

20. The comparison of the results with the patients who had a GRWR ≥ 0.8 has shown no significant difference but MELD-score and BMI, which were both significantly higher.

Conclusion: Based on the results of our study, we conclude that the GRWR can be reduced safely even to 0.6 in patients with low MELD-score. More criteria are needed in order to individualize the GRWR threshold.

	GRWR < 0.8 (n = 43)	GRWR ≥ 0.8 (n = 403)	p-Value
Age (mean)	51 years	50 years	0.9
BMI (mean)	29	26	0.0001*
MELD-score (mean)	14	19	0.01*
Hospital stay (mean)	18 days	20 days	0.4
Postop. complications	10 (23%)	128 (31%)	0.2
Periop. mortality	3 (7%)	40 (9%)	0.8
Re-Transplantation	1 (2%)	11 (2%)	1.0
One-year-survival	93%	91%	0.5

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A CONSECUTIVE SERIES OF 100 CONTROLLED DCD-LIVER TRANSPLANTATIONS

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Introduction: Donation after circulatory death (DCD) have been proposed to partially overcome the organ donor shortage. DCD-LT remains controversial, with reported increased risk of graft loss and retransplantation. The authors retrospectively reviewed a single centre experience with controlled DCD-LT in a 12-year period.

Patients and Methods: 100 DCD-LT were consecutively performed between 2003 and 2014. All donation and procurement procedures were performed as controlled DCD in operative rooms. Data are presented as median (ranges). Median donor age was 57 years (16–83). Median DRI was 2.16 (1.4–3.4). Most grafts were flushed with HTK solution. Allocation was centre-based. Median recipient MELD score at LT was 15 (7–40). Mean follow-up was 35 months. No patient was lost to follow-up.

Results: Median total DCD warm ischemia was 19 min (10–39). Median cold ischemia was 235 min (113–576). Median peak AST was 1132 U/l (282–21 928). Median peak bilirubin was 28 mg/dL. Patient survivals were 90.7%, 75.5% and 70.7% at 1.3 and 5 years, respectively. Graft survivals were 88.7%, 72.1% and 67.1% at 1.3 and 5 years, respectively. Biliary complications included mainly anastomotic strictures and extrahepatic main bile duct ischemic obstruction, that were managed either by endoscopy or hepaticojejunostomy. No PNF or graft loss due to ischemic cholangiopathy was observed in this series.

Discussion: In this series, DCD LT appears to provide results similar to classical LT. Short cold ischemia and recipient selection with low MELD score may be the keys to good results in DCD LT, in terms of graft survival and avoidance of ischemic cholangiopathy. If symptomatic ischemic cholangiopathy is diagnosed, adequate management with endoscopy and surgical hepaticojejunostomy may avoid graft loss and retransplantation.

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UTILITY OF INTERPOSITION DACRON GRAFTS FOR RECONSTRUCTION OF ANTERIOR SECTOR DRAINAGE VEINS IN RIGHT LOBE LIVING DONOR LIVER TRANSPLANTATION

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Reconstruction of anterior sector (AS) drainage veins using interposition homologous or prosthetic grafts has been an established technique in right lobe (RL) living donor liver transplantation (LDLT). Material of choice used for this type of reconstruction have been cryopreserved homologous grafts, because of lower patency rates reported for prosthetic grafts. However, with relative shortage of cryopreserved grafts, prosthetic grafts have the advantage of their unlimited availability. This study investigates short-term patency rate of polyester (Dacron®) grafts used as venous conduit for AS drainage of RL grafts.

Between January 2014 and December 2014, 51 of 80 (63%) patients who underwent LDLT in our institution received a RL graft with AS venous reconstruction including isolated segment 5 (n = 5), isolated segment 8 (n = 6), or combined segment 5 and 8 (n = 40) drainage. A separate accessory

inferior right hepatic vein reconstruction was also performed in 16 (31%) patients. All reconstructions were performed using Dacron grafts.

