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TORONTO 2026

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

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Difficulty Differentiating Antiobesity Medication Side Effects from Surgical Complications

IFSO Sept 2026

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TORONTO 2026

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

16-2026

Disclosures

- W.L. Gore- speaker honorarium-teaching/moderating
- No commercial products will be discussed

The Clinical Problem



Antiobesity medications (GLP-1/GIP receptor agonists) and bariatric surgery are increasingly used **together, both** preoperatively and postoperatively

Objectives



Recognize the overlap

Identify which GI symptoms are shared between AOM side effects and surgical complications



Spot the red flags

Distinguish findings to determine need for urgent surgical evaluation vs medication management



Apply a framework

Use a structured, evidence-based approach to workup

Why the Overlap Is Growing



Obesity is a chronic disease

Why the Overlap Is Growing



34.8%

of bariatric surgery patients received preop GLP-1RA therapy in a recent surgical cohort

Clínica Univ. de Navarra, 2026

43% / 22%

of U.S. adults with diabetes / obesity report having used a GLP-1RA

J Endocrine Society, 2025

~2×

relative risk of nausea with GLP-1RA vs placebo after bariatric surgery

Meta-analysis, 6 RCTs, n=401

Clinical scenarios

- ✓ Preoperative GLP-1RA use for weight optimization before bariatric surgery
- ✓ Incidental use for T2DM management in patients who later pursue bariatric surgery
- ✓ Postoperative GLP-1RA/GIP therapy for insufficient weight loss or weight regain
- ✓ Patients presenting acutely after recent operation and active AOM use

Common Symptoms



GLP-1/GIP Receptor Agonists

- Central appetite suppression (hypothalamus/brainstem)
- Delayed gastric emptying via vagal afferents
- Reduced antral & duodenal motility, pyloric tightening
- Increased biliary cholesterol saturation with rapid weight loss



Bariatric Surgical Anatomy

- Smaller pouch/sleeve limits volume and rate of intake
- Altered anastomoses create sites for stricture & ulceration
- Mesenteric defects create potential space for internal hernia
- Rapid postop weight loss increases gallstone formation, hernia issues

Shared symptoms: nausea · vomiting · abdominal pain · bloating · reflux · early satiety

Case presentation



52-year-old woman, 12 month s/p robotic gastric bypass, started on semaglutide 1 month ago for low weight loss and subpar DM2 control

Presents with 3 days of nausea, intermittent vomiting, and epigastric discomfort after meals.



Is this simply an expected GLP-1RA side effect during dose escalation?



Could this be a gastritis, marginal ulcer, gallstone disease?



Could this be an internal hernia?



Does she need labs and imaging and urgent evaluation or safe for outpatient follow-up?

The Symptom Overlap

The same five complaints can point to either cause



Symptom	Suggests AOM side effect	Suggests surgical complication
Nausea / vomiting	Common ($\geq 10\%$), dose escalation	Stricture, marginal ulcer, SBO, internal hernia, gallbladder, ventral hernia
Abdominal pain	Common, usually mild/epigastric	Severe-Leak, ulcer perforation, internal hernia, ischemia
Bloating / distension	Delayed gastric emptying	Small bowel obstruction, dumping
Reflux / dyspepsia	Slowed motility, $\uparrow$ transit time	Stricture, hiatal issue, marginal ulcer, cholecystitis
Dehydration / AKI	Reduced intake, GI losses	Stricture with intolerance, uncontrolled vomiting

Red Flags for Surgery



Fever & tachycardia

Persistent tachycardia and fever are concerning for leak, abscess, or ischemia



Persistent bilious/forceful vomiting

Ongoing bilious vomiting suggests mechanical obstruction



Distension with peritoneal signs



Referred shoulder pain / hiccoughs

Suggests biliopancreatic limb obstruction with a distended remnant



GI bleeding or melena



Amylase/lipase in the hundreds + rising LFTs

Biliary disease vs limb obstruction

Source: High-risk, low-incidence diseases — bariatric surgery complications, Am J Emerg Med (2024)

Elevated Amylase & Lipase



BP-Limb Obstruction

- ✓ Distended excluded remnant stomach; LUQ fullness
- ✓ Referred shoulder pain, tachycardia, hiccups
- ✓ Amylase/lipase typically in the HUNDREDS, not thousands
- ✓ LFTs may be mildly elevated in chronic obstruction
- ✓ Can be pancreatic or biliary disease



