
— MASS TORT LITIGATION

Before You File

What the GLP-1 Litigation Teaches About Clinical Case Vetting

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Few drugs have moved from niche to mainstream as fast as the GLP-1 receptor agonists. Semaglutide and tirzepatide, sold as Ozempic, Wegovy, Mounjaro, and Zepbound, are now among the most prescribed medications in the country, for diabetes and for weight loss. The litigation has grown just as quickly.

The federal gastrointestinal cases sit in MDL 3094 in the Eastern District of Pennsylvania, created in February 2024 and now before Judge Karen S. Marston. Public trackers put the pending count at roughly 4,000. The claims mostly involve gastroparesis, with others alleging ileus, intestinal obstruction, and gallbladder injury. In December 2025 the Judicial Panel on Multidistrict Litigation created a second MDL, 3163, for claims of non-arteritic anterior ischemic optic neuropathy (NAION), a sudden, painless loss of vision in one eye. That panel also sent the cases to the Eastern District of Pennsylvania. Europe's drug safety committee concluded in 2025 that NAION is a very rare side effect of semaglutide. The manufacturers dispute causation, and nothing has been tried.

I want to use this litigation to talk about something that applies to every mass tort, whichever side you're on: vetting the individual claim against the medical record before it costs you time, money, or credibility.

THE RULING THAT RESHAPED THE DOCKET

In August 2025, Judge Marston took up a question that sounds technical but turned out to matter a great deal: can a physician reliably diagnose gastroparesis without doing a gastric emptying study? The court said no. Plaintiffs alleging drug-induced gastroparesis have to have had a gastric emptying study at the time of diagnosis.

A large share of claimants had been diagnosed on symptoms alone: nausea, vomiting, early fullness, a note in the chart that said “likely gastroparesis.” Those claims now face a problem that no amount of advocacy can fix.

The broader lesson is that a clinical diagnostic standard can become a legal threshold, sometimes overnight. Good vetting anticipates that. It asks from the start whether the diagnosis would hold up to a gastroenterologist’s scrutiny, because eventually it will have to.

General causation is being fought across the whole docket now. Under the case management order, expert reports were exchanged early in 2026, expert depositions closed in April, and briefing on motions to exclude and for summary judgment ran through the summer. The outcome will shape every case. But even a win on general causation doesn’t carry an individual claim. That’s where the record comes in.

A FICTIONAL CLIENT

She’s 58, with type 2 diabetes. Her doctor started semaglutide for blood sugar control. Over the next few months she had nausea, vomiting, and felt full after a few bites. Her primary care physician wrote “possible gastroparesis” and lowered the dose. Six months in, she stopped the drug. She’s better, but not back to normal, and she wants to know if she has a case.

FIRST, PROVE WHAT SHE ACTUALLY TOOK

It sounds too basic to mention. It isn’t.

Get the pharmacy dispensing records, not her memory and not the prescription alone. You need the product, the manufacturer, every fill date, and the dose at each fill. With GLP-1s this step catches a surprising number of problems, because compounded semaglutide and tirzepatide were sold widely during the shortage years, through telehealth companies and medical spas as well as pharmacies. A compounded product isn’t the brand product the MDL defendants make, and it raises entirely different questions. FDA took both drugs off its shortage list in 2025, but plenty of patients were on compounded versions before then, and some don’t know it.

Then line up her symptoms against the dosing. These drugs are titrated up over weeks. Did the nausea start after the first dose, after a step up, or months later on a stable dose? A clean temporal link doesn’t prove anything by itself. A missing one can sink the claim.

SECOND, TEST THE DIAGNOSIS THE WAY THE COURT WILL

Did she have a gastric emptying study? When, and how was it done? The accepted standard is a four-hour solid-meal scintigraphy study. Shorter or nonstandard protocols invite challenge.

There's a clinical wrinkle here that's easy to miss. GLP-1 drugs slow stomach emptying on purpose; it's part of how they work. A study done while she was still taking the drug may simply be measuring the drug's expected effect. Clinical guidance generally calls for holding medications that affect gastric motility before testing. So ask: was she on the drug when the study was done? If yes, what does that do to the interpretation? A repeat study after she stopped, if one exists, may be the most important page in her chart.

THIRD, TAKE HER DIABETES SERIOUSLY

This is the question I'd ask first if I were defending the case, so it's the one I'd want answered first if I were bringing it. Diabetes is one of the most common causes of gastroparesis. Years of high blood sugar can damage the vagus nerve and the nerves in the stomach wall.

Pull her diabetes history. How long has she had it? What do her A1c values look like over the last five years? Does she have neuropathy in her feet, retinopathy, kidney changes, or any other sign of nerve damage from diabetes? Did anyone chart GI symptoms before she ever started semaglutide? A clean pre-drug record in a patient with well-controlled diabetes and no neuropathy is a very different case from a patient with an A1c of 11 and numb feet.

Then build out her medication list for the whole period, before and during. Opioids slow the gut. So do anticholinergics, some antidepressants, and several others. Add prior abdominal surgery, thyroid disease, and recent viral illness to the list of things to rule in or out.

For the vision claims, the same logic applies with different risk factors: a small, crowded optic disc, sleep apnea, hypertension, diabetes, and certain other medications. You'll need the ophthalmology exam, specifically what was seen at the optic nerve, and ideally a sleep study if one exists.

FOURTH, LOOK AT WHAT HAPPENED AFTER SHE STOPPED

Did the symptoms go away, get better, or stay the same? Persistent symptoms can support a claim of lasting injury. They can also point to an underlying condition that was there all along. Which one it depends on everything above.

FIFTH, DOCUMENT THE DAMAGES HONESTLY

What did the injury cost her? ER visits, hospital stays, a feeding tube, procedures, long-term medications. Be careful with weight loss, because it's also the reason many people take these drugs. The question is whether the loss was excessive or harmful. Look for documented malnutrition, dehydration, electrolyte problems, or kidney injury.

WHY THIS MATTERS TO BOTH SIDES

For plaintiff firms, early review sorts claims into three piles: ready, needs more records or testing, and unlikely to meet the court's requirements. That third pile isn't a judgment about whether the client suffered. It's a judgment about whether this litigation can compensate her for it.

For defendants, the same review identifies claims with better explanations or diagnostic gaps, and that shapes motion practice, bellwether picks, and resolution strategy.

Bellwether selection is where weak vetting gets expensive. A case that looks strong on a plaintiff fact sheet can look very different once someone reads five years of primary care notes. It's better to find that out early.

THE RECORDS I'D WANT

- Pharmacy dispensing records covering the entire period of use
- Prescriber records showing the indication and every dose change
- Primary care records going back several years before the first dose
- Gastroenterology records, including the full gastric emptying study report with its protocol
- Endoscopy, imaging, and labs, including A1c over time
- ER and hospital records for related visits
- For vision claims: ophthalmology and neuro-ophthalmology records, optic nerve findings and imaging, sleep study

The one people skip is the pre-drug baseline. It's also the one that most often decides the case. You can't say something changed if you don't know what it looked like before.

SOURCES AND REFERENCES

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