Session I

Incomplete Resection of Hilar Cholangiocarcinoma

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1. Case presentation

54세 남환으로 2017년 1월 간문부 담관암(Bismuth type II) 진단 후 3차 병원에서 수술 진행 함. 담도 절제 후 담도-공장 문합술 계획하였으나, resection margin (+) 소견 보여 우측 간엽 절제술로 바꾸어 진행하던 중 보호자들과 언쟁 발생 함. 우측 간동맥 절제까지 진행한 상태로 더 이상 진행하지 않고 수술 중지함. 수술 후 좌측 간내 담도로 PTBD 삽입 후 퇴원시킴.

2. Diagnosis

Hilar cholangiocarcinoma (Bismuth type II or IIIb?)/Bile duct segmental resection/Resection margin (+)/Rt. Hepatic artery ligation/No bilio-enteric anastomosis/PTBD into the left hepatic duct

3. Therapy and Clinical course

FL/CCRT (2017. 6. 1~7. 4)

Left hepatectomy with caudate lobectomy/Remnant bile duct resection/Right hepatic artery reconstruction/Segmental resection of portal vein and anastomosis/Right hepatico-jejunostomy (2017. 7. 28. 8:25 AM~3:00 PM)

Adjuvant ChemoTx (FL #4) (2017. 9. 11~12. 11)

Pathologic CR and continue F/U

4. Conclusion

Hilar cholangiocarcinoma의 type 및 수술 방법이 잘못 판단되게 되면, 절제 불가능한 상태로 수술이 진행될 뿐 아니라, 여려 예기치 않은 상황이 발생될 가능성이 높다. 다학제 치료가 적절히 시행되면 수술이 불가능한 상황도 가능하게 할 수 있는 경우도 생길 수 있기 때문에 다학제 치료가 매우 중요하다고 판단한다.

Case short presentation

- 54 / M
- 2017. 1 Hilar cholangiocarcinoma Dx. (Bismuth type II)
- 2017. 2 Bile duct segmental resection (3rd referral hospital)

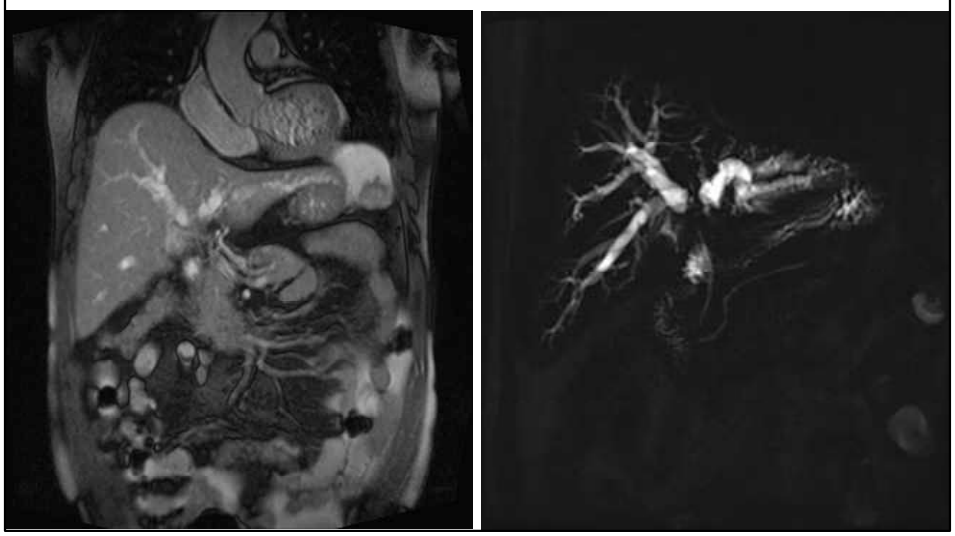
  → Resection margin (+)

