
XXVIII IFSO World Congress
9-12 September 2025 | Santiago, Chile
COMBINED THERAPIES, THE DAWN OF A NEW ERA
IFSO
SANTIAGO 2025
Debate 1: Sleeve DJB vs SAS-J
Kazunori Kasama MD, Yosuke Seki MD PhD
Yotsuya Medical Cube, Tokyo, JP
IFSO 2025 Santiago
Combined Therapies, The Dawn of a New Era
ifso2025.org

Disclosure Slide

XXVIII IFSO World Congress
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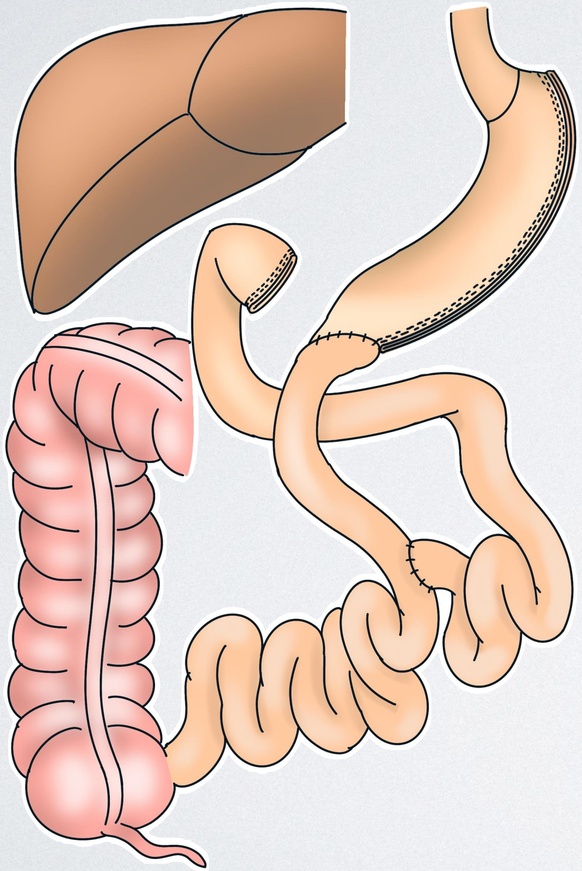
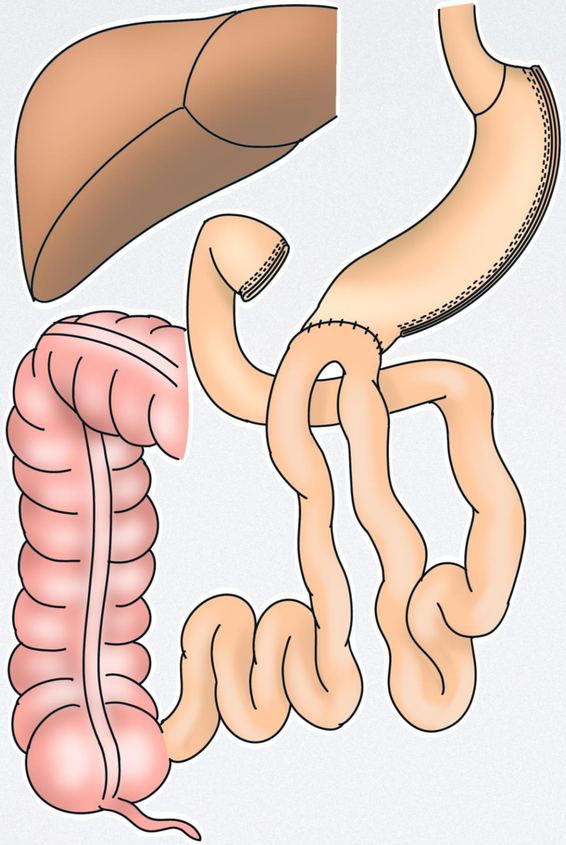
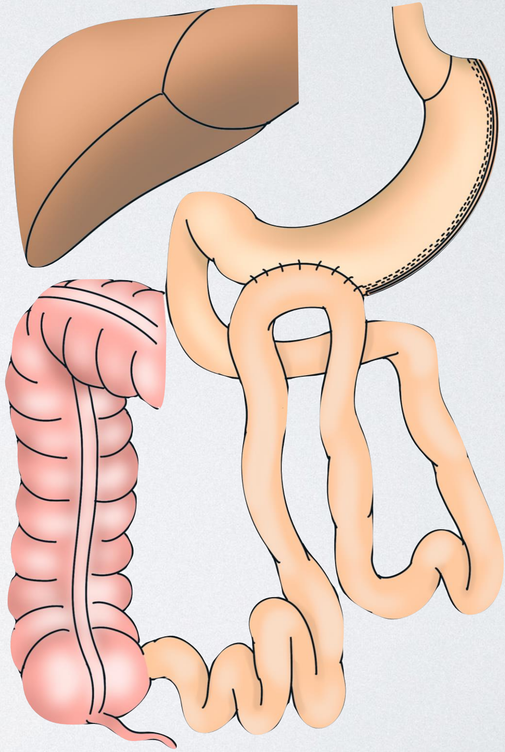
Nothing to disclose

