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Matthew Stewart  
Thomas Jefferson University

Perry Hammond  
Thomas Jefferson University

Ishani Khatiwala  
Thomas Jefferson University

Brian Swendseid  
Thomas Jefferson University

Farshid Taghizadeh  
Oregon Health and Science University

See next page for additional authors

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Outcomes of Venous End-to-Side Microvascular Anastomoses of the Head and Neck

Matthew Stewart, BS; Perry Hammond, BA; Ishani Khatiwala, BS; Brian Swendseid, MD; Farshid Taghizadeh, BS; Daniel Petrisor, DMD, MD; Tingting Zhan, PhD; Richard Goldman, MD; Adam Lugibuhl, MD; Ryan Heffelfinger, MD; Larissa Sweeney, MD; Joseph M. Curry, MD

INTRODUCTION

Microvascular free tissue transfer (FTT) is the standard treatment for the reconstruction of large complex head and neck defects. FTT is highly successful, with success rates >95% commonly reported in the literature. However, failure frequently results in significant functional and aesthetic morbidity and significantly increases costs and length of stay. The added challenges of subsequent reconstructive procedures are taxing for both the patient and the reconstructive team, with outcomes often falling short of expectations.

Many technical factors contribute to the success of FTT, but the most significant is the quality of the microvascular anastomosis and the geometry of the pedicle. There are a variety of techniques that may be successfully applied for anastomosis, including numerous techniques for arterial suturing and the recent introduction of an arterial coupler. Veins may be sutured or coupled and anastomosed end-to-end (ETE) or end-to-side (ETS). An ETE anastomosis, in which the vessel lumens are placed in parallel to each other, is preferred by many surgeons. Veins may be sutured or coupled and anastomosed end-to-side (ETS) as well. A second anastomosis and the use of the coupler for completing the anastomoses were significantly more likely to have a prior neck dissection (P < .001), suggesting the ETS method was utilized in select circumstances. A second ETS anastomosis improved survival of the FTT (P = .006), as did utilization of a coupler over suture (P = .002). Failure due to venous thrombosis was significantly more common with one ETS anastomosis instead of two ETS anastomoses (P = .042).

Conclusions: ETS is effective but is often used as a secondary technique when ETE is not feasible; as such, in this series, ETS was associated with higher failure. A second anastomosis and the use of the coupler for completing the anastomoses were associated with lower rates of failure.

Key Words: Free flap, end to side, end to end, pedicle, free flap failure, microvascular reconstruction, free tissue transfer.

Level of Evidence: 3

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currently utilized. Here we report a large, multi-institutional series of head and neck FTT with ETS anastomoses.

MATERIALS AND METHODS
Following approval by each institution’s Institutional Review Board, a retrospective chart review was carried out on all patients who received FTT of the head and neck. Patients who received surgery from 2006 to 2019 were included. A total of 2,482 FTT were reviewed. Six surgeons across two institutions completed the anastomoses. All surgeons typically performed the inset prior to proceeding with the anastomoses, and as a default performed ETE whenever the venous anatomy allowed. Generally, ETS was used as a second-line technique in the setting of a vessel-depleted neck. ETS was defined as an anastomosis requiring a venotomy. The following data were obtained on all patients: age, sex, tumor location, length of stay, history of prior head and neck surgery, and history of prior radiation. Operative notes were reviewed for the type of FTT, type of anastomosis technique (ETE or ETS), recipient vessel, number of anastomoses, and whether the anastomosis was completed with suture or couplers. FTT outcomes (survival or failure) were reviewed, and it was noted if the patient experienced FTT-related complications after the initial surgery such as hematoma, thrombosis, fistula, wound dehiscence, or wound infection.

