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TORONTO 2026

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



ifso2026.org



Roux-en-Y Gastric Bypass in the Best Metabolic Procedure?



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Adjunct Clinical Associate Professor of Surgery; MBRU; Dubai, UAE.

Master Surgeon in Metabolic and Bariatric Surgery (SRC; USA).

Surgeon of Excellence in Minimally Invasive Surgery (SRC; USA).

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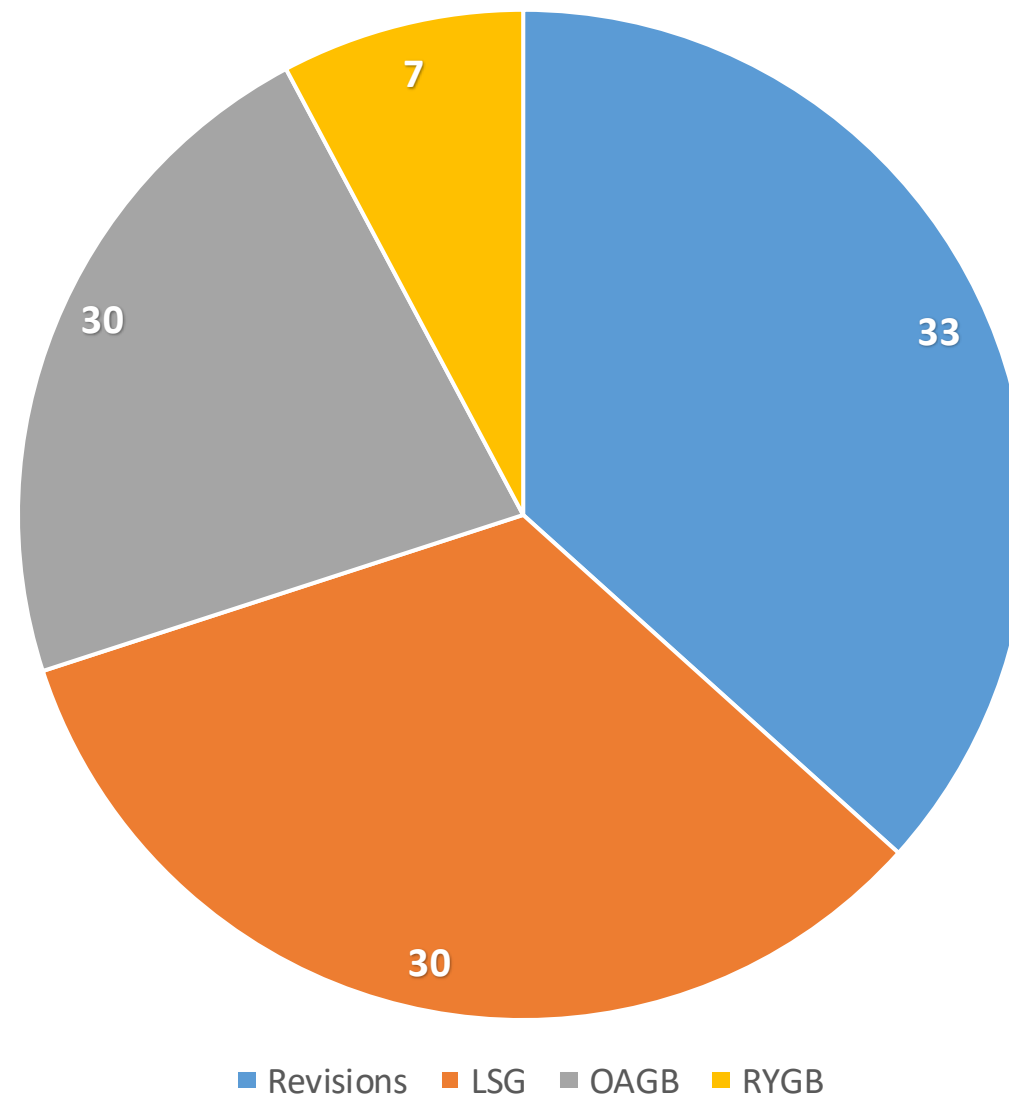
SCOPE Certified Metabolic and Bariatric Surgeon (UK).

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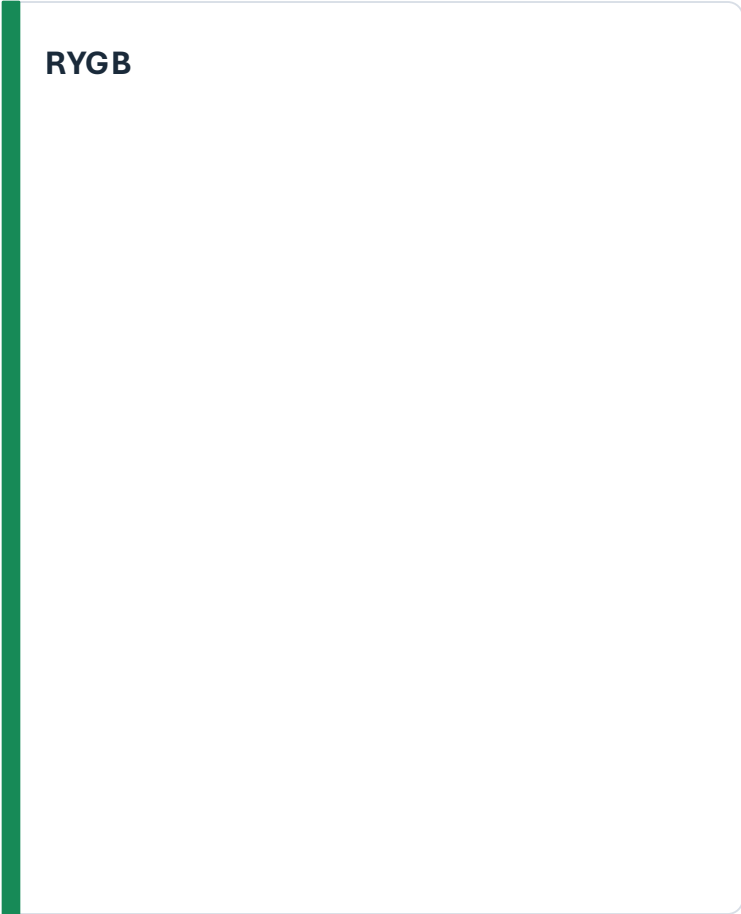
ACS Chapters

