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SORRENTO, 29 - 31 Ottobre 2025

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Dr. Matteo Monami
*Careggi Teaching Hospital,
Firenze*

Il Dr. M. Monami ha ricevuto speaking fees/grant da:

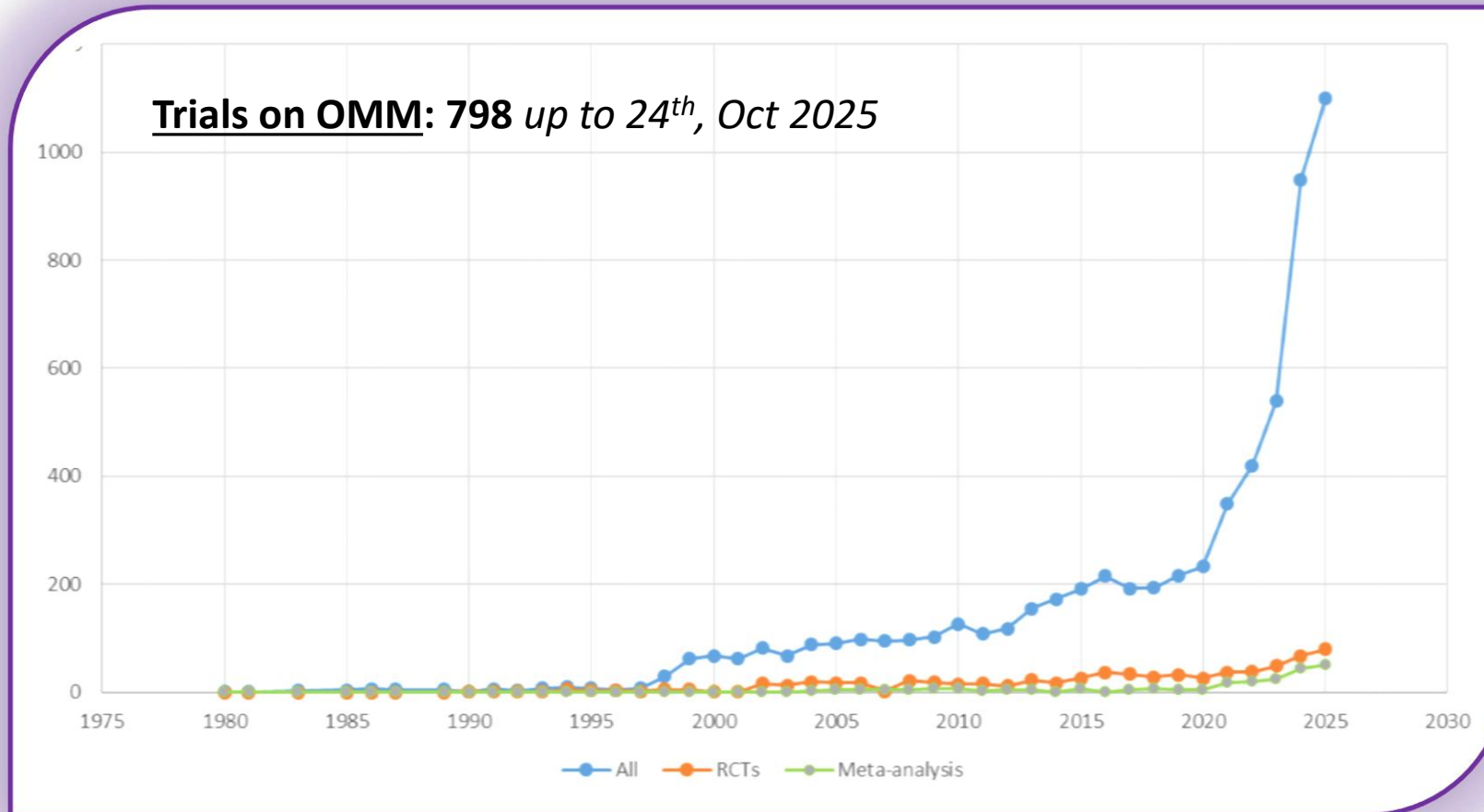
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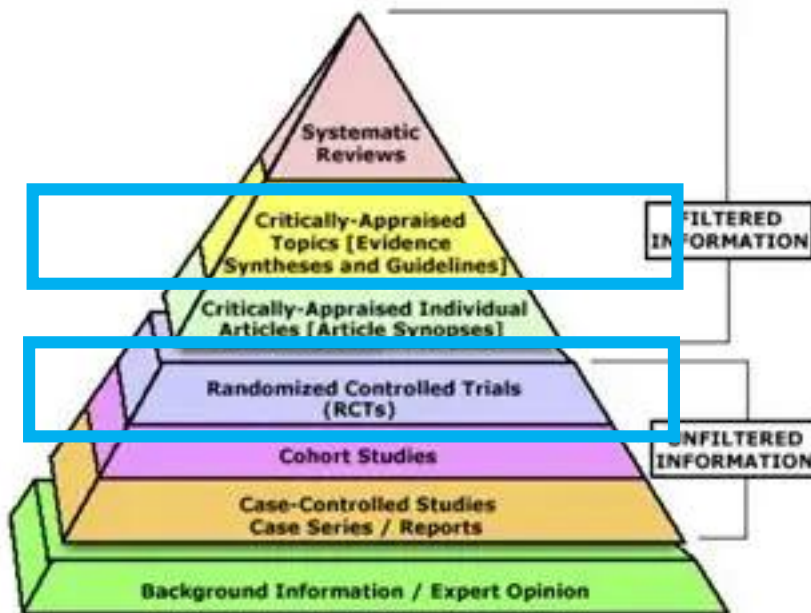
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How to manage all this info?

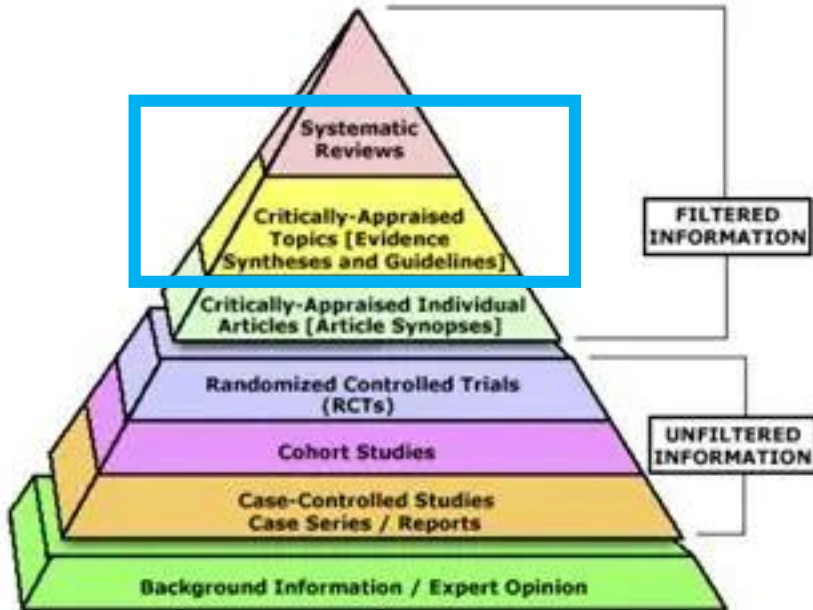
Search string: (obesity or overweight) AND (orlistat OR naltrexone OR bupropion OR Liragl. OR Semagl. OR Tirzep. OR phentermine/topiramate)



