Vascular Access Cannulation and Care

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Preserving the AVF as the patient lifeline: reduced mortality with the AVF compare to catheter

Vascular Access Major Cause of Hospitalisation

Complications Associated to VA Cannulation

% of VA cannulations

- Thrombosis
- Hemorrhage
- Infections
- Aneurysm

Yürügen and Erdogan, J Vasc Access 2001; 2: 119-124 (Data from Master Thesis at Istanbul University)
Do we know how cannulation is performed in our centre or country?
Vascular Access Cannulation: Study Design

● **Objective:**
  Snapshot on the current practice of vascular access cannulation

● **Design:**
  International, multi-centre, observational, cross-sectional survey

● **Centres:**
  Dialysis centres of the Fresenius Medical Care network in Europe, Middle East, Africa, participation on *voluntary basis*

● **Procedures:**
  Anonymous documentation of vascular access and its cannulation once per patient (Patient Questionnaire) at appointed date (April ‘09)
Vascular Access Cannulation: Inclusion criteria

- Patients treated with haemodialysis or haemodiafiltration during the week the survey was performed
- Vascular access via native fistula or graft
- Double needle haemodialysis
- No catheter, no single needle haemodialysis
Vascular Access Cannulation: Participating Countries and Centres

10 countries / 171 centres / 10,807 patients

(Numbers: Centres/Patients by country)

+ South Africa
Results
Type of Vascular Access

- Fistula
- Graft
Location of Fistula

- Arm
- Left
- Right
- Distal
- Proximal

- Leg

- Missing/Not assessable
Cannulation Techniques

1. Rope ladder technique
2. Area technique
3. Buttonhole technique

- Rope ladder: 31.0%
- Buttonhole: 6.1%
- Other/missing: 1.8%
- Area: 61.0%
Needles & Cannulation Procedure

- Needle type: Sharp, Blunt
- Back-eye needle: Yes, No
- Needle rotation: Yes, No
- Bevel direction: Upward, Downward
- First needle: Arterial, Venous

Missing data
Direction of Arterial Needle

- 37% Retrograde
- 63% Antegrade
Needle Size

15 G: 61.5%
16 G: 33.3%
17 G: 1.7%
Others: 1.0%
14 G: 2.4%
Nurses’ Experience in Dialysis

- < 6 mos: 4%
- > 6-2 mos: 4%
- > 2-5 yrs: 19%
- > 1-2 yrs: 7%
- > 5 yrs: 66%
- < 6 mos: 4%

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Summary

● Vascular access management and cannulation are important issues in haemodialysis care.
● Some variability in cannulation practises exists between countries and centres.
● Observations of this survey provide a broad basis to further study the relation between vascular access practices and patient outcomes.
Prevention of access complications has high priority in dialysis therapy and various recommendations exist aiming at maintaining access patency for long term use.

However, in practice, techniques for AVF cannulation are known to vary from clinic to clinic, mainly because of historical training approaches in the individual settings.

Examples:

- Needle Gauge?
- Puncture technique: which one is the best?
- Bevel up or down?
- Retrograde or antegrade arterial needle puncture?
Cannulation technique vs VA survival: Aim of the Study

- To investigate the impact of needle gauge, cannulation technique, bevel direction, retrograde or antegrade needling, blood flow and venous pressure on the survival of the vascular access.
Cannulation technique vs VA survival: Patients and Methods

Based on the April 2009 survey conducted in 171 dialysis units located in Europe, Middle East and Africa (the results have already been published¹), a cohort of patients was selected for follow-up to investigate vascular access survival.

Primary outcome in our analysis was the **time of the first surgical access intervention** resulting in the creation of a new access, where survey date serves as baseline.

The observation period was 3 years (from April 2009 till March 2012).

To adjust for individual patient differences, the following information was extracted from the clinical database: **Patient age and gender, BMI, prevalence of diabetes and the use of ACE inhibitors, platelet anti-aggregants, salicylic acid and anticoagulants.** Additionally the median blood flow prescriptions was documented at centre level at the time of the survey.

Cannulation technique vs VA survival: Results #1

- Out of the 10,807 patients enrolled for the original survey, access survival data was available for 7,058 (65%) from Portugal, UK, Italy, Turkey, Romania, Slovenia, Poland and Spain.

- Mean age was 63.5±15.0 years; 38.5% were female; 27.1% were diabetics; 90.6% had a native fistula and 9.4% had a graft. Access location was distal for 51.2% of patients. During the follow-up, 51.1% were treated with anti-aggregants and 2.8% with anti-coagulant.

Cannulation technique vs VA survival: Results #2

• Prevalent needle sizes were 15 G and 16 G for 63.7% and 32.2% of the patients, respectively (14 G: 2.7%, 17 G: 1.4%).

• Cannulation technique was area for 65.8%, rope-ladder for 28.2% and buttonhole for 6% of patients, and the direction of arterial puncture was antegrade for 57.3%. The bevel direction was downward for 29.8% of the patients. The prevalent combination between arterial needle puncturing and bevel direction was antegrade with bevel upward (43.1%) followed by retrograde with bevel downward (27.1%). The proportion of the two other combination, antegrade and retrograde with bevel downward were 14.2% and 15.6% respectively.

