The IFSO Consensus Conference on the Use of OMMs in the Context of MBS

Use of OMMs before MBS

Gerhard Prager

Prof. of Bariatric & Metabolic Surgery
Medical University of Vienna

President IFSO 2023/2024

Past President IFSO-EC 2018-2021

Disclosures

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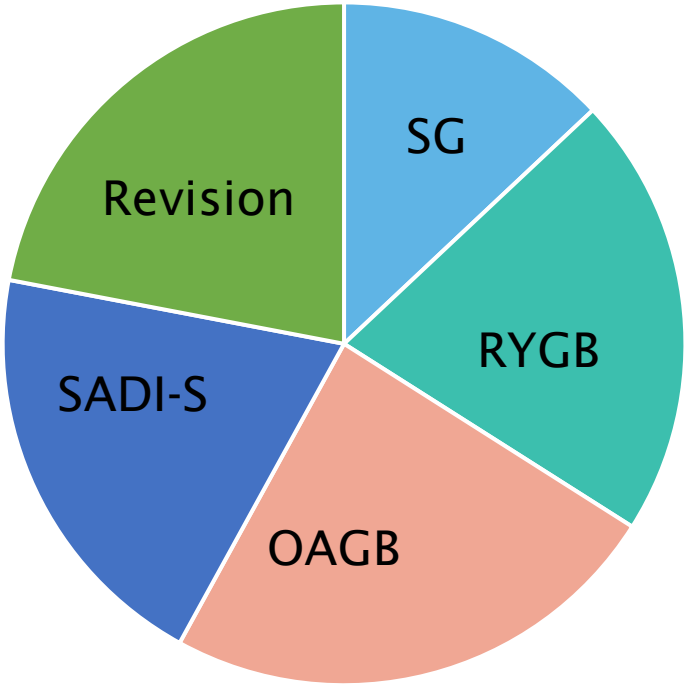
Case-Mix



LAGB	0%
SG	13%
RYGB	21%
OAGB	24%
SADI-S	20%
Revision	22%

Introduction

No top level evidence regarding efficacy of preoperative OMM treatment for reducing perioperative risks

Still scarce evidence for use of OMMs as adjunct therapy to MBS

Role in - suboptimal responders
- recurrent weight gain

unclear so far…

Objectives:

Bringing together leading physicians, surgeons, researchers and thought leaders in the realm of obesity medicine and MBS

Explore latest developments in OMMs and their synergies with MBS

Active participation: ASMBS, WOF, EASO, IDF

Core Scientific Committee
Gerhard Prager, *Austria*
Luca Busetto, *Italy*
Ricardo Cohen, *Brazil*

Systematic Review Committee
Mohammad Kermansaravi, *Iran*
Chetan Parmar, *UK*

Delphi Expert
Randy Levinson, *USA*

Invited Experts

METABOLIC BARIATRIC SURGEONS
Ali Aminian, *USA*
Ricardo Cohen, *Brazil*
Nicola Di Lorenzo, *Italy*
Khaled Gawdat, *Egypt*
Mohammed Hadad, *UAE*
Mohammad Kermansaravi, *Iran*
Lilian Kow, *Australia*
Marina Kurian, *USA*
Muffazal Lakdawala, *India*
Abdelrahman Nimeri, *USA*
Chetan Parmar, *UK*
Silvana Perretta, *France*
Luis Poggi, *Peru*
Jaime Ponce, *USA*
Gerhard Prager, *Austria*
Francesco Rubino, *UK*
Paulina Salminen, *Finland*
Phil Schauer, *USA*
Scott Shikora, *USA*
Michel Suter, *Switzerland*

OBESITY PHYSICIANS
Nasreen Al Faris, *Saudi Arabia*
Matthias Blüher, *Germany*
Luca Busetto, *Italy*
Lena Carlsson, *Sweden*
David Cummings, *USA*
Dror Dicker, *Israel*
Linong Ji, *China*
Lee Kaplan, *USA*
Arya Sharma, *Germany*
Sara Suliman, *UAE*
Wei Tham, *Singapore*
Josep Vidal, *Spain*
Tarissa Zanata Petry, *Brazil*

INTEGRATED HEALTH EXPERTS
Silvia Leite, *Brazil*
Mary O'Kane, *UK*
Andrea Schroeder, *New Zealand*

PARTNER SOCIETIES' REPRESENTATIVES
Jason Halford
EASO President, *UK*
Carel Le Roux,
WOF Clinical Care Committee
Ireland
Peter Schwarz
IDF President elect, *Germany*

PATIENTS' REPRESENTATIVES
Vickey Mooney, *Ireland*
Ximena Ramos Salas, *Sweden*

41 experts: Endocrinology, diabetology, internal medicine, gastroenterology, allied health, surgery, and patients

Impact on advancing collective understanding of obesity management in the context of MBS

Core Group:

Gerhard Prager
Randy Levinson (Delphi Expert)
Ricardo Cohen
Luca Busetto

Mohammad Kermansaravi
Chetan Parmar

Systematic Review

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Randy Levinson (Delphi Expert)

Mohammad Kermansaravi
Chetan Parmar

Systematic Review

1. Systematic Review
2. Evidence Paper sent to all experts
3. Each Expert 3-4 Delphi statements
4. Delphi process:
    a. 3 Delphi rounds BEFORE meeting
    (for B or less including feedback for each round)
    b. Delphi process at the meeting

Consensus (%)	Level
100%	A+
90-99.9%	A
80-89.9%	B
70-79.9%	C
60-69.9	D
<60%	failure

Day 1: Lectures - 3 Modules:

1. Use of OMMs before MBS
    a. How much weight loss do we need for health? Carel Le Roux
    b. Use and Choice of OMMs prior to MBS Josep Vidal
    c. Are there Subgroups with special Benefits from OMM Treatment prior to MBS? Nasreen Al Faris

