



“Proper VA maintenance requires integration of different professionals to create a VA team. This team should include a nephrologist, radiologist, vascular surgeon, infectious disease consultant, and members of the dialysis staff.”

Reference:

Santoro, D., Benedetto, F., Mondello, P., Pipitò, N., Barillà, D., Spinelli, F., Ricciardi, C.A., Cernaro, V. and Buemi, M. (2014) Vascular access for hemodialysis: current perspectives. International Journal of Nephrology and Renovascular Disease. July 8th. 7, p.281-94. eCollection 2014.

Current perspectives on vascular access for hemodialysis [@ivteam](http://ctt.ec/Ef98_+) #ivteam

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Abstract:

A well-functioning vascular access (VA) is a mainstay to perform an efficient hemodialysis (HD) procedure. There are three main types of access: native arteriovenous fistula (AVF), arteriovenous graft, and central venous catheter (CVC). AVF, described by Brescia and Cimino, remains the first choice for chronic HD. It is the best access for longevity and has the lowest association with morbidity and mortality, and for this reason AVF use is strongly recommended by guidelines from different countries. Once autogenous options have been

exhausted, prosthetic fistulae become the second option of maintenance HD access alternatives. CVCs have become an important adjunct in maintaining patients on HD. The preferable locations for insertion are the internal jugular and femoral veins. The subclavian vein is considered the third choice because of the high risk of thrombosis. Complications associated with CVC insertion range from 5% to 19%. Since an increasing number of patients have implanted pacemakers and defibrillators, usually inserted via the subclavian vein and superior vena cava into the right heart, a careful assessment of risk and benefits should be taken. Infection is responsible for the removal of about 30%-60% of HD CVCs, and hospitalization rates are higher among patients with CVCs than among AVF ones. Proper VA maintenance requires integration of different professionals to create a VA team. This team should include a nephrologist, radiologist, vascular surgeon, infectious disease consultant, and members of the dialysis staff. They should provide their experience in order to give the best options to uremic patients and the best care for their VA.

Other intravenous and vascular access resources that may be of interest (External links - IVTEAM has no responsibility for content).

Guide for intravenous chemotherapy and associated vascular access devices from Macmillan. CancerUK IV chemotherapy information.



