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TORONTO2026

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



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WILL METABOLIC BARIATRIC PROGRAMS SURVIVE THE TEST OF GLP-1s?





**SRI AUROBINDO
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VISION WITH ACTION

Sri Aurobindo Medical College & PG Institute, Indore



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DISCLOSURE

Mohit Bhandari MD

Consultant to:

- Johnson and Johnson
- Medtronic
- Intuitive Surgical
- Karl Storz
- Stryker
- Apollo Endosurgery
- Pentax
- Olympus
- Novo Nordisk
- Eli Lilly



The Scale of the Epidemic (Global & US)

A Public Health Crisis

More than 1 billion people worldwide live with obesity, yet most receive no evidence-based treatment. No single intervention can meet the scale or heterogeneity of this chronic disease.

1B+

Global Population with Obesity

We need all available tools—both medical and surgical—to address the cascading health effects of this chronic condition.



India's Dual Burden

A Rising Tide

India is facing a rapid rise in obesity. In 2021, almost a quarter of adults aged 15-49 were overweight or obese, rising to nearly 30% by 2024. This trend is visible across both urban and rural populations.

The World Obesity Atlas 2026 ranks India second globally: 41 million children aged 5–19 years live with high BMI, including 14 million with obesity.

~30%

Indian Adults Overweight/Obese (2024)



Indian Market

The "Nutrition Transition"

A shift towards diets higher in processed foods and lower in physical activity, accompanying economic growth and urbanization. This transition is affecting both affluent and poorer households across India.

The Double Burden

India uniquely faces a simultaneous challenge: significant undernutrition coexists alongside a sharply rising rate of obesity, requiring complex, nuanced public health strategies.



The Rise of the Medical Option

A New Era in Treatment

- GLP-1 receptor agonists have fundamentally changed the conversation around weight management globally.
- For decades, the gap between lifestyle intervention and bariatric surgery was virtually empty.
- Now, highly effective medical therapies have entered the mainstream, prompting patients to reconsider their care pathways and shifting the first line of defense.



Pharmacological Innovations

Medical Treatment Options

Medications for obesity management:

- GLP-1 receptor agonists (Incretins –GLP 1) (e.g., Semaglutide)
- Twincretins –GLP1 plus GIP (e.g. Tirzepatide)
- Triple Agonists (GLP-1, GIP, and glucagon) (e.g. Retatrutide)



The Medical Titans

Semaglutide (Wegovy / Ozempic)

A GLP-1 receptor agonist that mimics the incretin hormone. It slows gastric emptying, signals fullness to the brain, and improves insulin secretion. It established the modern baseline for highly effective anti-obesity medications.

Tirzepatide (Zepbound / Mounjaro)

A dual GIP/GLP-1 receptor agonist. By targeting multiple hormonal pathways, it has demonstrated even higher efficacy in clinical trials, pushing non-surgical weight loss expectations closer to the 20% mark.



The GLP-1 Appeal

- ▶ **Non-Invasive:** Avoids the risks associated with anesthesia, incisions, and surgical complications.
- ▶ **Substantial Weight Loss:** Patients routinely achieve 15% to 20% total body weight loss.
- ▶ **Cardiovascular Benefits:** Proven to reduce the risk of major adverse cardiovascular events (MACE).
- ▶ **Minimal Downtime:** Patients can incorporate weekly injections into their routine without taking time off work for recovery.
- ▶ **Non-procedural:** Treatment can be stopped, although discontinuation commonly leads to weight regain.



Unprecedented Adoption (US Data)

9.2%

Study Pop. Usage (2022-2024)

Skyrocketing Prescriptions

In U.S. claims data from 2022–2024, 9.2% received GLP-1 receptor agonists and 0.4% underwent metabolic and bariatric surgery—while more than 90% received neither treatment.

