Bloodless Liver Resection Using Radiofrequency Energy

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Introduction

Liver resection remains a major procedure carrying a significant risk of intraoperative bleeding leading to blood transfusion which has been shown to affect postoperative morbidity, mortality and long-term survival [1–4]. With improvements in surgical and anaesthetic techniques, and the development of new surgical tools, liver resection can now be performed in most centres with minimal blood loss [5–12]. However, these techniques for liver resection often require hepatic inflow occlusion (Pringle’s manoeuvre) during transection of liver parenchyma. Furthermore, clamping of hepatic pedicles increases the potential risk of liver dysfunction from ischaemia-reperfusion injury particularly in patients with underlying chronic liver disease [13, 14].

Intraoperative manoeuvres are commonly used to minimise the risk of intraoperative bleeding including hypotensive anaesthetics, hepatic pedicle clamping, and total vascular exclusion [7–12]. None of them are completely effective, and each adds a potential risk of causing liver dysfunction in patients with chronic liver disease [14]. In recent years, several techniques have been developed to reduce blood loss during transection of liver parenchyma without vascular clamping [14–16]. The main problems related to these methods are that although small vessels can be coagulated during transection, large vessels are usually left intact or injured, which can result in con-
siderable blood loss during the operation and which re-
quire tedious clipping and tying to achieve haemostasis.

In the last few years, the advent of new energy sources,
such as radiofrequency (RF), has had an increasing impact
on surgical practice, notably in the field of liver tumours.
The role of RF in liver surgery has been expanded from
simple tumour ablation to embrace routine hepatic resec-
tion by using an RF probe to develop a plane of coagulative
necrosis along the intended line of parenchymal transec-
tion [15, 16]. This technique was used for all hepatic resec-
tions performed in our department (either by the open ap-
proach or by a laparoscopic approach) in order to avoid
intraoperative haemorrhage and the need for routine post-
operative admission to the intensive care unit [17, 18].

The aim of the current study was to report the impact
of this technique on the reduction of blood loss during
liver resection without vascular clamping.

Patients and Methods

Between January 2000 and March 2006, 236 consecutive pa-
tients underwent RF-assisted liver resection for tumours in our
department. All patients underwent careful preoperative assess-
ment of their disease including either spiral computed tomogra-
phy or magnetic resonance imaging. Patient data were collected
prospectively, including demographic details, nature and number
of tumours, operative procedure, operating time, blood loss, blood
transfusion requirement, morbidity, mortality and length of hos-
pital stay. Operative time was defined as the overall time of the
surgical procedure from skin to skin, while the resection time was
defined as the time from the start of RF ablation to completion of
parenchymal transection. Every patient presenting with grade II
(or higher) complications according to Dindo et al. [19] classifica-
tion were recorded as having postoperative complication. Blood
loss was recorded as the combination of the weight of the surgical
swabs and the amount of blood in the suction system for the whole
operative admission to the intensive care unit [17, 18].

The aim of the current study was to report the impact
of this technique on the reduction of blood loss during
liver resection without vascular clamping.

Results

A total of 417 tumours were resected in 236 patients.
Clinical details of these patients are summarised in Table 1.
The resection was performed using the monopolar RF
probe in 174 cases (156 by an open surgical approach and
18 by a laparoscopic approach), and a bipolar RF device
(Habib 4X, Rita Medical Systems Inc.) in 62 cases. Surgical
procedures ranged from single tumorectomy to right hep-
atectomy. There were 154 cases of tumorectomies or seg-
mentectomies, 14 multiple segmentectomies, 27 left lateral
segmentectomies, 11 left hepatectomies, and 30 right hep-
atectomies. Thus, major hepatectomy was performed in 41
cases (17%) and minor hepatectomies in 195 cases (83%).
All the procedures were achieved according to the previ-
ously described technique. None of the patients had vascular
inflow occlusion (Pringle’s manoeuvre).

Mean intraoperative blood loss was 157 ± 240 ml
(range 10–1,100). Mean blood loss during parenchymal
transsection was 90 ± 105 ml (range 10–590). Ten patients
(4%) received intraoperative blood transfusion, with a
mean of 2.5 units of red blood cells per patient. No pa-
ients required fresh-frozen plasma or postoperative
blood transfusion. The mean overall operative time was
215 ± 88 min, while the mean resection time was 66 ±
46 min.

Five patients were admitted to the intensive care unit
postoperatively because of associated co-morbidities (n = 3)
and long operative time (n = 2). Fifty patients (21%) developed postoperative complications. The complications
included pleural effusion (n = 26), intra-abdominal
collection (n = 20), biliary leak (n = 5), postoperative liv-
er failure (n = 2) and hepatic ischaemia (n = 1). This pa-
tient required a reoperation because of a tear in the he-
patic artery. Otherwise, none of the patients underwent
reoperation. The diagnosis of biliary leak was evident in
4 cases from wound drains, and were managed conserva-
tively. In 1 case, the leak was revealed by a biloma on CT
scan and required percutaneous drainage.

