

SPECIAL COMMUNICATION

Fistula First clarifies its message

Clifford M. Sales, MD, MBA,^a Rebecca J. Schmidt, DO,^b and FFBI Clinical Practice Workgroup,*
Summit, NJ; and Morgantown, WV

This material was prepared by the Mid-Atlantic Renal Coalition as part of the Fistula First Breakthrough Initiative Special Project, which is performed under contract HHSM-500-2006-NW005C, with the Centers for Medicare and Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. (J Vasc Surg 2010;52:1699.)

The goal of the Fistula First Breakthrough Initiative (FFBI) remains the reduction in morbidity and mortality associated with nonautogenous methods of hemodialysis (HD) access (catheters and arteriovenous grafts [AVGs]). The coalition seeks an autogenous access rate of 66% in prevalent HD patients. Early efforts of the FFBI addressed the benefits of autogenous access (arteriovenous fistulas [AVFs]) and the surgical techniques associated with optimal AVF creation. Concurrent efforts included education of stakeholders in the HD community on the importance of quality venous ultrasound (mapping) in the assessment of the patient in need of HD access.

The FFBI was successful in raising the prevalent fistula rate from 32.4% (May 2003) to 55.8% (June 2010) through its efforts. Concerns have surfaced, however, that emphasis on the fistula as the single best access choice has resulted in attempts to create AVFs in patients who might be better served with other means of dialysis access (AVG or catheter.) Consideration of a “fistula first” should be the rule for every patient and more complex AVFs may be achieved by experienced surgeons and teams dedicated to

vascular access formation. The initiative acknowledges, however, that a small segment of the population may not have the appropriate anatomy to support an AVF and may undergo AVF surgery that is unsuccessful. Venous mapping is required to identify this small group of patients for whom the “fistula only” approach may result in unsuccessful AVF creation. Indeed, these are the very patients in whom AVG placement may ultimately allow for secondary AVF placement, in addition to averting the need to provide access with a catheter.

Therefore, the original change concept No. 3 (<http://fistula.memberpath.com/Professionals/FFBIChangeConcepts.aspx>) “*Early referral to surgeon for ‘AVF only’ evaluation and timely placement*” is clarified as follows: Fistulas should be considered FIRST in all patients and clinical judgment applied when objective venous mapping documents anatomy unsuitable for creation of a functional AVF. In such cases, an AVG may be a more appropriate modality of HD access. Discussion among the nephrologist, surgeon, vascular technologist, and patient is key to producing the most positive outcome.

An important aspect of the FFBI has been to create a paradigm shift in the approach to HD access. As with the use of prosthetic conduits, which require a specific indication for below-the-knee reconstruction, the use of prosthetic material in creation of AV access requires justification, and an AVG placement should be considered *only* in patients in whom an AVF is anatomically precluded. In short, while the autogenous access remains the focus (“Fistula First”), avoidance of catheters (“Catheters Last”) is also important in the management of patients requiring renal replacement therapy.

Additional material for this article may be found online at www.jvascsurg.org.

From The Cardiovascular Care Group/Overlook Hospital;^a and Section of Nephrology, Department of Medicine, West Virginia University School of Medicine.^b

Competition of interest: none.

*Members of the Fistula First Work Group can be found in the Appendix (online only).

Reprint requests: Clifford M. Sales, MD, MBA, The Cardiovascular Care Group, 433 Central Avenue, Westfield, NJ 07090 (e-mail: csales@tcvcg.com).

The editors and reviewers of this article have no relevant financial relationships to disclose per the JVS policy that requires reviewers to decline review of any manuscript for which they may have a competition of interest.

0741-5214/\$36.00

Copyright © 2010 by the Society for Vascular Surgery.

doi:10.1016/j.jvs.2010.10.038

Appendix (online only). Fistula First Work Group

Lynda Ball, RN, MSN, CNN
Quality Improvement Director, Northwest Renal
Network
Seattle, Wash

Gerald A. Beathard, MD, PhD
Lifeline Vascular Access, Houston, Tex

Sue Cary, NP
Nephrology Department, Ochsner Health System
Baton Rouge, La

Danilo B. Concepcion, CCHT, CHT, CBNT
Operations Manager, St. Joseph Hospital Renal Service
Orange, Calif

Linda Duval, BSN, RN
Director, Quality Improvement, ESRD Network 13
Oklahoma City, Okla

Mary Fenderson, RN, CNN, MSHSA
Nephrology Nurse, FMQAI: The Florida ESRD
Network
Tampa, Fla

Richard S. Goldman, MD
Renal Medicine Associates, Clinical Associate Professor
of Medicine and Pediatrics, University of New Mexico
Health Sciences Center
Albuquerque, NM

Carol Lyden, RN, BSN, MS, CNN
Assistant Director of Quality Improvement and Patient
Services, IPRO ESRD Network of New York
Lake Success, NY

Peggy Lynch, BSN, RN, CNN

Network of New England, Medical Quality Manager
Woodbridge, Conn

Gordon McLennan, MD FSIR
Staff, Bioengineering & Imaging, Cleveland Clinic
Cleveland, Ohio

Klemens B. Meyer, MD
Division of Nephrology, Tufts Medical Center
Boston, Mass

Kimberly Mueller, MSSA, MSPH
Healthcare Analyst, HealthInsight
Salt Lake City, Utah

David Parlato, BA, RVT, FSVU
Director, Clinical Operations, Midwest Ultrasound Di-
vision, The Christ Hospital
Cincinnati Ohio

Clifford M. Sales, MD, MBA, FACS
The Cardiovascular Care Group/Overlook Hospital
Summit, NJ

Aimee Sanders, RN, BSN, CNN
Regional Quality Manager, Fresenius Medical Care,
Representing American Nephrology Nurses Association
BayMinette, Ala

Rebecca J. Schmidt, DO, FACP, FASN
Chief, Section of Nephrology, Department of Medi-
cine, West Virginia University School of Medicine
Morgantown, WV

Scott O. Trerotola, MD
Department of Radiology, University of Pennsylvania
Medical Center
Philadelphia, Pa