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Preoperative Massive Hemothorax in Living Donor Liver Transplantation; Arterial Trauma During Central Venous Catheter Insertion

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A 60-year-old man was admitted to the transplantation center because of HBV related HCC liver transplantation. He underwent central line cannulation at the right subclavian vein with a triple lumen 10 Fr. During a trial of repeated vessel approach, systolic blood pressure dropped to 50 mmHg. Manual compression was done, followed by AP Portable chest radiogram. Massive Hemothorax was found causing Left lung hazziness. On duplex examination by the radiologist, there was a leakage at the posterior wall of subclavian artery near the brachiocephalic trunk. A guiding catheter was inserted in the subclavian artery by transbrachial approach. This was treated with a 38×10 mm stent graft (Jostent;Abbott Vascular, Temecula, Calf). It was confirmed that there was no leakage by duplex examination. A chest tube was placed, and a large amount of blood (2,300 cc) was drained. After the stabilization of vital signs, living related liver transplantation underwent successfully. Radiological follow-up studies demonstrated that the function of patent stent-graft was normal.

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A Case of Hepatocellular Carcinoma with Intraductal Growing Extended into Intra- and Extra-Hepatic Bile Duct

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Introduction: Hepatocellular carcinoma (HCC) may involve the biliary tract in several different ways: tumor thrombosis, hemobilia, tumor compression, and diffuse tumor infiltration. Obstructive jaundice as the main clinical feature is uncommon in patients with HCC, so such case has possibility of being incorrectly diagnosed as cholangiocarcinoma. We experience a unusual type of HCC and herein report the case.

Case: We describe a 38-year-old man who presented with painless jaundice. Laboratory tests revealed abnormally high serum levels of total bilirubin (8.4 mg/dL) and direct bilirubin (8.1 mg/dL). The patient was found to have enhancing mass in the left intrahepatic bile duct (IHBD) and proximal common bile duct (CBD) without definite parenchymal mass on abdominal computed tomographic scan. The MRI shows similar findings to CT scan. The tumor marker evaluation shows that serum alpha-fetoprotein (AFP) and carcinoembryonic antigen (CEA) were elevated upto 1,353 IU/mL and 239 U/mL, respectively and carbohydrate antigen (CA) 19-9 was within normal range. Ultrasonography-guided mass biopsy targetting intrabile duct mass was done so as to differentiate hepatocelluar carcinoma with Klatskin tumor. Histopathologic findings was reported as compatible with HCC. At surgery, multilobulated mass was detected located in liver left lateral segment and it was extended along left IHBD to proximal CBD which was packed with intraductal protruding mass. But the wall of dilated CBD was soft, which indicated no any sign of tumour direct invasion, and an intraductal mass was suspected. Therefore, a choledochotomy was performed at the level of CBD bifurcation and then yellowish and soft intraluminal tumor mass was removed subsequently. The mass was not adherent to the bile duct wall and the gross appearance of CBD inner wall was smooth and normal. To clarify the diagnosis of negative invasion of CBD, an intraoperative frozen biopsy was done, indicating negative for malignancy. The patient underwent left hepatectomy and T-tube drainage. Histology and immunohistochemistry examnination confirmed that both liver parenchymal mass and intraductal mass were HCC.

Discussion: The reports for intraductal growing HCC is extremely rare, but Recently, the characteristics and intervention strategies of this unusual type HCC, clinically classified as 'icteric-type hepatoma' (Lin, et al. 1975), have been disclosed gradually. In the previous reports, direct tumour invasion of bile duct wall has not been noted in the most cases of this type HCC. Moreover,combined resection of bile