

Journal du programme de chirurgie vasculaire

DANS CETTE ÉDITION

- ENTREVUE CARMS MARDI 29 JANVIER 8h45 CRCHUM
- PAGE 3 SOIRÉE ACADÉMIQUE MERCREDI 30 JANVIER 18h30 CHUM
- PAGE 4 COMITÉ DE PROGRAMME MERCREDI 30 JANVIER 19h30 CHUM
- PAGE 5 COURS PATHOLOGIES VEINEUSES VENDREDI 1 FÉV 9h00 CHUM

SONDAGE DE L'APDVS



Voici un court sondage destiné aux résidents du programme: [lien](#)

HORAIRE DE LA VISITE EXTERNE : PAGE 6

ARTICLE INTÉRESSANT DE DOKMAK ET AL SUR LES CONDUITS AUTOLOGUES PÉRITONÉAUX: PAGE 7

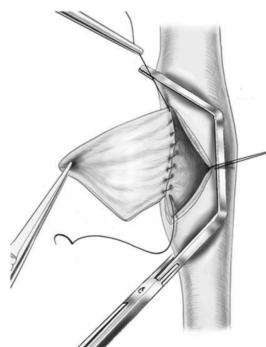


FIGURE 3. The PP patch is inserted laterally on the vein and the mesothelium is positioned in contact with the vessel lumen.

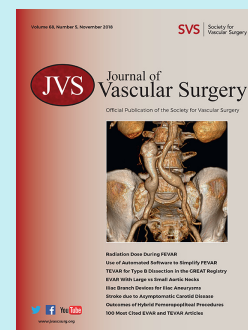
BONNE SEMAINE !

LIENS VERS NOS PÉRIODIQUES

EJVES, IF 3.88



JVS, IF 3.29



JVET, IF 2.73



Agenda académique (abonnement en webdiffusion en cliquant [ici](#))

DATE	TITRE	Professeur/présentateur	Lieu
29 janvier 2019 8h45	Entrevue comité d'admission		CRCHUM
30 janvier 2019 18h30	Soirée académique du programme	Dr Desaulniers	CHUM D17.2041
1er février 2019 9h00	Cours pathologie veineuse, chap 145-8 et 156-7, 160-1	Dre Myriam Letourneau-Montminy	En visio
8 février 2019	Visite externe		CHUM
15 février 2019 7h00	Journal Club	Dr Gagnon/Gauvin	En visio
15 février 2019 9h00	Atelier de simulation CORDIS	Dr Elkouri	CHUM
15 février 2019 13h00	Cours accès dialyse	Dr Jean Ethier	CHUM
22 février 2019 13h00	Cours prothèses , chap 63-64, 66,67,68	Dr Chaput	HMR
27 février 2019 18h30	Soirée académique du programme: qualité des soins	Dre Simard-Emond	CHUM
1 mars 2019	Examen formatif VSITE		CHUM
8 mars 2019 9h00	Cours Défilé thoracique	Dr Cartier	CHUM
8 mars 2019 13h00	Cours allogreffes et cours communication	Drs Febrer et Bourguoin	CHUM
22 mars 2019 7h00	Journal Club	Drs Chastant et Montreuil	En visio
22 mars 2019 13h00	Cours dissection et hématome intramural	Dr Blair	CHUM
29 mars 2019 13h00	Rapport des résidents		CHUM
4-6 avril 2019	Winnipeg meeting		
12 avril 2019	Journal club	Dr Gagnon/Chaput	En visio

Comment mieux apprendre ?



Par Dr Pierre Desaulniers

Professeur agrégé de clinique

Directeur du programme de médecine d'urgence spécialisée
Responsable du comité facultaire sur la sécurité des soins et la sécurité
des résidents

- **Stratégies de rétention**
- **Comment améliorer les cours**
- **Capacité d'attention**

Mercredi 30 janvier 2019

18h30

CHUM D17-2041 et

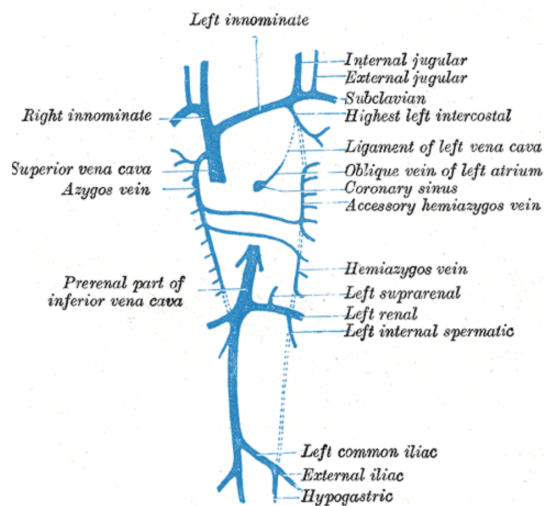
en visio au CHRTR-C1-166 Pavillon Ste-Marie

