

SHOULD WE GO

“ALL IN”

IN ROBOTIC MBS?

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Evidence first!



Disclosures

- Research Grant, Johnson & Johnson
- Research Grant, Medtronic
- Research Grant, GI Dynamics
- Research Grant, Hospital Oswaldo Cruz Bioscience Institute
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- Speaker, Johnson & Johnson, Medtronic, NovoNordisk, Lilly, Merck, Currax and Boston Scientific
- SAB: Morphic Medical, Medtronic, Johnson & Johnson, Regeneron

3 forces make the robotic MBS decision urgent

ADOPTION | 2015 → 2022

6.7–6.9% → 29.5–31.8%

Share of primary SG and RYGB performed robotically.

EVIDENCE

1.18M+

patients in the largest registry analysis



UNRESOLVED VALUE

+23–40 min

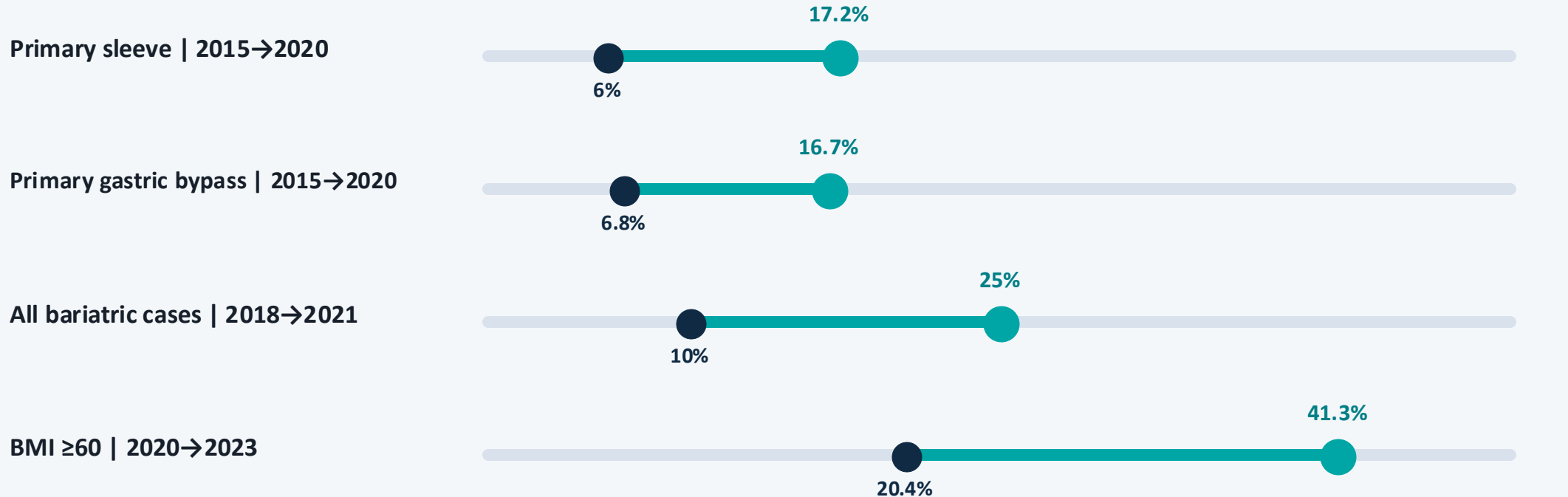
+\$1.5K–\$1.8K

Procedure-specific outcomes and long-term durability still matter.

Does the evidence justify routine robotic MBS—or selective use?

Robotic MBS adoption doubled or tripled

Percentage of bariatric operations performed robotically



What this means: adoption doubled or tripled even though studies have not shown better overall outcomes.

