

IN A YOUNG ASIA-PACIFIC PATIENT,
SLEEVE IS THE BEST FIRST CHOICE



Debate — IN FAVOUR

Dr. Manish Khaitan | IFSO Asia-Pacific 2026



Why the first operation matters more in the young

A 40–60 year horizon

The young patient does not need the most complex operation today. They need an effective operation that preserves options for decades.

Risk accumulates with time

Every bypassed segment, anastomosis, micronutrient dependency and internal-herniation risk is carried for life. Simplicity has long-term value.

APAC changes the calculus

Young Asian patients may develop metabolic disease at lower BMI, while follow-up, supplements, endoscopy and revision expertise vary widely across the region.



My proposition is deliberately practical

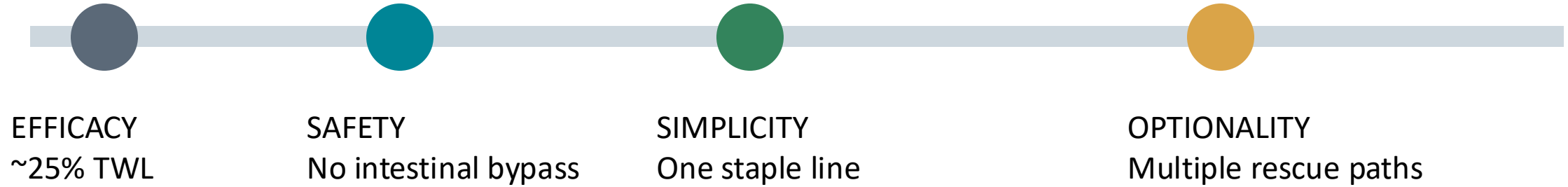
Best FIRST choice $\neq$ best operation for EVERY patient

For the typical young APAC patient who needs MBS and has no compelling bypass indication, sleeve gastrectomy offers the best balance of efficacy, safety, anatomy preservation and future optionality.

The debate is about the starting operation — not about denying RYGB/OAGB/SADI-S when disease phenotype demands them.



The sleeve advantage is a four-part equation



In a young patient, a slightly less powerful first operation can be the smarter lifetime strategy when it preserves anatomy and keeps escalation available.



1. Sleeve delivers clinically meaningful durable weight loss

Not a 'weak' operation

Randomized long-term trials show substantial and durable weight loss after sleeve; RYGB is often modestly superior, but sleeve remains highly effective.

Metabolic benefit

Major improvement in type 2 diabetes, hypertension, OSA, fatty liver disease and quality of life accompanies sustained weight reduction.

Enough for many young patients

When the phenotype does not demand maximal malabsorption, the incremental benefit of bypass must justify its additional lifelong complexity.

The key question

Do we need to spend our most complex operation first?



2. Young patients deserve preserved anatomy

Sleeve keeps the gastrointestinal tract in continuity.

- No small-bowel bypass
- No mesenteric defects / internal hernia from a Roux reconstruction
- Duodenum and biliary tree remain endoscopically accessible
- No gastrojejunal anastomosis
- Drug absorption is generally less altered than after bypass

For a patient who may need endoscopy, pregnancy care, chronic medication or abdominal surgery decades later, access matters.



3. Nutritional simplicity matters over 50 years

Lower deficiency burden

All MBS requires lifelong nutrition surveillance, but bypass procedures add malabsorptive mechanisms and a greater dependence on sustained supplementation and monitoring.

Real-world APAC follow-up

Patients move cities and countries; access to bariatric dietitians, assays and supplements is uneven. A robust operation should tolerate imperfect systems.

Pregnancy & life transitions

Young adults may face pregnancy, illness, medication changes and socioeconomic disruption. Preserving absorptive length gives a wider safety margin.





