

The Future of Risk: Comorbidities, Obesity and Cardiovascular Prevention



The poster features a stylized heart in the center, composed of two halves: the left half is red and textured, while the right half is blue and textured. A white ECG line is overlaid on the heart. Above the heart, the text 'Azərbaycan Kardiologiya Cəmiyyəti' is written in black. Below the heart, the dates '12 - 14 DEKABR 2025' and the location 'HILTON OTEL, BAKI' are displayed in red and black. At the bottom, there is a blue banner with contact information and logos for MICEBAKU and other partners.

Azərbaycan
Kardiologiya
Cəmiyyəti

XIV **MİLLİ**
KARDİOLOGİYA
KONQRESİ

12 - 14 DEKABR 2025
HILTON OTEL, BAKI

Qeydiyyat üçün : +994 50 207 09 45
Məlumat üçün : +994 99 885 23 07 | info@micebaku.com

MICEBAKU

Obesity: a shifting paradigm in cardiometabolic risk

Ana Abreu, MD, PhD

*Coordinator of CV Rehabilitation Unit, CV Department, Hospital Santa Maria, Lisboa
Director of Preventive Medicine Institute and Public Health and of Institute of Environmental Health
Faculdade Medicina Universidade Lisboa, Portugal
President of European Association of Preventive Cardiology, EAPC*

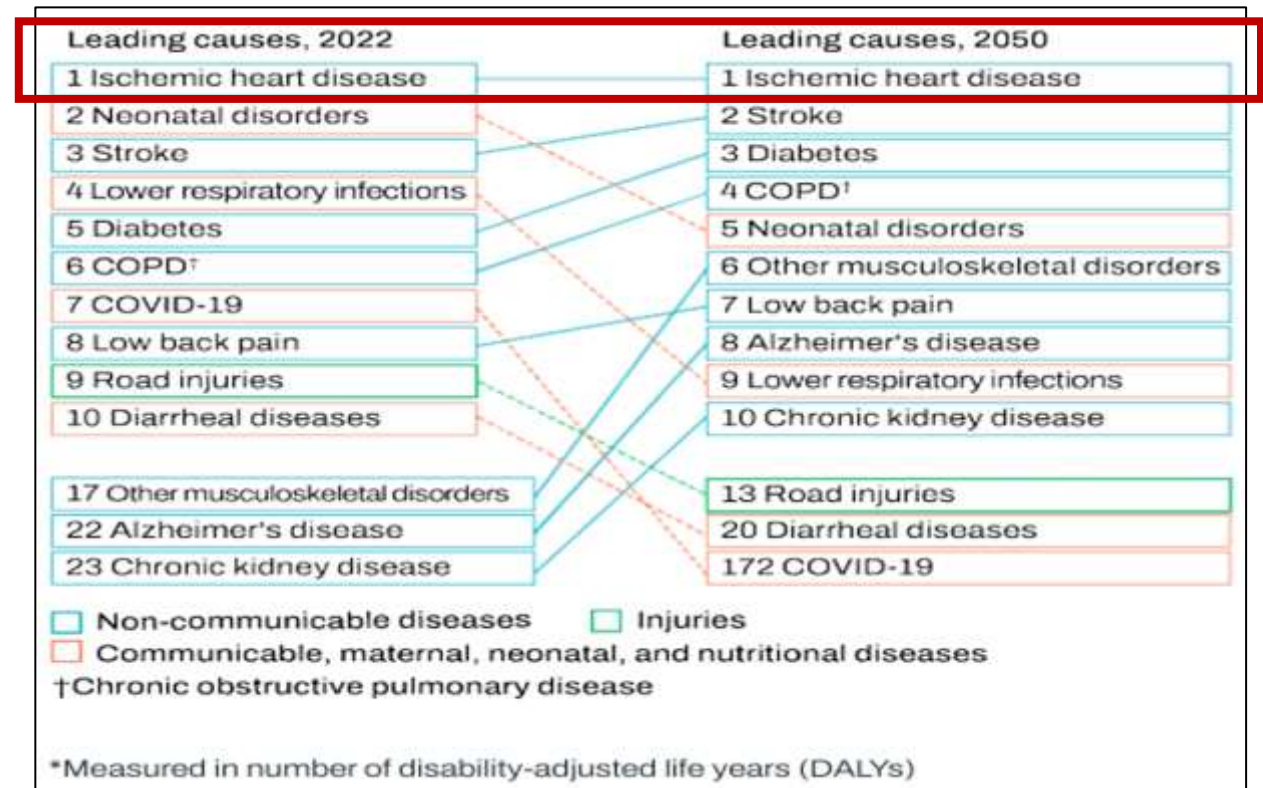


Global Burden of Disease

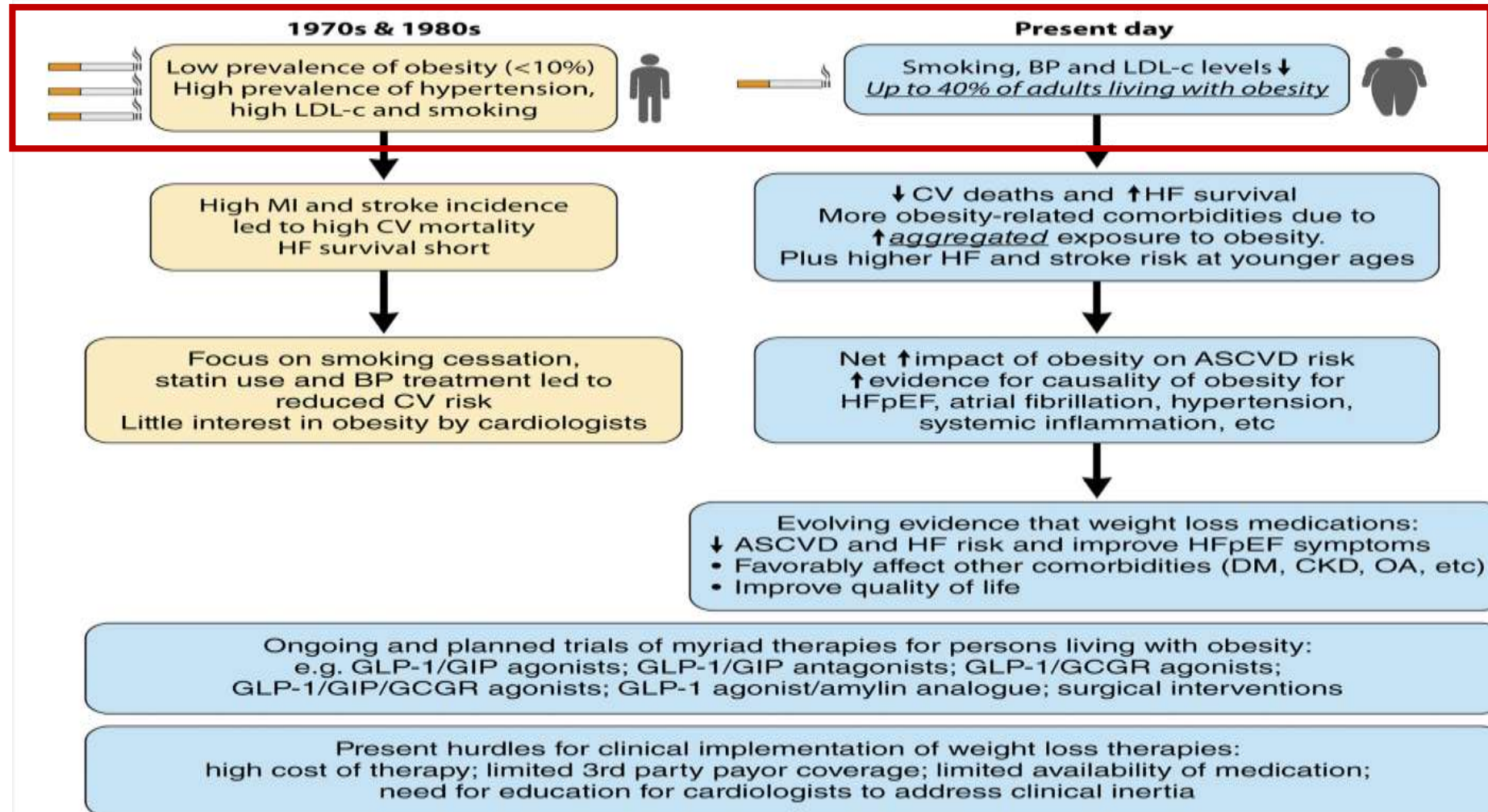
After 40 years of success in reducing CV burden, CV mortality rates are now increasing.

Future projections indicate that CV burden along with several CV risk factors will continue to rise.

The key reason is the rise of obesity & associated modifiable risk factors.



