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The kidney dietitian's role in supporting patients on Glucagon-like peptides-1 (GLP-1s)

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Aims and objectives

Aim:

To increase awareness and confidence in GLP-1 medications for kidney specialist dietitians

Objectives:

1. Understand the importance of our role in the use of GLP-1s in kidney patients living with obesity
2. Raise awareness of current guidelines and evidence of GLP-1s
3. Explore the short and long terms dietary goals in conjunction with GLP-1s
4. Provide an example of their use and dietary management of a patient on HD living with obesity on semaglutide

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Our role & it's value

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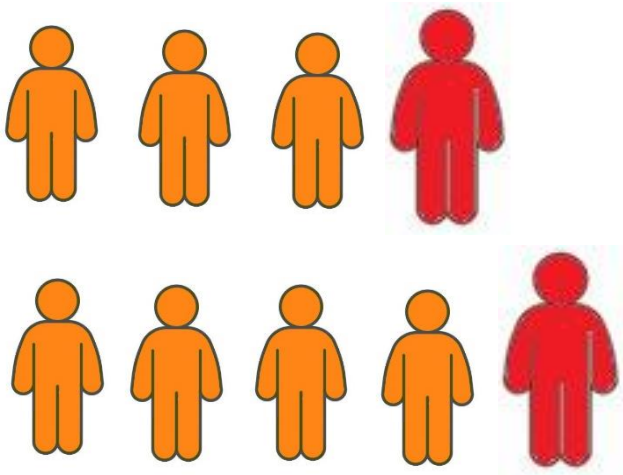
Publication, Part of Health Survey for England

Health Survey for England, 2022 Part 2

Official statistics, National statistics, Survey, Accredited official statistics

Publication Date: 24 Sep 2024
Geographic Coverage: England
Geographical Granularity: Country, Regions, Strategic Health Authorities



1 in 4 adults living with obesity one in five adults who were overweight, aged 35 and over had chronic kidney disease (stage 1 to 5).

- High body mass index (BMI) is a significant risk factor for developing CKD[1] .
- BMI thresholds hinder kidney transplantation[2] .

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Why do we need GLP-1's?

- Lifestyle modifications shown to induce substantial weight loss in only about 20% of patients with obesity[3].
- Kidney-specific nutrient restrictions may further limit the efficacy of these interventions alone in patients with kidney failure[3] .
- GLP-1s receptor agonists induce weight loss, offering attractive treatment options & a potential lifeline for some patients[2].
- Limited literature exists regarding semaglutide use in patients with advanced CKD[2].

Expected weight loss on a GLP-1

- **Research shows mean weight loss of 14.9% on 2.4mg of Semaglutide in 68 weeks (STEP 1 trial[4]).**

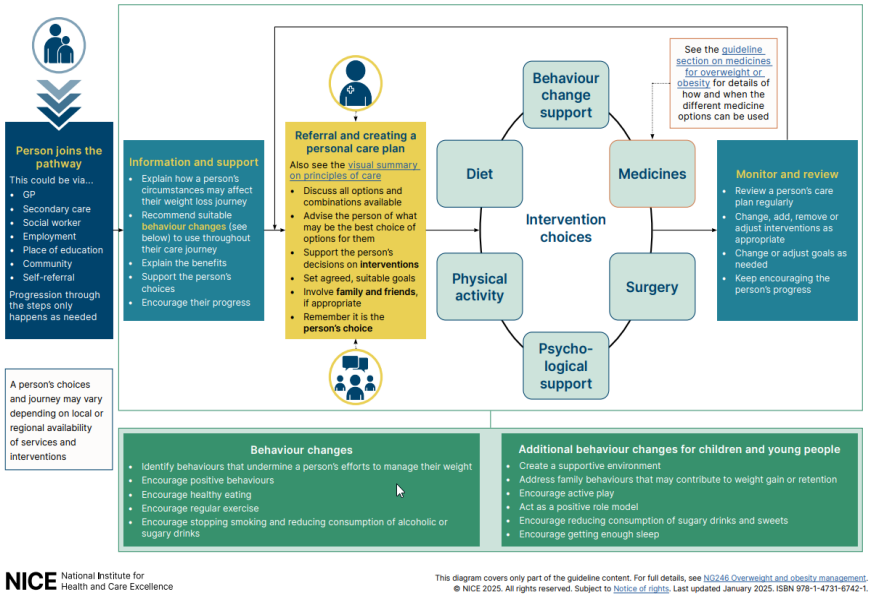
- **For Tirzepatide, average weight loss ranging from 15% to 22% of their initial body weight after 72 weeks when combined with a healthy diet and exercise[5].**