  Rt. Hepatic artery ligation & op. termination

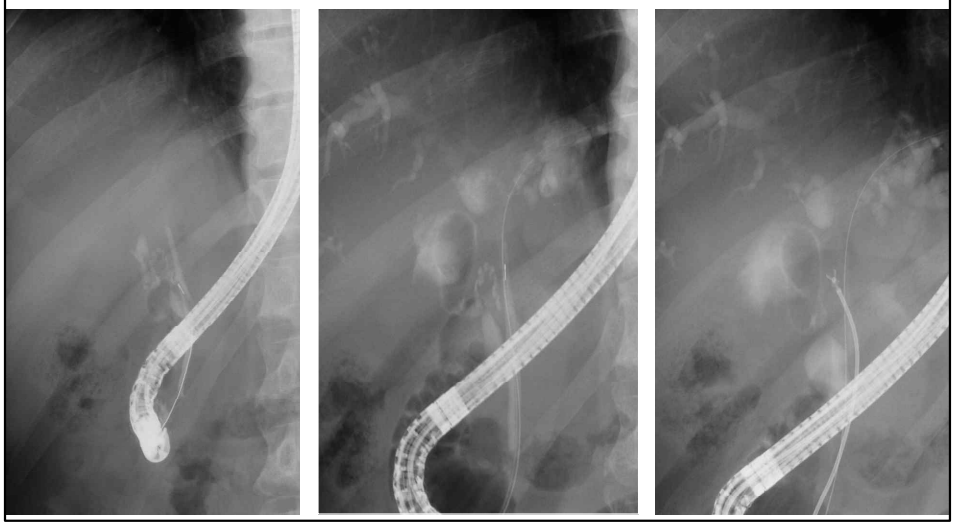
  No bilio-enteric anastomosis

  → PTBD into the left hepatic duct
- 2017. 4 Immunotherapy in Japan

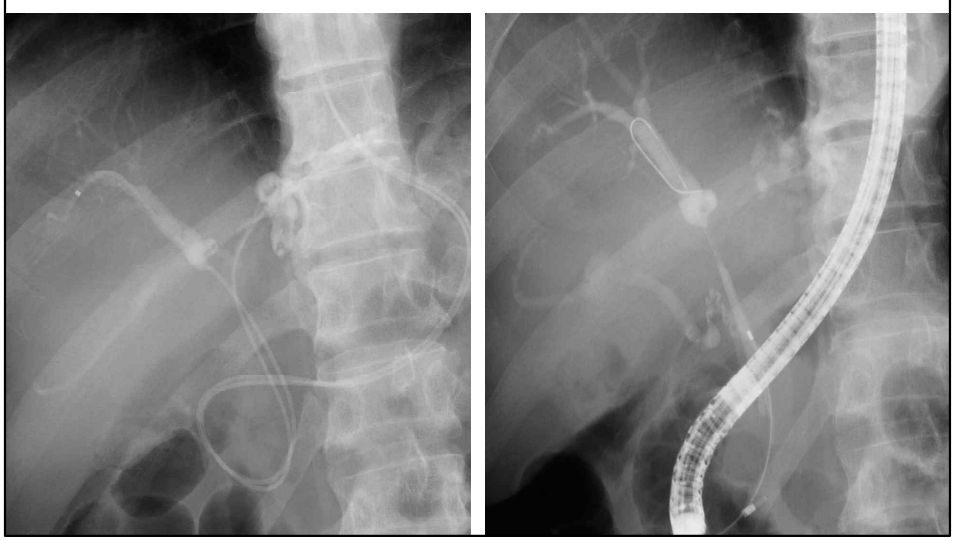