Evolution of Obesity: The impact in CV Medicine



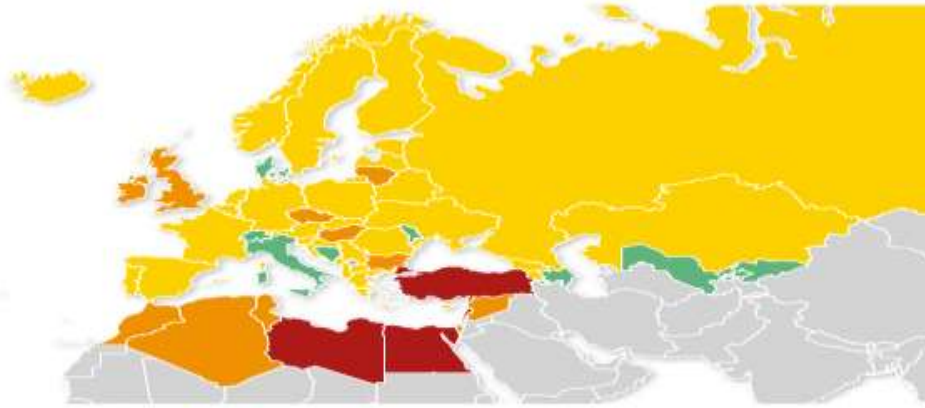
Cardiometabolic disease: Today's problem

- Obesity is now a pandemic with almost 1:4-5 European adults obese (23%).
- The prevalence of obesity is increasing in younger people affecting 20% of children and 40% of young adults, associated to other CV risk factors.
- Being obesity linked to insulin resistance, the prevalence of prediabetes and type2 DM is also increasing, and so it is premature ASCVD with early MI.
- Early metabolic deterioration due to overweight and obesity, which is underdiagnosed and undertreated, associates to all-cause mortality, CV risk and CV mortality. Two thirds of people with high BMI die due to CVD.

Centers for Disease Control and Prevention. National Center for health Statistics. Obesity and overweight. Accessed January 21, 2024.

Koskinas KC, Van Craenenbroeck EM, Antoniadou C, et al. , ESC Clinical Consensus Statement on Obesity and Cardiovascular Disease. Eur Heart J 2024; 45 (38): 4063–4098

