ASEAN LHC Vietnam 2026

HỘI PHẪU THUẬT GAN MẬT TỤY VIỆT NAM VSHBPS

ASEAN LHC 5.5

IN CONJUNCTION WITH

VSHBPS 2026

DA NANG, 15 - 16/05/2026

ASEAN LAPAROSCOPIC HPB SURGERY CONFERENCE 5.5
VIETNAM HBP SURGERY CONGRESS 2026

Minimal Access, Maximum Outcomes: Optimizing Multimodal Therapy for HPB Cancers

DA NANG, 15 - 16/05/2026

PROCEEDINGS

WELCOME MESSAGE

From President of Vietnamese Society of Hepato-Biliary-Pancreatic Surgery

Dear Distinguished Colleagues,

On behalf of the Vietnamese Society of Hepato-Biliary-Pancreatic Surgery (VSHBPS), it is my great honor to warmly welcome all distinguished professors, surgeons, researchers, and colleagues from Vietnam, ASEAN countries, and around the world to the ASEAN Laparoscopic HPB Surgery Conference 5.5 (ASEAN LHC 5.5) in conjunction with the Vietnam HBP Surgery Congress 2026 (VSHBPS 2026), held in Da Nang City, Vietnam.

This Conference holds particular significance as it marks the official establishment of the Vietnamese Society of Hepato-Biliary-Pancreatic Surgery (VSHBPS). This important milestone reflects not only the maturity and rapid development of HPB surgery in Vietnam, but also a shared aspiration to build a strong, cohesive professional community dedicated to advancing clinical excellence, research, and international collaboration.

In an era where surgical practice is continuously transformed by technological innovation and multidisciplinary integration, the field of hepatobiliary and pancreatic surgery has witnessed remarkable progress. Minimally invasive approaches, especially laparoscopic techniques, are increasingly redefining standards of care, while multimodal treatment strategies are opening new possibilities in the management of complex HPB diseases and cancers.

Under the theme "Minimal Access, Maximum Outcomes: Optimizing Multimodal Therapy for HPB Cancers" this Conference is designed as a comprehensive scientific forum where knowledge meets experience, and innovation meets practice. It provides an opportunity for participants to engage in meaningful discussions, share clinical insights, and critically reflect on both achievements and ongoing challenges in the field.

With the participation of leading experts and distinguished speakers from Vietnam, Southeast Asia, and internationally-including Korea, Japan, and the United States-we are confident that the scientific program will offer valuable perspectives and contribute to improving the quality of patient care across the region.

Beyond its academic value, this Conference also represents a platform for strengthening professional networks and fostering long-term collaboration among institutions and individuals who share a common commitment to advancing HPB surgery.

We would like to express our sincere appreciation to all speakers, delegates, partners, and sponsors for their invaluable support and contributions. Your participation is essential to the success of this event.

We wish you a productive, inspiring, and memorable experience at the Conference, and an enjoyable stay in Da Nang-one of Vietnam's most dynamic and welcoming coastal cities.

Sincerely,

ON BEHALF OF THE ORGANIZING COMMITTEE

A/Prof. Le Van Thanh
President
Vietnamese Society of Hepato-Biliary-Pancreatic Surgery

LOCAL ORGANIZING COMMITTEE

Congress President

A/Prof. Le Van Thanh
President
Vietnamese Society of Hepato-Biliary-Pancreatic Surgery, Vietnam

Organizing Chair

A/Prof. Le Thanh Son
Military Hospital 103, Vietnam

Scientific Program Chair

Dr. Tran Cong Duy Long
University Medical Center Ho Chi Minh City, Vietnam

Registration Chair

Dr. Ho Van Linh
Hue Central Hospital, Vietnam

Secretary General

Dr. Le Trung Hieu
108 Military Central Hospital, Vietnam

FACULTY

Chairpersons & Speakers

Kwang-Woong Lee	Seoul National University Hospital, South Korea
Joon Seong Park	Seoul National University College of Medicine, South Korea
Goro Honda	Tokyo Women's Medical University, Japan
Hop S Tran Cao	MD Anderson Cancer Center University of Texas, USA
Yoo-Seok Yoon	Seoul National University Bundang Hospital, South Korea
Adrian Chiow Kah Heng	Changi General Hospital, Singapore
Catherine Teh	Makati Medical Center, Phillipines
Lee Ser Yee	Singapore General Hospital, Singapore
Rawisak Chanwat	Bumrungrad International Hospital, Thailand
Shridhar Ganpathi Iyer	National University of Singapore, Singapore
Jan Jin Bong	Sunway Medical Center, Malaysia
Sai Aung Nyunt Oo	Yangon Specialty Hospital, Myanmar
Koh Peng Soon	University of Malaya Medical Center, Malaysia
Worakitti Lapisatepun	Chiang Mai University, Thailand
Attapol Titapun	Khon Kaen University, Thailand
Poowanai Sarkhampee	Sunpasitthiprasong Hospital, Ubon Ratchathani, Thailand
Le Trung Hai	Vietnam Association for the Study of Liver Diseases, Vietnam
Le Van Thanh	Vietnamese Society of Hepato-Biliary-Pancreatic Surgery, Vietnam
Ho Van Linh	Hue Central Hospital, Vietnam
Le Thanh Son	Military Hospital 103, Vietnam
Le Trung Hieu	108 Military Central Hospital, Vietnam
Nguyen Dinh Song Huy	Cho Ray Hospital, Vietnam
Nguyen Quang Nghia	Viet Duc University Hospital, Vietnam
Ninh Viet Khai	Viet Duc University Hospital, Vietnam
Vu Van Quang	108 Military Central Hospital, Vietnam
Nguyen Ham Hoi	Bach Mai Hospital, Vietnam
Phan Tan Thuan	Ho Chi Minh City Oncology Hospital, Vietnam

Chairpersons

Sa-ard Treepongkaruna	Rajavithi Hospital, Thailand
Wifanto Saditya Jeo	Cipto Mangunkusumo Hospital, Indonesia
Nguyen Thanh Xuan	Hue Central Hospital, Vietnam
Le Quan Anh Tuan	Vinmec Central Park International Hospital, Vietnam
Doan Tien My	Cho Ray Hospital, Vietnam
Pham Anh Vu	Hue University of Medicine and Pharmacy, Vietnam

Speakers

Tin Tin Mar	Yangon Specialty Hospital, Myanmar
Brian Goh	Singapore General Hospital, Singapore
Koh Ye Xin	Singapore General Hospital, Singapore
Pang Ning Qi	National University Health System, Singapore
Wipusit Taesombat	Chulalongkorn University, Bangkok, Thailand
Thakerng Pitakteerabundit	Prince of Songkla University, Hat Yai, Thailand
Tharatip Srisuk	Khon Kaen University, Thailand
Tran Cong Duy Long	University Medical Center Ho Chi Minh City, Vietnam
Pham Minh Hai	University Medical Center Ho Chi Minh City, Vietnam
Tran Doan Khac Viet	University Medical Center Ho Chi Minh City, Vietnam
Nguyen Thi Dung	Hanoi Oncology Hospital, Vietnam
Ngo Van Doan	Vinmec Times City International Hospital, Vietnam
Phan Phuoc Nghia	University Medical Center Ho Chi Minh City, Vietnam
Dang Nhu Thanh	Hue Central Hospital, Vietnam
Le Trong Binh	Hue University of Medicine and Pharmacy, Vietnam
Nguyen Ngoc Anh	Nhan Dan Gia Dinh Hospital, Vietnam
La Van Phu	Can Tho General Hospital, Vietnam
Nguyen Thai Binh	Hanoi Medical University Hospital, Vietnam

Duong Thi Ngoc Sang	University Medical Center Ho Chi Minh City, Vietnam
Phan Nhan Hien	Hanoi Medical University Hospital, Vietnam
Yoshio Masuda	Singapore General Hospital, Singapore
Nguyen Thanh Tien Dung	Nhan Dan Gia Dinh Hospital, Vietnam
Le Huy Luu	University of Medicine and Pharmacy at Ho Chi Minh City, Vietnam
Ho Dang Quy Dung	Cho Ray Hospital, Vietnam
Nguyen Thanh Khiem	Bach Mai Hospital, Vietnam
Nguyen Thi Lan	Viet Duc University Hospital, Vietnam
Ly Huu Tuan	Nhan Dan Gia Dinh Hospital, Vietnam
Ho Van Linh	108 Military Central Hospital, Vietnam
Nguyen Thu Ha	108 Military Central Hospital, Vietnam
Nguyen Long Duc	University Medical Center Ho Chi Minh City, Vietnam
Dao Duc Dung	Vinmec Times City International Hospital, Vietnam
Nguyen Hoang Ngoc Anh	108 Military Central Hospital, Vietnam
Nguyen Quoc Thanh	University Medical Center Ho Chi Minh City, Vietnam
Do Son Hai	Military Hospital 103, Vietnam
Le Ngoc May	Vinmec Times City International Hospital, Vietnam
Hoang Tuan	Viet Duc University Hospital, Vietnam
Natwutpong Leeratanakachorn	Rajavithi Hospital, Thailand
Tan Yen Pin	Tan Tock Seng Hospital, National Healthcare Group, Singapore
Nguyen Vuu Phat Loi	University Medical Center Ho Chi Minh City, Vietnam
Kai Ming Lai	Hospital Authority, Hong Kong SAR, China
Do Hai Dang	Viet Duc University Hospital, Vietnam
Pham Hai Trieu	Binh Dan Hospital, Vietnam
Carla Cai Zi	Malaysia
Luong Tuan Hiep	Bach Mai Hospital, Vietnam
Tran An Phong	Hue Central Hospital, Vietnam
Tran Nhat Ha	Nhan Dan Gia Dinh Hospital, Vietnam
Vu Hoai Anh	Hue Central Hospital, Vietnam

Poster Presenters

Lu Hoang Phi	Can Tho Central General Hospital, Vietnam
Nguyen Hoai Kim	Binh Dan Hospital, Vietnam
Bui The Phuong	Cho Ray Hospital, Vietnam
Nguyen Thi Kim Dung	Hanoi Medical University Hospital, Vietnam
Tran Van Thong	Hanoi Medical University, Vietnam
Nguyen Thi Huong	Hanoi Medical University Hospital, Vietnam
Tran Binh Duong	University of Medicine and Pharmacy at Ho Chi Minh City, Vietnam
Rangga Kusuma Maulana	Universitas Indonesia, Jakarta, Indonesia
Vo Phu Hau	University Medical Center Ho Chi Minh City, Vietnam
Rizky Dwi Kurnia Anwar	Universitas Indonesia, Jakarta, Indonesia
Vo Quan Thinh	University Medical Center Ho Chi Minh City, Vietnam
Vu Ngoc Tuan	108 Military Central Hospital, Vietnam
Nguyen Van Linh	Military Hospital 354, Vietnam
Nguyen Truong Giang	National Hospital for Tropical Diseases, Vietnam
Duong Thi Huong	National Hospital for Tropical Diseases, Vietnam
Doan Thanh Huy	Military Hospital 175, Vietnam
Nguyen Nguyen Duc	Binh Dan Hospital, Vietnam
Ho Trung Dung	Binh Dan Hospital, Vietnam
Van Van Hung	Binh Dan Hospital, Vietnam
Trinh My Tran	Nhan Dan Gia Dinh Hospital, Vietnam
Nguyen Van Manh	Military Hospital 175, Vietnam
Le Duc Trung	Military Hospital 175, Vietnam

CONFERENCE INFORMATION

Conference Venue

Ariyana Convention Centre (107 Vo Nguyen Giap Street, Ngu Hanh Son District, Da Nang, Vietnam)

Conference Registration

15-16 May 2026
Registration Counter is located at the foyer area, Ariyana Convention Centre
The counter will be opened daily from 07:30 – 16:00 hours.

Conference Satchel And Name Badge

Upon registration you will receive a Conference satchel with your name badge. You are required to wear your name badge to all sessions and events.

Exhibition

A state-of-the-art exhibition on medical and allied applications will be held during the Conference. Exhibition opening times:

Friday, 15 May 2026	08:00 - 17:30 hours
Saturday, 16 May 2026	08:00 - 17:00 hours

Catering

Food and beverage will be served during lunches and teabreaks throughout the Conference

PROGRAM AT A GLANCE

DAY 1 | FRIDAY, 15 MAY 2026	
HALL 1 - BALLROOM 1 (1ST FLOOR)	
Time	**Agenda**
7:30 - 8:00	**REGISTRATION**
8:00 - 10:25	**SESSION 1:** Standardizing Emerging Trends in Minimally Invasive Liver Resection and Transplantation
10:25 - 10:40	Poster Exhibition & Coffee Break
10:40 - 12:45	SESSION 2: Standardizing Laparoscopic Pancreatic Surgery
12:45 - 13:30	**LUNCH SYMPOSIUM** How to use CUSA in Hepatobiliary Surgery
13:30 - 14:00	Poster Exhibition & Coffee Break
14:00 - 14:30	**OPENING CEREMONY & INAUGURATION CEREMONY OF THE VIETNAMESE SOCIETY OF HEPATO-BILIARY-PANCREATIC SURGERY**
14:30 - 16:30	PLENARY SESSION: Hepato - Pancreato - Biliary Surgery in Asia: Developments and Emerging Trends
17:30 - 21:00	**GALA DINNER** ***Hien Nha Veranda Restaurant*** *(Bach Dang street, Hoa Cuong Ward)*

DAY 2 | SATURDAY, 16 MAY 2026			
HALL 1 - BALLROOM 1 (1ST FLOOR)		**Hall 2 - HOI AN MEETING ROOM (2ND FLOOR)**	
Time	Agenda	Time	Agenda
8:30 - 9:50	**SESSION 3:** Role of Multidisciplinary Team in Hepatocellular Carcinoma treatment (PART 1)	8:30 -10:20	**SESSION 6:** Complicated Issues in Biliary Surgery and Interventions
9:50 - 10:05	Poster Exhibition & Coffee Break	10:20 - 10:35	Poster Exhibition & Coffee Break
10:05 - 11:10	**SESSION 3:** Role of Multidisciplinary Team in Hepatocellular Carcinoma Treatment (PART 2)	10:35 - 12:40	**SESSION 7:** Challenges and Innovations in Pancreatic Surgery
11:10 - 11:55	**Lunch symposium**	12:40 - 13:00	Lunch & Poster Exhibition
11:55 - 13:00	Lunch & Poster Exhibition		
13:00 - 15:05	**SESSION 4:** Multidisciplinary Strategy Selection to Optimize Outcomes in Colorectal Liver Metastases	13:00 - 15:20	**SESSION 8:** Expanding Boundaries in Liver Transplantation
15:05 - 15:20	Poster Exhibition & Coffee Break	15:20 - 15:35	Poster Exhibition & Coffee Break
15:20 - 17:00	**SESSION 5:** Multimodal Treatment for Cholangiocarcinoma	15:35 - 16:55	**SESSION 9:** Tips, Tricks and Technical Mastery in HBP Surgery
17:00	**Best Poster Awards and Closing Ceremony** (Hall 1)		

SCIENTIFIC PROGRAM

Day 1 - Friday, 15 May 2026 Hall 1 - Ballroom 1 (1st Floor)

7:30 - 8:00	**REGISTRATION**
SESSION 1	**STANDARDIZING EMERGING TRENDS IN MINIMALLY INVASIVE LIVER RESECTION AND TRANSPLANTATION**
Chairs	**Goro Honda, Rawisak Chanwat, Le Van Thanh, Nguyen Hoang Bac**
8:00 - 8:15	**Extra Glissonean Approach in Laparoscopic Hepatectomy** ***Le Van Thanh*** *- Vietnamese Society of Hepato-Biliary-Pancreatic Surgery, Vietnam*
8:15 - 8:30	**Minimizing Blood Loss in Liver Parenchymal Transection** ***Vu Van Quang*** *- 108 Military Central Hospital, Vietnam*
8:30 - 8:45	**Role of Indocyanine Green (ICG) and Fluorescence-Guided Laparoscopic Surgery in Precise Anatomical Liver Resection** ***Rawisak Chanwat*** *- Bumrungrad International Hospital, Thailand*
8:45 - 9:00	**Liver Resection in Difficult Segments: Overcoming Anatomical and Technical Barriers** ***Goro Honda*** *- Tokyo Women's Medical University, Japan*
9:00 - 9:15	**Intraoperative and Postoperative Complications in MIS Major Hepatectomy - Prevention and Management (with Videos)** ***Koh Ye Xin*** *- Singapore General Hospital, Singapore*
9:15 - 9:20	**Break at the Main Hall & Sponsor Video Screening**
9:20 - 9:35	**Laparoscopic Donor Lateral Sectionectomy for Pediatric LDLT** ***Wipusit Taesombat*** *- Chulalongkorn University, Bangkok, Thailand*
9:35 - 9:50	**Laparoscopic Right Living Donor Hepatectomy** ***Le Van Thanh*** *- Vietnamese Society of Hepato-Biliary-Pancreatic Surgery, Vietnam*
9:50 - 10:05	**Safe and Precise Biliary Division in Laparoscopic Living Donor Hepatectomy** ***Worakitti Lapisatepun*** *- Chiang Mai University, Thailand*
10:05 - 10:20	**Glissonean Approach in Laparoscopic Living Donor Hepatectomy** ***Tran Cong Duy Long*** *- University Medical Center Ho Chi Minh City, Vietnam*
10:20 - 10:25	**Discussion & Session Wrap-up**
10:25 - 10:40	**Poster Exhibition & Coffee Break**
SESSION 2	**STANDARDIZING LAPAROSCOPIC PANCREATIC SURGERY**
Chairs	***Yoo-Seok Yoon, Lee Ser Yee, Koh Peng Soon, Ho Van Linh***
10:40 - 10:55	**Spleen-Preserving Distal Pancreatectomy for Benign Tumors: Tips and Tricks** ***Koh Peng Soon*** *- University of Malaya Medical Center, Malaysia*
10:55 - 11:10	**Standardization of Laparoscopic Distal Pancreatectomy for Malignancy** ***Lee Ser Yee*** *- Singapore General Hospital, Singapore*
11:10 - 11:25	**Methods of Pancreatic Stump Closure in Distal Pancreatectomy - An Update on How to Reduce POPF** ***Jan Jin Bong*** *- Sunway Medical Center, Malaysia*
11:25 - 11:40	**Standardized Technical Steps in Laparoscopic Pancreaticoduodenectomy for Malignancy** ***Yoo-Seok Yoon*** *- Seoul National University Bundang Hospital, Korea*

Day 1 - Friday, 15 May 2026 Hall 1 - Ballroom 1 (1st Floor)

11:40 - 12:10	**Debate on Pancreaticojejunostomy Technique: Cattell-Warren vs Blumgart** **· Cattell-Warren** ***Pham Minh Hai*** *- University Medical Center Ho Chi Minh City, Vietnam* **· Blumgart** ***Ho Van Linh*** *- Hue Central Hospital, Vietnam*
12:10 - 12:25	**Robotic Pancreaticoduodenectomy: An Emerging Trend or the Future Standard?** ***Brian Goh*** *- Singapore General Hospital, Singapore*
12:25 - 12:40	**Intraoperative and Postoperative Complications in MIS Pancreatic Resections - Prevention and Management (with Videos)** ***Pang Ning Qi*** *- National University Health System, Singapore*
12:40 - 12:45	**Discussion & Session Wrap-up**
12:45 - 13:30	**LUNCH SYMPOSIUM** **How to use CUSA in Hepatobiliary Surgery** ***Goro Honda*** *- Tokyo Women's Medical University, Japan*
13:30 - 14:00	**Poster Exhibition & Coffee Break**
14:00 - 14:30	**OPENING CEREMONY & INAUGURATION CEREMONY OF THE VIETNAMESE SOCIETY OF HEPATO-BILIARY-PANCREATIC SURGERY**
PLENARY SESSION	**HEPATO-PANCREATO-BILIARY SURGERY IN ASIA: DEVELOPMENTS AND EMERGING TRENDS**
Chairs	**Kwang-Woong Lee, Adrian Chiow Kah Heng, Sa-ard Treepongkaruna, Catherine Teh, Le Trung Hai**
14:30 - 14:45	**Vietnam Hepato-Biliary-Pancreatic Specialty (VSHBPS): Achievement and Development** ***Le Trung Hai*** *- President of the Vietnam Association for the Study of Liver Diseases, Vietnam*
14:45 - 15:00	**HPB Surgery in ASEAN and the Role of ASEAN LHC - Current and Future Perspectives** ***Adrian Chiow Kah Heng*** *- Changi General Hospital, Singapore*
15:00 - 15:15	**Multidisciplinary Team Approach to HBP Cancer** ***Hop S Tran Cao*** *- MD Anderson Cancer Center University of Texas, USA*
15:15 - 15:30	**Recent Advances in Liver Transplantation** ***Kwang-Woong Lee*** *- Seoul National University Hospital, Korea*
15:30 - 15:45	**Benefits and Risks of Conversion Surgery for Locally Advanced Pancreatic Cancer** ***Joon Seong Park*** *- Seoul National University College of Medicine, Korea*
15:45 - 16:00	**Standardizing ERAS Pathways in HPB Surgery** ***Catherine Teh*** *- Makati Medical Center, Philippines*
16:00 - 16:15	**The Role of Robotic-Assisted Surgery in Hepato-Pancreato-Biliary Surgery** ***Le Trung Hieu*** *- 108 Military Central Hospital, Vietnam*
16:15 - 16:30	**Discussion & Day 1 Wrap-up & Group Photo**
17:30 - 21:00	**Gala Dinner** ***Hien Nha Veranda Restaurant*** *(Bach Dang street, Hoa Cuong Ward)*

