IFSO

XXIX IFSO World Congress

1-4 September 2026 | Toronto, Canada

Will gastric bypass and sleeve gastrectomy remain the gold standard for primary surgery?

Dr. Felipe Rossi

SBCBM Elected Board of Directors

CERTIFICAÇÃO EM CIRURGIA BARIÁTRICA E METABÓLICA IQIII

TORONTO 2026

The Future of Obesity Management:
From Weight Loss to Health Gain

Disclosure Slide

IFSO

XXIX IFSO World Congress

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X	No, nothing to disclose
	Yes, please specify:

OVERVIEW

Agenda

01 **Sleeve & bypass today**

02 **Evidence for the newer techniques**

03 **Challenges ahead**

04 **Perspectives**

THE PATIENT IN FRONT OF YOU

Which patient are you facing?

Márcia · 45 years

105 kg · BMI 42 kg/m²

- T2DM on metformin + MASLD
- Lost 10 kg with semaglutide, but regained weight after stopping the drug

** AI-generated images (Gemini) based on the author's prompts.*

THE PATIENT IN FRONT OF YOU

Which patient are you facing?

Roberto · 45 years

165 kg · BMI 55 kg/m²

- Hypertension on 4 drug classes + Sleep Apnea on CPAP + MASLD
- GLP-1 analogue–naïve

** AI-generated images (Gemini) based on the author's prompts.*

01

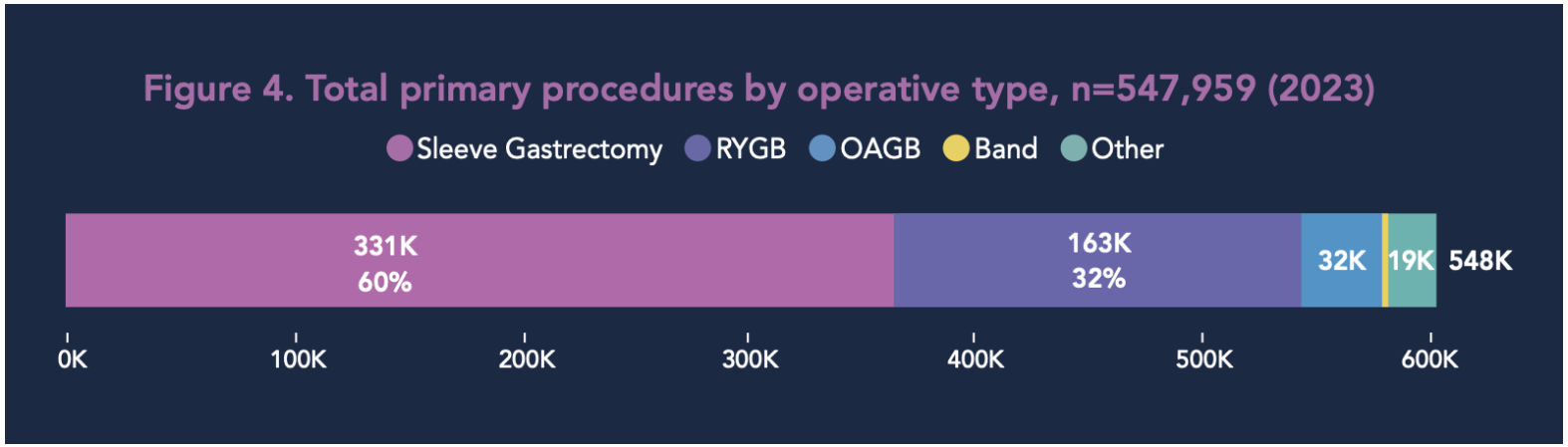
SECTION

Sleeve & bypass today

Where the two dominant techniques actually stand? — and why?

Where we stand in the world

Total primary procedures by operative type — 2023



Sleeve gastrectomy and Gastric Bypass remain the most performed primary procedures worldwide. OAGB is growing steadily — but sleeve and bypass are still the two operations the world runs on.

In Brazil, RYGB is still the most performed

Total

509.253

Liberados

449.280

41

MEAN AGE (Y)

43.2

MEAN BMI

82.8%

WOMEN

17.2%

MEN

Banda Gástrica Ajustável

999

Duodenal Switch

794

Bypass / Gastroplastia em "Y de Roux"

331.081

Sleeve / Gastrectomia Vertical

113.319

Bipartição Intestinal

1.976

OAGB

727

SADIS

291

Interposição Ileal

30

Data from the Barilife app (SBCBM, Brazil).

In Brazil, RYGB is still the most performed

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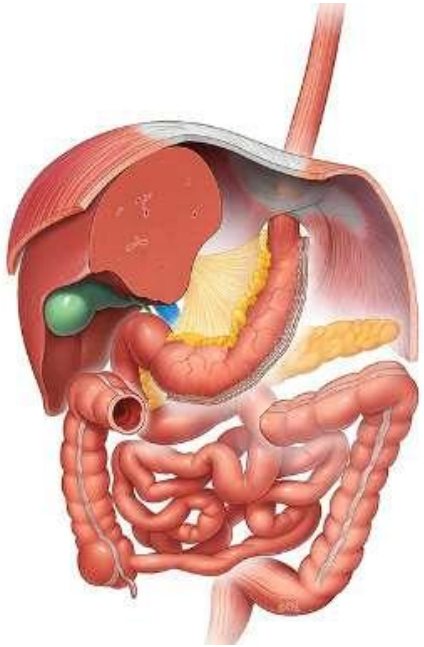
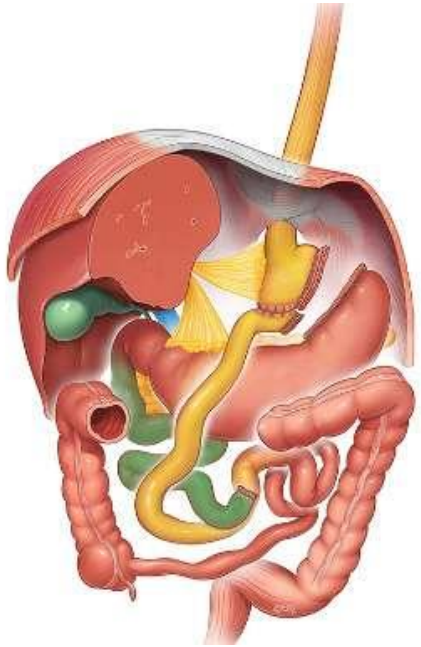
Data from the Barilife app (SBCBM, Brazil).

Why sleeve & bypass are, and will remain, the gold standard

Sleeve Gastrectomy



Roux-en-Y Gastric Bypass



Anatomical illustrations: Dr Levent Efe, courtesy of IFSO.

PREDICTABILITY

THE FOUNDATION

Predictability across the board

1

Teaching & reproducibility

Well-established learning curves, replicable technique

2

Standardization

Consistent across centers.

3

Operative time is predictable

Efficient, predictable procedures.

4

Costs are predictable

Predictable, package-based resource use.