Comité de programme – Ordre du jour

1. Lecture et adoption de l'ordre du jour
2. Points découlant
 - Visite externe : vendredi 8 février 2019
 - Formation pédagogique des professeurs
 - Comité d'admission CARMS 2019
 - Rapport du responsable de la recherche (Dr Chaput)
3. Date du prochain comité de programme 27 février 2019

Mercredi 30 janvier 2019
19h45 (après la soirée académique)
CHUM – D17 2041 et
en visio au CHRTR-C1-166 Pavillon Ste-Marie

Pathologies veineuses



Dre Myriam Létourneau-Montminy
Chirurgienne vasculaire

**Chapitres 145-8 et 156-7
et 160-1**
9ème édition Rutherford

Vendredi 1er février 2019

9h00-12h00 en visio

CHUM D17.2041

HORAIRE DE LA VISITE EXTERNE DU 8 FÉVRIER 2019

CHUM - Tour S - S04.730

HORAIRE RÉVISION EXTERNE		
Université de Montréal - chirurgie vasculaire		
Visiteurs :	Dr Michael Louis Schwartz (University of Toronto) Dre Mireille Grégoire (Université Laval) FMRQ – à confirmer Monsieur Denis Laliberté (Collège royal)	
Date :	Le vendredi 8 février 2019	
Location :	Tour Saint-Antoine-850 rue Saint-Denis -4ème étage Local –S04.730- CHUM	
Personne Ressource		
Directeur du programme	Adjoint (e) du programme	Personne Ressource PGME
Docteur Stéphane Elkouri	Madame Sabrina Abdeddaim	Monsieur Martin Gendron
514-890 8000 poste 15148 cell: 514-609-7833	514-890 8000 poste 26373	514-343-6111 poste 16008
Heure	RENCONTRE AVEC	ENDROIT
7h00-7h45	Réunion avec la vice-doyenne D ^{re} Marie-Josée Dupuis	Hôtel Novotel Montréal Centre, 1180 rue de la Montagne
7h45-8h00	Transport vers le lieu de visite- Par le directeur de programme docteur Stéphane Elkouri	Hôtel vers le CHUM
8h00-8h45	Révision des documents <i>Documents à la disponibilité du visiteur : procès-verbaux, dossiers d'évaluation des résidents</i>	Tour S S04.730-CHUM
8h45-10h00	Directeur du programme- Docteur Stéphane Elkouri Révision des documents	
10h00-10h15	Pause	
10h15-10h45	Directeur des fondements chirurgicaux Docteur Lucas Sidéris	
10h45-11h15	Chef de département universitaire Docteur Michel Carrier	
11h15-12h15	Résident (e) - Dre Catherine Boudreau (R1) - Dr William Fortin(R4) - Dr Olivier Gagnon (R3) - Dr Robin Chastant (R6)	
12h15-12h45	Dîner	
12h45-13h00	Discussion privée pour les visiteurs avant la réunion du Comité du programme de résidence	
13h00-14h00	Comité du programme de résidence : Drs -Nathalie Beaudoin(CHUM) –Daniel Bourgouin(CHRTR)-Jean François Blair (CHUM)-Miguel Chaput (HMR) -José Dufresne (CHRTR) -Stéphane Elkouri Directeur de programme -Guillaume Febrer (Président du comité d'évaluation) HSC -Valérie Gauvin CHRTR –Rafik Ghali (HMR)– Louis Guertin , Président de grappe de chirurgie –Jean René Houle (CSL) -Marie Andrée Lortie (CHRTR) – Bernard Montreuil (HMR) – Ricardo Ruz (CSL) -William Fortin R4, représentant des résidents seniors - Catherine Boudreau R1 représentante des résidents juniors	
14h00-15h00	Discussion privée pour les visiteurs	
15h00-15h15	Réunion de conclusion avec le directeur du programme et la vice-doyenne	

Parietal Peritoneum as an Autologous Substitute for Venous Reconstruction in Hepatopancreatobiliary Surgery

Safi Dokmak, MD, Béatrice Aussilhou, MD, Alain Sauvanet, MD, Ganesh Nagarajan, MS, Olivier Farges, MD, and Jacques Belghiti, MD

Objective: To evaluate the parietal peritoneum (PP) as an autologous substitute for venous reconstruction during hepatopancreatobiliary (HPB) surgery.

Background: Venous resection during liver or pancreatic resection may require a rapidly available substitute especially when the need for venous resection is unforeseen.

Methods: The PP was used as an autologous substitute during complex liver and pancreatic resections. Postoperative anticoagulation was standard and venous patency was assessed by routine computed tomographic scans.

