

Incorporating GLP-1s and Data Collection



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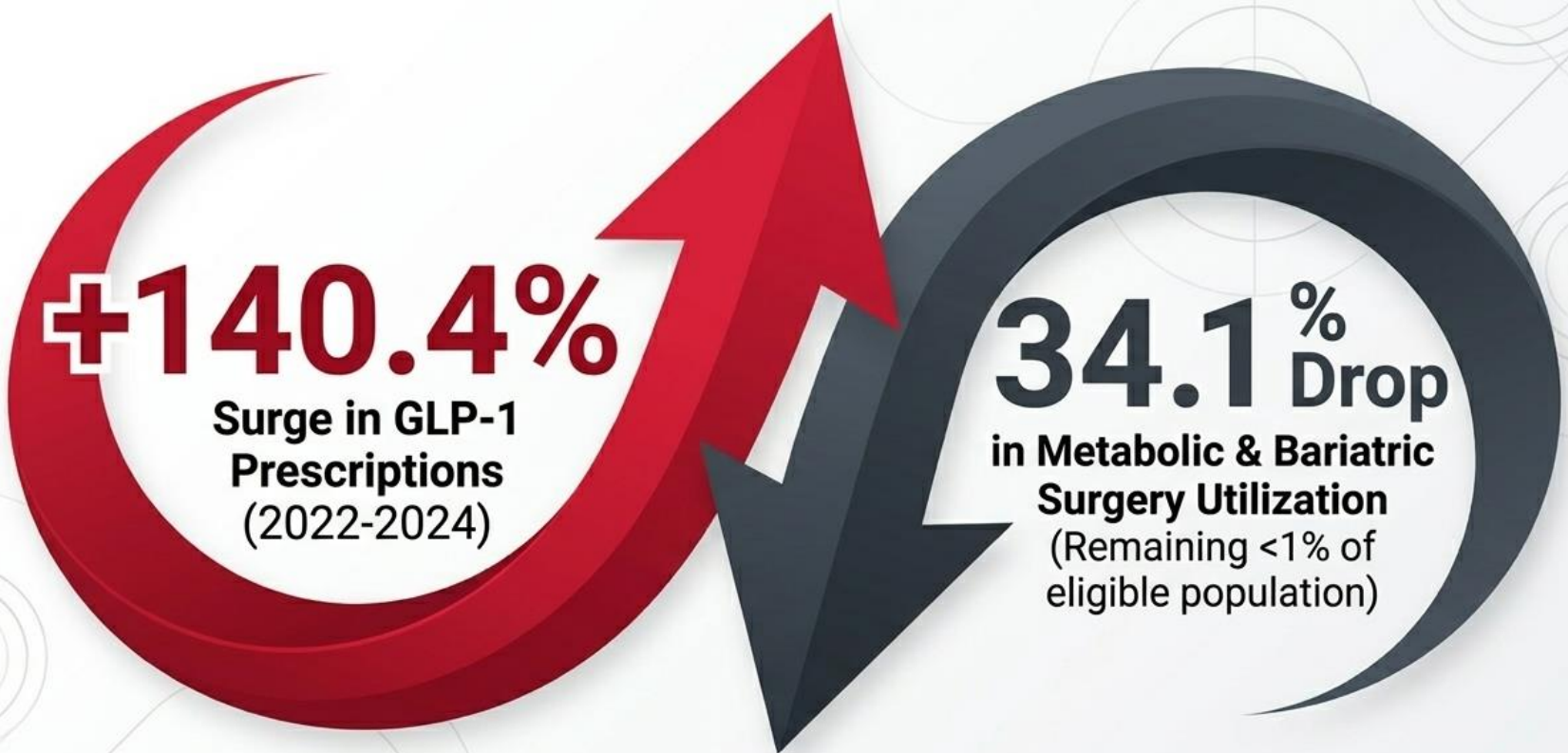
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Disclosures

- Ethicon Consultant
- Boston Scientific Consultant
- Optum Consultant
- American College of Surgeons Surveyor

The GLP-1 Impact

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+140.4%

**Surge in GLP-1
Prescriptions
(2022-2024)**

34.1% Drop

**in Metabolic & Bariatric
Surgery Utilization
(Remaining <1% of
eligible population)**

Over 90% of the eligible population receives neither treatment. GLP-1s are not a replacement for surgery; they are a massive expansion of the addressable market.

