Update: Nutrizione Clinica

Dr. med. Massimo Quarenghi

Spec. in medicina interna e nutrizione clinica (SSNC)

Medico caposervizio

Servizio di Nutrizione clinica e dietetica

Update: nutrizione clinica

25 minuti, 3-6 tematiche emerse da pubblicazioni recenti (ultimi 3-4 anni) che abbiano modificato in maniera significativa la pratica clinica quotidiana nella propria disciplina.

EFFORT II (**NCT04926597**)

Effect of Continued Nutritional Support at Hospital Discharge on Mortality, Frailty, Functional Outcomes and Recovery

Campione pianificato: **1’200 partecipanti**

Termine stimato: fine 2026

Individualised nutritional support in medical inpatients at nutritional risk: a randomised clinical trial

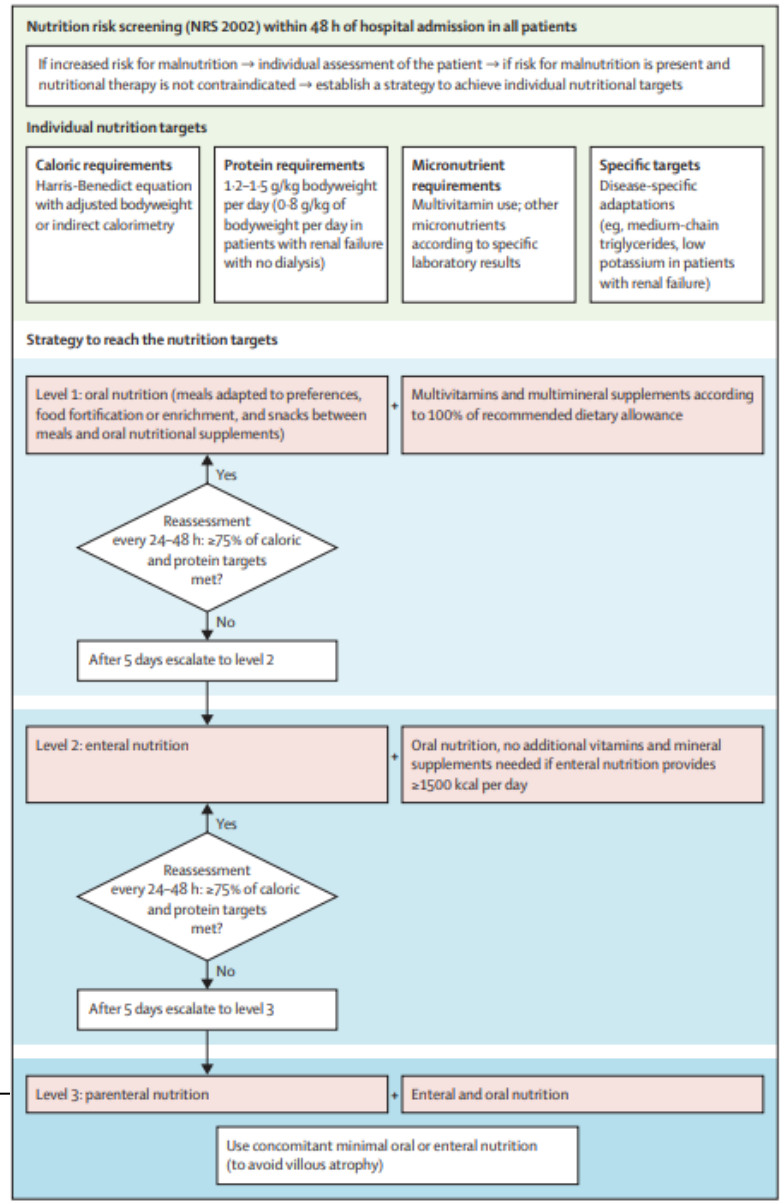
Philipp Schuetz, Rebecca Fehr, Valerie Baechli, Martina Geiser, Manuela Deiss, Filomena Gomes, Alexander Kutz, Pascal Tribolet, Thomas Bregenzer, Nina Braun, Claus Hoess, Vojtech Pavlicek, Sarah Schmid, Stefan Bilz, Sarah Sigrist, Michael Brändle, Carmen Benz, Christoph Henzen, Silvia Mattmann, Robert Thomann, Claudia Brand, Jonas Rutishauser, Drahomir Aujesky, Nicolas Rodondi, Jacques Donzé, Zeno Stanga*, Beat Mueller*

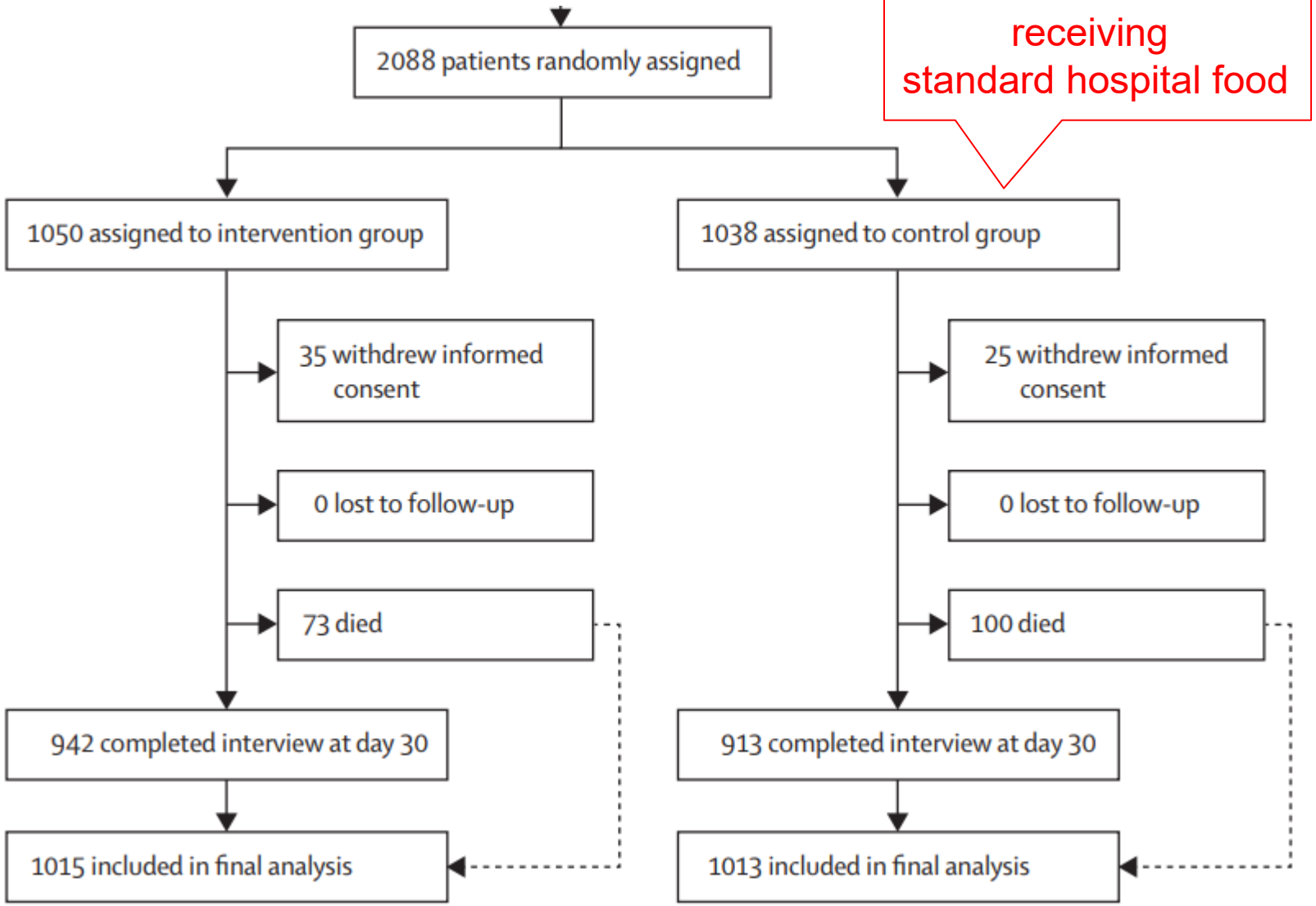
Lancet 2019; 393: 2312–21
Published Online
April 25, 2019
http://dx.doi.org/10.1016/S0140-6736(18)32776-4
See Comment page 2278
*Equally contributing senior

Summary

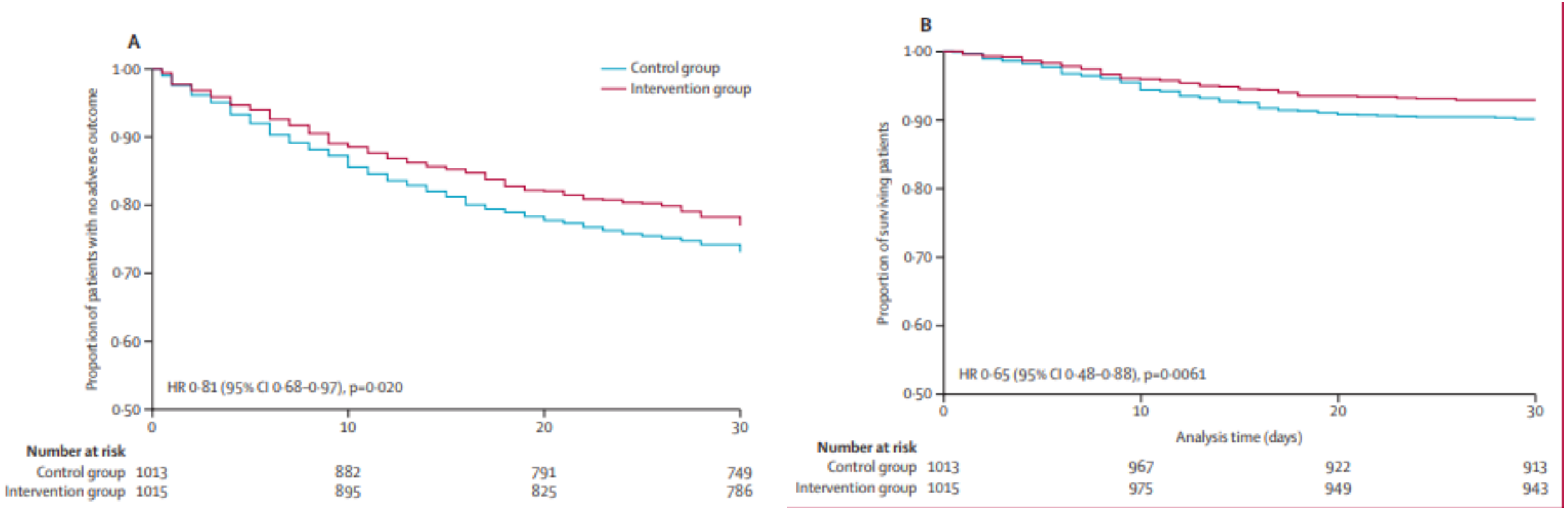
Background Guidelines recommend the use of nutritional support during hospital stays for medical patients (patients not critically ill and not undergoing surgical procedures) at risk of malnutrition. However, the supporting evidence for this recommendation is insufficient, and there is growing concern about the possible negative effects of nutritional therapy during acute illness on recovery and clinical outcomes. Our aim was thus to test the hypothesis that protocol-guided individualised nutritional support to reach protein and caloric goals reduces the risk of adverse clinical outcomes in medical inpatients at nutritional risk.

Effort-Trial





Effort-Trial: results



Kaplan-Meier estimates of the cumulative incidence of the primary endpoint and all-cause mortality (A) Time to the first event of the composite primary endpoint (log-rank p value=0·035). (B) Time to death (log-rank p value=0·031).

JAMA Network Open

Original Investigation | Nutrition, Obesit

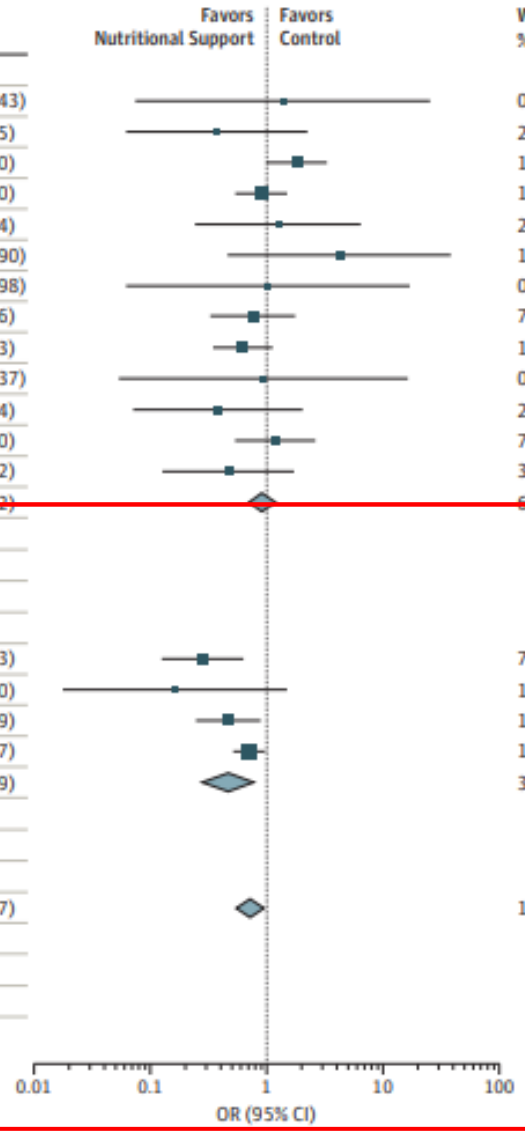
Association of Nutri
Among Medical Inpa
or at Nutritional Risk
An Updated Systema

Filomena Gomes, PhD; Annic Baumgartner, MD; L
Beat Mueller, MD; Philipp Schuetz, MD, MPH

Abstract

Figure 1. Forest Plot Comparing Nutritional Intervention vs Control for Mortality, Stratified by Publication Year

Study or Subgroup	Nutritional Support Events	Nutritional Support Total	Control Events	Control Total	OR (95% CI)	Weight, %
Trials published until 2014						
Broqvist et al,[14] 1994	1	9	1	12	1.38 (0.07-25.43)	0.9
Bunout et al,[15] 1989	2	17	5	19	0.37 (0.06-2.25)	2.2
Garibalia et al,[16] 2006	32	222	19	223	1.81 (0.99-3.30)	10.7
Hickson et al,[18] 2004	31	292	35	300	0.90 (0.54-1.50)	12.4
Hogarth et al,[19] 1996	5	9	8	16	1.25 (0.24-6.44)	2.5
Holyday et al,[20] 2012	4	71	1	72	4.24 (0.46-38.90)	1.5
Munk et al,[23] 2014	1	40	1	41	1.03 (0.06-16.98)	0.9
Neelemaat et al,[24] 2012	11	105	14	105	0.76 (0.33-1.76)	7.2
Potter et al,[26] 2001	21	186	33	195	0.62 (0.35-1.13)	10.9
Saudny-Unterberger et al,[30] 1997	1	17	1	16	0.94 (0.05-16.37)	0.9
Starke et al,[40] 2011	2	66	5	66	0.38 (0.07-2.04)	2.4
Vlaming et al,[32] 2001	14	274	12	275	1.18 (0.54-2.60)	7.8
Volkert et al,[41] 1996	4	35	8	37	0.47 (0.13-1.72)	3.8
~~Subtotal (95% CI)~~		~~1343~~		~~1377~~	~~0.94 (0.72-1.22)~~	~~64.1~~
Total events	129		143			
Heterogeneity: $\tau^2=0.00$, $\chi^2=12.19$, df = 12 ($P=.43$), $I^2=2\%$						
Test for overall effect: $z=0.47$ ($P=.64$)						
Trials published after 2014						
Bonilla-Palomas et al,[34] 2016	12	59	29	61	0.28 (0.13-0.63)	7.6
Cano-Torres et al,[35] 2017	1	28	5	27	0.16 (0.02-1.50)	1.5
Deutz et al,[36] 2016	15	313	30	309	0.47 (0.25-0.89)	10.0
Schuetz et al,[38] 2019	73	1015	100	1013	0.71 (0.52-0.97)	16.8
Subtotal (95% CI)		1415		1410	0.47 (0.28-0.79)	35.9
Total events	101		164			
Heterogeneity: $\tau^2=0.13$, $\chi^2=6.28$, df = 3 ($P=.10$), $I^2=52\%$						
Test for overall effect: $z=2.85$ ($P=.004$)						
Total (95% CI)		2758		2787	0.73 (0.56-0.97)	100
Total events	230		307			
Heterogeneity: $\tau^2=0.09$, $\chi^2=24.67$, df = 16 ($P=.08$), $I^2=35\%$						
Test for overall effect: $z=2.18$ ($P=.03$)						
Test for subgroup differences: $\chi^2=5.34$, df = 1 ($P=.02$), $I^2=81.3\%$						



A Mantel-Haenszel random-effects model was used. Squares indicate mean values, with the size of squares reflecting the weight and the lines indicating 95% CIs. Diamonds indicate pooled estimates, with horizontal points of the diamonds indicating 95% CIs. OR indicates odds ratio.

