

# XXVIII IFSO World Congress

9-12 September 2025 | Santiago, Chile



## Why I do not do RYGB ?

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# IFSO 2025 Santiago

Combined Therapies, The Dawn of a New Era

[ifso2025.org](https://ifso2025.org)

# Nothing to Disclose

Except by the fact that

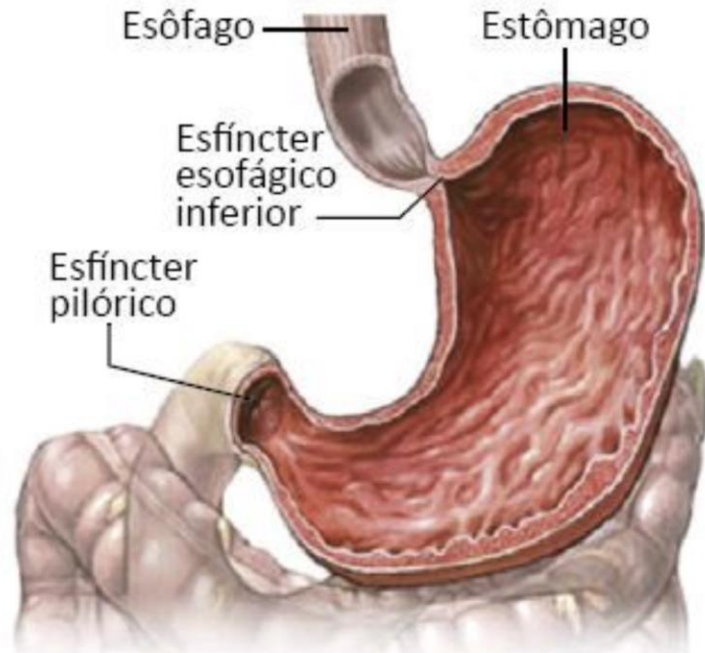
I do RYGB in Barret's Esophagus  
and large hiatal hernias...

## **Old Bariatric Procedures were designed for**

**Small Pouch  
Mechanical Restriction  
Slow emptying**

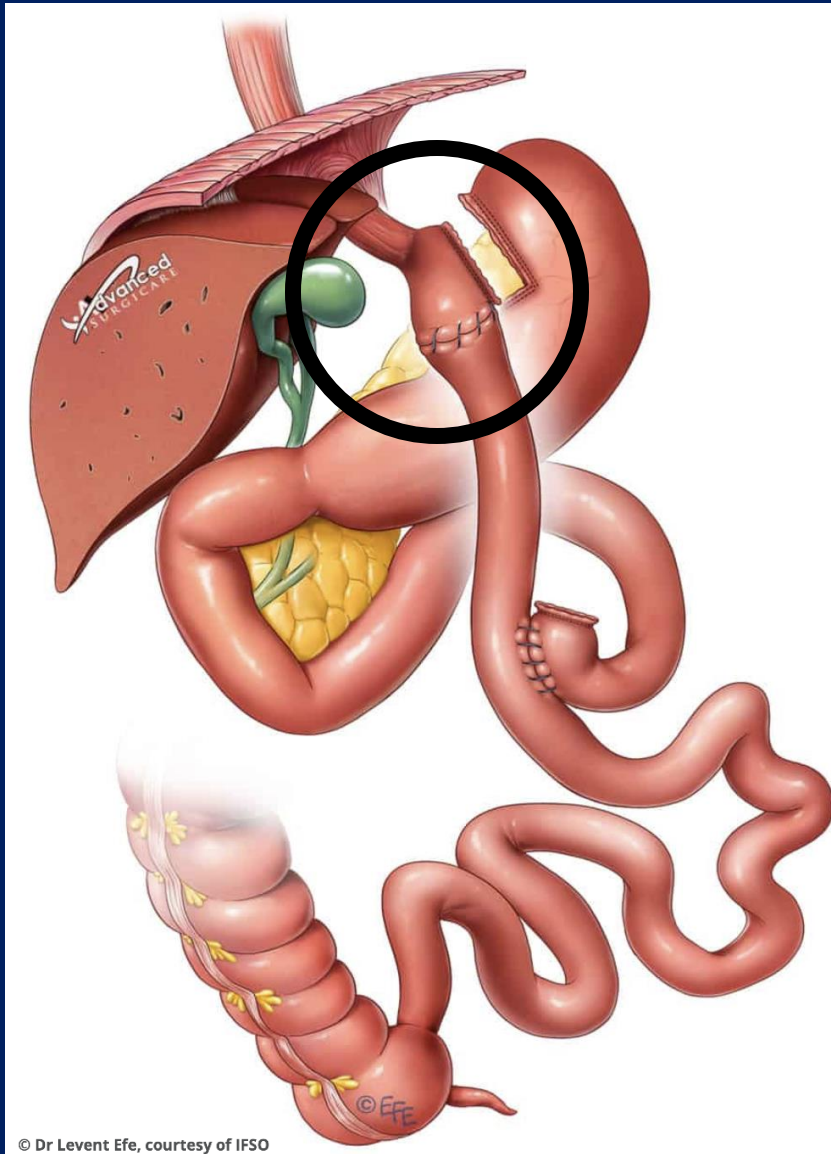
**Excluded Limb  
Malabsorption**

# Stomach Functions



- Osmolar Adjustments
- **Acid**
  - for bacterial reduction
  - Protein digestion
  - Chelation of Fe<sup>2+</sup>
  - Help in Ca<sup>2+</sup> absorption
- Intrinsic Factor for B12 absorption
- Gut hormonal controlled emptying

# The Gastric Bypass flaws



## The Small Pouch

(made for restriction)

