Vascular Access planning should always follow international guidelines

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I disagree

- All available guidelines are dated: KDOQI 2006
- None of these look at the resources available locally
- They are yet to take into account all recent works on Grafts and notably early cannulation grafts
Introduction

- Native access should always be favoured regardless of patients’ risk factors.
- Always have interventional radiologists 24/7 dedicated and interested.
- Vascular lab, always available or surgeon capable of performing US scans.
- Rescues should happen within 6 hours.
- It is a one solution fits all regardless of personal circumstances or local resources.
A Bespoke solution for each patient

- What is their life?
- Body image?
- Life expectancy?
- Self cannulation?
- Home HD?
- Risk factors?
- Risk of steal?
- Previously failed access?
- Surgical fatigue?
What is available locally?

- Easy to follow when in a large teaching hospital where everything is available or a phone call away
- What if the program is run from a smaller structure?
- If the surgeons have too work on multiple sites?
- If the IRs are not available because too busy or simply not interested?
- That means that all programs should be consolidated in big institutions only?
- Since all patients need to constantly be in and out of their hospital this will be hugely inconvenient and depressing

“In keeping with the company’s policy on after-hours availability, he’ll be buried with his phone.”
The guidelines are too old anyway

- The guidelines need to be revised and take into account the real performance of grafts and primary failure rates of native accesses.
- They also need to take into account personal circumstances and different types of patients.
- On over 80 YO with type II diabetes is not the same as a 45 YO with FSGS.
Conclusion

- Guidelines are useful when constantly revised and absorbing the change in patient population or even the disease.
- They absolutely need to take into account what is available locally and therefore should be flexible.