Rezumat

**Hepatoportoenterostomia în colestază obstructivă selectivă – un nou model experimental pe șobolan**

*Introducere:* Atrezia biliară reprezintă cea mai frecventă cauză de colestază obstructivă neonatală. În prezent, hepatoportoenterostomia (HPE) este singura modalitate de prelungire a vieții până în momentul efectuării transplantului hepatic, cea mai mare rătă de succes fiind înregistrată în primele 60 de zile de viață.

*Scop:* Ne-am propus să elaborăm un model experimental de drenaj al colestazei prin intermediul HPE.

*Material și metodă:* Obstrucția căilor biliares a fost indusă prin ligatură selectivă a ductelor corespunzătoare lobilor hepatici median și lateral stâng, la 20 de șobolani rasa Wistar. La 4 săptămâni postoperator s-a reintervenit chirurgical în vederea realizării drenajului biliar prin HPE. Integritatea anastomozei și modificările hepatice s-au evaluat după o săptămână.

*Rezultate:* Rata de supraviețuire a fost de 90%. Reintervenția chirurgicală a evidențiat aderență hepatobiliiare, cu fibroză la nivelul hilului hepatic. Microscopic, s-a evidențiat fibroza incipientă cu colestază moderată. După efectuarea HPE nu s-a decelat extravazare de bilă la nivelul anastomozei sau peritonită biliară. Evoluția a fost marcată de reducerea alimentației.

*Concluzii:* Modelul experimental propus pentru HPE este fiabil prin utilizarea tehnicilor de microchirurgie. Pe baza acestuia se pot studia modificările induse de obstrucția ductelor biliares.

Cuvinte cheie: atrezie biliară, drenaj biliar, colestază, experimental, portoenterostomie
Introduction

Biliary atresia (BA) is a rare perinatal pathology, with unknown etiology. The mechanisms responsible for BA are explained by several theories, involving immunologic factors, genetics, ischemia or infection (1). Progressive obstructive cholestasis is a key element of BA and, if not addressed, it eventually leads to liver failure and to patients' death. Despite the reported progress (2) in the management of BA and the subsequent cholestasis, the only alternative to efficiently relieve cholestasis on the long term in BA is liver transplantation. However, due to shortage of suitable liver donors and the adverse effects of lifelong immunosuppression non-transplant approaches are favoured as a first step. The internal drainage of the dilated intrahepatic biliary tree by the means of a Roux-en-Y jejunal loop – hepatoportoentero-stomy (HPE) - is lifesaving until a transplant becomes available. With this type of surgical procedure, patients can achieve a 88% survival rate at 5-years with their native liver, while the 10-year survival rate can be up to 77% (2,3).

Failure of HPE is frequent due to cholangitis and fibrosis and ultimately results in biliary cirrhosis. Several approaches aiming at controlling inflammation and improving the bile flow by means of corticosteroids, diet or ursodeoxycholic acid have yielded conflicting or inconclusive results. Given the relative rarity of this condition and the difficulty of performing randomized, controlled trials in this vulnerable patient population, animal studies could provide valuable information on the injury and repair processes after the biliary drainage by means of HPE. Several straightforward rodent models have been suggested, most involving the ligature of the common bile duct. However, this intervention is often associated with excessively high mortality and complications, such as hilum pseudocyst, ascites and hepatosplenomegaly (4,5).

Therefore, we aimed to develop a novel experimental model of HPE in the rat, a robust, adequately sized and cheap species using a two-stage microsurgical approach.

In order to induce the obstructive cholestasis, we have chosen a micro-surgical technique, because in the macro-surgical model, the ligature of the common bile duct was associated with higher mortality and...
complications, such as hilum infected pseudo-
cyst, ascites, hepatosplenomegaly, while micro-
surgery avoided these complications (6).

Material and Method

Experimental Design

The experiment consisted in two surgical
steps. The first surgical procedure was per-
formed in 20 rats and consisted in creating a
proximal biliary obstruction by resecting the
bile ducts in two hepatic lobes: median and left
lateral with a follow-up of 4 weeks. In 16 rats,
a second surgical procedure was performed
and a HPE was performed between the
hepatic parenchyma and an enteral loop in the
hilum of the two hepatic lobes with previous
bile duct resection, after the liver lobes were
biopsied. A number of 4 rats were kept as a
control group. Animals were monitored for
food intake and complications. A week after
the HPE, a re-laparotomy was performed in
all rats in order to assess the macroscopic
changes and to perform liver biopsies for
histologic assessment.

