

Vascular Access “The Arteriovenous Fistula”

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ABSTRACT

Dialysis using a peripheral access which has high patient compliance is easy to use and is inexpensive. Arteriovenous fistula is very essential for dialysis and the acceptance rate of failure for this procedure is important because it is not a curative procedure. Hence a failure in the technical aspect of procedure is unacceptable for the patient and the referring nephrologists. Hence a high success rate is mandatory. This experience from us will help for the doctors to improvise the skills. Our experience we preferred the standard left radiocephalic anastomosis (2/3rds of our patient). One on the right brachiocephalic was done due to failed previous Arteriovenous fistula surgery on the left wrist and forearm. And our anastomosis are mostly done end of the vein to side of the artery (83%). Our success rate is 83% which can be improved by preoperative Doppler study which will give the flow of the vessels and then the created fistula characters. Vascular access is a simple and convenient option for people on maintenance dialysis and can be done in our centre with a good success rate. The community of the patients with end stage renal disease can benefit since it is cost effective in our centre.

KEY WORDS: Hemodialysis access, Arteriovenous fistula, Surgical vascular fistula

Introduction

In today's world with a high incidence of diabetes mellitus and hypertension, end organs damage especially to the kidneys leading to end stage renal disease (ESRD) is common. The primary treatment in these patients is renal transplant but the availability of the organ and the cost factor means that there is always a significant waiting period before a patient gets

a suitable donor match. During this delay, the only solution to their problem is DIALYSIS [1]. For dialysis, the primary requirement is a central vascular access. Central line is a temporary access for dialysis and has its own associated complications including mortality [2-3]. Another form of dialysis is peritoneal dialysis which is surgically simple but has its own set of complications and is more expensive than dialysis via peripheral access. Therefore the only option left with is dialysis using a peripheral access which has high patient compliance, is easy to use and is inexpensive. The solution is an AV FISTULA. AV fistulae (AVF) are not risk free; complications range from failure, steal phenomenon, congestive heart failure, aneurysm, stenosis of central veins (Paget Schroetter syndrome) and wound complications [4-5]. The most commonly done fistula is the radiocephalic AVF which

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is created between the left radial artery and the distal cephalic vein. If this radiocephalic fails a brachiocephalic anastomosis between the brachial artery and the cephalic vein proximally is done.

Side-to-Side Anastomosis

The advantage of side-to-side anastomosis is its technical simplicity. The disadvantage is a definite risk of venous hypertension with swelling of the hand. This can be avoided by ligation of the distal run-off vein, thus achieving a functional side-to-end anastomosis.

End-to-End Anastomosis

The advantage of end-to-end anastomosis is that the fistula flow is limited, thus avoiding a hypercirculatory state. The disadvantage is that the anastomosis is technically more difficult. Problems particularly arise when there are large discrepancies in the luminal diameters between the artery and the vein. The most serious problem is, however, that ligation of distal limb of the radial artery may predispose to ischemia of the hand. A final disadvantage is that if venous thrombosis supervenes it will automatically extend into the arterial limb of the fistula.

Side-to-End Anastomosis

Although several techniques for anastomosis are available, the side-to-end anastomosis has deservedly become the most commonly used technique. It is absolutely indicated when artery and vein are far apart and must be brought closely together to create an anastomosis. As a further advantage, a venous thrombosis will affect only the venous limb if it supervenes. If the fistula has to be revised, it is easy to create an anastomosis at a more proximal site. This type of anastomosis poses a number of technical problems explain the high primary malfunction rates reported in some series [6].

Our experience

Here at our dialysis center we have an excellent nephrology team and a dialysis unit. On an average 75 patient get dialyzed every month. The patients requiring AV fistulas are referred to the department of surgery and the basic work up and general condition is looked into. The patient is explained about the procedure and the complications. Forearm exercises are taught to make the vein distend. The dominant artery at the wrist is checked by the simple Allen's test. Dialysis is preferably done within days of surgery to reduce the tissue edema and risk of post operative infection. Consent is taken for surgery.

