

Medical Review Board Statement Maximizing Primary Arteriovenous Fistulae for Pre-ESRD and Dialysis Patients

1. The Medical Review Board (MRB) of ESRD Network 18 supports the practice of constructing autogenous arteriovenous (AV) fistulae whenever possible in all new ESRD patients electing hemodialysis as their initial renal treatment modality (see #2 for exceptions). The MRB recognizes that some patients will not be good candidates for the procedure. However, current research (upon which the K-DOQI Clinical Practice Guidelines are based) demonstrates that native accesses have the best 4-5 year potency rates and require fewer interventions and hospitalizations than other accesses.
2. The MRB supports the K-DOQI recommendation of a 65% primary AV fistula construction rate for incident dialysis patients. Patients should be considered candidates for this procedure, unless one of the following is documented in the medical record:
 - a. The patient has a physical problem precluding an AV fistula, as documented (after a formal evaluation) by a vascular surgeon
 - b. Probability of a Living Related Transplant within 3 months
 - c. The patient refuses the procedure
3. The MRB also recommends that all prevalent patients who had a failed AV graft or catheter be re-evaluated for possible construction of a primary AV fistula.
4. In addition, the MRB concurs with the K-DOQI recommendation that each facility should establish a system for tracking types of accesses created and complication rates.
5. The MRB recommends that all physicians and facility staff use access-related terminology consistent with the K-DOQI guidelines. Specifically, the following terms/descriptions are appropriate:
 - a. Arteriovenous fistula - This term (a.k.a. AVF, AV fistula) applies to native access only (e.g. Cimino, brachiocephalic)
 - b. Graft - This term applies to any type of non-native or prosthetic access (e.g. PTFE, bovine)
 - c. Catheter - This access should be described as either temporary or permanent, and by location (e.g. internal jugular, etc.)
 - d. "Shunt" - This term is outdated, and is not an appropriate generic term

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"The basic tenet for vascular access monitoring and surveillance is that stenoses develop over variable intervals in the great majority of vascular accesses and, if detected and corrected, under-dialysis can be minimized or avoided (dialysis dose protection) and the rate of thrombosis can be reduced." (K/DOQI 2006 Updates)
FLOW METHODS IN DIALYSIS ACCESS (STENOSIS MONITORING)"The basic tenet for vascular access monitoring and surveillance is that stenoses develop over variable intervals in the great majority of vascular accesses and, if detected and corrected, under-dialysis can be minimized or avoided (dialysis dose protection) and the rate of thrombosis can be reduced." (K/DOQI 2006 Updates)

Medical Review Board Statement Vascular Access Surveillance (VAS) Program

The Medical Review Board (MRB) of ESRD Network 18 supports the K-DOQI guidelines on vascular access related to arteriovenous grafts. Specifically, this includes:

1. Each hemodialysis facility should establish a formal, organized vascular access monitoring/surveillance system, to track types of patient vascular accesses, location, and any type of diagnostic and treatment/intervention procedures done.
2. Regular assessment of clinical parameters should be done on each hemodialysis patient, particularly patients with AV grafts, to include access physical assessment and dialysis adequacy.
3. Results of any vascular access assessment should be documented on the patient record, and be included in an ongoing tracking system for the facility QAPI program.
4. Any of the K-DOQI recommended surveillance techniques might be included in the formal VAS program.
5. Persistent abnormalities in any of the monitoring/surveillance measurements should result in prompt patient referral for some type of formal diagnostic procedure (venography, angiography or fistulography).
6. Appropriate treatment/intervention in a timely manner is required when any significant stenosis is found, as a result of diagnostic procedures or other medical assessment.
7. Each hemodialysis facility should establish formal policies and procedures as part of the formal VAS program.

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