DJB VS SAS-J

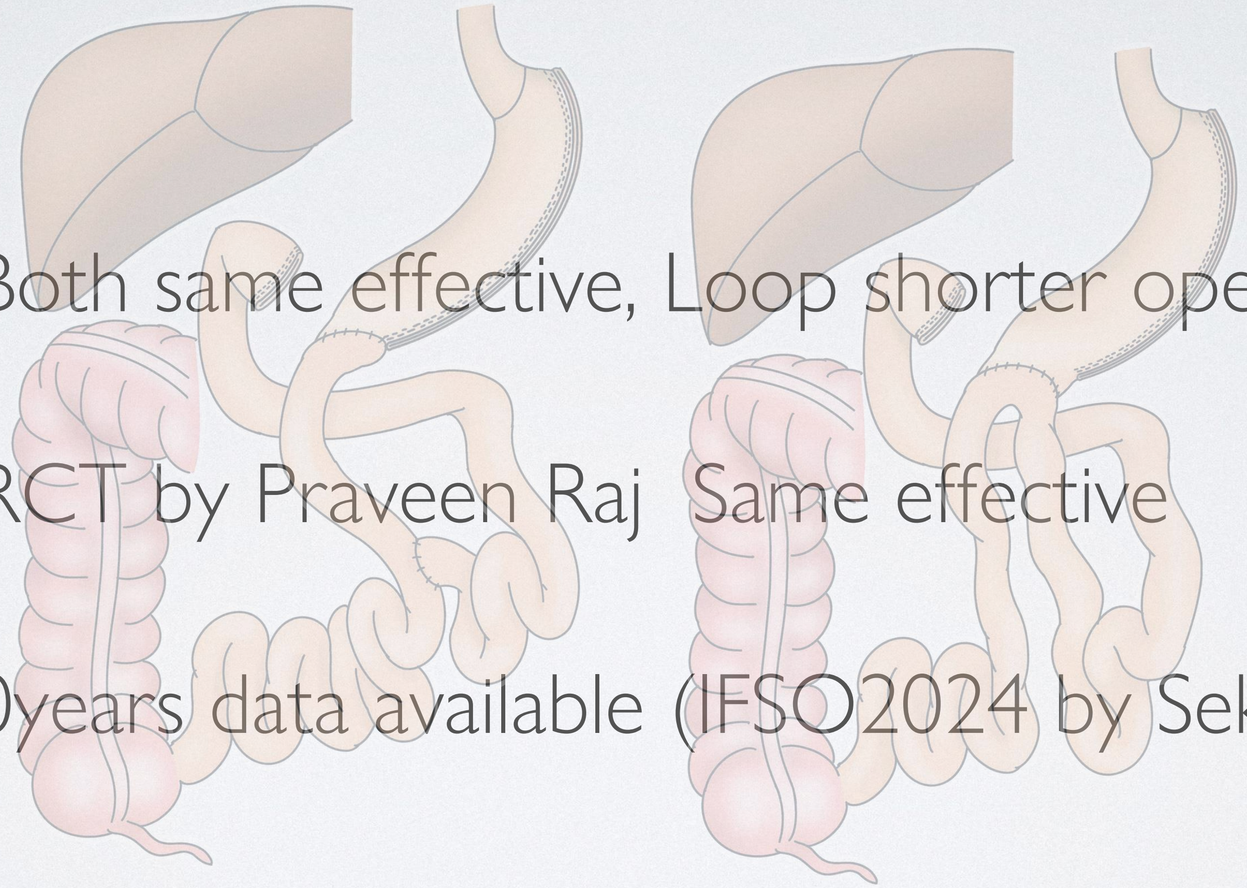




VS



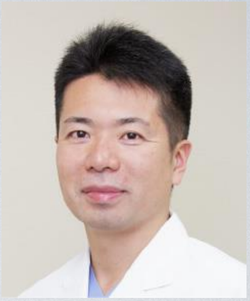
DJB

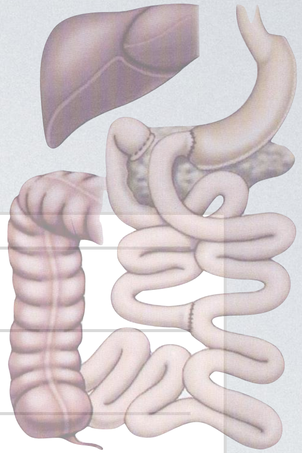


- RY and Loop; Both same effective, Loop shorter ope time
- DJB vs RYGB; RCT by Praveen Raj Same effective
- From 2007 , 10years data available (IFSO2024 by Seki,)