The study design was approved by the
Ethic Committee of “Iuliu Hațieganu”
University of Medicine and Pharmacy.

Animals

Female Wistar rats weighing 250-300 g were
used. All animals were maintained in the
animal facility of “Iuliu Hațieganu” University
of Medicine and Pharmacy in Cluj-Napoca, on
standard laboratory diet and water ad libitum.

Surgical Protocol

Anaesthesia

The animals were anaesthetized using a
Ketamine and Xylazine based protocol. The
necessary dose of Ketamine was 80 mg/kg and
Xylazine 8 mg/kg. A combination of the two
substances was obtained in a 2:1 proportion
Ketamine 10%; Xylazine 2% in an insulin
syringe sized 100 UI/ml. The animals were
weighed. An 18 UI solution was administered
for 150 g and for every 25 g excess weight, 3 UI
were added. If necessary, a reminder dose was
administered using 4 UI Ketamine 10%.

Microscopic bile duct ligature

In all 20 Wistar rats, a laparotomy was
performed using a midline incision. The liver
was retracted in cranial position and the bile
ducts of the four liver lobes were exposed
(Fig. 1. A). The bile ducts of the median and left
lateral lobes, accounting for about 60% of the
liver volume, were identified and ligatured
with 7-0 polypropylene near the hepatic
parenchyma with a second ligature placed
distally at 0.5 centimetres to the first one
(Fig. 1.B). The bile ducts between ligatures
were excised (Fig. 2 A, B). A part of the
common bile duct collecting the bile from the
two hepatic lobes was also excised between
ligatures. The bile ducts of the right lateral
and caudate lobes were left intact. A parenchy-
mal connection between the right lateral and
median lobe was searched in order to avoid
biliary drainage through collateral ducts. The
abdominal wall was closed using an 6.0
continuous suture made of polypropylene.

The presence of jaundice was evaluated, as
reported by Yunfu et al, by visual evaluation of
the eyes and skin (ears and tails) colour, on
day by day basis (7).

Hepatoportoenterostomy

After four weeks, 16 rats were selected for a
second surgical procedure and four animals
were kept as a control group, in order to
evaluate their survival and quality of life. A
re-laparotomy was performed and the macro-
copic and microscopic changes were assessed.
The hepatic lobes were biopsied. The adhe-
sions were sectioned and the hepatic hilum
was exposed. The fibrous tissue identified in
the hilum of the median and left lateral lobes
was excised proximal to the excised segment
of the bile duct, with adjacent hepatic
parenchyma, delineating an area of approxi-
mately 0.7 square centimetres (Fig. 3). The
second jejunal loop (5 cm distal from Treitz lig-
ament) was mobilized as an Roux-en-Y loop and sutured over the raw hepatic parenchyma using a 9.0 continuous polypropylene suture (Fig. 1A).

The biopsied tissue was analyzed microscopically, using HE staining and testing the positivity of fibrosis markers (Fig. 1B).

One week later, a re-laparotomy was performed once again in all 16 rats and the macroscopic changes were assessed. At the end of the procedure, the entire group was sacrificed using an anaesthetic overdose.

The pathological changes in the abdominal cavity were assessed macroscopically. The surgical procedures were performed and photographed using a Leica binocular microscope.

**Results**

Throughout the study, the survival rate was 90%. Death occurred in two rats (10%) because of an important bleeding from the hepatic lobes, during the second surgical procedure. Jaundice was absent in all rats, whether the hepatoportoenetrostomy was
performed or not. No parenchymal connection was identified between the median and right lateral hepatic lobes. In 10 rats, wound complications were registered 2 weeks after the first surgical procedure. In six animals, partial wound dehiscence was noticed, with local secretions. After wound cleaning and local antibiotherapy, the evolution was favourable with granulation and complete healing until the second surgical procedure. In other 4 rats, eventration (abdominal wall hernia) was noticed, which was solved during the second surgical procedure by direct suture. The second operation revealed adhesions between the liver capsule and the hepatic hilum. The microscopic analysis revealed an incipient fibrogenic process, with moderate, chronic cholestasis. A positive expression of the fibrotic markers was also identified. After

Figure 3. Macroscopic aspect. Fibrous tissue at the hilum of the median and left lateral lobe (arrow). M - median hepatic lobe; LL - left lateral hepatic lobe.

