From a strategic point of view, we are surprised to read that a European team gives greater importance to prosthetic graft placement than autogenous fistula creation at the elbow when a forearm fistula fails or is deemed not feasible. Such an attitude opposes all the findings of the international literature. In Europe, Rodrigue published mean secondary patency rates ranging from 3.6 to 5.1 years for autogenous elbow fistulas compared to only 1 year for grafts [3]. The American DOQI guidelines emphasize that prosthetic grafts should be placed only when brachiocephalic fistulas cannot be created [4]. In addition, forearm graft placement invariably results in a stenosis of the venous anastomosis, with either the basilic vein or the cephalic vein at the elbow, and this means that these veins which are damaged by a more or less extensive stenosis might be then unusable for autogenous fistula creation. The authors are therefore not convincing and shoot themselves in the feet when they write that “therefore it seems vital to obtain autogenous fistulas in all dialysis patients”.

Conflict of interest statement. None declared.

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Reply

Sir,

We acknowledge the special experience and success rates of Turmel-Rodrigues in the field of radiological interventional treatment of vascular access complications. Until now, no-one has been able to equal his high percentage of successful treatment of failing or immature fistulas. In this observation lies the weakness of Turmel-Rodrigues’ opinions and statements. He reports from a single centre experience with patients that were referred from other hospitals for interventional treatment. In our series, a consecutive group of patients with new radiocephalic AVFs created by a single surgeon were prospectively followed with clinical examination and duplex scanning. On defined criteria, angiography and when stenoses were