Prevalence of Obesity in ESC member countries

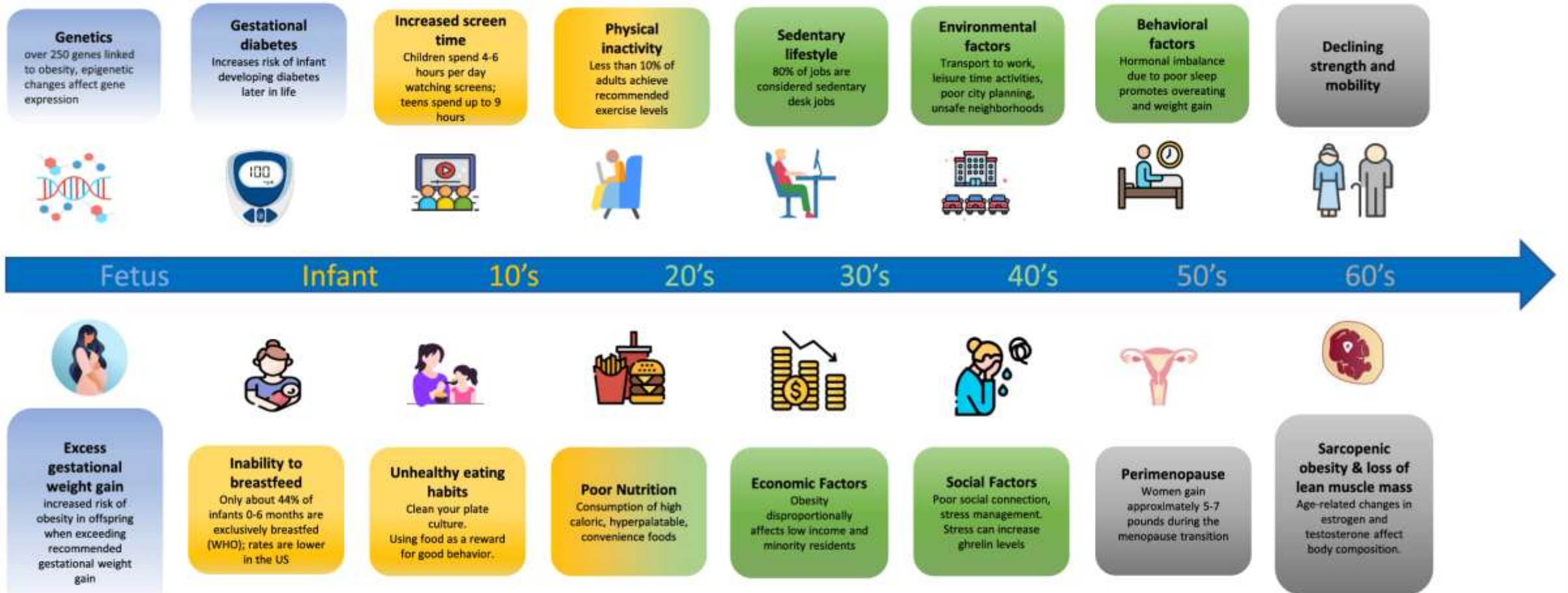


Estimated prevalence of obesity in adult population

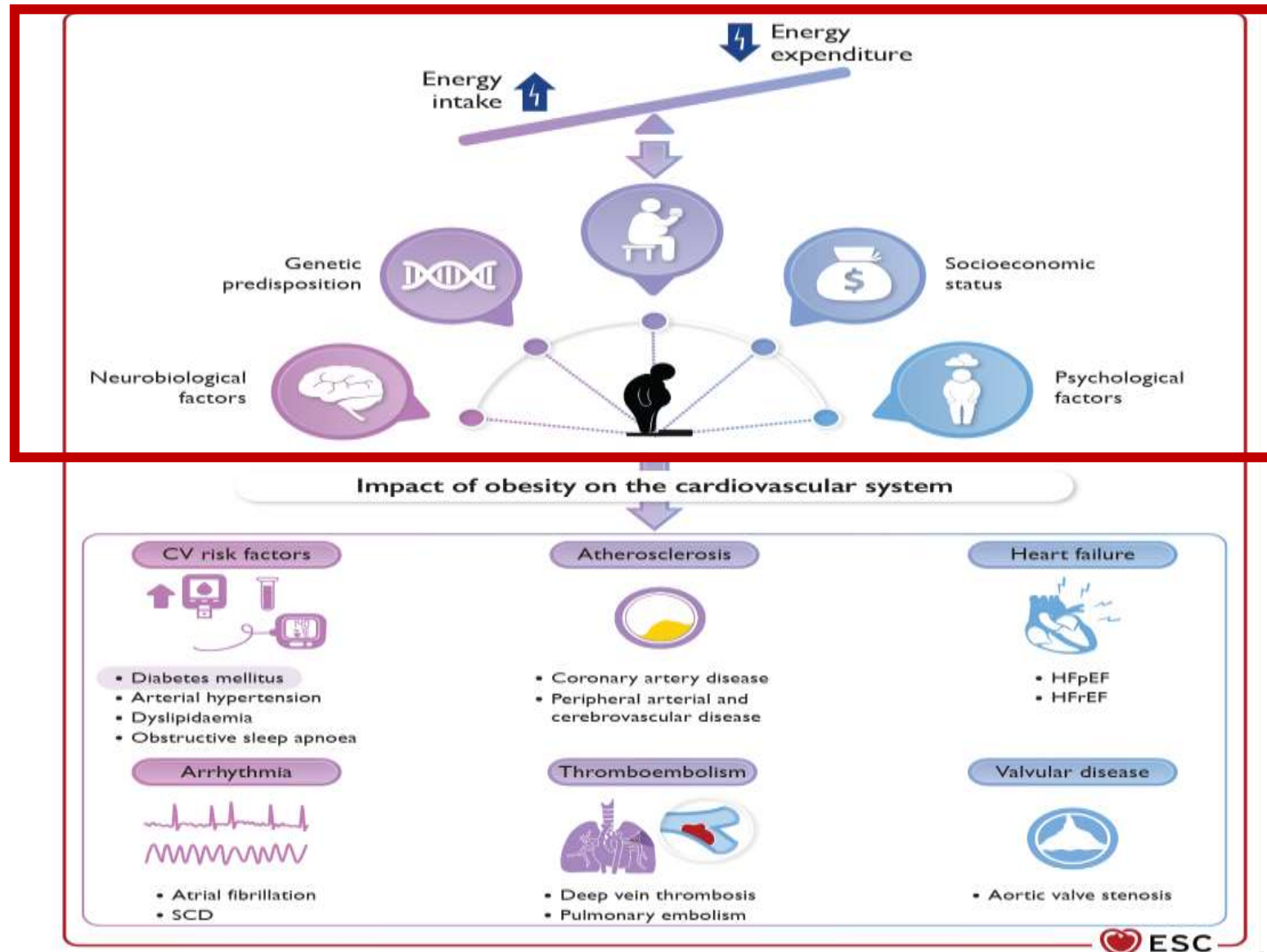
● <20% ● 20–24.9% ● 25–29.9% ● ≥30%

Uzbekistan	16.6%	Albania	21.7%	Bulgaria	25.0%
Kyrgyzstan	16.6%	Cyprus	21.8%	Ireland	25.3%
Bosnia and Herzegovina	17.9%	Iceland	21.9%	Czech Republic	26.0%
Moldova	18.9%	Belgium	22.1%	Morocco	26.1%
Switzerland	19.5%	Finland	22.2%	Israel	26.1%
Denmark	19.7%	Germany	22.3%	Lithuania	26.3%
Italy	19.9%	North Macedonia	22.4%	Hungary	26.4%
<u>Azerbaijan</u>	<u>19.9%</u>	Romania	22.5%	Tunisia	26.9%
Austria	20.1%	Luxembourg	22.6%	Algeria	27.4%
Slovenia	20.2%	Russia	23.1%	United Kingdom	27.8%
Armenia	20.2%	Poland	23.1%	Syria	27.8%
Netherlands	20.4%	Norway	23.1%	Malta	28.9%
Slovakia	20.5%	Montenegro	23.3%	Lebanon	32.0%
Sweden	20.6%	Latvia	23.6%	Egypt	32.0%
<u>Portugal</u>	<u>20.8%</u>	Spain	23.8%	Turkey	32.1%
Kazakhstan	21.0%	Ukraine	24.1%	Libya	32.5%
Estonia	21.2%	Croatia	24.4%		
Serbia	21.5%	Belarus	24.5%		
France	21.6%	Greece	24.9%		
Georgia	21.7%				

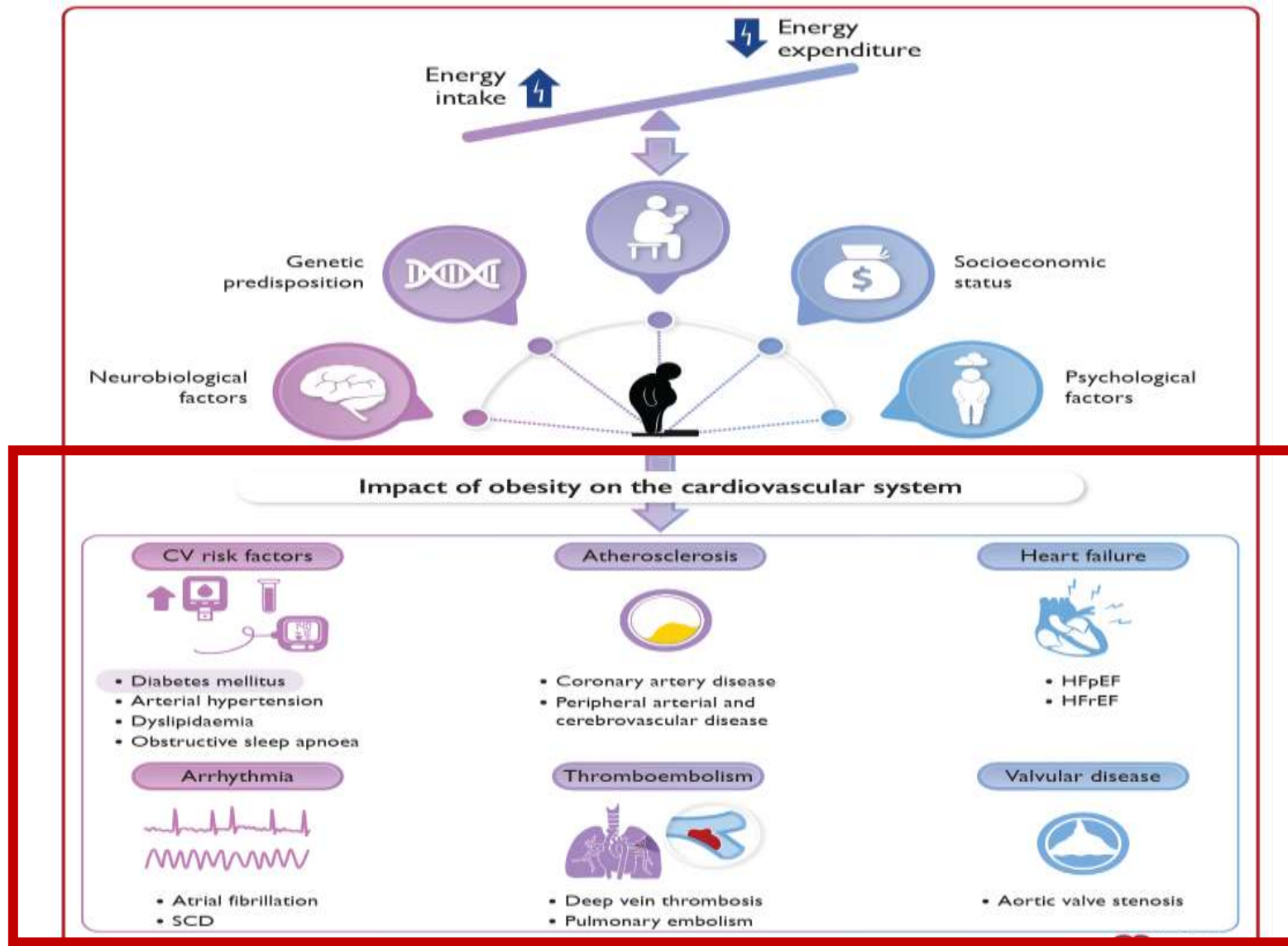
Looking at Obesity and CV Health along the Life Cycle



Main Causal Factors of Obesity



Main CV Consequences of Obesity



Obesity and CVD

- There is a significant association between BMI and increased CV risk, particularly HF, across all obesity classifications. Also, studies support a causal association between adiposity and CVD.
- Obesity contributes to atherosclerotic cardiovascular disease development through interconnected pathways (HTN, dyslipidaemia, insulin resistance, and chronic inflammation).
- Extensive cohort data suggest that obesity is more strongly linked to heart failure than to atherosclerotic cardiovascular events.

Wormser D, Kaptoge S, Di Angelantonio E, et al. Lancet 2011;377:1085–95.

Powell-Wiley TM, Poirier P, Burke LE, et al. Circulation 2021;143:e984–1010.

Zhou Z, Parra-Soto S, Boonpor J, et al. Curr Probl Cardiol 2023;48:101715.

Khan SS, Ning H, Wilkins JT, Allen N, et al. JAMA Cardiol 2018;3:280–7.

Nam GE. Cardiovasc Prev Pharmacother 2025;7(2):21-27

Obesity and atherosclerotic CAD

- **Visceral adiposity** promotes **systemic and vascular inflammation**, fundamental to all aspects of the atherosclerotic process, from fatty streak to atherothrombosis.
- Inflammation induced by obesity increases the likelihood of **LDL-C oxidation**, which promotes atherogenesis.
- **Insulin resistance** is associated with dyslipidemia (high TG; low HDL-C; high dense LDL-C) and metabolic syndrome (multiple CV risk factor including **abdominal obesity, atherogenic dyslipidaemia, elevated BP, insulin resistance with or without glucose intolerance, and proinflammatory and prothrombotic states**), which are linked to atherosclerosis.
- **Endothelial dysfunction** in obesity, principally caused by **diminished bioavailability of nitric oxide in the setting of inflammation and oxidative stress**, is also fundamental to atherosclerosis progression.

Rocha VZ, Libby P. Nat Rev Cardiol. 2009;6:399–409.

Ross R. Am Heart J. 1999;138(pt 2):S419–S420.

Couillard C, et al. J Clin Endocrinol Metab. 2005;90:6454–6459.

Grundey SM. Metabolic syndrome update. Trends Cardiovasc Med. 2016;26:364–373.

Engin A. Adv Exp Med Biol. 2017;960:345–379.

Obesity and Microvascular Coronary Disease

- Coronary microvascular disease is independently associated with higher BMI.
- It is pathophysiologically linked to **endothelial dysfunction** and possibly to **small vessel remodeling**.

Rocha VZ, Libby P. Nat Rev Cardiol. 2009;6:399–409.