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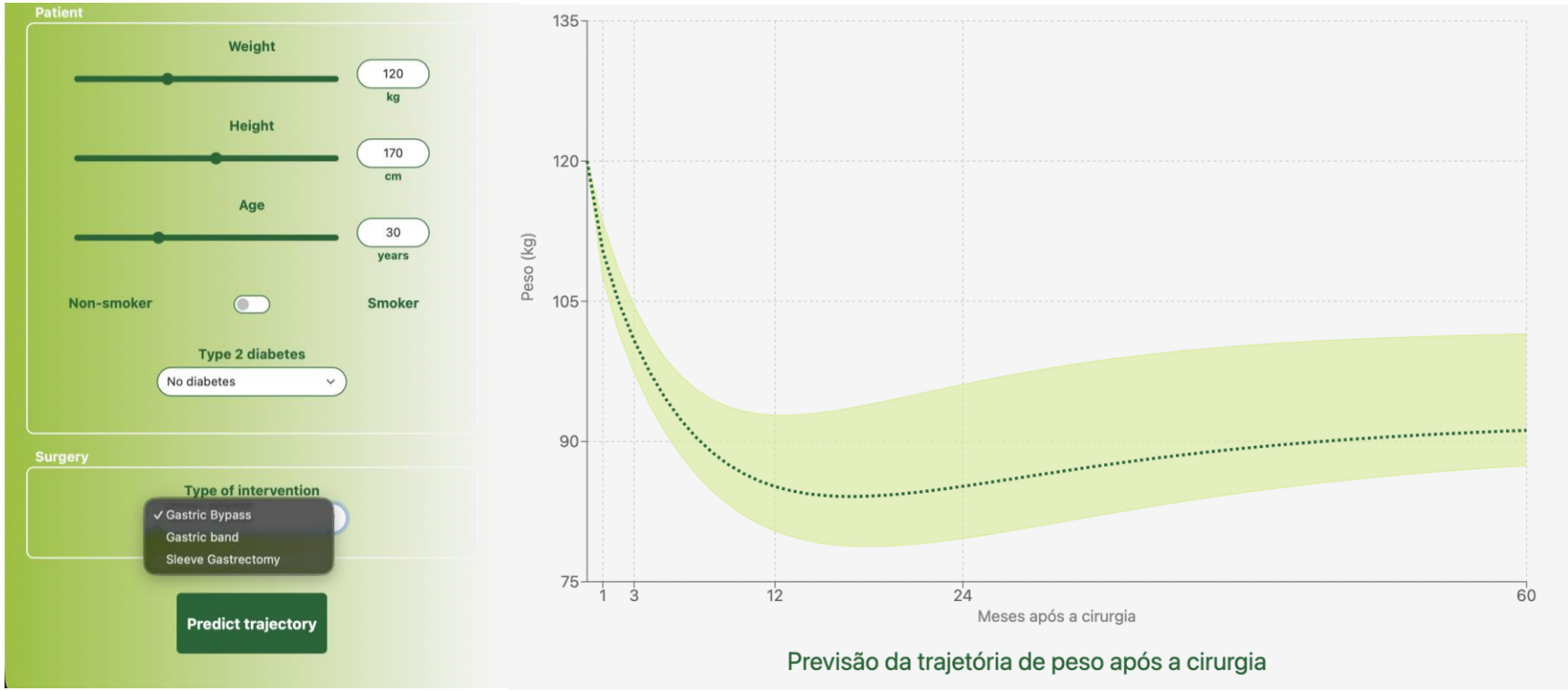
PREDICTABILITY ISN'T JUST IN THE OR – IT'S IN THE LONG-TERM OUTCOMES

Predicting individual weight trajectories



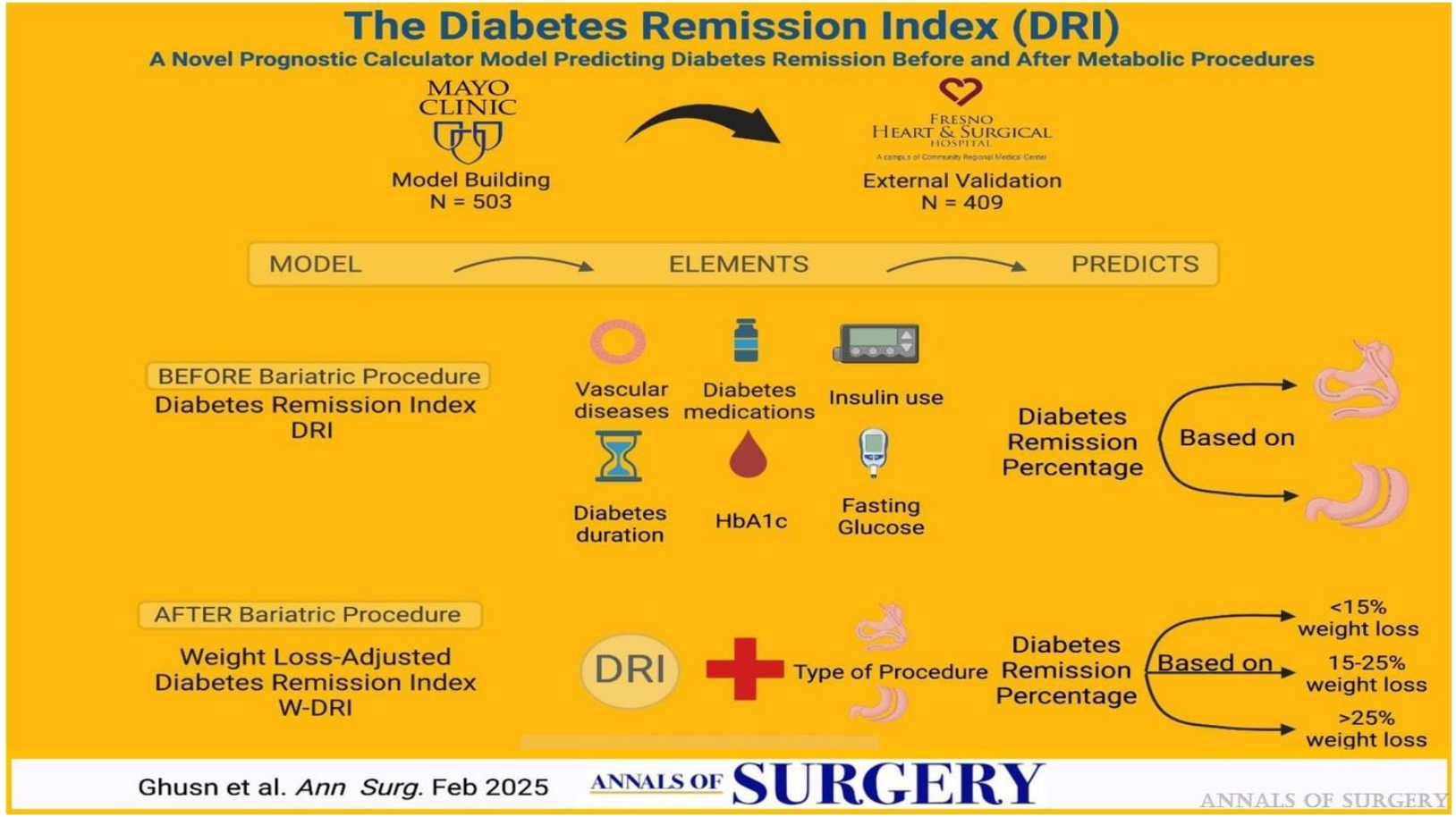
SOPHIA
Stratification of Obesity Phenotypes to Optimize Future Therapy

! A model that predicts individual 5-year weight-loss trajectories from simple variables – no lab test.

