Abstract# P-89

High MELD Score and Elderly Patients: Should Liver Transplantation Be Contraindicated? Rogerio C. Afonso, Maria Paula V. Coelho, Andre I. David, Marcio D. Almeida, Bianca D. Guardia, Renato Hidalgo, Andreia Evangelista, Gustavo R. Coelho, Guilherme Felga, Sergio P. Meira-Filho, Marcelo B. Rezende, Fernando Pandullo, Ben-Hur Ferraz-Neto. *Programa Integrado de Transplantes, Hospital Israelita Albert Einstein, Sao Paulo, Brazil*

Purpose: High MELD score and the elderly recipients are considered as risk factors for liver transplantation outcome. The goal of this study was to analyze the outcome of patients transplanted with high MELD scores (MELD > 30), comparing the elderly (Age > 60 yrs) to the younger patients (Age < 60yrs).

Patients and Methods: From July 2005 to March 2009, 240 liver transplants were performed at Hospital Israelita Albert Einstein and patients transplanted for acute liver failure or retransplants were excluded. Data were collected prospectively and from 195 patients, we analysed 47 with MELD ≥ 30. Patients were separated in 2 groups according to their age and MELD score as follow: **Group I** – MELD ≥ 30 and age ≥ 60 yrs (n=12); **Group II** - MELD ≥ 30 and age < 60 yrs (n=35). Groups were compared according to age, MELD score, hospital length stay, ICU stay, infectious and renal complications and survival.

Results: Table 1 shows the results.

Table 1 - Results

	Age	MELD	ICU stay	Hospital stay	Infection	Renal failure	Survival
Group I	65,25 (4,7)	35,08 (10,07)	14,08 days (21,21)	46,5 days (55,7)	50%	100%	66,7%
Group II	46 (12,6)	31,71 (6,58)	14,86 days (25,9)	34,1 days (31,7)	51,4%	85,7%	76,3%
	p<0,001	p=0,403	p=0,998	p<0,001	p=1,00	p=0,308	p=0,292

Conclusions: Advanced age should not be a contraindication for liver transplantation, even when considering recipients with higher MELD scores.

Abstract# P-90

First Results and Experience of a New Liver Transplant Centre. Efstathios A. Antoniou[1], Katerina Labathariou[2], Dimitrios Karoussos[2], Dimitrios Mantas[1], Dimitrios Dimitroulis[1], Nikolaos Nikitakis[1], Panorea Paraskeva[1], Paul Vernicos[3], Anastasios Smyrnis[1], Stylianos Kykalos[1], Evanthia Svolou[1], Kaliopi Tsinari[2], Ioannis Floros[3], Alkiviadis Kostakis[1]. *[1]Liver Surgery and Transplantation Unit, 2nd Propedeutic Surgical Department, University of Athens, 'Laikon' Hospital, Athens, Greece; [2]Anaesthetic Department, 'Laikon' Hospital, Athens, Greece; [3]ITU, 'Laikon' Hospital, Athens, Greece*

Introduction: We present the first results and experience of our centre during the first three years of its operation.

Methods: From July 06 to July 09, thirty two OLTx performed in our centre. All the OLTx performed by the same surgeon and there was a trained anaesthetic team. There was a wide range of causes of hepatic failure: viral hepatitis cirrhosis (B or C), PBC, PSC, ALD, epithelioid haemangioendothelioma (2 cases). Also, three cases for fulminant hepatic failure and one double transplant (liver and kidney) due to hepatic and renal failure, possible due to NSAID. One of the patient with HCV had also HCC and sigmoid colon Ca. He first had an OLTx and 2 months later the signoidectomy. The majority of the patients had MELD score greater to 23.

Results- Conclusion: There were 10 deaths in the first four months, post-transplant. First month survival was 80% and 72% first year survival. There was not any peri-operative death, nor any death due to surgery or anaesthesia. There were three post-operative septic shock deaths, one due to brain haemorrhage, one with primary non-function (PNF), one of heart attack, three deaths due to post-transplant bacterial infection and one due to right hepatic artery thrombosis (HAT). The last one re-transplanted but died due to massive splenic infarct and septic shock. There were two bile duct stenoses and one bile leak -patient with HAT.

Our results are quite similar to those of well established OLTx programs, despite the peculiar and difficult problems we faced during the above period. However, we think that detailed pre-OLTx assessment, well trained staff and commitment to OLTx by those who are involved to it, can give good results.