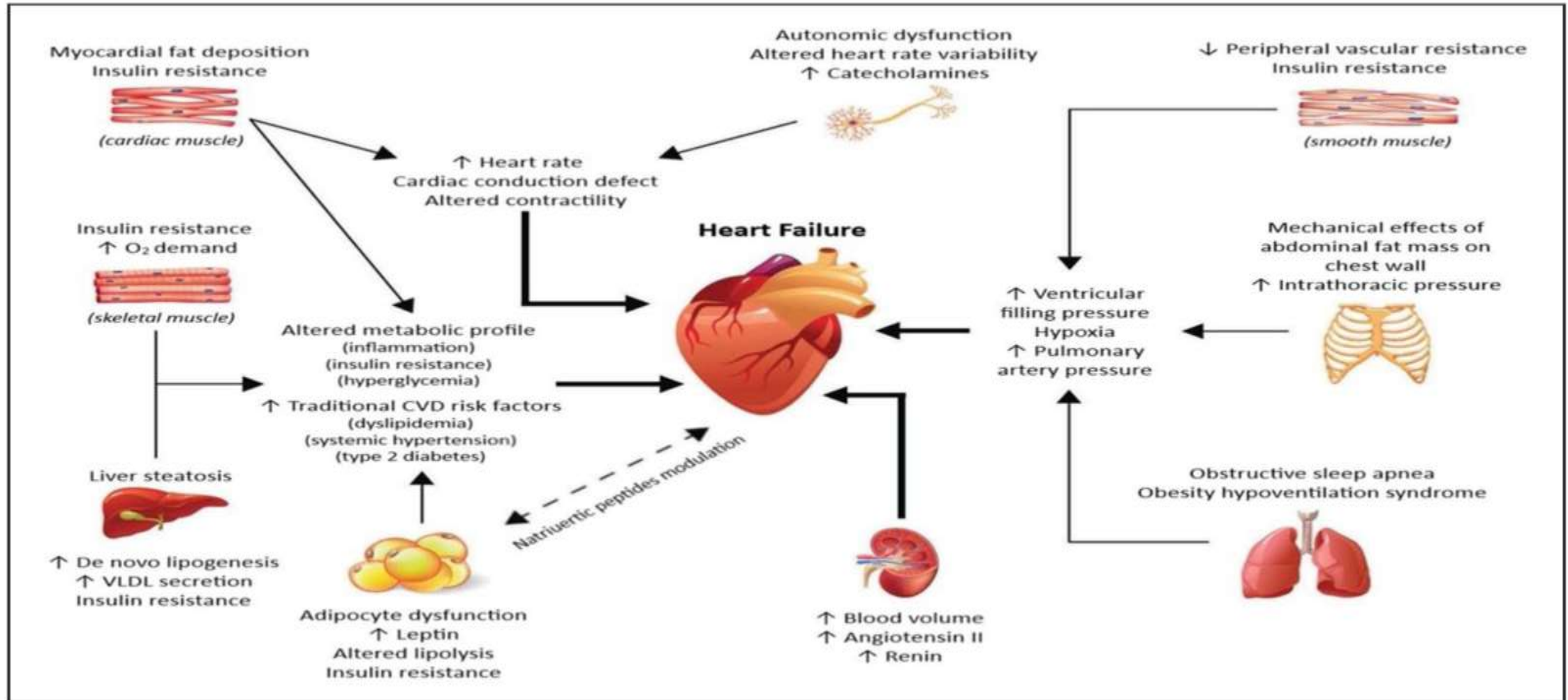
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Couillard C, et al. J Clin Endocrinol Metab. 2005;90:6454–6459.

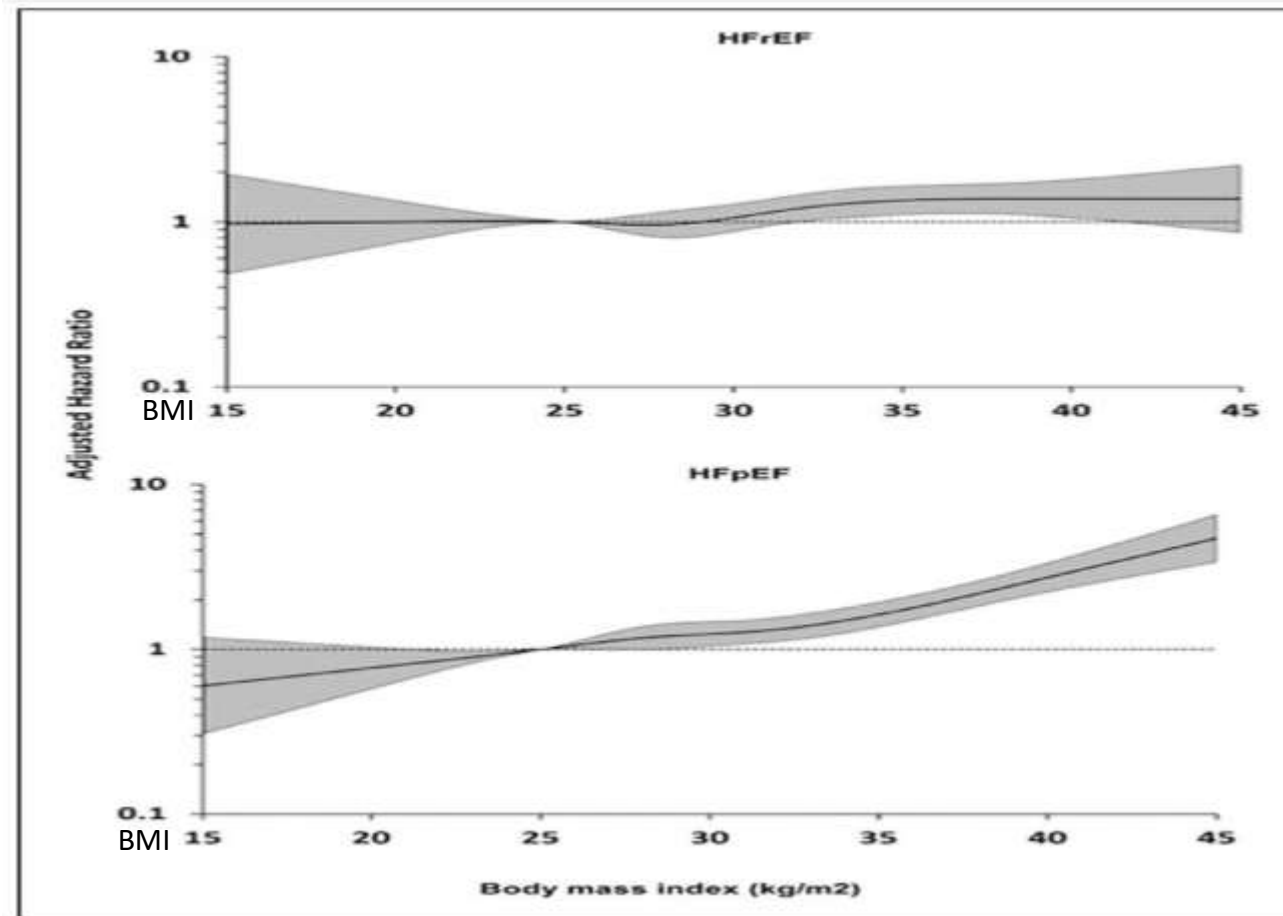
Grundey SM. Metabolic syndrome update. Trends Cardiovasc Med. 2016;26:364–373.

Engin A. Adv Exp Med Biol. 2017;960:345–379.

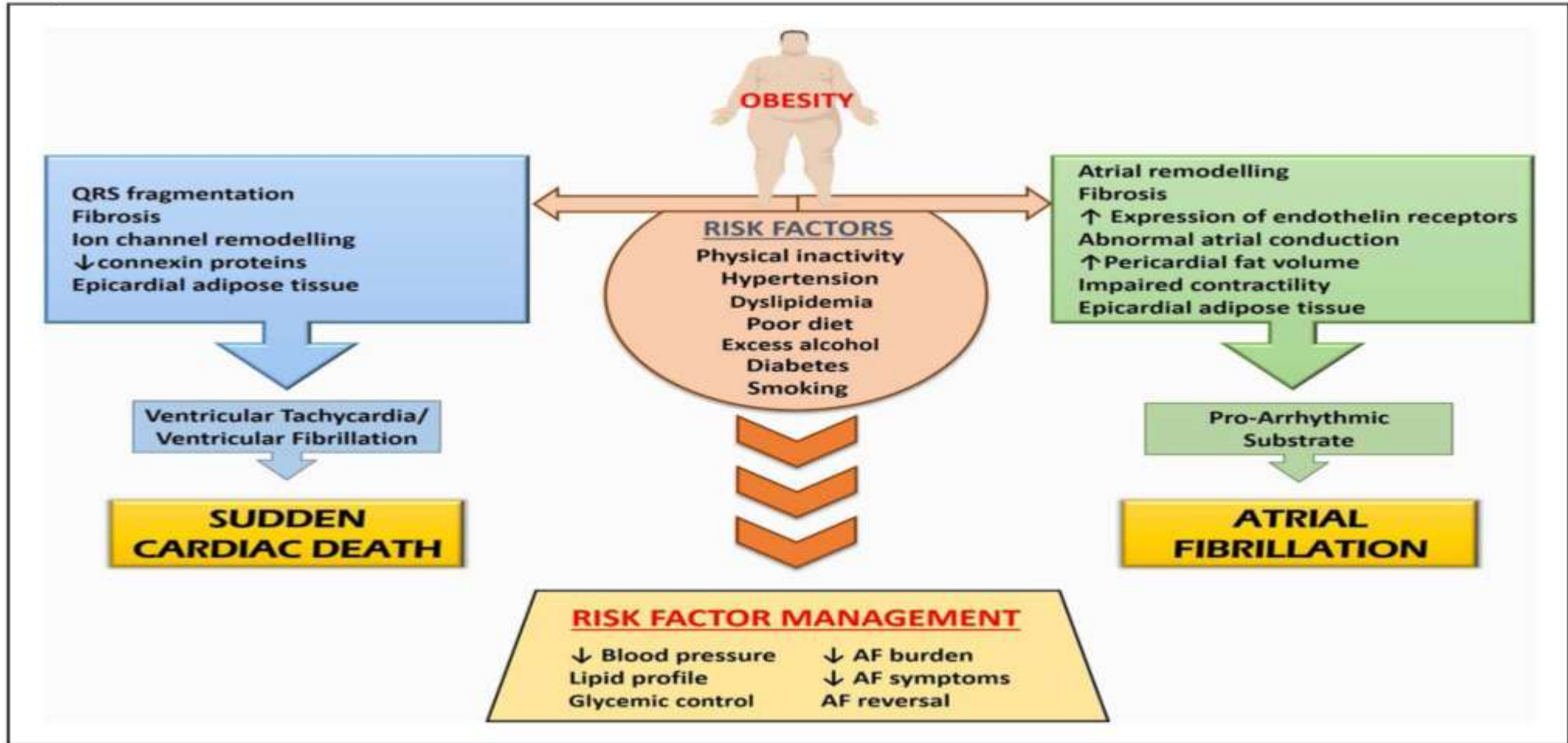
Obesity and Heart Failure Pathophysiology



