ASPIRE FUNCTIONAL AESTHETICS & WELLNESS

Beyond the Scale: A Smarter, Safer Approach to GLP-1 Therapy

Why the most effective GLP-1 protocols are about far more than the medication

Nikki Guzzo, PA-C & Brandon Guzzo | Aspire Functional Aesthetics & Wellness | June 2026

The Conversation Is Changing

When patients ask us about GLP-1 medications — Ozempic, Wegovy, Mounjaro, Zepbound — the first thing they usually want to know is: how much weight will I lose? That's a fair question. These medications are, without question, the most powerful fat-loss tools we have ever seen in pharmacology. But after years of working with patients on these protocols at Aspire, we've come to believe that framing GLP-1 therapy purely as a weight-loss intervention is one of the biggest missed opportunities in modern functional medicine.

The truth is that GLP-1 receptor agonists — and their newer, more powerful siblings that also activate GIP and glucagon receptors — are fundamentally **systemic metabolic medicines.** Their receptors are expressed in the heart, brain, liver, kidneys, gut, ovaries, bone cells, and immune system. When dosed correctly and supported by the right clinical infrastructure, they don't just change the number on the scale. They change the trajectory of a patient's entire metabolic health.

> **Our Philosophy:**
> *"A medication placed into a metabolic vacuum produces incomplete results. GLP-1 therapy works best when the full picture — thyroid, hormones, inflammation, body composition, mitochondrial health, genetics — is understood first."*
> **— Nikki Guzzo, PA-C**

What These Medications Are Actually Doing

GLP-1 (glucagon-like peptide-1) is a hormone your body produces naturally after eating. It signals the pancreas to release insulin, tells the brain you're full, slows gastric emptying, and reduces glucagon release. But its reach extends far beyond digestion — GLP-1 receptors have been found throughout the body, and the clinical implications are profound.

❤️ Cardiovascular

SELECT trial (n=17,604): 20% MACE reduction in non-diabetic obese patients. FDA-approved for this indication March 2024.

🫘 Kidney Protection

FLOW trial: 24% ↓renal composite endpoint ($p<0.001$). FDA-approved January 2025 for CKD progression prevention in T2DM.

🧠 Brain & Neurological

Reduces amyloid-β & tau accumulation linked to Alzheimer's. 8–12% ↓dementia risk in 300,000+ VA patients. Active trials: Parkinson's, MS, ALS.

😴 Sleep Apnea & Inflammation

Reduces airway inflammation independent of weight loss. ↓TNF-α, IL-1β system-wide. Downstream benefits for cortisol and metabolic rate.

🫁 Liver (MASH/MASLD)

Reduces hepatic fat, inflammation, fibrosis. Survodutide (GLP-1+Glucagon): 62% MASH resolution (FDA Breakthrough). Mazdutide: 80% liver fat reduction.

⏳ Longevity & Senescence

Delays cellular senescence; ↓visceral-fat 'inflammaging'; mitochondrial protection. Some of the most compelling longevity data in current literature.

The 2026 Study That Changed Our Protocol for Women

Castaneda R, Hurtado Andrade MD et al. The Lancet Obstetrics, Gynaecology, & Women's Health, January 22, 2026. Mayo Clinic / Wayne State University. n=120 postmenopausal women (BMI ≥27), tirzepatide ≥12 months; 40 concurrent MHT users vs 80 matched controls. Mean age 56.4 years. Mean follow-up: 18 months.

Tirzepatide Only	Tirzepatide + HRT	Statistical Result
−14.0% total body weight lost 18% reached ≥20% TBWL	**−19.2%** total body weight lost 45% reached ≥20% TBWL	**35% more weight lost** Δ −5.2% (95% CI: 1.90–8.54) **p = 0.0023** Additional benefits: ↓diastolic BP, ↓triglycerides, ↓AST in HRT group

The Body Composition Problem Nobody Talks About

Two landmark DXA body composition studies tell a sobering story — and reveal a meaningful difference between the two most-prescribed GLP-1 medications.

Semaglutide — STEP 1 & SUSTAIN 8 DXA data: In the STEP 1 DXA sub study (Wilding et al., NEJM, 2021; Neeland et al., Diabetes Obes Metab, 2024), lean mass accounted for approximately 45.2% of total weight lost (lean mass −6.92 kg; total weight loss −15.3 kg). The SUSTAIN 8 sub study found a nearly identical 43.4% lean fraction. Across the semaglutide literature, the consistently reported figure is that roughly **~40% of the weight lost on semaglutide is lean mass — not fat.**

Tirzepatide — SURMOUNT-1 DXA data: The SURMOUNT-1 DXA sub study (Look et al., Diabetes Obes Metab, 2025) showed a lean mass fraction of approximately 25–26% (lean mass −5.67 kg; total weight loss −22.1 kg at highest dose) — meaningfully better than semaglutide, but still representing 1 in every 4 pounds lost coming from muscle without a protection protocol.

