RECOGNITION OF THE FAILING FISTULA:

SUMMARY:

- An access blood flow of > 500 mls/min and a vein diameter of at least 4mm are recommended for a fistula or graft to adequately support haemodialysis treatment (Asif et al, 2006).
- A new access should be planned for and created in a timely manner to avoid exposing the patient to an increased risk of morbidity and mortality associated with a failing access (Asif et al, 2006).
- Physical assessment of the fistula indicates suboptimal performance, such as a discontinuous thrill, a higher or lower than normal pitch bruit, and a non-collapsible vein on arm elevation.
- There has been obvious degenerative changes to the fistula and overlying skin.
- Progressive enlargement of aneurysms and/or pseudoaneurysms, limiting the available area for needling.
- The fistula has undergone a number of interventions during its lifespan with a decreasing time between such interventions.
- A reduction in dialysis adequacy as measured by Kt/v on a constant dialysis prescription which does not improve with intervention.
- Increased evidence of recirculation which has not responded to intervention. If the BFR through the fistula is found to be below that of the dialysis machine, there is an increased risk of recirculation.

WHAT DO OTHER GUIDELINES SAY?

KDOQI (2006):

- There have been episodes of spontaneous bleeding, with an increased risk of a herald bleed taking place (KDOQI, 2006).

MANAGEMENT:

- The primary nurse is to monitor the patient’s access monthly and when changes to access occur using the Vascular Access Risk Assessment tool.
- Vascular Access Nurse (VAN) is to be notified of any concerns and will review the patient’s fistula.
- The VAN will organise for the patient to see the relevant Vascular Surgeon in their consult rooms which will require a referral from the patient’s Nephrologist or GP.
- Mapping of alternate limbs will be done in preparation for a new fistula or graft.
- Decisions on a new fistula will be made in consultation with the patient, their Vascular Surgeon and their Nephrologist.
OPTIMAL OUTCOME:

- A new native fistula will be planned for and created without undue risk to the patient and their dialysis regime.
- It may be necessary for the patient to have a temporary tunneled catheter to allow time for the new fistula or graft to mature before use.
- It may be necessary to have the failing fistula ligated, based on the patient’s medical condition, and at the discretion of the patient’s Nephrologist and Vascular Surgeon.

REFERENCES:

