Scholars Journal of Applied Medical Sciences (SJAMS) **ISSN 2320-6691 (Online)**
Sch. J. App. Med. Sci., 2014; 2(3A):949-955 **ISSN 2347-954X (Print)**
©Scholars Academic and Scientific Publisher
(An International Publisher for Academic and Scientific Resources)
www.saspublisher.com

Research Article

Vascular Mapping before Haemodialysis Access in CRF Patients and Evaluation of AVF Maturation by Doppler Ultrasound

Dr. L Kaushal[1], Dr. A Patil[2], Dr. V K Verma[3], Dr. C P Ahirwar*[4], Dr. Shamim[5]
[1]Head, Department of Radiology and Imaging, GMC, Bhopal, Madhya Pradesh, India
[2,4]Assistant Professor, Department of Radiology and Imaging, GMC, Bhopal, Madhya Pradesh, India
[3]Associate Professor, Department of Radiology and Imaging, GMC, Bhopal, Madhya Pradesh, India
[5]Resident, Department of Radiology and Imaging, GMC, Bhopal, Madhya Pradesh, India

***Corresponding author**
Dr. C P Ahirwar
Email: drchandraprakashradiologist@gmail.com

Abstract: This prospective hospital based study was undertaken to reckon the value of ultrasound in preoperative vascular mapping for AVF placement and in postoperative follow-up to evaluate its maturity and complications. 100 CRF patients who needed hemodialysis access underwent preoperative US vascular mapping and among them 62 patients, who were candidates for native fistulas were reviewed on 7th and 28th postoperative days. The results were analyzed and means were calculated using Epi-Info^{Ver7}. The mean diameters of the radial and brachial arteries were 2.37mm and 3.13mm respectively. The mean venous diameters for forearm and arm fistulas were 2.69mm and 3.18mm respectively. There was a significant increase in native AVF creation when PE was combined with US(62%) as compared to PE alone(19%). Vascular anatomy as defined by sonography, matched the operative findings in all but one (98.39% accuracy). The mean diameter of the venous limb and its flow volume of radio-cephalic and brachio-cephalic/basillic fistulas at 28 day were 3.97mm & 404 ml/min and 4.52mm & 470 ml/min respectively. 67.7% of fistulas were mature at 4 weeks. In conclusion, pre-operative ultrasonographic vascular mapping is valuable in selecting potential sites for vascular access, helping in maximizing the native AVFs and decreasing the negative surgical exploration rates. Post operative follow up is of value when the status of fistula maturity is in doubt and when complications are clinically suspected.
Keywords: Dialysis Access, AV fistulas, Doppler Ultrasound.

INTRODUCTION

Since its introduction in 1966, haemodialysis has revolutionized the management of patients with renal failure to an unforeseen extent. The expected life span of patients with end-stage renal disease has improved significantly and vascular access is the 'life line' of these patients, providing the route for HD therapy.

Vascular access procedures and complications have been major cause of morbidity accounting for over 20% of hospitalizations of dialysis patients in the United States and cost about $1 billion annually [1,2]. In an effort to improve vascular access outcomes the National Kidney Foundation published the Dialysis Outcome Quality Initiative (DOQI) set guidelines regarding the optimal management of vascular access [3]. AVF are the preferred access for HD because they are associated with a lower frequency of complications and greater longevity [4, 3]. Most of the AVF failures have been attributed to inadequate vessels used for surgery.

Physical examination is the traditional method of evaluation performed prior to hemodialysis access placement [5], however it is not fool proof.

With high-resolution US scanners, it is now possible to obtain precise anatomic knowledge, qualitative and quantitative data. It precisely identifies the quality of superficial veins and the status of the deep venous flow and also provides an analysis of the characteristics of arterial flow and wall, which may put a good functioning of AVF at risk.

After surgical creation, AVFs typically require several weeks to months of maturation and thus it would be advantageous to develop objective quantitative criteria to evaluate the suitability of fistulas for dialysis.

A blood pump usually routes 350-400 mL/min through a dialyzer. The definition of a functional access is an access that is able to deliver a flow rate of 350-400 mL/min without recirculation for the total duration of dialysis.