American College
of Surgeons



Best ≠ Most malabsorptive

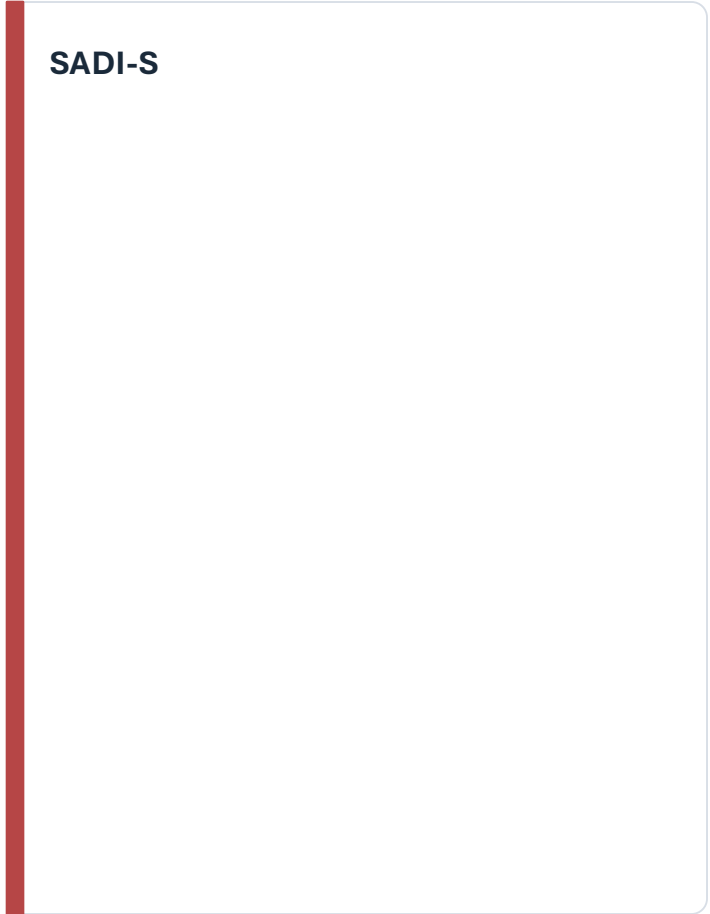
The “best metabolic procedure” should optimize outcomes over a patient lifetime—not just the 2-year %EWL curve.

A large, empty rectangular box with a light gray border, representing the RYGB procedure. A thick green vertical bar is positioned to the left of the box.

RYGB

A large, empty rectangular box with a light gray border, representing the OAGB / MGB procedure. A thick orange vertical bar is positioned to the left of the box.

OAGB / MGB

A large, empty rectangular box with a light gray border, representing the SADI-S procedure. A thick red vertical bar is positioned to the left of the box.

SADI-S

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The “best metabolic procedure” should optimize outcomes over a patient lifetime—not just the 2-year %EWL curve.

RYGB

OAGB / MGB

- Often similar or slightly greater weight loss
- Single anastomosis and shorter operative time appeal
- Concerns remain:
 - Bile reflux
 - GERD
 - Marginal ulceration
 - Malnutrition
 - Limb-length heterogeneity

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OAGB / MGB: Powerful but trade-off heavy

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- Strong 2-year efficacy and high metabolic potency
- Preserves pylorus; one anastomosis
- Evidence base is newer
- Key uncertainties:
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RYGB

- Proven diabetes remission and medication reduction
- Reliable anti-reflux reconstruction
- Less bile reflux exposure than OAGB
- Less hypoabsorptive nutritional burden than SADI-S
- Largest long-term data ecosystem
- Standardized revisional pathways

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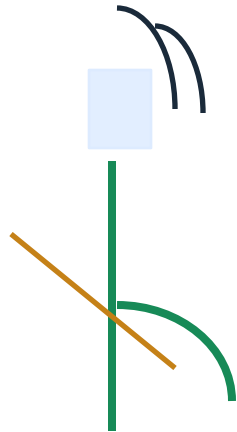
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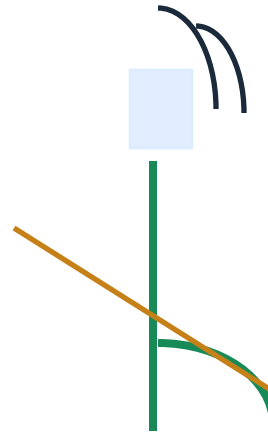
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Metabolic effect is not just bypass length: flow architecture determines reflux, ulcer risk, and nutritional controllability.

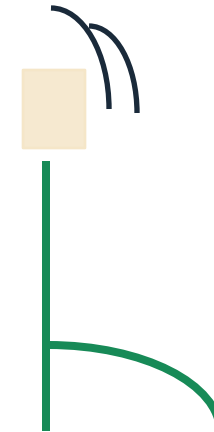
RYGB



OAGB / MGB



SADI-S



RYGB design

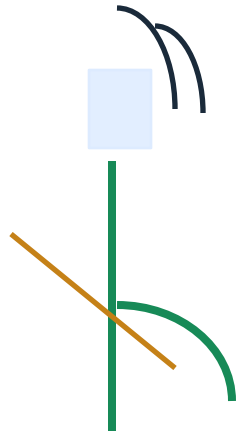
OAGB design

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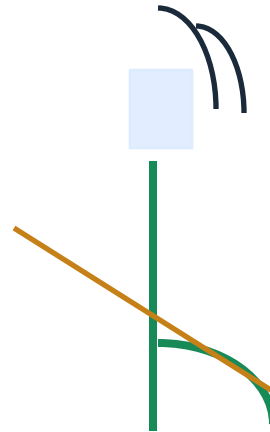
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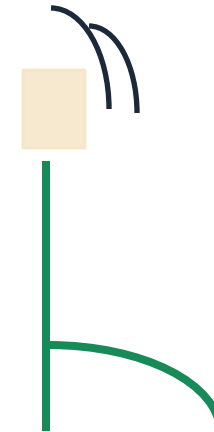


OAGB / MGB



bile can enter loop

SADI-S



RYGB design

OAGB design **concern**

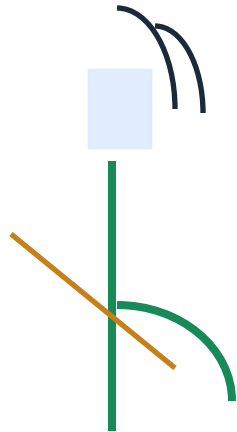
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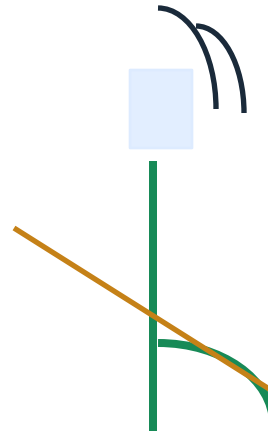
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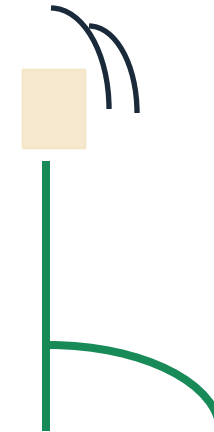


