Short Communication

Percutaneous intervention for restoration of patency of occluded lower limb arteriovenous dialysis access


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ABSTRACT

Background: Arteriovenous (AV) fistula thrombosis is a serious complication in patients undergoing hemodialysis, often presenting with symptoms of venous hypertension, failure to dialyse and uremic symptoms. Treatment is aimed to provide symptomatic relief and to maintain hemodialysis access site patency.

Aim: To describe our initial experience in the endovascular treatment of lower limb AV dialysis access (AV fistula) thrombosis and/or obstruction in patients undergoing hemodialysis.

Settings and design: This was a retrospective study carried out in a tertiary care center. Study duration was 24 months. Follow-up was variable.

Materials and methods: Two patients with chronic kidney disease with stage 5 renal failure undergoing hemodialysis presented with lower limb arteriovenous dialysis access (arteriovenous fistula) failure between July 2014 and September 2016. Both the patients underwent endovascular treatment and were analyzed retrospectively.

Results and conclusion: Both the patient underwent successful endovascular treatment for the failure of the lower limb AV dialysis access thrombosis and/or obstruction. One patient had minimal dye extravasation during manipulation of the guide wire, which ceased spontaneously. On follow-up, both patients maintained patency of the dialysis access and are undergoing successful hemodialysis. One patient had a recurrence of the thrombosis of the fistula at 9th month of the follow-up. Endovascular treatment was tried but could not succeed. However, we found endovascular treatment safe and effective in treating AV fistula failures.

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1. Introduction

As the life expectancy of patients with end stage renal disease has improved dramatically in recent years, maintenance of patency of dialysis access has become a challenging task. Lower limb arteriovenous (AV) fistula is constructed as a last resort when upper limb fistulas are obstructed, hence it is very important and technically challenging to salvage this fistula once they are obstructed.

2. Materials and methods

This was a retrospective study approved by the departmental ethical committee. Informed written consent was obtained from both the patients. Two patients with occluded lower limb arteriovenous fistulas underwent endovascular treatment in the department of cardiology. Both the patients were on hemodialysis for chronic kidney disease (CKD) with stage 5 renal failure under the renal transplant surgery department of our institute. Mean duration of dialysis before the intervention was 2.5 years. Both the patients had autogenous AV fistula for dialysis access.

Indications for treatment were excessive swelling in the lower limb, decreasing flow during a dialysis session, and pronged bleeding after cannulation.

Both had a history of multiple AV fistula failures of both the upper limb. When patients presented to us they had symptoms of fluid overload and uremia and had skipped hemodialysis for two to three cycles. There was no bruit over the AV fistula. Their lab investigations revealed high serum creatinine and hyperkalemia. After a clinical diagnosis of access failure, patients were referred for angiography and possible intervention to our department. Immediate dialysis was undertaken through the placement of a
temporary dialysis catheter and taken for intervention. Pre-
procedure Doppler study of the AV fistulas was done in both the
cases to confirm the acute thrombosis in the outflow of the fistulas.
A preliminary diagnostic venography was performed. Location,
length, and extent of thrombosis/obstruction were assessed.
Endovascular interventions were performed in the same sitting.

The first case was a 31-year-old male on once weekly
maintenance dialysis who came with a history of persistent
vomiting, anasarca, and breathlessness of 2 days duration and not
able to undergo dialysis since 1 week. He had a saphenofemoral
loop AV fistula on the left lower limb. Left femoral artery puncture
was taken by an antegrade technique (Fig. 1) and 7 F arterial
sheath (Cordis) was inserted. Fistulography was done using a 6 F
Judkins right catheter (Cordis). It showed multiple stenoses in the
outflow venous loop (saphenous vein) with normal arterial inflow
segment (Fig. 2). A 0.014-inch floppy tip hydrophilic coronary
guide wire, Sion Blue (Asahi Intecc Co. Ltd.) was used to cross the
obstruction and wired through the entire venous loop of the fistula.
The entire loop with obstruction was sequentially dilated with
non-compliant balloons of size 2.5 × 10 millimeters (mm) Sprinter
Legend balloon (Medtronic, Inc.), 3 × 20 mm Pantera balloon
(Biotronic AG) and 4 × 12 mm Pantera Leo balloon (Biotronic AG)
respectively. Finally, the obstructed segment was serially dilated
with 5 × 25 mm non-compliant Prostar stent balloon (Vascular
Concepts) at high pressures of 16 ATM (Fig. 3). Post procedure
angiogram showed good opening of the proximal saphenous
venous loop (Fig. 4) with good distal outflow. The patient was
started back on hemodialysis on the same day from the left lower
limb saphenofemoral fistula with the good flow during the dialysis.

