VASBI Position Statement on delivery of dialysis access services in the COVID 19 Climate

February 2021

Introduction

The COVID 19 Pandemic continues to put huge pressures on the delivery of elective surgical programmes in many NHS Trusts across the UK. With limited operating room and ITU capacity, reduced theatre staffing numbers and understandable concerns around unnecessary risk of nosocomial COVID transmission to patients whilst undergoing routine surgery, many organisations have made the decision to halt all non-essential procedures. Although a number of Trusts have worked hard to maintain some cancer services and undertake other category 1 and 2 graded cases, many have struggled to develop adequate green pathways to manage the increasing back log of cases. In addition, some specialty areas, especially non cancer ones have been considered lower priority services with regards to finding operating capacity. Dialysis access programmes are one such area and significant numbers of access programmes have been halted or have had very limited access to theatre over the past 10 months to the point that waiting lists are growing and the renal standard of care is being compromised.

Renal Requirements when nearing Dialysis

Renal patients are far from 'routine' or 'elective' surgical patients and good quality dialysis can only really occur smoothly and efficiently if patients have good dialysis access in place in the form of an Arteriovenous Fistula (AVF), Arteriovenous Graft (AVG) or Peritoneal Dialysis (PD) catheter. Significant number of renal patients are peri-endstage and on the brink of needing to start dialysis. If planned surgical procedures to establish dialysis access do not occur for such patients then they crash land, consume inpatient bed days, require temporary, then tunnelled catheters and ultimately have a worse outcome longer term. In the current climate they are at greater risk during the enforced acute admission of contracting COVID which further worsens their outcome.

It takes a minimum of 8 weeks to create an AVF and see it mature to be ready for haemodialysis. PD Catheters and AV Grafts require around 2 weeks after insertion to be at a point of readiness for dialysis. This means it is imperative that such patients must get their required surgery in a timely fashion if acute 'crash lander' admissions are to be avoided.

Recommended Categorisation of Renal Patients nearing End-stage

With this in mind all units that provide dialysis access services should recognise that renal patients near to starting dialysis are high priority patients and we strongly recommend that 3 months from starting dialysis, a renal patient needing access surgery to ensure dialysis can occur is graded a category 2 surgical patient.

It is therefore imperative that organisations provide renal services with the required facilities and resources to be able to deliver dialysis access procedures for their category 2 patients.

Requirements for patients on established dialysis

It should also be noted that many patients currently on haemodialysis or peritoneal dialysis can run into difficulties with their dialysis access and require interventions in order to maintain the functional patency of the access. It is essential that pathways exist to enable such interventions to occur as failure to do so will see patients lose their dialysis access and then require an emergency admission which will further increase COVID risks in an already high-risk group.

To that end <u>any established dialysis patient requiring surgical or radiological interventions to their dialysis access to maintain functional patency are also category 2 patients.</u>

Recommended Category 2 Access Cases to undertake to enable dialysis to occur

- Creation of Simple Radiocephalic (R/C) and Brachiocephalic (B/C) AVF under either Local or Regional Anaesthesia as Day case procedures especially for patients 2-3 months from needing to start. This will maximise chance of a reasonably mature AVF in place

- Where simple R/C and B/C options not possible but a BrachioBasilic could be created, this should occur initially as a LA 1st stage creation as a day case procedure. Within 6 weeks of creation and if working, a transposition procedure should then occur.

- Where a simple AVF is not possible and the placement of an AVG if deemed the right access for the patient, this must be facilitated with appropriate list capacity approximately 4 weeks in advance of starting dialysis

- In centres with infrastructure and expertise, creation of an ENDO AVF in radiology 3 months in advancement of starting dialysis should be considered as this will alleviate theatre pressures.

- Fistula revision surgery to maintain dialysis access patency must occur on designated elective lists or an emergency.

- Fistuloplasty to continue to occur to ensure access works well and dialysis maintained

- Declotting procedures to ensure access works and maintained

- PD catheter insertion must be facilitated if patients need to start dialysis and PD is chosen modality. This should be at least 4 weeks before dialysis needed to allow peritoneum to heal. Should patients have hernias that require repairing at time of catheter placement this should also occur to ensure PD can occur without complications.

Much of this case mix can be done via day case pathways but some patients will require overnight stays given many of these patients are ASA 3. This will be the case with some AVG placements, PD insertions and surgical declotting / revision procedures.

Renal Surgical Cases that can remain non-essential category 3 / 4 at present

- Aneurysmal fistula ligation / removal in transplant recipients with good allograft function. This procedure is often for cosmetic reasons and therefore non-essential. The only exception would be severe steal and / or high output failure

- Routine Hernias repairs. Renal patients with incisional hernia over a transplant wound, inguinal or umbilical hernias that are asymptomatic and not interfering with dialysis can remain on hold. The exception would be hernias affecting ability to undertake peritoneal dialysis or those hernias that become incarcerated and symptomatic.

- Parathyroids unless a severe clinical urgency

- Polycystic nephrectomy

Dialysis Access services need to be provided with a minimum of weekly day case theatre list capacity for simple LA fistulas to be able to occur as these are category 2 cases. There should be the availability of anaesthetic cover for cases requiring regional or general anaesthesia. This should be via established green pathways and, if organisations do not have this option, innovative partnerships should be sought with Private Healthcare sector organisations, many of whom are very willing to support such programmes during the pandemic period.

Patients undergoing surgery should follow local Trust protocols with regards to pre-operative swab testing, isolation and PPE during surgery (relevant in Local anaesthetic procedures)

Dialysis access maintenance remains of paramount importance for all patients on dialysis and ongoing pathways for radiological procedures as well as access to surgical lists for revision / salvage surgery must be facilitated to minimise emergency admissions and acute bed stays.

Each Trust will have its own ways of developing pathways that enable surgical workload to occur and this document does not intend to make any suggestions around how to do that as what works for one organisation may not for another. What this document does however do, is set out very clearly the need to recognise that peri end-stage dialysis patients are category 2 patients and access creation must be facilitated within a timely fashion.

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