A substantial proportion of fistulas (28%–53%) never mature adequately to be usable for dialysis due to ill-defined mechanisms [6, 7, 8, 9]. An AVF is typically not evaluated for maturity until 2–3 months after placement, not used until 3 months after placement [6] and nephrologists often wait up to 6 months before declaring the fistula a failure [10]. If the AVF never matures, this is time wasted. Well-defined criteria applied early after fistula placement to help identify fistulas likely to fail would be extremely useful [11]. Ultrasonography also help identify other complications associated with grafts and fistulas, including hematoma, pseudoaneurysm, and abscess [12].

It is estimated that 100,000 new patients of end stage renal disease (ESRD) enter renal replacement programs annually in India [13]. In a population based study from Bhopal, Modi et al have reported the average crude and age adjusted incidence rates of stage 5 CKD (ESRD) as 151 and 232 per million population[14]. With increasing prevalence of CKD and steeply raising trend in dialysis there is a current need of a low-cost easy to perform method that provides reliable information on sonographic mapping on planning access placement with subsequent decrease in negative surgical exploration [15] . It is this need that has motivated this study.

MATERIALS & METHODS

This hospital based prospective study of 100 cases of CRF who need hemodialysis access was conducted in the Department of Radiodiagnosis and Imaging at Gandhi Medical College and Hamidia Hospital, Bhopal, Madhya Pradesh from June 2012 to December 2013.

Inclusion Criteria

- Chronic renal failure-Stage IV & V [18].
- Clinically stable.
- Patients referred for native AVF in upper limb for haemodialysis.
- Willingness to attend follow-up Color Doppler ultrasound.

Exclusion Criteria

- Previously failed AV Grafts/ fistulas
- Deformed or scarred upper limb
- Upper limb arterial disorder like Reynaud's
- Need to puncture the graft before the end of study.
- All patients where AVF for access is contraindicated or technically not feasible or do not fulfill any inclusion criteria.

Source of Data

CRF patient who present to Department of medicine for dialysis are referred to the Department of Radiodiagnosis at GMC and HH, Bhopal, for Colour Doppler mapping for assessment of site for AV fistula formation before the procedure in done in CTVS department.

Methodology

Ultrasonographic evaluation with Colour Doppler is done for the preferred site of vascular access by evaluation of vessel size, patency and wall morphology.

Transverse plane is used to identify vessels and evaluate their diameter and wall thickness. Colour and Spectral Doppler waveforms are obtained in longitudinal plane of vessels selected for potential vascular access. Depth from the skin surface of the anterior wall of vein is measured. Arteries are assessed for intimal thickening and stenosis [16].

- The most distal site is used first, moving proximally, depending on the availability of good veins & disease free arteries.

The preoperative criteria to be met for vascular access are summarized as,

- Arteries 2.0 mm or larger
- Veins, 2.5 mm or larger for AVF, or 4.0 mm or larger for graft.
- Depth of the vein from the skin surface < 5 mm
- Superficial vein continuing to the deep venous system;
- Absence of central venous stenosis
- Absence of evidence of arterial stenosis segments

Patients who are candidates for upper limb native AVFs will be followed up with US at day 7 and 28 for assessment of diameter of the venous arm of fistula and flow volume.

Post Procedure Ultrasound Technique

The diameter and compressibility of the draining vein is studied routinely in the caudal, mid-, and cranial portions of the forearm, and similarly in the upper arm. The entire draining vein is scanned and the minimum diameter is measured.

The depth of the anterior wall of the AVF from the skin surface is also measured. Blood flow is measured in the AVF in ml/min using the volume flow measurement function of the duplex instrument at a site far enough from the anastomosis. Three measurements were performed, and the final value used in the study was the arithmetic mean.

Criteria For Maturation After The Procedure

- Vein diameter larger than 4 mm remote from the site of fistula.
- Vein located at a depth of <5 mm from skin surface.

- Flow volume > 400 mL/min safely away from turbulence at fistula site.

Method of Statistical Analysis

Means calculated using MS Excel and correlations using Epi Info Version7.

RESULTS

In the study population of 100 patients who were in need of a vascular access for hemodialysis, 63 were males and 37 were females.

