MAJOR HEPATIC RESECTION AS A LIVER GRAFT SAVING PROCEDURE

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Introduction

Retransplantation for failing graft is quite common after orthotopic liver transplantation (OLT). One of the reasons for liver retransplantation may be intrahepatic bile strictures, associated or not with hepatic artery thrombosis. However, liver retransplantation consumes a second liver graft in an area of organ shortage (1317 patient deaths on the UNOS waiting list in 1998). Moreover, liver retransplantation is associated with higher morbidity and mortality. Therefore, every attempt to save the liver graft should be performed before retransplantation. The aim of this paper is to report our experience with right hepatectomy as a graft-saving procedure in liver recipients.

Material and Methods

In a consecutive series of 170 adult OLT, 4 male patients (mean age: 45 years, 23 to 55) underwent right hepatectomy (Couinaud’s segments V, VI, VII, VIII) in the post transplant period. Causes of liver failure leading to OLT were HCV in 3 cases and chronic liver failure secondary to Wilson’s disease in one.

Three patients (Patients 1, 2, 3) developed intrahepatic biliary strictures, related to late hepatic artery thrombosis in one case. As these biliary strictures were mainly localized in the right part of the liver, classical right hepatectomy was performed (delay between OLT and right hepatectomy: 14, 75, 78 months).

The fourth patient (Patient 4) developed post transplant cholangitis and choledocholithiasis in the right liver. This patient underwent right hepatectomy 48 hours after OLT.

In all cases, classical right hepatectomy was performed without Pringle’s maneuver and without mobilization of the left liver and the surrounding adhesions in order to preserve its collateral vascularization. Parenchymal transaction was performed with an ultrasonic dissector and with the use of clips for hemostasis and bile leak. The transected surface was then sprayed with fibrin glue. A cell saver was used in all procedures.

Results

All patients are alive without retransplantation (mean follow-up 28 months, 13 to 48). One patient developed postoperative biliary fistula treated conservatively. Mean peroperative hospital stay was 20 days.

Patient 4 developed significant cholangitis secondary to late artery thrombosis and was replaced on the waiting list for retransplantation.

Conclusions

Major hepatectomy may be proposed as graft-saving procedure in selected liver recipients with good outcome on both patient and graft survival. The main indication seems to be preservation injury to the intrahepatic bile ducts that can be sometimes localized to a liver lobe. In our experience, diffuse intrahepatic bile duct strictures are difficult to manage conservatively and often require retransplantation.