

SADI Will Disappear With The Rise Of Magnetic Surgery

Rami Lutfi, MD FACS FASMBS DABOM

Clinical Professor of Surgery; Chicago Medical School

President and CEO Chicago Institute of Advanced Surgery

Disclosures:

- Consultant:
 - Medtronic
 - Johnson & Johnson
 - Gore
- Educational Grant:
 - Medtronic
 - Gore
- Investor & Medical Advisor:
 - GT Metabolic & Carrum Health

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Stephanie Orzech <sOrzech@kenes.com>
to me ▾

Wed, Jul 8, 5:08 AM ☆ 😊 ↩ ⋮



XXIX IFSO World Congress
1-4 September 2026 | Toronto, Canada



TORONTO 2026
The Future of Obesity Management:
From Weight Loss to Health Gain
ifso2026.org

Dear Prof. Rami Lutfi.

We would like to ask if you would take additional roles at the **XXIX IFSO World Congress** taking place between **1 – 4 September 2026** in **Toronto, Canada** in **PLENARY SESSION: IFSO GRAND DEBATES** which takes place **on Friday, 4 September 14:15 - 16:00**.

The role: to give the 10-min argument 'SADI WILL DISAPPEAR WITH THE RISE OF MAGNETIC TRANSIT BIPARTITION'

This would be 'against' Prof. Antonio Torres who gives the argument 'SADI WILL CONTINUE TO RISE AS THE BEST OPTION FOR RECURRENT WEIGHT GAIN AFTER SLEEVE'

Kindly let me know if you can accept these roles by **Tuesday, 14 July**.

Many thanks and looking forward to hearing from you.

Best wishes,

Stephanie

IFSO 2026 - update to your title in Grand Debates session ➤

Inbox x



Wed, Aug 5, 8:06 AM



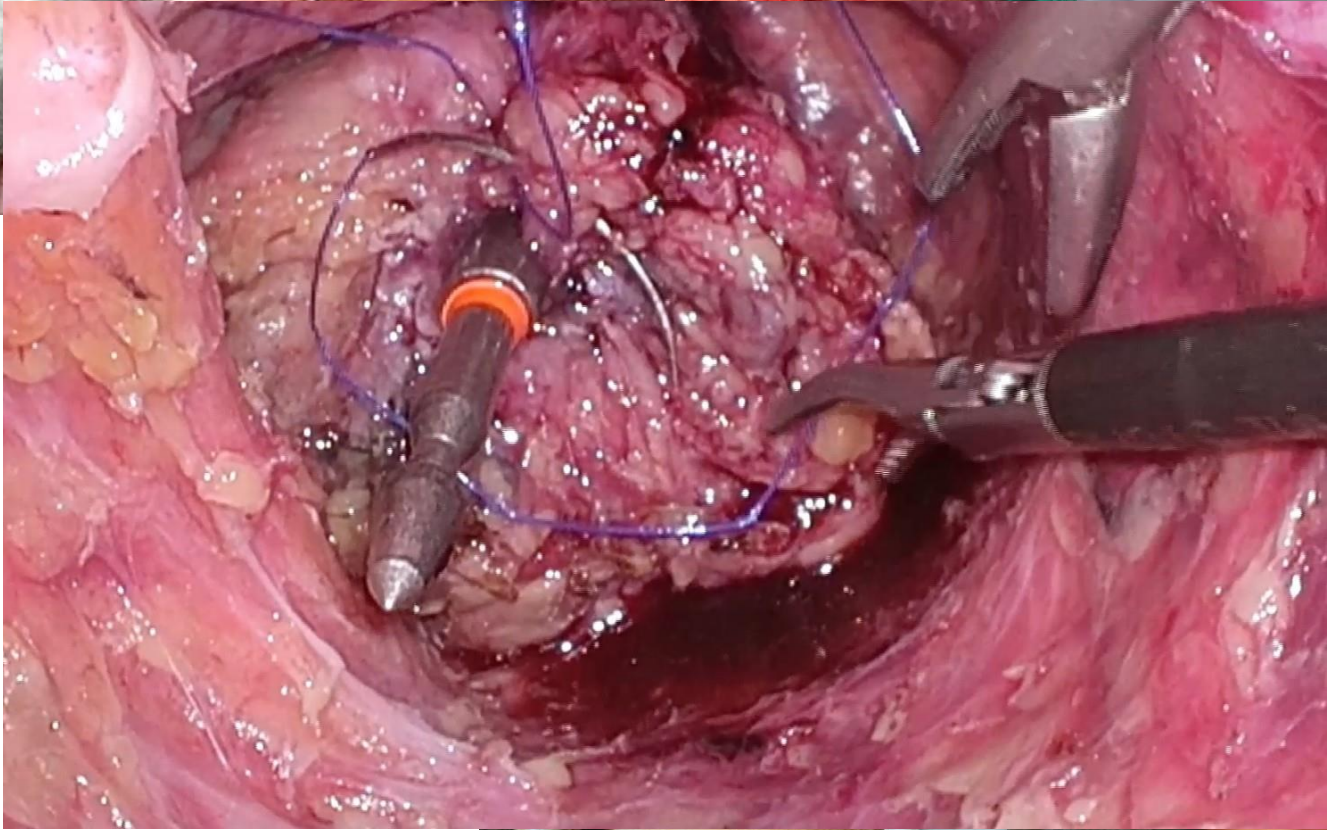
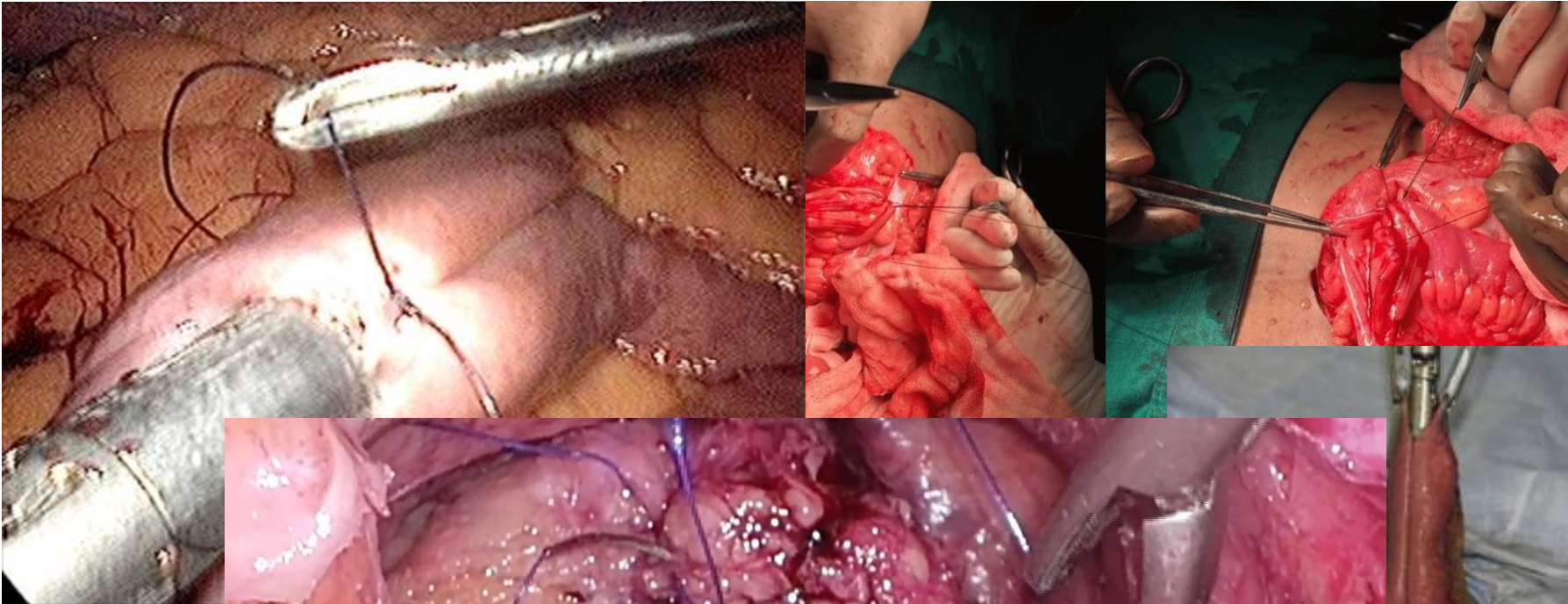
Stephanie Orzech

to me ▼

Dear Prof. Lutfi,

We just wanted to let you know that your presentation in the Prof. Boza's Grand Debates plenary session is now entitled: SADI WILL DISAPPEAR WITH THE RISE OF MAGNETIC SURGERY.

Many thanks and best wishes,
Stephanie









SADI - History

- SADI was pioneered by Sanchez-Pernaute and Torres in 2007 as a simplification of the duodenal switch (DS)
- Technically less demanding than traditional Duodenal Switch and had good outcomes for weight loss and obesity related comorbidity resolution.
- Preservation of the pylorus in SADI also stabilises blood sugar levels (BSLs) and reduces risk of biliary reflux from the duodenum and dumping syndrome, as the pylorus maintains gastric emptying at a physiological rate.
- Single anastomosis between the duodenum and the ileum 250 - 300cm from the caecum



2019



The IFSO Global Registry



6th IFSO Global Registry Report

2021

Prepared by

Wendy A Brown MBBS (Hons) PhD FACS FRACS

Lilian Kow BMBS PhD FRACS

Scott Shikora MD FACS FASMBS

Ronald Liem MD

Richard Welbourn MD FRCS

John Dixon PhD FRACGP FRCP Edin

Peter Walton MBA FRCP

Robin Kinsman BSc PhD

IFSO & Dendrite Clinical Systems

Surgery

Type of primary surgery

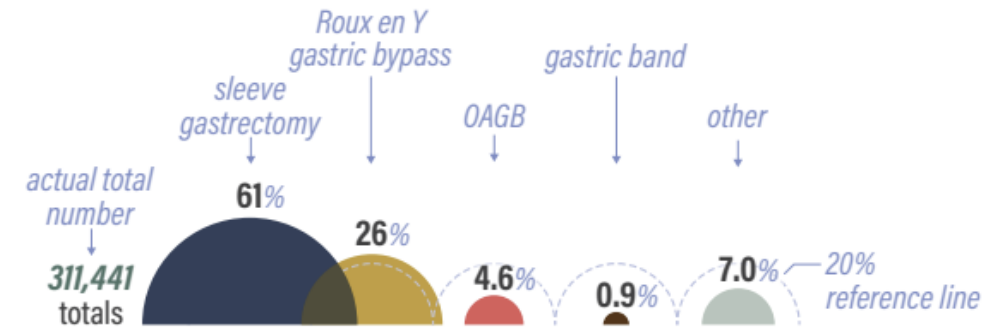
The majority of operations recorded in the registry are sleeve gastrectomies, followed in terms of volume by Roux en Y gastric bypass procedures. Other operations form a smaller proportion of the total, possibly reflecting current international practice. The graph below the table shows the data for the IFSO Regional Chapters. These data must be interpreted with caution as the data for each Chapter are not complete.

