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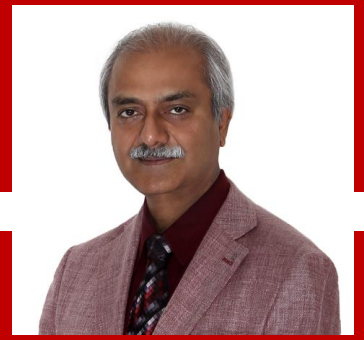
XXVIII IFSO World Congress

9-12 September 2025 | Santiago, Chile

SASJ

{ Sleeve + Sleeve-Jejunal bypass }

[Single Anastomosis Sleeve-Jejunal Bypass]



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IFSO

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No conflict of interest to report

Introduction - SASJ

Sleeve Gastrectomy with Sleeve-Jejunal bypass

(Single Anastomosis Sleeve-Jejunal Bypass {SASJ})

→is a single anastomosis, Sleeve Plus procedure

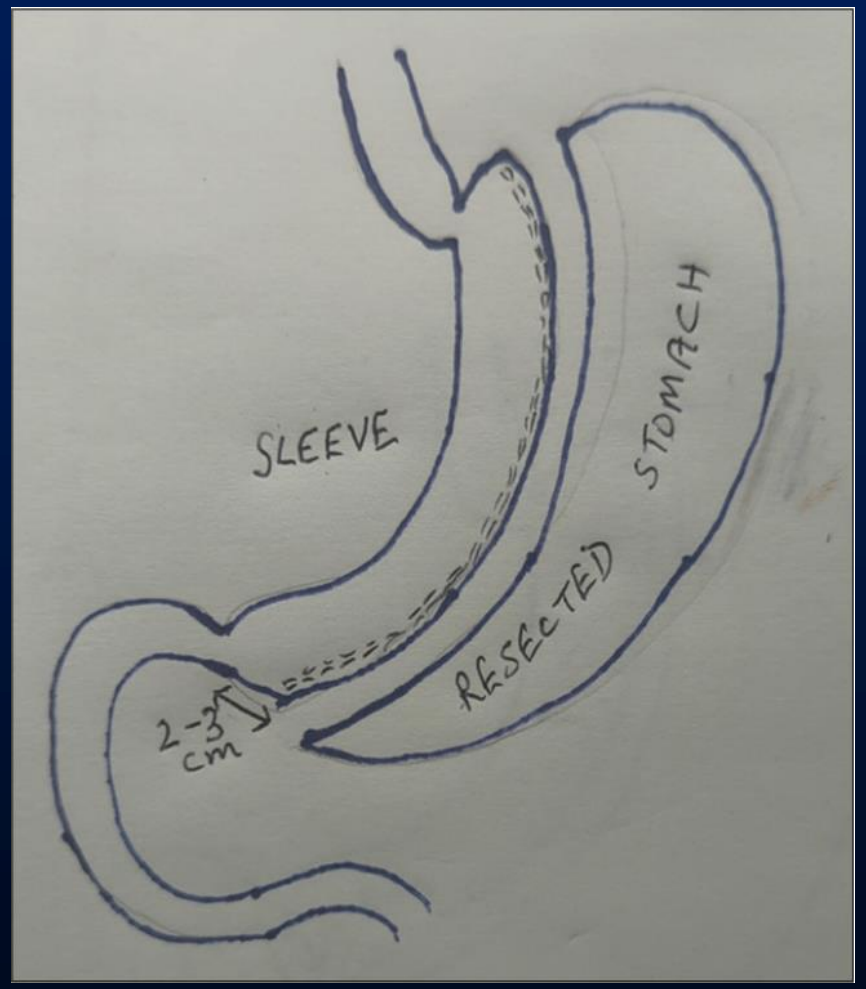
→ introduced as a loop modification of transit bipartition

→ Modified the Single Anastomosis Sleeve-Ileal bypass (SASI), to proximalise the anastomosis

