

Hemodialysis Arteriovenous Fistula After Transplant To Keep or Not to Keep?

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IJKD 2012;6:159-65
www.ijkd.org

Most of patients with a well-functioning kidney allograft ask their physicians whether it is safe to preserve the dialysis vascular access or not, as it becomes useless after successful kidney transplantation. They certainly do not want to have a second fistula placed if that were the case. Arteriovenous fistula (AVF) for hemodialysis has its risks and can be expensive as well as being associated with considerable morbidity. There are several important complications for AVF including bleeding, infections, nerve injury, early AVF or graft failure, venous stenosis, steal syndrome, thrombosis, and aneurysmal formation.¹ Physicians working in kidney transplant centers commonly face the difficult task of advising recipients whether it is safe to keep the access or not. There is no consensus on the strategy for keeping or ligating the AVF. Dialysis access issues should always be at the forefront of thought for any patient with end-stage renal disease—without access, the disease wins.

Hemodialysis vascular access usually remains patent following kidney transplantation.^{2,3} Surgical closure of the AVF can be indicated in kidney transplant patients with heart failure, high-flow AVF, fistula complications, and cosmetic reasons. Arteriovenous fistula ligation decreases left ventricular volume and mass in a stable kidney transplant recipient.³ Thus, in kidney transplants with well-functioning allografts and persistent left ventricular dilatation, closing of the AVF could be considered.³ It is of interest that although a functioning AVF has adverse effects on cardiac morphology and function,⁴ surprisingly, few studies have reported the impact of AVF on cardiac function among these patients after transplantation. Furthermore, cardiac impact of the functioning asymptomatic AVF for hemodialysis in kidney transplant patients is unknown.⁴

In the current issue of the *Iranian Journal of Kidney Diseases*, Soleimani and colleagues⁵ have published a study on 180 kidney transplant patients which shows that spontaneous AVF closure had no significant cardiac beneficial effects.⁵ They reported that left ventricular ejection fraction was improved in the functional AVF and closed AVF groups after kidney transplantation. In the patients with a functioning fistula, however, the left ventricular end-systolic and end-diastolic diameters were slightly smaller, and there was a significant reduction in interventricular septum diameter and left ventricular posterior wall diameter in the closed fistula group. Improvement of cardiovascular parameters was observed in both groups with patent and closed AVF, which can be mainly due to correction of uremia, normalization of hemoglobin level, and improved volume status in these patients. It is obvious that kidney transplantation corrects uremia, volume status, and anemia, as well as normalizing serum albumin and reducing the inflammation, which might lead to reduction of left ventricular hypertrophy (LVH).^{6,7} Soleimani and colleagues⁵ concluded that AVF closure is not routinely indicated after successful kidney transplantation.

Although LVH as a result of a functioning AVF is a common finding in kidney transplants and high-output cardiac failure may be improved after surgical AVF closure in these patients,³ the beneficial impact on the associated high cardiac morbidity and mortality is unknown. In addition, operative removal of the fistula has improved heart failure in some hemodialysis patients⁸; hence, AVF ligation might be a therapeutic option for refractory heart failure in kidney transplant patients. Some studies have shown that leaving AVF is a high risk of cardiac events such as LVH,^{2,3,9} high-output heart failure,³ hypertension, and aortic stiffness.^{1,10} In multivariable

analysis, functioning of the AVF is independently associated with arterial stiffness intensification.¹⁰ In a prospective study on 20 patients with well-functioning kidney transplants, AVF ligation results in a decreased left ventricular mass and a decline in the left ventricular end-diastolic diameter.³ Furthermore, in another prospective study on 17 kidney transplants, a reduction in left ventricular diameter and left ventricular mass are observed after surgical removal of AVF.² On the contrary, other researchers demonstrate that AVF has no important adverse effects on the cardiovascular system in prolonged periods.^{9,11} In a prospective study on patients with stable kidney allograft function, no significant differences were seen in the left ventricular mass and volume changes between recipients with and without the persistence of a patent AVF.¹¹ In another prospective study on 24 recipients of well-functioning kidney transplants, a reduction in the left atrial diameter was observed in patients with a closed AVF, but there were no differences in cardiac structure or function in patients with and without a patent AVF.¹² Moreover, no differences were seen in the left ventricle, cardiac index, ejection fraction, and LVH between 39 kidney transplants with patent AVF and 22 patients with occluded AVF.⁹ However, it should be noted that the number of patients included in these controversial studies was relatively small. Thus, further studies with a larger of sample are required to define whether the AVF closure will have a protective role on cardiac events.