Day 2 - Saturday, 16 May 2026 Hall 1 - Ballroom 1 (1st Floor)

SESSION 3	ROLE OF MULTIDISCIPLINARY TEAM IN HEPATOCELLULAR CARCINOMA TREATMENT
Chairs	Shridhar Ganpathi Iyer, Sai Aung Nyunt Oo, Nguyen Dinh Song Huy, Nguyen Quang Nghia
8:30 - 8:45	**Role of Multimodal and Personalized Approaches in the Optimal Management of Hepatocellular Carcinoma** ***Sai Aung Nyunt Oo*** - *Yangon Specialty Hospital, Myanmar*
8:45 - 9:00	**Curative Treatment for Early-Stage HCC: Ablation or Surgery?** ***Nguyen Dinh Song Huy*** - *Cho Ray Hospital, Vietnam*
9:00 - 9:15	**Surgical Decision-Making in Resectable HCC: Liver Resection or Transplantation?** ***Nguyen Quang Nghia*** - *Viet Duc University Hospital, Vietnam*
9:15 - 9:30	**Treatment Options for Intermediate-Stage HCC: Surgery, TACE, or Systemic Therapy?** ***Thakerng Pitakteerabundit*** - *Prince of Songkla University, Hat Yai, Thailand*
9:30 - 9:45	**Intermediate-Stage Hepatocellular Carcinoma: Role of Vascular Interventional Therapies** ***Tran Doan Khac Viet*** - *University Medical Center Ho Chi Minh City, Vietnam*
9:45 - 9:50	**Discussion**
9:50 - 10:05	**Poster Exhibition & Coffee Break**
10:05 - 10:20	**Systemic Therapies for Unresectable HCC: Current Updates and Curative Opportunities** ***Nguyen Thi Dung*** - *Hanoi Oncology Hospital, Vietnam*
10:20 - 10:35	**Surgical Treatment for Advanced Hepatocellular Carcinoma: Indications, Patient Selection, Outcomes, and the Role of Systemic Therapy?** ***Shridhar Ganpathi Iyer*** - *National University of Singapore, Singapore*
10:35 - 11:05	**Multidisciplinary Team Case Discussion in the Management of Hepatocellular Carcinoma** ***MDT Expert Panel: Shridhar Ganpathi Iyer, Sai Aung Nyunt Oo, Nguyen Dinh Song Huy, Nguyen Quang Nghia, Le Trong Binh, Nguyen Thi Dung*** • **Case discussion 1** ***Tin Tin Mar*** - *Yangon Specialty Hospital, Myanmar* • **Case discussion 2** ***Nguyen Quoc Thanh*** - *University Medical Center Ho Chi Minh City, Vietnam*
11:05 - 11:10	**Discussion & Session Wrap-up**
11:10 - 11:55	**LUNCH SYMPOSIUM** **The usefulness of HUGO RAS in clinical practice and expert opinions** ***Joon Seong Park*** - *Seoul National University College of Medicine, Korea*
11:55 - 13:00	**Lunch & Poster Exhibition**
SESSION 4	**MULTIDISCIPLINARY STRATEGY SELECTION TO OPTIMIZE OUTCOMES IN COLORECTAL LIVER METASTASES**
Chairs	Hop S Tran Cao, Catherine Teh, Le Thanh Son, Phan Tan Thuan
13:00 - 13:15	**Role of Imaging in Staging and Treatment Strategy Selection for Colorectal Liver Metastases** ***Ngo Van Doan*** - *Vinmec Times City International Hospital, Vietnam*
13:15 - 13:30	**Synchronous CRLM: Surgical Sequencing Selection?** ***Hop S Tran Cao*** - *MD Anderson Cancer Center University of Texas, USA*
13:30 - 13:45	**Technical Tips and Tricks for Minimally Invasive Simultaneous Colorectal and Liver Resection in Resectable SCLM** ***Shridhar Ganpathi Iyer*** - *National University of Singapore, Singapore*

13:45 - 14:00	**Systemic Treatment in Potential CRLM: Maximizing Resectability and Improving Long-term Outcomes** ***Phan Tan Thuan*** *- Ho Chi Minh City Oncology Hospital, Vietnam*
14:00 - 14:30	**Debate on Resectable Colorectal Liver Metastases: Upfront Curative Resection vs Neoadjuvant Chemotherapy** • **Upfront Curative Resection** ***Le Thanh Son*** *- Military Hospital 103, Vietnam* • **Neoadjuvant Chemotherapy** ***Le Ngoc May*** *- Vinmec Times City International Hospital, Vietnam*
14:30 - 15:00	**Case discussion: Multidisciplinary Strategy Selection to Optimize Outcomes in Colorectal Liver Metastases** ***MDT Expert Panel: Hop S Tran Cao, Catherine Teh, Le Thanh Son, Pham Anh Vu, Phan Tan Thuan*** • **Case discussion 1** ***Phan Phuoc Nghia*** *- University Medical Center Ho Chi Minh City, Vietnam* • **Case discussion 2** ***Dang Nhu Thanh*** *- Hue Central Hospital, Vietnam*
15:00 - 15:05	**Discussion & Session Wrap-up**
15:05 - 15:20	**Poster Exhibition & Coffee Break**
SESSION 5	**MULTIMODAL TREATMENT FOR CHOLANGIOCARCINOMA**
Chairs	**Attapol Titapun, Poowanai Sarkhampee, Doan Tien My, Ninh Viet Khai**
15:20 - 15:35	**An Update on Diagnosis and Surgical Management for Perihilar Cholangiocarcinoma** ***Ninh Viet Khai*** *- Viet Duc University Hospital, Vietnam*
15:35 - 15:50	**Percutaneous Transhepatic Intervention for Unresectable Malignant Hilar Biliary Obstruction** ***Le Trong Binh*** *- Hue University of Medicine and Pharmacy, Vietnam*
15:50 - 16:05	**Balance Strategy in Perihilar Cholangiocarcinoma: Resection Margin, Lymph Node Metastasis, and the Limits of Surgical Aggressiveness** ***Poowanai Sarkhampee*** *- Sunpasitthiprasong Hospital, Ubon Ratchathani, Thailand*
16:05 - 16:20	**Vascular Resection and Reconstruction in Perihilar Cholangiocarcinoma** ***Attapol Titapun*** *- Khon Kaen University, Thailand*
16:20 - 16:35	**Sustainability in Minimally Invasive Surgery for Cholangiocarcinoma** ***Tharatip Srisuk*** *- Khon Kaen University, Thailand*
16:35 - 16:50	**Case discussion on Multimodal Treatment for Cholangiocarcinoma** ***Nguyen Ngoc Anh*** *- Nhan Dan Gia Dinh Hospital, Vietnam*
16:50 - 17:00	**Discussion & Session Wrap-up**
17:00	**Best Poster Awards and Closing Ceremony**

SESSION 6	COMPLICATED ISSUES IN BILIARY SURGERY AND INTERVENTIONS
Chairs	Nguyen Thanh Xuan, Le Quan Anh Tuan, Koh Peng Soon
8:30 - 8:45	**Interventional Radiology in the Management of Benign Biliary Strictures and Bile Leak Post Operation** ***Nguyen Thai Binh*** - *Hanoi Medical University Hospital, Vietnam*
8:45 - 9:00	**Evaluation of Rigid Choledochoscopy under DSA Guidance via the Kehr Tract for the Management of Retained Bile Duct Stones after Surgery** ***Phan Nhan Hien*** - *Hanoi Medical University Hospital, Vietnam*
9:00 - 9:15	**Evaluation of the Effectiveness of Biliary Drainage Methods in the Treatment of Hepatobiliary and Pancreatic Cancers** ***Duong Thi Ngoc Sang*** - *University Medical Center Ho Chi Minh City, Vietnam*
9:15 - 9:30	**Laparoscopic Surgery for Biliary Stones in Elderly Patients: Primary Common Bile Duct Closure versus T-Tube (Kehr) Drainage** ***La Van Phu*** - *Can Tho General Hospital, Vietnam*
9:30 - 9:45	**Laparoscopic Left-sided Hepatectomy Using a Dilated Bile Duct-Oriented Approach as an Anatomical Landmark** ***Le Trung Hieu*** - *108 Military Central Hospital, Vietnam*
9:45 - 10:00	**Laparoscopic Hepatectomy for Recurrent Hepatolithiasis: Technical Tips and Outcomes** ***Dang Nhu Thanh*** - *Hue Central Hospital, Vietnam*
10:00 - 10:15	**Outcomes of Stone Removal and Biliary Dilation via Flexible Cholangioscopy in the Treatment of Stones with Benign Biliary Strictures** ***Do Son Hai*** - *Military Hospital 103, Vietnam*
10:15 - 10:20	**Discussion & Session Wrap-up**
10:20 - 10:35	**Poster Exhibition & Coffee Break**
SESSION 7	**CHALLENGES AND INNOVATIONS IN PANCREATIC SURGERY**
Chairs	Joon Seong Park, Yoo-Seok Yoon, Lee Ser Yee, Ho Van Linh, Nguyen Ham Hoi
10:35 - 10:50	**Role of Endoscopy in the Diagnosis and Treatment of Pancreatic Neuroendocrine Tumors (pNETs): From EUS-Based Diagnosis to EUS-Guided Ablation** ***Ho Dang Quy Dung*** - *Cho Ray Hospital, Vietnam*
10:50 - 11:05	**Clinical Outcomes of Preoperative Biliary Drainage Prior to Pancreatoduodenectomy: A Multicenter Cohort Study** ***Ly Huu Tuan*** - *Nhan Dan Gia Dinh Hospital, Vietnam*
11:05 - 11:20	**Laparoscopic RAMPS via the Ligament of Treitz Approach** ***Nguyen Thanh Tien Dung*** - *Nhan Dan Gia Dinh Hospital, Vietnam*
11:20 - 11:35	**Location-Based Parenchyma-Sparing Laparoscopic Approaches for Insulinoma: Balancing Functional Preservation and Operative Risks** ***Le Huy Luu*** - *University of Medicine and Pharmacy at Ho Chi Minh City, Vietnam*
11:35 - 11:50	**Adoption of Robotic Pancreatoduodenectomy: Initial Experience with the First 100 Consecutive Cases** ***Yoshio Masuda*** - *Singapore General Hospital, Singapore*

11:50 - 12:05	**Utilizing a Dual Superior Mesenteric Artery First Approach for TRIANGLE Operation in Borderline Resectable and Locally Advanced Pancreatic Cancer** ***Nguyen Thanh Khiem*** *- Bach Mai Hospital, Vietnam*
12:05 - 12:20	**Advancing Laparoscopic Pancreaticoduodenectomy: Tips, Tricks, and Oncologic Precision** ***Nguyen Ham Hoi*** *- Bach Mai Hospital, Vietnam*
12:20 - 12:35	**Laparoscopic Pancreatoduodenectomy: Tips and Tricks** ***Nguyen Thi Lan*** *- Viet Duc University Hospital, Vietnam*
12:35 - 12:40	**Discussion & Session Wrap-up**
12:40 - 13:00	**Lunch & Poster Exhibition**
SESSION 8	**EXPANDING BOUNDARIES IN LIVER TRANSPLANTATION**
Chairs	**Kwang-Woong Lee, Worakitti Lapisatepun, Nguyen Quang Nghia, Vu Van Quang**
13:00 - 13:15	**Surgical Perspective on the Management of Unresectable Hepatocellular Carcinoma** ***Ho Van Linh*** *- Hue Central Hospital, Vietnam*
13:15 - 13:30	**Totally Laparoscopic Right and Left Donor Hepatectomy** ***Phan Phuoc Nghia*** *- University Medical Center Ho Chi Minh City, Vietnam*
13:30 - 13:45	**Totally Laparoscopic Right Donor Hepatectomy in Living Donor Liver Transplantation and Recipient Hepatectomy: Initial Experience at a High-Volume Transplant Center in Vietnam** ***Vu Van Quang*** *- 108 Military Central Hospital, Vietnam*
13:45 - 14:00	**Synchronous Pure Laparoscopic Dual Donor Hepatectomy from Two Sisters for Their Father** ***Nguyen Long Duc*** *- University Medical Center Ho Chi Minh City, Vietnam*
14:00 - 14:15	**Hepatic Artery Variations in Laparoscopic Left Lateral Section Graft Procurement: A Case Series with Rare Variants** ***Dao Duc Dung*** *- Vinmec Times City International Hospital, Vietnam*
14:15 - 14:30	**Split Liver Transplantation from Deceased Donors: Expanding the Donor Pool in a Developing Transplant Program at 108 Military Central Hospital, Vietnam** ***Nguyen Hoang Ngoc Anh*** *- 108 Military Central Hospital, Vietnam*
14:30 - 14:45	**Management Strategy for Patients with HCC after Liver Transplantation** ***Ho Van Linh*** *- 108 Military Central Hospital, Vietnam*
14:45 - 15:00	**Immunosuppressive Strategies in Simultaneous Multivisceral Transplantation involving the Liver** ***Hoang Tuan*** *- Viet Duc University Hospital, Vietnam*
15:00 - 15:15	**Association between DXA-Derived Body Composition Parameters and Metabolic Syndrome in Liver Transplant Recipients** ***Nguyen Thu Ha*** *- 108 Military Central Hospital, Vietnam*
15:15 - 15:20	**Discussion & Session Wrap-up**
15:20 - 15:35	**Poster Exhibition & Coffee Break**

Day 2 - Saturday, 16 May 2026 Hall 2 - Hoi An room 2 (2nd Floor)

SESSION 9	TIPS, TRICKS AND TECHNICAL MASTERY IN HBP SURGERY
Chairs	Adrian Chiow Kah Heng, Wifanto Saditya Jeo, Rawisak Chanwat, Jan Jin Bong, Le Trung Hieu
15:35 - 15:40	**Totally Laparoscopic Radical Resection for Bismuth Type IIIb Klatskin Tumor** ***Do Hai Dang*** - *Viet Duc University Hospital, Vietnam*
15:40 - 15:45	**Laparoscopic Anatomical Left Hepatectomy for Hepatolithiasis in Situs Inversus Totalis: A Step-by-Step Approach** ***Le Trung Hieu*** - *108 Military Central Hospital, Vietnam*
15:45 - 15:50	**Robotic-Assisted Anatomical Segment 8 Segmentectomy Utilizing the Trac & Pac Technique** ***Natwutpong Leeratanakachorn*** - *Rajavithi Hospital, Thailand*
15:50 - 15:55	**Laparoscopic Management of Giant Hepatic Hemangioma in Segment I: Overcoming the Challenges of Size and Location** ***Le Trung Hieu*** - *108 Military Central Hospital, Vietnam*
15:55 - 16:00	**Extra Hepatic Glissonean, Hepatic Vein Guided Approach for Laparoscopic Left Hepatectomy for Left Intra-Ducal Papillary Neoplasm of Bile Duct (IPNB)** ***Tan Yen Pin*** - *Tan Tock Seng Hospital, National Healthcare Group, Singapore*
16:00 - 16:05	**Laparoscopic Segment 4 Hepatectomy: An Alternative Surgical Option for Patients with Hepatocellular Carcinoma** ***Dao Duc Dung*** - *Vinmec Times City International Hospital, Vietnam*
16:05 - 16:10	**Laparoscopic Reduced-Size Left Lateral Hepatectomy for Liver Transplantation** ***Nguyen Vuu Phat Loi*** - *University Medical Center Ho Chi Minh City, Vietnam*
16:10 - 16:15	**The Concept of "Green Junction" in Hyper-diluted Indocyanine Green Fluorescence Cholangiography in Laparoscopic Cholecystectomy** ***Kai Ming Lai*** - *Hospital Authority, Hong Kong SAR, China*
16:15 - 16:20	**Laparoscopic Management of Large Choledochal Cysts in Adults** ***Tran Nhat Ha*** - *Nhan Dan Gia Dinh Hospital, Vietnam*
16:20 - 16:25	**Percutaneous Cholangioscopic Lithotripsy Combined with the Rendezvous Technique under Methylene Blue Guidance in the Management of Intrahepatic Lithiasis and Complete Biliary Obstruction in Patients with Previous Biliary-Enteric Anastomosis** ***Pham Hai Trieu*** - *Binh Dan Hospital, Vietnam*
16:25 - 16:30	**Laparoscopic Anterior RAMPS for Pancreatic Body Adenocarcinoma: Early Experience from a Minimally Invasive Approach** ***Carla Cai Zi*** - *Malaysia*
16:30 - 16:35	**Artery First Approach in Laparoscopic Whipple Procedure** ***Vu Hoai Anh*** - *Hue Central Hospital, Vietnam*
16:35 - 16:40	**How We Perform Laparoscopic Total Pancreatectomy: Tail-First Mobilization and Counterclockwise Total Mesopancreas Dissection** ***Luong Tuan Hiep*** - *Bach Mai Hospital, Vietnam*
16:40 - 16:45	**Laparoscopic Procedure with Pancreatoscopy + Laser Lithotripsy in Chronic Pancreatitis** ***Tran An Phong*** - *Hue Central Hospital, Vietnam*
16:45 - 16:55	**Discussion & Session Wrap-up**

POSTER PRESENTATIONS

NO.	TITLE
1	**Total Laparoscopic RAMPS Using a Left-Posterior SMA First Approach for Distal Pancreatic Cancer: Step-by-Step Technique and Clinical Outcomes** ***Luong Tuan Hiep*** *- Bach Mai Hospital, Vietnam*
2	**Total Laparoscopic Radical Antegrade Modular Pancreato-Splenectomy Using a Left-Posterior Superior Mesenteric Artery First Approach for Distal Pancreatic Cancer: Step-by-Step Technique and Clinical Outcomes** ***Luong Tuan Hiep*** *- Bach Mai Hospital, Vietnam*
3	**Radiofrequency Ablation for Hepatocellular Carcinoma: Long-term Outcomes and Practical Challenges in Implementation** ***Lu Hoang Phi*** *- Can Tho Central General Hospital, Vietnam*
4	**The Value of the IWATE Criteria in Assessing the Difficulty of Laparoscopic Liver Resection for Hepatocellular Carcinoma at a Young Surgeons Training Center in Vietnam** ***Nguyen Hoai Kim*** *- Binh Dan Hospital, Vietnam*
5	**Case Report: Concurrent Portal Vein Stenosis and Small-for-Size Syndrome after Living Donor Liver Transplantation** ***Bui The Phuong*** *- Cho Ray Hospital, Vietnam*
6	**Late Cholangiocarcinoma Arising from a Choledochal Cyst after Cystoduodenostomy: Diagnostic and Surgical Features - A Case Report** ***Nguyen Hoai Kim*** *- Binh Dan Hospital, Vietnam*
7	**Solitary Fibrous Tumor of the Gallbladder: A Rare Case Report with CT and MRI Imaging Features** ***Phan Trong Nguyen*** *- Hanoi Medical University Hospital, Vietnam*
8	**Delayed Bile Leak after Gangrenous Cholecystitis: The Value of Hepatocyte-Specific MRI - A Case Report** ***Nguyen Thi Kim Dung*** *- Hanoi Medical University Hospital, Vietnam*
9	**Dual Immunotherapy: A New Advancement in the Treatment of Primary Hepatocellular Carcinoma** ***Nguyen Thi Minh Hue*** *- Cho Ray Hospital, Vietnam*
10	**Mesopancreatic Invasion and Surgical Outcomes of Pancreaticoduodenectomy for Periampullary Carcinoma at Bach Mai Hospital** ***Tran Van Thong*** *- Hanoi Medical University, Vietnam*
11	**Benign and Malignant Biliary Strictures on MRI in the Setting of Cholelithiasis: A Report of Two Cases** ***Nguyen Thi Huong*** *- Hanoi Medical University Hospital, Vietnam*
12	**Laparoscopic Central Pancreatectomy for Benign and Low-grade Malignant Tumors of the Pancreatic Neck and Body** ***Le Huy Luu*** *- University of Medicine and Pharmacy at Ho Chi Minh City, Vietnam*
13	**Laparoscopic Right Liver Graft Procurement** ***Tran Binh Duong*** *- University of Medicine and Pharmacy at Ho Chi Minh City, Vietnam*
14	**Application of ALPPS in Advanced Hepatocellular Carcinoma: Surgical Outcomes and Feasibility** ***Nguyen Long Duc*** *- University Medical Center Ho Chi Minh City, Vietnam*
15	**Dual-Graft Liver Transplantation Following Laparoscopic Right and Left Donor Hepatectomy: A Case Presentation** ***Nguyen Long Duc*** *- University Medical Center Ho Chi Minh City, Vietnam*