		Count	Percentage
Operation	Sleeve gastrectomy	128,382	50.2%
	Roux en Y gastric bypass	94,315	36.9%
	OAGB	19,421	7.6%
	Gastric band	8,539	3.3%
	Other	4,474	1.8%
	Duodenal switch with sleeve	253	0.1%
	Bilio-pancreatic diversion	147	0.1%
	Duodenal switch	78	0.0%
	Unspecified	11	
	All	255,620	

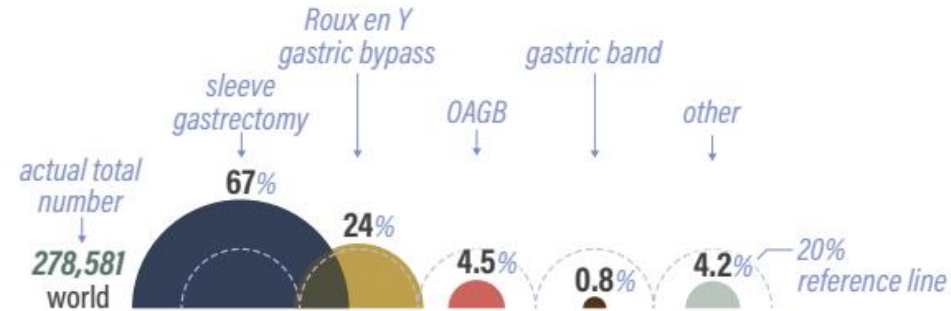
7th IFSO Global Registry Report

2022

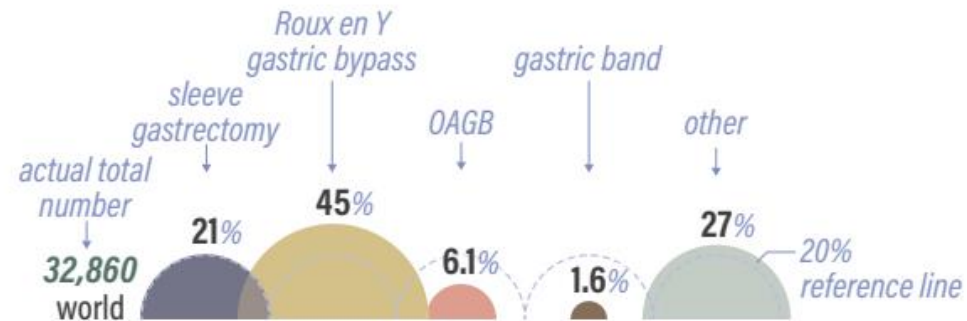
All procedures (primary and revisional) by type



Primary procedures by type World total of primary procedures



Revisional procedures by type World total of revisional procedures

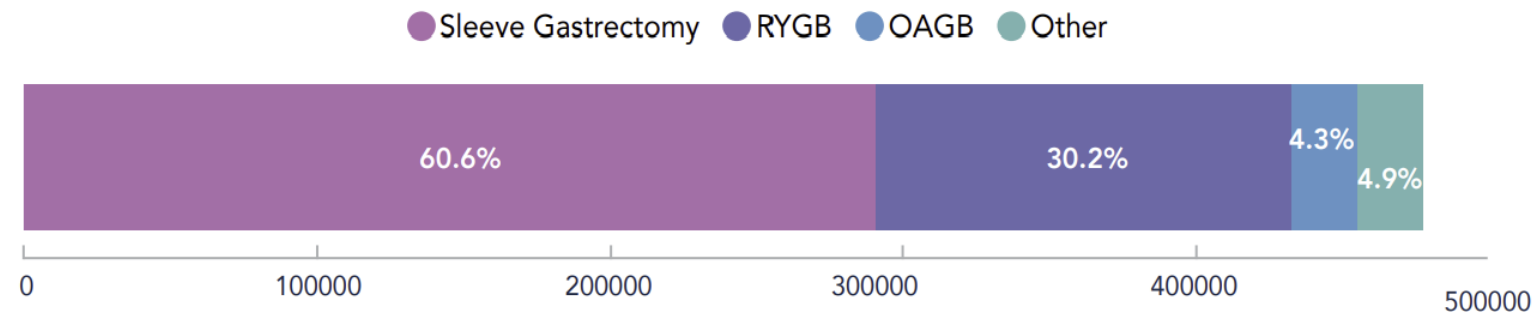




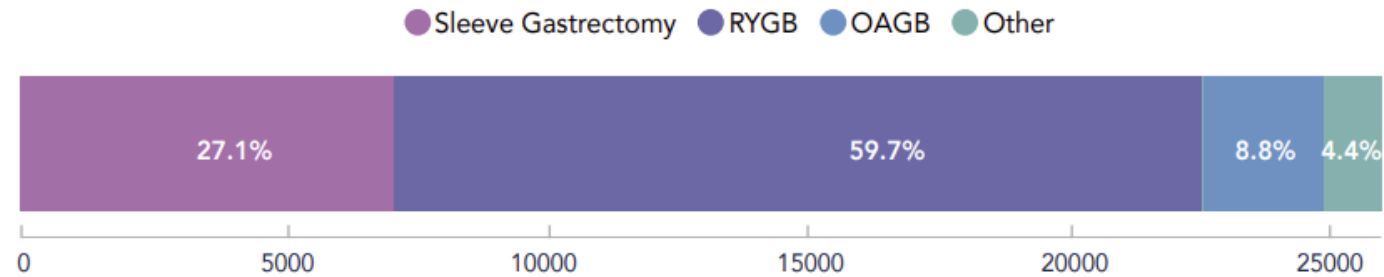
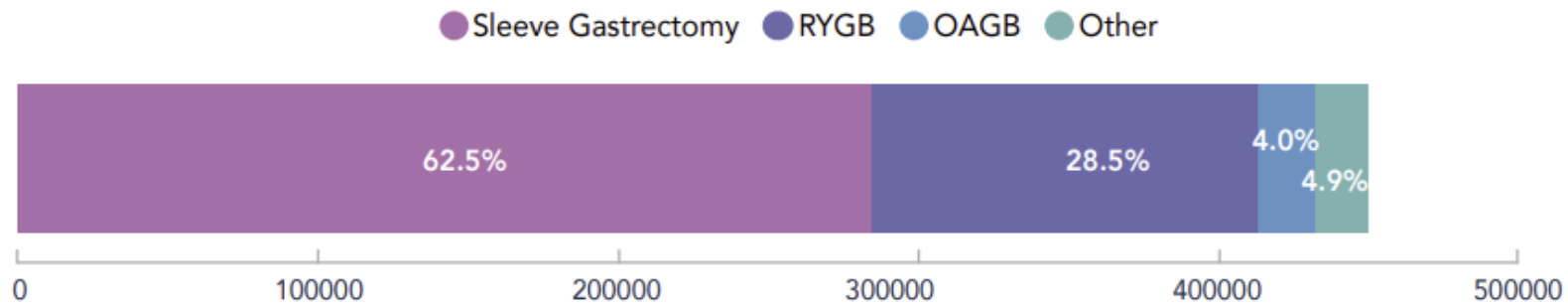
8TH GLOBAL REGISTRY REPORT



International Federation for Surgery for Obesity and Metabolic Disorders



All procedure types.



Revisional procedures (n= 25,938).



IFSO - International Federation for the Surgery and Other Therapies for Obesity

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Sep 3, 2026, 10:18 PM (10 hours ago)



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2024
REGISTRATION YEAR

10th

GLOBAL
REGISTRY
REPORT

Metabolic Bariatric Surgery
Worldwide



Figure 3. Total procedures by operative type (2024)

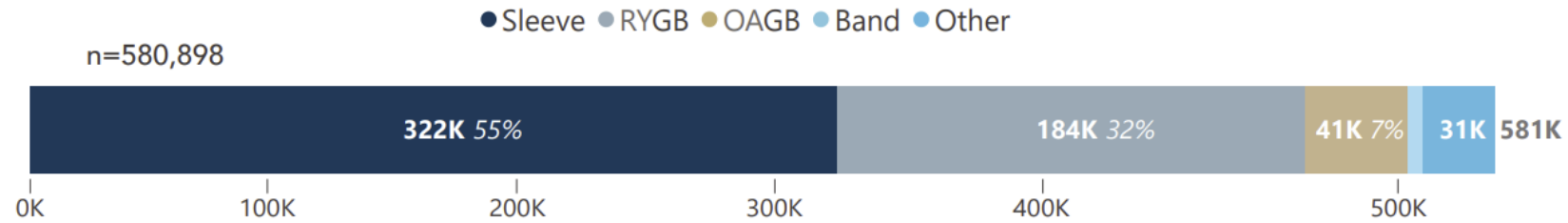


Figure 4. Total primary procedures by operative type (2024)

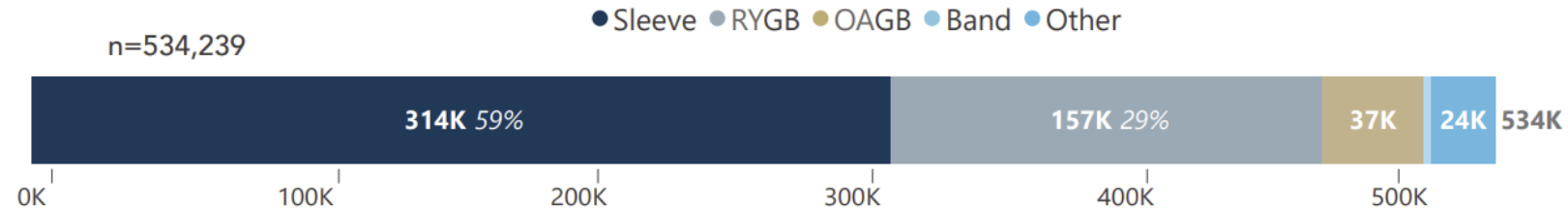
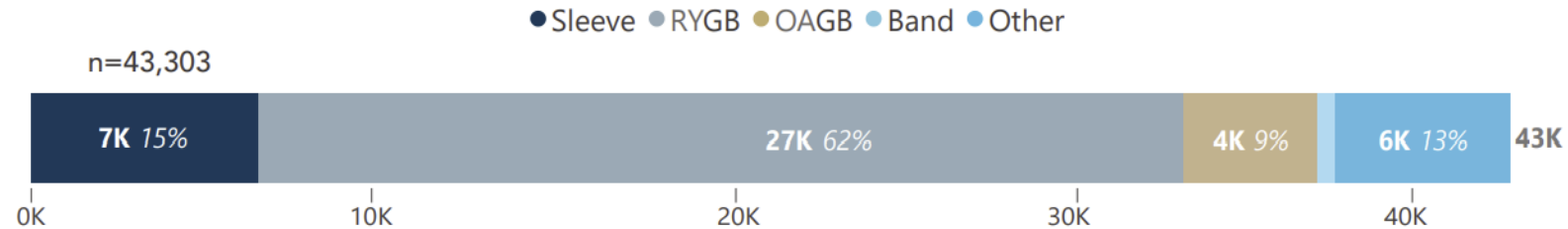


Figure 6. Total revisional procedures by operative type (2024)





OAGB AND SADI-S

Wednesday, September 10

8:00 - 9:30

- OAGB: Standardized Approach and Technical Considerations
- SADI-S: Standardized Approach and Technical Considerations
- OAGB: Medium-Long Term Results:
What the Evidence Tells
- SADI-S: Medium-Long Term Results:
What the Evidence Tells?
- OAGB: Short and Long Term Complications
What to Look for and How to Manage?
- SADI-S: Short and Long Term Complications
What to Look for and How to Manage?

ifso2025.org



Chair - Antonio J. Torres, Spain



L'ASSOCIATION CANADIENNE
des MEDECINS et CHIRURGIENS BARIATRIQUES
The CANADIAN ASSOCIATION of
BARIATRIC PHYSICIANS and SURGEONS



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in French

CABPS SESSION

THE PLACE OF DUODENAL SWITCH AND SINGLE ANASTOMOSIS DS IN THE METABOLIC BARIATRIC FIELD

Thursday 3 September 2026

- Long-Term Outcomes of Standard DS
- Surgical Technique – Robotic Duodenal Dissection and Anastomosis
- Nutritional Evaluation and Management of Protein Malnutrition
- Management of Leaks after DS and SADI
- Long-Term Outcomes of SADI-S versus RYGB
- Comparison of SADI-S versus SASI
- Long-Term Outcomes of SADI versus DS

TORONTO 2026



CHAIR

8

Laurent Biertho
Canada

There have been more surgeons trained, certified, and lectured on SADI than actual patients who have ever received one!!

Rami Lutfi

**“Those who fail to
learn from history
are doomed to repeat it”**

**- Winston Churchill
& Rami Lutfi
& Every Surgeon in Power**



2002

"Two-stage laparoscopic biliopancreatic diversion with duodenal switch: An alternative approach to super-super morbid obesity."

Chu, C. A., Gagner, M., Quinn, T., et al. (2002)
Surgical Endoscopy, 16, S069

Early Experience with Two-Stage Laparoscopic Roux-en-Y Gastric Bypass as an Alternative in the Super-Super Obese Patient

Obesity Surgery, 13, 861-864

Early Experience with Two-Stage Laparoscopic Roux-en-Y Gastric Bypass as an Alternative in the Super-Super Obese Patient

J.P. Regan, MD; W. B. Inabnet, MD; M. Gagner, MD; A. Pomp, MD

Division of Laparoscopic Surgery, Department of Surgery, Mount Sinai School of Medicine, One Gustave L. Levy Place, Box 1103, New York, NY, USA

Background: Surgical management of the super-super obese patient (BMI >60 kg/m²) has been a challenging problem associated with higher morbidity, mortality, and long-term weight loss failure. Current limited experience exists with a two-stage biliopancreatic diversion and duodenal switch in the super-super obese patient, and we now present our early experience with a two-stage gastric bypass for these patients.

with second-stage Roux-en-Y gastric bypass are feasible and effective procedures based on short-term results. This two-stage approach is a reasonable alternative for surgical treatment of the high-risk super-super obese patient.

Key words: Gastric bypass, laparoscopy, morbid obesity, super-super obese, sleeve gastrectomy, bariatric surgery

car site hernia, and urinary tract infection. There were no mortalities in the series.