blocking the emptying

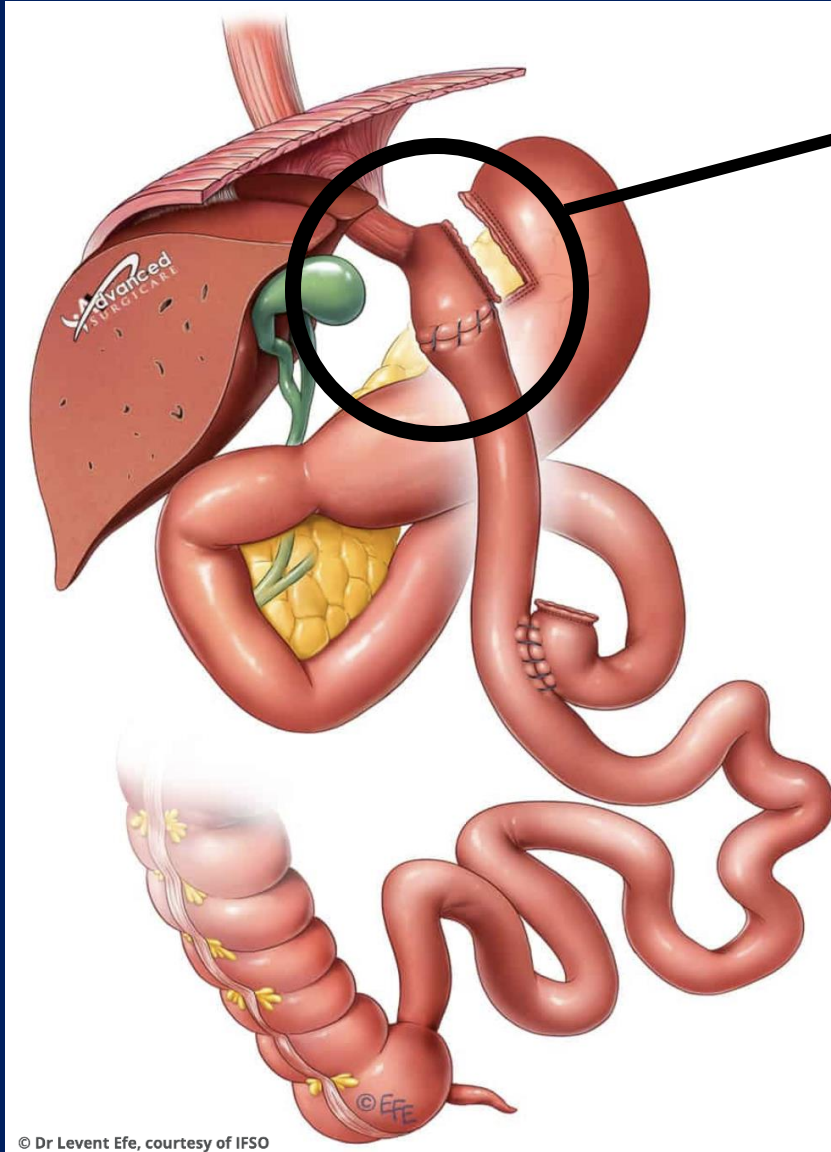
# Gastric emptying after RYGB

5 min Barium Images

**A MISTAKE THAT  
WORKED WELL**



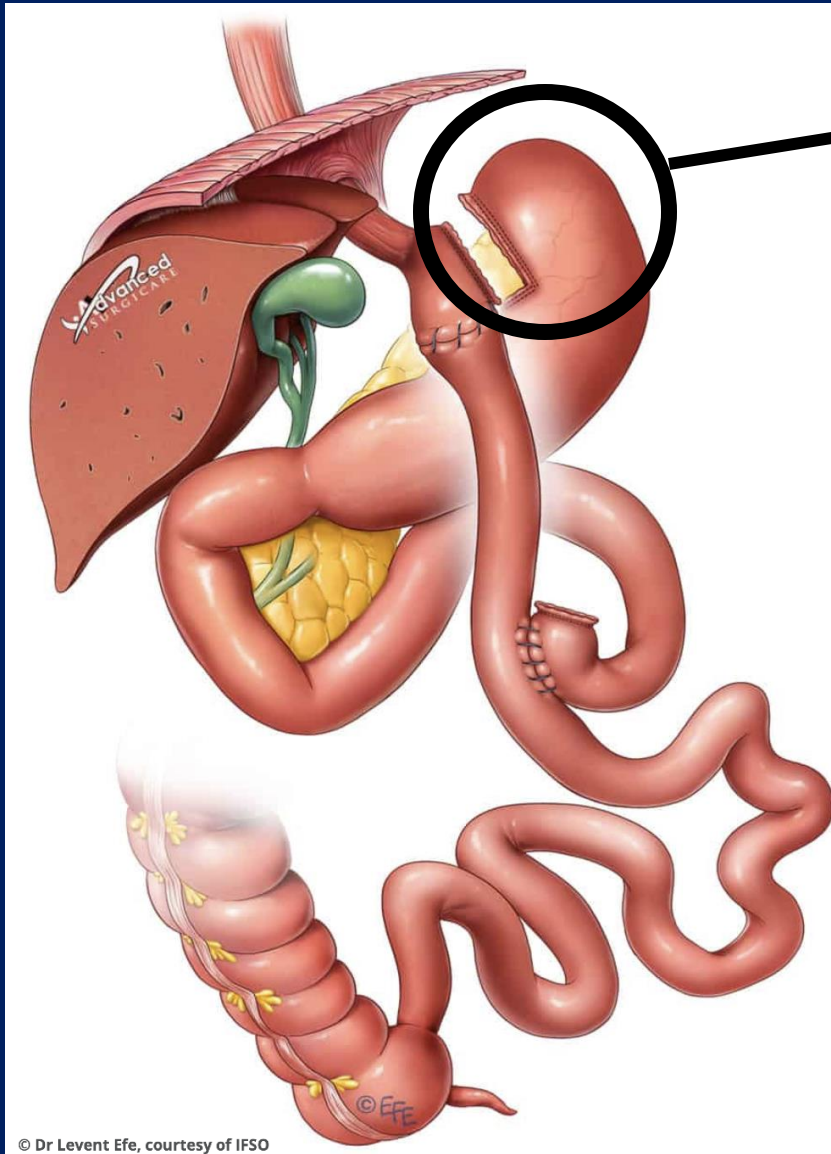
# The Gastric Bypass flaws



**By using the Small Pouch  
there is loss of most  
Gastric Functions**

**Dumping & hypoglycemia  
may appear**

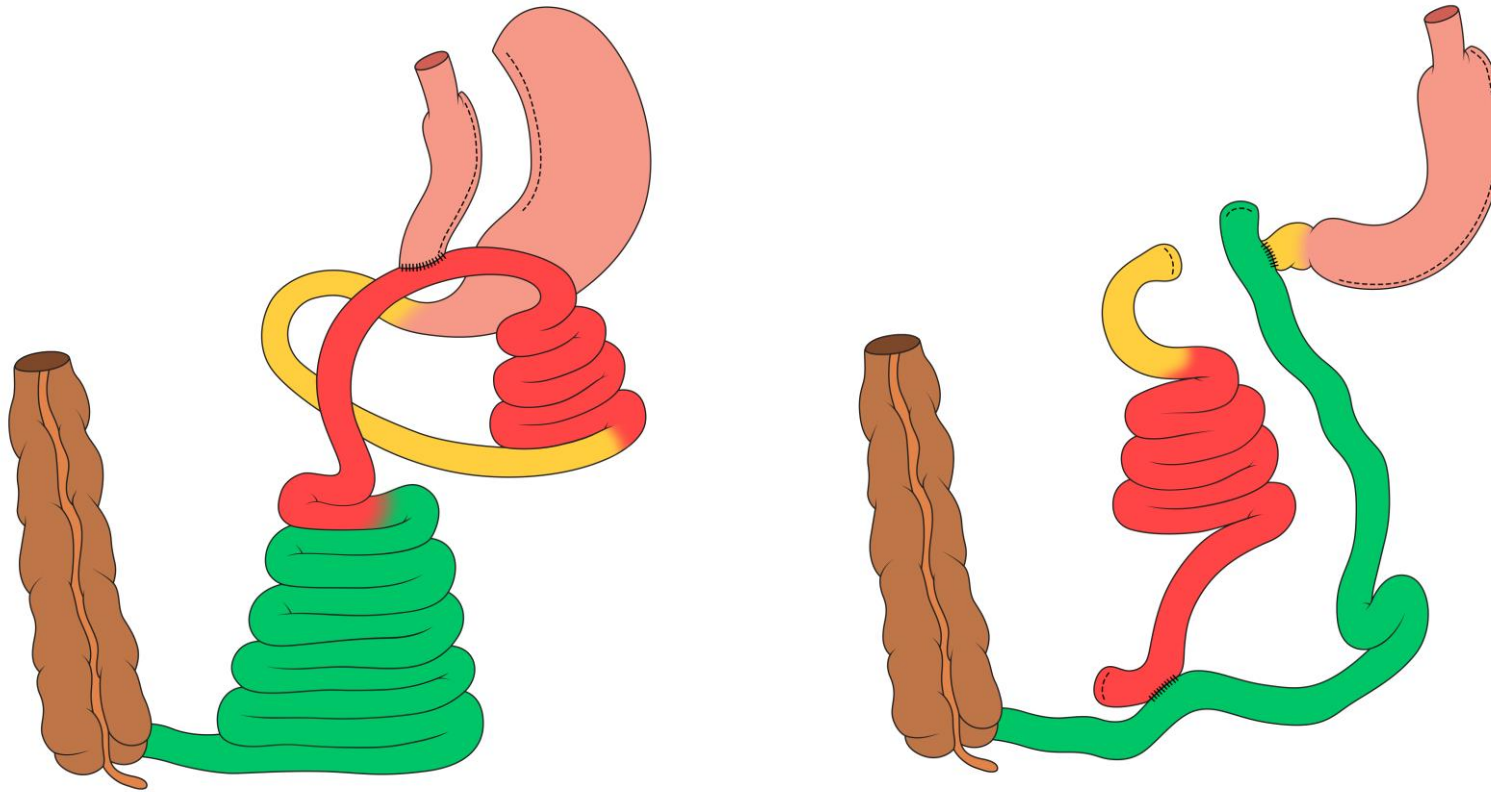
# The Gastric Bypass flaws



## By retaining the gastric fundus

- More Ghrelin
  - Anti-insulinic
  - Orexigen
- The Stomach out of endoscopic view