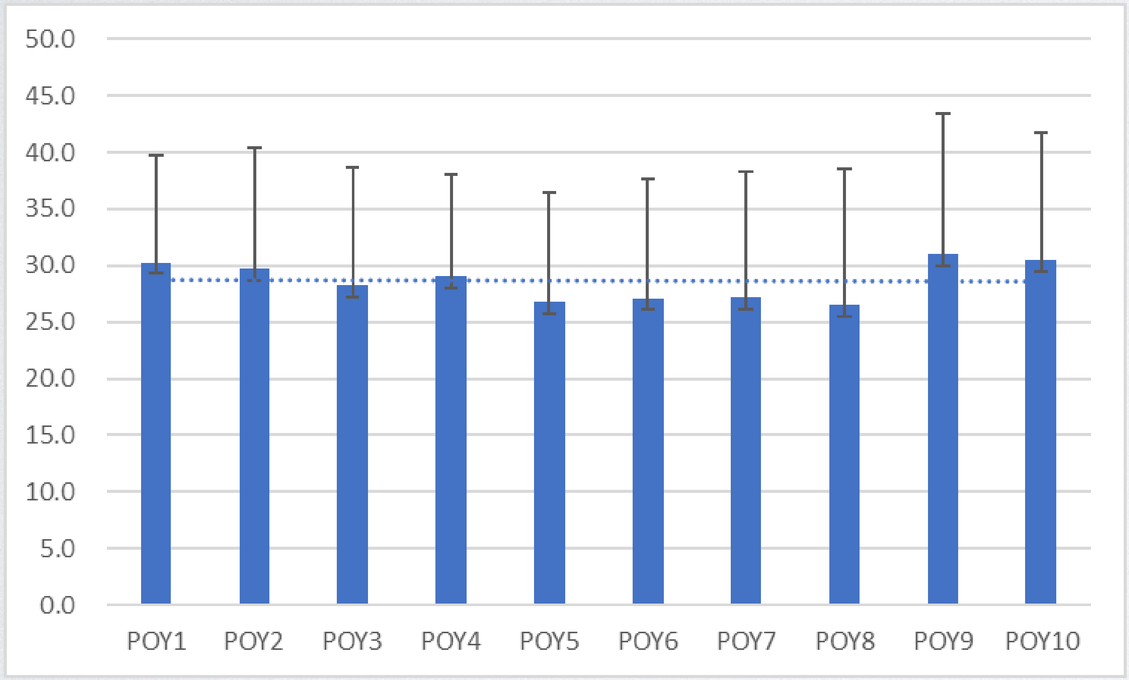
Yotsuya Medical Cube

SLEEVE DJB(RY)10YRS@YMC

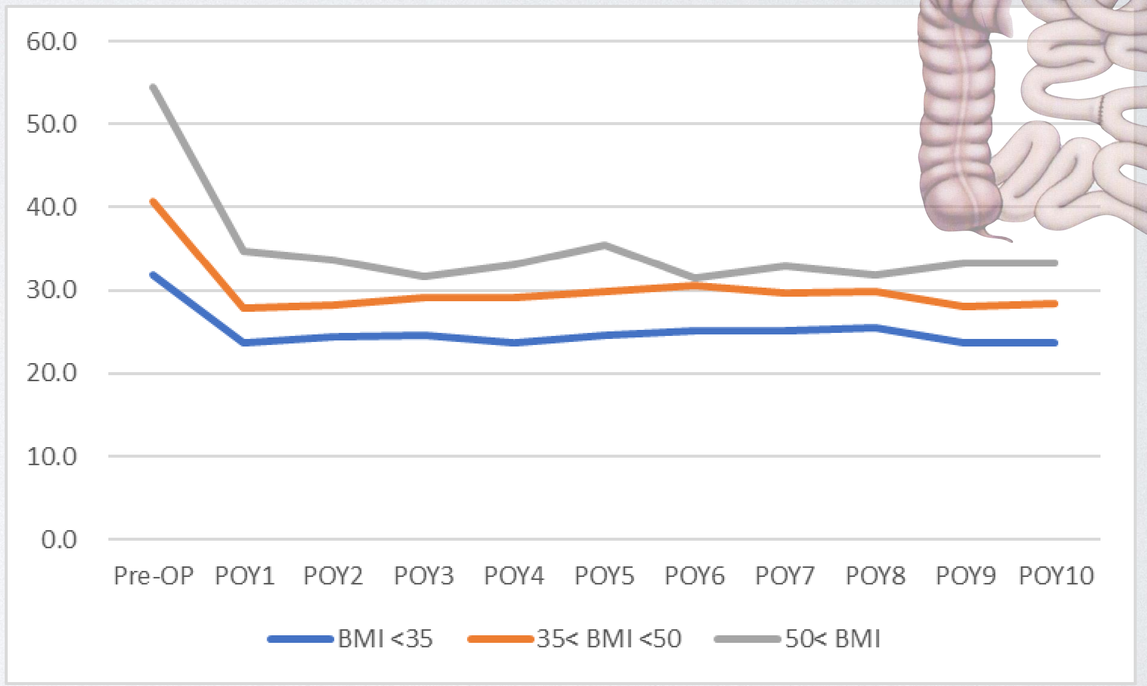




%TWL

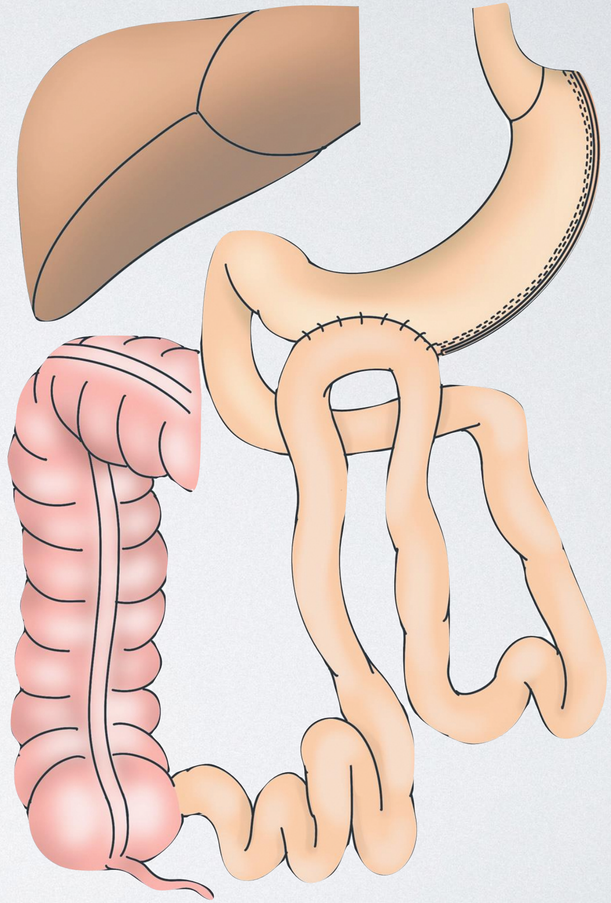


BMI (stratified)

