

When Medications Are Not Enough

Prof. Francesco Rubino, MD

Chair Metabolic and Bariatric Surgery

King's College London

Consultant (Hon) Bariatric Surgeon

King's College Hospital

Personal Disclosures

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~~*When are medications are not enough?*~~

**What actually warrants
an operation?**

*What are treating ? and does that thing warrant an
operation?*

The evidence we already have

**For decades there was no effective drug.
The condition “medications are not enough” was permanently satisfied.**

If

drug availability were the variable governing surgical uptake...

Then

uptake of surgery should have been high throughout that entire period.

But

it was not.

With no alternative at all, people still said no to bariatric surgery (weight loss surgery)

≈1%

or less of eligible people ever chose an operation

Across the entire pre-pharmacotherapy era.

The other 99%

- Diet and commercial programmes
- Self-management, repeated cycles
- Or nothing at all

They opted out of surgery against a known-inferior alternative.

The rule people generally use

If it is not broken, do not fix it — surgically.

- **Surgery is for what is broken** Present, established, demonstrable dysfunction.
- **Not for what might break** A certain, immediate, irreversible act is a poor instrument against a probabilistic, deferred harm.
- **This is not a knowledge deficit** It is a coherent decision rule — and it is not obviously wrong.

People consider surgery a fix for what is broken, not for what is not (yet)

BRCA2-Mutation

Everything argues for surgery as good intervention for a risk reduction

- Risk materialization approaching certainty
- The feared outcome is cancer
- Risk-reducing surgery is effective
- It is guideline-supported and funded

And yet

- Uptake is highly variable
- In many settings a minority choice
- Large numbers choose surveillance
- Few pursue surgery

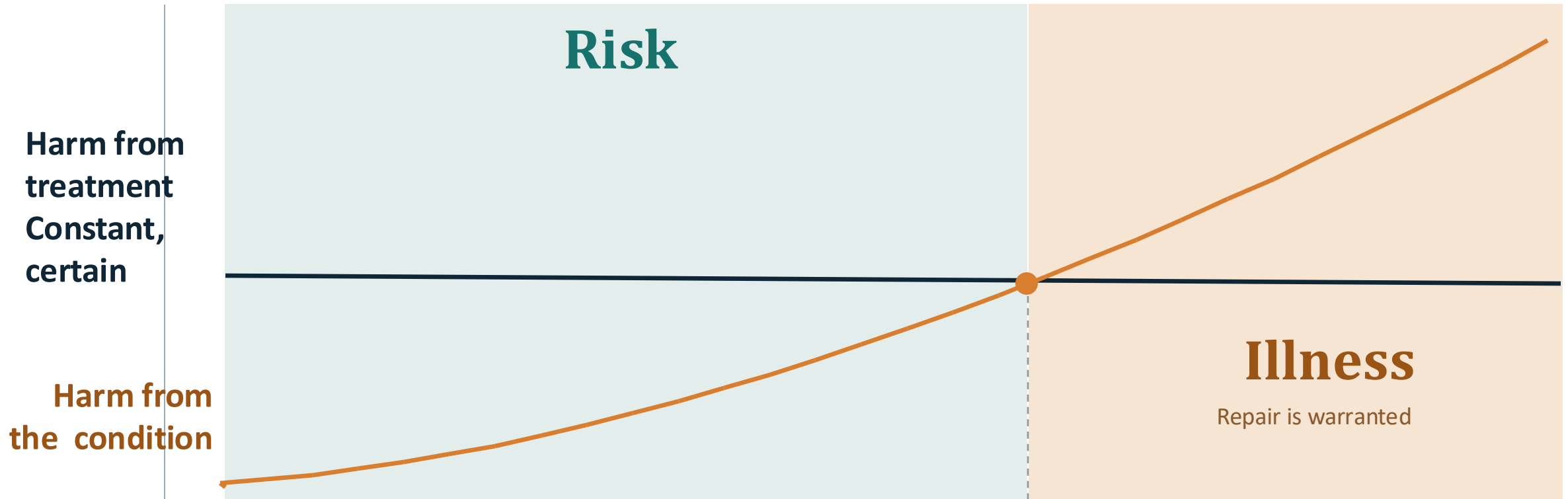
THE QUESTION PATIENTS INTUITIVELY ASK

*“Doctor — how risky and how costly
is what you are offering me?
And how certain is the harm
you are protecting me from?”*

The patient's perspective

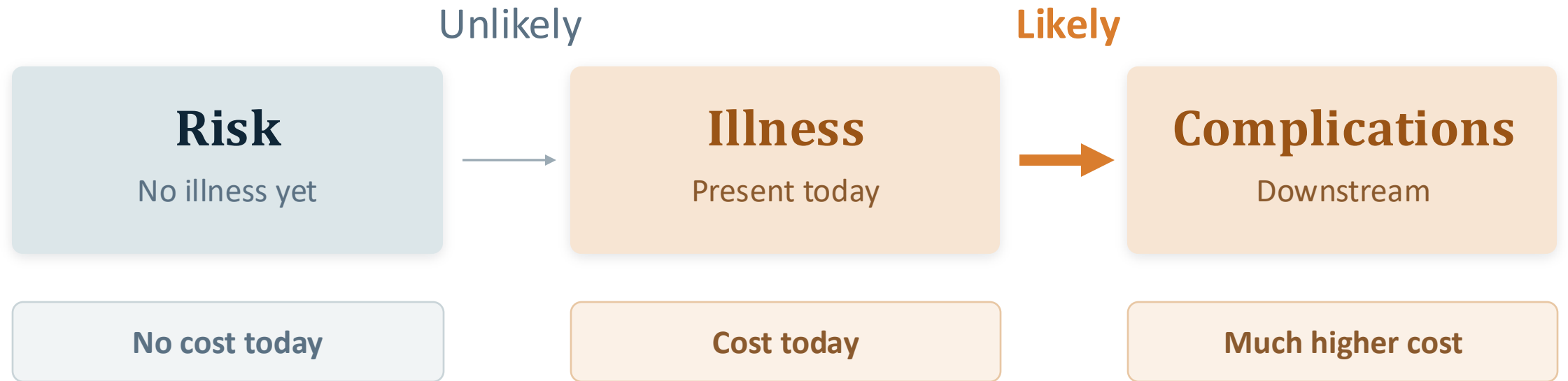
	Surgery	Illness
Risk	Certain, immediate, irreversible	Probabilistic, deferred
Cost	Certain, front-loaded, visible	It costs already (ill-health / money)
Felt today	Everything	Often nothing at all

