ASER AMERICAN SOCIETY FOR ENHANCED RECOVERY AND PERIOPERATIVE MEDICINE

PULSE

SEPTEMBER 2026

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Interactive Clinical Case: GLP-1 Receptor Agonists & The Preoperative Stomach. Navigating Guidelines Through Real-World Practice

Upcoming Conference Highlights

JOIN US FOR THE 2026 ASER ANNUAL MEETING!

Get an exclusive sneak peek inside at the preliminary schedule and key sessions.

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ASER AMERICAN SOCIETY FOR ENHANCED RECOVERY AND PERIOPERATIVE MEDICINE

PULSE

September 2026

You will notice us trying new things, too. This issue introduces our Case of the Issue, a clinical scenario worked through with the evidence behind each decision, and we are building our presence on social media, where every follow, comment, and shared case helps us reach the next colleague who has not yet found us. We are also collaborating with partner Societies- together we are stronger than alone.

Please also circle November 12 to 14 on your calendar. ASERPM 2026, our Annual Congress of Enhanced Recovery and Perioperative Medicine, takes place at the Texas Medical Center TMC Houston.

You can find us at:

MESSAGE FROM THE PRESIDENT

Dear Colleagues,
Welcome to the refreshed ASER PULSE newsletter!

Nearly every one of us, whatever our specialty, cares for surgical patients, and that is exactly who this society is for. Enhanced recovery and perioperative medicine belong to no single discipline; the goal is the same in every operating room, ward, and clinic: better recovery for every patient. If you have ever wondered whether the American Society of Enhanced Recovery & Perioperative Medicine (ASER PM) has something for your practice, the answer is yes, and this issue is a good place to start.

Above all, this newsletter is yours. Have a great case study, team photo, milestone, or lesson learned? We'd love to feature it! Send your submissions to info@aserhq.org.

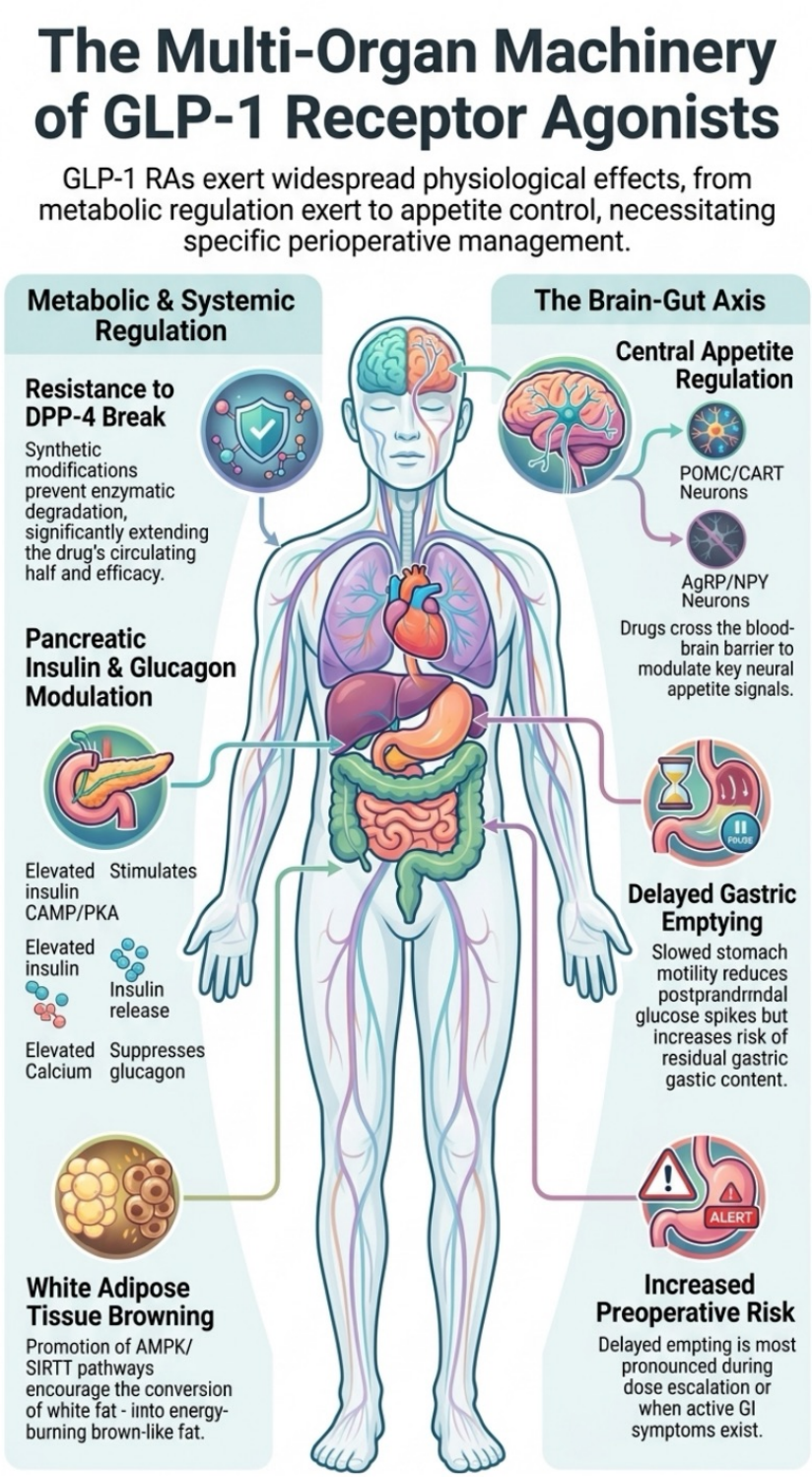
Enjoy the issue and see you in Houston!
Warm regards,

