ESPEN FACT SHEETS

NUTRITIONAL RISKS OF OBESITY-MANAGEMENT MEDICATIONS

People living with obesity can still be at nutritional risk during treatment

WHY NUTRITIONAL RISK MAY OCCUR?

Reduced appetite and early satiety smaller portions may reduce protein, fibre, fluid, and micronutrient intake

Nausea, vomiting, constipation, diarrhoea may reduce intake and increase dehydration risk.

Rapid weight loss potential risk of loss of fat-free mass and strength

Changes in appetite, satiety, food preferences and food reward may alter usual eating patterns and the relationship with food

WHICH PATIENTS MAY BENEFIT FROM CLOSER NUTRITIONAL MONITORING?

Older adults with frailty, sarcopenia or reduced muscle strength/function

Pre-existing **malnutrition**, **sarcopenia**, or **micronutrient deficiency**

Previous **metabolic** and **bariatric surgery** (MBS)

Eating disorders symptoms significant distress related to eating, body image, or other psychological factors related to eating

Rapid or excessive **weight loss**

Excessively restrictive diets, food allergies, limited dietary variety or nutritional adequacy

CKD, GI or liver disease, or complex **multimorbidity**

Limited access to food, including because of food insecurity or **financial constraints**

PRACTICAL NUTRITION PRIORITIES

Protein	Fibre	Fluids	Micronutrients	Food quality	Energy
1.0–1.5 g/kg* adjusted body weight/day (min. 60 g)	≥25 g/day, increased gradually	2.0–2.5 L/day, mainly non-caloric;** increased appropriately during heat or exercise	check for potential deficiencies if intake is <1200 kcal/day or in the presence of poor diet quality***	Nutrient-dense small meals, protein** at every meal	Avoid excessive restriction, especially if older

Adjusted body weight = reference weight + 0.25 × (actual − reference weight); reference weight = weight at BMI 25 kg/m².
**Protein requirements are individualised according to age, body composition, nutritional status, physical activity, renal function and clinical circumstances*
***Individualise (dietetic input) in heart failure, CKD or where fluid restriction is required, and other specialist contexts; ***provide supplements if necessary*

PROTECT HEALTH AND FUNCTION, NOT JUST WEIGHT

Track weight, waist circumference, waist-to-height ratio

Simple function test *e.g. hand grip strength or the 5x sit-to-stand test.*

A brief question: *"Have you noticed any new weakness, loss of strength, or greater difficulty carrying out your usual daily activities?"*



Protein + progressive resistance exercise preserve muscle

SCREEN FOR DISORDERED EATING (FEDS)

at baseline and at each review

meal skipping beyond satiety, purging or laxatives, compensatory exercise, loss-of-control eating, body-image distress, replace food-related rewards with other enjoyable activities

If positive: pause escalation, refer for **specialist support**



1.Dietetic review

Seek clinical review if:

persistent vomiting or dehydration; dizziness, weakness/fainting; sustained intake <800 kcal/day or inability to meet nutritional needs; rapid weight loss with new weakness or functional decline; deficiency signs (hair loss, glossitis, neuropathy, anaemia); positive FEDs screen or severe distress; prior bariatric surgery without appropriate supplementation or monitoring

2. Targeted blood tests (incl. micronutrients) → ***3. Review medication and dose*** → ***4. Multi-disciplinary discussion***

Abbreviations: CKD: Chronic Kidney Disease; GI: Gastro-intestinal; BMI:Body Mass Index; FEDS: Feeding and Eating Disorders

Dobbie LJ et al. Nutritional, functional, and psychological considerations for incretin-based therapies in adults: an EASO, EFAD and ECPO Consensus Statement. Lancet Diabetes Endocrinol 2026; DOI 10.1016/S2213-587(26)00122-1
Di Vincenzo O et al. EASO Position Statement on the Diagnosis and Management of Obesity in Older Adults. Obes Facts 2026;19(4):422–37.
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