2017-1-22 MRCP



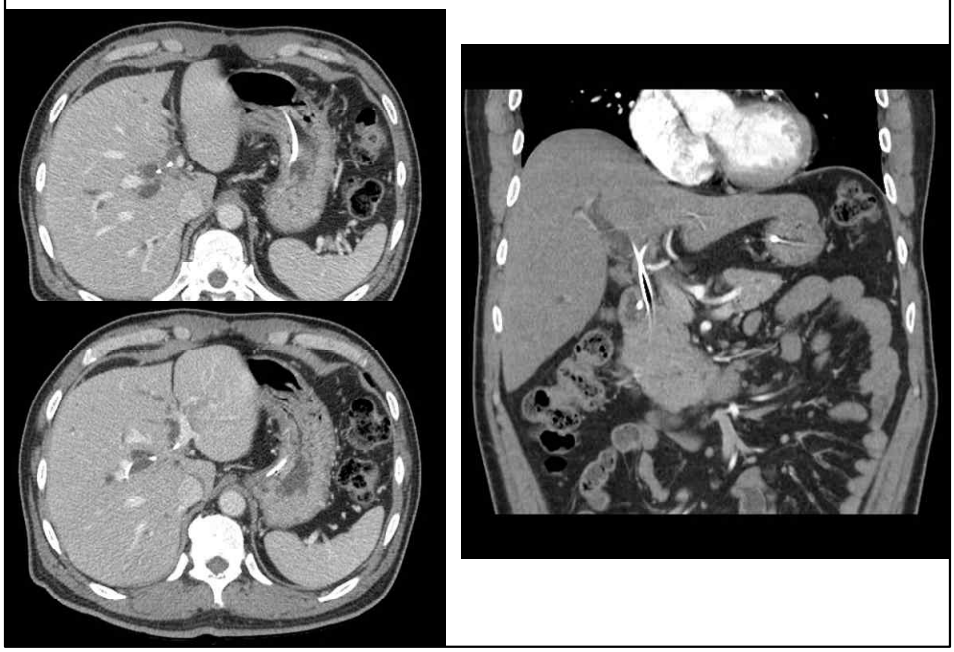
2017-1-23 ERCP



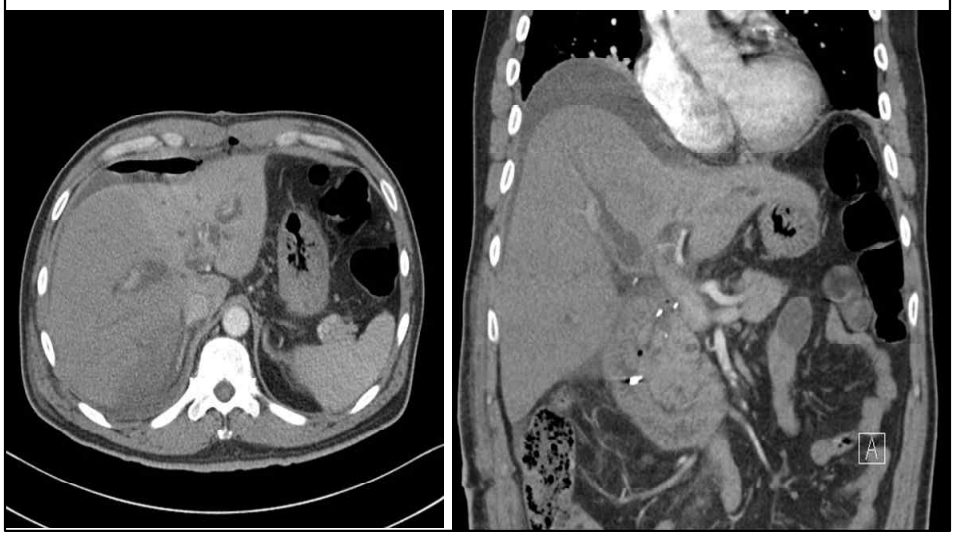
2017-1-26 2nd ERCP



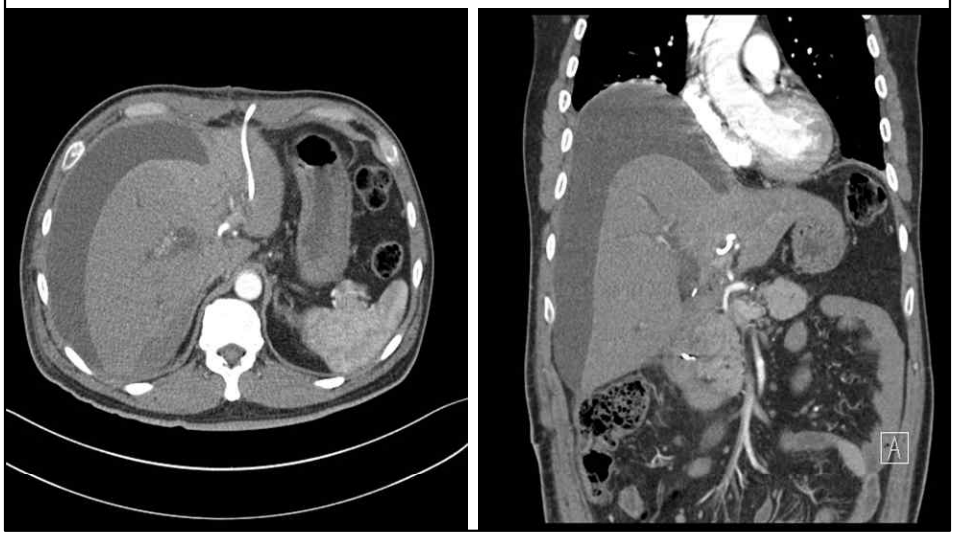
2017-2-21 Abd-pelvic CT



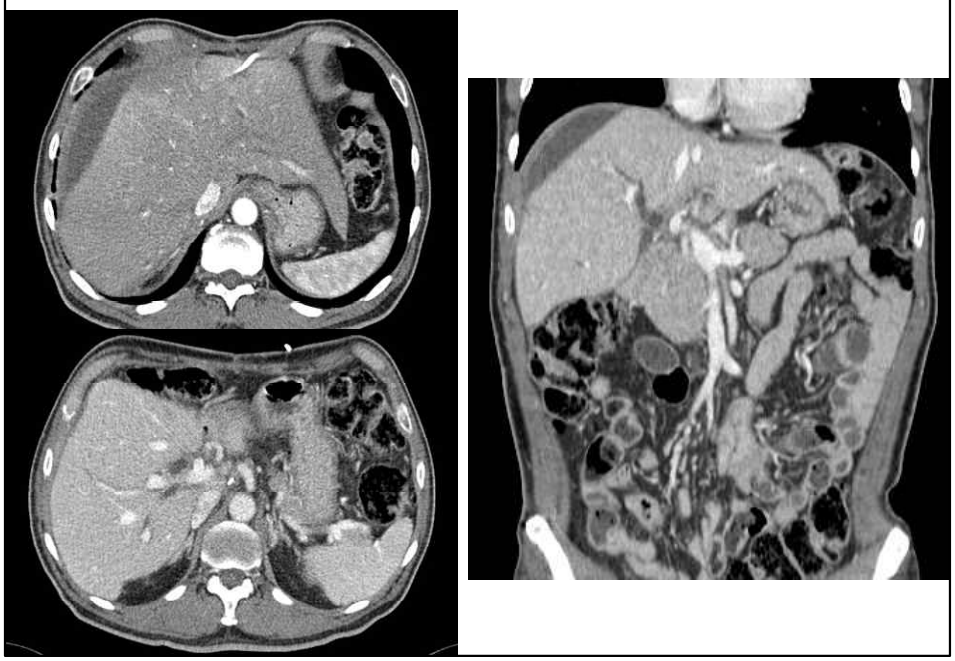
2017-2-26 Post-op. CT



2017-3-5 Abd-pelvic CT



2017-5-31 Abd-pelvic CT (CHA)



Our plan: CCRT

- CCRT 후 Operation 시도
  - Rt. hepatic artery reconstruction 시도
  - 성공하면 left hepatectomy 진행
  - 실패하면 RT 추가 후 LT 고려

