



Traitement Chirurgical des Sténoses : Quoi de Neuf?

Viviane Duédal, Paris.



Quelles Sténoses?

- Sténoses de la veine post-anastomotique
- Sténoses « hautes »



Réimplantation





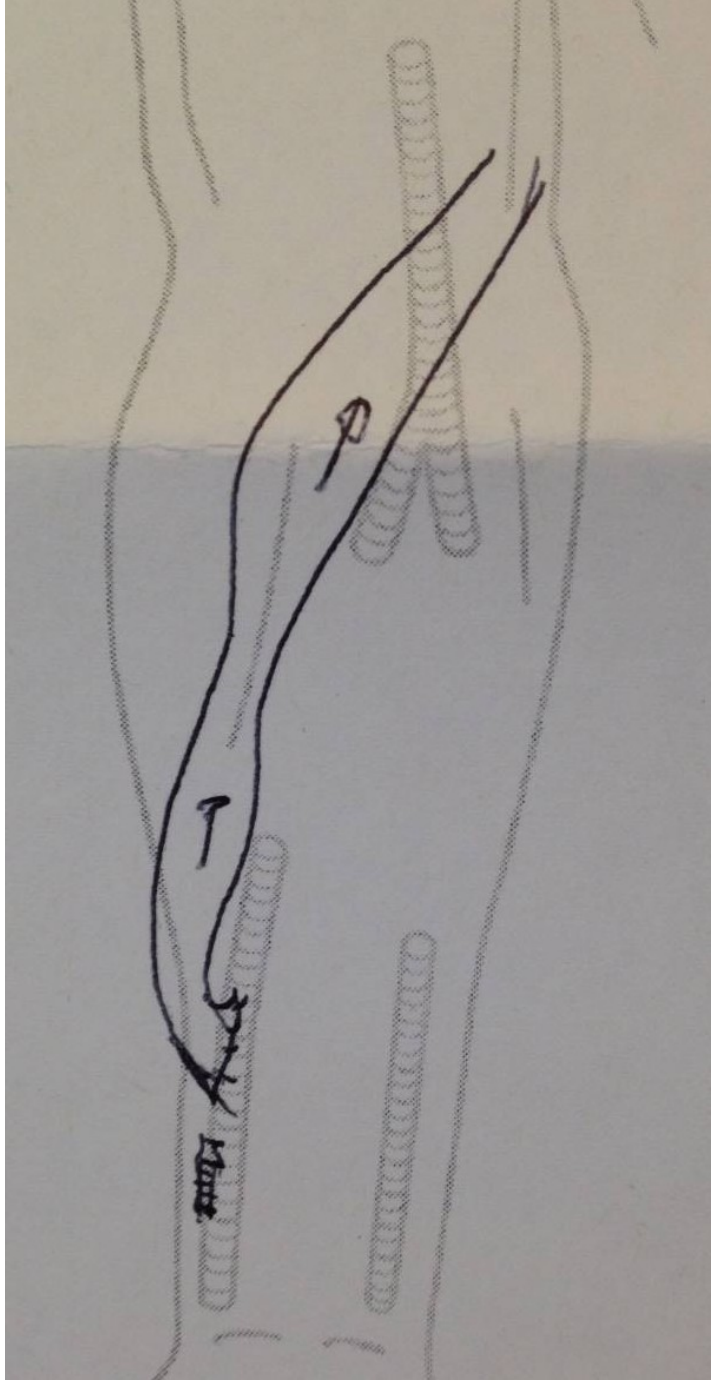
Réimplantation





Réimplantation







Réimplantation : Résultat à un an





Surgical versus endovascular management of thrombosed autogenous arteriovenous fistulae

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- Revue de la littérature de 1950 à 2013 :
130 articles concernant le traitement
des thromboses de FAV chez les
dialysés. 4 sélectionnés.

Table 1

Best evidence papers.