NO.	TITLE
16	**Laparoscopic Spleen-Preserving Distal Pancreatectomy Using Kimura Technique for Main Duct Intraductal Papillary Mucinous Neoplasm with Occult Invasive Adenocarcinoma: A Case Illustration** ***Rangga Kusuma Maulana*** *- Universitas Indonesia, Jakarta, Indonesia*
17	**Computed Tomography Liver Volumetry for Predicting Graft Weight in Living Donor Hepatectomy** ***Vo Phu Hau*** *- University Medical Center Ho Chi Minh City, Vietnam*
18	**Obesity is Often Considered A Barrier to Minimally Invasive Pancreatic Surgery—Yet This Case Proves Otherwise** ***Rizky Dwi Kurnia Anwar*** *- Universitas Indonesia, Jakarta, Indonesia*
19	**Right Liver Mobilization During Laparoscopic Posterior Sectionectomy or Segment 7 Subsegmentectomy: The UMC Experience** ***Vo Quan Thinh*** *- University Medical Center Ho Chi Minh City, Vietnam*
20	**Complete Mobilization of the Right Liver during Laparoscopic Posterior Sectionectomy or Segment 7 Subsegmentectomy: How We Do It** ***Vo Quan Thinh*** *- University Medical Center Ho Chi Minh City, Vietnam*
21	**Delayed Immunosuppression after Liver Transplantation in High-risk Patients: A Case Report** ***Doan Thanh Huy*** *- Military Hospital 175, Vietnam*
22	**Application of 3D CT-Based Liver Volumetry in Preoperative Decision-Making for Hepatic Resection: An Initial Experience at Binh Dan Hospital** ***Nguyen Nguyen Duc*** *- Binh Dan Hospital, Vietnam*
23	**A Modified Access Port to Facilitate Reconstruction in Laparoscopic Pancreaticoduodenectomy: An Initial Case Series** ***Ho Trung Dung*** *- Binh Dan Hospital, Vietnam*
24	**Evaluate the Results of Using Blumgart-Style Pancreaticojejunostomy in Pancreaticoduodenectomy Surgery at Binh Dan Hospital** ***Vo Van Hung*** *- Binh Dan Hospital, Vietnam*
25	**High-quality Fluorescence Cholangiography with Hyper-diluted Indocyanine Green Improves Patient Outcomes in Elective Difficult Laparoscopic Cholecystectomy** ***Kai Ming Lai*** *- Hospital Authority, Hong Kong SAR, China*
26	**Pancreaticopleural Fistula Managed Surgically at Military Hospital 175: A Case Report and Literature Review** ***Le Duc Trung*** *- Military Hospital 175, Vietnam*
27	**Comparison of 16g and 20g Needles in Percutaneous Trans-Hepatic Biliary Drainage: Real-World Data from Nhan Dan Gia Dinh Hospital** ***Trinh My Tran*** *- Nhan Dan Gia Dinh Hospital, Vietnam*
28	**Laparoscopic Liver Resection in Difficult Locations: Expanding the Limits of Minimally Invasive Liver Surgery** ***Vu Ngoc Tuan*** *- 108 Military Central Hospital, Vietnam*
29	**Outcomes of Simultaneous Hepatectomy and Colorectal Resection for Curative Treatment of Colorectal Liver Metastases** ***Nguyen Van Linh*** *- Military Hospital 354, Vietnam*
30	**Outcomes of Single-Stage Laparoscopic Cholecystectomy Combined with Endoscopic Retrograde Cholangiopancreatography (LC + ERCP) for Concurrent Gallstones: Experience at One Center** ***Nguyen Quang Huy*** *- People's Hospital 115, Vietnam*

NO.	TITLE
31	**Initial Application of Indocyanine Green (ICG) Fluorescence in Laparoscopic Surgery for Recurrent Biliary Stone Disease at Military Hospital 175** ***Nguyen Van Manh*** *- Military Hospital 175, Vietnam*
32	**How Long Is Safe? Re-evaluating Biliary Stent Lifespan in Real world practice** ***Carla Cai Zi*** *- Malaysia*
33	**Surgery for Liver Cancer with Involvement of the Inferior Vena Cava: Initial Experience of a Center** ***Nguyen Truong Giang*** *- National Hospital for Tropical Diseases, Vietnam*
34	**Combined Hepatocellular Carcinoma-Cholangiocarcinoma Presenting with Prolonged Fever: A Case Report** ***Duong Thi Huong*** *- National Hospital for Tropical Diseases, Vietnam*
35	**Surgery for Hepatocellular Carcinoma Patients with Portal Vein Main Trunk Thrombosis (Vp4): Initial Experience of a Single Center** ***Nguyen Truong Giang*** *- National Hospital for Tropical Diseases, Vietnam*

FACULTY

OVERSEAS FACULTY

Prof. Kwang-Woong Lee
President
Korean Liver Transplant Society
South Korea

Prof. Kwang-Woong Lee is a Professor of Surgery at Seoul National University Hospital and a leading specialist in liver transplantation and hepatobiliary surgery. He earned his BS, MD, and PhD degrees from Seoul National University.

Professor Lee completed his surgical residency at Seoul National University Hospital and subsequently pursued fellowship training in liver transplantation and transplantation surgery at both Seoul National University Hospital and Samsung Medical Center.

He is internationally recognized for his expertise in liver transplantation, hepatobiliary surgery, and transplant surgery, and has made significant contributions to surgical education and clinical research in South Korea.

Prof. Joon Seong Park
Seoul National University
College of Medicine
South Korea

Prof. Joon Seong Park is a Professor in the Department of Surgery at Seoul National University College of Medicine. He previously served as Professor and Associate Professor at Gangnam Severance Hospital, Yonsei University, where he specialized in hepatobiliary and pancreatic surgery.

Prof. Park also completed international academic training as a Visiting Professor in pancreatic cancer research at the University of Minnesota. His clinical and research interests focus on hepatobiliary-pancreatic surgery, pancreatic cancer, and advanced surgical treatment for HPB diseases.

He is widely recognized for his contributions to surgical education, clinical research, and the advancement of hepatobiliary and pancreatic surgery in South Korea and internationally.

Prof. Goro Honda
Institute of Gastroenterology
Tokyo Women´s Medical University
Japan

Prof. Goro Honda is the Chief Professor and Chairman of the Department of Surgery at the Institute of Gastroenterology, Tokyo Women's Medical University. He graduated from Kumamoto University School of Medicine in 1992 and earned his PhD from Kyoto University Graduate School of Medicine in 2009.

Prof. Honda is internationally recognized for his expertise in hepatobiliary-pancreatic surgery, minimally invasive surgery, and laparoscopic liver surgery. Before his current appointment, he held senior leadership positions at Tokyo Metropolitan Cancer and Infectious Diseases Center Komagome Hospital and New Tokyo Hospital.

He is an active leader in multiple Japanese and international surgical societies, including serving as Associate Editor of the Asian Journal of Endoscopic Surgery and a founding member of the International Laparoscopic Liver Society. Throughout his career, he has received numerous research grants and international awards, including the EAES Video Award and multiple Best Reviewer Awards from the Journal of Hepato-Biliary-Pancreatic Sciences.

Prof. Hop S. Tran Cao
MD Anderson Cancer Center University of Texas
USA

Prof. Hop S. Tran Cao is a surgical oncologist at The University of Texas MD Anderson Cancer Center. He currently serves as Vice Chair of Clinical Operations in Surgical Oncology and holds multiple leadership roles, including Medical Director of Minimally Invasive & New Technology in Oncologic Surgery (MINTOS) and Clinical Medical Director for Surgical Simulation Education.

Prof. Tran Cao is also an Associate Professor of Surgical Oncology at MD Anderson and an Adjunct Professor at Baylor College of Medicine. In addition, he contributes to clinical ethics as a Surgery Advisor in the Goal-Concordant Care Program.

With extensive experience in oncologic surgery, innovation, and medical education, Prof. Tran Cao is dedicated to advancing patient-centered cancer care and training the next generation of surgeons.

Prof. Yoo-Seok Yoon
Seoul National University
Bundang Hospital
South Korea

Prof. Yoo-Seok Yoon is a Professor of Surgery at Seoul National University College of Medicine and Seoul National University Bundang Hospital. He specializes in hepatobiliary-pancreatic surgery, minimally invasive surgery, pancreatic cancer, and biliary tract tumors.

Prof. Yoon completed his medical degree, master's degree, and PhD at Seoul National University and further trained as a research fellow in HPB surgery at Johns Hopkins Hospital. He has held several leadership roles in major Korean surgical societies, including President of the Korean Study Group on Minimally Invasive Pancreatic Surgery.

He is internationally recognized for his expertise in laparoscopic HPB surgery and has served on the editorial boards of leading journals including Annals of Surgical Oncology and the Journal of Hepato-Biliary-Pancreatic Sciences.

A/Prof. Adrian Chiow Kah Heng
Changi General Hospital
Singapore

A/Prof. Adrian Chiow is the Chief of Surgery and Senior Consultant in Hepatobiliary and Pancreatic (HPB) Surgery at Changi General Hospital, and a Visiting Consultant at Singapore General Hospital. His subspecialty interests include minimally invasive laparoscopic and robotic HPB surgery.

Clin Assoc Prof Chiow graduated with honors from the University of Melbourne and completed advanced HPB fellowship training at Royal Brisbane Hospital. He established the Advanced Laparoscopic HPB Service and Robotic HPB Program at Changi General Hospital.

He is also actively involved in medical education as a Clinical Associate Professor at Duke-NUS Medical School and holds adjunct academic appointments at both National University of Singapore and Nanyang Technological University. In addition to his clinical and academic work, he is widely recognized for his research and regional leadership in minimally invasive HPB surgery.

Dr. Catherine Teh
Makati Medical Center
Philippines

Dr. Teh is a board-certified surgeon, specializing in Hepatobiliary and Pancreatic Surgery. She is a graduate of the University of Sto. Tomas Faculty of Medicine and Surgery. She completed his residency in General Surgery at the Chinese General Hospital and Medical Center. She trained as a fellow in Hepatobiliary Surgery at the National Cancer Centre, Singapore. She pursued further training, with a clinical fellowship in Advanced Laparoscopy at University of Louis Pasteur and IRCAD, France.

A/Prof. Lee Ser Yee
Singapore General Hospital
Singapore

A/Prof. Lee Ser Yee is an Associate Professor and specialist in hepatopancreatobiliary (HPB) surgery, liver transplantation, minimally invasive surgery, and surgical oncology. He completed advanced subspecialty training in HPB surgery and liver transplantation in Singapore, followed by fellowships in advanced laparoscopic HPB surgery at NewYork-Presbyterian Hospital and HPB and Surgical Oncology at Memorial Sloan Kettering Cancer Center.

A/Prof. Lee is actively involved in surgical education and currently serves as Associate Professor (Adjunct) at Duke-NUS Medical School and Senior Clinical Lecturer at National University of Singapore. He is also Director of the Surgical Skills Continuum and Surgical Skills Center in SingHealth.

He has authored more than 100 scientific publications, two surgical books, and over 70 book chapters, and serves on the editorial and reviewer boards of numerous international medical journals. He is also a founding member of several professional surgical societies, including the Singapore HPB Association and the International Laparoscopic Liver Society.

Dr. Rawisak Chanwat
Bumrungrad International Hospital
Thailand

Prof. Yoo-Seok Yoon is a Professor of Surgery at Seoul National University College of Medicine and Seoul National University Bundang Hospital. He specializes in hepatobiliary-pancreatic surgery, minimally invasive surgery, pancreatic cancer, and biliary tract tumors.

Prof. Yoon completed his medical degree, master's degree, and PhD at Seoul National University and further trained as a research fellow in HPB surgery at Johns Hopkins Hospital. He has held several leadership roles in major Korean surgical societies, including President of the Korean Study Group on Minimally Invasive Pancreatic Surgery.

He is internationally recognized for his expertise in laparoscopic HPB surgery and has served on the editorial boards of leading journals including Annals of Surgical Oncology and the Journal of Hepato-Biliary-Pancreatic Sciences.

A/Prof. Iyer Shridhar Ganpathi
National University of Singapore
Singapore

A/Prof. Iyer Shridhar Ganpathi is a Singapore-based surgeon and academic specializing in hepatobiliary and pancreatic surgery. He serves as an Associate Professor of Surgery at the National University of Singapore and has held several senior leadership roles within the National University Health System, including Group Head and Senior Consultant (2018–2024). He is also Co-Director of the National University Centre for Organ Transplantation and has been actively involved in Singapore's liver transplant program as Surgical Director and Co-Director.

A/Prof. Ganpathi has contributed extensively to surgical education, accreditation, and policy through various national committees. He has also held prominent positions in professional societies, including serving as President of both the Hepato-Pancreato-Biliary Association (Singapore) and the Society of Transplantation (Singapore). Based at Mount Elizabeth Medical Centre, he is recognized for his leadership in complex abdominal surgery and organ transplantation.

Dr. Jan Jin Bong
Sunway Medical Centre
Malaysia

Dr. Bong is a highly experienced hepatobiliary and pancreatic (HPB) surgeon and currently serves as Senior HPB Consultant at Sunway Medical Centre. He obtained his medical degree and MD from the University of Leeds and completed advanced surgical training at several leading hospitals in London, including the Northwest Thames Higher Surgical Training Programme.

Dr. Bong is widely recognized in Malaysia and across the ASEAN region for his expertise in minimally invasive HPB surgery, particularly laparoscopic and robotic oncologic surgery. He has played a key role in advancing minimally invasive HPB surgery in Malaysia and has published extensively and presented at numerous international scientific meetings. He also serves on the editorial board of the Asian Journal of Surgery and previously served as Vice President of the ASEAN LHC Council.

Prof. Sai Aung Nyunt Oo
Yangon Specialty Hospital
Myanmar

Prof. Sai Aung Nyunt Oo is a general surgeon based in Yangon, Myanmar. He serves as a professor at the University of Medicine-2 and is affiliated with ARYU Hospital. His clinical and research work includes studies on liver transplantation outcomes, particularly in Myanmar.

Prof. Oo holds medical and surgical qualifications including M.B., B.S., M.Med.Sc (Surgery), and M.R.C.S., reflecting his expertise in general and hepatobiliary surgery.

A/Prof. Koh Peng Soon
University of Malaya Medical Center
Malaysia

A/Prof. Koh Peng Soon is an Associate Professor and Consultant Surgeon at the University of Malaya and University Malaya Medical Centre. He specializes in hepatobiliary and pancreatic (HPB) surgery, minimally invasive surgery, and liver transplantation.

A/Prof. Koh's research focuses on liver, biliary, and pancreatic cancers, particularly hepatocellular carcinoma, cholangiocarcinoma, and pancreatic cancer. He has been actively involved in multiple international and national research collaborations, including clinical trials and translational studies in hepatocellular carcinoma and liver transplantation.

He has authored numerous peer-reviewed publications in the fields of HPB surgery and liver transplantation, with particular expertise in living donor liver transplantation and minimally invasive HPB procedures.

Dr. Worakitti Lapisatepun
Chiang Mai University
Thailand

Dr. Worakitti Lapisatepun is an Associate Professor and surgeon specializing in hepatobiliary and pancreatic surgery at the Faculty of Medicine, Chiang Mai University. He earned his Doctor of Medicine degree from Chiang Mai University in 2011 and completed his surgical residency there in 2016.

Dr. Lapisatepun currently serves in the Division of Hepatobiliary Pancreatic Surgery, Department of Surgery, and is actively involved in both clinical practice and academic teaching.

Asst. Prof. Dr. Attapol Titatpun
Khon Kaen University
Thailand

Asst. Prof. Dr. Attapol Titapun is a hepatopancreatobiliary specialist and academic at Khon Kaen University, Thailand. He is affiliated with the Cholangiocarcinoma Research Institute and the Cholangiocarcinoma Center of Excellence, where he contributes to both research and clinical programs.

His expertise includes liver, pancreatic, and biliary tract surgery, with a particular focus on cholangiocarcinoma screening and care. Dr. Titapun is actively involved in research, education, and training, serving as a co-researcher in multiple projects and supporting graduate, postdoctoral, and clinical training programs.

Dr. Poowanai Sarkhampee
Sunpasitthiprasong Hospital
Ubon Ratchathani
Thailand

Dr. Poowanai Sarkhampee, MD, PhD, FRCST, is a hepatopancreatobiliary (HPB) surgeon at Sunpasitthiprasong Hospital in Ubon Ratchathani, Thailand. He specializes in complex liver surgery, with a particular focus on cholangiocarcinoma, including both perihilar and intrahepatic subtypes.

Dr. Sarkhampee has extensive experience in liver resection, vascular reconstruction, and multidisciplinary management of biliary tract cancers. He is actively involved in clinical research, with numerous publications in leading international journals addressing surgical outcomes, resection margins, and prognostic factors in cholangiocarcinoma.

In addition to his clinical work, he regularly presents at major international conferences, contributing to advances in HPB surgery and surgical oncology.

Dr. Tin Tin Mar
Yangon Specialty Hospital
Myanmar

Dr. Tin Tin Mar is a medical professional based in Yangon, Myanmar. She has held a leadership role in the HBPS department at Yangon Speciality Hospital, where she has contributed to advancing patient care, education, training, and medical research. Dr. Tin Tin Mar is also associated with ARYU Hospital, where she is involved in providing clinical services across multiple specialties, including heart care and gastrointestinal medicine.

She has received international recognition, including being welcomed by the Royal Australasian College of Surgeons as a recipient of a Myanmar Scholarship Program, highlighting her contributions to the medical field. Her work also extends into research, with involvement in studies related to liver transplantation and patient outcomes.

Prof. Brian Goh Kim Poh
Singapore General Hospital
Singapore

Prof. Goh is the Head of the Department of Hepatopancreatobiliary and Transplant Surgery at Singapore General Hospital and the National Cancer Centre Singapore. He also serves as Director of the SingHealth Liver Transplant Service and Surgical Director of Singapore's National Liver Transplant Program under the Ministry of Health.

Prof. Goh is internationally recognized for his expertise in hepatopancreatobiliary (HPB) surgery, liver transplantation, minimally invasive surgery, and surgical oncology. Since returning to Singapore in 2011, he has performed more than 1,000 laparoscopic and robotic major HPB procedures and is regarded as a regional pioneer in advanced minimally invasive and robotic HPB surgery.

He previously completed advanced fellowship training at the Mayo Clinic and is the only surgeon in Singapore certified by both the American Society of Transplant Surgeons and the Ministry of Health in abdominal transplantation. Professor Goh has authored extensive research, contributed to international expert consensus panels, and is widely invited as a lecturer, mentor, and proctor across the Asia-Pacific region.

Dr. Thakerng Pitakteerabundit
Prince of Songkla University
Hat Yai
Thailand

Dr. Thakerng Pitakteerabundit is a hepatobiliary surgeon and Assistant Professor in Surgery at Prince of Songkla University, Thailand. He serves as an attending staff member in the Hepatobiliary Unit at Songklanagarind Hospital, where he specializes in liver and biliary surgery.

Dr. Thakerng completed his surgical residency at Prince of Songkla University and has pursued advanced international training, including a fellowship in Pancreas and Biliary Surgery at Massachusetts General Hospital, Harvard Medical School. He has also undertaken visiting fellowships in Germany and received specialized training in liver transplantation in Thailand.

With a strong background in clinical practice and academic medicine, Dr. Thakerng is dedicated to advancing hepatobiliary and transplant surgery.

Dr. Tharatip Srisuk
Khon Kaen University
Thailand

Dr. Tharatip Srisuk is an Assistant Professor in the Department of Surgery at Khon Kaen University, specializing in hepatopancreatobiliary (HPB) and minimally invasive surgery. He earned his MD and surgical training from Khon Kaen University and holds the Diploma of the Thai Board of Surgery (FRCST).

Dr. Srisuk has completed advanced international training programs in Japan, the United Kingdom, France, and South Korea, focusing on liver transplantation and hepato-biliary-pancreatic surgery. In addition to his clinical and academic work, he is actively involved in several professional surgical organizations across Thailand and the Asia-Pacific region. His expertise includes general surgery, minimally invasive HPB procedures, medical education, leadership, and communication.

Dr. Pang Ning Qi
National University Health System
Singapore

Dr. Pang Ning Qi is a hepatobiliary and transplant surgeon in Singapore. He serves as Surgical Director and Consultant of the Liver Transplant Program at the National University Centre for Organ Transplantation (NUCOT), National University Health System.

He is also a Consultant in the Division of Hepatobiliary & Pancreatic Surgery and an Adjunct Assistant Professor at both the National University of Singapore and Nanyang Technological University. Dr. Pang holds multiple professional qualifications, including MBBS, MRCS, FRCS, MMed, MPH, and PhD.