Semaglutide vs Tirzepatide Lean Mass Gap: ~40–45% lean fraction (semaglutide) vs ~25–26% lean fraction (tirzepatide) — a ~15–20 percentage-point difference that constitutes one of the strongest arguments for preferring tirzepatide when clinically appropriate. On either agent, a muscle-protection protocol is not optional.

Semaglutide Only	Tirzepatide Only	+ Protein ≥1.6g/kg + Resistance 3–4×/wk	+ HRT + Protein + Training. (even postmenopausal)
~40–45% of weight lost = lean mass STEP 1 / SUSTAIN 8 DXA (Neeland 2024) ~1 lb muscle per 2.5 lbs lost. For 30 lbs total loss: up to 12 lbs could be muscle.	**~25–26%** of weight lost = lean mass SURMOUNT-1 DXA (Look 2025) Better than semaglutide, but still ~1 lb muscle per 4 lbs lost without a protocol.	**~11%** of weight lost = lean mass (89% fat) SURMOUNT-1 protein/exercise subgroup Protein + mechanical loading determines what tissue is lost — entirely within the patient's control.	**Best** body composition outcome **Estrogen:** activates ERα/ERβ in muscle; amplifies hypertrophy from training. HRT reduces bone loss 50–80%; WHI: 34% ↓hip fractures. **GIP (Tirzepatide):** receptors on osteoblasts may confer additional bone-forming benefit.

The Aspire Protocol: Precision Before Prescribing

"We don't believe in starting any patient on a GLP-1 medication without first understanding their full metabolic picture."

— Brandon Guzzo, Aspire Functional Aesthetics & Wellness

1

Comprehensive Lab Panel — Metabolic, Hormonal & Inflammatory Baseline

Full-spectrum blood panel: thyroid (TSH, Free T3, Free T4, Reverse T3, TPO/TgAb antibodies); sex hormones (estradiol, progesterone, testosterone, SHBG, DHEA-S, LH, FSH); adrenal markers; insulin resistance (fasting insulin, HOMA-IR, HbA1c); advanced lipid panel; inflammatory markers (hsCRP, homocysteine, fibrinogen); liver/kidney function; CBC; nutrient status (vitamin D, B12, folate, magnesium, ferritin, zinc); IGF-1, leptin, adiponectin. This is not a standard metabolic panel — it is a comprehensive metabolic investigation.

2

Thyroid Screening — Non-Negotiable for Every Female Patient

GLP-1 medications cannot correct impaired T4→T3 conversion or low thyroid signaling. Women who struggle most on GLP-1 protocols frequently have undertreated or unrecognized hypothyroidism. Hypothyroid patients with constipation are at meaningful GI motility risk. Per Dr. Amie Hornaman (The Thyroid Fix): optimized T3 + GLP-1 therapy consistently produces superior fat loss outcomes vs either intervention alone. We screen every female patient before initiating therapy.

3

Hormonal Optimization — Peri- and Post-Menopausal Assessment

In light of Castaneda et al. (2026), every postmenopausal woman is assessed for HRT candidacy. Full hormonal evaluation, contraindication review, individualized benefit/risk discussion. We re-check every 12 weeks after HRT initiation — sub-therapeutic estrogen = sub-therapeutic metabolic benefit. The most underutilized clinical lever in functional medicine for women on GLP-1 therapy.

4

Monthly Biometric Testing — Tracking What Actually Matters

Advanced body composition analysis every month. We track skeletal muscle mass (lbs and %), body fat %, visceral fat level, bone density markers, and cellular hydration (phase angle). Phase angle is one of the most sensitive early indicators of lean tissue health without a DXA scan. We do not manage GLP-1 therapy by scale weight alone — a patient can show 12 lbs lost while simultaneously losing muscle at an alarming rate. We catch these patterns early and intervene.

5

PNOĒ Metabolic Testing — Quarterly for Body Composition & Human Optimization Programs

Every patient in our Lose Body Fat & Gain Lean Muscle program or Human Optimization Program receives a PNOĒ breath analysis every quarter. Provides: VO_2max (cardiovascular fitness & longevity marker), RMR and MBR, fat vs carbohydrate utilization ratios, mitochondrial health indicators, aerobic/anaerobic threshold. GLP-1 medications affect metabolic rate and substrate utilization in ways that vary significantly between individuals. Quarterly PNOĒ + bloodwork allows data-driven protocol adjustments rather than assumptions.

