Prise en charge endoscopique bariatrique et métabolique de l'obésite : Recommandations Européenne et Américaine

JFHOD 2026 : FMC-HGE

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FMC HGE

Faculté de Médecine Aix+Marseille Université

Liens d’intérêts

- L'orateur a déclaré les liens d'intérêts suivants: Boston Scientific : research grant, Endotools : research grant, Taewoong: research grant, Boston Scientific, Endotools, Taewoong

Conflits d'interêts

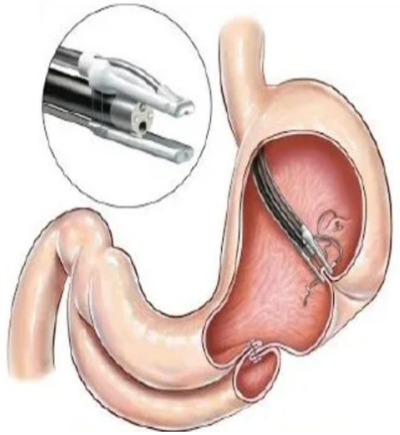
Boston Scientific : consulting

Taewoong: Consulting

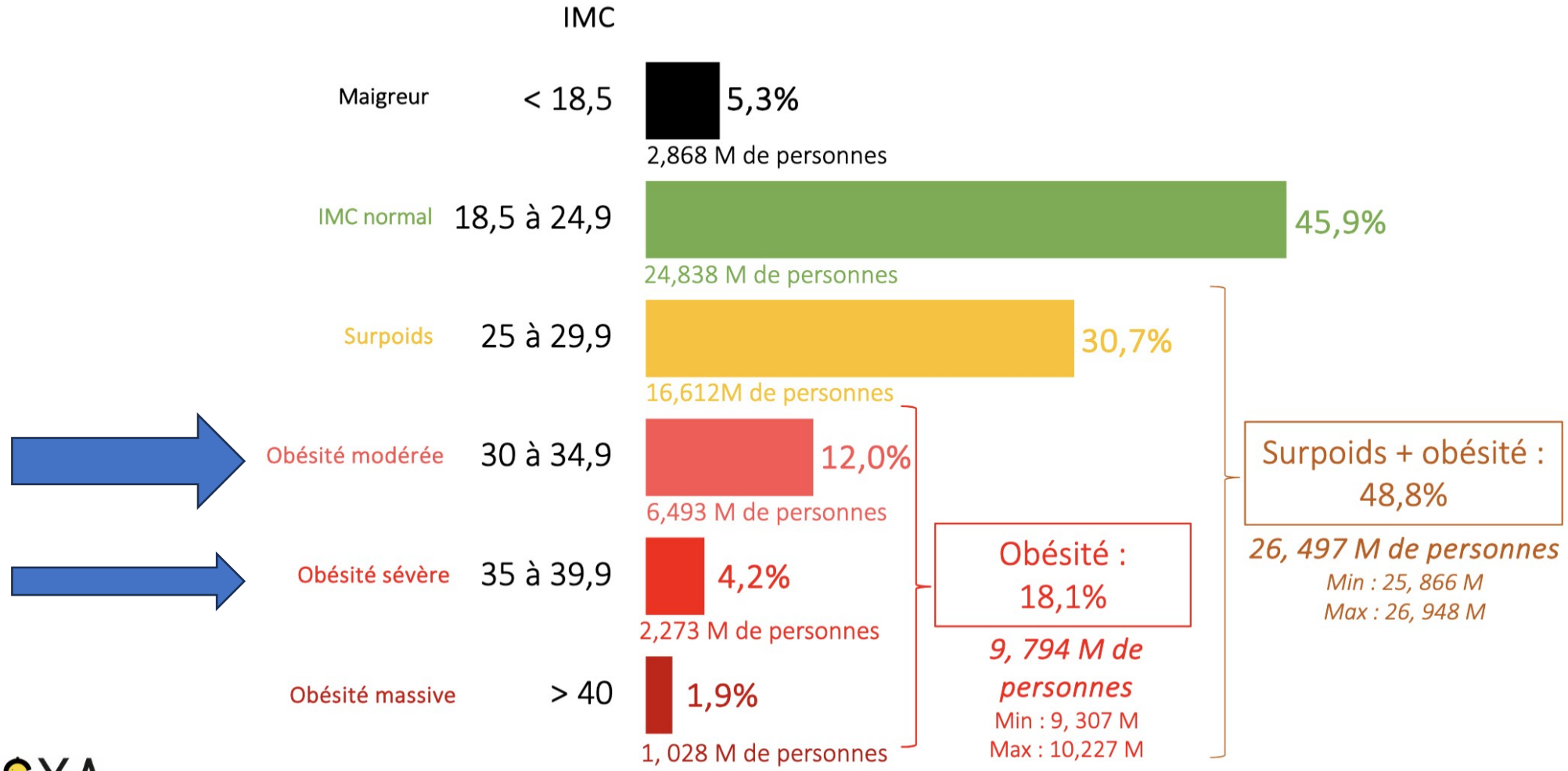
Endotools: Consulting

EBMT : Recommandations

- EBMT : Pour Qui ?
- EBMT : Pour quoi ?
- EBMT : Comment ?
- Avec quels résultats : bariatrique
  métabolique
  coût efficacité



Prevalence de l'obésité en France (OFEO 2024)



ODOXA
L'Opinion tranchée

LIGUE CONTRE OBÉSITÉ

RECOMMENDATIONS

ASGE Bariatric Endoscopy Task Force systematic review and meta-analysis assessing the ASGE PIVI thresholds for adopting endoscopic bariatric therapies

Bariatric Endoscopy= BMI> 35 Kg/m²

- **EWL > 25%** à 12 mois
- Difference d'EWL / Controls > 15%
- TBWL > 5%

New recommendations Are coming ASGE-ESGE

Adverse events:

- Severe Aes **< 5%**
- *If low risk*=> extended to BMI 30-35

EWL= Excess weight loss ; **TBWL**= Total body weight loss

Abu Dayyeh, ASGE GIE 2015

ASGE American Society for Gastrointestinal Endoscopy

GUIDELINE

ESGE

American Society for Gastrointestinal Endoscopy–European Society of Gastrointestinal Endoscopy guideline on primary endoscopic bariatric and metabolic therapies for adults with obesity

Pichamol Jirapinyo, MD, MPH,[1,*] Alia Hadefi, MD,[2,*] Christopher C. Thompson, MD, MSc,[1] Árpád V. Patai, MD, PhD,[3] Rahul Pannala, MD,[4] Stefan K. Goelder, MD, PhD,[5] Vladimir Kushnir, MD,[6] Marc Barthet, MD, PhD,[7] Caroline M. Apovian, MD,[8] Ivo Boskoski, MD, PhD,[9] Christopher G. Chapman, MD,[10] Paul Davidson, Ph.D,[11] Gianfranco Donatelli, MD,[12] Vivek Kumbhari, MBChB, PhD,[13] Bu Hayee, MD, PhD,[14] Janelle Esker, MS, RDN,[15] Tomas Hucl, MD, PhD,[16] Aurora D. Pryor, MD, MBA,[17] Roberta Maselli, MD, PhD,[18] Allison R. Schulman, MD, MPH,[19] Francois Pattou, MD,[20] Shira Zelber-Sagi, RD, PhD,[21] Paul A. Bain, PhD, MLIS,[22] Valérie Durieux, PhD,[23] Konstantinos Triantafyllou, MD, PhD,[24] Nirav Thosani, MD,[25] Vincent Huberty, MD, PhD,[2,†] Shelby Sullivan, MD[15,†]

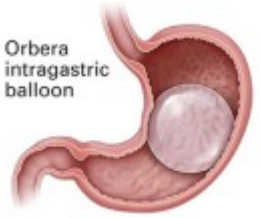
The guideline suggests the use of EBMTs plus lifestyle modification in patients with a BMI of $\geq$ 30 kg/m^2, or with a BMI of 27.0-29.9 kg/m^2 with at least 1 obesity-related comorbidity. Furthermore, it suggests the utilization of intragastric balloons and devices for endoscopic gastric remodeling (EGR) in conjunction with lifestyle modification for this patient population. (Gastrointest Endosc 2024;■:1-19.)

Jirapinyo P EBMT ASGE-ESGE Gastrointest Endosc 2024

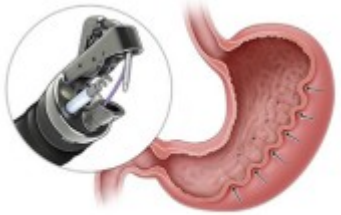
Mountain → Mouse

Recommendation 1: In adults with overweight or obesity, the ASGE–ESGE suggests the use of EBMTs plus LM over LM alone for patients with a body mass index (BMI) of ≥30 kg/m^2 or BMI of 27.0 to 29.9 kg/m^2 with at least 1 obesity-related comorbidity.
(Conditional recommendation, very low certainty)

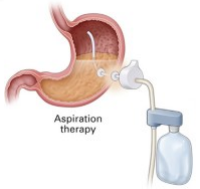
Recommendation 2: In adults with obesity, the ASGE–ESGE suggests the use of an IGB plus LM over LM alone.
(Conditional recommendation, moderate certainty)



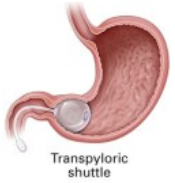
Recommendation 6: In adults with obesity, the ASGE–ESGE suggests treatment with EGR plus LM over LM alone.
(Conditional recommendation, moderate certainty)



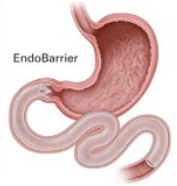
Recommendation 11: In adults with obesity, the ASGE–ESGE suggests treatment with AT plus LM over LM alone depending on device availability.
(Conditional recommendation, low certainty)



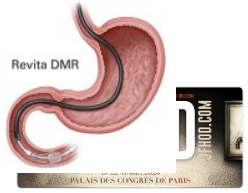
Recommendation 12: In adults with obesity, the ASGE–ESGE recommends treatment with TPS only in the context of a clinical trial.
(No recommendation, knowledge gap)



Recommendation 13: In adults with obesity and T2DM, the ASGE–ESGE suggests treatment with the DJBL plus LM over LM alone.
(Conditional recommendation, moderate certainty)



Recommendation 14: In adults with T2DM, the ASGE–ESGE recommends treatment with DMR only in the context of a clinical trial.
(No recommendation, knowledge gap)



