**Title: Trends on Extremity Vascular Trauma in Tikur Anbessa specialized hospital Addis Ababa, Ethiopia: A Retrospective Cross-Sectional study**

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***Abstract***

***Background:*** *Extremity vascular injuries are one of the major causes of limb loss and potentially preventable deaths after trauma. Although it’s a major challenge, especially in countries with less established trauma center, early diagnosis and intervention is important for better outcome. Amidst the high rates of vascular trauma and its associated consequences; little is known on the epidemiology, management strategies and outcomes in the Ethiopian setting.*

***Methods****: A retrospective observational study was conducted among all extremity vascular trauma patients who are admitted and treated at Tikur Anbessa Specialized hospital (TASH) with in the period of June 1, 2015 till May 30, 2020*

***Result:*** *A total of 85 patients with extremity vascular trauma, predominantly male 90.6%, were included in the study. The mean age was 27 ± 9 years. Penetrating trauma caused 89.4% of extremity vascular injuries. Majority of the injuries are caused by stab/sharp (40%), bullet (29.1%) and road traffic accident (17.7%). Brachial artery was the commonest vessel injured accounting for 36.5% followed by femoral artery injury of 22.4%. The commonest types of vascular injuries were complete transection (74.1%), laceration (15.3%) and partial transection (8.2%). The most commonly used method of vascular reconstruction was reverse interposition venous graft accounting for 45.9%. Other methods of reconstructions were ligation & hemostasis (20%), primary repair with End-to-End Anastomosis (17.7%), primary simple repair (15.3%) and venous patch (1.2%). A limb salvage rate of 91.8% was achieved despite a 67.1% of late presentation (>6 hour).*

***Conclusion****: Vascular injuries are mainly due violence and road traffic accidents; which are on the rise. Limb loss and mortality due to this injury can be mitigated by improving health policies, implementing emergency ambulatory system and provision of vascular services with better training centers.*

***Key words:*** *Trauma****,*** *Vascular injury, vascular reconstruction, and vascular repair.*

**Introduction**

Trauma is one of the leading worldwide health problems that cause an estimate of more than 5.8 million people to die each year (10% of the world’s total death). (1,2) Though vascular injury accounts for only 1-2% of the total injury, hemorrhages resulting from the injury are a major cause of potentially preventable deaths (3-6). Although uncommon following civilian trauma, vascular injuries may be responsible forjiu up to 20% of trauma deaths (7) and the highest utilization of hospital resources (3,4jiujiu8). Vascular injuries to the extremity are common accounting for up to half of all vascular injuries, and it is the third leading cause of potentially survivable injury (5,10,11).

Extremity vascular trauma patients tend to be predominantly male and mainly occur in the younger population with average ages in the 30’s (3,4,10). Extremity vascular injury can result from both blunt and penetrating mechanisms. Those with blunt vascular injury to the extremity have a higher rate of mortality (2-5%) than penetrating trauma; mainly due to associated non-vascular injuries in the blunt trauma. The amputation rate is also higher in blunt extremity vascular injuries (4,17).

In Ethiopia, injury is a major cause of mortality with an estimated rate of 12% and extremity injury resulting in fracture and/or dislocation is the commonest one (18, 19). Studies have also shown a higher incidence of amputation in trauma patients with comminuted fracture associated with vascular injury (12,14,20). In Ethiopia, a literature review showed very limited studies done on vascular trauma. Hence, the current study was done to determine the magnitude of extremity vascular injuries and their outcome among patients who are admitted and treated at TASH (Tikur Anbessa Specialized Hospital) in Ethiopia

**Materials and Methods**

Tikur Anbessa specialized hospital (TASH) is an 800-bed tertiary referral hospital that offers diagnosis & treatment for approximately 500,000 patients a year. The hospital receives patients that are referred from across the whole country and gives specialized clinical services including vascular surgery (43). The hospital is also a training center for both undergraduate and postgraduate training including a fellowship program on vascular surgery. The hospital is equipped with 14 operating theaters; one is dedicated for vascular surgery. Recently, the center has also acquired a new bi-plane and a monoplane cardiac catheterization laboratory that can also serve peripheral vascular disease.

A retrospective cross-sectional study was conducted on patients with Extremity Vascular Trauma between June 2015 and May 2020. All patients who were diagnosed and treated for extremity vascular trauma with a named blood vessel injury were included in the study.