Median error under **3 BMI points** at five years

Saux P, et al. Lancet Digit Health. 2023;5(10):e692–e702. Tool: bariatric-weight-trajectory-prediction.univ-lille.fr

The Diabetes Remission Index (DRI)



!

Predicts diabetes remission before and after metabolic procedures, individualized to each patient.

Predicted diabetes remission by procedure (DRI)

Summary

Review your responses

If everything looks correct, please click or tap the "Submit" button.

Question	Response
Which of the following diabetes-related vascular diseases have you been diagnosed with?	0
How many medication(s) have you been taking before undergoing the bariatric procedure including insulin?	0 or 1
Prior to surgery, what is your fasting glucose level range (mg/dL)?	120-139
Have you been using insulin before undergoing the bariatric procedure?	No
How many years have you had a formal diabetes diagnosis?	3-6
What is your HbA1c level range before undergoing the bariatric procedure?	7.0-7.9%

For Roux-En-Y gastric bypass (RYGB) surgery:

64.9% - 72.7%

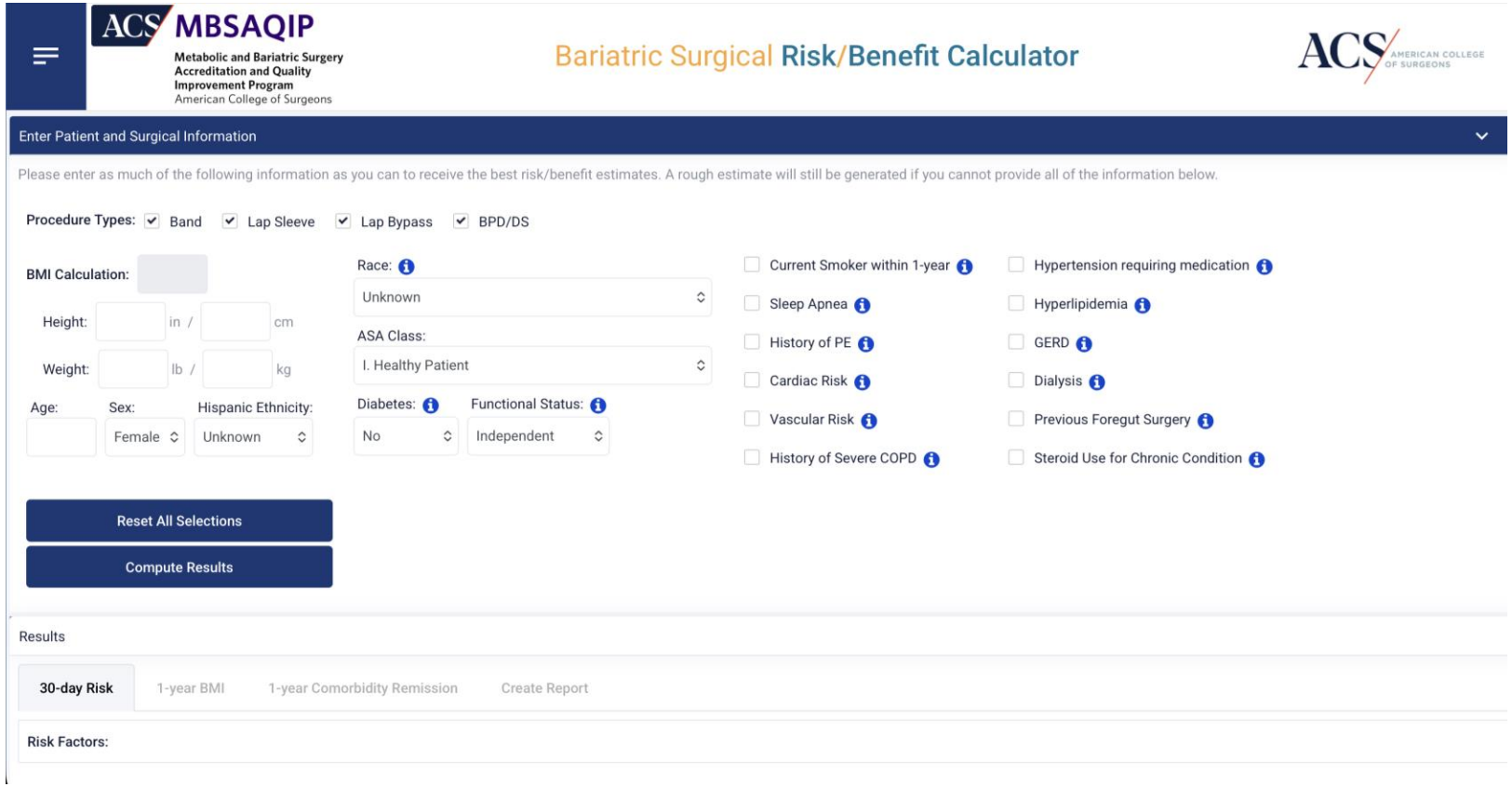
For Sleeve gastrectomy (SG) surgery:

45.8% - 53.6%

Based on your individual health data, your estimated probability of diabetes remission after surgery is listed above. This estimate considers factors such as your current health states, and the type of surgery, providing a personalized prediction of your potential for diabetes remission.