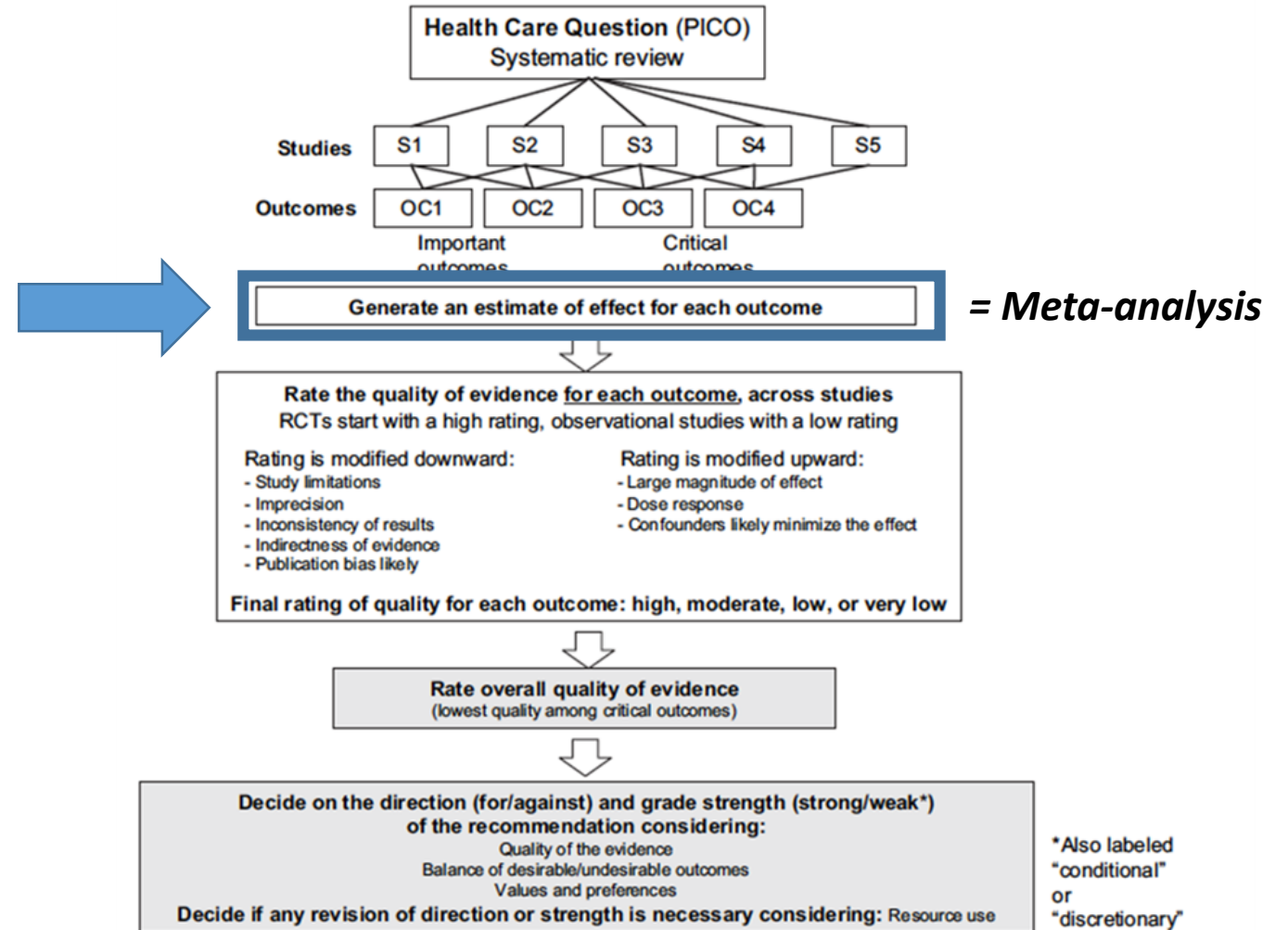
Pyramid of scientific evidence: efficacy and safety based on RCT



How to manage all this info?



GRADE



How to manage all this info?

Italian Clinical Practice GRADE-based Guidelines on the Diagnosis and Treatment of Overweight and Obesity endorsed by the Italian National Institute of Health.

Rocco Barazzoni^{1*}; Silvio Buscemi^{2*}; Luca Busetto³; Paolo Sbraccia⁴; Simona Bo⁵; Emanuele Cereda⁶; Marco Chianelli⁷; Sonja Chiappetta⁸; Riccardo Dalle Grave⁹; Walter de Caro¹⁰; Giovanni Docimo¹¹; Giuseppe Galloro¹²; Primiano Iannone¹³; Frida Leonetti¹⁴; Fabrizia Liso¹⁵; Maria Caterina Manca¹⁶; Gerardo Medea¹⁷; Manuela Merli¹⁸; Anna Maria Moretti¹⁹; Giuseppe Navarra²⁰; Uberto Pagotto²¹; Barbara Paolini²²; Giovanni Papa²³; Nicola Perrotta²⁴; Andrea Pession²⁵; Vincenzo Piloni²⁶; Vincenzo Provenzano²⁷; Cecilia Ricciardi Rizzo²⁸; Maurizio Santomauro²⁹; Cristina Segura Garcia³⁰; Federico Spandonaro³¹; Samir Sukkar³²; Patrizia Todisco³³; Dario Tuccinardi³⁴; Andrea Vania³⁵; Valentina Vanzi³⁶; Riccardo Williams³⁷; Iris Zani³⁸; Benedetta Ragghianti³⁹; Giovanni Antonio Silveri³⁹; Amanda Belluzzi⁴⁰; Maria Masulli⁴¹; Maddalena Redini⁴²; Matteo Monami³⁹.

SIO¹

Comment

<https://doi.org/10.1038/s41591-025-03765-w>

Framework for the pharmacological treatment of obesity and its complications from the European Association for the Study of Obesity (EASO)

Barbara McGowan, Andreea Ciudin, Jennifer L. Baker, Luca Busetto, Dror Dicker, Gema Frühbeck, Gijs H. Goossens, Matteo Monami, Paolo Sbraccia, Borja Martinez-Tellez, Euan Woodward & Volkan Yumuk

EASO²

 Check for updates

Guideline

Pharmacotherapy for obesity management in adults: 2025 clinical practice guideline update

Sue D. Pedersen MD, Priya Manjoo MD MSc, Satya Dash MD, Akshay Jain MD, Nicole Pearce, Megha Poddar MD

■ Cite as: CMAJ 2025 August 11;197:E797-809. doi: 10.1503/cmaj.250502

Canadian³

AACE



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AACE Clinical Guidance

American Association of Clinical Endocrinology Consensus
Statement: Algorithm for the Evaluation and Treatment of Adults
with Obesity/Adiposity-Based Chronic Disease – 2025 Update

Karl Nadolsky, DO, FACE, DABOM¹, W. Timothy Garvey, MD, MACE²,
Monica Agarwal, MD, FACE², Alex Bonnacaze, MD³, Bartolome Burguera, MD, PhD⁴,
Michelle DeGeeter Chaplin, PharmD⁵, Marcio L. Griebeler, MD⁴,
Samantha R. Harris, MD⁶, Jeffrey N. Schellinger, MCN, RD⁷,
Juliana Simonetti, MD, DABOM⁸, Reshmi Srinath, MD⁹, Volkan Yumuk, MD, FACE¹⁰

AACE⁴

¹Barazzoni R, et al., EWD, 2025; Manuscript submitted

²McGowan B, et al., Nat Med, 2025; 3229–3232

³Pedersen S, et al., CMAJ 2025; E797-809

⁴Nadolsky, et al., Endocrine Practice 2025; In press.

How to manage all this info?

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Comment

Framework for the pharmacological management of obesity and its complications: European Association for the Study of Obesity (EASO)

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EASO²

 Check for updates



Guideline

Pharmacotherapy for obesity management in adults: 2025 clinical practice guideline update

Satya Dash MD, Akshay Jain MD, Nicole Pearce, Megha Poddar MD

doi: 10.1503/cmaj.250502

Canadian³

**Endocrine
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endocrinepractice.org

**Endocrinology Consensus
Statement on the Prevention and Treatment of Adults
with Type 2 Diabetes – 2025 Update**

Anthony Garvey, MD, MACE²,
David A. Heise, MD³, Bartolome Burguera, MD, PhD⁴,
Antonio L. Griebeler, MD⁴,
Michael J. Heise, MD, PhD⁵,
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Methods

Characteristics	Canadian ¹	EASO ²	AACE ³	SIO ⁴
GRADE	 		 	
Network Meta-analysis				
Up to May 2025				
RCT duration				
ASCVD				
Heart failure				
Prediabetes/diabetes				
MASH/MASLD				
OSAS				
OA				
Hyperten./Dyslipid.				
Surgical/Endos. options				

¹Pedersen S, et al., CMAJ 2025; E797-809

²McGowan B, et al., Nat Med, 2025; 3229–3232

³Nadolsky, et al., Endocr Pract, 2025; In press

⁴Barazzoni R, et al., EWD, 2025; Manuscript submitted

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Abstract

Background: Pharmacotherapy is a key component of comprehensive obesity management, alongside behavioural therapy and metabolic and bariatric surgery. In this guideline, we update the pharmacotherapy recommendations in the 2020 Canadian clinical practice guideline on obesity in adults and in the 2022 pharmacotherapy for obesity management revision to provide current recommendations for clinicians on the efficacy, safety, and appropriate use of pharmacotherapy in the management of obesity in adults.

