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IFSO GLOBAL STATEMENT

The Venice Declaration: Obesity as a Disease—A Call to Action for Diagnosis, Multimodal Treatment, and Policy Change

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Obesity is a chronic, multifactorial disease and represents one of the most pressing global health challenges of the twenty-first century, affecting over 1 billion people worldwide [1]. Despite its widespread prevalence and clear evidence of its biological nature, obesity remains underdiagnosed, undertreated, and often misperceived as a lifestyle choice rather than a complex disease. The International Federation for the Surgery of Obesity and Metabolic Disorders (IFSO) issues this global declaration to reinforce the urgent need for a paradigm shift in the perception, diagnosis, and management of obesity. This declaration highlights the burden of obesity, identifies the key barriers to care, and advocates for implementing comprehensive, multimodal, and multidisciplinary treatment strategies to improve patient outcomes and reduce the global health burden.

Obesity: A Global Epidemic and Public Health Priority

According to the Global Burden of Disease Report, obesity has nearly tripled since 1975, and it is now a leading cause of preventable mortality, contributing to the following [2]:

- Cardiovascular and respiratory diseases
- Endocrine-metabolic disorders
- Gonadal dysfunction and impaired fertility
- Hormonal and non-hormonal cancers
- Musculoskeletal dysfunction
- Mental health conditions
- Limitations of day-to-day activities

Despite its rising prevalence, obesity remains inconsistently recognized as a disease across healthcare systems, perpetuating diagnostic and therapeutic inertia, delays in care, and limited access to comprehensive, evidence-based multimodal treatments. There is an urgent need to develop strategies that effectively prioritize patients for treatment, enabling better allocation of healthcare resources.

Obesity as a Complex, Multifactorial Disease

- Obesity results from complex genetic, biological, environmental, behavioral, and socioeconomic interactions. The traditional view of obesity as merely a lifestyle-related imbalance between calorie intake and expenditure is overly simplistic and obsolete. Modern evidence highlights that obesity is driven by:
- Neurohormonal dysregulation (e.g., leptin and ghrelin imbalance, decreased synthesis and release of the insulin-sensitizing hormones, adiponectin, increased secretion of proinflammatory cytokines such as TNFα, interleukin (IL)− 6, and IL- 1β by both macrophages and adipocytes, increased sympathetic nervous activity, impaired insulin signaling or hyperinsulinemia)
- Genetic Predisposition
- Epigenetic Modifications
- Socioeconomic Inequalities

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- Psychosocial factors
- Overeating, high-fat diet, and physical inactivity

Recognizing obesity as a multifactorial disorder with deep and detrimental effects on neuroendocrine, metabolic, and psychosocial balance is paramount to guiding proper diagnosis, clinical decision-making, and, above all, healthcare policies [3].

The Challenge of Diagnostic Inertia and Therapeutic Inertia

Despite the significant burden posed by obesity, the absence of a nuanced diagnostic approach contributes to persistent diagnostic and therapeutic inertia, both of which remain critical barriers to effective care.

Diagnostic Inertia is the failure to recognize a patient as affected by a specific disease, i.e., a patient without acknowledged hypertension and high blood pressure labeled "in range" by healthcare professionals. Diagnostic Inertia refers to the case of obesity labeled as "healthy" when the disease is not associated with manifested and codified dysfunctions of organ systems.

Conversely, with the term *Therapeutic Inertia*, we refer to a failure to initiate or intensify evidence-based obesity therapies when indicated by clinical guidelines, resulting in limited or delayed initiation of more effective strategies [4–6].

This *Diagnostic and Therapeutic Inertia* is driven by the following:

- Lack of professional training in obesity management.
- Misconceptions about obesity prevention and therapeutic strategies.
- Social stigma.
- Bias against obesity as a lifestyle-driven condition.
- No timely and equitable access to comprehensive care and evidence-based treatments
- Fragmented healthcare systems with limited access to multidisciplinary care.

Importantly, diagnostic and therapeutic inertia are not limited to healthcare professionals or systems. Many individuals living with obesity do not recognize their condition as a medical disease. Very often, patients delay seeking help because they do not perceive themselves as ill, or they feel ashamed due to internalized weight stigma (self-stigma). This contributes to late engagement with healthcare services, often only after serious complications have developed. As a result, these individuals remain invisible within the healthcare system, further reinforcing diagnostic delays and therapeutic inertia. Public education campaigns, including health education in schools, should address these misperceptions, helping people identify obesity early and encouraging timely, stigma-free access to care.

