OPI COSENZA

SIAN

2° Convegno Regionale Calabria
Infermieri di Area Nefrologica

30 Giugno 2024 Hotel San Francesco Rende (Cs)

Le Competenze Infermieristiche in Nefrologia:
La nuova sfida per il riconoscimento professionale.

U.O.C RADIOLOGIA INTERVENTISTICA
Ospedale Annunziata
Dir. G. Guido
Dr. T. De Bartolo – Dr. F. A. Iannace

Treatment of stenosis and thrombosis in AV Fistulae & AV grafts

Guideline 7

7.1. For venous outflow stenosis percutaneous transluminal angioplasty (PTA) is the first treatment option. *(Evidence level III)*

7.2. Thrombosed autogenous and graft fistulae should be treated either interventionally or surgically. Individual centers should review their results and select the modality that produces the best results for that center. In some centers this will be interventional radiology and in others surgery. *(Evidence level III)*

VASCULAR ACCESS SOCIETY

Nephrol Dial Transplant (2007) 22 [Suppl 2]: ii88–ii117
doi:10.1093/ndt/gfm021

NDT Nephrology Dialysis Transplantation

EBPG on Vascular Access

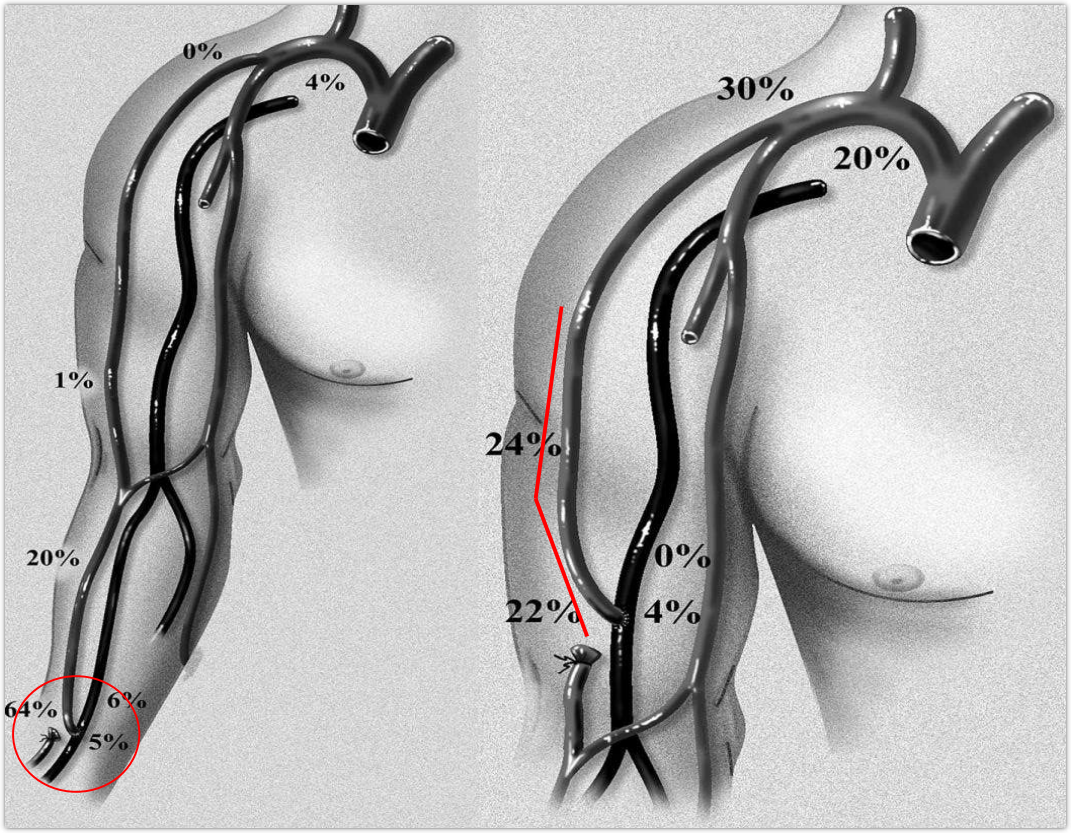
Jan Tordoir[1], Bernard Canaud[2], Patrick Haage[3], Klaus Konner[4], Ali Basci[5], Denis Fouque[6], Jeroen Kooman[7], Alejandro Martin-Malo[8], Luciano Pedrini[9], Francesco Pizzarelli[10], James Tattersall[11], Marianne Vennegoor[12], Christoph Wanner[13], Piet ter Wee[14] and Raymond Vanholder[15]

