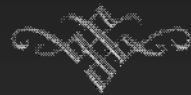


Bibliographie Récente

Ajaccio 2009



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Effectiveness of haemodialysis access with an autologous tissue-engineered vascular graft: a multicentre cohort study

Todd N McAllister, Marcin Moruszewski, Sergio A Garrido, Wojciech Wystrychowski, Nathalie Dusserre, Alicia Marini, Krzysztof Zagalski, Alejandro Fiorillo, Hernan Avila, Ximena Manglano, Jorge Antonelli, Alfred Kocher, Marian Zembala, Lech Cierpka, Luis M de la Fuente, Nicolas L'Heureux

www.thelancet.com Vol 373 April 25, 2009

Caractéristique de la population

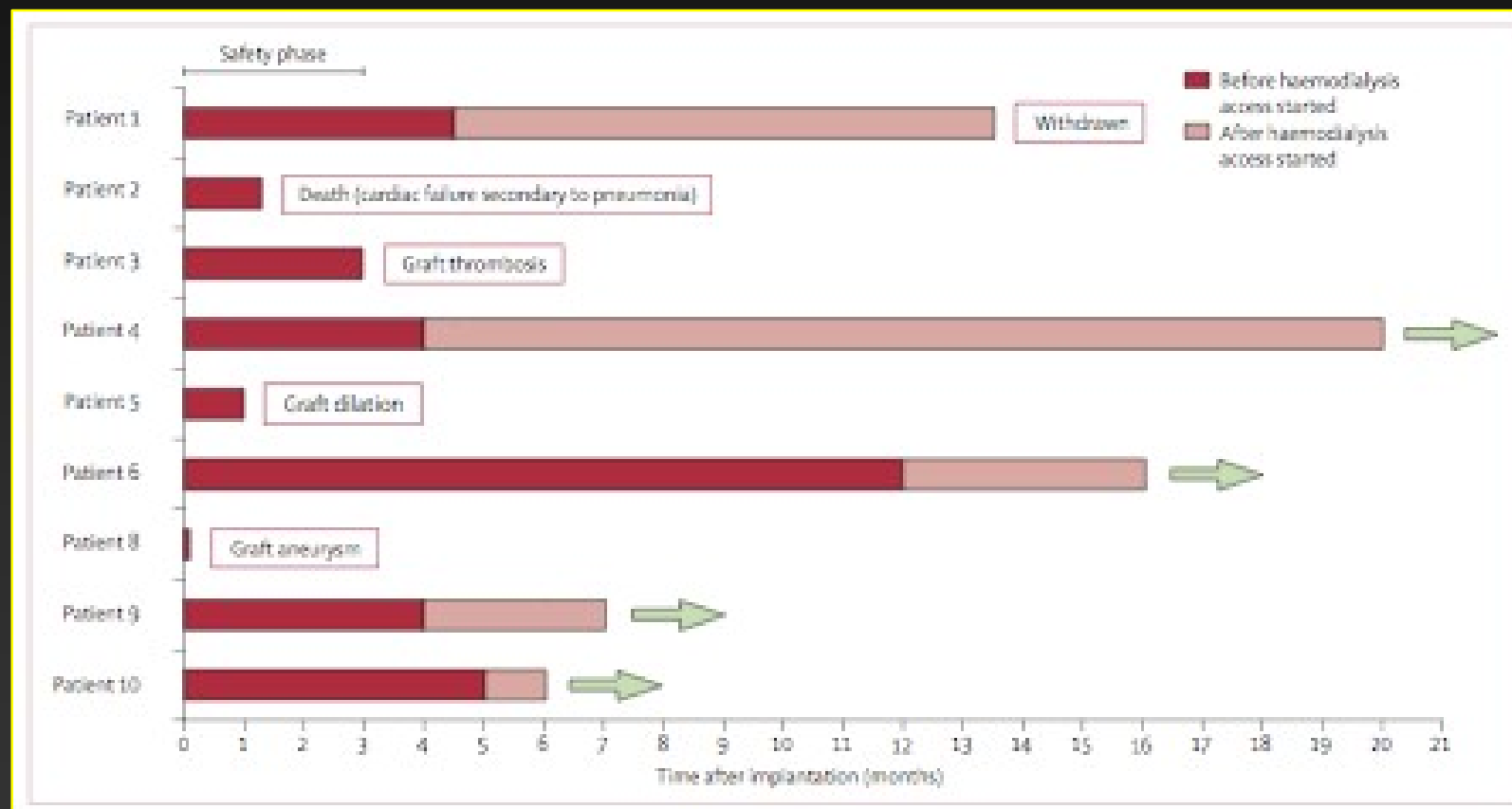


	Sex	Age (years)	Smoking history	Diabetes	Controlled hypertension*	Number of previous catheters	Number of previous grafts	Previous graft intervention	Duration of haemodialysis before study (months)	Haemodialysis access graft during safety phase (0-3 months)
Patient 1	Female	56	--	-	x	3	2	x	61	ePTFE
Patient 2	Male	61	Current	Type 2	x	1	1	x	15	Arteriovenous fistula
Patient 3	Female	68	--	-	x	1	1	x	63	Catheter
Patient 4	Male	77	--	-	x	2	1	x	32	Arteriovenous fistula
Patient 5	Male	29	--	-	x	4	3	x	16	ePTFE