Jirapinyo P EBMT ASGE-ESGE Gastrointest Endosc 2024

IFSO : RECOMMANDATIONS SUR SLEEVE GASTROPLASTY

- IFSO = International Federation of surgery of obesity

  44 articles , 15714 patients

  TBWL : 12 mois 17.2 % et 24 mois 15%

  morbidité 1,25 %

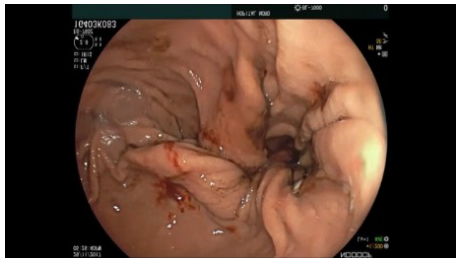
Obesity Surgery (2024) 34:4318–4348
https://doi.org/10.1007/s11695-024-07510-z

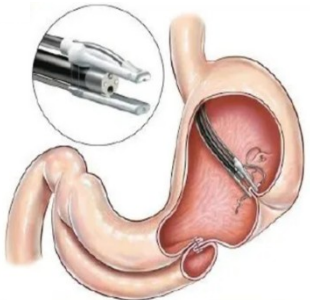
IFSO

RESEARCH

IFSO Bariatric Endoscopy Committee Evidence-Based Review and Position Statement on Endoscopic Sleeve Gastroplasty for Obesity Management

Barham K. Abu Dayyeh[1,10] · Christine Stier[2] · Aayed Alqahtani[3] · Reem Sharaiha[4] · Mohit Bandhari[5] · Silvana Perretta[6] · Sigh Pichamol Jirapinyo[7] · Gerhard Prager[8] · Ricardo V. Cohen[9]





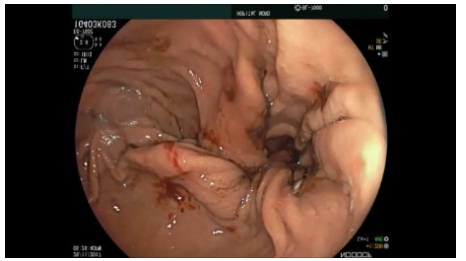
- Gastroplastie pertinente pour obésité classe 1 et 2
- Gastroplastie pertinente pour obésité classe 3 non opérable
- Possible chez adolescent

- Pas de recommandation pour ballon et DJBPL : niveau de preuve faible

Abu Dayehh BK. Obes Sur 2024; 34: 43-49

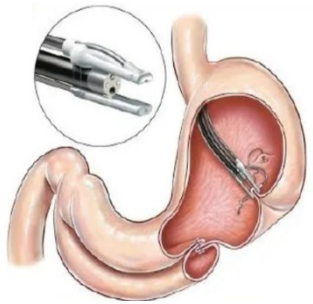
SOFFCO : RECOMMANDATIONS SUR SLEEVE GASTROPLASTY

- Efficace et sûre (1,5 à2,3%)



- Indication pour obésité classe 1 et 2 sans comorbidité

  pour obésité classe 3 non opérable



ELSEVIER

Available online at ScienceDirect www.sciencedirect.com

Elsevier Masson France EM|consulte www.em-consulte.com/en

Journal Surgery

RECOMMENDATIONS

Position statement and guidelines about Endoscopic Sleeve Gastroplasty (ESG) also known as ''Endo-sleeve''☆

Clément Baratte[a], Hugues Sebbag[b], Laurent Arnalsteen[c], Thomas Auguste[d], Marie-Cécile Blanchet[e], Salomon Benchetrit[f], Adel Abou-Mrad[g], Fabian Reche[h], Laurent Genser[i], Robert Caiazzo[j], Andrea Lazzati[k], Jean-Marc Catheline[l], Guillaume Pourcher[m,n], Pierre Leyre[o], Sandrine Kamoun-Zana[p], Fabien Stenard[q], Thibaut Coste[r], Adrien Sterkers[s], Claire Blanchard[t], Tigran Poghosyan[a], François Pattou[u,*], Silvana Perretta[v], Maud Robert[w,x]

Baratte C J Visc Sur 2025; 162:71-8

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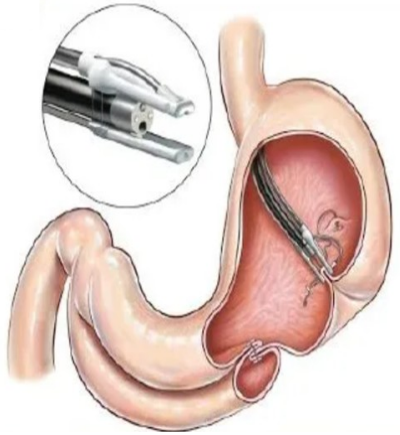
  métabolique
  coût efficacité



Les raisons de la prise en charge de l'obésité

- **Un bond épidémique** :

  obésité+surpoids 38 % de la population (2,6 milliards)

  en 2035 : 50 % de la population (4 milliards)

  obésité : 14% en 2025 à 24% en 2035

- **Des conséquences métaboliques** :

  augmentation linéaire du DT2 avec obésité (RR =5)

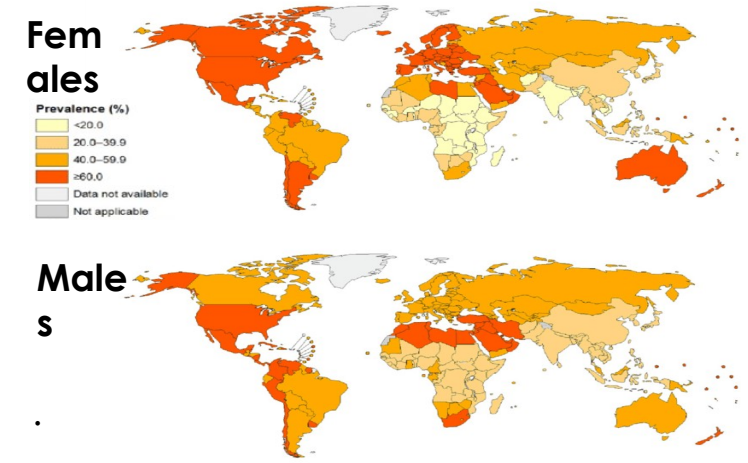
  MASH : première cause de TH prévue en 2030 aux US

- **Une Surmortalité** :

  association épidémiologique : 1 décès sur 13 en Europe

  perte espérance de vie entre 3 et 14 ans (moyenne 8 ans)

Prevalence of overweight and obesity in adults 2016



Albon E and NIHR. Health Technology assessment 2025; 69;28

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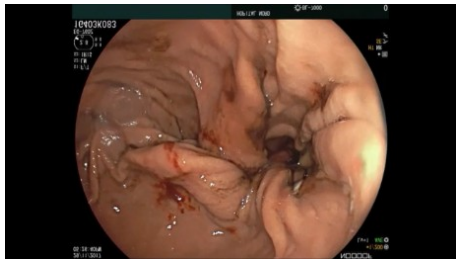
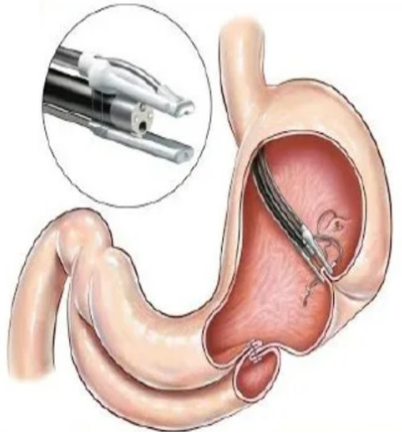




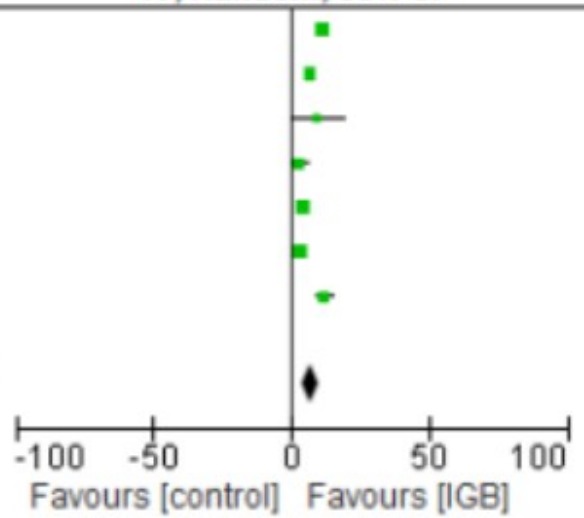
- Avec quels résultats : bariatrique
  métabolique
  coût efficacité

IGB Efficacy

%TWL at 6 months

Study or Subgroup	Experimental (IGB) Mean	SD	Total	Control Mean	SD	Total	Weight	Mean Difference IV, Random, 95% CI
Abu Dayyeh 2019	14.9	7.2	187	3.6	5.8	101	16.2%	11.30 [9.77, 12.83]
Courcoulas, 2017	10.2	6.56	125	3.3	5.02	130	16.2%	6.90 [5.46, 8.34]
Fuller, 2013	14.2	18.14	29	4.8	18.14	30	6.0%	9.40 [0.14, 18.66]
Ponce 2013	8.4	3.67	21	5.4	3.67	9	14.4%	3.00 [0.13, 5.87]
Ponce, 2015	7.6	5.5	167	3.6	6.3	126	16.3%	4.00 [2.62, 5.38]
Sullivan 2018	7.1	5	174	3.6	5.1	176	16.6%	3.50 [2.44, 4.56]
Vicente Martin, 2019	14.4	7.63	32	2.4	3.48	34	14.4%	12.00 [9.11, 14.89]
Total (95% CI)			**735**			**606**	**100.0%**	**6.89 [4.09, 9.70]**

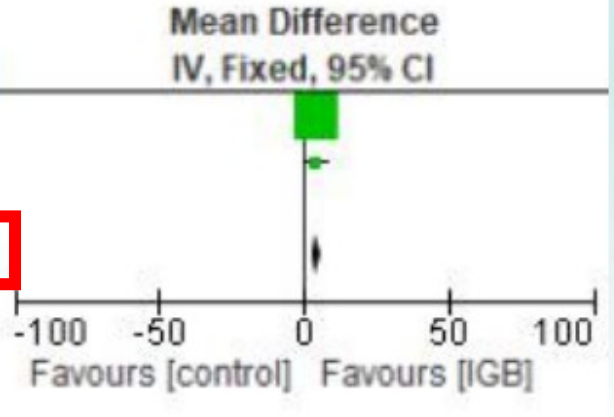
Heterogeneity: Tau² = 12.05; Chi² = 98.26, df = 6 (P < 0.00001); I² = 94%
Test for overall effect: Z = 4.82 (P < 0.00001)