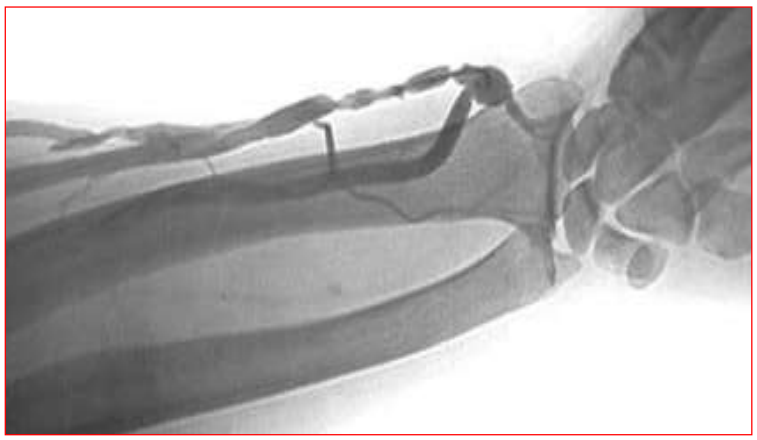
HOME MADE CASES

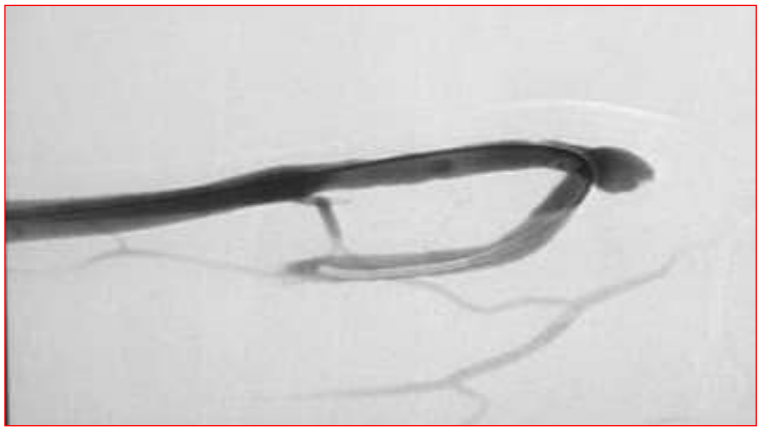
PTA

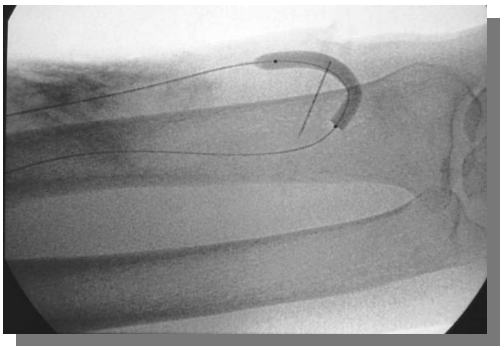
STENTINO

TROMBOLISIS/**THROMBECTOMY**

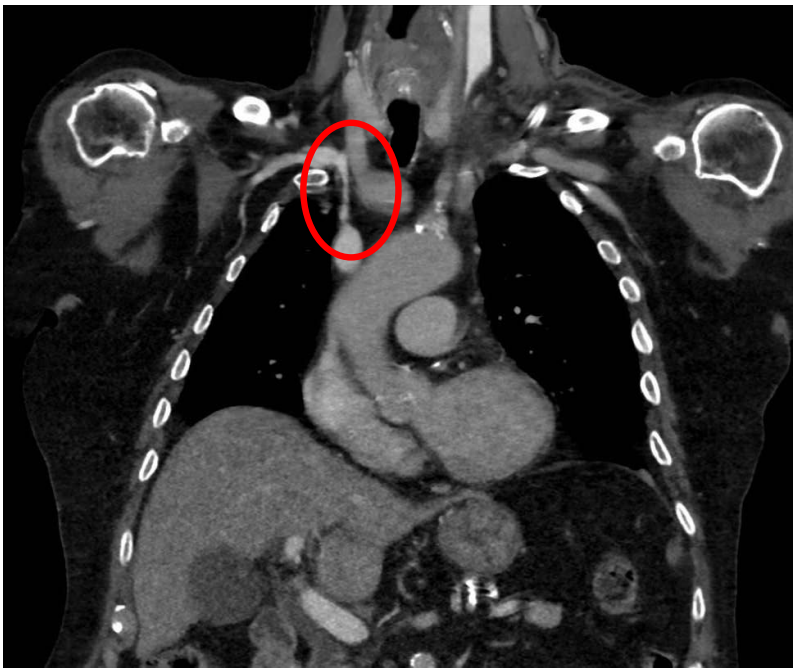








Agosto 2023



NEW TECHNOLOGIES PUT THE THRILL BACK IN DIALYSIS ACCESS

Sponsored by BD

Endovascular Treatment of Dysfunctional Vascular Access: From Fundamentals to an Algorithmic Approach

Choosing the ideal device for the right location in dialysis access management.

