Results: There was no significant difference in demographics, comorbidities, or type of access between the two groups. Overall access loss and revision were higher and statistically significant in group 1 vs. group 2 (Table 1). Access thrombosis was also significantly higher in group 1 vs. group 2 (Table 1). Graft failure was significantly higher in the first year compared to native fistula failure in both groups (n = 14 vs. 2; p value <0.001). Although not statistically significant, access infection tended to be higher in the first year compared to native fistula failure in both groups (n = 14 vs. 2; p = 0.03). Access thrombosis was more frequent in the first year of follow-up.

Discussion: Access surveillance has a greater impact on preventing graft loss vs. native fistula loss during the first year of follow-up.

Disclosure of Financial Relationships: nothing to disclose

PUB434

Deadlock in Hemodialysis Angioaccess (DHDDA) Thanh Cao Hiu, Cridlig Joelle, Michele Kessler, Luc Frimat. Nephrology, CHU Nancy, ??Vandoeuvre, France.

The authors reported observations of deadlock in hemodialysis angioaccess (DHDDA) of 15 patients with ARF and on hemodialysis with native fistulae since 59±18 years, treated by hemodialysis from 1982 to 2008, median primary graft patency was 14 days and median cumulative graft patency was 38 months. Co-morbidity as diabetic mellitus and obesity were noted in 8 patients, arteriopathy and cranioradial in 12, calciphylaxis and chronic inflammatory diseases in 4. Risk factors involved in DHDDA were: high incidence of central vein catheterism (CVC) (6±4 catheters per patient including 4±3 non-tunneled-catheters and 3±3 permanent tunneled catheters (PTC) (Canuda) per patient. Only 1 patient did receive 2 subclavian catheters before DHDDA situations. They received up to 11±6 surgical angioaccess failures including fistula, PTFE, or shunt. Only 3 patients received radio-vascular in forearm as the first angioaccess while 12 did receive proximal fistula or PTFE. Femoral accesses including catheters, PTFE and saphen vein bypasses were attempted in 9 patients. Stenoses of cave system-central veins occurred in most of the patients (stenoses of internal jugular vein in the first year compared to native fistula 10, femoral & iliac veins: 3). Than to Angioplastics, 11 permanent tunneled catheters were inserted and 6 new angioaccess operated. Without the need of angioplasty, 3 s/cavum PT catheters, 2 femoral vascular accesses and 1 brachial PTFE bypass were performed. These last angio-access comprised aggressive but still fragile solutions: 1 patient was to be transplanted in emergency, 7 still kept PT catheters, 7 could receive proximal Fistula or PTFE AA (including 2 ligations, 2 stenoses treated by angioplasties and 2 stenoses treated by PTFE bypass). Percutaneous dialysis were contraindicated or failed in all and transplant was possible in another patient. Hospitalisations were frequent, unpredictable and stressful. 4 patients died 1 to 6 months after the last AA. In conclusion, the situation of DHDDA in our 15 patients was the combination of numerous angioaccess failures and CV catheters & stenoses. Management of DHDDA are time consuming. Multi-disciplinary efforts and patience are needed.

Disclosure of Financial Relationships: nothing to disclose

PUB435

Percutaneous Trans-Lumbar (PTL) Dialysate Catheter Placement, Unto Superior Vena Cava (SVC), Guided by Computed Tomography, a Case Report Javier Castillo Tapia, 1 Alejandro Chavez, 1 Salvador Mendoza, Patricia Pehra, 1 Armando Avila, 1 Juan Rochin Teran, 2 Leticia Martinez, 1 Luis Evangelista Carrillo, 1 Abel Puentes Camacho, 1 Jorge Andrade-Sierra, 1 Leonardo Pazarin, 1 Mario Sandoval Sandoval, 1 Enrique Rojas-Campos, 2 Alfonso Patricio Peña, 1 Armando Avila, 2 Juan Rochin Teran, 2 Leticia Marquez, 1 Luis IMSS, Guadalajara, Jalisco, Mexico.

Introduction: In HD when common vascular accesses (VA) are unavailable it is necessary to consider other sites. The first Latin-American, PTL placement unto SVC, CT guided. Case. Female 28 yrs. ESRD (vesicoureteral reflux). 2 renal transplants (1992,1999), from LRD (father) and CD, lost for AR at 36 and 16 mo. HD since Feb-2002, 18 VA (6 malhurk, 4 PTFE, 4 arteriovenous, 3 native fistulas). Fistula: 127±86 months. Co-morbidity as diabetic mellitus and obesity were noted in 8 patients, acute phase C positive; cross-match positive (99%), PRA HLA C-I (100%) and C-II (100%). Female 28 yrs. ESRD (vesicoureteral reflux). 2 renal transplants (1992,1999), from LRD (father) and CD, lost for AR at 36 and 16 mo. HD since Feb-2002, 18 VA (6 malhurk, 4 PTFE, 4 arteriovenous, 3 native fistulas). Fistula: 127±86 months. Co-morbidity as diabetic mellitus and obesity were noted in 8 patients, acute phase C positive; cross-match positive (99%), PRA HLA C-I (100%) and C-II (100%). Last VA.

Disclosure of Financial Relationships: nothing to disclose

PUB437


Introduction: In spite of the National Kidney Foundation’s initiative to increase use of autogenous fistulas for vascular access, many patients continue to undergo hemodialysis with arteriovenous (AV) grafts. Clotted AV grafts are treated with endovascular or surgical thrombectomy. The outcomes of thrombectomies performed within 2 months of graft creation were assessed.

Methods: We retrospectively analyzed the outcomes of all AV grafts placed at our medical center over a 5 year period that required thrombectomy within 60 days of creation. Technical success was defined as the immediate restoration of graft patency. Primary patency was calculated from debut to first intervention and cumulative patency from debut to permanent graft failure. We also compared the outcomes for grafts undergoing thrombectomy at ≥30 days vs ≤30 days.

Results: Of 709 AV grafts placed, 98 grafts (14%) clotted within 60 days of creation and underwent percutaneous or surgical thrombectomy, including 63 (9%) within 30 days of graft creation, and 35 (5%) at 31-60 days after creation. Grafts clotting within 30 days of creation typically underwent surgical thrombectomy and those clotting after 30 days usually underwent percutaneous thrombectomy. The immediate technical success was 82%. The median primary graft failure was 14 days and median cumulative graft failure was 38 days.

Key: TH- Thursday; F- Friday; SA- Saturday; FC- Free Communication; PO- Poster Session; PUB- Publication Only

Underline represents presenting author/disclosure.