While those patients with an injury to the named blood vessel proximal to the junctional zone (central injury), proximal to the axillary artery (upper extremity), proximal to the common femoral artery (lower extremity), and non-extremity peripheral vascular injuries were excluded.

Records were reviewed to examine demographic, anthropometric, residence, occupation, duration, type, site, mechanism, and any other associated injuries. A clinical, laboratory, radiological, echocardiographic, operative data, type of repair, perioperative complications, hospital stay, and other covariates like other morbidity and mortality were collected using a structured data abstraction format prepared for this study. Data were collected through self-administered a structured questionnaire from an existing HMIS logbook, registry book, and patients chart at TASH. During data collection the principal investigator did supervise all activities during the data collection. Data completeness and consistency were checked on spot questionnaires, and missed variables were turned back for correction. Data was then cleaned manually for consistency, for any missing values and finally, entered in to SPSS Version 23.0 for analysis. Descriptive analysis was performed using SPSS version 23 to describe the study variables. Frequency analysis was run for socio-demographic, clinical diagnosis and management outcome. Finally, the findings were described in the text, percent, and means and presented using frequency tables & charts.

An ethical clearance was granted from Institutional Review Board; Collage of Health Science Addis Ababa University. A letter of permission to retrieve a medical record of needed patients from an archive was then obtained from Tikur Anbessa Specialized Hospital. Every aspect of human rights, which includes the right to privacy and confidentiality, was maintained throughout the study; and measures were taken to maintain anonymity by not including patients’ names in the questionnaire.

# **Result**

A total of 85 patients with extremity vascular trauma who attended and were treated at the TASH surgical department, and who met the eligibility criteria were enrolled in the study. Extremity vascular trauma accounts for 62% of the total vascular injuries attended during the five-year study period.

## Socio-demographic & economic characteristic

Among the total of 85 extremity vascular trauma patients, 77(90.6%) were males while the remaining 8(9.4%) were females. The ratio of male to female was 9.6:1. The median age (IQR) was 26 years with the range being from 13 to 60 years. Most of the cases (78.8%) were between the age group of 15 to 35 years. Urban residents accounted for 45(52.9%) and 40(47.1%) were from a rural area of the country. In this study, majority of the patients were an employee of the government or private sector 33(38.8%) and students 22(25.9%). Additionally, farmers were 15(17.7%) and daily laborers were 7(8.2%). **(Table 1)**

## Clinical Presentation, Mechanism of Injury and Diagnosis

As shown in Table 2 majority of the patients 57(67.1%) presented after 6 hours of injury. Penetrating trauma accounted for 89.4% of the cases; which is significantly higher than blunt trauma (10.6%). Unintentional injuries were the primary causes for 43(50.6%) of extremity vascular trauma and Intentional injuries, which have a relatively equal proportion; resulted in 42(49.4%) of vascular trauma. Stab (or Sharp) injuries 34(40%) were the commonest causes of extremity vascular trauma, which was followed by Bullet injury 25(29.4%). Other causes were Road Traffic Accident 15(17.7%), Grinder or Machine injury 5(5.9%), Fall 4(4.7%), Iatrogenic 1(1.2%), and Suicidal 1(1.2%).

Table 1: Sociodemographic characteristics of patients with extremity vascular trauma in Tikur Anbessa specialized hospital, Addis Ababa, Ethiopia.

|  |  |  |
| --- | --- | --- |
| **Category/ Characteristics** | **Frequency** | **Percent (%)** |
| **Age** |  |  |
| < 15  15-24  25-34  35-44  45-54 | 3  33  34  11  2 | 3.5  38.8  40  12.9  2.4 |
| ≥ 55  Mean Age | 2  27.02 +/- 9.3 | 2.4 |
| **Sex** |  |  |
| Male | 77 | 90.6 |
| Female | 8 | 9.4 |
| **Residence** |  |  |
| Urban | 45 | 52.9 |
| Rural | 40 | 47.1 |
| **Occupation** |  |  |
| Government or Private employee  Student | 33  22 | 38.8  25.9 |
| Farmer | 15 | 17.7 |
| Daily Laborer | 7 | 8.2 |
| Unemployed  Merchant | 3  3 | 3.5  3.5 |
| Retired | 2 | 2.4 |

Diagnosis of extremity vascular trauma was made clinically in 55.3% of patients and the remaining was diagnosed by using Doppler 37(43.5%) and Computed Tomographic Angiography 1(1.2%). There was an associated injury; apart from the vascular injury; in 39(45.9%) of cases, with 14(35.9%) of them having more than one. **(Table 2)** The commonest associated injury was bone fracture (with or without dislocation), which accounted for 28(71.8%); followed by Peripheral Nerve Injury of 22(56.4%). Median nerve injury was seen in 10(45.5%) cases and is the commonest peripheral nerve injured.