Anoushka Afonso, MD, FASA
President American Society of Enhanced Recovery and Perioperative Medicine

ASER AMERICAN SOCIETY FOR ENHANCED RECOVERY AND PERIOPERATIVE MEDICINE

Case of the issue: GLP-1 receptor agonists and the preoperative stomach

Details describe a composite patient assembled for teaching purposes.



A 58-year-old woman with type 2 diabetes (HbA1c 7.8%) and a BMI of 36 arrives for elective laparoscopic cholecystectomy. Four months ago she started weekly semaglutide, and she is still in the dose-escalation phase. Her last injection was three days ago. Nobody asked about the drug at scheduling, and it never came up in the preoperative clinic.

She followed the instruction she received: last solid food ten hours before arrival, clear carbohydrate drink finished two hours ago. In the preoperative bay she mentions, almost by accident, two weeks of bloating, early satiety, and occasional nausea.

What would you do next?

- A. Proceed as scheduled; on paper, her fast exceeds every guideline minimum.
- B. Postpone and reschedule after she has held semaglutide for a week.
- C. Proceed with rapid sequence induction, treating her as a full stomach.
- D. Perform a gastric point-of-care ultrasound and let the findings decide.

The answer is D.

That comment prompts a gastric point-of-care ultrasound in the right lateral decubitus position, which shows solid content in the antrum despite a textbook fast.

After a three-way conversation among anesthesiologist, surgeon, and patient, the case is postponed. She returns later that week after a 24-hour clear-liquid diet, a symptom check, and a repeat scan showing an empty antrum. The surgery and recovery were uneventful; the debrief focused entirely on optimizing the clinical pathway rather than managing patient complications.

Why this keeps happening?

Which patient on a weekly GLP-1 receptor agonist is most likely to arrive with a full stomach despite fasting correctly?

- A. Two years on a stable maintenance dose, with no gastrointestinal symptoms.
- B. A few months in, still dose-escalating, with bloating and early satiety.
- C. All of them; the risk is the same regardless of dose and duration.
- D. Only a patient who injected on the morning of surgery.

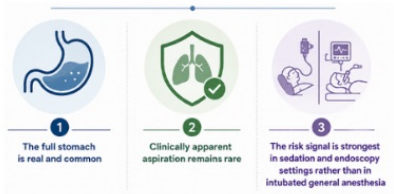
The answer is B, and she is the patient in this case.

GLP-1 RAs (semaglutide, tirzepatide, etc.) slow gastric emptying, peaking during drug initiation, dose escalation, or active GI symptoms.

With ~1 in 8 US adults using these medications for diabetes, obesity, or cardiovascular indications, proactive perioperative and ERAS management is essential.