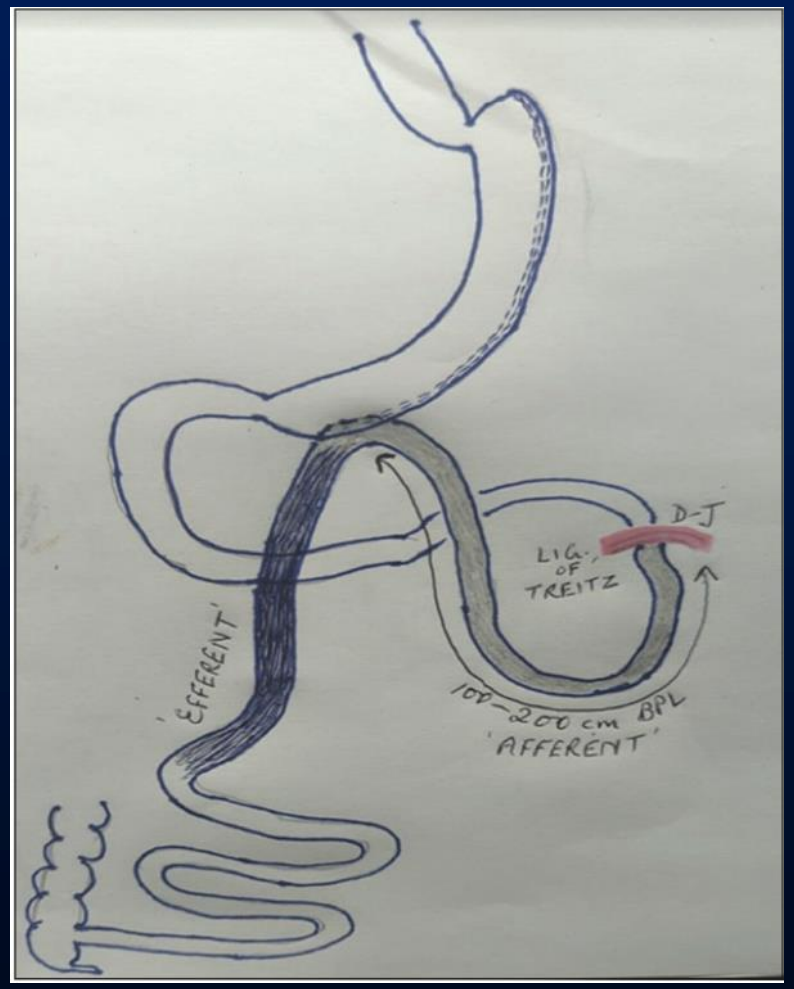
→ maintaining biliary access by avoiding duodenal transection

→ creating a functional bypass to achieve weight loss and diabetic resolution

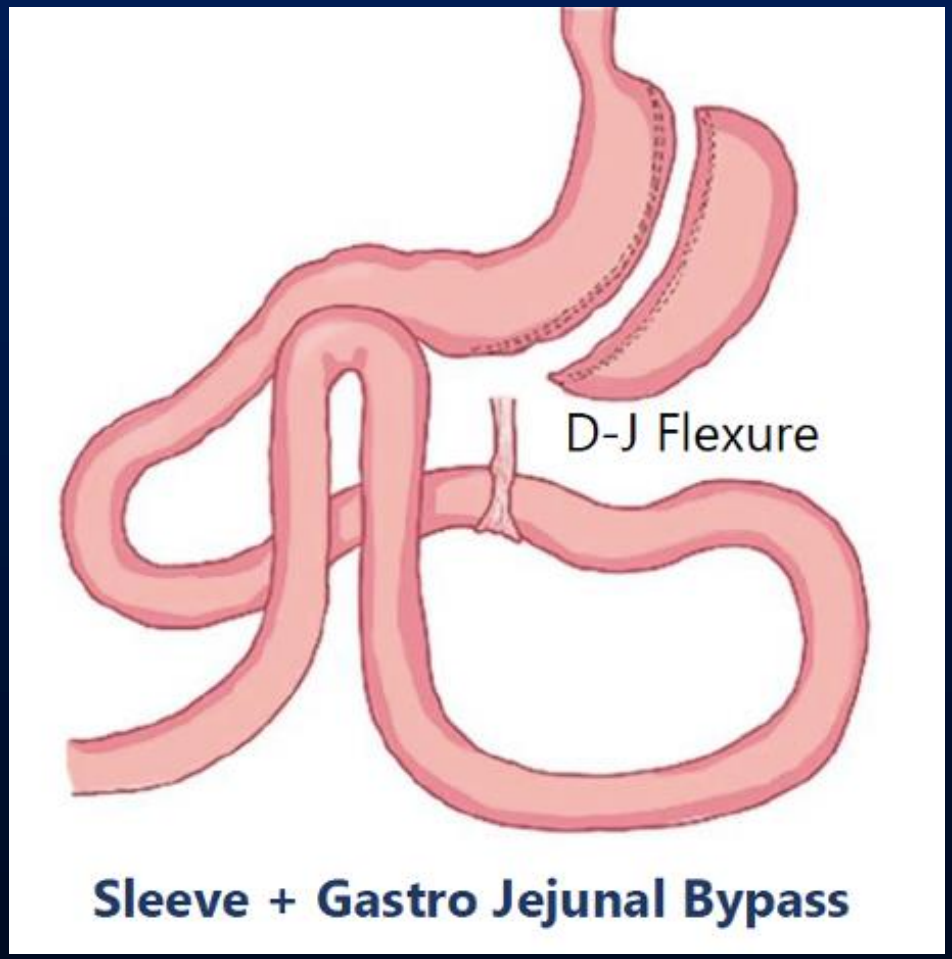
1st Step ➔ Standard Sleeve {Antral Resecting} - 36Fr bougie

