EDITORIAL

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Trends in Treatment of Obesity: Is it a "déjà vu" Moment for Surgeons?

The World Health Organization (WHO) classifies obesity as a chronic, relapsing disease.[1] It results from complex interactions between genetics, neurobiology, eating behaviours, diet availability, market forces, and the environment.[1] This global public health crisis affects over a billion people and is increasing in nearly every country. Since 1990, adult obesity rates have more than doubled, and adolescent rates have quadrupled. In Malaysia, 54.4% of adults are overweight or obese, increasing to 70.1% with Asian BMI criteria.[2] Among children and adolescents, rates rose from 8% in 1990 to 20% in 2022.[1] This trend threatens worker productivity, healthy aging, and health system resilience.

Malaysia is undergoing a nationwide obesogenic transition driven by biological, behavioral, and environmental factors, including unbalanced diets, sedentary lifestyles, and demographic changes. Authorities have implemented several measures, including affordable farmers' markets, nutritious school meal programs, healthy cafeteria guidelines, regulations on unhealthy food marketing, and higher taxes on sugary drinks. The latest Clinical Practice Guidelines (CPGs) recommend comprehensive lifestyle modifications, along with medical nutrition therapy and physical activity. The guidelines also recommend pharmacotherapy to further enhance these measures.[2] If these measures fail despite patient compliance, surgery should be considered.

The main benefits of surgery-induced weight loss include remission of metabolic effects and improved quality of life. Common procedures performed by surgeons are the Roux-en-Y gastric bypass (RYGB) and sleeve gastrectomy (SG). At one year, mean weight loss is 31.2% for RYGB and 25.2% for SG; at five years, RYGB achieves 25.5% and SG 18.8%.3 Both the Finnish (SLEEVEPASS) and Swiss (SM-BOSS) trials consistently showed that RYGB is more effective than SG for percent excess weight loss.[3]

Malaysia has the highest obesity rates in Southeast Asia, leading to more bariatric surgeries. These procedures involve resection or bypass of the upper gastrointestinal tract and carry adverse effects, especially in younger patients. Skilful marketing often overshadows the adverse scientific evidence on metabolic surgery. Thus, surgeons must emphasize the need for a strict postoperative diet and exercise regimen. Weight regain occurs in 20–25% of patients after initial loss. Unlike other surgeries for benign conditions, surgeons must commit to long-term follow-up with these patients.[3]

Obesity management globally is shifting toward primarily non-surgical modalities. This trend is driven by new medications that can now achieve 15–25% weight loss, comparable to results from previous bariatric surgery.[3] Injectable Tirzepatide, Semaglutide, and Liraglutide deliver significant weight loss and reduce cardiovascular risk. New agents such as Retatrutide and oral elecoglipron, by targeting multiple pathways, also provide favorable results.

These developments have renewed interest in medical therapy in Malaysia, partly because many patients are reluctant to undergo surgery. Ideally, patients need comprehensive support and realistic expectations for lasting weight loss with medical therapy. In practice, weight loss averages 8–12%, whereas clinical trials report 12–20%.[4]

Major challenges remain. For example, high costs and lack of insurance limit access to obesity medications. Clinicians often prescribe these drugs for their metabolic benefits or other approved uses to address these issues. Managing obesity requires advanced monitoring and personalized treatment plans, as it is a chronic disease that requires long-term effort.

This evolving modality raises an important question: Is obesity treatment approaching a 'peptic ulcer moment'? In the 1970s, radical surgeries for peptic ulcers, including Truncal Vagotomy and Antrectomy, were common. Cimetidine, the first H_2-receptor antagonist, was introduced in 1977 and transformed treatment. In 1982, after Drs. Barry Marshall and Robin Warren discovered *Helicobacter pylori,* whose eradication drastically reduced the need for surgery. The launch of PPI in 1988 further shifted treatment from surgery to medicine. This transition marked a major change for surgeons. Have we reached the same point in obesity care? To answer this vexed question, be mindful of the key differences from ulcers. Obesity has no single cause. It results from complex interactions among areas such as genetics, neurobiology, eating behaviours, diet availability, market forces, and environment. In contrast, identification of the pathophysiology of peptic ulcers enabled targeted medical treatment. Management of obesity requires a multidisciplinary team to address all related issues, much as in oncology.

Although medication has advanced, major challenges persist. GLP-1 drugs are highly effective but are not a cure, unlike eradicating *H. pylori* to treat ulcers. GLP-1 drugs target neurobiology, not eating habits. Surgery remains the most durable option for severe obesity and metabolic disease, with higher long-term diabetes remission and sustained weight loss rates. Until behavioral change is achievable, surgery will remain the dominant approach to alleviating obesity. Medical options now supplement, not replace, surgery for obesity.

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Prof. Dr. Nasser Mohammad Amjad
Department of Surgery
Kulliyyah of Medicine
International Islamic University Malaysia
MALAYSIA