

The Shrinking Incision

Why surgery survives—but
loses the default

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Please keep your objections sterile.

Disclosures

- Research Grant, Johnson & Johnson
- Research Grant, Medtronic
- Research Grant, GI Dynamics
- Research Grant, Hospital Oswaldo Cruz Bioscience Institute
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- SAB: Morphic Medical, Medtronic, Johnson & Johnson, Regeneron

Surgery survives. The mainstream model does not.

DEFAULT  **SELECTIVE**

01

GERD

02

Appendix

03

Coronary

04

Obesity

05

Same pattern

The operation survives. The waiting list changes.

GERD: medication narrowed surgery's role

5-year estimated remission

92%

Esomeprazole

optimized long-term therapy

85%

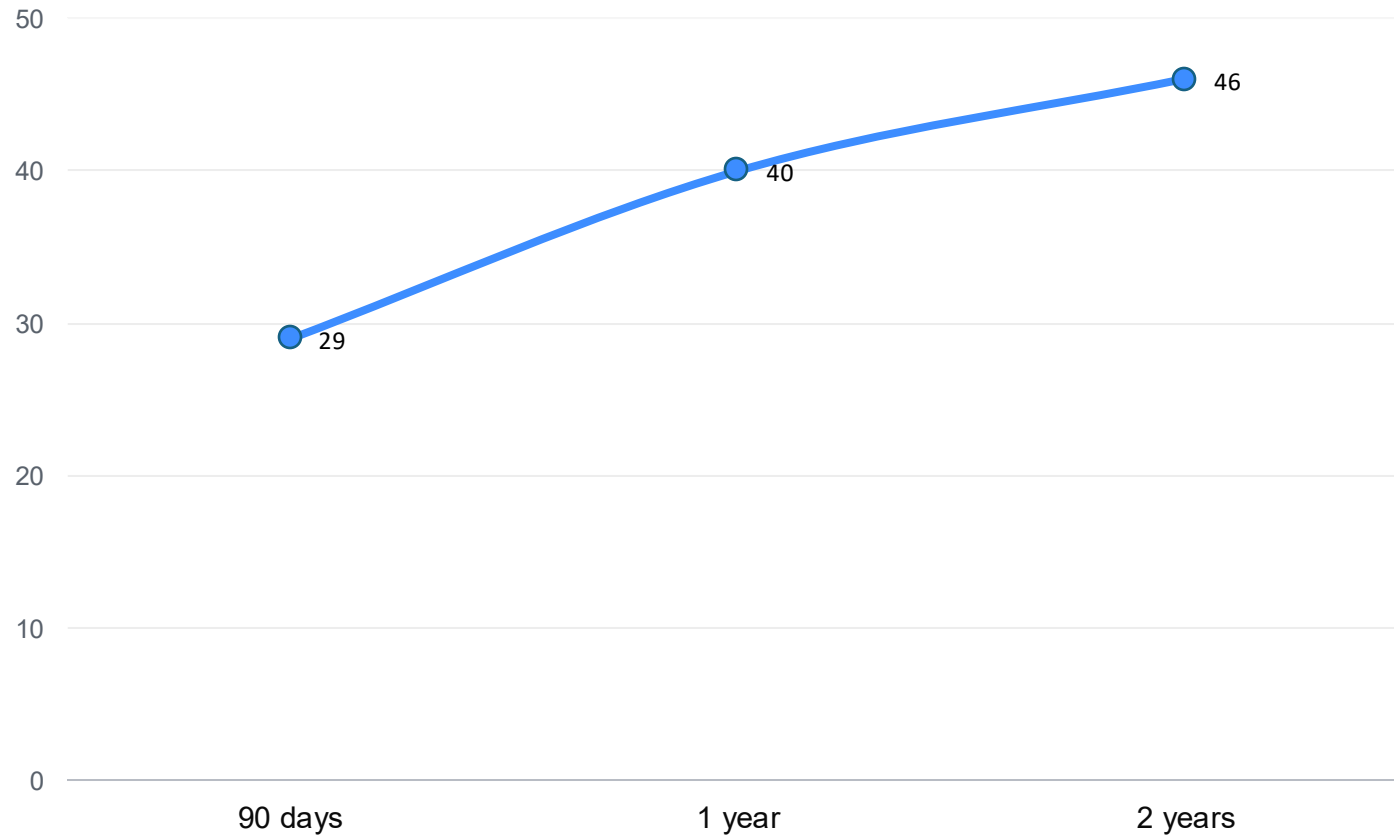
Laparoscopic surgery

standardized antireflux procedure

When medication controls disease, surgery becomes selective.

Surgery still matters for selected symptoms and trade-offs. It just lost the automatic invitation.

