MDFORLIVES IN-DEPTH INSIGHT REPORT

GLP-1 Therapy in Endocrinology: Where Long-Term Management Gets Hard

A global peer report on incretin penetration, access-driven discontinuation, GI tolerability, treatment plateaus, lean-mass monitoring, maintenance dosing, and the next wave of GLP-1 based therapies.

Endocrinologists · 6 countries · Global peer perspectives

33 Complete responses	**42** Survey records	**6** Countries represented	**78.6%** Completion rate

THE CLINICAL QUESTION

As GLP-1 based therapy becomes routine, where is long-term management becoming most difficult for endocrinologists?

The survey points to a shift from choosing whether to prescribe an incretin toward managing whether the treatment can remain effective, affordable, tolerable, and sustainable over time. Financial access is the strongest reported cause of discontinuation, while gastrointestinal side effects, plateaus, muscle preservation, and maintenance dosing add different kinds of complexity.

Read together, the responses suggest that therapeutic success does not simplify care. It creates a longer management pathway in which clinicians repeatedly balance clinical benefit with what patients can tolerate, afford, and maintain.

> **Coverage:** United States, United Kingdom, Canada, Italy, France, Germany. Survey findings are presented as the opinions and practice patterns reported by participating professionals.

EXECUTIVE SUMMARY

The pattern in one view

Across the dataset, the strongest signal is durability. Incretin exposure is high, but persistence depends on a series of practical decisions that occur after initiation. The findings below show how endocrinologists are navigating that transition.

01 / SIGNAL

Access can override efficacy

Financial barriers are the leading reported reason for first-year discontinuation, separating clinical response from real-world persistence.

02 / SIGNAL

The class retains clinical confidence

Most respondents adapt dose or molecule after GI intolerance rather than moving immediately away from incretin therapy.

03 / SIGNAL

Maintenance is becoming its own treatment phase

Lower-dose maintenance is more common than complete withdrawal after treatment goals are reached.

04 / SIGNAL

Monitoring is not equally mature

Lean-mass risk is recognized, but objective body-composition measurement is not yet routine in this cohort.

> **Reading across the findings:** Three different kinds of durability pressure appear together: treatment access, biological tolerability, and uncertainty about how to maintain benefit after the active weight-loss phase. The survey also adds a fourth layer, monitoring, because lean-mass preservation is being addressed more often through nutrition and exercise than through routine objective measurement. Reading these signals together makes the long-term workload more visible than any single discontinuation statistic.

SECTION 01

Incretin exposure is already high across endocrinology practice

CONTEXT

High prescribing penetration changes the nature of endocrine follow-up. Once a large share of the weekly caseload is receiving incretin-based therapy, even uncommon management problems become recurring operational issues.

DATA

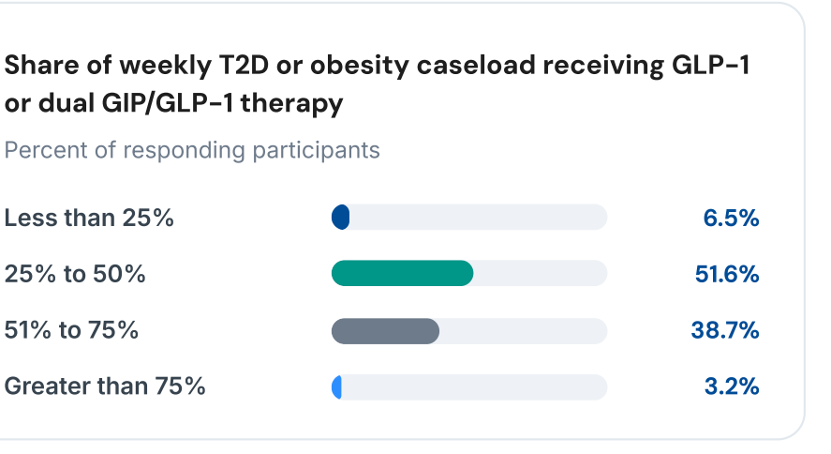
51.6% report that 25% to 50% of their weekly T2D or obesity caseload is receiving a GLP-1 or dual GIP/GLP-1 therapy, and another 38.7% place the share at 51% to 75%.

