

BLOOD TRANSFUSION IN PATIENTS WITH SICKLE CELL DISEASE REQUIRING LAPAROSCOPIC CHOLECYSTECTOMY

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Background: Surgery in patients with sickle cell disease is associated with high morbidity. To reduce this high morbidity, different preoperative transfusion regimens were introduced. However, blood transfusion is associated with problems. This prospective study aims to establish the safety of conducting laparoscopic cholecystectomy without transfusion in sickle cell disease patients.

Methods: Forty patients (16 males and 24 females; mean age 26.6 years) undergoing laparoscopic cholecystectomy for cholelithiasis were divided into 2 matched groups: Group I "no transfusion" (n24 patients; 60%) and Group II "transfusion" (n16; 40%). In Group II, 9 patients (22.5%) received a simple transfusion and 7 (17.5%) a partial exchange transfusion.

Results: Group II patients had significantly higher levels of Hb-S prior to transfusion. They developed a significantly higher complication rate (25% vs. 0%) and subsequently longer hospital stay (3.92 vs. 2.11.4). Moreover, there was no significant difference in the complications between the simple transfusion and partial exchange transfusion subgroups.

Conclusion: Surgery in SCD patients is safe without a preoperative blood transfusion. Moreover, preoperative blood transfusion is associated with significantly higher postoperative complications and longer hospital stay. Hence, a "no transfusion" policy is recommended.

CLINICAL TRIALS AND OUTCOME RESEARCH: ONCOLOGIC SURGICAL APPROACH FOR LARGE HEPATOCELLULAR CARCINOMA

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Introduction: The size of the tumor is known to be one of the prognostic factors in hepatocellular carcinoma (HCC). Only hepatic resection is expected to be a curative treatment for large HCC. However, the forceful manipulation of the liver can result in tumor rupture and spillage of tumor cells into circulation. Safe technique and inhibition of recurrence needs to be established for improvement of outcome. The anterior approach consisting of initial inflow control and parenchymal transection prior to mobilization of the right liver is a no-touch technique for large HCC. Randomized controlled study of anterior vs. conventional approach demonstrated significantly less frequent major operative blood loss and superior overall survival with the anterior approach. The purpose of this study is to clarify the significance of the anterior approach on outcome and the relationship between tumor size and initial recurrence site.

Methods: 1. Between 2000 and 2006, 126 consecutive patients who underwent hepatic resection with curative intent for large right HCC more than 7 cm were identified from a prospective database. The 36 patients who had anterior approach (AA) were compared with the remaining 90 patients who had conventional approach (CA). Demographic, laboratory, and tumor specific variables were analyzed using Kaplan-Meier, log rank and Cox regression analyses.

2. Between 2001 and 2010, 293 patients with a solitary HCC and without macroscopic vascular invasion that underwent primary surgical resection were analyzed. The initial recurrence site was compared according to the tumor size.

Results: 1. There was no significant difference between AA and CA groups regarding clinical, laboratory and pathological parameters except gender. Median disease-free survival time was 46 months in the AA group compared with 11 months in the CA group (HR 0.44, 95%CI 0.26-0.71, P<0.001). Overall survival was significantly better in AA than that in CA (HR 0.35, 95%CI 0.17-0.66, P<0.0013). Multivariate analysis found anterior approach and surgical margin to be independent predictors of recurrence (HR: 0.26, 95% CI: 0.11-0.56, HR: 7.45, 95% CI: 2.56-18.98) and survival (HR: 0.354, 95% CI: 0.20-0.62, HR: 4.31, 95% CI: 1.59-9.91), respectively.

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2. The rate of lung metastasis as an initial recurrence was significantly higher (24.0%) in patients with HCC more than 7cm, compared with those in patients HCC less than 2cm (9.3%) and 2-7cm (5.0%), though there was no significant difference among three groups in initial recurrence site, including liver (approximately 40%) and bone (approximately 5%).