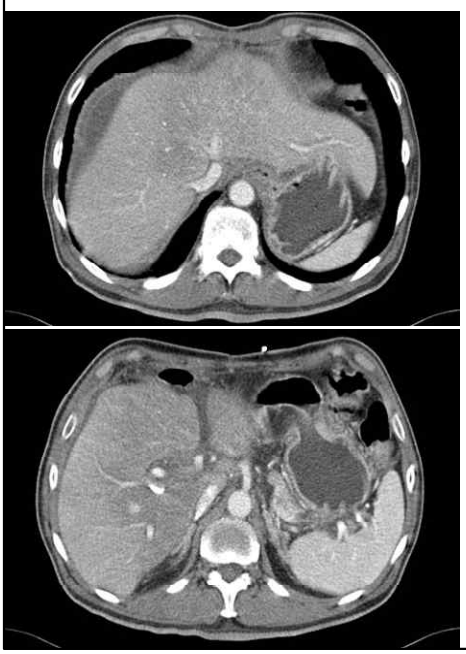
- 2017. 6. 1 ~ 7. 4

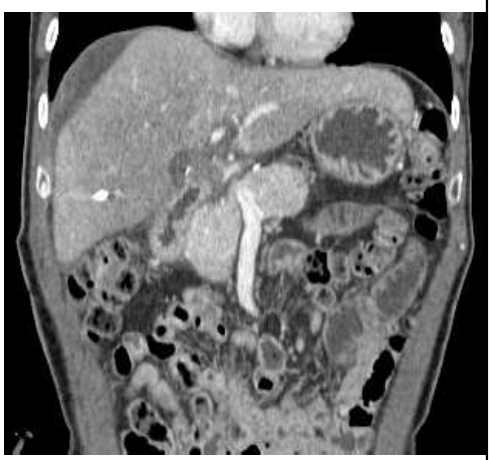
  FL / CCRT

- 2017. 6. 8

  Rt. PTBD

2017-7-14 F/U Abd-pelvic CT





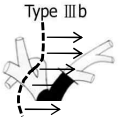
2017-7-28. Second operation

1. First operation: Segmental resection of CBD, Rt. HA ligation, No anastomosis of hepatic duct
2. Postoperative PTBD
3. No Tx. for 3 months
4. Neoadjuvant CCRT
5. Second operation
   1) Vascular resection and reconstruction (Rt. Hepatic artery reconstruction with gastroduodenal artery, Segmental resection of PV and reconstruction with Gor-Tex graft)
   2) Left hepatectomy with caudate lobectomy
   3) Hepaticojejunostomy

Type Ⅱ

Segmental resection of CBD 후 upper margin positive로 Rt. Hepatectomy 진행하려 하였으나 보호자 거부로 수술 stop

