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Session Title : Postoperative Management and Long-Term Outcome

How to manage biliary complications in the recipient (focusing on the LDLT)

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Biliary tract complications are frequently observed after liver transplantation recipients and account for a significant cause of morbidity and mortality after the operation. Common complications are anastomotic strictures, non-anastomotic strictures, bile leaks, stone or cast formation, biloma, and hemobilia. Biliary complications depend upon the type of transplant performed, either a deceased donor or living donor liver transplant (DDLT and LDLT, respectively), and the anastomosis chosen by the surgeon (duct-to-duct or hepaticojejunostomy(HJ)).
The most common complication after LDLT is a biliary stricture. The initial treatment modality is endoscopic for duct-to-duct anastomosis or percutaneous for HJ anastomosis. If endoscopic treatment fails, one could try to convert to percutaneous treatment. In cases of failed endoscopic and percutaneous therapy for biliary stricture, magnet compression anastomosis (MCA) is an alternative method. MCA is a minimally traumatic and highly effective procedure and represents a new paradigm for benign biliary strictures that are difficult to treat with conventional methods. Currently, a short removable full-covered self-expandable metal stent (SEMS) is used to dilate stricture and prevent re-stenosis. The application of these various modalities is expected to increase the success rate of biliary stricture treatment after LDLT.
A bile leak is a risk factor for strictures and vice versa. The anastomosis site is the most common. ERCP is very effective for both diagnosing and treatment of a bile leak. The biliary stenting can effectively treat the bile leak after LDLT. Especially, full-covered SEMS is the best option for resolving the biliary stricture and bile leak at the same time.
As the LDLT experience increases and the surgical techniques improve, the incidence of biliary tract complications after LDTL may decrease. However, some biliary complications are

inevitable. Nevertheless, we can manage them effectively. Therefore, biliary complications after LDLT are no longer an Achilles' heel.