%TWL at 12 months

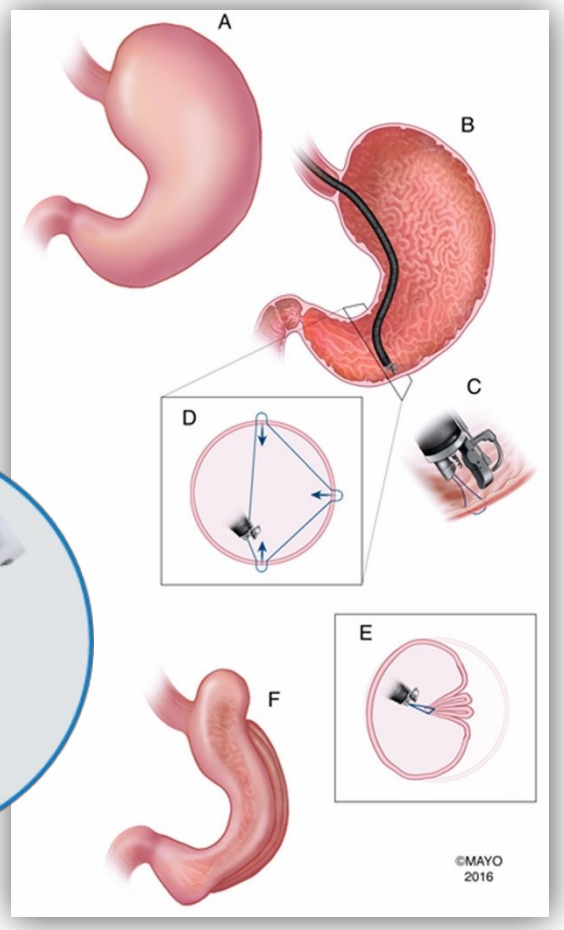
Study or Subgroup	Experimental (IGB) Mean	SD	Total	Control Mean	SD	Total	Weight	Mean Difference IV, Fixed, 95% CI
Courcoulas, 2017	7.6	7.48	125	3.1	5.9	130	84.6%	4.50 [2.84, 6.16]
Fuller, 2013	9.2	6.65	23	5.2	6.65	22	15.4%	4.00 [0.11, 7.89]
Total (95% CI)			**148**			**152**	**100.0%**	**4.42 [2.90, 5.95]**

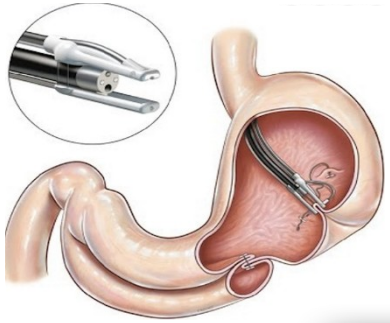
Heterogeneity: Chi² = 0.05, df = 1 (P = 0.82); I² = 0%
Test for overall effect: Z = 5.69 (P < 0.00001)



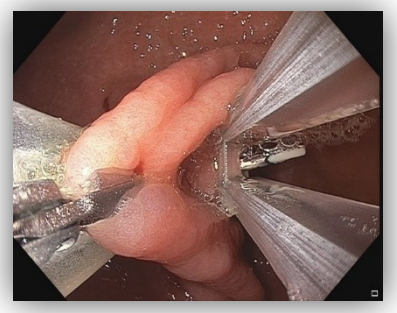
Endoscopic Sleeve Gastroplasty ?

OVERSTITCH®
(Apollo EndoSurgery, Etats-Unis)

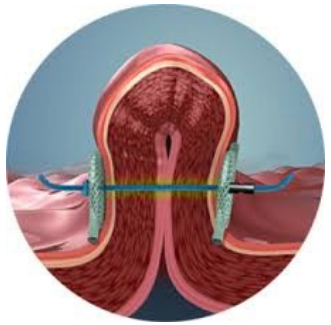


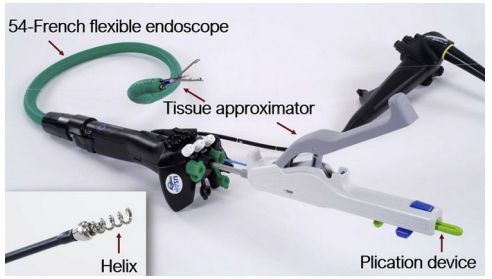


ENDOMINA ®
(Endo Tools Therapeutics, Gosselies, Belgium)

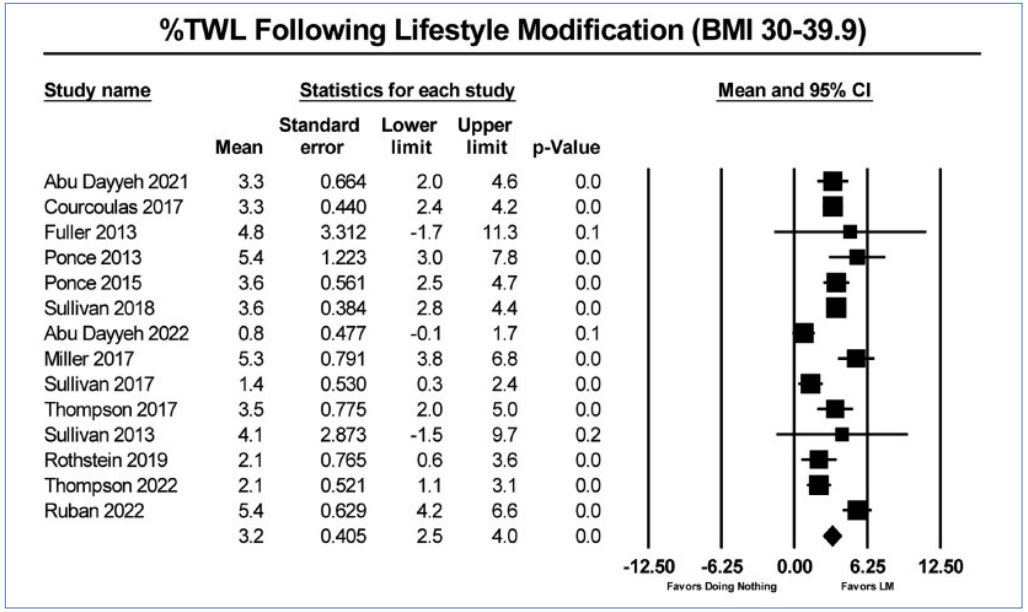


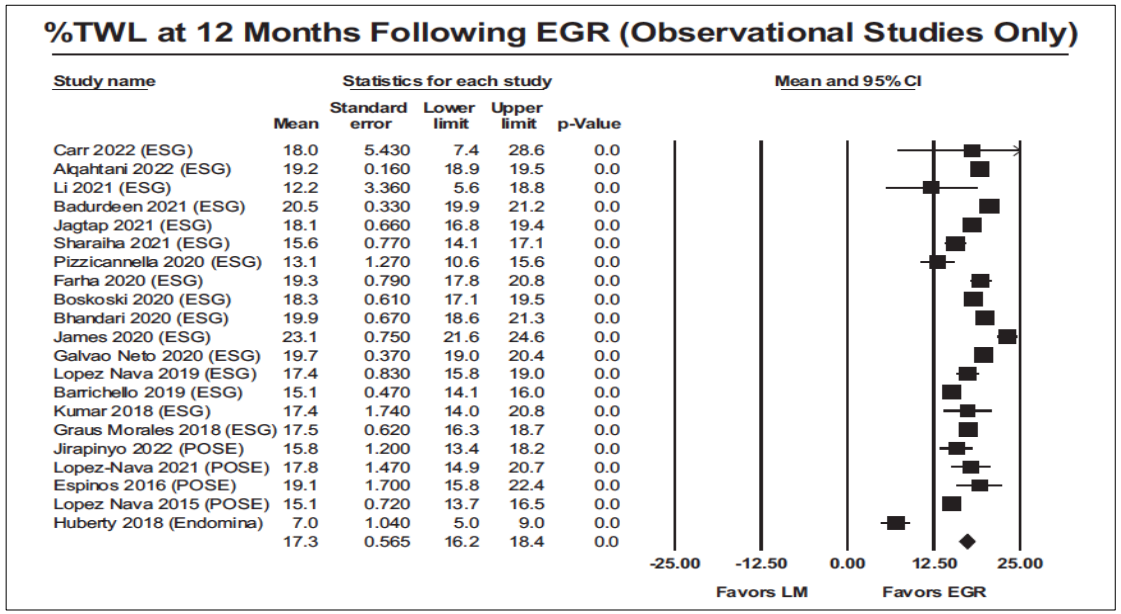
INCISIONLESS OPERATING PLATFORM®
(USGI Medical, Etats-Unis)
Système POSE





Modification « Lifestyle » ne sont pas suffisant





LM alone
3% at 12 months

LM + ESG
17,3% at 12 months

Jirapinyo P et al Endoscopy 2024,56(437-456)

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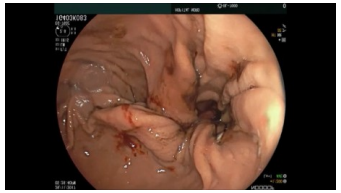
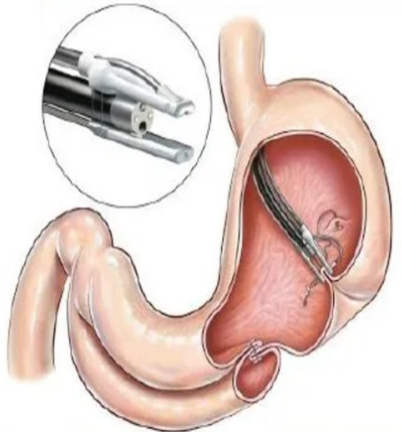




- Avec quels résultats : bariatrique
  métabolique
  coût efficacité

Endoscopic sleeve gastroplasty : étude randomisée

- RCT Endomina :