Paziente malnutrito:

ELSEVIER

Nutrition
Volume 85, May 2021, 111068

Applied nutritional investigation

Phase angle is associated with length of hospital stay, readmissions, mortality, and falls in patients hospitalized in internal-medicine wards: A retrospective cohort study

Rosaria Del Giorno M.D. [a, b], Massimo Quarenghi M.D. [c], Kevyn Stefanelli M.Sc. [d], Alice Rigamonti [c], Carlotta Stanglini [c], Valentina De Vecchi M.D. [a], Luca Gabutti M.D. [a, b]

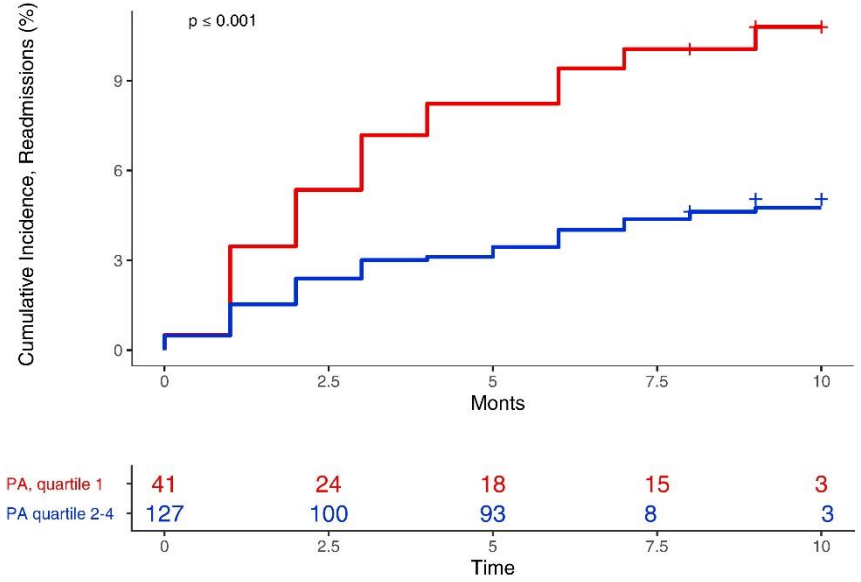


Fig. 1. Cumulative incidence of readmissions according to PA quartiles:
quartile 1 (red line) compared with quartiles 2 to 4 (blue line).

P value by log rank. PA, phase angle.

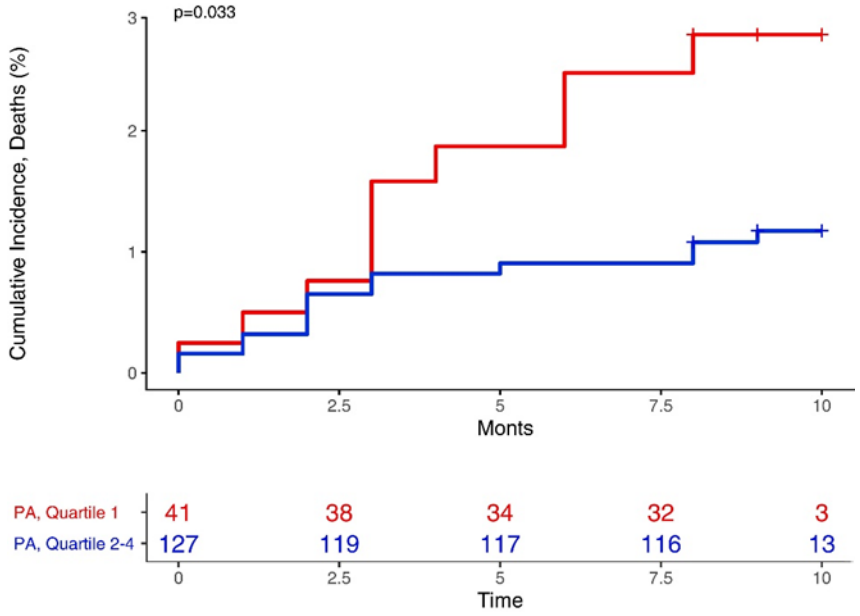


Fig. 2. Survival curves, stratified by PA quartile: cumulative incidence of deaths in quartile 1 (red line) compared with quartiles 2 to 4 (blue line). *P* value by log rank. PA, phase angle.

Malnutrizione

nutrients

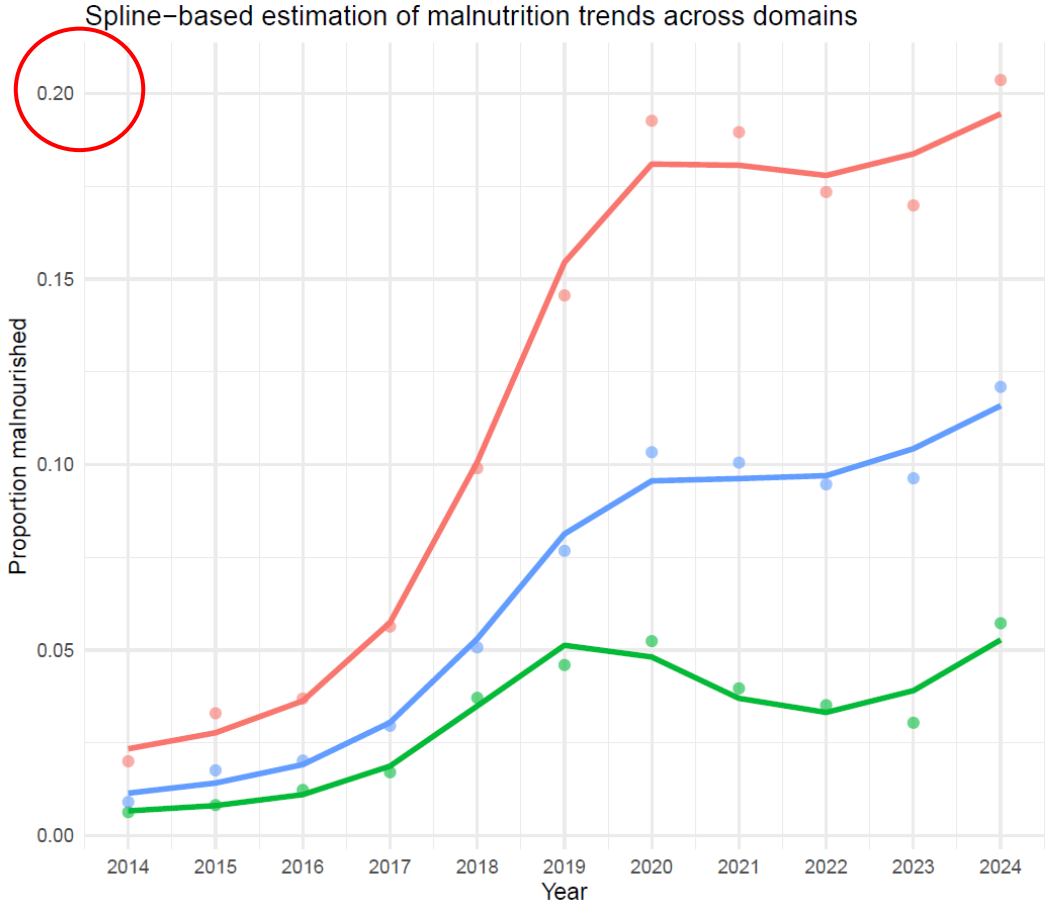
MDPI

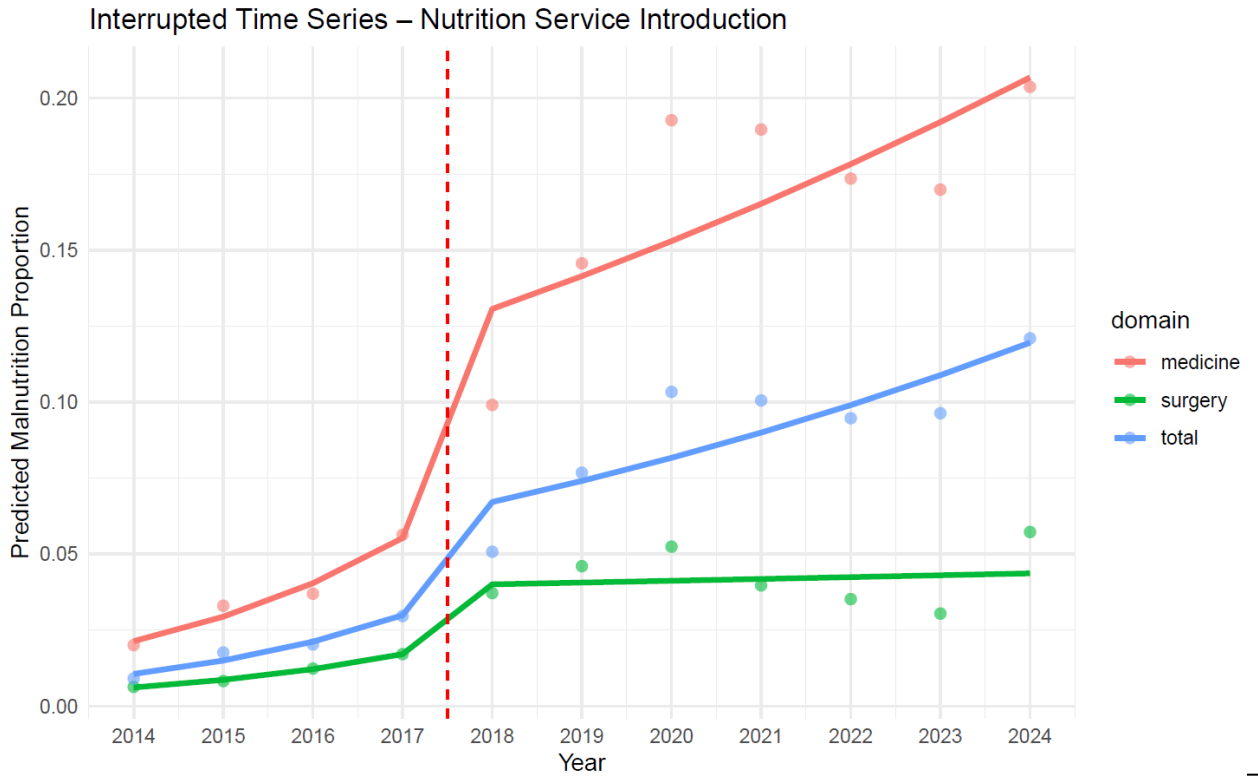
Article

An 11-Year Retrospective Analysis of the Prevalence of Malnutrition Diagnosis at Discharge in a Multi-Site Hospital: The Impact of Introducing a Clinical Nutrition Service

Giorgia Preatoni [1,2], Dario Bertolotti [3], Giulia Galligani [2], Nicola Ossola [3] and Massimo Quarenghi [1,2,*]

Published: 24 September 2025





Effect of Continued Nutritional support at Hospital Discharge on Mortality, Frailty, Functional Outcomes and Recovery Trial: The EFFORT II Project

Team: Prof. Philipp Schuetz, Prof. Beat Müller, Prof. Zeno Stanga, Dr. Nina Kaegi-Braun, Pascal Tribolet, Dr. Emilie Reber, Carla Gressies

Contact information: Prof. Dr. med. P. Schuetz, Head of General Internal Medicine, Kantonsspital Aarau, Switzerland, Email: Schuetzph@gmail.com

Termine stimato: fine 2026

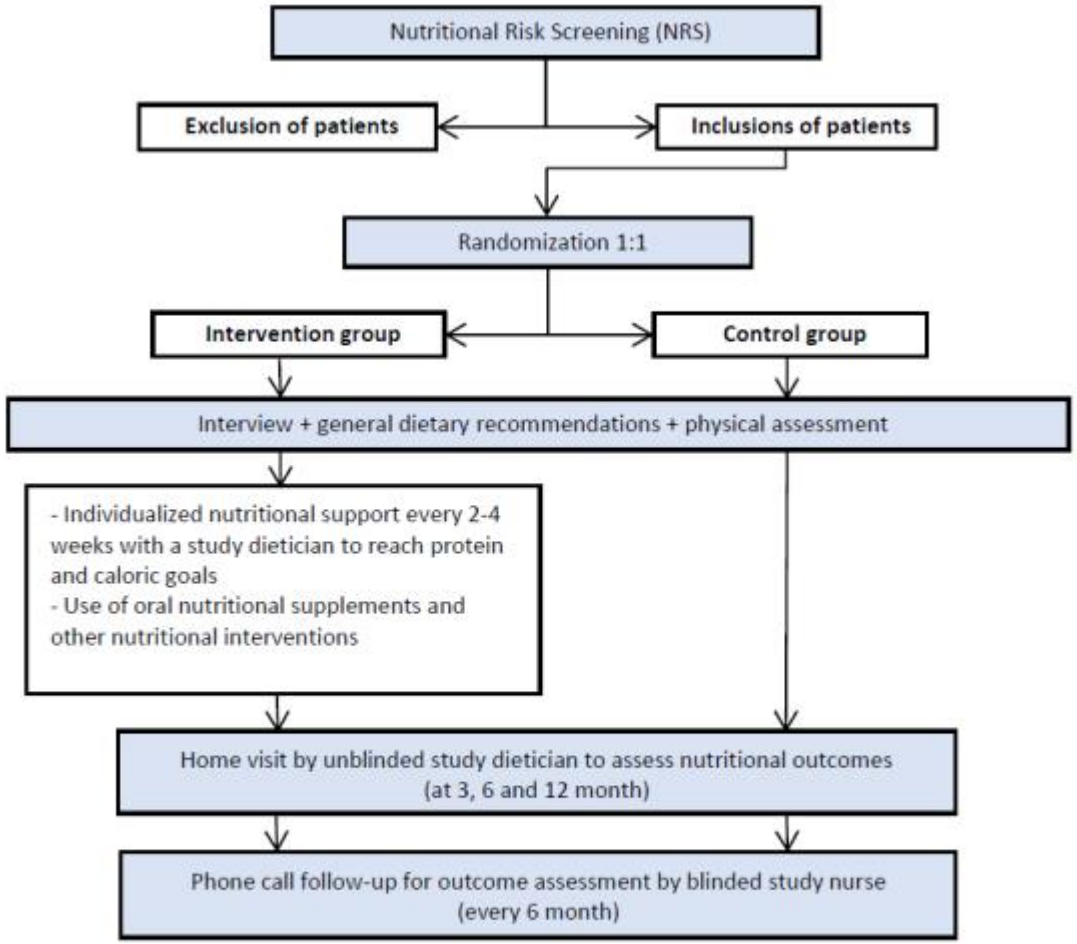


Fig. 1: EFFORT II Study Flow Chart

Malnutrizione: Take home messages

- FREQUENTE NEI NOSTRI PAZIENTI POLIMORBIDI
- DOBBIAMO RILEVARLA
- PRENDERLA A CARICO RIDUCE LA MORBI-MORTALITA’
- ASPETTIAMO I RISULTATI DELLO STUDIO EFFORT-II

Pag. 10

- What's new in … **Exercise to prevent sarcopenia in older adults (May 2025)**

the ineffectiveness of strength programs

that do not emphasize robust exercises

with progressive increases in load.

