



XXIX IFSO World Congress

1-4 September 2026 | Toronto, Canada

**Personalized Care for People
Living with Obesity**

Sara Suliman

TORONTO2026

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



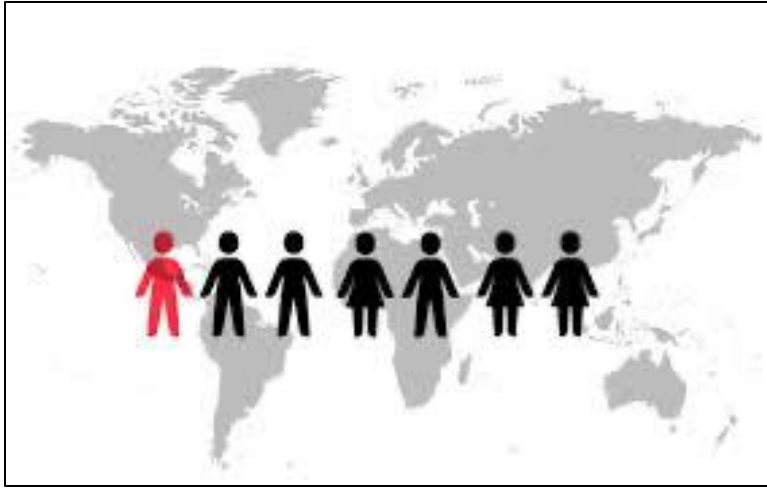
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Disclosure Slide

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☒	Yes, please specify:

Company Name	Honoraria/ Expenses	Consulting/ Advisory Board	Funded Research	Royalties/ Patent	Stock Options	Ownership / Equity Position	Employee	Other (please specify)
Novo Nordisk	x	x						
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**1 in 7 individuals worldwide
currently living with obesity**

2.5 million living with overweight and obesity

More than a billion people obese worldwide, research suggests

🕒 3 days ago · 💬 Comments



By Smitha Mundasad

Health reporter

More than a billion people are living with obesity around the world, global estimates published in The Lancet show.

This includes about 880 million adults and 159 million children, according to 2022 data.

B B C

NEWS

Obesity


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Chronic

Persists without
ongoing treatment

Relapsing

High rates of weight
regain are expected

Progressive

Worsens over time
without
intervention

Biologically Driven

Hormones and brain
circuits regulate
weight

Treatable

Effective therapies
are available

Management of obesity has to be effective, safe, life-long, evidence-based and personalised

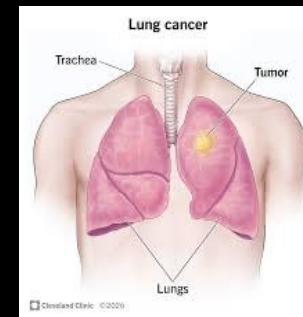


Obesity management

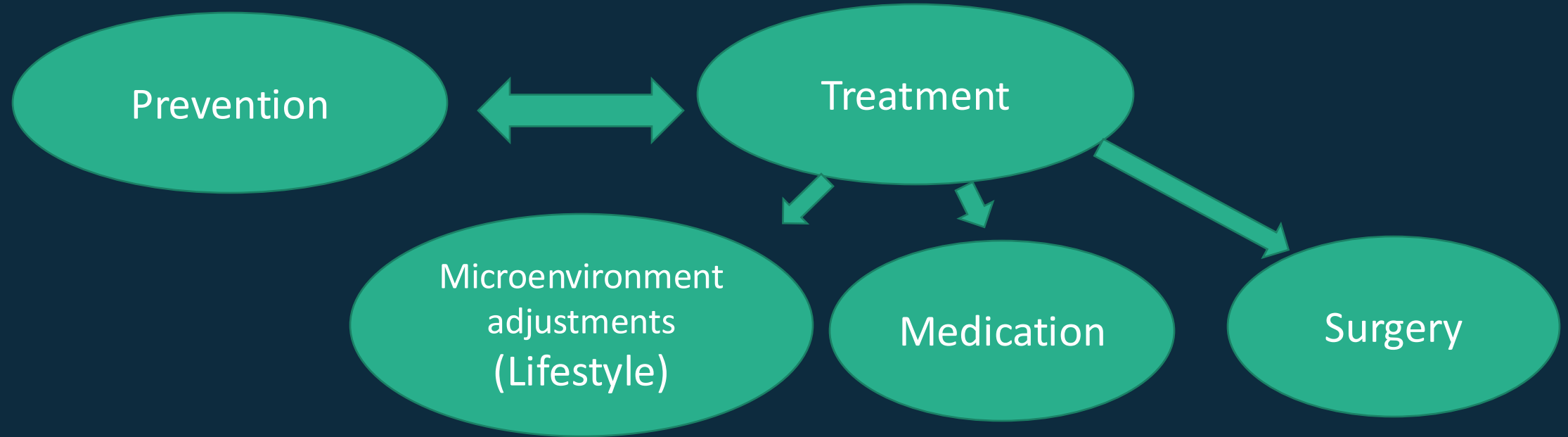
Prevention



Treatment



Obesity management

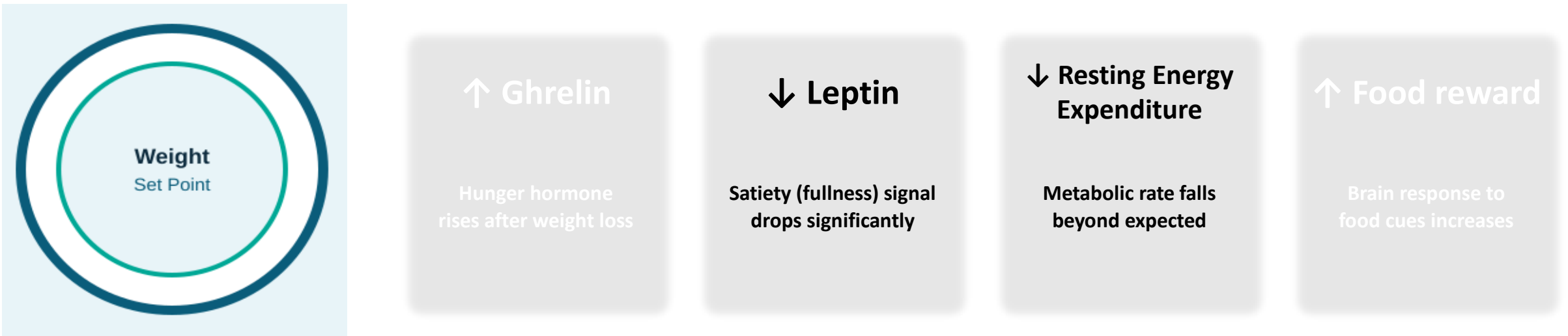


Prevention is key to manage the current epidemic
However, once obesity is established treatment is required
Having medication or surgery is not “an easy way or cheating”

The Body Weight Set Point: like a thermostat in summer...

Why Losing Weight is Biologically Hard

After weight loss, hormonal changes actively oppose further loss and drive regain

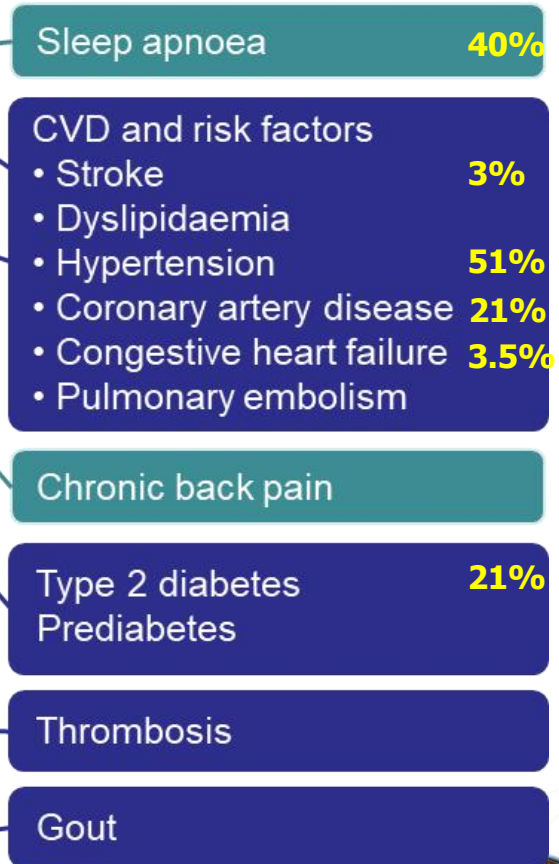
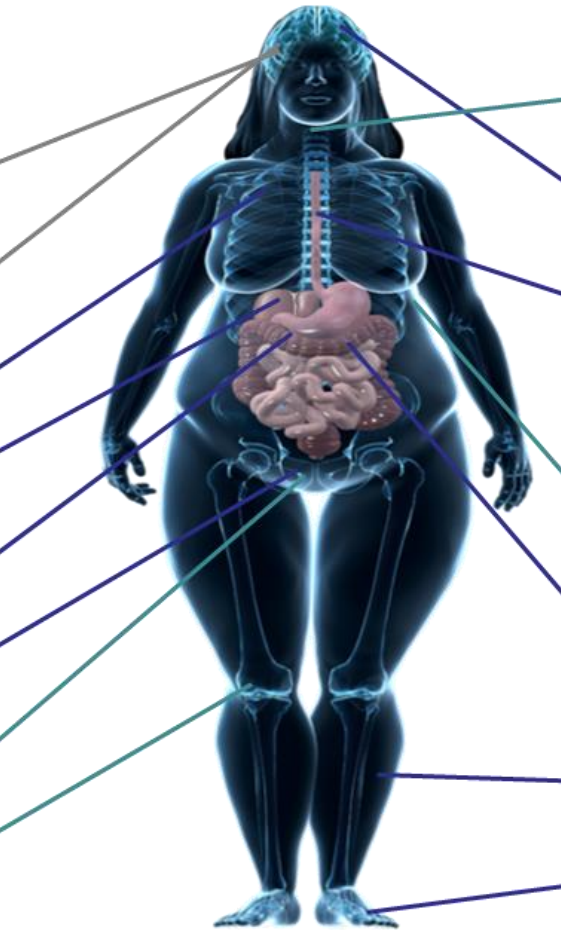
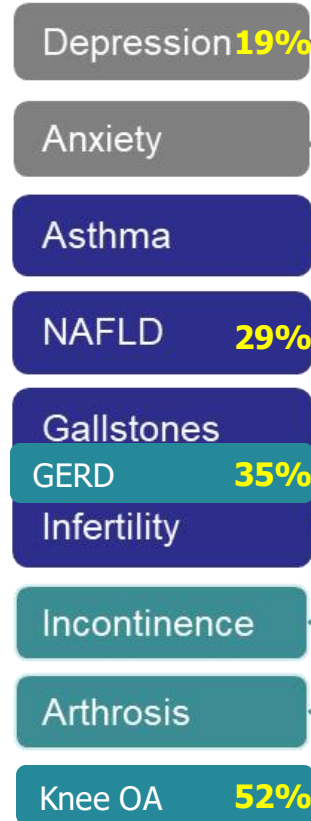
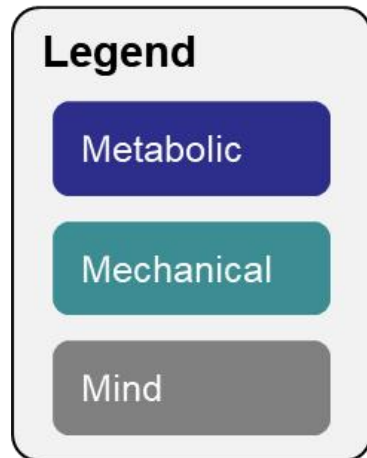