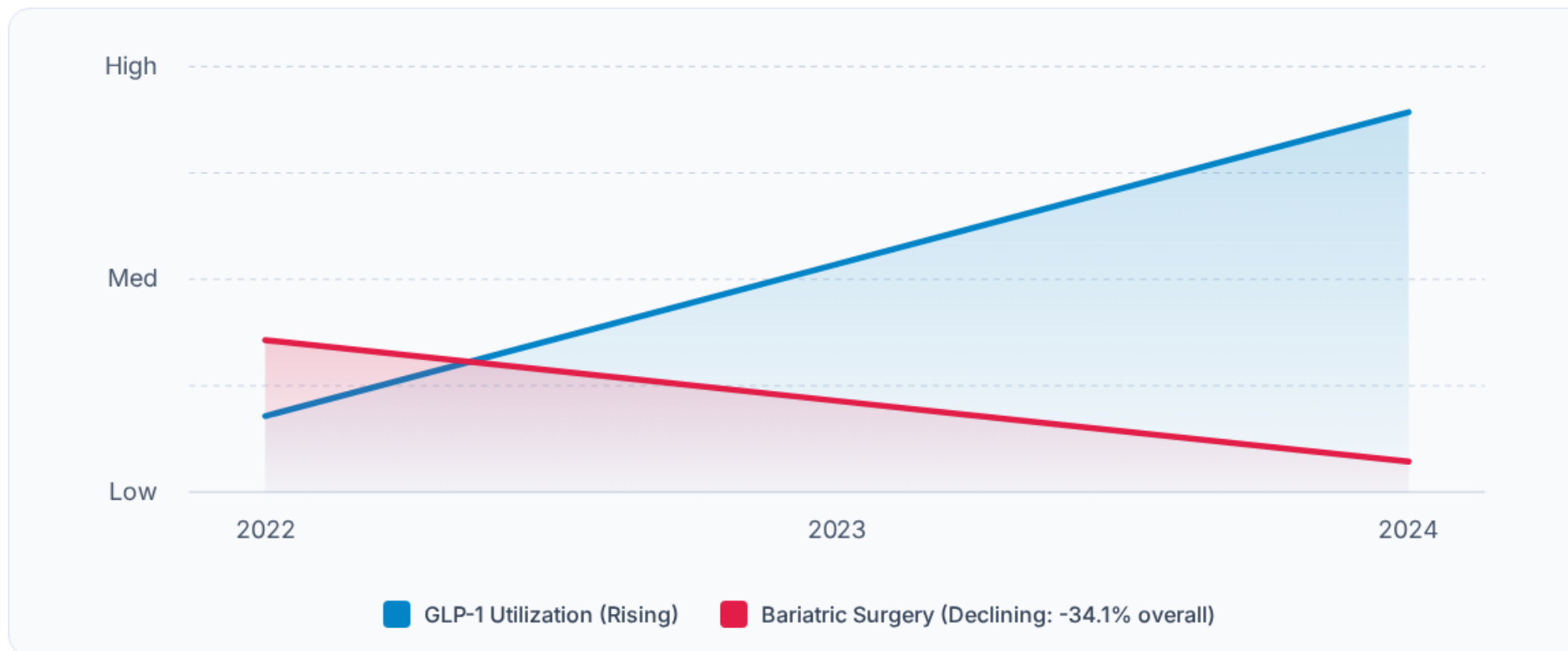
— HARVARD T.H. CHAN SCHOOL OF PUBLIC HEALTH (2026)



The Impact on Bariatric Surgery

Is this the end of surgery—or the
beginning of integrated care?





From 2022 to 2024, GLP-1 RA use rose 140.4% while metabolic and bariatric surgery use fell 34.1% in U.S. claims data.



Drivers of the Surgical Slowdown

Patient Preference

Many patients prefer to begin with a non-procedural option. The accessibility and perceived ease of GLP-1 therapy are reshaping the pathway to surgery.

Insurance & Cost Hurdles

In many regions (including India), out-of-pocket costs drive decisions. While surgery is a high upfront cost, long-term GLP-1 use can become even more expensive over a lifetime, especially without robust insurance coverage.



The Defense of Surgery

Why surgery remains essential in comprehensive obesity care.