- **New drugs in the pipeline show up to 25% weight loss (comparable to bariatric surgery).**

- **Our Kidney Fitness in Transplantation (K-FiT) service so far has shown average of 7.7% weight loss in 21 patients (mean of 4.53kg) in 6 months (compares to 4.6kg in 12 pts over 12 weeks)[(4)].**

What do the guidelines say?

Overweight and obesity management: the potential care journey



NICE National Institute for Health and Care Excellence

https://www.nice.org.uk/guidance/ng246

Semaglutide for managing overweight and obesity (TA875)

Semaglutide is recommended as an option for weight management, including weight loss and weight maintenance, alongside a reduced-calorie diet and increased physical activity in adults, only if:

- Used for a **maximum of 2 years**, and **within a specialist weight management service** providing multidisciplinary management of overweight or obesity (including but not limited to tiers 3 and 4), and
- they have **at least 1 weight-related comorbidity** and a **body mass index (BMI) of at least 35.0 kg/m2 or**
- **a BMI of 30.0 kg/m2 to 34.9 kg/m2** and meet the criteria for referral to specialist overweight and obesity management services in NICE's guideline on overweight and obesity management.

www.nice.org.uk/guidance/ta875

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What do the guidelines say?

Tirzepatide for managing overweight and obesity

Tirzepatide is recommended as an option for managing overweight and obesity, alongside a reduced-calorie diet and increased physical activity in adults with a **BMI of at least 40 kg/m^2** (adjusted for BME), & **4 or more weight-related comorbidities** such as:

- **high blood pressure**
- **dyslipidaemia (abnormal blood fats)**
- **obstructive sleep apnoea**
- **cardiovascular disease**
- **type 2 diabetes.**

https://www.nice.org.uk/guidance/ta1026

Why are we needed?

- When GLP-1s are discontinued, weight regain is common—with up to two-thirds of the lost weight regained within 1 y[6].

- GLP-1s do not work for everyone, highlighting the complexity of obesity as a disease.

- Patients living with obesity more likely to have suboptimal dietary patterns prior to starting treatment, important to maximise nutrient intake when a lower calorie intake is consumed.

- Kidney patients are complex and likely have other long-term conditions they help support managing.

- Cultural challenges & addressing weight stigma. Use person-first language around obesity.

https://www.bda.uk.com/news-campaigns/campaigns/campaign-topics/managing-and-preventing-obesity/eliminating-weight-stigma-comms-guidelines.html

BDA The Association of UK Dietitians

British Nutrition Foundation

Joint Position Statement regarding GLP-1/GIP Receptor Agonists in people living with obesity and/or type 2 diabetes

Our position statements set out our views on an important area in nutrition and may provide guidance to researchers, regulatory agencies and policy makers, health professionals, the food industry and the media. This position statement was produced by expert nutrition scientists representing both organisations and reviewed by the British Nutrition Foundation's Scientific Committee and BDA's specialist obesity and diabetes groups.

The British Dietetic Association and British Nutrition Foundation support the use of prescribed GLP-1 RA and GLP/GIP RA* when prescribed safely and appropriately in line with national clinical guidelines. These medications should be prescribed alongside a reduced-calorie diet and increased physical activity for adults living with obesity and/or type 2 diabetes with high risk of adverse effects of obesity. There is now considerable evidence of their efficacy at least in the shorter term, that they engender clinically significant weight loss, improvement in glycaemic control, cardiorenal protective benefit and improved quality of life.

https://www.bda.uk.com/resource/new-joint-statement-regarding-glp-1-gip-receptor-agonists-for-people-living-with-obesity-and-or-type-2-diabetes-released.html

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Dietetic Management

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How do we best support?

- Gap between pharmacological research and nutrition research.
- Dietary data lacking from randomized controlled trials of GLP-1s.

Dashti and Szczerbinski (2025) https://advances.nutrition.org/article/S2161-8313(25)00134-6/fulltext

- Nutrition is paramount & should be a foundational element of care, not a secondary add-on.
- Omission of detail of behavioural components in published literature, makes it impossible to determine its contribution to reported outcomes & what care would be effective.