Where an operation becomes rational



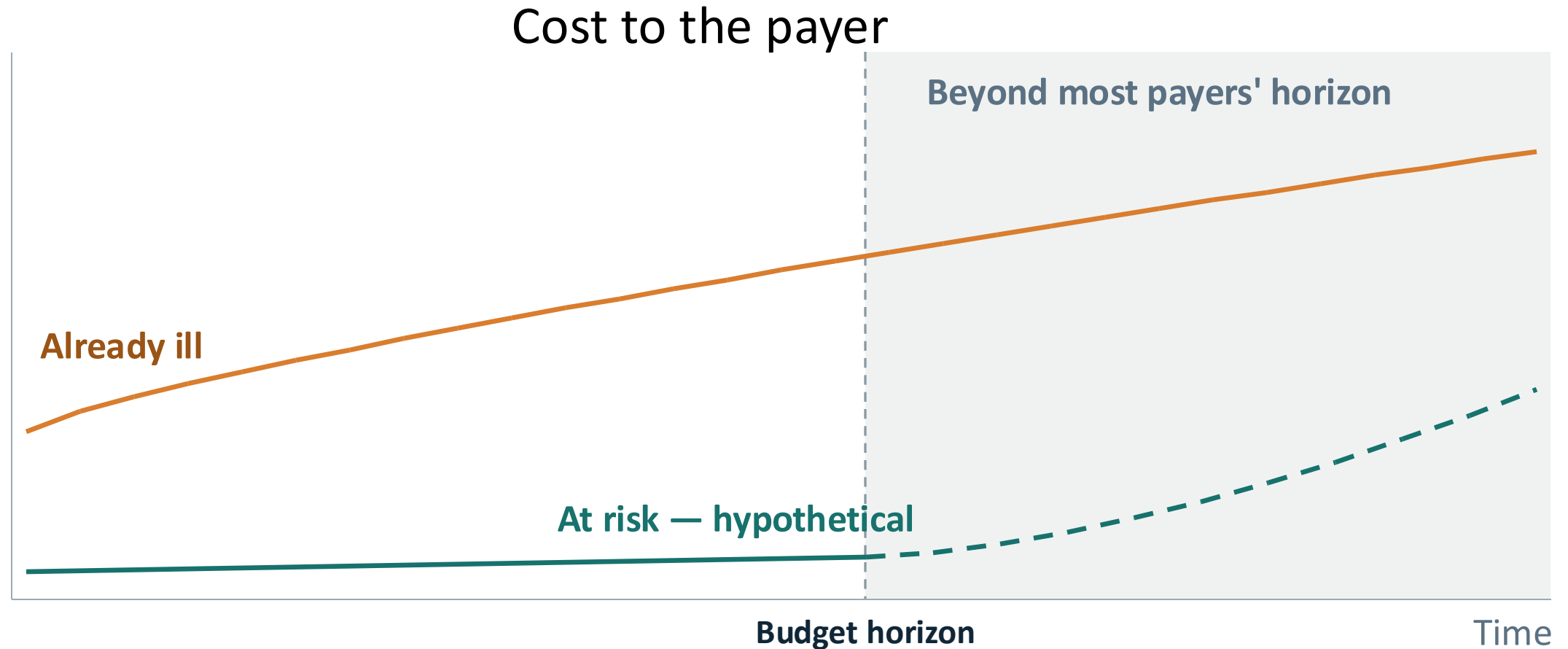
Surgical risk exists whether the patient is ill, or not

The payer perspective



Money spent at the first gap mostly buys nothing, because most people never cross it. Money spent at the second buys down a cost the payer is going to meet anyway.

The payer perspective



The at-risk patient's cost may never arrive — and if it does, it may well arrive on somebody else's balance sheet.