Dr. Wipusit Taesombat
Chulalongkorn University
Bangkok, Thailand

Dr. Wipusit Taesombat is an Associate Professor of Surgery at Chulalongkorn University and a specialist in hepatobiliary-pancreatic and transplant surgery at King Chulalongkorn Memorial Hospital. He completed advanced fellowship training in laparoscopic surgery, robotic surgery, and liver transplantation in the United States and South Korea.

Dr. Taesombat is internationally recognized for his expertise in minimally invasive liver surgery and hepatobiliary-pancreatic surgery. He has published extensively in peer-reviewed journals and is a frequent invited speaker at major international HPB and laparoscopic surgery conferences.

Dr. Koh Ye Xin
Singapore General Hospital
Singapore

Dr. Koh Ye Xin is a Senior Consultant at Singapore General Hospital in the Department of Hepatopancreatobiliary and Transplant Surgery. He also serves as Director of the Centre for Digestive and Liver Diseases and Surgical Director of the SGH Liver Transplant Programme.

Dr. Koh obtained his FRCS (Edinburgh) in 2017 and has received several prestigious awards, including the SingHealth Duke-NUS Nurturing Clinician Scientist Scheme Award and the Singapore General Hospital Overseas Fellowship Award. He completed advanced fellowship training in pancreas, liver, and multivisceral transplantation at the Cambridge Transplant Unit and was an Asia-Pacific Fellow of the Japanese Society of Hepato-Biliary-Pancreatic Surgery.

In addition to his clinical leadership roles, Dr. Koh is actively involved in medical education as a Clinical Associate Professor at Duke-NUS Graduate Medical School. He has authored more than 80 peer-reviewed publications and serves as Associate Editor for Frontiers in Surgery, with research interests in transplantation, pancreatic diseases, and regenerative medicine.

LOCAL FACULTY

Prof. Le Trung Hai

President
Vietnam Association for the Study of Liver Diseases
Vietnam

Prof. Le Trung Hai is a Major General, Professor, Senior Physician, and Distinguished Teacher, recognized as one of Vietnam's leading experts in hepatobiliary surgery and organ transplantation. As of 2026, he serves as President of the Vietnam Hepato-Biliary Association and the Vietnam Chapter of Hepato-Biliary-Pancreatic Surgery, while also holding leadership roles as Principal of Hanoi Medical College and Medical Director of Hanoi General Hospital.

Professor Hai previously served as Deputy Director General of the Military Medical Department under the Ministry of National Defence and Deputy Director of Surgery at 103 Military Hospital, Military Medical Academy. He is widely regarded as a pioneer in liver and kidney transplantation in Vietnam and was a co-author of the "Organ Transplantation Work," which received the prestigious Ho Chi Minh Prize in Science and Technology in 2005.

In addition to his clinical and academic achievements, he currently chairs the Oncology Committee of the Armed Forces and continues to play a major role in advancing hepatobiliary surgery and transplantation in Vietnam.

A/Prof. Le Van Thanh

President
Vietnamese Society of Hepato-Biliary-Pancreatic Surgery
Vietnam

A/Prof. Le Van Thanh is an Associate Professor, senior military physician, and leading hepatobiliary-pancreatic surgeon at 108 Military Central Hospital. He currently serves as Acting Director of the Institute of Gastrointestinal Surgery and Head of the Department of Hepatobiliary and Pancreatic Surgery. He is also currently serving as Deputy Chief Medical Officer for the Surgical Affairs of the Vinmec Healthcare System. With more than 35 years of medical and military service, he has extensive expertise in hepatobiliary-pancreatic surgery and liver transplantation.

A/Prof. Thanh graduated from the Military Medical Academy and later obtained his PhD in Medicine. He also completed advanced clinical training in France, including at hospitals in Nancy and the Legouest Military Hospital. Throughout his career, he has held numerous leadership positions at 108 Military Central Hospital and has contributed significantly to surgical education, research, and clinical practice in Vietnam.

In recognition of his professional contributions, he was awarded the title of "Excellent Physician" by the Vietnamese government and received a Prime Minister's Certificate of Merit in 2025.

Dr. Ho Van Linh
Hue Central Hospital
Vietnam

Dr. Ho Van Linh is a leading Vietnamese surgeon specializing in general surgery and surgical oncology at Hue Central Hospital. He currently serves as Deputy Director in charge of professional affairs and previously held positions as Head of the Department of Surgical Oncology and Head of the Direction and Outreach Department.

Dr. Linh is widely recognized for his expertise in oncologic surgery and his contributions to surgical care and professional training in Central Vietnam. In addition to his clinical leadership, he actively participates in academic and advanced professional activities in the field of cancer surgery.

A/Prof. Le Thanh Son
Military Hospital 103
Vietnam

A/Prof. Le Thanh Son is a medical doctor and senior surgeon specializing in gastrointestinal surgery. He currently serves as Head of Department and Director of the Gastrointestinal Surgery Center at Military Hospital 103, under the Vietnam Military Medical University.

Dr. Son holds a PhD in Surgery and has extensive experience in clinical practice, medical education, and surgical leadership. Since his appointment in 2020, he has played a key role in advancing gastrointestinal surgical services and training within the institution. His work focuses on improving surgical outcomes and contributing to the development of modern digestive surgery in Vietnam.

Dr. Tran Cong Duy Long
University Medical Center Ho Chi Minh City
Vietnam

Dr. Long is a leading Vietnamese surgeon specializing in hepatobiliary surgery, minimally invasive surgery, and liver transplantation at University Medical Center Ho Chi Minh City. He currently serves as Head of the Hepatobiliary Cancer and Liver Transplant Unit and Deputy Head of the Department of Hepatobiliary and Pancreatic Surgery.

Dr. Long is widely recognized for his pioneering contributions to laparoscopic hepatobiliary surgery and liver transplantation in Vietnam. He was among the first surgeons to introduce advanced liver-splitting techniques and received first prize recognition at an international world congress on laparoscopic liver surgery.

In addition to his clinical leadership, Dr. Long is actively involved in surgical innovation, academic activities, and the advancement of hepatobiliary and transplant surgery in Vietnam.

Dr. Le Trung Hieu
108 Military Central Hospital
Vietnam

Dr. Le Trung Hieu is a transplant and hepatobiliary-pancreatic surgeon at 108 Military Central Hospital, where he currently serves as Director in charge of the Human Organ and Tissue Transplantation Center. He is also a lecturer in gastrointestinal surgery at the 108 Institute of Clinical Medical and Pharmaceutical Sciences.

Dr. Hieu graduated from the Military Medical Academy in 2012 and completed advanced training in hepatobiliary-pancreatic surgery and liver transplantation in France and South Korea. He earned his PhD in Gastrointestinal Surgery in 2023 and has received numerous prestigious awards for scientific innovation and surgical research in Vietnam.

He has authored more than 20 scientific publications, including international ISI and Scopus-indexed papers, and has been recognized internationally with awards and invited presentations at major HPB and minimally invasive surgery congresses across Asia and Europe. Dr. Hieu also serves as Secretary General of the Vietnam Hepato-Pancreato-Biliary Surgery Society and is an active member of several international HPB and transplant surgical associations.

Dr. Nguyen Dinh Song Huy
Cho Ray Hospital
Vietnam

Dr. Nguyen Dinh Song Huy is a senior hepatobiliary surgeon and currently serves as Head of the Liver Tumor Department and Deputy Director of the Oncology Center at Cho Ray Hospital. He is widely recognized for his extensive experience in the diagnosis and treatment of liver tumors and liver cancer.

Under his leadership, the Liver Tumor Department became the first unit in Vietnam to implement microwave ablation (MWA) technology for liver cancer treatment, officially approved and introduced nationwide in 2013. The department is now regarded as one of the country's leading comprehensive centers for modern liver tumor treatment.

In addition to his clinical work, Dr. Huy actively participates in public education and health communication programs on liver cancer through national television, radio, and community outreach activities in Vietnam.

A/Prof. Nguyen Quang Nghia
Viet Duc University Hospital
Vietnam

A/Prof. Nguyen Quang Nghia is an Associate Professor, senior surgeon, and leading expert in hepatobiliary surgery and organ transplantation at Viet Duc University Hospital. He currently serves as Director of the Transplant Center and is widely recognized for his expertise in liver transplantation, kidney transplantation, and complex hepatobiliary surgery.

A/Prof. Nghia has extensive experience in the surgical treatment of liver cancer, biliary tumors, and advanced organ transplantation techniques. He has played a key role in many landmark transplant procedures in Vietnam, contributing significantly to the development of transplant surgery and improving outcomes for patients nationwide.

Dr. Ninh Viet Khai
Viet Duc University Hospital
Vietnam

Dr. Ninh Viet Khai is a senior gastrointestinal surgeon at Viet Duc University Hospital in Hanoi, Vietnam. He currently serves as Deputy Director of the Organ Transplant Center, where he is involved in both clinical practice and leadership.

Dr. Khai holds a PhD in Digestive Surgery and has extensive experience in hepatobiliary and gastrointestinal surgery, including organ transplantation. In addition to his surgical work, he plays an active role in managing transplant programs and advancing specialized surgical care.

He has been recognized for his contributions to the medical field with the title of "Excellent Physician" awarded by the Ministry of Health.

A/Prof. Vu Van Quang
108 Military Central Hospital
Vietnam

A/Prof. Vu Van Quang is an Associate Professor, medical doctor, and specialist in gastrointestinal and hepatobiliary-pancreatic surgery at 108 Military Central Hospital. He currently serves as Deputy Director of the institute and Head of the Department of Hepatobiliary-Pancreatic Surgery. Dr. Quang graduated from the Military Medical Academy in 2008 and has dedicated his career to digestive and hepatobiliary surgery.

He has undertaken advanced international training in gastrointestinal surgery at Spandau Hospital Berlin, hepatobiliary-pancreatic surgery at Kyushu University Hospital, and hepatobiliary-pancreatic surgery and transplantation at Pusan National University Yangsan Hospital. Since joining 108 Military Central Hospital in 2009, he has held several clinical and leadership positions in the Department of Gastrointestinal Surgery and the Department of Hepatobiliary-Pancreatic Surgery.

Dr. Quang is also actively involved in academic research, with numerous publications in the Vietnam Journal of Gastroenterology and the 108 Clinical Medicine and Pharmacy Journal. His professional interests focus on hepatobiliary-pancreatic surgery, digestive surgery, and transplantation surgery.

Dr. Phan Tan Thuan
Ho Chi Minh City Oncology Hospital
Vietnam

Dr. Phan Tan Thuan is a senior medical oncologist at Ho Chi Minh City Oncology Hospital, where he serves as Head of the Research and Training Dept. With over two decades of experience in oncology, he specializes in the treatment and research of cancers, particularly breast cancer, GI tract, GU tract cancers and also rare tumors.

In addition to his clinical responsibilities, Dr. Thuan leads the hospital's Clinical Research Unit (CRU), where he is actively involved in numerous phase II- III clinical trials, helping expand patient access to innovative therapies.

Dr. Pham Minh Hai
University Medical Center Ho Chi Minh City
Vietnam

Dr. Pham Minh Hai is a specialist in hepatobiliary-pancreatic surgery and minimally invasive surgery at University Medical Center Ho Chi Minh City. He currently oversees the Center for Laparoscopic Surgery Training and is actively involved in advanced laparoscopic procedures, including liver and pancreatic resections.

Dr. Hai has extensive expertise in minimally invasive hepatobiliary-pancreatic surgery and the management of complex gastrointestinal diseases. He is also actively engaged in clinical research and has contributed to scientific publications and case reports involving challenging digestive and hepatobiliary conditions.

Recognized as an expert in laparoscopic surgery, Dr. Hai plays an important role in surgical training and the advancement of minimally invasive techniques in Vietnam.

FACULTY ABSTRACTS

VIETNAM HEPATO-BILIARY PANCREATIC SPECIALTY ACHIEVEMENT AND DEVELOPMENT

2026 Update Clinical Practice Guidelines for HCC in Vietnam

Trung Hai LE

The Vietnam Hepato-Biliary Pancreatic specialty was proud of Professor Ton That Tung's world-famous hepatectomy method and the Ho Chi Minh Awards for Hepato-cellular carcinoma (HCC) treatment (2017), for Organ transplantation (2005), including liver transplantation, and the First Prize in the world for video clips of laparoscopic liver resection in Paris, France (2017) .... Recently many advances in Hepato-Biliary Pancreatic (HBP) surgery, including laparoscopic hepatectomy and liver transplantation (Tx) such as living donor liver Tx, deceased donor split-liver Tx, ABO blood group incompatibility liver Tx, liver Tx with 2 grafts from 2 living donors, liver Tx for very young patients and need a liver resection to reduce volume ...

From a chapter of VASLD when founded in November 2018, luanched in Hue on June 2019, recognized by International Hepato-Pancreatic Biliary Association (IHPBA) and Asia-Pacific Hepato-Pancreatic Biliary Association (APHPBA) in April, 2019 and now upgraded to Vietnam Society of Hepato-Biliary Pancreatic Surgery in February, 2026.

Over the past 7 years, the Vietnam Society of Hepato-Biliary Pancreatic Surgery has successfully fulfilled its historical mission of promoting the specialty of HBP surgery in multimodal treatment, particularly excelling in liver transplantation, laparoscopic surgery, and the application of advanced hepatobiliary and pancreatic techniques, establishing a strong position in the region and internationally. Prof KK Madhavan - President of APHPBA and now President of IHPBA praised: Vietnamese Chapter of HBP Surgery is our youngest but one of the most important Chapter in Asia Pacific. This presentation shows details many events of scientific activities and achievement, expert training and team expansion, international activities, excellent international experts and close friends, honors and appointement ... as well as the program for 2026 - 2028 of VSHBPS and VASLD.

The presentation also shows about 2026 Update Clinical Practice Guidelines for HCC in Vietnam with key general and surgical aspects such as General screening for HCC with ultrasound and AFP test; The role of MRI primovist and artificial intelligence (AI) in supporting the early and accurate diagnosis of HCC; The multidisciplinary diagnostic and therapeutic team; The principles, and some key details of HCC treatment and laparoscopic hepatectomy as well as liver transplantation for HCC; The systemic and immunotherapy treatment after liver Tx for HCC; Post-treatment monitoring and follow-up notes for HCC as well as screening strategy after liver Tx and nutrition for HCC patients ... The 2026 update clinical practice guidelines for HCC will improve the prevention and treatment of HCC, contributing to reducing the burden of this disease in Vietnam.

RECENT ADVANCES IN LIVER TRANSPLANTATION

Kwang-Woong LEE

The field of liver transplantation (LT) is currently undergoing a transformative paradigm shift, driven by the maturation of surgical platforms, innovations in organ preservation, and breakthroughs in systemic oncological therapy. This presentation outlines the convergence of three revolutionary pillars-minimally invasive surgery (MIS), dynamic organ preservation, and immunotherapy-that are redefining the standards of care in 2026.

First, the standardization of MIS has reached a global milestone. At Seoul National University Hospital (SNUH), pure laparoscopic donor hepatectomy (PLDH) has achieved 100% adoption for routine cases, with over 960 cases validating its safety and reproducibility. Concurrently, robotic recipient surgery is transitioning from technical innovation to clinical assessment, offering superior 3D visualization and wristed dexterity that enhance the precision of complex vascular and biliary anastomoses, leading to remarkably accelerated patient recovery.

Second, dynamic organ preservation is replacing static cold storage as the new gold standard. Systems such as Hypothermic Oxygenated Machine Perfusion (HOPE) and Normothermic Machine Perfusion (NMP) allow for active physiological resuscitation and real-time viability assessment of marginal grafts. Beyond clinical outcomes, the implementation of "Day Shift" protocols-facilitated by prolonged perfusion-has transformed transplant logistics by converting high-risk overnight procedures into scheduled daytime surgeries, significantly reducing surgical fatigue.

Third, the integration of immune checkpoint inhibitors (ICIs), specifically Atezolizumab plus Bevacizumab, is expanding the frontiers of LT for advanced hepatocellular carcinoma (HCC). While ICIs offer unprecedented down-staging success and the eradication of micrometastases, they present a "double-edged sword" regarding graft-immune risk. Adhering to a strict "Washout Governance"-ideally a 90-day interval before LT as suggested by the 2026 AISF consensus-is critical to mitigating T-cell mediated rejection.

In conclusion, the synergy of robotic precision, dynamic preservation, and strategic immunotherapy is not only enhancing donor safety and expanding the donor pool but also improving the long-term oncological survival of transplant recipients.

Keywords: *Liver Transplantation, Robotic Surgery, Machine Perfusion, Immunotherapy, HCC Down-staging, HOPE/NMP, SNUH.*

METHODS OF PANCREATIC STUMP CLOSURE IN DISTAL PANCREATECTOMY – AN UPDATE ON HOW TO REDUCE POPF

Jan Jin BONG

Post-operative pancreatic fistula (POPF) is one of the most common and feared complications after distal pancreatectomy, either with or without splenic preservation. It is the primary source of morbidity and potential mortality after distal pancreatectomy. Early clinical manifestation includes bloating, epigastric pain and early satiety, leading to delayed gastric emptying and poor oral intake. Sentinel bleeding observed in the drain may lead to rupture of pseudo-aneurysm of splenic vessels secondary to corrosive erosion from the pancreatic enzyme, and eventually to life-threatening haemorrhage. Prolonged POPF may lead to multi-drug resistant infection, increased hospital cost, and prolonged stay.

Risk factors for POPF development include obesity and increased visceral fat, hypoalbuminemia, young age, concomitant splenectomy, and vascular resection. In the modern era, the incidence of POPF remains high even in the high-volume centers, ranging from 15% to 60%.

Techniques of stapling to prevent POPF have been described, and include pre-firing slow compression of staplers, optimal selection of stapler cartridges to match the pancreatic tissue thickness, and mesh reinforcement of the staplers. In addition, the use of fibrin glue, the wrapping with omentum, polyglycolic mesh, Tachoseal patch, and falciform ligament have all been described with various successes.

Based on recent high-quality research, prophylactic pancreatic drainage after distal pancreatectomy does not reduce the risk of POPF. The PANDORINA trial, a major multicenter study, showed that omitting drainage did not increase major complications and was associated with fewer Grade B/C fistula (12% vs. 27%). A 2024 meta-analysis of 3,610 patients concluded that a no-drain policy not only reduced POPF, risk but also fewer reinterventions, fewer readmissions, and a shorter hospital stay.

Finally, the question of whether prophylactic octreotide reduces the risk of POPF rate after distal pancreatectomy remains controversial. The French PREFIPS randomized clinical trial found no significant difference in clinically significant POPF rate between subcutaneous Octreotide and continuous intravenous Somatostatin. However, a long- acting somatostatin analogues – Lanreotide – given as a single dose preoperatively has been shown to reduce POPF rates to 11% and 3% after pancreaticoduodenectomy and distal pancreatectomy respectively. On going multi-centre, phase III randomized controlled trial will hopefully answer this question.

LOCAL ABLATION VERSUS LIVER RESECTION FOR EARLY HEPATOCELLULAR CARCINOMA

Dinh Song Huy NGUYEN

Background & Objective: Hepatocellular carcinoma (HCC) remains a leading cause of cancer-related mortality worldwide. For patients with early-stage disease (BCLC 0 or A), Liver Resection (LR) and Local Ablation (LA) – most commonly Radiofrequency Ablation (RFA) or Microwave Ablation (MWA) – are the primary curative-intent treatment modalities. While LR offers definitive tumor removal, LA provides a minimally invasive alternative with lower perioperative morbidity. This study aims to evaluate and compare the long-term oncological outcomes and safety profiles of these two approaches.

Methods: A systematic search was conducted across many treatment guidelines and major databases to compare the role of LR and LA for treatment of early HCC (solitary tumor ≤ 5 cm or up to 3 nodules each ≤ 3 cm).

Results: Survival Outcomes: LR is associated with significantly better DFS compared to LA, particularly for tumors > 3 cm, due to a lower risk of local recurrence. Although LA show comparable OS for very early-stage HCC (single nodule < 2 cm), LR generally demonstrates superior 5-year OS rates in the broader early-stage population.

Safety & Recovery: LA consistently demonstrates a lower incidence of major complications and significantly shorter hospital stays. Postoperative morbidity was higher in the LR group, especially in patients with underlying cirrhosis or portal hypertension.

Recurrence Patterns: Patients undergoing LA experienced higher rates of local tumor progression, whereas the risk of "de novo" distant intrahepatic recurrence was relatively similar between both groups over long-term follow-up.

Conclusion: For early-stage HCC, Liver Resection remains the gold standard for providing superior local control and long-term disease-free survival. However, Local Ablation is a highly effective alternative that offers comparable overall survival for tumors < 2 cm with a more favorable safety profile. The choice of treatment should be individualized, considering effectiveness and safety of each modality, tumor-related factors (size, number, location, accessibility), patient-related factors (liver function, ECOG performance status, ASA Physical Status Classification) and resource-related factors.

