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GLP-1 Receptor Agonists: Rewriting the Perioperative Fasting Guidelines

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Dear Editor,

Type 2 diabetes and obesity together have grown into one of the biggest public health and economic burdens of our time.

Glucagon-like peptide-1 (GLP-1) receptor agonists—semaglutide (Wegovy) and tirzepatide (Mounjaro) among them are now widely prescribed for both diabetes control and weight loss. Their growing popularity has created a fresh challenge for anaesthetists: the existing perioperative fasting guidelines need to be rewritten to keep pace. These drugs slow gastric emptying, and several case reports have shown that patients can still have significant residual gastric content even after following standard nil-by-mouth (NBM) protocols [1, 2]

We believe every patient on a GLP-1 receptor agonist should be treated, provisionally, as having a full stomach for aspiration risk regardless of how long they have fasted or when they last took the drug. Point-of-care gastric ultrasound of the antrum, where available, offers a better way to judge this on an individual basis than relying purely on fixed fasting windows or the drug's half life [3]. If solid

residue is found, the options include postponing elective surgery, decompressing the stomach with a nasogastric tube where feasible, performing rapid sequence induction with cricoid pressure, or avoiding supraglottic airway devices in favour of endotracheal intubation.

Guidance from professional societies has shifted, but not uniformly. The American Society of Anaesthesiologists' (ASA) 2023 consensus statement recommended withholding the drug beforehand while keeping standard fasting intervals unchanged. That advice drew criticism for being weakly evidence-based and for risking unnecessary glycaemic instability.

By October 2024, the ASA's updated multi society guidance reaffirmed in 2025—took a different approach: continue the medication, but extend preoperative fasting to 24 hours of clear liquids for higher risk patients [4]. Many institutions have yet to adopt this change, and practice on the ground still varies widely.

What is needed now is greater consistency across society guidelines, along with wider use of gastric ultra-sound as part of routine preoperative

assessment for this expanding group of patients.

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