PREOPERATIVE DIAGNOSES,1. End-stage renal disease.,2. Left subclavian vein occlusion.,3. Status post chronic tracheostomy.,4. Status post coronary artery bypass grafting.,5. Right subclavian vein stenosis.,POSTOPERATIVE DIAGNOSES,1. End-stage renal disease.,2. Left subclavian vein occlusion.,3. Status post chronic tracheostomy.,4. Status post coronary artery bypass grafting.,5. Right subclavian vein stenosis.,OPERATIVE PROCEDURE,Creation of autologous right brachiobasilic arteriovenous fistula - first stage.,INDICATIONS FOR THE PROCEDURE,This patient has a known left subclavian vein occlusion. The right subclavian vein has an estimated 50% stenosis. The patient has a catheter traversed in the right innominate vein. The right basilic vein was judged to be suitable for usage on vein mapping.,OPERATIVE FINDINGS,The basilic vein was of an adequate size, but somewhat sclerotic. A first stage autologous right brachiobasilic arteriovenous fistula was created. A grade 2 was felt at completion.,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 regional nerve block. The patient also received intravenous sedation. The right arm was prepped and draped in the usual sterile fashion. We used ultrasound to locate the basilic vein at the cubital fossa.,A small transverse incision was made slightly above the basilic vein. The basilic vein was identified and immobilized. The basilic vein was of a good size, but somewhat sclerotic. The underlying fascia was

incised and the brachial artery was identified and immobilized. The brachial artery was normal. We then divided the basilic vein distally. The distal end was ligated using silk suture. The brachial artery was clamped proximally and distally. A small longitudinal arteriotomy was made in the brachial artery. We did not give heparin. The end of the basilic vein was then sewn end-to-side to the brachial artery using a running 7-0 Prolene suture. ,Just prior to completion of the anastomosis, it was flushed and anastomosis was completed. Flow was then established. A grade 2 was felt in the outflow basilic fistula. Hemostasis was secured. The wound was then closed in layers using interrupted PDS sutures for the fascia and a running 4-0 Monocryl subcuticular suture for the skin. A 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 transferred to the recovery room in satisfactory condition.