Keywords: Hepatocellular Carcinoma, Liver Resection, Radiofrequency Ablation, Microwave Ablation, Early-stage HCC.

UPDATE ON DIAGNOSIS AND SURGICAL TREATMENT FOR PERIHILAR CHOLANGIOCARCINOMA

Viet Khai NINH

Perihilar cholangiocarcinoma was firstly described by Gerald Klatskin in 1965. It includes two types: one is extrahepatic - arises from hilar bile duct (right, left and common bile duct) and the other is intrahepatic but invaded into hilus. This malignant lesion is the most common in all cholangiocarcinoma (account for 50-70%). Klatskin tumor is often lately diagnosed due to admitting the hospital with advanced stage tumor entailing a obstructed jaundice. Preoperative staging diagnosis is difficult even with modern imaging facilities. Resectability range from 32 – 80%, different for each study. Surgical treatment for this disease is still challenging even for experienced surgeons. Standard surgery is a major liver resection combined with extrahepatic duct resection and lymph node dissection. The extended resection provides high radical resection rate and increase survival time. The 5 years survival is highly correlated with the radical resection. The 5 years survival rate range 27 – 45% for radical resection (R0), but in contrast, 0 - 23% for non radical resection (R1 – positive microscopic margin, R2 – positive gross margin). Nowadays, guidelines and consensuses on this disease was validated, so we would like to update the useful informations.

EVALUATION OF RIGID CHOLEDOCHOSCOPY UNDER DSA GUIDANCE VIA THE KEHR TRACT FOR THE MANAGEMENT OF RETAINED BILE DUCT STONES AFTER SURGERY

Nhan Hien PHAN

Purpose: To evaluate the safety and effectiveness of rigid choledochoscopy under digital subtraction angiography (DSA) guidance via the Kehr tract for the treatment of retained bile duct stones following surgery.

Materials and Methods: A retrospective study was conducted on 20 patients with retained bile duct stones after surgical stone removal with T-tube (Kehr) drainage between January 2024 and December 2025. All procedures were performed under local anesthesia with conscious sedation without general anesthesia. A 16F access sheath was introduced into the common bile duct through the mature Kehr tract under DSA guidance. Rigid choledochoscopy was used to assess stone location and size. Depending on stone characteristics, basket extraction, balloon dilation, laser lithotripsy, or a combination of techniques was applied. Technical success was defined as complete removal of target stones. Complications were recorded and classified according to the Society of Interventional Radiology (SIR) criteria.

Results: Among the 20 patients (50% female; mean age 64.1 ± 14.9 years), the mean interval between surgery and intervention was 2 months; 85% had previously undergone open surgery. Stone locations included intrahepatic ducts (30%), common bile duct (25%), and combined intra- and extrahepatic ducts (45%). Multiple stones (>2 stones) were observed in 85% of patients. Technical success was achieved in 95% of cases. One patient (5%) required conversion to a percutaneous transhepatic approach due to tortuosity of the Kehr tract preventing access to the common bile duct. Two patients (10%) developed bile leakage after drain removal and were successfully managed by reinsertion through the existing tract. No major complications (SIR grade C or higher) were observed.

Conclusion: Rigid choledochoscopy under DSA guidance via the Kehr tract is a minimally invasive, safe, and effective technique for the management of retained bile duct stones after surgery, with a high technical success rate and low complication profile.

Keywords: Retained bile duct stones; Kehr tract; choledochoscopy; DSA.

ROLE OF ENDOSCOPY IN THE DIAGNOSIS AND TREATMENT OF PANCREATIC NEUROENDOCRINE TUMORS (PNETS): FROM EUS-BASED DIAGNOSIS TO EUS-GUIDED ABLATION

Dang Quy Dung HO

Background: Pancreatic neuroendocrine tumors (pNETs) are increasingly detected because of advances in imaging and endoscopic ultrasound (EUS). EUS plays a central role not only in lesion detection and tissue acquisition, but also in minimally invasive local therapy, particularly EUS-guided radiofrequency ablation (EUS-RFA) and ethanol injection in selected cases.

Aim: To highlight the current role of endoscopy in the diagnosis and treatment of pNETs, integrating a representative clinical case with recent evidence from literature.

Case presentation and review: We report a 10-year-old boy with persistent hypoglycemic symptoms after prior distal pancreatectomy for insulinoma. Follow-up CT revealed a 20-mm lesion in the pancreatic head. EUS demonstrated a well-defined hypoechoic mass without vascular invasion, and EUS-FNA confirmed a grade 1 neuroendocrine tumor. EUS-RFA was performed using a linear echoendoscope and a 19G RFA needle. Hypoglycemic symptoms resolved after treatment, and fasting glucose at 10 days was 102 mg/dL.

Recent evidence supports EUS as a high-yield platform for small pNET detection, contrast-enhanced characterization, tissue diagnosis, and therapeutic planning. For treatment, EUS-RFA has shown excellent technical success and high clinical or radiologic response, particularly for insulinomas and small low-grade non-functioning pNETs. Comparative studies suggest fewer adverse events and shorter hospitalization than surgery in selected patients, while recent meta-analyses confirm that both EUS-RFA and EUS-guided ethanol injections are effective minimally invasive options, with RFA appearing more consistent for insulinoma control.

Conclusion: Endoscopy, especially EUS, now spans the full continuum of pNET care-from detection and histologic confirmation to image-guided local ablation. In carefully selected patients, EUS-RFA represents a safe and effective organ-preserving alternative to reoperation or formal pancreatic resection.

LAPAROSCOPIC RAMPS USING A LIGAMENT OF TREITZ-FIRST APPROACH FOR A PANCREATIC NECK–BODY TUMOR

Thanh Tien Dung NGUYEN

Radical antegrade modular pancreatosplenectomy (RAMPS) is an oncologic procedure for tumors of the pancreatic body and tail. A ligament of Treitz-first approach may facilitate early definition of the posterior dissection plane before pancreatic transection.

We report a 75-year-old female patient, BMI 18.7 kg/m², with a 10-year history of type 2 diabetes mellitus, presenting with left upper quadrant discomfort without weight loss. CEA and CA 19-9 were normal. MSCT showed a 21 × 20 mm hypoattenuating pancreatic body lesion with upstream main pancreatic duct dilatation. MRI revealed an 18 × 20 × 20 mm hypovascular lesion at the pancreatic neck–body junction, with abrupt ductal cutoff and splenic vein contact over approximately 17 mm from the portosplenic confluence, without venous thrombosis.

Laparoscopic RAMPS was performed using a ligament of Treitz-first approach. Early posterior dissection allowed identification of the left renal vein, Gerota's fascia, the left adrenal gland, and the retroperitoneal plane, facilitating vascular assessment and subsequent en bloc resection.

Operative time was 240 minutes, with 20 mL blood loss. Pathology confirmed R0 resection, with 10 examined lymph nodes and no nodal metastasis. The patient ambulated on postoperative day 1, developed a low-output biochemical leak, and was discharged on postoperative day 5. She is currently receiving adjuvant gemcitabine plus capecitabine.

This approach is feasible and may support safe oncologic posterior plane dissection in selected cases.

LOCATION-BASED PARENCHYMA-SPARING LAPAROSCOPIC APPROACHES FOR INSULINOMA: BALANCING FUNCTIONAL PRESERVATION AND OPERATIVE RISKS

Huy Luu LE, *Quang Nghe HUYNH, Hien Thao Ly NGUYEN*

Background: Insulinoma is a rare subtype of pancreatic neuroendocrine tumors, characterized by unregulated insulin hypersecretion, leading to recurrent episodes of hypoglycemia with a spectrum of neuroglycopenic manifestations such as confusion, seizures, and potentially life-threatening events. Surgical resection remains the only curative treatment. Given that most insulinomas are benign and small in size, maximal preservation of pancreatic parenchyma and function is a key consideration in selecting the surgical approach. However, the optimal surgical strategy remains controversial, particularly in balancing minimally invasive approaches, functional preservation, and the risk of postoperative complications. This study aims to present and evaluate a location-based, parenchyma-sparing laparoscopic surgical strategy for insulinoma.

Methods: A retrospective study was conducted on nine patients with insulinoma, in whom the surgical approach was individualized according to tumor location. Enucleation was performed for lesions located in the pancreatic head. For tumors in the neck or body of the pancreas, either enucleation or central pancreatectomy was indicated, while tumors in the pancreatic tail were managed by limited distal pancreatectomy with spleen preservation. In cases with a high risk of main pancreatic duct injury, additional reconstructive procedures, including pancreaticogastrostomy or pancreaticojejunostomy, were performed. Perioperative outcomes and postoperative complications were collected and analyzed to assess the feasibility and safety of this strategy.

Results: Nine patients (predominantly female) with tumor sizes ranging from 3.5 mm to 30 mm were included. Tumors were distributed across the pancreatic head, body, and tail. Parenchyma-sparing laparoscopic techniques were flexibly applied according to tumor location. Conversion to open surgery was required in some cases due to intraoperative difficulties in tumor localization.

Postoperative pancreatic fistula occurred in a considerable proportion of patients, predominantly biochemical leaks (Grade A), which were successfully managed conservatively. One patient developed severe postoperative hemorrhage requiring reoperation. Another complex case involved pulmonary embolism associated with prolonged pancreatic fistula, necessitating repeated hospital admissions and intensive medical management combined with drainage. However, the patient ultimately achieved complete recovery after long-term follow-up.

No mortality was observed. All patients experienced complete resolution of hypoglycemic symptoms after surgery. Pancreatic function was preserved in the majority of cases.

Conclusion: A location-based, parenchyma-sparing laparoscopic surgical strategy for insulinoma is feasible and effective in achieving disease control while preserving pancreatic function. However, this approach is technically demanding and may be associated with an increased risk of complications, particularly pancreatic fistula and complex postoperative courses. Therefore, careful patient selection, accurate intraoperative assessment, and surgeon experience are critical factors in optimizing surgical outcomes.

ADOPTION OF ROBOTIC PANCREATODUODENECTOMY: INITIAL EXPERIENCE WITH THE FIRST 100 CONSECUTIVE CASES

Yoshio MASUDA, Bryant LOW, CHEONG; Zhongkai WANG; Hwee-Leong TAN,

Darren W. CHUA, Ek-Khoon TAN, Ye-Xin KOH, Brian K. P. GOH

Background: Despite the growing adoption of robotic pancreatoduodenectomy (R-PD), there remains a paucity of literature examining the learning curve associated with R-PD and the comparison of outcomes between early and later phases of institutional experience in R-PD. Accordingly, this study analyses 100 consecutive R-PD cases at a tertiary centre in Singapore, comparing outcomes across the initial and subsequent 50 cases to assess the effect of the learning curve, and benchmarking low-risk patients against international open PD (O-PD) standards.

Methods : This study is a post-hoc review of 210 consecutive patients who underwent minimally-invasive PD between 2016 to 2025, of which 100 patients who underwent R-PD were included. Baseline characteristics and perioperative outcomes were identified, and univariate analyses were conducted to evaluate differences between the first 50 cases (Group 1) and subsequent 50 cases (Group 2). Benchmarking was also performed for low-risk cases against known O-PD cut-offs.

Results : Comparison between Groups 1 and 2 demonstrated a significant decrease in major postoperative complications (46% vs. 24%; p= 0.04), clinically significant post-operative pancreatic fistula (Grade B/C POPF) (39.1% vs. 18.2%; p=0.05), POPF graded Clavien-Dindo Grade 3 and above (21.7% vs. 4.5%; p=0.03) and delayed gastric emptying (46% vs. 14%; p=0.00). Following risk stratification, Group 2 achieved ten of 11 benchmarks, compared with five of 11 in Group 1.

Conclusion: This study supports the safe and effective implementation of R-PD within a high-volume hepatopancreatobiliary program. Outcomes improved substantially after 50 cases, with low-risk patients in Group 2 achieving nearly all international O-PD benchmarks.

Keywords: *robotic pancreatectomy; robotic pancreatoduodenectomy; Whipples procedure; minimally invasive surgery; robotic pancreas; total pancreatectomy*

UTILIZING A DUAL SUPERIOR MESENTERIC ARTERY FIRST APPROACH FOR TRIANGLE OPERATION IN BORDERLINE RESECTABLE AND LOCALLY ADVANCED PANCREATIC CANCER

Thanh Khiem NGUYEN

Background: The TRIANGLE operation has emerged as an important surgical strategy in pancreatoduodenectomy (PD) and total pancreatectomy (TP) for borderline resectable and locally advanced pancreatic ductal adenocarcinoma (PDAC). This study presents a combined posterior and left-sided superior mesenteric artery (SMA) first approach to facilitate circumferential perivascular dissection and improve oncologic radicality.

Method: Patients with PDAC who underwent PD or TP using a combined posterior and left-sided SMA first approach as part of the TRIANGLE operation between December 2020 and December 2024 were retrospectively analyzed. Clinical characteristics, operative details, short-term outcomes, and pathological findings were reviewed and compared with a historical cohort undergoing single SMA first-approach resections.

Results: A total of 148 patients were included, comprising 43 in the dual-approach group and 105 in the single-approach group. The dual-approach technique enabled proximal and distal control of the SMA, facilitating complete circumferential lymphadenectomy and TRIANGLE dissection. Compared with the single-approach group, the dual-approach group had a significantly higher lymph node yield (35.47 vs. 25.6, $P < 0.001$) and a lower rate of direct tumor-positive resection margins. Operative time and intraoperative blood loss were higher in the dual-approach group. Postoperative morbidity and mortality were comparable between groups.

Conclusions: The TRIANGLE operation incorporating a combined posterior and left-sided SMA first approach in PD or TP is a safe and effective technique for borderline resectable and locally advanced PDAC. This dual approach may improve oncologic clearance and increase the likelihood of R0 resection while maintaining acceptable short-term outcomes.

Keywords: TRIANGLE Operation, Combined Posterior and Left-Sided First Approach, Borderline resectable and locally advanced pancreatic cancer

ADVANCING LAPAROSCOPIC PANCREATICODUODENECTOMY: TIPS, TRICKS, AND ONCOLOGIC PRECISION

Ham Hoi NGUYEN

Background: Laparoscopic pancreaticoduodenectomy (LPD) for Periampullary Malignancies remains technically demanding, particularly in achieving safe vascular dissection and adequate oncologic clearance. This study aimed to highlight key tips and tricks of a standardized left-posterior superior mesenteric artery (SMA) first approach with circumferential lymphadenectomy around the SMA and common hepatic artery and total mesopancreas dissection, while evaluating its safety and oncologic outcomes in a developing-country setting without robotic platforms.

Method: A prospective study was conducted in 47 patients with Periampullary Malignancies who underwent LPD using this standardized technique between January 2021 and December 2025. Demographic characteristics, operative variables, pathological findings, postoperative outcomes, recurrence patterns, and survival outcomes were analyzed.

Results: Mean age was 58.9 ± 8.9 years, and 54.1% of patients were older than 60 years. Mean operative time was 426.2 ± 78.5 minutes, including 99.9 ± 27.7 minutes for the SMA-first phase. Mean lymph node yield was 32.4 ± 12.2, including 7.1 ± 5.6 left-sided SMA nodes. Mesopancreas metastasis was identified in 29.7%, and reactive fibrosis in 45.9%. Metastatic left-sided SMA lymph nodes were found in 13.5% of patients. Postoperative pancreatic fistula occurred in 22.6%, mostly biochemical leak or grade A; one patient required conversion. One patient developed refractory diarrhea. Mean postoperative hospital stay was 14.1 days, and there was no 90-day mortality. On multivariate analysis, metastasis of left-sided SMA lymph nodes was the only independent predictor of both disease-free and overall survival ($P < 0.05$).

Conclusions: LPD using a left-posterior SMA first approach with circumferential arterial lymphadenectomy and total mesopancreas dissection is safe, feasible, and oncologically effective for Periampullary Malignancies. This standardized strategy provides practical technical tips and tricks to improve dissection accuracy, vascular control, and oncologic precision, even in resource-limited settings without robotic systems.

LAPAROSCOPIC PANCREATODUODENECTOMY: TIPS AND TRICKS

Thi Lan NGUYEN

Introduction: Laparoscopic pancreaticoduodenectomy (LPD) is one of the most technically demanding procedures in hepatopancreatobiliary surgery. This study aimed to evaluate the early outcomes, tips and tricks of LPD performed at the Department of Hepatobiliary Surgery, Viet Duc University Hospital.

Patients and Methods: This was a retrospective descriptive study of 10 patients who underwent LPD at the Department of Hepatobiliary Surgery, Viet Duc University Hospital.

Results: The mean age was 60.9 years. The most common presenting symptoms were abdominal pain and jaundice (50%). Tumors were most frequently located in the distal common bile duct (40%) and the ampulla of Vater (40%). Eight out of ten cases (80%) were completed entirely laparoscopically, while two cases (20%) required conversion to open surgery due to inflammatory infiltration of the pancreatic tissue. The mean operative time for totally laparoscopic procedures was 430.5 ± 170.8 minutes. The mean estimated blood loss was 275 ± 282.2 mL. Malignancy was confirmed in 80% of patients, and R0 resection was achieved in 100% of cases. The mean resected lymph node was 4.4. According to ISGPS criteria, POPF Grade B was 18.2%, and no Grade C . No cases of bile leakage or postoperative hemorrhage were observed. The mean postoperative hospital stay was 15.5 days. 90-day mortality was 0%.

Conclusion:

Laparoscopic pancreaticoduodenectomy is a feasible and safe procedure when performed at specialized high-volume centers, providing favorable early outcomes with a high rate of R0 resection and satisfactory postoperative recovery.

Keywords: Laparoscopic pancreaticoduodenectomy; early outcomes; Viet Duc University Hospital.

ASSOCIATION BETWEEN DXA-DERIVED BODY COMPOSITION PARAMETERS AND METABOLIC SYNDROME IN LIVER TRANSPLANT RECIPIENTS

Quoc Khanh LE, Thi Hao DAO, Thi Van Anh NGUYEN, Thi Huong NGUYEN, Hong Trang NGUYEN, Cam Linh LE, Thi Phuong Nam CHU, ***Thu Ha NGUYEN***

Metabolic syndrome after liver transplantation is a common complication that increases disease burden, treatment costs, and adversely affects patients' quality of life post-transplant. Body composition assessment enables precise identification of changes in muscle mass, fat mass, and visceral fat, factors that are closely associated with the risk of metabolic syndrome. Compared with conventional anthropometric indices, this approach provides a more detailed regional evaluation of body composition and allows for more effective stratification of metabolic risk.

Objectives: To evaluate the association between body composition parameters measured by Dual-energy X-ray absorptiometry (DXA) and metabolic syndrome (MetS) in liver transplant recipients.

Subjects and Methods: A cross-sectional study was conducted on 80 outpatient liver transplant recipients at the 108 Military Central Hospital. MetS was diagnosised using NCEP ATP III criteria. Body composition was assessed via DXA. Multivariate logistic regression analysis (adjusted for age and gender) was performed to identify independent predictors of MetS.

Results: The prevalence of MetS was 27.5%. Unadjusted univariate analysis revealed that fat mass index , appendicular lean mass index (ALMI), and visceral adipose tissue (VAT Mass) were significantly associated with an increased risk of MetS (p<0,05). However, after adjusting for age and gender, ALMI remained the only independent predictor of MetS (aOR = 2.54; p = 0.008). Central adiposity markers, including VAT Mass (OR =1,003; p = 0,006), Android Fat% (OR =1,07; p = 0,02), and Trunk/Limb ratio (OR = 12,26; p = 0,01) were positively correlated with hyperglycemia. Conversely, hypertension and hypertriglyceridemia showed no significant association with DXA parameters (p > 0.05).

Conclusion: ALMI is an independent predictor of MetS in liver transplant recipients, while hyperglycemia is closely linked to central fat distribution. Utilizing DXA-derived parameters facilitates individualized nutritional strategies to preserve graft function.

Keywords: *Liver transplantation, DXA, metabolic syndrome, logistic regression, ALMI, body composition.*

TOTAL LAPAROSCOPIC RADICAL RESECTION FOR BISMUTH TYPE IIIB KLATSKIN TUMOR

*Viet Khai NINH, Duc Hung DUONG, **Hai Dang DO**, Tuan HOANG, Duc Trung NGUYEN*

Background: Perihilar cholangiocarcinoma (pCCA) remains a surgical challenge, with radical resection being the only curative treatment. While open surgery is traditional, Emerging evidence suggests that laparoscopic surgery may offer promising outcomes. This case report details a successful laparoscopic approach for Klatskin tumor type IIIb.

Method: A 49-year-old male with epigastric pain was diagnosed with pCCA Bismuth type IIIb via imaging. We performed a laparoscopic procedure involving: hilar dissection (skeletonizing the right hepatic artery and portal vein), extrahepatic bile duct (BD) resection with frozen section margin control, left hepatectomy combined with segment I (caudate lobe) resection using CUSA, and lymphadenectomy (stations 8 and 12).