The Spectrum of Obesity

Obesity is a continuum of progression from pre-clinical stages, where there is confirmed excess adiposity without signs and symptoms with variable levels of health risk but no ongoing illness, to clinical obesity, a chronic disease due to excess adiposity alone, and characterized by signs and symptoms of ongoing organ dysfunction and/or reduced ability to conduct daily activities. Excess adiposity is confirmed by body mass index (BMI) plus one anthropometric parameter (waist circumference, waist-to-hip, or waist-to-height ratio) or 2 of the anthropometric measures without the need for BMI. Direct body fat measurements, such as a DEXA scan, can be used if available.

Previous definitions of obesity (i.e., severe or morbid obesity, BMI ≥ 40 kg/m^2 or ≥ 35 kg/m^2 with complications) should no longer be used since patients affected by pre-clinical or clinical obesity can be denied access to care due to lack of supposed complications. Nevertheless, individual alterations of organ structure or function erroneously referred to as complications lack specificity as diagnostic methods of obesity as a standalone disease.

BMI-based metrics of obesity can misclassify excess adiposity and could both under or overdiagnose disease. Moreover, BMI does not differentiate between fat and lean mass or account for differences in body fat distribution.

Stage	Definition	Challenges
Pre-clinical obesity	Characterization of excess adiposity without signs and symptoms of organ dysfunctions due to obesity. Risk of developing clinical obesity, but not to be considered a pre-disease state It requires confirmation of obesity levels of excess adiposity, not merely based on BMI, going beyond the term "overweight." BMI should be used only as a surrogate measure of health risk at a population level for epidemiological studies or screening purposes rather than as an individual measure of health	Highly heterogeneous condition which may lead to misdiagnosis and underestimation It differs from metabolically healthy obesity because it is defined by the preserved function of all organs, not only those involved in metabolic regulation People with pre-clinical obesity should undergo evidence-based health counseling, monitoring their health status over time, and, when applicable, appropriate intervention to reduce the risk of developing clinical obesity and other obesity-related diseases, as appropriate for the level of individual health risk Research is needed to investigate the distinct prognostic value of dysfunctions of various organs/tissues caused by excess adiposity
Clinical obesity	Chronic illness stems from alterations in the function of organs or the whole organism, directly induced by excess adiposity, independent of other adiposity-related diseases. It can lead to life-altering or life-threatening complications Diagnosis of clinical obesity requires one or both of the following main criteria: evidence of reduced organ or tissue function due to obesity or substantial, age-adjusted limitations of daily activities reflecting the specific effect of obesity on mobility, other basic activities of daily living, or both	Healthcare professionals could consider the fulfillment of both anthropometric and clinical criteria time-consuming People with clinical obesity should have timely access to comprehensive care and evidence-based treatment to induce improvement (or remission, when possible) of clinical manifestations of obesity and prevent progression to end-organ damage Weight-based bias and stigma are significant obstacles in efforts to prevent and treat obesity effectively Developing appropriate staging systems to predict complications and mortality associated with clinical obesity can inform clinical management and prioritization of access to care. Staging clinical obesity should, therefore, be considered an important research priority

Adapted from The Lancet Diabetes & Endocrinology Commission, Definition and diagnostic criteria of clinical obesity, 2025[3]

Multimodal and Combined Treatment Strategies

IFSO strongly advocates for a multimodal and personalized approach to obesity treatment, integrating the following:

- Lifestyle interventions (nutritional, physical activity, and psychological support)
- Pharmacotherapy
- Endoscopic treatments
- Bariatric and metabolic surgery

Evidence shows that combined approaches yield better outcomes than isolated interventions. The selection of therapies should be tailored to the individual patient based on the severity of obesity, organ system dysfunctions, and patient preferences [7].