Patient 6	Male	78	Previous	-	x	7	1	x	50	ePTFE
Patient 7	Male	89	--	-	x	1	1	x	Withdrawn	--
Patient 8	Female	62	Current	-	x	1	3	x	94	ePTFE
Patient 9	Female	58	--	-	x	1	3	--	26	ePTFE
Patient 10	Female	54	Current	Type 1	x	1	4	x	100	ePTFE

x denotes a positive result for the indicator. ePTFE=expanded polytetrafluoroethylene. *Diagnosed before enrolment into the study and kept in normal range with treatment.

Table: Demographic indicators of ten patients before implantation of the vascular graft

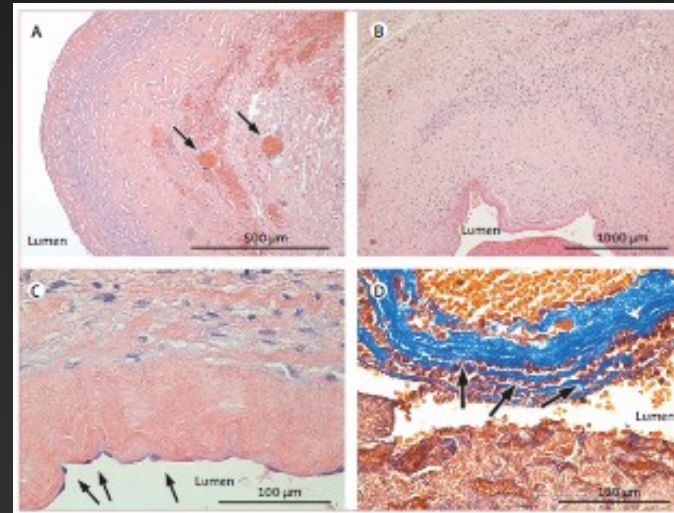
Résultats



Résultats

10 patients (9 implantations)

- obtention d'un vaisseau 6 à 9 mois
- 9 implantation
- 5 utilisables
- Faisabilité
- Nécessite de plus amples essais



Randomized clinical trial comparing decellularized bovine ureter with expanded polytetrafluoroethylene for vascular access

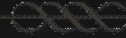
E. S. Chemla and M. Morsy

South West London, Surrey and Sussex Renal Transplant Unit, St George's Hospital, Blackshaw Road, London SW17 0QT, UK
Correspondence to: Mr E. S. Chemla (e-mail: eric.chemla@stgeorges.nhs.uk)

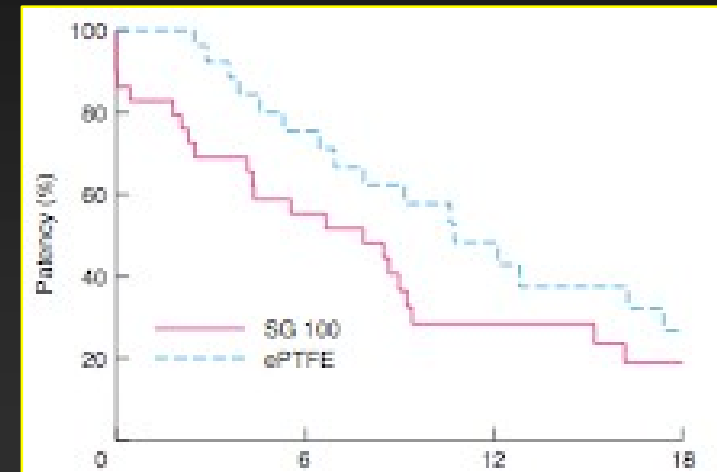
British Journal of Surgery 2009; 96: 34–39