Operative procedure

The procedure is done under local anesthesia. Patient is supine with left arm extended supported by a hand trolley. A surgeon, skilled assistant surgeon and a scrub nurse are required. Subcutaneous 5000IU of heparin is given just prior to surgery. And an incision of about 5cms made. The vein is mobilized first then the artery. The lie of the vein is important to avoid kinking, twisting or acute angulation. A tension free anastomosis [Figure 1] is made with double arm 6-0 prolene using continuous sutures. A thrill in the venous limb of the fistula immediately after performing the anastomosis indicates a functional AV fistula. Subcutaneous tissue and skin is closed. After skin closure look for thrill again. Sterile non compressive dressing is then applied. And before shifting out of the OT the thrill is checked for again. The patient is asked to continue the hand exercises post operatively. The sutures were removed on post operative day 7 if the wound was healthy. Most fistulas mature within a month and ready for dialysis.

We have done 12 AV fistulas. The details are enlisted in the Table 1.

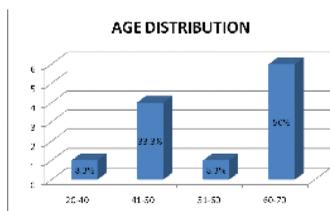
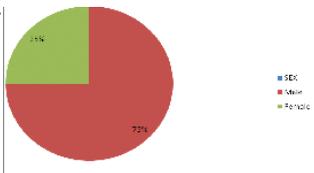
Sex	Age	Indications	Site of anastomosis	Type of anastomosis	Complications
M	65	ESRD	Left RC	End to side	Nil
M	67	ESRD	Left RC	End to side	SSI
F	68	ESRD	Left RC	End to side	Nil
M	62	ESRD	Left RC	End to side	Nil
M	60	ESRD	Left RC	End to side	Nil
M	47	ESRD	Left RC	End to side	Nil
F	50	ESRD	Right BC	End to side	Bleeding
M	67	ESRD	Left BC	End to side	Nil
M	45	ESRD	Left RC	End to side	SSI
M	21	ESRD	Right BC	Side to side	Nil
F	55	ESRD	Left RC	End to side	Nil
M	45	ESRD	Left BC	Side to side	Nil

ESRD – end stage renal disease, RC- radiocephalic, BC – brachiocephalic, SSI –surgical site infections

Data Interpretation

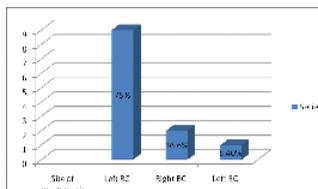
The data was entered in Microsoft excel and graphs were generated.

1. Distribution of patients with respect to sex, in our group predominantly males 75 percentage.

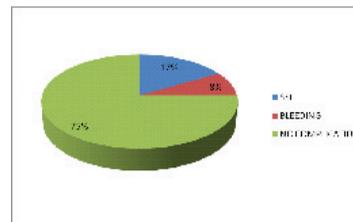
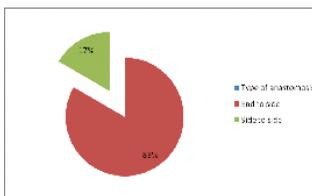


2. Age distribution – 50% of the patients were more than 60yrs of age. And 33.3% of patients were between 41 to 50yrs of age.

3. Site of the AV fistula – 75% of fistulae were left radiocephalic.

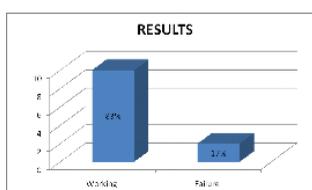


4. 83% (10) of our anastomosis were between end of the vein to side of the artery.



5. 75% of the patients had no post operative complications.

6. The success rate of our series is the 83% and failure rate 17% which is at par with other centers.



Discussion

The experience in Sri Lakshmi Naryana Institute of Medical Sciences, Puducherry is a beginning to a new level of our services provided to our

patients. This is the first of its kind done in the institute. That we did a successful AV fistula in a 21year old male patient after two failed fistulas done elsewhere is worth mentioning. Our results show that most of our patients are male, 75% of who are above the age of 60yrs. We preferred the standard left radiocephalic anastomosis (2/3rds of our patient). One on the right brachiocephalic was done due to failed previous AV fistula surgery on the left wrist and forearm. And our anastomosis are mostly done end of the vein to side of the artery (83%). We had complications[7] in the form of surgical site infections in 17% which is expected in a uremic patient. One patient had bleeding due to heparin which managed with protamine. 75% had no complications. Our success rate is 83% which can be improved by preoperative Doppler study which will give the flow of the vessels and then the created fistula characters[8]. Vascular access is a simple and convenient option for people on maintenance dialysis and can be done in our centre with a good success rate. The community of the patients with end stage renal disease can benefit since it is cost effective in our centre.

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Figure 1: End to side Cephaloradial Arteriovenous

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