  71 patients; moy BMI 34.8

  ESG+lifestyle vs life style

  Suivi 1 year

  EWL 38.6 % vs 13.4%

  TBWL 11 % vs 2.7%

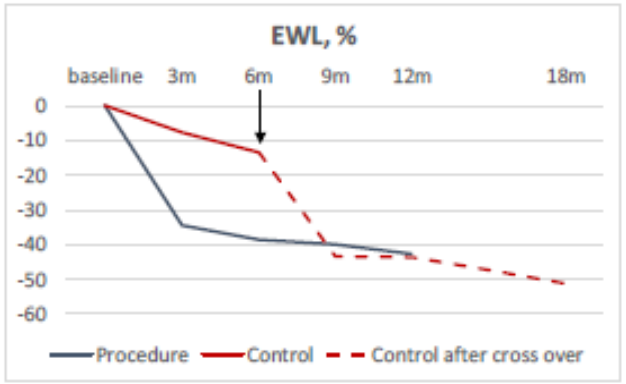
  A 1 an

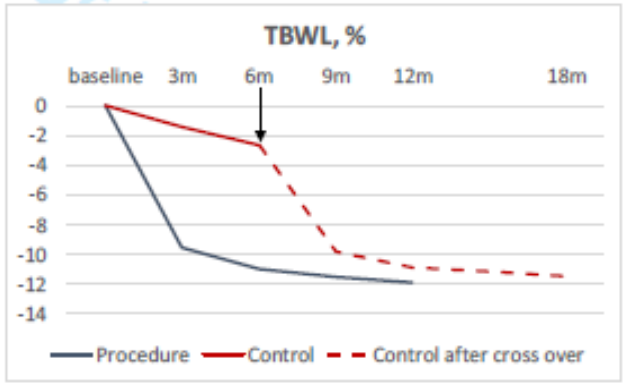
  EWL 43.6%-51.3%

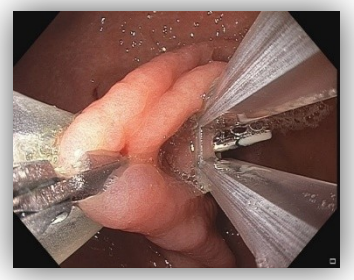
  TBWL 10.9%-11.5%

  BMI 29.7-30.1

  Aes : pas de complication sévère







	Treatment 12 months	Control 18 months
N	41	16
>5% TBWL	75,6%	68,8%
>10% TBWL	51,2%	50,0%
>15% TBWL	34,1%	43,8%

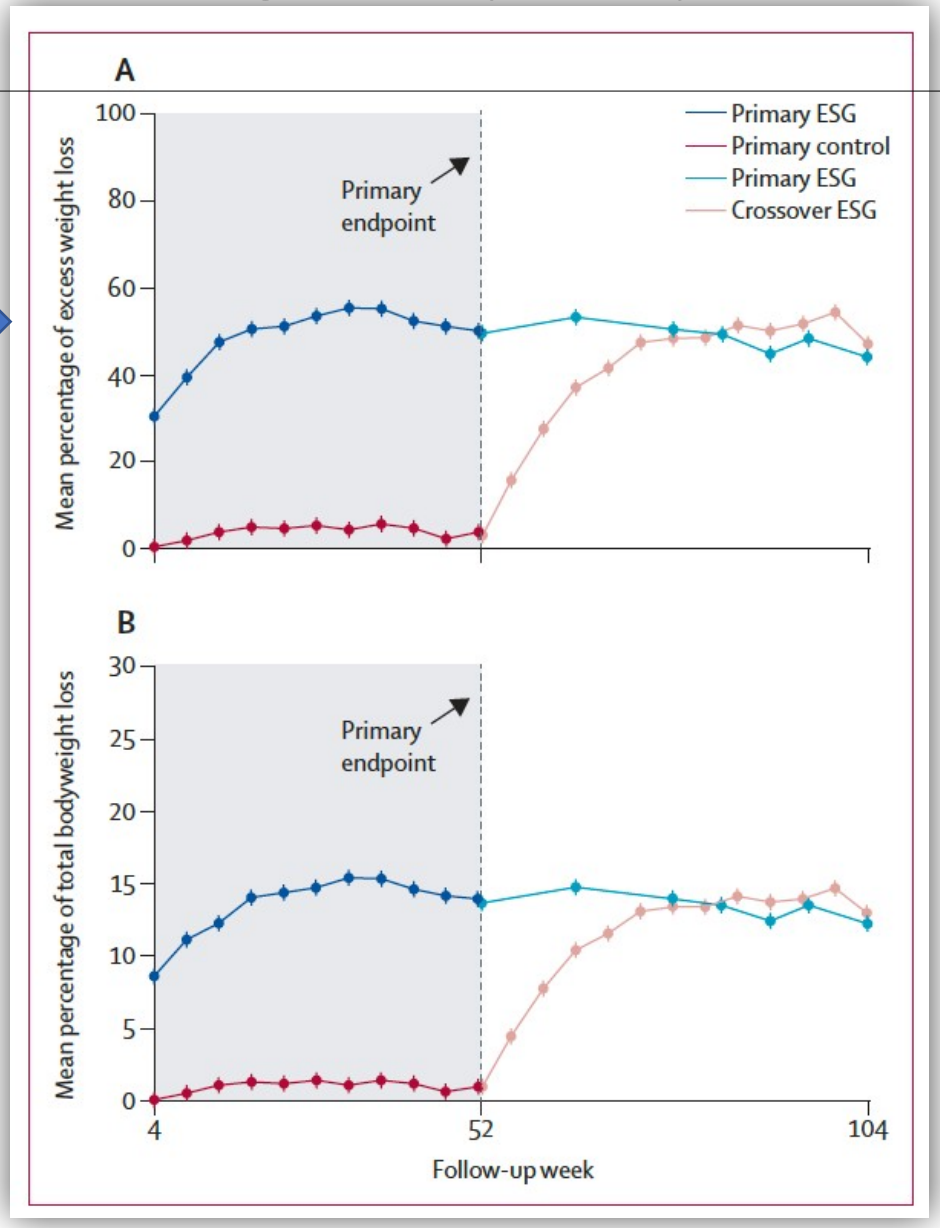
Huberty V, Barthet M, Deviere J. Gut 2020

Endoscopic sleeve gastroplasty : étude randomisée

MERIT study

TBWL

EWL



Prospective, randomized controlled study with crossover

85 class I or II vs 124 contrôles

TBWL : 13.6% vs 0.8%; p<0.0001

Améioration des comorbidités (1 ou plus)

80 % vs 45 %

12% vs 45 % worsened

EWL à 2 ans > 25% : 68 % (ESG group)

Aes 2 %

Abu Dayyeh BK, et al. Lancet. 2022 Aug 6;400(10350):441-451

Endoscopic sleeve gastroplastie : Méta-analyses

- Meta-analysis : 1859 patients in 8 studies

	6months	12 months	24 mois
TBWL%	14.86 %	16.43 %	20.01%
EWL%	55.75 %	61.84 %	60.4 %

pool incidence of moderate AEs : 2.3%, no mortality

- Meta-analysis : 1772 patients in 8 studies

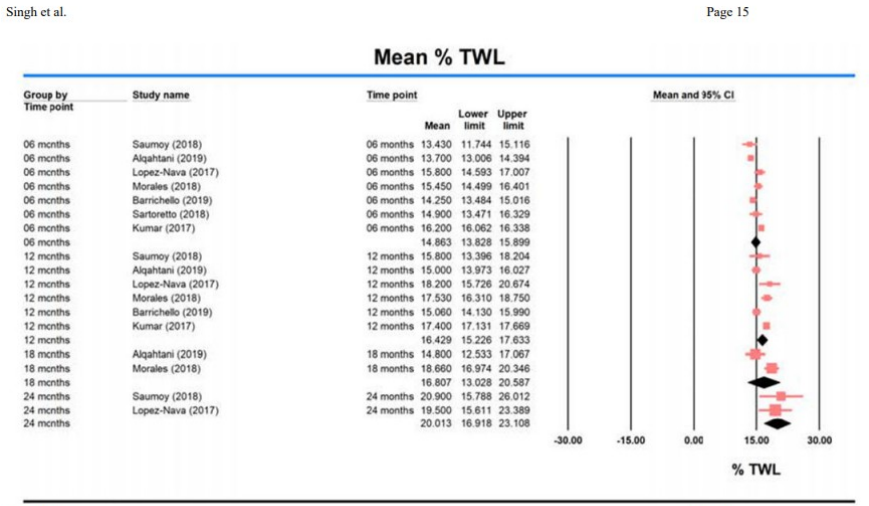
	6months	12 months	24 mois
TBWL%	15.1 %	16.5 %	17.2 %
EWL%	57.7 %		

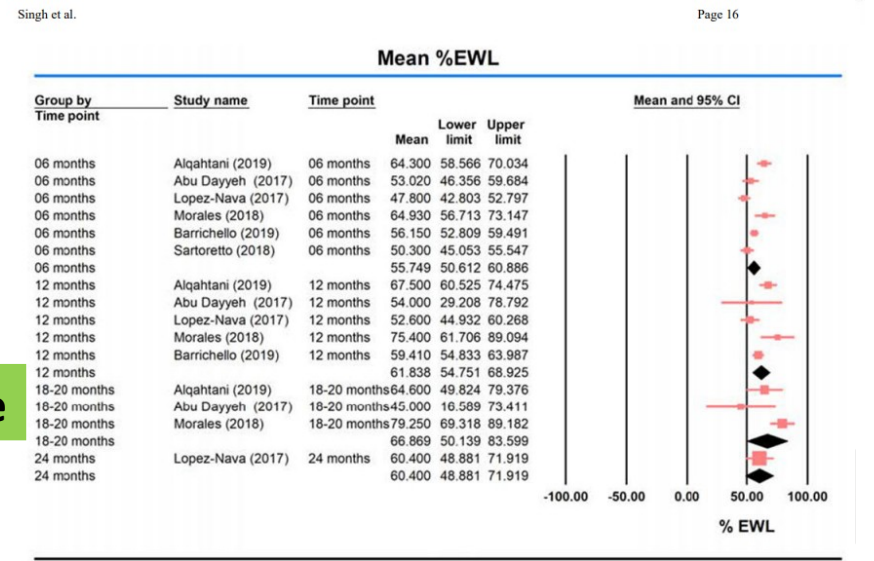
pool incidence of severe AEs : 2.2%, no mortality

pain , bleeding, leakage, fluid collections

Réponse prolongée

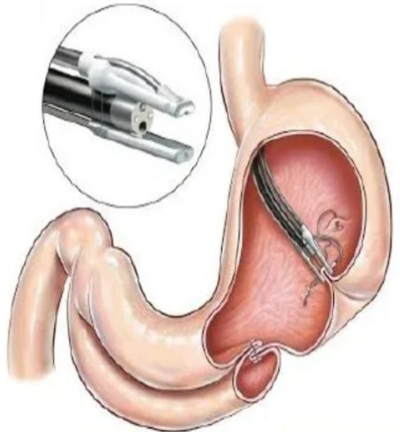
Singh S Surg Obes Relat Dis 2020; 16:340-51;
Hedjoudje A Clin gastroenterol Hepatol 2020; 18:1043-53





EBMT : Recommandations

- EBMT : Pour Qui ?
- EBMT : Pour quoi ?
- EBMT : Comment ?
- Avec quels résultats : bariatrique
  métabolique
  coût efficacité



Etude « EBMT » ….

