"Why do nephrologists seem to like CVCS so much?"

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1 CURRENT PERSPECTIVE OF AN AMERICAN NEPHROLOGIST ABOUT VASCULAR ACCESS

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The DOPPS Study revealed huge differences in vascular access use between the U.S. and Europe. Ten years ago, AVF were used in only 25% of American hemodialysis patients, as compared with 80% in Europe. Although patient characteristics, such as age, sex, race, and cardiovascular disease affect the frequency of AVF use, differences among countries, regions, and individual units persist even after adjustment for these variables. The mortality of U.S. hemodialysis patients is about 35% higher in the U.S. than in Europe. Remarkably, when one adjusts for vascular access practice, there is no longer a survival difference. This observation is consistent with previous reports demonstrating a dramatic difference in mortality when catheter-dependent patients are converted to an AVF. Taken together, these observations highlight the importance of practice patterns on achieving optimal AVF use.

The KDOQI guidelines (1997) and Fistula First initiative (2002) have encouraged American nephrologists to increase AVF use. These efforts have been extremely successful. Thus, from 2000 to 2008, AVF use in the U.S. has increased from 24 to 52%, with a corresponding decrease in AVG use from 58 to 22%. However, American nephrologists have encountered several significant challenges. First, a high proportion (40-60%) of AVF fail to mature despite routine preoperative vascular mapping. This has led to appreciation of the need to assess immature AVFs in a timely fashion, and intervene surgically or radiologically to convert them to mature AVFs. Second, there has been intense interest in understanding the pathogenesis of AVF non-maturation and identifying pharmacologic interventions to improve fistula maturation. Thus, for example, the DAC fistula trial found that clopidogrel reduced early AVF thrombosis, but did not prevent fistula non-maturation. Third, an unfortunate byproduct of aggressive efforts to achieve AVFs in most patients has led to an increase in catheter use from 17 to 26%, with a corresponding huge increase in catheter-related bacteremia. As a result, an ongoing debate in the American medical community is questioning whether some high-risk patients would be better served by receiving an AVG (rather than an AVF), so as to avoid prolonged catheter-dependence.

2 ACCESS MONITORING

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Most AVG fail due to irreversible thrombosis, superimposed on an underlying stenosis. This observation suggests that early detection of hemodynamically significant (>50%) stenosis, followed by preemptive angioplasty, prevents AVG thrombosis. Several noninvasive methods have been developed to monitor for AVG stenosis. Clinical monitoring consists of information routinely collected during dialysis. It includes physical examination (absent thrill, discontinuous bruit, or edema distal to AVG); Problems noted during HD (difficult cannulation, aspiration of clots, inability to achieve target dialysis blood flow, or prolonged bleeding from needle sites); or an unexplained decrease in dialysis dose (Kt/V). Surveillance methods include access flow monitoring (abnormal value is flow <600 ml/min or decreased >25% from baseline); measurement of static dialysis venous pressure (abnormal value is a ratio of intra-graft to systemic blood pressure>0.6; or duplex ultrasound (abnormal value is a peak systolic velocity ratio >2 across the stenotic lesion). Several observational studies have measured the frequency of AVG thrombosis before and after implementing a program to monitor for graft stenosis. These studies have all shown a 40 to 80% reduction in AVG thrombosis after starting the program.

Six randomized clinical trials (RCT) have compared AVG thrombosis and survival in patients undergoing stenosis surveillance, as compared with a control group. In each study, the frequency of angioplasty was higher in the surveillance group. However, none of the studies observed a difference in graft thrombosis between the two randomized arms, and only one study found an improvement in graft survival. A 2008 meta-analysis of the RCTs found no decrease in the risk of thrombosis (relative risk of 0.94; 95% CI, 0.77 to 1.16; 446 participants) or access loss (RR of 1.08; 95% CI, 0.83 to 1.40) with surveillance compared with controls without the use of such techniques. Deployment of stent-grafts may improve the outcomes. However, a recent RCT showed no difference in AVG thrombosis between stent grafts and balloon angioplasty.

Only one RCT has evaluated surveillance and preemptive PTA in AVFs. It showed better AVF survival in patients undergoing flow monitoring. However, there is uncertainty about whether surgical revision is superior to angioplasty.

