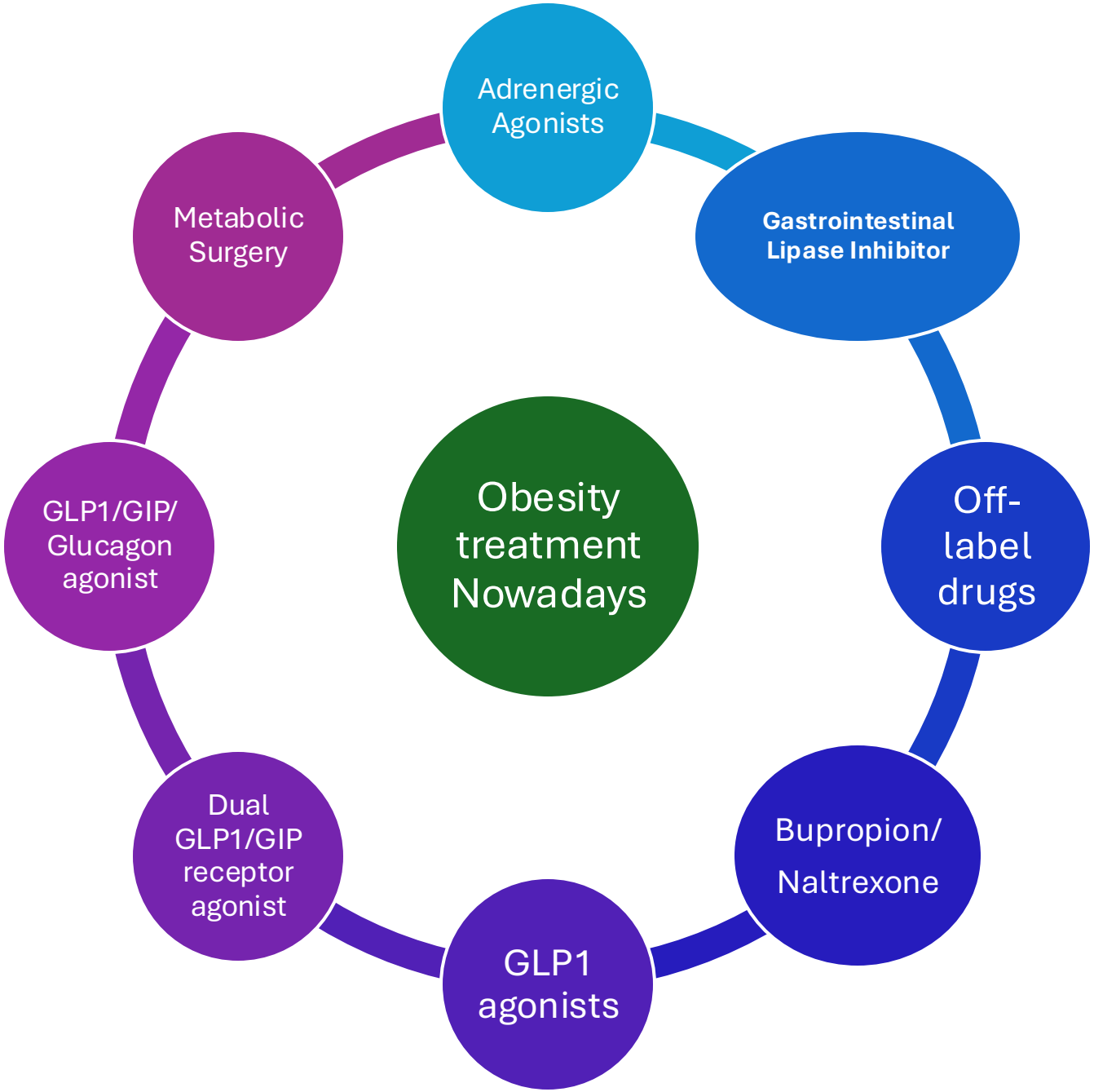
Measure BMI • Confirm adiposity • Stage health impact • Treat to target

Rubino et al., Lancet Diabetes Endocrinol 2025 | Busetto et al., Nat Med 2024 | ADA Obesity Standards 2026

In the past...


