<table>
<thead>
<tr>
<th>Title</th>
<th>Living donor liver transplantation without the use of blood products.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Author(s)</td>
<td>Liu, CL; Fan, ST; Lo, CM; Wei, WI; Yong, BH; Lai, CL; Wong, J</td>
</tr>
<tr>
<td>Citation</td>
<td>Hong Kong Medical Journal = Xianggang Yi Xue Za Zhi / Hong Kong Academy Of Medicine, 2002, v. 8 n. 3, p. 192-195</td>
</tr>
<tr>
<td>Issued Date</td>
<td>2002</td>
</tr>
<tr>
<td>URL</td>
<td><a href="http://hdl.handle.net/10722/53399">http://hdl.handle.net/10722/53399</a></td>
</tr>
<tr>
<td>Rights</td>
<td>Hong Kong Medical Journal. Copyright © Hong Kong Medical Association.; This work is licensed under a Creative Commons Attribution-NonCommercial-NoDerivatives 4.0 International License.</td>
</tr>
</tbody>
</table>
Living donor liver transplantation without the use of blood products

We report on two patients who presented with unresectable hepatocellular carcinoma complicating hepatitis B liver cirrhosis. After evaluation, both patients were accepted for liver transplantation. Being aware of the scarce availability of cadaveric liver grafts and the long waiting time, family members volunteered to be donors for the two patients. Living donor liver transplantation using right lobe liver grafts, including the middle hepatic vein, was subsequently performed without the use of blood products in both the donors and recipients. All involved recovered uneventfully from their respective operations.

Introduction

Orthotopic liver transplantation (OLT) is typically associated with a large volume of blood loss, although transfusion requirements have gradually decreased with refinements in surgical and anaesthetic techniques. There are even a few reports in the literature of successful liver transplantation without transfusion of red cells in Jehovah’s witnesses. In recent years, living donor liver transplantation (LDLT) using right lobe liver grafts has been frequently employed, especially in countries where there is scarce or no supply of cadaveric liver grafts. However, LDLT can be technically demanding in both the donor and recipient operations. We report two cases in which successful LDLT using right lobe liver grafts was performed without the use of blood products in both the donors and recipients.

Case reports

Case 1

A 51-year-old Chinese man had a history of chronic hepatitis B–related liver cirrhosis and splenectomy for thrombocytopenia in 1995. He also had a history of left lateral segmentectomy for a 2 cm hepatocellular carcinoma (HCC) in 1998. Histological examination of the resected specimen showed a 2 cm HCC with lymphovascular permeation (TNM stage II disease). The postoperative course was complicated by a single episode of gastrointestinal bleeding from oesophageal varices, which was controlled by injection sclerotherapy. Thereafter, he was maintained on oral propranolol.

Two years after hepatic resection, a 7 cm HCC recurrence was detected in the right lobe of the liver on computed tomography (CT). The patient’s clinical condition was explained in detail to his family members who, after discussing the effectiveness and limitations of various treatment options, including local ablative therapy, regional chemoembolisation, and liver transplantation, opted for the latter. After evaluation, the patient was put on the transplant recipient waiting list. Being aware of the scarce availability of cadaveric liver grafts and a long waiting time of more than 2 years, the patient’s wife, aged 44 years, volunteered...
Living donor liver transplantation
to be a liver donor. The patient’s family members were not
solicited for liver donation, and the decision to undertake
LDLT was based entirely on the wife’s voluntary intent. An
independent psychological assessment performed by a clinical
psychologist confirmed that her decision to donate was made
without coercion. Both the husband and wife were
informed of the possible morbidity and mortality of the
donor and recipient operations. Donor evaluations, includ-
ing blood biochemistry, CT with volumetric measurement,
and hepatic angiography, confirmed that the wife was in-
deed suitable to be a liver donor.2,3 At the time of the
operation, laboratory studies of the recipient showed a plate-
let count of 67 x 10⁹/L (normal range, 150-450 x 10⁹/L), a
haemoglobin level of 145 g/L (normal range, 140-175 g/L),
an albumin level of 30 g/L (normal range, 35-50 g/L), a
bilirubin level of 15 µmol/L (normal range, 5-21 µmol/L), an
aspartate aminotransferase level of 128 U/L (normal
range, 20-48 U/L), an alanine aminotransferase level of
105 U/L (normal range, 10-40 U/L), an alphafoetoprotein
(AFP) level of 43 ng/mL (normal range, 0-20 ng/mL), and
a prothrombin time of 12.8 seconds (normal range, 10-
13 seconds).

The donor operation began with a bilateral subcostal
incision with upward midline extension. Operative cholan-
giography was performed with fluoroscopy to outline the
biliary anatomy. The right hepatic artery and right portal
vein were isolated at the liver hilum. Parenchymal tran-
section was performed to the left of the middle hepatic vein
using an ultrasonic dissector without portal vascular inflow
clamping. When the recipient’s total hepatectomy was
complete, the donor’s right lobe liver graft, together with
the middle hepatic vein, was harvested and back table perfusion with University of Wisconsin solution started. The
intra-operative blood loss was 500 mL and the donor did
not require any blood product transfusion. Her postopera-
tive course was uneventful and she was discharged home
on the seventh day after the operation.