The second case was a 31-year-old female with CKD on
maintenance dialysis twice weekly with uremic symptoms from
the past 3 days. She had a saphenofemoral loop AV fistula on the
right lower limb. Left femoral arterial access was taken and 7 F
arterial sheath (Cordis) was inserted. Fistulography was done with
6 F Judkins right catheter (Cordis) after crossing over to the right
superficial femoral artery (Fig. 5). It showed complete occlusion of
the venous outflow with normal arterial inflow segment (Fig. 6).
The fistula was hooked with 3.5 F Judkins right (Cordis) catheter
and 0.35 inch Terumo J tipped wire was used to cross the
obstruction (Fig. 7). It was exchanged with 0.35-inch Amplatz
stiff wire (Cook International) with the help of Slipcath (Cook
International). The entire venous loop with the obstruction was
sequentially dilated with 5 × 20 mm Bard balloon (Bard Corp.) and
6 × 60 mm Admiral Balloon (Medtronic–Invatec) at 20 to 22 ATM.
(Figs. 8). Post procedure angiogram showed good opening of the
proximal saphenous venous loop with good distal outflow (Fig. 9).

Technical success was defined as a procedure without signifi-
cant residual stenosis or without complications. Technical failure
was defined as the inability to cross/dilate the lesion or significant

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Fig. 1. Diagram showing the Saphenofemoral loop arteriovenous fistula of left lower limb and the catheter course in the first patient. The black arrow indicates the catheter course. CIA—common iliac artery, IIA—internal iliac artery, EIA—external iliac artery, CFA—common femoral artery, SFA—superficial femoral artery, PFA—profunda femoral artery, SF Junction—saphenofemoral junction, AV—arteriovenous.

Fig. 2. Fistulogram with 6 F Judkins right catheter showing multiple stenoses in the outflow saphenous venous loop in the first patient.

Fig. 3. Fistulogram showing serial dilatation of the stenotic segments with the high-pressure noncompliant balloon in the first patient.
residual stenosis (>30%). A complication was defined as any event which is not routinely observed after the procedure, requiring treatment with endovascular or surgical intervention.

3. Results

Both the patients were on Dialysis with mean duration 2.5 years. The access site was saphenofemoral fistula in both the patients, one on the right side and the other on the left side with mean duration 9 months. Mean duration of fistula failure was 5 days.

Technical success was achieved in both cases. Both the patients underwent successful percutaneous angioplasty with balloon dilatation with no immediate complications observed. Both the patients underwent successful dialysis from the same fistula immediately.

Immediate complication observed was extravasation of dye to subcutaneous tissues during manipulation of the guide wire in the second patient. However, the fistula was crossed successfully and dilated with balloons. Post balloon dilations venograms showed a spontaneous cessation of the dye extravasation, which precluded any further intervention to stop bleeding.

At 6th month follow-up, both patients continued to have maintenance hemodialysis through the lower limb saphenofemoral fistula with no further complications.

However, the second patient presented with delayed complication, namely re-occlusion at 9th month with subsequent failure to undergo dialysis (Fig. 10). She was taken up for repeat intervention which failed possibly due to localized tear/dissection while negotiating the guidewire through the occluded segment (Fig. 11).

