UNIVERSITY OF TORONTO LIVER / PANCREAS TRANSPLANT PROGRAM

LIVER / PANCREAS RETRIEVAL OPERATIVE NOTE

Hospital: _____ Date: _____

Patient Name: _____ Medical Record Number: _____

Surgeons: _____

The patient was prepped and draped in the usual sterile fashion. A midline incision was made from the sternal notch down to the pubic bone. The abdominal incision was continued and the peritoneal cavity was entered. The sternum was opened with a sternal saw. A brief exploratory was then performed. The falciform ligament was divided between ties. The liver was then examined for colour, texture, and for aberrant vessels. The left triangular ligament was divided and the diaphragm was incised bilaterally for exposure. 200 grams of IV Mannitol and 120cc of Betadine was injected into the duodenum via the bg tube by the anesthetist.

The small intestine was retracted, the ascending colon, duodenum, and head of pancreas were mobilized and the IVC exposed up to the level of the left renal vein. The SMA was exposed at this level. The IMA was identified and divided, the aorta was freed up distal to this, and free ties placed around it. Next, the portal hepatic was dissected. The common bile duct was cut above the tie so that free flow of bile could be seen. The gallbladder was opened and irrigated with normal saline until clear fluid was seen in the common bile duct. Dissection then continued across the porta. The supraduodenal vessels were ligated with ties. The gastroduodenal artery was identified and ligated. Dissection continued along the superior border of the pancreas and the splenic artery was identified. The left gastric artery and vein were identified and, if there was no evidence of an aberrant left hepatic artery, they were divided between ties. If an aberrant left hepatic artery was present, the left gastric artery was preserved by dividing its small branches to the lesser curvature of the stomach.

The lesser sac was opened by dividing the entire gastrocolic ligament. The transverse mesocolon was dissected off the pancreas and the SMV identified inferior to the pancreas. Short gastric vessels were identified and divided between ties. The pancreas was then assessed and deemed suitable for procurement. The inferior border of the pancreas was dissected off the retroperitoneum and the spleen mobilized by dividing its ligamentous attachments. The superior edge of the pancreas was dissected and the distal pancreas mobilized to the splenic artery origin. The IMV was divided between ties. The ligament of the Treitz was divided and the fourth part of the duodenum mobilized.

The crura of the diaphragm were then divided and the aorta was exposed at the hiatus. The portal vein was exposed and stay sutures of Prolene were placed at a point ensuring enough length for both grafts. The patient was then fully heparinized. The distal aorta was ligated and cannulated. In conjunction with other retrieval teams, perfusion with UW solution proceeded. Crushed iced was placed on the liver, pancreas, and kidneys. A venotomy was made in the portal vein and cannulated for perfusion. The duodenum was then divided with a GIA stapler just distal to the pylorus and at the duodenojejunal junction. The small bowel mesentery with SMV and SMA was divided using a GIA stapler. The liver was dissected free with a portion of the diaphragm. The inferior vena cava was divided above the renal veins. The aorta was divided just distal to the SMA. The liver and pancreas were removed *en bloc*. Perfusion to the kidneys was then re-established by placing a vascular clamp on the aorta. After identifying the ureters, the iliac arteries and veins were removed. A portion of the spleen and mesenteric lymph nodes were removed for HLA typing.

ADDITIONAL NOTES

Aberrant Vessels: _____

Organs Retrieved: _____

Other: _____

Signature: _____