Obesity Management Medications & Metabolic/Bariatric Surgery: The present and not the Future

Ricardo Cohen

Chair, World Obesity Federation Clinical Care Committee

President IFSO Global 2024-2025

President Brazilian Society for Metabolic and Bariatric Surgery (SBCBM) 2011-2012

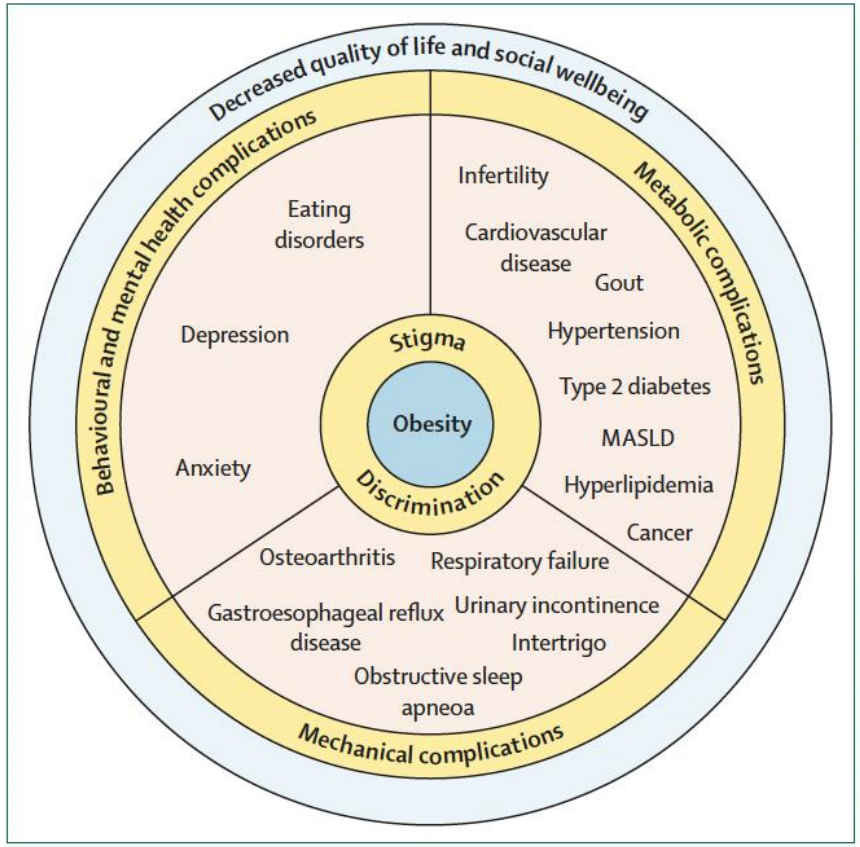
President IFSO LAC 2018-2019

Disclosures

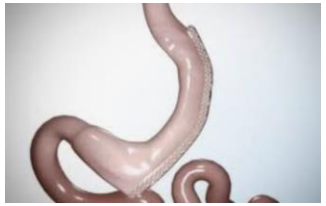
- Research Grant, Johnson & Johnson
- Research Grant, Medtronic
- Research Grant, Hospital Oswaldo Cruz Bioscience Institute
- Research Grant,Marlex, Brazil
- Speaker, Johnson & Johnson, NovoNordisk,Lilly,Merck, Boston Scientific
- SAB: Morphic Medical, Medronic, Johnson & Johnson,Regeneron

Is Not Just “Weight”

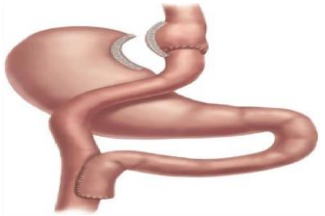
Clinical obesity is a multifaceted complex disease with signs, symptoms and complications



Lingvay I, Cohen RV et al, Lancet 2024



Bariatric/metabolic Surgery



- ✓ Long-term significant WL (Sjostrom L,JAMA,2012)
- ✓ Physiologic mechanisms (Cummings D, D Care 2006)
- ✓ Durable T2D remission (glucocentric endpoint(Courcoulas A,JAMA 2024)
- ✓ Renoprotective (Cohen RV, Lancet EC,2022)
- ✓ Decrease CV risk factors (Sjostrom L,JAMA,2012)
- ✓ Decrease CV events and mortality (Aminian A, JAMA,2019)
- ✓ Safe (Arterburn D, JAMA 2022)

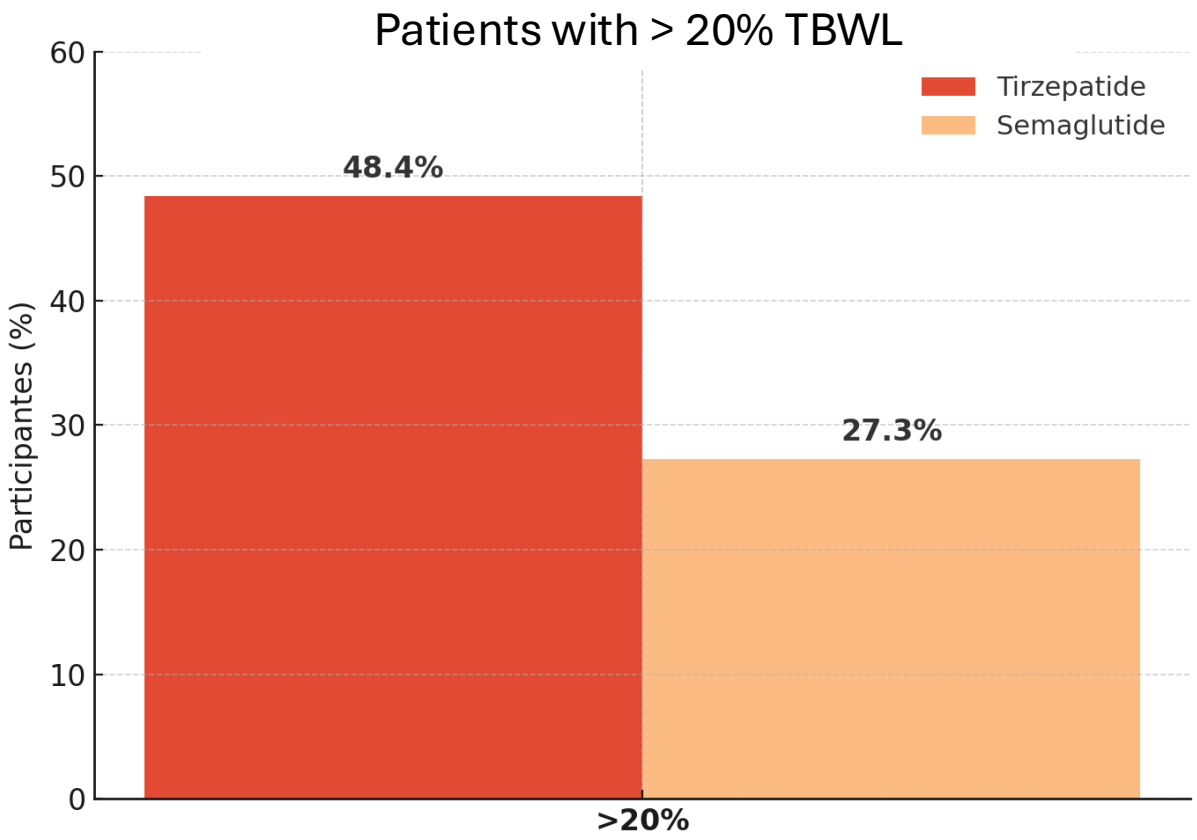
The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Tirzepatide as Compared with Semaglutide for the Treatment of Obesity

Louis J. Aronne, M.D.,[1] Deborah Bade Horn, D.O.,[2] Carel W. le Roux, M.D., Ph.D.,[3,4] Wayne Ho, M.D.,[5,6] Beverly L. Falcon, Ph.D.,[7] Elisa Gomez Valderas, M.Sc.,[7] Sagar Das, M.Sc.,[7] Clare J. Lee, M.D., M.H.S.,[7] Leonard C. Glass, M.D.,[7] Cagri Senyucel, M.D., Ph.D.,[7] and Julia P. Dunn, M.D.,[7] for the SURMOUNT-5 Trial Investigators*

May /25



Retatrutide (TRIUMPH-1)

Phase 3 topline obesity results from Eli Lilly • May 21, 2026

Investigational once-weekly triple agonist: GIP + GLP-1 + glucagon

2 MAIN HEADLINE

Up to 28.3%

mean weight loss at 80 weeks

4 mg	9 mg	12 mg	Placebo
-19.0% (-47.2 lb)	-25.9% (-64.4 lb)	-28.3% (-70.3 lb)	-2.2% (-5.5 lb)