BY PANAGIOTIS M. KITROU, MD, MSc, PHD, EBIR, AND DIMITRIOS KARNABATIDIS, MD, PHD, FCIRSE

Stent Grafts Provided Superior Primary Patency for Central Venous Stenosis Treatment in Comparison with Angioplasty and Bare Metal Stent: A Retrospective Single Center Study on 70 Hemodialysis Patients

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2016, Vol. 50(4) 221-230

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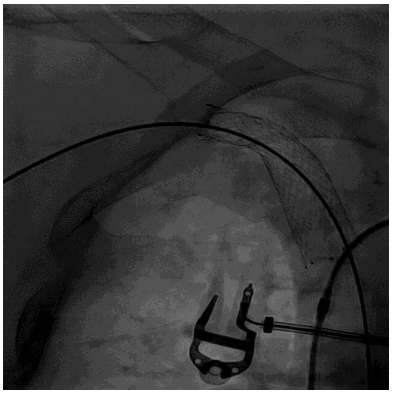
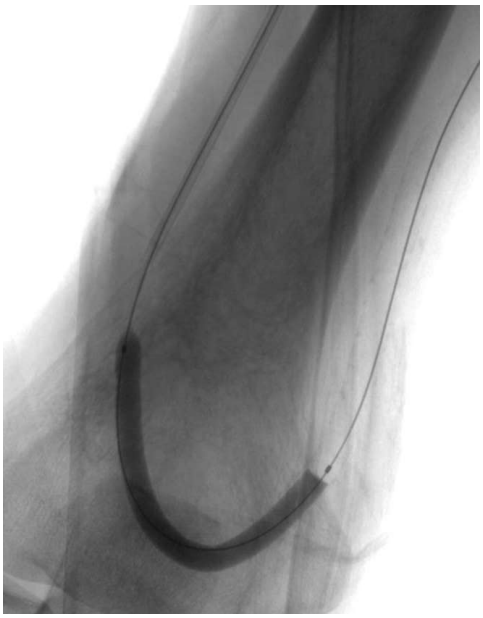
SAGE

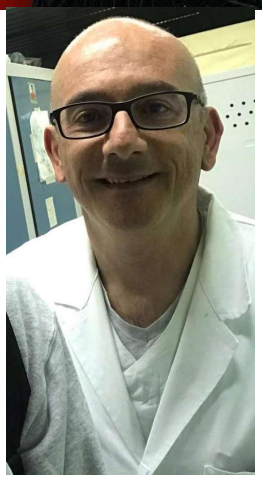
Pietro Quaretti, MD[1], Franco Galli, MD[2], Lorenzo Paolo Moramarco, MD[1], Riccardo Corti, MD[3], Giovanni Leati, MD[3], Ilaria Fiorina, MD[3], Carmine Tinelli, MD[4], Giovanni Montagna, MD[2], and Marcello Maestri, MD[5]

