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**Total laparoscopic right hepatectomy with tumor thrombectomy for Hepatocellular carcinoma with bile duct tumor thrombus**

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Session abstract will be presented in: **Liver/Pancreas Video Session**

Number of Reviewers: **4**
Total Score: **21**
Mean Score: **5.25**

| Score | Reviewer | Reject Comment | Overall Comment |
|---|---|---|---|
| 6 | bhavesh devkaran | | |
| 6 | Deborah Keller | | Excellent visual and voice guidance. |
| 3 | Rebecca Kowalski | | Okay video. Audio is not well synced to what is going on in the video. |
| 6 | Tonia Young-Fadok | | Digital voice-over |

**Introduction:** Hepatocullular carcinoma presenting with obstructive juandice caused by bile duct tumor thrombus is an uncommon event. The role of laparoscopic hepatectomy and clinical outcomes are remaining controversy.

**Summary of case:** The patient was 55 years old male with chronic hepatitis B viral infection, presented with progressive jaundice for 1 month prior to visit. MDCT scan showed dilated intrahepatic bile duct both lobe of livers, and HCC at right lobe of liver, with tumor thrombus extended from right hepatic duct down to common bile duct. The liver function and volume were satisfied. We decided to perform laparoscopic right hepatectomy with tumor thrombectomy.

**Operative technique:** Patient was supine in French position under general anesthesia. The operation started with divided round ligament, and falciform ligament. Intra-operative ultrasound was performed to confirm the extension of tumor. Cholecystectomy was done. The cystic duct was double ligated with hemolock clips then divided. Liver mobilization was done starting from lateral to medial until IVC was identified and dissected. Short hepatic veins were dissected and ligated. After liver was mobilized, right hepatic artery was identified and dissected lateral to common bile duct, then double ligated. Right portal vein was identified and dissected, then encircle with silk and ligate with vascular staple. Demarcation line was seen and marked. Liver parenchymal transection was gently performed using CUSA. Hepatic vein branches were ligated with hemolock clips and ligasure. Parenchymal transection was continued until right hepatic duct was identified. Right hepatic duct was opened by scissor, Then Tumor thrombectomy was done using suction and normal saline irrigation. Choledochoscope was used to exam left intrahepatic duct and distal common bile duct. No tumor thrombus was found. Parenchymal transection was continued until right hepatic vein was identified and divided using vascular stapler. Right hepatic duct stump was closed with PDS 4/0 continuous technique under laparoscope. After the specimen was removed via supra-pubic incision. Bleeding and bile leakage was checked. Then 2 jackson pratt drain were placed.

In summary, total operative time was 360 minutes, Blood loss was 630 ml, No post operative complication, total hospital stay was 6 days. Pathologic report showed Hepatocellular carcinoma moderate differentiation with free margin. Neither residual nor recurrence of tumor was observed from post operative CT scan at 3 months.

**Conclusion:** Laparoscopic hepatectomy wtih tumor thrombectomy for hepatocellular carcinoma with bile duct tumor thrombus was safe and feasible. However, it is a highly technical demand procedure.

**https://youtu.be/rjQeDxw1-gI**