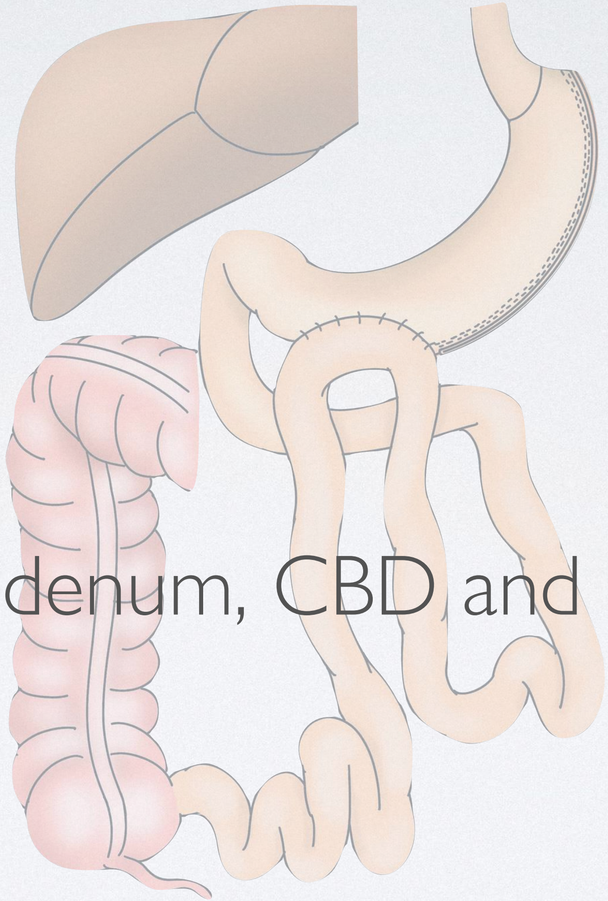


SAS-J

- No cutting duodenum
- GJ anastomosis (one anastomosis with stapler)
- Shorter ope time
- **Limited data ： No 10years data available**
- **Technical Variability**