NotebookLM

GLP-1 US Utilization

Four years of uptake

United States, 2022 – 2026

11%

of US adults currently take a GLP-1 for weight loss — up from 3% in 2024

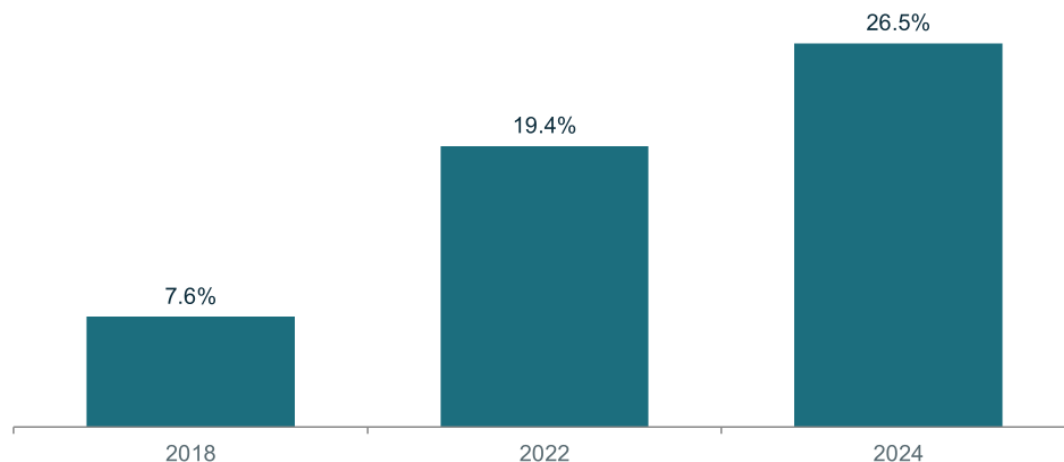
~10M

US adults using a GLP-1 in 2025

~300×

growth in GLP-1 prescriptions, 2018–2025, in a 20-million-patient EHR cohort

GLP-1 injectable use among US adults with diagnosed diabetes

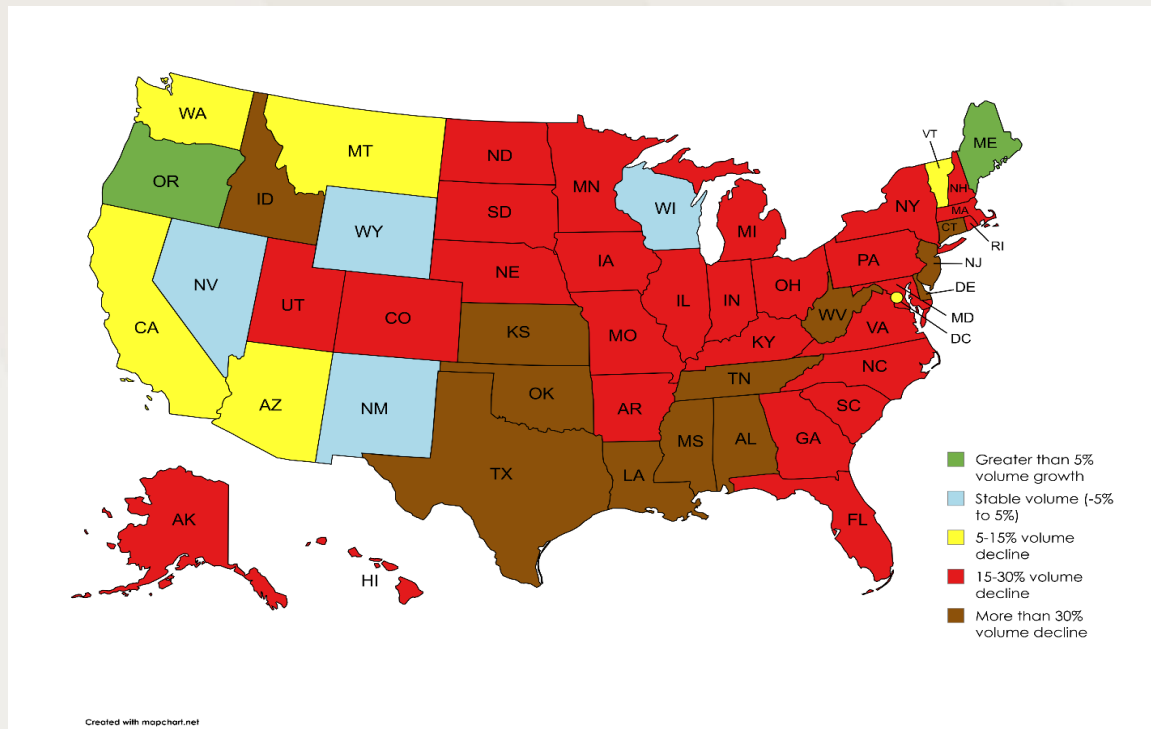


26.5% equates to 6.9 million adults with diabetes — and that is only the labelled diabetes indication.

Gallup, GLP-1 usage reaches new high, 2026. • Vahratian A, Warren A. NCHS Data Brief No. 537, Aug 2025. • KFF Health Tracking Poll, Nov 2025. • Forbes Health GLP-1 statistics, 2026. • UCSD real-world analysis, presented ASMBS 2026 (ASMBS news release, 5 May 2026).

The decline is geographically pervasive

State-level rate of change, 2022 – 2024 (n=883 continuously participating centres)

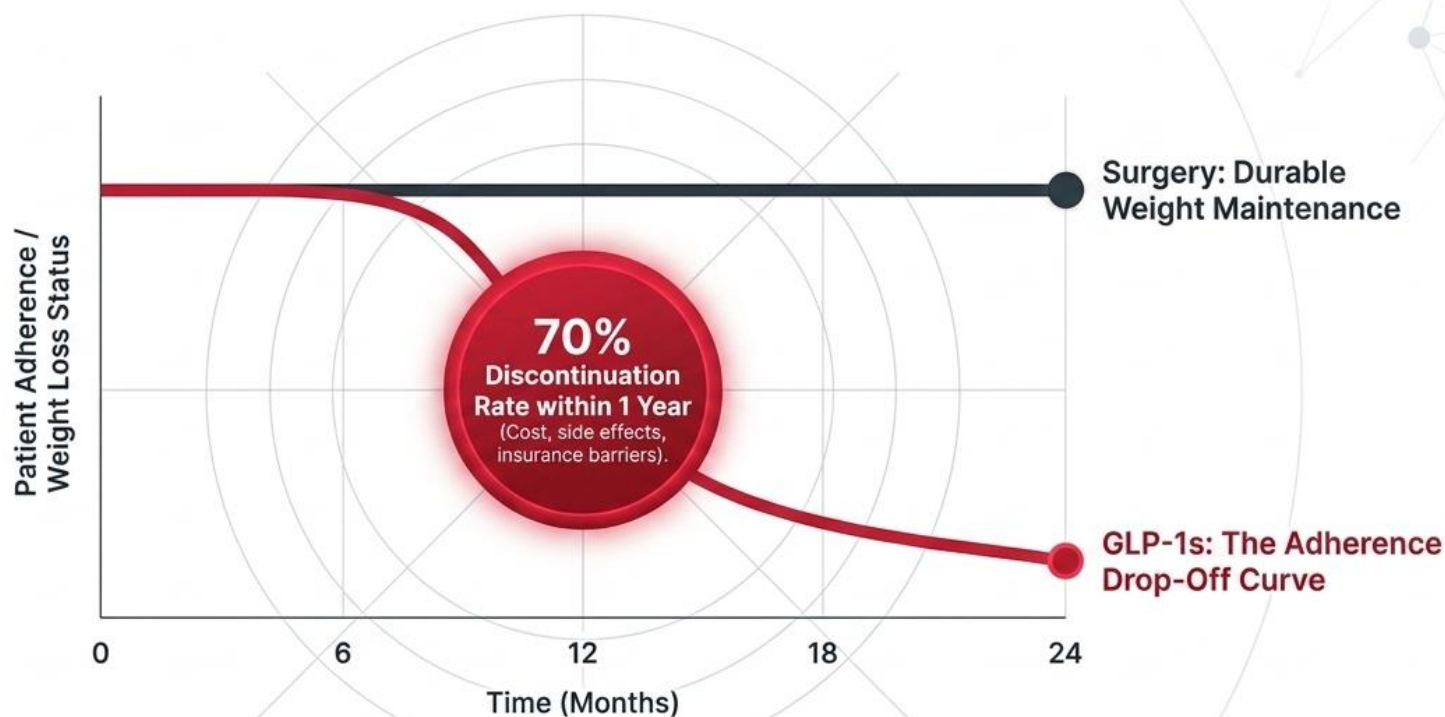


- 39 states lost more than 15% of volume
- 12 states lost more than 30%, concentrated in the South
- Only Oregon and Maine grew by more than 5%
- The states with the highest obesity prevalence declined the most

Disease burden and treatment delivery are moving in opposite directions.