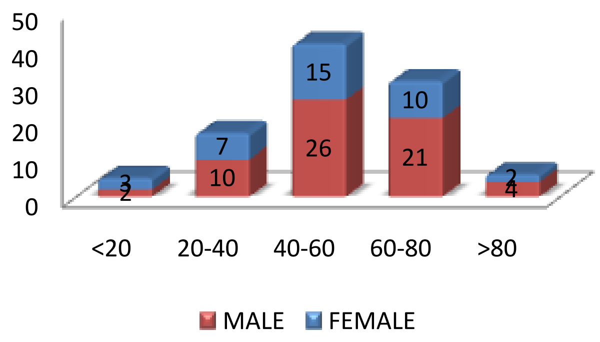

Fig. 1: Distribution of study population according to sex and age

62 of the 100 patients were diabetic, 71 were hypertensive and 45 had both morbidities. These vascular risk factors are associated with increased risk of AVF failure [17].

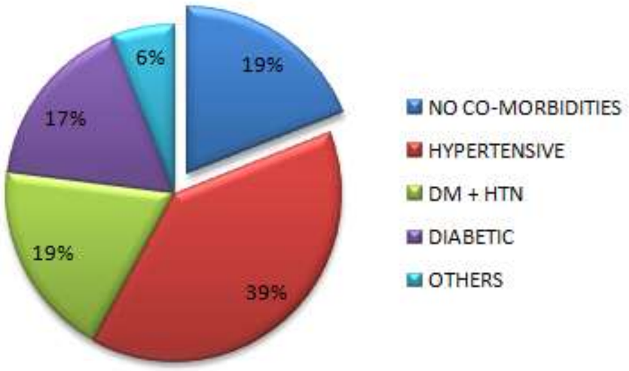

Fig. 2: Distribution of Co- Morbidities

In the present study, 62 patients who underwent Preoperative US mapping had native upper limb fistula placed successfully and 38 had vessels suitable for graft placements.

The most common upper limb fistula was radio-cephalic fistula. Of the 62 native fistulas made 42 were radio-cephalic, 31 and 11 each in the dominant and non dominant limb respectively. 19 were brachial artery cephalic vein fistulas. Basilic artery transposition was done in 1 patient.

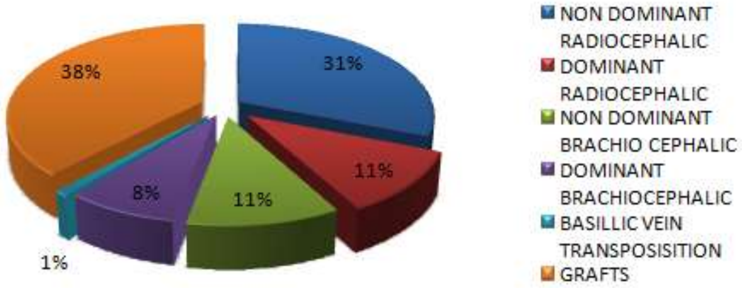

Fig. 3: Type of Vascular Access

Table: 1 Diameter of Vessels Used in Access

Artery	N	Mean Dia. (mm)	Medain	Std. Deviation	Min (mm)	Max (mm)
Radial A (Wrist)	42	2.37	2.4	0.117	2.1	2.6
Brachial A (Arm)	20	3.13	3.1	0.240	2.8	3.6
Vein	**N**	**Mean Diam. (mm)**	**Median**	**Std. Deviation**	**Min (mm)**	**Max (mm)**
Cephalic V (Wrist)	42	2.69	2.7	0.132	2.5	3
Cephalic V (Elbow)	19	3.18	3.2	0.185	2.9	3.5
Basillic V (Elbow)	1	3.2				

Table 2: Diameter and Volume of Radiocepahlic and Brachiocephalic/Basillic

Diameter (mm)	Day 7			Day 28		
	Mean	Median	Std. Dev.	Mean	Median	Std. Dev.
Radiocepahlic	2.83	2.80	0.155	3.97	4.05	0.42
Brachiocephalic/Basillic	3.47	3.4	0.229	4.52	4.6	0.451
Volume (ml/min)	**Day 7**			**Day 28**		
	Mean	Median	Std. Dev	Mean	Median	Std. Dev
Radiocepahlic	274.0	280.0	33.48	404.0	410.0	49.78
Brachiocephalic/Basillic	335.5	340	37.38	470	465	54.77