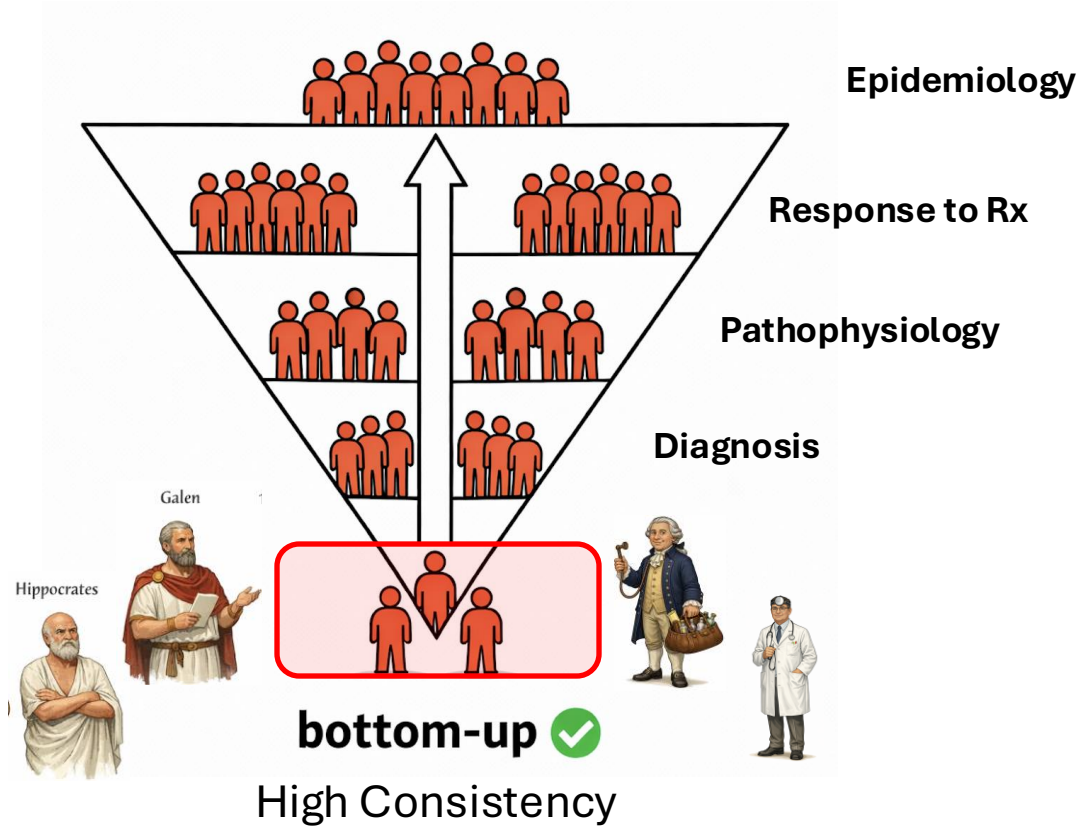
**If the rule is “fix what is broken,”
we have to define broken**

*Obesity has been treated as one entity, defined by a
number that describes neither disease nor function.*

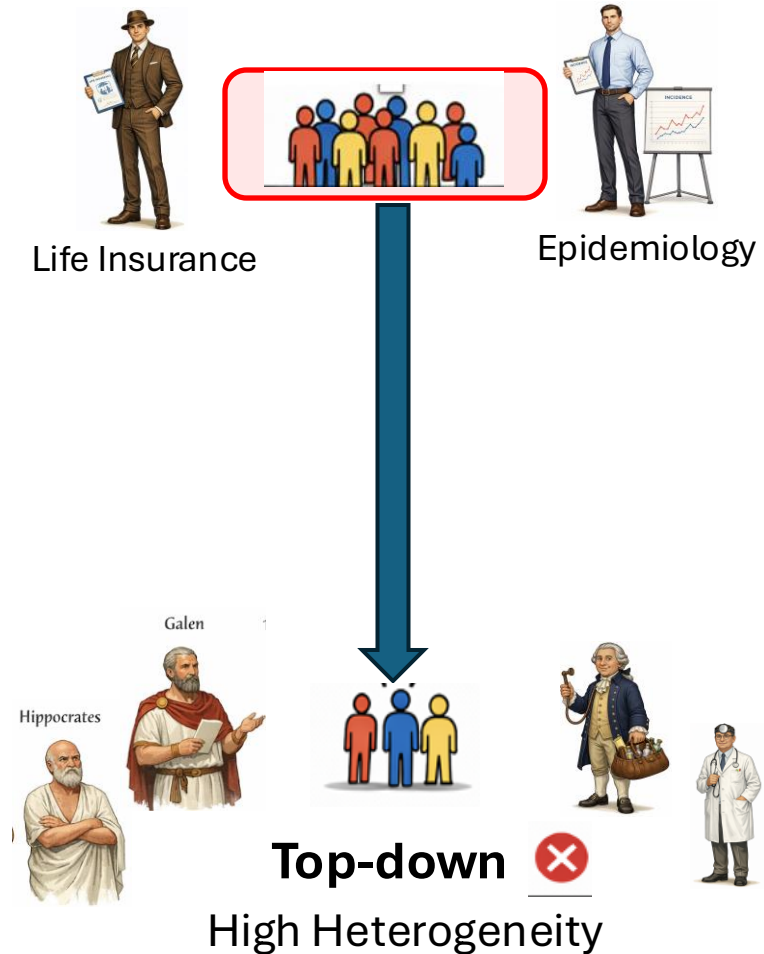
Practical Purpose of Disease Definition: Medicine vs Obesity