OAGB / MGB



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SADI-S



sleeve + short common channel

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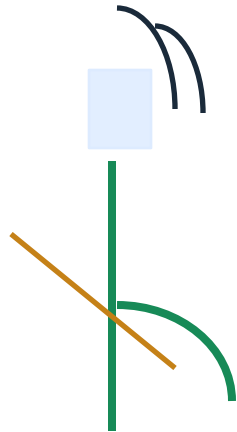
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Greater distalization can increase metabolic potency, but makes protein/fat-soluble vitamin surveillance more consequential.

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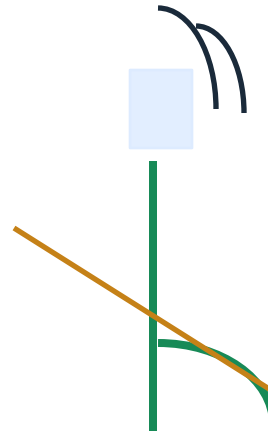


bile diverted

RYGB design **advantage**

Roux limb **routes bile away** from the pouch/esophagus while retaining a **controlled mixed restrictive–malabsorptive physiology**.

OAGB / MGB

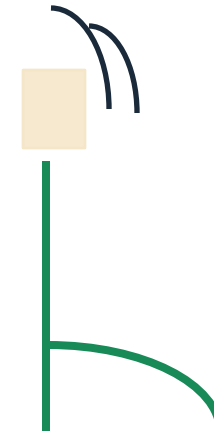


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Decision hierarchy for “best metabolic procedure”

A procedure should be judged across endpoints that matter to patients, endocrinologists, and surgeons.

1. Metabolic efficacy

2. Weight durability

3. Reflux physiology

4. Nutritional safety

5. Evidence maturity

6. Revisional resilience

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- HbA1c control
- Medication reduction
- Diabetes remission durability

2. Weight durability

- Sustained %TWL / %EWL
- Relapse and rescue options

3. Reflux physiology

- GERD prevention/treatment
- Bile exposure
- Esophagitis risk

4. Nutritional safety

- Protein-energy risk
- Iron/B12
- Fat-soluble vitamins
- Adherence burden

5. Evidence maturity

- RCTs
- Registries
- Long-term follow-up
- Standardization

6. Revisional resilience

How safely the operation can be revised/rescued

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How safely the operation can be revised/rescued

RYGB is the only option that scores strongly in all six domains simultaneously.

RYGB has the strongest mature diabetes evidence base

The most clinically persuasive RYGB evidence is not merely bariatric: it is metabolic-surgery evidence with randomized and long-term follow-up.



Randomized evidence



Longer horizons



Real-world durability

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STAMPEDE: at 5 years, metabolic surgery plus intensive medical therapy outperformed intensive medical therapy alone for:

- Glycemic control
- Weight loss, medication reduction
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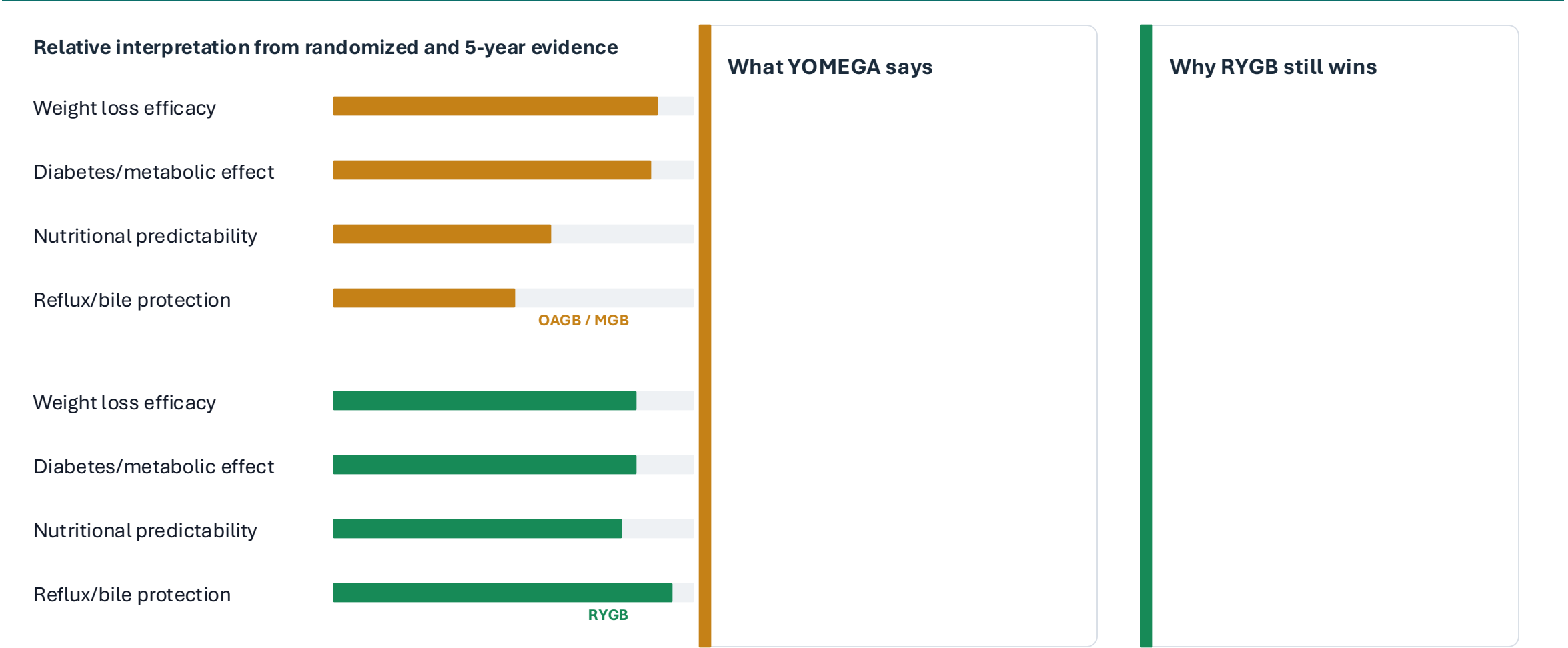
Real-world durability

Large long-term RYGB cohorts report sustained weight loss and diabetes remission beyond 10–15 years.