Adrenergic Agonists
Gastrointestinal Lipase Inhibitor
Off-label drugs
Bariatric Surgery
Obesity treatment in the past

The more,
the better.



Next-generation incretins lead in weight-loss efficacy

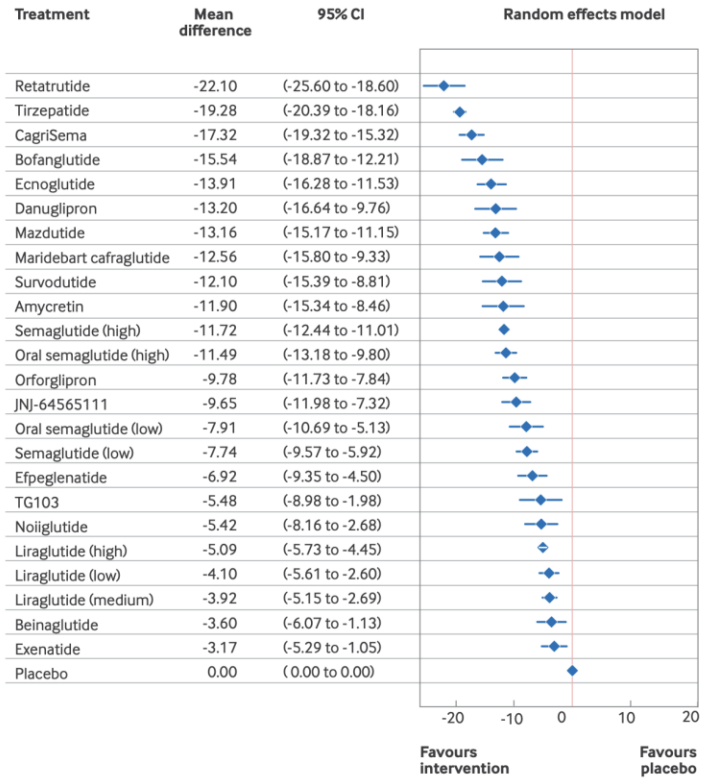
Network meta-analysis of adults with overweight or obesity without diabetes

STUDY AT A GLANCE

58
randomized trials

24,214
participants

Adults without diabetes
Minimum treatment duration: 12 weeks



Forest plot of network effect sizes between glucagon- like peptide 1 receptor agonists and placebo for body weight. Dose categories are labeled as low, medium, or high based on the approved or guideline-recommended dosing ranges. Data are mean difference (%) with 95% confidence interval (CI)

Efficacy differs meaningfully across agents—but rankings are not a substitute for head-to-head evidence

Indirect comparisons; several confidence intervals overlapped. Tolerability and regulatory availability must also guide treatment selection.

Chen D, et al. BMJ Med. 2026;5:e003026. doi:10.1136/bmjmed-2026-003026

But, more than that...