Ibsen et al. (2025)

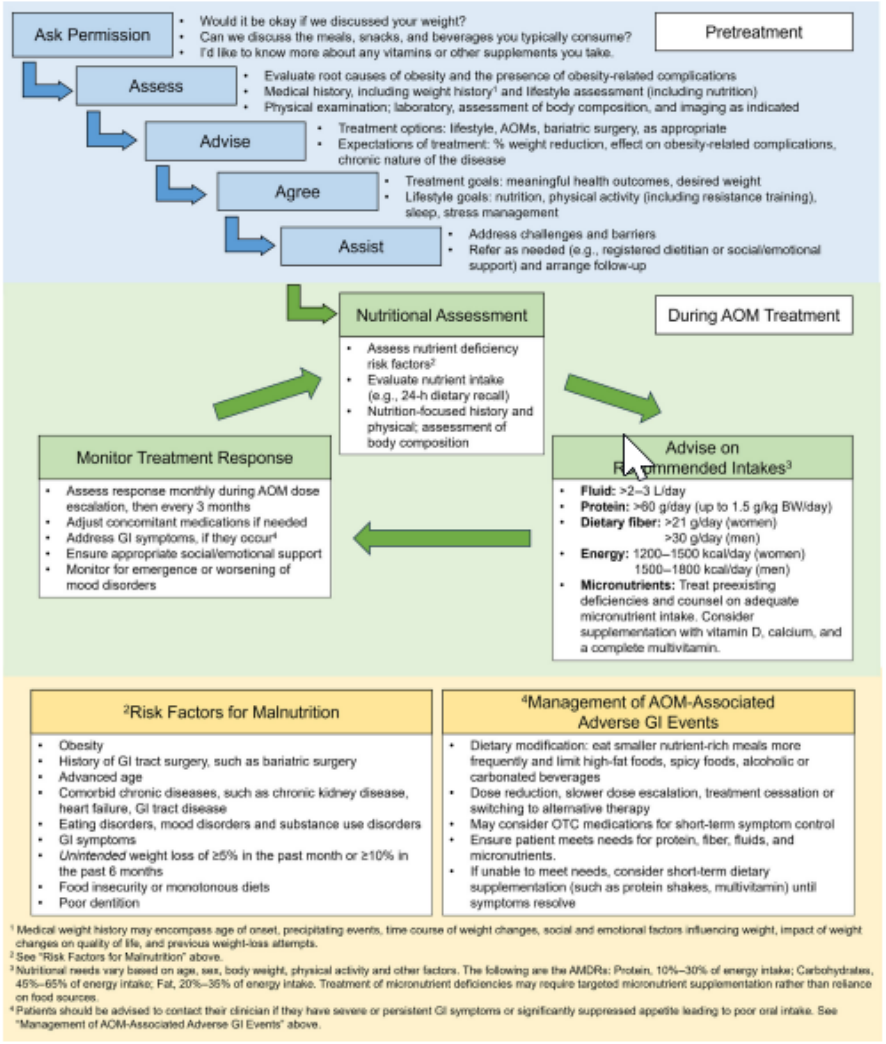
https://ajcn.nutrition.org/article/S0002-9165(25)00457-5/fulltext

What does the literature tell us?

Almandoz et al., 2024

- The 5 A's model (Ask, Assess, Advise, Agree, Assist)

