Methods: A retrospective analysis of patients undergoing liver resection from 2014 to 2016 was performed. Patients with only lesions in the posterior segments and received curative resection were identified for the study. The patient demography, operative procedure, preoperative imaging study, and postoperative morbidity, length of hospital stay (LOS) were compared between open and lap LR group.
Results: Among more than 300 liver resection, 27 patients with lesions only at the posterior segments were identified. The procedure ranged from wedge resection to anatomic bisegmentectomy. 18 patients underwent open liver resection (open LR) while 9 patients underwent pure lap LR without transdiaphragm trocar. Child A liver cirrhosis was found in 4 patients from open LR group and 3 from the lap LR group. The postoperative morbidity was found in 9/18 (50%) of open LR group and 2/9 (22%) in lap LR group. The LOS was 10.5 days (range, 7 to 28) in open LR group and 8 days (range, 5 to 15) in lap LR group.
Conclusion: Lap LR for lesion in posterior segment tended to have shorter LOS and less postoperative complication in comparison to the open procedure.

P26.06
IS THERE ANY DIFFERENCES IN OUTCOME OF SYNCHRONOUS LIVER RESECTION FOR COLORECTAL METASTASES STRATIFIED BY TYPE OF COLORECTAL RESECTION?

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Background: The optimal surgical strategy for treating colorectal cancer with synchronous liver metastases is controversial. We aimed to evaluate the outcomes of simultaneous colorectal cancer and liver metastases resection in a single center.
Methods: The prospectively collected data of all cases with synchronous colorectal liver metastases received simultaneous resection with curative intent were analysed retrospectively.
Results: Between January 2005 and October 2016, 114 patients underwent simultaneous resection of primary colorectal cancer and liver metastases. Tumor was localized in right side in 26 (22%), left side in 42 (37%) and rectal in 46 (41%) patients. Perioperative mortality was in 3 (2.6%) patients from the all cohort. Postoperative complications was observed in 32 (28%) patients and the majority of them (75%) were grade 1 to 3 according to Clavien-Dindo classification. Neither Perioperative mortality nor postoperative complications rates after simulatanous resection were different among the groups of right colon, left colon and rectal cancer (4%, 2.5% and 2% respectively, p; 0.89) and (17%, 33% and 34%respectively; p: 0.29)]. 5 year overall survival of the whole cohort was 54% and 3 years overall survival was 67 %.
Conclusion: Simultaneous resection for primary colorectal cancer and liver metastases is a safe procedure, and can be carried out without excess morbidity in carefully selected patients; regardless of the location of the primary tumors and type of hepatectomy.

P25.08
IS THERE STILL A PLACE FOR CHOLANGIOCARCINOMA IN THE ALPPS?

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Background: Although the first case of ALPPS was successfully performed in a patient with phCCA, due to the high morbility and mortality CCA is often considered a relative contraindication to ALPPS.
Methods: We retrospectively analyzed our single center experience on the use of ALPPS for Cholangiocarcinoma focusing on postoperative complications, patient survival and tumor recurrence.
Results: Between November 2010 and November 2016 we performed 21 ALPPS for suspected cholangiocarcinoma (6 phCCA, 11 iCCA, 2 Gallbladder carcinoma (GBCA) and 2 Klatskin-mimicking IPN) with a feasibility of 100%. Median age was 70 years. BDA was performed in 17 patients (5 phCCA, 9 iCCA, 2 GBCA and 1 IPN). T-Tube was used in 1 iCCA and 1 GBCA at Stage 1. A R0 status was reached in 15 patients (4 phCCA, 7 iCCA, 2 GBCA, 2 IPN). Morbidity was 100% for phCCA, 82% for iCCA, 100% for GBCA, 33% for IPN. The postoperative mortality rate was 50% for phCCA, 18% iCCA, 0% GBCA and IPN. ASA-Score 3, preoperative stent, Liver fibrosis, PHLF≥B after Stage 2 were identified as independent risk factors for postoperative mortality. The overall disease-free survival at 1 year was 67% for phCCA, 43% for iCCA. 1 iCCA died after recurrence. The 3y OS was 50% for phCCA and 67% for iCCA, but excluding the postoperative death was 100% for phCCA and 90% for iCCA.
Conclusion: Despite a high morbidity, with a precise patient selection mortality can be avoided and ALPPS can be used with intention to treat also for cholangiocarcinoma.

IS TUMOR DETACHMENT FROM VASCULAR STRUCTURES A TECHNICAL OPTION FOR INTRAHEPATIC CHOLANGIOCARCINOMA?

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P27.02.
Background: R0 resection is the standard for mass-forming cholangiocarcinoma (MFCCC). A recent study validated the possibility to detach colorectal liver metastases