Appendicitis: antibiotics made surgery optional



30-day health status

YES

Antibiotics were noninferior

What actually shrank

By two years, 54% had not undergone appendectomy.

The appendix survived. So did the surgeon—just with fewer cases.

Stable CAD: routine intervention became selective

ROUTINE INVASIVE STRATEGY

NO

No overall reduction in the primary composite or death over median 3.2 years.

Hard outcomes

SYMPTOMATIC PATIENTS

YES

Health-status gains were largest when angina was daily or weekly.

Selected benefit

Not a CABG-only trial. The reflex referral still needed revascularization.

Drug efficacy is moving faster than surgical innovation

Mean body-weight reduction

20.9%

Tirzepatide • 2022

SURMOUNT-1 • 72 weeks

25.0%

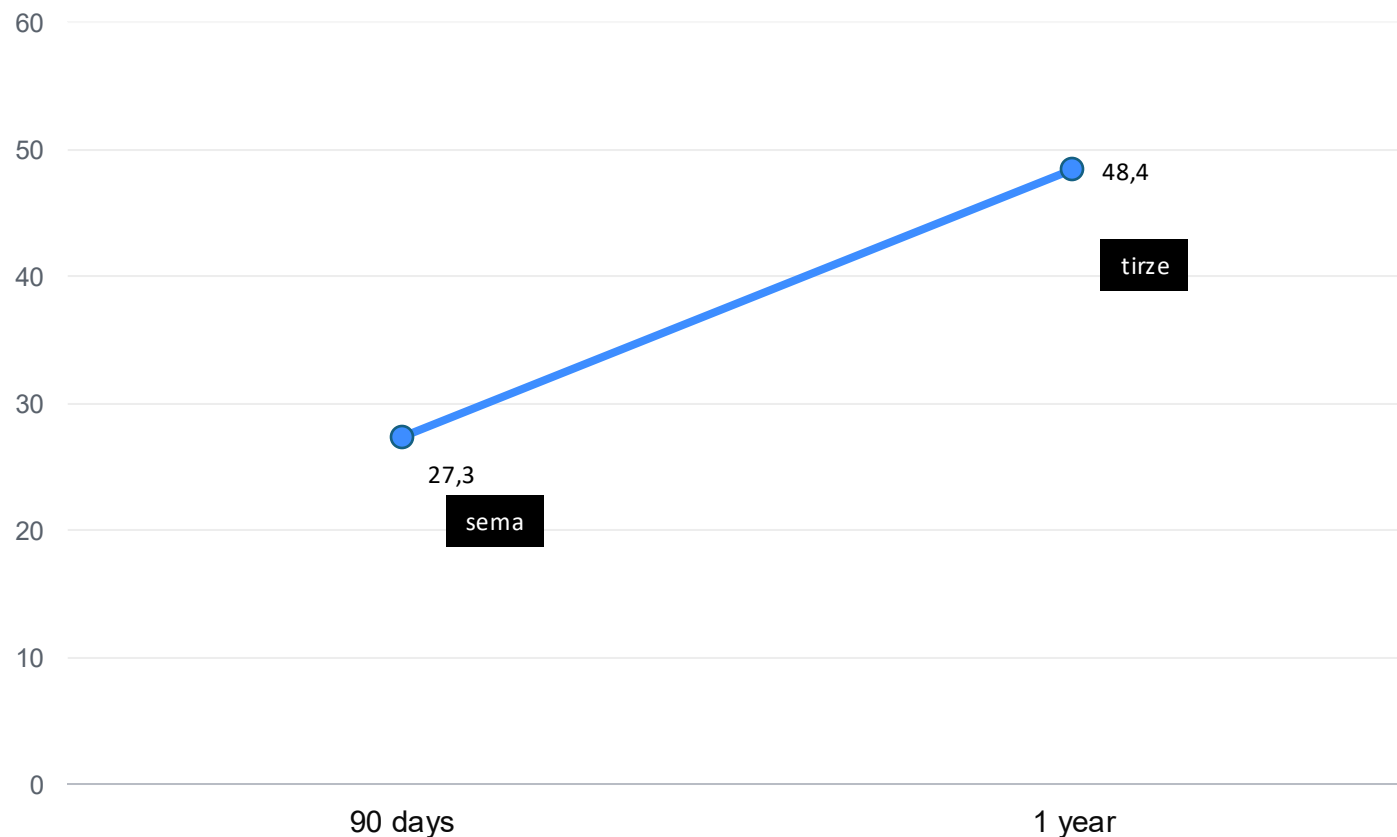
Retatrutide • 2026

TRIUMPH-1 • 80 weeks • TRT estimand

The benchmark did not merely rise—it entered surgery's neighborhood.

Different trials and estimands; the strategic point is innovation speed, not a head-to-head comparison.

