ATW 2022 Nov. 17(Thu)~19(Sat), 2022
CONRAD SEOUL, Seoul, Korea

Submission No.: PG01-5342
Session : Postgraduate Course 1 (Liver)
Date & Time, Place : November 17 (Thu), 08:30-10:00, Room 3F-1
Session Title : Living donor Hepatectomy (Video session)

Open Donor Right Hepatectomy in LDLT

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Donor right hepatectomy is the most frequently conducted procedure in LDLT. Traditional open method is still performed in most of the centers rather than minimally invasive procedure. To begin with, right subcostal incision with midline extension is performed. The gall bladder is firstly dissected till only cystic duct is connected to CBD. A catheter is inserted into GB and ligated and fixed to the level of Hartman pouch for intra-operative cholangiography. . After the cholangiography, the planed site of right IHD division is marked with hemoclip. Then, right hepatic artery and portal vein is dissected out and looped with vascular tap after removal of GB. The suspensory ligaments of right liver are divided so that the whole course of IVC and the point of right hepatic vein draining into IVC are exposed. If there is large inferior HV, it is looped with vascular tap. A penrose drain is pulled from anterior to the RHV, aside IVC, and then anterior to right HA and PV , to liver hilum. The margin of right liver is marked along MHV under sonography or after temporary right HA and PV clumping. The liver parenchyma is divided with CUSA and bipolar coagulator. Large draining branches of V5 and V8 are divided after Hemolock clipping. After completing the parenchyma division, the right IHD is divided at the site of hemoclip mark previously, and then the RHA, RPV, right CHD, and RHV are divided sequentially. Perfusion set is inserted into RPV for preservation solution infusion. Some preservation solution is injected into HA and bile duct also. If the parenchyma dose not show complete wash out of blood, then the Hemolock at V5 or V8 might be released for better wash out and preservation. At the bench table, each structures which need to be reconstructed should be checked again. Meticulous trimming of surrounding soft tissue to make it easy for anastomosis is needed. If there is V5 or V8 larger than 5mm, they are reconstructed and connected to RHV with 6-8 mm PDFE vascular conduit, and this finishes the donor right hepatectomy.