

ECHO OBN - SESSION RESOURCE

2026-2027

**Modern GLP Therapy & Bariatric Surgery:
Two pillars of care, working together**



What is ECHO OBN?

ECHO Ontario Bariatric Network bridges the gap between community providers and specialized bariatric expertise across Ontario. Through focused, interactive virtual sessions, clinicians and allied health gain practical strategies they can immediately apply in their own practices.

ECHO OBN is among the world's largest coordinated knowledge-sharing networks in bariatric and obesity care.

Thank you for your contribution and being part of something so important and special to the healthy weight loss and life-long health community.

Your dedication and impact on patient care will not go unnoticed.

10

Participating Bariatric Centres of Excellence

10

Different Healthcare Disciplines Welcomed

45 min

Session Format, Practical & Focused

Why ECHO OBN Matters



Stay Current

Help caregivers keep up with new obesity medications, surgical care, and long-term management strategies in a rapidly evolving field.



Provincial Expertise

Connect multidisciplinary teams at Ontario's Bariatric Centres of Excellence directly to community practitioners.



Real Patient Cases

Share anonymized cases from our own participants and provide guidance to others experiencing similar challenges.



CME Credits

Deliver CME accredited sessions while sharing practical approaches to real clinical challenges.



Fits Busy Schedules

Redesigned 45-minute sessions require no lengthy preparation — high value, low burden.



Community of Practice

Connect with clinicians and care givers across Ontario managing similar patients and navigating shared challenges.

All New for 2026

NEW FOR 2026

01

Shorter, High-Impact Sessions

Redesigned to run approximately 45 minutes. Focused on high-value discussion — brief teaching paired with case discussion so participants gain practical insights without significant preparation time.

02

Consistent Schedule

A reliable, recurring schedule throughout the year strengthens momentum and makes it easier for clinicians to participate regularly.

03

Modernized Website and Outreach Strategy

Streamlined access with a modernized website and renewed provincial engagement tools. All sessions are now accessed via the website making it the anchor of the ECHO OBN program.

04

3 Cases Per Session

Each session is anchored in three real patient cases, curated to reflect common challenges across medical, surgical, nutritional, behavioral, and psychosocial dimensions.



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Key Learning Points - Case I



Surgical Options @ OBN

Surgical Options for Ontario Patients


Vertical Sleeve
Gastrectomy
25-35%


Roux-en-Y
Gastric Bypass
25-35%


Single or Double
Duodenal Switch
35-40%

Average Total Weight Loss (TWL)

Restrictive vs. Malabsorptive

Restrictive>>Hormonal

Hormonal>>Restrictive

Malabsorptive>>Hormonal

Metabolic Disease Remission



Surgically Reversible

No

Yes

No

Long Term Weight Loss Durability



Post op Heartburn

10-20%, treatable

Anti-Reflux

Uncommon

Post op Marginal Ulcers

None

10-15%

Uncommon

Post op Internal Hernias

None

2-8%

~5%

NSAIDs safe

Yes

No

Yes

Risk of Malnutrition

Minimal



Risk of Medication Malabsorption

Rare



Procedure	VSG	RYGB	DS/SADI
Mechanism of Action	Restrictive + Hormonal	Restrictive + Hormonal + Malabsorptive	Restrictive + Hormonal + Malabsorptive
Key Features	• 50–60% 10yr EWL • ~45 min procedure • Technically easier in High BMI patients	• 50–60% 10yr EWL • Anti-reflux procedure • Technically challenging, sometimes prohibitive in High BMI patients and those with previous abdominal surgery	• 60–70% 10yr EWL • Best rate of obesity comorbidity remission • 1 or 2 stage procedure • Technically challenging, sometimes prohibitive in High BMI patients and those with previous abdominal surgery
Notable Considerations	• NSAID safe • No malabsorptive component to impact oral medication profile • Irreversible, but can be revised, converted • Re-operation rate 2.97% • Increases GERD in ~20% of patients • Staple line leaks can be more challenging to manage compared to RYGB	• NSAID unsafe (Marginal ulcers) • Malabsorptive component can affect oral medication absorption • Reversible • Re-operation rate 0.7–7.5% • Anastomotic strictures • Internal hernias • Marginal ulcers (NSAID unsafe) • Dumping syndrome • Biliary complications can be challenging to manage	• NSAID safe (pylorus preserved) • Good 2nd stage procedure for weight recidivism • Malabsorptive component can impact oral medications and put patients at high risk for macro- & micronutrient deficiencies • Reversing can be difficult • Internal hernias • Biliary complications can be challenging to manage

*Lists represented here are not comprehensive nor intend to be, statistics may vary between sources.

