

1155 PROPHYLACTIC OPERATIONS IN PORTAL HYPERTENSION DUE TO EXTRAHEPATIC PORTAL VEIN OBSTRUCTION IN A DEVELOPING COUNTRY: LESSONS LEARNED AFTER 26 YEARS

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BACKGROUND: Although the mortality from the first episode of variceal bleeding in patients with cirrhosis may reach 70%, prophylactic portosystemic shunts have been abandoned as they increase long-term mortality due to progressive post-shunt liver failure. However, in patients with extrahepatic portal venous obstruction (EHO), because of the good liver function, variceal bleeding rather than liver failure is the common cause of death. In developing countries shortage of tertiary health care facilities and blood banks leads to a further increase in mortality due to variceal bleeding. Therefore we studied the efficacy of prophylactic operations to prevent variceal bleeding in patients with portal hypertension due to EHO. **METHODS:** Between 1976 and 2002, we prospectively enrolled patients with EHO, who had no history of variceal bleeding, for prophylactic surgery. These patients were included if they had high risk oesophago-gastric varices (grade III-IV, gastric fundal varices), growth retardation, symptomatic biliary obstruction due to biliary calculi or portal hypertensive biliopathy, bleeding diathesis due to hypersplenism and came from remote areas with poor access to tertiary health care facilities. Following surgery these patients were prospectively followed up with regard to occurrence of variceal bleeding, encephalopathy, pedal edema, jaundice and ascites. **RESULTS:** A total of 74 patients (48 males) was prospectively enrolled. The mean age of the patients was 17 years (range 6-55 years). Overall 61 (82.4%) patients underwent proximal lienorenal shunts and 13 underwent splenectomy and devascularization (splenic vein not available). The operative mortality was 1.4%. No patient developed overwhelming post splenectomy sepsis. Hypersplenism present in 49 (66%) patients was reversed in all. 56 patients (76.7%) were followed up for a mean period of 58 months (range 6-228 months). The late complications included one death 6 months after discharge, 2 patients developed membranoproliferative glomerulonephritis and only one had variceal bleeding. No patient developed post shunt encephalopathy. Of the patients followed up, 93% were free of symptoms. **CONCLUSIONS:** Prophylactic operations are safe with good long-term results in patients with EHO. In developing countries, such patients with high-risk esophago-gastric varices and/or hypersplenism, with poor access to medical facilities, should be offered prophylactic lienorenal shunt surgery.

1156 SURGICAL RECONSTRUCTION OF IATROGENIC INJURIES OF THE PROXIMAL COMMON BILE DUCT

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Between January 1994 and June 2003 a series of 45 patients were operated on at our hospital for iatrogenic biliary injuries. Injuries, according to the Strasberg classification, were type E2 in 22 patients, type E3 in 17 patients and type E4 in 6 patients. Thirty patients (66.67%) had undergone open cholecystectomy and laparoscopic cholecystectomy was the primary procedure in 15 (33.33%) patients. Previous repair had been attempted in 12 (26.67%) patients. A total of 46 hepaticojejunostomies was performed. Postoperative death occurred in 2 patients (4.44%). Outcome was graded as excellent, good or poor depending on clinical symptoms, liver function tests, and the need for reintervention due to anastomotic stricture. The mean follow-up was 2.5 + 0.2 years with the longest follow-up 8 years. Following our first repair, 38 of the 43 patients (88.37%) had excellent results, 1 (2.33%) had good results, and 4 (9.30%) had poor results. An early repair was performed in 12 patients (26.66%) out of 45. Except for one patient who died in the postoperative period the results in the other 11 were very satisfactory. We conclude that surgical reconstruction offers excellent or good results for the vast majority of patients with iatrogenic lesions of the proximal common bile duct. Moreover, early repair in carefully selected patients gives equally satisfactory results. This observation requires further confirmation in controlled clinical studies.