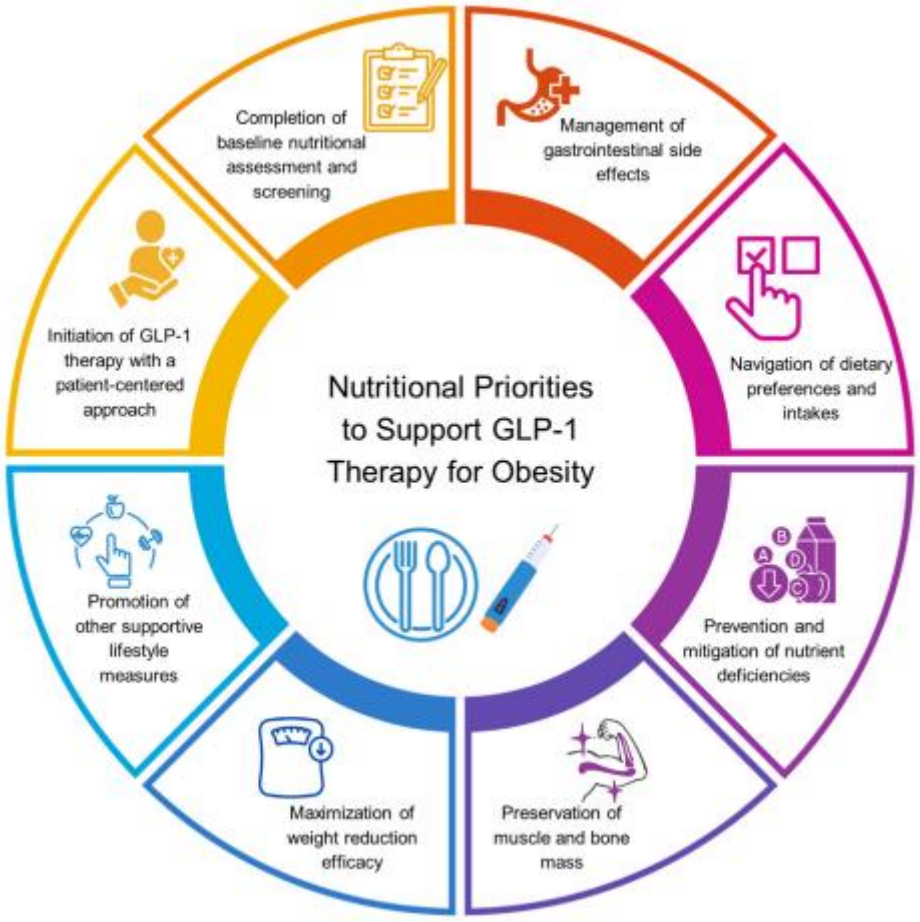
- Daily recommendations
  - 2-3L of fluid per day (not suitable for CKD?)
  - Energy 1200-1500kcal/day (women) & 1500-1800kcal/day (men)
  - Protein 10%-35% of energy intake OR >60-75g/day or 1.5g/kg and personalised
  - Fibre > 21g/day (women) & >30g/day (men)
  - Carbohydrates 45%-65% of energy intake
  - Fats 20%-30% of energy intake (healthy fats)
  - Micronutrient considerations



What does the literature tell us?

Mozaffarian et al, 2025

- 5A's framework
- Protein
  - 0.5g/kg-2g/kg
  - 1.5g/kg or target 80-120g/d
- Strength training
  - 3 times a week
  - 150mins moderate-intensive aerobic activity/week
- Regular support with a Dietitian optimises care
- Consider lifestyle interventions
  - sleep quality, stress



Assessment

- Weight history & previous attempts to lose weight
- Address expectations & weight loss goals
- Eating patterns & preferences

BUT we know weight loss is complex….

MDT Approach

Consider

- Social
- Emotional
- Psychological

- **Support with behaviour change**
- **Monitoring**

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Short term dietary goals

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Managing side-effects & toleration

- Work with clinician re: dose adjustment (consider weight loss, appetite, intake & side-effects)