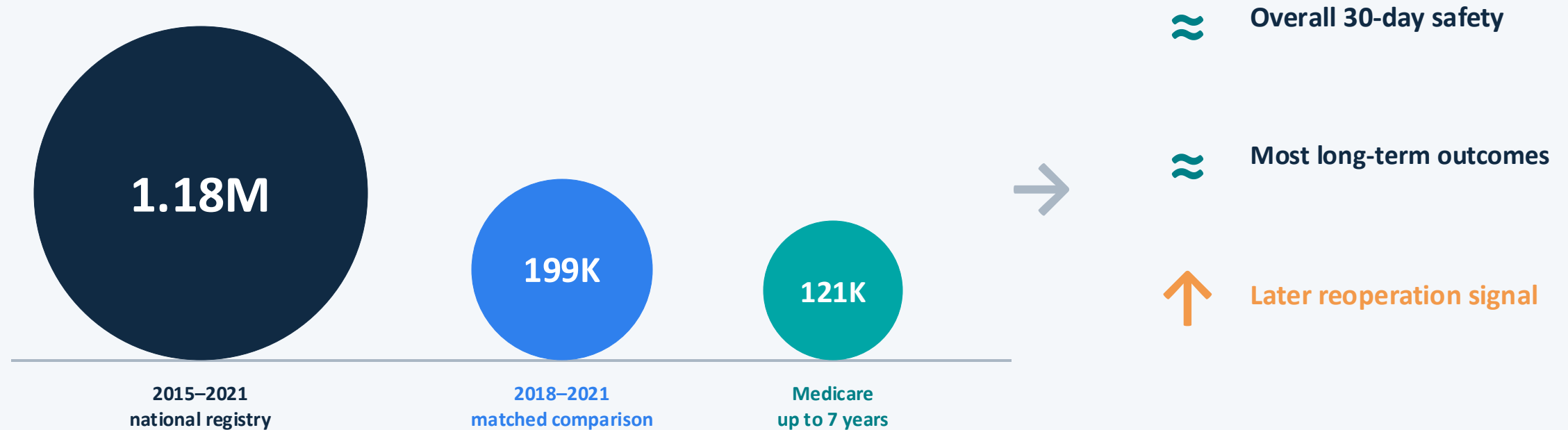
0%

50%

Large datasets show similar overall safety—not superiority

Most differences are small and depend on the operation being performed

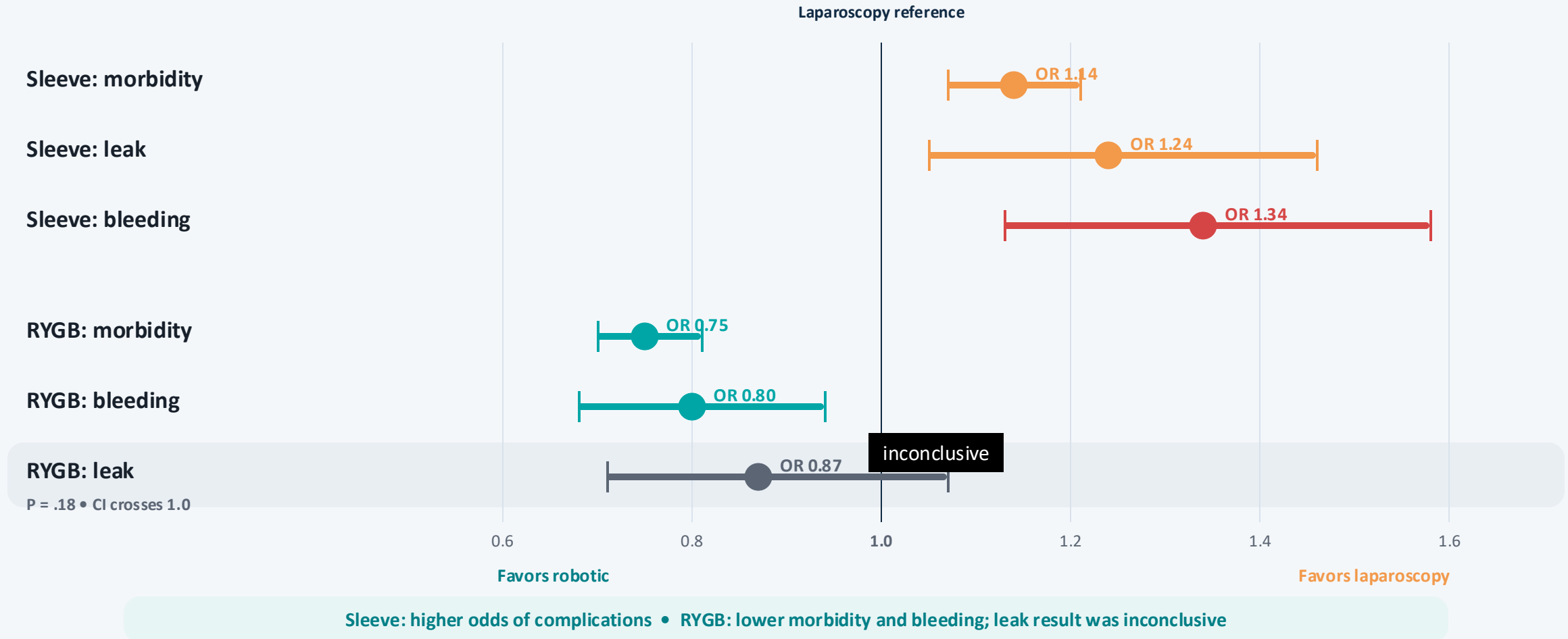
PATIENTS ANALYZED



Similar safety ≠ equal value: time, cost and procedure-specific outcomes still matter.

The short-term signal depends on the operation

Odds ratios with 95% CIs; a CI crossing 1.0 is not statistically significant



BMI ≥ 60 : adoption doubled without a safety advantage

32,295 patients | serious complications 3.1% vs 3.4% | robotic time +23 min