BMI and HF Association



Obesity and cardiac arrhythmias



Classification of overweight and obesity in adults by BMI

Box 1 WHO classification of overweight and obesity in adults

- BMI 20 to <25 kg/m²: Normal weight
- BMI 25 to <30 kg/m²: Overweight
- BMI ≥ 30 kg/m²: Obesity
 - BMI 30 to <35 kg/m²: Obesity Class 1
 - BMI 35 to <40 kg/m²: Obesity Class 2
 - BMI ≥ 40 kg/m²: Obesity Class 3 (severe obesity)

Easy to use but not accurate!

Importance of body fat distribution

- **Body fat distribution**, beyond **total fat mass**, critically influences CV risk. **Central obesity** and **visceral fat accumulation** independently predict adverse CV outcomes.
- An international consensus statement emphasized that even within identical BMI categories, CV risk escalates with increased waist circumference .
- A meta-analysis revealed visceral fat accumulation is independently associated with increased CV events and mortality risk, regardless of BMI.
- A Mendelian randomization study provided causal evidence linking body fat distribution to CVD independently of BMI.

Despres JP. Circulation 2012;126:1301–13.

Ross R, Neeland IJ, Yamashita S, et al. Nat Rev Endocrinol 2020;16:177–89.

Czernichow S, Kengne AP, Stamatakis E, et al. Obes Rev 2011;12:680–7.

Dale CE, Fatemifar G, Palmer TM, et al. Circulation 2017;135:2373–88.

Classification of Obesity beyond BMI

A significant shift in diagnostic criteria of obesity is moving beyond BMI alone, emphasizing diverse **anthropometric indicators** to assess excess of fat accumulation, because:

- BMI does not detect phenotypes as “normal weight obesity” and “metabolically unhealthy normal weight”.
- Individuals with similar BMI may have different cardiometabolic risk.
- Metrics of **abdominal adiposity (waist circumference, waist-to-height ratio and waist-to-hip ratio)** are useful to refine CM risk stratification beyond BMI).

This change has substantial implications for CV disease risk assessment and prevention.

Links to cardiovascular risk profiles

- **Expanded anthropometric measurements strongly correlate with cardiometabolic risk profiles.**
- Individuals with higher visceral fat frequently exhibit insulin resistance, dyslipidaemia, and hypertension.
- Obesity-related dyslipidemia, characterized by elevated TG, decreased HDL-C, and increased small, dense LDL-C, is closely associated with higher atherosclerosis risk.
- These metabolic profiles serve as important early indicators of CVD risk, underscoring the importance of comprehensive anthropometric assessments.

Chait A, den Hartigh LJ. Front Cardiovasc Med 2020;7:22.

Garvey WT, Kwon S, Zheng D, et al. Diabetes 2003;52:453–62.

Nam GE. Cardiovasc Prev Pharmacother 2025;7(2):21-27

Risk assessment of the Obese Patient

Central to risk assessment in obese patients is the control of CV risk factors: HTN, dyslipidemia, impaired glucose metabolism are common companions of obesity. The assessment must include examination of these factors and pharmacological and lifestyle interventions.

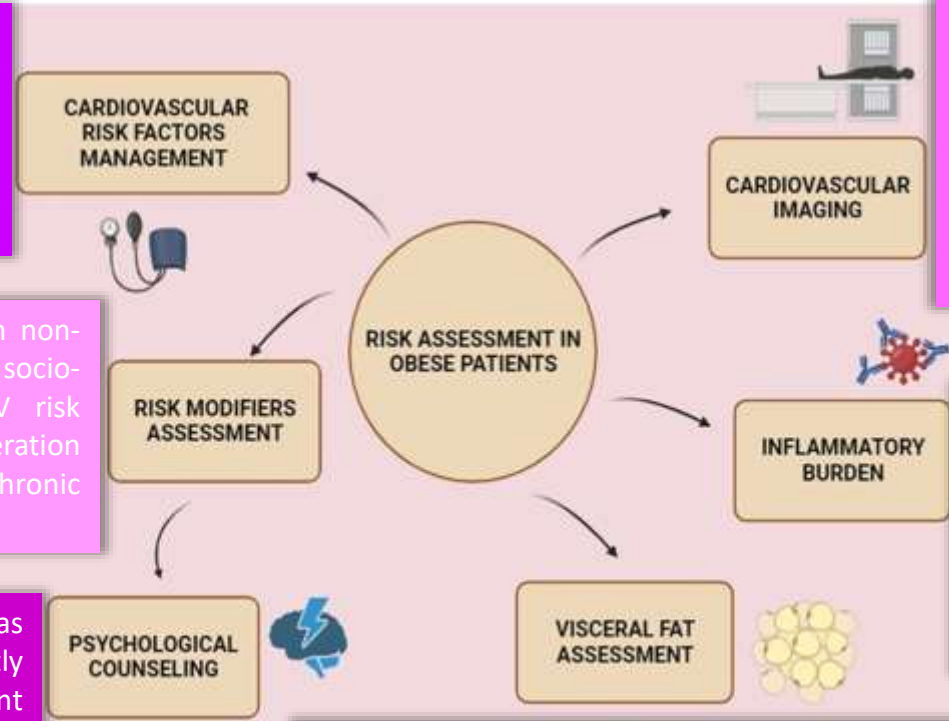
Risk modifiers are more frequent in the obese than in non-obese population. Factors as genetic predisposition, socio-economic status, and ethnicity can modify the CV risk associated with obesity. It is essential to take into consideration comorbidities (endocrinological, nephrological, chronic inflammatory diseases and obstructive sleep apnea).

Obesity often coexists with psychological factors such as stress, depression, and anxiety, which can significantly impact CV health. A comprehensive risk assessment should integrate a psychological evaluation.

Visceral fat is a key player in the pathophysiology of obesity-related CV complications. Its close association with insulin resistance and dyslipidemia makes it a crucial parameter for CV risk assessment. It is important the significance of body fat distribution and adipose tissue function in metabolic health, evaluated by DEXA (abd CT).

Advancements in imaging technologies for CV risk assessment in particular in obesity, CT angiography and MRI provide detailed insights in obese patients (early detection of atherosclerotic plaques, cardiac remodelling, evaluation of epicardial and pericardial adipose tissue), allowing more precise risk assessment and targeted intervention in obese patients.

Obesity is characterized by a chronic low-grade inflammatory state. Assessing the inflammatory burden becomes pivotal in understanding CV risk. Elevated levels of inflammatory markers, such as C-reactive protein, may serve as indicators of increased CV risk in obese patients.



