PREOPERATIVE DIAGNOSES,1. End-stage renal disease.,2. Diabetes.,POSTOPERATIVE DIAGNOSES,1. End-stage renal disease.,2. Diabetes.,OPERATIVE PROCEDURE,Creation of right brachiocephalic arteriovenous fistula.,INDICATIONS FOR THE PROCEDURE,This patient has end-stage renal disease. Although, the patient is right-handed, preoperative vein mapping demonstrated much better vein in the right arm. Hence, a right brachiocephalic fistula is being planned.,OPERATIVE FINDINGS,The right cephalic vein at the elbow is chosen to be suitable. It is slightly sporadic, but of an adequate size. An end-to-side right brachiocephalic arteriovenous fistula was created. At completion, there was a great thrill.,OPERATIVE PROCEDURE IN DETAIL,After informed consent was obtained, the patient was taken to the operating room. The patient was placed in the supine position. The patient received a regional nerve block. The patient also received intravenous sedation. The right arm was prepped and draped in the usual sterile fashion.,We made a small transverse incision in the right cubital fossa. The cephalic vein was identified and mobilized. The fascia was incised, and the brachial artery was also identified and mobilized. The brachial artery was free off significant disease. A good pulse was noted. The cephalic vein was mobilized proximally and distally. The brachial artery was mobilized proximally and distally. We did not give heparin. The brachial artery was then clamped proximally and distally. The cephalic vein was also clamped proximally and distally. Longitudinal arteriotomy was

made in brachial artery, and a longitudinal venotomy was made in the cephalic vein. We then sewn the vein to the artery in a side-to-side fashion using a running 7-0 Prolene suture.,Just prior to completion of the anastomosis, it was flushed, and the anastomosis was then completed. A great thrill was noted. We then ligated the cephalic vein beyond the arteriovenous anastomosis and divided it. This surrounded the anastomosis as an end-to-side functionally. A great thrill remained in the fistula. Hemostasis was secured. We then closed the wound using interrupted PDS sutures for the fascia and a running 4-0 Monocryl subcuticular suture for the skin. Sterile dry dressing was applied.,The patient tolerated the procedure well. There were no operative complications. The sponge, instrument, and needle counts were correct at the end of the case. I was present and participated in all aspects of the procedure. The patient was then transferred to the recovery room in satisfactory condition. A great thrill was felt in the fistula completion. There was also a palpable radial pulse distally.