2. Use of OMMs after MBS
    a. Evidence &Timing for Omms in case of recurrent weight gain or inadequate initial response Lee Kaplan
    b. Treatment with OMM due to recurrent weight gain/persistent metabolic disease Dror Dicker
    c. Evidence & Rationale for continuous or intermittent use of OMM after MBS Dave Cummings
    d. Endoscopic Procedures and OMM Silvana Perretta
    e. Comparison of the Efficacy of OMM with and without MBS Kwang Wei Tham

3. The Future
    a. A perspective on Cost-Effectiveness of OMM and MBS Ricardo Cohen
    b. What is in the pipeline? Matthias Blüher
    c. What will be the Role of Revisional Surgery with Modern Pharmacotherapy? Phil Schauer
    d. How to deal with the Challenges of MBS and lifelong OMM use Arya Sharma
    e. Potential Need for further Studies Francesco Rubino

Day 2:

Delphi Process & Discussion

Day 1: Lectures - 3 Modules:

1. Use of OMMs before MBS
    a. How much weight loss do we need for health? Carel Le Roux
    b. Use and Choice of OMMs prior to MBS Josep Vidal
    c. Are there Subgroups with special Benefits from OMM Treatment prior to MBS? Nasreen Al Faris

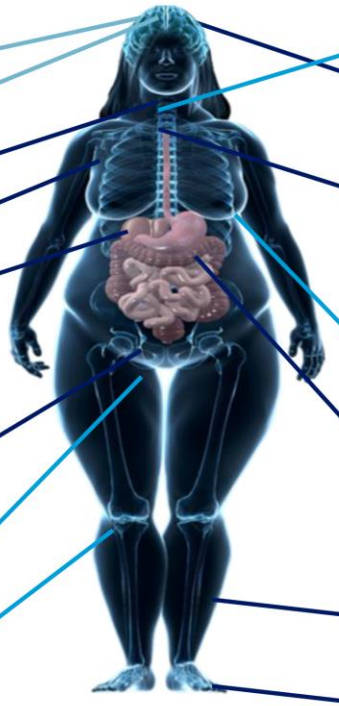
1. Statements on Use of OMMs before MBS:

	Grade	Consensus (%)	Nr.of rounds	Nr.of total votes
Clinical obesity is a disease that requires treatment	A+	100	2	39
Patients should be informed of the risks and benefits of evidence-based treatment options for obesity	A+	100	1	37

1. Statements on Use of OMMs before MBS:

	Grade	Consensus (%)	Nr.of rounds	Nr.of total votes
A minimum of 5% weight loss has shown metabolic improvements; however, greater weight loss is associated with broader clinical benefits, including a reduction in mortality	A	97	3	39

Obesity is associated with multiple comorbidities and complications



Metabolic

Mechanical

Mental

Depression

Anxiety

Asthma

NAFLD

Gallstones

Infertility
- Subfertility
- hypogonadism (male)
- PCOS
- pregnancy complications

Incontinence

Knee osteoarthritis

Sleep apnoea

CVD and risk factors
- Stroke
- Dyslipidaemia
- Hypertension
- Coronary artery disease
- Coronary heart failure
- Pulmonary embolism

Chronic back pain

T2D
Prediabetes

Thrombosis

Gout

Cancers*

Physical functioning

CVD, cardiovascular disease; NAFLD, non-alcoholic fatty liver disease
*Including breast, colorectal, endometrial, oesophageal, kidney, ovarian, pancreatic and prostate; T2D, type 2 diabetes

Adapted from Sharma AM. *Obes Rev*. 2010;11:808-9; Guh *et al. BMC Public Health* 2009;9:88; Luppino *et al. Arch Gen Psychiatry* 2010;67:220–9; Simon *et al. Arch Gen Psychiatry* 2006;63:824–30; Church *et al. Gastroenterology* 2006;130:2023–30; Li *et al. Prev Med* 2010;51:18–23; Hosler. *Prev Chronic Dis* 2009;6:A48

Carel Le Roux

Clinical and Translational Report

Cell Metabolism

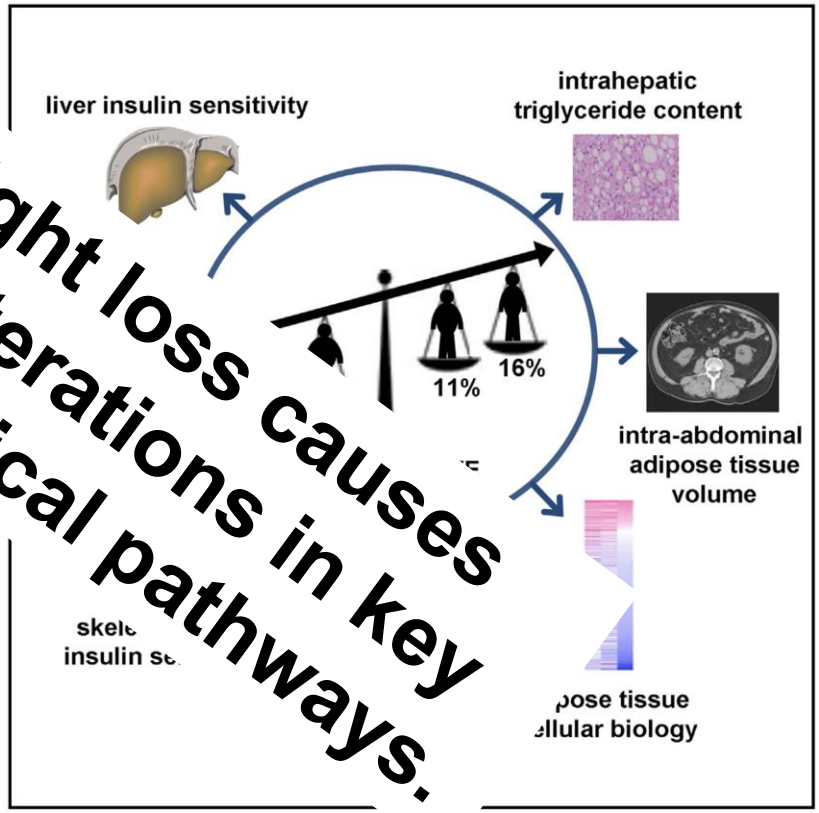
Effects of [illegible]te and Subsequent Progressive Weight L[illegible]bolic Function and Adipose Tissue [illegible]s with Obesity

Progressive weight loss causes dose-dependent alterations in key adipose tissue biological pathways.