Received: 25 June 2024 | Revised: 24 September 2024 | Accepted: 21 October 2024

DOI: 10.1111/jgs.19266

CLINICAL INVESTIGATION

Journal of the
American Geriatrics Society

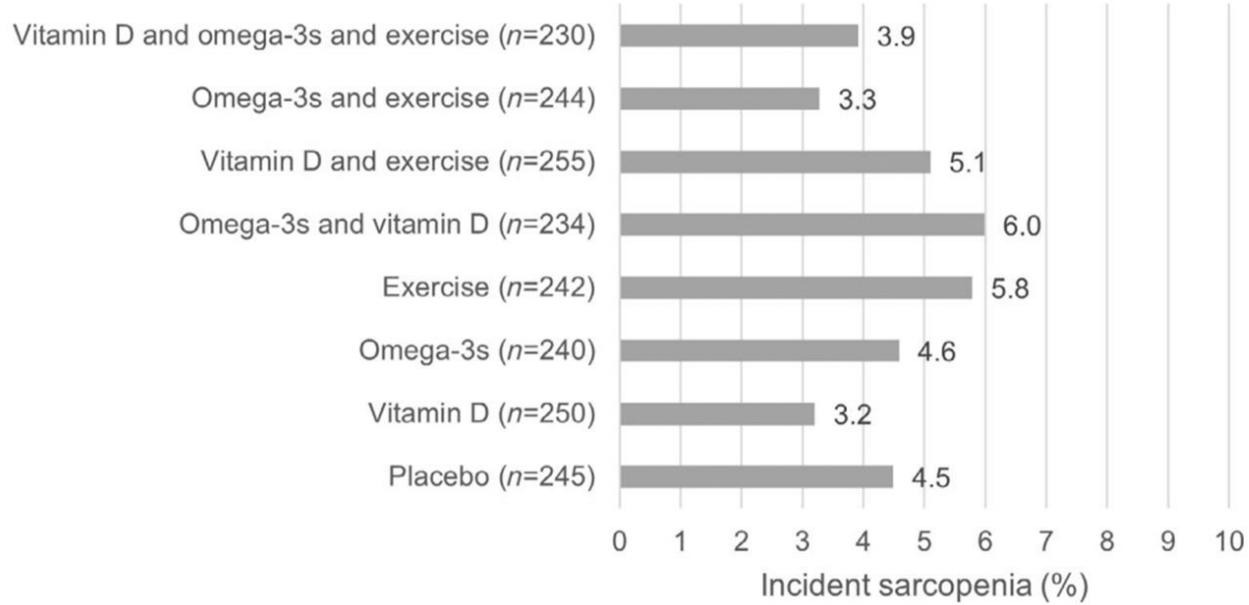
Effect of vitamin D, omega-3 supplementation, or a home exercise program on muscle mass and sarcopenia: DO-HEALTH trial

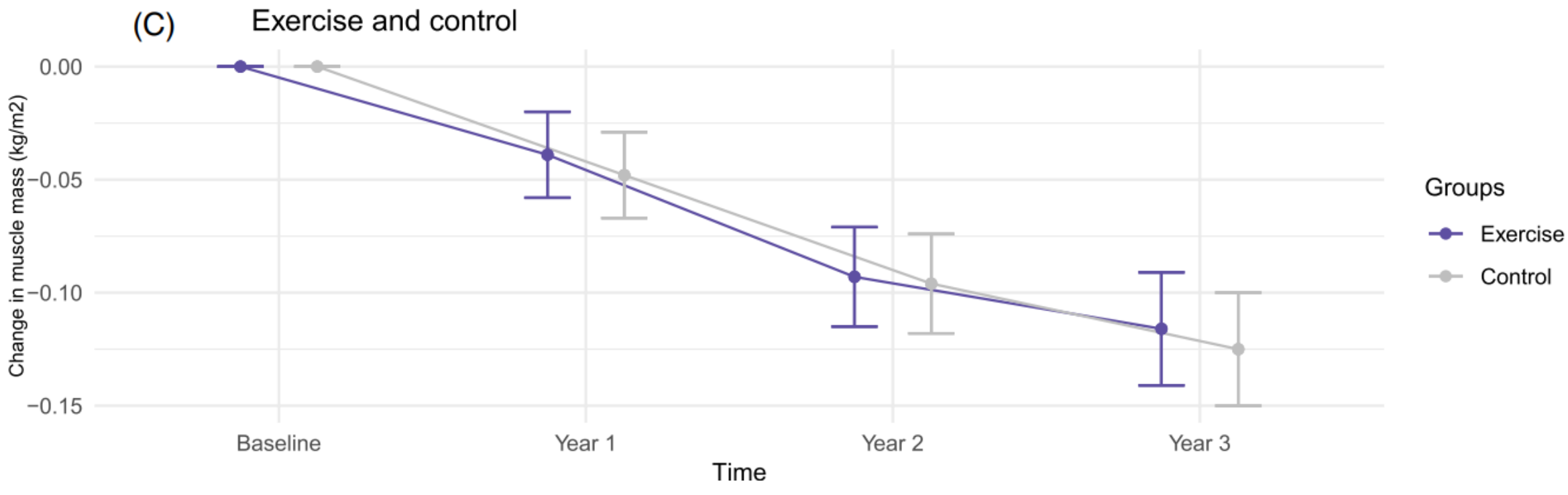
n = ~1.495 , ≥ 70 a,

l'intervento di esercizi semplici (3×/settimana)
(5 movimenti a corpo libero / leggera resistenza, ***senza progressione del carico***)

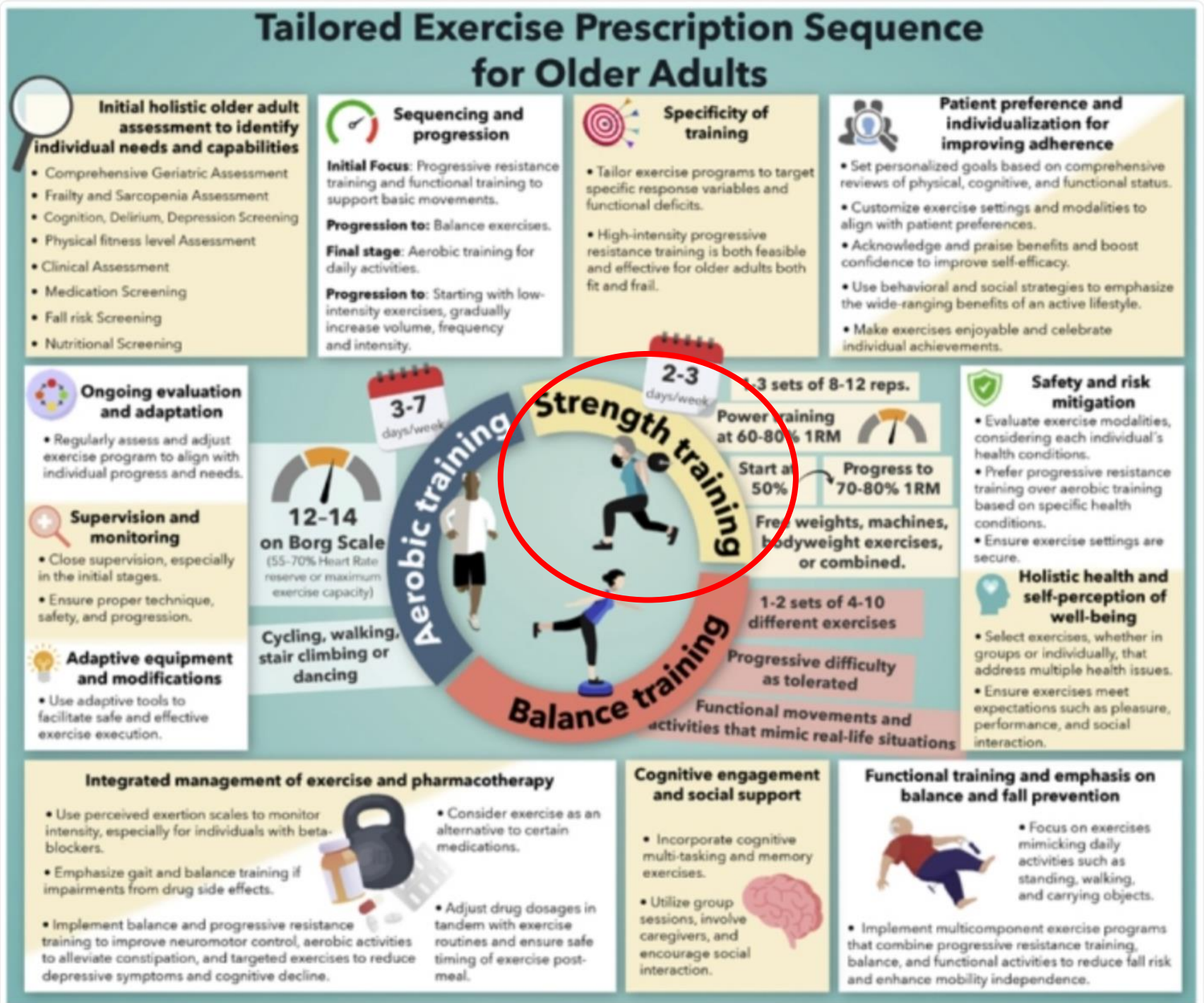
non ha ridotto né l'incidenza di sarcopenia né la perdita di massa muscolare in 3 anni

FIGURE 2 Incident sarcopenia in the eight treatment groups over 3 years ($n = 1940$).





