

RESULTS

In this study 50 patients were examined 17 females, 33 males. The males ages were between 25-72Y (mean 56Y). The

females ages were between 21-76Y (mean 29Y.). The different pathological conditions are presented in {Table 1}.

Γ.	•	•	•	•	•	•	•	•	
Budd-Chiari corrected by shunt in follow up.		Hepatic hydated disease.	Pancreatic tumour.	Primary biliary cirrhosis.	Post endoscopic cholecystectomy complications.		Hepatic masses including metastasis, nepatocential current of cases	Hepatic cirrhosis post virus hepatitis or alcohol addiction. 22	
	3 cases	4 cases	case	4 cases	2 cases	2 cases	cases	cases	6 cases

 ϕ The portal system anatomic abnormalities are illustrated in Table (2).

	Arterioportal fistula	Portal vein tritor cauou	· · · · · · · · · · · · · · · · · · ·			
	Tumoral arteroportal fistula	7 (4%)	2	4 4 6 123 3 4 T	I WAARIO	±Va CD
(due to currhosis)	Low SMA arteroportal fistula	1 (2%)		\circ	+ Ve Angio.	.VeCD
		C		0	- Ve Angio.	+ Ve CD

however CD could detect 4 cases. CD could not detect a low SMA arterioportal fistula, as this fistula was deeply abdominal, in Table (2), showed that celiomesenteric arterioportography could detect 5 cases with portal anatomic abnormalities,

an area rich of gases.

 ϕ CD examination was done for 50 cases, the results of the various portal system vessels examination are presented in

			-	1 22 48	I DIAL A TATORIA
				2 (4%) cases	ca (X) thrombosis
	ď	0		No. 22, 40	thrombosis
0				2 (4%) cases	Splenic vein
		c	0	26260 (/0/ 0	
	0	COmpression):	No. 48		
			the main rv)		
		No 30 (due to mass	(III OIII OOSIS AA	22, 33, 21	
		opacification).	the ambosis in	No. 3, 6, 13, 17,	thrombosis
	-	28, (due to faint	(due to distal	/ (14%) cases	P.V branch
	,	*4 (8%) cases No. 4, 1,	1 (2%) case	2 (140/) 2000	
C	0	140. 17, 01		48	
	seen by CD	Mo 17 34		No. 11, 22, 42,	T V DILOTTO
	with patent shunt	faint onacification)		4 (8%) cases	by thrombosis
,	1 (2%) case 45	*7 (7%) cases (due to	\ \ \ \ \		
0	Hansprannan		4,000		
	manenlantation)				
	hepatic				Patent PV
difficult	(uncomplicated		0	26 (52%)	DVI
1 (2%) case (xo	1(2%) case No. 46	O			
1 (20/) case No 43	pominima		c	+Ve Migro.	
		+ve Augur.	-ve Angio.		
not performed	(angio is not	Aug.	+ve CD	+ve CD	
- (e. Hig.)					İ
± vie Angio CD is II		(XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX			Die 3}.
					1. 2)

(12%) PV or its branches diagnosed by CD examination as patent vessels, however in *angiography the portal vein or its CD examination could not examine perfectly the portal venous system in 1 cases (2%). Table (3), illustrates that in 6 cases compression by adjacent masses, by the dilution of contrast that occurs in patients with portal hypertension, or by the presence branches were non opacified suspecting their thrombosis. The celiomesenteric arterioportography was misleaded by, the vessels

of near PV thrombosis

The direction of blood in the different portal system vessels are presented in {Table 4}.

	- 1			U	49 (98%)	CMAN
		0	0	>	NO. 11, 37	
0				C	2 (4%) cases	IMV
c	0	0	0			
		No. 7, 39	-		48 (96%)	Splenic V
	0	7 (4%) cases	0			
10,00		24, 25, 38	Seen Seen			branches
15 33		cases No.			45 (80%)	Portal vein
25 No 8	C	3 (6%)	0	0	(/0/0/	
*2 (60%)		No. 44			48 (90%)	Portal vein
C	0	1(2%) case	0	0	+ ve Anglo.	
- ve Anglo.	+ ve Angio.	+ ve Angio.	- ve Angio.	. Ve CD	+veCD	
+veCD	-ve CD	+veCD	+ ve CD	Hepaword	4	
	Hepatofuge					