Results: Total operative time was 440 minutes with 300 ml blood loss and no transfusion required. Pathological examination confirmed a 1.2 cm tumor (T1N0M0) with R0 resection margins and no lymph node metastasis. The patient recovered well and was discharged on postoperative day 11 without complications. At 1-year follow-up, there was no evidence of recurrence.

Conclusions: Laparoscopic left and segment I hepatectomy with extrahepatic BD resection is a feasible and safe alternative to open surgery for Klatskin tumor type IIIb in selected cases. It offers the benefits of minimally invasive surgery while achieving oncological radicality (R0 resection).

EXTRA HEPATIC GLISSONEAN, HEPATIC VEIN GUIDED APPROACH FOR LAPAROSCOPIC LEFT HEPATECTOMY FOR LEFT INTRA-DUCTAL PAPILLARY NEOPLASM OF BILE DUCT (IPNB)

Yen Pin TAN, *Fui jin CHONG*

Background: Laparoscopic liver resections are increasingly becoming the standard of care. However, for major liver resections, minimally invasive liver resections can still be technically challenging with significant morbidities. In recent years, hepatic vein guided approach (HVGA) has been advocated in laparoscopic liver resection to guide precise anatomical liver resection and to reduce risk of disorientation. Additionally, the extrahepatic Glissonean approach allows for selective inflow control, facilitating the demarcation of the resection boundary and reduces ischemia to the remnant liver. We would like to share our usual laparoscopic left hepatectomy technique utilitising extra hepatic glissonean and HVGA in a case for suspected left sided IPNB.

Methods : Mdm T is a 70-year-old Chinese lady with history of hypertension, hyperlipidemia and metabolic dysfunction-associated steatotic liver disease with F4 fibrosis. She was on annual follow up for a 3cm segment 2/3 liver cyst causing mild biliary dilatation. Her most recent MRCP showed new diffusion restriction within the cyst which was concerning for malignant degeneration. After a multidisciplinary tumour board discussion, patient was offered laparoscopic left hepatectomy.

Results: Intra-operatively, an extrahepatic Glissonean approach was used to control the vascular inflow. ICG was given for negative staining to guide liver parenchymal transection. The dissection was performed in a caudal-cranial approach with the middle hepatic vein serving as an anatomical guide and using single energy ultrasonic shear crush clamp technique. The estimated blood loss was 100ml and total operative time was 3 hours. Post-operatively, the patient recovered well and was discharged on post-operative day 4. Final histology was a mucinous cystic neoplasm with low grade dysplasia.

Conclusion: Extra-hepatic glissonean in flow control, hepatic vein guided approach with the use of adjunct negative ICG staining is a safe and efficient method t perform precise anatomical laparoscopic left hepatectomy with satisfactory perioperative outcome.

THE CONCEPT OF "GREEN JUNCTION" IN HYPER-DILUTED INDOCYANINE GREEN FLUORESCENCE CHOLANGIOGRAPHY IN LAPAROSCOPIC CHOLECYSTECTOMY

Kai Ming LAI

Introduction: Indocyanine Green (ICG) fluorescence cholangiography was used to delineate biliary structure in laparoscopic cholecystectomy. Recently, low dose of ICG was advocated to reduce the fluorescence in liver background to improve the quality of cholangiography. In our center, we routinely used intravenous hyper-diluted ICG (HD-ICG) at 0.025mg on induction.

Methods: A 61-year-old lady, with history of acute cholecystitis and cholangitis required repeated endoscopic retrograde cholangiography (ERCP), underwent laparoscopic cholecystectomy. In previous ERCP, papillotomy and balloon sphincteroplasty were performed. Latest ERCP confirmed stone clearance in the common bile duct (CBD) and common hepatic duct (CHD). 0.025mg intravenous ICG was injected on induction of anesthesia for HD-ICG fluorescence cholangiography in laparoscopic cholecystectomy.

Results: Standard 4-port laparoscopic cholecystectomy was performed. During operation, surgeon was allowed to freely switch between white-light and fluorescence imaging. Fluorescence was identified at CBD and CHD (green region) upon entry of peritoneal cavity at 18 minutes after ICG injection. Cystic duct was not enhanced by ICG initially (non-green region). The "green junction" was defined as the junction between "green" and "non-green region", which is the theoretical position of T-junction. Dissection was started at the green junction to avoid unnecessary surgical exploration and dissection in a difficult gallbladder. Cystic duct and gallbladder were transiently enhanced by ICG during operation. Critical view of safety was achieved under ICG-guidance. The cystic duct was controlled and divided according to ICG-guidance. No bile leak was detected at the end of operation. Operative time was 58 minutes. Blood loss was minimal. The patient was discharged on post-operative day 1.

Conclusions: HD-ICG fluorescence cholangiography enabled the identification of "green junction" and facilitated dissection in difficult laparoscopic cholecystectomy.

LAPAROSCOPIC ANTERIOR RAMPS FOR PANCREATIC BODY ADENOCARCINOMA: EARLY EXPERIENCE FROM A MINIMALLY INVASIVE APPROACH

Carla CAI Zi

Introduction: PDAC (Pancreatic ductal adenocarcinoma) remains a surgical challenge, requiring meticulous dissection to achieve adequate oncological margins and lymphadenectomy. Anterior Radical Antegrade Modular Pancreato-Splenectomy (RAMPS) offers these advantages, but its laparoscopic application remains technically demanding. This video demonstrates a fully laparoscopic approach of anterior RAMPS together with cholecystectomy and intraoperative cholangiography.

Case: The case features a 61-year-old lady diagnosed with 3cm x 2cm body of pancreas PDAC on contrast-enhanced CT pancreatic protocol and confirmed by endoscopic ultrasound-guided fine needle biopsy (EUS-FNB). She also has cholelithiasis and previous choledocholithiasis cleared endoscopically. The operation started with laparoscopic cholecystectomy followed by intraoperative cholangiography to delineate biliary anatomy and exclude retained common bile duct stones. Laparoscopic anterior RAMPS was then performed. The specimen was retrieved via a Pfannenstiel incision.

Results: Patient was discharged home well on post-operative day 4 with an uneventful recovery. Post-operative histopathology confirmed moderately differentiated ductal adenocarcinoma pT2N0, with satisfactory lymph node harvest and clear resection margin across all aspects.

Conclusion: Laparoscopic anterior RAMPS with splenectomy is a safe and feasible approach for selected patients with pancreatic body adenocarcinoma. This technique enables meticulous dissection, adherence to oncologic principles, and successful en-bloc resection while maintaining the advantages of minimally invasive surgery.

HOW WE PERFORM LAPAROSCOPIC TOTAL PANCREATECTOMY: TAIL-FIRST MOBILIZATION AND COUNTERCLOCKWISE TOTAL MESOPANCREAS DISSECTION

*Thanh Khiem NGUYEN, Ham Hoi NGUYEN, **Tuan Hiep LUONG**, Van Duy LE, Dinh Toi DO, Viet Anh DO, Phuong Anh VU*

Introduction: Despite advances in minimally invasive HPB surgery, total pancreatectomy is rarely performed laparoscopically because it requires meticulous vascular control and comprehensive retropancreatic dissection. We present a reproducible technique of laparoscopical total pancreatectomy (LTP) integrating a tail-first pancreatic mobilization with a counterclockwise dissection sequence to facilitate en bloc total mesopancreas dissection and nodal clearance.

Technique description: After establishing laparoscopic access, the pancreatic tail and body are mobilized retrogradely with spleen preservation. Dissection is initiated at the inferior margin of the pancreatic body, advancing from the left toward the right, and then extended in a counterclockwise direction to complete circumferential release of the body–tail segment. The splenic vessels are controlled and divided at the terminal portion of the tail while maintaining splenic perfusion. The mobilized pancreas is then gently tractioned to the right, which widens the retropancreatic working space and improves laparoscopic angles for arterial identification and dissection, including the splenic artery, gastroduodenal artery, and arteries within the retropancreatic plane. This setup also supports a right SMA-first step by providing earlier and clearer exposure of the SMA-related dissection field.

Results: Case 1 underwent laparoscopic total pancreatectomy with a tail-first, counterclockwise total mesopancreas dissection; operative time was 490 minutes and blood loss were 100 mL, and pathology confirmed a low-grade IPMN involving the pancreas from head to tail. Case 2 underwent the same laparoscopic strategy for multifocal pancreatic neuroendocrine tumors (NETs). In both cases, the tail-first mobilization with rightward traction improved retropancreatic exposure and facilitated en bloc total mesopancreas dissection with standard lymphadenectomy. This approach appears feasible for diffuse or multifocal pancreatic neoplasms such as IPMN and multifocal NETs.

Conclusion: The combination of tail-first retrograde mobilization and counterclockwise progression may simplify the most technically challenging phase of LTP-retropancreatic vascular dissection - while maintaining oncologic principles of en bloc mesopancreas removal and lymphadenectomy.

Laparoscopic total pancreatectomy, Total mesopancreas dissection, Tail-first approach, Counterclockwise technique

TOTAL LAPAROSCOPIC RAMPS USING A LEFT-POSTERIOR SMA FIRST APPROACH FOR DISTAL PANCREATIC CANCER: STEP-BY-STEP TECHNIQUE AND CLINICAL OUTCOMES

*Thanh Khiem NGUYEN, Ham Hoi NGUYEN, **Tuan Hiep LUONG,** Van Duy LE, Dinh Toi DO, Viet Anh DO, Phuong Anh VU*

Background: Radical antegrade modular pancreato-splenectomy (RAMPS) is intended to improve posterior margin clearance and lymph node dissection in distal pancreatic ductal cancer However, laparoscopic RAMPS remains technically demanding, particularly in achieving early vascular control and complete posterior dissection. This study aimed to present a standardized step-by-step technique and evaluate the clinical outcomes of total laparoscopic RAMPS using a left-posterior superior mesenteric artery (SMA) first approach.

Method: Patients with resectable or borderline resectable distal PDAC who underwent total laparoscopic RAMPS with a left-posterior SMA first approach between January 2021 and December 2025 were prospectively analyzed. Operative details, postoperative outcomes, pathological findings, and short-term oncologic outcomes were evaluated.

Results: Twenty-two patients underwent the procedure. Mean age was 60.1 ± 9.2 years. Mean operative time was 378 ± 66 minutes, and mean blood loss was 242 ± 115 mL. R0 resection was achieved in 93.8% of patients, with a mean lymph node yield of 29.3 ± 10.8. Major complications (Clavien–Dindo ≥ III) occurred in 2 patients (6.3%), and there was no 90-day mortality. Posterior margin invasion was found in 2 cases (6.3%), while nodal metastasis was observed in 43.8%. At a median follow-up of 18 months, 1-year disease-free survival and overall survival were 71.9% and 87.5%, respectively.

Conclusions: Total laparoscopic RAMPS using a left-posterior SMA first approach is safe, feasible, and oncologically sound for distal PDAC. The technique facilitates early vascular control, improves posterior mesopancreas clearance, and offers a reliable minimally invasive option for radical distal pancreatectomy, including in centers without robotic platforms.

Keywords: Laparoscopic RAMPS, Total mesopancreas dissection, Left-Posterior SMA-first approach, Distal pancreatic cancer

THE VALUE OF THE IWATE CRITERIA IN ASSESSING THE DIFFICULTY OF LAPAROSCOPIC LIVER RESECTION FOR HEPATOCELLULAR CARCINOMA AT A YOUNG SURGEON TRAINING CENTER IN VIETNAM

Hoai Kim NGUYEN, Thien Lai VO, Van Hung VO, Xuan Binh DAU, Phuoc Cong Thanh NGUYEN, Thanh Phuoc BUI

Introduction: Laparoscopic liver resection (LLR) has been increasingly applied in the treatment of hepatocellular carcinoma (HCC) due to its advantages, including reduced surgical trauma, decreased blood loss, and shorter hospital stay compared to open surgery. However, LLR remains a technically demanding procedure with a steep learning curve, particularly in centers implementing training programs for young surgeons.

The Iwate criteria (IC), proposed at the International Consensus Conference on LLR, is a scoring system that evaluates surgical difficulty based on six preoperative factors and classifies cases into four levels: low, intermediate, advanced, and expert. IC has been shown to be useful in predicting surgical difficulty, postoperative complications, and the risk of conversion to open surgery in patients undergoing LLR for HCC. However, data on its application in training settings in Vietnam remain limited.

This study aimed to evaluate the value of the Iwate criteria in surgical practice and in the training of young surgeons in laparoscopic liver resection.

Methods: A retrospective study was conducted on 52 patients with HCC who underwent LLR at Binh Dan Hospital from 2023 to 2025. Surgical difficulty was assessed preoperatively using the Iwate criteria based on six factors and categorized into four levels: low, intermediate, advanced, and expert.

Analyzed variables included operative time, intraoperative blood loss, length of hospital stay, postoperative complications, and the rate of conversion to open surgery. Logistic regression analysis was used to identify independent risk factors for conversion, and receiver operating characteristic (ROC) curves were constructed to evaluate the predictive value of the Iwate score.

Results: The median operative time was 205 minutes (range: 45–570 minutes). According to the Iwate classification, 23.1% (n=9) of cases were classified as low difficulty, 55.8% (n=29) intermediate, 15.4% (n=8) advanced, and 5.8% (n=3) expert level.

The Iwate score showed a statistically significant association with operative time, blood loss, and length of hospital stay ($p < 0.05$). The rate of postoperative complications increased with higher difficulty levels, being 0% in the low group, 37.9% in the intermediate group, 25% in the advanced group, and 66.7% in the expert group ($p < 0.05$).

Patients requiring conversion to open surgery had significantly longer operative time, greater blood loss, and longer hospital stay compared to those who underwent purely laparoscopic procedures ($p < 0.01$). Independent risk factors for conversion included higher Iwate difficulty score (OR 4.2; 95% CI: 1.5–11.6; p=0.006), tumor location near major vessels (OR 5.2; 95% CI: 1.3–21.1; p=0.019), and intraoperative events not controllable by laparoscopy (OR 11.3; 95% CI: 2.6–49.8; p=0.001).

ROC analysis demonstrated that the Iwate score had a moderate predictive value for conversion to open surgery, with an AUC of 0.734. At a cutoff value of 6.5, sensitivity was 50% and specificity was 87.5%.

Conclusion: The Iwate criteria is an effective tool for preoperative assessment of the difficulty of laparoscopic liver resection, as well as for predicting postoperative complications and the risk of conversion to open surgery in patients with HCC.

In the context of a young surgeon training center in Vietnam, the Iwate scoring system shows promising practical value in case stratification and in supporting the development of a safe, standardized, and competency-based training pathway for laparoscopic liver resection.

CASE REPORT: CONCURRENT PORTAL VEIN STENOSIS AND SMALL-FOR-SIZE SYNDROME AFTER LIVING DONOR LIVER TRANSPLANTATION

The Phuong BUI

Background: Hemodynamic complications, particularly small-for-size syndrome (SFSS) and portal vein stenosis (PVS), remain major challenges in living donor liver transplantation (LDLT). The coexistence of these two conditions further complicates diagnosis and poses a significant threat to early graft function.

CasePresentation: A 42-year-old male with alcohol-related cirrhosis (MELD score: 25) underwent right lobe living donor liver transplantation with a graft-to-recipient weight ratio (GRWR) of 0.84%.

Postoperative Course: From postoperative day (POD) 1–3, the patient developed acute kidney injury, hyperbilirubinemia, and massive ascites (2–3 liters/day).

Diagnosis and Intervention: Computed tomography (CT) revealed stenosis at the portal vein anastomosis associated with thrombosis of a subsegmental branch of segment VII. On POD 8, portal vein stenting was performed. Post-intervention measurements demonstrated an increase in portal venous pressure distal to the anastomosis (from 24 mmHg to 30 mmHg). Due to slow clinical improvement (persistent hyperbilirubinemia and refractory ascites), SFSS was suspected. On POD 10, splenic artery embolization was subsequently performed to modulate portal inflow.

Results: Following interventions, graft hemodynamics stabilized, bile output increased (>300 mL/day), and serum bilirubin gradually decreased to 2 mg/dL. The patient achieved clinical stability and was discharged on POD 55.

Conclusion: This case highlights the effectiveness of combined endovascular interventions (portal vein stenting and splenic artery embolization) in managing complex hemodynamic complications after LDLT. Close monitoring of portal venous pressure and flow is essential for early diagnosis and preservation of graft function.

DELAYED CHOLANGIOCARCINOGENESIS IN CHOLEDOCHAL AFTER CYSTDUODENOSTOMY – DIAGNOSTIC AND SURGICAL CHARACTERISTICS: A CASE REPORT AND LITERATURE REVIEW

*Thien Lai VO, Ho TRAN, **Hoai Kim NGUYEN**, Thanh Phuoc BUI*

Overview: Choledochal cyst is a rare congenital malformation of the biliary system that carries a 20–30% risk of malignant transformation if not completely resected or treated only by internal drainage via cyst-enterostomy. We present a rare clinical case of late malignant transformation of the biliary tract occurring 38 years after a choledochoduodenostomy, highlighting diagnostic challenges and important considerations in surgical planning.

Case Presentation: A 39-year-old female patient with a vague history of internal drainage surgery for a choledochal cyst at the age of one was admitted due to progressive jaundice and dark urine for one month, accompanied by fever and chills. No abdominal pain was reported. Clinical examination revealed jaundice and signs of infection. Laboratory tests showed elevated direct bilirubin and leukocytosis with neutrophil predominance. Tumor markers were within normal limits. Abdominal MSCT and MRI revealed a mass-like lesion at the upper third of the common hepatic duct, causing intrahepatic biliary dilatation. The lesion could not be clearly distinguished from biliary tract tumors, duodenal tumors, or Lemmel's syndrome. Upper gastrointestinal endoscopy revealed only a duodenal diverticulum at the D2 segment. The patient was scheduled for surgery to determine the nature of the biliary obstruction. Intraoperatively, the diagnosis was confirmed as malignant transformation of a choledochal cyst on the background of prior internal drainage (choledochoduodenostomy). Surgical management included complete excision of the cyst, lymph node dissection, and Roux-en-Y hepaticojejunostomy. Postoperative histopathology revealed a moderately differentiated adenocarcinoma of pancreatobiliary type, with no malignant cells found at the resection margins or regional lymph nodes.

Conclusion: It should be emphasized that the standard treatment for choledochal cyst is complete excision combined with hepaticojejunostomy. In cases where this is not feasible, cyst-enterostomy may serve as an alternative; however, meticulous life-long follow-up is crucial for early detection and timely management of complications. Moreover, thorough exploration of surgical history and detailed preoperative planning are vital for accurate diagnosis and appropriate surgical intervention.

Keywords: Choledochal cyst, cholangiocarcinoma, choledochoduodenostomy, hepaticojejunostomy.

DELAYED BILE LEAKAGE AFTER GANGRENOUS CHOLECYSTITIS: THE VALUE OF HEPATOBILIARY-SPECIFIC MAGNETIC RESONANCE IMAGING A CASE REPORT

Thi Kim Dung NGUYEN

Background: Bile leakage is a serious complication that may be easily overlooked following gangrenous cholecystitis because of its nonspecific clinical presentation. Conventional imaging modalities such as ultrasonography and computed tomography (CT) can detect intraperitoneal fluid but are limited in identifying the exact cause and site of leakage. Magnetic resonance cholangiopancreatography (MRCP) using hepatobiliary-specific contrast agents (Gadoxetic acid) is a non-invasive imaging technique that allows evaluation of the biliary excretory phase and direct visualization of bile leakage.

Case Presentation: An 82-year-old male was admitted with abdominal distension and persistent fever for two weeks. Physical examination revealed ascites and mild jaundice. Laboratory findings showed elevated C-reactive protein (CRP) and mildly increased bilirubin levels. Ultrasonography demonstrated a large amount of unexplained intraperitoneal fluid. Diagnostic paracentesis revealed an ascitic fluid-to-serum bilirubin ratio greater than 10, suggesting bile leakage. MRCP with Gadoxetic acid enhancement demonstrated delayed contrast extravasation from the gallbladder fundus. Surgical exploration confirmed bile leakage secondary to gangrenous cholecystitis. The patient had a favorable postoperative outcome following treatment.

Discussion: In suspected bile leakage related to gangrenous inflammation, postoperative complications, or invasive procedures, hepatobiliary contrast-enhanced MRCP enables accurate localization and assessment of the extent of bile leakage while simultaneously evaluating the entire biliary system without invasive procedures such as ERCP. This technique is particularly valuable in cases with delayed or atypical clinical presentation.

Conclusion: Gadoxetic acid-enhanced MRCP is a valuable non-invasive modality for the diagnosis of bile leakage, contributing to timely diagnosis and effective treatment planning.