2026 single-center data showing:

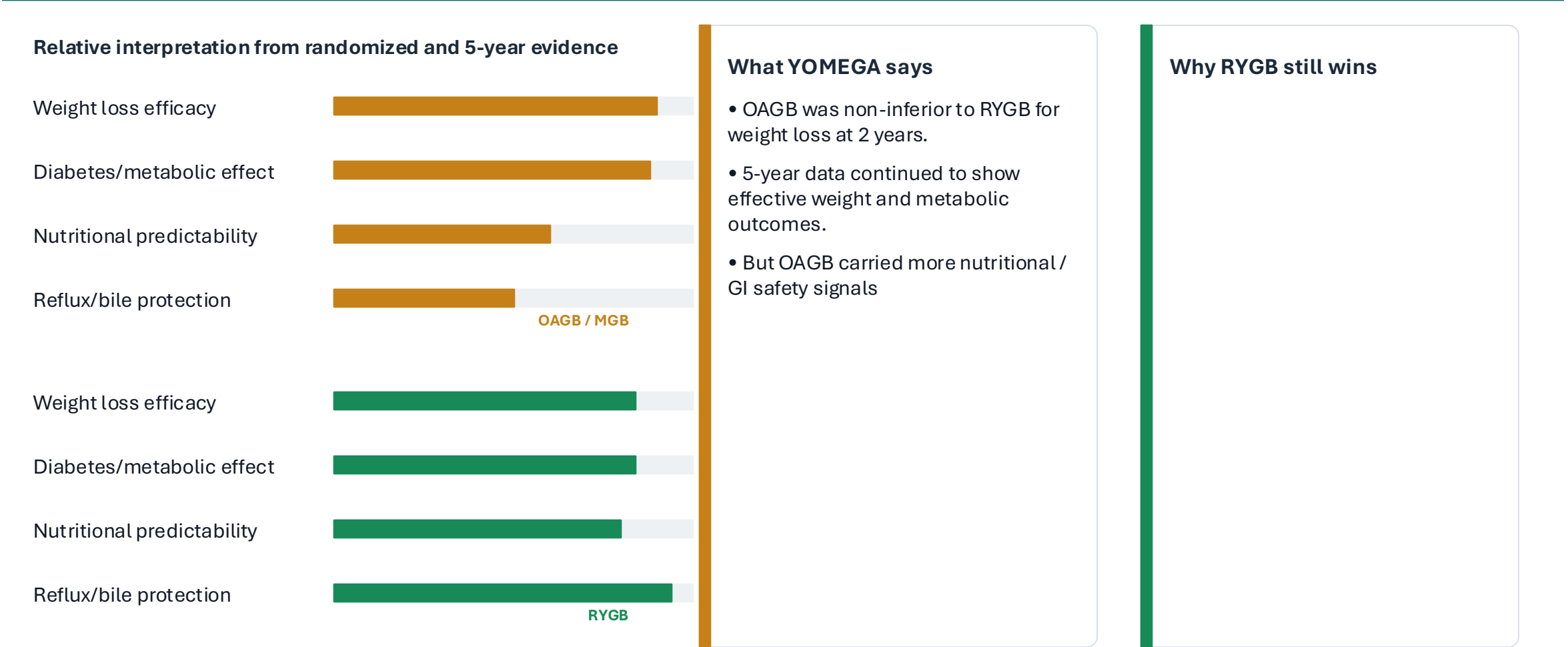
- Mean TBWL stabilizing around 23% at 10–20 years
- Diabetes remission of 38% at 15 years.

RYGB vs OAGB/MGB: similar efficacy, cleaner risk profile

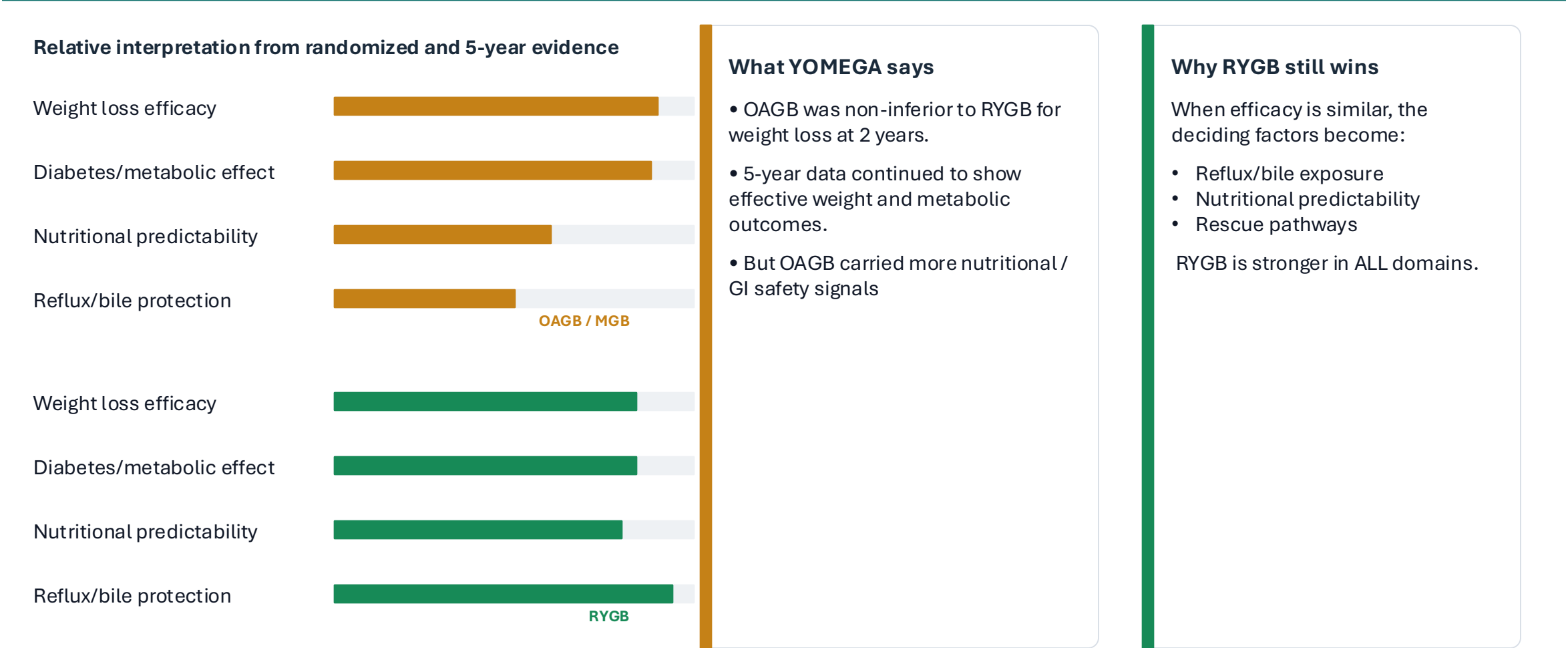


Robert et al., Lancet 2019 YOMEGA; Robert et al., Lancet Diabetes Endocrinol 2024 YOMEGA 5-year; SOARD 2025 comparable 5-year OAGB vs RYGB study.