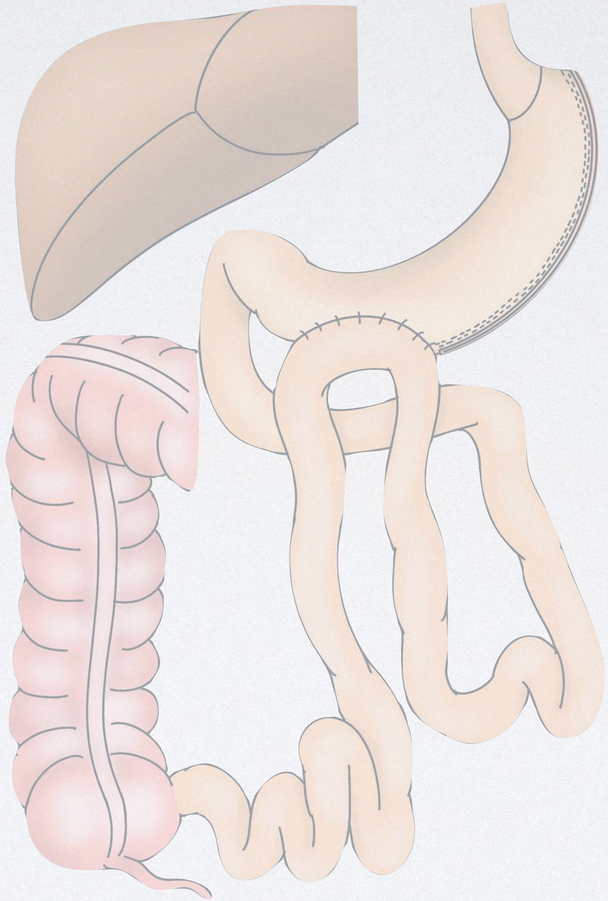
NO CUTTING DUODENUM



- Safe
- Endoscopic Access to duodenum, CBD and pancreatic duct

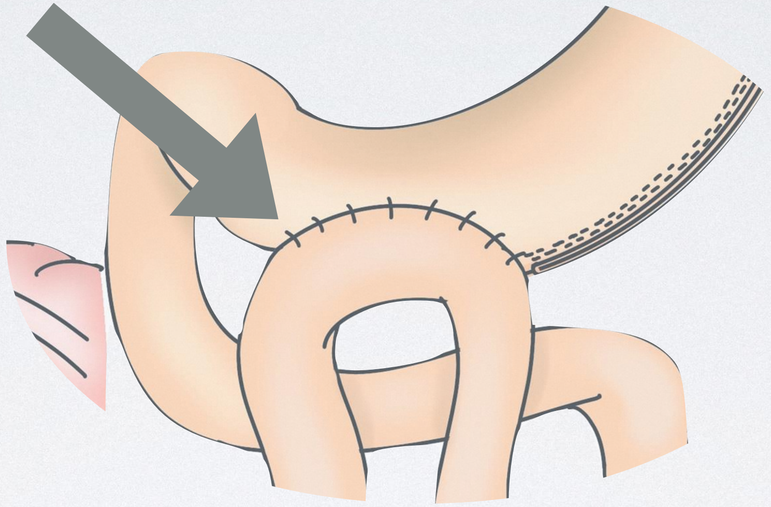
GJ ANASTOMOSIS (ONE ANASTOMOSIS WITH STAPLER)

- EASY
- May cause some trouble!



PROBLEMS OF GJ ANASTOMOSIS

- Dumping
- Ulcer
- Bile exposure to the stomach (may lead to reflex, **cancer**)



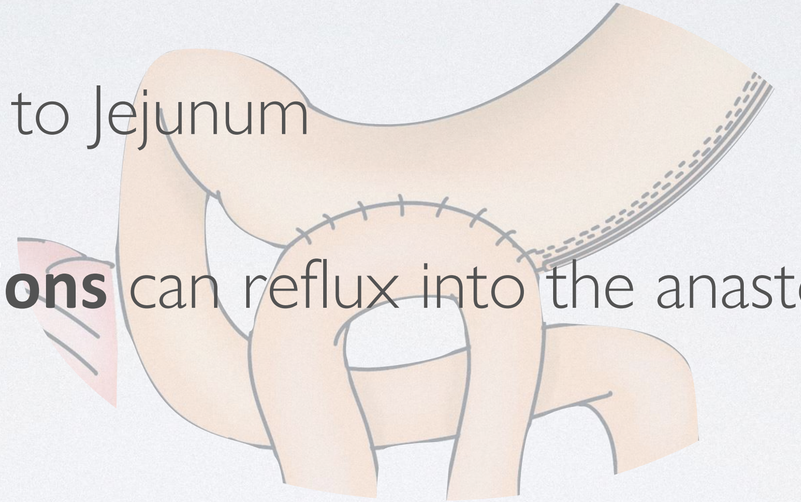
DUMPING AFTER SAS-J

- Anastomosis size differs among surgeons
- No pylorus preserved
- **More than 80% of the food directory goes to Jejunum**
- 8-10% reported