Moderate 5% w[illegible] multi-organ insulin [illegible] beta cell function

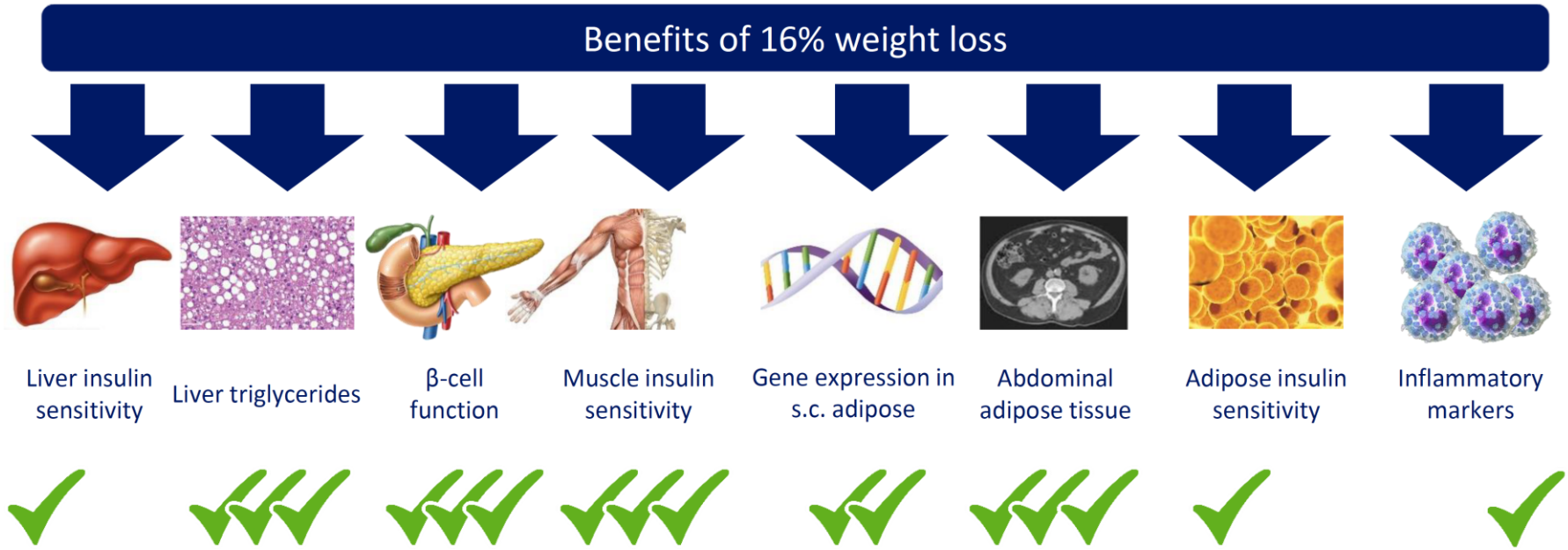
Additional weight loss of 11%- further increases insulin sensitivity muscle

Progressive weight loss causes stepwise changes in adipose tissue biology



Magkos et al., 2016, Cell Metabolism 23, 591–601

Progressive weight loss with calorie restriction has dose-dependent & tissue-dependent biological effects