Clinical and Preclinical Obesity

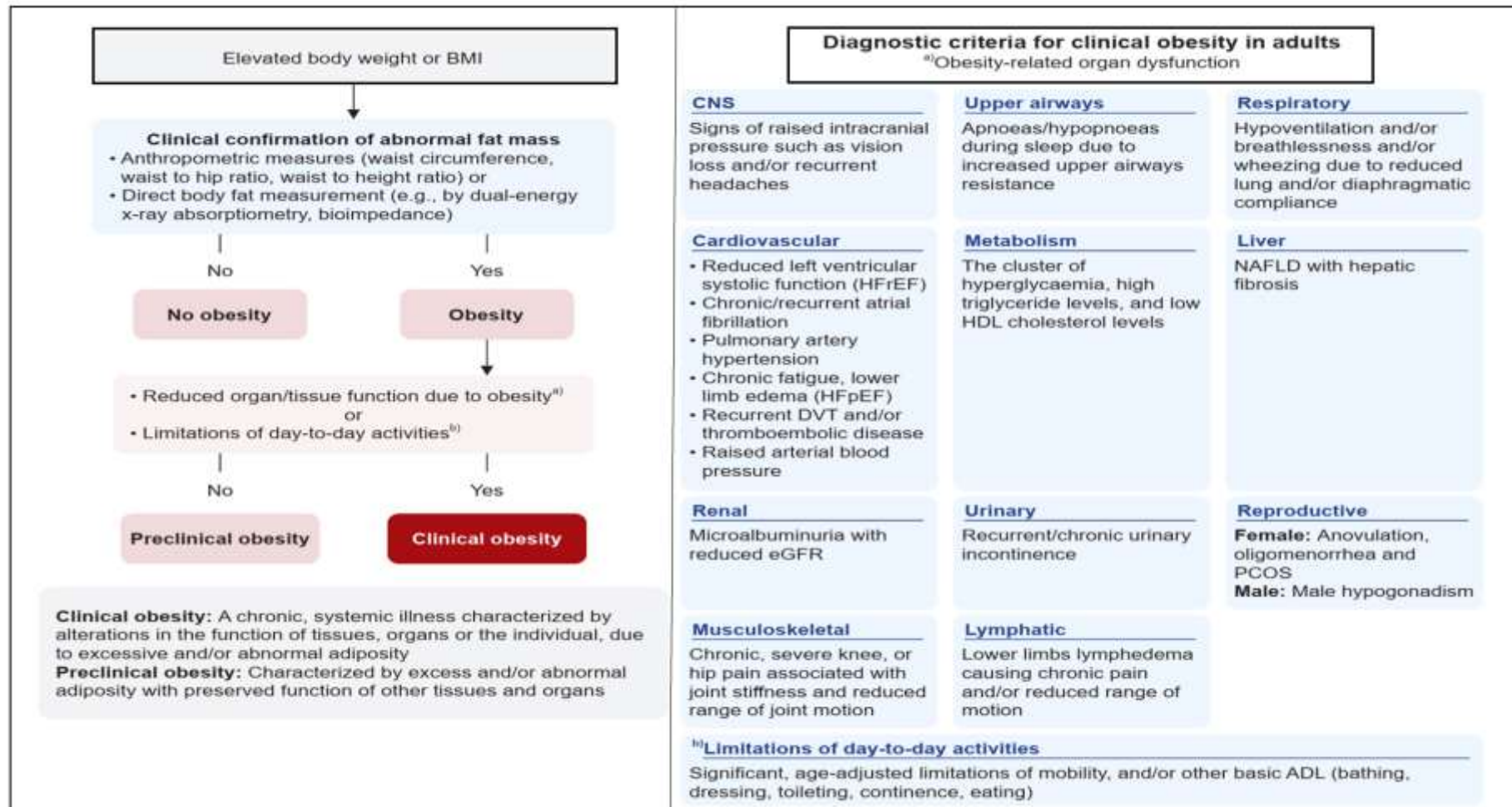
Lancet Diabetes & Endocrinology Commission proposed a paradigm shift redefinition, introducing the concepts:

- **Clinical obesity** - chronic systemic illness characterized by excess adiposity resulting in functional impairment in tissues, organs or overall individual health.
- **Preclinical obesity** – characterized by excess of adiposity without current functional impairment.

Clinical obesity requires active intervention aimed at reversing organ dysfunction and enhancing clinical outcomes, whereas preclinical obesity necessitates preventive strategies to halt or slow disease progression.

Diagnostic Criteria Clinical and Preclinical Obesity

Lancet Diabetes & Endocrinology Commission



Diagnostic Criteria Clinical and Preclinical Obesity

Lancet Diabetes & Endocrinology Commission


Advantages:

- Promotes personalized intervention strategies based on individual risk profiles
- Refines CV risk assessments by incorporating body fat distribution and functional parameters
- Promotes more efficient resource allocation
- Redefines treatment goals, shifting from weight loss only towards organ and individual functional improvements, beyond mere weight loss.

Management of Obesity

- Non-pharmacological measures: Diet, Exercise, Psychological intervention, CV risk factors control
- Pharmacological measures: new drugs to significantly lower body weight and some to improve CV prognosis (issues on cost and availability).
- Intra-gastric and Bariatric surgery: for severe specific cases of obesity

Weight Loss Interventions: Expected Effects on Weight Reduction

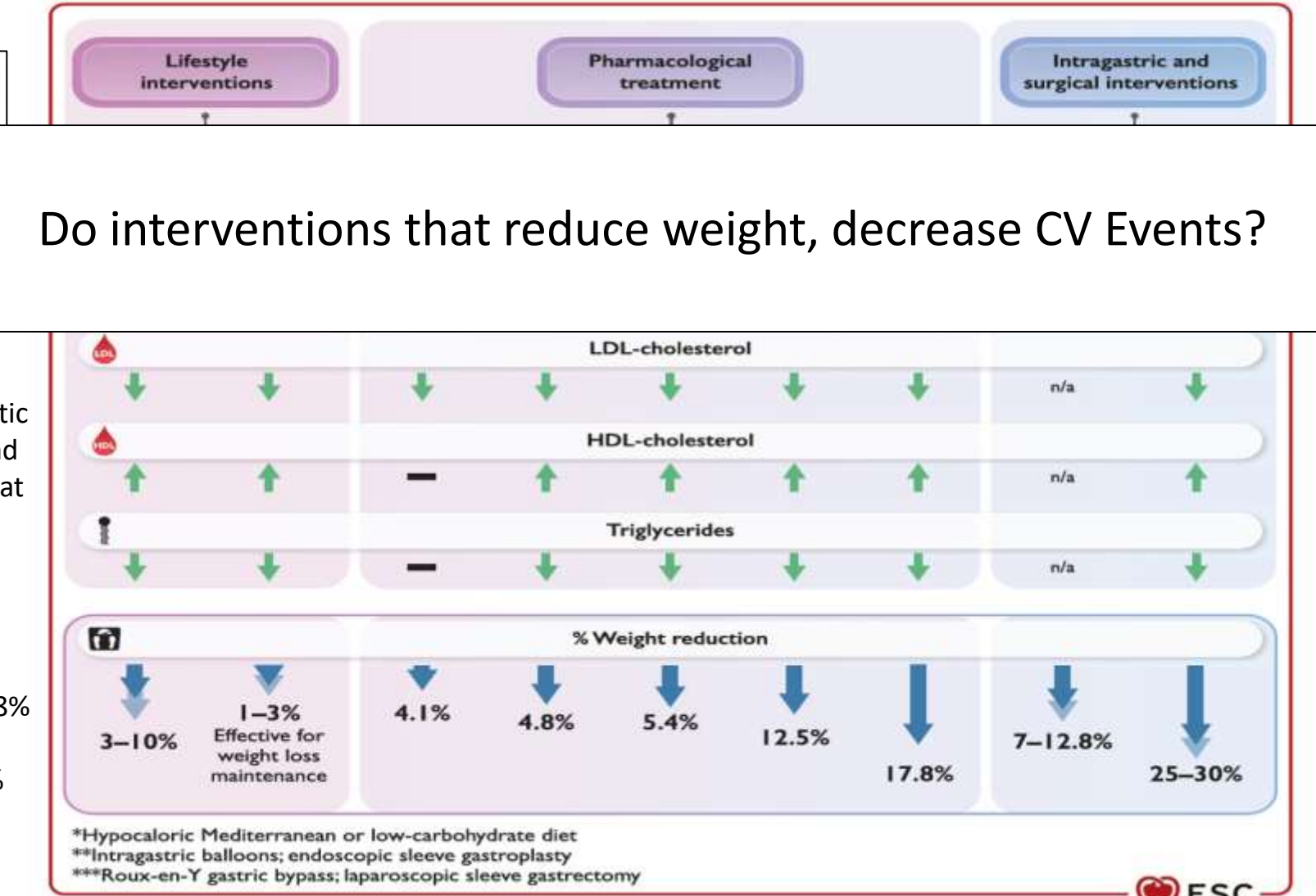

 European Heart Journal (2024) 45, 4063–4098
 European Society of Cardiology <https://doi.org/10.1093/eurheartj/ehae508>

SPECIAL ARTICLE
 Diabetes and metabolic disorders

Obesity and cardiovascular disease: an ESC clinical consensus statement

Konstantinos C. Koskinas^{1*†}, Emeline M. Van Craenenbroeck^{2,3*†}, Charalambos Antoniades⁴, Matthias Blüher⁵, Thomas M. Gorter⁶, Henner Hanssen⁷, Nikolaus Marx⁸, Theresa A. McDonagh^{9,10}, Geltrude Mingrone^{11,12}, Annika Rosengren^{13,14}, Eva B. Prescott^{15*‡}, and the ESC Scientific Document Group

- Lifestyle modification programmes (systematic review on the outcomes of weight loss) found 30% of participants with weight loss ($\geq 10\%$) at 1 year and 5-10% weight loss in 25%; 50% return weight participants after ~ 5 years.
- Drugs reduce weight from 4.% to 17.8%
- Intra-gastric procedures reduce weight 7-12.8%
- Surgical interventions reduce weight 25-30%



Look AHEAD trial -Action for Health in Diabetes

THE NEW ENGLAND JOURNAL OF MEDICINE

ORIGINAL ARTICLE

Cardiovascular Effects of Intensive Lifestyle Intervention in Type 2 Diabetes

The Look AHEAD Research Group*

ABSTRACT

BACKGROUND

Weight loss is recommended for overweight or obese patients with type 2 diabetes on the basis of short-term studies, but long-term effects on cardiovascular disease remain unknown. We examined whether an intensive lifestyle intervention for weight loss would decrease cardiovascular morbidity and mortality among such patients.