These biological adaptations persist long after weight loss, contributing to the high rates of weight recurrence observed without ongoing treatment.

Obesity Is Not About Appearance: its associated with > 220 health risks

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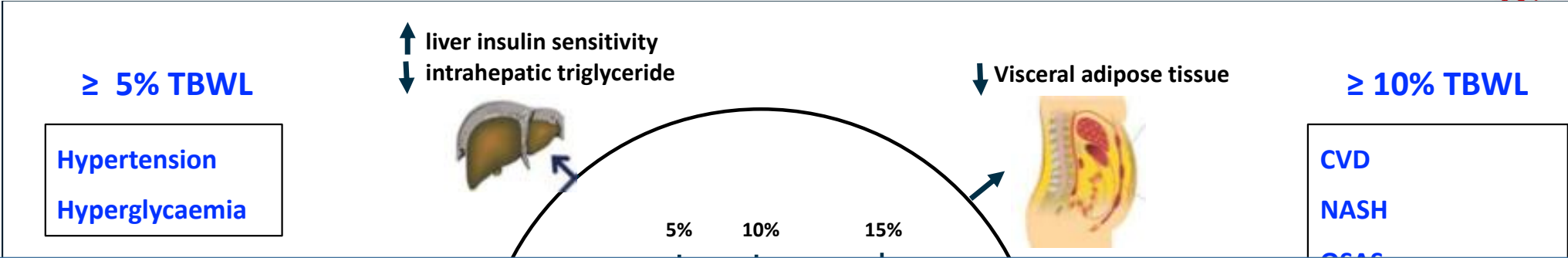
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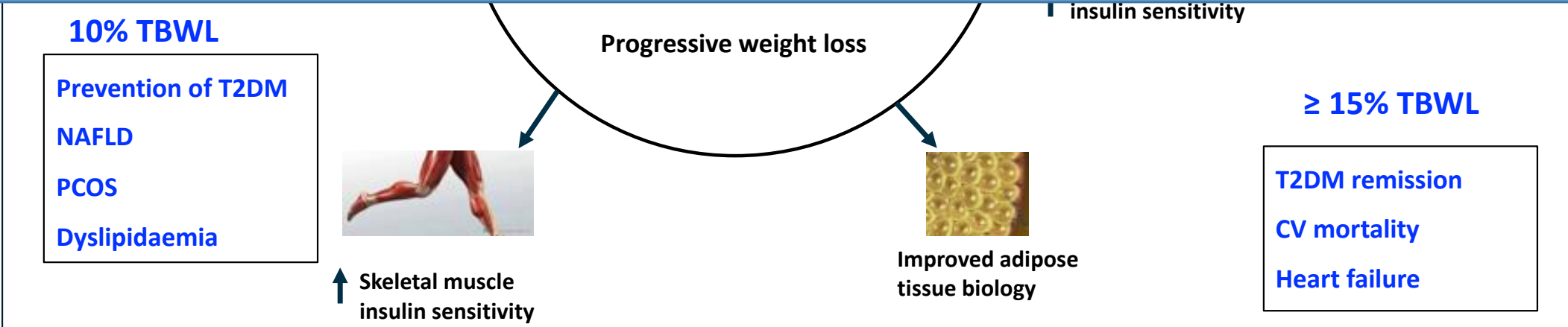
Cancer
PCOS 9-20%
Adverse pregnancy outcomes



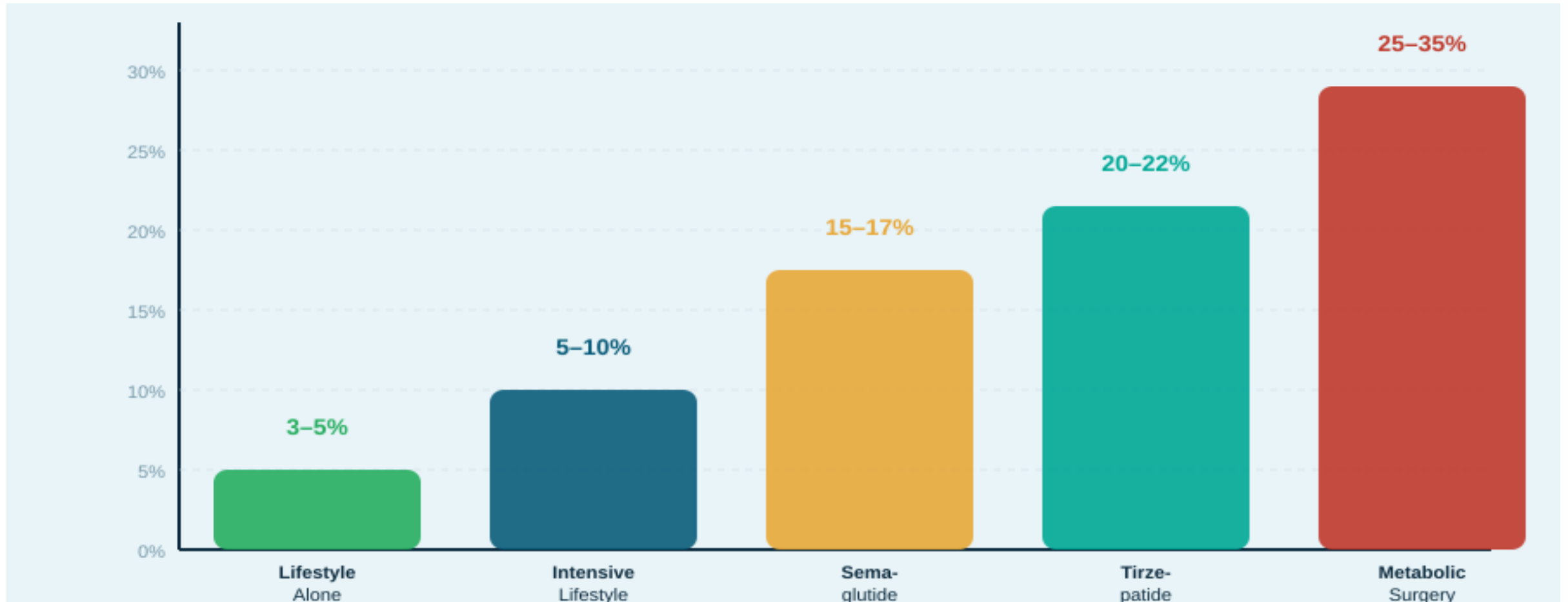
Obesity management reverses risk:



But, finding the most appropriate therapy for the individual we are treating
“personalization” is key



Expected Weight Loss by Treatment Type



Goals of Obesity management 2025:

Improvement in existing obesity complications

- Metabolic (DM, CVD ...)
- Structural: OSAS, OA
- Physical: fatigue, diminished ADL,
- Neoplastic
- Cognitive and psychosocial
- Inflammatory and autoimmune

weight loss +

Prevention of future obesity complications

Improvement in obesity symptoms:

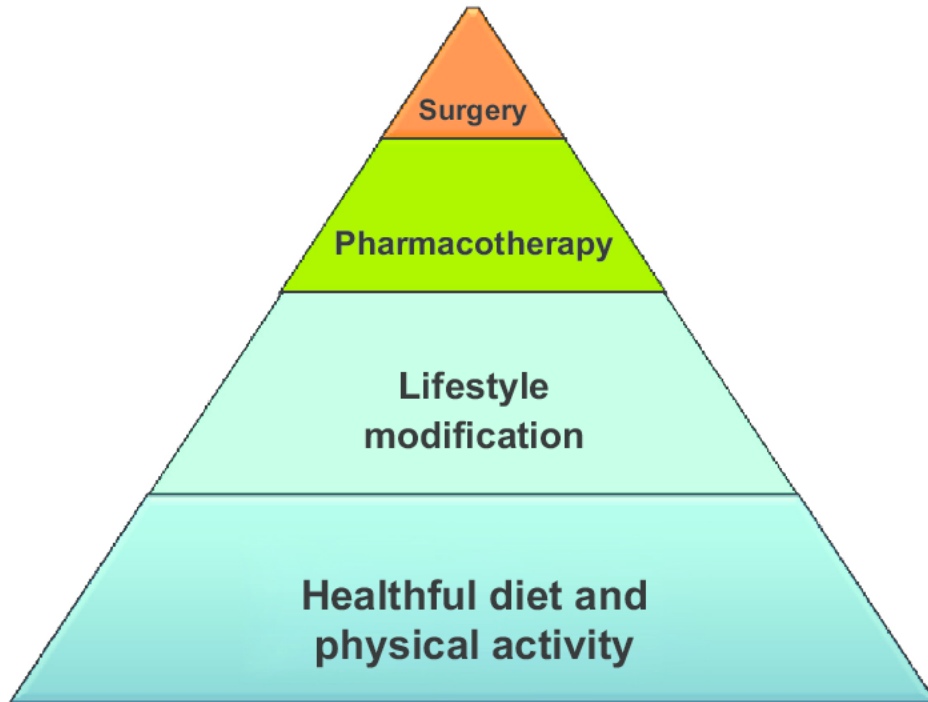
- Hunger/hyperphagia
- Excessive craving
- Diminished satiation or satiety,
- Excessive food focus, food obsession (food noise)



