



شبكة المعلومات الجامعية

بِسْمِ اللَّهِ الرَّحْمَنِ الرَّحِيمِ





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شبكة المعلومات الجامعية

التوثيق الالكتروني والميكرو فيلم

جامعة عين شمس

التوثيق الالكتروني والميكرو فيلم

قسم

نقسم بالله العظيم أن المادة التي تم توثيقها وتسجيلها
علي هذه الأفلام قد اعدت دون أية تغيرات



يجب أن

تحفظ هذه الأفلام بعيداً عن الغبار

في درجة حرارة من 15 – 20 مئوية ورطوبة نسبية من 20-40 %

To be kept away from dust in dry cool place of
15 – 25c and relative humidity 20-40 %



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بعض الوثائق الأصلية تالفة



شبكة المعلومات الجامعية



بالرسالة صفحات
لم ترد بالأصل

Arterial Extremity Trauma : Prognostic Indicators

Thesis

*Submitted for partial fulfillment of M.D degree in General Surgery
By*

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MB. Bch. (Cairo) M Sc. Surgery (Cairo)

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*Faculty of Medicine
Cairo University
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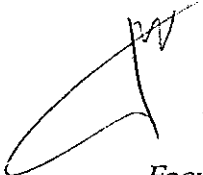
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جامعة القاهرة / كلية الطب

القصر العيسوي

محضر

اجتماع لجنة الحكم على الرسالة المقدمة من
الطبيب / أحمد محمد علي السعيد
تowards للحصول على درجة الماجستير / الدكتوراه
في الجراحة العامة

ARTERIAL Extremity Traumas

تحت عنوان: بالإنجليزية

Prognostic Indicators

باللغة العربية : الحوادث الوعائية في فترات أصابات

الشرايين بالأطراف

بناءً على موافقة الجامعة بتاريخ ١٩٩٩ / ٤ / ١ تم تشكيل لجنة الفحص والمناقشة للرسالة

المذكورة أعلاه على النحو التالي : -

- (١) د/ محمد علي حسن لسانيني استاذ الجراحة العامة وجراحة الأوعية الدموية - جامعة القاهرة - مشرفين
 - (٢) د/ أحمد سليم عام استاذ الجراحة العامة وجراحة الأوعية الدموية - جامعة القاهرة - متعن داخلي
 - (٣) د/ نبيل أمين محمد استاذ الجراحة العامة وجراحة الأوعية الدموية - جامعة عين شمس - متعن خارجي
- بعد فحص الرسالة بواسطة كل عضو منفردا وبما به تقارير منفردة لكل منهم انعقدت اللجنة متعه
في يوم الخميس ١٩٩٩ / ٤ / ١٥ بتقسيم مدرج لتعليم أطباء
بكلية الطب - جامعة القاهرة وذلك لمناقشة الطالب في جلسة علنية في موضوع الرسالة والتناشج
التي توصل اليها وكذلك الاسرار العملية التي قام عليها البحث .
قرار اللجنة :

مبارك سالم
مبارك سالم

توقيعات أعضاء اللجنة : -

المشرف والمتعن

المتعن الداخلي

المتعن الخارجي

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1. *As a result of the above, the Commission has concluded that the proposed transaction is in the public interest and that the proposed transaction is consistent with the public interest.*

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INTRODUCTION



Extremity vascular injuries can result in limb loss, serious life long functional disability or even death in characteristically young victims (Rutherford RB 1988)

The field of vascular trauma is one of the youngest surgical disciplines. Although physicians have long encountered the challenges of hemorrhage and ischemia from the injured vessels, most of our current knowledge of the principles and techniques involving arterial injuries had developed over the past 50 years (Frykberg, ER. 1995)

Experience obtained from the major wars of the twentieth century provides the basis for the present approach to civilian peripheral arterial injury's management (De Bakey. et al 1946) where 90% of those injuries occur in the extremities (Rich, N M. et al 1970)

During World War II, ligation of the injured artery was the routine procedure as attempt for life saving. For the popliteal artery this routine resulted in amputation rate of 73% (De Bakey et al 1946)

In spite of the very early attempts of arterial injury repair as that recorded by *Sir Halliwell* 1759 who repaired lacerated brachial artery and that by *Prof. Dr Murphy; Chicago* 1879 who successfully repaired a totally transected femoral artery (William Hunter. 1986). The formal application of arterial injury repair principles was only implemented at the Korean conflict. And in spite of the time lag of 10 hours average between injury and transfer, the application of this techniques resulted in drop of the amputation rate to 13% (Rich, N M. et al 1969).

Continued further improvement during the Vietnam War, where victim transfer time was reduced to 3 hours, together with the liberal use of autogenous vein grafts and improvement of the vascular repair skills, the amputation rate was kept the same (12.7%). (Rich, NM. et al 1970)

Physical limb trauma could be penetrating, iatrogenic, or blunt. Around 90% of all extremity arterial injuries are of penetrating variety, which are either high velocity or low velocity injuries. The formers are characterized by energy dissipation together with tissue cavitation that result in more damages than the original wound trajectory. Unlike the latter where the insult is mostly

confined to the wound trajectory (where the velocity is less than 1500 ft. /sec) (Perry MO. et al 1995)

Iatrogenic injuries present another form of arterial trauma mechanism specially to the femoral and brachial arteries due to their common use in interventional techniques e.g. cardiac cath.; angiography; angioplasty ...etc. This procedures carry 2-5% injury rate where females are more prone to injury due to their smaller arterial size (Feld R. et al 1992)

Blunt arterial injuries in spite of constituting only 10% of all arterial injuries. Yet it represent more morbid injury owing to the associated fractures, dislocation and crushed soft tissues as well as other systems affection. Motor vehicle accidents and fall from heights represent the most common causes (White .RA et al 1987)

In spite of the wide diversity of the etiological factors, the types of arterial injuries are usually contusion, intimal disruption, punctures, lateral disruption, arteriovenous fistula or transection of the artery (Modrall JG et al 1993)

Timing is a very crucial factor in prognosis of the limb salvage following arterial limb trauma. Clinically an extremity trauma should be examined thoroughly for arterial injuries where presentation of such injuries could be either Frank "Hard" or Doubtful "Soft"

Hard signs of arterial injuries include: absent pulses; active hemorrhage; expanding heamatoma; audible or palpable thrill or; distal ischeamia with pain pallor parathesia paralysis pulslessness coldness and color changes (Frykeberg et al 1995)

Soft signs; *unlike* hard signs; denote only that the probability of the presence of arterial injury can not be over looked. Which includes: small or stable heamatoma in the course of the artery; injury to anatomically related nerve; unexplained hypotension at presentation; history of active hemorrhage that no longer present and proximity of the wound trajectory to a major artery (Frykeberg et al 1995)