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50 patients of investigational group (IG) additionally were treated by Sibutramin, daily dosage contained 15 mg and PUPC (daily dosage contained 1368 mg Phosphatidylcholine). 30 patients of control group (CG) were treated by Sibutramin, daily dosage contained 15 mg.

**Results** All 50 patients of IG and 30 patients of CG were available for follow-up reliable decrease (12.8%) of BMI and leptin level. In IG patients BMI and leptin level (24.7±2.1%—16.2±1.2%) was registered compared to CG patients (BMI decrease—9.3%, leptin level 24.5±1.5% to 19.9±1.1%). Moreover after 6 months of treatment the mean value of disease activity evaluated by Metavir scale was A1 in IG and A3 in CG. The results of liver biopsy (histological examination) and Fibromax test showed, that in patients with ALD additionally treated by PUPC, the progress of hepatic fibrosis was significantly slow, then in CG (Fibromax test result: F1 vs F3) (p<0.06). In addition after 6 months of treatment we found significant increase of steatosis in CG, and its reduction in IG (p<0.08). Ultrasound studies were performed on the basis of liver attenuation value assessment and revealed the hepatic echo-texture had become significantly improved after Sibutramin treatment in 46/50 (92%) of patients, while there was no change in 7/30 (23.5%) individuals. Also in patients additionally treated by polyunsaturated phosphatidylcholine and Sibutramin we found significant reduction of glucose, insulin levels and of insulin resistance index HOMA. The usage of Sibutramin itself did not reveal significant changes.

**Conclusion** Study results suggest that Sibutramin combined with PUPC improves liver function and insulin-sensitivity, reduces steatosis and fibrosis in patients with obesity and effect of combined therapy is higher than of Sibutramin itself.

**Competing interests** None declared.

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**PTU-082**

**RIGHT AND EXTENDED RIGHT HEPATIC TRISECTIONECTOMY: SHORT AND LONG TERM OUTCOMES OF 332 RESECTIONS**

doi:10.1136/gutjnl-2012-302514c.82

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**Introduction** Despite advances in surgical and anaesthetic techniques over the last 2 decades, right hepatic trisectionectomy (RHT) is still a challenging procedure associated with higher rates of morbidity and mortality. Some patients may even require further extension of the resection to include part of segments II/III to achieve clearance (extended right hepatic trisectionectomy, ERHT). Aim of the study was to assess and compare the early and long-term outcomes of RHT and ERHT in our Unit.

**Methods** From January 1993 to December 2010, 252 RHT and 80 ERHT were performed (n=332). Resection for colorectal liver metastases (CRLM), HCC, cholangiocarcinoma and other were 127, 43, 25 and 57 for RHT and 60, 3, 2, 15 for ERHT respectively. Mean age was 58.3 vs 57.9 and 57.1% vs 55% were males (RHT vs ERHT, p=NS). There were 61 caudatectomy in the RHT group and 15 in the ERHT (p=0.36, NS); vascular resection (IVC or PV) was performed in 61 and 10 cases (p=0.18, NS), biliary reconstruction was performed in 75 and 7 cases (p=0.01) and total vascular exclusion was necessary in 26 and 6 cases respectively (p=NS). The amount of functional hepatic remnant was based on intra-operative judgement.

**Results** There were 23 in-hospital deaths (6.9%, RHT: 19, ERHT: 4; p=NS). Overall morbidity was 44% (RHT) and 47.5% (ERHT). Bile leak (17 vs 3), haemorrhage (14 vs 4), sepsis (33 vs 9), cardiovascular events (12 vs 1) and renal failure (12 vs 3) did not differ among the two groups (RHT vs ERHT, p=NS). There were 42 (12.6%) post-hepatectomy liver failure (according to “50.50 criteria”): 23 in the RHT group and 19 in the ERHT group respectively (p=0.001). Mean hospital stay was 15.8 vs 17.1 days (RHT vs ERHT, p=NS). In the CRLM cohort, 1, 5 and 10 year survival was 78%, 47% and 39% vs 79%, 47% and 37% (RHT vs ERHT, p=0.93, NS). Median survival was 49 and 43.9 months respectively (p=NS) and median follow-up was 59.7 and 56.5 months (RHT vs ERHT).

**Conclusion** RHT and ERHT are a major undertaking with significant morbidity and mortality but represent the only chance of cure in selected patients. Liver failure is higher in the ERHT group but does not translate in increased mortality. Long-term survival in CRLM is achievable and does not differ among the two groups. Extensive liver resections even beyond conventional boundaries should not be considered an absolute contraindication to surgery.

**Competing interests** None declared.