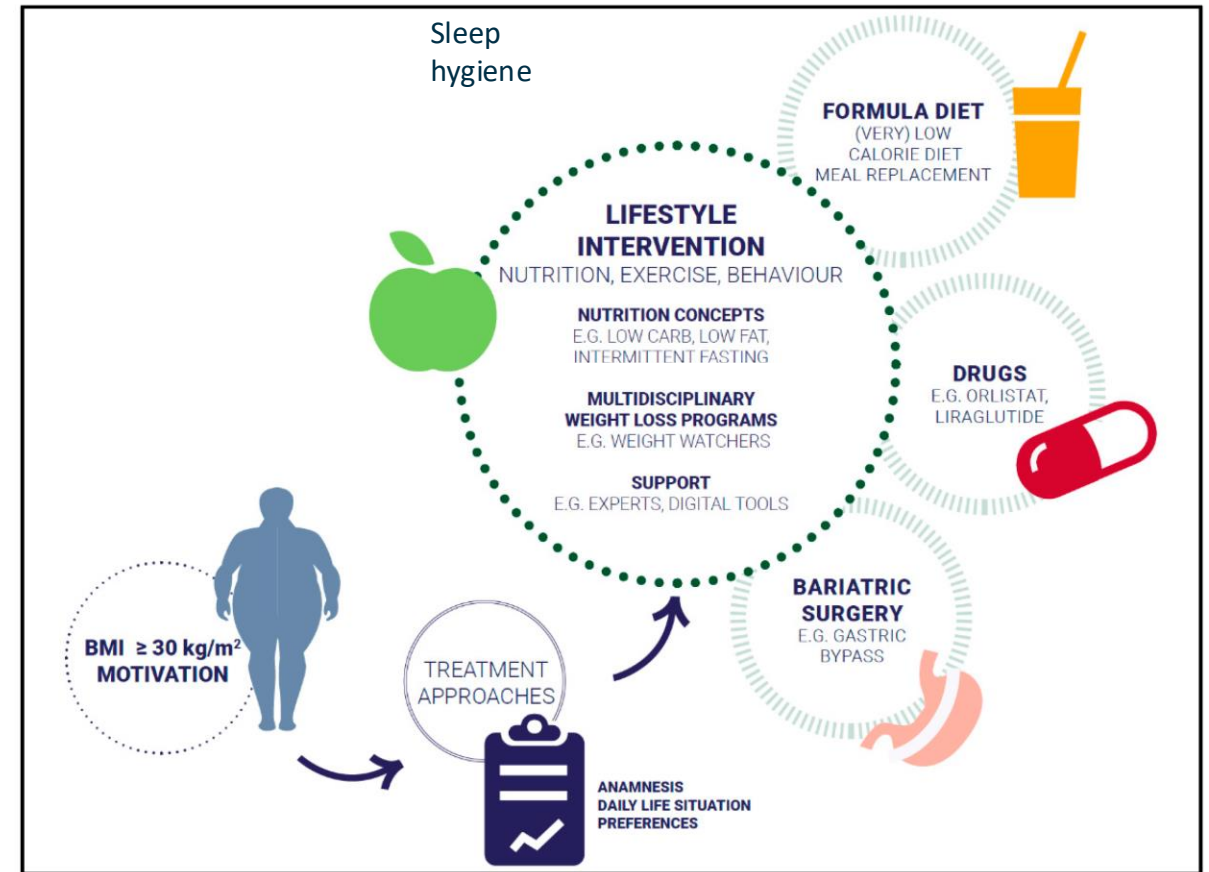
Obesity Management (wholistic and personalized):

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- Old model



New model

Personalisation of obesity therapy

Obesity is an umbrella term, in reality it encompasses >200 sub-types

Our aim is to choose: **Right patient + Right team + Right treatment**
⇒ Right outcome

Right treatment = the most effective **for that person**, manages complications, is well tolerated, is available and affordable (or reimbursed), is sustainable lifelong



Personalised/precision medicine

- The use of a person's own data to objectively gauge the efficacy, safety, and tolerability of therapeutics, and, subjectively, to tailor health recommendations and/or medical decisions to the individual's preferences, circumstances, and capabilities
- **Moving from one size fits all to individualized (personalized) therapy.**
- It can incorporate genetic, environmental, and clinical markers to improve accuracy at every stage of medical management, including:
 - Precision diagnostics (phenotypic, molecular: genomic, proteomic ...)
 - Precision prognostics (monitoring and prediction)
 - Precision treatment (therapeutics, nutrition, etc)
 - Precision prevention (epigenetic reprogramming)



Yet obesity still lacks a North Star



Data-driven answers to key questions are lacking:

- How do we diagnose obesity?
- How can we assess the risk of co-morbidities/complications? e.g. MASLD/OSAS
- Can we predict when obesity might start? Can we do anything to prevent it?
- **How will a person respond to therapy, and what is the best treatment for them?**
- What is the likely prognosis/likelihood of disease progression?
- What is our treatment target?





In comparison: DM has a far more “personalised care” model

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- HbA1c targets for different risk groups
- Use of biomarkers LDL, Lpa, BNP to help risk stratify individuals
- Targeted data-driven therapy (eg CVD risk →GLP1, CKD→SGLT2 etc)
- Management of co-mordity targets (BP, lipids, etc)
- Adapted models for low income settings



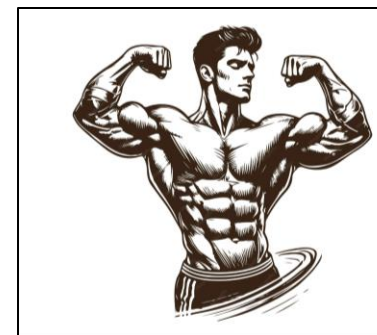
Historically obesity diagnosis and classification was based on BMI alone:

$Wt (kg)/Ht (m)^2$

Classification	BMI (kg/m ²)
Underweight	<18.5
Normal range	≥18.5 and <25
Overweight	≥25 and <30
Obesity	≥30
Obesity class I	≥30 and <35
Obesity class II	≥35 and <40
Obesity class III	≥40

Disadvantages of BMI:

- Does not differentiate between fat and muscle
- Does not identify fat distribution
- Does not account for age, gender or ethnic variability



