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Difficult recipient total hepatectomy

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Lecture : The key step in LDLT is obtaining inflow and outflow, including hepatic artery, portal vein and bile duct to make functional liver graft after implantation. However, in cases with previous major hepatic surgeries, placed vena cava metallic stent or previous liver transplantation or previous hepatic surgery with portal vein thrombosis, are among the most difficult cases to perform to perform transplant hepatectomy followed by actual vascular reconstruction. In order to obtain hilar vascular structures with previous hilar surgeries, intrahepatic Glissonean dissection is the key technique. The technical point in the technique is dissect liver parenchyma using a scissor to obtain intrahepatic 1st degree Glissonean pedicles under inflow control. In my presentation, I am going to show intrahepatic Glissonean dissection technique performed for a case with right hepatectomy with hilar dissection and re-do DDLT after previous LDLT with Roux-en-Y bile duct reconstruction. Another case is re-do DDLT after LDLT followed by metallic IVC stent placement for vena cava stenosis. In the case, pericardium was opened through the diaphragm and supra-hepatic vena cava was controlled in the pericardium, followed by total hepatectomy including stented IVC. Sure, the hilar dissection was performed using intrahepatic Glissonean dissection technique. The last topic is vanished portal vein with huge collateral vessels for portal inflow via the previous cut surface into the native liver. The point of such a case is even though the portal vein looks vanished on CT scan, thrombosed portal vein with a diameter could be identified and used for PV-PV reconstruction. In conclusion. Pringle maneuver, Intrahepatic Glissonean dissection and the use of unvarnished portal vein for reconstruction is the key techniques in difficult transplant hepatectomies.