**Procedures more potent than a RYGB have larger and longer pouches**



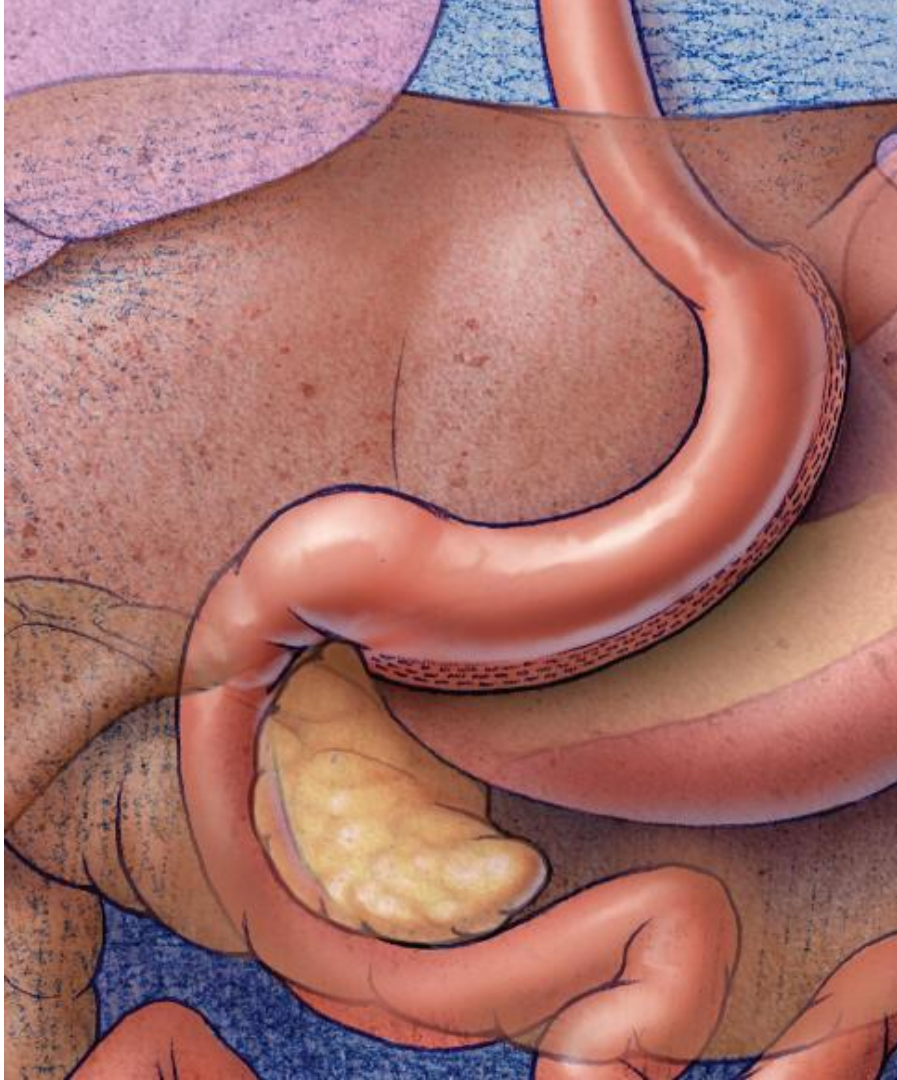
## Objectives in Surgery

~~Small Pouch~~  
~~Mechanical Restriction~~  
~~Slow emptying~~



Long tubular Pouch  
No mechanical Restriction  
Rapid emptying

# The sleeve maintains quite well the gastric functions

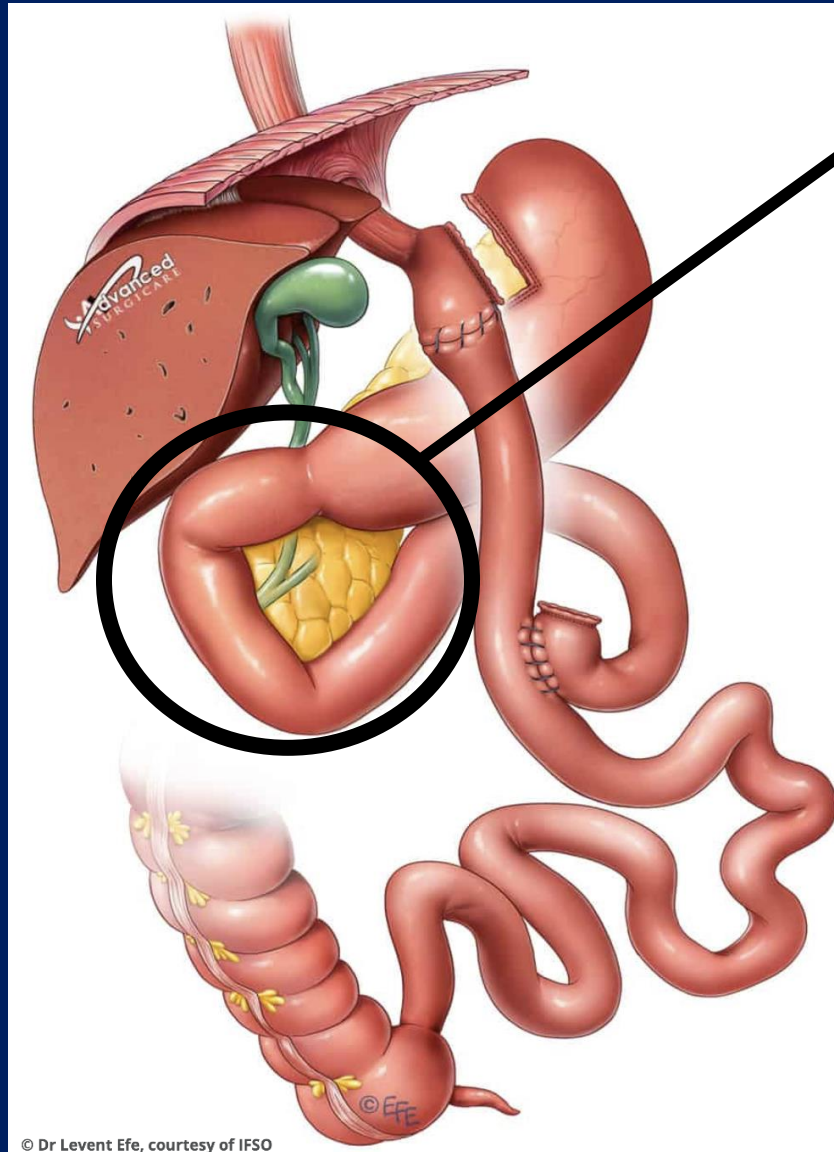


## Maintaining:

- Organ structure and functions
- Antrum and pylorus
- All epithelium sequences
- Removal of gastric fundus
- Reduces Ghrelin
- Speeds up the transit
- All under endoscopic access

THE MAXIMAL GASTRIC REDUCTION  
THAT MAKES PHYSIOLOGICAL SENSE

# The Gastric Bypass flaws



**Exclusion of the proximal gut**

Made for caloric malabsorption

But caloric malabsorption  
not even occurs...

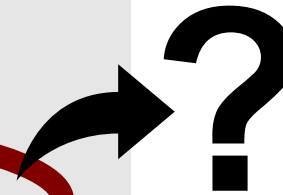


ANOTHER MISTAKE THAT  
WORKED WELL

4 TO 8M OF NORMAL SMALL BOWEL

## Objectives in the Traditional Bariatric Surgery

**Small Pouch**  
**Mechanical Restriction**  
**Slow emptying**  
**Excluded Limb**  
**Short Common Channel**  
**Malabsorption**





**1960's**

**JUJUNO-ILEAL  
BYPASS (JIB)  
END-TO-SIDE (PAYNE)**



**Importance of small bowel peptides  
for the improved glucose  
metabolism 20 years after  
jejunoileal bypass for obesity.**

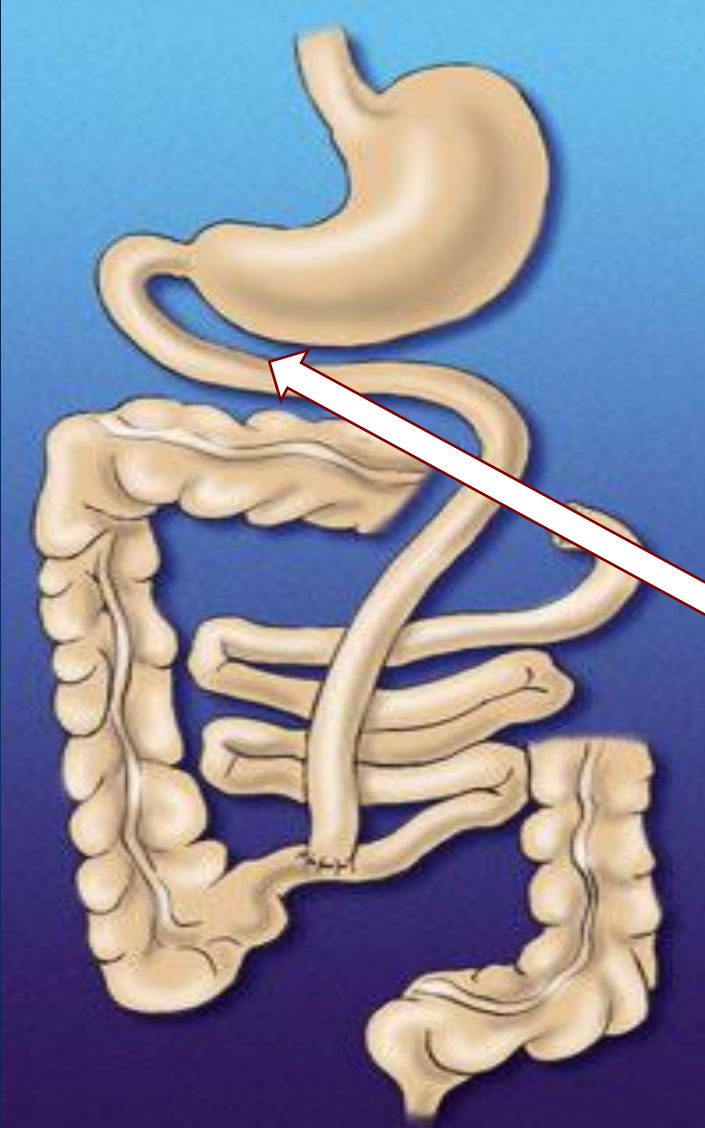
Naslund E, Backman L, Holst JJ, Theodorsson E, Hellstrom PM.

**GLP-1 is much elevated 20 years later**

**1960's**

**JUJUNO-ILEAL  
BYPASS (JIB)  
END-TO-SIDE (PAYNE)**

Obes Surg 1998 Jun;8(3):253-60

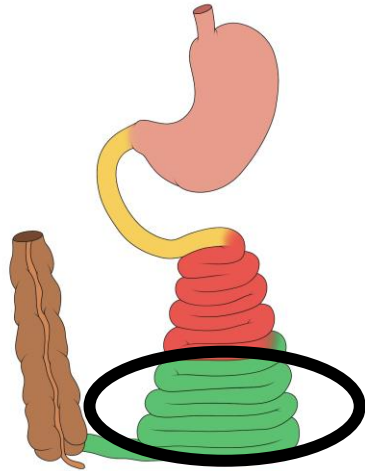


And where is the duodenum ?

In transit !!

1960's

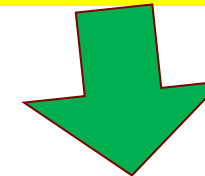
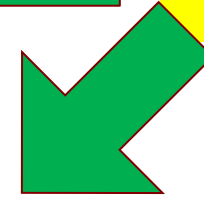
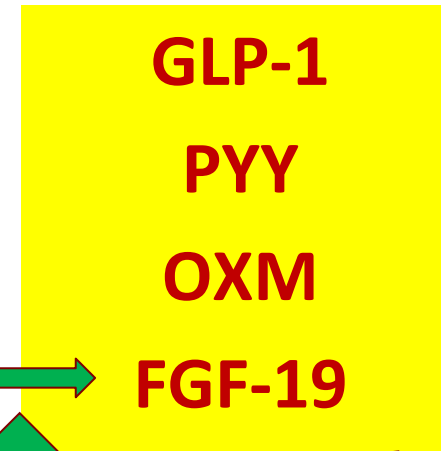
JUJUNO-ILEAL  
BYPASS (JIB)  
END-TO-SIDE (PAYNE)



**Absorption  
of nutrients  
in the ileum**



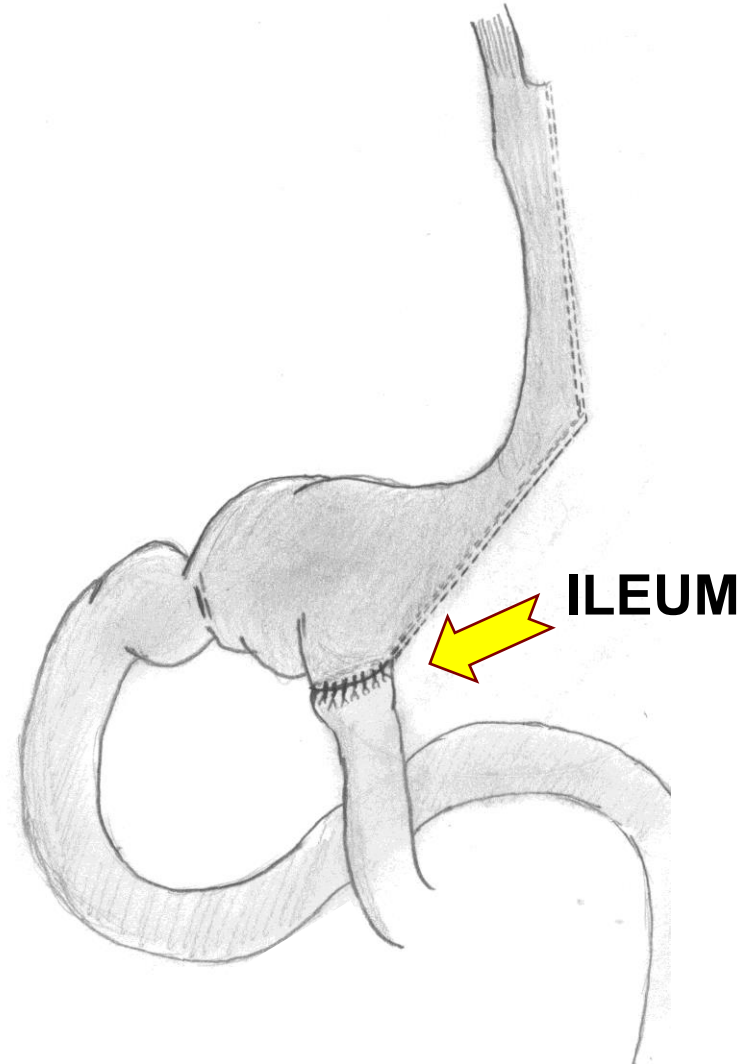
**Reabsorption of  
bile in the ileum**



- **Block gluconeogenesis**
- **Estimate insulin secretion**
- **Insulin sensitivity**
- **Maintain Beta Cell Trophism**
- **Clearance of Triglycerides**
- **Enhance Adiponectin**
- **Block gastric Emptying**

- **Increase Brown Fat tissues**
- **Enhance Energy Expenditure**
- **Modify food preferences**
- **Reduce Hepatic Steatosis**
- **Satiety**
- **Reduce Food intake**
- **Weight loss**

