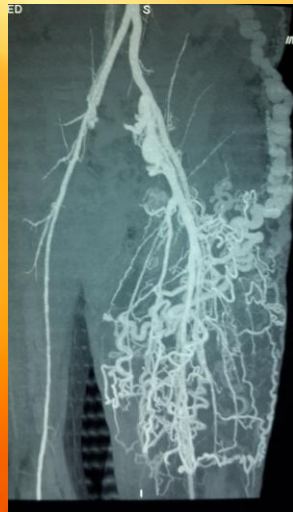


Patients: 24 traumatic AV Fistula were treated by endovascular insertion of stented grafts (Fluency BARD) in the involved arterial segment. They all had a late presentation (1-4 months post injury). They were low (Fem –Pop or below.)

Exclusion: Higher fistulas did not present the problems that were met in the lower ones because of the larger vessels size that allowed easier manipulations.



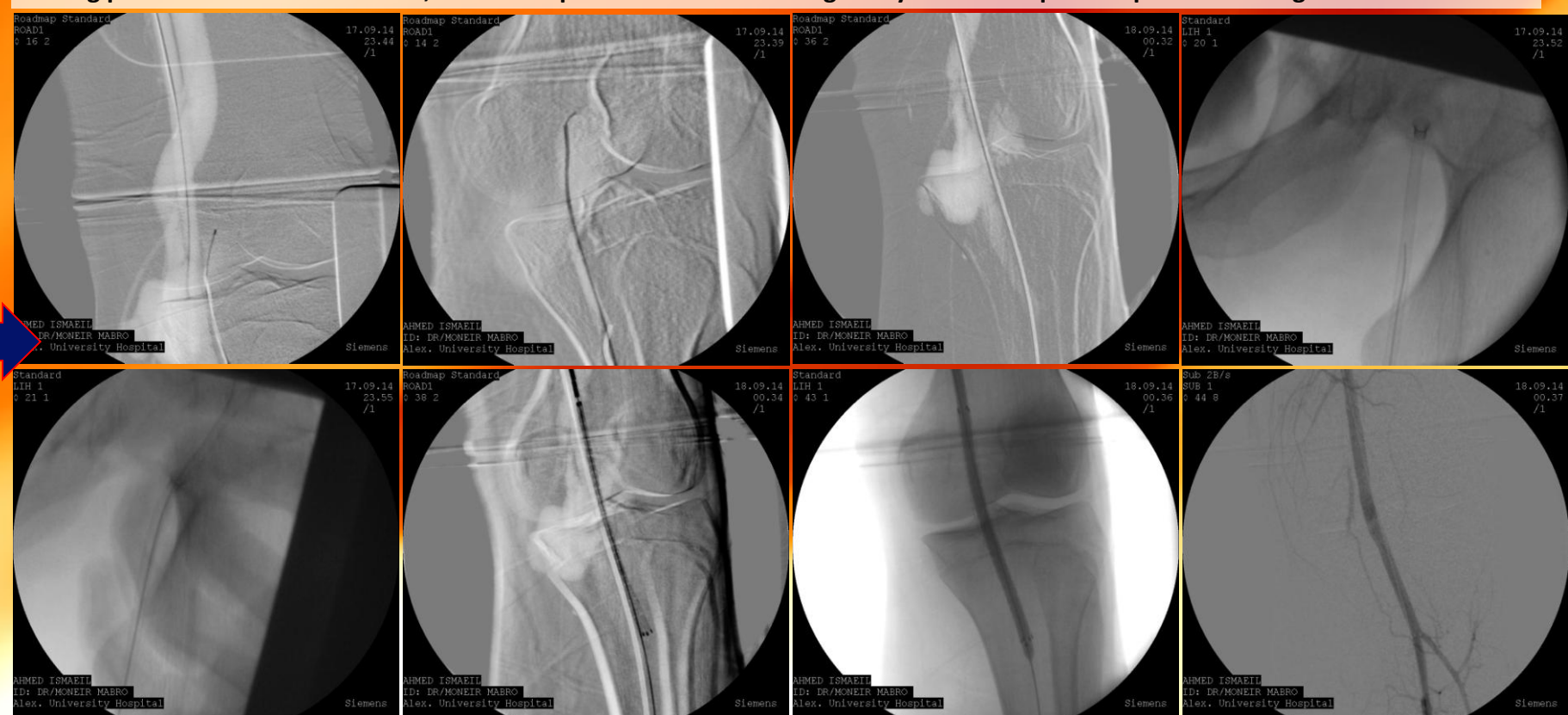
Technique: In the beginning, we started by antegrade entry, made a road map for the fistula and used stiff wire maneuvering trying to cross the distal artery.



First Difficulty: However, a problem was always encountered with the high grade fistula in the lower part of femoropopliteal, or popliteal Tibial segments. The high flow and turbulence usually carried the wire into the fistula body, passing into the vein. Trials to use a hydrophilic vertebral catheter did not help much and caused perforation in three cases.



Solution: We found that the best approach was obtained by dual entry; an antegrade as a guide, and a retrograde through the distal involved artery (Rendez-vous). Having passed the wire from below, the whole procedure is done antegradely . This was quite helpful in crossing the fistula.



Second Difficulty: A second problem was a very atretic, spastic and small distal artery due to the large proximal fistula steel. This caused stagnation in the stent graft after deployment, and sluggish distal flow.



Solution: There was need to balloon dilate the whole distal involved artery, to avoid the high flow resistance of the outflow artery which can induce graft thrombosis if the flow speed drops below the graft thrombotic threshold velocity.