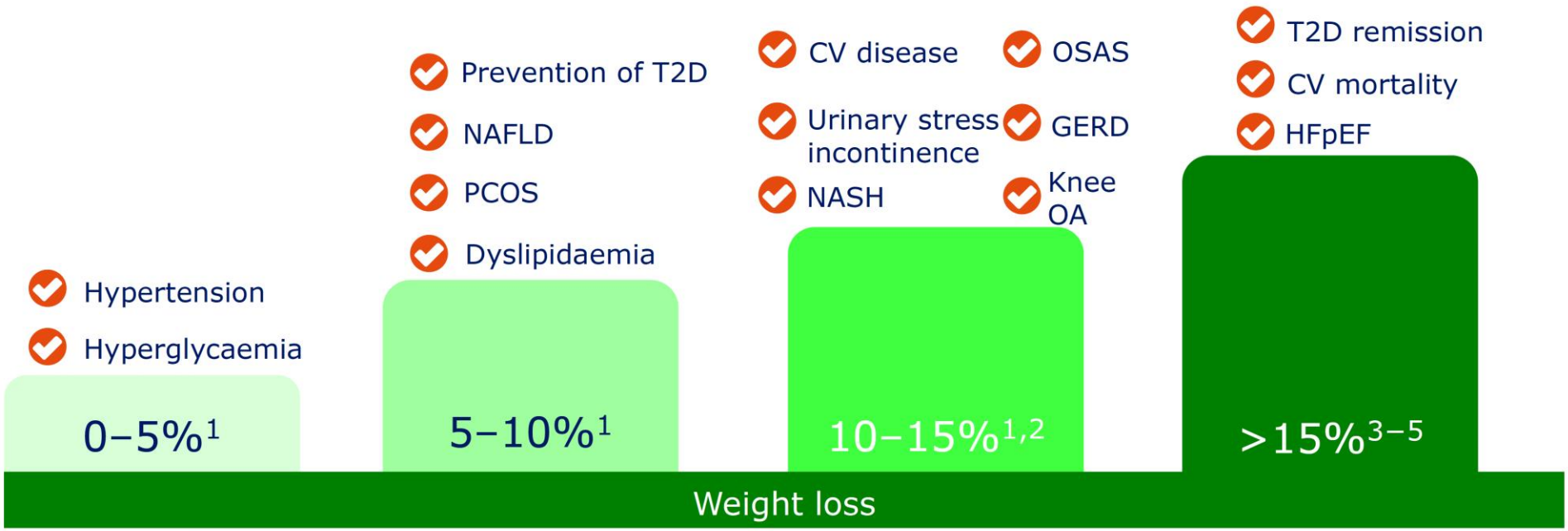


Carel Le Roux

Magkos et al., 2016, Cell Metabolism 23, 591–601

Greater weight loss leads to improved health

Towards greater weight loss and overall health improvement



CV, cardiovascular; GERD, gastro-oesophageal reflux disease; HFpEF, heart failure with preserved ejection fraction; NAFLD, non-alcoholic fatty liver disease; NASH, non-alcoholic steatohepatitis; OA, osteoarthritis; OSAS, obstructive sleep apnoea syndrome; PCOS, polycystic ovary syndrome; T2D, type 2 diabetes
1. Garvey WT *et al. Endocr Pract* 2016;22:1–20; 2. Look AHEAD Research Group. *Lancet Diabetes Endocrinol* 2016;4:913–21; 3. Lean ME *et al. Lancet* 2018;391:541–51; 4. Benraoune F and Litwin SE. *Curr Opin Cardiol* 2011;26:555–61; 5. Sundström J *et al. Circulation* 2017;135:1577–85

Finnish diabetes prevention study: More weight loss = Less Diabetes
DIRECT Study: More Weight Loss = more Diabetes Remission
Look AHEAD: Greater Weight Loss = Greater health Benefits
SELECT Trial: 9.8%TWL = 20% less nonfatal CV events

Carel Le Roux

SELECT Trial

The NEW ENGLAND JOURNAL of MEDICINE

ESTABLISHED IN 1812 DECEMBER 14, 2023 VOL. 389 NO. 24

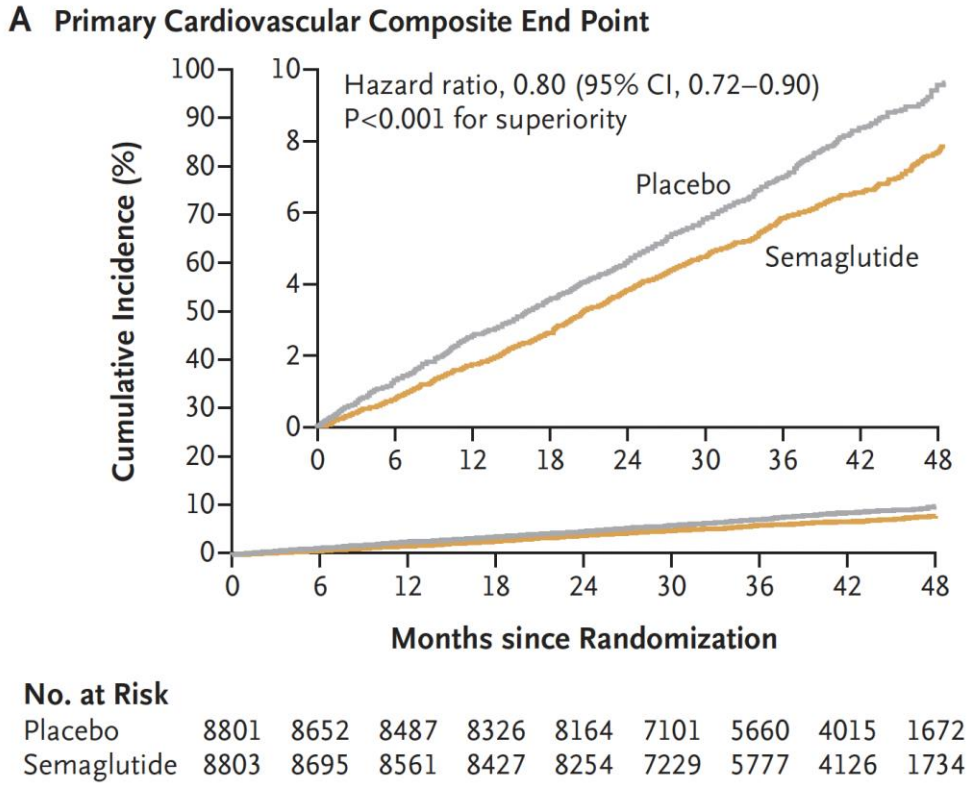
Semaglutide and Cardiovascular Outcomes in Obesity without Diabetes

A. Michael Lincoff, M.D., Kirstine Brown-Frandsen, M.D., Helen M. Colhoun, M.D., John Deanfield, M.D., Scott S. Emerson, M.D., Ph.D., Sille Esbjerg, M.Sc., Søren Hardt-Lindberg, M.D., Ph.D., G. Kees Hovingh, M.D., Ph.D., Steven E. Kahn, M.B., Ch.B., Robert F. Kushner, M.D., Ildiko Lingvay, M.D., M.P.H., Tugce K. Oral, M.D., Marie M. Michelsen, M.D., Ph.D., Jorge Plutzky, M.D., Christoffer W. Tornøe, Ph.D., and Donna H. Ryan, M.D., for the SELECT Trial Investigators*

multicenter, double-blind RCT
Patients >45a with preexisting CVD and BMI >27 but no history of diabetes.