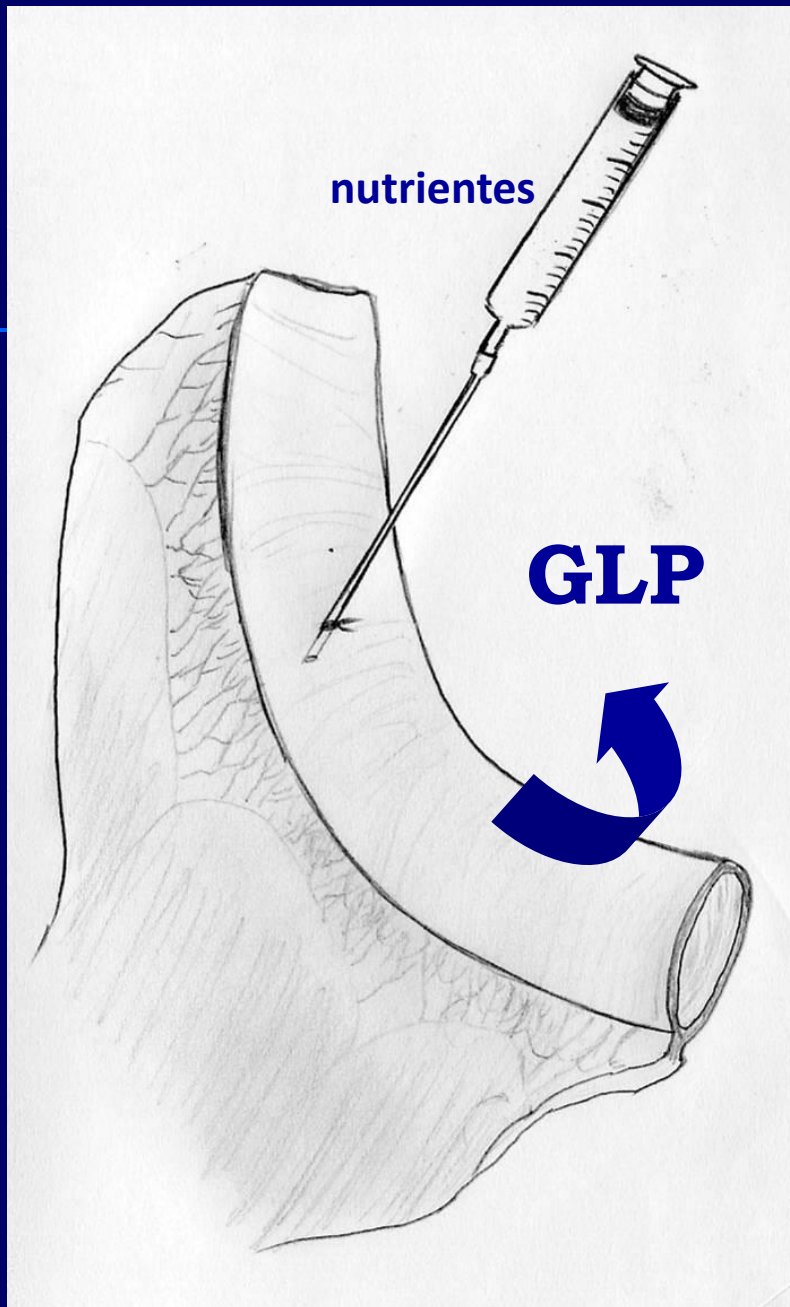
**Oh! But there is  
no exclusion !!**



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**“Under all experimental conditions, ileal carbohydrate increased plasma GLP-1 by 80-100% (all  $P < 0.005$ ). Ileal lipid perfusion had similar effects”**

If exclusion were crucial,  
medications WOULD NOT WORK !!!



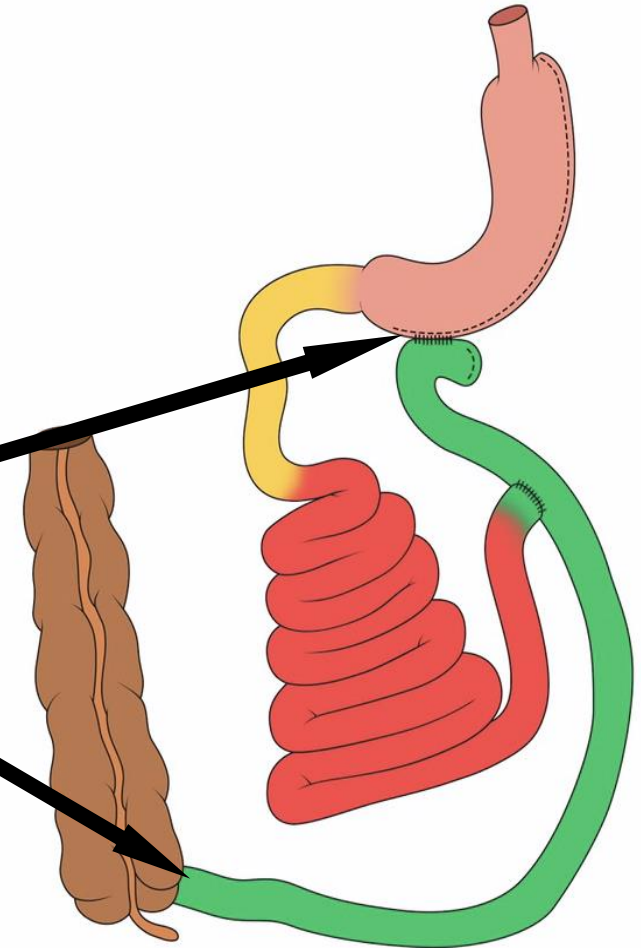
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# Sleeve + ileal stimulation

The smallest distance that  
does not provoke  
clinical malabsorption

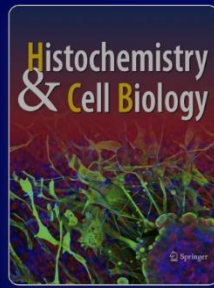


# Sugar Transporters

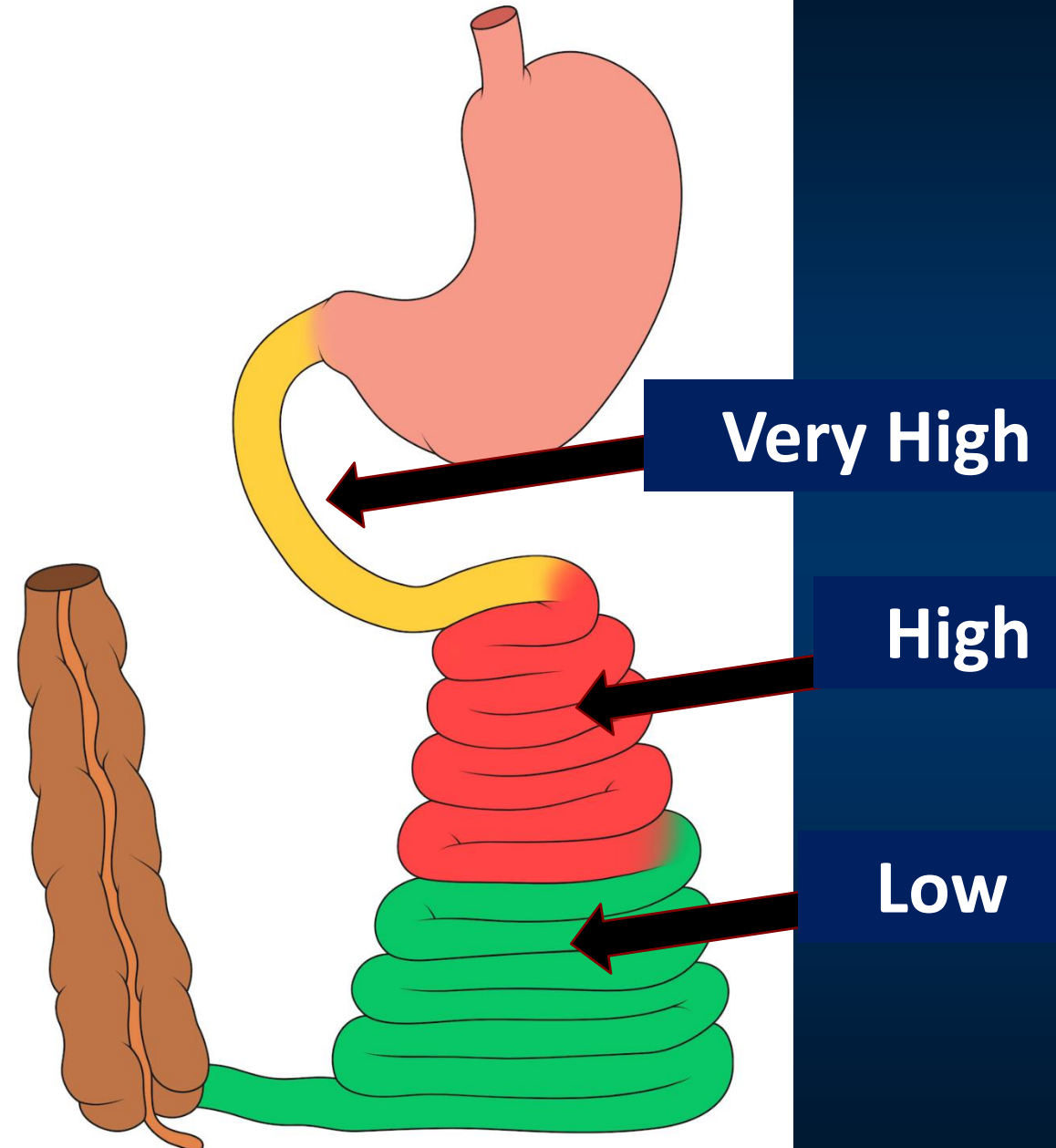
# Comparative expression of hexose transporters (SGLT1, GLUT1, GLUT2 and GLUT5) throughout the mouse gastrointestinal tract

Original Paper | Published: 28 January 2011

Volume 135, pages 183–194, (2011) [Cite this article](#)