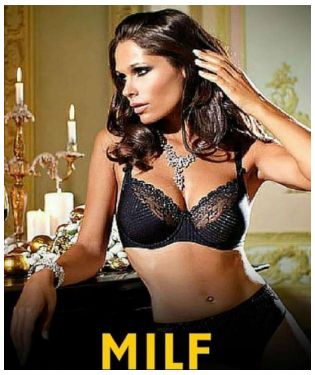
Abstract

Purpose: To compare patency in dialysis patients following different endovascular treatment of symptomatic central venous stenosis. **Materials and Methods:** A 10-year retrospective evaluation in 70 patients (32 men) dialyzing through vascular access (33, 47%) and tunneled catheters (37, 53%) was made. Three cohorts were compared: angioplasty alone (22), bare metal stent (28), and stent graft (20). Patencies were described with Kaplan–Meier method, and Cox uni- and multivariate models were analyzed to find factors associated. **Results:** All patients had a favorable anatomical and clinical outcome. Restenosis occurred in 22 (31%) of 70 patients requiring 41 additional interventions; 34 of 70 patients died (median follow-up 19.4 months). Primary patency at 3, 6, 12, and 24 months was 100%, 100%, 100%, and 84% for stent graft versus 90%, 79%, 58%, and 43% for angioplasty ($P = .014$) versus 84%, 80%, 75%, and 46% for bare-metal stent ($P = .062$). The overall comparison was more favorable for stent graft ($P = .020$) when the sites of lesions were matched. Patencies for angioplasty and bare-metal stents were equivalent ($P = .141$). A lower risk of restenosis (hazard rate [HR] 0.20, confidence interval [CI] 0.06-0.7) and fewer reinterventions ($P < .01$) were associated with stent graft, whereas age (HR 1.04, CI 1.001-1.08) and cardiovascular disease (HR 2.26, CI 1.06-4.84) influenced the overall survival. No difference in assisted primary patency was found. **Conclusion:** Stent graft seems to improve primary patency for central venous stenosis and requires fewer reinterventions in a dialysis population with a high prevalence of long-term catheters.









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https://doi.org/10.1186/s12882-023-03361-5

BMC Nephrology

RESEARCH Open Access

The efficacy of percutaneous transluminal
tula
iovenous

http://www.kidney-international.org
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Endovascular management in
arteriovenous fistula for hem
ure fistula

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Vascular and Interventional Radiology • Re

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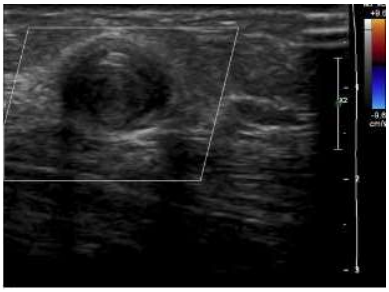
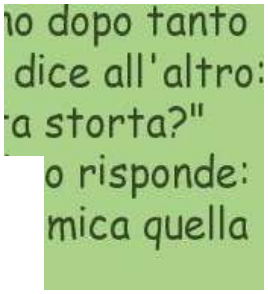
Radiology

AJR FOCUS ON:

Arteriovenous Fistulas and Their Characteristic Sites of Stenosis





Management of autogenous AV fistula thrombosis

Fistula thrombosis should be treated as soon as possible or within 48 h. The duration and site of AV

post-anastomotic vein segment as result of anastomotic stenosis or may begin at the needle site. When the clot is localized at the anastomosis in radial-cephalic and brachial-cephalic fistulae, the outflow vein may remain patent due to the natural side branches that continue to carry venous blood flow. In these accesses it is possible to create a new proximal anastomosis [7,13]. Thrombosis in transposed basilic vein fistulae usually leads to clot propagation of the entire vein. Although comparative studies are missing, the available literature [4,5,14–22] suggests that thrombosed autogenous AV fistulae should, preferably, be treated by interventional radiology. The single exception may be forearm AV fistulae, thrombosed due to anastomotic stenosis. It is likely that in such cases, proximal re-anastomosis will provide good results.

Interventional thrombolysis

Thrombolysis can be performed mechanically or pharmacomechanically [23–25]. While the immediate success rate is higher in grafts than in autogenous AV fistulae (99 *vs* 93% in forearm fistulae), the primary patency rate of the forearm AV fistula at 1 year is much higher (49 *vs* 14%). One year secondary patency rates are 80% in forearm and 50% in upper arm AV fistulae, respectively [14]. In AV fistulae, the combination of a thrombolytic agent (urokinase or tissue plasminogen activator = tPA) with balloon angioplasty resulted in an immediate success rate of

Management of AV graft stenosis

A diameter reduction of >50% of the lumen together with a significant flow decline is considered as an indication for treatment [26].

Stenosis at the arterial anastomosis

As in autogenous fistulae, most arterial inflow stenoses in grafts can successfully be treated by PTA [27]. Stenosis of the arterial anastomosis itself can be dilated, if only the afferent artery and the graft at the anastomosis are affected and there is no stenosis in the efferent artery. If there is an additional stenosis of the efferent artery, angioplasty of the anastomosis alone will enhance graft flow with the risk of peripheral ischaemia due to reduced peripheral arterial perfusion. In these patients, either dilatation of the efferent artery by interventional radiology or through surgical revision of the anastomosis may resolve the dilemma.