Conclusions: Laparoscopic sleeve gastrectomy

Reprint requests to: Alfons Pomp, MD, FACS, Weill Cornell Medical College, 525 E., 68th St., Box 294, New York, NY 10021, USA. Fax: 212-746-5236; e-mail: alp2014@med.cornell.edu

higher peri-operative morbidity and mortality associated with one-stage bariatric procedures. Gagner et al⁵ have reported a 38% major complication rate and a 6.25% mortality rate associated with one-stage laparoscopic BPD-DS in patients with BMI ≥65, compared to an 8.3% major complication rate

Oct 2007

OBES SURG (2008) 18:487–496
DOI 10.1007/s11695-008-9471-5

CONSENSUS SUMMIT

The First International Consensus Summit for Sleeve Gastrectomy (SG), New York City, October 25–27, 2007

Mervyn Deitel · Ross D. Crosby · Michel Gagner

About 7 years ago, some surgeons who were performing the DS operation began to do the first part (the lesser curvature gastric tube) as a first-stage for poor-risk patients, intending to do the second stage (DS or RYGBP) later [1–8]. It was noted that patients occasionally lost significant weight so that they did not require the second stage. Also, the SG was performed in some patients whose weight was not severe enough to warrant the usual bariatric operations [9–16]. Eventually, some surgeons performed the SG as their sole bariatric operation, going on to a second stage only where the weight loss was inadequate [17]. These surgeons, in future SGs, constructed a narrower gastric tube, which increased the weight loss [9].

R. D. Crosby
Biomedical Statistics Neuropsychiatric Research Institute,
120 8th St. S., POB 1415, Fargo, ND 58107-1415, USA

M. Gagner
Department of Surgery, Mount Sinai Medical Center,
4300 Alton Rd., Miami Beach, FL 33140, USA

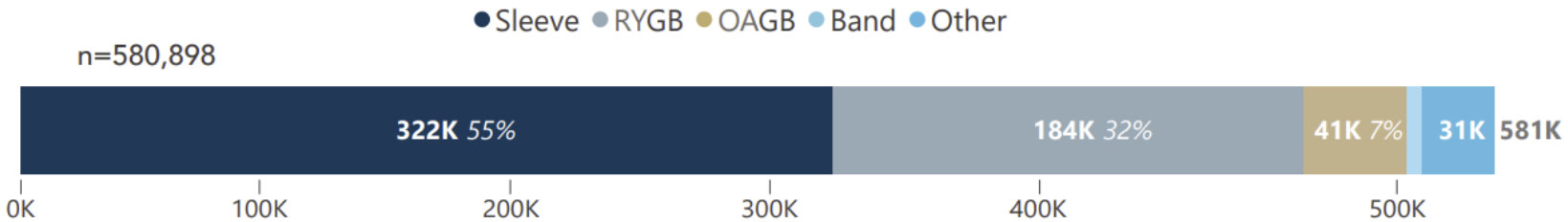
Summary, there are multiple technical variations currently for the LSG. There is variation in the size of bougie beside which the linear cutting staplers are placed to divide the stomach. There is variation in the level at which the surgeons start the division in the antral area. Many surgeons leave in most of the antrum for its pumping, emptying

**The First International Consensus Summit for Sleeve
Gastrectomy (SG), New York City, October 25–27, 2007**

Mervyn Deitel • Ross D. Crosby • Michel Gagner

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OBES SURG (2007) 17:1614–1618
DOI 10.1007/s11695-007-9287-8

MODERN SURGERY: TECHNICAL INNOVATION

Proximal Duodenal–Ileal End-to-Side Bypass with Sleeve Gastrectomy: Proposed Technique

Andrés Sánchez-Pernaute · Miguel Angel Rubio Herrera ·
Elia Pérez-Aguirre · Juan Carlos García Pérez ·
Lucio Cabrerizo · Luis Díez Valladares · Cristina Fernández ·
Pablo Talavera · Antonio Torres

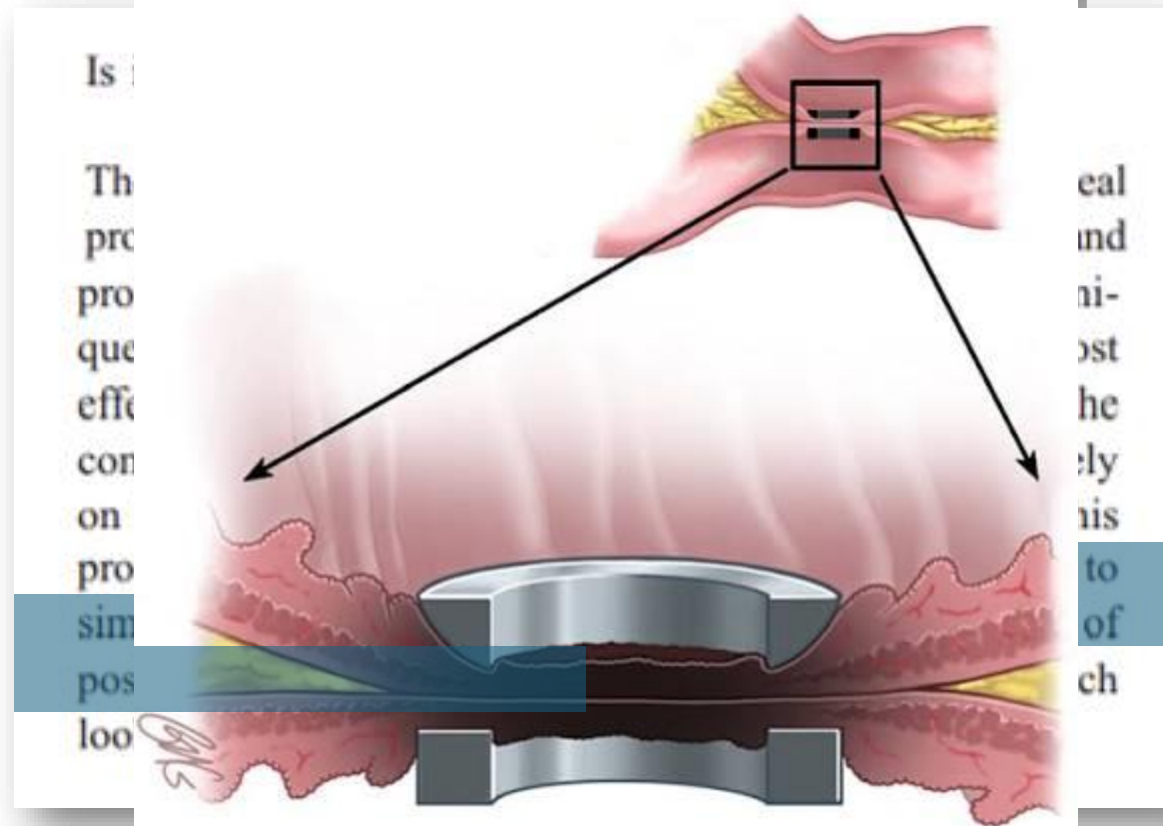
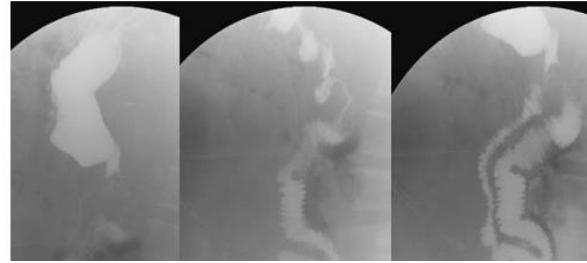
Published online: 27 November 2007
© Springer Science + Business Media B.V. 2007

Abstract Proximal duodenal–ileal end-to-side bypass with sleeve gastrectomy is a new bariatric technique based on the biliopancreatic diversion with duodenal switch in which after the sleeve gastrectomy, the duodenum is anastomosed to the ileum in a Billroth-II fashion. A 200-cm common channel-alimentary limb is devised. Anticipating an appropriate weight loss, at least similar to that obtained after gastric bypass, theoretical benefits for operated patients are a shorter operative time, the performance of only one

anastomosis, and no mesentery opening. A prospective trial is now being conducted to find out the results of the procedure and to compare them to those obtained with gastric bypass and standard duodenal switch.

Keywords Proximal duodenal–ileal bypass · Morbid obesity · Surgical technique · Loop duodenal switch · Operative complications

Fig. 3 Postoperative gastrografin swallow after a loop duodenal switch. The water-soluble contrast comes through the duodeno-ileal anastomosis and fills the efferent- alimentary-common limb (1, 2). With the progression of the contrast, part of the afferent-biliopancreatic loop is also filled with contrast (3)



results in a 30% reduction of operative time.

Is it Safe for the Patient?

Is it Necessary to Search for a New Procedure?

The number of bariatric operations suggests that the ideal procedure for every patient has not been described yet, and

The first thing to comment about safeness is that this operation IS NOT a mini-bypass [3]. In mini gastric bypass, the anastomosis is performed between the intestine and the lesser curvature of the stomach, and this warrants the



Patient Selection and 30-Day Outcomes of SADI-S Compared to RYGB: a Retrospective Cohort Study of 47,375 Patients

Materials and Methods The 2020 Metabolic and Bariatric Accreditation and Quality Improvement Program (MBSAQIP) registry was analyzed, comparing SADI-S to RYGB. Bivariate analysis was performed to determine intergroup differences. Multivariable logistic regression determined factors associated with serious complications and mortality.

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Abstract

Results We evaluated 47,375 patients, with 501 (1.1%) receiving SADI-S. Patients undergoing SADI-S had higher body mass index (51.4 ± 9.7 kg/m² SADI-S vs. 44.6 ± 7.9 kg/m² RYGB; $p < 0.001$), and more metabolic comorbidities including non-insulin dependent diabetes (21.7% SADI-S vs 19.0% RYGB; $p = 0.011$), insulin dependent diabetes (12.0% SADI-S vs. 8.6% RYGB; $p = 0.011$), and hypertension (54.9% SADI-S vs 47.6% RYGB; $p < 0.001$). Patients undergoing SADI-S experienced more anastomotic leaks (2.2% vs. 0.5%; $p < 0.001$), reoperations (5.0% vs 2.6%; $p < 0.001$), pneumonias (1.6% vs 0.5%; $p < 0.001$), had sepsis more frequently (1.4% vs 0.3%; $p < 0.001$), and required more unplanned reintubations (1.2% vs 0.3%; $p = 0.004$). SADI-S was independently associated with serious complications (OR 1.45, CI 1.09–1.95, $p < 0.001$) but was not a predictor of mortality (OR 3.29, $p = 0.060$).

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Conclusions In comparison to RYGB, patients undergoing SADI-S were found to have more metabolic comorbidities. Compared to RYGB, SADI-S has worse perioperative outcomes and is independently associated with serious complications. It remains unclear whether this represents a learning curve or true findings and prospective studies analyzing the risk–benefit ratio following SADI-S are needed.

Table 2 Thirty-day post-operative outcomes for patients undergoing single anastomosis duodeno-ileal bypass with sleeve gastrectomy (SADI-S) to those undergoing Roux-en-Y gastric bypass (RYGB)

	SADI-S <i>n</i> = 501 <i>n</i> (%)	RYGB <i>n</i> = 46,874 <i>n</i> (%)
Anastomotic leak	11 (2.2)	215 (0.5)
Gastrointestinal bleed	7 (1.4)	352 (0.8)
Readmission	38 (7.6)	2703 (5.8)
Reintervention	14 (2.8)	901 (1.9)
Reoperation	25 (5.0)	1221 (2.6)
Urinary tract infection	1 (0.2)	223 (0.5)
Deep SSI	2 (0.4)	79 (0.2)
Sepsis	7 (1.4)	121 (0.3)
Wound disruption	0 (0)	46 (0.1)
Unplanned intubation	6 (1.2)	146 (0.3)
Acute renal failure	5 (1.0)	82 (0.2)
Pneumonia	8 (1.6)	214 (0.5)
Myocardial infarction	1 (0.2)	14 (0.03)
Outpatient dehydration treatment	19 (3.8)	1925 (4.1)
Emergency re-presentation	4 (9.5)	641 (13.2)
Cerebral vascular accidents	0 (0)	16 (0.03)
Serious complications	53 (10.6)	3905 (8.3)
Mortality	3 (0.6)	60 (0.1)

SADI-S, single anastomosis duodeno-ileal bypass with sleeve gastrectomy; RYGB, Roux-en-Y gastric bypass; SSI, surgical site infection

Table 3 Multivariable logistic regression for 30-day mortality

Risk factor	Odds ratio
SADI-S (as compared to RYGB)	1.45
Age (compared by decade)	0.96
Male gender	0.78
BMI	0.94
Renal insufficiency	1.84
Dialysis dependence	1.55
Previous MI	1.62
GERD	1.25
Hypertension	1.10
Hyperlipidemia	1.07
Diabetes	0.85
Non-insulin dependent	1.15
Insulin dependent	
COPD	1.42
Smoker	1.16
Prior DVT	1.39
Sleep apnea	1.04

