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LIVER TRANSPLANTATION BY LAWRENCE J. KOEP, M.D., AND THOMAS E. STARZL, M.D.

Comments

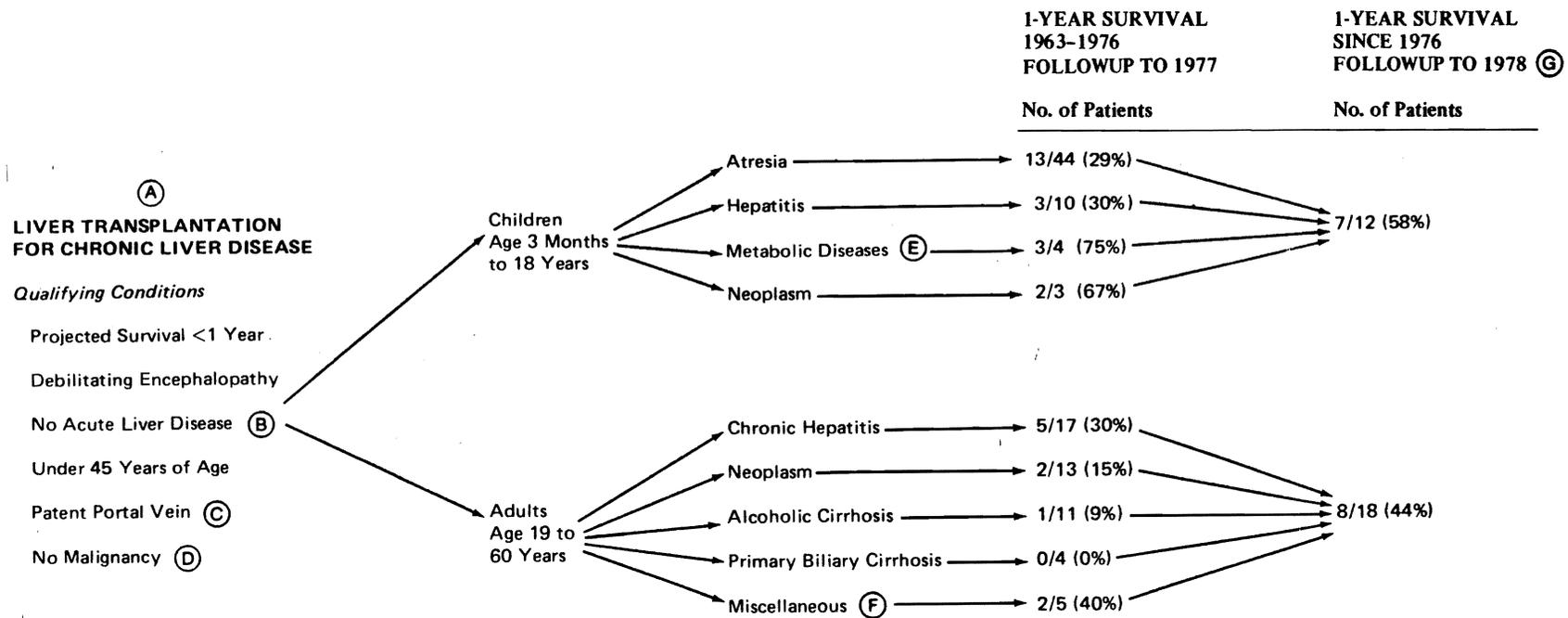
- A. There are only two groups of liver transplants that are large enough for statistical analysis — our own and that of Calne in England. This chapter pertains only to our own experience.^{1,2}
- B. The prognosis for acute hepatitis is so difficult to project that a terminal condition is recognized too late to provide adequate time for locating a suitable donor.
- C. Portal vein patency is imperative in order to provide the hepatic homograft with necessary hepatotrophic factors. Portosystemic shunts are taken down at the time of surgery. We prefer to do distal spleno-renal shunts in potential recipients, though an end-to-side portacaval shunt can readily be taken down also. Hepatic artery occlusion is not a contraindication, since the donor hepatic artery can be anastomosed to the aorta, but this entails considerably more dissection.
- D. The Denver experience has been poor in malignant disease, and recipients with malignancies are now generally avoided. Our longest survivor, however, had a small incidental hepatoma. Calne has had a more favorable experience with malignancies.³
- E. Metabolic diseases treated by hepatic transplants are Wilson's disease, alpha₁-antitrypsin deficiency, and tyrosinemia.
- F. Miscellaneous causes for adult hepatic transplantation are secondary biliary cirrhosis, sclerosing cholangitis, massive hepatic necrosis, Budd-Chiari syndrome, and congenital biliary hypoplasia.
- G. A number of changes were made in August 1976 that resulted in improved survival. This latest group is presented separately as an indication of the survival currently enjoyed. Survival rates beyond one year include small numbers from all disease categories. The longest survivor is in good health 9 years after transplantation.

References

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Prognosis of Surgical Disease

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