- Systematic review and meta-analysis : suivi après Endoscopic Sleeve Gastroplasty

  7525 patients dans 28 séries

  But : TBWL et rémission co-morbidités

- TBWL : %
  - short term (1y) 16.2
  - medium term (3y) 15.4 %

- Rémission comorbidités:
  - diabètes 55.4 %
  - HTA 62.8%
  - apnée 51.7%
  - dyslipidemia 56.3%

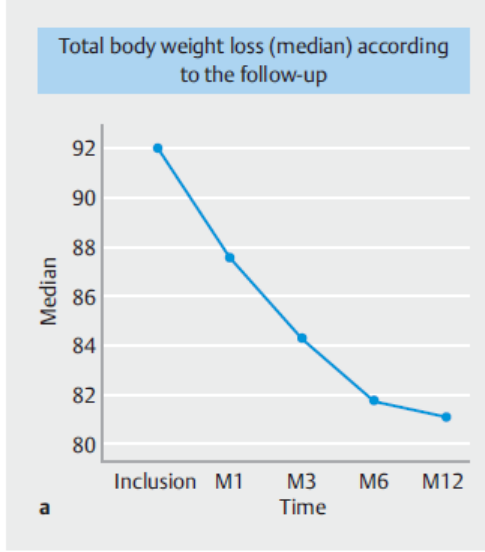
Fehervari M Obes Surg 2023;33: 3525-3538

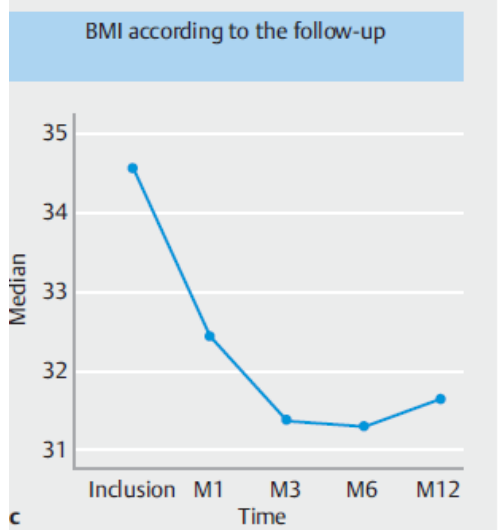
Thieme

Endoscopic sleeve gastroplasty: Prospective assessment of weight loss and metabolic impact

OPEN ACCESS

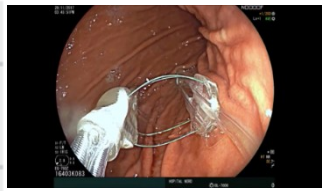
Authors
Marc Barthet[1], Geoffroy Vanbiervliet[2], Jean-Michel Gonzalez[1], Maxime Thobois[3], Yoann Poher[4], Marion Blin[4], Shani Diai[5], Nathalie Lesavre[4], Sandrine Boullu[4]

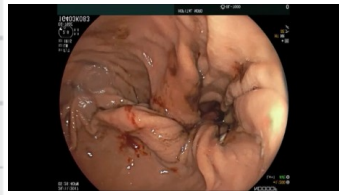




▶ **Table 1** Weight loss outcomes.

	Inclusion	1 month	3 months	6 months	12 months	*P*
Primary endpoint						
TBWL response > 5 (% and 95%CI)	NA	19 (67.9)	23 (82.1)	23 (82.1)	23 (82.1)	< 0.001
Secondary endpoints						
TBWL (%)	NA	6.01	9.05	11.13	11.05	< 0.001
EWL (%)	NA	23.69	34.79	41.61	40.98	< 0.001
BMI value (kg/m2): median (IQR)	33.99 (32.15–35.29)	31.91 (29.78–33.48)	31.04 (29.04–32.65)	31.24 (28.66–32.25)	31.66 (28.65–32.48)	< 0.001
BMI class						< 0.001
Class I	19 (67.90%)	15 (53.60%)	16 (57.10%)	17 (63%)	16 (64%)	
Class II	9 (32.10%)	5 (17.80%)	2 (7.10%)	0	0	
Overweight	0	8 (28.60%)	10 (35.80%)	10 (37%)	9 (36%)	

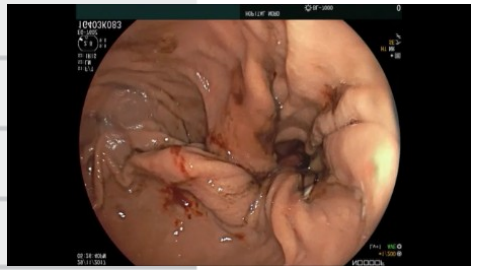




▶ **Table 2** Metabolic outcomes.

	Inclusion	12 months	*P* value*
	m (IQR)	m (IQR)	
Glycemia (mmol/L)	**5.30 (4.80–5.60)**	**5.00 (4.70–5.30)**	**0.011**
HbA1c (%)	**5.60 (5.37–5.82)**	**5.50 (5.37–5.70)**	**0.003**
Triglyceride (mmol/L)	0.90 (0.80–1.40)	0.90 (0.65–1.45)	0.275
Liver function test (IU/L)			
▪ ASAT	21.50 (18.75–23.00)	21.00 (19.00–26.00)	0.891
▪ ALAT	**20.00 (15.50–26.25)**	**18.00 (13.00–24.00)**	**0.006**
▪ GGT	**22.50 (18.00–30.00)**	**17.00 (14.00–30.00)**	**0.009**
▪ ALP	71.00 (63.50–85.00)	67.00 (60.00–87.00)	0.211
Arterial pressure (mmHg)			
▪ Systolic	**123.50 (113.50–141.75)**	**122.00 (112.00–129.00)**	**0.016**
▪ Diastolic	70.00 (63.25–79.25)	68.00 (63.00–68.00)	0.132
Ferritin (µg/L)	88.30 (44.20–142.07)	65.00 (36.50–135.60)	0.382

*P value for paired-sample t-tests or Wilcoxon tests.
ASAT, aspartate aminotransferase; ALAT, alanine aminotransferase; ALP, alkaline phosphatase; GGT, gamma-glutamyl transpeptidase; m (IQR), median (interquartile range).



3 RCT en route…

TESLA-NASH- NCT04060368

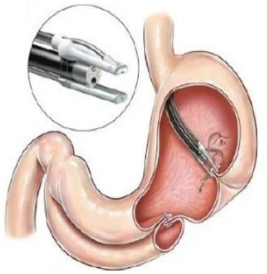
ESG vs. Sleeve laparoscopique

Lucía Lavín-Alconero et al. Trials 2021

ENDO-NASH- NCT04653311

ESG vs. lifestyle

Vincent Huberty et al.



ESTIME -Up coming Diabetes T2
ESG vs medical treatment

NASH-APOLLO- NCT03426111

ESG vs. lifestyle

Jose Luis Calleja et al.

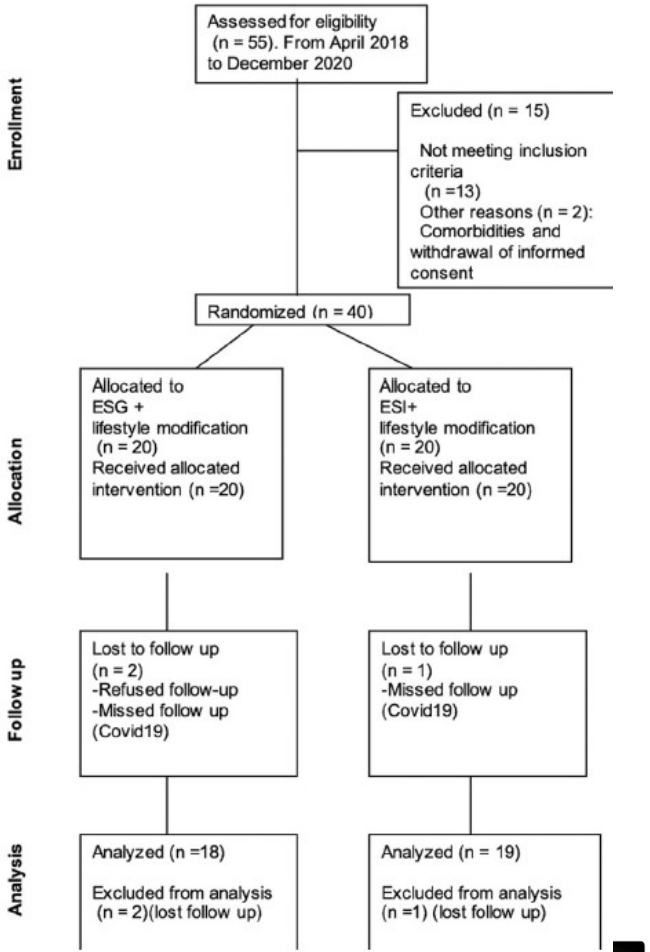
Clinical Gastroenterology and Hepatology 2025;23:1556–1566

HEPATOLOGY

Endoscopic Sleeve Gastroplasty Plus Lifestyle Intervention in Patients With Metabolic Dysfunction-associated Steatohepatitis: A Multicenter, Sham-controlled, Randomized Trial

Javier Abad,[1] Elba Llop,[1] María Teresa Arias-Loste,[2] Diego Burgos-Santamaría,[3] José Luis Martínez Porras,[1] Paula Iruzubieta,[2] Javier Graus,[3] Belén Ruiz-Antorán,[4] María Rosario Sánchez Yuste,[5] Manuel Romero-Gómez,[6] Agustin Albillos,[3] Javier Crespo,[2,§] and José Luis Calleja[1,§]

[1]Department of Gastroenterology and Hepatology, Hospital Universitario Puerta de Hierro, Majadahonda, Spain; [2]Department of Gastroenterology and Hepatology, Hospital Universitario Marqués de Valdecilla, Santander, Spain; [3]Servicio de Gastroenterología y Hepatología, Hospital Universitario Ramón y Cajal, Madrid, Spain; [4]Department of Clinical Pharmacology, Hospital Universitario Puerta de Hierro, Majadahonda, Spain; [5]Department of Pathological Anatomy, Hospital Universitario Puerta de Hierro, Majadahonda, Spain; and [6]UCM Digestive Diseases and Ciberehd, Hospital Universitario Virgen del Rocío, Sevilla, Spain