The recipient operation also began with a bilateral sub-
costal incision with upward midline extension. Marked ad-
hesion relating to two previous upper abdominal operations
was encountered. Total hepatectomy was performed with
preservation of the hepatic arterial branches, left and right
portal veins, and stumps of the hepatic veins. However,
intra-operative cell salvage was not employed because of
the presence of malignancy. The liver graft was implanted
to the orthotopic position, with hepatic venous anasto-
moses of the right hepatic and middle hepatic veins being
followed by right portal vein anastomosis. The graft began
functioning immediately on reperfusion, as evidenced by bile production, and was soft in consistency. Hepatic
arterial anastomosis was performed using microvascular
techniques. Doppler ultrasound showed patency and nor-
mal pulsatile waveforms in the hepatic venous anastomoses.
Roux-en-Y hepatico-jejunostomy was constructed to the
right hepatic duct. The intra-operative blood loss was
800 mL and the total fluid replacement was 3500 mL. The
recipient remained haemodynamically stable throughout
the operation and did not require any blood product trans-
fusion. His postoperative immunosuppressive therapy con-
sisted of steroids and tacrolimus. He was also put on oral
lamivudine for hepatitis B prophylaxis. He was extubated
on postoperative day 1, resumed a hospital diet on postop-
erative day 2, and was discharged home on postoperative
day 17. Pathological examination of the liver explant con-
firmed the preoperative radiological diagnosis and showed
macronodular cirrhosis of the liver, with a 7 cm moderately
differentiated HCC.

Case 2

A 49-year-old Chinese man was attending the surgical
clinic for the management of multifocal HCC complicating
hepatitis B–related liver cirrhosis. He had been a known
hepatitis B carrier since 1995 and had a slightly raised AFP
level of 26 ng/mL. Computed tomography demonstrated
three foci of HCC inside a cirrhotic liver, the largest one
being 2.5 cm in diameter. Regional chemoembolisation
was given once. However, unsatisfactory treatment was evi-
donent on subsequent CT, which demonstrated incomplete
lipiodol staining and growing tumours. The patient’s clinical
condition was explained in detail to his family members
who, after discussing treatment options, which included
continuation of regional chemoembolisation and liver
transplantation, opted for transplantation. After evaluation,
the patient was put on the transplant recipient waiting list.
Being informed of the scarce availability of cadaveric liver
grafts and a long waiting time of more than 2 years, the
patient’s son, aged 22 years, volunteered to be a liver donor.
The family members were not solicited for liver donation,
and the decision to undertake LDLT was based solely on
the son’s voluntary intent. An independent psychological
assessment performed by a clinical psychologist confirmed
that his decision to donate was made without coercion.
Both the father and son were informed of the possible mor-
bidity and mortality of the donor and recipient operations.
Donor evaluations, including blood biochemistry, CT
with volumetric measurement, and hepatic angiography,
confirmed that the son was indeed suitable to be the liver
donor. At the time of the operation, laboratory studies of
the recipient father showed a platelet count of 234 x 10⁹/L,
a haemoglobin level of 132 g/L, an albumin level of 32 g/L,
a bilirubin level of 13 µmol/L, an aspartate aminotransfer-
ase level of 34 U/L, an alanine aminotransferase level of
45 U/L, an AFP level of 7 ng/mL, and a prothrombin time of
12.3 seconds.

The donor operative procedure was essentially the same
as that reported in the case 1 donor. The intra-operative blood
loss was 250 mL and the donor did not require any blood
product transfusion. His postoperative course was unevent-
ful and he was discharged home on the sixth day after the
operation.

The recipient operative procedure was also essentially
the same as that reported in the case 1 recipient. Again,
immediate graft function was noted. The intra-operative blood loss was 1300 mL and the total fluid replacement was 7500 mL. The recipient remained haemodynamically stable throughout the operation and did not require any blood product transfusion. His postoperative immunosuppressive therapy also consisted of steroids and tacrolimus. He was also put on oral lamivudine for hepatitis B prophylaxis. He too was extubated on postoperative day 1, resumed a hospital diet on postoperative day 2, and was discharged home on postoperative day 17. Pathological examination of the liver explant confirmed the preoperative radiological diagnosis and showed liver cirrhosis, with three foci of moderately differentiated HCC.

Discussion

Following its introduction more than a decade ago, LDLT has significantly eased the crisis of donor organ shortage for liver transplantation. First performed successfully in children,14 application of this innovative technique has recently been extended to adults through the use of a right lobe graft.15 It is now the main source of liver grafts in areas where there is scarce or no supply of cadaveric grafts.

Donor safety is of prime importance during LDLT.9 In particular, minimising blood loss during donor hepatectomy minimises the risk of postoperative morbidity due to hepatic dysfunction, as well as the risk of transmissible disease due to contaminated blood product transfusion. Since the establishment of the liver transplant programme in our institution in 1991, hepatectomy has been performed for 90 donors. To date, none has required any blood product transfusion, with the exception of a single patient who had anaemia from thalassaemia and received one unit of homologous blood transfusion.

