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OPERATION RECORD

NAME DAVID BLACK UNIT NO. 0105371564 DOB 01/05/37

CONSULTANT Mr O J Garden UNIT SLTU DATE 21/04/96

SURGEON K K Madhaven

ASSISTANT 1 Mr Ian Baxter R
ASSISTANT 2 Mr R K PRASEEDOM SR

ANAESTHETIST DR A LEE
URGENCY Routine

ANAESTHETIC General

PRINCIPAL DIAGNOSIS/OPERATION
OTHER CONDITIONS/OPERATIONS
LIVER Surgeon: K K Madhaven
Cirrhosis/portal hypertension
Orthotopic liver transplant
LSA 1203200000

OPERATIVE FINDINGS AND TECHNIQUES

Incision - bilateral subcostal incision with extension upwards into the epigastrium over the midline. Muscles were divided in the line of the incision.

Operative Findings - there was some turbid ascitic fluid in the abdominal cavity. The liver was cirrhotic and shrunken and there was splenomegaly. There was moderate portal hypertension especially in the posterior peritoneal region and the lesser omentum. The rest of the viscera were normal.

Details of procedure - after opening the abdomen it was realised that there was a moderate amount of portal hypertension and dissection of the infra hepatic cava was extremely difficult. The peritoneum over the Morrison's pouch was opened and the vena cava was approached by kocherising the proximal duodenum. There were large amounts of vascular tissue around the vena cava and these had to be ligated and divided. Finally an adequate length of the infra hepatic cava was bared to perform a porta caval anastomosis. The portal dissection was thereafter performed from left to right with ligation of the hepatic arteries and the bile duct. The portal vein was exposed and this was dissected further into the liver till the bifurcation. Both branches of the portal vein were ligated using silk and divided. The portal vein was clamped proximally and an end to side porta caval shunt was anastomosed with the side of the vena cava which was side clamped using a Satinsky clamp. Following release of the porta caval anastomosis there was decrease in bleeding from the various porto systemic sites and therefore the dissection of the liver was proceeded with. The left lobe of the liver was initially dissected until the left hepatic vein was exposed. Thereafter, the right lobe of the liver was divided and the entire length of the vena cava was exposed from the right side. There was a large accessory right hepatic vein which had to be clamped, divided and oversewn. The peritoneum over the left side of the caudate lobe was divided and by retracting the liver upwards it was gradually dissected off the inferior vena cava with ligation of the various venous branches. The main right hepatic vein was also divided and secured using sutures. Following this the liver was attached to the vena cava only with the common stump of the

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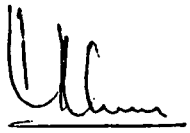
middle and left hepatic vein. This was clamped using the vena caval clamp and the liver was excised.

Following haemostasis in the raw area the new liver was taken out of ice and a supra hepatic anastomosis was performed using continuous 3/0 prolene. Following this it was decided to perform revascularisation using the portal vein and therefore an end to end portal anastomosis was performed using 5/0 prolene. Following release of the portal clamps the liver vascularised well and the initial 150 - 200 mls of blood was allowed to flush through the liver out of the inferior vena cava. The donor cava was thereafter clamped and the supra hepatic clamp was removed and perfusion re-established. Thereafter the donor's common hepatic artery was anastomosed end to end to the left hepatic artery of the recipient. Following release of clamps there was good flow through the arteries with good arterial vascularisation of both lobes of the liver. The lower end of the donor cava was closed using continuous 4/0 prolene. Similarly the vena caval end of the previously disconnected porta caval shunt was also closed using 4/0 prolene. An end to end bile duct anastomosis was performed using 5/0 PDS in an interrupted fashion. This was performed without the aid of a T-tube. Biopsy was taken from the left lobe of the liver and sent for post perfusion histology. The abdominal cavity was washed out using warm saline and tetracycline following which once again haemostasis was confirmed. The umbilical hernia site was approached from inside and a 2/0 nylon stitch was put in a figure of eight of fashion from within the abdominal cavity to tackle the hernia. Two number 32 drains were introduced and one placed in the supra hepatic region and one in the infra hepatic region behind the bile duct anastomosis. Abdomen was closed in layers, muscle closed in two layers with number one PDS and skin closed using staples.



K K MADHAVAN
Consultant Surgeon

Have you checked that the code and operation description are correct!