INSIGHT

Incretin care has moved into the mainstream of this cohort. The relevant question is increasingly how to manage duration, monitoring, and treatment burden at scale.

WHY IT MATTERS

This level of exposure makes follow-up workflow, access support, nutrition counseling, and adverse-effect management part of the core service model.


Share of weekly T2D or obesity caseload receiving GLP-1 or dual GIP/GLP-1 therapy

Percent of responding participants

The pattern also changes what "experience" with the class means. Clinicians are seeing not only early responders but patients at every stage of the treatment arc: initiation, escalation, plateau, interruption, maintenance, and restart.

That wider exposure can create faster learning in practice, but it also exposes evidence gaps that short efficacy trials may not answer, especially around long-term body composition, dose de-escalation, and persistence.

The significance of this finding becomes clearer when it is read against the rest of the dataset. These therapies are no longer an occasional specialist option in this cohort. They are embedded deeply enough in routine caseloads that downstream management issues become everyday endocrinology work. Broader indications, strong glycemic and weight effects, and expanding cardiometabolic evidence have increased exposure, while the chronic nature of therapy keeps patients in ongoing follow-up. The percentage therefore sits inside a broader decision environment rather than operating as a stand-alone trigger.

SECTION 02

Affordability is the largest reported reason for stopping therapy

CONTEXT

The strongest threat to continuity in the survey comes from outside pharmacology. Patients can be clinically eligible, responding, and motivated, yet still lose access because the financing of treatment changes.

DATA

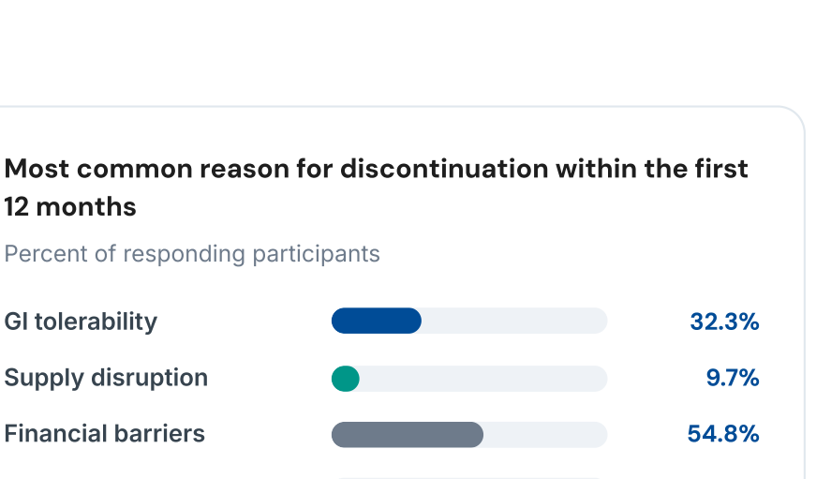
54.8% identify financial barriers as the most common reason for discontinuation within 12 months, compared with 32.3% for gastrointestinal tolerability and 9.7% for supply disruption.

INSIGHT

The treatment pathway is partly an access pathway. In this cohort, affordability appears more likely than side effects to break continuity.

WHY IT MATTERS

When access changes unpredictably, clinicians may need to manage interrupted dosing, alternative therapies, or renewed authorization work even when the original regimen is effective.


Most common reason for discontinuation within the first 12 months

Percent of responding participants

The finding helps explain why clinical efficacy alone cannot predict persistence. A therapy that produces strong metabolic results may still become unstable if coverage is temporary, prior authorization is repeated, or out-of-pocket cost changes.

It also helps contextualize the survey's administrative-time finding: access work is not peripheral paperwork when it directly determines whether the patient remains on therapy.

The significance of this finding becomes clearer when it is read against the rest of the dataset. The strongest break in persistence is not described as lack of efficacy. It is whether treatment remains economically reachable over time. Coverage denials, copays, and formulary restrictions can interrupt therapy even when the clinical response is acceptable, turning treatment continuity into an access problem. The percentage therefore sits inside a broader decision environment rather than operating as a stand-alone trigger.

