

For the patient with the tumor firmly attached or invaded to the diaphragm, partial resection of the diaphragm is mandatory. After liver resection, intraoperative cholangiography may be necessary for checking bile duct injury with bile leakage. In conclusion, for huge tumors located in the hilar area, central bisectionectomy is optimal method for complete resection of tumor with more preserving non-tumorous hepatic parenchyme for safety of the patient.

We report central bisectionectomy for the giant hepatocellular carcinoma located on the hilar area to evaluate whether this procedure represent a valuable technique in this situation.

2. Totally laparoscopic living donor right hepatectomy

Department of Surgery, Sungkyunkwan University
School of Medicine, Korea

Choon Hyuck Kwon

Laparoscopic approach for hepatectomy is known to reduce hospital stay, decrease morbidity, improve cosmetic results and allow early return to normal life compared to open surgery. Living donors would be the patient group who would benefit most from laparoscopic approach but due to technical difficulties it has not been performed much for right hepatectomy. The author presents living donor right hepatectomy done by totally laparoscopic approach.

The right hepatectomy was done as usual manners as in open surgery. In short, after the round ligament, the falciform ligaments were dissected, the right side of the liver was mobilized up to the IVC. The right hepatic artery and right portal vein was isolated after division of the cystic artery and duct and clamped with bulldog clamp to verify the demarcation line between left and right, but was left intact during the whole procedure and the inflow control was not done. Ligasure was used to divide the parenchyma close to the capsule, but CUSA along with bipolar electro-

cautery was used for deeper dissection. After most of the liver parenchyma was divided, the bile duct was divided. The whole glissonian structure other than the artery and portal vein was left intact to preserve the microcirculation around the biliary tree to decrease possible bile duct complication in the recipient. The remnant bile duct was closed using prolene 5-0 in a continuous fashion. The retrieval bag was wrapped around the graft and 12cm Pfannentiel incision was done before division of the artery or veins to decrease warm ischemic time. Double clips were used for ligation of the artery and divided. To not sacrifice any length of PV and HV, one sided Endo-TAE was applied on the remnant donor side and cut along the stapler line after applying only a bulldog clamp on the graft side veins. The back table graft perfusion was done within 5 minutes of warm ischemic time. The donor did not require transfusion, recovered without any complication and was discharged on day 7. The recipient recovered uneventfully.

Living donor right hepatectomy by totally laparoscopic approach, although technically demanding, may be done safely in centers specialized for living donor liver transplantation and laparoscopic liver surgery. It may offer good cosmetic outcome with quicker return to normal life as long as it is done safely.

3. Laparoscopic anatomic right anterior sectionectomy of liver using a hanging maneuver and glissonian approach

Department of Surgery, Konyang University College
of Medicine, Korea

In-Seok Choi

Introduction

Laparoscopic anatomical right anterior sectionectomy of liver is rarely reported due to large cut-surface area and difficulty of bleeding control.