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The Young APC Patient — Session Debate



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“Sleeve Is Not the Best First Choice for the Young APC Patient”

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TORONTO2026 The Future of Obesity Management:
From Weight Loss to Health Gain

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The Real Question Spans Fifty Years, Not Thirty Days

“Best first choice” cannot be judged on short-term outcomes alone.

- 1 Sleeve is simple, fast, and technically appealing — that is exactly why it has become so popular.
- 2 A young APC patient carries this decision for fifty years or more of life after surgery.
- 3 “Best” must be measured by long-term safety, durability, and lifetime nutritional cost — not by day thirty.

If we judge only the first month, we miss the next fifty years.



ARGUMENT 1 · DURABILITY

Sleeve's Weight Loss Doesn't Last

5-year retrospective cohort · $n = 2,255$ adolescents & young adults.

5-YR TOTAL WEIGHT LOSS [1]

30.2% **23.4%**

RYGB

Sleeve (SG)

WEIGHT REGAIN RATE [1]

27.1% **13.9%**

Sleeve (SG)

RYGB



Short-term loss is the easy part.

Young patients face a lifetime of weight fluctuation — durability should decide the first choice, not convenience.



ARGUMENT 2 · GERD RISK

GERD Is Sleeve's Most Common Long-Term Complication

8-year, prospective, multicenter cohort · n = 228 adolescent patients.

9% → 27%

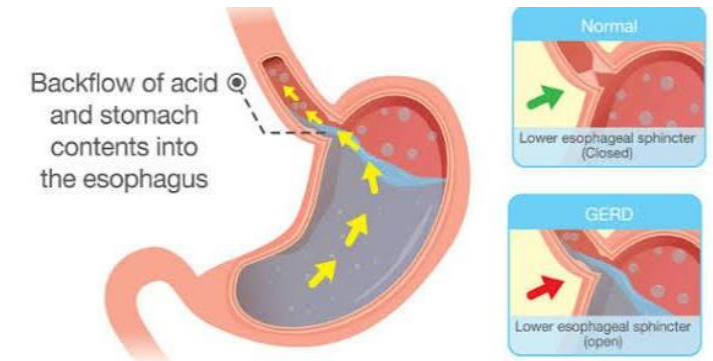
GERD prevalence after sleeve, pre- to post-op (P < 0.05) [2]

aOR 2.67

Odds of new GERD at 8 years, sleeve vs. baseline [2]

No change

GERD prevalence after RYGB, pre- to post-op [2]



Normal vs. GERD: the valve that fails.

Lifelong reflux, Barrett's esophagus, even esophageal cancer — that is not what “best first choice” should mean.



ARGUMENT 3 · BONE HEALTH

Sleeve Weakens Bone at the Age It Should Be Building

A 2-year longitudinal study showed that after Sleeve, adolescent patients experienced an **8.5% decrease in total hip bone mineral density**, while the control group remained stable.

TOTAL HIP BMD, CHANGE AT 2 YEARS [3]

-8.5%
Sleeve (SG)

+0.1%
Control group

For context: 87.6% of adolescent procedures in the Israeli National Bariatric Registry were sleeve — despite this signal. [4]



Healthy bone (left) vs. bone loss after sleeve.

Trading peak bone mass — built only once, in adolescence — for faster short-term weight loss is a steep price.



ARGUMENT 4 · LIFELONG NUTRITION

Sleeve Isn't the “Nutrition-Safe” Option Either

Micronutrient outcomes after sleeve gastrectomy, adolescent cohorts.

~45%

low serum ferritin (iron deficiency) 5 years after sleeve [5]

~50%

vitamin D insufficiency before surgery — needing years of supplementation after [5]

FOUR SYSTEMS AT RISK

Muscle
Protein

Bone
Calcium, Vit D

Neuro
B-Vitamins

Blood
Iron, Folate

Decades of mandatory monitoring and supplementation are a real burden for a young patient — not a footnote.



ARGUMENT 5 · IRREVERSIBILITY

One Path Can Be Undone. The Other Cannot.

For an eighteen-year-old, the psychology of “no way back” is itself a clinical risk.

SLEEVE: NO WAY BACK

Removes about 80% of the stomach — permanently. The removed tissue does not regenerate. [6]

No procedure can restore the original stomach anatomy afterward, whatever the reason.

BYPASS: A PATH BACK

More complex to perform, but partially reversible if severe complications occur. [7]

A risky path back still beats no path back at all for a young person facing 50 years of change.



Bypass reroutes; sleeve removes stomach for good.

Primum non nocere — first, do no harm. Taking away a young person’s ability to change their mind is a harm we can avoid.



ARGUMENT 6 · FOLLOW-UP CRISIS

A Safety Net Young Patients Don't Show Up For

Retrospective cohort · ages 14–26 · tracked at 12 and 24 months.

75.3%

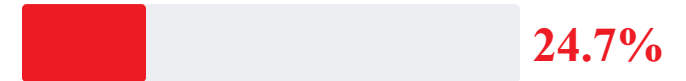
lost to follow-up at 12 months
[8]

93.1%

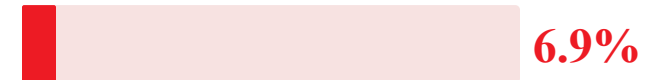
lost to follow-up at 24 months
[8]

STILL REACHABLE FOR CARE

At 12 months



At 24 months



Share of young patients still reachable for lab and bone monitoring.