8803 semaglutide 2.4mg
8801 placebo

Semaglutide: 20% better in CV composite end point with 9.8% TWL



primary cardiovascular end point was a composite of death from cardiovascular causes, nonfatal myocardial infarction, or nonfatal stroke

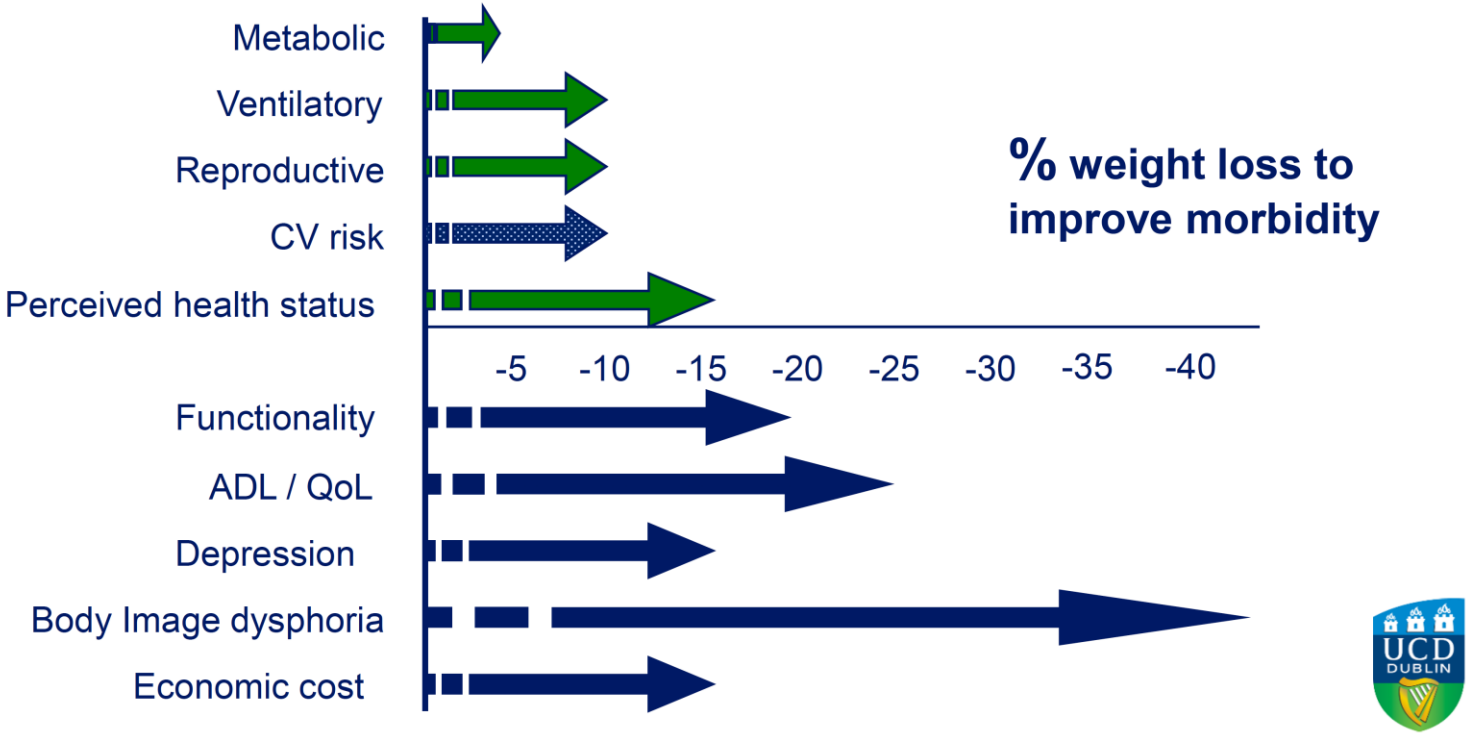
NEJM 389;24 December 14, 2023

Metabolic surgery: shifting the focus from glycaemia and weight to end-organ health

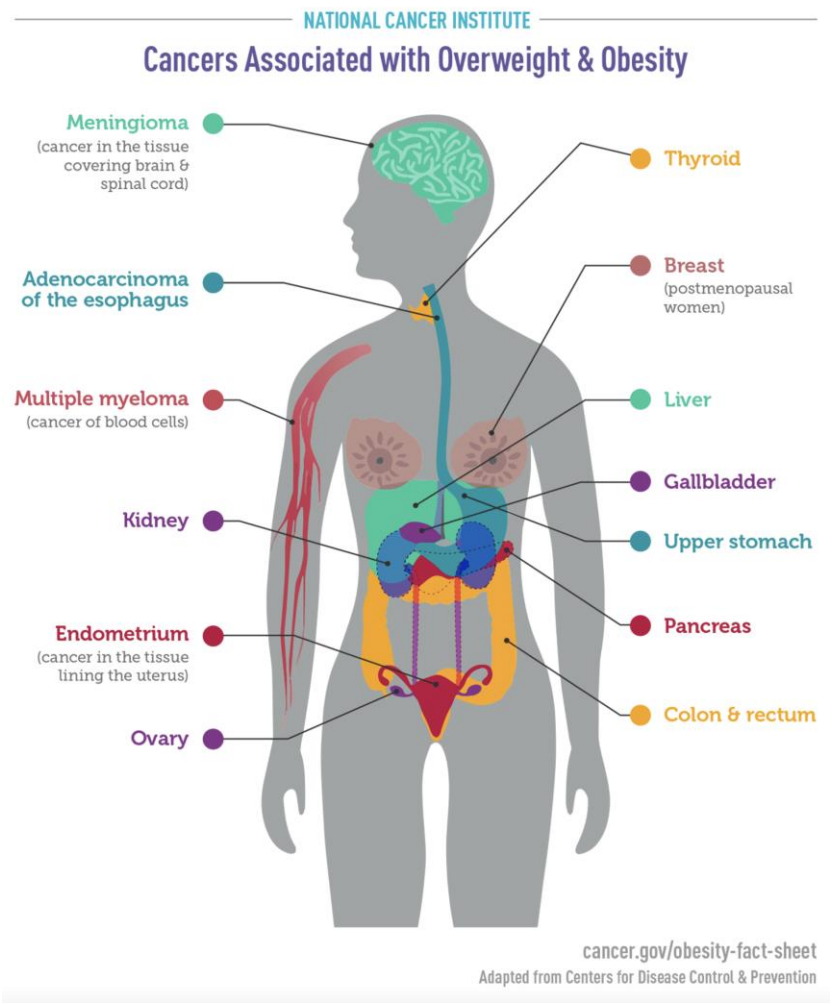
Alexander D Miras, Carel W le Roux

How much weight loss is required?

Miras and le Roux. Lancet Diabetes and Endo 2014

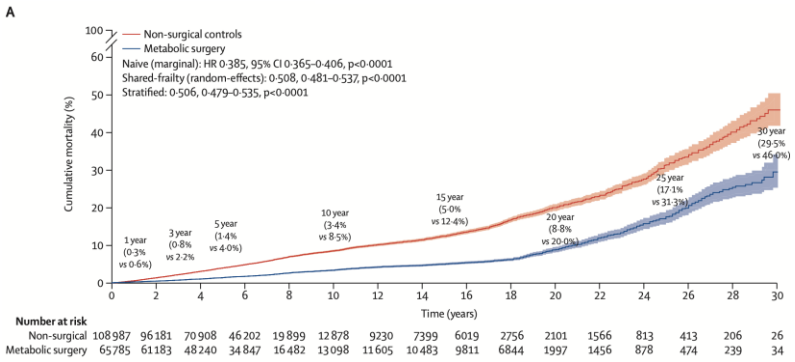


Lancet Diabetes Endocrinol 2014; 2: 141–51



More weight loss = Less Cancer

THE LANCET



MBS leads to:
Less CV events - Less cancer deaths - Less Diabetes ass. Deaths - Less Liver morbidity…

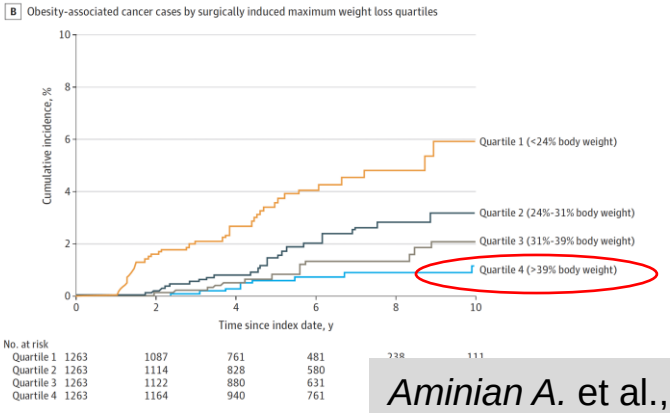
Syn NL et al., Lancet 2021

Research

JAMA | Original Investigation

Association of Bariatric Surgery With Cancer Risk and Mortality in Adults With Obesity

Ali Aminian, MD; Rickesha Wilson, MD; Abbas Al-Kurd, MD; Chao Tu, MS; Alex Milinovich, BA; Matthew Kroh, MD; Raul J. Rosenthal, MD; Stacy A. Brethauer, MD; Philip R. Schauer, MD; Michael W. Kattan, PhD; Justin C. Brown, PhD; Nathan A. Berger, MD; Jame Abraham, MD; Steven E. Nissen, MD



Aminian A. et al., JAMA 2022

1. Statements on Use of OMMs before MBS:

	Grade	Consensus (%)	Nr.of rounds	Nr.of total votes
A minimum of 5% weight loss has shown metabolic improvements; however, greater weight loss is associated with broader clinical benefits, including a reduction in mortality	A	97	3	39

1. Statements on Use of OMMs before MBS:

	Grade	Consensus (%)	Nr.of rounds	Nr.of total votes
There is insufficient high-level evidence to recommend the routine use of OMMs for weight loss before MBS	A+	100	2	37

The available evidence on the use of OMMs

Author (year)	AOM used	Main outcome measurement	Study design
Hung-Chieh (2023)	Orlistat+LS vs LS	• Pre-surgical WL @ 6 w	Retrospective
Malone (2012)	Orlistat vs placebo	• Pre-surgical WL @ 3 and 6 m	Prospective not randomized
Rubio-Herrera (2023)	Lira 3.0 (in non-DM), Sema 1.0 (in T2D)	• Pre-surgical WL @ 6 and 12-m • Withdrawal of surgical wating list	Retrospective
Wilmington (2024)	Lira 3.0	• Pre-surgical WL @ 6, 12, 26, 52 w	Retrospective
Martines (2023)	Lira 3.0, IGB	• Pre-surgical WL @ 6 m	Prospective not randomized
Morton (Abstract, 2018)	Phen low dose vs placebo	• Pre-surgical WL @ 14 w	RCT (n=53)
Guisado-Macías (2016)	Fluoxetine (F) 40, Topiramate (T) 200, F-40+T-200	• Pre-surgical WL @ 6 m	Prospective-observational
Sari (2021)	Topiramate ± Metformin	• Pre-surgical WL	Case report (3 cases)
Alabduljabbar (2023)	*Review article*	----	

LS: Lifestyle; WL: weight los; lira: liraglutide; sema: semaglutide; Phen: Phentermine; RCT: randomized controlled trial

With thanks to Dr. Kermansaravi and Dr. Parmar

The available evidence on the use of OMMs

Author (year)	AOM used	Main result	Additional outcomes
Hung-Chieh (2023)	Orlistat+LS vs LS	ORL+LS no… …S @ 6 w	Operation time, LOS, 30-d complication rates not different
Malone (2012)	Orlistat vs placebo	…m	none
Rubio-Herrera (2023)	Lira 3.0 (in non-DM), Sema 1.0 (in T2D)	…/Lira 3.0)	None
Wilmington (2024)	Lira 3.0	…	Remission of preDM: 72% @ 12 m
Martines (2023)	Lira 3.0, IGB	…).005)	The IGB group > WL following SG
Morton (Abstract, 2018)	Phen low dose vs …	…ups	None
Guisado-Macías (2016)	Fluoxetine (F) 40, Topiramate (T) 200, F-40+T-200	…8.0	None
Sari (2021)	Topiramate ± Metformin	• Pre-surgical …	Case report (3 cases)
Alabduljabbar (2023)	*Review article*	----	

LS: Lifestyle; WL: weight los; lira: liraglutide; sema: semaglutide; Phen: Phentermine; RCT: randomized controlled trial

With thanks to Dr. Kermansaravi and Dr. Parmar

Nonetheless, evidence is lacking on the impact of the use of the new OMMs on surgical outcomes.