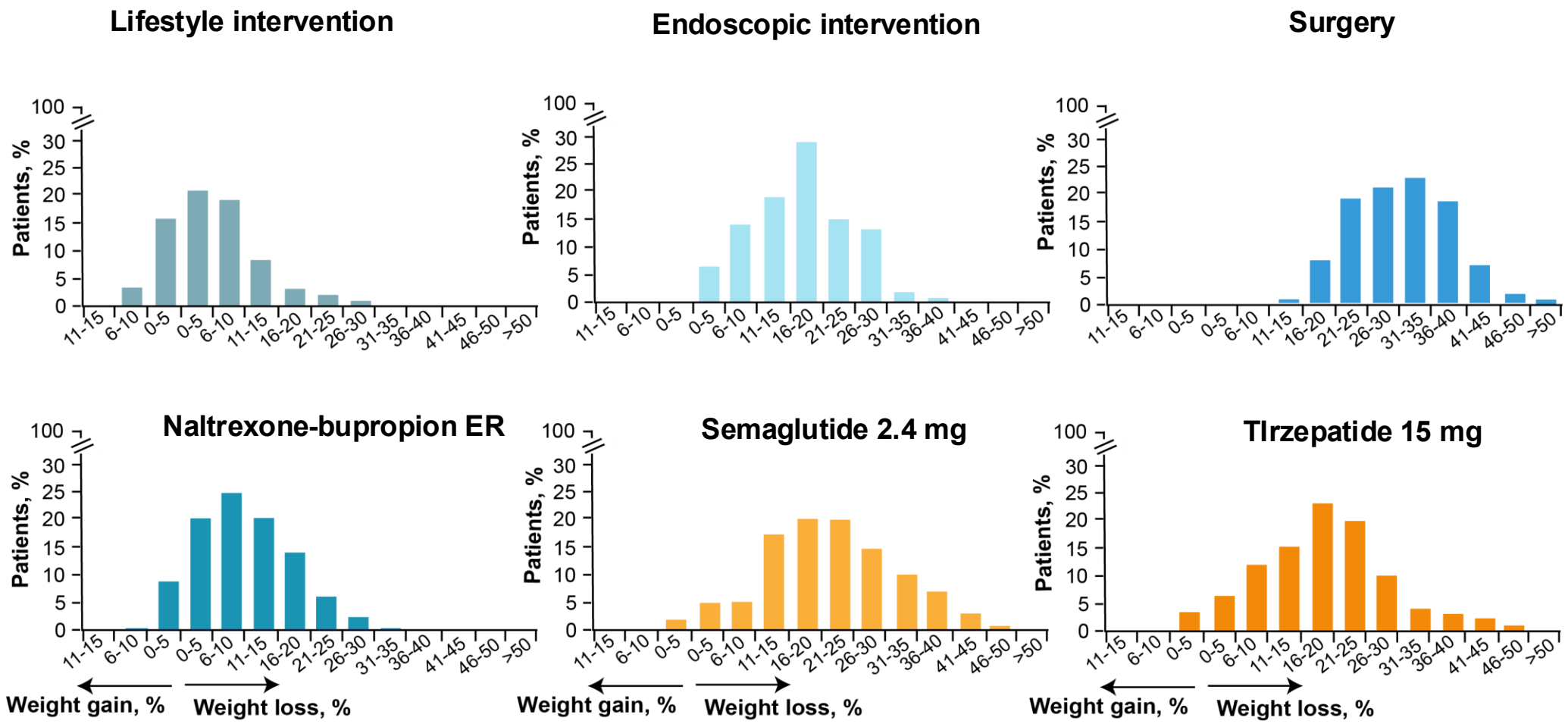
All 3 retatrutide doses met primary / key secondary obesity endpoints.

3 HOW MANY PATIENTS REACHED MAJOR WEIGHT-LOSS THRESHOLDS?

	4 mg	9 mg	12 mg	Placebo
≥25% loss:	27.8%	52.9%	62.5%	2.2%
≥30% loss:	15.3%	37.9%	45.3%	0.5%
≥35% loss:	5.9%	20.8%	27.2%	0.3%

45.3% of patients on 12 mg lost ≥30% of body weight.

Heterogeneity of response to weight loss interventions



Perdomo C, Cohen RV et al, Lancet, 2023

There is no magic bullet for obesity

*Ildiko Lingvay, Priya Sumithran, Carel W le Roux, *Ricardo V Cohen*
ricardo.cohen@haoc.com.br

Lancet DE, July 2023

There is no magic bullet for obesity

Treating obesity has wide-ranging benefits on health and wellbeing.[1] Advances in medications for obesity have sparked interest, and excessive unregulated media attention has driven unprecedented demand for these new agents. However, the media coverage risks propagating the view that there is a magic bullet treatment for obesity.

Obesity is a chronic and relapsing condition with a complex multifactorial pathophysiology that spans genetics, metabolic maladaptation, neuroendocrine abnormalities, and major shifts in lifestyle, food composition, and societal inequities. An effective approach to obesity treatment must be multifactorial, individualised, and adaptable over time. The treatment will often require a combination of modalities and long-term therapy, akin to the accepted approach for other chronic diseases. The new medications will neither cure obesity nor render other approaches obsolete, including lifestyle interventions and metabolic surgery.

Although the latest generation of medications for obesity shows average results of 15–20% body weight loss per patient, seemingly even without major lifestyle interventions,[2] a few points are worth noting. First, weight loss observed in clinical trials using any obesity treatment has a Gaussian distribution, and up to 20% of participants do not experience clinicaly significant weight loss. Additionally, up to 10% of patients will struggle to tolerate the side effects from the medications.[2] Second, even people who meet the treatment goals with obesity pharmacotherapy might decide to explore metabolic surgery for long-term maintenance of weight loss and health gains. Third, the benefits of obesity medications cease if the medications are stopped.[3] Fourth, regardless of the weight loss method or its effect on bodyweight, a healthy lifestyle remains the cornerstone of optimising health.

Lifestyle interventions also are a valid and independent obesity management strategy. For up to 20% of patients, optimising nutritional quality, eating habits, eradicating maladaptive behaviours, and incorporating physical activity will successfully sustain weight loss and health gains.

Metabolic surgery also remains an effective therapy for obesity, reducing cardiovascular events, microvascular complications, some types of cancer, and all-cause deaths. As obesity is progressive, 10–20% of patients might regain a substantial amount of weight after surgery, often resulting in suboptimal control or relapses of the health issues related to obesity, and necessitate additional weight loss interventions (eg, use of medications). The inverse is also likely to be true for pharmacotherapy.

Combining surgical and medical approaches is standard practice in chronic disease management (eg, coronary disease). In oncology, a range of adjunctive treatments (eg, chemotherapy, radiotherapy, or immunotherapy) might be used in addition to surgery to improve outcomes. Likewise, in the treatment of type 2 diabetes and obesity, a combination of metabolic surgery and medications is associated with excellent glycaemic control, weight loss, and even reversal of diabetic complications.[5] Patients with advanced forms of obesity often have suboptimal responses to lifestyle, medical, or surgical interventions alone; thus, combination treatment might be necessary.

A chronic multifactorial disease requires an approach that is long term, multifactorial, flexible over time, and tailored to the individual. We should not promote one form of treatment by dismissing the other options. We need to combine our efforts and use the right tools, at the right time, and for the right person to achieve optimal care and maximise health benefits for our patients.

IL received grants paid to the Institution from Novo Nordisk, Pfizer, Merck, Sanofi, Boehringer-Ingelheim, and Mylan; and received consulting fees, covered travel expenses from Novo Nordisk, Eli Lilly, Johnson & Johnson, Merck, Pfizer, Sanofi, Boehringer Ingelheim, Zealand, Bayer, Intercept, Valeritas, Structure, Carmot, Shionoghi, Mediflix, and WebMD. PS received research grants paid to their institution from National Health and Medical Research Council; and declares co-authorship of manuscripts with medical writing assistance from Novo Nordisk. RVC received a research grant paid to the Institution from Johnson & Johnson, Medtech, and Medtronic; received honoraria for lectures, presentations, and speakers bureaus from Johnson & Johnson, Medtech, Medtronic, Janssen Pharmaceuticals, Novo Nordisk, and Abbott; and is a member of the Scientific Advisory Board for Baritek and GI Dynamics. CWIR reports grants from the Irish Research Council, Science Foundation Ireland, Anabio, and the Health Research Board; serves on advisory boards and speakers panels of Novo Nordisk, Herbalife, GI Dynamics, Eli Lilly, Johnson & Johnson, Glia, Irish Life Health, and Boehringer Ingelheim, Currax, and Rhythm Pharma; CWIR is a member of the Irish Society for Nutrition and Metabolism; he was the chief medical officer and director of the Medical Device Division of Keyron in 2021; CWIR was gifted stock holdings in Keyron and divested all of them in 2021; CWIR continues to provide scientific advice to Keyron for no remuneration and provides obesity clinical care in the Beyond BMI clinic and is their shareholder.

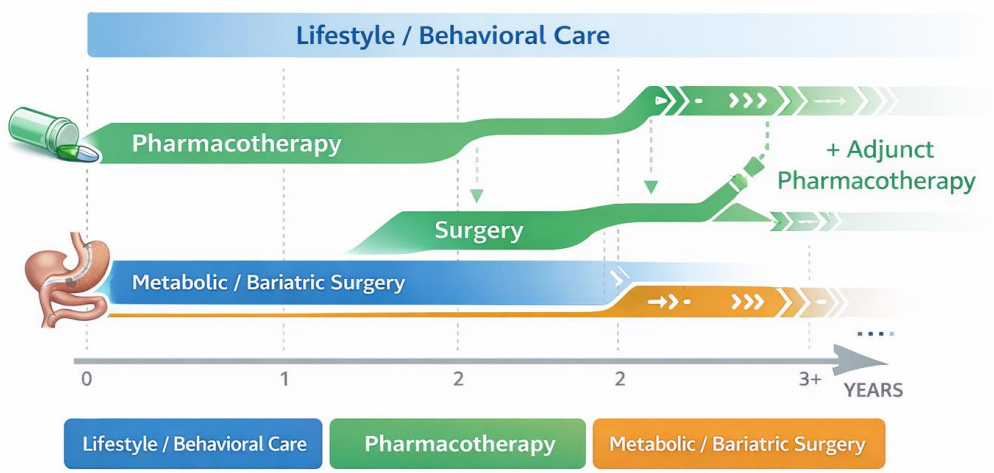
*Ildiko Lingvay, Priya Sumithran, Carel W le Roux, *Ricardo V Cohen*
ricardo.cohen@haoc.com.br

