VASCULAR INJURY

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OUTLINE

DIAGNOSTIC MODALITIES

COMPLICATIONS

COMPARTMENT

ANATOMIC EXPOSURE

FEMORAL Vs

POPLITIAL Vs

SHANK Vs

PEREPHIRAL VASCULAE INJURY

- Distal to Deltopectoral Groove
- Distal to Inginal ligament
- Hard signs of Vascular injury needs Surgery

Hard Signs

- Observed pulsatile bleeding
- Ongoing heamorrhage with shock
- Arterial thrill by manual palpation
- Bruit over or near the artery
- Abscent distal pulse
- Signs of distal ischemia
- Visible expanding hematoma

Soft Signs

- Significant hemorrhage by History
- Small non expanding heamatoma
- Decreased pulse compared to the contralateral extremity
- Bony injury
- Wound proximity (1 cm from Vs)
- Neurologic abnormality(anatomicaly related nerve)

Hard vs. Soft signs of Vascular injury

Hard signs	**Soft signs**
Active arterial (pulsatile) bleeding	Minor bleeding
Pulseless/ ischemia	Injury in proximity to major vessel
Expanding pulsatile hematoma	Small to moderate size hematoma
Bruit or thrill	Associated nerve injury
	ABI < 0.9
Operation Mandatory	***Further W/U***

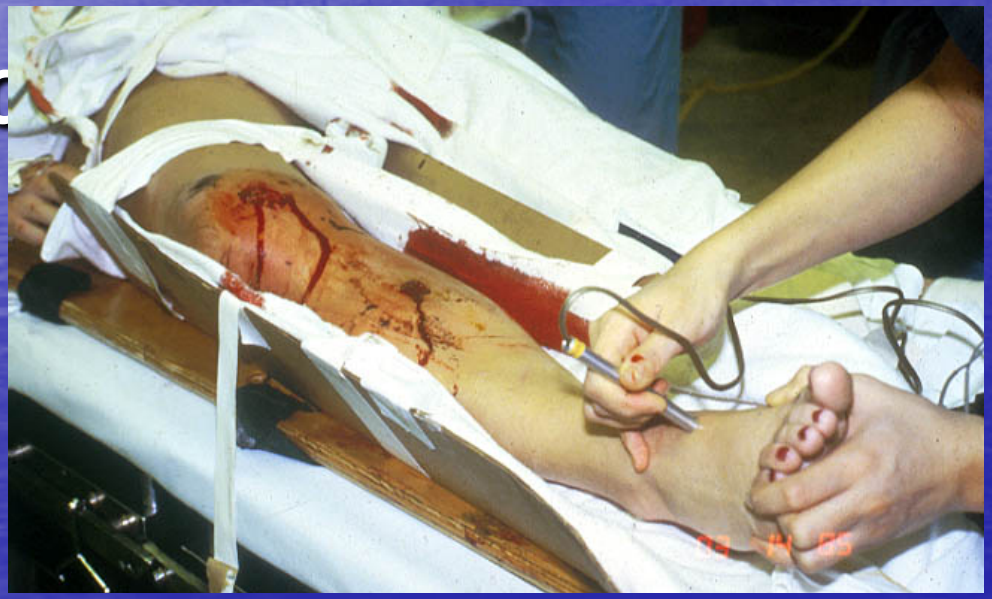
Doppler ultrasound

- Ankle Brachial Index
  - < 0.90 = 87% sensitive, 97% specific for arterial injury
  - In absence of hard signs, can substitute this for *screening* arteriography.

Doppler ultrasound

- Determine presence/absence of arterial supply

Assess adec

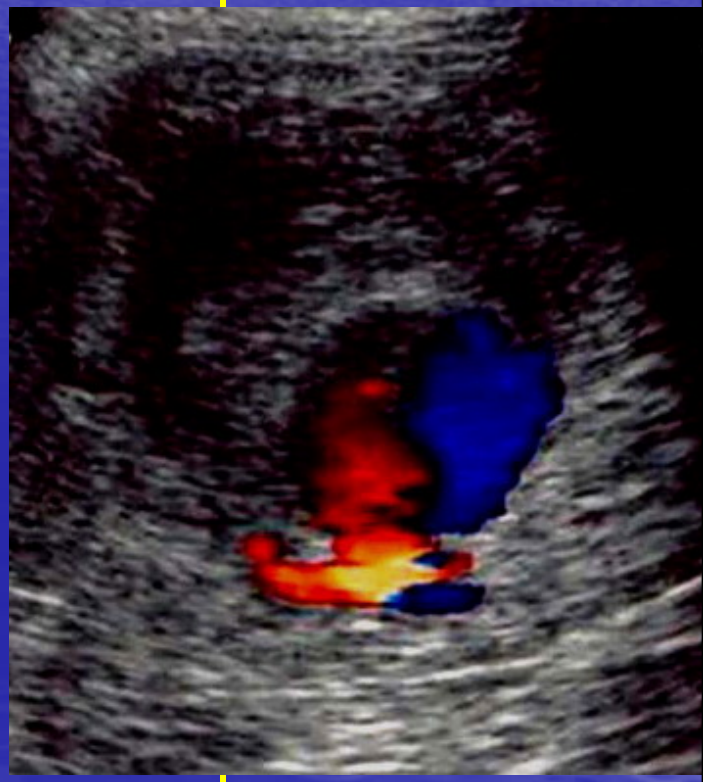


PRESENCE OF SIGNAL DOES NOT EXCLUDE ARTERIAL INJURY !

Imaging Study
Duplex US

Reliable for
Injury to arteries and veins –
A-V fistulas –
Pseudoaneurysms –
Thrombosis –

*It has 95% sensitivity &99 % specificity



Imaging study
CT Angio

* Ct angiograph

faster, less expensive and less invasive

90-100 % sensitivity and 98% - 100 %specificity

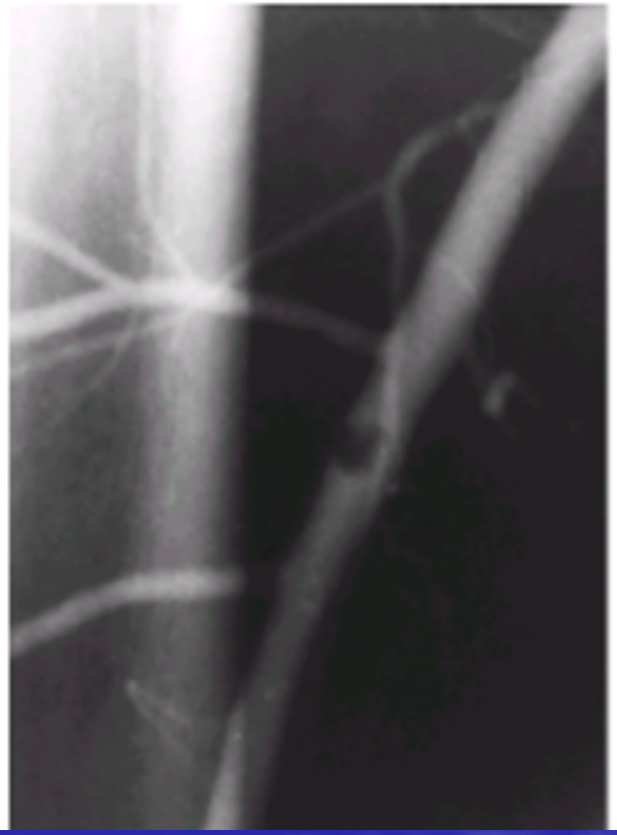
* diagnostic study of choice

*Limitations:

- difficulty differentiating spasm from occlusion
- artifact from high attenuation structures like bullet fragments or other foreign matter

Indications for angiography

- Hemodynamic stability
- Uncertain diagnosis
  - Soft signs
  - PVD
- Unclear location
  - Multiple wounds, fractures
  - Shot gun wounds
  - GSW parallel to an artery



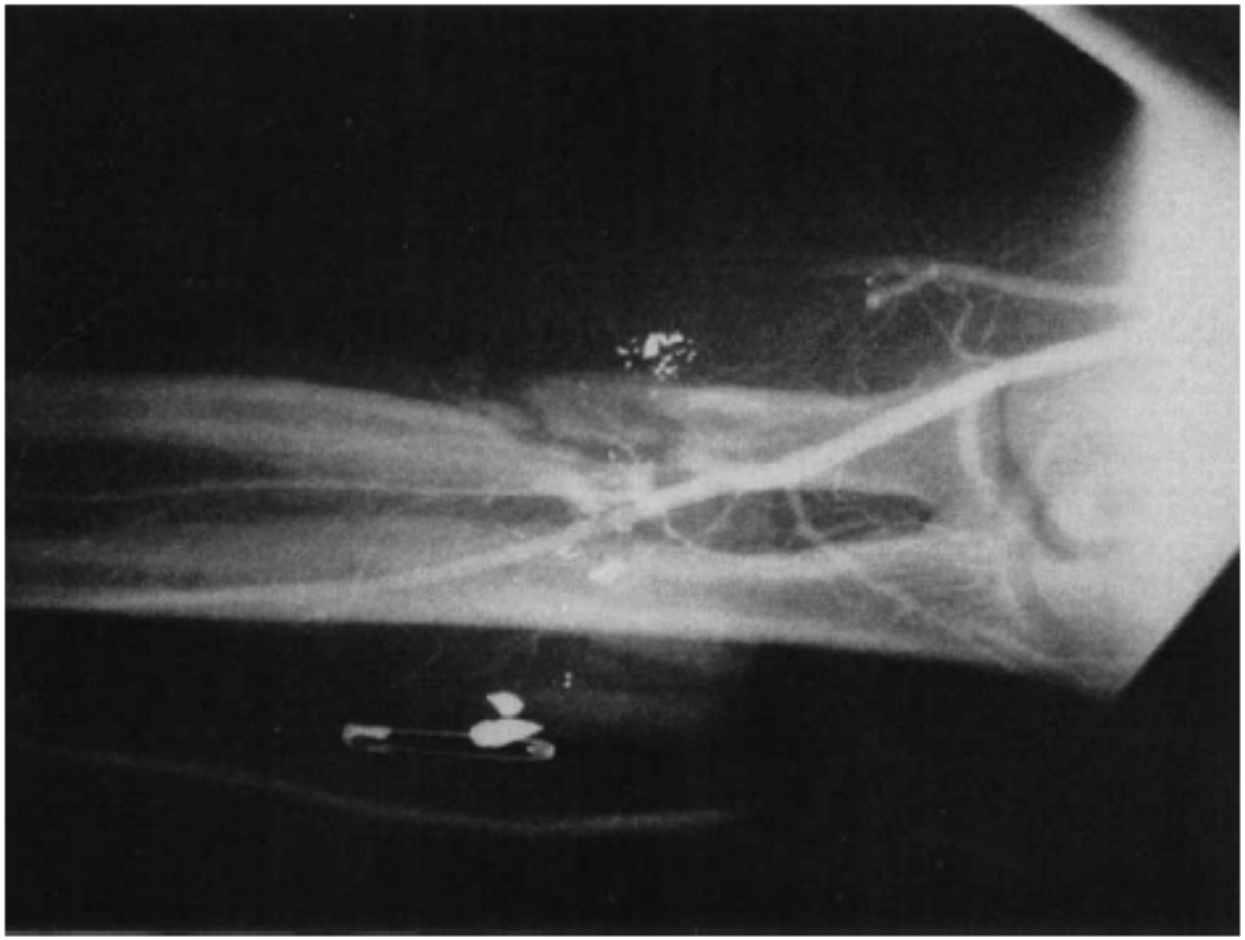
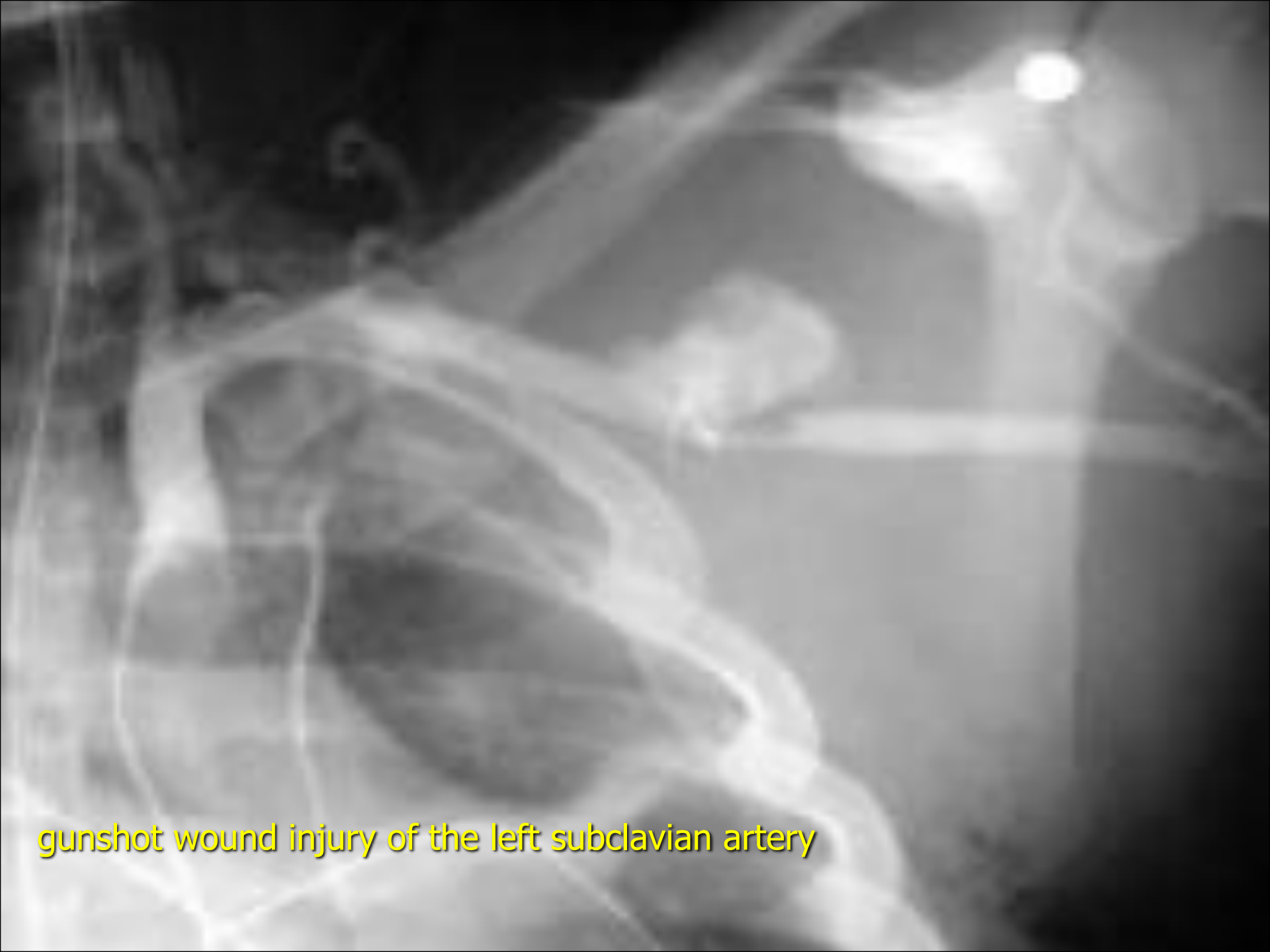


Figure 3. Upper-extremity arteriogram after gunshot wound to the arm with fracture of radius and cutoff of radial artery just below the bifurcation of the brachial artery.

