PRACTICAL NUTRITIONAL, FUNCTIONAL AND PSYCHOLOGICAL MANAGEMENT FOR ADULTS USING INCRETIN-BASED THERAPY

This resource is intended to support clinical discussion led by a healthcare professional and should be adapted to individual patient needs, local protocols and available resources.

EASO
European Association for the Study of Obesity
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CORE NUTRITIONAL MANAGEMENT DURING INCRETIN-BASED THERAPY

BASELINE NUTRITION & RISK SCREEN

- **Dietary habits:** food choices (including protein and fibre sources), meal patterns, appetite, eating behaviour, fluids, alcohol, allergies, preferences, and cultural factors
- **Risk factors:** older age, post-MBS, CKD/liver disease, prior deficiencies, frailty/sarcopenia risk, food insecurity
- **Measures:** weight, BMI and waist-to-height ratio (WtHR)
- **Function:** consider a functional test e.g. 5x sit-to-stand or adjusted handgrip strength
- **Body composition:** DXA or BIA if available
- **Baseline labs (pragmatic):** full blood count, vitamin B12, iron status (incl. ferritin); consider folate, vitamin D, calcium/parathyroid hormone, magnesium, CRP, albumin according to risk and resources

ADEQUACY WHEN APPETITE IS LOWER

- **Prioritise nutrient-dense foods:** across food groups
- **Protein:** individualise intake, targeting 1.0–1.5 g/kg adjusted body weight per day (minimum ≥60 g/day)
- **Fluids:** 2.0–2.5 L/day (individualise for HF/CKD; increase with heat/exercise)
- **Fibre:** ≥25 g/day (increase gradually with fluids)
- **"Protein first" at meals:** distribute intake across the day
- **Consider protein supplementation:** if dietary intake is insufficient (dietitian-led)

IMPROVE TOLERABILITY TO SUPPORT ADHERENCE

- Slow or flexible dose escalation when symptoms occur
- Small, lower-fat meals; eat slowly; stop at comfortable fullness
- **Nausea:** bland foods, smaller portions, cool foods
- **Reflux:** avoid large late meals; reduce high-fat/spicy foods; remain upright after eating
- **Constipation:** fibre + fluids + movement; consider psyllium (titrate slowly)
- **Diarrhoea or vomiting:** prioritise hydration and electrolytes

! Persistent vomiting, severe abdominal pain, dehydration, or inability to meet nutrition needs - **urgent clinical review**

Consider thiamine where vomiting is prolonged

PREVENT DEFICIENCIES DURING REDUCED INTAKE

- **Energy <1500 kcal/day**
  → High risk of inadequate micronutrients
  → Intensify medical nutrition therapy; review diet quality; complete multivitamin-mineral supplement
- **Energy <1200 kcal/day**
  → Consider daily complete multivitamin-mineral
  → Consider protein supplementation
- **Energy <800 kcal/day** OR requirements unmet despite support
  → Consider dose reduction, pause, reduce-titration or discontinuation
  → Use shared decision-making to mitigate malnutrition and disordered-eating risk
- **Monitor clinical signs:** fatigue, alopecia, neuropathy, poor wound healing
- **Annual labs at minimum:** full blood count, vitamin B12, ferritin/iron
- **Post-MBS:** follow appropriate post-surgical monitoring protocols

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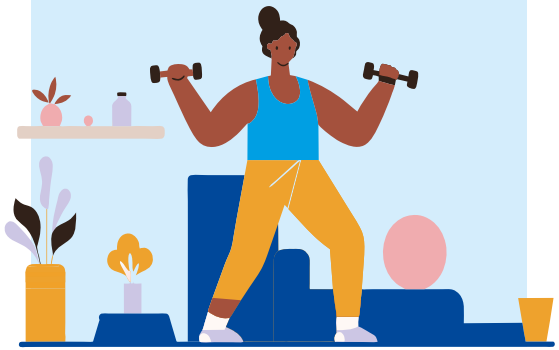
MONITORING, PRESERVATION AND ESCALATION

PROTECT MUSCLE DURING WEIGHT LOSS

- Weight loss with incretin-based therapy includes lean mass loss
- Protein + progressive resistance training are essential countermeasures
- Combine resistance and aerobic training; individualise and progress gradually
- **Monitor function:** consider either sit-to-stand, SARC-F or hand-grip strength
- Higher-risk groups (older adults, frailty, sarcopenic obesity, post-metabolic-bariatric surgery, rapid weight loss) require consideration of closer monitoring and specialist input



MONITOR → ADJUST → SUSTAIN

- **Initiation & each dose change:** intake adequacy, GI symptoms, hydration, mood and disordered-eating screening
- **Every 2–3 months in year one or at 5%, 10%, 15% weight loss:** diet quality, supplements, function (aHGS/STS), body composition if available
- **Annually:** laboratory monitoring and long-term plan review

Use shared decision-making to start, delay, pause, down-titrate or discontinue incretin-based therapy, balancing benefits against nutritional, functional and psychological risk

SCREENING AND GUIDANCE

- Screen for disordered-eating behaviours and eating-disorder risk
- Provide anticipatory guidance at initiation, titration, plateaus and cessation
- Support identity and coping shifts; plan alternatives to food-based coping
- Screen sensitively for food insecurity and access barriers
- Adapt plans to cultural context, cost, cooking facilities and support needs

MULTIDISCIPLINARY DELIVERY IS ESSENTIAL

- Dietitian-led medical nutrition therapy is central
- Prescribers manage dosing and medication interactions
- Physiotherapists support exercise and physical function
- Psychologists support eating behaviour, identity and coping
- Nurses and pharmacists reinforce education and medication safety