SADI-S, single anastomosis duodeno-ileal bypass with sleeve gastrectomy; RYGB, Roux-en-Y gastric bypass; BMI, body mass index; MI, myocardial infarction; GERD, gastroesophageal reflux disease; COPD, chronic obstructive pulmonary disease; DVT, deep vein thrombosis

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Risk factor	Odds ratio	95% confidence interval	<i>p</i> -value
SADI-S (as compared to RYGB)	3.29	0.95–11.34	0.060
Age (compared by decade)	2.37	1.77–3.18	<0.001
Male gender	1.78	0.97–3.27	0.061
BMI	1.46	1.26–1.69	<0.001
Renal insufficiency	7.21	2.91–17.87	<0.001
Dialysis dependence			
Previous MI	2.74	1.05–7.17	0.040
GERD	1.73	0.98–3.05	0.057
Hypertension	1.49	0.73–3.03	0.278
Hyperlipidemia	1.08	0.58–2.00	0.802
Diabetes (as compared to no diabetes)	0.75	0.36–1.58	0.456
Non-insulin dependent	0.97	0.45–2.08	0.941
Insulin dependent			
COPD	0.19	0.02–1.49	0.113
Smoker	1.24	0.46–3.35	0.670
Anticoagulation	1.34	0.56–3.20	0.512
Operative duration	1.00	1.00–1.00	0.027
Anastomotic leak	20.65	9.44–45.19	<0.001
Postoperative bleed	9.90	4.69–20.90	<0.001
Prior DVT	2.50	0.91–6.90	0.077

SADI-S, single anastomosis duodeno-ileal bypass with sleeve gastrectomy; RYGB, Roux-en-Y gastric bypass; BMI, body mass index; MI, myocardial infarction; GERD, gastroesophageal reflux disease; COPD, chronic obstructive pulmonary disease; DVT, deep vein thrombosis

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Revisional surgery for malnutrition after SADI-S: prevalence, indications, techniques and outcomes

Andrés Sánchez-Pernaute¹ · Bibiana Lasses¹ · Leyre López Antoñanzas¹ · Miguel Ángel Rubio² · Clara Marcuello² · Natalia Pérez Ferré² · Antonio Torres¹ · Elia Pérez-Aguirre¹

Published online: 28 May 2024

Table 1 Indications for surgery, findings, and surgical attitude

Case nº	Limb length	Indication	Other causes	Time to surgery	Nº of admissions	Real length	Technique	Stomach
1	200	Diarrhea	Hypocalcemia	65	5	200	SADI-S 350	Re-sleeve
2	200	Malnutrition	Diarrhea	114	2	200	SADI-S 350	
3	200	Malnutrition		28	1	200	RnY DS	
4	200	Malnutrition	Diarrhea	120	1	200	SADI-S 300	
5	200	Malnutrition	Aged	28	2	200	RnY DS	
6	200	Liver failure	Alcohol	133	1	200	SADI-S 300	Re-sleeve
7	200	Diarrhea		37	1	250	SADI-S 350	
8	250	Malnutrition		156	1	170	SADI-S 300	
9	250	Malnutrition		17	2	250	RnY DS	
10	250	Malnutrition	Schizophrenia	16	1	250	Duodeno-duodenostomy	
11	250	Malnutrition		40	1	250	SADI-S 350	Re-sleeve
12	250	Liver failure	Viral hepatitis	23	3	220	Duodeno-jejunostomy	
13	250	Malnutrition		19	3	150	SADI-S 350	
14	250	Malnutrition		76	1	190	SADI-S 350	
15	250	Liver Failure	Alcohol	16	1	250	SADI-S 350	
16	250	Malnutrition		20	1	200	SADI-S 300	
17	250	Malnutrition		50	3	230	SADI-S 320	

Bold values are those that could have a prognostic significance

the nutritional issues [3, 4]. Despite this greater absorption, some patients still present with hypoalbuminemia and other deficiencies [5], perhaps secondarily to a wrong selection, errors in the limb measurement or poor adherence to diet and supplementation. The management of malnourished patients

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Revisional surgery for malnutrition after SADI-S: prevalence, indications, techniques and outcomes

Andrés Sánchez-Pernaute¹ · Bibiana Lasses¹ · Leyre López Antoñanzas¹ · Miguel Ángel Rubio² · Clara Marcuello² · Natalia Pérez Ferré² · Antonio Torres¹ · Elia Pérez-Aguirre¹

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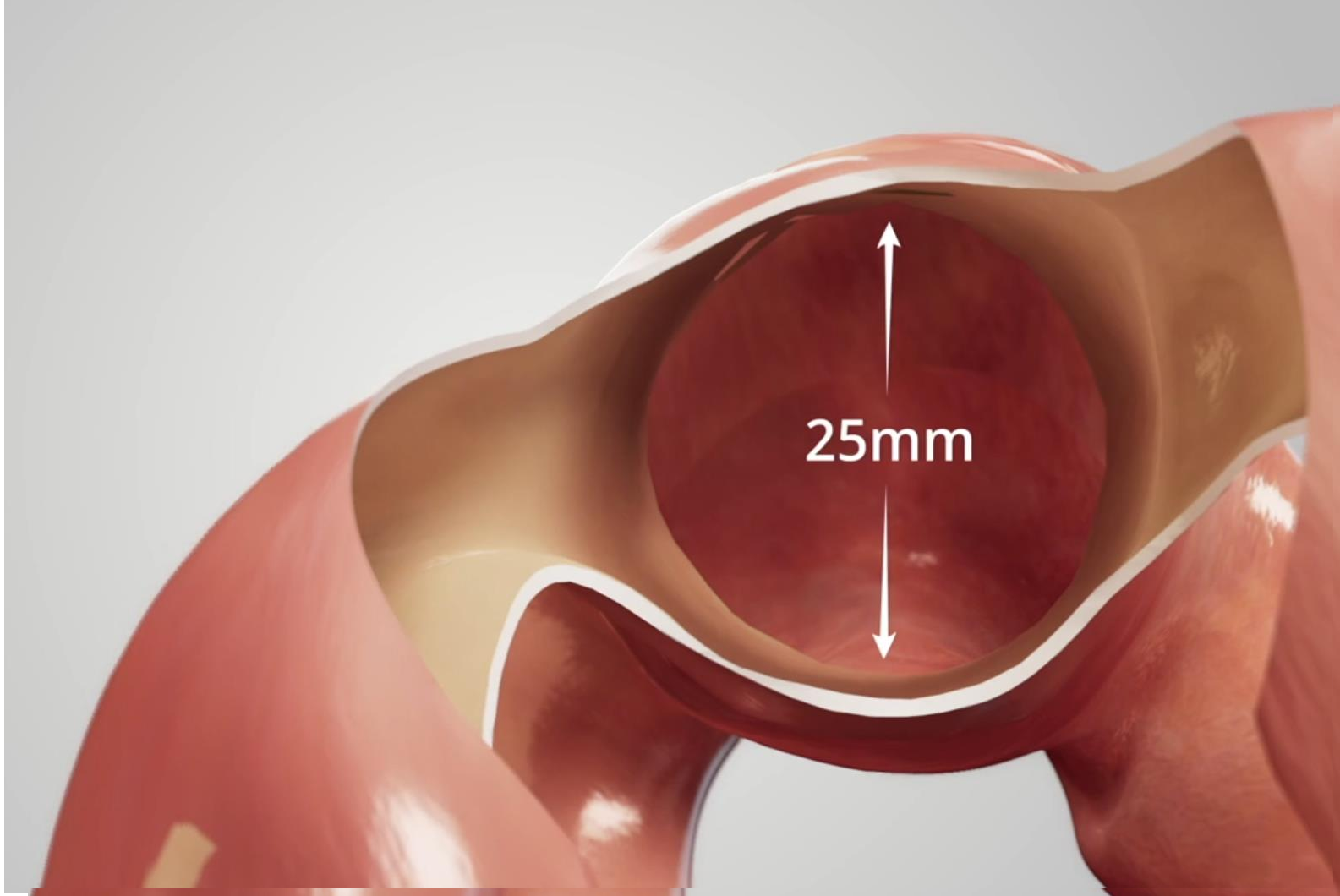
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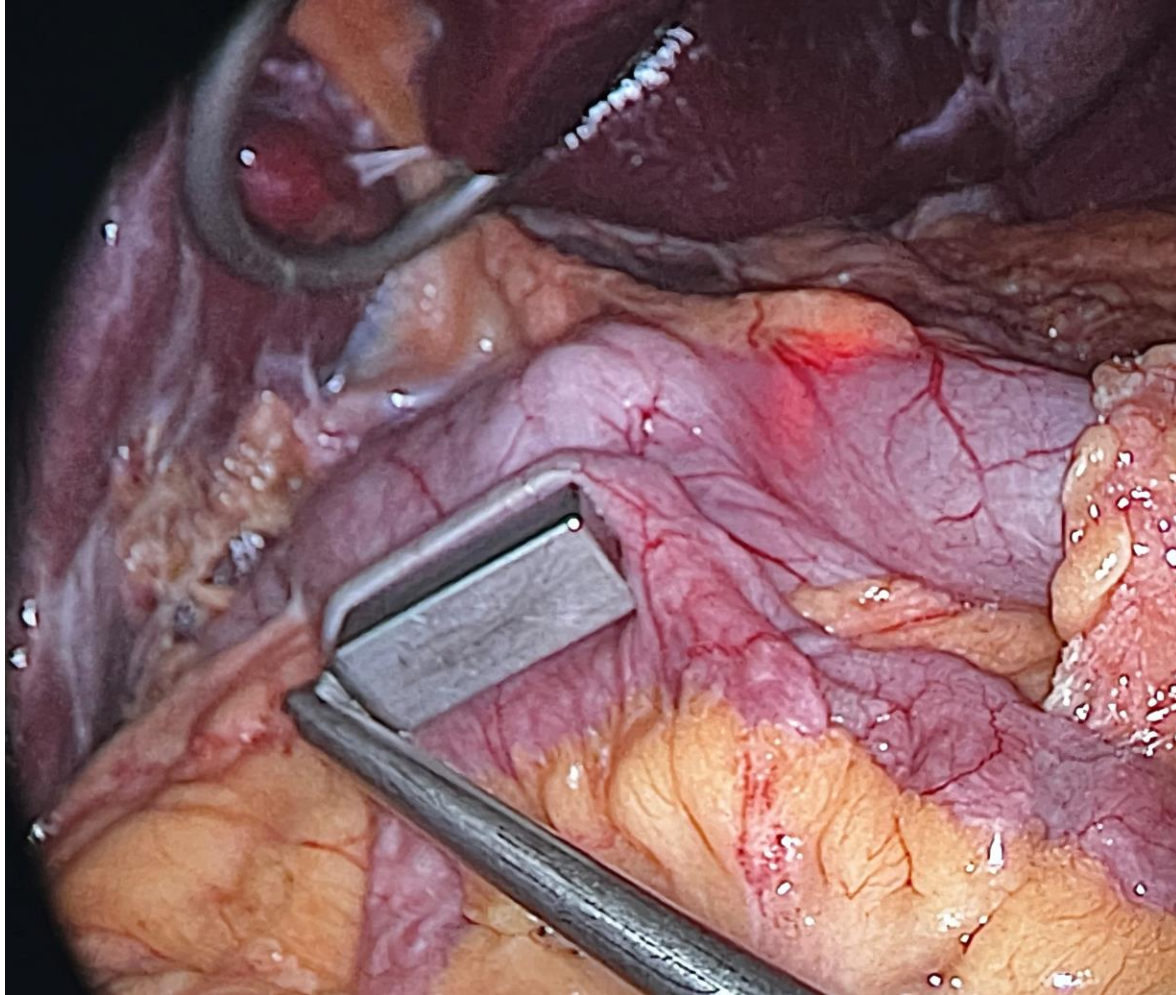
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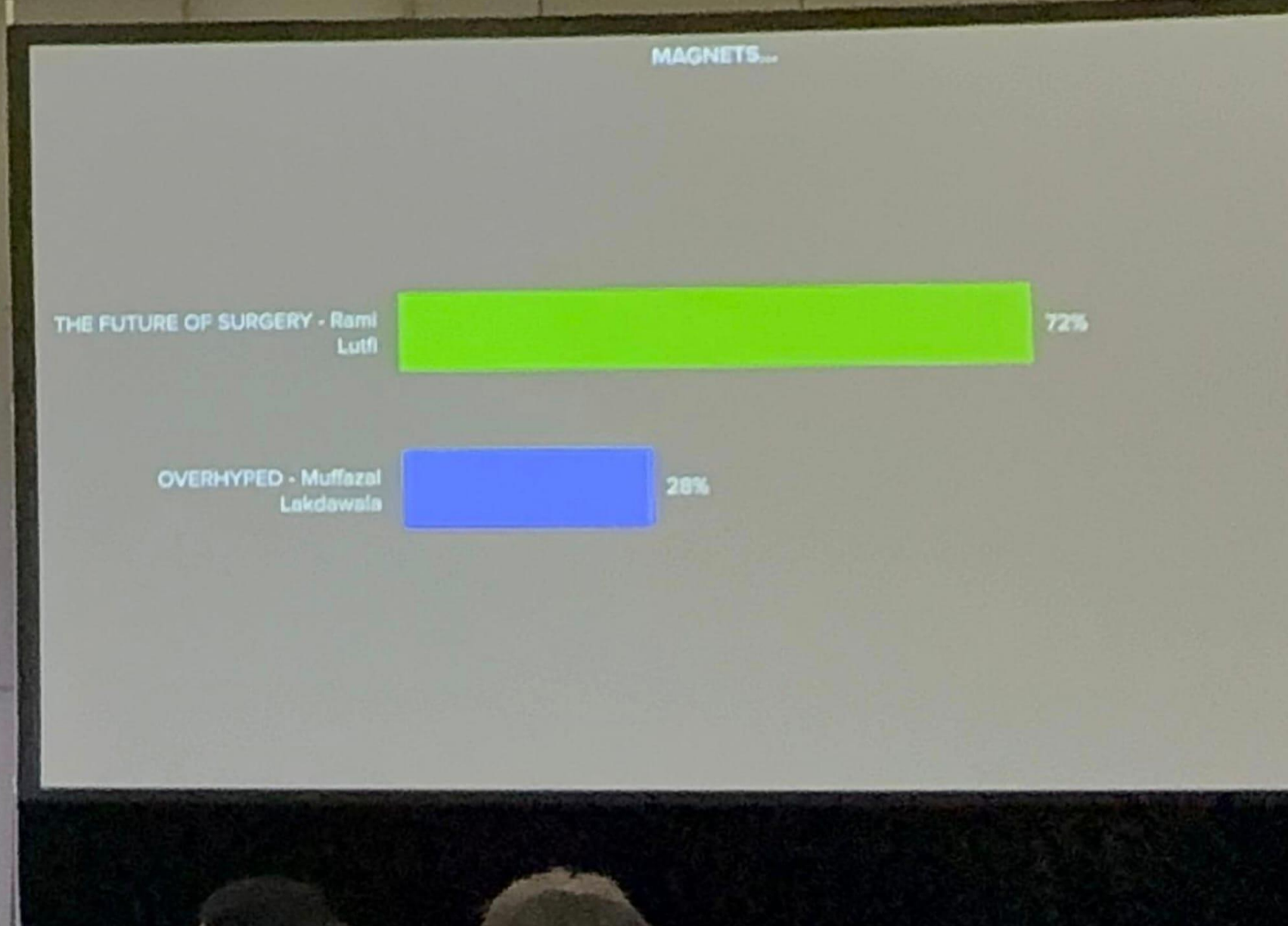
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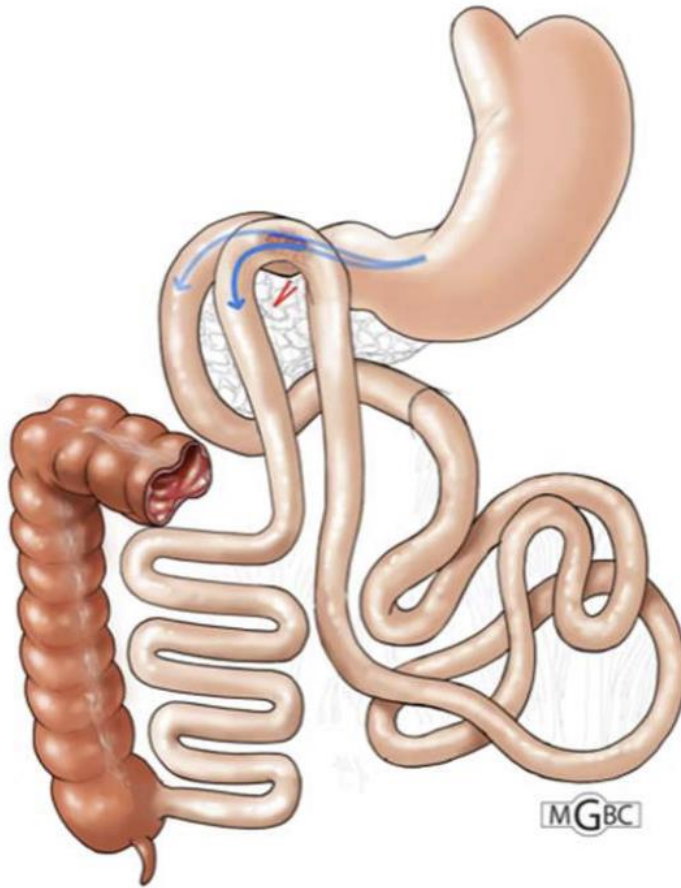