Obes Surg. 2022 Jun 6;32(8):2807–281

ULCER AFTER SAS-J

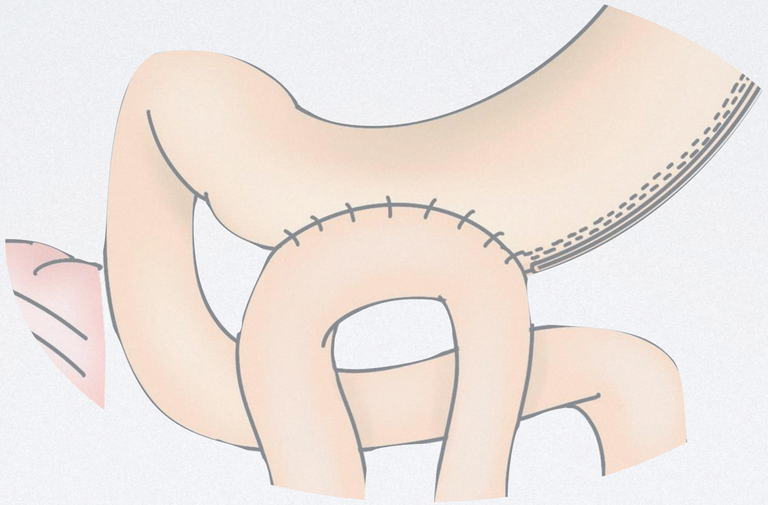
- Marginal ulcer
- **Gastric Acid** directory goes to Jejunum
- **Bile and pancreatic secretions** can reflux into the anastomosis, aggravating mucosal damage.
- **Ischemia** at the anastomosis (Gap between two staplers: sleeve and anastomosis)
- 2-5 % reported



Obes Surg. 2022 Jun 6;32(8):2807–281

BILE EXPOSURE

- **Reflex**
- **Cancer**



BILE REFLEX
(NOT BILIARY ESOPHAGITIS)

1. Sewefy et al., 2022 (as a revisional procedure)

Obes Surg. 2022 Jun 6;32(8):2807–2813.

In a prospective cohort of 43 patients, **significant biliary gastritis occurred in 9.3%**with **biliary vomiting and epigastric pain.**

2. Abdelzaher et al., 2023 (prospective study)

The Egyptian Journal of Surgery 42(1):p 171-177, January-March 2023.

biliary vomiting was observed in 6%

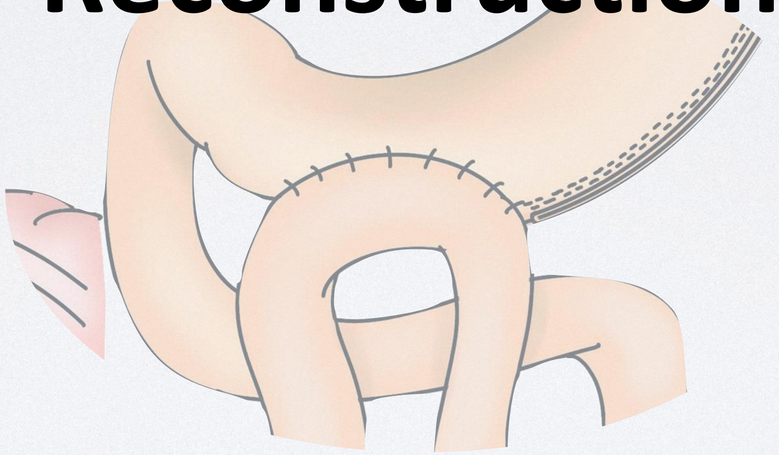
3. Meta-analysis & comparative data (2025)

International Journal of Surgery 111(8):p 5268-5279, August 2025.

biliary gastritis incidence ranged from **3.3% to 6.6%**

CANCER DUE TO BILE EXPOSURE

Carcinogenic Risk after B-II Reconstruction



BILE REFLUX AND CARCINOGENESIS

Bile acids cause chronic inflammation, oxidative stress, and DNA damage

Promotes intestinal metaplasia → dysplasia → carcinoma

Most pronounced around the anastomosis in Billroth-II reconstructio

Cancer risk increases even in absence of H. pylori

Caygill 1994 (Gut)：Kaminishi 1993, Maehara 1996：Katai 2010, Nozoe 2002：

Ann Surg Oncol (2011) 18:670–676
DOI 10.1245/s10434-010-1425-1

Annals of
SURGICAL ONCOLOGY
OFFICIAL JOURNAL OF THE SOCIETY OF SURGICAL ONCOLOGY

ORIGINAL ARTICLE – GASTROINTESTINAL ONCOLOGY

Treatment and Outcome of Patients with Gastric Remnant Cancer After Resection for Peptic Ulcer Disease

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[1]Department of Surgery, Memorial Sloan-Kettering Cancer Center, New York, NY; [2]Department of Epidemiology and Biostatistics, Memorial Sloan-Kettering Cancer Center, New York, NY