SERIOUS COMPLICATIONS

p = 0.149

3.1%

3.4%

LAP

ROB

OPERATIVE TIME

minutes

83.5

106.5

LAP

ROB

+23 min

ROBOTIC UTILIZATION

share of BMI ≥ 60 cases

20.4%

41.3%

2020

2023

ADOPTION DOUBLED

but adjusted safety did not improve (OR 0.99)

Robotic MBS was associated with higher reoperation hazards

At seven years, SG and RYGB had higher adjusted hazards; other outcomes were similar in 121,521 Medicare patients

ADJUSTED HAZARD OF REOPERATION VS LAPAROSCOPY

Laparoscopy reference

Sleeve gastrectomy

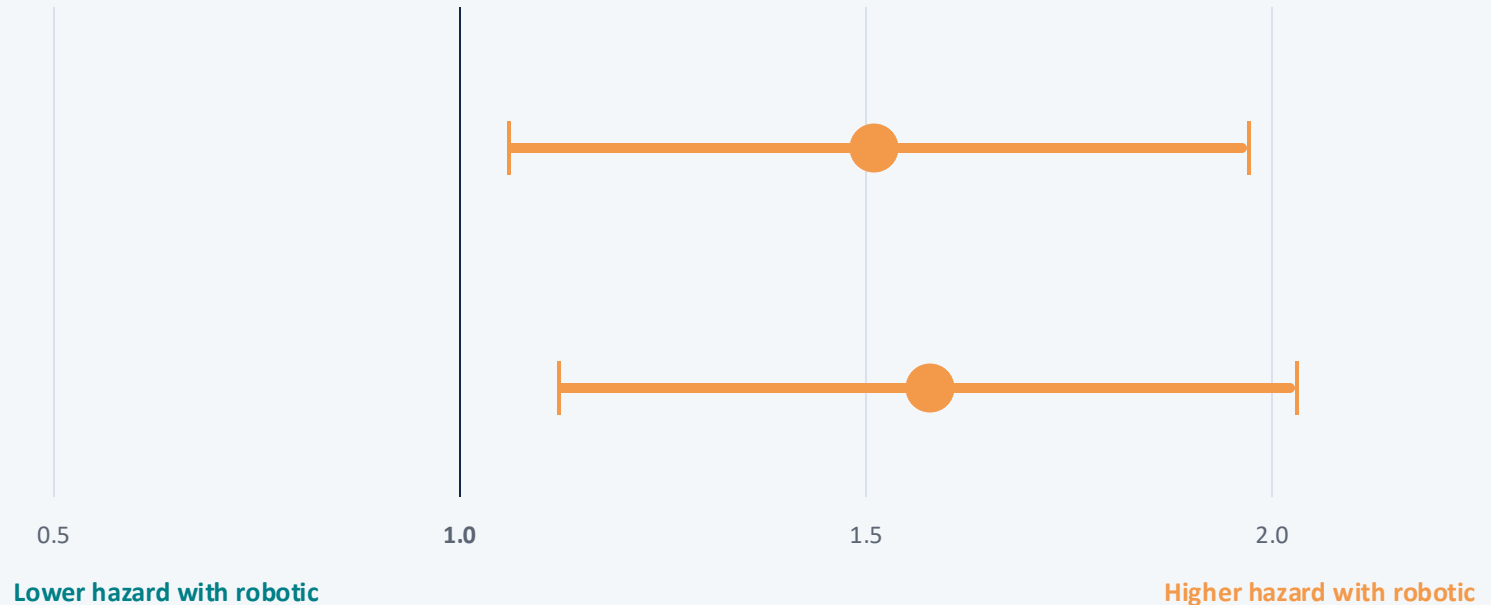
aHR 1.51 (1.06–1.97)