Selection of Weight Loss Pharmacotherapy

Criteria for Pharmacotherapy

Pharmacologic treatment is recommended for individuals with BMI ≥ 30 or ≥ 27 with obesity-related comorbidities like diabetes or hypertension.

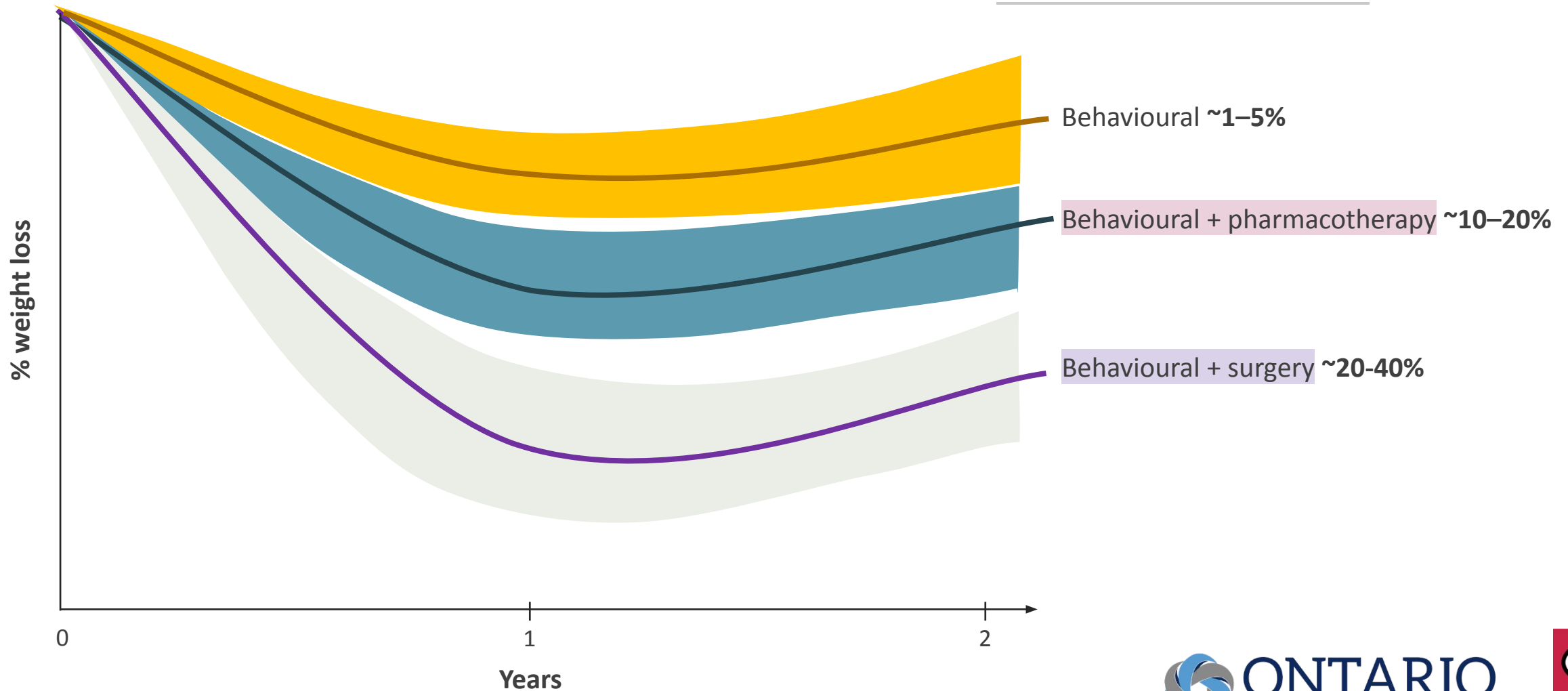
Approved Medications

Orlistat, naltrexone–bupropion, and GLP-1 receptor agonists are approved agents targeting appetite, absorption, or reward pathways.

