LETTER

The GLP-1 Medication Safety Gap: Why Every New Obesity Prescription Should Trigger a Pharmacotherapy Review

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Dear Editor,

Obesity pharmacotherapy has entered a new era, but prescribing safeguards have not necessarily kept pace. The 2026 American College of Physicians living guideline suggests semaglutide or tirzepatide with lifestyle modification for eligible adults [1]. In the head-to-head SURMOUNT-5 trial, mean weight loss at 72 weeks was 20.2% with tirzepatide and 13.7% with semaglutide [2]. This efficacy creates a less visible challenge: as appetite, glycemia and weight change, the safety of the patient's existing medication regimen may change as well. Initiation of an incretin-based anti-obesity medicine should therefore trigger a structured pharmacotherapy review, not merely a new prescription.

The first checkpoint is preventable medication-related harm. In people with type 2 diabetes, improved glycemic control may require adjustment of insulin or sulfonylureas to reduce hypoglycemia risk. The American Diabetes Association's 2026 Standards of Care explicitly advise reassessing these agents when initiating a GLP-1 receptor agonist or dual GIP/GLP-1 agonist [3]. Clinicians should also review blood pressure, orthostatic symptoms, diuretic use and volume status when intake is reduced or vomiting occurs. This is a call for individualized reassessment, not indiscriminate discontinuation of therapies that confer cardiovascular or kidney benefits.

The second checkpoint is nutritional and functional safety. Gastrointestinal adverse effects and reduced food intake can undermine protein adequacy, hydration and micronutrient intake in susceptible patients. A 2025 multidisciplinary advisory recommends integrating nutrition assessment, sufficient protein, resistance activity and symptom management into GLP-1 treatment [4]. Frailty, low muscle strength, persistent vomiting or an unusually rapid decline in intake should prompt closer assessment. A falling body weight should not automatically be interpreted as a complete measure of treatment success.

The third checkpoint is communication across care settings. Perioperative GLP-1 management is a clear example: contemporary multisociety guidance advocates individualized assessment of delayed gastric emptying and aspiration risk rather than automatic withholding for every patient. Dose escalation, gastrointestinal symptoms and the planned procedure must inform decisions made with the anesthesia and prescribing teams [5]. The medication list should carry this information into surgical assessment, emergency care and discharge reconciliation.

Finally, treatment continuity deserves advance planning. A 2026 systematic review documented clinically relevant weight regain after discontinuation of weight-management medicines, reinforcing the need to discuss affordability, supply interruptions, adverse effects and longer-term follow-up before therapy begins [6]. Patients should leave initiation visits knowing whom to contact if treatment is interrupted and when a dose adjustment or re-evaluation is needed.

We propose a five-domain, pharmacist-supported review at treatment initiation, each major dose escalation and care transitions: (1) indication, access and patient goals; (2) hypoglycemia-prone and other potentially affected co-medications; (3) gastrointestinal tolerance, hydration and nutritional function; (4) upcoming procedures and interprofessional communication; and (5) continuity and monitoring plans. This is a pragmatic implementation proposal, not a validated intervention. Its value should be tested through medication discrepancies, symptomatic hypoglycemia, unplanned care, treatment persistence, patient-reported function and equity of access—not weight change alone.

The success of incretin pharmacotherapy should be measured not only in kilograms lost, but also in avoidable medication harm prevented and benefits maintained.

Declarations

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