56 (12.7%) had trifurcation, 71 (16.13%) had right posterior segment duct (RPSD) draining into left hepatic duct (LHD), 66 (14.09%) had RASD draining into LHD, and 7 (1.5%) had RPSD draining into cystic duct. Of the 61 left lobe grafts, 55 (90%) had standard anatomy. Multiple duct openings were seen in 33% patients. The presence of 2 or 3 ducts requiring Roux-Y HJ (12%) or cystic duct (4.2%) usage were considered Class 2. Donors with >3 ducts at hilum or significant duct opening into the opposite lobe precluded donation and were considered Class 3. Overall, on the basis of imaging among 501 donors, 85% were Class 1, 13% Class 2, and 2% Class 3 donors.

Conclusion: Variations in hilar anatomy are a rule rather than exception and require innovative reconstruction. Classification of donors based on anatomic variations has direct implications on the selection of donors and also helps in operative planning.

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WHICH IS BETTER? DUCT-TO-DUCT/ HEPATICOJEJUNOSTOMY/BOTH—IN A RIGHT LOBE GRAFT WITH TWO DUCTS IN ADULT LIVING-RELATED LIVER TRANSPLANTATION

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Background: Even though biliary anatomy variations were used to preclude liver donation in the initial days, it is not uncommon to accept a precious donor with 2 ducts on a right lobe graft in adult living-related liver transplantation (ALRLT). The aim is to study the best option of ductal reconstruction in ALRLT when there are 2 ducts to be anastomosed.

Method: We retrospectively analyzed our series of ALRLT from October 2006 to May 2011. Of 585 grafts, 107 right lobe grafts had 2 ducts to be reconstructed. These were grouped into 3: Group A ($n=71$) who underwent duct-to-duct anastomosis with or without ductoplasty, Group B ($n=8$) who got hepaticojejunostomy with or without ductoplasty, and Group C ($n=28$) who got 1 duct-to-duct and the other hepaticojejunostomy. Outcome in these 3 groups was analyzed. The parameters taken into consideration were bile leak without sepsis and collection, biloma alone requiring early interventions like percutaneous drainage, re-exploration for biliary issue, conversion of duct-to-duct to hepaticojejunostomy, stricture formation, need for late endoscopic, and/or percutaneous intervention and mortality. The data were analyzed using Predictive Analytics SoftWare version 18.

Result: Group A had the majority of patients. Of 71 patients, 17 (23.94%) had bile leaks. Of these, 11 patients were re-explored for biliary sepsis and converted into hepaticojejunostomies, 9 patients underwent early ERCP for bile leaks, 24 (33.80%) patients developed biliary anastomotic stricture for which ERCP and stenting was done and 7 patients required rendezvous procedure. Nine (12.67%) patients expired in the early postoperative period. In Group B, there were 8 patients and 3 (37.5%) of them developed controlled bile leak which settled over 3 weeks, but no other complication or mortality in this group. In Group C, there were 28 patients, but only 2 (7.4%) developed bile leak which improved without any interventions and there were no mortality too.

Conclusion: In our experience, the best option for ductal reconstruction when there were 2 ducts in ALRLT is 1 sectorial duct to the common hepatic duct and the other as hepaticojejunostomy. This method has the least complication rate and best results.

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RIGHT POSTERIOR SECTORAL GRAFT PROCUREMENT IS ALWAYS POSSIBLE IF RIGHT POSTERIOR SECTORAL PORTAL VEIN CAN BE DIVIDED EXTRAHEPATICALLY

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Background: In adult living-related liver transplantation (ALRLT), the availability of donors is limited and encountering a precious donor with difficult anatomy/volumetry is not uncommon. The right posterior sector graft (RPSG) was introduced in ALRLT to overcome the graft-size mismatch when the donor liver had a small left lobe (low remnant volume). The feasibility of RPSG is more dependent on the portal venous anatomical considerations than on the volumetry parameters. This study highlights the importance of the portal venous anatomy in tailoring the type of donor hepatectomy for ALRLT.

Materials and Method: We performed 3 cases of RPSG of 80 consecutive ALRLTs done from January to April 2011. Rest of them was standard right lobe grafts with/without middle hepatic vein or left lobe grafts. A remnant volume of >30%, graft recipient weight ratio (GRWR) >0.7 and the presence of extrahepatic posterior sector portal vein on CT angiography were the important factors in the selection criteria for all the 3 cases. In all 3 patients, the presenting donor was the only donor they had (precious donor). In 2 donors, the standard right lobe graft resulted in a low remnant liver volume. One donor had unfavorable biliary anatomy for right/left lobe grafts giving >2