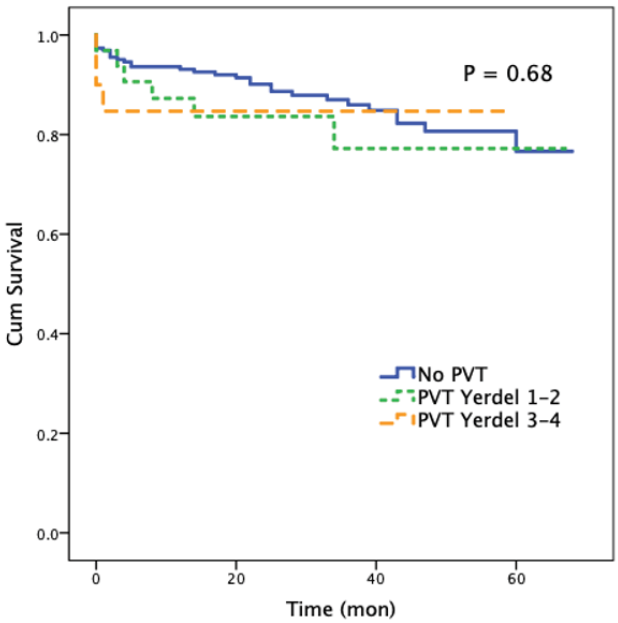
As shown in Figure 2, no significant difference in survival between the groups was evident. However, the group of advanced PVT (Yerdel3-4), was characterized by a higher rate of relaparotomy (p=0.006).



Conclusions: Sufficient portal inflow is necessary to secure graft and patient following the LT. Patients with advanced PVT may demonstrate outcomes comparable to non-PVT recipients if the appropriate surgical and perioperative strategy was chosen.

P-010

Living donor liver transplantation in unresectable huge hepatocellular caricinoma with congenital absence of the portal vein: a case report

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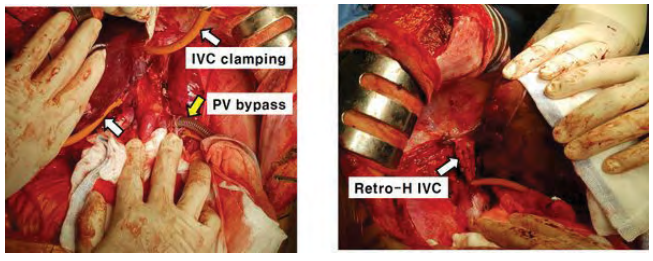

Fig 1. No tough total hepatectomy

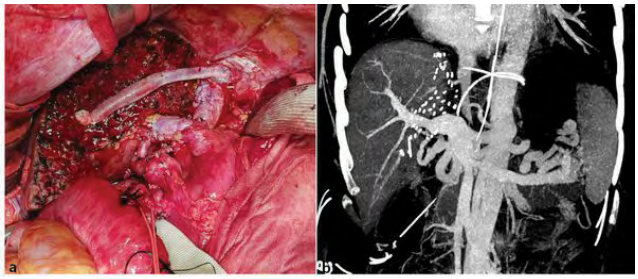

Fig 2. Post operative findings.

Congenital absence of te Portal Vein (CAPV) increased with the development of imaging techniques. A treatment method for HCC with CAPV has not yet been established. We report a transplant case of a patient with unresectable huge HCC with CAPV. A 34-year-old man visited the local hospital for reconstructive surgery after head trauma. A huge HCC was discovered incidentally during preoperative examination. He was healthy except for two head trauma. He visited our center for HCC treatment. Radical resection was impossible due to a large tumor of about 15 cm and multiple nodules suspected of hepatocellular carcinoma. He has a congenital absence of portal vein (CAPV) with a portal vein shunt. We decided to do LDLT. Prior to LDLT, embolization was performed twice to reduce tumor burden. LDLT underwent using right lobe from his brother on 28 March 2019. Before the liver mobilization we first did hilum dissection. The large collateral vein was dissected as long as possible. No-touch liver resection was performed with a left approach. (Fig 1.) The graft portal vein was anastomosed with a collateral vein. When the doppler was checked the post operative one day, Middle hepatic vein (MHV) and inferior right hepatic vein (IRHV) was undetected. We immediately inserted stents in the MHV and IRHV. He was discharged 14 days after surgery without further complications. (Fig 2.) The everolimus was added 1 month after transplantation and steroids were stopped 3 months after transplantation. He is doing well with no recurrence. Since hepatocellular carcinoma for CAPV is due to PV obstruction, LT may be a good choice for patients suffering from HCC with CPAV.

P-011

Simultaneous right lobe live donor liver transplantation and off-pump coronary artery bypass grafting

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Background: Advanced coronary artery disease is quite common among liver transplant candidates and is considered a contraindication for liver transplantation. On the other hand, liver failure also increases the risk for cardiac surgery. Thus, combined

liver transplantation and coronary artery bypass grafting might be an effective solution to overcome these concomitant severe conditions.

Methods: Among the 878 adult liver transplant recipients; two required combined liver transplantation and coronary artery bypass grafting. The cardiac procedure was performed off-pump on the beating heart and LIMA was used for LAD anastomosis while saphenous vein grafts were used for the RCA and OM (obtuse marginal) vessels. The first patient was 66 years old cirrhotic male due to HBV cirrhosis with a MELD score of 18 and severe CAD at LAD and RCA. The second patient was a 65 years old cirrhotic female due to NASH and HCC and severe CAD at LAD, RCA, and OM. Both patients underwent first coronary artery bypass grafting, then a right lobe live donor liver transplant procedure was performed.

Results: Both patients tolerated the procedures well and the postoperative courses were uneventful in the ICU in terms of heart and liver functions. They were discharged home on days 15 and 18 and are currently alive and well during the 10 and 43 months of follow-up.

Conclusions: Liver transplantation and coronary artery bypass grafting appear to be safe and effective in cirrhotic patients with advanced CAD. Patients seem to benefit most from multidisciplinary preoperative evaluation and coordination between cardiac and liver transplant surgery teams.

P-013

Management of hepatic duct in right lobe total robotic donor hepatectomy

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Description of the video:

Background: During right lobe (RL) total robotic donor hepatectomy (RDH), surgeons have different preferences of timing (early versus late) and techniques of right hepatic duct (RHD) division and closure, using Titanium clips, Hem-o-lok® clips, or suture closure. We describe our technique which is safe, reproducible and replicates the open technique. Of 3423 LDLT from 2004-21, 41 were RDH- the first 5 hybrid and 36 intended as total RDH. There were 4 conversions, while 32 were total RDH. Donors with graft size >1000gm, GRWR < 0.8%, donor remnant < 35%, multiple RIHV, >2 hepatic ducts, and Type C/D portal vein were excluded.

Technique: The RHD planning is done on preoperative 3D MRCP. After RL mobilization and cholecystectomy, the right hepatic artery is dissected on the right, from the undersurface of the bile duct with a needle driver and bipolar Maryland forceps. The inferior edge of the RHD is defined, the hilar plate lowered, the HD confluence and the left edge of the left HD identified. After 60-70% transection (including caudate), the HD confluence is displayed with traction on the cystic duct stump, and RHD(s) is/are divided with scissors. The HD stump is sutured with continuous 6-0 PDS; separately in case of multiple HDs. The remaining hilar plate is sharply divided, bleeding controlled with swab pressure and sutures. The transection is completed with the hanging maneuver. After graft removal, the hilar plate is oversewn with 6-0 PDS. HD stump is checked for leaks with methylene blue via the cystic duct.