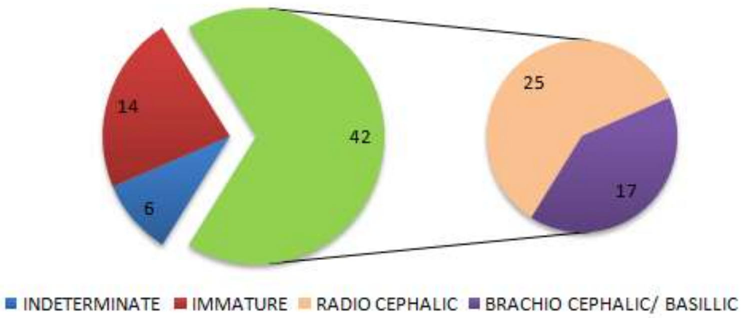

Fig. 4: Maturity at 4 Wks According to Fistula Site

The mean diameter of the venous limb and its flow volume at 28 day at the radio-cephalic and brachio cephalic/ basillic fistulas were 3.97mm & 404 ml/min and 4.52mm and 470 cc respectively. Of the 20 upper arm fistulas 17 (85%) met all the laid criteria for maturity. Of the 42 radio-cephalic fistulas only 25 (59.5%) met all the criteria for maturity and 13 (30.95%) were immature at 4 weeks. This is at least partly contributed by the fact that the distal forearm fistulas have reduced caliber of the arterial and venous limbs as compared to the proximal fistulas (2.37 and 2.69 mm Vs 3.13 and 3.18 mm respectively).

DISCUSSION

In our study evaluation by physical examination favorable anatomy was found in 19 patients and was inconclusive in 81 patients.

In patients who had favorable forearm anatomy under physical examination, ultrasound validated the findings. Of the 81 patients who had unfavorable or in-assessable vascular anatomy, 43(62%) had vessels suitable for native upper limb fistulas.

Table 3: Comparison of present study with other studies for increase in AVF creation when PE was combined with US for pre-operative vascular mapping

Author/ Study	PE (%)	PE + DUSG (%)
Silva *et al*. 1998 [18]	34%	64%
Allon *et al*., 2001 [6]	14%	63%
Malvroh *et al*., 2002 [19]	0% (n=62)	77%
Wells *et al*., 2005 [20]	73% (n=145)	86.5%
Present study	19%	62%

Diameter of the vessels is an important criterion for successful AVF construction. In a study by Malvroh et al[19], mean radial artery diameter measured by US and surgery was 2.3 + 0.66 (range: 1.4 – 3.2) and 2.1+ 0.58 (range: 2.1-2.8) respectively. In our study the mean diameter of the radial artery in patients who were candidates for radio-cephalic fistula was 2.37 mm and that of brachial artery in patients with upper arm fistulas was 3.13 mm. The mean venous diameter for forearm fistulas was 2.69 and that of upper arm fistulas was 3.18

In the present study, four anatomical variations were detected by US. Two were of high brachial artery bifurcation and one cephalic vein duplication and one patient with hypoplasia of the cephalic vein at the arm.

With thorough knowledge of anatomical variations and clear depiction of the vascular anatomy as by US, there is substantial decrease in negative surgical exploration rates. Malvroh et al, [19] documented 0% negative surgical exploration rate. Another study by Allon *et al*. [6] showed 11% (28 of 256) negative surgical exploration rate. In the present study there was a single case i.e., Negative surgical exploration rate 2 %. This was attributed to the variations in venous branching around the cubital fossa region.

Schillinger *et al*., observed 50% stenosis or occlusion rate at the site of subclavian cannulation [21]. In the present study out of the 5 patients who had history of central venous access through the subclavian route, 4 (80%) had either complete or partial thrombus in the deep venous system precluding possibility of further fistula formations. This substantiates the routine use of US preoperative screening, as it might provide with indirect evidences of thrombosis, or even better it may provide direct visualization of the thrombus as was in our case. However as suggested by Schillinger et al the value of angiography in these cases cannot be over emphasized.

Of the 100 patients, 62 who had native upper limb AV fistulas were followed up at 7 days and 28 days.

Historic study on fistula maturation by Robbin *et al*. observed that a single US evaluation for minimum venous diameter and blood flow rate at 2–4 months can be used to accurately assess the likelihood of AVF maturation [22].