6

Microdosing Philosophy — The Aspire Standard

The majority of GLP-1 side effects are not caused by the medication — they are caused by dose escalation that happens too quickly. Standard pharmaceutical escalation schedules are designed for populations, not individuals. We begin at the lowest viable dose, hold until body composition data, energy, appetite response, and labs confirm readiness, and advance slowly. This is not optional caution — it is an ethical obligation. A patient who stops therapy due to debilitating nausea has not been served by aggressive titration.

Genetics, Methylation & Gut Microbiome Testing

For comprehensive human optimization patients: genetic testing covering methylation (MTHFR, COMT), detoxification capacity, nutrient metabolism variants, and hormonal processing genes — explaining why identical protocols produce different results between patients. Paired with gut microbiome analysis: a disrupted microbiome can blunt GLP-1 receptor sensitivity, impair signaling molecule synthesis, and sustain the inflammation these medications target. Baseline microbiome testing allows targeted interventions to maximize GLP-1 response from day one.

Best Practices: Protecting Muscle & Bone

The Aspire Commitment:
We do not consider GLP-1 therapy successful if a patient loses 20 pounds but arrives at their goal with less muscle, weaker bones, nutrient deficiencies, and no understanding of how to maintain results. Success means a stronger, healthier body — measurably confirmed in our biometric and metabolic data every single month.

Minimum Protection Protocol for Every Patient

- Protein ≥1g/lb body weight per day — minimum for lean mass preservation during active caloric deficit
- Resistance training 3–4× per week — the non-negotiable mechanical loading signal
- Creatine supplementation assessment — evidence stronger than most clinicians acknowledge
- Micronutrient monitoring: B12, Vitamin D (target >30 ng/mL), Magnesium, Iron, Calcium 1,000–1,200mg/day
- Hydration protocols — GLP-1s reduce thirst signals; cellular hydration tracked monthly via phase angle

For Postmenopausal Women — Additional Protocol

- Baseline DEXA scan before initiating therapy; follow-up at 12 months
- HRT candidacy assessment and individualized benefit/risk discussion (informed by Castaneda 2026)
- Estradiol recheck 8–12 weeks after HRT initiation to confirm therapeutic levels
- Tirzepatide preferred over semaglutide where appropriate — GIP receptor component may confer bone protection

For Our Patients: What to Expect & What to Ask

If you are considering GLP-1 therapy, here are the questions you should feel empowered to ask — whether you're seeing us or any other provider:

Questions to Ask Your Provider:

- "Has my thyroid been fully investigated?" — Not just TSH & T4. A complete panel including Free T3, Reverse T3, and antibodies is required.
- "What is your plan for monitoring my muscle mass?" — If there's no body composition monitoring plan, push for one.
- "Am I a candidate for hormone therapy?" — If you are postmenopausal, the 2026 Lancet data makes this a real clinical conversation.
- "What is your dosing philosophy?" — Aggressive escalation is the primary driver of side effects. Data should drive the timeline, not a calendar.

Day-to-Day Best Practices on Therapy:

- Protein first, every meal — prioritize complete protein sources; supplement if needed to hit targets
- Supplement amino acids with ONLY Perfect Amino brand to avoid glucose spikes.
- Lift weights/resistance bands if necessary starting point — there is no substitute for mechanical loading in preserving muscle during caloric restriction
- Stay hydrated — GLP-1s can suppress thirst signals; active electrolyte hydration is essential
- Report side effects before stopping — dose adjustment resolves the vast majority of GI issues
- Be patient with plateaus — a weight plateau can accompany continued fat loss and muscle gain; body composition data tells the real story

The Most Effective and Responsible Way Forward

GLP-1 receptor agonists represent a genuine paradigm shift in metabolic medicine. The breadth of their systemic benefits — cardiovascular, neurological, hepatic, renal, hormonal, and longevity-related — is unlike anything we have seen in our careers. We are genuinely excited about what these medications make possible for our patients.

But excitement does not replace responsibility. Prescribing a GLP-1 without comprehensive metabolic investigation, thyroid optimization, hormonal assessment, body composition monitoring, and a microdosing philosophy grounded in data is not just a missed opportunity — it can produce real harm.

At Aspire, our protocol is our answer to that responsibility. We believe it is the most effective and most ethical way to administer these extraordinary medications. And we are proud to offer it to every patient who is the right fit and who is willing to comply with our protocols.

Comprehensive testing → Precision dosing → Monthly biometric tracking → Quarterly metabolic & lab reassessment → Genetics + microbiome → Muscle & bone protection → Hormonal optimization
This is the Aspire GLP-1 Protocol — the most thorough, data-driven, and responsible approach we know how to build.

Clinical References

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This article is for educational purposes only. Not individualized medical advice. Consult a qualified HCP before initiating any medication. Observational study findings (Castaneda 2026) do not establish causality — prospective RCTs are ongoing.