University of Texas Southwestern Medical Center, Dallas, TX, USA (IL); Monash University, Central Clinical School, Melbourne, VIC, Australia (PS); Diabetes Complications Research Centre, University College Dublin, Ireland (CIWR); Diabetes Research Centre, Ulster University, Coleraine, UK (CIWR); The Center for the Treatment of Obesity and Diabetes, Oswaldo Cruz German Hospital, São Paulo 01327–001, Brazil (RVC)

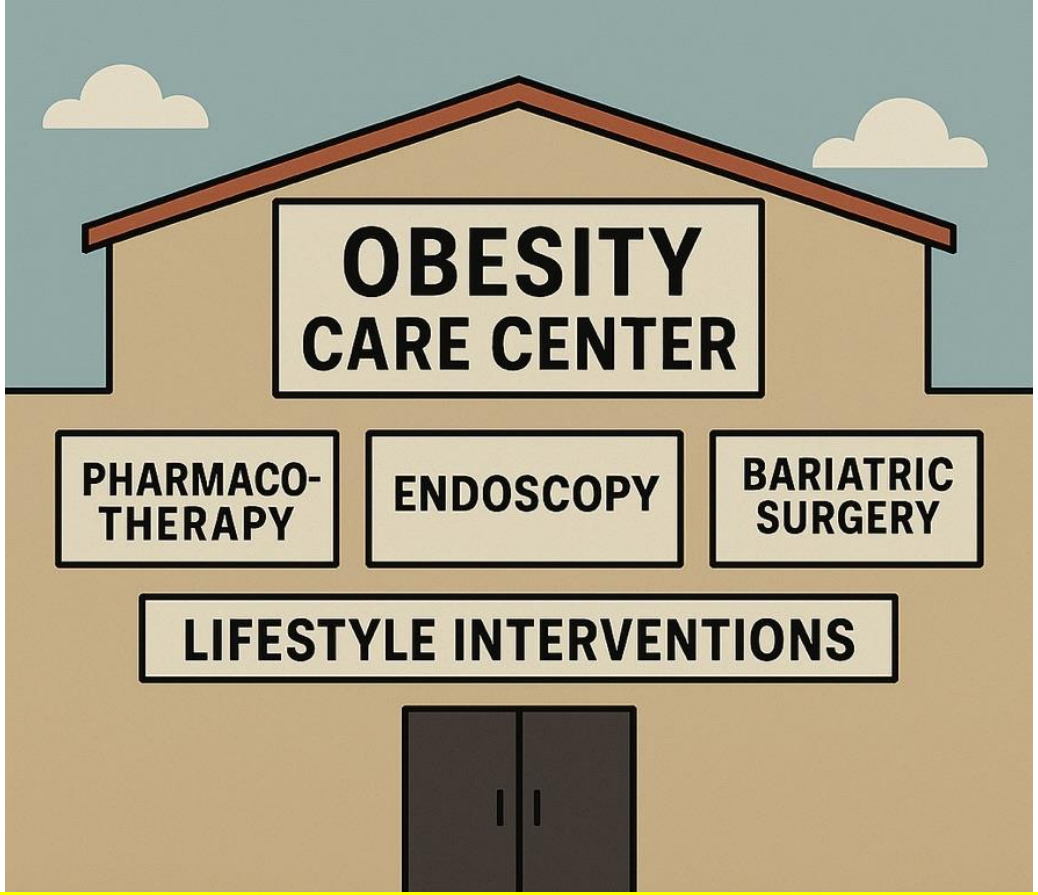
1 Lingvay I, Sumithran P, Cohen RV, le Roux CW. Obesity management as a primary treatment goal for type 2 diabetes: time to reframe the conversation. *Lancet* 2022; **399:** 394–405.
2 Perdomo CM, Cohen RV, Sumithran P, Clément K, Frühbeck G. Contemporary medical, device, and surgical therapies for obesity in adults.*Lancet* 2023; **401:** 1116–30.
3 Wilding JPH, Batterham RL, Davies M, et al. Weight regain and cardiometabolic effects after withdrawal of semaglutide: the STEP 1 trial extension. *Diabetes Obes Metab* 2022; **24:** 1553–64.
4 Look ARG. Eight-year weight losses with an intensive lifestyle intervention: the look AHEAD study. *Obesity* 2014; **22:** 5–13.
5 Cohen RV, Pereira TV, Aboud CM, et al. Gastric bypass *versus* best medical treatment for diabetic kidney disease: 5 years follow up of a single-centre open label randomised controlled trial. *EClinicalMedicine* 2022; **53:** 101725.

DECISIONS ARE AS IMPORTANT AS INCISIONS

BEST OUTCOMES



- **In the GLP-1 era, the question is no longer surgery versus medications**
- **The standard of care becomes sequencing and combination**
- **Multimodal treatment is here to stay**



INTERNATIONAL FEDERATION FOR THE SURGERY AND OTHER THERAPIES FOR OBESITY

Metabolic surgery
&
Pharmacotherapy

Obesity Surgery
https://doi.org/10.1007/s11695-020-04934-1

IFSO

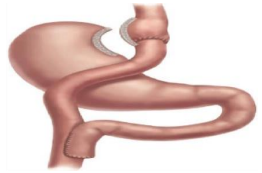
BRIEF COMMUNICATION

Check for updates

Bariatric Surgery: There Is a Room for Improvement to Reduce Mortality in Patients with Type 2 Diabetes

Carel W. le Roux [1] · Johan Ottosson [2,3] · Erik Näslund [2,4] · Ricardo V. Cohen [5] · Erik Stenberg [2,3] · Magnus Sundbom [2,6] · Ingmar Näslund [2,3]

Received: 6 July 2020 / Revised: 13 August 2020 / Accepted: 14 August 2020

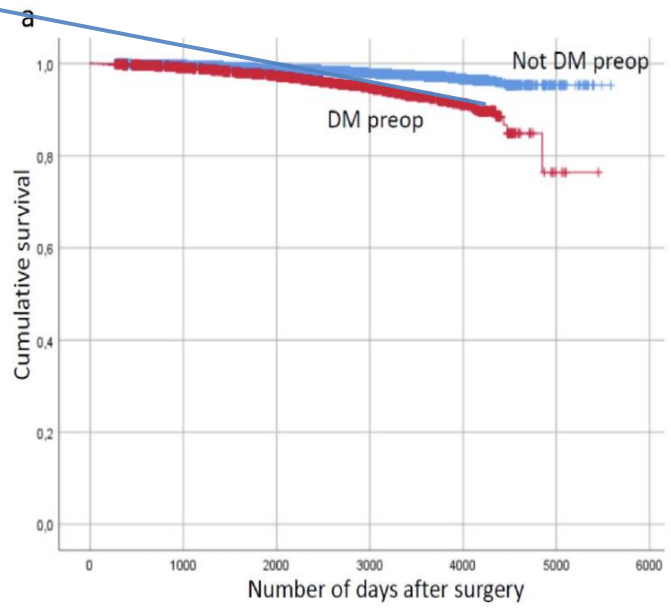


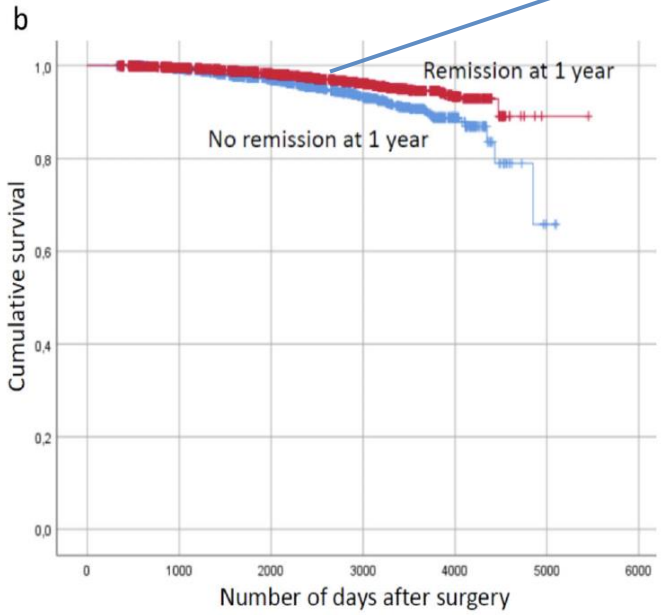
SoReg, Scandinavian Obesity Surgery Registry

65,345 pts up to 10y FU, all after RYGB

Operated pts with uncontrolled T2D @ 1 year have higher mortality during FU

Adjuctive pharmacotherapy





JAMA | Original Investigation

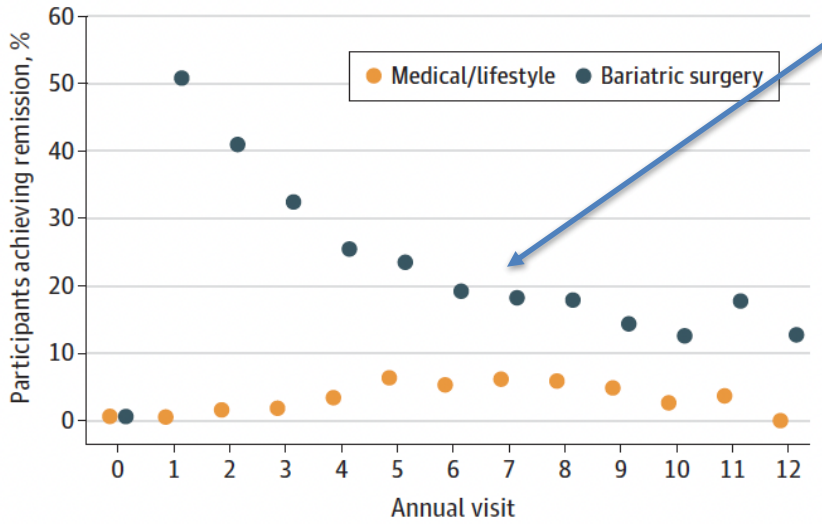
Long-Term Outcomes of Medical Management vs Bariatric Surgery in Type 2 Diabetes

