Arterioporal shunting as an alternative to microvascular reconstruction after hepatic artery resection

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**Background:** Portal vein and hepatic artery resection and reconstruction may be required in radical surgery for biliary cancer. Microvascular reconstruction requires special equipment and training, and may be difficult to accomplish when the arterial stump is small, there are multiple vessels or it lies deep within the wound. This study examined the feasibility and safety of arterioporal shunting as an alternative to arterial reconstruction.

**Methods:** Over 30 months, ten patients with biliary cancer (bile duct carcinoma in six and gallbladder carcinoma in four) underwent radical surgery with *en bloc* resection of the hepatic artery and end-to-side arterioporal reconstruction between the common hepatic or gastroduodenal artery and the portal trunk.

**Results:** No patient died. Complications included bile leakage in two patients and liver abscess in one. Routine angiography performed 1 month after surgery revealed shunt occlusion in three patients. Once the existence of hepatopetal arterial collaterals had been confirmed in the remaining patients, the shunt was occluded by coil embolization.

**Conclusion:** Arterioporal shunting represents a safe alternative to microvascular reconstruction after hepatic artery resection. However, its potential to increase the rate of cure and safety require further assessment in a larger series with longer follow-up.
Introduction

Locally advanced biliary cancer often involves the portal vein and hepatic artery within the hepatoduodenal ligament, and concomitant resection may be required for cure. Perineural invasion, a common mode of spread in biliary cancer\(^1\),\(^2\), may necessitate concomitant hepatic artery resection even when there is no cancer cell infiltration into the arterial wall because the autonomic nerve plexus surrounds the hepatic artery circumferentially. Portal vein resection is now considered a safe procedure with favourable results\(^3\)–\(^6\). However, hepatic artery resection is less common, because the reconstruction is more complicated and requires microvascular techniques\(^7\),\(^8\). The anastomosis may be difficult or impossible to perform when the arterial stump is small, there are multiple vessels, or it is located deep within the wound.

An experimental study using dogs subjected to hepatobiliary dearterialization demonstrated that arterioporal shunting (APS) reduced acute hypoxic hepatic injury and improved hypoxia in the bile duct, permitting successful choledochojejunostomy\(^9\),\(^10\). There are however, few reports of the clinical application of APS and its clinical consequences are unknown\(^11\)–\(^14\). The present study assessed the feasibility and safety of APS as an alternative to microvascular anastomosis after hepatic artery resection in radical surgery for biliary cancer.
Patients and methods

Over a 30 month period from May 2000, ten patients with biliary cancer (bile duct carcinoma in six and gallbladder carcinoma in four) have undergone radical surgery with en bloc resection of the hepatic artery and APS. The first patient had undergone left hepatectomy, and APS was employed at an emergency operation to salvage a dearterialized hepatobiliary system that resulted from accidental injury to a right hepatic artery encased by tumour. Because the distal stumps of the right hepatic artery were small, multiple and deeply located, microvascular anastomosis was abandoned in favour of APS. In the remaining nine patients, preoperative investigation with computed tomography and intraductal ultrasonography suggested involvement of the hepatic artery, and informed consent was obtained before treatment.

All patients were men, aged between 56 and 81 (median 69) years. Hilar bile duct resection involving division of the left, right anterior, right posterior and caudate ducts individually, was performed in all patients and was used alone in four patients. One patient required a local wedge excision of adjacent liver. Left hepatectomy was performed for radical resection of the tumour in two patients and this was extended to the right anterior segments in a further patient. Two patients required concomitant pancreaticoduodenectomy, one of whom also needed a wedge hepatectomy. These three patients underwent portal vein resections. The concomitantly
resected hepatic arteries were the proper and right hepatic arteries in the
three patients who underwent left-sided major hepatectomy and the right
hepatic artery alone with preservation of the left hepatic artery in six
patients. The final patient had marked perineural invasion in the plexus
surrounding the hepatic artery, necessitating resection of the entire hepatic
artery including the distal part of the common hepatic artery.

**Surgical technique**

After removing the specimen and before biliary reconstruction, an
arterioporal shunt was created in an end-to-side fashion between the
common hepatic artery (when both the right and left hepatic arteries were
resected) or the gastroduodenal artery (when the left hepatic artery was
preserved) and the portal trunk. Side clamping of the portal vein allowed
the vein to remain patent during the vascular anastomosis. Interrupted 9/0
polypropylene (Ethicon, Edinburgh, UK) sutures were placed with the aid of
an operating microscope in the first two patients; thereafter a continuous
polypropylene 6/0 suture was employed using loupes. A thrill was
palpable on the wall of the portal vein after successful creation of the shunt.
Results

Perioperative results

The operating time ranged from 538 to 896 (median 759) min. The operative blood loss varied between 515 and 2880 (median 1720) ml and three patients required red blood transfusion. The serum concentrations of aspartate aminotransferase and alanine aminotransferase one day after operation ranged from 92 to 1265 (median 180) and 87 to 785 (median 125) units/l respectively, both returning to normal within a few days. The maximum postoperative concentration of total serum bilirubin was 22–71 (median 42 μmol/l). No patient developed hepatic failure.