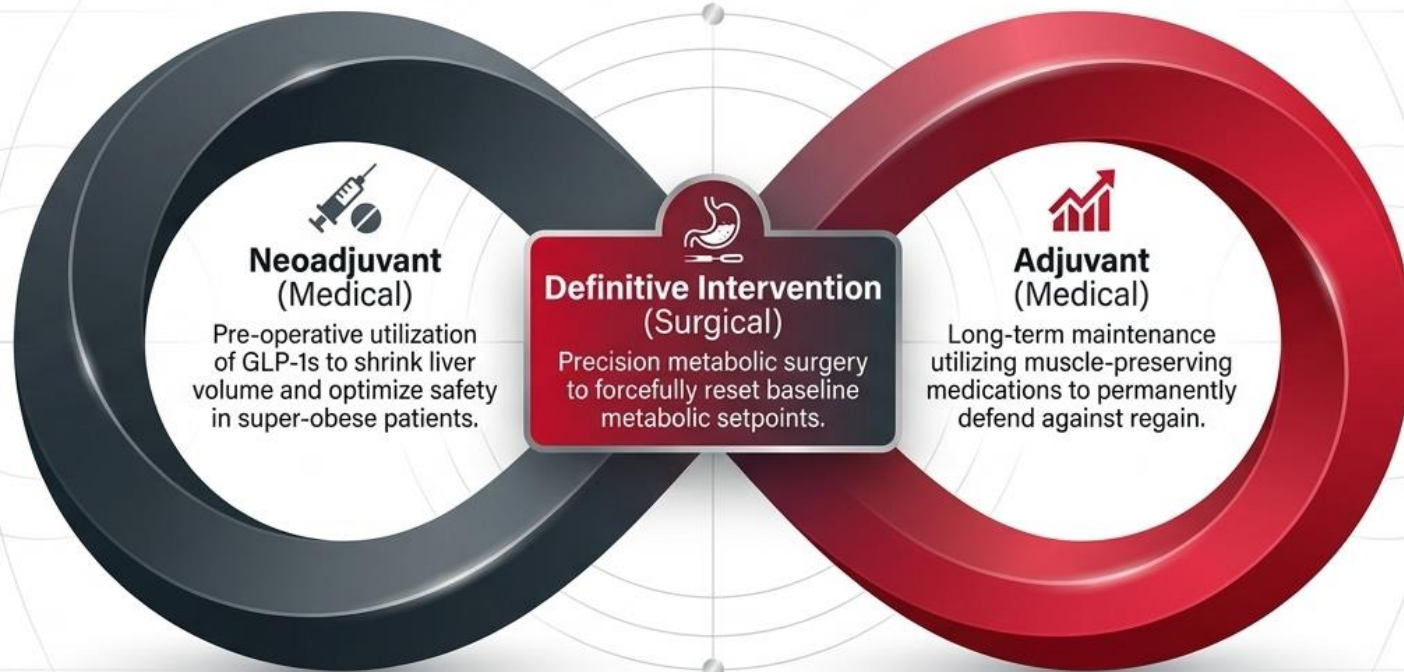
Figure 1 from Northup CJ, Albaugh VL, Clapp B, et al. ASBMS 2022–2024 procedural volume assessment (in press). • CDC adult obesity prevalence maps, 2024.

Patient Adherence & The Conversion Opportunity



Discontinuation leads to **proportional weight recidivism**. These patients do not leave the market; they become prime surgical candidates.

The “Cancer Model” of Obesity Care



“Obesity is a chronic, relapsing disease requiring a lifelong continuum of multimodal therapies.”

The Economics of the Infinity Model

The Attrition Opportunity:

70% of GLP-1 patients drop out within 1 year
-> Converted to surgical candidates.

The Breakeven Point:

Surgery becomes more cost-effective than continuous medications within 9 to 16 months.



Key Insight: Capturing the patient for decades yields vastly **higher lifetime value** than a single, episodic surgical fee.