The health impact of obesity has been defined in reverse

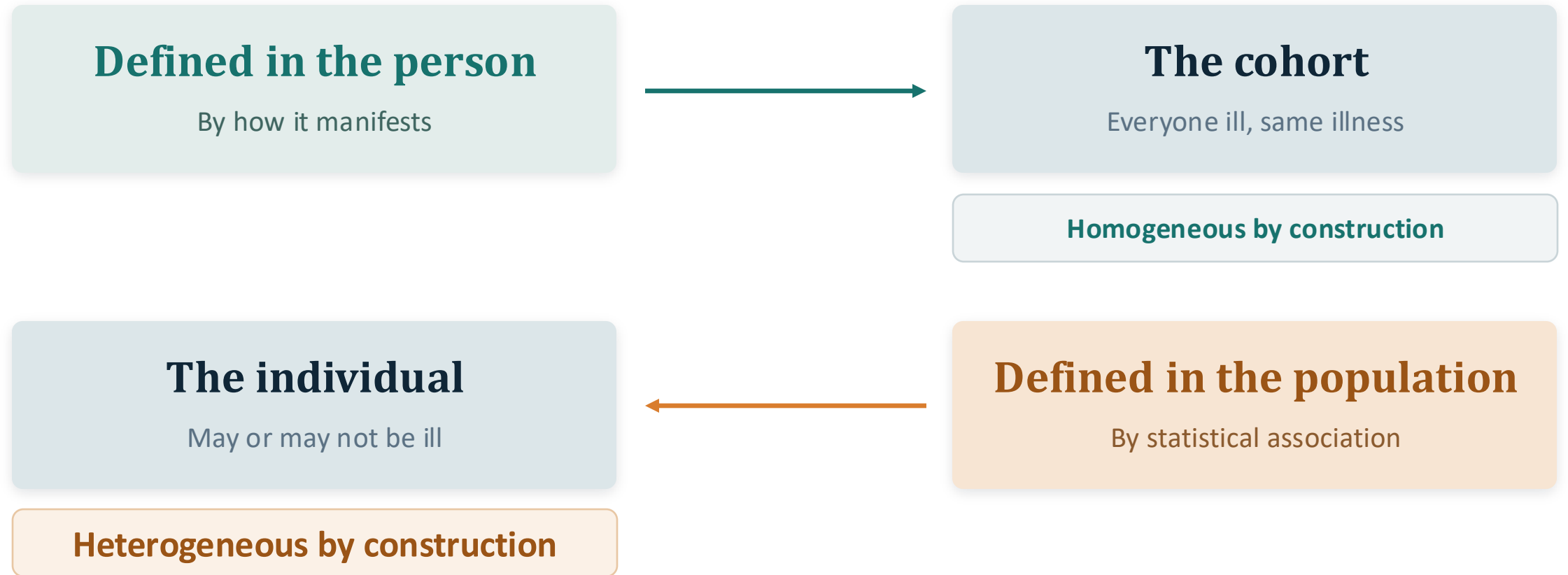
Medicine



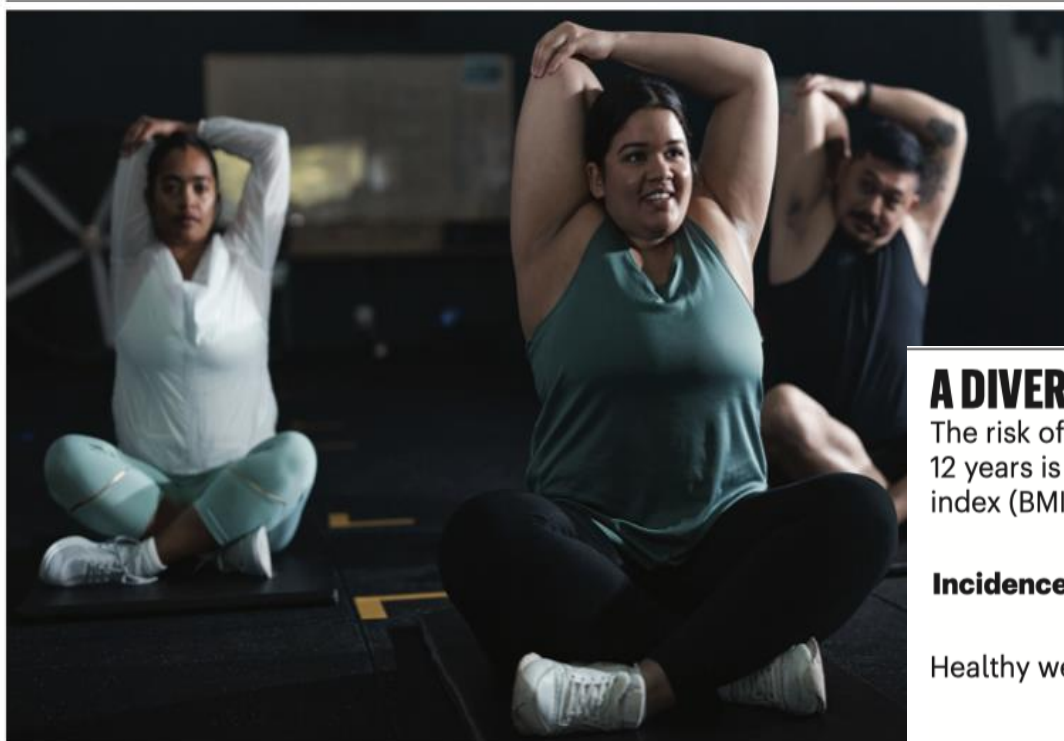
Obesity



The disease definition in opposite directions



The label tells you which group someone belongs to. It does not tell you whether they are ill.



People with the same body mass index can have radically different health statuses.

Why obesity shouldn't always be considered a disease

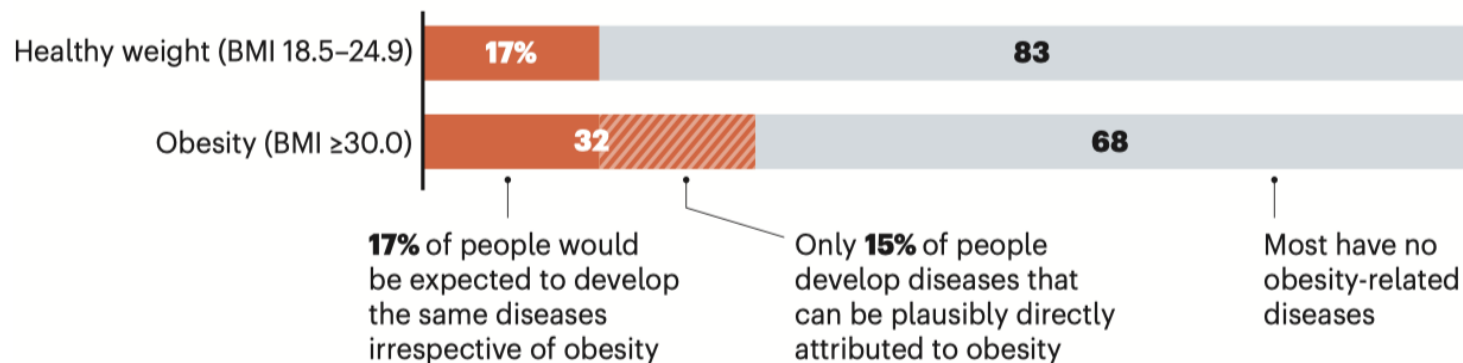
Francesco Rubino

Biological and clinical heterogeneity >>
Calling all obesity a disease serves no-one

A DIVERSE LANDSCAPE

The risk of developing one or more of 21 common 'obesity related diseases' over 12 years is higher in people with obesity than in those with a healthy body mass index (BMI). But these population-level statistics obscure a varied clinical picture.