## Sugar transporters



Sucrose =

Fructose

+

Glucose

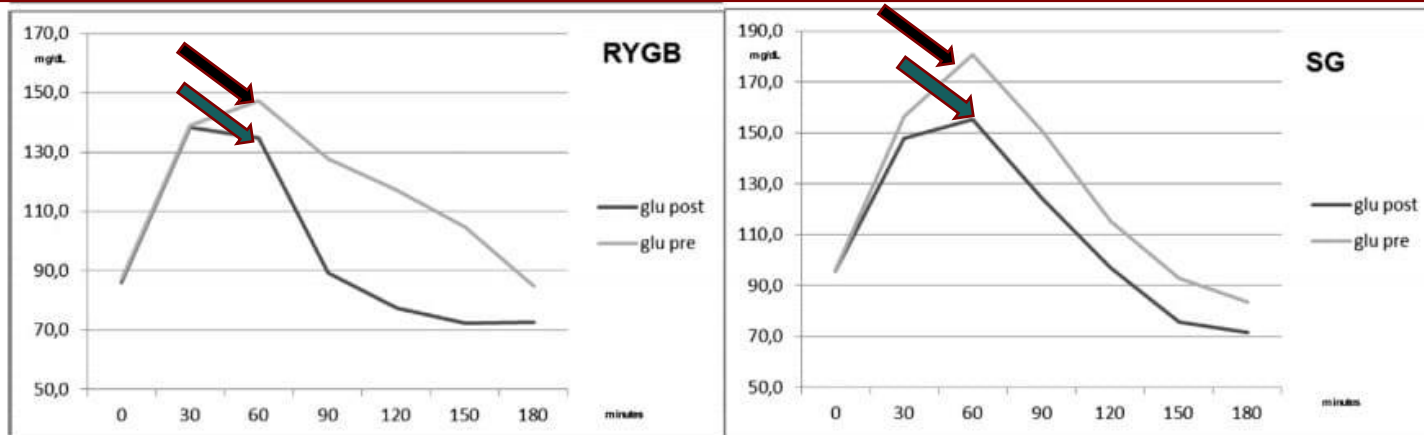
GLUT-5

SGLT-1

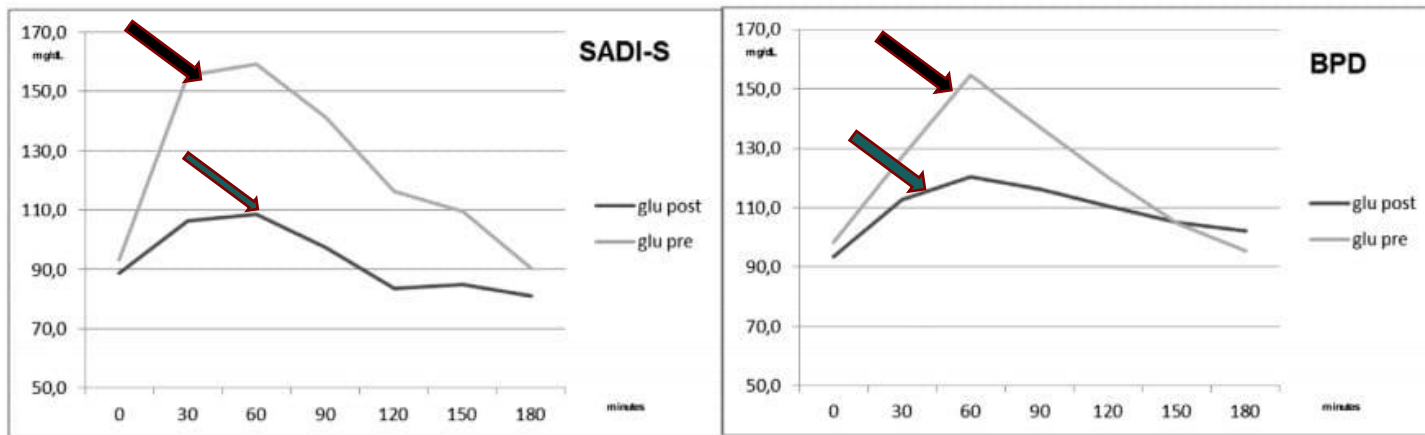
# The procedures mostly used today

Pre-op Glucose

Pos-op Glucose



**PRE AND POST OPERATIVE  
POST PRANDIAL GLUCOSE**



Pre-op Glucose

Pos-op Glucose

# Procedures that stimulate the ileum

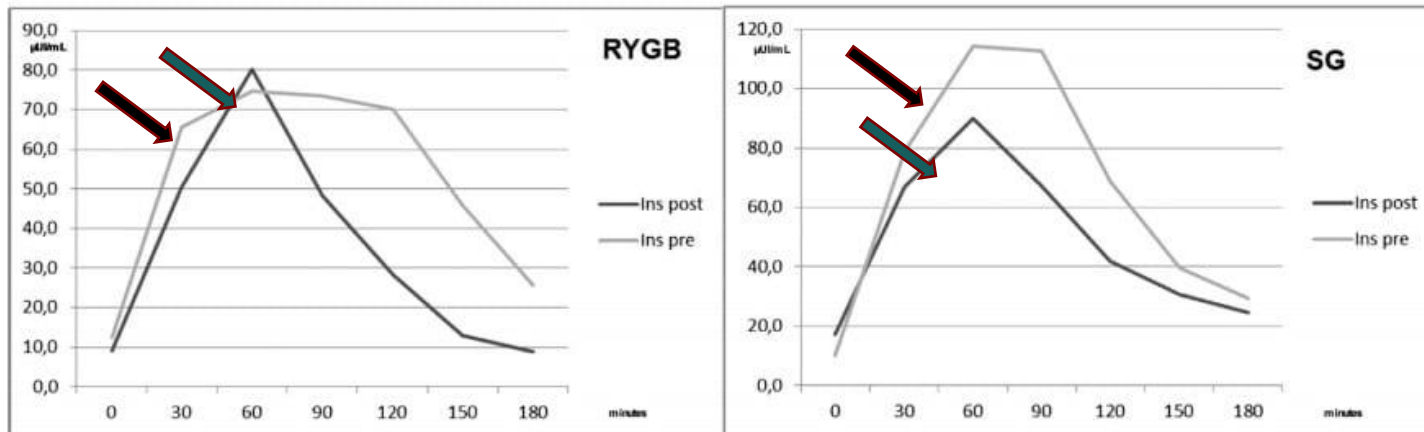
**PRE AND POST OPERATIVE  
POST PRANDIAL GLUCOSE**

**Ileal procedures do not  
create Glucose peaks**

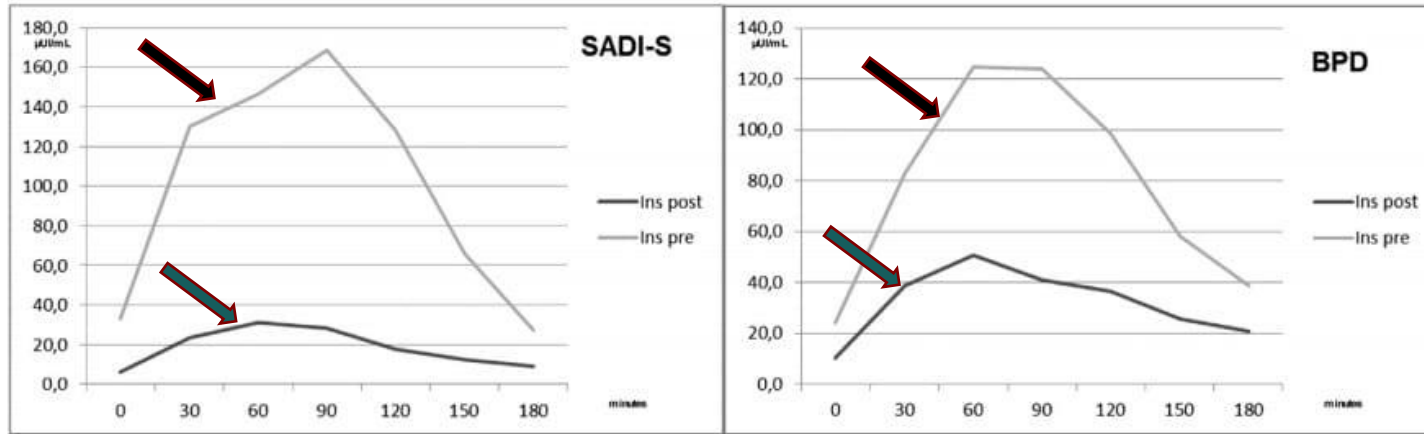
# The procedures mostly used today

Pre-op Insulin

Pos-op Insulin



**PRE AND POST OPERATIVE  
POST PRANDIAL INSULIN**



Pre-op Insulin

Pos-op Insulin

**Procedures that  
stimulate the ileum**

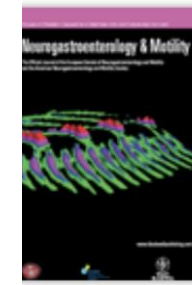
**PRE AND POST OPERATIVE  
POST PRANDIAL INSULIN**

**Ileal procedures do not  
create insulin peaks**

**No Dumping or Hypoglycemia  
in  
Transit Bipartitions**

**Lower Insulin helps to stay lean**

**Hypertrophy**



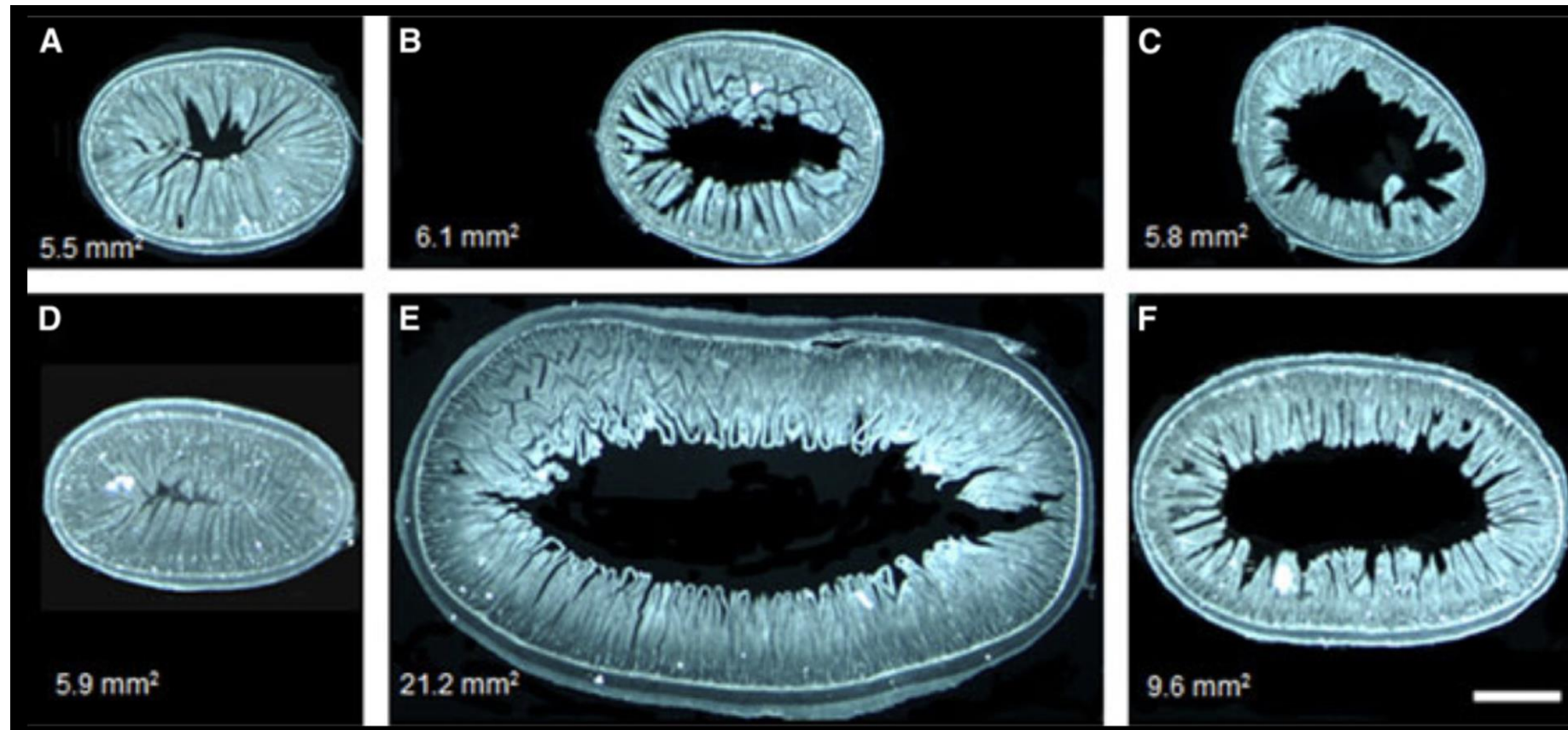