Statistical Analyses
SPSS software was used for all statistical analyses (IBM Corp., Released 2019, IBM SPSS Statistics for Macintosh, Version 26.0). Univariate analysis was performed using Fischer’s exact for categorical binary variables on each anastomosis. Failure or the presence of complication was noted and were found to be significant more common in those with prior surgery to the neck (n = 28, 35%) (P = .047, OR 1.9, 95% CI 1.0–3.3), but not prior radiation (n = 40; 22%) (P = .480, OR 1.2). Salivary fistula was more common utilizing suture (56%, n = 9/16) over couplers (43%, n = 7/16) (P = .046, OR 3.1, 95% CI 1.1–8.7) (Table III).

Select comorbidities and complications were reviewed for impact on the number of anastomoses and technique of completing the anastomosis. There were a total of 106 complications across 65 patients (29% of patients) (Table III). Fifteen venous thromboses were noted and were found to be significantly more common in FTT with one ETS anastomoses (93%, n = 14/15) as compared to two ETS (6%, n = 1/15) (P = .042, OR 7.2, 95% CI 9–55.8) (Table III). The incidence of arterial thrombosis, hematoma, wound dehiscence, and wound infections did not correlate with the number of anastomoses or methods used for the anastomosis (usage of couplers or suture).

Multivariate analysis of prior radiation, prior neck surgery, usage of a single ETS anastomosis, and the suture was performed to predict failure. The multivariable logistic regression model shows that FTT with one ETS anastomosis and utilizing suture were more likely to fail, with a P value of P = .030 (OR 5.2) and P = .012 (OR 3.1), respectively. Prior surgery to the neck trended toward significance in predicting failure (P = .051), whereas prior radiation was not found to be significant (P = .59) (Table IV).

The ETE cohort was compared to the ETS cohort. The ETE cohort was significantly less likely to have a prior neck dissection: 9% in the ETE group compared to 26% in the ETS group, P < .001 (OR 3.8, 95% CI 2.4–6.0). Prior radiation was similar between groups: 30% in the ETE cohort compared to 34% in the ETS cohort (P = .22). Failure rate in the ETE cohort was 3.4% as compared to 11.2% in the ETS cohort (P < .001, OR 2.7, 95% CI 2.0–5.2). The outcomes of ETE and ETS cohorts were then evaluated on several independent metrics to understand this difference: prior neck surgery and failures attributed to venous congestion. The ETE primary surgery cohort had a 2.5% failure rate (n = 52/2049), which was significantly lower than the ETS primary surgery.
cohort failure rate of 8.5% (n = 14/164) \((P < .001, \text{OR 0.3, 95\% CI 0.2–0.5})\). Similarly, the failure rate in the ETE group with prior neck dissection was 11.8% (n = 25/212) was also lower compared to the ETS group with prior neck dissection which was 17.5% (n = 11/57). This did not reach statistical significance \((P = .18, \text{OR 0.6, 95\% CI} \).
0.3–1.2). Finally, ETE versus ETS were compared for failure attributed to venous compromise. Thirty-six percent (n = 9/25) of the ETS and 19% (n = 15/77) of the ETE cohort failed due to venous congestion, which did not reach statistical significance (P = .11, OR 2.3, 95% CI 0.9–6.4).

**DISCUSSION**

ETS venous anastomosis has been described for FTT in the head and neck; however, FTT has evolved in the past two decades with widespread use of the coupler, improved success rates, and greater dissemination of technical knowledge. Although previous studies on ETS reviewed limited cohorts, they found ETE versus ETS to have similar FTT success rates. In our practices, ETS is used when ETE is not reasonably possible, and therefore, primarily represents a secondary technique. ETS anastomosis may be utilized in a variety of scenarios, most commonly the vessel-depleted neck, which can occur following previous radiation therapy or surgery. In this series, the use of ETS over ETE was associated with prior neck dissection (P < .001) reflecting the vessel-depleted neck. The overall failure rate in the ETS cohort (11.2%) was higher than that of the ETE cohort (3.8%, P < .001). We suspect that this also reflects its use as a secondary technique in more challenging cases. Determination of the exact features of the case resulting in a vessel-depleted neck leading to use of ETS may require a prospective approach to capture accurate data from each case. Further, we sought to evaluate the risk of venous failure according to the technique for venous anastomosis, and there was no significant difference found between the ETS and ETE cohorts (P = .11). This also suggests that although there was an increased rate of failure in ETS cases, the reason for FTT failure was likely multifactorial in nature and not entirely due to the type of anastomoses.