Author, date and country, study type (level of evidence)	Patient group	Outcomes	Key result	Comments
Tordior et al. [2] 2009 J. Vasc. Surg. The Netherlands Systematic review of non-randomised trials (Level 3 evidence)	36 studies investigating haemodialysis patients with autogenous AVF undergoing SM or EVM SM n = 6 EVM n = 30	Initial success rates (SM vs. EVM) One year patency rates (primary) (SM vs. EVM) Secondary patency rates (SM vs. EVM)	90% vs. 89% 74% vs. 40% 87% vs. 72%	No significant differences were found between the initial success rates of both SM and EVM. However, both one year patency rates (primary) and secondary patency rates were greater with SM. Limitations were the inclusion of only non-randomised studies and very small numbers of SM papers. Trials included were heterogeneous and of low quality and so could not be meta-analysed.
Kim et al. [3] 2011 Ther. Apher. Dial. Korea Retrospective cohort study (Level 3 evidence)	117 haemodialysis patients with autogenous AVF undergoing SM or EVM SM n = 87 EVM n = 30	Initial success rates (SM vs. EVM) Five year patency rates (post-interventional) (SM vs. EVM) Temporary dialysis catheter requirement (SM vs. EVM) Major complication rates (SM vs. EVM)	98.9% vs. 96.7% 89.9% vs. 96.7% 27.6% vs. 0%, p < 0.001 0% vs. 0%	No significant difference existed between success rates or major complication rates of SM and EVM. Five year patency rates (post-interventional) and temporary dialysis catheter requirements were both worse with SM. Methodological flaws included non-random treatment allocation and heterogeneous approaches to SM.
Hyun et al. [4] 2011 J. Korean Surg. Soc. Korea Retrospective cohort study (Level 4 evidence)	59 haemodialysis patients with autogenous AVF undergoing hybrid SM or EVM SM n = 40 EVM n = 19	Initial success rates (SM vs. EVM) Six month patency rates (primary) (SM vs. EVM) 12 month patency rates (primary) (SM vs. EVM) 24 month patency rates (primary) (SM vs. EVM) Procedure time (minutes) (SM vs. EVM) Mean hospital stay length (days) (SM vs. EVM) Complication rates (SM vs. EVM) Supply costs (Korean won) (SM vs. EVM) Total costs (Korean won) (SM vs. EVM)	92.5% vs. 68.4%, p = 0.005 85.9% vs. 36.8%, p < 0.001 81.1% vs. 26.3%, p < 0.001 81.1% vs. 21.1%, p < 0.001 108.1 ± 47.9 vs. 115.6 ± 63.5, p = 0.624 1 ± 2 vs. 2.3 ± 2.9, p = 0.058 17.5% vs. 15.8%, p = 0.870 3.75 × 10 ⁵ vs. 5.71 × 10 ⁵ , p = 0.065 1.56 × 10 ⁶ vs. 2.03 × 10 ⁶ , p = 0.019	Initial success rates, and six month, 12 month and 24 month patency rates (primary), and total costs were all significantly better with SM. Mean hospital stay length was shorter with SM. No significant difference was apparent between procedures times, complication rates or supply costs between SM and EVM. The study confounded by small sample size, non-randomisation and reliance on 'hybrid' SM.
Morosetti et al. [5] 2002 J. Vasc. Access. Italy Retrospective cohort study (Level 3 evidence)	54 thromboses in 475 haemodialysis patients with autogenous AVF undergoing SM or EVM SM n = 26 EVM n = 28	Initial success rates (SM vs. EVM) Six month patency rates (SM vs. EVM)	74% vs. 74.5% 88.5% vs. 73.5%	No significant differences in the initial success rates of SM or EVM were shown. Six month patency was greater for SM. Drawbacks included a low number of thromboses, non-random treatment allocation and retrospective data collection.

AVF = arteriovenous fistula, EVM = endovascular management, SM = surgical management.



Conclusions revue de la littérature

- Le succès primaire des procédures chirurgicales ou endovasculaires est équivalent (environ 90%).
- La perméabilité secondaire est meilleure pour les patients traités par chirurgie.
- Les patients traités par endovasculaire risquent moins le passage par KTC.
- Il manque une étude prospective randomisée pour préciser les indications des procédures.