there was hepatofugal flow (due to shunt stent stenosis). In 43 (86%) patients, there were hepatopet blood flow in the portal vein branch. however in 3 cases, •hepatofugal blood flow was detected in one of the portal vein branch (in 2 cases with tumoral cases, No. 8, 15, 33 with hepatopet flow in the main portal vein and in one portal vein main branch, however the other branch arterioportal fistula (No. 24, 38) and unexplained in one case (No. 25), confirmed by both techniques. There were another 3 had hepatofugal flow. *Angiography illustrated symmetrical hepatopete flow in the portal system. The injection of contrast media during angiography, masked the difference of blood flow direction in portal vein branches. Table (4), illustrates that in 48 patients studied by there were hepatopet flow in the main portal vein, and in one patient,

 φ is the second of the seco pes detected by CD examination and celiomesenteric arterioportography are presented in

		1 (2%) case. No. 11	
0	between SIVIA and INC. 1		
	fistula No. 38. (Artenoportal fisture	Ad	shunt.
	plexus No. 12. *Low SMA arterioportal	0	Idiopathic porto-systemic
0	2 (10%) cases *Portocave through uterine		Spienoreman commercial
No. 18, 26, 39	•	2 (4%) case. No. 38, 39	Giorgenal collaterals.
©3 (6%) cases.	0	vein. No. 15, 22	
		diagnosed as dilated left gastric	Retropancreatic collaterals.
	0	2 (40%) cases was incorrectly	veins.
0		1 (2%) case. 130. 5	Dilated para-oesophageal
-	0	1 (20/) page No 34	Patent paraumbilical vein.
		O	
©1 (2%) case, No. 9			hepatotugai ilow.
No. 17, 26	ascites case 32	No. 16, 23, 34, 37, 39	Dilated left gastric vein with
was faintly onacifiled	lation due lo	5 (10%) cases.	
On (AOA) Cases PV	+ ye Angio.	± ve Angio.	Types of consternis
- ve Angio.	: YE'CD	+ ye CD	{Table 5}.
+veCD			The various conact at types
		defected by CD Commission	ni colleteral types

Porto-portal collaterals. collateral presenting in the 14 (100%) cases, So it's clear that CD examination is more sensitive than celiomesenteric arterioportography presenting in 15 (88.2%) cases and failed in *2 (11.8%) cases however celiomesenteric arterioportiography could specify the type of celiomesenteric arterioportography had detected collaterals in 14 (70%) cases. Also CD examination could specify the type of collateral arterioportography or by each of them. CD examination could detect porto-systemic collaterals in 17 (85%) cases However in detecting portal collaterals, on the other hand, it has a less specificity in processing the type of collateral present. The contrast media dilution especially in cases with portal hypertension, leads to failure of opacification of the portal system collaterals in $^{\odot}$ 6 (31.6%) Table (5) illustrates 20 (40%) pathological portal collaterals either diagnosed by both the CD and celiomesenteric

Hepatic arterialization:

finding in cirrhosis, cork screw arteries. Arterialization was also diagnosed by CD when hepatic arteries were conspicuously diagnosed all by CD, however angiography could diagnose 4 cases, as the visualization of there vessels are technique dependent. larger in diameter and had higher frequency shifts compared with normal hepatic arteries. This was found in 6 cases (12%), The amount of contrast media injected and the time of imaging are the most important factors for that. It was diagnosed by CD in the presence of enlarged tortuous peripheral arteries similar to the well-known angiographic

examination looked for the inferior mesenteric vein in 38 cases as the rest of the patients either they had got tired and could not Inferior mesenteric vein: complete examination or the presence of abdominal gases or ascites harden the examination. The color Doppler could detect 1MV, the feasibility of its Doppler study and the change in the direction of blood flow in cases with portal hypertension. CD could not done in 2 cases (8%), as the Doppler angle could not properly adjusted. The normal celiomesenteric angiography with selective catherterization of the CT and SMA, can not demonstrate the normal 1MV in the venous phase. 1MV in 26 cases (68%) and could not be detected in 12 cases (32%). Also Doppler study could done in 24 cases (92%), and CD examination for the inferior mesenteric vein (1MV) was done to study the detectability of CD examination for the

shunt and CD examination had confirmed its good function, so there was no need for angiography. and the CD examination had confirmed vascular integraty, and there was no indication for angiography. The other case had a Celiomesenteric arterioportography was done in 48 cases. In the rest 2 cases, one case had get hepatic transplantation,