Conclusion: The anterior approach is a safe and effective technique for right hepatic resection for large HCC. The patients with large HCC more than 7cm showed a high risk for lung metastasis after resection. The anterior approach and adjuvant therapy, such as sorafenib, are recommended as an oncologic approach for patients with large HCC more than 7cm.

Disclosure of Interest: None Declared

IMPACT OF RECIPIENT CO-MORBID FACTORS ON OUTCOME OF LIVING-DONOR LIVER TRANSPLANTATION

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Background: liver transplantation has become the treatment of choice for patients with end-stage liver diseases (ESLD). Generally recipients with associated risks and comorbid factors such as (smoking, DM, hypertension, obesity, previous abdominal surgery, cardiac disease, renal disease, pulmonary disease, PVT) were believed to affect the outcome of liver transplantation adversely. The aim of the present study was to evaluate the influence of these nine co-morbid factors mentioned earlier on immediate outcome after liver transplantation. Methods: we retrospectively evaluated the records of 116 LDLT recipients at our center from April 2003 to March 2011. Forty-two patients were excluded. In the remaining 74 patients {mean age = 48.2±6.9, BMI = 27.9±5.5, MELD score = 22.68 ±5.5}.the outcome measures were packed red cell (PRC) transfusion in 48 hours, length of stay (LOS) in ICU and the hospital stay, hepatic artery thrombosis (HAT), postoperative portal vein thrombosis (PVT), biliary complications (BC), postoperative bacterial infection (POBI), re-operation and death.

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Results: The commonest indication for liver transplantation is HCV-related chronic liver disease 43 (58.1%) patients, followed by HCC 23 (31.1%). The commonest co-morbid factor is DM (n=27), renal disease (n=20), cardiac disease (n=18), previous abdominal surgery & pulmonary disease 15 patients for each, obesity (n=12), hypertension (n=10), and preexisting PVT (n= 6). Presence of co-morbid factors associated with slight increased PRC transfusion, but not associated with increased length of stay (LOS) in ICU and hospital. Postoperative PVT found in 3 (4.1%) patients, there was significant correlation with preexisting PVT. Biliary complications (BC) developed in 29 (39.2%) patients. There was significant increased BC in diabetic patients. Postoperative bacterial infection (PBI) found in 42 (61.9%) patients, without significant correlation to the comorbid factors. Postoperative mortality occurred in 20 (27%) patients, seven were hypertensive, and 12 were diabetic. There was significant correlation between postoperative mortality and hypertension & DM, which are considered as significant risk factors. Cases of the study population were further subdivided in to 3 categories according to the number of associated co-morbidities. Cases with one co-morbid factor (G1) 27 patients, cases with two co-morbid factors (G2) 26 patients, and cases with more than two co-morbid factor (G3) 21 patients. The outcome in the presence of multiple comorbid factors did not influence peri-operative morbidity. However, mortality was significantly increased in patient with multiple co-morbid factors. Peri-operative death in G1, G2, and G3, were 20%., 25%, and 55% respectively.

Conclusion: Presence of co-morbid factors such as hypertension, diabetes mellitus, cardiac disease, and renal disease found to increase postoperative morbidity, but did exclude the patient from liver transplantation. Patients with multiple co-morbid factors require special consideration since peri-operative mortality is significantly higher.

MAJOR LIVER RESECTION FOR PATIENTS WITH LIVER TRAUMA

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Introduction: The liver is the second most commonly injured organ in abdominal trauma, but liver damage is the most common cause of death after abdominal injury. In spite of there has been a paradigm shift in the management of patients who have stable hemodynamic with marked change toward a more conservative approach in the treatment of abdominal trauma has been noted during the last decades, urgent surgery continues to be the standard for hemodynamically compromised patients with hepatic trauma.

Aim of the work: to find out and assess the role of surgery and liver resection in the management of blunt liver trauma.