Incidence of obesity-related disease in UK Biobank data



The Lancet Commission redefinition of obesity

Clinical obesity

Ongoing organ dysfunction, or limitation of daily activities, directly attributable to excess adiposity.

Diagnosed on objective evidence of dysfunction — not on BMI alone.

Pre-clinical obesity

Excess adiposity with preserved organ function and preserved daily activity — carrying elevated future risk.

A risk state, not a present illness.

This is the formalisation of the distinction patients have been making intuitively all along.

The distinction between clinical and preclinical obesity

Pre-clinical obesity

= risk, not broken

- Risk reduction, lifestyle, pharmacotherapy
- Sometime surgical territory
- The 1% that consider surgery (**minus the ones that now will try drugs first**)

Clinical obesity

= broken now

- Established dysfunction needing durable repair
- The harm is present and certain, not deferred
- Here the operation answers the patient's real question



Original Investigation | Nutrition, Obesity, and Exercise

New Obesity Definition and Clinical Obesity Prevalence for Global Metabolic Bariatric Surgery

Simone Cremona, MD; Ricardo V. Cohen, MD; Francois Pattou, MD; Anna Casajoana, MD, PhD; Guilherme Sampaio Souza, RN; Violeta Raverdy, MD; Helene Verkindt, MD; Beatriz T. L. Blasio, MD; Pia Roser, MD; Robert Caiazzo, MD, PhD; David Benaiges, MD, PhD; Tarissa B. Zanata Petry, MD; Francesco Rubino, MD

Study Population

Multi-Center International Audit

An audit of routine practice at 4 high-volume tertiary centers located in the UK, Spain, France, and Brazil.



UK



Spain



France



Brazil

n = 2,316 Patients

adult candidates undergoing primary metabolic bariatric surgery (gastric bypass or sleeve gastrectomy)

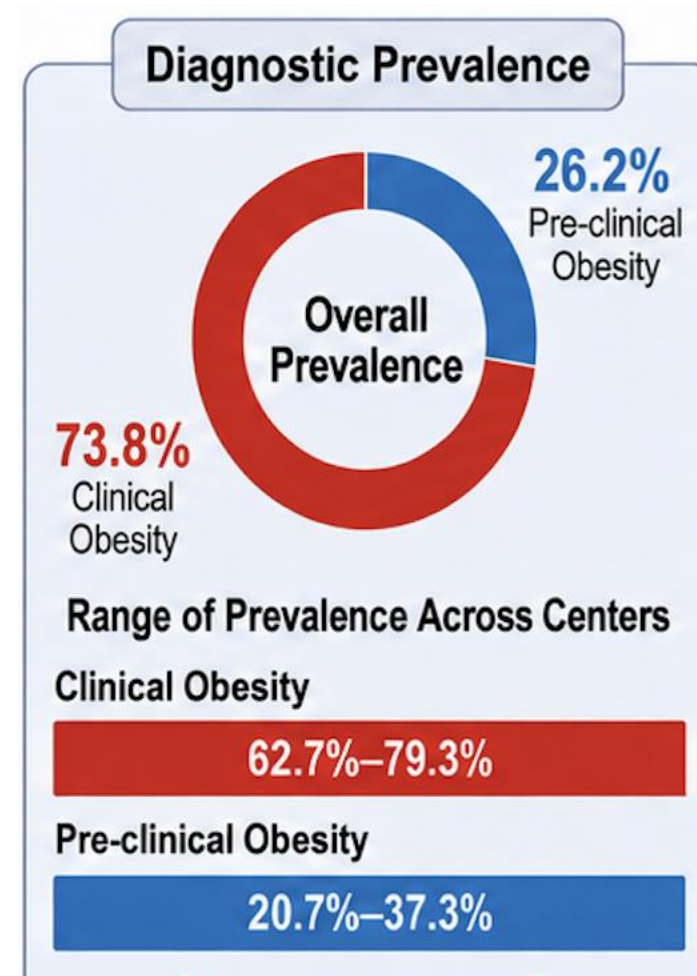
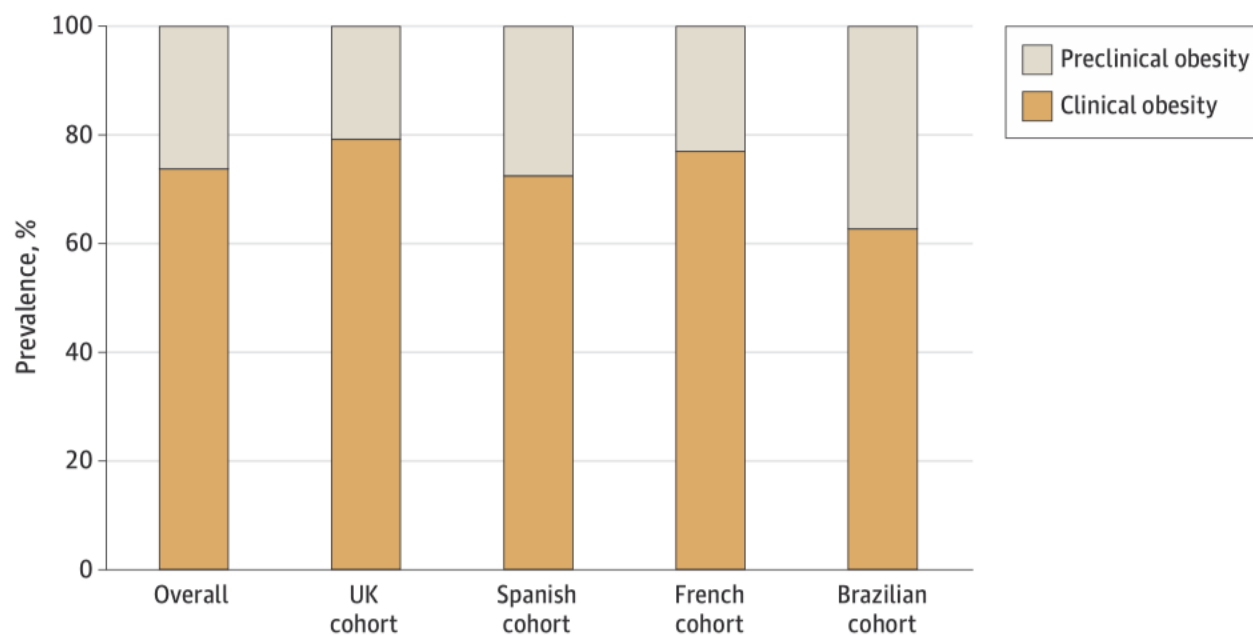