The different types of celiac trunk anatomic variants presented in 48 cases which studied by both CD and celiomesenteric arteriography, are presented in {Table 6}.

aorta (Case No. 35)	Agenesis of the CT and separate origin of the hepatic artery and of the splenic artery from the	Common celiomesenteric trunk (Case 170, 50)	Near origin of the C1 & Sivis (Case No. 33)	GALL CT & SMA (Case No. 22)		Type or russum.	Ta stuariant
	0		0	0	Angio.	+ ve	+ve CD
			-		Angio.	+ve	-ve CD
	0					- ve Angio.	+veCD

arterioportography and missed by CD. Too much gases were always present in the epigastric area and the epigastric masses however pancreatic or hepatic, harden the CD technique. 3 cases (6%) with different celiac trunk anatomic variants were found. They detected by celiomesenteric

Hepatic artery, different anatomic variant that are found, are presented in {Table 7}. These results are obtaied in the 48 cases examined by CD and angiography.

						_		T .	_	<u>.</u> [V				
The main hepatic artery from the aorta	Replaced right liebane and see the second		Accessory right includes	a right henatic artery from the SMA.			Replaced right hepanc artery nom the service of	from the SMA		Accessory left hepatic artery from left gastric artery.		Replaced left hepatic artery from left gasting and the	S 1ch castric artery		Variant	
0	No. 31	1 (2%) case	No. 33	1 (2%) case	4/	47	No. 30, 31, 42,	3 (8%) cases			0	No. 40	1 (2%) case	T VE Aligiu.	. Agric	Tun CD
1(2%) case No. 35				(0		No. G	1(2%) case		No. 1	1(2%) case	No.33, 37, 41	3(6%) cases	_		- ye CD +
	0				0			<u>.</u>			0		-	0	- ve Angio.	+ ve CD
case	1 (2%)	case	1 (2%)	case	1 (2%)		Cu	Sees	4 (8%)	case	1 (2%)	1 (20/)	2000	4 (8%)	number	Total

detect all the hepatic artery variants in the 12 cases (100%), however CD examination could detect 6 cases (50%). Table (7), illustrates that hepatic artery variants occurred in 12 cases (25%), celiomesenteric arterioportography could

Table (8) Presents cases studded by CD and celiomesenteric arterioportography to precise liver arterial supply. Cases of post hepatic transplantation is excluded and aniography were not done in 2 cases.

44 31 (70.5%) 12 (27.5%) 0 0 1 (2.3%)

Table (8) illustrates the high sensitivity of angiography (97.7%) in detecting hepatic arterial supply in compare with CD

sensitivity (70.5%).

 $oldsymbol{arphi}$ and $oldsymbol{arphi}$ Table (9) presents the different arterial pathology found in the splanchnic arteries, studded in 48 cases including cases of

post hepatic transplantation.

case	C	0	Splenic aneurysm
1 (2%)		cases	
C	0	*3 (6%)	Stenosed HA
,		cases	
		44 (92%)	Patent HA
0	IIIdos. IVO Ex	cases	
cases	artery were displaced of	1(0/0)	Stenosed C1
*3 (6%)	1 (2%) case C1 & hopans	*4 (8%)	
	CT & hengtic	cases	
		40 (83%)	Patent CT
I			
1 6 / H. B. C	- ve Angio	+ ve Angio	
+ va Angio		+ ve CD	
. v. CD			•

trunk and hepatic artery mild stenosis, due to large hepatic left lobe mass compression, but angiography found that, this stenosis however CD could detect 7 (70%) of them and faild to diagnose *3 (30%) of them. CD had a false positive result of celiac into these arteries on the other hand, the error of CD angle correction harden the diagnosis of stemosis in this area. was not a functional stenosis. As in angiography, cathetarization occurs to these arteries and contrast media is injected directly Table (9), illustrates that celiomesenteric arterioportography could detect *10 cases of splanchnic arteries stenosis,

Inferior mesenteric artery:

and the easability of doing Doppler study. The IMA could detected in 30 cases 79% only and the Doppler study could done in the abdominal gases harden the technique. Selective catheterization of the IMA was not done during the celiomesenteric 26 cases only 68%. The difficulty in the examination of the 1MA was due to inability to obtain the correct Doppler angle, also arterioprotography performed in this work. The inferior mesenteric artery (1MA) was searched for by CD in 38 cases to show the detectability of CD to this artery

Subhepatic veins and inferior vena cava:

subhepatic vein taking origin from the left subhepatic vein. Also CD examination identified subhepatic veins attenuation by the hepatic mass lesion in 5 cases (10%). No capsular derivations could be detected. Venography was performed for the case of CD examination of the subhepatic veins and inferior vena cava was done in 50 cases. 2 cases (4%) show a variant middle

Budd-Chiari with complicated shunt only.