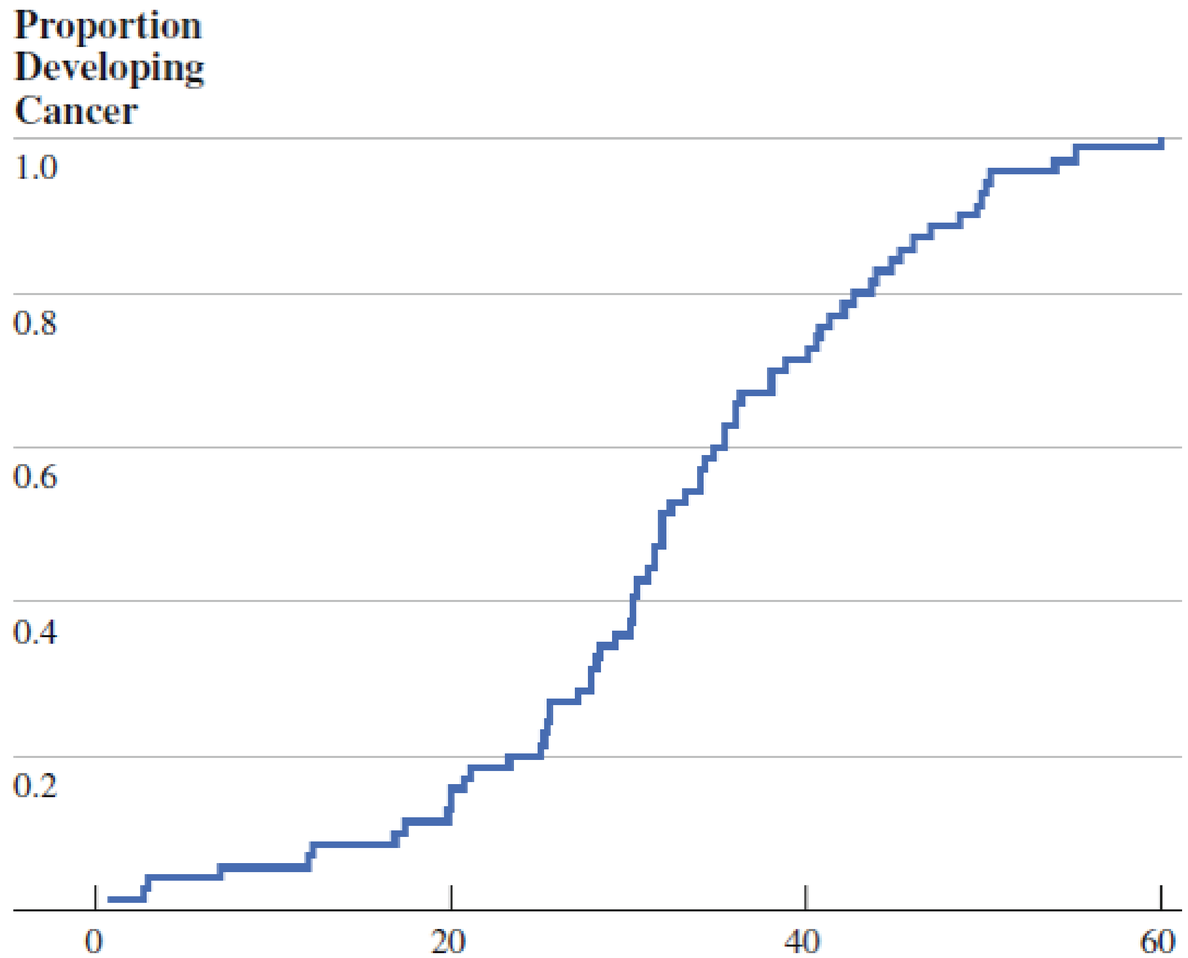
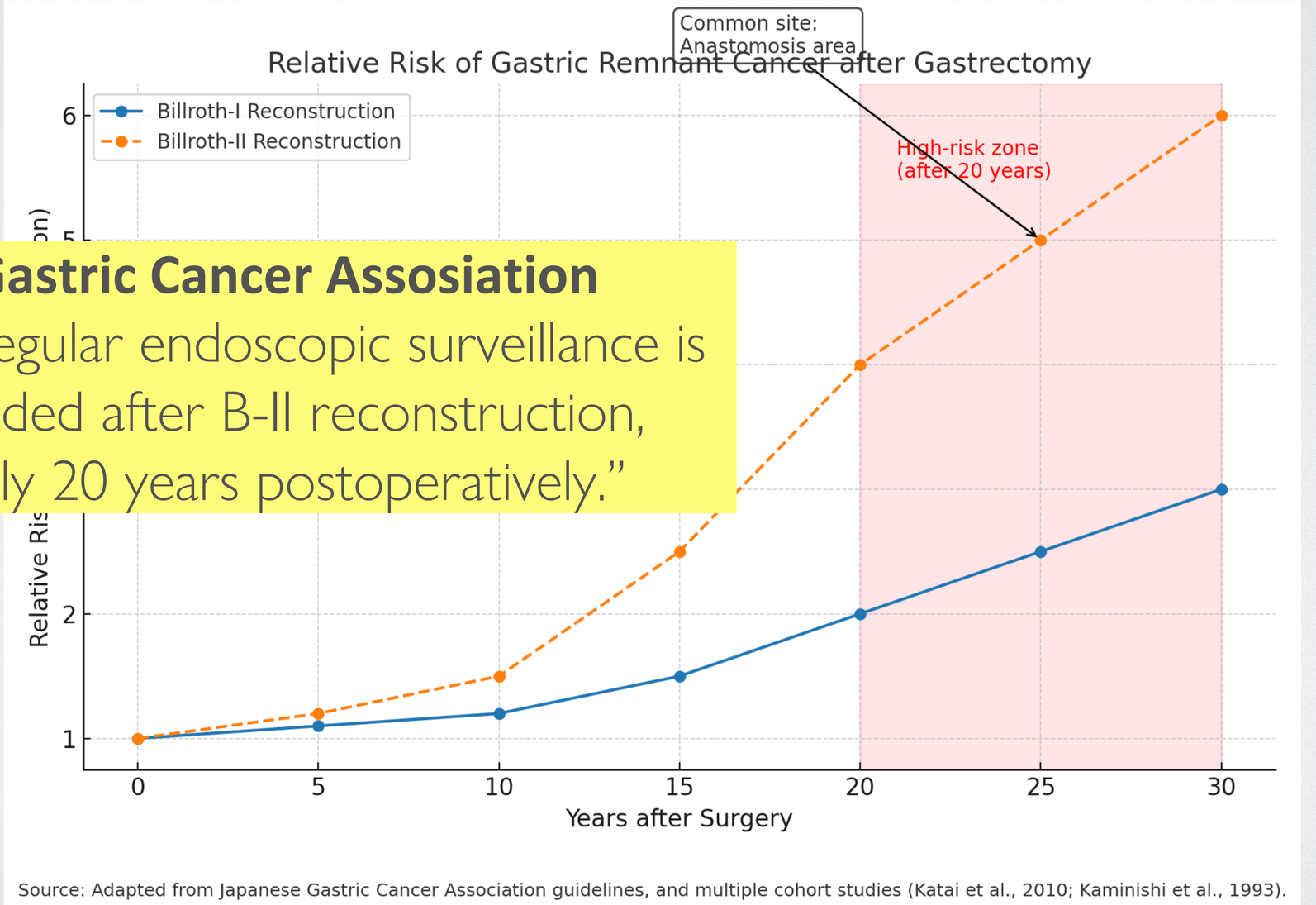