Type Ⅲb

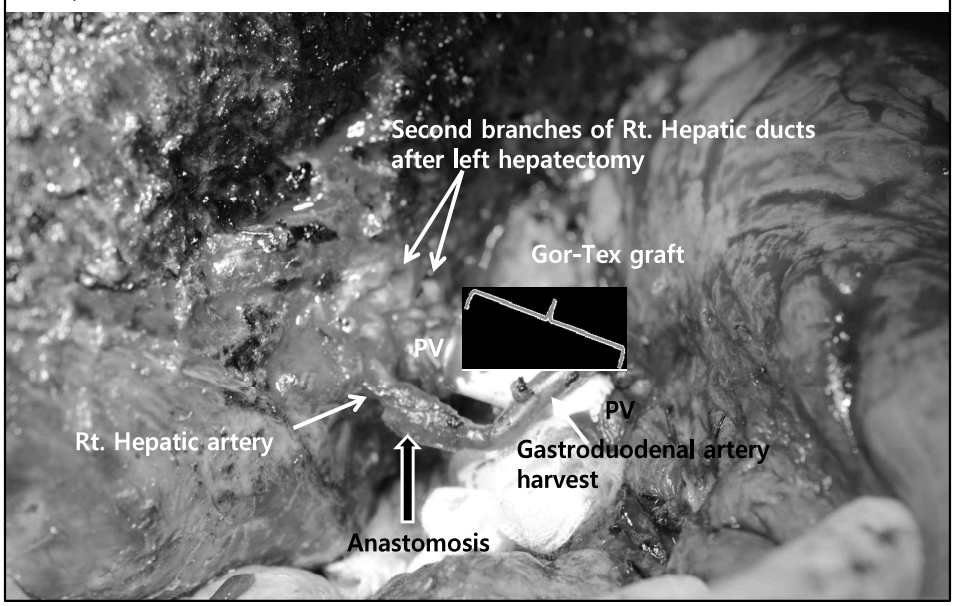


치료 없이 지내는 3개월동안 type Ⅲb로 진행하여 Left hepatectomy 시행

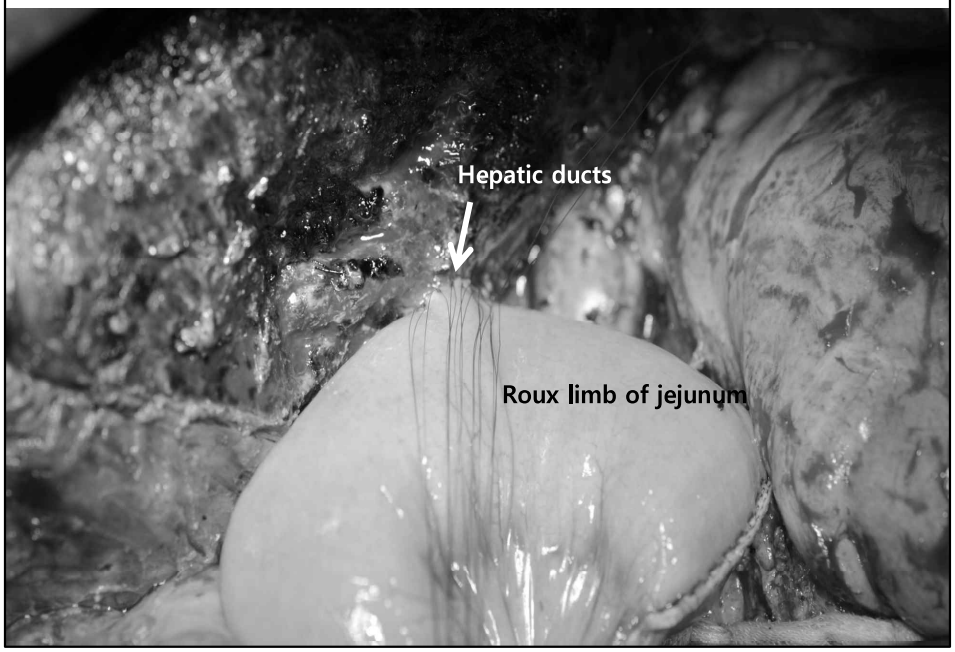
08:25AM → 23:00 PM

Blood loss: 3,000 cc

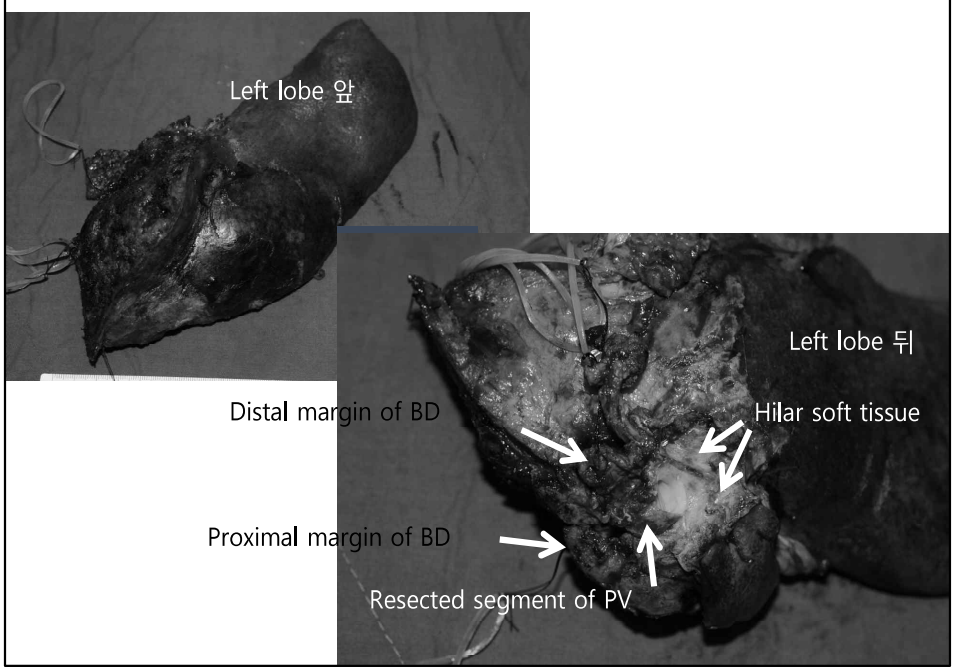
1. Vascular resection & reconstruction (Rt. Hepatic artery reconstruction with gastroduodenal artery, Segmental resection of PV and reconstruction with Gor-Tex graft)
2. Left hepatectomy with caudate lobectomy (hilar hepatic duct resection and exposure of second branches)



Hepaticojejunostomy



Left hepatectomy



Pathologic report

- Liver, left lobectomy :

- No residual lesion of known cholangiocarcinoma (hilar), post radiotherapy status,