It is important to know that most high-output heart failures are related to high-flow AVF, especially in cases of preexisting heart disease.^{6,7} In addition, symptomatic heart failure related to AVF is infrequent and usually happens in patients with an underlying cardiovascular disease.¹³ Moreover, cardiovascular events are a leading cause of death and kidney allograft loss after kidney transplantation.¹⁴ In the short-term and the long-term periods, an improvement of LVH after surgical closure of AVF can be observed.^{2,15} Nonetheless, exacerbation of diastolic pressure and residual concentric remodeling hypertrophy may attenuate the expected advantageous cardiac effects.^{15,16} Vajdic and colleagues have shown in a historical cohort study on 311 kidney transplant recipients that patients with an AVF closure have a better allograft function at 1 year following

transplantation and a decreased risk for future allograft loss when compared to those having a functional AVF.¹⁴ This study indicates an additional argument in favor of AVF ligation among kidney transplant patients with well-functioning grafts.

Although AVF ligation following kidney transplantation may be valuable for both cardiac and kidney function, there is no consensus on routine ligation of fistula. In addition, despite the controversial findings, many clinicians do not recommend routine AVF closure for patients with functioning AVFs. In addition, the risk of graft loss should be considered, as it might eventually lead to creation of a new vascular access. Therefore, closure of the AVF should be restricted to those who definitely meet the criteria including presence of a large AVF with a high flow, persistent left ventricle dilatation, low probability of graft loss, cosmetic reasons, and a high risk of cardiovascular diseases.³ Because the increase in diastolic blood pressure after AVF ligation can occur,¹⁶ we strongly recommend that blood pressure be monitored after AVF closure.

CONFLICT OF INTEREST

None declared.

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Carotid Intima-Media Thickness as a Marker of Atherosclerosis in Hemodialysis Patients

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The intima-media thickness, also called intimal medial thickness, is a measurement of the thickness of the artery walls, used in ultrasonography studies, to detect the presence and to follow up progression of atherosclerotic plaques.^{1,2} Since 1990s, carotid intima-media thickness (CIMT) has been used in many medical research studies for evaluating the regression or progression of atherosclerotic cardiovascular diseases. Many studies have found the relation between the CIMT and the presence of atherosclerotic changes. This measurement is regarded as a marker of atherosclerosis and its following risks.^{1,2} In addition, several studies have shown that changes in CIMT during the years is a marker of progression of atherosclerotic diseases and a determinant of cardiovascular risk over time.³⁻⁵ Although several investigations show the prognostic value of CIMT for predicting atherosclerosis, there are also studies that dispute these findings. Observational studies show that

CIMT is a measurement of the intima and media layers, but changes in early phases of atherosclerotic process are in the intimal layer. Furthermore, there are some studies which revealed the weak correlation between CIMT and atherosclerosis of the coronary arteries.⁶

Patients with chronic kidney disease are at a high risk for developing the cardiovascular atherosclerotic disease, and CIMT is an independent predictor of cardiovascular mortality in hemodialysis patients.^{7,8} In the current issue of the *Iranian Journal of Kidney Diseases*, Nassiri and coworkers⁹ report the relationship between the maximum and the mean CIMT in 75 hemodialysis patients on maintenance hemodialysis for at least 3 months with different cardiovascular disease risk factors. They conclude that the effects of cardiovascular risk factors on the mean and maximum CIMT might be different in dialysis patients. They found that 22 of the 75 patients had carotid atheroma plaques. The mean