ELSEVIER



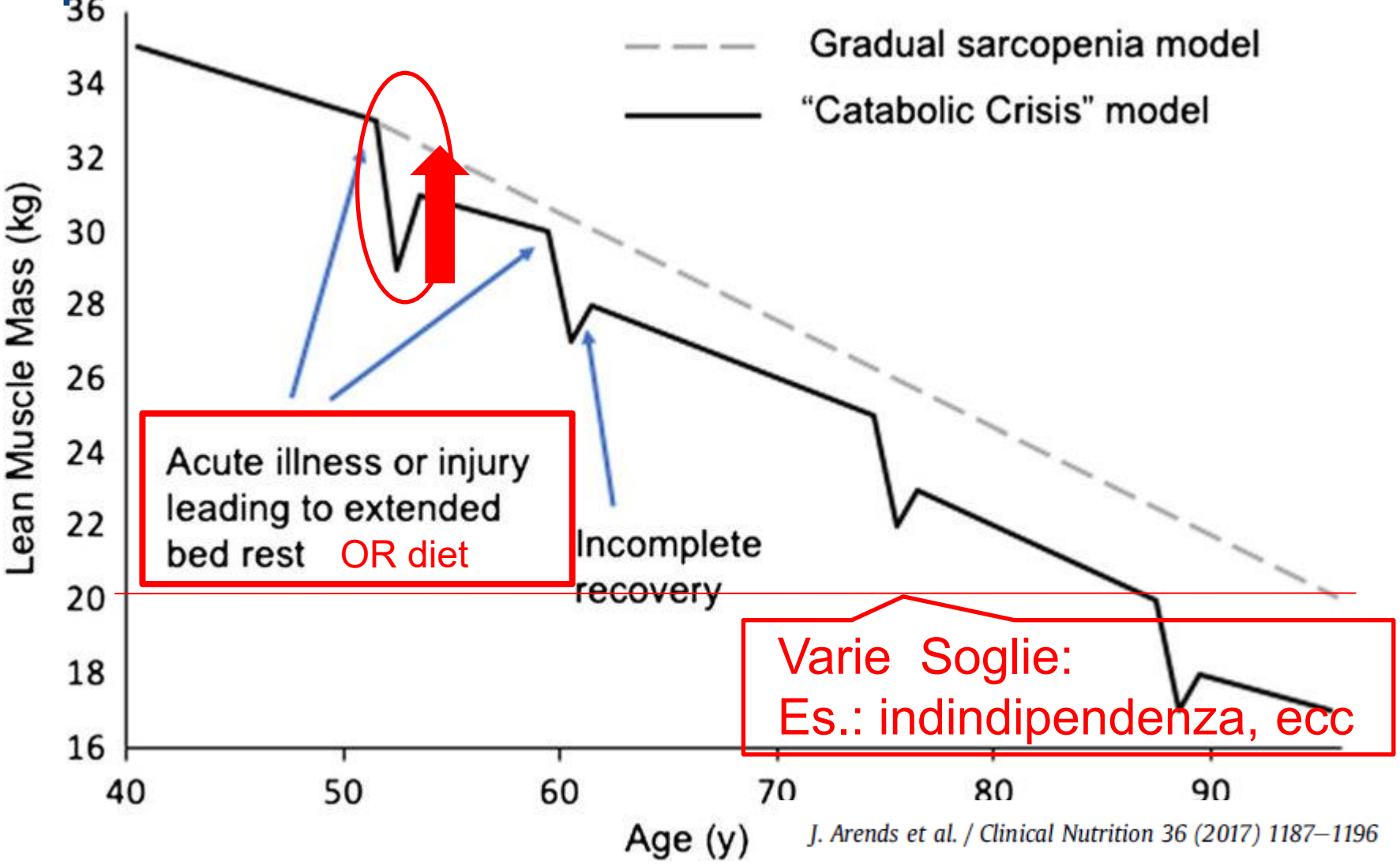
JNHA
THE JOURNAL OF NUTRITION, HEALTH AND AGING

Review

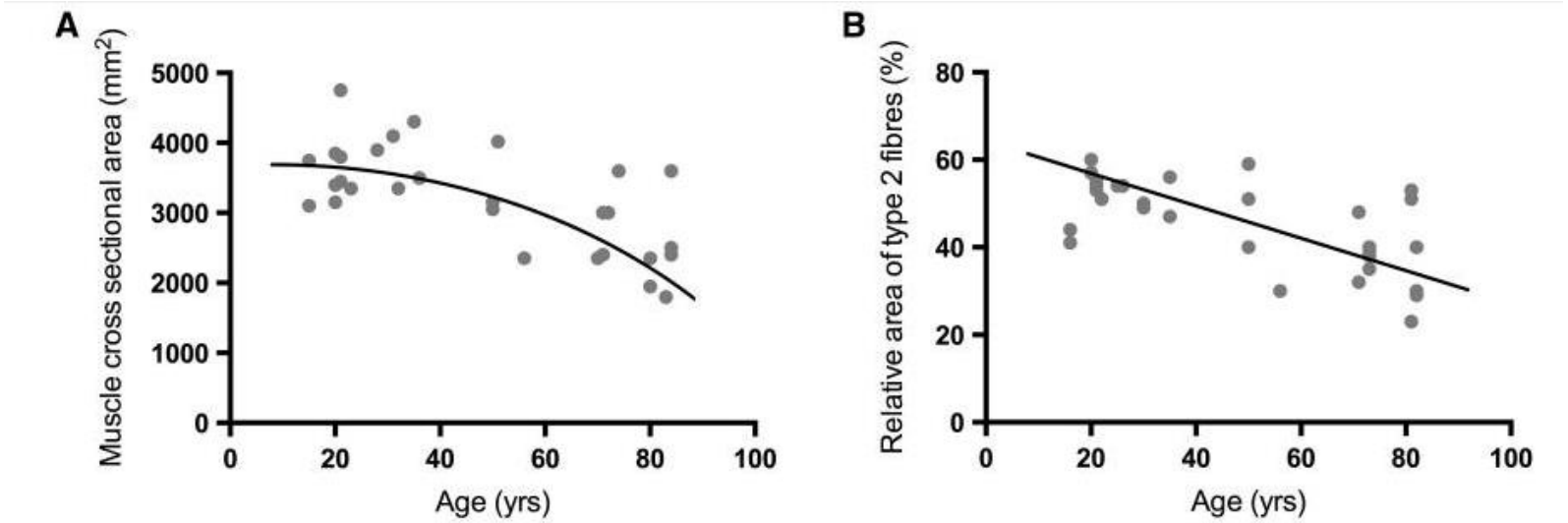
Globa… recon… longe… …e …lthy

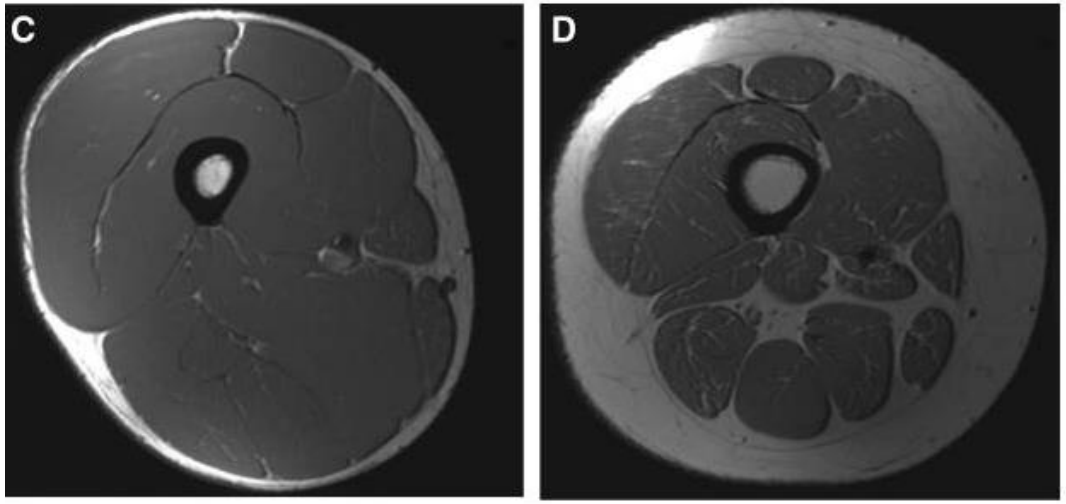
Mikel Izquie… …ischoff-Ferrari [f],

Sarcopenia


Gradual sarcopenia model
"Catabolic Crisis" model
Lean Muscle Mass (kg)
36
34
32
30
28
26
24
22
20
18
16
40
50
60
70
80
90
Age (y)
Acute illness or injury leading to extended bed rest OR diet
Incomplete recovery
Varie Soglie:
Es.: indindipendenza, ecc
J. Arends et al. / Clinical Nutrition 36 (2017) 1187–1196

Good news:





Male – 24 yrs
Body mass – 76kg
Fat mass – 10kg
Fat free mass – 57kg

Male – 66 yrs
Body mass – 81kg
Fat mass – 57kg
Fat free mass – 13kg
Average daily steps = 3141
PA >3MET per/day = 22mins

. 2016 Jan 20;17:497–510. doi: 10.1007/s10522-015-9631-7

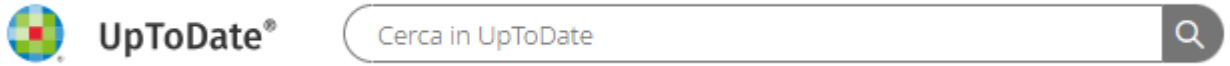
2 Take home messages

- Lottare contro la sarcopenia
- Alimentazione: energetica e proteica
- Stimolo fisico : esercizi con i pesi

SYLVESTER STALLONE PRONTO A TORNARE PER I MERCENARI 5? IL PRODUTTORE STUZZICA I FAN

I mercenari 4 | Articoli | Notizie | Immagini

Capitolo: sovrappeso/obesità



- What's new in …

  - New classifications for patients with obesity (February 2025)

New classifications for patients with obesity (February 2025)

- Body mass index (BMI) -> inadequate tool to fully capture an individual's obesity-related health status.
- Obesity-related health consequences
- new diagnostic categories for "preclinical" and "clinical" obesity.
- clinical obesity have objectively altered organ function or symptoms related to obesity,
- preclinical obesity have no identifiable health effects from extra weight.

The NEW ENGLAND JOURNAL of MEDICINE

April 21, 2022

RESEARCH SUMMARY

Calorie Restriction with or without Time-Restricted Eating in Weight Loss

Liu D et al. DOI: 10.1056/NEJMoa2114833

CLINICAL PROBLEM

Daily calorie restriction is a primary weight-loss strategy for patients with obesity, but most diet trials have shown only modest weight loss after a year, and maintaining weight loss is challenging. Time-restricted eating — a form of intermittent fasting involving a shortened daily eating period — has shown promise in pilot studies, but data on long-term efficacy and safety are lacking.

CLINICAL TRIAL

Design: A randomized trial examined the effects of time-restricted eating plus daily calorie restriction as compared with daily calorie restriction alone in obese patients.

Intervention: 139 patients in Guangzhou, China, with a body-mass index of 28 to 45 were randomly assigned to time-restricted eating (eating only between 8:00 a.m. and 4:00 p.m.) plus daily calorie restriction or to daily calorie restriction alone. All the patients were instructed to follow a diet of 1500 to 1800 kcal per day (for men) or 1200 to 1500 kcal per day (for women) for 12 months. The primary outcome was the difference between the two groups in the change from baseline in body weight at 12 months.

RESULTS

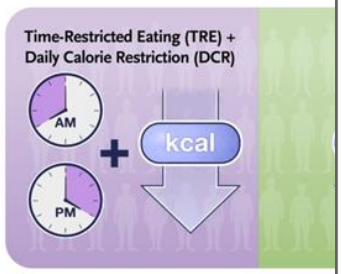
Efficacy: Among 118 patients who completed the 12-month follow-up visit, there was no significant difference in mean weight loss between the group assigned to time-restricted eating plus daily calorie restriction and the group assigned to daily calorie restriction alone.

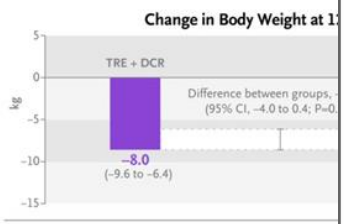
Safety: There were no substantial differences between the two groups in the number of adverse events. No deaths or serious adverse events were reported.

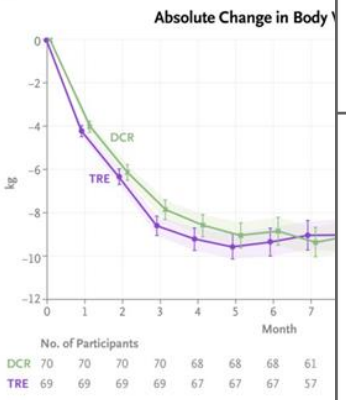
LIMITATIONS AND REMAINING QUESTIONS

- The findings cannot be generalized to other ethnic groups, to patients with diabetes or cardiovascular disease, or to different time-restricted–eating regimens.
- Total energy expenditure, which might have helped to explain individual differences in weight loss, was not measured.

Links: Full Article | NEJM Quick Take | Editorial



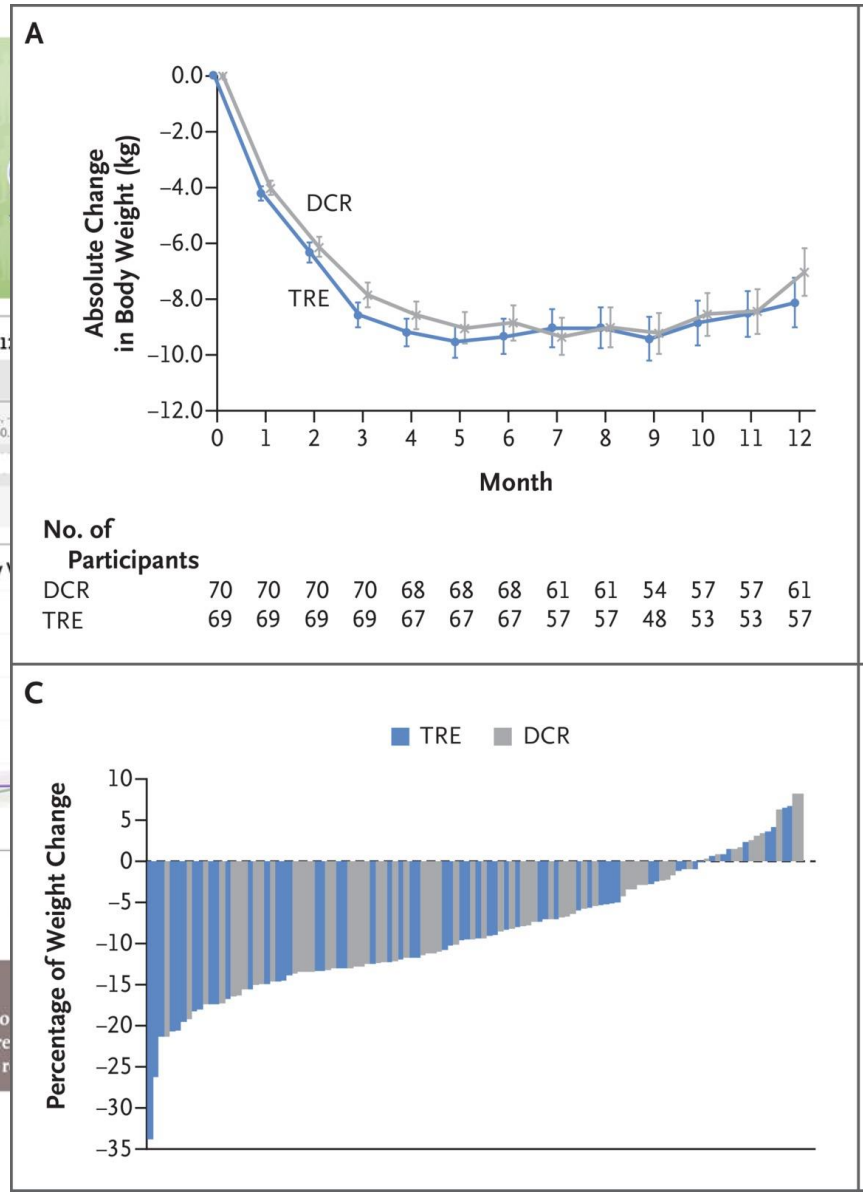




CONCLUSIONS

Among patients with obesity, daily calo
regimen of time-restricted eating offere
benefit as compared with daily calorie r

ell'obesità



Farmaci incretino-mimetici: news/futuro

- Funzionano?

WHY WAS THE TRIAL DONE?

For patients with obesity, semaglutide, a glucagon-like
tide-1 receptor agonist, is approved for weight manage
as a once-weekly subcutaneous injection. In a recent tri
oral semaglutide at a dose of 50 mg once daily resulted
significantly greater weight loss than placebo. However
efficacy and safety of lower doses of oral semaglutide a
unclear.

HOW WAS THE TRIAL CONDUCTED?

Adults with a body-mass index of 30 or greater — or 2
greater with at least one obesity-related complication —
without diabetes were assigned to receive oral semaglut
at a dose of 25 mg once daily or placebo, plus lifestyle
vention. The primary end points were the percent chang
body weight and a reduction in body weight of 5% or g
from baseline to week 64.

TRIAL DESIGN

- Phase 3
- Randomized
- Double-blind
- Placebo-controlled
- Location: 22 sites in Ca
  Germany, Poland, and
  United States

RESULTS

The estimated mean reduction in body weight was sign
cantly greater with oral semaglutide than with placebo.
ticipants in the semaglutide group were also significan
more likely to have a body-weight reduction of 5% or g
er. The most frequently reported adverse events were ga
intestinal disorders, which were more common with se
glutide than with placebo.

LIMITATIONS AND REMAINING QUESTIONS

- Approximately 20% of the trial population did not co
  plete the trial, so imputation for efficacy models was
  quired.
- Most participants were women, which may limit the
  eralizability of the findings.
- Because of the lack of an active semaglutide comparator —
  subcutaneous semaglutide or a higher dose of oral sema-
  glutide — it was not possible to compare adverse events
  for a given dose or administration method.

CONCLUSIONS

Among participants with overweight or obesity, oral semaglutide at a dose of 25 mg once daily resulted in significantly greater weight loss than placebo at 64 weeks.

NEJM QUICK TAKE

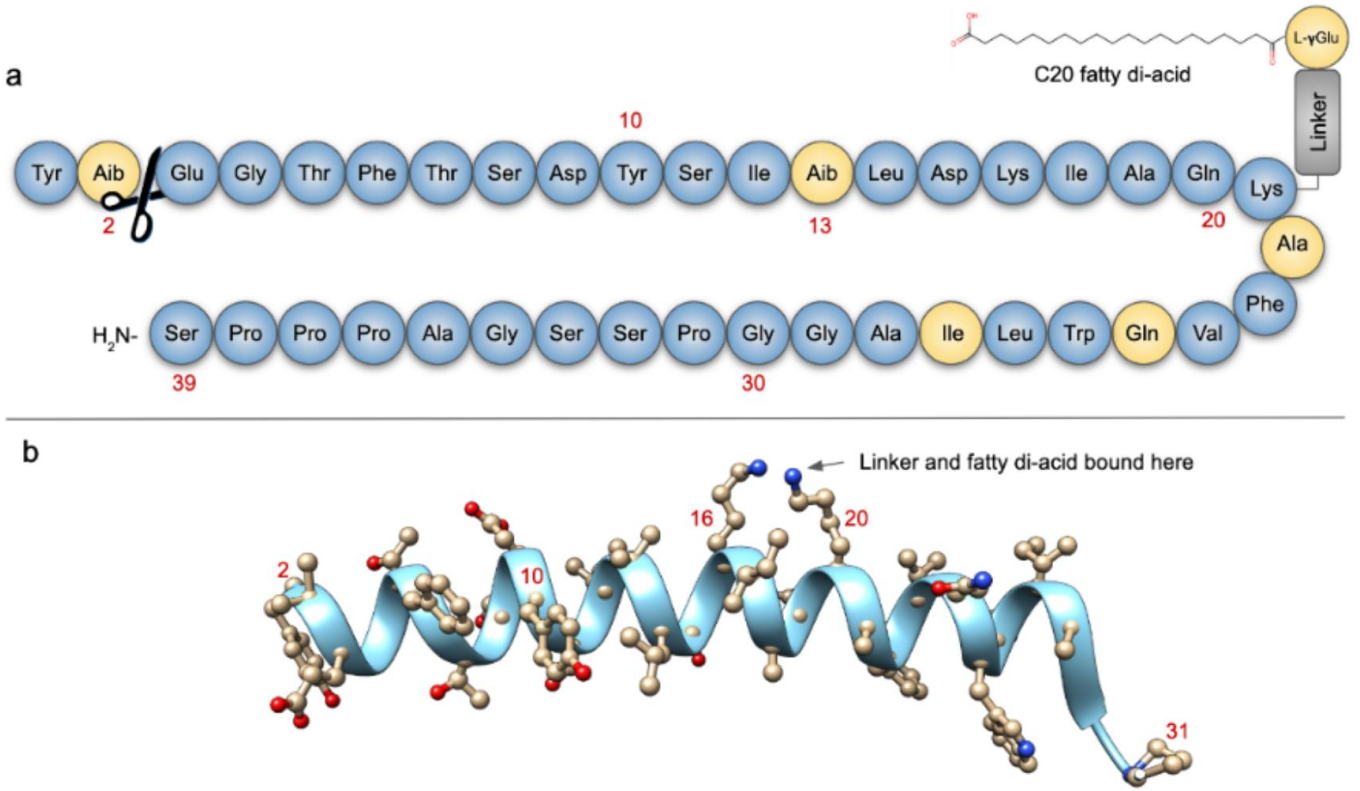
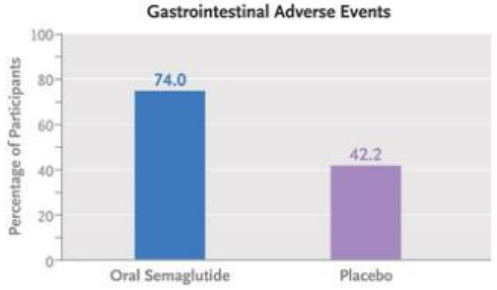


Figure 1. 2D and 3D structures of Tirzepatide. a. The sequence of Tirzepatide (PubChem) has 39 amino acids. The schematic is based on information presented in Knerr et al., 2020. Amino acid that are either modified or different from both GLP-1 or GIP are highlighted in yellow. The DPP4 cleave site is indicated with the scissors. b. 3D structure of Tirzepatide (PDB ID 7rgp, Sun et al., 2022). Note: The C20 fatty diacid was disordered in the 3D structure, so is not shown here. The receptor and G-protein chains are hidden here for clarity. Click here to view the full structures interactively.



