Early postoperative

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Many patients considered for multivisceral/intestinal trans - plantation have underlying prothrombotic tendencies. A defined prothrombotic disease may be characterised but a ombotic episodes without a history of multiple previous thr - specific diagnosis necessitates a need for anticoagulation after transplantation. Balancing the risks of bleeding and thrombo - sis after transplant is challenging. Enteric anastomotic leaks can occur after transplanta - tion, most commonly if an oesophagogastric anastomosis is /uni25CF undertaken. Given that the enteric anastomoses are performed on previously ischaemic bowel, often under circumstances where inotrope requirements are substantial, the rate of anas tomotic leaks is surprisingly low . When an enteric leak does occur, the immunosuppressed state of the patient can result in an atypical presentation. Therefore, a high index of suspicion is needed should a patient fail to progr ess as expected postoperatively . Proximal enteric anastomotic leaks, especially involving the oesophagus, are the most challenging to deal with. Oesoph agogastric anastomotic leaks have a significant morbidity and mortality in the general population and are even more chal lenging to manage in an immunosuppr essed patient. The use ® of an EndoVac has improved management of these patients. A vacuum (vac) sponge fixed to a nasogastric tube is placed endoscopically in the cavity at the site of the leak. This controls the leak and facilitates healing without operative intervention. Intra-abdominal collections are common and should be treated by aggressive radiological drainage where possible. T hese collections may be chylous and may require nutritional modifications, either PN or (if the patient is enterally fed) a medium-chain triglyceride diet should be adopted.

intestinal transplantation. Surgical Medical Early Vascular (thrombosis, Renal impairment bleeding, secondary Drug related (PRES, haemorrhage, mycotic TMA, pancreatitis) aneurysm) Infections (viral, bacterial, fungal) Enteric leak (anastomotic or non- GVHD anastomotic) PTLD Abdominal collections Acute cellular rejection (chylous, pancreatic, infected) Pancreatitis (graft or native) Stomal complications Late Thrombosis Renal impairment Mycotic aneurysm Acute cellular rejection Hernias Chronic rejection Stomal complications PTLD Immunosuppression- related malignancy GVHD, graft-versus-host disease; PRES, posterior reversible en cephalopathy syndrome; PTLD, post-transplant lymphoproliferative disease; TMA, thrombotic microangiopathy.

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