 ϕ

Post hepatic transplantation: In the 4 cases with post hepatic transplantation, the results of CD examination and celiomesenteric arterioportography

were as follow, {Table 10}.

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Aniography had no need in cases of post-hepatic transplantation, if the biological conditions and CD results had confirmed

the vascular integrity.

Interventional shunt:

angiography had no need to confirm this result. However in the TIPS case, CD examination firstly and angiography In the 2 cases with surgical porto-systemic shunt, the CD examination could confirm shunt good function, and

From cases of vascular intervention however surgical, as in cases with hepatic transplantation or surgical shunt, or angiographic (celiomesenteric arterioportography and inferior vena cavography) secondly could diagnose stent obstruction. intervention as TIPS, we can recognize that CD examination is an efficient technique to follow up the vascular patency, the

occurrence of thrombosis, shunt function.

Venous System

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Anglo Papatic cirhosis post Papatic cirhosis post Papatilia c, sicondi desquition Anglo CD -Ve -Ve -Ve -Ve -Ve From CT -Ve Anglo -Ve Anglo -Ve From CT -Ve From CT -Ve Anglo -Ve Anglo -Ve Anglo -Ve Anglo -Ve From CT -Ve -Ve Anglo -Ve Anglo -Ve Anglo -Ve From CT -Ve From CT -Ve -Ve Anglo -Ve Anglo -Ve Anglo -Ve Anglo -Ve From CT -Ve -Ve Anglo -Ve Anglo -Ve Anglo -Ve -Ve Anglo -Ve -Ve Anglo -Ve Anglo -Ve -Ve Anglo -Ve Anglo -Ve Anglo -Ve Anglo -Ve -Ve Anglo -Ve -Ve Anglo -Ve -Ve -Ve Anglo -Ve -Ve -Ve Anglo -Ve -Ve -Ve Anglo -Ve -Ve Anglo -Ve -Ve -Ve -Ve Anglo -Ve -Ve -Ve -Ve Anglo -Ve -Ve -Ve Anglo -Ve -Ve -Ve -Ve Anglo -Ve -Ve -Ve -Ve -Ve -Ve -Ve -V		annot be seen		1 \$	-	*	From CT	\$		*	Anglo	copic cholecystactomy			2/-
Anglo -Ve -Ve From CT -Ve -Ve detectable -Ve detectable -Ve hepstitic cirthosis post CD -Ve -Ve -Ve -Ve From CT -Ve -Ve -Ve -Ve -Ve mon - examined non - examined -Ve hepstitic cirthosis post -Ve		on - examined		1 5	V	 	From CT	* *	; \$	\$	8	ate of the distal CBD post			
Anglo — Ve — Ve From CT — Ve — Ve — Ve — Ve detectable — Ve detectable — Ve —		on • examined			i Ve	\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \	From CT	↓ ↓ ★ \$	1 i	 	CD Angle	c cirthosis post (is c, alcohol adequation			26-5
Comments CD —Ve —Ve From CT —Ve —Ve detectable —Ve non-examined non-examined		- 4	detectable	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	¥	\$			\$	\$	Anglo				25-64
The Comments of the Comments o						\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \			- %	**************************************	CD		- Valental	83300	
	Comment	Remodit .	AMA CANADA												

