chronic groups, respectively (1 was a case of clinical trial in 2014). The reason of introduction was renal function protection in 16 cases. Reduction of CNI was achieved in all cases. There were two cases whose trough level of everolimus accidentally and temporarily exceeded twice the reference range. Acute cellular rejection occurred in 1 ABO compatible case (6%). Median eGFR and reatinine levels at the initiation of everolimus in subacute and chronic groups were 32/38 mL/min/1.73 m2 and 1.46/1.47 mg/dL, respectively. Those values did not show marked changes after introduction. Finally, everolimus introduction was achieved in all cases.

Conclusion: The introduction of everolimus was achieved in subacute and chronic phases after liver transplantation in all recipients including ABO incompatible cases. As for the efficacy and safety, a longer period of observation is needed.

[O-1756]
SALVAGE LIVING DONOR LIVER TRANSPLANTATION FOR COLORECTAL CANCER LIVER METASTASIS: A CASE REPORT

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Introduction: Approximately half of the patients with Colorectal cancer (CRC) develop metastases to the liver. Surgical treatment of liver metastases (LM) is the only curative treatment option; however, only 20-40% of patients are candidates for liver resection. In CRC LM cases with unresectable disease, liver transplantation could be a solution with promising results from Norway.

Method: Here we present a case with unresectable CRC-LM who developed jaundice and cholangitis and underwent living donor liver transplantation (LDLT)

Result: A 42 yo male was referred to our center with cholangitis and jaundice who had multiple percutaneous biliary drainage and endoscopic drainage attempts. The patient was diagnosed with sigmoid colon adeno cancer with multiple liver metastasis 3 years ago and underwent low anterior resection and segment 5 wedge tumor resection (T3N2M1) followed with chemotheraphy (CHT). His LM responded to CHT however recurred after 14 months. He underwent liver resection (18months after initial surgery) followed CHT with capecitabine. He had recurrent liver metastasis for which he underwent portal vein embolization for anatomical resection which was not performed and consecutively transarterial radioembolization. The patient developed jaundice and cholangitis due to biliary compression which required multiple drainage attempts. He went on to have several bouts of cholangitis and severe biliary obstruction requiring multiple admissions and numerous drainage attempts. At referral to our center, his MELD score was 20 (Bil:9.8, INR1.54) and CEA 2737 ng/ml. He had PET scan which showed liver only disease. He had staging laparotomy where 3 hepatoduodenal lymphnodes were negative. After ethical commitee approval, our institutional transplant board decided LDLT. He underwent right lobe living donor liver transplantation and recovered uneventfully and discharged 4 weeks after LDLT. At discharge, his CEA level normalised gradually (53ng/ml) and PET scan was negative.

Conclusion: LDLT could be a life saving option for patients with unresectable CRC-LM patients with liver failure.

[O-1645]
CUSTOMIZED REDUCTION OF LEFT LOBE/LEFT LATERAL GRAFT IN PEDIATRIC LDLT RECIPIENTS: OUTCOMES OF A PROSPECTIVE STUDY

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Introduction: Graft size rather than GRWR has a more significant bearing on outcome in Pediatric LT. Disproportionate liver grafts are associated with complications such as intra-abdominal hypertension, portal venous thrombosis(PVT), and requirement of mesh for abdominal closure. We present our results following use of reduced-graft customized to the size of diaphragmatic recess for each patient.

Method: Patients undergoing LDLT were entered into a prospectively maintained database. Patients with weight$\leq$10 kgs, undergoing LDLT between March-2017 till November-2018 and minimum follow-up of 8-weeks post-surgery were included in the study. Patients were categorized according to the use of reduced graft and were reviewed for pre-operative factors, peri-operative complications, the incidence of PVT and overall outcome.

Result: Of 55 pediatric LDLTs during the study period, 40 patients(21 females,52.5%) fulfilled the study criteria and were included. Mean preoperative weight was 6.3 Kgs. Mean PELD score was 23.6 with 55% having PELD between 11-20 and 35% with PELD>20. There were no intraoperative mortalities. 36/40(90%) patients received reduced left-lateral or left-lobe graft. Mean graft-weight after reduction was 132.9 gms, mean reduced volume was 117.1 gms and mean GRWR was 2.1%. One patient developed PVT due to sudden post-operative hypotension. Five patients(12.5%) had PVT in postoperative period attributable to technical factors. All cases required reoperative intervention. Four PVT cases followed reduced-graft (11.1%) while 1 (25%) without reduction(P=0.42). Patient with reduced-graft had a significantly lower duration of ascitic drainage(P=0.005), biliary complications (P=0.023) and time to normalization of INR(P=0.011). Further, there was higher wound-related morbidity in patients without reduced-graft(P=0.06). Mesh was required for abdominal closure in 3/4(75%) patients without reduction and in none following reduction. There was no significant difference in hospital stay, ICU stay or in-hospital mortality between the two groups.

Conclusion: The customized reduced graft is an ideal procedure to reduce the incidence of PVT and other complications in pediatric LDLT recipients.