Résultats

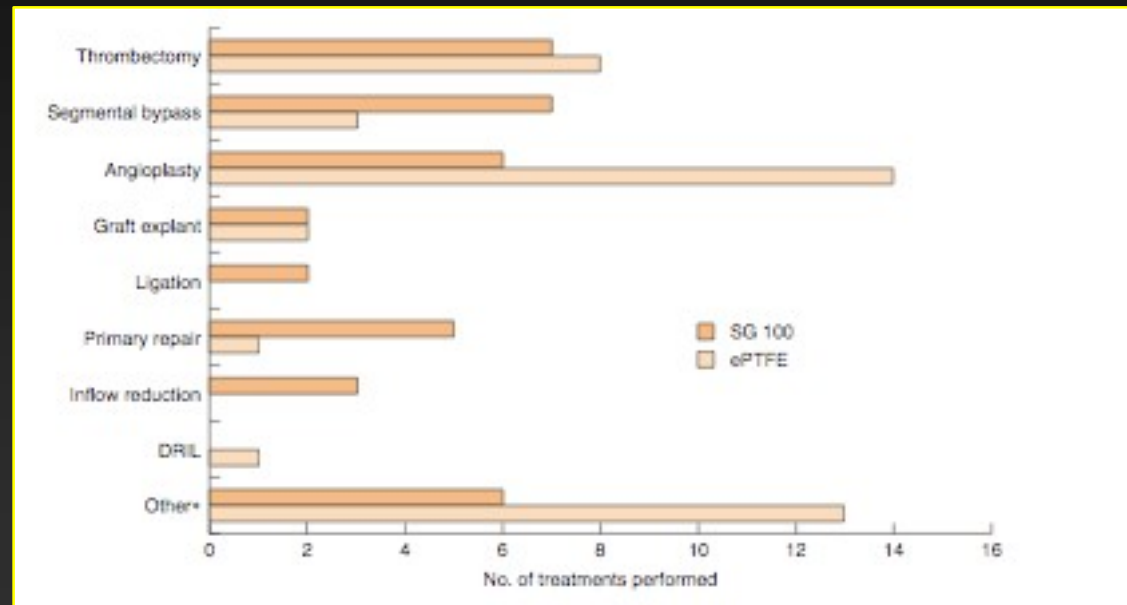
Synergraft 29pts/Ptfe 27pts



- A. Follow up
 - ü 469 jours
- B. Perméabilité primaire 1 an
 - ü Uretère 28%
 - ü Prothèse 48%
- C. Permeabilité primaire assistée 1an
 - ü Uretère 52%
 - ü Prothèse 64%
- D. 58 procédures
 - ü Afin de permettre la perméabilité
- E. Durée sans infection 1 an
 - ü Uretère 96%
 - ü Prothèse 91%



Conclusion

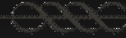


Haute thrombogénicité

Immunsation?

Le PTFE reste 1 premier choix

L'article de l'année 2008



The Society for Vascular Surgery: Clinical practice guidelines for the surgical placement and maintenance of arteriovenous hemodialysis access

Anton N. Sidawy, Lawrence M. Spergel, Anatole Besarab, Michael Allon, William C. Jennings, Frank T. Padberg Jr, M. Hassan Murad, Victor M. Montori, Ann M. O'Hare, Keith D. Calligaro, Robyn A. Macsata, Alan B. Lumsden, and Enrico Ascher

JOURNAL OF VASCULAR SURGERY
Volume 48, Number 5S

Critères d'évaluation

GRADE I
STRONG

GRADE II
WEAK

Table I. Conducting a systematic review

Define the question

- Specify inclusion and exclusion criteria
 - Population
 - Intervention or exposure
 - Outcome
 - Methodology
- Establish a priori hypotheses to explain heterogeneity
- Conduct literature search
- Decide on information sources: databases, experts, funding agencies, pharmaceutical, companies, hand-searching, personal files, registries, citation lists of retrieved articles
- Determine restrictions: time frame, unpublished data, language
- Identify titles and abstracts