LEADER

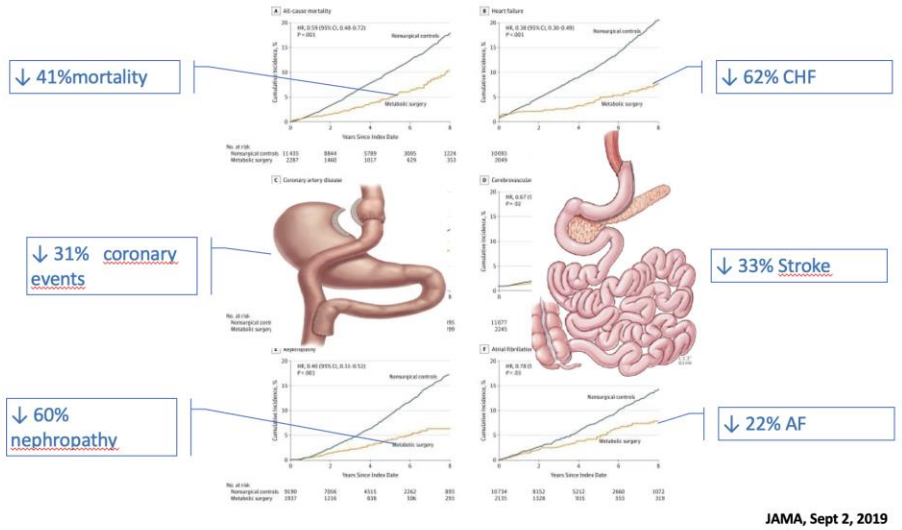
ORIGINAL ARTICLE

Oral Semaglutide and C
High-Risk Type 2 Diabe

Aut
Silv
Gro
Pub

ORIGINAL ARTICLE

Tirzepatide



JAMA, Sept 2, 2019

Ti
Ra
Sl

eline

March 2024 · Contemporary Clinical Trials 141(9):107516

DOI:10.1016/j.cct.2024.107516

OSWALDO CRUZ
HOSPITAL ALEMÃO

Incretinomiméticos

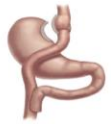
SUSTAIN-6: Results

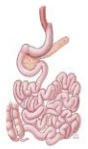
Bariatric–metabolic surgery versus lifestyle intervention plus best medical care in non-alcoholic steatohepatitis (BRAVES): a multicentre, open-label, randomised trial

Ornella Verrastro*, Simona Panunzi*, Lidia Castagneto-Gissey, Andrea De Gaetano, Erminia Lembo, Esmeralda Capristo, Caterina Guidone, Giulia Angelini, Francesca Pennestrì, Luca Sessa, Fabio Maria Vecchio, Laura Riccardi, Maria Assunta Zocco, Ivo Boskoski, James R Casella-Mariolo, Pierluigi Marini, Maurizio Pompili, Giovanni Casella, Enrico Fiori, Francesco Rubino, Stefan R Bornstein, Marco Raffaelli, Geltrude Mingrone

Lancet,2023

erved Ejection



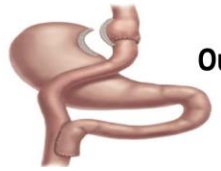


ORIGINAL RESEARCH

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

Carlos A. Schiavon, MD,[a,b] Alexandre B. Cavalcanti, MD,[c] Juliana D. Oliveira, CN,[a,b] Rachel H.V. Machado, CN,[a] Eliana V. Santucci, Ps,[a] Renato N. Santos, Srsx,[a] Julia S. Oliveira, Srsx,[a] Lucas P. Damiani, Srsx,[a] Débora Junqueira, MD,[c] Helio Halpern, MD,[c] Frederico de L.J. Monteiro, MD,[c] Patricia M. Noujaim, MD,[b] Ricardo V. Cohen, MD,[c] Marcio G. de Sousa, MD,[a] Luiz A. Bortolotto, MD,[c] Otavio Berwanger, MD,[a] Luciano F. Drager, MD[b,c]

JACC,2024



Outperforms the medical Tx

Gastric bypass *versus* best medical treatment for diabetic kidney disease: 5 years follow up of a single-centre open label randomised controlled trial

Ricardo V. Cohen,[a,*] Tiago Veiga Pereira,[b,c] Cristina Mamédio Aboud,[a] Tarissa Beatrice Zanatta Petry,[d] José Luis Lopes Correa,[e] Carlos Aurello Schiavon,[d] Carlos Eduardo Pompílio,[a] Fernando Nogueira Queiroz Pechy,[a] Ana Carolina Calmon da Costa Silva,[a] Lívia Porto Cunha da Silveira,[a] Pedro Paulo de Paris Caravatto,[a] Helio Halpern,[a] Frederico de Lima Jacy Monteiro,[a] Bruno da Costa Martins,[a] Rogerio Kuga,[a] Thais Mantovani Sarion Pelumbo,[a] Allon N. Friedman,[f] and Carel W. le Roux[f,g]

The Lancet Eclin , online Nov 11,2022

American Heart Association.

atients
d

, Seth
nD ,
PhD,
Study

EASO and ADA converge on a treat-to-health strategy

Different frameworks—one fundamental shift away from weight loss as the only endpoint

EASO 2026

Start with the health outcome

- Separate prevention from complication management
- Identify metabolic or mechanical consequences
- Match the medication to comparative RCT evidence for that endpoint
- Interpret rankings within—not across—outcome domains

ADA / OBESITY ASSOCIATION 2026

Build a person-centered treatment pathway

- Discuss pharmacotherapy as part of comprehensive care
- Select by goals, complications, efficacy, safety, preferences and access
- Treat obesity as a chronic disease
- Reassess and intensify when response is inadequate