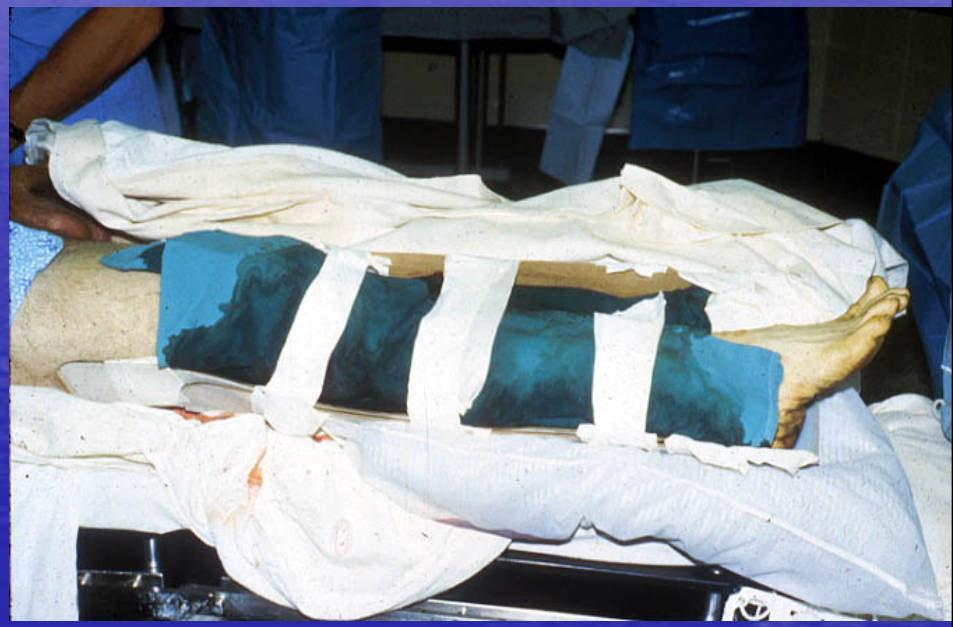

gunshot wound injury of the left subclavian artery

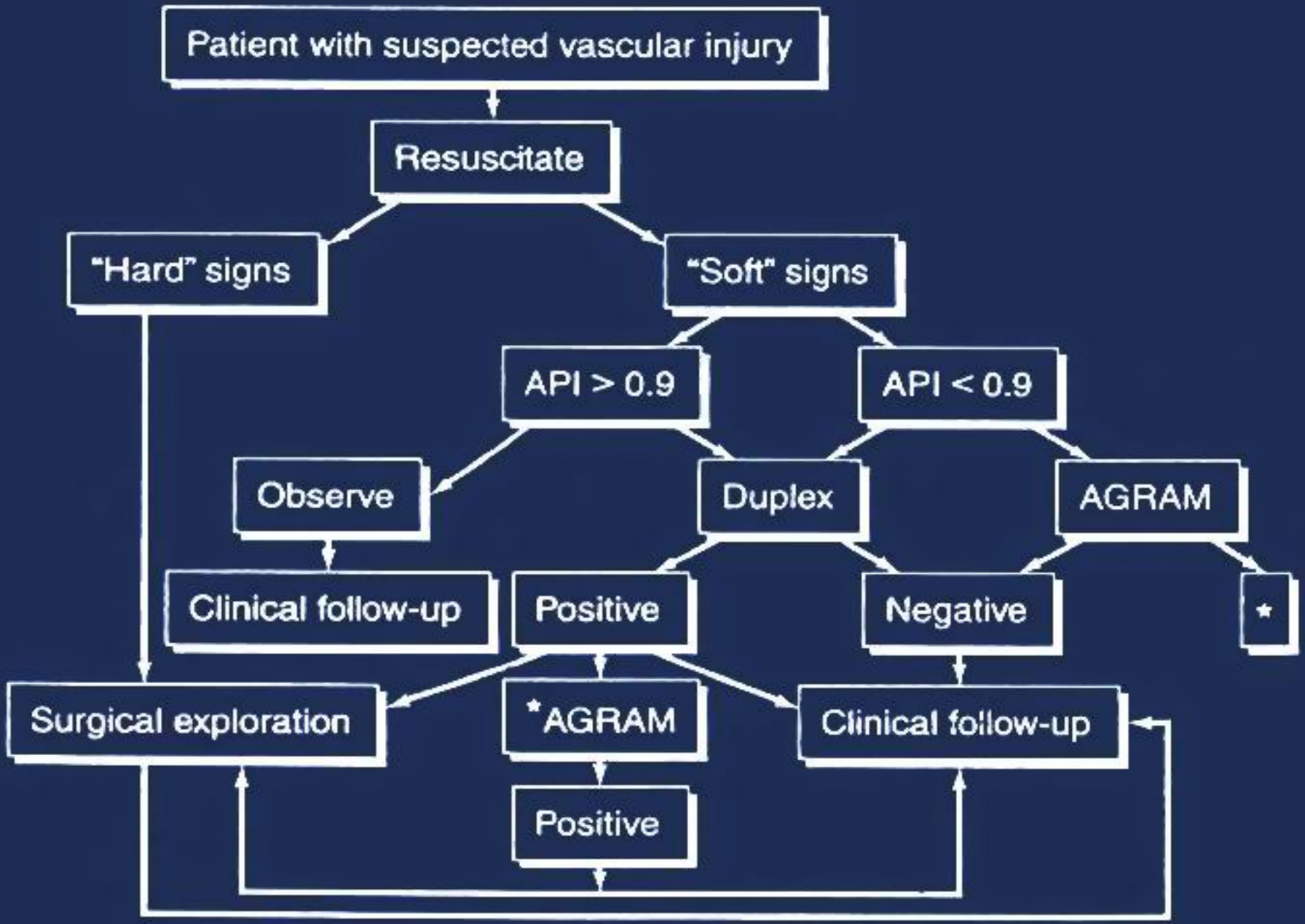
Management

- ABCs
- Active bleeding, limb threatening ischemia → OR
- Stable, good limb viability → may investigate
- Non-operative management → non-occlusive lesion in asymptomatic patient
- Pre-operative management
  - Prophylactic antibiotic. –
  - Single dose heparin iv if no C/I –
- Do not reperfuse dead limb! → amputation

Immediate treatment

- Control bleeding
- Replace volume loss
- Cover wounds
- Reduce fractures/dislocations
- Splint




Patient with suspected vascular injury
Resuscitate
"Hard" signs
"Soft" signs
API > 0.9
API < 0.9
Observe
Duplex
AGRAM
Clinical follow-up
Positive
Negative
*
Surgical exploration
*AGRAM
Clinical follow-up
Positive

Arterial injuries associated with fractures or dislocations

subclavian artery	Clavicle fracture
axillary artery	Shoulder fx/dislocation
brachial artery	Supracondylar humerus fx
brachial artery	Elbow dislocation
gluteal arteries	Pelvic fracture
iliac arteries	
femoral artery	Femoral shaft fx
popliteal artery	Distal femur fracture
popliteal artery	Knee dislocation
tibial arteries	Tibial shaft fx

Option of vascular repair

Arterial repair:

(1) direct arterial repair

(2) arterial patch repair

(3) interposition graft repair

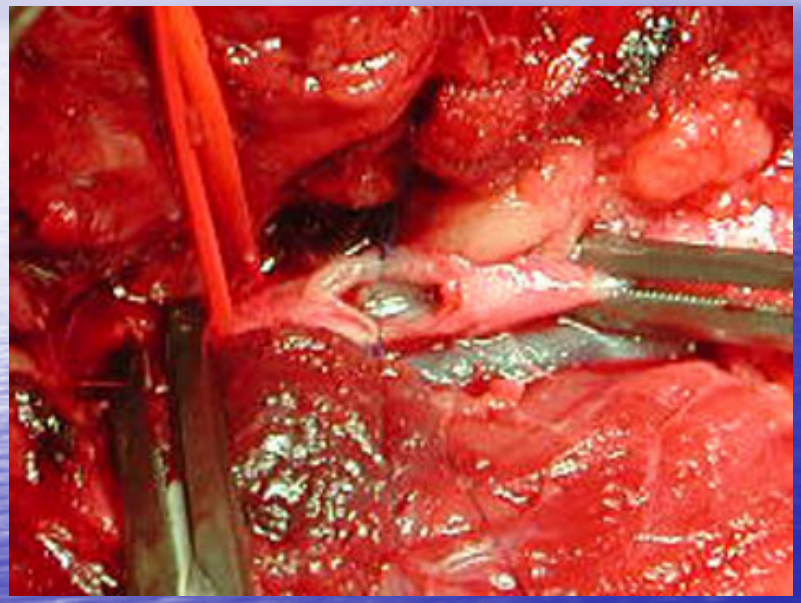
(4) bypass repair

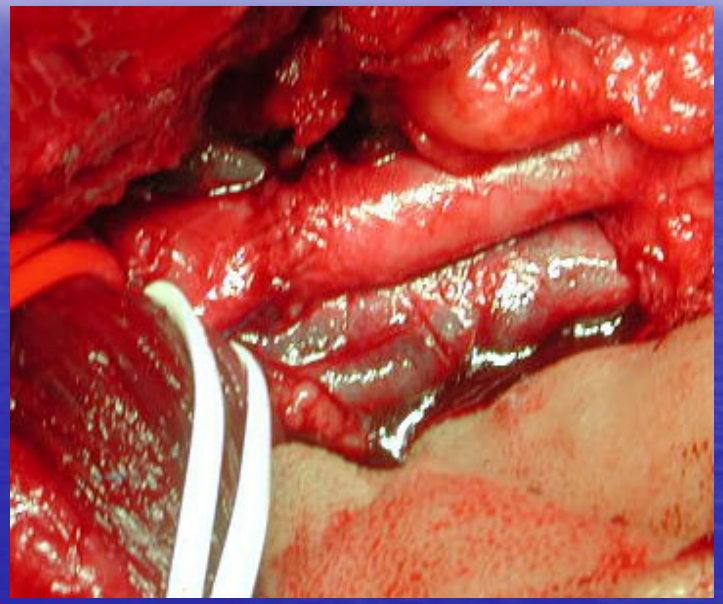
(5) ligation

Venous repair whenever possible

avoid ligation.