## Roux-en-Y gastric bypass surgery increases number but not density of CCK-, GLP-1-, 5-HT-, and neurotensin-expressing enteroendocrine cells in rats

M. B. Mumphrey, L. M. Patterson, H. Zheng, H.-R. Berthoud

**Bilio Pancreatic**

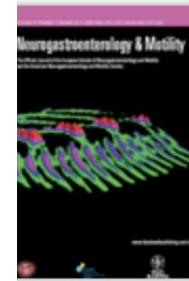
**Jejunum**

**ILEUM**



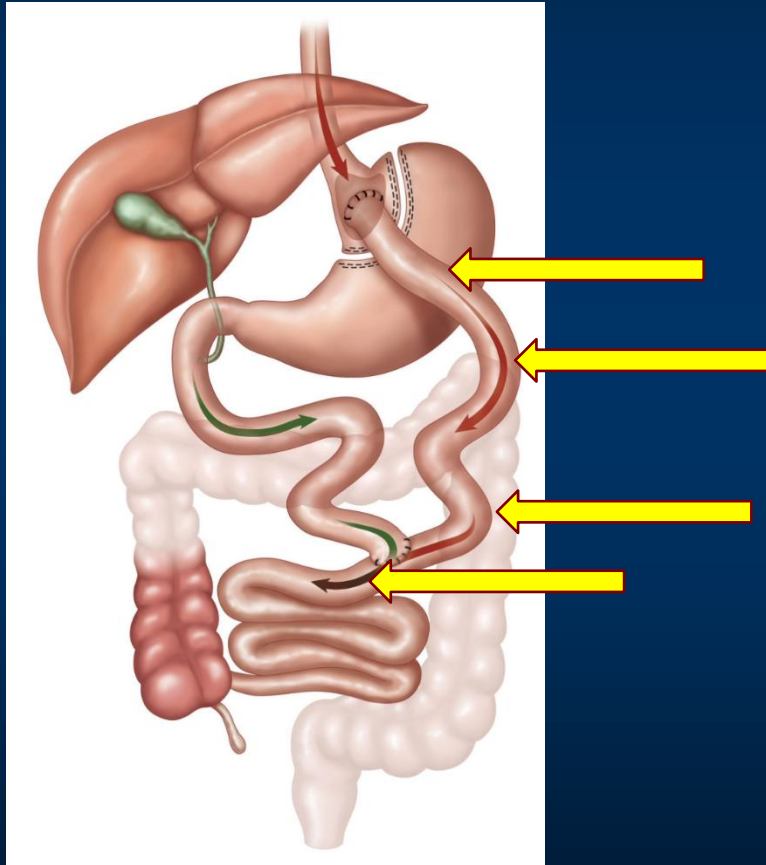
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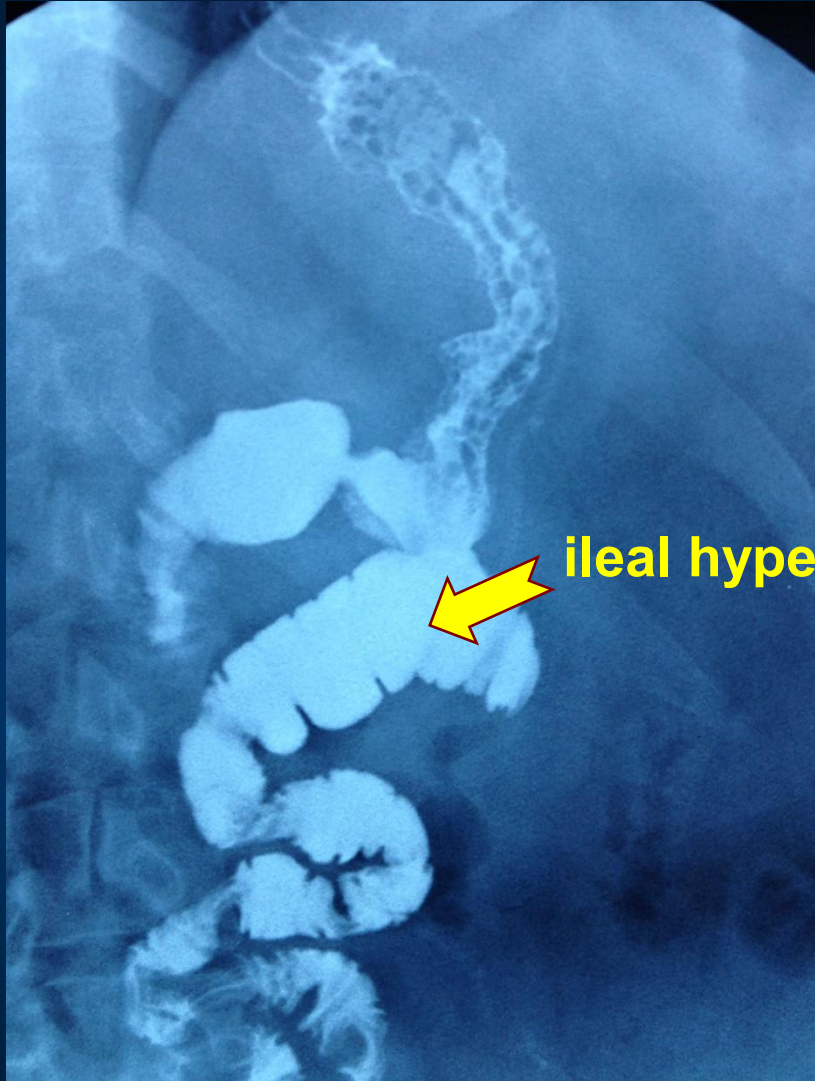


**...the number of enteroendocrine cells increases**  
**passively, and proportionally,**  
**as the gut adapts...**

# Post RYGB, the hypertrophy will occur in the proximal gut (jejunum)



Areas with more K cells and less L cells than the ileum



ileal hypertrophy

Areas with **more L cells** and the **mucosa that produces FGF-19**



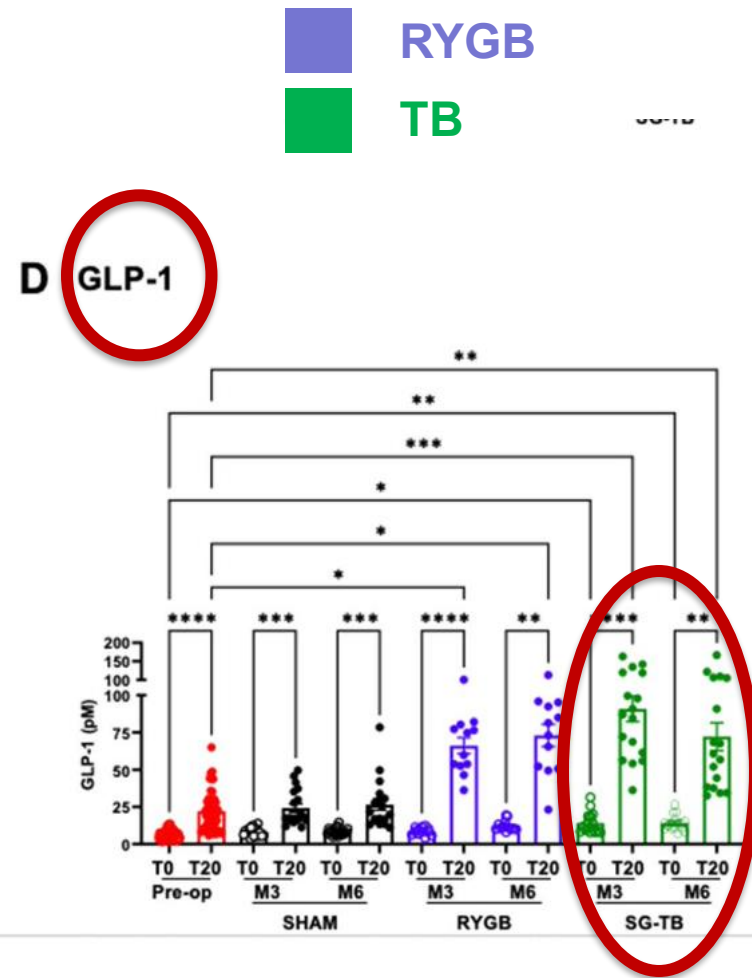
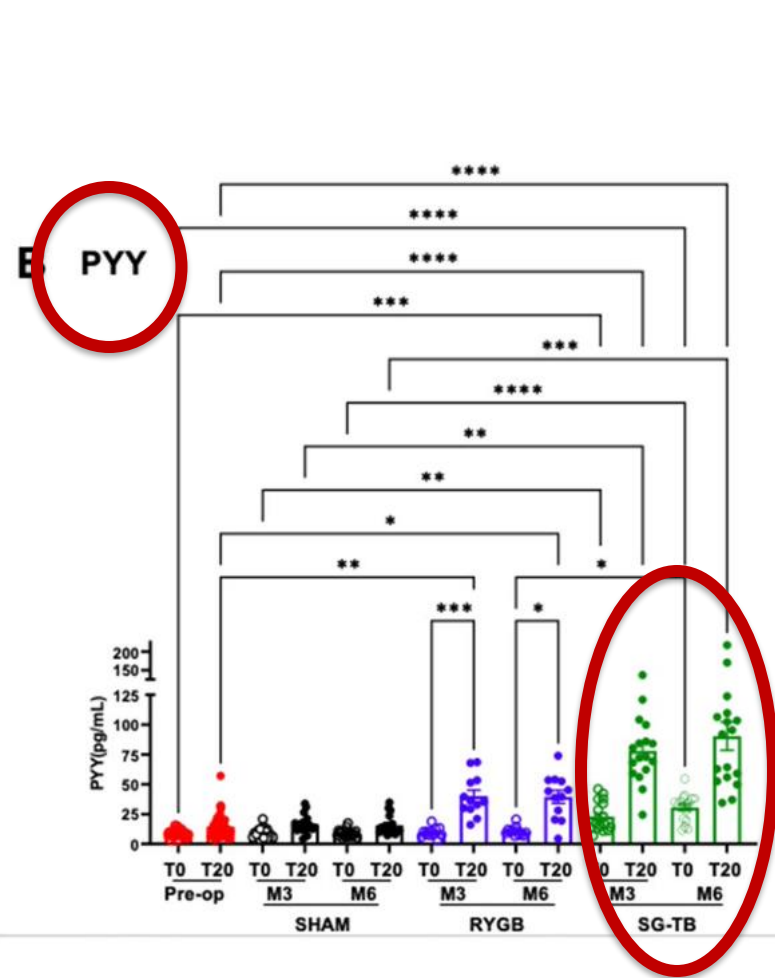
# Analysis of the Efficacy and the Long-term Metabolic and Nutritional Status of Sleeve Gastrectomy with Transit Bipartition Compared to Roux-en-Y Gastric Bypass in Obese Rats