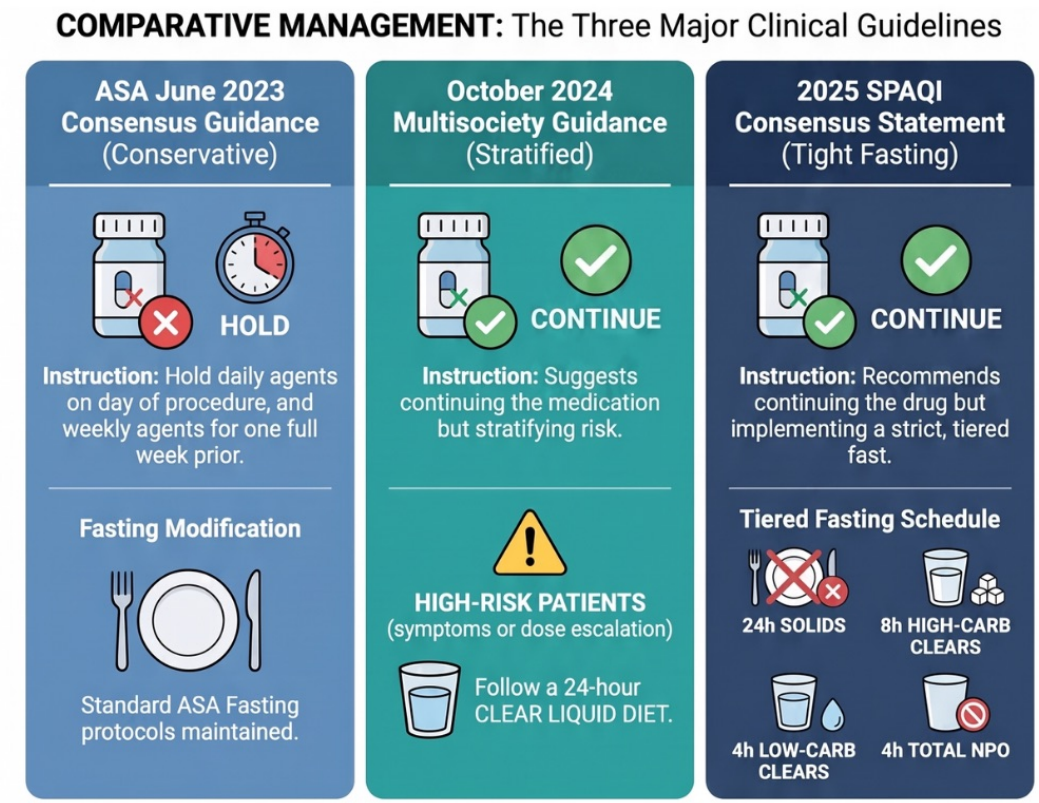
What the evidence actually shows?