= 51% higher relative hazard

Roux-en-Y gastric bypass

aHR 1.58 (1.12–2.03)

= 58% higher relative hazard

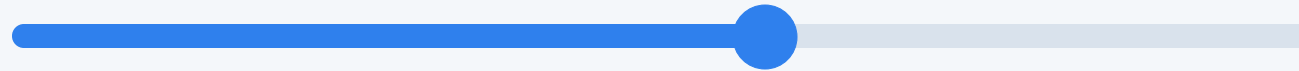


Relative hazard—not the absolute percentage of patients who underwent reoperation.

Robotic MBS adds 23–40 operating-room minutes

Additional operating-room time compared with laparoscopy

Sleeve | national registry



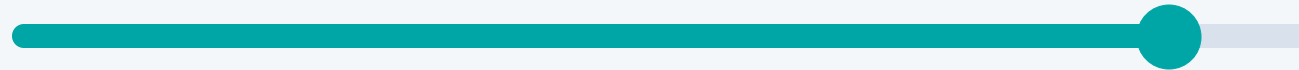
+26 min

BMI ≥ 60 | 2026 cohort



+23 min

RYGB | national registry



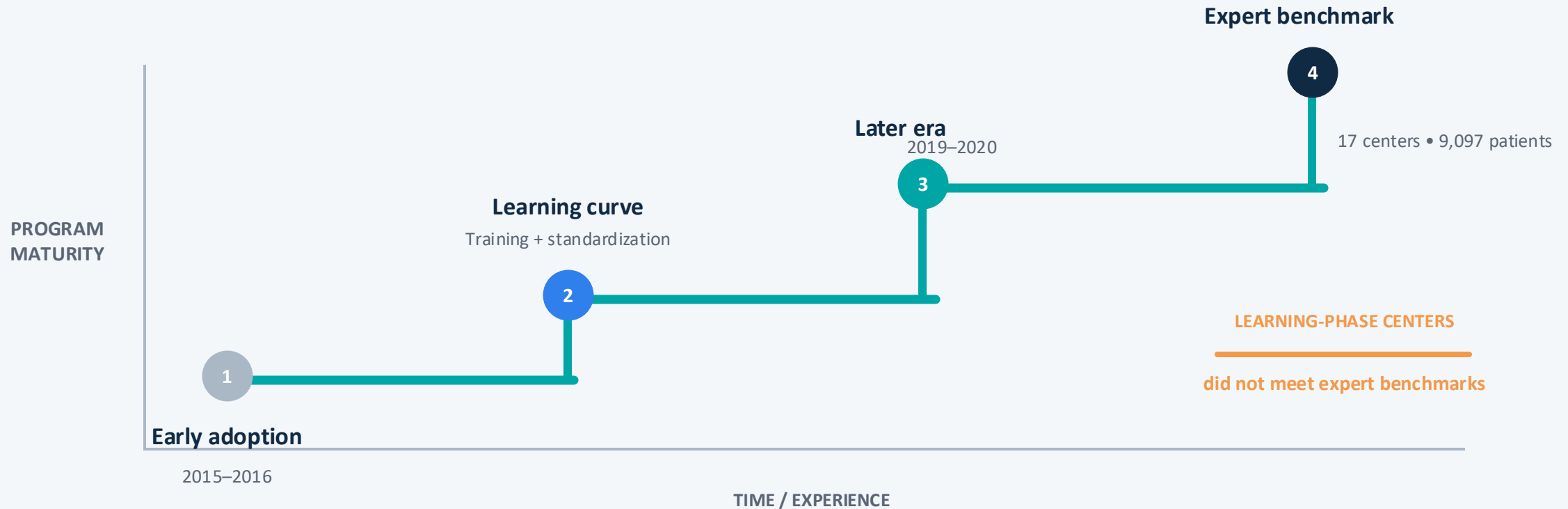
+40 min



Extra operating time is consistent; a clinical advantage is not.

Learning-phase centers missed expert benchmarks

Outcomes improved over time, but expert-center results were not immediately reproducible