A total of 205 participants were randomly assigned to receive oral semaglutide, and 102 to receive placebo. The estimated mean change in body weight from baseline to week 64 was –13.6% in the oral semaglutide group and –2.2% in the placebo group (estimated difference, –11.4 percentage points; 95% confidence interval, –13.9 to –9.0; P<0.001). Participants in the oral semaglutide group were significantly more likely than those in the placebo group to have body-weight reductions of 5% or more, 10% or more, 15% or more, and 20% or more (P<0.001 for all comparisons) and to have an improved IWQOL-Lite-CT Physical Function score (P<0.001). Gastrointestinal adverse events were more common with oral semaglutide than with placebo (74.0% vs. 42.2%).

CONCLUSIONS

Oral semaglutide at a dose of 25 mg once daily resulted in a greater mean reduction in body weight than placebo in participants with overweight or obesity. (Funded by Novo Nordisk; OASIS 4 ClinicalTrials.gov number, NCT05564117.)

filiations are listed at the end of
. Sean Wharton can be contact-
an@whartonmedicalclinic.com
rton Weight Management Clin-
Walker's Line, Burlington, ON,
7M 4Y1.

he OASIS 4 Study Group is pro-
the Supplementary Appendix,
at NEJM.org.

ed 2025;393:1077-87.
56/NEJMoa2500969

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Tirzepatide as Compared with Semaglutide for the Treatment of Obesity

Louis J. Aronne, M.D.,[1] Deborah Bade Horn, D.O.,[2] Carel W. le Roux, M.D., Ph.D.,[3,4] Wayne Ho, M.D.,[5,6] Beverly L. Falcon, Ph.D.,[7] Elisa Gomez Valderas, M.Sc.,[7] Sagar Das, M.Sc.,[7] Clare J. Lee, M.D., M.H.S.,[7] Leonard C. Glass, M.D.,[7] Cagri Senyucel, M.D., Ph.D.,[7] and Julia P. Dunn, M.D.,[7] for the SURMOUNT-5 Trial Investigators*

Author affiliations are listed at the end of the article. Dr. Aronne can be contacted at ljaronne@med.cornell.edu or at the Comprehensive Weight Control Center, Division of Endocrinology, Diabetes, and Metabolism, Weill Cornell Medicine, 1305 York Ave., New York, NY 10021.

*A list of the SURMOUNT-5 trial investigators is provided in the Supplementary Appendix, available at NEJM.org.

This article was published on May 11, 2025, at NEJM.org.

N Engl J Med 2025;393:26-36.
DOI: 10.1056/NEJMoa2416394

CME

ABSTRACT

BACKGROUND

Tirzepatide and sem
ment. The efficacy a
with obesity but wit

METHODS

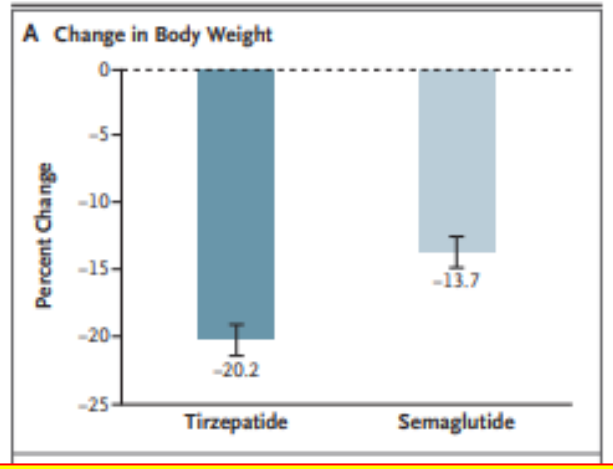
In this phase 3b, op
without type 2 dia
maximum tolerated
ated dose of semagl
weeks. The primary
to week 72. Key se
10%, 15%, 20%, ar
to week 72.

RESULTS

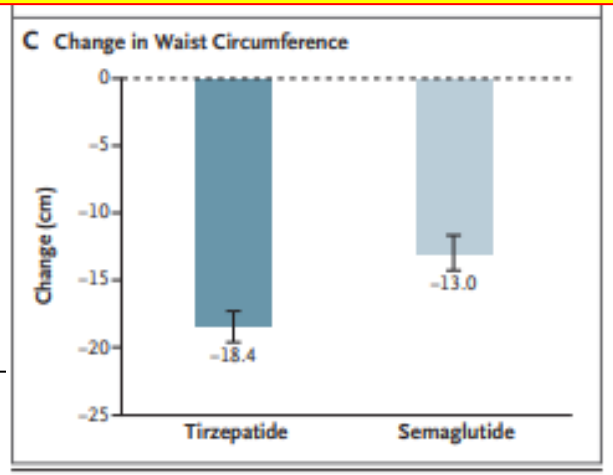
A total of 751 part
percent change in w
−21.4 to −19.1) with
glutide (P<0.001). The
(95% CI, −19.6 to −17.2) with tirzepatide and −13.0 cm (95% CI, −14.3 to −11.7) with semaglutide (P<0.001). Participants in the tirzepatide group were more likely than those in the semaglutide group to have weight reductions of at least 10%, 15%, 20%, and 25%. The most common adverse events in both treatment groups were gastrointestinal, and most were mild to moderate in severity and occurred primarily during dose escalation.

CONCLUSIONS

Among participants with obesity but without diabetes, treatment with tirzepatide was superior to treatment with semaglutide with respect to reduction in body weight and waist circumference at week 72. (Funded by Eli Lilly; SURMOUNT-5 ClinicalTrials.gov number, NCT05822830.)



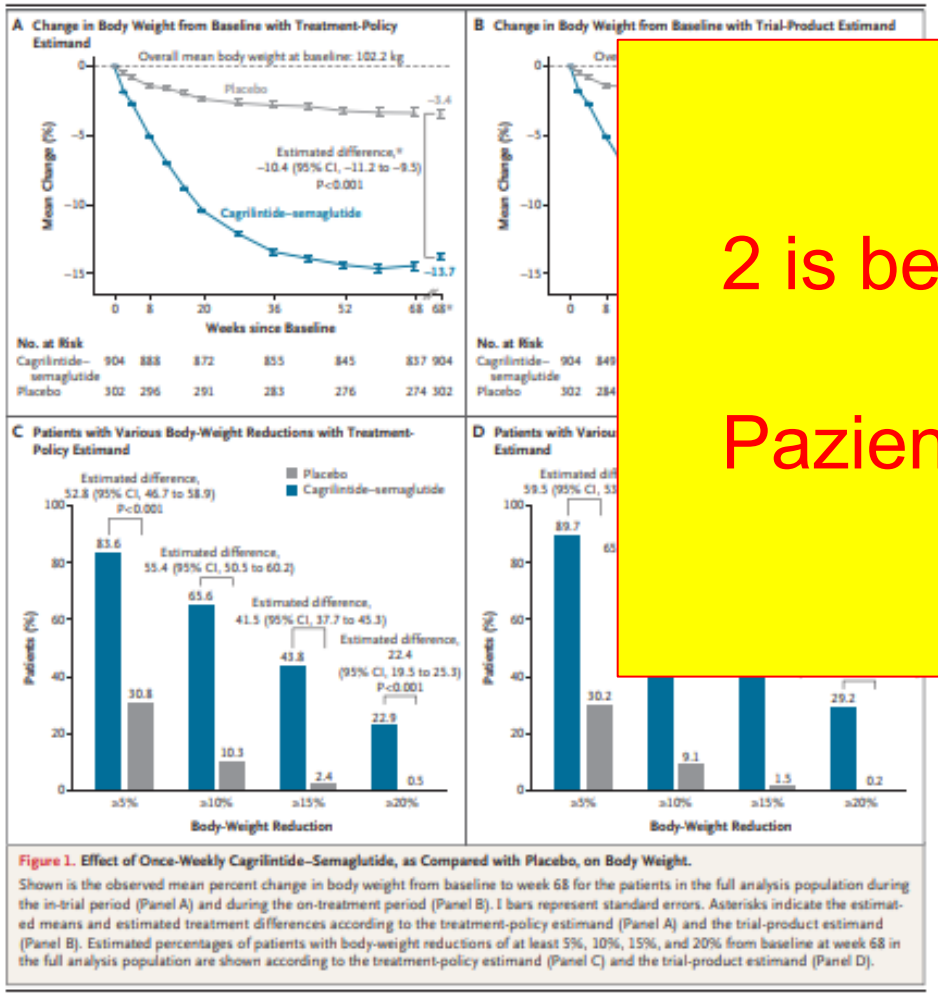
2 is better than 1



ORIGINAL ARTICLE

Cagrilintide–Semaglutide in Adults with Overweight or Obesity and Type 2 Diabetes

long-acting analogue of the hormone amylin



↓ Body

Figure 1. Effect of Once-Weekly Cagrilintide–Semaglutide, as Compared with Placebo, on Body Weight.

Shown is the observed mean percent change in body weight from baseline to week 68 for the patients in the full analysis population during the in-trial period (Panel A) and during the on-treatment period (Panel B). I bars represent standard errors. Asterisks indicate the estimated means and estimated treatment differences according to the treatment-policy estimand (Panel A) and the trial-product estimand (Panel B). Estimated percentages of patients with body-weight reductions of at least 5%, 10%, 15%, and 20% from baseline at week 68 in the full analysis population are shown according to the treatment-policy estimand (Panel C) and the trial-product estimand (Panel D).

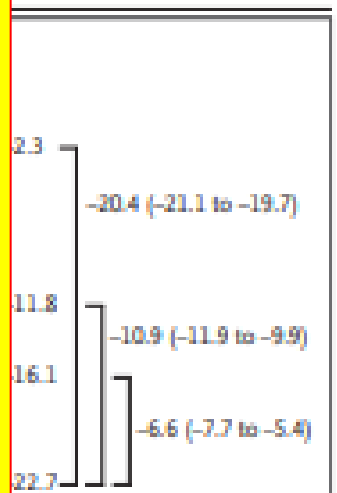
The NEW ENGLAND JOURNAL of MEDICINE
ESTABLISHED IN 1812 AUGUST 14, 2025 VOL. 393 NO. 7

Coadministered Cagrilintide and Semaglutide in Adults with Overweight or Obesity

W.T. Garvey,[1] M. Blüher,[2,3] C.K. Osorto Contreras,[4] M.J. Davies,[5,6] E. Winning Lehmann,[4] K.H. Pietiläinen,[7,8] D. Rubino,[9] P. Sbraccia,[10] T. Wadden,[11] N. Zeuthen,[4] and I.P.H. Wilding[12] for the REDEFINE 1 Study Group*

2 is better than 1

Paziente diabetico perde meno peso



No. at Risk							
Placebo	705	672	619	551	487	452	705
Cagrilintide	302	290	275	262	250	223	302
Semaglutide	302	290	269	253	238	220	302
Cagrilintide–semaglutide	2108	2016	1837	1691	1586	1455	2108

...ed by Novo Nordisk; REDEFINE 1 ClinicalTrials.gov number, NCT05567796.)

Se 2 meglio di 1..

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Triple–Hormone-Receptor Agonist Retatrutide for Obesity — A Phase 2 Trial

Ania M. Jastreboff, M.D., Ph.D., Lee M. Kaplan, M.D., Ph.D., Juan P. Frías, M.D., Qiwei Wu, Ph.D., Yu Du, Ph.D., Sirel Gurbuz, M.D., Tamer Coskun, M.D., Ph.D., Axel Haupt, M.D., Ph.D., Zvonko Milicevic, M.D., and Mark L. Hartman, M.D., for the Retatrutide Phase 2 Obesity Trial Investigators*

From the Departments of Medicine (Endocrinology and Metabolism) and Pediatrics (Pediatric Endocrinology), Yale University School of Medicine, New Haven, CT (A.M.J.); the Obesity and Metabolism Institute and Department of Medicine, Harvard Medical School, Boston (L.M.K.);

ABSTRACT

BACKGROUND

Retatrutide (LY3437943) is an agonist of the glucose-dependent insulinotropic polypeptide, glucagon-like peptide 1, and glucagon receptors. Its dose–response relationships with respect to side effects, safety, and efficacy for the treatment of obesity are not known.