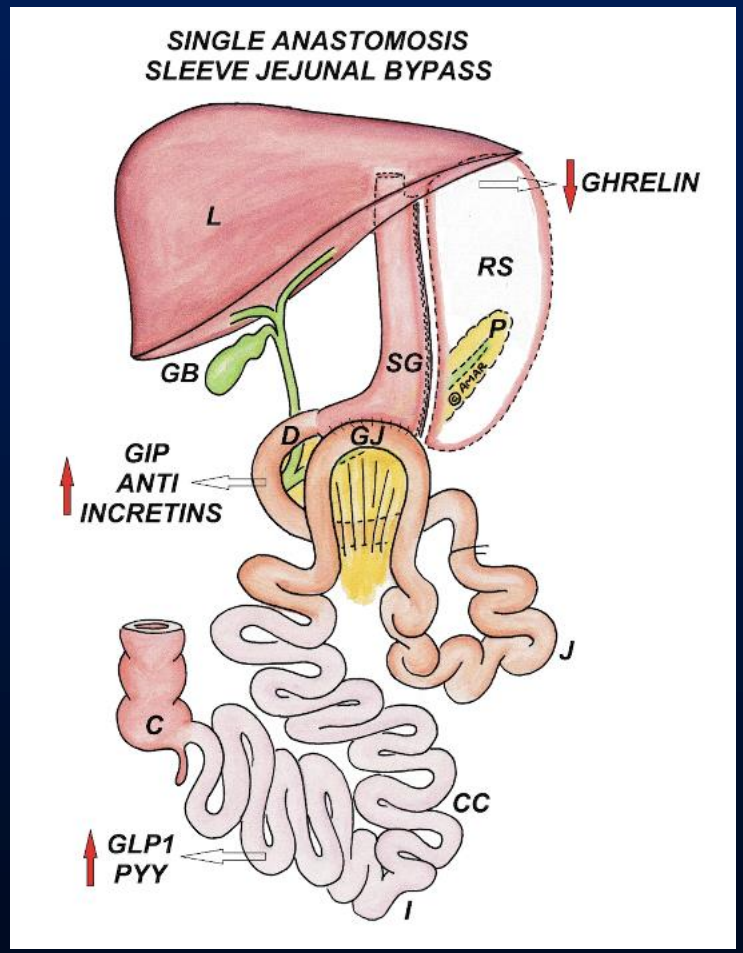


2nd Step➔ SG-Jejunal Anastomosis {with leak test and closure of Petersen's space}



Diagrams of SASJ





Procedure

-Laparoscopically, using 6 ports.

-Stapled Sleeve Gastrectomy -36-38 F gastric bougie for calibration.

-Jejunum is measured & marked at 150-200 cm from DJ flexure, with a 2-limb suture; prox to that with a 1-limb suture to establish proximal and distal aspects.

-Remaining small bowel is measured proximally from ileo-caecal valve (ICV) → evaluate total small bowel length → ensure sufficient common channel remains

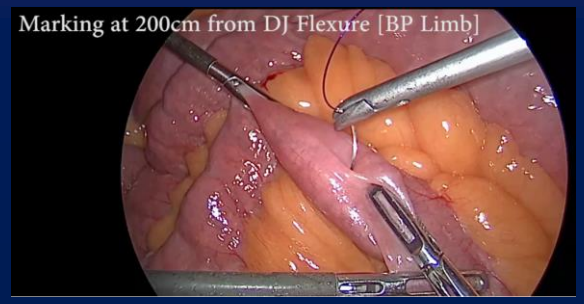
-Antecolic stapled anastomosis of marked jejunal loop to antral end of the sleeve

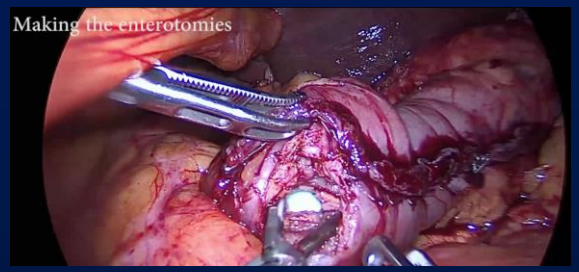
→ Blue 45 mm cartridge.