Methods: This guideline update follows the same methodology as the 2020 Canadian guideline on obesity in adults, adhering to the Appraisal of Guidelines for Research and Evaluation instrument and using the Shekelle framework to assess and grade evidence and to formulate recommendations. Building on the search conducted for the 2022 pharmacotherapy revision, we conducted a systematic literature review (search dates January 2022 to July 2024), supplemented by relevant trials published through May 2025, to identify studies assessing the efficacy of pharmacotherapy for weight management. We also conducted 13 targeted searches on the management of weight-related complications in 13 subpopulations with important adiposity-related health issues. We engaged primary care physicians, obesity medicine specialists, and people with lived experience of obesity to provide feedback on the recommendations.

Body weight

Pharmacotherapy options

Pharmacotherapy for obesity provides clinically meaningful weight loss ([Table 1](#), recommendation 3). In a randomized controlled trial (RCT) of 1961 people with BMI ≥ 30 , or BMI ≥ 27 and at least 1 weight-related coexisting condition, without diabetes, semaglutide 2.4 mg weekly with health behaviour modification resulted in a weight change of -14.9% at 68 weeks, compared with -2.4% with placebo (estimated treatment difference -12.4% , 95% confidence interval [CI] -13.4 to -11.5).¹⁸ The most common adverse effects with semaglutide were transient, mild to moderate nausea, vomiting, and diarrhea, leading to treatment discontinuation in 4.5% of participants versus 0.8% with placebo. Rare adverse effects included gallbladder-related issues (mostly gallstones) in 2.6% of the semaglutide group versus 1.2% with placebo, with pancreatitis reported in 0.2% with semaglutide versus 0% with placebo.¹⁸

In an RCT of 2539 adults with BMI ≥ 30 , or BMI ≥ 27 with at least 1 weight-related complication, but without diabetes, participants were randomly assigned to receive tirzepatide 5 mg, 10 mg, 15 mg, or placebo weekly for 72 weeks, in addition to health behaviour changes. At 72 weeks, the mean weight change with 5 mg, 10 mg, and 15 mg was -15.0% , -19.5% , and -20.9% , respectively, compared with -3.1% with placebo (estimated treatment difference compared with placebo -11.9% , 95% CI -13.4 to -10.45 for 5 mg weekly; -16.4% , 95% CI -17.9 to -14.8 for 10 mg weekly; and -17.8% , 95% CI -19.3 to -16.3 for 15 mg weekly).¹⁹ The most common adverse effects of tirzepatide were mild to moderate gastrointestinal symptoms (nausea, diarrhea, constipation) during dose escalation, with discontinuation rates of 4.3%, 7.1%, and 6.2% for the 5 mg, 10 mg, and 15 mg doses, respectively, and 2.6% in the placebo group. Rare adverse effects with tirzepatide included cholecystitis, which was reported slightly more frequently (0.6%) than with placebo (0%).¹⁹

Guideline

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Body weight

Pharmacotherapy for obesity management, in conjunction with health behaviour changes, should be offered to people with BMI ≥ 30 ,* or BMI ≥ 27 * with adiposity-related complications:

- Semaglutide 2.4 mg weekly (BMI ≥ 27 *) (level 1a; grade A)¹⁸
- Tirzepatide 5 mg, 10 mg, or 15 mg weekly (BMI ≥ 27 *) (level 1a; grade A)¹⁹
- Liraglutide 3 mg daily (BMI ≥ 27 *) (level 2a; grade B)²⁰
- Naltrexone–bupropion 16 mg/180 mg twice daily (BMI 27–45*) (level 2a; grade B)²¹
- Orlistat 120 mg 3 times daily (BMI 28–47*) (level 2a; grade B)²²

Body weight

After 56 weeks, patients in the liraglutide group had lost a mean ($\pm$ SD) of $8.0 \pm 6.7\%$ (8.4 ± 7.3 kg) of their body weight, whereas patients in the placebo group had lost a mean of $2.6 \pm 5.7\%$ (2.8 ± 6.5 kg) of their body weight ([Table 2](#)). Weight loss with

The Semaglutide Treatment Effect in People with Obesity (STEP 1) trial investigated the efficacy and safety of semaglutide 2.4 mg versus placebo in adults with obesity demonstrating an average percent weight reduction of 16.9% from baseline with 68 weeks of treatment.¹⁶⁶ The

	ORLISTAT	PHENTERMINE ^C	PHENTERMINE/ TOPIRAMATE ER	NALTREXONE ER/ BUPROPION ER	LIRAGLUTIDE	SEMAGLUTIDE	TIRZEPATIDE
WEIGHT REDUCTION[§]	4% (52 weeks)	5%–6% (28 weeks)	9.6%–9.9% (52 weeks) dose dependent	4.2%–5.2% (52 weeks)	9.2% (56 weeks)	16.9% (68 weeks)	22.5% (72 weeks)

In 4 56-week phase III trials,^{168,249,303,304} treatment with naltrexone/bupropion 32 mg/360 mg led to clinically significant weight reduction, ranging from 5.9% to 11.5% compared with placebo among

^{341, 342, 343} In the SURMOUNT-1 trial, the highest dose (15 mg) of tirzepatide resulted in an average weight reduction of 22.5% at 72 weeks, with nearly 40% of participants losing $\geq 25\%$ of their body

[§]Percent body weight reduction in treatment in Phase 3 trial

A systematic review and meta-analysis of the efficacy and safety of pharmacological treatments for obesity in adults

Received: 14 April 2025
Accepted: 26 August 2025
Published online: 2 October 2025

Barbara McGowan^{1,2}, Andreea Ciudin^{2,3,15}, Jennifer L. Baker⁴, Luca Busetto⁵, Dror Dicker⁶, Gema Frühbeck⁷, Gijls H. Goossens⁸, Matteo Monami⁹, Paolo Sbraccia¹⁰, Borja Martinez-Tellez^{11,12}, Euan Woodward¹³ & Volkan Yumuk¹⁴

This systematic review and network meta-analysis evaluated the efficacy and safety of obesity management medications (OMMs) in terms of reducing body weight and impact on obesity-related complications. Here a Medline and Embase search was performed up to 31 January 2025 for randomized controlled trials comparing OMMs versus placebo/active comparators in adults. Primary endpoint was percentage of total body weight loss (TBWL%) at the end of the study. Secondary endpoints were TBWL% at 1, 2 and ≥3 years, lipid profile, blood pressure, hemoglobin A1c, fasting plasma glucose, mental health, serious adverse events, quality of life, cardiovascular morbidity and mortality, remission of obesity-related complications and all-cause mortality. Fifty-six clinical trials were identified—orlistat (22), semaglutide (14), liraglutide (11), tirzepatide (6), naltrexone/bupropion (5) and phentermine/topiramate (2)—enrolling 60,307 patients (32,598 OMM and 27,709 placebo). All OMMs showed a significantly greater TBWL% versus placebo ($P < 0.0001$), more than 10% for semaglutide and tirzepatide. Both tirzepatide and semaglutide showed normoglycemia restoration, remission of type 2 diabetes and reduction in hospitalization due to heart failure. Semaglutide was effective in reducing major adverse cardiovascular events and reducing pain in knee osteoarthritis. Tirzepatide was effective in remission of obstructive sleep apnea syndrome and metabolic dysfunction-associated steatohepatitis. These results support the need to individualize the selection of OMMs.

