THE ARISING

ARISING HEALTH / READING COLLECTION

METABOLIC HEALTH / 01

Beyond the first prescription

GLP-1 medicines,
metabolic health,
and the connection to sleep.

Two full articles. One connected question.

What changes in people's health and capacity - and what makes that improvement sustainable?

JOHN GRIFFIN, MD

25 OCTOBER 2026 / VISUAL EDITION 1.1

Alive. Awake. Aware.

Educational reading. Imagined observatory artwork.
Scientific text and evidence review dates retained.



Beyond the first prescription

What a study of older adults can - and cannot - tell us about sustained GLP-1 use.

Study publication: October 22, 2026. Reading edition: October 25, 2026.

A medication's promise is tested in ordinary life: whether someone can obtain it, tolerate it and keep using it. Today's GLP-1 story starts there. In a large Israeli health-record study, older adults who collected more prescriptions had better weight and blood-sugar outcomes than those who collected only one or two. The result is worth following. It is not proof that continuing a drug caused every difference.

What the researchers compared

Zaritsky and colleagues studied records from Clalit Health Services for 13,387 adults aged 65 or older. Everyone had obesity and no diabetes at the start, and all had paired body-mass-index measurements. Sixty-nine percent were women. The researchers defined minimal exposure as one or two prescription dispensations and sustained exposure as three or more.

This definition matters. Three fills do not establish years of continuous treatment, an exact dose or actual medication use. The comparison was between two groups who had started treatment, not between people randomly assigned to a GLP-1 medicine and a placebo.

The findings

The primary outcome was improvement to a lower BMI category. That occurred in 55% of the sustained-exposure group and 30% of the minimal-exposure group. Blood-sugar categories also improved more often in the subset with paired HbA1c measurements, and diagnosed diabetes was less frequent in the sustained group.

The main statistical model adjusted for age, sex, socioeconomic status and other medical conditions. The study was published online in Diabetes, Obesity and Metabolism on October 22, 2026. Our appraisal here is limited to the primary abstract. It does not supply a follow-up duration, so these findings should not be turned into a fixed annual prevention estimate.

The question behind the association

People who continue treatment can differ from those who stop. Tolerability, access, other illness and health habits may influence both prescription fills and outcomes. Adjustment cannot remove every such difference. The authors explicitly describe observed changes after treatment initiation, rather than a proven causal treatment effect.

For longevity, the useful question reaches beyond a number on a scale: what changes in health and daily function, for whom, for how long, and with what trade-offs? This study addresses metabolic outcomes in a particular older population. It did not establish lifespan extension, measure every potential harm or answer whether one individual should take a medicine.

The next step is to connect these real-world patterns with randomized evidence and clearer information on duration, discontinuation and function. The possibility is substantial; the conclusion should remain the size of the evidence.

Primary source: PubMed 42919108

Where weight and sleep apnea meet

A 2024 randomized trial offers context for the newer GLP-1 headlines.

Study publication: 2024 (October 3 journal issue). Reading edition: October 25, 2026.

Sleep apnea makes an important connection between metabolic health and the night. But a connection is not enough: we need to know whether a particular treatment changes a meaningful outcome in a defined group of people. The SURMOUNT-OSA trials provide a more direct test than an observational headline.

Two trials, a specific population

The researchers ran two phase 3, double-blind randomized trials in adults with obesity and moderate-to-severe obstructive sleep apnea. One trial enrolled people not receiving positive-airway-pressure treatment at baseline; the other enrolled people who were receiving it. Participants received tirzepatide or placebo for 52 weeks. This is established 2024 evidence, revisited for context, not a newly completed October 2026 trial.

The primary measure was the apnea-hypopnea index, or AHI: the number of breathing interruptions or reductions per hour of sleep. It describes the sleep disorder. It is not a measurement of lifespan or proof that a future heart attack was prevented.

What changed

In the first trial, AHI fell by 25.3 events per hour with tirzepatide and 5.3 with placebo. The estimated between-group difference was 20.0 fewer events per hour, with a 95% confidence interval of 14.2 to 25.8 fewer. In the second trial, the corresponding difference was 23.8 fewer events per hour, with a 95% confidence interval of 17.9 to 29.6 fewer.