4. Discussion

In recent times survival of the patients with end stage renal disease has improved significantly. With this, there is a requirement for long term maintenance of patency of the dialysis access. According to some reports, only about 50% of all hemodialysis accesses remain patent for 3 years.1

Thrombosis is the most frequent complication of AV fistulas which results in loss of access for hemodialysis. Most episodes of thrombosis also coincide with the development of stenosis (in more than 85% of cases), which are generally located in the venous segment proximal to the arteriovenous anastomosis.2

Lower limb AV fistulas are constructed only as a last resort after exhausting of all upper limb options because it is surgically more complex, and higher chances of ischemic and infective. Saphenous or superficial femoral veins are commonly used venous outflow whereas arterial inflow is usually provided by either common femoral or superficial femoral arteries. The saphenous vein is mostly used either straight or in a loop fashion after ligating all its branches to make AV fistula.

In published series of saphenofemoral loop AV fistula by Pierre-Paul et al.,3 concluded a mean primary patency of 7 months, primary-assisted patency of 15 months and secondary patency of 16 months. The functionality of the access for dialysis was maintained in 71.4% of patients and almost all patients developed stenosis within the saphenous vein loop. According to available data suggest that saphenous vein grafts have higher complication rate and straight transposition of the vein has better outcomes compared with loop configuration.4 The superficial femoral vein has also been used as venous outflow, has higher patency rates but has higher ischemia complication.5

Our patients had a saphenofemoral AV fistula in a loop fashion and had an obstruction in the venous loop, which is the most common site of obstruction. Obstructed fistulas have been
traditionally corrected surgically but this minimizes future vascular access sites. Trans-catheter techniques have, in recent years, made it possible to treat these lesions percutaneously with more than 80% success rate and replaced surgical revision as the treatment of choice for failing or thrombosed fistulas and grafts. Although there has been no direct comparison between percutaneous transluminal angioplasty (PTA) and surgical revision, uncontrolled studies have reported a 95% success rate of PTA. The long term primary patency rates are 84% at 3 months, 57 to 67% at 6 months and 35 to 51% at 1 year. This success rate combined with superior convenience, lower chance of infection, sparing the patient's vein, less morbidity and enabling immediate dialysis without the need for a temporary central venous catheter has resulted in PTA being the treatment of choice for these lesions. Stenosis in the venous segments is extremely fibrous requiring very high-pressure dilation, sometimes requiring cutting balloon dilatation. Stenting is usually reserved only for severe recoil, perforations and surgically inaccessible sites only.

We did not try the local thrombolysis and thrombectomy. As the interventions were done after a mean duration of 5 days of the fistula failure, we assumed that the thrombus would be organized and may not yield to suction. Also, the chronic renal failure patients have a high risk of bleeding complications and thus we deferred the local thrombolysis. Studies with a larger number of patients are needed to determine if thrombectomy and local thrombolysis would be beneficial in such patients.

Our study had certain limitations. Firstly, it was a nonrandomized retrospective study. Secondly, the number of patients was very less. The lower limb AV fistulas are extremely rare and thus our encounter with them is very less. However, we have reported only our initial experience and further studies for longer time duration and with a larger sample size will be needed to assess
long-term outcomes in the Indian population. However, these procedures could be done at the cost of peripheral angioplasties, which are very much affordable to the patients already overburdened by the expenses of hemodialysis.

5. Conclusion

In recent times survival of the patients with end stage renal disease has improved significantly. With this, there is a requirement for long term maintenance of patent of the dialysis access. Though most common upper limb AV fistulas are constructed as the dialysis access, rarely we do encounter lower limb AV fistulas, especially when upper limb AV fistulas are exhausted. Lower limb AV fistulas have higher complications rates and obstructions may be frequently encountered. The endovascular treatment is an effective and safe method for treatment of occluded AV fistulas in patients undergoing hemodialysis. It has a high technical success rate without significant morbidity or mortality.

Source of finding

Nil.

Conflict of interest

Nil.

Acknowledgment

Nil.

References