*Table 2. Mechanism of injury, presentation, and diagnosis of extremity vascular trauma patients in TASH, Ethiopia*.

|  |  |  |
| --- | --- | --- |
| **Category/ Characteristics** | **Frequency** | **Percent (%)** |
| **Mechanism of injury** |  |  |
| **Type of trauma**  Penetrating  Blunt  **Specific Mechanism**  Stab/ sharp injury  Bullet injury  Road traffic accident  Grinder/ Machine injury  Fall  Iatrogenic  Suicidal | 76  9  34  25  15  5  4  1  1 | 89.4  10.6  40  29.4  17.6  5.9  4.7  1.2  1.2 |
| **Time of Presentation** |  |  |
| =<6 hour | 28 | 32.9 |
| 6-24 hour  >24 hour | 21  36 | 24.7  42.4 |
| **Method of Diagnosis** |  |  | |
| Clinical only  Clinical + Duplex study | 47  37 | 55.3  43.5 | |
| Duplex + CT Angiography | 1 | 1.2 | |
| **Associated Injury** |  |  | |
| Single injury  Two injury  More than two injury | 25  11  3 | 64.1  28.2  7.7 | |
| **Total** | **39** | **100%** | |
| Fracture or/and Dislocation | 28 | 71.8 | |
| Nerve injury  Thoracoabdominal injury | 22  4 | 56.4  10.3 | |
| Traumatic Brain Injury | 3 | 7.7 | |

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## Anatomical Distribution and Type of Vascular Injury

Vascular injuries to the upper and lower extremities were found to be proportionally distributed with 54.1% and 45.9%, respectively. The arterial injury was identified in 80(94.1%) cases and there was a concomitant venous injury to it in 42(52.5%). Also, an isolated venous injury was found in 5(5.9%) cases.

The commonest type of arterial vascular injury was brachial artery 31(38.8%) and femoral artery injury was the second common arterial injury with 19(23.8%). The most dominant type of vascular injury was complete transection with 63(74.1%), followed by laceration 13(15.3%), partial transection 7(8.2%), wall defect 1(1.2%), and contusion 1(1.2%); which could be with or without thrombosis. (Table 3)

*Table 3. Anatomical distribution and management with its outcome of extremity vascular injury in TASH, Ethiopia.*

|  |  |  |
| --- | --- | --- |
| **Category/ Characteristics** | **Frequency** | **Percent (%)** |
| **Anatomical Distribution** |  |  |
| **Upper Extremity Arterial Injury**  Brachial  Radial  Ulnar  Axillary  **Upper Extremity Venous Injury**  Brachial (Basillic, Cephalic or Median cubital)  Radial/ Ulnar  Axillary  **Lower Extremity Arterial Injury**  Femoral (CFA, SFA & PFA)  Popliteal  Tibio-peroneal (PTA, DPA)  **Lower Extremity Venous Injury**  Femoral (FV, GSV)  Popliteal | **46**  31  8  4  3  **24**  17  5  2  **34**  19  10  5  **23**  15  8 | 67.4  17.4  8.7  6.5  70.8  20.8  8.3  55.9  29.4  14.7  65.2  34.8 |
| **Injured Vessel** |  |  |
| Artery Only | 38 | 44.7 |
| Vein Only  Both | 5  42 | 5.9  49.4 |
| **Method of Management** |  |  |
| Reverse Interposition Venous Graft  Ligation (Hemostasis) | 39  17 | 45.9  20 |
| Primary Repair with EEA  Simple Primary Repair  Venous Patch | 15  13  1 | 17.6  15.3  1.2 |
| **Fasciotomy** |  |  |
| Yes (Prophylaxis) + Post-op (2 patients)  No | 29  56 | 34.1  65.9 |
| **Outcome** |  |  |
| Improved  Disability | 55  30 | 64.7  35.3 |
| **Disability** |  |  |
| Palsy | 18 | 60 |
| Amputated limb  Wound Contracture | 7  5 | 23.3  16.7 |
|  |  |  |