Choose treatment for the outcome the patient needs—not for the BMI category alone

Ciudin et al., Nat Med 2026 | ADA Professional Practice Committee for Obesity, 2026

EASO 2026: treat the outcome—not just the weight

A living evidence map based on 62 randomized trials—not a universal drug ranking

NO COMPLICATION PRESENT

Prevent organ dysfunction

Primary endpoint
Total body weight loss

Strongest effects:
Tirzepatide, then semaglutide

METABOLIC ADIPOSITY

Reverse metabolic dysfunction

Select by dedicated evidence for:
T2D • prediabetes • CVD
HFpEF • MASLD/MASH

2026 liver update:
MASH—semaglutide & tirzepatide
Fibrosis—strongest for semaglutide

MECHANICAL ADIPOSITY

Reverse mechanical dysfunction

Select by dedicated evidence for:
Obstructive sleep apnea
Knee osteoarthritis

Outcome-specific evidence:
OSA—tirzepatide
Knee OA pain—semaglutide

The best drug for weight loss is not automatically the best-evidenced drug for every complication

EASO Algorithm 2.0: Ciudin et al., Nat Med 2026;32:1962–1966

ADA 2026: inadequate response should trigger intensification

Obesity pharmacotherapy is long-term treatment—and therapeutic inertia is not neutral

Not meeting intermediate goals by ~6 months?
Reassess effectiveness and avoid treatment inertia

1	2	3	4	5
START	**TITRATE**	**REASSESS**	**OPTIMIZE**	**INTENSIFY**
Begin low Select with the patient	Advance gradually Balance efficacy and tolerability	Monthly for the first 3 months Check goals and adverse effects	Use the maximum tolerated dose Maintain the lowest effective dose	Switch • add IBT combine • refer for MBS

At maximum tolerated dose: switch (C) • add intensive behavioral therapy (B) • combine medications (C) • refer for metabolic–bariatric surgery (A)

ADA Professional Practice Committee for Obesity. Diabetes Obes Cardiometab CARE 2026;1:5-36

What Happens When OMMs Are Stopped?

Trajectory of weight regain after cessation of GLP-1 receptor agonists: a systematic review and nonlinear meta-regression

Brajan Budini,[a,*,e] Steven Luo,[a,e] Martin Tam,[a] Isabel Stead,[a] Andrew Lee,[a] Angelica Akrami,[a] Antonio Vidal-Puig,[b,c,f] and Adrian Park[d,f]