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RYGB vs OAGB/MGB: similar efficacy, cleaner risk profile

YOMEGA supports OAGB efficacy but also highlights why RYGB remains the safer default.

Relative interpretation from randomized and 5-year evidence



What YOMEGA says

- OAGB was non-inferior to RYGB for weight loss at 2 years.
- 5-year data continued to show effective weight and metabolic outcomes.
- But OAGB carried more nutritional / GI safety signals

Why RYGB still wins

When efficacy is similar, the deciding factors become:

- Reflux/bile exposure
- Nutritional predictability
- Rescue pathways

RYGB is stronger in ALL domains.

Reflux is a decisive differentiator

RYGB:

- Small pouch
- Roux limb excludes bile from pouch
- Strong choice after sleeve with GERD
- Often selected as the revisional solution for reflux after other operations

OAGB:

Reflux is a decisive differentiator

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OAGB:

- Long gastric pouch and loop gastro-jejunostomy
- Potential bile exposure to stomach/esophagus
- 5-year YOMEGA follow-up reported substantial GERD and conversions to RYGB

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SADI-S: Not an anti-reflux operation

- SADI-S begins with a sleeve.
- RYGB is the more rational metabolic choice in patients with:
 - ✓ Clinically important reflux
 - ✓ Barrett's risk
 - ✓ Severe esophagitis

Nutritional safety: RYGB is demanding, but more predictable

The best metabolic operation should not buy early efficacy with avoidable lifelong malabsorption risk.

Domain	RYGB	OAGB / MGB	SADI-S
Protein-energy malnutrition			
Iron / B12			
Fat-soluble vitamins			
Diarrhea / steatorrhea			

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Iron / B12	Common, protocolized	Common; iron/fat-soluble concerns	Common; fat-soluble + protein focus
Fat-soluble vitamins	Less than distalized procedures	Higher concern with long BP limb	Central concern
Diarrhea / steatorrhea	Usually limited	YOMEGA safety signal	Core monitoring issue

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- ✓ **RYGB has known deficiencies that bariatric teams know how to prevent.**
- ✓ **OAGB and SADI-S introduce more limb-length and malabsorption sensitivity.**

RYGB vs SADI-S: Potency is not the same as default Superiority

What favors SADI-S

What favors RYGB

Best default conclusion

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- 2025 multicenter RCT reported superior 2-year weight loss versus RYGB
- Meta-analyses suggest strong diabetes and weight control outcomes
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- More standardized global follow-up algorithms
- Better choice in reflux disease
- Less dependence on aggressive lifelong fat/protein malabsorption management

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- RYGB remains the best general metabolic procedure because its benefit-risk profile is more proven across most diabetes and reflux phenotypes.

RYGB vs SADI-S: Potency is not the same as default Superiority

SADI-S is an exciting metabolic operation, but the RYGB argument rests on evidence maturity and safety predictability.

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Safety & rescue: RYGB has the most mature “failure-management ecosystem”

Long-term metabolic surgery is not just the index operation—it is the ability to manage relapse, complications, and revisions safely.

Training & standardization

Complications playbook

Revisional role

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- Internal hernia
- Dumping
- Micronutrient deficiency

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- That dual role strengthens its default position.

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A procedure that solves other procedures’ failure modes deserves “Best Default” status.

Patient selection: RYGB should be the default, not the only option

The strongest claim is clinically defensible: default to RYGB unless a specific phenotype makes OAGB or SADI-S more compelling.

Default to RYGB when:

Consider OAGB when:

Consider SADI-S when:

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Default to RYGB when:

- Type 2 diabetes with GERD or hiatal hernia
- Post-sleeve reflux or Barrett's concern
- Need for mature evidence and predictable follow-up
- Concern about adherence to intensive nutritional surveillance
- Patient values long-term certainty over maximum early weight loss

Consider OAGB when:

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Consider OAGB when:

- No reflux phenotype
- Center has high OAGB expertise
- Patient accepts bile-reflux/nutritional trade-offs
- Limb length is conservative and follow-up is robust

Consider SADI-S when:

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Default to RYGB when:

- Type 2 diabetes with GERD or hiatal hernia
- Post-sleeve reflux or Barrett's concern
- Need for mature evidence and predictable follow-up
- Concern about adherence to intensive nutritional surveillance
- Patient values long-term certainty over maximum early weight loss

Consider OAGB when:

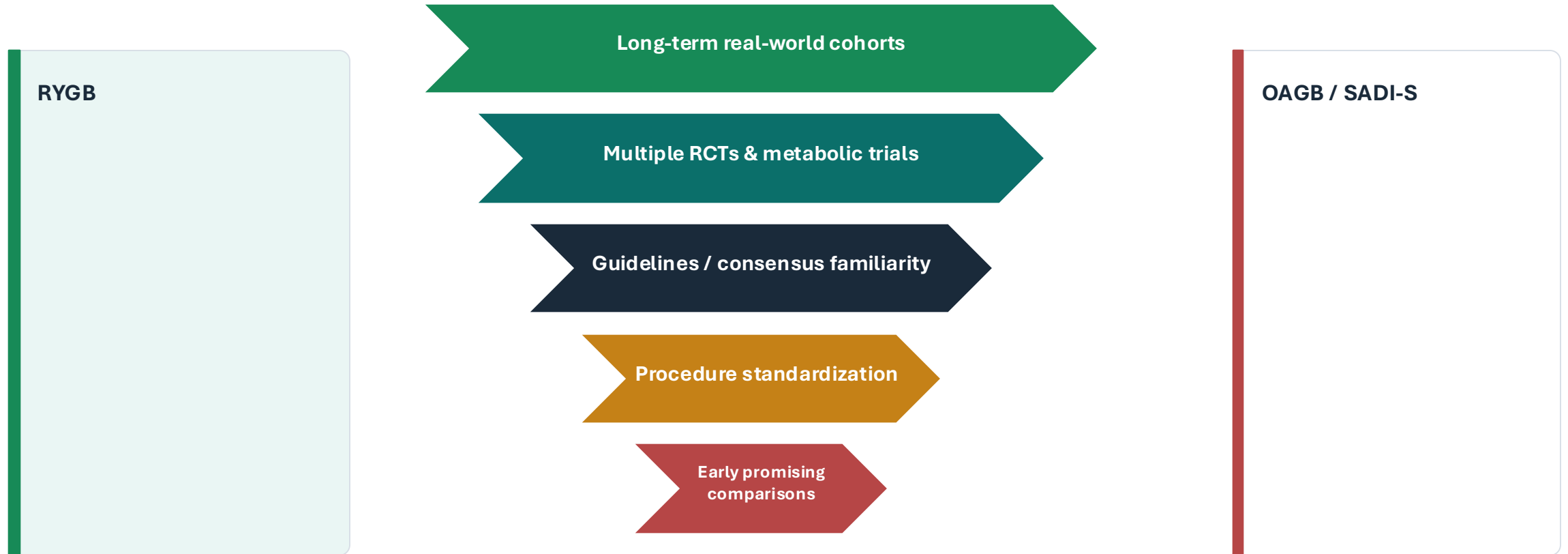
- No reflux phenotype
- Center has high OAGB expertise
- Patient accepts bile-reflux/nutritional trade-offs
- Limb length is conservative and follow-up is robust

Consider SADI-S when:

- Very high BMI / severe metabolic phenotype
- Need maximal weight loss
- No important GERD
- Patient and program can commit to long-term protein/fat-soluble vitamin surveillance

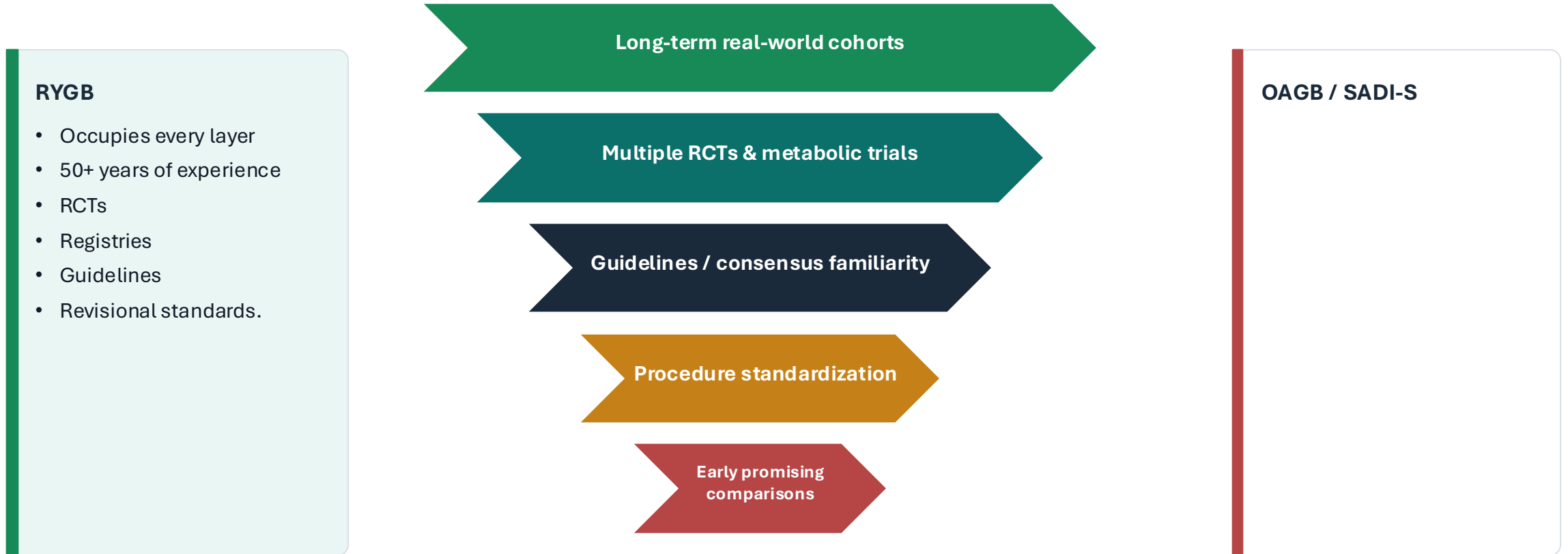
Evidence maturity pyramid favors RYGB

Maturity matters because metabolic surgery is a lifelong treatment.