Anita P. Courcoulas, MD; Mary Elizabeth Patti, MD; Bo Hu, PhD; David E. Arterburn, MD; Donald C. Simonson, MD, ScD; William F. Gourash, PhD; John M. Jakicic, PhD; Ashley H. Vernon, MD; Gerald J. Beck, PhD; Philip R. Schauer, MD; Sangeeta R. Kashyap, MD; Ali Aminian, MD; David E. Cummings, MD; John P. Kirwan, PhD

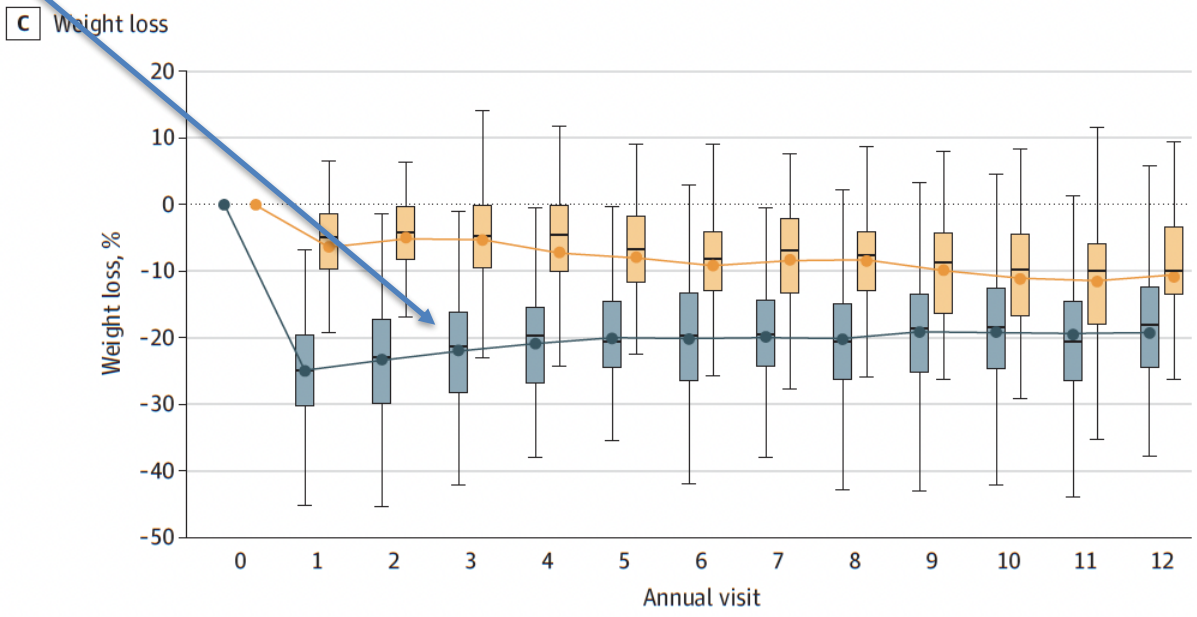
2024

Addition of pharmacotherapy

Figure 3. Diabetes Remission



No. of participants													
Medical/lifestyle	96	92	87	82	78	84	76	79	72	70	67	55	31
Bariatric surgery	166	164	151	149	140	146	108	131	116	125	117	99	82



No. at risk													
Bariatric surgery	166	164	161	158	144	149	122	139	121	126	121	106	85
Medical/lifestyle	96	91	84	86	79	78	77	75	73	73	70	60	34

Remission was defined as hemoglobin A_{1c} less than 6.5% and not receiving any medications for diabetes.

PUBLISHED EVIDENCE

The Foundation: *IFSO's International Consensus*

#1

MOST DOWNLOADED PAPER

British Journal of Surgery — 2025

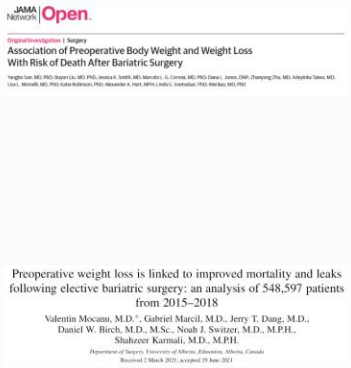
Reflects the scale of clinical demand for clear guidance on combining OMMs with metabolic bariatric surgery.

OMMs Before MBS: *Controversial Data*

> *There is **insufficient high-level evidence** to recommend the routine use of OMMs for weight loss before MBS.*

A+ IFSO CONSENSUS GRADE

Preoperative WL may influence perioperative outcomes


JAMA Network Open.

Association of Preoperative Body Weight and Weight Loss With Risk of Death After Bariatric Surgery

Preoperative weight loss is linked to improved mortality and leaks following elective bariatric surgery: an analysis of 548,597 patients from 2015–2018

Valentin Mocanu, M.D., Gabriel Marcil, M.D., Jerry T. Dang, M.D., Daniel W. Birch, M.D., M.Sc., Noah J. Switzer, M.D., M.P.H., Shahzeer Karmali, M.D., M.P.H.

Preoperative Weight Loss as a Predictor of Bariatric Surgery Postoperative Weight Loss and Complications

Jamil S. Samaan · Jasmine Zhao · Elaine Qian · Angelica Hernandez · Omar Toubat · Evan T. Alicuben · Yousaf Malik · Kulmeet Sandhu · Adrian Dobrowolsky · Kamran Samakar

Journal of Gastrointestinal Surgery 26.1 (2022): 86-93.

Preoperative WL does not influence perioperative outcomes and delays the operation


Preoperative weight loss: is waiting longer before bariatric surgery more effective?

Victor Eng, B.S., Luis Garcia, M.S., Habib Khoury, B.S., John Morton, M.D., M.P.H., Dan Azagury, M.D.

Received 18 April 2018; accepted 5 March 2019

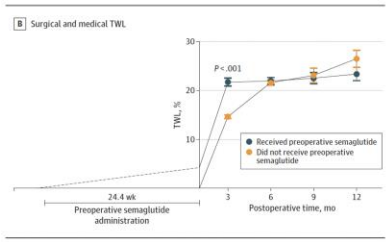
Surgery for Obesity and Related Diseases 15 (2019) 951–957

RESEARCH LETTER

Neoadjuvant Semaglutide, Bariatric Surgery Weight Loss, and Overall Outcomes

Vasundhara Mathur, MD
Katherine Wasden, BA
Thomas H. Shin, MD, PhD
Pourya Medhati, MD
Abdelrahman A. Nimeri, M
Ali Tavakkoli, MD
Eric G. Sheu, MD, PhD

JAMA Surgery Published online March 5, 2025



Neoadjuvant semaglutide:

- ✓ No WL benefits
- ✓ No greater intraop safety
- ✓ Surgical weight loss was significantly lower in patients treated with neoadjuvant semaglutide

Cohen RV et al, BJS, 2024 · 100% consensus, 2 rounds, 37 votes

IFSO CONSENSUS 2024 · AFTER SURGERY

OMMs After MBS: *When to Start*

> *Treatment with OMMs after MBS should generally be **withheld until the weight plateau** is reached — unless there is a compelling clinical need for earlier initiation.*

A+ IFSO CONSENSUS GRADE

RATIONALE

- Lets patients and physicians see the full effect of surgery before adding pharmacotherapy

EXCEPTION

- **BMI > 60 kg/m² — early initiation at 2–3 months postop**

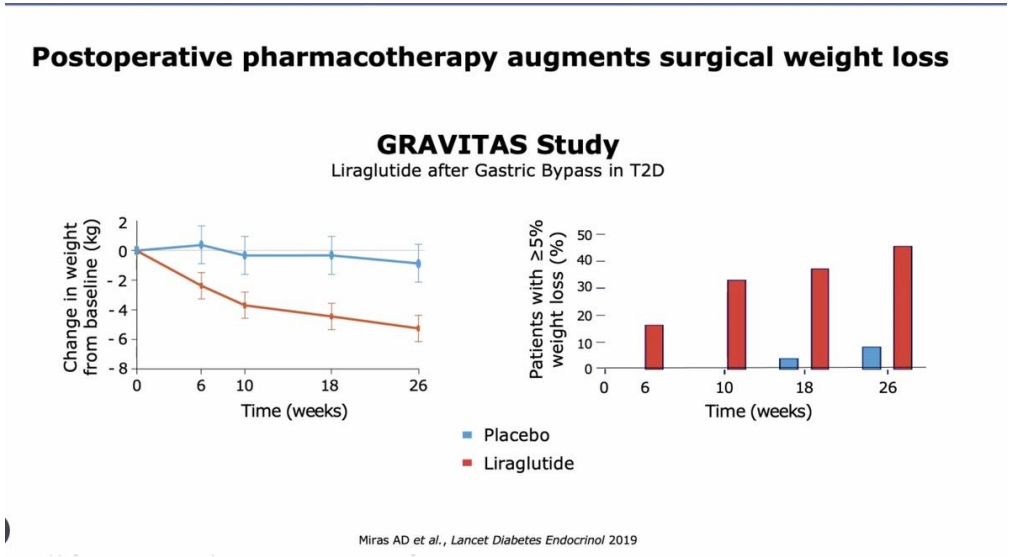
IFSO Consensus 2024 · Cohen RV et al, BJS, 2024 · 100% consensus, 3 rounds, 33 votes

