

EBL during liver resection was 165 (0 - 800) ml. Median preoperative serum creatinin (Scr) was 0.82 g/dl (0.5-1.74) and postoperative Scr was 0.74 g/dl (0.44-1.68) . CVP drop was associated with EBL ($P<0.001$). There was no significant impact of CVP drop on postoperative Scr. There was a transfusion rate of 2%. A univariate analysis showed a significant correlation of gender, pre-operative hemoglobin, non-anatomical resection and use of a Pringle maneuver to increased blood loss. Type of surgery (laparoscopic, open or conversion) had no impact on EBL. In a multivariate analysis CVP drop and wedge/non-anatomical/metastasectomy were predictors of lower EBL. In contrast posterosuperior resection, use of straight bipolar device (Ligasure) and duration of surgery were significantly related to higher blood loss.

Conclusions: CVP drop after HP is a strong independent predictor of EBL during liver resection. The technique of HP is safe and feasible with strict adherence to anesthetic protocol and has no negative impact on renal function. We advocate the routine use of HP to reduce perioperative blood loss and transfusion rates in liver surgery. Measurement of CVP drop as a predictive tool can help surgeons to decide if a laparoscopic approach is safe for resection of lesions in proximity to the vena cava, hepatocaval confluence or hepatic veins.

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Radioembolization using Yttrium 90 microspheres for unresectable liver metastases: a single centre experience.

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Introduction: Yttrium 90-loaded microspheres transarterial radioembolization is a selective internal radiotherapy (SIRT) directed against liver tumors. Many studies have demonstrated its efficacy for hepatocellular carcinoma (HCC), liver metastases of neuroendocrine tumors (NET) and colorectal (CRC) liver metastases.

Aim: Our purpose was to evaluate in our centre the efficacy and safety of SIRT for liver-dominant or exclusive tumors known to be less vascularized (patients with HCC and NET were here not analyzed).

Methods: Between 2011 and 2015, patients with liver dominant or exclusive metastases candidate for SIRT were prospectively registered in clinical database at the Cliniques universitaires St-Luc. All these patients underwent a pretherapeutic workup (liver angiography + ^{99m}Tc -MAA scintigraphy) to prepare the hepatic vascularization and exclude treatment contraindication (^{99m}Tc -MAA extrahepatic uptake). SIRT was performed 1 to 2 weeks after the workup for eligible patients. Disease response was evaluated by FDG-PET-scan (6 and 12 weeks). Median overall (OS) and progression-free survival (PFS) were

estimated using an accelerated life failure log-logistic model and compared by the Smirnov and weighted Gehan logrank tests. Other comparisons were made using the Wilcoxon-Mann-Whitney, Smirnov and Chi-squared tests.

Results: 76 patients (CRC=46, cholangiocellular=7, ocular melanoma=13 and others cancers types=10) were evaluated. 36 patients (47.4%) underwent SIRT and 40 patients (52.6%) were not treated (control group). Except for 99m Tc-MAA liver uptake, the 2 groups (SIRT vs Control) were not significantly different. mOS for SIRT patients (vs control) was significantly higher in the whole cohort (13,5 vs 6,8 months, $p=0.0055$) and CRC cohort (12,3 vs 5,5 months, $p=0.007$). Liver metastases burden >50%, FDG-PET progression after SIRT and progression in the treated liver were associated with a worse OS ($p<0.05$). No significant PFS difference was observed between groups. Disease control rate after SIRT was 51.6% and 32,3% at 6 and 12 weeks. None disease characteristics (including 99m Tc-MAA liver uptake) were significantly associated with tumor response. Serious adverse event occurs in 2,6% ($n=2$: 1 SIRT, 1 control).

Conclusions: As compared to the control group, SIRT was safe and was associated with an OS benefit for patients with liver dominant or exclusive malignancies.

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A prospective study on the impact of a NET specific multidisciplinary tumor board on individual treatment plans

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Introduction: Multidisciplinary care is ideal in the management of patients with cancer and is associated with improvements in diagnosis, treatment planning, survival, patient satisfaction and clinician satisfaction. Traditionally, multidisciplinary tumor boards (MDTs) focus on treating common cancers. Whereas for rare cancers the need for thorough MDTs remains a current challenge to face because knowledge on rare cancers is often confined to certain practicing physicians or only centers where patients are seen in high volume. To cope with this, a multi-institutional health network (nine hospitals) was set up in the region of Antwerp-Waasland in Belgium for the multidisciplinary care of gastroenteropancreatic neuroendocrine tumor (GEP-NET) patients, called "NETwerk". In this scenario, local multidisciplinary teams refer all GEP-NET patients to be discussed among NET specialists in