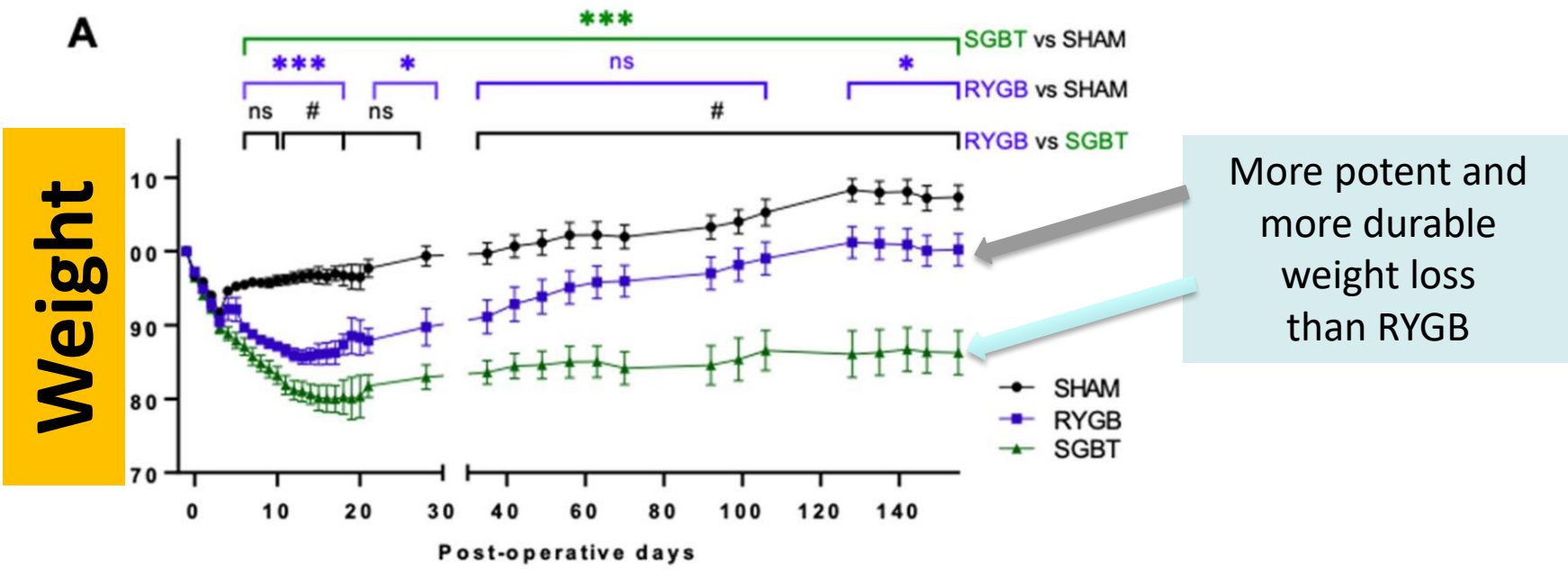
Clement Baratte<sup>1,2,3</sup> · Alexandra Willemetz<sup>1,2</sup> · Lara Ribeiro-Parenti<sup>1,2,3</sup> · Claire Carette<sup>1,4</sup> · Simon Msika<sup>1,2,3</sup> · Andre Bado<sup>1,2</sup> · Sebastien Czernichow<sup>1,4,5</sup> · Maude Le Gall<sup>1,2</sup> · Tigran Poghosyan<sup>1,2,3</sup> 

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**SGTB x RYGB**  
**Obese rats**  
**6 months in a rat = 15 years in a man**

