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Tips for outflow reconstruction in salvage or Re-LDLT

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Lecture : For technically successful LDLT, We should take care of Here 5 factors. Today, I will focus on Outflow reconstruction. As prerequisites for Post-transplant Good outflow, Following 3 Operative factors should be satisfied successfully. 1st, Bench operation of Graft's HVs, 2nd, Venoplasty of recipient's HV & IVC, and 3rd, securing the voluminous reservoir space after Total hepatectomy to accommodate liver graft. Key factors of Good outflow in Salvage or Re-LDLT are shown here. When you perform bench procedure in the graft side, HV orifice should be bigger than original one, and multiple HV openings such as Short HVs need to be transformed into one HV opening. In the recipient's side, venoplasty should performed to make an oval-shape bigger orifice, and then You should perform HV anastomosis having a shape of short-stumped posterior wall and pouch-shaped anterior wall. Securing the enough space to accommodate liver graft is also important to establish Good outflow. However, Due to operative characteristics, Mainly RUQ or sometime LUQ space after TH is often too small to accommodate the implanting liver graft. As a solutions, we should prepare sufficient vascular grafts for interposition or patch-venoplasty for Bench procedure. In the recipient's side, we should fully dissect retro-Hepatic IVC from retro-caval attachment at around Hepato-caval confluence for venoplasty or preparation of IVC total clamping when necessary. Also, we have to mobilize-down of Rt. kidney, adrenal gland, and even colonic hepatic flexure when graft-accommodating space is limited. As major considerations of HV reconstruction in Salvage or Re-LDLT, we need to prepare veno-venous bypass in advance, and also we have a plan how to reconstruct HVs. I will show several cases of salvage or re-LDLT cases as a viedo-clips, especially about outflow reconstruction. As a conclusion, in Salvage or Re-LDLT, in order to achieve post-transplant good outflow, we should balance 3 key factors including bench operation, recipient wenoplasty, and voluminous reservoir space after TH.