Patients and methods: this study included sixty five patients referred to the National Liver Institute (NLI), university of Menoufiya as a tertiary center during the last five years. The management option was based on hemodynamic status, radiological (ultrasound and CT) staging criteria. Analysis was done using SPSS 18. Statistical significance was set at P

Results: The age of these patients ranged from 4 to 38 years with a mean age of 20.4 years with male predominance (84%). Twenty seven (41.5%) patients were not previously explored and 5((7.6%)) were explored in NLI due to biliary peritonitis. Thirty eight (58.5%) were referred after primary exploration. Fourteen (21.5%) were managed conservatively and only 5 (7.6%) were opened for removal of packs after 48 hours. Twenty four (36.9%) were reexplored due to hemodynamic instability and CT criteria, 4(6.1%) were managed by conservative surgery (repair of lacerations). Twenty (30.7%) patients needed major liver resection, 3(4.6%) patients by left lateral segmentectomy, 2 (3%) patients by right posterior sector resection, and 15 (23%) patients underwent right hepatectomy with one (1.5%) perioperative mortality, one (1.5) postoperative portal vein thrombosis and 3 (4.6%) postoperative biliary complications.

Conclusion: hemodynamic stable patients can be managed safely non-operatively, while urgent surgery continues to be the standard for hemodynamic compromised patients with hepatic trauma.

NOP management doesn't lead to longer hospital stay. Low grade injuries can be managed non-operatively with excellent results.

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OUTCOME OF PEDIATRIC LIVING-DONOR LIVER TRANSPLANTATION: A SINGLE INSTITUTIONAL EXPERIENCE

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Background: Living related liver transplantation (LRLT) is the only available life- saving procedure for children with irreversible liver failure. The aim of the present study: was to evaluate the outcome of 32 children who underwent liver transplantation using grafts from living relatives. Methods: A retrospective single centre assessment of the results of the previously mentioned children as regard to the surgical complications & survival rate from April 2003 to June 2012 at our centre. There were 17 (53.1%) boys & 15 (46.9%) girls with a mean age of 5.85 ± 5.86 years (range 0.6-17.5), mean weight 20.3 ± 16.17 kg (range 7.5 - 65). Results: The main indications for liver transplantation were: biliary atresia (n=13) Byler's disease, Budd Chiari Syndrome & Cryptogenic liver cirrhosis (n=3 for each) and HCV (n=2). PELD score 12v (n=5) mean (16.2±4.32) range (11-21). GRWR mean (1.97±0.81) range (0.88-3.5). Postoperative complications included: wound infection in 5 patients Biliary (leaks & stricture 2 for each), renal impairment & chest infection (3 for each), GIT bleeding in 2 patients, HAT, PVT, pulmonary embolism & HV outflow obstruction (1 for each). There were no donor related complications. 11 out of 32 children died with a mortality rate of 34.38%. Cause of death was early graft dysfunction (n=3), sepsis & biliary leak with multiple organ failure (2 for each), HAT, HV outflow obstruction, pulmonary embolism & chronic rejection (1 for each). Conclusion: A satisfying outcome was achieved in most cases with good graft function & survival rate of 65.63%. Successful liver transplantation in a child is usually challenging with many obstacles yet to be overcome requiring all the combined expertise of the pediatric transplant team.

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PERIAMPULLARY TUMORS: EXPERIENCE WITH 2130 CASES

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Introduction Resection or no resection in periampullary tumors specially in advanced stage remains a point of controversy among surgeons. While some are against resection, looking for simple bypass either by surgery or via endoscopic stenting, others strongly believe that surgical resection is the best option for patients with periampullary tumors. Aim The aim of this work is to evaluate the outcome of different modalities of treatment of patients with periampullary tumors, surgical resection (Whipple operation), versus palliative bypass (surgical or endoscopic).

Method In the period from 2001 to 2010, 2130 patients were included in this study. Mean age was $58\pm11Y$ with no statistical significant difference between different groups. Male to female ratio was 1.64: 1. Larger mass mean size was detected in irresectable tumors 51 ± 18 mm compared to 37 ± 16 mm in patients who underwent surgical resection.