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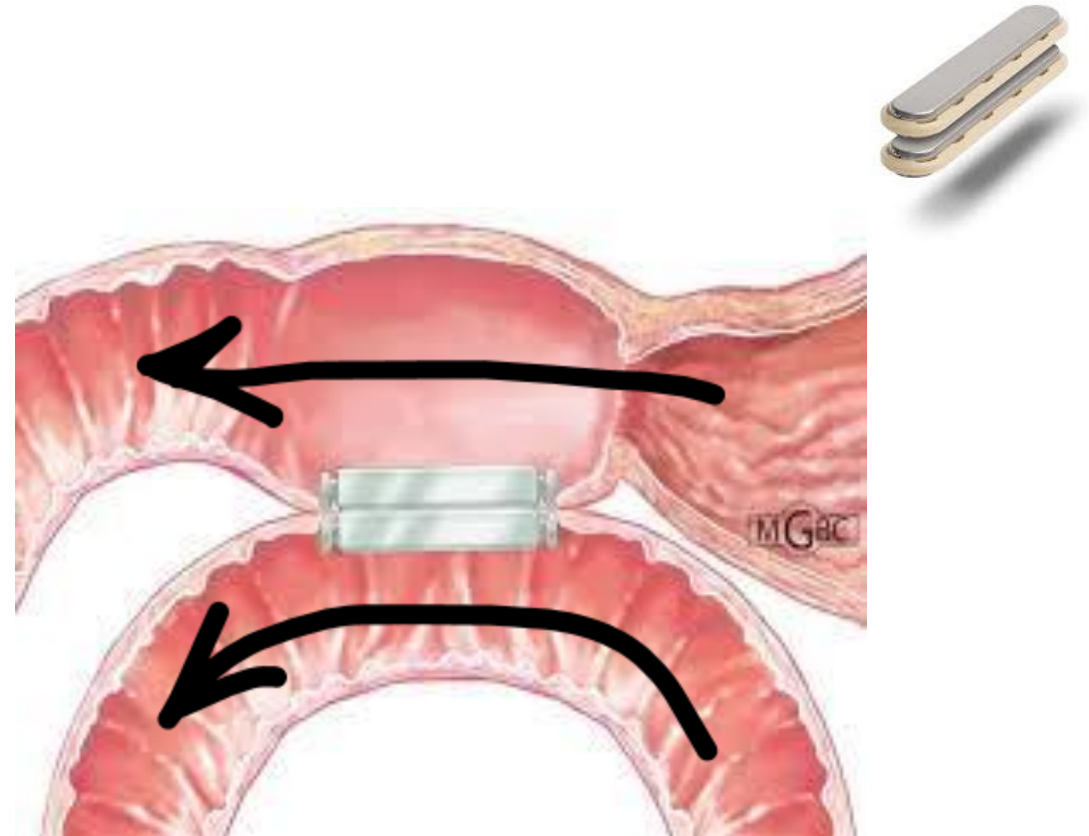
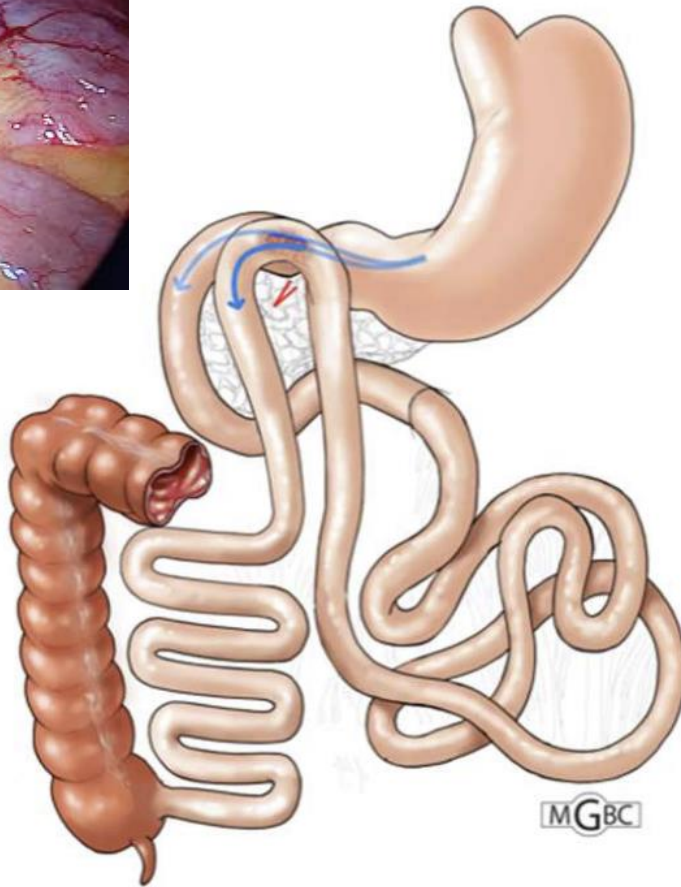
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Compression Magnet Anastomosis

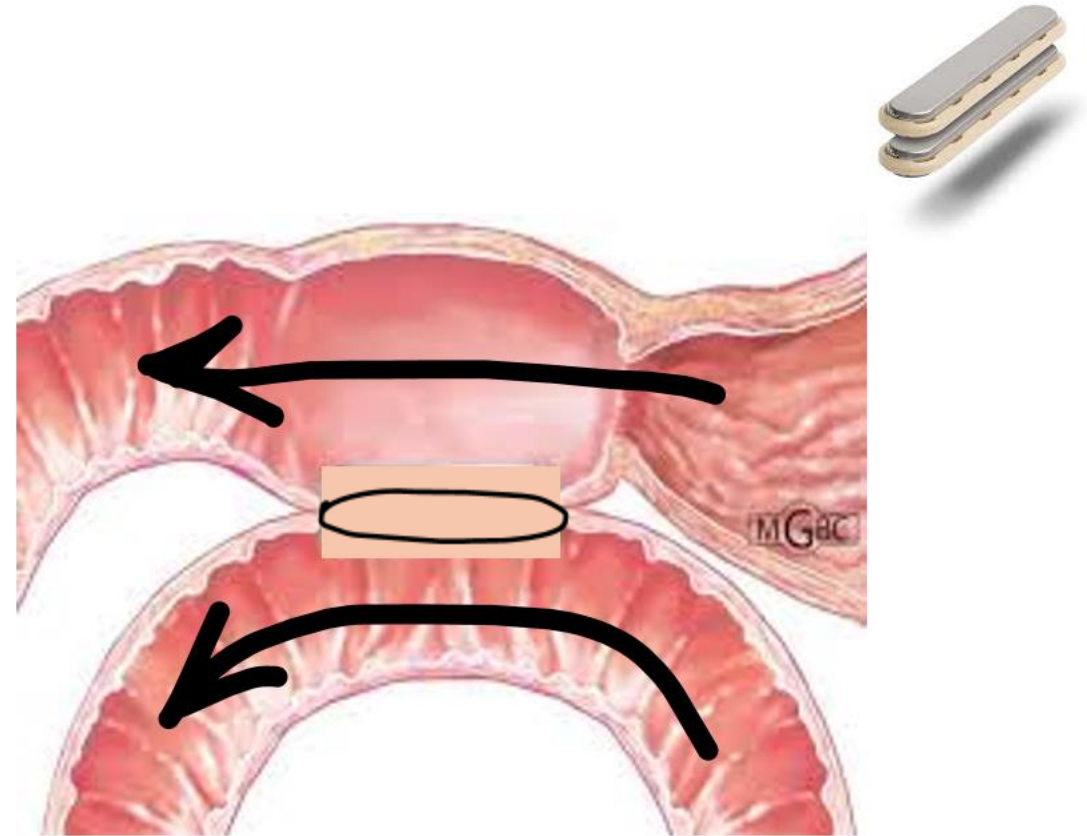
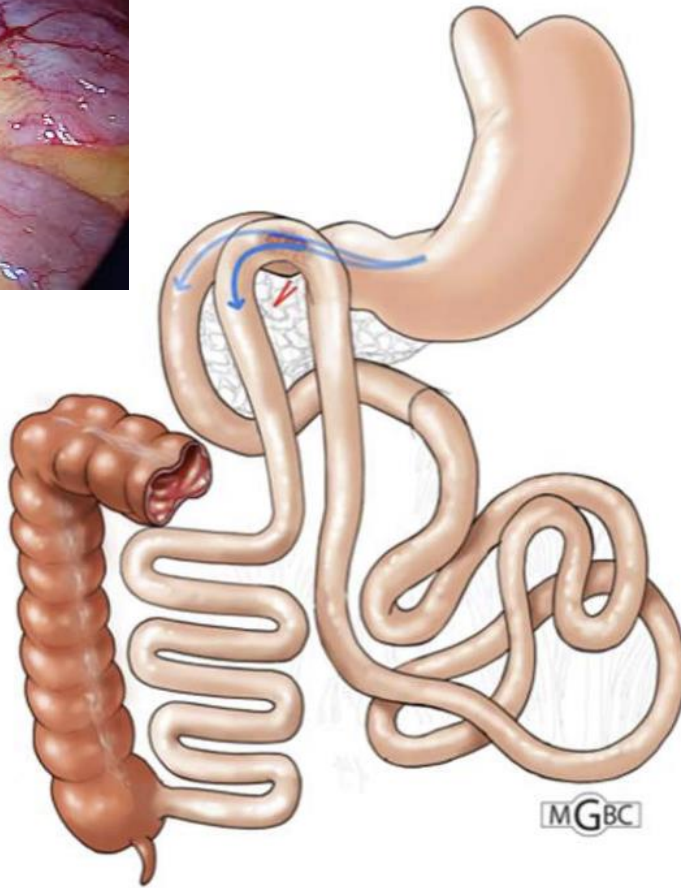