OMMs After MBS: *A Comparable Response*

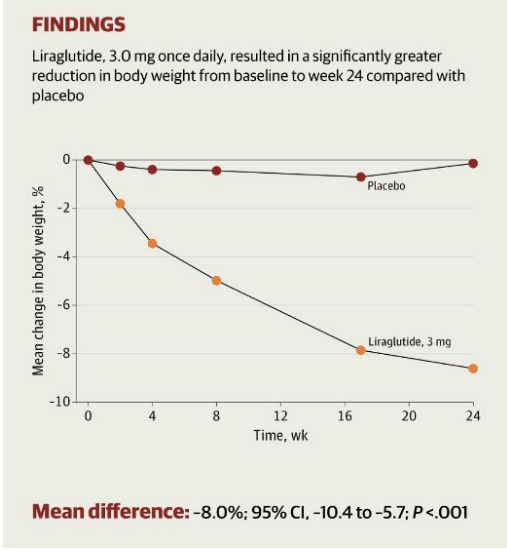
> *Emerging evidence indicates that the weight loss induced by OMMs is **similar** among people who have or have not undergone MBS.*

A+ IFSO CONSENSUS GRADE

GRAVITAS- Liraglutide T2D, after SG and RYGB



BARI-OPTIMISE — Liraglutide 3.0 mg after MBS



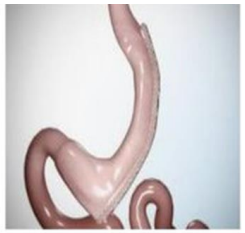
Cohen RV et al, BJS, 2024 · 100% consensus, 2 rounds, 36 votes

nature medicine

Article https://doi.org/10.1038/s41591-026-04416-4 **online 22 May 2026**

Semaglutide versus placebo in individuals with poor weight loss after bariatric surgery: a double-blinded, randomized, placebo-controlled trial

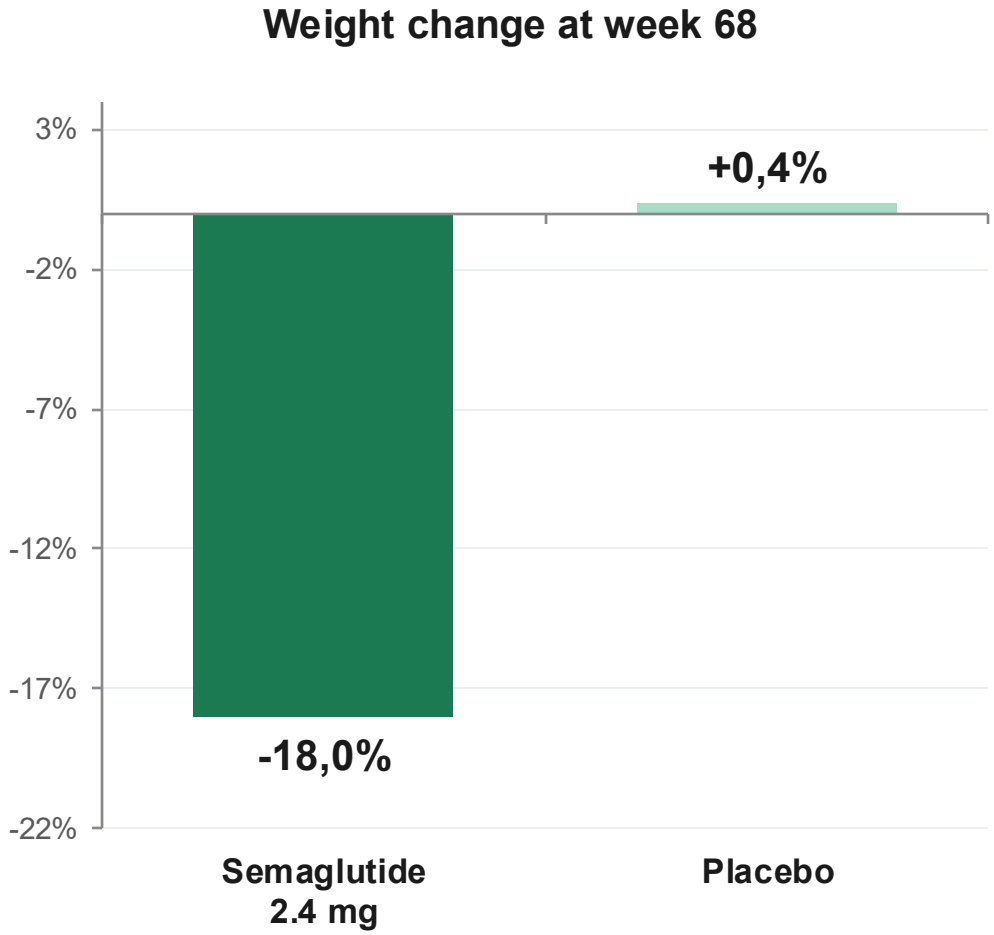
Population: Post-MBS patients with **weight regain or suboptimal weight loss** (lost less than 20% of body weight since surgery)



78.6% sleeve gastrectomy (55/70 participants)

Semaglutide 2.4 mg (34 patients) vs placebo (29 patients) for 68 weeks, with adjunctive lifestyle therapy

Mild side effects (GI symptoms); no treatment-related deaths



Adjusted difference: **-19.1%** (95% CI -23.4 to -14.8)
P < 0.001

OMMs After MBS: *Before Revisional Surgery*

> *For patients with recurrent weight gain, treatment with available OMMs should be **considered prior to revisional surgery**.*

A IFSO CONSENSUS GRADE

- Revisional MBS carries higher morbidity, with no robust data on outcomes
- OMMs offer an excellent safety profile and proven efficacy

META-ANALYSIS · CERTAINTY OF EVIDENCE

Bastos EL et al. — Weight Loss After Revisional Bariatric Surgery, Obesity Surgery, 2024

BMI	23 studies · 1,602 patients	VERY LOW CERTAINTY
%EWL	18 studies · 1,031 patients	VERY LOW CERTAINTY
%EBMIL	7 studies · 350 patients	VERY LOW CERTAINTY
%TWL	16 studies · 888 patients	VERY LOW CERTAINTY

OMMs After MBS: *Side-Effect Profile*

> *When used after MBS, there appears to be **no increased incidence of side effects** of OMMs compared to non-surgical cohorts.*

A — IFSO CONSENSUS GRADE

Side Effects Reported with Liraglutide post-MBS in BARI-OPTIMISE compared with SCALE

Adverse Events (AE)[a] in the BARI-OPTIMISE Study Population

Event	Participants who experienced an AE, No. (%)		
	Placebo (n = 35)	Liraglutide (n = 35)	Total (N = 70)
Total	20 (57)	28 (80)	48 (67)
Total AEs, No.[b]	75	37	112
Gastrointestinal events			
Nausea	7 (20)	18 (51)	25 (36)
Diarrhea	2 (6)	2 (6)	4 (6)
Constipation	2 (6)	9 (26)	11 (16)
Vomiting	1 (3)	1 (3)	2 (3)
Abdominal pain	1 (3)	2 (6)	3 (4)
Abdominal bloating	0	1 (3)	1 (1)
Dyspepsia	0	1 (3)	1 (1)

Table 3. Adverse Events and Serious Adverse Events.[a]

Event	Liraglutide (N = 2481)			Placebo (N = 1242)		
	No. of Patients (%)	No. of Events	Event Rate per 100 Exposure-Years	No. of Patients (%)	No. of Events	Event Rate per 100 Exposure-Years
Adverse events in ≥5% of patients	1992 (80.3)	7191	321.8	786 (63.3)	2068	193.7
Nausea	997 (40.2)	1429	63.9	183 (14.7)	223	20.9
Diarrhea	518 (20.9)	754	33.7	115 (9.3)	142	13.3
Constipation	495 (20.0)	593	26.5	108 (8.7)	121	11.3
Vomiting	404 (16.3)	597	26.7	51 (4.1)	62	5.8
Dyspepsia	236 (9.5)	282	12.6	39 (3.1)	44	4.1
Upper abdominal pain	141 (5.7)	171	7.7	43 (3.5)	49	4.6
Abdominal pain	130 (5.2)	163	7.3	43 (3.5)	53	5.0
Nasopharyngitis	427 (17.2)	586	26.2	234 (18.8)	302	28.3
Upper respiratory tract infection	213 (8.6)	247	11.1	122 (9.8)	149	14.0
Sinusitis	128 (5.2)	141	6.3	73 (5.9)	95	8.9
Influenza	144 (5.8)	170	7.6	66 (5.3)	84	7.9
Headache	327 (13.2)	441	19.7	154 (12.4)	220	20.6
Dizziness	167 (6.7)	203	9.1	60 (4.8)	65	6.1
Decreased appetite	267 (10.8)	283	12.7	38 (3.1)	39	3.7
Back pain	171 (6.9)	210	9.4	105 (8.5)	121	11.3
Arthralgia	125 (5.0)	133	6.0	71 (5.7)	80	7.5
Fatigue	185 (7.5)	203	9.1	65 (5.2)	72	6.7
Injection-site hematoma	142 (5.7)	154	6.9	93 (7.5)	101	9.5

Mok et al, JAMA Surg 2023 (BARI-OPTIMSE); SCALE. Pi-Sunyer NEJM 2015

Side Effects Reported with Liraglutide post-MBS: Retrospective study of 117 patients compared to SCALE

TABLE 2 Side effects for liraglutide 3.0 mg

Symptom	n (%)[a]
Nausea	34 (29.1%)
Constipation	13 (11.1%)
Diarrhoea	8 (6.8%)
Fatigue	7 (6.0%)
Headache	4 (3.4%)
Rash	4 (3.4%)
Indigestion	3 (2.6%)
Vomiting	3 (2.6%)
Dry mouth	3 (2.6%)
Bloating	2 (1.7%)
Sweating	2 (1.7%)
Other[b]	9 (7.7%)

[a]Percent calculated as [(number of patients reporting the side effect)/117] × 100.
[b]Other includes abdominal pain (n = 1), bruising (n = 1), decreased glomerular filtration rate (n = 1), depression (n = 1), flu-like symptoms (n = 1), heartburn (n = 1), hot flashes (n = 1), gas (n = 1) and pancreatitis (n = 1).