Ghusn W, et al. Ann Surg. 2025. doi:10.1097/SLA.0000000000006656

Estimating individual complication risk

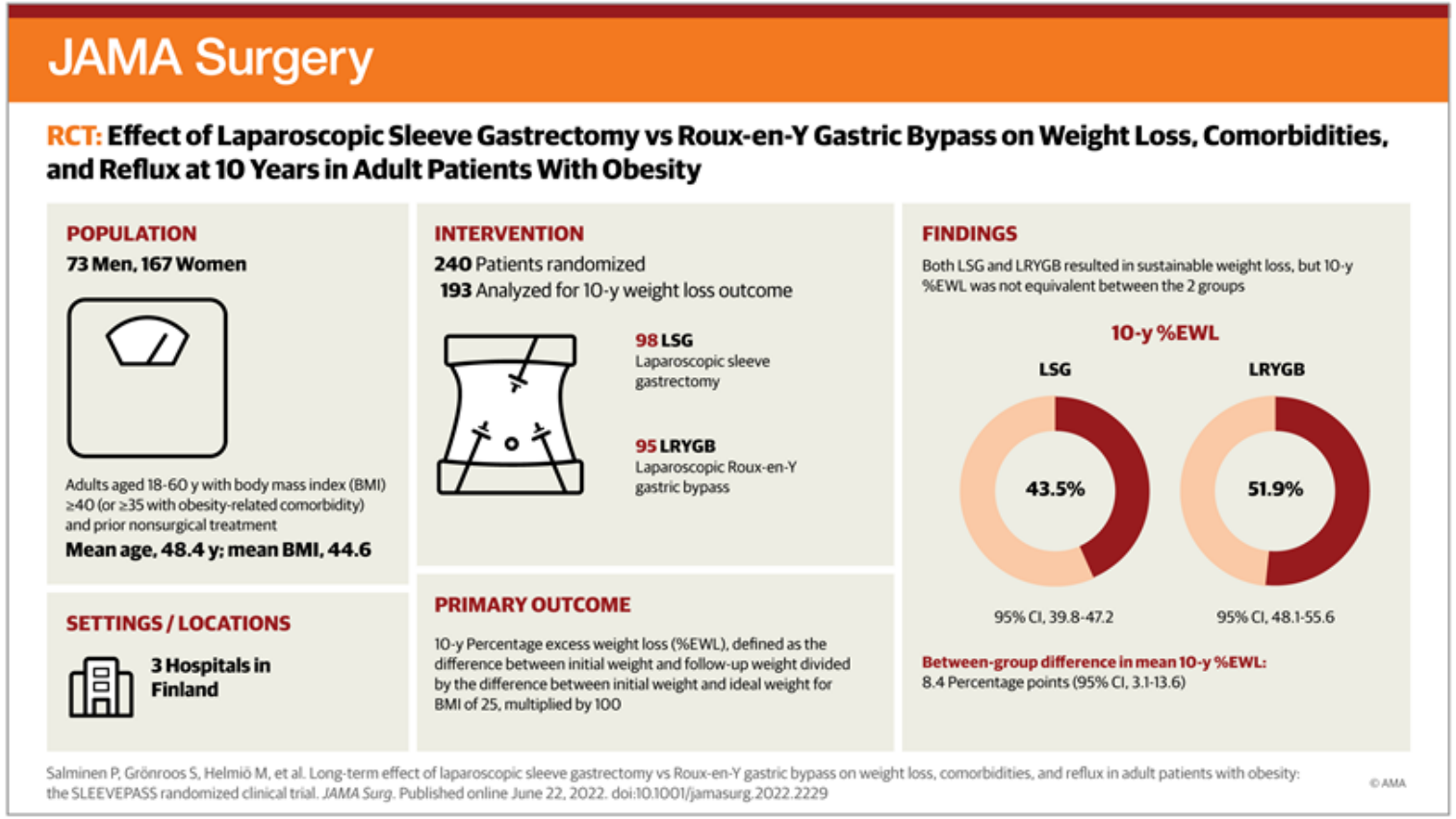


! Validated tools estimate individual complication risk, supporting shared, data-driven decisions.

Source: riskcalculator.facs.org/bariatric

BEYOND THE TECHNIQUE

Long-term outcomes (>10 years)



JAMA Surgery

RCT: Effect of Laparoscopic Sleeve Gastrectomy vs Roux-en-Y Gastric Bypass on Weight Loss, Comorbidities, and Reflux at 10 Years in Adult Patients With Obesity

POPULATION

73 Men, 167 Women

Adults aged 18-60 y with body mass index (BMI) ≥40 (or ≥35 with obesity-related comorbidity) and prior nonsurgical treatment

Mean age, 48.4 y; mean BMI, 44.6

INTERVENTION

240 Patients randomized

193 Analyzed for 10-y weight loss outcome

98 LSG
Laparoscopic sleeve gastrectomy

95 LRYGB
Laparoscopic Roux-en-Y gastric bypass

FINDINGS

Both LSG and LRYGB resulted in sustainable weight loss, but 10-y %EWL was not equivalent between the 2 groups

10-y %EWL

LSG: 43.5% (95% CI, 39.8-47.2)

LRYGB: 51.9% (95% CI, 48.1-55.6)

Between-group difference in mean 10-y %EWL:
8.4 Percentage points (95% CI, 3.1-13.6)

SETTINGS / LOCATIONS

3 Hospitals in Finland

PRIMARY OUTCOME

10-y Percentage excess weight loss (%EWL), defined as the difference between initial weight and follow-up weight divided by the difference between initial weight and ideal weight for BMI of 25, multiplied by 100

Salminen P, Grönroos S, Helmiö M, et al. Long-term effect of laparoscopic sleeve gastrectomy vs Roux-en-Y gastric bypass on weight loss, comorbidities, and reflux in adult patients with obesity: the SLEEVEPASS randomized clinical trial. *JAMA Surg*. Published online June 22, 2022. doi:10.1001/jamasurg.2022.2229

SLEEVEPASS TRIAL

Bypass and Sleeve sustained weight loss at 10 years (52% vs 43%);

Comparable diabetes remission;

more reflux and esophagitis after sleeve.

As weight loss becomes comparable to medications, demand will keep rising for long-term outcomes that are **RELEVANT** and **IMPACTFUL.**

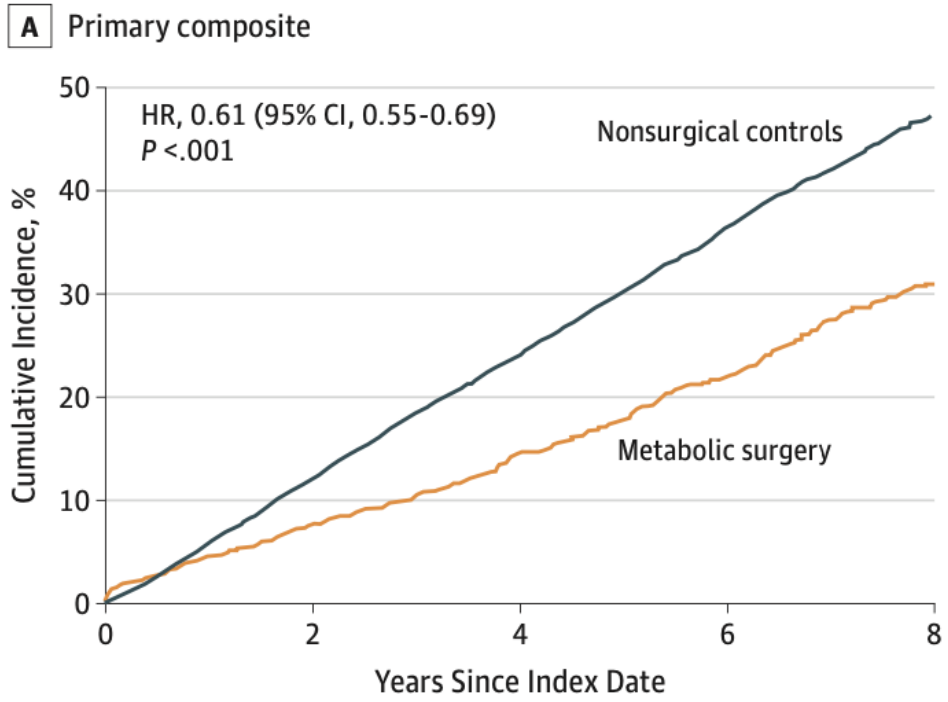
Salminen P, et al. SLEEVEPASS. JAMA Surg. 2022;157(8):656–666. doi:10.1001/jamasurg.2022.2229

