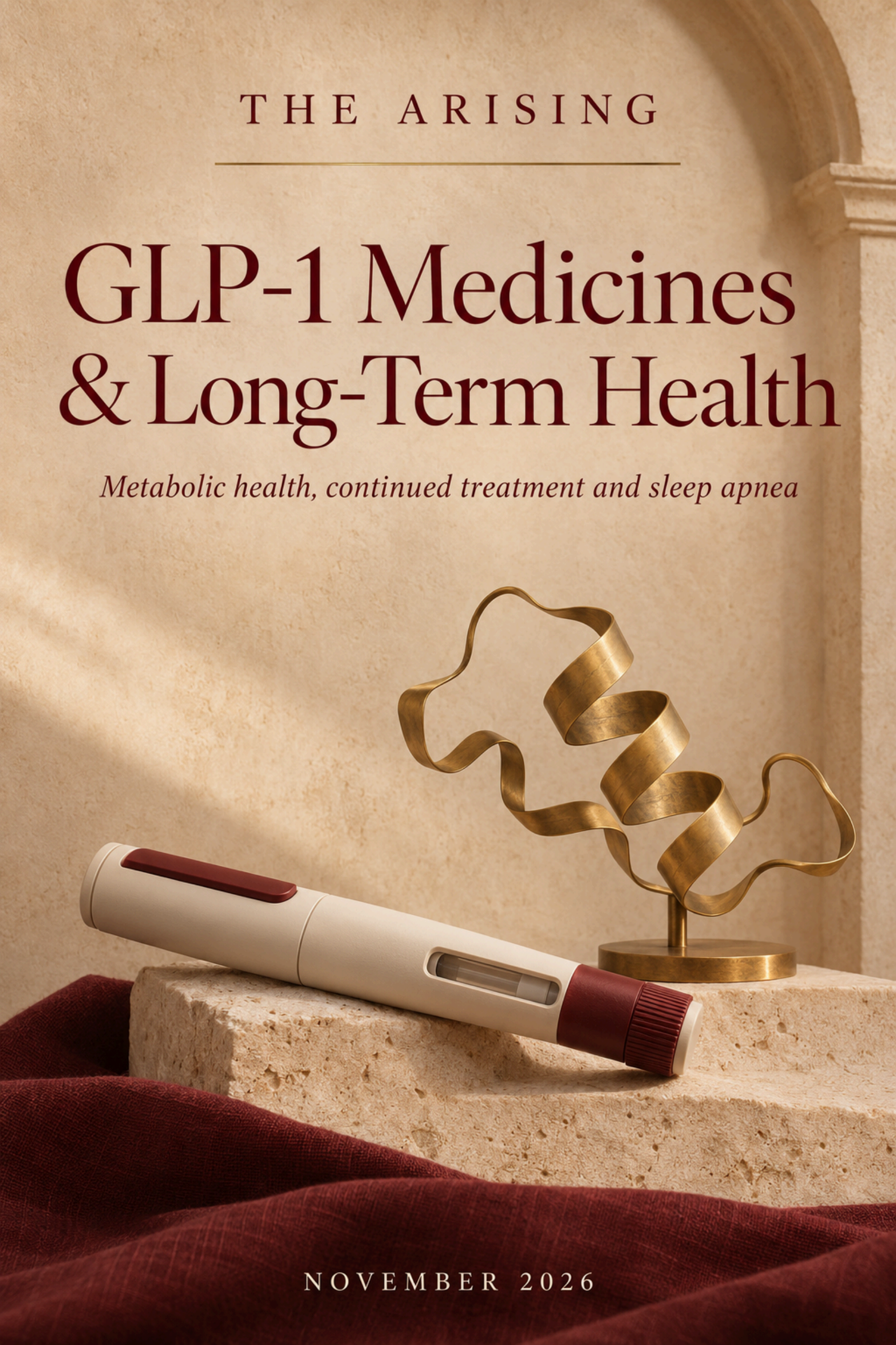
THE ARISING

GLP-1 Medicines & Long-Term Health

Metabolic health, continued treatment and sleep apnea



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GLP-1 Medicines: Weight & Health

GLP-1 medicines, sleep, and the life beyond a prescription

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A number can open a conversation. It cannot finish one.

For someone considering a medicine for obesity, that number might be their weight, a blood-sugar result, or the number of times their breathing is interrupted during sleep. Behind it is a life: stairs that have become difficult, a night that never feels restful, a treatment that helps but is hard to afford, or a wish to feel more at home in a changing body.

The useful question is not simply how far the number can move. It is what changes for the person, what the treatment asks of them, and whether its benefits remain worth its burdens over time.