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## Management and Outcome

Upon arrival (on referral) to TASH; eighteen (21.2%) patients had been operated at forwarding locations and ten (11.8%) patients came after a temporary shunt was applied to the injured vessels & eight (9.4%) patients had a ligated vessels for hemostatic purpose. In all patients who had a shunt, it was found to be non-patent. The material used was an intravenous set plastic tube and was applied to five patients with brachial artery injury and one for each injury to the SFA, Popliteal artery, PTA, ATA & Femoral vein.

Open surgical techniques were employed for all cases. As illustrated in Table 3 the method used for vascular reconstruction mainly was Reverse Interposition Venous Graft (commonly GSV) in 39(45.9%); followed by Ligation 17(20%), primary end to end Anastomosis 15(17.6%), and Simple Repair 13(15.3%) in which Fogarty thrombectomy was coupled for those with thrombectomy. The venous patch was done for one patient (1.2%) with a wall defect and for the patient with vascular contusion who had a thrombosis, an arteriotomy then thrombectomy was done. Fasciotomy was done in 29(34.1%); as prophylaxis in 27(93.1%) and post-operatively for compartment syndrome in 2(6.9%). The type anesthesia used were General Anesthesia in 66(77.6%); Spinal Anesthesia in 10(11.8%) and; Block in 9(10.6%) from which 2(2.4%) were converted to GA.

Surgical wound infection was the commonest post-op complication with 32(37.6%); followed by palsy 17(20%); failed repair 9(10.6%); sepsis 2(2.4%) and bleeding 1(1.2%). The amputation rate was 7(8.2%), which was done for failed vascular reconstruction. Good long-term outcome was achieved in 55(64.7%). The disability rate was 30(35.2%), which was due to palsy/weakness 18(60%), amputated limb 7(23.3%), and wound contracture 5(16.7%). No patients expired and all were discharged home. Length of hospital stay ranges from 2 to 102 days.

# **Discussion**

Vascular trauma, especially to the extremity, is a common health care problem in our setup; and prompt diagnosis and management of this injury is mandatory to reduce the risk of ischemic limb loss and hemorrhages threatening the life of the patient. An epidemiological approach to the characterization of many health care problems that has been applied so far showed a significant benefit. Though it has been shown to have a benefit, application of an epidemiologic approach to a civilian vascular trauma to the extremity has not been applied extensively; not only in our setup but also in most of the world (22). This study serves as a getaway to the current trends of the epidemiology and management outcome of extremity vascular trauma in our institution, TASH.

Vascular trauma to the extremity predominantly occurs in male than females with the range of 70 to 95% (4,23-26). Our study also shows a male predominance of 90.6%. Trauma in general is more common in the younger age group; accounts for the majority of mortality in the younger population of the USA (1). Perkins ZB, et al.(4) Murad M, et al.(33), and Sah B, et al.(26); all showed a higher incidence of vascular trauma in the younger, 30s, and/ 40s age group. The median age in our study was 26years with a 78.8% occurrence of extremity vascular trauma between the age group of 15 to 35 years. The study also has shown that it mainly affects the working force of the population. A Nigerian study by Adeoye, et al.(24) also showed a younger age group predominance in civilian vascular trauma.

Extremity civilian trauma from both blunt and penetrating mechanisms is common; despite having a difference in the pattern & mechanism of injury based on the age group; accounting for approximately 0.7% to 2%. (34) Though blunt trauma has a higher risk of limb loss and mortality; because of the high impact forces causing extensive damage to the soft tissue, bones and nerves; penetrating trauma tends to result in a higher rate of extremity vascular injuries to the long tracked vessels (17,29). Penetrating trauma accounts for 89.4% of extremity vascular injury in the current study. The commonest mechanisms of injury were found to be due to homicidal or interpersonal violence, which are stab or sharp injury of 40% and bullet injury of 29.4% followed by road traffic injury of 17.7%. A Nigerian study done by Adeoye et al. (24) and a UK study by Z.B. Perkins et al. (4) showed nearly the same patterns of the mechanism of civilian vascular trauma. A systemic review of trauma in Ethiopia done by A. Azaj, et al. (19) showed that the commonest mechanism of trauma, in general, was motor vehicle injury with an average of 30.3% followed by homicidal injury of 24.4%. Even if it doesn’t reflect the mechanism of injury pertaining specifically to the civilian vascular trauma, it can help us to mitigate and where to focus in terms of preventive measures.

