

Nutritional, functional and psychological considerations for incretin-based therapies

30-second summary:

This consensus statement from European organisations involved in obesity care, presented at the International Congress of Obesity and published in *The Lancet Diabetes & Endocrinology*, provides pragmatic guidance on nutritional, functional and psychological considerations to help people optimise benefits from incretin-based therapies for weight loss. Along with physical activity guidance, detailed advice is provided on medical nutrition therapy, including protein, fibre, fats and fluid intake, to both optimise weight loss and help reduce lean mass loss during weight loss. The consensus includes simple dietary and lifestyle recommendations to help people cope with potential adverse effects from therapy and proposes a useful framework for when to consider escalating psychological support. Guidance on anthropometric measurements to use at baseline and for monitoring are provided, along with advice on when to consider more detailed measurement of body composition. The guidance is summarised here, but anyone involved in managing people treated with incretin therapies are recommended to [read the full document](#).



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This consensus statement on nutritional, functional and psychological considerations for incretin-based therapies in adults was developed by a multidisciplinary team of experts from the European Association for the Study of Obesity (EASO), European Federation of Associations of Dietitians (EFAD) and the European Collaboration for People living with Obesity (ECPO), and was presented at the 2026 International Congress on Obesity in Mexico City and simultaneously published in *The Lancet Diabetes & Endocrinology*. The consensus covers a wide range of issues and aims to ensure people using incretin-based therapies get the best and safest care while using these drugs.

Medical nutrition therapy

Medical nutrition therapy, ideally delivered by a registered dietitian, aims to improve gastrointestinal tolerance and drug adherence by fine-tuning dose escalation, maintain the macro- and micronutrient content of the diet, support preservation of fat-free mass as much as possible, reduce risk of disordered eating and reinforce sustained healthy diet and behaviour change which will persist after therapy, helping to slow unintentional weight

regain. The nutritional recommendations are summarised in *Table 1*.

Dietary approaches which meet these recommendations and which can have wider health benefits include the Mediterranean diet, the DASH diet, the Healthy Nordic diet and Traditional Asian eating patterns. The consensus also offers dietary and behavioural strategies to minimise incretin side-effects. These are summarised in *Table 2*.

Nutritional psychology and mental health considerations

Screen for disordered eating and eating disorders; involve the psychology team if needed. Consider monitoring for reward substitution, liaising with addiction services if needed. If there is a history of psychological conditions, previous self-harm or suicide attempts, consider the possible impact of significant weight loss and need for psychological support.

If trained, use appropriate screening questionnaires and consider need for structured monitoring of mental health status throughout therapy for those with mental health conditions. If people are under psychiatric care or taking psychotropic drugs, consider shared care and

Citation: Brown P (2026) Diabetes Distilled: Nutritional, functional and psychological considerations for incretin-based therapies. *Diabetes & Primary Care* 28: [Early view publication]

Table 1. Nutritional recommendations.

Nutritional consideration	Recommendation	Encourage	Limit or avoid
Energy intake	Individualise; usually occurs automatically		If <800 kcal/day or nutritional requirements unlikely to be met, consider down-titrating or pausing therapy
Protein	1.0–1.5 g/kg adjusted body weight/day*† during weight loss, and 0.8–0.9 g/kg adjusted body weight/day for maintenance Supplement if needed	Spread throughout day – 20–30 g per meal Quality lean proteins – fish, skinless poultry, beef (small amounts), dairy, eggs, tofu, tempeh, unsalted nuts or seeds (<30 g)	Processed or high-fat meats
Fibre	≥25 g daily soluble fibre (oats, legumes, fruits, psyllium) and insoluble fibre (vegetables, whole grains, wheat bran) Build intake gradually	Prioritise high-fibre foods – vegetables, whole fruits, whole grains, legumes If constipation, add 3–5 g psyllium with fluid and build to 10 g/day	White bread, pasta, rice, cereals made from refined flours
Fats	Monounsaturated (olive oil, rapeseed oil) and polyunsaturated fats, especially oily fish	Extra-virgin olive oil, rapeseed oil, avocados, nuts, seeds, seafood	Reduce total fat, saturated fats, fried foods, full-fat dairy, crisps, cakes
Carbohydrates	Focus on complex carbohydrates	Wide variety of fruit and vegetables, whole grains, whole wheat, legumes and unprocessed foods	Refined and processed carbs, added sugars (including in tea and coffee), sugary cereals, white rice, snacks and sweets
Fluids	2.0 L/day women, 2.5 L/day men	Water, herbal, black and green teas; coffee in moderation	Sugary drinks, smoothies, fizzy drinks
Micronutrients	Nutrient-dense foods Consider multivitamin/mineral supplement if <1200 kcal/day	>5 fruit and veg daily; one third of intake should be higher-fibre	Nutrient-poor, energy-dense and ultra-processed foods

*If chronic kidney disease, 0.8–1.0 g/kg adjusted body weight/day may be most appropriate rather than higher levels.

†Adjusted body weight = reference body weight + (0.33 × [actual body weight – reference body weight]); reference body weight is body weight at BMI 25 kg/m².

review 1–2 weeks after therapy starts. If there is previous or recent substance or alcohol misuse, co-ordinate with addiction services and the mental health team.

Monitoring body composition and bone health

Simple anthropometric measurements (weight, waist circumference or waist-to-height ratio) and functional assessment (hand grip strength or sit-to-stand test; more details outlined in the consensus) are recommended for all, with detailed body composition (dual-energy

X-ray absorptiometry [DEXA] or bioelectrical impedance analysis [BIA]) considered at baseline and for monitoring in those at high risk or where there are clinical concerns, such as very rapid or substantial weight loss. When body composition data are available, a ≥3:1 ratio of fat:lean mass loss may be recommended, but direct evidence supporting this is limited. Progressive resistance exercise and adequate protein intake may support more favourable changes.

