

Dialysis

Vascular Access

3. Identification of patients requiring vascular access

CARI Guidelines

- a. The decision to place vascular access should be made jointly by physician, surgeon and patient after assessment and education. (level C evidence)
- b. Patients requiring vascular access should be assessed by a surgeon skilled in vascular access well before the anticipated start of haemodialysis, so that access is functioning well at commencement of dialysis. (level C evidence)
- c. A 'back up' arteriovenous fistula may not be needed in low risk peritoneal dialysis patients, especially if suitable for transplantation. (level B evidence)
- d. A 'back up' fistula should not be placed in those patients for whom a pre-emptive live donor renal transplant is planned. (level C evidence).
- e. Generally, it may not be advisable to use an arteriovenous graft solely as a 'back up' access device, in view of the reduced patency of a graft compared with that of an arteriovenous fistula (level C evidence).

What is the evidence?

Beckingham IJ, O'Rourke JS, Bishop MC, Finney RW. Are back-up arteriovenous fistulae necessary for patients on continuous ambulatory peritoneal dialysis? Lancet 1993; 341: 1384-1386. Retrospective case review. The majority of back-up fistulae were either unusable when required, or never used. Does not support their routine creation in CAPD patients.

What do the other guidelines say?

DOQI: No guidelines available

BRA: No guidelines available

CSN: To determine the type of access most suitable for an ESRD patient, the clinician should take the patient's history and perform a physical examination of the patient's venous, arterial, and cardiopulmonary systems. When indicated, the clinician should also order a diagnostic evaluation (opinion).

Implementation and Audit

Each patient should have an access chart on which date of insertion, date of use and complications are recorded