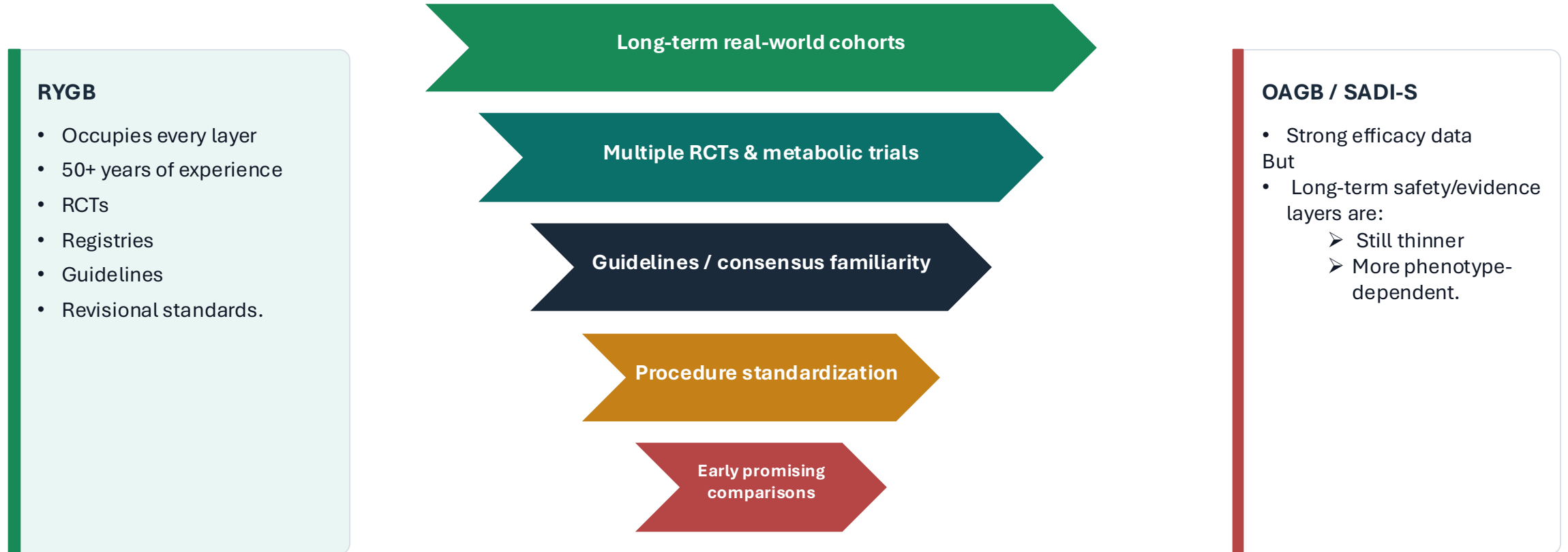
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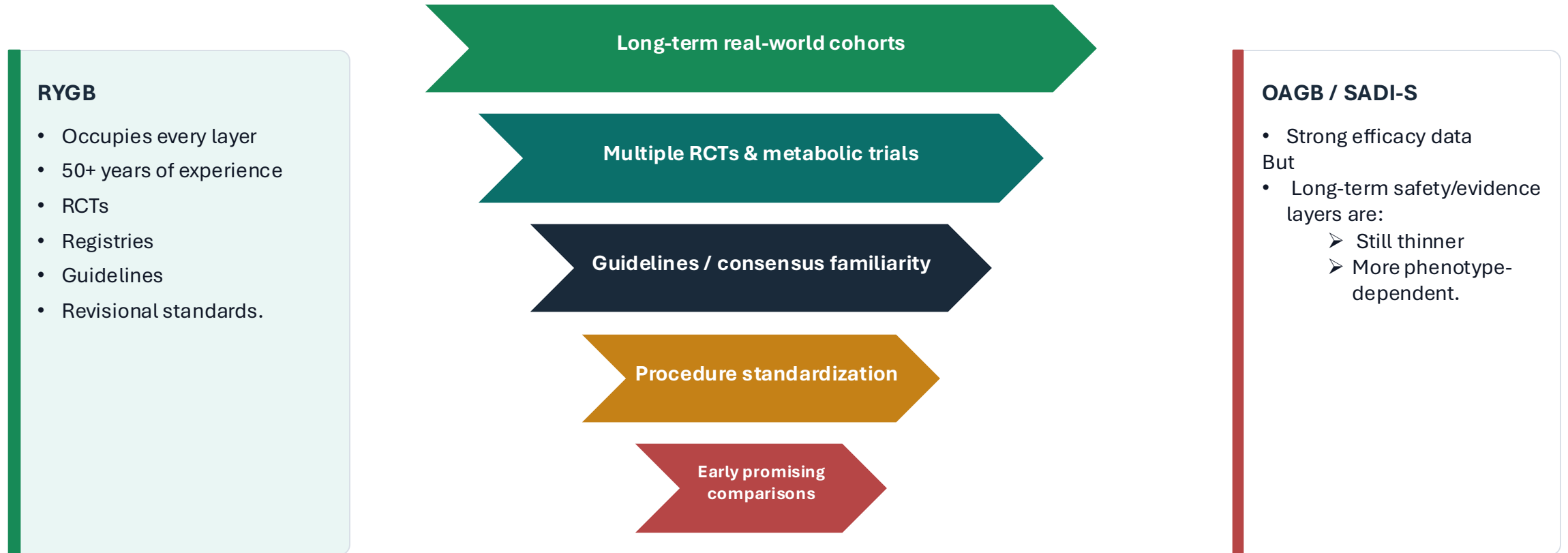


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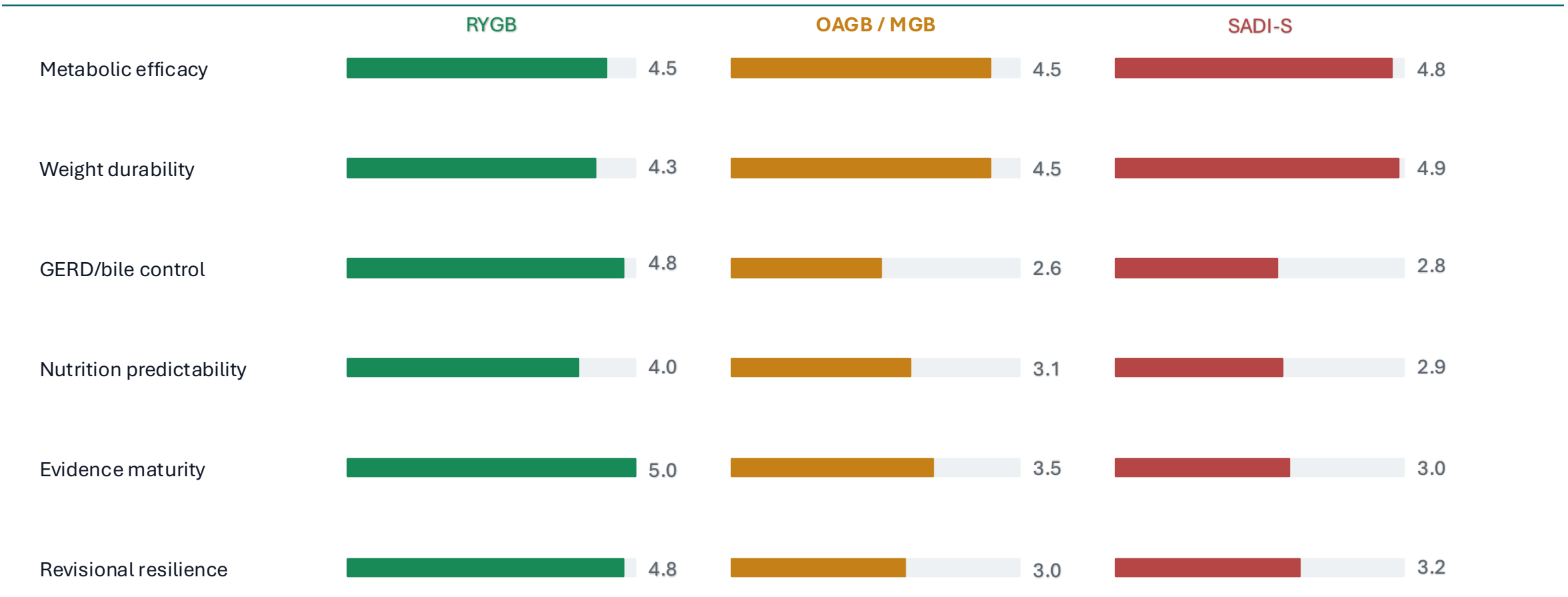
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The higher the clinical-stakes threshold, the more the mature, reproducible operation.