Apply inclusion and exclusion criteria

- Apply inclusion and exclusion criteria to titles and abstracts
- Obtain full articles for eligible titles and abstracts
- Apply inclusion and exclusion criteria to full articles
- Select final eligible articles
- Assess agreement on study selection

Extract data

- Data abstraction: participants, interventions, comparison interventions, study design
- Results
- Methodologic quality
- Assess agreement on validity assessment

Conduct analysis

- Determine method for pooling of results
- Pool results (if appropriate)
- Decide on handling missing data
- Explore heterogeneity, sensitivity, and subgroup analysis
- Explore possibility of publications bias

Critères d'évaluation

EVIDENCE BASED

1. HIGH
2. MODERATE
3. LOW
4. VERY LOW

Table II. Grading of Recommendations Assessment, Development and Evaluation guidelines

<i>Rating of evidence quality</i>	<i>Clarity of risk/benefit</i>	<i>Description of supporting evidence</i>	<i>Implications</i>
Strong recommendations			
High-quality evidence	Benefits clearly outweigh harms and burdens, or vice versa	Consistent evidence from well-performed randomized controlled trials or exceptionally strong evidence from unbiased observational studies ^a	Recommendation can apply to most patients in most circumstances. Further research is very unlikely to change our confidence in the estimate of effect.
Moderate-quality evidence	Benefits clearly outweigh harms and burdens, or vice versa	Evidence from randomized controlled trials with important limitations (inconsistent results, methodologic flaws, indirect or imprecise evidence), or unusually strong evidence from unbiased observational studies	Recommendation can apply to most patients in most circumstances. Further research (if performed) is likely to have an impact on our confidence in the estimate of effect and may change the estimate.
Low-quality evidence	Benefits clearly outweigh harms and burdens, or vice versa	Evidence for at least one critical outcome from observational studies, from randomized controlled trials with serious flaws, or indirect evidence	Recommendation may change when higher quality evidence becomes available. Further research is very likely to have an important impact on our confidence in the estimate of effect and is likely to change the estimate.
Very low-quality evidence (very rarely applicable)	Benefits clearly outweigh harms and burdens, or vice versa	Evidence for at least one of the critical outcomes from unsystematic clinical observations or very indirect evidence	Recommendation may change when higher quality evidence becomes available; any estimate of effect for at least one critical outcome, is very uncertain.
Weak recommendations			
High-quality evidence	Benefits closely balanced with harms and burdens	Consistent evidence from well-performed randomized controlled trials or exceptionally strong evidence from unbiased observational studies.	The best action may differ depending on circumstances or patient or societal values. Further research is very unlikely to change our confidence in the estimate of effect.
Moderate-quality evidence	Benefits closely balanced with harms and burdens	Evidence from randomized controlled trials with important limitations (inconsistent results, methodologic flaws, indirect or imprecise evidence), or unusually strong evidence from unbiased observational studies	Alternative approaches likely to be better for some patients under some circumstances. Further research (if performed) is likely to have an important impact on our confidence in the estimate of effect and may change the estimate.
Low-quality evidence	Uncertainty in the estimates of benefits, harms, and burdens; benefits may be closely balanced with harms and burdens	Evidence for at least one critical outcome from observational studies, from randomized controlled trials with serious flaws, or indirect evidence	Other alternatives may be equally reasonable. Further research is very likely to have an important impact on our confidence in the estimate of effect and is likely to change the estimate.
Very low-quality evidence	Major uncertainty in the estimates of benefits, harms, and burdens; benefits may or may not be balanced with harms and burdens	Evidence for at least one critical outcome from unsystematic clinical observations or very indirect evidence.	Other alternatives may be equally reasonable. Any estimate of effect, for at least one critical outcome, is very uncertain.

Modified from Schulz et al.¹¹

^aExceptionally strong evidence from unbiased observational studies includes (1) evidence from studies that yield estimates of the treatment effect that are large and consistent and (2) evidence where all potential biases may be working to underestimate an apparent treatment effect, and therefore, the actual treatment effect is likely to be larger than that suggested by the study data, and (3) evidence where a dose-response gradient exists.

Recommandation N 1

Quand doit on programmer l'abord vasculaire ?

