

### **Limited Central Hepatectomy for Centrally Located Tumors: Is There a Place for Standardization?**

Florin Botea<sup>1</sup>, Alexandru Barcu<sup>1</sup>, Adina Croitoru<sup>2</sup>, Dana Tomescu<sup>3</sup>, Irinel Popescu<sup>1</sup>

<sup>1</sup>Center of General Surgery and Liver Transplantation, Fundeni Clinical Institute, Bucharest, Romania

<sup>2</sup>Department of Oncology, Fundeni Clinical Institute, Bucharest, Romania

<sup>3</sup>Department of Anesthesia and Intensive Care, Fundeni Clinical Institute, Bucharest, Romania

#### **Abstract**

Anatomical central hepatectomy is technically demanding and is often excessive. It has an increased risk for insufficient remnant liver volume, especially in case of P8 dorsal pedicle for segment 7 and/or P5 dorsal for segment 6, and/or abnormal background liver. On the contrary, limited central hepatectomy (LCH) for centrally located tumors, based on preserving the P8 dorsal and some of P5 and P4 pedicles (depending on tumor placement) is conservative, and therefore has a low risk for insufficient remnant liver volume. It is less technically demanding, when compared to anatomical central hepatectomy. The right side of the resection plane is driven along the P8 dorsal pedicle intersecting the P8 ventral pedicle and as few of the P5 pedicles as possible. The left side of the resection plane is established according to tumor placement anywhere in between the Cantlie's plane and the falciform ligament. The video presents 5 cases that support the conclusion that LCH may be standardized, with good results, especially when using intraoperative ultrasound guidance.

**Key words:** liver resection, intraoperative ultrasound guidance, central hepatectomy