Result Surgical resection could be achieved in 450 cases (21%), in 392 (87.1%) the reconstruction was by pancreaticogastrostomy& 58 (12.9%) by pancreaticojejunostomy. A comparative study between the 2 modalities of reconstruction proved superiority to pancreaticogastrostomy. Surgical palliative bypass was done in 460 cases (21.5%). in 110 cases by Hepaticoojejunostomy Roux en Y and in 225 cases HJ + GJ & remaining of 125 pt other procedure was done. Last group of advanced cases include 1220 pt endoscopic stenting was done as a permanent drainage. The net results show although that endoscopic stent had the shortest hospital stay 2.5±5.8 days, it needs several readmissions ranging from 1-5 times, while hospital stay after surgical resection & surgical bypass were 11.7±8.6, 5.9±3 days respectively.

Hospital mortality after endoscopic stenting and surgical bypass is 5.7%, 2% respectively, while hospital mortality after surgical resection was 3.2%. The longest survival was after Whipple\'s operation 17.5 months compared to 5 and 3.8 months after palliative surgery & endoscopic stenting respectively.

Conclusion Surgery gives the best long term result, in advanced cases palliative procedure, surgical palliation in good risk pts endoscopic stenting – poor risk patient.



RESECTION OF HUGE HCC > 8 CM.

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Liver resection is indicated in patients with good liver function (Child-Pugh A) with absent or mild portal hypertension Long-term survival of selected patients is almost similar to survival results after LTx Liver resection can offer long-term survival even in patients with poor prognostic factors (large HCCs, PVT or HV thrombosis).

WHAT MAKES MEDICAL RESEARCH ETHICAL?

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Research is necessary for the advancement of knowledge, science and treatments of disease, it is a systematic investigation designed to develop or contribute to generalizable knowledge. Human subjects are absolutely essential to accomplish this task. Advances in science and medical treatment would not have evolved without the involvement of courageous human research participants. Research ethics is the application of a set of moral principles, or rules of behavior during conduction and publication of research involving human participants to ensure that the dignity, rights, safety and wellbeing of research participants are protected. So we need to think on what makes medical Research Ethical?

And how we write proposals to comply with recognized ethical standards.

Several requirements are needed and the fulfillment of each requirement in chronological order ensures that research has value, there is no exploitation, participants are treated fairly with respect, and that their interests are protected.

USING MULTIDETECTOR CT IN PREDICTING RESECTABILITY OF PANCREATIC HEAD TUMORS: SURGICAL AND PATHOLOGIC CORRELATION

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Background: Computed tomography (CT) is widely used to pre-operatively evaluate patients with pancreatic tumors.

Aim: The purpose of this study is to evaluate retrospectively, the ability of multi-detector computed tomography (MDCT) to predict resectability of pancreatic cancer on the basis of surgical outcome and pathologic correlation.

Patients and Methods: Sixty nine consecutive patients presenting between January 2007 and June 2010 with pancreatic head tumors were included in the study.examinations were performed with the samen64 slice CT scan (Brillinat Philips). All patients were imaged using a standardized MDCT protocol.Patients with disease that was clearly inoperable were excluded from the study. The remaining patients (32) had their CT studies double-reported using a standard method.Surgical and pathologic reports were reviewed and compared to CT results.

Results: Of the 32 patients evaluated, 65.6% had successful resection of pancreatic head tumors; while 34.4% had a palliative procedure. When compared to surgical outcome, the positive predictive value of multidetector computed tomography for resectability was 100%. On the basis of pathologic results (considering the surgical technique and the positive surgical margin as a microscopic picture), the negative predictive value of multidetector computed tomography for resectability fell to 65.5%,

Three patients deemed resectable following multi-detector computed tomography had positive margins at pathology.

Conclusion: There is improved prediction of resectability/unresectability with the introduction of MDCT. When compared to Helical computed tomography (HCT) studies, there is a rise in the rate of successful surgical resection with a concomitant decrease in the rate of palliative surgery. The positive predictive value of multidetector computed tomography for resectable disease is lower when pathologic correlation, as opposed to surgical

correlation, is used as the gold standard.



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