Nearly half crossed the **20% threshold**



Participants with $\geq 20\%$ loss

1.8x

Tirzepatide vs semaglutide

Why surgery should worry

The obesity contest is already drug versus drug—not drug versus placebo.

The “we are still more effective” slide has entered hospice.

Retatrutide has entered the surgical range

EFFICACY ESTIMAND

28.3%

Assumes participants remain on treatment without prohibited rescue.

Biological ceiling

TREATMENT-REGIMEN ESTIMAND

25.0%

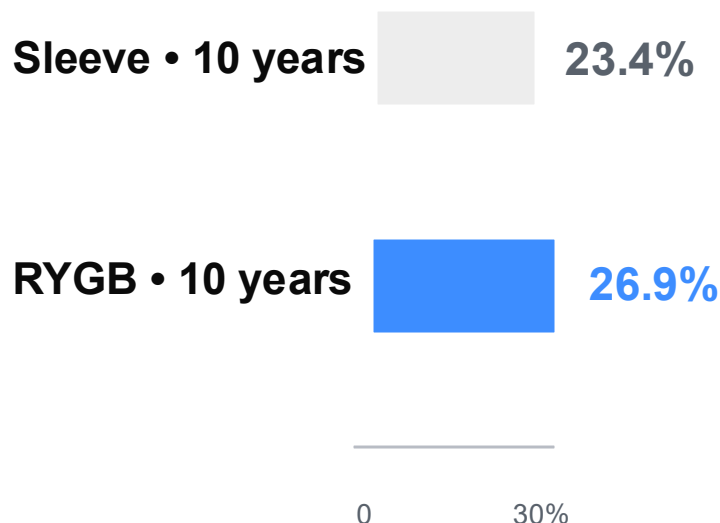
Counts discontinuation and other weight-management treatment.

Strategic reality

Even the footnote lost weight.

Medicine is now in surgery's numerical neighborhood

MEAN TOTAL WEIGHT LOSS — CROSS-TRIAL



25.0%

**Retatrutide • 80 weeks
treatment-regimen estimand**

Not head-to-head. Different populations, clocks, and treatment models.

Surgery's moat is now durability—not magnitude.

Unfortunately, pharma's clock is running faster.

5 forces turn surgery from default into "selection"

01	Efficacy	The numerical gap is closing.
02	Reversibility	A drug can be stopped; anatomy is harder to undo.
03	Scale	Manufacturing scales faster than operating rooms.
04	Iteration	Molecules improve every cycle.
05	Preference	No incision is the easier patient proposition.

The scar is small. The competitive problem is not.

After RYGB





The market does not disappear—it shifts upstream

PHARMA

Becomes first-line

chronic • combinable • scalable •
upstream

MEDTECH

Concentrates at the edge

revision • rescue

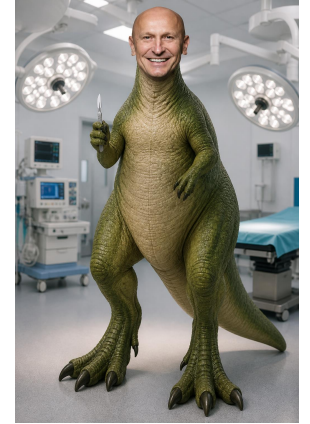
SURGEONS

Do fewer, harder cases

complexity • complications •
refractory disease

Smaller does not mean irrelevant. It does mean smaller.

Surgery does not disappear. It contracts.



Survival means becoming smaller—and more selective.

The no-brainer: treat disease, not kilograms/pounds, no BMIs only



Original Investigation | Nutrition, Obesity, and Exercise

New Obesity Definition and Clinical Obesity Prevalence for Global Metabolic Bariatric Surgery

Simone Cremona, MD; Ricardo V. Cohen, MD; Francois Pattou, MD; Anna Casajoana, MD, PhD; Guilherme Sampaio Souza, RN; Violeta Raverdy, MD; Helene Verkindt, MD; Beatriz T. L. Blasio, MD; Pia Roser, MD; Robert Caiazzo, MD, PhD; David Benaiges, MD, PhD; Tarissa B. Zanata Petry, MD; Francesco Rubino, MD