Compression Magnet Anastomosis



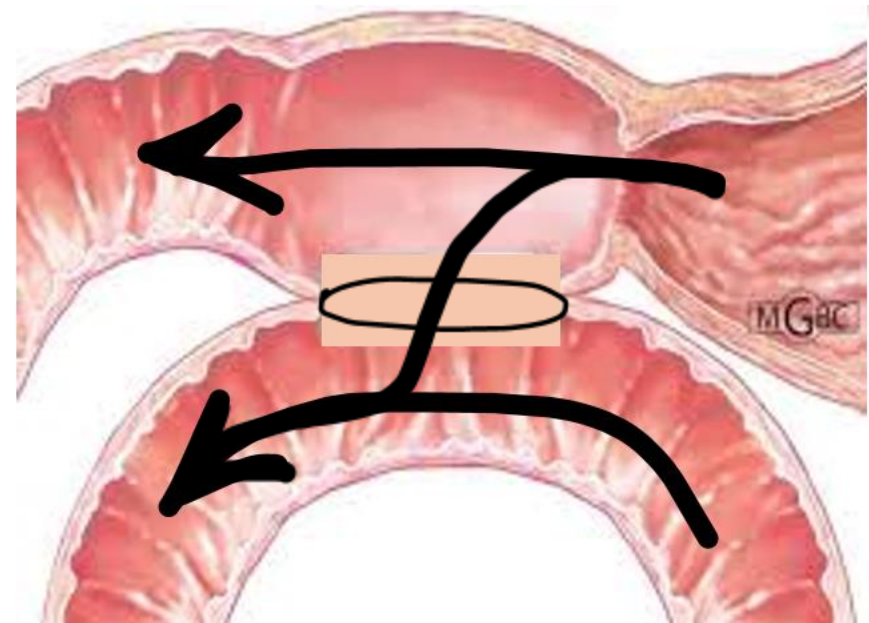
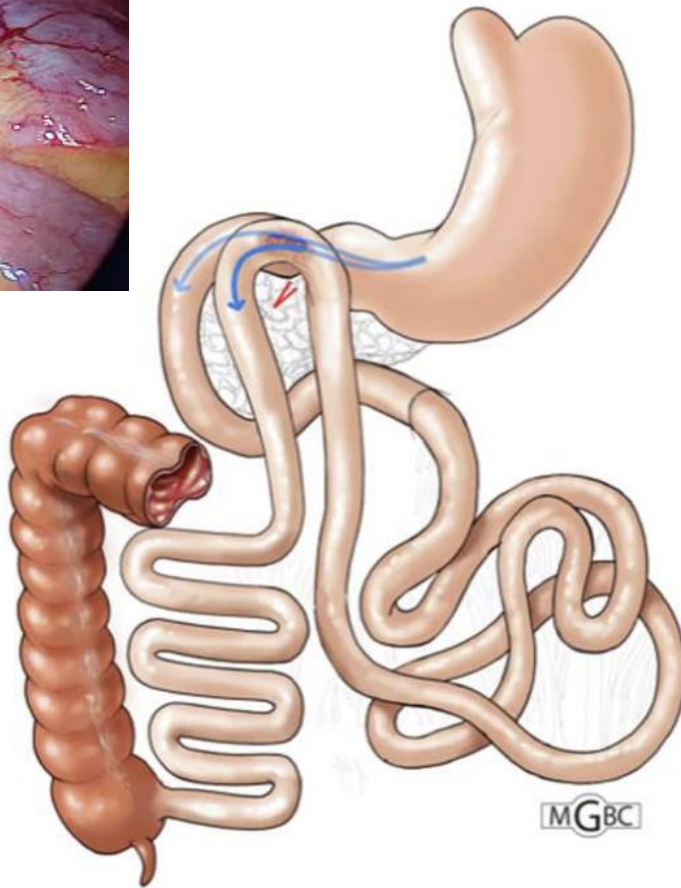
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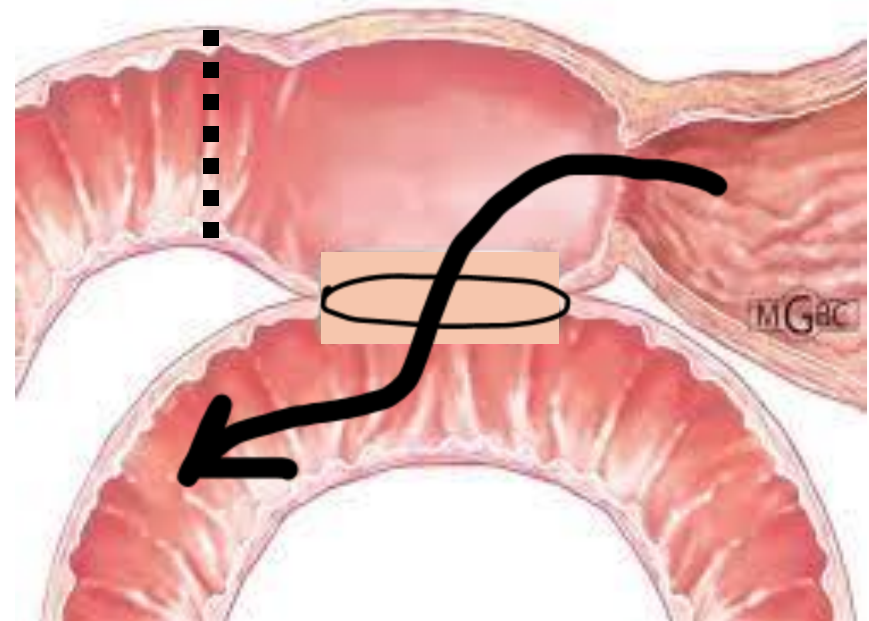
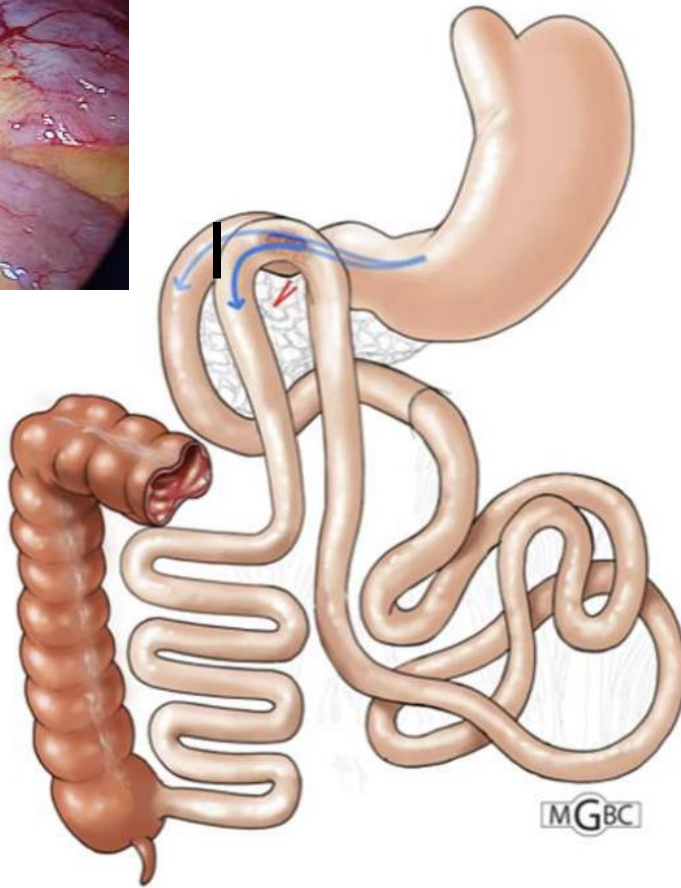
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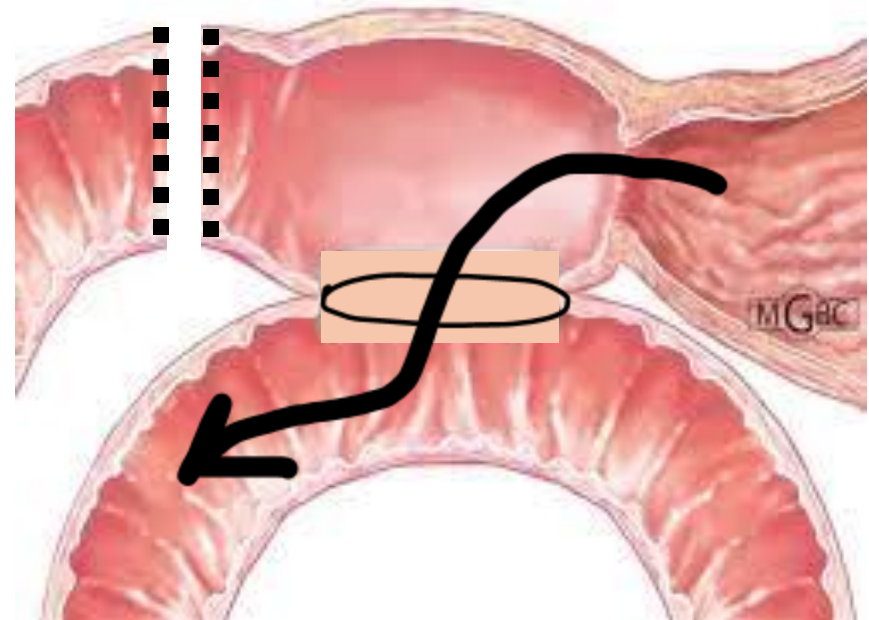
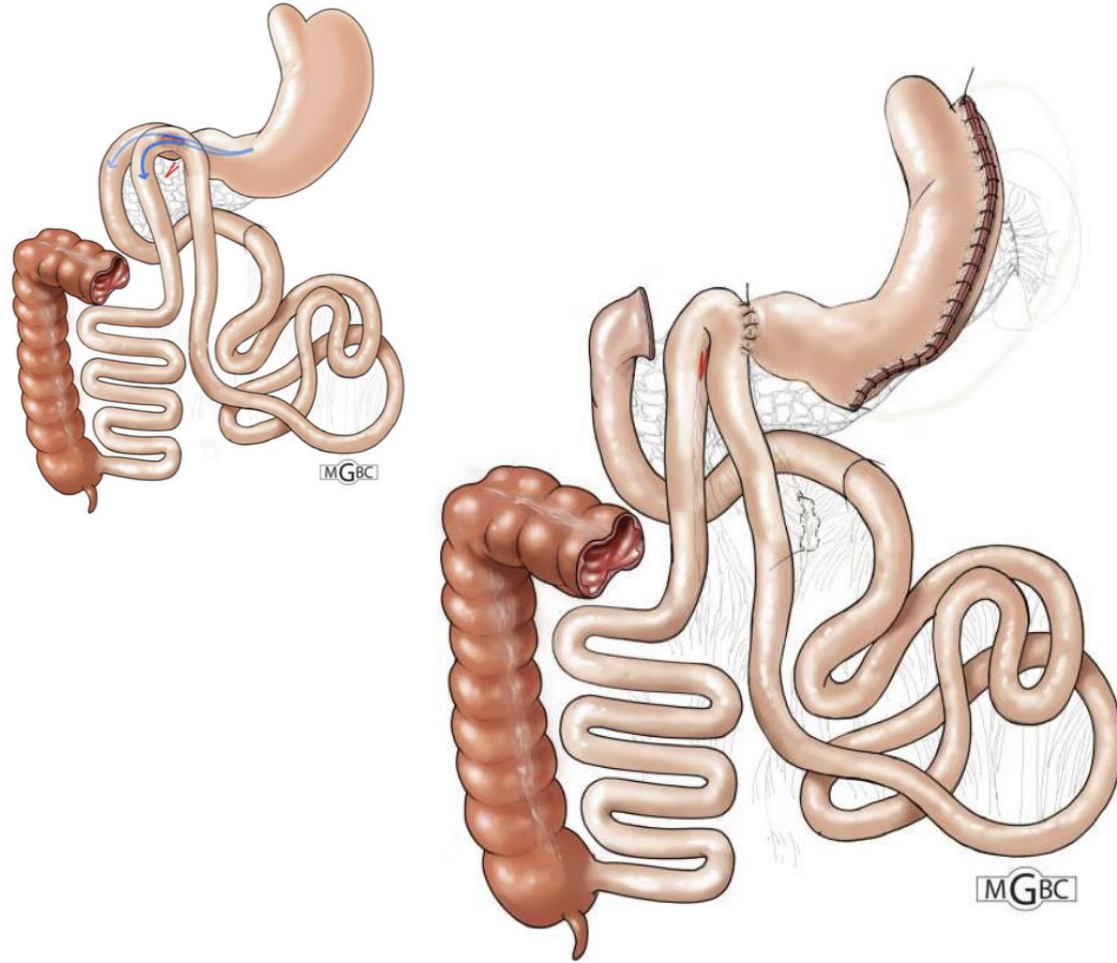


