The 2006 Joint International Congress of ILTS, ELITA, LICAGE Scientific Program May 3-6, 2006 Milan, Italy

All sessions will take place, unless otherwise noted, in the Milan Marriott Hotel

Wednesday, May 3

Astellas Sponsored Symposium
Unusual Problems in Liver Transplantation
Salone Washington and Club

8:00 am-5:00 pm

Poster Session 1
Chairs: Nigel Heaton, MD, and Timothy M. McCashland, MD
Manzoni and Monti

5:30-7:00 pm Presenters in Attendance

#1 **CHLDREN WITH IFALD REQUIRE HIGHER VOLUMES OF BLOOD PRODUCTS AT TRANSPLANTATION THAN THOSE WITH BILIARY ATRESIA.**
Gillian Derrick, James Bennett, Peter Bromley, Alistair Millar, Darius Mirza, David Mayer.
Anaesthesia, Birmingham Children's Hospital, West Midlands, United Kingdom; Transplantation Surgery, Birmingham Children's Hospital, West Midlands, United Kingdom; Transplantation Surgery, University Hospital Birmingham, West Midlands, United Kingdom

#2 **EFFECTS OF OPERATING ROOM TEMPERATURE OF 24 ^{0}C ON CORE TEMPERATURE OF LIVING DONOR PARTIAL HEPATECTOMY PATIENTS.**
Chih-Hsien Wang, Chao-Long Chen, Kuan-Hung Chen, Chih-Chi Wang, Bruno Jawan.
Department of Anesthesiology, Chang Gung Memorial Hospital, Kaohsiung, Taiwan; Departmenet of Surgery, Chang Gung Memorial Hospital, Kaohsiung, Taiwan

#283 **INTRACTABLE PRURITUS IN PATIENS WITH HCV. PERSONAL EXPERIENCE.**

Stefano Ginanni Corradini, Luca Poli, Massimo Iappelli, Massimo Rossi, Sabina Martelli, Vincenzo Morabito, Luigi Novelli, Gilnardo Novelli, Pasquale Bartolomeo Berloco.
Chirurgia Generale e Trapianti d'Organo "Paride Stefanini", Università "La Sapienza" Roma, Roma, Italy

#284 **PRE-OPERATIVE LIVER BIOPSY IS NOT MANDATORY IN THE WORK UP OF POTENTIAL LIVING DONORS FOR ADULT LIVING DONOR LIVER TRANSPLANTATION.**

Nazia Selzner, Stephanie Wilson, David Grant, Lesley Adcock, Les Lilly, Nigel Girgrah, Maha Guindi, Paul Greig, Gary Gallagher, Ian McGilvray, Philip Wong, Mark Cattral, Markus Selzner, Shimul Shah, Gary Levy.
Multi Organ Transplant Program, University Health Network - Toronto General Hospital, Toronto, ON, Canada; Department of Radiology, Toronto General Hospital, Toronto, ON, Canada; Pathology, Toronto General Hospital, Toronto, ON, Canada

#285 **RIGHT LOBE GRAFT FROM LIVING DONOR FOR ADULT RECIPIENTS: HOW SMALL CAN IT BE?**

Yasuhiro Fujimoto, Hidekazu Yamamoto, Hideya Kamei, Shunji Nagai, Yoshimasa Gouda, Tetsuya Kiuchi.
Transplant Surgery, Nagoya University Hospital, Nagoya, Aichi, Japan

#286 **ACUTE LIVER FAILURE CAUSED BY AMONITA PHALLOIDES POISONING TREATED BY EMERGENCY LIVER TRANSPLANTATION.**

Anna Skwarek, Mariusz Grodzicki, Abdulsalam Alsharabi, Bogdan Michalowicz, Krzysztof Zieniewicz, Pawel Nyckowski, Joanna Sanko-Rezner, Leszek Paczek, Marek Krawczyk.
Dpt of General, Transplant and Liver Surgery, The Medical University of Warsaw, Warsaw, Poland; Dpt of Immunology, Transplantology and Internal Medicine, The Medical University of Warsaw, Warsaw, Poland

#287 **EMERGENCY GRAFT REMOVAL AFTER LIVER TRANSPLANTATION.**

Olivier Detry, Arnaud De Roover, Jean Delwaide, Michel Meurisse, Pierre Honoré.
Dpt of Liver Surgery and Transplantation, University of Liège, CHU Sart Tilman B35, Liège, Belgium; Dpt of Hepatogastroenterology, University of Liège, CHU Sart Tilman B35, Liège, Belgium

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RIGHT LOBE GRAFT FROM LIVING DONOR FOR ADULT RECIPIENTS: HOW SMALL CAN IT BE?