Trauma to vessels of the extremity; based on the mechanism and level of vascular injury, might also have an injury to other tissues. Most patients with vascular injury to both the upper and lower limb can suffer from an associated injury, and it could reach up to 90% (13,17,24,26,35). Our study showed that 45.9% of cases with an associated injury. One of the risks to patients with the extremity vascular injury is limb loss; it is most commonly due to the magnitude of associated injuries to the soft tissue, bones (i.e., Gustilo III C open fracture), or nerves; apart from a delay in the diagnosis and/or revascularization & thrombosis of the injured vessel (32). Orthopedic fracture is the most commonly observed associated injury, followed by nerve injury (24,26). In Blunt trauma an associated fracture and/or dislocation could reach up to 95% (29) and if it is a comminuted fracture, regardless of the mechanism, the risk of amputation increases (14,20,30,31). The current study also showed that fracture and/or dislocation was the commonly associated injury, followed by nerve injury.

Ischemia tolerance time for muscles and nerves is only 6-8hour. So early presentation and intervention; within the golden period of injury; to the extremity vessels has a better limb outcome. This is facilitated by rapid transportation and the availability of a nearby trauma center or health facility, which is lacking in most low-income countries. A Nigerian (23) and Nepalese (26) study demonstrated that only 33% and 48%, respectively, of extremity vascular trauma patients presented within the golden hour. Our study also showed that a small proportion of patients, 32.9%, presented within 6 hours. In the Latin American survey, 78% of patients were managed within 6 hours of injury (28). Because of the urgent need for prompt management and lack of available diagnostic technology, most decisions in low-income countries are mainly based on clinical criteria (23,28). Clinical diagnosis was employed in 55.3% of patients in the current study.

The commonly injured vessel in our study was the brachial artery accounting for 36.5% followed by a femoral artery with 22.4%; in which Onakpoya, et al. (23) and De Silva, et al. (36) had shown a similar pattern with the upper extremity injury being predominant. Even if the anatomic distribution of extremity vascular trauma depends on the mechanism of injury, most studies reported an otherwise different pattern with a higher incidence of lower extremity injury and femoral artery injury being the commonest one (4,10,26-28).

Hafez et al. (31) noted that complete arterial transection is one of the factors that determined limb outcome after revascularization. The most frequent type of vascular injury as reported by Sah B, et al. (26) and Onakpoya, et al. (23) was complete transection with 62% & 67.5%, respectively. Our study has also shown a similar result; that complete transection was the commonest type accounting for 74.1%, which is followed by laceration (15.3%).

The goals in the management of extremity vascular trauma are immediate bleeding control, rapid resuscitation, and restoration of blood flow. A variety of surgical techniques has been employed to restore blood flow and the choice of repair was dependent on the extent and severity of vascular trauma. Open surgical techniques were used in all cases and reverse interposition venous graft was the most commonly used technique in our study, which was employed in 45.9% of cases. Khan, et al. (25) reported that a similar method was used in 53.1%; but studies done in Africa and other parts of Asia showed that the commonly used method was end-to-end primary anastomosis (23,24,26). Compartment syndrome has a negative impact on the limb outcome and the widespread application of an accompanying procedure, prophylactic Fasciotomy, based on the risk factor that has influenced its true incidence (37). In our study, Fasciotomy was done in 34.1% of cases.

The most common complication in this study was wound infection in 37.6% of cases. Similarly, different studies had shown wound infection as the commonest complication but with a lower incidence than the above (23,24,26). Extremity vascular injuries can also lead to significant disability. Viable limb with good long-term functional outcome was achieved in 64.7% of cases in our study. An African study from Nigeria reported a limb viability rate of 58.3% (23). The current study showed an amputation rate of 8.2% and there was no in hospital death. A factor that affects the outcome of vascular trauma to the extremity mainly includes limb ischemia time and blunt trauma or the presence of associated injury (4,23,25).

