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SINGLE ORIFICE OUTFLOW RECONSTRUCTION IN RIGHT LOBE GRAFT LIVING DONOR LIVER TRANSPLANTATION: A SINGLE-CENTER STUDY IN VIETNAM

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Background: Outflow reconstruction is one of the key requirements of a successful living donor liver transplantation. The aim of study is to evaluate the technical characteristics and results of outflow reconstruction in living donor liver transplantation using right lobe graft in a center in Vietnam.

Methods: The prospective study was performed on 52 cases of living donor liver transplantation using right lobe graft at 108 Military Central Hospital from January 2019 to December 2020. Polyester prostheses were used in reconstructing the MHV when the remnant liver volume was less than 35% of the donor liver volume. Venous branches with diameter ≥ 5mm were preserved and anastomosed to the prosthesis.

Results: There were 42 cases of using the extended lobe living donor liver transplant including the middle hepatic vein (HV) (80.8%) and 10 cases of the modified right lobe graft with the middle HV reconstructed from the V5 and/ or V8 branches (19.2%) by using polytetrafluoroethylene artificial vessels. We conjoined the MHV and RHV as a single orifice hepatic vein. The HV were enlarged to the left and downwards at the orifice of the recipient's right hepatic vein, with a mean incision length of 14 mm and 9.7 mm, respectively. A total of 15/52 accessory right inferior HV with diameter > 5 mm were anastomosed directly to inferior vena cava (IVC) in an end-to-side fashion in recipient (28.8%). There were 3 cases of middle hepatic vein obstruction (2 stenoses, 1 occlusion) (5.7%). The mortality rate of hepatic venous outflow obstruction was 1,9%. The caliber of HV anastomosis (< 30 mm) was an independent risk factor for hepatic venous outflow obstruction.

Conclusions: The single orifice hepatic vein reconstruction in LDLT using a right lobe graft is a simple and feasible surgical technique, and it does not require cadaveric vessels.

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