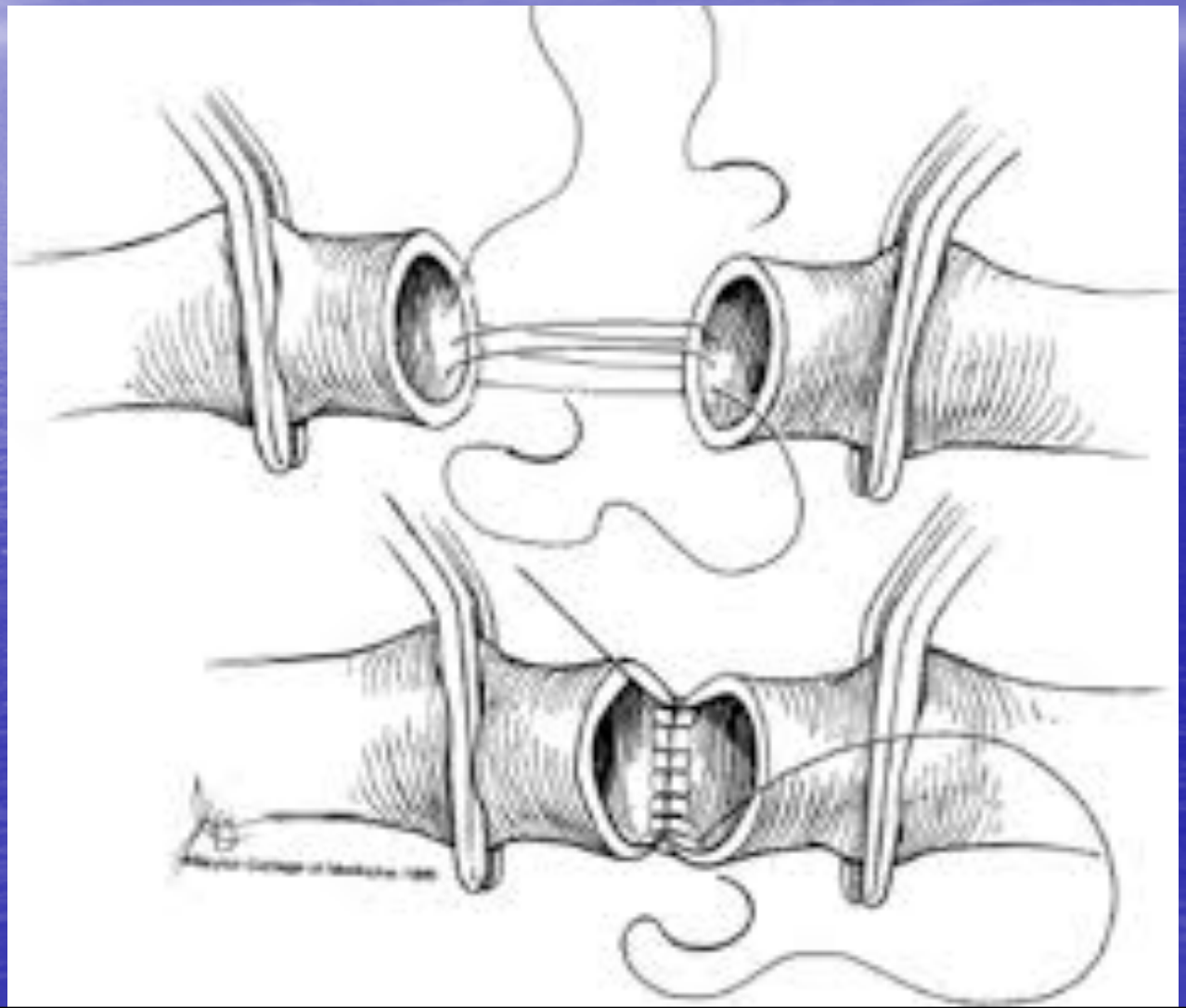
Tension-free primary repair



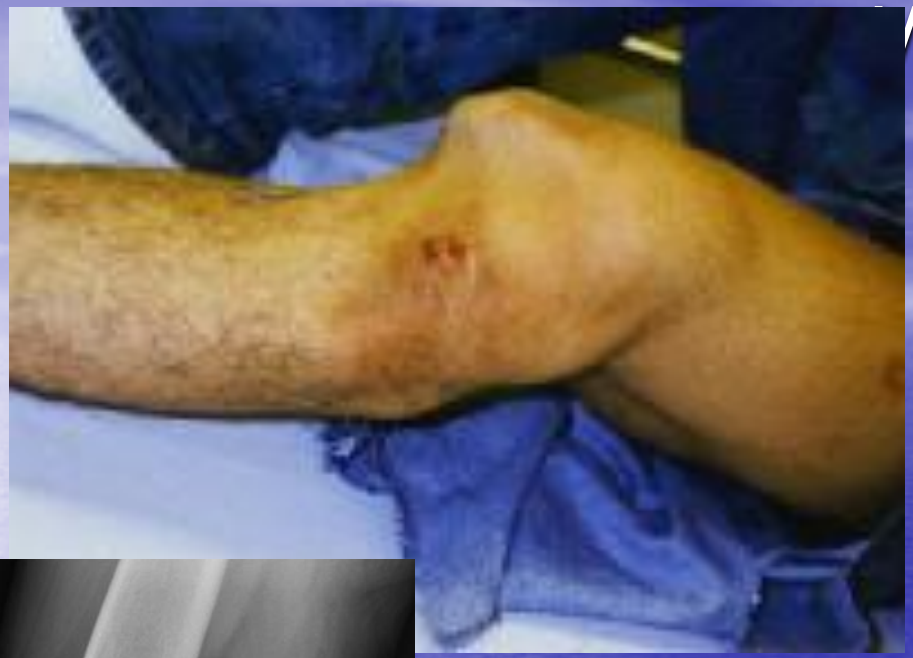


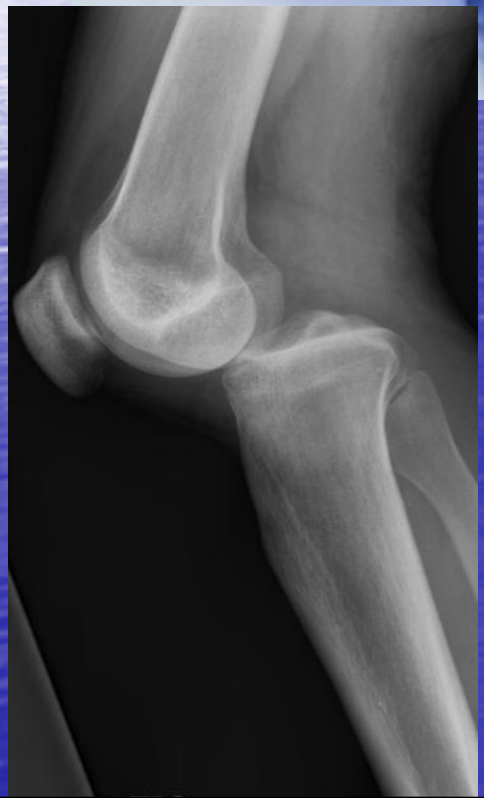
Primary repair → defect < 1-2 cm

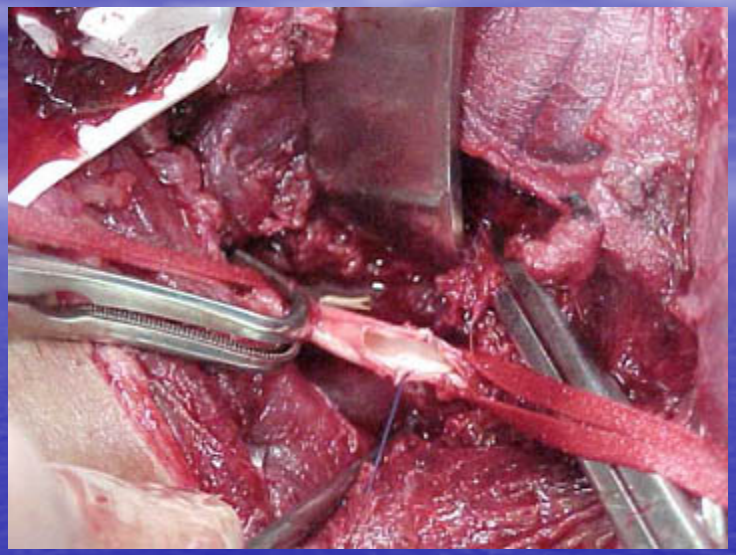
direct arterial repair

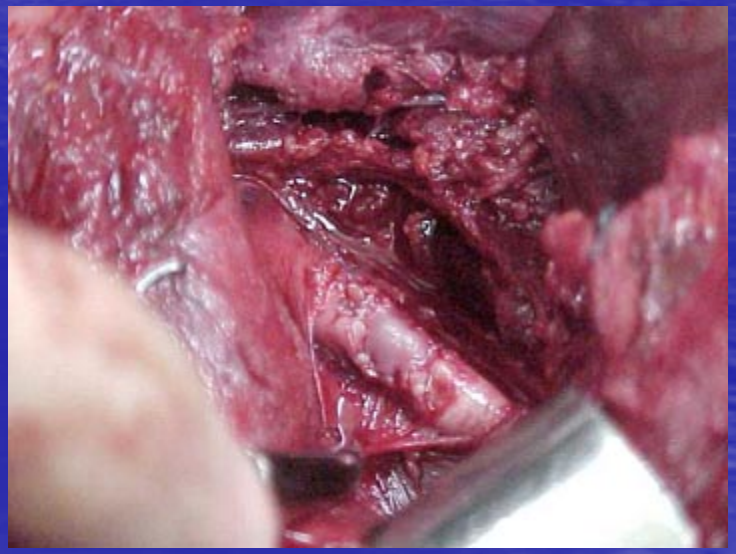


Vein patch angioplasty

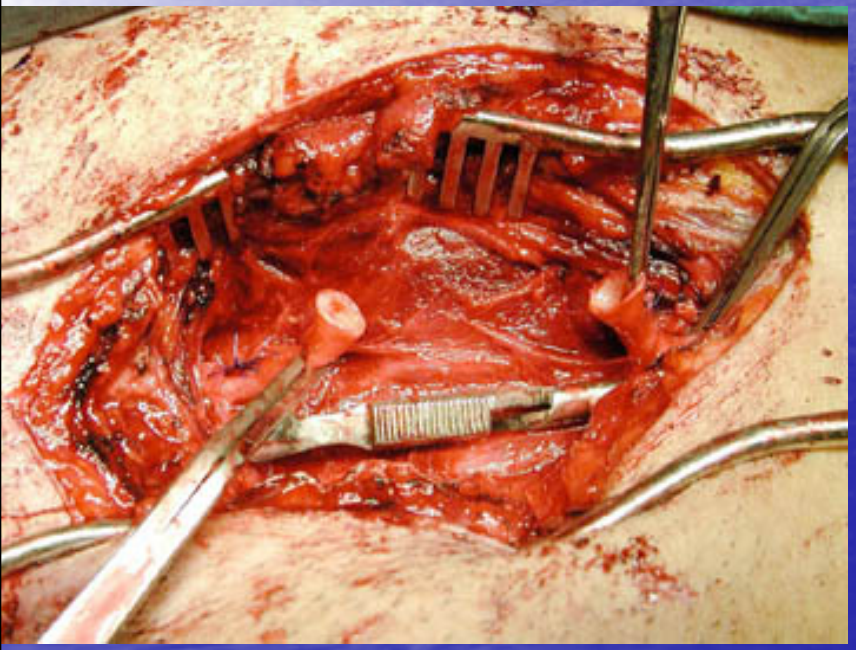




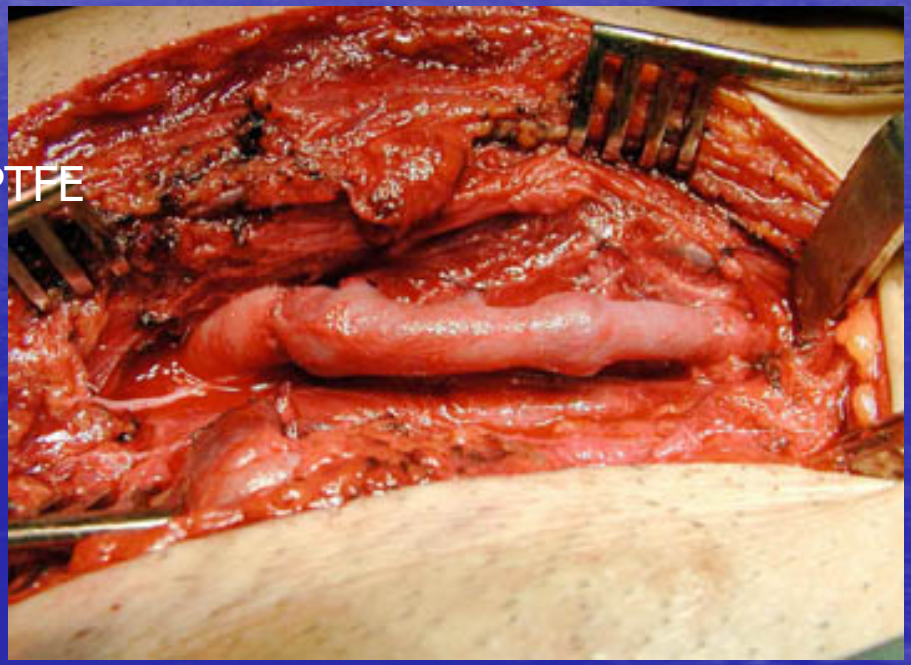




Interposition autogenous vein graft



PTFE



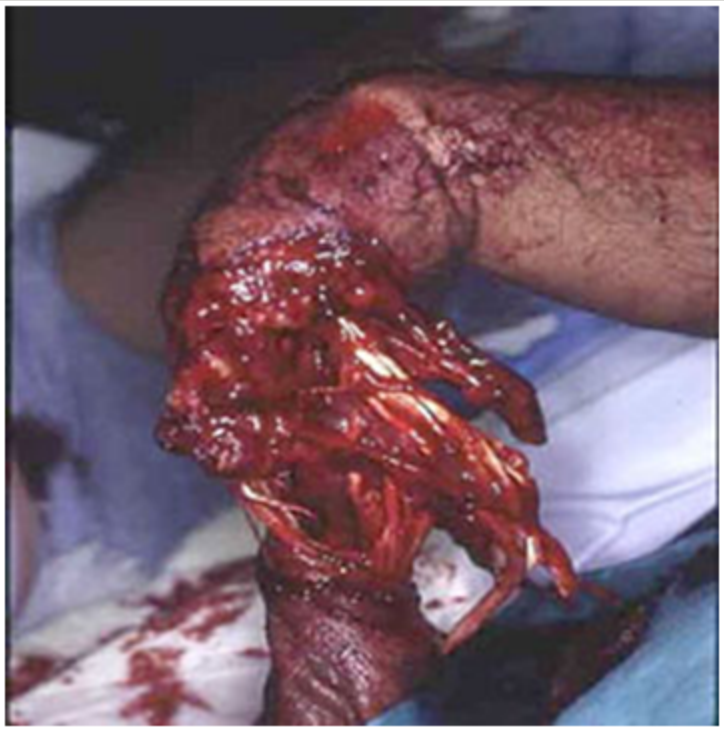
Venous injury

- Should be repaired in stable patient if technically feasible
  - Lateral venorrhaphy, EEA –
  - Complex repair (PTFE, SVG) –
  - Patency 75% –
  - Before arterial repair –

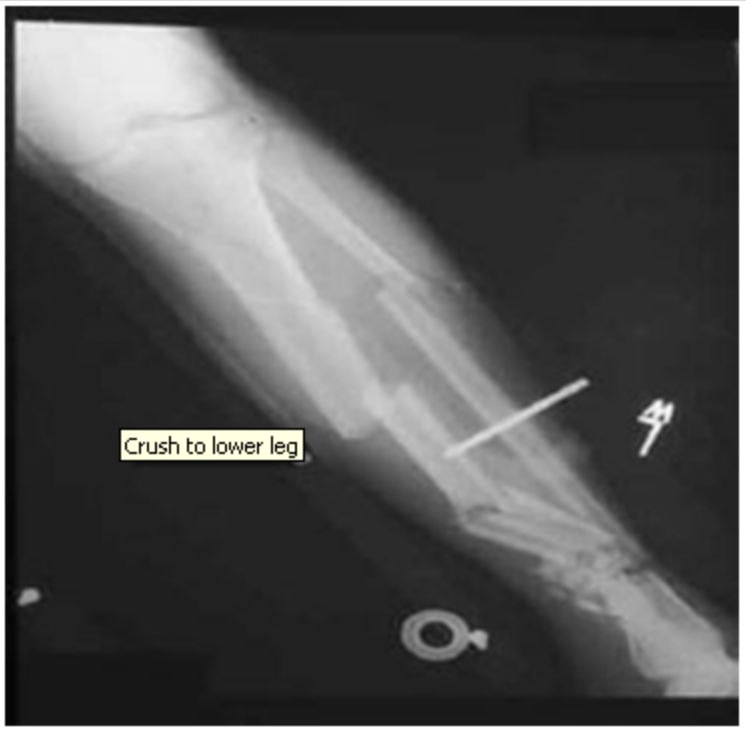
Limb threatening ischemia → Shunt a. → repair v.

- Ligation is safe alternative esp. in unstable patients, complex injuries.

What is the management ?



Mangled Upper Extremity



Crush to lower leg

Mangled extremity :injury that involve al least ¾ consisting of bone ,soft tissue ,vessel,nerves

Amputation

- Non-viable or non-salvagable limb
  - Irreversible limb ischemia–
- Safe life before limbs!!!
  - Amputation can be life saving in life – threatening extremity bleeding
- Functional outcome consideration

COMPLICATIONS OF VASCULAR INJURY MANAGEMENT

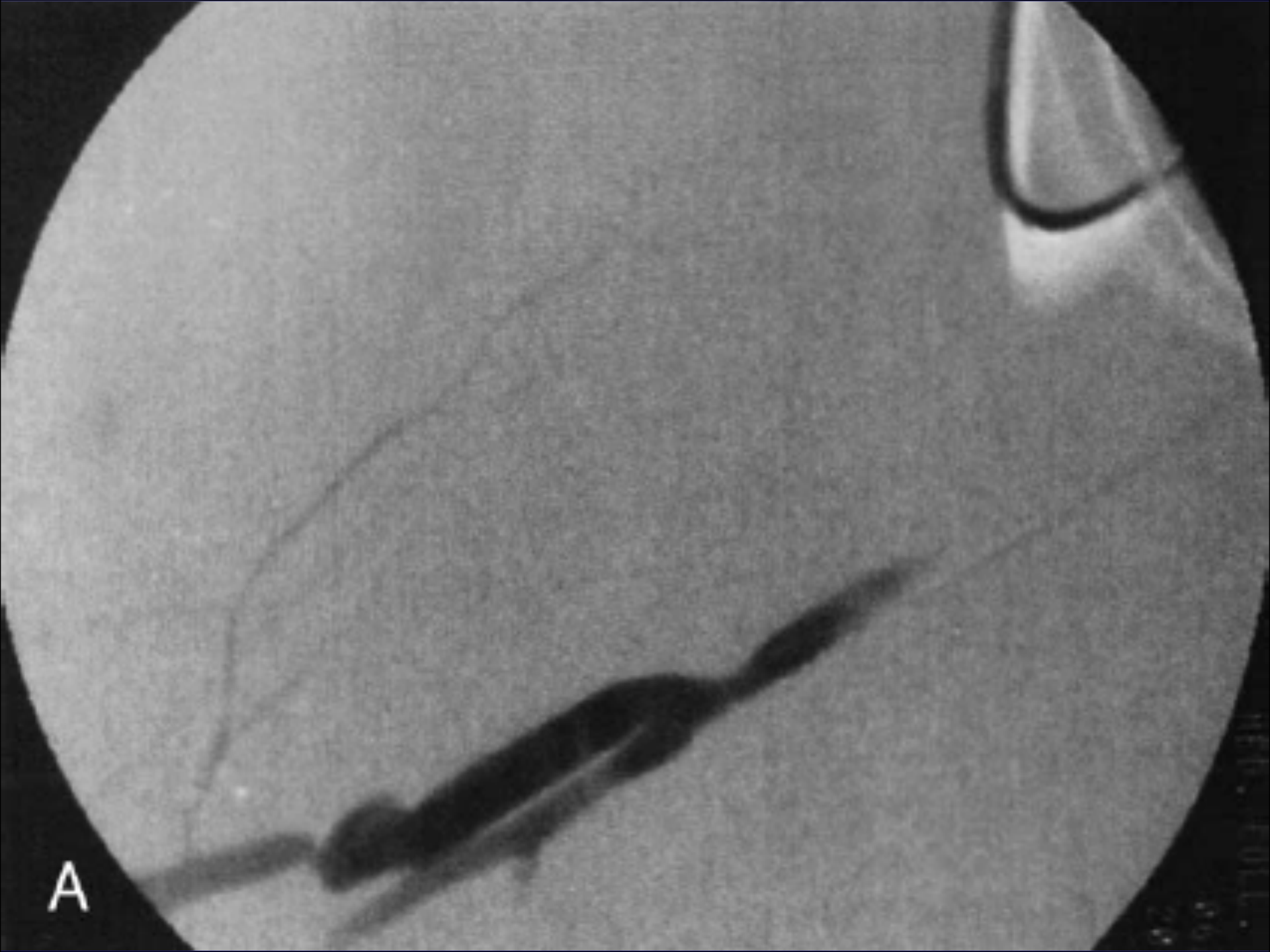
- Hemorrhage
- Thrombosis
- Infection
- Stenosis
- Miscellaneous

THROMBOSIS

- most important complication
- relatively common compared with other complications.