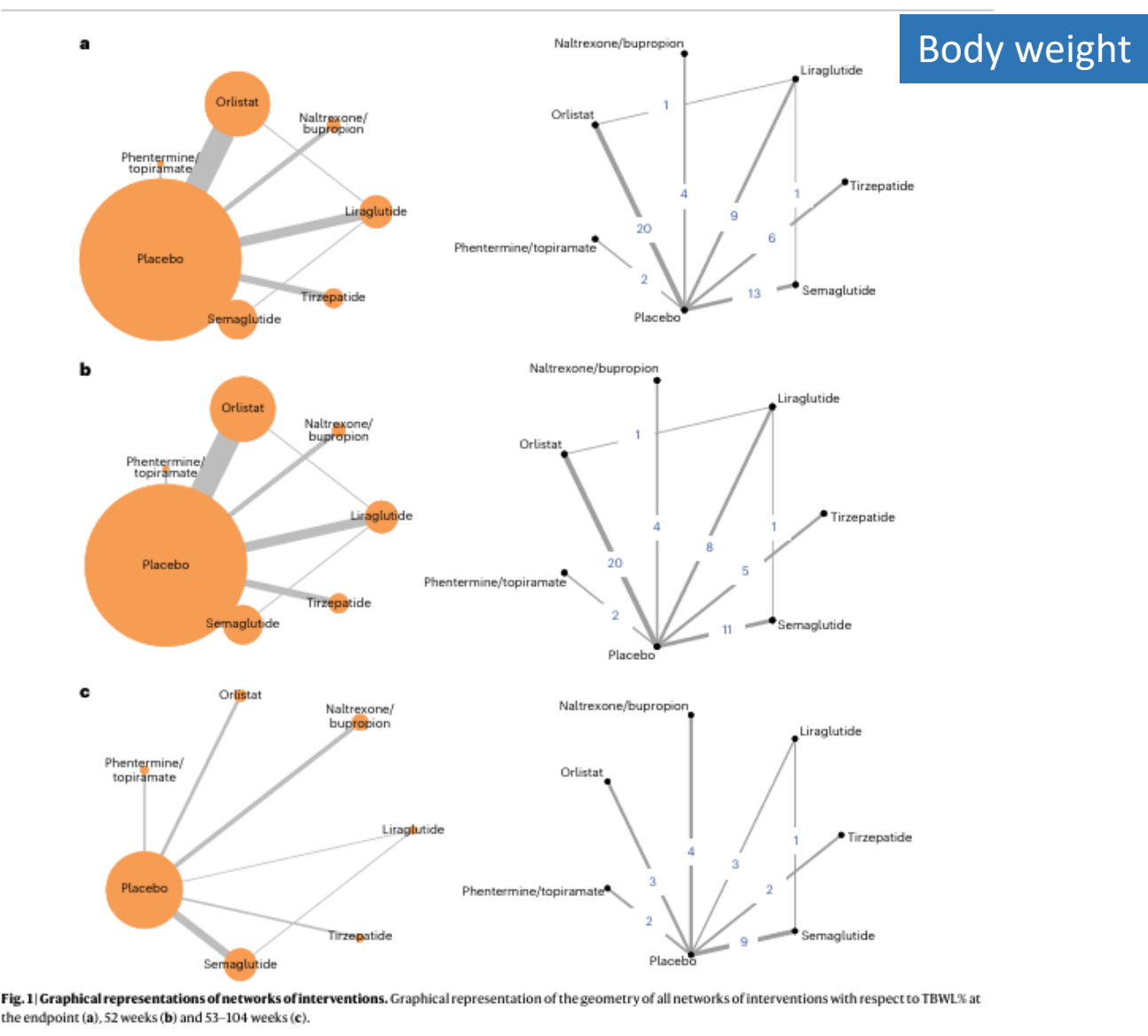


Fig. 1 | Graphical representations of networks of interventions. Graphical representation of the geometry of all networks of interventions with respect to TBWL% at the endpoint (a), 52 weeks (b) and 53–104 weeks (c).



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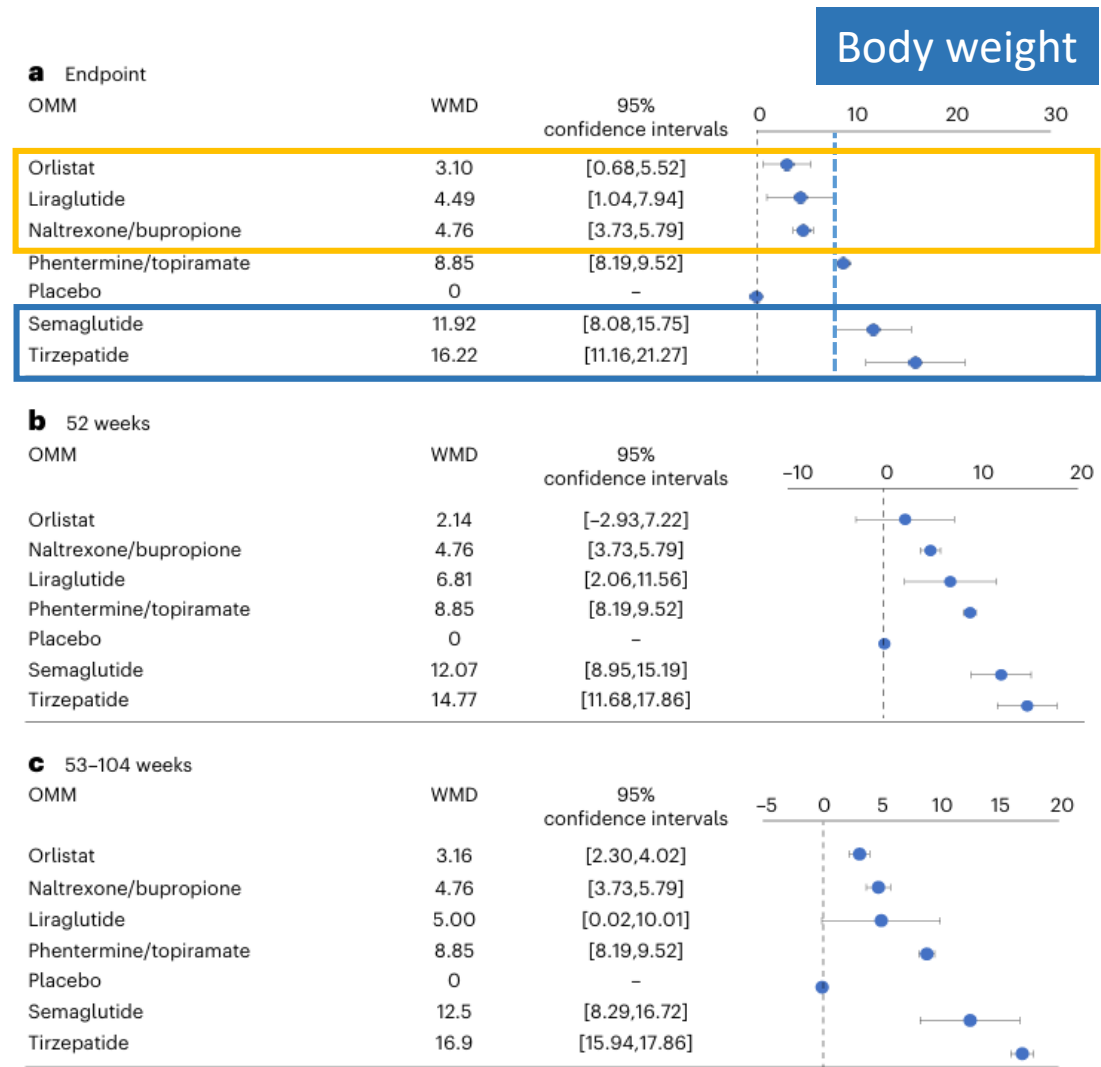
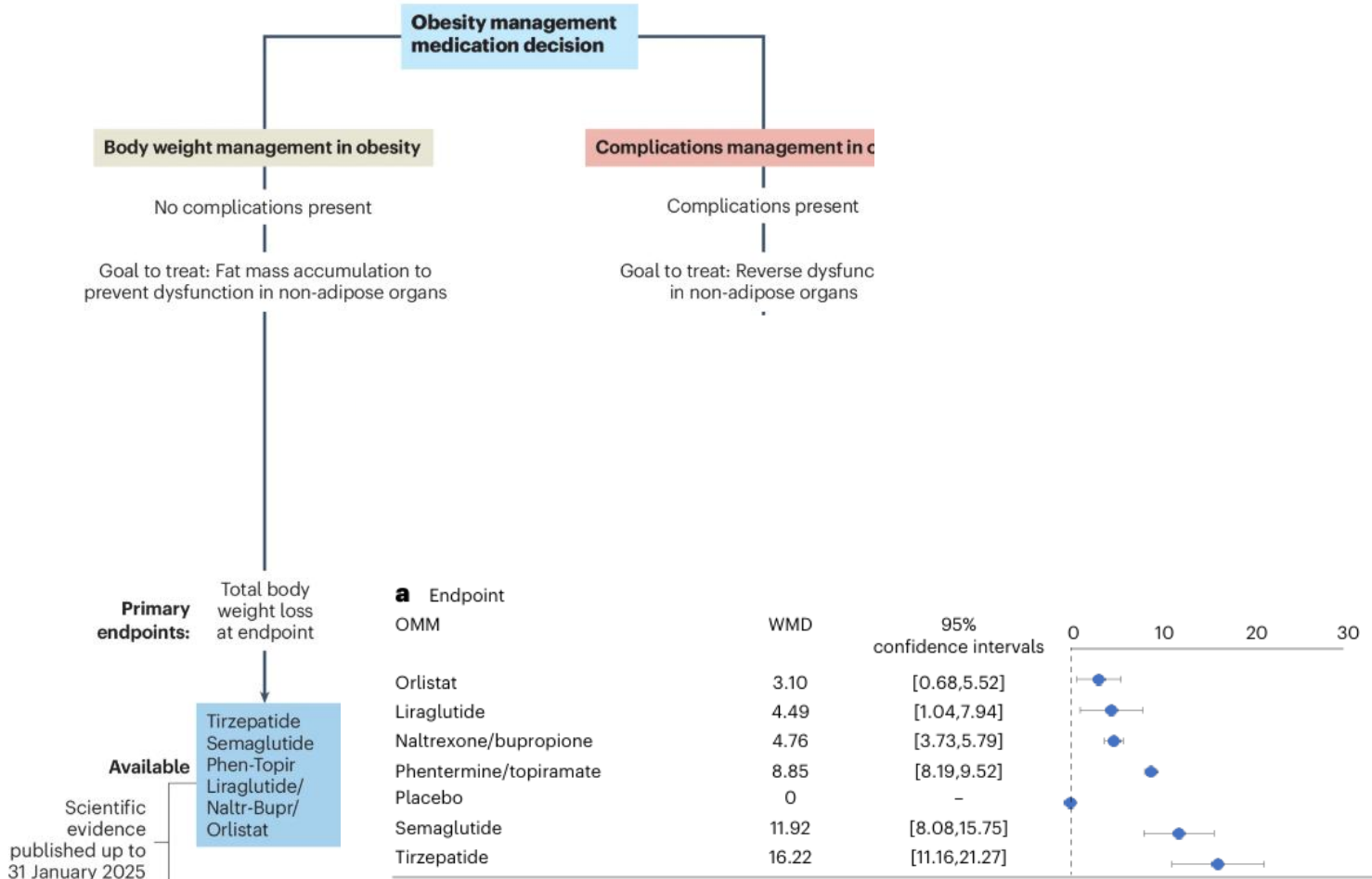