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Figure 1. Bar Graph of Prevalence of Clinical and Preclinical Obesity Among Metabolic Bariatric Surgery Candidates Across International Metabolic Bariatric Surgery Centers



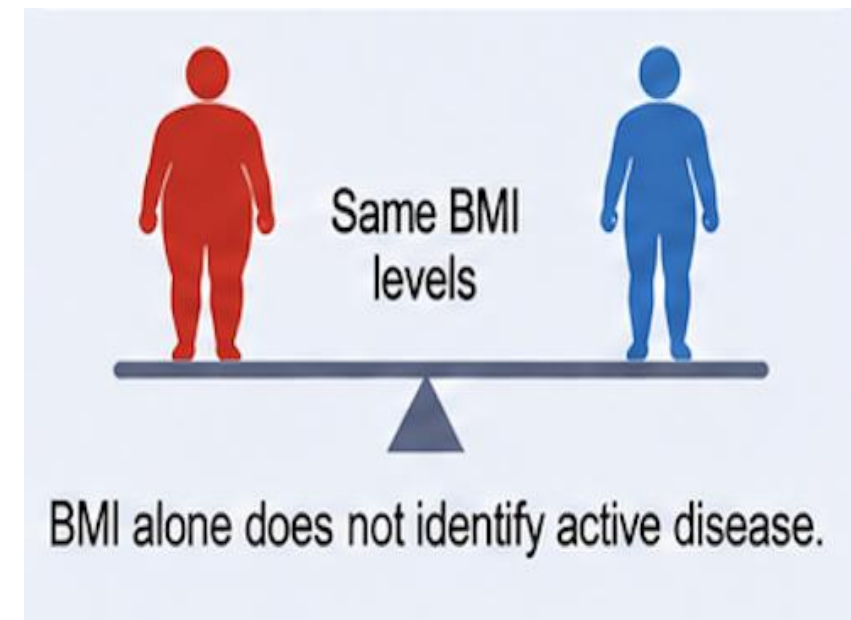
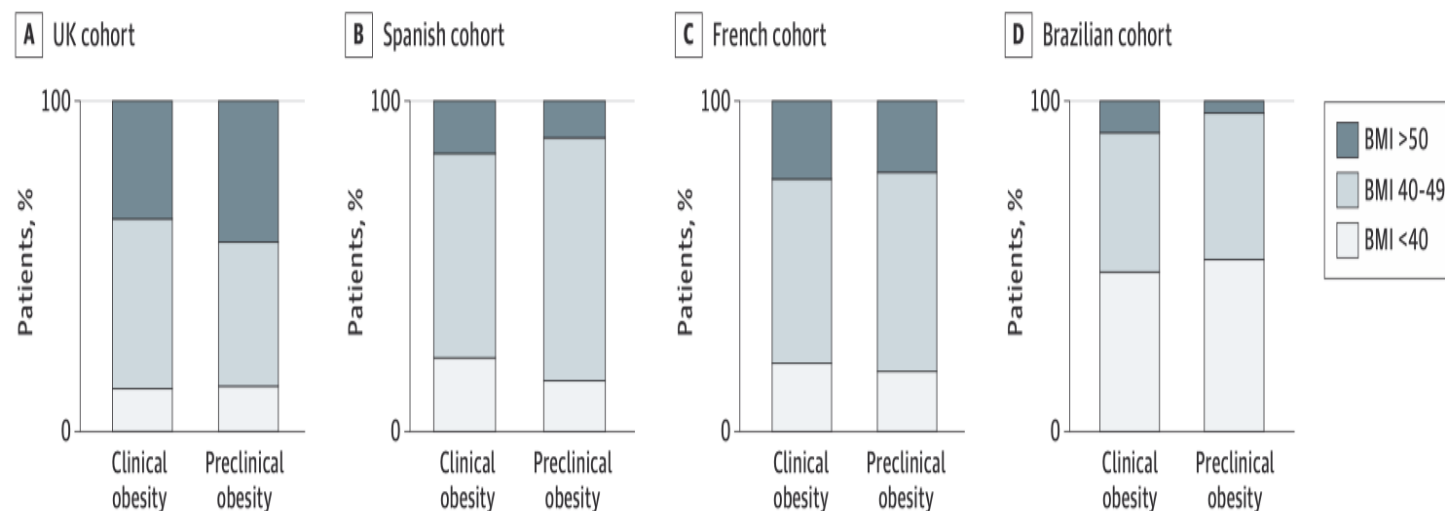