Figure 4. Hepatoportoenterostomy. (A) – Anastomosis in the median lobe (HP, arrow) and the proximal enteral end (IL, curved arrow); (B) – Portoenterostomy in the median hilum (HP, arrow) and entero-ental anastomosis (IA).
M - median hepatic lobe; LL - left lateral hepatic lobe; IL - intestinal loop; HP - hepatopancreaticoenterostomy; IA - intestinal anastomosis.

Figure 5. Microscopic aspect after 4 weeks of bile ducts ligature (HE x 40). Pericentrolobular activated stellate Ito cells, that mark the onset of fibrogenesis: stellate cells with hypercroma, condensed nucleus and hyperesinophilic cytoplasm; the cells were also positive for fibrotic markers.
cutting the adhesions, the hilum was exposed and a fibrous tissue was noticed in the area where the bile ducts were ligated, corresponding to the median and left lateral liver lobes. In the area where the fibrous tissue was excised with the adjacent hepatic parenchyma, no remarkably dilated bile ducts were identified. After the second procedure, no wound complications were registered, but local antibiotic prophylaxis was performed. One week after the HPE, there were no signs of dehiscence or bile extravasation from the hepato-enteral anastomosis and no signs of biliary peritonitis. We also noticed a reduction in food intake for the entire group. Rats in the control group, despite losing weight, had an almost normal activity.

Discussions

Biliary atresia (BA) has an accelerated evolution towards biliary cirrhosis, if an efficient drainage is not performed in time (8). Attempts to reproduce the pathological mechanism of the disease in order to study it and improve treatment are expected. However, because BA is the result of multiple pathogenic mechanisms, attempts have been made mostly in order to relieve or to delay cholestasis effects on the liver function. The choice to study obstructive cholestasis on rats turned out to be advantageous. An average survival rate of 83% was reported in studies where a single surgical procedure was performed. Deaths were preceded by bleeding secondary to sectioning the parenchymal connection between the lobes (9). In our study, the majority of animals survived to both surgical procedures, with an overall survival rate of 90%. We recorded only two deaths after the surgical re-intervention because of major bleeding.

A number of studies have obtained cholestasis by bile duct ligation in rats. Macro- and micro-surgical procedures were compared and the macro-surgical procedures had higher rates of post-operative morbidity. Beyond the risk of recanalization, there were also other complications like hilum biliary pseudocyst, hepatosplenomegaly, abscesses or death (5,6). In this study, we proposed a double micro-surgical ligation of the bile ducts, in the area they enter the hepatic parenchyma, with the resection of the biliary segment between ligatures, in order to avoid recanalization. None of the above mentioned complications were associated with this method.

All models that were based on the ligation of all the biliary ducts had an induced obstructive jaundice (6). The absence of jaundice in our study might be explained by the fact that we performed a selective bile duct resection. The four hepatic lobes of the anatomically normal rat allowed us to choose only two lobes for the procedure while preserving the other two. Tannuri et al. also reported the absence of the post-operative jaundice, even though they ligated and resected between ligatures, the bile ducts of three hepatic lobes, with only the fourth one left intact (9).

In the experimental group, the major post-operative complication has been the wound infection. Given the fact that dehiscence appeared two weeks after the first surgery, it was probably not related to the procedure. There is a general tendency of the rat with obstructive biliary drainage to develop infections, as described by Aller et al (6). But it was represented by peritoneal abscesses or systemic sepsis. In our model, the infection was superficial and had a rapid evolution towards healing using only local conservative treatment.

The eventration (abdominal wall hernia) was not described as a complication in other experimental models using the same abdominal wall closure technique (6). Their presence had no influence on the study and it was easily solved by direct suture.

It is known that after the bile duct ligation, the fibrotic changes are maximal after four weeks (9,10). The presence of the fibrous tissue could be explained by the anterior dissection performed in the area of the hepatic hilum and the resection of the bile ducts. Another important fact in discovering the ductules is wide dissection and resection of the portal fibrous remnant, as the micro-
biliary ductules can be mostly distributed laterally, not medially. Also, the number of ductules in the proximal end was observed to be the most within 2 mm from the transection area, decreasing gradually to the distal end (11). In this experimental model, the purpose of bile duct obstruction was to induce hepatic alterations similar to those determined by the cholestatic diseases.

We performed the resection of the fibrous tissue adjacent to the hepatic parenchyma, where no proximal segment of the bile ducts where identified. After the resection, in the created area no dilated bile ducts were spotted. In similar models, only histological and molecular changes are described (9), which could suggest that in order to have secondary dilated bile ducts, the obstruction needs to be extended. In this context, in order to prove the utility of this model, identification of fibrosis in the chosen period of time was considered sufficient.