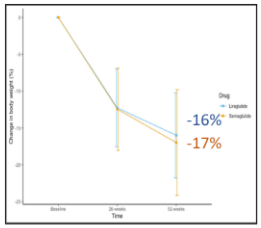
Currently, there is not enough data to tailor the choice of OMMs for patients with obesity.

The available evidence on the use of OMMs

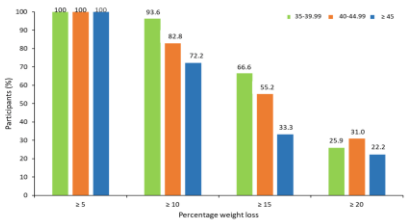
Liraglutide 3.0 (in non-T2D) or Semaglutide 1.0 (in T2D) and weight loss in subjects on a MBS waiting list

(**RETROSPECTIVE STUDY.** n=102, estimated time in waiting list >12 mo, age 53 y, female 69%, BM 43.5 kg/m²)

% Weight loss over time



% Weight loss category by BMI category



No data on the impact on glycemic control or surgical outcomes

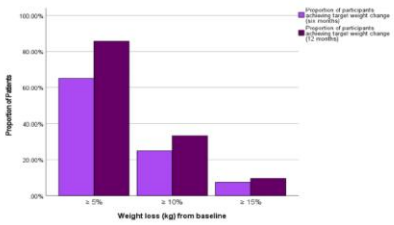
Rubio-Herrera MA et al. Biomedicines 2023

The available evidence on the use of OMMs

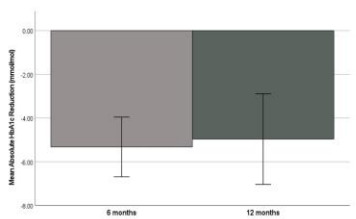
Liraglutide 3.0 and weight loss pre-MBS in subjects with pre-diabetes

(n=50, age 46 y, female 76%, BM 54.1 kg/m²)

% Weight loss category @ 6- and 12-mo



Change in HbA1c @ 6- and 12-mo



Remission of preDM → 92.3% 72.2%

No data on the impact on surgical outcomes

Wilmington R et al. Obesity Surgery 2024

Josep Vidal

1. Statements on Use of OMMs before MBS:

	Grade	Consensus (%)	Nr.of rounds	Nr.of total votes
The decision to use OMMs before MBS should be personalized to determine the most appropriate strategy for each patient's circumstances	A+	100	2	38

Rationale for OMMs before MBS:

1. Reduction of perioperative risk

2. Increased proportion of those achieving weight loss goals and comorbidity resolution after surgery

JAMA Network | Open

Original Investigation | Surgery

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

Yangbo Sun, MD, PhD; Buyun Liu, MD, PhD; Jessica K. Smith, MD; Marcelo L. G. Correia, MD, PhD; Dana L. Jones, DNP; Zhanyong Zhu, MD; Adeyinka Taiwo, MD; Lisa L. Morselli, MD, PhD; Katie Robinson, PhD; Alexander A. Hart, MPH; Linda G. Snetselaar, PhD; Wei Bao, MD, PhD

Reduction in 30 day mortality:

0%–5.0%:	24%
5.0%–9.9%:	31%
>10.0%:	42%

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.

Department of Surgery, University of Alberta, Edmonton, Alberta, Canada

Received 2 March 2021; accepted 29 June 2021

When compared to individuals who did not lose weight prior to surgery, >10% TBWL preoperatively :
-30% decreased odds of leaks
-40% decrease in odds of mortality

Mocanu V. et al. SOARD-(2021) 1–8

Sun Y,Liu B,Smith JK, et al. *JAMA NetwOpen.*2020;3(5):e204803

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

Jamil S. Samaan[1] · Jasmine Zhao[2] · Elaine Qian[2] · Angelica Hernandez[2] · Omar Toubat[2] · Evan T. Alicuben[2] · Yousaf Malik[2] · Kulmeet Sandhu[2] · Adrian Dobrowolsky[2] · Kamran Samakar[2]

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

Victor Eng, B.S.[a], Luis Garcia, M.S.[a], Habib Khoury, B.S.[b], John Morton, M.D., M.P.H.[a], Dan Azagury, M.D.[a,*]

[a]*Bariatric and Minimally Invasive Surgery, Stanford School of Medicine, Stanford, California*
[b]*David Geffen School of Medicine, University of California at Los Angeles, Los Angeles, California*

Received 18 April 2018; accepted 5 March 2019

Longer preop wait times do not result in improved weight loss or reduced adverse events….
…delay of treatment should be minimized

Surgery for Obesity and Related Diseases 15 (2019) 951–957
Samaan, Jamil S., et al. *Journal of Gastrointestinal Surgery*26.1 (2022): 86-93.