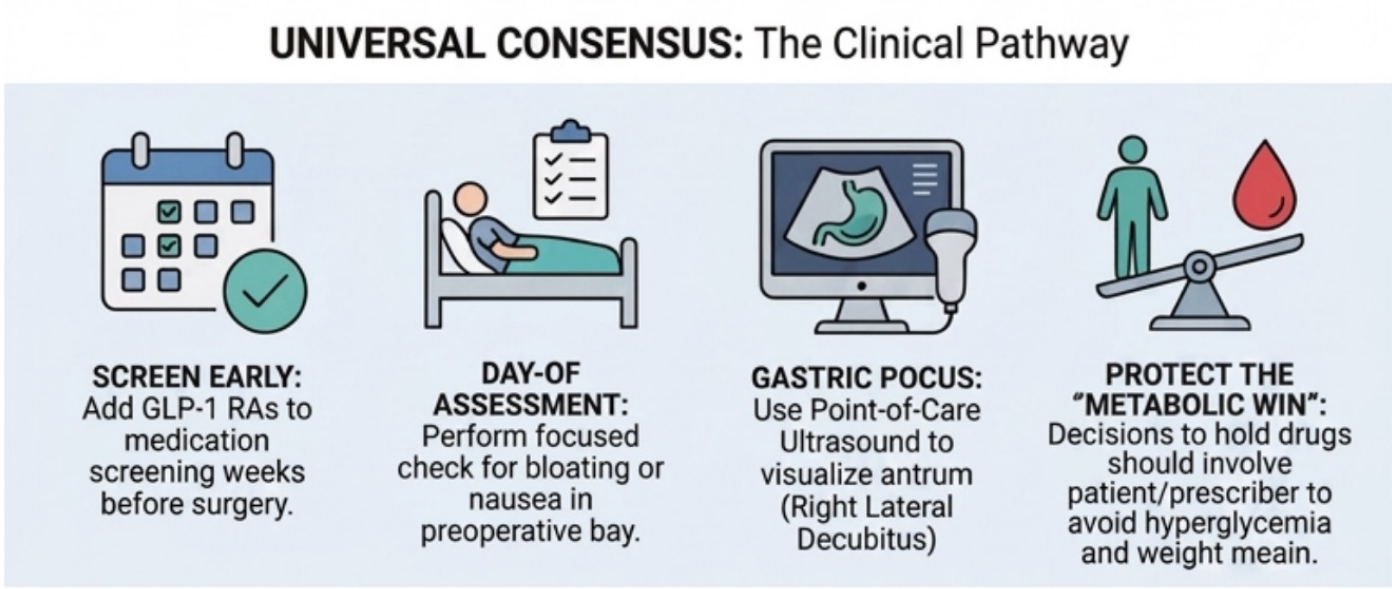
Surrogate Outcome (Full Stomach): Significantly increased under GLP-1 RAs despite fasting. Retrospective data shows retained contents in 24.2% vs. 5.1% (aOR 5.15) (Silveira 2023), and prospective ultrasound confirms a higher prevalence (56% vs. 19%) (Sen 2024).



Clinical aspiration remains rare with no overall risk increase in general surgical cohorts (0.8% vs. 0.7%, OR 1.07) (Wright 2025; Barlowe 2025). However, a large meta-analysis (N>1.25M) noted elevated risk during upper endoscopies (Tan 2025).

Where the guidance stands, and where it argues





References
- Silveira SQ, da Silva LM, de Campos Vieira Abib A, et al. Relationship between perioperative semaglutide use and residual gastric content: a retrospective analysis of patients undergoing elective upper endoscopy. J Clin Anesth. 2023;87:111091. PMID 36870274.
- Sen S, Potnuru PP, Hernandez N, et al. Glucagon-like peptide-1 receptor agonist use and residual gastric content before anesthesia. JAMA Surg. 2024;159(6):660-667. doi:10.1001/jamasurg.2024.0111. PMID 38446466.
- Wright JD, Chen L, Xu X, et al. Glucagon-like-peptide-1 (GLP-1) receptor agonist use and the risk of pulmonary aspiration in patients undergoing surgery. Int J Surg. 2025;111(6):4090-4093. doi:10.1097/JS9.0000000000002425. PMID 40359555.
- Barlowe TS, Anderson C, Sandler RS, et al. Glucagon-like peptide-1 receptor agonists do not increase aspiration during upper endoscopy in patients with diabetes. Clin Gastroenterol Hepatol. 2025;23(4):739-747. PMID 38759826.
- Tan Y, Zhang X, Lv XH, Sun YN, Yang JL, Xiao X. Glucagon-like peptide-1 receptor agonists increase the risk of residual gastric content and pulmonary aspiration on upper endoscopy: A meta-analysis. Dig Liver Dis. 2025 Jul;57(7):1377-1385. doi: 10.1016/j.dld.2025.03.002. Epub 2025 Mar 24. PMID: 40133086.
- Ushakumari DS, Sladen RN. ASA Consensus-based Guidance on Preoperative Management of Patients on Glucagon-like Peptide-1 Receptor Agonists. Anesthesiology. 2024 Feb 1;140(2):346-348. doi: 10.1097/ALN.0000000000004776. PMID: 37982170.
- Kindel TL, Wang AY, Wadhwa A, et al. Multisociety clinical practice guidance for the safe use of glucagon-like peptide-1 receptor agonists in the perioperative period. Clin Gastroenterol Hepatol. 2025;23(12):2083-2085 (Epub 2024 Oct 29; co-published in Surg Obes Relat Dis). doi:10.1016/j.cgh.2024.10.003. PMID 39480373.
- Oprea AD, Ostapenko LJ, Sweitzer B, et al. Perioperative management of patients taking glucagon-like peptide 1 receptor agonists: Society for Perioperative Assessment and Quality Improvement (SPAQI) multidisciplinary consensus statement. Br J Anaesth. 2025;135(1):48-78. doi:10.1016/j.bja.2025.04.001. PMID 40379536.