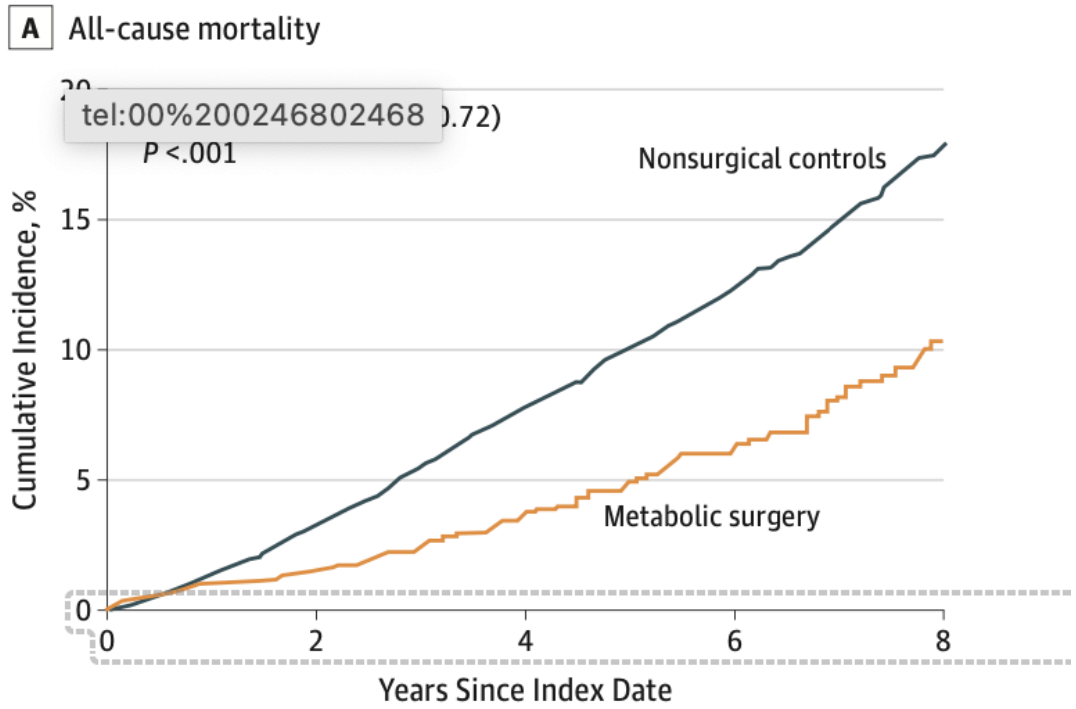
Cardiovascular outcomes (MACE)

JAMA | Original Investigation

Association of Metabolic Surgery With Major Adverse Cardiovascular Outcomes in Patients With Type 2 Diabetes and Obesity

Ali Aminian, MD; Alexander Zajichek, MS; David E. Arterburn, MD, MPH; Kathy E. Wolski, MPH; Stacy A. Brethauer, MD; Philip R. Schauer, MD; Michael W. Kattan, PhD; Steven E. Nissen, MD





! In patients with diabetes and obesity, metabolic surgery was associated with a 39% lower risk of MACE events over 8 years (HR 0.61; 95% CI 0.55–0.69).

Aminian A, Zajichek A, Arterburn DE, et al. Association of Metabolic Surgery With Major Adverse Cardiovascular Outcomes in Patients With Type 2 Diabetes and Obesity. *JAMA*. 2019;322(13):1271-1282. doi:10.1001/jama.2019.14231

Long-term cancer risk

LOWER

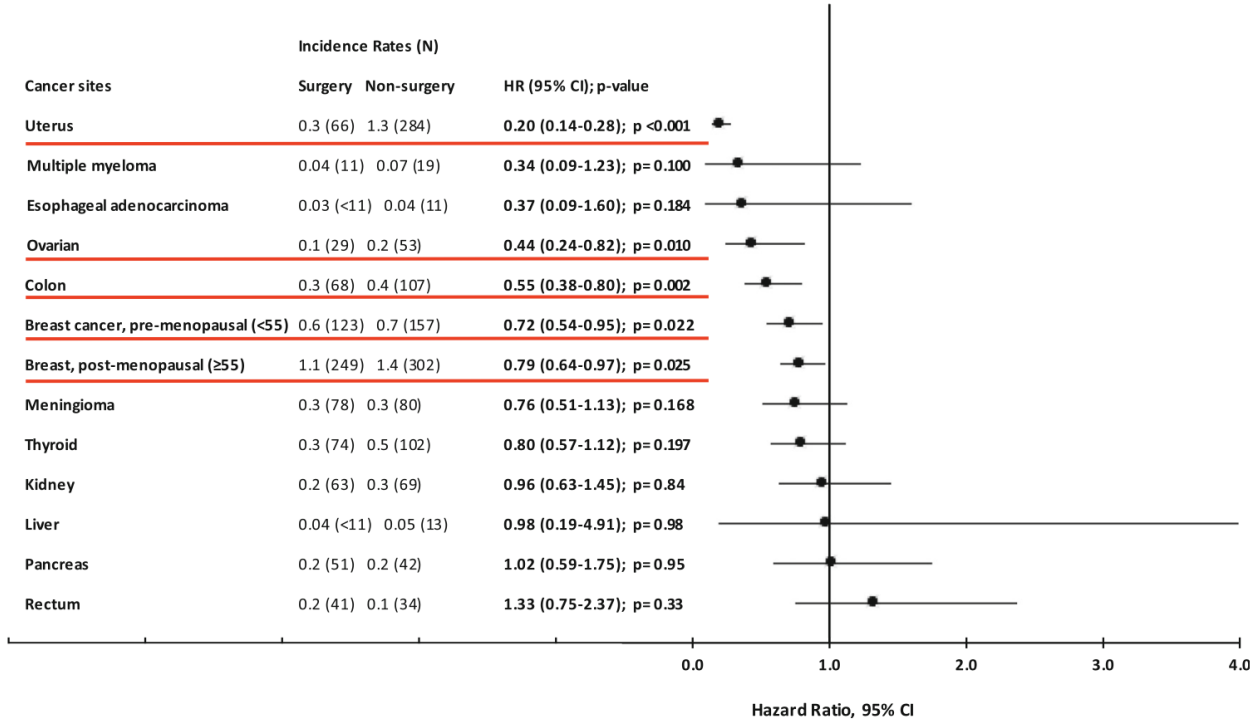
Bariatric surgery is associated with reduced long-term cancer incidence and lower all cancer mortality

ORIGINAL ARTICLE
Epidemiology/Genetics

Obesity THE OBESITY SOCIETY WILEY

Long-term cancer outcomes after bariatric surgery

Ted D. Adams[1,2,3] | Huong Meeks[4] | Alison Fraser[4] | Lance E. Davidson[2,5] | John Holmen[6] | Michael Newman[7] | Anna R. Ibele[8] | Mary Playdon[3,4] | Sheetal Hardikar[9] | Nathan Richards[1] | Steven C. Hunt[2,10] | Jaewhan Kim[11]



Adams TD, Meeks H, Fraser A, et al. Long-term cancer outcomes after bariatric surgery. *Obesity (Silver Spring)*. 2023;31(9):2386-2397. doi:10.1002/oby.23812