This study had several limitations. Since the study was a retrospective one, it is subjected to an information bias. Even if the source of information was from the hospital database and patients chart, because of its poor documentation it was difficult to get the full scale of the problem. And it was not from a well-organized trauma system, which would have given us better information. In addition, the study was done in a single tertiary hospital, so it doesn’t truly reflect the magnitude of the problem.

## Conclusions

Extremity vascular injury mainly affects the working force, young adults of society. It could be attributed to the rise of violence, which directly increases the incidence of extremity vascular injuries. Vascular injury to the extremity is a surgical emergency, where a delay in the diagnosis and treatment can lead to limb loss or death. The main factors in the delay could be attributed to lack of rapid transportation and unavailability of a nearby health facility equipped with trained professionals and vascular service. After arrival to the hospital; bleeding control, resuscitation, and restoration of blood flow are the mainstays of management. Even though, intervention with endovascular techniques is increasing in the western setup; because of the unavailability of its service in our setup, only open surgical techniques are applied.

## Recommendation

The Ethiopian Ministry of Health should emphasize the preventive measures to tackle the rising incidence of vascular injuries due to violence and road traffic accidents, by collaborating with the Ministry of Transportation. Also should work on the expansion of vascular services with trained health professionals. Teaching hospitals should integrate a well-organized trauma system into their trauma centers if there is any. Health professionals training, who are equipped with the management of vascular injuries, should be made by these hospitals. Clinicians need to be aware of the impact of vascular injuries and their potential outcomes. They should also be well trained and vigilant in the management of vascular injury to the extremity. Further study should be employed by all concerned bodies to assess the overall magnitude of extremity vascular injuries at the community level.

# **Reference**

1. Kauvar DS, et al. The epidemiology and modern management of traumatic hemorrhage: US and international perspectives. Crit Care. 2005;9(5):S1–S9.
2. World Health Organization; WHO, editor. Global Health Estimates, Injuries and Violence: the facts 2012; Geneva, Switzerland: WHO; 2014; ISBN 978 92 4 150801 8

([www.who.int/healthinfo/global\_burden\_disease/projections/en/index.html](http://www.who.int/healthinfo/global_burden_disease/projections/en/index.html))