One would assume that a preoperative strategy to identify suitable vessels for AVF creation would naturally evolve into decreased early failure rates and an increased proportion of prevalent patients dialyzing with an AVF, but this may not always be the case. In a study by Patel et al, the implementation of preoperative Ultrasonography and angiography to aggressively increase AVF creation resulted in a greater number of AVFs, but had the unintended consequence of reducing the AVF maturation rate from 73% to 57%[23].

Table :4 Comparative data on Effect of Preoperative Vascular Mapping on Vascular Access Outcomes from various studies.

Author	Technique	AVF Creation rate	% of Usable AVF
Silva (1998) [18]	USS	14% (pre) to 63% (post)	8% (pre) to 64% (post)
Allon (2001) [6]	USS	34% (pre) to 64% (post)	16%(pre) to34% (post)
Huber (2002) [24]	USS + angiography	90%	71%
Patel (2003) [23]	PE + USS + angiography	61% (pre) to 73% (post)	73% (pre) to 57% (post)
Asif (2005) [25]	USS	77 %	All functional at follow-up

In our study at 4 weeks 42 out of the 62 fistulas (67.7%) were mature. However one should bear in mind that it is too early in course of natural history of fistulas to comment on its maturity. Hence follow up studies to access the long term functionality and failure rates are indicated.

Regarding postoperative complications, in our study 2 cases of post operative hematomas were noted, which were managed supportively.

There was a single case of thrombosis of the venous arm was reported in a patient with radio-cephalic fistula, which needed vascular surgical intervention.

CONCLUSION & RECOMMENDATIONS

- Pre-operative vascular ultrasonographic mapping is valuable in selecting potential sites for vascular access, helping in maximizing the native AVFs and decreasing the negative surgical exploration rates.
- US mapping deserves merit particularly when physical findings are inconclusive.
- In light of evidence suggesting high incidence of thrombosis following central venous access [21] it would be appropriate to evaluate these patients with angiography, though US in our study picked up these.
- Post operative follow up is of value when the status of fistula maturity is in doubt and when complications are clinically suspected.
- There is however uncertainty in the literature on, whether routine preoperative US is fruitful in

patients with positive physical examination[26], if increasing AVF creation translates to increase in maturation[6], if aggressive routine monitoring of a hemodialysis access, can predict or affect subsequent thrombosis or cumulative patency [27-29] and regarding the time scale cut-off beyond which interventions are warranted. Further studies in this regard are in place.