Yasuhiro Fujimoto[1], Hidekazu Yamamoto[1], Hideya Kamei[1], Shunji Nagai[1], Yoshimasa Gouda[1], Tetsuya Kiuchi[1]. [1]Transplant Surgery, Nagoya University Hospital, Nagoya, Aichi, Japan

Backgrounds:
Liver transplantation with graft from living donor almost always accompanied by small-for-size syndrome to various extent. The ratio, graft weight divided by recipient body weight is believed to be useful to evaluate whether the graft is sufficient for the metabolic demand of the recipient or not. In LDLT (living-donor liver transplantation), the GRWR (graft weight to recipient body weight ratio) over 1.0% has been believed to be necessary. Recently, we experienced the LDLT cases with good posttransplant outcome and survival in spite of GRWR less than 0.8%.
Patients & Methods:
This study was done by retrospective chart review. From April 1997 to September 2005, 76 liver transplants were performed in Nagoya University. They include 45 LDLT for adult recipients. Among them, 32 adults received right lobe graft [GRWR 1.04(median), 0.69 – 1.61]. The GRWR for 5 recipients is less than 0.8%. Pretransplant status, reason for transplant, MELD score, ABO compatibility, GRWR, inflow modification (ligation of splenic artery, partial portacaval shunt), HV anastomosis are reviewed. Posttransplant parameters such as prothrombin time, serum bilirubin, amount of ascites, hospital stay and survival are also analyzed.
Results:
The recipient profiles are summarized in the table. No recipient died in this group. Multiple veins were reconstructed with all patients. One recipient suffered prolonged hyperbilirubinemia, the possible cause of which is hemolytic anemia.
Conclusions:
The outcome of LDLT with small graft (GRWR < 0.8%) is satisfactory. Relatively low MELD score and ideal ABO match has a possibility to contribute to the good results. The difference in background of this report and previous reports declaring the importance of GRWR over 1% includes graft type (left or lateral vs. right), recipient age (children vs. adults) and era (improved management).

Recipients with small graft (GRWR <0.8%)

Age, Sex	disease	MELD	ABO	GRWR	HVs	Hospital stay (days)	Follow up (months)
55, M	LC, HCC	15	identical	*0.70	RHV, IRHV	50	21, alive
61, M	HBV, HCC	16	identical	+0.73	RHV, V8	39	11, alive
40, M	HBV	20	compatible	0.78	RHV, V8	#115	6, alive
48, M	HCV, HCC	11	compatible	0.69	RHV, V8	47	5.6, alive
59, M	HCV, HCC	7	compatible	+0.71	RHV, V8, IRHVx2	40	3.7 alive

* portacaval shunt, +ligation of splenic artery, #prolonged hyperbilirubinemia

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ACUTE LIVER FAILURE CAUSED BY AMONITA PHALLOIDES POISONING TREATED BY EMERGENCY LIVER TRANSPLANTATION.

Anna Skwarek[1], Mariusz Grodzicki[1], Abdulsalam Alsharabi[1], Bogdan Michalowicz[1], Krzysztof Zieniewicz[1], Pawel Nyckowski[1], Joanna Sanko-Rezner[2], Leszek Paczek[2], Marek Krawczyk[1]. [1]Dpt of General, Transplant and Liver Surgery, The Medical University of Warsaw, Warsaw, Poland; [2]Dpt of Immunology, Transplantology and Internal Medicine, The Medical University of Warsaw, Warsaw, Poland

Accidental ingestion of the *Amanita phalloides* mushroom is not uncommon in Poland. It results in severe poisoning leading to profuse lver tissue necrosis. Liver transplantation appears to be a life-saving procedure. It has to be undertaken urgently, as the period between the onset of clinical symptoms and the fatal outcome does not usually exceed 48 hours. Distending this period is possible by means of intensive artificial liver support therapy.
Clinical Material includes 9 critically ill comatous patients poisoned with *Amanita phalloides*, admitted in the period 2000-2005. All of tem presented with deep metabolic disorders and severe coagulopathy. All were listed for for super-urgent OLT, 6 underwent albumin dialysis in the Promethaeus system. 3 patients recovered, 6 were transplanted after waiting time ranging from 18 hrs to 5 days
Results: 3 of the dialysed patients improved and did no require OLT. 1 patient died in the moment of reperfusion, 2 in the postoperative period. 3 transplanted patients fully recovered.
Conclusion: Despite their extremely severe condition, *Amanita* poisoned patients can be saved by OLT, if it is performed early enough. The Promethaeus system effectively substitutes the liver function in the pre-transplant period, essentially delaying the fatal outcome. In some cases it allows to avoid transplantation.