METHODS

In 16 study centers in the United States, we randomly assigned 5145 overweight or obese patients with type 2 diabetes to participate in an intensive lifestyle intervention that promoted weight loss through decreased caloric intake and increased physical activity (intervention group) or to receive diabetes support and education (control group). The primary outcome was a composite of death from cardiovascular causes, nonfatal myocardial infarction, nonfatal stroke, or hospitalization for angina during a maximum follow-up of 13.5 years.

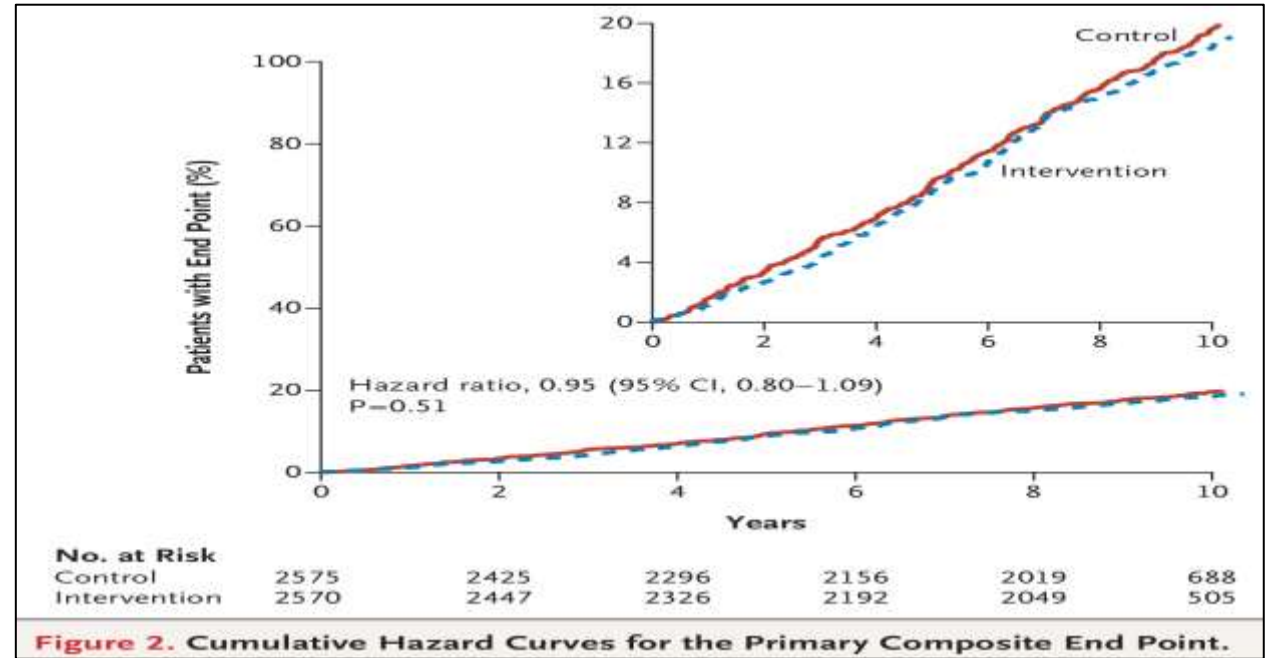
RESULTS

The trial was stopped early on the basis of a futility analysis when the median follow-up was 9.6 years. Weight loss was greater in the intervention group than in the control group throughout the study (8.6% vs. 0.7% at 1 year; 6.0% vs. 3.5% at study end). The intensive lifestyle intervention also produced greater reductions in glycated hemoglobin and greater initial improvements in fitness and all cardiovascular risk factors, except for low-density-lipoprotein cholesterol levels. The primary outcome occurred in 403 patients in the intervention group and in 418 in the control group (1.83 and 1.92 events per 100 person-years, respectively; hazard ratio in the intervention group, 0.95; 95% confidence interval, 0.83 to 1.09; $P=0.51$).

CONCLUSIONS

An intensive lifestyle intervention focusing on weight loss did not reduce the rate of cardiovascular events in overweight or obese adults with type 2 diabetes. (Funded by the National Institutes of Health and others; Look AHEAD ClinicalTrials.gov number, NCT00017953.)

The Look Ahead Trial showed no CV benefit.



* There was a positive effect in a post hoc analysis among participants with more substantial (>10%) weight loss in year 1. Because the progression of atherosclerosis takes time, much larger weight losses, sustained over longer periods, are likely needed to obtain benefits on major adverse cardiovascular events (MACE).

Gregg E. *Lancet Diabetes Endocrinol* 2016;4(11):913-921

Evidence for cardiovascular effects of drug-induced weight loss

Therapeutic interventions targeting obesity, particularly with glucagon-like peptide-1 receptor agonists (GLP-1), have shown promising CV benefits, as shown in some of many trials:

- **STEP-HFpEF** (*Research Study to Investigate How Well Semaglutide Works in People Living With Heart Failure and Obesity*) showed that weight reduction with semaglutide significantly improved symptoms and quality of life in patients with HFpEF and obesity. Additional studies confirmed that caloric restriction and exercise training similarly enhance CV fitness in this patient population.
- Beyond HFpEF, several large-scale CV outcome trials have validated significant CV advantages associated with GLP-1. The **PIONEER 6** (*Peptide Innovation for Early Diabetes Treatment 6*) trial with oral semaglutide and the **SUSTAIN 6** (*Trial to Evaluate Cardiovascular and Other Long-term Outcomes with Semaglutide in Subjects With Type 2 Diabetes*) trial with injectable semaglutide established CV safety, with trends toward reduction in major adverse CV events (MACE).
- Similarly, the **REWIND** (*Researching Cardiovascular Events with a Weekly Incretin in Diabetes*) trial using dulaglutide reported a 12% reduction in MACE among a broad participant group, many of whom lacked established cardiovascular disease. These cardiovascular benefits likely result from multiple mechanisms, including reduced adiposity, improved endothelial function, anti-inflammatory effects, and direct CV actions.

Kosiborod MN, Abildstrom SZ, Borlaug BA, et al. *N Engl J Med* 2023;389:1069–84.

Kitzman DW, Brubaker P, Morgan T, et al. *JAMA* 2016;315:36–46.

Husain M, Birkenfeld AL, Donsmark M, et al. *N Engl J Med* 2019;381:841–51.

Marso SP, Bain SC, Consoli A, et al. *N Engl J Med* 2016;375:1834–44.

Gerstein HC, Colhoun HM, Dagenais GR, et al. *Lancet* 2019;394:121–30.

Drucker DJ. *Cell Metab* 2016;24:15–30.