Consider closer and personalised monitoring in older people and those with pre-frailty or frailty, and consider prioritising functional status (activities of daily living, mobility, strength) when judging treatment benefit or harm in these groups. Consider escalation to the multidisciplinary team or specialist review if there is emerging functional decline, suspected sarcopenia or inability to meet protein or exercise goals.

Obesity is associated with higher bone density yet higher fracture risk, for reasons which are not fully understood, and weight loss is associated with bone mass loss and higher fracture risk, independent of how the weight loss is achieved. Associated modest bone loss proportional to weight loss occurs with incretin therapies, so counsel regarding maintaining calcium and vitamin D intake. Regular resistance and weight-bearing exercise may help mitigate bone loss, but there is limited evidence of impact on fracture risk. If at risk of osteoporosis, use the Fracture Risk Assessment Tool (FRAX®) or DEXA to assess at baseline; note, however, that FRAX is not validated during rapid weight loss and may underestimate risk in obesity.

If there is known low bone density or high fracture risk, consider need for referral or osteoporosis therapy along with incretin therapy. If there are possible absorption problems, consider need for injectable rather than oral osteoporosis therapies. Refer to the falls clinic if at risk.

Physical activity

Physical activity is important for general health and particularly cardiovascular risk reduction, as well as supporting weight loss and, particularly, preventing weight regain. Actively encourage any increase in activity levels, especially in people who are currently sedentary. Resistance exercise may be most effective for minimising loss of lean mass during weight loss, but all types of physical

activity assist with weight loss and maintenance, along with caloric deficit.

Individualise progressive increases in physical activity towards the [2026 public health recommendations](#). Reduce sedentary time and break up prolonged sitting. Provide guidance on how to progress exercise programmes and monitor regularly.

Socioeconomic factors

Obesity is more common in lower socioeconomic and ethnic minority groups, who may have more difficulty accessing medical care. Obesity is common in those living with food insecurity, which affects 5–20% of European populations and restricts access to healthy foods and the ability to follow the dietary recommendations summarised earlier. Screen for food insecurity and be aware of cultural dietary habits when offering support.

The consensus highlights the importance of dietetic support, which is unfortunately not widely available here in the UK. The authors highlight the importance of individualising guidance offered in all areas when implementing their consensus recommendations.

Implications for practice

People in the UK receiving NHS prescriptions for incretin drugs for weight loss are doing so as part of specialist obesity and weight management services, where these are available, and should be receiving the advice recommended here. However, currently, most people receiving incretin drugs for weight loss in the UK are purchasing them privately, and these people are receiving variable education and wraparound care from their providers. Most practices do not have the resources or the time to provide unfunded support to implement this consensus in the latter group.

However, people considering initiating or already using incretin drugs do consult us about other conditions or attend our surgeries with side-effects from the medication or asking for support, so it can be useful to have written guidance delivering key messages ready to share.

Developing and supporting a progressive exercise plan will require referral to an exercise-on-prescription scheme, so it is important to know what is available in our area, and how to refer.

Table 2. Dietary and behavioural strategies to minimise incretin side-effects.

Adverse effect	Recommendations
General advice	Regular, evenly spaced, small meals; use smaller plate; avoid fluids while eating, avoid strong smells if nausea; keep food diary to identify triggers
Nausea, vomiting	Take anti-nausea medication exactly as directed; eat when medication most effective; eat plain food immediately on waking
Persistent vomiting	Risk of dehydration, electrolyte imbalance, nutrient loss, weakness, arrhythmias, thiamine and other nutrient deficiencies; schedule urgent review; clinicians to consider down-titration/pausing therapy; consider eating disorder
Constipation	Gradually increase fibre intake to 25 g/day; 2.0–2.5 L fluids daily; movement; kiwi fruit and prunes; psyllium supplement if constipation persists; review constipating medications
Diarrhoea	Medical nutrition therapy assessment may suggest low-fat/low-lactose meals; limit sugar alcohols (e.g. sorbitol), caffeine and alcohol; food and symptoms diary; soluble fibre from fruits, vegetables, oats and psyllium; adequate hydration
Early satiety	Small, frequent meals; don't skip meals; protein first; soft or easily digested meals; liquids after or between, not before or with, meals
Dyspepsia	Small, frequent, low-fat meals; limit spicy or fatty food and caffeinated or fizzy drinks; eat slowly and chew well
Fatigue	Regular meals; complex carbohydrates; adequate protein; stay hydrated; iron and B vitamins; limit sugar; may need blood tests if persists
Headache	Stay hydrated; eat regular meals
Dizziness	Stay hydrated; eat small, regular meals; avoid standing too quickly
Belching/eructation	Eat slowly, chew well; avoid fizzy drinks; avoid chewing gum; limit gas-producing foods

The shortage of dietitians and psychologists in most parts of the UK means that these professionals are only accessible for people with very complex needs who are facing significant challenges with incretin medications.

Although we will want to limit our involvement and encourage people to seek guidance from their private provider, we share responsibility for keeping people safe when they consult us, and this consensus supports us in doing so. Some of the guidance it provides may also be applicable when we prescribe incretin-based therapies for type 2 diabetes. ■

Dobbie LJ, Tolvanen L, Alves D et al (2026) Nutritional, functional, and psychological considerations for incretin-based therapies in adults – an EASO, EFAD, and ECPO consensus statement. *Lancet Diabetes Endocrinol* 8 Jul [Epub ahead of print]. [https://doi.org/10.1016/s2213-8587\(26\)00122-1](https://doi.org/10.1016/s2213-8587(26)00122-1)

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Read the consensus in full
(purchase or institutional access required)