- early occlusion rate of 9.1%,

- Inadequate arterial debridement
- A second adjacent injury
- Residual distal arterial thrombus
- Severe stenosis at the suture line
- Undue tension due to significant missing arterial segment
- Twisting or too long graft to cause a kink or external compression of the graft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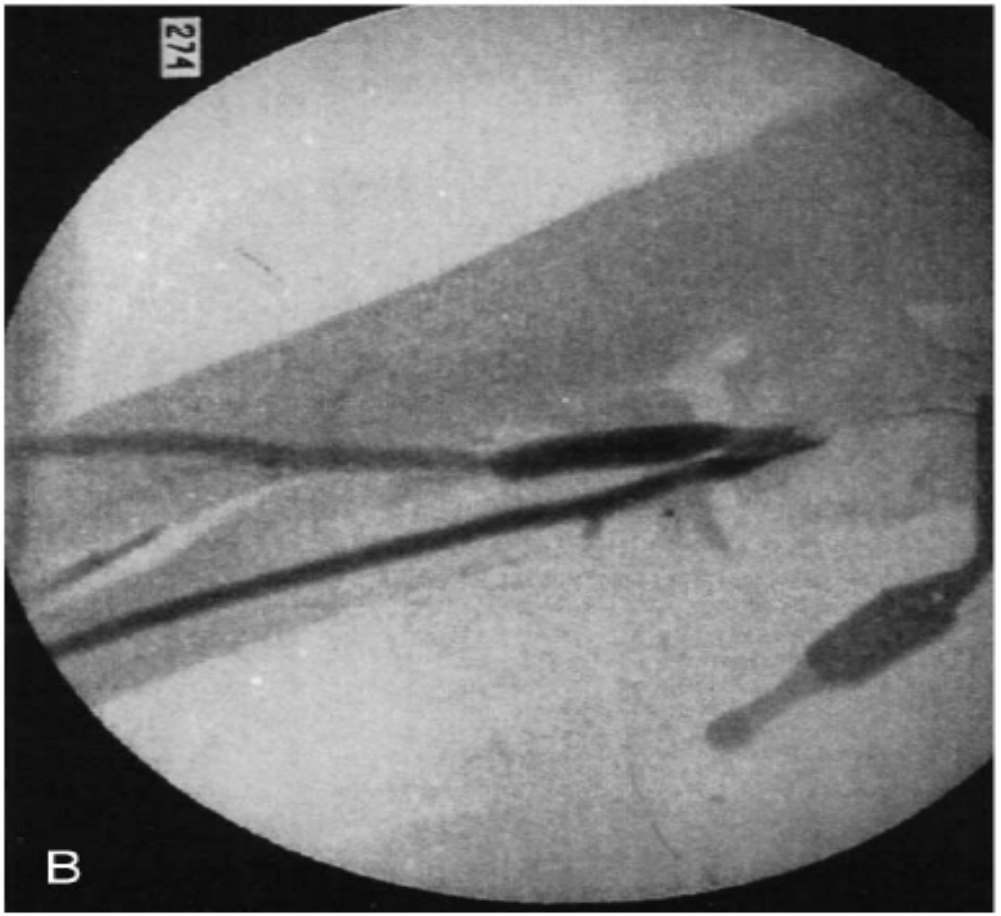


Figure 4. *A*, Completion angiogram after brachial ulnar interposition vein graft. Note the kink in the distal end of the graft secondary to redundancy. *B*, Completion angiogram after revision of the distal anastomosis showing smooth emptying of graft with good runoff by way of the ulnar artery.

INFECTION

- Primary skin closure in a war wound
- Placement of a vascular graft in an area of established infection
- Inadequate soft tissue debridement in an attempt to conserve tissue for coverage of a vascular repair
- Inadequate debridement of a damaged vessel

STENOSIS

- Technical complication
- Tight suture repair.
- Lateral repair without sufficient remaining wall
- Residual arterial wall damage.
- Tension on the suture line

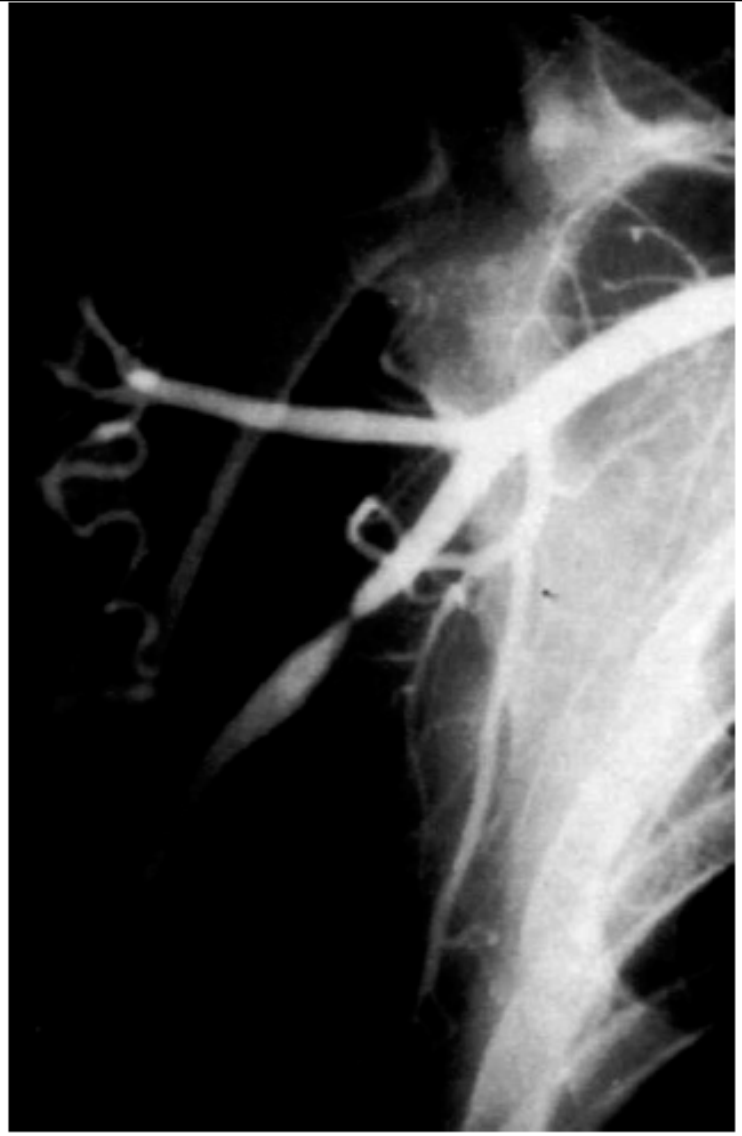


Figure 12. Arteriogram demonstrating severe stenosis of the proximal anastomosis of an autogenous saphenous vein graft at the right brachial-axillary artery junction which was performed in Vietnam. Although prominent collateral circulation existed between the humeral circumflex and deep brachial arteries, the patient developed discomfort with repetitive motion of his right hand (see Figs. 13 and 14). (*From* Rich NM, Baugh JH, Hughes CW. Significance of complications associated with vascular repairs performed in Vietnam. Arch Surg 100:646–651, 1970; with permission.)

MISCELLANEOUS COMPLICATIONS

Acute

- Errors in diagnosis

second associated or adjacent arterial injury

Improper identification of the arteries may occur

- Edema
- Embolization
- Disseminated intravascular coagulopathies

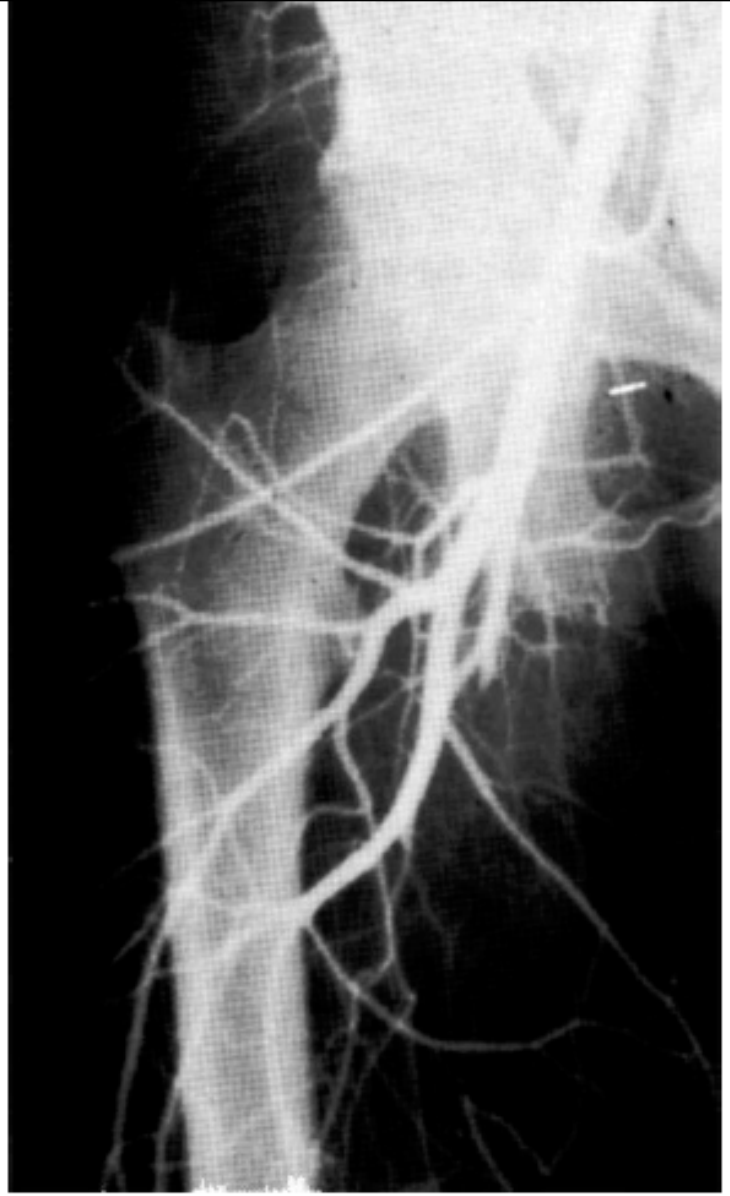


Figure 15. A knowledge of anatomy is mandatory to prevent complications as noted above. It was documented in Vietnam that a *large* profunda femoris artery was ligated. This angiogram later confirmed the clinical suspicion that the superficial femoral was the artery that was ligated. (Vietnam Vascular Registry No. 1129, NMR.) (*From* Rich NM, Spencer FC: Vascular Trauma. Philadelphia, WB Saunders, 1978, p 120; with permission.)

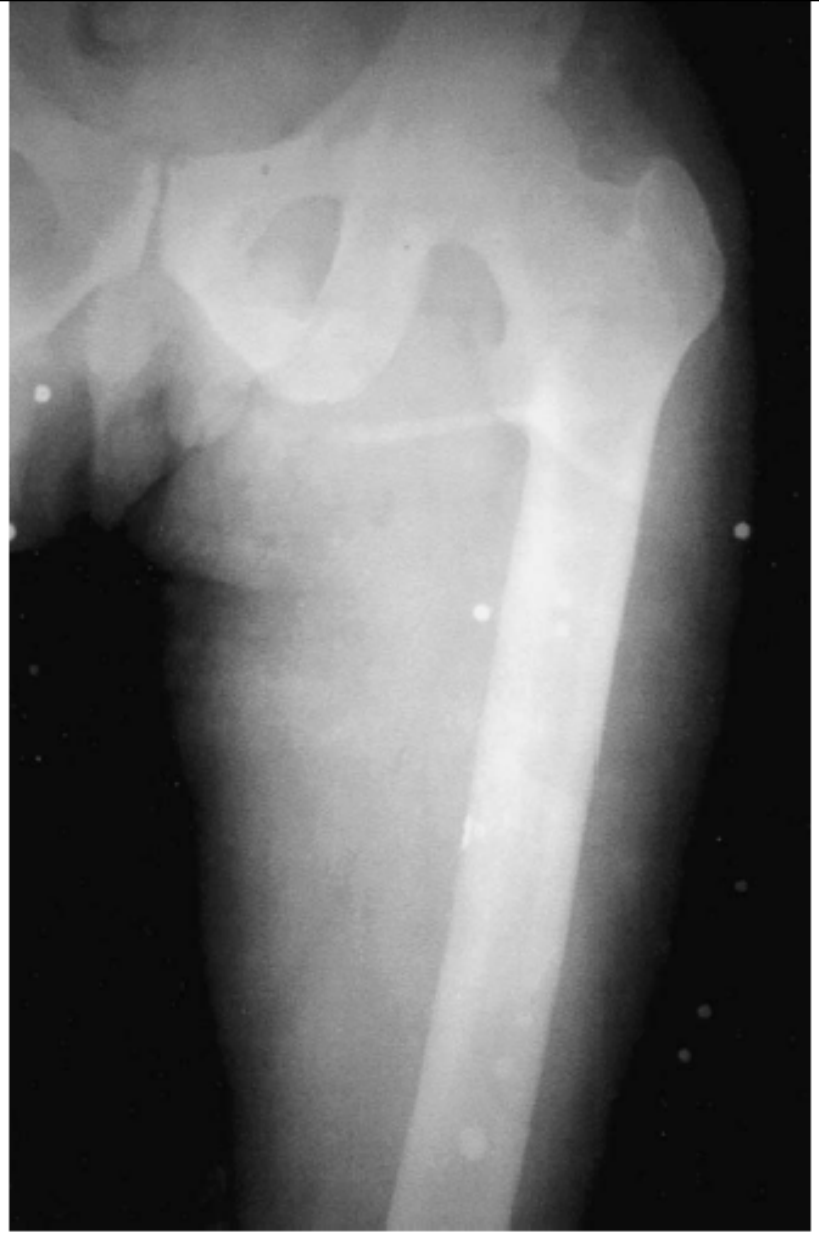


Figure 3. Multiple small pellets and significant swelling of the left lower extremity are visualized in this patient who sustained a shotgun wound to the left thigh 10 years before presenting to the hospital complaining of increase in size of the extremity, ulcerations in the distal extremity, and the presence of a thrill.