Eat smaller meals

Stop eating when full

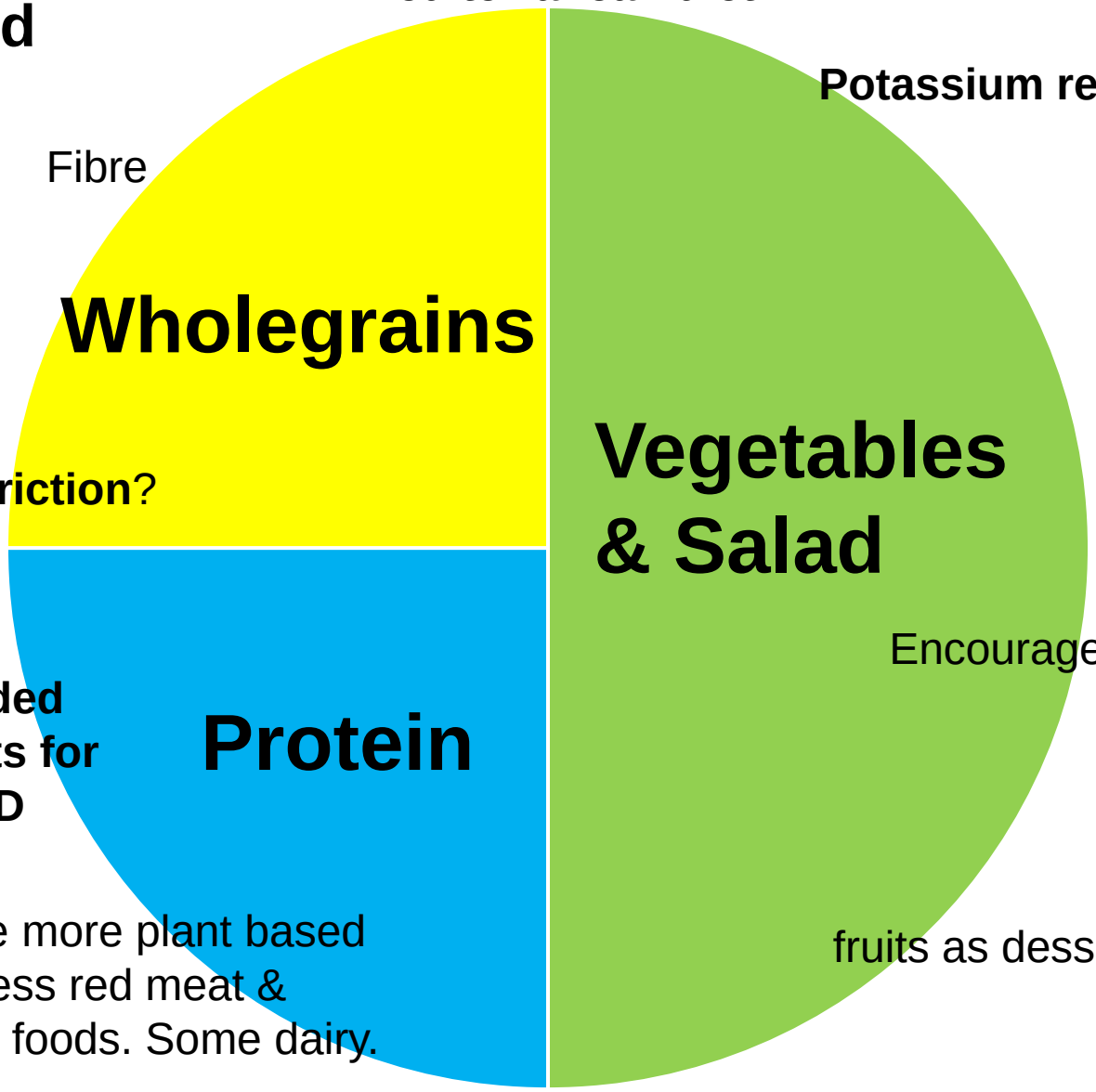
Try bland foods

Avoiding fatty foods

Drinking water

https://zepbound.lilly.com/hcp/dosage

- Support other HCP working with these patients e.g. HD units



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Long term dietary goals

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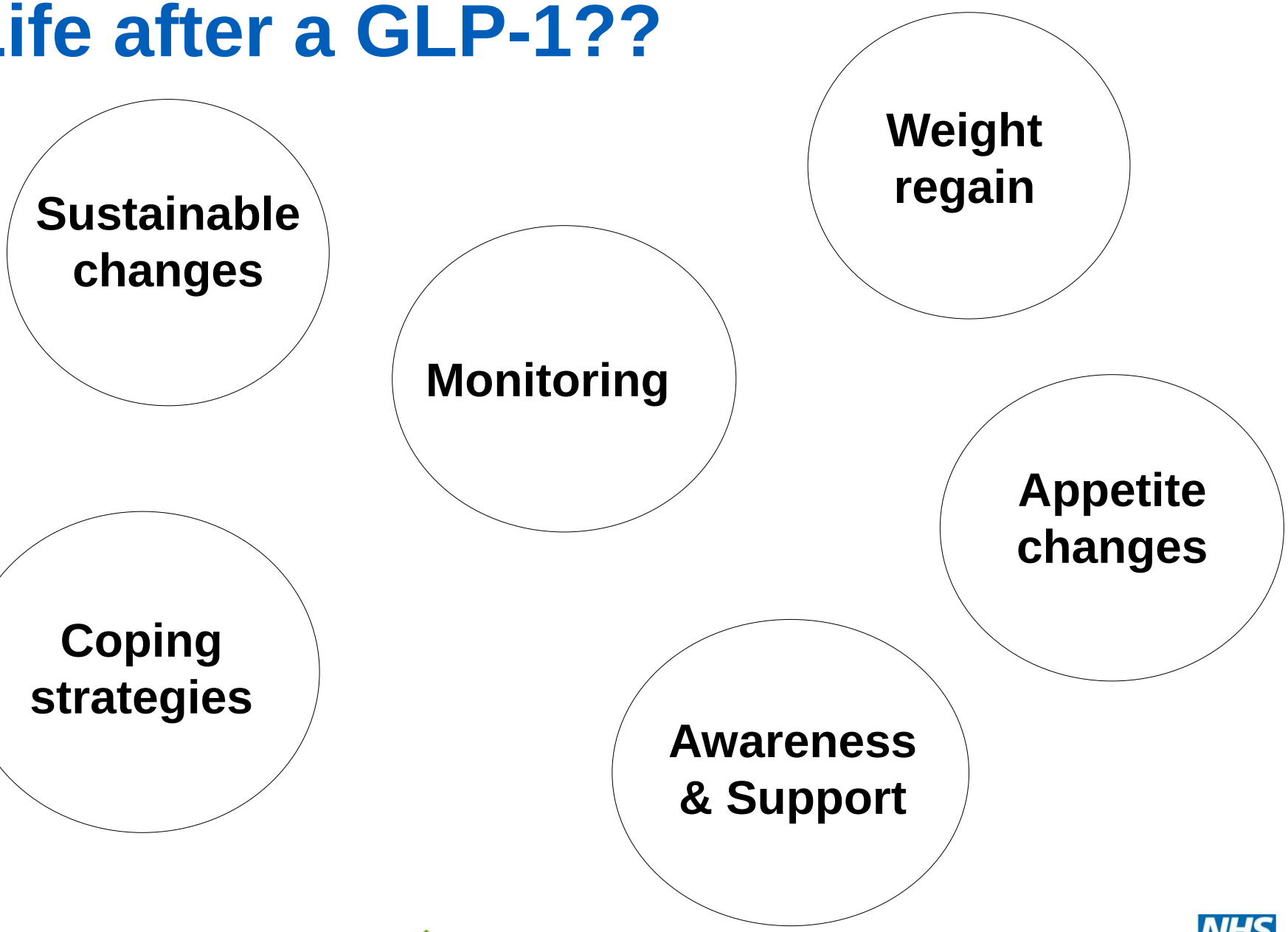
Outcomes

- **Body composition**
  - Weight
  - Waist circumference
  - Hand grip

- **Diet quality**