The Rt. and Lt. HA, give small a	non - examined	non - examined	 ↓ *		 	From CT	+ Ve	l *	i 1	Anglo	Lt. lobe cystic lesion. hyperechogenic and partially calcified in US, 77 Hydatid cyst. pre- operative planing.	52Y d	43-	
Can not well do due to seven	non · examined	non - examined	- Ve	- V.	1 4	From CT	+ 46	5	; ; ; ; ; ; ; ; ; ; ; ; ; ; ; ; ; ; ;					
	non - examined	non - examinad	1 5	replaced Rt. HA. It gives the replaced Rt. HA.	 	*CT gives only the LL HA *Replaced Rt. HA from SMA *CT gives only the Lt HA			It gives only the Lt. HA It gives only the	CD Anglo	Ch. pancrestitis with false cyst juxtaduodenal.	50Y d	42-	
	Cannot examin	Detectable	1 %	It gives the	 	Tuesteed Rt. HA			CT gives only the RL HA	Angio	Ch. pancrentus.	54Y 0	<u></u>	
Cannot compliate the source patient lifess	non - examined	non - examined		1 1	· Þ	From CT Replaced Lt. H	1 1	\$	- ¥	G	duodenectomy.	_	1	
du xam du	- Ve	DOI:	!	1 5	1 \$	From CT + Lt. gastric artery (Replaced HA)	l ve	! ≴ :	i i	Angio	Ch. hepatitis, pancresite tumour? sarcoma - pisning before pancresiteo	64Y +	40- g	
,	non - examined	detectable	1 Ve	1 \$	I &	From CT+Lt.	- V		1					
	non - examined	non - examined	! *	V	1 %	From CT	+	+ \$		Anglo	Yinnay Comment	+0	39- 45Y	= 7.
	! \	detectable	\ \	* Va	l V *	From CT	1 4	1 \$	*	GB .	Dimay billary cirrhosis.	-	-	
						: 	ariery .	n gastroduodensi arleny						
compression	nined	non examined	1 l	1 1 4 4	\ \ \	From CT	- Ve	- Ve + Ve	1 1 \$ \$	CD	Rt. lobe turnour	+0	38-677	ω T
Difficult examination due to mass	1 4						1							
Difficult examination due to sever distortion by the pancreatitis.	nined		Cannot be seen	Cannot be seen C ?? Rt. HA from SMA	* * * *	From CT - Lt. Replaced HA from Lt. gastric A ?? Rt. HA from SMA	+ * *		!!	CD Anglo	Alcoholic ch. pancreattis	٩	497	37-
Difficult Doppler examination due to	· Ve				-	-		i i	1 \$	Angio	dilatation of intrahepatic biliary radicals.			20-
	non - examined	<u> </u>	\ \$ \$	¥ %	↓ ↓ ≰ ≰	From CT	\ \	· •	*	G	al pancreatic lesion with		2	
	- Ve	Detretanic:		,										
Common		IMA.		AWS: A					Apply the second					A

	50-52Y		70 ×		48-50Y	47-30Y d	46-40Y o	45-43Y Q	44-407 2	
	Hepatic transplantation in 4/84 and developed hepatic A. stenools in 6/94.		O Follow up after 1 month		bed pt. general condition. Follow up after 6 month hepstic transplantation.		Hepatic transplantation since 6 month.	Budd - Chian with periocaval shunt correction since 2 years	TIPS since 6 mouth in case of Budd-Chiari follow up.	
Anglo	8	Anglo	8	Anglo	6	.CD Angle	CD Angio	CD Anglo	Anglo	
						\ \	- - 	 	 \$ \$	
· *	i \$! %	\$	1	- Ve	- ¥		\$	\$ \$	
		l s	1 4	ا *	, *	H Ve	\$	\$		
<u> </u>						From SMA		From CT	From CT	
Stenosed proper HA + non visualization of HA. branches	Stenosed proper HA + non visualization of HA, branches	Stenosed Lt. HA	Stenosed Lt. HA	· Ve		; S S	:	5		
e i co						Rt. HA gives replaced Rt. HA	gives replaced		1 4	
		· Ve	! *			- Y6	l Ve			Ve
		non - examined	non - examined						non - examined	
1.3		non - examined							non - examined	non - axamined
							NO DIRECTOR .	No lead for la	No pead for it	Comme