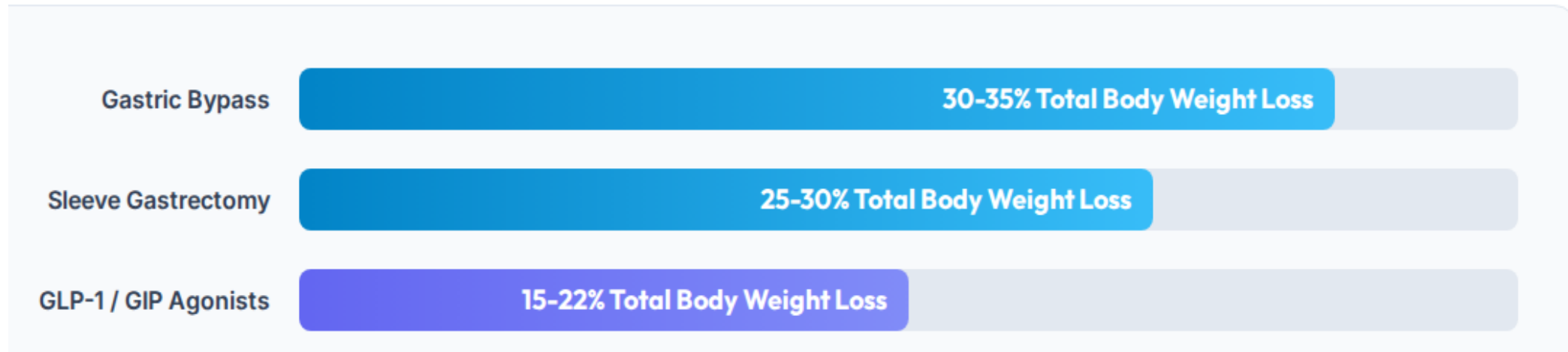


The Gold Standard

- ▶ **Decades of Data:** Bariatric surgery has over 60 years of proven long-term results regarding safety and durability.
- ▶ **Maximum Efficacy:** Remains the most effective treatment for severe obesity (BMI > 40), yielding 25% to 35% sustained weight loss.
- ▶ **Metabolic Effects:** Surgery alters gut–brain signalling, bile-acid pathways and appetite regulation—not merely food intake.
- ▶ **Long-Term Remission:** Achieves significantly higher rates of type 2 diabetes remission than medications alone.



Weight Loss Efficacy Comparison



In a 2026 analysis of 30 comparative studies (>430,000 patients), surgery produced >20 percentage points greater weight loss at 12 months.



Surgical Superiority in Comorbidities



Type 2 Diabetes

Type 2 diabetes remission was 42 percentage points higher after surgery than with GLP-1 therapy at 12 months.



Hypertension

Hypertension remission was 12.8 percentage points higher after surgery at 12 months.



High Cholesterol

Hyperlipidaemia remission was 20.8 percentage points higher after surgery at 12 months.



Durability is Key

The Surgical Advantage

- Obesity is a lifelong disease. The greatest vulnerability of medical therapy is adherence and tolerance. Once medications are discontinued, benefits frequently diminish rapidly.
- Because surgery permanently alters the anatomy and gut-brain signaling axis, the benefits are highly durable over a patient's lifespan, outlasting the temporary suppression of injectables.



The Limitations of GLP-1s

Where medication alone may fall short.



Why Patients Discontinue GLP-1s



Financial Burden

Costs can be prohibitive, especially in markets like India where out-of-pocket expenses dominate. Lifetime continuous use becomes a major economic barrier.



Tolerability

Nausea, vomiting, diarrhea, and severe constipation are common. For a significant percentage of patients, these GI side effects make long-term use intolerable.



Supply Chain Issues

Unprecedented global demand has led to chronic shortages. Patients frequently experience interruptions in care, which disrupts their metabolic progress.



The Rebound Effect

- ▶ **Chronic Condition Reality:** GLP-1s treat obesity while actively taken; they do not cure it.
- ▶ **Weight Regain:** In the STEP 1 extension, participants regained about two-thirds of their prior weight loss within 1 year after stopping Semaglutide/Tirzepatide.
- ▶ **Return of Comorbidities:** As weight returns, so do associated conditions like hypertension and diabetes.
- ▶ **Long-Term Treatment:** Patients need realistic counselling about duration, adherence, access, cost and monitoring.



Synergy, Not Competition

The future is comprehensive, sequential and combined
care.



Combining Forces



Pre-Op Optimization

Using GLP-1s prior to surgery to induce initial weight loss, shrink the liver, and make the subsequent surgical procedure safer and technically easier.



Managing Plateaus

When weight loss plateaus after surgery, anti-obesity medication can provide clinically meaningful additional loss.