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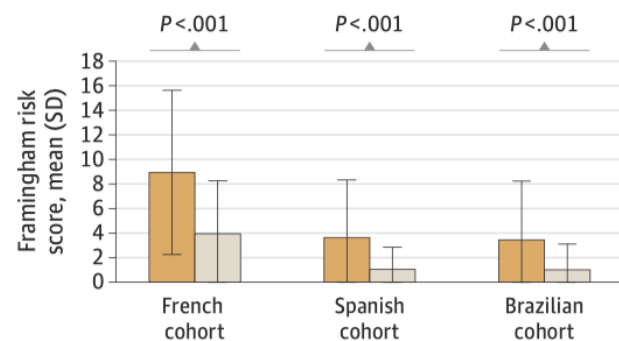
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Figure 2. Bar Graphs of the Distribution of Body Mass Index (BMI) Categories Among Patients With Clinical and Preclinical Obesity Across International Metabolic Bariatric Centers

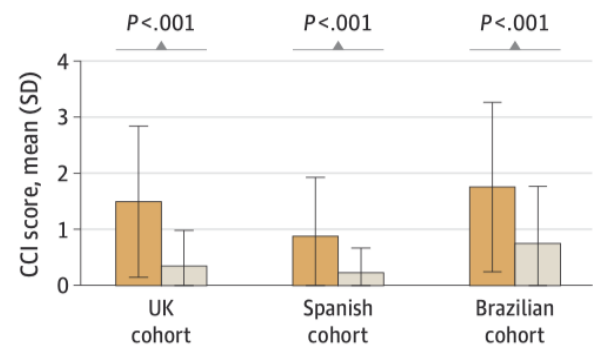


Proportion of patients within each BMI (calculated as weight in kilograms divided by height in meters squared) category.

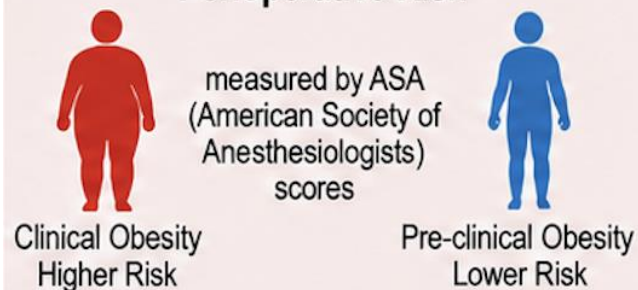
B Framingham risk score



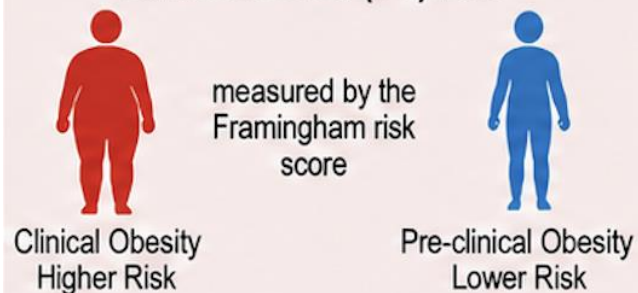
A CCI score



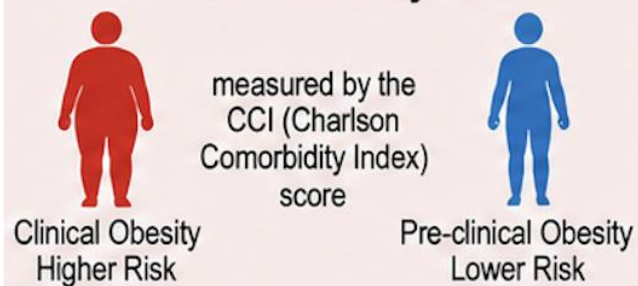
Perioperative Risk



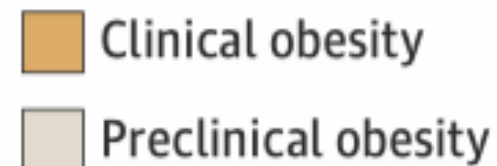
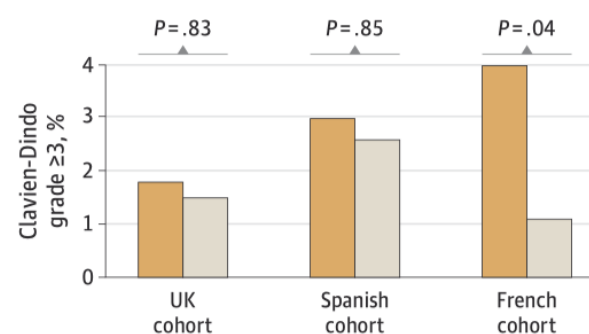
Cardiovascular (CV) Risk



