arrival. Four other children succumbed to the liver failure prior to transplant. Reasons for failure to transplant are due to lack of suitable donor for 1 patient and the inability to secure legal permissions for the other 3 patients. In each of these latter 3 (50% of the cohort), one of the parents was evaluated, suitable and willing for donation.

Conclusion: Only 1 of the 6 children could receive a transplant for AHF. A complicated and tortuous legal process for permission to transplant resulted in long delays and “death while waiting” in half of these children. These deaths are preventable. Though a strong legal system is required to protect the exploitation of unsuspecting donors, in the scenario of AHF, this leads to unacceptable, fatal delays. A concerted effort is essential from the liver transplant community to rectify this unfortunate situation.

22

VASCULAR COMPLICATIONS IN LIVING DONOR PEDIATRIC LIVER TRANSPLANT (LDLT)

MM Zameer, Pavitra, C Vinay, S Rao, AJ D'Cruz, Dayananada

Pediatric Solid Organ Transplant Group, Narayana Hrudayalaya, Bangalore

Background: Children undergoing LDLT are at greater risk of vascular complications, leading to significant morbidity, graft loss, and mortality.

Aim: To assess the incidence, treatment, and outcomes of vascular complications in a cohort of children who had undergone LDLT in our center.

Materials and Method: A retrospective study was carried out from the records of children who had LDLT in our center. A daily protocol Doppler study of graft liver was done in all patients in the first posttransplant week.

Result: Thirty-two children underwent 32 LDLT over a 5-year period. Seven children had vascular complications (3 hepatic artery thrombosis [HAT], 3 portal vein obstruction, 1 hepatic vein obstruction). Recanalization was achieved in all. There was no graft loss. Incidence of HAT was 9.3% ($n=3$). All instances were detected in the first 24 h posttransplant on routine Doppler studies and underwent surgical recanalization—success was achieved in two and the third required endovascular thrombolysis and stenting. All 3 demonstrated adequate arterial inflow after correction and no long-term sequelae occurred in the 2 who have followed up for >2 years. One child had early postoperative acute portal vein thrombosis. Surgical recanalization was not possible and inferior venacaval flow was diverted into the graft portal vein. The child succumbed soon thereafter. One other child developed portal vein thrombosis on a table soon after anastomosis and required reconstruction with a vein patch. There had been

no further problems with this child. One other child developed late portal vein stenosis with symptomatic portal hypertension. This child responded well to endovascular dilatation, and no stent was used. One child developed a partial occlusion of hepatic venous outflow resulting in graft congestion and responded to the creation of a ventral hernia. Of the 32 children, 18 children with biliary atresia had 6 (33%) vascular complications, while only 1 of the 14 (7%) with other primary pathology had such complications (the hepatic venous occlusion occurred in this child).

Conclusion: Incidence of vascular complications is high in pediatric LDLT. The subset of children with biliary atresia has a much higher incidence of vascular complications. The only complication in nonbiliary atresia child could be attributed to a tight abdominal closure. Children with biliary atresia are more prone to vascular complications and need modifications in the technique of vascular reconstruction to achieve good results.

23

POSTLIVER BIOPSY ARTERIOPORTAL FISTULA IN LIVING DONOR LIVER TRANSPLANT—A CASE REPORT

S Ramachandra, S Saigal, N Saraf, R Kakodkar, R Mohanka, S Goja, A Rastogi, B Menon, S Baijal, AS Soin
Institute of Liver Transplantation and Regenerative Medicine, Medanta—The Medicity, Gurgaon, India

In living donor, liver transplantation percutaneous liver biopsy is the gold standard for accurately and safely studying liver histology and is relatively safe. We report a case of arterioportal fistula in a living liver donor after a percutaneous liver biopsy, which was successfully managed by coil embolization.

Case Report: A 41-year-old female, a potential liver donor, underwent a liver biopsy as per protocol. Percutaneous liver biopsy was done using an 18G biopsy gun and the procedure was uneventful. Her liver biopsy showed 40% macrosteatosis. A repeat biopsy was planned after therapy.

Second biopsy was done after 8 weeks and the procedure was uneventful, but the patient came back to the emergency room (ER) after 2 days with right hypochondriac pain and vomiting with doubtful history of melena. The ultrasonography done in the ER showed gallbladder sludge with changes of acute cholecystitis; upper GI endoscopy was normal. Endoscopic ultrasound (EUS) showed cholelithiasis and hemobilia. An endoscopic retrograde cholangiopancreatography was performed showing hemobilia with clots in the common bile duct; an endoscopic sphincterotomy was conducted removing the blood clot from the common bile duct (CBD) and a 10 F × 10 cm plastic stent placed. She received i.v. antibiotics along with 1 unit of blood.