PREOPERATIVE DIAGNOSIS:, Aortoiliac occlusive disease.,POSTOPERATIVE DIAGNOSIS:, Aortoiliac occlusive disease.,PROCEDURE PERFORMED:, Aortobifemoral bypass.,OPERATIVE FINDINGS: , The patient was taken to the operating room. The abdominal contents were within normal limits. The aorta was of normal size and consistency consistent with arteriosclerosis. A 16x8 mm Gore-Tex graft was placed without difficulty. The femoral vessels were small somewhat thin and there was posterior packing, but satisfactory bypass was performed.,PROCEDURE: , The patient was taken to the operating room, placed in a supine position, and prepped and draped in the usual sterile manner with Betadine solution. A longitudinal incision was made after a Betadine-coated drape was placed over the incisional area. Longitudinal incision was made over each groin initially and carried down to the subcutaneous fat and fascia. Hemostasis was obtained with electrocautery. The common deep and superficial femoral arteries were exposed and then these incisions were covered with antibiotic soaked sponges. Attention was then turned to the abdomen, where a longitudinal incision was made from the pubis xiphoid, carried down subcutaneous fat and fascia. Hemostasis was obtained with electrocautery. The abdomen was entered above the umbilicus and then this was extended with care inferiorly as the patient has undergone previous abdominal surgery. Mild adhesions were lysed. The omentum was freed. The small and large intestine were run with no evidence of abnormalities. The liver and gallbladder were

within normal limits. No abnormalities were noted. At this point, the Bookwalter retractor was placed. NG tube was placed in the stomach and placed on suction. The intestines were gently packed intraabdominally and laterally. The rest of the peritoneum was then opened. The aorta was cleared, both proximally and distally. The left iliac was completely occluded. The right iliac was to be cleansed. At this point, 5000 units of aqueous heparin was administered to allow take effect. The aorta was then clamped below the renal arteries and opened in a longitudinal fashion. A single lumbar was ligated with #3-0 Prolene. The inferior mesenteric artery was occluded intraluminally and required no suture closure. Care was taken to preserve collaterals. The aorta was measured, and a 16 mm Gore-Tex graft was brought on the field and anastomosed to the proximal aorta using #3-0 Prolene in a running fashion. Last stitch was tied. Hemostasis was excellent. The clamp was gradually removed and additional Prolene was placed in the right posterolateral aspect to obtain better hemostasis. At this point, strong pulses were present within the graft. The limbs were vented and irrigated. Using bimanual technique, the retroperitoneal tunnels were developed immediately on top of the iliac arteries into the groin. The grafts were then brought through these, care being taken to avoid twisting of the graft. At this point, the right iliac was then ligated using #0 Vicryl and the clamp was removed. Hemostasis was excellent. The right common femoral artery was then clamped proximally and distally, opened with #11 blade extended with Potts scissors. The graft was _____ and

anastomosed to the artery using #5-0 Prolene in a continuous fashion with a stitch _____ running fashion. Prior to tying the last stitch, the graft and artery were vented and the last stitch was tied. Flow was initially restored proximally then distally with good results. Attention was then turned to the left groin and the artery grafts were likewise exposed, cleared proximally and distally. The artery was opened, extended with a Potts scissors and anastomosis was performed with #5-0 Prolene again with satisfactory hemostasis. The last stitch was tied. Strong pulses were present within the artery and graft itself. At this point, 25 mg of protamine was administered. The wounds were irrigated with antibiotic solution. The groins were repacked. Attention was then returned to the abdomen. The retroperitoneal area and the anastomotic sites were checked for bleeding and none was present. The shell of the aorta was closed over the proximal anastomosis and the retroperitoneum was then repaired over the remaining portions of the graft. The intraabdominal contents were then allowed to resume their normal position. There was no evidence of ischemia to the large or small bowel. At this point, the omentum and stomach were repositioned. The abdominal wall was closed in a running single layer fashion using #1 PDS. The skin was closed with skin staples. The groins were again irrigated, closed with #3-0 Vicryl and #4-0 undyed Vicryl and Steri-Strips. The patient was then taken into the recovery room in satisfactory condition after tolerating the procedure well. Sponges and instrument counts were correct. Estimated blood loss 900 cc.