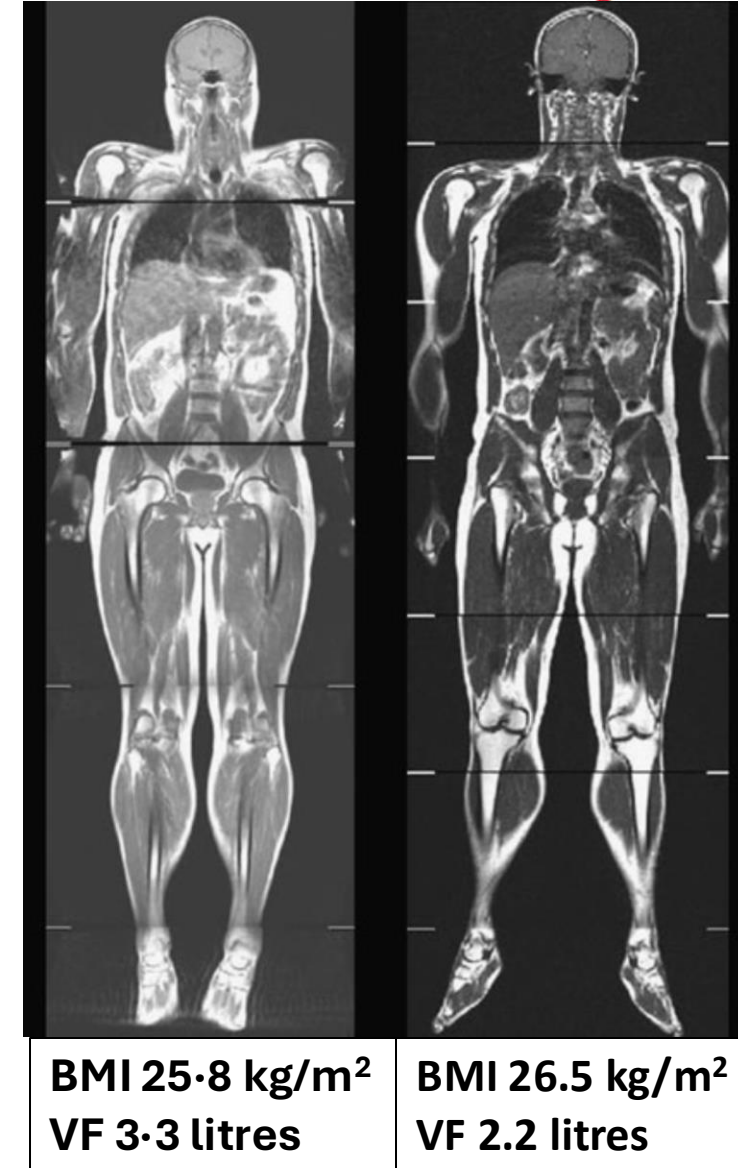
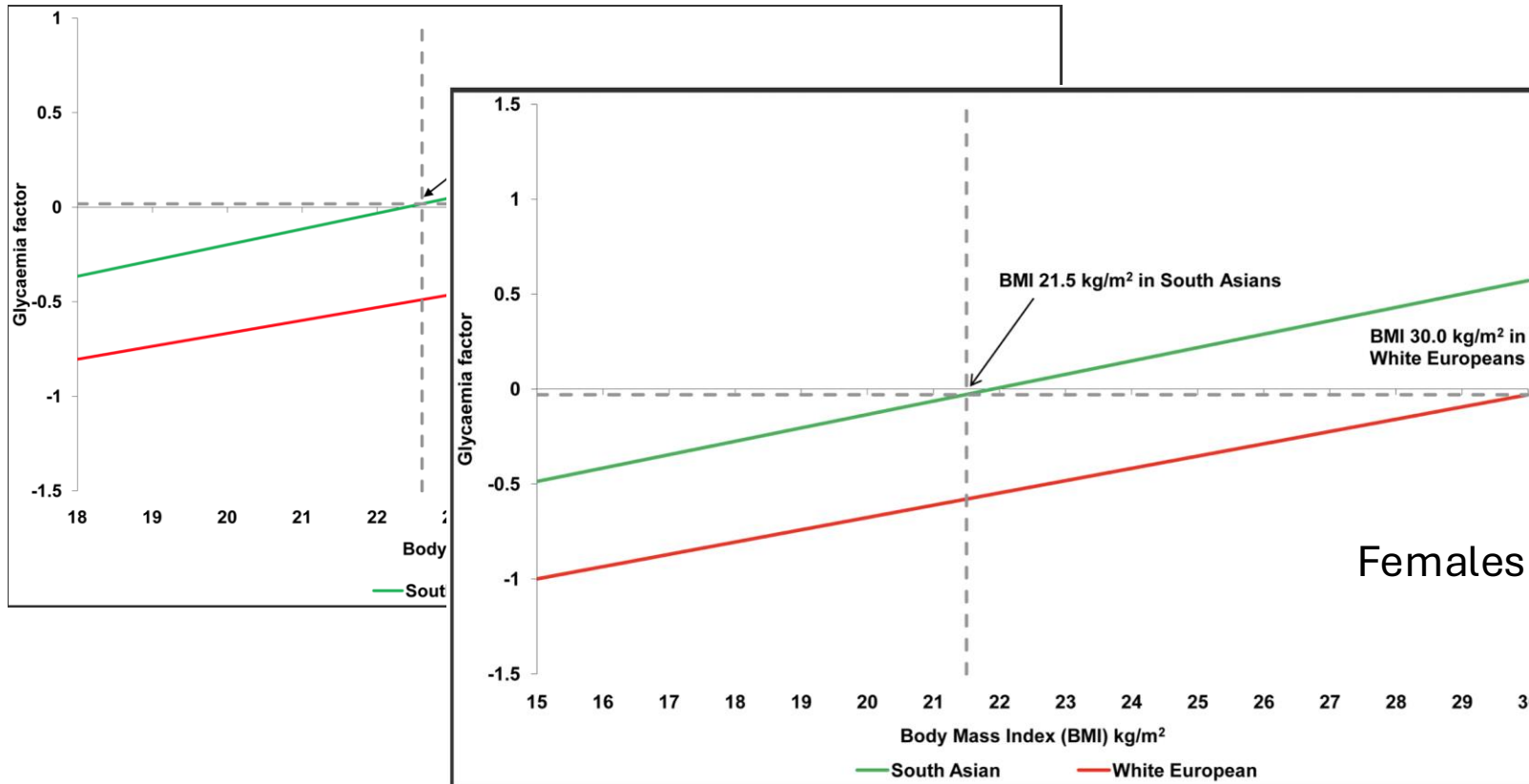
✓ Metabolically **HEALTHY**
— BMI overestimates risk



⚠ Metabolically **AT RISK**
— BMI underestimates risk

* For Caucasians, different scales are available for different ethnicities

But the disease of obesity is driven by biology (Sex, age, ethnicity.....etc):



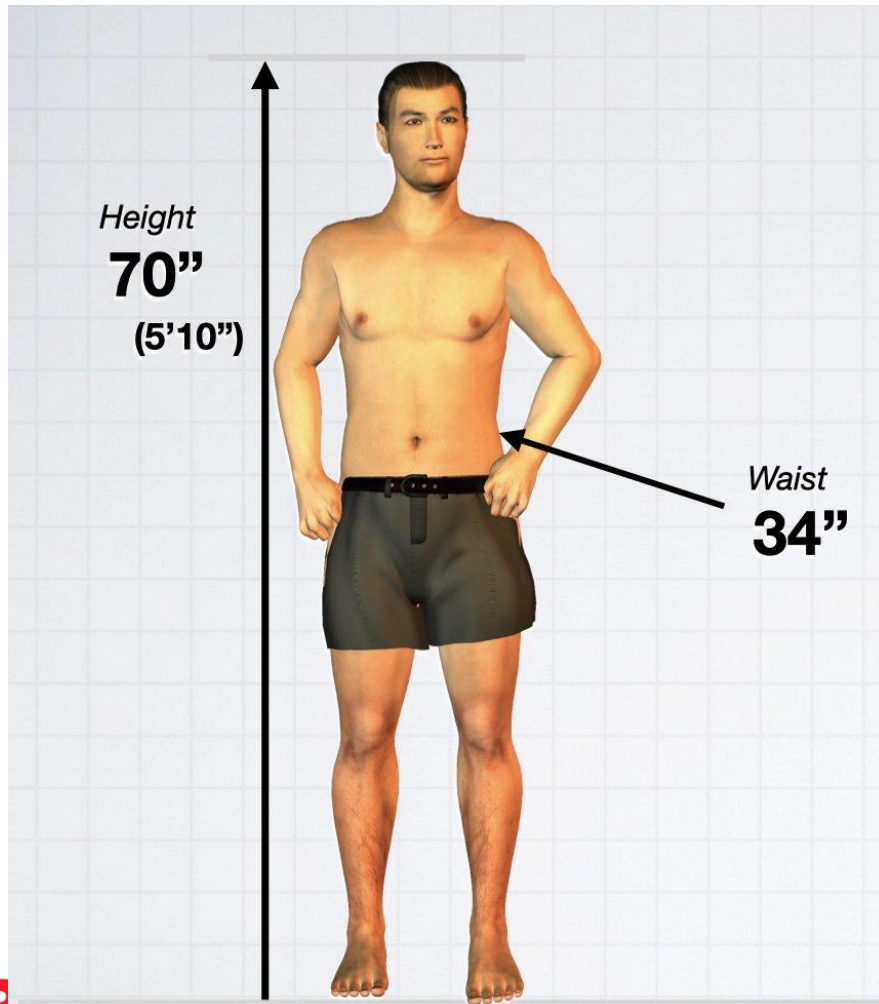
Other factors that may affect obesity risk and response to therapy (personalised risk):

- Sex
- Age
- Fat distribution
- Sarcopaenia
- Social determinants of health
- Access to care (diagnostic tools or treatment options)
- And many more....



A simple anthropometric measure that helps stratify risk:

Waist to Height ratio



Waist-to-height ratio (WHtR) =

$$\frac{\text{Waist Circumference}}{\text{Height}}$$

<0.5 normal risk

0.5 – 0.6 high risk

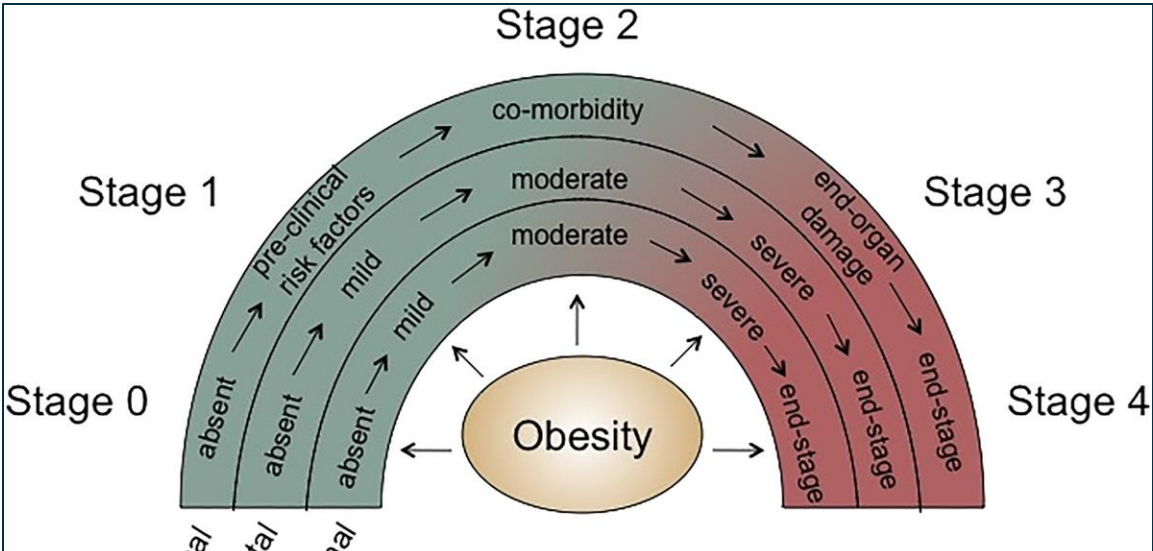
>0.6 very high risk



To improve further, different staging systems were adopted:

Edmonton Obesity Staging System

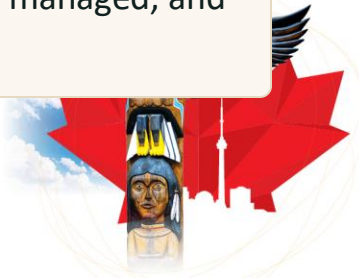
- BMI is a marker of obesity however it does not classify the disease
- Functional classification such as the EOSS, is more informative for prioritisation of therapeutic options