Le traitement chirurgical est recommandé pour les FAV distales présentant une sténose post-anastomotique, sauf risque chirurgical particulier.



Pour des raisons anatomiques, les indications chirurgicales sont plus discutables pour les FAV proximales.



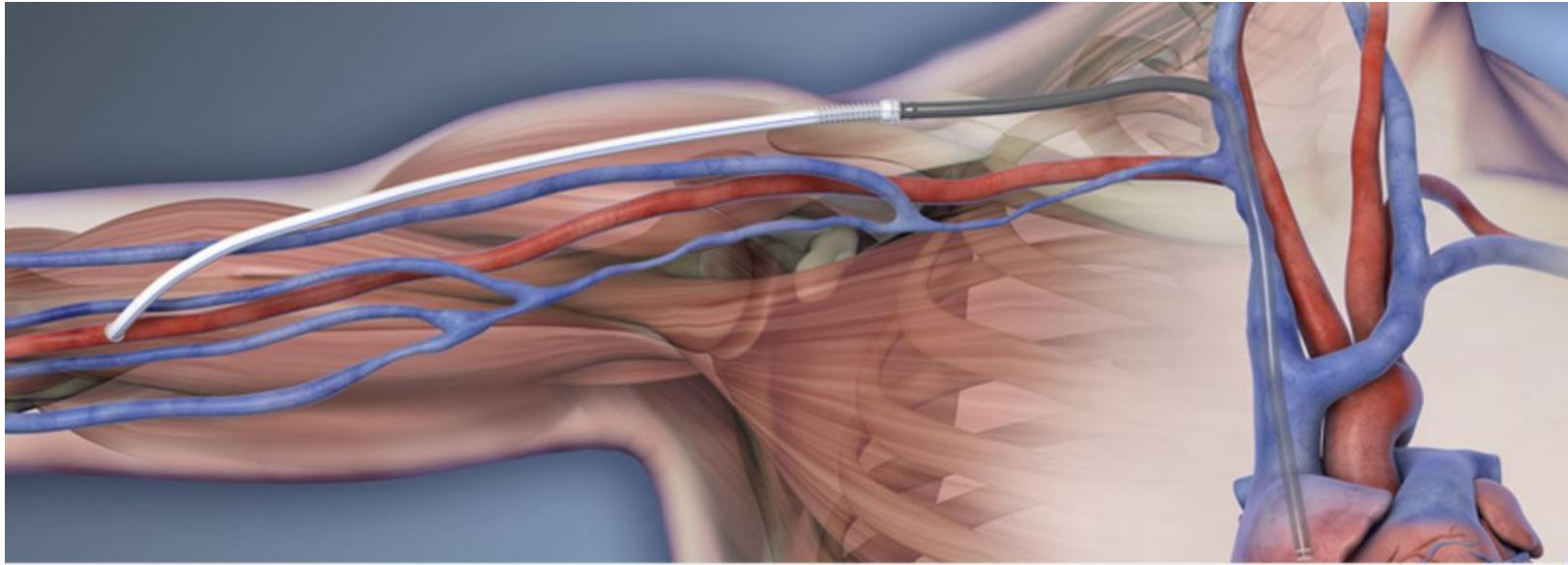
Toute sténose anastomotique ne nécessite pas un traitement.



Très peu d'indications chirurgicales pour les sténoses « hautes », vu les performances de l'endovasculaire.



Hero Graft





Hero Graft

- Catheter-dependent or approaching catheter-dependency
- Failing fistulas or grafts due to central venous stenosis

Fewer infections

69% reduced infection rate compared with catheters¹

Superior Dialysis Adequacy

1.7KtV, a 16% to 32% improvement compared with catheters¹

High Patency Rates

Up to 87% cumulative patency at 2 years^{1,2}

Cost Savings

A 23% average savings per year compared with catheters³

HeRO Graft Components