2022 American Society for Metabolic and Bariatric Surgery (ASMBS) and International Federation for the Surgery of Obesity and Metabolic Disorders (IFSO): Indications for Metabolic and Bariatric Surgery

Dan Eisenberg, M.D.[a,*], Scott A. Shikora, M.D.[b], Edo Aarts, M.D., Ph.D.[c], Ali Aminian, M.D.[d], Luigi Angrisani, M.D.[e], Ricardo V. Cohen, M.D., Ph.D.[f], Maurizio De Luca, M.D.[g], Silvia L. Faria, Ph.D.[h], Kasey P. S. Goodpaster, Ph.D.[d], Ashraf Haddad, M.D.[i], Jacques M. Himpens, M.D., Ph.D.[j], Lilian Kow, B.M.B.S., Ph.D.[k], Marina Kurian, M.D.[l], Ken Loi, M.B.B.S., B.Sc. (Med)[m], Kamal Mahawar, M.B.B.S., M.Sc.[n], Abdelrahman Nimeri, M.D., M.B.B.Ch.[o], Mary O'Kane, M.Sc., R.D.[p], Pavlos K. Papasavas, M.D.[q], Jaime Ponce, M.D.[r], Janey S. A. Pratt, M.D.[a,s], Ann M. Rogers, M.D.[t], Kimberley E. Steele, M.D., Ph.D.[u], Michel Suter, M.D.[v,w], Shanu N. Kothari, M.D.[x]

"*While there has been initial enthusiasm for weight loss prior to surgery, there are no data to support the practice of insurance-mandated preoperative weight loss; this practice is understood to be discriminatory, arbitrary, and scientifically unfounded, contributing to patient attrition, unnecessary delay of lifesaving treatment, and progression of life-threatening co-morbid conditions . A multidisciplinary team can help assess and manage the patient's modifiable risk factors with a goal of reducing risk of perioperative complications and improving outcomes; the decision for surgical readiness should be primarily determined by the surgeon*. "

Surgery for Obesity and Related Diseases 18 (2022) 1345–1356

1. Statements on Use of OMMs before MBS:

	Grade	Consensus (%)	Nr.of rounds	Nr.of total votes
The decision to use OMMs before MBS should be personalized to determine the most appropriate strategy for each patient's circumstances	A+	100	2	38

Special Circumstances can be:

BMI > 60 kg/m^2,
Cirrhosis/Huge Livers
heart failure/progressed CVD
end-stage kidney disease

1. Statements on Use of OMMs before MBS:

	Grade	Consensus (%)	Nr.of rounds	Nr.of total votes
Healthy nutrition, including adequate protein consumption, as well as resistance exercise, is recommended for those treated with OMMs prior to MBS	A	97	2	36

New OMMs lead to greater weight loss:

Deficiencies
Lean Body Mass loss

1. Statements on Use of OMMs before MBS:

	Grade	Consensus (%)	Nr.of rounds	Nr.of total votes
In general, preoperative treatment with OMMs should be discontinued prior to MBS to minimize perioperative risk	A	94	3	35

LOE III

Impact of GLP-1 RA and other „new“ OMM on Gastric emptying Risk of Aspiration

American Society of Anesthesiologists Consensus-Based Guidance on Preoperative Management of Patients (Adults and Children) on Glucagon-Like Peptide-1 (GLP-1) Receptor Agonists

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American Society of Anesthesiologists®

- For patients on daily dosing consider holding GLP-1 agonists on the day of the procedure/surgery. For patients on weekly dosing consider holding GLP-1 agonists a week prior to the procedure/surgery. (June 29, 2023)


XXVIII IFSO World Congress
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CONGRESS OF THE INTERNATIONAL FEDERATION
FOR THE SURGERY OF OBESITY AND METABOLIC DISORDERS
- EUROPEAN CHAPTER -

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IFSO Consensus Conference 2023

Section 1. Definitions and Reporting Standards

Former ~~"Morbid~~ Obesity", "~~Super~~ Obesity"

"Morbid" Obesity: Obesity Grade 3

"Super" Obesity: Obesity Grade 4

Scientific Evidence for the Updated Guidelines on Indications for Metabolic and Bariatric Surgery (IFSO/ASMBS) - unpublished

BMI CRITERIA FOR MBS

- **MBS for BMI 30 - 34.9 kg/m^2 (7-35)**
  - **PRISMA Appendix 1 [PubMed, Cochrane, Embase]**
  - **Systematic Review Table 1**

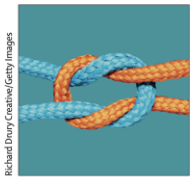
- *MBS is recommended for patients with T2DM and a BMI of 30-34.9 kg/m^2.*
- *MBS is recommended for patients with a BMI of 30-34.9 kg/m^2 and one obesity-associated medical problem.*
- *MBS should be considered in patients with a BMI of 30-34.9 kg/m^2 who do not achieve substantial or durable weight loss or co-morbidity improvement using nonsurgical methods.*

Level of Evidence 2a

Grade of recommendation B

Obes Surgery 2024/SOARD 2024

Lancet Diabetes & Endocrinology Commission on the Definition and Diagnosis of Clinical Obesity



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Obesity was first recognised as a disease by WHO in 1948, then between 2013 and 2022 by several medical societies and countries.[1-8] However, the notion that obesity is a disease and not merely a risk factor for other illnesses remains highly controversial, both within and beyond medical circles. This debate constitutes far more than arcane semantics, and seriously affects the provision of therapeutic strategies to improve health among people living with obesity.

On one side of the controversy, there is concern that defining obesity as a disease could have negative and overdiagnosis of obesity. In our opinion, the risk of overdiagnosis is a legitimate concern, especially for policy makers, because a blanket definition of obesity as a disease would classify approximately 30–40% of people in many nations as having this illness.[9] This definition could render over a third of these populations suddenly eligible for claims of disability or expensive treatments. Such claims would effectively make obesity a financially and socially intractable issue. In summary, there is apprehension within and outside the medical profession that categorising obesity as a disease could

The **Lancet commission** worked for more than 2 years on a (new) **definition of clinical obesity as a disease**

The results will be published in a few weeks

Endorsed by IFSO

→ **Obesity as a disease**
→ Awareness policy makers/healthcare providers
→ Enable Access to (effective) treatment

Lancet, Vol 11, April 2023; 217

IFSO European Chapter

See you in Vienna

SAVE THE DATE

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Lose Weight – Live Longer

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Conclusion

- Obesity as a **chronic relapsing disease** requires different interventions (surgical, endoscopic, pharmaceutical, etc.)
- **Surgical interventions** have demonstrated long-term durable success
- Importance of **evidence based** treatment in bariatric/metabolic patients
- Several **new therapy options** available (Indications: Weight regain? Low BMI patients? etc.)