Conceptual curve—not a quantitative effect estimate

Robotic MBS added \$1.5K–\$1.8K per case

Average direct hospital cost in national data, US dollars

Sleeve



RYGB



What this means: routine robotic use needs a measurable patient or workflow benefit to justify an additional \$1.5K–\$1.8K per case.

Payments from robotic-surgery companies **increased 8x**

Open Payments, 2013–2024

\$857.5M

TOTAL, 2013–2024

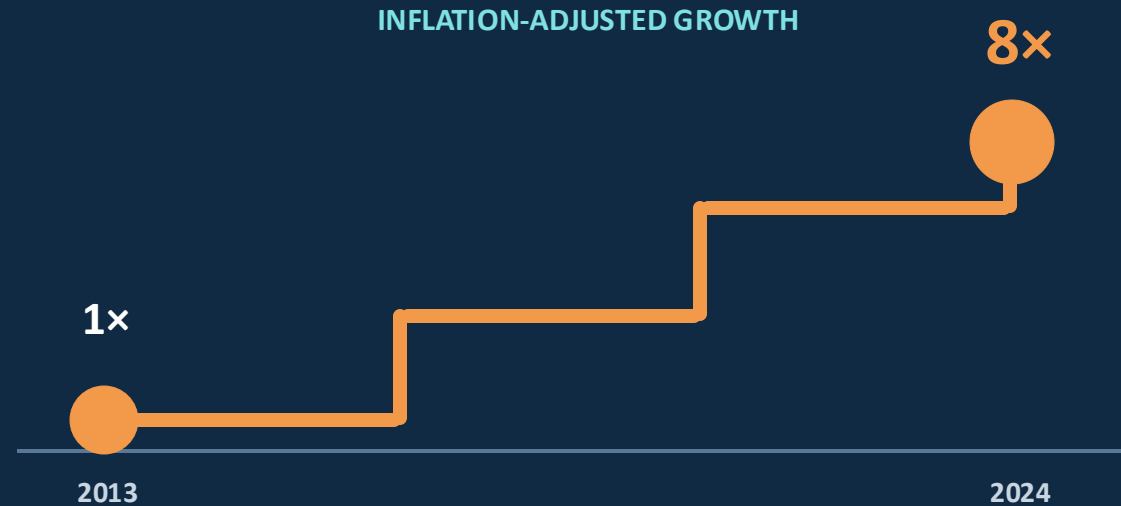
WHO RECEIVED THE MONEY?

81% physicians

19% hospitals

\$695.6M

\$161.9M



PAYMENTS $\neq$ CAUSATION

But they justify disclosure, independent outcome review and cost oversight—especially during rapid adoption.