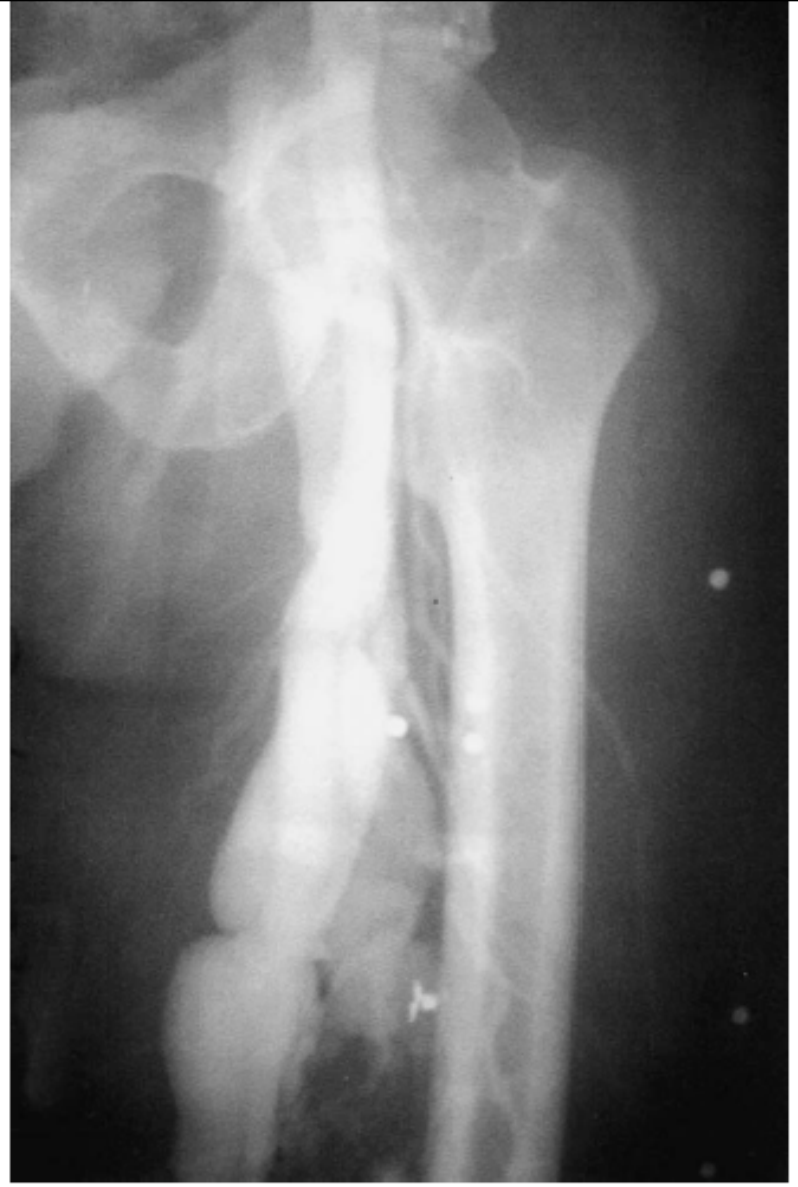


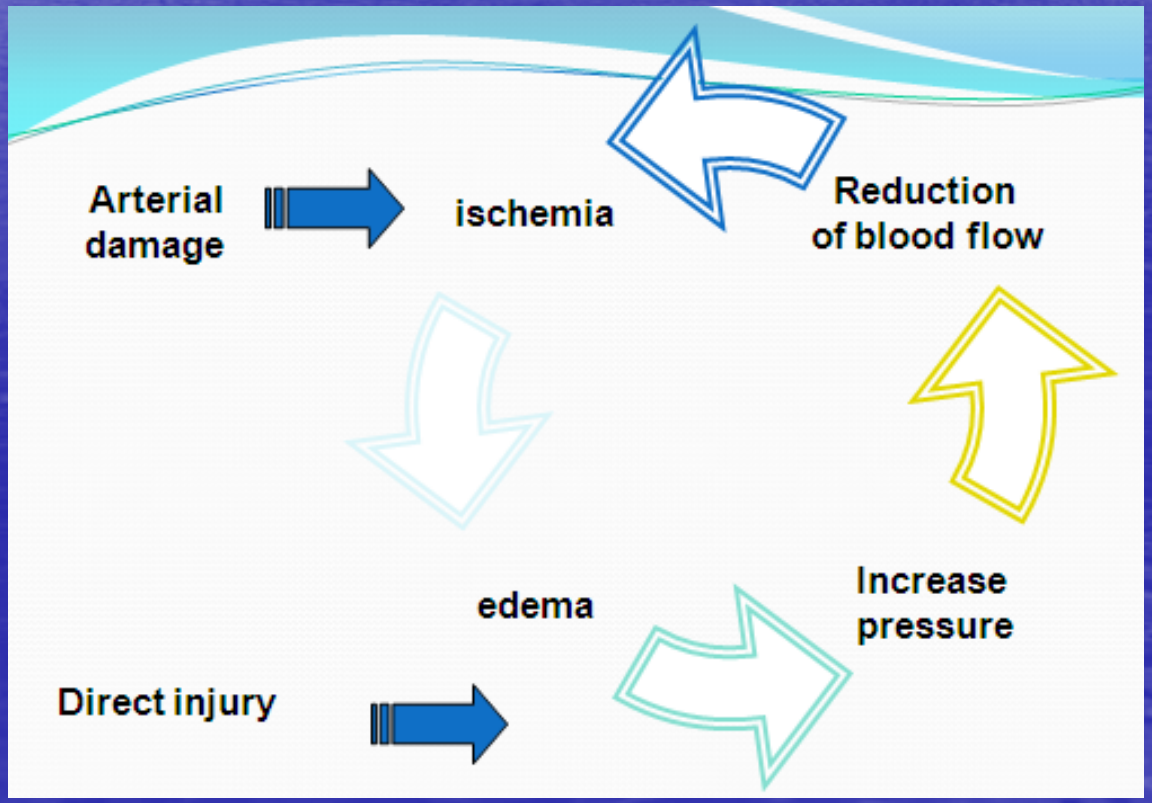
Figure 4. Arteriogram shows a large superficial femoral arteriovenous fistula with massive dilation of the left femoral and iliac vein. The fistula was repaired with a resection and interposition graft of the superficial femoral artery and repair of the vein from within the fistula. The patient had an uneventful recovery with healing of the ulcers and decrease in size of the extremity.

Delayed

1. Chronic pain Drapanas et al (1970)7 found that chronic pain was a complaint in10.2%
2. Decreased function
3. Ischemic changes
4. Systemic complications
5. Arteriovenous fistulas and false aneurysms
6. Arteriosclerotic changes
7. Aneurysmal graft changes

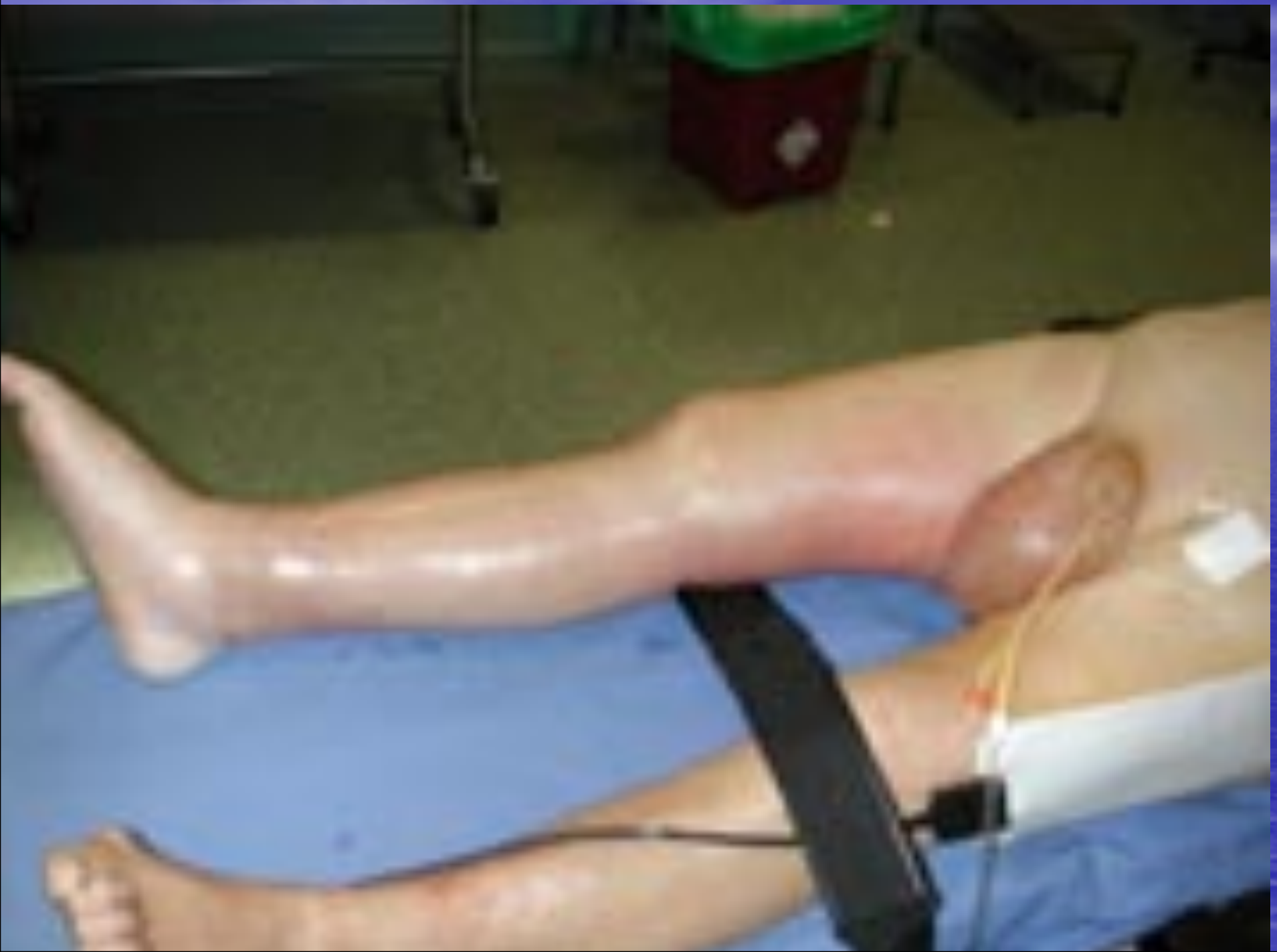
Compartment Syndrome

- occurs when muscle swells within osteofacial compartment pressure exceed capillary pressure they end up with ischemia



SYMPTOMS AND SIGNS

- Suspect it and diagnose it early.
- A full-blown compartment syndrome can be recognized easily, but it is likely that irreversible damage has already occurred



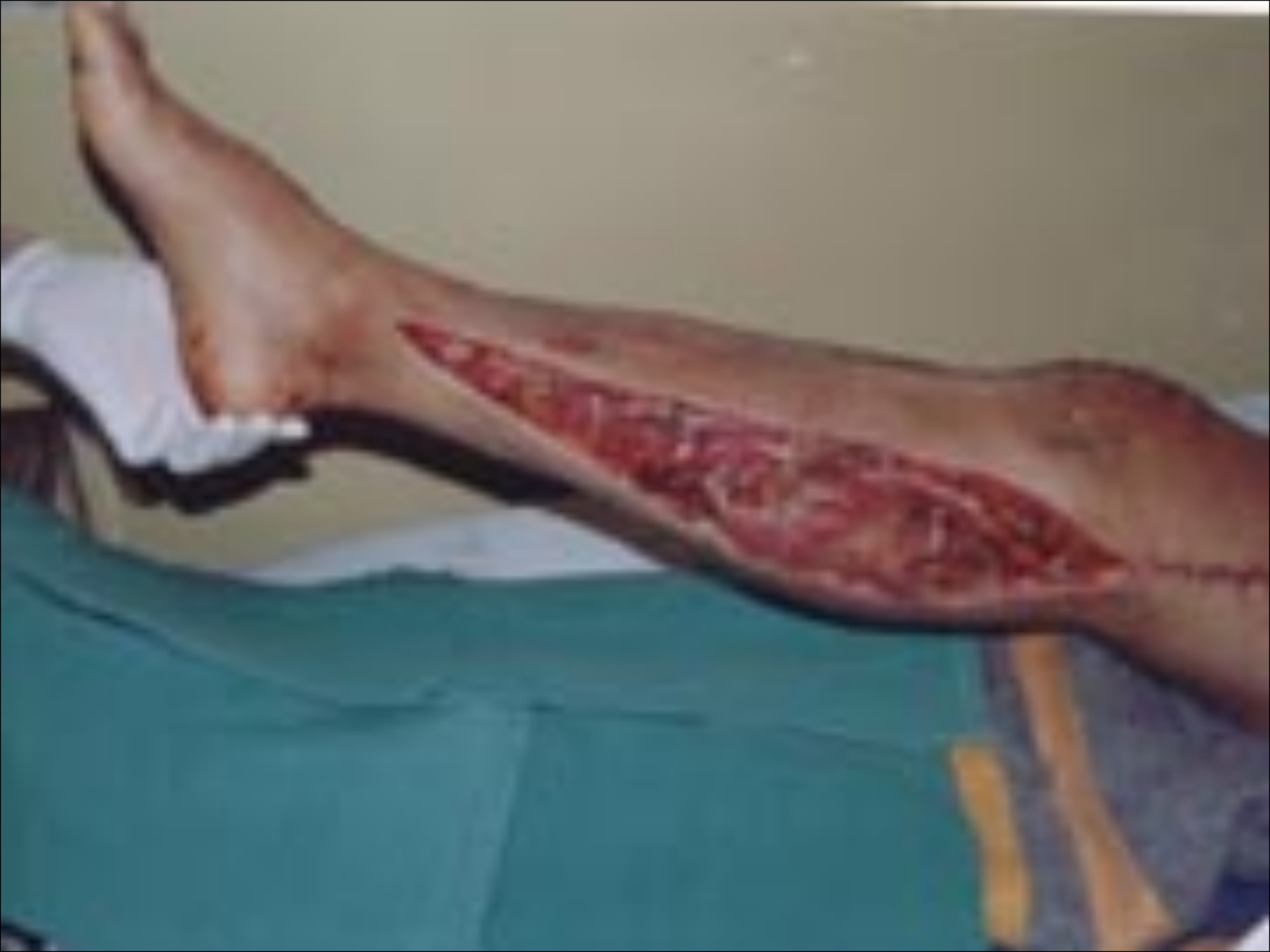
- Pain, aggravated during stretching of the muscle group involved.
- Pressure.
- Paresthesia.
- Paralysis, late manifestation
- Pulselessness very late stages
- Pallor