Sleeve vs bypass as the FIRST operation in a young patient

Dimension	Sleeve	RYGB / bypass-based
Weight loss	High; durable	Often higher
Anatomy	GI continuity preserved	Re-routed / bypassed
Nutritional burden	Lower	Higher lifelong burden
Internal hernia	No Roux mesenteric defects	Procedure-specific risk
Endoscopic access	Duodenum/biliary access retained	Altered access
Revision options	RYGB, OAGB, SADI-S/DS	More constrained
Best first role	Default when no bypass indication	Phenotype-driven escalation
Best role	Early disease, preference, adjunct	Severe/complex disease, durability

4. Sleeve preserves the future — this is its strategic advantage

A sleeve is not a therapeutic dead end. It is a platform.

If weight loss is inadequate or weight recurs → intensify lifestyle / pharmacotherapy → consider conversion to RYGB, OAGB, SADI-S or DS according to phenotype.

If severe reflux develops → conversion to RYGB remains available.

Young patients gain something invaluable: the ability to escalate treatment when biology changes.



5. The GLP-1 era makes sleeve MORE logical as a first step

Modern obesity care is no longer surgery alone. Anti-obesity medication can augment sleeve outcomes for suboptimal response or recurrent weight gain.

That changes the lifetime strategy: start with a lower-complexity anatomical intervention, preserve the gut, and add pharmacotherapy or conversion only when needed.

The young patient can now receive SEQUENTIAL therapy rather than maximal anatomical intervention on day one.



A lifetime escalation pathway

FIRST

Sleeve
Effective restriction
+ hormonal effect
Preserve GI
continuity

THEN

Optimize
Nutrition + exercise
+ AOM
Treat biology early

IF NEEDED

Convert
RYGB for reflux /
selected T2D
OAGB or SADI-S for
greater weight effect

LIFELONG

Surveillance
Choose the next
step from the
patient's evolving
phenotype



Who is the ideal young patient for sleeve-first?

- Young adult with severe obesity but no compelling bypass-specific indication
- No significant pre-existing GERD / large hiatal hernia / Barrett's oesophagus
- Moderate metabolic disease where maximal diabetes effect is not essential
- Need to preserve duodenal/biliary access
- Concern about long-term nutritional adherence or follow-up reliability
- Preference for a simpler operation after informed shared decision-making
- Patient who values a staged lifetime strategy



Where I would NOT defend sleeve as first choice

- Severe or objectively proven GERD, erosive oesophagitis or Barrett's — RYGB often has the advantage
- Diabetes phenotype where a stronger metabolic operation is clearly needed
- Very high BMI / extreme obesity where sleeve alone is unlikely to achieve the therapeutic target
- Failed prior sleeve physiology or anatomy
- Disease-specific reasons to select another procedure

A good debate argument must survive its exceptions. Patient selection is the strength — not the weakness — of sleeve-first.



The strongest argument against sleeve is reflux — acknowledge it

Reflux is the Achilles heel, not a reason to abandon the operation.

Long-term randomized evidence shows more reflux-related problems and more reflux-driven reoperations after sleeve than after RYGB.

Therefore: screen properly, perform objective evaluation when indicated, avoid sleeve in Barrett's/severe GERD, repair relevant hiatal pathology, and maintain endoscopic surveillance according to guidance.

The correct response to a known limitation is selection — not universal bypass.



The sleeve-first philosophy

RIGHT
PATIENT

RIGHT
FIRST STEP

PRESERVE
OPTIONS

ESCALATE
IF NEEDED

For the young patient, success is not choosing the biggest operation. It is choosing the operation that controls disease today without unnecessarily spending tomorrow's options.



Take-home message

Sleeve is effective enough for many young patients.
It is anatomically conservative: no intestinal bypass and preserved endoscopic access.
It carries a simpler nutritional and reconstructive burden across a long lifetime.
It leaves multiple medical and surgical rescue options open.
Its major limitation — reflux — can and must drive careful selection.

Therefore, in the appropriately selected young APAC patient, SLEEVE is the best FIRST choice — because first choice should optimize lifetime strategy, not just maximum day-one potency.



“Do not spend all your anatomy at the first operation.”



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