  - Important to make each meal count
  - Focus on building sustainable eating habits

- **Micronutrients**
  - No evidence/guidance yet for supplements

Life after a GLP-1??



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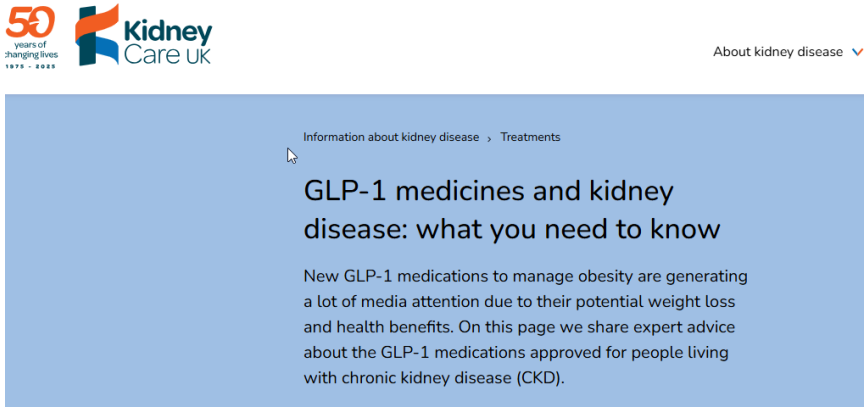
Available Resources

- British Heart Foundation
- Kidney Nutrition Group
- Local bariatric diet sheets
- Kidney Beam (exercises)
- Mindful eating (BDA, headspace, calm)
- Sleep (BDA, sleep charity)
- Lilly website (if appropriate)