Fig. 2 | Network forest plots. Network forest plots showing the effects of each OMM on TBWL% at the endpoint (a), 52 weeks (b) and 53–104 weeks (c).

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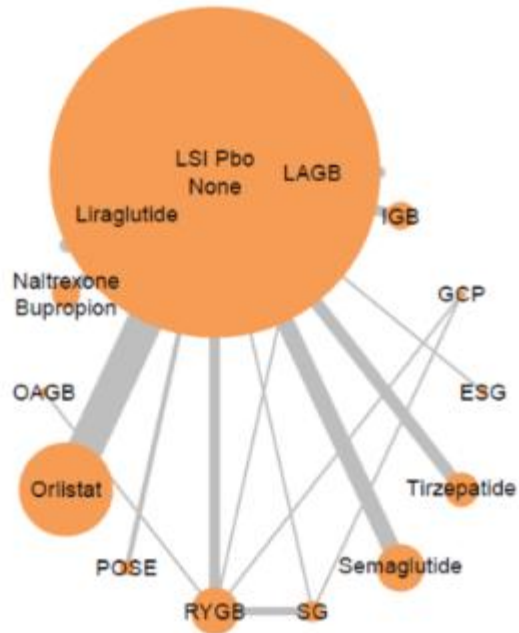


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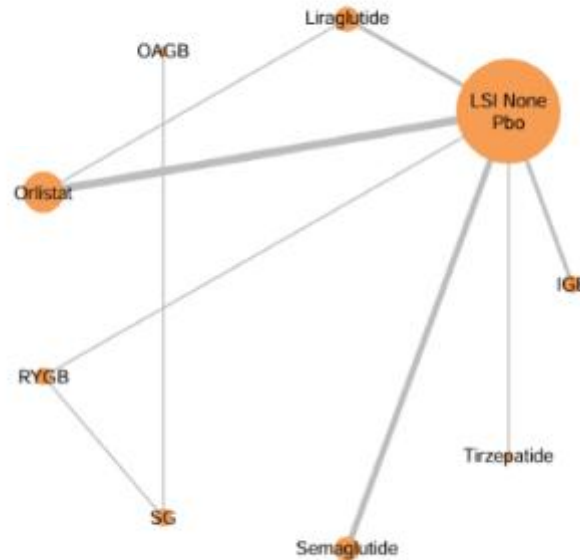
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Body weight

Class II obesity



Class I obesity



Class III obesity

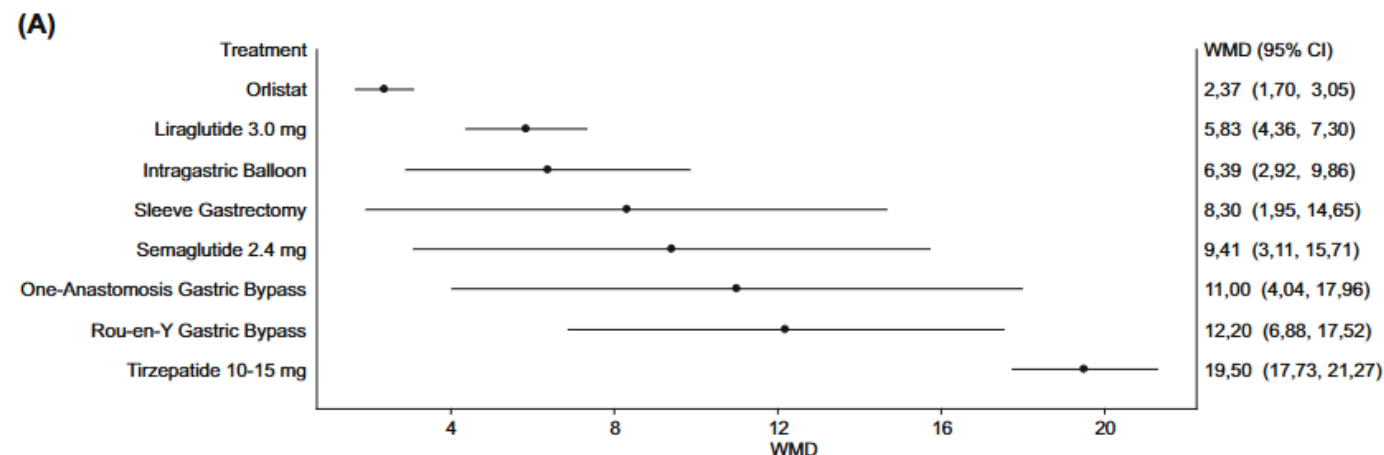


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Class I obesity²

Body weight¹



PICO 10 – In subjects with BMI between 30 and 34.9 kg/m², which anti-obesity strategy (OMM, Metabolic Bariatric Surgery – MBS, or EBP – Endoscopic Bariatric Procedures) associated to MNT, is preferable for the treatment and management of obesity?