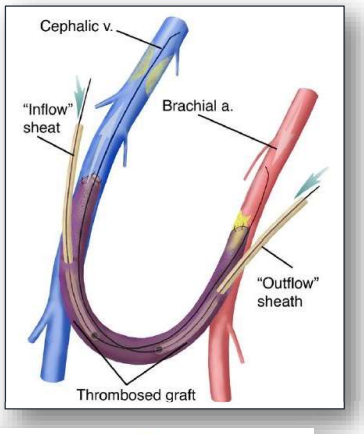
Intra-graft stenosis

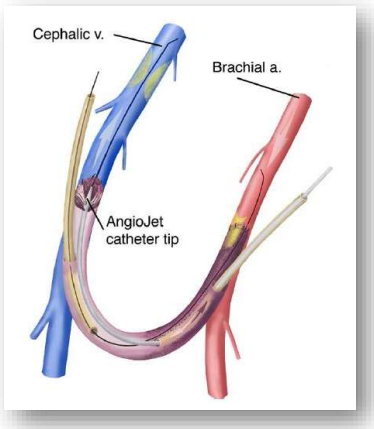
Intra-graft (or mid-graft) stenoses are found in the cannulation segment of grafts. They result from excessive ingrowth of fibrous tissue through puncture holes. These stenoses can be treated by PTA [28], graft curettage [29], or segmental graft replacement. When only a part of the cannulation segment is replaced, the access can be used for haemodialysis

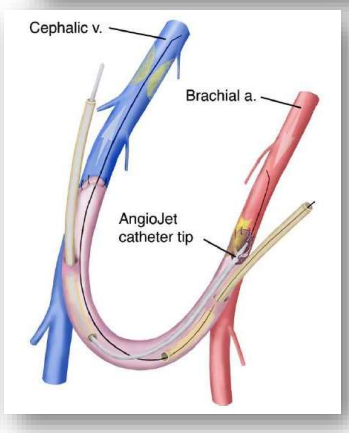
Vascular Access Society

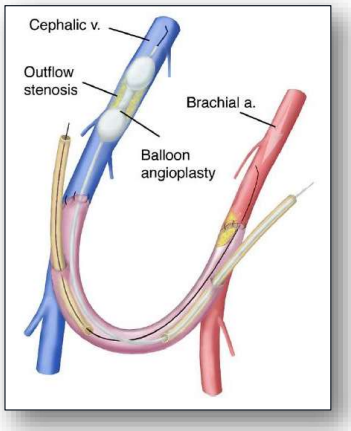
VASCULAR ACCESS SOCIETY

Tecnica del doppio approccio









FAV native e GRAFT- Risultati

- Tasso di successo tecnico per trombosi migliore graft versus vs fistole native *, al contrario della pervietà primaria ad 1aa (FAV=49% versus graft=26%->da recidiva stenosi)

Turmel Rodriguez, CVIR 2004

- Successo clinico fistole native 84%
- Successo clinico graft 71%

Tromb Garcia Medina, Nefrologia 2009 %)

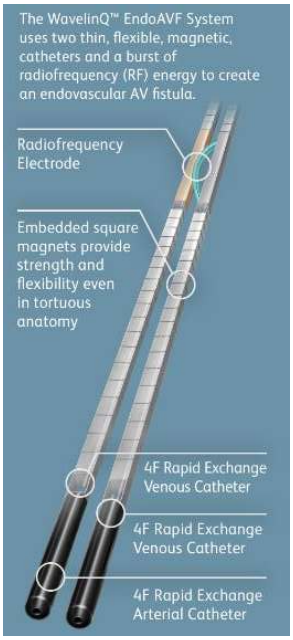
When Not to Perform Percutaneous Thrombectomy of a Clotted Native Fistula

Ten scenarios in which this therapy may not be the best option for hemodialysis fistula treatment.