1. Loh SA, et al. Existing trauma and critical care scoring systems underestimate mortality among vascular trauma patients. J Vasc Surg. 2011;53: 359–366.
2. Perkins ZB, et al. Epidemiology and outcome of vascular trauma at a British Major Trauma Centre. Eur J Vasc Endovasc Surg. 2012;44:203–209.
3. Eastridge BJ, et al. Death on the battlefield (2001–2011): implications for the future of combat casualty care. J Trauma Acute Care Surg. 2012;73(6):S431–S437.
4. B. Beck, et al. Potentially preventable trauma deaths: A retrospective review. Int. J. Care Injured. 2019;50:1009–1016.
5. Sugrue M, et al. Vascular injury in Australia. Surg Clin North Am. 2002;82(1):211-219.
6. Caps MT., The epidemiology of vascular trauma. Semin Vasc Surg. 1998;11(4):227-231.
7. Perler, et al. *Rutherford’s Vascular and Endovascular Therapy: Extremity Vascular Trauma*. Philadelphia, PA: Elsevier, 2019.
8. Mattox KL, et al. Five thousand seven hundred sixty cardiovascular injuries in 4459 patients. Epidemiologic evolution 1958 to 1987. Ann Surg. 1989;209:698–707.
9. Barmparas G, et al. Pediatric vs adult vascular trauma: a National Trauma Databank review. J Pediatr Surg. 2010;45:1404–1412.
10. Berhe G, et al. Patterns and Causes of Amputation in Ayder Referral Hospital, Mekelle, Ethiopia: A Three-Year Experience. A Three-Year Experience. Ethiop J Health Sci.2017;28(1):31-36.
11. Franz, et al. A 5-year review of management of lower extremity arterial injuries at an urban level I trauma center. J Vasc Surg 2011;53:1604-10.
12. Z. B. Perkins, B. Yet, S. Glasgow, E. Cole, W. Marsh, K. Brohi et al. Meta-analysis of prognostic factors for amputation following surgical repair of lower extremity vascular trauma. BJS 2015;102:436–450.
13. Topal, et al. Lower extremity arterial injuries over a six-year period: outcomes, risk factors, and management. Vasc Health Risk Manag. 2010;6:1103–1110.
14. Clouse, et al. Upper Extremity Vascular Injury: A Current In-Theater Wartime Report from Operation Iraqi Freedom. Ann Vasc Surg 2006;20:429-434. DOI: 10.1007/s10016-006-9090-3
15. Tan TW, Joglar FL, Hamburg NM, Eberhardt RT, Shaw PM, Rybin D, et al. Limb outcome and mortality in lower and upper extremity arterial injury: a comparison using the National Trauma Data Bank. Vasc Endovascular Surg. 2011;45(7):592-7.
16. World Health Organization; WHO, editor. Noncommunicable Diseases (NCD) Country Profiles: Ethiopia 2016; Geneva, Switzerland: WHO 2018.
17. A. Azaj, et al. Trauma in Ethiopia Revisited: A systematic Review. East Cent. Afr. J. surg. July 2013;18(2):108-118.
18. Kauvar, et al. National trauma databank analysis of mortality and limb loss in isolated lower extremity vascular trauma. J Vasc Surg. 2011;53:1598-603.
19. Gupta R, Rao S, Sieunarine K. An epidemiological view of vascular trauma in Western Australia: a 5-year study. ANZ J Surg. 2001;71(8):461e6.
20. Nebyou S, Dawit G, Berhanu N. Pattern of Vascular Diseases at Tikur Anbessa Specialized Hospital, Addis Ababa, Ethiopia. Ethiop J Health Sci. 2019;29(3):377.
21. Onakpoya UU, et al. Pattern of extremity arterial injury and outcome of repair in Southwest, Nigeria. Niger J Surg. 2019;25:85-90.
22. P. O. ADEOYE, et al. Civilian Vascular Injuries in an Urban African Referral Institution. East African Medical Journal. 2013;90(12):404-8.
23. Khan, et al. Vascular injuries of the extremities are a major challenge in a third world country. Journal of Trauma Management & Outcomes. 2015;9:5. DOI 10.1186/s13032-015-0027-0.
24. Sah B, Shrestha KG, Tiwari KK, Reddy A. Analysis of Consecutive Cases of Vascular Injury in Tertiary Level Hospital in Central Nepal. JCMS Nepal. 2017;13(3):357-62.
25. Jian-Long Liu, et al. Literature review of peripheral vascular trauma: Is the era of intervention coming? Chinese Journal of Traumatology. 2020;23:5-9.
26. Sonneborn R, Andrade R, Bello F, et al. Vascular trauma in Latin America: a regional survey. Surg Clin North Am. 2002;82:189-94.
27. Rozycki, et al. Blunt Vascular Trauma in the Extremity: Diagnosis, Management, and Outcome. J Trauma. 2003;55:814 –824.
28. Mullenix, et al. Limb salvage and outcomes among patients with traumatic popliteal vascular injury: An analysis of the National Trauma Data Bank. J Vasc Surg. 2006;44:94-100.
29. Hafez, Woolgar, and Robbs. Lower extremity arterial injury: Results of 550 cases and review of risk factors associated with limb loss. J Vasc Surg 2001;33:1212-9.
30. Feliciano, et al. Evaluation and Management of Peripheral Vascular Injury. J Trauma. 2011;70:1551–1556.
31. Murad M, Eweda A, Abdel-Moamen H, Hussien M, Elsaghir M. Vascular trauma and its management: one and a half years after the 25th January revolution. Journal of the Arab Society for Medical Research. 2013;8:43–47.
32. Konstantinidis A, Inaba K, Dubose J, et al. Vascular trauma in geriatric patients: a national trauma databank review. J Trauma Acute Care Surg. 2011;71(4):909–916.
33. Franz, et al. Management of Upper Extremity Arterial Injuries at an Urban Level I Trauma Center. Ann Vasc Surg. 2009;23:8-16.
34. De Silva, et al. Challenges in the management of extremity vascular injuries: A wartime experience from a tertiary centre in Sri Lanka. World Journal of Emergency Surgery. 2011;6:24.
35. B.C. Branco, et al. Incidence and predictors for the need for fasciotomy after extremity trauma: A 10-year review in a mature level I trauma center. Int. J. Care Injured. 2011;42:1157–1.