The primary abstract also reports improvements in body weight, hypoxic burden, blood pressure and patient-reported sleep outcomes. Gastrointestinal adverse events were the most frequent side effects and were mostly mild to moderate. Eli Lilly funded the trials. These findings concern tirzepatide in the studied population; they do not automatically establish an identical effect for every GLP-1 medicine.

What the result does not settle

The trial does not establish that all sleep apnea disappears with weight loss or that prescribed airway-pressure treatment can be stopped. It also does not separate every contribution of weight loss from other possible pathways. Long-term outcomes beyond the trial and decisions for an individual require additional evidence and clinical assessment.

Today's newsletter also describes conference reports about GLP-1 medicines and sleep apnea. Those reports raise useful questions, but their numerical claims are not reproduced here because their underlying abstracts have not been checked for this booklet. Randomized results, retrospective associations and conference reporting deserve different levels of confidence.

This is why the sleep collection and the metabolic story belong beside one another. Breathing, sleep, weight and function can be related while remaining distinct outcomes. Following the connections should make our questions more precise.

Primary source: PubMed 38912654

Keep following the question.

The article is a beginning. The collection is where the connections unfold.

This PDF is a dated edition. A downloaded copy does not update itself; the living collection can change as evidence and explanations improve.

01 Read the current GLP-1 companion

02 Explore sleep, light, cortisol and brain health

03 Open the illustrated sleep booklet

04 Read the October 25 Substack Note

05 Join the LinkedIn discussion

06 Follow the Bluesky thread

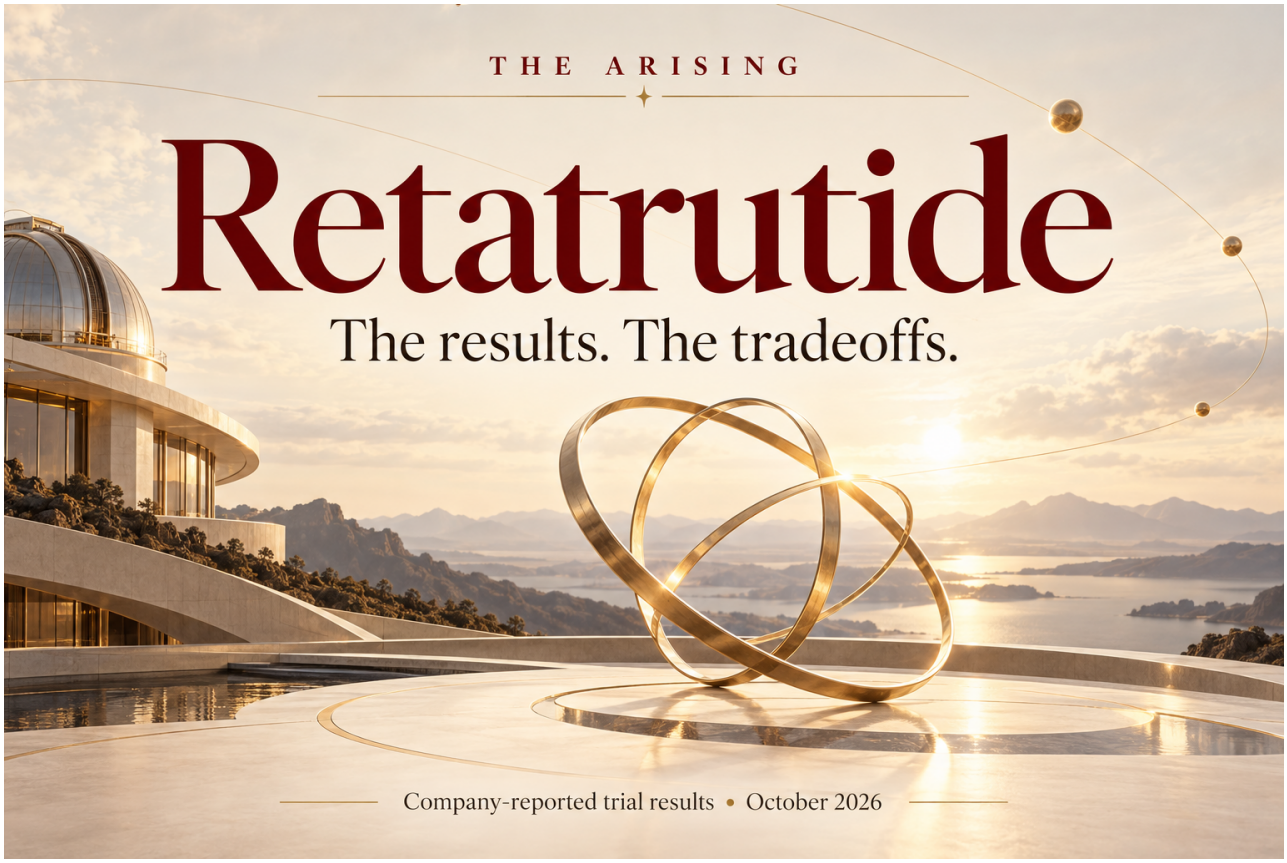
Source and update note

The GLP-1 cohort and SURMOUNT-OSA primary PubMed abstracts were checked October 25. Full texts, supplements and a comprehensive correction search were not appraised. The 2026 conference-derived percentages are held rather than promoted. This is not a systematic review.

Version 1.1 replaces the botanical artwork with a celestial, science-fiction design and Arising branding. The two scientific articles are unchanged. This design update is not a new evidence audit.

Clinical outcomes, associations, mechanisms and lifespan extension are distinct claims. Bring questions about symptoms or medication to your own clinician.