Table 1. Patients’ characteristics: diagnosis, number and size of
tumours (values are mean ± SD)

<table>
<thead>
<tr>
<th>Clinical details</th>
<th>Mean age, years</th>
<th>Males/females</th>
<th>Diagnosis</th>
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<tr>
<td></td>
<td>58 ± 12</td>
<td>127/109</td>
<td>Metastases 170 (72%)</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Hepatocellular carcinoma 37 (15%)</td>
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<td></td>
<td></td>
<td></td>
<td>Cholangiocarcinoma 9 (4%)</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Gallbladder carcinoma 5 (2%)</td>
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<td></td>
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<td></td>
<td>Adenoma 3 (1.2%)</td>
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<td></td>
<td></td>
<td></td>
<td>Focal nodular hyperplasia 4 (1.6%)</td>
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<td></td>
<td></td>
<td></td>
<td>Haemangioma 4 (1.6%)</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Mean tumour size, mm 43 ± 29</td>
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<td></td>
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<td>Mean number of lesions 1.9 ± 1.4</td>
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</table>
There were no intraoperative deaths, but 5 patients died postoperatively (2.1%). Two developed postoperative liver failure, 1 after an extended right hepatectomy with hepaticojejunostomy for hilar cholangiocarcinoma, and 1 after resection of a 79-mm hepatocarcinoma from segment VII in a cirrhotic liver. For the remaining 3 cases, the cause of death was multifactorial with multiorgan failure and systemic sepsis and cardiac failure, but in none of these cases was multiorgan failure as a result of liver failure. The overall mean postoperative stay was 11 ± 10 days.

Discussion

Using a RF-assisted technique, liver resection can be performed with minimal blood loss and low transfusion rate without dissection or clamping of the hepatic pedicle. In our experience, the mean blood loss is 157 ml and the transfusion rate is 4%, which is lower than most of previously published series [1, 4–7, 9, 11, 20–23].

Concern has been expressed about the low rate of major hepatectomy undertaken in our centre. We believe, like others, that even if segmental and non-anatomical resections are commonly classified as minor hepatectomies, they can be more challenging and technically more demanding than a classical lobar resection [1]. The low rate of major hepatectomy (17%) we report is because we can easily perform nearly bloodless non-anatomical resections in order to spare liver parenchyma using the RF-assisted technique. Furthermore, we have never had to apply Pringle’s manoeuvre to complete a resection and therefore we experienced a very low rate of postoperative liver failure (2 patients). However, we do observe routinely a transient increase in transaminase and bilirubin levels following liver resection, with a peak at day 1 and normalisation at day 7. This transient abnormality in the liver function tests was probably related to the zone of coagulative necrosis left behind along the resection margins. To avoid leaving too much coagulated tissue behind, <1 cm of tissue is now left at the margin, which is sufficient to ensure vascular and biliary occlusion for haemostasis and biliary control. These abnormalities are very different from ischaemia-reperfusion injury to the liver which can occur during hepatic inflow occlusion (continuous or intermittent), and which is known to predispose to postoperative liver failure [2, 24–27].

The overall postoperative complication rate was 21% in this series, consistent with or better than most reported large series ranging from 16 to 45% [1, 4–6, 9, 20–23]. However, none of the complications was directly related to the resection technique. Pleural effusion was the most common postoperative complication in line with other series that used different parenchymal transection techniques [5, 11, 13, 28]. Postoperative intra-abdominal collection was observed in 20 patients (8%), but only 5 had proven abscesses which needed radiological drainage, the others were treated conservatively, and none of them had any sign of biloma.

There is no requirement to tie blood vessels or bile ducts with the RF-assisted resection technique and there has been concern about the risk of postoperative haemorrhage or bile leak. However, in our experience, no patient bled postoperatively, and the rate of biliary complication was also low (2.1%). These figures indicate that biliary control and blood vessel control were effective with RF energy.

Although the technique of liver resection with monopolar or bipolar RF for liver resection is safe to apply, a detailed knowledge of liver anatomy plus excellent surgical skills remain crucial. The RF energy cannot be applied close to the hilum or hepatic veins, and dissection of these regions has to be performed by trained hepatobiliary surgeons. RF is a tool to help surgeons divide the liver parenchyma safely and with minimal blood loss.

In conclusion, the RF-assisted liver resection technique offers hepatobiliary surgeons an additional method for performing liver resection with minor intraoperative blood loss, a low transfusion requirement, low mortality and low morbidity.

References