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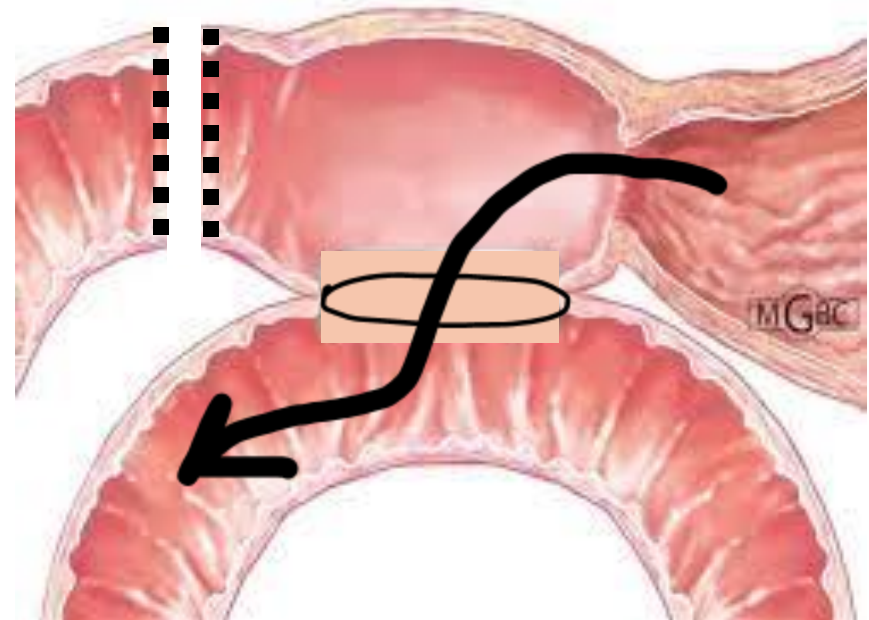
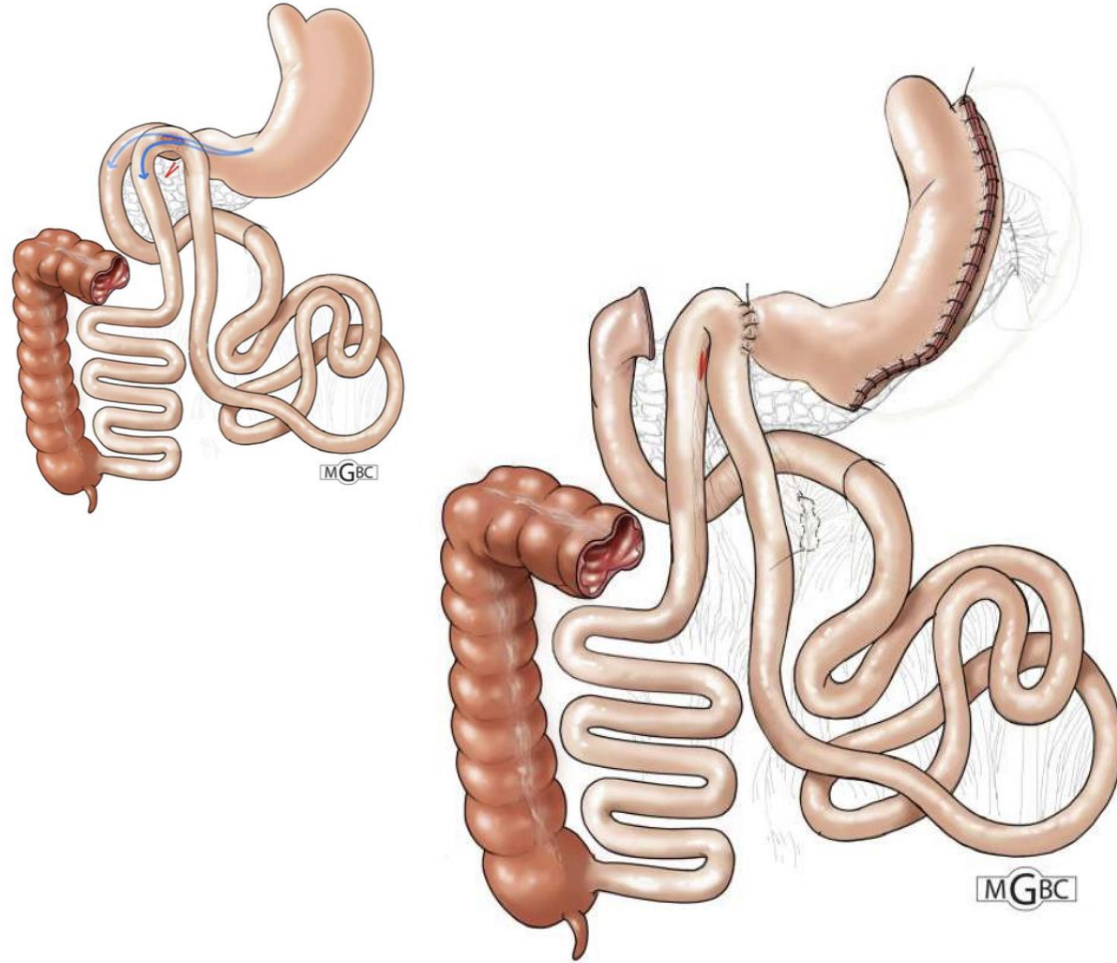


Compression Magnet Anastomosis



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Compression Magnet Anastomosis



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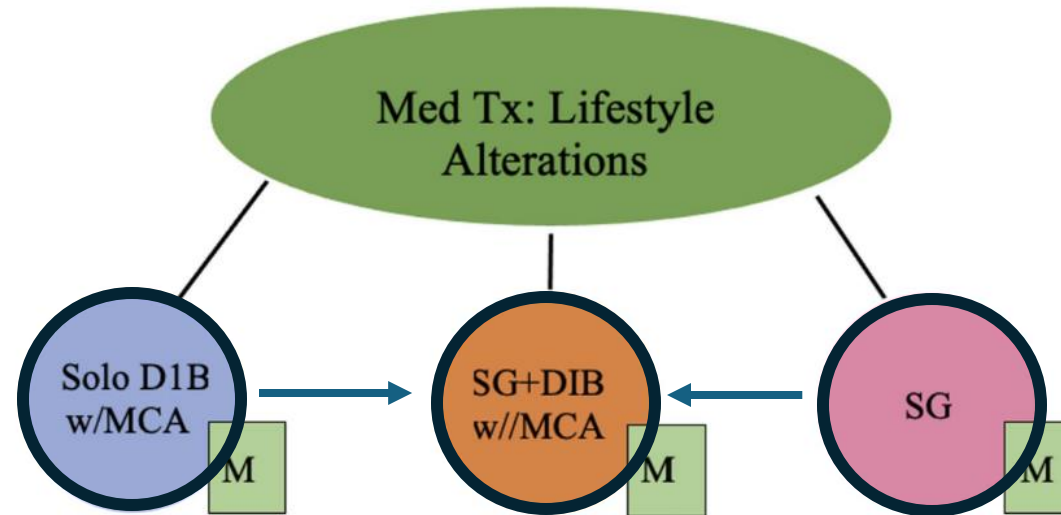
Jaime

Stage

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Abstract

One- and two-step meta require revisional surgery. Conventional noninvasive medical management is significantly less effective and durable than MBS, and also, not risk free. The chronic relapsing nature of severe obesity and its comorbid diseases suggests the value of a *staged minimally invasive* (SMI) treatment approach that anticipates the necessity of long-term obesity management. SMI strategies consider briefer stepwise surgical and medical treatments that can be deployed serially and/or concomitantly. By modeling obesity management on principles similar to those of staged cancer or heart failure treatment, the SMI approach offers patients safe, flexible pathways wherein each treatment stage delivers meaningful efficacy and, if needed, a clear roadmap to the next best therapeutic option. This perspective article proposes a conceptual framework for consideration and research validation.

Key Points

- 1- and 2-step MIS for chronic relapsing severe obesity may still need revisional MBS
- *Staged minimally invasive* (SMI) strategies offer safe flexible surgical+medical paths
- SMI approaches provide efficacy at each stage + roadmap to next best therapy option
- SMI approaches may reduce or remove persistent barriers to MBS utilization

Keywords Metabolic/bariatric surgery · MBS · Conventional medical therapy · Sleeve gastrectomy · SG · Duodeno-ileal anastomosis · DIB · Single-anastomosis duodeno-ileostomy · SADI · Magnetic compression anastomosis · MCA · Magnetic DIB

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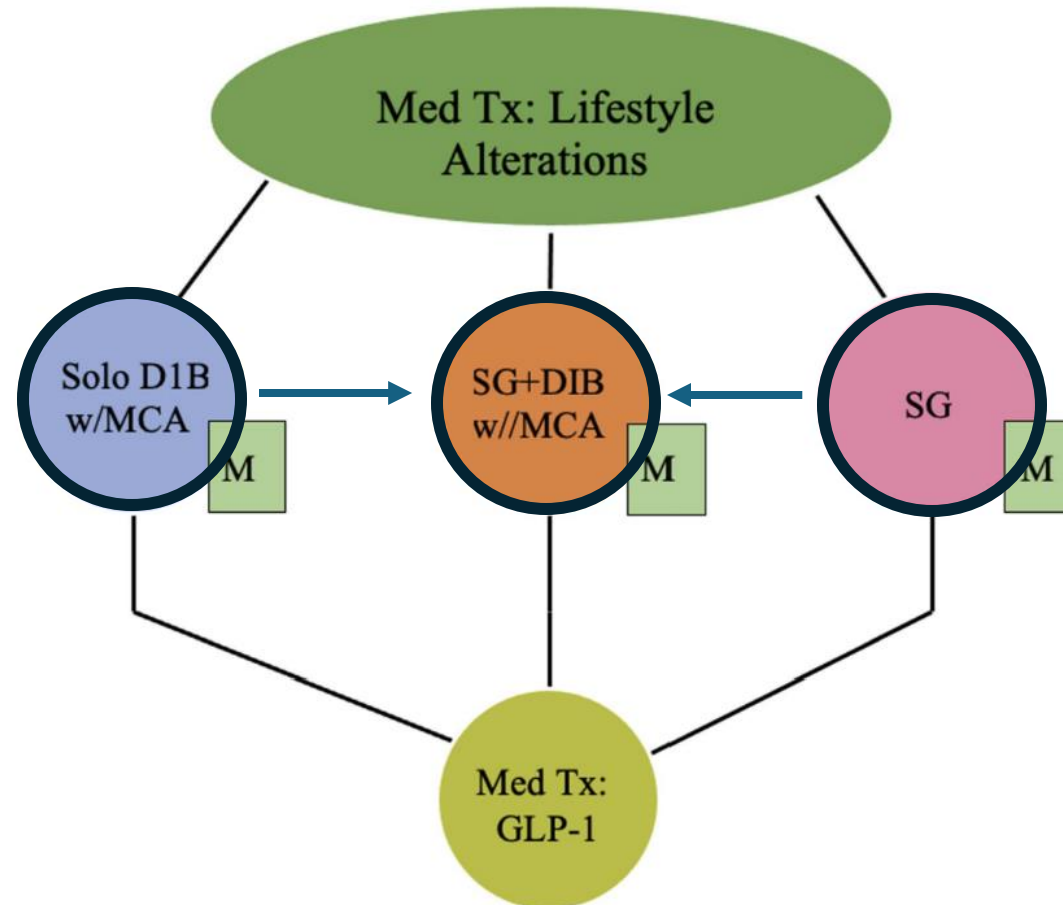
Stage

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Abstract

One- and two-step meta require revisional surgery than MBS, and also, not the value of a *staged* management. SMI strategies concomitantly. By modeling the SMI approach offers if needed, a clear roadmap for consideration and research validation.