We also sought to evaluate the significance of a second anastomosis when ETS was performed. Two ETS anastomoses were associated with a significantly decreased incidence of FTT failure (2%) as compared to single ETS (13%, P = .006). Performing two venous anastomoses has been a topic of debate. Two venous anastomoses have been postulated to be advantageous due to providing additional outflow, which can compensate for a compressed or kinked vein. This is thought to protect against congestion and mitigate the development of stasis and subsequent FTT compromise. Turner and Smith reported 106 radial forearm FTT using two ETS; they demonstrated favorable outcomes with success rates >99%. A meta-analysis released in 2015 strongly supported the use of two venous anastomoses to reduce FTT failure and thrombosis: of 6,842 FTT reviewed, they report a failure rate of 3.1% for a single anastomosis and 1.3% for double anastomoses. In this series, the majority of failures were those with one ETS anastomosis. Retrospectively determining the rationale and necessity of a second anastomosis is challenging, but the findings do suggest that if a second ETS is possible, there may be benefit.

The ETS cohort was analyzed by coupler versus sutured anastomosis showing increased success rates with use of the coupler. Consistent with other institutions, our groups have adopted the venous coupler as first choice for venous anastomosis. The vein was typically sutured only in cases where coupling was suboptimal or not possible. Authors have argued suture anastomosis is more prone to inadequate eversion of the vessel, intraluminal adventitia exposure, and vessel leaks compared to the coupler. Yap et al. reviewed venous thrombosis rates between utilizing couplers and suture for the anastomoses, and reported reduced venous thrombosis rates when coupler were utilized for the venous anastomosis. The authors attributed this to decreased technical errors as compared to sutured anastomoses. It is our preference to perform microvenous anastomosis with the coupler. In general, we have sutured when the coupler is not possible: at times trying the coupler first and if not able to place it, the vein was then sewn. It has been our experience that after prior neck dissection the jugular vein is less pliable. Using the coupler requires significant mobilization of the jugular vein above and below the planned ETS and also requires significantly more thinning of the adhesive scar from the wall to allow the venotomy to be easily exerted over the coupler spikes. When this is not possible or acceptable, then suturing the ETS is necessary.

There are several limitations of this study, including its retrospective nature and relatively small sample size for ETS cases. Further, ETS was utilized as a secondary technique that makes direct comparison between the groups limited. Further study in a prospective setting would be necessary to fully determine the precise effects of ETS on flap success.

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**TABLE IV.**

Multivariate Analysis of End-to-Side (ETS) Anastomoses to Predict Failure.

<table>
<thead>
<tr>
<th></th>
<th>Odds Ratio</th>
<th>Correlation Coefficient (95% CI)</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior head and neck radiation</td>
<td>0.8</td>
<td>0.3–2.0</td>
<td>.585</td>
</tr>
<tr>
<td>Prior neck dissection</td>
<td>2.3</td>
<td>0.9–5.7</td>
<td>.081</td>
</tr>
<tr>
<td>1 Venous ETS anastomosis</td>
<td>5.2</td>
<td>1.2–23.2</td>
<td>.030</td>
</tr>
<tr>
<td>Suture</td>
<td>3.1</td>
<td>1.3–7.4</td>
<td>.012</td>
</tr>
</tbody>
</table>

CI = confidence interval.
CONCLUSION
ETS is an effective technique and in this series was used more often as a secondary technique in the vessel-depleted neck. ETS was associated with higher failure that ETE, but use of the coupler and a second anastomosis were associated with lower failure rates.

BIBLIOGRAPHY