SECTION 03

Side effects more often trigger adaptation than class abandonment

CONTEXT

Gastrointestinal adverse effects are a familiar challenge with incretin-based therapies, especially around dose escalation. The survey shows how clinicians try to preserve class benefit when tolerability becomes the limiting factor.

DATA

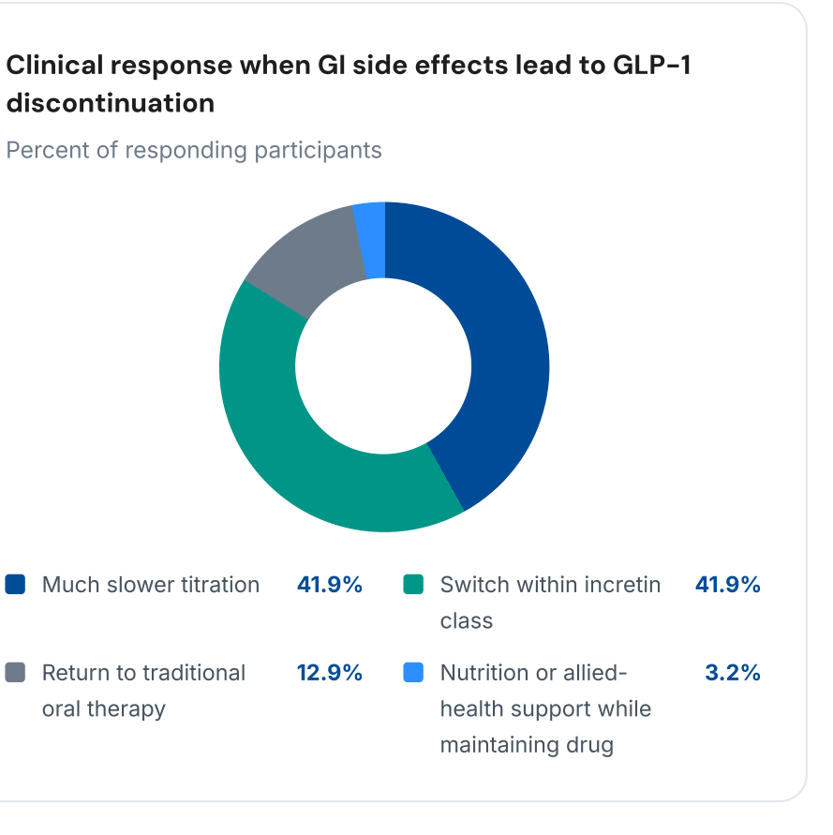
41.9% use a much slower titration schedule and 41.9% switch to a different molecule within the same class after GI intolerance. Only 12.9% move back to traditional oral therapies.

INSIGHT

Most respondents treat intolerance as modifiable rather than as proof that the class has failed for the patient.

WHY IT MATTERS

The result suggests a high level of therapeutic commitment, but it also implies additional visits, counseling, dose changes, and symptom surveillance behind persistence.


Clinical response when GI side effects lead to GLP-1 discontinuation

Percent of responding participants

This adaptive pattern is consistent with the broader principle of individualized titration in current ADA guidance, where the optimal dose is not automatically the maximum approved dose.

The clinical nuance is that "continuing the class" can still represent several very different strategies: slowing the same agent, switching molecules, temporarily reducing exposure, or rebuilding the regimen around tolerability.

The significance of this finding becomes clearer when it is read against the rest of the dataset. The class itself retains clinical value in the eyes of most respondents even when the first treatment experience is difficult. Tolerability can vary with dose escalation, molecule, eating patterns, and individual gastrointestinal sensitivity, leaving room to modify the pathway without giving up the mechanism entirely. The percentage therefore sits inside a broader decision environment rather than operating as a stand-alone trigger.

SECTION 04

A plateau usually creates a reassessment window, not an immediate switch

CONTEXT

A treatment plateau can represent different clinical realities. Weight may stabilize while glycemia remains controlled, or multiple outcomes may stop improving together. The survey asks how long clinicians allow that pattern to persist before altering medication.