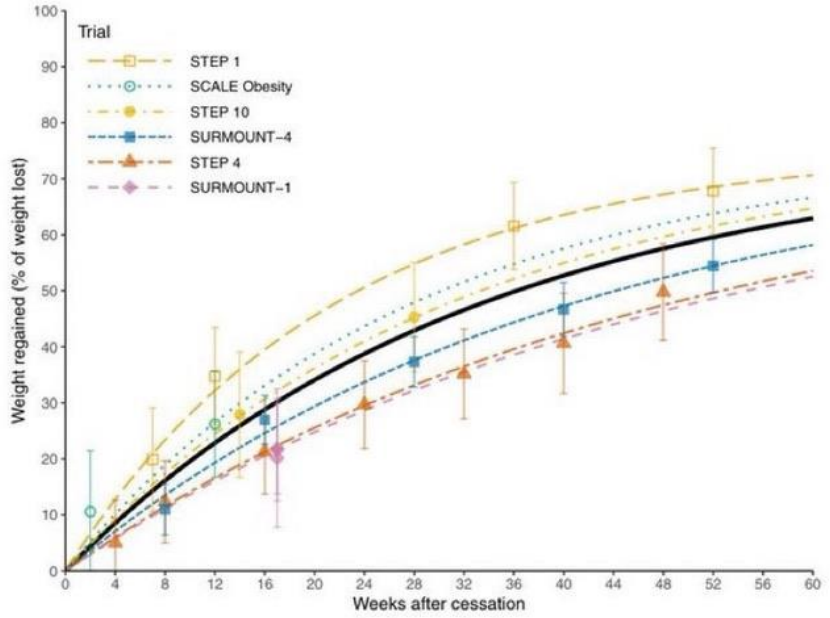
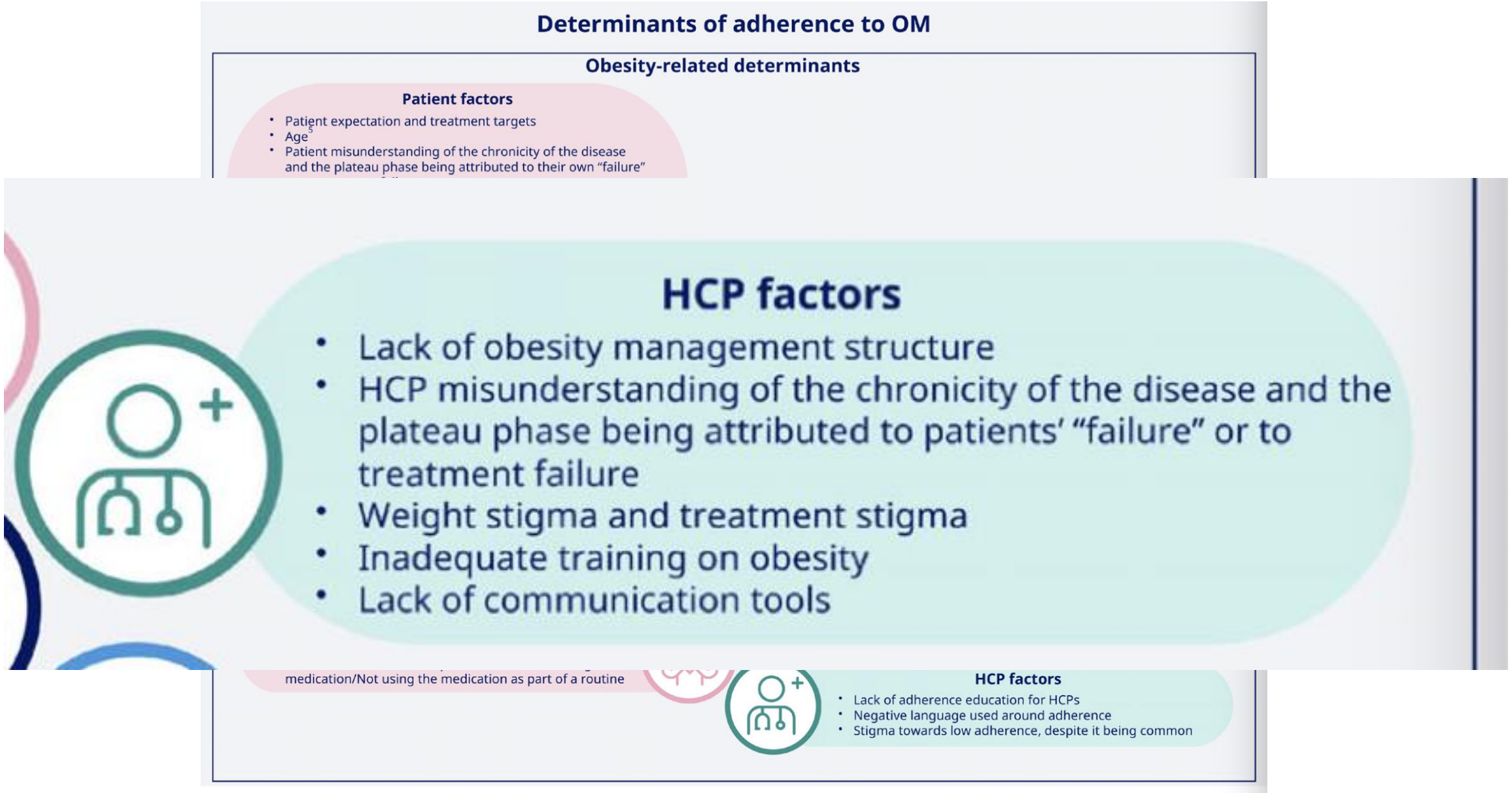


Fig. 2: Fitted trajectories of weight regain following cessation of glucagon-like peptide 1 receptor agonists (GLP-1RAs), based on clinical trial data. Regression was conducted with an exponential recovery function. Semaglutide was given in STEP 1,[9] STEP 4[10] and STEP 10[35]; tirzepatide was given in SURMOUNT-1[7] and SURMOUNT-4[11]; liraglutide was given in SCALE Obesity.[12] The black line indicates the pooled fitted trajectory.

