

Postoperative Day 1 Discharge Following External Iliac to Posterior Tibial Bypass in High-Risk, Elderly Patient

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Introduction

Peripheral bypass surgery typically requires several days of postoperative monitoring

This is considered a high-risk procedure, and risks may be increased in patients with multiple comorbidities.

Endovascular options for limb salvage are often effective and lower risk; they are not always feasible options for severe disease.

This case report examines an ilio-tibial bypass performed in a high risk, elderly patient

Individualized approach with surgeons / family strongly focus on limiting hospital stay, limb salvage, and improving quality of the remainder of her life.

Case Report

86-year-old female prior CABG COPD, HTN, CKD

She presented with severe rest pain and a nonhealing ulcer of the right foot (CLTI)

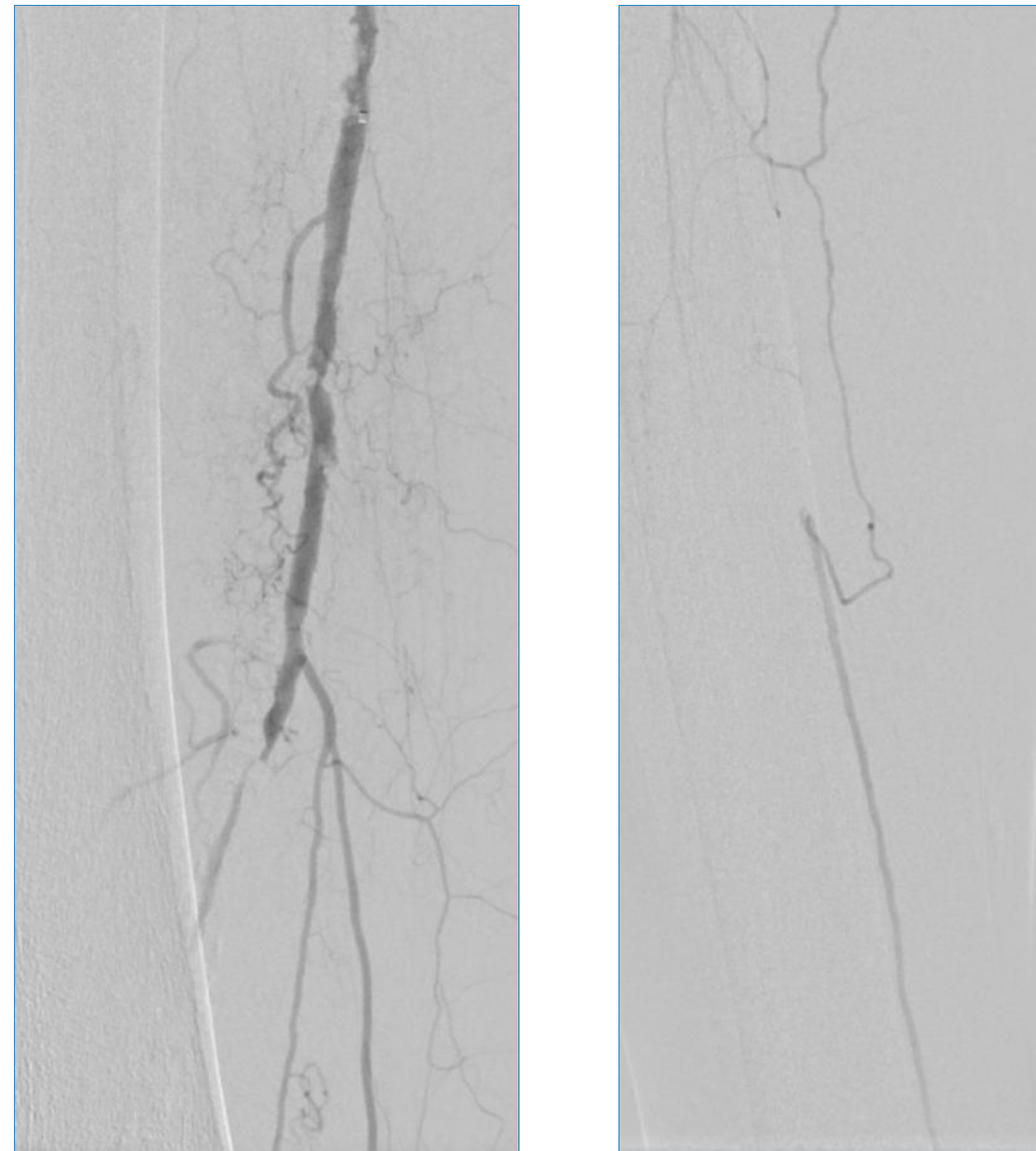
A diagnostic lower extremity angiogram demonstrated long-segment occlusion of the SFA with reconstitution at the posterior tibial artery.

The lesion was unable to be crossed, and endovascular salvage was deemed infeasible.

The option of no revascularization and possible amputation was discussed with the patient and her family, and they expressed deep wishes for preservation of the limb, requesting any options to reduce her pain and improve the quality of her remaining life.

Only feasible surgical option was an iliofemoral to tibial bypass – discussed at length with the patient and family

Very high-risk surgery and patient: Preoperative surgical planning included specific goals of limiting her hospital stay and mitigating risks in her perioperative course.



Within 1 week, the patient underwent a right iliac to posterior tibial bypass under sedation and spinal anesthesia, using a synthetic (Distaflo) graft.

The surgery took less than two hours, and excellent biphasic signal was noted postoperatively.

Patient was kept on aspirin and low dose anticoagulation and discharged home on postoperative day 1 with close monitoring by family and visiting nurses.

The dressing was removed at her follow up appointment on postoperative day 3 with wide patency of the graft noted on ultrasound.

At 6 months, graft remains patent, wounds have healed, and pain resolved

Patient passed within 1 year due to unrelated processes

Discussion

Limb salvage vastly improves quality of life for patients with CLTI, but open bypass risks, surgical complications, delayed hospital stay, and cost effectiveness must be considered.

This case discusses a high-risk surgical patient, who typically may not be considered a candidate for open revascularization.

Due to specific patient factors, strong support system, and detailed surgical planning, an individualized approach could be constructed.

Early discharge especially in this setting is unconventional but may be safe and beneficial for certain patient-specific goals.

We were able to limit hospital LOS, thus reducing infection risk and patient costs, without compromising on postoperative rest or rehabilitation

With optimal patient selection, both inpatient costs could possibly be significantly reduced with early and safe postoperative discharge.

Surgical limb salvage may be safely offered to a wider range of carefully selected patients to improve quality of life even in the elderly.

Conclusions

This case supports an individualized approach of limb salvage following distal bypass surgery in a high-risk elderly patient with early but safe discharge and optimal postoperative outcomes.

We draw attention to meticulous surgical technique, strong social support systems, accommodating infrastructure and postoperative care, as well as careful preoperative planning to obtain the desired improvement in quality of life.

Further investigation is warranted to assess feasibility of this strategy for well-selected patients.