ple variable sized masses in right hepatic lobe and segment IV, variable sized nodules in both lungs and about 1 cm sized nodule in left adrenal gland in the imaging studies. Largest liver mass is more than 10 cm. We performed a palliative right trisectionectomy. At the 32-months after surgery, the patient is still alive with a good general performance status. (Case 3) a 50-year-old man had huge mass replaced right hemiliver with malignant thrombosis in right posterior portal vein and invasion of right and middle hepatic vein. We performed right hemihepatectomy, diaphragm excision due to invasion, and evacuation of tumor thrombus from hepatic vein and plasty of IVC. During the 5-months follow-up period after surgery, imaging studies revaled no unusual postoperative findings. (Case4) a 66-year-old man had two large (10 cm and 11 cm) nodular HCC, three tiny intrahepatic metastatic lesions in left lobe, tumor thrombus in right hepatic vein and thromboembolism in both pulmonary artery. We performed a right trisectionectomy. At the 2-months after surgery, imaging study showed no evidence of recurred HCC. (Case 5) a 43-year-old woman had 5 cm sized IHCC in the caudate lobe with invasion of IVC and main portal vein. After preoperative chemo-and radiotherapy, left trisectionectomy and resection of IVC was performed. At the 15-months after surgery, she is well tolerated despite of IVC throumbus.

Conclusion: In spite of macroscopic extrahepatic metastases or major vessels involvements, extensive surgery for primary hepatic malignancy could lead to a relatively favorable outcomes. An aggressive surgical treatment would be an optional treatment modality to improve survival.

IV-6

Left Trisectionectomy for Hepatocellular Carcinoma after Portal Vein Embolization (Video Presentation)

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Background: Major hepatic resections are increasingly performed for large hepatocellular carcinoma (HCC) to achieve complete resection and provide the possibility of cure, given that liver transplantation or ablative therapy is not indicated for these tumors. However, major hepatic resection is frequently contraindicated in many HCC patients because of the increased risk of postoperative hepatic failure. Portal vein embolization (PVE), which induces atrophy of the embolized lobe with compensatory hypertrophy of the nonembolized future liver remnant, has been increasingly used to reduce the risk of postoperative hepatic failure in patients undergoing major hepatic resection. Here, I introduce my video clip. 63 year-old patient with HBV-LC and HCC was admitted to undergo liver resection after TACE from another hospital. The patient's MRI showed two abutting large mass in S4 and S8 of the liver and the tumor in S4 that was suspicious of invasion to left lateral section. There were no extrahepatic metastases in chest CT, bone scan and whole body PET. The laboratory findings were as follows; CBC 6100-13.7-40.9%-214k, PT 90.3%, SGOT/SGPT 57/25, TB 1.0, AFP 4918 ng/ml, PIVKA II >20,000 mAU/ml and ICGR15 14.1%. We decided to perform left trisectionectomy after left and right anterior PVE because of the small remnant right posterior liver volume. The operative time was 320 mins and estimated blood loss was less than 800 ml. There was no complication and no transfusion. The patient was discharged on postoperative day 13.