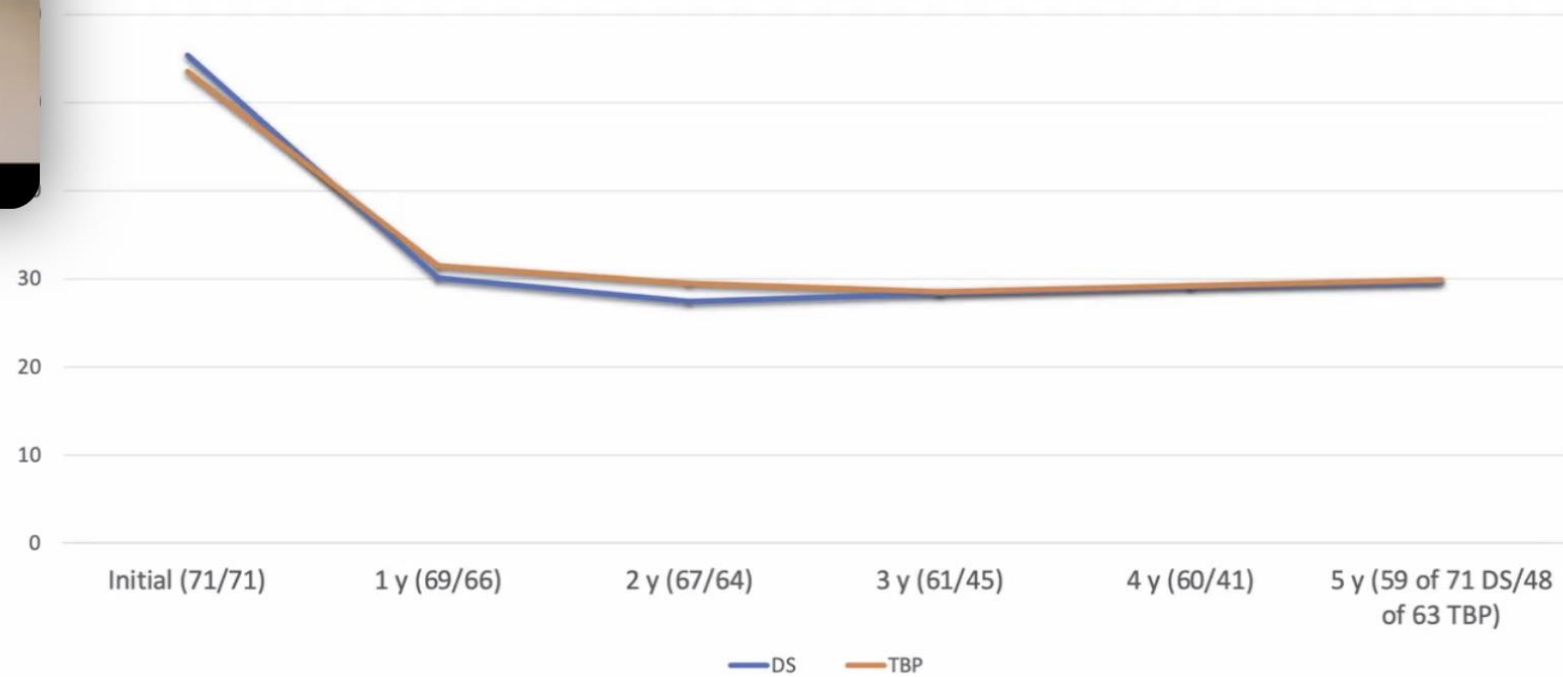




Baratte C et al. Obes Surg 2023



## BMI evolution between DS and TBP



Prof. Philippe Topart - France

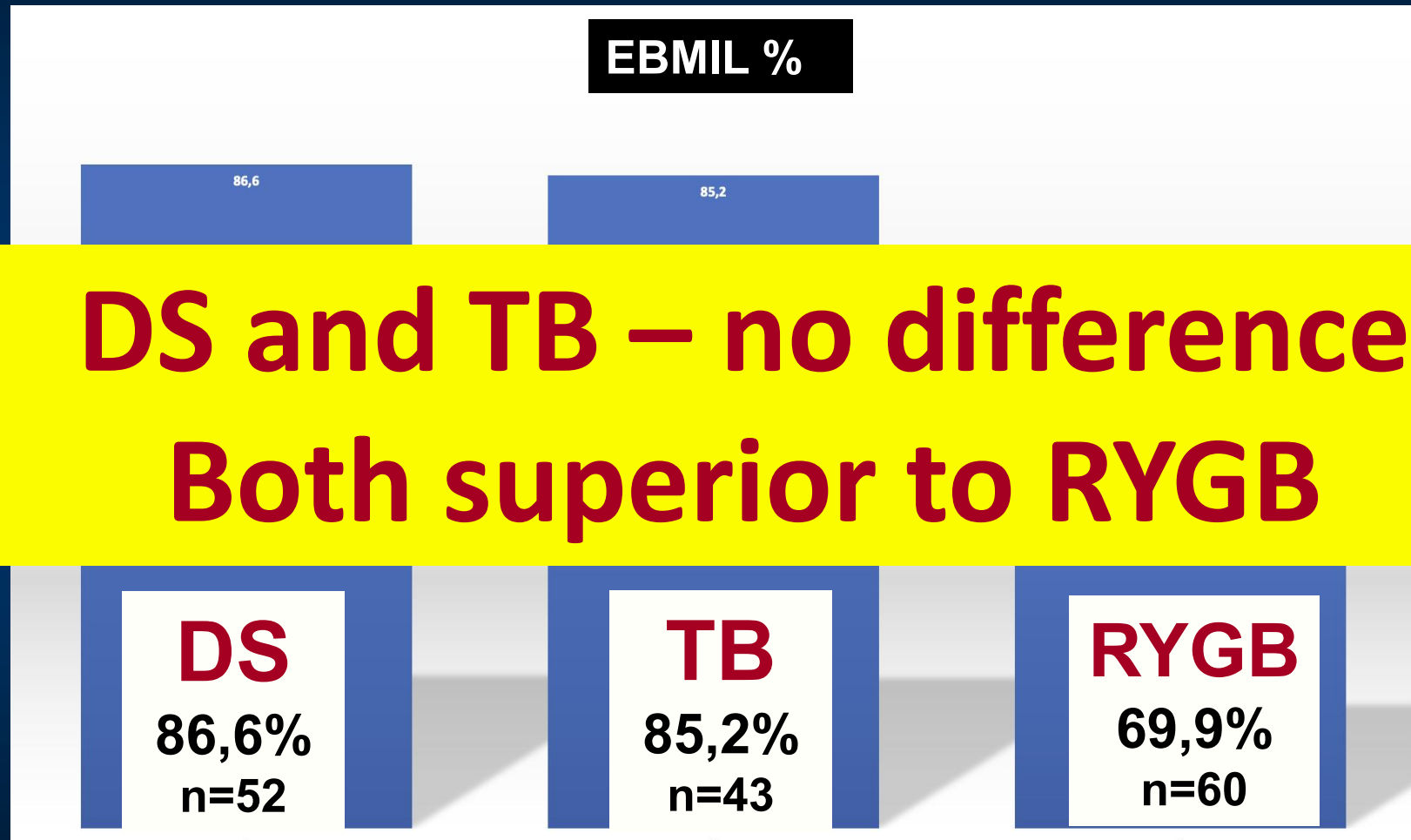
# Comorbidities

Remissions at 2 years Post Op - France

## TB and DS – no difference

- **Diabetes**                      **TB 90%**                      **DS 88%**
- **Hypertension**                      **TB 81.8%**                      **DS 61.9%**
- **Sleep Apnea**                      **TB 84%**                      **DS 78%**

# EBMIL % at 4 years Post Op - France



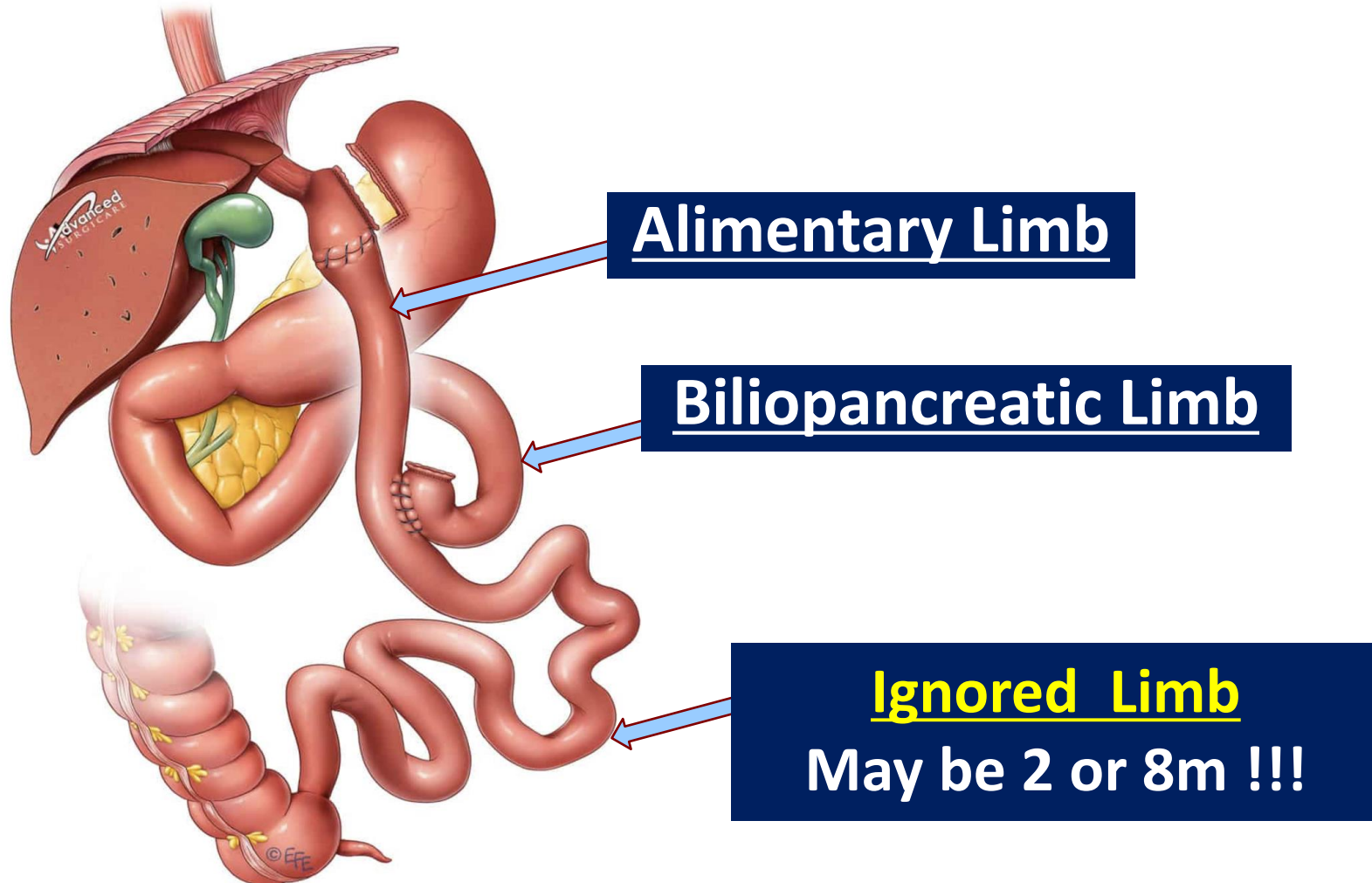
**DS and TB – no difference  
Both superior to RYGB**

**Weight Loss and  
remission of comorbidities  
depend on**

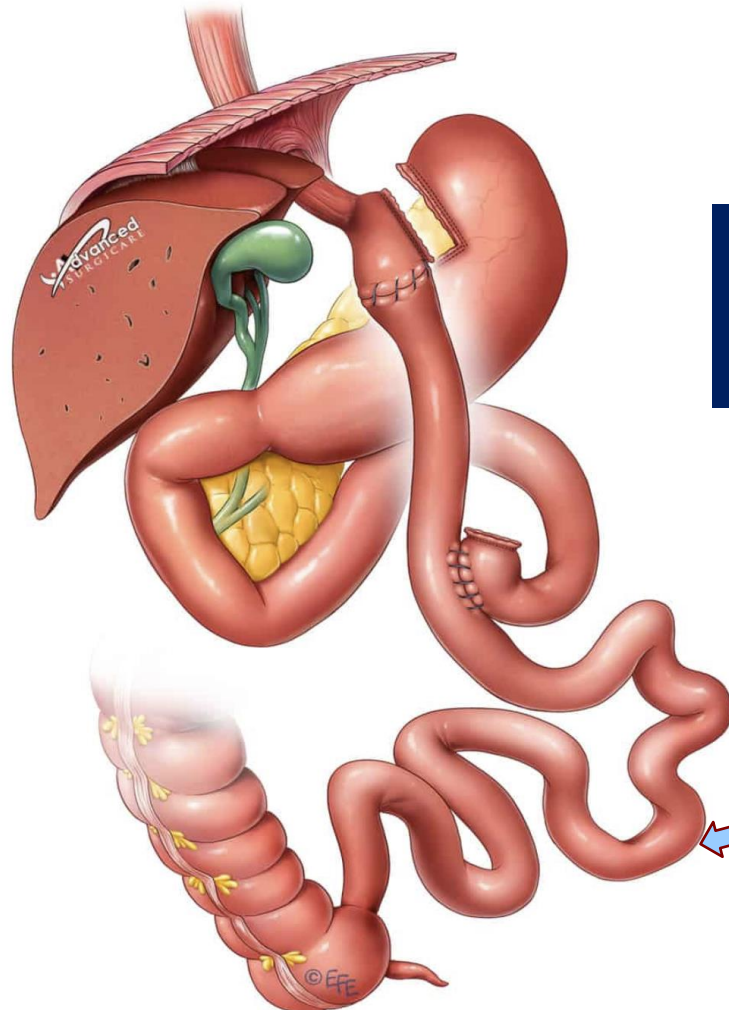
**DISTAL STIMULATION**

**NOT ON EXCLUSIONS**

# **RYGB – the deactivated parts are measured**



# RYGB



The Ignored Limb is the crucial one !  
This turns RYGB very unpredictable

Ignored Limb

## What are the costs that Metabolic Surgery does NOT have to pay ?

- The minimal pouch
- Loss of Gastric functions
- An excluded Gastric Fundus
- ...producing Ghrelin
- Complete loss of control of gastric Emptying
- Hypoglycemia
- Dumping
- Loss of proximal gut functions
- Loss of Endoscopic access
- Rapid exposure to highly absorptive area
- Peaks of Glucose
- Peaks of insulin
- Lower stimulation of Distal Gut Hormones
- Unpredictable Common channel
- More frequent weight regain
- More complex anatomy
- Difficult to do adjustments
- Difficult to convert or revise
- The smaller remission of Diabetes & Comorbidities
- Still keeping traces of restriction and malabsorption
- To keep the stigma of Bariatric Surgery

**Bariatric Surgery  
should become a  
Pure Metabolic Surgery**

# Pure Metabolic Surgery is our Evolution



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Thank You