Staging changes decisions

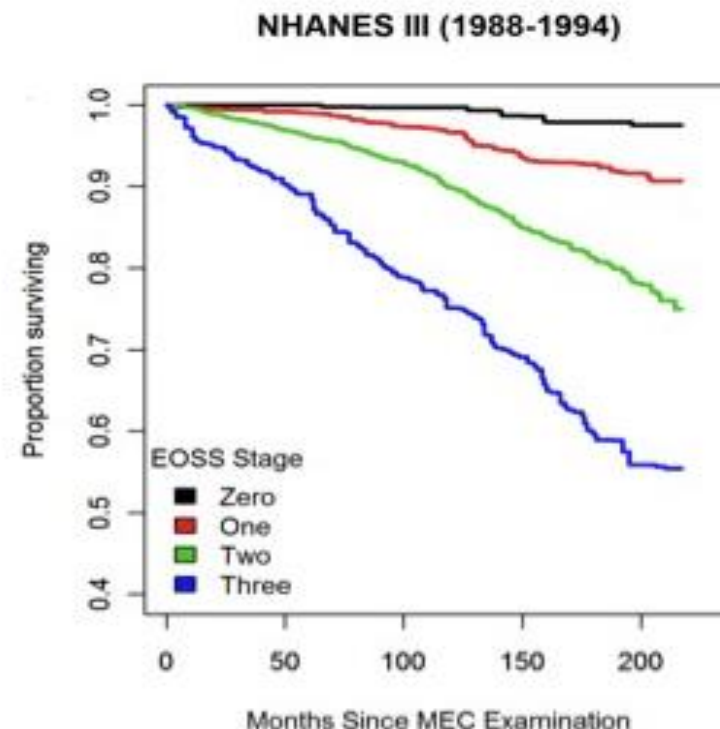
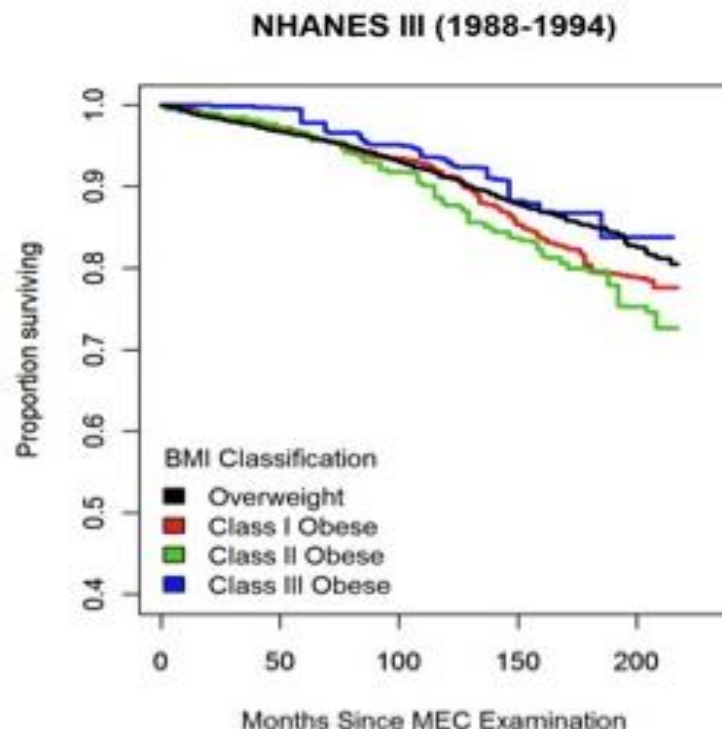
- EOSS predicts mortality better than BMI does — a person at BMI 42 and stage 0 and a person at BMI 32 and stage 2 are not the same clinical problem, and the second is the more urgent.
- The GCC and Lebanon regional recommendations use EOSS explicitly to determine the level of care at which a patient should be managed, and recommend referral to specialised care for stage 2 or above regardless of the response to lifestyle intervention.

OR Mild obesity-related psychology and/or mild impairment of wellbeing	Moderate functional limitations in daily activities	impairment of wellbeing	limitations
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Edmonton Obesity Staging System predicts mortality:

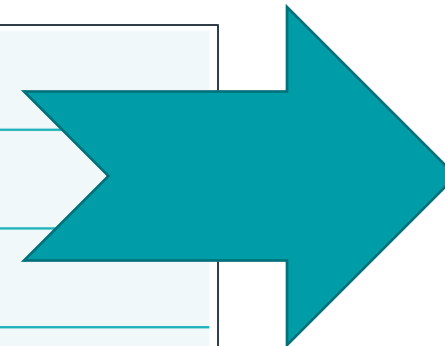
Predicts mortality (NHANES study)



Edmonton Obesity Staging System (EOSS): personalisation of care

- Considers the severity of obesity based on a clinical assessment of weight-related health problems, mental health and quality of life (unlike BMI alone)
- EOSS provides a framework for clinical decision-making, prioritisation and management and can roughly determine the healthcare level at which a patient may require treatment: primary, secondary, or tertiary care level

Stage 4	End-stage
Stage 3	End-Organ Damage
Stage 2	Established Comorbidity
Stage 1	Pre-clinical Risk Factors
Stage 0	No Apparent Risk Factors



Secondary/
Tertiary care



Further progress in obesity management guidance (consensus based attempt to personalize obesity care)

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The Lancet Diabetes & Endocrinology Commission

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Framework for the pharmacological management of obesity and its complications from the American Association for the Study of Obesity

[Barbara McGowan](#) , [Andreea Ciudin](#) , [Jennifer L. Baker](#), [Luca Frühbeck](#), [Gijs H. Goossens](#), [Matteo Monami](#), [Paolo Sbraccia](#), [Bo](#) & [Volkan Yumuk](#)

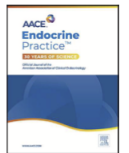
[Nature Medicine](#) **31**, 3229–3232 (2025) | [Cite this article](#)

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Endocrine Practice 31 (2025) 1351–1394



www.endocrinepractice.org



AACE Clinical Guidance

American Association of Clinical Endocrinology Consensus Statement: Algorithm for the Evaluation and Treatment of Adults with Obesity/Adiposity-Based Chronic Disease – 2025 Update



Karl Nadolsky, DO, FACE, DABOM ¹, W. Timothy Garvey, MD, MACE ², Monica Agarwal, MD, MEHP, FACE, DABOM ², Alex Bonnacaze, MD ³, Bartolome Burguera, MD, PhD ⁴, Michelle DeGeeter Chaplin, PharmD ⁵, Marcio L. Griebeler, MD, FACP, DABOM ⁴, Samantha R. Harris, MD, DABOM ⁶, Jeffrey N. Schellinger, MCN, RD ⁷, Juliana Simonetti, MD, DABOM ⁸, Reshmi Srinath, MD, DABOM ⁹, Volkan Yumuk, MD, FACE ¹⁰

¹ Michigan State University College of Human Medicine, East Lansing, Michigan

² University of Alabama at Birmingham, Birmingham, Alabama

³ Pinehurst Medical Clinic, Pinehurst, North Carolina

⁴ Cleveland Clinic, Cleveland, Ohio

⁵ Appalachian Mountain Health, Asheville, North Carolina

⁶ Scripps Clinic, San Diego, California

⁷ UT Southwestern Medical Center, Dallas, Texas

⁸ University of Utah Health, Salt Lake City, Utah

⁹ Icahn School of Medicine at Mount Sinai, New York, New York

¹⁰ Istanbul University-Cerrahpaşa, Cerrahpaşa Medical Faculty, Istanbul, Turkey

Lifestyle therapy alone: who, and for how long?

Reasonable as sole therapy when

- Preclinical obesity by the Lancet Commission definition — excess adiposity, no organ dysfunction, no limitation of daily activity
- EOSS stage 0–1, no established adiposity-related complication
- Recent-onset dysglycaemia where diabetes prevention is the goal (ADA 3.3: $\geq 5\text{--}7\%$ loss, ≥ 150 min/week)
- The person has been offered pharmacotherapy and declines it —

What 'lifestyle therapy' actually means

- ADA 8.8a: high-frequency counselling — at least 16 sessions in 6 months — targeting a 500–750 kcal/day deficit, irrespective of macronutrient composition
- ADA 8.11: maintenance requires monthly contact, weekly or more frequent self-weighing, and 200–300 min/week of activity for ≥ 1 yr
- ADA 5.39 / 8.14: protect lean mass — resistance training, adequate

With professional advice by trained experts in Medical nutritional therapy, physical activity and protecting lean mass, behavioural - mental health & sleep

Adjuvant lifestyle therapy is key to all treatment modalities

Intervention, if 25% is not achieved after a further 12–24 weeks, or the person is at EOSS stage 2 or above, refer to specialised care.

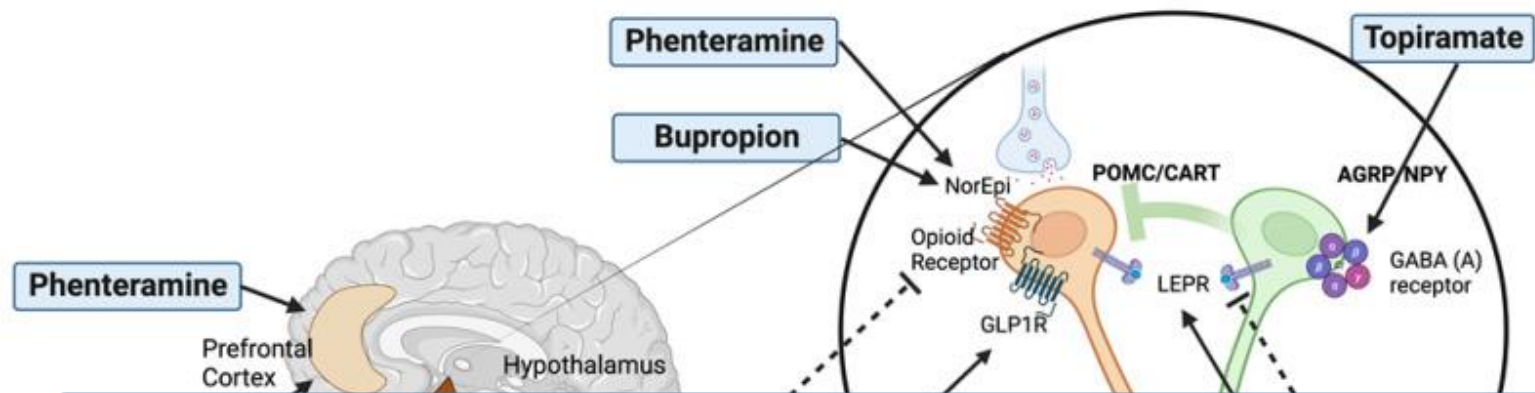
Waiting longer does not improve the odds — it only adds years to the seven-year delay.