JUNE 2014 ENDOVASCULAR TODAY

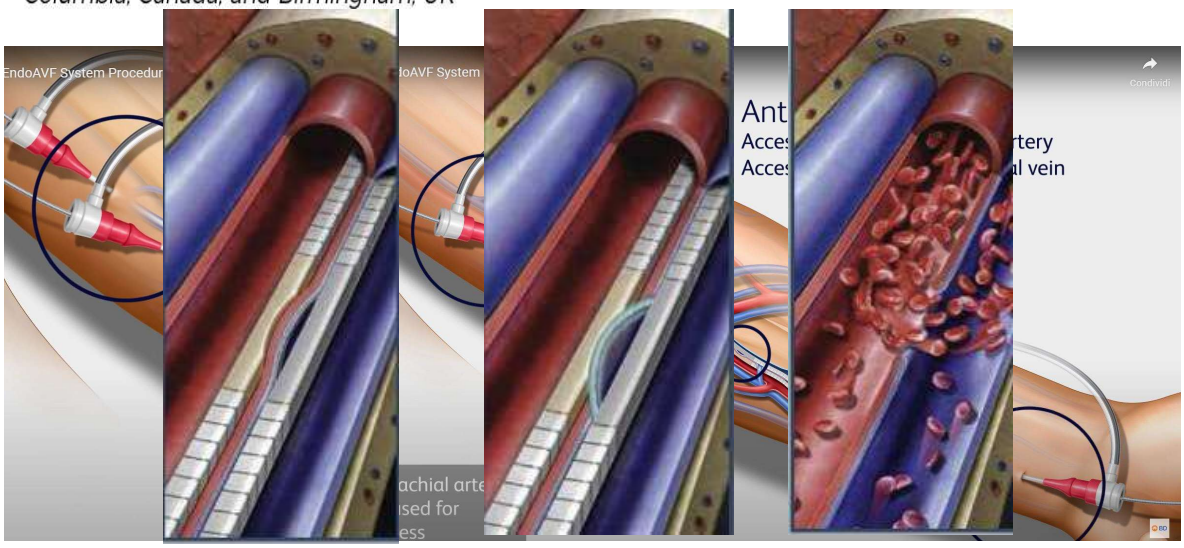
BY JONAS W. REDMOND, MD, AND TIMOTHY W.I. CLARK, MD, FSIR

- Fistola infetta (eritema e flogosi cutanea per la flebite da trombosi)
- In presenza di ischemia distale da ipoperfusione
- Fistola aneurismatica (<5cm) con ampia deposizione trombotica (embolismo polmonare 59%)
- Ulcerazione sito di puntura o aree di necrosi cutanea
- Trombosi ripetuta (caso per caso) <1 m
- Stenting esteso
- Pz.emodinamicamente instabili, con limitata riserva cardio-polmonare, shunt destro-sinistro

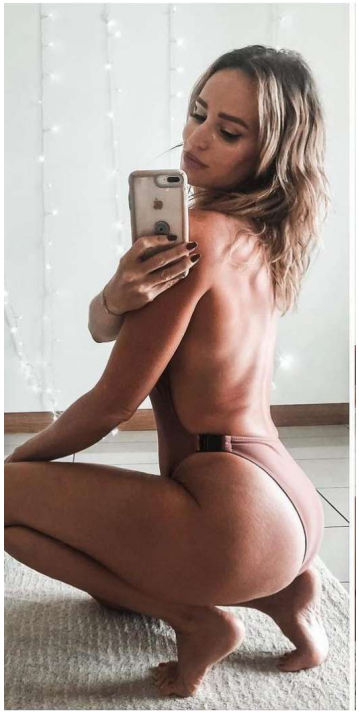


Percutaneous arteriovenous fistula creation with the 4F WavelinQ EndoAVF System

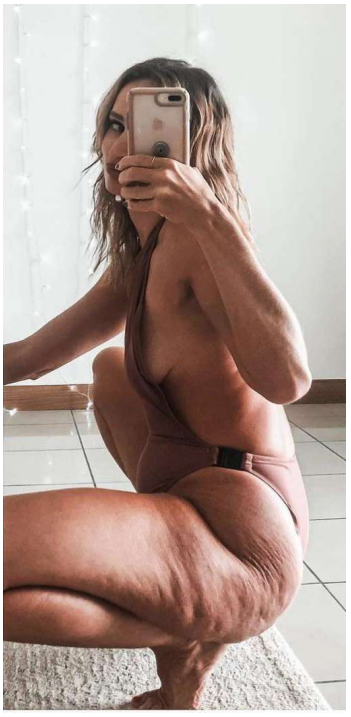
Todd Berland, MD,[a] Jason Clement, MD,[b] Nicholas Inston, MD,[c] Paul Kreienberg, MD,[d] and Kenneth Ouriel, MD,[e] on Behalf of the WavelinQ 4 French Investigators, *New York and Albany, NY; British Columbia, Canada; and Birmingham, UK*



CONCLUSIONI



INSTAGRAM VERSUS REALITY



GRAZIE PER L’ ATTENZIONE…E ATTENZIONE A NON SBAGLIARE IDRAULICO