Orthotopic liver transplantation is typically associated with a large volume of blood loss. Bontempo et al10 reported a median red cell transfusion requirement of 10 units in an unselected liver transplant population. Fortunately, increased understanding of coagulopathy and fibrinolysis,11 together with improvements in surgical haemostasis using argon beam coagulation and the introduction of intra-operative cell salvage, have led to a reduced demand for blood product transfusion.12 However, cell salvage is expensive and requires relatively sophisticated equipment and trained personnel to perform. Theoretically, disseminated intravascular coagulation, adult respiratory distress syndrome, and renal failure can arise from the reintroduction of fat microemboli, denatured protein, free haemoglobin, cell fragments, and platelet-leukocyte microaggregates into the blood stream, although better designed studies have so far failed to show a significant increase in these complications.13 Unfortunately, both our transplant recipients had HCC and hence were not considered suitable candidates for cell salvage because of fears of retransfusing exfoliated cancer cells.

The timing of the procedure is particularly crucial. Because of the infrequent supply of cadaveric grafts at our centre, patients put on the waiting list have to wait at least 2 years before they can have a transplant. It is our experience that more than half of these candidates succumb to major complications before a timely graft is available. In addition, even if a transplant does eventually take place, the operation can be difficult because of extensive vascular adhesions that have arisen as a result of repeated episodes of spontaneous bacterial peritonitis occurring in the interim. Both our patients had HCC and, given their clinical conditions, it did not seem appropriate to wait for cadaveric grafts to become available. Living donor liver transplantation, however, enabled early transplantation to take place, before decompensation of liver function and associated coagulopathy had occurred, thus allowing the operations to be done successfully without the use of blood products.

In a recent meta-analysis of prospective, randomised, controlled studies of pharmacological strategies designed to decrease bleeding associated with cardiac surgery, administration of aprotinin decreased the risk of allogenic blood transfusion.14 The use of aprotinin to decrease transfusion requirements in patients undergoing OLT is supported by the results of a recent multicentre, randomised study,15 although the effectiveness of this approach has been challenged.16 Aprotinin is not routinely given to patients undergoing liver transplantation at our centre, and was not given to either of the two recipients reported here.

Meticulous surgical technique and haemostasis with electrocautery and argon beam coagulation contributed significantly to the avoidance of blood transfusion in the two recipients described here. Maintaining haemostasis was particularly important, since both patients had HCC and one had a history of two previous upper abdominal surgeries. Another major contributory factor was our increasing experience with, and refinement of, the LDLT technique using right lobe liver grafts.17 We placed great emphasis on careful reconstruction of the right and middle hepatic vein anastomoses, so that liver graft dysfunction and congestion would not occur. Liver graft congestion increases bleeding from the cut surface of liver and the hepatoduodenal area due to unresolved portal hypertension. Excessive blood loss during liver transplantation can result in unfavourable outcomes, including cerebrovascular complications.18 Furthermore, perioperative transfusion has been found to promote recurrence of HCC after hepatic resection and result in shorter disease-free and overall survival.19,20 Avoidance of blood product transfusion will thus be one of our aims in future liver transplant operations.

Liver transplantation is a recognised treatment for HCC in selected patients, and the survival results of those chosen to undergo OLT for HCC are not inferior to those undergoing OLT for non-malignant disease. Mazzaferro et al21 reported excellent disease-free and overall survival rates of 92% and 85%, respectively, 4 years after OLT in 35
Living donor liver transplantation

patients with a solitary HCC not exceeding 5 cm in diameter or no more than three tumours, with none greater than 3 cm in diameter. To justify the use of scarce cadaveric liver grafts in this population, many transplant centres have employed the Mazzaferro criteria to select candidates for OLT. However, the same selection criteria should not be strictly applied to patients undergoing LDLT, as the grafts are ‘dedicated to the beloved’ of the donors. Moreover, because the recipients of LDLT are not competing with other recipients for cadaveric grafts, the survival results of LDLT for HCC should be compared to those in the absence of transplantation in any attempt to justify the technique. In fact, the Mazzaferro criteria have been questioned in recent studies, and expanding the tumour size limits does not seem to have adversely affected survival rates. Yao et al., for example, reported excellent survival results of 90% and 75.2% at 1 and 5 years, respectively, in patients undergoing OLT for HCC ≤ 8 cm in size.

Although LDLT can be performed without the use of blood products in selected patients, this does not imply that it can or should be recommended for all patients with HCC. The efficacies and drawbacks of treatment options available should be discussed with potential donors and recipients, and ethical issues should be addressed adequately. Of paramount importance is a proper psychological assessment of the donor to assure appropriate voluntarism on their part. This informed consent must be gained before establishing the suitability of their liver for transplantation through the usual functional and radiological tests.

Conclusion

Living donor liver transplantation without the use of blood products still poses a major challenge, but can be achieved in selected patients, including those with HCC, provided the surgical technique and perioperative care are of a sufficiently high standard, and a timely graft is available.

References