

Editorial

Liver Transplantation in Pediatrics

Yasuhiko Sugawara *

Department of Transplantation/ Pediatric Surgery, Postgraduate School of Life Science, Kumamoto University, 1-1-1 Honjo, Chuo-ku, Kumamoto 8603-8556, Japan; E-Mail: yasusuga-ky@umin.ac.jp

* **Correspondence:** Yasuhiko Sugawara; E-Mail: yasusuga-ky@umin.ac.jp

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Since the first case, which was indicated for biliary atresia by Starzl in 1967, the pediatric liver transplantation has gradually developed so far. The 5-year survival rate is currently around 85–90% in well-established centers of pediatric liver transplantation [1].

Apparently, liver transplantation has now become the standard treatment for the children with chronic end-stage liver disease, tumors (hepatocellular carcinoma, hepatoblastoma), metabolic diseases, and acute liver failure [2]. The techniques to harvest and procure split-liver grafts from deceased or living donors have been refined. The availability of organs has increased, and the waitlist mortality of the patients has decreased. Around 90% of the patients on the waitlist now eventually undergo liver transplantation [1].

The postoperative care has been well optimized by the introduction of a multidisciplinary team consisting of transplant surgeons, pediatricians, pediatric transplant hepatologists, transplant coordinators, psychologists, and social workers [3]. The clinical efforts have shifted from preventing mortality to improving the morbidity with satisfactory postoperative outcome. It is important to tailor the immunosuppressive drugs to prevent acute or chronic cellular rejection or antibody-mediated rejection. It can also contribute to avoiding infection and posttransplant



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lymphoproliferative disease. The patients must be closely followed up, and the liver enzymes, function, and immunosuppressive drug levels should be monitored. Adherence to the medication is sometimes challenging in adolescents and young adults, and at the same time, nonadherence results in rejection and graft loss.

An interesting issue is that some children can be introduced to the operational tolerance. According to the multicenter trials on the withdrawal of the immunosuppressive drugs, a successful tolerance rate of approximately 60%, in the selected recipients based on a biochemical and histological basis, was observed [4].

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