REFERENCES

1. Feldman HI, Kobrin S, Wasserstein A; Hemodialysis vascular access morbidity. J Am Soc Nephrol, 1996; 7: 523−535.
2. Hakim R, Himmelfarb J; Hemodialysis access failure: A call to action. Kidney Int, 1998; 54: 1029−1040
3. National Kidney Foundation: K/DOQI Clinical Practice Guidelines for Vascular Access.Am J Kidney Dis, 2000; 37(suppl 1):S137-S181, 2001.
4. Allon M, Robbin ML;Increasing arteriovenous fistulas in hemodialysis patients: Problems and solutions. Kidney Int, 2000; 62:1109-1124.
5. White GH;Planning and patient assessment for vascular access surgery. In Wilson SE. Vascular access: principles and practice. 3rd ed. St Louis, Mo: Mosby-Year Book, 1996; 6.
6. Allon M, Lockhart ME, Lilly RZ, Gallichio MH, Young CJ, Barker J, Deierhoi MH, Robbin ML; Effect of preoperative sonographic mapping on vascular access outcomes in hemodialysis patients. Kidney Int, 2001;60:2013- 20.
7. Miller PE, Tolwani A, Luscy CP, et al; Predictors of adequacy of arteriovenous fistulas in hemodialysis patients. Kidney Int, 1999; 56(1):275-280.
8. Palder SB, Kirkman RL, Whittemore AD, Hakim RM, Lazarus M, Tilney NL; Vascular access for hemodialysis: patency rates and results of revision. Ann Surg, 1985;202:235–239.
9. Won T, Jang JW, Lee S, Han JJ, Park YS, Ahn JH;Effects of intra operative blood flow on the early patency of radio-cephalic fistulas. Ann Vasc Surg, 2000; 14:468–472.
10. Beathard GA; Strategy for maximizing the use of arteriovenous fistulae. Semin Dial, 2000; 13:291–296.
11. Beathard GA, Settle SM, Shields MW;Salvage of the nonfunctioning arteriovenous fistula. Am J Kidney Dis, 1999; 33: 910−916.
12. Lockhart ME, Robbin ML; Hemodialysis access ultrasound. Ultrasound Q, 2001;17(3):157-167.
13. Kher V; End stage renal disease in developing countries. Kidney Int, 2002; 62: 350-362.
14. Modi GK, Jha V; The incidence of end-stage renal disease in India: A population-based study. International Society of Nephrology, 2006;70;2131-3.
15. Glover , Bendick P; Appropriate indications for venous duplex ultrasonic examinations. Surgery, 1996; 120(1):725-731.
16. Robbin ML, Lockhart ME; Ultrasound assessment before and after hemodialysis access. In: Zwiebel W, Pellerito J (eds). Introduction to Vascular Ultrasonography. Philadelphia, PA: Elsevier Saunders, 2005; 325–340.
17. Hodges TC, Fillinger MF, Zwolak RM ; Longitudinal comparison of dialysis access methods: Risk factors for failure. J Vasc Surg, 1997; 26: 1009−1019.
18. Silva MB Jr, Hobson RW 2nd, Pappas PJ, Jamil Z, Araki CT, Goldberg MC, Gwertzman G, Padberg FT Jr; A strategy for increasing use of autogenous hemodialysis access procedures: impact of preoperative noninvasive evaluation. J Vasc Surg, 1998;27:302-7. 80
19. Malovrh M;Native arteriovenous fistula: preoperative evaluation. Am J Kidney Dis, 2002;39(81):1218–1225.
20. Wells AC, Fernando B, Butler A; Selective use of Ultrasonographic vascular mapping in the assessment of patients before haemodialysis access surgery. Br J Surg, 2005;92:1439–1443.
21. Schillinger F, Schillinger D, Montagnac R, Milcent T; Post catheterization vein stenosis in haemodialysis: comparative angiographic study of 50 subclavian and 50 internal jugular accesses. Nephrol Dial Transplant, 1991; 6: 722–724
22. Robbin ML, Chamberlain NE, Lockhart ME; Hemodialysis arteriovenous fistula maturity: US evaluation. Radiology. 2002; 225(1):59-64.
23. Patel ST, Hughes J, Mills JL Sr;Failure of arteriovenous fistula maturation: an unintended consequence of exceeding dialysis outcome quality Initiative guidelines for hemodialysis access. J Vasc Surg, 200;38(3):439-45; discussion 445.
24. Huber TS, Ozaki CK, Flynn TC; Prospective validation of an algorithm to maximize native arteriovenous fistulae for chronic hemodialysis access. J Vasc Surg, 2002;36:452–459.
25. Asif A, Ravani P, Roy-Chaudhury P; Vascular mapping techniques: Advantages and disadvantages. J Nephrol, 2007;20:299–303.
26. Nursal TZ, Oguzkurt L, Tercan F, Torer N, Noyan T, Karakayali H, Haberal M;Is routine preoperative ultrasonographic mapping for arteriovenous fistula creation necessary in patients with favorable physical examination findings? Results of a randomized controlled trial. World J Surg, 2006; 30(6):1100-1107.

27. Dember LM, Holmberg EF, Kaufman JS;Value of static venous pressure for predicting arteriovenous graft thrombosis. Kidney Int, 2002; 61:1899–1904.
28. Dember LM, Holmberg EF, Kaufman JS; Randomized controlled trial of prophylactic repair of hemodialysis arteriovenous graft stenosis. Kidney Int,2004; 66:390–398.
29. Malik J, Slavikova M, Svobodova J, Tuka V;Regular ultrasonographic screening significantly prolongs patency of PTFE grafts. Kidney Int, 2005; 67:1554–1558.
30.

LIST OF ABBREVIATIONS

- ✓ AVF - Arteriovenous fistula
- ✓ CKD - Chronic kidney disease
- ✓ ESRD - End-stage renal disease
- ✓ HD – Haemodialysis
- ✓ mL/min- Millilitres per minute
- ✓ NKF-DOQI - National Kidney Foundation Dialysis Outcomes Quality Initiative
- ✓ PE - Physical examination
- ✓ PSV - Peak systolic velocity
- ✓ US - Ultrasound
- ✓ VA- Vascular access.