METHODS

We enrolled 338 adults, 51.8% of whom were men. The least-squares mean percentage change in body weight at 24 weeks in the retatrutide groups was –7.2% in the 1-mg group, –12.9% in the combined 4-mg group, –17.3% in the combined 8-mg group, and –17.5% in the 12-mg group, as compared with –1.6% in the pla-

N Engl J Med 2023;389:514-26.
DOI: 10.1056/NEJMoa2301972

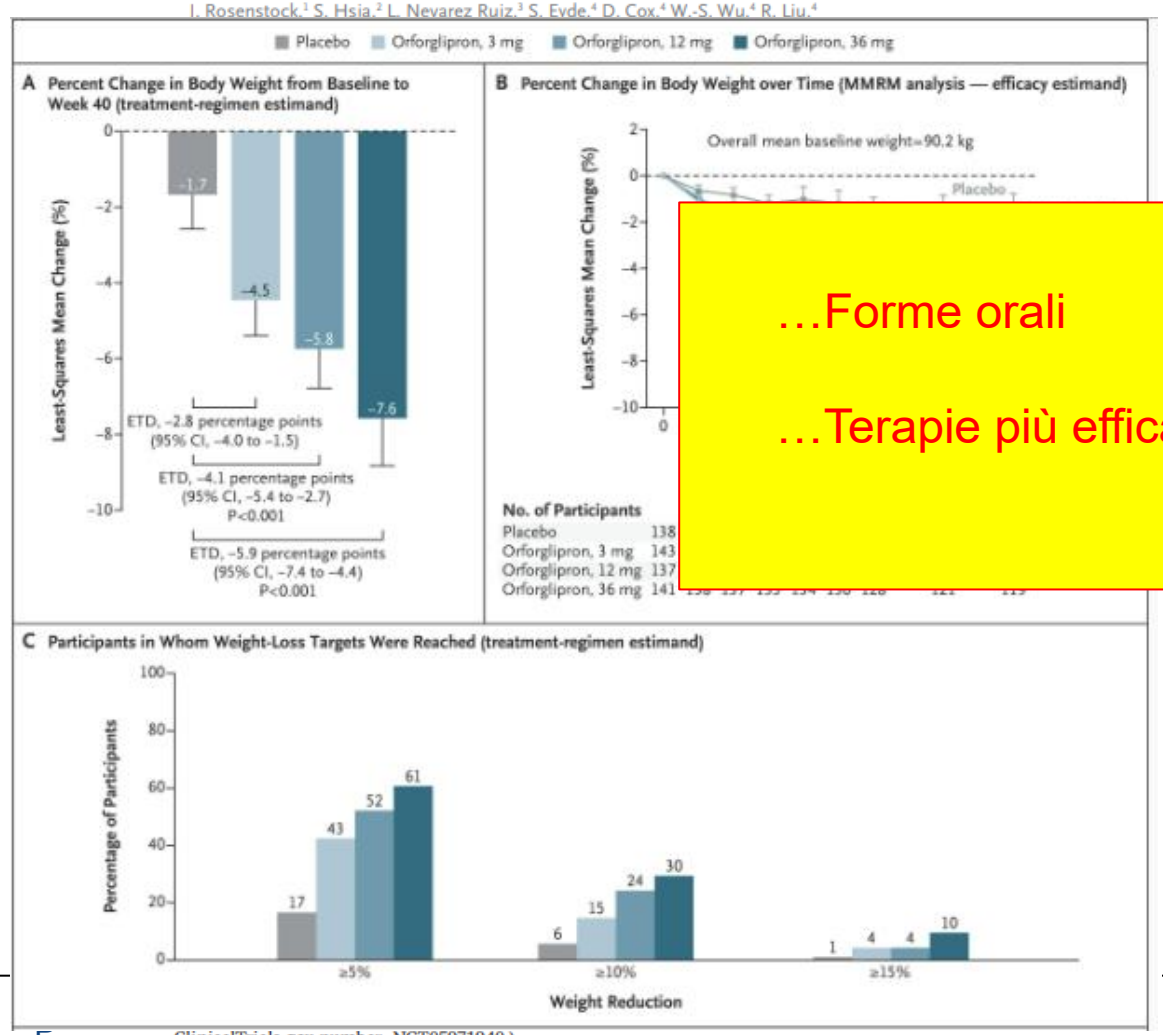
Futuro: probabilmente andremo a combinare più molecole/peptidi

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Orforglipron, an Oral Small-Molecule GLP-1 Receptor Agonist, in Early Type 2 Diabetes

I. Rosenstock,[1] S. Hsia,[2] L. Nevarez Ruiz,[3] S. Eyde,[4] D. Cox,[4] W.-S. Wu,[4] R. Liu,[4]

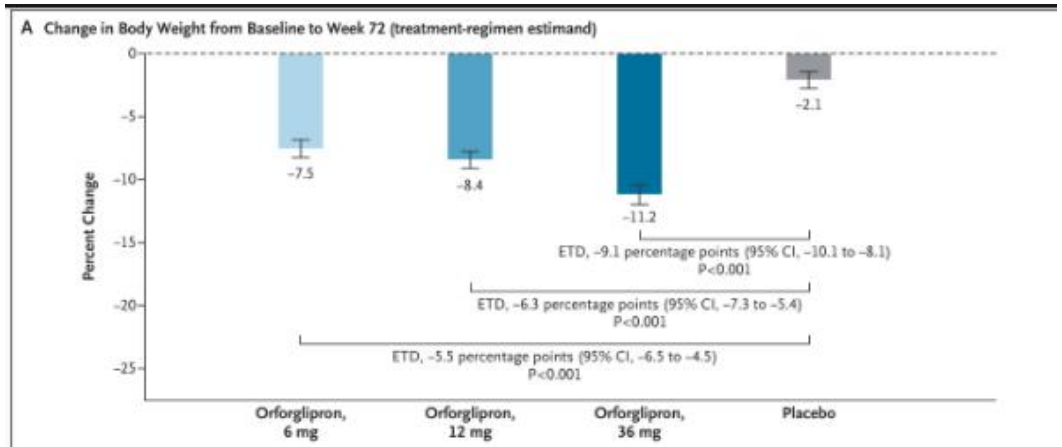


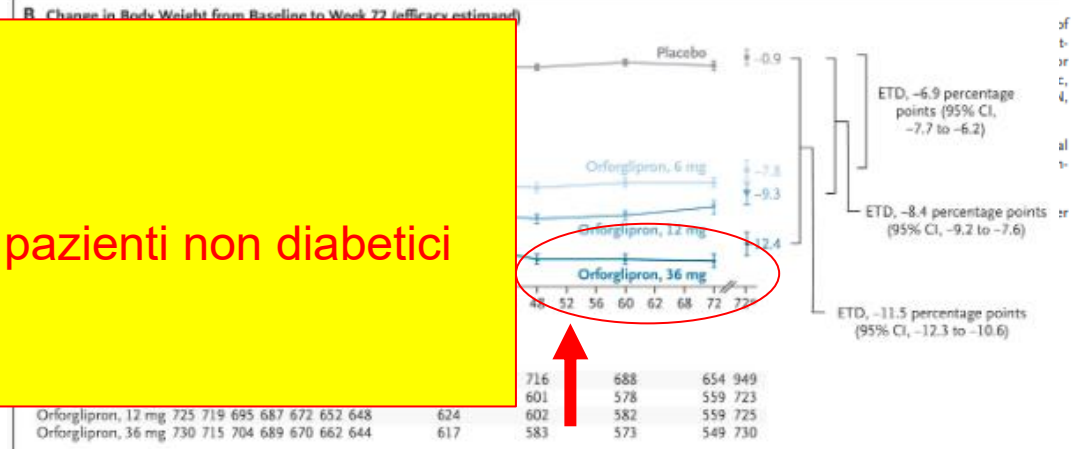
ClinicalTrials.gov number, NCT05971940.)

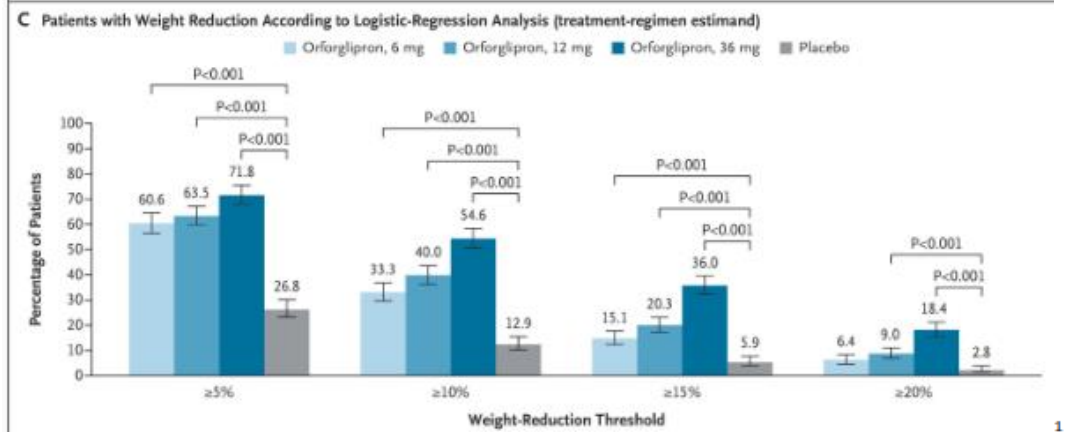
…Forme orali

…Terapie più efficaci in pazienti non diabetici

The NEW ENGLAND JOURNAL of MEDICINE







Futuro

The NEW ENGLAND JOURNAL of MEDICINE

ESTABLISHED IN 1812 SEPTEMBER 4, 2025 VOL. 393 NO. 9

Once-Monthly Maridebart Cafraglutide for the Treatment of Obesity — A Phase 2 Trial

A.M. Jastreboff,[1-3] D.H. Ryan,[4] H.E. Bays,[5] P.R. Ebeling,[6] M.G. Mackowski,[7] N. Philipose,[7] L. Ross,[7] Y. Liu,[7] C.E Burns,[7] S.A. Abbasi,[7] and N. Pannacciulli,[7] for the MariTide Phase 2 Obesity Trial Investigators*

ABSTRACT

BACKGROUND

Maridebart cafraglutide (known as MariTide) is a long-acting peptide–antibody conjugate that combines glucagon-like peptide-1 receptor agonism and glucose-dependent insulinotropic polypeptide receptor antagonism and that is intended for the treatment of obesity.

METHODS

We conducted a phase 2, double-blind, randomized, placebo-controlled, dose-ranging trial that included 11 groups as two cohorts. Participants with obesity (obesity cohort) were randomly assigned in a 3:3:3:2:2:2:3 ratio to receive maridebart cafraglutide subcutaneously at a dose of 140, 280, or 420 mg every 4 weeks without dose escalation; 420 mg every 8 weeks without dose escalation; 420 mg every 4 weeks with 4-week dose escalation; 420 mg every 4 weeks with 12-week dose escalation; or placebo. Participants with obesity with type 2 diabetes (obesity–diabetes cohort) were randomly assigned in a 1:1:1:1 ratio to receive maridebart cafraglutide at a dose of 140, 280, or 420 mg every 4 weeks (all without dose escalation) or placebo. The primary end point was the percent change in body weight from baseline to week 52.

RESULTS

The authors' full names, academic degrees, and affiliations are listed at the end of the article. Dr. Jastreboff can be contacted at ania.jastreboff@yale.edu or at Section of Endocrinology and Metabolism, Department of Medicine, Yale University School of Medicine, 333 Cedar St., P.O. Box 208020, New Haven, CT 06520.

*A complete list of the principal investigators is provided in the Supplementary Appendix, available at NEJM.org.

This article was published on June 23, 2025, at NEJM.org.

N Engl J Med 2025;393:843-57.
DOI: 10.1056/NEJMoa2504214

GLP-1 efficacia secondo modo d'uso

52° settimana

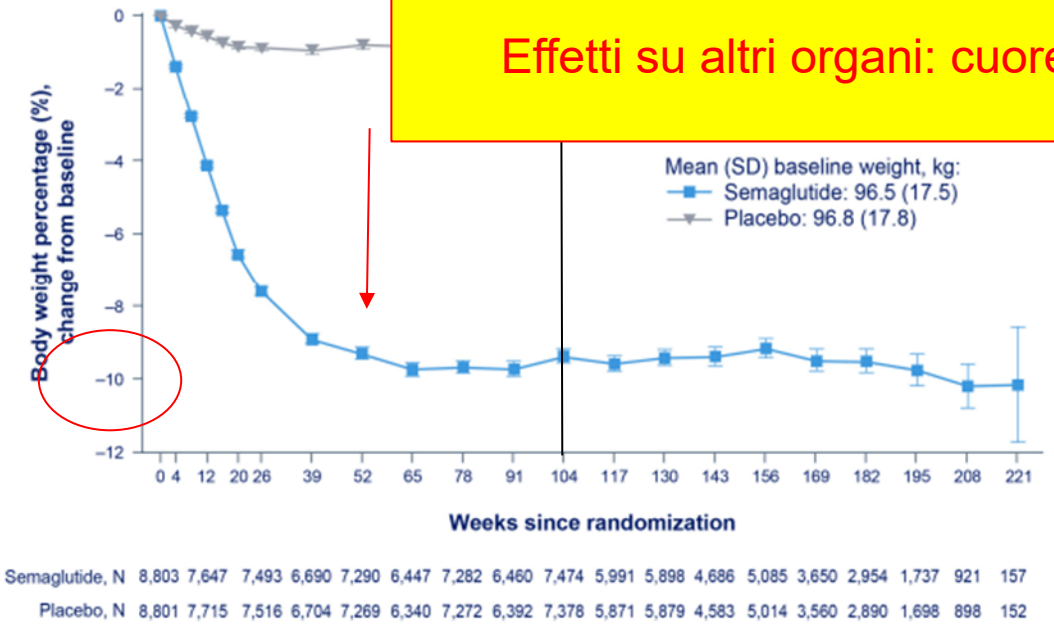
Sull'endpoint peso l'associazione con il regime è fondamentale

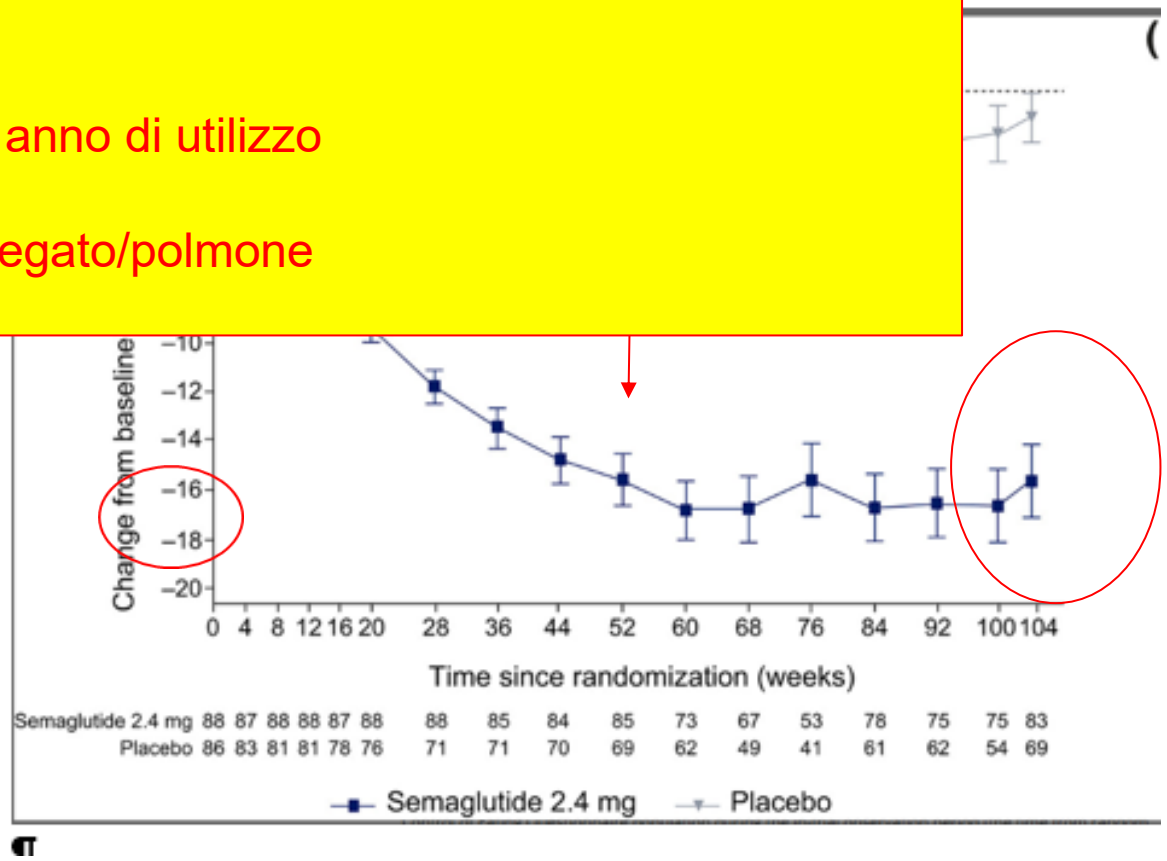
Massima efficacia nel primo anno di utilizzo

Effetti su altri organi: cuore/fegato/polmone

Figure S6. Effect of Semaglutide
Waist Circumference.