MESOPANCREATIC INFILTRATION AND SURGICAL OUTCOMES OF PANCREATICODUODENECTOMY IN THE TREATMENT OF PERIAMPULLARY CARCINOMA AT BACH MAI HOSPITAL

Van Thong TRAN

Objective: To determine the rate of mesopancreas invasion, its associated factors, and to evaluate the early outcomes of pancreaticoduodenectomy combined with total mesopancreas excision in the treatment of periampullary carcinoma. Methods: A longitudinal descriptive study was conducted on 53 patients with periampullary carcinoma who underwent open pancreaticoduodenectomy combined with total mesopancreas excision from January 2025 to December 2025 at Bach Mai Hospital. Results: Pancreaticoduodenectomy combined with portal vein resection was performed in 24.6% of cases, and level 2 mesopancreas excision in 79.2%. The rate of mesopancreas metastasis was 37.7%, with the mean dimensions of the mesopancreas being 47.9 x 51.1 x 26.6 x 21.8 mm. The rates of mesopancreas invasion and lymph node metastasis were significantly associated with the tumor location. Postoperative complications included pancreatic fistula (17%), hemorrhage (15.1%), chylous leakage (9.4%), diarrhea (18.9%), delayed gastric emptying (11.3%), and Clavien-Dindo grade III complications (9.5%). There were no cases of mortality or discharge in terminal condition. Conclusions: Total mesopancreas excision is a feasible and safe surgical technique with a manageable complication rate. The high prevalence of mesopancreatic infiltration and lymph node metastasis in pancreatic head carcinoma necessitates the application of this procedure to optimize the R0 resection margin.

Keywords: Pancreaticoduodenectomy, Total mesopancreas excision.

BENIGN AND MALIGNANT BILIARY STRICTURES ON MRI IN THE SETTING OF HEPATOLITHIASIS: TWO CASE REPORTS

Thi Huong NGUYEN

Background: Differentiating benign biliary strictures caused by inflammation from malignant strictures such as cholangiocarcinoma in the setting of biliary stones remains a diagnostic challenge because of overlapping clinical manifestations and nonspecific imaging findings. Accurate pre-interventional diagnosis is essential for treatment planning and prognostic assessment. Magnetic resonance imaging (MRI) plays an important role in the non-invasive evaluation of biliary diseases.

Methods: We report two cases of biliary strictures associated with biliary stones. Both patients were admitted with abdominal pain and fever and underwent MRI evaluation. Imaging findings were analyzed and correlated with clinical presentation, laboratory data, and definitive postoperative histopathological diagnosis.

Results:

Case 1: A 67-year-old male presented with abdominal pain. Laboratory tests demonstrated elevated inflammatory markers and CA19-9 >1000 U/mL. Ultrasonography revealed dilatation and stones in the right posterior sectoral bile duct. MRI demonstrated biliary dilatation, hepatolithiasis, and stricture of the right hepatic duct associated with a hepatic lesion in the posterior sector. MRI findings included a long-segment stricture with asymmetric wall thickening. The corresponding liver parenchyma showed diffusion restriction on DWI/ADC, segmental atrophy, and poor enhancement across post-contrast phases. Surgical and histopathological findings confirmed infiltrative cholangiocarcinoma involving the posterior sector and right hepatic duct.

Case 2: A 68-year-old female presented with abdominal pain and fever. Laboratory findings showed elevated inflammatory markers and CA19-9 >1000 U/mL. Ultrasonography demonstrated hepatolithiasis with dilatation of the left lateral sectoral bile ducts. MRI revealed a short-segment biliary stricture without significant wall thickening but with a clear convergence sign. The left lateral liver segment was reduced in volume and showed arterial phase perfusion abnormalities; however, delayed-phase enhancement was homogeneous compared with the surrounding normal liver parenchyma. Surgical and histopathological examination demonstrated segmental hepatic fibrosis and atrophy associated with sclerosing cholangitis.

Conclusion: MRI provides multiple imaging features that may help differentiate benign from malignant biliary strictures. Important diagnostic criteria include the length of the stricture, enhancement pattern, degree of wall thickening, asymmetry, and associated adjacent hepatic parenchymal abnormalities.

Keywords: biliary stricture, cholangiocarcinoma, cholangitis, MRI, hepatolithiasis

LAPAROSCOPIC CENTRAL PANCREATECTOMY FOR BENIGN AND LOW-GRADE PANCREATIC NECK LESIONS

Le Huy Luu LE, *Quang Nghe HUYNH, Hien Thao Ly NGUYEN*

Background: Central pancreatectomy is a parenchyma-sparing surgical technique, typically indicated for benign or low-grade malignant lesions located in the pancreatic neck and body. Despite its significant advantage in preserving pancreatic function, the laparoscopic approach remains technically demanding and has been infrequently reported, particularly in Southeast Asia. This study aimed to evaluate the feasibility, safety, and postoperative functional outcomes of laparoscopic central pancreatectomy (LCP) in a selected patient cohort.

Methods: A retrospective case series of eight patients who underwent LCP at two tertiary referral centers was conducted. Inclusion criteria comprised tumors located in the pancreatic neck/body, benign or low malignant potential pathology, and sufficient residual pancreatic length to preserve function. The surgical technique involved laparoscopic resection and pancreatic reconstruction via posterior pancreaticogastrostomy. Perioperative and postoperative outcomes were collected and analyzed.

Results: Eight patients (mean age approximately 50 years, predominantly female) underwent surgery. Tumor size ranged from 3 to 5 cm. The mean operative time was 240–250 minutes, with minimal blood loss (<50 mL). No major complications, reoperations, or mortality were observed. Two cases of postoperative pancreatic fistula occurred, both classified as biochemical leaks (Grade A), requiring no intervention. The mean hospital stay was approximately 9 days. Both endocrine and exocrine pancreatic functions were preserved in most patients.

Conclusions: LCP is a minimally invasive, safe, and feasible procedure in carefully selected patients when performed by experienced surgeons. Although technically demanding with limited indications, this approach offers clear benefits in preserving pancreatic function and reducing surgical trauma. Initial results from Vietnam suggest that it is a valuable option in specialized centers.

LAPAROSCOPIC SPLEEN-PRESERVING DISTAL PANCREATECTOMY USING KIMURA TECHNIQUE FOR MAIN DUCT INTRADUCTAL PAPILLARY MUCINOUS NEOPLASM WITH OCCULT INVASIVE ADENOCARCINOMA: A CASE ILLUSTRATION

RRangga Kusuma MAULANA, Vania Myralda Giamour MARBU

Background: Main duct intraductal papillary mucinous neoplasm (MD-IPMN) carries a substantial risk of malignant transformation. Current guidelines recommend surgical resection when worrisome features are present. However, predicting occult invasive carcinoma preoperatively remains challenging even with advanced imaging. This case aims to highlight the diagnostic limitations and the oncological adequacy of laparoscopic spleen-preserving distal pancreatectomy (LSPDP) using the Kimura technique for MD-IPMN.

Methods: A 51-year-old male presented with recurrent abdominal pain requiring repeated hospitalization over six months. Serial MRI abdomen with gadoteric acid contrast demonstrated a multiloculated cystic lesion at the pancreatic tail communicating with a dilated main pancreatic duct (MPD diameter 0.9 cm, segment length 2.5 cm) with associated glandular atrophy, consistent with MD-IPMN with worrisome features (MPD dilatation 9 mm and pancreatic parenchymal atrophy). No high-risk stigmata were identified on imaging, including no enhancing intramural nodule, no MPD dilatation >1 cm, and no biliary obstruction. CA 19-9 was within normal limits (5 U/mL). The patient underwent elective LSPDP using the Kimura technique.

Results: The procedure was completed laparoscopically. Intraoperatively, the pancreatic texture was soft, a known risk factor for postoperative pancreatic fistula. Histopathological examination revealed IPMN with foci of invasive adenocarcinoma, staged pT1cNxMx - an unexpected finding not predicted by preoperative imaging or tumor markers. On postoperative day (POD) 5, biochemical leak Grade A (ISGPF classification) was detected and managed conservatively by maintaining the intraabdominal drain. The patient was discharged on POD 7 in good condition.

Conclusions: This case underscores the limitations of imaging and serum biomarkers in detecting occult invasive adenocarcinoma within MD-IPMN. Surgical resection is justified even in the absence of high-risk stigmata. LSPDP with the Kimura technique is a feasible, minimally invasive, and oncologically sound approach for tail MD-IPMN. Biochemical leak Grade A remains a manageable complication with conservative treatment.

OBESITY IS OFTEN CONSIDERED A BARRIER TO MINIMALLY INVASIVE PANCREATIC SURGERY – YET THIS CASE PROVES OTHERWISE.

Rizky Dwi Kurnia ANWAR

Background: Solid pseudopapillary neoplasm (SPN) of the pancreas is a rare epithelial tumor with low malignant potential, predominantly affecting young women. It most commonly arises in the pancreatic body and tail. Minimally invasive, spleen-preserving surgery is considered the optimal treatment; however, technical challenges may increase in obese patients.

Case: A 24-year-old woman presented with intermittent left upper abdominal pain. Imaging revealed a well-defined solid-cystic lesion measuring 2.5 × 3 × 2 cm in the pancreatic tail, without vascular invasion or distant metastasis. Her body mass index was 38.3 kg/m² (grade II obesity). A diagnosis of SPN was established based on clinical and radiological findings.

Management and Results: The patient underwent laparoscopic spleen-preserving distal pancreatectomy. The procedure was completed successfully without intraoperative complications, despite limited exposure due to increased intra-abdominal adiposity. Histopathological examination confirmed SPN with negative margins (R0 resection). The postoperative course was uneventful, with no clinically relevant pancreatic fistula. The patient recovered well with an optimal hospital stay.

Discussion: SPN has an excellent prognosis, with survival rates exceeding 95% after complete resection. Laparoscopic spleen-preserving distal pancreatectomy offers advantages in preserving immunological function and reducing splenectomy-related morbidity. Although obesity increases technical complexity, this approach remains safe and feasible in experienced hands.

Conclusion: Laparoscopic spleen-preserving distal pancreatectomy is a safe and effective treatment for SPN of the pancreatic tail, even in obese patients, providing favorable outcomes with minimal morbidity.

Keywords: Solid pseudopapillary neoplasm, distal pancreatectomy, spleen-preserving, laparoscopy, obesity

DELAYED IMMUNOSUPPRESSION AFTER LIVER TRANSPLANTATION IN HIGH-RISK PATIENTS: A CASE REPORT

*MVan Manh NGUYEN, **Thanh Huy DOAN**, Van Quynh NGUYEN, Duc Trung LE, Manh Khoe NGUYEN.*

Background: Immunosuppressive therapy is essential for preventing graft rejection after liver transplantation, with calcineurin inhibitors (CNIs), particularly tacrolimus, forming the backbone of most treatment regimens. However, early initiation of CNIs is associated with significant adverse effects, including nephrotoxicity and hemodynamic instability, especially in critically ill patients. Delayed immunosuppression (DIS) has been proposed as an individualized strategy to mitigate these risks while maintaining adequate control of graft rejection.

Case presentation: We report the case of a 39-year-old male with untreated chronic hepatitis B who presented with hepatic encephalopathy and acute-on-chronic liver failure (ACLF) on the background of decompensated cirrhosis. On admission, laboratory findings included prothrombin 27% (INR 2.2), AST 154 U/L, ALT 52 U/L, total bilirubin 210 µmol/L, direct bilirubin 90.2 µmol/L, creatinine 193 µmol/L, and serum ammonia 209 µmol/L. The MELD score was 35 and the AARC score was 12, indicating a poor prognosis.

The patient underwent five sessions of therapeutic plasma exchange (TPE) prior to emergency living donor liver transplantation, with a total ICU stay of 5 days. The graft was a right liver lobe from a 19-year-old male donor, weighing 512 gr, with venous reconstruction using a vascular graft. The transplantation was uneventful, with an operative time of approximately 10 hours and an estimated blood loss of 4.5 liters.

Given the patient's critical condition and high risk of early postoperative complications, particularly acute kidney injury (creatinine on postoperative days 0 and 1 were 178 µmol/L and 192 µmol/L, respectively), a delayed immunosuppression strategy was adopted. Induction therapy with corticosteroids and basiliximab was initiated immediately after transplantation, while tacrolimus and mycophenolate mofetil (MMF) were intentionally delayed until postoperative day 5.

In the early postoperative period, liver enzymes increased markedly, consistent with ischemia–reperfusion injury rather than acute rejection. Following initiation of tacrolimus and achievement of therapeutic levels, liver function progressively improved without clinical or biochemical evidence of rejection. Renal function remained stable throughout follow-up, and no severe infectious complications were observed.

Discussion: This case highlights the clinical feasibility of delayed initiation of CNIs in carefully selected high-risk liver transplant recipients. Current evidence suggests that, when combined with appropriate induction therapy, delayed tacrolimus does not significantly increase the risk of acute rejection and may reduce early renal dysfunction and drug-related toxicity. However, this approach requires careful patient selection, close monitoring, and individualized decision-making.

Conclusion: Delayed immunosuppression is not a standard protocol but may represent a valuable individualized strategy in critically ill liver transplant patients. Balancing the risk between rejection and infection remains the key principle in optimizing post-transplant outcomes.

Keywords: liver transplantation, delayed immunosuppression, tacrolimus, ACLF, case report, graft rejection

APPLICATION OF 3D CT-BASED LIVER VOLUMETRY IN PREOPERATIVE DECISION-MAKING FOR HEPATIC RESECTION: AN INITIAL EXPERIENCE FROM A SINGLE CENTER

Nguyen Duc NGUYEN

Background: Accurate assessment of future liver remnant is essential for safe hepatic resection. In centers without access to liver hypertrophy techniques such as portal vein embolization or ALPPS, preoperative decision-making relies heavily on precise future liver remnant estimation to determine surgical feasibility. Three-dimensional (3D) CT-based liver volumetry may improve anatomical visualization and volumetric accuracy. This study aimed to evaluate the initial experience of implementing 3D liver volumetry in preoperative decision-making.

Methods: A retrospective descriptive study was conducted at a newly established hepatobiliary unit from mid-2025. Patients with large or anatomically complex liver tumors, in whom major resection was anticipated, underwent 3D reconstruction and volumetric analysis using 3D Slicer software.

The future liver remnant was calculated based on 3D segmentation. The impact of 3D volumetry on surgical decision-making was assessed, including whether patients proceeded to resection or were deemed unsuitable due to insufficient FLR.

Results: A total of 10 patients were included. The median future liver remnant was 36%. Based on 3D volumetric assessment, 4 patients were considered suitable for hepatic resection, whereas 6 patients were deemed at high risk due to inadequate FLR and were not offered surgery.

In several cases, 3D volumetry provided additional anatomical and volumetric insights not clearly appreciated on conventional imaging, particularly in tumors involving or adjacent to major vascular structures. This contributed to changes in surgical decision-making by avoiding potentially unsafe resections.

Conclusion: 3D CT-based liver volumetry is a feasible and practical tool in the early phase of developing a hepatobiliary surgery program. In resource-limited settings without access to liver hypertrophy techniques, it plays a key role in determining surgical feasibility through more accurate future liver remnant assessment. Routine incorporation of 3D volumetry may improve patient selection and support safer surgical strategies.

A MODIFIED ACCESS PORT TO FACILITATE RECONSTRUCTION IN LAPAROSCOPIC PANCREATICODUODENECTOMY: AN INITIAL CASE SERIES

Trung Dung HO

Background: Laparoscopic pancreaticoduodenectomy (LPD) remains technically demanding, particularly during the reconstruction phase. Intracorporeal anastomoses are time-consuming and associated with a risk of postoperative complications, including pancreatic fistula. We describe a cost-effective, self-constructed Modified Access Port (MAP) designed to facilitate extracorporeal reconstruction through a minimal extraction site.

Methods: A retrospective case series was conducted of patients undergoing LPD at our center. The MAP was constructed using two rings fashioned from suction tubing and a sterile surgical glove. The extraction site was planned intraoperatively to optimize access for both specimen retrieval and reconstruction.

Following specimen removal, the MAP was inserted to provide soft tissue retraction and access for extracorporeal hand-sewn pancreaticojejunostomy and gastrojejunostomy, while hepaticojejunostomy was completed intracorporeally.

Results: A total of 8 patients underwent LPD using the MAP technique. The MAP provided adequate exposure of the anastomotic field through a small incision (mean 7 cm), corresponding to the specimen extraction site. This enabled precise hand-sewn anastomoses and improved surgical ergonomics during reconstruction. No intraoperative complications or device-related issues were observed. The use of MAP did not appear to increase postoperative complications, including clinically relevant pancreatic fistula.

Conclusion: The Modified Access Port is a simple, cost-effective adjunct that facilitates reconstruction in laparoscopic pancreaticoduodenectomy. By enabling extracorporeal hand-sewn anastomoses through a minimal incision, it preserves the benefits of minimally invasive surgery while improving technical feasibility. This approach may be particularly useful during the early adoption phase of LPD, especially in resource-limited settings.

EVALUATE THE RESULTS OF USING BLUMGART-STYLE PANCREATICOJEJUNOSTOMY IN PANCREATICODUODENECTOMY SURGERY AT BINH DAN HOSPITAL

Van Hung VO

Background: Postoperative pancreatic fistula (POPF) remains the most common and clinically significant complication following pancreaticoduodenectomy. The Blumgart-style pancreaticojejunostomy has been increasingly adopted and may reduce clinically relevant fistula rates. This study aimed to evaluate the outcomes of Blumgart-style pancreaticojejunostomy in patients undergoing pancreaticoduodenectomy.

Methods: A retrospective descriptive study was conducted including patients with periampullary tumors who underwent pancreaticoduodenectomy with Blumgart-style pancreaticojejunostomy at a single tertiary center between January 2018 and March 2026

Demographic data, operative details, and postoperative outcomes were analyzed, with particular focus on pancreatic fistula and overall complications.

Results: A total of 85 patients were included. The mean age was 57 ± 12 years. The mean operative time was 357 ± 105 minutes, and the mean postoperative hospital stay was 16.1 ± 7.8 days.

Postoperative complications occurred in 35 patients (41.2%). Pancreatic fistula was observed in 23 patients (27.1%), with only one case of grade C fistula. One patient required reoperation due to postoperative hemorrhage. There were no postoperative mortalities.

Conclusion: Blumgart-style pancreaticojejunostomy is a safe and feasible technique in pancreaticoduodenectomy, associated with a low rate of clinically severe pancreatic fistula. Its application may contribute to favorable postoperative outcomes and supports its routine use in pancreatic reconstruction.

COMPARISON OF 16G AND 20G NEEDLES IN PERCUTANEOUS TRANS-HEPATIC BILIARY DRAINAGE: REAL-WORLD DATA FROM NHAN DAN GIA DINH HOSPITAL

*Kim Long LE, Khanh Phat THAI, **My Tran TRINH**, Minh Quang TRAN*

Tri Nhan PHAM, Phu Cuong PHAM, Nguyen Khoi LE

Background: Percutaneous trans-hepatic biliary drainage (PTBD) is usually performed with either a large-bore 16-gauge (16 G) or a fine 20-gauge (20 G) needle, yet evidence for a bleeding advantage of the smaller needle is inconclusive.

Materials & Methods: We retrospectively analysed 102 malignant-obstruction PTBDs (57 with Secalon 16 G and 45 with fine-needle 20 G). Technical success was the primary end-point; secondary end-points were procedure time, overall bleeding and severe complications-defined as life-threatening haemorrhage or visceral perforation requiring intervention. Fisher's exact or Welch's t tests (two-sided; $\alpha = 0.05$) were used.

Results: echnical success was high in both groups-94.7 % with 16 G versus 84.4 % with 20 G ($p = 0.10$). Median procedure time was significantly shorter with 16 G (30 min, IQR 20–45) than with 20 G (40 min, IQR 25–50; $p = 0.013$). Overall bleeding occurred in 8.8 % and 11.1 % of cases, respectively ($p = 0.75$). Three severe complications-all in the 16 G arm (5.3 %) and all performed by inexperienced operators-included two massive haemorrhages and one subcapsular visceral perforation with focal bile peritonitis; none were observed after 20 G PTBD ($p = 0.25$). In left-lobe punctures, mean duct diameter tended to be larger in the 16 G group (12.8 ± 4.1 mm versus 10.7 ± 4.3 mm; $p = 0.076$), whereas right-lobe diameters were similar ($p = 0.74$).

Conclusion: Both needles yield high technical success and comparable overall bleeding. The 16 G needle shortens procedure time and is preferentially selected for markedly dilated ducts, but the present sample lacks power to establish a bleeding difference. A multicentre trial with at least 200 patients per arm is required to confirm superiority or non-inferiority of the 20 G needle in haemorrhagic safety. Importantly, inexperienced operators should avoid 16 G needles when performing PTBD.

Keywords: Percutaneous transhepatic biliary drainage, Malignant biliary obstruction, Bleeding complication.