02

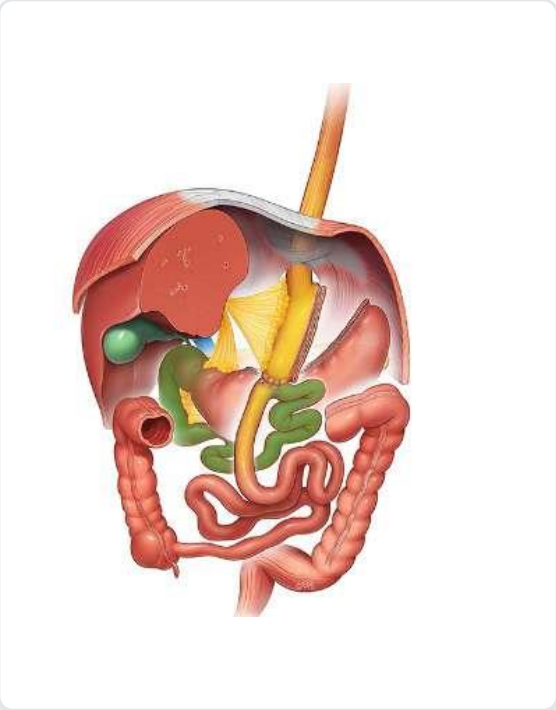
SECTION

Evidence for the newer techniques

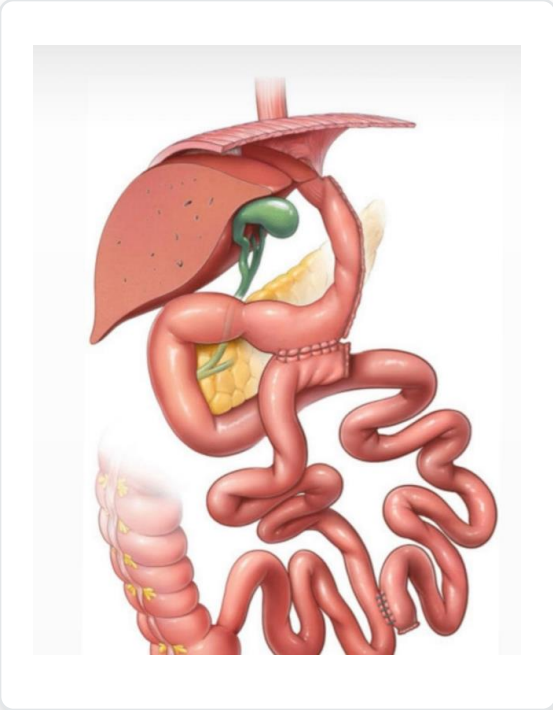
What the recent trials actually show.

NEWLY REGULATED

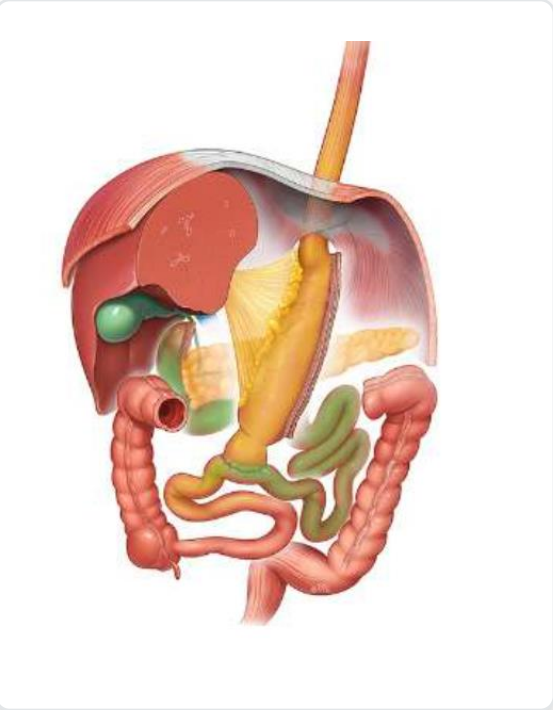
Three newer techniques



OAGB



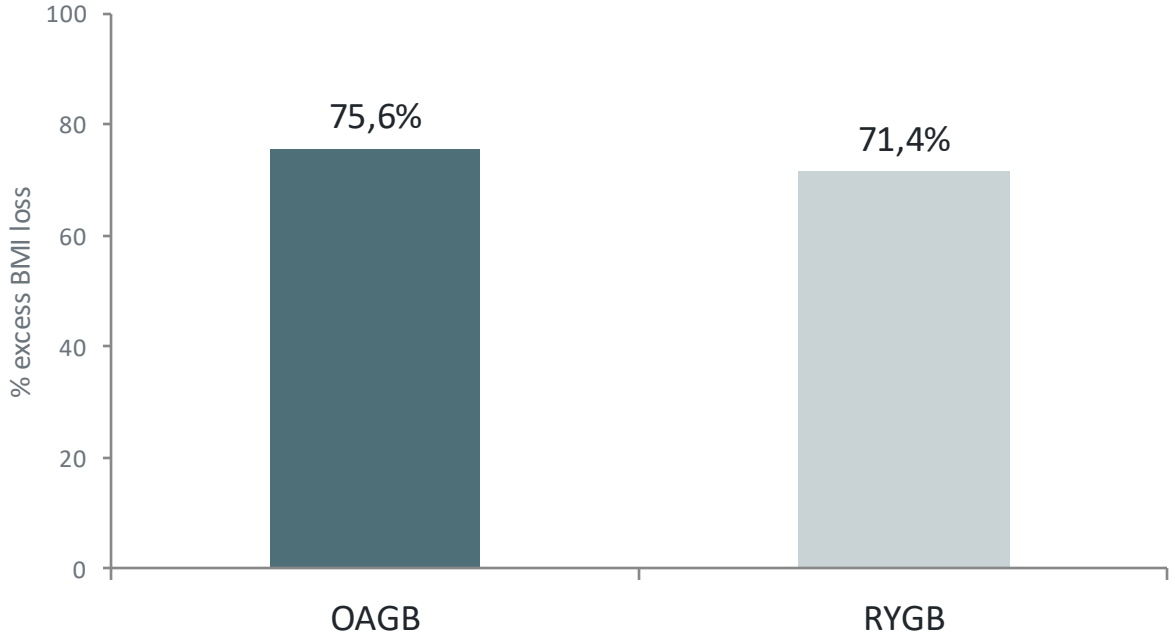
Transit Bipartition



SADI-S

Anatomical illustrations: Dr Levent Efe, courtesy of IFSO.

One Anastomosis Gastric Bypass — YOMEGA at 5 years



STRONGEST DATA

· 253 randomised (OAGB 129 / RYGB 124)

Efficacy and safety of one anastomosis gastric bypass versus Roux-en-Y gastric bypass at 5 years (YOMEGA): a prospective, open-label, non-inferiority, randomised extension study