The Paradigm Shift: Redefining Practice Survival

	Traditional Bariatric Practice	Comprehensive PCP Weight Model
Core Philosophy	Episodic Surgical Event. Acute intervention.	Chronic, Life-long, Relapsing Disease. Multi-factorial management.
Treatment Modality	Surgery-Centric. Single primary pathway.	Multimodal Ecosystem. Lifestyle, Integrative, Medical, Surgical.
Patient Access	Single Hospital Entry Point. Vulnerable to non-surgical attrition.	Distributed Network. Telemedicine and APP offices feeding the surgical hub.

How US health systems are absorbing the shift

Consolidation, closure, and repositioning

Program Closure

Hospital-based programmes have closed outright; elsewhere retiring bariatric surgeons are not being replaced. One regional insurer reported the number of bariatric operations it paid for halved over five years.

Loss of a profitable service line

Bariatric surgery has been a reliable contribution-margin service. Its contraction compounds post-pandemic financial pressure and weakens the case for institutional investment in obesity infrastructure.

Repositioning as comprehensive obesity centres

Surviving programs are absorbing pharmacotherapy, endoscopic therapy, nutrition, behavioural health and body contouring — trading procedural volume for longitudinal obesity care.

Philadelphia Inquirer, Bariatric surgery programmes face upheaval amid growing GLP-1 use, Feb 2026. • Medscape, Bariatric surgery adapts to the GLP-1 era, Apr 2026. • Lin K, Mehrotra A, Tsai TC. JAMA Netw Open 2024;7:e2441380. • Rohde SC, Chao GF, Abdel-Rasoul M, et al. JAMA Surg 2026, online ahead of print.

The GLP-1 Data Collection

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THE ASSET WE ALREADY HAVE

What MBSAQIP collects today

~959

participating
centers

177,789

cases in the
2024 PUF

200+

standardized
variables

≤ 5%

audit disagreement
rate required

1 Preoperative

- Demographics, BMI, functional status, ASA class
- Diabetes (diet / non-insulin / insulin), hypertension, GERD, OSA, hyperlipidemia
- Renal insufficiency, dialysis, COPD, tobacco use
- Prior VTE, MI, PCI, cardiac surgery; therapeutic anticoagulation
- Prior bariatric and foregut procedures

2 Operative & 30-day

- Procedure type, approach, revision / conversion detail
- Operative time, concurrent procedures
- Leak, bleed, SSI, VTE, readmission, reoperation, reintervention, mortality
- Five linked datasets: main, reoperation, readmission, intervention, BMI

3 Longitudinal

- 6-month and 1-year long-term follow-up files
- Weight at each follow-up interval
- Comorbidity status and remission
- Powers the MBSAQIP Bariatric Surgical Risk/Benefit Calculator

ACS MBSAQIP Participant Use Data File and Operations Manual; Optimal Resources for Metabolic and Bariatric Surgery, 2026 Standards.

WHERE THE DATA DISAPPEARS

One patient, four decision points

1

Neoadjuvant

GLP-1 RA as a bridge:
risk reduction, BMI
reduction, or change in
therapy?

2

Perioperative

Held or continued?
Retained gastric contents,
aspiration risk.

3

Adjuvant

Started early after
surgery for inadequate
weight loss, food noise,
other?

4

Recurrence

Started years later for
weight regain or
comorbidity relapse.

Captured in MBSAQIP today: the operation in the middle.

All four medication decisions sit outside the record without meaningful detail including which medication— each variable changes the exposure, the risk, and the outcome we then attribute to the operation.

We are attributing outcomes to an operation while an increasingly powerful co-intervention goes relatively unrecorded.

A registry that records only the operation will only ever tell half the patient story in 2026.

1 Medication exposure must be more than a single variable

2 The obesity medicine wall has to come down

Non-procedural patients at accredited centers should be in the registry

3 Health gain is the outcome to measure

We cannot measure it while half the treatment is invisible.

Ideal Data Collection

- Medication Dosing
- Duration of Treatment
- Impact of Weight Related Disease
- Side Effects- Mild/Severe
- Cessation Rate- Cause?
- Long Term Impact
- Recurrence

Three future needs

1

Define a minimum medication dataset

- Agent class and specific agent
- Indication (obesity / T2D / both)
- Start date and cumulative duration
- Dose and titration status
- Date of last dose before surgery
- Status at each LTFU interval

2

Link, rather than abstract

- Pipe pharmacy fill data in — do not ask reviewers to hunt for it
- Pilot in integrated systems first (VA, Kaiser, provincial systems)
- Bring medically managed patients into the denominator
- This is EHR data-linkage applied to medications

3

Randomize inside the registry

- Hold interval before induction
- Adjuvant pharmacotherapy vs revision for weight recurrence
- Neoadjuvant GLP-1 vs standard preparation in high-risk patients

Peri-operative safety

Does preoperative GLP-1 exposure change 30-day risk?