INITIAL APPLICATION OF INDOCYANINE GREEN (ICG) FLUORESCENCE IN LAPAROSCOPIC SURGERY FOR RECURRENT BILIARY STONE DISEASE AT MILITARY HOSPITAL 175

Van Manh NGUYEN; Thanh Huy DOAN; Van Quynh NGUYEN; Manh Khoe NGUYEN; Duc Trung LE; Hoang Gia NGUYEN

Background: Recurrent biliary stone disease is a complex condition in which laparoscopic surgery is often challenging due to postoperative adhesions and altered anatomy. Previous studies have reported conversion rates to open surgery ranging from 10% to 30%, with a considerable risk of intraoperative complications. Indocyanine green (ICG) fluorescence imaging enhances visualization of the biliary anatomy; however, its role in recurrent biliary stone surgery has not been widely studied.

Methods: A prospective descriptive study was conducted on 18 patients with recurrent biliary stones who underwent laparoscopic surgery combined with intraoperative choledochoscopy using ICG fluorescence at Military Hospital 175 from March 2025 to March 2026.

Results: The mean age was 54.24 years (range: 28–72), with a female predominance (77.8%). Most patients had a history of one previous surgery (55.6%), and 72.2% experienced recurrence after more than two years. Isolated common bile duct stones accounted for 61.1% of cases, while combined common bile duct and intrahepatic stones were observed in 38.9%. The conversion rate to open surgery was 5.6%. The mean operative time was 106 ± 25.5 minutes, and no intraoperative complications were recorded. The mean hospital stay was 7.2 days. The primary stone clearance rate was 88.9%, while the planned residual stone rate was 11.1%.

Conclusion: The initial application of ICG fluorescence in laparoscopic surgery for recurrent biliary stone disease appears to be feasible, safe, and effective.

Keywords: Indocyanine green; fluorescence imaging; laparoscopy; choledochoscopy; recurrent biliary stones.

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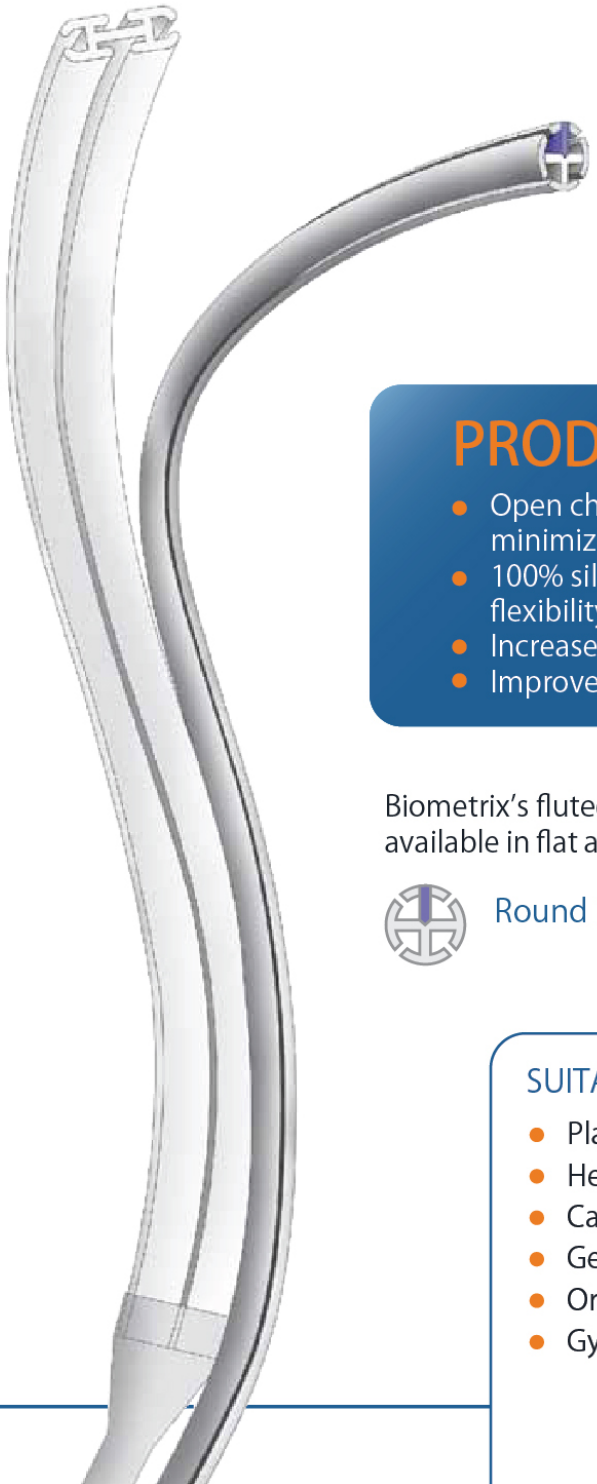

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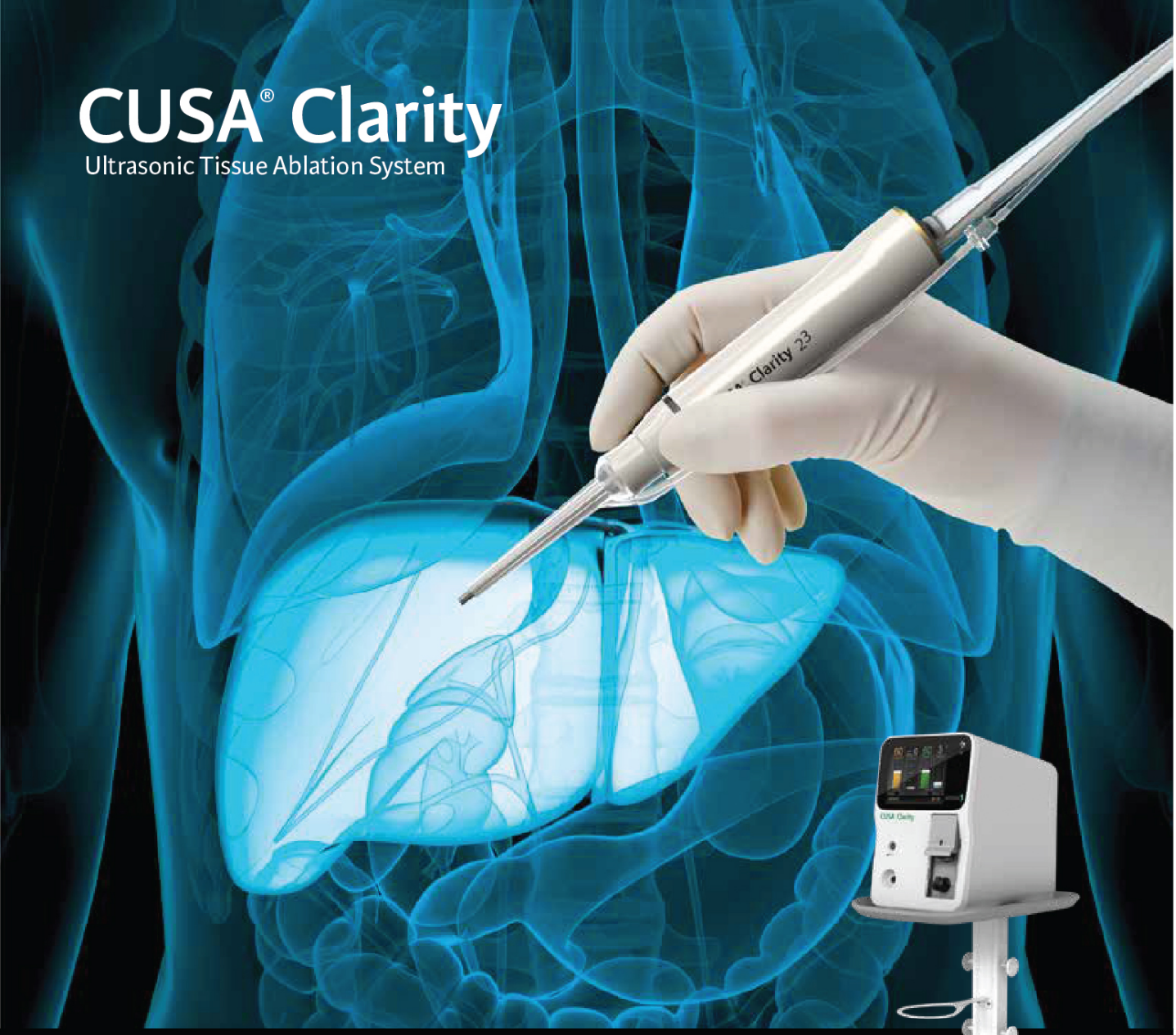

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– El Moussaoui, et al., *Minerva Chir.* 2018.

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– Ruiz-Tovar, et al., *Int J Surg.* 2018.

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– Gagner, et al., *Surg Endosc.* 2020.

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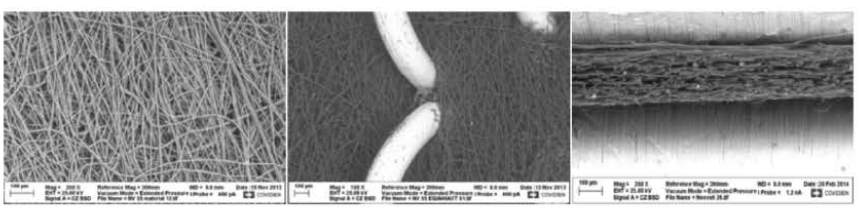
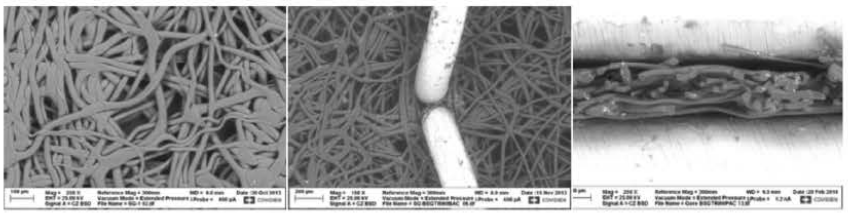


Tri-Staple™ 2.0 reinforced reload material morphology (250x), with staple leg penetration (150x), and a cross section (250x)†



Seamguard™* material morphology (250x), with staple leg penetration (150x), and a cross section (250x)†

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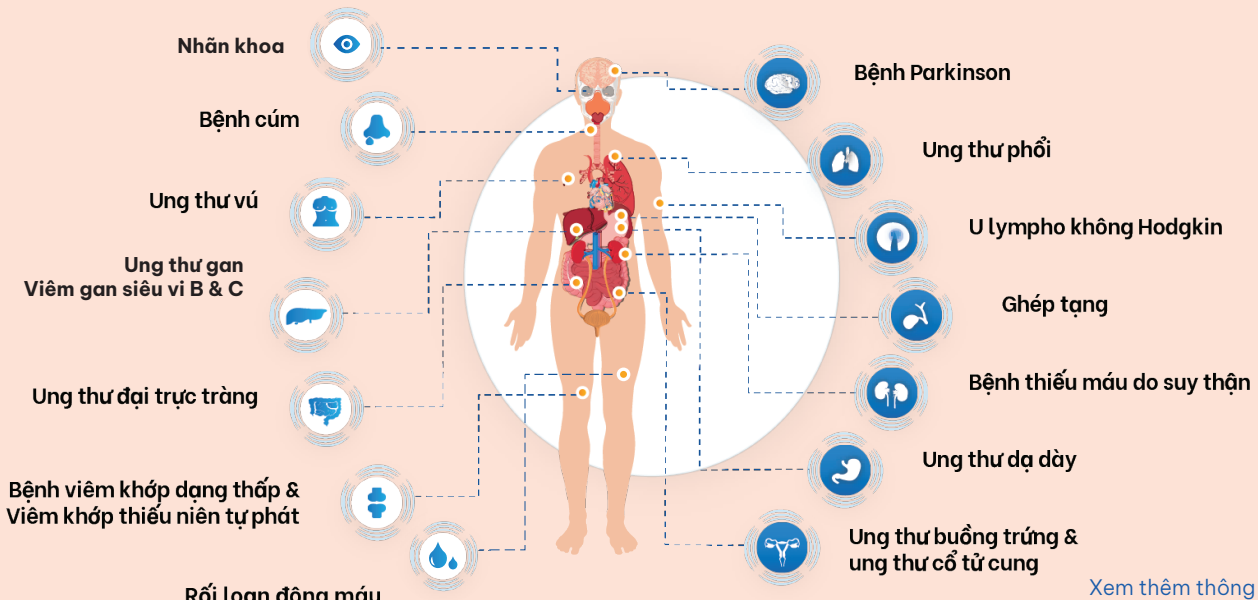

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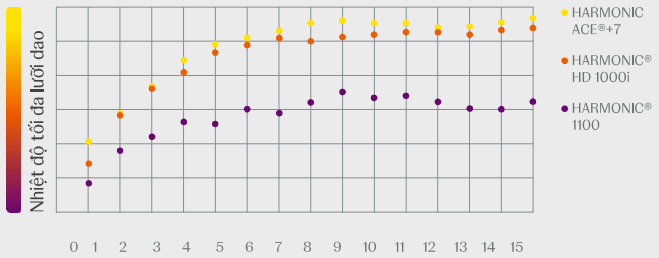

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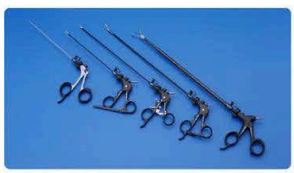
- Đánh giá tưới máu gan
- Phẫu thuật xâm lấn tối thiểu

Ứng dụng trong phẫu thuật cắt gan nội soi, phẫu thuật tổn thương gan, đánh giá tưới máu mô và hỗ trợ nhận diện đường mật trong phẫu thuật.



02 Panther Healthcare – Giải pháp Stapler thông minh thế hệ mới

Là đơn vị tiên phong trong phẫu thuật **xâm lấn tối thiểu (MIS)**, Panther Healthcare cung cấp dòng **Stapler điện thông minh** với ưu điểm:

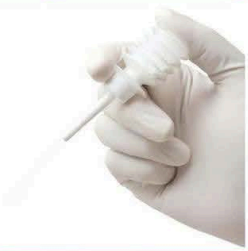
- Tối ưu lực bắn và độ chính xác
- Giảm sai số thao tác
- Nhận diện độ dày mô và điều chỉnh tốc độ bắn tương ứng
- Nâng cao hiệu quả khâu – đóng trong phẫu thuật

Ứng dụng trong phẫu thuật cắt thùy phổi, phẫu thuật tiêu hóa trực tràng, đại trực tràng.

03 Becton Dickinson (BD) – Kiểm soát chảy máu và vật tư phẫu thuật

BD Surgery cung cấp các giải pháp toàn diện về kiểm soát chảy máu và khâu đóng mô. Sản phẩm tiêu biểu **Arista™ AH** – bột cầm máu 100% nguồn gốc thực vật – sở hữu nền tảng bằng chứng lâm sàng vững chắc nhất hiện nay. Với hơn 20 nghiên cứu đa chuyên khoa, Arista™ AH giúp giảm thời gian cầm máu, giảm lượng máu mất và được FDA cấp chứng nhận PMA về độ an toàn, hiệu quả.

One Medical cam kết trở thành **đối tác chiến lược** của các cơ sở y tế và ngoại khoa Việt Nam.



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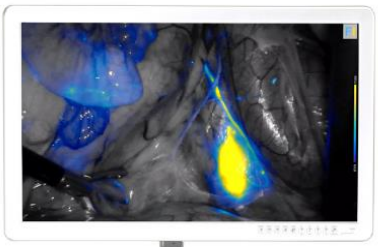

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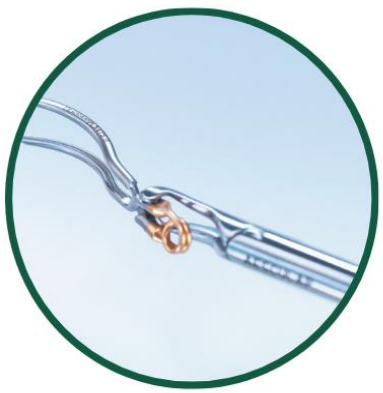

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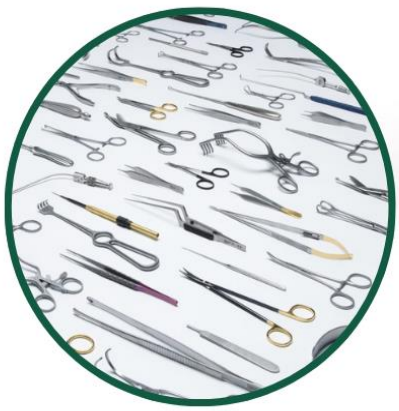

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HỆ THỐNG PHẪU THUẬT ROBOT DA VINCI XI

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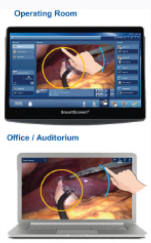
- Giảm xâm lấn cho bệnh nhân và nâng cao hiệu quả điều trị.
- Công nghệ hình ảnh huỳnh quang Firefly® tích hợp khả năng quan sát mạch máu, đường mật và tưới máu mô thời gian thực.



OR1 - GIẢI PHÁP PHÒNG MỔ TÍCH HỢP



- Kết nối và đồng bộ toàn bộ thiết bị trong phòng mổ
- Tín hiệu hình ảnh 4K truyền đi tốt không có suy hao.
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- Tối ưu mọi góc nhìn trong phẫu thuật nội soi.
- Tích hợp công nghệ ICG hỗ trợ nhận diện đường mật và tưới máu trong phẫu thuật.

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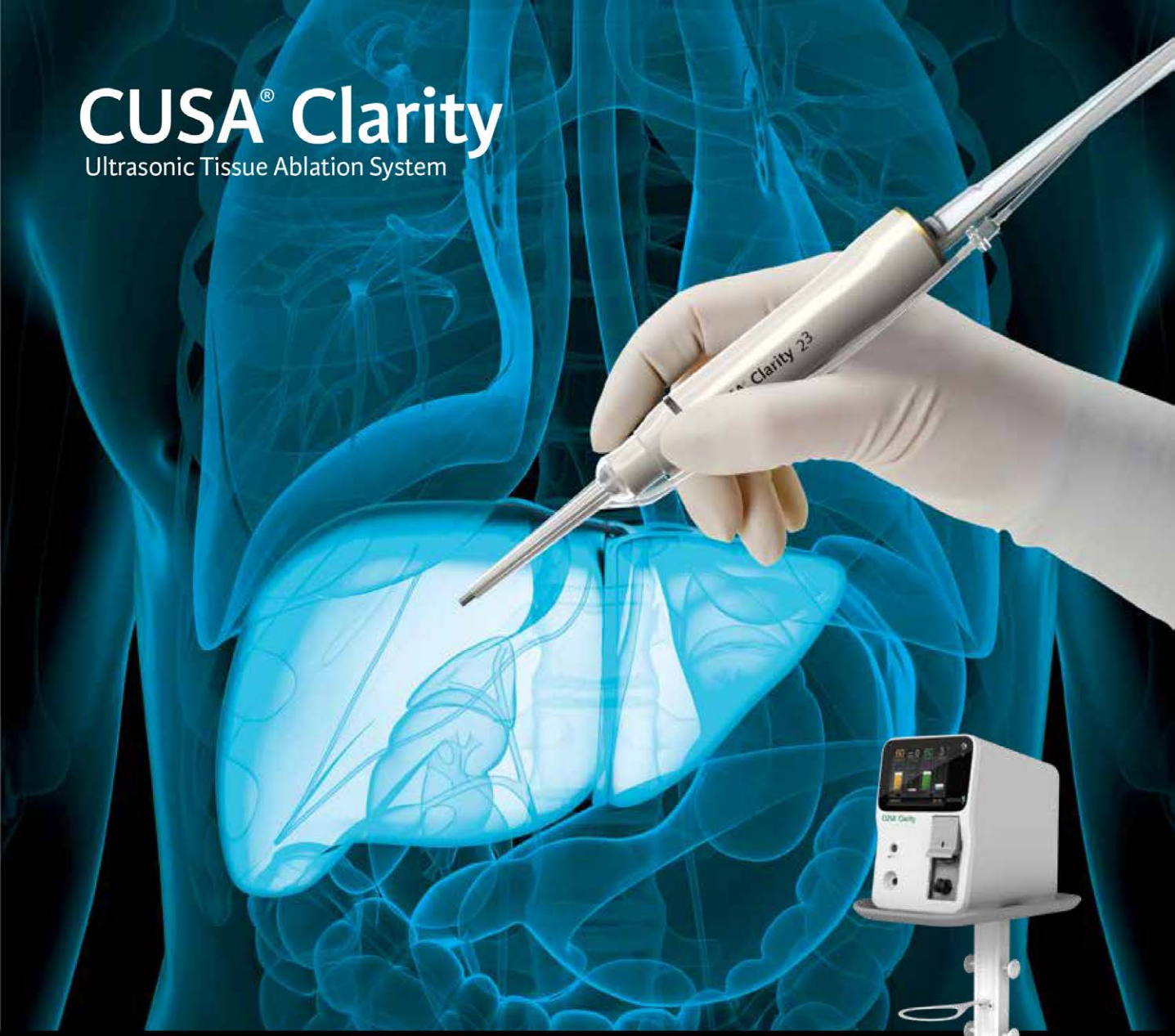

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