Medical management of obesity in 2026

Drugs approved by the FDA for long-term treatment

Avoid in pregnancy
& during breast feeding
(ALL)

May cause/worsen depression
(centrally acting)



Questions remain:

Which drug for whom? How likely are they to respond? Will they tolerate the medication? Can it improve the complications of obesity in that person? When do we start? When do we escalate treatment?

Titration and symptom-management – Key personalization targets for compliance

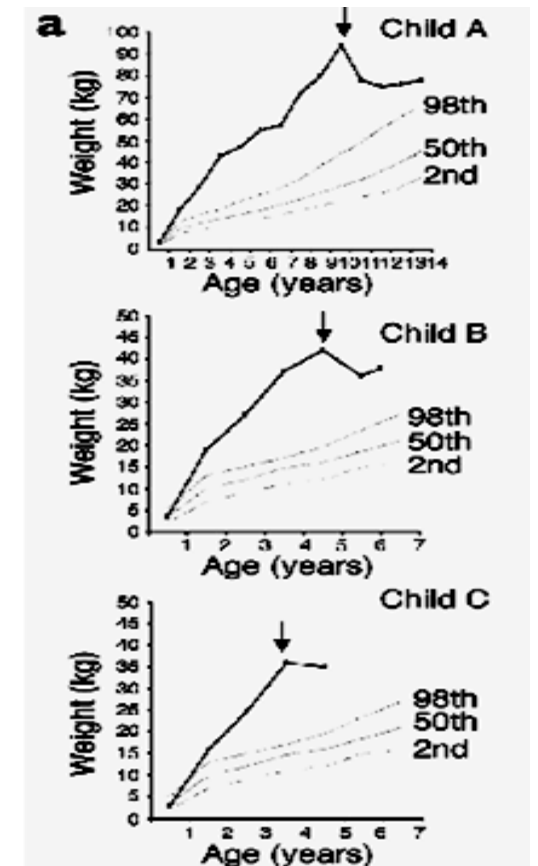
Semaglutide (Wegovy)	2021
Tirzepatide (Zepbound/Mounjaro)	2023
Semaglutide PO (Wegovy Pill)	2025
Orforglipron	2026

Monogenic Obesity:

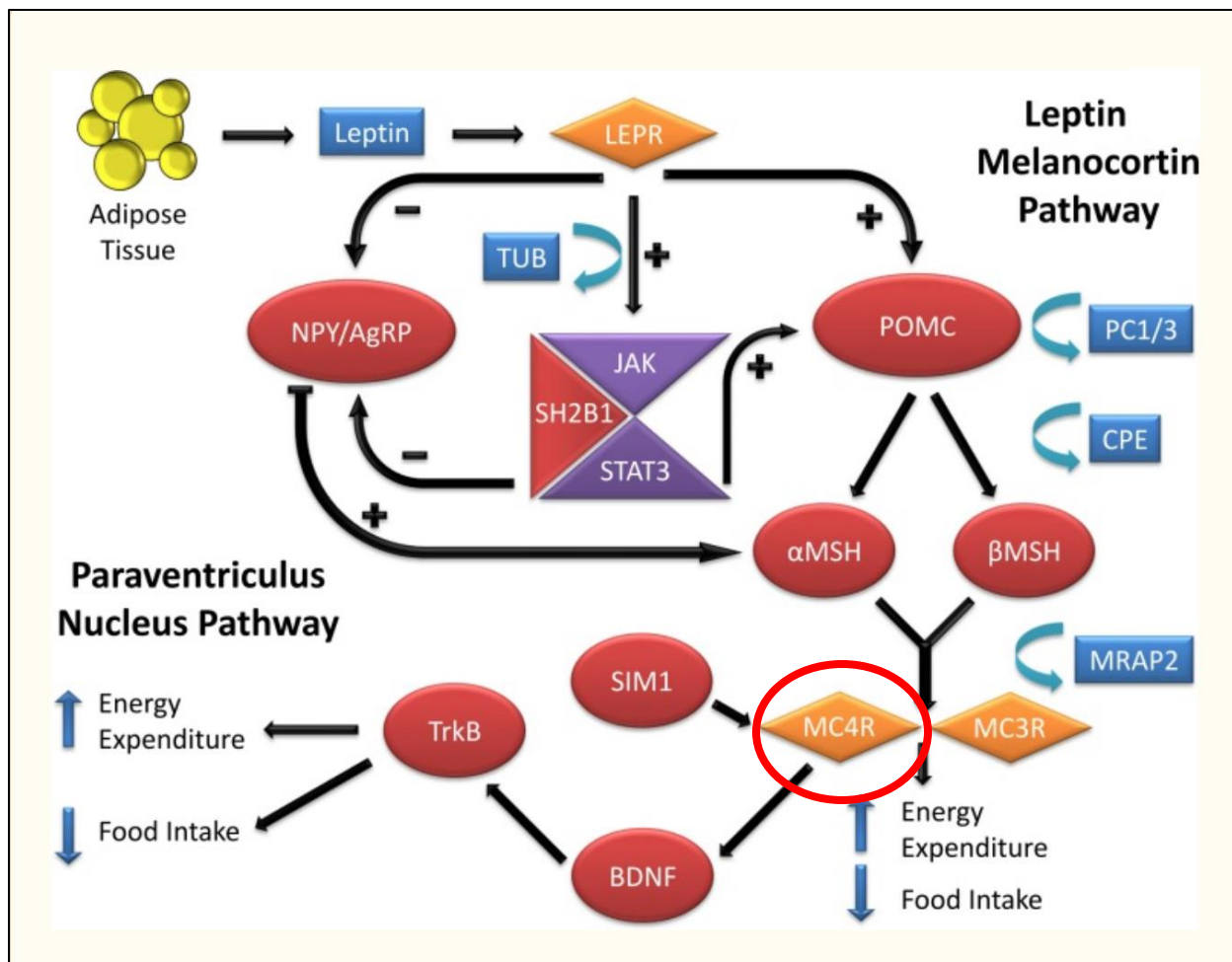
Leptin mutation (congenital leptin deficiency)



- Severe early-onset obesity
- Severe hyperphagia (hunger)
- Respond well to leptin therapy



Most monogenic obesity, is due to mutations in the brain hunger/satiety pathway (leptin melanocortin pathway)



Setmelanotide (Imcivree)

A melanocortin-4 (MC4) receptor agonist developed for the treatment of obesity arising from some of these mutations:

- Proopiomelanocortin (POMC)- 80% lost >10% wt
- Proprotein convertase subtilisin/kexin type 1 (PCSK1),
- Or leptin receptor (LEPR) deficiency – 45% lost >10% wt

Granted (PRIME) PRiority MEdicines designation by the EMA for the treatment of obesity and the control of hunger associated with deficiency disorders of the MC4 receptor pathway

Personalised medical therapies for Obesity

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Orlistat
(Xenical)



Qysmia
(Phenteramine +
Topiramate)



Contrave
(Naltrexone
/Bupropion
)

Orforglipron

? Gelesis

Studies completed

+/- Diabetes

Metformin

Liraglutide



Semaglutide
SC and PO



Tirzepatide



SURPASS-PEDS

Newer agents:
Triple agonists
Dual agonists
(GLP1/GIP or
Glucagon)
Amylin analogues
High dose GLP1s
And lots more 😊

Monogenic obesity

Leptin



Setmelanotide



Precision (personalized) prescribing

Match the molecule to the complication, not the scale



Established ASCVD

Semaglutide 2.4 mg

-20% MACE

SELECT, n=17,604



HFpEF + obesity

Tirzepatide + semaglutide

-38% HF events

SUMMIT; STEP-HFpEF: symptoms & 6MWD ↑



CKD + T2D

Semaglutide

-24% kidney events

FLOW



Obstructive sleep apnea

Tirzepatide

AHI ↓ ≈50-60%

SURMOUNT-OSA (≈25-30 events/h)



MASH (F2-F3)