Abstract# P-91

Survival Outcome after Early and Late Hepatic Re-Transplantation (Re-LT) for HCV(+) and HCV(-) Patients. Eliano Bonaccorsi-Riani, Olivier Julliard, Olga Ciccarelli, Chantal De-Reyck, Francine Roggen, Ziad Hassoun, Benoît Kabamba, Christine Sempoux, Jan Lerut. *Unit of Abdominal Transplant, Université Catholique de Louvain - Cliniques Universitaires Saint Luc, Brussels, Belgium*

AIM: Compare the outcome of patients who underwent early (< 3 months) and late (> 3 months after LT) re-LT in HCV(+) and HCV(-) patients (pts) in a single center retrospective study.

METHODS AND MATERIAL: From February 1984 to July 2009, 895 LT were performed in 789 adults (≥ 16 yrs) in our center. Ninety-eight (12,4%) pts needed a second graft, 21 pts were HCV(+) and 77 pts were HCV(-). In the HCV(+) group, 12 pts underwent early and 9 pts late re-LT, in the HCV(-) pts, 41 pts and 36 pts needed early and late re-LT. Demographic data, clinical scores,second graft and patient survival of both groups were compared and analysed.

RESULTS: HCV(+) pts were significantly older than HCV(-) pts (52,6± 9,5 vs 42,4±15,1 yrs) (p=0,004). Hepatocellular cancer was present in 20% of the HCV(+) pts and in 25% of the HCV(-) pts (ns). Mean time of late re-LT in HCV(+) and HCV(-) were 52,26±34,1 and 36,72±46,6 mo resp. (p=0,35). Mean follow-up was 69 mo (0,07 to 225). Main indications for early re-LT in HCV(+) and HCV(-) pts were graft dysfunction (7/12 and 23/41 resp.). Indications of late Re-LT in HCV(+) pts were HCV recurrence (7pts), ischemic type biliary lesion (ITBL) (1 pat) and HBV related cirrhosis (1 pat). ITBL was the main indication of late re-LT in the 19 HCV(-) pts, followed by chronic rejection in 10 pts. Actuarial 1-year patient survival rates after early re-LT for HCV(+) and HCV (-) pts. were 75% and 58% resp. (p=0,50). Actuarial and 1-year patient survival rates after late Re-OLT for HCV(+) and HCV(-) pts. were 89% and 83% resp. (ns). Actuarial and 5-year patient survival rates after early re-LT for HCV(+) and HCV (-) pts were 58% and 41% resp.(p=0,51). Actuarial and 5-year patient survival rates after late re-LT for HCV(+) and HCV(-) pts were 57% and 69% resp. (p=0,71). Six HCV(-) and only 1 pat. in the HCV(+) all needed a late second re-LT because ITBL.

CONCLUSION: In these series re-LT in HCV(+) pts had comparable early and long term results to HCV(-) pts as well in case of early as late re-LT. Retransplantation remains a valuable treatment option in HCV(+) pts having both early graft dysfunction and allograft viral recurrence.

Abstract# P-92

Low Volume Deceased Donor Liver Transplantation Alongside Living Donor Liver Transplantation. See C. Chan, Chung M. Lo, Albert C. Chan, Simon H. Tsang, Tan T. Cheung, William W. Sharr, Kenneth S. Chok, Sheung T. Fan. *Department of Surgery, Queen Mary Hospital, University of Hong Kong, Hong Kong, China*

Background:

Living donor liver transplantation (LDLT) is to date the only realistic life-saving treatment alternative to deceased donor liver transplantation. With advances in surgical techniques and therapeutics in the last decade, despite the use of a partial graft, which is often small-for-size, LDLT is at least as good as deceased donor liver transplantation (DDLT).

Methods:

We looked into the outcomes of DDLT, in low volume, by international standards, alongside a matured LDLT service. Comparison was made between our LDLT and overseas DDLT.

Results:

From 1991 to the end of 2007, we performed 185 DDLT (Era I, n=59, Era II, n=126). Era I coincided with the first 50 LDLT in our center and was considered the formative period. All donors were brain-dead and heart-beating with a median age of 47.5 (range, 9 – 76 years). Up to 65.9% of recipients were hepatitis B carriers. Up to 29.7% were transplanted on high urgency basis and 14.6% for hepatocellular carcinoma. The Model for End-stage Liver Disease score was 21 (range, 6 – 56). Before transplantation, 15.7% were in the intensive care unit and 19.7% in hospital. Hospital mortality rate dropped from 13.6% (8/59) of Era I to 4.8% (6/126) of Era II (p = 0.035). Recipient survival rates of Era I were 84.8%, 79.7%, and 76.3% and increased to 92.9%, 89.6%, and 88.0% at 1, 3, and 5 years (p = 0.0147). Only