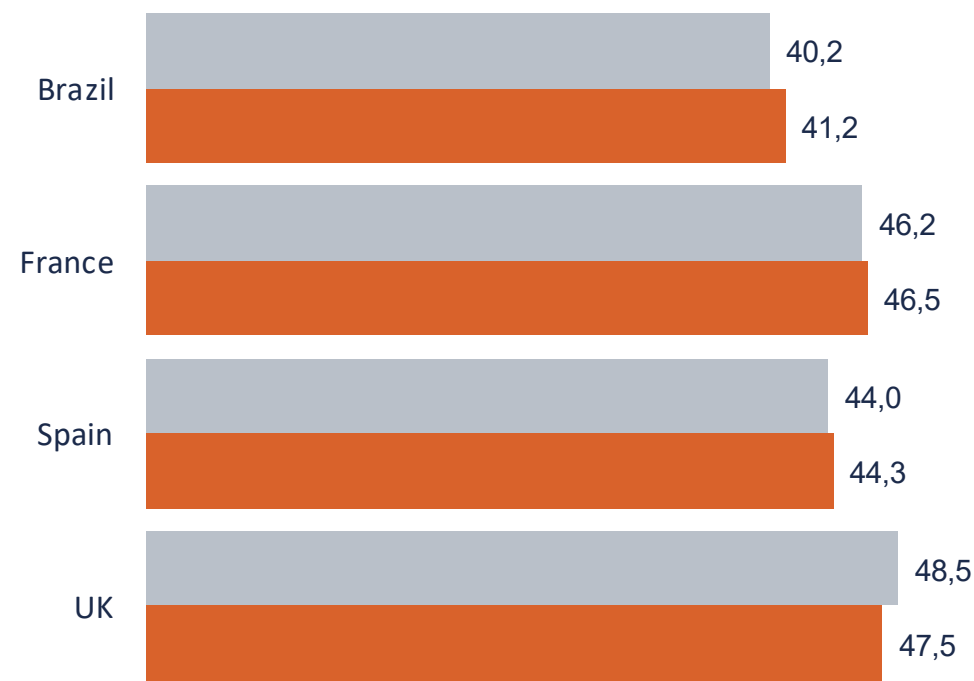
Same operation. Better indication. Earlier referral.

Same BMI. Very Different Disease.

Clinical vs preclinical obesity among 2,316 MBS candidates across 4 countries

BMI is nearly identical

Mean BMI by cohort, kg/m² — no significant difference in any cohort



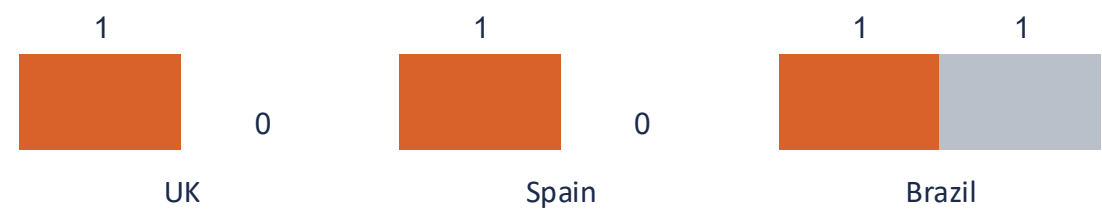
Across cohorts: clinical obesity 41.2–47.5, preclinical obesity 40.2–48.5 — BMI category mix (<40 / 40–49 / ≥50) was also comparable between groups.

Clinical obesity Preclinical obesity

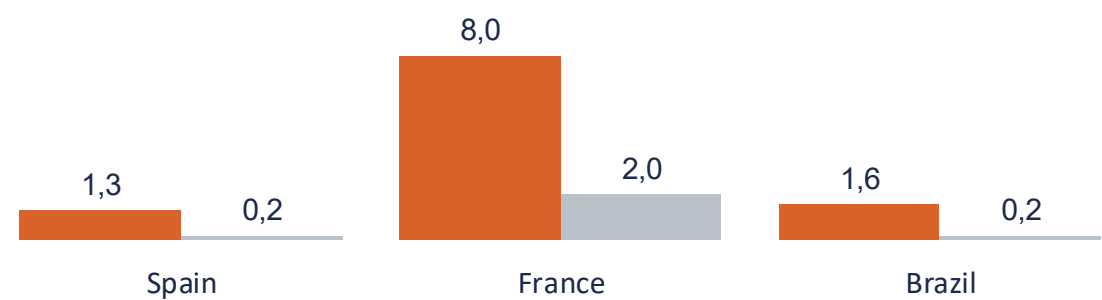
Disease severity is far greater in clinical obesity

— at every BMI level, in every cohort measured (P < .001 for all comparisons)

Charlson Comorbidity Index, median



Framingham 10-year cardiac risk score, median



Bottom line: BMI looks the same in both groups — disease burden does not. Clinical status, not body size, should guide surgical prioritization.

Weight-loss surgery?

Losing
relevance

Disease-directed metabolic surgery?

Our
lifesaver

Treat kilograms/pounds, arrive late.

Treat disease, move upstream.

Same scalpel. Better indication.

XXX IFSO WORLD CONGRESS

"Advancing Multimodal Obesity Care"

24-27 August 2027

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