Table 3. Adverse Events and Serious Adverse Events.[a]

Event	Liraglutide (N = 2481)			Placebo (N = 1242)		
	No. of Patients (%)	No. of Events	Event Rate per 100 Exposure-Years	No. of Patients (%)	No. of Events	Event Rate per 100 Exposure-Years
Adverse events in ≥5% of patients	1992 (80.3)	7191	321.8	786 (63.3)	2068	193.7
Nausea	997 (40.2)	1429	63.9	183 (14.7)	223	20.9
Diarrhea	518 (20.9)	754	33.7	115 (9.3)	142	13.3
Constipation	495 (20.0)	593	26.5	108 (8.7)	121	11.3
Vomiting	404 (16.3)	597	26.7	51 (4.1)	62	5.8
Dyspepsia	236 (9.5)	282	12.6	39 (3.1)	44	4.1
Upper abdominal pain	141 (5.7)	171	7.7	43 (3.5)	49	4.6
Abdominal pain	130 (5.2)	163	7.3	43 (3.5)	53	5.0
Nasopharyngitis	427 (17.2)	586	26.2	234 (18.8)	302	28.3
Upper respiratory tract infection	213 (8.6)	247	11.1	122 (9.8)	149	14.0
Sinusitis	128 (5.2)	141	6.3	73 (5.9)	95	8.9
Influenza	144 (5.8)	170	7.6	66 (5.3)	84	7.9
Headache	327 (13.2)	441	19.7	154 (12.4)	220	20.6
Dizziness	167 (6.7)	203	9.1	60 (4.8)	65	6.1
Decreased appetite	267 (10.8)	283	12.7	38 (3.1)	39	3.7
Back pain	171 (6.9)	210	9.4	105 (8.5)	121	11.3
Arthralgia	125 (5.0)	133	6.0	71 (5.7)	80	7.5
Fatigue	185 (7.5)	203	9.1	65 (5.2)	72	6.7
Injection-site hematoma	142 (5.7)	154	6.9	93 (7.5)	101	9.5

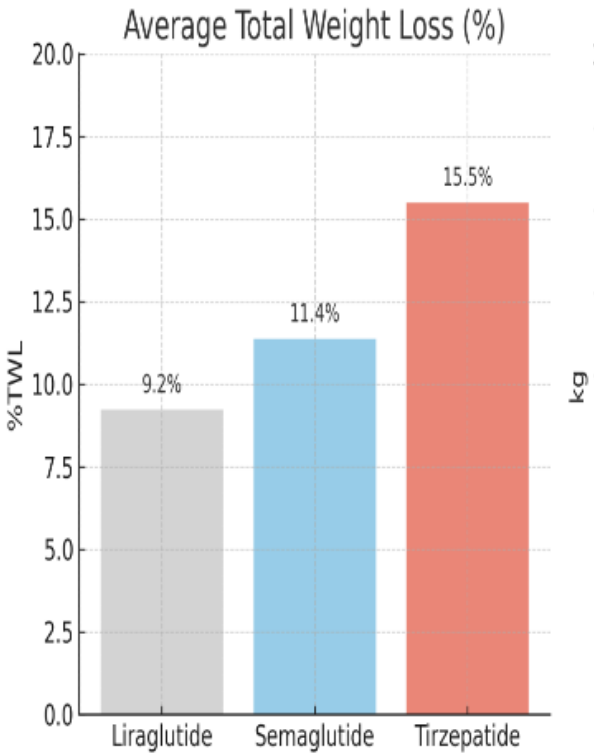
Wharton S, et. al. Clinical Obesity. 2019;9:e12323; SCALE. Pi-Sunyer NEJM 2015

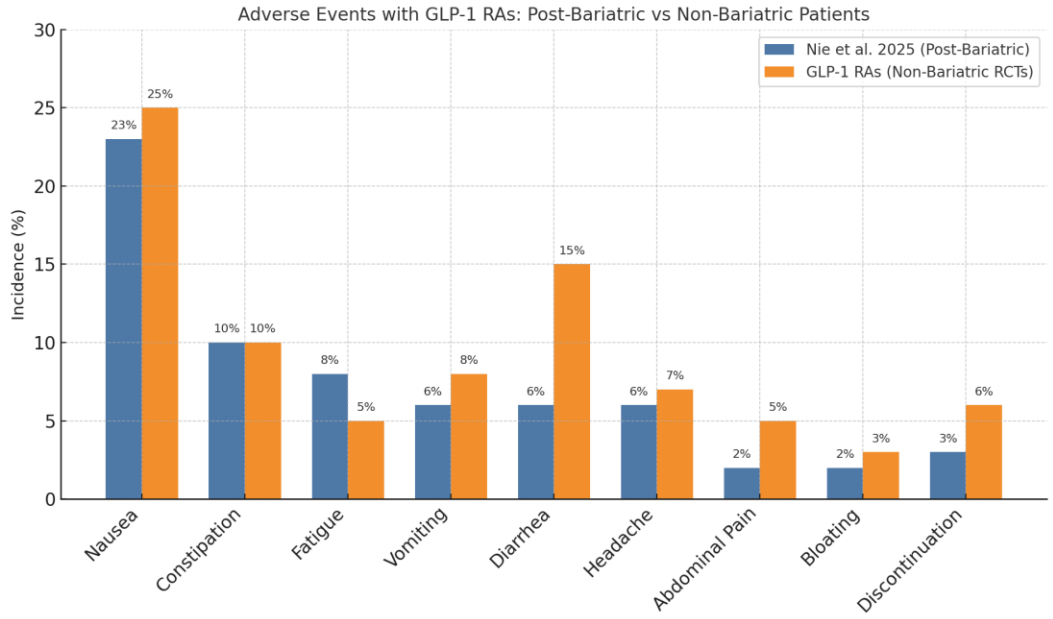
Obesity Surgery (2025) 35:808–822
https://doi.org/10.1007/s11695-025-07733-8

RESEARCH

Glucagon-Like Peptide-1 Receptor Agonists for the Treatment of Suboptimal Initial Clinical Response and Weight Gain Recurrence After Bariatric Surgery: a Systematic Review and Meta-analysis

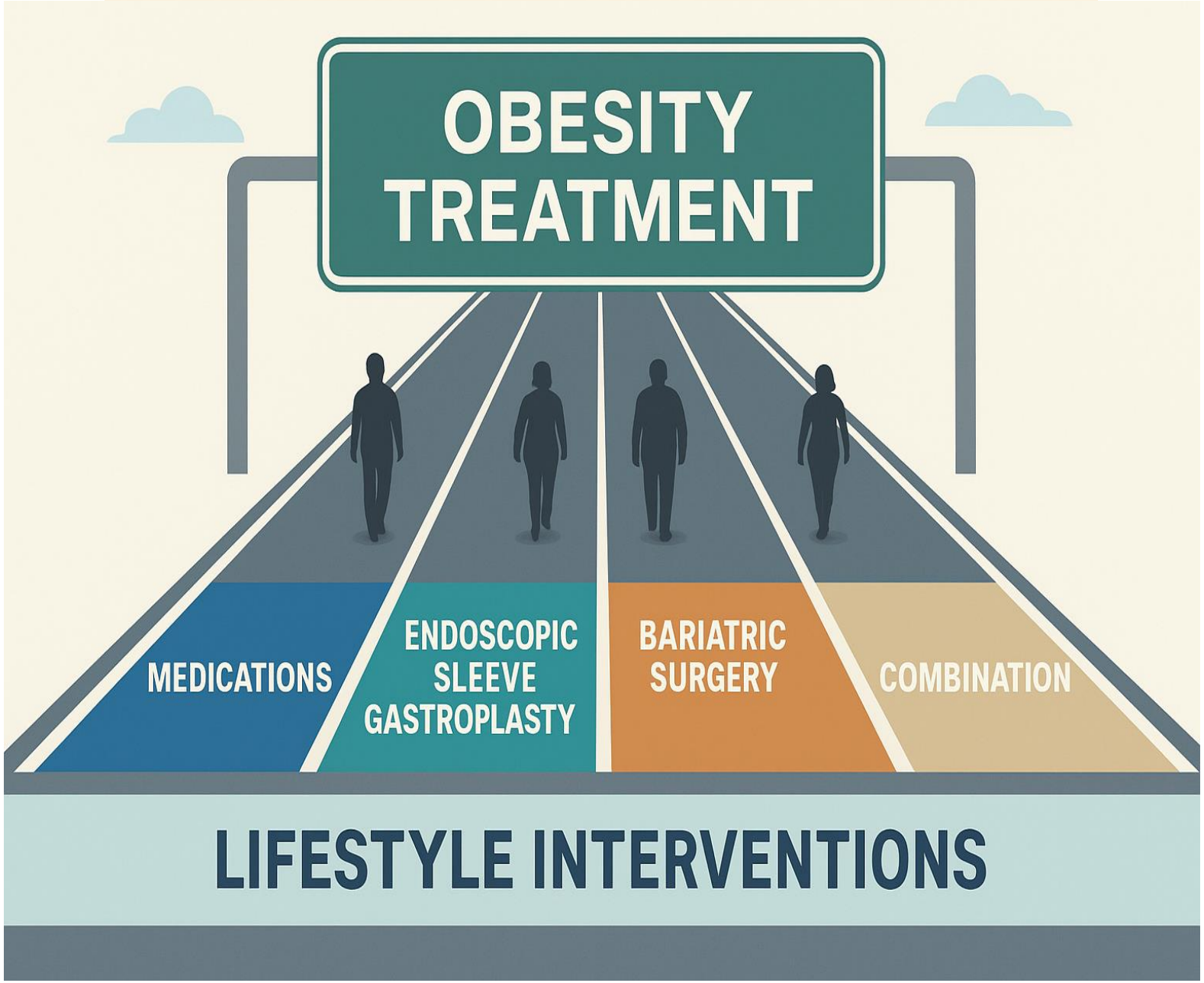
Yuntao Nie[1] · Yiran Zhang[2] · Baoyin Liu[1] · Hua Meng[1]