1157 LONG-TERM RESULTS AFTER CURATIVE RESECTION FOR CARCINOMA OF THE GALLBLADDER ACCORDING TO THE TNM STAGE

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BACKGROUND: Gallbladder carcinoma (GC) is a tumor of the biliary tract with a poor prognosis. Early GC is frequently asymptomatic and most patients are diagnosed with advanced stage disease. For Tis and T1 gallbladder cancers (stage IA, AJCC-2002), simple cholecystectomy (CT) is considered an adequate therapy requiring no further surgery. Wedge resection (W-R) of the gallbladder bed with lymph node dissection has been reported to improve survival from pathologic stages IB, IIA and IIB. Although extensive surgical treatment for advanced GC (stage III and IV) has been reported, recently its efficacy and long-term results have been disappointing. The aim of the present study was to evaluate retrospectively the long-term results of different surgical treatments. **PATIENTS AND METHODS:** 118 patients with GC were observed - 74 females (63%) and 44 males (37%), with overall age of 63 years (range 38-91). Gallbladder stones were present in 98 patients (83%) and incidental finding of the neoplasia during CT occurred in 25 (21%) (21 traditional CT and 4 laparoscopic). On the basis of the clinical staging, 20 patients (17%) have not been treated because of the tumor extension. 98 (83%) of the patients underwent surgery: in 35 the surgery was radical (36%) and palliative in 63 (64%). **RESULTS:** pTNM stage of the 35 radical resections was: 3 in IA, 10 in IB, 3 in IIA, 6 in IIB, 11 in III and 2 in IV. In long-term follow-up 22 patients (63%) died, 21 due to tumor recurrence (mean survival 11 months, range 2-35) and 1 (IA-pT1b) of natural causes 4 years post-operatively. The average survival rate of the 13 living patients (37%) was 84 months (range 8-225): 1 IA (pT1a) who underwent CT is alive at 26 months postoperatively; 5 IB (W-R) are alive with an average survival of 103 months (range 1-19 years); 2 IIA (W-R) are alive at 116 months (range 15 months to 18 years). Of the 60 stage III patients, 5 of 11 who underwent radical resection (3 right hepatectomies, 1 mesohepatectomy and 1 trisegmentectomy) are alive with an average survival of 313 months (range 8-154). In patients undergoing curative resection, 5-year survival was 15%: 30% in IB patients, 33% in IIA and 18% in III. The average survival rate in palliative treatment and non-operated patients was 3.5 months (range 1-6). **CONCLUSION:** Simple CT seems to be sufficient in T1a patients but inadequate in T1b (stage IA), in which is indicated a more aggressive surgical treatment similar to those for stages IB and IIA. Depth of tumor infiltration is an important prognostic factor and the presence of lymph node metastasis (stages III and IV) should not be a contraindication to aggressive surgery because it may offer a long-term survival or a good palliation.

1158 HEPATIC RESECTION IS THE OPTIMAL TREATMENT FOR MULTIFOCAL OR MULTIPLE LIVER ABSCESSSES

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OBJECTIVE: The aim of this study was to define the role of hepatic resection in the treatment of pyogenic liver abscesses. **DESIGN:** Retrospective cohort study. **SETTING:** Tertiary care, academic hospital. **METHODS:** 86 patients were diagnosed with pyogenic liver abscesses from 1997 to 2002. The patients were divided into 4 study groups. Group A was patients with small (<3 cm) abscesses treated with antibiotics alone (n = 6). Group B was patients treated with US- or CT-guided drainage (n = 54). This group was further subdivided into patients with solitary abscesses (group B1) and those with multiple abscesses (group B2). Group C (n = 20) was patients who underwent liver resection (wedge or segmental), either for complexity of abscess(es) or presence of another intra-abdominal process or failure of percutaneous treatment. **RESULTS:** Recurrence rate in group A was 0%. There was one death. Recurrence rate in group B1 was 19% and all were successfully treated with a second drainage. Two patients died. Recurrence rate in group B2 was 66%, half of which were successfully treated with repeated drainages while the others were treated with an operation. Two patients expired. The recurrence rate in group C was 0%. Two patients in this group expired. **CONCLUSIONS:** Recommendations for treatment of patients with hepatic abscesses are as follows. Simple <3 cm abscesses can be treated with appropriate antibiotic therapy. Larger, unilocular abscesses can be first managed with percutaneous drainage. Failure or recurrence following percutaneous drainage