A)





› N Engl J Med. 2023 Dec 14;389(24):2221-2232.

STEP 5. Obesity (Silver Spring). 2023 Mar;31(3):703-715.

Cosa succede con l'interruzione?

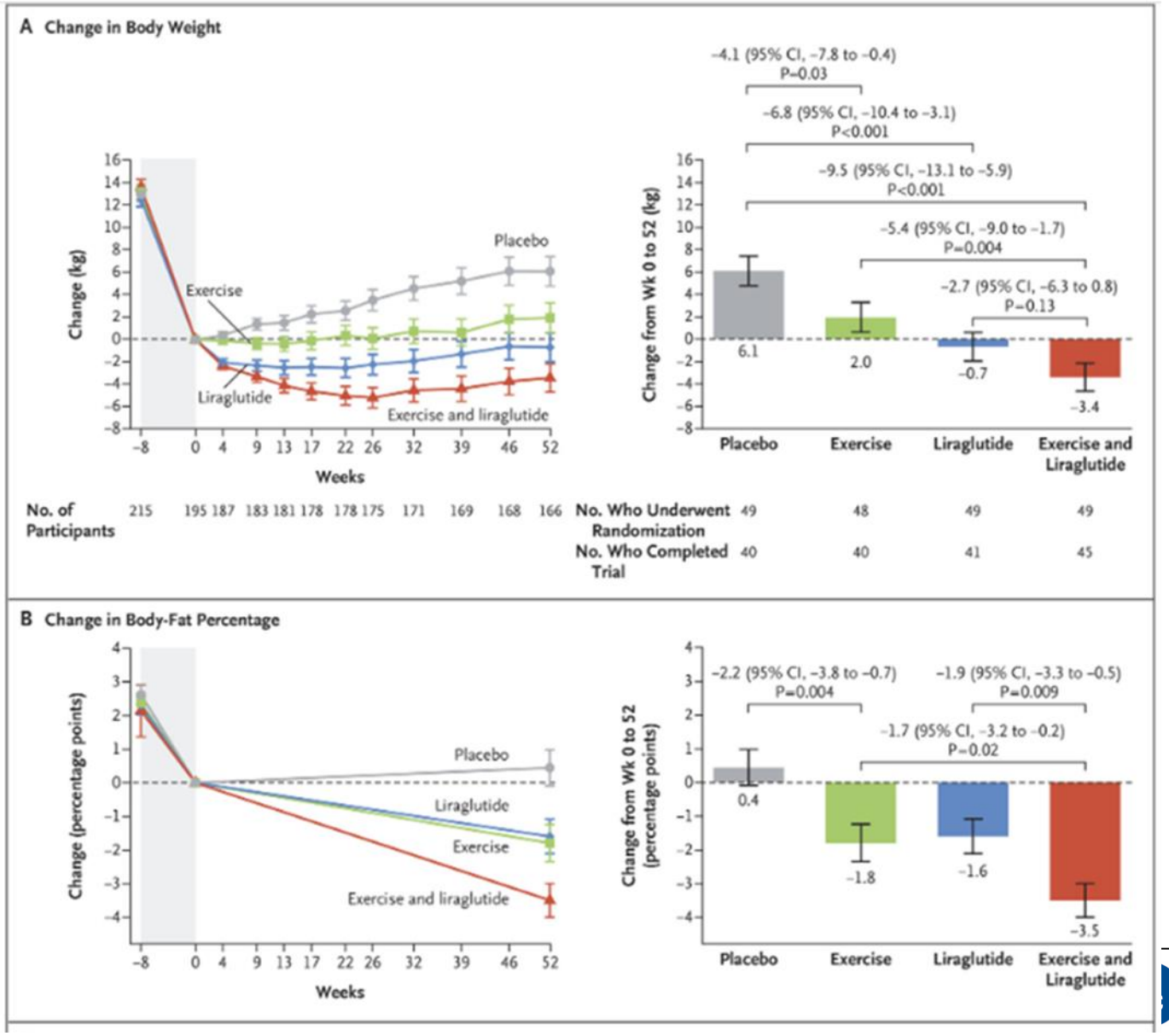
The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

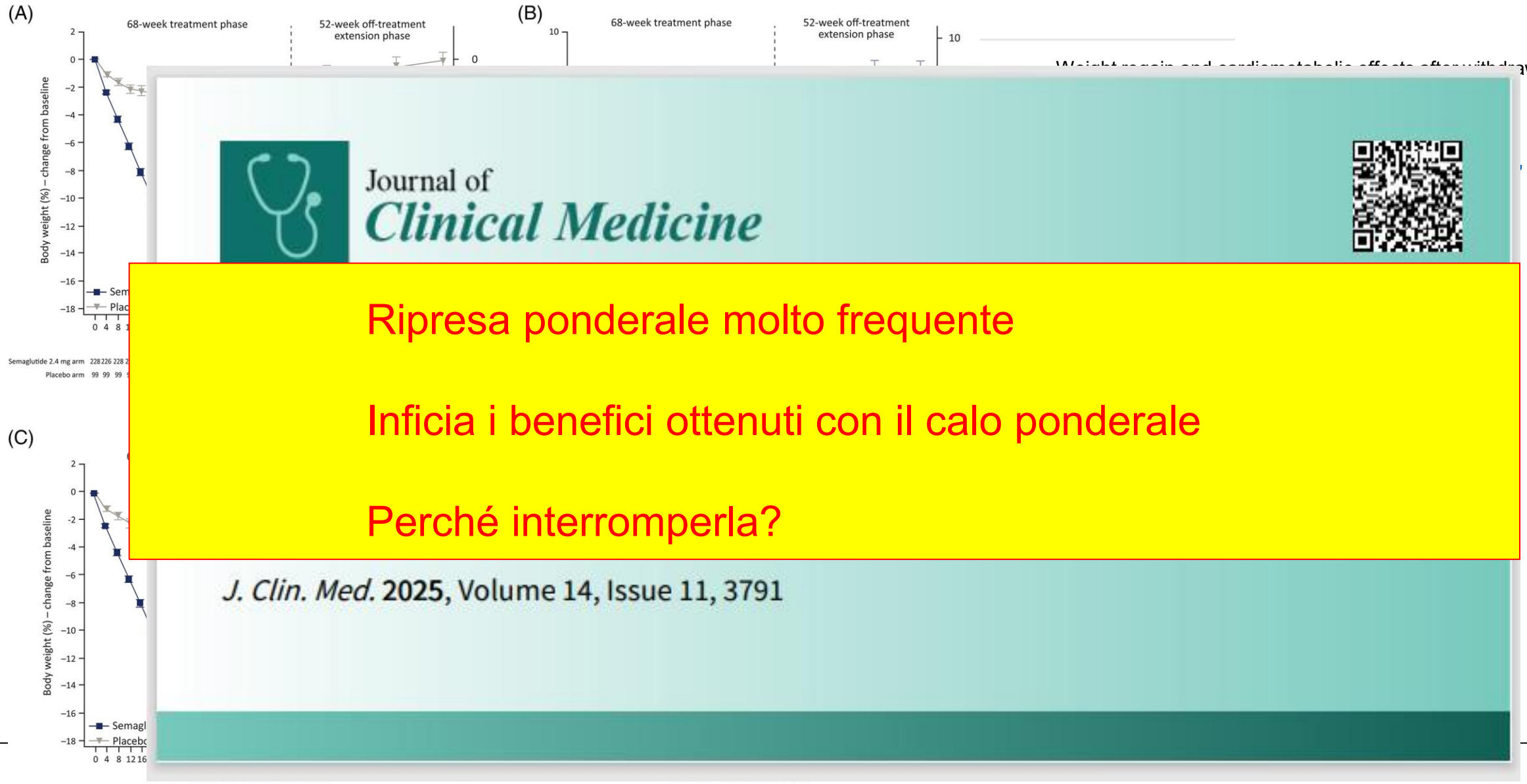
Healthy Weight Loss Maintenance with Exercise, Liraglutide, or Both Combined

Julie R. Lundgren, M.D., Ph.D., Charlotte Janus, Ph.D., Simon B.K. Jensen, M.Sc., Christian R. Juhl, M.D., Lisa M. Olsen, M.Sc., Rasmus M. Christensen, B.Sc.Med., Maria S. Svane, M.D., Ph.D., Thomas Bandholm, Ph.D., Kirstine N. Bojsen-Møller, M.D., Ph.D., Martin B. Blond, M.D., Ph.D., Jens-Erik B. Jensen, M.D., Ph.D., Bente M. Stallknecht, M.D., D.M.Sc., Jens J. Holst, M.D., D.M.Sc., Sten Madsbad, M.D., D.M.Sc., and Signe S. Torekov, Ph.D.

ABSTRACT



Cosa succede con l’interruzione?



Journal of *Clinical Medicine*

Ripresa ponderale molto frequente

Inficia i benefici ottenuti con il calo ponderale

Perché interromperla?

J. Clin. Med. **2025**, Volume 14, Issue 11, 3791

GLP-1 RA e agonisti duali: cosa ricordare nella pratica clinica

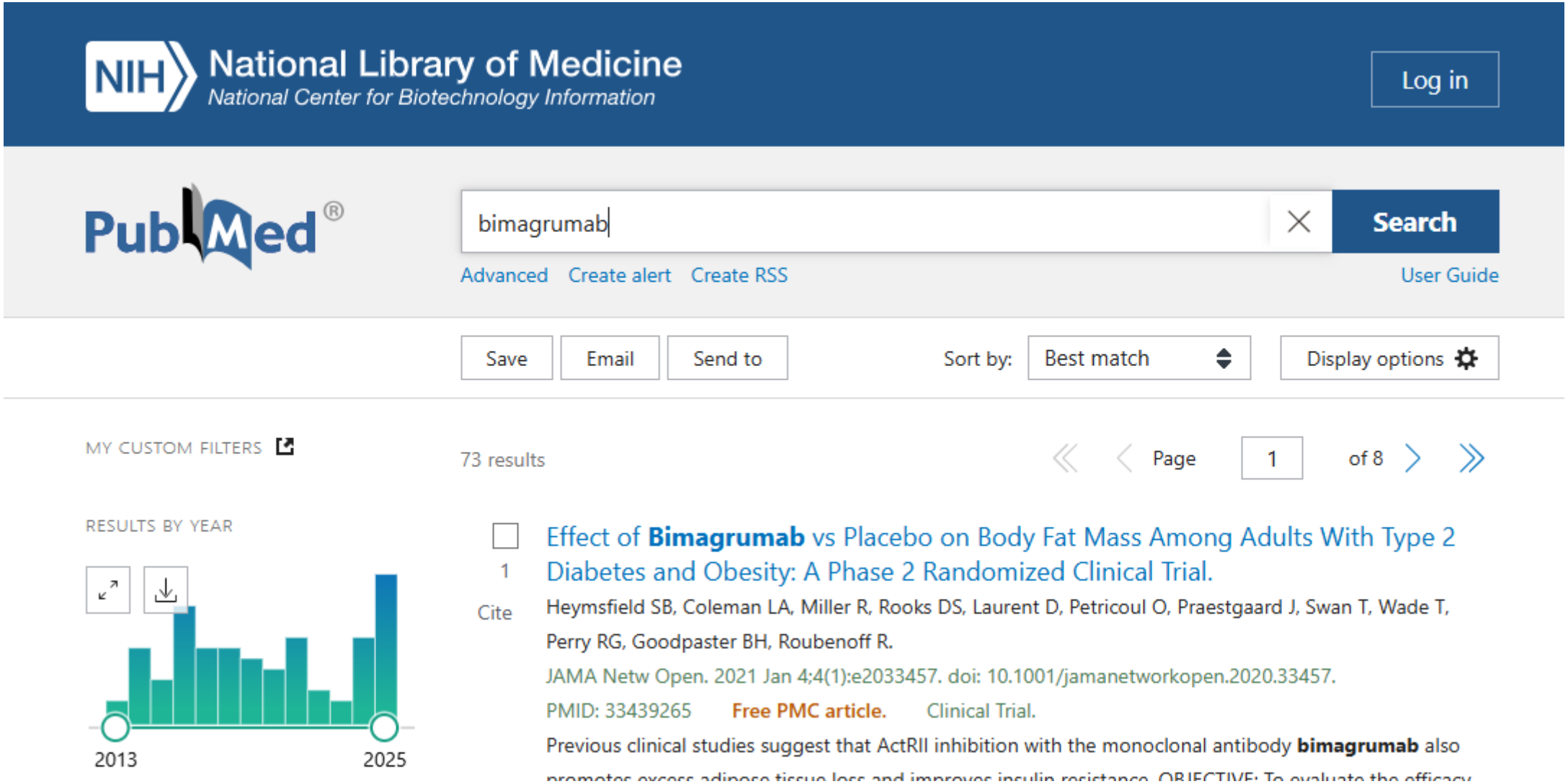
Finché si usano, funzionano

Effetto massimo nel primo anno

Risultati ottimali con presa a carico nutrizionale strutturata

Ripresa ponderale alla sospensione

Futuro?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Sort by:
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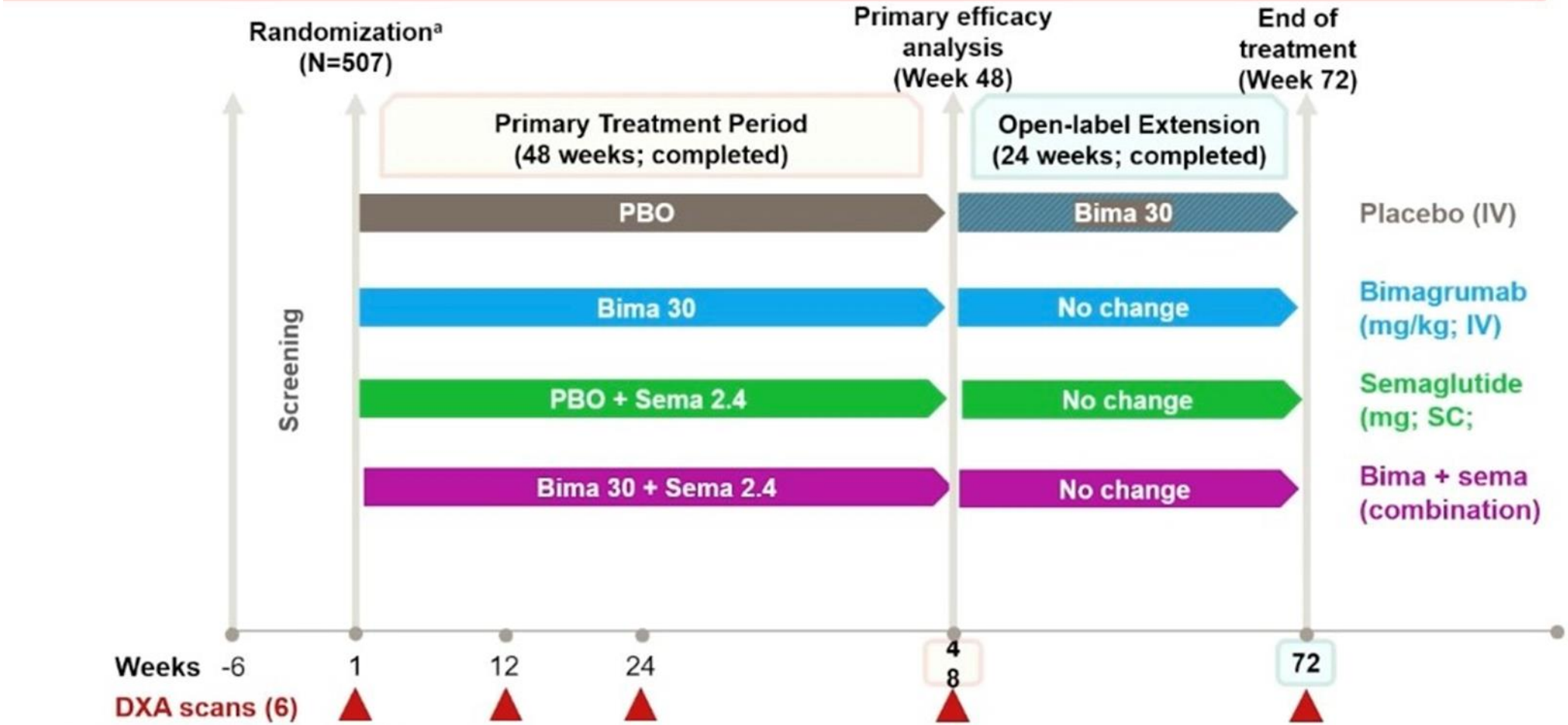
MY CUSTOM FILTERS
73 results
Page
1
of 8
RESULTS BY YEAR
2013
2025
1
Cite
Effect of Bimagrumab vs Placebo on Body Fat Mass Among Adults With Type 2 Diabetes and Obesity: A Phase 2 Randomized Clinical Trial.
Heymsfield SB, Coleman LA, Miller R, Rooks DS, Laurent D, Petricoul O, Praestgaard J, Swan T, Wade T, Perry RG, Goodpaster BH, Roubenoff R.
JAMA Netw Open. 2021 Jan 4;4(1):e2033457. doi: 10.1001/jamanetworkopen.2020.33457.
PMID: 33439265
Free PMC article.
Clinical Trial.
Previous clinical studies suggest that ActRII inhibition with the monoclonal antibody bimagrumab also