  1. Tumor necrosis : No
  2. Hemorrhage : No
  3. Intrahepatic duct stone : No
  4. Dilatation of left hepatic duct with regenerative hyperplasia
  5. Perihilar suture granuloma and fibrosis

Adjuvant chemoTx

- #1 Adj FL (5 days) 2017.9.11

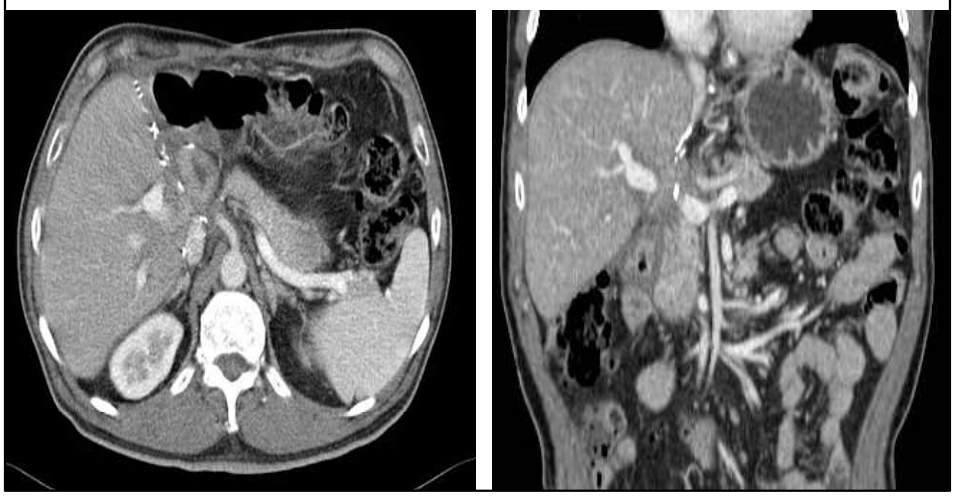
- #2 Adj FL (5 days) 2017.10.11

- #3 Adj FL (5 days) 2017.11.6

- #4 Adj FL (5 days) 2017.12.11

- Continuing immunotherapy in Japan (어보이 + 옵디보 + NK)

2017-12-4 F/U Abd-pelvic CT



Conclusion

- Accurate diagnosis of type and staging
- Accurate selection of operation method
- Multidisciplinary approach for pancreatobiliary cancer
- Never give up !!!