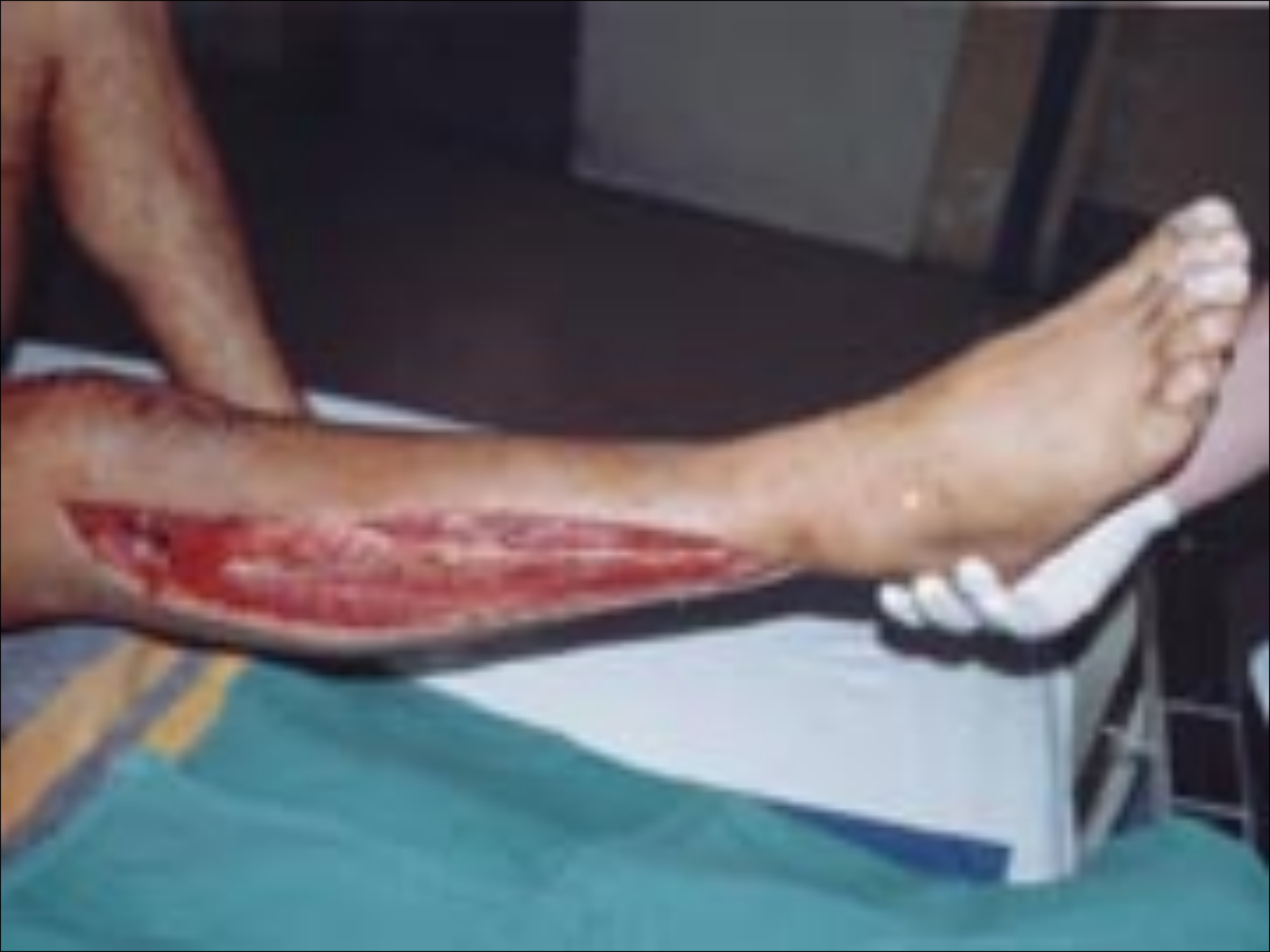
TREATMENT

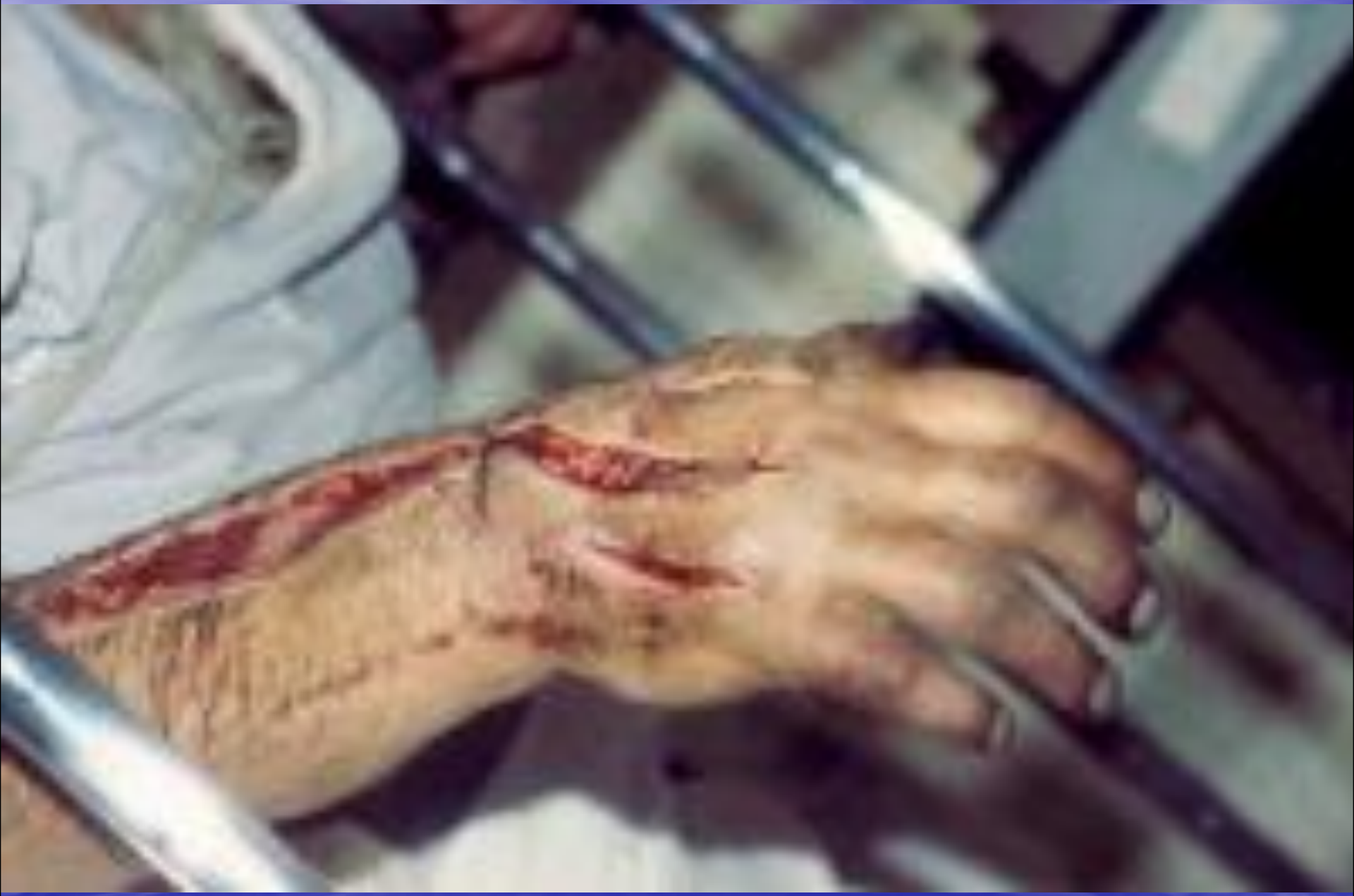
- Adequate skin incision and an adequate fascial incision
- Pharmacologic Interventions
- Mannitol

Fasciotomy

Fasciotomy to fully decompress all involved compartments is the definitive treatment for ACS in the great majority of cases







INDICATIONS FOR FASCIOTOMY

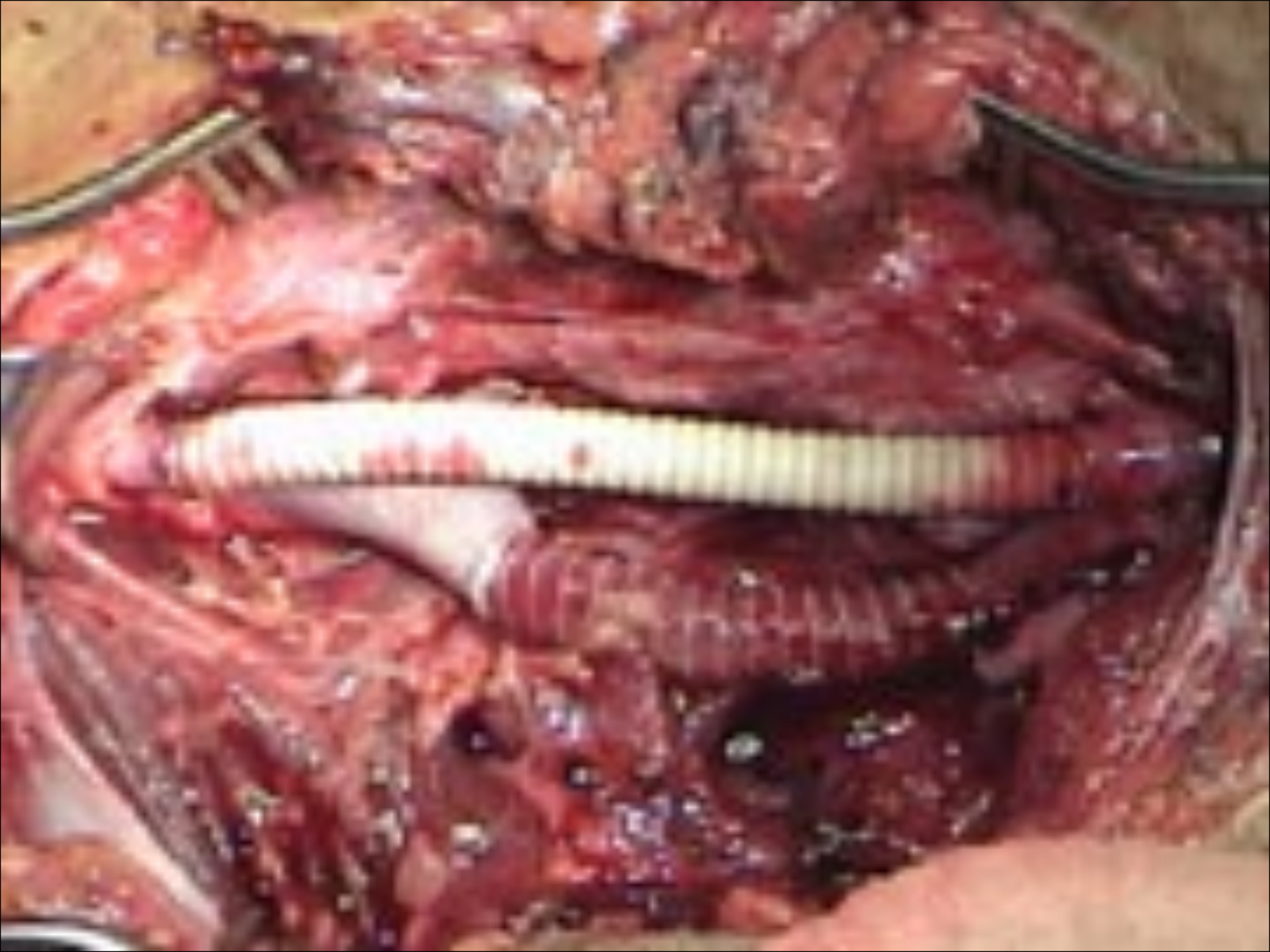
- Prolonged hypotension
- Swelling of the extremity
- Extensive soft tissue damage
- Combined venous and arterial injury
- Combined bony plus arterial or venous injury or both
- Delay between injury and definitive repair
- Compartmental pressure 35 mm Hg

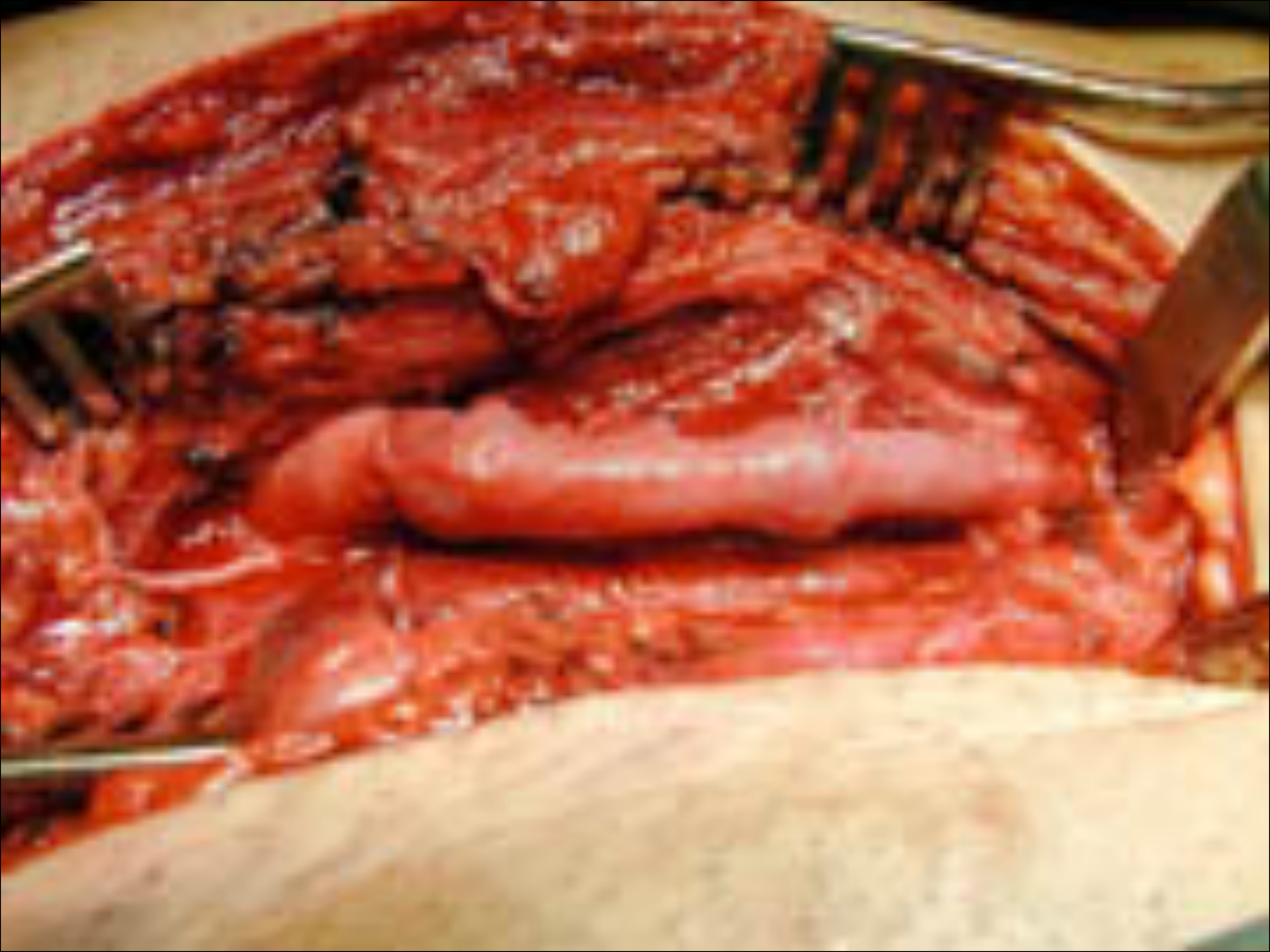
FEMORAL

- 70% of all arterial
- More than 90% penetrating
- most resulting from GSWs.
- Injuries to the femoral artery are not commonly associated with fractures of the femoral shaft