AOM-Associated Pancreatitis

- ✓ Rare but reported adverse event with GLP-1RAs
- ✓ Epigastric pain radiating to back, marked tenderness
- ✓ Lipase typically rises sharply, often >3x upper limit
- ✓ No mechanical/anatomic obstruction on imaging
- ✓ Requires medication discontinuation + supportive care

Biliary Disease



Both GLP-1RA–driven weight loss and post-surgical weight loss increase biliary cholesterol saturation and gallstone risk

Clues AOM-related cholelithiasis

- ✓ Weight loss correlates with duration of therapy and symptoms
- ✓ No recent anastomotic or foregut surgery
- ✓ Typical biliary colic pattern: postprandial RUQ pain

History clues favoring post-surgical biliary complication

- ✓ Onset temporally clustered after surgery
- ✓ Concurrent stricture or leak may alter presentation
- ✓ Consider cystic duct injury or bile leak if recent surgery

Ulcer & Stricture vs Dyspepsia

Timing and character of symptoms carry diagnostic weight



Weeks 0–12

Anastomotic stricture: postprandial pain, dysphagia, food intolerance, vomiting soon after eating

Weeks 2–8 (dose escalation)

GLP-1RA dyspepsia/nausea: worsens with dose increases, improves with slower titration

Months–years

Marginal ulcer: epigastric pain, nausea, GI bleeding, NSAIDs use, smoking, large pouch
Stricture: epigastric pain, dysphagia, food intolerance, vomiting, GERD

Up to 61% of marginal ulcers are asymptomatic; perforation occurs in ~1.4%

Internal Hernia



Easily missed

- ✓ Symptoms are intermittent, vague, and can mimic benign disease
- ✓ ~5% lifetime incidence after bypass procedures; can occur at any time
- ✓ Rapid, sudden weight loss creates mesenteric potential space
- ✓ Imaging can be helpful or nondiagnostic
- ✓ Delay risks bowel ischemia

Clinical takeaway

A post-bariatric patient on an AOM who develops new, unexplained, intermittent abdominal pain — even without classic obstructive signs — warrants a low threshold for CT imaging to exclude internal hernia before attributing symptoms to the medication.

Perioperative GLP-1RA Considerations



Jun 2023

ASA recommends holding GLP-1RAs before elective procedures (1 week dosing)

Oct 2024

Multisociety guidance (ASA, AGA, ASMBS): continue in most patients

Today

Risk-stratify by symptoms and dosing phase, not blanket discontinuation

Practical management points



GI symptoms (nausea, vomiting, dyspepsia, distension) predict increased residual gastric contents, screen on day of surgery



Higher-risk patients: dose-escalation, weekly dosing, higher doses



Mitigation: 24-hour clear-liquid diet, gastric ultrasound if available, rapid-sequence induction



Same aspiration risk framework surgical teams already use for endoscopy and induction, include AOM use

Source: ASA Consensus-Based Guidance (2023); Multisociety Clinical Practice Guidance, Clin Gastroenterol Hepatol (2024)

A Practical Diagnostic Framework



1

History & timing

Relation to dose/dose change vs postop;
NSAID/smoking use

2

Red-flags

Fever, tachycardia, peritoneal signs, bleeding,
referred shoulder pain

3

Targeted labs

CBC, lipase/amylase (magnitude matters), LFTs,
lactate, pregnancy test

4

Imaging

CT with contrast for obstruction/hernia/leak,
UGI series for motility

5

Endoscopy

EGD for ulcer, stricture, bleeding with aspiration
precautions if on AOM

6

Disposition

Low threshold for surgical consult

Case presentation #2



**48-year-old woman, 1wk s/p robotic gastric bypass,
started on farxiga(dapagliflozin) 4 days for subpar DM2 control**

Presents with lethargy, nausea, and severe acidosis. ER calls and tells you “She looks really sick”



Euglycemic diabetic ketoacidosis with sodium-glucose transporter type 2 (SGLT-2)



Check for ketones, serum pH ≤ 7.3 , bicarb level ≤ 18



Can worsen with diminished caloric intake



Treat with fluids, stop med, insulin gtt

Don't forget SGLT-2 inhibitors

Key Takeaways



Nausea, vomiting, and abdominal pain overlap heavily between AOM side effects and surgical complications



Magnitude of lab abnormalities and imaging findings help obstruction vs pancreatitis



Weight loss itself raises the shared risks of gallstones and internal hernia in pts with h/o MBS



Maintain a low threshold for imaging and surgical consultation



Apply the same aspiration-risk mindset to AOM users perioperatively that are used for bariatric anesthesia

Selected Literature



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Questions?

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Credits: layout and template style with Claude AI, infographics and images by Powerpoint and Freepik



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