Dacron graft patency was investigated in 75% (n = 38) of the patients using either Doppler ultrasound (n = 25) or computed tomography (n = 29). Dacron graft was patent in 32 of 38 patients (84.2%) in a median time of 37 (10.0–97.5) days after LDLT. In 6 patients with AS venous outflow obstruction, no significant clinical consequence was observed. There was 1 perioperative mortality due to sepsis and 1 graft loss due to initial poor function, which needed retransplantation. In a median follow-up of 7 (5–10) months, 49/51 (96%) patients were alive. Dacron grafts have high short-term patency rates comparable to those of cryopreserved homologous grafts; thus, they offer an excellent source of interposition material for reconstruction of AS drainage veins in RL LDLT.

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OUTCOMES FOLLOWING LIVER TRANSPLANTATION FOR HEPATOCELLULAR CARCINOMA USING DONOR AFTER CIRCULATORY ARREST VERSUS DECEASED BRAIN DEAD DONOR GRAFTS

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Background: Transplantation of liver grafts from donors after circulatory death (DCD) is now an accepted practice with equivalent outcomes when compared with standard deceased brain dead (DBD) donors. The outcomes of patients transplanted in the setting of hepatocellular cancer (HCC) with DCD versus DBD still remain controversial due to questionable poorer outcomes with DCD donors. However, prior studies have focused only on overall survival and ignored the impact of recurrence on survival.

Methods: A multicenter review of a combined HCC database (Ochsner Medical Center and Toronto General Hospital) was performed from 1/2008 to 12/2013.

Results: 385 patients (41 DCD and 344 DBD) were identified and included in the analysis. There were 49 recurrences (14%) in the DBD group versus 6 recurrences (14%) in the DCD group (p = 0.946). The recurrence-free survival was equivalent for the DCD versus DBD groups (p = 0.819). Similarly, overall 1/3 year survival was 94%/85% and 92%/83% for the DBD versus the DCD groups, respectively. In multivariate regression analysis, lymphovascular invasion, tumor number (>5), and tumor size (>5 cm) were shown to be significant predictors of tumor recurrence not donor type.

Conclusion: DCD liver transplants when performed in experienced centers yield equivalent oncologic outcomes for patients transplanted with HCC.

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BILIARY RECONSTRUCTION IN LIVER TRANSPLANT PATIENTS WITH PRIMARY SCLEROSIS CHOLANGITIS

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Objectives: Traditionally Roux-en-Y hepaticojejunostomy was the method of choice for biliary reconstruction in primary sclerosing cholangitis (PSC) in patients undergoing orthotopic liver transplantation. In this study, we compared the result of duct to duct anastomosis versus Roux-en-Y hepaticojejunostomy as biliary reconstruction in patients with primary sclerosing cholangitis who underwent liver transplant in Shiraz organ transplant center.

Methods and Materials: There were 69 patients with primary sclerosing cholangitis who underwent liver transplant. Mean follow up period was 36.5 months (18–55 months). We performed duct to duct reconstruction in those patients who had grossly normal bile duct during hepatectomy. In 29 cases duct to duct reconstruction was done and Roux-en-Y hepaticojejunostomy reconstruction in 40 cases. Data collecting form contained biliary complications (leak, stricture, and cancer in the remnant bile duct), documented episodes of rejection, and morbidity.

Results: In duct to duct group, two patients presented with anastomotic site stricture and one patient developed cholangiocarcinoma in distal bile duct which underwent pancreaticoduodenectomy (3/29). In Roux-en-Y group, five patients developed anastomotic stricture in the follow up (5/40). This difference was not significant (p value = 0.999). Also documented episodes of rejection were similar between two groups (Chi square test, p value = 0.66) and there was no significant difference.

Discussion: We concluded that duct to duct reconstruction is safe and may be the choice method for biliary reconstruction in some patients with PSC. In addition, due to innovations in ERCP, management of strictures in duct to duct group was more easy and feasible in comparison to revision of Roux-en-Y hepaticojejunostomy