

ORIGINAL ARTICLE

Safety of supramesocolic surgery in patients with portal cavernoma without portal vein decompression. Large single centre experience

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Summary

Background: Supra-mesocolic surgery (SMS) is complicated in patients with portal vein cavernoma (PC) and portal decompression is recommended. The aim of this study was to report a large single centre of SMS in patients with PC without portal decompression.

Methods: Between 2006 and 2013, all patients who met inclusion criteria were analyzed retrospectively. The primary endpoint was the feasibility rate, surgical and postoperative outcome. The secondary endpoints were the long-term outcome of patients who underwent biliary bypass for cholangitis. Risk factors for complications were studied.

Results: Thirty patients underwent 51 procedures. Pancreatitis was the main etiology of PC (19/30) and biliary obstruction was mainly related to the underlying disease and not to portal cholangiopathy (12/14). All planned procedures were successfully completed. Fourteen patients underwent biliary bypass. Median blood loss (250 ml), transfusion (n = 7), mortality (n = 0), overall morbidity (n = 12) and the median hospital stay (10 days). Good long-term control of cholangitis was achieved in the 9 patients alive with available follow-up. Significant risk factors for complications were a previous abdominal wall scar, previous intra-abdominal surgical field and liver fibrosis.

Conclusion: SMS can be safely performed in patients with PC. In patients with risk factors for complications, portal decompression should be discussed.

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Introduction

Portal vein cavernoma (PC) or cavernous transformation of the portal vein is defined by the presence of chronic obstruction of the main portal vein and the development of collateral venous circulation in the hepatic pedicle.¹ This collateral circulation develops within the porta hepatis including the wall of the bile duct and gallbladder to maintain hepatofugal portal flow to the liver. Associated thrombosis of the superior mesenteric or splenic

veins may occur resulting in segmental portal hypertension in the splenic and mesenteric systems. PC may be due to a procoagulant condition^{2–4} or secondary to a local inflammatory or neoplastic disease.³ Generally PC is asymptomatic, but patients can present with portal cholangiopathy characterized by cholangitis, jaundice or biliary colic^{3,5–7} secondary to mechanical biliary obstruction from the venous collaterals or ischemia.^{8–13} Patients with PC may undergo surgery for complications that are not directly related to PC but to the underlying etiology of the PC. Examples include distal biliary obstruction from chronic pancreatitis. PC is usually considered to be a contraindication to surgery due to the high risk of bleeding and mortality¹⁴ such that certain authors have suggested portal

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Abbreviations: SMS, supra-mesocolic surgery; PC, portal vein cavernoma.

decompression before surgery.^{6,14–16} In fact, the real risk in patients with PC and the added value of portal decompression are not well known. The aim of this study was to retrospectively evaluate all patients with PC who underwent supra-mesocolic surgery (SMS) without portal decompression since 2006.

Methods

Between February 2006 and September 2013, all patients who presented with PC and required SMS without prior portal decompression were reviewed. Demographic, clinical, past surgical history, radiological and surgical data as well as the post-operative outcome were prospectively recorded. Mortality was defined as any in-hospital death or death within 90 days after surgery and morbidity was defined according to the Clavien–Dindo classification.¹⁷ The postoperative outcome was evaluated in relation to the presence of previous abdominal wall scar, previous intra-abdominal surgical field, pedicular or extra-pedicular surgery. Previous intra-abdominal surgical field was defined as any redo surgery in a previously dissected surgical field, like biliary bypass in a patient who had already attempt of pancreaticoduodenectomy. Pedicular surgery was defined as any surgery on the hepatic pedicle (biliary bypass) or cholecystectomy. The primary endpoint was the feasibility rate, operative (transfusion, blood loss) and postoperative (complications, length of the hospital stay) outcomes. The secondary endpoints were the long-term outcome in patients who underwent biliary

bypass for cholangitis. A good outcome was considered in patients who experienced <3 episodes of cholangitis/year treated simply by antibiotics without the need of any endoscopic or percutaneous treatment.

Preoperative assessment

The diagnosis of PC was based on CT with vascular reconstruction. Patients with only partial or tumoral portal vein obstruction with limited collateral veins were excluded from this study. The extension of venous obstruction to major venous axis and the distribution of the collateral circulation within the PC were evaluated on CT scan. Surgery was contraindicated if severe portal deprivation could not be avoided. A complete radiological assessment by endoscopic retrograde cholangiopancreatogram and magnetic resonance imaging³ was performed in patients with biliary obstruction to assess the main cause and location of obstruction, either due to underlying etiology or portal cholangiopathy.

General surgical strategy

The gallbladder was systematically punctured during cholecystectomy to reduce tension, facilitate dissection and improve control of collateral veins. Dissection was retrograde (Fig. 1A). If the cystic duct was difficult to identify or hemorrhage was encountered, the pedicle was controlled and the cystic duct was sutured with the collateral veins. In general, there was some retraction of the infrahepatic area and inflammatory adhesions

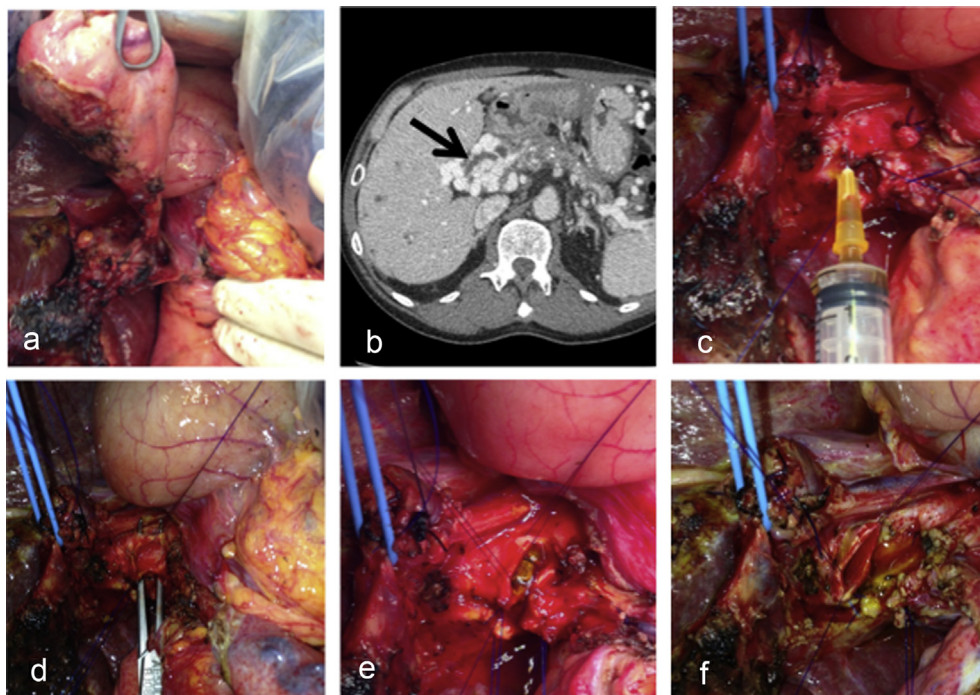


Figure 1 Anterograde cholecystectomy is performed (A). The upper right border of the bile duct (black arrow), relatively free of veins, is searched (B). The bile duct can be identified by puncture (C). Progressive transection of the bile duct (D). Stones extraction can be needed (E). The bile duct is ready for end anastomosis (G)

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