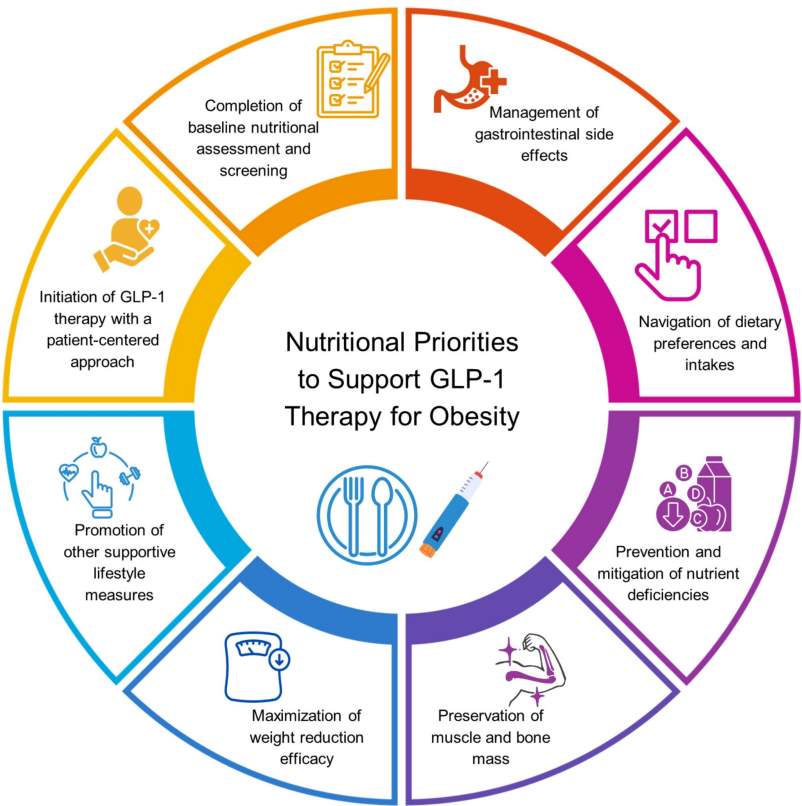
- + Individualized Treatment Considerations
- + Shared Decision-Making

	Liraglutide	Naltrexone/ Bupropion	Orlistat	Semaglutide	Tirzepatide
Mode of administration	Subcutaneous	Oral	Oral	Subcutaneous	Subcutaneous
Dose/frequency	3 mg daily	16/180 mg BID (8/90mg per tablet)	120 mg TID	2.4 mg weekly	5, 10, 15 mg weekly
Titration Schedule*	0.6mg daily x 1 week then 1.2mg daily x 1 week then 1.8mg daily x 1 week then 2.4mg daily x 1 week then 3.0 mg daily	1 tablet daily x 1 week then 1 tablet BID x 1 week then 2 tablets in AM, 1 tablet in PM x 1 week then 2 tablets BID	No titration	0.25mg weekly x 4 weeks then 0.5mg weekly x 4 weeks then 1mg weekly x 4 weeks then 1.7mg weekly x 4 weeks then 2.4mg weekly	2.5mg weekly x 4 weeks then 5mg weekly <i>If increase indicated after 4 weeks at 5mg then</i> 7.5mg weekly x 4 weeks then 10mg weekly <i>If increase indication after 4 weeks at 10mg then</i> 12.5mg weekly x 4 weeks then 15mg weekly
% weight loss, placebo subtracted	5.4% at 56 weeks ⁷	4.8% at 56 weeks ⁸	2.9% at 1 year ⁹	12.4% at 68 weeks ⁵	11.9% (5mg) 16.4% (10 mg) 17.8% (15 mg) at 72 weeks ⁶
Effect on weight over longer term, placebo subtracted	4.3% at 3 years ¹⁸	Not studied	2.8kg at 4 years ¹⁹	12.6% at 104 weeks ²⁸	11% (5mg) 17.4% (10mg) 18.4% (15 mg) at 176 weeks ²⁰
% of patients achieving $\geq 5\%$ weight loss	63.2% (vs. 27.1% with placebo) ⁷	48% (vs. 16% with placebo) ⁸	54% (vs. 33% with placebo) ¹⁰	86.4% (vs 31.5% with placebo) ⁵	85.1% (5mg) 88.9% (10mg) 90.9% (15mg) (vs 34.5% with placebo) ⁶
% of patients achieving $\geq 10\%$ weight loss	33.1% (vs. 10.6% with placebo) ⁷	25% (vs. 7% with placebo) ⁸	26% (vs. 14% with placebo) ¹⁰	69.1% (vs 12% with placebo) ⁵	68.5% (5mg) 78.1% (10mg) 83.5% (15 mg) (vs 18.8% with placebo) ⁶
% of patients achieving $\geq 15\%$ weight loss	14.4% (vs 3.5% with placebo) ⁷	12% (vs. 2% with placebo) ⁸	Not studied	50.5% (vs 4.9% with placebo) ⁵	48.0% (5mg) 66.6% (10mg) 70.6% (15mg) (vs 8.8% with placebo) ⁶