- We recommend that patients with advanced CKD disease (late stage 4, MDRD <20 to 25 mL/min) who have elected hemodialysis as their choice of renal replacement therapy be referred to an access surgeon in order to evaluate and plan construction of AV access

(GRADE 1 recommendation, very low-quality evidence).

Recommandation n° 1

selon le type d'accès

- TM A. If at the conclusion of the evaluation, upper extremity arterial and venous anatomy is adequate for an autogenous AV access, such access should be constructed as soon as possible to allow it enough time to mature and undergo further interventions that may be needed to ensure that the access is ready to be used when dialysis is initiated.
- TM B. If a prosthetic access is to be constructed, this should be delayed until just before the need for dialysis.

Recommandation n 2

stratégies opératoires

- A. Distale avant bras
- B. Autologue avant prothétique
- C. Bras non dominant, si les possibilités identiques
- D. Membre inférieur

A. AV accesses are placed as far distally in the upper extremity as possible to preserve proximal sites for future accesses.

B. When possible, autogenous AV accesses should be considered before prosthetic arteriovenous accesses are placed. These autogenous access configurations should include, in order of preference, the use of direct AV anastomosis, venous transpositions, and translocations.

C. Upper extremity access sites are used first, with the nondominant arm given preference over the dominant arm only when access opportunities are equal in both extremities.

D. Lower extremity and body wall access sites are used only after all upper extremity access sites have been exhausted.

(GRADE 1 recommendation, very low-quality evidence).

Recommandation n° 3

Premier choix pour la création d'un abord vasculaire

Autologue, avant bras

A. Radio-céphalique directe autologue, avant bras

B. Avant bras

First choice is forearm autogenous arteriovenous access
We recommend the placement of forearm autogenous arteriovenous access as the first choice for primary access for hemodialysis.

A. When arterial and venous anatomy is suitable, placement of autogenous radial–cephalic direct wrist access (Brescia-Cimino-Appel) or autogenous posterior radial branch–cephalic direct wrist access (snuffbox) is recommended.

B. In the case where arterial or venous anatomy does not allow placement of a direct access, forearm vein transposition or translocation are recommended. These procedures should use the maximal length of adequate vein and use arterial inflow from the forearm tailored to accommodate this length of vein.

(GRADE 1 recommendation, very low-quality evidence).

Recommandation n 4

En l'absence de possibilité autologue à l'avant bras

Choice of arteriovenous access when a patient is not a suitable candidate for forearm autogenous access.

For patients who have exhausted all forearm veins on both sides and, according to vein availability and surgical expertise, are suitable candidates for either forearm prosthetic access or upper arm access of any type, we suggest that the surgeon offer both alternatives to patients.

Grade II, VLQE

Recommandation n 5

le rôle de la surveillance

A. Surveillance clinique
ü Grade I, VLQE

A. Débit de pompe, PV
ü Grade II, VLQE

B. Echodop, fistulo
ü Grade II, VLQE

A. We recommend regular clinical monitoring (inspection, palpation, auscultation, and monitoring for prolonged bleeding after needle withdrawal) to detect access dysfunction (GRADE 1, very low-quality evidence).

B. We suggest access flow monitoring or static dialysis venous pressures for routine surveillance (GRADE 2, very low-quality evidence).

C. We suggest performing a Duplex ultrasound (DU) study or contrast imaging study in accesses that display clinical signs of dysfunction or abnormal routine surveillance (GRADE 2, very low-quality evidence).

Recommandation n° 6

Conversion prothèse avant bras en fav autologue

Conversion of a prosthetic AV access to a secondary autogenous AV access. We suggest that a plan and protocol for eventual conversion of forearm prosthetic access to a secondary autogenous AV access should be put in place at the presence of any sign of failing forearm prosthetic AV access, or after the first failure.

We suggest two strategies for transitioning suitable prosthetic AV access to secondary autogenous access before abandoning a functional prosthetic access:

- A. Conversion of the prosthetic access mature outflow vein to an autogenous access.**
- B. Identifying a new, remote site for autogenous access construction in a patient where the prosthetic access outflow vein is not deemed suitable.**

Grade II, VLQE

Recommandation n° 7

Prise en charge des dysfonctionnements



TM Management of nonfunctional or failed arteriovenous access.

TM We suggest open surgery, endovascular means, or a combination of both to maintain or restore patency in AV access.

Grade II, VLQE