Semaglutide

63% vs 34%

MASH resolution, ESSENCE



Prediabetes / T2D

Tirzepatide

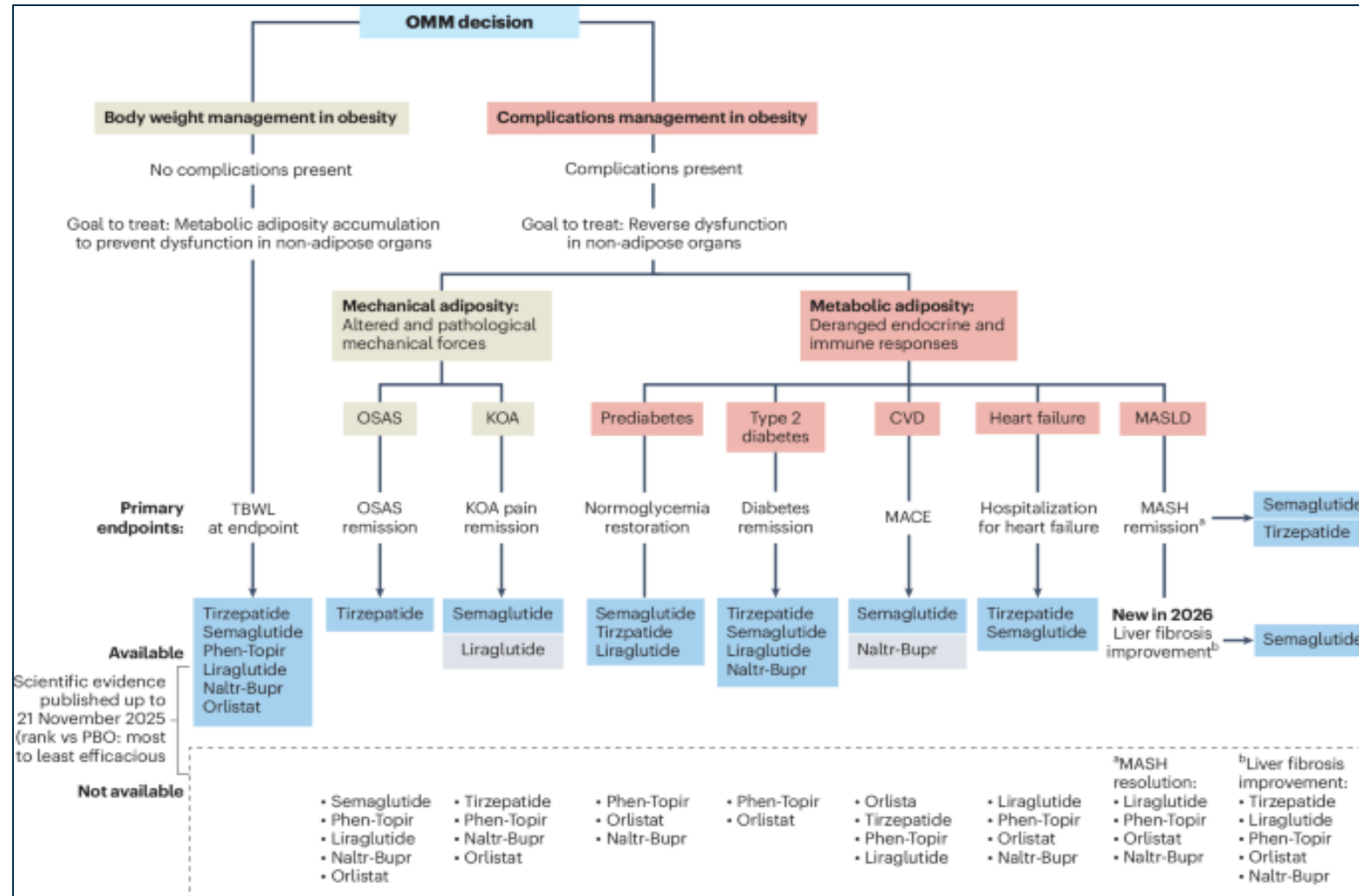
-94% T2D risk

SURMOUNT-1, 3-yr; knee OA: STEP 9 / TRIUMPH-4

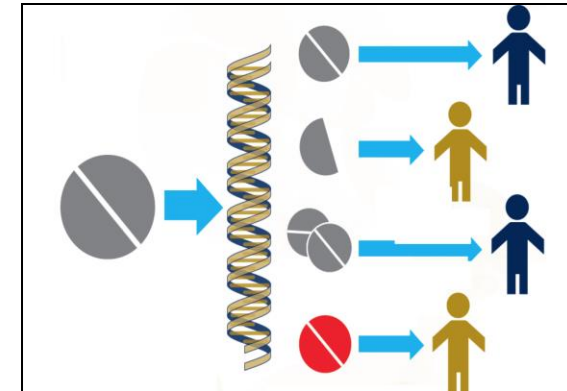
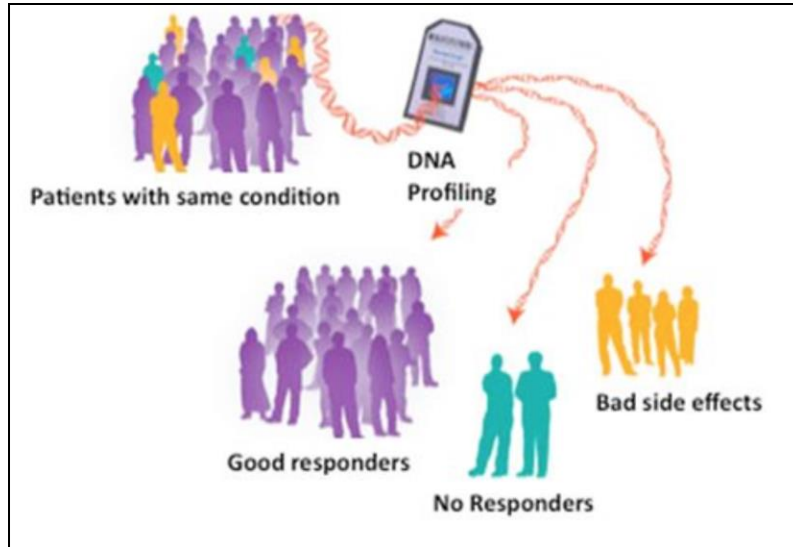
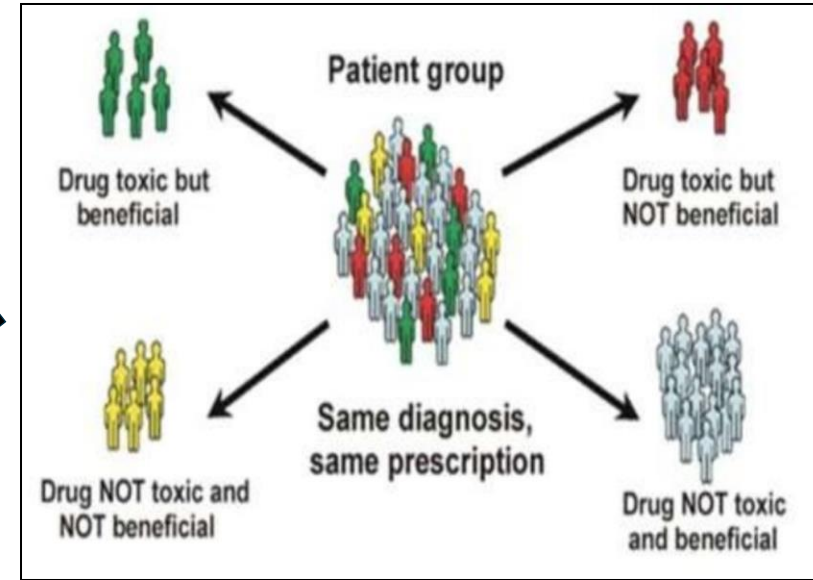


Framework for the pharmacological treatment of obesity and its complications from the European Association for the Study of Obesity (EASO)

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Pharmaco-genetics: further personalization of therapy



Endoscopic and device therapies: middle ground between OMM and MBS

Where they sit

- Endoscopic sleeve gastropasty reduces gastric volume by full-thickness suturing while preserving the fundus and slowing gastric emptying.
- The MERIT randomised trial in class 1 and 2 obesity reported mean total body weight loss of approximately 13.6% at 12 months; longitudinal series report 15–17.5%.
- Intragastric balloons are space-occupying and temporary; meta-analyses report roughly 13% total body weight loss at 6 months, with efficacy declining thereafter.
- Guidance: joint ASGE and ESGE guideline (2024); NICE

How to think about them

- Efficacy sits between contemporary OMMs and MBS, and below both tirzepatide and sleeve gastrectomy.
- Benchmarks: ASGE and ASMBS joint task force set a threshold of >25% excess weight loss at 12 months for primary endoscopic intervention, and >5% total body weight loss for non-primary use.
- Best-supported roles are **class 1 and 2 obesity, patients who decline or are unsuitable for OMMs and surgery, or bridging before a definitive procedure.**
- Durability and data quality remain actively debated.

The questions to ask before referring

What is this procedure for? If the goal is durable remission of type 2 diabetes, the evidence base points to MBS.

If the goal is 10–15% weight loss in class 1 obesity for a patient who will not consider an operation and cannot access or tolerate pharmacotherapy, an endoscopic option is a reasonable and evidence-supported choice — provided the aftercare is the same as for any other obesity treatment.

Metabolic Surgery: Highly Effective for Severe Obesity

Procedures

- Roux-en-Y Gastric Bypass (RYGB): 30–35% weight loss
- Sleeve Gastrectomy: 25–30% weight loss
- One Anastomosis Gastric Bypass

Clinical Impact

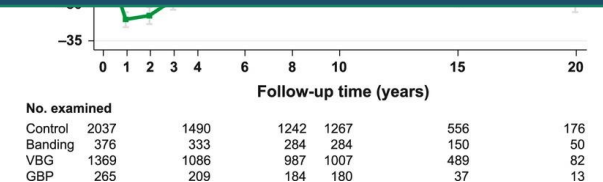
- T2DM remission in ~60–80% of cases
- Cardiovascular mortality reduced ~40%
- Hypertension resolution ~70%
- OSA resolution ~80–85%

Personalisation targets:

- **We are not choosing the operation — the surgical team is.**
- Factors to aid that choice: reflux history and any endoscopic findings, diabetes duration and current agents, an estimate of beta-cell reserve, nutritional and psychological risk, and the realistic prospect of lifelong follow-up
- Predictors of response – sex, age, DM,



Source: Schauer PR et al. NEJM · STAMPEDE Trial · IFSO Guidelines



Surgery is the paradigm of health gain — decades of hard outcomes

+6.1 yrs

median life expectancy (+9.3 yrs with T2D); ~50% lower long-term

3×

higher T2D remission than medical therapy at 7–12 yrs (~18% vs 6%)

–39%

major adverse cardiovascular events in obesity + T2D vs usual care

–32%

obesity-associated cancer incidence; –48% cancer mortality

Surgery remains a cornerstone of obesity management

Personalisation targets: patient selection, pre-op assessment, operation type, high volume centre/surgeon, combination with OMM

STAMPEDE (5 yrs): HbA1c ≤6.0% off medication in 29% (RYGB) and 23% (SG) vs 5% with intensive medical therapy — plus remission of OSA, MASLD, arthralgia, and gains in fertility and quality of life.