The evidence supports selective—**not routine**—robotic MBS

NO OVERALL SUPERIORITY



Most short-term outcomes are similar



The signal changes by procedure—sleeve and RYGB differ

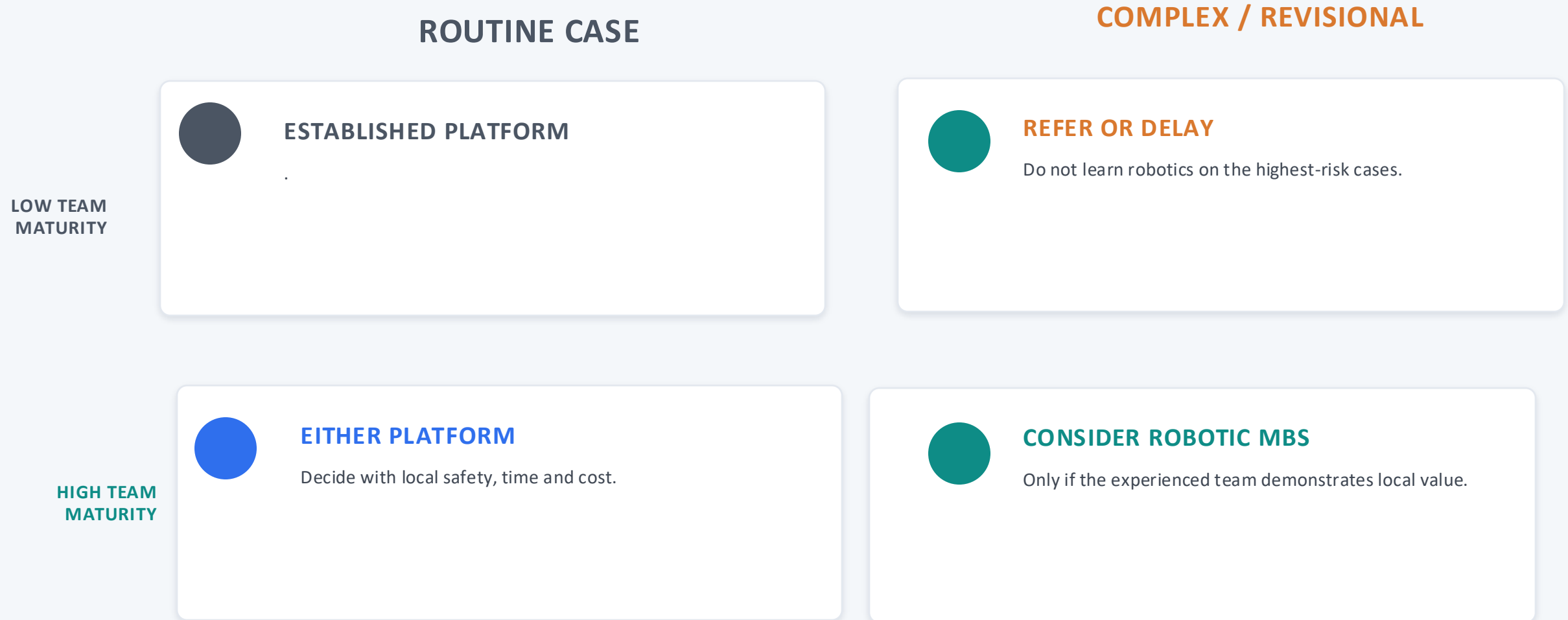


Robotic MBS usually adds operating time and cost

REAL MESSAGE: robotic MBS is an option—not the default. It must earn its place locally.

Match case complexity to team maturity

A practical framework — not a validated algorithm — Cohen RV



Track six domains locally—not just complications

Local Robotic MBS Dashboard



REVIEW QUARTERLY • COMPARE WITH LOCAL LAPAROSCOPY • REPORT BY PROCEDURE

BOTTOM LINE

NOT “ALL IN.”

PLAY THE RIGHT HAND.

Robotic MBS should be a selective bet—not the default.

PUSH CHIPS FORWARD ONLY WITH:

- 1 RIGHT PATIENT
- 2 RIGHT PROCEDURE
- 3 EXPERIENCED TEAM

...and a measurable advantage worth the time and cost.



SELECTIVE ADOPTION • MEASURED VALUE • COST ACCOUNTABILITY • TRANSPARENCY

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Thank you!



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