The modality by which haemodialysis (HD) is delivered varies widely and is influenced by clinical evidence, patient factors and the prevailing service configuration. The aim of this study was to determine the outcome and impact of access strategy on patient outcome by mapping out the HD journey in a cohort of incident patients” Murray et al (2018).

Abstract:

BACKGROUND: The modality by which haemodialysis (HD) is delivered varies widely and is influenced by clinical evidence, patient factors and the prevailing service configuration. The aim of this study was to determine the outcome and impact of access strategy on patient outcome by mapping out the HD journey in a cohort of incident patients.

METHODS: A 2-year cohort of consecutive incident HD patients from the point of referral for first dialysis access to completion of the first 365 days of HD was prospectively reviewed. Data were sought on access type; radiological, surgical and other access-related activity; bacteraemic events; admission rates and cumulative financial cost.

RESULTS: A total of 144 patients started RRT for the first time with HD over the 2-year period. All were followed up to 1 year after starting HD, generating a total of 47 753 observed HD days. Activity prior to starting HD for the full cohort was found to average 0.92 arteriovenous (AV) access creation procedures, 0.40 CVC insertions, 0.14 interventional radiology procedures and 0.41 ultrasound examinations per patient. The small number of patients who started on an AVG had a tendency towards higher pre-HD surgical and imaging activity than those who started on an AVF or CVC. Activity after starting HD varied greatly with the access type used at the start of HD, with AVF patients experiencing less hospitalization, procedure and imaging activity and financial costs compared with those who start HD with a CVC. Patients who started on an AVG had a tendency towards lower surgical activity rates and financial costs than those who started on a CVC.

CONCLUSIONS: Providing, maintaining and dealing with the complications of HD vascular access places a significant burden of activity that is shared across nephrology, surgery and
imaging services. A well-functioning AVF is associated with the lowest burden, whereas a failed AVF or CVC access is associated with the highest burden. Patient journeys are shaped by the vascular access that they use and we suggest that the contemporary pursuit of HD access should focus on delivering personalized access solutions.

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