Behavioural Intervention Limitations and Need for Intensification



Nutritional Priorities for GLP-1 receptor agonist therapy



Key dietary recommendations to support effective GLP-1 therapy¹.

Factors to encourage	Factors to minimize/avoid
Food groups Fruits (e.g., berries, apples, citrus fruits, banana, grapes, avocado) Vegetables (e.g., broccoli, leafy greens, tomatoes, carrots, peas, squashes) Whole grains (e.g., oats, quinoa, brown rice, and whole-grain breads, cereals, and pastas) Dairy (e.g., yogurt, milk, cheese) Lean proteins (e.g., poultry, fish/seafood) and eggs Nuts and seeds (e.g., almonds, peanuts, chia seeds, sesame seeds, hemp seeds) Plant fats/oils (e.g., olive, canola, avocado oils) Ginger or peppermint tea	Refined carbohydrates (processed grains, flours, added sugars) Sugar-sweetened beverages Red and processed meats Most fast foods Sweets and savory snacks
Eating habits² Regular, small meals at consistent times Flexibility with food choices Enjoy portion-controlled treats Ensure adequate fluids Minimal alcohol intake	Emotional, mindless, or nighttime eating Long periods without meals (i.e., becoming overly hungry) Consumption of large meals

Nutritional priorities to support GLP-1 therapy for obesity: a joint Advisory from the American College of Lifestyle Medicine, the American Society for Nutrition, the Obesity Medicine Association, and The Obesity Society

Dariush Mozaffarian^{1,2}, Monica Agarwal², Monica Aggarwal³, Lydia Alexander⁴, Caroline M Apovian⁵, Shagun Bindlish⁶, Jonathan Bonnet⁷, W Scott Butsch⁸, Sandra Christensen⁹, Eugenia Gianos¹⁰, Mahima Gulati¹¹, Alka Gupta^{12,13}, Debbie Horn¹⁴, Ryan M Kane^{15,16}, Jasdeep Saluja¹⁷, Deepa Samdhi¹⁸, Fatima Cody Stanford^{19,20}, Emily A Callahan¹





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Key Learning Points - Case II



GI SIDE EFFECTS of GLP-1 Receptor Agonists

15–30% Nausea

10–15% Diarrhea

5–10% Vomiting

Common Constipation

1

Educate

Before prescribing

- Counsel patients: most GI effects are mild and transient
- Advise smaller meals; avoid high-fat or spicy food
- Avoid fizzy/carbonated drinks
- Screen for pre-existing GI conditions (GERD, gastroparesis)
- Avoid in severe GI disease or gastroparesis