Two studies offer different windows into that conversation. One followed older adults after they began a GLP-1 medicine, comparing people who filled more prescriptions with those who filled fewer. The other assigned people with obesity and obstructive sleep apnea to tirzepatide or an inactive placebo for a year. Together they show why starting a treatment, continuing it and benefiting from it are related but different questions.

This is general education, not a recommendation to start, stop or change a medicine. A treatment decision needs the person's medical history, other medicines, goals and follow-up, not a magazine headline alone.

1. GLP-1 Medicines and Tirzepatide: Important Differences

“GLP-1” is often used as shorthand for several medicines discussed in relation to weight and blood sugar. It can make a complicated subject easier to talk about, but it can also hide important differences.

GLP-1 is a hormone involved in the body's response to food. Medicines that act on its receptor influence signals involved in blood-sugar control and appetite. Tirzepatide acts on two kinds of receptors, GIP and GLP-1, rather than GLP-1 alone. The receptor is the part of a cell that receives a particular signal. Different medicines, doses, uses and populations need their own evidence. [3]

That distinction matters here. The older-adult study concerned prescription exposure to GLP-1 receptor agonists, medicines that activate the GLP-1 receptor. The sleep-apnea trials tested tirzepatide specifically. A finding about one cannot automatically become a promise about every medicine people call a “GLP-1.” [1,2]

In the United States, Zepbound, a tirzepatide product, is indicated for moderate-to-severe obstructive sleep apnea in adults with obesity, alongside a reduced-calorie diet and increased physical activity. Its label also covers weight reduction and long-term weight maintenance in eligible adults. This is an approved use, not a guarantee of benefit for every person or an approval for every GLP-1-related medicine. [3]

Nor does a medicine's effect on weight answer every question about health. Sleep, daily function, side effects and the ability to continue treatment deserve attention in their own right.

2. Continued GLP-1 Use and Metabolic Health in Older Adults

Starting a medicine is a moment. Continuing it is an experience.

A person may find that treatment fits their life and helps them reach an important goal. Another may stop because of side effects, cost, access, another illness or a decision made with their clinician. Those possibilities help explain why researchers care about what happens outside the carefully organized setting of a trial.

Zaritsky and colleagues examined health records from Clalit Health Services in Israel for 13,387 adults aged 65 or older who had obesity and did not have diabetes at the start. All had body-mass-index measurements available at two time points; 69% were women. Body mass index, or BMI, relates weight to height. It is one way to follow weight change, not a complete description of a person's strength or health. [1]

Everyone in the study had begun treatment. The comparison was between people with one or two prescription dispensations and people with three or more. The researchers called those groups “minimal” and “sustained” exposure. A dispensation means a prescription was supplied, not proof that every dose was taken. Three fills also do not establish years of uninterrupted treatment. [1]

What the records showed

About 55 out of every 100 people in the group with more prescription fills moved to a lower BMI category, compared with 30 out of every 100 in the group with fewer fills. That is an observed gap of 25 percentage points. It is not a claim that every 100 people who continue treatment will produce the same result. [1]

The midpoint of the relative BMI changes was a reduction of 8% in the more-exposed group and 2% in the less-exposed group. These are changes in BMI relative to its starting value, not a measurement of muscle strength, stamina or years of life gained. [1]

Among 7,392 people with blood-sugar measurements at two time points, 34% in the more-exposed group moved to a better blood-sugar category, compared with 20% in the less-exposed group. These measurements used HbA1c, a blood test that reflects blood sugar over recent months. [1]

Diabetes diagnoses were recorded in 2.5% and 5.3%, respectively. Put another way, about 3 in 100 versus about 5 in 100 had a recorded diagnosis, with the exact gap between the reported percentages being 2.8 percentage points. The published summary does not supply the follow-up duration. Those figures therefore cannot tell us how many diagnoses were prevented in a year, or how long any difference lasted. [1]

Why the difference is not yet an answer about cause

For BMI-category improvement, the researchers used calculations to account for age, sex, socioeconomic circumstances and other medical conditions. That makes the comparison more informative, but it cannot remove every difference between people who continue and people who stop.

Imagine two people who begin the same medicine. One has reliable access, tolerates it well and returns regularly for follow-up. The other has trouble obtaining it and develops another illness. Their later health may differ for several reasons. Prescription counts alone cannot separate them all.

The study describes changes observed after treatment began. It does not prove that filling additional prescriptions caused the entire gap, establish longer life, or tell an individual how the balance of benefits and harms will turn out. [1]

Its practical value is more grounded: care does not end with a prescription. Whether a person can continue, what they experience while taking it, and what happens when they stop are part of the treatment story.