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EMERGENCY GRAFT REMOVAL AFTER LIVER TRANSPLANTATION.

Olivier Detry[1], Arnaud De Roover[1], Jean Delwaide[2], Michel Meurisse[1], Pierre Honoré[1]. [1]Dpt of Liver Surgery and Transplantation, University of Liège, CHU Sart Tilman B35, Liège, Belgium; [2]Dpt of Hepatogastroenterology, University of Liège, CHU Sart Tilman B35, Liège, Belgium

Introduction: Two-stage liver transplantation, i.e. a procedure rendering a patient anhepatic for a uncertain period of time before registration for emergent liver transplantation (LT), has been seldom described in case of unstable fulminant liver failure, of massive hepatic trauma or liver graft primary non function (PNF). In this report the authors describe their experience in early liver graft removal after LT.
Patients and methods: Four young female patients (mean age 36 years) underwent LT for various etiologies (PSC, HBV-HCC, alcohol-paracetamol, idiopathic cirrhosis). All underwent early (day 0 to day 14) emergent total liver graft removal for various reasons (uncontrollable preoperative hemorrhage, uncontrollable postoperative hemorrhage due to PNF, graft necrosis due to vascular occlusion) and were registered for urgent reLT. All went back to the ICU in an anhepatic state and underwent maximal supportive therapy including CVVH and MARS support (1 case). Body temperature was maintained between 34 and 37°C.
Results: All patients survived until a cadaveric liver graft became available. In 3 cases they underwent reLT after a mean anhepatic phase of 21 hours. Two survived without any sequel and are alive and well at follow-up. The fourth patient experienced an anhepatic phase of 84 hours. After reLT, the patient fully recovered from the neurologic point of vue and was extubated. She eventually died from multiple organ failure 14 days after reLT.
Discussion: These cases illustrate that survival in anhepatic state is possible for at least 24 hrs. The potential full neurologic recovery after 84 hours of anhepatic state (the longest ever reported to date) raises several questions on the pathogenesis of intracranial hypertension in acute liver failure, reinforcing the “toxic liver” hypothesis in the etiology of brain edema in this setting.

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CHRONIC MYELOID LEUKEMIA AFTER LIVING DONOR LIVER TRANSPLANTATION.

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Background and Objective: Acute leukemia(AL) following solid organ transplantation is rare with only 10 cases of AL being reported, including six cases of acute myeloid leukemia after liver transplantation. Chronic myeloid leukemia(CML) after liver transplantation has not been reported. We report a case of living donor liver transplantation recipient who developed CML 14 months following transplantation.
Patient and Methods: This patient is a case of Hepatitis B virus-related liver cirrhosis with recurrent hepatocellular carcinoma(HCC) after previously successful trans-arterial embolization. The patient’s liver transplant was uneventful. The immunosuppression used was tacrolimus-mycophenolate-prednisolone-based. Post-transplant he received 10 cycles of doxorubicin-based(10mg/m^2) chemotherapy due to microscopic portal vein thrombosis seen in explant liver histopathology. CML was diagnosed by bone marrow biopsy and chromosomal analysis. CML cytoreduction was managed by hydroxyurea and imatinib.
Results: The patient is alive up to present writing 40 months post transplant without any episode of liver graft rejection or HCC recurrence.

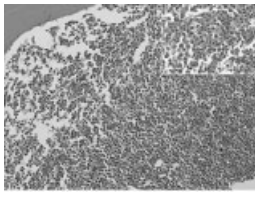

Figure1 -Bone marrow biopsy shows dense proliferation of hematopoetic cells comprsing mostly of intermediate stage and mature myeloid cells suggestive of chronic myeloid leukemia. Hematoxylin and eosin stain x 100(intel H&E x400)
Conclusion: Leukemias, although rare following solid organ transplantation, should be considered in the differential diagnosis of hematological abnormalities.