Department of Vascular Surgery

Femoral to Femoral or Iliac to Femoral Crossover Bypass Graft

Why do you need this operation?

You need this operation because you have either pain in your legs or a leg ulcer or gangrene caused by a blockage or narrowing of the arteries in the pelvic area supplying your legs. The narrowing or blockage is diagnosed on a scan. The leg pain becomes particularly noticeable when you exercise because your muscles need more oxygen that is carried in the blood, during exercise. The lack of oxygen to the muscles when you walk results in a cramp-like pain or ache.

As the arteries become more narrowed or blocked, there may not be enough oxygen getting to the muscles even when you are not walking and you might then get pain at rest. This usually occurs at night when you are lying in bed and can be eased by hanging your legs out of the bed or sleeping in a chair. If you get pain at rest, your leg is in danger and you are at risk of developing ulcers or gangrene. At this point you are at risk of losing your leg if you don't have this operation.

The purpose of this operation is to improve the blood supply to your bad leg. We will bypass the blocked arteries in your pelvis that supply your bad leg by taking some of the blood from your good leg.

Before your operation

You will usually have attended the pre-admission clinic about 1-2 weeks before your operation in order to allow time for the tests required to make sure you are fit for the operation. During this assessment you will have an electrocardiogram (ECG) and might also have a chest X-ray, especially if you are or have been a smoker. You might also see a vascular anaesthetist.

Coming into hospital

Please bring with you all the medications that you are currently taking. You will usually be admitted via the Same Day Admission Unit (SDAU).

The surgeon who will be performing your operation will see you and obtain your consent for the operation. You will also see the anaesthetist. If you have any questions regarding your operation or anaesthetic, please ask the doctors.

The operation

You will be taken initially to the anaesthetic room where you will be given your anaesthetic, and from there you will be taken into the operating theatre. You will either be put to sleep (general anaesthetic) or you will have a tube inserted into your back through which painkillers can be given to numb the lower half of your body (spinal or epidural anaesthesia). Sometimes you will have this as well as the general anaesthetic to provide pain relief following your operation.

Before you go to sleep a tube (cannula) will be inserted into your arm vein so that the

anaesthetic can be given. A tube may be inserted into an artery in your wrist to monitor your blood pressure during the operation. Whilst you are asleep, a urinary catheter will be inserted into your bladder to monitor your urinary output

You will usually have two vertical cuts, one in each groin, or one cut in the groin and another (horizontal) cut in the lower part of your tummy. An artificial blood vessel (graft) made of coated plastic or coated polyester or similar material, will be inserted to carry blood from the main artery going to your good leg to the main artery in your bad leg bypassing the blocked arteries. The artery going to your good leg will supply both legs with blood.

The wounds are often closed with a stitch under the skin that dissolves by itself or, very occasionally, with clips that need to be removed.

After the operation

Most patients will go directly back to the vascular ward following their surgery and will be allowed to eat and drink as tolerated. Occasionally if a patient has lots of medical problems prior to surgery they might need to go to the high dependency unit (HDU) for some additional support for 1-2 days following surgery. Occasionally a blood transfusion may also be required

The nurses and doctors will try and keep you free of pain by giving painkillers by injection via a tube in your back (epidural), or by a machine that you are able to control yourself by pressing a button.

The catheter is usually removed from the bladder on the morning after surgery. It is quite common to have some difficulty or discomfort passing urine at first after the catheter is removed.

You will usually be allowed to sit out on the evening the day after your surgery and we will try to get you walking to the toilet the day after that. Most people will be discharged 3 to 5 days after surgery.

A physiotherapist may see you to help you with your breathing to prevent you developing a chest infection and to help you with your walking.

What are the risks/complications?

The operation you are having is major surgery and there are general risks associated with any major procedure. You will have been assessed prior to your surgery to ensure you are fit enough to undergo an anaesthetic. However, every operation has a risk of you developing problems with your heart (heart attack), lungs (chest infection) or kidneys (acute kidney injury) which might not have been anticipated in your pre-operative assessment.