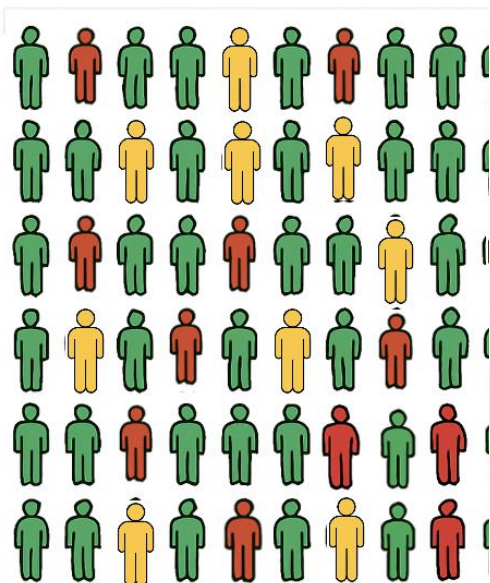
All-cause Mortality Risk



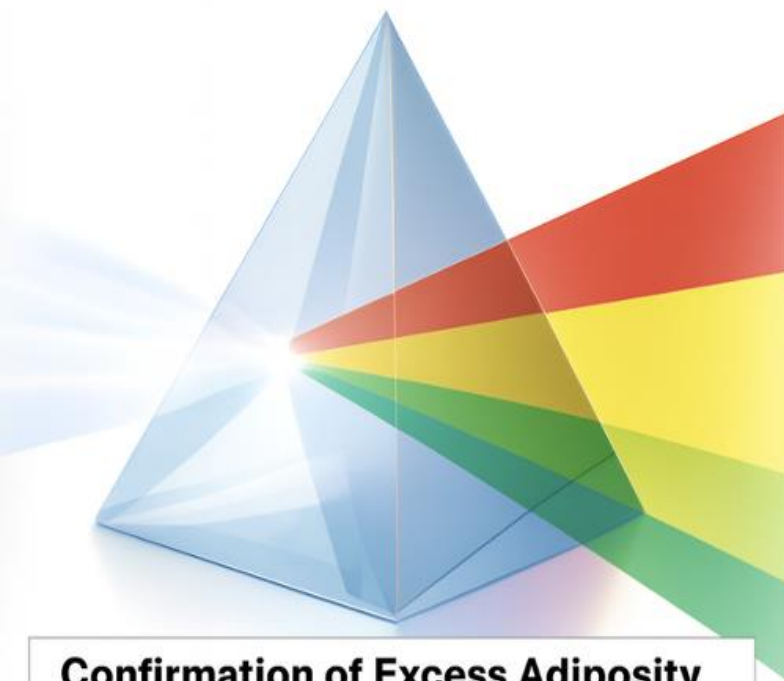
C Clavien-Dindo grade ≥ 3



Obesity



Diagnosis

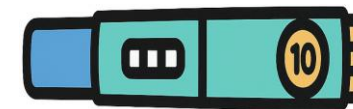


Confirmation of Excess Adiposity
Organ Impairment (Signs & Symptoms)

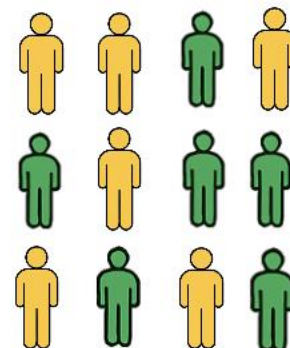
Clinical Obesity



Disease
Staging



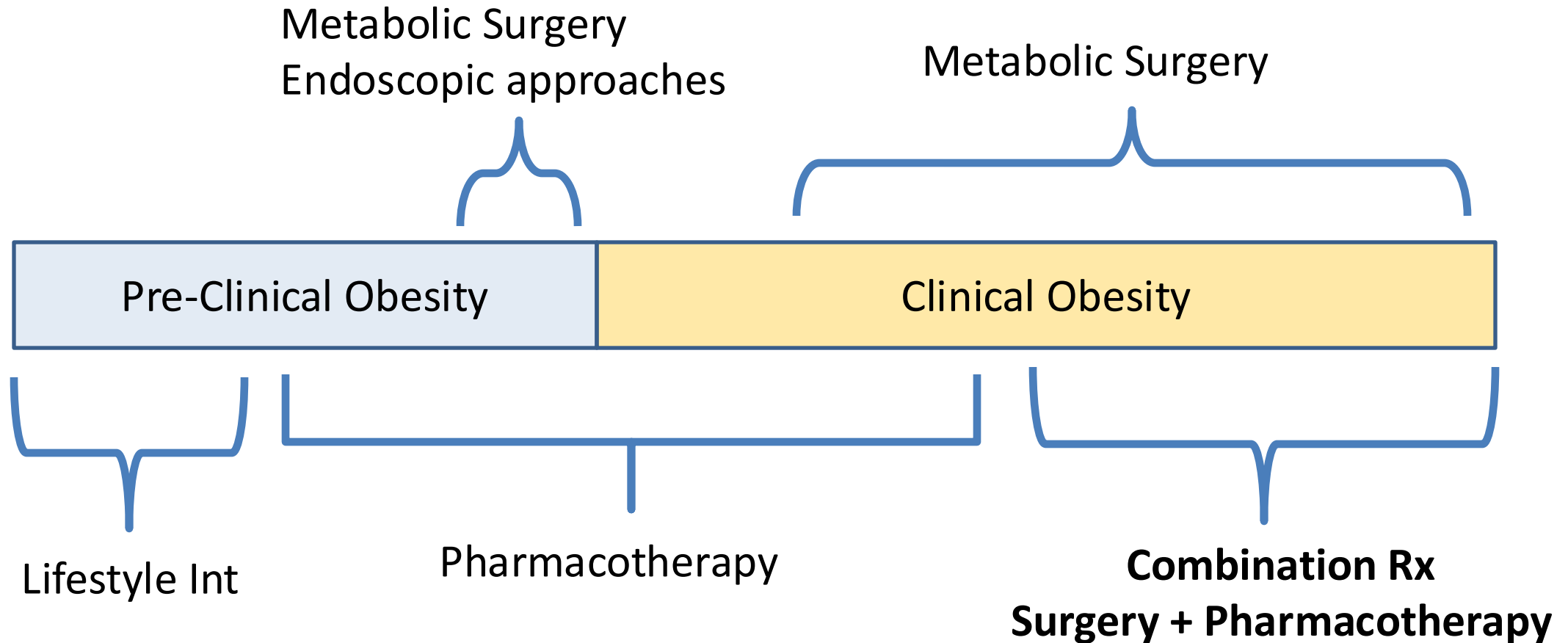
Pre-Clinical Obesity



Risk-
Scoring



The Future of Obesity Care



The future of surgery is not defined by where medications stop working.

It is defined by where something is already broken and needs durable repair.

Medications are expanding the pre-clinical space enormously — and that space was never ours. This is not a contraction of the field. It is the removal of a mandate surgery never actually held.