Hydrofluoric Acid Burn of the Hand – A Rare Emergency

J. Peter*, S.-M. Maksan, K. Eichler, T.C. Schmandra, T. Schmitz-Rixen
J.W.G. University Hospital, Department of Vascular Surgery, Frankfurt am Main, Germany

Introduction: We report on successful endovascular treatment of a hydrofluoric acid burn to the hand.

Report: A worker complained of severe pain in the fingers D II to D V after injury with 60% hydrofluoric acid. A digital subtraction angiography showed vasospasm of the common palmar digital artery. We selectively applied 20% calcium gluconate intra-arterially.

After treatment all arteries were perfused. Alprostadil, acetylsalicylic acid and clopidogrel were administered in conjunction. Pain symptoms improved and sensory and motor functions were restored.

Discussion: Immediate angiography and intra-arterial application of calcium gluconate are recommended to treat hydrofluoric acid burn to a limb.

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‘Trial of Stiff Guidewire’: A Useful Adjunct to Determining Suitability for Endovascular Aneurysm Repair

V.J. Gokani, N.G. Fishwick, E. Choke, M.J. Bown, R.D. Sayers
Department of Vascular Surgery, Clinical Sciences Building, Leicester Royal Infirmary, Leicester LE2 7IX, UK

Introduction: This study investigated our practice of performing a pre-operative ‘trial of stiff guidewire’ to assess whether iliac artery tortuosity may be overcome, prior to denying patients endovascular aortic aneurysm repair (EVAR).

Report: During the 58-month study period, 35 ‘trial of stiff guidewire’ procedures were performed, the thirty-one of whom ‘passed’ were suitable for EVAR. Four patients whose iliac anatomy could not be straightened (failing the trial of stiff guidewire) were offered open surgery only.

Discussion: If the iliac artery can be straightened using the stiff wire, to a bend less acute than 80°, patients may still be offered EVAR.

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Revascularisation of Internal Carotid Artery Aneurysm near the Skull Base

H. Ren, X. Song, J. Shao, C. Liu, Y. Zheng
Department of Vascular Surgery, Peking Union Medical College Hospital, CAM & PUMC, Beijing 100730, China

A 51-year-old man presented with a pulsatile neck mass. Computed tomography angiography (CTA) revealed a right internal carotid aneurysm. No neurological symptoms occurred for more than 40 years in this patient, which indicated a possible congenital lesion worsened by secondary atherosclerosis. The aneurysm extended from the carotid bifurcation nearly to the base of the skull, and a normal internal carotid artery (ICA) segment was found before entering the carotid canal. The distal end of the extracranial ICA was exposed by transecting the digastric muscle and removing the styloid process during the procedures. The external carotid artery (ECA) was chosen as the inflow source in order to shorten the clamping time of the ICA. His recovery was uneventful, and the follow-up at 2 years revealed that carotid artery patency was obtained.

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