3. Tirzepatide Reduced Sleep Apnea Severity in Two Trials

Obstructive sleep apnea happens when the upper airway repeatedly narrows or closes during sleep, interrupting breathing. The name sounds technical; the daily experience can be very familiar. Sleep does not feel restorative, daytime alertness suffers, and the night becomes a health problem rather than a pause from the day.

A connection between obesity and sleep apnea does not, by itself, prove that a particular medicine improves the sleep disorder. The SURMOUNT-OSA trials asked that more specific question. Published in 2024, they tested tirzepatide in adults with obesity and moderate-to-severe obstructive sleep apnea. [2]

Researchers conducted two trials lasting 52 weeks. Participants were assigned by chance to tirzepatide or placebo, an inactive comparison treatment. Neither participants nor the researchers assessing treatment knew which was assigned during the blinded part of the trials. This design helps make the comparison fairer than simply watching who chooses treatment. [2]

The two trials enrolled 469 people altogether: 234 in the first and 235 in the second. People with diabetes were excluded. Average ages were 47.9 and 51.7 years, so these

were not specifically studies of older adults. Both treatment and placebo groups received lifestyle counseling. [2]

One trial enrolled people who were not receiving positive airway pressure at the start. The other enrolled people who were. Positive airway pressure, often called PAP, uses a device to help keep the airway open during sleep. The two settings matter: they do not answer exactly the same treatment question. In the second trial, people continued PAP during the study but paused it for seven days before the sleep and symptom assessments at the start, week 20 and week 52. The reported AHI changes were therefore assessed off PAP, not while the device was helping keep the airway open. That research procedure is not an instruction for readers to pause treatment. [2]

What the researchers counted

The main measurement was the apnea-hypopnea index, or AHI: the number of breathing interruptions or reductions per hour of sleep. A lower number means fewer of these events on the sleep test. It does not directly tell us how long someone will live or whether a future heart attack will be prevented.

In the first trial, AHI fell by an average of 25.3 events per hour with tirzepatide and 5.3 with placebo. The estimated difference attributable to the treatment comparison was 20.0 fewer events per hour. The 95% confidence interval ran from 14.2 to 25.8 fewer events. That interval describes statistical uncertainty around the estimate under the analysis's assumptions: the results support a reduction, but its exact size remains uncertain. [2]

In the second trial, the estimated difference was 23.8 fewer events per hour, with an uncertainty interval of 17.9 to 29.6 fewer. These are average comparisons between groups, not a prediction of the change a particular person will experience. [2]

The trials also reported improvements in weight, blood pressure, the burden of reduced oxygen during sleep, and sleep-related outcomes reported by participants. These findings connect a sleep-laboratory measurement to other parts of the treatment experience without making every outcome interchangeable. [2]

Stomach and intestinal side effects were the most frequently reported adverse effects and were mostly mild to moderate. Two cases of acute pancreatitis, inflammation of the pancreas, were confirmed in the tirzepatide group in the second trial. These cases belong beside the more common side effects, even though most reported stomach and intestinal problems were mild or moderate. Eli Lilly funded the trials. The benefit, side effects, funding and population studied all belong in the same account. [2]

What this means for existing care

The findings do not mean that all sleep apnea disappears when someone loses weight. They do not show that every medicine in the wider GLP-1 conversation has the same effect. And they do not give someone permission to stop a prescribed airway-pressure treatment on their own.

If sleep symptoms or weight change during treatment, that can be a reason to discuss reassessment with the treating clinician. Whether existing treatment should change

depends on the person's condition and clinical assessment, not on borrowing an average result from a trial.

The studies also do not fully separate how much of the sleep improvement came from weight loss and how much may have come through other pathways. A successful trial can show that a treatment helped its participants without answering every question about how it worked.

4. Tirzepatide Safety: Side Effects, Warnings and Precautions

A helpful medicine can still be the wrong choice for a particular person. Understanding who was studied and what harms were measured is part of understanding the benefit, not a reason to ignore it.