We recommend to treat subjects with class I obesity (BMI 30-34.9 kg/m²) considering OMM as a first-line option in addition to MNT; surgical and endoscopic treatments should be considered as second-line options.

Strong recommendation in favor of the intervention, with moderate quality of evidence

¹Barazzoni R, et al., EWD, 2025; Manuscript submitted

²Barazzoni R, et al., Diab Obes Metab, 2025.

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Body weight¹

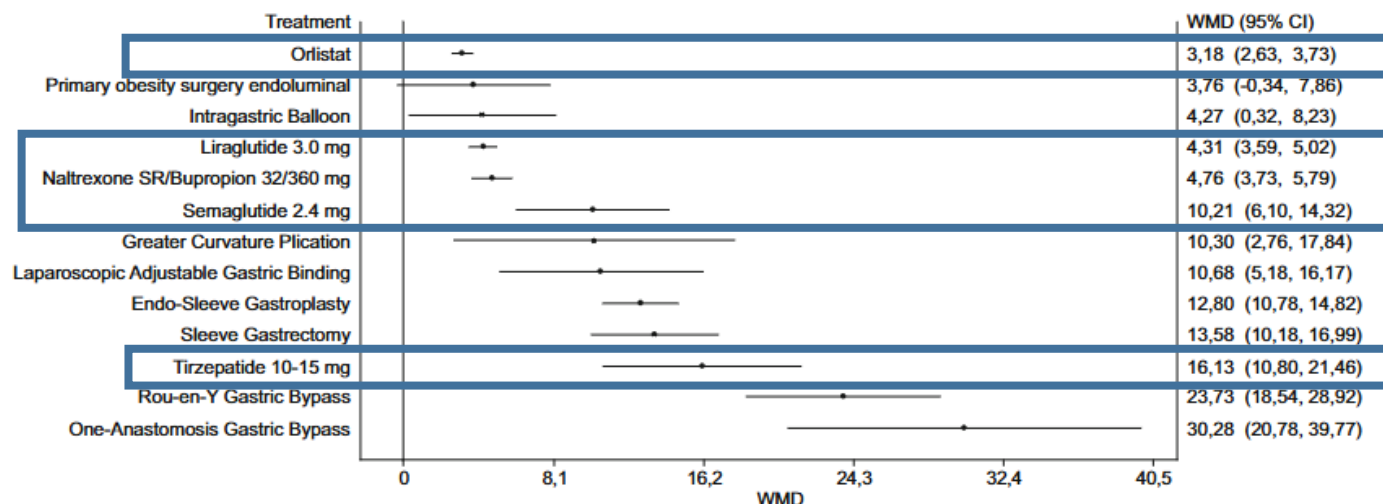
PICO 11 – In subjects with BMI between 35 and 39.9 kg/m², which anti-obesity strategy (OMM, Metabolic Bariatric Surgery – MBS, or EBP – Endoscopic Bariatric Procedures) associated to MNT, is preferable for the treatment and management of obesity?

We recommend to treat subjects with class II obesity (BMI 35-39.9 kg/m²) preferring OMM as a first-line option in addition to MNT; surgical and endoscopic treatments are valid options to be preferably adopted in case of failure of OMM.

Strong recommendation in favor of the intervention, with moderate quality of evidence

Class II obesity²

(B)



¹Barazzoni R, et al., EWD, 2025; Manuscript submitted

²Barazzoni R, et al., Diab Obes Metab, 2025.

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Body weight^{1,2}

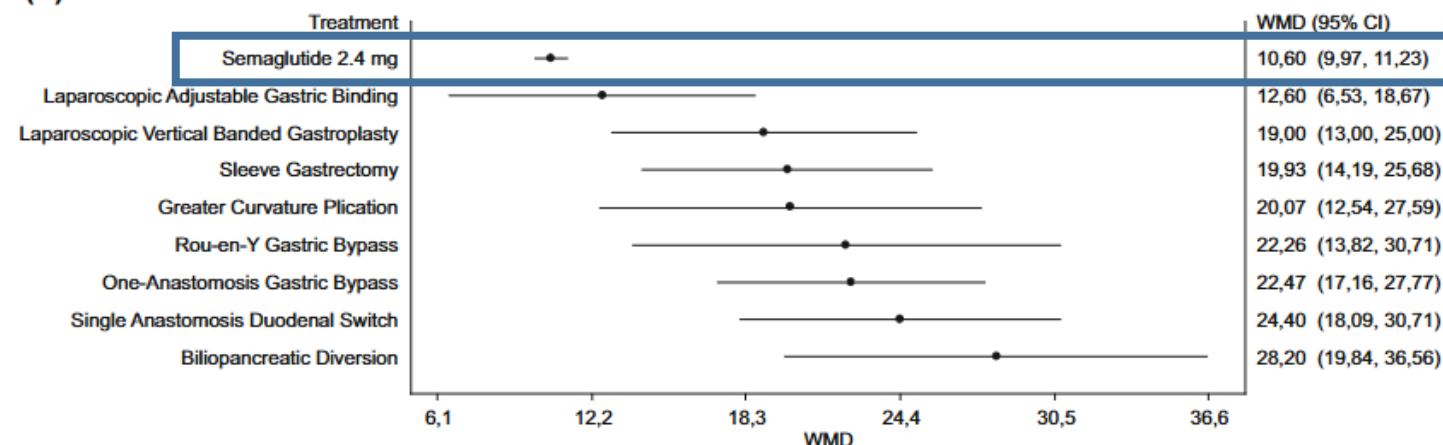
PICO 12 – In subjects with BMI $\geq 40\text{kg/m}^2$, which anti-obesity strategy (OMM, Metabolic Bariatric Surgery – MBS, or EBP – Endoscopic Bariatric Procedures) associated to MNT, is preferable for the treatment and management of obesity?

We recommend to treat subjects with class III obesity (BMI $\geq 40\text{ kg/m}^2$) preferring surgical over pharmacological and endoscopic options, in addition to MNT.

Strong recommendation in favor of the intervention, with moderate quality of evidence

Class III obesity²

(C)



¹Barazzoni R, et al., EWD, 2025; Manuscript submitted

²Barazzoni R, et al., Diab Obes Metab, 2025.

Italian Clinical Practice GRADE-based Guidelines on the Diagnosis and Treatment of Overweight and Obesity endorsed by the Italian National Institute of Health.

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Body weight¹

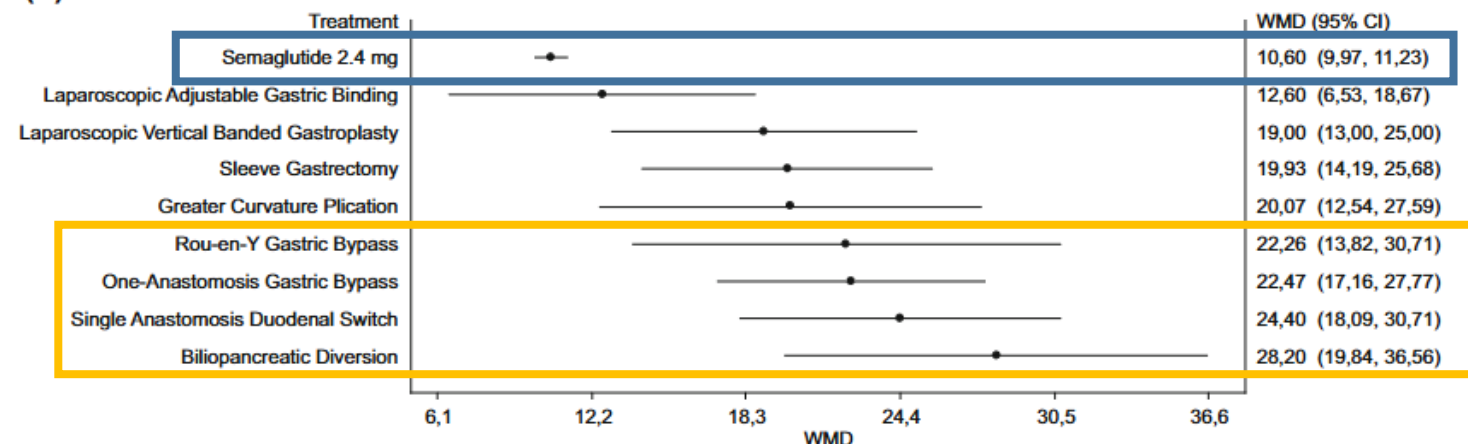
PICO 12 – In subjects with BMI $\geq 40\text{kg/m}^2$, which anti-obesity strategy (OMM, Metabolic Bariatric Surgery – MBS, or EBP – Endoscopic Bariatric Procedures) associated to MNT, is preferable for the treatment and management of obesity?