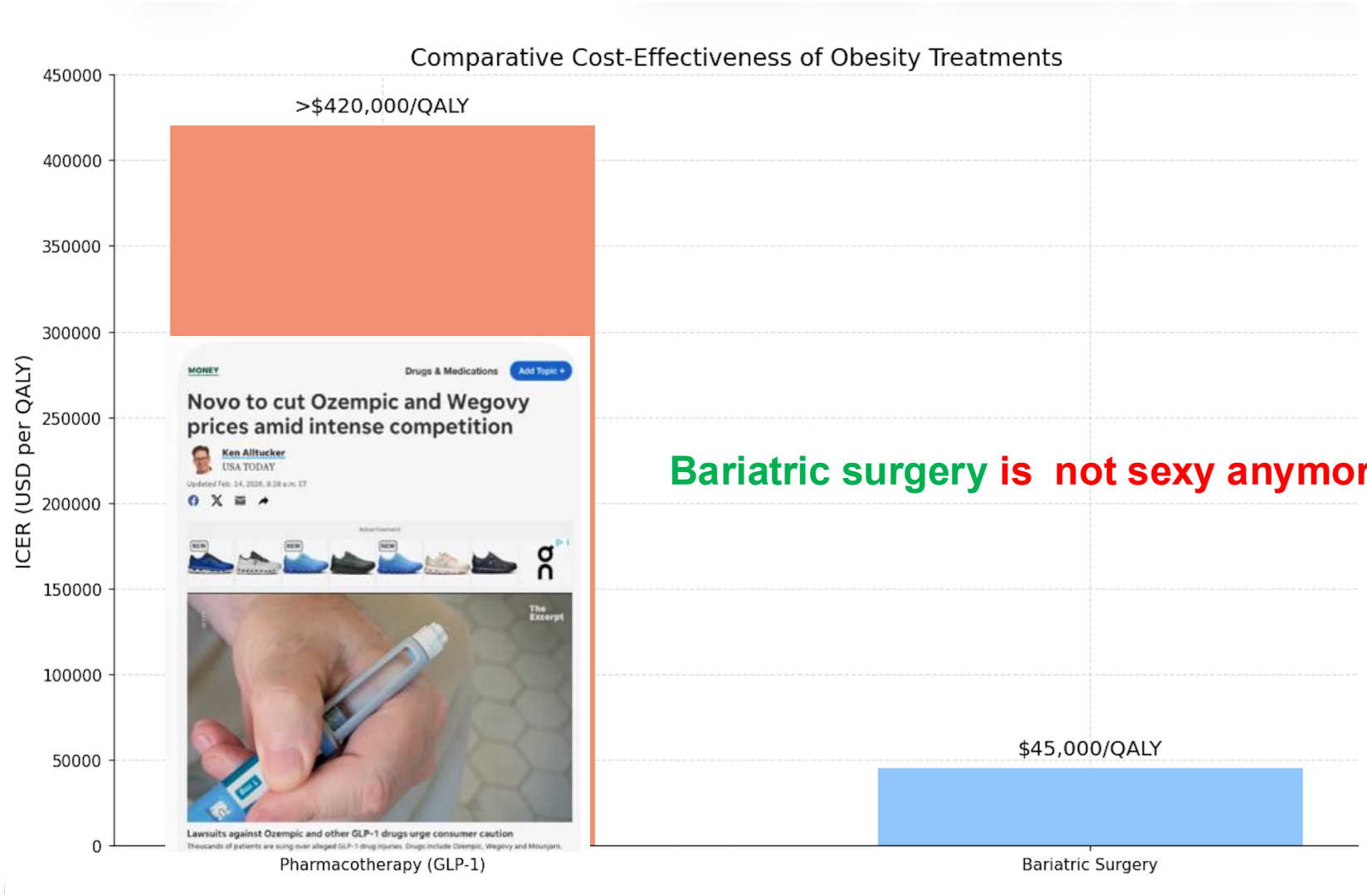




Indirect comparison with Step1 and Surmount 1 studies

Evidence-based

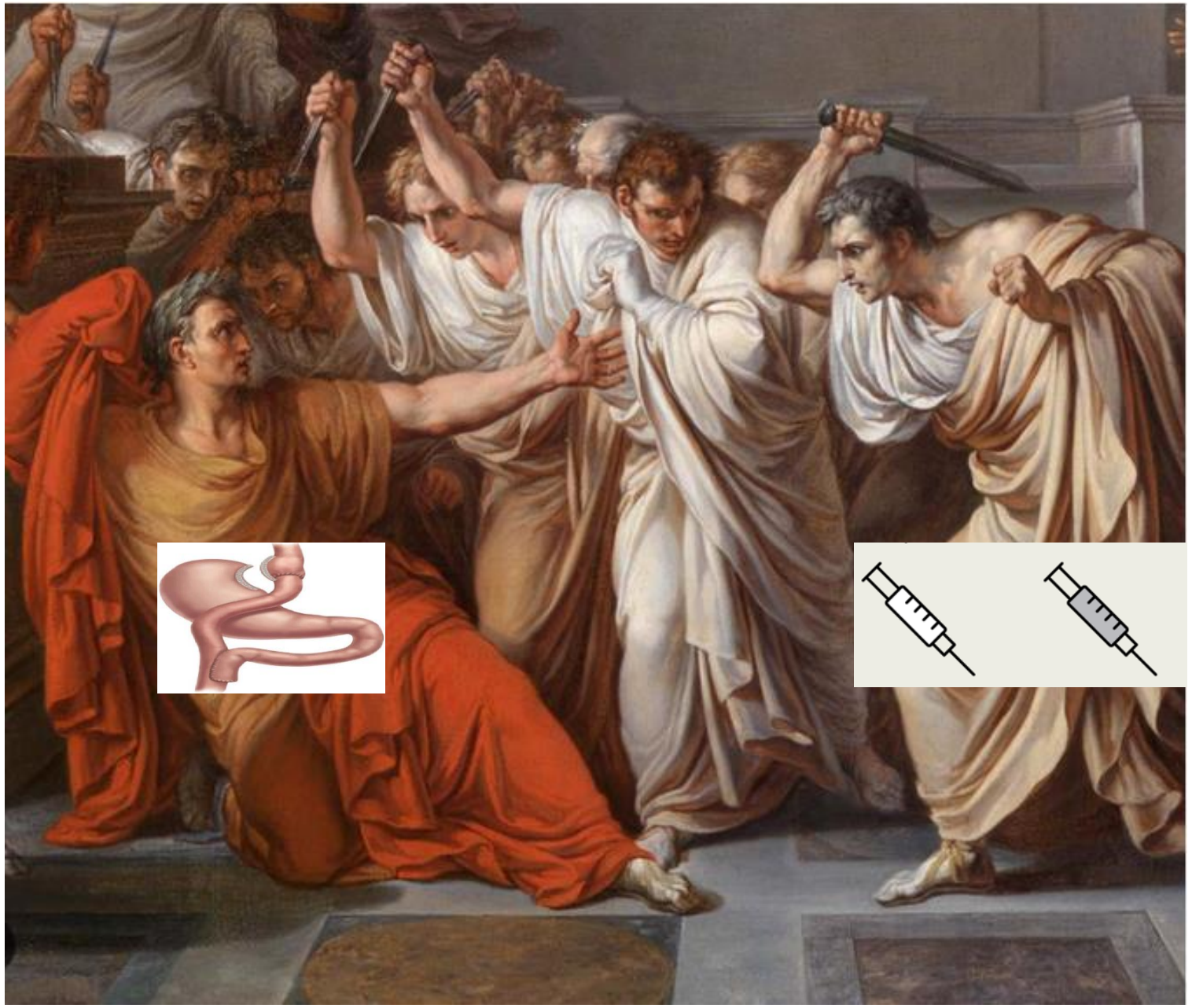




Bariatric surgery is not sexy anymore, but is cheap

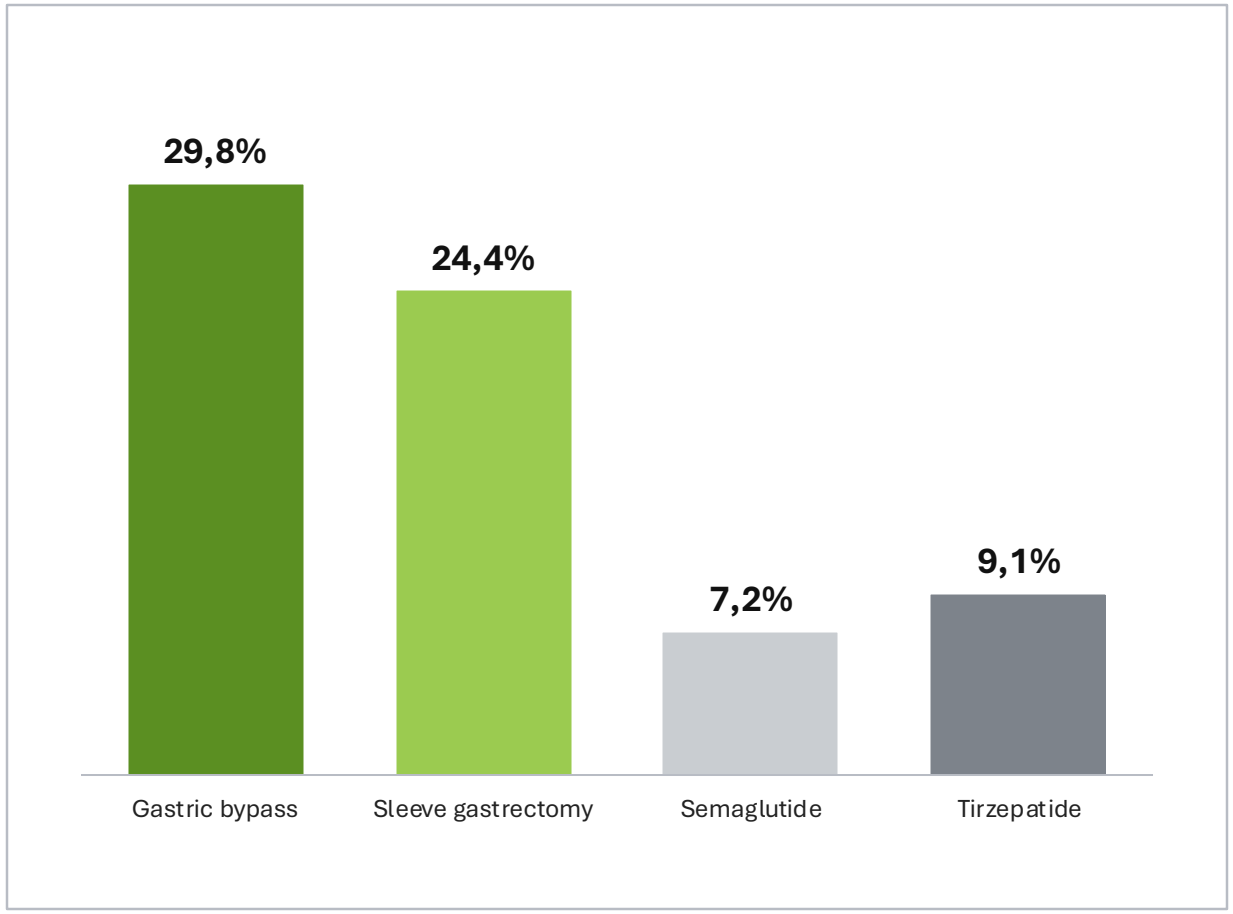
Chen, 2023;Kelly,2023;Chousboe,2024; ;Abbudayeh 2024 ;Hwang,2025


NEW CHALLENGES IN THE NEW ERA MODERN OBESITY TREATMENTS



The Death of Julius Caesar (1806) by Vincenzo Camuccini in the National Museum of Capodimonte, in Naples

At 1 year, surgery was associated with greater weight loss



Real-world data among adults with obesity showed **roughly 3× greater weight loss with surgery than with medication.**

4.1×
bypass vs semaglutide

2.7×
sleeve vs tirzepatide

S Brown A, et al. Obesity. 2026. doi:10.1002/oby.70246.

Metabolic surgery in era of modern pharmacotherapy

- ✓ Advancements in CV medications and PCI did not kill CABG
- ✓ Advancements in chemo, radio and immunotherapy did not kill cancer surgery
- ✓ Multifactorial disease, no magic bullet

Candidates in the new obesity treatment era

- Pts preference
- Extreme Obesity BMI > 50(still no data on OMMs)