Post-op: the part that belongs to us as IH – personalized followup

1 Lifelong nutritional monitoring

Micronutrient, nutritional and metabolic monitoring and supplementation.

2 Weight recurrence is expected, not exceptional

Monitor regularly for insufficient weight loss or recurrence; assess predisposing factors and consider additional interventions.

3 Bone health and sarcopenia

Assess bone loss and reduced lean mass follow all bariatric procedures. Combine adequate protein, calcium and vitamin D with resistance training (ADA 5.39), and assess fracture risk in older patients (ADA 4.8–4.13).

4 Post-bariatric hypoglycaemia

5 Mental health, alcohol and substance risk

ADA 8.27 (C): routinely screen for psychosocial and behavioural change after surgery and refer as needed. Alcohol pharmacokinetics change after bypass and problematic use is more common post-operatively.

6 Pregnancy, contraception and diabetes drugs

Advise on the interval before conception and on effective contraception.

Using Technology in Weight Management: personalized monitoring

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Tracking Tools: Mobile apps for diet and activity tracking



Telehealth: Virtual consultations for convenience and increased access.



InBody Machines: Regular monitoring of body composition.



Wearable Devices: Integration with fitness trackers



AI-Based Interventions: Personalized diet and activity recommendations using AI algorithms



Expect heterogeneity: variable response is the rule

Predict it, detect it early, act on it “Personalise care”

Know the patterns

- Pharmacotherapy: ≈10–15% of patients are limited responders even to potent incretins; early response (12–16 wks) strongly predicts 1-yr outcome
- Surgery: roughly 1 in 4 experience suboptimal response or clinically significant recurrent weight gain in long-term cohorts
- Predictors: diabetes duration/severity (e.g. DiaRem score for remission), baseline phenotype, mental health, medications, adherence support
- **It is biology and context — never “failure of willpower”**

Act early — a team protocol

-  Schedule response checkpoints: 12–16 wks (drugs), 6 & 12 months (surgery)
-  If off-trajectory: reassess adherence, dose, side effects, mood, sleep, weight-gain medications
-  Escalate or switch — do not persist unchanged for months (labels advise reassessment if <4–5% at 12–16 wks)
-  Reroute to the right teammate: dietitian, psychologist, pharmacist — before abandoning the pathway



The integrated health team IS the personalization engine



Dietitian

Phenotype-matched MNT, protein & micronutrient safety, pre/post-op nutrition



Nurse / coordinator

Navigation, education, follow-up cadence, early detection of off-trajectory patients



Pharmacist

Titration & side-effect management, interactions, deprescribing weight-gaining drugs, access



Psychologist

Binge-eating, depression, trauma, adjustment, body image — sequencing gatekeeper



Exercise specialist / PT

Resistance training & function — protecting muscle and bone during rapid loss



Surgeon + physician

Shared pathway: indications, procedure choice, medical optimization, escalation

Team-based, chronic-care models improves retention, adherence and outcomes — no single clinician can deliver phenotyping, therapy matching and lifelong follow-up alone.



Personalization across the lifespan: special population tailored pathways



Adolescents

- AAP 2023: offer intensive therapy early — pharmacotherapy from age 12, surgery for severe obesity in selected teens
- Teen-LABS: durable weight loss; T2D remission ≈86% at 5 yrs (higher than adults)
- Family-based, development-aware team care is non-negotiable



Reproductive health

- Fertility often improves rapidly with weight loss — proactive contraception counseling
- Discontinue incretin therapy ≥2 months before planned conception (per labels)
- Tirzepatide may reduce oral contraceptive efficacy — advise back-up at initiation/escalation



Older adults & sarcopenia risk

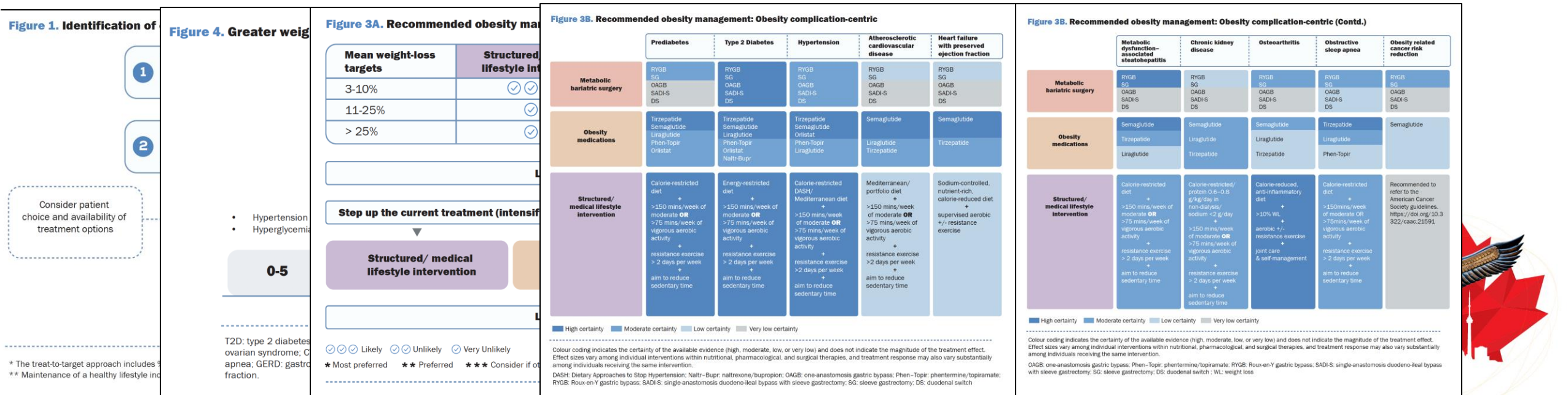
- Lean mass can be a substantial share of weight lost (≈25–40% in DXA substudies) — a real hazard when frail
- Prescribe resistance training + protein 1.2–1.6 g/kg/day; monitor function (chair-stand, grip, gait)
- Target function and independence, not BMI



Future Direction

IFSO/WOF Consensus guidelines

- Global representation, including members of IH – Dietician, behavioural health and OM
- Output: simple messaging for Primary care to help identify, stage and manage PLWO or refer them on

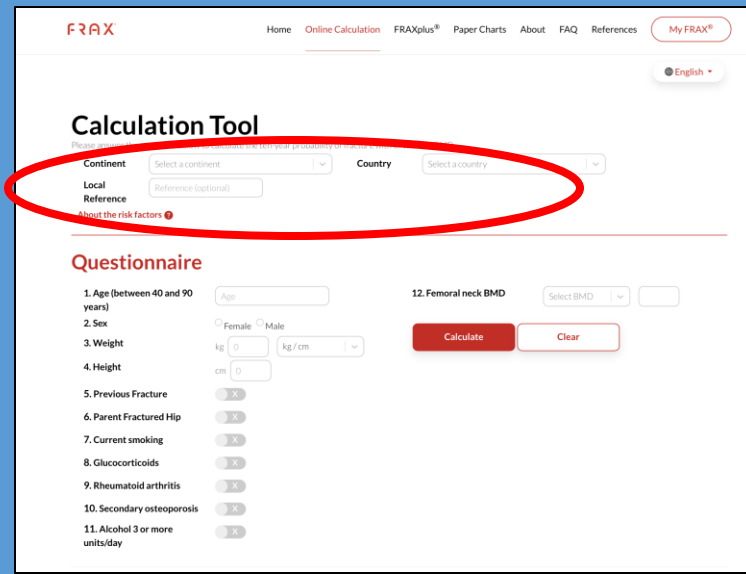


Future Direction

Data-Driven Nature Medicine commission on obesity

- Global representation, and data sources
- Output: A clinical decision support system – free to all - to enable improved access and equity- but also to offer personalised therapies suitable for local health systems

FRAX as an example of a decision support system



Global data used
to assess local risk

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Comment | Published: 12 May 2026
Data-Driven Decision Support in Obesity Management Commission: enabling more equitable and personalized obesity care
[Paul W. Franks](#) ✉, [Sara G. I. Suliman](#) ✉, [Nicholas J. Timpson](#) ✉, [Claudia Langenberg](#) & [Carel W. le Roux](#)
[Nature Medicine](#) **32**, 1959–1961 (2026) | [Cite this article](#)

Personalised obesity management offers better management, early identification, prevention of complications and cost savings (a win-win-win situation)

A data driven decision support system is therefore urgently needed to assist with:

- Predictive modelling to identify high risk individuals
- Assistance in personalising therapy
- Prioritisation of therapy for individuals and healthcare systems



One would not drive blind-folded, nor should we be treating individuals without individualizing investigations and therapy



Personalized care for people living with obesity

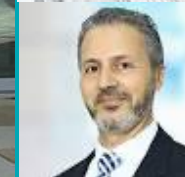
- 1 Diagnose the disease, not the BMI — clinical vs preclinical obesity, staged by severity
- 2 Phenotype every patient: drivers, complications, context and the patient's own goals
- 3 Match therapy to biology — lifestyle always; molecules chosen by complication; surgery timely, tailored, and still the durability benchmark
- 4 Plan the journey, not the event: expect variable response and recurrent weight gain; combine, sequence, and follow for life
- 5 The integrated health team is the intervention — from weight loss to health gain, together

Thank you to every dietitian, nurse, pharmacist, psychologist, exercise specialist, physician and surgeon in this room.

Multidisciplinary Team: Obesity management is a team sport



Sports physician



- **Gastro**
- **Cardiologist**
- **Pulmonologist**
- **Nephrologist**
- **Psychiatrist**
- **Radiologist**
- **Paediatrician**
- **Geneticist**
- **Anaesthetist**
- **Physiotherapist**
- **.....**

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