The main specific complication with this operation is blood clotting within the graft causing it to block. If this occurs it will usually be necessary to perform another

operation to attempt to clear the graft. If clearing the graft is not successful with a second operation or if it blocks again during the same admission, there is a risk of you having to undergo an amputation, although your surgeon will do everything possible to prevent this from happening.

Slight discomfort and twinges of pain in your wound are normal for several weeks following surgery, but wounds sometimes become infected and these can usually be successfully treated with antibiotics.

Sometimes if the wound gets infected, it might open up and require a longer stay in hospital and additional dressings may need to be applied to the wound to help it heal.

The wound in your groin may fill with fluid called lymph that may discharge from the wound between the stitches. This usually settles down with time.

You may have patches of numbness around the wound or lower down the leg, which is due to damage to small nerves to the skin. This can be permanent but usually gets better within a few months.

It is very common for the foot/leg to swell due to the improved blood supply. It can last many weeks or even months. Elevation of the legs when sitting will help the fluid disperse.

These risks/complications will be explained and discussed with you when the surgeon asks you to sign the consent form for the operation.

Going home

If dissolvable stitches have been used in the procedure, these do not need to be removed. If your stitches or clips are the type that needs removing and this is not done whilst you are still in hospital, arrangements will be made for the practice or district nurse to remove them and check your wound.

You may take a bath or shower once your wound is dry.

You may feel tired for several weeks after the operation but this should gradually improve as time goes by. Regular exercise such as a short walk combined with rest is recommended for the first few weeks following surgery followed by a gradual return to your normal activity. You should avoid heavy lifting for 12 weeks after the operation.

You may resume sexual relations as soon as this feels comfortable.

It is advisable not to drive for at least 4 weeks after surgery. Usually if you can get in and out of a bath without any discomfort and/or requiring any assistance you should be safe to drive. However, please check with your insurance company as policies vary with individual companies.

If you require a fit certificate for work please ask a member of staff before discharge. You should be able to return to work within 4-6 weeks following your operation, but if in doubt please ask your doctor.

You will usually be sent home on a small dose of aspirin or clopidogrel (antiplatelets) if you were not already taking them. This is to make the blood less sticky. You will also usually be advised to take a statin to reduce your cholesterol levels and to reduce your risk of cardiovascular disease progression.

What can I do to help myself?

If you were previously a smoker, you must make a sincere and determined effort to stop smoking completely. Continued smoking will cause further damage to your arteries and your graft is more likely to stop working.

General health measures such as reducing weight, maintaining a low fat diet and regularly exercising are also important. If you develop sudden pain or numbness in the leg that does not get better within a few hours, then contact the hospital immediately.

Please retain this information leaflet throughout your admission, making notes of specific questions you may wish to ask the doctors and/or nurses before discharge.

If you have any queries prior to the procedures outlined and the implications for you or your relatives/carers, please contact the Surgical Pre-Admission Assessment Clinic on 01603 287819.

If you have any queries following the surgery, please contact the ward from which you were discharged, via the main hospital switchboard on 01603 286286.

Points of contact:

Vascular Specialist Nurses

Norfolk & Norwich University Hospitals NHS Foundation Trust
Tel: 01603 287844 or 01603 647971 (Monday to Friday 9am-5pm)

Further information and support:

Vascular Surgeons (Secretaries):

Miss F J Meyer	01603 287136
Mr M P Armon	01603 287552
Mr DR Morrow	01603 286442
Mr R E Brightwell	01603 287394
Mr M S Delbridge	01603 286434
Mr P C Bennett	01603 286263
Mr W Al-Jundi	01603 287552

Professor P W Stather 01603 647289

NHS 111 service out of hour's advice

Vascular Surgical Society of Great Britain and Ireland
Tel: 020 7205 7150

Web address: www.vascularsociety.org.uk

Circulation Foundation
Tel: 020 7205 7151

Web address: www.circulationfoundation.org.uk

For help giving up smoking
Contact your local NHS Stop Smoking Service Smoke free Norfolk on 0800 08 54113 or your GP surgery, pharmacy for local support.

The NHS National Stop Smoking Helpline and website are a source of advice, help and support visit www.smokefree.nhs.uk.

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It has been given to you because it relates to your condition; it may help you understand it better. It does not necessarily describe your problem exactly. If you have any questions please ask your doctor.