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Case study

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1. Started K-FiT August 2024, wt = 119.8kg. Reduced wt. from 130kg since Dec 2023 but plateaued. Target for Tx activation = 117kg

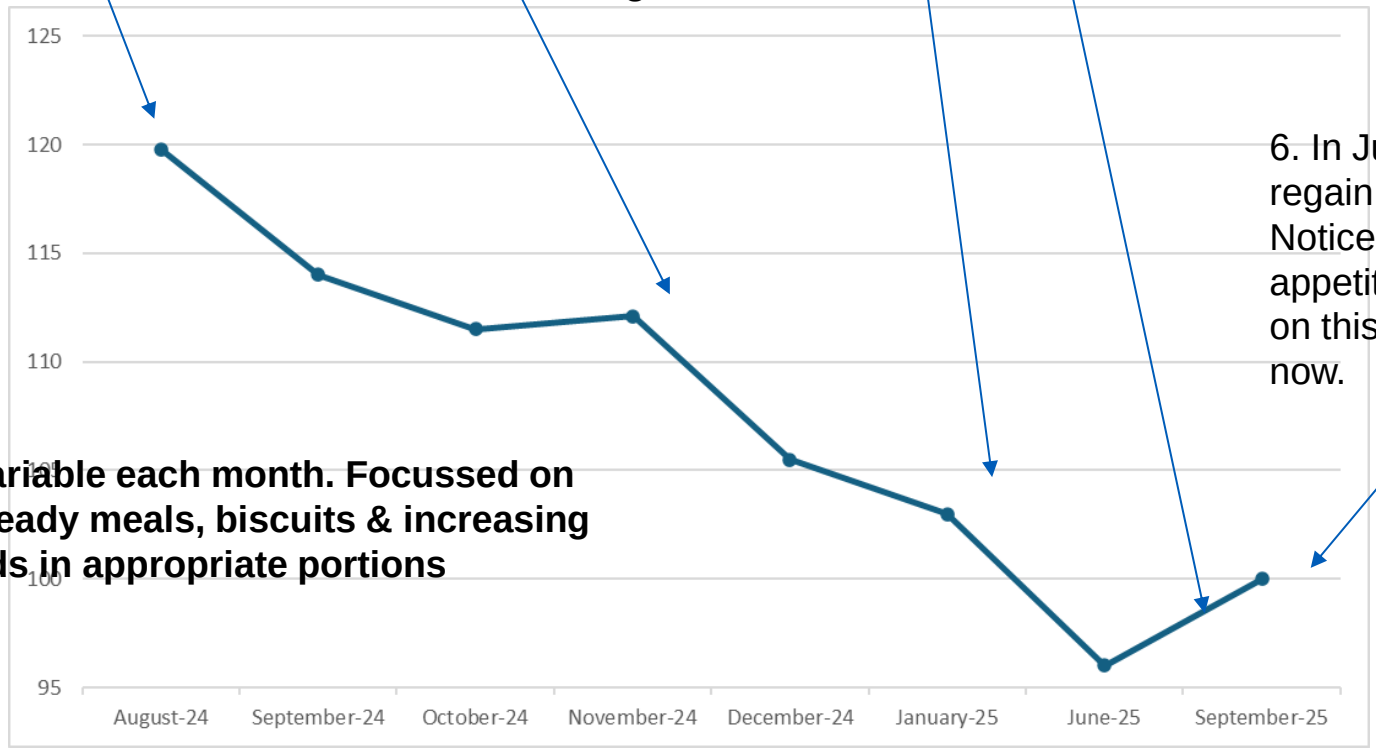
2. Tolerated semaglutide well, went up by ease at each monthly review

3. Activated Nov 2024 @ 112kg.

4. @ 6months, down 16.8kg (14%), 15cm reduction in WC

5. In July, Wegovy dose reduced to 2.4mg fortnightly

6. In July, 4kg wt. regain to 100kg. Noticed increase in appetite. Continues on this dose for now.



Wt. loss variable each month. Focussed on reducing ready meals, biscuits & increasing whole foods in appropriate portions

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Final thoughts

- Upskilling ourselves is key- obesity services are limited
- GLP-1s can be effective for SOME kidney patients
- Dietitian's play a central part in wrap-around care
- MDT input is crucial to its success
- A focus on function, strength, emotional wellbeing, quality of life- NOT just weight alone
- Sustainable weight loss requires long term change

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Thank you

Questions?

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