118.6

Oncologic outcomes of ABO-incompatible living donor liver transplantation for HCC patients.

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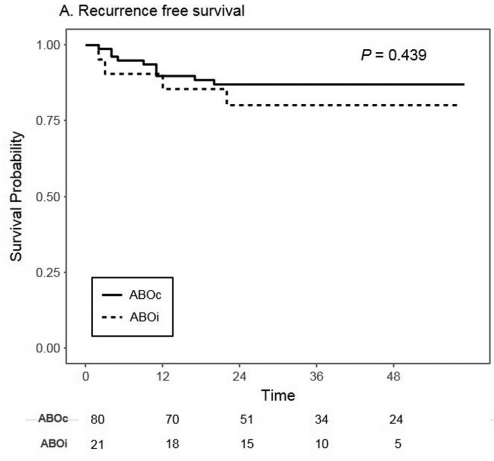
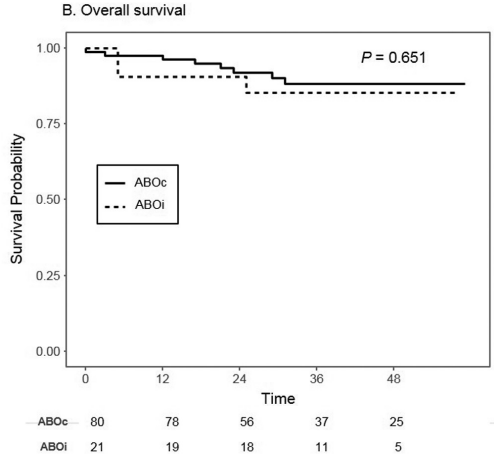
Background: ABO incompatible living donor liver transplantation (ABOi LDLT) could be one of the treatment options for hepatocellular carcinoma (HCC) to overcome organ scarcity. However, desensitization protocol including B cell depletion besides traditional T cell suppression could be a risk factor for HCC recurrence that is a major cause of graft failure and patient death. We analyzed oncologic outcomes of ABOi LDLT comparing to ABO compatible LDLT.
Methods: The data of 101 recipients who underwent LDLT for HCC were prospectively collected and reviewed. Of the patients, 21 patients underwent ABOi LT. We compared the pre- and post-transplant tumor factors, HCC recurrence and survival between ABOi and ABOc LT.
Results: There was no significant difference in pre-transplant tumor staging, recipient and donor demographics between the groups. One and 3-year recurrence-free survival rates were 89.8% and 86.9% for the ABOc LT group and 85.4% and 80.1% for the ABOi LT, respectively (P=0.439; Fig 1). One and 3-year overall survival rates were 96.3% and 88.1% for the ABOc LT group and 90.5% and 85.2% for the ABOi LT, respectively (P=0.651; Fig 2). In multivariate analysis, a pre-transplant AFP level over 400ng/mL was the only independent risk factor for HCC recurrence and poor patient survival.
Conclusions: The HCC recurrence survival and overall survival of ABOi LT were comparable to those of ABOc LT. ABOi LT is safe and feasible option for HCC patients.





118.7

Pain management in living donor hepatectomy.

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Introduction: Organ donation from living family members still composes the majority of organ source in our country. Living donor hepatectomy (LDH) is often associated with significant acute and chronic postoperative pain and postoperative outcomes are effected by pain perception.
Our postoperative analgesia regimen includes a thoracic epidural (bupivacaine 0.125%, fentanyl 0.1 mg/mL; 4 mL/h, bolus 5 mL, lockout 30 min) or intravenous (morphine, bolus 0.1mg/kg, lockout 10 min,) patient-controlled infusion. Two anaesthesiologists are dedicated to the Acute Pain Service and have the postoperative patients visited 4 times a day. Pain intensity is evaluated daily with an 11-point-numeric-scale (0–10) and prospectively registered in an electronic database. In case of ineffective epidural analgesia despite an additional bolus of local anaesthetic, the technique is changed to intravenous patient-controlled morphine infusion.
We aimed to investigate our clinics pain management protocols effectiveness in LDH patients.
Methods: We retrospectively investigated our pain management records from 2014 to 2019. Mode of analgesia technique, pain intensity, complications and side effects are recorded.
Results: A total of 20 patients were (women n:6, men n:14) analysed. The mean age was 27,5 years (IQR: 22,75-37). Patients were followed for 2-3 days postoperatively for acute pain management and values obtained for the first two days are evaluated (Figure 1).
Dural puncture happened in two patients but headache did not develop in both. Patients with intravenous patient controlled analgesia (n:3) had severe nausea (n:1) and constipation (n:1). None of the patients had hypotension or bradycardia in the postoperative period. Pain scores were higher in IV-PCA group.
Conclusions: The donors are healthy adults who must be taken care of intensely. As stated in ERAS (enhanced recovery after surgery) protocols high epidural catheter placement is an effective mode of acute postoperative analgesia technique in LDH.