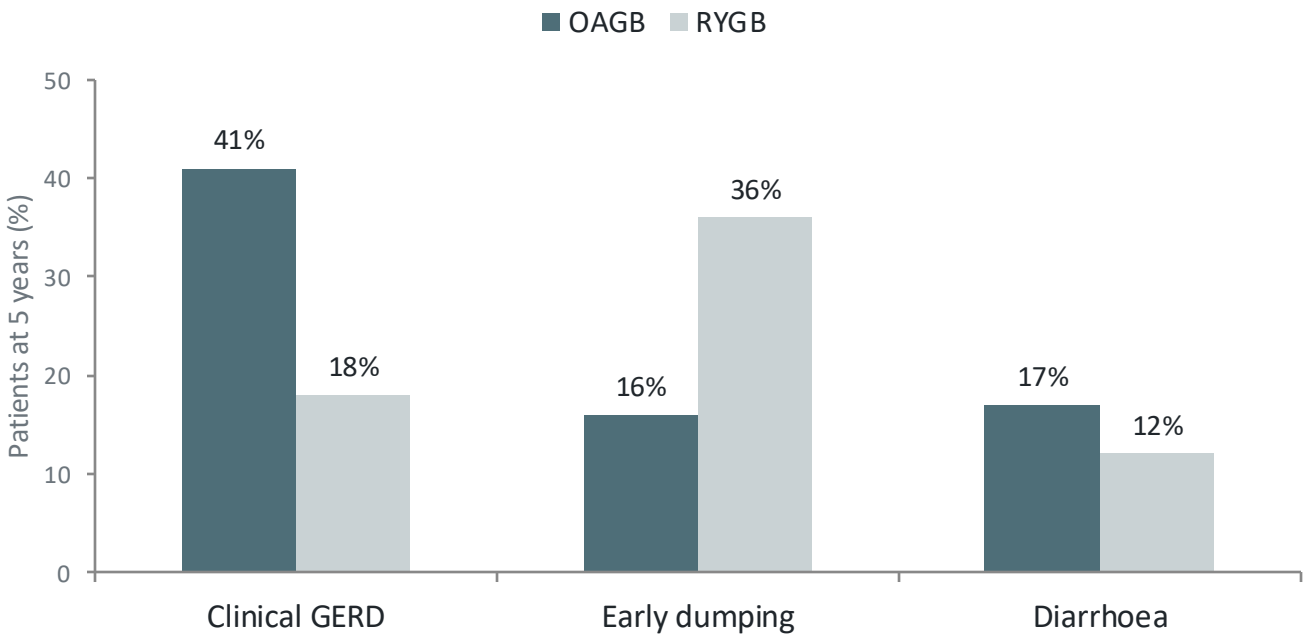
Maud Robert, Tigran Poghosyan, Delphine Maucort-Boulch, Alexandre Filippello, Robert Caiazzo, Adrien Sterkers, Lita Khamphommala, Fabian Reche, Vincent Malherbe, Adriana Torcivia, Toufic Saber, Dominique Delaunay, Carole Langlois-Jacques, Augustin Suffisseau, Sylvie Bin, Emmanuel Disse, François Pattou

Robert M, et al. YOMEGA. Lancet Diabetes Endocrinol. 2024;12(4):267–276. doi:10.1016/S2213-8587(24)00035-4

OAGB — weight loss vs. trade-offs

Efficacy and safety of one anastomosis gastric bypass versus Roux-en-Y gastric bypass at 5 years (YOMEGA): a prospective, open-label, non-inferiority, randomised extension study

Maud Robert, Tigran Poghosyan, Delphine Maucort-Boulch, Alexandre Filippello, Robert Caiazzo, Adrien Sterkers, Lita Khamphommala, Fabian Reche, Vincent Malherbe, Adriana Torcivia, Toufic Saber, Dominique Delaunay, Carole Langlois-Jacques, Augustin Suffisseau, Sylvie Bin, Emmanuel Disse, François Pattou



08%

of OAGB patients converted to RYGB, mostly for reflux or anastomotic ulcers.

! Weight loss and diabetes remission similar to RYGB, but more clinical reflux, more diarrhea and more anastomotic ulcers.

Robert M, et al. YOMEGA. Lancet Diabetes Endocrinol. 2024;12(4):267–276. GERD p=0.003; dumping p=0.006; diarrhoea NS.

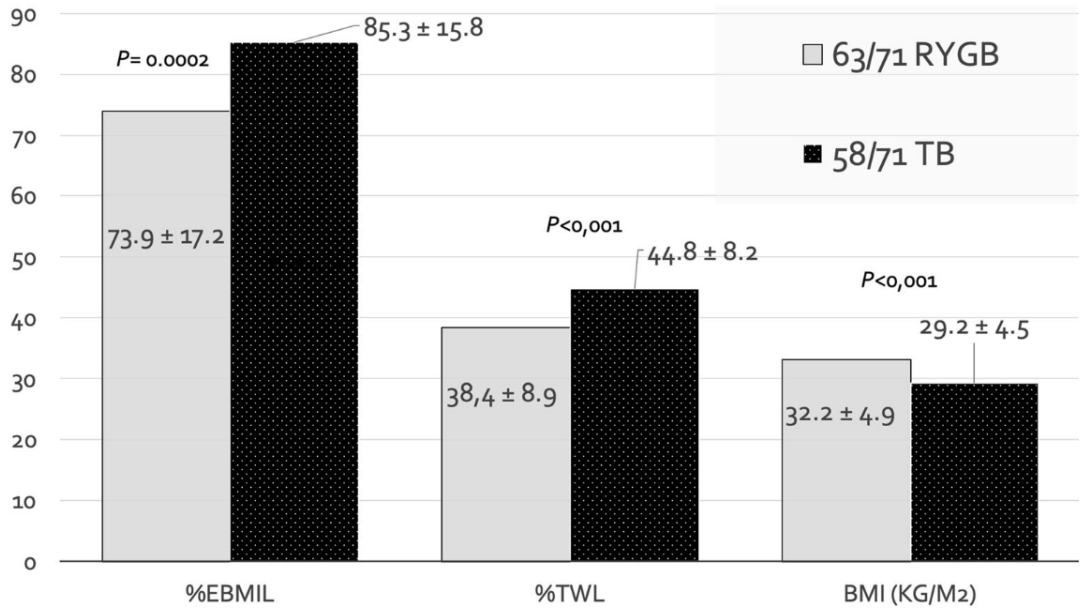
Sleeve + Transit Bipartition (SG+TB)

Obesity Surgery (2020) 30:3402–3407
https://doi.org/10.1007/s11695-020-04691-1

ORIGINAL CONTRIBUTIONS

Comparison of 2-Year Results of Roux-en-Y Gastric Bypass and Transit Bipartition with Sleeve Gastrectomy for Superobesity

Philippe Topart[1] · Guillaume Becouarn[1] · Jean-Baptiste Finel[1]



Weight-loss outcomes: RYGB vs SG+TB (superobesity)

Very little randomized data

In patients with BMI > 50

Greater weight loss with Bipartion against Bypass, and a higher incidence of diarrhea up to 2 years.

Topart P, et al. Obes Surg. 2020;30(9):3402–3407. doi:10.1007/s11695-020-04691-1

SADI-S — the SADISLEEVE trial

THE LANCET

Efficacy and safety of single-anastomosis duodeno-ileal bypass with sleeve gastrectomy versus Roux-en-Y gastric bypass in France (SADISLEEVE): results of a randomised, open-label, superiority trial at 2 years of follow-up

*Maud Robert, Tigran Poghosyan, Nicolas Romain-Scelle, Sebastien Czernichow, Dominique Delaunay, Adrien Sterkers, Litavan Khamphommala, Andrea Lazzati, Claire Blanchard, Robert Caiazzo, François Pattou, Emmanuel Disse, and the SADISLEEVE Collaborative Group**

	Mean %EWL (SD)		Primary analysis (regression model at 24 months with imputation)		Sensitivity analysis (linear mixed-effects model)		Complete-case analysis (regression model at 24 months)	
	RYGB	SADI-S	Adjusted absolute difference (95% CI)	p	Adjusted absolute difference (95% CI)	p	Adjusted absolute difference (95% CI)	p
ITT	−68·09 (28·70); n=191	−76·00 (26·65); n=190	−6·71 (−12·64 to −0·80)	0·026	−7·18 (−12·80 to −1·57)	0·012	−7·56 (−13·06 to −2·06)	0·0072
PP	−67·74 (28·48); n=184	−76·55 (25·95); n=163	−7·39 (−13·25 to −1·54)	0·014	−8·65 (14·25 to −3·05)	0·0026	..	..