B,

BELIEVE Study Design: Bimagrumab, Semaglutide, and Combination

Phase 2, multicenter, randomized, double-blind, placebo-controlled trial

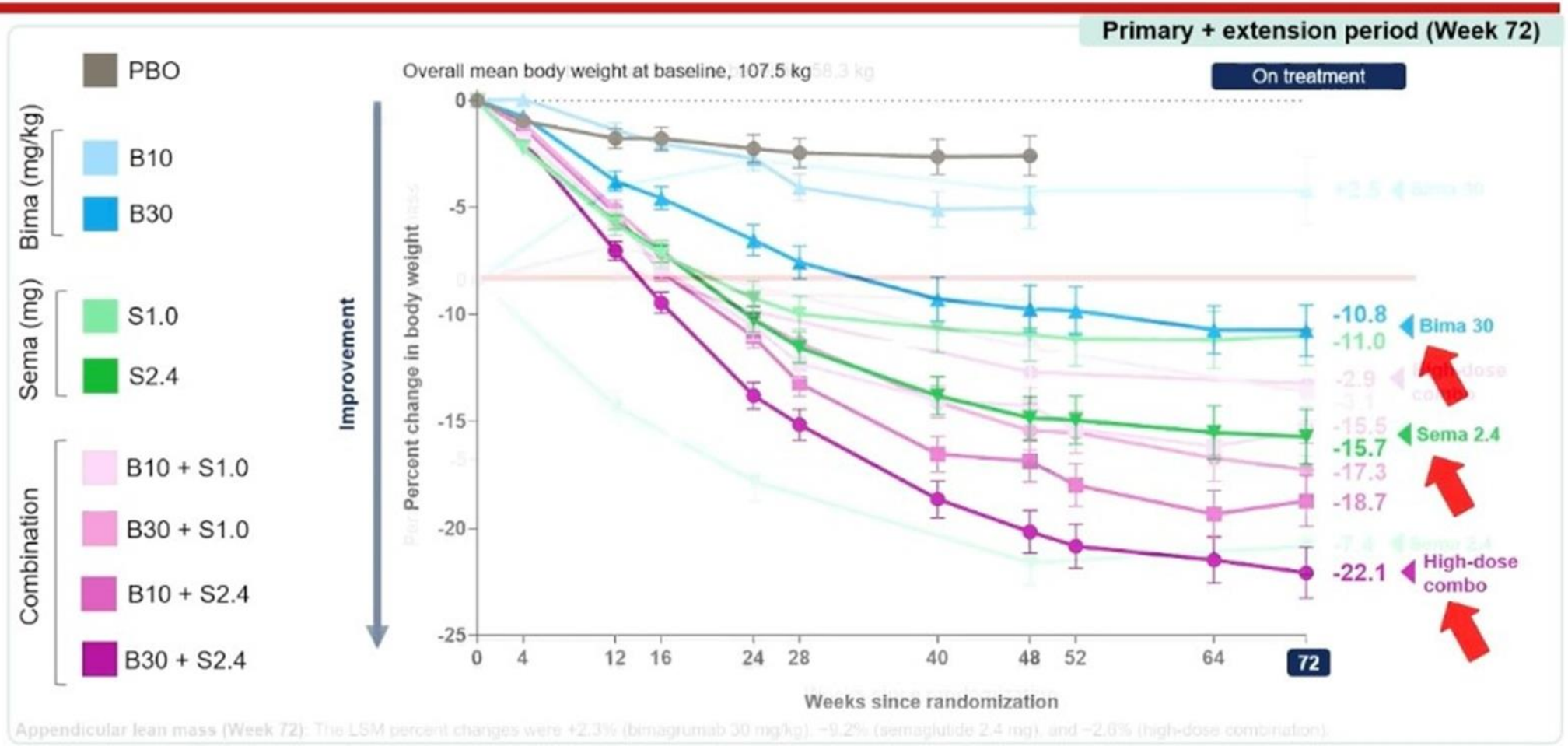


[a]Randomization was stratified by sex across the treatment groups.

Abbreviations: Bima, bimagrumab; DXA, dual-energy X-ray absorptiometry; IV, intravenous; N, number of randomized participants; SC subcutaneous; sema, semaglutide.

Body Weight: % Change from Baseline (Week 72)

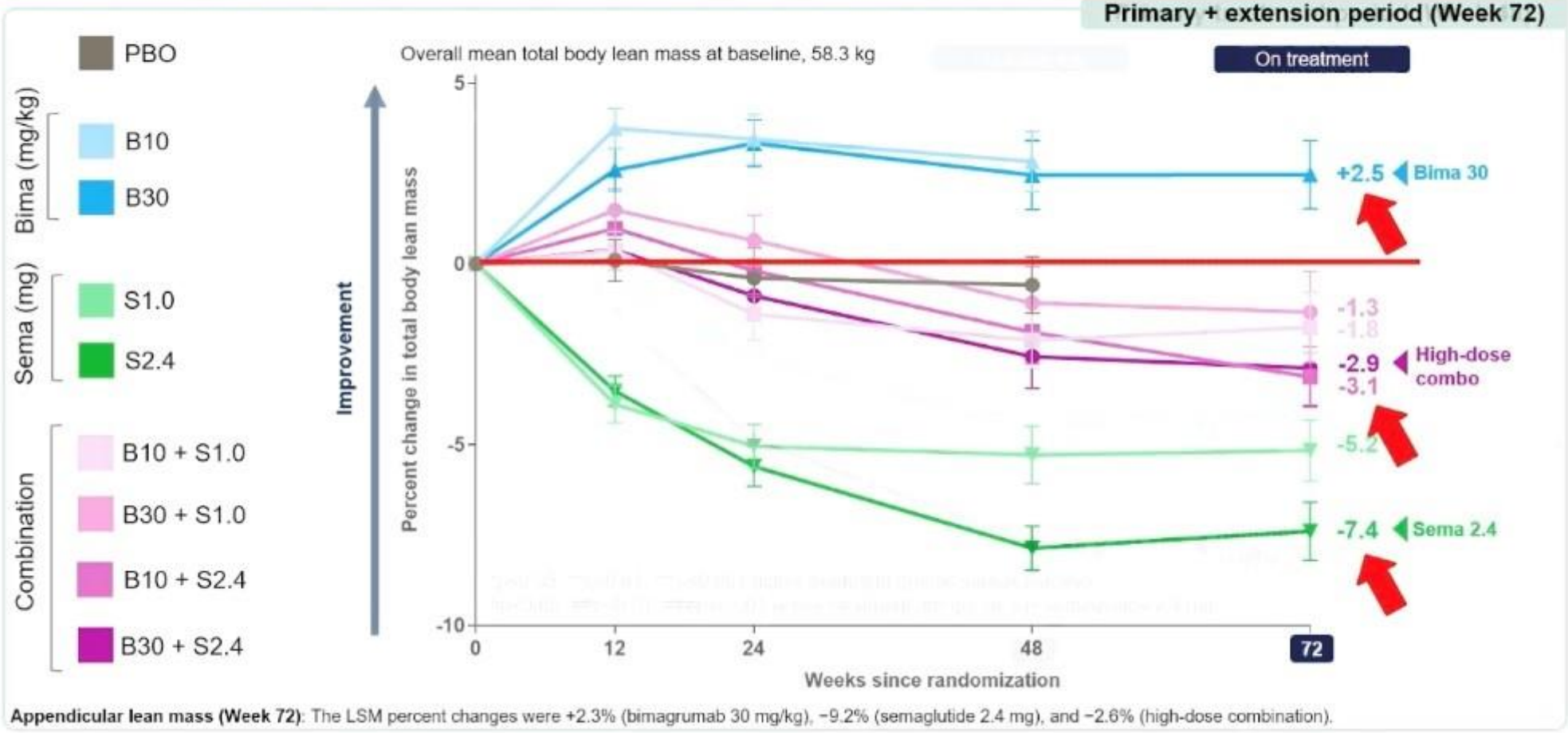
Combination therapy led to similar or greater weight reduction than semaglutide 2.4 mg



Data are presented as LSM ± SE. Percent changes are based on mixed model for repeated measures for the efficacy estimand.
Abbreviations: Bima, bimagrumab; combo, combination; LSM, least-squares mean; PBO, placebo; SE, standard error; sema, semaglutide.

Total Lean Mass: % Change from Baseline (DXA, Week 72)

Lean mass largely preserved with combination therapy

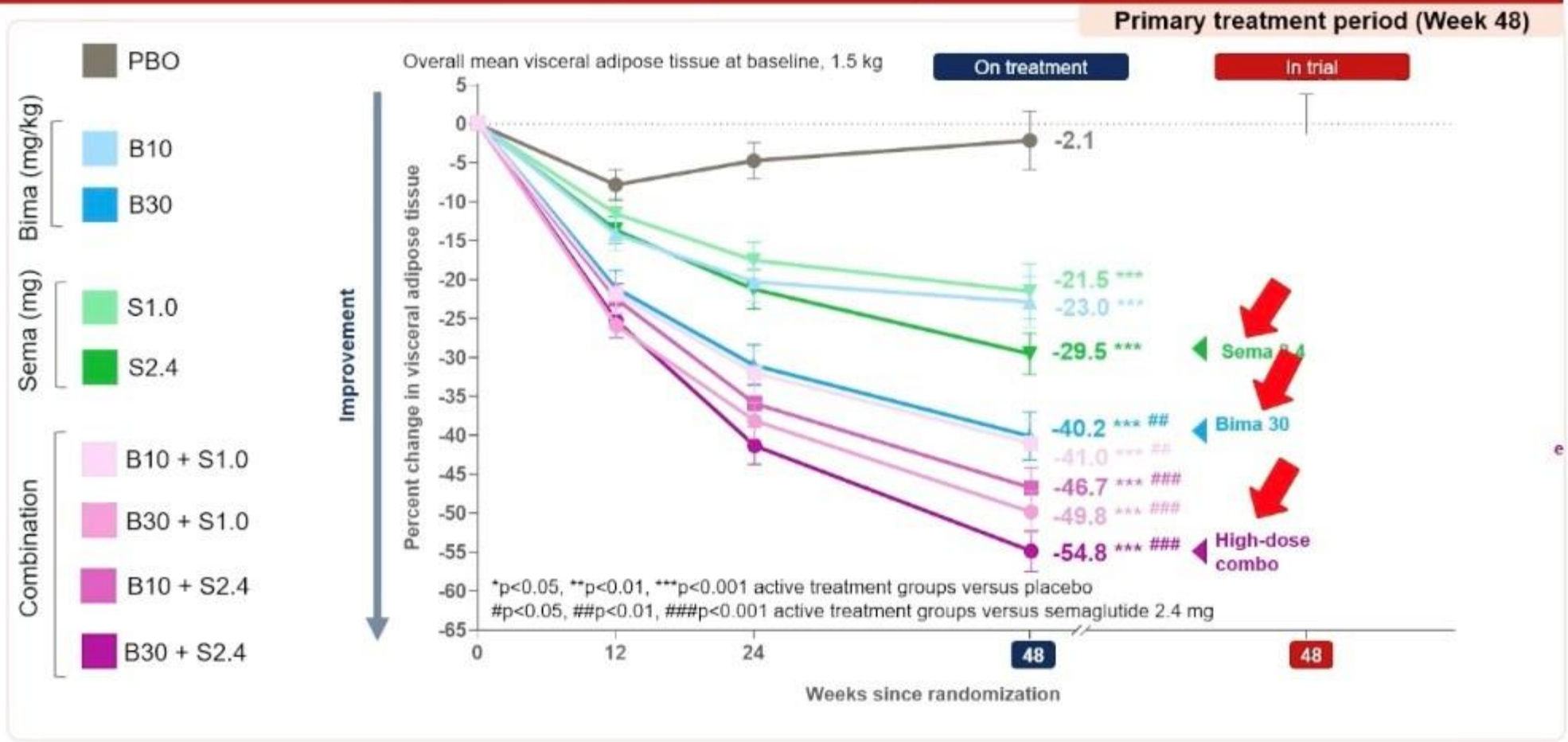


Appendicular lean mass (Week 72): The LSM percent changes were +2.3% (bimagrumab 30 mg/kg), −9.2% (semaglutide 2.4 mg), and −2.6% (high-dose combination).

Data are presented as LSM ± SE. Percent changes are based on a mixed model for repeated measures model for the efficacy estimand.
Abbreviations: Bima, bimagrumab; combo, combination; DXA, dual-energy X-ray absorptiometry; LSM, least-squares mean; PBO, placebo; SE, standard error; sema, semaglutide.

Estimated VAT: Percent Change from Baseline (DXA; Week 48)

Bimagrumab high-dose and combination therapy led to greater reduction in estimated visceral adipose tissue (VAT) than semaglutide 2.4 mg



Data are presented as LSM ± SE. Percent changes are based on mixed model for repeated measures for the efficacy estimand, and an analysis of covariance model with multiple imputation for the treatment-regimen estimand.
Abbreviations: Bima, bimagrumab; LSM, least-squares mean; SE, standard error; sema, semaglutide; VAT, visceral adipose tissue.

Attenzione:

- Trial di fase IIb che valutava bimagrumab da solo o in combinazione con tirzepatide in pazienti con obesità/diabete tipo 2, con l'obiettivo di indagare la perdita di peso e la preservazione della massa muscolare.

➔ Interrotto da Lilly prima di iniziare l'arruolamento:

➔ strategic business reasons

- È rimasto attivo un altro studio parallelo in soggetti obesi senza diabete

Take Home Messages

- Ricordiamoci della malnutrizione

Presente/frequente – rilevabile con uno screenig – presa a carico con impatto su morbi-mortalità

Associamo all'alimentazione proteica esercizi di forza a partire da 40 anni per preservare la nostra massa magra

Farmaci incretino-mimetici:

Funzionano- vanno usati correttamente – attenzione alla sospensione

"Ozempic", arriva il generico a basso costo. E Swissmedic lancia l'allarme

Dal 2026, in Canada sarà disponibile il farmaco generico. E sarà acquistabile nelle farmacie online anche dalla Svizzera. Ma rischi sono elevati