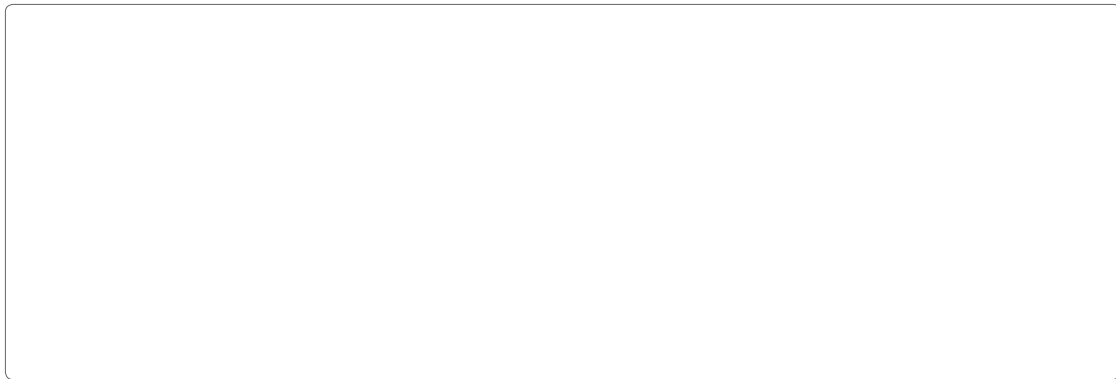


Effects of Juvenile Liver Transplantation and Transmesenteric Portal Vein Recanalization

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Keywords: Clinical Research/Practice; Complication; Surgical technical; Liver transplantation.

Introduction

Based on data from the Organ Procurement and Transplantation Network, the 5 year patient survival rate after Portal vein stenosis and thrombosis after liver transplantation may be asymptomatic or associated with a variety of clinical manifestations, such as ascites, variceal bleeding, splenomegaly [1], changes in liver function tests, and low platelet count. The introduction of innovative surgical techniques, the development of immunosuppressive therapy, and improvements in preoperative patient care have Percutaneous transhepatic angioplasty (PTA) is the first line of treatment for portal vein stenosis and has been extremely effective. However, stent placement has been an option to reduce the risk of recurrent stenosis, which can occur in 28%-50% of these patients. Recanalization of the portal vein via the peripheral transhepatic approach is difficult in patients with persistent (> one month) portal vein thrombosis (PVT), excluding venoplasty [2]. The failure rate in these patients can be as high as 75%. Sclerotherapy, surgical bypass, and retransplantation are all options for treatment when percutaneous venous angioplasty fails.

Transmesenteric portal vein recanalization (PVR) with stent placement for chronic PVT in children undergoing liver transplantation was the goal of this retrospective evaluation. At Srio Libanês Hospital and A. C. Camargo Cancer Center in So Paulo, Brazil, 566 children underwent liver transplants from November 2002 to December 2013. 28 recipients (4.9%) who developed chronic PVT and underwent PVR with stent placement using a transmesenteric approach following a minilaparotomy are the subjects of this study [3]. These procedures were carried out from August 2008 to December 2014, with July 2016 serving as a follow-up. The same transplant team's transplant surgeons, pediatric hepatologists, and interventional radiologists cared for the patients and determined the procedure's purpose and timing. GI bleeding (GIB), hypersplenism with a low platelet count (100,000/mm3), ascites, and/or endoscopic esophageal varices on a triphasic upper abdominal computed tomography (CT) scan with evidence of chronic PVT were all considered indications. As a first step in diagnosing chronic PVT, all patients underwent abdominal Doppler

ultrasound (US) imaging prior to abdominal CT. In one instance, magnetic resonance imaging (MRI) was utilized. From the medical records, demographic, clinical, and imaging data were gathered. The study was approved by the institutional review boards of both hospitals, and the children's relatives gave their informed consent [4].

Method

The number of pediatric liver transplants has increased across all age groups. However, there has also been a slight increase in the number of vascular complications in transplant recipients following anastomoses involving small structures. Additionally, portal vein sclerosis and biliary atresia, the most common reason for transplantation in children, may exacerbate difficulties during vascular reconstruction. Direct anastomosis between the donor's left portal vein and the recipient's portal vein trunk or the creation of an interposition vascular graft from the recipient's superior mesenteric-splenic vein connection to the left

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