signs of improvement and could be weaned-off ventilatory support and was finally discharged on POD 92.

Conclusion: Through this case, we would like to highlight the existence of cirrhotic cardiomyopathy in these patients which manifests as cardiac failure under stress as well as the need for tuberculosis prophylaxis in transplant recipients with a history of treated tuberculosis.

3

ANESTHETIC MANAGEMENT OF LIVER TRANSPLANTATION FOR FACTOR VII DEFICIENCY IN A 6-MONTH-OLD CHILD—THROMBOELASTOGRAPHY-GUIDED INTRA-OPERATIVE REPLACEMENT OF RECOMBINANT FACTOR VIIa

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Background: Inherited factor VII (FVII) deficiency is a rare hemorrhagic disorder caused by a defect in hepatic factor VII synthesis. Intravenous administration of recombinant FVIIa (rFVIIa) is widely used for the treatment of FVII deficiency, but this requires multiple, expensive injections, and the affected individuals face a constant risk of life-threatening hemorrhage. Liver transplant may offer a permanent curative treatment option in this classification of patients.

Aim: We describe the anesthetic management of a 6-month-old child, weighing 6.8 Kg, with a history of severe congenital FVII deficiency, who underwent a successful liver transplant at our institute. He is the youngest patient to receive a live donor liver transplant (LDLT) to overcome this deficiency.

Method: *Case summary:* A 6-month-old male baby, diagnosed as a case of FVII deficiency at 3 months of age, was taken up for LDLT. Intravenous induction, invasive central venous pressure and arterial blood pressure monitoring were done. Thromboelastography-guided titrated doses of rFVII were administered intra-operatively to ensure an optimal coagulation during the dissection phase. The thromboelastography-aided timing of rFVIIa administration also prevented hypercoagulation during the delicate vascular anastomosis. The total anesthetic duration was 12 hours. The child was shifted to the postoperative unit for elective ventilation and was extubated 8 hours later.

Result: FVIIa level improved in the postoperative period and was 24.3% on the seventh postoperative day. All other biochemical markers were near normal and liver function tests revealed improvement.

4

POSTOPERATIVE CHANGES IN COAGULATION PARAMETERS IN 105 PATIENTS UNDERGOING LIVE DONOR HEPATECTOMIES—IMPLICATIONS FOR EPIDURAL ANALGESIA

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Background: Epidural analgesia is effective in ameliorating the excruciating postoperative pain in donors. However, coagulation derangement has been reported following major hepatic resections and its safety in liver donors is debatable.

Type of Study: Retrospective, observational study in 105 patients undergoing live donor liver transplant (LDLT).

Aim: The primary aim of this study was to analyze changes in the postoperative coagulation parameters for the first 5 days and to establish whether postoperative changes in international normalized ratio (INR) are related to the amount of liver remaining after donor liver graft excision. The secondary aim was to comment on the safety profile of epidural analgesia in live donors.

Method: Coagulation derangement was defined as one or more of the following: peak INR ≥ 1.5 , peak aPTT ≥ 46 seconds, or nadir platelet count $\geq 100,000$. The worst INR recorded over the first 5 days was noted as the peak INR. The peak INR value was correlated with the remnant liver weight percentage (RLW%) applying the Karl-Pearson coefficient of correlation. All cases with INR ≥ 1.5 on postoperative day 5 were noted as a delay in the epidural catheter removal, and any neurological sequel was documented as an adverse event.

Result: Donors of 88.6% had a coagulation derangement, but with spontaneous recovery in 82.9% patients by postoperative day 5. Epidural catheter was safe in all patients in our series. A significant relationship ($P=0.05$) existed between the peak INR and the amount of liver remaining after graft excision.

Conclusion: Epidural catheter placement was safe in all donors.