Key Points

- 1- and 2-step MIS for chronic relapsing severe obesity may still need revisional MBS
- *Staged minimally invasive* (SMI) strategies offer safe flexible surgical+medical paths
- SMI approaches provide efficacy at each stage + roadmap to next best therapy option
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Abstract

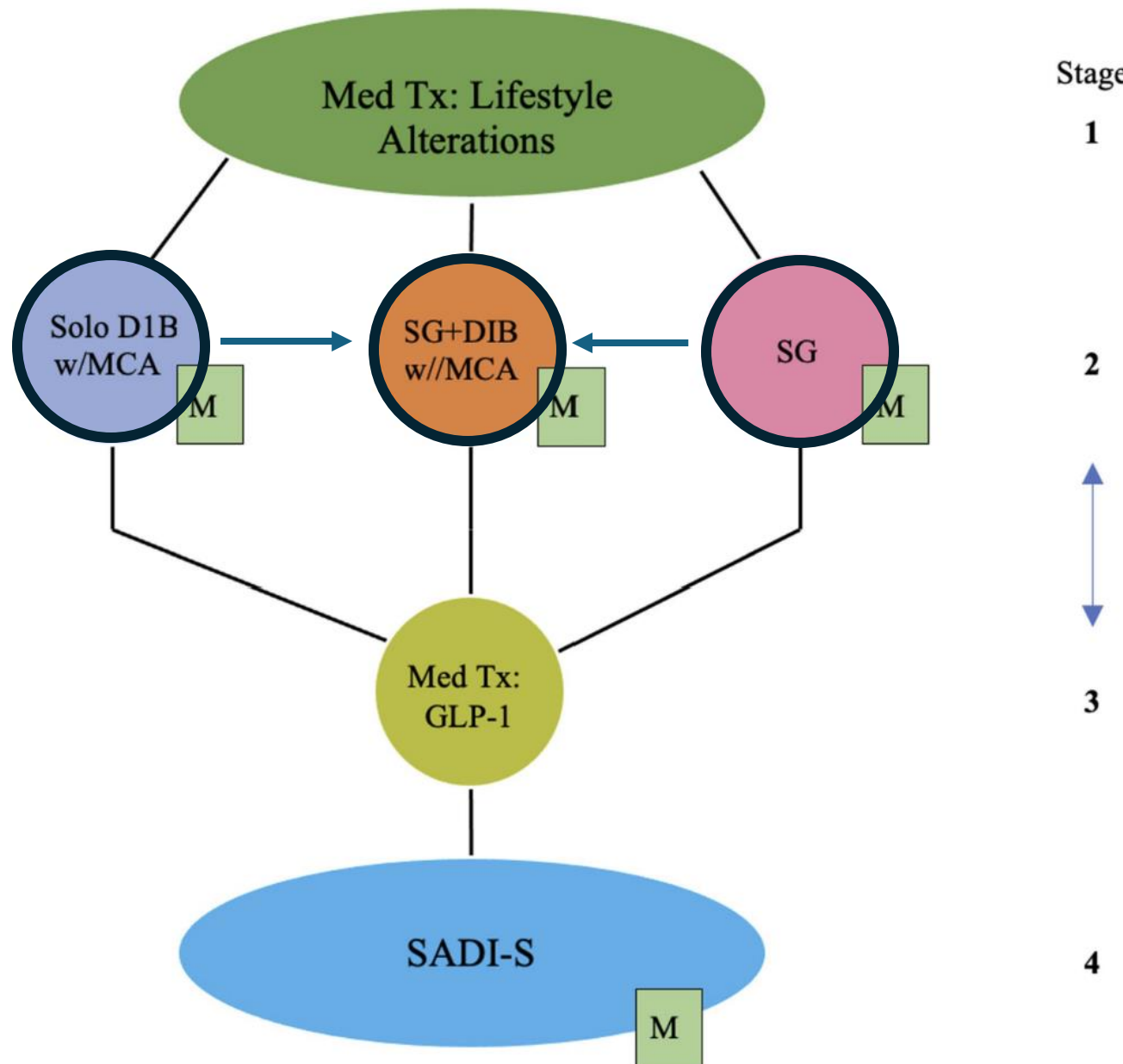
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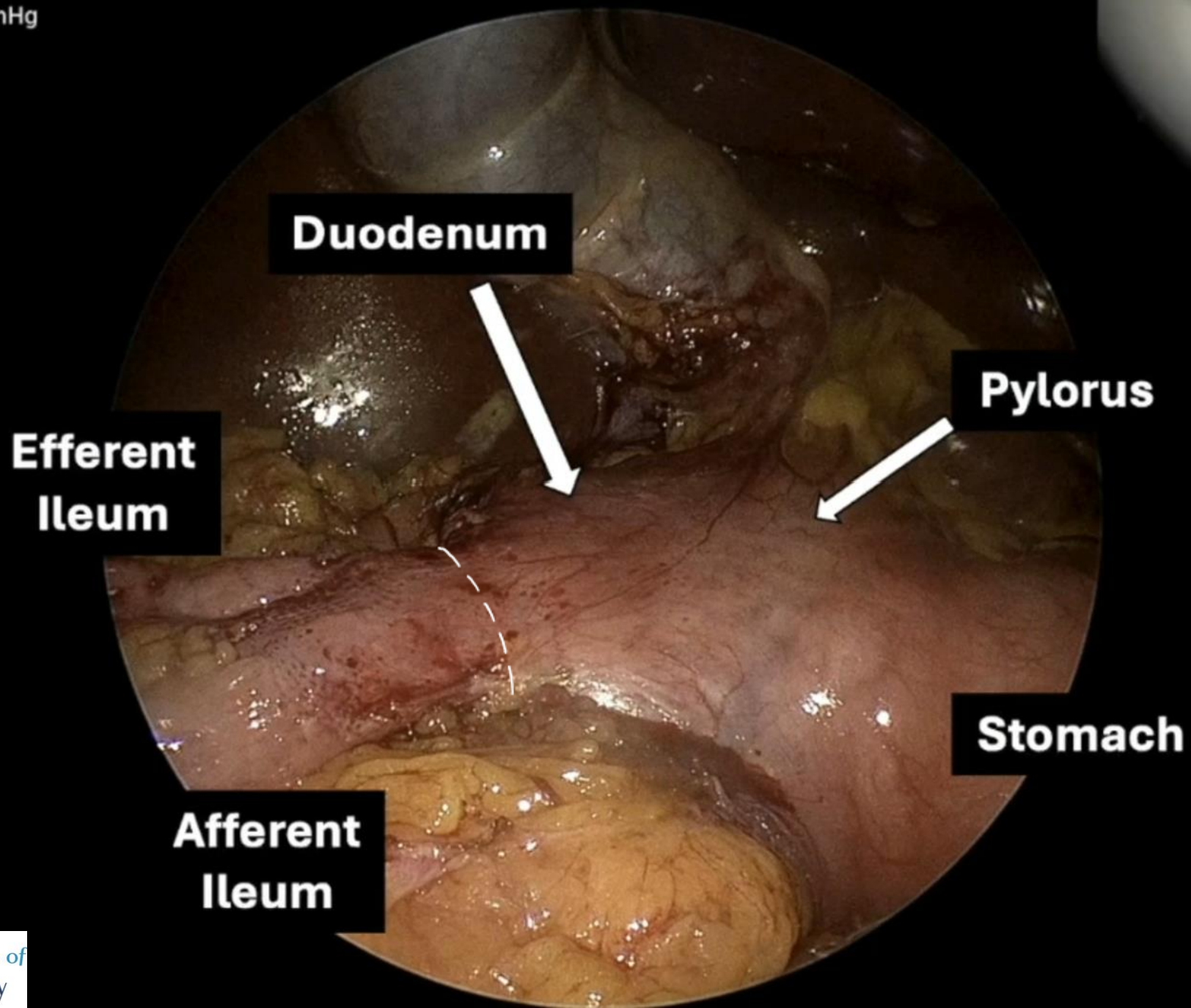
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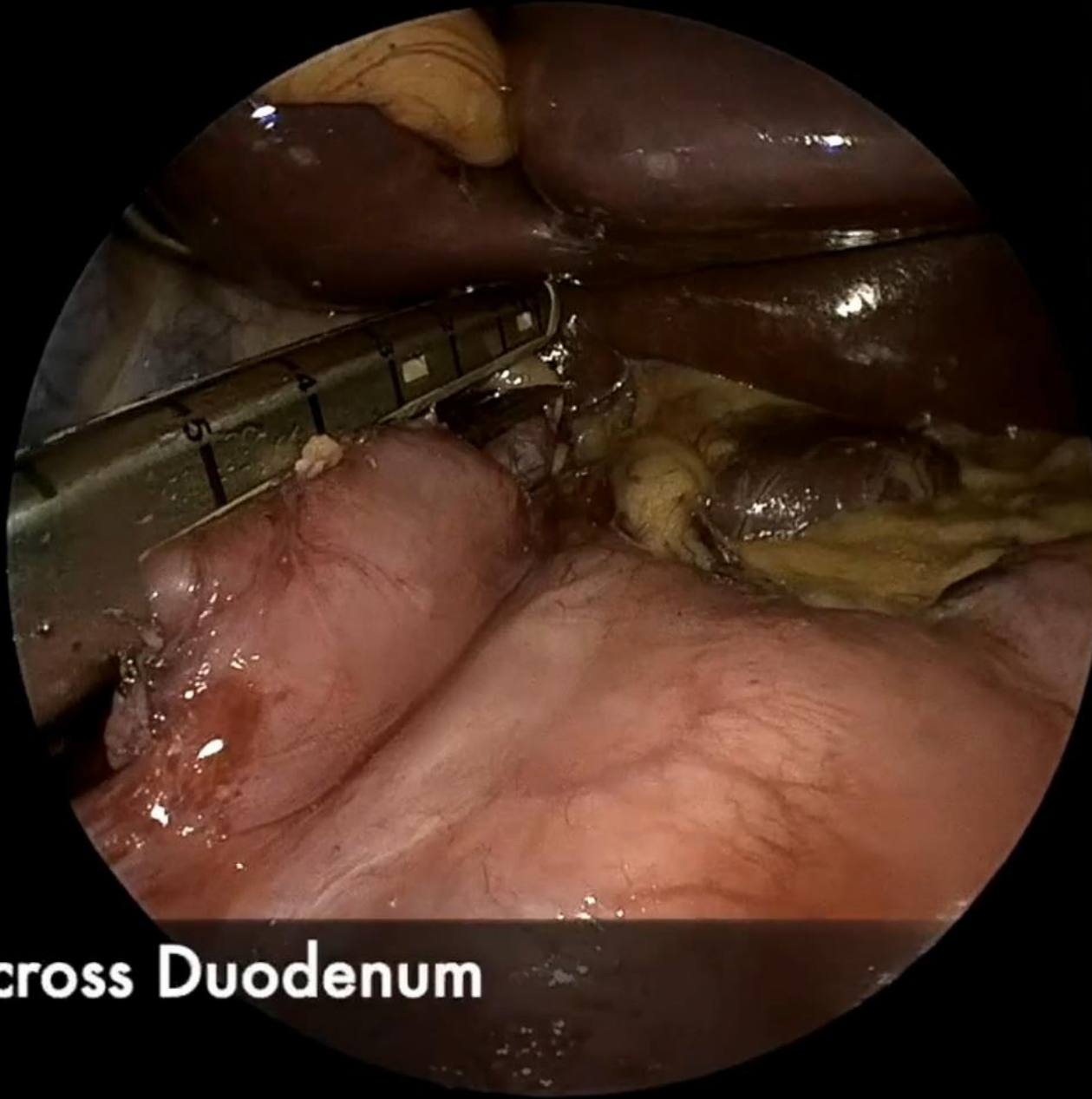


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Setpoint flow 0 l/min

Actual flow 0 l/min



Staple Fire Across Duodenum

Conclusion:

- There is no perfect operation
- GLP1 changed the rules of the game
- Surgery must evolve for safer and more outpatient settings
 - Compression Magnet Anastomosis may help decrease complications and attracts patients to come forward



**Thank you Antonio for your friendship
And for all you have done for our field and our IFSO**