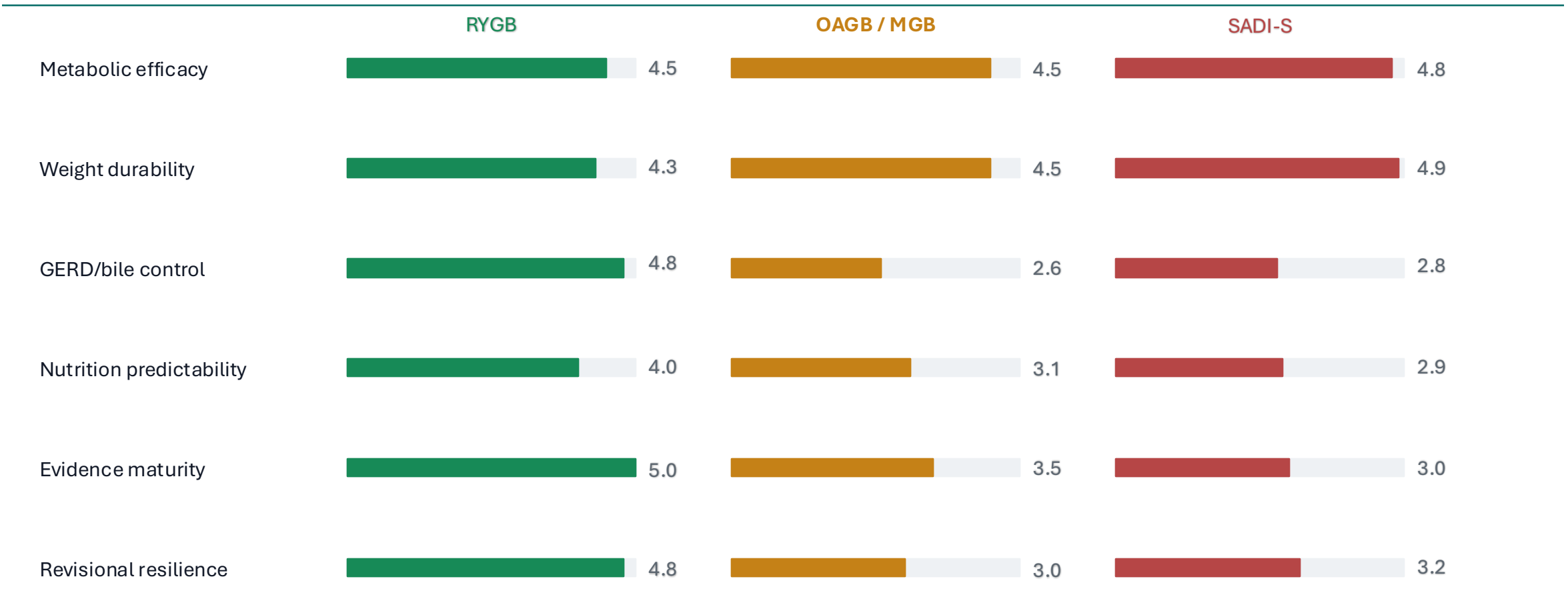
Integrated scorecard: RYGB is the most balanced metabolic operation

Scores are a synthesis of cited evidence and clinical risk domains, not a formal meta-analytic model.



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Conclusion: RYGB may not win every single endpoint but it wins the total metabolic-surgical value equation.

How to answer the expected objections

The strongest advocacy position is **BALANCED**, not **ABSOLUTE**.

“But OAGB is simpler and can lose more weight.”

“But SADI-S is metabolically stronger.”

“But RYGB has internal hernia and marginal ulcer risks.”

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True...**but**

If weight loss and diabetes remission are similar enough, then those factors become decisive:

- Bile reflux
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“But RYGB has internal hernia and marginal ulcer risks.”

Correct...**but**

The point is not zero risk.

The point is

- Recognized, teachable, surveillable risk.
- Decades of management experience
- A reconstruction that solves reflux and bile problems better than its competitors.

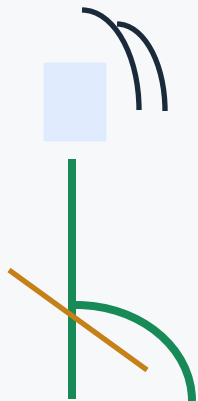
Roux-en-Y Gastric Bypass is the Best Overall Metabolic Procedure

VERDICT:

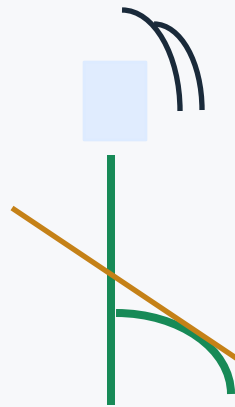
RYGB offers the strongest balance of:

- ✓ Proven diabetes efficacy
- ✓ Reflux control
- ✓ Nutritional predictability
- ✓ Safety infrastructure
- ✓ Long-term evidence maturity

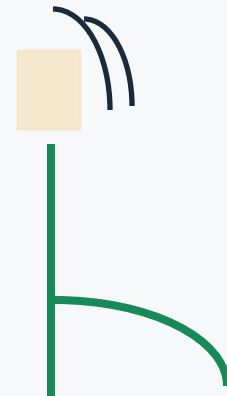
RYGB



OAGB



SADI-S



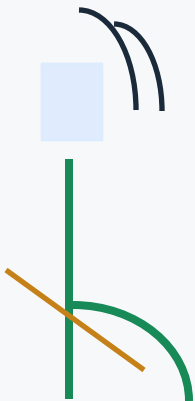
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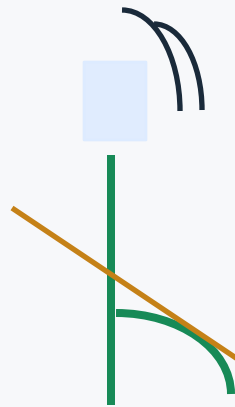
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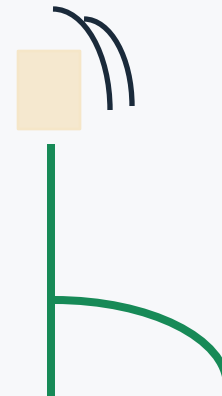
RYGB



OAGB



SADI-S



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