DATA

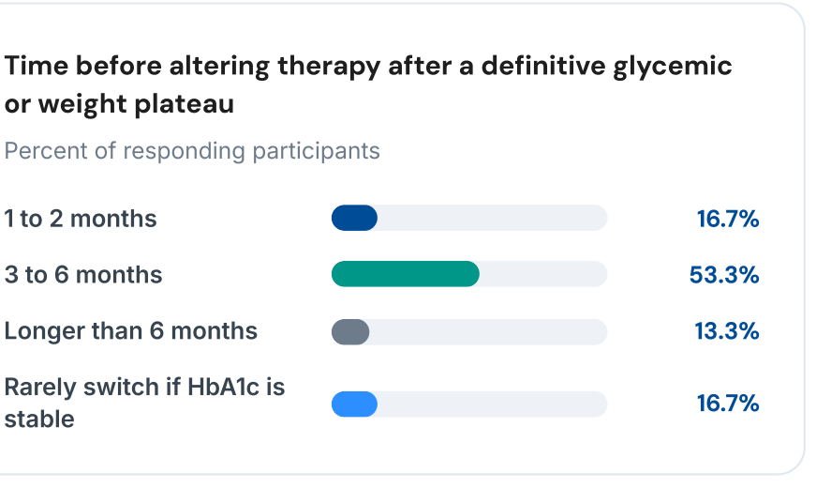
53.3% wait 3 to 6 months before changing therapy after a definitive plateau. Another 16.7% rarely switch if HbA1c remains stable regardless of weight plateau.

INSIGHT

Respondents are not using weight trajectory as a stand-alone trigger in every case. The broader metabolic picture continues to influence the decision.

WHY IT MATTERS

This creates a more complex definition of treatment success, particularly when weight, glycemia, cardiovascular risk, tolerability, and patient expectations move in different directions.


Time before altering therapy after a definitive glycemic or weight plateau

Percent of responding participants

The waiting window may also provide time to examine whether the plateau reflects adherence, nutrition, dose ceiling, or a biologic steady state rather than true loss of therapeutic effect.

For a patient who has reached a stable HbA1c but not a desired weight target, the clinical conversation may be fundamentally different from one in whom both glycemic and weight benefits are deteriorating.

The significance of this finding becomes clearer when it is read against the rest of the dataset. Weight and glycemic goals are not being treated as interchangeable endpoints. Stable HbA1c can justify a different response to a weight plateau than a broader loss of treatment benefit. Plateaus may reflect biology, adherence, nutrition, dose tolerance, or a new steady state, so many clinicians appear to allow time for the pattern to declare itself before changing treatment. The percentage therefore sits inside a broader decision environment rather than operating as a stand-alone trigger.

SECTION 05

Lean-mass protection is recognized, but monitoring remains uneven

CONTEXT

As incretin therapies produce larger weight changes, preserving function and nutritional adequacy has become a more visible part of long-term care. The survey explores how that concern translates into monitoring.

DATA

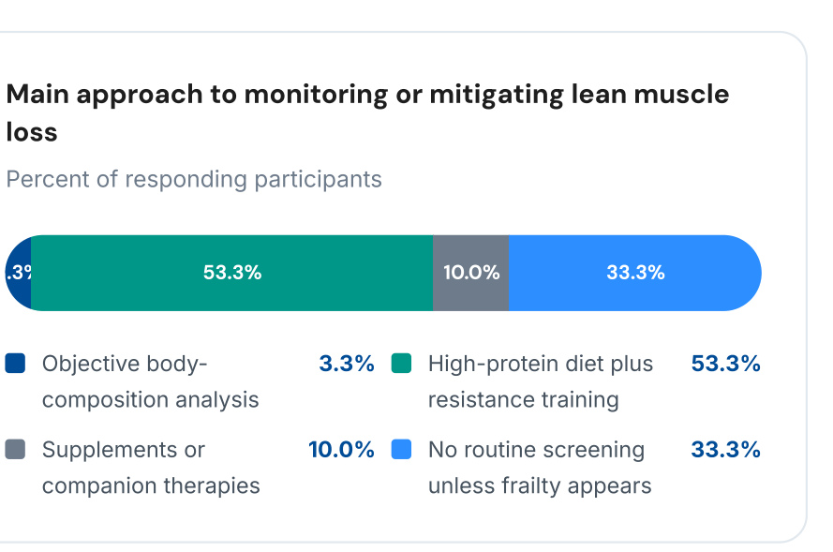
53.3% rely on a high-protein dietary threshold combined with structured resistance training, while 33.3% report no routine screening unless patients appear frail. Only 3.3% use routine objective body-composition analysis.

