

# Real-world weight reductions when switching incretins for weight loss

Switching to tirzepatide in people who had already achieved weight loss on GLP-1 receptor agonists resulted in additional meaningful weight loss at 6 months in this retrospective, real-world study published in *Obesity*. However, outcomes varied by previous weight-reduction status, whether the person had type 2 diabetes and their reason for switching. If people had already achieved 10% or more weight loss from previous treatment, they achieved a mean additional weight loss of 7.2%, versus 10.3% in those who were not already weight-reduced, with 55% of the weight-reduced group losing at least 5% additional weight, compared to 80% of those who were initiating tirzepatide close to their initial body weight. As has been documented in previous studies, weight loss was less in people who had type 2 diabetes than those without. This study can help inform our discussions with people who are considering switching injectable weight loss drugs and will help us support realistic expectations.

Many people prescribed GLP-1 receptor agonists for weight loss ask to switch to the dual agonist tirzepatide, owing to the widely publicised weight loss achievable with this drug. Even if they have achieved significant weight loss with their original GLP-1 RA drug, recommendations from family and friends may encourage switching. Likewise, if weight loss has failed to meet expectations (and hopefully we have helped people incorporate lifestyle changes and set realistic goals), people may blame this on being prescribed the “wrong drug” and expect that tirzepatide will offer improved results. However, it is important that people have realistic expectations of the likely incremental weight loss which may be achieved if they choose to switch, particularly given the increased costs if they are buying the drugs privately.

Although the SURMOUNT-5 randomised controlled trial identified greater mean weight loss with tirzepatide than semaglutide (20.2% vs 13.7%), the study excluded many people, including those who had previously received any weight loss medication or lost 5 kg or more in the 90 days prior to enrolment (Aronne et al, 2025). Until now, therefore, it has been difficult to provide evidence-based estimates of how much weight loss may be achieved when switching from another GLP-1 RA to tirzepatide, and this may have denied people the opportunity to make informed, shared decisions about switching.

## The present study

In this real-world, retrospective cohort study published in *Obesity*, Barenbaum and colleagues analysed 6-month weight loss documented on medical charts in people who were treated with at least 6 months of tirzepatide (10–15 mg weekly). People who had previously undergone bariatric surgery were excluded.

Of the 293 people included in the study:

- 59% had transitioned from another GLP-1 RA to tirzepatide.
- 45% were classified as “weight-reduced”, as they had lost at least 10% of their body weight prior to starting tirzepatide.
- 34% had type 2 diabetes; of these, half were weight-reduced when included in the study.
- Those switching from semaglutide ( $\geq 1.7$  mg weekly) were classified by their reason for switching to tirzepatide:
  - ▶ Non-response: <5% weight loss after at least 3 months on therapy.
  - ▶ Weight plateau: >5% weight loss but stable weight for at least 3 months.
  - ▶ Other reasons for switching.

## Results

The mean age of people who had switched from another GLP-1 RA to tirzepatide was 52 years, and mean BMI was 36.1 kg/m<sup>2</sup>.

At baseline, there was a similar sex and race distribution in the weight-reduced and



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non-weight-reduced groups. However, in the weight-reduced group, mean BMI was lower, type 2 diabetes was more common and there were more people who switched from another GLP-1 RA to tirzepatide.

At 6 months, weight-reduced patients had achieved a mean additional weight loss of 7.2%, whereas the non-weight-reduced group saw reductions of 10.3%. Weight loss of  $\geq 5\%$  occurred in 55% and 80% of the weight-reduced and non-weight-reduced groups, respectively.

As has been documented in other studies, including randomised controlled trials of these drugs, percentage weight loss was lower in people with type 2 diabetes than those without (*Table 1*).

Amongst 70 people who switched from a therapeutic dose of semaglutide, 61 switched due to non-response or weight loss plateau, and this combined group achieved an additional 5.3% ( $\pm 5.9\%$ ) weight loss:

- Those switching due to plateau achieved 8.1% further weight loss.
- Those switching due to non-response only achieved 2.9% further reduction.

Thus, although most people achieved meaningful weight loss when switching to tirzepatide from other GLP-1 RAs in the real world, it was less than the weight loss achieved in tirzepatide’s clinical trial programme.

The study authors also highlight that people who were responders to GLP-1 RA drugs seemed to achieve greater additional benefit from the dual agonist, whereas those who had not previously responded achieved smaller additional benefit. Overall, however, the sample sizes in each group were small, and this should be considered when reviewing the data. Other key limitations are that this was a retrospective study from a single centre; the follow-up was limited to 6 months after switching to tirzepatide; and residual confounding cannot be excluded.

### Other studies

Two important new studies that may help inform future discussions about maintenance of weight loss have just been published and presented at the European Congress on Obesity. SURMOUNT-MAINTAIN was a 112-week, placebo-controlled study which included a 60-week open-label weight loss period followed by a 52-week

**Table 1. Percentage body weight reduction after 6 months of tirzepatide therapy.**

|                         | Weight-reduced group | Non-weight-reduced group |
|-------------------------|----------------------|--------------------------|
| Type 2 diabetes (n=100) | 5.5%                 | 5.7%                     |
| No diabetes (n=193)     | 9.0%                 | 11.0%                    |

double-blind weight maintenance period, during which participants could receive rescue tirzepatide therapy after 24 weeks of randomisation if they regained at least 50% of lost weight (Horn et al, 2026). Overall, 25% of those who were switched to tirzepatide 5 mg from their maximal tolerated dose regained at least 50% of the weight lost, as did 67% of those switched to placebo. This suggests that ongoing therapy is often necessary to maintain weight loss, which supports the NICE guidance on tirzepatide, which does not pose a time-restriction on use.