We recommend to treat subjects with class III obesity (BMI $\geq 40\text{ kg/m}^2$) preferring surgical over pharmacological and endoscopic options, in addition to MNT.

Strong recommendation in favor of the intervention, with moderate quality of evidence

Class III obesity²

(C)



¹Barazzoni R, et al., EWD, 2025; Manuscript submitted

²Barazzoni R, et al., Diab Obes Metab, 2025.

Pharmacotherapy for obesity management in adults: 2025 clinical practice guideline update

Sue D. Pedersen MD, Priya Manjoo MD MSc, Satya Dash MD, Akshay Jain MD, Nicole Pearce, Megha Poddar MD

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Pharmacotherapy for obesity management, in conjunction with health behaviour changes, should be offered to people with BMI ≥ 30 ,* or BMI ≥ 27 * with adiposity-related complications:

- Semaglutide 2.4 mg weekly (BMI ≥ 27 *) (level 1a; grade A)¹⁸
- Tirzepatide 5 mg, 10 mg, or 15 mg weekly (BMI ≥ 27 *) (level 1a; grade A)¹⁹
- Liraglutide 3 mg daily (BMI ≥ 27 *) (level 2a; grade B)²⁰
- Naltrexone–bupropion 16 mg/180 mg twice daily (BMI 27–45*) (level 2a; grade B)²¹
- Orlistat 120 mg 3 times daily (BMI 28–47*) (level 2a; grade B)²²

*See recommendation 1.

Pharmacotherapy for obesity management, in conjunction with health behaviour changes, should be used long term, when effective, to:

- Avoid weight regain and regression of health benefits achieved with pharmacotherapy:
 - Semaglutide 2.4 mg weekly (level 1a; grade A)²³
 - Tirzepatide 10 mg or 15 mg weekly (level 1a; grade A)²⁴
 - Orlistat 120 mg 3 times daily (level 2a; grade B)²²
- Maintain weight loss and prevent weight regain following health behaviour changes alone:
 - Liraglutide 3 mg daily (level 2a; grade B)²⁵
 - Orlistat 120 mg 3 times daily (level 2a; grade B)²⁶
 - Tirzepatide 10 mg or 15 mg (level 2a; grade B)²⁷

Pharmacotherapy should be offered, in conjunction with health behaviour changes, to reduce the occurrence of major adverse cardiovascular events in people with established ASCVD and BMI ≥ 27 ,* in addition to standard of care for ASCVD:

- Semaglutide 2.4 mg weekly²⁸

*See recommendation 1.

Pharmacotherapy should be offered, in conjunction with health behaviour changes, to people living with heart failure with preserved ejection fraction and BMI ≥ 30 ,* in addition to standard of care, for weight loss and:

- A composite of reduction in cardiovascular death or a worsening heart failure event:
 - Tirzepatide 15 mg weekly²⁹
- Improvement in heart failure symptoms:
 - Semaglutide 2.4 mg weekly³⁰
 - Tirzepatide 15 mg weekly²⁹

*See recommendation 1.

Obesity pharmacotherapy, in conjunction with health behaviour changes, for people living with prediabetes should be offered for weight loss and to:

- Reduce the risk of progression to type 2 diabetes:
 - Liraglutide 3 mg daily (BMI ≥ 27 *) (level 2a; grade B)³¹
 - Orlistat 120 mg 3 times daily (BMI ≥ 30 *) (level 2a; grade B)³²
 - Tirzepatide 5 mg, 10 mg, or 15 mg weekly (BMI ≥ 27 *) (level 2a; grade B)³³
- Achieve normoglycemia:
 - Semaglutide 2.4 mg weekly (BMI ≥ 30 *) (level 1a; grade A)³⁴

*See recommendation 1.

Obesity pharmacotherapy should be offered, in conjunction with health behaviour changes, to people living with type 2 diabetes for weight loss and improvement in glycemic control:

- Semaglutide 2.4 mg weekly (BMI ≥ 27 *) (level 1a; grade A)³⁵
- Tirzepatide 10 mg or 15 mg weekly (BMI ≥ 27 *) (level 1a; grade A)³⁶
- Liraglutide 3 mg daily (BMI ≥ 27 *) (level 2a; grade B)³⁷
- Naltrexone–bupropion 16 mg/180 mg twice daily (BMI 27–45*) (level 2a; grade B)³⁸
- Orlistat 120 mg 3 times daily (BMI 27–43*) (level 2a; grade B)³⁹

*See recommendation 1.

Pharmacotherapy may be offered, in conjunction with health behaviour changes, in treating people living with MASH, for weight loss and:

- Resolution of MASH without worsening of fibrosis:
 - Semaglutide 2.4 mg weekly (level 2a; grade B)⁴⁰
 - Liraglutide 1.8 mg daily (BMI ≥ 25 *) (level 3; grade C)⁴¹
 - Tirzepatide 5 mg, 10 mg, or 15 mg weekly (BMI 27–50*) (level 3; grade C)⁴²
- Improvement in fibrosis without worsening of MASH:
 - Semaglutide 2.4 mg weekly (level 2a; grade B)⁴⁰
 - Tirzepatide 5 mg, 10 mg, or 15 mg weekly (BMI 27–50*) (level 3; grade C)⁴²

*See recommendation 1.

Pharmacotherapy should be offered, in conjunction with health behaviour changes, for weight loss and improvement in apnea-hypopnea index in people who are living with moderate to severe obstructive sleep apnea and BMI ≥ 30 ,* and who are:

- Unwilling or unable to use positive airway pressure therapy:
 - Tirzepatide 10 mg or 15 mg (level 1a; grade A)⁴³
 - Liraglutide 3 mg daily (level 2a; grade B)⁴⁴
- Using positive airway pressure therapy:
 - Tirzepatide 10 mg or 15 mg (level 1a; grade A)⁴³

*See recommendation 1.

Pharmacotherapy for obesity management should be offered, in conjunction with health behaviour changes, for people living with knee osteoarthritis and BMI ≥ 30 * for weight loss and reduction in knee pain:

- Semaglutide 2.4 mg weekly⁴⁵

American Association of Clinical Endocrinology Consensus Statement: Algorithm for the Evaluation and Treatment of Adults with Obesity/Adiposity-Based Chronic Disease – 2025 Update

Karl Nadolsky, DO, FACE, DABOM¹, W. Timothy Garvey, MD, MACE²,
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MEDICATIONS FOR OBESITY: INDIVIDUALIZATION OF THERAPY^a

KEY: ■ Preferred (evidence of benefit) ■ Insufficient evidence to prefer ■ Monitoring indicated ■ Contraindicated (evidence of risk/harm)