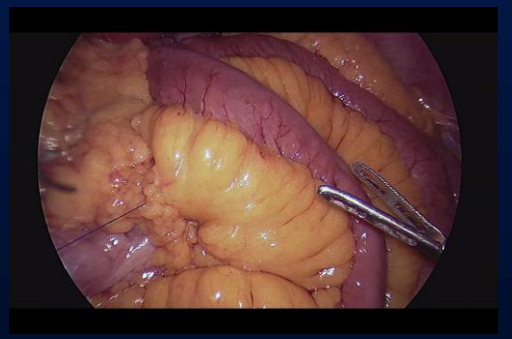
-Enterotomy is closed with 3-0 PDS with intracorporeal suturing.

-Leak test is done with methylene blue

-Petersen's space is closed with continuous 3-0 prolene sutures → prevent internal herniation.







Retrospective multi-center data analysis of 416 patients
6 centres in India
Follow-up of 1-8 yrs
sleeve gastrectomy followed by jejunal loop anastomosis, to antrum at 200cm from DJ flexure (or 150/100cm depending on total small bowel length)

Demographics

Preop Data	Mean
Age	42
BMI	43.8kg/m2 {30—74}
Diabetes Incidence	41%
HbA1c {incl Non-DM}	6.7% [4.9–16%]

Total Small Bowel Lengths in Surgery

	Mean {cms}
Total small bowel length (TSBL)	**709 (range 450–890)**
Common channel (CC)	**517 (range 330–570)**

RESULTS				
	Pre-Op	1 yr	3 yr	5 yr
HbA1c %	7.53	5.76	5.89	6
Remission of DM %	-- --	88.7	92	100
BMI kg/m2	43.8	28.3	26.5	27
% TWL	-- --	34.3	39	39.3
% Follow-Up	-- --	70.4	61.2	34.9

UNCONTROLLED Group ➔ HbA1c >8

- *

Diabetic Patients				
	Pre Op	1-yr	3-yrs	5-yrs
Mean HbA1c %	9.61	5.25	4.89	4.93
Range of A1C	8.1 - 16	4.7 - 6.7	4.8 - 5	4.8 - 5.1
Insulin usage %	59.10%	0%	0%	0%

Surprisingly, there was no reduction in weight loss efficacy, even with longer common channel lengths

- ➔ So why not Bypass at 150cm to be very safe ???

	%TBWL – 1yr	3yrs	5yrs
CC of 400-500cm	38.56	40.88	43.3
CC of 500-600cm	38.97	41.16	39.54
CC of 600-700cm	39.68	41.92	41.32
CC of 700-800cm	37.34	37.44	43.8
CC >800cm	34.8	37.3	43.3

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Original Article

Safety and Efficacy of Sleeve Gastrectomy with Sleeve Jejunal Bypass: An Advantage over Other Bypass Procedures – Multicenter 3 and 5 year Data

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*Ugale S, Palaniappan R, Bharucha M, Ugale A, Krishna N, Ugale A, *et al*. Safety and efficacy of sleeve gastrectomy with sleeve jejunal bypass: An advantage over other bypass procedures – Multicenter short-term follow-up data. J Bariatr Surg 2023

Sleeve Gastrectomy With Sleeve-Jejunal Bypass

➔Aimed at making a bypass procedure easier for all Bariatric (including younger) surgeons

[combines the ease of a SG,

with the widely accepted OAGB-MGB

& benefits of a Bipartition, using a loop anastomosis to create a bypass]

Best of ALL Worlds !!!

COMPLICATIONS

* Nausea, vomiting or diarrhoea, or dumping syndrome- 10 pts – 6 of them resolved with Conservaive Rx

--4 patients required a partial reversal of the procedure [disconnection of the jejunal bypass while retaining the sleeve]

--We don't have data on Marginal ulcers as yet; so also for GERD → Published literature also very unclear, but approx. 2—3% Marginal ulcers & 20—27% deNovo GERD

- No mortality from the procedure

Single Anastomosis Sleeve Jejunal Bypass (SASJ) Has Become the Leading Metabolic Bariatric Surgery in Taiwan

Editorial | Published: 14 August 2025

- *Lin, YH., Ser, KH., Lee, MH. *et al.* Single Anastomosis Sleeve Jejunal Bypass (SASJ) Has Become the Leading Metabolic Bariatric Surgery in Taiwan. *OBES SURG* (2025). https://doi.org/10.1007/s11695-025-07995-2

Advantages & *CONCLUSION*

1. ***Maintains endoscopic access to the biliary tree***
2. There is no excluded remnant stomach → important in countries with high incidence of gastric cancer.
3. No blind end - avoids bacterial overgrowth and blind loop syndrome.
4. ***Easier to perform - sleeve with a single anastomosis***
5. If necessary, Partial Reversal can be done in a simpler manner compared to other bypass procedures [leaving a Sleeve in place]
6. Nutritional stability even at 5 years → both routes from stomach are open
7. Could be positioned as the main bypass procedure in Bariatric and Metabolic surgery

THANK YOU

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