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ASER-PM

CONFERENCE NEWSLETTER

ANNUAL CONFERENCE - PERIOPERATIVE MEDICINE

ASER-PM UPDATE

A focused invitation for the peroperative medicine community.

SHARE YOUR WORK
MEET THE COMMUNITY
JOIN THE CONVERSATION

REGISTER ONLINE

ASER PEROPERATIVE MEDICINE

REGISTRATION FOR THE ANNUAL CONFERENCE

REGISTER ONLINE

Registration includes:

- Opening reception
- Access to all sessions and corporate workshops
- Abstract poster sessions
- Exhibitors and coffee breaks
- ASER conference materials

CALL FOR ABSTRACTS

Share your work with the ASER-PM community.

We invite you to submit abstracts for the ASER-PM annual conference. Bring forward the ideas, evidence and experiences shaping peroperative medicine.

SUBMIT YOUR ABSTRACT

ANNUAL CONFERENCE

SCHEDULE SNEAK PEEK

ASER-PM 2026 Preliminary Congress Program

Houston, TX | November 12-14, 2026

THURSDAY, NOVEMBER 12

- President's Welcome
- Workforce, Operations & Implementation Science
- Perioperative Monitoring Workshop
- Lifetime Achievement Award Lecture
- Poster Session, Abstract Awards & Welcome Reception

FRIDAY, NOVEMBER 13

- Pain Management & Recovery Optimization
- Precision & Personalized Recovery
- New Frontiers in Perioperative Medicine
- Interdisciplinary Care in Action

SATURDAY, NOVEMBER 14

- Meet the Expert — 9:00–10:00 AM, Blossom Hotel Lobby

VIEW THE FULL PROGRAM

aserhq.org/2026/program.php

Preliminary program subject to change.

ASER PERIOPERATIVE MEDICINE

HOW TO GET INVOLVED WITH ASER

ASER members can make an impact, build connections, and advance perioperative medicine by getting involved through ASER committees.

ASER COMMITTEES

- Education & Annual Meeting Committee
- Marketing and Outreach Committee
- Membership Committee
- Research Committee
- Trainee Committee
- Communications Committee
- Program Manager/Coordinator Committee

PROGRAM MANAGER/COORDINATOR COMMITTEE

A multidisciplinary networking forum for ERAS program coordinators, managers, and leaders.

- Share evidence-based clinical pathways
- Partner on patient education and engagement
- Support culture change and pathway adoption across the surgical continuum.

ASER-PM members may self-nominate for committees. Appointments are made by the Board, with two-year terms and participation in meetings, calls, and selected webinars.

GET INVOLVED

aserhq.org/web/about-committees.php

Trial of the Issue

TIVA or Volatile?

JAMA.
Published online August 12, 2026.
doi:10.1001/jama.2026.11065. PMID 42584898.

Total Intravenous vs Volatile Inhalational Anesthesia for Major Noncardiac Surgery

A Randomized Clinical Trial.

Shaman Jhanji, PhD1,2; Katie Booth, MSc3; Louise Hiller, PhD3; et al

Before you read: a one-tap poll.

In your own practice, roughly what share of major noncardiac cases do you maintain with propofol TIVA?

- Under 25%
- 25 to 50%
- 50 to 75%
- Over 75%

Hold that answer. We will come back to it.

Why this trial was needed?

TIVA use has grown fast over two decades, pushed by hypothesized cancer benefits and the carbon footprint of volatile agents, without a large randomized comparison in noncardiac surgery.
Cardiac surgery had MYRIAD (n=5,400, no mortality difference at one year). Noncardiac surgery had nothing comparable.
VITAL is that trial.

2 Design in one breath:
49 UK hospitals, 2,508 patients aged 50 or older having elective major noncardiac surgery, randomized 1:1 on the day of surgery to propofol infusion or a volatile agent.
Primary outcome: days alive and at home at 30 days (DAH30), powered for a one-day difference.