OBESITY-RELATED CONDITION	ORLISTAT	PHENTERMINE	PHENTERMINE/ TOPIRAMATE ER	NALTREXONE ER/ BUPROPION ER	LIRAGLUTIDE	SEMAGLUTIDE	TIRZEPATIDE
DIABETES PREVENTION	Benefit via weight reduction		Benefit via weight reduction		Benefit via weight reduction and incretin effect	Benefit via weight reduction and incretin effect	Benefit via weight reduction and incretin effect
TYPE 2 DIABETES	Benefit via weight reduction		Benefit via weight reduction	Benefit via weight reduction	Benefit via weight reduction and incretin effect	Benefit via weight reduction and incretin effect	Benefit via weight reduction and incretin effect
HYPERTENSION	Benefit via weight reduction	Monitor heart rate, BP Contraindicated in uncontrolled HTN	Monitor heart rate, BP; BP benefit observed in trials*	Monitor heart rate, BP Contraindicated in uncontrolled HTN	BP benefit observed in trials; Monitor heart rate	BP benefit observed in trials; Monitor heart rate	BP benefit observed in trials; Monitor heart rate
ASCVD		Contraindicated	Use with caution; Monitor heart rate, BP	Monitor heart rate, BP	Demonstrated prevention of ASCVD in T2D	Demonstrated prevention of ASCVD	Evidence in T2D and obesity pending
MASLD					Benefit observed in trials	Benefit observed in trials	Benefit observed in trials
DEPRESSION			Appropriate monitoring	Appropriate monitoring	Appropriate monitoring	Appropriate monitoring	Appropriate monitoring
ANXIETY		Appropriate monitoring	Appropriate monitoring	Appropriate monitoring			
CHRONIC KIDNEY DISEASE	Monitor for oxalate nephropathy		Do not exceed 7.5 mg/46 mg per day	Do not exceed 8 mg/90mg twice a day	Benefit in T2D; Avoid vomiting and volume depletion	Benefit in T2D; Avoid vomiting and volume depletion	Benefit in T2D; Avoid vomiting and volume depletion
SEVERE KIDNEY IMPAIRMENT	Monitor for oxalate nephropathy	Urinary clearance of drug	Urinary clearance of drug	Urinary clearance of drug	Avoid vomiting and volume depletion	Avoid vomiting and volume depletion	Avoid vomiting and volume depletion
NEPHROLITHIASIS	Calcium oxalate stones		Calcium phosphate stones				
HEPATOBIILIARY IMPAIRMENT	Monitor for cholelithiasis	Do not exceed 8 mg per day	Do not exceed 7.5 mg/46 mg per day	Do not exceed 8 mg/90 mg daily	Monitor for cholelithiasis	Monitor for cholelithiasis	Monitor for cholelithiasis
SEVERE HEPATIC IMPAIRMENT	Not recommended						

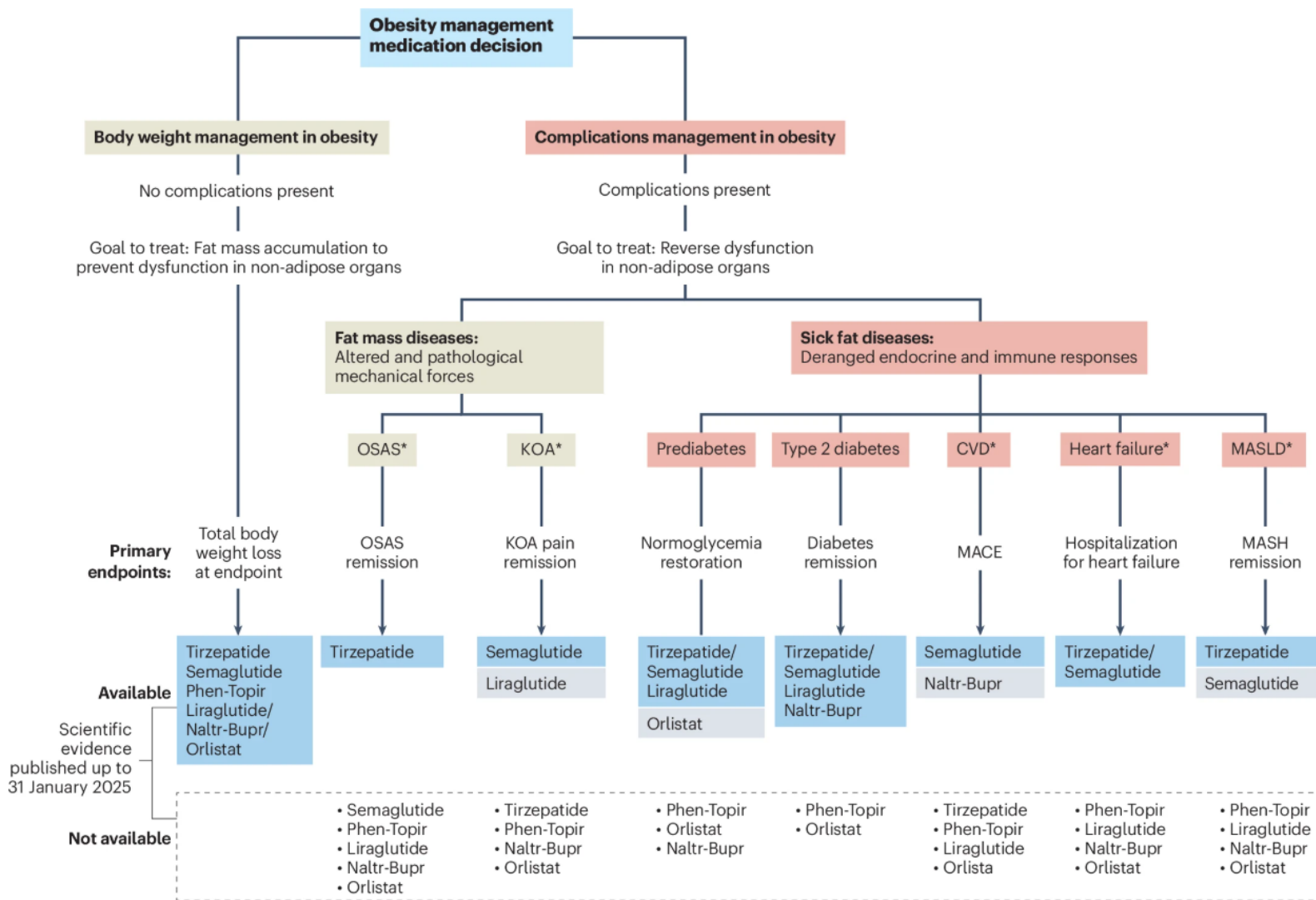
A systematic review and meta-analysis of the efficacy and safety of pharmacological treatments for obesity in adults

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Euan Woodward¹⁸ & Volkan Yumuk¹⁴



OMM across different Guidelines

Guideline

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nature medicine

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https://doi.org/10.1038/s41591-025-05878-7

AACE Clinical Guidance

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Characteristics	Canadian	EASO	AACE	SIO
<i>Cardiovascular disease</i>	Semagl.	Semagl. Naltr./Bupr.	Semagl. Liraglutid.* PT/NB	Semagl. (Overweight and Class I) Naltrexone/Bupropion (Class II)
<i>Heart failure</i>	Tirzep./Semagl.	Tirzep./Semagl.	Tirzep./Semagl.	Tirzep./Semagl. (Class II)
<i>Prediabetes</i>	Lirag./Orlis./Tirzep./ Semag.	Tirzep./Semagl. Liragl.	Lirag./Orlis./Tirzep./ Semag.	Lira/Orlistat (Class I) Semagl. (Class II)
<i>Type 2 diabetes</i>	Semag./Tirzep./NB/ Liragl./Orls.	Tirzep./Semagl. Liragl./NB	Semag./Tirzep./NB/ Liragl./Orls.	Semagl. (Class I) Tirze/Sema/Lira/NB (Class II)
<i>MASH/MASLD</i>	Semag./Tirzep./Lirag.	Tirzep. Semagl.	Semag./Tirzep./Lirag.	Tirzep. (Class II)
<i>Sleep apnea syndrome</i>	Tirzep./Lirag.	Tirzep.	Tirzep./Lirag.	Tirzep. (Class II)
<i>Knee osteoarthritis</i>	Semagl.	Semagl. Liragl.	Semagl.	Semagl. (Class III)

*Type 2 diabetes

OMM across different Guidelines

Guideline

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nature medicine

Article
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Characteristics	Canadian	EASO	AACE	SIO
Cardiovascular disease	Semagl.	Semagl.	Semagl.	Semagl. (Weight and Class I) Liraglutide/Bupropion (Class II)
Heart failure	Tirzepatide			Semagl./Semagl. (Class II)
Prediabetes	Liraglutide			Orlistat (Class I) Semagl. (Class II)
Type 2 diabetes	Semaglutide			Semagl. (Class I) Semaglutide/Liraglutide/NB (Class II)
MASH/MASLD	Semaglutide			Tirzepatide (Class II)
Sleep apnea syndrome	Tirzepatide			Tirzepatide (Class II)
Knee osteoarthritis				Semagl. (Class III)

*Type 2 diabetes