3 NONMATURING FISTULAS

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The biggest hurdle to increasing AVF use in U.S. hemodialysis patients is the high proportion of fistulas that fail to mature adequately to be used for dialysis. AVF non-maturation has increased in the past 20 years, and its frequency has ranged from 20 to 50% in several large observational studies. AVF non-maturation was observed in ~60% of patients in the DAC Study. Although preoperative ultrasound increases AVF placement, it has not decreased AVF non-maturation in most studies. AVF maturation can be assessed by clinical examination performed by the nephrologist or dialysis nurse. Clinically useful tests suggestive of underlying stenosis include failure of the fistula to collapse when the arm is elevated and lack of pulse augmentation when the outflow vein is occluded transiently. Experienced individuals can assess AVF maturation fairly accurately. In one study, dialysis nurses successfully predicted AVF usability for dialysis in 80% of patients. Postoperative ultrasound is very useful in assessing AVF maturation. One study evaluated AVF diameter and blood flow in predicting clinical success. If the diameter > 4 mm and flow >500 ml/min, 95% of AVF were used for HD. If diameter <4 mm and flow <500 ml/min, only 33% were successful. Postoperative US can also identify anatomic abnormalities, which if corrected surgically or radiologically, may convert an immature AVF to a mature one. Specifically, peri-anatomic stenosis can be treated by angioplasty or surgical revision; accessory veins can be ligated; and excessively deep fistulas can be superficialized. A recent study examined the impact of aggressive salvage procedures on fistula maturation. Among sonographically immature AVF not undergoing a salvage procedure, only 31% (8/26) were used successfully for dialysis. In contrast, among sonographically immature AVF undergoing 1 or more interventions, 78% (25/32) were successful. Similarly, other studies have shown that aggressive interventions can promote maturation of many immature AVFs.

In summary, all new AVF should be assessed clinically for maturity at 4-6
Objective: A method for hemodialysis catheter placement in patients with central thoracic venous stenosis or occlusion is described and initial results are analyzed.

Materials and methods: Twelve patients with a mean age of 63.2 years (42-80 years) with central venous stenosis or occlusion and who required a hemodialysis catheter were reviewed. All lesions were confirmed by helical CT or phlebography. Five patients had stenosis while seven patients were diagnosed with an occlusion of thoracic central veins. All patients were asymptomatic without sign of superior venous cava syndrome. After percutaneous transvenous catheterization or guide wire based recanalization in occlusions, a balloon dilation was performed and a stent was placed, when necessary, prior to the catheter placement.

Results: Technical success was 92%. Three patients had angioplasty alone and nine patients had angioplasty with stent placement. Dialysis catheters are analyzed. Central thoracic venous stenosis or occlusion is described and initial results are analyzed.

Technical success was 92%. Three patients had angioplasty alone and nine patients had angioplasty with stent placement. Dialysis catheters were successfully inserted through all recanalized access. No immediate complication occurred, neither did any patient developed a superior venous cava syndrome after the procedure. The mean follow-up was 21.8 months (8-48). Three patients developed a catheter dysfunction with fibrin sheath formation (at 7,11 and 12 months after catheter placement, respectively). Two were successfully managed by percutaneous endovascular approach and one catheter was removed.

Conclusions: For patients with central venous stenosis or occlusion and those that need a hemodialysis catheter, catheter insertion can be reliably achieved immediately after endovascular recanalization with acceptable technical and long-term success rates. This technique should be considered as an alternative procedure to place a new hemodialysis catheter through a patent vein.

31
ACCESS FLOW AND FINGER PRESSURES IN FOREARM AND UPPER ARM AVF

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The dialysis population is changing towards elderly patients with multiple comorbidities. This implies a shift to the use of upper arm access, because of lack of sufficient quality vessels for the creation of functional forearm radiocephalic arteriovenous fistulae (AVF). Upper arm AVF are associated with high volumeflow, which may result in steal syndrome, distal ischemia and cardiac failure.

To determine the clinical and hemodynamic outcome of forearm and upper arm access, all patients receiving a first AVF during a 3 years period were followed by regular duplex scans at 1, 6, 12, 26 and 52 weeks. Access flow and finger pressure were measured and complications and interventions recorded.

A total of 91 accesses were placed. Upper arm AVF were created in 50%, forearm AVF in 38% and graft AVF in 12% of patients. Nonmaturation occurred in 20% of the forearm AVF and 9% in the upper arm AVF. Mean flow in forearm AVF at 6 weeks was 1124 ml/min, compared to 1910 ml/min in upper arm AVF (p<0.001). Mean flow in forearm AVF at 6 months was 1591 ml/min, compared to 1904 ml/min in upper arm AVF (p<0.05). Ischemia developed in 1 patient (3%) with a forearm AVF and 5 patients (11%) with upper arm AVF. Mean finger pressures after 6 weeks are 95 mmHg in forearm fistula and 74 mmHg in upper arm fistula (P=0.014). After 6 months the finger pressures 100 mmHg and 71 mmHg (P=0.013) respectively.

Conclusion. Upper arm AVF generates high volume flows which cause higher risk on ischemia and low finger bloodpressures as compared to forearm AVF.