Between June 2007 and December 2011, 25 LDLT procedures were carried out in our unit. The criteria for donor selection included age, fitness for surgery and remnant liver volume. Donor demographics, graft type, complications, length of stay and overall survival were extracted. Donor morbidity was assessed objectively using the modified Clavien-Dindo classification. Continuous variables are expressed as mean ± SD.

**Results**

The mean donor age was 38.4 ± 11.0 years and donor BMI was 23.9 ± 2.8 kg/m². Two donors were abandoned on table due to complex arterial and biliary anatomy respectively. The graft type was right lobe (n=12, 52.2%), left lateral lobe (n=10, 43.5%) and left lobe (n=1, 4.3%). The graft weight was 528.5 ± 258.9 g. The morbidity was 21.7% (n=5). There were three Clavien grade II complications (wound infection, urinary infection and unknown sepsis needing antibiotics). One patient needed laparotomy for haemorrhage (Grade IIIb) and another patient had ultrasound guided drainage of subphrenic collection (Grade IIIa). None of our patients had any post-operative blood transfusion. The length of hospital stay was 7.9 ± 2.8 days. At the end of median follow-up of 21.4 months, all our donors were alive, with no long-term morbidity.

**Conclusion**

Our experience shows that donor hepatectomy for Living Donor Liver Transplantation is a safe procedure in a small volume unit. Our donor morbidity of 21.7% is comparable or better than most high volume centres across the world. Number of procedures performed by the unit shouldn’t be an hindrance to the introduction of live donor liver programme.

**Competing interests**

None declared.

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**Impact of Body Mass Index on the Outcome of Liver Transplantation in Children**

**Methods**

Data were retrieved from a prospectively maintained institutional database from 1994 to 2009. Patients were stratified into five BMI categories established by the WHO according to their Z scores: severe thinness (< -3), thinness (-2), normal weight (0), overweight (+2) and obese (+3). Primary outcome was to evaluate post-operative morbidity and secondary measures were overall patient and graft survival. Categorical variables were analysed by χ², and continuous variables by one-way ANOVA. Kaplan–Meier curves were used to study patient and graft survival.

**Results**

146 paediatric liver transplants recipients were identified, of which 152 patients with height and weight data were included. 12.2% of patients were underweight (Z score < -2 and -3), 8.3% were overweight (Z score +2 and +3) and the remaining 79.5% were normal weight for age. The overall morbidity was higher in underweight recipients in comparison to normal weight recipients (81.2% vs 42.8%, p=0.006). Post-operative septic events were common in underweight recipients in comparison to normal weight recipients (75.0% vs 25.7%, p<0.001). Underweight patients had significantly longer intensive care stay than normal weight patients (mean 5.6 vs 3.1 days, p=0.029). The length of ventilation period was longer in underweight recipients in comparison to normal weight recipients (mean 3.4 vs 0.9 days, p=0.001). There was no difference in the overall length of post-operative hospital stay between underweight and normal weight recipients (mean 54.2 vs 36.9 days, p=0.602).

There was no difference in the post-operative septic events, ITU stay, ventilatory period and hospital stay between overweight and normal weight. There was no difference in overall graft (p=0.049) and patient survival (p=0.984) between the three groups.

**Conclusion**

This is the only reported UK series on BMI and outcome following paediatric liver transplantation. Despite current standards of peritransplant management we have demonstrated increased overall morbidity in underweight patients, with increased rates of post-operative septic complications, longer ventilatory period, and increased length of intensive care stay. However, unlike earlier studies, patient and graft survival were not affected. This study does not demonstrate any effect of obesity on post transplant morbidity or mortality.

**Competing interests**

None declared.