

underwent LDLTx (7M/4F, median age 53 yrs [range 28–67 yrs], median MELD 13 [range 7–28], median graft-to-recipient-weight ratio 1.06 [range 0.73–1.53] with a median warm ischemic time of 40 minutes [range 30–59 minutes]). Urinary flow and samples of arterial blood and urine were taken prior to, during and 2 hours after the anhepatic phase of the LDLTx. Data are expressed as median with range. Differences were tested using Wilcoxon's test. A $p < 0.05$ was considered statistically significant. Results:

	Pre-anhepatic	Anhepatic	Reperfusion
Arterial Ammonia (μmol/L)	84 [40–156]	136 [79–229] ##	87 [51–129] **
Urinary Ammonia excretion (mmol/hour)	0.44 [0.02–6.00]	1.96 [0.32–12.55] #	4.00 [0.79–9.51] #

Legenda: significance from pre-anhepatic value, # $p < 0.05$, ## $p < 0.001$; significance from anhepatic, ** $p < 0.01$.

Conclusion: The anhepatic phase induces hyperammonemia that returned to normal 2 hours after the reperfusion of a partial liver graft. The kidneys significantly increased urinary ammonia excretion during the anhepatic phase which sustained after reperfusion, thereby contributing to the rapid normalization of ammonia homeostasis, confirming the pivotal role of the kidney in interorgan ammonia metabolism.

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DEFINING TRANSPLANTATION SUCCESS

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Usual methods of providing survival data on liver transplant patients focus on either waiting list mortality or post-transplantation survival. Since these two concepts are strongly related, combined pre- and post-transplantation survival figures would allow optimal assessment of the quality performance of different liver transplant programs.

This study presents a relatively simple and uniformly applicable view on assessing the outcome of patients listed for liver transplantation, combining pre- and post-transplant survival figures. All 542 patients having spent any time on the waiting time for liver transplantation in the Netherlands between September 2004 and December 2006 are included in this study.

Of 312 patients removed from the waiting list during the study period, 252 were transplanted, 46 died, 19 were removed due to contra-indications and subsequently died, 12 patients improved and four were lost to follow-up. The death rate per patient year on the waiting list was 10.4% as calculated in concordance with UNOS definitions. Mean waiting time for transplantation was 0.84 years.

The expected value for pre-transplantation mortality was $0.84 * 10.4\% = 8.7\%$.

One year post-transplantation patient and graft survival were 87.7% and 80.0% respectively.

Therefore, transplantation success, defined as the chance to survive up to transplantation and one year thereafter, without re-transplantation, was estimated at $91.3\% * 80.0\% = 73.0\%$.

In conclusion, this study presents a combined method of presenting pre- and post-transplantation survival data, allowing for quality assessment of the performance of different liver transplant programs.

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VERY EARLY HEPATIC ARTERY THROMBOSIS AFTER LIVER TRANSPLANTATION MAY NOT BE DETECTED BY POST-OPERATIVE TRANSAMINASE ELEVATION

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Purpose: To study the liver enzyme elevation secondary to very early HAT after liver transplantation.

Methods: A total of 231 primary, adult, single-organ liver transplants were performed from 1990 to 2007. Fifteen patients (6.49%), were diagnosed with very early HAT either by Doppler or by contrast enhanced computed tomography (ceCT) scan. Aspartate aminotransferase (AST) value ≥ 800 IU/ml within the first two postoperative days predicted early graft failure (within 90 days post-transplant) with 90% sensitivity and 100% specificity ($s=0.960$, $p=0.005$). Group A' patients ($n=9$) reached this threshold, whereas group B' patients ($n=6$) did not.

Results: All liver grafts with very early HAT finally failed, leading to either re-transplantation or patient's demise. Mean graft survival was 32.78 ± 22.82 and 221.17 ± 171.80 days for groups A' and B' respectively ($p=0.006$). Mean AST value two days after transplantation was 2688 ± 1226.18 and 375 ± 169.65 IU/ml for groups A' and B' respectively ($p=0.001$).

Conclusions: Very early HAT after liver transplantation has two distinct patterns of presentation. The first one is associated with high post-operative AST values and leads to rapid graft failure. The second is associated with mildly elevated post-transplantation AST values and leads to a much slower graft failure.

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THE EFFECT OF RECIPIENT RENAL FUNCTION ON SURVIVAL FOLLOWING ORTHOTOPIC LIVER TRANSPLANTATION (OLT)

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Background: One of the goals of the MELD system has been to give priority to patients with pre-transplantation renal insufficiency.

Aim: To evaluate the effect of recipient renal function on survival following liver transplantation.

Methods: This is a retrospective study of 138 patients that underwent OLT at a University Transplant Center in Greece during a period of 15 years. The demographic and clinical data of