PTU-083 CAUDATE LOBE RESECTION FOR COLORECTAL LIVER METASTASES: A MATCHED PAIR ANALYSIS

doi:10.1136/gutjnl-2012-302514c.83
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Introduction Tumours located in the caudate lobe can be challenging due to the anatomical relation of segment I with the inferior vena cava (IVC), the presence of multiple small caudate veins, variable bile ducts anatomy and difficult exposure during surgery. Some groups reported increased morbidity, smaller resection margins and inferior outcomes. Aim of the study was to compare the group of patients who underwent caudate lobe resection (CLR) with a group of patients without caudate lobe excision (NCLR).

Methods Over a 16-year period, from November 1994 to November 2010, 1295 consecutive liver resections for colorectal liver metastases were performed at our Institution. The cohort of caudate resection patients were age (±1 year), sex and number of resected segments matched with an exact number of other hepatic resection patients that did not include the caudate lobe. Seventy-five patients had CLR. Six patients who had isolated CLR were excluded leaving 69 cases from analysis.

Results ASA score, comorbidity, number of bilateral resections, Results cases from analysis. CLR. Six patients who had isolated CLR were excluded leaving 69

PTU-085 IMPACT OF TRANSIENT ELASTOGRAPHY (FIBROSCAN) IN THE MANAGEMENT OF PATIENTS WITH LIVER DYSFUNCTION IN A REGIONAL CENTRE IN NORTHERN IRELAND

doi:10.1136/gutjnl-2012-302514c.85
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Introduction Transient elastography (Fibroscan) is a simple, non-invasive method of assessing liver fibrosis. It is measured by an ultrasound transducer probe and results are expressed in kilo-Pascals (kPa) with liver stiffness values ranging from 2.5 to 75 kPa. The results are immediately available and are operator-independent. Liver biopsy has long been the gold standard to evaluate fibrosis. Unfortunately, it is invasive and associated with complications. In addition the accuracy of the histology sample is subject to significant heterogeneity. Our aim was to determine how effective Fibroscan is in reducing the need for liver biopsy.

Methods All patients undergoing Fibroscan during a 1-year period from 1 August 2010 to 31 July 2011 in the Royal Victoria Hospital, Belfast were included. Patients who had biopsy pre-planned for the same day as Fibroscan were excluded. The following data were recorded: demographic data, Fibroscan readings, indication for Fibroscan and whether or not Fibroscan prevented the need for subsequent liver biopsy. All patients had at least 10 valid readings.

Results 66 patients (36 male) underwent Fibroscan to evaluate if there was any evidence of advanced fibrosis or cirrhosis. The underlying liver diagnoses were Hepatitis C (30), fatty liver disease (7), primary biliary cirrhosis (7), hepatitis B (6), hereditary haemochromatosis (4), deranged liver function tests (4), alcoholic liver disease (3), orthotopic liver transplant (2) and 1 each for cryptogenic cirrhosis, primary sclerosing cholangitis and hypersplenism.

Thirty-nine patients had a normal Fibroscan of whom 37 (95%) did not require a follow-up liver biopsy. 27 patients had high readings suggesting advanced liver fibrosis or cirrhosis of whom 8 (30%)