INSIGHT

The prevention message appears stronger than the measurement infrastructure. Most respondents act through counseling, but relatively few quantify body composition routinely.

WHY IT MATTERS

The gap can make early loss of lean mass difficult to distinguish from expected weight reduction unless functional decline or frailty becomes visible.


Main approach to monitoring or mitigating lean muscle loss

Percent of responding participants

This is an area where clinic resources matter. Objective measurement requires equipment, interpretation, time, and often reimbursement pathways that are not available in every practice.

The pattern therefore may reflect infrastructure as much as clinical preference. It also helps explain why respondents' open-text evidence gaps frequently mention long-term body composition and muscle outcomes.

The significance of this finding becomes clearer when it is read against the rest of the dataset. The survey shows stronger consensus around prevention behaviors than around objective measurement of body composition. DXA or bioimpedance testing may not be built into every endocrine workflow, whereas nutrition and exercise counseling are more immediately available. The percentage therefore sits inside a broader decision environment rather than operating as a stand-alone trigger.

SECTION 06

Maintenance therapy is leaning toward dose reduction rather than stopping

CONTEXT

Reaching a goal does not end the treatment question. It begins a different one: how much pharmacologic intensity is needed to preserve benefit without adding unnecessary burden or cost.

DATA

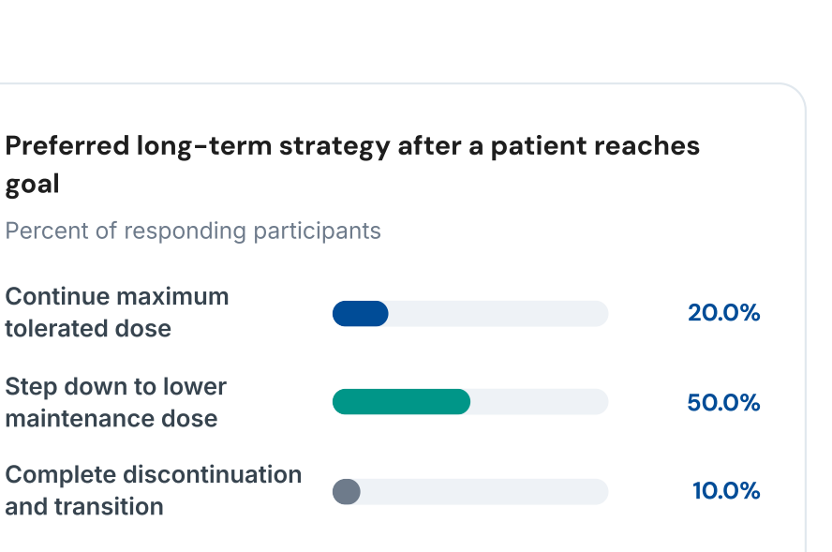
50.0% favor stepping down to a lower maintenance dose, 20.0% continue the maximum tolerated dose, 20.0% favor intermittent or pulse dosing, and 10.0% prefer complete discontinuation and transition.

INSIGHT

Maintenance is the dominant frame. Complete withdrawal is the least common default in this cohort.

WHY IT MATTERS

The pattern fits a view of obesity and type 2 diabetes management as chronic, while also showing uncertainty about the best dose and schedule once active weight loss is no longer the main objective.


Preferred long-term strategy after a patient reaches goal

Percent of responding participants

Current ADA guidance recognizes that pharmacotherapy may need to continue after goals are reached because withdrawal can be followed by weight recurrence and worsening cardiometabolic risk. The survey adds a real-world question that guidelines do not fully resolve: what maintenance intensity clinicians prefer.

The split across full-dose, step-down, intermittent, and discontinuation strategies highlights an evidence gap around long-term dosing architecture, not simply drug selection.

The significance of this finding becomes clearer when it is read against the rest of the dataset. Most respondents appear to view success as something that still requires pharmacologic maintenance, even when intensity may change. Concerns about weight recurrence and cardiometabolic deterioration after stopping therapy make complete withdrawal a less common default, while lower-dose maintenance offers a middle path. The percentage therefore sits inside a broader decision environment rather than operating as a stand-alone trigger.