Results: Thirty patients underwent vascular resection during pancreatic (n = 18) or liver (n = 12) resection, mainly for malignant tumors (n = 29). Venous resection was an emergency procedure in 4 patients due to prolonged vascular occlusion. The PP, with a mean length of 22 mm (15–70), was quickly harvested and used as a lateral (n = 28) or a tubular (n = 2) substitute for reconstruction of the mesentericoportal vein (n = 24), vena cava (n = 3), or hepatic vein (n = 3). Severe morbidity included Clavien grade-III complications in 4 (13%) patients but there was no PP-related or hemorrhagic complications. Histological vascular invasion was present in 18 (62%) patients, and all had an R0 resection (100%). After a mean follow-up of 14 (7–33) months, all venous reconstructions were patent except for 1 tubular graft (97%).

Conclusions: A PP can be safely used as a lateral patch for venous reconstruction during HPB surgery; this could help reduce reluctance to perform vascular resection when oncologically required. Clinical trials identification: NCT02121886.

Keywords: liver resection, pancreatic resection, parietal peritoneum, vascular graft, vascular reconstruction

(*Ann Surg* 2015;262:366–371)

Improvements in surgical techniques, perioperative management, and effective chemotherapy regimens have extended indications for resection of malignant hepatobiliary and pancreatic tumors with vascular invasion.^{1–9} Therefore, vascular resection is increasingly necessary to obtain an adequate resection margin and improve patient survival.^{1–9} Besides, tumor adhesions to adjacent veins are usually due to tumor invasion, but they may also only be inflammatory; aborting surgery because of presumed vascular extension can therefore be detrimental. Although most vascular resections associated with pancreatectomy can be reconstructed by simple venorrhaphy or end-to-end anastomosis, a segmental or lateral vascular graft may be required in 8% to 12% of cases.⁷ Vascular reconstruction

can be planned preoperatively if vascular invasion is evident and an appropriate vascular substitute can be prepared. Different sources of vascular substitutes are available including autologous veins,^{10–14} synthetic grafts with materials such as polytetrafluoroethylene (PTFE),^{15–17} cryopreserved veins,¹⁸ and veins from the resected liver.¹⁹ However, the decision to perform vascular resection may be made during dissection, due to vascular invasion or injury, while the mesentericoportal vein (MPV) or vena cava (VC) are clamped. In these emergency situations, an easily available substitute is needed to prevent prolonged ischemia. The difficulty of predicting the need for vascular resection during hepatopancreatobiliary (HPB) surgery has lead certain authors, including those in our group, to use either veins from the resected liver,¹⁹ the umbilical vein^{20,21} or the parietal peritoneum (PP) for VC reconstruction.^{22–25} We have been prospectively using the PP since 2010 for venous reconstruction during HPB surgery. This study reports a prospective series of 30 patients in whom the PP was used as an autologous substitute for vein reconstruction.

PATIENTS AND METHODS

Between December 2010 and September 2013, all patients operated for complex liver or pancreatic resection and requiring venous resection were evaluated for use of the PP as an autologous substitute for lateral or tubular venous reconstruction. During this period, the PP was considered as the first option for an autologous substitute (except in patients with suspected carcinomatosis), but other substitutes could be used if the PP was judged not appropriate by the surgeon. All demographic, perioperative, and postoperative outcomes were prospectively recorded. Complications were graded as pancreatic or liver specific and according to the Clavien-Dindo classification.²⁶ The protocol was approved by the Ethics committee, endorsed by the scientific committee of the International Hepato-Pancreato-Biliary Association (IHPBA) French chapter, and registered in clinicaltrials.gov (NCT02121886). Informed consent was obtained from all electively operated patients.

Assessment of Preoperative Vascular Invasion

Surgery was decided for each patient in a multidisciplinary meeting, and vascular invasion was systematically evaluated on computed tomographic (CT) scan performed at least 1 month before resection. Venous invasion was preoperatively assessed and classified as follows: (a) the absence of a fat plane separating the tumor and the vein and the presence of narrowing of the vein was considered to be “certain venous invasion”; (b) the absence of the fat plane between the vein and the tumor with no narrowing of the vein was considered to be “suspected venous invasion”; and (c) the presence of a fat plane between the vein and the tumor was considered to be “non suspected venous invasion.”

Peritoneal Substitute Procurement

The PP was harvested (Fig. 1) from the peritoneum of the diaphragm, the right or left hypochondrium or the falciform ligament, with a thin muscular or aponeurotic layer. The peritoneal layer of

From the Department of HPB Surgery and Liver Transplantation, Beaujon Hospital, Clichy, France.

Disclosure: The authors had no conflicts of interest in relation to this study.

Supplemental digital content is available for this article. Direct URL citations appear in the printed text and are provided in the HTML and PDF versions of this article on the journal's Web site (www.annalsofsurgery.com).

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