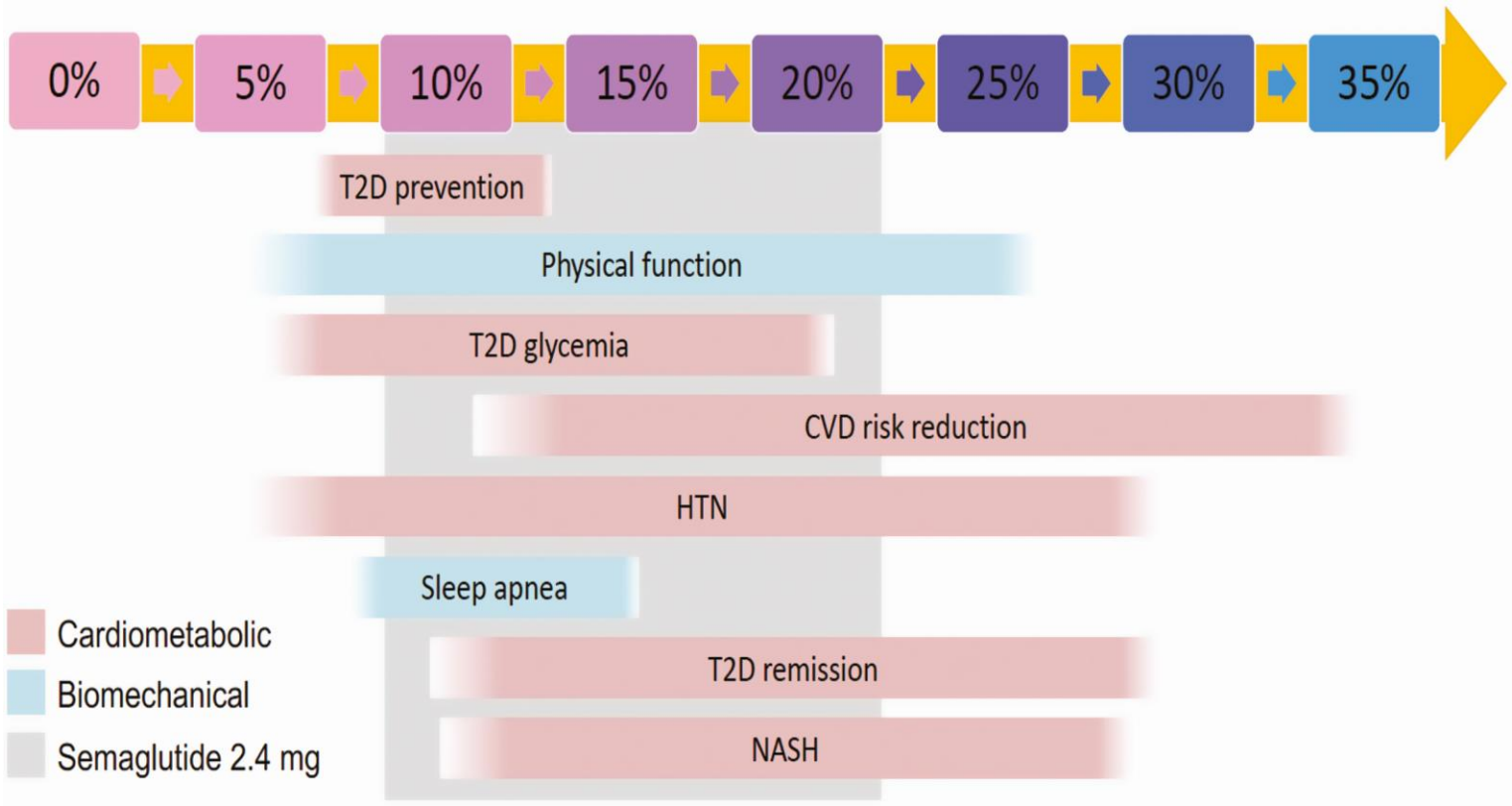
Most weight lost on OMMs is regained within 1–3 years of stopping

Budini B ,Lancet EClinicalMedicine., April 2026.