Inferior Vena Cava & Sub Hepatic Veins

				9	Alcoholic hepatic cirrhosis	٩	56Y	9-	
	- Ve	- Ve	-						· — · · · · · · · · · · · · · · · · · ·
	non - examined	non - examined	non - examined	Angio		٥	631	Ġ	تنطيع المستعدد
	- V	۱ چ	- Ve	S	Hepatic cirrhosis post hepatitis				
	non - examined	non - examined	non - examined	Anglo	V VI VIII	+	<u> </u>		
	- Ve	The middle branch is seen withen the mass	1 %	C	Large hepatic mass segment	•	31 /		
	non - examined	non - examined	non - examined	Angio		٩	30Y		
	\ \	The Lt. branch attenuated by the mass	- Ve	8	et lobe hepetic tumour	`-	_		F
	non - examined	non - examined	non - examined	Angio	Hapatic cirrhosis - nodula in asymetry VII	٩	62Y		
•	1 4	1 %	- ٧0	CD		+		+	1
Difficult examination due to gas.	non - examination	non - examined	non - examined	Anglo					
	- Ve	\ \	The middle SHV takes origin from the left SHV	8	Ch. pancrestitis		50Y Q	7 7	T
	non - examined	non - examined	non - examined	Anglo	+ ratropretonial tymphadenopathy		<u>२</u> व	- 	φ
	٧,	1	*	69	the liver	+-	_		T
	non - examined	non - exemined	non - examined	Anglo	• Cirrhotic liver post hepatitis B. • Rt. lobectomy due to HCC.		~	- 48Y	2.
	* V	1 V6	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	Ç.		-	-		
	non - examined	non - examined	non - examined	Anglo	• Rt. hepatic multiple nodules. • Cancer ampulia of vater.		<u>a</u>	417	
	- V•	- Ve	- 40						· Y
Comment	Caount Contractor								
		Town Trail	nterior vena Cava &	Interior V				,	

		-			segment VII , VIII .			
		and runs above the upper border of the mass.	1	e e	Nepatic cirrhosis post hepatitis C	724 0	19- 7:	
	- Ve	The Rt. SHV is attenuatted			· Enceptatiopassy and			
	non - examined	non - examined	non - examined	Angio	Liver cirrhosis due to Ch. hepatitis	<u> </u>	18- 577	
	 	l ve	1 %	CO		-	-	-
		non - examined	non - examined	Anglo	Ascites * Heemoptels			
	non - examined	I Ve	1	S	· Hepatic cirrhosis post hepatitis	•	755V	7
	Ve			Angio	• Rt. Lobe HCC nodule -		.	
	non - examined	non - examined	로 -	<u>.</u>	 Hapatic cirrhosis due to cholong, oscierosis grade i 	9	44	के
	- Ve	- Ve	- W					==
	non - examined	non - examined	non - examined	Anglo	Rt. Lobe HCC .	٩	724	15-
	: V	- V•	- 46	CB				
			non · examination	Anglo	Post hepatitis B			
	non - examined	non - examined			Lt. hepatic HCC nodule	٩	2	4
	- Ve	The Lt. SHV surrounds	- Ve	6				
	non - examinad	non - examined	non - examined	Anglo	Ch pancrasuus	٩	43Y	13-
	\ *	l ve	The middle SHV takes origin from the Lt. SHV	CD				T
Difficult examination due to gas.			shunt	Angio				
	- v•	1 %	name uterogonadice	6	Acoholic cirrhosis + Nodule	+0	457	12-
Difficult examination due to gas.	- Ve	- ٧٠	non - examined	Angio				
	non - examined	ron - examined] a	CB	Rt. lobe multinodular HCC	٩	¥ ×	= [
	- Ve	- V6		Anglo				
	non - examined	non - examined			Hepstic nodule segment Vi	+0	554	10-
	*	- Ve	- 1/4	CD				
Comment	100 Sec. 150							
							,	

	non - examined	non - examined	non - examined	Angio	Stanosed billary convergence post endoscopic cholecystectomy	+0	487	29-
	- Ve	- Ve	- 4					
	non - examined	non - examined	non - examined	Anglo	pancreatic head tumour planning for pancreatecodeudenctomy.	٩	654	28-
	· *	- V *	- Ve	8		1	1	<u> </u>
	USU - MARKINGA	non - examined	non - oxamined	Anglo	endascopic cholecystectomy	م	614	27-
	- 1	I Ve	- Ve	8	Stanosis of the distal CBD post	- -	_	
	non · •ו	non - examined	non - examined	Anglo	C and alcohol addiction	*	5116	26-
	- Ve	! \{	- V*	CD	Hapatic cirrhosis post hapatitis	,		
	i di a	non - examined	non - examined	Anglo		+<	641	25
		\ 	Į ¥	CD	Mukiple hepatic nodules	,		
	! Ve	non - examined	non - examined	Anglo	in a cirrhotic liver			Ť
	non - axamined	1	i Ve	69	HCC nodule segment VIII	1	200	_
	- W		Non - examined	Anglo				
	non - examined	non - examined		8	HCC of the hepatic dome	٩	77	23
	– Ve	- Ve	\$					
	non - examined	non - examined	non - examined	Angle CD	• Acute pencreatitis	٩	587	22-
	! V*	- Ve	¥.					
	non - exemined '	within the mass middly attennusted.	- Ve	Angle CD	 Hepatic cirrhosis after hepatitis C Nodule of segment IV . Planing before HT . 	٩	25Y	21-2
	TOTI - AARTINI TO	non - examined	non - examined	Anglo	encephalopathy, prepared for TIPS befor hepatic transplantation			20-
	and	! 4	! ≨	CD	• Hepattis C, hemoptesis, ascites			2000
Comment								32

