Endovascular Interventions of Juxtaanastomotic Stenoses and Thromboses of Hemodialysis Arteriovenous Fistulas: Some Overlooked Inaccuracies

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Editor:
In the January issue of the Journal of Vascular Interventional Radiology, Cohen et al (1) wrote that juxtaanastomotic stenoses that developed in lower forearm dialysis fistulas can be treated either by surgery or by percutaneous dilation. This is true. They also stated, however, that in an article published in 2006, Tessitore et al (2) “confirmed a comparable primary patency rate . . . between the two procedures.” This is not true.

Although Tessitore et al never mentioned “primary patency rates” in the main text, they clearly wrote that “the restenosis-free survival rates were significantly higher after surgery than after percutaneous transluminal angioplasty (PTA) (P = .036),” and Figure 2 of their article confirmed these significantly lower primary patency rates for PTA. It cannot be concluded that both approaches lead to “comparable primary patency rates.”

The other questionable point of the article by Cohen et al is that in the abstract and in the main text the authors report a 1-year primary patency rate of 64% after treatment of stenosed/thrombosed fistulas, which is higher than the 63% secondary patency rate at the same follow-up interval for the same group of fistulas. How do they explain this bizarre statistical result?

REFERENCES

Drs. Atar et al respond:
We appreciate the author’s interest in our report (1) and his valuable comments. Our article summarizing our data on the endovascular treatment of juxtaanastomotic stenoses/thromboses lesions reflects a paucity of reports comparing surgical with endovascular outcomes. Tessitore et al (2) compared the procedures and summarized their findings as follows, “This prospective comparative study confirms a higher restenosis rate after [percutaneous transluminal angioplasty] than surgery, but with strict surveillance for restenosis the two procedures show similar assisted primary patency.” Figure 3 in the article of Tessitore et al (2) summarizes the adjusted assisted primary patency rates, including initial procedure failures, and the graph shows similar curves between groups. Therefore, we think our comparison of our study (1) with the article of Tessitore et al (2) was justified, although “assisted primary patency rate” would have been a more accurate term to use.

Our 1-year primary and secondary patency rate results for occluded fistulas were 64% and 63%, respectively (1). We cannot argue with statistics; however, in the group of stenosed fistulas, the secondary 12-month patency rate was also 64%. We can assume that, when the occlusion had been treated, the fistulas behaved similarly to the stenosed fistulas, yielding the similar patency rates.

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None of the authors have identified a conflict of interest.
DOI: 10.1016/j.jvir.2010.09.026