Etude randomisée : patients avec MASH

- RCT Endoscopic Sleeve gastroplasty +LSM versus Sham endoscopy +LSM :

  40 patients avec biopsie MASH; FU 72 semaines

TBWL :	9.4 % vs 3.9%	p< 0.05
Liver stiffness:	5.63 Kpa vs 0.2 Kpa	p<0.05
Steatosis:	-0.94 vs -0.26	p=O.03
NAS :	no significant difference	
	but in patients with TBWL>10%	-4 vs -0.81, p=0.01

  Aes : 2 patients ESG groupe, résolu <72 h

Abad J Clin Gastroenterol Hepatol 2025; 1555-1556

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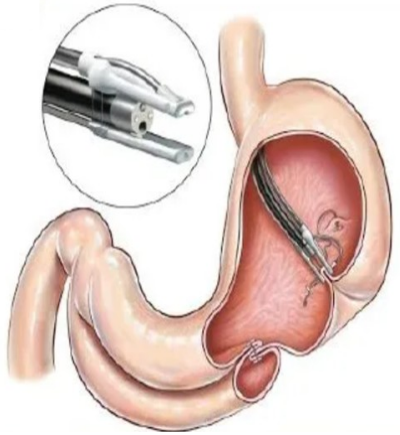
  coût efficacité
- Interactions pharmacologiques



ESG vs MBS/ GLP1 agonists

Etude Coréenne

Avec Efficacité des traitements : TBWL

- ESG : 15%
- GLP1 agonists : 15-20 %
- MBS : metabolic bariatric surgery : 25-30%

ESG meilleur rapport coût-efficacité dans IMC classe I

MBS coût efficaces pour IMC classe II et III

GLP1 agonistes non-coût efficaces en raison de leur coût

J Metab Bariatr Surg. 2025 Aug;14(2):97-105
https://doi.org/10.17476/jmbs.2025.14.2.97
pISSN 2287-2930-eISSN 2508-5956

Journal of Metabolic and Bariatric Surgery JMBS

Review Article

Check for updates

OPEN ACCESS

Cost-Effectiveness of Obesity Treatments: Glucagon-Like Peptide-1 Receptor Agonists, Endoscopic Sleeve Gastroplasty, and Metabolic/Bariatric Surgery

Yeon-Ju Huh [1,2]

[1]Office of Medical Education, Seoul National University College of Medicine, Seoul, Korea
[2]Department of Surgery, Seoul National University Hospital, Seoul, Korea

YJ Huth J Metab Bariatr Surg 2025; 18: 14:97-105

Rapport coût-efficacité dans le système Anglais NHS

- **1500 études** : Obésité en UK ; 29 % femmes et 26 % hommes

  3 modèles Markov

  LSG vs ESG

  ESG vs GLP1 agonist

  GLP 1 vs IGB

- Résultats :

LSG > ESG; QALY 10593 L Classe II et III

ESG > GLP1 a; QALY 7267 L Classe I et II

GLP1a > IGB Classe I et II

NIHR | National Institute for Health and Care Research

Health Technology Assessment

Check for updates

Extended Research Article

Cost-effectiveness of endoscopic treatments for obesity: a clinical evidence map and systematic review to inform a model-based cost-effectiveness analysis

Esther Albon,[1] Nafsika Afentou,[1] Janine Dretzke,[1*] James Hall,[1] Chidubem Okeke Ogwulu,[1] Malcolm J Price,[1] Ken Clare,[2] Rishi Singhal,[3] Abd Tahrani,[4†] Emma Frew[1†] and David J Moore[1*†]

TABLE 15 Summary of base-case results

Analysis	Cost (£)	QALY	ICER (£/QALY)
Model 1 (ESG vs. LSG)			
ESG	6425.10	3.2735	
LSG	8863.44	3.5037	
Difference	−2438	−0.2302	(LSG) 10,593
Model 2 (ESG vs. semaglutide)			
ESG	6223.58	3.5420	
Semaglutide	5829.35	3.4878	
Difference	394.23	0.0543	(ESG) 7267
Model 3 (IGB vs. semaglutide)			
IGB	6432.16	3.4385	
Semaglutide	5829.09	3.4878	
Difference	603.07	−0.0492	Semaglutide is dominant

Albon E and NIHR. Health Technology assessment 2025; 69;28

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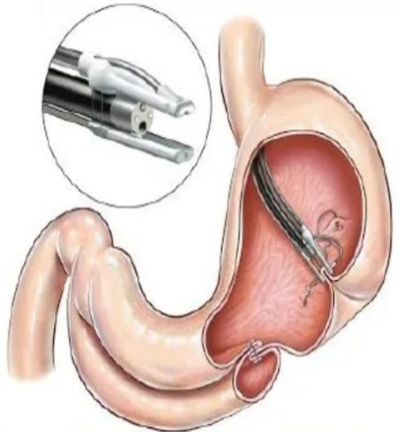
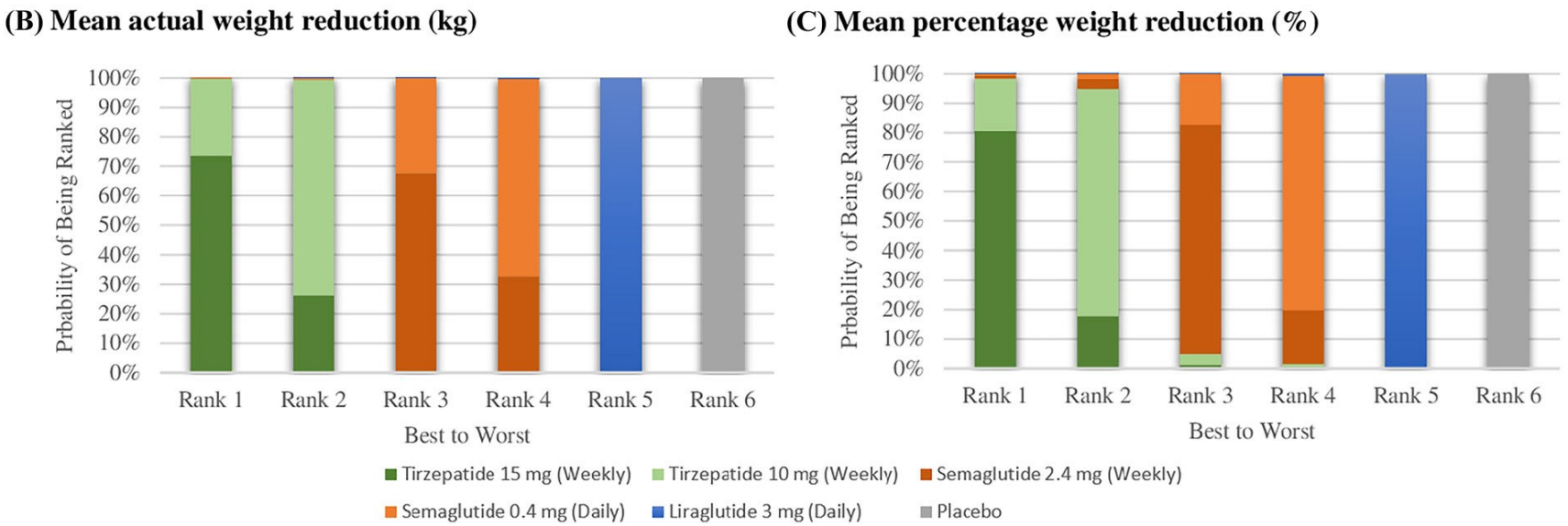
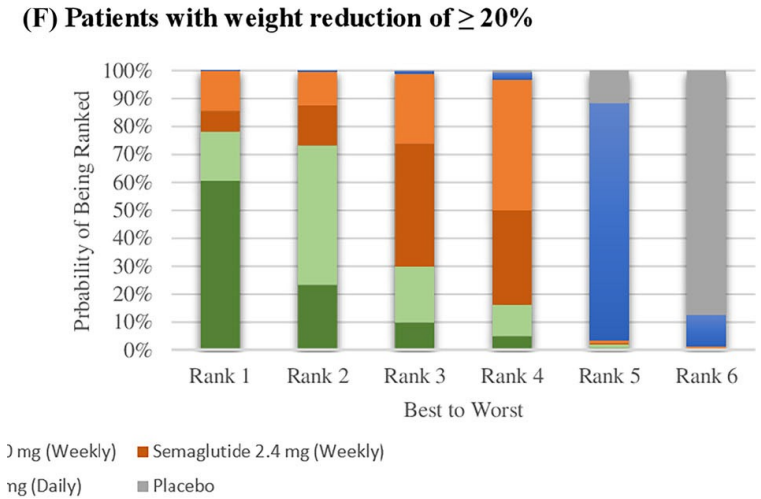


AGONISTE GLP-1 et autres …

Liraglutide,
Semaglutide,
Tirzepatide





Alkhezi OS, et al. Comparative effectiveness of glucagon-like peptide-1 receptor agonists for the management of obesity in adults without diabetes: A network meta-analysis of randomized clinical trials. Obes Rev. 2022 Dec 29:e13543

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Tirzepatide Once Weekly for the Treatment of Obesity

Ania M. Jastreboff, M.D., Ph.D., Louis J. Aronne, M.D., Nadia N. Ahmad, M.D., M.P.H., Sean Wharton, M.D., Pharm.D., Lisa Connery, M.D., Breno Alves, M.D., Arihiro Kiyosue, M.D., Ph.D., Shuyu Zhang, M.S., Bing Liu, Ph.D., Mathijs C. Bunck, M.D., Ph.D., and Adam Stefanski, M.D., Ph.D., for the SURMOUNT-1 Investigators*

ABSTRACT

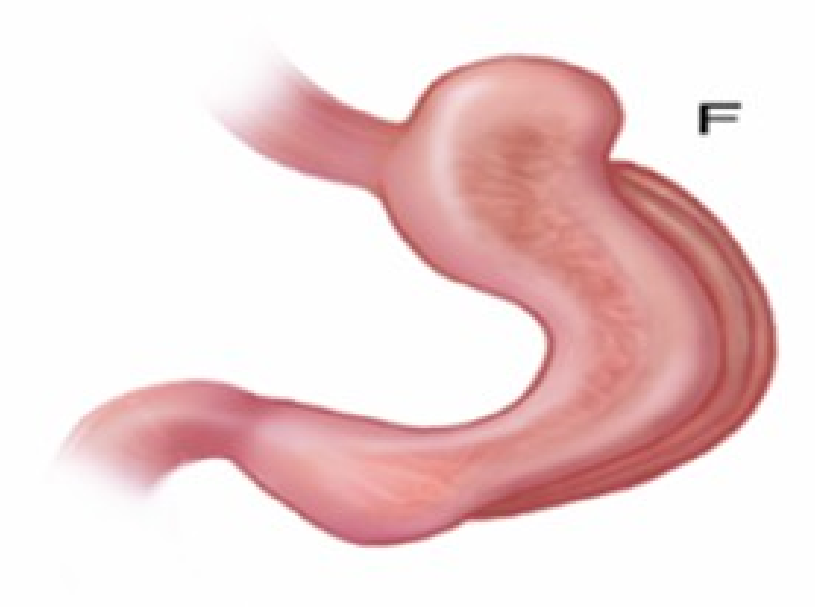
Phase 3 double-blind, randomized, controlled trial,
we assigned 2539 adults
72 weeks, 5 mg, 10 mg, 15 mg

5 mg : 15 % TBWL
10 mg : 19.5 % TBWL
15 mg : 20.9 % TBWL!!!