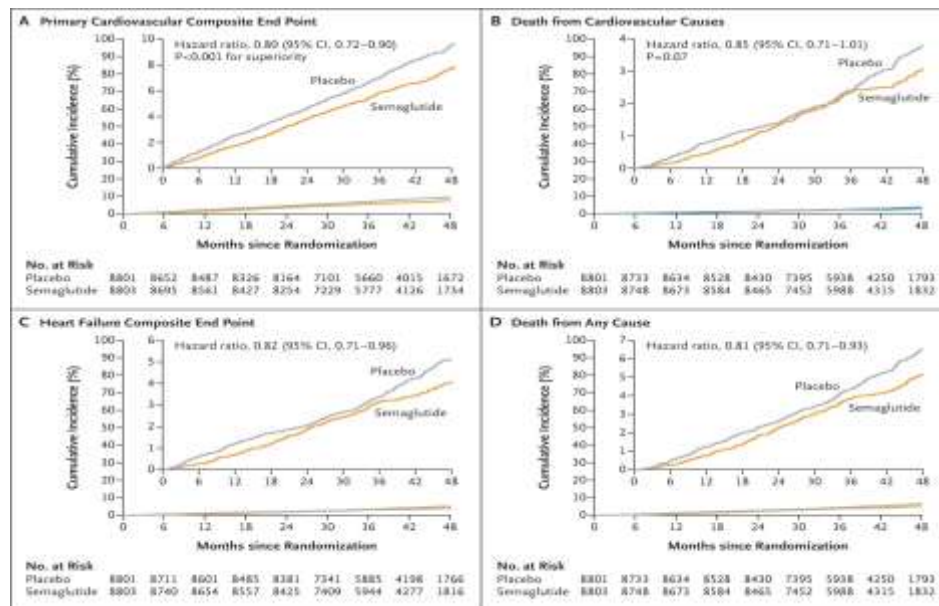


The SELECT Trial

AHA: *The SELECT trial offers a narrative of change urging the medical community to embrace obesity management as a cornerstone of CV and metabolic health.*

SELECT (*Semaglutide Effects on Cardiovascular Outcomes in People with Overweight or Obesity*) trial
 RCT 17,604 participants w/pre-existing CVD and obesity, no diabetes

Time-to-First-Event Analysis for Primary and Confirmatory Secondary Efficacy End Points.



RESULTS:

20% risk reduction for major CV events (composite event CV death, non fatal MI, non fatal stroke) in **semaglutide** arm (early effect).

Dramatic reduction in BMI and progression of diabetes.

CONCLUSION:

In patients with established CVD and overweight or obesity (no diabetes), weekly subcutaneous 2.4 mg **semaglutide** reduced the risk of MACE (death from CVD, nonfatal myocardial infarction, or nonfatal stroke) at a mean follow-up of 39.8 months.

Evidence for cardiovascular effects of weight loss

Collectively, this accumulating evidence underscores that addressing clinical obesity pharmacologically, particularly with GLP-1 receptor agonists, can offer substantial CV protection, representing a paradigm shift in CV risk reduction strategies in obese patients.

Kosiborod MN, Abildstrom SZ, Borlaug BA, et al. N Engl J Med 2023;389:1069–84.
Kitzman DW, Brubaker P, Morgan T, et al. JAMA 2016;315:36–46.
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Drucker DJ. Cell Metab 2016;24:15–30.
Lincoff AM, Brown-Frandsen K, Colhoun HM, et al. N Engl J Med 2023;389:222132.

Need for Holistic Approach to weight management




- There is a shift in the paradigm, understanding obesity as a chronic cardiometabolic disease, difficult to manage (reduce weight and maintain weight) without a holistic approach and combination strategies: lifestyle interventions, pharmacotherapy, and interventional or surgical procedures.
- A patient-centred approach is needed for the heterogeneous group of persons with obesity with distinct metabolic and CV risk profiles and differences in cultural backgrounds and preferences, requiring specific, individualized, and tailored treatments.
- The 10-year follow-up data of RCT *Diabetes Prevention Program* showed cumulative incidence of diabetes remained lower in the lifestyle group even in the setting of partial weight regain. Weight regain may not fully diminish benefits of weight loss on cardiometabolic health, but traditional lifestyle modifications programme likely require a greater focus on long-term weight management.

Need for Holistic Approach to weight management

- A multi-disciplinary team of specialists, including cardiologist, needs to conduct a complete medical, dietary, and activity history to uncover factors that may have contributed to weight gain.
- To support individual weight loss goals, a personalized treatment plan is individually tailored, including nutritional recommendations, education, eating strategies, activity adjustments, lifestyle modification, psychotherapy or behavioural therapy, coaching, and management of medications.
- The treatment period depends on each patients' degree of motivation and concurrent health conditions.
- For some patients, the evaluation determines that bariatric surgery as the most effective means of achieving weight loss goals.
- Drug treatment should be used as a complementary rather than substitutive treatment option. Long-term adherence to a healthy lifestyle remains critical in order to potentiate and maintain the favourable drug effects.

CENTENNIAL COLLECTION

Obesity and Cardiovascular Disease: A New Dawn

Naveed Sattar, MD , Ian J. Neeland, MD , and Darren K. McGuire, MD 

- The cardiology profession is at a new dawn with respect to obesity. Given that **many patients with or at elevated risk of CVD are now living with overweight and obesity and often have several other weight-related comorbidities**, evidence-based weight loss treatments that simultaneously lower MACE and other weight-related outcomes have the potential to be transformative.
- In addition, such new evidence should motivate cardiologists to **adopt weight-related interventions earlier in the disease course** to help prevent or delay the development of many adverse cardiovascular conditions and to improve patients' lives.
- If obesity is allowed to be unchecked, it is likely that **multimorbidity rates will continue to rise, and stroke and HF rates may even start to increase in younger groups**, threatening to reverse the gains of the preceding 3 or 4 decades.
- The time has come for the cardiovascular community to join others in medicine **to tackle the public health problem of obesity, and to help reduce the burden of cardiovascular and non cardiovascular consequences of excess adiposity in the dawn of this new age.**

Obesity and cardiovascular disease: an ESC clinical consensus statement

**Konstantinos C. Koskinas^{1*†}, Emeline M. Van Craenenbroeck^{2,3*†},
Charalambos Antoniades⁴, Matthias Blüher⁵, Thomas M. Gorter⁶,
Henner Hanssen⁷, Nikolaus Marx⁸, Theresa A. McDonagh^{9,10},
Geltrude Mingrone^{11,12}, Annika Rosengren^{13,14}, Eva B. Prescott^{15*†},
and the ESC Scientific Document Group**

The global prevalence of obesity has more than doubled over the past four decades, currently affecting more than a billion individuals. Beyond its recognition as a high-risk condition that is causally linked to many chronic illnesses, obesity has been declared a disease *per se* that results in impaired quality of life and reduced life expectancy. Notably, two-thirds of obesity-related excess mortality is attributable to cardiovascular disease. Despite the increasingly appreciated link between obesity and a broad range of cardiovascular disease manifestations including atherosclerotic disease, heart failure, thromboembolic disease, arrhythmias, and sudden cardiac death, obesity has been underrecognized and sub-optimally addressed compared with other modifiable cardiovascular risk factors. In the view of major repercussions of the obesity epidemic on public health, attention has focused on population-based and personalized approaches to prevent excess weight gain and maintain a healthy body weight from early childhood and throughout adult life, as well as on comprehensive weight loss interventions for persons with established obesity. This clinical consensus statement by the European Society of Cardiology discusses current evidence on the epidemiology and aetiology of obesity; the interplay between obesity, cardiovascular risk factors and cardiac conditions; the clinical management of patients with cardiac disease and obesity; and weight loss strategies including lifestyle changes, interventional procedures, and anti-obesity medications with particular focus on their impact on cardiometabolic risk and cardiac outcomes. The document aims to raise awareness on obesity as a major risk factor and provide guidance for implementing evidence-based practices for its prevention and optimal management within the context of primary and secondary cardiovascular disease prevention.

Take-Home Messages

- **Obesity is now recognized as chronic disease**, not only a CV risk factor. It is a heterogeneous condition in which individuals with similar BMIs may have distinct metabolic and CVD risk profiles.
- **Susceptibility to obesity-related CV complications depends largely on overall fat but mainly individual differences in regional body fat distribution**, which negatively affect cardiac structure and function.
- The increasing prevalence of obesity in populations with a longer life span, leads to the need to evaluate mechanisms underlying obesity-related cardiac dysfunction and to **improve the management of patients with cardiometabolic disease**.
- The dramatic increase in the proportion of young patients with severe obesity invokes the **need for more upstream interventions for the primary prevention and better treatment of obesity** to decrease CVD risk and complications.
- **Multidisciplinary, multilevel holistic approach needs combined strategies to be taken as early as possible.**

Participate at our Congress ESC Preventive Cardiology Congress 2026!



The poster features a central graphic of a heart surrounded by overlapping, semi-transparent petals in shades of green, orange, and red, with a glowing effect. The text is arranged on the left side, with the EAPC logo at the top left. The main title 'ESC Preventive Cardiology 2026' is in large green and orange letters. Below it, 'EAPC Annual Congress' is in black, and the dates and location '23-25 April Ljubljana, Slovenia' are in red. At the bottom left, the website and hashtag are provided. The ESC logo is at the bottom right.

 **EAPC**
European Association
of Preventive Cardiology

ESC
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2026
EAPC Annual Congress
23-25 April
Ljubljana, Slovenia

[escardio.org/ESCPrev](https://www.escardio.org/ESCPrev) | #ESCPrev26

 **ESC**

[https://www.escardio.org/Sub-specialty-communities/European-Association-of-Preventive-Cardiology-\(EAPC\)](https://www.escardio.org/Sub-specialty-communities/European-Association-of-Preventive-Cardiology-(EAPC))