It is already proven that in infants with cholestasis the characteristic histologic findings that predicts biliary atresia are bile ducts proliferation, ductular bile plugs, portal stromal edema, peribiliary neutrophilic infiltrates, bile ducts injury, portal fibrosis (12,13). Although there are reports in the literature stating that the accuracy of liver biopsies is not influenced by age (< 60 days) (14), other authors have proved, by comparing sequential histological findings, that the characteristic changes can be sparse initially, with only one or two elements present, and that a definitive biopsy can be obtained as early as 35 days of age, with a median of 3 weeks between the first and the definitive one. This is a known reason for delaying diagnosis (15).

The difficulty to obtain obstructive cholestasis in the selective bile duct ligature, for reasons of accessory bile ducts, is highlighted in other studies. They were able to achieve histological alterations only after sectioning the parenchymal connection between the hepatic lobes (9). It would be expected therefore to have minimal histological changes, in a experimental microsurgical liver model. Cholestasis, despite the absence of jaundice, can be demonstrated, in its early stages even by histological analysis. Taking into consideration that there is a hetero-geneous response of each hepatic lobe to the bile ducts obstruction, which have been demonstrated by the histological alterations (6), we could conclude that it would be necessary to reduce the capacity of the extrahepatic bile tract to a greater degree than a selective ligation as the microsurgical technique can achieve, for the jaundice to be present.

The standard principles of Kasai’s hepatoportoenterostomy include complete resection of the portions of the extrahepatic biliary system and reinstatement of bile flow through an anastomosis between the jejunum and the porta hepatis (16). Different modifications to the procedure have been proposed in order to improve outcome and reduce risk of complications. Even though the level of transection proved to be more important than the type of reconstruction, or that the significance of an intestinal valve on the final outcome is controversial, a limited and careful resection of the fibrous remnant and a meticulous anastomosis were the basic details associated with favourable outcomes (17).

A HPE model in rat was not described before. Other types of bilio-jejunal anastomosis have been described in rats. One model was a diversion in diabetic rats, where Lambert prosthetic choledoco-jejunostomy was performed (10) and the other one was a Roux-en-Y bilio-jejunal anastomosis performed as a method of biliary drainage after the common bile duct ligature (18). A choledoco-jejunal anastomosis was also described in dogs as a method of biliary drainage after bile duct injury (19). Practically, the efficiency of a choledoco-jejunal anastomosis was assessed. In our study, by resecting the bile ducts adjacent to the hepatic parenchyma, a bilio-jejunal anastomosis was impossible to realize and HPE was an effective solution. The liver parenchyma is a hemorrhagic and friable tissue. Deaths were registered in other models following bleeding secondary to less invasive maneuvers (18). In our case, in order to perform a partial resection of the parenchyma with the hepato-jejunal anastomosis and to
ensure the rat survival, the technique had to be flawless. Despite a very careful surgical technique, two rats died because of an important bleeding. A more prominent fibrotic transformation of the liver would be an advantage, a hard hepatic capsule being an important element in the anastomosis. We assessed the HPE after one week. There were no signs to suggest a dehiscence or bile extravasation through the anastomosis.

**Conclusions**

HPE is the only surgical procedure allowing a delay in the progress of hepatic alteration and with a long term native liver survival up to 44% (20). Despite that, 50% of patients require liver transplant two years after surgery (9), a reason to bring forth the need for further studies for understanding the pathogenic mechanisms of the disease and for treatment improvements.

The use of rats instead of mice had the advantage of an easier manipulation of the liver and a larger work area. Despite the absence of the gallbladder, the anatomy of the rat with four liver lobes (21), allowed us to induce hepatic changes in two of these, while using the remaining healthy ones as a control, and thus, having the experimental and the control liver on the same animal.

By creating this experimental model, we ascertained the fact that it is possible to obtain a reproducible and accessible training prototype, using microsurgical techniques. Relying on the short term findings emphasised in this paper, the model allows the study of this not fully understood pathology. It is an up-to-date problem to find new ways to increase survival in this rare disease and the above mentioned reasons are a strong mobile for our experiments.

**Conflicts of interests**

The Authors declare no conflicts of interest. We disclose all financial and material support.

**Ethics Approval**

The study design was approved by the Ethic Committee of “Iuliu Hațieganu” University of Medicine and Pharmacy, Cluj-Napoca, Romania (Nr. 81/01.02.2018).

**Author’s Contributions**

All authors contributed equally to this work.

**References**