Discontinuitation of treatment
5 mg : 4.3 % AEs
10 mg : 7.1 % AEs
15 mg : 6.2 % AEs

NEJM 2022; 387;205-2016

ESG & GLP-1 : combinaison ?

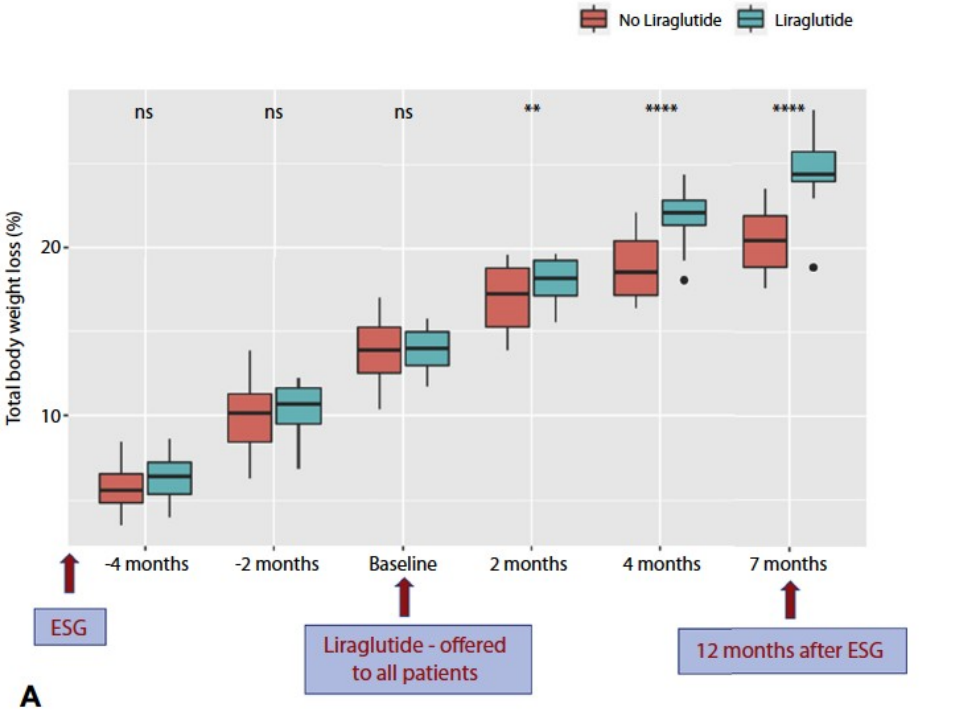


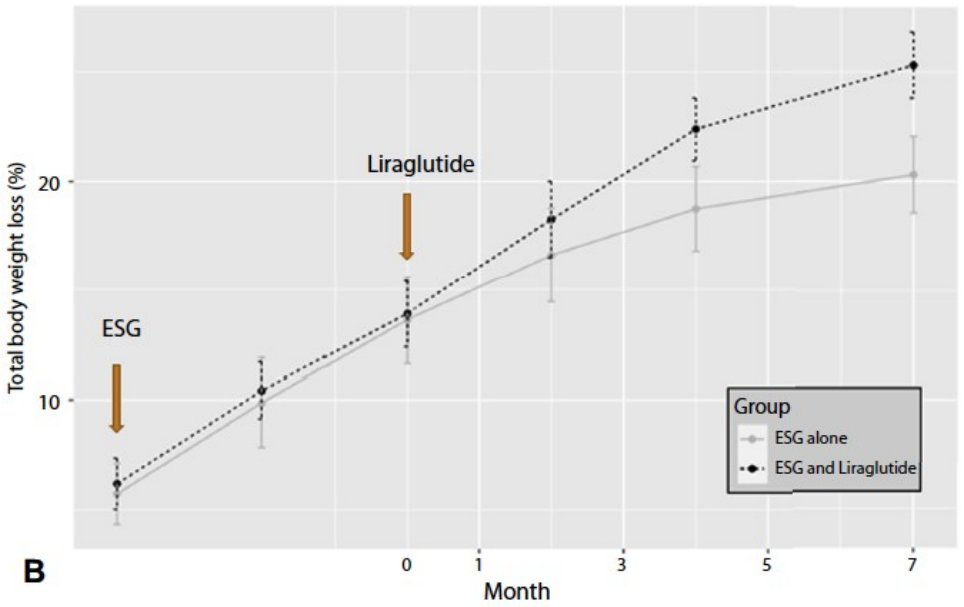
+

Mécanisme d'action non compétitif

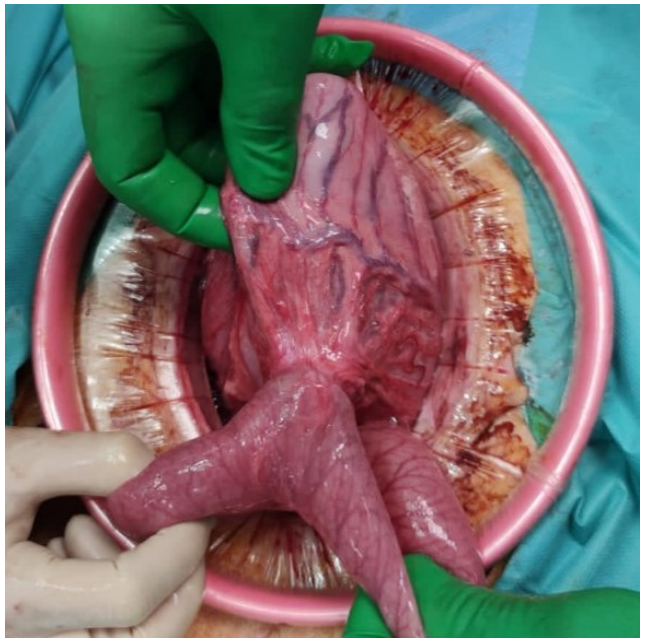
TABLE 2. Comparison of change in absolute weight loss, percent total body weight loss, body mass index loss, percent excess weight loss, visceral fat, and hemoglobin A_{1c} after ESG in patients using or not using liraglutide

Variable	Time (mo)	ESG alone (n = 26)	ESG and liraglutide (n = 26)	*P* value
Absolute weight loss, kg	2	16.93 (3.34)	18.63 (2.62)	.046
	4	19.23 (3.33	22.28 (3.26)	.002
	7	20.95 (3.21)	25.02 (3.80)	<.001
Absolute body mass index, kg/m^2	2	29.65 (1.20)	29.22 (1.88)	.334
	4	28.85 (1.10)	27.93 (1.76)	.028
	7	28.25 (1.06)	26.96 (1.60)	.001
Total body weight loss, %	2	16.57 (2.37)	18.43 (1.55)	.002
	4	18.82 (2.01)	22.02 (1.84)	<.001
	7	20.51 (1.68)	24.72 (2.12)	<.001
Body mass index loss, kg/m^2	2	5.92 (1.00)	6.61 (.77)	.007
	4	6.71 (.93)	7.90 (.95)	<.001
	7	7.31 (.86)	8.88 (1.14)	<.001
Excess weight loss, %	2	56.33 (7.58)	63.12 (12.51)	.022
	4	64.05 (6.43)	75.32 (14.19)	.001
	7	69.94 (6.30)	84.33 (14.57)	<.001
Visceral fat, %	7	10.54 (1.88)	7.85 (1.26)	<.001
Hemoglobin A_{1c}	7	5.40 (.45)	5.09 (.41)	.013





Le futur :
Un bypass endoscopique ?

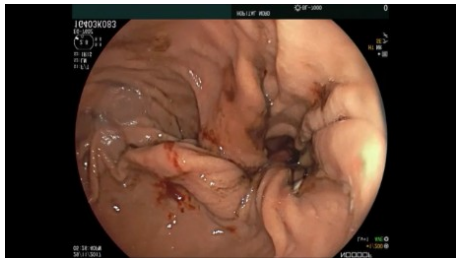


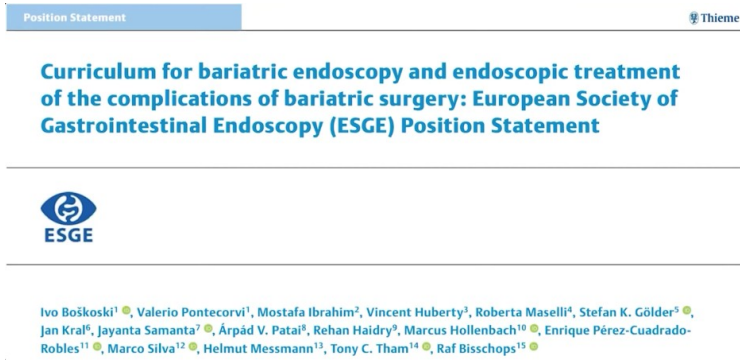
Etudes de validation et mise au point OAGBP

Etude	But	Période	N cochons	Suivi	Publication
Study 1	mise au point	Oct 2019 July 2020	6 white	9 mois	Sci Report 2022
Study 2b	reversibilité pour chirurgie	Fev 2021 Mai 2021	4 white/3 sham	3 mois	Obes Surg 2022
Study 3	OAGB validation miniporcs obèses	May 2021 August 2021	6 obèse/2 sham	3 mois	Sci Report 2022
Study 4	ESG suivie par OAGB	July 2022 Oct 2022	4 white	3 1/2mois	GIE 2024
Study 5	OAGBP minipigs obèses	Feb 2023 May 2023	4 white/2sham	3 mois	Obes Surg 2025