2

Escalate Slowly

Flexible titration

- Follow gradual titration per product monograph
- Titrate more slowly than schedule if GI symptoms emerge
- Pause at current dose until symptom-free, then retry
- Real-world median ~50 days to full dose vs. 28 days — this is normal

3

Effective Management

Stepwise — try each before moving down

Dietary modification

Smaller meals · avoid fatty/spicy food · ↑ fibre & water

Pause dose escalation

Hold at current dose until symptom-free, then retry more slowly

Reduce dose

Lower to last tolerated; GI AEs are dose-dependent

Short-term medications

PPI/H2-blocker for GERD · antiemetics (selective, short-term)

Stop & switch drug class

If GI side effects persist despite all above steps

Managing the gastrointestinal side effects of GLP-1 receptor agonists in obesity: recommendations for clinical practice

Sean Wharton ¹, Melanie Davies ^{2 3}, Dror Dicker ⁴, Ildiko Lingvay ⁵, Ofri Mosenzon ⁶,
Domenica M Rubino ⁷, Sue D Pedersen ⁸

STRATEGIES FOR MANAGING PSYCHOLOGICAL BARRIERS

COMMON PSYCH BARRIERS	WAYS TO OVERCOME THESE BARRIERS
• <i>Low motivation</i>	• Encourage self-monitoring, or joining a peer support group
• <i>Interpersonal stress and a perceived lack of support</i>	• Problem solving, which may include asking for help
• <i>Internalized weight stigma and expecting too much</i>	• Understand and name weight bias and stigma • Manage weight loss expectations and discuss "best weight" instead of "healthy BMI"

COMMON PSYCH BARRIERS	WAYS TO OVERCOME THESE BARRIERS
• <i>Negative self-talk</i>	• Introduce cognitive re-framing (e.g., CBT worksheet) • Come up with positive affirmations
• <i>Lack of awareness into problem eating triggers</i>	• Introduce a self-guided workbook • Offer a referral to a mental health provider
• <i>Forgetting why they have started to make these behaviour changes in the first place</i>	• Reflect on their values by asking open-ended questions: • What is most important to your health? How is your weight limiting you?

2020 Canadian Obesity Guidelines



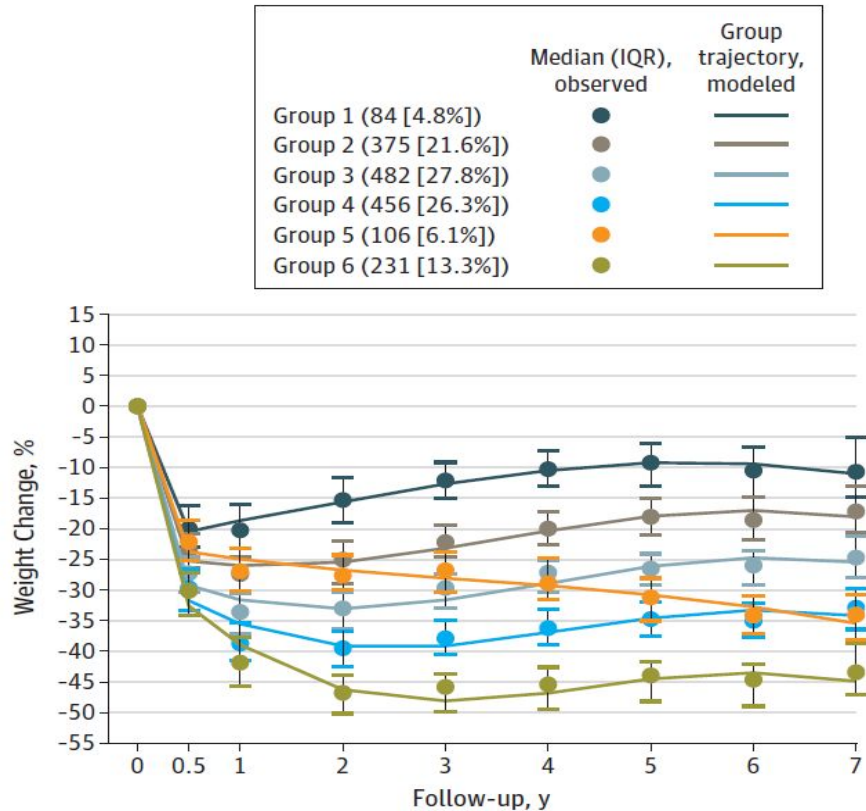
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Key Learning Points - Bonus Case



