THE USE OF EXTRAANATOMIC BY-PASSES IN VASCULAR SURGERY

Until now there are no precise criteria regarding the surgical management of extraanatomic by-passes. This incudes indications for surgery, by-pass application techniques and patient selection. The aim of the study is to elucidate this problem, by analyzing the outcomes of 38 patients with extraanatomic by-passes. All patients underwent surgery between 1987-2010. Critical ischaemia of the lower limbs associated with advanced cardiovascular and pulmonary pathology served as indication for the use of extraanatomic by-passes in 21 patients. Another group of 6 patients operated with extraanatomic by-passes had septic processes and 11 patients with vascular injuries associated with bacterial contamination and delabrante wounds. The results mostly depended on the peripheral vascular bed. In patients with critical ischaemia associated with atherosclerosis and advanced cardiovascular and pulmonary disease, or septic processes, the peripheral vascular bed was chronically affected, thus negatively influencing the results – thrombosis of the by-passes in the early postoperative period or after one year occurred in one half of patients. In patients with a satisfactory runoff, all by-passes were patent through all the observation period (from 1 to 11 years). In conclusion the extraanatomic by-passes represent an alternative choice for classical revascularization surgery in some groups of patients, and are the only solution for limb salvage. These interventions are indicated in patients with suppurative processes, to avoid the septic focus. Another group consists of patients with associated advanced cardiovascular and pulmonary pathology, thus the extraanatomic by-passes being less traumatic then the traditional ones. Extraanatomic by-passes are also indicated in cases of vascular injuries associated with bacterial contamination and delabrante wounds. Certainly these are procedures that every vascular surgeon must possess.

B48

RECONSTRUCȚIA VENEI CAVE INFERIOARE ÎN CAZ DE CONCREŞTERE ÎN EA A CANCERULUI RENAL

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În cazul tumorilor renale maligne, nu rareori (4%-10%) este implicată vena cavă inferioară, fapt ce prezintă o barieră seroiasă pentru intervențiile chirurgicale radicale. Acest studiu analizează rezultatele tratamentului chirurgical a 15 pacienți (14 cazuri de rinichi drept si 1 de rinichi stîng) cu concreștere tumorală în vena cavă inferioară, cu tromb metastatic în vena cavă și cu metastaze în ganglionii paracavali si paraaortali. Diagnosticul preoperator a fost înfaptuit prin USG, Duplex scanare, CT angiografie și angiografie. Era preferabilă embolizarea preoperatorie de arteră renală. La toți pacienții a fost efectuată nefrectomia, care includea și limfodisecția retroperitonială. La toți pacienții s-a efectuat restabilirea continuității venei cave inferioare prin diferite metode: înlaturarea trombului metastatic cu suturarea venei cave, rezecția venei cave cu restabilirea ei ulterioară prin protezare sau petic. La 13 pacienți invazia celulelor blastice în peretele venei cave inferioare a fost confirmată histologic postoperator. A decedat intraoperator un pacient la care a fost folosit circuitul extracorporeal, pentru înlăturarea trombului metastatic prelungit pînă la atriul drept. Cauza decesului a fost sindromul de coagulare intravasculară diseminată. Perioada postoperatorie la 14 pacienți a decurs fără complicații majore și s-au externat în stare satisfăcătoare. Datele obținute ne denotă faptul că pentru un tratament cît mai efectiv a acestor tumori, logic și rațional este de a efectua rezecția segmentului de venă lezat cu reconstrucția ulterioară cînd este posibil. Avansarea tehnicii chirurgicale și rezultatele pozitive obținute ne permit de a promova această tactică agresivă de tratament.

RECONSTRUCTION OF INFERIOR VENA CAVA IN CASES OF RENAL CANCER METASTATIC CAVAL WALL INVASION

In patients with malign renal tumors, inferior vena cava is involved in 4-10%, thus representing a serious barrier for radical intervention. The aim of this study is to analyze the results of surgical treatment of 15 patients (in 14 cases the right kidney was involved and in one case the left one), with metastatic caval wall invasion, metastatic thrombus in the inferior vena cava, and metastasis of paracaval and paraaortal lymph nodes. The preoperative diagnosis was made using ultrasonnography, duplex scanning, CT angiography and angiography. Preoperative renal artery embolization was preferable. All patients underwent nefrectomy with retroperitoneal lymph nodes dissection. The reconstruction of the inferior vena cava was made by several methods: removement of the metastatic thrombus with caval suturing, resection of vena cava with grafting or patching. In 13 cases the tumoral caval wall invasion was demonstrated by postoperative histology analysis. There has been one intraoperative lethal case in a patient that had a cardiopulmonary by-pass system applied for removement of a metastatic thrombus that has reached the right atrium. The cause of death was disseminated intravascular coagulation. In 14 cases the postoperative outcome was satisfactory, without major complications. In conclusion, the achieved results indicate that resection of the affected cava with its grafting is the elective method for a more effective treatment of these tumors.