Alive. Awake. Aware.



GLP-1 COLLECTION · OCTOBER 30, 2026 · v1.2

Retatrutide: greater weight loss, more treatment withdrawals

The next generation of metabolic medicines will be judged by benefits people can sustain. The Arising's October 29 full article examined retatrutide, an investigational medicine acting on GIP, GLP-1 and glucagon receptors. This October 30 update checks Lilly's original October 28 announcement and the trial registry.

What Lilly reported

In an 80-week randomized, open-label comparison with Ozempic 2 mg in adults with type 2 diabetes, the 12 mg retatrutide group had average weight loss of 20.9%, versus 9.4%. A1C fell by 2.2 versus 1.8 percentage points. These are company-reported topline results, not an independently replicated finding or a full peer-reviewed paper.

The tradeoff belongs beside the benefit

Treatment discontinuation because of adverse events was 7.9% with retatrutide 12 mg versus 2.7% with Ozempic. Common adverse events included gastrointestinal symptoms. A larger average benefit does not tell us whether a particular person will tolerate or benefit from treatment.

How the analysis was framed

The reported efficacy estimate assumes participants remained on treatment without additional glucose-lowering medication. It should not be read as the expected result for everyone who starts treatment. The original announcement supplies more detail than the secondary article: it reports 1,298 participants. The older September 28 registry still lists an estimated 1,250 and has no posted results. Those dated records are not interchangeable.

Where this fits in The Arising

Our GLP-1 collection follows glucose control, sleep, bone health and the ability to stay active. This trial addresses weight and A1C; it does not establish longer life, preserved muscle or fewer heart attacks. Those outcomes require their own evidence. Retatrutide remains investigational in Lilly’s announcement. This article is education, not advice to obtain or change a medicine.

What comes next

A full publication should clarify missing data, treatment-policy results, serious harms and subgroup differences. Sustained health and daily function remain the questions worth following alongside weight loss.

Lilly primary announcement, October 28, 2026
ClinicalTrials.gov NCT06260722
Source article: the-arising-2026-10-29(1).pdf, pp. 6-7. Review: announcement and registry only. Lilly-sponsored; full paper pending. Claim AR-20261030-RETA-01.
Alive. Awake. Aware.