Weight Trajectories After Bariatric Surgery 7-Year Outcomes

A Roux-en-Y gastric bypass



KEY FINDINGS

- Large prospective multi-centre study Wide variation in responses -- 6 distinct trajectory groups identified
- **All groups show weight rebound after 2-3 years except highest performers**
- Complete/total weight regain NOT commonly observed
- **~20% of patients have significant weight regain at 10 years**
- Group 1 (4.8%): minimal loss; Group 6 (13.3%): sustained excellent outcomes

Courcoulas AP, et al. JAMA Surg. 2018;153(5):427-434. Notice all trajectory lines trend upward after 2-3 years. Wide variation reinforces individualized approach to follow-up. We tell patients 20% have significant weight regain at 10 years.

GLP-1 RAs After Bariatric Surgery: Early Evidence

GLP-1 Receptor Agonist Combination Therapy Before and After Metabolic and Bariatric Surgery: A Review of Outcomes

Chang Seok Ko

Division of Gastrointestinal Surgery, Department of Surgery, Asan Medical Center, University of Ulsan College of Medicine, Seoul, Korea

Retrospective Studies

Table 1. Summary of studies using GLP-1 RAs as perioperative treatment

Author, Year	Country	Study design	Type of use	Sample size	Age (years)	BMI (kg/m ²)	Type of surgery	GLP-1 RA administration	Duration	Outcomes (TWL kg or %)
Munoz et al. 2024 [29]	Mexico	Prospective	Preoperative	37	44	56.0	N/A	Liraglutide daily 0.6–3.0 mg injection	12 weeks	5.50%
Ilanga et al. 2023 [30]	USA	Retrospective	Preoperative	31	N/A	60.6	RYGB (51.6%)	Mainly semaglutide (dose N/A)	4.9 months	16.7 kg
Mathur et al. 2025 [31]	USA	Retrospective	Preoperative	364	45	42.6	SG (89.3%)	Semaglutide (dose N/A)	24.4 weeks	4.0%
Jensen et al. 2023 [32]	Switzerland	Retrospective	Postoperative	50	50.0	34.0	RYGB (82.0%)	Semaglutide 1.0 mg weekly injection or 14 mg daily oral intake; Liraglutide 1.8 or 3.0 mg daily injection	6 months	8.8% (Sema: 9.8%, Lira: 7.3%)
Lautenbach et al. 2022 [33]	Germany	Retrospective	Postoperative	44	46.4	38.3	SG (65.9%)	Semaglutide 2.4 mg weekly injection	6 months	10.30%
Jamal et al. 2024 [34]	Kuwait	Retrospective	Postoperative	115	38.8	35.1	SG (100.0%)	Semaglutide, Tirzepatide (dose N/A)	6 months	Tirze: 15.5%, Sema: 10.3%

GLP-1 RA = glucagon-like peptide-1 receptor agonist, BMI = body mass index, TWL = total weight loss, N/A = not available, RYGB = Roux-en-Y gastric bypass, SG = sleeve gastrectomy.

Takeaways

- Semaglutide: consistent ~10% TWL at 6 months across SG and RYGB
- Tirzepatide: 15.5% TWL — superior dual GIP/GLP-1 mechanism
- Effect seen as early as 3 months post-initiation

Limitations

- All studies retrospective
- Small sample sizes
- Short follow-up (≤6 months)
- No RCTs yet — evidence base still emerging



ECHO OBN

SHORT, HIGH IMPACT SESSIONS

Thank you for joining us today!

Email new cases and share thoughts.
Reach us at echoobnadmin@stjoes.ca

CASE-BASED LEARNING THAT REFLECTS REAL PRACTICE



REGIONAL EXPERTISE, PROVINCIAL COLLABORATION