39- 45Y Primary billary cirrhosis	38.		3/- 491			36- 61Y o' Focal pancreatic lesion + Dilated IHBR		35, 404			34- 31Y Q Hepatic cirrhosis, post hepatitis C		33- 70Y Cholangiocarcinoma of		32- 41Y Primary biliary chrhosis plaining		31- 69Y of Munificeal MCC in top of hepatic		30- 69Y of Hepatic cirrhosis and local livery, segment v1? metastasis?		
Anglo	Anglo	CĐ	Angio	c B			CD	Anglo	CĐ	Angle	CB	Angeo	8	1		3	Angio	8	Angio	CD	
non · examined	non - examined	l Ve	non - examined	l ≨		non - examined	. *	non - examined	The Rt. SHV gives accessory branch	non - exammed		L X	nined Det	1 8	non - examined	- \$	non - examined	- Ve	pon - examined	- V	
non - examined	non - examined	- **	non - examined		1 4	non - examined	! *	non - examined	\\		non - examined	L Ve	the mass.	The LL SHV surrounds	non - examined	i Ve	non - examined	Ve	non - examined	1 %	
non - exemined	1 4	non - examined	- 4	non - examined	- Ve	non - examined	1 4		non . examined	.	non - examined	- Ve	non - examined	l ∀ •	non - examined	Ve	non - examined	 	non - exemined	:	- Va
																		V 2 +			Commen

-	non - examined	non - examined	man . eveninad	Audia	Hepetic transplantation since 2 months and now presented by disturbed liver function.	9	- 52Y	56	
			- Ve	69					
	- 46	non - examined	non - examined	Angio	rollow up after 1 month	+0	Y65	49-	
	non - examined	:	1 Y	69		 			
	- Ye	707	non - examined	Anglo	hepatic transplantation.	٩	50Y	48-	<u>.</u>
	non - examined			8	a month			T	
	- Va	- Ve			pad pr. general con-				
		hepato fugetiow in SHV, - hepato fugetiow in SHV, - narrowed ratro hepatic IVC	stent portocave	Angio	obstructed and recent porto cavel shunt since a weak				
	i v	inition and a stant with			Budd - Chiari since 1 year with history of mesocayal surgicel abant since 6 mobiles	م	307	47-	
		Patent portocaval stent with hepatoruge flow in SHV	stent portocave	CD Angeo					
	non - examined	non - examined	non - examined	į 9	Hapatic transplantation since a month.	٩	404	46-	 -
	- Ve	- V6	- 4.						
			·	Anglo	Budd - Chiarl with portocavel shurk correction since 2 years	+0	43Y	45-	
		Patent stent	stent portocave between middle SHV and PV.	CB		╁	-		
No need	+ ٧.	Stenosed by another one.		Angio	of Budd-Chieri tenow up-				
	+ 4	ne de la companya de	l V•		TIPS since 6 mouth in case		A .	4	Ta
the second secon		+ ve Reversal of blood flow	- 40	S	cyst. pre- operative planing.	9 2			
	non - examined	non - examined	non - examined	Angio	Lt. tobe cystic fesion, hyperechogenic and pertiatly hyperechogenic and pertiatly		3	52Y	43-
		*	Ve	33					
	non - examined	non - examined	non - examined		Ch. pencreatitis with false cyst juxtaduodensi.	 § 9	~	507	42.
	[.	\$	- Ve	8		-			
	non - examined	non - examined	non - examined	Angio	Ch. pancreathis.	<u></u>	<u>a</u>	544	41-
		- V	**************************************	8	duodenectomy.	duod	-		
	- W	non - examined	non - examined	Anglo	turnour 7 sarcoms - planing	tum o	+0	647	40-
	non - examined		! ≴	CO		C. T			
	- V•	- Va							
	CANCEL STREET								
Connect.	Talkata C								