- Suboptimal response to med tx
- Intolerance to pharmacotherapy

Candidates in the new obesity treatment era

Contraindications to medicines

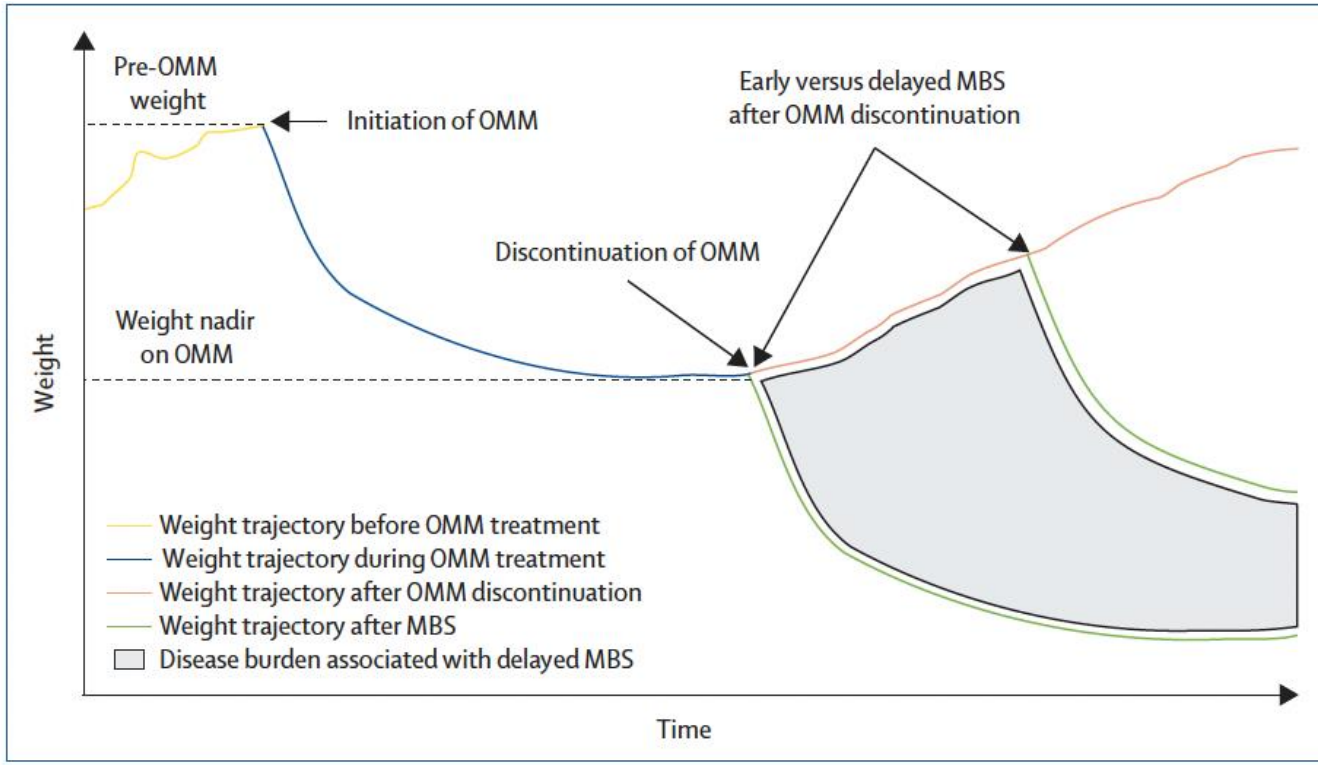
Cost

International Federation for the Surgery of Obesity statement on metabolic bariatric surgery after pharmacotherapy-induced weight loss in clinical obesity

Lancet Diabetes Endocrinol 2(
Published Online
July 22, 2025
https://doi.org/10.1016/
S2213-8587(25)00198-6

*Ricardo V Cohen, Gerhard Prager, Carel W le Roux, Ildiko Lingvay, Paulina Salminen
ricardo.cohen@haoc.com.br

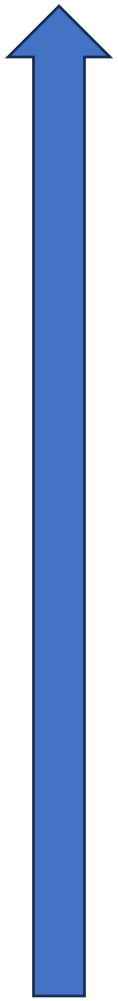
- Good outcomes, however:
- Lack of access
- Long-term side effects
- Cost of continued Tx
- "I don't want it anymore



Obesity treatment TODAY

Oncology model
What would an oncologist do ?

Access to full spectrum of therapy



Most invasive

Least invasive

Reoperative therapy

Adjuvant therapy

Combination therapy, when needed

Obesity Management Medications

Surgical treatment

Adapted from Lingvay I , Cohen R, Lancet 2024

ricardo.cohen@haoc.com.br

@rvcohen(twitter)

OSWALDO CRUZ

CENTRO ESPECIALIZADO EM **OBESIDADE E DIABETES**