PRACTICE PATTERN

What may be sitting underneath the responses

These are interpretive patterns, not clinical recommendations. They describe the tensions that appear across the survey when individual findings are read together.

Open-text responses repeatedly return to the same unresolved themes: long-term safety, hard cardiovascular and renal outcomes, lean-mass and body-composition effects, affordability, adherence, duration of therapy, maintenance dosing, and rebound after withdrawal. These comments deepen the quantitative pattern by showing that endocrinologists are looking beyond early weight or HbA1c response toward what happens over years of treatment.

Persistence is partly economic

Access pattern

The largest reported discontinuation driver is financial, suggesting that treatment durability can depend on coverage as much as pharmacology.

Adaptation protects class continuity

Tolerability pattern

Dose and molecule changes are used more often than class abandonment, indicating continued confidence in the underlying mechanism.

Success creates a maintenance question

Long-term pattern

After goals are reached, respondents more often reduce or continue therapy than stop it completely.

Measurement capacity trails awareness

Monitoring pattern

Lean-mass risk is visible in clinical thinking, but objective body-composition monitoring remains uncommon in this cohort.

CLOSING PERSPECTIVE

Incretin therapy is becoming a durability discipline

The central story in this survey is not whether endocrinologists believe GLP-1 based therapy works. High weekly exposure and the preference to adapt therapy after intolerance suggest substantial clinical confidence. The more difficult questions emerge after confidence has already been established.

Financial barriers are the clearest break in continuity. Gastrointestinal tolerability creates another layer of adaptation, but clinicians most commonly slow titration or switch within class rather than abandon the mechanism. Plateaus are often observed for several months, and stable glycemia can justify staying the course even when weight loss has leveled off. These are all signs of a treatment category maturing from episodic prescribing into chronic management.

The same transition exposes areas where routine practice is still catching up. Lean-mass preservation is addressed mainly through nutrition and resistance training, while objective measurement remains rare. Maintenance strategy is also unsettled, with half favoring lower-dose continuation but meaningful minorities preferring full-dose or intermittent approaches.

Taken together, the opinions point to a future in which the value of incretin therapy will be judged not only by early weight or HbA1c change, but by whether benefit can be sustained through cost, tolerability, body composition, patient expectations, and years of follow-up.

Questions professionals continue to ask

This topic remains dynamic. The questions below reflect common practical searches around the field rather than retrospective questions about this survey.

Why do patients stop GLP-1 therapy even when it is working?

Common reasons include gastrointestinal side effects, cost or insurance barriers, supply interruptions, and difficulty sustaining long-term treatment. The relative importance of each factor varies by patient and health system.

What happens when weight loss plateaus on a GLP-1 therapy?

A plateau can prompt reassessment of adherence, dose tolerance, nutrition, physical activity, metabolic goals, and whether glycemic or cardiometabolic benefits are still being maintained.

Can GLP-1 treatment contribute to loss of lean muscle mass?

Significant weight loss can include both fat and lean mass. Protein intake, resistance exercise, nutritional adequacy, and assessment of frailty or body composition may become relevant depending on the patient.

Is GLP-1 therapy usually stopped after a patient reaches a weight goal?

Many obesity treatments are considered chronic therapies because stopping can be followed by weight recurrence. Long-term dosing and maintenance strategy are individualized around benefit, tolerability, access, and patient goals.

How are gastrointestinal side effects managed during incretin therapy?

Clinical approaches can include slower dose escalation, dietary adjustments, symptom review, dose modification, or changing agents. Persistent or severe symptoms require clinical reassessment.

What new incretin therapies are endocrinologists watching?

Pipeline development includes multi-receptor agonists, oral non-peptide GLP-1 agents, amylin combinations, and higher-dose formulations, with interest focused on efficacy, tolerability, convenience, and long-term outcomes.

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SELECTED EXTERNAL CONTEXT

1. American Diabetes Association, Standards of Care in Diabetes 2026 - Obesity and Weight Management
2. American Diabetes Association, Standards of Care in Diabetes 2026 - Pharmacologic Approaches

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