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Side-to-side caval anastomosis in liver transplantation

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Sir: We read with interest the report by Lerut and Gertsch regarding side-to-side cavo-cavostomy in complicated piggyback liver transplantation [2]. They describe a patient in whom the liver implantation piggyback method resulted in a severe stenosis of the recipient's inferior vena cava, a complication that, to the best of our knowledge, has not been reported before. The stenosis was corrected successfully by a side-to-side cavo-cavostomy. This observation prompted the authors to devise a technical modification of the piggyback procedure, and they concluded that the side-to-side cavocavostomy is a useful rescue aid in this situation.

In our view, an alternative conclusion is that the side-to-side caval anastomosis may be recommended as the first choice procedure for caval reconstruction, as described recently by Belghiti et al. [1]. In addition to obviating the need for veno-venous bypass, this approach would reduce the indications of the piggyback technique, except in the situation where the recipient's inferior vena cava is agenetic or thrombosed up to the level of the hepatic veins. Our recent experience with 22 transplants using Belghiti's procedure, without morbidity or mortality related to the technique, strengthens this alternative conclusion.

References

 Belghiti J, Panis Y, Sauvanet A, Gayet B, Fékété F (1992) A new technique of sideto-side caval anastomosis during orthotopic hepatic transplantation without vena caval occlusion. Surg Gynecol Obstet 175: 271–272

- 2. Lerut J, Gertsch P (1993) Side-to-side cavo-cavostomy: a useful aid in "complicated" piggy-back liver transplantation. Transpl Int 6: 299–301
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Treatment of a late renal allograft lymphocele with a Denver shunt

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Sir: Lymphocele is a well-recognized complication following renal transplantation with a reported incidence of between 0.6% and 18.1% [1,5]. Lymphoceles may appear as early as 1 week and as late as 17 years postoperatively. Kidneys with lymphoceles that occur late and produce large amounts of lymphatic fluid from the transplanted kidney surface have been described as "weeping kidneys." [6]. The treatment of late-occurring lymphoceles is challenging; such lymphoceles may result in the loss of a functioning allograft. In this case report, we present the treatment of a complex lymphocele discovered 17 years after successful renal transplantation with a Denver shunt.

The patient, a 44-year-old white male, developed end-stage renal disease in 1971 secondary to Fabry's disease. In June 1973, a cadaveric renal allograft was transplanted to the right iliac fossa using standard vascular techniques.

In September 1989, the patient presented with the sudden onset of severe right lower quadrant pain,

fever up to 39.3 °C, and tenderness over the renal allograft. On admission, his white blood cell count (WBC) was $16.6 \times 10^{\circ}$ /l with 60 % segmented neutrophils and 2% bands, and his creatinine level was elevated to 194 µmol/l. Ultrasonography demonstrated a complex, septated fluid collection 2-3 cm in diameter surrounding the kidney. Under ultrasound guidance, an 8 Fr catheter was placed. Analysis of fluid was consistent with a lymphocele (creatinine 133 µmol/l, amylase 18 U/l). Gram stain and cultures were negative. A CT scan obtained after catheter drainage showed a high-attenuation fluid collection around the kidney along the quadratus lumborum consistent with a subcapsular hematoma. In addition to drainage, therapy consisted of 4 days of intravenous antibiotics an a 10-day course of oral antibiotics. The catheter was removed 10 days after placement when drainage was minimal. The patient remained asymptomatic for 1 year.

On 6 August, 1990, the patient came to our institution reporting a 2month history of increasing abdominal girth, pain, and anorexia. Physical examination revealed tense ascites with fluid wave. Laboratory studies were normal, including normal serum albumin, creatinine, and liver function tests. Paracentesis yielded a clear yellow fluid with gram stain that was culture-negative for organisms.



Fig.1 Large lymphocele displacing transplanted kidney from right to left side of pelvis