FIG. 1 Proportion of patients developing gastric remnant cancer relative to the time from initial gastric resection for peptic ulcer disease (median time = 32 years (range 3–60 years)

CANCER RISK
B-II VS B-II



Japan Gastric Cancer Assosiation

"Long-term regular endoscopic surveillance is recommended after B-II reconstruction, particularly 20 years postoperatively."

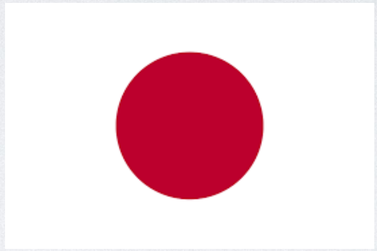
Source: Adapted from Japanese Gastric Cancer Association guidelines, and multiple cohort studies (Katai et al., 2010; Kaminishi et al., 1993).

SURGERY FOR GASTRIC REMNANT CANCER(1° WAS BENIGN)

More than 30 years

Year	Institution	Duration				Reconstruction
2000	Germany_Munchen	1982~1998	50	50	26.5	BII→47(94%)
2003	China	1979~2000	67	64	NA	BI : BII = 27 : 40
2009	China	1993~2003	89	42	29.9	BI : BII = 9 : 33
2009	Turkey	1996~2007	26	26	32.0	All BII
2010	Japan_95	~2008	887	417	33.9	BII benign → 417
2011	USA_MSC	1985~2011	105	105	32.0	BII → 97(92%)
2014	Italy_8	1990~2012	176	176	34.6	BII → 167(95%)
2015	Korea_Bundang	2003~2012	34	13	30.9	BI/BII/RY/EG=10/20/2/2
2015	Korea_YMC	1998~2012	210	53	NA	167/210(79.5%) → BII
2016	Japan_NCC, East	1992~2013	88	43	33.9	BI/BII/RY=16/27/0
2016	Japan_Keio	1970~2012	122	49	26.4	BI : BII = 15 : 34

NATIONAL GASTRIC CANCER SCREENING



- Only 2 countries in the world
- Japan started 1983 , Korea 2002
- Screening endoscopy (elder than40yrs) is covered by the public costs.
  e.g. 0-10 USD ; personal pay

CLINICAL IMPLICATIONS

- B-II patients = high-risk of cancer group due to bile reflux
- H. pylori eradication can reduce overall risk
- However, bile reflux risk persists even after eradication
- Long-term endoscopic surveillance essential
- = Good for the countries which have the system of endoscopic surveillance