Leak, bleed, reoperation, readmission — risk-adjusted, at a sample size no trial will ever reach.

How long is long enough to hold?

Society guidance still conflicts on hold intervals and fasting. A registry with dose and last-dose date could settle it empirically.

Does aspiration risk differ by agent and by escalation phase?

Semaglutide versus tirzepatide; maintenance dose versus active titration.

Does medication-induced preoperative weight loss reduce operative risk?

Or does it simply select a different patient? Only a registry can separate the two.

Challenges

- Large Patient Numbers
- Extraction Difficulties
- Numerous Variables
- Stopping/Starting Medication
- Lack of Follow up

The current state MBSAQIP challenge

1

Chart review cannot see outside the chart

MBSCRs abstract from the medical record. A prescription written by a primary care physician, a telehealth platform or a med spa is simply not there to abstract.

2

The product is not always identifiable

Compounded and direct-to-consumer semaglutide and tirzepatide leave no reliable NDC or dose trail — and enforcement has been reshaping that market month to month.

3

Exposure is not a yes/no variable

Agent, indication, start date, dose, titration phase, last dose before surgery, cumulative duration. A single checkbox will produce a uselessly noisy variable.

4

Abstraction burden is real

Reviewers are already at capacity and audited at a five percent disagreement threshold. Every field we add must be defensible, definable and auditable.

Even perfect capture leaves hard problems

54%

of patients discontinued a GLP-1 RA within one year — 65% among those without type 2 diabetes; 72% and 84% respectively by two years.

Data governance

Linking a surgical registry to pharmacy claims across two countries, fifty states and ten provinces raises consent, privacy and data-use questions Sweden simply does not face.

1 Adherence, not prescription, is the exposure

A filled prescription is not a treated patient. Persistence must be modelled, not assumed.

2 Difference by indication runs both ways

Patients who reach surgery are sicker and more complex than those who receive medication.

3 Adjuvant Use Creates Problems for Data Collection

Post-operative medication start dates create classic survivor bias unless handled with target trial methods.

4 Long Term Follow up

Patients lost to long-term follow-up are the ones most likely to have changed treatment.

The GLP-1 Horizon

Oral agents, higher-efficacy injectables, and the unanswered question

Dec 2025

Oral semaglutide 25 mg (Wegovy pill) approved — first oral GLP-1 for weight management

Mar 2026

Semaglutide 7.2 mg high-dose injectable approved

Apr 2026

Orforglipron (Foundayo) approved — first small-molecule oral GLP-1, no food or water restriction

Pending

CagriSema filed Dec 2025; REDEFINE-4 missed non-inferiority vs tirzepatide (20.2% vs 23.6% at 84 weeks)

Phase 3

Retatrutide TRIUMPH-1 reported ~25–28% weight loss (May 2026); survodutide, MariTide, amycretin behind it

None of these agents has been tested prospectively in BMI ≥ 40 kg/m². Efficacy attenuates as metabolic disease advances — precisely the population for whom surgery remains indicated.

FDA approvals: oral semaglutide 22 Dec 2025; semaglutide 7.2 mg 19 Mar 2026; orforglipron 1 Apr 2026. • McGowan B, Ciudin A, Baker JL, et al. Nat Med 2025;31:3317–29. • Davies M, Færch L, Jeppesen OK, et al. Lancet 2021;397:971–84. • Novo Nordisk REDEFINE-4, Feb 2026. • Eli Lilly TRIUMPH-1, May 2026.

Conclusion

- GLP-1s Have Dramatically Impacted Surgical Volume
- Compounding of GLP-1s Remains a Marginal Practice and High Risk for Litigation
- GLP-1s Have Started a New Conversation Around Weight Loss
- Data Collection is Mandatory to Evaluate these Treatments

An aerial photograph of the Vanderbilt University Medical Center campus. The image shows several large, multi-story brick and glass buildings. In the foreground, there is a paved plaza with a brick pattern, a few people walking, and a person on a bicycle. Lush green trees are scattered throughout the scene. The sky is blue with some white clouds. Large white text is overlaid on the image.

Thank you!

Questions?

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