Sharma et al. Obesity Reviews. 2025;26:e13885

Treating ABCD/obesity to target for prevention and treatment of complications.

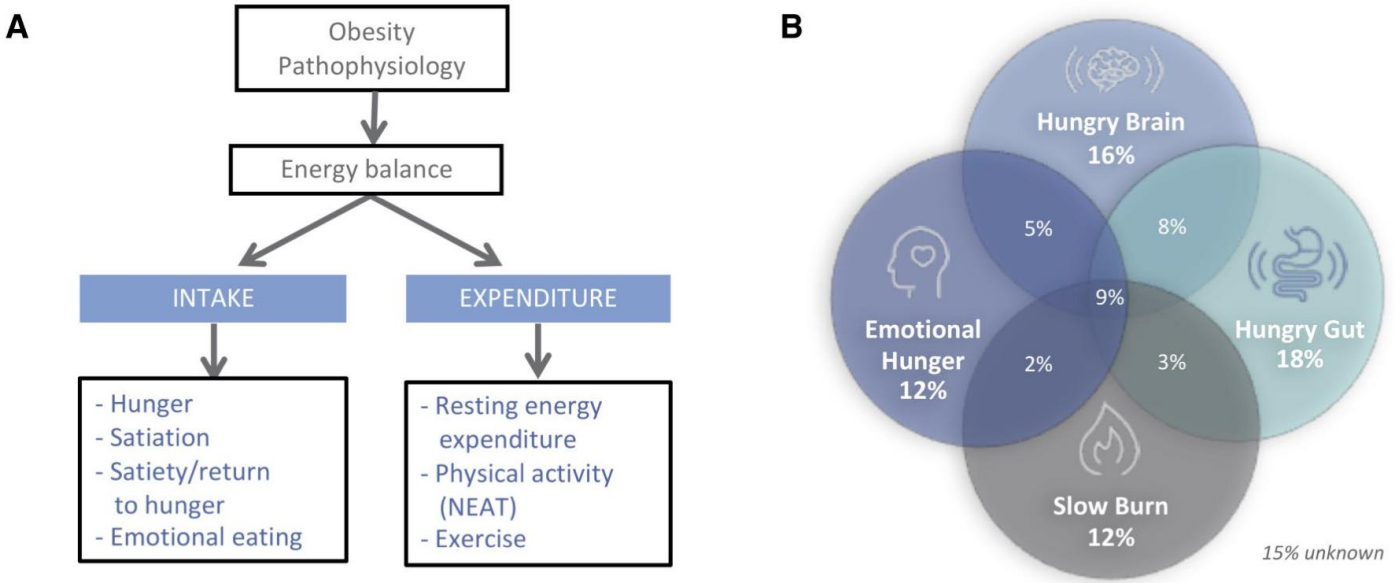


J Clin Endocrinol Metab, Volume 107, Issue 4, April 2022, Pages e1339–e1347, https://doi.org/10.1210/clinem/dgab848

Personalized Care

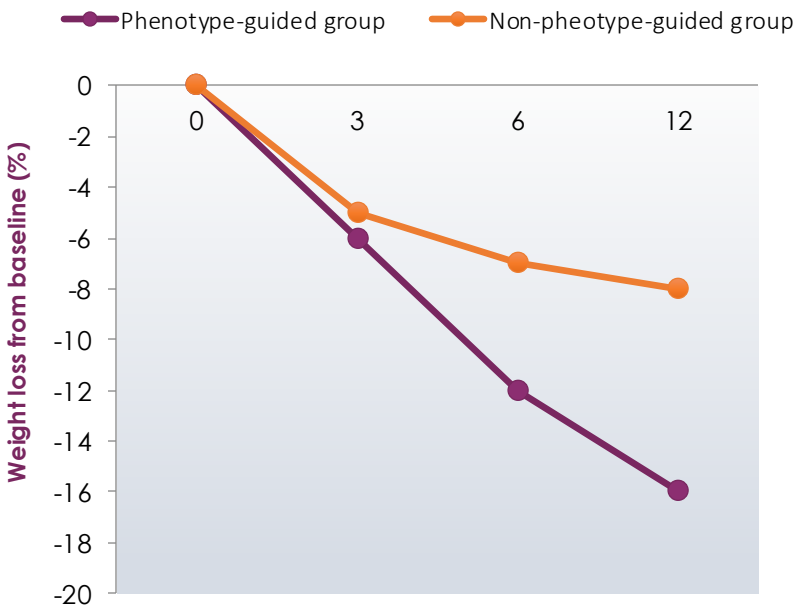
Selection of Antiobesity Medications Based on Phenotypes Enhances Weight Loss: A Pragmatic Trial in an Obesity Clinic