Models were adjusted for minimisation factors (type 2 diabetes status and history of sleeve gastrectomy) and random intercept for study centre. Missing data were handled using multiple imputation by chained equations. Sensitivity analyses included complete-case and longitudinal mixed-effects regression models. Missing data for the primary outcome: 78 participants (21%), 45 (58%) in the SADI-S group and 33 (42%) in the RYGB group. EWL=excess weight loss. ITT=intention to treat. PP=per protocol. RYGB=Roux-en-Y gastric bypass. SADI-S=single anastomosis duodeno-ileal bypass with sleeve gastrectomy.

Table 2: **Primary and sensitivity analyses of the mean difference %EWL between SADI-S and RYGB**

22 Hospitals (RCT)

380 patients

30% with BMI > 50 kg/m²

SADI-S showed superior weight loss vs RYGB, with more cases of severe diarrhea.

Robert M, et al. SADISLEEVE. Lancet. 2025;406(10505):846–859. doi:10.1016/S0140-6736(25)01070-0

03

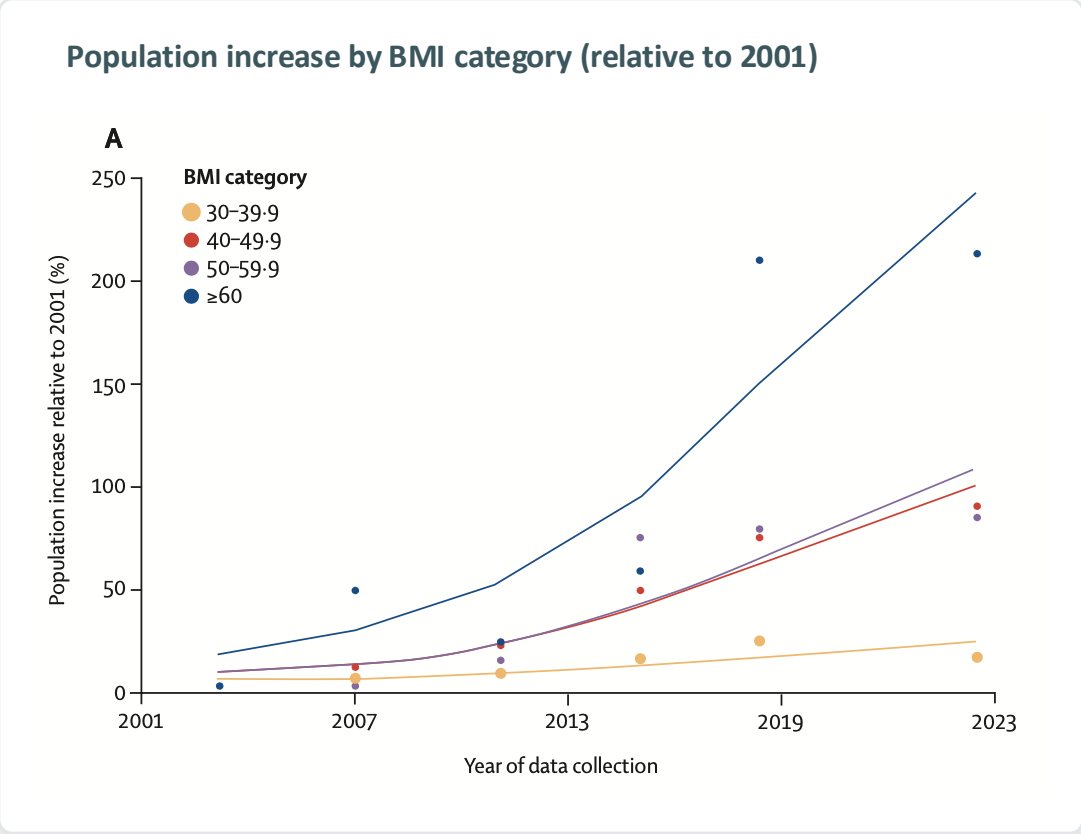
SECTION

Challenges ahead

Heavier, younger, and more complex patients.

We face increasingly severe cases

- Disproportionate growth of patients with BMI > 60
- Rising prevalence in men and younger patients
- Teenagers with increasingly severe, early-onset obesity



04

SECTION

Perspectives

Evidence, judgment, and the individual patient.

PERSPECTIVES

We live in the post-truth era

Post-truth describes a social context in which personal emotions and beliefs shape public opinion more than objective facts and evidence.

- Facts get relativized
- Amplification of opinions and emotions via social media
- Distrust of scientific and medical institutions

TRUTH
“I think, therefore I am.”

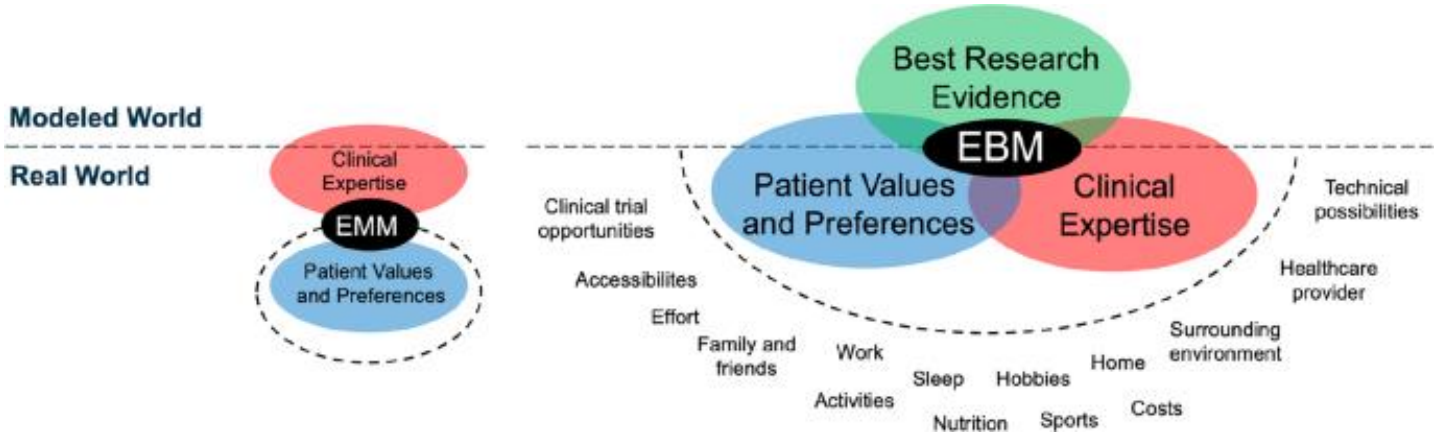
POST-TRUTH
“I believe, therefore I’m right.”

Real-world decision-making

The choice of bariatric procedure should weigh three things together:

1. **Best scientific evidence**
2. **The surgeon's experience**
3. **The patient in front of us**

Evidence-based medicine: evidence · expertise · patient values



So — which technique for which patient?

Márcia · BMI 42 · T2DM

?

Roberto · BMI 55 · superobesity

** AI-generated images (Gemini) based on the author's prompts.*

Conclusions

Sleeve & bypass remain the gold standard

- We can Standardized then
- Predictable outcomes and complications
- Robust evidence with long-term results
- Safety in clinically complex cases

Newer techniques — promising in specific cases

- Evidence still young: few studies, short follow-up
- Higher risk of nutritional complications
- Expected to grow as BMI > 60 becomes more common

26º Congresso Brasileiro de Cirurgia

BARIÁTRICA E METABÓLICA

Belo Horizonte /MG

30 SET A 02 OUT 2026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