There were no deaths, although three patients suffered complications. Bile leakage developed in two patients, from the hepaticojejunostomy in one and of unknown origin in the other. The leakage resolved with external drainage within 2 weeks.

Angiography was performed 4 to 5 weeks after surgery in all patients. The arterioportal shunt was found to be occluded in three patients and hepatopetal arterial collaterals had developed. In the remaining seven patients, the shunt was occluded by coil embolization to prevent portal hypertension in future, after confirming the presence of a collateral arterial supply to the liver via the hepaticojejunostomy, the inferior phrenic artery or the contralateral hepatic artery. A liver abscess developed immediately after embolization in one patient and was successfully managed by
Pathological findings

Histological examination of resected specimens revealed a positive surgical margin in two patients; otherwise, the resections were considered curative. Infiltration of the hepatic artery was detected in two patients and primary tumour and/or perineural invasion close to the arterial wall in the other eight patients. Lymph node metastasis and perineural invasion had occurred in six and seven patients respectively.

Postoperative survival

Three patients died from their disease 23, 21 and 11 months after surgery from local, hepatic and peritoneal recurrences respectively. One patient died suddenly from an unknown cause at another hospital 1 month after discharge. The remaining six patients are alive 26, 11, 8, 4, 3 and 1 month after surgery.
Discussion

In radical hepatobiliary surgery, the peribiliary arterial network is disrupted by skeletonization. Therefore, total interruption of the hepatic arterial flow may cause serious postoperative complications related to biliary ischaemia, including disruption of the bilioenteric anastomosis and liver abscess, even though hypoxic hepatic parenchymal injury does not occur as long as portal flow is maintained. Restoration of biliary arterial flow seems important. Arterial reconstruction using a microvascular anastomosis is useful, but is difficult or impossible in some patients.

The biliary blood supply depends primarily on hepatic arterial flow, and APS has been devised as a way of improving hepatic function and preventing liver failure. An experimental study demonstrated that APS improved biliary oxygen saturation after hepatobiliary dearterialization from 28 per cent of normal to 57 per cent. The mechanism responsible is unclear, although back-flow and/or back-diffusion from the sinusoidal network or presinusoidal shunt has been suggested.

Hepatopetal arterial collaterals developed in all ten patients within one month in the present study and the shunt was closed when still patent to prevent portal hypertension. Clinical cases of portal hypertension and oesophageal varices after APS have been reported. Whether biliary ischaemia-related complications develop or not seems to depend on the total arterial flow.
oxygen supply to the bile duct through the arterioportal shunt and the arterial collaterals. Therefore, once the arterial collaterals have been established, the arterioportal shunt is no longer necessary.

APS is simpler than microvascular anastomosis and may be used when arterial reconstruction is impossible. Furthermore, the use of an arterioportal shunt may increase the proportion of patients where surgery might be considered curative when hepatic arterial resection is necessary.

The hepatic artery does not need to be isolated within the hepatoduodenal ligament so that en bloc resection of the hepatic artery and the surrounding nerve sheath, potentially harbouring perineural invasion, may increase curability. This is particularly true in cases of resection of the right hepatic artery, which runs close to the hilar bile duct. Six patients in the present study underwent resection of the right hepatic artery and APS for this reason.

As Miyazaki et al.\textsuperscript{17} and Tsuge et al.\textsuperscript{15} have pointed out, right hepatic artery resection does not require arterial reconstruction as long as the hepatic ductal confluence or the hilar plate\textsuperscript{19} is preserved because interlobar arterial communications are adequate. In the present series, however, all patients underwent resection including the hilar plate, which mandated arterial reconstruction or APS.

Iseki et al.\textsuperscript{12} reported three successful cases of concomitant hepatic artery resection with APS for pancreatobiliary cancer and stated that...
mesenteric APS has the advantages of choice of arterial size, a site removed from the primary operative field and ease of shunt closure by transarterial embolization. The authors employ hepatic or gastroduodenal APS rather than mesenteric APS based on experimental evidence that shunt flow similar to original hepatic arterial flow, is optimal.9,10

The satisfactory perioperative results in the present study endorse the feasibility and safety of APS. The effect of APS in three patients whose shunt was occluded at the time of postoperative angiography could not be assessed because the duration of patency was unknown. The incidence of bile leakage is similar to the incidence seen after radical surgery without hepatic artery resection and did not require further surgical intervention. The late development of a liver abscess in one patient was temporally related to coil embolization of the shunt, although the pathogenesis was obscure.

APS appears to be a safe alternative to microvascular reconstruction after hepatic artery resection in radical surgery for biliary cancer. The safety of the procedure and its potential for increasing curability need to be confirmed in a larger series of patients.
References