More than 9 in 10 young patients are gone from care within two years — by the time anemia or bone loss shows up, the window to intervene has closed.

[8] Sherard C, et al. *Obes Surg.* 2025;35:1415-1422. doi:10.1007/s11695-025-07767-y.



ARGUMENT 7 · BENEFIT-RISK TRADE-OFF

“Safer” Sleeve Still Means a Worse Trade-Off

Same 5-year cohort (n = 2,255) · plus a meta-analysis of 3 surgical techniques.

30.2% vs 23.4%

5-yr TWL%, RYGB vs. sleeve — sleeve trails on efficacy [1]

2.09×

RYGB’s complication risk vs. sleeve, adolescent meta-analysis [9]

87.1%

of IFSO Asia-Pacific experts already view GB as safe first-line [10]



“Safer” is only half the equation.

If “safer at 30 days” becomes “best,” we are trading 50 years of health for a lower complication count.

ARGUMENT 8· CULTURE & PSYCHOLOGY

“Best” Also Has to Mean Culturally Acceptable

A surgical decision in Asia-Pacific is never a purely technical one.

1 Cultural conservatism

The body is seen as a gift from one's parents, not to be damaged — “part removed” feels categorically different from “nothing removed.”

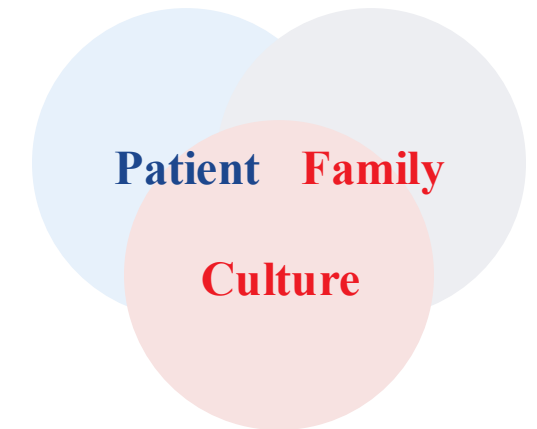
2 A family decision, not a solo one

In Asia the whole family usually weighs in. Families object to organ-removing procedures far more often than Western families do.

3 Instinctive fear of “no way back”

“What’s removed never comes back” can outweigh any technical safety argument — that lifelong psychological weight is itself a harm.

WHO IS PART OF THE DECISION



40% of Asian patients rank “no organ removed” as their #1 factor; 87.1% of IFSO Asia-Pacific experts back organ-preserving GB as safe first-line.



CLOSING STATEMENT

The Best First Choice Must Survive Fifty Years

Sleeve is simple, safe, and effective — in the short term. But we are talking about a patient with **fifty more years** of life ahead of her. “Best first choice” cannot be built on **thirty-day data alone**.

Sleeve's weight regain is higher. Its reflux risk **nearly triples**. Its bone health is compromised at exactly the age it should be building. And its safety net exists mostly on paper — **93% of young patients are gone from follow-up within two years**.

The stomach that is removed **never comes back**. For families already uneasy about removing an organ, that isn't just a lost chance to reconsider — it can mean **refusing treatment altogether**.

Is it fair to trade half a century of health, the right to change one's mind, and cultural peace of mind, for a moment of “safety”?

The best first choice must be **individualized, reversible, and built to last fifty years** — not thirty days.
On every count, **sleeve is not the answer**.

Thank you.



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References

Full citations for the data cited in this talk, in order of first use.

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- [2] Rode JB, Zeineddin SA, Khoury JC, et al. Gastroesophageal Reflux and Gastrointestinal Symptoms After Metabolic and Bariatric Surgery in Adolescents: An 8-Year Follow-up Analysis. *J Pediatr Surg.* 2025;60(4):162215.
- [3] Mitchell DM, Singhal V, Animashaun A, et al. Skeletal Effects of Sleeve Gastrectomy in Adolescents and Young Adults: A 2-Year Longitudinal Study. *J Clin Endocrinol Metab.* 2023;108(4):847-857.
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- [5] Xanthakos SA, Khoury JC, Inge TH, et al. Nutritional Risks in Adolescents After Bariatric Surgery. *Clin Gastroenterol Hepatol.* 2020;18(5):1070-1081.e5.
- [6] American Society for Metabolic and Bariatric Surgery. Bariatric Surgery Procedures: Sleeve Gastrectomy. Updated May 2021. asmbs.org/patients/bariatric-surgery-procedures.
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- [9] Ahmed W, Jawed K, Hussain K, et al. Outcomes of bariatric surgery in Adolescents: A meta-analysis comparing three surgical techniques. *Am J Surg.* 2025;245:116354.
- [10] Kermansaravi M, Chiappetta S, Musella M, et al. One anastomosis gastric bypass in children and adolescents: An international expert survey. *Clin Obes.* 2025;15(5):e70018.