Role of Lifestyle Interventions (Nutritional, Physical Activity, and Psychological Support)

Lifestyle interventions play a crucial role in obesity management; patients should always be encouraged to adopt a healthy and balanced lifestyle, add psychological support, limit processed and high-calorie food intake, and practice regular physical activity. Several studies assessing the effect of lifestyle interventions on weight loss and quality of life have confirmed that physical exercise aids in improving functional capacities and reducing the risk of metabolic dysfunctions. Although physical exercise alone does not cause substantial weight reduction, it preserves fat-free mass, which may be beneficial in terms of favorable outcomes in body composition. Therefore, the potential effects of adding specific lifestyle interventions should be considered equally applicable to patients who receive structured lifestyle interventions before and after pharmacotherapy, bariatric endoscopy, and metabolic bariatric surgery [7].

Role of Pharmacotherapy

Obesity management medications (OMMs) can be integrated into the multimodal treatment of obesity at various stages:

- Preoperative: to optimize patients' status for MBS
- Postoperative: to enhance overall outcomes and health impact of obesity over time in terms of organ system dysfunctions and as adjunctive therapy for patients with weight recurrence and/or suboptimal clinical response. In some clinical circumstances, for example, osteoarthrosis and heart failure with preserved ejection fraction, the adjuvant use of OMMs may improve outcomes, leading to additional weight loss

Moreover, newer OMMs have been demonstrated to have a greater efficacy on glycemic control, metabolic dysfunction

associated with steatotic liver disease (MASLD), and obstructive sleep apnea syndrome (OSAS) remission. Therefore, they could also have unfavorable outcomes not observed with older agents. Less than 10% of patients affected by the above-mentioned diseases are under pharmacological treatment [8].

Role of Bariatric Endoscopy

Endoscopic bariatric and metabolic therapy (EBMTs) have been refined over the past decades and are now increasingly performed globally. Endoscopic treatments are generally divided into gastric and small-bowel devices and/or procedures, focusing primarily on weight loss and remission of metabolic conditions. According to recent data coming from literature, endoscopic bariatric procedures performed as an option in obesity management are the following: intragastric balloons (IB), EndoBarrier System (EBS), and endoscopic sleeve gastroplasty (ESG). Adding OMM or EBMT to MBS versus MBS alone is associated with higher efficacy in weight loss and remission of related obesity complications [8, 9].

Role of Bariatric and Metabolic Surgery

Bariatric and metabolic surgery remains the most effective long-term treatment for obesity and its related complications. However, less than 1% of eligible patients worldwide currently have access to surgical treatment.

IFSO calls for the following:

- The expansion of MBS eligibility criteria is based on obesity as a standalone disease with its own identity and not based on corpulence or other concomitant diseases.
- Equitable access to obesity care
- The integration and interconnection of MBS within multidisciplinary obesity care pathways

Addressing Therapeutic Inertia Through Education and Policy

IFSO commits to reducing therapeutic inertia by promoting the following:

- Comprehensive Training Programs for healthcare professionals
- Global Adoption of Obesity Clinical Pathways
- Public health campaigns to address and fight weight bias and stigma
- Collaboration with policymakers to ensure equitable access to care

The IFSO Global Call to Action

> "IFSO considers pre-clinical and clinical obesity not as personal failures but as stages within a complex, chronic, and relapsing disease requiring urgent, evidence-based, and comprehensive care. IFSO urges governments, healthcare systems, and global health organizations to recognize obesity as a public health priority and to adopt multimodal, patient-centered care strategies that address the entire continuum of obesity. This nuanced definition of clinical obesity enables healthcare providers to prioritize treatments for those most in need, design personalized therapeutic approaches, accurately stratify risk among individuals with pre-clinical obesity, and optimally allocate healthcare resources."

We, the International Federation for the Surgery of Obesity and Metabolic Disorders (IFSO), declare the following:

1. Obesity is a complex, chronic disease that demands recognition as a standalone condition; obesity is a spectrum, varying from pre-clinical to clinical obesity, with different scopes of treatments, comparable to other chronic illnesses.
2. Diagnostic and therapeutic inertia must be urgently addressed through comprehensive education, evidence-based clinical guidelines, policy prioritization, and societal reframing.
3. Weight bias and stigma must be actively challenged and eliminated across healthcare systems, clinical practices, public policies, and broader society.
4. Global access to comprehensive, multimodal, and multidisciplinary obesity care must be significantly expanded, including structured lifestyle interventions, pharmacological therapies, endoscopic procedures, and bariatric metabolic surgery.
5. National healthcare systems must implement integrated care pathways to ensure consistent and effective obesity management.

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