• Median blood flow was 350-400 mL/min.

Needle size, blood flows and venous pressure levels

KM vascular access survival according to VP
Cox model with primary outcome vascular survival
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<th>Category</th>
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Cannulation technique vs VA survival: Summary

In summary, the study revealed that area cannulation technique, despite being the most commonly used, was inferior to both rope-ladder and buttonhole for the maintenance of Vascular Access functionality.

With regard to the effect of needle and bevel direction, the combination of antegrade position of arterial needle with bevel up or down was significantly associated with better access survival than retrograde positioning with bevel down.

Cannulation technique vs VA survival: Summary

Results referring to the type and location of access and the technical parameters (i.e. venous pressure) were as follows:

There was an increased risk of access failure for graft versus fistula, proximal vs distal location, right arm vs left arm, and the presence of a venous pressure greater than 150 mmHg.

The results on venous pressure are worth considering. A venous pressure of 200-250 mmHg is considered acceptable by the scientific community; the results of this study put these values under discussion. However, further investigations are required to clarify the topic fully.

Recommendations for the best cannulation practice
Physical examination of AVF/AVG:

LOOK

LISTEN

FEEL

Using our eyes, ears and fingertips, we assess AVF/AVG for complications.
INSPECT (observe and look for):

Oedema, redness, swelling, bruising, haematoma, rash or break in skin, bleeding, other exudate, aneurysm or pseudo-aneurysm
PALPATE (touch and feel):

Character of pulse, change in temperature, atypical warmth, tenderness
Direction of the flow, flow characteristics along the fistula (thrill versus pulse)

N.B. The thrill should feel like a continuous vibration, not a strong pulsation
Vascular Access Assessment and Preparation

Auscultate (Listen to the fistula):

Auscultation for bruit along the vein for the quality of the sound and its amplitude

N.B. The bruit – a whooshing sound – should be strong and continuous; each sound linked to the one before

In case of absence of bruit and/or thrill, DO NOT cannulate the AVF/AVG!
Preparation

Proper needle-site preparation by both the patient and staff reduces infection rates.

- Disinfect AVF site before needle insertion. Allow to air dry for 30–60 seconds.
- Start at the chosen cannulation site and move outwards in a circular rubbing motion that will carry bacteria away from the selected needle insertion site.
- Repeat skin preparation if the site is touched by the patient.
- If using the buttonhole cannulation technique, disinfect before and after scab removal.
Cannulation technique

• The rope-ladder technique should be the first choice. It provides almost the same results in terms of access survival as the buttonhole, and requires fewer pre-requisite to be successful.

• There are few exceptions which indicates the buttonhole cannulation as the absolute best option:
  ✓ when there is a limited area for cannulation sites,
  ✓ for the potential home dialysis patients candidate for self-cannulation.
Arterial needle direction

Antegrade: with the flow

Retrograde: against the flow

Both needles antegrade:
1. Easier for nurse to puncture
2. Easier for self-puncturing
3. May be fistula protective
Discussion: Antegrade puncturing may be fistula protective

- Increased risk of haematoma formation from retrograde filling
- Tract closure through flow force by antegrade puncture

From: Woodson & Shapiro: D&T: Feb/Mar. 1974, 29-30
Effect of bevel direction in the arterial needle position (antegrade/retrograde)

1. Bevel Up - Antegrade Puncture
2. Bevel Down - Retrograde Puncture

Bionic Medizintechnick GmbH
Haemostasis

To avoid bruising, compression is essential for good haemostasis. One finger should be positioned over the external insertion site (skin) and the second over the internal insertion site (vessel entry). Pressure should be sufficient to stop bleeding but not so great as to stop the flow of blood through the vascular access.
Patient education

• Educate patients to:
  • Look at VA arm to detect any abnormalities
  • Use a stethoscope if possible to check if there is a good blood flow through the VA; and teach them to recognise the ‘bruit’ sounds
  • Use palpation, to feel a rhythmic vibration/buzzing sensation (thrill) by putting their hand on the VA.
  • Importance of hygiene
Patient education

• Patients must be educated:
  • To recognise, prevent and report any signs and symptoms of infection, such as:
    * Redness
    * Fever
    * Swelling, warmth to touch
    * Pain
    * Exudate
  • Teach patients the importance of maintaining a constant temperature in the area of the VA:
    • Avoid excessive heat
    • Avoid excessive cold
1. Rope-ladder cannulation technique as preferred option and only when there is a limited area for cannulation sites, or for the potential self-care dialysis patients choose buttonhole

2. Insert arterial needle in the antegrade direction (blood flow direction) and with bevel direction downward for both needles

3. In the case of arterial needle retrograde position, the direction of the bevel should be upward

4. 15 G needles are recommended

5. Blood flow ≥350 ml/m

6. Venous pressure around 150 mmHg

7. Perform a correct haemostasis

8. Educate the patients to care for the VA
ÇOK TEŞEKKÜR EDERİM