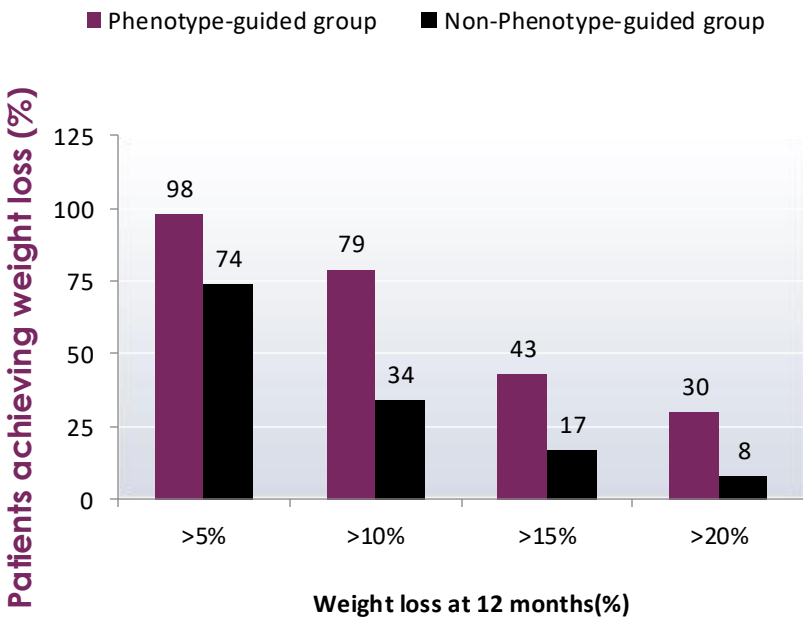
Andres Acosta [1], *Michael Camilleri* [1], *Barham Abu Dayyeh*[1], *Gerardo Calderon*[1], *Daniel Gonzalez*[1], *Alison McRae*[1], *William Rossini*[1], *Sneha Singh*[1], *Duane Burton*[1], *and Matthew M. Clark*[2]



Obesity | VOLUME 29 | NUMBER 4 | APRIL 2021

Individualized therapy is associated with better weight-loss outcomes





The proportion of patients who lost at least 10% of their body weight at one year was 79% versus 34% with non–phenotype-guided treatment.

The phenotype-guided approach was associated with 1.75-fold greater weight loss after one year.

Acosta et al. Obesity 29(4):662-671, 2021.

Who to treat—and when?

Treatment need and urgency follow disease burden and risk—not BMI class alone

1

CONFIRM

Is excess adiposity present?

BMI + waist-to-height ratio
Body composition when needed

2

STAGE

Is health already affected?

Medical, functional and psychological manifestations

3

TARGET

What must treatment achieve?

Prevention, complication improvement, function or QoL

4

TREAT & INTENSIFY

Is treatment potent enough?

Monitor response; escalate, switch or combine if off target

CLINICAL OBESITY

Treat without delay to improve or restore health and function

COVERAGE IS A SEPARATE DECISION

Labels and payers may still apply BMI thresholds

Rubino et al., Lancet Diabetes Endocrinol 2025 | Ciudin et al., Nat Med 2026 | ADA Obesity Standards 2026

XXX IFSO WORLD CONGRESS

"Advancing Multimodal Obesity Care"

24-27 August 2027

ifso2027.org

IFSO PARIS 2027

See you in

PARIS

Thank you

tpetry@haoc.com.br
@dratarissapetry

OSWALDO CRUZ
HOSPITAL ALEMÃO