The same team also authored the ATTAIN-MAINTAIN trial, a double-blind study which randomised participants who had previously been treated with tirzepatide or semaglutide for 72 weeks to placebo or orforglipron, an oral, small-molecule GLP-1 RA (Aronne et al, 2026). Orforglipron recipients were more likely to maintain significant weight loss at week 52 than placebo recipients (74.7% vs 49.2% in those previously on tirzepatide, and 79.3% vs 25.5% in those previously on semaglutide). The authors concluded that once-daily oral orforglipron minimised weight changes after weight reduction with tirzepatide or semaglutide, and that this may be an effective approach after discontinuing injectable weight loss therapy. Orforglipron is not yet licensed in the UK. Unlike oral semaglutide, orforglipron has no restrictions on dosing.

### Implications for practice

Whether or not we are involved in NHS prescribing of weight loss drugs, we are likely to be involved in discussions with people who are considering initiating or switching injectable therapies privately, as 2026 data suggest that 1.6 million adults across England, Wales and Scotland used weight loss drugs in the previous year (Jackson et al, 2026).



This new retrospective cohort study aimed to gather real-world data from the very wide range of scenarios in which people choose to switch from GLP-1 RAs to tirzepatide when using these drugs primarily for weight loss. These included switching from a variety of different GLP-1 RAs, having been successful or not in losing significant amounts of weight on their initial drug, with different reasons for switching (plateau or non-response), and whether or not the individuals had type 2 diabetes. Although a relatively small study, it does provide data which may help us to manage “real-world” expectations, allowing us to share estimates with people who are considering injectables for weight loss or switching to tirzepatide.

We already have mean weight loss data for people combining lifestyle changes with semaglutide (14.9% versus 2.4% with placebo at 68 weeks) or tirzepatide (15.0–20.9% versus 3.1% with placebo at 72 weeks) from randomised controlled trials (Wilding et al, 2021; Jastreboff et al, 2022). Although people who have already lost significant weight on other drugs can still expect to achieve meaningful additional weight loss if they switch to tirzepatide, they must be reminded not to expect to achieve the losses widely publicised. Likewise, those who switch from semaglutide to tirzepatide can expect to achieve additional weight loss if they have been responders, but if they have lost little weight after at least 3 months on semaglutide then additional weight loss is likely to be significantly less when switching to tirzepatide. This is an important message to share.

We are also likely to be involved in discussions about weight maintenance as increasing numbers of people become unable to sustain private funding of injectable weight loss drugs. Lifestyle and behaviour changes remain important (as indeed they are during drug use), including eating

patterns which include more real or unprocessed food and restriction of ultraprocessed foods, and getting sufficient quantity and quality of sleep, which may impact appetite and weight. Physical activity offers significant health benefits, and both resistance and aerobic exercises are increasingly important during weight maintenance. The individual and synergistic effects of all three lifestyle behaviours, [sometimes referred to as SPAN](#), are well supported by evidence.

Orforglipron is in development for weight loss and type 2 diabetes management but is not yet licensed in the UK, so pricing compared to injectable weight loss drugs is as yet unknown, and it is not clear whether this will be available for primary care prescribing.

At the moment, however, for people who cannot afford to continue using these drugs privately, we can only support with lifestyle and behaviour change advice, [orlistat](#) and referrals to local services. This means it is very important to know what is available both in our local area and online, such as resources from NHS England. ■

Aronne LJ, Horn DB, le Roux CW et al; SURMOUNT-5 trial investigators (2025) Tirzepatide as compared with semaglutide for the treatment of obesity. *N Engl J Med* **393**: 26–36

Aronne LJ, Horn DB, le Roux CW et al (2026) Orforglipron for maintenance of body weight reduction: The double-blind, randomized phase 3b ATTAIN-MAINTAIN trial. *Nat Med* **13** May [Epub ahead of print]. <https://doi.org/10.1038/s41591-026-04386-7>

Barenbaum SR, Gonzalez A, Verzani Z et al (2026) Real-world weight-loss outcomes in weight-reduced patients treated with tirzepatide. *Obesity (Silver Spring)* **28** Mar [Epub ahead of print]. <https://doi.org/10.1002/oby.70179>

Horn DB, Aronne LJ, Wharton S et al (2026) Tirzepatide for maintenance of bodyweight reduction in people with obesity in the USA (SURMOUNT-MAINTAIN): A multicentre, double-blind, randomised, placebo-controlled trial. *Lancet* **12** May [Epub ahead of print]. [https://doi.org/10.1016/S0140-6736\(26\)00656-2](https://doi.org/10.1016/S0140-6736(26)00656-2)

Jackson SE, Brown J, Llewellyn C et al (2026) Prevalence of use and interest in using glucagon-like peptide-1 receptor agonists for weight loss: A population study in Great Britain. *BMC Med* **24**: 1

Jastreboff AM, Aronne LJ, Ahmad NN et al; SURMOUNT-1 investigators (2022) Tirzepatide once weekly for the treatment of obesity. *N Engl J Med* **387**: 205–16

Wilding JPH, Batterham RL, Calanna S et al; STEP 1 Study Group (2021) Once-weekly semaglutide in adults with overweight or obesity. *N Engl J Med* **384**: 989–1002

### Real-world weight-loss outcomes in weight-reduced patients treated with tirzepatide

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### Practice points

1. Switching from other GLP-1 receptor agonists to tirzepatide may result in additional weight loss; however, people who did not respond to previous incretin therapy are likely to have lesser benefit than those who did respond.
2. Lifestyle advice remains important both when taking weight loss drugs and when stopping. Consider SPAN (Sleep duration, Physical Activity and Nutrition).
3. [Wraparound care](#) is an essential part of prescribing tirzepatide for weight loss in primary care.