CASE 1

Does She Even Qualify?

BMI 33.5 — Clinical Obesity vs. Bariatric Eligibility

The Future Is Not Less Surgery — It Is More Demanding Surgery

Moderator: R. Cohen

Patient Snapshot

39-year-old woman, referred while on semaglutide 2.4 mg

CONFIRMING THE DIAGNOSIS — BMI ALONE DOESN'T ESTABLISH EXCESS ADIPOSITY BELOW 40 KG/M²

33.5

Current BMI (kg/m²)
35.6 pre-therapy

108

Waist circumference (cm)

0.65

Waist-to-height ratio
threshold is >0.5

THE CLINICAL PICTURE

−11%

TBWL on semaglutide
9 months — plateaued

2

HF hospitalizations
in past 12 months

1

MI + coronary stent 4 y ago

Three Organ Systems, One BMI Number

Severity here is not tracking with the number on the scale — and not every line below is airtight

C

Cardiac

HFpEF and Previous Cv event

- LVEF preserved at 55%
- CV event 4 y ago
- NT-proBNP persistently elevated
- 2 decompensation admissions in 12 mo
- NYHA class II–III
- *Also 12 years of hypertension — obesity's causal contribution is contested*

H

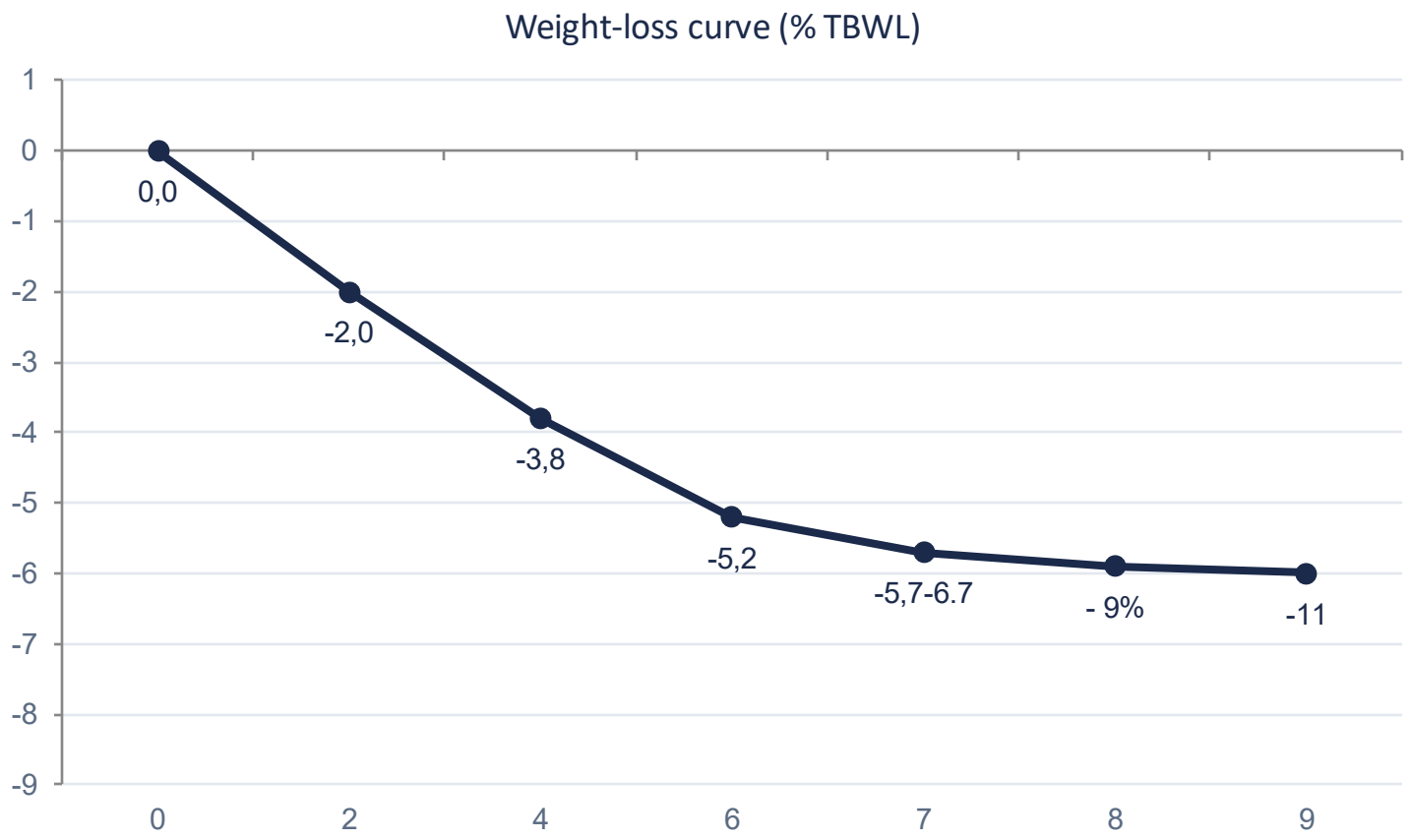
Hepatic

MASH

- ALT 68 U/L, persistently elevated
- FibroScan-confirmed F1–F2 fibrosis
- No decompensation to date
- Fibrosis stage unchanged since drug start
- *No biopsy performed — fibrosis stage is estimated, not histologic*

A Real Response — Then a Plateau

9 months of semaglutide 2.4 mg — the only pharmacotherapy tried so far



What the curve doesn't show

3 months pre-referral

1st HF decompensation admission — before semaglutide was even started

Month 7

2nd HF decompensation admission — despite ongoing weight loss

Month 9 (now)

At the labeled maintenance dose. Tolerating it well — she is not obviously drug-limited

A real response. Not enough. And she's already at her ceiling on this drug.

Escalate to Tirzepatide, or Operate Now?

She's at semaglutide's maintenance dose, plateaued at −6% TBWL. The room has to decide.

OPTION A

Escalate to Tirzepatide

THE CASE FOR

- Dual GIP/GLP-1 agonism — meaningfully higher average efficacy in head-to-head trials
- She's tolerated GLP-1 therapy well so far — reasonable odds she tolerates the switch
- Avoids surgical risk in a patient with active HFpEF and hypoventilation

THE CASE AGAINST

- No guarantee of response — she may simply plateau again, one tier up
- More time on a trial-and-error drug switch while her cardiac trajectory is already established
- Sequential-agent access and reimbursement aren't guaranteed in every system

OPTION B

Operate Now

THE CASE FOR

- Removes her from a slow, uncertain drug-switching cycle while organ disease is active
- Strongest, most durable evidence base of any intervention on HFpEF and OSA outcomes
- Meets the 2022 ASMBS/IFSO and Lancet clinical-obesity criteria today

THE CASE AGAINST

- BMI 33.5 falls outside classic thresholds many payers and committees still use
- Operating on unoptimized, active HFpEF and early hypoventilation is its own hazard
- Forecloses whatever a drug class switch might still have offered
- The ASMBS/IFSO 30–34.9 tier was built around T2D, not her complications

Two defensible answers. The panel has to pick one.