Long-Term Rescue

For post-surgical weight recurrence, GLP-1 therapy can be an effective adjunct and may reduce the need for revisional procedures.



The Complex Patient

Surgery for Severe Cases

- The Harvard study noted that patients who underwent surgery tended to be more medically complex than those prescribed GLP-1s or receiving no treatment.
- This reinforces surgery's role as the definitive treatment for advanced obesity and severe metabolic syndrome, while GLP-1s may serve a broader, less acute population



The Evolution of Programs

Adapting to survive and thrive in the GLP-1 era.



From Surgical to Metabolic Centers

- ▶ **The Risk:** Programs defined only by procedures may lose relevance as treatment begins earlier and increasingly with medication.
- ▶ **The Pivot:** Evolve from a surgical service into a comprehensive metabolic and obesity-care centre.
- ▶ **Broader Access:** In-house medical treatment brings more patients into evidence-based care and supports appropriate escalation.
- ▶ **Continuity of Care:** When medical patients inevitably plateau or seek permanent solutions, the surgical team is already their trusted provider.



The New Multidisciplinary Team



Bariatric Surgeons

Remaining the core experts in anatomical metabolic change, handling severe obesity, and performing complex initial and revision surgeries.



Obesity Medicine Specialists

Physicians dedicated to prescribing, managing, and titrating complex anti-obesity medications, managing side effects and prior authorizations.



Dietitians & Therapists

Critical for ensuring nutritional adequacy, preventing muscle loss, and addressing the behavioral roots of obesity across all modalities.



Program Survival Strategies

Proactive Education

Clinics must educate patients upfront about the long-term data. Transparency about GLP-1 discontinuation rates, lifetime costs, and the superior durability of surgery builds trust and sets realistic expectations.

Streamlined Care Pathways

Create seamless transitions between medical, endoscopic and surgical pathways, with clear escalation criteria and shared follow-up.



The Surgical Mandate

"While GLP-1 medications are an important advance, they do not match the magnitude or durability of outcomes achieved with metabolic and bariatric surgery, which remains one of the most underutilized treatments in medicine."



Addressing Muscle Mass

- ▶ **The Hidden Risk:** Both surgery and GLP-1s cause rapid weight loss, which inherently includes the loss of lean muscle mass.
- ▶ **GLP-1 Concerns:** Studies highlight that a significant portion of weight lost on GLP-1s can be lean mass, raising concerns about sarcopenia.
- ▶ **The Program Advantage:** Comprehensive bariatric programs are uniquely equipped to mitigate this through established nutritional counseling and physical therapy partnerships.
- ▶ **Protect Lean Mass:** Embed resistance training, adequate protein and functional monitoring across every treatment pathway.



Treatment Modality Comparison (Overview)

Feature	GLP-1 / GIP Agonists	Bariatric Surgery
Avg. Weight Loss	15% - 22% (at 72 weeks)	25% - 35%+
Financial Cost	High, recurring (Lifetime)	High, upfront (One-time)
Durability	Low (Regain upon stopping)	High (Anatomical change)
Invasiveness	Low (Subcutaneous injection)	Moderate (Laparoscopic surgery)
Diabetes Remission	Moderate (While taking drug)	Superior (Highly durable)



MOHAK-Algorithm

AOMs vs. Surgery vs. Endoscopy ?

Patient Profile	Ideal Treatment Approach
BMI 27–35 kg/m ² with metabolic disease	AOMs ± ESG
BMI 35–40 kg/m ² , hesitant about surgery	ESG ± AOMs
BMI 40+ kg/m ² , multiple comorbidities	Bariatric surgery
Post-bariatric weight regain	AOMs ± Endoscopic revision
Ineligible for surgery (high risk)	AOMs ± Endoscopic treatment



The Verdict: Integration Is Survival

A Thriving Future

- Programs built around one modality will struggle. Programs that integrate medication, endoscopy, surgery, nutrition, physical activity and long-term follow-up can lead the next era of obesity care.
- *GLP-1s are not the test bariatric programs must survive. Fragmented care is. The programs that integrate every effective modality will become the centre of lifelong obesity care.*



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"Advancing Multimodal Obesity Care"

24-27 August 2027

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