OPERATIVE MANAGEMENT

- proximal injuries it is wise to initially expose the distal common iliac vessels through a separate incision control before entering the femoral triangle.
- The length of the sterile field includes the entire abdomen to the toes in both lower
- bleeding can be controlled by direct pressure from the source of bleeding
- Blind clamping is strongly discouraged





- In combined arterial and venous injuries, the vein is repaired first
- Published data clearly show that venous repairs improve the likelihood of successful arterial repairs and minimize potential long-term complications

Associated Venous Injuries

The only proven benefit of venous ligation is reduced operating time

1) improved patency of associated arterial repairs because preserved venous patency maintains normal distal vascular bed resistance, thus optimizing blood flow and reducing stagnation; and

(2) reduced incidence of chronic venous insuf-ficiency and associated postphlebitic syndrome

- autogenous saphenous vein graft is the conduit of choice
- polytetrafluoroethylene can be used with good results
- If vein ligation is performed, early fasciotomy is indicated

POPLITIAL

- 12% of all arterial injuries
- the civilian sector has provided the bulk of experience with these injuries,

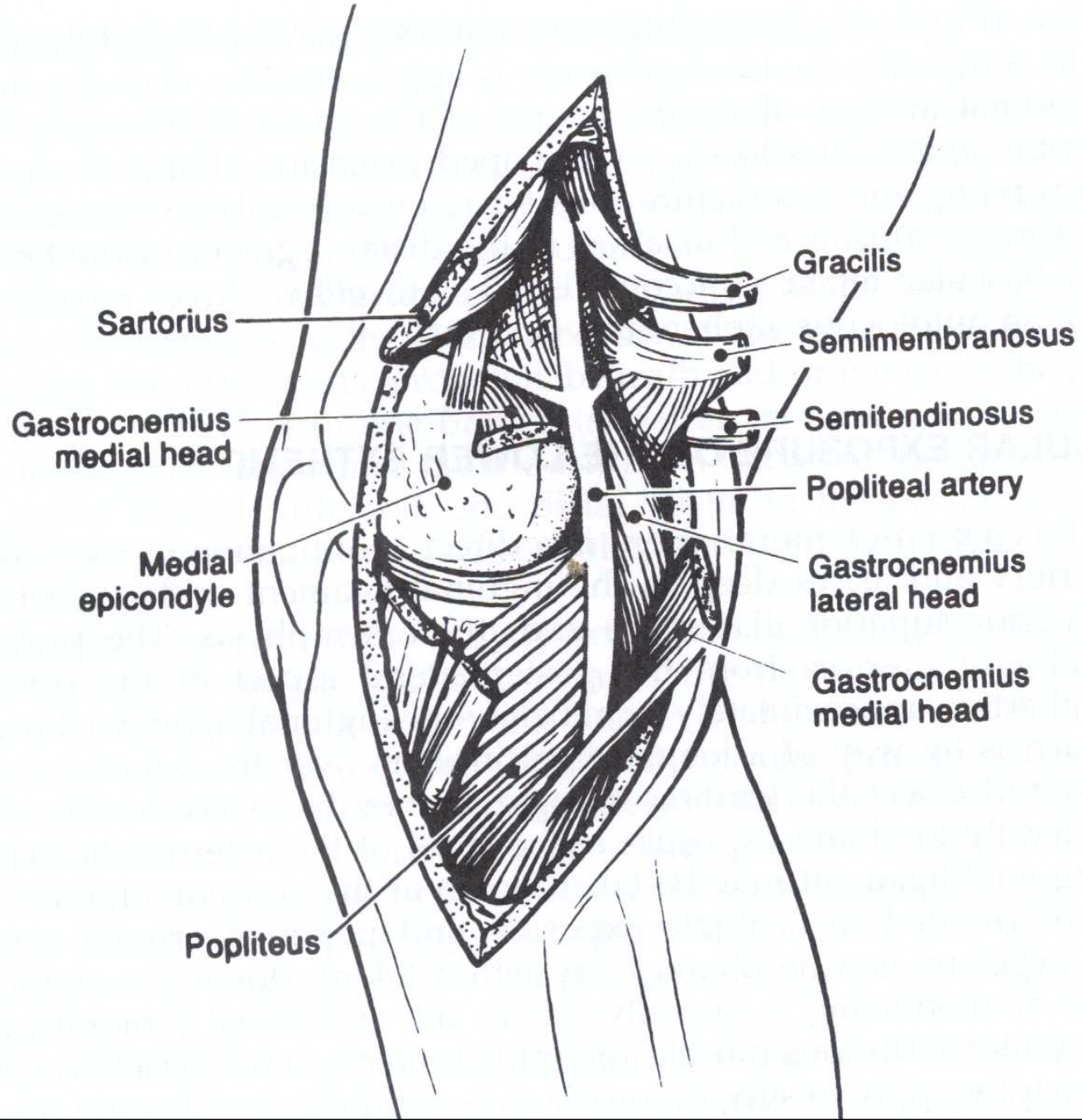
- blunt mechanisms account for 20% to 75% of all cases.

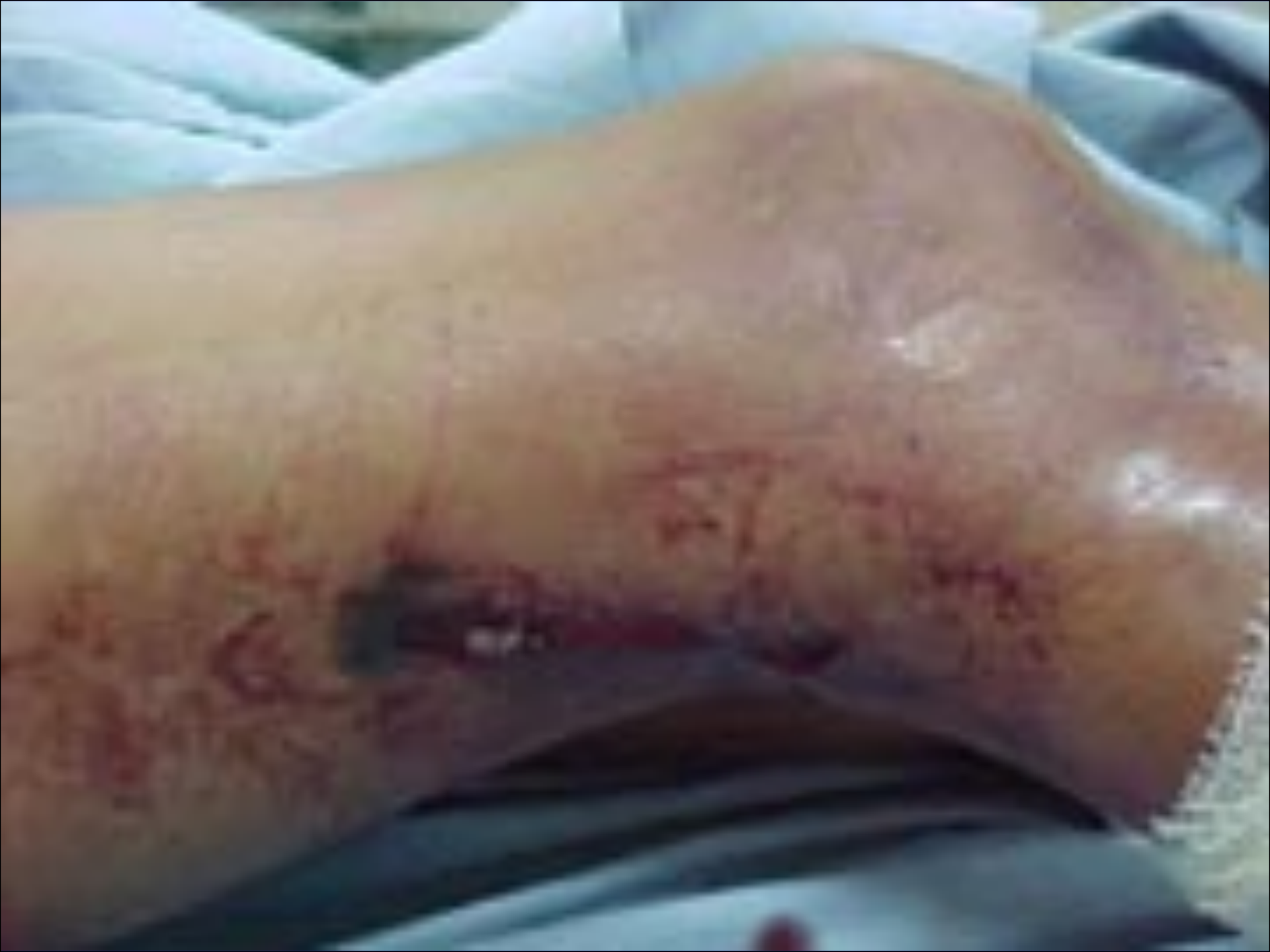
DIAGNOSIS

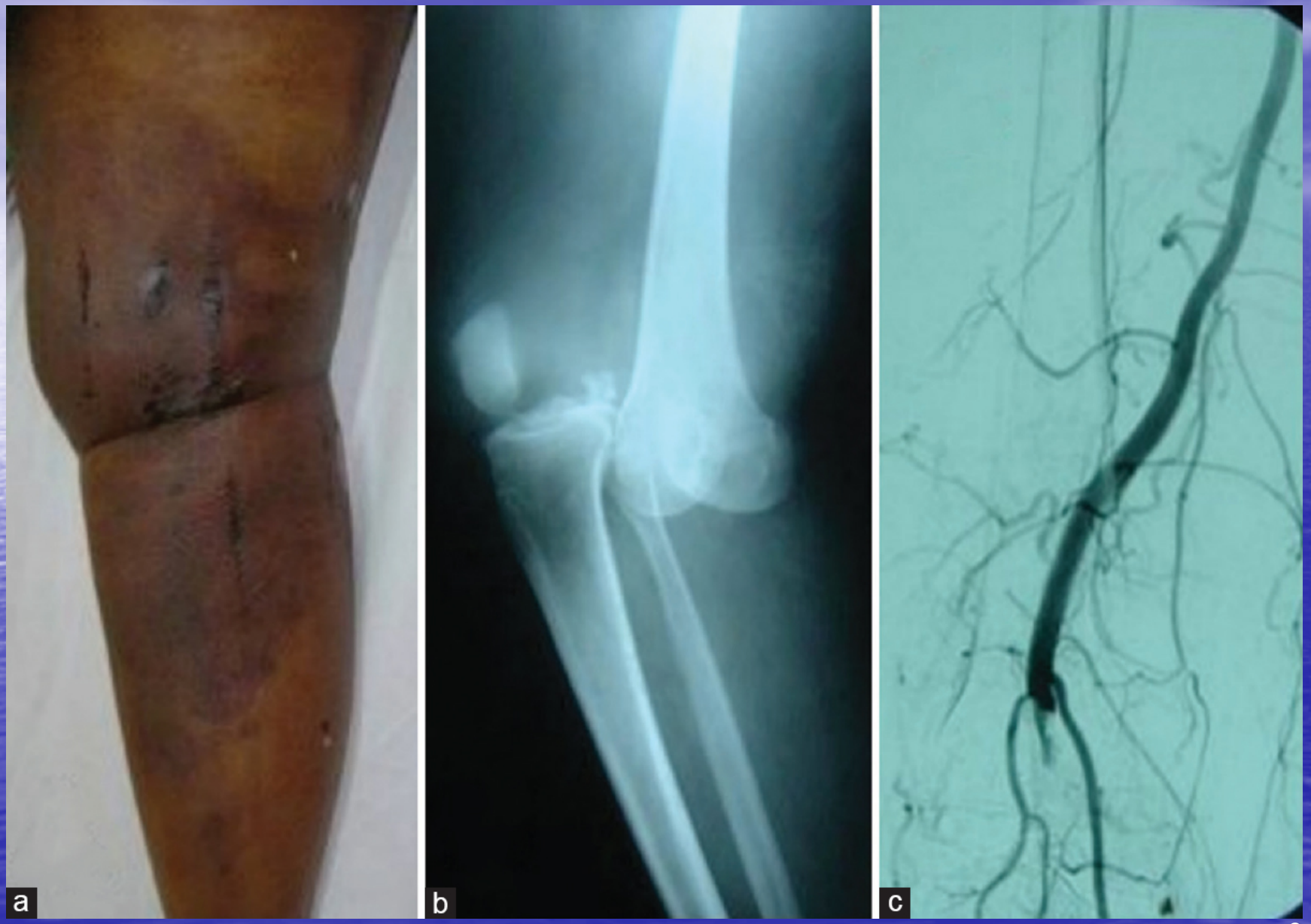
- Most cases present with “hard” signs of vascular injury,
- clinical picture DIAGNOSIS

TREATMENT

- **Surgical Repair**
- Medial longitudinal incision placed 1 cm posterior to the distal femur and proximal tibia
- End-to-end anastomosis
- Division of geniculate collaterals to achieve mobility should be avoided
- Prosthetic grafts across the knee joint generally have lower patency rates than does vein and are best avoided
- popliteal vein injuries should be repaired.