The current prescribing information matters because a trial report is not a complete safety guide. Zepbound carries a boxed warning, the strongest warning in U.S. prescribing information, about thyroid C-cell tumors seen in rats. Whether this risk applies to humans is unknown. It must not be used by people with a personal or family history of medullary thyroid carcinoma, a particular thyroid cancer, or with multiple endocrine neoplasia syndrome type 2 (MEN 2), an inherited condition involving endocrine tumors. A known serious allergy to tirzepatide or the product’s other ingredients is also a reason not to use it. [3]

Other important risks include severe stomach or intestinal reactions, kidney injury associated with dehydration, gallbladder problems and pancreatitis. Combining it with insulin or certain diabetes medicines called sulfonylureas can increase the risk of low blood sugar. These are reasons to review the whole medication list, not just the new prescription. [3]

Pregnancy, oral contraception and planned surgery or procedures need specific discussion. The label directs stopping Zepbound when pregnancy is recognized; contact the prescribing team promptly. It also warns that oral hormonal contraceptives may work less well after treatment starts or the dose increases, and gives instructions for a non-oral method or additional barrier protection. Before anesthesia or deep sedation, tell the team about tirzepatide because delayed stomach emptying can increase the risk of stomach contents entering the lungs. [3]

This is not the full safety list. The linked prescribing information and the clinical team are the places to resolve individual questions, including what symptoms require urgent care. The label also notes that too few older adults participated in the sleep-apnea studies to establish whether their response differs from younger adults. The older-adult record study and the sleep-apnea trials should not be treated as interchangeable evidence for that age group. [3]

The sleep-apnea study's description of mostly mild-to-moderate stomach and intestinal effects should not become “the medicine has only mild side effects.” Nor can the

older-adult record study settle safety for every person aged 65 or older. A study can reveal a useful pattern while leaving important questions unanswered.

For someone already taking treatment, reporting what is actually happening is more useful than trying to fit a success story. Trouble eating comfortably, new symptoms, difficulty obtaining the medicine, or uncertainty about another treatment are reasons for a conversation with the prescribing team. Follow the prescribing team’s safety instructions and seek timely care for concerning symptoms. A study schedule is not a substitute for those instructions.

5. Reviewing the Benefits and Burdens of GLP-1 Treatment

The research becomes more useful when it helps people ask specific questions.

For one person, the important change may be sleep that leaves them more alert. For another, it may be a measured blood-sugar improvement. Someone else may care most about moving comfortably through an ordinary day. These are different goals. A favorable result on one measurement does not tell the whole story.

A follow-up conversation can begin with five questions:

• **What were we trying to improve?** Name the original treatment goal rather than allowing the scale to become the only goal by default.

• **What has actually changed?** Bring symptoms and daily experiences alongside the measurements the clinical team is tracking.

• **What has treatment been like?** Side effects, access, expense and the work of continuing matter to whether a plan is sustainable.

• **What still needs attention?** Ask how eating, physical function, sleep and other treatments fit together in the care plan.

• **What happens next?** Understand when the plan will be reviewed and whom to contact if circumstances change.

These questions are not a self-treatment checklist. They are a way to make the conversation reflect the person receiving care.

Three everyday conversations

An older adult whose treatment has become hard to continue. They have filled two prescriptions and are unsure about the next one. The record study does not tell them that a third fill guarantees a better outcome. It does suggest a useful conversation: what is making continuation difficult, what has changed so far, and what choices fit their health and circumstances? The reason behind the prescription count matters more than being placed in the study’s “minimal exposure” category.

Someone who uses PAP and hears that a medicine can treat sleep apnea. They may reasonably want to know whether the finding applies to them. The trial gives them something specific to ask about: adults with obesity and moderate-to-severe sleep apnea were studied, and the PAP group paused treatment under research supervision before assessments. It does not provide a home experiment to copy. Their own sleep assessment and care team determine what happens next.

A person whose weight has changed but whose day still feels difficult. The scale may show progress while eating, sleep or daily activity still needs attention. Bringing those experiences to follow-up makes the treatment conversation more complete. A result that looks encouraging on paper should not make the person feel they must stay silent about its costs or disappointments.

These are illustrative situations, not reports of actual patients. Like the studies, they point toward better questions rather than one answer for everyone.

The older-adult study reminds us to look beyond starting treatment. The sleep-apnea trials remind us to identify the medicine, the population and the outcome precisely. Neither asks us to choose between hope and caution. Both become more valuable when we keep them together.

The point is not a smaller number at any cost. It is a clearer account of what a treatment can offer, what it requires, and how that fits into a life worth living.

Sources and further reading

[1] Zaritsky and colleagues. Sustained Versus Minimal GLP-1 Receptor Agonist Exposure and Metabolic Outcomes in Older Adults Without Diabetes. Published October 22, 2026. Primary publication record.

[2] Malhotra and colleagues. Tirzepatide for the Treatment of Obstructive Sleep Apnea and Obesity. New England Journal of Medicine. 2024;391:1193–1205. Primary publication record. Full text. Published correction.

[3] Eli Lilly and Company. Zepbound (tirzepatide), U.S. prescribing information. Official DailyMed label.

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