CONCLUSION

- Endosleeve gastroplastie doit être associé à LSM :
  indiquée pour classe I et classe II sans comorbidité
  coût-efficace
- Efficace : pour la perte de poids
  pour amélioration de 50 % des comorbidités : MASH , diabète
- Curriculum SFED Académie : endoscopie bariatrique
  20 ESG; 10 IGB
- Remboursement : dossier en cours




Position Statement

Thieme

Curriculum for bariatric endoscopy and endoscopic treatment of the complications of bariatric surgery: European Society of Gastrointestinal Endoscopy (ESGE) Position Statement

ESGE

Ivo Boškoski[1], Valerio Pontecorvi[1], Mostafa Ibrahim[2], Vincent Huberty[3], Roberta Maselli[4], Stefan K. Gölder[5], Jan Kral[6], Jayanta Samanta[7], Árpád V. Patai[8], Rehan Haidry[9], Marcus Hollenbach[10], Enrique Pérez-Cuadrado-Robles[11], Marco Silva[12], Helmut Messmann[13], Tony C. Tham[14], Raf Bisschops[15]

Points Forts

- L’endoscopie bariatrique est aussi métabolique, avec un effet sur le diabète Type 2, l’hypertension artérielle, la MASH

- Les principales modalités dites restrictives sont le ballon intragastrique, l’endosleeve. L’endosleeve a fait l’objet de 2 études randomisées et leur effet sur la perte de poids est de l’ordre de 15% avec une morbidité <2%

- L’endoscopie métabolique fait appel au resurfaçage de la muqueuse duodénale (duodenal mucosal resurfacing), au bypass duodenojejunal (Duodenojejunal bypass liner) avec pour cible principale le diabète type 2. L’endoscopie restrictive a aussi un impact métabolique

- Les recommandations Américaines et Européennes considérent (suggèrent) que les cibles principales sont les patients classe I (IMC ≥ 30 kg/m² et IMC < 35 kg/m²) ou II sans comobidité (IMC≥ 35 kg/m² and < 40 kg/m²); Elles ont étendu l’indicationde traitement endoscopique aux patients en surpoids avec co-morbidité (>= 27 kg/m²)

- Malgré plusieurs études coût-efficacité, basées sur des modèles de Markov, confirmant un rapport coût-efficacité favorable de l’endosleeve essentiellement en cas d’obésité classe I, le traitement par endosleeve gastroplastie n’a toujours pas obtenu de remboursement.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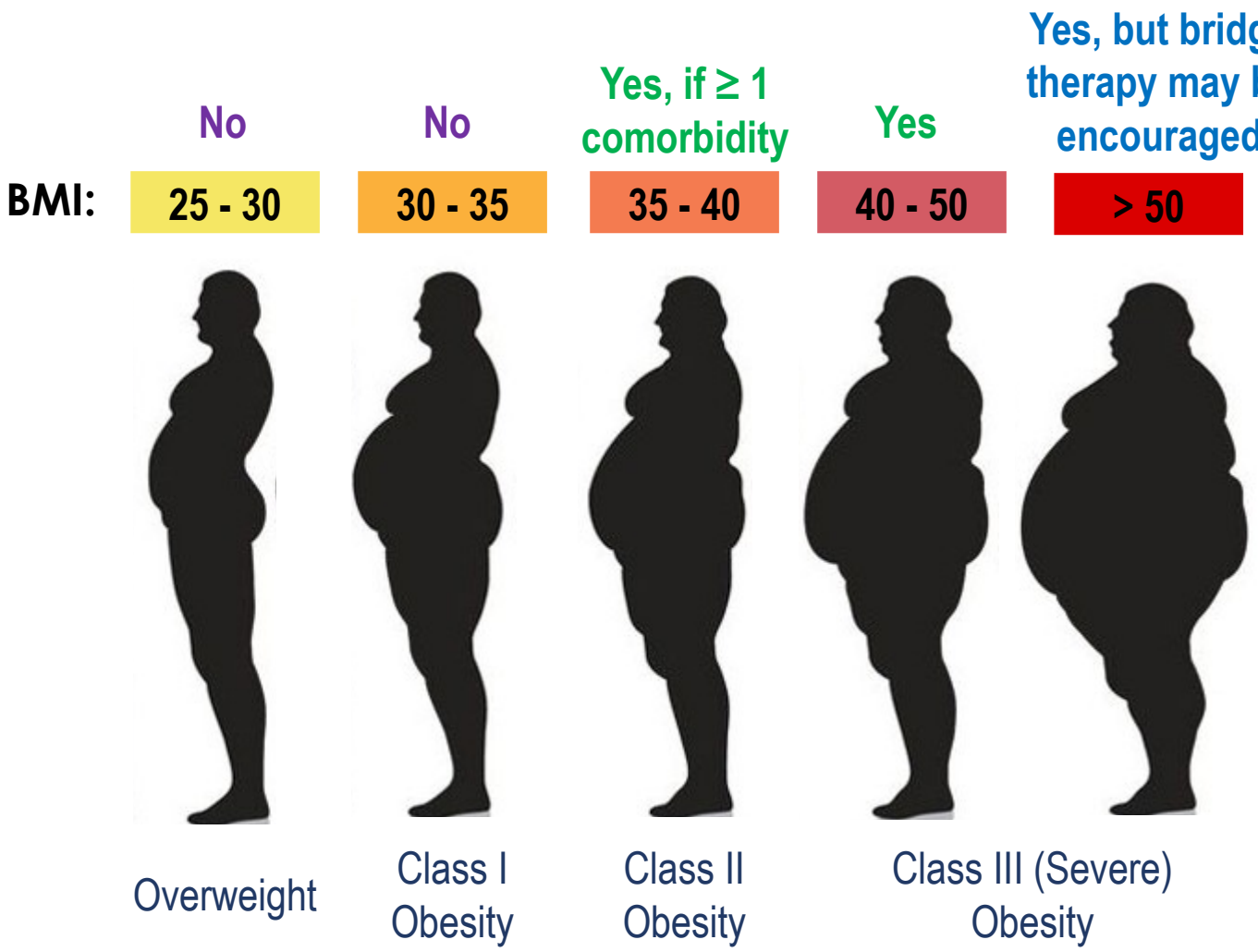
Bariatric Surgery – Gold standard for severe obesity

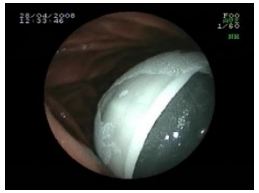


- Bariatric surgery has become safer
- Can be done laparoscopically
- When BMI is too high (>50 kg/m^2), bridging interventions may be encouraged
- Endoscopic procedures can be utilized as bridging interventions
  - Balloons
  - Sleeve gastroplasty
  - Duodenal-jejunal bypass liner
  - Potentially MMM-like procedure

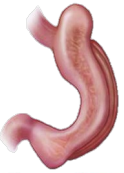
Refs: 13-14

The Endoscopic Weapons (Weight loss+metabolic effect) …

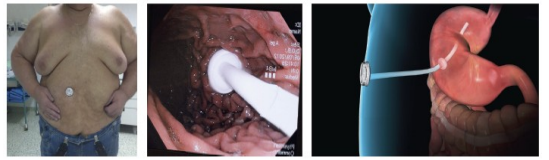
- Intragastric balloons (IGB) TBWL 4.8%



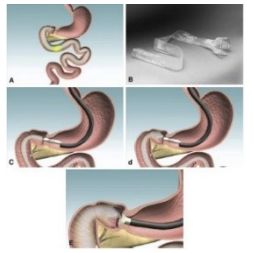
- Endoscopic Sleeve gastroplasty (ESG) TBWL 15%



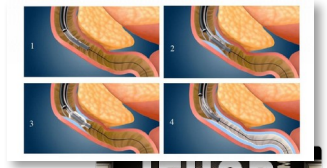
- Aspire TBWL 16.6%



- Duodenojejunal bypass liner (DJBL) NA glycemia target



- Duodenal mucosal resurfacing (DMR) NA glycemia target



Ren M J Clin Trans Hepatol 2022;10:986-984; Jirapinyo P ASGE-ESGE guidelines submitted 2023

Endoscopic sleeve gastroplasty : suivi à long terme

- Prospective study : 5 années suivi

  Patients >30 Kg/m²

  216 patients

  At 5 years : TBWL 15.9%

  90% and 61% maintained TBWL > 5% and 10 %

  pool incidence of AEs : 1.3%, no mortality

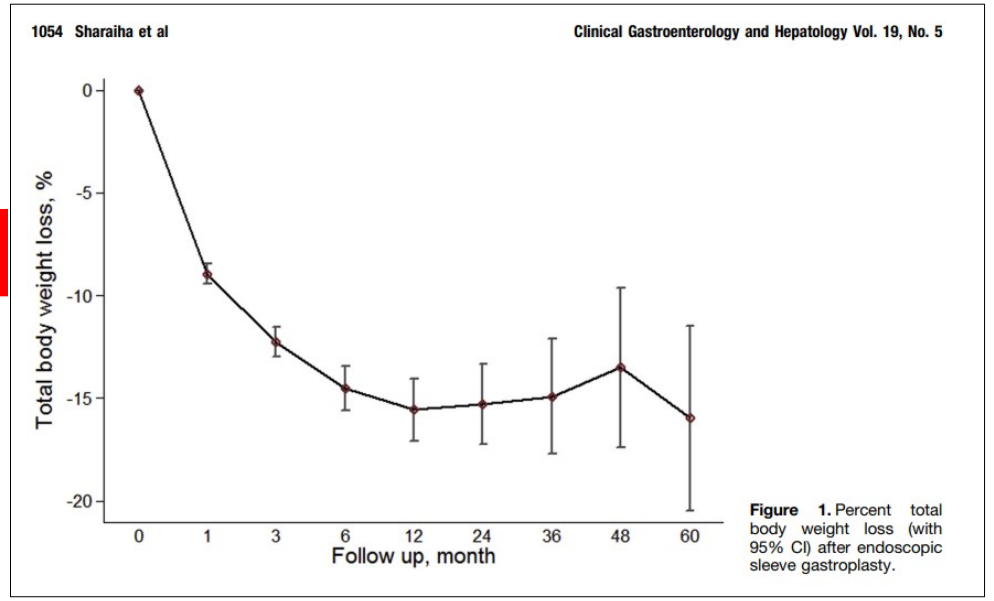


Figure 1. Percent total body weight loss (with 95% CI) after endoscopic sleeve gastroplasty.

Sharaiha R Clin Gastroenterol Hepatol 2021 ;19:1051-7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