Gracilis
Sartorius
Semimembranosus
Gastrocnemius
medial head
Semitendinosus
Popliteal artery
Medial
epicondyle
Gastrocnemius
lateral head
Gastrocnemius
medial head
Popliteus

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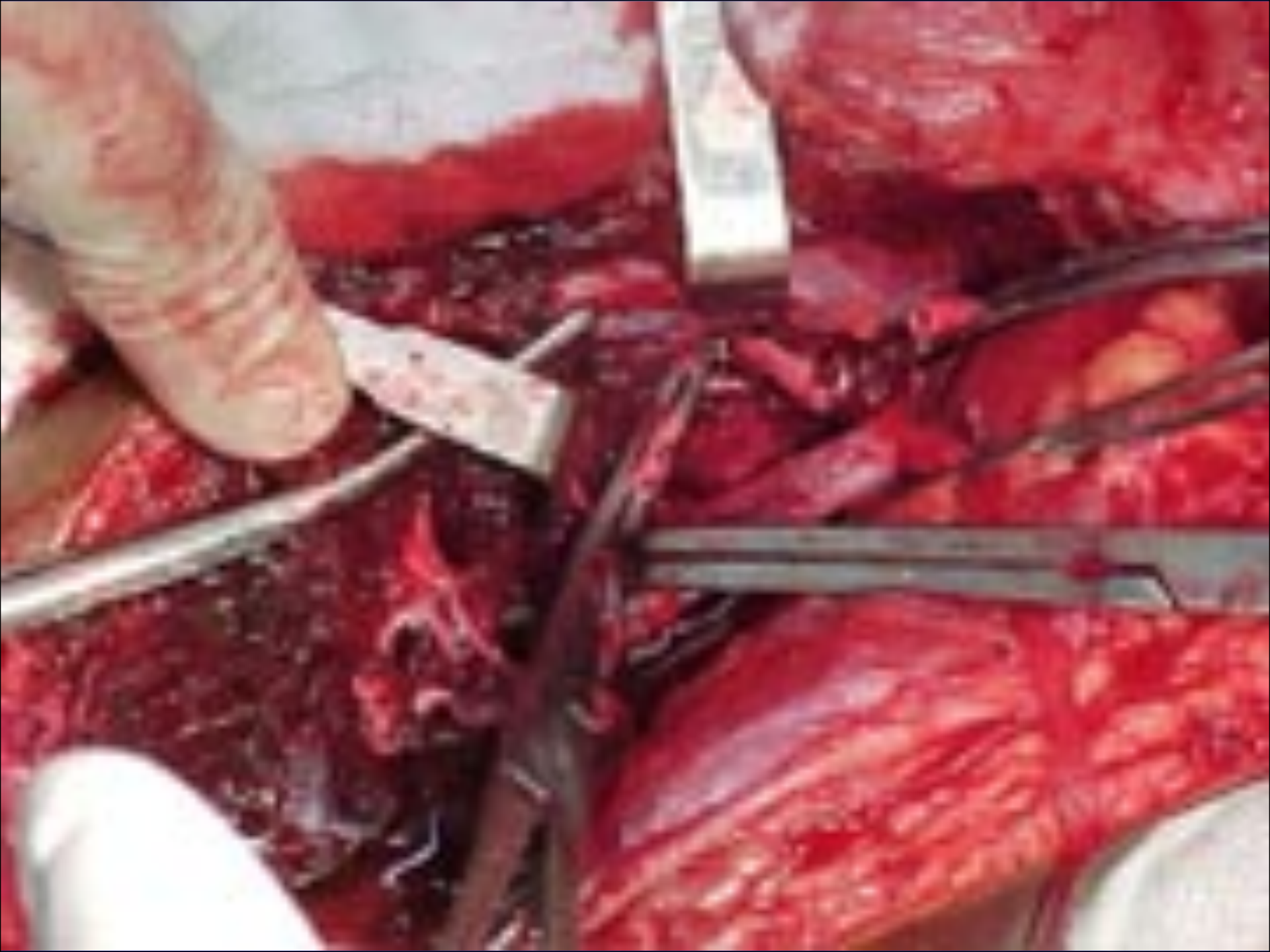

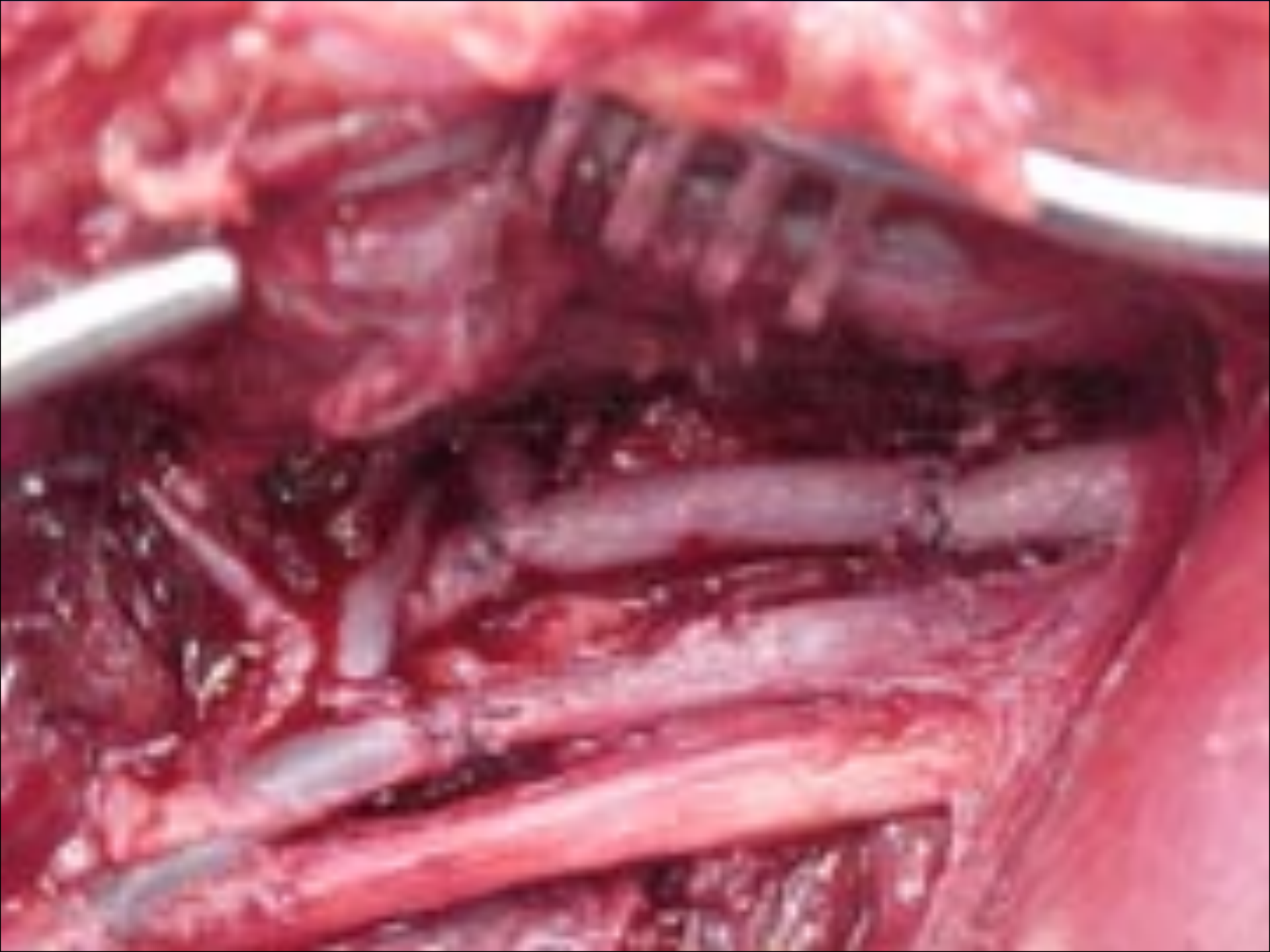

Shank vessels

- management is still controversial.
- uncertainty of the number of patent arteries needed for limb viability.
- Some suggested that ligation of shank vessels is safe as long as one patent vessel remains.
- Others argue that there is a 14% amputation rate after ligation of one of the tibial vessels,
- 65% after ligation of two vessels,
- any injury to the shank vessels, with the exception of isolated peroneal injury, should be repaired

DIAGNOSIS

- “hard andsoft signs”
- (ABI).
- Color-flow duplex
- Angiography

Associated Injuries

- thorough neurologic examination
- 10% and 58%.
- Associated bony injuries are reported to occur in approximately35% of cases

posterior tibial artery or peroneal artery

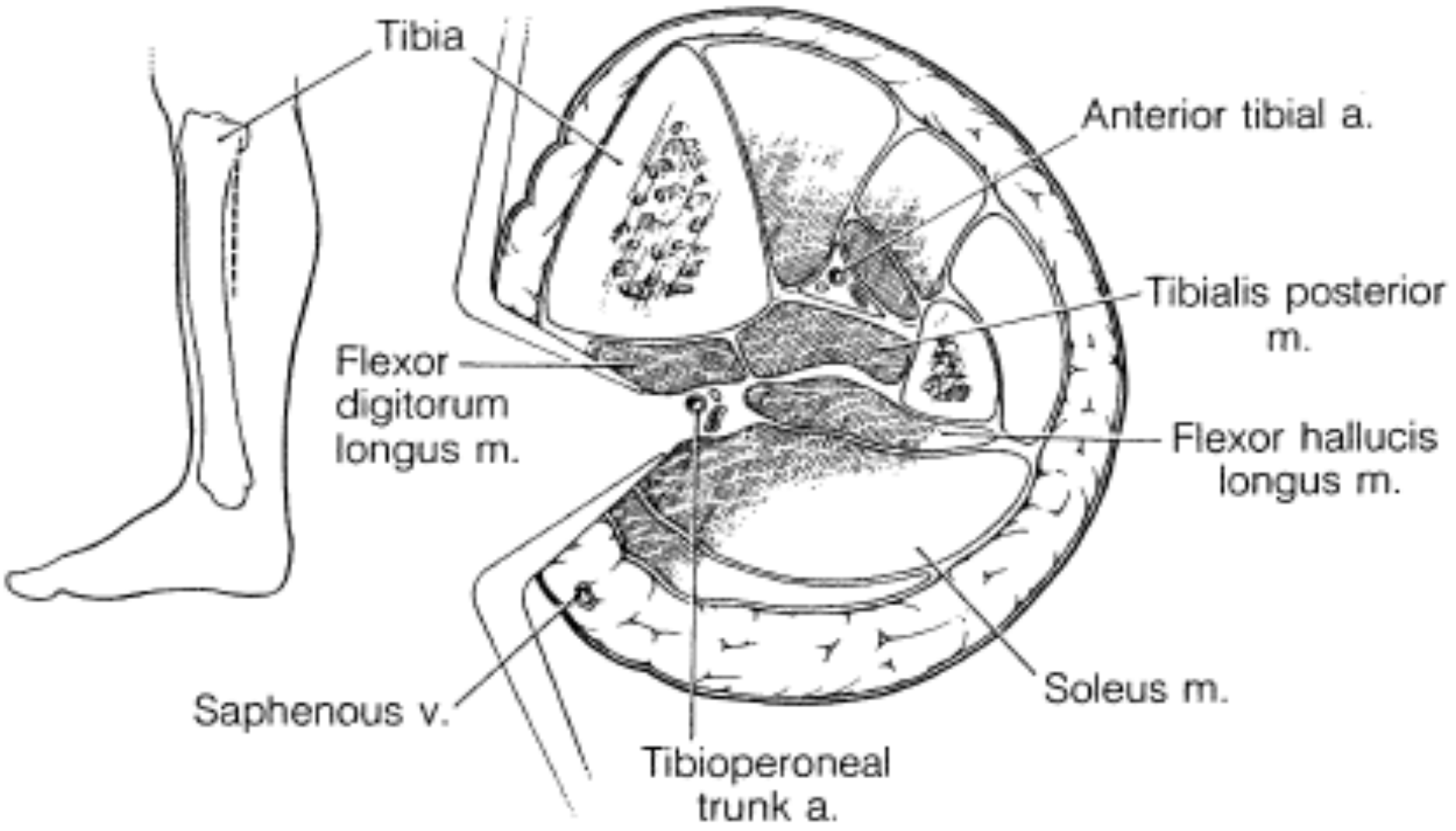

Figure 1. Operative exposure: Tibioperoneal trunk.

Anterior Tibial Artery

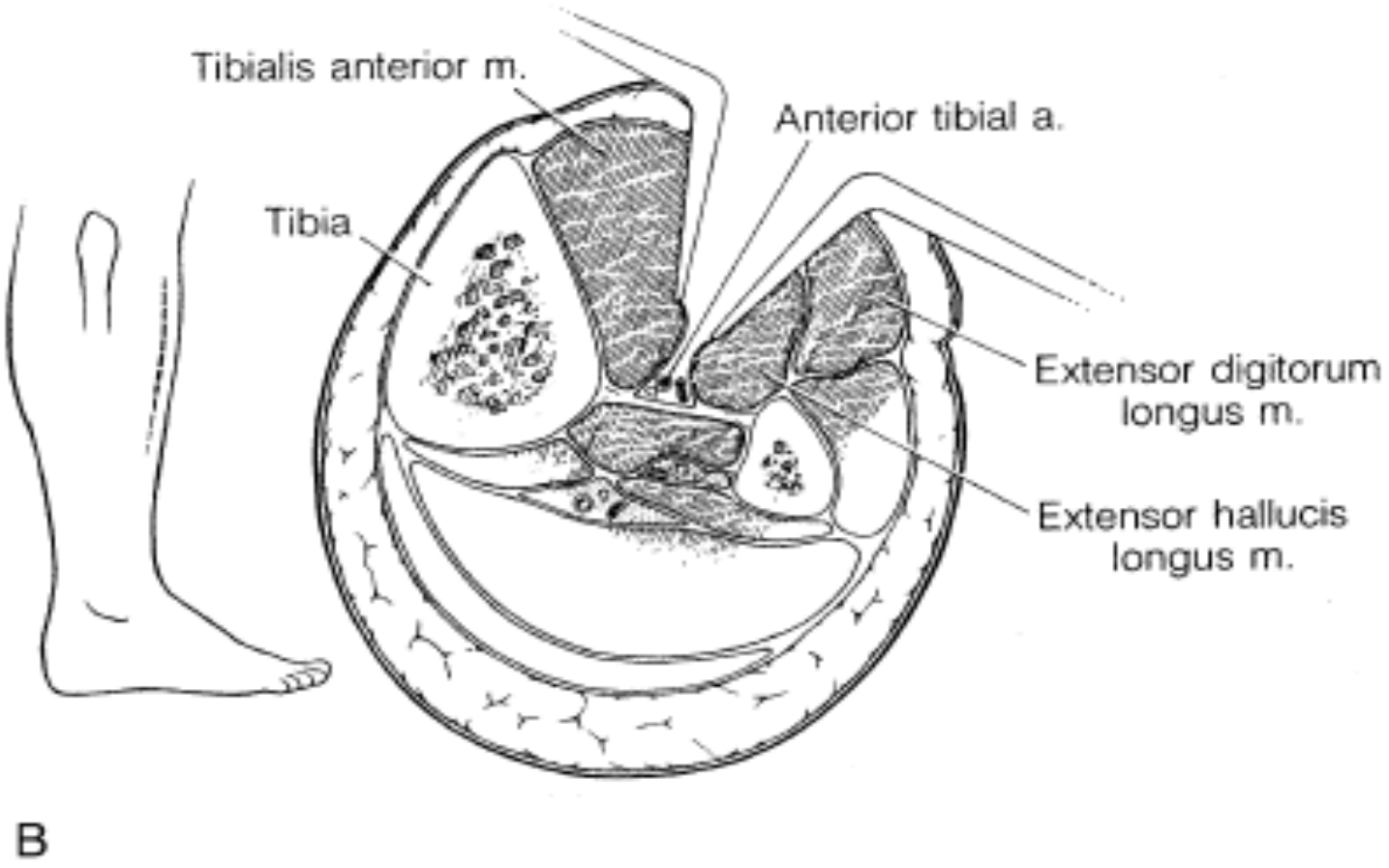

Figure 3. Operative exposures: (Lateral) Shank arteries mid-leg *(A)*, anterior tibial arter *(B)*.