3 Question: **What did you expect VITAL to show?**

- TIVA improves DAH30
- Volatile improves DAH30 (cardioprotection)
- No difference
- TIVA is worse because of awareness

4 The answer is C.

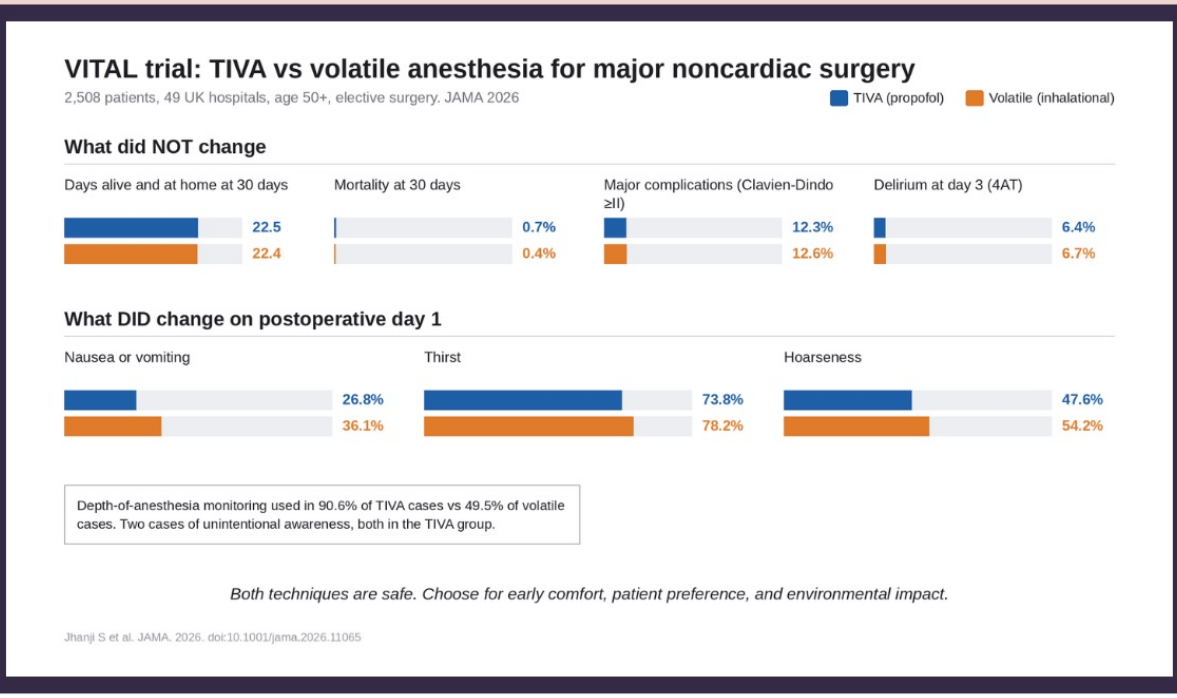
DAH30 was **22.5 days with TIVA** and **22.4 with volatile** (IRR 1.00, 95% CI 0.99 to 1.02).
Mortality did not differ at 30 days (0.7% vs 0.4%), 90 days (1.1% vs 1.6%) or six months (3.0% vs 3.9%).
Clavien-Dindo grade II or higher complications: 12.3% vs 12.6%.
Delirium at day 3: 6.4% vs 6.7%. QoR-15 at day 3: 103.8 vs 103.6.

5 **The one place the techniques diverged was day 1 comfort.**

TIVA patients reported less nausea or vomiting (26.8% vs 36.1%), thirst (73.8% vs 78.2%) and hoarseness (47.6% vs 54.2%). The PONV gap is 9 absolute points, about one patient spared per 11 treated, on top of routine dexamethasone in 78%.

6 **What it means for enhanced recovery:**

Neither technique compromises survival, complications or recovery at home in elective noncardiac surgery. That reassurance runs both ways. The day−1 symptom advantage of TIVA is real currency in an ERAS pathway: fewer nauseated patients means earlier oral intake and mobilization.



Back to the poll: If VITAL changes your number, tell us why.