is a very rare among such inherited disorders. Timely intervention and definitive treatment can change the prognosis in this group.

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AN EVALUATION OF THE DONOR PROFILES AND OUTCOMES OF DONORS IN LIVING DONOR LIVER TRANSPLANT (LDLT)

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Background: The non-availability of organs from deceased donors has led to living donor based-transplantation programs in our country; any morbidity/mortality associated with the living donors could result in major setbacks to the transplant program.

Aim: This study aimed at an analysis of the donor profiles in liver transplants. The pre-operative condition, duration of the hospital stay, and outcomes were analyzed in the intra-operative and immediate postoperative period until the time of discharge from the intensive care unit (ICU).

Materials and Method: Retrospective analysis of prospectively recorded data of liver donors was done from August 2004 to November 2010. Total transplants – 78, deceased donors – 6, and living donor liver transplantation (LDLT) – 72 at a tertiary care referral center was performed. The demographic profile of the donors, comorbidities, the length of the hospital stay, and ICU stay was analyzed. The post-operative highest bilirubin, international normalized ratio (INR), lowest platelet count, morbidity, and mortality were also studied.

Result: The median age among the donors was 40 years (range 21–56 years), male 56 (78%), female 16 (22%), comorbidities DM-2, hypertension-6, DLP-2, median hospital stay 11 days (7–49), median postoperative hospital stay, 10 days (6–4), median ICU stay, 2 days (1–40). The grafts were right lobe with middle hepatic vein (MHV) 54 (75%), right lobe without MHV 8 (11%), left lobe with MHV 7 (10%), left lobe without MHV (34%). The postoperative average serum bilirubin levels were 2.85 mg/dL (1–23), INR 2.11 (1.32–5.57) and platelets 160,000/cmm (26–332). There was no donor mortality in the 78 donors studied. Sixteen patients had grade I morbidity—ascitic leak 4 patients, minor wound dehiscence – 4, and pyrexia – 8. Fourteen patients had grade II morbidity—urinary tract infection – 6, respiratory tract infection – 3, wound infection – 2, positive blood culture – 1, liver dysfunction – 1, and pressure sore – 1. Seven patients had grade III morbidity—sub-diaphragmatic collection – 3, postoperative bile leak – 1, incisional hernia – 2, and delayed abdominal closure – 1. Major grade IV morbidity occurred in 3 patients, superior mesenteric vein thrombosis and hepatic venous outflow

obstruction which were managed surgically. One patient had a small-sized residual liver and prolonged ICU stay.

Conclusion: LDLT donation can have significant morbidity. Careful and critical postoperative evaluation and timely intervention can avoid long-term consequences and improve outcomes.

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EARLY POSTOPERATIVE MORTALITY IN RECIPIENTS FOLLOWING DECEASED DONOR LIVER TRANSPLANTATION (DDLT)—A CLINICAL PROFILE

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Background: Liver transplant often results in hemodynamic and biochemical changes in the immediate postoperative period, often causing more concern.

Aim: To study the pre-operative clinical profile, and the hematological and biochemical changes in the immediate postoperative period up to 7 days following deceased donor liver transplantation (DDLT) patients.

Method: A detailed assessment of the patients' pre-operative clinical diagnosis, the presence of comorbid illness and postoperative hematological, biochemical, microbiological, and clinical events was made between survivors and those who died. Various parameters were compared between 2 groups to understand the various factors that determined early postoperative outcome in DDLT patients.

Result: A total of 26 patients, categorized into Group I – 18 patients (survivors) and Group II – 8 (mortality). There was no difference in the fluctuation of hemoglobin levels between the 2 groups ($10\% \pm 4\%$). Early leukocytosis and persistent azotemia predicted early morbidity and mortality. A significant fall of platelet count predicted mortality. Transaminases showed a significant rise between the second and third postoperative days, stabilized and then showed downward trends between the seventh and ninth postoperative days in both groups. Hypernatremia predicated early mortality. Cause of death was due to intra-operative events such as cardiac arrhythmias, and due to ischemic cardiac events (2), pulmonary thromboembolism (1), and hepatic artery thrombosis (1), and sepsis and multiorgan failure (4). Two patients required renal replacement therapy for resistant renal failure in Group II.

Conclusion: Pre-operative comorbid illness, postoperative worsening azotemia, persistent leukocytosis, and sepsis and cardiac events in the immediate postoperative period predict an outcome post-DDLT.